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An Evaluation of UNAIDS Joint Programme Country Envelopes: 2018–2022

Country case studies

India

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BUF	Business Unusual Funds
CE	Country Envelope
Cosponsor	United Nations entities that cosponsor the Joint Programme against HIV/AIDS
COVID-19	Coronavirus Disease 2019
DSDM	Differentiated Service Delivery Model
GSACS	Gujarat State AIDS Control Society
HIV	Human Immunodeficiency Virus
ILO	International Labour Organization
Joint Team	United Nations Joint Team on HIV/AIDS
JPMS	Joint Programme Monitoring System
LGBT	Lesbian, Gay, Bisexual, Transgender
NACO	National AIDS Control Organization
NACP	National AIDS Control Programme
NHM	National Health Mission
PLHIV	People Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PWN+	Positive Women's Network
SDG	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
TB	Tuberculosis
UBRAF	Unified Budget Results and Accountability Framework
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UCO	UNAIDS Country Office
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
WFP	World Food Programme
WHO	World Health Organization

1 INTRODUCTION AND CONTEXT

1.1 Purpose and scope of the case study

This case study is part of a wider evaluation which aims to assess the relevance, coherence, efficiency, effectiveness, sustainability and results of the UNAIDS Country Envelopes (CE) over the years 2018-2022, with a view to improving UNAIDS programming and results achieved through the United Budget, Results and Accountability Framework (UBRAF) 2022-2026.

The scope of the evaluation is to:

- Assess the global and country allocation model to ensure CE funds are allocated to countries most in need.
- Assess the role of the CE funds in addressing priority gaps and needs in national responses.
- Assess the role of CEs in supporting more strategic and prioritised joint planning and coordination.
- Assess the efficiency and effectiveness of the CE funding mechanism including disbursements, implementation and reporting.
- Assess the results of CE funding, including the contribution to UBRAF outputs and higher-level results.
- Explore alternative allocation and disbursement models for joint funds including lessons learned.

Six countries were chosen for the case studies: Cote D'Ivoire, India, Iran, Kyrgyzstan, Andean Region (Peru/Ecuador/Bolivia) and Zambia. The case studies have been supplemented by document review and key informant interviews (KII) at the global and regional levels.

1.2 Approach, methods and limitations

The evaluation is theory-based and has involved the development of a Theory of Change (See Annex 8) that has served as an overall analytical framework for the evaluation. The Theory of Change outlines the relationships between the CE funding and interventions and how these are expected to bring about change and results for national responses. The Theory of Change also includes a forward-looking component through the use of Strategic Priority Outcomes of the new Strategy 2021-2026, the intention being to help identify existing gaps for the achievement of the new strategy and to inform future HIV programming recommendations. Ten evaluation questions, based on OECD DAC Evaluation Criteria[1] were identified refined and mapped to the Theory of Change.

The country case studies focus mainly on qualitative analysis of plans of the United Nations Joint Team on HIV/AIDS (Joint Team) and the implementation and results of CE-funded activities. Additionally, the case studies focus on eliciting lessons learned, factors helping or hindering the use and effectiveness of CE. This case study – in India - was conducted through document review, field visits and KIIs with staff of the UNAIDS Country Office (UCO) and Cosponsors, government ministries and Community based Organizations working with and providing HIV-related community services, private sector organizations working in fields where people are considered to be at risk to the infection, research institutes and academics and donors. As part of the study, the Consultant undertook a visit to Gujarat, the focus of most of the activities in the CE during 2018-2021. Visits were undertaken to field sites in three cities of Gujarat state namely, the capital Gandhinagar, Ahmedabad and Vadodara. In all, 14 key informant interviews, 5 group discussions and 6 field visits involving 216 individuals were conducted in June and July 2022, both face-to-face and using zoom due to the COVID-19 situation. Where possible, quantitative analysis has been undertaken of the

[1] https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

data provided by UNAIDS. A list of key informant interviews, group discussions and field visits is in Annex 1. A bibliography of documents reviewed is in Annex 2.

Due to the limited time available for the country study it was not possible to conduct an in-depth evaluation of each CE funded activity. The purpose of the country case studies was to collect country evidence to answer ten overarching evaluation questions (see Annex 9). The India country study has examined how the CE has contributed to relevance, coherence, efficiency, effectiveness and sustainability and results, while also purposively focusing on the strategic value of Gujarat as a focus state through a 'deeper dive'.

Meetings could not be held with national programme managers due to their busy schedule and with the representative of the WFP in Delhi. Limitations in terms of time meant that the Consultant could not visit all of the areas of work. Also, worth mentioning is, in spite every effort a meeting with the National Health Mission (NHM) responsible for maternal and child health in the state could not be arranged.

1.3 About this report

This report is organized into six sections. Section 2 briefly describes the national HIV context of India and its programmatic response. It covers the main issues facing the country and the financing available for the programme. Section 3 lays out the strategic orientation and programme approaches of the UNAIDS Joint Programme in India between 2018 and 2022, outlining the allocations received by Cosponsors under the programme. Section 4 uses data shared by UNAIDS, documents accessed and those shared by Cosponsors, and field visits to triangulate the observations made. It discusses the findings of the case study organized in three sub-sections: relevance and coherence, implementation, and results and sustainability. The box at the commencement of each sub-section summarises the discussion of findings that follows. Section 5 considers how closely the work of the Joint Programme has followed the Theory of Change and areas that might benefit from greater attention. Finally, Section 6 presents the conclusions that derive from the findings and provides recommendations for moving forward. Also presented is a 'deep dive' into the focus on the Joint Programme's work in Gujarat.

2 NATIONAL HIV CONTEXT AND PROGRAMME RESPONSE

2.1 Overview of the epidemic

The first case of HIV was detected in India in 1986. Three and a half decades later today, there are 2.4 million or so PLHIV in the country; of these, 70,000 children are below the age of 15 years. Despite dire warnings to the contrary, the prevalence of HIV in India has remained modest, growing to a peak of 0.54% in 2000-2001 to fall to the present-day 0.20%. But because of its large population base, India has the third largest number of cases in the world. There are approximately 63,000 new infections each year and approximately 42,000 AIDS-related deaths.[2] Overall India has recorded a declining trend in new cases, prevalence and AIDS-related deaths.

Concentration in high-risk groups continues to characterise the Indian epidemic. The highest prevalence rates are found among People who Inject Drugs (6.3%), with prevalence rates among Hijra/Transgender persons[3] (3.1%), Men who have Sex with Men (2.7%), Prison inmates (2.1%) and

[2] UNAIDS. 2022. Accessed on 17 Sep 2022 at https://www.unaids.org/en/regionscountries/countries/india.

[3] Hijra are born as biological/anatomical males who reject their 'masculine' identity and identify either as women, or not-men, or in-between man and woman, or as neither man nor woman.

Female Sex Workers (1.6%) also being significant.[4] States of India with the highest prevalence rate are Mizoram, Nagaland and Manipur in India's north-east where the infection is particularly prevalent among drug users, followed by Andhra Pradesh, Meghalaya, Telangana, Karnataka, Delhi, Maharashtra, Puducherry, Punjab, Goa and Tamil Nadu.[5]

Diffusion into the general population has remained low (0.24%). Slightly elevated prevalence has been recorded among antenatal women in the HIV Sentinel Surveillance study of 2019, particularly among the poor and illiterate, those living in the states of Nagaland, Mizoram, Tripura, Manipur and Meghalaya and among spouses of migrants and truck drivers/helpers.[6] In all, 144 priority districts have been identified in the country with a prevalence of over 1% or more than 5,000 People Living with HIV/AIDS (PLHIV). These districts have approximately 63% of PLHIV, 49% of new HIV infections and 55% of the Prevention of Mother-To-Child transmission (PMTCT) needs.

2.2 National HIV policy and programmatic response

The National AIDS Control Programme (NACP) is implemented by the National AIDS Control Organization (NACO), Ministry of Health and Family Welfare. The programme is credited with significantly slowing the epidemic in India and is expected to help India reach its aim to end HIV/AIDS as a public health threat by 2030. Having completed four phases since it began in 1992, NACP has evolved into one of the world's largest HIV/AIDS programmes and is now in its fifth phase.
NACP aims to ensure that 99.5% of the population remains HIV free. To this end, it is undertaking prevention, detection and treatment services in facility and community settings for high-risk, vulnerable and other 'at-risk' populations and PLHIV. Recent initiatives that are expected to play a crucial role in its success are the HIV/AIDS Prevention and Control Act (2017), Test and Treat Policy, Universal Viral Load Testing, Mission Sampark, Community-Based Screening and transition to Dolutegravir-based Treatment Regimen.

The specific objectives of the NACP Phase-V are as below[7]:

- 95% of people who are most at risk of acquiring HIV infection use comprehensive prevention.
- 95% of HIV positive know their status, 95% of those who know their status are on treatment and 95% of those who are on treatment have suppressed viral load.
- 95% of pregnant and breastfeeding Women Living with HIV (WLHIV) have suppressed viral load towards attainment of elimination of vertical transmission of HIV.
- Less than 10% of PLHIV and key populations experience stigma and discrimination.

India's performance on the 90-90-90 goals has been just short of the targets with 78% out of estimated PLHIV aware of their HIV status, 83% on ART and 85% virally suppressed. Phase-V aims to reduce annual new HIV infections and AIDS-related mortalities by 80% by 2025-26 from the baseline values of 2010. It aims to attain elimination of vertical transmission and elimination of HIV/AIDS related stigma.

NACP Phase-V strengthens a community-led system on the decentralized model of district-level programme monitoring and community feedback loop. The programme promotes equity and inclusiveness by protecting and securing the human rights of people infected and affected by HIV. The programme integrates appropriate gender sensitive HIV/AIDS services and improves programme

[4] Ministry of Health and Family Welfare, National AIDS Control Organisation. 2021. Sankalak Status of the National AIDS Response. 3rd Ed.
[5] Ministry of Health and Family Welfare, National AIDS Control Organisation. 2021. Sankalak Status of the National AIDS Response. 3rd Ed.
[6] http://naco.gov.in/sites/default/files/ANC%20Report_9th%20June_Highress%20for%20web%20%282%29.pdf
[7] Ministry of Health and Family Welfare, National AIDS Control Organisation. 2022. Strategy Document National AIDS and STD Control Programme Phase-V (2021-2026)

responsiveness to the needs of women living with HIV, young and adolescent girls, vulnerable women and transgender people.

NACO has formalized partnerships with 18 key Ministries & Departments of Government of India to strengthen the multi-sectoral response to HIV.[8] In the health sector, it is consolidating convergence with the NHM responsible for maternal and child health care; National TB Elimination Programme through HIV-TB cross-referrals and single window delivery of TB and HIV services; with the National Viral Hepatitis Surveillance Programme for evidence generation with the integration of Hepatitis B and Hepatitis C as an additional biomarker; and with the National Mental Health Programme through technology-enabled approaches to link beneficiaries to services. It proposes to engage corporates and professional medical associations to mainstream the HIV prevention-testing-treatment services. NACO works with the Ministry of Social Justice and Empowerment to extend the coverage of de-addiction centres and social protection schemes to eligible high-risk groups, bridge populations as well as PLHIV.

2.3 National response challenges and priority areas/gaps that need addressing

Several challenges have been identified for the NACP over the years. Many have to do with the federal structure of the country and the fact that health provisioning is a state subject. Some of these have been circumvented through the 'State AIDS Control Society' model although the model is not without its own administrative problems. However, the issue of inadequate state funding of the general health systems remains.

Areas of concern[9] [10] with respect to testing are related to coverage of targeted Interventions, gaps in detection, linkage losses and access to the full range of prevention services and linked laboratory services. Difficult-to-reach groups are increasingly using virtual platforms – an area in which it has been challenging to intervene. Population groups that must be reached include prison inmates, vulnerable youth, adolescents and pregnant women.

Areas of the treatment and care segment of the care cascade that require further attention include linkage losses from Integrated Counselling and Testing Centres, Differentiated Service Delivery Models (DSDM), PMTCT, viral load testing, provision of antiretroviral (ARV) drugs, adoption of new treatment guidelines and suboptimal use of the link Antiretroviral Therapy (ART) centres. Quality of care and gaps in the retention cascade make treatment and care patchy. Mainstreaming of the care of general health needs of this population to the health system continues to remain problematic. Stigma and discrimination have shown improvement but still remain a matter of concern.

Finally, there are broader organizational issues such as a high attrition rate of staff, need for increased training capacity and improved supervision capacity. Other areas are engagement with the private sector and more and better operational research. Communication needs to be improved, especially for those in the general population and use of blood components enhanced. Supply chain management and a coherent IT system are critical to improved programme outcomes.

[8] Convergence Plan between NACP and DOHFW. Accessed on 17 Jul 2022 at https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1079&lid=150

[9] Priority Areas for HIV Programme (April 2021 – March 2024) Accessed on 15 Jul 2022 at https://main.mohfw.gov.in/sites/default/files/Program%20priority%20Areas%20for%20EOI.pdf

[10] Ministry of Health and Family Welfare, National AIDS Control Organisation. 2022. Strategy Document National AIDS and STD Control Programme Phase-V (2021-2026)

2.4 Financing of the national response

NACP Phase-V is a central sector scheme, fully funded by the Government of India, with an outlay of ~US$ 1 940 million for a period of 5 years from 1st April 2021 to 31st March 2026. It is predominantly (~ 93%) supported through the domestic budget.

The outlay for NACP Phase-V includes ~US$ 90 million (~4.5%) from the current grant cycle (April 2021 to March 2024) of the Global Fund. All other funders make up the remaining 2.5% of the funding for the programme, with the largest being the US Government. No gap in financing has been identified.

3 UNAIDS JOINT PROGRAMME STRATEGIC ORIENTATION AND PROGRAMME APPROACHES

3.1 Joint Programme and Joint Plans

The Joint Team brings together and coordinates the efforts of the UN against the HIV epidemic. The Joint Team has made valuable contributions in responding to the epidemic, both through its own interventions as well as through the support it has provided to the government of India and its state governments. But in recent years, budget and capacity cuts have led to closure or mainstreaming of the HIV work of the Cosponsors, weakening the visibility and prioritization of HIV in the Joint Programme.

The implementation of the 2022-2026 UNAIDS UBRAF (programme of work) relies on core resources mobilised by the UNAIDS Secretariat for the Joint Programme, as well as funding from Cosponsors' regular and extra-budgetary resources. Funding from the core UBRAF to support the work of Cosponsors including the implementation of the Joint Plan of the Joint UN Team on HIV/AIDS is in the form of CE funding. CE funding was first introduced in the 2018-2019 biennium to address three overarching objectives:

- To deploy human and financial resources where they are needed most.
- To reinvigorate country-level joint work and collaborative action.
- To reinforce accountability and results.

India receives a CE of approximately US$ 2 million per biennium. The UCO in India welcomed the CE, seeing even this amount as having the potential to put HIV back more widely on the UN agenda. Business Unusual Funds (BUF) were received in 2019 and 2020 in addition to the CE funds. CE funds available for HIV programming were supplemented in 2018 and 2020 by Cosponsors – more so in 2018. No funds other than the CE have been received since then (see Table 1). The financial data presented below was provided to the evaluation team by the UNAIDS finance department.

Table 1: Funds allocation (2018-2023) in US$

YEAR	CE	BUF	OTHER SOURCES	TOTAL
2018	793,050		513,176	1,306,226
2019	1,000,000	104,999		1,104,999
2020	1,001,312	104,999	238,075	1,344,386
2021	991,017			991,017
2022	954,000			954,000
2023	84,966			84,966
Total	**4,824,345**	**209,998**	**751,251**	**5,785,594**

The Cosponsors in the Joint Team in India are: ILO, UNDP, UNESCO, UNFPA, UNICEF, UNODC, UN Women, WFP, WHO, the World Bank. Allocations under the CE were made to most Cosponsors in

each year except the WFP – which was allocated funds only in 2021 and 2022, and UN Women – only in 2022 and 2023. The World Bank did not receive any funds under the CE but reported results in 2018 and 2020 against the Joint Plan of the Joint Team.[11]

The process of awarding funds under the CE is based on a system of solicitation of proposals for the biennium from Cosponsors, with a rough allocation indicated for each. Proposals received are discussed between the UCO and the Cosponsor to finalise the allocation. While funds were allocated for one year each of the 2018-19 biennium, this has changed since the 2022-2023 biennium with funds being allocated for two years.

In all, 306 activities were planned by the Cosponsors in 2018-2019, 2020-2021 and 2022-2023. The largest numbers were by far by UNICEF (62). WFP (7) and UN Women (15) have understandably the fewest since they did not participate each year. The largest share of the CE was allocated to UNDP, UNICEF and WHO between 2018- 2021. Their overall absorption rates for the period were respectively, 76%, 89% and 88%. UNFPA received a modest amount but had an absorption rate of 99%. WFP was only able to expend 14% of the funds allocated during the period.

Table 2: Allocation, expenditure and absorption data per Cosponsor (2018-2019, 2020-2021) in US$

COSPONSOR	ALLOCATION 2018 & 2019	EXPENDITURE 2018 & 2019	ABSORPTION 2018 & 2019	ALLOCATION 2020 & 2021	EXPENDITURE 2020 & 2021	ABSORPTION 2020 & 2021
ILO	200,000	153,615	77%	219,300	190,353	87%
UNDP	240,000	249,299	104%	585,400	379,844	65%
UNESCO	200,000	157,963	79%	220,900	163,072	74%
UNFPA	220,000	197,609	90%	239,800	257,815	108%
UNICEF	460,000	381,084	83%	320,000	309,798	97%
UNODC	300,000	219,796	73%	233,600	180,766	77%
UN Women						
WFP				34,000	4,815	14%
WHO	380,000	300,886	79%	310,000	308,574	100%
World Bank						
Total	**2,000,000**	**1,669,252**	**83%**	**2,163,000**	**1,795,037**	**83%**

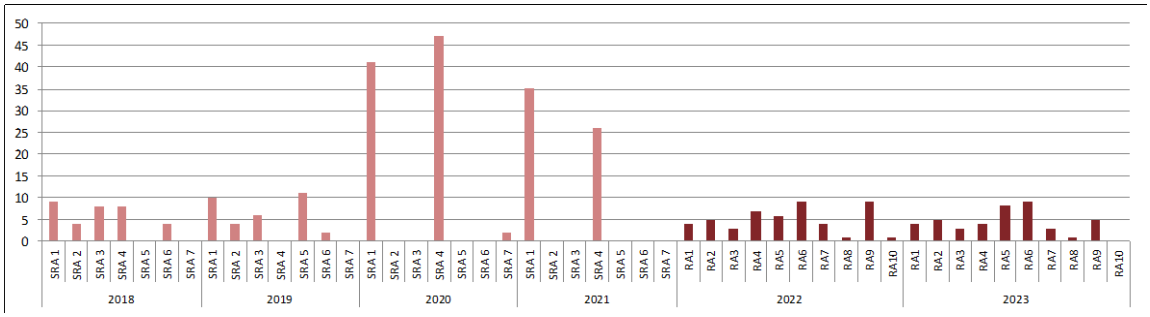
Reporting shows that all Strategy Result Areas were addressed with the exception of Strategy Result Area 5.[12] Interestingly, this result area which reads "Women and men practice and promote healthy gender norms and work together to end gender-based, sexual and intimate-partner violence to mitigate risk and impact of HIV" has been an integral part of the national programme and indeed, of the Joint Programme's own activities, e.g., activities to operationalize the HIV and AIDS (Prevention and Control) Act, 2017. Activities covered the spectrum of UBRAF Results Areas 2022-2026. From 2020, when SDG markers were introduced, the main focus has remained on SDG 3, 5 and 10 and to some, but a much lesser extent on SDG 16.[13]

[11] Data from India, CE and BUF Allocations 2018-2023, Official UNAIDS figures

[12] Strategy Result Areas relate to the Fast Track Strategy and UBRAF 2016-2021.

[13] SDG 3: Ensure healthy lives and promote wellbeing for all ages
- SDG 5: Achieve gender equality
- SDG 10: Make cities and human settlements inclusive, safe, resilient and sustainable
- SDG 16: Provide access to justice for all and build effective, accountable and inclusive institutions at all levels

Figure 1: SRA/RA markers I per Cosponsor I 2018-2023



From Official JPMS data

The work under the CE was initially focused on the Gujarat state with some spill over to other states that were a priority for a particular Cosponsor. Later this focus became less concentrated, and more and more activities took place at the national level or in other states. The work under the CE was well aligned to national priorities. See Annex 3 for a summary of the investments by biennium.

The first year was a period when several assessments were carried out to understand the situation in Gujarat with regard to communities, the HIV epidemic and the programme. The areas of concentration of the programme were: disseminating information and education on sexual and reproductive health and rights (SRHR) among adolescents; new HIV prevention approaches; roll out of new testing strategies; improved data to monitor results; and human rights, stigma and discrimination.

In 2019, progress was reported in the following areas: access to treatment; elimination of mother to child transmission; programmes for adolescent HIV; engagement with key populations in respect of testing, treatment and care; support to the community on human rights, stigma and discrimination; HIV and health services integration; and contribution to the SDG agenda. Informal and formal workers were reached both with information as well as screening and treatment, the LGBT space was opened using consultations and research, the adolescent programme took off and law enforcement and prison systems were drawn into the programme. With integration of the HIV and health system, both PMTCT and SRHR support for sex workers received a boost.

In 2020, apart from the areas of HIV testing and treatment, HIV prevention and contribution to the integrated SDG agenda, two new areas were addressed: sustainability and system strengthening, and contribution to the COVID-19 response. COVID-19 wiped out many of the plans for the year. But where possible, virtual meetings and reviews supported implementation issues such as on TB/HIV, treatment literacy, Dolutegravir roll out and mental health of key populations and PLHIV during COVID-19 including of adolescents living with HIV and AIDS. National guidance was drafted on Pre-Exposure Prophylaxis, Advanced Disease Management and DSDM with support from partners.

In 2021, some of the activities planned for 2020 were continued, not been completed because of the pandemic. Work extended well beyond Gujarat: PLHIV women in five states were organized into self-help groups and there was wide dissemination of 11 new video-clips on the thematic areas of the HIV Act 2017. In Gujarat, the first community based organization of LGBT was formed. Work with workers in the diamond, textiles and transport sectors continued with case-based surveillance provided in additional districts. Migrants and truckdrivers continued to be a focus. PMTCT targets were achieved in 7 districts, and the capacity of district AIDS prevention and control units for planning and monitoring of HIV screening of pregnant women and assisted partner notification enhanced.

The Joint Programme has engaged several partners during its course. Although the CE is small in the context of India's response to HIV/AIDS, there are few donors in the country and CE offers a welcome fund to carry out work that is not covered by the NACP.

A major interlocutor has been the Government of Gujarat in the form of the Gujarat State AIDS Control Society -GSACS. They have been the primary partners in the work that the UN has done. Another key partner has been NACO at the central level. While they have had less to do with the work that was carried out in Gujarat state, they have played a role in the work done at national level and with other states. Their acquiescence is a requirement for the work to have been carried out at all. The programme has also engaged government ministries and institutions in other health areas such as the NHM; National TB Elimination Programme; National Viral Hepatitis Surveillance Programme; and National Mental Health Programme.

The programme also engages ministries and institutions in the non-health sectors of government such as the Ministry of Labour and Employment; Ministry of Social Justice and Empowerment; the National Council of Educational Research and Training and State Councils of Educational Research and Training; VV Giri National Labour Institute; Central Board of Workers' Education; Employees State Insurance Scheme; and law enforcement and prison systems authorities in several states.

Cosponsors have worked with a large number of implementing partners in the health sector. These have been community-based and civil society organizations; paediatric Centres of Excellence and medical colleges; consulting organizations; and research bodies. The programme has also drawn in private for profit sector entities such as leaders and workers of the diamond, textiles and transport sectors, local philanthropists and potential employers of PLHIV who have been skilled under the programme.

The US Government has been a collaborator in several initiatives through its agencies – Centers for Disease Control and USAID. The support provided by Joint Team on Pre-Exposure Prophylaxis, Self Testing and Transgender policy, and UCO's facilitation of government support was appreciated by them, as was the work by WHO on treatment modalities and UNICEF on PMTCT, adolescents and social campaigns. The Global Fund is an important donor to the HIV/AIDS response of the country and as such represents a key partner.

4 CASE STUDY FINDINGS

4.1 Relevance and coherence of the CE model

CE funds have helped bring HIV/AIDS back onto the agenda of the Cosponsors. The core mandate and strengths of Cosponsors were leveraged to build a programme of work that supported the efforts of GSACS, and led the way in some areas. By focusing tightly on one geography, a greater impact was sought than could be envisaged if thinly spread. Programming at the country level has helped titrate the requirement to the task. Joint work involving a number of Cosponsors is increasing. While the UCO did not have an explicit monitoring remit, it played a leading, mentoring and convening role. It nurtured potentially catalytic initiatives and rallied support for them. Regional and global support was helpful but added to the layers of clearances required. Lack of a shared vision for the programme in Gujarat has meant that the narrative has had to be stitched together in retrospect.

4.1.1 Initial response to CE

When CE was first implemented, the UNAIDS Country Director held discussions with the Cosponsors to 'talk, share and learn'. It was clear that CE funds could not go far in a country like India, that Cosponsors had, in many cases, to begin or renew their work on HIV/AIDS and that it would require some groundwork to establish a programme of work to inform policy at the country level. It was concluded that the funds would have to be used strategically – to use them to highlight issues that were important to the epidemic but not receiving enough attention.

Extensive discussions between the Cosponsors led to the view that taking a state approach may be the best use of CE funding in India. Gujarat state was chosen after careful study of the available data, deliberations within the UN Joint Team, with the GSACS and keeping NACO in the loop. This focus gradually expanded in the subsequent biennium (2020-2021), with the state focus becoming quite blurred in the current (2022-2023) biennium.

Flexibility in respect of geography was gradually introduced from the 2nd biennium onwards, but many Cosponsors elected to stay largely focused on Gujarat. CE afforded many Cosponsors the opportunity to work closely with those most at risk and with most affected groups, not commonly available in other programmes. The flexibility made it possible for several Cosponsors to translate their experience in Gujarat to other parts of the country or nationally.

4.1.2 A common HIV voice

Another objective of the CE was to reenergise the Joint Programme from which HIV/AIDS had dropped off the agenda and bring Cosponsors back on the team. CE funding allowed the Cosponsors to return to their core mandate and strengths. The offer of funding helped, but the structured framework that the CE offered was even more helpful. Cosponsor management in the country believes that HIV/AIDS continues to be an important area of concentration within the UN given its intersection with human rights and vulnerabilities. Joint planning, a clear vision of how each Cosponsor's expertise could add to the response and a strategic focus would amplify the contribution of the Cosponsors. This includes spotlighting aspects such as inclusion, gender, non-discrimination and equity in the programme.

When the CE began, the Cosponsor capacity on HIV had been declining. A recent Country Capacity Assessment shows a large gap in human resources on HIV/AIDS in the UN system in India.[14] CE helped Cosponsors to maintain the capacity and, in a few cases, enhance it with CE funding. CE helped agencies to hire staff to refocus the attention to HIV - UNESCO is an example. This has been made possible by the programming of money at the country level rather than at the regional or headquarters level.

With time set aside for it, Cosponsors are able to think about how their mandate can be realised through work on HIV/AIDS. UCO offered suggestions on connections between Cosponsors' work plans during planning meetings. Meetings to discuss progress opened up avenues of cooperation and synergy between agencies. There is a greater willingness to working together - UNDP for example, proposes to collaborate and share costs with other Cosponsors on consultations. WHO and UNICEF plan to collaborate on work on adolescents living with HIV.

[14] Draft Country Capacity Assessment Report Mar22

4.1.3 A strategic shift

The Joint Team was the basis of coordination across agencies to ensure that there was no duplication of activities. Coordinated through regular meetings, plans were chalked out and implementation discussed with a quarterly cadence promoting exchange and collaboration. HIV/AIDS work had previously been taking place within the silos of different UN agencies, if at all. With the coming of the CE, this has changed. These funds have helped to prompt HIV/AIDS projects in the portfolios of all Cosponsors in the country.

The UN has begun to understand that it could bring technical experience to their projects, gain the needed insights and use that to strategically influence policy. This process of conditioning Cosponsors to work from their mandate and strengths to design and implement innovations has been realised in some cases. Cosponsors found that advocacy and scale up of projects to the country level has been much easier with the engagement of all the Cosponsors. The CE experience suggests that when all Cosponsors are actively engaged, their complementary expertise can help to yield results.

CE offered the opportunity for the UN to systematically support the national response to HIV not only in the health sector, but also in other sectors, thereby addressing the totality of the social services and processes required by those at risk of HIV and those living with HIV. The work under CE acted in some cases as a path lighter for the priorities of the government. Albeit that much of the work was localised in Gujarat state, it allowed learning and experience from implementation in the state to be translated to the national level, as well as to other states.

4.1.4 The role of UCO

UCO staff has played a leadership, mentoring and convening role in the implementation of the CE. It conceived of the state approach as a way to maximise the impact of the small amount of funds made available. It worked with Cosponsors to build a response that took into account their mandate and existing familiarity of the geography and subject. Where needed, it introduced Cosponsors to the Gujarat government, helped to identify suitable partners in the state and offered suggestions on appropriate areas of gaps that Cosponsors could fill.

UCO staff built a plan with the Cosponsors for each biennium through meetings with individual Cosponsors as well as wider meetings. When an agency such as UNFPA began its work in Gujarat, it was unsure of how to move forward with the agenda of SRHR and HIV. They were responsible for initiating a dialogue between UNFPA's partner in Gujarat – Chetna – and the GSACS, after which things fell into place. In the case of UN Women, they used an existing programme on which to piggyback their work on HIV, driving at the intersection of marginalization due to poverty, HIV, women's lack of skills and exposure. Discussion on quality assurance at the regional and headquarters levels appears to be restricted to financial approvals and technical review of proposals already agreed at country level.

It is unclear which agency holds the remit for monitoring the Joint Programme at the country level. At one level, the UCO is responsible for 'organising' the Cosponsors by supporting their work, ensuring that their proposals are vetted and approved, holding joint progress meetings and seeing that reporting is completed. But it seems that the monitoring of projects is not within their remit. Steering the Joint Team without a clear mandate to UCO for monitoring the projects poses challenges. It is not clear where the boundaries of monitoring lie between the line of command of the Cosponsor and UCO as the steer of the Joint Programme.

4.1.5 Collaboration within the UN

Even with the modest funds provided under the CE, the Cosponsors were able to collaborate effectively to present the face of the One UN. There have been several collaborative outcomes of CE funding that bear mention:

- Cosponsors came together to provide inputs to 11 identified thematic booklets for adolescents of which HIV/AIDS was one of the modules, SRHR another and mental health a third. These have been disseminated to all states under the government's push to improve school health and wellness under its Ayushman Bharat programme.
- WHO provided technical assistance to UNESCO to support their work through PWN+ on women and adolescents living with HIV.
- The Joint Team has carried out surveys that show a higher prevalence among adolescents 15-19 years of age and shared the reports with NACO, NHM and other government departments, putting adolescent SRHR and HIV on the radar of these departments. WHO and UNICEF collaborate on programmes for adolescents living with HIV.
- UNODC and WHO worked together on training of law enforcement and prison staff on HIV.
- WHO collaborated with UNICEF and UNAIDS on PMTCT programmes in the state.

However, the process has not been without its challenges. Not a lot of conscious effort has put into creating the sense of one team - this has happened organically. However, not all Cosponsors covered the same geography within the state, thus having less of a direct state-wide effect than hoped for. In some cases, such as with UNODC, there was the feeling that the choice of state constrained their ability to make an impact and that additional perspectives from PWIDs and PLWHIV including from other states would have been useful. There is considerable experience among the Cosponsors and some strong opinions about what they would like to contribute. This meant that the negotiation of allocation of funds could sometimes be knotty. Monitoring of the programme on spending and allocation has also been laidback. Notwithstanding the impact of COVID-19 on collaborative efforts, another area that has remained weak is the communication of results to the wider audience.

4.1.6 Regional and global support

The function of the country, regional and headquarter levels of each Cosponsor varies based on their internal structure. Most Cosponsors felt that there was encouragement by their regional and headquarters offices to work with other UN agencies.

In some cases, regional offices have been involved in the financial plan approvals for CE funding, although spending is approved locally for most Cosponsors. Technical support is generally available from headquarters. Once the proposals are developed by the Cosponsor in country, their regional and/or headquarter offices are involved in approving their plans. These are then shared with UNAIDS at country and regional levels. Comments on the plans are provided mostly from that level, with not as much involvement of the UNAIDS Secretariat at Geneva.

The regional office of UNAIDS was quite active in supporting the plans for biennium 2. Cosponsors were appreciative of the webinars and training carried out to help them formulate their plans. A global training webinar was held over three days. Beside this, virtual discussions were organized to better understand planning and processes for CE. It also built their capacity on the use of planning and reporting software (Joint Programme Monitoring System).

4.2 Implementation

CE funds provided an opportunity to the state of Gujarat to fund ideas not provided for under government support. The CE programme of work was finalised in consultation with GSACS but suffered from a lack of a needs assessment or visioning exercise that would have made it more intentional. Work was inevitably 'projectized' because of the different Cosponsor systems in place for approval and reporting. Budgets were small and window-for-use short, leading to breaks in implementation and making long-term projects a challenge. Nevertheless, a range of partnerships was established to generate results. While the CE programme did not attract a great deal of additional funding, in-kind support was widely available. Civil Society was consulted, the programme was gender responsive and attended to human rights concerns of the communities affected, but more could be done in these regards. Work during COVID-19 by several Cosponsors was appreciated by the communities and GSACS.

4.2.1 CE allocation

The allocation of the CE funds has been carried out by UCO in a pragmatic manner. There was no existing needs assessment or pre-formulated vision of what the state needed. Perhaps this was why much of the work in the 1st biennium related to needs or situation assessments. GSACS played an important role in the brainstorming that went before the allocation of funds in 2018. While funds were small, they were useful to meet needs not funded under NACP.

Allocations are not predetermined, but the envelope for each Cosponsor is roughly indicated. The funds were allocated more or less equally between the Cosponsors, with one or two receiving more funds bearing their existing capacity on HIV/AIDS in mind. Proposals were also reviewed based on whether they could realistically be completed in the timeframe and funds assigned. Proposals presented were discussed by the Cosponsor with UCO staff and then relayed to the regional/headquarters of each Cosponsor for guidance. After this, the plan was consolidated and shared with the UNAIDS regional and headquarters team for their inputs. The Joint Team did not begin with a vision for what the funds ought to support. Rather each proposal was judged on the basis of guidance received from various levels within the system and alignment to national programme priorities. Perhaps this is why the Joint Team Country Reports read much as a set of achievements rather than the attainment of a vision.[15]

UNDP received BUF funds in 2019 and 2020 after a competitive process involving proposal submission. But these were treated much as CE funds and no exceptional attention was paid to the manner in which they were expended, nor were they separately reported.

4.2.2 A 'projectized' approach

The UN is set up to run projects and has not broken out of that mould. For the Joint Team to implement their plans, they had to be broken down into a 'project' that could be reported within their internal systems, so that money could be moved and spent. Although the time has come to provide thought leadership, the tools and instruments that are available continue to be those to run projects.

Several constraints have made it difficult for the CE funded programme to be anything but projectized: internal systems and processes require a projectized input; donor funded activities that the UN carries out come with the expectation of measurable results; CE itself requires 'numeric' reporting; and staff retrenchment has meant that there is a lot of inexperienced staff. Inexperience

[15] Country Report India 2018, 2018-19 and 2020

has in turn meant that some staff have had a learning curve both with regard to their own Cosponsor system as well as that of the Joint Programme. Further, inexperience also delays the ability to take the big picture and build policy-oriented programmes of work. Guidance from UNAIDS regional and headquarters as well as their own Cosponsor offices have had their own influence. For example, one criticism that was made was that Cosponsors are pressed to tailor their programmes to the 'boxes' of the new Global AIDS Strategy – even though the strategy was developed in close consultation with Cosponsors. On the other hand, staff are felt to be project oriented, constrained by the system to stay with known ways of working and doing.

4.2.3 Limited budgets, short windows

Since their work on HIV/AIDS was heavily dependent on CE funds, limited budgets reduced the options available to Cosponsors. Cosponsors such as ILO, UNDP, UNICEF, UNODC and WHO topped up CE funds with supplementary funds. But for others, certain interventions and activities for vulnerable populations could not be considered, such as regional training on a mental health training module for the LGBT community. With time, the Cosponsors became more conversant with the programme and state and were able to take forward those aspects of their portfolio that were most relevant to the programme and had the greatest potential for take up by other states or nationally.

A problem flagged by almost all Cosponsors was the short window of time in which funds are to be expended each year. Even when the funding is approved, there are internal processes and checks and balances that need to be completed to ensure that policies and procedures are being followed. In the 1st biennium, funds became available only in April and are to be reported against by the November of each year. This has led, at least in a few cases to the programme having long breaks between implementation phases. In the 2nd biennium, year 1 funds were made available for expenditure even in year 2 in view of the COVID-19 pandemic. The CE release for the 3rd biennium circumvents the short window problem by confirming the funding envelope for 2 years rather than one, but with the caveat that plans must be revisited based on output and need. Cosponsors in India have welcomed the change as making their work easier as funding cycles do not interrupt implementation timelines. However, the nature of projects being funded has not changed much.

4.2.4 Leveraging partnerships

Although activities are not discussed with partners other than GSACS at the time of the joint planning, they are discussed with implementing partners and stakeholders at the time of work planning and actual implementation. For example, UNDP conducted stakeholder consultations in partnership with the Humsafar Trust in order to support the development of the Transgender Act. Key economic sectors of the Gujarat economy were engaged through sensitization of management and by instituting workplace champions to reach the formal and informal workforce through labour unions and PLHIV networks.

The UN worked with a range of partners in delivering its programme in Gujarat and elsewhere. Partners have ranged from civil society organizations such as Lakshya Trust, positive people's groups such a PWN+ and the Gujarat Network of Positive People, medical colleges such as the BJ Medical College to state and national education policy setting bodies such as the state and national Council for Educational Research and Training, companies in the private sector such as Reliance and Ranjit BuildCon, to Ministries of Labour and Employment, Human Resource Development, Health and Family Welfare among others. Besides these, a large number of contracted agencies helped implement the programme.

Examples of the way in which these partnerships played out include:

- UNESCO engaged the PWN+ by conducting workshops for its members on HIV and cervical cancer.

- ILO was instrumental in developing bridges between NACO, the Ministry of Labour and Employment and the workforce. It has advocated on the need of a policy to protect the informal workforce since approximately 90% of the workforce is in the informal sector.
- All UN agencies have begun to advocate for the Human Papilloma Virus vaccine, which is not yet mainstreamed into the national immunization guidelines.
- The Niti Aayog, India premier planning agency has established an LGBT sub committee. UNDP worked closely with USAID and NACO to organise the second LGBT symposium.
- Programme Sampoorna in 6 districts of Gujarat linked SRHR and HIV by training sub-district staff using CE funds in Gujarat.

4.2.5 Additional support

Although the CE funds could not leverage additional funding, some examples bear mentioning. Through modest funding to UCO, the Centers for Disease Control was able to leverage the political and bureaucratic relationships as well as Civil Society contacts that UCO has developed, helping to further its work on HIV-TB and multi-month dispensation of ARVs. Funds for programmes initiated by CE funds are often topped off by GSACS funding, or in kind support by various partners on the ground. For example, workplaces will print informational material in support of voluntary counselling and testing work on their premises or host simple refreshments for groups of their workers participating in ILO run programmes. A study by UNESCO on the issue of homophobia and bullying of transgender people in schools, which paved the way for a school health and wellness programme in Gujarat, has also been funded in Tamil Nadu state. Gujarat was the first state to apply DSDM using CE funds, finalised in consultation with key population groups leading to the development of national guidelines. Once in place, additional funding became available from several partners.

4.2.6 Civil Society connects

CE has helped to build bridges between the government and civil society which is implementing the initiatives, as well as with civil society partners in other states. This has contributed to cross learning, with implementing civil society organizations bringing ground level experience to the knowledge of the GSACS and NACO. Civil society on its part is complimentary about the role of UCO staff. It felt that they were approachable, collaborative and open to requests. For instance, the PWN+ had wanted to begin a programme for cervical cancer screening and create the linkages with government programme to sustain this. UCO was approached and was able to help them.

Cosponsors work with civil society – consultation takes place, albeit quick and short. Civil Society has noted an increase in their involvement at many levels – community participation in the process; awareness building among beneficiaries; stakeholder consultation during COVID-19 reprogramming of activities; tele counselling of sex workers, etc.

Yet some feel that community consultation is inadequate during the planning process. The view was also advanced that community-led programmes are often not led by communities, but by civil society organizations which are better resourced, not acknowledging that the lack of resources is what prevents community-led organizations from developing that capacity.

In respect of the Civil Society markers[16], most activities fall to the Civil Society marker 1 or 2. Most of the Civil Society marker 3 activities were by ILO and UNDP. There seems to be a shift to Civil Society marker 2 activities in 2022-2023. See Annex 4.

[16] Civil Society marker 1: Consultation and engagement with civil society/community
Civil Society marker 2: Consultation and engagement with civil society/community and civil society/community is responsible for implementing the activity direct funds from Joint Programme
Civil Society marker 3: Conceived and designed by civil society/community, and civil society/community is responsible for implementing the activity (i.e. receives direct funds from Joint Programme)

4.2.7 Attention to Gender

The vast majority of planned activities carry a Gender marker 2 (74%) and another 9% carry a Gender marker 3.[17] ILO conducted most of the Gender marker 3 activities and UNDP followed by UNICEF. See Annex 5.

Field visits confirmed the attention being paid to transgender persons, to women in the labour force and to WLHIV through specific activities. Also in focus were adolescent girls and boys in work helmed by UNESCO in schools as well as pregnant women through UNICEF support to PMTCT. ILO has implemented programmes directed to women in the workforce as well as supported activities for women in informal work through the establishment of self-help groups.

Unfortunately, UN Women with the coordination mandate on gender within the UN system, has come on board the CE modality only in 2022. UN Women sees this opportunity as providing a first hand experience of implementing something that is so important, not just to learn, but to showcase the many perspectives of intersectionality.

4.2.8 Human Rights

Much of the work carried out in Gujarat from 2018 onwards was rooted in human rights. For example, ILO began its work with a study on stigma and discrimination and advocacy for its reduction in selected workplaces. UNDP supported the establishment of a Transgender Welfare Board in the state as well as a governance mechanism to track progress on human rights. UNESCO developed a tool kit to be used by teachers and school authorities on prevention of school-related Gender Based Violence including homophobic and transphobic bullying. WHO supported the development of Community Based Testing and Self-Testing action plans for the 9 high HIV burden districts, giving at risk populations the option of testing themselves as and when they would like.

In respect of the Human Rights marker[18] introduced in 2022, the larger number of activities fell to marker 2 (65%) and a quarter (25%) to marker 3. All of ILO's activities were classified as Human Rights marker 3. Both WHO and WFP reported that all their activities were rated as being Human Rights marker 1. See Annex 6.

4.2.9 Pivoting to COVID-19

All active Cosponsors pivoted to address the COVID-19 needs of the population in 2020. The pandemic put the plans for the 2020-2021 biennium into disarray. As staff took stock of the situation, virtual meetings and reviews were used to support implementation issues. Some plans of 2020 had to be completed in 2021 due to the evolving COVID-19 situation. Outreach was not possible and online training difficult due to poor outreach and connectivity issues. This period also saw changes in the staffing at the UN.

Despite the difficulties encountered, work continued through the Cosponsors. Funds were reprogrammed with the assistance of the UCO staff. For instance, in-person training had been envisaged for work on operationalization of the HIV Act. With NACO going ahead with animation videos, funds were utilised to conduct online training using those. WHO guidance on COVID-19 was translated at national and state level into strategies such as: travel pass for ART beneficiaries,

[17] Gender Marker 0: No contribution to gender equality and/or empowerment of women and girls
Gender Marker 1: Limited contribution to gender equality and/or empowerment of women and girls
Gender marker 2: Significant contribution to gender equality and/or empowerment of women and girls
Gender marker 3: The principal objective is to advance gender equality and/or empowerment of women and girls

[18] Human Rights marker 1: Limited contribution to realization of human rights
Human Rights marker 2: Significant contribution to realization of human rights
Human Rights marker 3: Principal contribution is the realization of human rights

distribution of commodities, infection control for Targeted Interventions sites, multi-month dispensation of ARVs, safe supply of blood and blood products and supply chain management support. It helped spread awareness amongst PLHIV about the availability of ART services and drugs during COVID-19. UNICEF supported adolescent health and PMTCT service continuity by strengthening COVID-19 measures, e.g., through multi-month distribution of ARVs to over 70,000 PLHIV through community health workers. It strengthened the state COVID-19 response by supporting psychosocial care. And finally, built the capacity of health care workers to respond to COVID-19 during the pandemic. UNODC disseminated infographics on COVID prevention and control among prisoners and prison staff in 11 languages to different prisons across India and procured and distributed masks, soap and other necessities among their target population. UNESCO developed training resources for the School Health Programme in India in the context of the COVID-19 and trained master trainers. UNDP supported COVID-19 vaccination for PLHIV and vulnerable communities. It worked with the Lakshya Trust to conduct COVID-19 vaccination camps with members of the transgender community. It is now strengthening community processes of community-based organizations to facilitate COVID-19 vaccination and other interventions among key populations, in part through the orientation staff in Targeted Interventions. Over 31,000 PLHV were enrolled in the newly available social protection schemes. Civil society organizations provided ~400 unemployed PLHIV with dry food, transportation allowance to reach ART services, and training for income generation. Self-help groups of 20 PLHVIV, mostly women also received seed money to start new businesses.

In fact, analysis of the COVID-19 markers[19] indicates that about a third of activities (35%) planned between 2020 and 2023 are directed to COVID-19 response, with UNICEF leading the way. Understandably, COVID-19 directed activities were especially high in 2020 and 2021 and are gradually tapering off. See Annex 7.

4.3 Results and sustainability

Overall, the Joint Programme has been able to achieve much more than expected in view of the envelope size and challenges it faced. Contributions to prevention, treatment, paediatric AIDS and vertical transmission have found their way into the work of the national government. The programme promoted a community-led, human rights oriented, gender and youth conscious response. It has encouraged innovation in social protection, helping to create assets that are being used countrywide. Its work during the COVID-19 epidemic has been appreciated in Gujarat. UCO has played a useful role through its unique ability to bring government and civil society face-to-face in developing and reviewing programmes. Of the factors that have hindered the effort, translating the idea of joint working of UN agencies towards a common goal into practice using a single funding stream has posed an unfamiliar challenge.

CE and BUF funds have enabled the Joint Team to address each of the outcome areas of UBRAF. For the size of the envelope available, the UN system has punched above its weight. The one area that has not been explicitly reported is output 8: Funded Response: capacities built to develop and implement sustainable responses. This may be because the largest part of the funding (93%) of the HIV/AIDS response in India is domestically funded.

4.3.1 Prevention, Treatment, Paediatric AIDS and Vertical Transmission

CE has made a significant contribution to the Prevention, Treatment and Paediatric aspects of the epidemic. Several of the initiatives that began under CE funding have found their way into the work of the government. The NACO AIDS App is one, which is now available in 11 different Indian

[19] COVID-19 marker was simply ticked as being either a Yes or No.

languages. Another example is the modules and videos on mental health and psychosocial issues that were developed during the COVID-19 pandemic and that have been scaled up to other states. Another case in point is the study on community readiness for Self-Testing which broke new ground. It was discussed at a national consultation. Similarly Pre-Exposure Prophylaxis guidelines are being developed with the support of consultations and expert feedback. New strategies have been formulated to address the needs and vulnerabilities that web/social media based key populations face. The learning from this effort has been reflected in Universal Health Coverage agenda through a national consultation. Work being carried out by UNODC on drug use and HIV in closed settings is helping to bring law enforcement and health officials to the same table. And at the same time, ILO is helping to set the stage for community-based screening of workers in diamond, textile and transport sectors, migrants and truckers. In Gujarat, 99% of health centres began to provide HIV screening services and 210 integrated counselling and testing centres were established.

Some approaches that have been attempted for treatment literacy for PLHIV are finding an audience elsewhere. On NACO's request, the training was extended to the northeastern states of Mizoram, Nagaland and Manipur. In Gujarat itself, DSDM was validated by the community, which identified the modality that best suited it. DSDM was rolled out in 10 ART sites, 10 Care and Support Centres and Link ART centres. The national guidelines were developed and once in place, several partners came to support it. Food and nutrition guidelines for PLHIV treatment, care and support have been updated by WFP.

A notable intervention has been the integration of HIV with SRHR in districts of the state beginning with a few districts. Thirteen fact sheets were developed as part of Project Sampoorna, which has found its way into the NACP Phase-V. The Country Report notes that in Gujarat in 2021, 1.4 million pregnant women were registered for ANC of which 97% were tested for HIV, and of those tested positive (xx%), 98% were placed on ART. Seven of 33 districts achieved PMTCT targets and 16 of 33 achieved registration and testing targets during 2021. The GSACS capacity for planning and monitoring for HIV among pregnant women and better access to quality ART services was enhanced. UBRAF funding enabled validation of the PMTCT burden of 19 states, a National District Gap Analysis to be conducted and roadmap development consultation to be held. Close to 1000 staff were trained in Assisted Partner Notification; PMTCT services linkages in districts with leakages were strengthened; and partnership established with the positive people's networks to identify gaps in the continuity of services. Paediatric HIV care received a boost; ~300 specialists were trained in 5 medical colleges and 712 master trainers received training on detection, referral and management of adolescent sexual abuse.

4.3.2 Community-led Responses, Human Rights, Gender Equity and Young People

CE and BUF funding have enabled the UN system to contribute to make the programme community-led, human rights oriented, gender-conscious and young people oriented. UNESCO is working with the NHM and PWN+ to provide support on the SRHR component. Positive people's networks have also been engaged in building the capacity of outreach workers with a focus on retention. UNDP worked with the peer-based organization the Humsafar Trust to develop recommendations for welfare measures for transgender persons.

A good part of the work is focused on human rights issues at a ground level. UNDP reports its consultation on transgender population issues has been well received. The consultation has contributed to the development of a 5 year road map, recommendations on social protection and governance mechanism to track access to entitlements. There was wide dissemination of 11 video clips on thematic areas of the HIV Act 2017 and drafting of State Action Plans during a National Consultation on Mainstreaming of HIV response. Strong high level political support of the Ministry of Social Justice and Empowerment has been fostered resulting in the promotion of the Transgender Welfare Framework to help reduce stigma and discrimination. A new association, the National

Transgender, Thirunangai, Kinnar, Hijra Association, has been set up with 25 Transgender community leaders from across the country. Further, the funds have helped establish a framework for community system strengthening, a national steering group representing key populations and PLHIV and create tools for Community Led Monitoring and conducting pilots in this regard. Gender Based Violence prevention in schools was a focus area and posters in English, Gujarati, Hindi and Tamil reached approximately 16 million students in these states.

Gender issues have been addressed in a variety of ways as has been seen in the example provided above. UNFPA expanded its understanding of its brief to not only work with female health care workers to enhance their understanding of HIV transmission, but also with workers of ART centres and Targeted Interventions to build capacity on SRHR principles. Dialogue was initiated which led to the estimation of community needs. There are currently 10 self-help groups in the state that are helping women choose from a menu of livelihood options.

ILO has helped to organise poor PLHIV women into self-help groups in five states i.e., Maharashtra, Delhi, Tamil Nadu, Rajasthan and Uttar Pradesh. In addition, in Gujarat, ILO is working with the Gujarat State Network of Positive People to provide PLHIV women with capacity building and seed money support to start small ventures. Migrant construction workers are hard to reach and their access to services is also limited. ILO is working with a community-based organization - Gujarat AIDS Prevention to reach over 15 000 migrant workers in 5 districts.

A UNESCO funded study on bullying and violence faced by LGBT led to collaboration to support a programme against school bullying. Work to skill and employ transgender persons has snowballed into an understanding with the government of Tamil Nadu to do similar work in the state with additional funding of US$ 2.3 million. The School Health Programme has been upgraded with a Health and Wellness approach and Master Trainers from medical colleges and nodal officers have been trained thoroughly on School Health Programme resources. A Gujarat district level situational analysis of adolescent services became the basis of adolescent HIV related services. Its recommendations have been implemented in one district including recruitment of medical officers and peer educators in 31 Adolescent Friendly Health Clinics and convergence with the Adolescent Anaemia Reduction and Prevention of Child Marriage Act programmes.

4.3.3 Funded Response, Integration and Social Protection and Humanitarian Settings and Pandemics

The NACO App in 11 languages provides information to enhance knowledge and improve the uptake of HIV and social protection services. The programme was able to pivot to the COVID-19 epidemic and the needs of PLHIV. Field visits testified to the benefits of the programme among the community. Eligible informal workers have been linked to social protection measures.

CE funding has encouraged innovation, helping to fund assessments among prisons in the country. This enabled the development of a training manual for law enforcement and prison administration officials on drug use and HIV. UNODC intervention was able to create bridges between multiple law enforcement agencies at national and state level, which has enhanced the programme of work.

The focus of the Joint Team has not been on the funding of the HIV/AIDS programme in the country, primarily because the response is well funded in India and because 93% of the funds are already domestically sourced. However, it will be worthwhile to keep an eye on those figures given the economic difficulties that the country and world are likely to face in the coming years.

4.3.4 Factors that helped in the CE process

Leadership provided by UCO has helped the CE process roll out effectively. It was seen as being collaborative, and a large launch attended by all Cosponsors helped to set the stage for their support to the GSACS. CE afforded Cosponsors the opportunity to work closely with those most at risk and with most affected groups – not common in other programmes.

The process of inviting proposals was useful as the discussion of each proposal with UCO staff helped to align the work to national and state priorities. There was buy-in from state counterparts of the work to be carried out in the state. The national programme was also kept informed, although their involvement was less active than usual with UNAIDS led work. Perforce, the proposals played to the strength of each Cosponsor, creating a collage of activities that covered the range of UBRAF outputs. CE funding became an important platform where UN partners could converge with others having common interests.

There was some encouragement of innovative and catalytic activities although it might be argued that this happened somewhat organically rather than being entirely intentional. Gujarat served to act as an incubator of initiatives to respond to the evolving HIV/AIDS epidemic while demonstrating the diverse approaches that the UN system can bring to bear on a common theme. The availability of local implementing partners with high capacity made the process smoother than might otherwise have been the case. The role of UCO staff in nurturing the relationships that Cosponsors were able to have with GSACS and NACO was also important.

Country level Cosponsors cited support provided by regional and headquarters offices in approving and clearing the projects and expenditures linked to CE as being helpful. Support was also available from the regional UNAIDS office – more so from the 2nd biennium onwards – for planning and reporting through webinars and workshops.

The three decades of the epidemic in India has organized the community, in part through the support of the UN system, in particular UCO and UNDP. A strength of their work has been its connectedness with the higher echelons of the national programme on the one hand and the community on the other. This ability to bring community face-to-face with policy-makers has been a key value that the Joint Programme has benefited from.

4.3.5 Factors that hindered the CE process

A major criticism of the CE process might be the lack of a vision for how the funds under CE could best be used for maximum impact. There were several reasons for this: the evidence base in respect of the situation in Gujarat was weak, especially in the fields that the Cosponsors worked in and in some cases, the Cosponsors themselves had little prior experience of HIV/AIDS work. Since many were unfamiliar with Gujarat as a state in which to work, building up a composite picture of what could be done was difficult in the early years.

Staff turnover has meant that there was lack of experience with the UN system, the subject matter and the geography in which the CE programme of work was being implemented. Apart from intra-UN communication snarls, there were limitations as the roster of local implementing partners had to be built in each field of work. Added to this was the ‘lack of ambition’ of the Cosponsors in thinking that they could make a difference. In some cases, their inexperience of the UN system as well as with the scope of work also restricted their ability to think outside the box.

While innovation was urged and guidance encouraged Cosponsors to take up activities that were likely to be catalytic, this could not be effectively done in the absence of a gap analysis. When the pandemic intervened, several Cosponsors mooted innovative activities that helped make the lives of

PLHIV easier during the worst of the pandemic years. Some activities also proved catalytic, but as has been noted above, only some of the work was intentionally catalytic. Showcasing the work in a way that catches the attention of other donors, of government counterparts and the HIV/AIDS community more widely is an important step in scaling an idea from one area to others.

A major hindrance was the COVID-19 pandemic itself. COVID-19 disrupted the programme of work, limited the conduct of in-person service delivery and training programmes and reduced HIV/AIDS supplies. It also limited the ability both of key populations and PLHIV, as well as programme staff, to reach service points. This meant that the work had to be reprogrammed, new ways of doing it developed and the wherewithal created for those new ways to work. All this had to be done in a Joint Team context, by people already under strain with regard to their own futures.

Funding was both constrained and delayed in arriving in country. The planning process as well as multiple layers of clearance translated to a short window for the use of the funds. Another administrative issue is the delay in availability of funds each year. The problem was particularly acute when funds allocation was only for a year, with actual availability for spending of 8 months. But even with funds available for 2 years, mid-term approvals remain required for year 2 spends.

As the agency on the ground interfacing most directly with the government and civil society, UCO faced questions about the volume of funds available under CE. Clearly, the funds available for India through the CE for the Joint Programme were miniscule in the context of the NACP. This meant that the activities had to be planned carefully and only those that could be sustained by the funds available could be funded.

Adding to UCO's difficulties as the steer of the Cosponsors on CE is that it does not have the authority to review the work of others. It is not the disburser of the money nor is it designated to lead the Cosponsor group. This makes its position as the face of the UN's work in CE areas of activity, tricky to say the least. This is an issue that needs to be resolved if efficiency and effectiveness is sought to be improved.

5 THEORY OF CHANGE

Despite its challenges, the Joint Programme has been reasonably successful in achieving the outcomes that the CE sought. The diversity of capabilities that the UN has, the effective coordination of their efforts and the defined scope of operations, all helped to focus Cosponsors' work in alignment with national priorities. That is not to say of course, that the programme could not be improved.

Theory of Change outputs were well addressed, particularly outputs 5: Funding supports activities that address Gender Equity, Human Rights and community responses, and 6: Funds are used to strengthen national responses to COVID-19 in the context of HIV. Areas that were addressed well, but could benefit from additional attention are:

- UBRAF core funds are prioritised and used strategically based on country needs
  The Joint Team has not developed a shared understanding of the prioritization of country needs and the strengths of the UN agencies that could be used to address them. So, although the Joint Programme does align well with the national programme, there has been no preference assigned to any actions over others through prioritization. To the extent possible, the Joint Programme has co-opted all Cosponsors without exception.
- Funding mechanisms strengthen Joint Team internal and external collaboration and strategic planning processes
  It was seen that the momentum to internal and external collaboration was greater in the 2nd and 3rd biennium; perhaps as the broader UN system developed a greater familiarity with the

approach and each other and added capacity. However, interviews do not indicate that this was nurtured, rather that it happened somewhat organically. A strategic planning process needs to be encouraged through the instrument of either funding requirements or results reporting.

- Quality assurance processes reinforce transparency and accountability of the Joint Programme This area seems to be the weakest link in the Theory of Change – it was not clear that quality assurance processes had been intentionally and effectively applied, except by GSACS insofar as programming was concerned. Guidance on what areas to focus on and what the support might look like seemed limited. Community participation during Cosponsor visits to assess activities does not take place routinely. Discussion on quality assurance at the regional and headquarters levels appears to be restricted to financial approvals and technical review of proposals already agreed at country level. And the remit for monitoring remains ambiguous.
- Agencies are able to mobilise additional resources through catalytic and innovative use of funds The main criticism that can be made here as well is that the attention to innovation and catalytic potential of approaches seems less intentional than organic. There does not seem to be enough attention to a strategy that ensures that priority and vexed issues of the national response to HIV/AIDS are addressed through the CE.

6 CONCLUSIONS AND CONSIDERATIONS GOING FORWARD

6.1 Summary conclusions

India instituted an HIV/AIDS response in 1986 soon after the first case was detected. It has successfully contained the epidemic with the help of development partners. Working through a system of state level bodies -the State AIDS Control Societies, the NACP has led the way in addressing the global commitments and national priorities. The UN system has been a key partner in India's fight against HIV/AIDS, assisting a spectrum of technical needs and building community capabilities.

The CE financing model for HIV/AIDS was prompted by an overall reduction in funding, necessitating a strategic rethinking of how the work of the Joint Programme could be made more efficient and effective. Although intended to address the needs of only a small number of countries, the actual number has been much higher than originally envisaged. This has meant that the funding is split across a large number of recipient countries, shrinking the volume of funds available to each. With 10 Cosponsors in India, the demand on the funds has been intense.

The Joint Team has supported the programme with CE and BUF funds since 2018. During this period, it has leveraged its key relationships to deliver a programme of work in Gujarat, other states and the national level. CE helped bring back HIV/AIDS onto the agenda of the Cosponsors by offering funds for projects (and in some cases, staffing), and a common platform. There were concerns: the quantum of funds, their actual availability through the year and clearances through double-barrelled systems. Steering the Joint Team without a clear mandate to UCO for monitoring the projects has posed its own challenges.

The Joint Programme focused primarily on the state of Gujarat for much of the period. Although the Joint Team did not develop a shared vision, UCO did its best during discussions on work programmes with Cosponsors to ensure that the approved projects were responsive to government priorities, used innovative methods, were potentially catalytic and coherent with each other. However, this approach was less than perfect. In 2020, the pandemic disrupted the programme but also offered opportunities to the Cosponsors to develop innovative and responsive systems for delivery of services. Despite this, Gujarat served as an incubator for many initiatives. Funded by the CE, with the support of GSACS and the support of civil society, these have had an accelerator effect on the HIV response in the state.

While the Joint Programme has not been able to generate additional money in country, it has led to expansion of the programme to other states and in-kind support to its programmes. Examples include the school homophobia and transgender anti-discrimination project by UNESCO and work supported by ILO in private sector companies. Civil Society has been consulted in design and planning of projects; ILO and UNDP also had programmes that were conceived, designed and implemented by Civil Society particularly in the context of the COVID-19 pandemic. Gender issues are another area that has received significant attention. In focus have been transgender persons, women in the workforce, adolescent girls and boys, pregnant women, women prisoners, residents of women's shelter homes and WLHIV. Most of the work carried out through the programme is rooted in human rights, with 90% reported as being Human Rights markers 2 and 3. The programme pivoted well towards COVID-19, seeing that aid became available to at-risk persons and PLHIV received support through the pandemic. About a third of all activities were for COVID-19 related work; funds were reprogrammed with the assistance of the UCO staff.

The CE-funded activities speak to all of the UBRAF outcomes. It has helped the UN find a common HIV/AIDS voice. The support from regional and global offices was welcomed. It strengthened the role of UCO as the convenor of the UN response to HIV/AIDS. It has shown the way for the Joint Programme to believe that its interventions have the potential for bringing about policy change. The work by Cosponsor agencies to deliver jointly on tasks has made the concept of the one UN more compelling.

Just some of the impressive achievements reported include: a 5 year road map, social protection recommendations and a governance mechanism to track progress on human rights; 8,000 formal workers from 30 companies and 15,000 informal migrant workers reached – 1675 workers were screened, 32 were found seropositive and all were linked to ART; posters on school related Gender Based Violence prevention were printed in English, Hindi, Tamil and Gujarati and disseminated to approximately 34,500 schools (~4 million students) in Gujarat and 60,000 schools across Tamil Nadu, reaching 12 million students. With CE support, 99% of primary health care centres began to provide HIV screening services and 210 prioritised integrated counselling and testing centres. Altogether, 298 specialists across 5 medical colleges were trained on paediatric HIV care; and 712 master trainers received capacity development on detection, referral and management of child (adolescent) sexual abuse.

During the COVID-19 pandemic, CE funds contributed to more than 70,000 PLHIV receiving their ART through decentralized, community-led HIV testing and DSDM in Gujarat. Technical assistance helped to enrol 31,101 PLHIV and persons from key populations to newly established COVID-19 social protection schemes. Around 400 unemployed PLHIV in 6 targeted states were supported to receive dry food, allowance for transportation to ART services and capacity building to initiate income generating activities during the pandemic through community-led organizations. Also supported was the establishment of self-help groups of 20 PLHIV, mostly women, who were provided with seed money to start small businesses.

Despite the small amount of money available through the CE, the UN is in a good position to influence policy as a grouping of multilateral agencies. Agencies like WHO that are recognised internationally as being the 'authority' on health are able to leverage that reputation to assist counterparts make crucial decisions and take path breaking initiatives. For example, WHO helped translate global guidance to state level issues during the pandemic. This is an approach that could pay off as agencies work closely with state level interlocutors in the country. Many of the activities under the Joint Programme have proven catalytic. While the choice of work may or not have been expected to be catalytic at the outset, it is clear that they were nurtured and supported to reach their logical outcome. Nevertheless, it is possible that other activities could be catalytic with better

communication effort and support. For example, ILO's reach out to the extensive informal sector of Gujarat through industry could provide a model for the work that the NACP supports in other states. Innovation is an area that has been less visible in the Joint Programme, mostly seen in its COVID-19 work. Multi-month dispensing of ARVs and using health staff to deliver crucial supplies and food to PLHIV are among the key examples. However, that there are more problems that need solving: how to digitally reach the youth, out of school adolescents, informal workers that make up 90% of all workers, keep HIV/AIDS awareness on the mind map of society among many others.

6.2 Considerations for strengthening CE funding model and operations at country level

While the operationalization of the CE has overall been successful, there are clearly some pressure points which if released, would enhance the efficiency and effectiveness of the funds.

6.2.1 Resource availability

- The process of CE allocation between Cosponsors and within each Cosponsor's brief, needs to be streamlined. In part, this could be solved by the development of a shared vision and broad work plan for HIV/AIDS over a 3-5 year period for the UN programme in the country, developed taking the regional and headquarter offices of Cosponsors on board.
- A common criticism of the CE funds was that they arrive late and have to be spent quickly – this criticism needs to be resolved. The vision and broad work plan could certainly reduce the iterations that the proposals presently go through. This exercise needs to be undertaken.
- A concern has been the length of the 'projects'. While having allocations for two years for the same outcome partly circumvented this difficulty, a percentage of the funds could be allocated for 'long duration' outcomes allowing promising innovative ideas enough time to be tested and fine-tuned.
- There have been calls for greater resource mobilisation at the country level from private sector and bilateral agencies. However, while this possibility has always been open, it has not yielded the results hoped for. A more likely outcome is 'in-kind' support that the programme has seen such as the support from private sector for programmes intended for its workers. This outcome could be pursued more purposefully in the future.
- One option to maximise the utilization of funds and encourage collaboration between Cosponsors would be to have 'call down funds'. This would mean that funds are transferred to the country office and called down by a Cosponsor on approval of a proposal, as and when needed. This would reduce the 'dead' time of the funds and ensure that all funds are constantly in use. However, this approach could be administratively challenging, especially because multiple Cosponsors -and Cosponsor systems- are involved. Further examination of this option may be fruitful.

6.2.2 Administrative bottlenecks

- An administrative issue that has implications for the effectiveness and efficiency of the programme is the monitoring remit for the programme. As of now, it is not clear where the boundaries of monitoring lie between the line of command of the Cosponsor and UCO as the steer of the Joint Programme. This is a vexed question, but a solution would enhance the working of the programme. This area would benefit from a frank discussion between the Cosponsors.
- Progress meetings have been effective in ensuring a common information base between Cosponsors. They have created a familiarity with each other's programmes of work, built cooperative relationships between representatives of different agencies and stimulated collaborations. The communication opportunities afforded helped to achieve better results. Systematic efforts should be instituted for intra-Joint Team communication.

6.2.3 Remit of work

- The Gujarat decision has paid dividends for the Joint Team. They are now recognised for the work that they have done in Gujarat and their on-the-ground initiatives have been translated to other states and the national level. Many feel that the time is now right to shift attention to other areas. The northeastern state of Mizoram has a rising epidemic and an administration keen on collaboration with the UN system. A smaller geography than Gujarat, it presents several challenges that could gain from the Gujarat experience and extend it.
- An important action that could facilitate the work is to set parameters to define focus areas negotiated with the heads of agencies. Once finalised, the elements of focus and framework could be discussed with NACO. That would help to set boundaries within which the Cosponsors would work and proposals would by and large fall within that remit. Defining the framework could help to bring larger impact and tell a more complete story on the CE work.

6.2.4 The UN Role

- The Joint Programme could benefit from showcasing its experience and results to regional and global levels, offering other countries a chance to learn and apply learning. Knowledge sharing could provide value to the Joint Programme, but equally to the Indian programme. The span of learning could be extended much further than simple dissemination within the HIV/AIDS world by encouraging Cosponsors to lead knowledge products.
- A particular value of UNAIDS is its access to community groups. By bringing civil society participation into the monitoring of its own work, UNAIDS can build its credibility further, as well as ensure civil society input to its future efforts to address HIV/AIDS in the country.
- The UN system is seen to be natural coordinator of the donor support to the HIV/AIDS response of the country. Cosponsors have well developed networks in their own fields. It has well-maintained, strong relationships with various ministries and departments of the government. Donors see the role of the UN system to be convening, with a focus on policy and advocacy. It may be worthwhile to take this responsibility forward.
- Thus far, the Joint Programme has done much to support the HIV/AIDS programme. It is perhaps now time to shift the focus from ‘what the Cosponsors can do to support the HIV/AIDS programme’ to ‘how HIV/AIDS awareness and action can be mainstreamed into all of the work that the Cosponsor supports’. That would greatly expand the influence of the work that Cosponsors are doing and bring the awareness of HIV/AIDS to every aspect of social life.

DEEP DIVE: GUJARAT

When the CE funding became available, a somewhat unusual decision was taken in the UN office in India. It was decided to concentrate all CE resources on only one state of the country – Gujarat, rather than the more common geography agnostic approach.

Choosing Gujarat

Gujarat was an unusual choice for two reasons: one, the UN had never before focused its HIV/AIDS work on one state of the country and two, Gujarat had not been identified as one of the most affected states of the country with respect to HIV/AIDS.[20] The underlying logic was based on several considerations, both data related and otherwise: HIV prevalence data; its political prominence and hence the visibility it could provide to the UN programme; lack of development partner support; and the good governance history of the state on HIV/AIDS suggesting probable uptake of any innovations. A key consideration was the fact that a Cosponsor – UNICEF, already had an office in the state.

The leadership of UNAIDS in country held the view that the money available under CE funding was likely to be marginal to the funding of the national HIV/AIDS programme but might be of value to a state. It was also felt that demonstration of catalytic and innovative experiences in Gujarat could be translated to the programme at the national level and in other states. Extensive discussions between the Cosponsors led to a finalization of the approach. However not all Cosponsors were convinced by this approach, and grumblings were heard even in 2022. This exclusive focus dwindled in the subsequent biennium, and the state focus has become blurred in the current biennium.

Gujarat as incubator

It was felt that Gujarat could be a good demonstration site for this new way of working. Gujarat has served as an incubator for activities, some of which are reflected in the NACP Phase-V plans. One of the models that came out of the Gujarat engagement is SRHR-HIV integration, described as a 'trailblazer'. The Sampoorna project developed with UNFPA after a detailed situation analysis, integrated SRH rights and HIV preventive services and care for key populations and PLHIV. A consultation led by UNDP for state level rules for implementation of the HIV/AIDS Act 2017 has been mirrored in other states. UNESCO has used CE funds to support the school health programme in which teachers have been trained to be Health and Wellness Ambassadors. Funds have been used by WHO to support the development of an app for treatment literacy and adherence, a study on s-testing and treatment cascade monitoring. UNICEF has supported the development of the NACO AIDS app in 10 languages, which provides service facilities tracking, and connects to social media pages and the 1097 helpline. The Shramik Shakshamta programme by ILO is an intervention to reach the unorganized sector in high priority districts. UNODC has worked with law enforcement and prison staff.

Responding to COVID-19 in Gujarat

The Cosponsors worked closely with community-led organizations to respond to the COVID-19 pandemic. In Gujarat, more than 70,000 PLHIV received their ART through decentralized, community-led HIV testing and DSDM during the COVID-19 pandemic. UCO had strongly advocated for multi-month distribution with US government and other partners as a way for treatment to reach PLHIV, while WHO worked hard to make differentiated treatment services available. Multi-month distribution was key in tiding over the COVID-19 impact. The adoption of Dolutegravir as a preferred first line of treatment is cited as a result of intense advocacy and technical assistance. Thousands of maternal and child healthcare providers were trained to improve PTMCT. The Joint Team supported expansion of HIV prevention and mental health counselling services among young people and key

[20] UCO has previously had a district focus under its CHARCA project and a northeast focus under its AusAID funding.

populations reaching over 4 million young people from the LGBT community online. The development of a module and videos was an innovative way to provide mental health support.

HIV situation today

Gujarat is among the well performing states of the country on HV/AIDS surpassing, for the most part, the performance of the country as a whole. Adult HIV prevalence has declined from 0.21% in 2017 to 0.19% in 2020, and HIV incidence per 1000 uninfected population from 0.06 to 0.03 in the same period. New infections have declined 72% between 2010 and 2020, 0.5 times higher than the national decline. However, the decline in AIDS-related deaths from 2010 to 2020 has been lower at 74% as compared with 82% for the country as a whole.[21] Gujarat has been supported by at least 8 UN agencies since 2017 – each performing to its strengths to bring their expertise to the HIV/AIDS programme.

[21] Department of Health and Family Welfare, Gujarat State AIDS Control Society. 2022. Unified Budget Results and Accountability Framework. UBRAF Activities. (PowerPoint)

ANNEXES

ANNEX 1: KEY INFORMANT INTERVIEWS, GROUP DISCUSSIONS AND FIELD VISITS

#	Name	Designation	Organization
Key Informant Interviews			
1	Chiranjeev Bhattacharjya	National Programme Manager	UNDP
2	David Bridger	Country Director India	UCO
3	Joel Rehnstrom	Director, Independent Evaluations	UNAIDS Secretariat
4	Kanta Singh	Deputy Country Representative	UN Women
5	Marjolein Jacobs	Senior Strategic Information Advisor	UCO
6	Nalini Chandra	Strategic Information Advisor	UCO
7	Nandini Kapoor Dhingra	Senior Programme Advisor	UCO
8	Rohini Gupta	Paediatric AIDS	WHO
9	Sarita Jadav	National Programme Officer	UNESCO
10	Seema Joshi	Criminal Justice Expert	UNODC
11	Shahmeena Hussain	Project Director	GSACS
12	Syed Mohammed Baqar	Senior Technical Specialist	ILO
13	Syed Hubbe Ali	Health Specialist	UNICEF
14	Vimlesh Purohit	National Programme Officer	WHO
15	Suruchi Pant	Regional Office Rep	UNODC
Group Discussions			
1	Civil Society	Indian Drug Abuse Prevention, Kripa Foundation, Gujarat State Network of People Living with HIV, Sakhi Jot Sangathan and India All Committee Member of Sex Workers, Independent Consultants, Alliance Indi	
2	GSACS and team	Rajesh Gopal APD and Team	
3	UNAIDS Country Team	David Bridger and Team, Joel Rehnstrom	
4	United Nations Joint Team on HIV/AIDS	WHO, UNFPA, UNESCO, UNDP, ILO, UCO	
5	UNFPA Team	Saswati Das, Bimla Upadhyay, Nalini Srivastava	
Field Visits in Ahmedabad and Vadodara			
1	BJ Medical College, Ahmedabad	ART centre, ICTC, STI, PMTCT	
2	Lakshya Trust	MSM-GBT communities – awareness, COVID-19 support, community-based testing, multi-month dispensation	
3	Garima Greh	Shelter Home for transgender people	
4	Gujarat AIDS Awareness and Prevention Unit	HIV/AIDS awareness among workers –Metro Rail Corporation	

5	Gujarat State Network of Positive People	HIV Act, community-based testing, voluntary counselling and testing of workers, COVID-19 support, treatment literacy, multi-month dispensation
6	Vikas Jyot Trust	FSW community - awareness, COVID-19 support, multi-month dispensation

ANNEX 2: DOCUMENTS REVIEWED

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- Alliance India, GSACS, Sampoorna, UNFPA. 2020. Strengthening Integration of Sexual and Reproductive Health and HIV Services in Gujarat – situational assessment and baseline study report.
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- ILO. 2020. Article on Reaching Migrant Workers under VCT@work in Gujarat, India in times of COVID-19.
- Joint Secretary, Ministry of Education. 2020. Letter reg Celebration of International Day against violence and bullying at school, including cyberbullying.
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- Ministry of Health and Family Welfare, National AIDS Control Organisation. 2022. Strategy Document National AIDS and STD Control Programme Phase-V (2021-2026).
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- NCERT, UNESCO. (undated). Brief on Safe Online Learning in times of COVID-19.
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- Rao. 2016. MidTerm Appraisal of the National AIDS Control Programme Phase IV. (Power Point).
- School Education Department, Government of Tamil Nadu, UNESCO. 2019. Agreement of Cooperation on Health and Wellbeing in Schools.
- UNESCO. (undated). Comic Book on 11 themes on growing up.
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- UNICEF. (undated). Human interest Stories from the field
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- _____. Priority Areas for HIV Programme (April 2021 – March 2024).
- _____. 2019. Policy Framework to address Tuberculosis, TB related co-morbidities and HIV in the World of Work in India

ANNEX 3: SUMMARY OF ACTIVITIES PLANNED FOR 3 BIENNIUMS

Biennium	Lead agency	Note
2018-19	ILO	Much of the work focused on A Voluntary Counseling and Testing @work. Outreach expansion to both formal and informal sectors. Co-optation of GNSP+ on advocacy with workplace owners.
	UNDP	Focus on HIV Act and MSM/TG populations. TG Welfare Board set up in Gujarat.
	UNESCO	Initial study, advocacy, App development, toolkit for students and teachers on Comprehensive Sexuality Education. Wide coverage with posters in schools in Gujarat and Tamil Nadu.
	UNFPA	Initial start with assessment and capacity building and development of materials on SRH-HIV interface. Followed by intervention to build synergies at district level.
	UNICEF	Focus on eMTCT services through training, data verification and guidelines development
	UNODC	BSS activities in Gujarat particularly in prisons. Work in prisons to build support for community based screening, engendering the harm reduction response. High level meeting with 22 other states to share experiences.
	WHO	Work to introduce new advances in HIV treatment and care. Support to EMTCT programme, Viral Load scale up. Self Testing study and dissemination. Study on use and responses to KPs on virtual space
2020-21	ILO	Focus on Diamond, Textile and Transport sectors important in Gujarat. Focus on informal women workers through testing, capacity building and support to WLHIV. Collaboration to strengthen the National Policy framework on HIV/AIDS.
	UNDP	Maintained focus on HIV Act, TG Welfare Framework. Development of the National Transgender, Thirunangai, Kinnar, Hijra Association. Framework for Community System Strengthening and Community Led Monitoring.
	UNESCO	Plans more ambitious, but all but wiped out by COVID-19.
	UNFPA	Strengthened capacity at district facility level. Empowerment of FSW to seek care from integrated facilities.
	UNICEF	Expanded focus to include adolescents, school going children and private sector.
	UNODC	Capacity in Department of Social Justice facilities on HIV programme. Engendered response extended to SRH-HIV services, hygiene kits for residents of women's homes. Training of LE officials and building documentation that supports their involvement.
	WFP	Food and nutrition guidelines for PLHIV treatment, care and support updated.
	WHO	Introduction of new advances in HIV treatment and care. Work disrupted by COVID-19. WHO guidance on COVID-19 translated at national and state level into strategies.
	World Bank	
2022-23	ILO	Primary focus on informal and migrant workers for testing, linkages to treatment and social protection schemes. Setting up collaboration between NACO and Ministry of Labour and Employment.
	UNDP	Continued focus on TG welfare and LGBTQI community processes and stigma and discrimination. Attention to social protection measures, skilling of TG groups and their mainstreaming into society at large.

	UNESCO	Plans significantly more ambitious - extension to other states, coverage of schools with 2 million students. Also building tools and action against substance abuse and schoolyard bullying including of TG.
	UNFPA	Consolidate integrated approach for community level engagement on SRH-HIV information and services for key population groups. Undertake communication support in collaboration with UNICEF, UNODC and other partners.
	UNICEF	Continued focus on eMTCT, adolescent health
	UNODC	Continued work from previous biennium
	UN Women	Support to education and livelihood opportunities of WLHIV and affected families
	WFP	Mainstreaming of HIV with different livelihoods and food safety net programmes of government
	WHO	Work with Paediatric Centres of Excellence to build capacity of ART centre staff on adolescent counselling. Build capacity in Gujarat on monitoring and new developments in the programme. Support NACO at national level and in 2 states.

ANNEX 4: CIVIL SOCIETY MARKERS

Annex 4: Civil Society markers | per Cosponsor | 2018 - 2023

	2018			2019*			2020*			2021			2022			2023		
Co Sponsor	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3	1	2	3
ILO	2	2	1			1	1	4	3	1	4	4	1	2	1	1	2	1
UNDP	2		1				2	5		1	2		1	6	4	1	6	4
UNESCO	5		1				9			7				5			5	
UNFPA	3			1			2	7		1	11		1	3		1	3	
UNICEF	6			6			26			16				4			4	
UNODC	1	2	2				10	2		3			5	1		4	1	
UNWOMEN													1	5		1	5	
WFP										4				3				
WHO	4	1		1	1		12	4	0	6	1		3			3		
World Bank							1											
Total	23	5	5	8	1	1	63	22	3	39	18	4	12	29	5	11	26	5

* Most activities not assigned a Civil Society marker

From Official JPMS data

ANNEX 5: GENDER MARKERS

Annex 5: Gender markers | per Cosponsor | 2018 - 2023

	2018			2019*			2020				2021			2022			2023		
Co Sponsor	1	2	3	1	2	3	0	1	2	3	1	2	3	1	2	3	1	2	3
ILO	1	3	1			1	1	4		3	4	1	4	2	1	1	2	1	1
UNDP		3							7			3		1	6	4	1	6	4
UNESCO		6						1	8		2	5			4	1		5	
UNFPA		3			1				9			12			4			4	
UNICEF		6			6				26			16			3	1		3	1
UNODC	2	3						3	8	1	1	2		4	1	1	3	1	1
UNWOMEN															6			6	0
WFP												4			3				
WHO		5			2			5	11		4	3		3			3		
World Bank									1										
Total	3	29	1	0	9	1	1	13	70	4	11	46	4	10	28	8	9	26	7

* Most activities not assigned a Gender marker

** Three activities were not assigned a Gender marker

From Official JPMS data

ANNEX 6: HUMAN RIGHTS MARKERS

Annex 6: Human Rights markers | per Cosponsor | 2022 - 2023

	2022			2023		
Co Sponsor	1	2	3	1	2	3
ILO			4			4
UNDP		6	5		4	7
UNESCO		5			5	
UNFPA		4			4	
UNICEF		4			4	
UNODC		5	1		4	1
UNWOMEN		6			6	
WFP	3					
WHO	3			3		
World Bank						
Total	6	30	10	3	27	12

From Official JPMS data

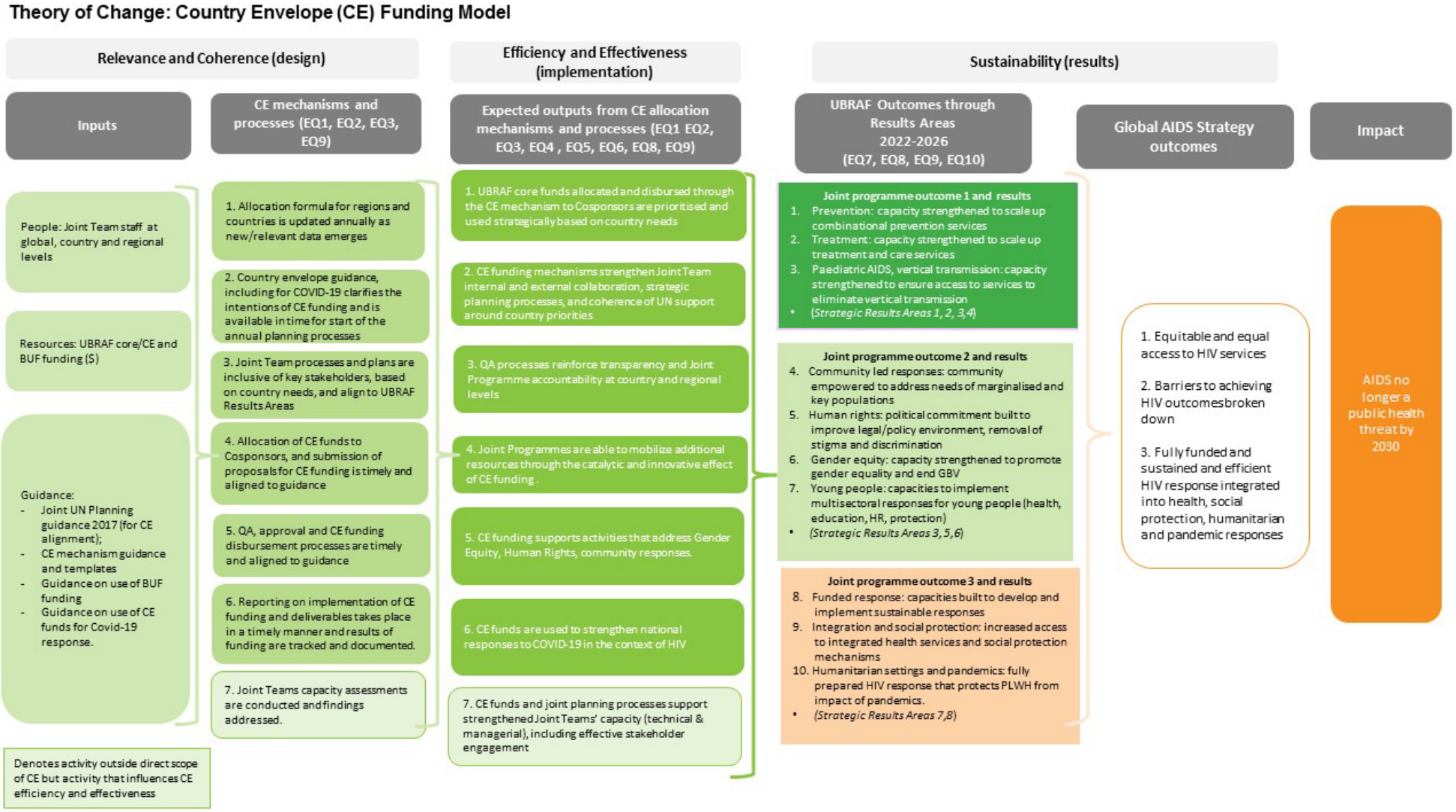
ANNEX 7: COVID-19 MARKERS

Annex 7: COVID markers | per Cosponsor | 2020 - 2023

	2020		2021		2022		2023	
Co Sponsor	Y	N	Y	N	Y	N	Y	N
ILO	3	5	4	5	1	3	1	3
UNDP	4	3		3	5	6	3	8
UNESCO	2	7	1	6	1	4	0	5
UNFPA	2	7	2	10	1	3	1	3
UNICEF	16	10	12	4	3	1	3	1
UNODC	6	6		3	2	4	2	3
UNWOMEN						6		6
WFP			2	2		3		
WHO	6	10	1	6		3		3
World Bank		1						
Total	39	49	22	39	13	33	10	32

From Official JPMS data

ANNEX 8: THEORY OF CHANGE: COUNTRY ENVELOPE (CE) FUNDING MODEL



ANNEX 9: TEN EVALUATION QUESTIONS

Ten evaluation questions
Strategy and Design (Relevance and Coherence): *These questions are concerned with the design of the country envelope allocation model and whether the design is strategic and appropriate to achieve its intended purpose.*
Evaluation question 1: How well is the country envelope allocation mechanism working? Consider relevance and coherence of a. global allocation model as a mechanism to ensure allocations are targeting highest priority countries and effectively decentralises decision making and allocations to regions and countries most in need b. country allocation model as a mechanism for ensuring performance based and differentiated funding allocations to cosponsors, based on country needs
Implementation (Efficiency and Effectiveness): *These questions are concerned with the implementation of the country envelope model, specifically whether the processes set up to implement the model are working well and as intended.*
Evaluation question 2: How well are the structures and processes to support the implementation of the country envelope model working in practice? Consider efficiency and learning of: a. prioritisation and use of funds b. transaction costs associated with due diligence, managing and reporting on country envelope and BUF funds vis-à-vis volume of country envelope funds c. ease of use of guidance and templates for country envelope and BUF funding d. timeliness of funding disbursement processes e. timeliness and effectiveness of global, regional quality assurance processes
Evaluation question 3: To what extent have country stakeholders (govt, civil society, PLWH, key population groups, and other partners) been engaged in UN joint planning and implementation at country level?
Evaluation question 4: To what extent have country envelope and BUF funding contributed to addressing gender equality, human rights, and community responses[22]?
Evaluation question 5: To what extent have country envelope and BUF funds supported the adaption of HIV programming during the COVID-19 pandemic in a flexible and timely way? How has COVID-19 impacted on the implementation of country envelope activities?
Results and sustainability *These questions are concerned with identifying key results arising from country envelope funding as well as alternative funding models that might benefit the Joint Programme's support to national HIV responses.*
Evaluation question 6: To what extent have the country envelope and BUF funds achieved the country envelope outputs/results, as intended (see ToC): a. strategic use of funds based on country needs b. improved accountability of UN funding and actions c. improved collaboration and leverage with partners through country envelope planning processes (internally between Joint Team members and with external partners) d. catalysing action and innovation[23]
Evaluation question 7: What results have been generated through country envelope funding and how are country envelopes contributing to the achievement of UBRAF outputs 1-10 and higher-level Global AIDS Strategy outcomes?
Evaluation question 8: To what extent have the country envelope funds enhanced and changed the capacity of Joint Teams and supported the mobilisation of resources[24] at country level?
Evaluation question 9: What are the main factors helping or hindering the achievement and sustainability of results? Consider

[22] Please note that supporting communities has been a priority for the Joint Programme but has not had a specific Strategic Results Area under the previous Fast Track Strategy. The concept of community-led responses' is recent, in the new Global AIDS Strategy and is unlikely to be articulated in country envelopes before 2022. All Cosponsors are expected to contribute to this, so there is no defined lead Cosponsor agency in the Division of Labour.

[23] See definitions in p.15

[24] Mobilisation of resources in the context means human, financial and technical resources for the Joint Programme and for the national response.

a. country capacity b. internal guidance, processes, and requirements c. other factors
Evaluation question 10: What other models exist as potential alternatives for funding the work of UN agencies at country level?

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