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

Country case studies

Zambia

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ABBREVIATIONS AND ACRONYMS

AGYW/ABYM	Adolescent Girls and Young Women/Adolescent Boys and Young Men
AIDS	Acquired Immuno-Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
BUF	Business Unusual Funds
CE	Country Envelope
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organization
DHIS	District Health Information System
DSDM	Differentiated Service Delivery Model
EHG	Euro Health Group
EID	Early Infant Diagnosis
HIV	Human Immuno-Deficiency Virus
ILO	International Labour Organization
IOM	International Organization for Migration
JUNTA/Joint Team	Joint UN Team against HIV/AIDS
KP	Key Population
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex
MoH	Ministry of Health
MoHA	Ministry of Home Affairs
MoJ	Ministry of Justice
NAC	National HIV/AIDS/STI/TB Council
NDP	National Development Plan
PLHIV	People Living with HIV/AIDS
PMTCT/eMTCT	Prevention of Mother-to-Child Transmission/Elimination of Mother-to-Child Transmission
RMNCH	Reproductive, Maternal, Newborn and Child Health
RNASF	Revised National HIV/AIDS Strategic Framework
SDG	Sustainable Development Goals
SGBV	Sexual and Gender-based Violence
SRHR	Sexual and Reproductive Health and Rights
SWOT	Strengths, Weaknesses, Opportunities, Threats
UBRAF	Unified Budget Results and Accountability Framework
UCO	UNAIDS Country Office
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
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

UNSDCF	United Nations Sustainable Development Cooperation Framework for the Republic of Zambia, 2023-2027
WHO	World Health Organization
ZAMPHIA	Zambia Population-based HIV Impact Assessment
ZCS	Zambian Correctional Services

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Our sincere thanks go to Dr Tharcisse Barihuta, UNAIDS Country Director, Zambia and the Country Office team for facilitating the contributions of UN agencies and other key informants to this evaluation in addition to providing his own valuable insights. A special thanks also goes to Louisa de Wet who provided tireless support to the evaluation team to ensure a fruitful country visit.

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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.

This case study[1] has been supplemented by document review and key informant interviews (KII) at the global and regional levels.

1.2 Approach/Methods/Limitations

The evaluation is theory-based and has involved development of a Theory of Change (See Annex 4) 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[2] were identified, refined, and mapped to the Theory of Change.

This country case study focuses mainly on qualitative analysis of plans of the Joint UN Team against AIDS (Joint Team) and the implementation and results of CE-funded activities. Additionally, the case study focuses on eliciting lessons learned and factors helping or hindering the use and effectiveness of CE. This case study was conducted through document review, key informant interviews (KIIs) with staff of the UNAIDS Country Office (UCO) and Cosponsors, government ministries, PEPFAR, and with civil society organizations (CSOs) including community-based organizations and faith-based organizations. In all, 15 key informant interviews (KIIs) (n= 43 persons) and 2 group discussions (with the JUNTA and CSOs) were conducted in August 2022. Interviews were conducted face-to-face and using zoom due to lack of presence in country of some Cosponsors. Where possible, quantitative analysis has been undertaken of the data provided by UNAIDS. A list of all KIIs is found in Annex 1 along with a list of CSOs who attend a workshop/group discussion in Annex 3. A bibliography of documents reviewed is found in Annex 2.

The UN Joint Team on HIV-AIDS in Zambia has implemented 48 activities funded through country envelopes from 2018-2021 and an additional 15 activities under implementation in 2022 (see Annex 6 for more details). Due to the limited time available for the country study it was not possible to conduct

[1] Zambia is one of 6 case studies including Cote d'Ivoire, India, Iran, Kyrgyzstan, and Peru/Ecuador/Bolivia.
[2] https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

an in-depth evaluation of each CE funded activity. The purpose of the country case study was to collect evidence to answer ten overarching evaluation questions (see Annex 4). The Zambia country study has examined how the CE contributed to relevance, coherence, efficiency, effectiveness and sustainability and results, while also purposively focusing on the strategic value of specific condom programming activities led by UNFPA through a 'deeper dive'.

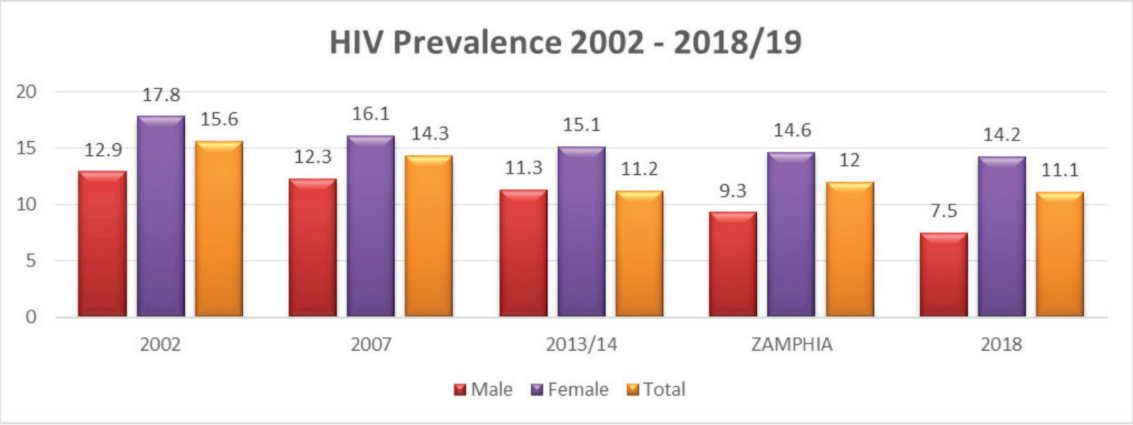
2 National HIV Context and Programme Response

2.1 Overview of the epidemic

Zambia has high HIV prevalence and incidence rates and a generalized and mature HIV epidemic, with the majority of new HIV infections transmitted through unprotected heterosexual sex. Co-morbidities and opportunistic infections add to the HIV burden. HIV and AIDS continues to pose a significant challenge to Zambia's socio-economic development. HIV incidence rate is reported at 0.51% for 15-24 years, 0.40% among 15-49, and 0.36% among 15-64 years.[3]

According to the Spectrum 2022, there are 1,336,056 Zambians estimated to be living with HIV. Using these estimates, women remain disproportionately affected (62%) by HIV; AGYW between 15 and 24 years of age have an incidence rate of 0.5% compared to 0.2% for adolescent boys and young men (ABYM) in the same age group.

Figure 1: HIV Prevalence among adults (15-49 years) over time and disaggregated by sex



Source: ZDHS 2002, 2007, 2013, 2018, ZAMPHIA 2016.

There are regional variations in the HIV situation in Zambia. Among persons aged 15-49 years, the Copperbelt province has the highest prevalence of 15.4% followed by Lusaka province at 15.1%. Central and Southern provinces report 12.4% prevalence while Western is 10.6%, Luapula 7.9%, Eastern 7.4%, and Northern 5.6%. Muchinga and North-Western provinces have the lowest prevalence rates estimated at 5.4% and 6.1% respectively.[4]

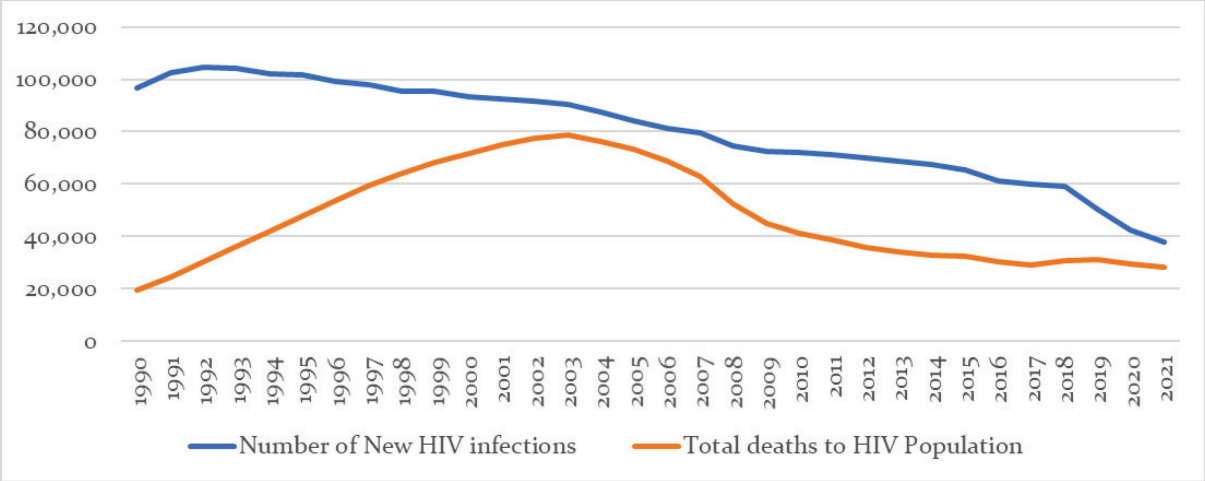
The current national HIV incidence is 0.7% (1.08% females, 0.33% males) according to the Zambia Population-based HIV Impact Assessment (ZAMPHIA), 2016. Ninety percent of new infections are driven by factors such as multiple and concurrent sexual partnerships, mother to child

[3] Zambia Demographic Health Survey 2018 (ZDHS, 2018)
[4] Revised National Aids Strategic Framework 2020 – 2023

transmission, low and inconsistent condom use, low levels of male circumcision (and low uptake of voluntary male medical circumcision – VMMC)s, mobility and labour migration. [5]

Zambia has recorded significant improvements in health with corresponding reductions in the burden of disease. The reductions, however, have not been adequate and the burden of disease remains high. Spectrum estimates that in 2021, AIDS estimated deaths for Zambia was 19,000 persons. AIDS estimated deaths in Zambia fell gradually from 71,000 persons in 2002 to 19,000 persons in 2021. This decline has been attributed to the success of the anti-retroviral therapy (ART) programme in the country. The survival and retention of people on ART at 12 months has increased from 65% in 2010 to 90% in 2021. [6] Similarly, mortality attributed to AIDS in infants has reduced from a peak of 10.2% in 2000 to 4.7% in 2019 according to the National AIDS, STI and TB Council (NAC) reports. The figure below shows the trends in AIDS-related deaths.

Figure 2: AIDS related Deaths 1990-2021



Source: Spectrum 2022

2.2 National HIV policy and programmatic response

The Revised National HIV/AIDS Strategic Framework (RNASF 2020-2023) is the sixth in a series of national HIV/AIDS strategic frameworks and is a three-year strategy aligned with the Vision 2030, Seventh National Development Plan (7NDP), National HIV/AIDS Policy, and international and regional commitments. The priority focus for the RNASF 2020-2023 is to intensify combination HIV prevention in the national multi-sectoral HIV response with a view of reducing new HIV infections which currently stand around 38,000 per year[7]. The RNASF recognises the HIV/AIDS epidemic as a socio-developmental challenge and, therefore, incorporates emerging issues in the epidemic response and the application of the Fast-Track strategies to achieve the 95-95-95 targets by 2025 and the ultimate elimination of new HIV infections by 2030.

The overarching goal of the RNASF is to reposition prevention of new HIV infections as the main focus of the national multi-sectoral HIV and AIDS response. Thus, greater emphasis has been placed on scaling-up HIV combination prevention services that enable individuals to maintain their HIV negative status as well as improve access to HIV testing, quality treatment and care services. HIV combination prevention will also target people living with HIV (PLHIV) with positive health, dignity and prevention (PHDP) interventions which began in 2019 to reduce transmission of HIV. **Young people are the population group targeted under the RNASF.** The RNASF was developed in the context of the COVID-19, PEPFAR's Country Operational Plan (COP) 2020 as well as the 7NDP 2017-2021 and its principle of

[5] MoT 2016
[6] Spectrum 2022
[7] Global Fund HIV/TB Funding Request 2021-2023

'***NOT LEAVING ANYONE BEHIND'***. While the Global Fund HIV/TB Funding Request 2021-2023 was developed based on the RNASF.

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

HIV models suggest that the number of new HIV infections in Zambia still exceeds the number of deaths amongst PLHIV. Though the updated Spectrum 2022 model shows that this gap has reduced, the country must invest strategically to achieve sustained HIV epidemic control. This includes a central focus on prevention of new infections.

Equally important to ensuring control of the epidemic is addressing key systems barriers including (not all inclusive) inadequate: supply chain including commodity distribution, domestic resource mobilization, health workforce, local support for laboratory systems, and CSO engagement. In addition, maintaining a reliable procurement and supply chain for laboratory commodities remains a challenge and a key priority of the government (RNASF). These barriers affect the ability to retain patients on treatment and prevent new infections from occurring.

There are several challenges and gaps that were identified in the RNASF as major bottlenecks for addressing a strategic response to the HIV pandemic in Zambia. One of the biggest challenges has been the poor HIV and sexual and reproductive health indicator outcomes for adolescents and young people. Despite several interventions being initiated, data has shown that the various HIV prevention projects have not made a difference at impact and outcome levels.

Most of the areas that that need further attention when it comes to the HIV response are related to stigma and discrimination. Discrimination against people living with and affected by HIV is often driven by social-economic status, ethnicity, gender, gender identity and sexuality among other factors. There are still huge barriers when it comes to access to services for key populations, paediatric HIV case finding and treatment. Additionally, there has been a persistent disproportionate increase of infections among adolescent girls and young women. Gender norms exacerbated by taboos about sexuality influence the ability of AGYW to protect their health and prevent acquiring HIV, seek health services and make informed decisions about their sexual and reproductive health (SRH) and lives.

2.4 Financing of the national response

Zambia has traditionally demonstrated high levels of commitment to the HIV response through its contributions to human resources for health, policy guidance, and infrastructure serving as the backbone of the health system and all epidemic control efforts. That said an overwhelming portion of the national response to HIV in Zambia has been financed through external funding. This external funding is mainly provided by the United States government through PEPFAR (COP 2022 estimated funding of US$ 401 million), followed by the Global Fund (two HIV/TB grants of up to a combined total of US$ 262 million for 2021-2023)[8] both of whom contribute essential financial and technical assistance to fill the gaps in the government's HIV response.

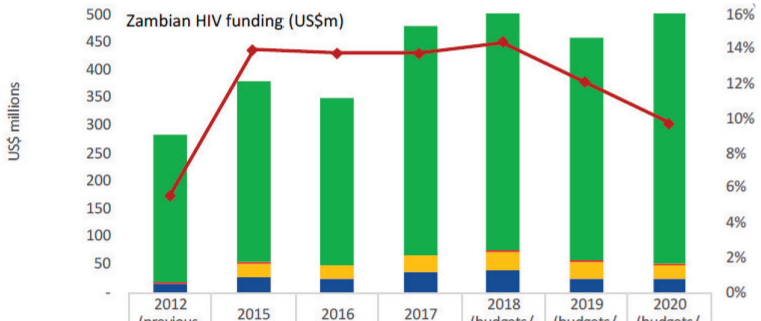
Zambia, under its long-term financing strategy for HIV, highlights integration of social health insurance, public subsidies, and national budget provisions for public health. HIV funding is explicitly included in the national budget, which is reflective of all sources of funding including external donors. Yet only 8% of government expenditure goes to health with 44.6% of total health expenditure financed by external resources. Additionally, on average less than 10% of the annual HIV response is financed by the domestic public and private sector funding (according to the most recent NASA 2015-2017) with

[8] https://data.theglobalfund.org/location/ZMB/overview

average execution rate for budgeted domestic HIV resources over the last three years of less than 50% with the COVID-19 pandemic contributing to reduced budget execution in 2020/2021.[9]

Data from the most recent NASA, 2022, was not available at the time of the evaluation. However, the 2017 NASA showed a 13.8% public contribution to the overall funding of HIV, noting that this included around US$ 30 million per annum for MoH indirect spending to support service delivery. These resources were estimated by the National Health Accounts (NHA 2016).

Figure 3: Trends in HIV expenditure – proportion of total on right axis



	2012 (previous NASA)	2015 (NASA)	2016 (NASA)	2017 (NASA)	2018 (budgets/ exp-repts)	2019 (budgets/ exp-repts)	2020 (budgets/ exp-repts)
External funds	263.63	326.32	299.50	410.74	435.62	399.31	454.57
Private funds	3.09	1.69	1.70	1.92	2.59	2.63	2.43
Est. MOH embedded HIV-HR costs (NHA)	-	26	23	30	33	30	24
Public funds (MOH+other ministries)	15.84	27.49	24.96	35.41	40.74	25.67	24.89
Public %	6%	14%	14%	14%	14%	12%	10%

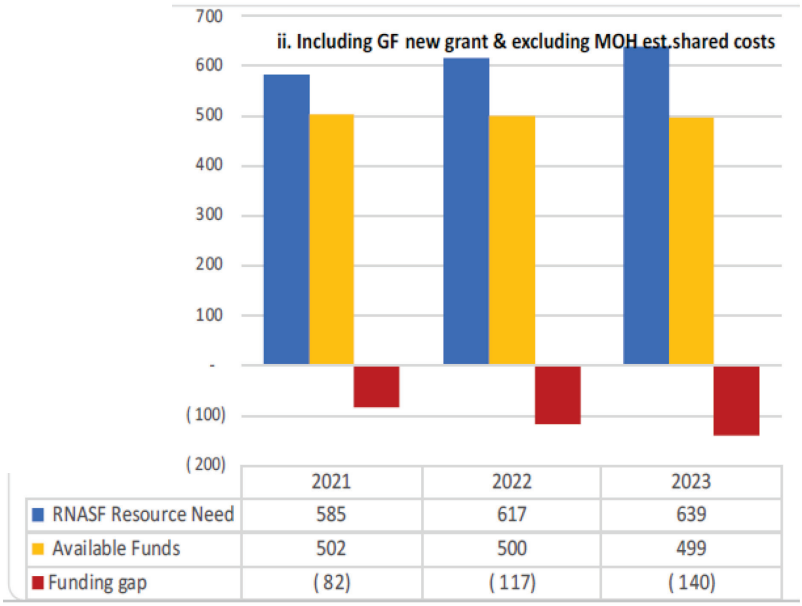
Source: Global Fund Funding Request 2021-2023; NASF MTR, NAC, 2020 – includes Global Fund funding for the 2020 grant assuming 100% absorption.

There is a persistent, and considerable, funding gap for the Zambian HIV response (see below) which threatens to undermine implementation of the RNASF. The most significant gaps, with regard to intervention areas, can be seen for AGYW, key populations and ART. This is particularly worrying as although health, including the HIV response, is prioritized as a key economic investment, financing of responses is under increased pressure due to a recession resulting from the COVID-19 pandemic and a collapse in the price of copper[10], which accounts for around 70% of Zambia's exports. As a result of this downfall Zambia has been reclassified to a low-income country for the first time since 2011, effectively reversing a decade of development gains.

[9] PEPFAR Country Operational Plan, 2022. UNAIDS and PEPFAR co-convened a multi-stakeholder sustainability index and dashboard and responsibility matrix consultative workshop in 2021. The workshop was designed to seek consensus around the gains in sustainability across different domains and elements of the HIV response. The MOH ultimately validated the findings and discussed with other government ministries, multilateral organization and civil society how to align responsibilities and resources to advance HIV programming. This data is based on the Domestic resource mobilization element of the sustainability index.

[10] Copper accounts for around 70% of Zambia's exports.

Figure 4: Available HIV funds versus resources needed and potential funding gaps



	2021	2022	2023
RNASF Resource Need	585	617	639
Available Funds	502	500	499
Funding gap	(82)	(117)	(140)

Source: Global Fund Funding Request 2021-2023

3 UNAIDS Joint Programme Strategic Orientation and Programme Approaches

UNAIDS coordinates the planning and resources of nine Cosponsors (for the 2022-2023 biennium[11]) under the Joint Team response to HIV in Zambia. The Joint Team is comprised of ILO, IOM, UNDP, UNHCR, UNICEF, UNFPA, UNODC, WHO, and World Bank.

3.1 Joint Programme and Joint Plans

The Joint Team supports Zambia's development priorities through the 2016–2021 United Nations Sustainable Development Framework (UNSDF)[12] which highlights the collective efforts of the UN and Joint Team for supporting transformation in Zambia. The Joint Plans are anchored in the five pillars of the Seventh National Development Plan (7NDP) thereby helping to foster more efficient and effective work on the fight against HIV and AIDS. Most recently, with the leadership and high-level advocacy of UNAIDS, together with other Joint Team members, the response to HIV and AIDS in Zambia remains an important strategy in the 8NDP (2022-2026) under Development Outcome 4: Reduced poverty, vulnerability, and inequality. Inclusion of this strategy within the 8NDP was seen as critical to maintaining HIV as a high priority agenda item going forward. According to key informants, this advocacy on the part of UNAIDS, along with the voice of the collective Joint Team, also ensured that HIV remained a key priority in the UNSDCF 2023-2027 (in the final stages of approval).

> *"To maintain gains made in the response to AIDS, a strong push is needed to keep HIV as an important component of the UN Cooperation Framework in the broader context of sexual and reproductive health in the country. The JUNTA remains an effective theme group and the UNAIDS country director keeps the UN Country Team well informed." (Joint team member)*

Under the scope and guidance of the UNDAF, the UN Joint Team formulated its Joint Plans which are in line with the National HIV and AIDS Strategic Framework (NASF 2017-2021) and the Revised NASF

[11] For 2018-2019 it was 6 Cosponsors' and 2020-2021 it was 7 Cosponsors
[12] The United Nations Development Assistance Framework (UNDAF) for Zambia 2016-2021.

(2020-2023)[13]. The Joint Plans address the ten high impact intervention areas and five critical enablers of the RNASF through focus on four main strategic areas including leveraging communities for acceleration of eMTCT, prevention with a focus on young people and key populations, health systems strengthening and sustainability of HIV and AIDS financing[14]. Both the Joint Plans and the RNSAF focus on effective evidence-based investments targeting key populations while ensuring that all Zambians have access to services and stigma and discrimination are reduced with a goal of improving health outcomes.

The table in Annex 6 sets out an overall description of activities contained in the Joint Plans developed for the three biennia under the Country Envelope funding mechanisms. The activities are categorized by Cosponsor, biennia, overall allocation level and strategic result area (SRA). The SRA in column three is derived from the JPMS categorization. Of note is that Cosponsors are allowed to choose only one SRA from a dropdown menu, however some Cosponsors stated that UNAIDS typically defines the SRA in the system not the Cosponsor. The information in brackets in column four (activity description) attempts to expand upon the SRAs to reflect the focus of the Cosponsors more accurately. This additional categorization is based on the evaluation team's interpretation of documentary evidence triangulated with information gathered from key informants.

3.2 Overview of Joint Team Cosponsors

An overview of the Joint Team Cosponsors overall funding (presented as expenditures) in addition to specific CE and BUF funding levels and expenditures are presented in this section.

Table 1 shows that CE funding in the 2018-2019 and 2020-2021 biennia was US$ 1.1 million and US$ 1.15 million respectively which included US$ 50,000 in BUF funding for UNDP in 2021. The funds were distributed among five Cosponsors in 2018-2019 and seven Cosponsors in 2020-2021. CE country funding to Cosponsors has remained stable over time except for a nearly 50% reduction to UNODC in 2021 which correlates with UNDP receiving CE funding for the first time (US$ 95,000). CE funding for the 2022-2023 biennium decreased slightly for all Cosponsors correlating to the addition of ILO and UNHCR as CE funding recipients, bringing the overall total of Cosponsors to nine (see below table). Of note is the considerable sum of CE funding for UNDP as a new initiate in 2021 of which more than 50% was BUF (US$ 50,000).

UNODC and WHO have traditionally received the lion's share of CE funding (combined 46% in 2018-2019 and 48% in 2020-2021) while World Bank has traditionally received the smallest (8% in 2020-2021); not surprising given World Bank typically funds large scale projects/responses through government grants and does not have a country presence but participates in the Joint Team. Also of note is the significant drop in UNODC and WHO combined CE funding in the 2022-2023 biennium (down to 24% of the total CE funding) yet still representing the top recipients over the six-year period (2018-2023).

[13] RNASF 2020-2023, Leaving no one behind on the fast track to controlling the HIV epidemic by 2020 and ending the threat of HIV and AIDS as a public health issue by 2030, May 2020

[14] United Nations Sustainable Development Partnership Framework, Annal Report 2020

Table 1: Allocation data per Cosponsor per year - 2018-2023

Cosponsor	2018	2019	2020		2021		2022	2023	Total 2018-2023
	CE	CE	CE	CE	BUF	CE & BUF	CE	CE	CE & BUF
UNODC	125,000	125,000	214,000	127,000		127,000	59,000	59,000	709,000
WHO	125,000	125,000	86,900	118,000		118,000	75,000	75,000	604,900
UNICEF	125,000	125,000	87,200	69,900		69,900	75,000	75,000	557,100
UNFPA	95,000	95,000	80,000	79,900		79,900	70,000	70,000	489,900
UNESCO	80,000	80,000	39,100	69,500		69,500	55,000	55,000	378,600
World Bank			42,800	40,700		40,700	30,000	30,000	143,500
UNDP				45,000	50,000	95,000	88,000	88,000	271,000
ILO							53,000	53,000	106,000
UNHCR							45,000	45,000	90,000
Total	550,000	550,000	550,000	550,000	50,000	600,000	550,000	550,000	3,350,000

Source: JPMS route reporting and Performance monitoring report provided by the UNAIDS finance team

Based on data provided by UNAIDS HQ (standardized reporting) absorption rates present a mixed picture for the 2018-2019 biennium. Among three Cosponsors, CE funding was almost fully utilized while two other Cosponsors struggled reporting just under 80% absorption in one case (UNODC with the largest amount of funding of all Cosponsors)[15] and well under at 39% absorption in the other case (UNESCO). Overall, the absorption rate for the 2018-2019 biennium (85%) was significantly less than the 2020-2021 biennium which recorded an over absorption rate of 109% (based on absorption of funding from previous years). Delayed receipt of funding which in turn resulted in a delayed implementation, along with other obstacles to implementation including human resource constraints, were cited as contributing to less-than-optimal absorption rates.

Table 2: CE allocation, expenditure, absorption data per Cosponsor 2018 & 2019 / 2020 & 2021

	2018 & 2019			2020 & 2021			Grand Total		
Co-sponsor	Allocation US$	Expend-iture US$	Absor-ption	Allocation US$	Expend-iture US$	Absorp-tion	Allocation US$	Expend-iture US$	Absorp-tion
UNODC	250,000	196,766	79%	341,000	371,275	109%	591,000	568,041	96%
WHO	250,000	239,539	96%	204,900	206,841	101%	454,900	446,380	98%
UNICEF	250,000	244,512	98%	157,100	157,100	100%	407,100	401,612	99%
UNFPA	190,000	190,000	100%	159,900	166,610	104%	349,900	356,610	102%
UNESCO	160,000	62,594	39%	108,600	182,706	168%	268,600	245,300	91%
World Bank				83,500	83,497	100%	83,500	83,497	100%
UNDP				95,000	78,761	83%	95,000	78,761	83%
ILO									
UNHCR									
Total	1,100,000	933,411	85%	1,150,000	1,246,790	109%	2,250,000	2,180,201	96%

Source: Performance monitoring report provided by the UNAIDS finance team

3.3 Main partnerships engaged in implementing the Joint Plans and country envelopes

The Joint Team in Zambia collaborates with national (government and non-governmental organizations including CSOs and private sector organizations) and other international partners (Global Fund, USAID,

[15] The 79% absorption rate was attributed to late arrival of funds in country due to delays on the part of UNODC HQ which impacted upon implementation.

CDC, SIDA, etc) to support the planning, development, and implementation of the nationwide HIV responses.

The main governmental partners with whom the Joint Team is engaged include the ministries of general education, gender, health, home affairs, justice, and religious affairs. In addition, the Joint Team works closely with the Zambia Correctional Services (ZCS), the Zambia Congress of Trade Unions (ZCTU) and the Zambia Federation of Employers (ZFE). The Joint Team has provided both financial and technical support, increasingly focusing on technical support, to these governmental entities / state institutions often through contracted specialists who conduct targeted pieces of work (e.g., development of a policy, strategy or guidelines; capacity building workshops and trainings). Technical specialists serving as staff members of the Cosponsors also engage with the various ministries and state institutions (e.g., WHO normative guidance support for establishing treatment guidelines including for HIV self-testing). In line with this, respondents to the online survey[16] indicated that potentially more efficient and effective ways of using the total amount of funding available for CE would be to "focus on utilizing funds for advocacy, policy formulation, normative guidance and human resource support".

CSOs are engaged in programmes and interventions at a more grass roots level with a focus on building the capacity of communities, key populations and linking communities to services. The Joint Team works with over 10 CSOs (see Annex 3 for a list of CSOs (not comprehensive) who attended a workshop in relation to this evaluation. These CSOs are often the recipients of capacity building efforts conducted by technical specialist contracted by Cosponsors. There are also contracted implementing partners carrying out critical work at the community level (e.g., Mothers2Mothers conducting eMTCT/PMTCT and prevention activities targeting AGYW, young girls and boys, among others[17]).

The US Government has been a collaborator in several initiatives through its agencies – Centers for Disease Control and USAID. The support provided by the Joint Team on Pre-Exposure Prophylaxis (PrEP), self- testing, condom promotion and the UCO's facilitation of government support was appreciated by PEPFAR, 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 and as such represents a key partner.

4 CASE STUDY FINDINGS

4.1 Evaluation question findings related to relevance and coherence

Evaluation Question 1: How well is the Country Envelope allocation mechanism working?

Summary of findings

- The process of allocating CE funding is conducted in a participatory manner at country level involving all Cosponsors. However, funding decisions are not based on performance or a clear set of documented criteria as per the CE guidelines but guided by "inclusiveness", a communal desire across the Cosponsors to ensure that everyone is involved.

[16] As part of this evaluation an online survey, consisting of 17 questions, was administered to all countries where CE funding is allocated to solicit to gather further information. Nine respondents from Zambia completed the online survey.

[17] Mothers2Mothers began HIV implementation in 2008 with their Mentor other Model (with PEPFAR funding) and has since implemented the Comprehensive HIV/AIDS Management Programme (CHAMP) and is currently implementing activities as part of a consortium with John Snow Inc. under and AIDS-Free Era programme in Copper Belt and Central Provinces. UNICEF support to M2M represents a small portion of their overall funding.

- Support provided by regional mechanisms, principally RATESA, has the potential to influence a more transparent and strategic allocation of CE funding but needs further strengthening.
- Although the Joint Plan and CE proposals are well aligned with the SDGs, UBRAF Strategic Areas and country priorities (of which there are many) further prioritization of interventions is warranted to ensure that the CE is addressing critical strategic priorities for the country tapping into the competitive advantage of Cosponsors.
- Strong opinions were expressed on the need of the Joint Team to refocus, moving away from activity implementation which is best done by bigger partners (USAID, CDC, principal recipients of the Global Fund) and focus on policy development, elaboration of normative guidance, strategic planning and analysis and high-level advocacy as examples.

The process of allocating country envelope funding is conducted in a participatory manner at country level involving all Cosponsors. However, funding decisions are not based on performance or a clear set of documented criteria as per the CE guidelines but guided by "inclusiveness", a communal desire across the Cosponsors to ensure that everyone is involved. As reported by KIs from the Joint Team, the CE allocation decision-making process is carried out through a round table meeting engaging all Cosponsors which immediately follows an announcement by UNAIDS with respect to CE allocation. An assessment of the UBRAF strategic priorities as well as government strategic areas where support is needed including discussion on agencies that are most suited to address those areas and provide support (based on their competitive advantage) is undertaken. Key informants noted that discussions are not guided by past performance, nor the true catalytic/innovate nature of proposed interventions. Rather, activities/interventions are often a continuation from previous years/biennia.

Strategically the Joint Team is trying to address the epidemic based on epidemiological data with a focus on prevention and young key populations. Politically however, increasingly the money is being spread more thinly across a greater number of Cosponsors.

"Limiting the number of agencies who received funding in the first two rounds of the country envelopes created tension and led to difficult discussions about who should administer the funds with some agencies feeling left out and side-lined".

"Reducing the agencies risks them deprioritising HIV".

"By funding many agencies, as is currently the case, the envelope funds lose their focus, and a better approach would be to allocate the funds to fewer agencies."

*"Sharing for the sake of sharing resources is not the best way to go – to see results must conduct a proper assessment and give an agency based on their ability, skills and experience in implementing that. Need to use science to disburse the resources. Need to focus so that when 2027 comes we can say with **this** funding under **this** activity we are accountable for **these** results from **this** agency".*

All quotes are from Joint Team members

Support provided by regional mechanisms, principally RATESA, has the potential to influence a more transparent and strategic allocation of CE funding but needs further strengthening.

The Joint Team in Zambia is supported by the Regional AIDS TEAM for Eastern and Southern Africa (RATESA). This support includes technical input into the draft CE proposals led by the Zambia focal point within RATESA who coordinates input from other regional members before feeding back to the country. RATESA also serves a wider quality assurance (QA) role, beyond reviewing the summary template priorities, results areas and activities for the country and in the past BUF funding applications. This expanded role includes adjourning meetings with the wider RATESA team and the Joint Team to discuss proposed interventions. Strategic direction provided by the regional team to focus on key populations in the 2020/2021 biennium including a suggested increase in funding for the Cosponsor mandated to focus

on KPs exemplifies the level of support provided. RATESA has also played a role in reviewing BUF proposals resulting in UNDP funding approval in 2021 and non-approval of the UNODC proposal[18].

The level of RATESA input is reported by members to have evolved over time aiming to ensure a focus on catalytic and innovative interventions within the Joint Plans. However further strengthening of their internal processes and mechanisms, according to the members, is needed and is currently under refinement. Future activities of the RATESA, once the focal point mechanism is further institutionalized and operational, include regular calls to countries to identify technical assistance needs, strengthening oversight through six monthly calls with the Joint Team to discuss progress against the Joint Plan and annual joint missions to Zambia.

Although the Joint Plan and CE proposals are well aligned with the SDGs, UBRAF Strategic Areas and country priorities under the RNASF (of which there are many) further prioritization of interventions may be warranted to ensure that the CE is addressing *critical* strategic priorities for the country tapping into the competitive advantage of Cosponsors. The strategic priority areas identified under the RNASF, in line with the Vision 2030, 7NDP, National HIV/AIDS Policy and other international and regional commitments are all encompassing and vast. The plan recognizes that HIV and AIDS poses a "socio developmental challenge" and warrants a multi-sectoral response. In addition to strategic priority areas the MoH and the NAC have also identified a vast number of activities that they consider strategic and for which they seek assistance from development partners and agencies to plan and implement. Moving forward the plan should also be aligned with eth NDP8 priorities.

Strong opinions were expressed by Joint Team members on the need of the Joint Team to refocus, moving away from activity implementation which is best done by bigger partners (USAID, CDC, principal recipients of the Global Fund) and focus on policy development, elaboration of normative guidance, strategic planning and analysis and high-level advocacy as examples. These are areas that are difficult for development partners (e.g., PEFPAR which is the biggest financial contributor to the fight against HIV and AIDS in Zambia) to fully engage in, due in part to political orientation and mandates. This is where the comparative advantage of the Cosponsors appears to lie. This in turn would target strategic interventions that can change or maintain the course of the response, as opposed to engaging in trainings and workshops (as examples) which were reported to be duplicative at times and require hiring in resources or contracting implementing partners which poses a management and financial burden on an already small CE. Different respondents to the online survey (specifically those from Zambia only) expressed that a potentially more efficient and effective way of using the total amount of funding available for CEs was to "engage in proper planning and funds should be allocated to UN agencies based on their competencies" and that there is a need for "prioritizing key interventions and combing efforts" where "the current approach seems to be a distribution of funds to Cosponsors ….. we need prioritised areas of interventions".

Both the MoH and the NAC cited examples of key achievements realized with the leadership and support of the Joint Team. These high-level achievements highlight the comparative advantages of the Cosponsors and include (not an all-inclusive list):

- Development of the first National Comprehensive Condom Strategy 2020-2025 (spearheaded by UNFPA in collaboration with the MoH and NAC)
- Revision of treatment guidelines in line with international standards and norms (work carried out by WHO relying heavily on in-house staff funded in part by CE)
- The role of UNICEF as "enormous and transformative in terms of work being done with regards to PMTCT" including eMTCT and the development of the triple elimination plan which "puts us on the map toward elimination, moving from just prevention"

[18] Although clarity was sought as per the reason for non-funding an answer was never provided to the evaluation team.

- Development of an overarching workplace policy for the country (ILO)
- Joint Team overall strategic contributions to both the Global Fund Funding Requests (e.g., focus on condom programming) and the PEPFAR Country Operational Plans (e.g., continued focus on eMTCT)

The successes outlined above, utilizing CE funding, are grounded largely in the design and development of policy and strategy level interventions and less so on-the-ground operational level interventions. That said, the successes pave the way for design of interventions which are taken up by the government, other development and implementing partners as well as civil society organizations. The overall notion of more strategically focusing Joint Team support to capitalize on their competitive advantages is recognized and welcomed by government.

4.2 Evaluation findings related to efficiency and effectiveness of Joint Programme Country Envelope mechanisms and processes

Evaluation Question 2: How well are the structures and processes to support the implementation of the country envelope model working in practice?

- Overall processes were seen as not complicated but guidelines seen as "too much".
- Delays in receipt of CE funding has affected implementation and subsequent results.
- Overall, transaction costs associated with CE/BUF funding according to Cosponsors were not considered onerous.
- BUF funding was seen by some to be potentially both catalytic and innovative in nature, however results of the funding are yet to be realized and the 2022/2023 biennium seems to be back to business as usual rather than unusual.

Overall processes were seen as not complicated but guidelines were seen "as too much". Guidelines were cited by most informants to be clear and improved upon while others were of the opinion that they were lengthy with regard to the ultimate outcome (e.g., more than 20 pages of guidelines in order to produce a less than 5-page report).

With respect to the digital JPMS platform it was considered relatively easy to work with once certain glitches were resolved (e.g., showing incomplete reporting when reporting was finalized, lack of access by some Cosponsors, etc). In comparison to other systems for reporting (many Cosponsors have multiple funding sources and reporting requirements) UBRAF requirements were considered straight forward and "one of the easiest". That said, the reporting against gender and civil society markers, which is obligatory, was seen as not relevant for certain activities therefore interpreting the results of such categorization should be done with caution. Additionally Cosponsors who manage multiple sources of funding for HIV and health in general, mentioned the challenge of attributing results to CE funding as the funds are intermingled and are by and large additive in nature.

Delays in receipt of CE funding has affected implementation and subsequent results. Again, although the processes for requesting and reporting on actual funds is not onerous, the disbursement of funding was cited by all respondents as delayed. The reported reason of the delay is from Cosponsor HQ to country offices. Although most Cosponsors receive funding late into the first quarter of the fiscal year, longer delays have been reported which seriously affect activity implementation and achievement of targets in line with workplans. The latest guidance, guaranteeing two years of funding, is a welcome change and is thought to benefit strategic planning and

achievement of results in addition to providing more financial security through guaranteed two year funding.

Overall, transaction costs associated with CE/BUF funding according to Cosponsors were not considered onerous. Despite the relatively small amount of funds received by all Cosponsors (e.g., for 2022 only one of the nine Cosponsors received over US$ 80,000) and the planning, decision-making and reporting processes associated with CE funding, Cosponsors felt that the funding was worth it. It is recognized by informants that although efficiency of dealing with small amounts, which are mostly additive in nature, may not be ideal the process of bringing all Cosponsors to the table has facilitated coordination of efforts and fostered a level of accountability for results. That said, transaction costs for certain Cosponsors are more onerous when responsible for "channelling" funding to others (e.g., UNODC to IOM, UNDP to IOM, etc.).

Despite citing a lack of onerous transaction costs associated with CE funding more effort is needed to showcase results of the Joint Team. Development of the annual reports was considered straight forward however regional and HQ levels have noted that more detail should be included around impactful reporting highlighting the results/impact the Joint Team has achieved. It was cited by informants that development of the narrative summary lacked contribution of all Cosponsors which is critical to determining results to be highlighted.

BUF funding was seen by some Cosponsors as potentially catalytic and innovative in nature, however results of the funding are yet to be realized and the 2022/2023 biennium seems to be back to business as usual rather than unusual. UNDP has traditionally worked in the KP space lobbying and influencing policy, including with parliamentarians, to ensure a focus on those most marginalized in the HIV response. Government has openly recognized a lack of information on the universe of key populations (particularly youth and LGBTQI) within the country. On that premise UNDP, with support from the regional team (RATESA and UNDP regional offices), explored the use of technology and innovative service delivery options to reach these KPs with prevention services. The BUF application, approved by RATESA (US$ 50,000), provided the space to explore more out of the box thinking (at that time) and an opportunity to plan and implement with "no rules as to what kind of specific areas you need to think about". This differed from previous CE planning and design processes which were seen by some Cosponsors as more prescriptive.

Despite the progress on implementation of the BUF funding, a process that was seen as straight forward by UNDP, others believed the BUF was not helpful and that very little time was granted to developing a proposal and there was "inconsistency around information about the process". BUF, despite it being considered an interesting idea, could have benefited from a simplification of the system according to informants. Key informants noted the "push" in the 2022/2023 guidance for more innovation to change the scenario of HIV in line with the BUF principles. However, based on the joint workplan and key informants "the talk was there but the endgame was the same" with the principles of BUF not necessarily resonating in the outcome of the 2022/2023 joint planning processes with business carrying on as usual.

Evaluation Question 3: To what extent have country stakeholders (govt, civil society, PLHIV, key population groups, and other partners) been engaged in UN joint planning processes and implementation at country level?

- Government and development partners applaud the involvement of Joint Team members in planning and implementation of the national HIV response. However, their input, along with that of civil society and implementing partners, into the UN joint planning exercises was minimal to non-existent.
- Civil society continues to play a diminished role in the Joint Team and national HIV planning and response despite a national coordination mechanism for CSO engagement.
- Despite a lack of inclusive planning for CE allocation outside of the Join Team, the CE is leveraging partner support, through some catalytic activities, for the national response and producing results.

Government, development partners and CSOs applaud the involvement of Joint Team members in planning and implementation of the national HIV response. However, their input, along with that of implementing partners, into the UN joint planning exercises was minimal to non-existent. The presence and input of Joint Team members in national HIV and other health and non-health related platforms is seen as critical. This, coupled with their strong technical engagement and consultation with key national stakeholders during strategic planning exercises including production of the RNASF, Global Fund Funding Requests and PEPFAR COP was highly valued (see previous section for examples of input into planning exercises).

Although the Joint Team engages in internal coordinated and collaborative planning processes, there is a noted lack of engagement with other key HIV stakeholders. These stakeholders include government, CSOs, PLHIV and partners who are not systematically consulted during the Joint Team proposal development/planning process which poses a threat to accountability, ability to form synergies, and sustainability. This lack of participation is seen by CSOs as a potential missed opportunity. According to CSOs, who gathered in a workshop, as part of this evaluation, designed to flesh out the strengths, weaknesses, opportunities and threats of working with the Joint Team and in the HIV sphere, their role in shaping the proposals for CE funding was seen as a critical weakness and "nearly non-existent".

"It would be ideal to have CSO involvement in work plan development because they are the ones who roll-out the activities on the ground. (e.g., the penal code is a policy we are working on, which could take 50 years to do while there are a lot more immediate issues that they would like to address with more immediate results" (Cosponsor quote)

The exception was planning efforts undertaken by UNICEF with Mothers2Mothers where both parties expressed engaging "around the table" to develop annual plans that are then fine-tuned when receiving resources. That said it was difficult to determine if that planning process was directly related to CE funding as Mothers2Mothers is engaged beyond CE funding by UNICEF as well as other development partners.

Civil society continues to play a diminished role in both the Joint Team and the national HIV planning and response despite a national coordination mechanism for CSO engagement, which may be reflective of their lack of presence in Joint Planning. Lack of involvement of CSOs in Joint Team proposal development and further planning exercises was cited as contributing to a dilution of partner interventions, lack of coordination which leads to duplication and wastage of scarce resources, and an overall lack of

"Restoring the power for the local organization to deliver against development" (CSO quote)

sustainability in programming (see Annex 3, SWOT analysis results). This lack of involvement/engagement is not unique to the Joint Team as CSO participation in the HIV response is not supported through domestic resource allocation. In addition, funding of CSOs from the government budget is legally not permitted. Therefore, the CSOs rely predominantly on external donors for financial and technical support including from the Joint Team to not undermine their role in community-based service delivery. In that respect, a need was expressed to restore the power to the communities and use their capacity for development through channelling Joint Team resources into local capacity strengthening of CSOs as funding through central government will not result in a "trickle-down effect" and a bottom-up approach is thought to yield more results.

Despite a lack of inclusive planning for CE allocation outside of the Joint Team, the CE is leveraging partner support, through catalytic activities for the national response, and producing results. These results include:

- **Development of the first National Comprehensive Condom Strategy 2020-2025** (spearheaded by UNFPA in collaboration with the MoH and NAC) – CE allocation to this activity was nominal (US$ 35,000) to secure technical assistance to develop the first ever comprehensive condom strategy with a strong focus on young people and a total marketing approach. The development was brought to the forefront based on analysis conducted by UNFPA and a presentation of gaps to the Condom Technical Working Group (TWG). In addition, UNFPA leveraged its convening power as part of the Joint Team to reignite the TWG fostering active participation of government, PEPFAR, and Global Fund representatives and guaranteeing evidence-based programming, through innovative measures. Fundamentally the strategy is meant to address rising rates of teenage childbearing (estimated at 29%) which is highest in rural areas coupled with low condom use (24% among females and 49% among males aged 15 to 24) which place youth at higher risk of acquiring HIV.[19] According to the NAC, had UNFPA not spearheaded the development of the strategy "it would not have happened otherwise".

  UNFPA then used the strategy, along with its experience implementing CONDOMIZE and YoungSmartFree campaigns reaching youth throughout the country, to lobby with Global Fund to include condom programming in the most recent Funding Request. This effort resulted in the approval of US$ 5 million for condom programming. In true catalytic nature, based on the strategy and raising the visibility of condom programming in part through inclusion in Global Fund programming, Zambia was chosen as one of four countries to implement the Global Fund "Demand Generation for Condoms through Online and Mobile Applications" under their Condom Strategic Initiative[20] due to begin implementation in July 2022.

  An assessment of the campaigns is pending, delayed due to COVID-19, therefore downstream results are yet to be reported.

- **Transformative work being done by UNICEF to improve paediatric prevention and treatment including development of the triple elimination plan.** The government called on UNICEF, building on its comparative advantage as an agency, to step up is engagement in the adolescent arena to address increasing neonatal mortality and poor outcomes which often result from high-risk pregnancies linked to teenage pregnancies. As a starting point the quality of the data for PMTCT/eMTCT was of deep concern to the government and development partners. Therefore,

[19] Zambia Demographic and Health Survey, 2018
[20] https://www.ungm.org/Public/Notice/176065

UNICEF, with support from HQ and in collaboration with the MoH and other development partners and using a nominal amount of CE funding (US$ 25,000) undertook a PMTCT data deep dive.

The deep dive triangulated existing data sources to ascertain the HIV epidemic state as it related to PMTCT of HIV and paediatric HIV (at national and subnational levels). UNICEF analysed data on pregnant and breastfeeding mothers and HIV Exposed Infants, that longitudinally track HIV testing, HIV treatment and final outcomes of the mother-baby pairs, using multiple data sources and methods, for the past three years – 2019, 2020 and 2021. The exercise formed the basis for capacity building of key programme and strategic information personnel for generating and using data for decision making.[21] Capacity building efforts focused on the key emerging issues and identification of next steps.

This deep dive triggered further investment in training of government health care workers to analyse their data, tease out the bottlenecks and identify and implement remedial actions. CDC and USAID contributed to the orientation and planning of trainings. It is hoped that "this exercise will change the PMTCT narrative and strengthen eMTCT systems and response", results of the exercise are yet to be measured.

Another example of the catalytic nature of the CE funding is the **support provided to the Ministry of Education and through partners in selected districts to ensure access to comprehensive sexuality education (CSE) linked to SRHR services undertaken by a collaboration between UNESCO, UNFPA, and UNICEF.** This catalytic intervention, begun in 2018, is grounded in an implementation science study whose objective was to improve the SRH outcomes of adolescents in Zambia implemented under a partnership between UNESCO and UNFPA (in addition to Population Council) and eventually the support of UNICEF. The study was solely funded with CE contributions, ultimately aimed to strengthen the linkages between schools and health facilities offering SRH services for in-school adolescents and measure which interventions would impact on reducing teenage pregnancy and child marriages and increasing access to SRH services. The study arose as the CSE efforts of the government showed limited or no linkages between schools and health facilities to facilitate adolescents' ability to access and use SRH services to address girls' vulnerability to HIV/STI infections, teenage pregnancy, and child marriage, all of which are high in Zambia. The results of the study, including the design of different intervention models, are currently being rolled-out and scaled up in Zambia. Planned Parenthood Zambia is one of the organizations that has taken up the model and is implementing it across the country.

"The envelope funds have been catalytic, a launchpad for additional funding and very worthwhile, notwithstanding bureaucratic processes and many meetings required to reach agreement on the funds. Close collaboration has been established between UNESCO and the UNAIDS country office, UNFPA and UNICEF."

This work has also sparked the impending launch of Education Plus Initiative22 in Zambia, a recent globally launched joint initiative between UNAIDS, UNESCO, UNFPA, UNICEF, UN Women, where implementation and mobilization of resources are envisaged for Zambia. The work of UNESCO, UNFPA and UNICEF in the field of CSE and linkages to SRH targeted young women and girls is seen in part as the impetus for targeting Zambia.

[21] Fina concept note on PMTCT data deep dive

[22] The 'Education Plus' initiative is a high-profile, high-level political advocacy drive to accelerate actions and investments to prevent HIV. It is centred on the empowerment of adolescent girls and young women and the achievement of gender equality in sub-Saharan Africa—with secondary education as the strategic entry point. https://www.unaids.org/en/topics/education-plus

Worth noting is the critical role of the Joint Team in helping tamper the recent controversy around CSE plaguing rising up to the parliamentarian level. UNESCO and UNFPA, with the guidance and advocacy gravitas of the UNAIDS Country Representative, together with ministry colleagues, lobbied with parliamentarians and influential religious leaders in an effort to safeguard CSE/SRHR services which were under threat of discontinuation due to misinterpretations which were thought to challenge cultural/religious beliefs. A positive resolution was arrived at in Parliament and activities are able to continue as planned. Without UNESCO, UNFPA, and UNAIDS dedication, passion and influencing/convening power the country

Evaluation Question 4: To what extent have country envelope and BUF funding contributed to addressing gender equality, human rights and community-led responses?

- CE investment in gender equality is challenging to qualify let alone quantify, even more so for human rights and community responses given that reporting within the JPMS is not broken down by those investments/categories.
- Addressing gender equality is a core principle for the activities reported by UNICEF, UNESCO, UNFPA and ILO.
- Tackling human rights issues is rooted in the work of UNODC and UNDP and the ILO's Scaling Up HIV Testing in the World of Work under the CE.

CE investment in gender equality is challenging to qualify let alone quantify, even more so for human rights and community responses given that reporting within the JPMS is not broken down by those investments/categories. The table below highlights the categorisation of activities under the first two biennia by gender marker. As can be seen only one activity, implemented by UNICEF was categorized as having gender as a principal objective while the majority categorized the activities as having a significant contribution. That said, none of the 69 activities were categorized as SRA5: Gender inequality and gender-based violence. As stated under the finding for EQ2 interpretation of the data presented below should be undertaken with caution as it was obligatory to choose a gender marker regardless of the activities and in certain cases Cosponsors said that UNAIDS categorized the activities for them. The same is true for the categorization of SRA with both Cosponsors and UNAIDS completing the column in the JPMS. Regarding SRA 6 – Human rights, stigma and discrimination, no activities were categorized during the 2018-2022 period and no "marker" exists for human rights categorization within the JPMS.

Table 3: Gender markers 2018-2021

Gender Marker	# of activities	Agency	SRA	Focus
1	3	WHO, UNODC, IOM	1,3	Health promotion on HIV and comorbidities for workplaces and institutions of higher learning targeting men; Technical support to develop and implement HIV, AIDS, TB and STI workplace policy for correctional facilities; Roll out of Treatment guidelines for people on the move (Migrants, Truck drivers, SWs; KPs)
2	27	WHO, UNICEF, UNESCO, UNFPA, UNDP, UNODC, WB	1, 3, 4, 7	Variety of activities, most of which are not clearly focused on gender with the exception of addressing teenage pregnancy, condom distribution fo young people, addressing "other" sex, key populations database (focus on LGBTQI), policy development for KPs (MSM, sex works, transgender people)
3	1	UNICEF	2	Technical support and scale up eMTCT programme in targeted districts - prevention package for PMTCT for pregnancy and breastfeeding AGYW

Source: JPMS; 17 blank activities

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

The picture is similar regarding civil society markers as can be seen in Table 5 below. Only one Cosponsor, UNDP, reported that civil society helped conceive and design activities focusing on changing the penal code and unfavourable registration legislation (criminalization of same sex, consensual relationships and changing sex on national identity cards)amongst other activities targeting KPs. Civil society marker one showed that 23 activities were categorised as involving civil society in the consultation and engagement process without responsibility for implementation, however as previously stated involvement of CSOs did not take place during the design phase according to them (see also Annex 3). While the focus of activities categorized as marker two reflect UNICEF's role with Mothers2Mothers (described previously), it is unclear how judicial reviews were designed by civil society/community as this was not found in the reporting and was not mentioned by informants. To reiterate, interpreting the civil society marker categorisation in the JPMS should be done with caution which calls into question the value of such a categorization.

Table 4: Civil society 2018-2021

CS Marker	# of activities	Agency	SRA	Focus
0	2	WHO, UNODC	1,3	Health promotion on HIV and comorbidities for workplaces and institutions of higher learning; Technical support to develop and implement HIV, AIDS, TB and STI workplace policy for correctional facilities
1	23	UNODC, UNFPA, UNESCO, WHO UNICEF	1,2,3,4,7	Strengthening coordination mechanisms for testing, health promotion for HIV testing/HIVST, community literacy, eMTCT, paediatric services, CSE support, condom programming, PWID assessment, digital database for KPs, etc
2	4	UNICEF/UNDP	2,3	Technical support to develop and implement an HIV prevention package for PMTCT of HIV targeting AGYW; Technical support and scale up eMTCT programme in Targeted districts; Strategic Judicial reviews on unconstitutional provisions in the penal code and related legislation; coordinate and conduct trainings in 4 Provinces on the KP M&E system and its data management
3	2	UNDP	3	Dialogue on the unconstitutionality of the penal code and registration legislation provisions held.; SADC KP Strategy roll out with key sectors like gender and youth in addition to justice and health

Source: JPMS; 17 blank activities
Civil Society Marker 0 - no consultation with civil society/community and no engagement with civil society/community; 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 (i.e. receives 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)

Addressing gender equality is a core principle for the activities reported by UNICEF, UNESCO, UNFPA and ILO. UNICEF has made concerted efforts under the CE to address gender inequalities through the provision of technical support to develop and implement an HIV prevention package for PMTCT targeting pregnant and breastfeeding AGYW. In addition, they are ensuring accurate reporting against eMTCT activities by scaling-up the use of a PMTCT dashboard/scorecard through integration into the District Health Information System (DHIS) platform. This, coupled with the eMTCT/PMTCT deep dives, help to ensure that advancement in gender equality and empowerment of young girls is at the forefront of their programming. UNESCO and UNFPA, with CE funding, are also tackling gender equity through continued development and refinement of the CSE programme and linking it to SRH services for both in and out-of-school youth with a focus on AGYW. ILO is addressing the needs of AGYW in the employment sector linking them to employment where possible and HIV interventions to reduce their vulnerability through gender transformative approaches (addressed through gate keepers) to ensure norms, culture and traditions that place AGYW at risk are addressed. This entails working with key populations including young sex works and transgender people.

The challenges of working on gender equality and HIV in the community, according to the document review and as identified by informants, include addressing cultural norms that predispose young people to HIV and religious beliefs which often exacerbate the cultural norms (e.g., the Catholic community does not encourage condom distribution).

Tackling human rights issues is rooted in the work of UNODC and UNDP and the ILO's Scaling Up HIV Testing in the World of Work under the CE.
UNODC, building off work done by the Global Fund, is addressing the legal environment for key populations and working with different civil society organizations to strengthen their coordination and ability to reach the most marginalized KP populations to ensure access to services. Together with the NAC they have trained media to improve on negative perceptions of KPs anchored in human rights principles. Their long-standing support to KPs (both through CE funding and their agency mandate), through targeting LGBTQI, men who have sex with mem (including young key populations), sex workers, PWUD and prisoners to improve access to comprehensive HIV packages was cited by many informants. UNDP has trained law enforcement officers, recognizing their important role in addressing legal and policy barriers that increase risk to HIV, on human rights, detainee rights, emerging issues, and complaints mechanisms.

With BUF funding UNDP has engaged in judicial reviews in an attempt to address harmful laws that violate human rights (criminalization of same sex, consensual relationships and the categorization of one's sexual orientation on identity cards). Additionally, UNDP is attempting to address the strategic information gap on key populations (data is either missing or outdated) through development of a platform (previously discussed) to quantify the KP baselines and provide confidential and safe services virtually or through referrals.

WHO has also focused on the provision of rights-based education and awareness for private sector enterprises from varying sectors with CE funding (funding of a Programme Officer under CE).

Evaluation Question 5: To what extent have country envelope and BUF funds supported the adaptation 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?

- WHO, along with UNICEF worked closely with the MoH and implementing partners (namely Mothers2Mothers) to fast-track activities to those patients on ART by enacting the already approved, but not regularly administered, six multi-month dispensing (6MMD) of ART and task-shifting communication and mobilisation of those in HIV care to collect their next ART refill early.
- At the request of the MoH and the MOE, UNESCO was asked to package messages around issues of HIV, gender-based violence, and SRHR for learners who were at home during lock-down periods.
- WHO in collaboration with the ILO and UNODC were able to reprogramme funds, through a simple and straight forward process, to target COVID-19 activities.

On 10 April 2020, a mere month after the first cases of COVID-19 were reported in Zambia, the MoH released a memo prioritizing screening and testing for COVID-19 in health care facilitates across the country. Subsequently, an increased strain on the health care system was witnessed with high needs for hospitalization as well as high mortality levels as the pandemic progressed[23]. Overall, the country has recorded over 330,000 confirmed cases of COVID-19 with more than 4,000 deaths[24].

[23] Conical Operational Guidelines, PAC 2020
[24] https://covid19.who.int/region/afro/country/zm

WHO, along with UNICEF worked closely with the MoH and implementing partners (namely Mothers2Mothers) to fast-track activities to those patients on ART by enacting the already approved, but not regularly administered, six multi-month dispensing (6MMD) of ART and task-shifting communication and mobilisation of those in HIV care to collect their next ART refill early. The COVID-19 pandemic pushed the Joint Team to establish approaches that minimized direct contact for recipients of care to health facilities to ensure their safety. Part of those efforts included a focus on and scaling-up of multi-month dispensing (MMD) to tackle the threat of interruption in treatment. These efforts, coupled with community-based differentiated service delivery models, have reached individuals with services based on their needs and preferences. An assessment of the impact of COVID-19 mitigation guidance on HIV care 3 months before and after guidance implementation was carried out. The study has shown that "timely issuance and implementation of COVID-19 mitigation guidance …. significantly increased early return to ART clinics, potentially reducing interruptions in HIV care during a global public health emergency".[25] This practice has since continued and will remain standard practice for those patients that are stable. WHO also served an essential role in developing critical case management guidelines and IEC materials aimed at raising awareness and generating demand for COVID-19 vaccines targeting YPLHIV and financing short-term health care providers for case management.

At the request of the MoH and the MoE, UNESCO was asked to package messages around issues of HIV, gender-based violence, and SRHR for learners who were at home during lock-down periods. These individuals were considered more vulnerable as a key population (youth) than normal given they were not in school, economic situations were in flux in households and their access to services and information were curtailed. With existing CE funding UNESCO helped develop relevant radio spots to address the key areas mentioned above. As a continuation of the activities, UNESCO leveraged SIDA funding to "go beyond" messaging and purchase appropriate PPE and hand washing machines to protect youth and teachers once they returned to school.

WHO in collaboration with the ILO and UNODC were able to reprogramme funds, through a simple and straight forward process, to target COVID-19 activities. The reprogramming was discussed at regional level and HQ to guarantee agreement and a common approach to allocation of the funding. WHO, in collaboration with ILO, purchased PPE in full for health workers and CSO actors to continue sensitization and mobilization at the community level (US$ 40,500 of CE funding). UNODC reprogrammed "travel" funding to support the Ministry of Home Affairs and the correctional facilities, together with IOM, with provision of PPE, IEC materials and equipment for isolation facilities.

The collective and collaborative efforts highlighted above, coupled with the support of UNAIDS particularly their high-level advocacy role, was considered a positive example of how a Joint Team approach can make a difference even with little financial investment.

[25] https://reliefweb.int/report/zambia/mitigating-effects-COVID-19-hiv-treatment-and-care-lusaka-zambia-after-cohort-study

4.3 Evaluation findings related to results and sustainability

Evaluation Question 6: To what extent have the country envelope and BUF funds achieved (country envelope) results (see TOC)?
Evaluation Question 7: What results have been generated through country envelopes and how are country envelopes contributing to the achievement of UBRAF outputs (and possibly, higher-level results)?

- Strong evidence exists of the Cosponsors contribution to the HIV response in Zambia in line with national policies, strategies, guidelines, and protocols as well as the wider SDGs and targets.
- The UNAIDS Secretariat has been at the forefront of not only engaging with Cosponsors but ensuring their coordination and collaboration in an effort to achieve results. UNAIDS has also engaged in high level advocacy efforts resulting in the continued focus of HIV in the 8NDP and the new UN cooperation framework and the establishment of a CSO Self Coordinating Mechanism.
- Based in part on the comparative advantage of the different Cosponsors, coupled with the much-lauded leadership of UNAIDS, the Joint Programme has been reasonably successful in achieving the outcomes that the CE sought.

"Tricky part about reporting – all activities come from annual plans with core funds, donors, UBRAF, etc. For example, with advocacy –use UBRAF to meet religious leaders, core funding for parliamentarians but with one result "to get their buy-in. Difficult to tease out what is core funded – isolating results becomes difficult and can result in double reporting" (Cosponsor quote)

The following highlights CE contribution to the achievement of UBRAF outputs (following the ToC) and main results achieved by the various Cosponsors based on documentary evidence and key informant interviews. It is worth noting that results are not always quantifiable, an issue raised by several informants, which makes reporting against outcomes challenging and often a "bean counting game" that misses the higher-level research, policy and advocacy support and influence realized by the Cosponsors through CE funding. In addition, the results are mostly part of a wider effort funded from various pots, therefore teasing out the contribution of CE funding, particularly at an activity implementation level, is often not possible and therefore quantifiable results must be interpreted carefully. As pointed out by one respondent to the online survey, "expected results are exaggerated for the little amounts" of CE funding, which also reflects upon reporting as whole on activities rather than on specific CE contribution. In line with this, of the nine respondents from Zambia who answered the online survey, 67% said that the country envelop allocations are too small to achieve results. This does not negate the contribution to wider interventions but illustrates that one their own, CE results may not be substantial.

Contribution to prevention, treatment, paediatric AIDS and vertical transition (SRA 1,2,3,4)
Prevention of HIV, particularly among youth, is at the forefront on the RNASF due to rising rates of HIV infection among young key populations. The Joint Team has focused considerable effort on addressing the needs of this target group (youth) through extensive programming/technical assistance aimed at preventing/eliminating mother to child transmission of HIV and treating and ensuring viral load suppression for those mothers and babies who are in need. This work, spearheaded by UNICEF, has expanded over the biennia to include early infant diagnosis (EID) and HIV testing and retention on ART programmes particularly in low performing districts. However, it was noted that less than 50% of exposed infants had no final status outcome therefore, UNICEF, with seed money from CE funding,

implemented a "mop up" campaign looking at a cohort of babies to determine their final status. This campaign was then rolled out countrywide supported by outreach work from Mothers2Mothers with positive results, although not solely attributable to CE funding. That said teenage pregnancy rates suffered a backslide during COVID-19. UNICEF also engaged in efforts to improve reporting (see EQ3) which have taken place throughout the CE biennia and are highly appreciated by government and other donors interviewed. These efforts are seen as critical contributions to strengthening ministerial programme planning and implementation.

WHO, through a Programme Officer (over 50% FTE from CE) assisted Zambia as one of the first countries to introduce self-testing despite original scepticism on the part of the MoH. WHO brought their negotiation and advocacy skills to the highest political level advocating for HIV self-testing (HIVST) which resulted in the design and implementation of a pilot and subsequent roll out of the STAR[26] initiative in the country. In a similar pattern, the intervention of WHO to engage in difficult, politically charged discussions, to further prevention efforts was undertaken for PrEP and the vaginal ring to name a few.

ILO, praised by the NAC for their work on promoting VCT in the workplace through the VCT@work programme, capitalized on the work of WHO. This included training champions to promote HIV awareness around HIVST (among other prevention measures) and provision of grants to constituents including the Zambian Congress of Trade Unions (ZCTU) and the federation of employers, etc. ILO trained 101 workplace champions across 10 districts and 11,000 self-test kits were distributed in 2019 alone. They trained an additional 60 workplace champions in collaboration with the ZCTUs in the management of HIVST in the workplace and 2,500 HIV self-test kits were distributed in various workplaces in 2020. A further 52 workplace champions were trained in 2021 in collaboration with the Zambia Federation of Employers.

Comprehensive Sexual Education (CSE) activities which also focus on prevention are covered under integration and social protection SR8 below and discussed previously under EQ3. Of note from a results perspective is that from the research/study model, initiated in 2017 to establish pilot models for CSE implementation, it was shown that adolescent pregnancy had declined overall in all intervention study arms by 2022. This is considered a significant achievement and reflective of the CE efforts.

Condom promotion activities, funded in part under CE, include campaigns and distribution of commodities discussed at length in other parts of this report, which have contributed to raising awareness particularly among youth (results yet to be assessed). UNFPA has also reported the distribution of 1 million condoms at various hotspots in 2020, coupled with distribution in settlements through UNHCR/MoH, and over 2 million condoms distributed during campaigns in 2021. Over 220,000 youth were reached with prevention messaging as part of the Condomize and YoungSmartFree campaigns in 2021 alone. This was made possible in part due to UNFPA's efforts to develop the first ever comprehensive condom programming strategy, done with CE funding (see Annex 7 for more information).

UNODC has worked with IOM and UNDP on workplace HIV treatment guidelines for migrants and mobile populations with rollout happening in 2021/2022 after MOH endorsement. UNODC has also been actively involved developing a size estimation for PWUD/PWID in four major cities, results awaiting triangulation with spectrum modelling. Hotspots within the cities have been mapped in addition to available treatment services and facilities available. This exercise led to the creation of national harm reduction guidelines.

[26] STAR is a Unitaid-funded initiative launched in 2005 with three key goals: to catalyse the global market for HIV self-testing (HIVST), to generate evidence for decision-making, and to create an enabling environment for HIVST scale-up. https://www.psi.org/project/star/about/

Contribution to community-led responses, human rights, gender equality and young people (SRA 3, 5, 6)

Despite that no activities in the JPMS are coded as SRA5 and SRA6 efforts have been targeted at addressing human rights and gender equality as can be seen below.

WHO has focused on community literacy supporting the National HIV/AIDS/STI/TB Council and the Ministry of Health as well as civil society on HIV testing services, ART, viral load suppression, VMMC, eMTCT of HIV and syphilis, PrEP, MDR TB, TPT and viral hepatitis B (see also following contribution section). UNICEF's work has also targeted community response to eMTCT/PMTCT awareness through Mothers2Mothers which includes a focus on pregnant and breastfeeding AGYW, activities completed by core funds from UNICEF as well as other donor contributions. Also at the community level, targeting young people in particular young girls, is the work of UNESCO, UNFPA and UNICEF by developing models, and scaling them up, for CSE and SRH linkages (see also following contribution section).

In 2021 UNFPA developed and piloted comprehensive SRHR/HIV/SGBV community-based information and services activities in two provinces reaching a total of 22,984 adolescents and young people. Trained staff at community service points provided services including HTC, condoms, STI screening, PrEP and pregnancy testing. This included referral of 4,486 adolescents and young people for services not available at the community spots.

UNDP has engaged in dialogue around the unconstitutionality of the penal code and registration legislation; however, such engagement has not led to change. Informants stated that it is not strategic to work on laws, as change takes significant time, rather a focus should be on working with society first, addressing the concerns at a level where people can advocate for change. To that extent, UNDP has focused on training journalists (private and public media houses) to address stigma towards KPs. This training has also extended to law enforcement who play a role in addressing barriers that increase risk of HIV for vulnerable key populations. As previously mentioned, (see EQ4) UNDP is nearing completion of a platform (App) that will, for the first time in Zambia, present numbers of KPs by group and further provide virtual access to support and health services including referral if in-person consultation is needed.

BUF funding was used in part to develop a digital database (platform) for KP communities for advocacy and communication strategies to be used by the Zambia Key Population Consortium to advocate for services for the KP communities. This platform includes an App to 1) ascertain the number of KPs among the different population groups – something that was also missing when developing Global Fund Funding Requests, 2) facilitate access for KPs to anonymous online services or referral to appropriate "safe" service providers/facilities, and 3) serve as a confidential data base for bio information for the lesbian, gay bi-sexual, transgender, queer and intersex (LGBTQI)/KPs in Zambia. As of December 2021, a consultant was engaged to develop the application which is "95% complete" as of September 2022. Delays in implementation of the activity are associated with delayed funding (from UNDP HQ to UNDP country office) and staffing shortages including a five-month vacancy period for the position of National HIV/AIDS project analyst. Implementation is however still in line with the principles of BUF funding which is meant to "drive measurable change on a critical or priority topic" over a 12-to-24-month period focusing on neglected areas/gaps in the response.

Contribution to funded response, integration and social protection, and humanitarian settings and pandemics (SRA 7, 8)

CE Contribution to SR7 and SR8 is scant, as can be seen below, with the exception of integration and social protection. Note that the response to COVID-19, the only pandemic response mentioned by informants, is covered under EQ5. Activities below were funded in part by CE allocations.

Humanitarian settings - UNHCR, with a mandate of saving lives, protecting rights, and building a better future for refugees, forcibly displaced communities and stateless people, received funding for the first time in the 2022-2023 biennium (US$ 90,000). As previously mentioned, they have undertaken a study to assess the HIV and COVID-19 needs for migrants, refugees and crisis-affected mobile populations living with HIV in the humanitarian settings (settlements). The results of the study, still pending, will inform programming to respond to the need to ensure a resilient HIV response for the target group. It is assumed, but yet to bet reported on, that the work will fill the gaps left through public services and complement existing activities focusing on HIV/SRH awareness campaigns. These will be conducted through peer educators and community supporters, ensuring access to friendly corners for in and out of school youth as well as anti-AIDS clubs where prevention messages are shared, condom distribution and access to VMMC to name a few.

Contribution to funded response – The majority of the work done by the World Bank, in general, is analytical in nature. To that extent, with CE funding, they have engaged in two pieces of research geared at ensuring that HIV is considered in the wider context of spending on RMNCH (a recognised exercise) and an analysis of efficiency gains that can be achieved through more accurately predicting HIV yields. These pieces are grounded in health systems strengthening efforts and are in line with their engagement in the UHC agenda in country, for which the WB is applauded by MoH. Concrete results of these pieces of research are difficult to discern in the literature and were not elaborated by informants, however that is often the case with pieces of research.

> "Country envelopes allow us to go an extra mile on a bigger project but getting the data and analytics that will help them in getting the healthcare package that they want." (Cosponsor quote)

Integration and social protection - UNESCO together with UNFPA and UNICEF focus on integrating life skills training with HIV prevention messaging. This is done through increasing dialogue on SRHR including the prevention and management of HIV, and early and unintended pregnancy and support for CSE/life skills education in targeted provinces. UNESCO successfully reached nearly 100% of grade 5-12 learners in Zambia by December 2018. The number of students reached has increased across the biennia and furthermore reached out-of-school youth. Additionally, since 2018 UNFPA has focused on integrated HIV prevention and SRHR services for young people aimed at addressing the triple threat of HIV, STIs and teenage pregnancy being faced by young people in the target districts.

The WHO, through CE funding to a Programme Officer (over 50% FTE), played a critical role in advocating for inclusion of services for HIV co-morbidities in the Global Fund Funding Request (Window 2c). The funding request was approved with a focus on Hepatitis B and C, including the procurement of test kits which was seen as a major success. WHO also helped formulate policies aimed at strengthening TB preventive therapy (resulting in a 200% increase in coverage for initiation and completion) and scale up of viral hepatitis prevention and treatment which led to screening for pregnant women with a focus on those living with HIV.

The ILO supported the NAC to develop an Overarching National Workplace Policy on HIV/AIDS/TB and Wellness which is applicable to both private and public sector workplaces. The policy, integrating TB and HIV service provision, was lauded by the NAC who is mandated to support the multisector response to HIV. Although the development is new, the policy (which serves as a template which can be adapted) has been shared with workplaces who are trying to comply with the government mandate of having an HIV policy and wellness plan in place. Sixty workplace champions were trained in 2020 in collaboration with ZCTU, and 52 were trained in 2021 in partnership with ZFE. The training focused on equipping the champions with knowledge and skills on how to facilitate the implementation of HIVST in their respective workplaces. ILO further distributed 17,500 HIVST kits between 2019 and June 2022 of which 3,538 were in the informal sector. Through the ILO interventions, 217 out of 220 workers that tested positive for HIV were successfully linked to treatment.

Additionally, during the COVID-19 pandemic the ILO supported the Zambian People living with HIV and AIDS (NZP+) in income generation activities (production of sanitizer) to mitigate the negative impact of the pandemic; 231 households of PLHIV with 1,075 benefitted from social cash transfers based on sales; 60% of the beneficiaries were female headed households. They are also praised for their work on promoting VCT in the workplace through the VCT@Work programme including training champions to promote HIV awareness and provision of grants to constituents including unions themselves (e.g., ZCTU) and federation of employers, etc. In 2019 alone 101 workplace champions were trained across 10 districts and 11,000 self-test kits were distributed.

Evaluation Question 8: To what extent have country envelopes enhanced and changed the capacity of Joint Teams and supported the mobilisation of resources (human, financial, technical) at country level?

- CE funding has enabled the mobilization of additional resources (both financial and technical) from the agencies and other development partners.
- Use of the Joint Team capacity assessment is seen as a potential missed opportunity to prioritize CE funding. The contribution of the capacity assessment is not clear in the overall the planning process.

CE funding has enabled the mobilization of additional resources (both financial and technical) from the agencies and other development partners. Examples include UNFPA's work during the first biennium undertaken collaboratively with UNESCO to promote linkages of HIV prevention and SRHR services for young people. In line with this work, UNFPA with their focus on out-of-school youth (UNESCO focusing on in-school youth), as previously mentioned, was able to advocate for targeted condom programming funding in the latest Global Fund Funding Request (US$ 5 million) based on production of the first ever national comprehensive condom strategy and various campaigns funded through CE allocations. This also resulted in the inclusion of Zambia in a multi-country strategic initiative focusing on condom programming, funded by the Global Fund, and implemented through a partnership between UNAIDS Country Office and UNFPA.

Although results are pending, UNHCR conducted an assessment of the effects of COVID-19 on HIV among refugees and migrants. Once available, the results will form the basis of a resource mobilization plan to address the needs of these populations.

UNICEF's long-standing work on analysing eMTCT/PMTCT data, together with UNAIDS Country Office and in collaboration with the NAC and MoH, aimed at improving the efficiency and effectiveness of programming have been lauded by government and donors. This has resulted in USAID and CDC supporting the latest PMTCT deep dive effort including the training of key government staff.

Although the above efforts are considered catalytic and generated a more enhanced response to HIV and AIDS programming needs, it was recognized by almost all Cosponsors that activities in general would most likely have been carried out even without CE funding but maybe not at the same scale. In other words, existing funding, or mobilizing funding elsewhere, could have been employed.

Evaluation Question 9: what are the main factors helping or hindering the achievement of results?

- Factors that helped the achievement of CE results include:
  - Strong commitment, leadership and advocacy by the UNAIDS Country Team
  - Flexibility in CE funding most notably the ability to fund critical Cosponsor staff
  - Good collaboration and coordination among Cosponsors and national stakeholders.

- Factors that hindered the achievement of CE results include:
  - Spreading the resources too thinly
  - Critical human resource constraints.
  - Lack of prioritization

The following factors helped the achievement of results:

- **Strong commitment, leadership and advocacy by the UNAIDS Country Team**. The UNAIDS Secretariat is highly respected by Cosponsors, other donors, governmental organizations and CSOs as the leading agency in promoting the HIV response. They do this through policy level advisory and advocacy, provision of strategic information including provision and analysis of data for evidence-based decision making, capacity development at national and local levels (both within and beyond government institutions) and through its coordination and leadership role vis a vis the Joint Team and joint planning exercises.

- **Flexibility in CE funding most notably the ability to fund critical Cosponsor staff.** As previously mentioned, the inputs into national planning, strategizing, development of normative guidance (HIVST, eMTCT, etc) and responding to COVID-19 to name few by the WHO Programme Officer are seen by all as absolutely critical to the successful implementation of the HIV response. This flexibility, to fund human resources, tapped into by other Cosponsors as well, is seen as highly strategic and a game changer.

- **Good collaboration and coordination among Cosponsors and national stakeholders.** The introduction of the CE funding model, through its various mechanisms and processes, has fostered improved coordination and planning efforts as well as and complementarity and joint implementation across the Cosponsors. Joint Cosponsors implementation efforts are many and cover a range of SRAs. These efforts extend to joint implementation with national stakeholders in planning and implementation of the national response to HIV. CE funds have been used to address country strategic priorities and identify gaps and needs in the national response.

The following are noted as challenges to achieving results:

- **Spreading the resources too thinly**. In line with the mantra of "inclusiveness" and an apparent lack of robust strategic planning and prioritization the result is spreading resources across all Cosponsors which often results in activities that are a small part of a larger intervention or funding pot and therefore are additive in nature. This makes demonstrating results attributable to challenging.

- **Critical human resource constraints.** The overall decrease of funding that affected all UN agencies in the last few years has contributed to a decrease in the number of staff in Cosponsor country offices including the UNAIDS Secretariat. That, coupled with the ability of Cosponsors to recruit adequately qualified staff has resulted in delayed implementation for Cosponsors and hence delay in results. According to informants, the lack of staff with time to devote to HIV has contributed to less-than-optimal participation in Joint Team meetings and in ensuring that activities are programmed, implemented and reported upon in a timely and quality manner. Also, the technical level of staff has had an impact on implementation with more junior staff often not in a position to push forward critical agendas. The lack of human resources in country, relying on regional

expertise, was also noted as a challenge to implementation. Critically, UNAIDS staff, down two people from the last biennium are struggling to keep up with their vital role in the response to HIV in the country including for knowledge management.

- **Lack of prioritization - Current use of the Joint Team capacity assessment, the contribution of which is not clear in the overall the planning process, is seen as a potential missed opportunity to prioritize CE funding which could have affected results.** The Joint Team is required to indicate all staff working on HIV at country level and input the information into the JPMS as part of the Joint Plan development process. This overview of the Joint Team capacity is meant to "provide information on the number of staff working on HIV and the Joint Teams' indicative capacities".[27] The results should enable the Joint Team to ascertain where human resource strengths and weaknesses lie and assess the agencies commitment to their role under the division of labour. This in turn should inform the joint planning exercise. The results of the 2022/2023 Joint Team capacity assessment, including UNAIDS who is not a recipient of CE funding but coordinates planning and reporting, alongside an updated categorization based on key informant interviews is presented below.

Table 5: Joint Team capacity overview

Agency	Positions (OPM)*	Total FTE	Positions – 2021 (JPMS)	Total FTE	Positions Info from agencies Aug 2022	Total FTE
UNODC	2	1.5	3	2.25	2	LOE unclear (1 in country not FTE)
WHO	1	1.0	3	1.35	3	1.35
UNICEF	2	1.8	1	1	1	1
UNFPA	3	.8	7	4.1	7	4.1
UNESCO	3	3.0	2	.75	2	.75
World Bank	3	.7	2	.4	2	.4 (not in country)
UNDP	2	1.2	1	1	1	1
ILO	2	1.1	1	1	1	1
UNHCR	1	.2	1	1	1	.3
IOM			2	.4	2	.4
UNAIDS	5	5.0	8	8	6	6
Total Positions	24		31		28	

* Annex 7: Human resources data table, 2020 – UNAIDS Joint Programme Capacity Assessment, Final Report, Version 28 April 2022

Discrepancies exist between what was reported in the 2022 Capacity Assessment (although data was from 2020), data from the JPMS and information gathered during interviews with country level Cosponsors. This could reflect lack of clarity as to categorization of full or part time staffing or subjectivity with some overestimating their staffing levels in hopes it would reflect positively on their CE allocation while others meticulously calculated their HIV staffing levels. The difference could also reflect the mobility of staff resulting in vacancies or the inability to recruit new staff among some Cosponsors. This includes upcoming positions that as of August 2022 remained vacant as reflected in columns six and seven in the above table.

The value of the exercise was unclear to Cosponsors, for example it was unknown how the results of the overview were used for determining which agency had a comparative advantage with regard to responding to key strategic areas (each Agency is designated strategic areas) and how they could contribute meaningfully with appropriate funding. That said the future use of a well thought through

[27] 2022-2023 Guidance Joint UN Plan

capacity assessment could help drive strategic programming and more efficient and effective distribution of CE funding.

Evaluation Question 10: What other models exist as potential alternatives for incentivising UN joint planning and funding at country level?

- The overall model was lauded for promoting collaboration among the Joint Team members and for its flexibility. However, a lack of strategic planning and maximizing the impact of the relatively small pot of CE funding is seen as a continuous challenge.

- Other means of better allocating and strategically using the funds, cited by informants and specific to Zambia, include:
  - Focus on one theme/strategic priority/flagship programme per year or biennium and reduce the number of Cosponsors
  - Consider a regional "pooling" approach to funding
  - Link the CE funding to longer term (five year) Joint Programme based on the most recent cooperation framework.

The overall model was lauded for promoting collaboration among the Joint Team members and for its flexibility, however, a lack of strategic planning and maximizing the impact of the relatively small pot of CE funding is seen as a continuous challenge. Flexibilities mentioned by informants included using CE funding for Cosponsor staff which has contributed to high level policy and strategy inputs covering the HIV response from treatment to care and prevention. The adaptation of a two-year funding cycle with funding upfront, has lent itself to more strategic planning and more realistic implementation (ability to shift activity timelines as implementation challenges arise) was also cited as a positive flexibility adapted during the third biennium.

Other means of better allocating and strategically using the funds, cited by informants and specific to Zambia, include:

- **Focus on one theme/strategic priority/flagship programme per year or biennium and reduce the number of Cosponsors.** More focus on critical strategic priority areas based on in-depth targeted analysis is needed to see where value-added lies, to increase efficiency and reduce the risk of spreading funding and activities too thinly. The top priorities of the government (there are a plethora of priorities) should be revisited and a targeted Joint Team response developed, based on a model or proof of concept, focusing on one theme/strategic priority/flagship programme per year or per biennium. Cosponsors with the comparative advantage, which will ultimately not include all Cosponsors, would then be targeted for CE funding based on sound proposals. This requires clearly defining what impact is wanted/achievable and how the money can be best programmed to realize results. Such a scenario could help address the current practice of spreading smaller amounts of funding over a wide range of interventions which are seen by several informants as "less transformative and more additive".

- **Consider a regional "pooling" approach to funding** – It was expressed that a regional approach may further prioritize efforts at country level moving away from the less strategic and "inclusiveness" model. This approach could be informed by the 2gether4SRHR[28] programme (triggered by UBRAF funding in Zambia according to informants) which focused on four strategic areas including creating an enabling legal and policy environment, supporting national scale-up of services, empowering people to exercise their rights and access services, and amplifying lessons learned across all

[28] 2gether4SRHR is a joint United Nations (UN) regional programme, funded by SIDA, that combines the efforts of UNAIDS, UNFPA, UNICEF and WHO to improve the sexual and reproductive health and rights (SRHR) of all people in Eastern and Southern Africa (ESA), particularly adolescent girls, young people, and key populations (KP)

countries in the region. The 2gether4SRHR modality differs from CE in that it brings four agencies together at the regional level (WHO, UNAIDS, UNICEF and UNFPA) to plan, implement and monitor activities at country and has a "tighter framework, keeping everyone on the ball …. with processes that ensure teams meet on a regular basis at various levels including a technical team once per month and deputy and regional directors' meetings". Activities at country level are awarded based on a competitive bidding process. A final evaluation is in progress of the modality and could be used to help shape the discussion around similar mechanisms for UBRAF funding.

- **Link the CE funding to a longer term (five year) Joint Programme based on the most recent cooperation framework**. This Joint Programme would then be used to mobilize additional resources while maintaining the catalytic role of the CE. This would help move away from the mindset that "we have the CE, and this is what it will be" to more holistic and catalytic thinking.

5 THEORY OF CHANGE

Based on the comparative advantage of the different Cosponsors, coupled with the much-lauded leadership of UNAIDS, the Joint Programme has been reasonably successful in achieving the outcomes that the CE sought. The level of coordination and cooperation among Cosponsors is commendable and has aided alignment of Joint Team activities within the Joint Plan and with the national priorities, however, further engagement in strategic thinking and prioritisation is warranted.

Table 6: Results against the theory of change

RELEVANCE AND COHERENCE (DESIGN)		
Inputs		
Joint Team staff at country level	Yes	UNAIDS Secretariat staff and nine Cosponsors (UNDP, UNFPA, UNHCR, UNICEF, UNODC, UNESCO, ILO, World Bank and WHO) plus IOM are implementing the 2022-2023 Joint Plan. In total there are 28 staff of which more than 9 are full time including from UNAIDS, UNICEF, ILO and UNFPA. Collaboration and facilitated communication channels through regular JUNTA meeting (monthly) facilitate achievement of results.
Resources: CE and BUF funding ($)	Yes	2018-2019 (US$ 1.1million); 2020-2021 (US$ 1.1million); 2022-2023 (US$ 1.15million)
Guidance (Joint UN Planning guidance 2017., CE mechanism guidance and templates, Guidance on use of BUF funding, Guidance on use of CE funds for COVID-19 response.	Yes	UNAIDS made guidance and templates available in timely fashion and organized and facilitated planning meetings. Regional support for proposal development was also cited. However, some guidance was seen as too long and too tedious to read and could benefit from simplification.
1. Allocation formula for Zambia is updated annually as new/relevant data emerges	Yes	The allocation is discussed annually with all Cosponsors however there is question as to whether it is based on strategic planning and addressing critical priority areas or rather guided by "inclusiveness" principles. There is a flexibility for example CE funding can be used for staffing (most notably for WHO whose technical assistance has been lauded by government, development partners, CSOs and other Cosponsors) and CE funds can be reprogrammed in specific situation (e.g., COVID-19 pandemic).
2 Country envelope guidance, including for Co-19 clarifies the intentions of CE funding and is available in time for start of the annual planning processes	Yes	Cosponsors received guidance and instructions on the CE funds allocation, disbursement and priority areas. The flexibility of the CE allocation model enabled reprogramming of the funds during the COVID-19 outbreak based on Joint Team discussions and priority setting.
3. Joint Team processes and plans are inclusive of key stakeholders, based on country needs, and align to UBRAF Results Areas	Partly	Although the Joint Team engages actively and has strong coordination mechanisms with government and non-government organizations, CSOs (including KPs) and private sector in planning for the countries response to HIV and programming for that response, evidence shows that these groups are not part of the Joint Plan planning process. Processes and plans are also aligned with UBRAF Result Areas.
4. Allocation of CE funds to Cosponsors, and submission of proposals for CE funding is timely and aligned to guidance	Yes/partly	The allocation of funds is discussed among the Joint Team during regular meetings with the guidance of UNAIDS. Cosponsors then develop proposals to address the key gaps in the country programming, however, the level of involvement of key stakeholders in that planning process was not optimal.
5. QA, approval and CE funding disbursement processes are timely and aligned to guidance	Partly	QA processes were seen as timely and facilitated by RATESA. However, across all three biennia informants reported delays in the disbursements of CE funds (from Cosponsors HQ to country level, not UNAIDS HQ to Cosponsor HQ).
6. Reporting on implementation of CE funding and deliverables takes place in a timely manner and results of funding are tracked and documented.	Yes	Reporting on implementation of CE funding and deliverables takes place in a timely manner. However, there is no standard template to be used for reporting. Teasing out the results that are attributable to CE funding is challenging as Cosponsors often work with various funding streams on the same programming activities without discerning where the funding is coming from.
7 - Joint Teams capacity assessments are conducted, and findings addressed	Partly	Although Joint Team capacity assessments are included in the JPMS there is a lack of understanding on how to calculate division of labour and a lack of clarity as to how results are used in decision making around allocations which is seen as a missed opportunity to plan and prioritize strategically capitalizing on the Cosponsors comparative advantages

1. UBRAF core funds allocated and disbursed through the CE mechanism to Cosponsors are prioritised and used strategically based on country needs.	Yes/ partly	The CE funds allocation is aligned with SDGs, UBRAF SRAs, with UNSDCF and address country needs in accordance with the RNASF, however, it is not clear that optimal prioritization is achieved in part due to spreading the allocation too thin.
2. CE funding mechanisms strengthen Joint Team internal and external collaboration, strategic planning processes, and coherence of UN support around country priorities –	Yes	The joint planning process in Zambia is strengthening Join Team internal collaboration. There is a strong collaboration and engagement with key national stakeholders during implementation to support the national HIV response and address country needs and gaps but less so during the planning.
3. QA processes reinforce transparency and Joint Programme accountability at country and regional levels –	Yes	The increase role of RATESA is appreciated and expected to be strengthened in the coming year/s. At country level all activities and budgets are uploaded into JPMS once QA is complete.
4. Joint Programmes are able to mobilize additional resources through the catalytic and innovative effect of CE funding.	Yes	The CE funding model has demonstrated the catalytic nature of some activities which have fostered additional funding, partnerships and programmes through nominal investments designed to fill critical gaps. However, according to information, most activities would have been conducted with other funding/inputs but not necessarily at the same level or at the appropriate time.
5. CE funding supports activities that address Gender Equity, Human Rights, community responses	Yes	There have been multiple interventions funded through the CE to support gender equity (partially targeting young girls/mothers) and human rights (targeting KPs such as MSM, SW, LGBTQI, PWUDs, etc) and related community responses.
6. CE funds are used to strengthen national responses to COVID-19 in the context of HIV	Yes/Partly	The efforts of WHO to establish clear response, treatment and immunisation guidelines was seen as essential to ensuring a timely and efficacious response to COVID-19. Inputs from other Cosponsors, many of which focused on provision of PPE and other commodities, were welcomed but were relatively small compared to other support received. Only two Cosponsors officially reprogrammed fundings to address COVID-19 needs.
7. CE funds and joint planning processes support strengthened Joint Teams' capacity (technical & managerial), including effective stakeholder engagement	Yes	The regular biennial funding basis of the CE model has increased the motivation of the Cosponsors to engage more collaboratively in the joint planning and implementation processes.
Joint programme outcome 1 and results 1. Prevention: capacity strengthened to scale up combinational prevention services 2. Treatment: capacity strengthened to scale up treatment and care services 3. Paediatric AIDS, vertical transmission: capacity strengthened to ensure access to services to eliminate vertical transmission (*Strategic Results Areas 1, 2, 3,4*)	Yes	The CE allocation by SRAs is as follows: SRA1- testing and treatment (21%), SRA2 - eMTCT (19%), SRA3 – prevention among young people (45%), SRA4 - KPs (12%) amounting to 97% of the CE funding. This clearly indicates the contribution of this model to UBRAF outcome 1. The CE has facilitated the Joint Team efforts of advocating, facilitating, and strengthening partnerships among governmental agencies (e.g., MoH, NAC, MoJ, MoGE, MoJ, MoHA, MoRA, etc), and providing support to CSOs to coordinate work within HIV prevention programmes. With CE support innovative approaches have been applied to delivering HIV services, as well as in promoting HIV testing and raising awareness about HIV prevention and treatment and ensuring linkages to services for YKP and KP in general. CE funds were catalytic leading to increased funding, expansion of programmes and closer coordination and collaboration among all key stakeholders on programmes ad interventions related to achievement of the Joint Programme outcome 1.
Joint programme outcome 2 and results 4. Community led responses: community empowered to address needs of marginalised and key populations 5. Human rights: political commitment built to improve legal/policy environment, removal of stigma and discrimination 6. Gender equity: capacity strengthened to promote gender equality and end GBV	Yes	The CE funding allocation model has no clearly defined activities in the JPMS across the biennia that address SRA5 and SRA6. Yet there have been interventions addressing gender-based-violence, tackling the legal and political environment to ensure the rights of key populations (MSM, LGBTQI, TG, SW, PWUD) including those in prison settings and mobile populations and ensuring linkages to SRHR and CSE for young people both in and out of school.

7. Young people: capacities to implement multisectoral responses for young people (health, education, HR, protection) • *(Strategic Results Areas 3, 5,6*)		
Joint programme outcome 3 and results 8. Funded response: capacities built to develop and implement sustainable responses 9. Integration and social protection: increased access to integrated health services and social protection mechanisms 10. Humanitarian settings and pandemics: fully prepared HIV response that protects PLWH from impact of pandemics. • *(Strategic Results Areas 7,8*)	Partly	UNAIDS added value in policy level advisory and advocacy, provision of accurate information and updates on the HIV data and analysis through spectrum estimates, to support evidence-based decision making and strategic information and planning is widely recognised. UNAIDS spectrum estimates are used for prioritisation and programming of the HIV response. A health prioritization analysis including conduct of an investment case for RMNCAH (including HIV- related needs) was conducted by WB. This along with engaging in predictive analytics to more accurately predict HIV testing yields are means to addressing financing and ensuring its sustainability. UNHCR has also engaged in a study to assess the needs of refugees and migrants in lieu of the COVID-19 pandemic, results of which will be used for programming. Various capacity building efforts have been spearheaded by CE funding including, importantly, training of government staff in the analysis of data for **strategic programming purposes** and course correction as needed. From an operational perspective capacity building has included training correctional staff to ensure access to adequate and human-rights based services for those in prison, and training youth champions and teachers to impart prevention messaging.

6 CONCLUSIONS AND CONSIDERATIONS GOING FORWARD

6.1 Summary of conclusions

- **The UNAIDS Secretariat is well respected and recognised (by Cosponsors, other donors, governmental organizations and CSOs) as a leading agency in promoting the HIV response**. This is evident through their engagement at the policy and advocacy level as well as provision of strategic information used to help design the overall response. Their leadership role in convening the Joint Team and sharing of information/guidance as well as providing technical direction around the CE is applauded and has produced tangible results. However, the team is overstretched, making oversight and reporting upon CE activities challenging given commitments outside of the CE realm.

- **CE funding is a welcome initiative however the criteria and processes used to allocate funds could be more strategic with further prioritization of intervention areas/priorities and Cosponsors.** The CE funds are spread thinly over many Cosponsors and a wide range of activities with a lack of strategic/thematic prioritization considering each Cosponsor's comparative advantage. This may arise from responding to several of the many priorities of the government and a lack of clarity around whether these are, or what are, the most critical areas. The allocation is based on an "inclusiveness" approach. This has diluted the funding and poses a risk to the efficiency and effectiveness of CE funding in achieving tangible and meaningful results.

- **Late disbursement of CE funding, which has plagued the CE since inception, has resulted in low absorption rates for some Cosponsors and delayed implementation thereby affecting results.** The adjustment to a two-year planning cycle presents an opportunity for Cosponsors to achieve results in a more efficient and effective manner with the possibility of adjusting activities/plans as implementation progresses which should in turn improve upon absorption rates.

- **CE guidelines and reporting requirements could be improved** upon and simplified with timelier disbursement of funding.

- **Consideration of staffing patterns, based on a robust joint team capacity determination**, are important during the planning and decision-making processes for allocation of CE funding. This is a means of demonstrating, along with inclusion of HIV response activities in the agency overall development plans, their dedication/expertise to the HIV response and can help determine where they can best contribute to the Joint Team overall activities, if at all.

- **Despite a lack of inclusive planning for CE allocation outside of the Joint Team, the CE is leveraging partner support, through some limited catalytic activities (see EQ3), for the national response and producing results.** However, tapping into the knowledge and practical implementation experience and know-how of CSOs is a missed opportunity. This includes their perspective and insights into the bigger picture issues affecting community-based and key population response bottlenecks which require high-level input and support, something the Cosponsors are poised to address.

- **BUF funding has the potential to demonstrate a catalytic effect, however, the principles are not being carried forward in the current biennium.** BUF funding for a KP platform (nearing completion) is poised to report, for the first time, the number of KPs by group which could feed into future informed programming for the overall KP response. However, it seems that business is back to usual rather than unusual with regard to prioritization under the 2022/2023 biennium meaning that innovation and catalytic interventions are not at the forefront of CE planning and implementation.

- **Overall, the CE has contributed toward achievements defined in the NASF and the UBRAF Strategic Results Areas, however, quantifying the results is often challenging and difficult to separate from overall contributions of the Cosponsors.** This is due in part to the nature of activities focusing on provision of technical assistance for policy, strategy, and advocacy efforts in addition to research which do not lend themselves to "counting beans". In addition, the activities are by and large additive rather than catalytic, complementing other funding/programmes being implemented by the Cosponsors.

- **Categorization of activities by SRA**, with the option of only choosing one SRA, is **not reflective of the full nature of interventions** and therefore does not show fully the contribution to UBRAF strategic results areas.

- **The strong commitment, leadership and engagement of the UNAIDS Secretariat is seen as critical to realizing overall results.** Other critical factors in achieving CE results and their ultimate contribution to UBRAF outcomes and country impact include active collaboration and coordination among Cosponsors and national stakeholders.

6.2 Summary of considerations

Strategic Level

- **Engage in a more focused strategic planning process with the aim of identifying on one or two priority/thematic areas** per biennia and designing a wholistic response to those priorities/areas. This would necessarily imply fewer Cosponsors receiving more money to achieve greater impact. The effort should be undertaken with the support of RATESA and in coordination with the MoH and NAC at a minimum but ideally involve CSO representatives. The engagement should be undertaken in a retreat to ensure that adequate time and attention are given to this critical activity.

- This focused strategic planning implies tapping into Cosponsors comparative advantage identifying what the UN can do without duplicating the work of others. **CE funding should aim to continuously raise the bar to focus on the strategic level** (e.g. policy and strategy development, engagement in high-level advocacy), where Cosponsors are best placed to have impact with limited funding, **rather than activity level**. In line with that, the role of the Regional team could be further explored, and clearly defined in a joint exercise involving RATESA and the Joint Team, as there is potential to provide a more influential, transparent and strategic allocation model.

- Consider **exploring a more in-depth regional pooling approach** to funding taking into consideration the lessons learned from other regional approaches.

- Although outside of the CE funding, the staffing of the UNAIDS Country Office is critical to the entire CE process including knowledge management. Therefor ensuring adequate staffing at UNAIDS and a defined remit to oversee coordination and knowledge management is essential.

Operational level

- As part of the more focused strategic planning processes, the Joint Team **should scrutinise the staffing across the Cosponsors to determine their priority and capacity to respond/contribute to the HIV response at country level** (staff within the country). The joint capacity overview process should entail an open and frank discussion among Cosponsors as part of the strategic planning process and could be facilitated by RATESA and geared toward tapping into Cosponsor competitive advantage.

- RATESA should play of more influential role in strengthening the transparency and strategic allocation of CE processes. As a first instance this could include increased participation of regional agency focal points in the coordination mechanism along with improved oversight at country level including for implementation of the funding and results being achieved.

- **More simplified and straight forward guidance** and to a degree processes for planning, implementation and reporting on CE funding should be considered, developed, and implemented as time is precious.

- **Direct disbursement from UNAIDS to country level Cosponsors** should be considered, to the extent possible, to avoid significant delays which affect implementation timelines and ultimately results.

- Consideration should be given to **more granularity within the JPMS** with respect to categorization of SRAs to be more reflective of the nature of interventions. This could include the option to choose a primary and secondary SRA categorization or in the instance of gender and community activities the option to leave blank if not relevant. At a country level the categorization should ideally be done as a joint exercise or at a minimum by the Cosponsor responsible for implementation of the intervention.

ANNEX 1: PEOPLE /GROUPS INTERVIEWED

Organization	Name (Designation)
CIVIL SOCIETY GROUP DISCUSSION	Mumba Ngoma- CBTO Chilufya Mwaba-Phiri – Zambia Health Education and Communication Trust Chanda Chisenga Nkhoma – Restless Development Mark Besa Ngoma – Alliance for Accountability Advocates Mwale Banda- WAFE Priscilla Banda – Mothers 2 Mothers Fred Chungu – Network of Zambian People Living with HIV Glenda Kunda – Intersex Society of Zambia Mercy Moyo – Christian Women Rock Mangobe Mbizule – Decisive Minds Chilekwa Chisanga, Asiya Zulu – REPSSI Rodrick Nyendwa- Tubombelepamo Lando Sinkamba – Zambia Disability Network
MINISTRY OF HEALTH	Mrs Mable Mweemba Musheke – Chief of Public Health Department Dr Bupe Musonda - HIV Advisor Dr Patrick Lungu – National TB Programme Manager Dr Patricia Bobo – Assistant Director, Child Health and Nturition
NATIONAL HIV/TB/STI COUNCIL (NAC)	Connie Osbourne – Director General Fortune Chibamba – Director of Programs Rita Kalamatila - Knowledge Management Coordinator Jean Simalonda - IECO Katongo Silwizya - Acting DPP Annie Kalesha - Finance Manager Chris Chikatula - Global Fund Admin Duncan Banda - Internal Auditor
ILO	Theresa Mukeya – National Project Officer Simphiwe Mabhele – Technical Advisor, RATESA Member
IOM	Knowledge Mareyanadzo – Migration and Development Programme Officer Joseph Mwamba Yowela – National Migration Health Officer
UN RC OFFICE	Beatrice Mutali – Resident Coordinator of the UN System Emmanuel Chinyama – Development Coordination Officer, Economist
UNAIDS COUNTRY OFFICE	Tharcisse Barihuta – Country Director Yvonne Makasa – Logistic Coordinator Heston Phillips – M&E Advisor Crispin Silungwe – Operations Manager Louisa de Wet – Programme Analyst Kenneth Mwansa – Country Community Mobilization and Networking Adviser
UNESCO	Alice Saili – Country Team Leader Mwilu Leonard Mumbi – Programme Officer
UNHCR	Jocekshan Foyoh- Education Officer Wycliffe Matende - Health and Nutrition Officer
UNICEF	Penelope Campbell – Country Representative Kebby Musokotwane- PMTCT Lead Edgar Lungu – HIV Lead

UNFPA	Gift Malunga – Country Representative John Mwale – Country Manager - Global Fund Strategic Initiative Programme Coordinator Joy Masheke – Adolescent Sexual Reproductive Health and Youth Programme Specialist
UNODC	Nellie-Mukuka Nalwamba – Programme Administrator Gunasekaran Rengaswamy – Regional Programme Officer, Southern Africa
UNDP	Kingford Mkandawire – Project Associate Emmanuel Banda - National HIV/AIDS project analyst (former, left in December 2021)
USAID/PEPFAR	Neha Safaya - Acting PEPFAR Deputy Coordinator Lungowe Mwenda- Mwapela - Deputy PEPFAR Coordinator Strategic Information
WHO	Lastone Chitembo – Programme Officer
WORLD BANK	Katherine Ward- DDS Team Member WB's Health, nutrition and Population Global Practice, Focal Point for WB in UNAIDS Joint Programme

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ANNEX 3: CSO MAPPING AND SWOT RESULTS

Mapping of CSOs to UBRAF result areas 1-10

The following mapping was based on self-identification by the CSO's who participated in a workshop facilitated by the evaluation team; 11 CSOs and the Civil Society Self-Coordinating Mechanism were represented. CSOs were identified by the Cosponsors and UNAIDS and meant to represent those that have activities funded under the Country Envelope allocations; this could not be fully corroborated by the evaluation team. This mapping does not represent a comprehensive list of CSOs working with the Cosponsors under Country Envelope funding.

CSOs in attendance were asked to identify in which results areas they work and with which Cosponsor. The results of the self-mapping exercise are presented below.

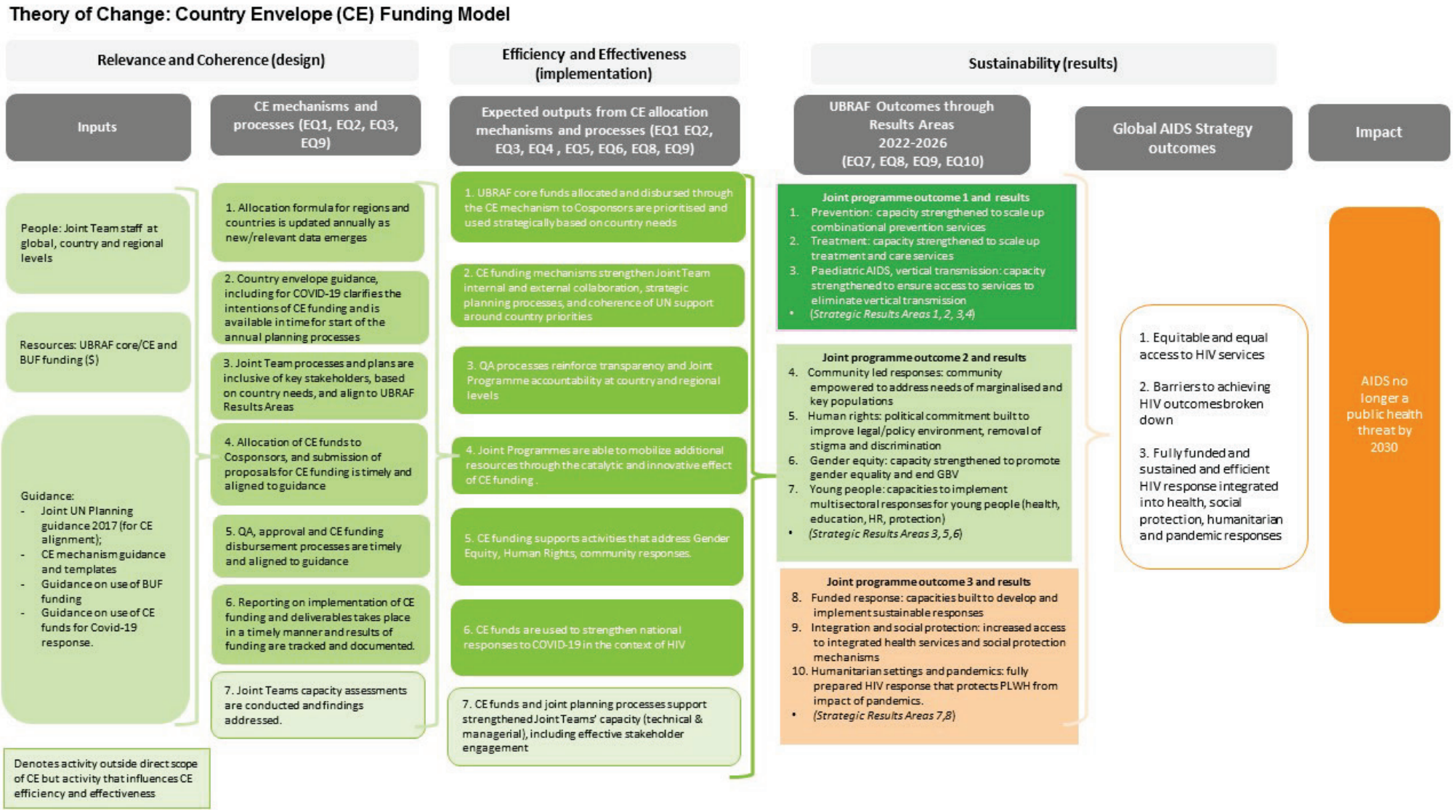
Result Area	Cosponsor	NGO
1. Prevention	UNODC	Christian Women Rock HIV Prevention in Prisons
	UNESCO	REPSSI
	UNAIDS	Civil Society Self-Coordinating Mechanism
	UNCEF	Mothers2Mothers
	UNFPA	Zambia Health Education and Communications Trust (ZHECT)
	UNICEF	Tubombelepamo
2. Treatment	UNICEF	Mothers2Mothers
	UNAIDS	Positive Minds
	UNODC	Positive Minds
3. Paediatric AIDS	UNICEF	Mothers2Mothers
4. Community-led response	UNDP	Women's Alliance for Equality
	UNODC	Women's Alliance for Equality
	UNICEF	Mothers2Mothers
	UNAIDS	Intersociety of Zambia
5. Human rights	UNESCO	REPSSI
	UNICEF	Restless Development
	UNESCO	Network of Zambian People Living with HIV/AIDS (NZP+)
	UNAIDS	Intersociety of Zambia
6. Gender equity	UNESCO	Restless Development
	UNDP	Women's Alliance for Equality
7. Young people	UNFPA	AAAZ
	UNFPA	Zambia Health Education and Communications Trust (ZHECT)
	UNESCO	REPSSI
	UNICEF	Mothers2Mothers
8. Funded response (only World Bank)	-	-
9. Integration and social protection	ILO	Network of Zambian People Living with HIV/AIDS (NZP+)
	UNESCO	REPSSI
10. Humanitarian settings and pandemics (only UNHCR)	-	-

Others present: Zambian Disability Network (not currently working with UN organizations

The CSOs presented in the table on the previous page were also asked to conduct a strengths, weaknesses, opportunities and threats exercise with a focus on their interactions with the Joint Team in addition to identifying the threats (in general) to implementation. The results of the SWOT analysis are presented below.

Strengthens	**Weaknesses**
1. Consistency with strategies 2. Provision of adequate funding for programmes 3. Provision of technical support to partners 4. Transparency and accountability in Calls for Proposal 5. Good communication channels and physical presence 6. Ability of the Joint Team to work with government and desire to embed activities within government 7. Attention to workplan development and review of results	1. Abrupt end in funding of programmes 2. Ending programmes before end of strategic plans 3. Rigidness in provision of funding (conditionalities) 4. Limited engagement in planning 5. Lack of support to form synergies among partners (Coordination among partners) 6. Lack of consideration for level of effort from partners. (e.g., contingencies in project funding) 7. Some agencies are not transparent in provision of expressions of interest 8. Lack of sustainability in programming 9. Prescriptive funding support 10. Imbalance of funding going to government versus CSOs 11. Late disbursement of funding
Opportunities	**Threats**
1. Link to government – as CSOs don't have that link so Joint Team bridges the gap 2. Includes a provision for addressing persons with disabilities in calls for proposals 3. Provisions to engage partners 4. Technical capacity strengthening of partners 5. Promotion of synergies among partners 6. Funding of partners at various levels 7. Resource mobilisation efforts 8. Increase visibility of partners and GRZ 9. COVID 10. Tap into the wide range of CSOs with whom they work to foster collaboration	1. Dilution of partners interventions 2. Lack of coordination among supported partners leads to duplication of efforts and wastage of scarce resources 3. COVID 4. Changes in funding landscape – including external factors (e.g., the conflict in Ukraine) 5. Climate Change 6. Short-term funding opportunities reduce likelihood of impact 7. Competition among CSOs 8. Political environment – e.g., lack of recognition for LGBTQI, push back on the CSE

ANNEX 4: THEORY OF CHANGE



Assumptions

Inputs/mechanisms to CE outputs

Relevance and coherence (design)

- Global CE allocation model is dynamic and annual allocation updates reflect changing dynamics of HIV epidemics.
- Country envelope funding is allocated to Cosponsors at country level in transparent manner, based on clear and understandable criteria.

Efficiency and effectiveness (implementation)

- Joint Team members are informed about each other's work. They collaborate effectively to ensure country envelope support is relevant to country needs and represents a coherent set of UN actions (including in relation to UN Div of Labour)
- Joint Teams engage with (external) country partners including CSOs and key population groups in UN Joint Planning processes to ensure country priorities are reflected and supported.
- Country envelope allocations and processes are flexible enough to adapt to emerging programming needs e.g., COVID-19
- QA structures and processes improve relevance and accountability of country envelope funds.
- Country envelope processes (allocation, proposal, disbursement and reporting) are timely, and not burdensome or transaction heavy.
- The implementation period is sufficiently long to ensure CE/BUF activities are implemented as intended.
- Joint Teams have capacity to work on COVID-19 reprogramming of CE funds

CE outputs to UBRAF outputs (and GAS strategic priorities)

Sustainability (results)

- UNAIDS capacity (human resources) is sufficient to implement Joint Plans and country envelope activities.
- Country envelope funding is catalytic and supports the achievement of UBRAF outputs and outcomes.
- There is sufficient balance of country envelope investments to ensure UBRAF outputs contribute to the three strategic priorities of the Global AIDS Strategy.

ANNEX 5: 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[29]?
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[30]
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[31] at country level?
Evaluation question 9: What are the main factors helping or hindering the achievement and sustainability of results? Consider 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?

[29] 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.

[30] See definitions in p.15

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

ANNEX 6: CE/BUF ACTIVITIES PER YEAR PER COSPONSOR

Table 7: CE/BUF activities per biennium 2018-2022 and orientation of funds

Co-sponsor	CE allocation – US$	SRA (high priority area)	Number of activities	Description of activities
UNODC 2018/2019	250,000	SRA4	7	**(Human rights, integration and social protection) – Strengthening coordination mechanisms for KP –** supporting NAC to hold KP TWG meetings resulting in adaptation of comprehensive HIV guideline for KP programmes with an aim to contribute to improved access for KPS (PWID, people in prisons); engaging a consultant to build capacity of 9 CSOs; developing of an advocacy strategy for KPs through high level policy dialogue (consultant) to address legal and policy barriers for KPs; engaging in media training for improvement of KP perception men who have sex with men (MSM), people who inject drugs (PWID), transgender and sex workers; adapting comprehensive HIV guidelines for KP for MSM, PWID, people in prisons and closed settings, transgender people and sex workers (validated and UNODC supported printing and dissemination); developing advocacy strategy for KPs (consultant) targeting MoH, Ministry of Home Affairs, Ministry of Justice, Ministry of Religious Affairs.
UNODC 2020/2021	341,000	SRA3	7	**(Human rights, integration and social protection) - Conducting an HIV impact assessment for the prison setting** generating current SI on the situation in prisons; conducting a rapid assessment of PWID and people who use drugs (PWUD); enhancing capacity of health workers for people on the move through piloting a framework for patient information sharing between countries (migrants, truck drivers, KP – MSM, SWs and PWID/PWUD, and prisoners); developing a KP strategy for 2020-2024, safety and security plan and social network strategy manual with KP to be used for recruitment, referral and retention in HIV care; rolling out treatment guidelines for people on the move (migrants, truck drivers, SWs, YKPs and other vulnerable groups) working with IOM; coordinating and conducting capacity building programmes for provision of gender response/sensitive public and private harm reduction services.
UNODC 2022/2023	118,000	SRA3	2 (2022)	**(HIV prevention, human rights) –** Bringing partners to prison health advisory committee (PHAC) to design a need-based implementation and distribution plan for male and female condoms and lubricants through consultative process with Zambian Correctional Services (ZCS); engaging in advocacy and technical assistance (TA) for provision of harm reduction-based services for PWIDS based on Harm Reduction Guidelines – advocacy for inclusion of medicines for opioid substitution therapy interventions and other commodities in two public facilities and strengthening partnerships with private providers
WHO 2018/2019	250,000	SRA1	4	**(Testing and treatment, eMTCT/paediatric AIDS) - Strengthening coordination mechanisms for HIV testing** (HTS campaigns in 4 cities and subsequent roll out with focus on HIVST) and developing and disseminating HIVST guidelines; working with private sector enterprises to ensure they are equipped with basic rights-based education and awareness on eMTCT, pre-exposure prophylaxis (PrEP), HIVST, TB, viral load suppression (VLS), hepatitis prevention and control for PLHIV.
WHO 2020/2021	204,900	SRA1	3	**(Testing and treatment, eMTCT/paediatric AIDS)** – **Promoting HIV and co-morbidities for workplace and institutions** of higher education through capacity building of champions; providing technical and financial support to the NAC and CSOs to conduct community literacy on HIV testing services, ART, VLS, VMMC, eMTCT, PrEP, etc. through electronic and print media.
WHO 2022/2023	150,000	SRA1	2 (2022)	**(HIV treatment)** – **Scaling up of country and community capacities for testing, treatment, care, support and integrated services** – TA and financial support for advocacy, adaption, dissemination of guidance and tools for prevention and treatment for children, adolescents and adults focused on VMMC, case finding, linkage, treatment, retention and viral load testing.; supporting case finding and improvement of treatment outcomes; ensuring clear messaging and community awareness on updated guidance for HIV.
UNICEF 2018/2019	250,000	SRA2	5	**(HIV prevention, eMTCT/paediatric AIDS, young people**) - **Supporting eMTCT through review/bottleneck analysis** and workshop to develop a plan; building capacity of low performing districts; providing technical and financial assistance to (Western, North-Western and Luapula provinces) for eMTCT implementation and advocating for scale up to other provinces.

Co-sponsor	CE allocation – US$	SRA (high priority area)	Number of activities	Description of activities
UNICEF 2020/2021	157,100	SRA2	3	**(HIV prevention, eMTCT/paediatric AIDS, young people) – Expanding paediatric HIV services including early infant diagnosis (EID), testing and retention on ART** – increased coverage of EID for all exposed at 6 weeks, working with districts to ensure a full range of services; developing a package to strengthen HIV prevention for PMTCT, ANC in target districts focusing on AGYW who test HIV negative during PMTCT settings both during pregnancy and breast-feeding period; developing a package of essential HIV prevention interventions such as tools and operational guidelines and supervision and mentorship to health care workers and fo6llow up monitoring; TA for scale up of eMTCT in targeted districts targeting AGYW, scale up of PMTCT dashboard/scorecard integrated in the DHIS2.
UNICEF 2022/2023	150,000	SRA2	1 (2022)	**(Paediatric AIDS/vertical transmission) – Developing a roadmap for triple elimination of PMTCT, congenital syphilis and hepatitis.**
UNFPA 2018/2019	190,000	SRA3	4	**(HIV prevention, young people, key populations)** – **supporting implementation for SBCC in and out of school youth** through comprehensive multi-media campaign for condom use (targeted districts); developing comprehensive condom programming strategy with a focus on young people.
UNFPA 2020/2021	159,900	SRA3	4	**(HIV prevention, young people, key populations) - Designing, rolling out and integrating HIV prevention and SRHR services for youth** (address HIV, sexually transmitted infections (STIs) and teenage pregnancy); supporting community condom outreach interventions (National Condom Comprehensive Strategy) through designing messages to combat myths and targeting community-based delivery points and outreach campaigns.
UNFPA 2022/2023	140,000	SRA3	1 (2022)	**(Young people) – supporting delivery of integrated ASRHR/HIV/SGBV package of community level comprehensive adolescent health information and services** using the differentiated service delivery approaches.
UNESCO 2018/2019	160,000	SRA3	1	**(Young people)** – **Establishing linkages between comprehensive sexual education (CSE) and utilization of sexual reproductive health and rights (SRHR) services** in partnership with UNFPA and Pop Council conducting a multi-year implementation science study with three study arms to create a model for CSE and SRHR – targeting 23 schools and surrounding health facilities (2018 baseline); planning for linking learners to health and HIV services; developing and app for integrated CSE and HIV.
UNESCO 2020/2021	108,600	SRA3	3	**(Young people) – Support the analysis and reporting of HIV-related indicators in the education** management and information system (EMIS); implementing parent-child communication programmes using the Our Talks manual; rolling out linkages model to various provinces (based on initial 2-year implementation); engaging in community mobilization on CSE for gate keepers (religious and traditional leaders).
UNESCO 2022/2023	110,000	SRA3	2 (2022)	**(HIV prevention, young people) – Supporting implementation of CSO an SRH interventions in higher institutions of learning –** for students and staff including gate keepers; scaling up CSE and SRHR linkages activities/models for adolescents and young people.
World Bank 2020/2021	83,500	SRA7	2	**(Fully funded HIV response, integration and social protection)– Engaging in health prioritization analysis including investment case for RMNCAH including HIV needs** – in coordination with review of the national health strategic plan ensuring HIV spending seen in the wider context of spending on RMNCAH; implementing an efficiency analysis to improve efficiency through better prediction of HIV testing yield.
World Bank 2022/2023	60,000	SRA7	1 (2022)	**(Fully funded HIV response)– Building capacity of key stakeholders to ensure HIV response is sustainably funded and equitably, effectively and efficiently implemented –** supporting MOH with analytical work, policy design and implementation to advance the development fo the National Health Care Package (NHCP), appropriate integration of HIV and other essential services in UHC efforts, and the linking of NASF to investment cases.

Co-sponsor	CE allocation – US$	SRA (high priority area)	Number of activities	Description of activities
UNDP 2020/2021	95,000 (50,000 BUF)	SRA3	5	**BUF funding (Human rights, key populations, testing and treatment)– Establishing a digital database for KP communities**; engaging in dialogues on the penal code with Ministry of Home Affairs and Ministry of Justice advocating for "other" sex; strategic judicial reviews to challenge harmful laws on criminalization of same sex consensual relationships. **(Human rights, key populations, testing and treatment)** Rolling out the SADC KP strategy with key sectors (gender/youth) working with MoH, Gender and Justice to integrate SADC protocols into the strategic framework and laws at national level as well as in policy formulation; conducting training in 4 provinces of the KP M&E system and its data management procedures (NACMISONLINE)
UNDP 2022/2023	176,000	SRA3	2 (2022)	**(HIV prevention, Integration and social protection) - Strengthening HIV and SRH interventions within the transport sector –** though the technical working group (TWG) to address challenges of those on the move and along migration affected communities through workshops for services providers, awareness raising on HIV to the transporters and people along the migration corridors (IOM to implement through UNDP
UNHCR 2022/2023	90,000	SRA6	2 (2022)	**(Humanitarian settings and pandemics) – Assessing HIV and COVID-19 needs, for migrants, refugees and crisis affected mobile populations** living with HIV in humanitarian settings; integrating HIV and COVID-19 services for migrants, refugees and cross affected mobile populations in systems for health in humanitarian settings
ILO 2022/2023	106,000	SRA8	0	**(HIV treatment, young people, integration and social protection) – Promoting HIV sensitive social protection for people living with HIV and key populations.**

ANNEX 7: DEEPER DIVE UNFPA DEVELOPMENT OF THE NATIONAL COMPREHENSIVE CONDOM STRATEGY 2020-2025

DEEPER DIVE – UNFPA	
1.1. Background, rationale and alignment of activity	
Cosponsor agency:	UNFPA
Implementers (partners):	MoH, NAC, civil society organizations, provincial and District HIV and AIDS Committees (DHACs), USG through USAID – input into development of the strategy
Biennium:	CE 2018-2019 and 2020-2021
Name of activity funded by country envelope or BUF funds	Development of the first ever comprehensive condom programming strategy with a strong focus on young people (Strategy development) (2018). Followed by support to implementation of a multimedia SBCC campaign aimed at increasing risk perception and condom use among young people through placement of media products in hotspots (2019) and communities with condom outreach interventions (2020 and 2021). Activities in 2019-2021 were guided by, and in line with, the strategy developed in 2018.
Strategic priority area (SRA)	SRA3
Gender Marker	Gender Marker 2 - Significant contribution to gender equality and/or empowerment of women and girls
Civil Society Marker	Civil Society Marker 1 - Consultation and engagement with civil society/community
Alignment	- Aligned with UBRAF outcome 1 (People living with, at risk of and affected by HIV obtain equitable access and reap equitable benefits from HIV prevention, treatment, care and support services) and 2 (Communities of people living with, at risk of and affected by HIV, including key populations, women and young people, are empowered, enabled and effectively resourced to lead HIV service delivery, advocate for and enjoy their right to health, and social and structural drivers of the HIV epidemic are removed). - Aligned with Joint programme results areas 1 (HIV prevention), 4 (community-led responses) and 7 (Young people)
How will expected outputs or deliverables of the activity contribute to addressing the country need/gap?	Young people are fuelling the epidemic in Zambia as the biggest contributors to the number of new infections on an annual basis. Zambia has the 7th highest prevalence rate globally among people aged 15-49 years and a high teenage pregnancy rate. It is proven that condoms, which provide triple protection (against HIV, STIs and pregnancy) but only if used correctly and consistently. However, based on the 2018 DHS, only 35% of females and 54% of males reported using a condom when having sex with a non-spouse or live-in partner of more than 12 months. Equally distressing is only 34% of females and 49% of males aged 15-24 used a condom at the last high-risk sex with a non-regular partner. This, at time when prevalence among young people (15-24 years) was 5.6% and 1.8% among females and males 14-25 years respectively[32]. Development of the comprehensive condom strategy has helped to shape and ramp up this important prevention method as well as

[32] Global Fund HIV/TB Funding Request 2020-2022; Zambia Global AIDS Monitoring Report, 2019

	increasing overall awareness of HIV prevention addressing the triple threat (HIV, STIs, pregnancy) with a strong focus on youth.
Budget and timeline:	CE funds: US$ 35,000 (2018-strategy development) Roll on effects: US$ 35,000 (2018-printing of strategy), SBCC campaigns (US$ 54,540-2018, US$ 60,000 2019), community condom outreach (US$ 26,028-2020, US$ 54,000-2021)
1.2 Implementation	
Nature of activity and participation	UNFPA, according to key informants not least of all the government, was cited as playing a critical role in the identification of gaps in prevention programming based on analysis of critical data. These gaps were highlighted to the condom TWG which then led to the development, funded by UNFPA, of the strategy which was the first of its kind in Zambia. UNFPA contracted technical expertise to assist in the development of the strategy and to ensure a focus on youth within the document. It was noted that without the technical and financial support of UNFPA the strategy would not have been developed. This support has extended to include development (ongoing) of an M&E framework to accompany the strategy.
Activity implemented (on time, on budget and as intended):	Based on documentary evidence and conducted interviews the strategy was developed in a timely fashion and within budget.
Evidence of implementation:	The budget has been implemented with UNFPA reporting a 100% expenditure rate.
Challenges, bottlenecks, unintended consequences experienced	No particular challenges were noted with the development of the strategy however for subsequent interventions grounded in the strategy design (community mobilization, condom distribution including in prisons (mainly UNODC), etc., challenges have arisen. These include resistance to condom distribution in the prison setting (an assessment conducted by UNODC showed that more than 90% of inmates were against the provision of condoms as was seen to encourage bad behaviour) as well as resistance among religious communities (e.g. Catholic communities).
1.3 Results	
Results as they relate to country envelope outputs:	First ever comprehensive condom strategy and accompanying M&E framework (ongoing development) which has helped in the realization of subsequent results including: • Support to the government for the development and implementation, in four fast track cities in addition to tertiary colleges, of an HIV prevention campaign to increase risk awareness and condom use among young people (Young, Smart, Safe #HIVFree) – 2018 and subsequent years • Using an integrated service delivery approach, part of the comprehensive condom strategy, UNFPA supported moonlighting activities at tertiary institutions which included dissemination of the campaign materials, SRH services and condom demonstration and provision. • Subsequent support (technical and financial) to the development and implementation of the CONDOMIZE! campaign. Together with Young, Smart, Safe #HIVFree) the campaigns were rolled out in over 50 districts reaching more than 500,000 adolescent and young people with prevention information in addition to distributing more than 1 million condoms (2020) • Work continued with the CONDOMIZE! Team at the MoH to engage in community sensitization to increase condom uptake at hot spots and

	along border areas including distribution of over 2 million condoms and reaching more than 220,000 youth with prevention messages.
Describe results likely to arise from the activity in the next 6 - 12 months:	It is expected that an evaluation will take place to measure the knowledge, attitudes, and practices of young people with relation to condom use and to show both increased awareness but also correct and consistent use. This will then help further target activities and ability to adjust messaging as needed. It is anticipated that through technical expertise contracted by UNFPA, currently focusing on development of the M&E framework, then a dashboard will be built to assist in interpretation of results for future planning and course correction in addition to dissemination of results.
How catalytic is/was the activity (use/insert rating if possible – example overleaf):	**Multiplier effect:** UNFPA used the strategy, along with its experience implementing CONDOMIZE and YoungSmartFree campaigns reaching youth throughout the country, to lobby Global Fund to include condom programming in the most recent Funding Request (2020-2023). This high-level advocacy resulted in the approval of US$ 5.1 million for condom programming. In true catalytic nature, based on the strategy and raising the visibility of condom programming in part through inclusion in Global Fund programming, Zambia was chosen as one of four countries to implement the Global Fund "***Condom Strategic Initiative***". Without the strategy it was stated by informants that these two critically important subsequent interventions would not have taken place.
UNAIDS role in following up activity and results:	The UNAIDS Joint Programme continued to concentrate on monitoring the implementation of planned activities to achieve set results. These results contributed to the 2025 targets that informed the priorities and the targets of the UNAIDS Strategy beyond 2021. This was at the centre of inclusive strategic discussions in preparation for and during the UN General Assembly High-Level Meeting on HIV/AIDS.
Critical success factors:	The technical capacity to analyse the data for decision making purposes, gravitas to reinvigorate and guide the condom TWG, and ability to advocate with government and development partners to develop a comprehensive strategy and push forward the integrated prevention agenda. Helping ensure that future interventions get the attention and funding needed to guarantee continued access to messaging and condoms, particularly for youth but also reaching other key populations.
Lessons learned from implementing the activities using country envelope funding:	High level advocacy and strategy development, tapping into the comparative advantage of the Cosponsor can lead to overall policy and strategy design which has a long-lasting multiplier effect.

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