Evaluation Department

Norad

# Evaluation of Norwegian HIV/AIDS Responses

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# Evaluation of Norwegian HIV/AIDS Responses

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# Preface

At the turn of the century, there was an increasing concern about the lack of results in fighting the hiv and aids epidemic, and a number of international initiatives were launched. Norway has aimed at being in the frontline in these international efforts, and over the last ten years several billion Norwegian kroner have been spent to support the combat of the disease. While during this period a number of reviews and studies have been carried out to monitor the use of Norwegian funds, few independent evaluations have been undertaken to assess this support. It was about time, then, to take a more comprehensive look at the Norwegian efforts to help fighting hiv and aids over the last decade.

The main purpose of the evaluation has not been to feed into a particular process to revise policies, but to ascertain results, fill knowledge gaps and give guidance to enhancing the effectiveness of the Norwegian response to the hiv and aids pandemic.

Impact of our efforts can only be measured at country level. In the three countries that are part of this evaluation - Ethiopia, Tanzania, and Malawi – a slight improvement of the prevalence rate is seen for youth between 15 and 24 years of age. Improvement in knowledge about the disease has increased in two of the three countries, while increased condom use is registered in all three. The report is clear that Norway has contributed positively to the national efforts, in some cases to major achievements with long-term positive impact. The report pictures Norway as a partner that is willing – maybe more than others – to support national leadership in the fight against hiv and aids. This form of support may lead to less visible results, but is likely to lead to greater impact, the report states.

At the global level Norway has been a continuous and consistent player that – according to the report – has contributed significantly to lasting changes in the international aid architecture while at the same time enabling national ownership.

This praise does not mean, however, that there are no weak points or lessons to be learned. At country level Norwegian aid through various channels does not seem to be well enough co-ordinated. Opportunities to learn from each others' experience and add value to Norway's contribution are missed, which also may have prevented an optimal use of resources. In mainstreaming hiv and aids concerns into general development cooperation there seems to be room for improvement as well.

It is interesting to note that this study is yet another evaluation that highlights - as a main advantage of Norwegian aid - the flexibility of Norway's contributions and our willingness to take risks and engage where others may be reluctant. Other evaluation reports have pointed out that this flexibility is not without costs, as it may weaken the efforts to ensure that substantial results are achieved. And the authors of this report also make the point that Norway seems to have limited staff capacity to engage at country level, which may endanger the impact at field level. When monitoring and evaluation seem to be a weak link as well, this report adds to the increasing evidence that not enough attention is paid to ensuring that Norwegian development aid benefits the common man and woman in the villages and towns of developing countries.

Oslo, October 2008

Asbjørn Eidhammer

*Director of Evaluation*

# Abbreviations

| Term | Meaning |
|---|---|
| ABES | Alternative Basic Education Services |
| AIDS | Acquired Immunodeficiency Syndrome |
| ART | Anti-retroviral therapy |
| ARV | Anti-retroviral |
| BLM | Banja La Mtsogolo (Marie Stopes International affiliate in Malawi) |
| CBO | Community Based Organisations |
| CSO | Civil Society Organisation |
| DAC | Development Assistance Committee (of OECD) |
| DFID | Department for International Development (United Kingdom) |
| DHS | Demographic and Health Survey |
| EDHS | Ethiopian Demographic and Health Survey |
| FBO | Faith Based Organisation |
| GBS | General Budget Support |
| GFATM | Global Fund for AIDS, TB and Malaria |
| GHSS | Global Health Sector Strategy |
| GNI | Gross National Index |
| GTZ | German Technical Cooperation |
| HIV | Human Immunodeficiency Virus |
| HCT | HIV Counselling and Testing |
| IAVI | International AIDS Vaccine Initiative |
| IEC | Information, Education and Communication |
| IPM | International Partnership for Microbicides |
| MAP | Multi-country AIDS Programme (World Bank) |
| M&E | Monitoring and Evaluation |
| MDG | Millennium Development Goal |
| MFA | Ministry of Foreign Affairs |
| MOH | Ministry of Health |
| NAC | National AIDS Commission |
| NACP | National AIDS Control Programme |

| | |
|---|---|
| NCA | Norwegian Church Aid |
| NGO | Non-Governmental Organisation |
| Norad | Norwegian Agency for Development |
| ODA | Official Development Assistance |
| OECD | Organisation of Economic Cooperation and Development |
| OVC | Orphan and Vulnerable Children |
| PLWHA | People living with HIV/AIDS |
| PMTCT | Prevention of Mother to Child Transmission |
| SCN | Save the Children Norway |
| STI | Sexually Transmitted Infection |
| TACAIDS | Tanzania Commission on AIDS |
| TB | Tuberculosis |
| TDHS | Tanzania Demographic and Health Survey |
| ToR | Terms of Reference |
| UN | United Nations |
| UNGASS | UN General Assembly Special Session on HIV/AIDS |
| UNICEF | United Nations Children's Fund |
| UNFPA | United Nations Population Fund |
| UNAIDS | Nations Programme on HIV/AIDS |
| USAID | United States Agency for International Development |
| VCT | Voluntary Counselling & Testing |
| WHA | World Health Assembly |
| WHO | World Health Organization |

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# Executive Summary

This report is the synthesis of the evaluation of Norwegian support and response to HIV/AIDS[1] in the three African countries of Ethiopia, Malawi and Tanzania, and Norwegian contribution to international aid architecture at a global level. The year 2000 marked a shift in the Norwegian approach to HIV/AIDS, whereby the response to the epidemic was made a priority for Norwegian Development Cooperation. Norway's commitment to halt the epidemic led to the development of Norway's policy on HIV/AIDS and resources were channelled through a variety of organisations and programmes. Norway also interacted at all levels (global to community) and adopted inclusive, integrated and participatory approaches in tackling the epidemic.

The objectives of the evaluation were to:
- Assess progress towards key outcomes related to the national HIV/AIDS response
- Assess the factors affecting the outcomes (substantive influences)
- Assess key Norwegian contributions (outputs) to outcomes
- Assess the Norwegian partnership strategies
- Extract lessons learnt, findings and recommendations on how to enhance the development effectiveness of the Norwegian HIV/AIDS response at the country level

The approach adopted for the evaluation was both objective and participant oriented. Methods and tools selected helped structure discussions and elicited information from key stakeholders in the three countries and institutions at global level (a list of respondents is in Annex 2), and enabled triangulation of findings across different sources.

## Evaluation Findings

### Progress towards key outcomes

Progress made in the three countries studied was assessed based on five key outcome and three key impact indicators as defined by the United Nations Programme on HIV/AIDS (UNAIDS) for a generalised epidemic. Assessments were made using various national surveys, in particular, the Demographic Health Surveys (DHS).

Available data on the outcome indicators are not sufficiently complete to demonstrate clear trends. Some positive signs do emerge though. Improvements can be seen in two of the three countries for knowledge about prevention of HIV and age at first sex. Condom use has also increased in all countries, more so among men than women. Data about school attendance by orphans as compared to non-orphans suggest very low levels in the three.

Data on impact indicate positive though slight improvements in the extent of HIV infection among 15 to 24 year olds but well below the 25 percent reduction targeted by UNAIDS in 2005 in all three countries. Two countries report 70 to 80 percent of people still alive one year after starting Anti-Retroviral Therapy (ART). There are no data yet to show progress with the proportion of infected infants born to mothers with HIV.

### Factors affecting the outcomes (substantive influences)

Aside from the underlying factors that fuel the epidemic and are documented in the three country reports, this evaluation has identified a range of other factors and challenges affecting an improved national response and the achievement of planned outcomes. These are categorised as: poor leadership and lack of commitment; ineffective coordination; lack of human resources and poor capacity in the sectors; increased focus on ART at the expense of other bio-medical responses; increased location of programmes and interventions in urban centres as compared to rural domains that house a majority of the people; challenges with

1 Human immunodeficiency Virus and Acquired Immunodeficiency Syndrome.

implementation of effective decentralisation; and poor capacity in implementing monitoring and evaluation.

Norway's contributions clearly supported national leadership of HIV/AIDS response by promoting and facilitating national coordination across sectors in line with the Three Ones. Norway also engaged in negotiations with other stakeholders to ensure that government takes the lead in policy and management of responses to the epidemic. In addressing the challenges of inadequate human resources, Norway has emphasised health sector capacity in the latter part of the period of this evaluation, an effort that is still on-going, and supported efforts both at global level to develop strategies and in the three countries to recruit and build capacity of human resources, especially in the health sector, in order to respond to the epidemic.

In tackling the challenges with Monitoring and Evaluation (M&E), Norway has normally being flexible and adaptive to the existing M&E systems and has not added to the transaction costs or reduced ownership in M&E. Despite Norwegian efforts and supports in tackling some of these challenges, none of the three countries attained the target set by UNAIDS for 2005.

**Key Norwegian contributions to outcomes**

There was no formal HIV/AIDS strategy developed for Norwegian support in the three countries, but Norway's strategy can be characterised as having the aim of engaging widely across prevention, care and impact mitigation to combat the epidemic. In Ethiopia, Norway is a small bilateral donor and the Organisation of Economic Cooperation and Development (OECD) Development Assistance Committee (DAC) official statistics show that annual disbursement increased from $23.6m in 2000 to $41.8m in 2006. In contrast, Norway has been a significantly large bilateral donor to both Malawi and Tanzania. The annual disbursement to Malawi increased fivefold over the period. The total volume of aid rose from around NOK 59 million in 2000 to over NOK 320 million in 2006; while the annual disbursement for Tanzania increased over the period from around NOK 309 million in 2000 to over NOK 483 million in 2006.

Norwegian resources to the three countries were channelled through multiple modalities including global instruments (the World Bank's Multi-country AIDS Programme (MAP) and the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), the multilaterals (UNFPA[2] and UNICEF[3]), research institutes and Civil Society Organisations (CSOs). Aside from the financial contributions, the technical assistance provided (through multilaterals, research institutes and Non Governmental Organisations (NGOs)) has contributed to the capacity development of stakeholders in the country. Analysis of the intervention logic in the three countries indicates that the various channels have contributed to the outputs and outcomes especially in terms of possible reduction in prevalence rates and mitigating impacts of the epidemic.

**The Norwegian partnership strategies**

No formal partnership strategy has been developed by Norway for the various partners engaged at country and global levels. Partnership arrangements at country level were *ad hoc* and based on joint working in the context of international treaties and demand responsive approaches. This reflects broad engagement with various partners. The diversity of partners is a defining characteristic of Norway's programme. Partners see Norway as being flexible and demand responsive which enables them to take an independent view of problems and respond according to the need rather than follow a headquarters-defined agenda.

**Linkage of Norwegian contributions and progress at global level and in the three African countries**

There is no formal strategy regarding the choice between the various channels of support but deciding factors are developmental goals and countries' own efforts in combating the epidemic. At global level, Norway's main strategy is aimed at ensuring improvements to the international aid architecture through active engagement with different actors to ensure that aid flows contribute to impact to halt the epidemic. This effort has contributed positively to

2 United Nations Population Fund.
3 United Nations Childrens Fund.

improved and coordinated global aid architecture and organisation reforms that have led to improvements in fragmented responses to HIV and AIDS.

Norway's actions at country level followed a pattern that is coherent with global actions that involved support to several distinct strands such as implementation of global policies, national strategies, broad support to multilateral agencies, NGOs and research institutes. Norwegian support to HIV/AIDS accorded priorities to programmes and interventions that promoted institutional capacity building, targeting vulnerable groups, collaboration among partner organisations and responding to gender issues and poverty dimension of the epidemic. All these are in line with global commitments and national strategies that contributed to the progress made in the three countries, even though there is paucity of data to ascertain the actual progress.

**Issues and lessons learnt**

Lessons that emerged from the evaluation are related to issues that require further attention in halting the epidemic. They include:

- Willingness to support national responses may lead to less visible results in terms of the Norwegian contribution. But overall, it is likely to lead to greater impact.
- To combat the epidemic effectively, global policies and strategies must be translated comprehensively into actions at country level.
- Norway has been responsive, and willing to take risks and engage with issues in advance of other donors.
- A multisectoral response requires mainstreaming. Experience here has not yet been effective, often reflecting severe shortages of capacity.
- Norway is regarded as a flexible, realistic partner with strong values. But a lack of strategy on partnership relations undermines setting priorities.
- Success at promoting aid harmonisation has not been extended to the coordination of work by NGOs and their alignment with national plans.
- Norway has limited staff capacity to engage at country level yet now faces higher demands as more implementation works through sector and pooled funding mechanisms.

## Recommendations

There is the need to continue support through the multiple channels as engagement at various levels is required for combating the epidemic. Norway should be proactive in enhancing connectivity of programmes and strategies.

Strengthen leadership and coordination of programmes at all levels. This could be linked with Norway's good governance programmes in the countries.

Support the review of the Global Health Sector Strategy (GHSS) and engage with other partners for full implementation at country level. The components of the GHSS are relevant and would address some of the issues arising from the evaluation in the three countries.

Ensure broader and more formal approach to strategy development in tackling the epidemic.

Continue support to civil society organisations considering the important roles they are playing especially in covering hard to reach areas and vulnerable groups.

Provide support to HIV mainstreaming in order to ensure a true multi-sectoral response which is required to tackle the epidemic effectively.

Work with other partners to address weak monitoring and evaluation systems in the countries.

# 1 Introduction

This report is the synthesis of the evaluation of the Norwegian response to HIV and AIDS in three African countries – Ethiopia, Malawi and Tanzania, and Norway's contributions to the international aid architecture in response to the epidemic.

The Norwegian government has provided support to HIV and AIDS response since 1986 through various implementing institutions including country level support to government and civil society organisations to combat the epidemic. A number of reviews and studies have been conducted to monitor progress. An external evaluation commissioned by the Ministry of Foreign Affairs (MFA) was undertaken in 1997 covering the five year period – 1990 to 1995 with country focus in Tanzania, Uganda and Zambia.

In 2000-2001 Norad and MFA intensified response to HIV/AIDS through establishing this as a priority focus. MFA published a position paper in 2000, where the main strategic choice made was that Norway should give priority to supporting the development of the national HIV/AIDS response at country level, and be a supportive and flexible donor in this effort, as well as pursuing the links between HIV/AIDS and development in a broad sense. In addition some issues of special concern were identified.

Also in 2000 an AIDS Project was established in MFA, comprising the top level management in each department. Areas of relevant intervention for each department were identified, and the Directors General met with the Minister for Development Cooperation at regular intervals to report on action taken. An AIDS Project was also launched in the Norwegian Agency for Development Cooperation (Norad), including representatives from the various departments, identifying areas of relevance for mainstreaming of HIV/AIDS. The Project reported to the Board of Directors on a regular basis.

In order to mobilise more broadly in Norway, two structures were also set up in 2000/2001. AIDSNETT, a network of Norad, NGOs and research networks involved in HIV/AIDS work internationally, aimed at competence building, policy dialogue and experience sharing; and the AIDS FORUM, comprising leaders from the army, the church, youth organisations, trade union, the business sector, media and sport organisations, to mobilise HIV/AIDS work in their own sector. They met regularly with the minister and invited high level visitors.

Thus, the main organising principles during 2000-2004, were mainstreaming, competence building, and high priority and close attention from the leadership in Norad/MFA, as well as mobilising civil society. This work aimed at providing a solid base for the future work. After a complete reorganisation in 2004, an MFA/Norad HIV/AIDS "Theme Group" was established in 2005, to facilitate a better coordination between Norad and MFA. This joint MFA/Norad group has been working closely together ever since, under the leadership of the later appointed AIDS-ambassador.

In the international arena, HIV/AIDS became an increasingly central theme in development with various changes over the years in the institutional landscape to deal with the epidemic. The decision in 2000 for HIV/AIDS to be a priority for the Norwegian development cooperation also coincided with the time of growing political attention to HIV/AIDS through the adoption of Millennium Development Goals (MDGs) by world leaders and the declaration of commitment from the UN General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001, meetings of the UN Security Council and G8 summits.

In advancing this course, the Norwegian government instructed the development administration to contribute as far as possible to limit the spread of the epidemic, and Norad and the MFA channelled resources and support through a variety of organisations and

programmes. HIV/AIDS is a long term emergency that requires new, strategic and effective approaches at both international and country levels especially with the provision of social services. Norway realised the need to interact at all levels and adopt integrated, inclusive and participatory approaches from international to community levels to contribute to the control of the epidemic.

To assess the extent to which Norway has contributed to the response, the Norwegian government commissioned this evaluation. The primary purpose of the evaluation is not to provide input into a revision of the Norwegian HIV/AIDS policy since the current Position Paper was introduced in November 2006. The evaluation is expected to provide strategic guidance towards the implementation of the Position Paper, and in particular strategic guidance for enhancing the development effectiveness of the Norwegian HIV/AIDS response at the country level. The Position Paper could be adjusted based on inputs from the evaluation.

The main purpose of the evaluation is to ascertain results (accountability), fill knowledge gaps, provide lessons learnt and suggest recommendations on how to enhance the development effectiveness of the Norwegian HIV/AIDS response at country level. Specifically, the evaluation focus would be on assessing Norway's role and contribution in influencing key outcomes[4] of the national HIV/AIDS responses in Ethiopia, Malawi and Tanzania.

## 1.1 Evaluation Objectives

The objectives of the evaluation were to:

- Assess progress towards key outcomes related to the national HIV/AIDS response.
- Assess the factors affecting the outcomes (substantive influences).
- Assess key Norwegian contributions (outputs) to outcomes.
- Assess the Norwegian partnership strategies (how Norway works with relevant partners).
- Extract lessons learnt, findings and recommendations on how to enhance the development effectiveness of the Norwegian HIV/AIDS response at the country level.

The evaluation covers the period 2000 to 2006. In accordance with the terms of reference the evaluation design has been kept simple, relying on reliable secondary data and avoiding nonessential information. A brief summary of methodology is set out here.

## 1.2 Evaluation Approach

A combined approach was adopted in order to address the terms of reference. The overall approach is results oriented to ensure a focus on impact, outcomes and outputs of Norwegian responses to HIV/AIDS rather than inputs and activities. The elements of the approach were:

- Objective Oriented: to make clear the goals and objectives of the evaluation and the review of what has been supported by Norway in the three African countries and at global level in relation to the key outcomes and the relevance of the support.
- Participant Oriented: this approach placed participating respondents at the centre of the evaluation design and influenced the data collection tools that were used to ensure a participatory approach to the evaluation process.

The approach also guided selection and choice of evaluation methods.

## 1.3 Evaluation Methods

Both quantitative and qualitative methods were adopted for this evaluation. The methodologies and the tools were selected to ensure that the specific evaluation questions are addressed and to enable cross referencing or 'triangulation' of findings across different sources. Methods are listed first, followed by tools.

a. Document Reviews – Various documents were collected from Ministry of Foreign Affairs, Norad, Royal Norwegian Embassies in the three countries studies, government institutions, multi and bilateral agencies, country level multi-lateral institutions, Norwegian NGOs, indigenous NGOs, local implementing institutions and beneficiaries. Secondary data were

4 Reference is made to the OECD/DAC definition of outcomes as the likely or achieved short term and medium term effects of an intervention's output (output being defined as the products, capital goods and services from an intervention).

synthesised from these documents for analysis to review inputs, output level results, contributions to the outcomes and changes in the key outcomes indicators during the period.

b. Key Informant Interviews – Short interview topic guides were developed by the team focussing on the issues appropriate to the various stakeholders. This enabled the evaluation team members to elicit information consistently and to clarify issues or areas of concerns as required. The questions were developed based on the evaluation framework and focussed specifically on answering the key evaluation questions set out in the evaluation objectives.
c. Focus Group Discussions (FGD) – These were used mostly for implementing institutions and beneficiaries. Group discussion enabled a mix of views to emerge enabling the team to ensure consistency with the contents of documents reviewed and information gathered from other sources.
d. Field Visits – Field visits were conducted to implementing organisations and beneficiaries in the three countries. The purpose of the field visits was to validate information elicited from documents and explore perceptions and experiences not recorded in formal reports. The field visits also afforded us an opportunity to meet with some primary beneficiaries.
e. Snowball Sampling – This special non-probability method was used to locate respondents through referrals from initial subjects to generate additional subjects that benefited from the Norwegian Programme for Development, Research and Education (NUFU)[5] in Tanzania to elicit information on how they had contributed to the HIV/AIDS response in the country.
f. Email / Web Survey – The team undertook an email survey to gather opinions and perceptions of stakeholders in agencies and institutions that could not be reached for face to face interviews using a concise and limited set of questions.
g. Telephone Interviews – The consultants requested that stakeholders, unable to respond to the email survey, contact them for telephone interviews. Telephone interviews were also conducted for a number of stakeholders who preferred to talk to the team rather than responding to the email survey.

## 1.4 Evaluation Tools

a. Evaluation Framework – The framework was the core planning tool that enabled the team to state step by step how each of the objectives would be addressed in order not to leave out any issue or area that was critical to the evaluation objectives. The framework also provided the structure to itemise the sources of information that would address the evaluation questions and the necessary indicators.
b. Timeline Tool – A timeline was constructed to generate information on the sequencing of actions and interventions on HIV/AIDS that took place during the evaluation period (2000 – 2006).
c. Force-field Analysis – This tool was utilised among various stakeholders to identify forces/factors that enhanced effective utilisation of resources to achieve key outcomes; or those forces that held back achievement of outcomes. The discussion amongst participants using this tool gave insights into the areas of success and challenges facing the various programmes.
d. Stakeholder Analysis – This tool was used by the team to categorise the relative influence, importance and interest of various stakeholders that Norway had worked with in utilising resources to achieve the key outcomes.

The evaluation drew heavily on available research, data and documentation from existing progress reports, self evaluations, independent evaluations and studies performed by Norway and other development partners, including national research and monitoring data.

5 The Norwegian Programme for Development, Research and Education (NUFU) is a Norwegian programme for academic research and educational co-operation based on equal partnerships between institutions in the South and in Norway.

## 1.5 Reliability and Validity

The tools and methods were used to ensure consistency that would enable the evaluation team to draw satisfactory conclusions about the evaluation. The reliability of the evaluation was considered in terms of equivalence and consistency. The equivalence reliability was determined by relating data collected with progress made by the country in the key outcome areas defined by UNAIDS for a generalised epidemic. Use of the tools also enabled the team to assess the consistency of information from all parties consulted and the contribution of Norwegian support in this regard.

As regards validity, the methods and the tools utilised enabled the team to gather data for analysis and to draw inferences as regards the progress the country was making in achieving the key and impact outcomes, as well as the extent of the Norwegian contribution to the HIV/AIDS response both at global and country levels. In addition, cross referencing of information was done as part of the evaluation process especially where respondents informed the team that certain results had arisen as a result of Norwegian support for the implementation of their programmes.

Progress in the fight against HIV/AIDS is the results of multiple actions by many organisations and individuals. It is not feasible to try and identify a simple direct causal link between the work of a particular agency and progress towards outcomes and impact. In accordance with guidance given in the terms of reference discussion of attribution of impact to Norway's contributions is not the overriding priority in the evaluation. But in each of the country reports the team has discussed probable factors that have contributed to change in outcome and their interrelationships with Norway's inputs and outputs. Those findings are reflected in this Synthesis.

This report is set out in five chapters. Chapter one covers the introduction, evaluation approach and methodology used. Chapter two reviews the Norwegian contribution at a global level and in the three African countries studied, as well as programmes and strategies supported. Chapter three presents delivery of outputs, chapter four covers progress towards outcomes and factors affecting progress and effectiveness of Norwegian support. Chapter five concludes the report and covers lessons learnt and recommendations.

# 2 Norwegian Contributions to HIV/AIDS Responses in Three African Countries and at a Global Level

## 2.1 Introduction

This chapter presents the analysis of the Norwegian contribution to the HIV/AIDS responses during the period 2000 – 2006. The chapter covers financial contributions, programme and strategies of engagement at global and country level and relevance to HIV/AIDS response. The year 2000 marked a shift in Norwegian approaches to HIV/AIDS with an increase in the volume of support and a more explicit policy position (HIV/AIDS and Development, 2000). Norwegian aid over the evaluation period more or less reflects these policy positions, with only some small changes in priorities. The organisation of HIV/AIDS work in Norway was also changed and broadened. A project team was established in Norad and later an AIDS Forum and an AIDS network which includes other institutions and sectors were established. There was also a project at MFA, and an advisor from Norad was transferred to MFA for some months to coordinate HIV/AIDS project across the different developments in MFA.

In 2001, an internal action plan for Norad's intensified efforts appears to have been influential with HIV/AIDS becoming a main thematic priority. In 2002, the focus was on prevention and treatment and using a mainstreaming approach for impact mitigation with measures to increase competence in Africa. Prevention measures were to continue to support women, youth and children, including the Prevention of Mother to Child Transmission (PMTCT). Accessibility and affordability of treatment was of paramount importance. The period 2003 to 2006 focussed more on increased support to the multilaterals and the global instruments. Health systems capacity was given stronger focus. A new Policy Position Paper was developed in November 2006. (See Annex 3 for a detailed timeline of Norwegian policy)

A range of Norwegian contributions in terms of provision of funds and technical assistance were channelled through bilateral engagement, multilateral agencies, global instruments such as the GFATM and NGOs to tackle the epidemic. Hence, the evaluation looked critically at the various engagements, utilization of these resources and achievements in terms of contributions to the outcomes and impact indicators as defined by UNAIDS for a generalised epidemic. In particular, the evaluation asked if the various strands were coordinated. Norway's support to HIV/AIDS will be described at two levels in this report – support to international aid architecture and to the three African countries – Ethiopia, Malawi and Tanzania.

This chapter starts with an overview of global events during the period. This is followed by a short summary of Norway's financial contribution globally and to the three study countries. Norway's programmes and strategies are then reviewed firstly at a global level then at a country level.

## 2.2 Major Events Affecting the Response to HIV/AIDS

Table 1 set out a timeline of major global events that have influenced the international aid architecture to fight HIV/AIDS.

*Table 1 Timeline of major events*

| Institution | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|---|---|
| GFATM | G8 proposal for a global fund | | Global fund established | (*Norwegian work on procurement system*) | (*Norway Chair, M&E[6]&Audit*) (*TERG*)[7] | | |
| GAVI[8], IAVI[9], IPM[10] | GAVI launched | | IPM established | | Improved focus on advocacy for mobilisation | | |
| UN | Security council addresses AIDS in military | UNGASS w/ declaration | | | Joint UN programme launched | | UN programme operational. UNGASS follow-up |
| UNAIDS | | First 5 year evaluation | | The Three Ones developed | The Three Ones approved; Global coalition on women and AIDS | Global Task Team established *(Norway Chief Facilitator)* | |
| WB/MAP | MAP established ACTafrica[11] | (*Seed money & Norwegian Trust Fund*) | | | | | |
| WHO[12] | Accelerated access initiative | | Guidelines for ARV (*Health sector & AIDS Strategy*) | 3 by 5 initiative[13] | High Level Forum on MDGs 2004-05 | | |
| Other | | WTO[14] Doha declaration of access | | | Clinton foundation-Norwegian cooperation | | UNITAID established |

*Only major events or clear shifts in the various institutions listed (gradual changes not mentioned)*

6 Monitoring and Evaluation.
7 The Technical Evaluation Reference Group (TERG) is an advisory body providing independent assessment and advice to the Board of The Global Fund to Fight AIDS
8 The Technical Evaluation Reference Group (TERG) is an advisory body providing independent assessment and advice to the Board of The Global Fund to Fight AIDS
9 International AIDS Vaccine Initiative
10 International Partnership for Microbiocides.
11 AIDS Campaign Team for Africa.
12 World Health Organisation.
13 The 3 by 5 initiative aims to have 3 million people on treatment by 2005. This is a WHO initiative to address mortality resulting from AIDS by improving access to treatment.
14 World Trade Organisation.

The various events outlined in Table 1 shaped the global architecture in response to HIV/AIDS, based on the needs and actions to be taken as a result of improved scientific knowledge and better ways of dealing with the epidemic in a result oriented manner.

## 2.3 Financial Contributions

Norwegian aid has been high and increasing every year throughout the period, constituting close to 1 % of GNI. In 2003, total net ODA was $2.04 billion. Norwegian aid spread over approx. 120 countries and sub-Saharan African countries alone received 48%. Bilateral aid constituted 72% of Norwegian ODA in 2003[15].

Current reporting standards limit the ability of the MFA accurately to identify the amount of money disbursed specifically in support of HIV/AIDS. This is because many programmes in particular with multilateral organisations combine support for HIV/AIDS with other work and routine statistical reporting does not distinguish among multiple purposes. A recent new study by OECD, supported by UNAIDS has attempted to overcome these problems and has identified disbursements for all major donors for 2005 and 2006. These are shown for Norway as global disbursement in Table 2[16]. The same table summarises financial flows directed towards HIV/AIDS in the three study countries which can be more closely identified based on figures provided by the MFA.

*Table 2 Norwegian financial support for HIV/AIDS globally and by country[17]*

| | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|---|---|
| Global disbursement for HIV/AIDS (NOK million) | | | | | | 200.1 | 258.3 |
| Total | 207,321 | 146,492 | 227,401 | 263,223 | 229,421 | 245,205 | 268,169 |
| HIV/AIDS | 424 | 8,841 | 48,168 | 45,644 | 40,022 | 23,330 | 28,043 |
| % | 0% | 6% | 21% | 17% | 17% | 10% | 10% |
| **Malawi** | | | | | | | |
| Total | 59,827 | 86,699 | 124,225 | 199,370 | 183,090 | 316,181 | 322,421 |
| HIV/AIDS | 7,000 | 16,664 | 32,428 | 50,447 | 61,217 | 129,862 | 114,860 |
| % | 12% | 19% | 26% | 25% | 33% | 41% | 36% |
| **Tanzania** | | | | | | | |
| Total | 309,419 | 314,161 | 372,710 | 476,955 | 401,637 | 388,410 | 483,482 |
| HIV/AIDS | 15,286 | 4,872 | 68,832 | 65,184 | 95,037 | 55,669 | 57,354 |
| % | 5% | 2% | 18% | 14% | 24% | 14% | 12% |

No firm trend can be identified from the two global figures, but in the three study countries provision of support to HIV/AIDS has risen substantially in both absolute and percentage terms over the period, with proportionately the highest allocations in Malawi.

## 2.4 Norway's Programmes and Strategies

Fighting poverty is the main axis of Norway's overall strategy with consideration to a rights-based approach and provision of support to service providers that align their activities with national policy frameworks. There is no formal strategy regarding the choice between the different aid channels (bilateral, multilateral and NGOs), but deciding factors are development goals and countries' own efforts in reaching the MDGs with emphasis on achieving results. Norway prioritises support to areas where it can effectively contribute to poverty reduction and they include: education, health, HIV/AIDS, rights of vulnerable groups and WEHAB[18] initiatives, some of which includes HIV mainstreaming.

Owing to the way Norwegian development assistance is organised there are many actors involved in Norwegian programmes and strategies for HIV/AIDS. Bilateral cooperation was mainly managed by Norad until 2004 and later delegated to the respective Norwegian embassies. Support via Norwegian NGOs has, with some exceptions, been managed through

15 Norway (2004), DAC Peer Review: Main Findings and Recommendations – http://www.oecd.org/documentprint as at 12/05/2008
16 OECD (2007) Aid Activities in Support of HIV/AIDS Control, 2000-2007. Paris (Table 1).
17 Data for financial allocations at country level are based on the use of a policy marker in the Norad official database whereby programmes are marked as having none, a main or a significant objective of tackling HIV/AIDS.
18 WEHAB includes water, energy, health, agriculture and biological diversity.

Norad's department for civil society throughout the period. Multilateral cooperation is managed by the Ministry of Foreign Affairs, involving a section for global initiatives and gender equality under the Department for UN, Peace and Humanitarian Affairs as well as the sections in charge of cooperation with the respective multilateral institutions.

The Department of Health and HIV/AIDS in Norad is in responsible for quality control in terms of HIV/AIDS and key aspects of strategy development, and provides technical backstopping to other units. The actual inputs from the department, however, to a large degree depend on requests from the embassies and other units for technical assistance. Most embassies do not have HIV/AIDS technical expertise among staff. In recent years all embassies have been asked to reduce the number of sectors they are engaged in, making it difficult for many to keep a focus on HIV/AIDS as a priority and even as a cross-cutting issue.

A number of structures have been in place during the period to facilitate better coordination between the different units. These include AIDS projects in MFA and in Norad, respectively; AIDSNETT to also include NGOs and research networks involved in development cooperation relating to HIV/AIDS; AIDS FORUM to facilitate mobilisation in Norway among NGOs, Sweden-Norway Regional Team in Lusaka to provide guidance to HIV mainstreaming, trade unions, business, media etc. After the reorganisation of Norwegian development assistance in 2004, through which bilateral aid was delegated from Norad to embassies, an MFA/Norad "theme group" was established to facilitate better cooperation. Embassies do not participate directly in that group.

The organisation of Norwegian assistance raises some questions regarding efficiency and optimal utilisation of available technical resources, which have not been studied in-depth for this evaluation; however, some aspects of coordination are identified in the country evaluations and the global report.

Analysis of Norway's programmes and strategies will be discussed at two levels: global and country level.

## 2.5 Strategies and Engagement at Global Level

At the end of the 1990s, although much progress had been made in achieving a more coherent and better coordinated approach to HIV/AIDS, many challenges still remained. The work of multilateral and bilateral donors was often fragmented and poorly harmonised, there was a need for a big expansion in funding to meet the needs for treatment and UNAIDS was making only slow progress towards an expanded, multi-sectoral response.

Norway's major strategy globally aimed at ensuring improvements to the international aid architecture. The approach adopted included active engagement with different actors – bilateral and multilateral agencies, as well as national governments within the donor and recipient nations to ensure that flows of aid contributed to the necessary impact to halt the epidemic. The global paper developed for this evaluation reported in detail the evolution of the global aid architecture in relation to HIV/AIDS. Norway played a visible and active role in many of the organisational reforms that led to the improvements in fragmented responses to HIV/AIDS. The most notable of Norway's contributions at the global level include:

- Support to the establishment and operations of UNAIDS as the lead United Nations (UN) joint programme
- Harmonisation and coordination including the Three Ones principles
- Support to the establishment and operations of the Global Fund to Fight AIDS Tuberculosis and Malaria (GFATM)
- Engagement of Norway with four other countries to initiate international drug purchase facility
- Development of a pivotal sector policy for WHO
- Health systems strengthening
- Support to research

These are reviewed in turn.

### 2.5.1 Establishment and support to UNAIDS

Norway was a key donor that supported the establishment of UNAIDS and served as a board member of the UNAIDS Programme Coordinating Board from 2000 to 2002 and from 2006 onwards. Norway also seconded personnel to UNAIDS head office. The Senior Policy Adviser seconded part-time to UNAIDS was charged with the responsibility of broad consultation that contributed to the establishment of the Three Ones to enhance country level coordination. Norway has also frequently engaged through participation as member and chair in committees and working groups, and played facilitating roles to various processes, including the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, the Global Steering Committee on Scaling up Towards Universal Access (including chair of the subgroup on health personnel and capacity).

### 2.5.2 Harmonisation and coordination including the "Three Ones" principles

A major priority of Norway has been harmonisation and coordination at national and international level. Norway contributed to harmonisation through its involvement in the various institutions, promoting coordination between international agencies and supporting development of mechanisms to enable better coordination. Several of the processes in which Norway has been a key agency have also served to bring multilateral organisations closer to each other. Examples include World Bank and UNAIDS through ACTafrica[19]; UNAIDS and UN Security Council through UN Office on AIDS, Security and Humanitarian Response, the Global Fund to address health system strengthening, UNAIDS and WHO on Health Sector and most institutions through the Three Ones.

### 2.5.3 Support to the establishment and operations of the Global Fund for AIDS, Tuberculosis and Malaria (GFATM)

Following the initiative for a global fund, Norway has, in addition to funding, contributed to the institution through the transitional working group with Norwegian inputs reflecting an insistence on harmonisation, organisational and governance issues. Subsequent formal involvement has been via board membership. Norway represented the Point 7 group as alternate board member in 2005-2006, and before that time played an active role in developing the positions of the Point 7 group on the board. Furthermore, Norway has been member, chair or co-chair of various working groups. Among the interests that Norway has focused on through Point 7 board representation or working groups are that GFATM should focus on targeting the poorest and most affected countries.

### 2.5.4 Drug pricing

Norway played a key role in achieving a reduction in price of antiretroviral drugs to ensure affordability and enhance coverage to reduce mortality as a result of AIDS. A major step taken was in hosting a conference in 2001 with the World Trade Organisation (WTO). A second issue related to affordable drugs was financing. Norway engaged with four countries to establish the International Drug Purchase Facility which subsequently led to the founding of UNITAID. Norway provides financial support for the implementation of the initiative and serves on the board of UNITAID. UNITAID has also enjoyed political support from Norway. The presence and active participation of Norway on boards of other agencies or as chair in other committees in agencies such as the GFATM, WHO, UNAIDS have added value in the direction to which UNITAID board benefits from the expertise of Norway's representative.

### 2.5.5 Support to the development of a pivotal sector policy for WHO

Norway supported WHO technically and financially for the development of strategies to define and strengthen the health sector in responding to HIV/AIDS within the broad multi-sectoral response as endorsed by the World Health Assembly (WHA) resolution in May 2000. Norway provided leadership to the development of the Global Health Sector Strategy (GHSS). The Norwegian representative chaired the Global Reference Group and participated in wide regional consultations for the development of the document. The GHSS document has four components, namely; Prevention and Health Promotion, Treatment, Health Standards and Health Systems, and Informed Policy and Strategy Development. The GHSS document was endorsed by WHA in May 2002.

19 AIDS Campaign Team For Africa

### *2.5.6 Health systems strengthening*

Norway worked with a range of institutions to address challenges facing the weak health systems in developing countries to ensure that support became an explicit priority under the international commitment for Universal Access. Norway played a proactive role in increasing focus on the health personnel crisis in Africa through engagement with other institutions that led to the establishment of the Global Health Workforce Alliance, and also provided further support to WHO for the development of the guideline for "Treat, Train and Retain" which is now gathering momentum for implementation.

### *2.5.7 Norway's contribution and support to research*

Norway has supported research on vaccines through the International AIDS Vaccine Initiative (IAVI) and in the development of prevention options for women through the International Partnership for Microbicides (IPM) with relatively high volumes of financial support.

Norway has also supported research programs, higher education and collaboration between research institutions in North and South within the area of HIV/AIDS, health and related sectors, involving a substantial number of researchers and education at higher (master) level of students in African countries and Norway.

## 2.6 Norwegian Support to Country Level Responses

Norway's support at country level follows a pattern that is coherent with global actions. Norway has adopted a multi-faceted form of engagement with several distinct strands:

- Support to implementation of global policies
- Funding of global institutions and programmes at country level
- Policy advice and technical assistance to global agencies
- Bilateral country programmes targeted to support national policies and institutions
- Selective in-country support to multilateral programmes and implementation of global initiatives
- Broad-based support in-country to NGOs, CSOs, and research organisations
- Funding through Norwegian NGOs with a high level of visibility in Norwegian society

The mix of these elements varies according to the country circumstances. Thus, for example, the strategy adopted in response to the epidemic is comparable in Tanzania and Malawi. Bilateral support was organised to support the national HIV framework for multisectoral responses and additional support given to NGOs to deliver interventions in response to the epidemic. In contrast, Norwegian support in Ethiopia was directed at multilateral agencies and Norwegian NGOs to work with local NGOs to respond to the epidemic. In all three cases, support was aimed at engaging widely across prevention, care and impact mitigation.

Interestingly, despite such a diverse approach with many partners and actors, Norway did not prepare a specific country programme strategy on HIV/AIDS in any of the three countries. Norwegian support to HIV/AIDS accorded priorities to programmes and initiatives that promoted:

- Institutional capacity building
- Targeting vulnerable groups
- Collaboration among partner organisations
- Response to gender, poverty and socio-economic dimensions of the epidemic

Details of programmes and strategies supported during the period 2000–2006 in the three countries studied are presented in the various country reports. It is noteworthy that all the programmes and interventions supported are in line with global commitments and national strategies that are expected to contribute to the key outcomes and impact indicators as defined by UNAIDS. In addition to this bilateral support are programmes implemented through the World Bank MAP and GFATM resources which were major sources for financing the HIV/AIDS response in these three countries; Norway is a donor to both institutions.

Conduct of research and building research competencies was another key partnership programme supported by Norway through cooperation between the Universities, research centres in Norway and Universities and research institutes in the three countries studied. For example, Tanzania benefitted from the Norwegian Programme for Development, Research

and Education (NUFU) to meet the demand/shortage of counsellors in the health sector. In Ethiopia, the establishment of Armauer Hansen Research Institute has enhanced the conduct of operational research that will impact on the effective co-management of HIV/AIDS and Tuberculosis.

### *2.6.1 HIV mainstreaming*

HIV mainstreaming was identified as a strategy for combating the epidemic at the beginning of the period under evaluation[20]. The period also witnessed the development of national HIV/AIDS strategic frameworks in the three countries with consideration and plans for the implementation of a true multi-sectoral response. Norway supported mainstreaming of HIV in the agriculture sector in Malawi and road construction in Tanzania – the two countries that enjoyed bilateral support. In addition, workplace HIV interventions were implemented in the power sector in Tanzania, and beneficiaries of NUFU supported programmes also carried out some HIV interventions in their places of work. The situation differs in Ethiopia where significant progress was not made in this area during the period under evaluation owing to various reasons from low commitment from institutional leaders, lack of technical capacity to drive the process forward and resources for implementation.

### *2.6.2 Gender mainstreaming*

Gender related factors which contribute to fuelling of the epidemic were identified in the three countries studied for this evaluation. These factors include; increased incidence of sexual practice between older men and young girls, sexual harassment, socio-economic disempowerment, early marriage, unfocussed interventions to address vulnerability of girls, ineffective communication strategy, female genital mutilation, amongst others.

Norway's policy recognised the close linkage between women, HIV/AIDS in relation to powerlessness and breach of rights. Norway supported programmes that promoted measures to enhance sexual and reproductive health and rights in efforts to combat HIV infection and improve the quality of life for women who are already infected. For example, Norway supported UNICEF and UNFPA in Ethiopia to work with local NGOs to implement key various interventions such as the Girls forum project, support to Association of Women living with HIV. Save the Children Norway, Ethiopia established Alternative Basic Education Services (ABES) in rural areas to reduce vulnerability of girls to rape, STI/HIV infection, and supporting interventions on eradication of female genital mutilation. These interventions aimed at empowering females especially young girls to reduce vulnerability to HIV. UNICEF and UNFPA efforts in working with government also resulted in the institutionalisation of gender issues. Although this has only been limited to the development of policies and strategies as they still face challenges with implementation of the policy and strategy in a holistic and sustainable manner.

It is worthy to note that there is no specific systematic reporting on gender as a particular area of outputs in the three countries and there are also challenges of ensuring effective coordination of gender responsive programmes.

## 2.7 Relevance of the Strategies and Programmes

The evaluation concludes that the strategies and programmes are in line with Norwegian policies in responding to HIV/AIDS from 2000-2006.[21] The content of the policies shaped much of Norwegian aid to HIV/AIDS during the period. Norway's support responded to the epidemic based on priorities in the three countries studied and helped to shape the global response through engagement with stakeholders at international level. In the three countries, the programmes responded in the early years before national systems were put in place and were well established. Subsequently, direct bilateral support through provision of technical assistance, financing and utilisation of the funding from World Bank MAP helped create the national systems and reinforced implementation of the Three Ones.

Norway's engagement in shaping the global response and the international AIDS architecture was in advance of the Rome and Paris initiatives on aid effectiveness. Norway's emphasis on

20 Mainstreaming is the term used for changing organisational policy and practice to reduce susceptibility to HIV and vulnerability to the impact of AIDS. A related concept is integration, where HIV/AIDS work is implemented along with or as part of development and humanitarian programmes. It is desirable to distinguish between the two, but mainstreaming is often used as a shorthand for both.

21 See Annex 3 on Overview of Norwegian policy statements and priorities regarding HIV/AIDS from 2000 – 2006.

adoption of integrated, inclusive and participatory approaches from international to community level was reflected in the various support, especially through engagement with NGOs to work with and reach vulnerable groups. Norway also worked with other donors in the country and at international level to promote partnership working in order to make progress towards multi-donor pooled funding aligned to national strategies in Tanzania and Malawi. Plans are on-going to expand and merge the UNFPA/UNICEF programme to enhance reach, coverage and effectiveness in Ethiopia.

Norway's commitments as outlined in the Policy Position Paper (2006) are still relevant in addressing the epidemic and vital to the achievement of key outcomes as defined by UNAIDS in 2010. Whilst some of Norway's commitments have been pursued rigorously at global level, they are yet to be translated into actions at country level. For example, the WHO Global Health Sector Strategy for HIV/AIDS (GHSS) 2003 – 2007, where few components have been implemented at country level. Exceptions are the 3 by 5 initiative and recently, the Train, Treat and Retain (TTR) initiative to deal with human resources. This evaluation is of the view that the GHSS is a vital and relevant document, for which full implementation would have possibly resulted in overcoming challenges in the health sector in responding to HIV and AIDS. Hence efforts must be geared up to ensure comprehensiveness in the implementation of such policy to ensure its relevance to the control of the epidemic.

**Summary of the Norwegian contribution in three African countries and at global level**

- Norway's approach has been driven by national policy and has adapted to changing global circumstances.
- The approach has been pluralistic with a number of coherent strands of engagement at global and country level.
- Norway has adhered to a clear set of principles with its concerns for rights, gender, the needs of vulnerable groups and for the primacy of national policies.
- The approach has been consistent with a high degree of continuity, especially with regard to support for the global aid architecture for HIV/AIDS.
- The approach at country level in the three countries varied according to country circumstances based on the needs of each country and available capacity at the embassy level. Despite working through a number of diverse approaches Norway did not prepare country programme strategies for HIV/AIDS in any of the countries.
- Norway's commitments as outlined in the Policy Position Paper are still relevant in addressing the epidemic and vital to the achievement of key outcomes as defined by UNAIDS in 2010.

# 3 Delivery of Outputs

This chapter summarises delivery of outputs in the three countries. Outputs are defined as the immediate, direct results from an intervention or input. During the period under evaluation, Norway supported a wide range of programmes and projects directly or through other channels such as multilateral institutions, NGOs, GFATM, and the World Bank MAP. The contributions of these various channels resulted in thousands of outputs which are too detailed to document here, but are summarised in terms of the national response for the three countries.

## 3.1 Ethiopia

Norway's resources to Ethiopia were channelled through a variety of agencies, primarily the Global Fund (GFATM), multilaterals (World Bank, UNFPA and UNICEF), research institutes and civil society organisations (CSOs), in which faith-based organisations played a prominent role. A bilateral cooperation was not developed owing to the difficult political situation in the country. Funds were channelled through UNICEF, UNFPA and local NGOs to implement youth focus programmes in relation to sexual and reproductive health and rights including HIV/AIDS.

Two national strategic frameworks were developed during the period under evaluation (2001–2005) and (2004–2008). The first framework covered five major areas: social mobilisation and Information, Education and Communication (IEC); creation of an enabling environment; Voluntary Counselling & Testing (VCT), condom promotion and universal precaution; impact mitigation; and development of national capacity including operational research and management systems. The five major areas were expanded and increased to twelve in the second multisectoral strategy with the adoption of six strategies for implementation which included; capacity building, community mobilisation and empowerment, integration with health programmes, leadership and mainstreaming, coordination and networking and focus on special targets. The implementation of these strategies in Ethiopia was possible through the availability of MAP and Global Fund resources. Some 63% out of 286,000 people in need of Anti-Retroviral therapy (ART) benefitted during the period. The two global initiatives (3 by 5 and GFATM) enhanced the number of cases on ART from 3,000 in mid-2005 to over 65,000 at the end of 2006. The 3 by 5 framework also enhanced the decentralisation of treatment and implementation of awareness of treatment availability. It shifted focus and broke the monopoly of expensive ART treatment that was only available in larger urban hospitals up till mid 2005.

A total of 11,700 People Living With HIV/AIDS (PLWHA) received home based care and 141,400 orphans and vulnerable children (OVC) received support. GFATM resources alone provided support to 56,500 OVC. The support to UNICEF and UNFPA resulted in the establishment of over 300 anti-AIDS clubs in schools. UNFPA supported interventions alone achieved:

- Capacity development of 12 local NGOs to manage sexual reproductive health and HIV/AIDS programmes and this resulted in the following achievements during the period under evaluation.
- Provision of Voluntary Counselling & Testing (VCT) to more than 21,000 people.
- Distribution of over 620,000 condoms.
- Treatment of 2,320 sexually transmitted infection (STI) cases treated in Family Guidance Association of Ethiopia clinic alone.
- Over 300,000 people received education on HIV.
- 1,590 PLWHAs reached with care support services and treatment of Opportunistic Infections.
- Over 140 OVC and commercial sex workers benefited from the support activities.
- Empowerment of 800 peer educators and 426 home based care providers.

- The establishment of well functioning 112 Anti AIDS Club & 40 youth information centres.

Projects supported by the Norwegian NGOs and PLAN International in collaboration with partner local NGOs, have reached over 100,000 youths with interventions ranging from IEC, library services, training, youth friendly services to HIV/AIDS awareness raising programmes. More than 1,000 OVC were supported in skills acquisition and to continue formal education. The young women's rehabilitation project alone empowered 103 female sex workers through capacity building and engagement in income generating activities, additional support was also provided to their children for educational activities.

## 3.2 Malawi

Norway has been a significant bilateral donor to Malawi, with a large country programme. The HIV/AIDS projects and programmes have been with a wide range of partner institutions. The core of the programme was to support the development of government activities. This was reinforced by actions directly though the health sector and was complemented by extensive programmes with NGOs designed both to mainstream HIV/AIDS and to support the work of civil society, with a special emphasis on faith-based organizations (FBOs) which are important parts of the social fabric in Malawi.

Similar to Ethiopia, two national HIV/AIDS frameworks were developed during the period covering 2000–2004 and 2003–2008 with a focus on prevention and behavioural change, treatment, care and support, impact mitigation, research development, monitoring and evaluation, resource mobilisation and utilisation, national policy coordination and programme planning.

Most indicators[22] relating to Information, Education and Communication as well as the promotion of Safer Sex Practices show outputs beyond targets for the period. 1,131 radio and television programmes were aired in 2006 and probably well beyond 2,000 in 2007, against a target of 1,500. Distribution of booklets and brochures (1,4 million) amount to more than four times the 2007 targets. Most of the population has been reached by messages relating to HIV/AIDS. In 2004, the Demographic and Health Survey (DHS) found that at least 66 percent of women and 80 percent of men reported having been reached; the number is likely to be significantly higher in 2006 owing to a very high increase in intensity. Almost 5 million young people have been exposed to life-skills based HIV/AIDS education; far beyond targets of 1,000,000 for 2007. More than 60,000 teachers and advisors have been trained in life-skills based education as this became a core subject in schools in the country.

The number of sites offering HIV Counselling and Testing (HCT) and persons tested has increased to about 300 compared with 14 in 2001 and well beyond targets. Estimates by National AIDS Commission (NAC) suggest that 12 percent of the population is accessing HCT, which is beyond the target for 2008 in the Strategic Management Plan.

For Prevention of Mother to Child Transmission outputs have been poor compared to targets. Nineteen percent of health facilities provided the minimum package of PMTCT services by 2006 (above 2007 targets) and 52,900 or 8.5 percent of pregnant women were counselled and tested. There is a remarkable increase towards 2007 (135,000 tested) but only 5 percent of HIV positive women are receiving the complete course of Anti-Retroviral (ARV) prophylaxis. Although there has been an increase, the numbers are very low compared to targets.

Anti-Retroviral Therapy (ART) stands out as perhaps the most impressive area in terms of outputs. By November 2007, the number of people who had ever started ART had increased to 114,000.[23] This is well beyond the 2007 targets of 50,000 and compared to only 3,760 patients on ART in 2003. The ART coverage is estimated at more than 30 percent, which is considered to be the highest in Southern Africa. In general, the service seems to be of high quality, with survival rates above 70 percent even after 24 months.[24] 77 percent of detected tuberculosis

22 Carlson et al (2006) September 2007 Malawi Health SWAp Mid-Term Review Summary Report as cited in Malawi report for this evaluation.
23 Pre-publication figure given during interview at the HIV/AIDS Unit, MOHP to update data from earlier in the year.
24 Ministry of Health (MOH) HIV/AIDS Unit and Report of the Malawi ART Programme, External Review Team, 4th - 15th September 2006, MOH, Charles Gilks et al; page 4: cohort survival is 71% of which 55% alive and 16% transfer out.

(TB) cases are successfully treated, which is close to the 2007 target of 80 percent. There is reportedly a relatively good integration between ART and TB treatment.[25]

In terms of community and home-based care and support, outputs are beyond targets. The number of households receiving external assistance to care for adults increased from approx 57,000 in 2004 to approx 181,000 in 2005/2006 (Carlson, 2006), well beyond the target of 80,000 for 2007. The number of people ever enrolled in organisations for People Living With HIV/AIDS (PLWHA) is 26,000, more than five times the targets for 2007. In support of Orphaned and Vulnerable Children (OVCs) there was a high degree of achievement of outputs at a national level. About 950,000 OVCs were supported which is approximately twice the 2007 target. During the last 12 month period (2006/2007) approximately 161,000 OVCs have been supported (Hera, 2007). One estimate says that 35 percent of all the OVCs received community support in 2005/2006, against 21 percent in 2004 (Carlson, 2006), and around 600 community initiatives to support OVCs have been supported.

## 3.3 Tanzania

Norway has been a significantly large bilateral donor to Tanzania. Norwegian resources were channelled through multiple modalities – General Budget Support (GBS), Basket Fund and Project Funds, the Rapid Fund Envelope, Foundation for Civil Society and direct support to NGO/FBO's. About 4.5% of GBS was allocated to Zanzibar and some Zanzibar NGOs have also accessed the Rapid Fund Envelope for HIV/AIDS response. In addition, resources were also channelled through Norwegian NGOs. Furthermore, GFATM and Tanzania MAP were confirmed as the major sources of funding for HIV/AIDS activities in the country. All these channels contributed to the progress made during the period.

Development partners including Norad supported the Ministry of Health and Social Welfare in the development of a national care and treatment plan to guide the procurement and distribution of ARVs. Seventy thousand (70,000) persons received ARV through public and private hospitals and represented 16% of those in need of treatment. Nevertheless, it is a substantial increase from about 2,000 persons that were on treatment in 2003. Voluntary counselling and testing sites grew from 289 in 2003 to 1,027 in 2006 with an increase in the number of people accessing services from 57,223 in 2002 to 680,520 in 2006. Although the Tanzania Health Indicator Survey (THIS – 2003/04) confirmed that this uptake is low as only about 15% of men and women are reported to have undertaken an HIV test. In addition to the VCT sites set up by the National AIDS Control Programme (NACP), Norway also supported CSOs to set up additional VCT centres and reached over 900,000 beneficiaries. Tanzania AIDS Commission (TACAIDS) reported 334 PMTCT centres at the end of 2006 and about 12% of eligible women were reported to have received a course of ARVs. However, the PMTCT programme was faced with the challenge of a poor return rate of pregnant women to deliver in hospitals – about 49% as compared to 89% that attended antenatal clinics.

Syndromic management of STIs were available in all hospitals, health centres and 60% of dispensaries by the end of 2006. Over 400,000 STI cases were treated in health facilities in 2006 as compared to 223,000 reported in 2003. Progress was recorded in availability of male condoms. One hundred and fifty million (150 million) were available in 2006 as compared to 50 million in 2003. Only 780,000 female condoms were distributed in 2006, although it is difficult to state if availability equates to demand and usage.

The Norwegian contribution made it possible for the CSOs/NGOs, government institutions and the private sector to increase the level of awareness on HIV/AIDS. The IEC interventions implemented by CSOs funded by Norway include conduct of outreach activities, development of IEC materials and organisation of concerts and events. These activities reached over 600,000 people in communities and schools between 2003 and 2006 and developed numerous IEC materials for distribution and education of the populace. Production of FEMA magazine alone grew from 15,000 to 95,000 every quarter with an estimated readership of 12 persons per copy and SiMchezo magazine targeting out of school youth and semi illiterates grew from 10,000 to 100,000 copies with an estimated readership of 15 persons per copy. The MEUTSA -YETU HIV/AIDS school project funded by Norwegian Nurses Association reached close to 7,000 pupils.

25 Report of the Malawi ART Programme, External Review Team, 4th - 15th September 2006, MOH, Charles Gilks et al.

Available data revealed that 29,610 OVC benefitted from one support or another. Litigation support was provided to widows and orphans especially in relation to inheritance issues. Norway took a leading role by funding TACOSODE as a training provider to build skills in about 80 CSOs in three Zones for care and support, management, project design and proposal writing. In addition, the NUFU programme contributed to institutional and capacity development especially in the area of HIV/AIDS counselling, while The MKAPA HIV/AIDS Fellowship Programme recruited and trained fellows posted to underserved, hard to reach rural districts. By 2007, 99 fellows have been trained and posted in 30 rural districts.

## 3.4 Intervention Logic

This evaluation used a logic diagram to model the potential benefits arising from Norwegian support. The illustrated intervention logic (see annex 4) showed how Norwegian support created a connectivity and coherent programme leading to development change in line with national priorities especially in relation to outcomes. The analysis of the intervention logic was at four levels namely: various inputs by Norway, outputs, institutional added value and direct and indirect outcomes that resulted in the impact of the country programmes on HIV/AIDS recorded in the countries studied so far. The actual programmes supported in the three countries resembled the model as far as level 1 and 2 (inputs and outputs) are concerned as the programmes have harnessed a wide range of implementing partners and shown flexibility in combining aid modalities.

The potential interactions and lesson learning expected at level 3 (institutional added value) were not achieved as there were no mechanisms to feed back the more diverse experiences even though Norway supported some innovative work, the evaluation revealed that full benefit has not been derived from those experiences to help inform other partners and contribute to the halting of the epidemic, although, the various programmes contributed directly or indirectly to impact on the epidemic.

**Summary of delivery of outputs**

- The approach was similar but differed in detail in the three countries. In Ethiopia the main channels were through multilateral agencies, research institutes and CSOs. In Malawi there was a large bilateral programme working through government and the NGO sector. In Tanzania support to government, through a Rapid Fund Envelope and direct support to NGOs.
- Faith-Based Organisations (FBO) were prominent channels in all three countries.
- Performance reported in the studies represents the national response, not activities funded only by Norway.
- Performance of many service-delivery functions such as IEC has mainly exceeded targets.
- Challenging functions, such as Prevention of Mother to Child Transmission (PMTCT), remain at a fairly low level of performance.
- Analysis of intervention logic developed for the three countries studied revealed that the programmes have contributed directly or indirectly to impact on the epidemic. There was no mechanism in place for experience sharing and learning which might have enhanced capacity in halting the epidemic.

# 4 Progress Towards Outcomes

This section of the report presents summary data on progress towards key outcomes and factors affecting them. The key outcomes are as defined by UNAIDS and include five knowledge and behaviour indicators and three core impact indicators for generalised epidemic. Tables summarising progress towards the key outcomes in the three countries are presented in Annex 5 from the reports of each country and are further synthesised below. The data generated for the analysis of progress were drawn mostly from the national Demographic Health Surveys (DHS) of each country. Data were not available for most of the indicators for the year 2000 and this was attributed to non-availability of UNAIDS guideline for key outcome and impact indicators prior to that year which affected the coverage and kind of data collected for the DHS. Even where data was available, the accuracy to ascertain the true status of the epidemic and progress in terms of response was a major source of concern. The findings in each of the outcome and impact indicators are presented in the following sections. The data presented in this section reflect the joint achievements of all parties supporting the national response in each country. Analysis in the country studies shows that Norway's contributions have been directed towards these outcomes but the performance cannot be attributed to any one donor or organisation.

## 4.1 Outcome Indicators

*Indicator: Percentage of young women & men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV (target: 90% by 2005; 95% by 2010) and Percentage who reject major misconceptions about HIV transmission (target: 90% by 2005; 95% by 2010).*

Data was available to assess progress in two of the three countries studied (Ethiopia and Tanzania). Both countries made progress if compared to the baseline recorded in year 1999/2000 but neither attained the target set by UNAIDS for year 2005. The Ethiopia Demographic Health Survey (EDHS, 2005) reported 41.1% females and 58.2% males that were able to identify correctly prevention of sexual transmission of HIV. Progress was recorded amongst females if compared to EDHS 2000 that reported 39.2% females and 64.8% males. In Malawi the same figures, 25% female and 37% males, were reported both in 2003–04 and 2005–06, while in Tanzania, 26% female and 29% male were reported by the Tanzania Demographic and Health Survey (TDHS) in 1999 and 45% female and 40% male were recorded by TDHS in 2004. This data indicates that despite all efforts and on-going interventions, more work will be required to attain the 95% target set for this indicator by 2010. The figures presented for Malawi and Tanzania also included data on those who rejected major misconceptions about HIV transmission. No data was available to compare with in 2000 in Ethiopia, but 32.7% female and 45.7% male were reported by EDHS in 2005 to have rejected major HIV/AIDS misconceptions.

*Indicator: Percentage of young women & men who have sex before the age of 15.*

Tanzania DHS reported 15% female and 20% male in 1999 with a reduction resulting in 12% female and 9% male in 2005. The only data available for Malawi was for year 2006 from a UNAIDS fact sheet; 15% women and 14% men, and in Ethiopia it was 16.1% female and 4.4% male in 2000 with a reduction in female to 15.8% and 1.7% male in 2005. Although the accuracy of this data is in doubt, nevertheless, it still gives a picture that more women than men have sex before the age of 15, and possibility of increase susceptibility to HIV infection.

*Indicator: Percentage of young women & men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months.*

Malawi reported 26% male and 8% female in 2003/04, and 12% male in 2005/06 but there was no data on females. There was no data available at any point in time for this indicator in Tanzania during the period under evaluation, while EDHS reported 5.8% female and 37.4% male. This is a major issue considering the fact that heterosexual relationships were identified as one of the major factors fuelling the epidemic in these three countries. In as much as there was no data to certify the accuracy of the progress in this indicator, especially for females, it is clear that females are still the worst affected considering the fact that major route of transmission of the virus is heterosexual in the three countries. Available data presented revealed that more males aged 15 – 24 have had sex with a non-marital and non-cohabiting sexual partner which are likely to be females.

*Percentage of young women & men aged 15-24 reporting the use of condom the last time they had sex with a non-marital, non-cohabiting sexual partner.*

*Fig. 1: Condom Usage*

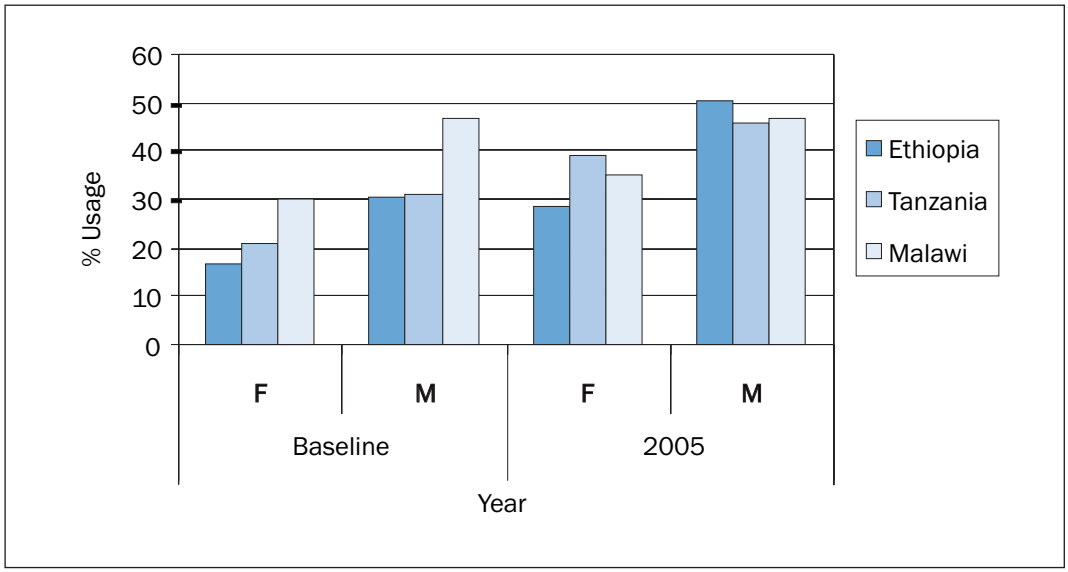



Figure 1 shows the percentage of condom use in the three countries with a clear increase for both sexes[26]. It is seen from the chart that more males are using condom as compared to females. This finding is related to cultural and socio-economic issues that prevent women from negotiating condom use for safer sex and the difficulties associated with the availability, accessibility and usage of female condoms.

*Indicator: Ratio of current school attendance among orphans to non-orphans, aged 10-14.*

Data for this indicator shows some improvement in both Tanzania and Malawi with ranges from 0.94 to 0,97 % in Malawi and 0,90 to 0,98 for males in Tanzania. The ratio for girls in Tanzania is reported to have dropped from 1,03 to 1,0. But the Ethiopian 2004 Welfare Monitoring Survey recorded the ratio of school attendance amongst orphans to non-orphans as 1:4 in urban areas and 1:6 in rural areas.

26 The baseline year varied between countries. It was 1999 for Tanzania, 2000 for Ethiopia and 2003/04 for Malawi.

## 4.2 Impact Indicators

*Indicator: Percentage of young women and men aged 15-24 who are HIV infected (target: 25% reduction in most-affected countries by 2005; 25% reduction globally by 2010).*

The data shows a slight decline in the percentage of young men and women aged 15 – 24 years who are HIV infected. In Ethiopia, analysis of available data revealed a decline of 17.3% in urban and 27% in rural locations. In Malawi, it was 10% and 7% in urban and rural locations respectively. In Tanzania, 6.7% and 5% reduction was reported amongst males and females respectively. Except for the reduction in rural locations in Ethiopia, none of these reductions attained the 25% reduction targeted by UNAIDS in 2005 for most affected countries.

*Fig.2: HIV Infected Young Men and Women in Malawi*

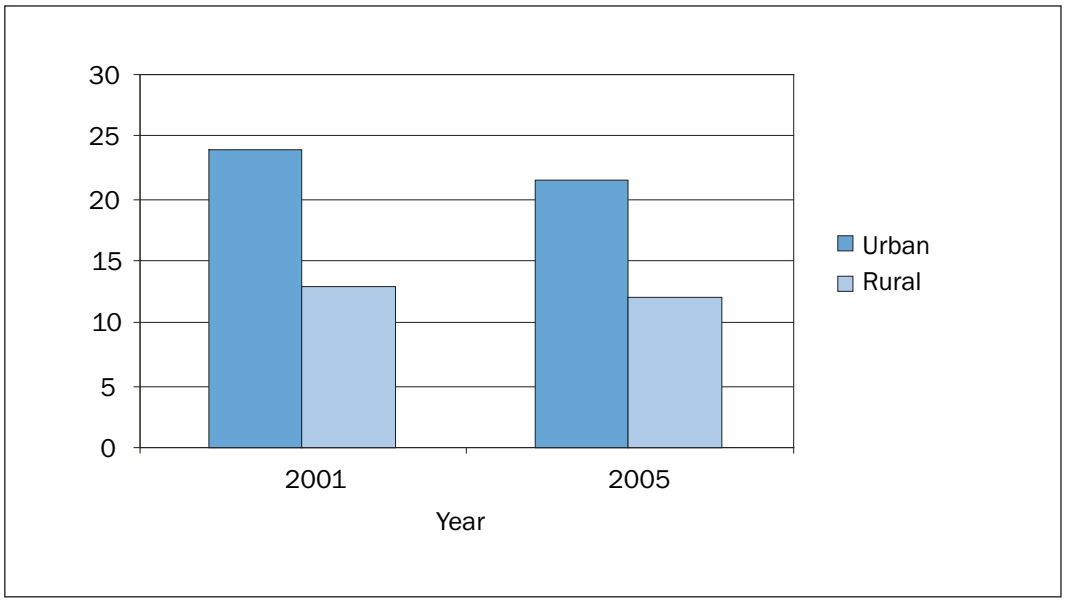



*Fig. 3: HIV Infected Young Men and Women in Tanzania*

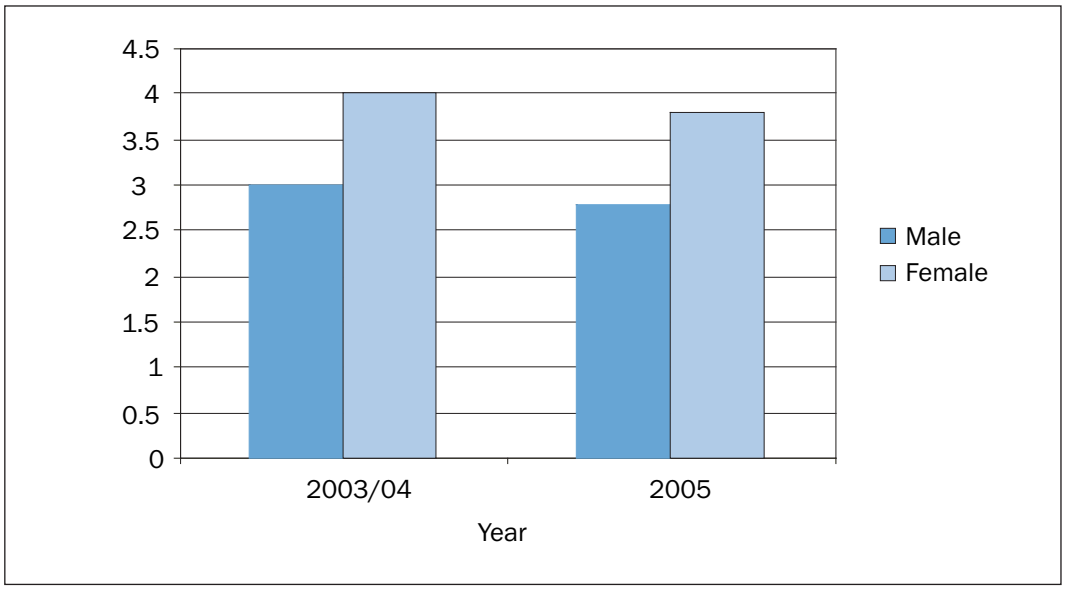
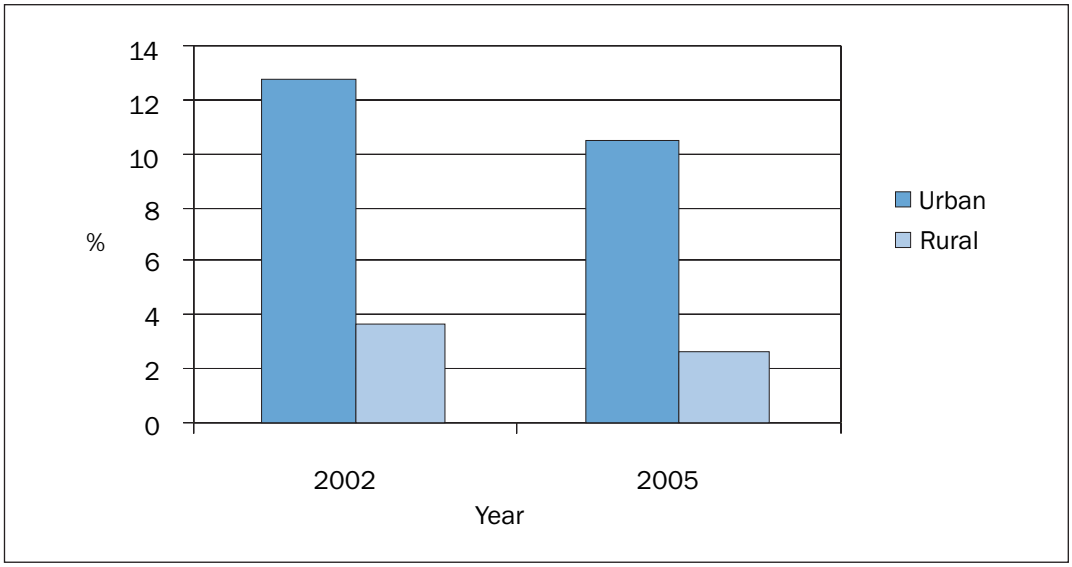


*Fig. 4: Young Men and Women HIV Infected in Ethiopia*




*Indicator: Percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy*
Malawi reported 81% and Ethiopia reported 76.7% in 2003 and 71.4% in 2004. No data was available to assess this indicator in Tanzania. Nevertheless, there are indications that the treatment programme has been effective in reducing mortality as a result of AIDS and related opportunistic infections considering the percentage of PLWHA who are alive 12 months after initiation of ARV treatment.

*Indicator: Percentage of infants born to HIV infected mothers who are infected (target: 20 % reduction by 2005; 50 % reduction by 2010).*
There are no baseline data for comparison to assess the extent of reduction in this regard. In 2003, Malawi HIV/AIDS mid term review of HIV/AIDS management plan reported 21% and the Tanzania Health Indicator Survey reported 25% but no survey or data on this indicator to compare progress made. There was no data available for this indicator in Ethiopia.

The outcomes arising from engagement at a global level have also contributed to the progress recorded at country level. For example, the Three Ones that are operational at country level, irrespective of the challenges have contributed to having harmonised and coordinated strategies that could be monitored and evaluated by the single national framework. The Global Health Sector Strategy, implementation of the 3 by 5 and the availability of Global Fund resources, have all contributed to the success recorded for treatment of AIDS cases and reduction in mortality as compared to what has happened in the past based on road maps developed and resources made available for implementation.

## 4.3 Factors Affecting Progress Towards Outcomes

There is a paucity of data in many cases to ascertain the true progress during the period under evaluation. On a positive note, available data revealed the best progress since HIV/AIDS was first discovered, both in terms of a very much better response and in terms of reduced incidence and in some countries prevalence. Despite this, none of the three countries attained the target set by UNAIDS for 2005, and more efforts will be required if these countries will move in anyway close to attaining the targets set for 2010. The reasons for slow progress are many and varied and are explored in the three country reports. The main issues are summarised here.

### *4.3.1 Leadership*

Political, administrative and technical leadership are required and important at ensuring an effective response to HIV/AIDS at all levels. Norway's contributions have clearly supported national leadership of the HIV/AIDS response by promoting and facilitating national coordination across sectors and later through the Three Ones principles. There are also numerous indications that Norway has engaged in negotiations with other donors and

government in ways that insist on the government as the lead agency and reduces direct engagement of donors in policy and management, thereby creating a greater scope for national leadership.

However, there are challenges faced by the countries studied to ensure this. Despite the commitment of the heads of state of the three countries at curtailing the epidemic, there is limited commitment and engagement of high-level politicians and leaders in other walks of life. This has affected the efforts at mounting a true multisectoral response to address the epidemic and is particularly significant for HIV prevention and behaviour change.

### *4.3.2 Ineffective coordination*

Norway's contributions have facilitated better coordination of the national response in the countries Norway has supported, and much of Norway's multilateral engagement has also contributed to better coordination on multilateral and national level. The establishment of the Three Ones in which Norway played a significant role was translated into action at country level. National AIDS Commissions were established in the three countries and are working. Also, Norway contributed to the capacity building of the commissions especially in the early days. However, their effectiveness has been reduced by limited coordination capacity at all levels, thus resulting in interventions that are still scattered and ineffective in bringing the desired change. Coordination in most cases is limited to grants provision and monitoring but does not necessarily extend to quality and coverage of activities in terms of choice of localities, provision of services and distribution of materials. This results in suboptimal use of resources. The National AIDS Commissions in the three countries face the challenge of taking on a more active coordinating role that will influence the priorities and programmes of service providers.

An area in which Norway seems not to have contributed significantly to better coordination is with the NGO sector. Norwegian NGOs have been operating more or less independently of the Norwegian country representatives that know the national contexts and might otherwise guide NGOs towards better adherence to the national response. Norad admittedly requires the NGOs to coordinate well at national level, but Norad has neither the capacity nor tradition for detailed follow-up of whether the NGOs fulfil this requirement. Hence, to the extent that some NGOs are nevertheless well coordinated with the national response it is not necessarily due to Norwegian government support.

Similarly, Information, Education and Communication activities are not subject to coordination and often seem randomly distributed. Since these are often carried out by NGOs there is little or no national coordination and the activities may be seen as 'supply based' rather than demand based. There is a large degree of overlap in IEC activities in some areas, while other areas do not benefit any.

### *4.3.3 Lack of human resource and capacity in the sectors*

There are insufficient qualified personnel at all levels which have resulted in low absorption of funds and implementation of a true multisectoral response. There is shortage of personnel especially within the health sector, poor and weak health systems in general. For example, Tanzania reported a 35% decline in the health workforce from 67,600 in 1994/95 to 43,650 in 2005/06[27]. In general, limited capacity seems to be the most critical limiting factor in the national response.

Norway has in particular in the latter parts of the period under evaluation put heavy emphasis on health sector capacity. Through direct financial and technical support to strengthening of health sector capacity in the countries and in putting health sector capacity on the agenda internationally Norway has probably had substantial positive contributions. But examples have been found where emphasis was not consistent. In one case in Malawi a Norwegian NGO in a 'strategic partnership agreement' with the Norwegian Embassy did indeed invest in health sector capacity but also invested heavily in other areas like IEC and advocacy, perhaps at the cost of even more support to the health sector. The absence of a partnership strategy reduced the ability of Norway to influence the setting of priorities. In Tanzania, Norway supported the Benjamin Mkapa Fellows Programme to contribute to competent and skilled

27 TACAIDS (2007) NMSF Human and Financial Assessment Report by AM Kireria & D Ngowi.

resources in the health sector to support HIV/AIDS responses especially in the rural areas. But the achievement recorded with 99 fellows in 30 rural districts as at 2007 is still far from the needs required in the sector to mount an adequate response.

#### *4.3.4 Diversion of resources and increased focus on ARV therapy*

Interestingly one of the explanations that have been given for the poor performance in the biomedical response (PMTCT and STI treatment) at country level is the diversion of resources in the health sector towards Anti-retroviral (ARV) treatment. The evidence is not yet clear about how true this is, but respondents argue that the success of ART has brought adverse performance in other very important outputs. It is significant that of the four components of the Global Health Sector Strategy (GHSS) developed by WHO and endorsed by WHA in May 2002 the treatment sub-section focussing on ARVs has received most attention. Lack of attention to other components of the GHSS to ensure comprehensive coverage and implementation of health sector response has inevitably had adverse effects.

Norway has to some extent served to compensate for the diversion of resources to ARV therapy through Norway's emphasis on health sector capacity. Although Norway has supported ARV it has not been among the major agencies in this field and has always insisted on a broad approach. However, we have not seen Norway explicitly targeting this possible side-effect of ARV.

#### *4.3.5 Location of programmes and interventions*

A disproportionally large number of service provision sites are located in urban areas in the three countries despite the fact that the majority of the populace live in rural areas. For example, in Malawi, large numbers of HIV Counselling and Testing (HCT) sites (around 50 percent) are located in urban areas while most of the population (85%) lives in rural areas, and the southern region (with the highest population) seems underserved. This situation is also applicable to other two countries especially with the reluctance of available skilled workers to work in the rural areas owing to lack of infrastructure and basic amenities required to make a good living.

IEC, care and support activities are often carried out mainly by NGOs and CBOs. These efforts often seem scattered and there seems to be little general consideration that the efforts represent optimal use of resources within the national response. As an example, much HIV/AIDS activities are based in the same communities where the NGOs are already operating. As a result several NGOs can concentrate their efforts in some areas while other areas do not benefit at all. While the selection of locations is easy to understand seen from the perspective of an NGO having limited capacity, it may be argued that NGOs contributions are 'supply driven' rather than 'demand based'.

Norway has generally supported the national response and insisted on a coordinated response also on local level, and supported a wide range of local interventions. Norwegian NGOs worked in the rural areas to reach the underserved population. An example is alternative basic education services in Ethiopia supported by SCN. But these efforts are still minimal as compared to the needs of rural populace. Norway has, however rarely specifically engaged in sectoral and geographic priorities at national level and even Norway's own contributions are not subject to country strategies with this regard.

#### *4.3.6 Decentralisation challenges*

For effective implementation and coordination of responses, the national frameworks are centred around involvement and participation of communities up to the lowest level of government. The application of the Three Ones concept at lower levels has proved to be quite challenging owing to lack of experience in participatory planning, coordination and sharing of responsibilities. The capacity of district assemblies to take on their role to coordinate HIV/AIDS at district and community level has shown to be poor. Informants state this is a main bottleneck in the national response. The integration of CSOs in local government plans in response to HIV/AIDS has been very weak and in effect under-uses the comparative advantages and resources of available actors. Weak integration has also resulted in limited adherence to national guidelines and effective reporting thus affecting compliance, quality assurance and reporting of activities.

Norway has supported decentralisation in general (although Norway withdraw from supporting further decentralisation in Malawi following the postponement of local elections) and focused much of its support to local level. Norway has also emphasised strong collaboration between public agencies, civil society and private sector also on local level.

#### *4.3.7 Challenges with monitoring and evaluation*

Monitoring and evaluation systems are in place but not optimal. High level surveys such as the DHS have gradually been adopted more or less systematically and many are now judged to be of international standard. The main concern lies with the implementation of recommendations and action points in government systems where evidence-based decision-making is not well established.

Routine data collection is also a bottleneck of the monitoring and evaluation systems. Data have to be collected from scattered and fragmented sources and much is supplied incomplete and inaccurate. The available data are collected for the sake of data collection and, again, not used by the government systems for planning and management. Hence it is difficult to determine the spread of the epidemic and plan adequately for the response.

Norway's contribution to the national response have normally been flexible and adaptive to existing monitoring and evaluation systems, hence Norway has neither added to transaction costs nor reduced ownership in monitoring and evaluation.

### 4.4 Specific Factors Affecting the Effectiveness of Norwegian Support

#### *4.4.1 Partnership strategy*

Norway is a valued and trusted partner, flexible and undemanding. Partners were asked about their experiences of working with Norway and to give examples of Norway's contributions. Responses were positive. Partners share Norway's objectives and values and rarely have disagreements that are not resolved through dialogue. The good relations between Norway and partners seem not to hinder Norway's critical inputs. There is a possibility that the flexibility and lack of hands-on management may involve unnecessary high risk of Norwegian contributions not being utilised effectively and efficiently. Such cases have not been found.

Norway's approach has been complemented by diversity. The spread of partners in all three countries reflects a broad engagement with government, civil society, international NGOs and multilateral institutions. In fact, the diversity of partners is a defining characteristic of Norway's programme. The evaluation has not found any evidence of a formal strategy behind the choice of partners. In many respects the diversity resembles a random selection. This can be explained, however, by what partners see as Norway's flexible and demand responsive approach. Partners commend Norway for taking an independent view of problems and responding according to need rather than to follow a set strategy or headquarters-defined agenda. Working on a small scale enables partners to explore innovative ways to tackle problems that might ultimately influence national policy. Support to education, adolescent girls literacy and child protection are all good examples of innovative work. Financing of private organisations like Banja La Mtsogolo (BLM) in Malawi takes pressure off national services and helps provide choice for citizens of Malawi. The diversity of partners needs to be seen as a healthy counterpoint in the context of national programmes in which most resources have been concentrated among a few core institutions.

#### *4.4.2 Limited or non-connectivity of Norwegian support*

Despite the strengths of the multiple channels adopted by Norway in responding to the HIV/AIDS epidemic, these channels are not well connected at country level. The agreements that make up the portfolios of projects described in this report originate from several distinct sources: funding directly through the Norwegian Embassy; funding by Norad and funding at a very small scale through other channels linked to research and education.

There is no attempt to provide an over arching framework at national level to guide the different strands of aid from Norad and MFA. Policies and practices in Norwegian development cooperation give the Embassy a limited role in guiding Norad support to NGOs either strategically or tactically. Even when Norwegian NGOs are highly qualified and well connected to national NGOs some do not have all the knowledge that the embassy possesses

of processes at national level and may need guidance. Further, some NGOs do not demonstrate full adherence to national policies and priorities and there is typically limited cooperation between various NGOs and between NGOs and public sector institutions working in the same areas. A better dialogue between the Embassy and Norwegian NGOs could have addressed this.

Experience does not seem to be shared across the portfolio. There are no formal mechanisms for learning across Norway's projects. The lack of connectedness is a feature of Norwegian policy with different funding modalities. There is a danger that opportunities are being missed to learn more from the portfolio and add greater value to Norway's contributions.

### *4.4.3 Capacity to operate in the new aid architecture*

One factor that needs to be taken into account is the changing orientation of country-based advisors as programmes shift from a project-based modality to pooled funding and budget support. Both international and nationally recruited professionals have to have the seniority and authority to engage with government and partners on policy development and programme implementation across both the health and social sectors and staffing at country level needs to be adequate to enable that.

Norwegian embassies are generally relatively poorly staffed compared to other donors; and while most of Norway's contributions have been positive towards the national responses there may be many missed opportunities to provide even more positive contributions simply owing to lack of capacity to participate in various forums. Greater Norwegian participation would not necessarily be at the cost of national ownership as Norway very often uses its participation in such forums to promote national ownership by challenging other (bilateral and multilateral) donors and promoting the view of the (recipient) government.

**Summary of progress towards outcomes**

- Data on five outcome indicators are not sufficiently complete to demonstrate clear trends, although available data revealed good progress since HIV/AIDS was discovered
- Improvements are seen in two of the three countries for knowledge about the causes of HIV and age of first sex, condom use has increased in all countries, more so among men than women, available data only shows progress in one country in having sex with a non-cohabiting partne, and data about school attendance by orphans suggest very low levels
- Data on impact indicate positive though slight improvements in the extent of HIV infection among 15 to 24 years old but well below target figures in all three countries. Two countries report 70 to 80 percent of people still alive one year after starting ART. There is no data yet to show progress with the proportion of infected infants born to mothers with HIV
- A range of factors affect the progress towards outcomes:
  - Limited commitment and engagement by high level politicians and public figures
  - Good progress has been made establishing NACs but they are more often seen as a funding conduit and monitor rather than a policy leader and coordinator of priorities
  - Health systems have suffered from a shortage of personnel
  - Concerns are raised by some observers that the flow of funds to ART has undermined other services, especially PMTCT and STI treatment
  - Urban bias in the provision of services
  - Implementation needs to be at local level yet local government is often weak
  - Poor and ineffective coordination at all levels
  - Increase attention and focus on ARV therapy
  - Good progress is being made with surveys to monitor outcomes and impact but standardisation of routine monitoring across all actors is a big challenge
- Norway works through a wide diversity of partners which brings many advantages. But there are poor connections across the implementation channels with limited learning and reduced coherence in programmes.

# 5 Lessons Learnt, Recommendations and Conclusions

This chapter draws together issues and lessons learnt from the evaluation and puts forward recommendations to enhance Norwegian responses to the epidemic and the implementation of the 2006 Policy Position Paper.

## 5.1 Lessons Learnt and Issues Emerging

The evaluation of the Norwegian response to HIV/AIDS resulted in a number of interesting features in relation to how Norway chooses to interact with stakeholders at global and country level, and how flows of aid should be coordinated to guide future policies and engagement.

### *5.1.1 Norway's willingness to support national response to HIV/AIDS*

Throughout the period under evaluation Norway has shown commitment to support a coordinated national response to HIV/AIDS in the countries supported, especially in Malawi and Tanzania. Norway has provided support to institutions like the National AIDS Commission to plan and later aligned behind those plans rather than following its own policies and programmes. Through the Three Ones approach this was further institutionalised and found support from most other donors; but well before the Three Ones Norway was supporting similar principles. Even if this approach to some extent may lead to less visible results identifiable specifically from Norwegian contributions it is likely to lead to much greater overall impact.

### *5.1.2 Translation of global policies and strategies to actions at country level*

This evaluation shows that the translation of global policies and strategies to actions at country level can impact positively on the epidemic and that a relatively small donor like Norway has been able to make a difference through investing in those processes. This is reflected in what has happened with the implementation of the Three Ones at country level and utilisation of the Global Fund. Unfortunately, there are other policies and strategies developed at global level which are still pending and have yet to be pursued comprehensively at country level. Examples include some components of the WHO Global Health Sector Strategy. Lack of comprehensiveness in the implementation of these strategies will result in waste of resources and ineffectiveness in tackling the epidemic.

### *5.1.3 Utilisation of Norway's comparative advantage, flexibility and risk taking*

Norway's most visible contribution to alleviating the HIV/AIDS epidemic has been in its flexible approach. Norway has also taken the initiative to respond to and guide the response to the epidemic. In a number of important instances Norway has led on interventions and strategies, whilst other donors came on board at a later date. The willingness of Norway to support when other donors were reluctant to engage was a clear revelation and strength. Examples include the support to Mkapa Fellows Programme in Tanzania and support to district level implementation in Malawi.

Although there is not enough evidence to conclude in general, there are some factors that lead the evaluation to believe that Norway may have become less flexible and risk taking in recent years. Most of the cases reported to this evaluation of Norway taking risks and supporting new initiatives are from the earlier part of the period under evaluation. The Norwegian embassies are generally subject to expectations to limit the number of contracts, which may give less space to engage with new partners (partly because not to enter into new partnerships is an easier way to reduce the number of partnerships than to cut existing ones). Generally, stricter expectations to produce results may also reduce incentives to take risks. The principles of the Paris Declaration on aid effectiveness may also be seen as limiting the space for an individual donor to take on specific roles in this regard. If that assumption is true, one of the main positive characteristics of Norway as a donor may be lower utilisation and less added

value of Norwegian contributions in the future. Given that Norway in most cases, is a relatively small donor in terms of volume, if Norway becomes less flexible and less risk taking it may lead to Norway's role as compared to other donors being diminished.

### *5.1.4 HIV mainstreaming*

To mount a true multisectoral response calls for all sectors to work and respond to the epidemic. This requires mainstreaming HIV/AIDS to be reflected in organisational policy and practice in order to reduce susceptibility to infection and vulnerability to the impact of the epidemic. Despite ongoing efforts, implementation of HIV mainstreaming varies and has had limited effect on organisations and programmes. In the most part, this is due to weak capacity and lack of commitment by organisations to mainstream HIV/AIDS. A true multisectoral response will not happen if HIV/AIDS is not mainstreamed across sectors. This will also have implications for the absorption of funds. Norway has supported implementation of HIV mainstreaming with positive outcomes and the strategic positioning of Norway may also add value in this area.

### *5.1.5 Partnership working*

Norway is valued as a partner that is flexible, realistic, having strong values and known to respond to issues that other partners are not interested in. Partners at all levels assessed Norway very positively for having shared objectives, few serious disagreements and not imposing conditions about areas or projects where Norway's resources should be spent. This may lead to certain risk of funds not being spent effectively and efficiently but it also greatly enables ownership, capacity building and reduced transaction costs at partners. Those benefits are very valuable for national and local partners. For international partners, including multilateral organisations and Norwegian and international NGOs, those benefits are of less value and should be balanced against the need for strict control to ensure funds are utilised effectively towards the national response.

### *5.1.6 Strategies and learning across partnerships*

Despite the significant flow of resources to diverse partners at country level Norway has not developed a partnership strategy that might have enabled more informed priorities between different partners and more effective utilisation of the partnerships. Nor have formal mechanisms been developed to learn from the experience of partners from different funding modalities, which reduces the added value from Norway's diverse approach.

### *5.1.7 Issue of coordination*

Norway has done well in promoting aid harmonisation. Norway is a key stakeholder in the establishment of the Three Ones which are operational at country level. However, the level of functionality is too weak to ensure a well coordinated multisectoral response. This is a major issue especially when it comes to leadership at district level and reporting mechanisms.

Many NGOs do not coordinate very well with the national response beyond reporting activities and participating in certain coordination forums. Norwegian NGOs are too diverse to conclude in general; most seem committed to coordinate at national level. However, beyond a general requirement Norway has not established effective measures to ensure that the NGOs supported by Norwegian in fact adhere to national priorities in their service delivery.

### *5.1.8 Capacity within the context of the new aid architecture*

Recent years' experiences from sector wide approaches and pooled funding indicate that donor coordination and harmonisation do not necessarily mean less demand on donor's capacities. The number of policy and technical working groups and other fora related to coordinated donor arrangements is huge and exceeds the number a relatively low staffed donor such as Norway is able to take part in. Furthermore, the technical knowledge needed is high and, as to a large extent programme management, policy dialogue and technical support is integrated, a high demand is put on the staff of the embassy to take part in the processes. To some extent it is not as easy to outsource some of these roles as the main 'capacity' in question is not technical competence but the diplomatic status of Norway.

Norway is generally supportive of the principles of the Paris Declaration not only through its own modalities but also in actively promoting the same principles vis-à-vis other donors. Norway is generally acknowledged by partners as being a positive influence within the donor community and in some cases challenges other donors who do not demonstrate willingness to coordinate. Paradoxically, to the extent Norway adheres to the principles of the Paris Agenda by limiting its participation in various forums it may involve missed opportunities to influence other donors to do the same.

## 5.2 Conclusions

Norway has developed an approach which has brought a distinct and coherent strategy embracing both global and country level actions.

Support at global level has been continuous and consistent and has contributed significantly to lasting changes in the international aid architecture towards better effectiveness and efficiency while at the same time enabling national ownership. This has been achieved by maintaining a relatively small core of professionals dealing with HIV/AIDS who were capable and mandated to be involved in general rather than limited forums and interventions, and by allowing a degree of flexibility and risk in funding.

Norway has succeeded in taking global issues into its approach at country level primarily through initiatives such as the Three Ones, and in doing so has maintained an approach that is founded on core principles of rights, tackling poverty and aid effectiveness.

Work at country level has been diverse and flexible, with few constraints placed on partners, promoting and enabling a national response under national leadership. In some cases Norwegian contributions have contributed to major achievements with long-term positive impact on the national responses, in particular when Norway responded to needs and showed flexibility and took risks when other donors were not willing or did not see the needs. In most cases it is likely that Norwegian support is utilised relatively effectively and efficiently.

The absence of a clear programme strategy for HIV/AIDS at country level and no overarching coordination of Norwegian development support at national level have led to concerns that the various strands are not coherent and have no means to learn from each other's experience. Hence opportunities to add value to Norway's contributions are missed. The lack of a clear partnership strategy means that the choice and priorities between various channels and partnerships are perhaps not based on well informed considerations to enable optimal use of resources.

## 5.3 Recommendations

The recommendations put forward in this report are based on issues emerging from the country studies and consultations at global level, with reference and consideration to Norway's HIV/AIDS policy position paper approved in 2006.

### *5.3.1 Continue support through multiple channels and enhance connectivity*

The Ministry of Foreign Affairs (MFA) should continue support through multiple channels as Norway's strategy of putting resources through various channels is yielding results. Support to global institutions is essential to develop guidelines for implementation of interventions at country level. However, Norway needs to engage strategically to ensure connectivity of these efforts in order to achieve the desired results. An example, is that of the WHO GHSS, which was developed, but whose implementation has been hampered despite all the resources committed to achieve this. In addition, at country level, efforts should be made to enhance connectivity of interventions supported by Norway.

### *5.3.2 Support to implementation of the Global Health Sector Strategy components*

The components of the Global Health Sector Strategy (GHSS) are still very relevant to the response despite that the strategy ended in 2007. MFA and Norad should work with other donors and institutions to promote comprehensive implementation of its various components. This will foster a holistic health sector response to the epidemic in order to have the desired impact without re-inventing the wheel. The components of the GHSS are well covered in the 2006 Norwegian policy position paper on HIV/AIDS, the embassies should engage with other

donors to support full implementation at country level, this will go a long way in addressing the epidemic.

### 5.3.3 Strengthen leadership and coordination of programmes at all levels of engagement

Leadership is vital and should be tied to good governance at country level. Strengthening leadership at all levels is important in fighting the epidemic and in addressing weak commitment and poor coordination of the HIV/AIDS response. Norwegian embassies should continue to engage actively to ensure strong leadership for country responses and effective coordination of programmes to halt the epidemic. Norad must continue to play an active role in providing technical assistance for successful implementation of policies and programmes both at international and national levels, while MFA should continue the lead in ensuring clear policy directions and engagement especially at global level.

### 5.3.4 Development of country programme and partnership strategies and framework for operations

Clear country programme and partnership strategies should be developed with respective partners spelling out the goals of the programme, expected outputs, rationale for the partnership with full consideration to managerial and technical inputs. At country level the strategy should also include principles to guide measuring performance in line with NAC processes.

### 5.3.5 Continued support to Civil Society Organisations (CSO)

The important roles played by the CSOs are already stated in this report and other preceding ones for this evaluation. NGOs are able to work in hard to reach areas thus contributing to the control of the HIV/AIDS epidemic and poverty reduction in general. NGOs have the capability to work and promote sexual health and rights for all groups, female and male as part of the efforts to fight HIV/AIDS. The need to invest more in this area is vital if significant changes are to be attained whilst waiting for government reform programmes in Africa to start to have the desired effect. This support should also extend to the strengthening of civil society networks to enable them make effective contributions and engage at policy level and coordination.

It is however of paramount importance that CSOs adhere to national coordination to increase efficiency and are willing to learn and share experiences with public agencies. Norway should be stricter in demanding that CSOs supported by Norway do so.

NGO's should, be required and guided to adhere to relevant national coordination mechanisms including sectoral, thematic and geographic priorities so that NGO contributions becomes 'demand based' rather than 'supply based'. Adherence to national coordination should of course only be required for service delivery, not advocacy.[28] One measure that could be tested is to support some kind of geographic mapping of which actual IEC activities have been supported in different localities and which localities and regions have so far benefited less (based on data already provided through national monitoring) and use that as basis for dialogue with NGOs.

### 5.3.6 Provide support to HIV mainstreaming

Norway should engage with other partners to ensure the provision of technical assistance and build the required capacity for effective HIV mainstreaming across sectors. This will foster effective deployment and utilisation of resources from all sources. There is also the need for Norway to plan for HIV mainstreaming into Norway's current development priorities now that programmes focus more on good governance, environment and natural resources, media and culture, energy and infrastructure, and maternal and child health. Commitment would be improved if clear instructions came from political leaders to ensure that mainstreaming is implemented at country level. Norad has the capacity to provide technical assistance and should play an active role in this regard. Improved utilisation of the regional support facility in Lusaka should be encouraged to disseminate new guidance for mainstreaming. This should be monitored to ensure compliance and effectiveness.

28 See e.g. White Paper no. 35 to the Storting (2003-2004), chapter 8.3, which states that NGOs are expected to coordinate service delivery with national strategies, while in advocacy it is important to respect the integrity and independence of the NGOs.

### *5.3.7 Work with other partners to address weak monitoring and evaluation systems*

Weak Monitoring and Evaluation (M&E) systems in the countries are a continuing challenge and stand to undermine the success of the Three Ones and management of national programmes. Norway is well placed to work with other partners to support functional M & E systems and it's application across all parties to the response.

### *5.3.8 Broader and more formal approach to strategy development*

Relatively few people have been involved in Norwegian efforts to fight HIV/AIDS both at global (multilateral) level and at country level. Often only one or two persons at the embassy have been in charge with little involvement of others. These people are highly qualified, but depending upon these few involves risks and reduces capacity. For example, the HIV/AIDS focal person in Tanzania is being redeployed to work on other programmes as HIV/AIDS is no longer one of the key focal areas. This will limit the roles played by Norway especially in the area of policy engagement and interventions to tackle the epidemic. Hence, there is need to retain the HIV/AIDS focal persons at the embassies to continue to pursue Norwegian efforts. Redeployment of HIV/AIDS focal persons without replacement may result in reduced commitment to HIV/AIDS response and may cause a setback to all the good work and investments of Norway at country level.

There is also the risk that problem and context analyses to guide Norwegian contributions are developed without utilising all available resources in particular since these analyses and corresponding strategies are normally not formalised.

# Annex 1: Terms of Reference of the Evaluation of Norwegian HIV/AIDS responses in three African countries: Ethiopia, Malawi & Tanzania.

## 1 Background[29]

### 1.1 The international HIV/AIDS architecture

Towards the turn of the century there was a rapid increase in concern and attention to the HIV/AIDS epidemic. In June 2001, the Declaration of commitment from the UN General Assembly Special Session (UNGASS) on HIV/AIDS set out the principles for a programme of action. Several of the Millennium Development Goals are central in relation to HIV/AIDS, including goal 6 and the target that the spread of HIV should be halted by 2015. In 2003, WHO and UNAIDS launched an initiative to treat three million people living with AIDS in developing countries and those in transition with antiretroviral treatment (ART) by the end of 2005 (the "3 by 5" target). In September 2005 the UN-summit confirmed commitment to the comprehensive goal of *universal access to HIV/AIDS-prevention, treatment, care and support by 2010*.

A growing number of external and national partners in the response led in many countries to overcrowding, inefficiencies and heavy sustainability challenges. The "*Three Ones*" key principles for concerted coordination and action at country level[30] were developed as a response. Concrete steps to achieve the Three Ones principles were presented through the report of the Global Task Team[31]. The recommendations from the Global Task Team were approved by UNAIDS' governing body in June 2005. The "Three Ones" key principles and the Task Team's recommendations are consistent with the OECD Paris Declaration on Aid Effectiveness, which has been central in shaping the current international aid architecture.

Three largely parallel and interacting trends can be noted since the turn of the century:

- a shift from advocacy to implementation.
- a shift in advocacy focus to access for all to treatment. While prevention remains a core strategy, rapid roll out of treatment, with its implications for drug prices and procurement, service delivery and infrastructure has become crucial for the response.
- a shift towards a more comprehensive agenda that include the broader impact of AIDS on society**,** with the epidemic in different stages within and across countries and regions, and with the broader impact on society becoming increasingly visible.

### 1.2 The Norwegian response to HIV/AIDS in developing countries

Norway started supporting HIV/AIDS activities in 1986, with multilateral support, primarily through the WHO Global Programme on Aids. On the bilateral side, support was given mainly through international, Norwegian and national *Non-Governmental Organisations* (NGOs) for activities in the area of prevention and advocacy, as well as home-based care and orphan support. Voluntary counselling and testing (VCT) and support for mapping the course of the epidemic was also given priority, and applied research in collaboration between Norwegian and national institutions and AIDS control programmes was part of the portfolio (i.e. Tanzania).

In the early response, HIV/AIDS as a theme was brought into the policy dialogue in annual negotiations in a number of the Norwegian partner countries. In some countries Norway was a central player in providing early support, such as to national NGOs in Zambia and supporting

29 This section uses information contained in the Background Document for Update of Norwegian Policy Positions, August 18th 2005, produced by the internal MFA/Norad Theme Group Health-HIV, hereafter referred to as the 2005 background document.

30 The "Three Ones" key principles: One national AIDS action framework, One national AIDS coordinating body and One national Monitoring and Evaluation System (www.unaids.org/en/about+unaids/what+is+unaids/unaids+at+country+level/the+three+ones.asp)

31 Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors 2005

VCT in an early phase in Uganda and the national AIDS control programme in Tanzania. HIV/AIDS was seen as a priority cross-cutting theme in the early phases of setting up collaboration with Malawi.

In 1990 an earmarked budget line for HIV/AIDS was instituted in order to strengthen the Norwegian response. The earmarked budget was stopped in 1996, the overriding rationale being that this kind of special allocations rather should be integrated in the general budget for development cooperation.

The major part of Norwegian funding for HIV/AIDS has been channeled through the *multilateral* system without earmarking certain activities. Norway has generally opted for being engaged multilaterally as a major donor to UNAIDS, as a small to mid-level donor (but a big donor in relation to population and GNI) to the Global Fund to Fight AIDS, TB and Malaria (GFATM), as a catalyst funder through Trust Funding of the World Bank HIV/AIDS response and through some multi-bilateral funding of some UN agencies at country level.

*Bilateral* funding appears to have been most ambitious in the early stages, but has continued with shifting focus in most Norwegian partner countries as part of the Norwegian country programme. Norway has supported coordination structures in Malawi, Tanzania and Zambia, and has also been involved in this kind of support in Ethiopia and Uganda.

At the international level, Norway has been actively engaged with funding, policy dialogue and technical advice towards shaping the UN response, such as the establishment of UNAIDS and its mode of operation. Norway has been particularly concerned with an effective UN response and leadership, a poverty and country level coordination focus (such as in setting up the Global Fund) and a focus on drug policies and drug prices. There has been collaboration in a broad likeminded group both in health and HIV/AIDS, contributing towards policy formulation and technical work both in UNAIDS and WHO. Issues around prevention strategies, coordination/harmonization and drug policies/procurement have been central to Norwegian contributions in these efforts. Collaboration with Sida, Sweden, was established through the regional AIDS team in Africa, first located in Harare from 2000, and later shifted to Lusaka.

In 2000, the HIV/AIDS challenge was made a priority for Norwegian Development Cooperation, with the formulation of a HIV/AIDS Policy Position Paper. Instructions were given to the development administration to contribute as far as possible to limit the spread of the epidemic, through mainstreaming and through specific mobilisation and support measures. The overall need for broad and inclusive national ownership, leadership and partnerships and the link to broader development planning was stressed. Published before the break through in ART, the entry point for the treatment agenda was procurement policies, affordability and availability of drugs and commodities. The more specific part of the policy was intended to drive some special focus areas in Norwegian development cooperation, with children, youth, male responsibility, work place and human rights issues as core elements.

In November 2006, the current Norwegian government introduced a Policy Position Paper on HIV/AIDS, defining current priorities in the Norwegian response. It takes account of the global HIV/AIDS architecture that has evolved since the former position paper was formulated.

The annual proposition to Parliament no. 1, 2006-07, stresses that the Norwegian *development cooperation* and *the HIV/AIDS response* must be more effectively *linked* in order to achieve the targets set on *universal access to prevention and treatment services*. Particular emphasis is also placed on the need to strengthen *UNAIDS* so that it can provide the necessary support to national level responses (p. 197).

## 2 Rationale and purpose of the evaluation

### 2.1 Rationale:

There are a number of reviews, studies and progress reports related to Norwegian financed HIV/AIDS interventions. These reports are much focused on inputs, outputs and processes and are mainly intended to satisfy monitoring needs. There are few independent evaluations of the Norwegian HIV/AIDS response. There is need for a systematic assessments of the Norwegian contribution at the country level to gain insight as to what extent Norway's HIV/AIDS support and Norway's development priorities, policies and support at the country level are effectively connected in order to meet the national HIV/AIDS response with the urgency that is required.

An evaluation of the Norwegian HIV/AIDS support was undertaken in 1997 (Report 1/97: Evaluation of Norwegian Assistance to Prevent and Control HIV/AIDS), commissioned by the evaluation unit of the Ministry of Foreign Affairs[32]. The evaluation reviewed the Special AIDS Grant, instituted by Parliament in 1990. It covered the period 1990-95, with Tanzania, Uganda and Zambia as case studies. Since then, no evaluation of the Norwegian HIV/AIDS response has been commissioned by the evaluation unit. Moreover, few of the evaluations that have been published by the unit, or jointly with partners, have included assessment of HIV/AIDS dimensions. However, a number of evaluations of the HIV/AIDS response of Norway's partners has taken place over the last four-five years, i.e. UNAIDS, WHO, UNDP, World Bank, GFATM, Sida, DFID and others.

### 2.2 Purpose

The primary use of the evaluation is not to provide input into a revision of the Norwegian HIV/AIDS policy since the current Position Paper was introduced in November 2006. The evaluation should provide strategic guidance towards the implementation of the Position Paper, and in particular strategic guidance for enhancing the development effectiveness of the Norwegian HIV/AIDS response at the country level. The Position Paper could be adjusted based on inputs from the evaluation.

The main purpose of the evaluation is to ascertain results (accountability), fill knowledge gaps, provide lessons learnt and suggest recommendations on how to enhance the development effectiveness of the Norwegian HIV/AIDS response at the country level. Specifically, the evaluation focus would be on assessing Norway's role and contribution in influencing key outcomes33 of the national HIV/AIDS responses in Ethiopia, Malawi and Tanzania.

The term "key outcomes" should, for the purpose of this evaluation, take as a reference the UNAIDS' knowledge and behaviour indicators presented in section 3.4.

The 2005 background document indicates that it may be in the area of coordination and alignment that the Norwegian contribution has been most consistent and significant, and refers to the fact that many of the Norwegian Embassies have been active in support of national AIDS councils or NGO coordination bodies[34]. The evaluation should systemize documentation and provide an assessment of what have been the consistent and significant effects of the different types of the Norwegian contributions, in terms of influencing on key outcomes at the country level.

## 3 Evaluation approach and framework

The evaluation framework and the approach should be presented in detail in the inception report (ref. section 7.3 on reporting).

### 3.1 Country cases

The evaluation should focus on three countries in Africa South of Sahara in which Norway has been involved for a number of years with development and HIV/AIDS related activities:

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32 The evaluation unit was moved to Norad in February 2004.

33 Reference is made to the OECD/DAC definition of outcomes as the likely or achieved short-term and medium-term effects of an intervention's output (output being defined as the products, capital goods and services from an intervention).

34 "Current Challenges in the AIDS Response; Norwegian Contributions and Forward Options", Background Document for Update of Norwegian Policy Positions, August 18th 2005, produced by the internal MFA/Norad Theme Group Health-HIV, here referred to as the 2005 background document, p 26.

*Ethiopia, Malawi* and *Tanzania*. Tanzania is a country where HIV/AIDS work has been going on for a long time, Malawi is a country severely hit by the epidemic, and Ethiopia represents a country from another part of the region than the hardest hit countries in Southern Africa. Together, the three countries reflect the different types of Norwegian involvement.

### 3.2 Focus on outcomes

The evaluation approach and framework should allow for an *outcome-based* and *country level focused* evaluation. The rationale for this lies in the purpose of the evaluation, with the emphasis on "key outcomes".

Outcome evaluations work backwards from the outcome[35]. They involve making judgements about the *interrelationship* between inputs and outputs on the one hand and outcomes on the other (but do not start by analysing projects). Standard objectives of an outcome evaluation are to *extract lessons learnt, findings and recommendations*. Although the review of contributions by a donor and its partners is an integral component of an outcome evaluation, the precise degree of *attribution* and *accountability* among the various actors is not an overriding priority. Rather, the framework must allow for a *shared model of accountability*.

### 3.3 Evaluation objectives

*Five key evaluation objectives* are proposed, reflecting the evaluation purpose:

1. Assess progress towards key outcomes related to the national HIV/AIDS response
2. Assess the factors affecting the outcomes (substantive influences)
3. Assess key Norwegian contributions (outputs) to outcomes
4. Assess the Norwegian partnership strategies (how Norway works with relevant partners)
5. Extract lessons learnt, findings and recommendations on how to enhance the development effectiveness of the Norwegian HIV/AIDS response at the country level.

The framework should build on the above key evaluation objectives. It needs to reflect the country context and be adjusted to the different role, priorities and partnership strategies of Norway in each of the three countries.

The evaluation should not include objectives regarding implementation and cost effectiveness issues. A clear focus on outcomes should be ensured and too many objectives would "overload" the evaluation task.

### 3.4 Defining key outcomes

The team should discuss and propose *key outcome indicators*, taking into account literature and research on how outcomes are best measured (i.e. through population-based data[36]). The approach should include the UNAIDS' *five knowledge and behaviour indicators* for generalized epidemics (but not necessarily be restricted to):

- percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (target: 90% by 2005; 95% by 2010)
- percentage of young women and men who have sex before the age of 15
- percentage of young women and men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months
- percentage of young women and men aged 15-24 reporting the use of condom the last time they had sex with a non-marital, non-cohabiting sexual partner
- ratio of current school attendance among orphans to that among non-orphans, aged 10-14.

The evaluation framework should briefly *clarify assumptions* regarding how key outcomes are assumed to lead to intended impact, referring to the *three core impact indicators* defined by UNAIDS for generalized epidemics:

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35 Re UNDP Evaluation Office's Guidelines for Outcome Evaluations (2002): Outcome evaluations take the outcome as the starting point and then assess a number of variables. The variables include whether an outcome has been achieved or progress made towards it how, why and under what circumstances the outcome has changed Norway's contribution to the progress or towards achievement of the outcome; and Norway's partnership strategy in pursuing the outcome.

36 such as information contained from a probability sample of the target population, generally collected from surveys (DHS, MICS, LSMS, etc.).

- percentage of young women and men aged 15-24 who are HIV infected (target: 25% reduction in most-affected countries by 2005; 25% reduction globally by 2010)
- percentage of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy
- percentage of infants born to HIV infected mothers who are infected (target: 20 % reduction by 2005; 50 % reduction by 2010).

## 4 Key Evaluation Objectives

This section highlights some elements that should be included when addressing the five key evaluation objectives (other elements could be added).

### 4.1 Assess changes towards key behaviour outcomes related to the national HIV/AIDS response (evaluation objective 1)

The team should assess changes in key behaviour outcomes, based on *available* data, research and documentation. Has intended outcomes in terms of key behaviour change been achieved or has progress been made towards it?

The approach must be sensitive to variances in behaviour outcomes of key populations.

The analysis should be disaggregated to the extent possible to reflect geographical dimensions (i.e. rural/urban) and key populations (i.e. adult men/adult women, young women/young men, girls/boys and orphans/non-orphans) and should also, to the extent possible, attempt to capture changes in outcomes for sex workers, men who have sex with men, injecting drug users and prisoners[37].

### 4.2 Assess the factors affecting key behaviour outcomes (evaluation objective 2)

The team should assess the factors affecting key behaviour outcomes, based mainly on literature review of available data, research and documentation.

The section should highlight the *most significant* factors that "drive" or inhibit change in key outcomes. When considering factors that represent substantive influences the team should:
- identify "drivers of change" (substantive influences, i.e. peer groups, social norms)
- include voices of the affected and infected

How has these factors limited or facilitated progress towards key outcomes?

Some monitoring reports points to the fact that too much HIV prevention work has been directed towards strengthening individuals' capacity to prevent the spread of the virus, while ignoring the underlying factors such as social norms and institution that fuel the epidemic.

The evaluation should include an assessment of the underlying factors fuelling the epidemic, including factors at micro level (individual, household), meso level (social group, peers, reference groups) and macro level (local, regional, national).

Factors related to income, gender, age, power relations, human capital, culture and religion should be discussed. Gender dimensions and human rights issues, especially for women and girls should be given special consideration. Important linkages between HIV/AIDS and gender norms and gendered practices, i.e. early marriages, female genital mutilation (FGM), should be presented. The legal context should also be discussed, particularly relating to work place policies, succession laws, the right to confidentiality, and protection of homosexuals. The correlation between violence against women and the risk of acquiring HIV should be considered, including factors that may influence or counteract sexual abuse and domestic violence.

Analysis of factors affecting/influencing key outcomes must be seen within the context of the national development agenda, the national HIV/AIDS response, the connectedness of the development agenda and the HIV/AIDS response in general and the role of external actors in this context. Indicators for national commitment and action have been developed and are

37 Ref "key populations" and definition of HIV risk and vulnerability, UNAIDS Report on the Global AIDS epidemic (chapter 5, 2006).

being reported on, such as country level reporting on "*National Commitment and Action*" [38]. These indicators could be included in the analysis as a way of documenting factors that may influence key outcomes. It is desirable to include the role of the district AIDS coordination committees in the analysis (how do they contribute, are they functioning, do they have resource?).

Many factors promote or inhibit changes in outcome. Only some of these may have inter-linkages with the interventions that are being evaluated. Having identified the most significant factors affecting/influencing changes in outcomes, the evaluation should focus the analysis on those factors that Norway, given its role as a long-term development partner in the country, may have a potential to influence in a positive direction, in terms of contributing to positive changes in key outcomes.

### 4.3 Assess Norway's role and contribution to key behaviour outcomes (evaluation objective 3)

This evaluation objective should be given special weight. The approach should reflect the Norwegian development portfolio in the country and it should be broad-based, including all types of channels and instruments. It should conclude with an assessment of Norway's role and contribution in the national HIV/AIDS response, taking into account the composition and totality of the portfolio supported by Norway in the country over the evaluation period.

When evaluating Norway's role and contribution account should be taken of the different channels and instruments employed, as the Norwegian HIV/AIDS support in a country has often been a mix of:

- support for coordination of the response (multilateral and bilateral, global and regional initiatives)
- support to NGOs
- bilateral support channelled via multilateral organisations,
- supplied through a combination of instruments:
  - funding (multilateral and bilateral, global and regional initiatives)
  - knowledge (policy advice, advocacy, technical assistance, evaluation, research collaboration)
  - partnerships.

The evaluation should assess the Norwegian role and contribution, employing the following *entry points* where relevant:

1. Norwegian supported policies and programs ***directly focused on HIV/AIDS*** activities such as:
   - *HIV/AIDS work* (focus on prevention, care, treatment, or support). Examples can be stand-alone programmes for i.e. behaviour change, treatment, or home based care programmes;
   - *integrated HIV/AIDS work* (focus on prevention, care, treatment, or support). Examples can be behaviour change, treatment, or home-based care programmes which are linked to, or part of, other work.

This analysis should also include an assessment of the contribution of the regional team supported by Sida and Norway and based in Lusaka, seen from the perspective of the particular country case. Norway's financial input towards targeted HIV/AIDS activities in the country should be documented and categorized.

2. Norwegian ***"core" country policies and program***, by assessing the extent to which HIV/AIDS dimensions have been *mainstreamed* in 2-3 selected priority policies and programs supported by Norway, specifically how they have been adapted to take account of susceptibility to HIV transmission and vulnerability to the impacts of aids. The task will be

38 Government funding for HIV/AIDS, Government HIV/AIDS policies (National Composite Policy Index), Life-skills-based HIV education in schools, Workplace HIV/AIDS control, Sexually transmitted infections: comprehensive case management, Prevention of mother-to-child transmission: antiretroviral prophylaxis, HIV treatment: antiretroviral combination therapy, Support for children affected by HIV/AIDS (only for countries with high HIV prevalence) and Blood safety. These indicators focus on policy and the strategic and financial inputs (for the prevention of the spread of HIV infection, the provision of care and support for people who are infected and mitigation of the social and economic consequences of high levels of morbidity and mortality due to AIDS). They also capture programme outputs, coverage and outcomes; for example, the prevention of mother-to child transmission and treatment with antiretroviral combination therapy (ref UNGASS Guidelines on Construction of Core Indicators, July 2005).

to assess HIV/AIDS mainstreaming, focusing on the extent that this may have contributed to influencing outcomes, i.e. in terms of making the target population more or less susceptible to HIV infection and more or less vulnerable to the impacts of epidemic.

3. The ***coherence*** **and** ***connectedness*** of different Norwegian channels and instruments in support of the national HIV/AIDS response. I.e. the extent to which the various outputs complement each other in the work towards reducing peoples' susceptible to HIV infection and reducing vulnerability to the impacts of AIDS. This assessment should also include the multilateral/global dimensions of the Norwegian support to the national HIV/AIDS response.

### 4.4 Assess Norway's partnership choices/strategies (evaluation objective 4)

This section should assess whether Norway struck the right balance amongst its strategic choices for optimizing HIV/AIDS outcomes, based on an assessment of *complementary partnerships*[39] choices at the country level, including also the multilateral/global partnerships.

The team should describe and analyse Norway's partnership choices and strategies over the evaluation period, both with national stakeholders and with other development agencies in terms of impacting on key outcomes through i.e. contributing to policy dialogue, capacity development, advocacy etc.

It should assess the extent to which Norway's partnership choices and strategies have taken account of the strengths (and weaknesses) of different partners, and whether links have been made with organisations that effectively can address different aspects and dimensions of the epidemic.

Have the partnership choices/strategies been relevant, effective and coherent in terms of ensuring contribution towards influencing key outcomes, i.e. through influencing on national commitment and action (ref section 4.2)?

### 4.5. Extract lessons learnt, findings and recommendations (evaluation objective 5)

Based on the findings, the evaluation should make recommendations to help inform future decisions on how to enhance the development effectiveness of the Norwegian HIV/AIDS response at the country level. It will be necessary to distinguish between findings at different levels and focus the analysis on those factors that Norway could have a potential to influence on. The recommendations should logically flow from the most central and relevant (3-4) findings, and should take due account of the current and planned role of Norway as a long term development partner in the country.

- Which strategic focus and actions will have the greatest developmental "pay-off"?
- What corrective actions are recommended for new, ongoing or future Norwegian work on the outcome in the country?
- What are the main lessons that can be drawn from the outcome experience that may have generic application?
- What are best practices in designing, undertaking, monitoring and evaluating outputs, activities and partnerships around the outcomes?

## 5 Scope

### 5.1 Country focus, sequencing and evaluation period

This evaluation focuses on three selected countries in Sub Saharan Africa: Ethiopia,

Malawi and Tanzania (ref. section 3.1). The country studies should be undertaken in sequence, starting with Ethiopia, then Malawi and Tanzania.

The evaluation should be forward looking. The rapid changes that have taken place in the international and national HIV/AIDS response means that we are evaluating a "moving target". To ensure relevance of findings and recommendations to future policy decisions, the focus should be on the *period 2000 – 2006* (an added benefit of this is that Norad's statistical

39 "Complementary partnership" concept: linking and sharing relative strengths and expertise with other organisations to ensure that different aspects of the aids pandemic are addressed.

data are available in the same form and format as a new system was introduced in 1999). The last evaluation commissioned by the evaluation unit covered the period 1990-95.

### 5.2 Broad-based coverage

The evaluation should cover all types of Norwegian channels and instruments for supporting national HIV/AIDS responses, implying that both the *bilateral dimensions,* including also support provided through *NGOs,* and the *multilateral/global dimensions* at the country level should be considered. Thus, the evaluation will not only assess the *direct* HIV/AIDS activities supported by Norway, but should also review the Norwegian development priorities and programs in the country regarding the extent to which HIV/AIDS dimensions have been *mainstreamed* in *selected priority* policies and programs supported by Norway. It should also include a review on the contributions of the main multilateral and global actors supported by Norway, focusing on assessing their influence on key outcomes in the national HIV/AIDS responses in the three countries. The review should be based on available reports and evaluations, as well as interviews with national stakeholders.

In addition, the evaluation should produce a paper outlining Norway's main HIV/AIDS contribution at the *international* level, focusing on documenting Norwegian inputs such as funding, policy dialogue and technical advice. The Norwegian inputs at this level should not be evaluated, but the paper should conclude with reflections regarding the linkages between the Norwegian HIV/AIDS support towards national responses in the three countries and the Norwegian inputs at the international level. This paper should be based on a desk review of Norway's inputs (funding, policy advice and technical advice) at the international level and selected interviews, but is not intended as an evaluation of Norway's strategic role in the development of the global HIV/AIDS architecture.

### 5.3 Methodology

To the extent possible, analysis should be based on desk studies. The evaluation design must be simplified, the team must utilize reliable secondary data and seek ways to cut out collection of nonessential information. The evaluation must draw heavily on available research, data and documentation from i.e. existing progress reports, self evaluations, independent evaluations and studies performed by Norway and other development partners, including also available national research and monitoring data.

The main evaluation focus should be the assessment of the Norwegian role and contribution (evaluation question 3), as well as the assessment of Norway's partnership choices/strategies (evaluation question 4).

The team should suggest the *outcome evaluation methods* that best can answer the evaluation questions and clarify how to deal with attribution. The evaluation framework and methods should be presented in detail and discussed in the inception report. Discussion of attribution is not the overriding priority, but the team should discuss probable factors that have contributed to change in outcome and discuss the interrelationships with inputs and outputs. When presenting the evaluation framework, attempt should be made to clarify evaluation constraints (budget, time, data and political constraints), including types of information that can and cannot be provided within these constraints.

The methods must reflect the cross-sectoral nature of the epidemic and the links between HIV/AIDS, poverty, gender, human rights and development. This requires a broad-based scope, posing methodological challenges that must be dealt with and discussed, while maintaining the evaluation focus on assessing the role and contribution of Norway. Cross-cutting issues such as gender shall be accounted for, in the data collection, the analysis, findings and recommendations.

Trends in the national HIV/AIDS situation and response, including the monitoring and evaluation system and the role played by different actors in the national HIV/AIDS response (government, private sector, civil society, external actors) should be presented. The role of Norway, including the Embassy, in relation to these actors should be assessed.

The evaluation will include basic financial and descriptive data on the Norwegian inputs. The team is responsible for the data collection.

The evaluation will include literature review, desk studies, country studies, interviews, focus group discussions/survey techniques and/or in-depth studies in each of the selected countries. It would involve one country visit to each of the countries and possibly one additional visit to the region for the purpose of presenting and discussing final reports. The literature review should ensure that the evaluation utilises available monitoring and outcome data and should highlight knowledge gaps at the outcome level in each of the country cases.

The interviews should involve a broad spectrum of informants and stakeholders, including primary beneficiaries (infected and affected households/individuals and groups), peer groups, resource persons and opinion leaders in the selected countries (including faith-based organisations), community-based groups, labour unions and associations, private sector organisations, country officials at relevant levels, including the local level, other donors and actors, etc.

Validation and feed-back workshops shall be held in the three countries before departure, involving key partners and stakeholders, and others who are relevant.

Guiding principles: triangulate and validate information, assess data quality in transparent manner and highlight data gaps and weaknesses (i.e. limitations of "household"-based data in a context with extended family relationships, street children, orphans, multiple partnerships, single "households", etc). The data material underlying the analysis shall be available.

### 5.4 Evaluation criteria and evaluation quality standards

The evaluation should refer to the DAC criteria on evaluation of international development cooperation; relevance, effectiveness, efficiency, sustainability and impact, as well as other sub criteria such as appropriateness, coverage, connectedness, and coherence have been designed to fit the special conditions of humanitarian assistance[40]. The team should clarify which criteria that will not be used, keeping in mind the focus on country perspectives and outcomes. It is suggested that the team should focus on assessment of *relevance, effectiveness* and *sustainability* in relation to the outcome level, including also consideration to *connectedness* and *coherence* issues. The reports will be assessed against *DAC evaluation quality standards*[41]. Comments will be collected from stakeholders and affected parties.

## 6 Stakeholders and Evaluation Products

Immediate stakeholders in Norway are the Ministry of Foreign Affairs, Embassies and Norad.

Immediate stakeholders in selected countries are implementing partners, including the national HIV/AIDS councils and programmes. Other stakeholders in Norway are staff of the development administration, Norad's Norwegian partners, the Auditor General, the Parliament and the interested Norwegian public. Other stakeholders in selected countries could be the public administration, the affected and the infected, the public in general and parliament.

The evaluation will produce the following documents:

- Inception report
- 3 country reports
- A paper documenting Norway's HIV/AIDS contribution at the international level
- A synthesis report, including lessons learnt and recommendations. This should be a brief report based on key findings, conclusions and recommendations of the three country reports.
- Stand-alone executive summaries of each country report as well as of the synthesis report.

40 Ref. Sida Evaluation Manual: Looking Back, Moving Forward, 2004, p 25 on Evaluation Criteria.
41 http://www.oecd.org/dataoecd/30/62/36596604.pdf

## 7 Work plan, budget, reporting and organisation

### 7.1 Tentative work plan

| ACTIVITY | DEADLINE |
|---|---|
| Contract signature | 11 June 2007 |
| Inception report | 12 July 2007 |
| Ethiopia Country Report Draft<br>Ethiopia Country Report Final | September 2007<br>November 2007 |
| Malawi Country Report Draft<br>Malawi Country Report Final | December 2007<br>February 2008 |
| Tanzania Country Report Draft<br>Tanzania Country Report Final | February 2008<br>April 2008 |
| Draft paper on Norway's contribution to the global HIV/AIDS architecture<br>Final paper on Norway's contribution to the global HIV/AIDS architecture | March 2008<br>April 2008 |
| Synthesis Report Draft<br>Synthesis Report Final | April 2008<br>May 2008 |
| Publication, distribution | June 2008 |
| Final presentation seminars<br>(one in Oslo, 1 in Africa) | June 2008 |

Deadlines with exact dates for submission of reports where this has not been indicated above will be determined when contract is entered into[42].

### 7.2 Budget

Number of person weeks stipulated: 60

### 7.3 Reporting[43]

The report will be in English. The evaluation team shall adhere to the terminological conventions of the OECD DAC Glossary on Evaluation and Results Based-Management[44], as well as the Norad Evaluation Guidelines[45].

The inception report will contain an evaluation framework, evaluation questions and present the evaluation approach, including detailed methodologies and data-collection strategies, which should answer satisfactorily to the tasks described in the ToR (no more than 10 pages, excluding annexes). A plan for further work will be included. This will further cover data collection, method, design, case studies, analysis and structure of report. See annex 1 for report specifications.

The paper documenting Norway's contribution at the international level during the evaluation period should be no more than 10 pages, excluding annexes, and should contain an executive summary.

The inception report will be submitted for approval to Norad's Evaluation Department.

The final reports will be presented in Oslo and in a regional workshop.

The reports will be in the name of the evaluation team, but be a product of Norad's Evaluation Department, and will be published by Norad.

42 Dates should be specified by tenderer in the proposals for tender.
43 See attached Report Specifications.
44 http://www.oecd.org/dataoecd/43/54/35336188.pdf
45 See. http://www.Norad.no/items/4620/38/6553540983/Evalueringspolitikk_fram_til_2010.pdf

### 7.3 Organisation

The evaluation will be carried out by an independent team of consultants. The contract will be issued by the Evaluation Department (Norad), according to standard procurement procedures. Evaluation management will be carried out by the Evaluation Department and the team will report to the Evaluation Department. All decisions concerning ToR, inception report, draft reports and reports will be taken by the Evaluation Department. Any modification to the ToR is subject to approval by the Evaluation Department. The Team is entitled to consult widely stakeholders pertinent to the assignment, but it is not permitted to make any commitment on behalf of the Governments of Norway.

a. A reference group will be established, chaired by the Evaluation Department, to advise and comment on the evaluation process and the quality of products. The evaluation team must take note of the comments. Where there are significantly diverging views between the evaluation team and stakeholders, this should be reflected in the report.
b. International evaluation team

   The team should consist of minimum three persons, and will report to Norad through the team leader. The team must have the following qualifications:

*Team leader*

- Proven successful team leading; the team leader must document relevant experience with managing and leading complex evaluations
- Advanced knowledge and experience in evaluation principles and standards in the context of international development

*Team as a whole*

- Suitability and complementarities of the Team should be related to approach and methodology, including advanced competence in behaviour social science
- Experience and knowledge in carrying out similar evaluations, reviews and/or research, particularly outcome and impact analysis and capacity to write concise reports
- Expertise on global and national HIV/AIDS architecture and working principles, HIV/AIDS research or evaluation
- Good knowledge of development cooperation instruments, international development policies and processes, including the multilateral development organisations
- Familiarity with case countries and/or similar types of countries in Africa
- Experience with gender sensitive analysis
- Gender balance in the team is an asset
- Languages: English, Norwegian

*Relevant national expertise from each case country:* A relevant and credible local consultant or firm should be selected for each country to work with the international team to facilitate the country level input, preferably from a national research institution, university or training institution.

# Annex 2: List of institutions and persons consulted

### List of institutions and persons consulted in Ethiopia

| Name | Position and Organisation |
|---|---|
| Bente Nilsson | Counsellor/Head of Development Cooperation, Royal Norwegian Embassy, Addis Ababa |
| Ashenafi Gizaw Beyea | Programme Officer, Royal Norwegian Embassy, Addis Ababa |
| Hussein Faris | Head of Planning & Programme Department, National HIV/AIDS Prevention & Control Office (HAPCO) |
| Mr. Hans Birkeland | Country Representative, Norwegian Church Aid |
| Kidist Belayneh | HIV/AIDS Programme Coordinator, Norwegian Church Aid |
| Ayehualem Tameru | Programme Officer, UNFPA |
| Samia Mohammaed | Assistant Programme Officer, UNICEF |
| Daba Fayissa | Project Officer, UNICEF |
| Mirgissa Kaba | Programme Office HIV/AIDS, UNICEF |
| Dr. Kidone Ghebrekidau | RH/FP Programme Officer, UNFPA |
| Helen Amdemikael | Gender & Advocacy Programme Officer, UNFPA |
| Dr Roger Salla Ntounga | UNAIDS Country Coordinator & Representative to African Union & United Nations Economic Commission for Africa |
| Bjørn Hagen | Country Representative, Save the Children Norway, Ethiopia |
| Melesse Delegega | Programme Coordinator Education, Save the Children Norway, Ethiopia |
| Shurmye W. Selassie | Field Office Manager, Save the Children Norway, Ethiopia |
| Yidnekachew Tilahun | HIV/AIDS Programme Coordinator, Save the Children Norway, Ethiopia |
| Solomon Kelkai | Programme Director, Save the Children Norway, Ethiopia |
| Dr. Abiyot Belai | RH Project Officer, AMREF |
| Dr. Howard Engers | Director of Institute & Vaccine Specialist, Armauer Hansen Research Institute |
| Serkalem Awlachew | Programme Manager (PLAN – Mary-Joy), Mary-Joy AID for Development |
| Dawit Adnew | Project Officer, Mary-Joy AID for Development |
| Fasil Asesneho | Community Development Coordinator, Mary-Joy AID for Development |
| Etalem Alemayohu | Community Development Worker, Mary-Joy AID for Development |
| Dr. Habtamu Woldeyes | Human Development Coordinator, Director, Ethiopian Evangelical Church Mekane Yesus (EECMY/DASSC) |
| Deed Jaldessa | EECMY/DASSC |
| Dereje Tolessa | Project Officer – HIV/AIDS, EECMY/DASSC |
| Mr. Haile-Leul Siyoum | Head of Department, Youth Programmes Coordination, Federal Ministry of Youth, Addis Ababa |
| Mr. Kassu Abdi | HIV/AIDS Focal Person/Former Head, Secondary Education Dept /Snr Expert School Improvement Programme, Federal Ministry of Education. |
| Prof. Hammed Ali | Head, Epidemiology Dept., Public Health Dept, Medical College Ethiopia. |
| Adeye Befecadu | Programme Officer, HIV/AIDS & Civil Society, Sweden International Development Agency. |
| Dr. Ibrahima Yusuf | Section Head, Psychosocial Services, Organisation for Social Services for AIDS (OSSA) |
| Santiago Bernal | Country Director, PLAN, Ethiopia |
| Dr Tezera Fisseha | Programme Support Manager, PLAN, Ethiopia |
| Jemal Mohammed | HIV/AIDS Programme Coordinator, PLAN, Ethiopia |
| Lakew Abode | Grant Consultant, New Life Community |
| Girmay Abadi | HIV/AIDS Coordinator, New Life Community |
| Asnake Hailu | Coordinator, HIV/AIDS Mainstreaming Unit, GTZ |
| Ashish Kumar | Programme Adviser, Network of PLWHA (NEP+) |

| Name | Position and Organisation |
|---|---|
| Tigabe Asres | Executive Director, NEP + |
| Hans Doctor | Head of Development Cooperation / Deputy Head of Mission, Embassy of the Kingdom of the Netherlands |
| Digafe Feleke | Director, PRO PRIDE |
| Meheret Lemma | Programme Officer, PRO PRIDE |
| Sr. Kelemework Abayueh | Counsellor, Markato Clinic |
| Beleto Zewale | Coordinator, Youth Association Centre, Addis Kararma |
| Tigist Tibebe | Coordinator, FGAE, Kirkos |
| Ayalew W. Semait | Executive Director, Association for Nationwide Prevention and Protection Against Child Abuse and Neglect (ANPPCAN) |
| Mekonnen Addisu | Snr. Programme Coordinator, ANPPCAN |
| Belay Zelleke | Snr. Programme Officer, ANPPCAN |
| Nehemie Mbakuliyemo | EPI Team Leader & Acting Country Representative, WHO |
| Dr. Akram A. Eltom | HIV/AIDS Country Team Leader, WHO |
| James Browder | HIV/AIDS Officer, USAID Ethiopia |
| Dr. Gebrelassie Okubagzi | Snr. Health Specialist, The World Bank, Ethiopia |
| Iyasu Haile Sellassie | Executive Director, Medico Socio Development Assistance for Ethiopia (MSDAE) |
| Marion Kelly | HIV/AIDS & Health Adviser, DFID Ethiopia |
| Duro Burje | Programme Officer, Addis – Ababa Evangelical Church Mekane Yesus (AASECMY) |
| Demissie Tassew | Programme Officer, Gemini Trust |
| Aklilu Nega | Programme Officer, Integrated Service for AIDS Prevention and Support Organisation |
| Dr Yesus Belele | Programme Officer, Ethiopian Aid |
| Saba Elmedhin | Programme Officer, Network of Ethiopian Women's Association |
| Sisay Worku | Programme Officer, Birhan Integrated Community Development Organisation (BICDO) |
| Sisay Abebe | Programme Officer, EVMPA |
| Jemal Abdella | Programme Officer, BICDO |
| Mekdine Admassie | Programme Officer, OSSA |
| Sr. Felekech Buldela | Programme Officer, Ethiopian Gemini Trust |
| Tesfamariam W/ Sembet | Programme Officer, MSDAE |
| Alezuzeh Chefihet | Programme Officer, Save Your Generation Ethiopia |
| Senait H. Giorgis | Programme Officer, Ethiopian Aid |
| Adinew Husien | Programme Officer, Family Guidance Association of Ethiopia |

## List of institutions and persons consulted in Malawi

| Name | Position and Organisation |
|---|---|
| Gunnar Føreland | Ambassador, Royal Norwegian Embassy |
| Leif B Sauvik | Counsellor – Deputy Head of Mission, Royal Norwegian Embassy |
| Øystein Botillen | First Secretary, Royal Norwegian Embassy |
| Augustin Chikuni | Programme Officer, Royal Norwegian Embassy |
| Ragnhild Seip | First Secretary Health, Royal Norwegian Embassy |
| Lena Farmen-Hall | Archivist, Royal Norwegian Embassy |
| Jan-Olav Pettersen | Economist, Royal Norwegian Embassy |
| Vibeke Tralim | First Secretary, Royal Norwegian Embassy |
| Abel Kawonga | Programme Officer, Royal Norwegian Embassy |
| Esnart Nawanga | Programme Officer Gender, Royal Norwegian Embassy |
| Jan Håkon Olsson | Former First Secretary Health, Royal Norwegian Embassy (by phone) |
| Monica Djupvik | Acting First Secretary Health, Royal Norwegian Embassy (by phone) |
| Desmond John | UNAIDS Country Coordinator |
| David Chitate | M&E Adviser, UNAIDS |
| Robert M Phiri | Executive Director, Public Affairs Committee |
| Dr Mary Shawa | Principal Secretary for Nutrition, HIV/AIDS, Office of the President & Cabinet |
| Biziwick S M Mwale | Executive Director, National AIDS Commission |
| Kelita Kamoto | Head, HIV/AIDS Unit, Ministry of Health |
| Valerie Young | Counsellor (Development) Head of Cooperation, High Commission of Canada |
| Johannes Lebede | Programme Manager HIV/AIDS, Canadian International Development Agency |
| Juan Ortiz-Iruri | Deputy representative, UNICEF |
| Amon Chinyophiro | Community Development Programme Manager, NASFAM |
| Kate Dresser | Corporate Development & Funding Advisor, NASFAM |
| Elsa Døhlie | Country Director, Norwegian Church Aid |
| Esther Masika | Programme Coordinator, HIV/AIDS, Norwegian Church Aid |
| Gerard Chigona | Programme Manager Gender and Good Governance, Norwegian Church Aid |
| Modesta Simango | Program Coordinator, Norwegian Church Aid |
| Julia Kemp | Health Adviser, DFID |
| Sarah Mtonya | HIV/AIDS Adviser, DFID |
| Kristina Ramstedt | Head, Swedish-Norwegian Regional HIV/AIDS Team for Africa, Lusaka |
| Ulf Kallstig | Deputy Head/Regional Adviser, Swedish-Norwegian Regional HIV/AIDS Team for Africa, Lusaka |
| Michael Tawanda | Regional Adviser, Swedish-Norwegian Regional HIV/AIDS Team for Africa, Lusaka |
| Amanda Ruth Manjolo | Executive Director, NAPHAM Secretariat |
| David Joe Nyirongo | Programmes Manager, NAPHAM Secretariat |
| Prof. R L Broadhead | Principal, University of Malawi College of Medicine |
| Robert Ngaiyaye | Executive director, Malawi Interfaith AIDS Association |
| Chimwemwe Luhanga | Finance and Administration Officer, Malawi Interfaith AIDS Association |
| Rev. Dr. Robert T. Mwaungulu | Executive Director, Ecumenical Counselling Centre |
| Mrs Elita Yobe | Programmes Officer, Ecumenical Counselling Centre |
| Rev. Francis C. Mkandawire | General Secretary, Evangelical Association of Malawi |
| Mohward Kasiya | Program Manager HIV/AIDS, Evangelical Association of Malawi |
| Blair Mlowoka | Head of Programs, Evangelical Association of Malawi |
| Ellen Molosi | Staff member, Evangelical Association of Malawi |
| Towera Nyika | Project Coordinator, Evangelical Association of Malawi |

| Name | Position and Organisation |
|---|---|
| Mathias Chindungwa | Coordinator for Ntchisi Evangelical Churches Consortium for social services (NECCOSS) |
| Pastor Mr S Kampira | Apostolic Faith Mission, Ntchisi |
| Pastor Mr T Kaliati | United Methodist Church |
| Pastor C.H. Chimphonda Banda | Seventh Day Adventist church, Ntchisi |
| Group of 18 volunteers | Ntchisi Evangelical Churches Consortium for Social Services (NECCOSS) HBC groups, caregivers in CBCC group, PLWHA group |
| Group of 8 members | Youth group, Ntchisi Evangelical Churches Consortium for social services (NECCOSS |
| Lexon J.C. Ndalama | Executive Director, Association of Church Educators in Malawi (ACEM) |
| Flemmings Mgemezulu | Regional Coordinator, Association of Church Educators in Malawi (ACEM) |
| MB Adyenji | Deputy Headmaster at Chibvala Primary School |
| Group of 21 persons | Representing the School Committee, Parents Association at Chibvala Primary School, and headmen of neighbouring communities |
| 17 teachers | Chibvala Primary School |
| Sanjay Awasthi | Country Programme Manager, Oxfam |
| Lingalireni Mihowa | Partnership Management Adviser, Oxfam |
| Felix Mtonda | Programme Coordinator Blantyre Rural, Oxfam |
| Holman Malata Phiri | Ag. Programme Manager, NAC Umbrella, Blantyre |
| Yohane Kamgwira | Incoming Programme Manager, NAC Umbrella, Blantyre |
| Dumisani Malija | Project Accountant, NAC Umbrella, Blantyre |
| Geoffrey Nkata | Capacity Building Officer, NAC Umbrella, Blantyre |
| Charles Makanga | District Commissioner, Blantyre District |
| Ofuru Nalivata | District AIDS Coordinator, Blantyre District |
| Josephine Chinerle | District Information Officer, Blantyre District |
| Baldwin Nkumbadzala | District Youth Officer, Blantyre District |
| Deus Chirwa | District Grants Officer, Blantyre District |
| Mercy Mpunga | District Programme Officer, Blantyre District |
| Agnes Napwanga | Senior Community Development Assistant, Blantyre District |
| Esther Ndaipalera | Assistant Social Affairs Officer, Blantyre District |
| Gama Chitekesa | Director, Comfort Arms of Needy Children's Care, Khombwe Epicentre, Blantyre |
| George Macheka | Director of Operations, Banja La Mtsogolo (BLM), Blantyre |
| Chikaiko Chadzunda | Director of Finance, BLM |
| Tiwonge Mhango | Regional Manager , South, BLM |
| Stella Ngoma | Regional Manager, Central and East, BLM |
| Nyanyiwe Mbeye | Technical Manager, Health, BLM |
| Maxwell Chiundu | Operations Research Manager, BLM |
| Brandina Kambala | National Youth Coordinator, BLM |
| Francis Salima | Centre Manager, Midina BLM Centre |
| Chimwemwe Nyasulu | CT Counsellor, Midima BLM Centre |
| Robert Nyambalo | Youth volunteer, Midima BLM Centre |
| Wyson Khola | Youth volunteer, Midima BLM Centre |
| Fatima Chipala | Youth counsellor, Midima BLM Centre |
| Alfred Matsimbe | Youth volunteer, Midima BLM Centre |
| Cephas Zaoneka | Youth Coordinator, Midima BLM Centre |
| Jervas Banda | CT Counsellor, Midima BLM Centre |
| Edward Mponda | Community Outreach Manager, BLM |

| Name | Position and Organisation |
|---|---|
| Edson Daudi | Regional Outreach Support Officer, BLM |
| Eva Helene Ostbye | Programme Coordinator, The Development Fund (Utviklingsfondet) |
| Dan Taylor | Director, Find Your Feet, UK |

### 3.1 List of institutions and persons consulted in Tanzania

| Name | Position and Organisation |
|---|---|
| Pius Wanzala | Programme Officer, Royal Norwegian Embassy Tanzania |
| Dr. R. O. Swai | Programme Manager, National AAIDS Control Programme, Ministy of Health, Tanzania |
| Mr. Ngosha S. Magonya | Commissioner External Finance Dept., Ministry of Finance |
| Judica Omari | Principal Economist & Focal Person Nordic Group, Ministry of Finance |
| Dr. Fatima | Executive Chairperson, Tanzania Commision for AIDS |
| Bengi M. Issa | Director of Finance, Administration & Resource Mobilisation, TACAIDS |
| Dr Jerome Kamwela | GFATM Monitoring & Evaluation Officer, TACAIDS |
| Richard K. S. Ngirrus | Policy & Planning Officer, TACAIDS |
| Morris Lekunle | District Community Response Officer, TACAIDS |
| Elise Jensen | HIV/AIDS Officer, USAID |
| Dr Esther Muia | Deputy Representative, UNFPA |
| Dr Chilanga Asmani | National Programme Officer – HIV/AIDS, UNFPA |
| Rutasha Dadi | Assistant Representative, UNFPA |
| Oddvar Bjorknes | Resident Representative, Norwegian People's Aid |
| Suleman R. Toroka | Liaison Officer, Norwegian People's Aid |
| Fredrick Glad-Gjernes | Country Representative, Norwegian Church Aid |
| Blandina Faustin | Programme Officer, Norwegian Church Aid |
| Fiona Chipunza | Policy Officer, Norwegian Church Aid |
| Augustina Mosha | Programme Officer, Norwegian Church Aid |
| Rev Godfrey Walalaze | Programme Officer, Norwegian Church Aid |
| Evans Rubara | Programme Officer, Norwegian Church Aid |
| Sarah Shija | Asst. Programme Officer, Norwegian Church Aid |
| Sabas Masawe | Project Coordinator, DOGODOGO Centre |
| Ruth Shija | Planning M & E Coordinator, Tanganyika Christian Refugee Service – The Lutheran World Federation |
| Justin Nyamoga | Director, HIV/AIDS Programme, Christian Council of Tanzania |
| Laurent Mapuada | Programme Officer, WCRP |
| Dr Ellen Mkondya – Senkoro | Chief Executive Officer, Banjamin William Mkapa HIV/AIDS Foundation |
| Dr Adeline Saguti Nyamwihura | Programme Manager, Banjamin William Mkapa HIV/AIDS Foundation |
| Ms Mariam Millinga | Finance & Admin Manager, Banjamin William Mkapa HIV/AIDS Foundation |
| Dr. Minou Fuglesang | Executive Director, Femina HIP |
| Dr. Myo Zin Nyunt | HIV/AIDS Coordinator, UNICEF |
| Dr Elizeus F. Ndyetabura | Assistant Resident Representative & Team Leader HIV/AIDS & Gender Unit, UNDP |
| Mathew Cogan | Programme Analyst HIV/AIDS & Gender Unit, UNDP |
| Dr Stella Stephen Chale | NPO HIV/AIDS Care & Treatment, WHO |
| Maximillian Mapunda | NPO Health Economist, WHO |
| Ms Feddy Mwanga | NPO Home Based Care, WHO |
| Mary-Beatrix Mugishagwe | Executive Producer/Director, Abantu Vision |

| Name | Position and Organisation |
|---|---|
| Dr. Cyprian Maro | Executive Director, EMIMA |
| Dr. Gongo | Former Programme Manager HIV, Norwegian People's Aid |
| Mr Simbamuwaka | Director, Monitoring & Evaluation, International Planned Parenthood Federation of Tanzania |
| Getrude Kihunrwa | Social Policy Advisor, DFID |
| Deodatha Mwakasisi | Deputy Programme Manager – Social Sector & Intl Systems, DFID |
| Dr. Musiba S. Mbilima | Secretary UDSM Technical Sub-committee on HIV/AIDS, University of Dar es Salaam |
| Antipas B. Mtalo | Head of VCT Programme, KIWAKKUKI |
| Theresa Sabuni | Head, HIV/AIDS Education Dept., KIWAKKUKI |
| Lydia M. Kissija | Asst. Head, HIV/AIDS Education Dept., KIWAKKUKI |
| Petronila Tarimo | Asst. Home Based Care Programme Officer, KIWAKKUKI |
| Dr Rehema Kiwera | Home Based Care Programme Officer, KIWAKKUKI |
| Eunice Maringo | Head of Finance Dept., KIWAKKUKI |
| Dafiosa Itemba | Executive Coordinator, KIWAKKUKI |
| Luililiael Mfangavo | Orphans Vulnerable Children Programme Officer, KIWAKKUKI |
| Joe Eshun | Director, Managing Consulting Deloitte |
| Dr Laetitia E. Sayi | HIV/AIDS Programme Coordinator, Ministry of Education & Vocational Training |
| Prof T. L. Maliyamkono | Executive Director, Eastern and Southern Africa Universities Research Programme |
| Dr Emmanuel G. Malangalila | Senior Health Specialist, The World Bank |
| Dr Luc Barriere – Constantin | Country Coordinator, UNAIDS |
| Magadlene Aquilin | HIV/AIDS Officer , Women Legal AIDS Centre |
| Mary Njau | Counsellor, Women Legal AIDS Centre |
| Emmanuel Mighay | Nursing Officer in-charge, Lutheran Hospital, Haydom |
| Lengai Sakaya | Village Administrator, SOS Arusha |
| Beatrice Christopher Matotay | FSP Coordinator, SOS Arusha |
| Reuben S. Kakunya | Principal Economist (Former Coordinator MEUSTA), Tanga Regional Administrative Secretary |
| Jon Lomøy | Ambassador, Norwegian Embassy |
| Hanne Therese Tilrem | First Secretary, Norwegian Embassy |
| Kristin Sverdrup | Head of Development Cooperation & Deputy Head of Mission, Norwegian Embassy |
| Bodil Maal | Programme Officer, Norwegian Embassy |
| Anthony Mwendamaka | Coordinator, WAMATA |
| Dr. Wycliffe Lugoe | NUFU coordinator, The University of Dar es Salaam, Faculty of Education |
| Kakoko, Deodatus, V.C | Assistant Lecturer, Muhimbili University College of Health Sciences |
| Mkumbo Kitila, A.K | Assistant Lecturer, University of Dar es Salaam |
| Basela, J.M | Assistant Lecturer, University of Dodoma |
| Libent Daphine | Assistant Lecturer and Dean of Students, Open University of Tanzania |
| Mabuga Paulina | Manager, University Students Accommodation Bureau, University of Dar es Salaam |
| Faustine China | Dean of Students, College of Business Education, Dar es Salaam |
| Machumu Maregesi | Assistant lecturer, Dar University College of Education |

## 3.2 List of institutions and persons consulted at global level

| Name | Position and Organisation |
|---|---|
| Sissel Hodne Steen | Norway's delegation to Geneva |
| Dr Winnie Mpanju-Shumbusho | Senior Adviser to Asst. DG HIV/AIDS, TB, Malaria & Neglected Tropical Diseases, World Health Organisation |
| Dr. Badara Samb | Advisor Health Systems Partnership and Coordination, World Health Organisation |
| Kebe Mohammed Amine | Planning, Resources Coordination and Performance Monitoring, World Health Organisation |
| Morten Ussing | UNAIDS |
| Luiz Loures | UNAIDS |
| Christoph Benn | Director, External relations, GFATM |
| Silvia Ferazzi | Manager, Donor Relations, GFATM |
| Pauline Mazue | Special Assistant to the Director of External Relations, GFATM |
| Philippe Duneton | Deputy Director, UNITAID |
| Gavin McGillivray | Head, Global Funds & Development Finance Institutions Department, UK, Department for International Development (DFID) |
| Carole Presern | DFID/GAVI |
| Gargee Ghosh | Senior Program Officer, Global Health Policy & Finance, Bill & Melinda Gates Foundation. |
| Susan Stout | World Bank |
| Jim Kolker | Head, HIV/AIDS Department UNICEF |
| Purnima Mane | Deputy Executive Director (Programme), UNFPA |
| Carlton P Evans | Policy and Programme Manager<br>Global Funds and DFIs Department, DFID |
| Dr Doreen Mulenga | Senior Adviser, HIV/AIDS, UNICEF |
| Jessica Koehs | Project Officer PARMO, UNICEF |
| Henriette Ahrens | PARMO, UNICEF |
| Mary Otieno | UNFPA |
| Kebedech Ambaye Nigussie | UNFPA |
| Gary Conille | UNFPA |
| Alain Sibenaler | UNFPA |

### 3.3 List of persons consulted in Norad & the Ministry of Foreign Affairs, Norway

| Name | Position and Organisation |
|---|---|
| Kristin Teigland | Senior Adviser, Evaluation Dept. Norad |
| Asbjørn Eidhammer | Director, Evaluation Dept., Norad |
| Gro Therese Lie | University of Bergen |
| Marit Berggrav | Senior Adviser, Global Health & AIDS Dept., Norad |
| Monica Djupvik | Adviser, Global Health & AIDS Dept., Norad |
| Anne Skjelmerud | Senior Adviser, Global Health & AIDS Dept., Norad |
| Ingunn Klepsvik | Assistant Director General, Norad |
| Kristin Hauge | Senior Adviser, Education & Research Dept., Norad |
| Reidun Sandvold | Senior Adviser, Education & Research Dept., Norad |
| Marit L. Karlsen | Senior Adviser, Civil Society Dept., Norad |
| Rikke Horn-Hanssen | Adviser, Civil Society Dept., Norad |
| Lillian Prestegård | Senior Executive Officer, Civil Society Dept., Norad |
| Olav Andreas Hernar | Senior Adviser, Quality Assurance Dept., Norad |
| Stine Thomassen | Statistics Dept, Norad |
| Aslak Brun | Deputy Director General, Dept. for Global Initiatives & Gender Equity, MFA |
| Johan Sørby | Focal Person East Africa, Ministry of Foreign Affairs |
| Olav Seim | Focal Person - World Bank, Ministry of Foreign Affairs |
| Ine Måreng | Focal Person – UN agencies, Ministry of Foreign Affairs |
| Janne Knutrud | Focal Person West & South Africa, Ministry of Foreign Affairs |
| Svein Skåre | Statistics Dept, Norad |

# Annex 3: Overview of Norwegian policy statements and priorities regarding HIV/AIDS[46]

*Note: the following overview refers only to the main, public policy documents and statements by the Norwegian government, in particular the state budget propositions. More detailed and/or internal strategy choices by MFA, Norad or other institutions as well as actual activities are not mentioned here.*

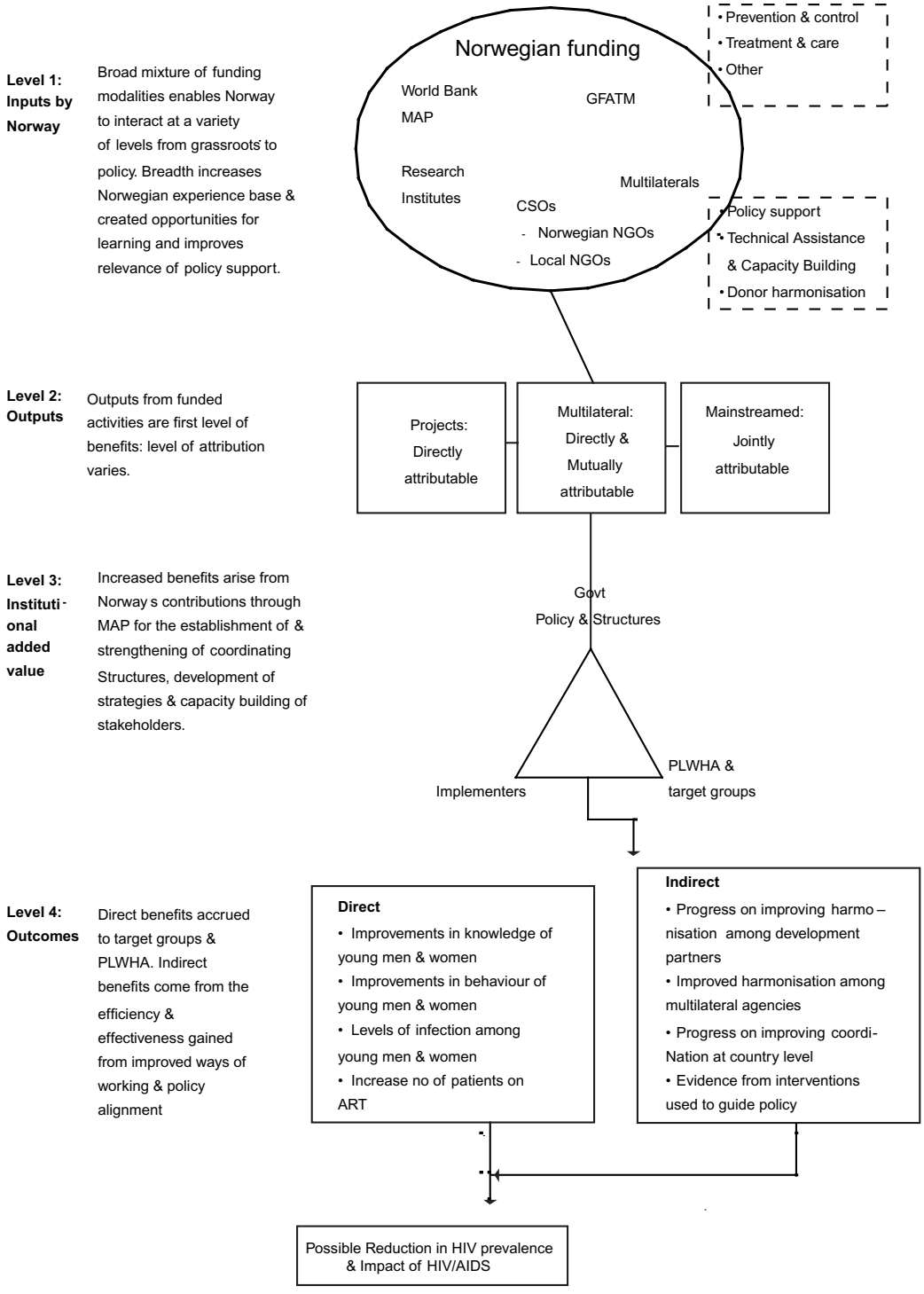
| Budget year | Main policy issues and priorities |
|---|---|
| pre 2000 (not consulted in detail) | Priority given to HIV/AIDS but not as one of the few major thematic priorities in Norwegian development cooperation. Shifts around 1994-1996 from HIV/AIDS specific interventions to a focus on integration. |
| 2000 | The government's '*Policy positions to guide Norwegian participation in an intensified effort to combat HIV/AIDS'* is presented. Its content reflects policy positions that shape much of Norwegian aid to HIV/AIDS throughout the period. It strongly insists on international coordination with UNAIDS as the major agency; support to contextually developed national plans under national leadership; linking HIV/AIDS to national development planning across sectors; donor coordination and partnerships between public, private and civil society organisations; joint efforts on all levels from international to local level; gender and age dimensions; addressing social exclusion. Among the more specific focuses are support to implement national policies 'on the ground' (locally); protection of children (including PMTCT) and youth; involvement of men (including a focus on the work place); a human rights approach against exclusion; accessible and affordable medical treatment; development of a vaccine.<br>State budget provides few references to HIV/AIDS as a priority under the headings 'social development', 'support to Africa'. Individual countries incl. Tanzania and Malawi. No reference to HIV/AIDS in the budget for Ethiopia. |
| 2001 | State budget proposes 'significant increase' in HIV/AIDS support through higher volumes, broader approach and more strategic support.<br>Three main 'arenas' identified:<br>Multilateral system with UNAIDS as a 'main actor' and 'pathfinder' (veiviser) and other multilateral institutions supporting within their areas of responsibility.<br>Country level emphasis on national AIDS programmes and a call for private sector and civil society to support these.<br>Establishment of several forums in Norway (Norad, MFA and cross-sectors) for increased focus and competence building on HIV/AIDS.<br>Brief references to HIV/AIDS in budgets for Tanzania and Malawi, not for Ethiopia. |
| 2002 | HIV/AIDS has become a main thematic priority (out of about eight priorities). All country programmes and thematic priorities shall now include measures to mitigate HIV/AIDS. Specific HIV/AIDS chapters in the budget supplement mainstreaming. Main priorities in budget:<br>Prevention and treatment is highlighted in the specific thematic approach while mitigation is more focused in the mainstreaming approach.<br>Increase in multilateral support.<br>More focus on bilateral cooperation, through support to national AIDS plans with a particular focus on districts and local communities.<br>Measures to increase competence in the region (Africa).<br>Norwegian public-private partnerships against AIDS will be promoted.<br>Continue prevention measures, support to women, youth and children (incl. PMTCT) will continue.<br>More focus on men's responsibility, including military forces.<br>Support to more accessible and affordable treatment.<br>The state budget seems to reflect a strategy choice, not explicitly stated elsewhere, that prevention and medical treatment shall be given priority in the specific thematic approach while mitigation is more focused in the mainstreaming approach.<br>HIV/AIDS are mentioned in budgets for Tanzania and Malawi, now as 'priorities' (as opposed to previous years). Ethiopia is not anymore a main partner country due to the war with Eritrea, but the regional approach to the Horn of Africa keeps main focus on Ethiopia and HIV/AIDS one of the thematic areas for support to Ethiopia. |

46 State budgets 1999-2006, documents referred to, media coverage (web search), Norad web site, various Norad and MFA documents and letters. See bibliography for details.

| Budget year | Main policy issues and priorities |
|---|---|
| 2003 | HIV/AIDS is still a main thematic priority. Stronger political leadership and strengthened alliances between state and civil society actors are highlighted. Heavy weight on prevention and (medical) treatment. Support to GFATM as a supplement to UNAIDS and other multilateral channels. Continued priority to HIV/AIDS in Malawi (close integrated with health) and Tanzania, and a stronger focus in Ethiopia. |
| 2004 | The document *Fighting Poverty Together, report no. 35 to the Parliament* (2003-2004), a general policy statement on Norwegian development aid are presented. The document becomes very influential during the rest of the evaluation period. It outlines a stronger Norwegian focus on national ownership and leadership, donor reform and coordination, better effectiveness and management of aid, and focus on the MDGs. Little direct references to HIV/AIDS but HIV/AIDS is relatively well mainstreamed.<br>In state budget, there is a general increase in priority to HIV/AIDS, in particular:<br>Participate in international efforts<br>Increase support to UNAIDS<br>Continue high support to GFATM<br>Increase support to IAVI<br>Increase support to IPM<br>Continue support to specific HIV/AIDS efforts through civil society and bilateral cooperation<br>Focus on integration of HIV/AIDS in various sectors in particular in Sub-Saharan Africa<br><br>The health personnel crisis are given more focus by the government in some public statements and reflected in a seminar (late 2004).<br>No major change in country priorities in Malawi and Tanzania. In Tanzania, HIV/AIDS support is specified as support to national plan, Haydom hospital, and mainstreaming. In Ethiopia HIV/AIDS is given stronger priority and linked to capacity building in public sector and 'work on local level'. |
| 2005 | No major shifts in policy. Priorities in budget:<br>Contribute to coordination of international efforts<br>Increased support to UNAIDS and UNFPA<br>Continued support to GFATM<br>Support WHO's work for medical treatment in poor countries<br>Increase support to IAVI and IPM<br>Increase specific HIV/AIDS measures in bilateral cooperation<br>Continue support to Civil society organisations<br>Integration of HIV/AIDS in various sectors, in particular SSA<br><br>At country level there is no change in stated priorities for Malawi. In Tanzania, the following is mentioned: medical treatment, support to mother/child and OVCs, support national plan for treatment. In Ethiopia HIV/AIDS is targeted through strengthen local organisations through UNFPA and UNICEF. |
| 2006 | No major shifts in policies in state budget. Priorities:<br>Increase support to UNAIDS, UNFPA and UNICEF<br>Double support to GFATM compared to previous year<br>Increase support for medical treatment in poor countries, through GFATM, WHO and in cooperation with the Clinton Foundation<br>Increase support to vaccine development and prevention for women<br>Increased focus on the health personnel crisis in Africa<br>Support African countries' research on HIV/AIDS, including Mandela Foundation<br><br>No major shifts in country priorities. In Malawi, there is increased focus on children and youth. In Ethiopia, HIV/AIDS support is specified as increased focus on women, capacity building in research institutions, and development of VCT services.<br><br>A new policy position on HIV/AIDS was presented in November 2006, which is believed to be influential after the period of evaluation. |

# Annex 4: Intervention Logic for Norwegian Responses to HIV/AIDS

**Norwegian support to HIV/AIDS Responses**



# Annex 5: Progress made against Indicators as defined by UNAIDS in the Three African Countries studied for the evaluation

*Table 1: Progress made against Indicators as defined by UNAIDS in Ethiopia*

| INDICATORS FOR GENERALISED EPIDEMIC AS SET OUT BY UNAIDS | PROGRESS MADE AGAINST THE INDICATORS | | | |
|---|---|---|---|---|
| | 2000 | | 2005 | |
| OUTCOME INDICATORS | F | M | F | M |
| -% of young women & men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV (target: 90% by 2005; 95% by 2010). | 39.2 | 64.8 | 41.1 | 58.2 |
| - % of young women and men age 15-24 who reject major misconceptions about HIV transmission or prevention, and who knows that a healthy looking person can transmit AIDS (target: 90% by 2005; 95% by 2010). | - | - | 32.7 | 45.7 |
| -% of young women & men age 15-24 who have had sex before the age of 15. | 16.1 | 4.4 | 15.8 | 1.7 |
| - % of young women & men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months. | - | - | 5.8 | 37.4 |
| - % of young women & men aged 15-24 reporting the use of condom the last time they had sex with a non-marital, non-cohabiting sexual partner. | 16.7 | 30.6 | 28.4 | 50.2 |
| ORPHANS SCHOOL ATTENDANCE | URBAN | | RURAL | |
| - Ratio of current school attendance among orphans to non-orphans, aged 10-14[47]. | 1:4 | | 1:6 | |
| - Ratio of current school attendance among total orphans aged 10-14 by location. | 9:10 | | 1:2 | |
| IMPACT INDICATORS | URBAN | | RURAL | |
| | 2002 | 2005 | 2002 | 2005 |
| -% of young women and men aged 15-24 who are HIV infected (target: 25% reduction in most-affected countries by 2005; 25% reduction globally by 2010)[48]. | 12.7 | 10.5 | 3.7 | 2.7 |
| - % of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy. | 2003 | 2004 | | |
| | 76.7 | 71.4 | | |
| -% of infants born to HIV infected mothers who are infected (target: 20 % reduction by 2005; 50 % reduction by 2010). | NA | | NA | |

*Table 2: Summary of progress towards outcomes and impact in Malawi*

| | | HIV/AIDS Management Plan (2003-2008) Mid Term Review | | UNAIDS Fact Sheet (June) | UNAIDS Update November |
|---|---|---|---|---|---|
| | 2001 | 2003-04 | 2005-06 | 2006 | 2007 |
| **OUTCOME INDICATORS** | | | | | |
| -% of young women & men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (target: 90% by 2005; 95% by 2010). | | Male 37%<br>Female 25% | Male 37%<br>Female 25% | | |
| -% of young women & men who have sex before the age of 15. | | | | 15% of women 14% of men | |

47 2004 Welfare Monitoring Survey.
48 Ethiopia Annual HIV/AIDS Monitoring & Evaluation Report (2005/06).

| | | HIV/AIDS Management Plan (2003-2008) Mid Term Review | | UNAIDS Fact Sheet (June) | UNAIDS Update November |
|---|---|---|---|---|---|
| - % of young women & men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months. | | Male 26%<br>Female 8% | Male 12%<br>Female ?% | | |
| - % of young women & men aged 15-24 reporting the use of condom the last time they had sex with a non-marital, non-cohabiting sexual partner. | | Male 47%<br>Female 30% | Male 46.8%<br>Female 35% | | |
| ORPHANS SCHOOL ATTENDANCE | | | | | |
| - Ratio of current school attendance among orphans to non-orphans, aged 10-14. | 0.94 (2001) | 0.97 (DHS 2004) | | | |
| IMPACT INDICATORS | | | | | |
| -% of young women and men aged 15-24 who are HIV infected (target: 25% reduction in most-affected countries by 2005; 25% reduction globally by 2010). | 24% urban<br>13% rural<br>11.4% Northern<br>9.9% Central<br>19.6% Southern | 14.2%<br>23% urban<br>12.4% rural | 14% (M&E)<br>12% (DHS)<br>21.6% urban<br>12.1% rural | | 12%<br>6.5% Northern<br>8.6% Central<br>16.5% Southern |
| - % of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy. | | 81% | | | |
| -% of infants born to HIV infected mothers who are infected (target: 20 % reduction by 2005; 50 % reduction by 2010). | | 21% | | | |

*Table 3: Progress towards key outcomes and impact indicators as defined by UNAIDS in Tanzania*

| | THIS | | TDHS | | | | UNAIDS[49] | |
|---|---|---|---|---|---|---|---|---|
| | 2003/04 | | 1999 | | 2004 | | 2005 | |
| **OUTCOME INDICATORS** | **F** | **M** | **F** | **M** | **F** | **M** | **F** | **M** |
| % of young women and men aged 15-24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (target: 90% by 2005; 95% by 2010). | | | 26 | 29 | 45 | 40 | | |
| % of young women and men who had sex before the age 15 years. | | | 15 | 20 | 12 | 9 | | |
| % of young women and men aged 15-24 years who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months. | | | - | - | - | - | | |
| % of young women and men aged 15-24 years reporting the use of condom the last time they had sex with a non-marital and non-cohabiting sexual partner. | | | 21 | 31 | 39 | 46 | | |
| ORPHANS SCHOOL ATTENDANCE | | | | | | | | |
| Ratio of current school attendance among orphans to non-orphans aged 10-14 years. | | | 1.03 | 0.90 | 1.0 | 0.98 | | |
| IMPACT INDICATORS | | | | | | | | |
| % of young women and men aged 15-24 years who are HIV infected (target 25% in most-affected countries by 2005; 25% reduction globally by 2010). | 4 | 3 | | | | | 3.8 | 2.8 |
| % of adults and children with HIV still alive 12 months after initiation with anti-retroviral therapy. | | | | | | | | |
| % of infants born to HIV infected mothers who are infected (target: 20% reduction by 2005; 50% reduction by 2010. | 25 | | | | | | | |

49 UNAIDS Fact sheet (December 2006).

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