UD

Evaluation Report 1.97

Evaluation of Norwegian Assistance to Prevent and Control HIV/AIDS

by Karolinska institutet/IHCAR & Stockholm Group for Development Studies AB

Ministry of Foreign Affairs

NORGENORWAYNORVEGENORWEGENNORUEGANORVEGIANORGE

Information from the
Royal Ministry of Foreign Affairs

The Ministry's Information Section provides information with regard to current foreign policy, trade policy and development cooperation policy. Informative material can be ordered from fax no. +47 22 24 27 87

Foreign Ministry switchboard,
Tel. +47 22 24 36 00
Fax +47 22 24 95 80 or +47 22 24 95 81

Information is available on Internet at http://odin.dep.no/ud

Office address: 7. juni plassen, Oslo
Mailing address: P.O. Box 8114 DEP,
N-0032 OSLO, Norway

Information to the media:
The Ministry's Press Spokesman and the Senior Information Officer on development cooperation can be contacted through the Foreign Ministry switchboard

Foreign journalists:
The Norway International Press Centre, NIPS, is the Foreign Ministry's service centre for foreign journalists in Norway, tel. +47 22 83 83 10

In countries outside of Norway, information on the Ministry of Foreign Affairs may be obtained from Norwegian embassies or consulates

Published by: The Royal Ministry of Foreign Affairs
April 1997
Print: GCSM AS, Oslo
Circulation: 800
300 reprinted June 1998
E-530 E
ISBN 82-7177-455-7

Evaluation of Norwegian Assistance to Prevent and Control HIV/AIDS

by Karolinska institutet/IHCAR &
Stockholm Group for Development Studies AB

A report submitted to the Royal Norwegian Ministry of Foreign Affairs
by Karolinska institutet, Department of Public Health Sciences, Division of
International Health Care Research (IHCAR) and Stockholm Group for Development Studies AB

The Ministry does not accept any responsibility for the information
in this report nor the views expressed, which are solely those of
Karolinska institutet/IHCAR and Stockholm Group for Development Studies AB

Preface

The Norwegian government has put considerable resources into prevention and control of HIV/AIDS since the late 1980s. In 1990 a Special AIDS Grant (SAG) was instituted by the Parliament. Guidelines for the Grant Management were issued in 1992 and an evaluation was scheduled for 1994. However, the plans for the evaluation were changed due to a growing reluctance to continue the SAG. It was, finally, decided to conduct the evaluation and a tendering procedure was initiated in August, 1995. Although there was a pending decision to turn down the SAG it was decided that the evaluation should be carried out and that it should consider which mode of supporting AIDS work might be most appropriate in the future. The assignment to conduct the evaluation was given to the Division of International Health Care Research (IHCAR) at Karolinska institutet, Stockholm, and the Stockholm Group of Development Studies (SGDS). The work was initiated in April, 1996.

By the end of June 1996, the evaluation team presented an Inception Report to the Norwegian Ministry of foreign Affairs (MoFA). Following clearance from the Ministry the country teams conducted their missions during August and September 1996. The progress of the work has continuously been reported to the Norwegian MoFA and the results of the evaluation, including country missions, are presented in this report.

The evaluation has involved a reference group and country missions composed by external and local teams. Each group or team has included medical, social science and health planning or economics competence.

The evaluation of the SAG includes different components:

- Documents and statistics on HIV/AIDS control projects supported by Norway have been reviewed as well as other relevant memos, publications etc;
- Interviews with key persons in the administration of the Norwegian Government and at seven Norwegian organisations that had received support have been conducted in Oslo and Bergen;
- A visit to Geneva was undertaken and the UNAIDS staff was interviewed as well as former World Health Organisation's Global Programme (WHO/GPA) staff members;
- Three country missions have been carried out to Tanzania, Uganda and Zambia. The full country reports will be found in the Annexes.

The main observations from the three country missions have been included in section 4, but can also be found in the country reports (Annex III, IV and V). These reports discuss the AIDS situation and Norwegian support to AIDS control in the countries more at length.

We would like to thank all those who have contributed to the work – interviewees and team members in the country missions, Norwegian staff at MoFA, Embassies and NORAD, aid workers and contributing specialists from different countries. A special thank to Terje Dalseng, who provided statistical background data.

Executive summary

In many countries, particularly in central and southern Africa, the AIDS epidemic has escalated tremendously during the early 1990s. Simultaneously, the epidemic is growing in other, relatively unaffected regions, for instance in South-East Asia and Eastern Europe. HIV is spreading far outside the «risk groups», identified in the early stages of the epidemic. People outside the «risky sexual behaviour» groups and new-born infants constitute a growing proportion of the HIV positive individuals, the majority of which are now women. Prospects for the future indicate that the epidemic in Africa will reach its peak during the first half of the next century. Cases are now reported from about 190 states in the world and in many of these the number of patients will grow tremendously.

Some donor countries have diminished their contribution to AIDS control activities. Norway, however, has maintained a high input. In 1990 the Norwegian Parliament instituted a SAG. The money was to be assigned to multi-lateral and bilateral aid and particularly AIDS-related projects, preferably preventive ones, directed towards women or children, and to be implemented by NGOs (Norwegian or local). Apart from this special grant support allocations for AIDS-related activities have been drawn from regular multi-lateral or bi-lateral funds. The total Norwegian contribution to AIDS control projects during the six-year period 1990–1995 amounts to about USD 78 million.

The evaluation

An evaluation of the SAG was planned to be conducted in 1994. Although discussions on turning down the Grant have delayed the process, it was decided that an evaluation of the Grant, including an assessment of relevance of possible strategies for the future, should be conducted. The Division of International Health Care Research (IHCAR), Karolinska institutet, Stockholm and the Stockholm Group of Development Studies AB (SGDS) were given the assignment to conduct the evaluation, starting from May 1996. This evaluation has been carried out through the joint efforts of a number of groups. A reference group has lead the evaluation and particularly explored the Special Grant from a Norwegian perspective and from the international organisations. Three country-programmes, in Tanzania, Uganda and Zambia, have been scrutinised in detail during country missions, conducted by joint external and local teams. All groups have included three kinds of competence, medical, social scientist and health planning or economics.

Major findings

The evaluation team has found that the Grant funds have been allocated via different routes:

- multi-lateral (or multi-bi-lateral) allocations via international organisations, particularly the global programme on HIV/AIDS of WHO;
- bi-lateral allocations to organisations, mainly NGOs in recipient countries and
- allocations to Norwegian NGOs for work in developing countries and in partnership with local private organisations.

Apart from the SAG financial support for AIDS work has been given via regular multi- or bi-lateral mechanisms. The Tanzanian – Norwegian AIDS project (MUTAN) has been allocated about 10 % of the total Norwegian support for AIDS activities during the six-year period.

Assessment of the utilisation of Special Grant funds

The evaluation team has found that considerable efforts have been made to develop guidelines for how to use funds. These guidelines have been used while reviewing different kinds of project proposals submitted to Norwegian authorities. The management of the grant has been flexible and by and large efficient, although it has also implied heavy administrative work. In Zambia, for example, the Embassy has assessed and supported about 20 projects each year and in Zimbabwe about 15. A special assignment of an AIDS advisor was inserted at the National Board of Health. This position has had a most important role in co-ordinating the Grant and securing management according to the given objectives.

A considerable number of projects, many of them fairly small and implemented in partnership between Norwegian and local NGOs from developing countries, have

thus been supported. Resource mobilisation and capability strengthening at the local level characterises many of these projects. This contributes to the general assessment that funds have been used in an appropriate way and that there is some hope for sustainability of initiatives. In addition, a number of Norwegian experts have gained important experience. Many of them could certainly play an important role in the continuous development of AIDS control programmes.

The evaluation has indicated that the central Norwegian authorities have not executed the full potential of the Grant in terms of possibilities for national, and to some extent, global AIDS control policy. A stronger function for policy development and follow-up of the results, including dissemination of experiences of different Norwegian organisations, could have improved the efficiency of the programme as such and could have strengthened the Norwegian resource base in the field. On the other hand, the Grant has probably contributed to making Norwegian ambitions in AIDS control well-known in the global community. One purpose of the SAG was to strengthen the HIV/AIDS activities under the bilateral programmes. The team has found little evidence that this has occurred.

The evaluation has found that the AIDS allocations have hardly – with one exception – been used for research work. The co-ordination with the National AIDS Control Programmes (NACP) in the different countries has, in some cases, been weak, but in other cases there has been close collaboration.

Conclusions and recommendations

The team concludes that the SAG has been a valuable, appropriate and by and large efficient way of supporting AIDS activities in developing countries during the early 1990s. It calls for continuous support and encourages Norway to continue to shoulder a central role in the development of a global strategy and for development of community working models for prevention of HIV/AIDS transmission and support to AIDS victims. It is, however, emphasised that a too broad community approach may result in a loss of focus on the most vulnerable groups. Some key factors for making individual projects relevant, effective and sustainable have been identified. The team puts a particular emphasis on involvement of the local community, local capacity strengthening, networking with other organisations, a continuous follow-up, preferably by using locally developed indicators and, at the same time, maintaining a focus on the most vulnerable groups.

The team recommends that the Norwegian Government continues its support to AIDS control, as suggested at least at the same level as during the last years. However, the rationale for a SAG is weak. More intense promotion of AIDS-related programmes in different sectors, e.g. within community development, educational or health projects is argued for. Norway could also strengthen the central level co-ordination and development of global AIDS activities by instituting an advisory group with the AIDS advisor as its secretary. This group could also aid in developing an agenda for action-oriented AIDS research and for opening up programmes in countries in for instance South-East Asia and Eastern Europe where the epidemic is growing.

Finally, the evaluation team has found strong support to suggest that Norway should give substantial support to the Joint United Nations Programme on AIDS (UNAIDS) through a high level of activity in relevant fora within the organisation particularly at central and national levels and by financial support to AIDS work within the co-sponsoring agencies and to individual countries. The particular Norwegian skill for working with NGOs should be utilised for future programme development.

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
ASD	AIDS and STD Control Office (at WHO)
BECCAD	Basic Education Child Care and Adolescent Development
CARITAS	Catholic Aid Organisation
CCO	Co-sponsor Committee
CEDHA	Centre for Educational Development in Health
CHEP	Copperbelt Health Education Project
CHIN	Children in Need
CMAZ	Churches Medical Association of Zambia
COPE	Complementary Options for Primary Education
CPA	Country Programme Advisor
DAP	Drug Action Programme
FHT	Family Health Trust
GPA	Global Programme on AIDS
HIV	Human Immunodeficiency Virus
HTA	High Transmission Area
ICH	Department of International Child Health, Akademiska sjukhuset, Uppsala, Sweden
IEC	Information, Education and Communication
IHCAR	Division of International Health Care Research at the Department of Public Health Sciences, Karolinska institutet, Sweden
LFA	Logical Framework Approach
LLH	National Association for Sexual Rights, Oslo
LPC	Leprosy Control Programme
MCDT	Micro Credit Development Trust
MNOK	Million Norwegian Crowns
MNOK	Million Norwegian Crowns
MoE	Ministry of Education
MoFA	Ministry of Foreign Affairs
MoH	Ministry of Health
MTP	Medium Terms Plan
MUTAN	Norwegian Tanzanian AIDS Projects
NAC	National AIDS Committee
NACP	National AIDS Control Programme
NAP	National AIDS Programme
NASTLCP	National AIDS, Sexually Transmitted Diseases, Tuberculosis and Leprosy Control Programme
NAVF	Norsk Almenvetenskaplig Forskningsråd
NCC	National Council for Children
NGO	Non Governmental Organisation
NOK	Norwegian Crown
NORAD	Norwegian Aid Agency for Development Co-operation
PAC	Action Programmes for Children
PCB	Programme Co-ordinating Board
PHC	Primary Health Care
Pinsevenn	The Norwegian Pentecostal church that has church-related programmes in Uganda including one that focuses on AIDS victims with Norwegian support
PRA	Participatory Rural Appraisal
PWA	Person with AIDS
SAG	Special AIDS Grant
SAIH	Students and Academics International Assistance Fund
SANASO	Southern Africa Network of AIDS Service Organisations
SGDS	Stockholm Group for Development Studies AB
STD	Sexually Transmitted Diseases
STP	Short Terms Plans
SWAAZ	Society for Women Against AIDS in Zambia
TB	Tuberculosis
ToR	Terms of Reference
UAC	Uganda AIDS Commission
UCOBAC	Uganda Community Based Association for Child Welfare
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Childrens Fund
UNPAC	Uganda National Plan of Action for Children
USAID	United States Agency for International Development
WAMATA	People in Struggle against AIDS in Tanzania
WHO	World Health Organisation
ZNAN	Zambian National AIDS Networks

Members of the reference and executive group

Name	Institution	Position
Bengt Höjer	IHCAR	MD, Assoc Prof, Chairman
Krister Eduards	SGDS	Economist
Göran Sterky	IHCAR	MD, Prof emeritus
Aud Talle	Institute and Museum of Anthropology, Oslo	Social scientist, Professor
Bawa Yamba	IHCAR	Social scientist
Gunnar Holmgren	ICH, Uppsala	MD
Staffan Uddeholt	SGDS	Health planner

Country team members

Tanzania

External	Local
Minou Fuglesang	Angwara Denis Kiwara
Stefan Hanson	Phare G M Mujinja
Staffan Uddeholt	Issa Musoke

Uganda

External	Local
Gunnar Holmgren	Jonathan Keith Gaifuba
Annika Johansson	Grace Bantebya Kyomuhendo
Staffan Uddeholt	Christine Oryema Lalobo

Zambia

External	Local
Gunnar Holmgren	Chimutalanje Lwengi
Staffan Uddeholt	Francis Phiri
Bawa Yamba	

List of contents

1.	**Norwegian support strategies**	9
1.1	Norway fights AIDS	10
1.2	Global response	10
2.	**The AIDS epidemic – a brief overview**	11
2.1	Development of the epidemic	11
2.2	Stages in attempts to mitigate the epidemic	11
3.	**Norwegian HIV/AIDS-Allocations 1990–1995**	17
3.1	Strategy	17
3.2	Guidelines for the SAG	17
3.3	Organisation	18
3.4	Allocations to HIV/AIDS control activities	19
3.5	Multilateral support through the UN system	19
3.6	Bi-lateral support through Norwegian embassies abroad	20
3.7	NGO support through Norwegian private organisations	20
4.	**Findings from country and project studies**	21
4.1	Introduction	21
4.2	Tanzania	21
4.3	Uganda	27
4.4	Zambia	36
4.5	Description of selected projects	41
4.6	The private organisations in Norway and the SAG	42
5.	**Discussion**	44
5.1	Approach	44
5.2	What denotes a «good project»?	45
5.3	Objectives and channels	46
5.4	Management and administration	48
5.5	Special Grant implications	49
5.6	AIDS research	50
5.7	UNAIDS – appropriate channel for future Norwegian support?	50
5.8	Future perspectives	52
6.	**Conclusions**	53
6.1	Grant objectives and framework	53
6.2	Management and administration	54
6.3	Effects and role of the Grant	55
7.	**Recommendations**	56
	Annexes	
I	Terms of Reference	58
II	Terms of Reference for Country Missions	64
III	Tanzania Country Report	67
IV	Uganda Country Report	95
V	Zambia Country Report	123

«Perhaps the greatest danger is that the world will learn to live with AIDS»

(GPA, external review, 1992)

1. Norwegian support strategies

1.1 Norway fights AIDS

In response to the rapidly spreading HIV/AIDS epidemic and the situation of emergency in the late 1980s, the Norwegian Parliament decided to allocate a «special grant» for AIDS control, the SAG. In Norwegian development co-operation, there has been a praxis of creating such «special grants» to enhance focus and activity in especially urgent or sensitive fields. The SAG was established in 1990.

Although the SAG had a vertical and narrow focus on one disease, it was a funding source aimed at being used multi-sectorially. The SAG was intended to be flexible, to be catalytic and to function as «seed» money to be used to encourage ministries, institutions and organisations to initiate and pilot activities and interventions. The intention was also that funding gradually should be absorbed in and taken over by regular bi-lateral country programmes or other regular funding mechanisms.

However, the over-arching policy for the Norwegian development assistance to developing countries is to «promote the establishment of a sustainable economy, that is independent of development assistance». Support of civil service reforms is a key area. The Norwegian policy towards developing countries fits with the ongoing attempt to decentralise the health sector. The MoFA Report No. 19 (1995) to the Parliament (Storting) states that Norway will give priority to supporting the development of primary health services and strengthening administrative systems, and not focus on particular diseases. Norway will in bi-lateral and multi-lateral programs emphasise contributions to integrated primary health care services.

This statement does not explicitly exclude contributions to vertical programs such as National HIV/AIDS/STD Control Programmes. But the statement is well adapted to the consequences of the decentralisation process within the developing countries themselves, i.e. provision of integrated health services to people at district and lower levels.

1.2 Global response

There is a general feeling that the interest in AIDS in Western countries is less today than a decade ago. But, whereas the epidemic appears to have slowed down in the West, the opposite is the case in Africa where, in some countries, the HIV/AIDS epidemic has risen to alarming proportions, increasingly affecting vulnerable groups, such as women and infants, who do not belong to the conventional risk groups. Furthermore, the epidemic is also on the rise in a number of South-East Asian countries. The global picture is bleak. Some small achievements have, however, been noted in the control of the disease and in the latest days of 1996, it was reported that surveillance data from e.g. Uganda indicate a stabilisation of the epidemic.

With little hope of discovering an effective vaccine within the next 5–10 years, interventions have increasingly become focused on a limited number of areas: the control of «classical» STDs in order to reduce the risk of HIV transmission; multi-sectorial efforts to strengthen HIV prevention through education, targeting of the youth and community development programmes, etc. Home- based care programmes are becoming increasingly important with their purported educational/preventive consequences, as are other endeavours in order to reduce the impact and the social consequences of AIDS.

The most prominent international response has come from WHO and its GPA. Through the establishment of a broad UN programme, UNAIDS, in 1996, an organisational structure for the development of multi-sectorial efforts has been created.

It is tragic that HIV continues to infect more and more people in Third World countries while treatment for the disease is still non-existent. It is clear that increasing assistance is required from the richer countries – although these, rather cynically, are becoming less and less interested in problems of AIDS control programmes in the poorer countries, since the epidemic is partly phasing out in their own societies.

2. The AIDS epidemic – a brief overview

2.1 Development of the epidemic

The development of the HIV pandemic up till now may be separated into different phases. The first cases were detected in western cities in USA and in rural areas of central Africa. There seems to have been a spread within the cities and to new, mainly urban, sites. Cases were consecutively found in different areas of the world, at first among multi- partner sexually active persons like sex-workers and their clients and other persons with risky sexual behaviour. During the escalation phase the virus spread among risk groups, including some «new» ones like blood transfusion recipients, injecting drug users and others and in time reached the general population. During this phase also proportionally more women and new-born infants became infected. Some «western» countries seem to have entered into a fourth phase of stabilisation where the number of new HIV infected cases would roughly equal the number of AIDS related deaths. These different phases can be illustrated by the graphs below.

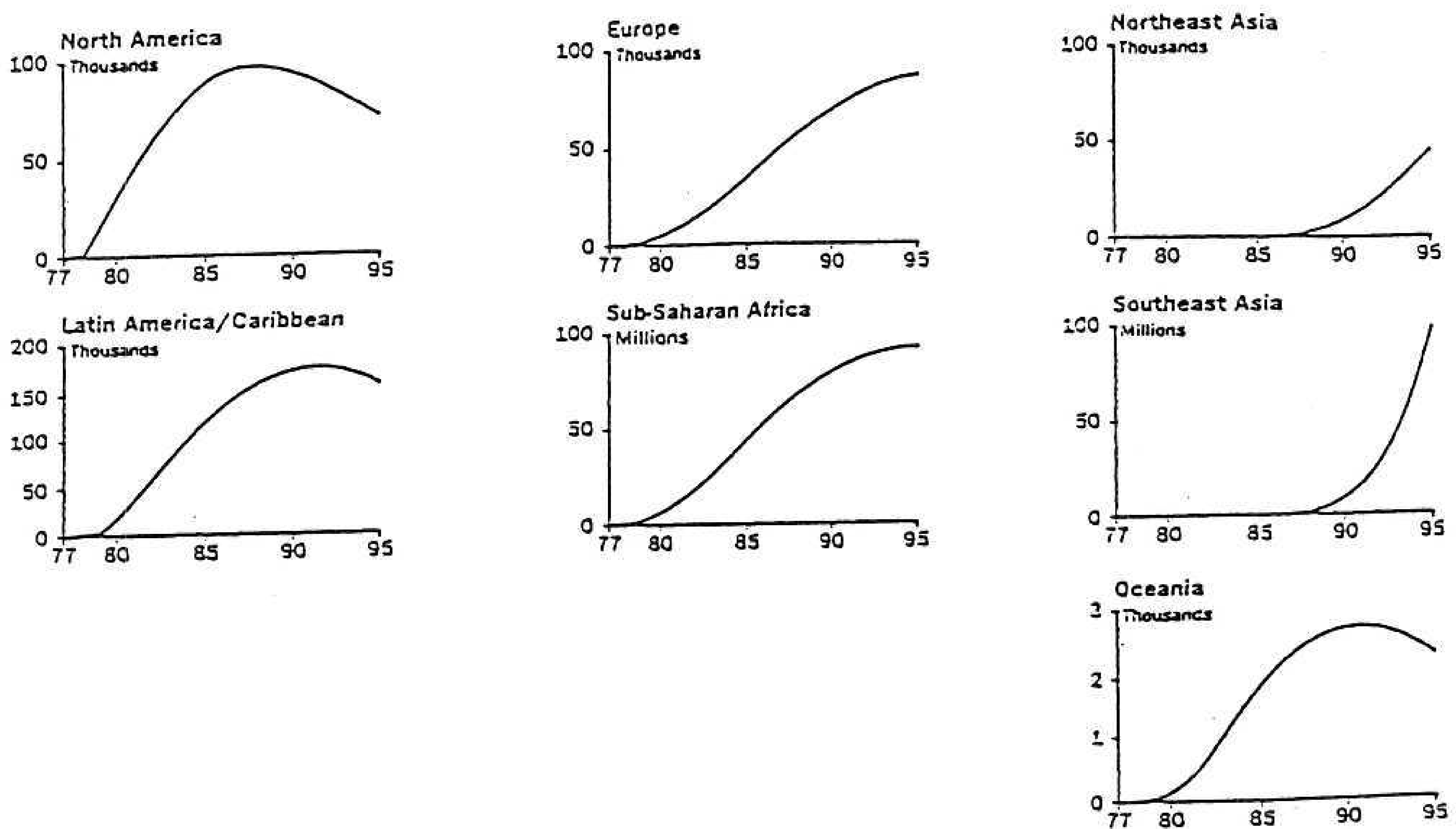


Figure 1: Annual rates of new HIV infections among adults by geographic region 1977–95. From Quinn, T: Global burden of the HIV pandemic. The Lancet Vol 348:99, 1996.

The emergence of AIDS has been followed by an increased concern about previously more or less neglected «conventional» STDs like gonorrhoea, syphilis, herpes, trichonomiasis and chlamydia infections. One reason is the fact that the spread of HIV and of «conventional» STDs resembles each other also in terms of cultural and social aspects. Another reason is that the presence of «conventional» STDs, particularly ulcerative diseases, increases the risk of HIV transmission up to four times. The global extent of these problems appears from the figures in table 1, summarising the 1995 WHO estimate that almost 25 million adults from at least 193 countries were by then HIV infected. On top of that comes about 1.5 million children.

Table 1: Geographical distribution of «curable» STDs and HIV infection among adults, 1995.

Region	**Prevalence curable STDs** million	**Prevalence HIV infections** million	**Cumulative HIV Infections** million
Africa	60	13*	16*
Asia	138	4*	4.1*
Europe	16	0.5	0.65
Latin-America and Carribean	24	1.7*	2
North America	8	0.75	1.3
Oceania/ Pacific	4	0.07*	0.075*
Global total	250	20*	24*

* Gonorrhoea, chlamydia infection, syphilis, and trichonomiasis. Data from WHO.

In each phase of the development of an epidemic the actions taken have, of course, been based on the knowledge available. Following the diagnosis of the first known cases of AIDS in 1982 our knowledge has increased step by step, including:

- characterisation of the virus, or rather viruses,
- production of possible (but unfortunately not effective) vaccines,
- demonstration of the «vertical» transmission from mother to infant,
- recent evidence that this kind of transmission can be reduced by drug treatment,
- indication that occurrence of «conventional» STDs might increase the risk for transmission,
- prove that the virus could be transmitted via breast milk.

A comprehensive list of relevant findings, based on published data, is presented in Box 1. Similarly, studies of the spread of HIV in different groups in the communities and increased understanding of in what way sexuality, gender roles and STD are perceived in different communities have been of great importance.

The social consequences in areas where the epidemic has escalated are immense. Communities in some countries of Africa have been heavily drained of people in the most productive ages, usually leaving a number of orphans to be taken care of by the grandparents or others.

The epidemic seems to have come to some degree of stabilisation in some «western» countries and there is also indication that it is levelling off in some African countries, although the peak incidence is expected to occur around the middle of the next century. In other areas, e.g. South-East Asia and Eastern Europe, the epidemics are indeed still in a relatively early stage. A general trend seems to be that young people get infected to a higher degree. In sub-Saharan Africa the peak incidence in women is 15–25 years and about two thirds of all cases are expected to occur among youth.

Box 1: Historical background of HIV/AIDS from a medical point of view

5 June 1981: Article in «Morbidity and Mortality Weekly Report» about 5 young men in San Francisco with Pneumocystis Carinii Pneumonia.

4 July 1981: Further article in «MMWR» about 26 young men with Kaposi's Sarcoma; 20 in New York, 6 in San Francisco.

1982
New disease named «Acquired Immune Deficiency Syndrome» AIDS.
Case definition of this syndrome established by Centre for Disease Control, Atlanta, Georgia.
First cases of «slim disease» encountered in Rakai district, Uganda. Finding published in 1983.

1983
Research group under Prof. Luc Montagnier (Francoise Barré-Sinoussi) discovers enzyme, reverse transcriptase in patient with persistent generalised lymphadenopathy.
Evidence for retrovirus as the cause for AIDS presented in «Science».

1985
First Global Conference on AIDS held in Atlanta, Georgia, USA and thereafter held annually until 1994 when a 2-year interval was introduced.
ELISA blood test for antibody to AIDS-related virus developed. By the end of the year most industrialised countries had started testing all blood for transfusion.
First case of AIDS in Asia diagnosed in a male sex worker in Thailand.
WHO suggests a clinical definition for AIDS in Africa where HIV testing may not be possible, the so-called Bangui definition with major and minor symptoms.

1986
Internationally acknowledged name for virus «Human Immunodeficiency Virus».

1987
HIV2 virus found in AIDS patients in West Africa.

1988
41st World Health Assembly passes a resolution establishing the principle of Human Rights for HIV/AIDS affected people with a call for the abolition of all stigmatisation and the acknowledgement of confidentiality of testing.
Report from Nairobi, Kenya on the value of peer education amongst commercial sex workers on increased condom use and reduction in HIV spread.

1989
First evidence published of protective effect of male circumcision on HIV transmission from Nairobi, Kenya. This reduces the risk to 1/3 that of uncircumcised.

1993
CDC in Atlanta, Georgia show after detailed analysis only definite 36 cases of HIV transmission to health workers during patient contact in the United States with another 75 possible cases. Most of the transmission was after needle-stick injuries.

1994
Evidence presented that Zidovudine therapy during pregnancy from week 14 to 34 reduces HIV transmission to the child by 2/3.

1995

Evidence presented of rapid replication of HIV (1 billion a day) during the whole of the «latent» period.
First results of «Delta» programme shows that combination of anti-viral therapy has a significant effect on survival.
Max Essex launches his theory about the different behaviour of different clades of HIV1 which explains the different transmission patterns in Europe/North America and Africa.
Evidence presented from research in Mwanza region in Tanzania of a 40 % reduction in HIV transmission if STD's are effectively diagnosed and treated.
Discovery of Fusin, a protein co-factor that is necessary for the HIV virus to invade a T-helper cell.

1996

Combination (»triple») treatment, particularly if including protease inhibitors, was shown to delay and possibly stop the development of the disease. However, the treatment is extremely expensive and has to be given for years.
Preliminary reports from Uganda indicates a decrease in HIV transmission in some groups of the population during the last five years.
Very rapid spread of HIV in the states in former Soviet Union was reported, based on data from Ukraina and other areas. New WHO recommendations that HIV positive women should not breast-feed if alternative feeding is available and could be afforded.

2.2 Stages in attempts to mitigate the epidemic

Medical response

At WHO, a Special Programme on AIDS was instituted in 1987. After three years the name was changed to GPA. Special National AIDS programmes were organised at MoH and supported by WHO.

As a result of cases with confirmed AIDS, almost all African countries established national AIDS Task Forces during the second half of the 1980s. With the assistance of WHO one-year STPs were developed and financed, folloed by three to five-year MTPs. The AIDS Task Forces were developed into NACP, organisationally located as departments within the Ministries of Health.

The first resource mobilisation efforts and the responses from donor countries were influenced by the ambition to stop the epidemic. In combination with the awareness of the limited knowledge of the mechanisms causing the spread of HIV infection, enormous resources were allocated to development and implementation of NAP with the different components, i.e. epidemiology, blood transfusion services, laboratory and clinical services and IEC activities. National media campaigns were launched with information brochures and posters distributed in hundreds of thousands to the general public and/or to specific groups.

The need to increase biomedical and behavioural knowledge related to the HIV/AIDS infection resulted in numerous research projects initiated and operated by research institutions in countries in Europe and USA and to an increasing extent in collaboration with universities in countries in the Third World.

The perception of the catastrophic impact of HIV/AIDS affecting entire countries resulted in comprehensive project designs with operational research, methods development and direct intervention activities separately or in intended interaction.

Focus on prevention and social consequences

In early 1990s, with increasing awareness of all diverse aspects of the epidemic, new features were identified and accepted. HIV/AIDS would remain as a continuous health hazard in all socio-economic segments of the societies. With no vaccine or medical treatment available in a foreseeable future, change of sexual behaviour was identified as the only individual preventive action to be taken. A number of medical interventions were scientifically scrutinised in order to reduce the risk of being infected (e.g. treatment of STDs and breastfeeding) and to improve the management of AIDS-related diseases (e.g. TB). More effective peer education and counselling gradually replaced the massive media campaigns.

The societies had to deal with social and economic consequences of AIDS, of which an increasing number of orphans appeared to be the most visible. The increasing number of orphans created a need for extending social support beyond what had previously been demanded. It also highlighted the irrelevance of trying to address only orphans, who lost one or two parents due to AIDS. All orphans in a local community had to be cared for.

The care was initially distributed as food and housing contributions, as contributions to school fees and uniforms and even the construction and operation of orphanages. Gradually more sustainable activities were developed focusing on various community development efforts and addressing vulnerable children and families in the community.

Multi-sectorial response

A repeatedly-emphasised request in reviews of NACPs addressed the need for increased mobilisation of and involvement from sectors outside the health sector. This has in many countries resulted in the development of National AIDS Plans in several ministries and government institutions outside the ministries of health. The demand for an expanded multi-sectorial response to the AIDS-epidemic resulted in the creation of the UNAIDS. The responsibility to provide countries with a more co-ordinated UN organisations' support has as from January 1, 1996 been transferred from WHO/GPA to UNAIDS.

The creation of UNAIDS

The Special Programme on AIDS at WHO was established in 1987. It grew into the largest programme at WHO and changed its name to GPA. It was terminated by the end of 1995, when the new UNAIDS programme was established as a joint UN programme, sponsored by UNDP, UNESCO, UNFPA, UNICEF, WHO and the World Bank. Donors – and in particular the Scandinavian countries – were active in pushing the transformation of global AIDS activities into a multi-sectorial endeavour. Two key reasons for the establishment of UNAIDS are given by the office itself (UNAIDS – an overview. UNAIDS, 1996):

- the need for a broader-based , expanded response to the epidemic in sectors ranging from health to economic development and
- the need to provide leadership and better co-ordinated UN system support to countries.

An «expanded response» to the HIV/AIDS epidemic is aimed at global, national and possibly local levels. Major strategies are:

a) support at country level to enhance national capabilities to take action on HIV/AIDS and ensure sustainable long-term response and
b) to identify and develop «international best practice» based on lessons learnt from the past and ongoing efforts.

UNAIDS is governed by a Programme Co-ordinating Board (PCB) with 22 representatives from different countries, coming from the co-sponsoring organisations (6), donor agencies (7), NGOs (5) and others. There is also a separate CCO, conducting meetings 2–4 times a year. The UNAIDS office is so far situated within the WHO premises at WHO and is headed by one of the former deputy directors of GPA, Dr Peter Piot.

In each country a UN Theme Group on HIV/AIDS is established as the basis for the externally supported AIDS activities. Representatives of the co-sponsoring agencies and possibly other members constitute the group, which is expected to work in close collaboration with the national co-ordinating body on HIV/AIDS. A rotating chair is suggested and the group should be assisted by a CPA, recruited and employed by UNAIDS. The Theme Group is meant to be the focus and co-ordinating body for the external support for

AIDS control. A Resident Co-ordinator will be appointed and is given the responsibility and accountability for co-ordination of the UN system and reports to the UN Secretary- General.

UNAIDS has started to set up inter-country teams, probably on five sites in different parts of the world with the main task to provide and foster technical collaboration. There are also thematic PCB working groups (e.g. on monitoring/evaluation and orphans) and technical task forces.

UNAIDS has been working for a year. So far, approximately 50 CPAs have been recruited but many of them have recently taken up their duties. A Strategic Plan for 1996 – 2000 has been developed and endorsed by the PCB.

The biannual budget for 1996 – 1997 is USD 120 million, added to this is another USD 20 million for strengthening AIDS activities via the co-sponsoring agencies, mainly to avoid duplications of programmes and for activities on global and regional, but not local, level. Out of the regular budget 40 % is allocated for staff and 60 % for activities. This could be used also for small pilot projects, for hiring co-sponsoring agencies etc.

The efforts to strengthen multi-sectorial involvement within recipient countries and within the UN organisations must be relevant for and applicable also to bilateral donor agencies. Generally, HIV/AIDS funds are administered by health departments at donors' headquarters and by Health Programme Officers at the Development Co-operation Embassies.

The six years under review in the present evaluation cover almost one half of the total time span since AIDS was recognised. How should Norway direct it's ambition to contribute to global health development by joining the fight against AIDS? Have the right decisions been taken while designing the strategy to combat a health problem that grows at an unbelievable speed, day by day, influencing life and death of individuals and societies and in itself being influenced by the most intimate behaviour of human life, by traditions and social structures and in itself calling for mobilisation of whatever scientific power mankind may have to find biomedical methods for prevention and cure?

3. Norwegian HIV/AIDS-allocations 1990–1995

3.1 Strategy

From the initiation of the SAG the Norwegian Government has been clear about its wish to use the funds in a way that should make it possible to intervene where, when and if urgent action was deemed important. This ambition to work in a flexible way, avoiding too much bureaucracy has sometime led to a vagueness in strategies and decisions that in itself well may be justified, but also makes it more difficult to evaluate the different steps in the process.

The explicit rationales for establishing the specific Grant as stated in the ToR for the evaluation, were to make the Norwegian support *visible*, to promote a *flexible response* to the rapidly expanding epidemic, and to provide long-term *support for NGOs* engaged in HIV/AIDS prevention. From the very beginning it was decided that the grant should have «*multi-lateral*» and «*bi-lateral*» components. The team was told that a kind of tradition to allocate fairly equal shares to the two components was firmly established. In reality, there has been a slight dominance of multi-lateral grants (Table 2).

3.2 Guidelines for the SAG

The guidelines adopted by the MoFA in 1992 for the implementation of the AIDS Grant state three main objectives:

- to strengthen preventive work with HIV/AIDS;
- to reduce personal and social effects of the HIV infection, and
- to mobilise international and local resources for AIDS work.

As these formulations are not objectives in the strict sense of the word, and are neither quantified nor qualified, operations and results cannot be strictly evaluated against them. However, this methodological comment for the record does, of course, not mean that the programme cannot be evaluated. It only means that precise qualitative or quantitative assessment of results, as compared to specified objectives, cannot be offered.

Within the framework of these three overall objectives ten statements guiding the work under the SAG were formulated. These are reflected in the ToR for the evaluation (Annex I, 1.5)

Special emphasis should, according to the SAG guidelines, be given to:

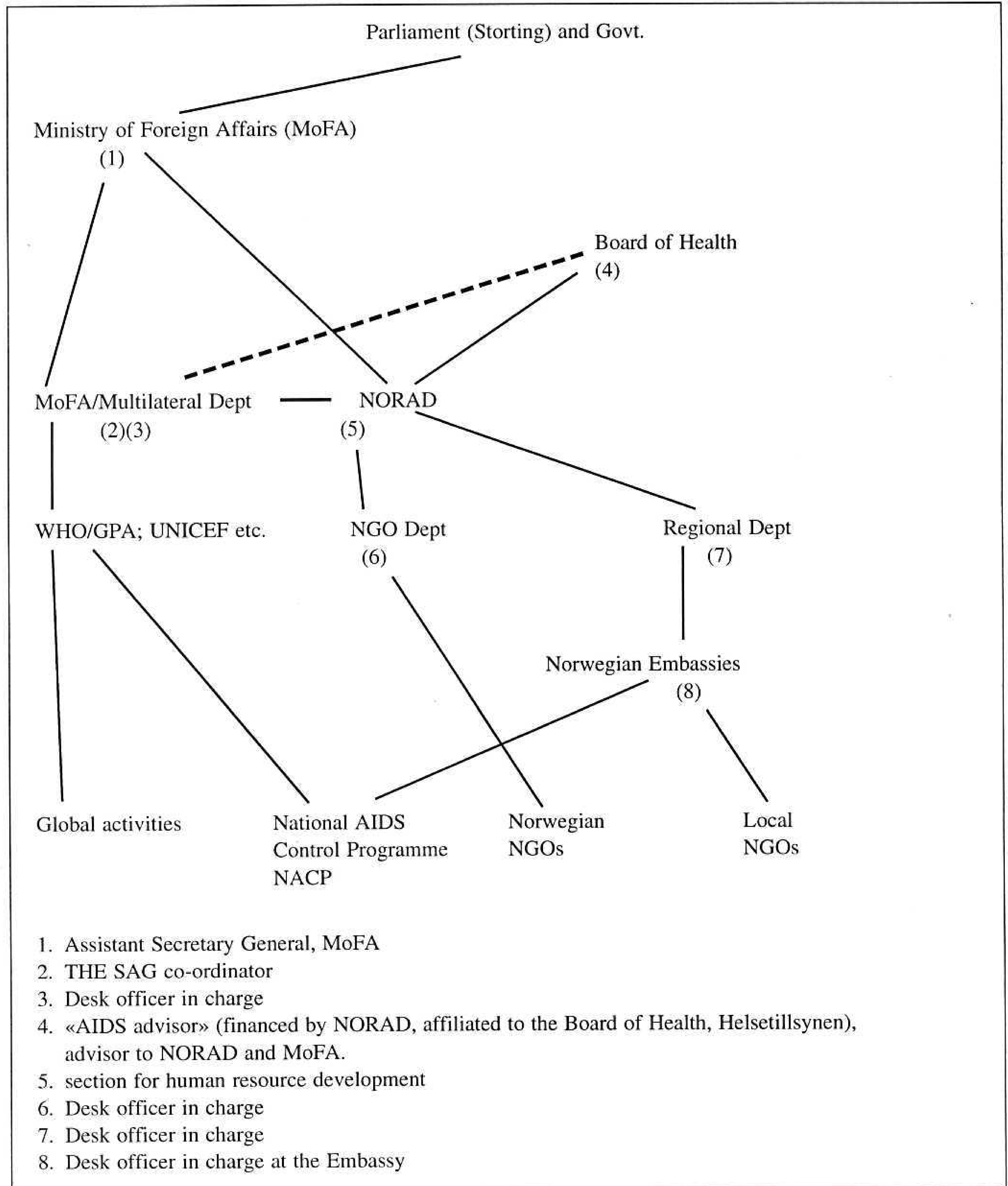
1. Long-term aid co-operation and integration of HIV/AIDS activities in regular development co-operation systems.
2. Support to national HIV/AIDS-programmes and committees.
3. Support to WHO's leading role in technical matters.
4. Review the country programmes in high-epidemic countries for a possible strengthening of HIV/AIDS control activities.
5. Activities directed towards women and children.
6. Flexibility in order to secure participation of «weak» groups and to improve multi-sectorial response.
7. The SAG should be used mainly preventively, but exemptions in pilot projects might be acceptable.
8. There should be a focus on Africa south of Sahara, but projects in South Asia and Central Africa might be supported to some extent.
9. Flexible arrangements for transition into shared financing of NGO projects.
10. An evaluation to be conducted in 1994.

The Grant guidelines do not enter explicitly into the operationalisation of these objectives and specified items. As could be expected in a decentralised administrative tradition, this task seems to have been delegated to the operational units that implement the Grant, although this is not made explicit. The guidelines do, however, provide some guidance as regards specific areas and types of interventions, strategic perspectives for the future, and which channels to use. The logical step to follow from the establishment of this guidance would be that the operational units concerned elaborate the mandate, presenting, *inter alia*, their own operationalisation of the objectives given. The idea to do an evaluation of the SAG already in 1994, of the experiences of Norwegian support for the combating of AIDS, could in effect have been intended as a contribution to the further elaboration of guidelines for the Grant.

3.3 Organisation

The SAG has been managed by the MoFA, with the responsibility for bi-lateral aid given to NORAD. A special position as «AIDS advisor» was instituted at NORAD but located at the Board of Health (Helsedirektoratet). The advisor takes an active role in different kinds of international AIDS activities and he or she gives advice to MoFA and NORAD on allocation of grants.

Figure 2: The organisation of the SAG is illustrated in the following figure:



1. Assistant Secretary General, MoFA
2. THE SAG co-ordinator
3. Desk officer in charge
4. «AIDS advisor» (financed by NORAD, affiliated to the Board of Health, Helsetillsynen), advisor to NORAD and MoFA.
5. section for human resource development
6. Desk officer in charge
7. Desk officer in charge
8. Desk officer in charge at the Embassy

3.4 Allocations to HIV/AIDS control activities

The figures presented below are based on official development co-operation statistics. Due to differences in the coding of projects throughout the period there are some uncertainties related to the figures presented. Thus, e.g. projects coded as AIDS-projects partly include other health areas and general health projects which to some extent deal with HIV/AIDS. Some funds used for AIDS-projects may have been left out, e.g. a UNICEF education project in Uganda. This project has been funded via Norway's general support to UNICEF and is hence not classified under a HIV/AIDS code. Further comments on the validity of the figures are presented in the report «AIDS-Tiltak og Norske Bistandsmidler 1990–1995». (MoFA Norway, 1996)

The overall assistance to HIV/AIDS during the period amounts to around NOK 520 million (USD 77 million). This equals around 1 % of the overall Norwegian aid during the period. Of this amount NOK 400 million (78 %) has been allocated from the SAG. The SAG's share of the total support to HIV/AIDS has fallen from 83 % in 1990 to 70 % in 1995. Substantial contributions from other budget lines have been allocated from country programme support to the MUTAN programme in Tanzania (NOK 57 million) and from regular funds for support to Norwegian NGOs. It is worth noticing that during 1990–1995 more than 95 % of the SAG allocated by the Parliament was utilised. The proportion of bi-lateral and multi-lateral budget allocations is given in Table 2.

Table 2. Bi-lateral (via NORAD) and multi-lateral allocations of SAG funds during 1990–1995. Amounts in 1000 NOK.

	Bi-lateral		**Multi-lateral**	
	1000 NOK	%	1000 NOK	%
1990	25 803	39	40 000	61
1991	23 106	32	49 000	68
1992	30 364	45	37 491	55
1993	31 830	49	32 770	51
1994	32 967	51	32 000	49
1995	30 271	44	37 895	56
Total	174 341	43	229 156	57

More than half (NOK 273 million) of the AIDS allocations have been directed to projects/programmes in African countries. An additional substantial share of the total allocations to global programmes (NOK 180 million) has been directed to countries in Africa, mainly from multi-lateral contributions to WHO/GPA. An overview of the disbursements is given in Table 3.

Table 3. Total disbursements for AIDS activities 1990 – 1995.

	MNOK	%
UN organisations	252	49
Local and regional organisations and institutions	67	13
Tanzanian authorities	58	11
Norwegian private organisations	120	23
Norwegian institutions	1	0,2
Others	22	4
Total	520	100

The total contribution to WHO/GPA amounts to NOK 210 million (40 % of the total AIDS allocation). This represents 1/3 of the total contributions from Norway to WHO during the six year period.

3.5 Multilateral support through the UN system

A major share of the allocations distributed via MoFA has been channelled to WHO/GPA and, since 1995, to its successor UNAIDS.

Apart from the core-funding to the programme (WHO/GPA) this support has also been channelled on to specific countries (so called multi-bilateral aid). Nine NACP programmes have received funds in Tanzania (10.0 MNOK 1990–95); Zambia (10.0); Zimbabwe (9.0); Namibia (6.0); Angola (5.5); Botswana (5.0); Mozambique (4.0); Uganda (4.0) and Eritrea (2.5).

The TB programme at WHO also received allocations from the SAG in 1994 and 1995. Other international organisations that have received a substantial support is UNICEF (about 15 MNOK allocated for «AIDS prevention») During the last years specific activities in UNICEF country programmes in, for instance, Tanzania and Zimbabwe have been earmarked.

3.6 Bi-lateral support through Norwegian embassies abroad

Channelling funds via the SAG has made it possible to direct funds to programmes in individual countries via the Norwegian embassies. This route is hence different from the regular bilateral aid (usually managed via country programmes) and from the multi-bilateral system. As has been illustrated in figure 2, this part of the SAG is channelled via the Regional department of NORAD. A majority of the projects that have been funded via this arrangement, have been local NGOs. This is particularly so in Zambia and Zimbabwe. In total, local NGOs in about ten countries have been supported via local SAG budgets.

In some cases projects have been funded through different/other arrangements: The MUTAN project. In Tanzania, MUTAN has been given more than 50 MNOK during the period under review, as will be described in some detail below. This programme has been managed via the regular bilateral country programme, outside the SAG.

Obviously, the extent to which this opportunity to support local AIDS programmes via the SAG has been used has varied greatly between different embassies. Some countries with no regular health programme via NORAD, e.g. Zambia, has used this extensively. The same is true for Zimbabwe and, to some extent, also Botswana, Nicaragua and a few others. It should also be mentioned that there is a specified NGO allotment at the embassies, which can be used for AIDS programmes but which is not linked to the SAG. In a following sections some projects, particularly from Zambia, will be discussed.

3.7 NGO support through Norwegian private organisations

Norwegian NGOs have traditionally speaking always had a central role in society. This is also true in aid work, which has always been a concern of different NGOs, large or small. The major NGOs in Norway run AIDS-projects, e.g. The Norwegian Church aid (Kirkens Nødhjelp) Norwegian Red Cross, Save the Children Norway (Redd Barna) and, to a lesser extent, Norwegian Peoples Aid (Norsk Folkehjelp). The organisations assisting in international AIDS support efforts vary a great deal in their basic objectives, ideology and strategies. There are human development or relief organisations, religious groups, a student association; the National Association for Sexual Rights and a few more.

One of the main reasons given for instituting the SAG in 1990 was that SAG should «promote long-term interventions by Norwegian NGOs». Some ideas on the rationalle for this may be found in NORAD's «Guidelines for support to activities in developing countries via NGOs», issued in 1994. They emphasise that «The growth of a non-military governed society, with dynamic and representative private organisations, is central for economic, social and political development». The document also states that «Private organisations play an important role in the development of a basis for a vital democracy...». Experience shows, according to the guidelines, that private organisations have a particular potential for promotion of piece, human rights, empowerment of deprived people and that aid via them reaches poor people more easily than other kinds of aid. It is, however, also stated that many projects aim at acute need of help rather than to promote sustainability. There is a strong recommendation that the main task for NGOs would be to *support* NGOs in the collaborating country and that these should direct the activities, while the external organisation should have an advisory role.

Norwegian private organisations that have received a minimum of one million NOK are listed in Table 4. A number of local NGOs have also got support but, as illustrated in the figure below, via the Embassy of Norway and not via NORAD. The total disbursements to Norwegian private organisations amount to almost one quarter of the total AIDS allocations 1990 – 1995 (Table 4).

Table 4. Disbursements for AIDS activities to Norwegian NGOs 1990 – 1995

	MNOK
Redd Barna (Save the Children) / Norway	34,0
Red Cross / Norway	32,0
Norwegian Church Aid	18,0
CARITAS / Norway	13,0
Salvation Army	8,6
Adventist Church	3,7
National Association for Sexual Rights (LLH)	3,5
Student's and Academics Assistance International Fund	1,7
Pentecostal Church	1,5
Baptist Church	1,1
Norwegian Nurses' Association	1,1
Total	118,2

4. Findings from country and project studies

4.1 Introduction

In the following section findings from these undertakings will be reviewed. Particularly, observations from the country studies will be reported, but briefly a few other projects will also be discussed.

As stated in the ToR (Annex 1), three country studies were included in the evaluation. Tanzania, Uganda and Zambia were chosen by the MoFA since a substantial share of the total AIDS related support had been allocated to these countries and since the kind of activities supported in the three countries were designed in different ways. Activities in a total of 38 countries have been supported through the SAG during the years under evaluation. Some of these have been reviewed by simple desk studies.

The country studies were planned during a tour to the three countries in May, 1996. By mid-August the first mission, to Tanzania, took off and was followed by missions to Zambia and Uganda in September. Each external team visited the country in question for about two weeks.

The teams were constituted by three external and three local consultants. Each one of these sub-teams were comprised of one medical doctor, one social scientist and one health planner/economist.

The ToR for the country missions are attached, see Annex II. The country reports also include a description of the countries, the AIDS situation, the Norwegian support and the observations by the team. The observations are also included in the text that follows below. In all countries activities have been supported via multinational organisations, especially by the former GPA. In Tanzania the bulk of support has been given to a regional project, MUTAN, in Zambia the support to local NGOs has been extensive and in Uganda, two major Norwegian NGOs have had a central role – in collaboration with local NGOs. In this section follows a brief description of the main findings from the three studies.

4.2 Tanzania

Official figures give a cumulative number of AIDS cases in Tanzania by the end of 1995 of about 81.500. Norway has contributed about 78 MNOK during 1990 – 1995, mainly to the Norwegian / Tanzanian AIDS project and, with smaller input, via UN organisations and NGOs.

Tanzania is one of the countries in Africa which has been severely affected by the HIV pandemic. Since 1988 the NACP, located within the MoH, has been struggling to prevent the further spread of the disease by initiating surveillance, education and counselling. The situation represents a burden for the already strained health system. Current NACP strategy reflects the health and civil sector reforms being undertaken in the country. A multi-sectorial involvement is promoted as well as collaboration with NGOs, decentralisation and community involvement. Activities have been financed to a large degree by various donors, although this source of funding is decreasing.

In the Norwegian support to HIV/AIDS control in Tanzania, activities and programmes funded via the SAG have played a minor role.

In contrast, support to the MUTAN channelled via the bi-lateral «country programme», has been highly visible. This project, focusing on research, intervention and capacity building, was generously funded. It was relatively «relevant» and «effective» and had a multi-sectorial focus. It was also in line with NACP priorities, but it was established as a separate structure. Thus activities, budgets and competence building were not an integrated part of NACP. The project design proved, with time, to be inappropriate, in view of the current health system reform in Tanzania, a policy change of NORAD focusing increasingly on the need to strengthen local management structures, insurance of national and community ownership as well as long-term sustainability. As a result the project was brought to an end at mid-term in 1995.

The SAG in Tanzania has essentially been used to channel general support to NACP and small scale support to the NGO sector with a few exceptions. The SAG funding has had a constructive effect, stimulated pioneering activities and helped build capacity. However, only in one exception (a UNICEF education project) has it been channelled directly to a sector other than that of health. The multi-sectorial ambition of the SAG has been well

in line with the goals of the newly established UNAIDS, and with NACP strategy. However, the challenge to mobilise other sectors such as that of education largely remains unfulfilled. So far the Ministry of Education in Tanzania as well as the education section within NORAD, the donor, has not earmarked funding for HIV prevention.

Observations

Assessing the MUTAN project

A lot has been said about MUTAN. However, the Tanzania country study generated some additional comments and reflections about both the strengths and weaknesses of this project and to what degree it can be said to have been a sustainable project in the Tanzanian context. Sustainability is a basic condition for Norwegian development aid. It implies that the invested money should yield tangible, lasting results. But sustainability has many dimensions and its definition can vary depending on context and policies. For the MUTAN project the following can be said to be relevant: The capacity to continue activities, to disseminate accumulated knowledge, to transform the knowledge into action and to maintain the new level of competence. The process by which the local agents/authorities gradually take over responsibilities for planning and implementing as well as financial matters is also of importance and should be considered.

From what we can gather from our interviews and other review documents about MUTAN, it seems evident that most of the activities undertaken by the project, be they research, institutional strengthening, competence building or public health interventions, were in line with the NACP plans for AIDS control and therefore relevant. Achievement can also be said to be high from the perspective of what was set out as objectives. Indeed, in this context, the project was a success and we feel that it is important to underline this. NORAD and the different teams appraising MUTAN seem to be in agreement about this. The production of scientific multidisciplinary work has been impressive as has the production of academic degrees. It is clear that the results of the research studies, which have been widely disseminated through journals and presentations at scientific meetings, have contributed to a general understanding of the character of the HIV/AIDS problem both in Tanzania and internationally. We met several researchers and programme officers in Tanzania who mentioned the usefulness of MUTAN studies for their own research and intervention work. Many of the experiences made have been integrated into the national competence building programme (that is the national capacity to cope with HIV/AIDS). Several people, who were involved in MUTAN, have key positions in HIV/AIDS prevention work today.

The studies that have had a clear intervention profile coupled with that of capacity building can be said to be successful in institutional development. The hospital-based counselling research, intervention and training programme has, for instance, generated knowledge, capacity and experience that have been used in the national programme. Likewise, the school component in the public health education programme developed a curriculum which is being used as a base for developing a national school AIDS curriculum. There are other examples as well. The anthropological studies of bar workers have been useful for the HTA project operated in collaboration with AMREF.

It is more difficult to say what implications the research findings have had at the local level. Although the MUTAN activities have had an impact on attitudes and behaviour – to what extent can research and intervention activities be said to have initiated a sustainable local development or community mobilisation around HIV/AIDS prevention? On the other hand, was the project really designed with this aim in the first place? As the capacity of the local health systems is limited and lacks resources, it is unrealistic to think that local staff will act upon research findings and transform these into interventions without monitoring and support. Strengthening the capacity of local health staff to absorb and assimilate new ideas and initiatives was not central in MUTAN as we interpret it. Sensitisation of district staff to the real conditions that prevail at community level can be done through involving and training them in participatory planning and a community-based approach. Such a participatory approach involving and enabling a feeling of local ownership and strengthening of local planning processes should perhaps have been developed more in many of MUTAN programmes. Today, it is a widely acknowledged fact, that for projects to be effective and achieve sustainable development, communities have to be empowered and mobilised to identify and address their problems and needs, plan and take action and ownership of projects, i.e. they have to feel that the project is important to them and that they are accountable and can demand accountability of other actors involved. This fundamental insight is core to the

whole democratisation and civil service reform process which is going on in East Africa. The need for such a community development perspective has evolved forcefully in the development debate during the 1990s. The usefulness of broadening the perspective/approach in this direction did, however, not emerge as a major issue in the MUTAN. However, a community counselling component was under development in the counselling programme when the project was closed down.

It is clear that the MUTAN, as an AIDS control programme in the Tanzanian context, experienced an exclusive funding situation. The payments for activities in the Arusha and Kilimanjaro regions for the years 1992–1994 corresponded to 65 % of the total NACP funding for the whole country. In 1993 payments in the MUTAN project were equal to NACP payments for the whole of Tanzania (USD 1,3 million). This created a national imbalance in favour of these two regions.

Furthermore, it created an «awkward» situation for the project, accentuated by the fact that during the first years, 60 % of the budget went to Norwegian expatriates for their participation and capacity building. This was however altered to 40 % during the project's last years, when increasing amounts of funds went to interventions. However, throughout, only 10 % went to capacity building of Tanzanians. The project was «top heavy» with expatriates and therefore its legitimacy would come to be questioned in a time when development support accentuated strengthening of local structures and capacities. Thus, many have argued that the project was not cost-effective. The strong regional focus and the separate administrative structure which delegated all decision making over funds to the UoB rather than the NACP further augmented this awkward situation.

MUTAN was a child of its times but it is obvious that the project soon became an «odd child» which did not fit into the mainstream design framework and priorities of the NORAD's bilateral country support. Therefore it was to live a «troubled life». It was created in a spirit of collaboration to meet an acute need. It was designed as a project with a strong research focus as this was identified as a priority in the early phases of the epidemic. NORAD should be congratulated for its quick response in support of research. However, every responsible participant in the planning and execution process envisaged the structure to be maintained for at least 10 years as it is known from experience that a long-term perspective is necessary for this sort of research activity. Yet, NORAD was soon to feel uneasy with the design and set-up of MUTAN project even though it participated in its inception. The two assessment studies, commissioned by NORAD, also expressed scepticism about the design of the project, the balance between research and implementation and its sustainability potential. Considering that NORAD's mandate is intervention in a number of sectors and that their development policy focuses on local sustainability and management of development projects, and the increasing focus on this over the last years, the feeling of uneasiness was perhaps a logical reaction. However, one can ask why the project was incepted as it was in the first place, and planned for two five-year terms with NORAD's full support. Although MUTAN staff could probably have gone much further in their attempts to moderate their approach, we have not found much evidence of constructive attempts by NORAD to help find a new, more sustainable path for the project.

NORAD's decision to terminate the MUTAN project after «half time» has obviously been a painful process for all parts involved. Tension and poor communication seem to increasingly have characterised the relation MUTAN/NORAD. The indecision about the continuation of the project and the final message of its end has obviously been detrimental to the moral of HIV/AIDS control work in the region and in Tanzania as a country generally. It will probably take some time to find new and constructive ways to continue. Hopefully, NORAD will continue to support the activities initiated by MUTAN that have created a social demand, have a sustainability potential and can mobilise community participation in HIV prevention. A more appropriate organisational framework within which to do this, is needed. Furthermore, future support to AIDS control activities in other regions should take account of the experiences made by MUTAN. Finally, use should be made of the competent resource people in Norway and Tanzania, that have been trained during the course of the project.

Assessment of the SAG

Funding over the SAG to the *Tanzanian NGOs* has been highly *relevant*. The significant contribution of the NGOs to the fight against the epidemic is well known. In Tanzania the NGOs working with AIDS have emerged in order to fill the gap where the public health sector has clearly failed in the provision of basic care and services. With the experience of the key role well-functioning NGOs have played in Norwegian civil so-

ciety, Norwegian development aid has been instrumental in promoting their involvement in collaborating countries such as Tanzania.

WAMATA, for instance, represents an important and unique forum for the victims of AIDS in Tanzania today. The legal and human rights of the victims are addressed and the organisations counselling and home based care-programmes constitute a supplement to the limited health services offered to the public. The strength of the organisation builds, to a large degree, on the engagement of the many people who have felt the consequences of AIDS on their own families. This involvement is vital for the sustainability of the organisation. The Norwegian embassy in Tanzania has drawn funding in support of the WAMATA from its SAG as well as its local NGO budget. The support has mainly been used to strengthen the management capacity of the staff. This is an additional prerequisite for the organisation's sustainability and survival.

The fact that WAMATA is struggling to become a nation-wide organisation and has already made achievements in this direction also motivates continued Norwegian support at this point in the development of the organisation.

AMREF and their collaborating partners in the HTA programme, which included the NGOs but also implementing agencies such as MUTAN, have been successful in reaching their target; high risk groups. AMREF is known from experience to be an effective implementing organisation.

If we look at the Norwegian SAG-funded component in the HTA programme, which was implemented by the MUTAN in Arusha/Kilimanjaro, it is interesting to note that the ambition has been to develop a community focus, promoting the community capacity to address HIV. This aspect is, as we have already discussed, an important criteria for sustainability of interventions.

Furthermore, a horizontal approach has been applied including STD care and treatment in HIV prevention. This ambition reflects that the AMREF is concerned about the need to move away from a narrow vertical, AIDS centred approach. The need to broaden the perspective to include STD care and even reproductive health is now widely acknowledged by both professionals and donors including the Norwegians. Sexual and reproductive health is after all intimately related in the lives of ordinary people. The approach is thus in line with Norwegian aid policy promoting a move towards primary health care.

It is interesting to note that AMREF as well as CEDHA, two of the local NGOs that have received substantial support over the SAG, have had a close working relationship with MUTAN. This is worth a comment.

Our observations and analysis show that MUTAN project had a good working relationship with local NGOs. The experience the project generated has been used fruitfully by AMREF and CEDHA.

AMREF staff expressed that the MUTAN research had been very useful in their work with the HTA project. For MUTAN, the collaboration with AMREF meant a possibility to operationalise research and become more intervention-oriented, something which was requested in the critical assessment studies.

This collaboration was full of potential. Had the MUTAN project not been closed down, the collaboration might have represented the stimulus that could have helped to orientate other components of the larger MUTAN project in a more community-centred and participatory direction.

Although MUTAN implemented the HTA project component in the Arusha/Kilimanjaro regions, this was an AMREF project. The latter took the initiative to set up the collaboration. The fact that the Norwegian embassy earmarked the SAG funding for such a collaborative activity, which would reap benefits from the experiences of these two organisations and in the process strengthen both at a certain point in time, is proof of a certain flexibility on the part of the embassy.

CEDHA had a working relation with MUTAN from the start, some of the staff were involved in, and therefore funded by MUTAN. That the CEDHA news bulletin *AIDS Link* received funding via the SAG, can be explained by the fact that their mere collaborations with the Norwegian MUTAN project made it easy for the CEDHA staff to gain knowledge about the existence of the SAG and therefore natural for them to request funding from this source. They could also present a familiar context, when arguing for the need for the news bulletin vis à vis the Norwegian decision makers.

Norwegian support to the NGOs working with AIDS in

Tanzania will continue to be important in the years to come.

Such support should also benefit attempts to establish networks or clusters of the NGOs at regional and national level in order to ensure joint planning and avoid overlap and conflict. MUTAN played a central role in co-ordinating the local NGOs in Arusha/Kilimanjaro regions. WAMATA is also trying to play a strategic role in this work. The NACP is formally responsible for such co-ordination but has so far not managed to take on this role in a satisfactory manner.

Quite a few things can be said about the adaptation of the SAG grant guidelines to supported NGO activities. We have found that the support to the NGOs has been in line with the long-term policies of the NACP which is stipulated in the guidelines.

Although some NGO activities have been directed particularly towards women and children, such support has not been prominent. However, «weak groups» are also spelt out as a priority in the guidelines. The orphans and the PWAs specifically addressed in the WAMATA activity, as well as the bar workers/prostitutes in the AMREF project, certainly belong to this category.

The major part of the NGO allocation from the SAG has not been used multi-sectorially. Most of the support has been directed to the health sector and this is a weakness. The guidelines further state that grant money should be used mainly preventively. Although large sums, for example, to WAMATA have been used for institutional capacity building, salaries, and travels, most other activities supported can be said to have been «preventive» (the concept defined broadly). All the NGOs have been part-financed from the SAG as the guidelines stipulate. In principle the SAG support activity can easily continue as the NGO support, that is, be drawn from the Norwegian embassy NGO budget in the future.

The SAG support through *multi-lateral channels* can generally be said to have been used for relevant activities.

The WHO/GPA support has been channelled directly to different NACPs, as a support to the co-ordination and implementation of AIDS control activities at country level. The activities of the Tanzanian NACP have been reviewed on several occasions, most recently in 1995. Comments about the general function and achievement of the NACP may be in place, as well as how Norwegian aid in the future can help support the move towards a more multi-sectorial and community-based approach to AIDS control in Tanzania.

Many actors in the Tanzanian AIDS prevention field, feel that the NACP is not playing the dynamic, efficient role it should as a national, multi-sectorial co-ordinating body. The explanation for this can be found in the current structure and position of the NACP within the MoH which is considered unsuitable for such a co-ordinating role. A new proposed structure was recommended after a review in 1995. In this the NACP is made a more autonomous body directly under the Prime Minister's office. This would facilitate the NACP's possibility to communicate directly with the principal secretaries of different ministries in contrast to the present situation where communication is slow and bureaucratic as everything has to pass through the principal secretary of the MoH. However, the proposed restructuring has not yet received the final approval of the government. There are also other constraints on the efficient functioning of the NACP. The National AIDS Committee which is a multi-sectorial senior level body created to advise the government in policies relating to AIDS control, does not meet as scheduled. Furthermore, this body has little status and power as there is little governmental support at top level, for AIDS prevention in Tanzania, in contrast to, for instance, Uganda where the president himself has taken a leading role in the fight against AIDS. Difficulties have arisen in the effort to make HIV prevention a multi-sectorial undertaking. Other ministries are still not making AIDS a priority issue. Although most of the eleven sectorial ministries now have an AIDS technical advisory committee and focal persons who oversee AIDS activities in their sector ministry, and function as liaison persons to the NACP, there is little priority, plans and funding for such interventions. One example is AIDS education in schools which is an urgent but neglected issue. The MoE is still not giving this issue a high priority.

This is illustrated well by the UNICEF's highly relevant Primary School AIDS education programmes. The programme received SAG funding channelled via the multi-lateral channel as well as via the Norwegian embassy SAG budget in Tanzania. UNICEF's attempt to work with the Ministry of Education on AIDS prevention was a positive initiative but it soon stranded. Until 1995, funds for the programme were sent directly to the MoE in Tanzania. The latter was in turn responsible for trans-

ferring these funds to the district level. The issue of sex education is, however, still very controversial in Tanzania and there is clearly a reluctance to act. As a result, funds took too long to reach the district level which hampered programme implementation. From early 1995 onwards, funds for the programme have been sent directly from UNICEF to the District Executive Directors. The latter are now accountable directly to UNICEF for the funds. The UNICEF project is well in line with the NACP objective to involve other sectors in addition to that of health. Furthermore, to strengthen the capacity at the district level to deal with AIDS prevention by, for instance, making district AIDS plans part of broader district health plans.

In this attempt and in many other respects, the UNICEF programme is well in accordance with the SAG grant guidelines. It is directed particularly at women and children, so called «weak groups» and it is clearly preventive.

Furthermore, the programme is among the few control programmes in Tanzania which is working in the education and not in the health sector. The only point which diverges from the grant guidelines is the fact that the Primary Education Programme is not part-financed. UNICEF has received all its funding for the programme through the SAG!

Although it may be seen as problematic that UNICEF has by-passed the MoE, UNICEF programme is in line with the NACP and does get the job done. Norwegian support to the UNICEF activity is highly appropriate. It is a pioneering programme and among the few which successfully addresses young peoples needs, uses the education system as a base and has taken up the challenge to strengthen the district capacity to work with AIDS.

The NACP and many other actors working with HIV/AIDS prevention in Tanzania have welcomed the establishment of the UNAIDS in the country. Currently the discussions centre much around the possible impact it may have, as its aim is to expand the multi-sectorial response to the AIDS epidemic and provide countries with a more co-ordinated UN organisation support. Basically, this idea supports the efforts of the NACP to gain a more independent role in relation to the MoH. The Resident Representative of the UNDP in Tanzania, has established the first UN «Theme Group» on HIV/AIDS, with the resident representative of WHO as its first chairperson (two-year period). Other members of the group are the different local representatives of the involved UN agencies. There are, however, also plans to involve bilateral organisations to plan, share information and mobilise resources. A Country Programme Advisor has been appointed. Awaiting her arrival in September 1996, a short-term consultant was acting to prepare the new organisational set-up. We were told by this consultant that the UN Theme Group on HIV/AIDS will function within the context of the national response and is not a replacement of the NACP. The Theme Group will be in constant communication with the NACP and will consult the following on a regular basis, as well as bi- and multi-lateral donors, NGOs, private sector, religious organisations, academic and research organisations as well as other relevant agencies. On the recipient side the NACP is committed to improving the multisectorial response to HIV/AIDS as well as strengthening district teams' co-ordination. The 1995 Review of the National AIDS Control Programme, however, recognises the wide gap between the NACP budget and the available funds and recommends the sectorial Ministries, regions and districts to allocate funds in their budget for HIV/AIDS control activities. A logical consequence of this recommendation is that assistance for instance to AIDS education activities in schools should in the future be financed from Norwegian development aid education sector funds and not from health sector funds.

The establishment of UNAIDS in Tanzania poses clear challenges for the continued Norwegian support in whatever form it will take after the SAG.

As mentioned earlier, Norway is a strong supporter of UNAIDS. For 1996 UNAIDS gave a general contribution of NOK 22 million. For the NACPs there was another NOK 13 million available through UNAIDS, of which some funding is planned for the NACP in Tanzania.

The MoFA should set up guidelines for how country representations should follow up the work of UNAIDS in Tanzania. For instance, Norway could decide to promote certain issues in the theme group.

Norwegian «country programme» support to the health sector in general in Tanzania, is as we have noted, not to be considered in the future we were told by Norwegian embassy staff. However, general contributions to the NACP, will be an exception to this. Such bilateral allo-

cations will be financed from a budget line for miscellaneous projects. The support can be general contributions to implementation of the national AIDS-plan as well as ear-marked contributions to specific projects or programme areas, e.g. UNICEF. However, the Norwegian policy to focus future support in the health sector to broad primary health services will raise questions on the interpretation when it comes to assistance to the fight against HIV/AIDS.

The extent to which efforts will be made to change the NACP from being a mainly vertical programme in the health sector to becoming an integrated component of the primary health care services in Tanzania will also have consequences for the Norwegian support. This will depend on the ongoing health sector reform process.

The transfer of funding for education from the SAG to funds for bilateral country programme support is an ultimate goal, but problematic. It presupposes a specific proposal and request from the MoE, which may have difficulties in materialising in a situation where scarce resources have to be shared between several different activities of high priority. At present, both sides, the donors and the recipients, still mobilise HIV/AIDS funding from health sector funds as well as the SAG. Specialised ministries, should propose bi- and multilateral financial assistance from the respective sector funds. Norwegian aid on the other hand, should recommend HIV/AIDS components to be included in health education components in various bi-lateral sector support agreements (e.g. infrastructure).

4.3 Uganda

Nearly 10 % (1,5 million people) of the population in Uganda are estimated to be HIV positive. The reported cumulative number of AIDS cases is reported to be about 48.000 and the number of orphans over one million (1995). Norwegian support to AIDS control 1990 – 1995 amounts to about 35 MNOK, mainly via Redd Barna, CARITAS and Global Programme on AIDS.

Uganda has received Norwegian support for its AIDS programmes mainly through support for Norwegian NGOs and some support to the then NACP in the early years through WHO/GPA. The assistance has come from the SAG and from regular funds for NGOs.

Redd Barna has been the dominating Norwegian NGO and started its work in a specific relief operation aimed at AIDS orphans in the Masaka district. However, it soon realised that this focus had unfortunate side-effects leading to stigmatisation and dependency. It turned its programme into a broadly-based child-centred community development programme, developed alongside the use of a structured Participatory Rural Appraisal. This broader approach has now been launched in a wider area. Redd Barna will cease to apply for specific AIDS funds and will as from 1997 address future programme proposals regarding regular NGO funding.

Redd Barna has been the facilitator for the establishment of the Micro-Credit Development Trust. This is a Trust that aims to loan money to poor rural people, especially women, to increase their possibility of economic independence. These loans are for income-generating activities.

CARITAS has been working in a Home-Based-Care programme in the Masaka district based around Kitovu Hospital and has received Norwegian support for the orphans project within this programme. It is also moving into a broader community development programme. Pinsevenn have a very small programme that is focusing on income-generating activities for HIV-affected people.

The change of focus from a narrow relief approach to a broader community development programme involving not only victims of AIDS-related diseases but vulnerable groups in general raises the question if ear-marked support to HIV/AIDS is still the best way to allocate support for people suffering from social and economic consequenses of AIDS. Redd Barna has come to a conclusion of their own. The organisation will not request any specific HIV/AIDS-funding for their work in Uganda as from 1997. The work programme will be entirely financed from the regular NGO funds from NORAD in addition to the Redd Barna's own 50 % financial input. A reasonable recommendation is that CARITAS and the Pentecostal Church should prepare for integrating HIV/AIDS activities in the regular agreement on financial support for co-operation in Uganda.

Uganda has one of the most integrated AIDS approaches of any country in Africa. Its recent sentinel surveys suggest that there are some encouraging trends. HIV spread appears to be slowed down or is even decreasing in some areas. However, the support that WHO/GPA used to give to the NAP has stopped and its successor

UNAIDS does not want to be seen as a funding agency but rather as a co-ordinating agency.

The two UN agencies, which have active programmes that will positively affect the AIDS situation, are UNICEF with its Basic Education Child Care and Adolescent Development (BECCAD) programme and UNDP with its HIV/AIDS Prevention and Poverty Reduction Programme.

Uganda is among the few countries, if not the only one, to have established a multi-sectorially-oriented NAP, organisationally located outside the MoH. The UAC reports directly to Office of Presidential Affairs. Comments on the UAC, given to the evaluation team, were often critical, emphasising lack of decision-making and multi-sectorial co-ordinating capacity. In Tanzania and Zambia, on the other hand, all actors outside the Ministries of Health were critical to the role of the NACPs because of the lack of multi-sectorial authority that followed from the position at a relatively low level in the MoH.

The latest review of the NAP in Uganda in 1989, concluded that the response by ministries and institutions and organisations in the public and private sectors to meet the epidemic was inadequate, because they felt the AIDS prevention and control was not their responsibility. A new review of the overall Ugandan AIDS Programme was planned for October-November 1996. Its conclusions regarding the UAC will be followed with great interest by NACPs and by multi- and bi-lateral donors and most probably influence national decisions on the future or-ganisational design in response to the epidemic.

Observations

In the context of the recent developments in Uganda, particularly the decentralisation policy and the changing HIV/AIDS strategies as described above, some major issues related to the Norwegian support will be discussed. The Redd Barna project in Masaka is the largest of the projects supported by Norway, and most of our observations therefore refer to this, but the CARITAS and the Pentecostal Church projects are also commented upon.

Has the Norwegian assistance been flexible in its response to the crisis?

Ugandans are not used to dealing with chronic and on-going crises. Instead they have experience of dealing with disasters which strike suddenly. The awareness is now spreading that the HIV/AIDS epidemic is not a sudden disaster but will remain a chronic crisis for many decades to come.

Since the beginning, most Norwegian support to HIV/AIDS in Uganda has focused on the AIDS orphans. Many donors who engaged in payment of school fees for orphans, realised that their response caught them in a web of long-term support. In a community where school enrolments are very low, singling out payment of fees for orphans creates a rift and resentment among those members of the families on whose care and support the orphans depend. Also, relief creates a dependency syndrome.

After the first years of trial and error, the Masaka project shifted its strategy from acute relief to an integrated community approach. On the whole, we find this to be an appropriate and flexible response. It is also noteworthy that Redd Barna has continued to receive support from the SAG even after leaving the «AIDS orphan» profile and adopting a broader approach. This shows commendable flexibility from the Norwegian donors.

CARITAS and the Pentecostal Church have also shown flexibility in responding to the need for greater community involvement, but they have gone less far than Redd Barna in this respect. For CARITAS this is normal, since for the mission hospitals, the HIV/AIDS clients are the focus for their activities, and not community development as such. However, the problem of creating dependency is a real one, and *both projects have to find a balance between caring for the AIDS sick and their children on the one hand, and the need to strengthen the capacity of communities to care for its members on the other.*

How sustainable are the activities supported by Norway?

A review carried out in 1994 of the Masaka project raised a number of concerns, notably over the high project costs. The review recommended to *enhance cost-effectiveness* by including a larger number of sub-counties and villages, to change the project from its vertical to a more horizontal structure and to reduce the number of expatriate staff.

Our impression is that the project reacted adequately to

this critique. The coverage increased from one to seven sub-counties. All project staff are now Ugandans, trained as multi-purpose workers rather than specialised in one sector only, which clearly makes the operations more cost-effective.

An important dimension of sustainability is the extent to which a project is integrated in administrative and other structures at different levels, and how it contributes to *capacity building* within these.

The Masaka Project operates basically at three levels: village, sub-county and district. The *village level* is where most activities take place – renovation of schools, income generation, agricultural extension etc. The project works directly with the local leaders, Teachers and Parents Associations, women's and farmers' groups and groups of students. The PRA method has been used in several villages as a way to strengthen community capacity to cope with its problems.

> *Participatory Rural Appraisal (PRA)*
> The aim is to mobilise the community in a process of identifying and prioritising among its needs and developing plans to improve the situation. The role of the project is to stimulate and facilitate the process and assist with technical know-how, but never to provide solutions. The process moves through five stages, from pre-planning and sensitisation, through training of facilitators, social mapping and mobilisation of local resources after which groups are formed, basically according to gender and age. Each group then develop its own plans. Women's and children's issues are kept central. In the last stage, plans are implemented, often with the help of funds from income generating projects. The whole process may take between one to two years.
>
> Experiences from the Masaka project have made it possible to identify certain conditions for a successful PRA: allowing the process to take time; exchange visits from successful groups in other villages to learn from their experiences; appropriate interventions in the middle of the process to stimulate interest (e g videos, sports programmes); credits rather than grants; keeping the group size rather small.

The next level is the *sub-county*, which co-ordinates several villages, mobilises resources and is the channel to reach the decision makers at district level. The project has worked closely with local officials, provided management training and facilitated the development of sub-county planning. Plans of Action for Children, PACs, have been developed in several sub-counties and others are in the process of developing and adopting them.

The question of local sustainability is closely related to the process at *district level*. Unless the locally defined needs and aspirations are listened to and responded to by competent staff in the district administration, the local process is likely to die out quickly. The local community can do certain things by itself, but it cannot staff a health centre or a school, develop curricula, eradicate animal or crop diseases etc.

Decentralised planning is new in Uganda, and there is a lack of competence and experience at district levels. Training and technical support is required. To meet this need has been one of the main objectives of the Masaka project in recent years. The project co-ordinates closely with District Planning Unit in Masaka and its technical Departments (Health, Education, Agriculture, etc.). Two Redd Barna staff have been seconded to the District Medical Office, several district staff have been trained and participated in workshops, funded by Redd Barna.

The project has facilitated the development of the District PAC and given support to training of village health committees, community health workers, traditional birth attendants, teachers and school managers, including training in AIDS and counselling. Redd Barna also supports training of teachers for pre-primary education and for a new programme developed by UNICEF for out-of-school children called COPE, Complementary Options for Primary Education.

Our impression is that Redd Barna is doing commendable work in building technical competence and strengthening the planning process from district to village level. This is an appropriate strategy for building a sustainable programme. It remains to be seen how sustainable the process is after the project has phased out. Our impression is that the activities in the village still depends much on the encouragement and professional input of the project, but that basically a sound and viable process has taken off well.

According to several of our informants, the weakest link in the chain is at sub-county level. Being the nearest political/ administrative level above the villages – and an important one – it lacks the natural community anchorage, while being far from the power centre at district level. *To continue to build capacity and sustain the planning process at sub-county level is probably one of the most vital tasks for the project to ensure future sustainability.*

An important dimension of sustainability is the degree to which a project becomes *economically viable* for the beneficiaries. One common approach, used by all three Norwegian NGOs operating in Uganda, is to increase economic self-sufficiency through income generation. Community groups are given credits and assisted with technical and managerial know-how to engage in small projects, e. g. growing cash crops, small animal husbandry like pig or chicken raising, village industries such as making bricks, or establishing a forest plantation.

A common problem in income generation projects mentioned by the Masaka project staff was the lack of time, especially of the women. Many families are single-adult families, mostly women-headed. They were already stretched to the limit with responsibility for farming, household chores and child care, sometimes including a number of orphans. Overworking is especially acute in the rainy season when the children are away at school and cannot help with domestic chores and field-work. Involving men in order for them to take a greater share of the domestic burden was felt to be important, but many men are away for extended periods working on coffee plantations or in town. It is interesting to note that one of the key factors for success in income generation was that the groups should be uni-sex, i.e. either men or women, but that the treasurer should always be a woman (even in men's groups).

Redd Barna plans to gradually pull out of the Masaka project over a period of 5 years. This seems reasonable, but it should be stressed that the economic base for groups and communities to take over full economic responsibility may take a long time. Phasing out too early could be devastating for activities that are not yet economically viable. The successful operation of the MCDT (see below) will be crucial in this regard.

For the two projects supported by CARITAS and the Pentecostal Church, the question of sustainability is more difficult to judge. Although justified on humanitarian grounds and with good educational results – over 8000 orphans have been educated with CARITAS funding, some have even been paid for university training – one of the negative aspects of singling out AIDS orphans for direct, external support is obviously that communities are not empowered to take over responsibility when the support is phased out. A review of CARITAS Orphan project some years ago recommended that the dependency on external support should be reduced. Efforts are being made in this direction – in 1996 CARITAS paid 65 % of school fees and it is planned to reduce this proportion to 50 %. Families are encouraged to generate their own incomes in small projects to contribute to school fees. However, it was not clear to us what the plans were for granting credits, nor how the groups would be trained to manage such projects.

It should be noted that the Orphan project is part of Kitovu hospital's mobile home care of AIDS patients, which is increasingly working with community participation, including the training of volunteers. Hopefully the orphan project will gradually be part of more comprehensive approaches to assist communities to care for its members in need, where the AIDS orphans constitute a large but not exclusive part.

The project operated by the Pentecostal Church is much smaller than CARITAS' project but similar in that the focus is on HIV/AIDS clients and their families. With the ethos of community solidarity and leadership, which permeates the Pentecostal project, it is now also moving towards greater community involvement by encouraging income-generation activities. Our understanding was that the project depends much on one expatriate staff, a member of the Pentecostal Church. At the time of our visit this person had recently arrived in Uganda and had no previous experience of community work in Africa, which clearly makes the task very difficult.

<u>Has emphasis been given to activities directed towards the most vulnerable groups?</u>

When the Masaka project shifted its emphasis from an orphan relief to a broader community development approach, it reduced the ethical dilemma of singling out AIDS as a criteria for receiving support, as well as the risk of stigmatisation. On the other hand, the project lost its initial focus on the most vulnerable. The Redd Barna is highly aware of this problem and seeks to address it in different ways. Income-generating projects especially for the benefit of poor children is one way. For example

in some villages the project, together with Teachers and Parents Associations, has assisted schools to undertake small income-generating projects, run by the pupils. The benefit from sale of the produce goes into a fund to pay for costs for schooling for orphans. Groups of women in the area who run income-generating projects also contribute from their profits to this fund.

One should be aware that «community development» does not automatically lead to equity and concern for the most vulnerable. The «community» concept may hide highly diversified power structures and interests, which do not necessarily favour the most vulnerable groups. For example, the fact that over one third of all households in Masaka are single-adult households, mostly poor and headed by a woman, while the leadership is predominantly male, is reason for being attentive to gender and equity dimensions of community development activities (see point 4.8.).

One way used in the Masaka project to identify the poorest and most vulnerable groups and individuals has been to use the PRA technique described above, especially the so called poverty ranking exercises. However, experience shows that even in this way, older women and the poorest of the poor tend to be left out of the process. It is also recognised that the poorest and most marginalised may be left out in income-generating activities (they have to be able to pay a small fee every week).

A new and promising initiative to overcome this problem is the establishment of the MCDT (see Box). This may be one of the most significant ventures in bringing sustainability to poor communities. If plans come to fruition it will result in poor women themselves having shares in the bank and owning it. However, there is still the risk that the poorest of the poor and the most vulnerable are left behind and may need special support measures get incorporated in the benefits of the MCDT.

The Micro-Credit Development Trust (MCDT)

This is based on the ideas from the Grameen Bank in Bangladesh where the whole credit system is geared to the needs of poor women. Initiated by a number of Redd Barna staff members, the Ugandan MCDT was launched on October 5, 1996. The objective of the scheme is to provide support and help to poor people so that they can improve their own conditions through productive enterprises and social development activities. The Founding members were carefully selected from a cross section of Ugandans who had demonstrated concern about, and commitment to, the improvement of the condition of poor people in the country. They contributed their own resources (USD100 per member) to be used together with funding and assistance from Redd Barna and other donors to start the scheme. It is intended that the MCDT will eventually stand on its own feet economically and be owned by the borrowers who would have shares in the bank.

What indications are there of multiplier effects?

As described above, the three NGO projects supported by Norway developed during a very dynamic period in Uganda, when responsibilities were delegated from central level to the districts, and new inter-sectorial approaches were tested to address the HIV/AIDS epidemic. The UAC was established and an NGO coordination body created, offering fora for sharing ideas and experiences. It is difficult, therefore, to trace multiplier effects or replication of ideas to a specific organisation or projects. Certain Redd Barna initiatives are, however, possible to single out for their replication effects, e. g. the «Stepping Stones» programme, developed jointly by Action Aid and Redd Barna. With the help of text books and a video, the programme uses discussions, role playing and PRA to encourage community groups to identify and analyse their problems and needs. The programme has proved valuable in dealing with sensitive issues such as sexual behaviour and HIV/AIDS prevention, but is also useful in many other areas of improving health. The training is, howeve, time-consuming and quite complicated, and it remains to be seen how reproducible the method is in a wider context. It has now been introduced in many parts of Uganda and in other countries in the region.

The MCDT, for which Redd Barna has been one of the main instigators, seems to be an initiative with very large potentials for replication and for reaching out to the poorest groups. The Grameen Bank in Bangladesh, which is the model for the Ugandan MCDT, has spread to over 50 counties over the whole developing world and is providing loans to millions of poor women. The legal hurdles to the Uganda MCDFD has still to be cleared.

The community development approach used in the Masaka project is by no means unique in Uganda. However, our impression is that the way the approach has been developed within the project, not least the patient use of PRA, is exemplary and ought to be replicated in other contexts.

CARITAS' Orphan project may not provide much of replication effects as such; rather it represents an approach which was typical for the earlier years of the HIV/AIDS crisis. The Orphan project is however part of Kitovu Hospital's pioneering work for community care of the HIV/AIDS clients and their families. Together with Nsambya mission hospital in Kampala, Kitovu's experiences have provided example for other parts of Uganda, and also for other countries. Redd Barna has facilitated this by funding members from Kitovu Hospital HIV/AIDS team to visit similar projects in Zambia to share experiences.

Has the Norwegian support gone to preventive activities?

Indirectly Norway have supported preventive work through its over all support to UNICEF in Uganda. UNICEF's BECCAD programme is a comprehensive programme for AIDSs prevention, which aims at addressing the needs of children and adolescents by creating an enabling environment and strengthening self-respect and problem solving capacity. The girl child is in special focus. Parents, teachers and community leaders are involved in the programme, executed through the district administration.

The pedagogic and developmental approach of BECCAD are clearly innovative and seems in many ways more advanced than what we know from our own country. We had no possibility to asses their contribution to reducing risk behaviour among adolescents but there is no doubt that they represent a major step forward in education for HIV/AIDS prevention. Redd Barna has been actively involved in the introduction of BECCAD in Masaka and is a member of the District Multi-sectorial Committee on Population and Development, which is responsible for this programme.

In the Masaka project, members of the income generating groups are encouraged to become Behaviour Change Agents. Peer educators are trained in primary schools using role playing, songs and plays. Teachers have been trained as TOTs and pupils have developed the skills of introducing behaviour change in areas such as sexual behaviour, nutrition, immunisation, oral rehydration therapy in diarrhoea and environmental hygiene. They have established health clubs at schools. Most of these are in primary schools but some secondary schools are also involved.

These are useful activities, but education is clearly not enough. It is important to keep in mind that average age for first sexual encounter for out-of-school youth in Uganda is 13,5 and for school children 15 years. A major problem of HIV/AIDS prevention among youth is the lack of good contraceptive counselling and services. This is still a very delicate issue in Uganda. We encourage Redd Barna to clarify its stand on how to address the need for STD treatment and contraceptive counselling and services to adolescents. We are uncertain about the extent to which the project actually addresses this need in its programmes (UNICEF some years ago had no such component in their AIDS prevention programme for adolescents, but is now including it).

Accountability

The potential problems for an NGO like the Redd Barna of interacting closely with the processes at district level should not be overlooked. The decentralisation policy puts new and heavy responsibilities at the district administration. District officials may often get bogged down by a whole range of new tasks and requirements, for which they are not yet fully equipped, including handling funds. Checks and balances must be built into the structure to avoid embezzlement and corruption, but these are not always effective. For example, a «money tracer study» carried out by a UN agency concluded that development funds had a tendency to get blocked at district level, and that corruption was not uncommon.

NGOs themselves are of course not spared the problem of corruption. Money for AIDS programmes has been easily available (some would say too easily), in comparison with other health issues. One major weakness of

NGOs generally is the weak accountability. We found no evidence of this in the three Norwegian NGOs, but it is maintained that the mushrooming of local NGOs in a climate of easy money has increased the danger of corruption. The use of the «open accounting» system has proven to be useful. This involves a monthly scrutiny of the books by a representative group from the NGO, which increases transparency in accounting and a feeling of ownership of the financial process. Favouring the appointment of women treasurers seems to be beneficial.

Have the activities given due emphasis to ethical and cultural issues and to human rights?

In the Masaka project, a number of observations and reports give the impression that cultural and ethical issues are well taken care of. The whole ethos of PRA takes great cognisance of local culture and never forces outside ideas on people but rather they develop their plans in their own context. Cultural values are respected and the process is a democratic one. Other examples: corporal punishment is said to have been reduced in the schools where the projects operates, and child abuse is less common. School uniforms are now no longer mandatory, allowing some of the poorest, including orphans, to come to school in simpler clothes.

A fine example of respect for cultural values is a study carried out by Redd Barna among the Karimojong, a pastoralist group in the North of Uganda, perceived as backward and problematic by the larger society. Negative to education, they refuse to send their children to school. The study was made to find out the reasons for this:

> *«Unearthing the Pen»*
>
> In this nomadic area, colonial approaches during the world war to recruit soldiers into the army led to clashes with the traditional leaders. The symbol of the recruiting officers – the pen – was cursed. The reason behind the antipathy to education was not understood until this curse was revealed. After deep discussions with the community leaders, a traditional ceremony was held in the presence of all the community leaders to remove the curse. This ceremony was called «unearthing the pen» and provides an unprecedented opportunity and ideal starting point for supporting education in that area.

Redd Barna has been active in the protection of children's rights and child advocacy in Uganda in different ways, notably in its support to The NCC, which will hopefully become an important body for the monitoring and protection of children's rights. In support of the implementation of the UNPAC, Redd Barna has trained a team of «Child Advocacy Programme Officers», CAPO. Among their tasks is to sensitise and train in children's rights issues in the districts and sub-counties.

The need for legal protection of orphans was brought to our attention in many ways, e. g. by the reported increase of child-headed households in Masaka: When the parents die, relatives often take the land of the diseased, to which the children have the legal right. The result is that an increasing number of orphaned children decide to stay on their land rather than move to another family. The project, together with the District Probation Officer, has conducted training sessions with local leaders at various levels on children's rights and legal issues affecting children. We did not have the opportunity to assess to what extent violations of children's rights are followed up by legal or other action, nor the issue of violation of AIDS widower's rights.

How good is the monitoring and development of indicators?

Among the Norwegian NGOs, the most detailed plans have been developed by Redd Barna, following the standard LFA format which includes monitoring and indicators. Certain indicators are relatively easy to identify and report, e. g. the proportion of orphans in school and out-of-school, whether corporal punishment is still used in schools and if so how frequently, the number of successful income- generating projects, the number of villages that have completed the Action Programme for Children, PAC, etc. The project produces regular reports presenting the developments of these indicators.

Example of indicators that are currently not used but could be included in the regular monitoring of the project are the well-being ranking score, which is used to identify the most vulnerable in the community by the members of each of the PAC programmes. This score should in due course show if there is a change for the better. Each of the groups that have income-generating projects are trained to become behaviour change agents in the rest of the community. Their progress could be monitored by qualitative indicators using focus group interviews, key informants and other appropriate methods. Indicators monitoring the involvement of girls and

women in the process of community development, in education activities, access to and constraints in receiving credits etc, ought to be developed and periodically reported. BECCADS monitoring system may be of value to the project in this regard. Men's involvement in community development activities and in income generation is another area where both quantitative and qualitative monitoring is important. Gender disaggregation of quantitative indicators should be done whenever feasible.

One problem with indicators is that they are usually developed for the benefit of the donors and seldom together with the beneficiaries. Doubt has been voiced about the value of advanced models of monitoring and evaluation in which the beneficiaries are not stake-holders. It is felt that indicators ought to be developed within the community and together with the community members, on criteria that will benefit the community. These ideas are being introduced in the Masaka project. The aim is to strengthen a process of monitoring and evaluation which is «owned» by the community and will give its members a clear indication of progress in their work. For example, one of the women involved in developing indicators described the process as being «like when you are cooking plantain bananas wrapped in banana leaves. When the steam starts to rise you know the bananas are cooked».

We fully support the idea of «community owned» indicators, but there is obviously also a need for external monitoring and evaluation, to meet the demands of NGOs' accountability to their funders, and occasionally for a more analytical view of project process and impact. It is important to recall that the initial criteria for selecting Masaka district, both for the Redd Barna project and for CARITAS Orphan project, was the extraordinarily high HIV prevalence rate and the large proportion of grandparent/ children households in the district. An increasing number of households are child-headed, reflecting the strains on the extended families, as well as the weak legal protection for orphans. A bitter truth is that the number of people dying in AIDS and AIDS orphans will continue to increase in Masaka over the coming years. With an HIV/AIDS prevalence rate which ranks among the highest in the world for a rural area, no-one knows how the communities will react to increasing rates. *There is a critical need, therefore, to monitor the progression of the HIV/AIDS epidemic and its impact on the communities. How will they cope with the even higher stress on the extended family system, how will institutions like schools and health centres cope, how sustainable will the community participation process be in this perspective? Is there a limit on the number of orphans that a community can cope with?*

Has the Norwegian support improved co-ordination and multi-sectorial approaches?

Our observations concerning the Masaka project have demonstrated an increasing degree of co-ordination between the project, other local and international NGOs in the district and district administration in multi-sectorial approaches, particularly education, health and income generation. *Our impression is that the project has taken up the challenges and opportunities offered by the decentralisation process in a commendable way, and now functions as a catalyst between various actors at district level and below in multi-sectorial and participatory processes.*

With their different aims and focus, this is less the case for CARITAS the Pentecostal Church, although both projects interact when needed with local structures and CARITAS with local and international NGOs (e. g. UCOBAC, Redd Barna, World Learning).

The extent to which Norway has contributed to national level co-ordination is more problematic to see. Norway supported the NACP within the MoH up to 1992, when funding was withdrawn. The establishment of the UAC, in 1991 was met with great interest and hopes for a more efficient multi-sectorial NACP, replacing the vertical programme within the MoH. The team has been informed that the reason why Norway did not continue its funding to the national AIDS co-ordinating body, was that many other donors by then had shown interest to give support.

It seems that the hopes for effective co-ordination have not yet come to fruition. We heard several actors outside the Commission commenting on the inadequate capacity of the Commission to prioritise and co-ordinate the ministries' AIDS Control Plans. For example, the MoE proposed an NACP work plan for 1996 amounting to almost USD 500,000, of which less than half was approved by the UAC. The main component of this programme is the production of a Counselling Manual for Teacher Counsellors in schools and colleges and executing workshops for teachers, a program that can be regarded as having a top priority for AIDS prevention. However, by September 1996 only a small fraction of the allocated sum had been disbursed. The

planned activities had been seriously delayed and the concerned staff members were demoralised.

If this example is significant for the situation 5 years after the establishment of the UAC, *there is cause for concern and a need to analyse the reasons for the low efficiency of the Commission and the low level of resource mobilisation for sectors outside health.* One reason may be the fact that HIV/AIDS programmes were previously almost entirely health sector funded. This again is related to the fact that WHO was the major funding agency for HIV/AIDS programmes and that donor support channelled through WHO are normally health sector funds.

It is a sad experience from other countries and programmes that central integration units tend to become passive and bureaucratic. It may be unrealistic to expect a central organ that is not in daily contact with felt needs to retain a sense of urgency in their task of providing national leadership. However, an effective central coordinating body for multi-sectorial AIDS programmes is obviously essential in a county like Uganda and all donors have a responsibility to contribute to this.

As regards UNAIDS the picture is not very clear, especially with regard to funding. UNAIDS is not a funding body but a co-ordinating body. Currently there is a vacuum in the Uganda AIDS Control Programme, that has been created from WHO/GPA to UNAIDS as far as funding is concerned. The NACP in the MoH last year spent USD 1.3 million and at present only USD 250,000 have been earmarked for 1996–1997. This currently shows a very big gap and it is apparent that some of the activities will stop. This problem and other issues critical for the role and function of UNAIDS in Uganda will be brought up in discussion in the co-ordinating committee.

The advantages and disadvantages of an integrated approach

It is gratifying to note that 13 Ministries have accepted a role in the prevention and control of HIV/AIDS. However it is not yet clear to what extent HIV/AIDS is integrated into the on-going programmes of respective ministries. A general view, shared by the team, is that integration of HIV/AIDS mainly has advantages, but there are also potential dangers in this approach. The fears are that if HIV/AIDS is «mainstreamed» into other programmes and activities, it may be marginalised, funding reduced and the outcome specific to HIV/AIDS intervention would be very difficult to measure.

One particular concern is that the integration of AIDS orphans into the wide category of disadvantaged children may obscure the very unique and tragic character of the orphan crisis, and reduce funding. The study on «The Situation of Orphans within the Family and Community Contexts in Uganda» conducted by UNICEF, UCOBAC and the Ministry of Labour and Social Affairs showed that the situation of orphans within the family and community context is worse than that of other children. To allow the orphans to completely «merge» into a general community development ethos might be counter-productive and a disservice to the many orphaned children in the Ugandan community. *A challenge for the future will be to keep the balance between an integrated approach, while maintaining a focus on the most vulnerable groups, where the AIDS orphans will constitute an increasingly large share towards the year 2000.*

How can NGO activities and Government programmes interact?

The tone of national AIDS programmes within the various ministries tends to be set by the Minister. However, he/she is often enslaved by the «tyranny of the urgent», the immediate political problems that must be solved quickly and so the responsibility for an on-going chronic crisis like AIDS tends to become the responsibility of the Permanent Secretary. He/she attends the UAC meetings but, lacking the political power of the Minister, may become passive about AIDS-programmes. In some districts the District AIDS Committees have struggled to obtain the funds from the Councils and this has damaged their capacity to function effectively.

Decentralisation is a sound reform since at the district level the need of AIDS interventions cannot be denied. If the decentralisation ethos of the government sector can be combined with the focused, flexible approach of NGOs as in the Masaka district, the result can be a dynamic process that strengthens both sectors.

The advantages and disadvantages of support through international and local NGOs

To the ordinary Ugandan, the term international NGO means resources. It also means expatriate involvement and in some cases a relief approach. The history of Uganda gave rise to the feeling that most international NGOs are relief oriented and come to the assistance of the community during crisis times. Since 1986 this picture has gradually changed. It is still true that NGOs from the developed countries enjoy patronage, not only

because of their culture of transparency and accountability, but also because their benefactors abroad tend to have more confidence in their abilities. In this way the communities benefit much more from support executed through their work. Also, because they are alien, they tend to perform their activities with impartiality. The focus on intervention is need, rather than other factors such as ethnic origin. The international NGOs in many cases come without biases and formed opinions and are therefore likely to listen to the communities.

It must be mentioned, however, that one of the biggest disadvantages with such support is the lack of sustainability. In many cases, because of the logistical support these international NGOs enjoy, when they pull out, the communities cannot sustain the programmes initiated. Unless weaned off this dependency the community promptly falls back and relapses into the original state.

The great assets of an NGO like the Redd Barna lie in the combination of having the technical competence, flexibility and impartiality of an international NGO, and at the same time the credibility to be able to establish «partnership» with local institutions at all levels, government as well as NGO. Such programmes have a good potential for being sustainable even after the pulling out of the international NGO.

Sustainability is built at the grass roots. Local participation must be stimulated and people empowered to take control over their own lives. The Norwegian NGOs contribute to this in different ways, in accordance with their specific mandate and mission. The achievements are good, but small in the context of the enormous efforts needed to combat HIV/AIDS in the Ugandan society. There is a plethora of local initiatives – community groups, small NGOs, mutual aid groups and associations – engaged in different ways to alleviate the hardships caused by AIDS in their own communities and to prevent its further spread. To catch this spirit of the civil society and assist in creating an enabling environment for viable local initiatives to develop on their own terms is, in our opinion, one of the most challenging and inspiring tasks for the future.

4.4 Zambia

In Zambia official estimates indicate that more than 15 % of the population has become HIV infected and the cumulative number of reported AIDS cases in 1993 was almost 30,000 and the number of orphans is estimated to 250,000. The total Norwegian input into AIDS control was 54 MNOK during 1990 – 1995.

AIDS is the most common cause of mortality in adults in Zambia today. According to current epidemiological projections, the HIV infection rate in Zambia will reach 28 % in 1998.

Zambia is in the process of reforming the health sector funding process, the objective being a more integrated approach. Norway does not have a bi-lateral agreement with Zambia for health sector support. Consequently, much of the support for HIV/AIDS prevention that Zambia has received from Norway has come from the SAG, and gone to NGOs. Support to the NACP has been channelled through WHO/GPA. This will have some consequences for future Norwegian funding. Norway is the largest funder of AIDS prevention work by NGOs in Zambia. The largest NGO recipients are FHT, Kara Counselling Trust, CMAZ and the CHEP. A substantial amount of funds has been disbursed through decisions taken at the Embassy of Norway in Lusaka. The amounts involved ranged from NOK 3,000 to 3 296,000. This puts a huge administrative burden on the local NORAD programme officers. Nonetheless, this decentralised system of funding has enabled Norway to acquire a reputation locally as a swift and flexible funder. Consequently Norwegian support in the field of HIV/AIDS prevention has been visible and enterprising due to a willingness to support novel approaches. Home-Based Care is one such example. Efficiency and effectiveness were objectives that appear to have received a high level of fulfilment in the activities of the NGOs supported. Likewise the objective of capacity building and sustainability. However short-term goals of HIV/AIDS prevention make the realisation of this goal somewhat difficult to measure. The same goes for the issue of whether these programmes have been cost-effective. There seems to be a built-in disharmony between the objective of care and prevention, on the one hand, and cost-effectiveness of interventions, on the other. With Home-Based Care, for example, where it is postulated that care has a preventive effect, it is difficult to measure in monetary terms the cost-effectiveness of measures taken. However, it is the impression of the evaluation team that many positive results and much positive impact has been achieved by the projects supported.

Observations

The following are the major questions which arise out of the original aims of the SAG and the terms of reference of the country studies:

1. *Is the Norwegian assistance in the field of AIDS visible in Zambia?*

The answer from all the key informants is an emphatic affirmative. They all maintain that Norway has the widespread reputation of being the most significant funder of AIDS programmes in Zambia. Significantly, this is achieved without Norwegian support being flaunted to get support in the press. «Unlike other donors they [Norwegians] do not call the press to photograph them giving you a check», were the words of the director of a large NGO that received considerable funding from Norway. Many of the more successful NGOs have at one time or another of other received Norwegian support.

2. *Has the Norwegian assistance been flexible in its response to the epidemic?*

Here an affirmative answer was forthcoming from a number of the key informants without prompting, on being asked about the special features of the style of funding from Norway. Flexibility and the willingness to support new strategies and interventions are, according to programme implementers in the NGOs interviewed, the distinguishing characteristics of Norwegian funding. «Other donors will tell you exactly how they want you to use their money. NORAD approves your projects and funds you without telling you what sort of persons you should employ. But they are interested in what you do. They will keep visiting you in the field.» With regard to innovativeness in funding, Norway was the first to support Home Based Care in Zambia. This has proved to be a very insightful venture because it is now generally accepted that Home Based Care, combined with community counselling, has a considerable impact on prevention. It also reinforces local cultural notions of the importance of caring for one's own. Two other examples might be added here. The first: Norway began supporting NGOs before other donors realised the importance of this as a channel for HIV/AIDS work. The second: Support for developing the multi-sectorial approach (as elaborated below) came from Norway early on.

3. *Has the assistance promoted long-term programmes by NGOs?*

The NGOs interviewed have had problems with long-term planning because of the one-year funding cycle. Several of the beneficiaries are currently in the middle of, or in the process of, planning long-term (3-year) strategic responses to the epidemic. These include CMAZ, CHEP and FHT. These projects hope to get some assurance that support for longer periods may be forthcoming in the future. Kara Counselling Trust, on the other hand, appear to have always included long term contingent planning in its agenda. It must be added that such endeavours have been partly facilitated by Norwegian funding, that has provided a core base which makes long term visions possible, in the first place.

4. *Has the assistance promoted long-term integration in development co-operation?*

Norwegian assistance has been important in bringing about networking among the NGOs. Networks such as ZNAN, CHIN, SANASO have all received Norwegian support for their activities. This support has further also stimulated a more integrated approach in the national programme, as well as in the international organisations through UNAIDS and the local country theme groups.

5. *Has it improved co-ordination at country level?*

The evaluation team finds that at present the co-ordination at the country level is still far from satisfactory. A decisive factor remains where the national AIDS programme is located. As long as it remains in the MoH its co-ordination prospects will remain limited. It would only be regarded as a section within the health ministry which has relatively more resources than the others. To improve co-ordination therefore the National programme will require a location independent of the MoH, so as to highlight the multi-sectorial necessity of HIV/AIDS prevention. A recommended strategy would be if it NAP were elevated to the office of the President or vice-president, for example. This would not only imbue it with the authority needed to co-ordinate the programme but also underscore the seriousness with which the government views the fight against HIV/AIDS. Norway could play an important role in advocating an accelerated movement in this direction.

6. *Has it supported WHO's leading role in technical matters?*

The WHO's GPA has been given support through the SAG and has also been a channel for funds to Zambia. There is little doubt that the ability of GPA, the predecessor to UNAIDS, to co-ordinate and provide technical support was partly facilitated by the grant. However, GPA's method of promoting virtually the same national

plans in all countries was widely criticised because of its «top-down» approach. Nonetheless it must be admitted this was quite effective. Even more so when it the approach was later modified by means of tailor-making responses for specific needs of particular countries. It was WHO which started the local Country Theme Groups in Zambia in an effort to integrate the response of the UN agencies in the country with regard to HIV/AIDS. Originally Theme Group gatherings were also attended by donors, but this has changed. The donors no longer attend the Theme Group gatherings.

Opinions differ at to how effective the Theme Group has been as a body. Its mandate seems unclear. Further, with the appearance of UNAIDS at country level there appears to be some confusion about the roles of the two roles of WHO and UNAIDS, respectively. Although some overlapping and duplication is inevitable some form of co-ordination and definition of mandates seems necessary.

7. *Has it responded to the socio-economic consequences of the epidemic?*

Most of the NGOs that we have met have had interesting responses with a variety of skills-training for affected individuals, families and children e.g. CHEP, CINDI, Hope House, SWAAZ, and Tasintha. These projects have all made clear efforts to ameliorate the socio-economic effects of the epidemic. Sustainable income generation, however, is not easy to achieve within a short span of time. It is thus still too early to say if any of these efforts will have a lasting impact. It must be noted, however, that the response from Government Agencies in similar programmes has been less evident. It was only in the Ministry of Sport, Youth and Child Development that the evaluation team found some indication of an attempt to address the socio-economic effects of the epidemic.

8. *Has emphasis been given to activities directed towards women and children?*

Here some of the NGOs supported by the grant have been outstanding in their efforts in this direction. Virtually all those we interviewed showed clear evidence of this emphasis but especially noteworthy were SWAAZ, Tasintha, and Hope House, CINDI, CHEP in this regard. We might add that in line with more recent thinking it is important that men not be isolated from programmes that aim to improve the position of women and children. The active support of men has to be forthcoming or hopes of reducing the spread of HIV are doomed to failure. This is particularly true in a country such as Zambia where asymmetrical gender relations are important factors in sexual behaviour.

9. *Has support been given to «weak groups»?*

Targeting vulnerable groups such as Commercial Sex Workers and Orphans is particularly important where the social and community support systems are weak. Many such groups have been reached through the SAG. SWAAZ, Kara Counselling Trust through Hope House, CINDY, CHEP and, to some extent, FHT, have all placed special emphasis on the targeting of weak groups. However, the team found that with FHT, the emphasis appears to have been more placed on building up a sound central management structure, with the effect that small local groups, such as, the anti-AIDS clubs in schools outside the Lusaka area have largely remained unsupported.

10. *Has support gone to multi-sectorial approaches?*

The NORAD was probably the first donor in Zambia to adopt the multi-sectorial approach. Within this approach funds are ear-marked for ministries other than health, to facilitate the appointment of a focal point staff member. This person is appointed by Cabinet Office and is, through the Permanent Secretary answerable to Cabinet Office for the AIDS activities undertaken in that particularly ministry. However, as yet this support is only in the form of «seed money» and the plans prepared by the focal points persons have largely been stifled by lack of resources.

11. *Has the grant mainly gone to preventive activities?*

This is a question that needs to be addressed in a wider review and figures are not available to give a clear answer. The team found that prevention has been an inherent aspect of all the projects supported. It is however, difficult to assert that prevention has been the main concern of all the projects. The team agree, however, with the view that HIV/AIDS prevention in Zambia cannot be completely divorced from care. Such a separation would be doomed to failure. We thus agree with those who postulate, for example, that one of the strengths of the Home-Based Care approach, which combines care and preventive community counselling lies in the enzyme effect of having the two linked. It was probably unrealistic to assume in the early stages that prevention through IEC could be done on its own without a linkage to a care component. In this sense, we found a care element in most of the programmes that we

studied. Particularly worthy of mention are FHT and CHEP.

The clearest example of a project that focuses mainly on prevention through IEC activities is the George Matero peer-education project. This project was initiated by the NASTLP and funded by NORAD. The evaluation team was particularly impressed with the commitment and enthusiasm evident from the work of the group. This appears to have resulted in good response from the community, far beyond the size of the project.

12. Has the grant led to capacity building?

The team found that capacity building has occurred on two levels: on the institutional level and on the individual level. As an example of the first, a number of the local NGOs that have received support from NORAD have now built up capacity that is widely recognised internationally as being of a high order. Such recognition has sometimes resulted in instances when people from neighbouring countries have come to Zambia for training in aspects of HIV/AIDS prevention. CMAZ, CHEP, Kara Counselling, SWAAZ, and FHT are organisations worthy of mentioning. The particular aspects of training that are of relevance to other countries are the participatory methods that emphasise linking up the communities with the health-related work, and bring about a bottom-up approach in tackling the problems related to AIDS. On the individual level many persons involved in these projects have gained from continuous exposure to international contexts of HIV/AIDS prevention and research work. NORAD has contributed to this through support for the projects as well as through direct contributions for travels to international conferences and workshops.

13. Have the activities supported by the grant achieved their immediate objectives?

This is not a formal evaluation of individual projects and none of the projects have yet used the Logical Framework Approach. Hence, the team cannot aspire to assess accurately whether the immediate objectives have been met. However, some observations are in order. The aim of bringing knowledge about HIV/AIDS to the groups and communities concerned has been met by many of the projects. Evidence is available about increased condom distribution and sales and some of the credit must go to sensitisation brought about by NORAD-funded programmes. Evidence of behaviour change is more difficult to assess and impossible to study in the short time available. Even here, group discussions and informal interviews give some credence to the likelihood that behaviour change is now a fact of life in Zambia among sensitised groups. This is especially so when they themselves have been involved in the decision-making about which changes are necessary in order to reduce the risk of HIV spread.

14. What key factors have been involved in allowing these objectives to be achieved?

Some of the key factors stem from of the above:

a) Linkage between care and prevention (see 11 above). This link creates a fruitful atmosphere of mutual reinforcement
b) Harnessing the enthusiasm of individuals and NGOs yet within a network of the NAP. Some of the vigorous promoters of activities could well have been stifled under a more rigid structure within the NASTLP but have been able to flourish in the freer atmosphere of an NGO.
c) Allowing communities to make the decisions themselves based on sound scientific evidence about which behaviour change is necessary. CHEP and Chikankata have been promoting the approach of presenting the options and the health evidence on which these options are based, but giving freedom to the communities to make up their minds about the response that they will adopt.
d) Giving the NGOs enough freedom and flexibility to try new ideas and to do things in another way so that they retain ownership of the programmes. Again and again this has been brought out by key informants to be the main strength of the Norwegian support.
e) Early support to inter-sectorial collaboration.

15. What other effects intended and unintended have resulted from the support?

a) Kara Counselling aimed to focus on counselling and rehabilitation services but found that the demand for counselling services was rather weak. The real demand was for skills training that leads to income generation. Communities still have to be sensitised on the value of counselling services and it is thought that this will slowly grow.
b) FHT found that anti-AIDS clubs in schools were hampered and incomplete without a parallel movement for teachers. This has now started on a small scale but plans are underway to expand this vital approach.
c) CHEP health educators found that the uniformed

services were especially awkward to contact and that rapport with them had to be built up slowly and with special techniques.

CHEP found that traditional healers had to be involved in the health education programmes but they are a difficult group to contact with lots of problems, and they are by no means a homogeneous group. This is a particularly important key group to target in HIV/AIDS prevention. CHEP found that traditional healer engaged in dubious and dangerous activities such as sexual intercourse with their clients professing to treat them for infertility, as well as other conditions.

The evaluation team wish to add that points listed above represent unintended consequences that are not dependent on a weakness in the design of the project activities. Rather they were contingent outcomes which most of the projects have now began to take into account in the design of subsequent phases of their work.

16. How do activities supported by the grant compare with national programmes?

This is impossible to assess accurately in our study but some observations lend weight to the conviction that the NORAD funded programmes have been more imaginative, more bottom-up in approach, less bureaucratic and more in touch with vulnerable communities than national programmes.

The programmes run by NGOs are in line with national AIDS plans and complement rather than collide with them.

17. Have the activities been carried out efficiently?

There is a need for a review of the Mid-Term-Plans and there are many unanswered questions about the cost-effectiveness of some of the NASTLP activities. Generally we have been impressed with the efficiency of the NGOs in their implementation. CHEP and CMAZ, Kara Counselling and Family Health Trust give a first impression of efficient, well-run organisations. However, concerns were expressed about the mushrooming of new NGOs who might not be so serious in their approach, where much of the funds have gone to building up central administrations. This may be the other side of the coin, as it were: the flexibility which is the strength of NORAD funding, where not much emphasis is placed on a rigid auditing system, continuous reviews and continuous writing of progress reports, might also sometimes be misused. However, although some implementers of projects expressed this fear, we got no direct information about the misuse of funds in this way. It will seem however that stricter rules are now being applied which will make this potential problems less likely to occur.

18. Have the activities placed due emphasis on ethical and cultural issues and on human rights?

Generally our interviews and focus group discussions showed a high level of respect for cultural, ethical and human rights issues. There are special NGOs that have focused on the needs of commercial sex workers, orphans and out of school youth. These are groups that could easily have been exploited with a domineering approach but this has not been what we have found. However, certain cultural issues such as the tradition of ritual cleansing by sexual means which is present among some tribal groups has had to be faced. Using methods of community counselling and the participatory approach such issues have been resolved with acceptable alternatives which do not destroy cultural values. However, such changes have to be agreed upon by whole communities if they are to have an impact in terms of behaviour change.

19. How sustainable are the activities supported by the grant?

This is a question to which the evaluation team cannot provide a clear answer from the evidence available. It is true, however, that many of the NGOs have tried to established income-generating activities into their skills-training, but as yet these supply only marginal incomes. Some of the strategic planning that is now taking place – for example, in FHT and CMAZ – may come up with more sustainable models in the future. At present it is probably unrealistic to expect any real sustainability in programmes in Zambia. This is chiefly because of the overall national economic state of the country, and the dire economic circumstances of the most vulnerable groups that are being targeted by these programmes.

20. What indications are there of multiplier effects or replication of the ideas coming from grant supported activities?

Zambia has some fine examples of models that have been tested by Norwegian assisted groups that have then gone on to be replicated elsewhere in the country and in the world. These include Home-Based Care, anti-AIDS clubs in schools, focus on out-of-school youth in CHEP programmes, Kara Counselling with

skills transfer at Hope House, the SWAAZ programmes that have involved women's movements in many parts of the country, and the special outreach among prostitutes of Tasintha.

4.5 Description of selected projects

In this section we comment on a few projects as well as on the implementing Norwegian private organisation. As stated above, there is a wide range in terms of content, ideology, partnership, geographical location etc. between different projects supported by the SAG. The following review aims at presenting this variety rather than presenting findings on the individual projects in relation to the SAG objectives. However, observations about individual projects have, whenever appropriate, been used for the general conclusions and recommendations. A few major projects have not been mentioned in this report and there is also a variety of minor projects via the local Norwegian authorities in e.g. Nicaragua. These do, together, give a profile to the SAG, but it has not been within the scope of this evaluation to scrutinise the Grant on this level.

Norwegian Church Aid runs a number of aid projects world-wide. A strategy for the international aid was approved in 1991. It emphasises the ecumenical character of the work and the combination of long-term development and emergency relief. Partnership in implementation of programmes is another guiding principle. From the late 80s Norwegian Church Aid has a special emphasis on AIDS. One example is the work in Kenya, which was launched as a AIDS project, initiated around 1991. There has been a focus on training in AIDS at different levels, including general awareness-raising and counselling. The project seems to have widened to the community level where home-based care and general community development tasks come more and more into the picture. The Church implements this programme in collaboration with other churches and NGOs in a form of consortium. An assessment of the project was conducted in 1994. The importance of the collaboration and networking with other Kenyan organisations was highlighted, as was the local capacity building.

The strategy of community development focus in collaboration with local NGOs has also been used in a project in northern Thailand (Chiang Mai). The representatives of the organisations emphasise the importance of the encouragement given by the then AIDS advisor and of the fact that NORAD offered 100 % financing in the beginning. Without these two factors the AIDS oriented projects, at least the one in Thailand, would not have been realised. The Norwegian Church Aid also has a strong regional network, which facilitates the use of experiences from e.g. Thailand in e.g. Lao PDR and Vietnam. The Thailand project was evaluated in 1996.

Redd Barna (Save the Children/Norway) is one of the larger private organisations in the country. It runs an international programme and a programme in Norway. In 1990 Redd Barna entered into specific AIDS activities by opening up the Masaka project in Uganda, which has been described above (4.3). These activities were, according to information given to the team from different sources, initiated after contacts taken by the then AIDS advisor and NORAD. This project was explicitly meant to be a «model» project for support to orphans. As time went on it was turned into a community development-oriented project. Following the SAG principles it was initially totally funded via NORAD, but during the last few years a Redd Barna contribution has been demanded and has now reached the 20 % share regularly requested by NORAD. Redd Barna has a general agreement with NORAD which is revised each year. The organisation feels that it would be better to include the AIDS activities in this frame agreement.

Redd Barna are also involved in a project in northern Thailand, supported via the SAG. These projects are now coming to an end. They have, as far as the evaluation team has found, not been evaluated in the same way as the Masaka project in Uganda. Some common features can be recognised between the Redd Barna projects in Uganda and Thailand. In both countries, there has been a focus on some target groups, in Thailand information and support to persons with AIDS, persons with a known high-risk sexual behaviour etc. but the approach has been towards community oriented interventions.

Redd Barna has also implemented projects supported via the SAG in Ethiopia and Mozambique.

Norwegian Peoples Aid is the largest private organisation in Norway and has its roots in different professional and labour unions. It has a large international programme for promotion of human rights, poverty alleviation, gender equality, local partnership and sustainable development. In spite of the priority given to AIDS

work in Norwegian foreign aid strategy the Peoples Aid has not entered into such programmes, but rather attempted to consider AIDS within the existing programmes. The evaluation team has got the impression that the organisation has not been completely successful in this ambition, perhaps due to lack of specific competence in AIDS work.

An interesting perspective is emerging through a possible collaboration between the Peoples Aid and the *Norwegian Association for Sexual Rights (LLH)* in Oslo. This small private organisation runs an AIDS prevention programme in Soweto in South Africa. Apart from general prevention this township project has an explicit humanitarian objective to prevent social isolation of AIDS victims. The LLH members make strong efforts to implement and follow up the project, but have very limited resources. Raising a self-contribution (e.g. 20 %) may be impossible for them and planning, monitoring, reporting and quality control may in the end be too much for a small organisation. A joint venture with Norwegian Peoples Aid, which is now discussed, might be a highly appropriate solution with strong synergistic effects.

Norwegian Red Cross has a number of relief projects in Africa South of Sahara. Most of them are launched in areas where there is war or unrest and they operate under a framework agreement (rameavtale) between Red Cross and NORAD. One of these projects deals with prevention of AIDS and activities to support AIDS victims. The project is launched as a joint venture with Kenyan Red Cross. The experiences so far seem to illustrate the problems in developing projects in areas where not even the local partner may have a strong position by the end of the project. Norwegian Red Cross is currently in a process of finding ways to support the Kenyan partner by also involving other Kenyan organisations with a special competence in this work. This project also illustrates that there are ways to include AIDS projects under regular funding, like the framework agreement, and not necessarily via the SAG. This is certainly true for larger organisations and, as mentioned above, also Redd Barna argued that they would rather favour such a solution.

The SAIH is a rather large organisation in terms of number of members. The majority of students at some colleges and universities are enrolled. However, the administrative capacity is limited. One of the programmes run by SAIH is the «National Integrated AIDS-Awareness Iinitiative» in South Africa. This is an impressive initiative where SAIH collaborates with about 70 South African organisations, mainly NGOs, and a few AIDS organisations. A feasibility and planning study was conducted in 1995 and the report analyses the problems that may be faced, but also gives strong support to the network approach applied. There are plans for the gradual take-over by South African NGOs. SAIH seem to be a private organisation with competence to develop programmes in collaboration with local counterparts without strong support, apart from financial, from Norwegian authorities. However, it has struck the evaluation team that there is a fairly weak follow-up of these kinds of projects and a poor exchange of experiences between the NGOs in Norway. A kind of joint report meetings seem to have been held on some occasions, but there has been no systematic effort has been made in order to promote the development of the Norwegian organisations.

4.6 The private organisations in Norway and the SAG

As already stated, the SAG has (according to information from different representatives of NGOs and NORAD) certainly been an imperative prerequisite for the initiation and development of many AIDS-related projects. The full financing by NORAD and the role of the AIDS advisor have been critical factors.

On the other hand, a strong criticism concerning NORADs way of managing the SAG was voiced by several persons met. It was felt that NORAD had established a complicated reporting system, which also had been changed several times at short notice. All information, it was said from one source, had at least during some periods, been requested in the Norwegian language, which meant that the staff in Norway sometimes had to translate reports submitted by collaborating NGOs from other countries. It was also felt that more should have been done in terms of follow-up of projects through joint discussions between NORAD and different NGOs involved. Some meetings had been organised, but no systematic activities had been organised in order to develop the Norwegian competence by sharing experiences. The efforts by some AIDS advisors were acknowledged, but otherwise it was felt that NORAD is interested in the formalities but not much in the content. To some extent it seems that the NORAD representatives are aware of these problems, but it was also claimed that the formalities had been simplified and that

NORAD has to be strict in order to be in a position to supply the Government auditors with appropriate information. It is also argued that the content of the programmes is normally supervised by the AIDS advisor, who may sometimes not have had enough time to follow up the programmes, e.g. by organising seminars.

The team concludes that the formalities of NORAD could have been managed in a more flexible way and that there have been gaps in the information. These kinds of shortcomings should, however, be seen in the light of the complexity of managing a programme like the SAG.

5. Discussion

Based on the preceding section, where the main findings of the evaluation are presented this section will address and discuss a few core themes that emerge from the material, in response both to the ToR and to the comments of MoFA dated August 5, 1996, to the evaluation team's inception report.

5.1 Approach

As elaborated upon in section 2 above, HIV/AIDS, perceived as an acute disaster in the Eighties, has become a pandemic and a chronic crisis. The objectives and design of HIV/AIDS interventions have had to change in order to cope with the prevailing situation – and will have to continue to adapt. Broader approaches have become necessary, as a prerequisite for long-term sustainability. Community-oriented programmes, based on local initiative and on addressing the socio-economic impact of the disease, are one of the responses.

Several country-level interventions testify to the change in perspective and objective. The MUTAN project in Tanzania provides an illustration of how a project approach that was seen as relevant and adequate in the Eighties, was no longer acceptable in the Nineties. The MUTAN example also shows that if the capacity of local health systems is limited, local staff will not act upon research findings and transform these into interventions without monitoring and support from outside. The conclusion of many of the involved parties, including the MUTAN project staff in Bergen is that a higher profile of intervention should have been formulated from the beginning. As just stated above, the reformation of the MUTAN intervention – or the formulation of what will follow – remains to be done.

Another clear illustration of the change in perspective is the Redd Barna project in Uganda. Its current approach to make them support vulnerable groups is geared towards empowering communities to be more capable to identify and address their own needs and problems, i.e. an effort at identifying and initiating sustainable processes at the local level. The country team recommends that this case should be well documented and shared with other organisations in Uganda and outside the country.

It has also become increasingly evident that interventions have to be more carefully targeted than was often the case in the early stages of the epidemic. In Tanzania only few interventions have been directed at women and children, e.g. UNICEF's school education programme and a separate women's group. The Zambia team reports that NGOs have had interesting responses to needs with a variety of skills training for affected individuals, families and children, while the response of government agencies is usually less innovative. The SAG funds have been targeted at vulnerable groups, such as commercial sex workers and orphans. The members of uniformed services were difficult to contact; activities had to be built up slowly. Efforts at involving traditional healers also proved difficult, not least because they are by no means a homogeneous group. One overall conclusion here is that interventions need to also address men, if efforts at reducing the spread of HIV are to have an effect.

There is also scope for broader perspectives. In Zambia, the home-based care approach demonstrates an interesting enzyme effect by linking care with preventive community counselling. And anti-AIDS clubs in schools proved ineffective without parallel initiatives directed at teachers. Although support for developing a multisectorial approach came early from Norway, figures clearly indicate the difference between estimated needs within non-health sectors and the more general availability of funds there for HIV/AIDS interventions.

It seems as if several projects, starting from a target group (e.g. commercial sex workers or orphans) orientation and a clear focus on AIDS have moved towards targeting community development and broader health problems like Sexual and Reproductive Health in general. The Masaka project has developed from orphan to community focus and from AIDS to wider health interventions.

The NGO projects have in some cases moved from target group focus to community interventions, but still focusing on AIDS. The project run by Norwegian Church Aid in Tanzania is another example where initial activities were focused on the target group (commercial sex workers) but were switched towards community activities in order to reduce the risk for girls to

have to go into prostitution. There is an apparent dilemma: Widening from a clear focus may «dilute» the programme, ultimately giving less attention to the victims, or potential victims, of AIDS.

At the national levels, integration is a key issue. In Uganda, the integration of HIV/AIDS into other programmes of the MoH or into ongoing programmes of other ministries, is reported as unclear. One reason for holding back in the first respect is fear that if HIV/AIDS is integrated into a local PHC context, it will be marginalised and receive reduced funding. The country team suggests that now, five years after the establishment of the Uganda AIDS Commission, the reasons for the low level of mobilisation outside the health sector should be analysed, and conclusions drawn for future action. The team further emphasises the role of decentralisation and of the local councils in the country, where various sectors of the Ugandan government services are being decentralised to the district level, a process that works against verticalism. The Tanzanian and Zambian teams also address the issue, asking whether efforts will be made to change from being mainly a vertical AIDS programmes, in the health sector to an integrated component of PHC services.

The country teams also address the issue of co-ordination, which should be seen as part of the donor approach discussion. When donors want to direct their money to specific purposes, implementors may find themselves in a fix, i.e. with needs that nobody will cover. Donors should get together over this, says the Zambia team, noting that there is still a long way to go before country level co-ordination is satisfactory. Donor organised coordinating committees may be useful, but can easily become involved in operations. If this happens, donors should raise the discussion about roles again, so that these can be kept separate, for the benefit of the programme. UNAIDS seem to have addressed these kind of problems by establishing country theme groups. It remains to be seen whether these will effectively carry out this task.

Summing up impressions as regards the approach to HIV/AIDS, the team finds two things convincingly demonstrated: (i) that both broader and more specifically targeted interventions are now required, and a sustained effort at integrating HIV/AIDS issues in almost all sectors of society, and (ii) that Norwegian aid on the whole has been able to adapt to these changes, and even in some cases contribute to creating and disseminating new knowledge.

5.2 What denotes a «good project»?

One ambition expressed at the creation of the SAG was that «models» for AIDS work -and particularly prevention of HIV transmission – should be developed and tried. The wide range of strategies supported and the diversity of the problems faced in the different settings makes, however, such a model development impossible. Nations and local communities must develop their own programmes, supported, of course, by experiences of strategies and intervention methods gained in other areas. Having said this, the team has found it possible to define some characteristics of projects supported by Norwegian aid.

A variety of project strategies have been given support via the SAG. It seems as if a more uniform community-oriented approach is now common. It is important that strategies are discussed with and made clear to everybody involved in the project. This is, in fact, a kind of prerequisite for the establishment of a flexible project design, where deviations from the initial strategies could be clearly described and argued for. The team also concludes that a community development approach seems to be most appropriate, but that it requires that focus on target groups will be retained. The focus on women and children seems a bit out-dated and not quite an appropriate strategy today. It is now generally agreed that special efforts to reach males is required if safe sex practices are to take root in community lifestyles.

The implementing organisations should at least have some staff with particular skills in AIDS work and should also have enough management capacity to make continuous follow-up, reporting and quality control possible. This may be impossible for small private organisations. Since it is, admittedly, important also to involve such organisations one idea could be to advise these to link up with other, bigger, organisations with a similar basic philosophy. Another possibility would be that the donor agencies stimulate the creation of local NGO networks and alliances.

As has been reported by the Zambia country team, a common feature for local NGOs with a seemingly successful programme is that they have a strong, capable and usually charismatic, dedicated person in the lead. It might be that such persons are more or less necessary during an initial period, but the organisation may need special support to develop a broader base. The successful programmes studied usually have a close co-operation with other NGOs or other institutions. Hence the

team argues that potential networking capacity should be an important factor to be considered while discussing support to NGO projects.

Some concern about the sustainability of projects, supported from abroad but implemented by local NGOs has to be expressed, based on the observations made. Networking and local capacity strengthening seem to be critical factors for sustainability. Other key factors for seemingly successful project identified by different NGOs are community people by project staff, the empowerment of both women and men, sound financial management, good training programmes, micro-credits, and – not least – allowing for the time needed for change to occur.

5.3 Objectives and channels

The discussion about the channelling of aid funds distinguishes between three options for the government – the multi- and bi-lateral and the Norwegian NGO option through NORADs «NGO» department. But looking more closely at these three options shows that further down the road, the options become mixed. While multilateral channelling has largely meant WHO/GPA or UNAIDS financing for NACPs only (or TB programmes in two cases), funds channelled bi-laterally and through Norwegian NGOs can end up in a variety of places.

Bi-lateral funds through the Norwegian embassies can reach NACPs, other government programmes, and local NGOs. A local NGO can actually approach four or five sources for Norwegian government funding for one and the same NGO HIV/AIDS project – the NACP receiving GPA funds, NGO funds administered by the Norwegian embassy, the SAG funds administered by the Norwegian embassy, and Norwegian NGO funds emanating from NORAD, either under the SAG or under the regular NGO budget. Another case in point is UNICEF's highly relevant Primary School AIDS Education Programme in Tanzania, which has received both bilateral as well as multi- and bi-lateral Norwegian funding.

Also the contents of channelling funds through Norwegian private organisations vary in that some of them have close links with the local receiving organisations and are involved in their activities, even taking a professional responsibility for the utilisation of funds, while some others act more in a broker function, establishing the necessary contact and channel between donor and recipient.

The conclusion of the pluralistic and varied character of the structure is that it is difficult to judge one channel *per se* as more efficient or sustainable than another. Specific aspects of project activities have to be analysed in a more context related and relative fashion, a fashion that also has to allow for variations in constituency, objectives and access to resources.

The multi-lateral option

in this context has meant supporting, through WHO and its GPA and lately through UNAIDS, NACPs in a type of multi-bi-lateral arrangement. This contribution – indeed a major one – has been important. As confirmed by the Tanzanian country report, these multi-lateral funds for NACP have been used for relevant activities, although the efficiency may be lower than in some other projects because the NACP has not proved to be the dynamic actor that the country needs.

A relevant question, more or less explicitly raised by the Zambia and Uganda teams, however, is whether NACPs have had too much money. The SAG has, – just like GPA as a whole – contributed to the establishment and sometimes overequipping of NACPs, at least compared with other health programmes, and with other sectors in the recipient countries, which has negatively affected the possibilities and future prospects of integration. The issue here is how to achieve a better integration in the future.

As for destination, one argument is that when Norwegian funds are allocated for multi-lateral use through WHO/GPA or UNAIDS, they should not also be designated for specific countries by Norway. The position is that country earmarked funds should be channelled bilaterally. A discussion is requested concerning the future choice of channelling funds earmarked for specific NACPs through UNAIDS, or bi-laterally. The evaluation team does not find the earmarking of funds for individual countries incompatible with multi-lateral financing. This is being practised by several donors, and gives the Norwegian government the double opportunity of supporting HIV/AIDS interventions in general, and individual governments that are accorded priority from the Norwegian side, at the same time.

Summing up its impressions of the multi-lateral option, the team finds that it offers substantial advantages for the government, including the additional benefit of supporting the UN system. However, the evaluation team argues that a more active Grant policy follow-up could have given a stronger base for the continuous development of Grant strategies.

As just stated, *the bi-lateral channel* encompasses a variety of operations given support. The MUTAN project, although not really representative for the bi-lateral channel but heavy in terms of financing, displays both high relevance and achievement. However, the exclusive funding situation produced a situation that was sub-optimal in several respects. Without pretending to have evaluated the project, the team finds that field impressions confirm the validity of the decision to terminate the intervention in the form it had then. In several respects, however, follow-up issues still remain to be handled by NORAD. Notably, some substantial results were obtained, results that should now be put to the service of AIDS control in Tanzania.

An overall assessment is (i) that the bi-lateral channel offers Norway more possibilities of determine the specific utilisation of Norwegian funds, and of increasing the quality of intervention, should this be desired, but also (ii) that these possibilities have a price tag.

The country teams report positively about *the third channel, the Norwegian NGO, or Private Organisations, interventions*. The Uganda report notes that international NGOs usually bring along both confidence and impartiality, also working with a more open mind and with more flexibility than local administrations would normally do. But if they withdraw too early, or without having ensured local capacity building, concerned communities can often not sustain the programmes started. The Zambia team reports that NGO interventions have been able to establish a link between care and prevention, to harness the enthusiasm of individuals and of NGOs, to allow communities to decide themselves, to work with freedom and flexibility, and to support inter-sectorial activities. With Norwegian financing, NGOs in Zambia have also produced some fine models of intervention that are now being replicated elsewhere in the country where the strategy fits sell into the local context.

In comparison with the multi-lateral channel, the bilateral channel – particularly the embassy funding of local NGOs – seems to be quite cost-intensive in terms of administration. The Zambian country report states that more than 20 decisions were taken per year, contributions averaging NOK 350,000, the smallest one being as little as 3,000. In Zimbabwe, where the SAG activity has apparently also been intensive, about 15 projects were initiated annually during 1992–1995. The evaluation team does not have information on the number of application not endorsed. The bi-lateral channel to local NGOs is also highly dependent on individuals, on who is managing the funds at the local embassy level. An active person can generate a substantial programme, while otherwise very little will happen.

As regards the sustainability of results obtained, the Zambian team reports question-marks, seeing sustainability rather as depending on the overall economic situation in the country, and thus not achievable at present. The team highlights two different aspects of sustainability: financial resources and human resource development. The latter has been achieved, at least partly. The country team does not define a type of actor or organisation as less or more successful in this respect, but states that NGOs at least have begun to consider the problem of sustainability seriously. The team further reports that in southern Africa, governments are more and more interested in mobilising NGOs for social sector work, including HIV/AIDS. However, this should not be seen that gradually bi-lateral health sector support may increasingly be channelled through NGOs.

The financier's requirements as regards reporting and follow-up varies considerably between channels. Norwegian private organisations feel that while MoFA accepts highly aggregated WHO/GPA reporting without any real possibilities of actually following up the use of the quite substantial Norwegian funds, NORAD's requirements as regards NGO reporting go into details to an extent that may affect the reliability of the data delivered. On the other hand, an independent argument is that the administration has no real quality control as regards the private organisations, in spite of the detailed reporting coming in. The team concludes that the system of follow-up of NGO projects might have to be reviewed, presumably limiting the requests for continuous follow-up, but instead reviewing larger and long-term projects more carefully.

Based on the findings reported in section 4 above, the team would also like to draw attention to the *potential built-in conflict between different agendas* and objec-

tives. In the evaluation work, it has sometimes proven difficult to say whether the SAG supported activities have achieved their objectives or not, as the organisations chosen as channels may have objectives of their own, possibly different from those of the SAG. That a donor who finances a package of activities within an agreed agenda of an organisation also finances other activities is a classical donor dilemma, to a varying degree present in this programme. Normally, donor influence varies with the degree of constitutional and financial independence of the organisation. While, for example, a consultancy company may be expected to have no – or only marginal – objectives in addition to the agreed agenda, a UN Specialised Agency or a Norwegian private organisation may have considerable agendas of their own that are going to be implemented in addition to the one agreed upon with the donor. Independent NGOs in recipient countries often take an intermediate position in this respect.

The team has noted that the strong political signals about the importance of combating HIV/AIDS as part of Norwegian foreign aid that were sent on the occasion of establishing the SAG have not been repeated – at least not explicitly – since then. This development is in line with the general change of attitude towards HIV/AIDS in the world and in Norway. This gradual change has been accompanied by a growing attention to the needs of also combating other STDs and other diseases, and of strengthening PHC services in a broader perspective. The team takes it that this view of health promotion as such has already affected Norwegian policy thinking in this respect, and will also be part of strategic decision-making for the future.

5.4 Management and administration

Depending on the choice of channel for implementing the SAG, procedures and conditions vary. More than 40 % of all SAG funds, over 210 MNOK, have gone through WHO, another 34 million going through UNICEF, the World Bank and UNDP. In terms of administrative and technical resources used per NOK disbursed, this multi-lateral component of the HIV/AIDS programme has clearly the lowest ratio. The MoFA multilateral department follows the programmes at the global level, giving a main priority to financing issues, and the technical contents and pace of implementation of AIDS programmes both at the global level and at country levels are being followed by the AIDS advisor, located at the Board of Health.

The department also invites the AIDS advisor to write annual proposals for the overall distribution of SAG funds. After being submitted to NORAD for comments, this proposal is subsequently transformed into a complete annual plan and submitted to the Minister for approval. The management in the department of an annual 50 MNOK in SAG funds is typically low-cost.

The bi-lateral component of the SAG, i.e. the one that flows through the Norwegian embassies and the NORAD permanent representatives there, uses more human resources. Embassies present their requirements to NORAD for the annual allocation of funds, just like UN organisations present theirs to MoFA. But in addition, Norwegian embassy staff is engaged in appraising every request from a local organisation or institution, subsequently also following implementation and reporting at the local level. While this requires, or sometimes presupposes that additional staff can be recruited locally – some embassies have asked not to be allocated funds from the Grant because it is complicated to handle – it also creates a continuous contact with local developments that can be fed back to Norway and used in the further execution of the programme.

As a complement to the country programmes, the SAG allows embassies to manage additional funding of HIV/AIDS activities. The Zambia team reports that the rather decentralised NORAD management model has contributed to the fact that the most effective and innovative NGO AIDS prevention projects in that country have all received Norwegian funding.

However, NORAD technical staff in Oslo feel that time does not permit them to interact in a satisfactory way with the embassies. Overall, technical competence within NORAD has been cut down, which means that the availability of technical advice is quite limited. Both bi-lateral and NGO staff within NORAD, and the multilateral department of MoFA, rely on the AIDS advisor in the Board of Health, who is in practice the only technical person in the structure, as well as an entry point into the technical sphere in Norway. As this person is used both for the SAG implementation in three channels and in practice also for policy formulation, the team finds that an unusually low-cost management construction has been formulated for the SAG. However, the team thinks that this also has a draw-back – a fully satisfactory monitoring and follow-up exercise has not taken place.

The NGO channel seems to use most Norwegian resources per NOK spent. All individual projects are scrutinised, at least, by the AIDS advisor, and by the staff of the NGO itself.

The team wishes to report that management procedures are not considered to be satisfactory by Norwegian private organisations, who convey the impression that NORAD staff are more anxious about the rules being followed than being concerned about the work as such, that NORAD's initial action oriented relations with private organisations have become more and more bureaucratic, and that administrative procedures tend to become more important than technical aspects.

Evidently, the team has also received expressions of appreciation, where the relation to NORAD is assessed as one of mutual confidence, and where the great value of the SAG funding for important purposes is confirmed. But the team found the expressions of dissatisfaction with the administrative aspects of the co-operation prominent enough to be reported back to those concerned.

5.5 Special Grant implications

In the field, as has been reported by the country teams, the SAG has played a significant role in helping to get activity off the ground. In Tanzania, the SAG has been instrumental in mobilising society, particularly NGOs. In Zambia, NORAD started early to support local NGOs on a broad scale and to require their co-ordination with NACP requesting NACP to evaluate NGO project applications before funding. Norway was probably the first donor to apply a multi-sectorial approach. Also in Zimbabwe, the SAG gave the Embassy an opportunity to reach organisations that could not have been to accessed through the country programme.

This confirms, as has also been reported in section 3, that one of the basic intentions behind the creation of the SAG, to attach a higher priority to HIV/AIDS in development co-operation, and to promote and finance HIV/AIDS interventions in an extra-ordinary fashion, was fulfilled. However, special funds which are a classical donor instrument for promoting a specific issue, usually also need special support measures, such as the revision of plans and methods for implementation as conditions change, or the follow-up and review of policy support for the intended operations. It is in this latter respect that the team finds it necessary to voice some criticism.

Initially, the AIDS policy function within Norwegian development co-operation was located at the bi-lateral department of MoFA, although logically it should probably have been located within the then programme department. At the time, the role of the programme department was being questioned as part of the debate around the division of responsibilities between MoFA and NORAD. For this reason, the SAG was already initially not endowed with a strong co-ordination function at MoFA, as compared with other Special Grants. The guideline decision of 1992 to hold an evaluation of the SAG in 1994 – to be used for a revision of the same the SAG guidelines – has to be seen in this light.

The formal responsibility for overall SAG management, presumably including policy development and co-ordination, has been with the multi-lateral department of MoFA and NORAD. However, there has been a focus on financial and management issues, and not much on comprehensive AIDS policy work, which has not been seen as a task for these bodies. In reality, current programme co-ordination is vested in the NORAD/Board of Health AIDS advisor, as has been stated in the preceding section and he/she has also been most influential in policy and strategy work. The team finds that a broader base for this work, including competencies from different fields and maybe also decision-makers, had given a stronger base for Grant planning.

It would appear, however, that follow-up action has been little or minimal. Apart from the current operational co-ordination performed by the AIDS advisor or other action based on his or her contributions, the team has found no co-ordination or other management input in terms of policy or guidelines since 1992. An introductory NORAD-NGO seminar in that year, addressing key issues in HIV/AIDS work, was also not followed-up.

Political priorities have changed. The inception and construction of the SAG was fundamentally triggered by a general feeling of an acute crisis, which was basically menacing the whole world, and by the attending political attention to the matter. With the change since then in perceptions of HIV/AIDS that have been referred to above, it is also logical that political priorities would change. But the team is critical of the lack of follow-up of performance and issues at professional and

technical levels by MoFA and NORAD. This may have entailed two types of consequences: (i) the SAG funds could have come to an even better use than they did, and particularly (ii) the HIV/AIDS aspect or issue could have been integrated into other sectors and programmes. This, in turn, could have facilitated the phasing out of the SAG, now imminent – but planned and known for several years -, and the switch of the financing of HIV/AIDS interventions from the SAG to regular sources, such as country programmes or NGO budgets. This could also have made the SAG an even more valuable tool in Norwegian development co-operation than it was.

The most important areas of concern in this policy follow-up perspective are – as has been discussed above – the approach aspects of HIV/AIDS interventions – bringing the multi-sectorial perspective, community participation, and the combination of prevention and care into programming at an early stage – and the integration of HIV/AIDS issues in other sectors and line ministries, and in other health programmes.

5.6 AIDS research

Norwegian aid does not follow any overriding policy in relation to research and its importance for development. The MoFA and NORAD have, however, supported research projects in developing countries and have also together with the Norwegian Research Council, NAVF attempted to stimulate Norwegian development research within the field of health. When the SAG was created in 1990, there were huge knowledge gaps in HIV/AIDS. In the SAG guidelines (1992) it is emphasised that AIDS-related research should be carried out in collaboration with local research institutions and aim at capacity building in developing countries. It also underscores that priorities should be defined by the developing country itself and that research should contribute to the local AIDS work.. There is, however, no statement that research could or should be supported via the SAG, which the evaluation team finds remarkable. One reason for this, given to the team, was that the Norwegian research capacity was weak. The SAG chose to give considerable support to GPA, which also conducted research. In order to monitor and evaluate this research, Norwegian development assistance, however, needed access to competent Norwegian researchers. This specific competence is best achieved through research in collaboration with developing countries. Research capacity building in low-income countries takes at least 10–15 years. Global experience tells that this is best achieved by bi-lateral endeavours and not through the UN system. It is also well known that multi-disciplinary and intervention research call on specific human skills, mutual trust and a long-term perspective. The evaluation team believes that the MUTAN project had the potential of achieving such capacity strengthening given the necessary adjustments. Only in this way, it is possible to draw valid conclusions and thus make recommendations for further application. Our conclusions and recommendations are that research should be promoted in order to further strengthen Norwegian development assistance in relation to HIV/AIDS. One way to achieve this is, in our mind, to stimulate Norwegian research in relevant fields, which would also increase the capacity for programme appraisals and follow-up. At present, priority should not be given to basic biomedical studies, but be directed towards human behaviour research and health systems research, e.g. concepts and believes in relation to HIV/AIDS, determinants for seeking care and intervention-oriented studies.

5.7 UNAIDS – appropriate channel for future Norwegian support?

Norway is one of the four biggest contributors to the UNAIDS budget. In 1996, USAID contributed about 30 % and Denmark, Norway and Sweden together another 30 %.

UNAIDS is now exploring possible alternative ways of funding AIDS activities, particularly through an activation of private-public mechanisms. A system is being developed where they try to get support from private companies to contribute to AIDS activities both through sponsoring AIDS-related projects and by stimulating companies to incorporate appropriate AIDS prevention measures in their regular activities. There seems to be a positive response to the idea to develop a mechanism through which donors could support projects in developing countries on a direct basis, but via the «UNAIDS International Business Council». This modality might be useful for e.g. NGO support to developing countries. These strategies are not to be used for the UNAIDS core funding, but could be a mechanism to facilitate complementary programmes.

A small office of AIDS and STD control (ASD) remains at WHO. There are three staff members and an

annual budget from WHO core funds and Japanese extra-budgetary funding, in all about USD 160,000 per year. Added to that come funds for eight health projects, previously run by GPA and still implemented via WHO. The main tasks are to give WHO input, particularly technical input to UNAIDS and to stimulate and coordinate AIDS-related activities within the different WHO programmes.

On a central management level the UNAIDS structure seems complicated. It might be important to get interested parties together on a Board and it might strengthen the feeling of ownership to have different actors on the Board (not only donors like in the GPA management committee), but the fact that the six sponsoring agencies have to agree on a joint STD strategy and funding mechanism may make management cumbersome. On the other hand these problems of intersectorial collaboration have to be solved on a global level in order for the basic idea not to become a failure on the local level.

The role of donors is also unique within the UN system in that they interact both directly with UNAIDS and with the individual co-sponsoring agencies. To avoid confusion and inefficiency the donors have to take similar stands in UNAIDS as well as in the six co-sponsoring agencies. This, in turn, means that donor communities will have to be very clear about their strategies – and make sure that they are promoted by all relevant country representatives within the UN system, down to country level.

The UNAIDS structure also raises the question of a possible need to strengthen the HIV/AIDS activities in some of the co-sponsoring agencies. If the system is to work smoothly the co-sponsoring agencies must have a) technical competence within their field which is relevant to AIDS and could be made accessible to UNAIDS;

b) awareness of and knowledge about AIDS in general in order to make them efficient partners in the programme development. This means that the six organisations should have resources enabling them to take these roles.

On the regional level there are offices of different UN agencies. UNAIDS is now going to set up inter-country teams in order to support the theme groups in the individual countries. The need is there, but the mandate has to be made very clear and precautions have to be taken in order to avoid clashes with the already existing structures.

On the countrylevel there are similar risks for confusion and frustration. Our country missions have met queries about the efficiency and appropriateness of UNAIDS. It is apparently not easily understood that UNAIDS tries to adopt a different role than GPA, with less external input and less funding capacity but with an emphasis on creating a sustainable infrastructure with sensitivity to the priorities set by the countries. It also has to be understood that setting up a new structure takes time.

The donors may prefer to follow their own priorities in terms of which countries and which programmes should be supported. It is our opinion that the donor community has to make sure that a core support to the UNAIDS organisation is primarily secured. Secondly, there could be room for donors to support individual countries or programmes according to their own choice. UNAIDS has taken up the challenge to develop private channels for funding and stimulating a private -public – NGO collaboration and to find ways of developing a mechanism where country theme groups, in collaboration with local AIDS programmes, set their priorities and request support directly from different donors. This might be a brand new mechanism which would stimulate a bottom-up approach hitherto not known in the UN system.

A general observation concerning the UNAIDS strategy is that it is process-oriented in an attractive way. There is a basic strategy to try to intensify the AIDS activities without making them some kind of emergency undertaking but rather to strengthen a process, built on local capacity and experience. The evaluation team finds it worth while to support this endeavour.

In terms of funding, Norway has been a most important actor in WHO/GPA. Since 1990 Norwegian contributions rank at place 5–6 among donors. About 1/3 of all Norwegian contributions to WHO programmes has been allocated to AIDS activities. Some funds have been used for «multi-bi»- programmes, especially for Tanzania, Uganda, Botswana, Zambia, Namibia and Zimbabwe. Norway has also been influential in programme development and operations, particularly through technical resource persons on a central level like C-O Wathne, S-E Ekeid and Jo Kittelsen. In conclusion, it is felt that Norway has a position and an experience in global AIDS programme development that should be maintained in the UNAIDS era. Norway

has also been pioneering in finding ways to work with NGOs, also within the multi-bi system and it has got a reputation of giving the support in a very flexible way and supporting human rights activities. The central positions of Norway as a member of UNAIDS Programme Co-ordinating Board and simultaneously the Board of WHO during the new mandate period, gives excellent possibilities for powerful action.

5.8 Future perspectives

The fight against the spread and impact of HIV/AIDS must go on. The evaluation team understands that the Norwegian government intends to continue to play its part in this important struggle. The team has also noted that all Special Grants within Norwegian development co-operation will be discontinued as from now, including the SAG.

In principle, the SAG support could easily be administered as components of multi-lateral support, as parts of country programmes, or continue as NGO support within the regular programmes of Norwegian private organisations. In the latter case, however, the budgets of some organisations will have to be increased to be able to cater for additional financing requirements.

In the cases where Norwegian country programmes are identified as the prime sources for continued HIV/AIDS project funding, the support to different line ministries needs to include a component of support for their HIV/AIDS programmes. The transfer of HIV/AIDS project financing from the SAG to country programmes is an ultimate goal, but as the SAG as a source of financing has been additional to the country programme this is also problematic, requiring agreement in substance and specific requests from the recipient government. This in turn would be easier to obtain if full effects of integration efforts could have been reckoned with.

6. Conclusions

The evaluation team has found that the Norwegian contribution to global HIV/AIDS control during 1990 – 1995, has given a significant input, financially and in terms of development of strategies on different levels. During this period of the development of the epidemic, the special construction of the SAG had a distinct impact on the development of programmes. Particularly it has been effective in mobilising Norwegian private organisations and NGOs in developing countries. In the following section main observations, with special reference to the objectives of the evaluation and requested conclusions (see Annex I), will be summarised. Although the SAG was turned down during the assignment of the evaluation team, some observations on the SAG management, which may be of some general interest, have also been included.

6.1 Grant objectives and framework

The team concludes that the guidelines of the SAG (1992) as well as other Norwegian AIDS activities were based on WHO/GPA strategies and hence, in concordance with them. The supported general objectives and intentions of the guidelines have by and large been followed. A few Norwegian NGO projects have been turned down before being accepted by NORAD, apparently due to lack of concurrence with the grant guidelines.

The team has also noted that, although support for improved multi-sectorial projects are mentioned in the guidelines, the SAG was, particularly during the first years, mainly used for activities within the health sector.

The SAG guidelines do also adhere to the over-arching policy for Norwegian aid and emphasises the aim to stimulate more HIV/AIDS related projects within the bilateral programmes. The team does, however, not find that SAG has significantly contributed to an increasing responsiveness to HIV/AIDS within the bilateral programmes. The three countries selected for review differs in terms of Norwegian health sector support: In Tanzania Norway has a bilateral health sector programme, in Uganda such a programme was finalised during the SAG period and in Zambia there is no such bilateral programme. Among these countries Tanzania has had the lowest utilisation of SAG allocations through the bi-lateral channel, in Uganda a few but generally large NGO projects have been supported while there has been a number of local NGO programmes in Zambia. The conclusion is that the construction of the SAG *per se* has not had any relationship with the presence of bilateral programmes in these countries.

During the six years under review the HIV/AIDS epidemic has changed, and so have the global and national strategies for control of the disease. The emphasis on flexibility, as expressed in the SAG guidelines, is hence appropriate, and so is the utilisation of different main channels of support. One consequence of this development is, however, that an assessment of the appropriateness of projects initiated during different periods has to be done with the dynamics of the HIV/AIDS issue kept in mind.

Multilateral support has taken slightly over 50 per cent of the SAG allocations. In general the distribution between different channels have been found to be appropriate. No explicit recommendation for the distribution between channels has been found, but according to information given to the team an equal share between multi- and bilateral channels has informally been argued for. The team has found that the «three channel system» has great advantages, but feels that a stronger and continuous strategy follow-up could have strengthened the programme. The AIDS advisor has an important function, but a technical input from specialists from different fields, working together with the MoFA offices, e.g. in a steering or reference group could have given a better opportunity to direct the SAG and increase the attention to the SAG in Norway.

In general, there seems to have been a clear focus on women and children in many projects, but as said above, it has been more and more common to target the activities to community work and not to certain target groups. During the course of this process, which in itself is definitely recommendable, special precautions have to be taken not to lose focus on weak groups and on the disease itself. A challenge for the future will be to keep the balance between an integrated approach, while maintaining a focus on the most vulnerable groups,

while the AIDS orphans will constitute an increasingly large share towards the year 2000. It is noteworthy that except for one school education programme few projects seem so far to have been focused on youth.

We have found that the co-ordination with the national programmes has varied a lot between different programmes. It is a general feeling that this is a rather weak point in the support. Tanzania seems to be one example where the Norwegian supported programmes have «bypassed» the NACP. The budget for the MUTAN project corresponded to 65 % of the budget of the NACP in Tanzania. Hence, the poor co-ordination could be explained by weaknesses by NACP and could rather illustrate a need to strengthen the capacity of these bodies. On the other hand, a practice was established in Zambia requiring that the national programme should endorse the NGO projects before funding, which illustrates a sound working mode.

In most programmes there is definitely a component of capacity and competence building, although this is sometimes not very well articulated. In a few programmes, like the Masaka in Uganda and the MUTAN project in Tanzania there has definitely been competence building on the side of the developing country and, particularly, in the MUTAN project in Tanzania, also on the Norwegian side. Projects like the SAIH-supported network in South Africa are also likely to have a strong capability strengthening effect in the community, although this is not often recognised. There has also been a strengthening of the Norwegian capacity, but it is not clear what expectations, targets and objectives MoFA and/or NORAD have in terms of strengthening the Norwegian resource base for development and research work related to AIDS.

Most local NGOs have been partly financed from the SAG. Many have had complementary funding from regular Norwegian Embassy funding for NGOs. In principle the SAG supported activity can easily continue as regular NGO support in the future. The budget for this activity is, however, under-utilised (in Tanzania).

The SAG has functioned as a complement to other funding sources. It is the conclusion of the evaluation team that other sectors and more regular funding must be encouraged to earmark money for AIDS related activity in the future.

The major proportion of Norwegian support has been directed either to WHO or to East African countries. In retrospect it could be stated that a more dynamic geographical approach, for instance supporting multi- and bilateral activities in the emerging high-endemic areas in South East Asia would also have been appropriate. An analysis of the situation during the latest years would also call upon attention to the emerging epidemics in Eastern Europe.

6.2 Management and administration

The team concludes that the MoFA has been open-minded in maintaining a relatively loose and decentralised system for management of the SAG. This would not have worked unless a special AIDS-advisor had been assigned, assisting in whatever matters might arise at MoFA, NORAD or elsewhere. The system has demonstrated a considerable strength, particularly in its flexibility.

The evaluation team has, however, identified some disadvantages with the SAG administration, e.g. that the SAG required a separate administrative system which could probably have been simplified. Another obvious problem is that the routines for support to Norwegian NGOs have been different from regular NORAD routines and have been changed during the period, which has created frustration among the applicants for funding.

The flexible system seems to have created confusion on what rules there were for part-financing and reporting by NGOs. It did also put a considerable administrative burden on some units, particularly Embassies in some countries. In fact, it seems that this administrative capacity might have had a certain impact on whether SAG funds have been used in a country or not. By and large the over-all management structure has, however, been found to harmonise with the grant intentions.

One major rationale behind the SAG was to make Norwegian AIDS interventions more visible. The management structure has certainly facilitated this, in the recipient countries, as well as at WHO/GPA. Norway became together with the other Scandinavian countries, not only an important donor but also a key actor, particularly at GPA, where also Norwegians served in high-ranking positions. To what extent the SAG, as such, has contributed to this visibility is uncertain, but it might be assumed that the manifested determination to the task had some bearing.

6.3 Effects and role of the Grant

Considerable and essentially successful efforts have been made to direct the SAG activities in line with the set objectives. There are also examples from several projects where innovative approaches have been tried. The explicit ambition to co-operate with partners in the recipient countries is also impressive and increases the possibility for sustainable achievements.

One example of a rather far-reaching system to strengthen the local impact is the development of indicators for monitoring the progress of the MASAKA project in Uganda. Since it was felt that indicators ought to be developed within the community and together with the community members a system aiming at strengthening a process of monitoring and evaluation which is «owned» by the community has been introduced.

It has hardly been possible to develop general models for AIDS work during the limited time of operation of SAG, and with so many different approaches and sites, but attempts are being made. There is a definite move towards developing community integrated support systems. A general problem is the weakness in disseminating experiences and the shortage of research documentation.

The issue of sustainability of projects is also complex. The team has got some indicators allowing us to mention a few factors which have turned out to have some bearing on the success of a project and possibilities for sustainability once the supporting organisation is gone. Community participation, autonomy and ownership are central factors. Enough freedom and flexibility to try innovative approaches are also important, as is support for inter-sectorial work and a combination of care and preventive work. Networking with other organisations and a plan for local capacity strengthening are other important factors.

Research has mainly been supported via the MUTAN project, i.e. outside the SAG. A more systematic and extensive approach particularly to intervention- and system-oriented research had been desirable.

The SAG has definitely made it possible for Norway to take an active and important role in the global discussion on AIDS. One cause is the substantial funding offered by Norway. But, in addition, from contacts in developing countries and discussions at WHO and UN-AIDS the team has got clear evidence that Norwegian AIDS work is well known mainly for its flexibility, its humanitarian features and its efficient implementation. The Norwegian support via NGOs is also well recognised. The team has also come to understand that Norway, after some initial hesitation, has now become a strong supporter of UNAIDS. This is clearly well known and gives Norway a central role in the future development of global AIDS work.

7. Recommendations

The Norwegian Government is recommended to continue to give a substantial support to control of the HIV/AIDS epidemic although the SAG is closed down. Norway now has an excellent opportunity to use SAG experiences for AIDS promotion on a global level due to the fact that Norway will in the running mandate periods have seats in the WHO Board and in the UNAIDS Programme Co-ordinating Board.

The team recommends the following to be particularly considered:

1. Channelling and framework

1.1 Grants from different sector programmes at NORAD – not only the health sector – should be allocated for HIV/AIDS control.

1.2 Different channels (multi-lateral-; multi-bi-; bilateral-) for the support allocations should be used also in the future.

1.3 Within the bilateral programmes ways to gear support directly to the district (or corresponding) level should be sought in countries where the decentralised government system is implemented. This would reduce the risk for verticalisation of programmes and presumably promote multi-sectorial activities.

1.4 A continuous support to Norwegian NGO projects is recommended. Whenever appropriate, this should be included in frame agreements with NORAD. Small organisations with limited administrative capacity should be advised to collaborate with bigger organisations. A part-financing system like the regular NORAD system seems reasonable.

1.5 Norwegian NGO projects should be given priority if they:

- address the community and promote community development
- identify relevant target groups, e.g. young women and men, children and orphans.
- operate in close collaboration with a local private organisation and/or within a local or regional network.
- have a trustworthy strategy for phasing out after a certain period of time.

2. UNAIDS

2.1 The UNAIDS co-sponsoring agencies should be supported in order to further develop their technical competence in HIV/AIDS matters. It is particularly important that the technical competence built up at WHO will be further developed.

2.2 Norway should retain its core support to UNAIDS and, via the UNAIDS initiative, find ways to support different sectors in bilateral development co-operation countries. A close co-ordination with the UNAIDS country theme groups is recommended.

3. Geographical areas

3.1 Norway should consider supporting countries where the epidemic is in an early stage and where strategies are poorly developed, particularly in South and South-East Asia and Eastern Europe.

3.2 In such countries the promotion of a variety of local projects, like in e.g. Zambia during the early 1990s would be beneficial. If NORAD runs a bilateral health sector programme with NGO grants in the country this will be easy. In countries where NORAD has only other sector programmes special efforts should be made to activate these for AIDS related activities via NGOs. In countries where there is no bilateral NORAD programme at all there is still a possibility to work through Norwegian private organisations or via international organisations, stimulating them to draw upon experiences gained from the SAG work, particularly the activities of the private organisations.

4. Research

4. An agenda for HIV/AIDS related research with the ultimate aim to test different intervention strategies should be established and promoted. It is recommended that the task to suggest guiding principles for this should be among the duties of the AIDS advisory group (see 5.2).

5. Policy development

5.1 The function as a special AIDS-advisor should be retained.

5.2 An AIDS advisory group should be constituted for development of policies, strategies and multi-sectorial approaches for Norwegian AIDS related aid and for continuous assessment of the AIDS activities. Experts from different fields should be appointed to this group in order to secure a broader base for the AIDS Control Support and the AIDS advisor could serve as the secretary.

Annex I

TERMS OF REFERENCE:
EVALUATION OF THE SPECIAL GRANT TO PREVENT AND CONTROL OF HIV/AIDS

I. INTRODUCTION

1.1 Norwegian development assistance to prevent and control HIV/AIDS was initiated in 1986. During the period 1986-89, approximately NOK 221 mill. was spent for this purpose funded from the Emergency Grant. In 1990 the Special Grant was established.

1.2 The rationale behind the Grant was i.a:

- to make Norwegian support and efforts in this area visible,
- to promote flexible use of Norwegian funds in relation to a quickly expanding epidemic,
- to facilitate implementation of long term efforts within the framework of NGOs.

1.3 For 1990 and 1991 NOK 55 mill. were respectively allocated for this purpose. The amount was increased to NOK 65 mill. in 1992. A similar amount was granted for 1993 and 1994. For 1995 70 mill. has been allocated. This represents a total amount of NOK 375 mill. for the whole period.

1.4 Channels for allocation, disbursement and use of the Grant are several. The Multilateral Department has provided core funding to WHO, UNICEF and UNDP. NORAD's part of the Grant has been administered by the Regional Department of Asia and Latin America (ALAT), the Regional Department of Africa(AFR), Department of NGOs, Volunteers and Cutural Cooperation (PRIV) and the Health Division (HELSE). Efforts against HIV/AIDS are also supported through other votes. A Technical Advisor has since 1988 been funded by NORAD, placed in the National Board of Health, in order to strenghthen technical follow- up of assistance.

So far the Special Grant has not been evaluated.

1.5.0 Grant-guidelines, adopted in 1992, are emphasizing the following:

1.5.1 Norwegian assistance to prevent and control HIV/AIDS in developing countries shall be strengthened through implementation of activities that promote integration in long term development cooperation such as country programmes, multi-bilateral efforts and assistance through NGOs.

1.5.2 Norway will promote coordination on country level, including strengthening of national HIV/AIDS programmes and -committees.

1.5.3 Norway will support WHO's leading role in technical matters.

1.5.4. In light of the spread of the epidemic and subsequent social consequences , NORAD should review their country programmes in severely affected countries in cooperation with local authorities with the purpose to strengthen Norway's efforts.

1.5.5. Particular emphasis shall be put on activities directed towards women and children

1.5.6. Flexibility shall be observed in the management of the Grant in order to secure support to the efforts and participation of "weak" groups, and to improve multisectoral approaches.

1.5.7. The Special Grant shall mainly be used preventively. Exempt of this main rule are pilot projects in new areas or with new technical content/orientation.

1.5.8. In applying the Grant, special priority will be given to Africa south of Sahara .

1.5.9. It is the aim that the Grant shall not be utilized to full- finance NGO-activities. Flexible transitional arrangements will be established.

1.5.10. An evaluation of the Special Grant shall be undertaken in 1994., based on accumulated experiences.

2. OBJECTIVES OF THE EVALUATION

2.1 The main purpose of the evaluation is to provide basis for the Ministry of Foreign Affairs (MFA) decision on the possible continuation of the Grant. The evaluation shall analyse the use of the Grant in relation to guidelines, Norwegian development policies and recommendations from the World Health Organisation(WHO).

2.2 An important evaluation-objective is to find out if the Grant has contributed to increased emphasis on HIV/AIDS-considerations in Norwegian assistance generally; advantages and disadvantages of the Grant-arrangement in relation to ordinary channels and what difference- if any- its existence has made, particularly in partner countries.

2.3 The purpose of the evaluation is to use data from i.a country studies - studies which are based among others on assessments of selected individual activities, to validate general conclusions and recommendations on future Norwegian HIV/AIDS-assistance, including its management and administration.

3. SCOPE OF WORK

The evaluation shall comprise, but not necessarily be limited to review, assess and analyse the following:

3.1 Grant-Objectives and Framework

The team shall:

3.1.1 assess the appropriateness of Grant-guidelines in relation to the prevalence and expected future trends of the epidemic, overall objectives of Norway's assistance and the recommendations of WHO.

3.1.2 discuss concurrence between guidelines and utilisation of the Grant in the bilateral and multilateral context. Specific emphasis shall be given to the following issues:

- have activities towards women and children been given due priority
- have coordination on national level been promoted and national programmes and committees strengthened
- have capacity- and competency-building in local and national organisations been prioritized
- are Norwegian funded activities duly integrated into the administration of recipient countries or relevant NGO-networks.

3.1.3 consider the Grant's volume and distribution through respective channels, in relation to overall aims, its function as a substitute for funding from regular sources and in relation to present geographical concentration, .

3.2 Management and Administration

Based on a systematic breakdown of activities/projects supported by the Grant, the evaluation team shall *briefly* describe and assess:

3.2.1 relevance and efficiency of the management model selected for Grant utilisation. Possible improvements shall be identified.

3.2.2 how the Grant has been introduced and promoted to potential applicants by the Programme-, the Multilateral Department and by NORAD, including the offices of Resident Representatives.

3.2.3 experience with the Grant in making Norwegian support visible and as a flexible tool for the implementation of the HIV/AIDS- guidelines. Can likely flexibility be maintained if the Grant is terminated, how and at what costs?

3.2.4 the advisory role of the Norwegian National Directorate of Health.

3.3 Effects and Role of the Grant

The Grant's channels converge in the partner countries. Impact, achievements of objectives (effectiveness), efficiency and sustainability of activities/projects will thus be considered in the country studies based on a selected review. The following perspectives shall be pursued:

3.3.1. Achievement of objectives

- To what extent have Grant supported activities/projects achieved their immediate objectives? What has been the wider impact of the activities?

- What are key factors determining the extent to which activities/projects are able to achieve their specific objectives?

- What are other effects, intended and unintended, resulting from the supported activities/projects?

- If feasible, achievements of Grant supported projects/activities shall be compared with those of country programmes.

3.3.2 Efficiency

- Have activities/projects been executed efficiently?

- Have overall costs been appropriate to range, level and distribution of benefits?

- If feasible, efficiency of Grant supported projects/activities shall be compared with those funded through the country programmes.

3.3.3 Effectiveness

- To what extent have Grant Supported projects/activities in planning and implementation to emphasized especially the needs of women, local capacity building, regard for ethical, cultural and human rights?

- If feasible, effectiveness shall be compared with projects/activities funded through the country programme etc.

3.3.4 Sustainability

-Are organisations/institutions/projects/activities supported likely to continue beyond project completion?

- Do activities etc. have the necessary support from beneficiaries, e.g in the form of active participation, operation of facilities and use of services?

- Do activities stimulate local mobilisation of resources?

- What indications of multiplier effects or projects' replicability exist?

- If feasible, sustainability shall be compared with projects/activities funded through the country programmes.

3.3.5 Specific issues

3.3.5.1 An assessment of the national aids programmes as focal points in the battle against aids shall be made. Similarly, the effectiveness of external support to the national aids-programmes and if they function as integral parts of the national health systems, shall be considered.

3.3.5.2 Has the Grant contributed to increased attention and improvement concerning HIV/AIDS activities in general assistance activities? It shall be analyzed whether activities funded from the Grant might have or have become financed from ordinary budgets. If ordinary financing of the selected activities has been available, the team shall discuss whether financing has been justified by other reasons.

3.3.5.3 To which degree has the Grant contributed to develop models to reduce social and economic consequences of HIV/AIDS?

3.3.5.4 Comment on possible differences in Grant-implementation between main partner countries, NGOs and multilateral organisations. Have procedures been established for the mainstreaming of aids related activities in the main multilateral agencies? -

3.3.5.5 Assess the profile/achievements of Norway in international fora/organisations with regard to policy development, innovative approaches etc.

4. CONCLUSIONS AND RECOMMENDATIONS

4.1 The team shall present conclusions regarding

- the extent to which the aims of the Grant have been achieved
- the impact, effectiveness, efficiency and sustainability of supported activities
- the relative effectiveness of the different channels of assistance
- adequacy of Grant-aims, -strategies, -financial frame, -regulations and -procedures
- advantages and disadvantages of the arrangement
- the coordination of the Grant on country level
- the Grant's catalytic role

4.2 Based on the above, the team shall discuss future options regarding prolongation or termination of the Grant. If relevant, recommendations concerning future financial frames, priorities, aims, guidelines, choice of channels, geographical concentration and administrative routines etc. shall be presented.

5. METHOD AND ORGANISATION

5.1 The evaluation shall be based on

-registry/document studies
-a breakdown of Grant-allocations
-interviews and dicussions with relevant personell
-field investigations in three countries (approach and methodology to be further discussed)

5.2 The evaluation shall be implemented by a team with international competence in the following disciplines:

-sociology(socialantropology)
-economy

-related health disciplines

5.3 NORAD and MFA will be requested to appoint contact persons to attend to and facilitate the contact between the evaluation team and these institutions.

5.4 The evaluation shall be implemented in 1996. A draft report shall be presented to the MFA before 1. December 1996. The assignment shall be completed before 15. December 1996.

Annex II

August 1996

TERMS OF REFERENCE FOR THE COUNTRY MISSIONS OF THE IHCAR/SGDS EVALUATION OF AIDS RELATED ACTIVITIES SUPPORTED BY THE GOVERNMENT OF NORWAY

Background

IHCAR has been contracted by the Norwegian Ministry of Foreign Affairs to conduct an evaluation of AIDS-related activities financially supported by the Norwegian Government 1990-1995. Evaluation of activities in individual countries constitute a central part of this evaluation.

Tanzania, Uganda and Zambia have been selected for such country studies.

The evaluation should consider projects (tiltak) supported through the Special AIDS Grant (SAG) as well as through bilateral country programmes (CP). The total funds for SAG during the stated period is about 365 mill NOK and via CP roughly 145 million NOK.

Key background documents

1. ToR for the whole evaluation: "Evaluation of the special grant to prevent and control HIV/AIDS". Norw. Min of Foreign Affairs, March 1996.
2. "AIDS-tiltak og norske bistandsmidel". Consultancy report by Terje Dalseng, May, 1996. (In Norwegian).
3. Inception Report. IHCAR/SGDS, June 1996.
4. "Notat" with comments on the Inception report. Norw. Min Foreign Affairs, August 1996. (In Norwegian).

General objectives

The objectives stated for the evaluation (see annex I) should guide the work. Particularly, the teams should evaluate the use of Norwegian funds for AIDS related activities in the three countries with regard to relevance, effectiveness, efficiency and sustainability.

Guidelines for the SAG were adopted in 1992 and emphasized the following items, that should particularly be considered (see also document 1) that:

1. the grant "should promote integration in long-term development",
2. it should "result in a better co-ordination of AIDS activities at country level",
3. special emphasis should be put on activities "directed towards women and children",
4. SAG management should be flexible in order to "secure support to "weak" groups and that a multi-sectoral approach will be used",
5. "the main thrust of the SAG projects should be preventive",
6. "NGO activities should be part-financed, only, through the grant and also receive financing from other sources",

Tasks

I. The assessment should include a brief description of the activities and overall assessment of their relevance, achievements and cost-effectiveness with special reference to the AIDS situation in the country and to other AIDS programmes or initiatives in the country. An assessment should also be made on the impact in terms of capacity and competence building.

II. Selected projects (tiltak) should be looked into more closely, including interviews with project workers, Norwegian and local staff in the country and beneficiaries. Other actors in the field (e g NAP; UNICEF; WHO;) may be approached to get a background to the HIV problem and AIDS prevention programmes in the country.

III. Consideration should be given to projects supported via WHO/GPA, NOGs, Ministry of Health, Universities etc. separately and advantages and disadvantages of different channels should be discussed.

Manning

The following country team leaders have been assigned:

Tanzania:	Dr *Minou Fuglesang*
Uganda:	Mr *Staffan Udeholt*
Zambia:	Dr *Gunnar Holmgren*

Each country mission will be constituted by a local and an external group, each one doing preparative work before the mission in the country. The teams will work together during a two-week mission in August or September 1996.

For each local group a leader who should initiate and co-ordinate the work before the external group has arrived has been appointed:

Tanzania:	Dr *A Akwira*
Uganda:	Mrs *C Oreyoba-Lalabo*
Zambia :	Mr *Francis Phiri*

Reporting

Oral presentation of the main findings should be given to Ministry of Health (NAP) and the Norwegian Embassy, if possible at a joint meeting, before the departure of the external team.

The local group will be asked to write short presentations on agreed topics, related to the specific sections of the evaluation, to present the team leaders before the departure of the external team, to participate in compiling a draft report and to comment on the final draft.

The country reports should adhere to the decided format (see Annex II) and should be finalised by the external team and be submitted to the project co-ordinator within two weeks after the end of the study.

IHCAR August 14, 1996

Bengt Höjer

Annex III

KAROLINSKA INSTITUTET, Department of Public Health Sciences,
Division of International Health Care Research (IHCAR)
and
Stockholm Group for Development Studies AB

EVALUATION OF THE NORWEGIAN GOVERNMENT'S SPECIAL GRANT TO PREVENT AND CONTROL HIV/AIDS

TANZANIA COUNTRY STUDY

Minou Fuglesang
Stefan Hansson
Angwara Denis Kiwara
Phare G M Mujinja
Issa Musoke
Staffan Uddeholt

March, 1997

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AIKA	AIDS Intervention in Kilimanjaro and Arusha project
AMREF	African Medical and Research Foundation
CEDHA	Centre for Educational Development in Health
CP	Country Programmes
DANIDA	Danish International Development Agency
GPA	Global Programme on AIDS
GTZ	German Agency for Technical Co-operation
	HBC Home Based Care
HIV	Human Immune Deficiency Virus
HTA	High Transmission Area
IEC	Informational Education and Communication
IHCAR	Division of International Health Care Research, Dept of Public Health Sciences, Karolinska institutet
KCMC	Kilimanjaro Christian Medical Centre
MoE	Ministry of Education
MoFA	Ministry of Foreign Affairs
MoH	Ministry of Health
MPH	Master of Public Health
MTP	Medium Term Plan
MUTAN	Norwegian-Tanzanian AIDS Project
NACP	National AIDS Control Programme
NAP	National AIDS Programme
NGO	Non-Governmental Organisation
NORAD	Norwegian Aid Agency for Development Co-operation
SAG	Special AIDS Grant
SAREC	Swedish Agency for Research Collaboration with Developing Countries
Sida	Swedish International Development Co-operation Authority
STD	Sexually Transmitted Disease
SWAA	Society for Woman Against AIDS
TAP	Tanzania AIDS Programme
TASO	The Aids Support Organisation
ToR	Terms of Reference
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UoB	University of Bergen
USAID	United States Agency for International Development
WAMATA	People in Struggle against AIDS in Tanzania
WHO	World Health Organisation
WHO/GPA	World Health Organisation/Global Programme on AIDS

Executive summary

Official figures gives a cumulative number of AIDS cases in Tanzania by the end of 1995 to about 81.500. Norway has contributed about NOK 78 million during 1990 – 1995, mainly to the Norwegian/Tanzanian AIDS project (MUTAN) and with smaller input, via UN organisations and Non-Governmental Organisations (NGOs).

Tanzania is one of the countries in Africa which has been severely affected by the HIV pandemic. Since 1988 the National AIDS Control Programme (NACP), located within the Ministry of Health (MoH), has been struggling to prevent the further spread of the disease by initiating surveillance, education and counselling. The situation represents a burden for the already strained health system. Current NACP strategy reflects the health and civil sector reforms being undertaken in the country. A multi-sectorial involvement is promoted as well as collaboration with the NGOs, decentralisation and community involvement. Activities have to a large degree been financed by various donors, although this source of funding is decreasing.

The Norwegian support to HIV/AIDS control in Tanzania activities and programmes has been drawn from different funding sources.

Support to the Norwegian/Tanzanian AIDS project (MUTAN) channelled over the bilateral «country programme», has played a major role and has been highly visible. This project, focusing on research, intervention and capacity building, was generously funded. It was relatively «relevant» and «effective» and had a multi-sectorial focus. It was also in line with the NACP priorities, but it was established as a separate structure. Thus activities, budgets and competence building were not a fully integrated part of the NACP. The project design proved, with time, to be inappropriate, in view of the current health system reform in Tanzania and a policy change of the Norwegian Agency for Development Co-operation (NORAD), increasingly focusing on the need to strengthen local management structures, and ensuring national and community ownership as well as long-term sustainability. As a result the project was brought to an end at mid-term in 1995.

The team is of the opinion that NORAD should work out ways in which to develop and continue the support of some of the most relevant and sustainable activities initiated by MUTAN. This can be done together with some of the resource people in Tanzania and Norway who's competence on HIV/AIDS control issues was exactly enhanced during the course of the project.

Support over the Special AIDS Grant (SAG) has played a more anonymous role but has been significant. In Tanzania the SAG funding has been channelled as general support to the NACP through the World Health Organisation/Global Programme on AIDS (WHO/GPA) and small scale support to NGOs such as AMREF and WAMATA with a few exceptions. Funding over the SAG has had a constructive effect, stimulated pioneering activities and has helped to build capacity. However, only in one exception (a UNICEF education project) has it been channelled directly to a sector other than that of health. The multi-sectorial guideline for utilisation of the SAG has been well in line with the goals of the newly established Joint United Nations Programme on HIV/AIDS (UNAIDS), and with the NACP strategy. However, the challenge to mobilise other sectors, such as that of education, largely remains. So far, the Ministry of Education in Tanzania as well as the education section within NORAD, the donor, has not earmarked funding for HIV prevention activities.

The team recommends efforts to be made to make the Norwegian support more multi-sectorial. Funds must in the future be drawn from activity of sectors. NORAD should also consider making its own advisory capacity on HIV/AIDS issues reflect a more multi-sectorial approach.

Finally, local NGOs need continued support. These could benefit from Norwegian assistance in this endeavour to form networks and alliances in order to share experiences and co-ordinate activity.

TABLE OF CONTENTS

1.	INTRODUCTION	73
2.	HIV/AIDS IN TANZANIA	75
3.	THE NORWEGIAN SUPPORT	77
4.	OBSERVATIONS AND FINDINGS	82
5.	CONCLUSIONS	88

1. Introduction

Tanzania, which includes the mainland and the islands of Zanzibar, belongs to a group of countries in Africa facing serious health and socio-economic problems as a result of the AIDS epidemic. As in all countries, the fight against AIDS continues as desired results have not been achieved.

The country has an estimated population of 27 million people (growth rate 2.8 % per year). The per capita income is less than USD 200. The deteriorating economic situation in Tanzania resulting from debt, trade deficits etc. has rapidly dilapidated the existing health sector infrastructure and demoralised health workers. This has resulted in low quality services in the public health facilities. While the country as a whole is undergoing structural adjustment and civil service reforms, the country has also embarked upon health sector reforms, encouraged by the donor community. The aim is to make the services more effective. Decentralisation, cost-sharing and private initiative are corner-stones in the reform process. HIV/AIDS represents a burden to an already strained health system. However, the government has taken action to reduce HIV transmission in collaboration with international agencies and donors. This report explores the Norwegian support in this context.

The present evaluation was **commissioned** by the Norwegian MoFA. The ToR specifically commissioned the evaluation of the SAG. The evaluation consisted of different components. Field investigations were undertaken in three countries: Tanzania, Uganda and Zambia. This report represents an attempt to assess, as far as possible, the specific impact of the Norwegian supported AIDS prevention activities in Tanzania. The evaluation team was asked to assess the degree to which the guidelines for the establishment of the SAG have been met, although emphasis was to be on the forward-looking aspects of AIDS prevention rather than the scrutiny of past performance.

The **evaluation team** comprised three external and three local members. The external evaluation team consisted of Minou Fuglesang and Stefan Hansson of the IHCAR, Department of Public Health Sciences, Karolinska institutet, and Staffan Uddeholt, representing the Stockholm Group for Development Studies. Angwara Denis Kiwara of Institute of Development Studies, Muhimbili University College of Health Sciences. Phare G M Mujinja of the Behavioural Science Department, also Muhimbili College and finally Issa Musoke of Department of Sociology, University of Dar es Salaam, made up the local country team. The evaluation team had backgrounds in medicine and health-related sciences, economics and project management, as well as social anthropology.

Two weeks, August 13–24, 1996, were spent conducting the Tanzania Country Study. Key project implementors, policy-makers and programme officers at relevant institutions, Ministries, Embassies and NGOs in Dar es Salaam were in focus for the study and office meetings were held with these. A visit of three days to Arusha was also undertaken. Four of the six team members made this trip to get better acquainted with the site and the people involved in the former MUTAN project. Meetings were held with groups of former MUTAN staff from Arusha and Moshi, respectively. In Arusha, we were also able to make visits to the «field». The STD clinic in Mt. Meru Hospital and the AIDS Information Centre in downtown Arusha, which were both initiated with support from MUTAN, were visited. The principle methods used for data collection were unstructured interviews, observations and reviews of collected documents. All the team members participated in interviewing of people we met. Different constellations of team members attended different meetings. Only at some were all six present. Even though appointments had been made, some of the key persons we wanted to interview were not available because of travel etc. (see Appendix 1: People met). The people we interviewed were generous with their time and the information offered.

The six team members worked well together. Communications and discussions were fruitful, resulting in a consensus interpretation of the observed situation. A summary of the review team's observations and findings were presented for discussion at a meeting held at the Norwegian Embassy for its staff and other interested parties, the day before the Swedish part of the team departed. The appointed team leader (Minou Fuglesang, social anthropologist), delegated the responsibility to compile and write up information on one specific topic

as well as to take minutes from meetings, to each team member. The former has been responsible for compiling this material and writing the final report.

The review team would like to acknowledge the friendliness with which we were received by the Norwegian Embassy in Dar es Salaam. The Embassy personnel did everything to facilitate the smooth execution of our assignment. We would also like to thank the implementors of the projects for their generosity in giving us much of their valuable time, and for sharing with us the triumphs – however small, and tribulations inherent in HIV/AIDS care, prevention and control work.

2. HIV/AIDS in Tanzania

The first AIDS cases were reported in Tanzania in 1983. Since then, the HIV/AIDS pandemic has been on the increase. The disease is spread mainly through heterosexual contact and affects the sexually active, most productive age groups (20–34 years). By 1986, all regions of mainland Tanzania reported AIDS cases. By the end of 1995, a cumulative total of 81, 498 had been reported to the National AIDS control programme. This number, however, does not reflect the true picture of the problem. The lack of diagnostic facilities, probably the lack of proper diagnostic knowledge, and the delays in reporting in the rural areas, are the main factors contributing to under-reporting. It is estimated that by the end of 1995, there were 400,000 cumulative AIDS cases for Tanzania. Apart from cases reported from hospitals, there are others which are reported by the surveillance system, but only one out of 4–6 AIDS cases in the country are estimated to be reported through that system. Using 1990 figures, it has been estimated that by the year 2000 there will be about 1,000,000 AIDS cases in Tanzania if the current rate of infection continues. At that time, there will be about three times as many persons infected by HIV as the number of AIDS cases. This situation represents a burden for the already strained health system. The government of Tanzania has been committed to the control of HIV/AIDS since 1985 when a National AIDS task force was set up. The NACP for Tanzania was formed in 1988 under the guidance and support of the WHO/GPA. It has the following goals: to prevent further transmission of HIV; to reduce personal and social impact of HIV infection and AIDS. The NACP is now implementing the MTP II with activity plans up to 1996. The main thrust of the MTP II can be summarised as follows:

- multi-sectorial involvement including NGOs
- decentralisation to the district level
- community involvement and mobilisation.

The NACP is a vertical programme. It has separate funding, personnel and resources and falls directly under the Director for Preventive Services of the Ministry of Health. Each region has until recently had a Regional AIDS Co-ordinator and each district, a District AIDS Co-ordinator with the responsibility to organise, monitor and collect information on AIDS activities. With the health sector reform there are, however, plans to abolish the regional functional executives as part of the decentralisation process. The Districts will be the «action centre» for all health sector related activities, nearer to the people but also directly accountable to them. District plans for HIV/AIDS will increasingly be in focus for the allocation of funds. These will be submitted to and co-ordinated by the NACP who will negotiate for the funds with donors. However, the capacity at district level for management and efficient financial control is still weak, therefore, a lot of competence building is necessary at this level.

The NACP activities have so far been reviewed several times, most recently in 1995. The review points to achievements and failures of the programme. One area of success is that of awareness. The majority of Tanzanians have now heard of AIDS and know the modes of HIV transmission. There is also record of behavioural change, a reported reduction of the number of partners and increase in condom use (NACP Workplan 1996–97). Moreover, communities are now increasingly concerned about the consequences of HIV infection. However, meaningful community involvement, initiative and responsibility taking has only been achieved in limited geographical areas where the prevalence is high. Youth, who are a vulnerable group for HIV infection, have not been mobilised. In order to provide care for patients, the NACP has acted as an implementor and undertaken training of health workers in clinical and counselling aspects. In the majority of places the AIDS case burden far outweighs the number of trained medical personnel. The existing health system has no capacity to care for them all. Furthermore, even after their training, health care workers fail to apply their knowledge appropriately due to shortages of essential testing facilities, supplies and lack of supervision in health institutions. The need for involving families, traditional healers and non-medical personnel in the training for care and counselling has been expressed in policies for HBC but little has been done as of yet.

Local NGOs have played a significant role in the country's AIDS Control Programme since the first AIDS cases were reported. These have complemented the work of the NACP making significant contributions in counselling, home based care and IEC. Since the 1980s, many NGOs working specifically with AIDS have been

set up. Currently, there are 111 such NGOs registered. Donors have been favourable to the involvement of the NGOs in AIDS prevention work and most of them have earmarked funding for the NGOs. The NGOs are perceived of as important as they fill the gap where the state fails to take the initiative and provide basic services. At the political level, they also play a leading role in the civil education process and as a basis for the emergence of a well functioning civil society. There is, though, a need for the NGO activities to be co-ordinated to ensure efficient use of funds, accountability, transparency and joint planning to avoid overlap and conflict. Although the relationship between the NACP and the NGOs is good, the technical advisory committee within the NACP set up has not been very effective at this co-ordination task. The Tanzanian TAP funded by the USAID seem to have had more success, supporting the networking of the NGOs, encouraging «clusters» to form in different regions and assisting in competence building.

Since its inception, the NACP and HIV/AIDS activities have been heavily financed by donors. The WHO/GPA and multilateral sources have contributed the largest amounts. The Government of Tanzania has only contributed an average of two percent of the funding, mainly for the manpower working on HIV/AIDS activities and the provision of working space for the programme. The WHO/GPA and other donors the UNICEF, SIDA, DANIDA have, however, decreased their contribution during the past years, an expression that is locally referred to as «donor fatigue». The only exception is the European Union which is financing STD control. Yet, if we compare disease expenditures in Tanzania, we see that in recent years, a considerable amount of funds were spent on AIDS/STD compared to the other eight most debilitating diseases, malaria, the «number one killer», being the only one receiving more. There is then, still a wide gap between resources needed to respond to the challenge of the HIV/AIDS epidemic and those currently available. Only a small proportion of what has been set up in the national AIDS plans and budgets has actually been funded (MTP II had a budget of about 62m USD but only received 10m USD.) This is partly because donors are of the opinion that project proposals presented are not relevant or realistic. To bridge the funding gap, sectional ministries, regions and districts have to demonstrate serious commitment by allocating funds in their budgets for AIDS control activities. The resources of local communities also have to be mobilised and this will require sensitising the community.

3. The Norwegian support

3.1 Main elements of Norwegian policies

In response to the rapidly spreading HIV epidemic and the situation of emergency in the late 1980s, the Norwegian parliament decided to allocate a «special grant» for AIDS control. In Norwegian development support, there has been a praxis of creating such «special grants» to enhance focus and activity in especially urgent or sensitive fields. The SAG was constructed in 1990 and has been co-ordinated by the MoFA. Although the SAG has a vertical and narrow focus on one disease, it is a funding source aimed to be used multi-sectorially. The SAG is intended to be flexible, to be catalytic and function as «seed» money to be used to encourage organisations and institutions to initiate and pilot activities and interventions. The idea is that these should gradually be absorbed in and taken over by more regular activities and services. The SAG is in other words a temporary, short-term funding scheme. The SAG guidelines, to some extent, influence the type of projects that are eligible for support.

However, the over-arching policy for the Norwegian development assistance to developing countries is to «promote the establishment of a sustainable economy that is independent of development assistance.» Support of the civil service reform and structural adjustment are also key activities. The policy for development aid to the health sector is to support the development of primary health care services and the strengthening of their management systems.

In the following we shall explore the consequences of these over-arching policies on the Norwegian support to HIV/AIDS control in Tanzania. Here, assistance to the health sector is no longer a priority within the bilateral country programme of NORAD. After the «country programme» review in 1993, a decision was made to limit support to seven sectors. The health sector was not one of these, and here support has more or less been phased out, including that which went to HIV/AIDS control. Yet, it was felt that phasing out support to AIDS prevention totally, would not be a good policy. Funding for HIV/AIDS control activities can in the future be extracted from a miscellaneous budget over the bilateral «country programme» frame. Furthermore, support to AIDS prevention can be channelled through the NGOs and volunteers in the health sector. See table

Table Norwegian Support to AIDS related programmes 1990–1995.

Figures in 1.000 NOK

	SAG/Special Aids Grants	CP/Country Programme	NGOs/Private Organisations
MUTAN		57 606	
WHO	10 000		
UNICEF	4 168		
Subtotal	14 168		
NGOs			
– Red Cross			596
– CEDHA	179		
– WAMATA	1 059		1 405
– AMREF	709		324
– SWAA	22		389
OTHER	1 326		459
Subtotal	3 295		
TOTAL	17 463	57 606	3 173
GRAND TOTAL		78 242	

3.2 The SAG to multilateral organisations

The Norwegian MoFA channelled 10 million NOK from the SAG budget during the period 1990–1995 through the **WHO/GPA** to the NACP. This was general support which was not «earmarked» for specific activities. It has therefore been used for general NACP activities, e.g. surveillance, regional AIDS plans and counselling programmes.

The **UNICEF** has received the SAG funding channelled through the MoFA, earmarked for its Tanzanian Primary School AIDS Education programme. In 1995, 3 million NOK was allocated (100 per cent of its funding) Moreover, in 1993 the SAG money for this project came directly from the local Embassy SAG budget (see below). The programme was developed in collaboration with the Ministry of Education and the NACP. Children of school-age are regarded as «the window of hope« as the prevalence of HIV is very low between 5 – 14 years. It is hoped that children in grades 5 – 7 in primary schools (age between 11 and 13 years) by receiving HIV/AIDS awareness education, will be encouraged to behave in a way that prevents the spread of HIV among them. The elders of the community are also involved

and informed. The programme is carried out in 50 districts both on the mainland and in Zanzibar. UNICEF started out by collaborating with the MoE, but because of constant delays in the disbursement of funds, a decision was taken to channel the money directly to the districts. UNICEF has a tradition of operating at the district level and therefore welcomes the decentralisation process initiated by the health sector reforms. District capacity-building is a major goal. (The project is part of a larger community-based activity including social mobilisation, AIDS education support, nutrition and sanitation. Each community decides on what aspects to prioritise.) The programme is integrated into District Plans, including AIDS plans. There are concrete plans for continued funding for the UNICEF activity (in 1996, 3 million NOK). The focus of the programme will broaden and include adolescent health, reproductive health and social care.

3.3 The SAG channelled through the Norwegian Embassy

The Norwegian Embassy in Dar es Salaam has had approximately 1 million NOK yearly of the SAG at its disposal to distribute to local organisations and activities. Application for funds and approval are all handled locally. Agreements can be set up with immediate effect. The NGOs in particular have benefited from this funding.

AMREF is one of the major NGOs active in the field of health/HIV prevention in Tanzania. Since the inception of the NACP in 1988, AMREF has collaborated closely with it by implementing some of the NACP's strategies like reaching out to high-risk groups (the Truck Drivers' project is well known). They have been pioneers in this area and in that of peer education, developing methods and training materials that have been widely used by other NGOs in the East African Region. AMREF has co-ordinated the nation-wide HTA-programme against the spread of HIV. This project was designed in collaboration with the NACP/ MoH (MTP II) and involves several other NGOs (Good Samaritan Foundation, World Vision in Health etc.) but also the GTZ and MUTAN as implementors in different regions. The programme targets communities along the main highways, mining and construction centres and boarder towns. These locations contain a high number of bars and guest houses, where female bar attendants offer sexual favours to obtain a necessary minimal income. The strategy is to select and educate bar workers as «peer health educators», motivate them to reduce their number of sexual partners, to distribute and promote the use of condoms, and to establish easier access to treatment for sexually transmitted diseases. AMREF has tried to widen the perspective so as to become a little less vertical in approach. The long-term strategy is to integrate AIDS prevention in primary health care. The idea is also to promote community capacity to address HIV/AIDS. AMREF has received support from different donors and from the Norwegian SAG for specific components of this programme.

WAMATA, which is an organisation for the support of AIDS victims, was set up in 1989 by a female relative of an AIDS victim. The aim is to mobilise people in the fight against AIDS and support people living with AIDS and their relatives. The agenda and model for the NGO draws on that of the TASO in Uganda, a victims organisation that has come to play a key role in AIDS care and prevention in that country. Today it has a membership of 70,000. WAMATA headquarters are in Dar es Salaam and it has branches in three other regional towns. It offers pre- and post test counselling (on how to accept the result and live positively with it), home-based care as well as clinical support to patients with AIDS. It conducts public education and counsels the general public, especially youth, on how to avoid getting infected. WAMATA also advocates the legal and human rights of people affected by AIDS (including orphans). It also acts as an umbrella organisation for a cluster of the NGOs working with AIDS issues. The Norwegian SAG support has been given to help WAMATA strengthen its management capacity, build competence among its staff etc. The organisation receives support from other donors, has income-generating projects and is engaged in community fund raising.

CEDHA in Arusha is a professional health system research and health manpower development institute established under the MoH. The aim of CEDHA is to strengthen and support the health care system by improving the relevance and efficiency of health staff training. CEDHA is a WHO collaborating centre and functions as a competence building centre for the east African region. CEDHA collaborated with MUTAN. It was the competence centre for the public health education activities and staff members collaborated on associated research. It has received the SAG support to publish its news bulletin AIDS Link, which targets health staff all over the east African region.

UNICEF's Tanzanian country office received, as mentioned, funding directly from the local embassy SAG budget for its Primary School AIDS Education Programme to get it off the ground and consolidate its focus. In 1993, 560,000 NOK was allocated.

Other organisations have received support for small-scale activities.

3.4 Norwegian embassy NGO allocations

The Norwegian embassy in Dar es Salaam disposes NOK 5 million yearly to support the activities of local NGOs, generally. Some of this support goes to the NGOs dealing with AIDS and therefore functions in some instances as a complement to the SAG funding. Complementary funds for AIDS activities have been solicited by the NGOs such as AMREF and WAMATA from this budget.

A problem faced by donors in Tanzania, including NORAD, is the low capacity of local NGOs to carry out activities, i.e. spend money. In the HIV prevention field for instance, there are few good and manageable project proposals submitted. The result is that there is more money available than can be spent (in 1995 only 3.5 million of 5 million was spent by the NGOs).

3.5 Support to MUTAN over the «country programme»

From the inception of MUTAN – the Tanzanian/Norwegian AIDS project in 1989, until 1995 when the project came to an end, contributions to the health sector in Tanzania were channelled mainly to this project over the «country programme» frame (average NOK 10 million per year). The project was designed by the MoH, Muhimbili Medical College and the UoB in the late 1980s as an attempt to prevent dissemination of HIV, to contribute to the alleviation of the consequences of the epidemic, both for individuals and the community at large, to identify the various aspects of the actual situation regarding HIV and AIDS in the two regions, to develop professional competence in this area within Tanzania and to contribute to the general knowledge about AIDS and possible strategies for its prevention». This was foreseen to be achieved mainly through research, competence building and intervention. At this point in time it seemed urgent to get activity off the ground to halt what was seen as a crisis. Different donors were initiating work in the AIDS field. The newly launched NACP, more or less allocated regions to the different donors in order to avoid duplication and ensure division of labour. It was decided that Norway would work with the Kilimanjaro and Arusha regions.

Many of the ideas for the MUTAN project were discussed during a comprehensive eight-week training course organised by the UoB in Bergen in 1988 following an initiative by the MoH in Tanzania. Senior key persons from the new NACP participated as well as people from the Muhimbili Medical College, the KCMC and the regional health authorities from Kilimanjaro and Arusha. The project had an unorthodox initiation as it was largely designed by experts in infectious diseases from both countries. Research was in focus for the new project as it was for the NACP. Little was known about HIV/AIDS at the time. To establish a national information base on HIV/AIDS, from which to initiate interventions seemed like a feasible and relevant goal. Different programmes on surveillance, public health education, anthropological and health seeking behaviour, counselling and HIV testing in hospitals and virology were set up. These differed, some had strong research components and others were more intervention oriented. The programmes, which were the backbone of MUTAN, are briefly discussed in Appendix 2.

Strengthening the national capacity to cope with HIV/AIDS was considered important and meant upgrading the skills of professionals at all levels and in every field associated with the fight against AIDS.

NORAD supported the project and participated actively in its inception. A project combining research, interventions and competence building can be said to have been a new operational model for NORAD, who was the sole funder. The project was initiated for a five-year period, with a planned continuation of five years.

Given its manifold objectives and activities and the need to assure effective research work and implementation of interventions, MUTAN set up a separate or parallel structure to that of the NACP. MUTAN had its own well-equipped offices, management structure and staff, who were provided with incentives in the form of tax-exempted allowances, so as to keep them from going to high-paying NGOs. There was, one can say, little confidence in the capacity of the Tanzanian health system, i.e. the central, regional and district government level to cope with the rapidly unfolding AIDS epidemic. This, together with the fact that there was limited

academic resources in Tanzania at the time, made it seem rational to let the UoB administer the project. All the funds for the project were to be channelled through the UoB, which would be accountable to NORAD. All decision making about financial concerns were consequently vested with the UoB. This ensured donor control of accounts and activities. Although the activities were regarded as part of the NACP and regional medical officers always participated in MUTAN meetings, MUTAN activities were never included in the NACP budget and reporting process. This obviously made it difficult with transparency and a proper holistic planning for the region from the perspective of the national authorities. The separate structure set up and the independence of MUTAN contributed, we were told, to making many actors in the AIDS prevention field in Tanzania refer to MUTAN as a Norwegian NGO rather than as a part of the government system. Because of the perceived lack of national and local capacity to undertake the task ahead and implement the project, many expatriates were engaged to help develop such «capacity». The need to promote local and community ownership and «long-term sustainability» of all HIV prevention activities carried out was not a central concern at this time.

MUTAN definitely contributed to the establishment of multi-disciplinary, intervention-oriented research as part of the NACP. Competence building, that is educational strengthening of academic and other skilled personnel groups, took place to varying degrees in the different programmes. It involved many different institutions and people at all levels with a wide range of skills. At the academic level, three PhDs in Tanzania and three in Norway were or are near to be completed, plus half a dozen masters' degrees (see Appendix 3).

Direct support to regional AIDS prevention and the NACP was also provided by MUTAN. Some of the activities undertaken can be said to have secured core functions of the NACP. The regular support to the NACP activities in the region emerged in close collaboration and often upon request of the regional medical officers and the regional AIDS co-ordinator. The support of blood screening consisted of the purchase of additional test kits, especially when these were in short supply in the region. Laboratory equipment was also provided, combined with the training of laboratory technicians. This was of course also a prerequisite for research and intervention activities. MUTAN cars were also used to facilitate regular NACP supervision and activities in the districts. Furthermore, MUTAN helped initiate two STD clinics, and two information centres offering counselling and information in the regions. A national radio programme on HIV prevention information was also launched. These were all the first of their kind in the country. The hospital-based counselling programme trained counsellors who were working in the regional health services and the model has been used to establish a national programme. MUTAN also played an instrumental role in co-ordinating the collaboration between researchers, regional health authorities, the NGOs and church organisations in the region. Finally, MUTAN supported the KCMC (the referral hospital), which functioned as a resource base for the project, with running costs, thus facilitating its role as a zonal reference centre in the field of HIV/AIDS. In spite of the fact that MUTAN established a separate structure, it has to be emphasised that it was deeply involved with the NACP from the start when the project was designed and all through its existence.

Critical Voices about MUTAN

The MUTAN project was reviewed in February/March of 1992 by a joint Tanzanian-Norwegian team because of delay in getting the programme started and internal management problems. The review was critical. MUTAN's management routines were questioned as well as the high expenditure of the Norwegian collaborators. Furthermore, what was perceived as a poor balance between research and intervention activities was pointed out. It was recommended that ongoing research be made more action- and intervention-oriented and that competence building on the local, i.e. regional and district level, be increased to balance the dominance of the academic competence building. This criticism was met with ambivalence by the MUTAN project staff (see the final MUTAN report, April 1996). Some points were welcomed, others rebutted, particularly that MUTAN should be working in «isolation». However, efforts were made to make amendments.

In preparation for the continuation of MUTAN for a second phase 1994–1999, a new project proposal was compiled and submitted to NORAD for approval in August 1993. In October- a three-member Norwegian appraisal team of this proposal was appointed. Although the team acknowledged some of the successes of MUTAN, it was by and large critical of the proposed project's organisation, which was interpreted as a continuation of MUTAN as a parallel structure to the

NACP with the UoB as the funding channel. The question of sustainability versus efficiency, i.e. a parallel structure being the most rational way to organise and administer the project, was taken up. It was also felt that the project did not fit in with current Norwegian priorities for development co-operation, i.e. recipient responsibility, and long-term economic, political and social sustainability. It was argued that activities should be integrated into the regional HIV/AIDS control work with more active participation from local professionals and administrative staff and it was questioned whether information generated through research was of use to the regions because of the limited intervention capacity of the regional authorities.

A decision to terminate the MUTAN project was made on the basis of this rather negative review. To sum up then, these were some of the reasons for the decision to close down the project:

- to ensure national and community ownership and long-term sustainability NORAD decided to support AIDS control via the NACP in the future,
- too much money was concentrated to a single project in two regions,
- the project used too much resources in terms of research and (individual) capacity building at the expense of interventions.

NORAD granted funds for a one-year extension (until June 30, 1996) to «hand over» the various activities to health authorities and other agencies, finalise competence building and plan further the NACP-supportive actions (the money was channelled through the NACP-KCMC).

A new proposal for continued support of some activities, referred to as the AIKA, was written by the MUTAN staff and submitted in April 1995. This proposal has been discussed on several occasions, by the involved parties. Amendments have been made to the proposed management structure to make it more consistent with current NORAD priorities for HIV control support to Tanzania. In August 1996, no decisions had been taken about what activities that would benefit from Norwegian funding.

4. Observations and findings

4.1 Assessing the MUTAN project

A lot has been said about MUTAN. However, the Tanzania country study generated some additional comments and reflections about both the strengths and weaknesses of this project and to what degree it can be said to have been a sustainable project in the Tanzanian context. Sustainability is a basic condition for Norwegian development aid. It implies that the invested money should yield tangible, lasting results. But sustainability has many dimensions and its definition can vary depending on context and policies. For the MUTAN project the following can be said to be relevant: The capacity to continue activities, to disseminate accumulated knowledge, to transform the knowledge into action and to maintain the new level of competence. The process by which the local agents/authorities gradually take over responsibilities for planning and implementing as well as financial matters is also of importance and should be considered.

From what we can gather from our interviews and other review documents about MUTAN, it seems evident that most of the activities undertaken by the project, be they research, institutional strengthening, competence building or public health interventions, were in line with the NACP plans for AIDS control and therefore relevant. Achievement can also be said to be high from the perspective of what was set out as objectives. Indeed, in this context, the project was a success and we feel that it is important to underline this. NORAD and the different teams appraising MUTAN seem to be in agreement about this. The production of scientific multi-disciplinary work has been impressive as has the production of academic degrees. It is clear that the results of the research studies, which have been widely disseminated through journals and presentations at scientific meetings, have contributed to a general understanding of the character of the HIV/AIDS problem both in Tanzania and internationally. We met several researchers and programme officers in Tanzania who mentioned the usefulness of MUTAN studies for their own research and intervention work. Many of the experiences made have been integrated into the national competence building programme (that is the national capacity to cope with HIV/AIDS). Several people, who were involved in MUTAN, have key positions in HIV/AIDS prevention work today.

The studies that have had a clear intervention profile coupled with that of capacity building can be said to be successful in institutional development. The hospital-based counselling research, intervention and training programme has, for instance, generated knowledge, capacity and experience that have been used in the national programme. Likewise, the school component in the public health education programme developed a curriculum which is being used as a base for developing a national school AIDS curriculum. There are other examples as well. The anthropological studies of bar workers have been useful for the HTA project operated in collaboration with AMREF.

It is more difficult to say what implications the research findings have had at the local level. Although the MUTAN activities have had an impact on attitudes and behaviour – to what extent can research and intervention activities be said to have initiated a sustainable local development or community mobilisation around HIV/AIDS prevention? On the other hand, was the project really designed with this aim in the first place? As the capacity of the local health systems is limited and lacks resources, it is unrealistic to think that local staff will act upon research findings and transform these into interventions without monitoring and support. Strengthening the capacity of local health staff to absorb and assimilate new ideas and initiatives was not central in MUTAN as we interpret it. Sensitisation of district staff to the real conditions that prevail at community level can be done through involving and training them in participatory planning and a community-based approach. Such a participatory approach involving and enabling a feeling of local ownership and strengthening of local planning processes should perhaps have been developed more in many of MUTAN programmes. Today, it is a widely acknowledged fact, that for projects to be effective and achieve sustainable development, communities have to be empowered and mobilised to identify and address their problems and needs, plan and take action and ownership of projects, i.e. they have to feel that the project is important to them and that they are accountable and can demand accountability of other actors involved. This fundamental insight is core to the whole democratisation and civil service reform process which is going on in East Africa. The need for such a community development perspective has evolved force-

fully in the development debate during the 1990s. The usefulness of broadening the perspective/approach in this direction did, however, not emerge as a major issue in the MUTAN. However, a community counselling component was under development in the counselling programme when the project was closed down.

It is clear that the MUTAN, as an AIDS control programme in the Tanzanian context, experienced an exclusive funding situation. The payments for activities in the Arusha and Kilimanjaro regions for the years 1992–1994 corresponded to 65% of the total NACP funding for the whole country. In 1993 payments in the MUTAN project were equal to NACP payments for the whole of Tanzania (USD 1,3 million). This created a national imbalance in favour of these two regions.

Furthermore, it created an «awkward» situation for the project, accentuated by the fact that during the first years, 60 % of the budget went to Norwegian expatriates for their participation and capacity building. This was however altered to 40 % during the project's last years, when increasing amounts of funds went to interventions. However, throughout, only 10 % went to capacity building of Tanzanians. The project was «top heavy» with expatriates and therefore its legitimacy would come to be questioned in a time when development support accentuated strengthening of local structures and capacities. Thus, many have argued that the project was not cost-effective. The strong regional focus and the separate administrative structure which delegated all decision making over funds to the UoB rather than the NACP further augmented this awkward situation.

MUTAN was a child of its times but it is obvious that the project soon became an «odd child» which did not fit into the mainstream design framework and priorities of the NORAD's bilateral country support. Therefore it was to live a «troubled life». It was created in a spirit of collaboration to meet an acute need. It was designed as a project with a strong research focus as this was identified as a priority in the early phases of the epidemic. NORAD should be congratulated for its quick response in support of research. However, every responsible participant in the planning and execution process envisaged the structure to be maintained for at least 10 years as it is known from experience that a long-term perspective is necessary for this sort of research activity. Yet, NORAD was soon to feel uneasy with the design and set-up of MUTAN project even though it participated in its inception. The two assessment studies, commissioned by NORAD, also expressed scepticism about the design of the project, the balance between research and implementation and its sustainability potential. Considering that NORAD's mandate is intervention in a number of sectors and that their development policy focuses on local sustainability and management of development projects, and the increasing focus on this over the last years, the feeling of uneasiness was perhaps a logical reaction. However, one can ask why the project was incepted as it was in the first place, and planned for two five-year terms with NORAD's full support. Although MUTAN staff could probably have gone much further in their attempts to moderate their approach, we have not found much evidence of constructive attempts by NORAD to help find a new, more sustainable path for the project.

NORAD's decision to terminate the MUTAN project after «half time» has obviously been a painful process for all parts involved. Tension and poor communication seem to increasingly have characterised the relation MUTAN/NORAD. The indecision about the continuation of the project and the final message of its end has obviously been detrimental to the moral of HIV/AIDS control work in the region and in Tanzania as a country generally. It will probably take some time to find new and constructive ways to continue. Hopefully, NORAD will continue to support the activities initiated by MUTAN that have created a social demand, have a sustainability potential and can mobilise community participation in HIV prevention. A more appropriate organisational framework within which to do this, is needed. Furthermore, future support to AIDS control activities in other regions should take account of the experiences made by MUTAN. Finally, use should be made of the competent resource people in Norway and Tanzania, that have been trained during the course of the project.

4.2 Assessment of the SAG

Funding over the SAG to the **Tanzanian NGOs** has been highly **relevant**. The significant contribution of the NGOs to the fight against the epidemic is well known. In Tanzania the NGOs working with AIDS have emerged in order to fill the gap where the public health sector has clearly failed in the provision of basic care and services. With the experience of the key role well functioning NGOs have played in Norwegian civil society, Norwegian development aid has been instrumen-

tal in promoting their involvement in collaborating countries such as Tanzania.

WAMATA, for instance, represents an important and unique forum for the victims of AIDS in Tanzania today. The legal and human rights of the victims are addressed and the organisations counselling and home based care-programmes constitute a supplement to the limited health services offered to the public. The strength of the organisation builds, to a large degree, on the engagement of the many people who have felt the consequences of AIDS on their own families. This involvement is vital for the sustainability of the organisation. The Norwegian embassy in Tanzania has drawn funding in support of the WAMATA from its SAG as well as its local NGO budget. The support has mainly been used to strengthen the management capacity of the staff. This is an additional prerequisite for the organisation's sustainability and survival.

The fact that WAMATA is struggling to become a nation-wide organisation and has already made achievements in this direction also motivates continued Norwegian support at this point in the development of the organisation.

AMREF and their collaborating partners in the HTA programme, which included the NGOs but also implementing agencies such as MUTAN, have been successful in reaching their target; high risk groups. AMREF is known from experience to be an effective implementing organisation.

If we look at the Norwegian SAG funded component in the HTA programme, which was implemented by the MUTAN in Arusha/Kilimanjaro, it is interesting to note that the ambition has been to develop a community focus, promoting the community capacity to address HIV. This aspect is, as we have already discussed, an important criteria for sustainability of interventions.

Furthermore, a horizontal approach has been applied including STD care and treatment in HIV prevention. This ambition reflects that the AMREF is concerned about the need to move away from a narrow vertical, AIDS centred approach. The need to broaden the perspective to include STD care and even reproductive health is now widely acknowledged by both professionals and donors including the Norwegians. Sexual and reproductive health is after all intimately related in the lives of ordinary people. The approach is thus, in line with Norwegian aid policy promoting a move towards primary health care.

It is interesting to note that AMREF as well as CEDHA, two of the local NGOs that have received substantial support over the SAG, have had a close working relationship with MUTAN. This is worth a comment. Our observations and analysis show that MUTAN project had a good working relationship with local NGOs. The experience the project generated has been used fruitfully by AMREF and CEDHA.

AMREF staff expressed that the MUTAN research had been very useful in their work with the HTA project. For MUTAN, the collaboration with AMREF meant a possibility to operationalise research and become more intervention oriented something which was requested in the critical assessment studies.

This collaboration was full of potential. Had the MUTAN project not been closed down, the collaboration might have represented the stimulus that could have helped to orientate other components of the larger MUTAN project in a more community centred and participatory direction.

Although MUTAN implemented the HTA project component in the Arusha/Kilimanjaro regions, this was an AMREF project. The latter took the initiative to set up the collaboration. The fact that the Norwegian embassy earmarked the SAG funding for such a collaborative activity, which would reap benefits from the experiences of these two organisations and in the process strengthen both at a certain point in time, is proof of a certain flexibility on the side of the embassy.

CEDHA had a working relation with MUTAN from the start, some of the staff were involved in, and therefore funded by MUTAN. That the CEDHA news bulletin AIDS Link received funding over the SAG, can be explained by the fact that their mere collaborations with the Norwegian MUTAN project made it easy for the CEDHA staff to gain knowledge about the existence of the SAG and therefore natural for them to request funding from this source. They could also present a familiar context, when arguing for the need for the news bulletin vis à vis the Norwegian decision makers.

Norwegian support to the NGOs working with AIDS in Tanzania will continue to be important in the years to come.

Such support should also benefit attempts to establish networks or clusters of the NGOs at regional and national level in order to ensure joint planning and avoid overlap and conflict. MUTAN played a central role in co-ordinating the local NGOs in Arusha/Kilimanjaro regions. WAMATA is also trying to play a strategic role in this work. The NACP is formally responsible for such co-ordination but has so far not managed to take on this role in a satisfactory manner.

Quite a few things can be said about the adaptation of the SAG grant guidelines to supported NGO activities. We have found that the support to the NGOs has been in line with the long-term policies of the NACP which is stipulated in the guidelines.

Although some NGO activities have been directed particularly towards women and children, such support has not been prominent. However, «weak groups» are also spelt out as a priority in the guidelines. The orphans and the PWAs were specifically addressed in the WAMATA activity, as well as the bar workers/prostitutes in the AMREF project, certainly belong to this category.

The major part of the NGO allocation from the SAG has, not been used multi-sectorially. Most of the support has been directed to the health sector and this is a weakness. The guidelines further state that grant money should be used mainly preventively. Although large sums, for example, to WAMATA have been used for institutional capacity building, salaries, and travels, most other activities supported can be said to have been «preventive» (the concept defined broadly). All the NGOs have been part-financed from the SAG as the guidelines stipulate. In principle the SAG support activity can easily continue as the NGO support, that is, be drawn from the Norwegian embassy the NGO budget in the future.

The SAG support through **multi-lateral channels** can generally be said to have been used for relevant activities.

The WHO/GPA support has been channelled directly to different NACPs, as a support to the co-ordination and implementation of AIDS control activities at country level. The activities of the Tanzanian NACP have been reviewed on several occasions, latest in 1995. Comments about the general function and achievement of the NACP may be in place, as well as how Norwegian aid in the future can help support the move towards a more multi-sectorial and community based approach to AIDS control in Tanzania.

Many actors in the Tanzanian AIDS prevention field, feel that the NACP is not playing the dynamic, efficient role it should as a national, multi-sectorial co-ordinating body. The explanation for this can be found in the current structure and position of the NACP within the MoH which is considered unsuitable for such a co-ordinating role. A new proposed structure was recommended after a review in 1995. In this the NACP is made a more autonomous body directly under the Prime Minister's office. This would facilitate the NACP's possibility to communicate directly with the principal secretaries of different ministries in contrast to the present situation where communication is slow and bureaucratic as everything has to pass through the principal secretary of the MoH. However, the proposed restructuring has not yet received the final approval of the government. There are also other constraints on the efficient functioning of the NACP. The National AIDS Committee which is a multi-sectorial senior level body created to advise the government in policies relating to AIDS control, does not meet as scheduled. Furthermore, this body has little status and power as there is little governmental support at top level, for AIDS prevention in Tanzania, in contrast to, for instance, Uganda where the president himself has taken a leading role in the fight against AIDS. Difficulties have arisen in the effort to make HIV prevention a multi-sectorial undertaking. Other ministries are still not making AIDS a priority issue. Although most of the eleven sectorial ministries now have an AIDS technical advisory committee and focal persons who oversee AIDS activities in their sector ministry and function as liaison persons to the NACP, there is little priority, plans and funding for such interventions. One example is AIDS education in schools which is an urgent but neglected issue. The MoE is still not giving this issue a high priority.

This is illustrated well by the UNICEF's highly relevant Primary School AIDS education programmes. The programme received SAG funding channelled via the multilateral channel as well as the Norwegian embassy the SAG budget in Tanzania. UNICEF's attempt to work with the Ministry of Education on AIDS prevention was a positive initiative but it soon stranded. Until 1995, funds for the programme were sent directly to the MoE in Tanzania. The latter was in turn responsible for transferring these funds to the district level. The issue of sex education is, however, still very controversial in Tan-

zania and there is clearly a reluctance to act. As a result, funds took too long to reach the district level which hampered programme implementation. From early 1995 onwards, funds for the programme have been sent directly from UNICEF to the District Executive Directors. The latter are now accountable directly to UNICEF for the funds. The UNICEF project is well in line with the NACP objective to involve other sectors in addition to that of health. Furthermore, to strengthen the capacity at the district level to deal with AIDS prevention by, for instance, making district AIDS plans part of broader district health plans.

In this attempt and in many other respects, the UNICEF programme is well in accordance with the SAG grant guidelines. It is directed particularly at women and children, so called «weak groups» and it is clearly preventive.

Furthermore, the programme is among the few control programmes in Tanzania which is working in the education and not in the health sector. The only point which diverges from the grant guidelines is the fact that the Primary Education Programme is not part-financed. UNICEF has received all its funding for the programme through the SAG!

Although it may be seen as problematic that UNICEF has by-passed the MoE, UNICEF programme is in line with the NACP and does get the job done. Norwegian support to the UNICEF activity is highly appropriate. It is a pioneering programme and among the few which successfully addresses young peoples needs, uses the education system as a base and has taken up the challenge to strengthen the district capacity to work with AIDS.

The NACP and many other actors working with HIV/ AIDS prevention in Tanzania have welcomed the establishment of the UNAIDS in the country. Currently the discussions centre much about the possible impact it may have, as its aim is to expand the multi-sectorial response to the AIDS epidemic and provide countries with a more co-ordinated UN organisation support. Basically, this idea supports the efforts of the NACP to gain a more independent role in relation to the MoH. The Resident Representative of the UNDP in Tanzania, has established the first UN «Theme Group» on HIV/ AIDS, with the resident representative of WHO as its first chairperson (two-year period). Other members of the group are the different local representatives of the involved UN agencies. There are, however, also plans to involve bilateral organisations to plan, share information and mobilise resources. A Country Programme Advisor has been appointed. Awaiting her arrival in September 1996, a short-term consultant was acting to prepare the new organisational set-up. We were told by this consultant that the UN Theme Group on HIV/AIDS will function within the context of the national response and is not a replacement of the NACP. The Theme Group will be in constant communication with the NACP and will consult the following on a regular basis, as well as bi- and multilateral donors, NGOs, private sector, religious organisations, academic and research organisations as well as other relevant agencies. On the recipient side the NACP is committed to improving the multi-sectorial response to HIV/AIDS as well as strengthening district teams' co-ordination. The 1995 Review of the National AIDS Control Programme, however, recognises the wide gap between the NACP budget and the available funds and recommends the sectorial Ministries, regions and districts to allocate funds in their budget for HIV/AIDS control activities. A logical consequence of this recommendation is that assistance for instance to AIDS education activities in schools should in the future be financed from Norwegian development aid education sector funds and not from health sector funds.

The establishment of UNAIDS in Tanzania poses clear challenges for the continued Norwegian support in whatever form it will take after the SAG.

As mentioned earlier, Norway is a strong supporter of UNAIDS. For 1996 UNAIDS will have a general contribution of NOK 22 million. For the NACPs there are another NOK 13 million available through UNAIDS, of which some funding is planned for the NACP in Tanzania.

The MoFA should set up guidelines for how country representations should follow up the work of UNAIDS in Tanzania. For instance, Norway could decide to promote certain issues in the theme group.

Norwegian «country programme» support to the health sector in general in Tanzania, is as we have noted, not to be considered in the future we were told by Norwegian embassy staff. However, general contributions to the NACP, will be an exception to this. Such bilateral allocations will be financed from a budget line for miscellaneous projects. The support can be general contri-

butions to implementation of the national AIDS-plan as well as ear-marked contributions to specific projects or programme areas, e.g. UNICEF. However, the Norwegian policy to focus future support in the health sector to broad primary health services will raise questions on the interpretation when it comes to assistance to the fight against HIV/AIDS.

The extent to which efforts will be made to change the NACP from being a mainly vertical programme in the health sector to becoming an integrated component of the primary health care services in Tanzania will also have consequences for the Norwegian support. This will depend on the ongoing health sector reform process.

The transfer of funding for education from the SAG to funds for bilateral country programme support is an ultimate goal, but problematic. It presupposes a specific proposal and request from the MoE, which may have difficulties in materialising in a situation where scarce resources have to be shared between several different activities of high priority. At present, both sides, the donors and the recipients, still mobilise HIV/AIDS funding from health sector funds as well as the SAG. Specialised ministries, should propose bi- and multilateral financial assistance from the respective sector funds. Norwegian aid on the other hand, should recommend HIV/AIDS components to be included in health education components in various bi-lateral sector support agreements (e.g. infrastructure).

5. Conclusions

The Norwegian SAG as well as the MUTAN project were initiatives taken to deal with what was perceived of as an acute short-lived catastrophe – the AIDS epidemic. This was in the late 1980's and it was urgent to get activities off the ground. Such Norwegian, as well as other donor-supported initiatives, had a relief approach focusing on the generation of basic knowledge mainly among the target groups. However, more than half a decade has past and during that time, we have come to realise that the AIDS pandemic is a chronic ongoing crisis; it is here to stay. A broad, long-term strategy is needed in this situation. During the same period, development policies have changed as have local (Tanzanian) politics and priorities. Health sector and civil service reforms are noteworthy. The design and objective of AIDS control activities, must be adapted to this changing situation in a flexible manner if they have become inappropriate. It is quite clear that broader, more holistic approaches are needed. Further effort has to be made to make AIDS prevention an integrated part of all sectors, i.e. education, as well as primary health care service. Emphasis has increasingly to be vested at district level in mobilising and strengthening the capacity of the community as well as the local health system. Community-based initiatives are a prerequisite for long-term sustainability; the socio-economic impact of the epidemic affects whole communities in their development. This broader perspective has emerged with time, with the process of ongoing activities and the generation of knowledge, successes and failures. Such a »historical» perspective is thus necessary as it sets the stage for redefining and adapting approaches. Both the SAG and the MUTAN project came of age in the mid 1990s. It has become evident that there is a need to move on to a new phase.

The SAG has played a significant role helping to get activity off the ground and mobilising civil society (NGOs) in Tanzania. Support to HIV/AIDS control activities can be solicited through other channels in the future. The MUTAN project was closed down by NORAD before anticipated as its design was deemed inappropriate to the developmental concerns of the mid 1990s. The Tanzania country study team see the validity of this decision. However, there has obviously been problems in reaching a consensus about how project activities and experiences should evolve into a new phase. The significance of different types of research and the »efficacy» of different modes of management and implementation has been contested as we have seen. A lot of experience, knowledge and competence were gained in the course of the project. For these seeds of initiative to grow and contribute to the continued development of AIDS control in Tanzania, it seems urgent for decisions to be taken about the plans that have been drawn up. Finally, that a more fruitful dialogue should be initiated between the actors involved.

Appendix 1

People met

People met in Dar es Salaam

1. Tore Gjös, Chargés d'Affaires, Norwegian Embassy
2. Ms. Reidun Sandvoll, Programmme officer, NORAD
3. Prof. Maselle, S.Y., Muhimbili
4. Dr. E.F. Ndyetabura, UNDP
5. Ms. Amina Ali, UNICEF, Aids project officer
6. Mrs. Kari Ebbe, UNICEF, Community mobilization officer
7. Mr. Tibeikwitira, WAMATA
8. Dr. M.T. Leshabari, Muhimbili
9. Dr. U D Warning, WHO representative
10. Ms. Dr Temu, UNFPA
11. Dr. Richard Rolde, Coordinator, GTZ
12. Tim Manchester, PSI Condoms
13. Dr. Kipujo, NACP
14. Mr. John Male, AMREF

Former MUTAN staff met

From the Arusha Region:

1. Mwamini Nyakwela, Regional AIDS Counsellor
2. Christopher Mremi, Regional AIDS Control Coordinator
3. Dr Fred Makiago, Head of STD Clinic
4. Mrs. Haule, STD clinic nurse
5. Miraji Ngomu, AIKA office staff
6. Mrs. Massawe, Counsellor Chawakua Information. Centre
7. Dr N. Ole Kingori, coordinator of MUTAN

From the Kilimanjaro Region:

1. Ms. Vicky B. Kessy, Adm. officer, MUTAN
2. Dr. E. J. Masenga, Dermato-venereologist, K.C.M.C.
3. Ms. Peris Urasa, Regional AIDS Counsellor.
4. Dr. Ulomi, S.S., Regional Medical Officer
5. Sr. Margaret Mshana, Coordinator Kiwakkuki Information Centre
6. Prof. John Shao, Director, KCMC
7. Mr. E. Adamowasam, Regional AIDS Control Coordinator
8. Dr. Nkya C.E.
9. Mrs. Marycemma H. Msuya, Nurse tutor, KCMC
10. Mr. Maraji S. Ngomuo, Project Accountant

Appendix 2

Summaries of the major programmes of MUTAN:

Surveillance programmes

MUTAN was actively involved in the implementation of the national AIDS surveillance programmes of blood donors as well as pregnant women. In addition, a series of seven population-based HIV screening surveys were conducted in the Arusha region between November 1991 and April 1994. These surveys tend to confirm that women and poor people are most vulnerable to HIV infection. The local HIV epidemic seems to spread from urban to rural areas along major highways. A cohort study in which a total rural village population (in Kahe ward) was screened for HIV confirmed these findings, and gave further insight into the important role played by other STDs in the transmission of HIV. A spin off of the Kahe study was the establishment of an STD clinic in Moshi. The surveillance studies all generated knowledge that has been instrumental in the implementation of NACP activity.

Public Health education

MUTAN assisted the National AIDS Control Programme in creating and evaluating innovative HIV/AIDS educational programmes. These programmes have been implemented throughout the Arusha and Kilimanjaro regions and were designed to reach a variety of target groups through public meetings, intensive courses, two information centres, a radio programme and school-based programmes. The latter included a research component. Follow-up surveys indicated that a large proportion of the population were receiving in-depth HIV/AIDS information.

Social anthropology and health care-seeking behaviour

Anthropological field research has been conducted in five different local communities all of which, except one, are rural and with a rather low HIV prevalence. The general objectives of the studies were to collect information on 1) the organisation and meaning of sexuality and the people's perception of risky sexual behaviour, 2) disease knowledge and explanation, including knowledge of HIV/AIDS, and 3) the health care system and people's health-seeking behaviour. As HIV/AIDS is to a large extent sexually transmitted, it is particularly important to single out the cultural context of risky sexual behaviour.

Counselling and HIV testing in hospitals

In 1989, when the MoH prescribed counselling of people suspected to be HIV infected, there was no tradition for this in the hospital system. A culturally appropriate role for local counsellors was identified through reseach in the area and an intensive training programme was organized to train such HIV/AIDS advisors from the two regional hospitals in Arusha and Moshi. These have also been key participants in the training of other counsellors, whom they participate in supervising in the districts. In all, 384 HIV/AIDS counsellors have been trained for the two regions, and they have counselled approximately 40,000 people. (Over the five-year period) The experience and findings generated from the research and intervention programme on counselling have continually influenced the development and improvement of these activities. The hospital counselling programme has proved to be sustainable and the action research programme has expanded to involve community-based (village) counselling.

HIV testing and virology

The virology programme was designed to investigate various aspects of HIV infection in Tanzania including an investigation of test systems' kits for the detection of HIV antibodies, establishment of quality control measures to ensure optimal laboratory procedures and characterisation of the virus at the molecular and biological levels. The programme has comprised research, intervention, surveillance and education as part of the NACP. HIV testing of blood donors was already introduced in 1988 during the pre-project in the Arusha and Kilimanjaro regions. The first scientific evaluation of a new diagnostic test for the detection of HIV and recommendations for the use of rapid tests countrywide was initiated by MUTAN.

Appendix 3

Dissertation related to the MUTAN project.

Doctoral degrees:

- Holm-Hansen, C: Detection and characterization of HIV-1 from Tanzania and Romania. Dr. philos., University of Bergen, 1995. ISBN 82–7788–023–5.
- Howlett, W: Neurological disorders in Tanzania; studies on HIV-1, Guillain-Barré syndrome and konzo. Dr. med., University of Bergen, 1995. ISBN 82–7815–000–1.
- Mnyika, KS: Epidemiology of HIV-1 infection in northern Tanzania. Dr. med., University of Bergen, 1996. ISBN 82–7815–003–6.

Doctoral theses to be finalized in 1996:

- Haram, L: «Eyes have no curtains»; modern Meru women and the political economy of female sexuality. Dr. polit., University of Bergen.
- Heguyes, ES: (Title forthcoming) PhD, University of Swansea, Wales.
- Lie GT: The disease that dares not speak its name: studies on factors of importance for coping with HIV/AIDS in northern Tanzania. Dr. psychol., University of Bergen.
- Lugoe, WL: Prediction of Tanzanian studentš HIV risk and preventive behaviours.Dr. philos., University of Bergen.

Masters degrees:

- Blystad A: The Pastoral Barabaig: Fertility, Recycling and the Social Order. Cand. polit., University of Bergen, 1992.
- Lillestøl S: Universitetet I Bergen – ein mottakarorientert bistandsf¢rvalter? Eit case studie av MUTAN, eit AIDS prosjekt I Tanzania. Cand. polit., University of Bergen, 1993.
- Lugoe, WL: A study of HIV risk behavior among secondary school pupils in Arusha, Tanzania. M.Sc (Master of Science, Health Promotion), University of Bergen, 1994.
- Ngomuo ET: Perceptions af AIDS and AIDS prevention strategies among health workers in Moshi rural district, Kilimanjaro, Tanzania. M.Sc. (Master of Science, Healt Promotion), University of Bergen, 1994.
- Ole-King'ori, N: Socio-cultural factors and HIV tranmsmission in Arusha and Kilimanjaro. M.P.H. (Master of Public Health, Epdimediology), Royal Tropical Institute, Amsterdam, 1993.
- Rekdal, OB: Endring og kontinuitet I iraqe samfunn og kultur. Cand. polit., Univeristy of Bergen, 1991.

Annex IV

KAROLINSKA INSTITUTET, Department of Public Health Sciences,
Division of International Health Care Research (IHCAR)
and
Stockholm Group for Development Studies AB

EVALUATION OF THE NORWEGIAN GOVERNMENT'S SPECIAL GRANT TO PREVENT AND CONTROL HIV/AIDS

UGANDA
COUNTRY STUDY

Gunnar Holmgren
Jonathan Keith Gaifuba
Annika Johansson
Grace Bantebya Kyomuhendo
Christine Oryema Lalobo
Staffan Uddeholt

March, 1997

Acronyms

Acronym	Meaning
AIDS	Acquired Immune Deficiency Syndrome
AWOFS	AIDS Widows and Orphans Family Support
BECCAD	Basic Education Child Care and Adolescent Development
CEO	Chief Executive Officer
CARITAS (Latin forrace)	The Catholic Relief Agency. This agency has received Norwegian support for its Orphans project
CPA	Country Programme Advisor
DACC	District AIDS Co-ordinating Committee
HIV	Human Immunodeficiency Virus
ICASA	International Conference on AIDS and STDs in Africa
IGA	Income Generating Activity
IMAU	Islamic Medical Association of Uganda
LFA	Logical Framework Approach
MCDT	Micro Credit Development Trust
MoH	Ministry of Health
NACP	National AIDS Control Programme
NCC	National Council for Children
NGO	Non-Government Organisation
NOK	Norwegian crowns
NORAD	Norwegian Aid Agency for Development Co-operation
PCU	Pentecostal Churches of Uganda
Pinsevenn	The Norwegian Pentecostal church that has church-related programmes in Uganda including one that focuses on AIDS victims with Norwegian support
PRA	Participatory Rural Appraisal
PWA	Person with AIDS
RB	Redd Barna, the Norwegian Save The Children's Fund. Originally came to Uganda specifically for an orphans' relief programme in one sub-county in Masaka district
SAG	Special AIDS Grant.
TASO	The AIDS Support Organisation
UAC	Uganda AIDS Commission
UCOBAC	Uganda Community Based Association for Child Welfare
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNPAC	Uganda National Plan of Action for Children
USAID	United States Agency for International Development
USD	United States dollars
UShs	Uganda shillings
WHO/GPA	World Health Organisation's Global Programme on AIDS

Executive summary

Nearly 10 % (1,5 million people) of the population in Uganda are estimated to be Human Immunodeficiency Virus (HIV) positive. The reported cumulative number of Acquired Immune Deficiency Syndrome (AIDS) cases is reported to be about 48.000 and the number of orphans over one million (1995). In the age groups between 15 to 19, the number of reported AIDS cases among women is six times higher than that of men. Between the ages 20 to 25, there are twice as many women while men dominate in all age groups above 30. Recent sentinel surveys indicate that HIV spread has slowed down or is even decreasing in some areas.

Uganda has one of the most integrated approaches to HIV/AIDS of any country in Africa and is among the few countries that have established a multi-sectorial National AIDS Control Programme (NACP). This is co-ordinated by the Uganda AIDS Commission (UAC), which reports directly to the Office of Presidental Affairs. As from 1996 the Joint United Nations Programme on HIV/AIDS (UNAIDS) operates in Uganda, with the WHO Resident Representative as chairperson.

Norwegian support to AIDS control in Uganda in the period 1990 – 1995 amounts to about Norwegian crowns (NOK) 35 millions and has come both from the Special AIDS grant (SAG) and from regular funds for Norwegian Non-Government Organisations (NGOs). The three NGOs that have received funding are Redd Barna (RB), The Catholic Relief Agency (CARITAS), and the Norwegian Pentecostal Church. Support has also been channelled through the Global Program on AIDS to the NACP. Norwegian support to the NACP expired in 1992.

Redd Barna, which has received the largest funding, started its project in Masaka as a specific AIDS orphans relief operation. This has turned into a comprehensive child centred community development programme. Redd Barna has also been one of the instigators of the establishment of the National Council of Children (NCC) and of the Micro-Credit Development Trust (MCDT) aiming to loan money to poor rural people for income-generating activities. CARITAS supports an AIDS orphan project essentially by providing school fees. This project is also attempting to widen its community base and lessen dependency on external support. The Norwegian Pentecostal Church operates a small project focusing on income-generating activities for HIV/AIDS afflicted families.

The change in focus of the Redd Barna project from direct relief to AIDS-affected individuals and families to a wider development approach, is typical for many AIDS-related projects in Uganda, NGOs as well as government. The evaluation team is of the opinion that this is basically a sound development. This has come with the realisation that AIDS is not an acute disaster but a chronic crisis that has to be tackled in long-term, sustainable community development approaches. The projects supported by CARITAS and the Pentecostal Church also attempts to increase community involvement and self-sufficiency. Their approach is basically limited to the community level, whereas the Masaka project addresses the need for capacity building throughout the whole system from district level and below.

CARITAS and the Pentecostal church, by the very nature of their organisations, can not be expected to engage in comprehensive community development activities like the Redd Barna. Both do a commendable work to assist families and individuals in need. However, creating dependency is problematic and both projects should be encouraged to find a balance between their support for the AIDS afflicted and their families on one hand and the need to strengthen the coping capacities of the communities to care for its own members, on the other.

It is the view of the team that future Norwegian assistance to HIV/AIDS in Uganda should focus on community based programmes. Many other donors support national level programmes and integration in Uganda. While co-ordinating closely with UACP and UNAIDS, Norwegian assistance should draw full benefit from the experiences gained by the three Norwegian NGOs working in Uganda, particularly the Masaka project. Appropriate channels should be identified to multiply and adapt the strategies of participatory community development, integrated in district planning, as developed by the Masaka project. More emphasis should be paid to

developing »community owned» indicators to monitor the processes, with special attention to gender issues and vulnerability.

The team is concerned, however, that when specific HIV/AIDS interventions are replaced by more integrated development support, donor interest may wane and funding decrease. It is extremely important, therefore, to maintain high vigilance of the development of the epidemic and its socio-economic consequences, including the needs and human rights of AIDS widows and orphans. At national level, this is the responsibility of UAC, NCC, and other specialised bodies . The linkage to donors will be maintained through the UNAIDS. We recommend the Norwegian Embassy and NGOs working in Uganda to follow closely the activities of UNAIDS through participation in the Theme Groups and in other ways.

LIST OF CONTENTS

1.	INTRODUCTION	101
2.	HIV/AIDS IN UGANDA	102
3.	NORWEGIAN SUPPORT	105
4.	OBSERVATIONS AND DISCUSSION	106
5.	CONCLUSIONS	115

1. Introduction

Uganda's recent history is one of major internal upheavals. Apart from the North, where there is still unrest, the rest of the country now enjoys considerable stability. Most of the country is fertile and has sufficient rainfall. Agriculture is the main export earning sector. The country is at present doing well in a macro-economic perspective, but poverty is still widespread and severe, not least because of the previous civil unrest and the present AIDS epidemic.

This country study was carried out by a team of three Ugandan consultants and three Swedish consultants. The two teams prepared certain aspects of the study before the country mission proper, when they merged in a joint working group and divided the responsibilities during the main study period. The Ugandan team members were Christine Ortema Lalobo, consultant with World Learning Inc, team leader; Jonathan Gaifuba, Head of Health Education Department, Ministry of Health and Grace Bentebya, Lecturer, Department of Women's Studies, Makerere University. The Swedish team members were Gunnar Holmgren, MD, Unit for International Child Health, Uppsala University, Swedish team leader; Annika Johansson, sociologist, International Health Care Research, Karolinska Institute, and Staffan Uddeholt, economist/consultant.

Different sources of information were used: (i) Key informant interviews, in all 26. The informants were chosen by the leader of the Ugandan team in order to reflect all aspects of the issues. Only one of the interviews which was planned could not be carried out; (ii) Review of secondary data. A considerable amount of documents and reports were made available by Ministries, NGOs, and UN agencies; (iii) Seven study visits to observe project activities, outreach and interventions of NGOs; (iv) Six group interviews with representatives of specific groups of certain interest for the study; (v) Informal interviews with people met casually in the course of the study (Appendix 1).

2. HIV/AIDS in Uganda

2.1 The HIV/AIDS situation

Uganda was the first country in Africa to report the advent of AIDS in 1983 following the observation of the first cases of «Slim» in 1982. HIV/AIDS is the most serious public health problem in Uganda and a major cause of death among adults. About 1.5 million people (nearly 10 % of the population) are estimated to be infected with HIV. Sero-prevalence rate ranges from 4% in rural areas to 25 % in urban areas. Nearly 80% of those affected with HIV in Uganda are between the ages of 15 and 45. In the age groups between 15 to 19, there are six times as many girls among the HIV-positive. Between the ages 20 to 25 there are twice as many women, while after 30 the men dominate among reported AIDS cases.

As of December 1995, the cumulative number of AIDS cases reported to the NACP/MoH Surveillance unit was 48,312 (adults and children) but is likely to be much higher because of under-reporting and under-diagnosis. However, recent sentinel data points towards a turning point in the spread of the epidemic. In some areas in Uganda, recent data indicate that the rate of new cases of infection appears to be stable or decreasing.

Currently in Uganda the number of orphans is estimated to be between 1.2 to 1.5 million. During the past two decades war generated many orphans. Currently AIDS is the principle cause of orphanhood. It is projected that AIDS alone will be responsible for over 500.000 orphans in 1996.

2.2 National response and organisation for support

Since the seriousness of the epidemic became known, the government has taken a leading role in the fight against AIDS, and has demonstrated an openness regarding the realities and impact of HIV/AIDS. AIDS is discussed in the work place, at home, through religious organisations, in places of learning, within the communities, etc. There is an enabling environment, supportive of NGO initiatives. It is in conformation with the government policy that during the recent international AIDS conference in Kampala in 1996 (IX ICASA), PWA fully participated in the organisation and proceedings of the conference.

The initial strategies to combat AIDS in Uganda were based on the concept of individual risk behaviour as the cause of the spread. The first AIDS Control Programme, NACP, in the Ministry of Health, established in 1986 with the assistance of WHO, focused on individual risk-reduction; to stay free from AIDS was seen as an individual responsibility. Large scale mass media campaigns and education programmes spread the message of no sex before marriage, staying faithful within marriage or, at least, reducing the number of partners. (Condom use was not and is still not officially propagated). Gradually the messages became more targeted to specific groups: to «high risk groups» such as prostitutes and lorry drivers, to «ordinary» men and women, to soldiers, policemen, school children etc. Services for HIV testing, STD treatment and for counselling and care of the HIV/AIDS afflicted were expanded. However these early efforts to change risk behaviour met with little success, and no change in the spread of the epidemic could be noticed.

The necessity to confront AIDS prevention and the consequences of AIDS at the societal level became increasingly clear. Epidemiological data gave evidence of the unequal distribution of HIV/AIDS in society. For example, while in the initial stages the HIV prevalence was equally high among high and low economic groups, the shift has been towards higher prevalence among the poor. In Uganda, like in other African societies, AIDS is above all becoming a disease of the poor. More-over, the fact that young women are heavily over-represented among reported AIDS cases is a stark reminder of the subordinate position of Ugandan women and their exposure to sexual exploitation.

Efforts to reduce stigmatisation and avoid discrimination of HIV/AIDS victims have been an important component of HIV/AIDS programmes in Uganda. Based on a public health rational - realising that the HIV-positive would not come forth otherwise – and on ethical grounds, outstanding achievements have been made especially in the field of care and counselling and legal protection. Initiatives like the Philly Lutaaya programme have encouraged many PWAs to talk openly about their personal experience. The humanitarian approach of TASO and the mission hospitals in their programmes for counselling and care of people with HIV/

AIDS, have set examples also for other countries. Legal initiatives, e g the newly created Juvenile Courts and Uganda Association for Women Lawyers' «children's desk», cater for AIDS orphans rights and need for legal protection, while the protection of widowers is not yet as well developed.

When the staggering dimensions of the AIDS orphan tragedy became clear, a plethora of NGO initiatives as well as Government actions were initiated to care for the orphans and safeguard their rights. UNICEF assisted the formation of the consortium UCOBAC in order to build capacity of local groups through information sharing, advocacy, training as well as financial support to orphans activities. Many other organisations, including the Norwegian NGOs Redd Barna, CARITAS and the Pentecostal Church, also initiated programs aimed at addressing the orphan crisis. UNICEF gave support to the Ministry of Labour and Social Affairs to develop and place orphans' registers at the Parish level with the aim to monitor the orphan crisis and plan interventions. However, the use of this register came to a standstill or proved counterproductive. To single out AIDS orphans among all children in need turned out to be stigmatising and created dependencies and needs which no programme could meet.

Orphans in the Ugandan society

In traditional society, orphans were taken in as children of the family and became productive members. In severe crises such as wars, famine or epidemics, the communities would organise themselves and take charge. In the early years of the Amin regime, the social system of support was still viable, but gradually the toll of war, the displacement of the population and the breakdown of social services completely drained the family system of support. Orphans became a liability, another mouth to feed, more school fees to be paid. The onset of AIDS in Uganda came at a time when the economy and social services were already severely run down. Taking on orphans was done reluctantly and had negative economic consequences for the caretaker.

Children feel the impact of AIDS long before the parent/s die. As an adult falls ill the income falls. Girls get withdrawn from school first, in order to help with domestic chores at home. When parents die, children are often moved to the extended family and siblings are separated. There is a danger of discrimination in their new families between own and adopted children. This leads some children to run away and become street children. The majority of street children are orphans. They often end up in occupations where they are vulnerable to physical or sexual abuse. This is especially true of girls in domestic employment.

Most HIV/AIDS programmes in Uganda today have shifted from an individual focus, to efforts to reduce social and economic vulnerability and to create an enabling environment for behavioural change. The growing awareness that AIDS is not an acute disaster but a chronic condition in the Ugandan society has triggered off new programme approaches, aiming at strengthening community coping mechanisms, building capacity and ensuring programme sustainability within the larger system and in interaction between sectors. The creation of the Uganda AIDS Commission in 1991 can be said to reflect (if not being an instigator) of this «paradigm» shift.

This development has taken place during a period when important decentralisation reforms have been implemented in Uganda. Resource mobilisation and decision making for the social sector has been transferred from central to district level. This has implied a radical transfer of responsibility and initiative from the centre to the periphery, with great scope for a more democratic political system. However, it has also imposed extraordinary strain on district structures and functions, with implications for all programmes working with and through district systems.

This is the case for many of the national and international NGOs involved in HIV/AIDS-related community programmes in the country. Basically these are of four different types:

a) Projects focusing the HIV/AIDS clients and their families. The AIDS Support Organisation, TASO, and the mobile home care teams of the mission hospitals such as Nsambya in Kampala, the Kitovu hospital in Masaka district, and the Pentecostal Church are such examples. A number of programmes have been developed specifically for orphan care and provision of support: The AWOFS AIDS and the Orphan Project at Kitovu hospital, supported by CARITAS (see below).

b) Community based projects initially having the AIDS affected in focus, but widening the scope to the whole community, with the aim to strengthening community capacity to prevent transmission and to cope with the consequences of HIV/AIDS. Several small and large scale projects, usually run by a foreign NGO and with external support, have developed from an AIDS focus to a more integrated community approach. The Redd Barna project (see below) is an example of this.

c) Community initiatives for mutual aid, often without external support. These are small local groups, formed to address the needs of individuals and families hit by AIDS. Most common is that women come together in groups of 10 to 15, pooling resources and granting each other informal credits, helping each other in child care, in farming and income generation, taking up orphans of other families in the group, etc. Many of these women are older and take care of orphans of their deceased children.

d) Certain national associations have with minimal or no support from outside developed their own AIDS prevention and control programmes. One example is the Islamic Medical Association of Uganda which runs an AIDS programme including health education and family planning for women, education for school-children and men in the mosques etc. Having the confidence of their constituencies, they have sometimes with small means achieved impressive results with wide multiplying effects.

As from 1996, the UNAIDS operates in Uganda with the aim to co-ordinate the UN agencies and their support to national programmes. The Resident Representative of WHO has been selected as chairperson of the UNAIDS Theme Groups, and a Country Programme Advisor has been appointed. The Theme Groups are expected to be in constant communication with the Uganda AIDS Commission and with the different multi-sectorial National AIDS Programmes. They will consult on a regular basis the bilateral and multilateral donors, NGOs, private sector, religious organisations, academic and research organisations and other relevant organisations.

A comprehensive review of AIDS prevention and control activities in Uganda is planned for October-November 1996. The review will address the existing organisational and structural arrangements of the UAC, NACPs, DACCOs and other local structures and NGO networks.

3. Norwegian support

The Norwegian contributions to the AIDS Control Programme through WHO/GPA started in 1986 and continued up to 1992, at an annual level of NOK 2.0 million (no instalments were made in 1990). During the period 1990–95 Norway's total AIDS-related assistance to Uganda amounted to NOK 36.0 million. The assistance has been financed from the Special AIDS Grant and from funds for Norwegian NGO. The distribution between different channels are:

Norwegian support to AIDS programmes in Uganda 1990–95

Channel	MNOK
WHO/GPA	4.0*
Redd Barna	22.0
CARITAS	8.5
Pentecostal	1.5
Total	36.0

*(2.0 1991 and 2.0 1992)

Below is a short description of the three AIDS-related projects run by Norwegian NGOs:

Redd Barna project Social Consequences of AIDS

The project was initiated in 1990 in Masaka district, one of the most AIDS-affected districts in the country. It started as a relief operation in one sub-county, with Norwegian staff as direct implementers, focusing on assisting the AIDS-orphans. This approach proved to be costly and ineffective and with undesirable effects, as it tended to stigmatise the orphans while leaving other needy children without support. In response to a review in 1994, the project has changed from its relief focus to a multi-sectorial approach, cutting across social and economic sectors to become a child-centred community development project, with the aim to «improve living conditions for children in Masaka District with emphasis on increased access to education, health and nutrition».

The approach of the Masaka project is to strengthen community capacity to plan for and mobilise resources for priority needs for its children. Activities include school rehabilitation, agricultural extension and water supply, income generation for women's groups, credit schemes etc. Strengthening of district and sub-country co-ordination and planning for the social sector, especially for the District Plan of Action for Children, DPAC, is a major emphasis in the project.

CARITAS support for Kitovu Hospital Orphan project

Kitovu hospital in Masaka district was one of the first hospitals in Uganda to start mobile home care for AIDS-patients in 1987. Through the contact with AIDS-patients and their families, an orphan project was initiated in 1989. CARITAS has assisted 8000 orphans, of whom 85 % are AIDS-orphans. Most of the support has gone to payment of school fees. At present 65% of the costs for school fees are paid by the project; in 1997 will go down to 50 % in order to reduce reliance on external funding.

The project is now attempting of shift from the individual AIDS orphan focus, to include also other children in need and to increase community participation. Support for income-generating activities, school rehabilitation and training of community volunteers are some of the components. With funding from Redd Barna some members from Kitovu team have made study visits to home based care projects in Zambia.

Norwegian Pentecostal Churches support to PCU/ AIDS project

Since 1992 the Norwegian Pentecostal Church assists the PCUs AIDS programme in Mpigi district near Kampala. Groups of families affected by AIDS have been assisted in small income-generating projects to raise funds to pay for school fees for AIDS orphans, etc. The emphasis is on strengthening group solidarity, mutual aid and local leadership, to enhance community responsibility for the consequences of AIDS among its members.

4. Observations and discussion

In the context of the recent developments in Uganda, particularly the decentralisation policy and the changing HIV/AIDS strategies as described above, some major issues related to the Norwegian support will be discussed. The Redd Barna project in Masaka is the largest of the projects supported by Norway, and most of our observations therefore refer to this, but the CARITAS and the Pentecostal Church projects are also commented upon.

4.1 Has the Norwegian assistance been flexible in its response to the crisis?

Ugandans are not used to dealing with chronic and on-going crises. Instead they have experience of dealing with disasters which strike suddenly. The awareness is now spreading that the HIV/AIDS epidemic is not a sudden disaster but will remain a chronic crisis for many decades to come.

Since the beginning, most Norwegian support to HIV/AIDS in Uganda has focused on the AIDS orphans. Many donors who engaged in payment of school fees for orphans, realised that their response caught them in a web of long-term support. In a community where school enrolments are very low, singling out payment of fees for orphans creates a rift and resentment among those members of the families on whose care and support the orphans depend. Also, relief creates a dependency syndrome.

After the first years of trial and error, the Masaka project shifted its strategy from acute relief to an integrated community approach. On the whole, we find this to be an appropriate and flexible response. It is also noteworthy that Redd Barna has continued to receive support from the SAG even after leaving the «AIDS orphan» profile and adopting a broader approach. This shows commendable flexibility from the Norwegian donors.

CARITAS and the Pentecostal Church have also shown flexibility in responding to the need for greater community involvement, but they have gone less far than Redd Barna in this respect. For CARITAS this is normal, since for the mission hospitals, the HIV/AIDS clients are the focus for their activities, and not community development as such. However, the problem of creating dependency is a real one, and both projects have to find a balance between caring for the AIDS sick and their children on the one hand, and the need to strengthen the capacity of communities to care for its members on the other.

4.2 How sustainable are the activities supported by Norway?

A review carried out in 1994 of the Masaka project raised a number of concerns, notably over the high project costs. The review recommended to enhance cost-effectiveness by including a larger number of sub-counties and villages, to change the project from its vertical to a more horizontal structure and to reduce the number of expatriate staff.

Our impression is that the project reacted adequately to this critique. The coverage increased from one to seven sub-counties. All project staff are now Ugandans, trained as multi-purpose workers rather than specialised in one sector only, which clearly makes the operations more cost-effective.

An important dimension of sustainability is the extent to which a project is integrated in administrative and other structures at different levels, and how it contributes to capacity building within these.

The Masaka Project operates basically at three levels: village, sub-county and district. The village level is where most activities take place – renovation of schools, income generation, agricultural extension etc. The project works directly with the local leaders, Teachers and Parents Associations, women's and farmers' groups and groups of students. The PRA method has been used in several villages as a way to strengthen community capacity to cope with its problems.

Participatory Rural Appraisal

The aim is to mobilise the community in a process of identifying and prioritising among its needs and developing plans to improve the situation. The role of the project is to stimulate and facilitate the process and assist with technical know-how, but never to provide solutions. The process moves through five stages, from pre-planning and sensitisation, through training of facilitators, social mapping and mobilisation of local resources after which groups are formed, basically according to gender and age. Each group then develop its own plans. Women's and children's issues are kept central. In the last stage, plans are implemented, often with the help of funds from income generating projects. The whole process may take between one to two years.

Experiences from the Masaka project have allowed to identify certain conditions for a successful PRA: allowing the process to take time; use exchange visits from successful groups in other villages to learn from their experiences; appropriate interventions in the middle of the process to stimulate interest (e g videos, sports programmes); use credits rather than grants; keeping the group size rather small.

The next level is the sub-county, which co-ordinates several villages, mobilises resources and is the channel to reach the decision makers at district level. The project has worked closely with local officials, provided management training and facilitated the development of sub-county planning. Plans of Action for Children, PACs, have been developed in several sub-counties and others are in the process of developing and adopting them.

The question of local sustainability is closely related to the process at district level. Unless the locally defined needs and aspirations are listened to and responded to by competent staff in the district administration, the local process is likely to die out quickly. The local community can do certain things by itself, but it cannot staff a health centre or a school, develop curricula, eradicate animal or crop diseases etc.

Decentralised planning is new in Uganda, and there is a lack of competence and experience at district levels. Training and technical support is required. To meet this need has been one of the main objectives of the Masaka project in recent years. The project co-ordinates closely with District Planning Unit in Masaka and its technical Departments (Health, Education, Agriculture, etc). Two Redd Barna staff have been seconded to the District Medical Office, several district staff have been trained and participated in workshops, funded by Redd Barna.

The project has facilitated the development of the District PAC and given support to training of village health committees, community health workers, traditional birth attendants, teachers and school managers, including training in AIDS and counselling. Redd Barna also supports training of teachers for pre-primary education and for a new programme developed by UNICEF for out-of-school children called COPE, Complementary Options for Primary Education.

Our impression is that Redd Barna is doing a commendable work in building technical competence and strengthening the planning process from district to village level. This is an appropriate strategy for building a sustainable programme. It remains to be seen how sustainable the process is after the project has phased out. Our impression is that the activities in the village still depends much on the encouragement and professional input of the project, but that basically a sound and viable process has taken well off the ground.

According to several of our informants, the weakest link in the chain is at sub-county level. Being the nearest political/ administrative level above the villages – and an important one – it lacks the natural community anchorage, while being far from the power centre at district level. To continue to build capacity and sustain the planning process at sub-county level is probably one of the most vital task for the project to ensure future sustainability.

An important dimension of sustainability is the degree to which a project becomes economically viable for the beneficiaries. One common approach, used by all three Norwegian NGOs operating in Uganda, is to increase economic self-sufficiency through income generation. Community groups are given credits and assisted with technical and managerial know-how to engage in small projects, e g growing cash crops, small animal husbandry like pig or chicken raising, village industries such as making bricks, or establishing a forest plantation.

A common problem in income generation projects mentioned by the Masaka project staff was the lack of time, especially of the women. Many families are single-adult families, mostly women-headed. They were already stretched to the limit with responsibility for farming, household chores and child care, sometimes including a number of orphans. Overworking is especially acute in the rainy season when the children are away at school and cannot help with domestic chores and field-work. Involving men in order for them to take a greater share of the domestic burden was felt to be important, but many men are away for extended periods working on coffee plantations or in town. It is interesting to note that one of the key factors for success in income generation was that the groups should be uni-sex, i. e. either men or women, but that the treasurer should always be a woman (even in men's groups).

Redd Barna plans to phase out gradually of the Masaka project over a period of 5 years. This seems reasonable, but it should be stressed that the economic base for groups and communities to take over full economic responsibility may take a long time. Phasing out too early could be devastating for activities that are not yet economically viable. The successful operation of the MCDF (see below) will be crucial in this regard.

For the two projects supported by CARITAS and the Pentecostal Church, the question of sustainability is more difficult to judge. Although justified on humanitarian grounds and with good educational results – over 8000 orphans have been educated with CARITAS funding, some have even been paid for university training – one of the negative aspect of singling out AIDS orphans for direct, external support is obviously that communities are not empowered to take over responsibility when the support is phased out. A review of CARITAS Orphan project some years ago recommended that the dependency on external support should be reduced. Efforts are being made in this direction – in 1996 CARITAS paid 65 % of school fees and it is planned to reduce this proportion to 50 %. Families are encouraged to generate their own incomes in small projects to contribute to school fees. However, it was not clear to us what the plans were for granting credits, nor how the groups would be trained to manage such projects.

It should be noted that the Orphan project is part of Kitovu hospital's mobile home care of AIDS patient, which is increasingly working with community participation, including the training of volunteers. Hopefully the orphan project will gradually be part of more comprehensive approaches to assist communities to care for its members in need, where the AIDS orphans constitute a large but not exclusive part.

The project operated by the Pentecostal Church is much smaller than CARITAS' project but similar in that the focus is on HIV/AIDS client and their families. With the ethos of community solidarity and leadership, which permeates the Pentecostal project, is now also moving towards greater community involvement by encouraging income generation activities. Our understanding was that the project depends much on one expatriate staff, a member of the Pentecostal Church. At the time of our visit this person had recently arrived in Uganda and had no previous experience of community work in Africa, which clearly makes the task very difficult.

4.3 Has emphasis been given to activities directed towards the most vulnerable groups?

When the Masaka project shifted its emphasis from an orphan relief to a broader community development approach, it reduced the ethical dilemma of singling out AIDS as a criteria for receiving support, as well as the risk of stigmatisation. On the other hand, the project lost its initial focus on the most vulnerable. The Redd Barna is highly aware of this problem and seeks to address it in different ways. Income generating projects especially for the benefit of poor children is one way. For example in some villages the project, together with Teachers and Parents Associations, has assisted schools to undertake small income generating projects, run by the pupils. The benefit from sale of the produce goes into a fund to pay for costs for schooling for orphans. Groups of women in the area who run income generating projects also contribute from their profits to this fund.

One should be aware that «community development» does not automatically lead to equity and concern for the most vulnerable. The «community» concept may hide highly diversified power structures and interests, which are not necessarily favouring the most vulnerable groups. For example, the fact that over one third of all households in Masaka are single-adult household, mostly poor and headed by a woman, while the leadership is predominantly male, is reason for being attentive to gender and equity dimensions of community development activities (see point 4.8.).

One way used in the Masaka Project to identify the poorest and most vulnerable groups and individuals has been to use the PRA technique described above, especially the so called poverty ranking exercises. However, experience shows that even in this way, older women and the poorest of the poor tend to be left out of the process. It is also recognised that the poorest and most marginalised may be left out in income-generating activities (they have to be able to pay a small fee every week).

A new and promising initiative to over-come this problem is the establishment of the MCDT (see Box). This may be one of the most significant ventures in bringing sustainability to poor communities. If plans come to fruition it will result in poor women themselves having shares in the bank and owning it. However, there is still the risk that the poorest of the poor and the most vulnerable are left behind and may need special support measures get incorporated in the benefits of the MCDT.

The Micro-Credit Development Trust (MCDT)

This is based on the ideas from the Grameen Bank in Bangladesh where the whole credit system is geared to the needs of poor women. Initiated by a number of Redd Barna staff members, the Ugandan MCDT was launched on October 5, 1996. The objective of the scheme is to provide support and help to poor people so that they can improve their own conditions through productive enterprises and social development activities. The Founding members were carefully selected from a cross section of Ugandans who had demonstrated concern about, and commitment to, the improvement of the condition of poor people in the country. They contributed their own resources ($100 per member) to be used together with funding and assistance from Redd Barna and other donors to start the scheme. It is intended that the MCDT will eventually stand on its own feet economically and be owned by the borrowers who would have shares in the bank.

4.4 What indications are there of multiplier effects?

As described above, the three NGO projects supported by Norway developed during a very dynamic period in Uganda, when responsibilities were delegated from central level to the districts, and new inter-sectorial approaches were tested to address the HIV/AIDS epidemic. The UAC was established and an NGO-co-ordination body created, offering fora for sharing ideas and experiences. It is difficult, therefore, to trace multiplier effects or replication of ideas to a specific organisation or projects. Certain Redd Barna initiatives are, however, possible to single out for their replication effects, e g the «Stepping Stones» programme, developed jointly by Action Aid and Redd Barna. With the help of text books and a video, the programme uses discussions, role playing and PRA to encourage community groups to identify and analyse their problems and needs. The programme has proved valuable in dealing with sensitive issues such as sexual behaviour and HIV/AIDS prevention, but is also useful in many other areas of improving health. The training is however time-consuming and quite complicated, and it remains to be seen how replicable the method is in a wider context. It has now been introduced in many parts of Uganda and in other countries in the region.

The Micro Credit Development Fund, for which Redd Barna has been one of the main instigators, seems to be an initiative with very large potentials for replication and for reaching out to the poorest groups. The Grameen Bank in Bangladesh, which is the model for the Ugandan MCDF, has spread to over 50 counties over the whole developing world and is providing loans to millions of poor women. The legal hurdles to the Uganda MCDFD has still to be cleared.

The community development approach used in the Masaka project is by no means unique in Uganda. However, our impression is that the way the approach has been developed within the project, not least the patient use of PRA, is exemplary and ought to be replicated in other contexts.

CARITAS' Orphan project may not provide much of replication effects as such; rather it represents an approach which was typical for the earlier years of the HIV/AIDS crisis. The Orphan project is however part of Kitovu Hospital's pioneering work for community care of the HIV/AIDS clients and their families. Together with Nsambya mission hospital in Kampala, Kitovu's experiences have provided example for other parts of Uganda, and also for other countries. Redd Barna has facilitated this by funding members from Kitovu Hospital HIV/AIDS team to visit similar projects in Zambia to share experiences.

4.5 Has the Norwegian support gone to preventive activities?

Indirectly Norway have supported preventive work through its over all support to UNICEF in Uganda. UNICEF's BECCAD programme is a comprehensive programme for AIDSs prevention, which aims at addressing the needs of children and adolescents by creating an enabling environment and strengthening self-respect and problem solving capacity. The girl child is in special focus. Parents, teachers and community leaders are involved in the programme, executed through the district administration.

The pedagogic and developmental approach of BECCAD are clearly innovative and seems in many ways more advanced than what we know from our own country. We had no possibility to asses their contribution to reducing risk behaviour among adolescents but there is no doubt that they represent a major step forward in education for HIV/AIDS prevention. Redd Barna has been actively involved in the introduction of BECCAD in Masaka and is a member of the District multi-sectorial Committee on Population and Development, which is responsible for this programme.

In the Masaka project, members of the income generating groups are encouraged to become Behaviour Change Agents. Peer educators are trained in primary schools using role playing, songs and plays. Teachers have been trained as TOTs and pupils have developed the skills of introducing behaviour change in areas such as sexual behaviour, nutrition, immunisation, oral rehydration therapy in diarrhoea and environmental hygiene. They have established health clubs at schools. Most of these are in primary schools but some secondary schools are also involved.

These are useful activities, but education is clearly not enough. It is important to keep in mind that average age for first sexual encounter for out-of-school youth in Uganda is 13,5 and for school children 15 years. A major problem of HIV/AIDS prevention among youth is the lack of good contraceptive counselling and services. This is still a very delicate issue in Uganda and it is important for Redd Barna to clarify its own stand. We are uncertain about the extent to which the project actually addresses this need in its programmes (UNICEF some years ago had no such component in their AIDS prevention programme for adolescents, but is now including it).

4.6 Accountability

The potential problems for an NGO like the Redd Barna of interacting closely with the processes at district level should not be overlooked. The decentralisation policy puts new and heavy responsibilities at the district administration. District officials may often get bogged down by a whole range of new tasks and requirements, for which they are not yet fully equipped, including handling funds. Checks and balances must be built into the structure to avoid embezzlement and corruption, but these are not always effective. For example, a «money tracer study» carried out by a UN agency concluded that development funds had a tendency to get blocked at district level, and that corruption was not uncommon.

NGOs themselves are of course not spared from the problem of corruption. Money for AIDS programmes has been easily available (some would say too easily), in comparison to other health issues. One major weakness of NGOs generally is the weak accountability. We found no evidence of this in the three Norwegian NGOs, but it is maintained that the mushrooming of local NGOs in a climate of easy money has increased the danger of corruption. The use of the «open accounting» system has proven to be useful. This involves a monthly scrutiny of the books by a representative group from the NGO, which increases transparency in accounting and a feeling of ownership of the financial process. Favouring the appointment of women treasurers seems to be beneficial.

4.7 Have the activities given due emphasis to ethical and cultural issues and to human rights?

In the Masaka project, a number of observations and reports give the impression that cultural and ethical issues are well taken care of. The whole ethos of PRA takes great cognisance of local culture and never forces outside ideas on people but rather they develop their plans in their own context. Cultural values are respected and the process is a democratic one. Other examples: corporal punishment is said to have been reduced in the schools where the projects operates, and child abuse is less common. School uniforms are now no longer mandatory, allowing some of the poorest, including orphans, to come to school in simpler clothes.

A fine example of respect for cultural values is a study carried out by Redd Barna among the Karimojong, a pastoralist group in the North of Uganda, perceived as

backward and problematic by the larger society. Negative to education, they refuse to send their children to school. The study was made to find out the reasons for this:

> *«Unearthing the Pen»*
> In this nomadic area, colonial approaches during the world war to recruit soldiers into the army led to clashes with the traditional leaders. The symbol of the recruiting officers – the pen – was cursed. The reason behind the antipathy to education was not understood until this curse was revealed. After deep discussions with the community leaders, a traditional ceremony was held in the presence of all the community leaders to remove the curse. This ceremony was called «unearthing the pen» and provides an unprecedented opportunity and ideal starting point for supporting education in that area.

Redd Barna has been active in the protection of children's rights and child advocacy in Uganda in different ways, notably in its support to The National Council for Children, which will hopefully become an important body for the monitoring and protection of children's rights. In support of the implementation of the Uganda National Plan for Children, UNPAC, Redd Barna has trained a team of «Child Advocacy Programme Officers», CAPO. Among their tasks is to sensitise and train in children's rights issues in the districts and sub-counties.

The need for legal protection of orphans was brought to our attention in many ways, e g by the reported increase of child-headed households in Masaka: When the parents die, relatives often take the land of the diseased, to which the children have the legal right. The result is that an increasing number of orphaned children decide to stay on their land rather than move to another family. The project, together with the District Probation Officer, has conducted training session with local leaders at various levels on children's rights and legal issues affecting children. We did not have the opportunity to assess to what extent violations of children's rights are followed up by legal or other action, nor the issue of violation of AIDS widower's rights.

4.8 How good is the monitoring and development of indicators?

Among the Norwegian NGOs, the most detailed plans have been developed by Redd Barna, following the standard LFA format which includes monitoring and indicators. Certain indicators are relatively easy to identify and report, e g the proportion of orphans in school and out-of-school, whether corporal punishment is still used in schools and if so how frequently, the number of successful income- generating projects, the number of villages that have completed the Action Programme for Children, PAC, etc. The project produces regular reports presenting the developments of these indicators.

Example of indicators that are currently not used but could be included in the regular monitoring of the project are the well-being ranking score, which is used to identify the most vulnerable in the community by the members of each of the PAC programmes. This score should in due course show if there is a change for the better. Each of the groups that have income-generating projects are trained to become behaviour change agents in the rest of the community. Their progress could be monitored by qualitative indicators using focus group interviews, key informants and other appropriate methods. Indicators monitoring the involvement of girls and women in the process of community development, in education activities, access to and constraints in receiving credits etc, ought to be developed and periodically reported. BECCADS monitoring system may be of value to the project in this regard. Men's involvement in community development activities and in income generation is another area where both quantitative and qualitative monitoring is important. Gender desegregation of quantitative indicators should be done whenever feasible.

One problem with indicators is that they are usually developed for the benefit of the donors and seldom together with the beneficiaries. Doubt has been voiced about the value of advanced models of monitoring and evaluation in which the beneficiaries are not stake-holders. It is felt that indicators ought to be developed within the community and together with the community members, on criteria that will benefit the community. These ideas are being introduced in the Masaka project. The aim is to strengthen a process of monitoring and evaluation which is «owned» by the community and will give its members a clear indication of progress in their work. For example, one of the women involved in developing indicators described the process as being «like

when you are cooking plantain bananas wrapped in banana leaves. When the steam starts to rise you know the bananas are cooked».

We fully support the idea of «community owned» indicators, but there is obviously also a need for external monitoring and evaluation, to meet the demands of NGOs' accountability to their funders, and occasionally for a more analytical view of project process and impact. It is important to recall that the initial criteria for selecting Masaka district, both for the Redd Barna project and for CARITAS Orphan project, was the extraordinarily high HIV prevalence rate and the large proportion of grandparent/ children households in the district. An increasing number of households are child-headed, reflecting the strains on the extended families, as well as the weak legal protection for orphans. A bitter truth is that the number of people dying in AIDS and AIDS orphans will continue to increase in Masaka over the coming years. With an HIV/AIDS prevalence rate which ranks among the highest in the world for a rural area, no-one knows how the communities will react to increasing rates. *There is a critical need, therefore, to monitor the progression of the HIV/AIDS epidemic and its impact on the communities. How will they cope with the even higher stress on the extended family system, how will institutions like schools and health centres cope, how sustainable will the community participation process be in this perspective? Is there a limit on the number of orphans that a community can cope with?*

4.9 Has the Norwegian support improved co-ordination and multi-sectorial approaches?

Our observations concerning the Masaka project have demonstrated an increasing degree of co-ordination between the project, other local and international NGOs in the district and district administration in multi-sectorial approaches, particularly education, health and income generation. *Our impression is that the project has taken up the challenges and opportunities offered by the decentralisation process in a commendable way, and now functions as a catalyst between various actors at district level and below in multi-sectorial and participatory processes.*

With their different aims and focus, this is less the case for CARITAS the Pentecostal Church, although both projects interact when needed with local structures and CARITAS with local and international NGOs (e. g. UCOBAC, Redd Barna, World Learning). The extent to which Norwegian support has contributed to national level co-ordination is more problematic to see. Norway supported the NACP within the MoH up to 1992, when funding was withdrawn. The establishment of the UAC in 1991 was met with great interest and hopes for a more efficient multi-sectorial NACP, replacing the vertical programme within the MoH. The reason why Norwegian funds were withdrawn, was the judgement from Norwegian side that funding was adequate for the Commission.

It seems that the hopes for effective co-ordination have not yet come to fruition. We heard several actors outside the Commission commenting on the inadequate capacity of the Commission to prioritise and co-ordinate the ministries' AIDS Control Plans. For example, the Ministry of Education proposed an NACP work plan for 1996 amounting to 200 million UShs, of which less than half was approved by the UAC. The main component of the this programme is the production of a Counselling Manual for Teacher Counsellors in schools and colleges and executing workshops for teachers, a program that can be regarded as having a top priority for AIDS prevention. However, by September 1996 only a small fraction of the allocated sum had been disbursed. The planned activities had been seriously delayed and the concerned staff members were demoralised.

If this example is significant for the situation 5 years after the establishment of the Uganda AIDS Commission, *there is cause for concern and a need to analyse the reasons for the low efficiency of the Commission and the low level of resource mobilisation for sectors outside health.* One reason may be the fact that HIV/AIDS programmes were previously almost entirely health sector funded. This again is related to the fact that WHO was the major funding agency for HIV/AIDS programmes and that donor support channelled through WHO are normally health sector funds. It will be a challenge for the new UNAIDS to mobilise and channel funds to sectors outside the health sector. This will also mean mobilisation of these sectors in the donor countries. The recent review of the NACP in Uganda will be important to guide donors on needs and channels for various sectors and multi-sectorial programmes.

It is a sad experience from other countries and programmes that central integration units tend to become passive and bureaucratic. It may be unrealistic to expect a central organ that is not in daily contact with felt needs

to retain a sense of urgency in their task of providing national leadership. However, an effective central co-ordinating body for multi-sectorial AIDS programmes is obviously essential in a county like Uganda and all donors have a responsibility to contribute to this.

4.10 The advantages and disadvantages of an integrated approach

It is gratifying to note that 13 Ministries have accepted a role in the prevention and control of HIV/AIDS. However it is not yet clear to what extent HIV/AIDS is integrated into the on-going programmes of respective ministries. A general view, shared by the team, is that integration of HIV/AIDS mainly has advantages, but there are also potential dangers in this approach. The fears are that if HIV/AIDS is «mainstreamed» into other programmes and activities, it may be marginalised, funding reduced and the outcome specific to HIV/AIDS intervention would be very difficult to measure.

One particular concern is that the integration of AIDS orphans into the wide category of disadvantaged children may obscure the very unique and tragic character of the orphan crisis. The study on «The Situation of Orphans within the Family and Community Contexts in Uganda» conducted by UNICEF, UCOBAC and the Ministry of Labour and Social Affairs showed that the situation of orphans within the family and community context is worse than that of other children. To allow the orphans to completely «merge» into a general community development ethos might be counter-productive and a disservice to the many orphaned children in the Ugandan community. A challenge for the future will be to keep the balance between an integrated approach, while maintaining a focus on the most vulnerable groups, where the AIDS orphans will constitute an increasingly large share towards the year 2000.

4.11 How can NGO activities and Government programmes interact?

The tone of national AIDS programmes within the various ministries tends to be set by the Minister. However, he/she is often enslaved by the «tyranny of the urgent», the immediate political problems that must be solved quickly and so the responsibility for an on-going chronic crisis like AIDS tends to become the responsibility of the Permanent Secretary. He/she attends the UAC meetings but, lacking the political power of the Minister, may become passive about AIDS-programmes. In some districts the District AIDS Committees have struggled to obtain the funds from the Councils and this has damaged their capacity to function effectively.

Decentralisation is a sound reform since at the district level the need of AIDS interventions cannot be escaped. If the decentralisation ethos of the government sector can be combined with the focused, flexible approach of NGOs as in the Masaka district, the result can be a dynamic process that strengthens both sectors.

4.12 The advantages and disadvantages of support through international and local NGOs

To the ordinary Ugandan, the term international NGO means resources. It also means expatriate involvement and in some cases a relief approach. The history of Uganda gave rise to the feeling that most international NGOs are relief oriented and come to the assistance of the community during crisis times. Since 1986 this picture has gradually changed. It is still true that NGOs from the developed countries enjoy patronage, not only because of their culture of transparency and accountability, but also because their benefactors abroad tend to have more confidence in their abilities. In this way the communities benefit much more from support executed through their work. Also, because they are alien, they tend to perform their activities with impartiality. The focus on intervention is need, rather than other factors such as ethnic origin. The international NGOs in many cases come without biases and formed opinions and are therefore likely to listen to the communities.

It must be mentioned, however, that one of the biggest disadvantages with such support is the lack of sustainability. In many cases, because of the logistical support these international NGOs enjoy, when they pull out, the communities cannot sustain the programmes initiated. Unless weaned off this dependency the community promptly falls back and relapses into the original state.

The great assets of an NGO like the Redd Barna lie in the combination of having the technical competence, flexibility and impartiality of an international NGO, and at the same time the credibility to be able to establish «partnership» with local institutions at all levels, government as well as NGO. Such programmes have a good potential for being sustainable even after the pulling out of the international NGO.

Sustainability is built at the grass roots. Local participation must be stimulated and people empowered to take control over their own lives. The Norwegian NGOs contribute to this in different ways, in accordance with their specific mandate and mission. The achievements are good, but small in the context of the enormous efforts needed to combat HIV/AIDS in the Uganda society. There is a plethora of local initiatives – community groups, small NGOs, mutual aid groups and associations – engaged in different ways to alleviate the hardships caused by AIDS in their own communities and to prevent its further spread. To catch this spirit of the civil society and assist viable local initiatives to develop on their own terms is, in our opinion, one of the most challenging and important tasks for the future.

5. Conclusions

The period under review – 1990 to 1995 – has been one of radical rethinking and new approaches in HIV/AIDS – prevention and control in Uganda. Specific HIV/AIDS interventions have been replaced by more integrated development approaches. This is also reflected in the programmes of the three Norwegian NGOs working in HIV/AIDS related projects. While agreeing in principle to this development, the team is concerned, however, that when AIDS is made less visible donor interest may wane and funding decrease.

It is important, therefore, to maintain high vigilance of the development of the epidemics and its socio-economic consequences, including the needs and human rights of AIDS orphans and widowers. At national level, this is the responsibility of UAC. The linkage to donors will be maintained through UNAIDS. We recommend the Norwegian Embassy and NGOs working in Uganda to follow the activities of UNAIDS closely through participation in its Theme Groups and in other ways. It is clear that community capacity building for disadvantaged children as a whole, are in the long run the best way for dealing also with the plight of orphans. It is through the NCC that a balance has to be struck between losing the orphans completely in the pleas for integration, possibly increasing their vulnerability and risking stigmatisation by specific measure for this group. Redd Barna with its involvement in child advocacy in Uganda is well placed to engage in this critical issue and assist in policy formulation.

With regard to future Norwegian support to HIV/AIDS-related programmes in Uganda, the team recommends that *full benefit should be drawn from the experiences gained by the Redd Barna project in its efforts to strengthen district and sub-county co-ordination and resource mobilisation for community development activities.* As the Masaka project is gradually phased out, Redd Barna should be encouraged, and assisted if need be, to document the valuable experiences gained in the project and find appropriate channels and structures to disseminate and multiply this model of child oriented community work. PRA planning, a democratic and ethical tool for working with communities, should be promoted, as well as the operation of micro-credit schemes.

The vulnerability of girls and young women to HIV/AIDS, as mirrored in the statistics, and the heavy load falling on women as a consequence of AIDS, is recognised but not always made visible and acted upon. There is a need for in-built «gender watch dogs» at all levels. In the Masaka project, indicators on empowerment of girls and women should be developed and systematically monitored at community, sub-county and district level. Redd Barna could benefit from the work done by the UNICEF is BECCAD programme in this regard.

We recommend Redd Barna to co-ordinate with UNICEF in developing a policy for how to address the needs of adolescents for contraceptive counselling and services and STD treatment in connection with activities conducted by the two organisations. The team is of the view that continued Norwegian support to CARITAS and the Pentecostal Church should be made on conditions that these organisations make explicit plans on how to reduce dependency on external funding by their beneficiaries, and what level of external support is acceptable and needed in the medium and long term perspective. The Pentecostal Church in particular should be encouraged to seek closer contact with other similar projects and learn from their experiences of community work, particularly in income generation.

In conclusion, *it is our view that Norwegian assistance to HIV/AIDS in Uganda, while co-ordinating closely with UAC and UNAIDS, should focus its future support to community development programmes, integrated in district level planning.* The synergistic effects of an international NGO like the Redd Barna, combining high level technical competence with sound participatory approaches and flexible operation, offer great advantages and give visibility to Norwegian assistance.

In this context we suggest NORAD to commission a study of local NGOs, mutual aid groups and other community based associations involved in HIV/AIDS-related activities in selected districts of Uganda. Drawing upon the Masaka experiences, the aim of such a study would be to identify strategies and channels to strengthen local initiatives to prevent and cope with the consequences of HIV/AIDS in a culture and gender sensitive way.

Appendix 1

Structure of the local government

The Uganda Government adopted the decentralisation policy in 1991. When the decentralisation bill was passed the powers and decision process was handed over to the local councils who now have the responsibilities of developing their own districts.

There are 39 districts in the country and the centralisation statutes stipulate that:

1. Each district has a District Council. Members of the council are elected and their number varies from 55 to 120 according to the size of the district.
2. Every district has a District Executive Committee which is selected by the council. This committee handles the day to day business of the council. There are 9 members of the executive with a Chairman and Vice Chairman and other office bearers.
3. At county level this arrangement does not exist except in Kampala City which is like a district and the municipalities have Local Council (4) four and the executive of 9 members. The Chairman of the Executive Committee is usually the Mayor of the Municipality.
4. At sub-county level, the arrangement is a replication of the district setup. There is the Sub-County Council and the executive of 9 members with the Chairman, Vice Chairman and other office bearers.
5. The Sub-County Council is a corporate body. In other words it also makes decisions for the development of the sub-county. 50 % of the revenue collected at this level remains at the Sub-County for development purposes.
6. In terms of resources they account to the Chief Executive Officer for taxes collected, but they can also solicit for external assistance as far as development programmes are concerned.
7. Both at the District and Sub-County levels, there are plans which are developed by various sectors in conformity with the national priorities and plans. The central level issues guide lines as far as planning is concerned.
8. At Parish level there is Local Council two (2) set up on similar lines as above. Nevertheless resources from the sub-county are not allocated to Local Council two (2) but to Local Council one (1).
9. At village level, there is Local Council one (1) with a similar arrangement. However, at the district there are officers with designated functions and these are:

   a) The Chief Executive Officer (CAO). He is a civil servant and in charge of the administration and head of the civil servants working in the district. He reports to the Permanent Secretary, Ministry of Local Government. He is the Chief Accounting Officer of the district. He is the one who authorises expenditure of the district resources and makes sure the accountability is done by the implementors. The (CAO) is appointed by President's Office.

The Resident District Commissioner. He is an appointee of the President himself and reports directly to the President. He is there to ensure peace and security in the district and monitor implementation of programmes in the district.

Appendix 2

List of people met

HIV/AIDS PREVENTION AND POVERTY REDUCTION PROGRAMME-UNDP

Dr R.L Adupa	– Programme Manager
Ms Betty Ddungu	– Assistant Programme Manager
Mr Sam Ibanda	– Programme Officer HIV/AIDS UNDP.

REDD BARNA (HEAD OFFICE)
Mr Tony Kisadha
Mr Fikre Haile Meskel

UNAIDS
Mr James H. Carmichael

NATIONAL COUNCIL FOR CHILDREN
Mr Stephen Anan, Acting Secretary General
Mr George Opio
Ms Akandinka
Mr Zadok Nyakuni

AIDS WIDOWS AND ORPHANS SUPPORT
Fr Steve Collins

THE AIDS SUPPORT ORGANISATION-TASO
Mr Charles Kasoosi

UGANDA AIDS COMMISSION SECRETARIAT
Mr J.B. Mukasa, Ag Director General
Mr Kalungi, SYFA Desk Officer

PENTECOSTAL CHURCHES – «PINSEVENN»
Ms Malema Raila

ACP MINISTRY OF HEALTH
Dr Elizabeth Madraa, ACP Manager
Dr Opio, Epidemiologist

COMMUNICABLE DISEASES
Dr Sam Okware, Commissioner

WHO
Mr Kapitaine Khantaway

JINJA ISLAMIC MEDICAL ASSOCIATION OF UGANDA-IMAU
Dr. Kitimbo, Acting District Medical Officer, Jinja district LC V
Jinja Women, Parliamentary Representative
District Health Visitor
Community Of Nawongoma Parish

REDD BARNA (Masaka)
Mr Benon Webare, Manager
Mr Fred Gumisinge, CC/Nhusi sub-county
Mr Musoke Twaha Ssalongo, CC/Lwemiyaga sub-county
Ms Theo Walusimbi, Project Officer
Mr Paul Luberenga, CC/Butenga sub-county
Ms Jane F Kiwaina, CC/Mateete sub-county
Mr Abibu Ssewajjwa, CC/Kyazanga sub-county
Mr Julius Tukwasibwe, CC/Kalugu sub-county
Ms Molly M Kintu, Project Officer
Ms Theresa Namisanyo, Project Officer
Mr Absolam K Wasswa, Project Officer(Agriculture)
Mr B K Bwanika, Education Officer

MASAKA DISTRICT ADMINISTRATION
Mr Abasi Bwogi Kasoozi, District Planner
Ms Grace Katusiime, District Probation Officer
Ms Nalungwa, Statistician
Mr Musoke, District Education Officer
Ms Prossy Mutibwa, District Agricultural Officer
Dr. Nyanzi, the District Medical Officer
TASO (Masaka)
Mr Ssebagala Stephen, Counsellor Coordinator

KITOVU MOBILE-CARITAS
Clotilda Nanteza, Home Care Coordinator
Getrude Nabbasa, Midwife Counsellor
Evelyn Auma, Education Co-ordinator
John Kabuye, Co-ordinator, Rakai District

BUWENDA WOMEN'S GROUP
Angela Nalwaga
Madina Nsereko, Treasurer
Elizabeth Ssengendo, Secretary
Jane Nakato, Member
Takia Wamala, Member
Florence Kataira, Member
Asifa Kakande, Member
Solome Nantege, Member

KYAZANGA SUB COUNTY
Umalu Ssebulime, LC3 Chairman
Abasi Kassozi, LC3 Vice Chairman
and 13 other members of the community who participated in the planning process
of the Sub-County Plan of Action For Children.

MINISTRY OF LOCAL GOVERNMENT
Mr Jimmy Lwamafa, Director of Local Councils
Mr Martin Odwedo, Commissioner Local Council
Mr Edward Mugamba, Commissioner for Community Development
Mr Obong David, HIV/AIDS focal person

TB/LEPROSY PROGRAMME
Dr. Adatu, Head of National TB/Leprosy programme, Ministry of Health

NATIONAL CHEMOTHERAPEUTIC RESEARCH CENTRE
Mr Nathan Mubiru, Director

CHILD HEALTH DEVELOPMENT CENTRE
Dr Jessica Gitta, Director Child Health Development Centre

UNFPA
Dr Francois Farah, Mission Director UNFPA

MINISTRY OF LABOUR AND SOCIAL AFFAIRS
Dr David O Ogerim, Commissioner of Labour
Ms Harriet Luyima, Labour Officer

REDD BARNA (Headquarters)
Mr Leif Svendsen, Resident representative
Mr Fikre Halle Meskel
Mr Kasadha Tony

UNICEF
Anupama Rao Singh, Chief BECCAD Section
Kathleen Cravero, Country Representative

MINISTRY OF GENDER
Mr Edward Mugyimba

EUROPEAN UNION
Renee Christensen

MINISTRY OF EDUCATION
Mr Mbazira

Appendix 3

Programme

<u>September</u>

Sept. 23rd.	External Consultants arrive in Kampala
	Meet the local team of consultants
	16.00 Meet the UNDP HIV/AIDS prevention and poverty reduction programme, Dr. Thupa, Manager
Sept. 24th.	Meet the Redd Barna staff at their headquarters
	Meet the Uganda AIDS Commission Secretariat
Sept. 25th	Meet the National Council for Children, Stephen Anan
	Meet the UNAIDS representative James Carmichael
	Meet the UNICEF Country Representative, Kathleen Krevero
Sept. 26th.	Meet the ACP Manager, Dr. Elizabeth Madraa at the Ministry of Health, Entebbe
	Meet the Commissioner for Communicable diseases, Dr. Sam Okware, Entebbe
	Meet the WHO AIDS officer Dr. Kapitaine Khantaway
	Meet the AIDS Widows and Orphans Support, Father Steve Collins, Kampala
	Meet The AIDS Support Organisation, TASO, Mr Charles Kasoosi
	Meet the Pentecostal Churches Pinsevenn project manager, Ms Malema Raila
Sept. 27th.	Meet Dr. Jitta, Director of the Child Health Development Centre, Kampala
	Meet Mr. Nathan Mubiru, Director National Chemotherapeutic Research Centre
	Meet Dr. Francis Adatu, Head of National TB/Leprosy programme, MoH
Sept. 28th.	Travel to Jinja.
	Meet representatives for the Islamic Medical Association of Uganda
	Meet acting District Medical Officer, Dr. Kitimbo
	Travel to Nawongoma Parish to witness the opening of a community initiative Rural Health Centre which has received some support from YMCA International
Sept. 29th.	Travel to Masaka district
Sept. 30th.	Meet Mr. Benon Webare, Manager of Redd Barna Project and his field staff
	Meet District Health Team, Masaka District at their District Headquarters
	Meet the TASO counsellor/ coordinator in Masaka district, Mr Sebaggala Steven
	Visit Kitovu Hospital and meet the Mobile Team for Home-Based-Care

<u>October</u>

Oct. 1st	Field trip to Buwenda, Primary School, Women's Group with I.G.A.
	Visit to Kyazanga sub-county to hear of County Plan of Action for Children
	Field trip to Butenge sub-county Head office
	Kigungumika Primary School
	Bakyala Twekembe Women's group
	PRA group Namagoma Kalungu
Oct. 2nd.	Meet Anupama Rao Sigh, Chief BECCAD Section of UNICEF, Uganda
	Oct. 3rd.
	Meet Leif Svendsen, Resident Representative of Redd Barna and his staff for debriefing.
Oct. 4th.	Meet Benon Webare, Manager of Masaka Redd Barna project
	Meet Norwegian Chargé d'Affaires for Uganda for short debriefing
	Oct. 5th.
	External consultants fly back to Sweden

Annex V

KAROLINSKA INSTITUTET, Department of Public Health Sciences,
Division of International Health Care Research (IHCAR)
and
Stockholm Group for Development Studies AB

EVALUATION OF THE NORWEGIAN GOVERNMENT'S SPECIAL GRANT TO PREVENT AND CONTROL HIV/AIDS

ZAMBIA COUNTRY STUDY

Bawa Yamba
Gunnar Holmgren
Chimutalanje Lwengi
Francis Phiri
Staffan Uddeholt

March, 1997

Acronyms

AIDS	Acquired Immune Deficiency Virus
CHEP	Copperbelt Health Education Project
CHIN	Children In Need
CIDA	Canadian International Development Agency
CINDI	Children In Distress
CMAZ	Churches Medical Association of Zambia
CPA	Country Programme Advisor
FHT	Family Health Trust
HIV	Human Immune Deficiency Virus
IEC	Information, Education and Communication
IHCAR	Division of International Health Care Research, Karolinska institutet.
IMF	International Monetary Fund
KAP	Knowledge Attitude and Practice
MoE	Ministry of Education
MoFA	Ministry of Foreign Affairs
MoH	Ministry of Health
NACP	National AIDS Control Programme
NAP	National AIDS Programme
NASLP	National AIDS/STD/TB & Leprosy Programme
NGO(s)	Non-Governmental Organisation(s)
NOK	Norwegian Crowns
NORAD	Norwegian Aid Agency for Development Co-operation
ODA	Overseas Development Agency (United Kingdom)
SANASO	Southern Africa Network of AIDS Service Organisations
Sida	Swedish International Development Cooperation Agency (formerly SIDA)
STD	Sexually Transmitted Disease(s)
SWAAZ	Society for Women Against AIDS in Zambia
TB	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Family Planning Association
USAID	United States Agency for International Development
WFP	World Food Programme
WHO/GPA	World Health Organisation's Global Programme
Z.Kwacha	Zambian Currency
ZNAN	Zambian National AIDS Networks

Executive summary

In Zambia official estimates indicate that more than 15 percent of the population has become HIV infected and the cumulative number of reported AIDS-cases in 1993 was almost 30.000. AIDS is the most common cause of mortality for adults in Zambia today. It is the estimate of current epidemiological projections, that the HIV infection rate Zambia will reach 28 % in 1998. The number of orphans is estimated to 200 – 250.000. The total Norwegian input into AIDS control was 54 MNOK during 1990 – 1995.

Norway does not have a bilateral agreement with Zambia for health sector support. Consequently much of the support for HIV/AIDS prevention that Zambia has received from Norway has come from the Special AIDS Grant (SAG), and gone to Non-Governmental Organisations (NGOs). Support to the National AIDS Control Programme (NACP) has been channelled through World Health Organisation's Global Programme (WHO/GPA). Zambia is in the process of reforming the health sector funding process, the objective being an attempt to have a more integrated and intersectorial approach . This will have some consequences for future Norwegian funding. Norway is the largest funder of NGOs AIDS prevention work in Zambia. The largest NGO recipients are Family Health Trust, Kara Counselling Training Trust (Kara Counselling), The Churches Medical Association of Zambia (CMAZ) and the Copperbelt Health Education Project (CHEP). A substantial amount of funds has been disbursed through decisions taken at the Embassy of Norway in Lusaka. The amounts involved ranged from NOK 3.000 to 3 296.000. This puts a rather huge administrative burden on the local NORAD programme officers. Nonetheless, this decentralised system of funding has enabled Norway to acquire a reputation locally as a swift and flexible funder. Consequently Norwegian support in the field of HIV/AIDS prevention has been visible and enterprising due to a willingness to support novel approaches. Home-Based Care is one such example. Efficiency and effectiveness were objectives that appear to have received a high level of fulfilment in the activities of the NGOs supported. Likewise the objective of capacity building, sustainability. However, short term goals of HIV/AIDS prevention make the realisation of this goal somewhat difficult to measure. Similarly, the issue of whether these programmes have been cost-effective is not easily measured. There seems to be a built-in disharmony between the objective of care and prevention, on the one hand, and cost-effectiveness of interventions, on the other. Home-Based Care provides an example for this: where it is postulated that care at home has a preventive effect, it is difficult to measure in monetary terms the cost-effectiveness of measures taken, since it is not easy to assign a value for the net gains from prevention. However, it is the finding of the evaluation team that the Norwegian supported projects supported in Zambia have achieved a wide impact, and many positive results, as a result of the foresight of Norwegian programme officer in deciding to support new and untried models for HIV/AIDS prevention.

TABLE OF CONTENT

1.	INTRODUCTION	128
2.	COUNTRY PROFILE	129
3.	NORWEGIAN SUPPORT	131
4.	THE COUNTRY STUDY PROCESS AND METHODS	135
5.	GENERAL OBSERVATIONS AND FINDINGS	136
6.	CONCLUSIONS	141

1. Introduction

This evaluation was commissioned by the Norwegian Foreign Office. The report is an attempt to evaluate and assess the impact of Norwegian-supported AIDS prevention activities in Zambia. The initial ToR specifically commissioned the evaluation of the Norwegian Government's Special Grant to Prevent and Control HIV/AIDS, henceforth referred to as the SAG. The terms of reference for the evaluation as well as for the included three country studies (apart from Zambia also Tanzania and Uganda) are attached to the main evaluation report as Annex I and II.

The evaluation team comprised three external and two local members. The external evaluation team consisted of Bawa Yamba, of IHCAR, Division of International Health Care Research, Department of Public Health Sciences, Karolinska institutet; Gunnar Holmgren, Department of International Child Health, University of Uppsala; and Staffan Uddeholt, representing the Stockholm Group for Development Studies. Martin Phiri, Consultant, and Chimutalange Lwengi of University Teaching Hospital, Lusaka, made up the local country team. The team had backgrounds in medicine and health-related sciences, economics and project management, and sociology/social anthropology.

The Zambia Country Study involved the review of documents on Norwegian funding (much of which was made possible by the work of Terje Dalseng, who was commissioned by the Norwegian Foreign Office as a consultant to compile data for the evaluation team); a two-week country visit to Zambia, during which the evaluation team met and interviewed project implementers, policy makers, NGOs engaged in HIV/AIDS prevention, and some of the beneficiaries. An attempt was made to apply the participatory evaluation method in the field. However, the short time-frame available did not allow for an in-depth or exhaustive use of the method. Nonetheless, some other qualitative data collection methods were in the Zambia Country Study. These included focus group discussions, group interviews, and the observation of some of the project activities in the field. (See Appendix 3, People Met).

This report represents an attempt to assess, as far as possible, the specific impact of the Norwegian AIDS support to Zambia. It is hoped that the observations and findings presented in the study will help to improve as maximally as possible, the already considerable achievement and reputation that the Norwegian support in this field has attained. In order to enhance the impact of presentation we have chosen to present the findings in the form of clear questions and answers, rather than the presentation of a comprehensive text in which such issues are embedded. The presentation end with a conclusion directly pertaining to some key issues raised in the study in response to the main questions posed in the ToR. No recommendations are given in this report; those are presented in the synthesis report to which this is appended.

The review team would like to acknowledge the warmth and kindness with which we were received by the Norwegian Embassy in Lusaka. The Embassy personnel did everything to facilitate the smooth execution of our assignment. We would also like to thank the implementers of the projects for their generosity in giving us much of their valuable time, and for sharing with us the triumphs – however small, and tribulations inherent in HIV/AIDS care, prevention and control work.

2. Country profile

Zambia is a landlocked country with an area of 752, 614 square kilometres and a population of about 9 million. The country has a mixed economy which is dominated by the copper mining industry. Growth potential is recognised in other sectors such as agriculture, manufacturing and tourism. Due to persistent economic decline since the mid- 1970s, Zambia has had to accept some drastic structural adjustment programmes under IMF and World Bank supervision.

2.1 The health sector

The harsh economic climate of the last 20 years has crippled the Government's capacity to adequately provide social services like health and education. The health sector has been characterised by an increasing deterioration in infrastructure, a persistent decline in the quantity and quality of the health services due to poor staff morale, chronic shortages of drugs and medical supplies. This bleak situation has been aggravated by a general increase in endemic diseases, such as malaria, TB, and HIV/AIDS. Institutional management has also been rather weak and wasteful. By 1991, the year Zambia returned to a system of multiparty democracy, the general populace was clamouring for an improvement of the social service's delivery. Consequently, the Government reviewed the national health policies and strategies and critically assessed the sector's past performance, particularly its management and funding. This led to the establishment of a new primary health care strategy conveyed in the slogan «Health for All», based on the idea that the achievement of a healthy society was not only a medical issue but a political and socio-economic one as well. Therefore, there was a need for intersectorial collaboration with other ministries and institutions. With regard to health financing, the Government introduced user fees and health insurance schemes.

To support the major structural changes envisaged in the health reforms, a reorganisation at central, provincial and district levels was necessary. The core of the health strategy was to decentralise power to the districts through a District Health Management system. It reinforced the district as the basic unit of management, where bottom-up planning and implementation initiatives were to meet the thrust of national policies.

2.2 HIV/AIDS control and management

AIDS was first identified in Zambia in the mid -1980's and was quickly recognised as a major public health threat, capable of disrupting socio-economic development in the country. Accordingly, the Government established some interim structures to undertake surveillance, and IEC strategies to curb the spread of the disease. As the epidemic evolved it became imperative to reorganise the interim structures into what became the NAPCP. A further reorganisation of the NAPCP occurred in 1994 when it became the NASTLP. The programme, thus, incorporates other chronic diseases.

The NASTLP Management consists of seven functional units, dealing with anti-AIDS interventions and the reduction of the impact of the disease on society. The NASTLP's functions are wide-ranging. They include the planning, implementation and monitoring of the national AIDS programme. It is further charged with co-ordinating the AIDS prevention activities of other Government ministries, those of the provincial and district institutions, and the activities of donor agencies and NGOs. In view of the gradual acceptance that AIDS is not only a medical issue, the NASTLP is now charged with providing a multi-sectorial approval in terms of interventions.

A number of factors have contributed to the rapid spread of HIV/AIDS in Zambia. Among these are the high level of urbanisation – an estimated 42 % of the total Zambian population of 9 million live in towns and cities – and mining enterprises and large commercial farms, the mainstay of the country's economy, that attract migrant workers from other parts of the country to specific areas. This has resulted in a high level of intra-country mobility. Such factors, coupled with prevailing indigenous cultural practices, such as, polygyny, dry-sex, and scarification, have contributed to make the country particularly vulnerable.

Response to the pandemic came relatively early in Zambia. In 1986, a National AIDS Surveillance Committee and Intersectorial AIDS Health Education Committee was set up to co-ordinate AIDS control in the country. Then followed the establishment of a NACP based on the WHO/GPA model, which has undergone many subsequent phases of modification and restructuring along

with ongoing health reforms. The present structure, itself in a process of being transformed has been constructed to deal with chronic diseases in general. Such response, and a fairly dynamic health sector, have done much to combat HIV/AIDS in the country. But, perhaps, the greatest boost to AIDS prevention was the public acknowledgement by Kenneth Kaunda, the country's president at the time, that his own son died from AIDS. Early response, however, does not appear to have slowed down the pandemic in Zambia. AIDS is still one of the gravest threats to the future of the country. Projections for the period 1994–1998 show that over 250 000 people will die from AIDS and that about 320 000 children will become AIDS orphans. Current projections by the Ministry of Health further put the number of likely HIV infected people between 1993 and 1998 at 1,810,000, with the percentage of HIV infections increasing from 17,2 % to 27.9 %. Official prevalence figures from sentinel surveillances are given in Appendix 1.

Nonetheless, the comprehensive approach to the combat of HIV/AIDS in Zambia has yielded some innovative models, such as different structures of home-based care for persons with AIDS, anti-AIDS clubs in schools, and mobiles teams doing IEC work to curb the disease. Much of the HIV/AIDS prevention activities in Zambia has been done by NGOs, in collaboration with the Government's AIDS prevention programme. Funding for NGO activities has been solely through donor support. Norway has been the main funder of NGOs' AIDS prevention projects in Zambia. The sustainability and effectiveness of such outside support are issues that have increasingly began to concern not only donors, but are also viewed as important by the Zambian Government.

3. Norwegian support

3.1 Main elements of Norwegian policy towards developing countries

Ministry of Foreign Affairs Report no. 19 to the «Storting» (The Norwegian Parliament) states that Norway will give priority to the development of primary health services and strengthening administrative systems. Further, that instead of focusing on particular diseases, Norway will, in bilateral and multilateral programs, emphasise contributions to primary health services on a broader front.

3.2 Norwegian assistance to HIV/AIDS in Zambia

Norway does not have a health sector country programme co-operation with Zambia. Assistance to HIV AIDS programmes have been financed from the SAG and for funds for local NGOs-support.

The total financial assistance during the period 1990–95 has amounted to NOK 53.8 million. Three distribution channels were used for the disbursement of the funds:

Channel	MNOK
WHO/GPA	10.0*
MoH/NACP	3.1
Local NGOs	40.7
Total	53.8

*(2.0 million per year 1991–95)

The funds to local NGOs were allocated through 115 decisions made by the Embassy of Norway in Zambia. This represents an average of 23 decisions per year, with an average amount of NOK 353.913. The decisions for the provision of financial support to projects involve sums ranging from NOK 3.000 to 3. 296.000. More than 50 local NGOs, institutions and government agencies have signed at least one agreement with NORAD.

The following are the major recipient NGOs of Norwegian HIV/AIDS support:

NGOs	MNOK
CMAZ	1 743
Kara Counselling	3 080
Copperbelt Health Education	1 644
Family Health Trust	7 357
Total	13 824

It is worth mentioning that apart from the big four projects a number of smaller organisations, some of which, are listed below have also received Norwegian funding. Indeed, some of these smaller organisations depend on such funding for their existence. This projects listed below have received special attention in this evaluation not because they constitute a complete list of Norwegian supported organisations in Zambia. They have been chosen because they have played and continue to play an important role in HIV/AIDS prevention in Zambia. They constitute, thus, a deserving focus in an attempt to assess the effectiveness of Norwegian support in this context.

CMAZ (The Churches Medical Association of Zambia) is one of the largest NGOs working with HIV/AIDS prevention in Zambia. An umbrella organisation for all the churches of Zambia, its HIV/AIDS programme was conceived in 1986/87 to create an awareness of the imminent dangers of HIV/AIDS in the country. Its activities now include, amongst others, prevention through peer education, provision of counselling services, STD management, control of tuberculosis, and care of orphans. Later on Home Based Care was added to its activities when it became increasingly apparent that most urban hospitals were becoming congested with persons with HIV/AIDS related illnesses. The AIDS programme is co-ordinated from the CMAZ secretariat in Lusaka. The office liaises with government, co-ordinates with the organisation's member institutions and maintains regular contact with donor organisations. It also provides guidance and technical support to member institutions. Norway is a major funder of CMAZ.

Kara Counselling Training Trust, often referred to as «Kara Counselling». The trust started in 1980 as a small outreach and counselling organisation with a staff of 6 people. It has now developed into a professional organisation with a staff of over 60, operating from six centres. It operates from three main centres. Kara House, the administrative centre, also provides counselling services. Hope House is the centre for the PALS organisation. Composed mainly of HIV positives who lobby for the rights of HIV infected persons, PALS promote positive living for persons with HIV/AIDS. The organisation has now evolved into and independent body with a nation-wide distribution. Hope House also provides counselling, primary health care and basic health advice and skills training. The third is Thorn Park Hall, a training centre which provides diploma, and other advanced courses in counselling. Although its mission has continued to be counselling and provision of psychological support for persons with HIV/AIDS. Kara Counselling also publishes AIDS and Health News, a newsletter that provides free advice on counselling and on physical and psychological health for the general public, but particularly for those infected with the disease. Norway was one of the first funders of the Trust and still remains a major source of what might be termed core funding.

Copperbelt Health Education Project (CHEP). CHEP began in 1988 as a health education project solely devoted to the HIV/AIDS prevention. The strategy for this was the raising of public awareness on the dangers through IEC methods. It began not as a distinct organisation but as a branch of the Kitwe Rotary Club. Initial funding, that was crucial for the success of the project, came from NORAD. CHEP has now grown into one of the most successful HIV/AIDS prevention projects in Zambia. The project particularly targets vulnerable communities such as prostitutes, commercial farm workers, soldiers. Some Anti AIDS clubs within the Copperbelt also rely on CHEP for support. A characteristic approach of CHEP is peer education, production and distribution of posters, STD management, training workshops. Recently Home Based and AIDS orphans have become areas that have received special attention. Current activities include an attempt to mobilise and train Traditional Healers in HIV/AIDS prevention. NORAD has continued to be one of the major funders of CHEP.

Family Health Trust. Family Health Trust is a member of umbrella organisation the chief aim of which is strengthen the family against the ravages of HIV/AIDS. It is the largest NGO working with HIV AIDS prevention in Zambia. Apart from general IEC activities for AIDS prevention, FHT is also engaged in a wide range of activities. Home Based Care is perhaps the largest and most successful of these. Other components include the targeting of orphans through its CINDI project, youths in school through the Anti-AIDS clubs, and the devising of income generation activities for young families affected by HIV/AIDS. New directions of its work now include the targeting of out of school youth. FHT is the largest NGO recipient of Norwegian funding in Zambia. Linked with FHT through its chairperson (Mrs E. Mataka who is also the director of FHT) is the Zambia Network of NGOs in AIDS (ZAN).

Apart from the big four above, there are as mentioned before are a number of smaller NGO which receive support from NORAD. The following are some of these.

The **George Matero Project** is a project based in two compounds in Lusaka which employs drama, peer education as well as psychological and pedagogical strategies for HIV/AIDS prevention. Based in the Department of Psychology, University of Zambia the project has also links with the University of Harare's Department of Psychology.

TASINTHA is NGO that particularly targets prostitutes, and trains them in income generating skills so as to prevent them from reverting to prostitution. Its main strategy, apart from skills training, is the use of peer group pressure and persuasion. Members of the organisation, comprising mainly of former prostitutes, often enter bars and boldly pressure prostitutes into considering alternative and less risky forms of livelihood. The driving force of Tasintha is also the president of the Zambia segment of SWAAZ, society for Women Against AIDS in Africa.

3.3 HIV/AIDS Mechanisms and budget in Zambia

The total budget for 1996–97 amounts to USD 13 519 615 million. The available funds were (15 March 1996) USD 7 962 025 which give a shortfall of USD 5 557 590.

Programme area	Total cost available	Funds	Shortfall
A. Advocacy & mobilisation of new partners	2 040	353	1 686
B. Policy development	157	157	
C. Programme development	10 914	7 320	3 594
D. Operational costs	261	89	172
E. Supplies and equipment	148	148	
Total	13 520	7 920	5 600

The largest shortfalls are found in:

Programme area A, multi-sectorial activities in the civil service	USD 1.1 million
Support to NGOs	» 0.5 »
Programme area C, Condom procurement	» 2.5 »
Home care drugs	» 0.5 »
Laboratory test kits	» 0.4 »

NORAD is the only donor with ear-marked contributions to Multi-sectorial AIDS activities in the Civil service. The total activity cost is budgeted at USD 1.26 million, of which NORAD has contributed 124000, resulting in a shortfall of USD 1.1 million.

This clearly indicates the difference between the estimated needs within the sectors outside the health sector and the funds available for these sectors. One of the reasons behind the creation of UNAIDS, for example, was the need for an expanded multi-sectorial response to the AIDS epidemic. The figures above, however, show the need for both the national governments and donors to make contributions to the sectors outside the health sector, if any inter-sectorial HIV efforts are to become feasible.

The main foreign contributors are the EU, CIDA, France, Netherlands, NORAD, ODA, SIDA, UNAIDS, UNDP, UNFPA, UNICEF, USAID and WFP.

There are six identified national and donor-operated structures that deal with HIV/AIDS in Zambia:

1. Office of the Vice President
2. National AIDS/STD/TB/Leprosy Programme, NASTLP
3. Civil Service Co-ordination Mechanism
4. Zambian National AIDS Network, ZNAN
5. UNAIDS Theme Group
6. UN/Donor Agencies Co-ordination Committee on HIV/AIDS

As mentioned before the NASTLP is organisationally located within the Ministry of Health. It is not yet clear where it will be located in the new structure that is being constructed in the wake of the ongoing health reforms. However it is a fact that its present positioning as a unit within the Ministry of Health naturally limits its decision-making authority and confines it to implementation of activities within the Ministry of Health. For instance, in the present structure a decision that requires the involvement of sectors outside the health sector has to turn to the Office of the Vice President to imbue the decision with the dignity it requires.

Despite the attempts at all levels to make the fight against AIDS a multi-sectorial affair, it is still in practice the province of those involved with health sector issues. This was clearly the case even with the UN/Donor Agencies Co-ordination Committee on HIV/AIDS. Representatives in this body, during the time of this evaluation, were still mainly programme officers dealing with the health sector co-operation.

13.4 Some likely present and future consequences of the Health Reforms Zambia

The ongoing health reform sector will have some far-reaching consequences for HIV/AIDS prevention activities and funding in Zambia. The first major consequence is entailed in the idea that all health funding will in future be done in the form of a basket funding system. The idea is that all donors will be asked to put their funds into a «basket» that will then be used to fund an integrated «Essential Health Package». The likely result of this is that financial allocations will be made directly to the districts which will use the funds to address the health problems in the area. This means in effect the dismantling of the old system in which funds were often earmarked for particular diseases, such as, HIV/AIDS, TB, malaria, etc. Nonetheless, in the new system certain diseases have been given national priority, amongst them HIV/AIDS and malaria. Some donors have already given their approval to this new approach. This attitude, in effect, reflects the kind of thinking behind the abolishing of the earmarked funding system of which the SAG was a striking example. In the new funding system, certain activities will not be funded by the Ministry of Health as part of the Essential Health Package. The prime case worth mentioning here is Home Based Care services. These services are intended to be the responsibility of the local communities and family members of persons with AIDS. The rationale for this is that care skills need to be built into the local community and given by persons close to the person with AIDS. In this manner, it is felt that care will be more compassionate and efficient, as well as having an educative impact on the dangers of contracting HIV/AIDS

The Health Reforms aim at an increased intersectorial approach to AIDS prevention. Thus all ministries have now appointed an AIDS Focal Person who is charged with mobilising HIV/AIDS prevention activities in her/his respective ministry. Lack of resources at present, however, appears to hamper the activities of the AIDS Focal Persons. Another likely consequence of the Health Reforms, when fully implemented, is that the NASTLP will have a new role to play with regard to its ability to mobilise AIDS control activities across ministries. In the new system NASTLP will be located within a new Board of Health, which is distinct from the Ministry of Health. Such a strategy is expected to enhance the NASTLP's ability to plan and co-ordinate AIDS control activities, more effectively than it is able to do in the present system, where it is located within the Ministry of Health.

In the future bilateral donors will be asked to fund HIV/AIDS activities in sectors outside the Ministry of Health, through direct or multi/bilateral agreements with concerned ministries.

4. The country study process and methods

The multi-disciplinary composition of the evaluation team (backgrounds in bio-medicine, managerial economics and social anthropology) was reflected in that of the local country team. With regards to strategies for the country study, the team aimed to apply the participatory evaluation approach. Time, however, did not allow for a fully-fledged use of this method. Nonetheless, some rudiments of the approach were used. Early in the evaluation a team of three local consultants were identified who linked up with external consultants. The two teams started to prepare certain aspects of the study before the country study began in September. The two teams then merged in a joint working group and shared responsibilities during the main study period, which lasted for two weeks. The team then reached a consensus on the main findings. The country study ended with a debriefing at the Norwegian Embassy in Lusaka, during which some of the preliminary findings were presented.

This country study used five different methods to achieve as accurate a picture as possible.

1 Key informant interviews (17). These informants were carefully chosen by the leader of the local country team, the criterion for selection being the possession of specific knowledge on aspects of HIV/AIDS work in the country. In this way it was hoped that we would get a representative comprehensive picture of as many aspects of the questions that were important in understanding the situation as possible.
2 Review of secondary data. A considerable amount of information was made available by Ministries, NGOs and some of the UN agencies.
3 Study visits (6) to various project sites during which the members of the team were able to directly observe outreach activities and interventions of NGOs.
4 Group interviews (2) with specific groups of special interest for the study.
5 Informal interviews were conducted with persons met casually in the course of the study who were directly or indirectly involved with aspects HIV/AIDS research and prevention.

The findings below result from a triangulation and combination of the above methods and constitute an effort to present as accurate a picture of the state of affairs as possible.

5. General observations and findings

The following are the major questions which arise out of the original aims of the SAG and the terms of reference of the country studies:

1. Is the Norwegian assistance in the field of AIDS visible in Zambia?

The answer from all the key informants is an emphatic affirmative. They all maintain that Norway has the widespread reputation of being the most significant funder of AIDS programmes in Zambia. Significantly, this is achieved without Norwegian support being flaunted support in the press. «Unlike other donors they [Norwegians] do not call the press to photograph them giving you a check», were the words of the director of a large NGO that received considerable funding from Norway. Many of the more successful NGOs have one time of other received Norwegian support.

2. Has the Norwegian assistance been flexible in its response to the epidemic?

Here an affirmative answer was forthcoming from a number of the key informants without prompting, on being asked about the special features of the style of funding from Norway. Flexibility and the willingness to support new strategies and interventions are, according to programme implementers in the NGOs interviewed, the distinguishing characteristics of Norwegian funding. «Other donors will tell you exactly how they want you to use their money. NORAD approves your projects and funds you without telling you what sort of persons you should employ. But they are interested in what you do. They will keep visiting you in the field.» With regard to innovativeness in funding, Norway was the first to support Home Based Care in Zambia. This has proved to be a very insightful venture because it is now generally accepted that Home Based Care, combined with community counselling, has a considerable impact on prevention. It also reinforces local cultural notions of the importance of caring for one's own. Two other examples might be added here. The first: Norway began supporting NGOs before other donors realised the importance of this as a channel for HIV/AIDS work. The second: Support for developing the multi-sectorial approach (as elaborated below) came from Norway early on.

3. Has the assistance promoted long-term programmes by NGOs?

The NGOs interviewed have had problems with long-term planning because of the one-year funding cycle. Several of the beneficiaries are currently in the middle of, or in the process of, planning long-term (3-year) strategic responses to the epidemic. These include CMAZ, CHEP and FHT. These projects hope to get some assurance that support for longer periods may be forthcoming in future. Kara Counselling Trust, on the other hand, appear to always included long term contingent planning in its agenda. It must be added that such endeavours have been partly facilitated by Norwegian funding, that has provided a core base which makes long term visions possible, in the first place.

4. Has the assistance promoted long-term integration in development co-operation?

Norwegian assistance has been important in bringing about networking among the NGOs. Networks such as ZNAN, CHIN, SANASO have all received Norwegian support for their activities. This support has further also stimulated a more integrated approach in the national programme, as well as in the international organisations through UNAIDS and the local country theme groups.

5. Has it improved co-ordination at country level?

The evaluation team finds that at present the co-ordination at the country level is still far from satisfactory. A decisive factor remains where the national AIDS programme is located. As long as it remains in the MoH its co-ordination prospects will remain limited. It would only be regarded as a section within the health ministry which has relatively more resources than the others. To improve co-ordination therefore the National programme will require a location independent of the MoH, do as to highlight the multi-sectorial necessity of HIV/AIDS prevention. A recommended strategy would be if it NAP were elevated to the office of the President or vice-president, for example. This would not only imbue it with the authority needed to co-ordinate the programme but also underscore the seriousness with which the government views the fight against HIV/

AIDS. Norway could play an important role in advocating an accelerated movement in this direction.

6. *Has it supported WHO's leading role in technical matters?*

The WHO's GPA has been given support through the SAG and has also been a channel for funds to Zambia. There is little doubt that the ability of GPA, the predecessor to UNAIDS, to co-ordinate and provided technical support was partly facilitated by the grant. However, GPA's method of promoting virtually the same national plans in all countries was widely criticised because of its «top-down» approach. Nonetheless it must be admitted this was quite effective. Even more so when it the approach was later modified by means of tailor-making responses for specific needs of particular countries. It was WHO which started the local Country Theme Groups in Zambia in an effort to integrate the response of the UN agencies in the country with regard to HIV/AIDS. Originally Theme Group gatherings were also attended by donors, but this has changed. The donors do not now attend the Theme Group gatherings.

Opinions differ at to how effective the Theme Group has been as body. Its mandate seems unclear. Further, with the appearance of UNAIDS at country level there appears to be some confusion about the roles of the two roles of WHO and UNAIDS, respectively. Although some overlapping and duplication is inevitable some form of co-ordination and definition of mandates seems necessary.

7. *Has it responded to the socio-economic consequences of the epidemic?*

Most of the NGOs that we have met have had interesting responses with a variety of skills-training for affected individuals, families and children e.g. CHEP, CINDI, Hope House, SWAAZ, and Tasintha. These projects have all made clear efforts to ameliorate the socio-economic effects of the epidemic. Sustainable income generation, however, is not easy to achieve within a short span of time. It is thus still too early to say if any of these efforts will have a lasting impact. It must be noted, however, that the response from Government Agencies in similar programmes has been less evident. It was only in the Ministry of Sport, Youth and Child Development that the evaluation team found some indication of an attempt to address the socio-economic effects of the epidemic.

8. *Has emphasis been given to activities directed towards women and children?*

Here some of the NGOs supported by the grant have been outstanding in their efforts in this direction. Virtually all those we interviewed showed clear evidence of this emphasis but especially noteworthy were SWAAZ, Tasintha, and Hope House, CINDI, CHEP in this regard. We might add that in line with more recent thinking it is important that men not be isolated from programmes that aim to improve the position of women and children. The active support of men has to be forthcoming or hopes of reducing the spread of HIV are doomed to failure. This is particularly true in a country such as Zambia where asymmetrical gender relations are important factors in sexual behaviour.

9. *Has support been given to «weak groups»?*

Targeting vulnerable groups such as Commercial Sex Workers and Orphans is particularly important where the social and community support systems are weak. Many such groups have been reached through the SAG. SWAAZ, Kara Counselling Trust through Hope House, CINDY, CHEP and, to some extent, FHT, have all placed special emphasis on the targeting of weak groups. However, the team found that with FHT, the emphasis appears to have been more placed on building up a sound central management structure, with the effect that small local groups, such as, the anti-AIDS clubs in schools outside the Lusaka area have largely remained unsupported.

10. *Has support gone to multi-sectorial approaches?*

NORAD was probably the first donor in Zambia to adopt the multi-sectorial approach. Within this approach funds are ear-marked for ministries other than health, to facilitate the appointment of a focal point staff member. This person is appointed by Cabinet Office and is, through the Permanent Secretary answerable to Cabinet Office for the AIDS activities undertaken in that particularly ministry. However, as yet this support is only in the form of «seed money» and the plans prepared by the focal points persons have largely been stifled by lack of resources.

11. Has the grant mainly gone to preventive activities?

This is a question that needs to be addressed in a wider review and figures are not available to give a clear answer. The team found that prevention has been an inherent aspect of all the projects supported. It is however, difficult to assert that prevention has been the main concern of all the projects. The team agree, however, with the view that HIV/AIDS prevention in Zambia cannot be completely divorced from care. Such a separation would be doomed to failure. We thus agree with those who postulate, for example, that one of the strengths of the Home-Based Care approach, which combines care and preventive community counselling lies in the enzyme effect of having the two linked. It was probably unrealistic to assume in the early stages that prevention through IEC could be done on its own without a linkage to a care component. In this sense, we found a care element in most of the programmes that we studied. Particularly worth of mention are FHT and CHEP.

The clearest example of a project that focuses mainly on prevention through IEC activities is the George Matero peer-education project. This project was initiated by the NASTLP and funded by NORAD. The evaluation team was particularly impressed with the commitment and enthusiasm evident from the work of the group. This appear to have resulted in good response from the community, far beyond the size of the project.

12. Has the grant led to capacity building?

The team found that capacity building has occurred on two levels: on the institutional level and on the individual level. As an example of the first, a number of the local NGOs that have received support from NORAD have now built up capacity that is widely recognised internationally as being of a high order. Such recognition has sometimes resulted in instances when people from neighbouring countries have come to Zambia for training in aspects of HIV/AIDS prevention. CMAZ, CHEP, Kara Counselling, SWAAZ, and FHT are organisations worthy of mentioning. The particular aspects of training that are of relevance to other countries are the participatory methods that emphasise linking up the communities with the health-related work, and bring about a bottom-up approach in tackling the problems related to AIDS. On the individual level many persons involved in these projects have gained from continuous exposure to international contexts of HIV/AIDS prevention and research work. NORAD has contributed to this through support for the projects as well as through direct contributions for travels to international conferences and workshops.

13. Have the activities supported by the grant achieved their immediate objectives?

This is not a formal evaluation of individual projects and none of the projects have yet used the Logical Framework Approach. Hence, the team cannot aspire to assess accurately whether the immediate objectives have been met. However, some observations are in order. The aim of bringing knowledge about HIV/AIDS to the groups and communities concerned has been met by many of the projects. Evidence is available about increased condom distribution and sales and some of the credit must go to sensitisation brought about by the NORAD-funded programmes. Evidence of behaviour change is more difficult to assess and impossible to study in the short time available. Even here, group discussions and informal interviews give some credence to the likelihood that behaviour change is now a fact of life in Zambia among sensitised groups. This is especially so when they themselves have been involved in the decision-making about which changes are necessary in order to reduce the risk of HIV spread.

14. What key factors have been involved in allowing these objectives to be achieved?

Some of the key factors stem from of the above:

a) Linkage between care and prevention (see 11 above). This link creates a fruitful atmosphere of mutual reinforcement

b) Harnessing the enthusiasm of individuals and NGOs yet within a network of the NAP. Some of the vigorous promoters of activities could well have been stifled under a more rigid structure within the NASTLP but have been able to flourish in the freer atmosphere of an NGO.

c) Allowing communities to make the decisions themselves based on sound scientific evidence about which behaviour change is necessary. CHEP and Chikankata have been promoting the approach of presenting the options and the health evidence on which these options are based, but giving freedom to the communities to make up their minds about the response that they will adopt.

d) Giving the NGOs enough freedom and flexibility to try new ideas and to do things in another way so that they retain ownership of the programmes. Again and again this has been brought out by key informants to be the main strength of the Norwegian support.

e) Early support to inter-sectorial collaboration.

15. What other effects intended and unintended have resulted from the support?

a) Kara Counselling aimed to focus on counselling and rehabilitation services but found that the demand for counselling services was rather weak. The real demand was for skills training that leads to income generation. Communities still have to be sensitised on the value of counselling services and it is thought that this will slowly grow.

b) FHT found that anti-AIDS clubs in schools were hampered and incomplete without a parallel movement for teachers. This has now started on a small scale but plans are underway to expand this vital approach.

c) CHEP health educators found that the uniformed services were especially awkward to contact and that rapport with them had to be built up slowly and with special techniques.

CHEP found that traditional healers had to be involved in the health education programmes but they are a difficult group to contact with lots of problems, and they are by no means a homogeneous group. This is a particularly important key group to target in HIV/AIDS prevention. CHEP found that traditional healer engaged in dubious and dangerous activities such as sexual intercourse with their clients in a professed to treat them for infertility, as well as other conditions.

The evaluation team wish to add that points listed above represent unintended consequences that are not dependent on a weakness in the design of the project activities. Rather they were contingent outcomes which most of the projects have now began to take into account in the design of subsequent phases of their work.

16. How do activities supported by the grant compare with national programmes?

This is impossible to assess accurately in our study but some observations lend weight to the conviction that the NORAD funded programmes have been more imaginative, more bottom-up in approach, less bureaucratic and more in touch with vulnerable communities than national programmes.

The programmes run by NGOs are in line with national AIDS plans and complement rather than collide with them.

17. Have the activities been carried out efficiently?

There is a need for a review of the Mid-Term-Plans and there are many unanswered questions about the cost-effectiveness of some of the NASTLP activities. Generally we have been impressed with the efficiency of the NGOs in their implementation. CHEP and CMAZ, Kara Counselling and Family Health Trust give a first impression of efficient, well-run organisations. However, concerns were expressed about the mushrooming of new NGOs who might not be so serious in their approach, where much of the funds have gone to building up central administrations. This may be the other side of the coin, as it were: the flexibility which is the strength of NORAD funding, where not much emphasis is placed on a rigid auditing system, continuous reviews and continuous writing of progress reports, might also sometimes be misused. However, although some implementers of projects expressed this fear, we got no direct information about the misuse of funds in this way. It will seem however that stricter rules are now being applied which will make this potential problems less likely to occur.

18. Have the activities placed due emphasis on ethical and cultural issues and on human rights?

Generally our interviews and focus group discussions showed a high level of respect for cultural, ethical and human rights issues. There are special NGOs that have focused on the needs of commercial sex workers, orphans and out of school youth. These are groups that could easily have been exploited with a domineering approach but this has not been what we have found. However, certain cultural issues such as the tradition of ritual cleansing by sexual means which is present among some tribal groups has had to be faced. Using methods of community counselling and the participatory approach such issues have been resolved with acceptable alternatives which do not destroy cultural val-

ues. However, such changes have to be agreed upon by whole communities if they are to have an impact in terms of behaviour change.

19. How sustainable are the activities supported by the grant?

This is a question to which the evaluation team cannot provide a clear answer from the evidence available. It is true, however, that many of the NGOs have tried to established income-generating activities into their skills-training, but as yet these supply only marginal incomes. Some of the strategic planning that is now taking place – for example, in FHT and CMAZ – may come up with more sustainable models in the future. At present it is probably unrealistic to expect and real sustainability in programmes in Zambia. This is chiefly because of the overall national economic state of the country, and the dire economic circumstances of the most vulnerable groups that are being targeted by these programmes.

20. What indications are there of multiplier effects or replication of the ideas coming from grant supported activities?

Zambia has some fine examples of models that have been tested by Norwegian assisted groups that have then gone on to be replicated elsewhere in the country and in the world. These include Home-Based Care, anti-AIDS clubs in schools, focus on out-of-school youth in CHEP programmes, Kara Counselling with skills transfer at Hope House, the SWAAZ programmes that have involved women's movements in many parts of the country, and the special outreach among prostitutes of Tasintha.

6. Conclusions

This concluding section summarises some of the main finding of the evaluation team. They attempt to touch on the major issues requested by the ToR. Details of the issues raised here can be found under the relevant sections in the document.

The Issue of Sustainability and Capacity Building

Sustainability of the programmes can be considered as having two aspects. First, in this case there is the issue of whether the projects would be able to persist beyond Norwegian funding. Second, and this is interrelated to the first, there is the issue of whether there is an adequate transfer of skills and commitment going on in the projects so that local expertise can carry in the future. With regard to the first it must be reiterated that the economic situation in Zambia at present makes the transfer to government of these projects unlikely. With regard skill capacity building, however, there is certainly sufficient commitment in the Zambians involved some of in the projects to make an eventual transfer of the projects feasible. In most of the projects, of which Kara Counselling, CMAZ, FMT and CHEP we found serious attempt to address the issue of sustainability. This was, however, often frames as attempt at generating income rather than the building of local capacity. Therefore much time and training would be required to make these projects sustainable in the sense of skills transfer. Kara Counselling is a prime example of the latter. The director is a hard working and committed person, but the sustainablility of the project would require the transfer of skills and capacity to local people. Exemplary though they might be at present, such skills transer are a prerequisite if the projects are to survive Norwegian or other external funding. Similarly Family Health Trust is highly dependent upon the director, with no evidence of a like team capable of carrying out the work of the project independent of the present leader.

The Issue of Relevance.

This question has already be addressed in some detail in this evaluation. One further observations will be in order. The unifying relevance of the projects is that curbing the continued spread of HIV/AIDS and making a meaningful contribution to the lives of those who have been unfortunate to have contracted the disease. While the projects may all be said to be highly relevant, there is nonetheless the question whether what is relevant at project level, as it were, is also relevant for the recipient of the assistance. We have already noted that, for instance, The person with AIDS who went to Kara Counselling appeared to be more interested in skills training that in receiving counselling. Such conflicting priorities seems present in most of the project to some degree or other. They would require to be addressed as subsequent phases of the programmes designed.

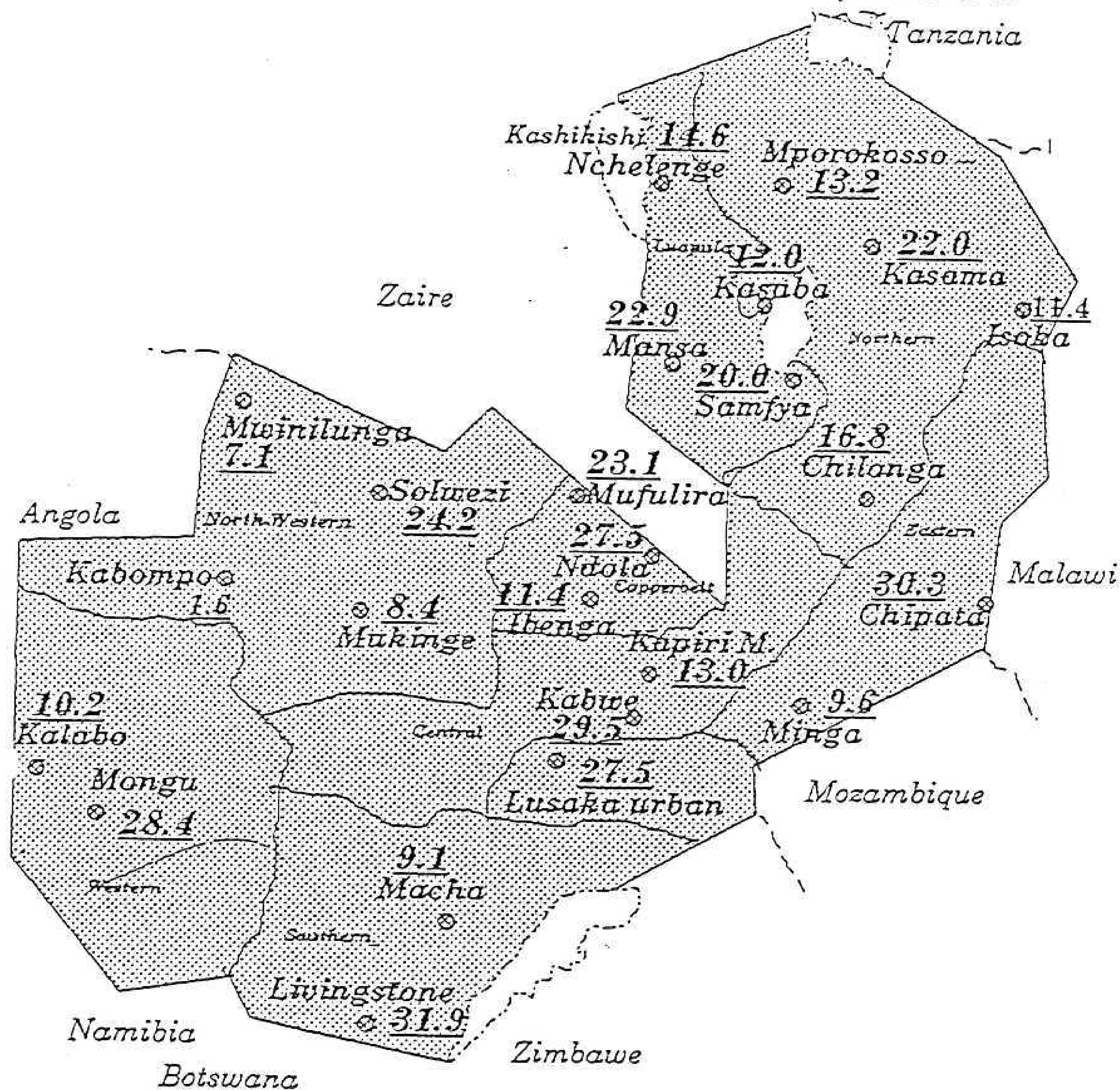
The issue of Impact

As an overall assessment the evaluation team found that the Norwegian support to Zambia has been both very visible and effective in terms of the impact in the fight against HIV/AIDS. This is reflected in the fact that the most effective and innovative AIDS prevention projects by NGOs in Zambia have all received substantial support from Norway. The rather decentralised style of administration of NORAD has done much to contribute to this favourable impression. It has enabled Norwegian programme officers to take swift decisions on the funding of projects, some of which require immediate attention, and to see them off the ground. The proximity of the programme officers to programmes, has also meant that they can monitor the various stages of the work that is being done. This, of course, reflects the flexibility which the guidelines for the use of SAG set as one of the conditions for its use. It may be that flexibility is an inherent characteristic of special grants in general rather than, in the case, the effect of a style of administration. Be that as it may, the conclusion of the study is that the Norwegian support has been both flexible and effective. There is however, another side to this. The large number of decisions that the programme officers have to make at the embassy, and the sometimes small projects supported must entail a great administrative burden. Every decision for support would require the same level of administrative input irrespective of the sums disburses. Therefore, while such numerous decisions for support contributes to making Norwegian funding visible in the field of HIV/AIDS, the number of small grants sometimes dispensed leaves some questionmarks with regard to the effectiveness and the administrative burden they involve. It is, of cause difficult to say whether substantial and large-scale projects are better

able to meet the demand for effectiveness than small scale ones. From the paradigm of piecemeal social engineering small-scale involvements are necessary but they need to be weighed against the administrative burden they entail.

Many of the support activities have been targeted at vulnerable groups, above all women and children, with great success.

HIV PREVALENCE (%) ZAMBIA ANTENATAL WOMEN 1994



* Lusaka Sites: Chelstone, Chilenje, Kalingalinga, Matero

* Sample size: Most areas close to 500, range 293-595.

Ref: Zambia NASTLP, Epidemiology & Research Unit.

APPENDIX 2

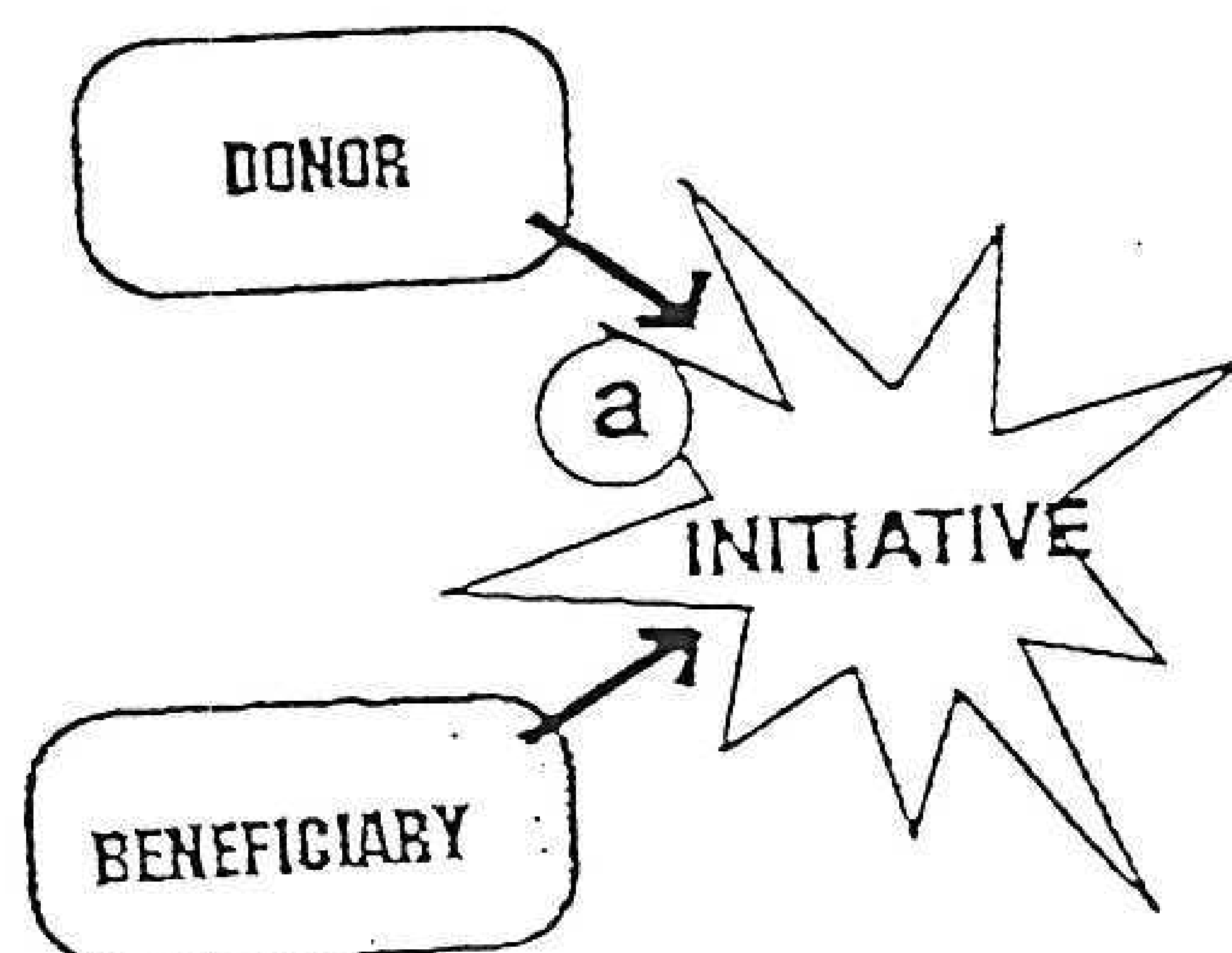
Participatory Evaluation Approach

Most evaluations of donor funded programmes have a token input from local resource persons and these are sometimes members of the evaluation team. However they seldom have any input until the evaluation starts and they are seldom involved in the extremely important stage of implementing some of the recommendations that may issue from the report. This is even more true of the local community who are affected by the programm. They are even less involved apart from being questioned by the evaluation team at best. They often never hear the results of the evaluation after it is over and are certainly not involved in decision making about changes resulting from the evaluation. They often continue life as if no-one had ever visited, questioned or inspected them.

This alternative model has been developed and used by Karl-Erik Lundgren of the Swedish Missionary Council.
It is a method that allows for self-correction during the development process. Being a joint effort it may be painful at times but it also has many valuable encouraging features. The climate of honest exchange between the people who are involved pre-supposes an attitude of openness and frankness.
Here follows a description of the various stages of the process:

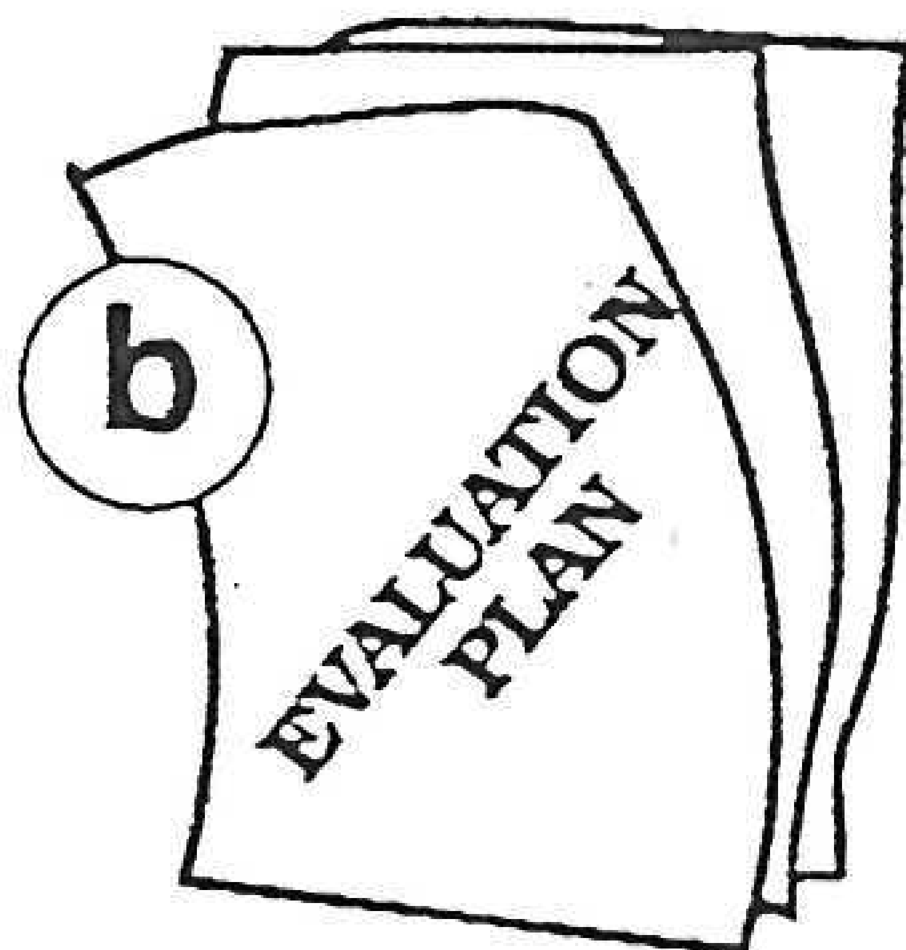
a. Initiation of the evaluation process

Normally there are several partners involved in a development programme. Ideally the initiative could come from any of the partners. It is important that the partners agree on the need for an evaluation. In practice the initiative usually comes from the donor in the high-income-country.



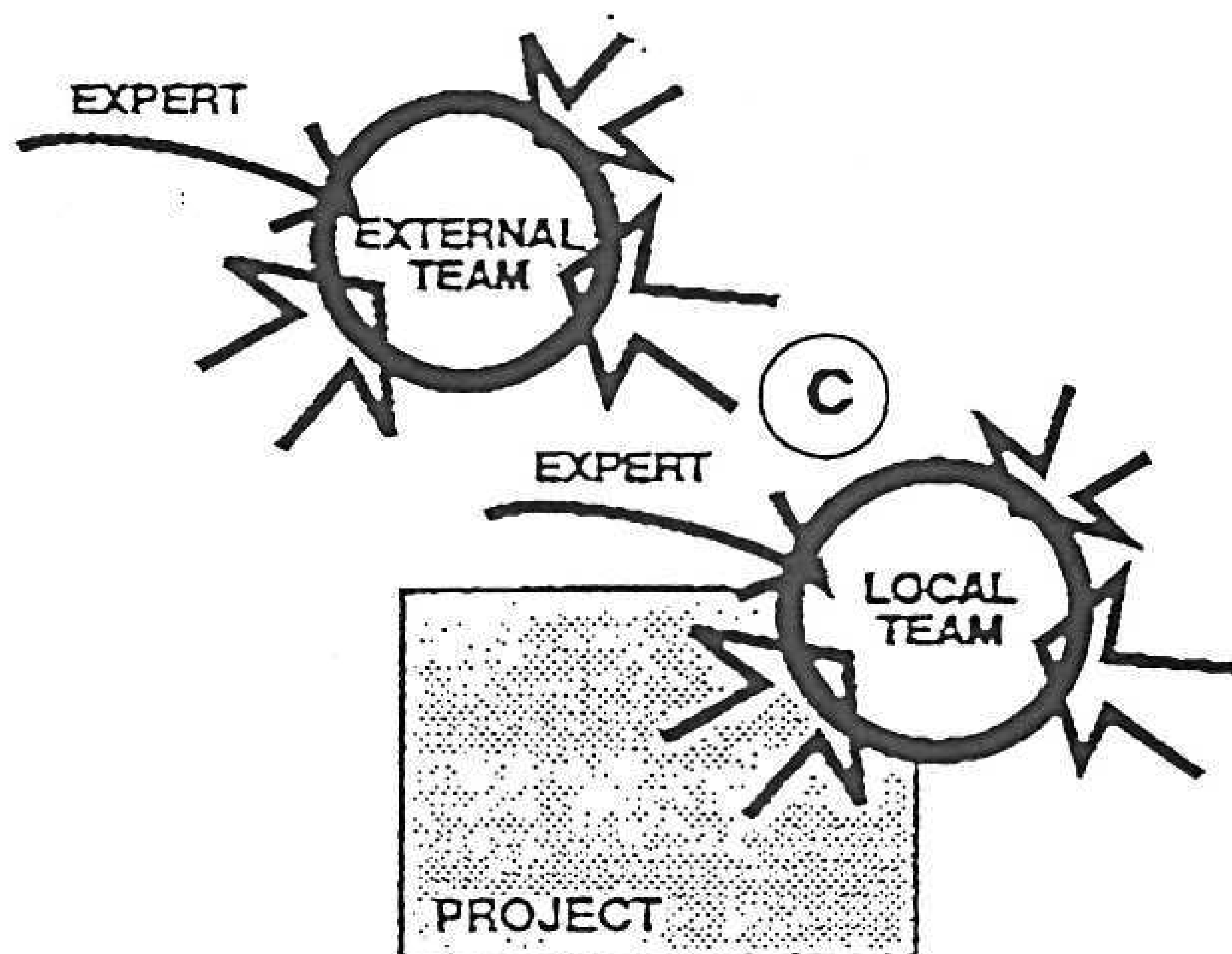
b. Terms of reference

Once the partners are agreed on the need it is important to write the aim and purpose of the undertaking. This is if possible an joint exercise with partners from low and high income countries having a significant enough input to make the terms an "owned" document.

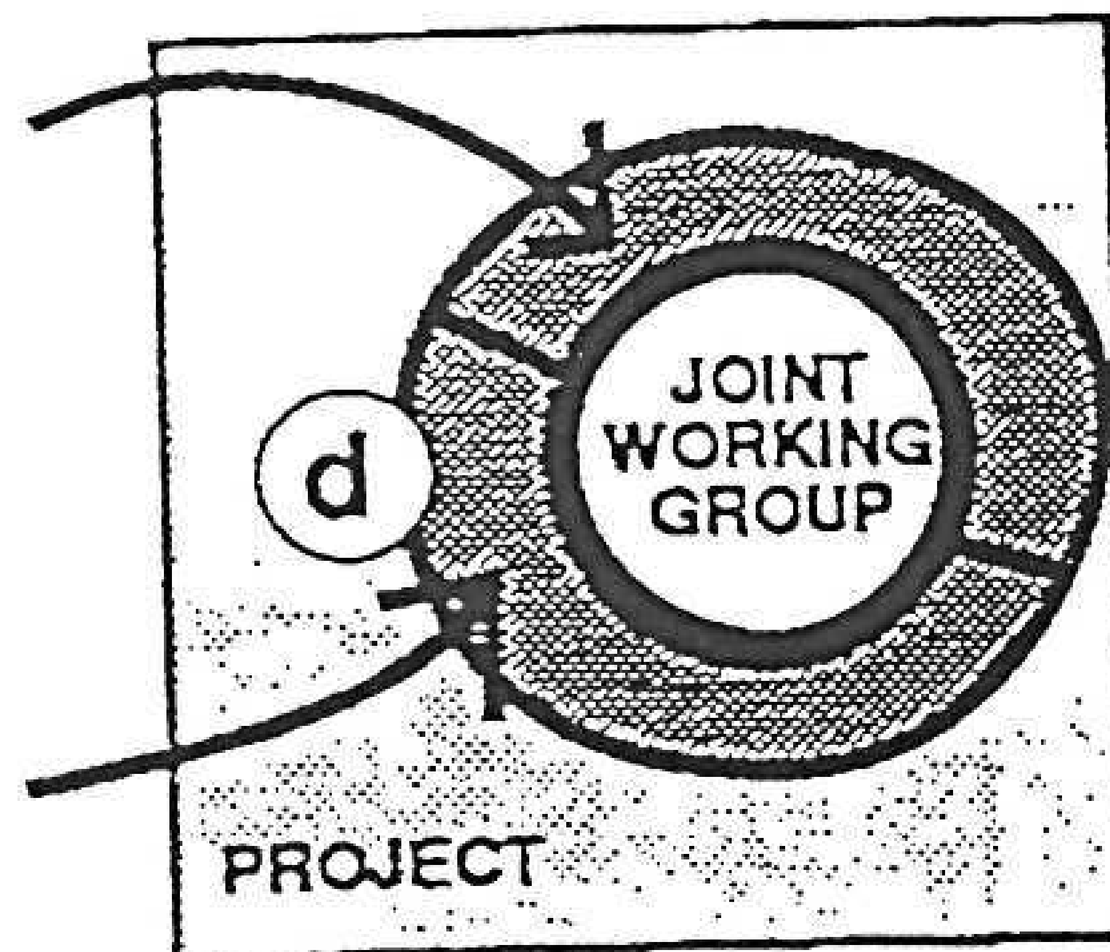


c. Nomination of a local team and an external team

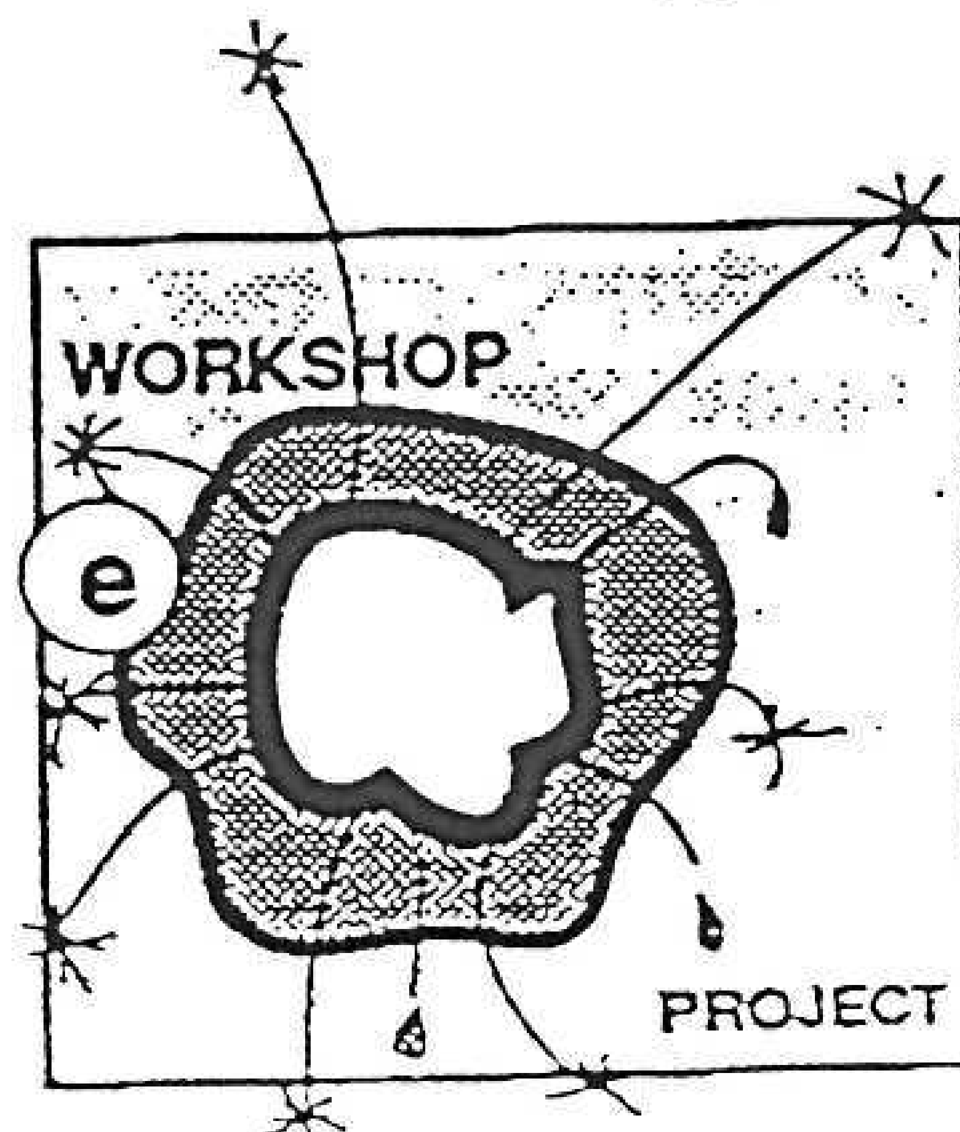
Prepartion for the evaluation work will be done both in the low and high income countries simultaneously. There will be one local team and one external team. Choosing the right members of the team is an important task which needs careful consideration by the partners. Once the two teams have been chosen and approved by each other the work can begin both in the low and high income country with meetings and interchange prior to the two teams meeting.



d. Local and external teams merge in one joint working group
The two teams meet in the programme country. The local team will brief the external team on their findings and vice versa. This is a stimulating experience of a combined operation where local responsibility is blended with external critique; through this dialogue the two teams are slowly merging into one joint working group that will continue to work together on common proposals and recommendations.



e. Workshop
Prior to the joint report being finalized there is a need for an in-depth debate and discussion over central issues unless the one team has already begun to dominate over the other.
It is therefore good to allocate enough time in the form of a workshop for these discussions. This is prior to handing over a report and debriefing. The workshop could last for one or two days or longer. This is a good opportunity for inviting other people e.g. field workers, Government and community representatives, board members etc. who are concerned about the project and who have something to contribute to the discussion.
The workshop is a forum for a broad debate about relevant questions related to the programme. It is also a place where the recommendations and statements are tested before the final writing up of the report.



f. Report

The joint working group appoints the ones who are to draft the report. This is preferably done at an early stage in the work. The report should be scrutinized and approved by the joint working group before it disperses. The report is in essence a confirmation of what the group has already agreed upon.

g. Follow-up meeting

It is useful to have a follow-up meeting 3-6 months later in order to see whether the recommendations of the joint working group have been implemented or whether they are still "hanging in the air".

It is important to note that in this model the report is not quite so central as usual since the process and especially the cross-fertilization of the joint working group plays such a central role. This culminates at the workshop which is the most important moment in the whole process.

This use of a joint evaluation team should be supplemented by the use of the more sophisticated qualitative methods for assessing the attitudes and behaviour of local communities in relation to the goals of the programme. Thus much attention should be given to this level of the evaluation as well as the central planners and implementers.

These qualitative methods include:

*Focus group discussions
*Key informant interviews
*Life histories
*Informal discussions and conversations

APPENDIX 3

List of persons met and organisations and project visited

Mr G. Mundia, Donor & NGO Coordination, Ministry of Health, Lusaka.
Dr Vincent Musowe, Chief Planner, Ministry of Health, Lusaka.
Father Micheal Kelly, Kara Counselling Trust, Lusaka.
Dr M. Banda, General Secretary, CMAZ, Lusaka.
Dr M. Sichone, Manager, NASTLP, Ministry of Health, Lusaka.
Prof. N. Luo, Chairperson, SWAAZ, Lusaka.
Mrs Merab Kiremire, Tasintha Project, Lusaka.
Dr Katuria, George/Matero Project, Lusaka.
Mr Lief Sauvik, Royal Norwegian Embassy, Lusaka.
Mr Kikakan Haugen, Royal Norwegian Embassy, Lusaka.
Mrs E. Mataka, Director Family Health Trust, Zambia.
Ms Pricilla Nkanza, Hope House, Lusaka
Pastor Elijah Longwan, Malambanyma Misssion.
Mpongwe Secondary School ANTI AIDS Club, Mpongwe.
Mr Avara Shimubanga, Mpongwe Mission Hospital.
Mr Aleck Nyirenda, Copperbelt Health Education Project, Kitwe.
Pals Group, Kitwe.
Mr E. Kalenga, Focal Point Person for HIV/AIDS, Sports training officer. Sport, Youth and Child Development, Lusaka
Mr Musante, CINDY, Lusaka

Notes

1) Cost and Impact of Home-Based Care in Zambia 1994, Ministry of Health Zambia, and WHO/GPA Geneva.

1) One member of the local team was unable to participate fully in the evaluation for private reasons.

EVALUATION REPORTS

1.87 The Water Supply Programme in Western Province, Zambia
2.87 Sosio-kulturelle forhold i bistanden
3.87 Summary Findings of 23 Evaluation Reports
4.87 NORAD's Provisions for Investment Support
5.87 Multilateral bistand gjennom FN-systemet
6.87 Promoting Imports from Developing Countries

1.88 UNIFEM - United Nations Development Fund for Women
2.88 The Norwegian Multi-Bilateral Programme under UNFPA
3.88 Rural Roads Maintenance, Mbeya and Tanga Regions, Tanzania
4.88 Import Support, Tanzania
5.88 Nordic Technical Assistance Personnel to Eastern Africa
6.88 Good Aid for Women?
7.88 Soil Science Fellowship Course in Norway

1.89 Parallel Financing and Mixed Credits
2.89 The Women's Grant. Desk Study Review
3.89 The Norwegian Volunteer Service
4.89 Fisheries Research Vessel - "Dr. Fridtjof Nansen"
5.89 Institute of Development Management, Tanzania
6.89 DUHs forskningsprogrammer
7.89 Rural Water Supply, Zimbabwe
8.89 Commodity Import Programme, Zimbabwe
9.89 Dairy Sector Support, Zimbabwe

1.90 Mini-Hydropower Plants, Lesotho
2.90 Operation and Maintenance in Development Assistance
3.90 Telecommunications in SADCC Countries
4.90 Energy support in SADCC Countries
5.90 International Research and Training Institue for Advancement of Women (INSTRAW)
6.90 Socio-cultural Conditions in Development Assistance
7.90 Non-Project Financial Assistance to Mozambique

1.91 Hjelp til selvhjelp og levedyktig utvikling
2.91 Diploma Courses at the Norwegian Institute of Technology
3.91 The Women's Grant in Bilateral Assistance
4.91 Hambantota Integrated Rural Development Programme, Sri Lanka
5.91 The Special Grant for Environment and Development

1.92 NGOs as partners in health care, Zambia
2.92 The Sahel-Sudan-Ethiopia Programme
3.92 De private organisasjonene som kanal for norsk bistand, Fase1

1.93 Internal learning from evaluation and reviews
2.93 Macroeconomic impacts of import support to Tanzania
3.93 Garantiordning for investeringer i og eksport til utviklingsland
4.93 Capacity-Building in Development Cooperation Towards integration and recipient responsibility

1.94 Evaluation of World Food Programme
2.94 Evaluation of the Norwegian Junior Expert Programme with UN Organisations

1.95 Technical Cooperation in Transition
2.95 Evaluering av FN-sambandet i Norge
3.95 NGOs as a channel in development aid
3A.95 Rapport fra presentasjonsmøte av "Evalueringen av de frivillige organisasjoner"
4.95 Rural Development and Local Government in Tanzania
5.95 Integration of Environmental Concerns into Norwegian Bilateral Development Assistance: Policies and Performance

1.96 NORAD's Support of the Remote Area Development Programme (RADP) in Botswana
2.96 Norwegian Development Aid Experiences. A Review of Evaluation Studies 1986-92
3.96 The Norwegian People´s Aid Mine Clearance Project in Cambodia
4.96 Democratic Global Civil Governance Report of the 1995 Benchmark Survey of NGOs
5.96 Evaluation of the Yearbook Human Rights in Developing Countries

1.97 Evaluation of Norwegian Assistance to Prevent and Control HIV/AIDS
2.97 «Kultursjokk og korrektiv» – Evaluering av UD/NORADs studiereiser for lærere
3.97 Evaluation of decentralisation and development
4.97 Evaluation of Norwegian Assistance to Peace, Reconciliation and Rehabilitation in Mozambique
5.97 Aid to Basic Education in Africa – Opportunities and Constraints
6.97 Norwegian Church Aid's Humanitarian and Peace-making Work in Mali
7.97 Aid as a tool for promotion of human rights and democracy: What can Norway do?
8.97 Evaluation of the Nordic Africa Institute, Uppsala
9.97 Evaluation of Norwegian Assistance to Worldview International Foundation
10.97 Review of Norwegian Assistance to IPS
11.97 Evaluation of Norwegian Humanitarian Assistance to the Sudan
12.97 Cooperation for Health Development WHO's support to programmes at country level

1.98 «Twinning for Development» Institutional Cooperation between Public Institutions in Norway and the South
2.98 Institutional Cooperation between Sokoine and Norwegian Agricultural Universities
3.98 Development through Institutions? Institutional Development promoted by Norwegian Private Companies and Consulting Firms
4.98 Development through Institutions? Institutional Development promoted by Norwegian Non-Governmental Organisations
5.98 Development through Institutions? Institutional Development in Norwegian Bilateral Assistence. Synthesis Report
6.98 Managing good fortune

Royal Ministry of Foreign Affairs

7. juni plassen, P.O. Box 8114 DEP, N-0032 OSLO, Norway
Telephone: 22 24 36 00 Telefax: 22 24 95 80/81