Evaluation Department

Norad

Evaluation of Norwegian HIV/AIDS Responses

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Norad
Norwegian Agency for
Development Cooperation
P.O.Box 8034 Dep, NO-0030 Oslo
Ruseløkkveien 26, Oslo, Norway

Phone: +47 22 24 20 30
Fax: +47 22 24 20 31

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Submitted by ITAD
Munirat Ogunlayi, Woldemedhin Haile

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Acronyms

AA	Addis – Ababa
AASECMY	Addis – Ababa Evangelical Church Mekane Yesus
ABES	Alternative Basic Education Services
AIDS	Acquired Immune Deficiency Syndrome
ALNAP	Active Learning Network for Accountability and Performance in Humanitarian Action
ANC	Ante-natal Clinic
ANPPCAN	Association for Nationwide Prevention and Protection Against Child Abuse and Neglect
ART	Anti-retroviral Therapy
BCC	Behavioural Change Communication
BICDO	Birhan Integrated Community Development Organisation
CBOs	Community Based Organisations
CSOs	Civil Society Organisations
CSW	Commercial Sex Worker
DFID	Department for International Development
EA	Ethiopian AID
EC	Ethiopian Calendar
EDHS	Ethiopian Demographic Health Survey
EECMY	Ethiopian Evangelical Church Mekane Yesus
EGT	The Ethiopian Gemini Trust
EMSAP	Ethiopian Multi-sectoral AIDS Programme
FGAE	Family Guidance Association of Ethiopia
FGM	Female Genital Mutilation
FMOH	Federal Ministry of Health
FHATCO	Federal HIV/AIDS Prevention and Control Office
GEMC	Gondar Education Media Centre
GFATM	Global Fund ti fight HIV/AIDS, Tuberculosis & Malaria
GTZ	German Technical Cooperation
HAPCO	HIV/AIDS Prevention and Control Office
HCT	Home based Care and Treatment
HIV	Human Immuno deficiency Virus
IEC	Information, Education and Communication
IGA	Income Generating Activities
IRS	Immune Reconstitution Syndrome
ISAPSO	Integrated Service for AIDS Prevention and Support Organisation
MAP	Multi- Country AIDS Programme
M & E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MFA	Ministry of Foreign Affairs
MOH	Federal Ministry of Health
MSDAE	Medico Socio Development Assistance for Ethiopia
NACP	National AIDS Control Programme
NACS	National HIV/AIDS Council Secretariat
NCA	Norwegian Church Aid
NEP+	Network of People Living with HIV
NEWA	Network of Ethiopian Women's Association

NGOs	Non Governmental Organisations
NLM	Norwegian Lutheran Mission
NMS	Norwegian Missionary Societies
Norad	Norwegian Agency for Development Cooperation
ODA	Official Development Assistance
OECD	Organisation for Economic Development Cooperation
OSSA	Organisation for Social Services for Ethiopia
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Program for AIDS Relief
PLWHA	Persons Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
SAPCAN	Strengthening AIDS Prevention & Control Activities of NGOs
SCN (E)	Save the Children Norway, Ethiopia
Sida	Swedish International Development Agency
SNNPR	Southern Nations and Nationalities Peoples Region
SPHPE	Single Point HIV Prevalence Estimates
SPM	Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response
SRH	Sexual Reproductive Health
STIs	Sexually Transmitted Infections
SYGE	Save Your Generation Ethiopia
TOC	Table of Content
UN	United Nations
UNAIDS	Joint United Nations on HIV & AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling & Testing
WACT	Women and Children Tracer
WHO	World Health Organisation

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Our special thanks to Norwegian Church Aid, Ethiopia for the support they provided especially for the conduct of field visits and to UNFPA and UNICEF for organising the stakeholders' workshop we held with their partners.

This report consists of executive summary and six chapters. Chapter one deals with the introduction, chapter two deals with the Epidemic in Ethiopia. Norwegian support to HIV/AIDS is documented in chapter three and chapter four covers delivery of outputs. Chapter five deals with progress towards key outcomes and factors affecting and the last chapter covers conclusions, lessons learnt and recommendations.

Executive Summary

Introduction

The Norwegian Government has provided support to the HIV and AIDS response since 1986 through various institutions, including country level support to government and civil society organisations, to combat the epidemic. The evaluation of the responses during the period (2000–2006) is being conducted to assess the extent to which Norwegian support has contributed to the response globally, regionally and within partner countries. Three African countries - Ethiopia, Malawi and Tanzania - that have benefited from Norwegian support were selected for the evaluation, and the assessment in Ethiopia was conducted between 18th August and 8th September 2007 by an independent team of consultants from ITAD (UK). Norway is one of the bilateral donors contributing to national HIV/AIDS responses in Ethiopia. Norwegian inputs during the period evaluated comprised financial support through multiple channels including global instruments such as the World Bank MAP[1], GFATM[2], multilaterals (UNFPA and UNICEF), support to research and NGOs. Technical support has also been provided to guide and ensure effective targeting of programme interventions.

Evaluation Objectives

The five key evaluation objectives reflect the evaluation purpose, and they are:

- 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

Evaluation Approach and Methodology

Objective-oriented and participant-oriented approaches were adopted for the evaluation, and both resulted in utilization of various methods, including document reviews, Focus Group Discussions (FGD), structured questionnaire, interviews and field visits. The selection of tools included use of an evaluation framework, timeline, force-field analysis, stakeholder analysis, and most significant change technique. The tools helped structure discussions and elicited information from key stakeholders namely - the government (FHAPCO[3], line ministries), multi-lateral institutions (UNFPA, UNICEF, UNAIDS, World Bank, WHO), bilateral agencies (The Netherlands, DFID, GTZ, SIDA, USAID - PEPFAR), Norwegian NGOs (SCN, NCA) and Norway's partner such as PLAN International and implementing NGOs supported by Norwegian resources (18 NGOs and FBOs[4]), service providers and beneficiaries.

The evaluation faced the risk of inadequate provision of information due to non-availability of the HIV focal person working in the embassy during the period evaluated. An additional challenge was the issue of attribution, since Norway is one of many donors supporting HIV/AIDS responses in the country. These challenges were managed through review of relevant documents and consultation with stakeholders who were knowledgeable and experienced with Norwegian support during the period. The evaluation team was able to elicit information for analysis to respond to the key evaluation questions and objectives.

1 MAP - Multi-Country AIDS Programme
2 GFATM - The Global Fund for AIDS, Tuberculosis and Malaria
3 FHAPCO - Federal HIV/AIDS Prevention and Control Programme Office
4 ANPPCAN, PRO-PRIDE, Mary-Joy AID, OSSA, New Life Community Organization, EECMY/DASSC, ISAPSO, FGAE, EVMPA, BICDO, MSDAE, EGT, SYGE, EA, NEWA, Gemini Trust, AASECMY, & Ethiopian Aid).

Evaluation Findings

Progress towards key outcomes related to the national HIV/AIDS response

Two contrasting estimates of HIV prevalence were in use in Ethiopia – 1.4% (EDHS[5], 2005) and 3.5% (ANC[6], 2005) - and efforts have been made to come up with Single Point HIV Prevalence Estimates (SPHPE) of 2.1%. All the estimates revealed that prevalence is higher amongst females, compared to males, irrespective of the location and various factors were identified as fuelling the epidemic relating to socio-cultural, economic, biological, sexual, political and gender aspects.

The country reported some decline in prevalence based on the results of surveillances conducted from 2002 – 2005, but the 2005/06 Annual Monitoring and Evaluation Report noted the limitation of the reliability of the data, giving three reasons: the need for more data points for trend analysis; limited utility in the interpretation of data from three time points for temporal changes in prevalence; and variation in the number of sites at the various periods of conduct of the surveillances.

The data available from EDHS 2000 and 2005 revealed an improvement in knowledge of HIV prevention and rejection of misconceptions, especially amongst females – 41.1% in 2005 as compared to 39.2% in 2000. But when compared with the target set by UNAIDS, more men (58.2% and 45.7% for prevention and rejection of misconceptions respectively) were more knowledgeable in these areas compared to women (41.1% - prevention and 32.7% - rejection of misconception) in the age group 15 – 24 years.

The engagement of international partners including Norway, in collaboration with national partners to establish and influence policies on HIV/AIDS yielded results in the country. Examples include the implementation of the "Three Ones", "3 by 5 initiative", and a functioning UNAIDS secretariat that takes responsibility for facilitating provision of technical assistance and leadership capacity building for HAPCOs, etc.

With the "3 by 5 initiative" and Global Fund for HIV/AIDS, Tuberculosis & Malaria (GFATM) initiatives in place and functioning in the country, the number of Persons Living With HIV/AIDS (PLWHA) on treatment has increased. At the end of 2006, 63% of 286,258 persons who need ART[7] were covered. Despite this progress, PLWHA stated lack of food and adequate nutrition as a major challenge facing them.

Assess key Norwegian contributions (outputs) to outcomes

Norway is a small bilateral donor to Ethiopia. OECD DAC official statistics revealed that annual disbursement increase from $23.6m in 2000 to $41.8m in 2006 except for year 2001 which recorded annual disbursement of $16.3m. Norway's resources to Ethiopia were channelled through various agencies. The channels include global instruments (World Bank MAP and GFATM), the multilaterals (UNFPA and UNICEF), research institute and CSOs[8]. Analysis of the intervention logic 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 in the country.

There was no formal HIV/AIDS strategy developed for Norwegian support to Ethiopia, but the *de facto* Norwegian strategy in Ethiopia can be characterised as having the aim of engaging widely across prevention, care and impact mitigation with primary support through multilateral agencies, secondary support through NGOs and provision of limited technical support in the country.

Norwegian support has been effective in contributing to the control of the epidemic, while the technical assistance provided (through multilaterals, research institutes and NGOs) has contributed to the capacity development of stakeholders in the country.

5 EDHS – Ethiopia Demographic Health Survey
6 ANC - Antenatal Clinic
7 ART – Anti-retroviral treatment
8 CSOs – Civil Society Organisations

HIV mainstreaming in the country was weak generally as confirmed by a survey conducted and reported by HIV/AIDS Prevention and Control Office (HAPCO[9]), although Norwegian support to UNICEF and UNFPA had contributed to HIV mainstreaming in the education and youth sectors. Wider implementation was still a major challenge. There was no HIV mainstreaming into other two priority areas of human rights, governance and peace and stability supported by Norway during the period because HIV/AIDS was also a priority area for interventions in the country.

Gender mainstreaming was stressed in all Norwegian supported HIV interventions in the country and recommendations of various reviews conducted, especially for UNICEF and UNFPA, were implemented. The government has developed a gender mainstreaming policy and strategy, but this has not been effectively implemented.

Factors affecting the outcomes (substantive influences)
Aside from the factors fuelling the epidemic in the country, there were other hindering factors affecting the achievement of key behaviour outcomes. Despite Norwegian supported interventions addressing some of these factors, coupled with the efforts of other donors, there are still gaps in addressing these underlying factors effectively.

There was lack of connectivity in Norwegian supported interventions which resulted in loss of synergy and sharing of best practices that could widen coverage and maximise impact to contribute to the achievement of key outcomes.

Monitoring and Evaluation (M & E) system is in place but it is weak and ineffectively coordinated, hence fails to ascertain the status of interventions and identify gaps in the country.

Norwegian support was greater in the area of youth interventions, support to orphans and home based care. There are still gaps in addressing PMTCT[10], health personnel and strengthening the health system despite the fact that these were documented and referenced in the Norwegian policy statement and priorities.

The Civil Society Networks in the country, including networks of PLWHA were formed during the period evaluated but lack capacity to ensure effective management and coordination of coalitions. This aspect is essential in relation to the strengthening of civil society organisations to engage actively in national response at policy level and also enhance partnership in management of interventions.

Assess Norway's partnership strategy
The nature of the partnership that stakeholders had with Norway was that of joint working, based on international agreements and development of memorandum of understanding (MOU).

There was no direct HIV/AIDS related partnership with the government of Ethiopia. The current choice of partners was based on the partners mandate and comparative advantages, especially the UN agencies. Further consultation with Norad will be required to explore how Norway has taken into account the strengths and weaknesses of these partners.

Lessons Learnt

Some lessons drawn from various projects implemented with Norwegian support during the period include:

- Recognition of the indispensable roles of grassroot actors especially the Anti-AIDS Clubs; the commitment and practical support of community members can be effective in ensuring ownership.
- Location of programmes and interventions in communities such as markets and schools (Alternate Basic Education Services) allows the needy community greater access to such services and reduces vulnerability.

9 HAPCO, 2007 Annual Report
10 PMTCT – Prevention of Mother to Child Transmission.

- Providing alternatives and mainstreaming economic empowerment interventions to improve livelihoods of the beneficiaries could go a long way to reduce risky behaviours, vulnerability to HIV infection and dependency.
- Partnerships based on mutual understanding can encourage accountability, responsibility and transparency.
- The lack of HIV/AIDS focal person limited full engagement of Norway in joint planning, management, monitoring and evaluation of activities.

Recommendations

Continuity of support through multiple channels - Engagement of Norway through multiple channels using the global instruments, multilaterals and the Norwegian NGOs was found to be effective in implementing some good practices that contributed to the progress made in achievement of the key behaviour outcomes and impact indicators. This effort should continue and expansion of these projects should be considered with clear targets and indicators for monitoring.

Support provision of technical assistance to HIV mainstreaming in key sectors - There is need for Norway to engage with other partners to ensure provision of technical assistance for effective HIV mainstreaming across sectors in the country. This will ensure effective deployment and utilisation of resources from World Bank MAP 2 and other sources. In addition is the need to consider capacity required for effective HIV mainstreaming into the current Norwegian priorities in the country that focus on Human Rights, Governance & Democracy, Peace & Stability and Natural Resource Management.

Focus on weak connectivity of interventions - The weak connections of activities supported by Norway in the country must be addressed. A forum should be created where the stakeholders (implementing partners) involved are able to plan collectively and interact with one another to share lessons and best practices towards the achievement of key behaviour outcomes. This strategy will enhance effective utilisation and coverage of interventions, especially with the forthcoming Norway supported joint UNFPA and UNICEF programme.

Norway to engage with government & other donors - Norway should engage more with the government (HAPCO) and other donors to add their voice to shaping of the responses at country level. This will enhance Norwegians' recognition in relation to their contributions to the control of the epidemic. Appointing a focal person in the embassy will ensure effective engagement and also take on the responsibility of coordinating the institutions involved in utilising Norwegian resources for HIV/AIDS.

Norway to work with other partners to address weak M & E systems – UNAIDS is providing technical assistance to FHAPCO to address weak M & E systems in the country, Norway should work with other partners in this regard as this will add significant value in ascertaining the status of response and identify gaps for subsequent interventions.

Development of Partnership Strategies and Framework for Operations – Clear 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. The strategy should also include the partnership principles and such principles should be adopted for the development of indicative framework to guide measuring of success in the utilisation of resources, management of projects and initiatives. Such strategies should be considered for adoption at all levels and channels utilising Norwegian resources for HIV/AIDS interventions.

Development of HIV/AIDS Country Programme Strategy – HIV/AIDS country programme strategy should be designed and developed with clear indicative logical frameworks. This should be done in consultation with stakeholders in order to address the needs of the country and fill gaps especially in areas where other development partners are not engaged and documented in Norway's 2006 HIV/AIDS Policy Position Paper. In addition, Norway could explore engagement of consortia based on expertise and comparative advantages to fulfil needs for the implementation of the programmes

Strengthening of Civil Society Networks – Norwegian support could make a difference in strengthening the networks of civil society including that of PLWHA[11], in order to enhance their representation and voices in policy influencing and be actively involved in decisions that will enhance their participation in the national response.

11 PLWHA – Persons living with HIV/AIDS

1 Introduction

The Norwegian Government has provided support to various initiatives to combat the HIV and AIDS epidemic since 1986 through various implementing institutions including country level support to government and civil society organisations. A number of reviews and studies have been conducted to monitor the utilisation of the funds and an external evaluation commissioned by the Ministry of Foreign Affairs (MFA) was undertaken in 1997 covering the five year period of 1990 – 1995. Since then, there have been significant changes and critical developments in the response to HIV/AIDS and Norway as a major bilateral donor has supported new structures, ideas and initiatives. Norway has also been an active agent in international policy development and technical support to multilateral institutions, in particular in establishing UNAIDS.

Following the announcement of the US$ 59 million World Bank loan to Ethiopia for HIV/AIDS programmes, the Embassy of Norway hosted a meeting with participants from UNAIDS, NGOs and the National AIDS Council in Addis Ababa in September 2000. This meeting was organized to assist the Embassy of Norway in planning its support to the national response towards the HIV/AIDS epidemic in Ethiopia. Presentations were given by attending organizations on ways in which Norway might be able to help them and others in the prevention and control of HIV/AIDS in Ethiopia. Participants were informed that most of Norway's support would be provided through the Ethiopian Multi-Sectoral AIDS Program (EMSAP) and that Norway would be happy to complement the Government's HIV/AIDS activities in the country through non-government initiatives. Since then, Norway has provided support to a number of multilateral institutions and Non-Governmental Organizations (NGOs) to combat the epidemic in the country.

To assess the extent to which Norwegian support has contributed to the response in Ethiopia, an evaluation of Norwegian responses to HIV and AIDS was conducted between August and September 2007. The main purpose of this 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 in Ethiopia. The specific focus of the evaluation is to assess Norway's role and contribution in influencing key outcomes[12] of the national HIV/AIDS responses in Ethiopia.

1.1 Evaluation Objectives

The five key evaluation objectives reflect the evaluation purpose, they are:

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.

1.2 Scope of the Evaluation

Ethiopia was the first of the three African countries where the Evaluation of the Norwegian HIV/AIDS responses is being conducted. The other two African countries to be evaluated are Malawi and Tanzania. The evaluation focussed on the period 2000 – 2006 and as it takes into consideration the rapid changes that have taken place in the international and national HIV/AIDS responses during this period, it is essentially evaluating a moving target.

12 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).

The conduct of the evaluation in Ethiopia was broad based looking critically into the various types of Norwegian channels and instruments that have supported national HIV/AIDS responses in the country during the evaluation period. The various channels include the multilateral agencies, global instruments and NGOs (Norwegian NGOs, INGOs and local NGOs) who were all consulted as part of the evaluation process.

The evaluation was based on the review of available reports and evaluations, as well as interviews with stakeholders in the country. It assessed the direct HIV/AIDS activities supported by Norway especially through the NGOs and the multilateral agencies, the contributions of main multilateral agencies and global actors and how their influences have contributed to the achievement of key outcomes in Ethiopia, and the extent to which HIV mainstreaming has been achieved in the country and how it has contributed to the achievement of the key outcomes.

The evaluation also reviewed Norwegian inputs such as funding, influence of policy dialogue, provision of technical guidance and the linkage between national response and the achievement of the key outcomes as defined by UNAIDS for generalised epidemic.

1.3 Evaluation Approaches and Methods

1.3.1 Evaluation approaches

Combined approaches were adopted for the evaluation:

- Objective Oriented Approach: ensured we set clear goals and objectives for the evaluation and the review of what has been supported by Norway in Ethiopia in relation to the key outcomes and the relevance of the support.
- Participant Oriented Approach: ensured we took participatory approach to the evaluation process and incorporated information from the participating respondents in answering the questions which are helpful for programme improvement purposes.

The two approaches were adopted considering the purpose of the evaluation and fulfilment of the evaluation objectives. In addition, they guided selection and choice of evaluation methods. While the approaches are results oriented thereby focusing on impacts, outcomes and outputs of Norwegian responses to HIV/AIDS rather than the inputs and the activities we recognise that the inputs informed the various activities conducted which resulted in the outputs and guided us in drawing inferences about the outcomes and possible impacts.

1.3.2 Evaluation methods

Both quantitative and qualitative evaluation methods were adopted for this evaluation. The methodologies and the tools were selected with consideration for OECD and ALNAP[13] criteria and to ensure all aspects of the evaluation questions were addressed.

a. *Document Reviews* – Documents were collected from Norad, the Norwegian Embassy in Ethiopia, government institutions, country level multi-lateral institutions, Norwegian NGOs, indigenous NGOs, local implementing institutions and beneficiaries. Secondary data were synthesised for analysis to measure results at input and output levels, contributions to the outcomes and changes in the key outcomes indicators during the period evaluated as defined by UNAIDS and in relation to the policy and guidelines issued by Norwegian government.
b. *Key Informant Interviews* – Interview guides were developed based on the evaluation framework with a focus on stakeholders. The guides enabled the evaluation team to elicit information in response to the questions and to clarify issues or areas of concerns as required.
c. *Focus Group Discussions* – Group discussions used mostly with implementing institutions and beneficiaries. Questions answered within a group of stakeholders provided useful information for the evaluation exercise whilst also maintaining consistency with the overall evaluation approach.
d. *Structured Questionnaire* – A more structured approach was used to elicit information specifically on partnership strategy, the effectiveness of the partnership and ways of improving future engagement. The tool maintained objectivity and respondents were given an opportunity to explore the issue further and come up with recommendations for improving future collaboration.

13 OECD – Organisation for Economic Development Cooperation & ALNAP – Active Learning Network for Accountability and Performance in Humanitarian Action.

1.3.3 Evaluation tools

a. *Evaluation Framework* – The framework provided the basic foundation for the evaluation, incorporating all the evaluation objectives, detailing how each of the objectives would be met and which information sources and indicators would be used to answer the questions.
b. *Timeline Tool* – The timeline generated information on various actions and interventions on HIV/AIDS that took place between the evaluation period (2000 – 2006). Data collected from this source was used for the analysis of the various interventions and to deduce information on how they have contributed to the achievement of the key outcomes.
c. *Force-field Analysis* – Used among various stakeholders in the country to identify forces/ factors that enhanced or held back effective utilisation of Norwegian resources to achieve key outcomes. The discussion amongst participants using this tool was essential in guiding recommendations and interventions to counter factors holding back achievement of key outcomes, especially in relation to future engagement.
d. *Stakeholder Analysis* – Stakeholders used this tool to categorise their influence, importance and interest in utilising resources to achieve the key outcomes. The process was useful in guiding decisions on future engagement of Norway in the country.
e. *Field Visits* – Field visits were conducted to implementing organisations and beneficiaries in Addis Ababa and Amhara regions. They provided an opportunity to meet primary beneficiaries, validate information on the impact of the various interventions and get their perspective on the effectiveness of Norwegian contributions and what improvements could be made. It also meant that the team could verify information from the document review and consultations with other stakeholders.
f. *Most Significant Change Technique* – Stakeholders examined the nature of change that has taken place as a result of the various interventions. It highlighted good examples of changes that had happened, factors that enabled successful change to be accomplished, barriers that were encountered and how such barriers were addressed. Aside the fact that this technique enabled us to assess the impact of the interventions on the beneficiaries, it also guided us in the selection of projects to be visited.

The above methodologies and tools were used to obtain information from key stakeholders which include the government (FHAPCO, line ministries), multi-lateral institutions (UNFPA, UNICEF, UNAIDS, World Bank, WHO), Bilateral agencies (The Netherlands, DFID, GTZ, SIDA, USAID - PEPFAR), Norwegian NGOs (SCN, NCA, PLAN), implementing NGOs supported by Norwegian resources (18 NGOs & FBO[14]s), PLWHA, service providers and beneficiaries (16 different groups – youths clubs, girls clubs, peer service providers, Orphans clubs, PLWHA, Positive Women and individuals mostly in rural areas and sub-cities).

The evaluation was faced with the possible risk of inadequate provision of information due to non-availability of HIV focal person working in the embassy during the period evaluated and challenge of attribution since Norway is one of the donors supporting HIV/AIDS responses in the country. In addition, there was a lack of data on some of the key behaviour outcomes in Ethiopian Demographic Health Survey (EDHS) 2000 which made comparative analysis impossible with the available data in 2005 EDHS, thus preventing a confirmatory status of progress made by the country in these areas. The risk and the challenges were managed through review of relevant documents and consultation with stakeholders that were knowledgeable and experienced in Norwegian supports during the period. These enabled us to elicit information for analysis to respond to the key evaluation questions and objectives.

1.3.4 Reliability and validity

The tools and methods were utilised to ensure consistency that would enable us to draw evidence based conclusions. The reliability of the evaluation was considered in terms of equivalence and consistency. The equivalence reliability was determined by relating data collected to progress made by the country in the key outcome areas in relation to the key outcome and impact indicators defined by UNAIDS for generalised epidemic. The tools also enabled us to assess the consistency of information from all quarters consulted and the contributions of Norwegian support.

14 ANPPCAN, PRO-PRIDE, Mary-Joy AID, OSSA, New Life Community Organization, EECMY/DASSC, ISAPSO, FGAE, EVMPA, BICDO, MSDAE, EGT, SYGE, EA, NEWA, Gemini Trust, AASECMY, & Ethiopian Aid).

The evaluation framework served as springboard for the tools utilised. It guided us to select tools for specific evaluation objectives and to be focussed in critically looking at issues that we were to assess.

In terms of validity, the methods and the tools utilised enabled us to gather data for analysis and to draw inferences with regard to the progress the country is making in achieving the key and impact outcomes as set out by UNAIDS for generalised epidemic, and the extent to which Norway contributed to HIV/AIDS response in the country. In addition, cross referencing of information was done as part of the evaluation process especially where respondents informed us that certain results have been achieved as a direct result of Norwegian support for the implementation of their programmes.

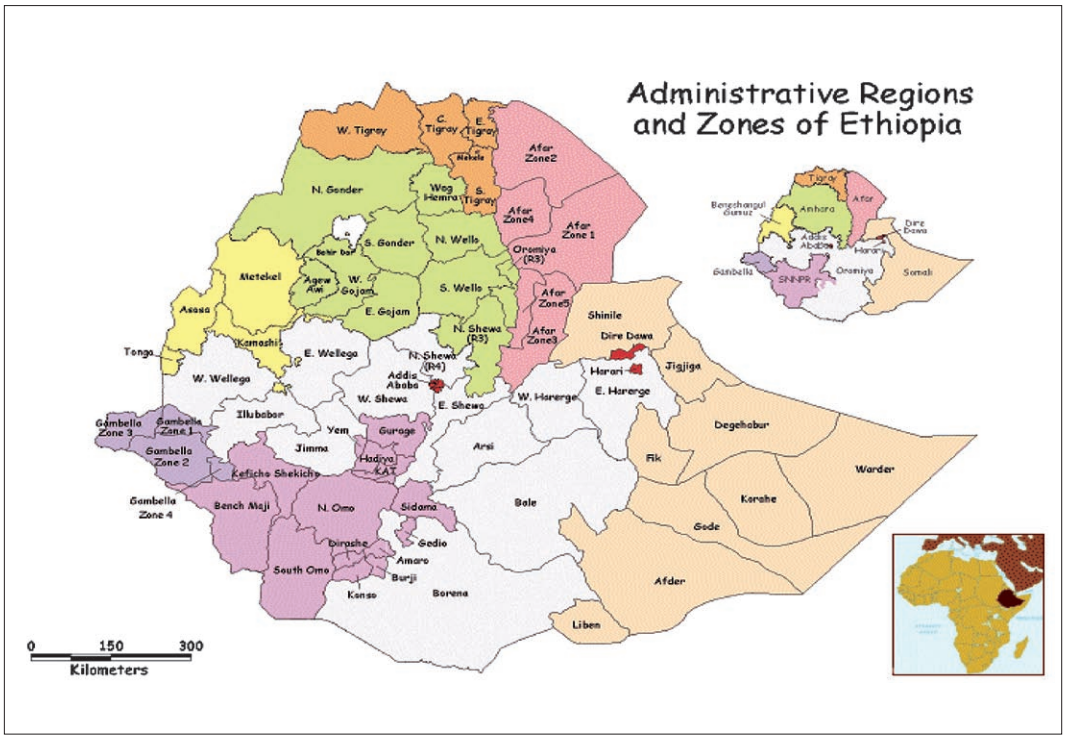
2 The Epidemic in Ethiopia

This chapter provides a brief outline on the setting of Ethiopia, the HIV/AIDS epidemic in the country, factors fuelling the epidemic and an overview of the national response. This chapter leads us to address the evaluation questions 1 and 2 that covered the assessment of progress towards key behaviour outcomes in the national HIV/AIDS responses and the factors affecting.

2.1 The Setting of Ethiopia

Ethiopia covers an area of about 1.1million square kilometres between latitudes 30 and 150 north and longitude 330 and 480 East, in the Horn of Africa, and is bordered by Djibouti, Eritrea, Kenya, Somalia and Sudan. The country is divided into 11 administrative regions, 68 zones, 654 Woredas (districts), and over 15,000 Kebeles (the smallest administrative units). With an estimated population of 76 million inhabitants, it has the second largest population in Sub-Saharan Africa, of which over 80% live in rural areas.

Fig. 1: Map of Ethiopia showing the Administrative Regions & the Zones



The country's economy is mainly agrarian where agriculture accounts for more than half of the Gross Domestic Product (GDP), and employs about 80% of the population (CSA, 2005). The population of Ethiopia is estimated to increase at an annual growth rate of 2.6%[15]. The age composition of Ethiopia's population is significantly dominated by youth Forty six percent of the total population are in the under 15 – age group, and with a further 30% between 15 – 24 years, the median age of the population is 17 years old..

There are more than 80 ethnic groups in the country each with their own distinct culture and language. The country is among the least developed in the world, and HIV/AIDS epidemic has further compounded the poor socio-economic status of the country in the last two decades.

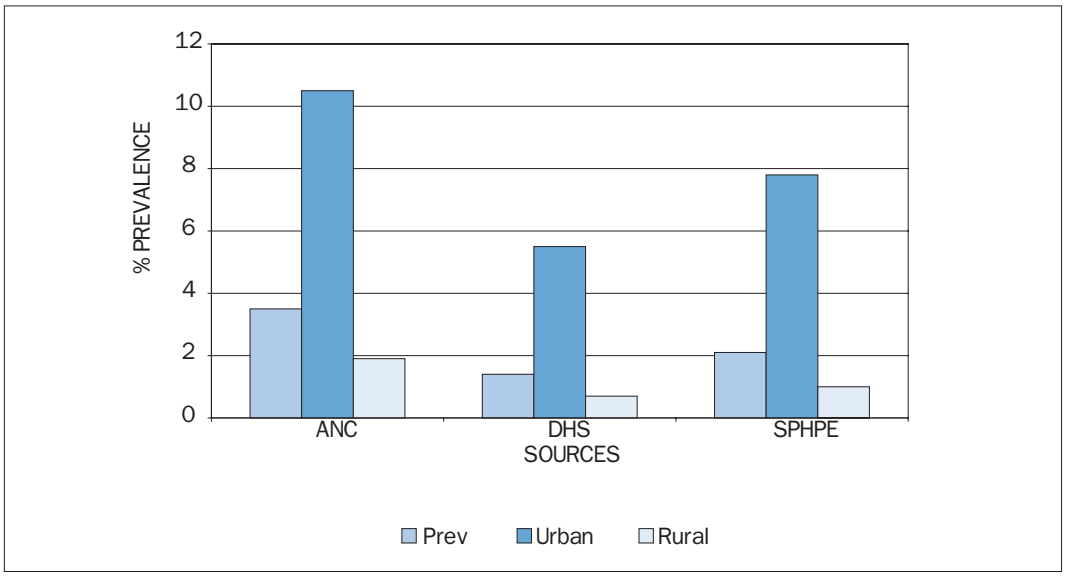
15 UNFPA documented Project Performances and good practices of UNFPA/NORAD SRH & HIV/AIDS Prevention Initiative (May, 2007).

2.2 HIV/AIDS Epidemic(s) in Ethiopia

HIV was first detected in Ethiopia in stored sera collected in 1984 and the first two AIDS cases were reported in 1986. Since then HIV/AIDS has become the biggest public health and developmental problem facing the country and was declared an emergency in 2002 by the Ethiopian government.

According to the Federal Ministry of Health (MOH), at the end of 2005 a total of 1.3 million adults and children were living with HIV in Ethiopia. In that year alone, there were an estimated 130,000 new HIV infections (more than 350 per day). This included 30,000 HIV positive births, and 135,000 (almost 370 per day) AIDS deaths (including 21,000 children aged under 15). Life expectancy in Ethiopia is falling as a result of the epidemic and is expected to drop from 59 to 50 years by 2010. The country also has one of the largest populations of children orphaned by AIDS in sub-Saharan Africa which is currently estimated at 775,000. AIDS has become the leading cause of mortality in the 15 – 49 age group, accounting for an estimated 43% of all adult deaths[16].

Fig. 2: Hiv prevalence 2005



Two contrasting estimates of HIV prevalence are currently in use, the 2005 ANC surveillance and the nationwide 2005 Demographic Health Survey (DHS). The 2005 DHS revealed a prevalence of 1.4% among the general adult population (15 – 49 year olds), 5.5% for urban and 0.7% for rural with prevalence rates among females twice that of males: 1.9% and 0.9% respectively.

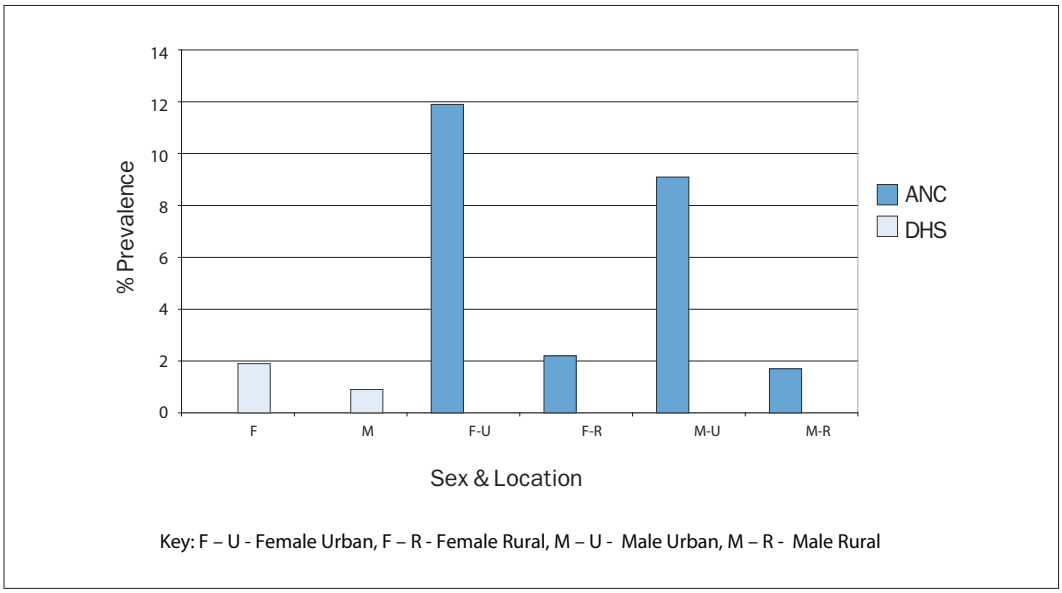
National data generated from the ANC surveillance revealed higher estimates with HIV prevalence rates of 3.5%; 10.5% for urban (9.1% among males and 11.9% among females) and 1.9% for rural (1.7% among males and 2.2% among females) (FMOH/HAPCO, 2006).

Both exercises were adopted by the implementing entities and the national authorities in Ethiopia because of the unique context of each exercise's methodological aims, assumptions and limitations (MOH, 2007). Based on this, the Federal HIV/AIDS Prevention and Control Office (FHAPCO) initiated a task force to conduct intensive technical analyses and consultations to achieve a technical consensus using the best available global methodologies and expertise in close consultation with all national and international partners. This effort resulted in calculated "Single Point HIV Prevalence Estimates (SPHPE)" which almost came up with average value from prevalence results recorded from the two sources - EDHS (2005) and ANC Surveillance (2005).

The breakdown of the HIV prevalence from ANC and EDHS according to gender is presented in fig.3 above, and data from the ANC surveillance provided further information according to location. It is clear from fig 3 that both sources revealed higher prevalence amongst females[17].

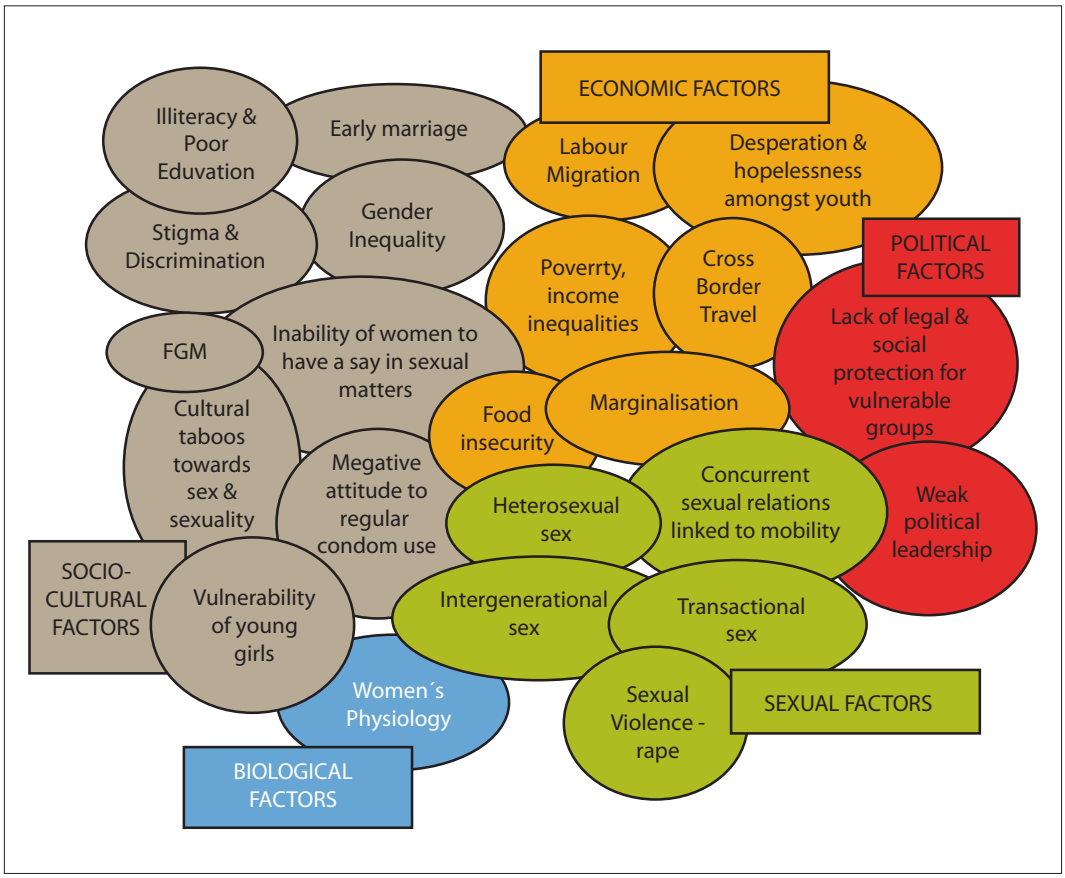
16 2005/06 Annual HIV/AIDS Monitoring & Evaluation Report Ethiopia.
17 Interventions supported by Norway at this period were reviewed to assess how they impact on gender related issues and the feminization of the epidemic in Ethiopia.

Fig. 3: 2005 HIV Prevalence by Gender



2.3 Factors Fuelling the Epidemic in Ethiopia

Fig. 4: Factors Fuelling the Epidemic in Ethiopia



Source: Information from Consultation & Domestic Documents

Figure 4 above illustrates the interwoven factors fuelling the epidemic which vary from region to region. These factors have been identified as part of formative assessments for Behavioral Change Communication (BCC) interventions. In addition, the BCC framework which was produced in 2004 also documented these factors. Moreover, they are related to the outcome of the prevalence in relation to the feminization of the epidemic in the country and have further confirmed the justification for a higher prevalence rate amongst women irrespective of the location.

2.4 An Overview of National Response to the HIV/AIDS Epidemic in Ethiopia.

A National HIV/AIDS taskforce was established in 1985 under the Federal Ministry of Health (MOH). In 1987 the National AIDS Control Program (NACP) was set up as a Department in the MOH responsible for directing and coordinating the implementation of the AIDS Control Programme. HIV/AIDS surveillance activities began in 1989. Two medium-term HIV/AIDS prevention & control plans were designed and implemented in 1989 and 1996 respectively with emphasis on Information, Education and Communication (IEC), condom promotion, surveillance, patient care and the expansion of HIV screening laboratories.

The HIV/AIDS Policy was formulated by MOH and adopted by the Council of Ministers in 1998. The policy supplemented several policies such as the Health policy and created an enabling environment for HIV/AIDS prevention and control. The HIV/AIDS Prevention and Control Office (HAPCO) was established in 2002 after 2 years of functioning as the National HIV/AIDS Council Secretariat (NACS). It had developed and implemented a five year (2000-2004) national strategic framework as part of the national response to HIV/AIDS. It focused on reducing the transmission of HIV and associated morbidity and mortality, and its impact on individuals, families and the society at large. The strategy was built on four issues: multi-sectoralism, participation, leadership and efficient management including adequate monitoring and evaluation.

The strategic plan for the succeeding four years (2005-2008), Strategic Plan for Intensifying Multi-Sectoral HIV/AIDS Response (SPM) was developed to intensify the multi-sectoral response to HIV/AIDS for the period. The SPM identified six strategic issues: capacity building, community mobilization and empowerment, integration of HIV/AIDS activities with health programmes, leadership and mainstreaming, coordination and networking, focus on special target groups and creating one monitoring and evaluation system.

Moreover, restructuring of the implementation and coordination mechanisms was done whereby the MOH has started to spearhead the implementation and coordination of the national programs. Encouraging achievements were reported to be seen within the last one and half years of the five years strategic plan (2007 HAPCO report). These include training and deployment of health extension workers implementing the health extension package, the construction and furnishing of various health institutions especially in rural areas, the massive scale-up of ART, HCT and PMTCT services and the significant involvement of communities in the provision of IEC/BCC, social care and support and other activities. This progress was reported to be due to commitment of government and development partners in the country. However, despite the fact that the country has SPM, there is a limited mainstreaming effort across sectors with the exception of the health sector where there have been more active interventions due to the availability of the GFATM and PEPFAR resources.

Summary of key points about the epidemic in Ethiopia:

- Data are problematic for absolute levels of prevalence but the feminisation of the epidemic in Ethiopia is very clear.
- Ethiopia has one of the largest populations of children orphaned by AIDS in Sub-Saharan Africa.
- Life expectancy in the country is falling as a result of AIDS and is expected to drop to 50 years by 2010.
- Various factors have been identified for fuelling of the epidemic in the country and these factors are socio-culturally, economically, biologically, sexually and politically related.
- The national response has been structured through an evolving institutional framework. Currently a HIV/AIDS Prevention and Control Office (HAPCO) under the chairmanship of the Minister for Health, has the lead coordinating role for the current 4-year strategic plan.

3 Norwegian Support to HIV/AIDS

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 changes in priorities during the period. 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.

An internal action plan for Norad's intensified efforts to combat HIV/AIDS in 2001, reflected the policy positions and seems to have been influential in Norad in the following years, with HIV/AIDS becoming a main thematic priority. In 2002, the focus was on prevention and treatment and using the mainstreaming approach for impact mitigation with measures to increase competence in Africa. The prevention measures were to continue to support women, youth and children (including PMTCT), and accessibility and affordability of treatment was of paramount importance. 2003 to 2006 focussed more on increase support to the multilaterals and the global instruments. (See annex 4 for details).

A new policy position paper was developed in November 2006 which reflects some changes in Norwegian aid and international policies during the period but it has limited relevance for the evaluation as it was published just before the end of the evaluation period. A range of Norwegian contributions in terms of provision of funds and technical assistance were channelled through multilateral agencies, global instruments such as the GFATM and NGOs to tackle the epidemic. Hence, the evaluation study looked critically at various engagements and utilization of these resources and achievements in terms of contributions to the outcomes and impact indicators as defined by UNAIDS for generalised epidemic.

3.1 Norwegian Engagement in Ethiopia

Norway is one of the bilateral donors contributing to HIV/AIDS responses in the country and Norwegian engagement at country level in HIV/AIDS responses started as far back as 1988 when no one was talking publicly about the infection[18]. The support at that time was provided by the Norwegian Faith Based institutions. Formal engagement by the Norway embassy in Ethiopia was intensified from year 2000 due to the alarming rate of the infection in Ethiopia and the interest of the Head of Development Cooperation in curtailing the epidemic. This period also coincided with the development of HIV policy position paper to guide Norwegian participation in an intensified effort to combat HIV and AIDS and also followed the approval of the World Bank MAP 1 (Muliti-Country AIDS Programme) for which Norway is a donor and aimed at addressing four pressing needs:

i. Strong political and government commitment to respond to HIV
ii. Create a conducive institutional environment with adequate resources to enable successful HIV/AIDS interventions to be scaled up to a national level
iii. Local response – by increasing community participation in and ownership of HIV/AIDS interventions through provision of financial resources and capacity building
iv. Move to a multi-sectoral approach in which all government sectors are appropriately involved, with improved coordination at national level and decentralisation through sub-national government structures.

Based on the above, the mandate for dialogue was presented and approved in 2001. Although there was no bilateral cooperation between Norway and Ethiopia there was direct Norwegian support to HIV/AIDS initiatives made at three levels of intervention; national, regional and

18 Discussion with EECMY/DACC HIV/AIDS Project Coordinating Team.

local. In line with the above, priorities were accorded to programmes with initiatives that promoted the following:

a. Institutional Capacity Building
b. Targeting vulnerable groups
c. Nurture collaboration among partner organisations
d. Response to gender, poverty and socio-economic dimensions of the epidemic.

In 2004, Norway gave stronger priority to HIV/AIDS in Ethiopia and specified capacity building in public sector and work at local level. Aside from this direct involvement, Norway has been very influential in global and regional HIV/AIDS architecture including G3 policies development and both technical and financial support from which Ethiopia has also benefited. Such financial global instruments include the World Bank Multi-country AIDS Programme and the Global Fund for AIDS, Tuberculosis & Malaria (GFATM). Some of the policy dialogue and technical aspects of Norway's engagement has resulted in "Three Ones" treatment and shaping of UN responses including establishment and strengthening of UNAIDS. These have also resulted in positive developments at country level for instance the "Three Ones" is in place, there is progress on coordination and harmonisation and more AIDS patients are currently on treatment in the country.

In addition, there are other Norwegian civil society organisations and Norway partners such as Save the Children Norway, Norwegian Church Aid, FOKUS, PLAN International, Norwegian Missionary Society and the Norwegian Lutheran Mission that received funding directly from Ministry of Foreign Affairs (MFA) and Norad and partner with local NGOs to implement HIV and AIDS interventions. These Norwegian CSOs are autonomous and their activities are independent of the support channelled through the embassy.

Despite that there are other donors in the country committing resources through PEPFAR and other HIV/AIDS programmes, Norwegian support through the multiple channels was strategic in contributing to the national HIV/AIDS responses. A HIV/AIDS donor forum exists in the country, but Norway is not involved in the discussions taking place at the forum, and this has limited the recognition of Norway and their contributions to stakeholders that are receiving Norwegian support and their beneficiaries.

3.2 Composition of Norwegian Financial Support

The overall flow of Official Development Assistance (ODA) to Ethiopia is summarised in official statistics extracted from the OECD DAC for the period 2000 – 2006 in Annex 6 Table 1. The table shows a total net aid flow of $219m from Norway which makes only 2% of total ODA net and equivalent to that of Sweden, Canada and Ireland. The data revealed that Norway is a small donor to Ethiopia as compared to USA, UK, Italy, etc as reflected in the table. Norway's annual disbursement increased over the period from $23.6m in 2000 to $41.8m in 2006 except for year 2001 which recorded annual disbursement of $16.3m. The sectoral allocation of aid is shown in Annex Table 2, using the DAC main sector codes. Specific flows to HIV/AIDS can be difficult to quantify. The DAC coding does not identify support to HIV/AIDS, which may be reflected under a wide range of categories. Norad has a coding system that marks programmes according to a "significant" or "main" objective to deal with HIV/AIDS. Annex 6 Table 3 shows the flow to HIV/AIDS according to this marker. During the period 2000 – 2006, NOK 93.6m (5.8%) and NOK 100.9m (6.4%) were marked as significant and main objective respectively.

Norway is one of the donors to MAP and GFATM resources and both have been confirmed as major sources of funding to the two strategic plans (2000 – 2004 & 2005 – 2008) and HIV/AIDS interventions in the country. So far, the country has utilised US$55.7m in MAP I which was concluded in 2006 and has developed an agreement of US$30m to cover 2007 – 2009 in MAP II. Equally, the country has received grants of US$700m in GFATM round II and IV respectively and so far utilised US$400m. The country is now looking forward to the approval of US$100m in Round 7. Disbursement to NGOs through bilateral and multilateral assistance amounted to NOK 195m (see Annex 6 Table 4) and further breakdown of the support is shown in Annex 6 Table 5.

Table 1: Overview of Norwegian Supported Interventions during the period 2000 – 2006.

PARTNER	PROJECT COMPONENTS	PERIOD	AMOUNT (NOK)
UNICEF	Youth HIV/AIDS Programming	2001- 05	13,020,294
	National Religious AIDS Weekend	2002	500,000
	Bridging funds HIV/AIDS	2005 - 06	5,123,000
	Short term funding HIV/AIDS	2006	1,463,000
UNFPA	Support to NGOs in HIV/AIDS	2002 - 05	12,621,250
UNFPA	Extension		2,716,000
Save the Children Norway, Ethiopia	HIV Prevention, Care, Support and Impact Mitigation.	2000 - 06	5,724,000
Norwegian Church Aid, Ethiopia	HIV Prevention, Care, Support and Impact Mitigation.	2001 - 06	4,723,860
PLAN International, Ethiopia	HIV Prevention, Care, Support and Impact Mitigation.	2004 - 06	305,2231
EECMY (with support from NLM & NMS)	HIV Prevention, Care, Support and Impact Mitigation.	2001 - 06	2,700,000
New Life Community (with support from HESO)	HIV Prevention and Income Generating Activities.	2001 - 06	1,365,179
Other activities supported by the embassy in Ethiopia	NACS Study Tour & TOT/VCT	2002	381,000
	CRDA Participation in International HIV Conference	2002	43,000
	Skills Training and Rehabilitation of CSWs	2002 - 04	302,000
	Enat HIV/AIDS Orphan Care	2002 - 03	195,000
	Legal Research - PLWHA	2003 - 04	60,000
	Specialised Exhibition on HIV/AIDS	2003	42,000
	Launch, HIV/AIDS National Partnership Forum	2004	40,000
	Conference on HIV/AIDS Counselling	2004	7,000

Source: Data provided by the Norwegian Embassy in Ethiopia and Norwegian NGOs/Implementing partners

From records made available at country level, between 2001 to 2006, the sum of NOK15,337,250 & NOK20,106,295 were channelled through UNFPA and UNICEF respectively to implement programmes aimed at building the capacity of key stakeholders. This included youths implementing youth friendly reproductive health and HIV response interventions and promoting youth focussed programmes and services with the intention of improving the sexual and reproductive health status of all population groups especially the youths in a gender sensitive way.

Resources from Norwegian NGOs utilised for HIV and AIDS response interventions in partnership with indigenous organisations during the period of evaluation amounted to about US$ 3.4 million[19]. The HIV and AIDS interventions managed by these agencies and organisations focussed on youth programming, IEC/BCC, Care and support of Orphans and Vulnerable Children (OVC), and Commercial Sex Workers (CSW) rehabilitation. These interventions did not include other interventions that are contributing indirectly to the prevention of vulnerability factors and impact mitigation of the epidemic such as educational development through provision of Alternate Basic Education Services (ABES[20]), Vocational Training and Income Generating Activities, Eradication of Female Genital Mutilation (FGM) and other harmful traditional practices.

19 Information as provided by the various organisations and documented in the timeline sheet in Annex 7.

20 ABES was an initiative supported by SCN Ethiopia to bring education close to the people and contributed to reduction of child abduction, rape and empower the girls on avoidance of early marriage.

3.3 Norway's Country Programme & Strategy

Although there is no specific country programme strategy on HIV/AIDS developed by Norway in Ethiopia the *de facto* Norwegian strategy in the country can be characterised as having the aim of engaging widely across prevention, care and impact mitigation. The summary of various interventions supported by Norway during the evaluation period, 2000 – 2006, is presented in Annex 8. These interventions are in line with the various global commitments and national strategies that are expected to contribute to the achievement of the key outcomes and impact indicators as defined by UNAIDS. This support is in addition to the contributions of Norway to World Bank MAP and GFATM which have been confirmed as the major source of resources for Ethiopia's HIV/AIDS programmes.

The table in the annex revealed that Norway's main partners in Ethiopia implementing and managing HIV and AIDS intervention are UNFPA, UNICEF, NCA, SCN, PLAN International, New Life Community and EECMY, in collaboration with local partners. UNICEF and UNFPA received the highest amount of funding during the evaluation period. Their engagement with MFA and Norad was through their headquarter offices especially in relation to allocation of resources.

3.4 Intervention Logic of the Programmes

In the Inception report for this study, an illustrative intervention logic was developed showing how Norwegian support might create a connected and coherent programme leading to development change in line with national priorities. Annex 9 contains a version of that logic edited to reflect the actual situation in Ethiopia.

The theoretical model envisaged a four stage process:

- Level 1 – A broad mixture of funding modalities enables Norway to interact at a variety of levels from grassroots to policy. Breadth increases Norwegian experience base, creates opportunities for learning and improves relevance of policy support.
- Level 2 - Outputs from funded activities are the first level of benefits, here the level of attribution varies according to the type of partnership.
- Level 3 - Potential increased benefits arise from Norway's ability to interact and exchange lessons and experience between policymakers, implementers in and outside government, target groups and PLWHA. Partnership strategies build on that experience.
- Level 4 - Direct benefits accrue to target groups and PLWHA. Indirect benefits come from the efficiency and effectiveness gains from improved ways of working and policy alignment.

The actual programme in Ethiopia closely resembles the model as far as levels 1 and 2 are concerned. The programme has harnessed a wide range of implementing partners and has shown flexibility in combining aid modalities. It is clear, as explained in Chapter 4, that considerable progress has been made with delivery of outputs across the whole spectrum of pillars in the national strategic framework.

The potential interactions and lesson learning envisaged at level 3 have been achieved to a certain extent considering the establishment of policy structures that guided the national response. But there does not seem to be any mechanism in place to feedback the more diverse experience from the investments in the various sectors. This issue is explored in the report and forms part of the discussion about progress towards outcomes, level 4 in the logic model, in Chapter 5.

Summary of Norwegian Support to HIV/AIDS in Ethiopia:

- Norwegian support to HIV/AIDS in Ethiopia commenced in 1988 when no one was talking publicly about the epidemic with initial focus on IEC.
- The interventions grew from 2000, the period which coincided with approval of MAP1 and development of HIV Policy Position Paper (PPP) to guide Norwegian interventions, although there was no specific country programme strategy for Ethiopia, but the de facto Norwegian strategy aimed at engaging widely across prevention, care and impact mitigation.
- Aside from resources that were channelled through MAP & GFATM, the UNFPA & UNICEF received the highest amount of funds during the period.
- These resources were utilised in implementing various interventions covering prevention, treatment, care and support and impact mitigation.
- The intervention logic model revealed that the actual programme resembles the model in levels 1 and 2, but no mechanisms are in place to feedback the more diverse experience from the various investments in other sectors.

4 Delivery of Outputs

This chapter looks into the role of Norway and its contributions to key behaviour outcomes (evaluation objective 3) and the partnership strategies (evaluation objective 4) in delivery of outputs. Since objective 3 was accorded special weight in the TOR, efforts have been made to explore the various channels and instruments employed by Norway in supporting HIV/AIDS in the country and how these have contributed to the achievement of the key outcomes using the relevant entry points.

Norway's partnership strategies were evaluated for effectiveness and how the partnerships have contributed to delivery of outputs and the progress the country has made towards the achievement of the key behaviour outcomes.

4.1 Programmes Supported and Delivery of Outputs

All the HIV/AIDS projects managed by Norwegian partners in the country in collaboration with indigenous organisations were reviewed for the evaluation. The reason for this was to enable the evaluation team assessed comprehensively how the various projects have contributed to the achievement of key outcomes in the country.

Since there are other players involved in the HIV and AIDS response in the country, progress cannot be solely accredited to Norwegian support. Given this qualification, the following are the various outputs that resulted from Norwegian supported interventions.

4.1.1 Contributions of World Bank MAP & the Global Fund for AIDS, Tuberculosis & Malaria (GFATM)

Federal HIV/AIDS Prevention and Control Office (FHAPCO) recognised that Norway is one of the donors to the World Bank MAP and GFATM both of which are major sources of funding for the development and implementation of the two strategic plans (2000 – 2004 & 2005 – 2008) and HIV/AIDS intervention areas in the country. FHAPCO was privileged to have this information from the dissemination of the MAP evaluation findings in African countries meeting in Kigali Rwanda in 2006. Although FHAPCO cannot ascertain the exact contributions of Norway to the country through these sources it was confirmed that the two sources have contributed to the progress made in responding to the epidemic in the country.

FHAPCO attributed the progress made so far to various interventions that addressed the factors fuelling the epidemic. These factors were addressed by implementing the priority areas of intervention stipulated in the National HIV Strategic Framework (2001-2005) that covered five major areas of:

- Social Mobilisation and IEC
- Creation of an enabling environment
- Voluntary Counselling Testing/Condom promotion/Universal precaution
- Impact mitigation and Development of national capacity including Operational Research
- Management systems to administer the national action plan.

The intervention areas were increased to twelve (12) in the multisectoral strategy developed covering 2004 – 2008 and they include: IEC/BCC, Condoms promotion and distribution, STI management, VCT, PMTCT, ART, Care & support including management of opportunistic infections, capacity building & community empowerment, mainstreaming, safe blood, universal precaution and operational research. To ensure effective implementation of these intervention areas, six strategies were adopted in the SPM which are:

- Capacity building
- Community mobilisation & empowerment
- Integration with health programmes
- Leadership and mainstreaming
- Coordination and networking
- Focus on special targets.

According to FHAPCO, these responses were possible due to core resources made available by the World Bank MAP and the GFATM. The World Bank MAP 1 fund was used largely to establish NAC and HIV secretariat and to implement the priority areas of intervention as stipulated in the HIV national strategic framework (2001-2005). A number of institutions accessed the fund, including line ministries and NGOs (83 NGOs at federal level), and over the years the number of institutions engaging in prevention, care and treatment have increased immensely[21].

Consultation with the World Bank revealed that MAP I focused on three areas which includes prevention through CSOs and sector ministries, capacity building of the HIV/AIDS Prevention and Control Office (HAPCO), and accessing emergency AIDS fund through grass root organizations, such as the Kebele which is the lowest government structure and indigenous CBOs. Fifty percent of the fund was allocated for the emergency AIDS fund. 166 Woredas were targeted for MAP I and ultimately 276 woredas were covered. The MAP I fund was planned to be implemented in 3 years but it took 5 years to utilize the fund, however it greatly contributed to the increased awareness on HIV/AIDS.

According to HAPCO (2007) progress report on HIV prevention and control programme, implementation of interventions as stated in the strategic plan has resulted in increased awareness and knowledge about HIV and AIDS and with GFATM and PEPFAR resources, the country has made significant progress in increasing the number of people accessing ART. The report confirmed that out of 286,000 who need ART, 63% were covered by end of 2006.

The 2004 guidelines for community and home based care to PLWHA developed by MOH and Addis Ababa University, were revised in 2006 to accommodate advances in this area. There is limited data on home based care providers and the services due to lack of monitoring and evaluation system at national level. However, according to the 2006 GFATM report, a total of almost 11,700 PLWHAs received home based care through the program. The HAPCO 2007 report also confirmed that there was an estimated 744,000 AIDS orphans at the end of 2005, placing Ethiopia as the second to Nigeria as the largest population of children orphaned by AIDS in Sub Saharan Africa. In 2006, 141,400 Orphans and Vulnerable Children (OVC) (84,800 through PEPFAR, 56,500 through the GFATM) received support. The type of support ranged from basic needs to education and support with income generating activities. But it is notable that most of these efforts are heavily concentrated in the urban areas.

Stakeholders at country level perceived Norway only as a financial donor to the World Bank MAP and GFATM and were not aware of their involvement and contributions in the establishment of the programmes and active participation in the board management of GFATM. The World Bank, other donors and the government recognised Norway as a donor to these resources but they are of the opinion that Norway should engage more at country level and act beyond just financial contributions. Such engagement they believe will add Norway's voice to others and contribute to shaping of policies, coordination, harmonisation and better utilisation of resources at country level.

4.1.2 Earmarked HIV/AIDS support to multilateral agencies in Ethiopia

UNICEF and UNFPA were supported to manage youth focussed interventions programmes and Sexual Reproductive Health/HIV prevention initiatives in collaboration with indigenous NGOs. These initiatives include; transport routes integrated HIV prevention project, care for PLWHAs and support to Orphans and community Based HIV projects.

Norway provided financial support to these multilateral agencies for the implementation of the interventions. In addition, Norad have conducted series of reviews and provided technical

21 Discussion with FHAPCO Head of Programme Planning and Management.

assistance to ensure that the project is well focussed and targeted strategically the factors fuelling the epidemic especially gender related issues and to enhance active gender participation.

According to UNICEF and UNFPA, empowering girls, building capacity of partners, capacity building of youth through life skills training and community dialogue all have resulted in social transformation, availability of youth friendly Voluntary Counselling & Testing (VCT) services, establishment of over 300 Anti-AIDS Clubs in schools including 8 universities have enhanced access of young people to these services. In addition, the empowerment of youth through these various interventions also resulted in recognition of youth and informed their active participation in youth policy formulation and strategy developments. The Family Guidance Association of Ethiopia youth friendly VCT integrated reproductive health services has been recognised as one of the best practices in the country by the Ministry of Health and has been included in the Adolescent Reproductive Health Strategy developed by the Ministry.

The UNFPA supported programme alone achieved the following:

- Provision of Voluntary Counselling & Testing (VCT) to more than 21,000 people.
- Distribution of over 620,000 condoms.
- Treatment of 2,320 STI cases treated in Family Guidance Association of Ethiopia clinic alone.
- Over 300,000 people received education on HIV.
- 1,590 PLWHAs were reached with care support services and treatment of Opportunistic Infections.
- Over 140 Orphans and Vulnerable Children and Commercial Sex Workers benefited from the support activities.
- Empowerment of 800 peer educators & 426 home based care providers.
- Establishment of well functioning 112 Anti AIDS Club & 40 youth information centres.

Source: UNFPA (2006) End report of Norad funded SAPCAN Project

4.1.3 Support to NGOs

It is clear from summary table presented in annex 8, that the Norwegian NGOs and other INGOs collaborated with indigenous local NGOs to implement and manage the interventions. These interventions were reported to be based on rights based perspective, in order to contribute to the progress recorded towards achievement of the key outcomes.

From the various projects supported by the Norwegian NGOs and PLAN International, summary of the table presented in annex 8 revealed that over 100,000 youths were reached with various interventions ranging from IEC, library services, trainings, youth friendly services and HIV/AIDS awareness raising programmes. More than 1,000 OVC were supported in skills acquisition and to continue formal education. The young women rehabilitation project implemented by AASECMY alone empowered 103 female sex workers through capacity building and engagement in Income Generating Activities, additional support were also provided to their children for educational activities.

The report of the various project reviews confirmed the benefits to the stakeholders and the extent of the project successes. In addition, beneficiaries of the selected projects visited confirmed the positive impact of the project and the significant changes that have happened in their lives (see 5.5).

The evaluation team observed that the Norwegian NGOs such as Save the Children, Norwegian Church Aid and Plan International (INGO) adopted unique approaches in working with local NGOs, government and the communities to reach the marginalised group especially children and girls in the inaccessible core rural areas, CSW, OVC, and youth.

4.1.4 Contributions to clinical & HIV/AIDS research

Norway is a major contributor to the establishment of the Armauer Research Institute in Ethiopia 37 years ago with focus on leprosy. Since then emphasis of the research institute has been shifted to various diseases on proportional basis - Tuberculosis (50%), leprosy (15%), Lechomaniasis (15%), and 20% focus on research on Malaria and HIV/AIDS. Financial supports for these activities have been provided to the end of 2006.

Specifically on HIV/AIDS, the institute focussed on translational and operational research that will impact on the effective co-management of HIV/AIDS and Tuberculosis thus contributing to the effective utilisation of GFATM and PEPFAR funds which are the major sources of funds for ART in the country and ultimately have impacted positively on the patients on ART.

Progress has been made in updating clinicians in Ethiopia on the management of drug toxicity of ARV in Tuberculosis patients and the assessment of Immune Reconstitution Syndrome (IRS) problems. Some of these studies are conducted by postgraduate students in collaboration with the Universities in Ethiopia. So far, the institute have graduated 45 MSc students, 6 PhD students and recently 13 PhD students have been registered. For sustainability of the research institute, a bold step was made in July 2004 to join the Ministry of Health. This integration has placed the institute in the strategic position of addressing the health issues of Ethiopians better through operational research and improving the services provided by 410 laboratories in the country.

4.1.5 Provision of technical assistance

A series of capacity building initiatives of stakeholders at all levels took place during the evaluation period. Study tours were conducted by National AIDS Council Secretariat (NACS) and key policy makers to other Eastern countries to learn about the impact and response to the epidemic. Additionally, UNICEF has been engaged at country level in the management of youth programmes and capacity building of regional HAPCOs and other implementers. UNFPA has managed SRH and HIV/AIDS prevention initiatives, successfully building the capacity of 12 indigenous NGOs and subsequently several CBOs to manage and implement various project interventions. These interventions have contributed to the development of stakeholders' capacity to become involved in the responses.

Youths Participating at Peer Educators FGAE Training Session.

Peer Educators & Members of Girls' Club Sharing Experiences at FGAE Youth Centre.

Norad's reviews of the various projects supported provided strategic guidance in terms of technical support which ensured effective utilisation of resources and positive contributions to the achievement of the key behaviour outcomes.

The Norwegian NGOs also provided technical assistance to their implementing partners in the areas of implementation of interventions, programme management, financial management, on the job training and exchange programmes, all of which, enhanced and ensured effective delivery of programmes. The technical assistance provided has been vital to the progress made towards the achievement of the outcomes considering lack of human resources and capacity for implementation of interventions as key challenges identified by stakeholders in the country during the consultation process.

4.2 Effects of Norwegian Engagement on HIV/AIDS Global Policies & Related Issues at Country Level

Norway was known to be a key stakeholder in the establishment of UNAIDS, Three Ones, 3 by 5 initiative, Global Task team on HIV/AIDS, coordination and harmonisation, drug policies and procurement and UN reform. The above were reported to have impacted on the national HIV/AIDS response and contributed to the progress made towards the achievement of the key outcomes at country level during the evaluation period.

- The "Three Ones" are in place and have started to function at country level. The country has HAPCOs as the coordinating bodies at national level and in the regions. Two HIV/AIDS National Strategic Frameworks have been developed during the evaluation period and have guided implementation of interventions by the government and the development partners including the indigenous organisations. In addition, the country has put in place the Monitoring and Evaluation System and have succeeded in coming up with an Annual HIV/AIDS Monitoring and Evaluation Report in 2006. Although there are still challenges as regards the effectiveness of the Monitoring and Evaluation System.
- The 3 by 5 initiative was confirmed to be the springboard on which the utilisation of GFATM resources was built on. The two global initiatives (3 by 5 & GFATM) have enhanced the number of cases on ART from 3,000 in mid-2005 to over 65,000 patients at the end of 2006. This achievement was recorded as a result of the boost of 3 by 5 which led to the development of the treatment framework and served as the first road map for treatment in the country. Up till mid-2005, ART was only available in larger urban hospitals and the treatment was expensive. The 3 by 5 framework developed enhanced the decentralisation of treatment and implementation of awareness of treatment availability.
- Dialogue on Drug Pricing & Procurement – The success recorded on scalability of AIDS cases on treatment cannot be documented without making reference to the efforts made globally on reduction of drug pricing and procurement. The positive effect of this global dialogue has contributed and resulted in increasing number of people on treatment in the least developed countries including Ethiopia.
- Coordination and Harmonisation - the UN agencies in the country have started the implementation of the UNDAF policy which has resulted in a functional UN joint team on HIV/AIDS. The newly established inter-agency task team was reported to have clear outcome indicators on HIV & AIDS. Also as part of coordination and harmonisation at country level, the UNAIDS is also working with the Donor Forum on HIV/AIDS to establish a pool of funds to support gaps and cover activities that are under funded. Some of the gaps already identified include; capacity building at woredas level, logistics for programme implementation and monitoring and logistics support for network of PLWHA.
- Establishment of UNAIDS - The presence of UNAIDS at country level has enhanced the implementation of the Three Ones, and UNAIDS is providing technical assistance in the following areas:
  - Leadership capacity building of HAPCO at national and regional levels to promote facilitation, coordination and managerial role of HAPCO in national response.
  - Capacity building in the use of Balance Score Card to make the management of HAPCO more business oriented.
  - Provision of technical assistance on the development of Plan of Action from 2008 – 2011.
  - Facilitating the setting - up of technical working group on M & E.
  - Secondment of M & E Advisor from UNAIDS to FHAPCO and training of the head of M & E unit to make the unit more effective and efficient in order to develop indicators that could be monitored and report progress to UNGASS.

4.3 Partnership Strategy

There is no direct HIV/AIDS related partnership with the government of Ethiopia and choice of partners was based on organisational mandate and comparative advantages to work on specific focal areas of HIV interventions. For example, Norway partnered with UNFPA and UNICEF to manage youth programme interventions based on their global mandates. The choice of local partners was based mostly on their capabilities, previous experiences and potential to implement and manage programmes.

A structured questionnaire was developed to obtain information on Norway partnership strategy and the effectiveness. The partners identified in the country that completed the

questionnaire include the UNFPA, UNICEF, PLAN International and local NGOs that partnered with Norwegian NGOs during the period evaluated.

The analysis of data from the questionnaire revealed that the type of partnership the implementing stakeholders had with various Norwegian organisations was that of joint working on HIV prevention, care, support and impact mitigation programmes. There was no partnership strategy developed for this purpose, but the joint working relationship was based on various international agreements and instruments for the achievement of the MDGs and implementation of Paris Declarations on aid effectiveness and harmonisation. At country level, the basic principle inherent in the relationships is respect to the national priorities in response to HIV and AIDS. To effect this, memoranda of understanding were signed by parties involved which stipulated description of programmes, the objectives, expected outcomes and key tasks that needed to be performed.

The Norwegian NGOs based their choice of partners (local CSOs) on certain criteria which include previous activities conducted and potential capability to deliver. Having stated this, it is not clear from the consultation how Norad and Ministry of Foreign Affairs have taken into account the strengths and weaknesses of their partners, especially the multilateral agencies and global instruments through which resources were channelled to work at country level; and whether Norway have explored the possibility of other organisations or sources that could be more effective in addressing different aspects and dimensions of the epidemic in the country. This is an area that will be further explored in subsequent consultation with stakeholders in Norway.

Major concerns expressed by these partners include limited capacity, and lack of focal person on HIV and AIDS which has reduced the level of engagement of Norway embassy to participate in joint planning, management, monitoring and evaluation.

Partners agreed that the partnership with Norwegian institutions had been effective in contributing to the progress the country is making towards the achievement of the key outcomes.

Despite these concerns, it was observed that the current partners are making impacts in the country. In terms of enhancing the effectiveness of the partnership, stakeholders are of the opinion that the capacity issue in the embassy must be addressed to improve engagement at two levels; ambassadorial level with the representatives of the UN, government and other developmental agencies involved in tackling the epidemic and at programme level to enhance participation in programme management, coordination of Norway supported interventions and adequate representation at donors forum.

4.4 Effectiveness of Norwegian Contributions to HIV/AIDS Responses in the Country

Although there are inadequate data to confirm the exact impact and positive effect of Norwegian contributions in curtailing the epidemic in the country, but analysis of information and available data confirmed the relevance and significance of Norwegian contributions. The establishment of structures as a pre-requisite condition for MAP 1 despite short comings have enhanced the management of resources from global instruments in combating the epidemic at country level. The GFATM resources have contributed significantly to the scalability of AIDS treatment through provision of ARVs and treatment of opportunistic infections. This definitely would have contributed to reduction in mortality cases as a result of AIDS. Norway's assistance in shaping the responses at global and regional level has also contributed immensely in shaping the responses at country level.

The initiatives managed by UNFPA, UNICEF within their mandate have empowered youth and stakeholders to address factors fuelling the epidemic in the country. It is therefore assumed these efforts will be relevant in curtailing new infections and mitigating impacts of the epidemic. The youth programmes contributed to the active participation of youths in the development of youth policy and strategy with five thematic areas which covered capacity development, social integration, health/HIV/AIDS, economic empowerment and political empowerment and participation.

The Norwegian NGOs and PLAN International have proved their relevance in contributing to the control of the epidemic in Ethiopia basically due to the various approaches, focus and

innovations adopted. The Norwegian NGOs have addressed the issue of HIV and AIDS from rights based perspective rather than charity needs focussed and have trained their partners to work with this approach as well and this have contributed to their ability to advocate for rights issues, such as advocating for legal rights of Orphans.

Save the Children Norway (SCN) focussed primarily on children and worked with local NGOs to educate and empower the children to protect themselves from being vulnerable to the infection. These programmes include; establishment of ABES to reduce vulnerability of girls to rape, STI/HIV infection and, supporting interventions on eradication of FGM and care and support for OVCs. The children participatory rural radio programme was also an innovation to transmit message on HIV/AIDS and other related development issues to the people in core rural areas with virtually no access to information.

The Norwegian Church Aid has been effective in the rehabilitation of CSWs. Achievement recorded through collaborations with Faith Based Organisations (FBOs) despite the moral issues and cultural sensitivity about the profession. The NCA have worked strategically through religious communities and organisations to tackle the issue of the epidemic. Aside their contributions to prevention, care and support, treatment of opportunistic infections, they also mitigate the impact of HIV through Income Generationg Activities (IGA) and care of OVC even at times up to higher education. These interventions helped to empower the children economically so they can become independent, responsible adults and ambassadors of the programme to other children and youths.

Similarly, PLAN International with their local partners and New Life Community are actively engaged in interventions that covers prevention to care and impact mitigation. The Norwegian Lutheran Mission and Norwegian Missionary Society have also supported the EECMY to implement programmes covering prevention, care and support including orphan care. The EECMY reported that they started IEC prevention activities on HIV/AIDS when HIV was not a topical issue due to guidance from their Norwegian partners.

We have started work on HIV/AIDS when no one was talking publicly on HIV/AIDS with Norwegian funds.

Aside from the fact that the organisations mainstreamed HIV/AIDS through their other developmental initiatives, they also accommodated some flexibility in the implementation and management of their initiatives the moment such is accommodated within their mandate. According to the implementing partners, this flexibility approach is not something that other donors will accommodate. The target and beneficiary audience of the interventions of the Norwegian NGOs also added credibility and relevance to their work.

Norwegian NGOs give priority to the marginalised and possibly "forgotten population". They are very good at targeting community areas that are neglected.

There are various perceptions of stakeholders as regards the relevance of the Norwegian contributions in combating the epidemic in Ethiopia. Some comments made to confirm this are as stated below:

Norway supports have been used to incubate innovations that have direct impact on the epidemic as funds are tied to specific results or interventions that achieve results (UNICEF).

We are happy at the contributions of Norway as the funds get to country level through various channels to combat the epidemic. But for the sake of recognition like other donors, there is need to have linkage with HAPCO as most people are not aware of their contributions (FHAPCO).

We consider Norwegian contributions as very important. Their resources have contributed to growing interventions and best practices in the country (UNFPA).

Refusal of girls to marry early has increased due to advocacy for a law to inhibit early marriage and interventions such as the rural radio programme to create awareness (SCN, Ethiopia).

Norway NGOs are the best donors. Our partnership is on equal footing. Partnership agreement is completed on time and there are minimal conditions to make partnership work. They accommodate flexibility if there are good and strong justifications. They follow up and provide technical assistance for the success of our interventions (Mary-Joy AID).

With Norwegian support, we have been empowered to turn the coffee ceremony to a more beneficial ceremony where women can discuss and be empowered on HIV and related issues (Girls Club, Awassa).

Norwegian funds have saved a lot of lives. They have supported so many OVCs to attend schools and today they are graduates. To save one live is not a joke not to talk of thousands of people. This is a great contribution to the development of the country which we are very proud of and appreciate (OSSA)

The effort of Norway in this regard is highly commendable. But their decision of Norway to stop supporting research in Ethiopia will create huge gap that could affect negatively on the implementation of other interventions. For example, if IRS is not addressed properly, it can result in increase mortality despite huge investment in treatment (Armaeur Hansen Research Institute).

Summary of Delivery of Outputs

- Various channels of support used by Norway were effective in contributing to the control of the epidemic and the progress the country is making towards the achievement of the key outcomes.
- The channels of support include the World Bank MAP, GFATM, Multilateral agencies (UNFPA & UNICEF), Hansen Armaeur Research Institute, Norwegian NGOs and INGOs
- The technical assistance provided through the various Norway supported interventions (multilaterals, research institutes and NGOs) have contributed to the development of capacity of stakeholders in the country in combating the epidemic.
- The engagement of Norway to establish and influence global policies on HIV/AIDS is yielding results at country level. Most of these global policies are in place in Ethiopia such as the implementation of the “Three Ones”, “3 by 5” etc.
- The presence of UNAIDS in the country have contributed to the establishment of the Three Ones and its implementation. UNAIDS is also making efforts to ensure functional M & E system in the country.
- The type of partnership that stakeholders had with Norway was that of joint working based on the various international agreements and development of MOU to guide the relationship. However, the partnership can be more effective, if the capacity issue within the embassy is addressed to enhance effective engagement.
- Stakeholders at various levels in the country held positive perceptions of Norway in contributing to the control of the epidemic, and Armaeur Hansen Research Institute was of the opinion that Norway’s decision to stop supporting research in Ethiopia will create a huge gap that could affect negatively the implementation of interventions especially in the area of treatment.

5 Progress Towards Key Outcomes and Factors Affecting

This chapter documents findings that respond to two key objectives of the evaluation (Evaluation objectives 1 and 2) as stated in the TOR. Available data were reviewed to assess changes in key behaviour outcomes and the efforts of other international partners and development agencies were recognised in this regard. Efforts were made to elicit information on Norway's role and contributions to the progress made. The factors driving or inhibiting change were also identified in consultation with stakeholders across board within the context of the national agenda and how the factors have facilitated or limited the progress the country is making towards the achievement of the key behaviour outcomes.

5.1 Progress Towards Key Outcomes

The progress towards key outcomes have been tabulated using the EDHS 2002 and 2005 and from other sources to assess and compare progress made during these periods. It is notable that the UNAIDS guideline for key outcome and impact indicators were not published until year 2001. The unavailability of the guideline prior to 2000 might have prevented comprehensiveness of data to cover the key outcome areas in EDHS conducted in year 2000. Nevertheless, this evaluation has reviewed the available data at country level to assess progress made towards key outcomes.

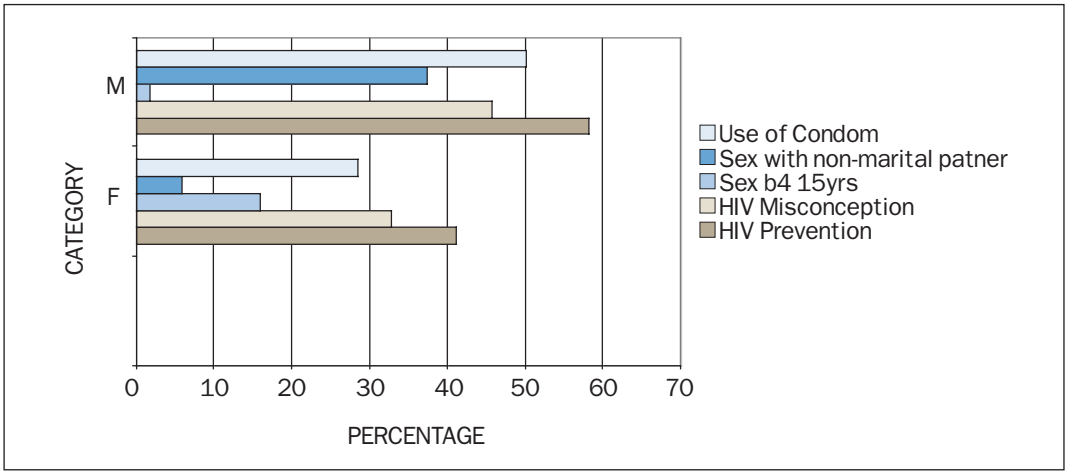
Table 2: Progress made against Indicators as defined by UNAIDS

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[23]	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)[24]	12.7	10.5	3.7	2.7

22 2004 Welfare Monitoring Survey
23 Ethiopia Annual HIV/AIDS Monitoring & Evaluation Report (2005/06)

INDICATORS FOR GENERALISED EPIDEMIC AS SET OUT BY UNAIDS	PROGRESS MADE AGAINST THE INDICATORS			
- % 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	

Fig. 5: HIV/AIDS key outcome indicators attained in 2005



The above chart (fig. 5) revealed clearly that more men have knowledge of HIV prevention, rejected misconceptions and used condoms with non-marital and non-cohabiting sexual partner. In the same vein, there was increasing percentage of males having sex with non-marital and non-cohabiting sexual partner and more females are reported to have sex before the age of 15 years. These findings are not surprising and are clearly related to the prevalence rates recorded from the various sources as well as the fuelling factors documented.

Table 3: Comparison of Progress with the Targets set

INDICATORS FOR GENERALISED EPIDEMIC AS SET OUT BY UNAIDS					
OUTCOME INDICATORS	**TARGETS BY 2005[25]**	**PROGRESS AS AT 2005**		**GAP**	
		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)	90%	41.1	58.2	48.9	31.8
- % who reject major misconceptions about HIV transmission (target: 90% by 2005; 95% by 2010)	90%	32.7	45.7	57.3	44.3
-% of young women & men who have sex before the age of 15	-				
- % of young women & men aged 15-24 who have had sex with a non-marital, non-cohabiting sexual partner in the last 12 months	-				
- % 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	-				
- ratio of current school attendance among orphans to non-orphans, aged 10-14	-				
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)	25% Reduction	See below			
- % of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy	-				
-% of infants born to HIV infected mothers who are infected (target: 20 % reduction by 2005; 50 % reduction by 2010)	20% Reduction	NA	NA		

There is limited data to compare with the targets set by UNAIDS for 2005. Although the country reported 35% decline amongst four health centres that have been involved in ANC surveillance during the period 1996 (20.7%) and 2005 (13.5%). The combined HIV prevalence rates of 25 urban sites with three rounds of ANC surveillance data (2002, 2003 and 2005) was reported to show a modest but significant declining trend during the period – 12.7% in 2002 and 10.5% in 2005. When Addis Ababa was excluded from the analysis, a more pronounced decline was reported in the remaining urban areas, ranging from 12.9% in 2002 to 9.8% in 2005. Equally, a decline was reported in seven rural sites that have at least three rounds of surveillance data – 4.5% in 2002, 3.3% in 2003 and 2.5% in 2005. However, it was noted that the monitoring and evaluation report where these data were extracted from confirmed limited reliability and that trend analysis required more data points as an observation made from only three time points has limited utility in the interpretation of temporal changes in prevalence particularly considering variations in the number of sites and various periods of the surveillances.

In terms of knowledge, fig. 6 revealed that more knowledge of HIV prevention and rejection of misconceptions is greater amongst males as compared to females. This relates to increasing vulnerability of women to HIV infection compared to men. The reasons are not far fetched and not different from the factors already stated to be fuelling the epidemic especially the gender related issues. Nevertheless, data from the two tables revealed some progress especially in areas in which data were available for 2000 to compare the progress made in 2005.

With regards to ratio of orphans in school as compared to non-orphans, analysis of data from Ethiopian Annual M & E report as reported by 2004 Welfare Monitoring Survey revealed that 24.8% and 18% of orphans in urban and rural areas respectively attended schools as compared to 75.2% and 82% of non-orphans attending school in urban rural areas respectively. And amongst total orphans surveyed, 91% and 55.5% of orphans attended school in urban and

24 Targets set by UNAIDS on key outcomes and impact indicators for generalised epidemic.

rural areas respectively. The above have implications for effective targeting of interventions and programmes in addressing these issues.

Fig. 6: Progress against targets

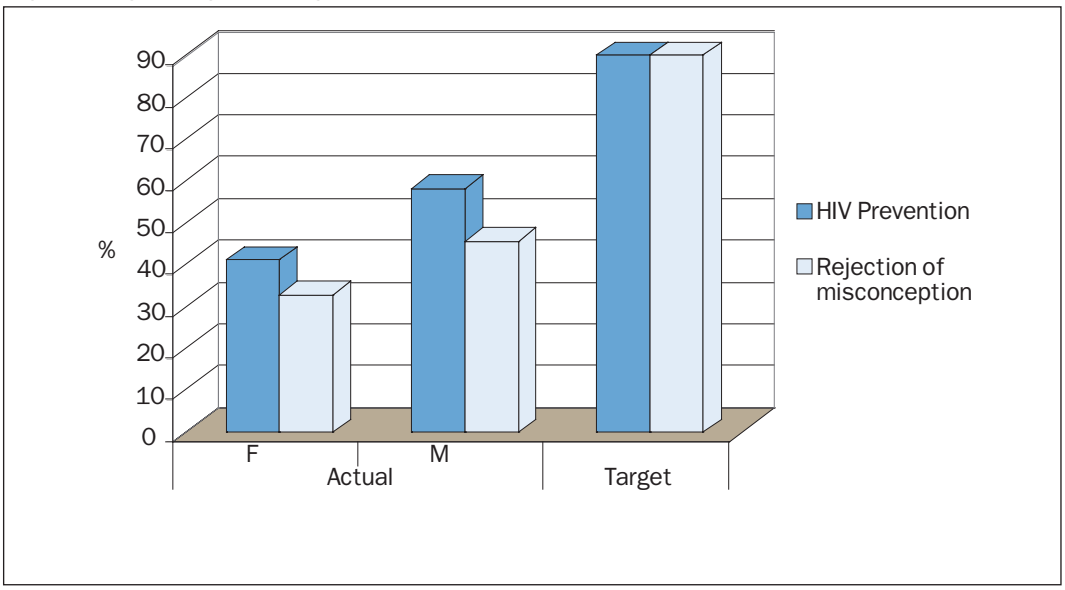


Fig. 7: School attendance amongst orphans to non-orphans

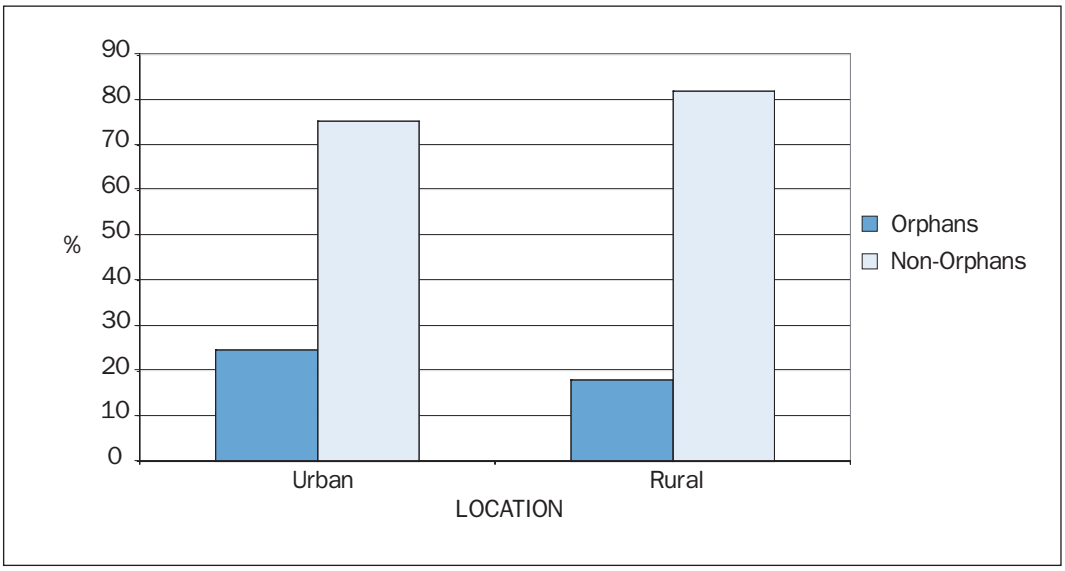
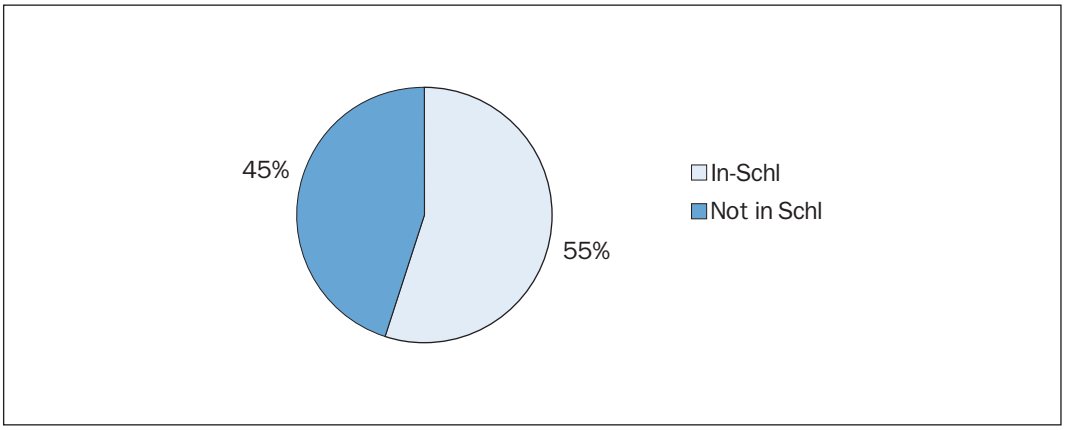


Fig. 9: School attendance amongst orphans in rural areas



5.2 HIV Mainstreaming

The country has not made any significant progress in the area of HIV mainstreaming as a strategy of combating the epidemic. A national mainstreaming guideline on HIV/AIDS interventions in federal ministries and organizations was produced by HAPCO in 2003, and to assess progress made in its implementation, a survey was conducted in 2006. 100 institutions - 70 government and 30 CSOs were covered in the survey. The findings of the survey revealed that amongst the stakeholders targeted for the survey, only 58% of government sector ministries, 83% of NGOs and 60 % private sector had included HIV/AIDS interventions as one of the activities in their programs.

Fig. 10: Organisational efforts on hiv mainstreaming

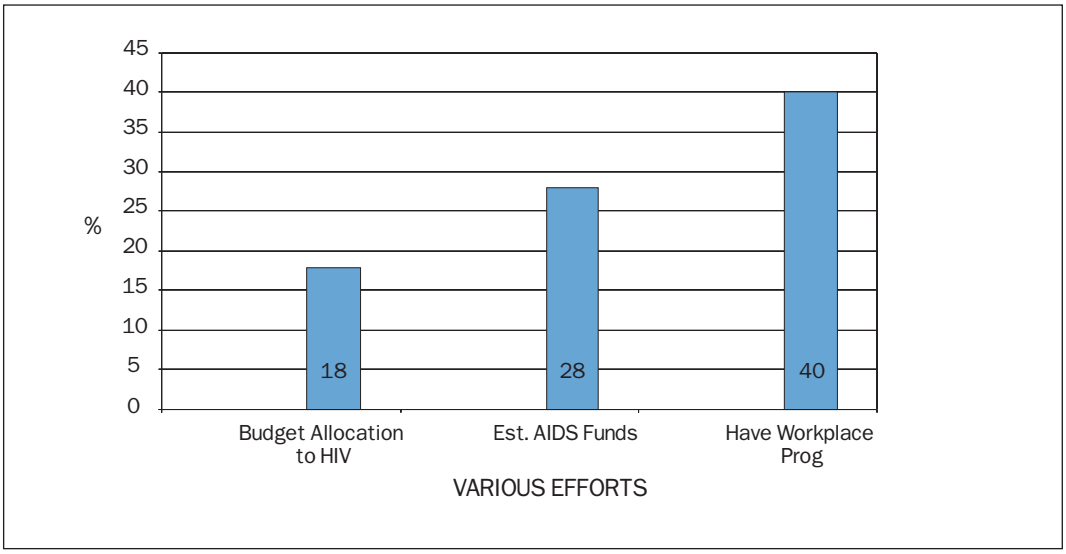


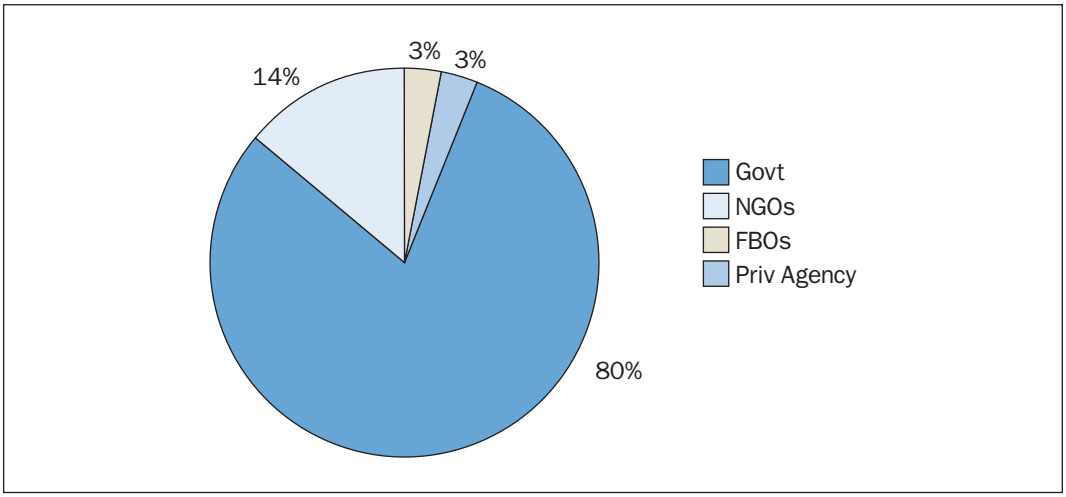
Figure 10 revealed the various efforts made by the institutions assessed. While 40% have made efforts to put in place workplace programmes the extent of the implementation of the programmes was not ascertained in the report and it was confirmed that proactive engagement is weak as organisations or ministries respond only when they get funding. Considering the UNDP indicator on mainstreaming, only 35 institutions (with percentage breakdown in fig. 11 below) have executed internal mainstreaming.

According to the study, the factors responsible for weak HIV mainstreaming implementation include:

- Low commitment and attention from the institution leaders
- Weak technical support
- The work related to HIV is considered as an additional task
- Limited clarity and understanding of mainstreaming since it is a new concept
- Limited financial and material support
- Limited availability and access to materials explaining HIV mainstreaming.

Despite the above hindering factors, the Curriculum Development unit in the Ministry of Education have succeeded in mainstreaming HIV/AIDS into school curriculum for 5-12 grades, including associated references and teachers guide. The ministry is also planning to include it in the first cycle (1-4). The unit secured about $US 500,000 from HAPCO for the development and publication of the curriculum and enjoyed provision of technical assistance from UNICEF in developing the curriculum and the various related materials. The curriculum unit distributed copies of the curriculum and related materials to the regional offices where onward distribution to the schools are expected for implementation. But many schools still have problems accessing the various reference materials and guides.

Fig. 11: Execution of internal mainstreaming by stakeholders



However, accomplishments of UNICEF and UNFPA in HIV mainstreaming especially with the Norwegian supported interventions include:

- Building the capacity of partners through training and workshops on mainstreaming
- Integrating VCT services in youth centres and other FP/RH services
- Incorporating HIV in young girls' program and women associations
- Building the capacity of the media to integrate youth dialogue and HIV interventions in their activities
- Infusing life skill program related to HIV in the education curriculum
- Including HIV in the national youth policy and strategy.

Norwegian NGOs and EECMY confirmed that it is a priority to mainstream HIV in their programmes in the various thematic areas, although information on the extent of implementation and budget allocated for this purpose was not available. They confirmed that a mainstreaming strategy and system is in place in the organization. Their partners are also encouraged to mainstream HIV in their development programs, through trainings, workshops and provision of materials. In addition, AMREF implemented HIV workplace interventions in 10 industries in South Eastern suburb of Addis-Ababa.

Even though Norway had stressed the need for HIV mainstreaming in 2 – 3 selected priority or policy areas, aside the efforts stated above in the UNFPA and UNICEF supported interventions, HIV was not mainstreamed into other development programmes supported by Norway in the country at this period. The priority areas for Norwegian support during the period 2000 – 2006 were human rights and governance, peace and stability and HIV/AIDS. The justification for not mainstreaming HIV in the other two thematic areas was because HIV/AIDS was also a priority area at this period.

Currently, HIV/AIDS is no more considered as one of the priority areas for Norwegian support in the country. The three main priority areas are:

- Human Rights, Good Governance and Democracy
- Peace and Stability
- Natural Resource Management.

It is envisaged that HIV/AIDS will be mainstreamed into the three priority areas, hence the need to address the issue of capacity and commitment to ensure this.

5.3 Gender Mainstreaming

Gender related factors which contribute to fuelling the epidemic have been identified. These factors include increased incidence of sexual practice between older men and young girls, sexual harassment, socio-economic dis-empowerment, poverty, inadequate access to information, ineffective communication strategy, unfocussed interventions to address the vulnerability of girls, early marriage and absence of sex education and counselling in the

school curriculum. Such factors have contributed to the increasing prevalence of HIV/AIDS for women between ages 15 – 24 years as shown in the prevalence rates and in the findings in relation to progress made in acquiring knowledge on HIV prevention and rejection of misconceptions.

Members of the audience – parents watching their daughters in the drama

Members of Prosperity Girls' Club, Awassa using drama to educate parents on Stigma Reduction at a coffee ceremony

FHAPCO identified the above as major issues and are trying to tackle them through programmes that will enhance economic empowerment, prevent gender violence, legal protection, improve negotiation power, PMTCT, and targeting female headed families Such programmes will be accorded top priority and need to address the situation of poverty and culture which are still the major hindering factors in addressing gender issues. For Norway supported HIV/AIDS interventions in the country, gender mainstreaming has been stressed in all the projects and recommendations of various reviews in this regard, especially for UNICEF and UNFPA, were adopted and implemented. Some examples of key initiatives responsive to gender issues that were embarked upon include:

The Girls Forum Project – The objective of the project was to protect and mobilise girls in and around schools against sexual violence and to create greater awareness on the need of nurturing and empowering the girl child in the regions and securing political commitment to protect young girls from the hazards of sexual harassment and exposure to HIV/AIDS.

The project which covered five regional towns reached 39 schools and recorded the following achievements:

- Sensitized regional government bodies on the problems facing girls in relation to education and communication about sex education
- Encouraged parent-child communication
- Recommended initiation and strengthening guidance and counselling in schools
- Conducted training on leadership and facilitation for girls
- Formed girls' forums in the five regions
- Developed a training manual and guidelines for girls forum with focus on rights promotion
- Launched the Voice of the Girl-Child which documented the activities of the project and impact for dissemination across the regions.

Domestic Female Workers Dialogue/Conversation – The majority of the domestic workers migrated from rural areas are the most neglected and invisible section of the population. Many are at risk of HIV infection. The study conducted by Population Council indicated that 14% of adolescent girls are employed as domestic workers and majority are under the age of 24 years old. The dialogue afforded them to voice their concerns about abuse inflicted on them by their employers and ways of addressing them.

Association of Women Living with HIV – This is a sub-association that was established by the youth clubs in Beza. They have a forum where they discuss issues of concern and are now trying to advocate for support from the authority responsible. They have been trained to care and provide support for one another. Members of the association who are benefiting from the

ART programme appreciated the impact of the treatment, but they also stated lack of food and inadequate nutrition as major challenges they face.

Coordinator of Girls' Club in Awassa explaining their initiative to support their programmes.

To institutionalise gender issues responsive programmes in the country, gender policies and strategies have been developed to guide the implementation in a sustainable and holistic way. But so far these efforts are only on paper as there have been challenges with implementation. Various efforts have been implemented in a number of programmes, and there have been challenges of ensuring effective coordination of gender sensitive and responsive interventions. This was a major source of concern for experts working in this area and has resulted in lack of adequate information on progress made and gaps in addressing gender related issues.

The gender policies are in place as well as strategies – but only on paper as there are still challenges with implementation. There must be clear indicators drawn to guide and make interventions business oriented with dedicated resource on M & E for gender projects. This will go a long way in improving how gender issues are currently been managed. (UNFPA).

5.4 Factors Affecting Progress towards Key Outcomes

The evaluation found that a number of projects reported timely delivery of interventions within budget and where required, additional funds were provided to support continuity of interventions. An example is the bridging funds made available to UNICEF to continue initiatives and implement some recommendations arising from the review reports. However, certain factors have been identified to affect progress the country is making towards the achievement of key behaviour outcomes and impact indicators.

Our assessment of the discussions held with various stakeholders using the stakeholder analysis and force-field tools (see annexes 7 and 10) revealed the following:

5.4.1 Hindering and supporting factors

The hindering factors identified are very critical in terms of subsequent interventions and strategy for the country. Some of the key factors identified include non-availability of skilled human resources, inaccessible terrain, retaining resources at the centre, problems of infrastructures, and skills gap in strategic positions. These issues cannot be addressed by NGO efforts and interventions alone and requires effective engagement at policy level with government authorities. Unfortunately, this component is lacking in Norwegian engagement in Ethiopia. For the epidemic to be tackled effectively, it is not enough to engage on policy issues at global level and put in funds through the global instruments or NGOs alone. There is a critical need for Norway to add voice to those of other partners for the effective utilization of the funds to address these key factors.

Some of the interventions supported by Norway are addressing some of the other hindering factors identified, but the interventions are not enough to achieve maximum impact and desired results. Most of the interventions do not have baseline surveys conducted to compare and assess the progress made in addressing these factors.

However, looking at the factors that supported achievement of the progress made towards the key outcomes, Norwegian supported interventions are laudable in this regard. There is Norwegian presence and contribution in the implementation of these supporting factors.

5.4.2 Ineffective coordination and non-timely release of funds

It was observed that federal HAPCO and regional HAPCOs were recognised as important stakeholders in relation to facilitation, creation of enabling environment, capacity building and coordination. Our assessment revealed that coordination of HIV/AIDS programmes in the country has not really been very effective due to lack of capacity and turn over of the leadership of some strategic positions.

The stakeholders, particularly the NGOs, do not see HAPCOs playing a critical role in making funds available to the non-government sectors for implementation of activities despite the efforts reported by HAPCO. But there are plans to address this concern in MAP II, as FHAPCO is already in dialogue with the World Bank. The proposed idea is that funds should be based on action plan developed and not on retirements of tranches allocated, which was the case in MAP 1 and resulted in delays to the retirement of funds.

This analysis has implications in terms of the ineffectiveness of the indirect engagement of Norway with the National coordinating body (FHAPCO), considering Norway's efforts in contributing effectively to the establishment of the "Three Ones" and contributions to the global instruments. There is likelihood that direct engagement in this regard with other donors in the country may have a positive effect on utilization of funds and possibly more impact on the epidemic.

5.4.3 Non-connectivity of the various channels of Norwegian support at country level

The connectivity of the various interventions is not as effective as it should be, as efforts are still localised with minimal inter-linkage. However, there is a connection of efforts within UNFPA and UNICEF, and NCA and SCN have a joint strategy on eradication of FGM in which HIV/AIDS was mainstreamed. NCA and UNFPA have recently initiated discussion as regards connectivity of efforts having realised that both institutions work with more or less the same NGOs, especially with the youth interventions and other prevention and care initiatives. Despite the fact that some of the implementing NGOs are aware of the existence of one another, they lack knowledge that they are implementing programmes funded by Norway. This has contributed to the lack of synergy and effect that would have further contributed to the success of the various initiatives through linkage, lessons learning and sharing of best practices.

5.4.4 Ineffective coordination of CSOs

The Civil Society Organisations are recognised as key players in national response to HIV/AIDS in the country. Some donors work with CSOs in Ethiopia for a quick response and to avoid bureaucracies, especially to implement programmes in inaccessible communities. Despite this engagement with donors, CSOs in the country are faced with the challenges of a well structured coordinating mechanism especially at regional and woredas level. Coupled with this is the capacity problem to effectively manage coalition bodies especially for the NEP+[25] that has recently been established. These weaknesses have limited the effective recognition of CSOs and their participation to implementation of interventions that are not well coordinated to ascertain the status of their contributions.

5.4.5 Ineffective utilisation of funds generated locally

Our analysis of the information elicited from stakeholders consulted revealed that external supports were more effectively utilised as compared to locally generated funds[26] due to easy accessibility of the resources and monitoring of the resources by the concerned donors. In addition, the external donors conducted some activities with the NGOs to guide use of the resources. Such activities include; review of proposals, capacity assessment and capacity building, provision of budget allocation to cover administration, logistics and capacity building, joint planning, monitoring of disbursed resources and reporting. The above conditions make the NGOs more focused and results oriented. Efforts have been made to put

25 NEP+ - Network of People Living with HIV/AIDS
26 Locally generated funds in this regard are funds that comes from government irrespective of the sources.

similar conditions in place for the locally generated resources but the implementation and effectiveness are doubtful.

5.4.6 Limited coverage of interventions

Aside the World Bank MAP 1 which was reported to have covered 276 woredas, Norwegian supported interventions covered 36 woredas, 32 towns/sub-cities and 3 kebeles[27]. The expectation would be for programmes and interventions funded by other donors to extend to and cover other woredas, but if MAP1 which was a major funding source covered less than half of the woredas in the country, then it would appear that there are challenges regarding the coverage of HIV interventions in the country.

The Norwegian NGOs (NCA and SCN) confirmed that about 4% of their budget was spent on HIV/AIDS interventions in this period and that this was low in terms of the priorities and areas requiring need in the country, thus affecting their ability to do more and the extent in which they can impact more positively on the epidemic.

5.5 Appreciative Enquiry and Most Significant Changes

Enquiries were made on the effectiveness of projects and initiatives and how these interventions have impacted and significantly changed the lives of stakeholders, especially in contributing to the achievement of the key outcomes. The factors that led to success include contributions made by Norway and other partners' assistance. Some are documented already, while others are still in the process of putting the best practices together. A few examples selected from reviewed reports and projects visits are outlined below. Some of these have already had multiplier effects.

The selections of projects visited were based on the focal areas directly supported by Norway. They include projects implementing interventions focussing on youths, Commercial Sex Workers (CSW), OVC and girls' forum project.

5.5.1 Host the family programme

Host the Family Programme is an initiative focusing on the rehabilitation of CSWs. So far, 103 CSWs have been successfully rehabilitated with support from NCA. The programme commenced as an evangelist initiative and has revealed the effectiveness of faith based community responses to HIV & AIDS especially from this perspective considering the issue of morality attached to the profession. The beneficiaries are supported in skills acquisition to empower them economically, be independent and remove their vulnerability to infection or poverty. In addition, their children are also trained in schools or supported in skills acquisition. Major factors that have contributed to the success of this initiative include; voluntarism on the side of members of the congregation, love and commitment, help to the family members especially the children.

One of success story

"My name is Frehiwot. I was born and raised in Wonji. I didn't know much about AIDS when I lived there as a young girl — except that I thought it was affecting some wicked people. When my mother died the situation was not good for me at home and I went to Debreziet to live with my aunty. Even there it was not good for me I could not go to school and continue my education. "

"Then I came to Addis Ababa and started working in one of the bar where I was persuaded by friends to work as a commercial sex worker. Within few years time I started experiencing health problem at which time I went for HIV testing and the result was HIV positive. I became depressed, believing I would die soon, like others whom I know died of HIV."

"I felt scared and alone. I knew instinctively to keep it quiet because of the stigma and keep on working. But while I was waiting for customer along the Kazanchis street one night the New Life Young women project staff invited me to come to their project place. I started coming to the New Life Young Women Project."

"What really struck me was seeing young women like me straightening up their life. Through the staff I met at project, I learned that I didn't have to be secretive or feel shameful. I now feel safe and normal."

"Because of HIV, I have faced depression, ongoing pain and numerous problems. By the counseling of the staff and care I have started ART which really tone down almost all my problems making it possible to take care of myself and still be active.

27 Data extracted and summarised from Timeline table in Annex 8.

5.5.2 Sensitisation of orthodox church leaders on non-replacement of ART with "Holy Water".

This sensitization programme implemented with support from NCA, has been effective in contributing to treatment adherence. The majority of Ethiopians are Christians and have a firm belief in their doctrines which include use of "holy water" for the purpose of cleaning sins and for healing. Most AIDS patients on ART were not adhering to the treatment regime because they believed that no other thing should be used when you take "holy water". In order to reverse this thinking amongst the members of the congregation who are on treatment, the Orthodox Church leaders were sensitised to increase their awareness and knowledge of the consequences of non-adherence to treatment. This sensitisation has led to churches including the use of holy water with medications when one is sick in sermons and counselling sessions. This has been reported to change the perception of people on ART.

5.5.3 Orphans' Programme Implemented by ANPPCAN in Gonder Town

There are a series of Orphans programmes supported in the country with Norwegian resources. In the case of the orphan project implemented by ANPPCAN with support from SCN in 2001 - 2002, 120,000 birr (US$ 13,333) was used to change the lives of 60 orphans selected out of initial 700 following a joint assessment with the community members based on their critical conditions after loss of both parents. The support to the orphans covered; allowance, house rent and food, medical support, school fees, scholastic materials and tutorial class programmes. At the end of two year project, there was no clear exit strategy in place and the funding ended. Having seen the positive impact of the project on the orphans, ANPPCAN requested support from another French donor to implement the exit strategy.

Experience of the 3 of the Orphans that received support: We were supported by OSSA/NCA from the time our parents have fallen sick and continued after their death. We are left with responsibility of caring for our siblings, and fending for the family. We are fortunate to get the financial, school and moral assistance that empowered us to pass the challenges we have faced with. If not our fate would have been on the street. Now we have graduated from college, and got decent job. Now we are in a better socioeconomic situation that allows us to give better care of our siblings and fight the enemy that claimed our parents. AIDS is real we are a living witness.

With the funding, the guardians of the orphans were empowered with the sum of money ranging from 2000 – 3000 birr (US$ 222 – 333) depending on the type of business they want to engage. The condition for obtaining this money was for the guardians to open an account in the name of each orphan in their custody, and save an agreed amount at the end of each month from the profit realised from the business. This has been very successful and so far, 53 of the orphans are in school and 66% of the guardians are keeping to the agreement of saving money at the end of the month for the care of these orphans as revealed by a monitoring exercise conducted recently.

Similarly, over 150 orphans received support from Organisation for Social Services for Ethiopia (OSSA) with funds from NCA. The support comprised of scholastic assistance, counselling, medical and finance for living cost such as food and housing. Beneficiaries of the Orphans' support programme have formed the "FIKIR BEHIWOT" (Love Through Life) Orphans and Youth Association and are working together to advocate for the rights of the orphans especially on legal issues as related to inheritance and other benefits that could be derived from government.

5.5.4 Transformation of a Small Football Club to 14 Youth Associations in Beza.

This youth football club was engaged in 2002 by OSSA/NCA and empowered to establish an anti-AIDS Club and implement Adolescent Sexual and Reproductive Health activities in their community. The youth association has worked successfully with NCA on TV-campaign

initiative and provision of youth focused entertainment based HIV/AIDS interventions has been the specialisation of Beza youth Association.

Members of Beza Youth Association in Yirgalem Town sensitizing the audience on HIV/AIDS.

Since 2006, they have grown progressively and have established 13 other youth associations covering urban and rural areas, including 4 female youth associations. They have expanded their interventions to include strengthening of PLWHAs and OVC to raise their voices to access various services through establishing associations and mobilisation of the community. Based on the positive effect of the empowerment and the spirit of caring for one another that Beza Youth Association has acquired over the years, they are currently caring for nine (9) street children.

In addition, they have also succeeded in mobilizing the community and other stakeholders in ensuring HIV positive pregnant mothers access Prevention of Mother to Child Transmission (PMTCT) services. This was done in collaboration with the local government offices such as Zonal Women Office, Health Centre, IDIRS (Community Burial Associations), Local District Offices, PLWHAs and the youth.

The assessment revealed that the projects implemented by these organisations have been successful and project implementers were of the opinion that there is no reason for HIV/AIDS projects not to be successful since they meet the needs of the beneficiaries.

The Nine "Brothers" (Street Children) cared for by Beza Youth Association in front of their Home reciting poem on "LOVE & Care for One Another"

No programme will fail because the nature of the interventions as it meets the needs of the people – no hardware is required such as land or maintenance of latrines like the sanitation projects (Mary-Joy, AID)

Summary of Progress Towards Key Outcomes & Factors Affecting

- There is limited data to assess comprehensively the progress the country has made during the period evaluated. Despite this, available data revealed some progress especially in the areas of knowledge of HIV prevention and rejection of misconceptions.
- HIV mainstreaming in the country is weak generally, although Norway support to UNICEF and UNFPA have contributed to HIV mainstreaming in the education and youth sectors but the full implementation is still a challenge.
- HIV/AIDS was not mainstreamed into other Norwegian supported development priority areas in the country at this period.
- Despite progress made, certain factors were identified to have supported or hindered the progress the country made towards the achievement of the key outcomes. Addressing these factors strategically is essential in order to have positive impact on the epidemic.
- The need for Norway to engage more effectively especially at policy level with government authorities for possible improved utilisation of resources was revealed with the stakeholder analysis.
- The lack of connectivity in the Norway supported interventions contributed to lack of synergy, lessons learning and sharing of best practices that probably would have widen coverage and prevent re-inventing the wheels.
- Various significant changes documented and seen during field visits confirmed the positive impact of the various Norway supported interventions and revealed some lessons that should guide future engagement.
- There is progress in the efforts to mainstream gender into HIV/AIDS programmes. Gender policy is in place but there are still challenges with full implementation. The need for clear indicators to make business oriented is essential for gender mainstreaming in the country.
- Appreciative enquires revealed that many of the interventions had Most Significant Changes (MSC) on the beneficiaries, and have empowered them to mitigate the impact of the epidemic or reduce vulnerability to infection.

6 Conclusion, Lessons Learnt and Recommendations

6.1 Conclusion

The evaluation of Norwegian responses to HIV/AIDS in Ethiopia between 2000 – 2006 have revealed that Norwegian support in tackling the epidemic is evident in contributing to the progress the country is making towards the achievement of the key outcomes and core impact indicators as defined by generalised epidemic by UNAIDS. Aside the World Bank MAP 1 and the GFATM that have served as major sources of funding for the country in addressing the epidemic, Norwegian support to the multilaterals, research and NGOs have contributed to strengthening of technical and institutional capacities for the effective management of SRH, HIV prevention, care, support and impact mitigation initiatives.

6.1.1 Progress towards outcomes

There is limited data to ascertain the exact progress the country has made during the period evaluated, but available data revealed some progress especially in the areas of knowledge of HIV prevention, rejection of misconceptions and tangible increase in the number of persons living with HIV that are on treatment against the targets set by UNAIDS. In addition stakeholders' perceptions are very positive as regards the contributions of Norway to the control of the epidemic and the effects that the projects have had on beneficiaries.

6.1.2 Key Norwegian contributions

There is no specific country strategy developed by Norway for Ethiopia, but Norway's *de facto* strategy of working through multiple channels has been effective in targeting various stakeholders at all levels especially creating the opportunity to reach the poor and the marginalised groups. Deliveries of output have been timely and within budgets.

The multiple channels of support in the country have contributed to key outputs which include development of HIV/AIDS policies and strategies, research outputs to guide management of cases on ARVs, capacity building of stakeholders for the development and management of HIV prevention, care, support, treatment and impact mitigation initiatives have contributed to improvements in HIV knowledge and behaviour, increase in number of ART cases and possible reduction of HIV prevalence in the country. Most of the projects integrated the issue of ownership from inception and throughout the various phases of the project, which is expected to contribute to the sustainability of the project. In addition, the benefits of the interventions have also led to government donating lands for building of schools (such as the case for the New Life Community Organisation and the expansion of the Alternate Basic Education Schools supported by SCN). In addition, various efforts have been made to establish clear exit strategies with some of the projects to ensure continuity and sustainability, but most services that are offered free will still require donor support to continue delivery of services that will impact positively on the lives of the populace.

6.1.3 Factors affecting progress towards outcomes

Although there were some supporting and hindering factors identified to have influenced the achievement of the key outcomes, these factors were analysed and documented in the report. The holding back factors need to be considered and addressed in subsequent engagement in order to contribute strategically and effectively to the achievement of key outcomes in the country. In addition, is the issue of connectivity of the Norwegian supported interventions which is still a major challenge, and this has led to loss of opportunity of learning from one another and sharing of best practices that would have enhanced the impact of the various interventions and coverage.

6.1.4 Partnership strategy

There is no clear partnership strategy developed by Norway for the various partners engaged in the country. The type of partnership adopted was that of joint working based on the various international agreements and development of MOU. Subsequent engagements can be improved with clearly developed strategy and framework for operations that will be useful in measuring success in the utilisation of resources and management of initiatives.

6.2 Lessons Learnt

Several lessons were shared by the implementers and managers of the various Norwegian supported interventions reviewed. Some of these are already documented and shared. In addition consultation with stakeholders revealed additional lessons. These lessons will be documented under two sub-headings; lessons from Norwegian supported programmes and lessons from the partnership strategy.

6.2.1 Lessons from Norwegian supported programmes

A series of lessons have been drawn from various projects implemented with Norway support. Some of the lessons include:

- Recognition of indispensable roles of grassroot actors especially the Anti-AIDS Clubs and commitment and practical support of the community members can be effective in ensuring ownership and sustainability of initiatives.
- Integration of SRH/FP services into HIV/AIDS particularly VCT programmes enhances provision of comprehensive care and increases the number of client, and the quality of services provided can enhance clients' preference for specific outlets irrespective of the distance.
- Location of programmes and interventions in central areas like markets and schools (ABES) allows the needy community greater access to such services.
- Providing alternatives and incorporation of economic empowerment interventions to improve livelihoods of the beneficiaries could go a long way in reducing risky behaviours, vulnerability to HIV infection and dependency. Such is the case in the various CSWs' interventions and economic empowerment to the families/guardians of the orphans.
- Attitudinal change requires continuous education and reinforcement of information.
- Activities like drama, music shows, story telling, sports competition etc. are very effective in attracting youths and in motivating their participation, education and inspiration to bring positive changes in their lives. In addition, implementation of IEC/BCC activities at different outlets including market places, schools, sporting events etc. have proved to be cost effective ways of disseminating information to reach a wide coverage of people.
- Planning and implementing a viable phase out strategy from the project inception and ensuring effective participation of stakeholders in the process can contribute to the continuity and sustainability of initiatives.

6.2.2 Lessons from partnership strategy

The joint working approach of Norway institutions with their implementing partners also revealed the following lessons:

- Mutual understanding and working to achieve similar goals and objectives motivated all to achieve the desired result.
- Limited capacity in terms of human resources can reduce and limit full engagement in joint planning, management, monitoring and evaluation of activities.
- Partnership based on mutual understanding can encourage accountability, responsibility and transparency.

6.2.3 Experiences to improve future engagement

The above lessons are drawn from experience in order to learn from, improve and guide future engagement. The lack of connectivity amongst stakeholders to share lessons and avoid duplication of efforts is a major issue that needs to be addressed for future engagements.

Although a lack of documented partnership strategy has not inhibited the implementation of activities and interventions during the period evaluated, but having a clearly spelt out partnership strategy can enhance better understanding on the side of each partner, on mode of operations and also enhance project outputs and outcomes.

6.2.4 Best practices

The identification of good practices is made to follow some of the key considerations outlined in the UNAIDS best practice document, (UNAIDS, 2000). According to the document, the concept of best practice is not reserved for ultimate truth or gold standards. However it means accumulating and applying knowledge about what is working and not working in different situations and context. In other words, it is both lessons learned and the continuing process of learning, feedback, reflection, and analysis (what works, how, why and so forth). The UNAIDS document further states that at its most basic, "Best Practices" suggest a simple maxim: "Do not reinvent the wheel; learn in order to improve it, and adapt to your terrain to make it work better".

The context used to define good practices in this report also follows the procedure stated above. In other words, for this review, "Good Practice" is anything that works in full or part for the organisations that implemented the project and that can be useful in providing lessons learned to others who would like to implement or get involved in similar endeavours. Having consulted and reviewed the implementation strategies and achievements made by the various projects, this evaluation was able to identify some good practices that could be valuable to others who would like to be involved in similar endeavours.

Some of these good practices include:

- Utilising various routes to channel support has been effective in targeting various levels of stakeholders especially the forgotten poor and marginaslied groups.
- Provision of quality and user friendly information services to youth through the establishment of resource centres with internet connected computers and library services to ensure that the female students are able to access information on SRH/HIV/AIDS and also learn to acquire computer skills in the process.
- Integration of VCT with basic RH and family planning services which have enhanced uptake of both services and contributing to the practice of safer sex amongst young people.
- Linking VCT and FP services using the market based approach have allowed the most needy section of the community to have access to HIV and RH services and enhance appropriate referral as required for clients to access other services such as antenatal care, ART, PMTCT etc.
- In addition, there are other various good practices that have impacted on the lives of the people positively already documented in this report (see 5.1.5, 5.4, 5.5 and 5.7).

6.3 Recommendations

The following are the key recommendations arising from the evaluation:

Continuity of support through multiple channels - Engagement of Norway through multiple channels using the global instruments, multilaterals and the Norwegian NGOs was found to be effective in implementing some good practices that contributed to the progress made in achievement of the key behaviour outcomes and impact indicators. This effort should continue and expansion of these projects should be considered with clear targets and indicators for monitoring.

Support provision of technical assistance to HIV mainstreaming in key sectors – There is need for Norway to engage with other partners to ensure provision of technical assistance for effective HIV mainstreaming across sectors in the country. This will ensure effective deployment and utilisation of resources from World Bank MAP 2 and other sources. In addition is the need to consider capacity required for effective HIV mainstreaming into the current Norwegian priorities in the country that focus on Human Rights, Governance & Democracy, Peace & Stability and Natural Resource Management.

Focus on weak connectivity of interventions - The weak connections of activities supported by Norway in the country must be addressed. A forum should be created where the stakeholders (implementing partners) involved are able to plan collectively and interact with one another to share lessons and best practices towards the achievement of key behaviour outcomes. This strategy will enhance effective utilisation and coverage of interventions, especially with the forthcoming Norwegian supported joint UNFPA and UNICEF programme.

Norway to engage with government & other donors - Norway should engage more with the government (HAPCO) and other donors to add their voice to shaping of the responses at

country level. This will enhance Norwegians' recognition in relation to their contributions to the control of the epidemic. Appointing a focal person in the embassy will ensure effective engagement and also take on the responsibility of coordinating the institutions involved in utilising Norwegian resources for HIV/AIDS.

Norway to work with other partners to address weak M & E system – UNAIDS is providing technical assistance to FHAPCO to address weak M & E system in the country, Norway should work with other partners in this regard as this will add significant value in ascertaining the status of response and identify gaps for subsequent interventions.

Development of Partnership Strategies and Framework for Operations – Clear 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. The strategy should also include the partnership principles and such principles should be adopted for the development of indicative framework to guide measuring of success in the utilisation of resources, management of projects and initiatives. Such strategies should be considered for adoption at all levels and channels utilising Norwegian resources for HIV/AIDS interventions.

Development of HIV//AIDS Country Programme Strategy - HIV/AIDS country programme strategy should be designed and developed with clear indicative logical frameworks. This should be done in consultation with stakeholders in order to address the needs of the country and fill gaps especially in areas where other development partners are not engaged and documented in Norway's 2006 HIV/AIDS Policy Position Paper. In addition, Norway could explore engagement of consortia based on expertise and comparative advantages to fulfil needs for the implementation of the programmes.

Strengthening of Civil Society Networks – Norwegian support could make a difference in strengthening the networks of civil society including that of PLWHA, in order to enhance their representation and voices in policy influencing and be actively involved in decisions that will enhance their participation in the national response.

Annex 1: Terms of Reference of Evaluation of Norwegian HIV/AIDS Responses in Three African Countries: Ethiopia, Malawi & Tanzania.

– See Appendix 1 page 285

Annex 2: List of Institutions and Persons Consulted

NO	NAME	ORGANISATION	POSITION	TEL/EMAIL
1.	Bente Nilsson	Royal Norwegian Embassy, Addis Ababa	Counsellor/Head of Development Cooperation	+251113710799 bn@mfa.no
2.	Ashenafi Gizaw Beyea	Royal Norwegian Embassy, Addis Ababa	Programme Officer	+251113710799 Ashenafi.gizaw@mfa.no
3.	Hussein Faris	National HIV/AIDS Prevention & Control Office (HAPCO)	Head of Planning & Programme Department	+251115503745 +251911254258 husfate@yahoo.com
4.	Mr. Hans Birkeland	Norwegian Church Aid	Country Representative	+251115512922 hansb@nca-ethiopia.org
5.	Kidist Belayneh	Norwegian Church Aid	HIV/AIDS Programme Coordinator	+251115512922 kidistb@nca-ethiopia.org
6.	Ayehualem Tameru	UNFPA	Programme Officer	tameru@unfpa.org
7.	Samia Mohammaed	UNICEF	APO	samohammed@unicef.org
8.	Daba Fayissa	UNICEF	Project Officer	dfayissa@unicef.org
9.	Mirgissa Kaba	UNICEF	Programme Office HIV/AIDS	mkaba@unicef.org
10.	Dr. Kidone Ghebrekidau	UNFPA	RH/FP Programme Officer	ghebrekidau@unfpa.org
11.	Helen Amdemikael	UNFPA	Gender & Advocacy Programme Officer	amdemikael@unfpa.org
12.	Dr Roger Salla Ntounga	UNAIDS	UNAIDS Country Coordinator & Representative to AU & UNECA	roger.salla.ntounga@undp.org
13.	Bjorn Hagen	Save the Children Norway (SCN), Ethiopia	Country Representative	BjornH@scne.org
14.	Melesse Delegega	SCN, Ethiopia	Programme Coordintaor Education	0911243255 melessed@scne.org
15.	Shurmye W. Selassie	SCN, Ethiopia	Field Office Manager	0918771001 shumyew@scne.org
16.	Yidnekachew Tilahun	SCN, Ethiopia	HIV/AIDS Programme Coordinator	0911990277 yidnekachewt@scne.org
17.	Solomon Kelkai	SCN, Ethiopia	Programme Director	0911220287 solomonk@scne.org
18.	Dr. Abiyot Belai	AMREF	RH Project Officer	0911413126 drmarkbel@yahoo.com
19.	Dr. Howard Engers	Armauer Hansen Research Institute	Director of Institute & Vaccine Specialist	+251113211334 +251911247529 engersh@ahrialert.org
20.	Serkalem Awlachew	Mary-Joy AID for Development	Programme Manager (PLAN – Mary-Joy)	0911612778 sercow@yahoo.com
21.	Dawit Adnew	Mary-Joy AID for Development	Project Officer	09116546358 Dawit_ae@yahoo.com
22.	Fasil Asesneho	Mary-Joy AID for Development	Community Development Coordinator	maryjoy@ethonet.et
23.	Etalem Alemayohu	Mary-Joy AID for Development	Community Development Worker	maryjoy@ethonet.et

NO	NAME	ORGANISATION	POSITION	TEL/EMAIL
24.	Dr. Habtamu Woldeyes	EECMY/DASSC	Human Development Coordinator	0911690737 habtamuw@eecmy.org drhabtamu@yahoo.com
25.	Deed Jaldessa	EECMY/DASSC	Director	0911695536 d.jaldessa@ethionet.et
26.	Dereje Tolessa	EECMY/DASSC	Project Officer – HIV/AIDS	derejetolessa@yahoo.com
27.	Mr. Haile-Leul Siyoum	Federal Ministry of Youth, Addis Ababa	Head of Department, Youth Programmes Coordination	axumaitk@yahoo.com
28.	Mr. Kassu Abdi	Federal Ministry of Education	HIV/AIDS Focal Person/ Former Head, Secondary Education Dept /Snr Expert School Improvement Programme.	0911087289
29.	Prof. Hammed Ali	Public Health Dept, Medical College Ethiopia	Head, Epidemiology Dept.	0911684399
30.	Adeye Befecadu	SIDA	Programme Officer, HIV/ AIDS & Civil Society	+251115180000 Adeye.befecadu@foreign.ministry.se
31.	Dr. Ibrahima Yusuf	Organisation for Social Services for AIDS	Section Head, Psychosocial Services	0911488313 ossa@ethionet.et
32.	Santiago Bernal	PLAN, Ethiopia	Country Director	0911206759 santiago.bernal@plan-international.org
33.	Dr Tezera Fisseha	PLAN, Ethiopia	Programme Support Manager	+251114670175 Tezera.fisseha@plan-international.org
34.	Jemal Mohammed	PLAN, Ethiopia	HIV/AIDS Programme Coordinator	+251114670175-82 Jemal.mohammed@plan-international.org
35.	Lakew Abode	New Life Community	Grant Consultant	gedionfk@yahoo.com
36.	Girmay Abadi	New Life Community	HIV/AIDS Coordinator	girmazole@yahoo.com
37.	Asnake Hailu	GTZ	Coordinator, HIV/AIDS Mainstreaming Unit	0911405023 Gtz-hamsu@ethionet.et
38	Ashish Kumar	NEP+ (Network of PLWHA)	Programme Adviser	program@evelopment.org
39.	Tigabe Asres	NEP +	Executive Director	0116181973 0911883665 aelwha@ethionet.et
40.	Hans Doctor	Embassy of the Kingdom of the Netherlands	Head of Development Cooperation / Deputy Head of Mission	0113711100 hans.doctor@minbuza.nl
41.	Digafe Feleke	PRO PRIDE	Director	09200620 propride@telecom.net.et
42.	Meheret Lemma	PRO PRIDE	Programme Officer	0911434649 mmhort@yahoo.com
43.	Sr. Kelemework Abayueh	Markato Clinic	Counsellor	0911686969
44.	Beleto Zewale	Youth Association Centre, Addis Kararma	Coordinator	0911403890
45.	Tigist Tibebe	FGAE, Kirkos	Coordinator	0911670122 tigisttibebe@yahoo.com
46.	Ayalew W. Semait	ANPPCAN	Executive Director	0911640739 Annppcan-eth@ethionet.et

NO	NAME	ORGANISATION	POSITION	TEL/EMAIL
47.	Mekonnen Addisu	ANPPCAN	Snr. Programme Coordinator	0918700525 mekonnenaty@yahoo.com
48.	Belay Zelleke	ANPPCAN	Snr. Programme Officer	0911640755 belayzellekebeshir@yahoo.com
49.	Nehemie Mbakuliyemo	WHO	EPI Team Leader & Acting Country Representative	0911200598 mbakuliyemon@et.afro.who.int
50.	Dr. Akram A. Eltom	WHO	HIV/AIDS Country Team Leader	0911058889 eltoma@et.afro.who.int
51.	James Browder	USAID Ethiopia	HIV/AIDS Officer	0911249522 jbrowder@usaid.gov
52.	Dr. Gebrelassie Okubagzi	The World Bank, Ethiopia	Snr. Health Specialist	+251116627700 Gokubagzhi1@worldbank.org
53.	Iyasu Haile Sellassie	MSDA Ethiopia	Executive Director	0911407833 Ethio.africa@yahoo.co.uk
54.	Marion Kelly	DFID Ethiopia	HIV/AIDS & Health Adviser	0911683239 m-kelly@dfid.gov.uk
55.	Duro Burje	AASECMY		amshiduro@gmail.com
56.	Demissie Tassew	Gemini Trust		dembeye@yahoo.com
57.	Aklilu Nega	ISAPSO		ISAPSO@ethionet.et
58.	Dr Yesus Belele	Ethiopian Aid		ethiopianaid@ethionet.et
59.	Saba Elmedhin	NEWA		newa@ethionet.et
60.	Sisay Worku	BICDO		bicdo@ethionet.et
61.	Sisay Abebe	EVMPA		evmpa@ethionet.et
62.	Jemal Abdella	BICDO		bicdo@ethionet.et
63.	Mekdine Admassie	OSSA		ossa@ethionet.et
64.	Sr. Felekech Buldela	EGT		
65.	Tesfamariam W/ Sembet	MSDAE		tesfawolbesembet@yahoo.com
66.	Alezuzeh Chefihet	SYGE		syg@ethionet.et
67.	Senait H. Giorgis	EA		ethiopianaid@ethionet.et
68.	Adinew Husien	FGAE		adnewh@yahoo.com

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Annex 4: Overview of Norwegian policy statements and priorities regarding HIV/AIDS[28]

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. State budget provides few references to HIV/AIDS as a priorities under the headings 'social development', 'support to Africa', and 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. Three main 'arenas' identified: Multilateral system with UNAIDS as a 'main actor' and 'pathfinder' (veiviser) and other multilateral institutions supporting within their areas of responsibility. Country level emphasis on national aids programmes and calling for private sector and civil society to support these. Establishment of several forums in Norway (Norad, MFA and cross-sectors) for increased focus and competence building on HIV/AIDS. Brief references to HIV/AIDS in budgets for Tanzania and Malawi, not for Ethiopia.

28 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
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: Prevention and treatment is highlighted in the specific thematic approach while mitigation is more focused in the mainstreaming approach. Increase in multilateral support More focus on bilateral cooperation, through support to national AIDS plans with a particular focus on districts and local communities. Measures to increase competence in the region (Africa). Norwegian public-private partnerships against AIDS will be promoted. Continue prevention measures, support to women, youth and children (incl. PMTCT) will continue more focus on men's responsibility, incl military forces. Support to more accessible and affordable treatment. The state budget seem 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. 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.
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 mainsteamed. In state budget, there is a general increase in priority to HIV/AIDS, in particular: 'participate in international efforts' increase support to UNAIDS continue high support to GFATM increase support to IAVI increase support to IPM continue support to specific HIV/AIDS efforts through civil society and bilateral cooperation focus on integration of HIV/AIDS in various sectors in particular in Sub Saharan Africa. The health personell crisis are given more focus by the government in some public statements and reflected in a seminar (late 2004). 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 specified to capacity building in public sector and 'work on local level'.
2005	No majors shifts in policy. Priorities in budget: contribute to coordination of international efforts increased support to UNAIDS and UNFPA continued support to GFATM support WHO's work for medical treatment in poor countries increase support to IAVI and IPM increase specific HIV/AIDS measures in bilateral cooperation continue support to Civil society organisations integration of HIV/AIDS in various sectors, in particular SSA. On 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.

Budget year	Main policy issues and priorities
2006	No major shifts in policies in state budget. Priorities: increase support to UNAIDS, UNFPA and UNICEF double support to GFATM compared to previous year. increase support for medical treatment in poor countries, through GFATM, WHO and in cooperation with the Clinton Foundation increase support to vaccine development and prevention for women increased focus on the health personnel crisis in Africa Support African countries' research on HIV/AIDS, incl Mandela Foundation 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. A new policy position on HIV/AIDS were presented in November 2006, which is believed to be influential after the period of evaluation.

Annex 5: Country Data Sheet (Summary of Country Profile)

HIV & AIDS ESTIMATES		
Number of people living with HIV	1,300,000	
Adults aged 15 – 49 HIV prevalence rate	1.4 – 3.5%	
Adults aged 15 and over living with HIV	380,000 – 1,200,000	
Women aged 15 and over living with HIV	190,000 – 730,000	
Deaths due to AIDS	38,000 – 130,000	
Children aged 0 – 14 living with HIV	30,000 – 220,000	
Orphan aged 0 – 17 due to AIDS	280,000 – 870,000	
COUNTRY PROGRESS INDICATORS		
Expenditure: National funds spent by government from domestic sources	-	
% of pregnant women receiving treatment to reduce mother to child transmission	0.3%	
% of HIV infected women and men receiving antiretroviral therapy	63% of 286,258	
School attendance amongst orphans	26%	
School attendance amongst non-orphans	43%	
Knowledge & Behavior	**Women**	**Men**
% of young women and men, aged 15 – 24 who correctly identify ways to prevent HIV	41.1%	58.2%
% of young women and men, aged 15 – 24 who had sex with a casual partner in the past 12 months	5.8%	37.4%
% of young women and men, aged 15 – 24 who had sex before age 15	15.8%	1.7%
% of young women and men, aged 15 – 24 who used condom last time they had sex with a casual partner	28.4%	50.2%

Annex 6: Norwegian Financial Inputs

Table 1:OECD DAC Official Statistics of ODA Net Aid Flows to Ethiopia – 2000 - 2006

Amount type	Current Prices (USD millions)								
Year	2000	2001	2002	2003	2004	2005	2006	Sum	%
Donor									
All Donors, Total	686.14	1103.67	1297.39	1593.97	1805.69	1909.98	1946.83	10344	100%
DAC Countries, Total	379.49	367.08	489.22	1033.33	1024.74	1185.09	1024.09	5503	53%
Multilateral, Total	291.56	708.73	774.3	528.12	743.98	695.84	897.6	4640	45%
G7, Total	260.15	232.85	357.53	836.01	805.79	935.84	780.22	4208	41%
DAC EU Members, Total	175.35	187.64	242.45	324.1	489.67	433.58	541.92	2395	23%
Non-DAC Countries, Total	15.09	27.86	33.87	32.52	36.97	29.05	25.14	201	2%
Austria	3.76	6.96	4.3	7.57	4.3	7.64	17.59	52	1%
Canada	10.94	12.38	6.88	38.02	59.48	64.93	62.48	255	2%
Denmark	2.56	2.75	2.68	2.97	2.62	4.06	5.74	23	0%
Finland	5.66	5.05	4.58	9.16	9.06	11.08	13.21	58	1%
France	9.41	6.61	10.18	15.56	26.25	15.87	17.35	101	1%
Germany	38.63	25.88	40.61	47.61	126.09	49.85	56.76	385	4%
Ireland	21.63	21.09	25.3	33.38	42.44	44.1	50.63	239	2%
Italy	25.97	13.56	49.24	47.57	11.21	86.93	105.39	340	3%
Japan	34.03	52.39	50.53	56.53	33.33	34.17	57.85	319	3%
Netherlands	25.72	44.18	34.79	57.23	57.52	58.66	49.76	328	3%
Norway	23.57	16.25	28.48	37.18	34.04	38.07	41.8	219	2%
Sweden	20.72	20.62	21.31	28.63	50.76	68.37	41.53	252	2%
United Kingdom	11.35	27.61	43.66	62.92	147.13	75.48	164.61	533	5%
United States	129.82	94.42	156.43	567.8	402.3	608.61	315.78	2275	22%
AfDF (African Dev.Fund)	22.2	29.01	78.24	10.87	63.89	118.45	138.01	461	4%
EC	68.99	100	116.55	149.14	112.65	163.47	194.37	905	9%
Global Fund (GFATM)	..	..	..	45.74	..	77.91	130.62	254	2%
Nordic Dev. Fund	0.66	4.8	2.65	3.56	2.19	7.38	2.63	24	0%
IDA	115.55	434.42	464.33	246.56	476.32	247.29	331.57	2316	22%
IFAD	3.14	3.93	5.05	8.68	8	12.71	16.3	58	1%
UNDP	18.84	17	13.33	10.65	10.97	12.06	17.17	100	1%
UNFPA	2.96	3.33	3.8	4.54	5.26	4.19	4.06	28	0%

Amount type	Current Prices (USD millions)								
Year	2000	2001	2002	2003	2004	2005	2006	Sum	%
UNHCR	16.3	18.38	19.15	14.39	8.84	8.24	8.9	94	1%
UNICEF	13.45	19.38	14.01	14.56	18.62	24.09	25.83	130	1%
WFP	36.02	27.31	23.53	15.23	9.83	14.08	15.97	142	1%
Other Bilateral Donors	11.91	16.02	27.56	29.94	25.45	24.1	23.3	158	2%

data extracted on 2008/06/03 16:50 from OECD.Stat

Table 2 Distribution of Norwegian aid by DAC main sector codes

Sum of Disbursed (1000 NOK)	Year								
DAC Main sector (code+name)	2000	2001	2002	2003	2004	2005	2006	Grand Total	%
111 - Education, level unspecified	3,379	3,856	3,295	6,201	6,000	6,000	9,076	37,808	2%
112 - Basic education	3,129	4,742	4,691	5,916	7,694	6,516	10,057	42,744	3%
113 - Secondary education	2,269	1,977	2,236	2,492	603	1,215	1,215	12,006	1%
114 - Post-secondary education	784	1,159	5,058	2,099	2,570	6,105	5,604	23,380	1%
121 - Health, general	10,580	11,950	14,483	19,853	26,717	17,873	10,907	112,363	7%
122 - Basic health	8,890	10,868	19,524	8,051	4,549	11,742	2,393	66,018	4%
130 - Population policies/ programmes and reproductive health	424	8,488	15,302	11,278	9,753	5,148	9,899	60,292	4%
140 - Water supply and sanitation	3,357	7,112	8,371	6,472	6,202	8,651	13,409	53,573	3%
151 - Government and civil society, general	25,986	10,699	25,595	19,050	34,862	25,717	30,956	172,864	11%
152 - Conflict prevention and resolution, peace and security	2,280	6,000	800	10,347	4,807	12,324	15,709	52,267	3%
160 - Other social infrastructure and services	14,419	8,346	10,814	14,494	17,801	11,782	6,992	84,647	5%
210 - Transport and storage	139	716	1,074	447	363	861	4,544	8,143	1%
220 - Communications	223	1,446	2,690	1,177	1,231	1,847	797	9,411	1%
230 - Energy generation and supply	477	3,919	154	10,000	5,384	21,660	2,638	44,231	3%
240 - Banking and financial services	346	378			5,398	4,856	3,343	14,320	1%

Sum of Disbursed (1000 NOK)	Year								
DAC Main sector (code+name)	2000	2001	2002	2003	2004	2005	2006	Grand Total	%
250 - Business and other services		30				491	321	841	0%
311 - Agriculture	33,171	21,172	15,657	21,197	17,099	9,599	11,952	129,847	8%
312 - Forestry							500	500	0%
321 - Industry			94	730	627	80	73	1,604	0%
322 - Mineral resources/ mining	1,800	3,535	157					5,492	0%
323 - Construction						61		61	0%
332 - Tourism				1			121	122	0%
410 - General environmental protection	2,059	4,205	836	909	826	1,741	29,305	39,881	3%
420 - Women in development (WID)	654	1,550	1,904	2,793	2,906	1,740	813	12,359	1%
430 - Other multisector	9,412	8,540	5,847	8,973	11,275	27,768	22,495	94,311	6%
520 - Developmental food aid / Food security assistance		3,517	4,767	5,562	552			14,398	1%
710 - Emergency food aid	46,080	3,828	17,202	18,610	0	15,747	10,000	111,466	7%
720 - Other emergency and distress relief	36,456	16,359	60,049	83,271	59,389	44,271	64,339	364,134	23%
998 - Unallocated/ unspecified	1,008	2,100	6,801	3,300	2,815	1,412	711	18,146	1%
Grand Total	207,321	146,492	227,401	263,223	229,421	245,205	268,169	1,587,231	100%

Table 3 Disbursement against HIV/AIDS marker

Sum of Disbursed (1000 NOK)	Year								
PM - HIV/Aids	2000	2001	2002	2003	2004	2005	2006	Grand Total	%
None	206,897	137,651	179,233	217,579	189,399	221,874	240,126	1,392,759	88%
Significant objective		529	20,673	21,919	16,840	14,629	18,996	93,586	6%
Main objective	424	8,312	27,494	23,724	23,182	8,702	9,047	100,886	6%
Grand Total	207,321	146,492	227,401	263,223	229,421	245,205	268,169	1,587,231	100%

Table 4 Disbursement for HIV/AIDS by type of assistance and agreement partner

Sum of Disbursed (1000 NOK)	Type of assistance			
Group of Agreement Partner	Bilateral	Multi-bilateral	Grand Total	%
NGO Regional	3,711		3,711	2%
NGO Local	980		980	1%
NGO Norwegian	136,527		136,527	70%
Not NGO	6,385	47,335	53,720	28%
Grand Total	147,602	47,335	194,938	100%
	76%	24%	100%	

Table 5 Disbursement by implementing institution and HIV/AIDS marker

Sum of Disbursed (1000 NOK)	PM - HIV/Aids			
Implementing Institution	Significant objective	Main objective	Grand Total	%
Addis Ababa Traffic Police	219		219	0%
ADRA-International	900		900	0%
AHRI	5,000		5,000	3%
AMREF		3,711	3,711	2%
ANPPCAN - African Network for Prevention and Protection Against Child Abuse and Neglect	1,652		1,652	1%
Anthropoligical Approach	2		2	0%
CfHD - Centre for Human Development, Ethiopia		52	52	0%
CHAD-ET - Children Aid Ethiopia	269		269	0%
Chilga Woreda Administration Office, North Gonder, Amhara Region		995	995	1%
College of Teachers Ed (ETH)	668		668	0%
CRDA - Christian Relief and Development Association, Ethiopia		54	54	0%
Dawn of Hope Ethiopia Association		42	42	0%
Demitu Gudeta	27		27	0%
Dr. Bernt Lindtjørn	17	3	21	0%
Dr. Mekonnen		61	61	0%
EECMY - Ethiopian Evangelical Church Mekane Yesus	19,756	1,156	20,912	11%
EMA - Ethiopian Medical Association		55	55	0%
ENAT (ETH)		195	195	0%
ESRDF (ETH)	171		171	0%
ETH Evangelical Church Mekane Yesu	10,106	1,062	11,168	6%
Ethiopia Ministry of Education	8,815		8,815	5%

Sum of Disbursed (1000 NOK)	PM - HIV/Aids			
Implementing Institution	Significant objective	Main objective	Grand Total	%
Ethiopia Ministry of Health	1,532		1,532	1%
Ethiopian Orthodox Church	292		292	0%
FAO - Food and Agricultural Organization of the United Nations	2,000		2,000	1%
FAO - Food and Agriculture Organization of the United Nations	7,770		7,770	4%
FSCE - Forum on Street Children	1,036	1,231	2,267	1%
Gondar Education Media Centre	954		954	0%
Gonder College	650		650	0%
Hiwot, Ethiopia	1,003		1,003	1%
ISAPSO - Integrated Services for AIDS Prevention and Support Organisations		3,287	3,287	2%
Jacinta M Maingi		19	19	0%
Jimma University		43	43	0%
Kazanchis Congregation of AASECMY, Ethiopia		302	302	0%
Kirkens Nødhjelp	342		342	0%
Local Government (ETH)	3,616		3,616	2%
Local healthauthorities (ETH)		6,390	6,390	3%
Management and System Consultancy		36	36	0%
Mary Joy Aid Through Development, Ethiopia	1,545		1,545	1%
Medical College (ETH)	652		652	0%
Ministry of Education	383		383	0%
Misc		500	500	0%
Misc Consultants	2	97	100	0%
Misc NGOs	1,131	15,338	16,469	8%
Missionaries of Charity		700	700	0%
Multi Purp. Com.Dev.	1,696		1,696	1%
National HIV/AIDS Prevention and Control Secretariat		40	40	0%
NBS		1,222	1,222	1%
NCG - Nordic Consulting Group	284		284	0%
NCTPE - National Committee on Traditional Practices in Ethiopia	34		34	0%
New Life Community, Ethiopia	2,061	1,439	3,500	2%
North Gonder Zone Education Department	5,017		5,017	3%
Norwegian Church Aid - local office	756		756	0%
Org for Social Services for AIDS		3,861	3,861	2%
PAJS - Professional Associations Joint Secretariat, Science and Technology Popularization Department		50	50	0%
Plan International		811	811	0%
Ratson	2,129		2,129	1%
Redd Barna	1,265		1,265	1%
Reg Govermt police commission (ETH)	652		652	0%
Regional Education Bureau	6,070		6,070	3%
REST - Relief Society of Tigray		34,469	34,469	18%
Rift Valley Children and Women Development Association	547		547	0%
Save the Children	502		502	0%
SFPI - Specialized Financial and Promotional Institution, Ethiopia	461		461	0%
SNNP police com	114		114	0%

Sum of Disbursed (1000 NOK)	PM - HIV/Aids			
Implementing Institution	Significant objective	Main objective	Grand Total	%
SOS Children's Villages Ethiopia	1,062		1,062	1%
Statens Legemiddelverk	64		64	0%
UNAIDS - UN Programme on HIV/AIDS		1,772	1,772	1%
UNICEF		14,500	14,500	7%
UNICEF- United Nations Children's Fund		5,105	5,105	3%
Unknown	2	24	25	0%
WAT - Women's Association of Tigray		2,419	2,419	1%
WeSMCO - Welfare for Street Mothers and Children Organization, Ethiopia		250	250	0%
Women and Child Tracer	360		360	0%
Yehenew Tsegaye		60	60	0%
Grand Total	93,586	101,352	194,938	100%

Table 6 Relationship between gender and HIV/AIDS markers

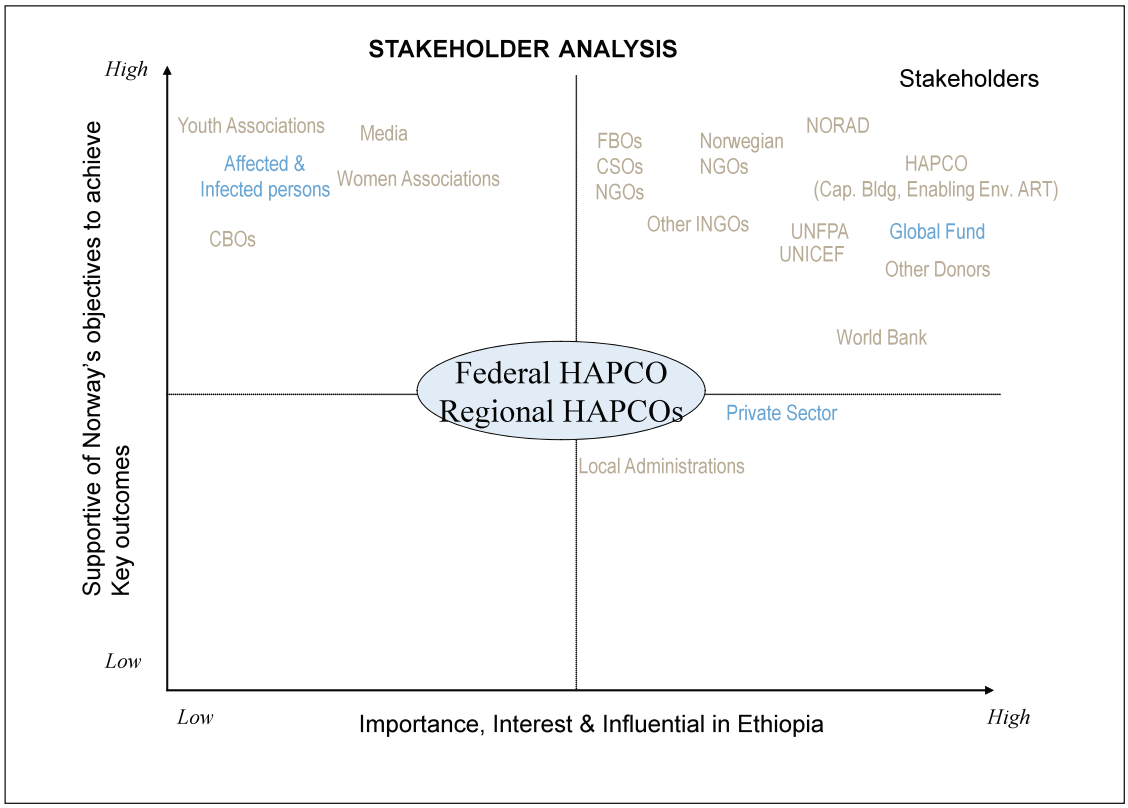
Sum of Disbursed (1000 NOK)	PM - HIV/Aids				
PM - Gender and equality	None	Significant objective	Main objective	Grand Total	%
None	1,102,733	45,938	46,500	1,195,171	75%
Significant objective	174,467	32,176	46,263	252,906	16%
Main objective	115,559	15,472	8,123	139,154	9%
Grand Total	1,392,759	93,586	100,886	1,587,231	100%
	88%	6%	6%	100%	

Table 7 Attention to HIV/AIDS and gender in sectoral programmes

Sum of Disbursed (1000 NOK)	PM - HIV/Aids				PM - Gender			
DAC Main sector (code+name)	None	Significant objective	Main objective	Grand Total	None	Significant objective	Main objective	Grand Total
111 - Education, level unspecified	100%	0%	0%	100%	25%	3%	73%	100%
112 - Basic education	44%	56%	0%	100%	97%	0%	3%	100%
113 - Secondary education	100%	0%	0%	100%	100%	0%	0%	100%
114 - Post-secondary education	100%	0%	0%	100%	99%	1%	0%	100%
121 - Health, general	84%	15%	0%	100%	75%	20%	5%	100%
122 - Basic health	79%	17%	4%	100%	60%	17%	22%	100%
130 - Population policies/ programmes and reproductive health	5%	1%	93%	100%	68%	20%	12%	100%
140 - Water supply and sanitation	99%	1%	0%	100%	47%	53%	0%	100%
151 - Government and civil society, general	99%	1%	0%	100%	87%	5%	9%	100%
152 - Conflict prevention and resolution, peace and security	100%	0%	0%	100%	100%	0%	0%	100%
160 - Other social infrastructure and services	64%	30%	5%	100%	78%	21%	1%	100%
210 - Transport and storage	100%	0%	0%	100%	100%	0%	0%	100%
220 - Communications	100%	0%	0%	100%	67%	13%	20%	100%
230 - Energy generation and supply	100%	0%	0%	100%	100%	0%	0%	100%

Sum of Disbursed (1000 NOK)	PM - HIV/Aids				PM - Gender			
DAC Main sector (code+name)	None	Significant objective	Main objective	Grand Total	None	Significant objective	Main objective	Grand Total
240 - Banking and financial services	100%	0%	0%	100%	85%	14%	1%	100%
250 - Business and other services	100%	0%	0%	100%	100%	0%	0%	100%
311 - Agriculture	66%	8%	27%	100%	35%	64%	1%	100%
312 - Forestry	100%	0%	0%	100%	100%	0%	0%	100%
321 - Industry	100%	0%	0%	100%	95%	5%	0%	100%
322 - Mineral resources/ mining	100%	0%	0%	100%	100%	0%	0%	100%
323 - Construction	100%	0%	0%	100%	100%	0%	0%	100%
332 - Tourism	100%	0%	0%	100%	100%	0%	0%	100%
410 - General environmental protection	100%	0%	0%	100%	72%	0%	28%	100%
420 - Women in development (WID)	74%	6%	20%	100%	0%	4%	96%	100%
430 - Other multisector	98%	2%	0%	100%	26%	46%	27%	100%
520 - Developmental food aid / Food security assistance	100%	0%	0%	100%	6%	94%	0%	100%
710 - Emergency food aid	100%	0%	0%	100%	92%	0%	8%	100%
720 - Other emergency and distress relief	100%	0%	0%	100%	96%	2%	2%	100%
998 - Unallocated/unspecified	100%	0%	0%	100%	100%	0%	0%	100%
Grand Total	88%	6%	6%	100%	75%	16%	9%	100%

Annex 7: Stakeholder Analysis



Annex 8: Time Line and Scale of Interventions

Name of Principal Norway Partner	Intervention Period	Types of intervention	Partners	Geographic coverage and # bene-ficiaries	Budget in USD
UNICEF	2001-2006	Community conversation, youth dialogue, life skills education, care and support, IGA, youth leadership, sub grants for OVC families, social mobilization to create to PMTCT by youth, IEC/BCC, basic facts on HIV/AIDS and awareness raising, Capacity building for implementing organizations, networking, conducting rapid assessment, Training on project management, media and youth activities	Regional HAPCO, FGAE, OSSA	Amhara region (9 woredas) 392,948	1.8M
		Establishment of youth network, IEC/BCC, Life skills education, VCT center establishment, Training on STIs, Supplies for AACs, youth dialogue, capacity building for youth and youth serving organizations, Youth friendly services, , leadership training, peer education, life skills, project design, OVC support, OVC rapid assessment, work with FBOS and CBOs, home based care, pastoralist based mobile HIV/AIDS education, life skills education, care and support, awareness raising and behavioral change, IEC/BCC materials distribution, community conversation	Regional HAPCO	Somali Region (7 woredas) 31, 315	
		IEC/BCC, Life skills education, VCT centre establishment, Training on STIs, Supplies for AACs, youth dialogue, capacity building for youth and youth serving organizations, Youth friendly services, Lambadia news letter, leadership training, peer education, life skills, project design, monitoring and evaluation FBOs and CBOs, home based care, Awareness raising on HIV/AIDS, media and youth activities, social mobilization and awareness raising on HI/AIDS	Regional HAPCO, FGAE, OSSA	Addis Ababa (5 sub cities) 561, 961	
		Mainstreaming HIV/AIDS, resource team establishment, IEC/BCC, Life skills education, VCT centre establishment, Training on STIs, Supplies for AACs, youth dialogue, capacity building for youth and youth serving organizations.	Regional HAPCO	Dire Dawa special administration (all 9 kebeles) 302, 626 beneficiaries.	

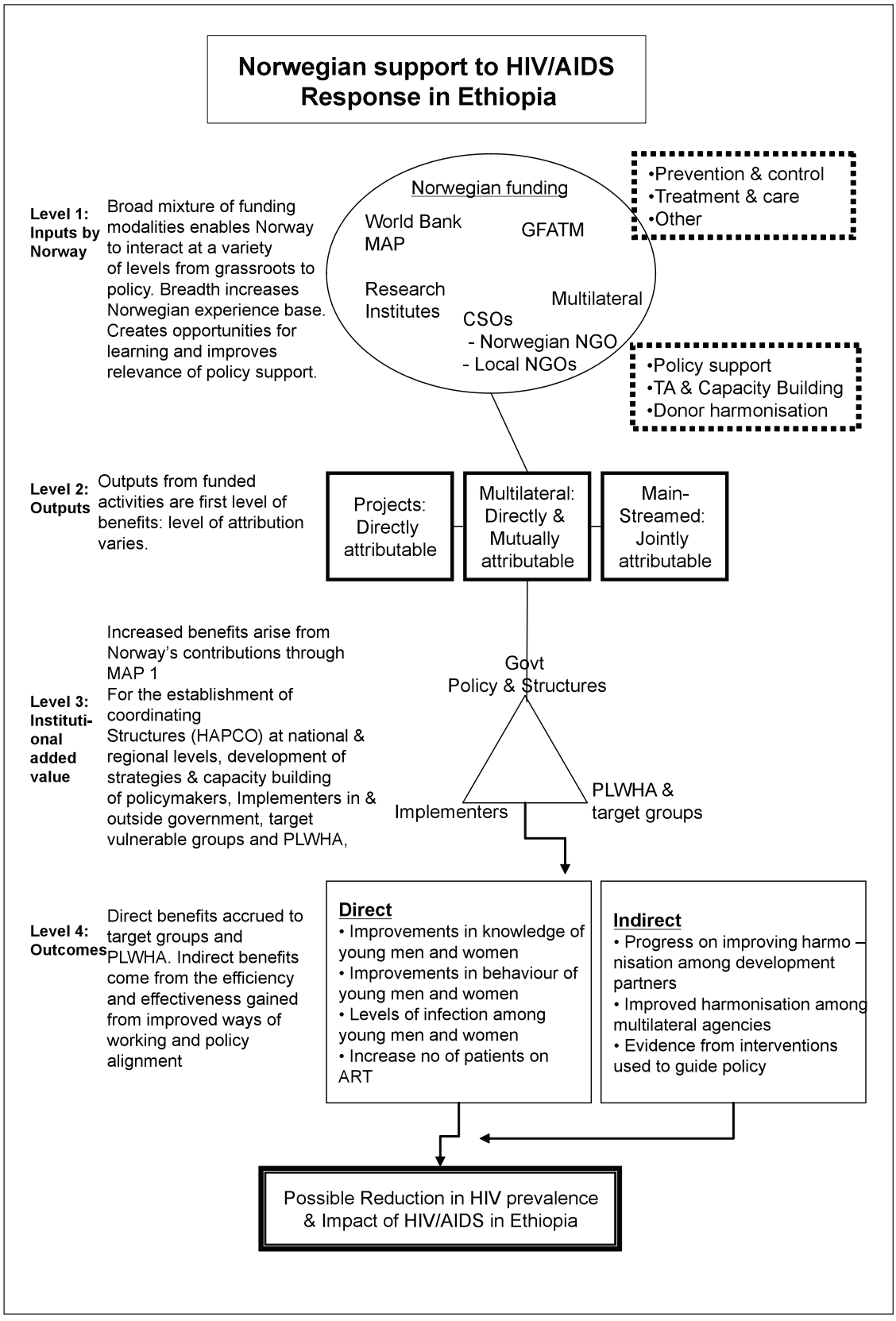
Name of Principal Norway Partner	Intervention Period	Types of intervention	Partners	Geographic coverage and # bene-ficiaries	Budget in USD
UNFPA	2002-2005	Provision of user friendly information services to female students of higher learning institutes, Integration of VCT with basic RH services, Linking VCT and FP service through the market based approach, Implementing mutually reinforcing clinical and peer services, Creating access to information to hard reach groups, Advocacy for policy change, Enhancing community conversation through a culturally appropriate approach, Use of telephone hotline for information delivery, Making the existing services youth friendly and ensuring the sustainability of youth center activities, Care and support to PLHAs and OVC	12 local NGOs (African AIDS initiative inc., African service comitee, BICDO, Ethiopian AID, EGT, FGAE, ISAPSO, MSDAE, EGLDAM, OSSA, PRO PRIDE, SIDO) and Government (MOY, HAPCO, MOH, MOE)	Science faculty of AA University, Amhara region (6 woredas), AA (9 sub-cities), Oromyia region (6 woredas), SNNPR (2 woredas), Tigray region (5 woredas), 10 towns across Addis Borena and Addis Moyale transport routes, 34 schools located in all regions. 1,376,792 (youth, CSWs, OVC, PLHA, destitute mothers, drivers, college students)	1.8 M
Norwegian Church Aid	2001-2006	Prevention, Care & support (both orphans and PLWHA), RH, VCT, Facilitating Treatment (ART and PMTCT), Empowering youth through established Anti Aid clubs (peer learning groups, trainings, creative art programs, IGA), Community mobilization, Advocacy and Networking; Income generating scheme CBO task force, FBOs task force, guardians club, youth clubs (girls, youth, orphans), PLWH association established	OSSA	SNNPR (3 towns) 161 PLHA, 123 OVC, 65 guardians	465,310
		-Spiritual/Moral, Educational, psychosocial support and IGA for orphans and the foster family /care givers - Home visit by clergies (share care taking burden of old grandmothers through counselling, and moral support)	EOC/DICAC	Tigaray Region (capital city, in 2 hospitals) 60 OVC, 15 clergies as Para Counsellors	63,815
		-Female sex workers rehabilitation project: Economic and Psychosocial Rehabilitation through Income generating scheme, medical, counselling, skill training and host family programs (volunteer congregation members host the beneficiaries provide love and care) -Networking and Advocacy with government and non government organisations on the rights of Female sex workers	Addis Ababa & surrounding Evangelical Church Mekane Yesus/ (AASECMY)-Young women rehabilitation project	Addis Ababa (Kazaniches congregation) 103 ex-female sex workers, and 55 of their children and their families	79,184

Name of Principal Norway Partner	Intervention Period	Types of intervention	Partners	Geographic coverage and # bene-ficiaries	Budget in USD
		- Care and support for OVC and PLHA - Prevention & Awareness raising programs for church leaders and evangelists - Awareness raising for orphans - IGA (oxen fattening, donkey carts, metal workshop, skill training, house maintenance, petty trade) - School assistance to orphans (paying Universities and Colleges for orphan headed households) - Mobilisation of church leaders to support affected households (home visit).	Evangelical Church Mekane Yesus/South Central Synod/ (EECMY/SCS)	SNNPR (one town) 40 OVC, 10 PLHA, 124 affected and infected families	72,018
		- Awareness creation program to Imams and Muslim communities - Skill training for OVC, and seed money for IGA initiations - School fees	Ethiopian Islamic Affairs Supreme Council/ Ethiopian Development Agency (EIASC/ EMDA)	Addis Ababa (1 sub city) 48 OVC, 80 Imams & Muslim communities	23,276
		- Advocacy on the rights of PLWH through IEC material production and dissemination (monthly news paper and biannual magazine) with regular distribution to Parliamentarians	Dawn of Hope PLWH Association	Addis Ababa Direct beneficiaries are Parliamentar-ians, School (youth clubs in school), Dawn of Hope members	57,784
		-Youth targeted prevention programs using drama, sport and music - Regular Saturday awareness raising program (community gather to attend the program) -IEC material production & distribution, - Library Services, training - Youth friendly counselling services - Peer to peer learning programs for In school and out of school youth programs on HIV, RH, HTPs - Community mobilization with out reach programs on holydays or other occasions; - Capacity building of other clubs (establishing other youth clubs); - Networking and advocacy	Tamra Youth Reproductive Health and Anti Aids Association (TYRHAAA)	Oromiya Region (1 town) 30,290 youth	52,776

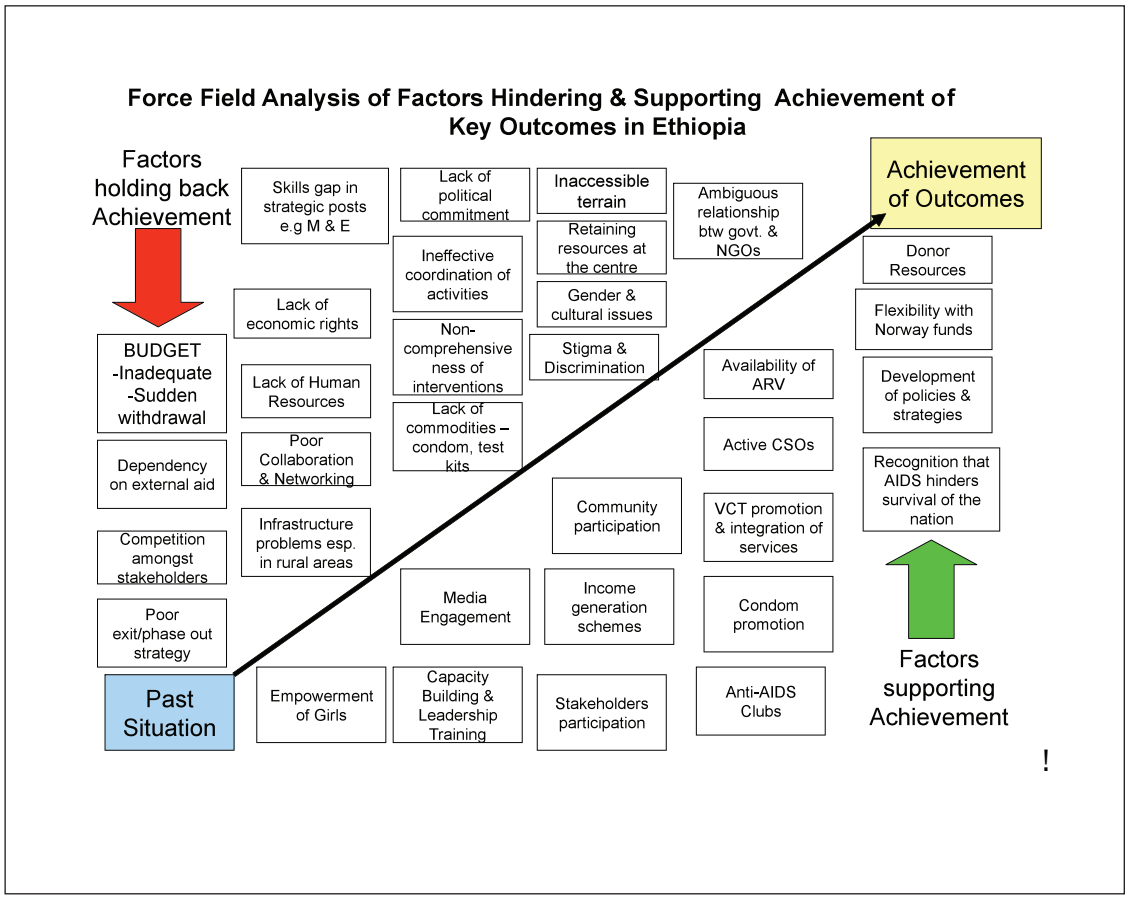
Name of Principal Norway Partner	Intervention Period	Types of intervention	Partners	Geographic coverage and # bene-ficiaries	Budget in USD
		-Youth targeted prevention programs using drama, sport and music, circus, - Regular Saturday awareness raising program. -IEC material production & distribution, - Library Services, FM Beza(media) - Youth friendly counselling services, - PMTCT, Peer learning programs on RH, HIV/AIDS, Substance of abuse - Empowering PLWH associations - OVC support - Child focused HIV/ AIDS awareness training - FBOs and CBOs capacity building - Education support to members (up to higher institution) & creating jobs - Networking and advocacy - Out reach programs (to surrounding rural areas with invitation of other organ) - Local resource Mobilisation to support PLHA & OVC - Engage in environmental protection activities Mobilising the youth	Beza Youth health & Counselling centre	SNNPR (1 woreda) 46,772 youth	60,626
Plan International	2004-2006	Building the capacity of "idirs" to transform them from providing funeral related services to development, including HIV/AIDS, care and support to OVC and PLHA through IGA, rehabilitation of CSWs through IGA, work with young people in life skill, IGA, RH, gender and HTPs	MoH, HAPCO, Mary Joy, ISAPSO, Youth asciations, PLHA Associations, and Idirs	Addis Ababa (2 Sub cities) 802,365	565,228
Save the Children Norway	2000-2006	HIV / AIDS prevention and support programme for school and out of school youth. HIV /AIDS prevention, care and support (access to information on HIV and AIDS and networking and creation of working relation ships with the wereda police office for child protection and prevention of abuse, community mobilization) Care and support for OVCs HIV/AIDS prevention programme for street children Provision of PMTCT and VCT services A radio programmed on HIV /AIDS prevention.	WACT (women and children tracer) organization, Queen of peace, MCDP (multi purpose community development project), Love for children, HAPCSO (Hiwot HIV/AIDS prevention, care and support organization), Mary Joy through development, Queen of peace, Gonder Education media centre (GEMC) Gonder University ,Medical Faculty, Alefa Woreda Administration, Chilga Woreda Administration.	Oromiya region (1 woreda, 3 kebeles), Addis Ababa (6 sub cities), Amhara region (1 town and the adjacent five weredas) 36,500 children and youth, 1000 street mothers and 4000 children, 1000 OVCs.	1,06M

Name of Principal Norway Partner	Intervention Period	Types of intervention	Partners	Geographic coverage and # bene-ficiaries	Budget in USD
New Life Community Organization (with support from HESO)	2003-2006	Awareness creation program on HIV, support to anti AIDS clubs through training, material support and youth center establishment, skills training for young women, and support to OVC	Anti AIDS clubs and CBOs	Addis Ababa, Gulele sub city 36,120 youth and community members &100 OVC	252,811
EECMY (supported by NLM, NMS)	2001-2006	- Health Service & HIV/AIDS, Prevention, Care & Support: - BCC at institutions, individual and community - Care and support to PLHA and orphans, including clinical and home based care - VCT, PMTCT, Universal precautions and STI services in 2 hospitals and 11 clinics	CBOs and government	SNNPR and Oromia regions	500,000

Annex 9: Intervention Logic of Programmes Supported by Norway



Annex 10: Results from Forcefield Analysis



Annex 11: Composition of the Evaluation Team

Dr. Munirat Ogunlayi – Team Leader for Ethiopia Country Study
Munirat holds a PhD degree in Medical Sociology and has more than 12 years of experience in programme management and evaluation. She is the ITAD Senior Consultant for HIV/AIDS and Poverty and has substantial experience in evaluating HIV and AIDS programmes at the institutional and project levels for NGOs, government, bilateral donor and multilateral agencies. She provided technical and managerial leadership to the evaluation in Ethiopia.

Derek Poate – Project Director
Derek is a Director at ITAD and has acted as team leader and project director for a number of international development assignments, including Countries Programmes Evaluation for DFID in Ghana, Kenya and Rwanda and served as technical leader for the evaluation of partnership of DFID with WHO and team leader for the five-year evaluation of UNAIDS. He is currently Team Leader for the evaluation of RBM in UNDP. He is a recognised M&E and performance assessment specialist.

Derek provided strategic and technical inputs into the evaluation in Ethiopia including development of evaluation methodology and review of the draft report.

Dr Woldemedhin Haile
Dr. Wolde is an Ethiopian & Public Health Physician with experience in leading HIV/AIDS country reviews in Ethiopia. He has 13 years experience at both middle and senior management levels of programme development planning, implementation, monitoring and evaluation including budget tracking and expenditure. He is experienced in using participatory tools, including PRA, Stepping Stones, LEPSA method and Community Conversation and an expert at planning and facilitating training. As an indigene of the country, Dr. Wolde took sole responsibility for review of documents written in Amharik (Ethiopian national language) and participated fully in the consultation process.

Country Report
Malawi

March 2008

Submitted by ITAD
Derek Poate, Øyvind Eggen, Robert White

Contents

Abbreviations

ACEM	Association of Christian Educators in Malawi
ACT	Artemisinin-based Combination Therapy
ADP	Agricultural Development Programme
AIDS	Acquired Immunodeficiency Syndrome
AIP	Annual Implementation Plan
ART	Anti-retroviral therapy
ARV	Anti-retroviral
ASO	AIDS Service Organisations
BLM	Banja La Mtsogolo (Marie Stopes International affiliate)
CABS	Common Approach to Budget Support
CACC	Community AIDS Coordination Committee
CBO	Community Based Organisation
CHAM	Christian Health Association of Malawi
CHBC	Community and home-based care
CMS	Central Medical Store
COM	College of Medicine
DAC	Development Assistance Committee (of OECD)
DAC	District AIDS Coordinator
DACC	District AIDS Coordination Committee
DEC	District Executive Committee
DFID	Department for International Development (United Kingdom)
DHRMD	Department of Human Resources Management and Development (OPC)
DIP	District Implementation Plan
DPD	Director of Planning and Development
EAC	East African Community
ECOWAS	Economic Community of West African States
EHP	Essential Healthcare Package
EHRP	Emergency Human Resource Programme
FBO	Faith Based Organisation
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GoM	Government of Malawi
GTZ	German Technical Cooperation
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Heath Management Information System
HR	Human Resources
HSA	Health Surveillance Assistant
IAWP	Integrated annual work plan
ICT	Information and Communication Technology
IEC	Information, education and communication
IGAD	Intergovernmental Authority on Development
IGO	Inter Governmental Organisation
INGO	International NGO
M&E	Monitoring and Evaluation
MANARELA	Malawi Network of Religious Leaders Living with and/or personally affected by HIV/AIDS
MANASO	Malawi Network of AIDS Service Organisations
MANET+	Malawi Network of People Living with HIV/AIDS
MDHS	Malawi Demographic and Health Survey

MEPD	Ministry of Economic Planning and Development
MFA	Ministry of Foreign Affairs
MIAA	Malawi Interfaith AIDS Association
MOEST	Ministry of Education Science and Technology
MOF	Ministry of Finance
MOH	Ministry of Health
MOLG	Ministry of Local Government and Rural Development
MOU	Memorandum of Understanding
MTCT	Mother to child transmission
MTE	Mid-term Evaluation
n.d.	Not dated
NAC	National AIDS Commission
NACARS	National AIDS Commission Activity Reporting System
NACP	National AIDS Control Programme
NAF	National Action Framework
NAPHAM	National Association of People Living with HIV/AIDS in Malawi
NASFAM	National Smallholder Farmer's Association of Malawi
NCA	Norwegian Church Aid
NGO	Non-Governmental Organisation
Norad	Norwegian Agency for Development Cooperation
NPA	National Plan of Action
NSF	National Strategic Framework
ODA	Official Development Assistance
OECD	Organisation of Economic Cooperation and Development
OI	Opportunistic infection
OPC	Office of the President and Cabinet
PHC	Primary Health Care
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother to child transmission
POW	Programme of Work
PS	Principal Secretary (e.g. Secretary of Health)
QA	Quality Assurance
SADC	Southern Africa development Community
SLA	Service Level Agreement
STI	Sexually transmitted infection
SWAp	Sector Wide Approach
TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
TWG	Technical Working Group
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	UN Population Fund
UNICEF	United Nations Children's Fund
UNIMA	University of Malawi
USAID	United States Agency for International Development
VACC	Village AIDS Coordination Committee
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WMS	Welfare Monitoring Survey

Executive Summary

This report presents the findings of an evaluation mission to Malawi to study the support by Norway to combat HIV&AIDS from 2000 to 2006. This country study is part of a larger evaluation to evaluate Norwegian support for HIV&AIDS to Africa, with similar studies in Ethiopia and Tanzania.

The objectives of the evaluation are 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.

Evaluation methodology

Objective-oriented and participant-oriented approaches were adopted for the evaluation, and both resulted in utilization of various methods, including document reviews, Focus Group Discussions (FGD), interviews and field visits. The selection of tools included use of an evaluation framework, timeline, force-field analysis, stakeholder analysis, and most significant change technique. The tools helped structure discussions and elicited information from key stakeholders namely – the government (NAC, line ministries), multi-lateral institutions (UNICEF, UNAIDS, World Bank), bilateral agencies (CIDA, DFID), Norwegian NGOs (NCA, the Development Fund) and implementing NGOs supported by Norwegian resources, service providers and beneficiaries.

The evaluation faced a major challenge with the issue of attribution, since Norway is one of many donors supporting HIV/AIDS responses in the country. The challenge was managed through review of relevant documents and consultation with stakeholders who were knowledgeable and experienced with Norwegian support during the period. The evaluation team was able to elicit information for analysis to respond to the key evaluation questions and objectives.

HIV/AIDS in Malawi

Malawi is a country in southern Africa with a population of approximately 12 million people and is the eighth worst affected country in the world from HIV/AIDS. Although statistics show that the prevalence rate has stabilized, the actual number of people infected and living with HIV and AIDS has been increasing over the years. The epidemic has a strong female bias. More than four times as many young women are affected than young men. AIDS has created large numbers of orphans and creates pressure on medical services. Comprehensive knowledge about HIV and AIDS remain low among Malawians while stigma and discrimination are still high.

There are a number of key factors driving the HIV and AIDS epidemic in Malawi. These include gender inequalities and women's subordination in sexual relationships, reinforced by harmful traditional and cultural beliefs, practices and norms.

The institutional response has been comprehensive. A National AIDS Control Programme (NACP) was established within the Ministry of Health in 1989 guided by a cabinet committee. Between 1987 and 1997, Malawi developed and implemented two Medium Term Plans (MTP I and II). A National HIV and AIDS Strategic Framework (NSF) was developed for the period 2000 – 2004 and saw the creation of the National AIDS Commission (NAC) in July 2001, to replace the NACP. Currently, the national response is set out in a National HIV and AIDS Action Framework (NAF) 2005 – 2009. Decentralised implementation is a cornerstone of the framework.

Despite the comprehensive organisational structures, capacity is a major problem especially in the health sector and in local government. The 2007 Public Expenditure Review identified the scarcity

of physicians, nurses and midwives as a major impediment to the delivery of essential health services.

Norwegian support

Norway has been a significantly large bilateral donor to Malawi. Norway's annual disbursement increased fivefold over the period. The total volume of aid has risen over the period from around NOK 59 million in 2000 to over NOK 320 million in 2006.

Specific flows to HIV&AIDS are difficult to quantify. Over the whole period, 32 percent of disbursed aid was identified as being for HIV/AIDS. This accounted for 12 percent in 2000, rose to a peak of 41 percent in 2005 and was 36 percent in 2006. Gender relations is a major aggravating factor in the Malawi epidemic and is also a cross-cutting issue for mainstreaming by Norway. About a quarter of Norway's portfolio was identified as addressing both gender and HIV/AIDS. Bilateral aid to government has been the main channel of support. A total of 49 percent of aid was disbursed to government, 40 percent through NGO channels, and a further 11 percent through agreements with multilateral agencies at country level.

The HIV/AIDS set of projects and programmes has been a diverse one with a wide range of partner institutions. A review of stakeholders shows that 56 percent of expenditure was devoted to partners with the potential for high influence over the national response, such as Ministry of Health, NAC and Norwegian Church Aid. Just under 40 percent of expenditure has been channelled through NGOs. The core was to support the development of a government programme. 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 Organisations (FBO) which are important parts of the social fabric in Malawi.

Norway identified a need to mainstream HIV/AIDS. One primary target was the agriculture sector owing to concerns about productive capacity and the effects of the disease on agricultural labour. A high proportion of sectors had programmes with HIV/AIDS components. More recent work by the Sweden-Norway Regional Team in Lusaka promotes a straightforward approach to design of mainstreaming based around three questions which take the form of a risk/mitigation assessment.

Delivery of outputs and Norway's contribution

Outputs are the immediate, direct results from an intervention or input. Assessment in this evaluation is based on reported achievements against the eight pillars of the National Action Framework (NAF) in reports for 2006 and 2007.

Delivery of outputs is at or above targets for information and education campaigns and HIV counselling and testing. Reporting on gender is not systematic. Some indications are that gender balance is good, but possibly men are not being reached as much as women. Support for Opportunistic Infections (OI), Sexually Transmitted Infections (STI) and Prevention of Mother To Child Transmission (PMTCT) is below target. Norway has financed a large number of Information, Education and Communication (IEC) outputs including early support for mainstreaming in agriculture; core support to NAC underpins the national response in all pillars; support to HIV Counselling and Testing (HCT) comes through the health sector essential health package; and Norway has given specific support for girl's literacy and to counter gender-based violence.

Progress with Anti-Retroviral Treatment (ART) has been highly impressive; a high proportion of TB cases are successfully treated; and Community and Home Based Care (CHBC) outputs are above targets. Norwegian support has been direct, such as for ART; through support for the health sector; and for CHBC via National Aids Commission (NAC) and Norwegian Church Aid. Outputs for impact mitigation are good for orphans and vulnerable children and counselling, in particular through Faith-Based Organisations (FBO). Norwegian support has been strong and direct in both areas, plus interventions in agriculture.

Progress with mainstreaming has seen some improvements in the workplace but still below targets, and generally better progress only among dedicated HIV/AIDS organisations. Partnerships have improved through the NAC Partnership Forum. Capacity building remains the weakest area, with high vacancy levels still in the health system and problems at district level. Norway has been a

leading advocate of mainstreaming and has supported district level for both planning and implementation.

There is a high level of alignment behind the National Action Framework. Monitoring and Evaluation (M&E) design is effective but challenges remain with the NAC Activity Reporting System (NACARS) at district level and to reduce dual reporting by NGOs.

Norwegian support for a joint Swedish-Norwegian Regional Support facility based in Lusaka has had little effect on outputs during the period of the evaluation but has potential both to support the Malawi country programme and to improve the engagement of regional Inter-Governmental Organisations (IGO).

Progress towards outcomes

The main features are that prevalence is seen to remain in the 12% to 14% range with slight but growing evidence of a downward trend. HIV prevalence is declining in urban areas from about 30% in 1999 to 16% in semi urban sites and 25% to 19% in urban sites in 2005. There are signs of improvements in knowledge of HIV/AIDS prevention and in high-risk sexual behaviour. Supporting statistics reveal a mixed picture with some generally favourable trends. For example, condom use at high risk sex is improving with greatest use amongst the more educated. The proportion of 15 – 24 year olds who had an HIV test in the last 12 months increased. Some behaviour is also changing with small but positive improvements in the proportion of men having sex with multiple partners; age of sexual debut; and percentage of youth never having sex.

Factors affecting outcomes

There has been a strong emergence of public, private and civil society response to the epidemic to provide bureaucratic and technical leadership. Despite the personal commitment of the President, there is limited engagement of high-level political leaders in driving the response. There are no prominent traditional authorities, media personalities, sports people or business leaders who have taken a leadership role. This vacuum is particularly significant for HIV prevention and is compounded by a lack of clear accountability of roles in this area.

A comprehensive institutional framework has developed and the major achievement is to have progressed substantially towards the ‘Three Ones’. The channelling of funds through NAC to districts, and support by donors through technical working groups and partnership forums has created a national response that is strongly state-centred and reliant on the government bureaucracy, especially at district level.

Prevention activities tend to get lower priority in terms of coordination. The comprehensiveness of the structures and diversity of actors creates a challenge for all parties to coordinate activities and share information. The complex governance structure results in unclear demarcation of responsibilities and enables organisations to ‘cherry-pick’ areas in which they work. There is low implementation and coordination capacity compounded by insufficient mapping of current activities and partners.

The health sector in Malawi is limited by severe capacity constraints. These include shortage of personnel with a ratio of doctor/population of about 1:44,000 and nurse/population of 1:3,600; poor infrastructure; weaknesses in planning, budgeting, decision making, implementation and monitoring; drug supply shortages, and limited and unequal access to health facilities due to distance and costs, in particular affecting women. These capacity constraints affect the outcome of the national response to HIV/AIDS in many ways.

The National Action Framework is based around a programme of response through community based organisations at district level. The district response faces problems. Elections due in 2005 have not yet been held and observers detect a lack of political will to continue with decentralisation. NAC identified weaknesses in district capacity at an early stage and has used intermediary ‘umbrella’ organisations to provide support and facilitate the grant process down to Community-Based Organisations (CBO).

There has been an enormous increase in IEC relating to HIV/AIDS during the period of evaluation, with thousands of radio programmes, awareness campaigns, leaflets and brochures being delivered. However, this area of the HIV/AIDS response is characterised by a very high number of

stakeholders involved, most of them non-governmental. As a consequence, while the evaluation period has seen a high increase in IEC activities at the same time it is likely that there has been a suboptimal use of resources.

Norway's partnerships

Norway has had a wide range of partners, but the greater share of expenditure, 73 percent, was disbursed through ten implementing institutions with arrangements that lasted four or more years. This conveys a high degree of continuity in the programme and reflects awareness that the fight against HIV/AIDS requires long term and predictable commitments. Consistency and continuity has been complemented by diversity but the channels of Norwegian support are not well connected at country level. The lack of connectedness is a feature of Norwegian policy with different funding modalities.

Issues

Is Norway more effective supporting projects than sector programmes? Norway's most visible contributions were when it was flexible and taking risks. Looking at the different phases of Norwegian support it seems the most important parts have been the willingness to support things overlooked by other donors.

Sector programmes have high commitments for coordination and technical support. Experiences from the health Sector-Wide Approach (SWAp) as well as the national AIDS response in Malawi demonstrate that donor coordination and harmonisation does not necessarily mean that managing aid has become simpler. Norway has chosen a 'hands off' approach to its partners. Arguably, Norway can still influence national HIV&AIDS policy without having to engage directly in projects. Both the health Sector-Wide Approach (SWAp) and NAC are well funded by Norway, but the Embassy has given priority for its health sector staff on the health SWAp (for which Norway is currently secretary to the donor coordination group) rather than NAC.

Hands-off engagement and separate structures of support to Norwegian NGOs means lost opportunities for added value. While there are good arguments for 'hands-off' collaboration with important Malawi partners, with other partners it becomes clearer that some opportunities may be lost. A number of examples are given that demonstrate where opportunities exist to build on experience and feed back lessons to improve performance. That would require the embassy to take a more proactive role in the work of their development partners and this might run contrary to Norway's development ethos.

Being a good partner is different from organising good partnerships. Norway is valued as a partner for being flexible, realistic, having strong values and bringing good technical expertise. Its partners assess Norway very positively for having shared objectives and few serious disagreements. But partnership is seen as a way of working rather than a strategy to achieve objectives. The Norwegian HIV/AIDS support in Malawi does not have a strategy to choose partners and develop partnerships.

Conclusions

Progress towards outcomes

Malawi has achieved great progress in fighting the epidemic. Norway has played a significant part in these achievements, by providing core support to the national response, through the health sector and NAC, and by a flexible approach to funding targeted interventions that complement the mainstream programmes and allow of innovation and independence. Norway has worked both through core programmes and targeted support for non-governmental organisations, and to mainstream efforts in a variety of sectors.

Factors affecting the outcomes

Five broad factors have been identified as critical to the national response: leadership; the institutional framework; capacity in the health sector; decentralisation; and proliferation and fragmentation of IEC.

Norwegian outputs and contribution to outcomes

Norway has provided support broadly in line with the evolving national framework, through core funding for the National AIDS Commission. During the earlier years of the period under review Norway supported a number of targeted interventions that seized opportunities to promote

mainstreaming or respond to a demand that other donors had not picked up. The programme has been directly relevant to the policies of the Norwegian Government and Norad, and has responded to the specific characteristics of the epidemic in Malawi.

Norwegian partnership strategies
The channels of Norwegian support are not well connected at country level. It is also clear that the potential institutional benefits that could arise from exchange of lessons and experience between different types of support at country level are not being realised. Staff at the embassy argue strongly that a defining feature of Norwegian support is the hands-off approach. But it is reasonable to question whether the value of Norwegian aid is diminished by so many independent actions. There has not been any strategy to choose partners and develop partnerships, instead, relationships developed in response to opportunities and availability of resources.

New challenges
In coming years the focus of the response, both in terms of service delivery and monitoring, will shift to the districts. NAC and its central partners need to further their capacities to support the districts. In particular, NAC will need to enhance its capacity to both support M&E systems and to analyse implementation and outcome information in order to be able to fulfil its role as coordinator of the response. Norway has considerable experience in all these areas and is well placed to support the process over and above core funding of NAC.

Recommendations

- Continue with the core support for the health SWAp and NAC.
- Promote and support mapping of existing services to help NGOs become more demand-responsive for IEC.
- Work to make mainstreaming more effective and bring wider involvement of the private sector.
- Create greater linkages with the regional team to promote peer support through regional inter-governmental organisations to stimulate improved actions to overcome cultural barriers to the response.
- Without compromising the hands-off approach to working with partners the embassy could consider forming a community of practitioners for learning and feedback to policy, using that community as a peer mechanism to help improve quality and effectiveness, especially of IEC.
- The SWAp and support to NAC require a high level of engagement. Norway should re-examine the staffing implications that come with programme-based approaches to ensure that the national response receives the necessary support from the embassy.
- Whilst there is no evidence of major inefficiencies arising from Norad's support to NGOs independently from the embassy it is clear that this is not necessarily well aligned with the embassy strategy and sub optimal use of resources is likely. One possible solution would be to bring Norad and the main Norad partners into the 3 year planning cycle as a joint partner, with shared ownership of the analysis and country objectives.
- Last, there is a need to clarify the technical advisory role of Norad vis a vis the regional team and set guidance on how to get the best from both resources.

1 Introduction

This report presents the findings of an evaluation mission to Malawi from 12th to 29th November 2007, to study the support by Norway to combat HIV&AIDS. The mission consisted of Derek Poate, Oyvind Eggen[1] and Robert White. This country study is part of a larger evaluation to evaluate Norwegian support for HIV&AIDS to Africa, with similar studies in Ethiopia and Tanzania. The Norwegian Embassy represents Sida in Malawi and although Sida is a silent partner, it provides half the Embassy's support to the HIV and AIDS response and this should be borne in mind throughout the report.

The objectives of the evaluation are specifically 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 years 2000-2006. In accordance with the terms of reference the evaluation is based primarily on desk studies. 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.

1.1 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 Malawi 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.

1.2 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.
- Document Reviews – Various documents were collected from Norad, Royal Norwegian Embassy in Malawi, government institutions, country level multi-lateral institutions, Norwegian NGOs, indigenous NGOs, local implementing institutions and beneficiaries. Secondary data were 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.
- Key Informant Interviews – Short interview topic guides were developed by the team on a day-to-day basis focussing on the issues appropriate to the various stakeholders. This enabled the evaluation team members to elicit information consistently and to clarify issues

1 In a previous assignment Mr Eggen worked with the Development Fund. To avoid any possible conflict of interest Mr Eggen did not participate in any meetings or discussions concerning that organisation. He also conducted a Baseline for Norwegian Church Aid in 2001.

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.

- 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.
- Field Visits – Field visits were conducted to implementing organisations and beneficiaries in Central and Southern Regions. 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 an opportunity to meet with some primary beneficiaries.

1.3 Evaluation Tools

- 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 is critical to the evaluation objectives. The framework also provided the structure to itemise the sources of information that will address the evaluation questions and the necessary indicators.
- 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).
- 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.
- Stakeholder Analysis – This tool was used by the team to categorise the relative influence, importance and interest of various stakeholders that Norway has worked with in utilising resources to achieve the key outcomes.

The evaluation has drawn 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 also available national research and monitoring data. Sources are referenced throughout the text and a bibliography appears at Annex 3. Interviews were held with a wide range of key informants from national and international bodies. A list of people the team consulted is at Annex 2.

1.4 Reliability and Validity

The tools and methods were utilised to ensure consistency that would enable us 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 us to assess the consistency of information from all parties consulted and the contributions of Norwegian support in this regard.

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

1.5 Structure of the Report

The report is set out in seven chapters. Following this introduction, Chapter 2 reviews the epidemic in Malawi and presents background and contextual information. Chapter 3 describes the financial support provided by Norway and explains the structure of programmes. Chapter 4 details the delivery of outputs to the national response and describes Norway's specific contribution. Chapter 5 presents the best available evidence about progress towards outcomes,

reviews the factors affecting that progress and discusses Norway's partnership strategy. Chapter 6 consolidates the material and highlights issues arising and some lessons. Chapter 7 concludes and puts forward recommendations.

2 The Epidemic in Malawi

Chapter two sets out the current status of the epidemic and provides a brief history of the national response. Data are drawn from published sources, some of which vary in detail. Footnotes are provided to references in Annex 3.

2.1 Extent and Nature of the Epidemic

Malawi is a country in southern Africa with a population of approximately 12 million people and is the eighth worst affected country in the world from HIV/AIDS. HIV spread quickly among the popu lation in the early 1980s, and the first AIDS case was diagnosed in 1985. According to UNAIDS Fact Sheet (June, 2007) the national prevalence rate among pregnant women is 16.9% with some variations in the geographical regions as follows: southern region at 21.7%; central region at 14.3%; and northern region at 14%. The national HIV prevalence estimates based on sentinel surveillance have remained stable at around 14% - 15% since 1997. According to the Malawi Demographic and Health Survey (MDHS 2004), the population based HIV prevalence was 12.7% with more women (13.3%) infected than men (10.2%). MDHS regional estimates were as follows: southern region at 17.6%; central region at 6.5%; and northern region at 8.1%. Heterosexual contact is the main mode of HIV transmission in Malawi with Mother to Child Transmission (MTCT) accounting for about 25% of all new HIV infections (NAC 2004).

More people continue to be infected. Although statistics show that the prevalence rate has stabilized, the actual number of people infected and living with HIV and AIDS has been increasing over the years. In 1987, it was estimated that there were about 52,251 people living with HIV and AIDS. The figure rose to 750,108 by 2002 and in 2003, it was estimated that there were 760,000 adult Malawians living with HIV and AIDS, 58% of whom were women (NAC, 2003). In 2005, approximately 930,000 Malawians were estimated to be HIV infected which included 83,000 (9%) children in the age group 0 – 14 years (UNAIDS Fact Sheet, June 2007). In the same year, there were 96,552 new AIDS cases with 21,735 (22%) of them children below the age of 15 years. In 2005, there were 86,592 AIDS related deaths with 21,118 (24%) of those deaths were children of 0 – 14 years of age. As many as 177,301 people were estimated to be in need of AIDS treatment in 2005. It is estimated that about 100,000 people will have been put on Anti-Retroviral Therapy (ART) by December, 2007 (HIV and AIDS Unit).

The epidemic has a strong female bias. Statistical comparison by gender shows that HIV infection rates in young girls and women is much higher than in boys and men of corresponding age, below 30 years. Several factors such as poverty and cultural practices expose girls and women to HIV and AIDS more than boys and men. More and more of the infected people are falling ill and dying each year.

IDS has created large numbers of orphans and creates pressure on medical services. Deaths from AIDS among adults have resulted in a dramatic increase in the number of orphans. There are approximately 1 million orphans in Malawi with 45% of these due to AIDS (NAC, 2003). Another visible consequence of HIV and AIDS in Malawi is the increase in the number of people seeking medical care. The effects of HIV and AIDS have been felt by all sectors of the Malawian society, especially the social services. In the health sector, HIV/AIDS patients occupy more than half of the medical ward beds, and almost three quarters of all TB patients are HIV positive (Oxfam, 2005).

2.1.1 HIV prevalence by age and sex

Young women are most at risk. The Malawi Demographic and Health Survey (2004) shows a slightly declining infection rate among young adults aged 15 to 49 years (Table 1). But more than four times as many young women are affected than young men (Table 2).

Table 1 HIV prevalence rates

Year	HIV Prevalence (15 – 49 years)
2001	15%
2003	14.4%
2004	12%

Table 2 Percentage of Women and Men with HIV

Age Group	Women	Men
All ages	13%	10%
15 – 19 years	4%	Less than 1%
15 – 24 years	9%	2%
30 – 34 years	18%	20%

2.1.2 HIV prevalence by district

HIV is more prevalent in the south. Levels of HIV among women and men are 20% or higher in Blantyre, Mangochi, Thyolo and Mulanje, according to the 2004 MDHS. All these districts are in the Southern region of the country. HIV rates are 5% or less in Kasungu in the Central region and Mzimba in the Northern region. According to the 'HIV and AIDS in Malawi: 2003 Estimates and Implications', HIV occurs mostly in the Southern region, where it is estimated that twice as many people are infected as in the Centre and the North.

Table 3 Prevalence by locality

Area of Malawi	% Young People Living with HIV (15-24 years)
Southern Region	9%
Central Region	6%
Northern Region	3%
Urban Areas	7%
Rural Areas	6%

Source: MDHS (2004)

2.1.3 Knowledge levels and preventive behaviour

Comprehensive knowledge about HIV and AIDS, including the rejection of the two most common local misconceptions about the epidemic, remain low among Malawians at 38.6% for men and 22.4% among women (UNAIDS Fact Sheet, June 2007). Comprehensive knowledge of abstinence, condom use and faithfulness as methods for HIV prevention vary among high risk groups as follows: 2.5% - 6.3% among Police Officers; 49% among truck drivers; 40.2% - 46.8% among primary and secondary school teachers; 34.2% - 35.4% among vendors and traders; 27.1% - 43% among estate workers; 36.7% among fishermen; and 50% among sex workers.[2]

Stigma and discrimination remains high with only 30.8% female and 29.7% males in the age group 15 – 49 years expressing specific positive attitudes towards people living with HIV. Statistics indicate that 15% of women and 14% of males aged 15 – 24 years have had sex by the age of 15 years. The median age at first sexual intercourse for the 20 – 24 years age group shifted from 17.1 in 2003 to 17.4 in 2004 among females and the from 17.7 to 18.1 among males (UNAIDS Fact Sheet, June 2007). 1.7% females and 13.2% males aged 15 – 24 years reported having sex with two or more partners in the last 12 months. In the general population 12.9% of females and 15.1% males aged 15 – 49 years reported ever being tested for HIV and receiving their results.

2 The extremely low level of knowledge for the police force seems intuitively unlikely. It highlights the difficulties of collecting data of this nature and the problems of ensuring consistent quality.

2.1.4 Factor facilitating the spread of HIV

There are a number of key factors driving the HIV and AIDS epidemic in Malawi.[3] These include gender inequalities and women's subordination in sexual relationships. Harmful traditional and cultural beliefs, practices and norms such as wife inheritance, death cleansing and other sex rituals also facilitate the spread of HIV among Malawians (see Box 1).[4]

Box 1 Gender based sexual violence in traditional practices

Forced sex exists in customs such as *kulowa kufa*, common in the Shire Valley, where a widow is forced to have sex with the deceased husband's relative. Cultural rituals such as *fisi* and *kusasa fumbi*, practiced in some parts of central and southern region allow grown up men to have sex with newly initiated girls. In the north some cultures compel young girls to entertain chiefs through sex during installation of chiefs ceremony.

Child abuse includes, for example, the *kupimbira* practice, where a parent uses a female child as surety for a debt from a wealthy man. If the parent fails to pay the debt, they forfeit their child to the debtor who usually takes her as a wife. This is practiced by some societies common in Rumphi and Karonga, northern Malawi. Another form of sexual abuse is sex, usually forced, between related people, e.g. an uncle and a niece or a father and a daughter.

In some parts of Rumphi a widow is compelled to crawl on all fours to her husband's grave every day for a given period as a demonstration of mourning.

Source: Public Affairs Committee Pamphlet funded by Norwegian Church Aid

These traditional values have a modern counterpart. The Malawi political tradition created by Presidents Banda and Muluzi includes a particularly strong element of male dominance and sexual exploitation. Women were used at three levels in the Banda period: for public expression of the personal aggrandisement of the president; as informers for the party at community level; and providing sexual favours to party leaders and functionaries. Post Banda the exploitation was less overt but no less widespread (Booth et al 2006, page 11).

Another key factor facilitating the spread of HIV is the high incidence of untreated sexually transmitted infections which increase the chances of HIV infection. Poverty and vulnerability among most Malawians have accelerated the spread of HIV in Malawi, with women and girls resorting to commercial sex work as a survival mechanism. Wide spread stigma and discrimination of people living with HIV is another factor facilitating the spread of HIV. Stigma and discrimination has prevented people from seeking services such as HIV Counselling and Testing in order to know their status and protect themselves and their partners.

2.2 History of Malawi's Response to the Epidemic

With the first AIDS case diagnosed in Malawi in the mid 1980s, the Government of Malawi designed strategies aimed at controlling its spread. These included establishing a National AIDS Control Programme (NACP) within the Ministry of Health in 1989. A Cabinet Committee on 'Health and HIV and AIDS' was formed to create policy and provide political direction to the Ministry of Health in the fight against HIV and AIDS. Between 1987 and 1997, Malawi developed and implemented two Medium Term Plans (MTP I and II). The MTP I was implemented between 1989 and 1993, and it emphasized blood screening for transfusion to prevent HIV transmission. In addition to the blood screening, The Government also initiated an information, education and communication (IEC) campaign to inform and educate the public about HIV transmission and its prevention.

The MTP II was developed and implemented between 1994 to 1998, expanding the IEC campaign and blood screening activities of MTP I. In addition, MTP II also focused on

3 This section summarizes a section from a book entitled: The Impact of HIV and AIDS on Livelihoods, Poverty and the Economy of Malawi by Lisa Arrehag, Stefan Vylder, Dick Durevall and Mirja Sjoblom – Sida Studies No. 18.
4 Malawi is now doing a study on "Knowing your Epidemic". In it, concurrent multiple partnerships are identified as a huge risk factor.

syndromic management of Sexually Transmitted Infections (STIs). A sentinel surveillance system was established to provide good and reliable epidemiological data on the epidemic. Some notable achievements were registered during implementation of MTP I and II, which include the following:

- Almost universal awareness of HIV/AIDS in the general population
- HIV screening of all the blood donated for transfusion
- Adoption of the syndromic management of STIs

2.2.1 Preparation of the National Strategic Framework for multi-sector response

Between 1998 and 2000, the Government of Malawi through the Strategic Planning Unit in the National AIDS Control Programme with support from development partners conducted a nationwide mobilization, capacity building and strategic planning process which led into the development of the National HIV and AIDS Strategic Framework (NSF) for the period 2000 – 2004. The NSF provided guidance for a multi-sectoral approach to the national HIV and AIDS responses at community, district and national levels and its goal was to reduce incidence of HIV and sexually transmitted infections and improve the quality of life of those infected and affected by HIV and AIDS.

In order to improve multi-sector planning, implementation, and co-ordination of HIV and AIDS activities, the Government of Malawi established the National AIDS Commission (NAC) in July, 2001 to replace the NACP. The NAC was created within the Office of the President and Cabinet (OPC) and its operations are overseen by a Board of Commissioners with representatives from the Government, Non-Government at organisations, faith based organisations, and the private sector. Currently, NAC reports to the Office of the President and Cabinet through the Principal Secretary for Nutrition, HIV and AIDS.

2.2.2 Development and implementation of HIV and AIDS policy

Following the development of the NSF, the Government of Malawi developed a National HIV and AIDS Policy in 2003 to help intensify and consolidate the efforts in the HIV and AIDS response. The policy instrument addresses HIV and AIDS and incorporates most of the current international policy principles. It is aimed at reducing infections and vulnerability, to improve provision of treatment, care and support for people living with HIV and AIDS (PLWHA) and to mitigate the socioeconomic impact of the epidemic (UNDP, 2006).

2.2.3 Development of HIV and AIDS National Action Framework (NAF)

Following the successful implementation of the NSF and its subsequent review, the Government of Malawi developed and adopted the HIV and AIDS National Action Framework (NAF) 2005 - 2009 to guide the national response. The NAF acknowledges the achievements made during the implementation of the NSF and goes further to provide a new vision to spur renewed impetus in the national response. The NAF has identified gaps in service coverage for HIV and AIDS prevention, treatment, care and support. It also clearly points out that Malawi faces its biggest challenge in translating universal awareness of HIV and AIDS into behaviour change. It also notes that mitigation interventions have largely remained undeveloped, and that treatment is an emerging, critical issue that needs to be addressed.

In terms of the next phase in the national response, the NAF identifies eight priority areas which form the basis of annual plans and reviews in the implementation process:

- Prevention and behaviour change
- Treatment, care and support
- Impact mitigation: economic and psychosocial
- Mainstreaming, partnerships and capacity building
- Monitoring and evaluation
- Research
- Resource mobilization, tracking and utilization
- National policy coordination and programme planning.

2.2.4 Institutional set up

In order to address the HIV and AIDS epidemic, the Malawi Government has put in place a framework for effective and efficient co-ordination, management and monitoring of the

epidemic as well as to provide the needed leadership for the response. At conceptual level, the framework includes the following:

- The National HIV and AIDS Policy
- The Malawi HIV and AIDS National Action Framework (2005-2009)
- The Constitution of the National AIDS Commission Trust
- The Principle of Three Ones.

Given the multi-sectoral nature of the response, governance arrangements at institutional level involve several key players with national, sector and district level roles and responsibilities.

National Assembly. The national response is linked to the National Assembly through the Parliamentary Committee on Health which oversees all health related issues including HIV and AIDS.

Office of the President and Cabinet (OPC). The Department of Nutrition and HIV and AIDS takes the lead within OPC and is headed by a Principal Secretary who reports directly to the President.

National AIDS Commission (NAC). Established in 2001 initially under Ministry of Health (MoH) then moved to OPC in 2003. NAC has the overall co-ordinating authority of the HIV and AIDS response in Malawi, led by a Board of Director with a Secretariat.

Partnership Forums advise the NAC and allows agreement to be reached on key issues. **Technical Working Groups** (TWGs) of stakeholders from different sectors and background work with the NAC on specific areas, such as on health, education, Behaviour Change Interventions (BCI) and research.

Central Ministries and Departments. Office of the President and Cabinet, the Ministry of Finance, the Law Commission, Malawi Human Rights Commission and NACP. OPC provides political and technical support for adequate allocation of resources and the Ministry of Finance allocates funds and monitors how the funds are being used. The OPC and the Ministry of Finance are key in giving the response a political commitment.

Line Ministries and Departments. Ministry of Health (MoH)[5] has the lead role implementing the biomedical aspects of the national response. Line ministries, departments, and parastatal organisations are responsible for establishing focal points for HIV and AIDS activities, mainstreaming HIV and AIDS, preparing budgets for HIV and AIDS activities, and reviewing policy guidelines relating to HIV and AIDS and human resource management and development. Some line ministries reach the majority of the population and are represented at lower levels. These include key ministries such as: Women and Child Development; Education; Agriculture; and Defence. The Ministry of Women and Child Development has developed an Orphan and Vulnerable Children (OVC) Policy and National Plan of Action (NPA) to scale up the response to orphans and vulnerable children.

District Assembly. The District Executive Committee (DEC) heads the district response. The District AIDS Co-ordinating Committee (DACC) reports to the Director of Planning and Development (DPD), because HIV and AIDS are seen as a development issues. The DACC has five technical sub-committees responsible for youth, orphan care, home based care, prevention, and fundraising. Each district develops a five year HIV and AIDS Plan as part of the District Development Plan.

Under the DACC are Community AIDS Coordinating Committees (CACCs) and Village AIDS Coordinating Committees (VACCs), whose presence and effectiveness vary in different districts, with other districts having effective structures while others either do not have or have ineffective structures.

Umbrella Organisations. Umbrella organisations are International Non-Governmental Organisations (INGOs) that help NAC distribute funding to District Assemblies. Four INGOs are currently involved: World Vision, CARE Malawi, Plan International, and CPAR (Canadian Physicians for Aid and Relief). Umbrella organisations receive and assess proposals from the

5 Formerly Ministry of Health and Population (MOHP)

District Assemblies and disburse resources where the proposals have been approved. Their roles also include capacity building and monitoring resources use.[6]

Private Sector. The role of private sector organisations is to mainstream HIV and AIDS activities into their human resource development and management functions. The private sector is under the umbrella of the Malawi Business Coalition against HIV/AIDS (MBCA). They are expected to review and adopt policies affecting personnel management, and conduct ongoing HIV and AIDS impact assessment at all levels, including the medical and health needs of employees.

NGO. NGOs (both local and international) are key implementing agencies as they complement Government in the national response. They work with formal and informal CBOs to carry out advocacy, assist communities to mobilise resources locally, document best community practices, and support capacity building programmes in collaboration with NAC. The NGO sector is vital in helping communities cope with the socio-economic and psychosocial effects of HIV and AIDS. The Malawi Network of AIDS Service Organisations (MANASO) is a national networking and coordinating body for AIDS Service Organisations (ASOs) established in 1996 and exists to contribute towards the reduction of HIV/AIDS prevalence and alleviation of suffering caused by the epidemic in Malawi through coordination, facilitation of capacity building, mobilization and allocation of resources to ASOs in Malawi.

Faith Based Organisations. FBOs work directly with communities on HIV and AIDS prevention, and provision of social and psychological support. They play a pertinent role in the prevention and mitigation of the HIV and AIDS impact. Faith based organisations are under the umbrella of the Malawi Interfaith AIDS Association (MIAA). This secretariat was set up in 2003 to help faith communities to unite in the fight against HIV and AIDS. Another important institution is the Malawi Network of Religious Leaders Living with and/or personally affected by HIV and AIDS (MANARELA).

Organisations of People Living with HIV and AIDS. The national response identifies People Living with HIV/AIDS (PLWHA) as its main target, aiming especially for increased acceptance of PLWHA. Through their associations, PLWHA play a vital role in the response. However, they need to be supported with more secure and substantial funding and to have clearly defined roles (such as Home Based Care (HBC) and counselling) in the delivery of services. The role of PLWHA is coordinated by the Malawi Network of People Living with HIV/AIDS (MANET+) and the National Association of People Living with HIV/AIDS in Malawi (NAPHAM).

Community Based Organisations. CBOs play a critical role in the national response by focusing on capacity building for individuals, families and communities. CBOs use existing social capital to respond to HIV and AIDS challenges and continue to advocate for volunteers. CBOs as grassroot structures are filling the gap by mitigating the socio-economic and psychosocial impact. However, they have been faced with severe funding shortages and volunteers leaving due to lack of training. This prompted a need for the umbrella organisation structure, in order to channel resources from the Global Fund to CBOs at district and community levels.

2.2.5 Capacity constraints

Despite the comprehensive organisational structures, capacity is a major problem especially in the health sector and in local government. The Public Expenditure Review in 2007 identified the scarcity of physicians, nurses and midwives as a major impediment to the delivery of essential health services. Vacancy rates ranging between 30 to 80 percent of skilled posts are reported in government and CHAM health facilities.[7]

An estimated 2,000 health workers are living with AIDS (*Ibid* para. 267). Although HIV/AIDS is by no means the major cause of the drastically declining number of Ministry of Health (MoH) health workers, it is a significant contributor through staff deaths, incapacity, and absenteeism. For instance, 8 MoH staff died in 1990 compared to 270 in 1999 and 200 in

6 At the time of the country visit plans were for the Umbrella Organisations to be phased out.
7 Government of Malawi and The World Bank (2006) Public Expenditure Review. Ministry of Finance

2000.[8] In addition to death due to HIV/AIDS, precipitating factors causing the skilled staff shortage include poor working conditions, and better-paying opportunities to work abroad. In this respect, starting in 2006 the Government of Malawi (GoM), with financial support from DFID and other donors, has boosted substantially the salary of skilled health workers in Malawi (see below). The staffing crisis was also worsened by the historically inadequate production of new workers (around 300 nurses and 20 doctors annually). An emergency training program, launched a couple of years ago, is expected to produce, among others, 3950 new nurses up to 2009/10, to nearly double the 2004/05 stock of 4717.

2.2.6 Key sources of funding

International donors represent 96% of the commitments for HIV/AIDS in Malawi with the National Government covering the remaining 4%. The funding towards HIV/AIDS under NAC is channelled through the following arrangements:

- Basket Funding which pools resources from a group of donors: the Global Fund, Department for International Development (DFID), the World Bank, the Royal Norwegian Embassy, Sweden, the Canadian International Development Agency (CIDA) and the Malawi Government. Under the Ministry of Health, contributions towards HIV and AIDS are through the Sector Wide Approach (SWAp).
- Discrete Funding which comes from specific, separate donors: CDC, UNDP, United States Agency for International Development (USAID) and others.

Table 4 shows the major sources of funding towards HIV and AIDS:

Table 4 Committed Funds 2002-2008 by Source of Funds

Bilateral Sources		**Multilateral Sources**		**Government**	
Source	**Million US$**	**Source**	**Million US$**	**Source**	**Million US$**
USAID	31.20	Global Fund	184.00	NAC	8.00
DFID	7.20	African Dev. Bank	60.44	Ministries: 2% ORT	5.44
CDC	3.59	World bank	47.32		
CIDA	6.40	UNICEF	11.91		
NORWAY	8.40	WFP	17.92		
JICA	0.73	UNFPA	4.12		
		WHO	2.20		
		UNDP	2.11		
		UNAIDS(Secretariat)	1.38		
Total	57.52	Total	271.05	Total	13.44
Percentage	17%		79%		4%

Source: UNAIDS RST – ESA: Issues, Constraints and Recommendations for Rapid Disbursement of HIV and AIDS Funds – Study Findings from Ethiopia, Malawi and Zambia (May, 2006)

8 Though cause of death is not specified, 59 percent of MOH deaths were those between the ages of 30 to 44 (UNDP, 2002), the same age range where HIV/AIDS infection is concentrated.

Summary of the epidemic and current response

- Malawi is the eighth worst-affected country in the world.
- Although statistics show that the prevalence rate has stabilized, the actual number of people infected and living with HIV and AIDS has been increasing over the years.
- The epidemic has a strong female bias. HIV infection rates in young girls and women are much higher than in boys and men of corresponding age, below 30 years.
- HIV is more prevalent in the southern region of the country.
- Comprehensive knowledge about HIV and AIDS remains low among Malawians at 38.6% for men and 22.4% among women.
- Stigma and discrimination remains high with only 30.8% female and 29.7% males in the age group 15 – 49 years expressing specific positive attitudes towards people living with HIV.
- Gender inequalities and women's subordination in sexual relationships are key factors driving the epidemic.
- Government has responded with many initiatives:
  - National AIDS Control Programme (NACP) created within the Ministry of Health in 1989.
  - Cabinet Committee on 'Health and HIV and AIDS'
  - Two Medium Term Plans (1987 and 1997)
  - A National HIV and AIDS Strategic Framework (NSF) 2000 – 2004.
  - National AIDS Commission (NAC) established in July, 2001 to replace the NACP.
  - A National HIV and AIDS Policy (2003)
  - National HIV and AIDS Action Framework (NAF) 2005 – 2009
- International donors represent 96% of the commitments for HIV and AIDS in Malawi with the national Government covering the remaining 4%. Committed funds for the period 2002-2008 amount to US$342.01 million, of which the Global Fund is the largest single contributor at 54%.

3 Norwegian support to HIV/AIDS

This chapter presents a summary and analysis of the overall flow of Norwegian Aid to Malawi during the period 2000 to 2006. The main source of statistics is the official database supplied to the evaluation mission, from which tables are presented in Annex 5.[9] Reference is made to other sources for comparison as appropriate. In addition, there is other Norwegian aid that flows indirectly to Malawi, including multilateral channels and research collaboration, such as through NUFU, which are not necessarily registered by country in the database. The chapter starts with an overview of financial flows and then analyses the country strategy and programme.

3.1 Disbursement of Aid Funds

Norway has been a significantly large bilateral donor to Malawi. The overall flow of official development assistance (ODA) to Malawi is summarized in official statistics from the OECD – Development Assistance Committee (DAC) for the period 2000 to 2005 in Annex 5 Table 1. This shows a total net aid flow of $2.8 billion. Of that, aid from the DAC countries comprised 58 percent or $1.6 billion. Norway's contribution was 5 percent of total net ODA, equivalent to Germany and Japan and third largest bilateral donor after the United Kingdom and United States.

Norway's annual disbursement increased fivefold over the period. The total volume of aid has risen over the period from around NOK 59 million in 2000 to over NOK 320 million in 2006. The sectoral allocation of that aid is shown in Annex 5 Table 2, using the DAC main sector codes. Allocation to these categories is not always precise, especially where programmes with multiple objectives have to be allocated against a single code. But a clear picture emerges that nearly 70 percent of the aid has been concentrated in 4 main sectors: health is largest at 29 percent, followed by general budget support (16 percent), government and civil society (13 percent) and agriculture (10%). Half the total aid was disbursed in the most recent two years 2005 and 2006, owing mainly to large expansions in general budget support and sector support to health. A food security emergency in 2005 also accounted for a one-off increase of NOK 47 million.

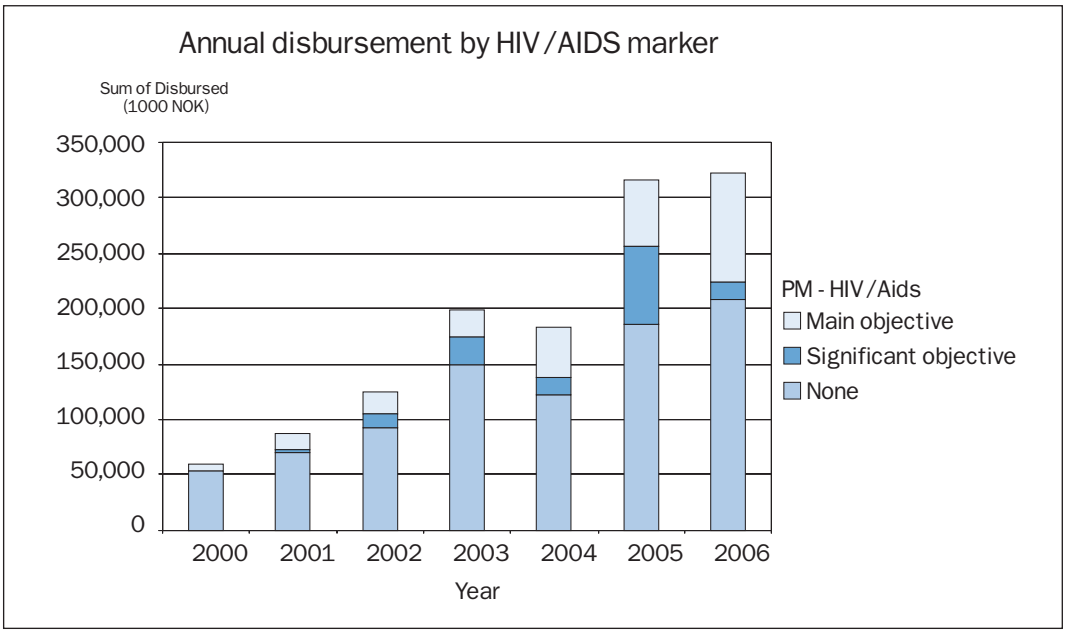
Norway gave relatively large contributions to institutions like GFATM and UNAIDS during the first years of the period under evaluation (relatively less during the latter part as their general budgets increased significantly) which would have supported Global Fund grants to Malawi and the boost given to ART. Norway was also actively involved in developing modalities for these institutions' work and in policy development. Among other things, Norway promoted administrative requirements of GFATM more compatible with national systems, and development of the 'Three Ones'. Furthermore Norway supported the World Bank's Multi-Country Aids Program and tried to influence the Bank at management and board level to give priority to HIV&AIDS. Although indirect and difficult to state in precise terms it is no doubt that the support of Norway to improve the capacities of these multilaterals has helped on the national response in Malawi.

Specific flows to HIV/AIDS can be difficult to quantify. The DAC coding does not identify support to HIV/AIDS, which may be reflected under a wide range of categories. Norad has a coding system that marks programmes according to a 'significant' or 'main' objective to deal with HIV/AIDS. Annex 5 Table 3 shows the flows to HIV/AIDS according to that marker. Over the whole period, 32 percent of disbursed aid was marked for HIV/AIDS. This accounted for 12 percent in 2000, rose to a peak of 41 percent in 2005 and was 36 percent in 2006. Total spending amounts to about NOK 30 per head of population (Figure 1). In addition

9 The report quotes from these figures as an authoritative source. Reports by NGOs and studies by the auditor general have shown inconsistencies in coding of data and a highly variable 'content' of cross-cutting policies in aid programmes marked by cross-cutting policy markers that are not mutually exclusive. The arguments presented in this evaluation mainly concern broad trends in the programmes and underlying errors are not thought to be significant for the conclusions drawn.

to the funds allocated directly to Malawi, Norwegian financial support was also given through the multilateral channels. The pro-rata contribution to Malawi is small in scale compared with the bilateral country programme, but influence on the policies and operations of the Global Fund and other bodies has a positive bearing on the national response.

Figure 1 Flow of aid to HIV/AIDS by year

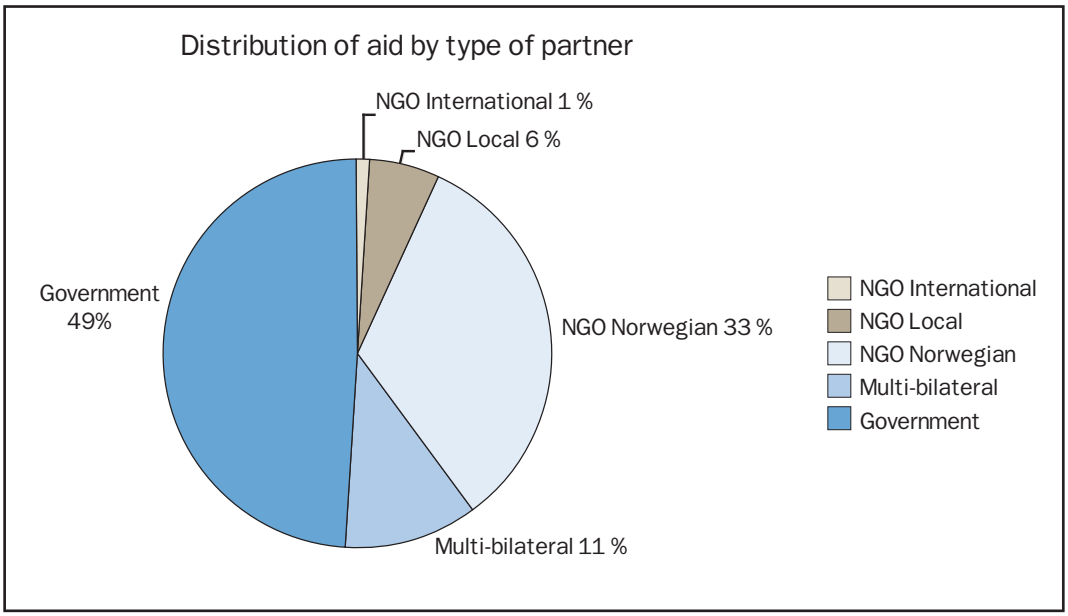


The 'marking' does not take account of the size of components that are relevant to HIV/AIDS and some relevant programmes are not marked for HIV/AIDS. The spending 'marked' to HIV/AIDS is a close approximation of the focus of the programmes, but only an approximation. For example, the Norwegian Embassy funds a programme of support between Statistics Norway and the Malawi National Statistics Office to support annual welfare monitoring and other periodic surveys. These include information about social trends linked to the epidemic and as such are of value to policy makers. But this programme is not marked for HIV/AIDS.

Gender relations are a major aggravating factor in the Malawi epidemic and are also a cross-cutting issue for mainstreaming by Norway. Annex 5 Table 6 shows the inter-relationship between spending on gender and equality, with HIV/AIDS. Over the seven years 2000-2006 52 percent of the portfolio was marked for neither gender nor HIV/AIDS. About a quarter of the portfolio was marked for both gender and HIV/AIDS. Very few HIV/AIDS projects were not also marked for gender, but a significant minority, about 15 percent of all spending was on gender issues without an HIV/AIDS element. Annex 5 Table 7 shows the coding for HIV/AIDS and gender against DAC sector codes. The only programmes of any size not to have been marked at all for both gender and HIV/AIDS content are budget support and energy. Other sectors have all had some element of gender and HIV/AIDS content, though not in all projects.

Bilateral aid to government has been the main channel of support. A total of 49 percent of aid was disbursed to government, 40 percent through NGO channels, and a further 11 percent through agreements with multilateral agencies at country level (Figure 2 and Annex 5, Table 4). The allocation to multilateral agencies was initially higher in the earlier years until a growth in commitments to government that started in 2004. The distribution between Norwegian NGOs and government was almost 50:50 during the period 2002-2004, but similarly reduced with the expansion of funding direct to government in 2005 and 2006.

Figure 2 Aid to HIV/AIDS by partner



3.2 Norway's Country Programme and Strategy

The Norwegian strategies for cooperation with Malawi are found in the embassy's operational plans (*Virksomhetsplan*) for each year and three-year periods, as well as general policies and strategies and thematic priorities. The Malawi country strategy for 2001 up to 2005 is seen as reflecting these. It has never been formally updated and embassy staff confirms that it was retained until finalisation of the Malawi Growth and Development Strategy published in 2007. In addition, a range of Norwegian support to Malawi falls to some extent outside the scope of the country strategy, e.g. support by Norad through Norwegian NGOs in Malawi. These must nevertheless adhere to both Norwegian development policies and Malawi policies but do not necessarily need to fit in the country strategy as implemented by the embassy.

The 2001-2005 strategy set out four main areas of support:
- Good governance
- HIV/AIDS prevention
- Macro-economic reform
- Health sector development

Within the HIV/AIDS area the strategy identified priorities as support for the National AIDS Control Programme (NACP, now superseded by the National AIDS Commission, NAC); preventive activities in sector programmes; capacity development, especially for NACP; creation of an NGO/CBO grants facility; and all Norwegian development assistance was expected to have an HIV/AIDS component.

The HIV/AIDS set of projects and programmes has been a diverse one with a wide range of partner institutions. Annex 5 Table 5 lists all the partner implementing institutions together with the funds disbursed according to the HIV/AIDS marker. A total of 44 project agreements marked as being 'significantly' about HIV/AIDS have been implemented by 36 partners, these constitute the main actions of mainstreaming in the country programme. A further 48 projects implemented by 24 partners are marked as 'mainly' about HIV/AIDS. This table excludes direct support to multilateral institutions.

Actions in support of HIV/AIDS are categorised by the National AIDS Commission under the eight pillars set out in paragraph 0. There is no simple way to classify the Norwegian-supported activities into these pillars. The 2007 Public Expenditure review estimates the share of expenditure on HIV/AIDS activities in 2004/05 as being 40% for treatment, care and support, 24% for advocacy and prevention, 11% for leadership and coordination, 3% for M&E, 16% for capacity building, and 6% for impact mitigation.[10] To the extent that

10 Government of Malawi and The World Bank (2006) Table 4.6

Norwegian support has become more predominantly channelled through large national programmes, these percentages apply across the programmes as a whole.

The stakeholder analysis in Annex 6, Tables 1 and 2, illustrates the diversity of implementing partners and types of intervention. Chapter 4 gives more details in analysis of outputs delivered. A review of stakeholders shows that 56 percent of expenditure was devoted to partners with the potential for high influence over the national response, such as Ministry of Health, NAC and Norwegian Church Aid. Just under 40 percent of expenditure has been channelled through NGOs, most of whom are assessed as being of 'medium' influence in contributing to the national response. Implementation has closely followed the priorities set in the country strategy.

From the outset of Norwegian involvement with the fight against HIV/AIDS the country strategy has been designed to support national priorities. Norway helped directly with the establishment and formation of an HIV/AIDS Secretariat and has maintained support for the NACP and NAC ever since. The strategy was pluralistic from the outset. The core was to support the development of a government programme. 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 Organisations (FBO) which are important parts of the social fabric in Malawi. Examples include NASFAM, Oxfam, Harvest Help/Find Your Feet and CISANET in the agriculture sector; BLM, Christian Health Association of Malawi, and SOS Children's Village for civil society, Norwegian Church Aid, Malawi Council of Churches, Association for Christian Educators and Public Affairs Committee for FBOs.

3.2.1 Timeline

Table 1 sets out a summarised timeline of key features in Norwegian support since 2000. A more detailed version appears as Annex 7. The timeline seems to show an evolution of the programme with four overlapping themes:

- Entry support - when Norway moved into the sector and played a catalytic role in helping establish the NACP and develop the national strategic framework
- Expansion and diversity – with the growth of programmes with NCA and other civil society channels, plus mainstreaming into other sectors
- Consolidation– working to build donor consensus around both a health SWAp and pooled funding for the NAC
- Concentration – the trend at the end of the period to deliver a larger budget but concentrated in fewer larger-scale programmes

Analysis of the Norad database suggests that support for new interventions peaked in 2003/04 with a gradual consolidation thereafter.

Table 5 Timeline of Norwegian support to combat HIV/AIDS in Malawi[11]

Norwegian financial support and Embassy activities								
	Other activities/ interventions	Embassy works to establish Health SWAP Promote integration of TB and HIV/ AIDS	Embassy active in donor coordination within health, GAVI, HIV/ AIDS, gender. Progress in SWAps	Norway donor representative in CCM/ GFATM MoU for basket funding of TB programme	Promotion of better coordination between Unicef/ UNFPA and Government SWAP is established	Embassy is active in TB programme	Focus on district level in the national AIDS program Gender emphasised in NAC and SWAP	
	Other HIV/AIDS relevant support	TB programme Gender mainstreaming in programmes	Integration of TB treatment and HIV/AIDS HIV/AIDS awareness in schools Strengthening of medical college and support to increased intake	Adolescent girls literacy incl. HIV/AIDS components NCA/CHAM health programme Various NGOs National Gender strategy	Support to health SWAP Integration of HIV/AIDS in support to agriculture Life skills education programme (Unicef/ UNFPA)	Increased support to agriculture incl. HIV/ AIDS	New and increased support to gender (NGOs) Sharp increase in support to health SWAP Support to improved and increased nurse education	Increased UNDP cooperation Sharp increase to health SWAP
	HIV/AIDS specific support and activities	Support to NACP secretariat Development of HIV/AIDS plans in 21 districts	Support to National Aids Secretariat (as the only donor to core budget) Various NGO support within HIV/AIDS Support to AIDS plan in 12 districts	HIV/AIDS programme with Norwegian Church Aid, churches, and CHAM.	Support to national HIV/ AIDS Strategic Framework through NAC Life Skills in Schools (Unicef/ UNFPA)	NAC support through NAC pool fund ARV treatment with MSF NGO support to a larger extent channelled through NAC	Continuation and increase in previous support	Continuation and increase in previous support
Yr		**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**

3.2.2 Intervention logic

This evaluation has used a logic diagram to model the potential benefits arising from Norwegian support. In the Inception report for this study an illustrative intervention logic was developed showing how Norwegian support might create a connected and coherent programme leading to development change in line with national priorities. Annex 8 contains a version of that logic edited to reflect the actual situation in Malawi.

The theoretical model envisaged a four stage process:

- Level 1 – A broad mixture of funding modalities enables Norway to interact at a variety of levels from grassroots to policy. Breadth increases Norwegian experience base, creates opportunities for learning and improves relevance of policy support.
- Level 2 - Outputs from funded activities are the first level of benefits: here the level of attribution varies according to the type of partnership.
- Level 3 - Potential increased benefits arise from Norway's ability to interact and exchange lessons and experience between policymakers, implementers in and outside government, target groups and PLWHA. Partnership strategies build on that experience.

11 Based on embassy reporting (virksomhetsplan), DAC statistical database and other sources. For programme support only new programmes or initiatives are listed; most programmes continue the following years if not otherwise specified.

- Level 4 - Direct benefits accrue to target groups and PLWHA. Indirect benefits come from the efficiency and effectiveness gains from improved ways of working and policy alignment.

The actual programme in Malawi closely resembles the model as far as levels 1 and 2 are concerned. The programme has harnessed a wide range of implementing partners and has shown flexibility in combining aid modalities. It is clear, as explained in Chapter 4, that considerable progress has been made with delivery of outputs across the whole spectrum of pillars in the national strategic framework.

It is less clear that the potential interactions and lesson learning envisaged at level 3 have been achieved. The coordination structures developed for the health sector and NAC have the potential to provide the fora to share experience. But there do not seem to be any mechanisms to feedback the more diverse experience from small-scale investments mainstreaming in other sectors. And the NGOs supported by Norad do not necessarily participate in NAC fora.[12] It can be argued that 'internal' Norwegian coherence is not so important as long as all Norwegian contributions support the nationally coordinated efforts. Of course there must be a minimum of policy coherence adherence to national policies. As Norway has supported some innovative work, the concern is that full benefit is being derived from those experiences to help inform other partners. This issue is explored in the report and forms part of the discussion about progress towards outcomes, level 4 in the logic model, in Chapter 5.

3.2.3 Selection of mainstreamed sectors and specific projects to investigate in more detail

The analysis set out in this chapter was used to identify programmes and partners for follow-up and field study during the evaluation. The planned list was:

- The health sector-wide programme
- National AIDS Commission
- Norwegian Church Aid
- Malawi College of Medicine
- National Smallholder Farmer's Assoiciation of Malawi(NASFAM)
- Banja La Mtsogolo (BLM)
- Keeping Kids in School (Unicef/Ministry of Education)
- Life skills for youth (UNFPA/Unicef)
- Development fund (Utviklingsfondet)

These programmes represent a substantial proportion of the total expenditure, comprise a number of quite long-running partnerships, cover core areas of mainstreaming in agriculture and include government, faith-based and other non-governmental organisations. Owing to availability of staff from implementers and, at the request of the Embassy, in order not to overburden organisations that had recently been evaluated, some programmes in the list received only a desk review or office-based interview. Opportunities were taken for additional visits were to ACEM and Oxfam.

3.3 Mainstreaming

Norway identified a need to mainstream HIV/AIDS early during the period under evaluation. One primary target was the agriculture sector owing to concerns about productive capacity and the effects of the disease on agricultural labour and the viability of smallholder farming. The 2001-2005 strategy explicitly endorsed the GoM National Strategic Framework which planned to incorporate the battle against HIV/AIDS as a major component in all relevant sectors. The strategy itself stated that '…all Norwegian development assistance will have an HIV/AIDS component', though embassy staff interpret that statement as an expression of the importance of the issue for dialogue and policy support rather than a financing commitment.

12 The partnership forum is a multisectoral forum whose members represent all stakeholders.

Box 2 What is mainstreaming?[13]

Mainstreaming as a concept reflects a desire for HIV/AIDS to be at centre-stage, part of the mainstream. The phrase is widely used as a programming and planning concept. But implementation is diverse with varying effects on organisations and programmes. Norad has found it helpful to distinguish between integration and mainstreaming.

Integration is where AIDS work is implemented along with, or as part of, development and humanitarian work. It is conducted in conjunction with, and linked to, other projects, or within wider programmes.

Mainstreaming within an organisation is about changing organisational policy and practice in order to reduce the organisation's susceptibility to HIV infection and its vulnerability to the impacts of AIDS. Mainstreaming in the work of an organisation results in adapting development and humanitarian programmes in order to take into account susceptibility to HIV transmission and vulnerability to the impacts of AIDS.

In this report 'mainstreaming' is used for simplicity as a generic phrase. Reference is made to integration where appropriate.

A high proportion of sectors had programmes with HIV/AIDS components and some 32 percent of expenditure overall was marked as relevant to HIV/AIDS (Annex 5 Tables 3 & 7). Even so, there is a question about what exactly mainstreaming means and how organisations should set about it (see Box 2). The approach taken by Norway was to identify specific sectors and provide support. The main examples are the projects working in agriculture and a smaller scale involvement with education and literacy. The evaluation has not found evidence of a wider policy dialogue in other sectors other than through programmes such as the health SWAp.

The approach taken by GoM is structured around line ministries setting aside a recommended 2 percent of their annual budget for HIV/AIDS related activities. According to the mid-term evaluation of the Strategic Management Plan a large part of those funds was for introducing and sustaining workplace policies. There was little evidence of a systematic process of analyzing how HIV and AIDS currently impacts on each sector now or what the impact might be in the future. Where they do exist, strategies to address HIV/AIDS are not well integrated into the departmental workplans and cannot be said to be a normal and routine function of government. HIV/AIDS interventions are compartmentalised in discreet projects taken forward with little attention to each stakeholder's comparative advantage. (Carlson et al 2006, page 21)

More recent work by the Sweden-Norway Regional Team in Lusaka promotes a straightforward guide to mainstreaming based around three questions which take the form of a risk/mitigation assessment:

1. What is the impact of AIDS (illness or deaths) on the programme's ability to achieve it's objectives? And therefore what measures are we putting in place to minimize these impacts?
2. What aspects of implementing the programme will facilitate the transmission of HIV? And therefore what measures are we putting in place to minimize those impacts?
3. What aspects of the organisation's modus operandi will inhibit the transmission of HIV? And therefore what measures are we putting in place to encourage such actions?

The evaluation team reviewed recent examples where consideration of the effects of HIV/AIDS has been noted in the development of a new project.[14] From the examples seen, there is clearly potential for this structured approach to be taken up in Norway's Malawi country programme.

3.4 Relevance of the Strategy and Programme

The evaluation concludes that the programme has been directly relevant to the policies of the Norwegian Government and Norad, and has responded to the specific characteristics of the epidemic in Malawi. The programme responded urgently in the early years before national systems were well established. Direct bilateral support at country level has helped create the

13 See, for example: Anne Skjelmerud, Mainstreaming and AIDS, Norad (n.d.). UNDP HIV and Development Programme Issues Paper 33. 'Mainstreaming the Policy and Programming Response to the Epidemic' (n.d.)

14 Cultural Support Scheme for the Copyright Society of Malawi (COSOMA); and the NAO/SNAO Institutional Cooperation Project.

national systems that have enabled a large expansion in multilateral funding. The fight against HIV/AIDS was recognised as needing a broad-based approach, with specific attention to the role of civil society and the importance of religion and faith-based organisations in the country. The programme promoted partnership working and worked towards multi-donor pooled funding aligned to national strategy, in line with and in advance of commitments under the Paris declaration.

Summary of issues about Norwegian support

- Norway has been a significantly large bilateral donor, contributing some 5% of net official development assistance with a fivefold increase in annual disbursement over the period.
- Some 32% of Norway's aid was 'marked' as being for HIV/AIDS, with unknown amounts of support in other programmes not identified.
- About half Norway's aid was marked for both HIV/AIDS and, or gender. General budget support and energy were the only sectors where no operations were marked in this way.
- Some 49% of aid was channelled bilaterally through government, 40% through NGO channels and 11 percent bilaterally through multilateral organisations.
- Stakeholder analysis suggests that 56% of the implementing partners are judged to have a 'high' potential to influence the national response.
- The evaluation is unable to quantify support from Norway directly against the eight pillars of the National AIDS Framework, but the work of specific projects can be associated with specific interventions.
- The timeline shows that Norway's support has been closely aligned with national policy with a clear trend towards actions that pool funding and harmonise donor working behind national objectives.
- The various channels of support for HIV & AIDS do not demonstrate the extent of lesson learning and policy feedback envisaged in the logic model developed for this evaluation
- Norway took a lead in mainstreaming by identifying specific sectors for support: mainly agriculture and a smaller scale involvement in other sectors.
- The regional support facility in Lusaka has a helpful new guideline to help plan mainstreaming.

4 Delivery of Outputs

During the period of evaluation Norway has supported a wide range of programmes and projects, each having a number of outputs. A full list of outputs would include thousands of entries and is not seen as appropriate for the purpose of this report. Furthermore, although outputs are expected from all projects and programmes there is a considerable degree of variation with regards to documentation of the outputs and the degree of detail, which make a simple aggregation difficult. Instead, this chapter tries to categorise various classes of outputs from the various types of interventions to enable a general impression of the outputs, and provide more detailed presentation of outputs from selected programmes. Following the review of outputs a short section reviews the contributions from the Joint Swedish-Norwegian Regional Support Facility base din Lusaka.

4.1 What is Meant by Outputs?

Outputs are defined as the immediate, direct results from an intervention or input. The OECD-DAC definition is 'The tangible immediate and intended results to be produced through sound management of the agreed inputs. Examples of outputs include goods, services or infrastructure produced by a development intervention, meant to help realize its purpose.'[15] A key element is that management can be held fully accountable for delivery of outputs.

In line with Norwegian development strategies, in most cases Norway and most Norwegian institutions involved in development aid do not implement the programmes themselves. In this report, therefore, outputs normally refer to outputs from the activities carried out by a partner (implementing) institution utilising funding from Norway, rather than the more narrowly defined outputs from the Norwegian interventions or inputs alone (which would in most cases simply mean more income to a partner institution).

In cases of basket funding, pool arrangements or budget support it may be difficult to trace particular outputs directly back to Norwegian contributions. In such cases the report has nevertheless chosen to regard the outputs from the partner institution as outputs from Norwegian support; this is justifiable when presenting the logic of relations between inputs, outputs and outcomes; however, wh en quantifying there is the risk of double counting. Hence when quantifying outputs from pooled resources in this report, only a share of outputs reflecting Norway's share of total inputs is included.

For various reasons, support from Norway may have a high multiplier effect. Some factors point towards a general assumption that in many cases support from Norway can be attributed to a relatively larger share of the overall outputs of an institution than Norway's share of the inputs. First, Norway often tends to support the core budget of an institution (e.g. National Aids Coordination Committee and National Aids Commission) that other donors are more reluctant to do, enabling the institution to 'deliver' more outputs in programmes financed by other donors. Second, Norway has in many cases demonstrated a higher degree of flexibility, allowing Norway to fund components or phases other donors are not willing or able to fund. In some case it can be argued that relatively small amounts from Norway has enabled institutions to utilise much higher volumes of support from other donors, which might not have been available or might have been utilised in a much less optimal way if it wasn't for Norwegian funds. Third, implementing partners say that Norway has less rigid administrative requirements compared to other donors, which enables more optimal use of resources with less transaction costs than funding from other donors. Given that the above logic is true, outputs of the activities of a partner institution reflecting Norway's share of inputs to the same institution may be seen as a minimum degree/number/share of how much of the outputs can be attributed to Norway.

15 OECD-DAC (2000) Glossary Of Evaluation And Results Based Management (RBM) Terms. DCD/DAC/EV(2000)6.

4.2 Source, Structure and Review of Output Data

The main sources of material in this chapter are recent monitoring reports on the national response. There is generally limited access to aggregated data on outputs at national level, and reports to some extent show variable and sometimes inconsistent figures. Most of the outputs presented in this report, if not otherwise specified, refer to either the mid-term evaluation of the implementation of the Malawi HIV & AIDS Strategic Management Plan (Carlson *et al* 2006), for which data were collected during 2006, or the Independent Multi-Disciplinary Review Team's draft report as of September 2007 (Hera 2007).

Outputs are normally, if not otherwise specified, compared to national targets as specified for 2007 in the National HIV/AIDS Action Framework, and not e.g. targets for the individual programmes supported by Norway, or milestones in the Integrated Annual Working Plans (IAWP). IAWP targets were developed in 2005. National targets for the end of the evaluation period, 2006, were not developed. Hence the targets are not precisely referring to the period of evaluation and neither were they the actual targets against many of the interventions; however it seems most appropriate to use the same sets of targets as those used for monitoring the national response. In some cases the 2008 targets of the HIV/AIDS Strategic Management Plan, developed in June 2003, are used; targets against which more of the Norwegian supported interventions have been developed.

Outputs are presented according to the eight priority areas of the National HIV/AIDS Action Framework 2005-2009 (NAF, see para. 0), even though most of the Norwegian inputs and partners' interventions were developed against either the National AIDS Strategic Framework (2000-2004) or the HIV/AIDS Strategic Management Plan (2003-2008). For most priority areas and objectives only outputs for which national targets are set and outputs monitored on aggregate levels (Annex 1 to NAF) are presented. Outputs relating to other objectives are referred to when of particular interest to Norway's support, e.g. in agriculture and health sector as well as in gender.

Most of the outputs refer to the latter parts of the evaluation period. When referring to aggregate numbers over time they of course cover the full period, and even when not it is more appropriate to use the latter period as outputs from Norwegian support in the first part of the period is likely not to produce most of the outputs before the latter part.

For some of the aggregated outputs the data sources do not specify whether they refer to outputs delivered last year or to outputs delivered since the start of the National HIV/AIDS Action Framework, the HIV/AIDS Strategic Management plan, or total outputs ever. For some of the targets periods have not been specified. Furthermore, some indicators of outputs are not consistent with targets. This report does not explicitly mention or discuss potential inconsistencies between outputs and targets as it is not of crucial importance for the purpose of this evaluation.

4.2.1 Prevention and behavioural change

Most indicators relating to *Information, Education and Communication (IEC)* (e.g. number of radio programmes, brochures etc) as well as the *promotion of Safer Sex Practices* (number of teachers trained, number of youth exposed to HIV/AIDS education, condoms distribution, etc) show outputs beyond targets for the period, with significant increase during the last years of the period. 1131 radio and TV programmes were aired in 2006 (Carlson 2006) and probably well beyond 2,000 in 2007 (Hera 2007) against a target of 1,500. Distribution of booklets and brochures (1,4 mill) 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 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 due to a very high increase in intensity. Lack of access to radio is considered among the most important factor hindering reaching all citizens.

Almost 5 million young people have been exposed to life-skills based HIV/AIDS education; far beyond targets of 1,000,000 for 2007. This is now a core subject in school (planned two lessons a week). More than 60,000 teachers and advisors have been trained in life-skills based education. A range of other indicators also indicate very good progress within this area; however some concern is raised that high risk sub groups seem to be under represented and that there may be a gender imbalance in terms of fewer males reached (Hera 2007).

The number of sites offering *HIV Counselling and Testing* (HCT) and persons tested has increased significantly. There are about 300 sites offering HCT, an increase from 14 in 2001 and well beyond targets. Still, a disproportionately large number of the 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 (Hera 2007). Estimates by NAC suggest that 12 percent of the population is accessing HCT, which is beyond the target for 2008 in the Strategic Management Plan. However; some data indicate a significant gender imbalance in terms of 30 percent more women than men accessing HCT (Hera 2007), other data suggest equal use [separate report on gender issues as Annex 5 to Carlson 2006].

Clinical services for *Opportunistic Infections (OI) and Sexually Transmitted Infections (STI)* have shown poor performance in terms of outputs, and although there seems to have been a significant improvement the last year's targets were not reached (detailed aggregate data are limited). A shortage of drugs for STI treatment is a major obstacle.

For *Prevention of Mother to Child Transmission* (PMTCT) 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). Only 5 percent of HIV positive women are receiving the complete course of ARV prophylaxis (Carlson 2006). Although there has been an increase, the numbers are very low compared to targets. The NAF 2007 targets were 73 percent of HIV positive women receiving Anti-retoviral (ARV) and 230,000 being counselled and tested.

Interestingly one of the explanations that have been given for the poor performance in the biomedical response (PMTCT and STI treatment) is the diversion of resources in the health sector towards ARV treatment; hence it can be argued that the success of ART brought adverse performance in other very important outputs.

In terms of *gender*, there is no specific systematic reporting on gender as a particular area of outputs, only as integrated in reporting on various other outputs (however gender is reported at outcome level). Gender balance in terms of who are targeted by the various prevention and behavioural change interventions seem relatively good; with some underutilisation by males to some of the services. However explicit addressing of gender issues and unequal vulnerability is reported to have progressed relatively slow (Hera 2007, Annex 5 to Carlson 2006). It is also notable that PMTCT is among the areas of the poorest outputs, and that female condom distribution is very poor and prices are higher than male condoms. Furthermore, harmful traditional practices, which are more harmful to women and girls than to males, have been given relatively little emphasis (Annex 5 to Carlson 2006).

On the other hand, a range of outputs within general gender and women's empowerment are of relevance to the national HIV/AIDS response but is normally not integrated and reported in HIV/AIDS interventions. To the extent such outputs leads to general improvement in the status and relative empowerment of women and girls they are likely to greatly contribute to lower vulnerability of girls and women to infection and hence to outcomes within the national HIV/AIDS response. National level indicators are not found on this area of priority.

Norwegian contributions to outputs: Norway has financed a large number of IEC outputs either through direct funding, through various grant facilities including the NAC grant facility, or through HIV/AIDS mainstreaming of programmes in other sectors. Early in the evaluation period some limited HIV/AIDS information was included in education programmes supported by Norway; later it became a much larger and more explicit part of Norway's support to the education sector. Most NGOs supported, including Norwegian NGOs and their Malawi partners have included IEC activities in their programmes within several sectors. In particular during the latter half part of the evaluation period the combined number of HIV/AIDS related IEC activities supported directly and indirectly by Norway is high; reflecting a high volume of Norwegian support and the fact that most institutions are believed to have mainstreamed HIV/AIDS at least to the extent that they use their organisational structure and activities to promote HIV/AIDS information.

Of particular interest is the support through Norwegian Church Aid to all major religious (Christian and Muslim) organisations and their various umbrella organisations and associated organisation during the latter half part of the evaluation period. Churches and Muslim organisations have a relatively strong influence on behavioural change. In Malawi, as elsewhere, religious organisations have taken varying positions with regards to mainstream HIV/AIDS prevention messages; the issue of condoms being the most controversial. Nevertheless many churches have taken part in promoting preventive messages even since the start of the evaluation period. NCA has probably had a significant positive influence on these organisations' interest, willingness and commitment to use their organisational structure to promote HIV/AIDS related messages and has perhaps reduced tendencies in some of the organisations to present inappropriate and stigmatising HIV/AIDS information, although some controversies (including condoms) remain. NCA is actively working within the thematic area of gender based violence. Religious leaders have been particularly concerned in this area. NCA influence is seen more at a central or higher level of the organisations and in urban areas in the period of evaluation; its strategy now points towards reaching out to 'grassroot' level. NCA also supports a wide range of IEC activities financially through church organisations. On district and local level NCA has promoted and supported cooperation within IEC, prevention and care between several churches and even Muslim organisation that normally do not cooperate, probably leading to improved exchange of ideas, knowledge and experiences and perhaps better efficiency.

Norwegian support through NCA has also promoted and supported HIV/AIDS education in church owned schools through the Association of Christian Educators in Malawi (ACEM). After a period of widespread education of 17,000 ACEM teachers with little follow-up, NCA support now focus on quality HIV/AIDS and life skills education in fewer selected schools with better follow-up. Focus in the preventive messages in these schools is on abstinence and faithfulness; not condom use.

For NASFAM, National Smallholder Farmer's Association of Malawi,Norway was supporting the initial establishment of their HIV/AIDS activities, which involved a range of IEC outputs reaching out to at least 100,000 NASFAM members. When NASFAM was able to utilise support from NAC grant facility it was not natural to utilise direct Norwegian support for those purposes. NASFAM states that the initiative to integrate HIV/AIDS in the organisation was taken by the organisation itself and not as a result of a dialogue with Norway.

Norway was instrumental in the establishment and strengthening of the National Aids Commission Secretariat, which now manages the Grant Facility providing support to a large number HIV/AIDS initiatives by public, private and civil sector organisations, many of which are related to prevention and behavioural change. As of June 2006 MWK 786 mill had been provided to 'advocacy and prevention interventions'. Although Norway contributes to relatively small parts of the Grant Facility a weak association between Norwegian support and all the outputs from the facility can be justified by the fact that Norway was instrumental in establishing the structure that enabled the Facility.

Norway has been a long-term supporter to the work of Banja la Mtsogolo within sexual reproductive health, which includes HCT, treatment of Sexually Transmitted Infections (STI), HIV/AIDS awareness, HIV prevention interventions targeting youth, and condoms distribution. During the period of evaluation BLM has increased the number of clinics from 5 to 30, each with a number of outreach centres spread over most of the country with particular focus on reaching poor and marginalised communities. The combined number of clients reached is over than 3 million. Their work also includes all prisons in Malawi. Support from Norway during the period varies, but is typically around 10 percent.

Clinics-based prevention including HCT, STI treatment and PMTCT is also supported Norway's support to establishment of the health sector discussed elsewhere. Most of the outputs from this support are believed to be seen in future, however some improvements are seen through the first years of the SWAP (Carlson et al September 2007).

The relatively poorer performance of clinical treatment of STIs and PMTCT compared to other areas within prevention and behavioural change is directly associated to poor health sector in general. This illustrates that the outputs from support to the health sector, a priority

area of Norway, are still not sufficient to serve the planned targets of the national response to HIV/AIDS. The general observation that the biomedical response outputs have been weakest as compared to targets is of particular interest for Norway as Norway has supported the health sector during most of the period of evaluation.

Norway has supported a range of gender related activities, including support to Ministry of Gender, the National Gender Policy and Strategy, Adolescent Girls Literacy Project, support to legal reforms, gender components of the work of Norwegian and Malawi NGOs, in particular through Norwegian Church Aid and their collaboration with churches in Malawi of which outputs are seen at least on higher and central level in the church organisation. Support from Norway has led to a number of outputs among others within legislation such as the Prevention of Domestic Violence Act, gender issues in churches, domestic (gender based) violence, and probably in gender relations in general. Any improvement in the relative position of women is likely to reduce their vulnerability to HIV infection and to ease conditions for many of the infected and affected; hence outputs from Norway's support to gender could be regarded outputs within the national HIV/AIDS response even though it is not reported as such.

4.2.2 Treatment, care and support

Within clinical care, *ARV therapy (ART)* stands out as perhaps the most impressing area in terms of outputs. As of March 2007 100,000 persons had ever started ART in Malawi [accurate number 99,535]. As of November 2007 the number is 114,000.[16] This is well beyond the 2007 targets of 50,000 and compared to only 3,760 patients on ART in 2003 it is a very high increase. The ART coverage is estimated at more than 30 percent, which is considered to be the highest in Southern Africa (Carlson 2006). The service is free; however since transport and accommodation costs is not covered by the programme, attendance still has a high cost for most rural populations. In general the service seems to be of high quality and successful. A relatively high death rate during first three months may be due to patients generally starting treatment to late, but the survival rate is above 70 percent even after 24 months.[17] A majority of those receiving ART are women (Annex 5 to Carlson 2006).

77 percent of detected 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.[18]

In terms of *Community and Home-Based Care and support* (CHBC), 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. *[A 2007 report - Hera 2007 reports a combined number of 362,000 households receiving support but this probably involves double counting when the same household receives various kinds of support]*.

Various services to CHBC have been developed and provided. The number of people ever enrolled in organisations for people living with HIV and AIDS (PLWHA) is 26,000, more than five times the targets for 2007. There is a significant increase in the latter part of the period.

Gender dimensions are not well reflected in most reporting on output within this priority area. There is little doubt that most of the labour and the burden of CHBC are carried by women. It is also very likely that the fact that travel and accommodation to ART is not covered by the programme, serves to exclude more women and girls than men from attendance, in particular in rural areas.

Norwegian contributions to outputs: Norway has been a major supporter to the establishment of the health SWAp and later to its financing. Progress of the SWAp so far shows improvement in the access to health services in general, improvements in some services including ART, and general improvement in the health sector, all of which contribute to improved clinical treatment.[19] Furthermore, Norway has supported a (relatively) massive

16 Figure given during interview at the HIV/AIDS Unit, MOHP.
17 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.
18 Report of the Malawi ART Programme, External Review Team, 4th - 15th September 2006, MOH, Charles Gilks et al
19 Malawi Health SWAp Mid-Term Review, draft summary report, September 2007

increase in the capacity to educate health personnel including medical doctors and nurses, and also improved quality of education. Outputs are starting to emerge after the specific period covered by this evaluation and are believed to be of major potential importance to the capacity of the health sector in future.

Norway has directly financed ARV treatment through support via MSF Norway for 2004-2006. There is little doubt that among the preconditions for ART success are the general capacity in the health sector as well as the establishment and effective functioning of NAC and the National HIV/AIDS Action Framework. Despite concerns noted above in para 4.16 about the distorting effect resources for ART can have on wider health sector performance, Norway has been steadfast in support for the health sector as a whole throughout the evaluation period.

Norway has supported Malawi's TB programme since the start of the evaluation period and in particular emphasised and facilitated integration of the TB programme with HIV/AIDS since around 2001. Norway also facilitated and supported the establishment of a 'TB basket' effective from 2003. This support is likely a contribution to the good performance of TB treatment in general, which is highly relevant also for the HIV/AIDS response and may have facilitated a relatively good integration between TB treatment and ART later in the period.

Norway has contributed to establishment and support to Community and Home Based Care through support to churches and church organisations via Norwegian Church Aid; as smaller components of programmes carried by other NGOs with Norwegian support; and indirectly through NAC's Grant Facility that supports a large number of home based care activities.

4.2.3 Impact mitigation

In support to Orphaned and Vulnerable Children (OVCs) there has been a high degree of achievement of outputs on national level. About 950,000 OVCs have been supported so far, about 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). Reporting at aggregate (national) level seems relatively poor and the numbers may be higher (Hera 2007). Around 600 community initiatives to support OVCs have been supported.

Impact mitigation in agriculture is not reported on aggregated (national) level in the national HIV/AIDS response, but may be seen as a part of Impact objective number 6 and 7 (IM6 and IM7) in the NAF and is also included in earlier national HIV/AIDS strategies. The Ministry of Agriculture has developed a policy and strategy for 2003-2008 but the HIV/AIDS programme in the Ministry seems poorly supported. However, a range of outputs have been produced by other agencies involved in agriculture. Bunda College, NASFAM, research institutions like ICRISAT and SARRNET as well as some NGOs have provided support to introduction of less labour demanding technology, high yielding crops and crops providing more appropriate nutrition, diversification of crops (hence minimising risk), irrigation, etc, all of which may serve to reduce the impact of AIDS for farmers in terms of economy, nutrition and health, increasing time available for care and support to sick household members, and others. Aggregate data on these outputs are not available/have not been produced for this report.

There are obvious gender dimensions related to OVCs, support to OVCs and to other aspects of impact mitigation; among others women and girls normally are socially and economically more vulnerable and have less alternatives available when being orphaned or widowed. These have not been elaborated at national output level in available reports.

Norwegian contributions to outputs: Norway has financed a range of activities to support OVCs through support to Norwegian and Malawian NGOs including church based organisations, SOS Village, Plan and other NGOs focusing particularly on children. Similarly, Norwegian support to Unicef and to education programmes has included special components to support OVCs. Furthermore Norway has indirectly contributed to outputs by part financing the NAC Grant Facility, which funds a large number of initiatives to support OVCs.

Within the area of NAF Impact Mitigation objective 5 (IM5), which in particular aims at enhancing the involvement of Faith Based Organisations (FBOs) in offering spiritual

counselling to People Living With HIV and AIDS (PLWHA) and affected families, Norway has through Norwegian Church Aid supported a change in interests and positions at central level of the main religious organisations, and in establishment and support to the Ecumenical Counselling Centre (ECC) that provides training in HIV/AIDS counselling in churches. While the quality of training seems good, there is not sufficient monitoring of actual improvements in counselling at local level.

Within agriculture Norway has supported a range of outputs within agricultural and natural resource management that serve to strengthen the capability of farmers to cope with HIV/AIDS. This include some of the research by Bunda College, interventions by NASFAM, research institutions like ICRISAT and SARRNET as well as the support through some NGOs. Funding through the Development Fund is a good example of flexibility to enable an NGO to seek complementary partnerships to pursue innovative work to help reduce the burden of manual work on households affected by HIV&AIDS and to promote patterns of cultivation that support improved diets and nutrition.

4.2.4 Mainstreaming, partnership and capacity building

During the first part of the evaluation period it can be argued that significant progress was seen in terms of Mainstreaming, Partnership and Capacity Building. The establishment of NAC under the Office of the President and Cabinet, dramatically improved coordination among donors, development of national strategies and framework all are crucial to this priority area.

However, these outputs are mainly seen in institutions that are working directly within the national HIV/AIDS response. In other institutions mainstreaming and capacity building have been relatively poor. Most of the large public (73 %) and private (57%) institutions have policies and mainstreaming programmes in place, an increase of about 20 percent since 2004, but well below 2007 targets of 100 percent of the public and 65 percent of the private institutions. Most large employers provide training in HIV/AIDS and many provide support to affected employees. Data on actual content and implementation of the policies and programmes of public and private institutions and on mainstreaming in civil society organisations have not been found at aggregate (national) level. Reports tend to conclude that mainstreaming is generally weak. It seems to be best in NGOs, in particular international NGOs, and poor in public sector. The human capacity shortage in public sector is among the explanations given for low progress, and lack of *'high level advocacy to bring planners at the central and district levels into the process'* (Carlson 2006).

Most of the Government ministries and departments have HIV and AIDS workplace programme, and both the Ministry of Labour and Department of Human Resource and Development have initiated some work on HIV and AIDS workplace policies and programmes. NAC has also developed a Conceptual Framework for Mainstreaming HIV and AIDS in development policies, programmes, projects and action plans in 2006. It is in the process of developing Guidelines for Mainstreaming HIV and AIDS in the Public, Private and Civil Society Organisations.

Owing to the importance attached by Norway, mainstreaming is dealt with as a specific issue in Chapter 5. Box 3 highlights a relevant good example that was supported by Norway.

Box 3 Mainstreaming HIV/AIDS in smallholder agriculture

The approach by the National Small Holder Farmer's Association of Malawi (NASFAM) can serve as a case of relatively good mainstreaming. This organisation with reportedly around 100,000 members has integrated HIV/AIDS in its work and has launched a HIV/AIDS programme implemented in all levels of the organisation. The programme involves capacity building on HIV/AIDS with a wide range of relevant issues (gender, nutrition, OVCs, etc); coordination with DACCs at local level; prevention, care and mitigation focussing on agriculture, and other measures. As one component it tested out a number of HIV/AIDS interventions in collaboration with farmers, which laid the basis for new techniques and interventions now being integrated in other parts of the organisations' work. Within prevention, care and support it focused upon what could be done in the agricultural sector. E.g. within prevention it aimed at strengthening food and livelihood security with a focus on women to reduce socio-economic behaviour that increased the risk of infection; within care it focused on nutrition; and within mitigation the focus was on alleviating labour loss and mitigating economic impacts (in agriculture). An external evaluation concluded positively and suggests that about 500,000 people have benefited from the programme.

Capacity building is perhaps the most crucial area of non-performance. In general, limited capacity seems to be the most critical limiting factor in the national response (Carlson 2006). This is valid assessment in ministries as well as at local and district level. Among others the capacity of district assemblies to take their role to coordinate HIV/AIDS at district and community level has shown to be poor and informants state this is a main bottleneck in the national response. Despite efforts by NAC to support district administration, by funding a District AIDS Coordinator (DAC), and providing an 'umbrella support facility' for the DAC, including two additional staff in most districts, a combination of weak capacity and slow administrative and financial procedures have held back the disbursement of funds. Donors have also become reluctant to give support to district level capacity building owing to the government having failed to hold democratic elections for district assemblies that were due in 2005. Private and public sector coordination is also assessed as being very poor (Carlson 2006 p. 24). It can be argued that these problems serve to reduce the overall outputs within several of the other priority areas of NAF.

Norwegian contributions to outputs: Norway has contributed to mainstreaming in several of its partner institutions, by financing the related activities and in some cases by promoting (perhaps even 'pushing') mainstreaming in partner dialogue. Within Norwegian support to sectors like education programmes and agricultural programmes its partner organisations have gone through HIV/AIDS mainstreaming during the periods of Norwegian support. The initial phase of the mainstreaming in NASFAM was for example financed by Norad, until funding was given by the NAC Grant Facility. Norad's contribution to and requirements of mainstreaming in Norwegian NGOs have probably supported mainstreaming not only within the Norwegian NGOs but also to a varying extent their partner organisations in Malawi.

As far as capacity building is concerned joint Norwegian/Swedish support has enabled a substantial increase in the number of doctors under training and also degree-level related skills such as Pharmacy and Medical Laboratory Technology. The goal was to increase the admission rate to 60 students per year and that was achieved for Premed by 2006. Gender ratio is still low, but improving towards 38 male doctors to 20 female targeted for 2008. Norway and Sweden's support was critical in helping to fund student hostels, recreation and a library/resource centre that are essential for students to be accommodated at the college.[20] Support to Christian Health Association of Malawi (CHAM) for nursing courses is on track to double the number of nurses being trained to lower than degree level. (see Box 4).

20 University of Malawi College of Medicine (2007)

Box 4 Facing the health personnel crisis

Malawi has a severe shortage of qualified personnel on all levels in the health sector. This is one of the main capacity constraints for the biomedical response to HIV&AIDS. The number of doctors and nurses per 100,000 citizens is only a fraction of the corresponding number in most other African countries. The main reasons are low capacity in education of health personnel, loss of personnel due to AIDS and their emigration to other countries for work.

Norway has supported Malawi College of Medicine since 2001. The cooperation has involved general upgrading of the institution to enable it to increase intake of students from around 20 to more than 60 annually. Cooperation in research and education is established between College of Medicine and Universities in Norway to improve quality in education. Training of the College's own tutors has led to a decrease in the use of foreign tutors from 80 to 66 percent. The share of female students has more than doubled to 31 percent.

Nurse education is also supported by Norway, mainly through an agreement with Norwegian Church Aid and Christian Health Association of Malawi (CHAM), which operates most of the training institutions. The programme is expected to double the capacity to 766 graduates annually, and improve the standard of education from 'certificate' to 'diploma'. In an early phase it was identified that one of the main capacity constraints were in infrastructure. There were not enough housing for students, and among tutors the lack of proper housing was identified as an important disincentive to stay in the nursing schools that are often rural and relatively remote. Hence large parts of the programme consist of infrastructure development. Another component is in quality in education, for which cooperation has been established with 6 Norwegian University Colleges.

Incentives have been improved for both doctors and nurses to ensure that as many as possible stays in service in Malawi. Loss of personnel to jobs abroad seems to be reduced, and loss of personnel due to AIDS is greatly reduced as result of ARV treatment.

4.2.5 Research and development, monitoring and evaluation [priority area 5&6].

Research and development is being conducted within a range of issues and the targets (milestones) set in the Integrated Annual Work Plans (IAWP), has to a large extent been achieved. This includes Annual Sentinel Surveillance, Behavioural Surveillance Survey, and research within Treatment and Care, PMTCT and ART, followed by Annual Research dissemination conference.

Monitoring and Evaluation systems are in place, but not optimal. The concepts and design of the system are judged to be of sound international standard, but the main concerns are implementation capacity. Routine data collection is the main bottleneck, especially in the NAC Activity Reporting System (NACARS) and Health Management Information System (HMIS). Data are collected from scattered and fragmented sources and much is supplied incomplete, too late for current quarterly reporting and not very accurate. Government systems are not used to using data for planning and management so the demand-side of the process is also weak. Grant recipients who do not receive funding from NAC feel little obligation to report and those that are funded do not treat this function very seriously.

The systems are under revisions with the main concern at the present time being capacity at district level and finding ways to encourage the diverse range of implementing partners to report against a single common format and reduce the burden on their field units. NAC wants districts to be able to design their work plans on the basis of local evidence about the response, and taking into account work by the private and non-governmental sectors. At present, the M&E system is not sufficiently effective as to achieve this.

Norwegian contributions to outputs within Research and Development, Monitoring and Evaluation: Norway has supported research and development within the health and

agricultural sectors, of which some components are relevant to HIV/AIDS. Some of the Norwegian support to district level HIV/AIDS strategies early in the period under evaluation may have enabled better monitoring and evaluation. Norwegian support to National Statistics Office has perhaps led to better possibilities of monitoring and evaluation in future.

4.2.6 Resource mobilisation and utilisation

The positive approach to organising a national response by the Government of Malawi is evident from the strong and sustained financial support made available by development partners. For the period 2003-2008 total planned contributions amounted to an initial sum of $264,922,600, increased by a further $12,896,444 after 2006. By June 2006, cumulative disbursement was $81,331,144 leaving an undisbursed balance of $183,591,456. Projections of the funding shortfall for the remainder of the NAF period range between $33 million and $168 million depending on assumptions about continued implementation at the current level or a step up in scale to full implementation of the NAF.

The pattern of spending is heavily influenced by the money from the Global Fund which although a pool donor, is in fact earmarked for treatment activities, especially ART[21]. Spending during the first two years was 44% of total budget, with allocations to capacity building, treatment, care and national leadership all close to plan. In 2004/05 disbursement was up to 70%, with an increase across all the other pillar areas. In 2005/06 disbursement fell to 36% owing to a delay in Global Fund disbursement.

The clearest test of the national capacity for financial management is seen with NAC's grant facility. This programme is the main channel of resources to the public sector, NGO/CBOs and the private sector. Good progress has been made but the 2006 MTE (Carlson et al 2006) judges the system to be still a learning exercise. It has increased the flow of resources and has been especially critical in developing home based care and support, but the systems are still characterised by slow approval and disbursement procedures (typically taking 5 months compared with a target of 3 month).

During the period 2003-2006 total funds available were MK 27,474,000,000; committed MK 13,057,041,672; disbursed MK 5,233,609,437; and spent MK 4,336,624,114. As a percentage of committed, 40% was disbursed and 33% spent. But as a percentage of available, disbursed was only 19% and spent 16%. Leaving aside spending on leadership, coordination and programme management: 17% was on prevention & advocacy; 11% sectoral mainstreaming; 37% treatment, care and support; 13% impact mitigation; 17% capacity building and partnership and 5% M&E & research.

The MTE found that in addition to the slow processes the grant system has tended to foster poor linking of plans and activities, fragmentation among departments applying for grants, and separate procurement plans and exercises. The fund has supported an abundance of short-term, small-scale projects at district and community levels, but the fragmented nature has reduced scope for scaling up and achieving economies of scale, or for organisations to approach the fund for more strategic support.

The MTE concluded that the approach fits the three ones, and follows international best practice. It augments existing services rather than substitutes, and targets communities and organisations rather than individuals. But the lack of reliable flows reduces impact of interventions and raises questions about effective use of resources.

In terms of mobilising international resources, Norway has both provided its share of resources [Chapter 3] and has probably enabled better access to resources from other international sources as well as better utilisation of all resources through its support to establishment and strengthening of NAC, its role in pool arrangements and its support to the Paris agenda. Norway reportedly played an important role in establishing the NAC pool. Initially there were some disagreements between various donors and the government, to which Norway played a role as a broker. Norway also took the initiative to bring in UNAIDS as the honest broker between NAC and the donors and played a role in building partnership between donors and the UN. Norway (as a board member) has also taken an active role in

21 Channelled through the Health Sector SWAp.

getting GFATM better aligned and coordinated with national systems and efforts. The fact that GFATM is a part of the NAC pool is an indication of a high degree of coordination, which is likely to have improved the overall outcomes of the national HIV/AIDS response. NAC's grant funding is said to have been modelled on early support by Norway in this area.

4.2.7 National policy coordination and program planning

A chronology of national plans was presented in Chapter 2 (para 0 et seq.). The two overarching objectives during the period have been firstly, to achieve consensus among all national parties and development partners behind (initially) the Strategic Management Plan and then the National Action Framework (NAF) and secondly, to achieve the 'Three Ones'. The most recent assessment was made by the Mid-Term Evaluation (MTE) of the SMP Carlson et al 2006) and the Independent Review Team (IRT) report for 2007 (Hera 2007). This section draws heavily on those sources alongside interviews with development partners.

All the International and National NGOs visited were aware of the National Action Framework and all stated that it is one of the starting points for planning their activities within Malawi. In addition, the INGOs all had their own organisational policies, which guided their activities, although none felt that there was any significant conflict between these two basic starting points for their planning. The IRT found no evidence of any activities being undertaken that could be construed as being outside the NAF.

Further, all NGOs indicated that they used the relevant national policy or guidelines for the design of their programmes. Indeed a number of the INGOs visited were active participants in a variety of NAC Technical Work Groups that had been instrumental in developing these guidelines.

Thus in principal, it would appear that the first of the 'Three Ones', an agreed National Action Framework, is widely accepted as the basis of HIV/AIDS activities in Malawi.

In addition there have been some attempts to go beyond this first 'one', the single National Action Framework, to try to include activities, beyond those funded through the NAC funding envelope, into a single annual work plan. In the 2004/05 and 2005/06 IAWPs there were attempts to include the activities by organisations not funded by NAC. It proved hard to monitor the progress of these activities, as they were not reported on through the NACARS and these were dropped from the 2006/07 IAWP. Further progress in these areas will depend on decentralisation and further development of the M&E system.

The second principle, a single AIDS Coordinating body is also widely accepted in Malawi. NAC is recognised by all the NGOs and INGOs as having this role and they all look to the NAC to ensure the necessary policies to design activities and guidelines, to provide the necessary detail for implementation, are in place.

The actual coordinating role of NAC is however more difficult to define and the IRT identified the following roles as being key to the role of coordinating the response to AIDS in Malawi:

- Ensuring the necessary policy frameworks, both macro-level (e.g. legislation) and more micro-level (policies and guidelines for activity implementation) are in place.
- Providing Technical support to implementing agencies and partners
- Monitoring the response to ensure that it is balanced both in terms of programmatic content (preventative activities and curative activities in the 'right' proportion) and in terms of geographic focus (more activities where need is greatest).
- Using leverage to ensure that any evidence of an imbalance in the programme is corrected.

The first three years of IAWPs has seen a great deal of policy development such that there is policy and guidance available for most areas of the response.[22] The IRT believes that there is a now a solid body of policies and guidelines in place in Malawi that enable implementing agencies to undertake their activities in a systematic way. The foundations for dealing with the epidemic are largely in place.

22 A glaring exception to this has been the establishment of a formal legal framework for NAC and its activities, however draft legislation is now nearing completion.

Over the last three to four years NAC has, using either its staff or consultants, provided support in various forms to implementing partners. NAC has supported institutions to generate proposals that have not only attracted funding from the Global Fund but from many funding agencies both in and out of Malawi. NAC has been instrumental in guiding development of prevention messages, care and support and mitigation activities. This is evident in many institutions (including those visited in this review mission) although lack of capacity may have prevented NAC from providing all the TA was requested.

In terms of programme emphasis, this is more problematic as, at present, it is hard to know what the right balance is. It is only just stating to be possible to answer such questions as 'are we doing enough on prevention or are we providing enough support to OVC?' Only as more information on impact starts to become available will NAC be able to know whether what has been implemented so far is having an effect and whether the current balance of activities is correct.

This is now starting to happen with the results being learned through the Triangulation exercises and other studies. These are starting to show differences in the epidemic (the six broad types of epidemic that were characterised through the first Triangulation exercise) and differences in the response (Greater access to ARVs for those living near roads, a lower availability of HTC services in certain areas demonstrated in the second Triangulation exercise) and NAC will need to be able to encourage a 'rebalancing' of the programme by those responsible for implementation.

Similarly in terms of geographic balance, NAC started off with a simple community demand driven approach designed to kick start the programme by supporting any organisation (within reason) who wanted to contribute to the implementation of the NAF. This has been very successful in stimulating CBO activity in the districts. NAC now recognises that there is a need to start focusing these energies to the areas of greater need. Thus resource allocation formulae have been adopted to try to balance budgets to the districts, taking into consideration population and HIV prevalence, as well as other factors. As more information becomes available it may be possible to further refine the formulae to improve targeting.

Unlike many similar countries in Southern Africa, NAC has one very strong lever for influencing programme balance. In Malawi a very high proportion of AIDS funding is managed by NAC,[23] and thus NAC should be able to use its financial weight to ensure that any necessary 'rebalancing' is undertaken. Thus if, for example, it is found that OVCs in a particular district are not being adequately served it can stimulate additional OVC activity by contracting new organisations to provide services, either directly or through the development assistance.

Despite this one strong lever, another significant part of the response is hard for NAC to influence, the non-NAC funded NGO sector. Apart from a requirement for INGOs, NGOs and CBOs to register with government agencies at either national or district level there appear to be no formal mechanisms available to NAC to influence what activities are carried out (as long as they fit within the NAF) by an NGO with its own funding are where they are carried out. This has not really mattered so far as the first phase of the effort against AIDS has been geared to stimulating an increase in any resources in support of the fight.

The third one is a unified country level Monitoring and Evaluating System. Despite much progress with the development of system design, difficulties remain in obtaining comprehensive nationwide information from the implementing organisations, particularly those that are outside the NAC funding framework. A number of problems were perceived for these non-NAC funded organisations:

- The reporting format they used was not compatible with NACARS.
- There were no formal mechanisms for reporting if they were not funded by NAC.
- There was no legal requirement that they reported to NAC.
- There was little or no feed back if they did report to NAC.

Dual reporting is a particular problem. INGOs all have their own reporting requirements, which necessitate the collection of information in a format (to a greater or lesser extent)

23 A recent study 'Pioneers, Partners, Providers: The Dynamics of Civil society and AIDS funding in Southern Africa. 2007, OSISA' estimates that the Malawi NAC controls a much higher proportion, 60%, of total AIDS spending than the counterpart organisations in any of the other six countries studied (average 11%).

different from NACARS. As these institutional M&E formats fit into their parent organisations requirements for cross-national monitoring it is very likely that these will have to remain as a condition for continued funding. This would suggest that dual M&E reporting will remain as a burden for the CBOs supported by these organisations.

With the planned increased engagement of the NGOs at District level, the NGOs will either be participating in the District structures themselves, where they have district level staff, or encouraging their partner CBOs to participate, where they themselves have no district presence. It is anticipated that this greater engagement will result in closer liaison between the DAC and the 'non-NAC' funded activities at District level. The District Assemblies should be in a better position to ensure reporting from these organisations.

Within the Faith Based Organisations (FBO), there have been significant improvements in terms of better coordination among these organisations throughout the period. On central level all the major FBOs coordinate their activities through a range of umbrella organisations, including Malawi Interfaith AIDS Association, Ecumenical Counselling Centre, Malawi Council of Churches, Association of Christian Educators in Malawi, Public Affairs Committee and other organisations. Muslim organisations are also involved in coordination on central level. On local level there is also some coordination.

However, there still seems to be relatively little coordination between FBOs and the National Response. Informants in most FBOs interviewed by the evaluation team acknowledge the need to share information with NAC and report accordingly. However, they seem not to accept that NAC is an authoritative agency to which they should listen, learn and adapt. This is not limited to the controversial issues like 'the condom issue' but also more generally; their strategies seem to a very little extent developed with reference to the National HIV/AIDS Action Framework although most of their activities fit into it. By far the most important aspect of NAC to which the FBOs seem to relate is the Grant Facility as a potential source of funding.

Norwegian contributions to National Policy Coordination and Program Planning: Norway has been a major supporter of national policy coordination and program planning through its support to NACP and later to NAC throughout the period. In particular Norwegian support is believed to have been of crucial importance during the early years of the evaluation period when few other donors gave priority to this issue. Norway played a leading role in developing the "Three Ones" principles, using Malawi as a case country. In 2002-2003, Dr. Møgedal (at that time the special adviser to the Head of UNAIDS) worked in particular with Malawi to discuss and further elaborate the approach that came to be known as the '3-Ones' principles. Malawi was used as a case to discuss and agree on what to be presented at the International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) later the same year.

Through Norwegian Church Aid Norway has supported improved coordination among the Faith Based Organisations; however it is not clear whether NCA has also contributed to better coordination between these and national policy coordination and program planning.

4.2.8 Outputs in the health sector

There is a range of outputs within the health sector to which Norway has contributed and that are of high relevance for achievements of outputs and outcomes in the national HIV/AIDS response. Some of those of most direct relevance to HIV/AIDS are mentioned above. Also in general terms a strengthened health sector will support the national response to HIV/AIDS. For example, free services for mothers and children is believed to be reason for a doubling of women attending antenatal clinics, enabling HCT and if necessary PMTCT (if service available), and an increase in the number of nurses and doctors, respectively, to population, and assumed further increase in the years to come as the result of training/education, incentives and better use of human resources. The national Tuberculosis Programme has shown good performance with support from during the period, and Norway was in particular instrumental in integrating TB with HIV/AIDS. During the latter part of the evaluation period there has been some improvements in the health sector; more is believed to come in the following years.

The health sector has been included in Norway's support to Malawi since the first agreement in 1997. Throughout the evaluation period support has focused on TB treatment (since 2000); support to Medical College (since 2001) to increase education of medical doctors; support to

CHAM via Norwegian Church Aid (since 2002) including support to double the intake of students to nurse education and improved quality of the education; and support to the Sector Wide Approach (SWAP) for the health sector (since around 2002). Support to the SWAP included active facilitation by Norway during the establishment and later financing of the Programme of Work (POW), which focused on provision of the Essential Healthcare Package to all Malawians. All these interventions are believed to enable a relatively high degree of improvement in the capacity and quality of the health sector in general.

4.3 The Joint Swedish-Norwegian Regional HIV and AIDS team for Africa[24]

The Regional Team is a facility based in Lusaka and hosted by the Swedish Embassy. The facility was developed following a series of Swedish policy and strategy decisions and has the goals to contribute to reduction of HIV transmission and improvement in the lives of the infected and affected, by providing support to prevention, care and treatment, and impact mitigation initiatives in Sub-Saharan Africa. These goals will be achieved through: (a) strengthening the capacity of Inter-Governmental Organisations (IGOs); (b) supporting regional programmes and initiatives, and (c) engaging in dialogue.

Norway joined the regional facility in 2002 with appointment of a member of staff. A review by Norad based on inputs from embassies concluded that the cooperation with Sweden is useful and agreements were made for the provision of two seconded staff. The first took up post in August 2006 and the second has not yet been appointed. Norway also agreed to contribute financially. Initially NOK 30 million was transferred by the end of 2006, with a planned annual contribution of NOK 50-60 million.

The Regional team has two broad roles, the first, allied to supporting regional structures such as SADC, EAC, ECOWAS and IGAD. The second, support to bilateral programmes. Bilateral support is largely offered on a demand-responsive basis. Requests from Malawi have been slow to emerge and have only started to pick up in 2007, outside the reference period of this evaluation. In part this reflects staff coming to terms with the new facility, but also an element of uncertainty about when to deal directly with the team. The 'normal' channel of requests for support according to embassy staff in Malawi is that Norad is still the first point of call. Lack of ownership by Norwegian embassies to the 'Swedish' team and different organisational structures between Norway and Sweden are also seen as a challenge.

Apart from support to Malawi, the regional hub dealt with other Norwegian Embassies across the continent in 2006:

- Abuja – introduction of the regional team and concept of Workplace Policy
- Kampala – introduction of the team and discussion on support to Northern Uganda that led to a direct advisory mission
- Nairobi – joint mission with Norad to map out relevant organisation
- Lusaka – a mini-seminar on mainstreaming was held
- Maputo – introduction to the team and up-date on the portfolio

As well as embassy support during 2006 the regional team undertook work on livelihood and food security; impact on systems; workplace, intergovernmental organisations; sexual and reproductive health and rights, gender, communication, human rights and stigma; capacity building, comparative research and networking.

The SADC region is the global epicentre of the epidemic, with 55 percent of all persons in the world living with HIV.[25] SADC itself has started to take an increasingly prominent role and has built capacity through a Joint Financing Arrangement with a group of bilateral donors and UNAIDS under the leadership of the Swedish-Norwegian Team. The regional team's role in supporting regional structures has the potential to be the most innovative and transforming aspect of the team's work. Some aspects deal directly with regional issues such as cross-border arrangements that affect the moments of goods and have a direct impact on HIV vectors such as truck drivers.

24 Source, Notes from interviews at the Regional Team Office, Lusaka; The regional HIV and AIDS Team for Africa, Annual Report 2006.

25 Specifically Angola, Botswana, DRC, Lesotho,, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Zambia, and Zimbabwe; excluding Tanzania, Mauritius, Seychelles and Madagascar.

Others are less tangible. One stated objective is securing greater ownership of the statistical evidence about the disease at national level through an annual update process which aims to turn disputes about the validity of data and implications for national response inwards nationally and regionally rather than outwards towards UN bodies as has happened in the past. The team's strategy is to use IGOs to create peer processes that enable countries to interpret and respond to the disease. This resonates directly with analysis in the Malawi Drivers of Change report which argued that '*A co-ordinated effort on a continental scale might alter the incentive structure facing the leaders of countries like Malawi in a way that donor action at the country level cannot*.' (Booth et al 2006, page xv).

Assessment of performance of the regional team in future reviews will be helped by a more structured presentation of objectives and measurable indicators recommended in a review by the team's reference group of African experts towards the end of 2006 and being taken up in the draft plan for 2008-2010.

4.4 Effectiveness of Output Delivery

There are many areas in which the national HIV/AIDS response has made impressive progress. There have been considerable achievements in increasing access to HIV testing, treatment and care. More Malawians are using HIV testing and treatment services and are benefiting from community care than were originally planned at this point in time. Other areas of progress include the creation of a comprehensive M&E plan, strong partnership between NAC and development partners and amongst development partners. Weaknesses remain however. Despite high levels of effort on prevention, behaviour change is slow to emerge. And capacity remains a considerable constraint among implementing partners. Norway has provided diverse and wide-ranging support through both core programmes and targeted support for non-governmental organisations and to mainstream and integrate efforts in a variety of sectors.

Summary of issues about delivery of outputs and Norway's contribution

- Outputs are the immediate, direct results from an intervention or input. Assessment in this chapter is based on reported achievements against the eight pillars of the National Action Framework in reports for 2006 and 2007.
- Delivery of outputs is at or above targets for IEC and HCT. Reporting on gender is not systematic although some indications are that gender balance is good, possibly men are under represented. Support for OIC, STIs and PTMTC is below target.
- Norway has financed a large number of IEC outputs including early support for mainstreaming in agriculture; core support to NAC underpins the national response in all pillars; support to HTC comes through the health sector essential health package; and Norway has given specific support for girl's literacy and to counter gender-based violence.
- Progress with ART has been highly impressive; a high proportion of TB cases are successfully treated; and CHBC outputs are above targets. Norwegian support for ART through MSF helped prepare for expanded coverage supported by the Global Fund; and for CHBC via NAC and Norwegian Church Aid.
- Outputs for impact mitigation are good for OVCs and counselling in particular through FBOs. Norwegian support has been strong and direct in both areas, plus interventions in agriculture.
- Progress with mainstreaming is mixed, with most notable improvements in the workplace but still below targets, and generally better progress only among HIV/AIDS organisations. Partnerships have improved through the NAC forum. Capacity building remains the weakest area, with high vacancy levels still in the health system and problems at district level. Norway has been a leading advocate of mainstreaming, with early and extensive work to integrate in agriculture; and has supported district level for both planning and implementation.
- M&E design is effective but challenges remain with NACARS at district level and to reduce dual reporting by NGOs.
- There is a high level of alignment behind the National Action Framework and to a large extent the 'Three Ones' are being achieved.
- Norwegian support for a joint Swedish-Norwegian Regional Support facility based in Lusaka had little effect on outputs during the period of the evaluation but has potential both to support the Malawi country programme and to improve the engagement of regional IGOs.

5 Progress Towards Outcomes and Factors Affecting

This chapter reviews the latest available data on outcomes and impact, and examines a range of factors that affect the national response. Mainstreaming is an important aspect of tackling HIV&AIDS and that is reviewed in this chapter together with an assessment of Norway's approach to partnerships in the country programme.

5.1 Reported Results

The disease and the national response are widely reported from many sources but clear trends are hard to identify. Since 2000 there has been a substantial investment to improve statistical system to monitor the disease. There is now a regular programme of DHS surveys (2004 and next due in 2009); BSS (2004, currently being finalised); and Sentinel Surveillance (2005, currently being finalised). In addition, the government conducts an intensive one week monitoring exercise every year and a new programme of annual welfare monitoring surveys started in 2005, with reports available for 2005 and 2006.

Table 6 reports the headline statistics for the primary impact and outcome indicators concerning prevalence and behaviour change. Whilst the data are extensive, there is little information about statistical precision, nor the consistency of sampling and data collection across the time periods, so it is difficult to estimate how robust any trends are. The main features are that prevalence is seen to remain in the 12% to 14% range with slight but growing evidence of a downward trend.[26] There are early signs of improvements in knowledge of HIV/AIDS prevention and in high-risk sexual behaviour.

A broader overview of progress can be seen from the summary recorded in the April 2007 Mid-year progress review for the Annual Workplan for the National Action Framework. This presents information from the NAC M&E system and shows a more positive range of improvements, more predominantly at output level, but with the potential to contribute to improving outcomes:

- Condom use at high risk sex: 51.9 % women & 69% men in urban areas v. 35.8% women & 58% men in rural areas. Greatest use amongst those with highest education levels
- HIV testing: proportion of 15 – 24 who had an HIV test in last 12 months increased from 14% in 2005 to 22% in 2006
- Care & support: 213,823 households receiving external assistance in 2006 compared to 411,975 in 2005
- Impact mitigation: 395,342 OVCs supported in 2006 compared to 59,996 in 2005
- ART: 7% on treatment were children (aged 14 & below)
- Decrease in proportion of men having sex with multiple partners from 33% (2000) to 12% (2004)
- Sexual debut improved from 17.7 to 18.1 years among men & 17.1 to 17.4 for girls
- Percentage of youth never having sex increased from 38.9% to 47.7% (men) & 42.7% to 47.8% (women) between 2000 and 2004
- HIV prevalence is declining in urban areas from about 30% in 1999 to 16% in semi urban sites & 25% to 19% in urban sites in 2005. However increase over same time in rural areas from 11% to 14%.

The general trends are that the disease burden has remained stable at around 14-15% since 1997, with significant regional variation. There is little evidence of significant change in behaviour. But good progress has been made with treatment, care and support, and for impact mitigation.

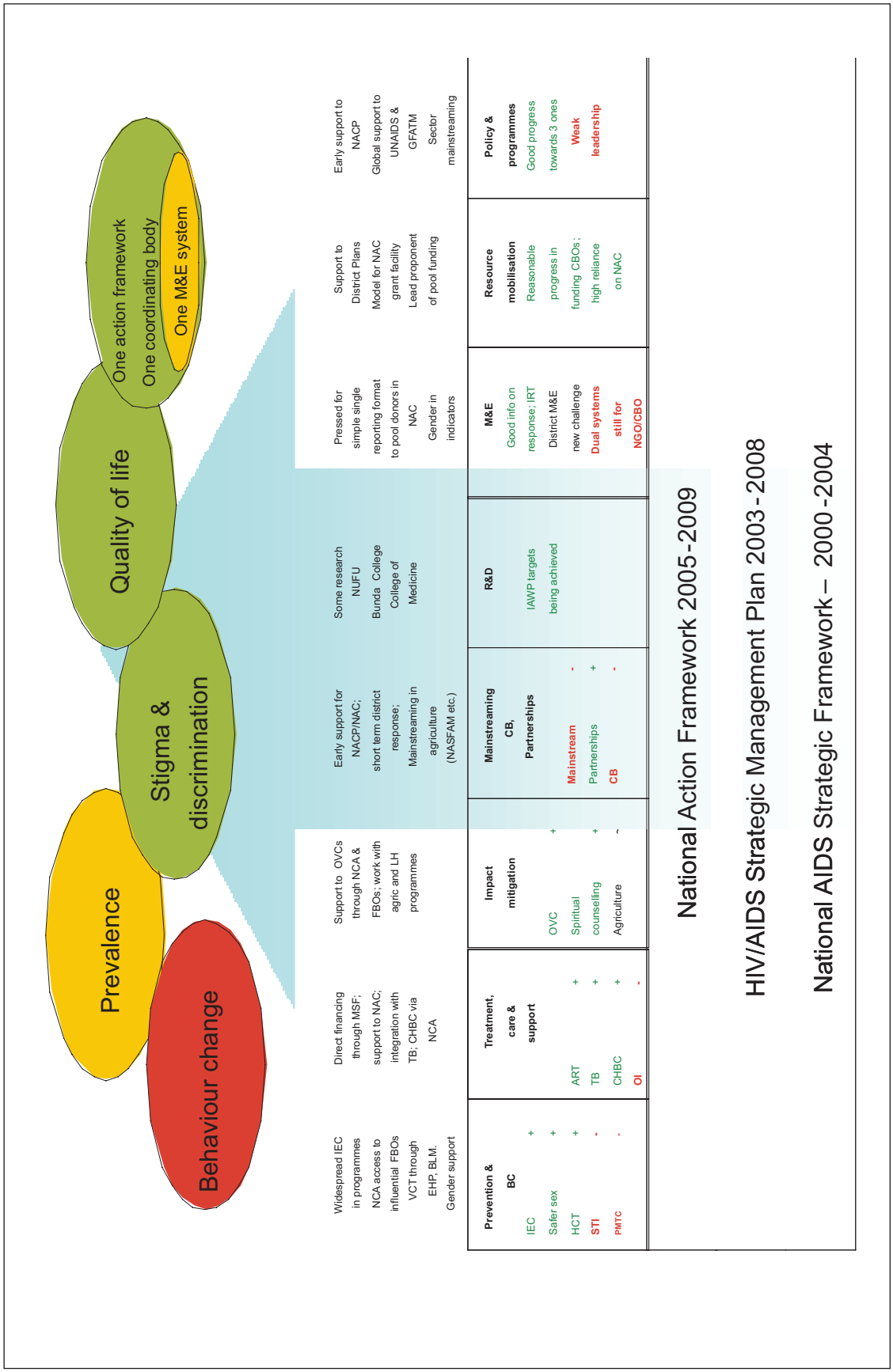
26 The UNAIDS 2007 Update was published during the last few days of the country visit for this evaluation. The latest assessment is that the epidemic in Malawi has stabilised and there is a real decrease in prevalence in urban areas. Furthermore, several of the indicators suggest some statistically significant improvements in knowledge and sexual behaviour (UNAIDS 2007).

Figure 3 presents a schematic diagram to illustrate national progress in delivery of outputs and Norway's contribution. Progress towards outcomes is signified by a simple colour coding scheme where green is good, gold is intermediate and red represents progress below targets. The diagram highlights areas of above and below target delivery of outputs by the national response and then indicates specific areas where Norway has supported that progress. Although the diagram does not indicate relative concentrations of resources, it is clear that Norway has contributed to some extent across all eight pillars of the action framework.

Table 6 Summary of progress towards outcomes and impact

		HIV and AIDS Management Plan (2003-2008) Mid Term Review		**UNAIDS Fact Sheet (June)**	**UNAIDS Update November**
IMPACT INDICATORS	2001	2003-04	2005-06	2006	2007
-% 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 13% rural 11.4% Northern 9.9% Central 19.6% Southern	14.2% 23% urban 12.4% rural	14% (M&E) 12% (DHS) 21.6% urban 12.1% rural		12% 6.5% Northern 8.6% Central 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%			
OUTCOME INDICATORS[1]					
-% 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% Female 25%	Male 37% Female 25%		
-% of young women & men who have sex before the age of 15				15% of women 14% of men	
- % 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% Female 8%	Male 12%		
- % 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% Female 30%	Male 46.8% Female 35%		
- ratio of current school attendance among orphans to non-orphans, aged 10-14.	0,94 (2001)	0.97 (DHS 2004)			

Figure 3 Schematic illustration of Norway's contribution to the national response



5.2 Factors affecting progress towards outcomes

5.2.1 Challenges

Malawi has managed an impressive performance in many aspects of the national response. But the continued high prevalence and slow response in behaviour change means the country faces an unchanging burden stretching into the foreseeable future. It is therefore important to identify constraints to improving performance. UNAIDS identifies the following challenges facing stakeholders in 2007.[27]

- Limited engagement of high-level political leaders in driving the response, compounded by a lack of clear accountability of roles for HIV prevention.
- Complex governance structure resulting in unclear demarcation of responsibilities and failure to maximize the engagement of key players. Insufficient knowledge of the AIDS epidemic and its key drivers in Malawi, with resultant challenges in targeting interventions.
- Challenges in implementation:
  - low implementation and coordination capacity compounded by insufficient mapping of current activities and partners;
  - limited engagement of civil society (community-based organisations and faith-based organisations) in prevention activities;
  - insufficient coordination (e.g. multiple free-standing external reviews within a short period).
- Challenges in demonstrating results: given the level of external assistance that Malawi currently receives, the need to show results is keenly appreciated by all stakeholders. But the challenge of demonstrating results in the face of weak monitoring and evaluation systems cannot be underestimated.
- Challenges in funding: the imminent expiry (in 2008) of the initial Global Fund grant looms as a potential funding crisis, especially in light of underperformance on Global Fund grants and the absence of demonstrable results.

These issues resonate with the findings of this evaluation and are discussed under five headings: leadership; institutional framework; capacity in the health sector; decentralisation; and proliferation and fragmentation of IEC.

5.2.2 Leadership

Political, administrative and technical leadership are important factors in steering a national response. In the early stages of the epidemic, Malawi lacked effective leadership in all three categories. From mid 2000, there has been a strong emergence of public, private and civil society response to the epidemic to provide the bureaucratic and technical leadership. This has effectively harnessed efforts to respond around areas of treatment, care and support and impact mitigation. Some of the beneficial effects can be seen in the widely acknowledged improvements in stigma and discrimination that appears to have accompanied the expansion in HIV counselling and testing (HCT).

Although the Government has set up a Department of Nutrition and HIV and AIDS under the Office of the President and Cabinet, the political leadership has not been that visible, which has resulted into the national response being driven largely by the technical and administrative dimensions. Despite the personal commitment of the President, there is limited engagement of high-level political leaders in driving the response. There are no prominent traditional authorities, media personalities, sports people or business leaders who have taken a leadership role.[28] This vacuum is particularly significant for HIV prevention and is compounded by a lack of clear accountability of roles in this area.[29] The deeply conservative culture and entrenched patterns of harmful traditional practices, sexual exploitation and gender-based violence are only slowly getting public attention. Most stakeholders do seem to acknowledge this is a problem and even at community level there seems to be a relatively high degree of openness to talk about it, but it remains not yet adequately targeted.

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27 www.unaids.org/en/Regions_Countries/Countries/malawi.asp

28 Some good work is being done. The former vice president of Malawi, Mr Malewezi is the good will ambassador (patron) of National Association of People living with HIV/AIDS (NAPHAM).
Several musicians, sports clubs and media houses – including MBC who recently won an award due to their radio programmes on HIV/AIDS – are taking the response head on. Lucius Banda and Wambali Mkandawire promote messages during their concerts. In addition, Miss Malawi and Big Brother Africa have been promoters of HIV prevention.

29 See for example the Aide Memoire from the NAC Annual review Meeting October 2006 para 5.3.

5.2.3 Institutional framework

A comprehensive institutional framework has developed during the period under review and the major achievement is to have progressed substantially towards the 'Three Ones': one national framework of action; one coordinating authority; and one national M&E system, although the latter is less well developed. The National AIDS Commission is widely regarded as effective and reports to the President through a multisectoral Board of Commissioners made up of nominees from key constituencies.

In 2006 a Department of Nutrition, HIV and AIDS was created in the President's Office (OPC). The Principal Secretary describes the role of this unit as creating a split between policy (OPC) and implementation coordination (NAC) but also includes a role for OPC in developing a new implementation system in the country through community workers.

A variety of other coordination bodies represent different constituencies. The Malawi Global Fund Coordinating Mechanism and the Malawi Partnership Forum are other multisectoral and constituency-based coordination bodies. The Malawi Business Coalition Against AIDS coordinates private-sector response but is only present in big cities, and its membership limited to large business enterprises, mainly multinational organisations. Non-profit civil society response is coordinated by umbrella organisations as well as faith-based forums. Organisations for people living with HIV are coordinated by two major networks: the Malawi AIDS Network and the National Association of People Living with HIV/AIDS in Malawi.

Donor coordination takes place through the HIV and AIDS Development Group. Some donors pool their resources through the National AIDS Commission while others channel resources through other mechanisms. All donors finance implementation of the National AIDS Action Framework.

The role of the state is pre-eminent. The channelling of funds through NAC to districts, and support by donors through technical working groups and partnership forums has created a national response that is strongly state-centred and reliant on the government bureaucracy, especially at district level. One illustration of that was reported by the IRT in the report for 2006-2007 by the Independent Multidisciplinary Review Team (HERA 2007). They observed that Malawian CBOs are more dependent on a single source of funding than the CBOs in five other neighbouring countries. On average Malawian CBOs received support from 1.65 different sources while in Zambia each CBO had support from, on average, nearly 3 supporting agencies. As NAC is the primary source of funding for the Malawian CBOs, the district level response will be dependent on the successful continuation of the programme. [30]

Prevention activities tend to get lower priority in terms of coordination. The comprehensiveness of the structures and diversity of actors creates a challenge for all parties to coordinate activities and share information. The complex governance structure results in unclear demarcation of responsibilities and enables organisations to 'cherry-pick' areas in which they work. To a large extent prevention is delegated to NGOs and CBOs over which NAC seems to have little authority. E.g. prevention activities in schools seem to have been given much less attention during the period under evaluation than civil society organisations IEC (currently there is an effort to improve focus on prevention activities in schools). Some of the most important civil society organisations, the faith based organisations, seem to look upon NAC as a source of funding and a body to report to, not as a body to guide their own work. As a result, to some extent it seems that activities are supply driven, with implementers free to choose the areas in which they work. NAC wants to move to a situation where funding though the districts responds to local statistics about the epidemic and takes account of the work of all implementers in the area. But at present, the M&E system is not able to provide the data to support a more demand-responsive way of working. The district plans follow generic patterns rather than being driven by the local situation. There is low implementation and coordination capacity compounded by insufficient mapping of current activities and partners.

30 Birdsall, K. and Kelly, K. (2007).

5.2.4 Capacity in the health sector

The health sector in Malawi is limited by severe capacity constraints. These includes shortage of personnel with a ratio of doctor/population of about 1 per 44,000 and nurse/population of 3,600;[31] poor infrastructure; weaknesses in planning, budgeting, decision making, implementation and monitoring; drug supply shortages, and limited and unequal access to health facilities due to distance and costs, in particular affecting women. These capacity constraints affect the outcome of the national response to HIV/AIDS in several ways.

In the area of *prevention and behavioural change*, STI treatment and Prevention of Mother to Child Prevention are directly related to infection rates and limited capacity means higher infection rates. More indirectly lack of capacity to provide Voluntary Counselling and testing (VCT) services may lead to less infected people being referred to ARV treatment or other services, and less people are hence subject to counselling relating to behavioural change. Furthermore, outreach community health work including primary health care, which could otherwise potentially have been instrumental in prevention and behavioural change, is affected by limited capacity (as well as priorities between primary health care and clinics based services). While VCT services are relatively well developed, STI treatment and PMTCT have shown less progress during the period and several sources refer to capacity constraints as one reason for this, and primary health care and outreach services are very limited. Notably, perhaps the best services within these areas are carried out by BLM, which is an NGO supported by Norway.

In the area of *treatment, care and support*, limited health sector capacity may affect the ability to deliver ARV treatment (ART), treatment of Opportunistic Infections (OI), TB treatment and other HIV/AIDS relevant services as well support to Home Based Care activities. In fact, ART and TB treatment is functioning very well given the constraints, while OI treatment shows poorer progress.

Several reports raise concerns that ART to some extent happens at the cost of other HIV/AIDS services within the health sector including PMCTC, STI and OI treatment, among others owing to drug supply focussing on ARV at the cost of other drugs. This is not an argument to stop or reduce ART but a good illustration of the dilemmas relating to capacity constraints. On the other hand the fact that a large number of infected health personnel are able to stay alive and in work due to ART suggest that ARV also strengthens the sector.[32]

The health Sector Wide Approach (SWAp) involves massive investments in health sector capacity during the period 2004-2010. In addition, investments in education of medical doctors and nurses as well as better incentives are believed to lead to a significant capacity increase in the health sector. So far the SWAp shows relatively good progress towards outcomes relevant for the HIV/AIDS response including planning, coordination, access to services, human resources and availability of drugs, but critical issues remain and there is even a risk of reversal of progress (Carlson 2007). Outputs from investment in education are not yet seen but have the potential to be substantial in the years to come.

5.2.5 Decentralisation

The National Action Framework is based around a programme of response through community based organisations at district level. To a large extent the focus of the period up to 2006 has been to create the structures and mechanisms that enable an effective response, and emerging evidence shows signs of effectiveness. The orientation towards district implementation was a logical consequence of political moves towards decentralization that characterised the years up to 2004. District assemblies were elected and a variety of initiatives directed funding down to local assemblies, building on democratic structures that separated political accountability from implementation through the district executive committee. That process has stalled.

The district response faces problems. Elections due in 2005 have not yet been held and observers detect a lack of political will to continue with decentralisation. Although the district implementation plans are in place and a resource allocation for the districts has been agreed,

31 These include all registered; all of them are not necessarily involved in health services (Carlson et al 2007).
32 One calculation done by HIV/AIDS Unit at the Ministry of Health even seems to conclude that the increase in infected health personnel being able to work compensate for the use of human resources in ART.

districts were slow to receive funds from NAC because of absence of special bank accounts, a problem that has largely been overcome in 2007.

NAC identified weaknesses in district capacity at an early stage and has used intermediary 'umbrella' organisations to provide support and facilitate the grant process down to CBO. Technical assistance includes posting a grant officer and programme officer to work with the District Aids Coordinator already financed by NAC. Challenges faced by these umbrellas in developing an efficient district response were investigated in Blantyre district and the results are set out in a diagram in Annex 8. This 'force field' analysis identifies a solid base of factors that support the response, but also notes a wide range of problems holding back the response, including corruption and weak accountability, absence of political leadership, conflicts between rival mechanisms' procedures and staff capacity. The districts are not yet well placed to meet the coming challenge.

NAC will need to be able to support the preparation of district implementation plans (DIPs) to ensure that they respond to the evidence that is increasingly becoming available about the impact of the response. The Independent Review Team (IRT) identified specific concerns for the districts to develop plans that are as comprehensive as possible and include non-NAC funded activities.[33] The information contained in the DIPs will need to include external financial allocations such that a comprehensive picture of total resources available, rather than just NAC resources, can be used to inform NAC district allocations (i.e. if a district is receiving considerable non-NAC support, it may be appropriate to reallocate some NAC funds to districts that are receiving less external support). At present, the response is not closely tailored to local conditions but in future the design of DIPs will need to reflect impact findings and it will also need to be able monitor the performance of district programmes to ensure that DIPS are being implemented as planned. This will require NAC to able to monitor, and use, expenditure information broken down by district and programme area.

5.2.6 Proliferation – and fragmentation – of IEC

There has been an enormous increase in Information, Education and Communication (IEC) relating to HIV/AIDS during the period of evaluation, with thousands of radio programmes, awareness campaigns, leaflets and brochures being delivered. However, this area of the HIV/AIDS response is characterised by a very high number of stakeholders involved, most of them non-governmental. The total number of organisations amounts to hundreds or perhaps thousands. Except for some controversial issues (like the issue of condoms) the activities show a relatively large degree of similarity in terms of the information and messages promoted and the methodologies used; hence it is not necessarily a problem that so many actors are involved in terms of mainstreaming of the IEC as such but there are questions about quality and coverage.

The coordination by National Aids Commission (NAC) of these activities is in most cases limited to monitoring and provision of grants to some of the organisations. NAC has no (or has chosen not to use) authority to influence on where, when and how the various organisations carries out its activities.

The large number of organisations involves a significant risk that the overall resources are not used optimally. Most civil society organisations limit their work to certain communities and areas and as long as there is no effective mechanisms on national level to influence on the organisations' choice of localities, unequal distribution of IEC to various communities is likely. Some communities may have been subject to several IEC efforts by different organisations while others have still not been reached. Observations during field visits for this report indicate this.

A good example can be seen in education. Schools have been targeted by the government, by multilateral and non-governmental organisations, but to a varying degree and normally with insufficient monitoring that teachers follow up. Some schools are governmental, many are owned by churches, others are private/commercial and they have different relations to government, NGOs or multilateral organisations. This involves the risk of suboptimal use of resources and that some schools and pupils are being exposed to high quality IEC perhaps supported by several different

33 HERA 2007.

organisations while others are not. As one example, teachers of a school visited by the evaluation team had not received any training before July 2007, except for a one day visit by an International NGO with which the teachers lost contact afterwards.

As a consequence, while the evaluation period has seen a high increase in IEC activities at the same time it is likely that there has been a suboptimal use of resources. There are many communities, schools and other groups that are still not reached although the total number and scope of IEC activities have been more than enough to reach all. NAC faces a challenge to take a more active coordinating role to identify unmet needs within IEC and influence civil society organisations to meet those needs. However, such a role of the government vis-à-vis NGOs is rarely seen. (See Box 5)

Box 5 Faith Based Organisations

Faith Based Organisations are influential on people's knowledge, attitudes and behaviours and their involvement is crucial in the fight against HIV&AIDS. They are often subject to controversies due to issues like condom promotion and some religious leaders communicating messages that serve to strengthen stigmatisation and discrimination. At the same time they are among those carrying the heaviest burden of the disease, as they carry out more care and support activities for the sick than any other non-governmental institutions, mostly on a voluntary basis. In addition, in a country like Malawi the churches are also major providers of health and education services.

At the start of the period under evaluation, many FBOs and their leaders were to a large extent characterised by silence about HIV&AIDS, and if any statements were made about the pandemic it was often negative towards PLWHAs. This has changed significantly, in particular at central and higher level of the biggest faith based organisations. Now all major organisations are actively discouraging stigmatising communication and have initiated a range of different activities aimed at prevention, care and support for the affected. An umbrella organisation, Malawi Interfaith Aids Association, is established. Traditional services of the church like pastoral care and counselling, home based care, and other social services are better adapted to help HIV&AIDS affected people. Church representatives talk openly about sexuality and the risk of HIV infection, however with a slightly different angle than the mainstream approach; the condom issue is still controversial but not as tense as previously. They often use theological arguments, which may seem unfamiliar to outsiders but are supposedly effective within the congregations. An Ecumenical Counselling Centre provides training in proper counselling. Hundreds of local initiatives are supported and in some areas all the different churches and even Muslim organisation organise in 'clusters' to better use their resources. Interestingly, many neo-Pentecostal churches ('born-again churches') are joining forces with the 'mainline' churches in the fight against HIV&AIDS; a few years back many of these churches were among the most active in stigmatising PLWHA and several seemed to trust divine healing of AIDS rather than prevention, care and support.

However, at local and district level the diversity is still enormous; many church and Muslim leaders have not yet changed their agenda and their communication around HIV&AIDS.

The church organisations have received support from Norwegian government through Norwegian Church Aid for many of their HIV&AIDS activities during the period. They also receive private support from Norwegian Church Aid for core activities. A workshop held in 2002 and 2003 on 'breaking the silence', supported by Norwegian government through Norwegian Church Aid was reportedly an important event in the shifting agenda of the FBOs.

A contributory factor may be the nature of indicators used to monitor (and manage) IEC. For the Strategic Management Plan output indicators are based on measures such as the number of television or radio programmes produced, or brochures and booklets distributed. These are very simple measures, hardly better than monitoring the implementation of activities, and convey no information that would indicate potential for behaviour change, nor about the

intensity with which target groups are receiving these messages. There is a need to shift the focus of management onto the results of IEC. Better formulation of output indicators could be used to stimulate outcome-based management with a clearer focus on changing behaviour.

5.3 Programme and Partners

Norway has had a wide range of partners. Analysis in Chapter 3 (para. 3.12) set out the range of implementing institutions that made up Norway's programme over the seven year period. Annex 5, Table 5 lists the partners. Table 7 shows a frequency distribution that analyses how many institutions received funds by number of years funded and percentage of the total disbursement on HIV/AIDS.

Table 7 Continuity of funding and proportion of disbursement

Number of years funded	1	2	3	4	5	6	7
Number of institutions[34]	15	4	9	3	4	2	1
Percentage of total disbursed	15%	7%	6%	38%	7%	17%	11%

Most spending was concentrated on few partners and spread over four to seven years. A relatively large number of institutions received one-off payments. In some cases this reflects response to a specific issue, such as humanitarian relief or sponsoring a specific event. But the greater share of expenditure, 73 percent, was disbursed through ten implementing institutions with arrangements that lasted four or more years. This conveys a high degree of continuity in the programme and reflects awareness that the fight against HIV/AIDS requires long term and predictable commitments.

Consistency and continuity has been complemented by diversity. The spread of partners also 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. There has not been 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 such as the College of Medicine 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. Other partners, such as Oxfam or the Development Fund are exploring innovative ways to tackle problems on a small scale that might ultimately influence national policy. Norway's funding of districts to prepare implementation plans helped maintain momentum at a time when donors could not agree on funding through NAC. Support to education, adolescent girls literacy and child protection are all good examples of innovative work outside the SWAp. Financing of organisations like BLM 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 a programme in which most resources have been concentrated among a few core institutions.

Since 2005 a new institutional set-up for Norwegian assistance has been the so-called strategic partnerships between a Norwegian Embassy and relevant partners, often Norwegian NGOs. In Malawi a strategic partnership has been established with among others Norwegian Church Aid. It allows for a much closer coordination between the work of the Embassy and the Norwegian supported NGOs. Reports and ongoing changes in NCA's work indicate that such change leads to better coherence and better utilisation of Norwegian funds through NCA and it is believed that this mechanism will lead to more coherence and better effectiveness and efficiency of total Norwegian support in future. Still there is potential for even grater coordination, not least within the health sector where the work of the Embassy through the health SWAp and NCA through its cooperation with CHAM is closely integrated.

But in other respects, the channels of Norwegian support are not well connected at country level. The agreements that make up the portfolio of projects described in this report originate from several distinct sources: funding directly from the embassy; funding by Norad and funding at a very small scale through other channels linked to research and education. There

34 The number of institutions recorded here does not equal the list in Annex 5 Table 5 owing to rationalisation of double counting and removal of items linked to named individuals.

has been some support to research and development through collaboration between Norwegian and Malawian institutions and researchers mainly in the latter part of the period, or through specific research financed as part of development programmes. These activities are rather weakly linked to the other Norwegian partners involved. A relatively large share of projects and partners registered in the database as support to Malawi relates to *Fredskorpset* exchange of personnel which normally has very weak links to the other Norwegian support.

A main disconnect is between Norad and embassy projects. The embassy staff are required to comment on proposals for Norad funding and ensure that activities are compatible with the national framework. Policies and practices in Norwegian development cooperation give the Embassy a limited role in guiding the Norad support to NGOs either strategically or tactically. Even when the Norwegian NGOs are highly qualified and well connected to national NGOs some do not have all the knowledge that the embassy possess 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 such.

Norway's experience with a range of large and small projects seems to differ from some other bilateral donors. Others describe their smaller projects as giving a 'national face' to their aid programme. Norway's practice of working largely through intermediaries and of taking a largely hands-off approach to monitoring and supervision actually leaves some final recipients unaware of Norway as the source of funding.

Experience does not seem to be shared across the portfolio. There are no formal mechanisms for learning across Norway's projects. NAC works though a wide range of partnerships and technical working groups. Most if not all final recipients of Norwegian aid belong to one or other of these and so arguably their experiences will be shared by themselves through these fora. So it might be reasonable to argue that lessons are fed back to national level. There are clear examples of this. The current NAC grants facility is said to be modelled on learning from Norway's experience with district support

But Norway is not managing that process and only gaining from it indirectly. 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.

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. Box 6 lists example contributions.

Box 6 What partners think about Norway's contribution

- Norway is instrumental in both the SWAp and the NAC pool funding. It pushes for simplified mechanisms such as utilisation of a single report to pool donors.
- Norway gave money to enable NAC to move forward at a time when some issues were holding back progress while donors were discussing how to respond.
- Norway has been a good chair of the pool donors, always looking to simplify procedures.
- Norway argued that the NAC workplan should be approved by the NAC Board rather than agreed first by donors and then the Board.
- Quarterly reviews used to be restricted to NAC and the pool donors only. Norway pushed for inclusion of discrete donors as well and this is now agreed.
- Norway's approach is very corporate, not based around personalities.
- It took a long time for pool money to be made available, grant procedures were very cumbersome with long delays. Norway was visible in pushing to improve things.
- The visit by the Norwegian AIDS Ambassador together with the Dutch in 2006 was very influential on NAC and the government.
- CHAM finds it hard to access pool resources. Funding comes through MOH although some new mechanisms have been developed for more direct financing. Norway's support to CHAM has been very helpful.
- Norway's advisers have had a high profile and been influential at driving policy.
- Norway is willing to take risks.
- Norway is a valued contributor when proposals and documents are being reviewed. Feedback from Norad is regarded as very high quality and contributions to missions are effective.
- The high visibility of health sector specialists in the embassy has been widely appreciated.
- Diplomatic engagement by the embassy is influential and supportive of the aid programme

Source: Interviews during the country visit

Partners were also frank about shortcomings. Norway is said to have missed opportunities for a greater involvement in the M&E task force and technical working group where issues of quality are of concern. Human resource limitations also limit the scope to be equally active in both the Health SWAp and the NAC. Partners argue that Norway would be more influential if it had greater involvement in the NAC where there are fewer bilateral pool donors.

5.4 Progress towards Objectives, Sustainability and Connectedness

Malawi has achieved great progress in fighting the epidemic during the period of this review. The disease burden has remained stable at around 14-15% since 1997, with significantly higher prevalence in the southern region. Despite a high level of effort on information and education campaigns there is little evidence of significant change in behaviour. But good progress has been made in those areas that are more manageable with treatment, care and support, and for impact mitigation. The quality of life of thousands of Malawians who are infected and affected by the disease has improved. Norway has played a significant part in these achievements, by providing core support to the national response, through the health sector and NAC, and by a flexible approach to funding targeted interventions that complement the mainstream programmes and allow of innovation and independence.

Little clear evidence has emerged in this review about the potential for sustainability. Given that the greater part of support from Norway has gone to core funding, it is arguable that the organisations that have been supported are more likely to have developed sustainable programmes, although the extent of their reliance on donor funding cannot be estimated.

The channels of Norwegian support are not well connected at country level. There is no attempt to provide an overarching framework to guide the different strands of aid from Norad and through the embassy. It is also clear that the potential institutional benefits that could arise from exchange of lessons and experience among Norwegian institutions between different

types of support at country level are not being realised. It is reasonable to question whether the value of Norwegian aid is diminished by so many independent actions.

Staff at the embassy argue strongly that a defining feature of Norwegian support is the hands-off approach. Norway is actively involved in a dialogue around developing programmes and strategies, but when an agreement is made Norway 'withdraws' as much as possible. This enables some more flexibility, involves lower transaction costs, but perhaps most of all it is believed to support a transfer of ownership and responsibility from donor to the partner institution. However, it seems like the same argument is used both on the relation with Malawi (recipient) institutions and the relations with other bilateral and multilateral donors and Norwegian NGOs. In the latter, a hands-off approach is not necessarily feasible; ownership is not a major objective when it refers to other donors and foreign agencies. Even if transaction costs increase, the overall effectiveness and efficiency of Norwegian support may increase if Norway utilises its role as a donor to these agencies in influencing them to apply a similar hands-off approach to their Malawian partners and in other ways make their contribution to the national processes even better.

Summary of progress towards outcomes, factors affecting, mainstreaming and partnerships

- The disease and the national response are widely reported from many sources but clear trends are hard to identify.
- Prevalence remains in the 12% to 14% range with slight evidence of a downward trend. There are no visible improvements in knowledge of HIV/AIDS prevention nor in high-risk sexual behaviour.
- A positive range of improvements can be seen in other indicators more at output level, but indicative of progress towards improving outcomes.
- There is limited engagement of high-level political leaders in driving the response. No prominent traditional authorities, media personalities, sports people or business leaders have taken a leadership role. This vacuum is particularly significant for HIV prevention.
- A comprehensive institutional framework has developed and the major achievement is to have progressed substantially towards the 'Three Ones' although the national M&E system is less well developed.
- The national response is strongly state-centred and reliant on the government bureaucracy, especially at district level.
- Implementation through district level is central to the national strategy but decentralisation has stalled. At present, the district response is not closely tailored to local conditions
- The complex governance structure results in unclear demarcation of responsibilities and enables organisations to be supply driven about the areas in which they work.
- The health sector in Malawi remains limited by severe capacity constraints.
- There are concerns that the allocation of resources necessary for success with ART is detrimental to other HIV/AIDS services within the health sector including PMTCT, STI and OI treatment.
- IEC is characterised by a very high number of stakeholders with a significant risk that the overall resources are not used optimally
- Norway has had a wide range of partners, but the greater share of expenditure was disbursed through ten implementing institutions with arrangements that lasted four or more years
- The diversity of partners and demand responsive approach are defining characteristics of Norway's programme.
- The channels of Norwegian support are not well connected at country level. There is a danger that opportunities are being missed to learn more from the portfolio and add greater value to Norway's contributions.

6 Issues and Lessons

This review of Norway's support to HIV/AIDS in Malawi has identified a number of interesting issues concerning how Norway chooses to interact with national institutions and other development partners, and how much the overall flow of aid should be coordinated around common aims. Few specific lessons emerge from this single country study, but the issues themselves are germane to future policy.

6.1 Is Norway More Effective Supporting Projects than Sector Programmes?

Norway's most visible contributions are when it is flexible and taking risks. Looking at the different phases of Norwegian support it seems like the most important parts have been the willingness to support things other donors did not support so much. The early years of the period are characterised by Norway becoming involved with a wide range of partners, intervening to support the NAC, helping to maintain the momentum at district level, to promote mainstreaming in agriculture and other sectors and to promote activities through NGOs. At the same time it was working towards pooled funding and sector programmes. Now that the health SWAp is working and NAC gets pooled funding it seems that Norway has less of a distinctive role to play. Do sector programmes negate Norway's comparative advantage? Being a small bilateral donor willing to be flexible allowed the programme to respond to demand and take risks. Arguably, that is not the role of core funding through either NAC or the health sector.

A key lesson therefore concerns what contribution Norway wants to make. Direct finance is important; but at country level, supporting innovation and being able to respond flexibly to specific demands of strategic importance may be more significant to help support the national response, when set against the large resource flows from the Global Fund and World Bank which will tend to be used for more routine activities.

Two current issues highlight where there is still a need for innovation. IEC is prominent among interventions yet has delivered little behaviour change. New thinking is needed on how knowledge can be transformed into action. Conventional IEC through CBOs is unlikely to break new ground under routine NAC funding. Other ways of facilitating behaviour change utilising a broader set of organisational structures (including traditional structures, schools, public services) could be explored and a more demand-driven approach should be applied rather than IEC being to a large extent dependant on initiatives by NGOs and CBOs in the communities selected. A second area is mainstreaming. This is widely acknowledged. For example, the Ministry of Agriculture and Food Security, together with development partners and other stakeholders are trying to incorporate and mainstream HIV and AIDS in preparations for the planned new sector strategy. The Ministry is currently in dialogue with and receives technical support from the regional team in Lusaka. The Norwegian Embassy initially facilitated this interaction and has an opportunity to bring fresh perspectives and also link to policy development at a regional level.

For Norway to return to predominantly smaller project and programme support rather than sector approaches would generally lead to higher transaction costs for the partners and would contradict the intentions and commitments of the Paris Declaration. The argument is not made against Norway mainly supporting sector and pooled arrangements but to make sure that Norway continues to be able to utilise one of its main comparative advantages; flexibility and willingness to take risks.

6.2 Sector Programmes Have High Commitments for Coordination and Technical Support

Arguably, Norway can still support national HIV&AIDS policy without having to engage directly in projects. Contributions through technical working groups and partnership fora

provide an avenue for debate. Both the health SWAp and NAC are well funded by Norway, but the embassy has taken a decision to prioritise the allocation of time for its health sector staff on the health SWAp (for which Norway currently chairs the donor coordination group) rather than NAC. Staff resources are not sufficient for an equal level of effort to both health and HIV/AIDS.

Experiences from the health SWAp as well as the national AIDS response in Malawi so far seem to demonstrate that donor coordination and harmonisation does not necessarily means that managing aid has become simpler. The number of policy and technical working groups and other fora related to coordinated donor arrangements is huge and exceeds by far 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.

Norway has chosen a 'hands off' approach to its partners and will to a large extent try to avoid using its position as a donor to influence partners' priorities, in particular at the level of 'micro management'. This policy supports a limited representation in various forums and negotiations and in the country in general. Furthermore, the embassy seems to be of the opinion that there are too many donor representatives being too involved in the programmes and hence leaving too little space for Malawi partners. However, many Norwegian priorities and policies are directly supportive of the principles of the Paris declaration and Norway is generally acknowledged by partners as being a positive influence within the donor community. It is arguable that Norway under-utilises opportunities owing to the way Norway has organised its sector representation in Malawi.[35]

Development partners argue that policy influence comes from the seat at the table not the size of the budget and partners say Norway is missing in NAC. Often it is not the statements or arguments or budgets that decides how policy is influenced, but the 'number of voices' in these forums. Informants say that there is a big difference whether there are one or two donor representatives who take a particular stance in a forum and note that like-minded bilateral donors have an important countervailing role to play alongside other parties. (For example, the UN tends to be relatively over-represented by each agency present in country.)

Interestingly, a perverse effect of working through a silent partnership (e.g. with Sida) means fewer seats and voices in the forums; hence lost opportunities to influence other donors. So by doing the 'right thing' for harmonisation Norway reduces its chances of influencing.

6.3 Hands-off Engagement and Separate Structures of Support to Norwegian NGOs Means lost opportunities for Added Value

Norway is described by government and non-government partners as being flexible and hands-off. This is clearly attractive but is there any added value? Some embassy staff argue that Norway's added value is precisely in giving partners freedom of action. Other views point to areas where greater interaction might strengthen projects and programmes.

While there are good arguments for a 'hands-off' collaboration with important Malawi partners and perhaps in particular those partners who are responsible for the national response, with other partners it is clear that some opportunities may be lost. Norwegian support to Norwegian NGOs is managed by Norad and to a large extent falls outside of the embassy's scope. Norad has few means to check whether the NGOs adapt to the national framework or benefit from the experience of other NGOs in the country. The embassy does review proposals for fit with national policy but thereafter has no role of interaction with implementers but cannot instruct the NGOs directly. The embassy normally chooses a relatively low level of detail in the dialogue with NGOs.

A large share of Norwegian efforts through NGOs has gone into various IEC, care and support activities, in particular through Norwegian Church Aid (under a Norad agreement until 2004 before entering into a direct contract with the embassy). The efforts seem scattered and there seem to be little general consideration that the efforts represent optimal use of resources

35 The Royal Norwegian Embassy in Lilongwe argues that its use of staff resources follows policy as part of an aligned group of donors and the allocation of effort reflects a cyclical role as secretary to the pool donors for the Health SWAp.

within the national response. It is not known how the NGOs have chosen the interventions and selected communities and to what extent this has been done with reference to actual demands or rather a 'supply driven' approach in which the NGOs choose to add on some HIV/AIDS activities within areas where they are already operating.

The support through Norwegian Church Aid has been of a very high volume throughout the latter part of the period under evaluation. Much has been related to IEC through FBOs. NCA has also been collaborating with CHAM, which organize health facilities providing a large share of all the health services in Malawi. That collaboration has been limited to a massive increase in education of nurses, but otherwise relatively few areas with relatively little engagement by NCA beyond financing. Hence it may be argued that NCA has given priority to IEC rather than the biomedical response to HIV/AIDS. Given that IEC is within the areas having shown the highest outputs and the biomedical response is among the weakest part of the national HIV/AIDS response and that general health sector capacity (in which CHAM units are a crucial components) is also weak, it may be argued that some of NCA's priorities have been unfortunate to the extent that support to IEC through FBOs has happened at the expense of more resources to improvement of the health sector through CHAM. During the same period the embassy has been heavily involved in supporting the health sector through the SWAp approach. The fact that the embassy only to a limited extent discusses priorities with NCA and seldom enters into details regarding NCAs priorities may have been a lost opportunity to encourage NCA to give more priority to support the health sector.

Another example concerns how Norway's partners align with the NAC. Interviews indicate that NAC is seen by many stakeholders mainly as a source of funding and an information sharing body. NGOs and churches report and apply for funding but they don't look upon NAC as a real authority, e.g. by trying to adapt their strategies to NAC. Norway might as part of its work to support the 'Three Ones' be more active in influencing all stakeholders of Norwegian support to adhere to NAC as an authority.

In all examples opportunities exist to build on experience and feed back lessons to improve performance. But that would require the embassy to take a more proactive role in the work of their development partners and this might run contrary to Norway's development ethos.

6.4 Being a Good Partner is Different from Organising Good Partnerships

Norway is valued as a partner for being flexible, realistic, having strong values and bringing good technical expertise. Its partners assess Norway very positively for having shared objectives and few serious disagreements. But partnership is seen as a way of working rather than a strategy to achieve objectives. The Norwegian HIV/AIDS support in Malawi does not have a strategy to choose partners and develop partnerships. To a large extent partners are self-selecting, being successful applicants or repeat applicants for grants. Given that only a small proportion of aid flows outside the health SWAp, NAC and NCA, a partnership strategy could be used to guide who Norway will partner with and what objectives to achieve.

Summary of issues and lessons

- Norway's most visible contributions were when it was flexible and taking risks. There is a risk that the conformity of sector programmes negates Norway's comparative advantage
- The demands of both the health sector SWAp and support to NAC have led the embassy to prioritise staff time for the SWAp. This has significantly reduced Norway's influence on the national response.
- Being a hands-off donor is attractive to partners but opportunities exist to use experience to guide programmes.
- Partnerships are seen as a way of working rather than an organisational approach to tackle problems.

7 Conclusions and Recommendations

This chapter draws together the conclusions from the Malawi country study and puts forward some recommendations. The findings have been summarised in a text box at the end of each chapter following a short concluding statement and these are synthesised here. The structure of this chapter follows the four substantive evaluation objectives in the terms of reference, reproduced in chapter 1 and Annex 1, section 3.3.

7.1 Conclusions

7.1.1 Progress towards outcomes

Malawi has achieved great progress in fighting the epidemic during the period of this evaluation. The disease burden has remained stable at around 14-15% since 1997, with significantly higher prevalence in the southern region. The latest surveys suggest there has been a decline in some urban areas. Despite a high level of effort on information and education campaigns there evidence of significant change in behaviour has been slow to emerge. But good progress has been made in those areas that are more manageable for treatment, care and support, and impact mitigation. The quality of life of thousands of Malawians who are infected and affected by the disease has improved.

There are many areas in which the national HIV&AIDS response has made impressive progress. There have been considerable achievements in increasing access to HIV testing, treatment and care across the country. More Malawians are using HIV testing and treatment services and are benefiting from community care than were originally planned at this point in time. In particular in the area of ARV treatment Malawi has shown an impressive progress; the fact that one of the weakest health sectors in Africa has been able to manage ARV treatment to more than 100,000 people exceeds most expectations. Other areas of progress include the creation of a comprehensive M&E plan, strong partnership between NAC and development partners and amongst development partners. Weaknesses remain however. Despite high levels of effort on prevention, behaviour change is slow to emerge. And capacity remains a considerable constraint among implementing partners. Norway has played a significant part in these achievements, by providing core support to the national response, through the health sector and NAC, and by a flexible approach to funding targeted interventions that complement the mainstream programmes and allow of innovation and independence. Norway has worked both through core programmes and targeted support for non-governmental organisations, and to mainstream efforts in a variety of sectors.

7.1.2 Factors affecting the outcomes

Five broad factors have been identified as critical to the national response: leadership; the institutional framework; capacity in the health sector; decentralisation; and proliferation and fragmentation of IEC. Discussion in Chapter 5 shows how a strong technical and administrative solution has been developed that lacks political leadership and champions in both traditional and modern sectors of society. The public sector plays a central role in funding community-based organisations, and as a result, the state bureaucracy, especially through district administrations, is critical to continuing progress. Capacity in the health sector is still very weak but with massive efforts underway to train doctors and nurses, an area where Norway has made vital contributions. The success in harnessing the involvement of large numbers of CBO and FBOs is partly offset by the proliferation of IEC and substantial expenditure with little evidence of change in behaviour. Much of the work seems to be supply driven and lacks any quality assessment or response to demand.

7.1.3 Norwegian outputs and contribution to outcomes

Norway has provided support broadly in line with the evolving national framework, through core funding for the National AIDS Commission. During the earlier years of the period under

review Norway supported a number of targeted interventions that seized opportunities to promote mainstreaming or respond to a demand that other donors had not picked up. Several examples of mainstreaming can be found in agriculture and education, and other work includes efforts to counter gender-based violence. Norway supported new facilities at the College of Medicine that have directly enabled an expansion in degree programmes and capacity and has been supporting an ambitious programme by CHAM to double the number of nurses educated to lower-than degree levels. Norway also gave support to district for planning and implementation.

Progress with ART has been highly impressive; a high proportion of TB cases are successfully treated; and CHBC outputs are above targets. Norwegian support has been direct, such as for ART through MSF; through support for the health sector; and for CHBC and other community responses via NAC and Norwegian Church Aid. Outputs for impact mitigation are good for OVCs and counselling, in particular through FBOs. Norwegian support has been strong and direct in both areas.

The evaluation concludes that the programme has been directly relevant to the policies of the Norwegian Government and Norad, and has responded to the specific characteristics of the epidemic in Malawi. The programme responded urgently in the early years before national systems were well established; the fight against HIV/AIDS was recognised as needing a broad-based approach, with specific attention to the role of civil society and the importance of religion and faith-based organisations in the country.

7.1.4 Norwegian partnership strategies

The channels of Norwegian support are not well connected at country level. There is no attempt to provide an overarching framework to guide the different strands of aid from Norad and through the embassy. It is also clear that the potential institutional benefits that could arise from exchange of lessons and experience between different types of support at country level are not being realised. Staff at the embassy argue strongly that a defining feature of Norwegian support is the hands-off approach. But it is reasonable to question whether the value of Norwegian aid is diminished by so many independent actions.

The country programme promoted partnership working and worked towards multi-donor pooled funding aligned to national strategy, in line with and in advance of commitments under the Paris declaration. A diversity of partners and demand responsive approach are defining characteristics of Norway's programme. Over the period Norway has had a wide range and large number of partners, but the greater share of expenditure was disbursed through ten implementing institutions with arrangements that lasted four or more years, indicating consistency and continuity of the core relationships. There has not been any strategy to choose partners and develop partnerships, instead, relationships developed in response to opportunities and availability of resources.

7.1.5 New challenges

In the most recent review of the national response, the independent review team argued that the Malawi national response to the HIV/AIDS epidemic in recent years can be seen as the first phase of a response in which the building blocks have been laid. Policies, procedures and guidelines have largely been developed to guide the multi-sectoral response and a large number of partners have been supported to participate in many aspects of the emergency. During the last twelve months these efforts have started to bear fruit with a significant increase in focussed activity and the emergence of evidence that these activities are starting to have an impact. Now, as M&E systems start to deliver, considerably more information has become available to enable a more sophisticated response.

In coming years the focus of the response, both in terms of service delivery and monitoring, will shift to the districts with very significant funds planned to flow through these relatively new and untried institutions. NAC and its central partners need to further their capacities to support the districts as they take on this new role both technically and managerially. In particular, NAC will need to enhance its capacity to support M&E systems and to analyse implementation and outcome information in order to be able to fulfil its role as coordinator of

the response. Norway has considerable experience in all these areas and is well placed to support the process over and above core funding of NAC.

7.2 Recommendations

Continue with the core support for SWAp and NAC. These underpin the national response and are in line with Norwegian policy and commitments under the Paris declaration. But in addition, maintain a portion of the country budget for flexible and demand responsive work. The focus of these actions cannot be prescribed, but clearly, district implementation, monitoring and evaluation and quality improvements, especially to IEC, are all high priority

The role of NGOs in the national response, in particular perhaps within IEC, has great potentials for improvements. One problem is that IEC activities are to a large extent 'supply driven' meaning that individual NGOs themselves decide where to provide their services. To enable better utilisation of the NGOs within the national response, Norway could suggest and if necessary support studies of demand for IEC, e.g. along geographic and socio-economic parameters. An easy part of this would be a mapping of communities with regards to what kinds of IEC services have already been provided. This fits directly with plans to reorient services at district level to take consideration of where needs are greatest. In addition, quality of services provided should be taken into consideration for national NGOs (with less strict demands for CBOs for which their main quality is that they are local).

Another important area is mainstreaming, where Norway was an early exponent. Making it more effective and bringing wider involvement of the private sector are all challenges where Norway can bring direct support.

The work of the regional team to promote peer support through regional IGOs is interesting and potentially of long-lasting influence in the region. This should be supported and links made with country programmes including Malawi, to stimulate improved actions to overcome cultural barriers to the response.

Maintaining a hands-off approach to working with partners is important to the country team. But that should not be a reason for not learning and sharing experience. The embassy could consider forming a Community of Practitioners for learning and feedback to policy, using that community as a peer mechanism to help improve quality and effectiveness, especially of IEC.

Any thoughts that programme-based approaches would reduce the transaction costs to embassy staff have been shown to be misplaced. The SWAp and support to NAC require a high level of engagement. CIDA tackles this by funding technical advisory support at country level through their programme budget. Norway should re-examine the staffing implications that come with programme-based approaches to ensure that the national response receives the necessary support from the embassy.

Whilst there is no evidence of major inefficiencies arising from Norad's support to NGOs independently from the embassy, it is clear that this is not necessarily well aligned with the embassy strategy and sub optimal use of resources is likely. Strategic partnerships between NGOs and the Embassy probably enable good coordination with those particular NGOs but do not help coordination with the others. One possible solution would be to bring Norad and the main country partners into the 3 year planning cycle strategy as a joint partner, with shared ownership of the analysis and country objectives. This could be done by annual meetings between the Embassy, Norad and main NGO partners of Norway working in the country, e.g. during early fall when embassy plans are prepared. Separate meetings or workshops with NGOs, e.g. utilising the loosely organised 'Malawi network' in Norway may also serve to improve information sharing and coordination.

Last, there is a need to clarify the technical advisory role of Norad vis-à-vis the regional team and set guidance on how to get the best from both resources.

Annex 1: Terms of Reference of Evaluation of Norwegian HIV/AIDS Responses in Three African Countries: Ethiopia, Malawi & Tanzania.

– See Appendix 1 page 285

Annex 2: List of Institutions and Persons Consulted

NAME	POSITION /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 and 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

NAME	POSITION /ORGANISATION
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
Mathias Chindungwa	Coordinator for Ntchisi Evangelical Churches Consortium for social services (NEC-COSS)
Pastor Mr S Kampira	Apostolic Faith Mission, Ntchisi
Pastor Mr T Kaliati	United Methodist Church
Pastor C.H. Chimphon-da 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 (NEC-COSS
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

NAME	POSITION /ORGANISATION
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
Edson Daudi	Regional outreach support officer, BLM
Eva Helene Østbye	Programme Coordinator, The Development Fund (Utviklingsfondet)
Dan Taylor	Director, Find Your Feet, UK

Annex 3: Overview of References and Documents

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UNDP Malawi Office (December, 2006) Malawi Governance and AIDS Diagnostic Paper

University of Malawi College of Medicine (2007) Norway/Sweden support to Malawi College of Medicine. End of Phase II Report.

Annex 4: Country Data Sheet

People	2000	2005	2006
Population, total	11.5 million	12.9 million	13.2 million
Population growth (annual %)	2.6	2.2	2.1
Poverty headcount ratio at national poverty line (% of population)	..	..	..
Life expectancy at birth, total (years)	40.4	40.5	..
Fertility rate, total (births per woman)	6.2	5.8	..
Mortality rate, infant (per 1,000 live births)	94.9	78.9	..
Mortality rate, under-5 (per 1,000)	155.3	125.3	..
Births attended by skilled health staff (% of total)	55.6	..	..
Malnutrition prevalence, weight for age (% of children under 5)	25.4	..	..
Immunization, measles (% of children ages 12-23 months)	73	82	..
Prevalence of HIV, total (% of population ages 15-49)	..	14.1	..
Primary completion rate, total (% of relevant age group)	67.2	57.4	..
School enrolment, primary (% gross)	139	122.3	..
School enrolment, secondary (% gross)	31.6	28.3	..
School enrolment, tertiary (% gross)	..	..	..
Ratio of girls to boys in primary and secondary education (%)	92.2	98.6	..
Literacy rate, adult total (% of people ages 15 and above)	..	..	..
Economy			
GNI, Atlas method (current US$)	1.7 billion	2.1 billion	2.3 billion
GNI per capita, Atlas method (current US$)	150	160	170
GDP (current US$)	1.7 billion	2.1 billion	2.2 billion
GDP growth (annual %)	1.6	2.8	8.4
Inflation, GDP deflator (annual %)	30.5	15.4	13.9
Agriculture, value added (% of GDP)	39.5	34.7	35.5
Industry, value added (% of GDP)	17.9	19.4	19.8
Services, etc., value added (% of GDP)	42.5	45.9	44.7
Exports of goods and services (% of GDP)	25.6	27.3	28
Imports of goods and services (% of GDP)	35.3	52	52.8
Gross capital formation (% of GDP)	13.6	15.3	16.3
Source: World Development Indicators database, April 2007			
Number of people living with HIV/AIDS			940,000
Chidren aged 0 to 14 living with HIV			91,000
Adults aged 15 and up living with HIV			850,000
Women aged 15 and up living with HIV			500,000
Deaths due to AIDS			78,000
Orphans aged 0-17 due to AIDS			550,000
National Programmes			
Percentage of pregnant women receiving treatment to reduce mother-to-child transmission			0.023
Percentage of HIV-infected women and men receiving antiretroviral therapy			0.2
School attendance among		orphans	81%
		non-orphans	87%

People	2000	2005	2006
Knowledge and Behaviour		Men	Women
Percentage of young people aged 15 to 24 who correctly identify ways to prevent HIV		36%	24%
Percentage of young people aged 15 to 24 who had sex with a casual partner in the past 12 months		62%	14%
Percentage of young people aged 15 to 24 who had sex before 15		N/A	N/A
Percentage of young people aged 15 to 24 who used a condom last time they had sex with a casual partner		47%	35%

Source: UNAIDS www.unaids.org/en/regions_countries/countries/malawi.asp

Annex 5: Norwegian Financial Inputs

Table 1 OECD DAC Official statistics of net aid flows to Malawi 2000-2005

Aid type	**206: ODA (OA) Total Net**							
Amount type	**A: Current Prices ($million)**							
Donor Year	2000	2001	2002	2003	2004	2005	Total	%
DAC Countries, Total	269.24	195.82	224.9	313.66	308.21	322.07	1633.90	58%
Multilateral, Total	170.74	197.35	141.58	201.31	191.62	250.83	1153.43	41%
G7, Total	226.93	146.57	169.41	250.88	237.92	219.59	1251.30	44%
DAC EU Members, Total	157	125.45	118.89	176.59	188.25	182.33	948.51	34%
All Donors, Total	446.18	403.73	376.31	517.44	501.4	575.34	2820.40	100%
Canada	6.69	10.96	8.54	16.66	16.02	17.03	75.90	3%
Denmark	24.86	21.55	7.78	4.17	4.72	3.38	66.46	2%
Germany	25.45	19.82	24.03	29.4	24.63	25.33	148.66	5%
Ireland	0.61	0.46	3.08	4.23	4.61	7.56	20.55	1%
Japan	38.53	18.29	18.81	31.41	18.96	19.7	145.70	5%
Netherlands	1.6	13.07	16.86	7.33	15.76	19.41	74.03	3%
Norway	6.8	9.64	15.56	28.16	27.17	49.09	136.42	5%
Sweden	5.11	2.27	7.65	13.93	15.88	19.28	64.12	2%
United Kingdom	96.89	66.49	50.19	111.07	119.5	101.96	546.10	19%
United States	59.32	30.55	61.15	59.51	56.75	53.13	320.41	11%
AfDF (African Dev.Fund)	16.08	8.2	20.83	25.99	21.23	25.8	118.13	4%
EC	48.93	65.02	52.14	79.89	64.44	72.61	383.03	14%
Global Fund (GFATM)	..	..	..	0.31	25.94	15.19	41.44	1%
Nordic Dev. Fund	4.84	3.5	2.3	4.16	4.21	4.13	23.14	1%
IDA	81.18	106.55	47.98	69.14	65.25	104.76	474.86	17%
UNDP	2.35	1.69	2.77	4.6	5.56	7.71	24.68	1%
UNFPA	1.13	2.48	2.94	3.18	3.99	3.68	17.40	1%
UNICEF	3.93	4.28	4.93	4.95	4.88	6.05	29.02	1%
WFP	1.77	4.42	7	4.18	4.87	5.5	27.74	1%

Table 2 Distribution of Norwegian aid by DAC main sector codes

Disbursed amount (1000 NOK)	Year								
DAC Main sector (code+name)	2000	2001	2002	2003	2004	2005	2006	Grand Total	%
111 - Education, level unspecified	1,185		2,288	2,529	2,921	680	1,669	11,272	1%
112 - Basic education		5,150	2,972	261	2,783	2,290	1,702	15,158	1%
113 - Secondary education			162	259	226	348	560	1,555	0%
114 - Post-secondary education	251			50	800	417	802	2,320	0%
121 - Health, general	110	4,576	8,152	9,115	20,335	54,774	104,136	201,197	16%
122 - Basic health	3,361	5,768	14,423	21,998	18,552	10,152	7,490	81,743	6%
130 - Population policies/programmes and reproductive health	7,144	8,507	8,885	18,969	23,519	16,995	11,670	95,688	7%
140 - Water supply and sanitation		4,600	4,690	5,651	5,243	5,464	947	26,595	2%
151 - Government and civil society, general	10,249	12,903	21,521	28,516	32,736	27,989	35,231	169,146	13%
152 - Conflict prevention and resolution, peace and security	60							60	0%
160 - Other social infrastructure and services	1,905	1,504	6,706	10,064	7,945	21,456	17,616	67,195	5%
220 - Communications				15				15	0%
230 - Energy generation and supply	372	25,701	13,807	18,634	2,038	816		61,368	5%
240 - Banking and financial services							660	660	0%
250 - Business and other services	95	170	398	11,500	83		83	12,328	1%
311 - Agriculture	10,699	12,154	24,946	12,615	13,501	19,006	37,142	130,064	10%
312 - Forestry	1,674	2,882	219	300				5,075	0%
321 - Industry			232		29	84		344	0%
322 - Mineral resources/ mining				237				237	0%
410 - General environmental protection			200	453	5,160	438	3,418	9,669	1%
420 - Women in development (WID)	294	857	890	914	737	196	625	4,512	0%
430 - Other multisector		855	2,390	9,690	7,210	23,313	17,582	61,039	5%
510 - General budget support				40,000	37,330	57,670	70,000	205,000	16%
600 - Action relating to debt	22,350							22,350	2%
710 - Emergency food aid			2,000	3,000	1,943	47,240	1,229	55,411	4%
720 - Other emergency and distress relief		500	8,500	3,703		26,850	9,844	49,397	4%
998 - Unallocated/ unspecified	77	573	846	899		4	15	2,414	0%
Grand Total	59,827	86,699	124,225	199,370	183,090	316,181	322,421	1,291,813	100%
	5%	7%	10%	15%	14%	24%	25%	100%	

Table 3 Disbursement against HIV/AIDS marker

Amount Disbursed (1000 NOK)	Year								
PM - HIV/Aids	2000	2001	2002	2003	2004	2005	2006	Grand Total	%
None	52,827	70,035	91,797	148,923	121,873	186,319	207,561	879,335	68%
Significant objective		2,159	13,250	24,777	16,062	69,227	16,600	142,075	11%
Main objective	7,000	14,504	19,179	25,670	45,156	60,635	98,260	270,403	21%
Grand Total	59,827	86,699	124,225	199,370	183,090	316,181	322,421	1,291,813	100%
% to HIV/AIDS	12%	19%	26%	25%	33%	41%	36%	32%	

Table 4 Disbursement by type of assistance and agreement partner

Amount Disbursed (1000 NOK)	Type of assistance			
Agreement Partner	Bilateral	Multi-bilateral	Grand Total	%
NGO International	4,000		4,000	1%
NGO Local	22,948		22,948	6%
NGO Norwegian	137,241		137,241	33%
Not NGO	203,291	44,998	248,289	60%
Grand Total	369,980	44,998	412,478	100%
	89%	11%	100%	

Table 5 Disbursement by implementing institution and HIV/AIDS marker

Amount Disbursed (1000 NOK)	HIV/Aids		
Implementing Institution	Significant objective	Main objective	Grand Total
ACEM		1,912	1,912
BLM - Banja la Mtsogolo		7,127	7,127
Bunda College of Agriculture	2,000		2,000
CDCC		1,415	1,415
CHAM - Christian Health Association MWI	19,164	6,907	26,071
CHRR - Center for human rights & rehab	734		734
CISANET - Civil Society Agriculture Network	951		951
Diakonhjemmets Høgskole	367	1,521	1,887
Government of MALAWI	4,629		4,629
HACI - Hope for African Children Initiative		4,437	4,437
Harvest Help	1,833		1,833
Høgskoler (various)	1,270		1,270
ICRISAT	1,925		1,925
Interconsult International AS	16		16
Malawi Department of Poverty and Disaster Management Affairs	20,000		20,000
Malawi Ministry of Education	2,100	8,000	10,100
Malawi Ministry of Finance	17,569		17,569
Malawi Ministry of Health	3,650	114,595	118,245
Malawi Ministry of Health, District health Management Team (DHMT)		3,400	3,400
Malawi National AIDS Control Programme		17,500	17,500
MCoM - Malawi College of Medicine		4,594	4,594
Misc Consultants	6		6
Misc NGOs	452	1,623	2,075

Amount Disbursed (1000 NOK)	HIV/Aids		
Implementing Institution	**Significant objective**	**Main objective**	**Grand Total**
Mua Mission	100		100
NASFAM - National Smallholder Farmers Association of Malawi	20,500		20,500
National AIDS Commission		26,250	26,250
Nord-Østerdal Videregående Skole	626		626
Norwegian Church Aid	22,485	39,554	62,039
Oxfam	4,000	2,341	6,341
PAC - Public Affairs Committee, Malawi	5,564		5,564
Plan Norge	4,000		4,000
SARRNET - Southern African Root Crops Research Network	1,878		1,878
SOS Children's Village of Malawi Trust	1,090	4,200	5,290
Stiftelsen SOS-Barnebyer	645		645
The Malawian Authority	659		659
UNAIDS		1,489	1,489
UNDP	1,900		1,900
UNFPA		10,804	10,804
UNICEF	1,882	6,340	8,222
Unknown		6,290	6,290
World Bank		15	15
Grand Total	142,075	270,403	412,478

Table 6 Relationship between gender and HIV/AIDS markers

Disbursed (1000 NOK)	HIV/Aids				
Gender and equality	**None**	**Significant objective**	**Main objective**	**Grand Tot al**	**%**
None	673,558	32,551	20,374	726,483	56%
Significant objective	185,690	85,746	211,526	482,962	37%
Main objective	20,086	23,778	38,504	82,368	6%
Grand Total	879,335	142,075	270,403	1,291,813	100%
	68%	11%	21%	100%	

Table 7 Attention to HIV/AIDS and gender in sectoral programmes

Percentage disbursed	HIV/Aids			Gender				
DAC Main sector (code+name)	**None**	**Significant objective**	**Main objective**	**None**	**Significant objective**	**Main objective**	**Total (1000 NOK)**	**%**
111 - Education, level unspecified	20%	22%	58%	17%	25%	58%	11,272	1%
112 - Basic education	29%	18%	53%	31%	69%		15,158	1%
113 - Secondary education	28%	72%		28%	72%		1,555	0%
114 - Post-secondary education	100%			100%			2,320	0%
121 - Health, general	36%		64%	22%	73%	5%	201,197	16%
122 - Basic health	91%	7%	2%	65%	34%	1%	81,743	6%
130 - Population & reproductive health			100%	9%	71%	20%	95,688	7%
140 - Water supply and sanitation	45%	55%		45%	20%	35%	26,595	2%
151 - Government and civil society, general	93%	6%		59%	32%	10%	169,146	13%

Percentage disbursed	HIV/Aids			Gender				
DAC Main sector (code+name)	None	Significant objective	Main objective	None	Significant objective	Main objective	Total (1000 NOK)	%
152 - Conflict, peace and security	100%			100%			60	0%
160 - Other social infrastructure and services	85%	3%	12%	54%	46%		67,195	5%
220 - Communications	100%			100%			15	0%
230 - Energy generation and supply	100%			100%			61,368	5%
240 - Banking and financial services	100%			100%			660	0%
250 - Business and other services	7%	93%		7%	93%		12,328	1%
311 - Agriculture	84%	13%	3%	50%	38%	12%	130,064	10%
312 - Forestry	100%			99%	1%		5,075	0%
321 - Industry	100%			100%			344	0%
322 - Mineral resources/ mining	100%			100%			237	0%
410 - General environmental protection	100%			100%			9,669	1%
420 - Women in development (WID)	100%			0%	34%	66%	4,512	0%
430 - Other multisector	24%	51%	26%	21%	79%		61,039	5%
510 - General budget support	100%			100%			205,000	16%
600 - Action relating to debt	100%			100%			22,350	2%
710 - Emergency food aid	20%	75%	5%	57%	43%		55,411	4%
720 - Other emergency and distress relief	98%	2%		95%		5%	49,397	4%
998 - Unallocated/ unspecified	99%		1%	99%	1%		2,414	0%
Grand Total	68%	11%	21%	56%	37%	6%	1,291,813	100%

Annex 6: Stakeholder Analysis

Table 1 Categorisation of implementing partners

Implementing Institution	Total NOK'000	Years	HIV Code	Category	Influence HML[34]
Malawi Ministry of Health	118,245	4	2	A1	H
National AIDS Commission	43,750	7	2	A1	H
UNFPA - UN Population Fund	10,804	5	2	A2	M
Malawi Ministry of Education	10,100	4	2	A1	M
UNICEF	8,222	3	2	A2	M
BLM - Banja la Mtsogolo	7,127	5	2	A3	M
Malawi Ministry of Health, (DHMT)	3,400	1	2	A1	H
UNAIDS - UN Programme on HIV/AIDS	1,489	2	2	A2	M
CDCC	1,415	3	2	A3	M
MCoM - Malawi College of Medicine	4,594	3	2	A1	H
Kirkens Nødhjelp (Norwegian Church Aid)	39,490	4	2	A3/B	M
CHAM - Christian Health Association Malawi	26,071	4	2	A3/B	H
Norwegian Church Aid - local office	22,549	5	2	A3/B	M
Oxfam	6,341	6	2	A3/B	M
ACEM	1,912	3	2	A3/B	L
SOS Children's Village of Malawi Trust	5,290	5	2	B	L
Miscellaneous NGOs	2,075	4	2	B	L
Diakonhjemmets Høgskole	1,887	3	2	C	L
Unknown	6,290	2	2	E	L
HACI - Hope for African Children Initiative	4,437	2	2	E	L
Malawi Ministry of Finance	17,569	1	1	A1	H
PAC - Public Affairs Committee, Malawi	5,564	5	1	A3	M
Government of MALAWI	4,629	1	1	A1	H
UNDP - UN Development Programme	1,900	1	1	A2	M
NASFAM	20,500	2	1	A3	M
Bunda College of Agriculture	2,000	1	1	A1/D	L
Plan Norge	4,000	1	1	B	L
ICRISAT	1,925	3	1	B	L
SARRNET	1,878	3	1	B	L
Harvest Help	1,833	2	1	B	L
CISANET - Civil Society Agriculture Network	951	3	1	B	L
Stiftelsen SOS-Barnebyer	645	3	1	B	L
Høgskolen i Bergen, Helse og sosialfag	694	1	1	C	L
Høgskolen i Bergen	342	1	1	C/D	L
Høgskolen i Vestfold	234	1	1	C/D	L
CHRR - Center for human rights & rehab	734	1	1	E	L
The Malawian Authority	659	1	1	E	L
NORD-ØSTERDAL VIDEREGÅENDE SKOLE	626	1	1	E	L
Mua Mission	100	1	1	E	L
Interconsult International AS	16	1	1	E	L
Malawi Dept of Poverty & Disaster Management Affairs	20,000	1	1	E (A?)	M

36 Estimate by the evaluation mission: H-High influence over national policy-makers or with large reach to civil society, or comprehensive coverage across all the national pillars; M-Medium influence, owing to narrower reach and coverage; L-Low, small scale, targeted interventions.

Table 2 Disbursement by partner influence and category[37]

NOK'000	Influence				
Category	**High**	**Medium**	**Low**	**Grand Total**	**%**
A1	192,187	10,100		202,287	52%
A1/D			2,000	2,000	1%
A2		22,415		22,415	6%
A3		34,606		34,606	9%
A3/B	26,071	68,380	1,912	96,363	25%
B			18,597	18,597	5%
C			2,581	2,581	1%
C/D			576	576	0%
E			12,862	12,862	3%
Grand Total	218,258	135,501	38,528	392,287	100%
	56%	35%	10%	100%	

Categories:

A Embassy country programme
A1 Government; A2 Multilateral; A3 NGO
B Norad funded NGO
C Fredskorpset exchange programme ('VSO')
D Research collaboration or collaboration between higher education institutions
E Other/unknown

37 Totals in the table do not necessarily agree with data in Annex 5 owing to removal of records with inconsistent data or small payments to named individuals in the database.

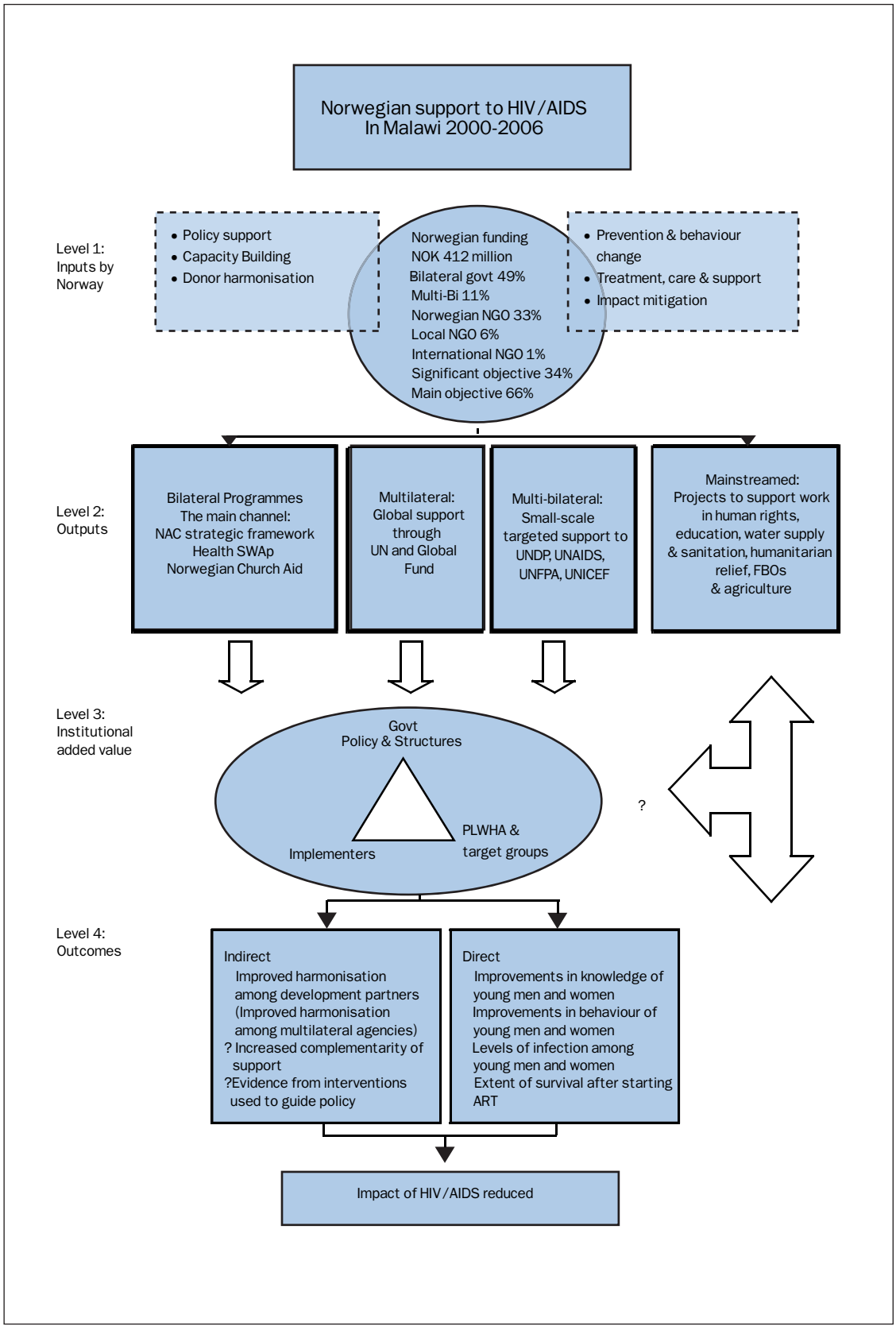
Annex 7: Timeline of Country Policies and HIV/AIDS Programmes/Initiatives

Year/ period	Norwegian support, Embassy activities and/or outputs			Context
	HIV/AIDS specific support	**Other support relevant for HIV/AIDS and mainstreaming**	**Other activities/interventions**	
2000	Support to NACP secretariat and activities in strategic plan. An NGO/CBO grant facility is planned for co-financing between donors. Support to development of HIV/AIDS plan in 21 districts Strategic AIDS plan translated into Chichewa, printed and distributed to all districts. Support to rapid testing and screening in Lilongwe	Support to TB programme TB research TB conference Support to Unicef/MoE for 'Keeping Kids in School' with a few HIV/AIDS components (until 2005)	Participation in the health SWAP working group. Talks with MoA and UNFPA on training of extension workers in HIV/AIDS Cooperation with other donors to increase AIDS in education sectors Embassy works actively to increase cooperation between NACP and TB programme. Dialogue with College of Medicine about education of medical doctors. Gender dimensions included in assessments. Activities promoting women empowerment identified.	Significant weakening of AIDS secretariat due to low salaries and key persons quitting
2001	Support to NGO's HBC, VCT, etc. Radio program for youth Support to implementation of AIDS plan in 12 districts. Norad only supporter of NAS	DOTS TB treatment in all districts, increased coordination with HIV/AIDS HIV/AIDS awareness in schools GAVI/EHP support Training of teachers and debt repayment for Medical College (cont'd support until 2006). Support to BLM on sexual reproductive health, focus on youth, HIV/AIDS components (until 2006)		Aids commission established National AIDS secretariat staffed. AIDS plan in all districts.
2002	Support to National Aids secretariat (NAS) and NAC as the only donor to core budget HIV/AIDS programme with Norwegian Church Aid and church organisations (until 2006)	Health support to CHAM via Norwegian Church Aid (until 2006) Support to some health services (MoHP) University cooperation with Norway within health Support to Program office for National Gender Strategy/later to Ministry of Gender (until 2005). Support to Unicef on Adolescent Girls literary (AGLIT) (until 2005) SOS Children's Village support (until 2006)	Norway member of ICC for GAVI and appointed by MoH to represent the bilateral donors in CCM for global funds. Norway is the donor representative in GFATM Malawi.	Health SWAP agreed College of Medicine has full classes with support from Norway/Sida MoU for TB basket funding Malawi application for GFATM approved.

Year/ period	Norwegian support, Embassy activities and/or outputs			Context
	HIV/AIDS specific support	Other support relevant for HIV/AIDS and mainstreaming	Other activities/interventions	
2003	Support to national HIV/ AIDS Strategic Framework (through NAC). Support to Unicef and UNFPA program 'Life Skills in School' (until 2006)	Support to Health SWAP. Support to Bunda College including HIV/ AIDS (not reported whether HIV/AIDS was included in previous yrs support to BCA). Support to HIV/AIDS in NASFAM	Embassy promotes coordination between Unicef/UNFPA and govt re: Life skills for youth.	SWAP is established Agreement on TB basket
2004	NAC support through NAC Pool Fund Support to MSF ARV Treatment (until 2006)		Embassy active in Programme Steering Group on NTP (TB)	
2005	Support to NAC via pool fund	Increased support to agriculture incl HIV/AIDS components Various new and increased support to gender (mainly through NGOs) Programme to increase capacity and quality of nurse education	Embassy focus on district level in the national AIDS program Gender perspective emphasised in NAC and SWAP	Malawi's 2nd GFATM application approved.
2006		Norwegian support to TB integrated in SWAP.	Embassy participates in improvement of NAC's M&E system, incl integration of gender specific indicators. Embassy supports strengthened role of UNDP in capacity building Embassy focus on gender in health and HIV/AIDS.	

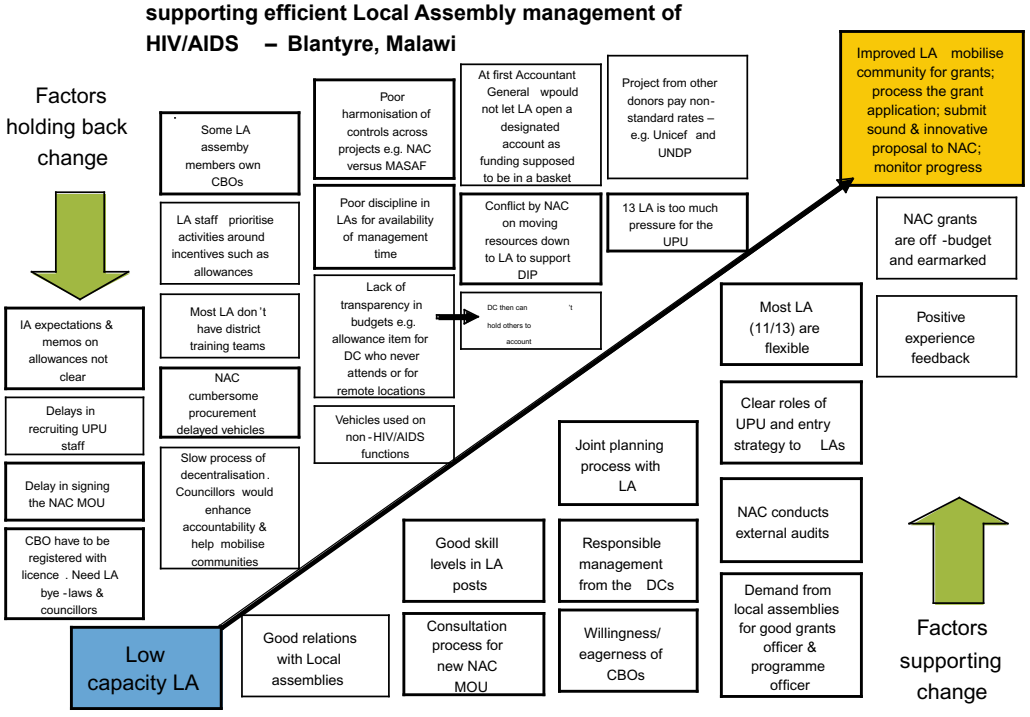
Notes:
Embassy reporting and database are not always consistent; errors are likely to occur in the table.
Embassy reporting varies in level of detail, in particular with regards to activities beyond funding.
Some programmes are marked with HIV/AIDS policy marker in database but not included in this table as their relevance to HIV/AIDS are regarded minor or very indirect, e.g. Water and Sanitation, some agreements with Ministry of Finance, etc.

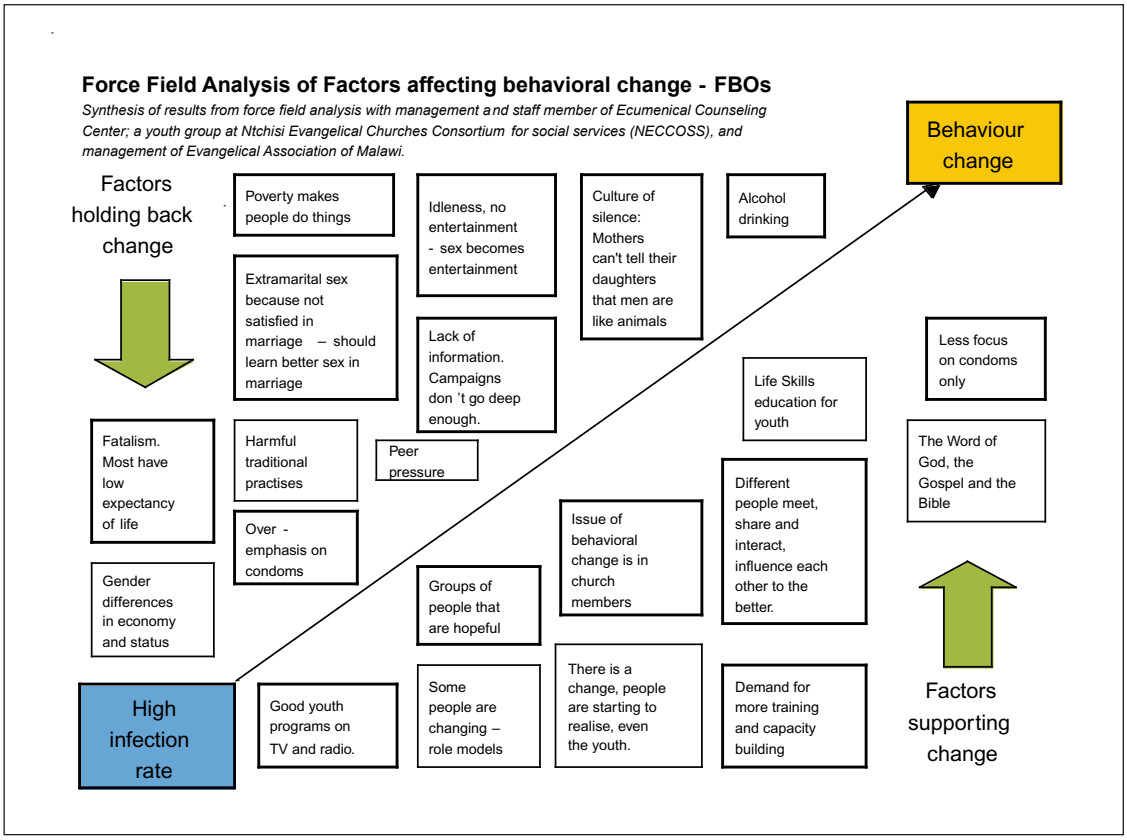
Annex 8: Intervention Logic for the Country Pwrogramme

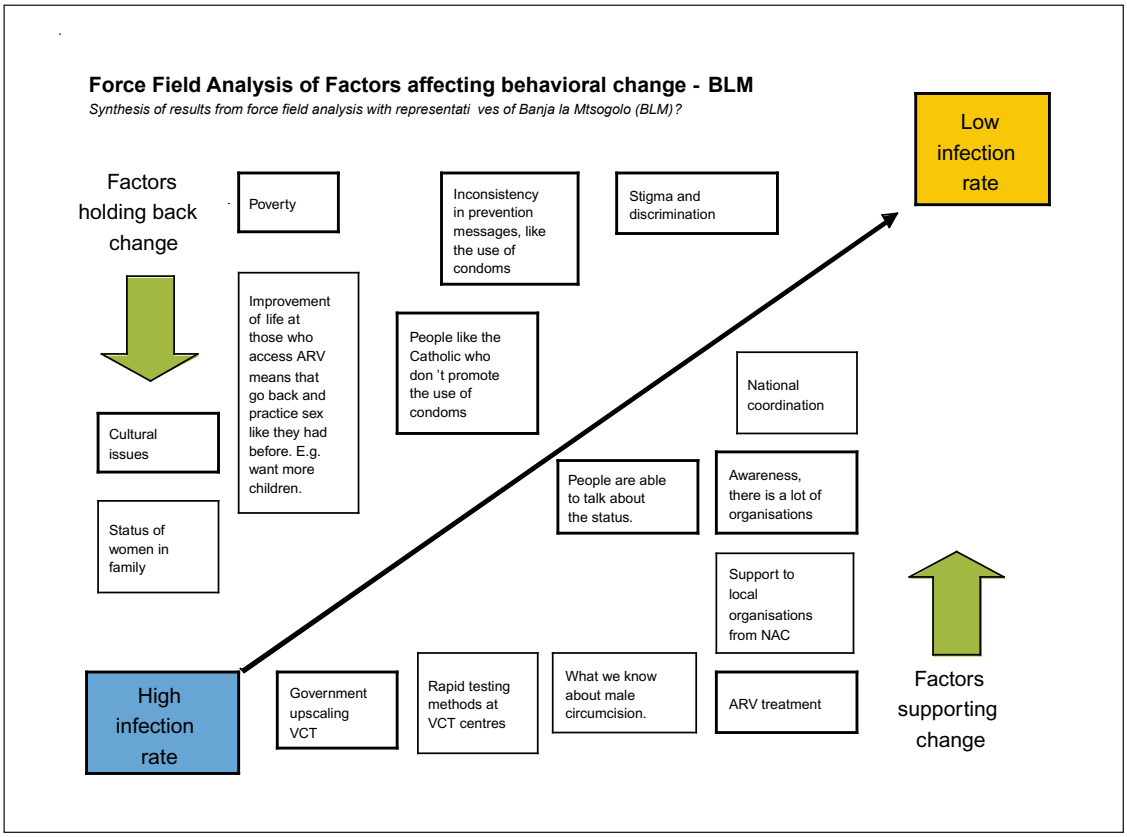


Annex 9: Results from Appreciative Enquiry/Force Field Analysis

Figure **Factors for and against NAC umbrella project unit supporting efficient Local Assembly management of HIV/AIDS – Blantyre, Malawi**







Appreciative enquiry

Public Affairs Committee (PAC) supported by Norad through the World Conference on Religion and Peace (WCRP) based in the USA. Also a recipient of grant funding through Norad support for Norwegian Church Aid(NCA). PAC facilitates passing money to its membership, which is broadly based among churches and church networks in Malawi.

What areas of success are identified for the PAC?
- The use of information billboards
- Committees established at district level

For the latter, what are the main features that contributed to the success?
- A high level of community empowerment
- Working through a consistent structure of PAC both for HIV/AIDS related work and previous activities such as gender-based violence
- The fact that PAC has a credible name at local level and therefore is respected and advice is listened to
- The level of funding available. NCA gave adequate funds to support task teams at all levels and a district coordination team

Lessons learnt:
- It is important to 'manage' the leadership of groups to make sure there is diversity in leadership and avoid issues such as 'family members' holding all posts
- PAC recognises the need to follow-up grants and check on how money was used
- It is important to have a 'system' and not rely on individuals who are prone to follow their own interests

Country Report
United Republic of Tanzania

May 2008

Submitted by ITAD
Munirat Ogunlayi, Wambura Mwita, Cornelius Murombedzi

Contents

Acronyms

ABCT	AIDS Business Coalition of Tanzania
AIDS	Acquired Immunodeficiency Syndrome
ALNAP	Active Learning Network for Accountability and Performance in Humanitarian Action
AMREF	African Medical and Research Foundation
ANC	Ante-natal Clinic
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BCC	Behavioural Change Communication
BF	Basket Funding
CARF	Community HIV/AIDS Resourse Funds
CBOs	Community Based Organisations
CHBC	Community Home Based Care
CMAC	Council Multisectoral HIV/AIDS Committee
CSP	Civil Society Programme
CTC	Care and Treatment Counsellors
CSOs	Civil Society Organisations
CSW	Commercial Sex Worker
DFID	Department for International Development
DP	Development Partners
DPG - A	Development Partners Group on HIV/AIDS
EADCF	East African Development Communication Foundation
EHP	Emergency Hiring Project
EMIMA	Elimu Michezo na Mazoezi
EPP	Estimation and Projection Package
ESAURP	Eastern and Southern African Universities Research Programme
FBO	Faith Based Organsiations
FGM	Female Genital Mutilation
GBS	General Budget Support
GFATM	Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
GOT	Government of Tanzania
HAART	Highly Active Antiretroviral Therapy
HAVACOP	Haydom Voluntary HIV/AIDS Control Programme
HCT	Home based Care and Treatment
HIP	Health Information Project
HIV	Human Immuno-deficiency Virus
IEC	Information, Education and Communication
IGA	Income Generating Activities
IPPF	International Planned Parenthood Federation
JAS	Joint Assistance Strategy
KIWAKKUKI	Kilimanjaro Women's Group Against AIDS
KWIECO	Kilimanjaro Women Information Exchange and Consultancy Organization
LGA	Local Government Authorities
M & E	Monitoring and Evaluation
MDA	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MFA	Ministry of Foreign Affairs
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MOHSW	Ministry of Health and Social Welfare
MOU	Memorandum of Understanding

NACP	National AIDS Control Programme
NCA	Norwegian Church Aid
NGOs	Non Governmental Organisations
NMSF	National Multisectoral Strategic Framework on HIV/AIDS
NNA	Norwegian Nurses Association
Norad	Norwegian Agency for Development Cooperation
NPA	Norwegian People's Aid
NSGRP	National Strategy for Growth & Poverty Reduction
NUFU	Norwegian Programme for Development, Research and Education
OECD	Organisation for Economic Development Cooperation
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Program for AIDS Relief
PF	Project Funds
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
POL	Popular Opinion Leaders
PMORALG	Prime Minister's Office, Regional Administration & Local Government
PS	Project Support
RFE	Rapid Funding Envelope
RAS	Regional Administrative Secretary
Sida	Swedish International Development Agency
SOS	Save Our Souls
SRH	Sexual Reproductive Health
STIs	Sexually Transmitted Infections
TACAIDS	Tanzania Commission on AIDS
TACOSODE	Tanzania Council for Social Development
TAC	Technical AIDS Committees
TAS	Tanzania Assistance Strategy
TCRS	Tanganyika Christian Refugee Services
TDHS	Tanzania Demographic Health Survey
THIS	Tanzania HIV/AIDS Indicator Survey
TMAP	Tanzania Multi- Country AIDS Programme
TOC	Table of Content
Tshs	Tanzanian schillings
UMATI	Uzazi na Malezi Bora Tanzania
UN	United Nations
UNAIDS	Joint United Nations on HIV & AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UNV	United Nation Volunteers
VCT	Voluntary Counselling & Testing
WAMATA	Walio Katika Mapambano na AIDS Tanzania
WFN	Women's Front Norway
WHO	World Health Organisation
WHO - GPA	World Health Organisation Global Programme on HIV/AIDS
WLAC	Women's Legal Aid Centre
ZAC	Zanzibar AIDS Commission
ZACP	Zanzibar HIV/AIDS Commission Programme

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This report has been prepared by independent team of consultants from ITAD Ltd (UK). The team is very grateful to staff of Norad and the Norwegian Embassy in Dar es Salam for the support they provided us during the period. We appreciate the valuable time of all the stakeholders met and the support, information and relevant documents shared with us for the evaluation.

Executive Summary

The Norwegian Government has provided support to the HIV infection and AIDS response since 1986 through various institutions, including country level support to government and civil society organisations, to combat the epidemic. The evaluation of the responses during the period (2000–2006) was conducted to assess the extent to which Norwegian support had contributed to the response globally, regionally and within partner countries – Ethiopia, Malawi and Tanzania were selected for the evaluation. This report presents the findings of an evaluation mission to Tanzania conducted from 19th January to 8th February 2008 to study Norwegian support to combat HIV infection & AIDS in the country.

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.
- Extract lessons learnt, findings and recommendations on how to enhance the development effectiveness of the Norwegian HIV/AIDS response at the country level.

Evaluation Approach and Methodology

The selection methods and tools helped structure discussions and elicited information from key stakeholders namely - the government institutions (TACAIDS[1], NACP, line ministries, Tanga RAS, University of Dar es Salaam), multi-lateral institutions (UNFPA, UNICEF, UNAIDS, World Bank, WHO), Bilateral agencies (DFID, SIDA, USAID- PEPFAR), Delloitte and Touche, Norwegian NGOs (NPA, NCA), implementing NGOs supported by Norwegian resources (16 NGOs & FBO[2]s), PLWHA, service providers and beneficiaries across 5 regions.

The evaluation faced the risk of inadequate provision of information due to staff turn over in TACAIDS and multilateral agencies, but this was mitigated by reviewing relevant documents and consultation with stakeholders who were knowledgeable and experienced with Norwegian support during the period.

Country Context

United Republic of Tanzania is the largest country in East Africa with a population of approximately 35 million people. Tanzania is still one of the poorest countries in Africa and the world. About 18.7% of its population lives below its national food poverty line and 35.7% below the national basic needs poverty line (2000/2001)[3].

Evaluation Findings

Progress towards key outcomes related to the national HIV/AIDS response

A community based HIV/AIDS Indicator Survey conducted in 2004 showed HIV prevalence of about 7% (6.3% for males and 7.7% for females) among adult aged 15 – 49 years, but this rate is lower than the rate obtained from surveillance data reports (2003 – 2005). The prevalence rate was 8.7% with a range of 4.8% to 15.3% in some areas. Prevalence for both women and men increases with age until it reaches a peak: for women aged 30-34 years (13%) and for men ten years later at age 40– 44 years (12%). In December 2005, the number of people living with HIV/AIDS (PLWHA) was estimated at 2 million and the government has so far registered 2 million AIDS orphans. These show a substantial increase of about

1 TACAIDS – Tanzania Commission for AIDS
2 UMATI (IPPF), Benjamin Mkapa HIV/AIDS Project, Abantu Visions, EMIMA, Shidepha+, WAMATA, EADCF (Femina HIP), DogoDogo Centre,TCRS, WLAC, KWIECO, KIWAKKUKI, SOS Children's village, Haydom Lutheran Hospital, Foundation for Civil Society and ESAURP
3 United Republic of Tanzania (2005). The National Strategy for Growth & Reduction of Poverty.

400,000 cases of PLWHA since 2003 (which was 1.6 million), and an increase of about 1 million orphans in the same period[4].

The mode of HIV transmission is mainly heterosexual and there are a number of key factors driving the HIV infection and AIDS epidemic in Tanzania. These include multiple partner relationships, intergenerational sex, gender inequalities and women's subordination in sexual relationships and risky traditional and cultural practices.

The institutional response has been comprehensive and has grown over recent years. The Government of Tanzania, with technical support from WHO's Global Programme on AIDS (WHO-GPA), formed the National AIDS Control Programme (NACP) in Mainland Tanzania and the Zanzibar AIDS Control Programme (ZACP) which formulated short-term plans. HIV/AIDS was declared a national disaster in 1999 by President Benjamin Mkapa. The Tanzania Commission for AIDS (TACAIDS) and the Zanzibar AIDS Commission were established in 2001 and 2002 respectively and mandated to provide strategic leadership and coordination of multi-sectoral responses to the epidemic, monitoring and evaluation, research, resource mobilization and advocacy. TACAIDS, in collaboration with other stakeholders, developed the Tanzania National Multi-sectoral Framework on HIV/AIDS (2003–2007) with the goals to reduce the spread of HIV, improve the quality of life of those infected with and affected by HIV, and mitigate the social and economic impact of the epidemic.

The country reported decline in HIV prevalence from 9.6% in 2001 to 8.7% in 2003/04 to 8.2% in 2005/06[5] This is seen as significant given the interpretation of data from three time points for temporal changes in prevalence and the slight evidence of a downward trend among 15 – 24 years between 2001 – 2006. The data available from the Tanzania Demographic Health Survey (TDHS) in 1999 and 2004 revealed an improvement in knowledge of HIV prevention and rejection of misconceptions, especially amongst females aged 15 – 24 years (45%) in 2004 as compared to 26% in 1999 and the percentage of young women and men who had sex before the age of 15 years has reduced from 15% and 20%, to 12% and 9%, respectively.

The engagement of international partners including Norway, in collaboration with national partners to establish and influence policies on HIV/AIDS yielded results in the country. Examples include the "3 x 5 initiative" and GFATM initiatives. The support of Norway and other partners has resulted in an increase in the number of people living with HIV/AIDS (PLWHA) receiving treatment. By the end of 2006, TACAIDS reported that out of a total of 400,000 to 500,000 in need of ART, only 70,000 people were receiving ARVs through public and private hospitals representing 16% of those in need of treatment; a substantial increase from about 2,000 people in 2003.

Assess key Norwegian Contributions (outputs) to outcomes

Norway has been a significantly large bilateral donor to Tanzania. Norway's annual disbursement increased over the period from around NOK 309 million in 2000 to over NOK 483 million in 2006. Norwegian resources were channelled through multiple modalities – General Budget Support, 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 RFE for HIV/AIDS response. In addition, resources were also channelled through Norwegian NGOs. Furthermore, GFATM and TMAP 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. Analysis of the intervention logic indicates that the various channels have contributed to the outputs and outcomes especially in terms of possible reduction in prevalence rates and impact mitigation.

There was no formal HIV/AIDS strategy developed, but the *de facto* Norwegian strategy in Tanzania can be characterised as having the aim of engaging widely across prevention, care and impact mitigation with support to government, multilateral agencies, NGOs and FBOs.

Progress with ART has been highly impressive; a high proportion of STI cases are successfully treated and community and home based care (CHBC) outputs are increasing.

4 United Republic of Tanzania UNGASS Indicators Country Report January 2003 – December 2005
5 NACP (2007) HIV/AIDS/STI Surveillance Report (Jan. – Dec. 2006)

Norwegian support has been direct, such as for ART through support to NACP, and for CHBC via NACP, Norwegian Church Aid and direct support to NGOs. Outputs for impact mitigation are good for orphans and vulnerable children and counselling, in particular through FBOs and NGOs.

Progress with mainstreaming is mixed. Norway has been successful in mainstreaming HIV/AIDS in projects and schools in five districts in the Tanga region. The public sectors are making progress through implementation of one or two interventions.

Factors affecting the outcomes (substantive influences)

Aside from the factors fuelling the epidemic in the country, there were other hindering factors affecting the achievement of key behaviour outcomes. The key challenges are categorized as leadership and institutional arrangement, funding availability, human resources, logistics and supply chain system, and monitoring and evaluation challenges. These factors must be considered and addressed in subsequent engagement in order to contribute strategically and effectively to the achievement of key outcomes in the country.

There is proliferation of Civil Society Networks in the country; including networks of PLWHA, but there is lack of cooperation in working together and capacity to ensure effective management and coordination of coalitions. This is essential in relation to the strengthening of civil society organisations to engage actively in national response at policy level and enhance partnership in management of interventions.

Assess Norway's partnership strategy

There is no clear partnership strategy developed by Norway for the various partners engaged in the country and there is no over-arching framework to guide various strands of support from Norway. Partnership arrangements adopted were based on joint working based on the various international agreements and demand responsive approaches. Subsequent engagements can be improved with clearly developed strategies and frameworks for operations that will be useful in measuring success in the utilisation of resources and management of initiatives.

Issues and Lessons Learnt

Norway's Visible Contributions: Norway's most visible contributions have been in areas where a flexible and risk taking engagement was needed in the HIV/AIDS response. Looking at the different phases of Norwegian support, it seems that the most important have been those where it has been the first to support interventions with other donor support following thereafter. Limitation of support on HIV/AIDS through Geeral Budget Support (GBS) alone will no doubt negate Norway's comparative advantage of setting pace to respond to issues quickly.

Can Norway make a difference in HIV mainstreaming to sectors? Norway's success in mainstreaming HIV/AIDS into sectors and projects in Tanzania set examples that HIV mainstreaming is do-able. Norway could facilitate capacity building involving the Norway/SIDA Lusaka team to better absorb and utilize Tanzania Multi- Country AIDS Programme (TMAP) for non-health sector responses. Although the exclusion of HIV/AIDS as one of the key thematic areas of Norwegian engagement is a concern, but it is also seen as an opportunity for Norway to emphasize HIV mainstreaming and use their comparative advantages of flexibility and taking risks to achieve key results.

Engagement with Partners and the need for a HIV Focal Person: Norway has been very active in influencing policy in Tanzania and in engagement with other donors to achieve results in line with the principles of the Paris Declaration on Aid Effectiveness. Withdrawal of Norway from the steering committee of RFE and some of the pooled resources with the movement of the HIV/AIDS focal person to another job within the embassy will definitely create a huge capacity gap that could prevent the translation of efforts at global level to in-country action. Even for HIV mainstreaming to be effective, there is need for policy influencing to guide effective implementation of a true multi-sectoral response.

Is there a need for separate structure(s) of support to NGOs as an added value to the National Response? Norwegian support to NGOs was facilitated via methods during the period evaluated, but continuity of funding has been an issue. Considering the fact that these organizations are working in hard to reach areas to save lives, the inability to access resources locally for implementation of programmes is a concern and raises the question, "what happens to all the initial investments that Norway has put into these NGOs?" Opportunities exist to build on experiences and feed back lessons to improve performance. However, this would require the need to play a more proactive role in the work of these development partners.

Issue of Coordination: Norway is a key stakeholder in the establishment of the "Three Ones" – One coordinating body, one strategy and one monitoring and evaluation system. The three are in place in the country, but has not functioned as expected to ensure a well coordinated multi-sectoral response. There are also an issue with PLWHA groups and NGOs – they are not well organized and there are certain tensions between different networks making the coordination of various groups difficult especially in becoming one national functional advocacy body. For a wide coverage of a true multi-sectoral response, an effective coordination is required and this means addressing the underlying factors.

Recommendations

Continue support through the General Budget Support (GBS) - the aid modality preferred by the government of Tanzania. But in addition, maintain a portion of the country budget for flexible and demand responsive work with support to Civil Society Organisations (CSOs) to address some of the weak areas and for direct implementation of interventions.

Support provision of technical assistance to HIV mainstreaming in key sectors to ensure effective deployment and utilisation of resources from World Bank Tanzania Multi- Country AIDS Programme (TMAP) and other sources. The need to consider effective HIV mainstreaming into the current Norwegian streamlined priority areas is essential. Effective engagement of the Norad for provision of technical assistance will add value in this area.

Strengthen leadership at Regional and District Levels as part of the good governance programme to complement the on-going strong leadership at national level and address the challenges that the response to the epidemic is currently facing at these levels.

Address limited connectivity of interventions with emphasis on implementation of the recommendations and plans arising from the forums conducted to enhance effective utilisation and coverage of interventions.

Norway to continue to engage with government & other donors on HIV/AIDS - Norway should consider retaining the HIV/AIDS focal person within the embassy to engage with the key stakeholders, identify gaps and coordinate the institutions involved in utilizing Norwegian resources for HIV/AIDS responses in Tanzania.

Norway to work with other partners to address weak M & E system for monitoring HIV infection and AIDS response in the country to ascertain an accurate depiction of status.

Development of Partnership Strategies and Frameworks for Operations should be considered for adoption at all levels and channels utilising Norwegian resources for HIV/AIDS interventions.

Support strengthening of Civil Society Networks including PLWHA to work collaboratively, in order to enhance their representation and voices in influencing policy and be actively involved in decisions that will enhance their participation in the national response.

The Norwegian Programme for Development, Research and Education (NUFU)[6] is adding value to the institutional and capacity development in the country and should continue considering the valuable contributions to capacity development and addressing shortage of personnel in the sectors in Tanzania especially HIV/AIDS counselling. The programme

6 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.

should retain its strength of collaboration based on broad participation and exchange of staff and students and there should be clear linkage of the programme with the sectors especially health sector in order to utilise the trained graduates effectively in contributing to HIV and AIDS response in the country.

1 Introduction

This report presents the findings of an evaluation mission to Tanzania from 19th January to 8th February, 2008 to study Norwegian support to the HIV/AIDS response in the country. The Norwegian Government has provided support to various initiatives to combat the HIV infection and AIDS epidemic since 1980s through various implementing institutions including country level support to government and civil society organisations.

To assess the extent to which Norwegian support has contributed to the response in Tanzania, an evaluation of Norwegian responses to HIV infection and AIDS was conducted. The main purpose of the evaluation was to ascertain results, fill knowledge gaps, provide lessons learnt and suggest recommendations on how to enhance the development effectiveness of the Norwegian HIV/AIDS response in Tanzania. The specific focus of the evaluation was to assess Norway's role and contribution in influencing key outcomes[7] of the national HIV/AIDS responses in Tanzania.

1.1 Evaluation Objectives

The five key evaluation objectives reflect the evaluation purpose, they are 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.

1.2 Scope of the Evaluation

Tanzania was the third of three African countries where the evaluation of the Norwegian HIV/AIDS responses was being conducted. The other two African countries are Ethiopia and Malawi. The evaluation focussed on the period 2000 – 2006 and took into consideration the rapid changes that have taken place in the international and national HIV/AIDS responses during this period.

The conduct of the evaluation in Tanzania was broad based, looking critically into the various types of Norwegian channels and instruments that have supported national HIV/AIDS responses in the country during the evaluation period. The various channels include the bilateral support to United Republic of Tanzania, multilateral agencies, global instruments and NGOs (Norwegian NGOs and local NGOs) who were all consulted as part of the evaluation process.

The evaluation was based on the review of available reports and evaluations, as well as interviews with stakeholders in the country. It assessed the direct HIV/AIDS activities supported by Norway through support to the government, the NGOs and the multilateral agencies, the contributions of main multilateral agencies and global actors and how their influences have contributed to the achievement of key outcomes in Tanzania. In addition, HIV mainstreaming focussed activities in the country and how they have contributed to the achievement of the key outcomes was also assessed.

The evaluation also reviewed Norwegian inputs such as funding, influence of policy dialogue, provision of technical guidance and the linkage between national response and the achievement of the key outcomes as defined by UNAIDS for generalised epidemic.

7 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).

1.3 Evaluation Approaches and Methods

1.3.1 Evaluation approaches

Combined approaches were adopted for the evaluation;

- Objective Oriented Approach: ensured we set clear goals and objectives for the evaluation and review of what has been supported by Norway in Tanzania in relation to the key outcomes and the relevance of the support.
- Participant Oriented Approach: ensured we took a participatory approach to the evaluation process and incorporated information from the respondents in answering the questions which are helpful for programme improvement purposes.

The two approaches were adopted considering the purpose of the evaluation and fulfilment of the evaluation objectives. In addition, they guided the selection and choice of evaluation methods. While the approaches are results oriented thereby focusing on impacts, outcomes and outputs of Norwegian responses to HIV/AIDS rather than inputs and activities, we recognise that the inputs informed the various activities conducted which resulted in the outputs and guided us in drawing inferences about the outcomes and possible impacts.

1.3.2 Evaluation methods

Both quantitative and qualitative evaluation methods were adopted for this evaluation. The methodologies and tools were selected with consideration for OECD and ALNAP[8] criteria to ensure all aspects of the evaluation questions were addressed.

a. Document Reviews – Documents were collected from Norad, the Norwegian embassy in Tanzania, government institutions, country level multi-lateral institutions, Norwegian NGOs, indigenous NGOs, local implementing institutions and beneficiaries. Secondary data were synthesised for analysis to establish results at input and output levels. As well as for assessing contributions to the outcomes and changes in the key outcomes indicators during the period evaluated as defined by UNAIDS and in relation to the policy and guidelines issued by the Norwegian government.
b. Key Informant Interviews – Interview guides were developed based on the evaluation framework with a focus on stakeholders. The guides enabled the evaluation team to elicit information in response to the questions and to clarify issues or areas of concern as required.
c. Focus Group Discussions – Group discussions were used mostly with implementing institutions and beneficiaries. Questions answered within a group of stakeholders provided useful information for the evaluation exercise whilst also maintaining consistency with the overall evaluation approach.
d. 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 NUFU programme to elicit information on how they have contributed to HIV and AIDS.
e. Field Visits – Field visits were conducted to implementing organisations and afforded us the opportunity of meeting some the beneficiaries in Kilimanjaro region, and validated information on the impact of the various interventions. It also provided an opportunity to obtain their perspective on the effectiveness of Norwegian contributions and what improvements could be made. Through this the team could verify information from the document review and consultations with other stakeholders.

1.3.3 Evaluation tools

a. Evaluation Framework – The framework provided the basic foundation for the evaluation, incorporating all the evaluation objectives, detailing how each of the objectives would be met and which information sources and indicators would be used to answer the questions.
b. Timeline Tool – The timeline generated information on various actions and interventions on HIV/AIDS that took place during the evaluation period (2000 – 2006). Data collected from this source was used for the analysis of the various interventions and to deduce information on how they have contributed to the achievement of the key outcomes.
c. Force-field Analysis – Used among various stakeholders in the country to identify forces/ factors that enhanced or held back effective utilisation of Norwegian resources to achieve

8 OECD – Organisation for Economic Development Cooperation & ALNAP – Active Learning Network for Accountability and Performance in Humanitarian Action.

key outcomes. The discussion amongst participants using this tool was essential in guiding recommendations and interventions to counter factors holding back achievement of key outcomes, especially in relation to future engagement.

d. Stakeholder Analysis – Stakeholders used this tool to categorise their influence, importance and interest in utilising resources to achieve the key outcomes. The process was useful in guiding decisions on future engagement of Norway in the country.
e. Most Significant Change Technique – Stakeholders examined the nature of change that has taken place as a result of the various interventions. It highlighted good examples of changes that had happened, factors that enabled successful change to be accomplished, barriers that were encountered and how such barriers were addressed.

Above methodologies and tools were used to obtain information from key stakeholders which include the government (TACAIDS, NACP, line ministries, Tanga RAS, University of Dar es Salaam), multi-lateral institutions (UNFPA, UNICEF, UNAIDS, World Bank, WHO), Bilateral agencies (DFID, SIDA, USAID- PEPFAR), Delloitte and Touche, Norwegian NGOs (NPA, NCA), implementing NGOs supported by Norwegian resources (16 NGOs & FBO[9]s), PLWHA, service providers and beneficiaries across 5 regions of Dar es Salaam, Tanga, Manyara, Kilimanjaro and Arusha.

The evaluation was faced with the possible risk of inadequate provision of information due to staff turn over in TACAIDS and amongst the multi-lateral agencies, non-availability of reports of activities that were supported during the period in few cases. There is also the challenge of attribution since Norway is one of many donors supporting HIV/AIDS responses in the country. In addition, data utilised to assess progress made towards the achievement of key behaviour outcomes are from various sources with slight variations in the various reports as regards progress made so far. The risks and challenges were managed through the review of relevant documents, consultation with HIV/AIDS focal person at the embassy and stakeholders that were knowledgeable and experienced in Norwegian support during the period. These enabled us to elicit information for analysis to respond to the key evaluation questions and objectives.

1.3.4 Reliability and validity

The tools and methods were utilised to ensure consistency that would enable us to draw evidence based conclusions. The reliability of the evaluation was considered in terms of equivalence and consistency. The equivalence reliability was determined by relating data collected to progress made by the country in the key outcome areas in relation to the key outcome and impact indicators defined by UNAIDS for generalised epidemics. The tools also enabled us to assess the consistency of information from all quarters consulted and the contributions of Norwegian support.

The evaluation framework served as a springboard for the tools utilised. It guided us to select tools for specific evaluation objectives and to be focussed in critically looking at issues that we were to assess.

In terms of validity, the methods and the tools utilised enabled us to gather data from a number of sources for analysis and to draw inferences with regard to the progress the country is making in achieving the key and impact outcomes as set out by UNAIDS for a generalised epidemic, and the extent to which Norway contributed to HIV/AIDS response in the country. In addition, cross referencing of information was done as part of the evaluation process especially where respondents informed us that certain results have been achieved as a direct result of Norwegian support for the implementation of their programmes.

1.3.5 Structure of the report

This report is set out in six chapters. Following this introductory chapter, Chapter 2 reviews the epidemic in the United Republic of Tanzania, and presents background and contextual information. Chapter 3 describes the financial support provided by Norway and explains the structure of programmes. Chapter 4 details the delivery of outputs to the national response and

9 UMATI (IPPF), Benjamin Mkapa HIV/AIDS Project, Abantu Visions, EMIMA, Shidepha+, WAMATA, EADCF (Femina HIP), DogoDogo Centre,TCRS, WLAC, KWIECO, KIWAKKUKI, SOS Children's village, Haydom Lutheran Hospital, Foundation for Civil Society and ESAURP.

describes Norway's specific contribution. Chapter 5 presents the best available evidence about progress towards outcomes, reviews the factors affecting that progress and discusses Norway's partnership strategy. Chapter 6 consolidates the material and highlights issues arising and some lessons, concludes and puts forward recommendations.

2 The Epidemic in Tanzania

This chapter sets out the current status of the epidemic and provides a brief history of the national response. Data are shown from published sources, some of which vary but footnotes are provided for reference purpose and explaining where possible the variations.

2.1 National Overview

The United Republic of Tanzania comprising of Tanzania Mainland and Zanzibar is the largest country in East Africa covering 940 000 km[10] and sharing borders with eight countries: Kenya and Uganda to the north, Burundi, the Democratic Republic of Congo, Rwanda and Zambia to the west, and Malawi and Mozambique to the south. The total population is approximately 34,569,232 million people, of which Zanzibar accounts for about 3%[11]. It has 26 administrative regions (21 in Tanzania mainland and 5 in Zanzibar) and 130 administrative districts (of which 10 are in Zanzibar and 120 on the mainland).

The union between Tanganyinka and Zanzibar in 1964 identified special areas as "Articles of Union". The Articles of Union sets out the administrative responsibilities assigned to the Revolutionary Government of Zanzibar and those that are attended to under the provision of the United Republic of Tanzania. Three Ministries fall under the Union Government and are managed from the mainland. These are the Ministry of Defense, Home Affairs and Foreign Affairs. The day to day management of union matters is under the responsibility of the Vice President's Office who is based in the mainland. For the rest, in practice the Mainland and Zanzibar function as two separate countries. This is also the case with respect to the response to HIV/AIDS. As a result, Zanzibar and Mainland have separate and fully independent AIDS Coordinating bodies, the Tanzania Commission on AIDS (TACAIDS) on the Mainland and the Zanzibar AIDS Commission (ZAC) in Zanzibar, with totally separate histories and functioning in very different HIV/AIDS environments.

Tanzania is still one of the poorest countries in Africa and the world. According to its own data, 18.7% of its population lives below its national food poverty line and 35.7% percent below the national basic needs poverty line (2000/2001)[12]. Little progress has been made in reducing poverty in the last 10 to 15 years. Poverty is an overwhelming rural reality and 87% of the population lives in the rural areas. However, Tanzania has ambitious plans to dramatically reduce poverty by 2010. The country has developed the Tanzania Development Vision 2025 and National Strategy for Growth and Poverty Reduction – MKUKUTA.

In addition to the differences between the country's urban and rural environments, there are substantial regional disparities resulting from "the distribution of population, endowment in natural resources, climatic conditions, as well as the distribution of infrastructure, such as transport, schools and health facilities[13]".

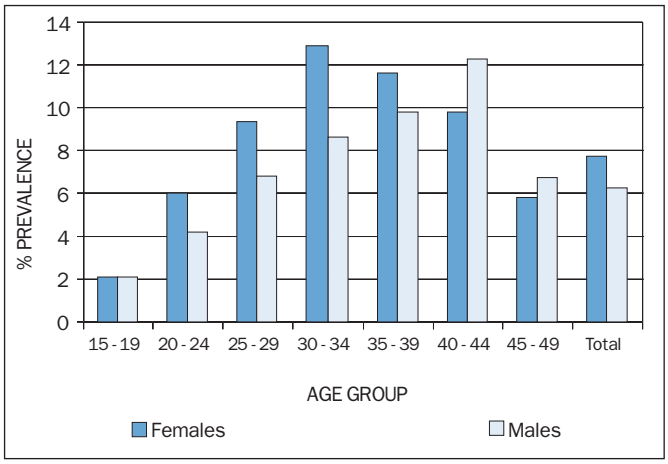
Tanzania has accomplished remarkable progress in the last 15 years with regard to some social developments, for example, the primary education net enrollment rate improved to 90.5% in 2004 compared to 58.8% in 1990. However, illiteracy remains high, especially among women (29.3%, estimate 2003[14]). Infant mortality has been reduced from about 100 deaths per 1000 live births in the period 1995 – 1999 to 68 deaths per 1000 live births in the period 2000 – 2004, probably due to the success of immunization coverage[15], however child malnutrition remains widespread.

10 Report on the global AIDS Epidemic (2006), UNAIDS, Geneva.
11 Knocke et al (2005) The 3 ones principle: Assessing progress in their application in the United Republic of Tanzania.
12 United Republic of Tanzania (2005). The National Strategy for Growth & Reduction of Poverty.
13 United Republic of Tanzania (2005). The National Strategy for Growth & Reduction of Poverty.
14 www.cia.gov/cia/publications/factbook/print/tz.html cited by UNAIDS 2007.
15 National Bureau of Statistics/ORC Macro (2005). Tanzania DHS 2004/05.

2.2 HIV/AIDS Epidemic in the United Republic of Tanzania

The first case of HIV/AIDS in Tanzania was clinically diagnosed and reported in 1983 in the Kagera region. By 1986, all regions of the Mainland had reported HIV/AIDS cases and the first AIDS case was reported in Zanzibar[16]. Since then the epidemic has spread rapidly throughout the country to all regions, from urban to rural communities. In Tanzania Mainland, the epidemic shows strong regional variation ranging from hardest hit regions of Mbeya (14%), Iringa (13%) and Dar es Salaam (11%)[17] and to the lowest prevalence in Kigoma (2%) and Manyara (2%). Community and Household HIV/AIDS Indicator Survey conducted in 2004 showed HIV prevalence of about 7% (6.3% for males and 7.7% for females) among adult aged 15 – 49 years with urban residents having considerably higher infection levels (10.9%) than rural residents (5.3%). This rate is lower than the rate obtained from epidemiological surveillance data reports (2003 – 2005), which suggest a prevalence rate of 8.7% with a range of 4.8% to 15.3% in some areas, resulting in a cumulative total of 176,102 reported cases since 1983. Prevalence for both women and men increases with age until it reaches a peak: for women at age 30-34 (13%) and for men ten years later at age 40 – 44 (12%).

Fig.1: Hiv Prevalence by Age Group 15 - 49 Yrs in Tanzania Mainland



As of December 2005, the estimated number of people living with HIV/AIDS (PLWHA) was 2 million and the government has so far registered 2 million AIDS orphans. These shows a substantial increase of about 400,000 cases of PLWHA since 2003 (which was 1.6 million), and an increase of about 1 million orphans in the same period[18]. The Ministry of Health – Tanzania Mainland's National AIDS Control Programme – report that about 4% of 754 of the AIDS cases which were reported during 2003/04, were below 15 years of age and most of them are likely to have acquired the infection through mother to child transmission. The age group 20 – 49 years remained the most affected for both sexes, an observation which has remained consistent for several years since the beginning of the epidemic in the country.

The WHO Estimation and Projections Package (EPP) and the spectrum model estimated that 1,810,000 people (adult and children) were living with HIV/AIDS in Tanzania Mainland in 2003/04. Out of these, 850,000 were males and 960,000 were females and about 645,000 estimated children who have lost their mother/father or both parents to AIDS and who were alive at the end of 2003/04[19]. On the basis of estimation that only 1 in 4 AIDS cases were reported, a total of 187,940 cases are likely to have occurred in year 2003/04 alone (females being 98,290 and 89,650 males). Assuming total absence of antiretroviral (ARV drugs) in the country up to end 2004, the estimated annual deaths in Tanzania Mainland for the year 2003 was 160,000 (UNAIDS, 2004 Report on the Global AIDS Epidemic) and NACP report of April 2005, has estimated the number of annual deaths due to AIDS in 2004 as 187,940 (89,650 males and 98,290 females).

In 2003, the Ministry of Health and Social Welfare (MOHSW) in Zanzibar with the support from the UN system conducted an HIV population based survey in both Unguja and Pemba Islands. This study established HIV prevalence in the general population at 0.6%. Women show infection rates (0.9%) that are five times higher than their male counterparts (0.2%). The wide gender difference in prevalence, particularly among the youth, was a significant revelation that highlighted the vulnerability of women compared with men[20].

16 2006 HIV/AIDS Services Provision Assessment, NBS/ORC.
17 TACAIDS (2005). Tanzania HIV/AIDS Indicator Survey 2004/05.
18 United Republic of Tanzania UNGASS Indicators Country Report January 2003 – December 2005.
19 TACAIDS, 2005.
20 2006 Services Provision Assessment Survey, p 172.

2.3 Factors Fuelling the Epidemic

The predominant mode of transmission has remained heterosexual, constituting up to 77% of all reported cases during 2003/04[21]. Mother to child transmission constituted about 5% where as blood transfusion was reported at 0.5%. In about 17% of the reported cases, the mode of acquisition of infection was not reported. But other factors reported to be influencing the spread of the epidemic in Tanzania include multiple partnership relationships, intergenerational sex, male dominated gender relationships and risky cultural practices. In Zanzibar, the main predominant mode of HIV transmission has remained heterosexual constituting about 90% of cases. Data from ZACP estimates that mother to child transmission accounts for approximately 4%, which includes transmission through breast-feeding. Transmission through body fluids, blood products, skin piercing and other surgical instruments accounts for the remaining 6% of the infection. Factors influencing the spread of the epidemic in Zanzibar are similar to those on the mainland and include multiple partnership relationships, intergenerational sex, stigma, gender disparities and risky cultural practices. Others factors include poverty, unemployment, drug abuse, cultural/traditional practices, inheritance of widows/widowers, Female Genital Mutilation (FGM) and internal displacements especially in the mining areas.

2.4 Overview of HIV/AIDS Responses

The initial institutional response was the establishment of a national AIDS Task Force in 1985, followed by the establishment of the National AIDS Control Program (NACP) in 1988. The main intervention strategy was the promotion of safer sex behaviors in the general population, youth and mobile populations along high transmission areas. Massive information, education and communication (IEC) campaigns were carried out, together with condom promotion and distribution throughout the country. In recent years more innovative approaches including peer health education, school based female guardian program and curriculum based family life education have been introduced in selected regions. In between blood safety measures, STD control and health worker training have been instituted.

In response to the HIV/AIDS epidemic, the government of Tanzania, with technical support from WHO's Global Programme on AIDS (WHO-GPA), formed the National AIDS Control Programme (NACP) in Mainland Tanzania and the Zanzibar AIDS Control Programme (ZACP) under the Ministry of Health and Social Welfare (MoHSW). Each of the AIDS control programmes formulated a short-term plan (1985-1986 for the NACP and 1986-1987 for the ZACP) followed by three successive five-year plans (1987-1991, 1992-1996, and 1998-2002). In 1999, HIV/AIDS was declared a national disaster by President Benjamin William Mkapa. This was followed by the establishment of the Tanzania Commission for AIDS (TACAIDS) in 2001 and the Zanzibar AIDS Commission in 2002. Both commissions were mandated to provide strategic leadership and coordination of multi-sectoral responses to the epidemic, monitoring and evaluation, including research, resource mobilization and advocacy. TACAIDS, in collaboration with other stakeholders, developed the Tanzania National Multi-sectoral Framework on HIV/AIDS (2003–2007). The plan's main goals are to reduce the spread of HIV, improve the quality of life of those infected with and affected by HIV, and mitigate the social and economic impact of the epidemic.

21 TACAIDS 2005.

Summary of key Issues about HIV/AIDS Epidemic in Tanzania

- Tanzania is one of the poorest countries in Africa and the world.
- There is strong regional variation in the HIV prevalence in the country ranging from hardest hit regions with a prevalence rate of 14% to regions with the lowest prevalence rates of – 2% in Tanzania mainland, and 0.6% in Zanzibar amongst the general population. The prevalence is higher in females than males.
- As of December 2005, an estimated 2 million people were living with HIV/AIDS and the government had registered about 2 million orphans.
- Predominant mode of transmission is heterosexual, mother to child transmission, infected blood and blood products. Other factors include multiple partnership, intergenerational sex, cultural practices, etc.
- National response to HIV/AIDS started in 1985 with focus on health sector response. The Tanzania Commission on AIDS (TACAIDS) and the Zanzibar AIDS Commission (ZAC) were established in 2001 and 2002 respectively to provide strategic leadership and coordination of multisectoral responses to the epidemic.

3 Norwegian Support to HIV/AIDS

This chapter presents the analysis of Norwegian Aid to Tanzania during the period 2000 to 2006. The main source of statistics is the official database supplied to the mission and reference is made to other sources for comparison as appropriate. This chapter also discusses the Norwegian country programme strategy and engagement with various partners in the country as well as the discussion on the intervention logic of the programme.

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 reflects these policy positions, with only some changes in priorities during the period. 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.

An internal action plan for Norad's intensified efforts to combat HIV/AIDS in 2001 reflected the policy positions and seems to have been influential in Norad in the following years with HIV/AIDS becoming a main thematic priority. In 2002, the focus was on prevention and treatment and using the mainstreaming approach for impact mitigation with measures to increase competence in Africa. The prevention measures were to continue to support women, youth and children (including PMTCT), and accessibility and affordability of treatment was of paramount importance. 2003 to 2006 focussed more on increased support to the multilaterals and the global instruments.

A new policy position paper was developed in November 2006 which reflects some changes in Norwegian aid and international policies during the period but it has limited relevance for the evaluation as it was published just before the end of the evaluation period. A range of Norwegian contributions in terms of funds and technical assistance were channelled through multilateral agencies, global instruments such as the GFATM and NGOs to tackle the epidemic. Hence, the evaluation study looked critically at various engagements and utilization of these resources and achievements in terms of contributions to the outcomes and impact indicators as defined by UNAIDS for generalised epidemic.

3.1 Norwegian Engagement in the United Republic of Tanzania

Development Cooperation between Norway and Tanzania started in the early 1960s in the form of Technical cooperation in the field of public administration, health and education. From 1995, the co-operation was guided by the Memorandum of Understanding on development, the thrust being to promote a sustainable economy. With a view to further strengthening and developing the relations between the two countries, representatives of the Government of the Kingdom of Norway and the Government of the United Republic of Tanzania held consultations in Dar es Salaam on 5 December 2001, and arrived at an understanding of the overall priorities and the framework for future cooperation between the two countries for the planning period 2002-2006. Agreed minutes of these consultations were signed on 7 December 2001.

The framework for development cooperation between Norway and Tanzania for the five-year period was within the Poverty Reduction Strategy Paper (PRSP) and the Tanzania Assistance Strategy (TAS)[22]. Both documents were launched as a basis for increased economic growth and poverty reduction. These documents also represent a basis for cooperation and assistance from other international development partners.

Based on the PRSP, the two Governments agreed that further progress in the following areas for the period 2002 – 2006 was crucial for achieving Tanzania's development objectives[23]:

22 Memorandum of Understanding between the Kingdom of Norway & The Government of the United Republic of Tanzania signed on June 2002.
23 Guidelines for Norwegian Development Cooperation with Tanzania (2002 – 2006).

a. Good governance, democracy and human rights, including support to public reform programmes and measures to combat corruption.
b. Reduction of income poverty through rural sector development including support to the management of natural resources and the road sector with emphasis on rural roads.
c. Social development, with emphasis on the education sector and support for HIV/AIDS control.

It was also agreed that special attention will be paid to HIV/AIDS prevention and control in all areas of cooperation.

Another request made by the government of Tanzania in September 2004 was for Norway to support the National HIV/AIDS Care and Treatment Plan with the goal to rapidly scale up care and treatment with the objective of reaching 400,000 HIV positive individuals on ARVs by 2008, the agreement was signed in November 2005. The Norwegian government also partnered with other development agencies to establish two basket funds – Rapid Fund Envelope and the Civil Society Foundation Fund though meant for broader social development issues but also provided support to civil society organisations for the implementation of short term HIV/AIDS interventions.

In addition to direct engagement with the government of Tanzania, Norway has also had very active engagement during the period evaluated with NGOs and FBOs in supporting HIV/AIDS interventions. Norwegian NGOs such as Norwegian People's Aid, Norwegian Nurses Association, FOKUS, and Norway Women's Front have all been on the ground partnering with local organisations and regional authorities in the fight against HIV/AIDS. Norwegian Church AID became fully operational in Tanzania in 2005, but had prior engagement with FBOs in Tanzania, operating through their regional office in Nairobi.

3.2 Composition of Norwegian Financial Support

The composition of Norwegian financial support to the government and people of the United Republic of Tanzania, comes in many forms and are channeled through various sources. This aspect of the report presents a summary and analysis of the overall flow of Norwegian Aid to Tanzania during the period 2000 to 2006. Similar to the Malawi country report [24], the main source of statistics is the official database supplied to the evaluation mission, from which tables are presented in Annex 5[25]. This evaluation focused mainly on the Tanzania Mainland considering the fact that most support from Norway during the period was directed here.

3.3 Disbursement of Aid Funds

Norway has been a significantly large bilateral donor to Tanzania. The overall flow of official development assistance (ODA) to Tanzania is summarized in official statistics from the OECD – Development Assistance Committee (DAC) for the period 2000 to 2005 in Annex 5 Table 1. This shows a total net aid flow of $8.4 billion. Of that, aid from the DAC countries comprised 65 percent or $5.4 billion. Norway's contribution was 4 percent of total net ODA, equivalent to Germany and the sixth largest bilateral donor after the United Kingdom, Japan, Netherlands, Denmark, and United States. Norway's annual disbursement increased over the period. The total volume of aid has risen over the period from around NOK 309 million in 2000 to over NOK 483 million in 2006. The sectoral allocation of that aid is shown in Annex 5 Table 2, using the DAC main sector codes.

As stated in the Malawi country report, specific flows to HIV/AIDS can be difficult to quantify. The DAC coding does not identify support to HIV/AIDS, which may be reflected under a wide range of categories. Norad has a coding system that marks programmes according to a 'significant' or 'main' objective to deal with HIV/AIDS. Annex 5 Table 3 shows the flows to HIV/AIDS according to that marker. Over the whole period, 13 percent of disbursed aid was marked for HIV/AIDS. This accounted for 5 percent in 2000, rose to a peak of 24 percent in 2004 and was 12 percent in 2006.

24 Country Report -The Evaluation of the Norwegian HIV/AIDS Responsesin African Partner Countries:Malawi, ITAD 2008.
25 The report quotes from these figures as an authoritative source. Reports by NGOs and studies by the auditor general have shown inconsistencies in coding of data and a highly variable 'content' of cross-cutting policies in aid programmes marked by cross-cutting policy markers that are not mutually exclusive. The arguments presented in this evaluation mainly concern broad trends in the programmes and underlying errors are not thought to be significant for the conclusions drawn.

Norwegian resources in Tanzania were channelled through multiple sources – General Budget Support (GBS), Basket Funding (BF) and Project Funds (PF), the Rapid Fund Envelope (RFE), Foundation for Civil Society (FCS) and direct support to NGO/FBO's such as the Haydom Hospital, WAMATA, Abantu Visions, WLAC and EADCF. In addition, resources were also channelled through Norwegian NGOs (Norwegian Peoples Aid, Norwegian Church AID, Norwegian Nurses Association, Norwegian Women's Front, JURK and FOKUS). Furthermore, GFATM and TMAP were confirmed as the major sources of funding for HIV/AIDS activities in the country – both Tanzania Mainland and Zanzibar jointly accessed the TMAP. Norway was a donor to both sources during the period evaluated.

The government acknowledged the contributions of Norway through the three major sources of funding (GBS, BF and PF) and the RFE, although not aware of their contributions to TMAP, GFATM and support provided by Norwegian NGOs possibly due to flows of funds directly to benefiting local NGOs. This evaluation cannot really ascertain how the contributions of the various sources are captured to determine the true progress of the response to the epidemic in the country.

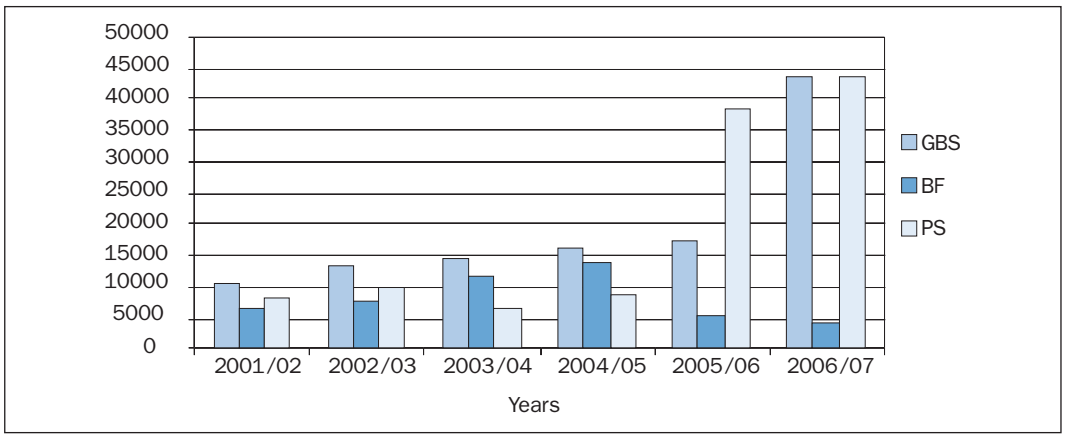
General Budget Support (GBS): This is in line with MKUKUTA and the Joint Assistant Strategy (JAS). Tanzania's most preferred aid modality is General Budget Support, as it enhances predictability of resources, national planning, use of government system, national ownership, accountability and transparency. GBS is supported in the country by 11 bilateral and three multilateral development partners. Between 2002 and 2005, GBS has achieved 100 percent disbursement of committed funds with up to 90% disbursed in the first half of the financial year[26].

Basket Funds (BF): This is the second major source in which development partners and the Government of Tanzania (GOT) pool resources together for implementation of a specific sector/ thematic area normally specified in a Memorandum of Understanding (MOU). The MOU specifies the common procedures for approval, disbursement of funds, procurement, accounting, reporting, auditing, assessment, and monitoring and evaluation. At the time of this evaluation, there are about 13 basket funds operating in different Ministries, Departments and Agencies (MDA's) and Local Government Authorities (LGA).

Project Support (PS): This is targeted towards implementation of a specific project by the donor with clear specific MOU and other procedures that are attached to it. The average volume of the Norwegian disbursement to the GOT was Tshs 46.4 billion under project support for a period of six years (2001/02 to 2006/07) representing 7% of the total bilateral support (Tshs 504.2 billion) to the government.

The total volume of disbursement by Norway has consistently increased from Tshs 28.4 billion in 2001/02 to Tshs 91.1 billion in 2006/07 following the government of Tanzania's adoption of the Joint Assistance Strategy for Tanzania in 2006 as a framework to guide the management of development cooperation between the Government and development partners (DPs), including the management of external resources for the entire government and across the civil society in the country[27].

Fig. 2: Norway Actual Disbursement by Aid Modalities



26 Presentation of Norway Support to Tanzania by J. Omari (2008) to the Evaluation Team.
27 Remark by Deputy Permament Secretaty Treasury at the working session on JAST Implementation & GBS process for MDAs, 2007.

There was tremendous increase in GBS and PS in 2006/07 as compared to other years with a decrease in basket fund support to GOT. GBS rose from 29% in 2005/06 to 48% in 2006/07, project support from 47% to 62% and basket fund decrease from 9% to 5% during the same period. 4.5% of the GBS was allocated to Zanzibar and some Zanzibar NGOs have also accessed the RFE for HIV/AIDS.

Since the GBS is to support implementation of government priorities according to the plans submitted by Ministries, Departments and Agencies (MDA) in line with MKUKUTA, it is not clear how HIV/AIDS is prioritised in budget allocation although it was reported that this was accounted for in MDA plans[28]. Over the years, the funds available for HIV programmes have increased substantially both from government and the DPs as shown in the table below:

Table 1: Trends in Public Expenditure on HIV and AIDS (Tshs, Billion)[29]

	Actual 2002/03	Actual 2003/04	Actual 2004/05	Actual 2005/06	Budget 2006/07
Total Public & Donor Expenditure on HIV/AIDS	47.06	61.3	148.43	290.84	406.67
Government	7.1	8.1	12.6	35	60.3
Development Partners (Donors)	39.96	53.2	135.83	255.84	346.37
Donors spending as % of total HIV/AIDS spending	84.9	86.8	91.5	88.0	85.2
Total HIV/AIDS spending as a % of:-					
Total Govt Spending	2.47	2.91	4.56	7.52	5.63
Total Revenue	3.6	4.7	8.37	14.12	11.0
Nominal GDP	0.41	0.52	1.14	2.02	1.65

Source: PER 2003, PER 2004, PER 2005, PER 2006, Ministry of Finance External Database, TACAIDS Mid-term evaluation of the National Multi-sectoral Strategic Framework, March 2006, National Bureau of Statistics, Tanzania in Figures 2005, Ministry of Finance Budget Speech, 2006/07.

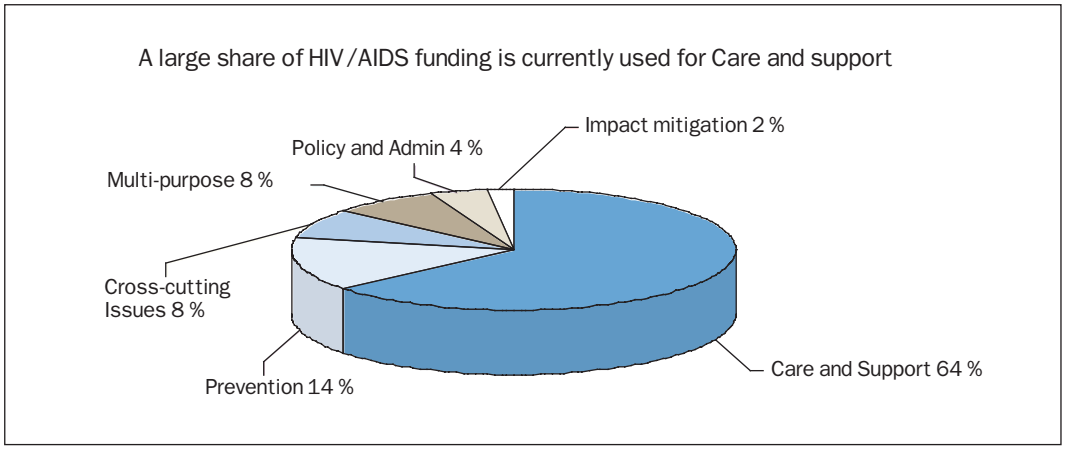
On average the government funding for the National Multisectoral Strategic Framework on HIV/AIDS (NMSF) has remained low despite the scaling up of initiatives, while the rest is covered by support from development partners and other agencies including the United States Government (USG) (PEPFAR), the Global Fund to fight AIDS, TB and Malaria (GFATM) and the World Bank[30]. The total expenditure on HIV and AIDS interventions in the country (including donors' off-budget spending) was equivalent to 7.5% of total Government budget spending in 2005/06 and about 14% of the total Government revenue. This arrangement poses quite a significant challenge for the financial sustainability of the National Multisectoral Strategic Framework on HIV/AIDS (NMSF).

The Ministry of Health and Social Welfare (MoHSW) and Tanzania Commission on AIDS (TACAIDS) accounted for over 95% of budget and 97% of actual spending on HIV in 2005/06. Some of the TACAIDS spending represents funds transferred to other MDAs and to districts. The thematic area of Care and Support has received over 64% of the spending on HIV and AIDS, while prevention received only 14%. The fund allocation in the other thematic areas is presented in Figure 1. The high trends of expenditure on Care and Treatment is attributed to the rolling out of initiatives for ARVs and related logistics including the training of health care workers, however, there is cause for concern bearing in mind the equally important role prevention interventions have in the overall National Response.

Although the government has put together financial management procedures and mechanisms to facilitate and support the process of implementation of HIV intervention at the level of Ministries, Departments and Agencies (MDAs), Local Government Authorities(LGAs), Council Multisectoral HIV/AIDS Committee (CMAC) and Civil Society Organisations (CSO), these mechanisms are marred with bottlenecks causing undue delay in disbursement and accountability of funds, consequently affecting the absorption capacity of key partners and the delivery of HIV programmes, especially at local levels[31].

28 Discussion with Commissioner of External Finance and TACAIDS.
29 2nd National Multi-sectoral strategic framework on HIV/AIDS (2008 – 2012)
30 NMSF Human and Financial Assessment Report. AM Kireria & D Ngowi. TACAIDS. March 2007.
31 2nd National Multi-sectoral Strategic Framework on HIV/AIDS (2008 – 2012)

Figure 3: Funding for HIV and AIDS by Thematic Areas (2005/06)



Source: Deloitte and Touché study (2006).

Support to Projects: The three key projects documented to have been supported with resources channelled through the government exchequer system under this component of AID modality by Norway are:

- Creating Institutional Capacity of NGOs in 2003 to implement HIV/AIDS activities in three zones.
- Support to NACP for the implementation of National Care and Treatment Plan in collaboration with other partners.
- Support to Benjamin William Mkapa's Foundation for Human Resources in Health for the scaling up of Anti-retroviral Therapy (ART) provision .

NGO Basket Fund Through Collaboration with other Development Partners: Norway in collaboration with other development partners established two types of basket funds to enhance access of NGOs to funds for the implementation of activities. The funds are the Rapid Fund Envelope and the Civil Society Foundation Funds. Norway's contributions to the two funds - Rapid Fund Envelope NK3,750,000 (0.02% of total fund) and the Civil Society Foundation Fund $683,644 (5.23% of total fund) respectively. The RFE fund has grown from $3m in 2002 to $16m in 2007 with the sum total of $360,000 as Norwegian contributions. Norway was very active in the steering committee but has indicated its intention of pulling out of the RFE mechanism.

Aside from the above, Norway is also a donor to two other main resources for funding of the HIV/AIDS programme in Tanzania – the Tanzania Multi- Country AIDS Programme (TMAP) and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM). The TMAP is a grant of $70million, $5million of which goes to Zanzibar between 2003-2008. The TMAP was granted when there were minimum funds from other donors for HIV/AIDS interventions. There has been low disbursement rate of about 60 – 70% due to proliferation of resources from other donors notably GFATM and the President's Emergency Program for AIDS Relief (PEPFAR), with the Tanzania Multi- Country AIDS Programme becoming a gap-filling resource. An extension of one year has been granted to utilise the remaining funds. The two GFATM programmes concerned with HIV/AIDS[32] are:

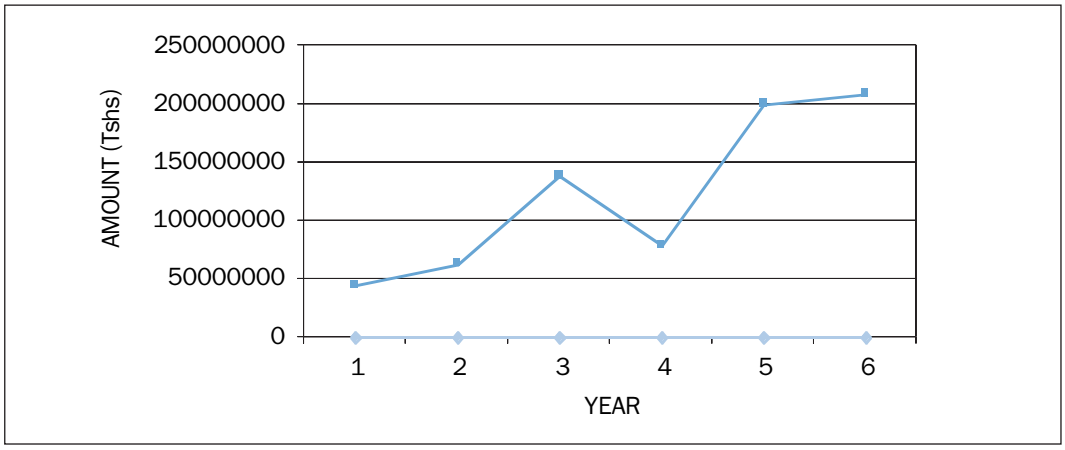
- The round 3 HIV/AIDS and TB programme with an approved phase 1 budget of $83m for scaling up of VCT started in September 2004 and should have ended in September 2006, but there has been no disbursement from GFATM since April 2006 and total expenditure has only reached $20m.
- The round 4 GFATM HIV/AIDS grant has a total commitment of $293m for a five year programme approved in September 2005. Currently, only the disbursement of the phase one support ($88m) has been approved, and actual disbursement to date is $59m.

Support to Multilaterals and NGO/FBOs: Norway has provided direct support to UNICEF, UNFPA, local NGOs and FBOs between 2000 and 2006[33]. From records made available at country level, UNICEF was supported with NOK3,200,000 in 2000 for the HIV/AIDS Out of School Youth Interventions. Haydom received NOK7,106,193 from 2002 – 2005. Direct

32 Foster et al (2007) Tanzania Public Expenditure Multisectoral HIV/AIDS Review.
33 These organisations include WAMATA, WLAC, EMIMA, EADCF, Lutheran Hospital Haydom.

Support was also provided to local NGOs during this period[34] and Norwegian People's Aid (NPA) was supported with NOK1,550,000 for the interventions at country level. The resources to some of these organisations grew from year to year. For example, the grant to Women's Legal Aid Centre to implement HIV/AIDS activities grew from 45million Tshs in 2001 to over 200million Tshs in 2006 as presented in the chart below

Fig. 4: Norway grants to WLAC from 2001 - 2006



Aside from the formal Norwegian government engagement for the support of the HIV/AIDS programme in the country, other Norwegian bodies played active roles and provided funds for local NGOs and regional authorities for the implementation of HIV interventions. Notably amongst the NGOs are:

Norwegian Programme for Development, Research and Education (NUFU) Contributions to HIV& AIDS Response

There are several programmes supported by NUFU in the country that contributed to HIV and AIDS response directly or indirectly. But the key partnership programmes that are directly linked with HIV and AIDS during the evaluation period and allocation include:

- University of Bergen/University of Dar es Salaam Counselling, Education and Health Promotion: A Research and Competence Building Programme - 4 362 600 NOK
- Health Systems Research and Health Promotion in Relation to Reproductive Health in Tanzania - 8 176 000 NOK
- Gender, generation and communication in times of AIDS: The potential of 'modern' and 'traditional' institutions - 6 816 600 NOK

Support from Norwegian NGOs

Various Norwegian NGOs namely Norwegian Church Aid, Norwegian People's Aid, Women's Front Norway, Norwegian Nurses Association, FOKUS and JURK all provided financial and technical support for various programmes of HIV and AIDS interventions that contributed to the progress the country is making in achieving the key outcomes during the period.

Norwegian Nurses Organisation: The organisation provided funds to work collaboratively with the Tanga Regional Authority to implement MEUSTA-YETU school HIV/AIDS project in six districts in the first phase (1995 – 1999) years; and five districts in the second phase (2001 to 2005).

JURK International also worked with Kilimanjaro Women Information Exchange and Consultancy Organisation (KWIECO) and provided financial support to the tune NK1,806,585 for 2005 to 2006 to implement human rights, gender and HIV/AIDS related programmes.

Women's Front Norway: This organisation has been providing support to a local women organisation KIWAKKUKI since 1998 and financial support provided grew from 27 million

34 - WAMATA, 2287000; KRIKS, 721,000; Ilula Orphanage, 120,000; Abantu, 2,000,000, EMIMA, 22,400; ESAURP, 260,000; FEMINA, 4,700,000.

to 57 million Tshs with total sum of 230 million Tshs during the period evaluated. The breakdown of the support is presented in the table below.

Table 2: Summary of grant received from Women's Front Norway

Year	Amount (Million Tshs)[35]	Amount (NOK)
1998	17.2	72,799.5
1999	26	110,045.8
2000	27	114,232.8
2001	15	63,462.7
2002	24.6	104,103.2
2003	34	143,882.5
2004	36.2	153,192.5
2005	36.4	154,055.8
2006	57	241,241.3
2007	72	304,986.3
2008	65.7	278,300

Norwegian Church Aid: The Norwegian Church Aid in Tanzania received support of NOK 6.5million from the embassy to support its partners in the implementation of OVC programme in 2005 - 2006. Prior to this period, support to NCA partners in Tanzania was via the NCA East African Regional office in Nairobi.

Most of the support is in the range of two to four year duration, aside from the support through GBS. The support to KIWAKKUKI and Tanga by Norwegian NGOs are long term, ten years in duration and only few, such as support to Abantu Visions, Ilula Orphanage and ESAURP were one-off support.

3.4 Norway's Country Programme and Strategy

Norway did not have a specific country programme and strategy for the United Republic of Tanzania during the period, but the memorandum of understanding signed in June 2001 revealed that the Norwegian government was committed to support the Tanzanian government Poverty Reduction Strategy through the modality that best suited the government. The General Budget Support (GBS) was meant to support government priorities as documented in MKUKUTA and HIV/AIDS was mainstreamed which thus led to the development of the first National Multisectoral Strategy Framework (NMSF). Since the Norwegian government is committed to supporting the Government of Tanzania's priorities, it could as well be inferred that Norway was one of the donors that supported the implementation of the first NMSF on HIV/AIDS through the GBS, Program Support, Rapid Funding Envelope, Foundation for Civil Society and other support to NGOs during the period. The projects implemented by NGOs with support from the embassy and Norwegian NGOs are reported in Annex 6. The strategy and some of the projects supported during the period are discussed below:

3.4.1 National Multi-sectoral Strategic Framework (NMSF) on HIV/AIDS (2003–2007):

The National Multi-sectoral Strategic Framework has 9 goals that were expected to be reached in the period 2003 – 2007. The goals were in line with international commitments by the Government of Tanzania as incorporated in the MDGs (2000) and UNGASS (2001). The goals addressed the overall impact of the National Response and achievements in different thematic areas.

- **Thematic Area 1:** This covered cross-cutting issues related to the Creation of an Enabling Environment for the National Response. The issues covered in this thematic area include Advocacy, Fighting Stigma, Denial and Discrimination, Regional, District and Community

35 The figures (amount) were provided in Tshs and converted to NOK using the currency converter from www.xe.com.ucc/convert.cgi. 1 Tshs = 0.00422624 NOK as at 15th May 2008.

Responses, HIV Mainstreaming including HIV/AIDS and Development in Poverty Reduction Policies (MKUKUTA).

- **Thematic Area 2:** This thematic area aimed at reducing the spread of HIV prevalence through increased knowledge of HIV transmission and prevention. The prevention thematic area has nine major intervention areas which include; STI Control and Case Management, Condom Promotion and Distribution, Voluntary Counselling and Testing, Prevention of Mother to Child Transmission (PMTCT), Health Promotion for Specific Population Groups: Children and Youth, Girls and Women, Men and Disabled People, School Based Prevention for Primary and Secondary Level, Health Promotion for Vulnerable Groups, Workplace Interventions (Public, Private and Informal Sector), Safety of Blood, Blood Products and Universal Precaution in Health and Non-health Care Settings including waste management.
- **Thematic Area 3:** This covered HIV/AIDS Care and Support and covered two key intervention areas of provision of ARVs and treatment of opportunistic infections; and home/community based care and support.
- **Thematic Area 4:** This thematic area covered Social and Economic Impact Mitigation and aimed at enhancing the effectiveness of traditional social networks to cope with the increasing burden of HIV infected and affected families, orphans and other vulnerable children. Intervention areas covered; Economic and Social Support for Persons, Families and Communities affected by AIDS, Support for orphans, and Impact Mitigation.

Other explicit areas covered by the NMSF are Monitoring, Evaluation and Research, and Institutional and Management Framework for the NMSF.

3.4.2 National Care and Treatment Plan:

Most of the funding from Norway is channelled through the National Care and Treatment Plan to contribute to and improve the quality of treatment and care for persons living with HIV/AIDS (PLWHA). This includes blood safety, availability of ARVs and other medications for the treatment of opportunistic infections, home based care, local support groups and partners, information and education to reduce the stigma associated with HIV/AIDS. Strengthening of health care structure in Tanzania and expansion of the capacity for health care personnel, health facilities and comprehensive training are all part of the programme supported during the period.

3.4.3 Rapid Fund Envelope (RFE):

The Rapid Fund Envelope is an innovative partnership between the Tanzania Commission for AIDS (TACAIDS), the Zanzibar AIDS Commission (ZAC), nine bilateral donors, and one private foundation. Established in 2002, the RFE's purpose is to enable civil society institutions in Tanzania to participate fully in the national multi-sectoral response to the AIDS epidemic, and to fill the gap created for late take off of the TMAP and GFATM as a short term mechanism for CSOs to access funds for implementation of HIV/AIDS interventions. The RFE provides grants to Tanzanian non-profit civil society organisations, academic institutions, and civil society partnerships for essential, short-term projects aligned with the National Policy on HIV/AIDS and the National Multi-Sectoral Strategic Framework. Urgent, best practice or innovative projects are funded in six priority areas of:

- Prevention, advocacy, information/education/communication, and behavior change communication
- Care and support for HIV/AIDS and related opportunistic infections
- Impact mitigation of the effects of the epidemic, including orphans and vulnerable children
- Research to provide baseline information or assess effectiveness
- Institutional strengthening, including capacity building in monitoring and evaluation
- Interventions for children aged 0—8 years who are infected or affected by HIV/AIDS

The participating donors are Bernard van Leer Foundation, CIDA, Embassy of Finland, Irish Aid, DANIDA, Royal Netherlands Embassy, Royal Norwegian Embassy, Swiss Agency for Development Cooperation (SDC), DFID and USAID.

Now that the Global Fund to Fight AIDS, Tuberculosis, and Malaria, the World Bank Multi-sectoral HIV/AIDS Project, the Clinton Foundation, and the U.S. President's Emergency Plan for AIDS Relief are bringing massive support for HIV/AIDS programs in Tanzania, the RFE

focuses on filling gaps in technical and geographical support, funding innovations, testing replication, and supporting institutional strengthening.

3.4.4 The Foundation for Civil Society:

The Foundation for Civil Society is a Tanzanian non-profit company, designed and funded by a group of like-minded development partners, and governed by an independent Board. It was previously known as the Civil Society Program (CSP). The Foundation was registered in September 2002 and started operations in January 2003. The Foundation aims to establish an intermediary support mechanism for civil society organisations in Tanzania which will enable effective engagement in poverty reduction efforts as set out in the Government of Tanzania's policies: Vision 2025, the Tanzania Assistance Strategy, and the National Strategy for Growth and Reduction of Poverty (NSGRP).

The Foundation is one of the largest support mechanisms for civil society in Tanzania, and is committed to delivering grant aid and supporting capacity-building initiatives as a means of strengthening effective engagement in poverty reduction through engagement in four thematic areas of policy, governance, advocacy strengthening and safety nets (thematic area where HIV/AIDS falls into).

3.4.5 Benjamin Mkapa Fellows Programme:

This is an innovative programme supported financially by the government of Norway and dedicated to addressing the gaps in human resources in the health sector which is key in the scaling up of HIV/AIDS care and treatment. The purpose of the programme is to contribute to competent and skilled human resources within the health sector through recruitment, training, deployment and retaining skilled professionals to support the aggressive implementation of Tanzania's response to HIV/AIDS including but not limited to the National Care and Treatment Programme. The Programme recruited and educated health personnel specifically on HIV/AIDS in order to enhance their capacity and motivate them to work in remote areas. The selection criteria of districts covered include:

- High HIV prevalence rates
- Severe shortage of human resources or expertise in HIV/AIDS care and treatment
- Difficult geographical accessibility and distant from regional hospital.

Two prong approaches of monetary and non-monetary incentives constitute the package for the retention of fellows. The monetary package include relocation allowance, enhanced salary, housing allowance, gratuity of 5% of the three year basic salary by the end of three years contract. The non-monetary package includes intensive induction training on comprehensive management of HIV/AIDS, provision of laptops and mobile phones with monthly airtime, NSSF benefits including Social Health Insurance Benefits, and refresher course on HIV/AIDS and related fields twice a year.

3.4.6 Norwegian Programme for Development, Research and Education (NUFU) Programme

The NUFU programme is a partnership programme aims to build up research and research competence in Tanzania through cooperation between the Universities and research centres in Norway and Tanzania. The programme operates through individual projects and has several advantages to the Tanzanian institutions. There are sevaral HIV/AIDS related programs funded by NUFU as earlier stated. But the key program that emanated during the evaluation is the "UiB/UDSM Counselling, Education and Health Promotion: A Research and Competence Building Programme". This program was created as a partnership programme between the University of Dar-es-Salaam and the University of Bergen to meet the demand/shortage of counsellors in the health sector and was implemented from 2002 to 2006.

In addition to the various programmes and strategies discussed above, some local NGOs also implemented various projects supported directly by the embassy or Norwegian NGOs. These various projects are briefly described and presented in Annex 6.

3.5 Intervention Logic of the Programme

This evaluation has used a logic diagram to model the potential benefits arising from Norwegian support. In the Inception report for this study, an illustrative intervention logic was

developed showing how Norwegian support might create a connected and coherent programme leading to development change in line with national priorities. Annex 9 contains a version of that logic edited to reflect the actual situation in Tanzania.

The theoretical model envisaged a four stage process:

Level 1 – A broad mixture of funding modalities enables Norway to interact at a variety of levels from grassroots to policy. Breadth increases Norwegian experience base, creates opportunities for learning and improves relevance of policy support.
Level 2 - Outputs from funded activities are the first level of benefits: here the level of attribution varies according to the type of partnership.
Level 3 - Potential increased benefits arise from Norway's ability to interact and exchange lessons and experience between policymakers, implementers in and outside government, target groups and PLWHA. Partnership strategies build on that experience.
Level 4 - Direct benefits accrue to target groups and PLWHA. Indirect benefits come from the efficiency and effectiveness gains from improved ways of working and policy alignment.
The actual programme in Tanzania closely resembles the model as far as levels 1 and 2 are concerned. The programme has harnessed a wide range of implementing partners and has shown flexibility in combining aid modalities. It is clear, as explained in Chapter 4, that considerable progress has been made with delivery of outputs across the whole spectrum of pillars in the national strategic framework.

It is less clear that the potential interactions and lesson learning envisaged at level 3 have been achieved. The coordination structures developed for the national HIV/AIDS response have the potential to provide the fora to share experience. But there do not seem to be any mechanisms to feedback the more diverse experience from small-scale investments in mainstreaming in the projects supported by Norway during the period evaluated. Although the embassy conveyed forum of NGOs and partners supported by Norway to meet once in every two years with a specific theme for discussion, but not necessarily sharing experience in relation to HIV/AIDS and these NGOs do not necessarily participate in TACAIDS fora, and no mechanism is in place to share these experiences. Norway is recognized as a key partner in the DPG on HIV/AIDS and engagement of Norway in various steering committees and their innovative interventions have contributed to policy influencing and progress the country is making towards the achievement of key outcomes.

Summary of Norwegian Support to the HIV/AIDS Response in Tanzania:

- Norwegian engagement started in the early 1960s. The technical cooperation was strengthened in 2001 with a Memorandum of Understanding to support the overall priorities and development framework of the country which included HIV/AIDS for the period evaluated.
- Composition of Norwegian financial support to the government and the people of Tanzania comes in many forms and are channeled through various sources – with government (GBS, BF and PS), RFE, CSF, Norwegian NGOs and direct support to local NGOs.
- Norway did not have a specific country programme strategy for Tanzania during the period evaluated, but all interventions supported were within the broad scope of the National Multisectoral Strategic Framework on HIV/AIDS with a focus on prevention, treatment, care, support and impact mitigation.
- The intervention logic model revealed that the actual programme resembles the model in levels 1 and 2, but no mechanisms are in place to feed back the more diverse experience from the investments in the various sectors.

4 Delivery of Outputs

This section will focus on delivery of outputs on the various thematic areas considering that Norway supported Tanzania through GBS and various public sectors accessed resources for HIV/AIDS interventions at the period. In addition are projects and interventions supported by Norwegian resources directly or through other channels in which Norway has contributed such as the Tanzania Multi-Country AIDS Programme, Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM), Rapid Funding Envelope and CSF, and CSOs that are either funded directly by the Royal Norwegian Embassy or being supported by Norwegian based NGOs operating in Tanzania or from Norway. The contributions of multilateral institutions in terms of their specific outputs were also examined in the context of interventions in the thematic areas.

The National Multisectoral Strategic Framework on HIV/AIDS (NMSF) (2003-2007) provided the framework in which institutions at national district and village level contributed to the national response against HIV/AIDS during the period under review. It guided the multi-sectoral response involving public, private sectors, local and international NGOs interventions to address thematic areas of cross-cutting issues, prevention, HIV/AIDS care, treatment and support, social and economic impact mitigation and enabling environment, monitoring, evaluation and research and the institutional and management framework. One of the challenges is the ability to capture the information from the players at different levels and document their contributions to the national response[36].

4.1 Cross Cutting Issues Related to the National Response (Enabling Environment)

This is the first thematic area in NMSF and addresses issues of leadership, creation of enabling environment, creation of structures to broaden response and HIV mainstreaming. The 2003 – 2007 NMSF envisioned to address a number of broad cross-cutting issues (enabling environment) to enhance successful implementation of the various strategies outlined under each thematic area in the framework. In terms of advocacy, the past Tanzanian President Benjamin William Mkapa provided high - level political leadership in the official launches of the TACAIDS, the National HIV and AIDS policy in 2001 and the NMSF (2003 – 2007). The advocacy tone set by the President is reported to have reverberated from the national to the regional and district levels where majority of Civil Society Organisations (CSO) (93%) and members of Council Multi-sectoral AIDS Committees (CMACs) (92%)[37] reported some levels of advocacy by political, government and religious leadership at different forums. Similar efforts were noted among the parliamentarians who decided to establish the Tanzania Parliamentarian's AIDS Coalition (TAPAC) in 2002 with advocacy as one of its mandates.

Although some progress was noted in the growing number of political leadership involvement in advocacy activities related to HIV, much of it is reported to be based on the need to fulfill their public responsibilities rather than real commitment and accountability to the national response efforts. Further, the low level of advocacy had been attributed to lack of skills both among the political leadership and key stakeholders involved in HIV interventions. In an effort to enhance and broaden more effective advocacy by key stakeholders including media institution, TACAIDS successfully developed and launched the National Communication Strategy in November 2005 which was immediately followed with the drafting of Media Advocacy Strategy.

36 Evaluation team discussion with TACAIDS.
37 Review of NMSF (2003 – 07) reported in 2nd NMSF (2008-2012).

4.1.1 Fighting stigma, denial and discrimination

Through advocacy activities, CSOs and the networks of People Living with HIV/AIDS (PLWHA) have made the public more aware about the issues associated with stigma, denial and discrimination and their implications for PLWHA. PLWHA have been recognized as a force in the overall national response against the epidemic and are now represented in key HIV Committees tasked with coordination of multi-sectoral initiatives in the country.

Stigma and discrimination against PLWHA however, are still a major challenge marginalizing infected individuals at the level of the family, workplace and the community and are creating unnecessary suffering. PLWHA are still being discriminated in accessing health care and other social services in violation of their basic human rights. The absence of an effective, national level PLWHA umbrella organisation in Tanzania may have worked against efforts to fight stigma and discrimination and reduce denial among the PLWHA. TACAIDS has for the past few years supported efforts towards the formation of a National Council of PLWHA (NACOPHA). This umbrella body has faced challenges relating to clarity of mandate and competition between members [38]. Discussions have continued to iron out misunderstandings between members, differences of approach and there are positive indications towards growing consensus on the importance of the national council as a coordinating body for the PLWHA.

4.1.2 Regional, district and community response

The government has through the Prime Minister's Office Regional Administration and Local Government (PMORALG) established an HIV response structure through its "Decentralization by Devolution" policy covering the entire country with multi-sectoral committees on HIV at district, ward and village levels. This initiative was based on the understanding that the "fight against AIDS" has to be organised and coordinated by appropriate structures which are close to the communities and which can respond to the specific threats and opportunities. Since TACAIDS does not have regional and district offices, 11 Regional Facilitating Agencies (RFAs) were established, each covering two regions, as an extended arm of TACAIDS to provide technical and financial support to community based initiatives.

However, limited managerial and technical skills among the key local players in planning, implementing, monitoring and evaluating community specific programmes have become a major impediment in providing effective local responses to HIV[39]. Furthermore, while all the councils have established functional CMACs and training was provided to council members, the respective committees are yet to be established in some wards and villages. Finally, the 'Three Ones' Principle which has been guiding the National Response appears to be compromised in some regions and LGAs due to lack of relevant technical capacity and limited experiences by actors to form partnerships and collaboration between sectors .

4.2 Mainstreaming HIV and AIDS

HIV/AIDS mainstreaming is a sub-component under theme one (cross-cutting issues) in the NMSF 2003 – 2007. This section of the report documents the efforts made in this area by Norway and Government of Tanzania in implementing a true multisectoral response. Norway identified a need to mainstream HIV/AIDS early during the period under evaluation. The embassy mainstreamed HIV/AIDS into two key projects during the period evaluated considering the need to mitigate risks of HIV infection as a result of the project and subsequent impact.

Two key projects supported by the embassy and which HIV/AIDS was mainstreamed were the Songwe-Tunduma Road Rehabilitation Project and Zanzibar Rural Electrification project and are discussed below. Other projects supported by Norwegian NGOs are also documented as well as discussion on HIV mainstreaming through public sector response.

4.2.1 Integration of HIV/AIDS interventions in the Songwe-Tunduma Road Rehabilitation Project:

HIV/AIDS was integrated as one of the components of the Occupation Safety and Health (OSH) issues on this project; and the workplace intervention on HIV/AIDS was seen as the

38 2nd NMSF 2008 -12.
39 Evaluation team discussion with TACAIDS.

most successful as far as OSH is concerned in the project. The key achievements recorded[40] by the interventions are tabulated below:

Table 3 Key achievements

No	Planned Activity	Achievements
1.	Sensitisation meeting of all workers and selection of peer educators	13 one day seminars reaching 435 labourers (54%), and 16 peer educators selected
2.	7 days training on peer education for 16 workers	- 15 out of the 16 workers trained as peer educators - pre and post workshop evaluations revealed 64% and 88% respectively, an indication that learning took place
3.	Conduct of peer education to fellow workers	Sessions conducted – but no documentation as regards numbers of workers and community members reached
4.	Distribution of condoms and IEC materials to fellow workers	Peer educators were active in distributing condoms and IEC materials
5.	Awareness creation on VCT and treatment of STI	- Peer educators were consulted by fellow workers for advice in regard to STIs - Peer educators also influenced some fellows to undergo male circumcision
6.	Drama and theatre performance on awareness creation on HIV/AIDS	Drama performances conducted in 30 villages
7.	VCT	122 labourers went for VCT (15%).
8.	Treatment of STIs	9,855 STI cases treated
9.	Support to Health Facilities	10 dispensaries received additional support including STI drugs

As can be seen from the table, several activities were carried out, but it is difficult to measure the results of the activities. The high number of STI that accessed treatment is a good result, but also an indication that people are engaged in unprotected sexual relationships. However, it is not known how many of these clients were construction workers, as the STI services had probably been poor before the project provided STI drugs[41]. It is also an indication of benefits accrued to the community members outside the construction workers in reducing vulnerability and susceptibility to HIV infection.

4.2.2 The Zanzibar Rural Electrification Project:

This project identified the need for the implementation of HIV/AIDS workplace interventions to protect company employees; immediate family members and company clients from acquiring HIV/AIDS. Activities conducted include rapid assessment of HIV/AIDS Knowledge and Sexual Practices among SFPC staff through training of staff on HIV/AIDS awareness, printing and distribution of pamphlets and distribution of male and female condoms for the staff of State Fuel and Power Corporation.

4.2.3 HIV Mainstreaming into the NPA Refugee Supported Programme.

This intervention took place in the Greater Lukole Camp located in Ngara district in the Kagera region in Western Tanzania. The camp was opened in 1993 to accommodate Burundian refugees and was later expanded to accommodate refugees located from other camps and further influxes. Considering the fact that refugees are at increased vulnerability to HIV transmission, implementation of HIV/AIDS prevention and care has been going on in the camps since 1997 and further collaboration of UNHCR, UNICEF and NPA resulted in the expansion of intervention to PMTCT following a baseline assessment conducted in December 2000. The expansion to implementation of PMTCT interventions was piloted from October 2002 to 2004 targeted the camp population of approximately 90,000 and the surrounding communities. The PMTCT intervention was reported to be the first in any refugee setting[42]. Interventions used include community sensitization, training of health care workers, VCT,

40 Report from the Assessment of HIV & AIDS Component of Songwe – Tunduma Road Rehabilitation Project (2007).
41 Mwisongo A. et al (2007) Report from the Assessment of HIV/AIDS Component of Songwe-Tunduma Road Rehabilitation Project in Tanzania Mainland.
42 Rutta et al (2008).

infant feeding, counseling and administration of Nevirapine. Main outcomes include increase in HIV testing acceptance rates, percentage of women receiving post test counseling, increase in Nevirapine uptake and reduced HIV prevalence among pregnant women and their infants. Ninety-two percent of women (n=9,346) attending antenatal clinics accepted VCT.

All women who were tested for HIV received their results and post test counseling. The HIV prevalence rate among the population was 3.2% (301/9346) and overall nevirapine intake was 97%. Only 14% of male counterparts accepted VCT. Due to repatriation, parent's refusal and deaths, HIV results were available for only 15% of infants born to HIV infected mothers. Overall the HIV programme was successfully integrated into existing antenatal care services in the community and was acceptable to the majority of pregnant women. The project was faced with the challenge of repatriation of refugees before administration of nevirapine, which made it difficult to measure the impact of the PMTCT programme. The success of the programme has been documented in an international journal to disseminate the learning (Rutta et al, 2008).

4.2.4 HIV mainstreaming by Norwegian NGOs and Partners:

The partners of Norwegian Church Aid mainstreamed sexual and reproductive health including HIV/AIDS to the DogoDogo Street Children and Masai Girls programme, Norwegian People's Aid and TCRS succeeded in mainstreaming HIV/AIDS into refugee programmes, EMIMA mainstreamed into sport activities, KWIECO and WLAC also integrated HIV/AIDS into provision of legal services and promotion of human rights.

4.2.5 HIV mainstreaming and public sector response:

HIV/AIDS was seen as a developmental issue and documented in the MKUKUTA and further development of the NMSF 2003-2007. In addition, a paper was presented on "Mainstreaming HIV/AIDS in the Poverty Reduction Strategy" to stakeholders at the annual review of the Multisectoral Response Against HIV/AIDS in Tanzania in 2004 which spelt out the impacts of HIV/AIDS and linkage to the MDGs and recommendations on how various sectors will advance HIV mainstreaming. The report on public sector response obtained from the World Bank in Tanzania revealed that funds allocated to MDA to cater for the public sector response has increased from one billion Tshs in 2003/04 to 3.5 billion in 2006/07. 20 MDA have so far conducted situational and impact analyses on the effects of HIV on their sector and strategic plans have been developed for five years including appropriate interventions to counter the negative effects of the epidemic on their workforce (internal mainstreaming) and 'target-group' (external mainstreaming). The plans have been used to prepare Medium Term Expenditure Framework (MTEF). Despite the increment, only Ministries of Education and Health have been more advanced in the implementation of the plans as compared to other MDA. Nevertheless, other MDAs have at least one component of the HIV mainstreaming activities especially in relation to condom supply and awareness creation. All the MDAs have their Technical Advisory sub-committees in place and HIV Focal Point Persons which in most cases are officers who are not at decision making level, which has had negative implications in advancing mainstreaming responses in the various MDAs.

Lessons learnt from mainstreaming efforts by the public and private sectors show lack of comprehensiveness and sustainability due to lack of leadership and commitment, inadequate technical skills to execute the programmes, and limited human and financial resources. Experiences from the district response initiatives show lack of integrated planning in the execution of district, ward and village level responses to HIV. Non-health and health planning officers appear to be working in isolation both in analysing and monitoring the impact of the epidemic and its implications to development. This has been one of the reasons for the low progress in mainstreaming of HIV in MKUKUTA.

4.3 Prevention

The thematic area of prevention in the NMSF of 2003 to 2007 focussed on reducing the spread of HIV and increased knowledge of HIV transmission in the population and key intervention areas that have been supported by development partners. Norway has made significant contributions in supporting prevention measures by providing resources to Governments and CSOs, a number of which have developed innovative interventions to increase awareness and hence influence behaviour to reduce the incidence of HIV/AIDS.

Various interventions supported by Norway directly or indirectly are documented below with their outputs.

4.3.1 Sexually Transmitted Infection (STI) control and case management

Significant progress has been made in expanding STI services in the country. By the end of 2006, services for STI syndromic management were available in all hospitals, all health centres and about 60% of dispensaries. More than 400,000 patients with STI were reported to have been diagnosed and treated in health facilities in 2006, compared to 223,000 in 2003[43]. However the 2005 evaluation of STI delivery revealed low usage of services by young people, frequent drug stock-outs and lack of systematic counselling of STI patients to use condoms and the importance of HIV/AIDS testing. Regrettably there is no quantitative data on the prevalence of STI nationally during the period under evaluation as there is a close relationship between STI infections and the spread of HIV.

Norway funded the Haydom Voluntary AIDS Control Programme (HAVACOP) within Haydom Lutheran Hospital in Mbulu District, and STI control and management was a key component of the programme. The STI component commenced in December 2004 and was not only confined to tests at the hospital and health centres. The Male Mobile Clinic was introduced targeting men who did not come for testing at the health facilities. There was significant interest in the service which combined advocacy work on STI and measures to avoid it and what to do once you have contracted it. Whilst the statistics of STIs available are for one year, they indicate high levels of STI infection (27%) in these remote communities in Manyara region, posing serious risks for the vulnerable segments of the female population.

The Male Mobile Clinic concept (the service was available to women as well) is an innovative approach in penetrating remote parts of the country, with high levels of poverty and difficulties in accessing health facilities.

4.3.2 Condom promotion and distribution

Promotion and distribution of condoms has always been a prerogative of MOHSW and done through health service outlets, but the introduction of social marketing of condoms which also includes female condoms has complemented and even surpassed the free distribution of condoms through the health facilities. There has been increased availability of male condoms from 50 million in 2003 to 150 million in 2006, the demand level was quite significant compared to female condoms. It was reported that 780,000 female condoms were distributed in 2006[44]. It is hard to tell if availability equates to demand and usage of condoms. Condoms are funded through Global Fund. HAVACOP as part of its awareness campaign to increase knowledge of HIV also utilised part of its resources from Norway to purchase condoms that were freely distributed to communities during the STI campaigns to reduce levels of infection and potential exposure to HIV.

There is no quantitative data to indicate the number of condoms distributed in the communities. This initiative in condom distribution through private and non-governmental facilities is a demonstration of the need to spread the channels for distributing condoms in the fight against HIV to avert the uneven distribution of condoms between rural and urban communities. Condoms have mainly been an urban phenomenon during the period under review and the uptake of female condoms has been low due to cost, acceptability especially in the rural communities due to cultural and religious sensitivity. There is a suggestion that the low uptake of female condoms is partly due to the way the female condom is designed and women's perceptions of the condom being negative. Broadly there are issues about availability of the female condom on the market, and that demand is high for male condoms as this is a recognised form for prevention.

4.3.3 Information, Education and Communication (IEC)

The Norwegian contribution has made it possible for the CSO/NGOs government institutions and the private sector to increase the level of awareness on HIV/AIDS. The interventions by CSOs funded by Norway included developing key messages on sexual behaviour and change, sensitization and awareness creation, outreach trips to workplaces, high risk areas, campaigns

43 NMSF (2003 – 2007) review report documented in 2nd NMSF (2008 – 12).
44 NMSF (2003 – 2007) review report documented in 2nd NMSF (2008 – 12).

and outreaches using popular opinion leaders (POL), mass events and activities including concerts and use of high profile hip-hop and Bongo-Flava artists, community wide rap concerts and testimonials by PLWHA, sports and cultural events followed by discussions on HIV/AIDS[45]. IEC materials including posters, t-shirts, khangas etc. have been distributed to communities making a significant contribution to increasing awareness and reducing discrimination and stigma against those that are positive. It is noted however that discrimination and stigma are a real challenge that needs addressing.

The table below gives an indication of the number of people reached by IEC campaigns to increase awareness on HIV/AIDS by CSOs funded by Norway. These activities were in the regions of Kagera, Kigoma[46],Kilimanjaro[47], Manyara[48]and Tanga.[49]

Table 4: Attendance at functions to raise awareness of HIV/AIDS issues

Activity	2003		2004		2005		2006	
	Community	Schools	Community	Schools	Community	Schools	Community	Schools
Outreach Number attending	136642	118889	99601	100450	25612	20023	103333	9267
IEC Materials T-shirts Caps	50000 5000 3000							
Concerts/ Events[50]	8000	24000					12000	

The table has been constructed using information collected during the interviews. This serves to confirm the work being done by CSOs as part of the strategy to increase awareness. Whilst the figures might be low it indicates contribution to awareness to the national effort that is coordinated by TACAIDS. HAVACOP has attempted to measure the impact of its awareness programme and its results have still to be made available.

FEMINA HIP education programme succeeded in the production and distribution of FEMA magazine[51] which grew from 15,000 to 95,000 every quarter. Each quarterly issue reaches over one million readers with an estimated readership of 12 persons per copy. The organisation also published two booklets of 150,000 copies on "Living Positively with HIV/AIDS" in partnership with soul city, with funding support from RFE. The publication of Si Mchezo magazine produced bi-monthly 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[52].

EMIMA – reached over more than 3,000 youths in 2006 alone through their various programs which are delivered through 7 centres in Dar es Salaam and also outreach activities in Arusha and Moshi. The Kicking Aids Out games and peer coaching were expanded to reach out to more youths and people in the community. The success of the programs relied heavily on the commitment and performance of peer leaders, project coordinators, facilitators, and sports managers[53].

4.3.4 Voluntary Counselling and Testing (VCT)

There has been a considerable increase in the number of VCT sites from 289 in 2003 to 1027 in 2006. The National AIDS Control Programme (NACP) has been the main institution in establishing VCTs. Increasingly the CSOs are setting up VCTs and this has been made possible through project funding direct or indirect to the CSO/NGO sector from development partners including Norway. Campaigns and outreaches on awareness have also been targeting

45 CSOs include WAMATA, KWIECKO, KIWAKKUKI, TCRS, EMIMA ,HAVACOP and MEUSTA - YETU.
46 TCRS.
47 KWIECO, KIWAKKUKI.
48 HAVACOP.
49 MEUSTA-YETU.
50 Kibondo Refugee Camps.
51 At the launch of the project, the magazine was known as 'Femina'. This was subsequently changed to 'Fema' thus differentiate the magazine from the project.
52 Femina HIP Limited Final Report (2006).
53 EMIMA Narrative Report (2003).

people and encouraging them to know their status and take reasonable steps to protect themselves. The number of people tested increased from 57,223 in 2002, to 140,000 in 2003 and increased significantly to 680,520 in 2006[54]. Despite this considerable roll out, the uptake of VCT is quite low in the country. According to Tanzania HIV/AIDS Indicator Survey (THIS, 2003/04), only about 15% of men and women are reported to have undertaken an HIV test. Women and men living in urban areas are two to three times more likely to have been tested than those in rural areas. One of the reasons for the low uptake is related to limited access to VCT services, particularly in the rural areas. Low public awareness about the benefits of knowing one's HIV status, insufficient human resources with skills in counselling and fear of stigma are also barriers to increased VCT utilization.

Norway has funded CSOs to set up VCT facilities in addition to those set up by NACP. In the HAVACOP programme, at Haydom Lutheran Hospital, selected staff have been trained to conduct tests and provide counselling. Table 4 illustrates the level of uptake of VCT services conducted by two CSOs that have received project funding from Norway. The table also has information on PMTCT and tests that have been carried to ascertain the status of pregnant and nursing mothers.

Table 5: Number of VCT and PMTCT tests carried out

Service[55]	2003	2004	2005	2006[56]
VCT	10542	12677	19127	8276
PMTCT	5337	8733	12749	4849

There is a 'positive association' between HIV/AIDS awareness campaign and the number of those going for testing at VCT centres. This is demonstrated by the experience at Haydom Lutheran Hospital; however the uptake for the service as a percentage of the adult population is low which confirms the concerns at the national level.

4.3.5 Prevention of Mother-to-Child Transmission (PMTCT)

According to TACAIDS, about 12 % of eligible women are reported to have received a course of ARV to reduce the transmission of HIV to their children on delivery in 2006. By end of 2006, there were 334 PMTCT centres in the country providing counselling and testing for pregnant women, short course preventive regimens to prevent mother to child transmission, counselling and support for safe infant feeding practices, family planning counselling and referral for long-term ART for the child. However, the PMTCT programme is faced with the challenge of poor return rate of pregnant women to deliver in hospitals (89% attend ANC but only 49% deliver in the health facilities basically due to poor state of infrastructures and lack of privacy in most cases), and the rate of effectiveness cannot be determined due to poor return rate thus making it difficult to affirm HIV status amongst these infants and children. The lessons learnt from the MoHSW and UNICEF initiated pilot project informed the need to scale up PMTCT services to 710 health facilities by end of 2006 to address low coverage and increase uptake of PMTCT services, but this was met with the challenges of over-centralised planning of the roll out of services, stock-outs of ARV drugs due to forecasting and supply/ logistic problems.

The funding of HAVACOP by Norway demonstrates the importance of decentralization in the management of health facilities and in conducting VCT and PMTCT tests at the local level. There is however an issue of failure by NACP to supply ARV drugs for those that tested positive. HAVACOP provided scope for collaborative research on PMTCT, HAART, OI treatment and clinical research with Sørlandet Hospital, Kristiansand and Ullevål University Hospital, Oslo. The research done contributed to a better understanding of the treatment regime, importance of adherence to treatment. Whilst the research was highly technical, it included the development of treatment literacy brochures distributed to PLWHA. There is no documentation to indicate that NACP has benefited from the research that has been conducted. The expansion of HIV mainstreaming in refugees' programmes to include PMTCT is already documented above in the section on HIV mainstreaming.

54 TACAIDS (2008) National Multi-sectoral Strategic framework report for the period 2003-2007.
55 Facilities at Haydom Lutheran Hospital and WAMATA's branches, three of which were constructed with funding from NORAD.
56 Haydom Lutheran Hospital figures cover up to May 2006.

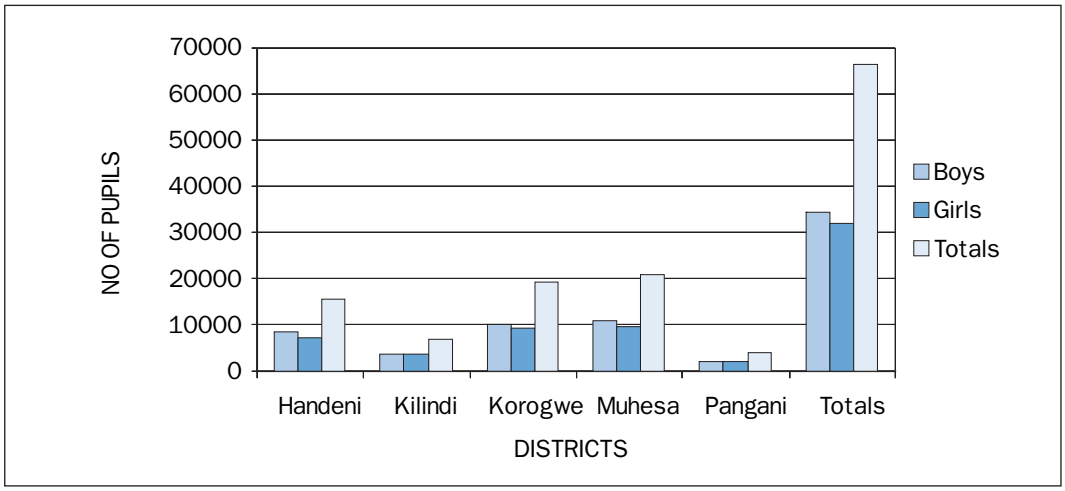
4.3.6 School based prevention for primary and secondary level

According to TACAIDS review of the NMSF 2003 – 2007, the Ministry of Education and Vocational Training had an Education Sector Strategic Plan for HIV/AIDS, guided implementation of a comprehensive HIV and life skills training in schools and teachers' colleges. They have mainstreamed HIV into the education curriculum, however the process of implementation differs from school to school. Guidelines and structures are in place for implementation and to monitor implementation however there have been limited resources coming through TMAP. Progress has been made in some schools in having counselors selected by the school community, peer educators responsible for extra curricula activities at which HIV/AIDS are discussed by pupils. There are varying degrees of activities around spreading the messages about HIV/AIDS and prevention. All secondary and about 1,500 primary schools are at different stages of implementing the strategy[57].

Fema magazines are distributed quarterly at the rate of 50 copies per school and have reached a total of 1,530 secondary schools in all regions. The Fema magazines have been confirmed as the main material for teaching HIV/AIDS in the school and formation of Fema clubs also play an important role in HIV/Sexuality education in schools. HIV and Sexuality education have also been integrated into Moral Ethics and Environmental Studies – a curriculum developed Ministry of Education and Vocational Training Zanzibar in collaboration with development partners[58].

The MEUSTA – YETU, the HIV/AIDS School Education Project funded by Norway through the Norwegian Nurses Association, has proved to be a successful model in mainstreaming HIV/AIDS into education and involving members of the local community. Fig. 5 showed the number of pupils taught in the five districts that benefited from the 2nd phase of the project as reported by the one year post project review conducted in 2006.

Fig. 5: Pupils Receiving Hiv/aids Education As At 2006



The national educational authorities visited the programme and looked at options of replicating it in other regions. It was however difficult to establish how far national authorities took the ideas of MEUSTA-YETU into account in mainstreaming HIV/AIDS into the curricula.

4.3.7 Workplace interventions (public, private and informal sectors)

The TACAIDS NMSF review (2003 – 2007) suggests that public and private sectors have initiated limited workplace programmes on HIV. The AIDS Business Coalition of Tanzania (ABCT) initiative in the business sector has resulted in a number of companies introducing prevention and care measures for employees. The membership of ABCT has grown from 23 members in 2004 to 52 members in 2006. Most MDAs have developed some HIV workplace programmes for their staff, overall, the implementation level of these programmes has been quite slow due to lack of sector specific HIV and AIDS policy, leadership, commitment and

57 Discussion with HIV/AIDS Programme Coordinator, Ministry of Education & Vocational Training, Dar es Salaam.
58 Femina HIP Limited Final Report (2006)

skills among the focal persons and Technical AIDS Committees (TACs) in implementing the planned activities. At the end of 2006, 39 MDAs have at least one component of HIV/AIDS interventions that was being or has been implemented. These include sensitisation activities, training of workplace peer educators, IEC materials and condom distribution.

4.4 HIV/AIDS Care and Treatment

The 3 by 5 initiative in which Norway was a key stakeholder pushed the boosted chances for government of Tanzania to receive donor support for the National Care and Treatment Plan (NCTP) that was developed before 2003. Norwegian support was in line with the global of 3 by 5 initiative of WHO to scale up treatment for PLWHA. Prior to the implementation of the NCTP, Norway initiated a regional programme that included Tanzania to strengthen capacity of district health structures that were critical in the provision of treatment and care of PLWHAs. In collaboration with WHO as an implementing partner, Norway funded "Strengthening District Health Systems To Address Priority Health Problems Project". Outputs included:

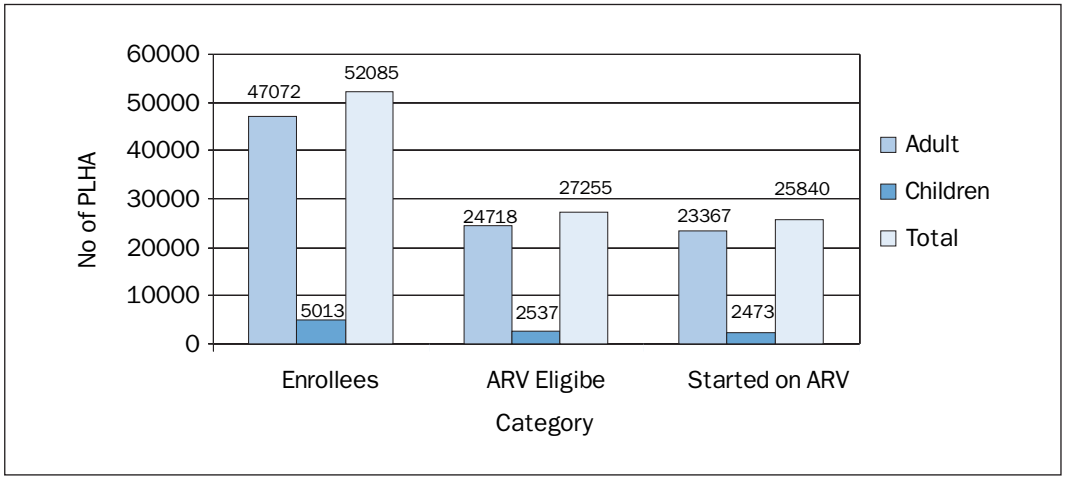
- capacity to generate and use evidence for decision-making enhanced;
- national capacity to respond to and adequately support the needs of the district health system enhanced;
- capacity to operate a district health system strengthened;
- selection and coverage of priority health interventions improved;
- community participation in health development; Education and practice in health sciences strengthened; and
- functional monitoring, evaluation and management mechanisms of the project set-up[59].

This pilot project provided was a good indicator to NACP National Care and Treatment Plan on the issues to be addressed in strengthening health infrastructure to support the scaling up of ART.

The National AIDS Control Programme in the Ministry of Health and Social Welfare had the mandate to make ARVs available to those infected by the pandemic. The government with the support of development partners including Norad developed a NCTP to guide the procurement and distribution of ARVs, the procurement and distribution of laboratory equipment, reagents and supplies for ART sites, training of care and treatment teams. Norwegian funds (Tshs 1.3 billion) were used to procure Haematology and Chemistry testing equipment[60] distributed to 10 regional hospitals and 13 districts as part of strengthening health facility structures in order to scale up distribution and use of ARVs to treat infected patients.

According to the NACP progress report (2006), a total of 714 health care workers (HCW) from the selected 104 sites were trained and additional support in the form of practical and theoretical training was provided by collaborating partners. It is however worth noting that the uptake of ARVs has been slow.

Fig. 6: Distribution of PLHA on ARV from 96 Health Facilities from Oct. 2004 to Jan. 31, 2006



59 WHO (2005). Strengthening District Health Systems to Address Health Problems.
60 MOHSW (2006) Report on the progress of the National Care and Treatment Plan: January to December 2005.

Up to 31st January 2006, the ART Programme had enrolled a total of 52,085 patients/clients. Among them, children aged under-15 years were 5,013 and adult male and female were 47,072. The programme identified 27,255 (52.3% of enrollees) as ARV drug eligible patients. Of the ARV eligible patients, 25,840 (94.8% of ARV eligible) were started on ARV drugs and the remaining 1,415 (5.2%) were still undergoing preparations for ARV therapy. Among the 25,840 patients who started on ARV drugs, 2,473 were children aged under-15 years old. These children constitute 9.6 per cent of all patients started on ARV drugs. Nearly half (49.3%) of children enrollees were started on ARV drugs. Among 1,415 patients eligible for ARV drugs undergoing preparations for ARV therapy 67 (4.5%) were under-15 years old[61].

By the end of 2006, TACAIDS reported that out of a total of 400,000 to 500,000 in need of ART, only 70,000 persons were receiving ARVs through public and private hospitals representing 16% of those in need of treatment; a substantial increase from about 2,000 persons in 2003.

The Counselling and Social Support Services in line with provision of Care and Treatment achieved the following;

- Reviewed the National VCT and HBC Guidelines to reflect the roles of Counsellors and HBC providers in ART services particularly in the ARVs adherence support
- Reviewed the national Curriculum for training Counsellors and HBC providers at health facility and community levels
- Developed a Curriculum to train community based ART and DOT supporters
- Conducted refresher trainings to the District Counsellors and HBC trainers to specifically equip them with ART knowledge and skills in which participants were trained regarding their roles on referral and networking with CTCs.

The IEC unit also developed and printed materials, covering areas of the introduction of ARVs in the country, the use and the importance of adhering to treatment. They included calendars (280,000), brochures (1,151,000), posters (294,000) and news letters (400,000). Other programme print materials; Health Sector strategy (2,000), Clinical Guidelines for Management of HIV/AIDS in Tanzania (20,000), Summary of Health Sector Strategy (10,000) and National Care and Treatment Plan (1,000). These materials were distributed to all ART sites providing treatment.

In terms of addressing critical issues of Human Resource for Health, Norwegian Support to Benjamin William Mkapa HIV/AIDS Foundation have recruited, trained and posted 30 fellows to underserved rural districts as at September 2006 and this has grown to 99 fellows in 2007 serving in 30 rural districts.

4.5 Community and Home Based Care (CHBC)

Closely associated with treatment is the issue of care and support for those on ARVs when outside the hospital setting and those that are positive but not eligible for ARVS and requiring support and treatment for Opportunistic Infections (OIs). According to the figures from TACAIDS, there were 1.2 million persons in need of drugs for OIs and it is clear that resources are overstretched to meet the additional demands for opportunistic infections. Communities and CSOs have played a critical role in providing care and support for those that are infected. The WHO has supported the development of Community and Home-based Care guidelines for use by CSOs in terms of treatment and nutritional support particularly for those on ARVs.

CHBC has proved to be a major challenge in terms of supporting those infected and affected by the pandemic. CSOs and CBOs and networks of PLWHA have been pivotal in offering services that include treatment of opportunistic infections, economic and social support for persons, families and communities affected by AIDS. There is a multi-pronged approach that includes MOHSW and civil society sector working with international development partners to strengthen capacity of CSOs/CBOs and networks of PLWHA to provide care and support including personnel without a health background. 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 to secure funding for care and

61 The references for all the outputs in section 4.4 include MOHSW NACP (2006) Progress Report of the National Care and Treatment Plan (2004 – 06). & 2006/07 Annual Report of the BMFP.

support. The UNDP attached UNVs to 136 districts in Tanzania Mainland and Zanzibar to strengthen CSO networks and support CSOs in applying for resources. The World Bank TMAP enabled TACAIDS in building structures Regional Facilitating Agencies (RFA) in regions within the local government authorities to provide technical support to CSOs and CBOs in making applications for resources. The weaknesses in the reporting mechanism have not made it possible to quantify the level of care and support being given to PLWHA. Estimates made by WHO (5000 persons receiving care and support) indicate a low level of support from community and home based care. Despite impressive numbers of support projects major concerns remain about the quality of care and support provided, the availability and adequacy of supplies including drugs and supervision of these projects.

4.6 Social and Economic Impact Mitigation

The devastating impact of HIV/AIDS has eroded the coping mechanism of social and family networks to support infected and affected families, orphans and other vulnerable children. According to TACAIDS, over 1600 CSOs have secured resources including the TMAP Community AIDS Resource Fund (CARF) and are actively engaged in income generating activities to support the affected and infected. One of the major challenges is the orphans and most vulnerable children and the response from government institutions to deal with this issue. It is estimated that there are 2.2 million orphans of which 1.1 million are the most vulnerable. Norway contributes through a number of channels including direct budget support, basket and project funding to support the vulnerable groups. The support has focused on providing orphans with educational opportunities and making provisions for food, shelter and clothing. During the period under review, Norway supported WAMATA a network of those living positively with resources to provide nutritional food for those on ARVs and IGAs for their day to day upkeep.

CSOs have actively participated in providing for orphans, by paying fees and purchasing uniforms and books. The support has also included providing resources to those looking after orphans to ensure that they have nutritional food for healthy living. Some innovative outputs included empowering of families looking after orphans by developing their micro-enterprise business skills and providing small loans to embark on income generating projects[62]. Media (film production) has been used to create awareness of the impact of the epidemic on the OVCs and highlighting government responsibility to OVCs[63].

The visit by Consultants to some of the CSOs providing services to OVCs gives an indication of the efforts being made to ensure OVCs are catered for at the local level. The CSOs' annual reports, where available quantify the numbers benefiting from the interventions (see table 5) and what seems not to be available is the national picture of the support to OVCs. The table 5 below shows support given to OVCs and PLWHAs to ensure quality of life and opportunities opened for OVCs.

Table 6: Number of OVCs and PLWHA supported by CSOs

Types of Intervention	2003	2004	2005	2006
	No of OVCs supported by CSOs			
Educational support for OVC[64]	9195	2517	7	1775
Nutritional support[65]		2250	2802	3850
Shelter[66]			17	
IGA support Families[67]		200		88
Food and Nutritional support for PLWHA[68]	830	2075	1187	2227

The support at local level for impact mitigation by CSOs indicates dedication and commitment at the grass roots level and the degree of flexibility in deciding what to support on the basis of available resources. The Norwegian support strengthens the argument for

62 SOS Village Arusha.
63 Abantu Visions.
64 WAMATA and KIWAKKUKI and SOS Village.
65 KIWAKKUKI, HAVACOP and SOS Village.
66 KIWAKKUKI constructed houses for OVCs.
67 KIWAKKUKI provided soft loans for families supporting OVCs. SOS had a similar scheme 'Family Strengthening Programme' offering training and soft loans.
68 KIWAKKUKI and HAVACOP.

decentralization in the provision of services involving greater participation of civil society, with local government playing a coordinative role. The CSOs are at the same time filling the gaps as there are limited resources coming from central government.

Norwegian Church Aid through their partners also provided support to significant number of OVCs during the period. For example, Christian Council of Tanzania supported 590 orphans in 2006 alone. WLAC and KWIECO interventions provided litigation support to widows and orphans especially in relation to inheritance issues to prevent further impoverishment.

4.7 Partnership Strategy

There is no documented partnership strategy in place determining criteria and selection of partners that engage in implementing programmes or being channels of Norwegian resources. Practice seems to show that Norway is guided by the broad principles of collaboration with other development partners in supporting the Paris Declaration on Aid Effectiveness and the Three Ones principle.

The vision for reducing the spread of HIV/AIDS, provision of treatment, care and support for impact mitigation is the basis for entering into strategic partnerships at different levels. The first one already referred to above is partnership with other development agencies operating in Tanzania. Norway is a member of the Development Partners Group on HIV/AIDS (DPG –AIDS) that meets regularly to review strategies in supporting the national response in Tanzania. Norway and other like-minded donors entered into a partnership arrangement to mobilise resources for provision of ART, and RFE and CSF to support CSOs providing services for the infected and affected. This experiment has raised interest in looking at alternative funding channels targeting CSOs in the event that direct budgetary support proves inadequate as a channel to fund CSO interventions in the national response.

Norway has also entered into a 'functional' partnership strategy taking the form of a contractual relationship on funding arrangements. Whilst an element of common vision still remains, primacy is given to the funding arrangements and recipients held accountable for using the resources. The arrangements have details on disbursements and reporting. This is the relationship that existed for HAVACOP project in Haydom. Another form of functional partnership used by Norway is the framework agreement with Norwegian NGOs to act as funding intermediaries for Norwegian Church Aid, NPA or local Norwegian NGOs with partnerships abroad such as Norwegian Nurses Association supporting Tanga Regional Authority HIV/AIDS Education project, JURK supporting KWIECO in Moshi. This strategy removes the burden of accountability on the Norwegian government.

The multiple partnership strategies have been effective as channels for mobilising resources and for allowing relationships between Norwegian NGOs and CSOs in Tanzania to exist. But these varied relationships have not really created avenues for sharing of experiences and expertise in responding to HIV/AIDS pandemic.

4.8 Effectiveness of Norwegian Contributions to HIV/AIDS Responses

This evaluation revealed that Norway's contribution has been significant in supporting the national response to HIV/AIDS. The contribution has been relevant in that it has been based on priorities determined in the context of NMSF and has targeted specific interventions. The magnitude of resources contributed during the period under review is documented in chapter 3.

Partners such as the NACP commended Norway for being the first development partner to support Tanzania on the screening of blood before transfusion to ensure blood safety in 1987. According to the head of NACP, this route of transmission has been eliminated today (NACP 2007[69]). Norway was also commended by the NACP for being the first development partner to support national care and treatment plan in 2003 (NACP 2007). Norwegian resources have also supported the Foundation of Civil Societies, an organisation building the capacity and providing grant support to CSO engaged in poverty reduction efforts as set out in the Government of Tanzania polices (Vision 2025; Tanzania Assistance Strategy and Poverty Reduction Strategy documents). Norwegian resources also provided support to CSOs working in the following areas:

69 Discussion with the NACP Programme Manager by the Evaluation team.

- Prevention, advocacy, information/education/communication, and behaviour change communication
- Care and support for HIV/AIDS and related opportunistic infections
- Impact mitigation of the effects of the epidemic, including orphans and vulnerable children
- Research to provide baseline information or assess effectiveness
- Institutional strengthening, including capacity building in monitoring and evaluation
- Interventions for children aged 0—8 years who are HIV infected or affected by HIV/AIDS.

Box 1: Partners' Perceptions of Norway's Contributions

- NACP commended the pivotal support from Norway in funding the MKUKUTA budget, and HIV/AIDS programs like National Care and Treatment Plan especially in filling gaps for the take-off of the Anti-retroviral Therapy programme.
- Norway is always interested in funding projects that other donors might not be interested in initially and such projects have always turned out to become innovative like Benjamin W. Mkapa HIV/AIDS Fellowship programme which addresses the gaps in human resource capacity to scale up HIV/AIDS Care and Treatment.
- Norway is valued as a key contributor when plans and strategies are being developed and documents reviewed in the DPG-AIDS meetings.
- Norway has supported many projects that are considered as the best practices in the HIV/AIDS response in Tanzania. E.g. HIV/AIDS school intervention project (MEUSTA), Femina Health Intervention Project which publishes and distributes a youth friendly magazine focussing on sexual and reproductive health and human rights issues.
- Norway including Norwegian NGOs funded our course and did not impose their projects. In addition they provided us with the required capacity to ensure that we succeed in implementing and managing the projects. Supervision provided is supportive and these have enhanced our capacity and changed our ways usual ways of operations.

Source: Interviews during the country visit

Norway has been an active contributor in supporting the National Care and Treatment Plan that emphasised procurement of ARV drugs and in strengthening health infrastructure. Norwegian resources were used in the procurement of ARVs for patients weighing less than 60 kg and facilitated the full take-off of the ART programme in the country. In addition, Norway's contribution was utilised for the procurement of Haematology and Chemistry testing equipments distributed to 10 regional hospitals and 13 districts as part of strengthening health facility structures to scale up ARV treatment and opportunistic infections.

As part of the programme to support care and treatment, Norway took a leading role by funding Tanzania Council for Social Development (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 to secure funding for care and support. This was a clear message to strengthening the multisectoral character of the response to HIV/AIDS. Norway's support to the Benjamin Mkapa fellowship programme provided skilled health and medical professionals that became key technical officers collaborating with and assisting the district health teams in strengthening the HIV/AIDS prevention, care and treatment. This effort has resulted in four fold increase and the usefulness of the programme has attracted interests. The Clinton Foundation provided funds for recruitment and training of additional fellows and the Foundation has been selected by MoHSW to implement Emergency Hiring Project (EHP) funded by GFATM. In addition, the achievements recorded by the fellowship programme prompted the inclusion of Mkapa Foundation as a member of Human Resource for Health Technical Working Group of MoHSW whereby experience of fellows programme and EHP is being used to guide policy strategic thinking towards addressing HRH crisis[70].

As a result of Norway's contribution towards the global initiative to make ARVs available, it was possible to get 70,000 people on ARVs through public and private hospitals representing 16% of those in need of treatment. This constitutes an important step towards resolving the

70 BMAF Annual Progress Report (July 2006 – June 2007).

blocks hindering availability of ARVs in the country and enabling appropriate steps to be taken to scale up.

Norway funded the Haydom Voluntary AIDS Control Programme (HAVACOP) within Haydom Lutheran Hospital in Mbulu District, and STI control and management was a key component of the programme. The STI component commenced in December 2004 and was not only confined to tests at the hospital and health centres. The Male Mobile Clinic was introduced targeting men who did not come for testing at the health facilities. The Male Mobile Clinic (the service was available to women as well) concept is an innovative approach in penetrating remote parts of the country, with high levels of poverty and difficulties in accessing health facilities.

The NUFU programme provided Tanzanian institutions with structural access to information, the latest technology, professional networks, and publication outlets within a framework of long-term and mutually beneficial relationships built on respect and shared interests. The partnership approach allows for broad participation in collaboration projects and a mutually beneficial exchange of staff and students.

The "UiB/UDSM Counselling, Education and Health Promotion: A Research and Competence Building Programme" has trained 85 students in total. Of these, 6 have been trained at a PhD level, 79 trained at masters level (49 have graduated, 30 are on-going). Most of the projects conducted by these students during their study term were on HIV/AIDS prevention, care and treatment and impact mitigation. When students graduate, they are absorbed in jobs that require counselling profession, and most of the students were employed by NGOs working in HIV/AIDS field such as AMREF or were employed as educators. Already, some are working as Deans of Students or as Assistant Lecturers in various universities and colleges. A major challenge was lack of information on where most of these graduates are employed. But a snowball sampling was utilised to reach 7 of the graduates who are currently working as educators[71]. But the assumption is that since most of these students are trained as counsellors, they would be working in the counselling profession especially with the expansion and promotion of VCT in the country. In addition, the graduates consulted reported that they were directly involved in the control of HIV/AIDS through counselling of students at their workplaces.

Norwegian funding was also directed to NGOs providing orphans with educational opportunities and making provisions for food, shelter and clothing protecting the rights of children and marginalised and vulnerable groups. Through these resources, innovative outputs achieved included empowering of families looking after orphans by developing their micro-enterprise business skills and providing small loans to embark on income generating projects, media (film production) used to create awareness of the impact of the epidemic on the OVCs and highlighting government responsibility to OVCs.

Norwegian support to CSOs made it possible to develop key messages on sexual behaviour and change, sensitization and awareness creation programmes, outreach trips to workplaces, high risk areas, campaigns and outreaches using popular opinion leaders (POL), mass events and activities including concerts and use of high profile hip-hop and Bongo-Flava artists, community wide rap concerts and testimonials by PLWHA, Sports and cultural events followed by discussions on HIV/AIDS. The CSOs have distributed IEC materials including posters, t-shirts, khangas etc. to communities making a significant contribution to increasing awareness and reducing discrimination and stigma against those that are positive. It is noted however that discrimination and stigma are a real challenge that still needs addressing.

Norway has funded CSOs to set up Voluntary Counselling & Testing (VCT) facilities and train counsellors to carry tests and provide counselling. This support strengthens local capacity to offer VCT. The lessons learnt from the MOHSW and UNICEF initiated pilot project provided the initiative to scale up PMTCT services to 710 health facilities by end of 2006. According to TACAIDS about 12 % of eligible women are reported to have received a course of ARV to reduce the transmission of HIV to their children on delivery in 2006.

71 Another graduate that benefited from the programme is Suzan Lyimo - a member of parliament, but difficult to get hold of her since the house was in session to obtain her perception of the programme and how the graduates have been well utilised in the country.

Norwegian resources have been used to procure ARVs for pregnant and nursing mothers. They have also funded clinical research on PMTCT to increase the effectiveness of the programme in preventing transmission from mother to child.

The MEUSTA – YETU, the HIV/AIDS School Education Project funded by Norway through the Norwegian Nurses Association has proved to be a successful model in mainstreaming HIV/AIDS in education and involving members of the local community. The national educational authorities visited the programme and looked at options of replicating it in other regions. It was however difficult to establish how far national authorities took the ideas of MEUSTA-YETU into account in mainstreaming HIV/AIDS into the curricula.

Norwegian Church Aid (NCA) support to their partners has energised faith response to HIV/AIDS in the country. The DogoDogo Street children programme and the Masai Girls Programme have empowered children and youth to reduce vulnerability to infection. In addition the NPA initiation of PMTCT interventions in refugee settings have been documented in an international journal to disseminate learning from the project.

The connectivity of some of Norwegian support also added value to the response. For example, the support to the study conducted on HIV/AIDS orphan and the film produced on "Childhood robbed" has been very significant in raising the plight of the orphans especially amongst the policy makers and donors. This film has received numerous awards including an award from UNICEF and has been shown on state and private owned TV stations.

Having a dedicated Programme Officer managing HIV/AIDS programme during the period evaluated in the embassy has been effective in ensuring contribution of Norway to support policy issues and national response as a whole. The HIV focal officer represented Norway at various meetings of DPG on HIV/AIDS and that of DPG and TACAIDS. In addition, Norway also served on steering committee of RFE to approve decisions of projects to be funded. The functional position of the Programme Officer has also contributed to the limited connectivity of interventions via the meeting of stakeholders benefiting from Norwegian resources that are held once in two years. Shift of Norway priority areas of interventions in Tanzania and change of the responsibility of the HIV/AIDS focal person will create a vacuum irrespective of which aid modality is adopted.

Summary of Delivery of Outputs

- Development partners including Norad supported Ministry of Health and Social Welfare in the development of a national care and treatment plan to guide the procurement and distribution of ARVs.
- By the end of 2006, out of a total of 400,000 to 500,000 in need of Anti-retroviral Therapy only 70,000 persons were receiving ARVs through public and private hospitals representing 16% of those in need of treatment.
- WHO has supported the development of Community and Home-based Care guidelines for use by CSOs in terms of treatment and nutritional support particularly for those on Anti-retrovirals.
- 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 to secure funding for care and support.
- Significant progress has been made in expanding STI services in the country. STI syndromic management services are available in all hospitals, health centres and 60% of dispensaries.
- There has been increased availability of male condoms from 50 million (2003) to 150 million (2006) demand levels quite significant compared to female condoms 780,000 condoms distributed in 2006.
- The Norwegian contribution has made it possible for the CSO/NGOs government institutions and the private sector to increase the level of awareness on HIV/AIDS.
- There has been a considerable increase in the number of VCT sites increasing from 289 in 2003 to 1027 in 2006.
- According to TACAIDS about 12 % of eligible women are reported to have received a course of ARV to reduce the transmission of HIV to their children on delivery in 2006.
- MEUSTA – YETU, the HIV/AIDS School Education Project funded by Norway through the Norwegian Nurses Association has proved to be a successful model in mainstreaming HIV/AIDS into education and involving members of the local community.
- The AIDS Business Coalition of Tanzania (ABCT) initiative in the business sector has resulted in a number of companies introducing prevention and care measures for employees.
- The multiple partnership strategies have been effective as channels for mobilising resources and for allowing relationships between Norwegian NGOs and CSOs in Tanzania to exist. These have become avenues for sharing experiences and expertise in responding to HIV/AIDS pandemic.
- MKAPA HIV/AIDS Fellowship Programme has recruited and trained fellows and posted to 23 hard to reach districts.
- DogoDogo Street Children Programme integrated HIV/AIDS to reduce vulnerability and the inclusion of Prevention of Mother to Child Transmission in Refugee Programme has been documented in an international journal.
- The Norwegian Programme for Development, Research and Education programme contributed to institutional and capacity development especially in the area of HIV/AIDS counselling.

5 Progress Towards Outcomes and Factors Affecting the National Response to HIV/Aids in Tanzania

This chapter presents the data on the behavioural outcome and the impact of HIV infection interventions in Tanzania. It also examines factors that may have affected the progress of the national response to HIV/AIDS in the country. A review of data and information on the spread of the AIDS epidemic, the nature and extent of the national response to the epidemic and the impact of results between 2000 and 2006 was conducted. In this review, the spread of the epidemic was evaluated through independent surveys such as the Tanzania HIV/AIDS indicator survey (THIS 2003/04) and sentinel surveillance (2001 and 2005) surveys; the national response was monitored through consultations with key stakeholders and documents review while the impact of the interventions was evaluated through Tanzania Demographic Health Surveys (TDHS) (1999 and 2004) and other independent surveys.

5.1 Progress towards Key Outcomes and Impact Indicators

Table 7: Progress made against indicators as defined by UNAIDS

	THIS		TDHS				UNAIDS[72]	
	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 the 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							

Table 6 presents the data HIV/AIDS key outcome and impact indicators as defined by UNAIDS for generalised epidemic. The Tanzania commission for AIDS reviewed the progress the country was making in responding to the AIDS pandemic using the UNGASS indicators

72 UNAIDS Fact sheet (December 2006).

in 2006. This review showed more positive range of improvements at the outcome level even though the targets set out by UNAIDS for 2005 were not attained. For instance:

- 17% of young women and 26% of young men aged 15-24 years said to have used condoms the first time they had sexual intercourse.
- 23% of women and 46% of men engaged in higher-risk sex in the last 12 months. Of those, 38% of women and 50% of men reported using condom in the most high-risk sex. In urban settings, women and men were more likely to engage in high-risk sex (32% versus 51% respectively). Less than 2% of the males reported to have had sex with a prostitute in the last 12 months.
- Among sexually active youth aged 15-24 years, 37% of women and 81% of men had sex with a non-regular partner in the last 12 months. Young men who engaged in sex with a non-regular partner were slightly more likely than women to use condom (47% verses 42%). Urban youth, both women and men were more likely than their rural counterparts to engage in sex with a non-regular partner (49% for women and 86% for men in urban versus 41% for women and 79% for men in rural).

The nationwide HIV infection indicator survey which was carried out in 2003-04 showed that HIV infection prevalence was 7.0% (6.3% males, 7.7% females) among adults aged 15-49 years with urban residents having considerably higher infection levels (10.9%) than rural residents (5.3%).

Figure 7: Trends of HIV prevalence among ANC attendees of all ages (2001-2006)

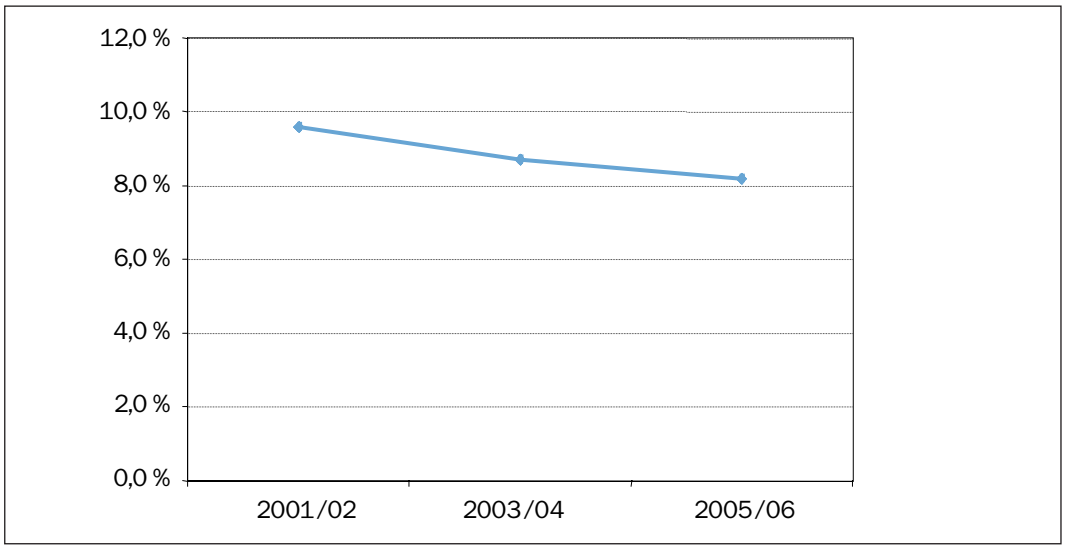
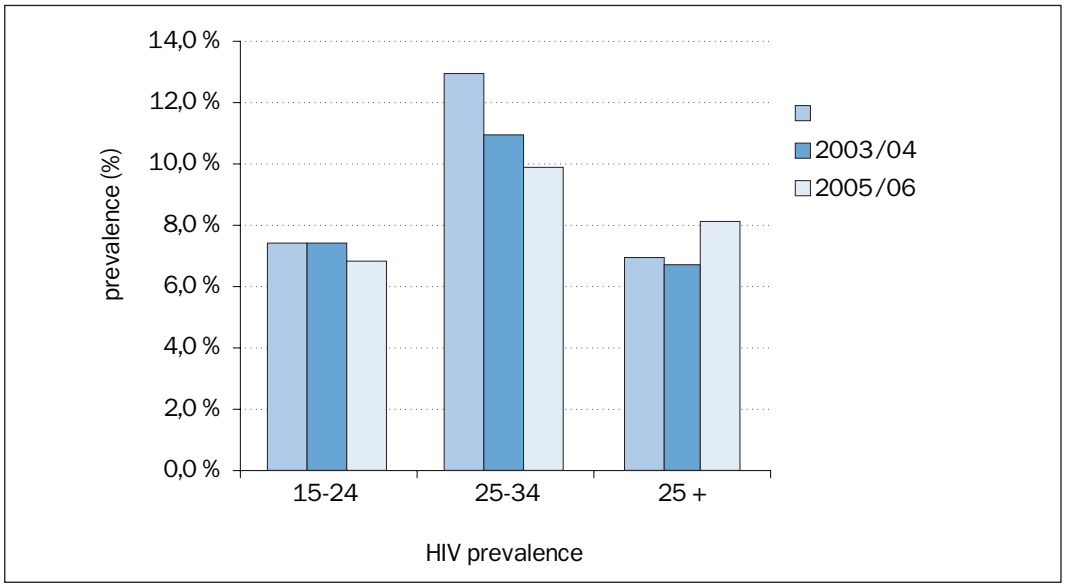


Figure 8: Comparisons of age groups specific HIV prevalence among ANC attendees between 2001-2006



HIV infection prevalence trends among ANC attendees of all ages between 2001 and 2006 suggested there was a decline in HIV infection prevalence, from 9.6% (95% CI: 8.9-10.2) in 2001/02 to 8.7% (95% CI:8.3-9.1) in 2003/04 to 8.2% (95% CI: 7.9-8.5) in 2005/06. This finding was statistically significant, with P=0.001[73] (See Figure 7) presented above.

HIV infection among youth aged 15-24 years represent more recent infections and serves as an important indicator for detecting trends in both prevalence and incidence in a population[74]. Data from ANC attendees aged from 15-24 years suggests of slight evidence of a downward trend within this age group between 2001 and 2006 (See Figure 8).

Data from the Ministry of Education showed that by June 2007, there were 748,641 orphans (386,796 boys; 361,845 girls) in primary schools and 80,438 (42,850 boys; 37,588 girls) in secondary schools in Tanzania[75].

Table 8: School Attendance by Survivorship of Parents and by OVC Status

For children 10-14 years of age, the percentage attending school by parental survival and by OVC status and the ratios of the percentages attending for parental survival and OVC status, according to background characteristics, Tanzania 2004-05					
	Both parents deceased		Both parents alive and living with at least one		
Background characteristic	Percentage attending school	Number of children 10-19	Percentage attending school	Number of children 10-14	Ratio
Sex					
Male	83.0	72	86.3	2,304	1.0
Female	96.9	70	86.8	2,204	1.1
Residence					
Urban	(95.1)	59	95.9	882	1.0
Rural	86.0	83	84.3	3,626	1.0
Wealth quintile					
Lowest	*	17	74.2	967	1.0
Second	*	12	81.4	970	1.0
Middle	*	26	87.1	900	1.0
Fourth	(84.8)	32	95.3	912	0.9
Highest	(99.4)	54	97.9	758	1.0
Total	**89.8**	**142**	**86.6**	**4,508**	**1.0**

Note: Figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on fewer than 25 unweighted cases and has been suppressed.

The above table extracted from the report of TDHS 2004 revealed that attendance rates differ little among orphans and non-orphans, with about 9 in 10 children aged 10-14 attending school at some level. The TDHS report analysed further that this indicator is based on the assumption that orphans are accurately represented in the survey. This may not be true if a sizeable proportion of 10-14 year old orphans live on the streets or in institutional settings not captured in the TDHS sample.

5.2 Factors Affecting Progress Towards Outcomes

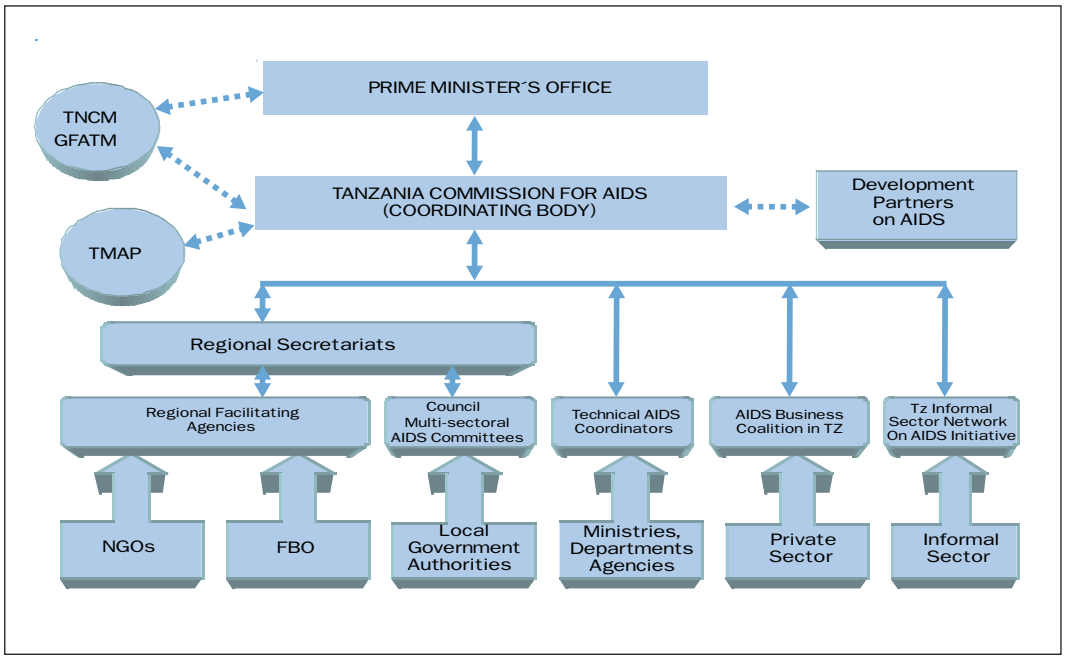
Despite that the country is making significant progress in its response to HIV/AIDS, the continued high HIV infection prevalence in the country in the review period meant that the country did not meet the UNAIDS target of reducing the prevalence by 25% by 2005 among 15-24 year olds (see Table 6). In addition, there is little progress in behaviour change, universal access of ART and impact mitigation which means the country is facing many challenges. These challenges could broadly be classified into five, namely; Leadership and Institutional Arrangement, Funding Availability, Human Resources, Logistics and Supply Chain System, and Monitoring and Evaluation challenges.

73 NACP (2007) HIV/AIDS/STI Surveillance Report (January – December 2006).
74 TACAIDS (2006) Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS).
75 MOE (2007) The Position of the Education Sector Response within the Overall District HIV and AIDS Response.

5.2.1 Leadership and institutional arrangement

The Government of Tanzania at the national level was strongly committed to the fight against HIV/AIDS in the review period (2000-2006) and that commitment continued to expand. The government created Tanzania Commission for AIDS (TACAIDS) in 2001 to lead the national response to HIV/AIDS; launched the National Multi-Sectoral Strategic Framework (NMSF) for HIV/AIDS for 2003-2007 to provide strategic orientation for implementation of the response; signed memoranda of understanding between the government of Tanzania and its partners including Norway to articulate a joint implementation strategy for planning, monitoring and evaluation, and resource mobilization for the NMSF. Ministerial and District AIDS Committees were established (See Figure 9) and Regional Facilitating Agencies (RFA) were put in place to coordinate and provide technical support to build capacity of Multi-sectoral AIDS Committees at district councils and village levels.

Figure 9: Coordination of HIV/AIDS National Response in Tanzania



Source: Interviews with TACAIDS

Private-sector involvement continued to expand, with increased membership of the AIDS Business Coalition Tanzania. Donor support remained strong and is well coordinated through the AIDS subgroup of the Development Partners Group, which has facilitated harmonization and alignment of national priorities, including resource mobilization.

However, little progress has been achieved in mounting a true multisectoral response to address the epidemic in the MDAs due to numerous challenges.

- Commitment and capacity at the regional and district levels remains weak, mitigating the impact of the strong commitment evident at the national level.
- There is insufficient numbers of personnel as well as limited technical capacity at all levels which have resulted into a very low absorption of funds, particularly at district level, jeopardizing future funding from the international donor community.
- There is limited coordination capacity at the national, regional, district and lower levels which has resulted into scattered interventions that are ineffective in bringing about the desired change. It is unclear at all levels, which organization is providing which HIV service in which area and for which target group.

The application of the "Three Ones Principle" at district level has proved to be quite challenging to all actors due to lack of experience in participatory planning and coordination and sharing of responsibilities across sectors. The integration of the CSOs in the council plans has been weak and this has limited coverage of efforts and leveraging on the comparative advantages of these actors. In addition, the weak institutional capacity and proliferation of

civil society networks has caused confusion in identifying who to engage in the fight against HIV/AIDS[76].

At community level, there are several thousands formal and informal community-based organisations (CBOs), including faith-based organisations (FBOs). These have made substantial contributions to the National Response, particularly where they have access to technical and financial resources through NGOs, but most of the efforts are not captured to determine the true status of the national response. Many of the NGOs are also involved in the ART roll-out, despite their numbers, the capacity and the quality of services and interventions which these CBOs provide vary tremendously. Adherence to national guidelines and better integration into community and district plans are additional challenges which need to be addressed to enhance coverage and progress towards outcomes.

5.2.2 Funding

Over the years, the funds available for HIV programmes have increased substantially both from the government and the development partners as shown in Table 1. The thematic area of care and support has received over 64% of the spending on HIV/AIDS (See figure 3), while prevention received only 14%. The high trends of expenditure on Care and Treatment is attributed to the roll out initiatives for ARVs and related logistics including training of health care workers, however, there is cause for concern bearing in mind the equally important role prevention interventions have in the overall National Response.

The government has put together financial management procedures and mechanisms to facilitate and support the process of implementation of HIV intervention at the MDAs, LGAs, CMAC and CSO levels, these mechanisms are marred with bottlenecks causing undue delay in disbursement and accountability of funds, consequently affecting the absorption capacity of key partners and the delivery of HIV programmes especially at local levels. The long delay experienced in accessing the GFATM resources have been reported[77] to be largely attributed to GFATM approach that ignores domestic planning, budgeting, approval and implementation timetables and the multiple approval stages before funds are finally released for spending thus making it difficult to rely on GFATM financing for HIV/AIDS interventions. In fact, the MoHSW has been reluctant to include GFATM funds in the budget before disbursement approval has been secured, the uncertainty of support from GFATM is a major concern to the evaluation team considering the fact that is one of the major funds that is supposed to enhance acceleration of national response and facilitate achievement of key outcomes.

5.2.3 Human resources

One of many notable achievements in the national response was the deployment of human resources through the Ministries, Departments and Agencies, the LGAs, the private and informal sectors, and CSOs. According to the Civil Service Department database, for example, there are about 19,696 workers in the MDAs and local government with some skills in HIV interventions. These have been the key movers of HIV interventions in their respective sectors, but it's worthy to note that that the skills are not adequate to deliver a true multisectoral response.

The health sector which manages a substantial part of the National Response particularly in the area of care and treatment and impact mitigation is reported to have a serious shortage of human resources. The health workforce, for example, is reported to have been declining over the years by 28% from 67,600 in 1994/95 to 48,500 in 2001/02, and by further 10% to 43,650 in 2005/06[78]. In 2002, the key cadre of health care workers including nurses, clinical officers, and laboratory technicians was reported to be at 50% or less of the agreed staffing norms in 1999[79] although the level was slightly above 60% among the doctors. Although, efforts have been made in recruiting and training health care workers especially in relation to the ART roll-out plan, this area still remains a major challenge in the future.

76 NMSF 2008 -2012.
77 Tanzania Public Expenditure Multisectoral HIV/AIDS Review Report (2007).
78 NMSF Human and Financial Assessment Report. AM Kireria & D Ngowi. TACAIDS. March 2007.
79 Wyss, K. (2004), Human Resources for Health Development for Scaling up ARVs in Tanzania. WHO/Swiss Tropical Institute.

5.2.4 Sustainability of the NUFU programme

The NUFU programme is run on shared interest between Tanzanian Institutions and Norwegian Institutions, sustainability depends heavily on the commitment of the Norwegian institutions and the Norwegian researchers. Although a long track record of collaboration between Tanzanian Institutions and their Norwegian counterparts is the programme's major strength, it also makes it vulnerable. If the programme is to be sustainable, adequate good Norwegian researchers must continue to participate in the projects for it to fulfil North-South Collaboration, a criteria for further funding to continue to contribute to the shortage of trained staff in the health care sector in Tanzania. For instance, psychology department at the University of Dar es Salaam was mentioned as the only graduate department providing psychology training in Tanzania. Most behavioural change communication strategies require psychology training for effective implementation. To meet this demand, more funding, materials and trainers are needed.

5.2.5 Logistics and supply chain management

Lessons learnt from the implementation of NMSF 2003 – 2007 show substantial efforts focused on addressing the 'front line' human and financial resources requirements with minimal planning of infrastructure and 'back-office' support in addressing the epidemic. By virtue of being the first sector tasked with the responsibility of coordinating the national response to the epidemic, the health sector through the NACP has managed over the years to put together reasonable logistic structures both from the national, regional and district levels responsible for delivery of relevant services and products.

However, bureaucratic procurement systems and procedures in the existing health sector structures do not appear to lend themselves to rapid implementation of the National Response. Frequent stock-outs of drugs and reagents and lack of VCT kits are some among the noted shortcomings associated with the difficulties in the procurement system. The distribution of free condoms through the health care facility outlets has been seen as 'medicalisation' of condoms, providing access to few people likely to use the health care facilities while limiting access to other specific groups.

5.2.6 Monitoring and evaluation

Tanzania established a national HIV monitoring and evaluation system (TOMSHA) that tracks the progress the country has made with the objectives defined in the National Multisectoral HIV Strategic Framework. However, the M&E system still faces huge challenges:

- It is difficult to determine the spread of HIV infection and thus plan adequately because the only regular source of data for determining the dynamics of the epidemics in the review period was one round of the Tanzania HIV/AIDS epidemic survey in 2003/04 and the ANC sentinel surveillance conducted after every 2 years.
- There is also an urgent need for qualitative research into and data on drivers of epidemic to provide the foundation for evidence-based HIV infection prevention interventions targeting specific cultural or environmental areas and specific populations, including women, young people and people at risk, to replace the general approach taken to date.
- It is also difficult to ascertain the impact of HIV infection services (HIV infection prevention, treatment care and support, and impact mitigation services) that are being provided across the nation.

5.3 Progress Towards Objectives, Sustainability and Connectedness

During the period evaluated, the prevalence of HIV infection amongst ANC attendees dropped from 9.6% in 2001/02 to 8.2% in 2005/06[80]. In addition, tangible progress was also recorded in the country as reflected in the indicators as set out by UNAIDS even though the targets set out by UNAIDS for 2005 were not attained.

A significant part of support from Norway is channelled through GBS which funds the government poverty reduction priorities. Through GBS, the government engages in open dialogue with development partners including Norway in a transparent and accountable way, which builds government systems to be accountable and transparent not only to the development partners like Norway but also to the citizens of Tanzania.

80 NACP (2007) HIV/AIDS/STI Surveillance Report (January – December 2005).

There is some level of connectivity of the activities funded by Norway in the country level. For instance, the Norwegian resources were used to support a study on the situation of orphans in Tanzania[81]. The findings from that study were used to raise awareness on plight of orphans which in turn led the Norwegian resources to be channelled to support Illula orphanage program in Iringa Region. Norway also supported ABANTU Visions to develop and produce a film on the plight of orphans in Tanzania. However, despite Norway's support to NACP, there was no documentation or information as regards use of outcomes of the collaborative research on PMTCT, OI, and HAART between HAVACOP, Solandet Hopsital and Ulleval University in Oslo. The Royal Norwegian Embassy in Tanzania has made tangible efforts in facilitating meetings of partners supported in Tanzania once in two years with a particular theme for discussion and to create an avenue to discuss and share experiences, but it is not clear how plans and recommendations from such meetings are implemented. The connectivity of activities supported by Norway at country level and partnership with other partners and key players in the National Response has been possible due to a focal person dedicated to managing HIV/AIDS programme in the Embassy.

Summary of progress towards outcomes and factors affecting

- Data from ANC attendees suggest a decline in the epidemic in Tanzania from 2001 to 2006. This is supported with data from the youngest age group (15-24 years) which suggests that the prevalence in this age group may be slightly declining.
- There is also visible improvement in knowledge of HIV/AIDS prevention.
- At the national level, there is high level of engagement of the political leaders while commitment and capacity of political leaders at the regional and district levels remains weak.
- A comprehensive institutional framework has been set-up, the "Three ones" are in place. Coordination of activities at all levels remains a challenge and the Monitoring and Evaluation system is still very weak.
- The health sector in Tanzania is severely limited by capacity constraints to ensure Universal Access.
- Norway's resources are channeled through multiple sources, but largely through general budget support, basket funding and directly through project funding.
- This diversity of funding reflects Norway's strategy of supporting demand driven approaches.
- The Royal Norwegian Embassy has made tangible efforts to ensure connectivity of activities funded by the Norwegian resources and partnership with other stakeholders have been enhanced due to availability of a key focal person dedicated to HIV/AIDS.
- The change in the roles and responsibilities of the HIV focal person in the embassy due to change in the priority areas will definitely create a vacuum in the country, and could affect the role of Norway in ensuring implementation of achievements recorded at global level.

81 ESAURP, 2002 HIV/AIDS Orphans study: Identification and Needs Assessment.

6 Conclusion, Lessons Learnt and Recommendations

This chapter draws together the conclusions from the Tanzania country evaluation and puts forward some recommendations. The findings summarized at the end of each chapter have also been synthesized here. This chapter has been structured to follow the four evaluation objectives as reflected in the terms of reference reproduced in chapter 1 and Annex 1, section 3.3.

6.1 Conclusion

The evaluation of Norwegian responses to HIV/AIDS in Tanzania between 2000 – 2006 has revealed that Norwegian support in tackling the epidemic has contributed to the progress the country is making towards the achievement of the key outcomes and core impact indicators as defined by generalised epidemic by UNAIDS. The Norwegian Government was identified as among key donors supporting the General Budget, Basket Funds and Project Funds. Norwegian support to the multilaterals and NGOs has also contributed to the strengthening of technical and institutional capacities for the implementation of HIV prevention, care, support and impact mitigation initiatives. Owing to the fact that the national response to HIV/AIDS received support from several bilateral and multilateral organisations, it was difficult to attribute the progress made to a single donor.

6.1.1 Progress towards outcomes

Available data from various sources revealed some progress in tackling the epidemic during the period. For example, a slight decline has been revealed amongst ANC attendees from 9.6% in 2001 to 8.2% in 2006. Available statistics also revealed that there is progress especially in the areas of knowledge of HIV prevention, rejection of misconceptions and tangible increases in the number of people living with HIV that are on treatment against the targets set by UNAIDS. In addition stakeholders' perceptions are very positive as regards the contributions of Norway to the control of the epidemic and the effects that the projects have had on beneficiaries.

Furthermore, the country has put in place the "Three Ones" during this period even though there are still challenges. There have been considerable achievements in increasing access to HIV testing, treatment and care across the country. More Tanzanians are using HIV testing and treatment services and are benefiting from community care. In the area of ARV treatment Tanzania has shown impressive progress; despite that the country health sector is challenged with human resources limitations and still able to roll out the ARV to reach 70,000 PLWHA. Other areas of progress include the creation of the Development Partners Group on HIV/AIDS and the establishment of pooled funds to fill gap and enhance CSOs access to resources to implement interventions that will enable them to contribute to the key outcomes. Norway has played a significant part in these achievements, by providing core support to the national response, through the health sector and general budget support, and by a flexible approach to funding targeted interventions that complement the mainstream programmes and allow for innovation and independence. Norway has worked through both core programmes and targeted support for non-governmental organizations, and to mainstream efforts in some sectors.

6.1.2 Key Norwegian contributions

There is no specific country strategy developed by Norway for Tanzania, but Norway's de facto strategy of working through multiple channels has been effective in targeting various stakeholders at all levels especially creating the opportunity to empower women, reach the poor and the marginalised groups. It has also enhanced provision of support broadly in line with the evolving national framework through General Budget Support, Basket Funding and

Project Support and also set the pace in taking risks and funding interventions that most donors are reluctant to take up.

The multiple channels of support in the country have contributed to key outputs which include development of HIV/AIDS policies and strategies, research outputs to raise plight of orphans, capacity building of stakeholders for the development and management of HIV prevention, care, support, treatment and impact mitigation initiatives, improvements in HIV knowledge and behaviour, increase in number of PLWHA on ART and possible reduction of HIV prevalence in the country.

6.1.3 Factors affecting progress towards outcomes

Although there were some supporting and hindering factors identified to have influenced the achievement of the key outcomes, these factors were analysed and documented in the report. In chapter five of the report, the key challenges are categorized into five, namely; leadership and institutional arrangement, funding availability, human resources, logistics and supply chain system, and monitoring and evaluation challenges. These factors must be considered and addressed in subsequent engagement in order to contribute strategically and effectively to the achievement of key outcomes in the country. In addition, the issue of connectivity of the Norwegian supported interventions which was found to be limited must also be addressed to enhance opportunity of learning from one another and the sharing of best practices that will also enhance the impact of the various interventions and coverage.

6.1.4 Partnership strategy

There is no clear partnership strategy developed by Norway for the various partners engaged in the country and there is no over-arching framework to guide various strands of support from Norway. The type of partnership adopted was that of joint working based on the various international agreements and demand responsive approach. Subsequent engagements can be improved with clearly developed strategy and framework for operations that will be useful in measuring success in the utilisation of resources and management of initiatives.

6.2 Issues and lessons

This evaluation of Norway's support to HIV/AIDS in Tanzania has come up with a key number of interesting issues concerning how Norway chooses to interact with national institutions and other development partners, and how much the overall flow of aid should be coordinated especially in guiding future policies and engagement.

6.2.1 Norway's visible contributions

Norway's most visible contributions were when it was flexible and taking the initiative (risks). Looking at the different phases of Norwegian support, it seems like the most important parts have been where it has been the first to support interventions and donors coming on board to support thereafter. Such are the cases with the support to National Treatment and Care Plan, the Human Resource Fellowship Programme, support to KIWAKKUKI etc. The willingness of Norway to support initiatives other donors were initially reluctant to support was clearly revealed in this evaluation. Now that Norway has progressed to support the Government of the United Republic of Tanzania through general budget support and withdrawing their contributions gradually in the area of HIV/AIDS especially resources such as Rapid Funding Envelope (RFE) that CSOs are accessing, there is no doubt that this will negate Norway's comparative advantage of setting pace to respond to issues quickly as this will not happen with support through general budget support and other pooled funding channels. Although there will be huge transaction costs if Norway continues to fund smaller projects and would in general contradict the intentions and commitments of the Paris Declaration.

The argument is not made against Norway mainly supporting sector and pooled arrangements but to make sure that Norway continues to be able to utilise one of its main comparative advantages; flexibility and willingness to take risks. A key lesson concerns what contribution Norway wants to make. General Budget Support is important; but at country level, supporting innovation and being able to respond flexibly to specific demands of strategic importance may be more significant to help guide the national response, when set against the large resource flows from the Global Fund and World Bank which will tend to be used for more routine

activities, and more over with the challenges of accessing the funds in timely manner and capacity to utilize as well.

6.2.2 Can Norway make a difference in HIV mainstreaming to sectors?

The Tanzania Multi- Country AIDS Programme (TMAP) is meant to fund non-health sector responses to HIV/AIDS, since resources from GFATM and PEPFAR focus more on treatment. Unfortunately the TMAP has not really been well utilized due to low capacity within the MDA to mainstream HIV/AIDS in their sectors. Norway has mainstreamed HIV/AIDS into sectors and projects in Tanzania and has set examples that HIV mainstreaming is doable – an indication that Norway could play an active role to facilitate capacity building and aid better absorption and utilization of the TMAP. Moreover, with capacity of Norad being able to provide technical assistance to refocus attention to non-health sector responses.

The exclusion of HIV/AIDS as one of the key thematic areas that Norway will engage in subsequently is a concern considering the values and contributions that Norway is making to the national response. Nevertheless, this is seen as an opportunity for Norway to emphasise HIV mainstreaming and use their comparative advantages of flexibility and risk taking to achieve key results.

6.2.3 Engagement with partners and the need for a HIV focal person

Norway has been active in policy influencing in Tanzania and engagement with other donors to achieve results - an effort that Norway has been a key stakeholder at the global level especially in lobbying other donors to adhere more closely to the principles of the Paris Declaration. Withdrawal of Norway from steering committees and some of the pooled resources will definitely create a capacity gap. Moving the HIV/AIDS focal person to another job within the embassy will definitely create a huge gap that could prevent translation of efforts at global level into in-country action.

Even for HIV mainstreaming to be effective, there is need for effective policy influencing to guide an effective implementation of a true multi-sectoral response. Policy influencing comes from the seat at the table and not really the size of budget or programme, but the 'number of voices' in the forums. Lack of a focal person on HIV/AIDS within the embassy will definitely create a vacuum in this regard and could have negative implications for the translation of their efforts at global level.

6.2.4 Is there a need for separate structure(s) of support to NGOs as an added value to the National Response?

Norwegian support to NGOs comes through various ways during the period evaluated namely – pooled resources with other partners, direct support from the embassy and through the Norwegian NGOs notably in this regard NCA, WFN, JURK and NNA. Some of the NGOs have been receiving support before the National Multisectoral Strategic Framework on HIV/AIDS (NMSF) was developed but it was clear that their programme interventions still fall within the thematic areas of the NMSF. The various ways of support have implications notably:

- Direct funding to local NGOs in most cases is one-off and most are unable to access funding from other sources thereafter.
- Support from Rapid Funding Envelope (RFE) is of one-year duration due to rapid nature of the funds, feedback from NGO beneficiaries revealed that there is limitation to good utilization of the funds and the complaints about lack of capacity has prevented most NGOs from accessing the funds.
- Support from the Norwegian Nurses Association and the Women's Front Norway has been long term - 10 years duration. Despite this there are still issues with sustainability. KIWAKKUKI is putting plans in place, but have only succeeded in raising about 10% of the resources they are currently accessing.

These NGOs are able to work in hard to reach areas to save lives but unable to access resources locally for implementation of programmes. This is a major concern and raises the question "what happens to all the initial investments that Norway has put into these NGOs?" Opportunities exist to build on experiences and feed back lessons to improve performance and

contribute to national response. But this would require the need to play a more proactive role in the work of these development partners.

6.2.5 Issue of partnership

The Norwegian HIV/AIDS support in Tanzania does not have a strategy to choose partners and develop partnerships. Norway is valued as a partner for being flexible, realistic, having strong values and known to respond to issues that other partners will not be interested in. Its partners assessed Norway very positively for having shared objectives, few serious disagreements and not imposing in terms of areas of projects that should be funded. Although significant resources flow to the government system through Genral Budget Support, a partnership strategy could be used to guide who Norway will partner with and to achieve what objectives.

6.2.6 Issue of coordination

Norway is a key stakeholder in the establishment of the "Three Ones" – one coordinating body, one strategy and one monitoring and evaluation system. The three are in place in the country, but has not functioned as expected to ensure a well coordinated multisectoral response. The coordination at regional and community level has severe limitations despite the establishment of the RFA and CMAC, and this has resulted in lack of reporting of the various interventions and prevented the true status of the national response. TOMSHA – the monitoring and evaluation system has been developed, but not many partners reported on the usage during the evaluation.

There are many civil society organisations in the country that claimed designation of civil society network including PLWHA due to lack of organisation and tensions between different networks despite efforts by TACAIDS to coordinate the various groups into one national functional advocacy body. The tension and turf has also prevented the PLHIV groups and CSOs to advocate against stigma and discrimination in most communities in Tanzania. For a wide coverage of a true multisectoral response, effective coordination is required and this means addressing underlying factors.

6.3 Recommendations

The following are the key recommendations arising from the evaluation:

Continuity of support through multiple channels

Norway should continue with the core support of General budget Support since this is the preferred aid modality of the Government of Tanzania. This underpins the national response and is in line with Norwegian policy and commitments under the Paris Declaration. But in addition, maintain a portion of the country budget for flexible and demand responsive work and support to CSOs especially to address some of the weak and challenged areas of coordination at regional and district levels, monitoring and evaluation.

Support provision of technical assistance to HIV mainstreaming in key sectors

There is need for Norway to engage with other partners to ensure provision of technical assistance for effective HIV mainstreaming across sectors in the country. This will ensure effective deployment and utilisation of resources from World Bank TMAP and other sources. In addition, there is the need to consider the capacity required for effective HIV mainstreaming into the current Norwegian streamlined priority areas in the country that focus on Good Governance, Environment & Natural Resources, Media Information & Culture, Energy & Infrastructure, MDG 4 & 5 (Improving Maternal and Child Health). Norad could play an active role in providing technical assistance in this regard.

Leadership strengthening at regional and district Level

This could be part of the good governance programme. Strengthening leadership for HIV/AIDS response at this level will also complement the on-going strong leadership at national level and address some of the challenges that the epidemic is currently facing at regional and district levels.

Address limited connectivity of interventions

The connections of activities supported by Norway at country level must continue with emphasis on implementation of the recommendations and plans arising from the activities for connectivity of interventions. A forum should be created where the stakeholders (implementing partners) involved are able to plan collectively and interact with one another to share lessons and best practices towards the achievement of key behaviour outcomes. This strategy will enhance effective utilisation and coverage of interventions.

Norway to continue to engage with government & other donors on HIV/AIDS

Norway should consider retaining the HIV/AIDS focal person within the embassy to engage with the key stakeholders, identify gaps and coordinate the institutions involved in utilizing Norwegian resources for HIV/AIDS response in the country. This will ensure connectedness of responses and networking. Most importantly is engagement with other donors in the area of policy engagement to enhance voice and expansion of best practices that will impact positively on the epidemic.

Norway to work with other partners to address weak M & E system

UNAIDS is providing technical assistance to the Tanzania Commission on AIDS to address weak M&E system in the country, Norway should work with other partners in this regard as this will add significant value in ascertaining the status of response and identify gaps for subsequent interventions.

Development of partnership strategies and framework for operations

Clear 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. The strategy should also include the partnership principles and such principles should be adopted for the development of indicative framework to guide measuring of success in the utilisation of resources, management of projects and initiatives. Such strategies should be considered for adoption at all levels and channels utilising Norwegian resources for HIV/AIDS interventions.

Strengthening of civil society networks

Norwegian support could make a difference in strengthening the networks of civil society including that of PLWHA, in order to enhance their representation and voices in policy influencing and be actively involved in decisions that will enhance their participation in the national response. This kind of support should also address the rift and lack of cooperation that currently exist amongst the CSOs.

Continuity of the NUFU programme

The NUFU programme is adding value to the institutional and capacity development in the country and should continue considering the valuable roles of capacity development in addressing shortage of personnel in the sectors in Tanzania especially HIV/AIDS counselling. The programme should retain its strength of collaboration based on broad participation and exchange of staff and students. In addition, there should be clear linkage of the programme with the sectors especially health sector in order to utilise the trained graduates effectively in contributing to HIV and AIDS response.

Annex 1: Terms of Reference of Evaluation of Norwegian HIV/AIDS Responses in Three African Countries: Ethiopia, Malawi & Tanzania.

– See Appendix 1 page 285

Annex 2: List of Institutions and Persons Consulted

NO	NAME	ORGANISATION	POSITION	TEL/EMAIL
1.	Pius Wanzala	Norway Embassy		
2.	Dr. R. O. Swai	NACP, MOH	Programme Manager	+255 754 301125 swairo51@yahoo.com
3.	Mr. Ngosha S. Magonya	Ministry of Finance	Commissioner External Finance Dept.	+255 787678527 nmagonya@mof.tz
4.	Judica Omari	Ministry of Finance	Principal Economist & Focal Person Nordic Group	+255 713264405 jomari@mof.go.tz
5.	Dr. Fatima	TACAIDS	Executive Chairperson	
6.	Bengi M. Issa	TACAIDS	Director of Finance, Administration & Resource Mobilisation	bissa@tacaids.go.tz
7.	Dr Jerome Kamwela	TACAIDS	GFATM Monitoring & Evaluation Officer	jkamwela@tacaids.go.tz
8.	Richard K. S. Ngirrus	TACAIDS	Policy & Planning Officer	rngirus@tacaids.go.tz
9.	Morris Lekunle	TACAIDS	District Community Response Officer	+255713426399 mlekunle@tacaids.go.tz
10.	Elise Jensen	USAID	HIV/AIDS Officer	+255 744333319 ejensen@usaid.gov
11.	Dr Esther Muia	UNFPA	Deputy Representative	+255 754 781128 muia@unfpa.org
12.	Dr Chilanga Asmani	UNFPA	National Programme Officer – HIV/AIDS	+255 754 781124 asmani@unfpa.org
13.	Rutasha Dadi	UNFPA	Assistant Representative	+255 754 781126 dadi@unfpa.org
14.	Oddvar Bjorknes	Norwegian People's Aid	Resident Representative	+255 782 504355 oddvarb@npatz.or.tz
15.	Suleman R. Toroka	Norwegian People's Aid	Liaison Officer	+255 787620720 sulemant@npatz.or.tz
16.	Fredrick Glad-Gjernes	Norwegian Church Aid	Country Representative	+255 787 770811 fredrik@ncatanzania.org
17.	Blandina Faustin	Norwegian Church Aid	Programme Officer	+255 787641299 blandina@ncatanzania.org
18.	Fiona Chipunza	Norwegian Church Aid	Policy Officer	+255763764633 fiona.chipunza@nca.no
19.	Augustina Mosha	Norwegian Church Aid	Programme Officer	+255713410020 tina.mosha@nca.no
20.	Rev Godfrey Walalaze	Norwegian Church Aid	Programme Officer	godfrey.walaze@nca.no
21.	Evans Rubara	Norwegian Church Aid	Programme Officer	evans.rubara@nca.no
22.	Sarah Shija	Norwegian Church Aid	Asst. Programme Officer	sara.shija@nca.no
23.	Sabas Masawe	DOGODOGO Centre	Project Coordinator	+255 784 278039 dogodogo@bol.co.tz
24.	Ruth Shija	Tanganyika Christian Refugee Service – The Lutheran World Federation	Planning M & E Coordinator	+255 744309285 Rshija-dar@tcrs.or.tz

NO	NAME	ORGANISATION	POSITION	TEL/EMAIL
25.	Justin Nyamoga	Christian Council of Tanzania	Director, HIV/AIDS Programme	+255754899076 cctfaithaids@yahoo.com
26.	Laurent Mapuada	WCRP	Programme Officer	+255 754 286179 wcrptz@bol.co.tz
27.	Dr Ellen Mkondya - Senkoro	Banjamin William Mkapa HIV/AIDS Foundation	Chief Executive Officer	+255 754 299292 emsenkoro@ mkapahivfoundation.org
28.	Dr Adeline Saguti Nyamwihura	Banjamin William Mkapa HIV/AIDS Foundation	Programme Manager	+255 713 263355 asaguti@ mkapahivfoundation.org
29.	Ms Mariam Millinga	Banjamin William Mkapa HIV/AIDS Foundation	Finance & Admin Manager	+255 756065217 mmillinga@ mkapahivfoundation.org
30.	Dr. Minou Fuglesang	Femina HIP	Executive Director	+255 786875755 Femina-hip@raha.com
31.	Dr. Myo Zin Nyunt	Unicef	HIV/AIDS Coordinator	+255 786999633 mnyunt@unicef.org
32.	Dr Elizeus F. Ndyetabura	UNDP	Assistant Resident Representative & Team Leader HIV/AIDS & Gender Unit	+255 786960216 dr.elly.ndytabura@undp.org
33.	Mathew Cogan	UNDP	Programme Analyst HIV/AIDS & Gender Unit	+255 755994724 mathew.cogan@undp.org
34.	Dr Stella Stephen Chale	WHO	NPO HIV/AIDS Care & Treatment	+255 744823682 charles@tz.afro.who.int
35.	Maximillian Mapunda	WHO	NPO Health Economist	+255-754-228848 mapundam@tz.afro.who.int
36.	Ms Feddy Mwanga	WHO	NPO Home Based Care	+255 744 475185 mwangaf@tz.afro.who.int
37.	Mary-Beatrix Mugishagwe	Abantu Vision	Executive Producer/Director	+255 784787544 mbm@abantuvisions.com
38.	Dr. Cyprian Maro	EMIMA	Executive Director	
39.	Dr. Gongo	Norwegian People's Aid	Former Programme Manager HIV	
40.	Mr Simbamuwaka	IPPF Tanzania	Director, M & E	
41.	Getrude Kihunrwa	DFID	Social Policy Advisor	
42.	Deodatha Mwakasisi	DFID	Deputy Programme Manager – Social Sector & Intl Systems	
43.	Dr. Musiba S. Mbilima	University of Dar-es Salaam	Secretary UDSM Technical Sub-committee on HIV/AIDS	+255 784342454
44.	Antipas B. Mtalo	KIWAKKUKI	Head of VCT Programme	+255 784340563
45.	Theresa Sabuni	KIWAKKUKI	Head, HIV/AIDS Education Dept.	+255 754838745
46.	Lydia M. Kissija	KIWAKKUKI	Asst. Head, HIV/AIDS Education Dept.	+255 754841695
47.	Petronila Tarimo	KIWAKKUKI	Asst. HBC Prog. Officer	+255 784630127 Pefta2002@yahoo.com
48.	Dr Rehema Kiwera	KIWAKKUKI	HBC Programme Officer	+255713 329469 Rehema_1974@yahoo.com
49.	Eunice Maringo	KIWAKKUKI	Head of Finance Dept	+255 754304145 eunimaringo@yahoo.com
50.	Dafiosa Itemba	KIWAKKUKI	Executive Coordinator	+255 754624631 kiwakkuki@kilionline.com

NO	NAME	ORGANISATION	POSITION	TEL/EMAIL
51.	Luililiael Mfangavo	KIWAKKUKI	OVC Programme Officer	+255 754767122 luililiael@yahoo.com
52.	Joe Eshun	Deloitte	Director, Managing Consulting	+255 744604439 jeshun@deloitte.co.tz
53.	Dr Laetitia E. Sayi	Ministry of Education & Vocational Training	HIV/AIDS Programme Coordinator	+255 784341491 drisayi@yahoo.com
54.	Prof T. L. Maliyamkono	ESAURP	Executive Director	+255784220172
55.	Dr Emmanuel G. Malangalila	The World Bank	Senior Health Specialist	+255 744295208 emalangila1@worldbank.org
56.	Dr Luc Barriere - Constantin	UNAIDS	Country Coordinator	+255 786960203 Luc.barriere-constantine@undp.org
57.	Magadlene Aquilin	Women Legal AIDS Centre	HIV/AIDS Officer	+255 754 285 496 Likanda2000@yahoo.com
58.	Mary Njau	Women Legal AIDS Centre		+255 754 392 353 Mary88njau@yahoo.co.uk
59.	Emmanuel Mighay	Lutheran Hospital, Haydom	Nursing Officer in-charge	+255 787 328617 Mighay99@yahoo.co.uk
60.	Lengai Sakaya	SOS Arusha	Village Administrator	+255 754 577 604 sakayamokel@yahoo.com
61.	Beatrice Christopher Matotay	SOS Arusha	FSP Coordinator	+255 754 861 554 beatricematotay@yahoo.com
62.	Reuben S. Kakunya	Tanga RAS	Principal Economist (Former Coordinator MEUSTA)	+255 787 206040 tskakunya@yahoo.co.uk
63.	Jon Lomoy	Norwegian Embassy	Ambassador	Jlo@mfa.no
64.	Hanne Therese Tilrem	Norwegian Embassy	First Secretary	+255 782777024 hth@mfa.no
65.	Kristin Sverdrup	Norwegian Embassy	Head of Development Cooperation & Deputy Head of Mission	Krsv@mfa.no
66.	Bodil Maal	Norwegian Embassy	Programme Officer	bmaa@mfa.no
67.	Anthony Mwendamaka	WAMATA	Coordinator	+255 222701615 wamata@ud.co.tz
68.	Dr. Wycliffe Lugoe	the University of Dar es Salaam, Faculty of Education	NUFU coordinator	
69.	Kakoko, Deodatus, V.C	Muhimbili University College of Health Sciences	Assistant Lecturer	
70.	Mkumbo Kitila, A.K	University of Dar es Salaam	Assistant Lecturer	
71.	Basela, J.M	University of Dodoma	Assistant Lecturer	
72.	Libent Daphine	Open University of Tanzania	Assistant Lecturer and Dean of Students	
73.	Mabuga Paulina	University of Dar es Salaam	Manager, University Students Accommodation Bureau	
74.	Faustine China	College of Business Education, Dar es Salaam	Dean of Students	
75.	Machumu Maregesi	Dar University College of Education	Assistant lecturer	

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Annex 4: Country Data Sheet (Summary of Country Profile)

HIV & AIDS ESTIMATES		
Number of people living with HIV	1,400,000 (1,300,000 – 1,600,000)	
Adults aged 15 – 49 HIV prevalence rate	6.5 (5.8 – 7.2%)	
Adults aged 15 and over living with HIV	1,300,000 (1,200,000 – 1,400,000)	
Women aged 15 and over living with HIV	710,000 (640,000 – 780,000)	
Deaths due to AIDS	140,000 (110,000 – 180,000)	
Children aged 0 – 14 living with HIV	110,000 (43,000 – 210,000)	
Orphan aged 0 – 17 due to AIDS	1,100,000 (910,000 – 1,200,000)	
COUNTRY PROGRESS INDICATORS		
Expenditure: National funds spent by government from domestic sources	US$ 45,000,000	
% of pregnant women receiving treatment to reduce mother to child transmission	42,800[11]-	
% of HIV infected women and men receiving antiretroviral therapy	7.0%	
School attendance amongst orphans	73%	
School attendance amongst non-orphans	90%	
Knowledge & Behavior	**Women**	**Men**
% of young women and men, aged 15 – 24 who correctly identify ways to prevent HIV	45.0%	40%
% of young women and men, aged 15 – 24 who had sex with a casual partner in the past 12 months	36.0%	81.0%
% of young women and men, aged 15 – 24 who had sex before age 15	10.1%	10.7%
% of young women and men, aged 15 – 24 who used condom last time they had sex with a casual partner	42.0%	47.0%

Annex 5: Norwegian Financial Inputs

Table 1: OECD DAC Official Statistics of Net Aid Flows to Tanzania – 2000 - 2005

	Year							
Donor	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**Totals**	**%**
DAC Countries, Total	778.7	943.8	902.79	965.64	1028.7	871.03	5490.63	65%
Multilateral, Total	243.27	330.2	330.56	738.06	729.83	621.82	2993.74	35%
G7, Total	457.27	647.6	426.51	570.85	571.76	452.99	3127.01	37%
DAC EU Members, Total	475.21	594.2	683.38	687.18	766.16	607.02	3813.18	45%
Non-DAC Bilateral Donors,Total	-2.62	-5.47	-3.51	0.67	2.79	12.26	4.12	0%
All Donors, Total	1019.35	1269	1229.8	1704.4	1761.3	1505.1	8488.49	100%
Australia	2.04	1.88	0.96	0.47	1.23	0.95	7.53	0%
Austria	5.66	4.78	30.25	1.73	3.2	2.4	48.02	1%
Belgium	7.41	16.13	70.63	8.84	17.56	6.28	126.85	1%
Canada	11.64	8.38	8.25	34.33	32.71	33.01	128.32	2%
Denmark	68.75	66.63	69.89	85.48	93.93	84.73	469.41	6%
Finland	12.43	12.9	12.61	13.17	14.84	17.16	83.11	1%
France	15.8	13.13	15.98	1.55	119.95	4.51	170.92	2%
Germany	34.75	48.19	23.22	98.53	56.4	49.88	310.97	4%
Greece	..	0.01	0.04	0.02	0.15	0.07	0.29	0%
Ireland	15.87	16.42	24.79	26.53	32.22	35.1	150.93	2%
Italy	0.69	1.51	132.25	1.34	5.06	4.72	145.57	2%
Japan	217.14	260.4	58.2	74.47	52.52	36.11	698.88	8%
Luxembourg	..	0.22	0.47	0.14	0.2	0.17	1.2	0%
Netherlands	97.29	75.11	138.29	95.75	117.62	90.23	614.29	7%
New Zealand	0.32	0.97	0.61	1.07	1	1.19	5.16	0%
Norway	**35.17**	**34.93**	**46.67**	**67.37**	**59.6**	**60.3**	**304.04**	**4%**
Portugal	..	..	..	..	..	..	0	0%
Spain	0.29	1.86	0.31	2.45	5.76	4.05	14.72	0%
Sweden	63.54	47.27	61.42	66.18	83.64	91.81	413.86	5%
Switzerland	12.66	17.03	19.34	25.59	25.99	23.6	124.21	1%
United Kingdom	152.73	290.1	103.23	285.47	215.63	215.91	1263.04	15%
United States	24.52	25.91	85.38	75.16	89.49	108.85	409.31	5%
AfDB (African Dev.Bank)	..	..	..	..	..	..	0	0%
AfDF (African Dev.Fund)	26.41	9.72	17.05	44.58	55.71	114.7	268.17	3%
AsDB (Asian Dev.Bank)	..	..	..	..	..	..	0	0%
AsDF (Asian Dev.Fund)	..	..	..	..	..	..	0	0%
CarDB (Carribean Dev. Bank)	..	..	..	..	..	..	0	0%
EBRD	..	..	..	..	..	..	0	0%
EC	32.44	96.66	70.15	185.09	161.89	155.76	701.99	8%
GEF	..	3.27	0.66	0	0.24	0.46	4.63	0%
Global Fund (GFATM)	..	..	..	2.81	16.61	68.57	87.99	1%
MONTREAL PROTOCOL	..	..	..	..	..	..	0	0%
Nordic Dev. Fund	3.48	0.41	2.19	2.85	2.35	1.32	12.6	0%

	Year							
Donor	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**Totals**	**%**
IBRD	..	..	..	..	..	..	0	0%
IDA	109.38	119.9	146.3	424.85	474.15	275.16	1549.74	18%
IDB	..	..	..	..	..	..	0	0%
IDB Spec. Fund	..	..	..	..	..	..	0	0%
IFC	..	..	..	..	..	..	0	0%
IMF Trust Fund	..	..	..	..	..	..	0	0%
SAF+ESAF+PRGF(IMF)	27.35	37.08	29.34	0.56	-32.45	-48.3	13.58	0%
IFAD	5.51	6.54	5.59	7.04	8.28	8.2	41.16	0%
UNDP	8.74	5.24	5.55	6.81	7.17	7.81	41.32	0%
UNFPA	2.39	4.09	7.48	4.51	5.93	5.1	29.5	0%
UNHCR	22.37	25.05	27	22.12	..	1.53	98.07	1%
UNICEF	11.52	5.87	6.85	8.03	10.03	10.85	53.15	1%
UNRWA	..	..	..	..	..	..	0	0%
UNTA	3.02	2.17	3.36	3.85	2.55	3.46	18.41	0%
WFP	2.52	16.49	7.73	7.34	3.51	5.72	43.31	1%
Council of Europe	..	..	..	..	..	..	0	0%
Arab Agencies	-11.86	-2.29	1.31	17.62	13.86	11.48	30.12	0%
Czech Republic	..	..	..	0.01	0.03	0.17	0.21	0%
Hungary	..	..	..	..	..	9.57	9.57	0%
Iceland	..	..	..	..	..	..	0	0%
Korea	0.26	0.27	0.56	0.78	1.24	2.37	5.48	0%
Poland	0.04	0.03	0.03	0.04	0.03	0.06	0.23	0%
Slovak Republic	..	..	..	..	..	..	0	0%
Turkey	..	..	..	..	..	0.02	0.02	0%
Arab Countries	-3.04	-5.91	-4.27	-0.2	1.41	..	-12.01	0%
Other Bilateral Donors	0.12	0.14	0.17	0.04	0.08	0.07	0.62	0%
USSR (not in Total)	..	..	..	..	..	..	0	0%

Table 2: Distribution of Norwegian aid by DAC main sector codes

Sum of Disbursed (1000 NOK)	**Year**					
DAC Main sector (code+name)	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
111 - Education, level unspecified	302	969	10	558	516	2,161
112 - Basic education	11		52,340	53,701	52,600	2,951
113 - Secondary education	180		288	120	733	1,305
114 - Post-secondary education	27,699	31,735	26,446	23,966	16,510	24,101
121 - Health, general	20,869	29,770	12,640	26,941	14,460	17,859
122 - Basic health	1,473	746	326	227	3,762	7,283
130 - Population policies/programmes and reproductive health	15,960	3,015	8,421	9,543	26,617	29,028
140 - Water supply and sanitation	455	419	61			204
151 - Government and civil society, general	12,853	10,635	17,179	25,483	81,351	90,058
152 - Conflict prevention and resolution, peace and security						
160 - Other social infrastructure and services	16,540	16,993	21,171	10,470	5,596	8,226

Sum of Disbursed (1000 NOK)	Year					
DAC Main sector (code+name)	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**
210 - Transport and storage	18,303	31,867	27,875	77,057	658	28,072
220 - Communications	16	433	1,383	929	1,268	908
230 - Energy generation and supply	53,411	31,802	16,945	13,952	26,399	27,632
240 - Banking and financial services	4,155	673	956	1,848	1,642	1,800
250 - Business and other services	8,483	2,994	275	1,338	782	491
311 - Agriculture	9,051	20,881	20,175	18,744	15,420	8,755
312 - Forestry	19,255	3,628	12,470	4,321	3,660	4,258
313 - Fishing				34		
321 - Industry	1,993	225		4,000	5,541	172
323 - Construction		1,500		1,575	1,358	26
332 - Tourism		47				
410 - General environmental protection	27,437	42,551	24,063	15,183	19,653	23,818
420 - Women in development (WID)	1,992	1,095	290	463	551	644
430 - Other multisector	348	14	13	10,099	14,507	8,323
510 - General budget support	50,014	80,000	120,000	96,186	104,147	100,000
600 - Action relating to debt				62,200		
710 - Emergency food aid	2,700			2,000	2,415	
720 - Other emergency and distress relief	15,864	2,033	7,527	14,334	1,492	17
998 - Unallocated/unspecified	55	136	1,857	1,684		319
Grand Total	**309,419**	**314,161**	**372,710**	**476,955**	**401,637**	**388,410**

Table 3: Disbursement by type of assistance and agreement partner

Sum of Disbursed (1000 NOK)	Year								
PM - HIV/Aids	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**Grand Total**	
None	294,134	309,289	303,878	411,771	306,600	332,741	426,128	2,384,541	86.81%
Significant objective		2,935	60,311	54,501	67,162	25,520	49,504	259,933	9.46%
Main objective	15,286	1,937	8,521	10,683	27,875	30,149	7,850	102,301	3.72%
Grand Total	**309,419**	**314,161**	**372,710**	**476,955**	**401,637**	**388,410**	**483,482**	**2,746,774**	**100.00%**
	5%	2%	18%	14%	24%	14%	12%	13%	

Table 4: Disbursement by type of assistance and agreement partner

Sum of Disbursed (1000 NOK)	Type of assistance		
Group of Agreement Partner	Bilateral	Multi-bilateral	Grand Total
NGO International	332		332
NGO Local	6,938		6,938
NGO Norwegian	43,629		43,629
Not NGO	309,786	6,400	316,186
Grand Total	**360,684**	**6,400**	**367,084**

Table 5: Disbursement by implementing institution and HIV/AIDS marker

Sum of Disbursed (1000 NOK)	PM - HIV/AIDS		
Impl Inst	Significant objective	Main objective	Grand Total
AASTMT - Arab Academy for Science and Technology & Maratime Transport	1,440		1,440
Abantu Visions		2,000	2,000
Arbeidsforskningsinstituttet	106		106
Bunda College of Agriculture	64		64
Bunda Designated District Hospital	3,600		3,600
CCT - Christian Council of Tanzania	432		432
Courtyard hotel	36		36
Dar es Salaam	25		25
Diakonia Council of Churches	32		32
EADCF		4,700	4,700
EMIMA	292	21	314
ESAURP		260	260
Evang Luth Church in Tanzania	3,404		3,404
FN-sambandet	749		749
Haukeland Sykehus	4,439	2,000	6,439
Haydom Lutheran Hospital	32,730	7,106	39,836
Hogskolen I Akershus	978		978
IIRR - International Institute of Rural Reconstruction	332		332
Ilula Orphan Programme		524	524
JURK - Juridisk rådgivning for kvinner	526		526
Kirkens Nødhjelp	6,500		6,500
KRIK - KRISTEN IDRETTSKONTAKT	942	379	1,322
Kvinnefronten		2,252	2,252
Malawi National AIDS Control Programme		55,500	55,500
Medical Association of Tanzania		240	240
Misc		70	70
Misc Consultants	38		38
Misc NGOs	2,464	8,200	10,664
MoEC (TAN)	150,000		150,000
Norsk Folkehjelp	1,530	2,167	3,697
OCODE - Organisation for Community Development in Education	848		848
Price Waterhouse Coopers	126		126
SØRLANDETS SYKEHUS HF, KRISTIANSAND	750		750
SOS Children's Village of Tanzania Trust	760		760
TACAIDS - Tanzania Commission for AIDS		2,500	2,500
Tanga Regional Authorities, Tanzania	149	7,256	7,405
Tanzania Ministry of Finance	20,000	289	20,289
TCTF - Tanzania Culture Trust Fund	3,300		3,300
UNICEF		6,400	6,400
UNIVERSITETSSYKEHUSET I NORD-NORGE	1,040		1,040
University of Dar-es-Salaam	18,037		18,037
Unknown	1,264	1,373	2,637
Veidekke A.S		1,000	1,000

Sum of Disbursed (1000 NOK)	PM - HIV/AIDS		
Impl Inst	Significant objective	Main objective	Grand Total
WAMATA - Walio Katika Mapambano na AIDS		2,579	2,579
WLAC	3,000		3,000
Youth Sports Contact - Kriks, Tanzania		335	335
Grand Total	**259,933**	**107,151**	**367,084**

Table 6: Relationship between gender and HIV/AIDS markers

Sum of Disbursed (1000 NOK)	PM - HIV/AIDS			
PM - Gender and equality	None	Significant objective	Main objective	Grand Total
None	2,002,393	57,520	71,647	2,131,560
Significant objective	362,410	197,690	28,632	588,732
Main objective	19,738	4,722	2,022	26,482
Grand Total	**2,384,541**	**259,933**	**102,301**	**2,746,774**

Table 7: Attention to HIV/AIDS and gender in sectoral programmes

Percentage Disbursed (1000 NOK)	PM - HIV/AIDS				PM - Gender and equality			
DAC Main sector (code+name)	None	Significant objective	Main objective	Grand Total	None	Significant objective	Main objective	Grand Total
111 - Education, level unspecified	62.11%	37.89%	0.00%	100.00%	59.25%	40.55%	0.20%	100.00%
112 - Basic education	6.40%	93.29%	0.31%	100.00%	3.92%	96.08%	0.00%	100.00%
113 - Secondary education	100.00%	0.00%	0.00%	100.00%	42.05%	57.95%	0.00%	100.00%
114 - Post-secondary education	99.94%	0.06%	0.00%	100.00%	52.96%	47.04%	0.00%	100.00%
121 - Health, general	60.07%	39.70%	0.24%	100.00%	88.67%	11.33%	0.00%	100.00%
122 - Basic health	55.22%	37.42%	7.36%	100.00%	90.16%	6.95%	2.89%	100.00%
130 - Population policies/ programmes and reproductive health	4.23%	0.00%	95.77%	100.00%	72.28%	24.54%	3.18%	100.00%
140 - Water supply and sanitation	100.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
151 - Government and civil society, general	89.06%	10.72%	0.22%	100.00%	59.61%	38.22%	2.17%	100.00%
152 - Conflict prevention and resolution, peace and security	100.00%	0.00%	0.00%	100.00%	0.00%	20.00%	80.00%	100.00%
160 - Other social infrastructure and services	89.19%	7.47%	3.34%	100.00%	40.24%	57.25%	2.50%	100.00%
210 - Transport and storage	100.00%	0.00%	0.00%	100.00%	98.08%	1.92%	0.00%	100.00%
220 - Communications	100.00%	0.00%	0.00%	100.00%	45.07%	21.67%	33.27%	100.00%

Percentage Disbursed (1000 NOK)	PM - HIV/AIDS				PM - Gender and equality			
DAC Main sector (code+name)	None	Significant objective	Main objective	Grand Total	None	Significant objective	Main objective	Grand Total
230 - Energy generation and supply	100.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
240 - Banking and financial services	100.00%	0.00%	0.00%	100.00%	21.18%	78.82%	0.00%	100.00%
250 - Business and other services	100.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
311 - Agriculture	99.84%	0.16%	0.00%	100.00%	8.16%	91.78%	0.07%	100.00%
312 - Forestry	100.00%	0.00%	0.00%	100.00%	66.73%	33.27%	0.00%	100.00%
313 - Fishing	100.00%	0.00%	0.00%	100.00%	15.00%	85.00%	0.00%	100.00%
321 - Industry	100.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
323 - Construction	100.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
332 - Tourism	100.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
410 - General environmental protection	100.00%	0.00%	0.00%	100.00%	95.66%	4.34%	0.00%	100.00%
420 - Women in development (WID)	78.91%	21.09%	0.00%	100.00%	0.00%	28.72%	71.28%	100.00%
430 - Other multisector	100.00%	0.00%	0.00%	100.00%	60.77%	22.12%	17.11%	100.00%
510 - General budget support	100.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
600 - Action relating to debt	100.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
710 - Emergency food aid	100.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
720 - Other emergency and distress relief	100.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
998 - Unallocated/ unspecified	100.00%	0.00%	0.00%	100.00%	100.00%	0.00%	0.00%	100.00%
Grand Total	**86.81%**	**9.46%**	**3.72%**	**100.00%**	**77.60%**	**21.43%**	**0.96%**	**100.00%**

Annex 6: Programmes Implemented by NGO/FBOs with Support from Norway:

Lutheran Hospital Haydom:
Norway is involved in funding parts of the daily running expenses, including HIV/AIDS programmes of the two hospitals Haydom Lutheran Hospital and Bunda Designated District Hospital. The Haydom Lutheran Hospital HIV/AIDS programme aimed at providing cost effective way to raise awareness, reduce transmission and impact of HIV/AIDS in the programme area and beyond. The expected outputs were to reduce the risk of transmission; reduce vulnerability of marginalised groups and reduce the impact of the disease on patients, their families, communities and the nation at large.

The Femina Health Information Project (HIP):
The Femina HIP was initiated in 1999 by the East African Development Communication Foundation (EADCF) with the goal of responding to the huge communication challenge and vast unmet need for information in the context of the HIV/AIDS Epidemic in Tanzania. The holistic concept of healthy lifestyles was the approach adopted with the utilization of a communication strategy using edutainment, documentary journalism, participatory production and strategic partnerships to develop youth friendly and culturally sensitive formats and content to communicate messages about sexuality, risky behaviour, protection and healthy lifestyles. The second three year phase (2002 – 2005) FEMINA HIP project benefited from funding support from Norad and Sida for the expansion of FEMINA HIP, commenced SiMchezo (targeting rural out of school and semi-illiterate youth). In addition, the HIP produced TV talk shows and an interactive web site – all complemented by the production of one-off booklets. The magazines are widely distributed throughout the country.

WAMATA
WAMATA is an acronym for Kiswahili words "*Walio Katika Mapambano na AIDS Tanzania",* meaning those united in the fight against AIDS in Tanzania. It is a membership organisation and has over 15,000 members. The goal of WAMATA HIV/AIDS programme supported by Royal Norwegian Embassy is "To contribute to the reduction of the spread of HIV/AIDS and its impact on the infected (PLWHA) and affected orphans in particular, and on the country at large". The target areas were: Prevention of HIV transmission, Reduction of problems facing orphans, Reduction of Pathological, Economic and Legal Problems faced by PLWHA and Capacity Building.

Women's Legal Aid Centre (WLAC)
WLAC was supported by Royal Norwegian embassy from 2005 - 2007 to implement a three year Legal Aid Scheme for Women Project targeting children and women with the overall goal of *"promoting and protecting rights of women and children and helping to bring gender equality in Tanzania, through legal aid, legal research, litigation process, networking and conduct of outreach programmes".* The purpose of the project was to increase efficiency and effectiveness in legal aid services provided to women and children, to lobby and advocate for change of discriminatory laws and the strengthening of paralegal units. The expected results of the project include:

- Increased number of women to seek and utilise legal aid services from the WLAC clinic in search of legal remedies given the existing violations of women's human rights in Tanzania.
- Declaration of discriminatory inheritance laws of 1963 as unconstitutional.
- Increased women and children will seek legal remedies for violations of their rights through the paralegal units
- Provision of effective paralegal services through legal advice, awareness campaigns and counselling.

EMIMA:

EMIMA, which stand for "Elimu Michezo na Mazoezi", is the Volunteer youth sports and community service organization in Tanzania. It is driven as non governmental organization whose main purpose is to integrate sports and physical activity into the development process educating people using movement games and peer coaching on issues related to sport and life skills such as HIV-AIDS, STDS, health, environment, drug abuse, poverty and ignorance as well as children's rights. EMIMA projects include:

- **KAO Project:** aimed at integrating sport skills and HIV/AIDS epidemic. The project is conducted in all centers and managed by the project coordinator and peer coaches.
- **Club House Project**: started at Mtoni Center with the Mtoni club house accommodating 40 children at a time. The main aim for the club house is to keep records of the players (photograph), produce news letters, brochures, magazines and serve as a meeting place for players, parents and friends for entertainment and having fun. Through these activities, there is also the exchange ideas and perform a counselling unit function. The centre keeps the children out of the street in the evenings and provides them somewhere to go.
- **Peer Coaching and Networking Project:** more qualified players teach and coach other small boys and girls life skills and sport skills. They act as coaches helping to control the groups and are given all the responsibility and authority.
- **Orphans Project:** among the EMIMA players are orphans. Some are extremely disadvantaged and they are supported with scholastic materials and fees in close collaboration with distant or close guardians, and implementation of activities that promotes sense of belonging and reduce stigmatization in the society.
- **Peer Coach Educational Support and Sponsorship Project:** EMIMA provides education to the peer coaches to continue with formal education and vocational training by giving financial support to enable children from less advantaged groups to receive education and increases their chances of labour mobility after completing the education programs.
- **Outreach Activities:** to disseminate ideas of EMIMA to other organization and the society at large in order to promote sport participation and provide HIV/AIDS education through seminars and workshops. Main outreach activities include exhibitions, partnership with other organisations, lectures and seminars, newsletters, bullet boards, and Kicking AIDS Out walk through door to door community sensitisation.
- **Others are:** EMIMA Green Project, Paper Balls Project and English/Swahili Course Project.

Norwegian Church Aid

Specifically to HIV and AIDS, the Norwegian Church Aid has contributed significantly through local partners on direct HIV/AIDS interventions in the country. NCA worked through their six Faith Based Organisations local partners to address the issue of HIV/AIDS with focus on mainstreaming HIV/AIDS in the refugee programme, reducing vulnerability through the Street Children DogoDogo programme, empowering Masai Girls to reduce vulnerability to teenage pregnancies and other sexual and reproductive health issues, OVC, Community Empowerment, Skills acquisition and Income Generating Activities.

Norwegian People's Aid

Norwegian People's Aid supported EMIMA to mainstream HIV/AIDS in sport activities and also worked with other partners to mainstream HIV/AIDS to refugee programme the success of which has been documented in an international journal.

KIWAKUKKI

This is a women organisation that was triggered off by the theme of World AIDS Day in 1990 which focused on "Women and AIDS" to address the women's position in society which has through history been undermined by inadequate information and decision making power. The main inspiration was the need to accelerate women's access to information on HIV/AIDS, as an entry point to HIV prevention and care. The organisation whose membership has grown from 42 at the first annual general meeting in 1992 to over 6,000 and 160 grassroot organisations in 2007 have been receiving support from the Women's Front Norway for the implementation of their HIV and AIDS programmes with components covering Awareness Creation (through information centres, outreach activities and community theatres), Voluntary Counselling and Testing, Home Based Care, Orphans and Vulnerable Children. Following the development of the NMSF in 2003, KIWAKKUKI HIV/AIDS programme covered 16 out of

the 18 strategies streamlined by TACAIDS in the NMSF. This they counted as a major contribution to the national response.

KWIECO

This is a non-governmental organisation committed to protecting and advocating for the rights of people in the Kilimanjaro region. The organisation is the only legal aid provider in the region providing education, counselling and court representation to marginalised groups. The initial support the organisation received from HIVOS ended in 2003 and the Norwegian embassy provided a bridging fund to enable KWIECO to continue to access justice and equality for women and children in Kilimanjaro region while concretising plans for long term funding. JURK International subsequently provided support from 2005 to 2007 for the implementation of their programmes. The key components of the KWIECO programme include; Human Rights and Gender Education, Legal Counselling, Litigation Service, Children Legal Services and Lobby and Advocacy.

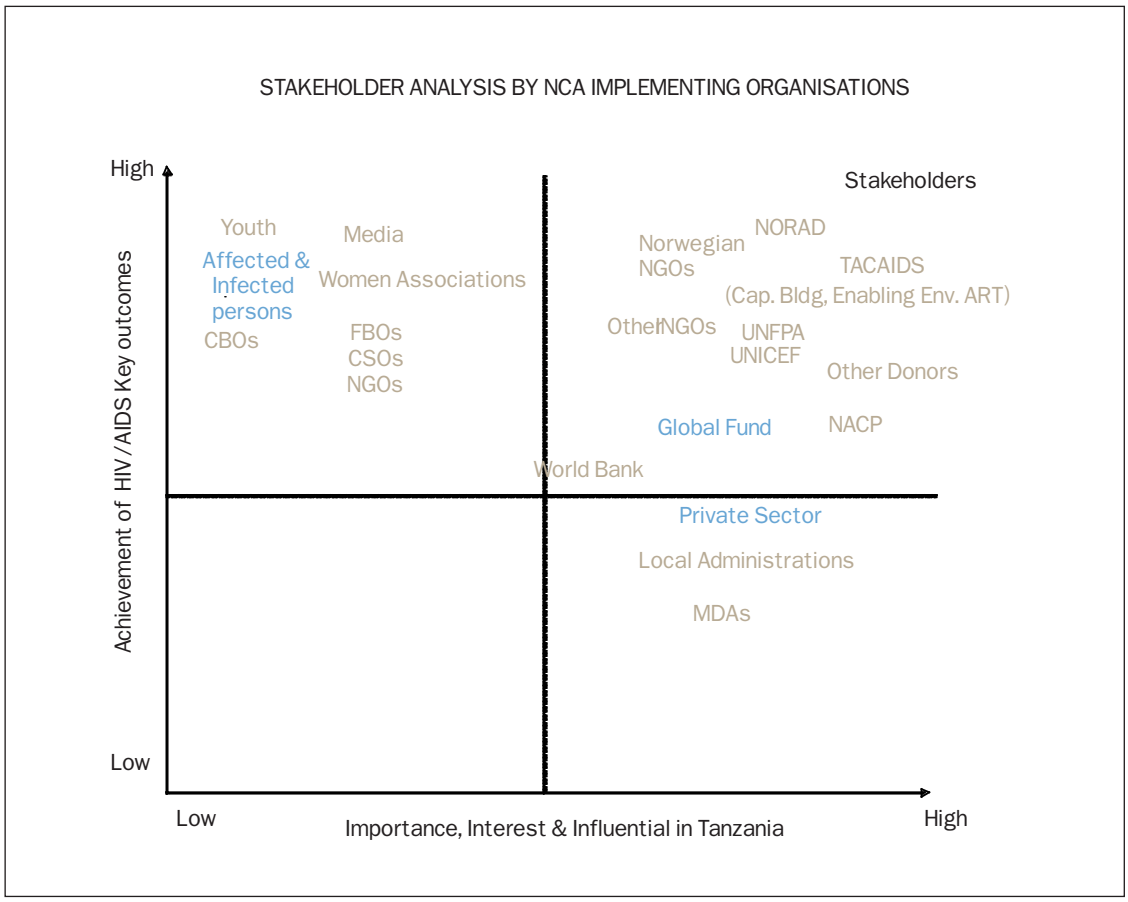
MEUSTA-YETU HIV/AIDS School Education Project:

This is a project supported by Norwegian Nurses Organisaton and managed by Tanga Regional School Authorities from 1995 to 2005[82]. The first phase covered seven districts of Tanga region, and the second and final phase (2001 – 2005) covered five districts of Muhesa, Pangani, Korogwe, Handeni and Kilindi. The aim of the project was to provide school children, their families and teachers with information about HIV/AIDS in order to help form good habits regarding sexual behaviour. In addition, teachers were provided with training in participatory teaching methods. The main activities carried out during the final phase of the project included:

- Training of HIV/AIDS (called EDU) teachers
- Conduct of meetings with school committees
- Provision of HIV/AIDS literatures to teachers
- Conduct of sensitisation meetings with local and district officials
- Monitoring and supervision.

82 MEUSTA-YETU HIV/AIDS School Education Project: One year Post Project Review (2007).

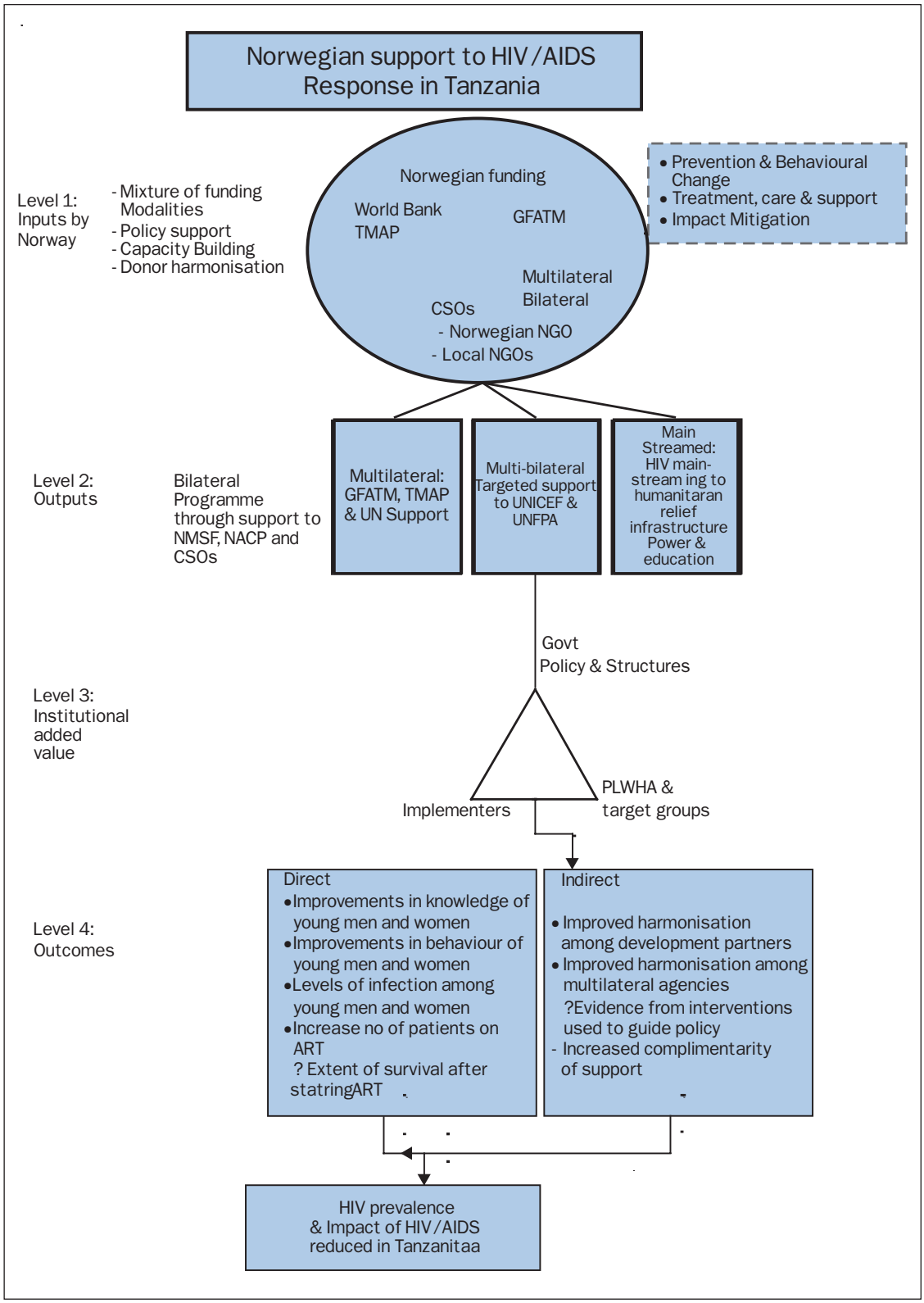
Annex 7: Stakeholder Analysis



Annex 8: Time Line of Country Policies and HIV/AIDS Programmes/Initiatives

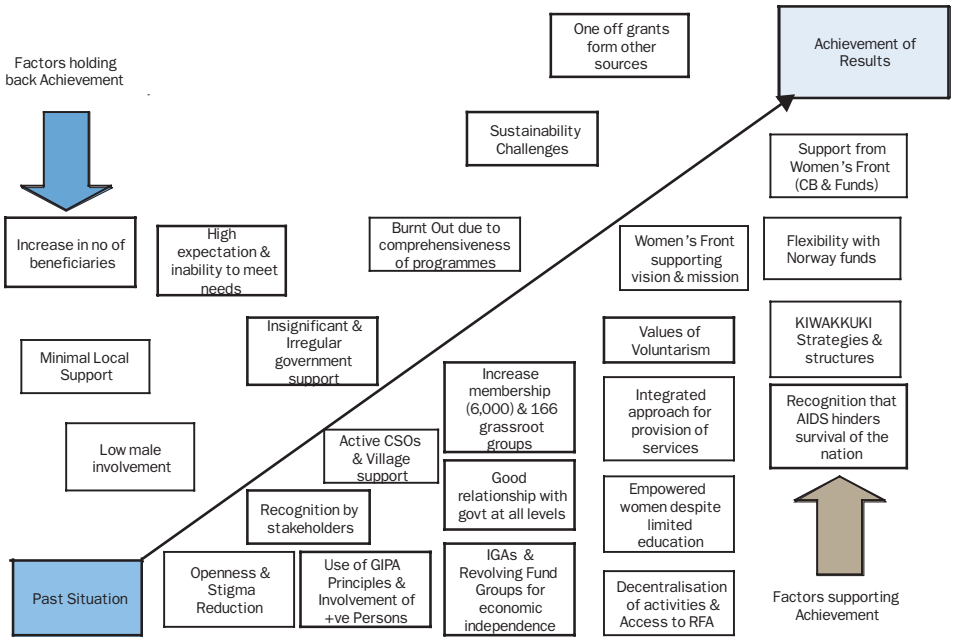
Year/Period	Norwegian Support and Embassy Activities			Context
	HIV/AIDS Specific Support	Other Support Relevant for HIV/AIDS & Mainstreaming	Other Activities & Interventions	
2000	-Support to Tanga RAS for the implementation of MEUTSA HIV/AIDS Project in Tanga region - Ongoing support KIWAKKUKI for the implementation of HIV/AIDS Programme			HIV/AIDS Policy developed
2001	-Support to WLAC - NCA support to implementing partners for the implementation of HIV/AIDS programme			TACAIDS Established
2002	- Support to RFEs for CSOs to implement HIV/AIDS interventions in Tanzania Mainland and Zanzibar - Support to Haydom Lutheran Hospital for the implementation of HAVACOP. -Support to EMIMA for the implementation of Kick AIDS Out Programme.	Expansion of HIV/AIDS programme to cover PMTCT in refugee camp implemented by NPA in collaboration with other partners	Support to ESAURP to conduct a study on orphans' identification and needs assessment.	ZAC Established.
2003	- Support to NMSF implementation through GBS,PF, TMAP and GFATM - Support to the Foundation for Civil Society for the implementation of Civil Society Programme which include HIV and AIDS. - Support to EACDP for the expansion of FEMINA HIP & FEMA magazines. - Support to RFE to provide funds for CSOs for the implementation of HIV/AIDS interventions.			1st NMSF developed and launched.
2004	-Support to NACP for the implementation of National Treatment and Care Plan. -Support to WAMATA			
2005	- Support to KWIECO for the implementation of HIV/AIDS and Empowerment Programme. - NCA established and provided support to more partners for the implementation of HIV/AIDS prevention, care and impact mitigation interventions.	HIV/AIDS Mainstreaming into Songwe-Tunduma Road Rehabilitation Project. Integration of HIV/AIDS Interventions into Zanzibar Rural Electrification Project	Support to Abantu Vision for a film production titled Childhood Robbed.	
2006	Support to Benjamin Mkapa Foundation for the implementation of Human Resource Fellowship Programme			

Annex 9: Intervention Logic of Programmes Supported by Norway

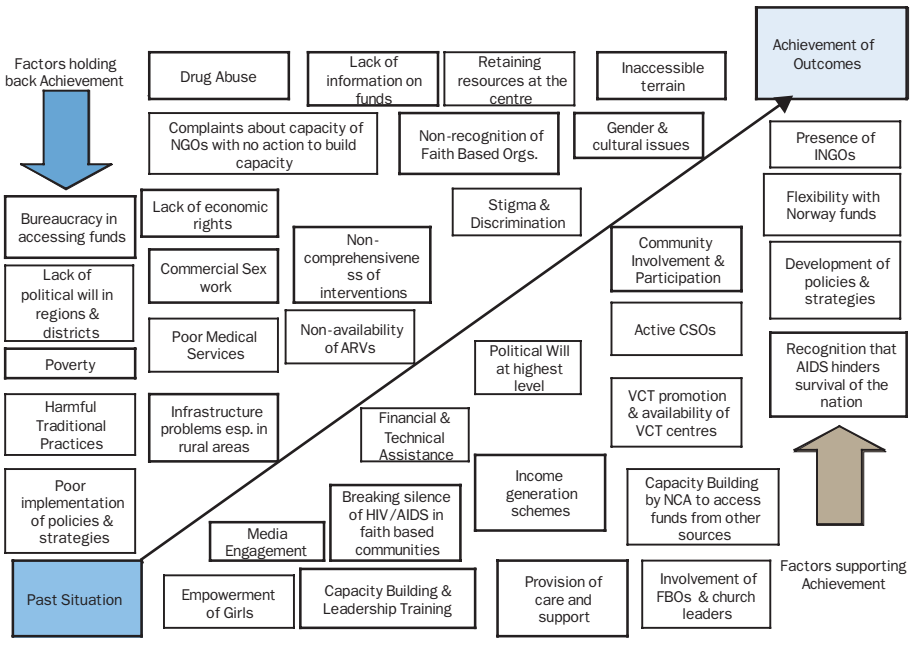


Annex 10: Results from Forcefield Analysis

Force Field Analysis of Factors Hindering & Supporting Achievement of HIV/AIDS Key Outcomes in KIWAKKUKI



Force Field Analysis of Factors Hindering & Supporting Achievement of Key Outcomes amongst Implementing Agencies of Norwegian Church AID in Tanzania



Annex 11: Composition of the Evaluation Team

Dr. Munirat Ogunlayi – Team Leader for Tanzania Country Study
Munirat holds a PhD degree in Medical Sociology and has more than 12 years of experience in programme management and evaluation. She is the ITAD Senior Consultant for HIV/AIDS and Poverty and has substantial experience in evaluating HIV and AIDS programmes at the institutional and project levels for NGOs, government, bilateral donor and multilateral agencies. She provided technical and managerial leadership to the evaluation in Tanzania.

Derek Poate – Project Director
Derek is a Director at ITAD and has acted as team leader and project director for a number of international development assignments, including Countries Programmes Evaluation for DFID in Ghana, Kenya and Rwanda and served as technical leader for the evaluation of partnership of DFID with WHO and team leader for the five-year evaluation of UNAIDS. He is currently Team Leader for the evaluation of RBM in UNDP. He is a recognised M&E and performance assessment specialist.

Derek provided strategic and technical inputs into the evaluation in Tanzania including development of evaluation methodology and review of the draft report.

Wambura Mwita
Wambura Mwita holds a PhD in Epidemiology and has more than 7 years in a wide range of disciplines including designing, implementing and analysing health research and in monitoring and evaluation for health interventions. He is a Senior Researcher with the National Institute for Medical Research in Mwanza, Tanzania.

Cornelius Murombedzi
Cornelius is a Principal Capacity Building Specialist with International Training and Research Centre (INTRAC) specialising in evaluations and organisational development. He has extensive experience in evaluating donor funded programmes and projects that are poverty related and including HIV/AIDS focusing on institutional and organisational arrangements at institutional and national level. He is a Civil Society specialist and supports civil society strengthening to enhance its contribution to poverty reduction, national responses to HIV/AIDS pandemic and governance.

Global Paper – Evaluation of Norwegian HIV/AIDS Responses

September 2008

Submitted by ITAD
Derek Poate, Munirat Ogunlayi, Øyvind Eggen

Contents

Acronyms

ActAFRICA	AIDS Campaign Team for Africa
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retroviral
CCM	Country Coordinating Mechanism
CHAI	Clinton HIV/AIDS Initiative
DFID	Department for International Development
GFATM	The Global Funds for HIV/AIDS, Tuberculosis and Malaria
GHSS	Global Health Sector Strategy
GTT	Global Task Team
HIV	Human Immuno Deficiency Virus
IAVI	International AIDS Vaccine Initiative
ICASA	International Conference on HIV/AIDS and STIs in Africa
IPM	International Partnership for Microbicides
M & E	Monitoring and Evaluation
MAP	Multi-AIDS Programme
MDG	Millennium Development Goals
MFA	Ministry of Foreign Affairs in Norway
NAC	National AIDS Commission
NGOs	Non-governmental Organisations
Norad	Norwegian Agency for Development Cooperation
OECD DAC	Development Assistance Committee of the Organisation for Economic Cooperation & Development
PEPFAR	President's Emergency Program for AIDS Relief
PLHIV	People living with HIV
SRH	Sexual and reproductive health
TRIP	Trade-related intellectual property
TTR	Treat, Train and Retain
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organisation
WTO	World Trade Organisation
WHA	World Health Assembly

Acknowledgements

This global paper has been prepared by an independent team of consultants from ITAD Ltd UK. The team is very grateful to staff of Norad and Ministry of Foreign Affairs for the support they provided us during the period. We appreciate all the key informants interviewed for their valuable time and for sharing essential documents and reports with us for this review.

Executive Summary

Introduction

This report is a descriptive summary and overview of Norwegian support to the international AIDS architecture in the period 2000-2006. It has been written as a contributory part of an evaluation of response to Norwegian Support for HIV/AIDS in three African Countries. Information has been gathered from desk reviews, key informant interviews, email survey and telephone interviews.

In the year 2000, the HIV/AIDS challenge was made a priority for Norwegian Development Cooperation; the time coincided with the period that HIV/AIDS was given growing political attention with the adoption of Millennium Development Goals (MDGs) by World Leaders.

HIV/AIDS is seen as a long term emergency that demands new, strategic and effective approaches at both international and country levels, especially with the provision of social services using participatory approaches from international to community levels. This has led Norway to interact at all levels to contribute to the control of the epidemic. The Norwegian Agency for Development Cooperation (Norad) and Ministry of Foreign Affairs (MFA) channelled resources and support through a variety of organisations and programmes.

Norwegian main contributions

Norwegian contributions during the period 2000– 2006 include multilateral financing, support to development of international and national policies and institutional structures, and country level programmes to halt the epidemic. The document 'Policy positions to guide Norwegian participation in an intensified effort to combat HIV/AIDS' (2000) forms the main policy guidance for Norwegian contributions at that time. The main features were: international coordination with UNAIDS as the major agency; support to contextually developed national plans under national leadership and linking HIV/AIDS to national development planning across sectors and on all levels; donor coordination; public-private-civil society partnerships; addressing gender and age dimensions; and social exclusion.

Norway's contributions were in accordance with these positions when it comes to general policies and institutional set-up, especially playing proactive roles in attempting to build and shape the international aid architecture towards greater harmonisation. Norway has given relatively high priority to supporting multilateral institutions, in particular those of the UN.

Norway was active and played a visible role in many of the decisions and organisational reforms that led to improvements in the development aid architecture. Four aspects that stood out clearly of many roles played by Norway and explored further in the report include:

- Support for UNAIDS as the lead UN joint programme
- Support to the establishment and operational procedures of the Global Fund to Fight AIDS, Tuberculosis and Malaria
- Development of a pivotal sector policy for WHO
- Promotion of the concept of the Three Ones.

Possible outcomes

Norway's contributions were diverse and extensive, and review of three specific cases has shown specific examples of the processes involved and implications.

Norway has always worked in partnership with other donors towards the multilateral institutions. The actual outcomes of Norwegian contributions are in most cases neither possible nor feasible to document. Most of the ideas and initiatives that have come up in the international HIV/AIDS response during the period are believed to have developed in a range

of interactions between different institutions and persons of which Norway has often played a catalytic part. It is, however, clear that Norway has been part of the processes that led to major achievements during the period, including establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)[1], the Three Ones concept[2], the 3 by 5 initiative[3] and the Universal Access initiative[4], and in these cases have supported the processes without having any identifiable negative influence. In some cases it is likely that "seed funding" from Norway has led to other donors becoming involved and hence multiplying Norwegian efforts.

Norway's support was instrumental in generating the international legitimacy for the establishment of UNITAID. This is seen by many observers as having contributed to a more complex international architecture that contradicts the general approach taken in other aspects of Norwegian assistance.

Conclusion

The key issues emanating from this review reveal that Norway is seen as a donor with:

- Consistent, predictable high level sources of finance
- Active approach to policy engagement with institutions through participation in committees and chairing governing bodies
- Focused primary engagement but effective in the provision of technical support especially in providing speedy and high-quality comments to policy and strategic papers of development partners.

Flexible interaction and provision of advisory roles especially when it comes to linkages of global policies to country programmes for implementation.

Some of the major contributions by Norway may be seen as a result of Norway seeing needs, trends and initiatives and responding fast to them. Much of this arises from the relatively small number of personnel in Norad and MFA who have been involved in HIV/AIDS over many years and the unique ability of the Norwegian HIV/AIDS Ambassador to bring political, technical, policy and diplomatic skills to bear on the work. This has led to generally good linkages across the various actions and also across institutions. Norway seems to be consistent in working on the same issues in different institutions, and insisting on a coherent approach. This linkage is also reflected in the country level responses. For example, the Three Ones are operational in the three countries studied for the evaluation. Deviations from the policy paper are mostly in priorities, not in general policy choices and can be read as adaptation to a rapidly changing context.

1 the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was created to finance a dramatic turn around in the fight against AIDS, tuberculosis and malaria.
2 The Three Ones concept includes One National Coordinating Authority, One Strategic Framework for HIV/AIDS Action and One Monitoring and Evaluation Framework. The concept is aimed at achieving the most effective and efficient use of resources, and to ensure rapid action and results based management in response to HIV/AIDS.
3 The 3 by 5 initiative was launched by UNAIDS and WHO in 2003. It was a global target to provide three million people living with HIV/AIDS in low and middle-income countries with life prolonging antiretroviral treatment (ART) by the end of 2005. It was a step towards the goal of making universal access of HIV/AIDS prevention and treatment accessible for all who need them as a human right issue.
4 The Universal Access initiative extends the promise of 3 by 5 targeting universal access to treatment, care and prevention by 2010. It is aimed at scaling up HIV/AIDS prevention, treatment, care and support, and ensures equitable access to services and information by all people that need them.

1 Introduction

This report is a paper documenting Norway's HIV/AIDS contribution at the international level, comprising a descriptive summary and overview of Norwegian support to the international AIDS architecture in the period 2000-2006. It has been written as a contributory part of an evaluation of response to Norwegian support for HIV/AIDS in three African countries.[5]

HIV and AIDS have become an increasingly central theme in development with various changes over the years in the international institutional landscape to deal with the epidemic. In the year 2000, the HIV/AIDS challenge was made a priority for Norwegian Development Cooperation; the time coincided with the period that HIV/AIDS was given growing political attention with the adoption of Millennium Development Goals (MDGs) by World Leaders. MDG 6 focuses directly on HIV and AIDS and states that the spread of HIV/AIDS should be halted by 2015. Instructions were given to the development administration in Norway to contribute as far as possible to limit the spread of the epidemic, especially with the declaration of commitment from the UN General Assembly Special Session (UNGASS) on HIV/AIDS in June 2001. That set out the principles for a programme of action and discussion. The subsequent meetings of the UN Security Council and G8 summits have placed HIV/AIDS firmly on the global agenda.

The Norwegian Agency for Development Cooperation (Norad) and Ministry of Foreign Affairs (MFA) channelled resources and support through a variety of organisations and programmes. HIV/AIDS is seen as a long term emergency that demands new, strategic and effective approaches at both international and country levels especially with the provision of social services. The response also requires integrated, inclusive and participatory approaches from international to community levels which has led to the need for Norway to interact at all levels to contribute to the control of the epidemic.

Norwegian aid in general during the period has gone through a range of reforms of which most are included in the concepts "new aid architecture", "new aid modalities" and later reflected in the Paris Declaration on aid effectiveness. Reforms include changes towards harmonization and donor coordination; focus on national ownership, planning and implementation; policy and sector reforms; budget support rather than project and programme support. Norway has been proactive internationally in implementing many of these reforms and relatively fast to adapt in its own development strategies. These reforms also affect the contributions towards HIV/AIDS. While the reforms supposedly lead to better outcomes and impact of the international efforts against HIV/AIDS, the same reforms make it difficult to precisely trace the actual outcomes of Norwegian contributions, as this report reflects.

The global paper is set out in four chapters. Chapter one covers the introduction, methodology used, justification for selection of methods and methodological challenges. Chapter two reviews contributions of Norway and various interactions at global level and international arena, including financial contributions. Chapter three presents selected sample case studies with discussion on the role of Norway, achievements and emerging issues. Chapter four concludes with discussion and analysis on linkages of the various actions taken and support provided during the period reviewed.

1.1 Methodology

Information was gathered through desk review of files and documents, key informant interviews, email survey and telephone interviews.

5 Reports of the Evaluation of the Norwegian Responses to HIV/AIDS in three African Countries – Ethiopia, Malawi and Tanzania.

Desk Reviews - Aside from documents that have been reviewed during the previous phases of this evaluation, various other documents were also reviewed which include, inter alia: documents from MFA, documents shared by the HIV/AIDS Ambassador - Dr Sigrun Møgedal, documents from the MFA and Norad archives, documents from the various agencies that were consulted including available annual reports, work programmes, project plans and reports, evaluation reports, Management Board minutes and reports, advisory forum minutes and sub group reports, internet site documentation, procedures manuals, and correspondence files.

These secondary data were valuable means of gathering information considering the periods covered by the evaluation and provided the foundation which subsequent interviews built on. Efforts were made to review and extract key information and findings both on how Norwegian support has contributed to the achievement of key outcomes at international arena. In addition, the findings from the desk review enabled us to review and refine questions for interviews and to triangulate with other sources.

Identification of Key Informants: The team worked with MFA, Norad and the HIV/AIDS Ambassador - Dr Sigrun Møgedal to develop a comprehensive list of stakeholders that have benefited from or worked with Norway during the period. Some were also identified from documents reviewed. Initial list developed was presented to Norad and agreed. This was subsequently built on in the process. The informants were contacted and a schedule was developed for the consultations. Where it was impossible to conduct face to face interviews, email survey and telephone interviews were conducted.

Key Informant Interviews: Face to face interviews were conducted with identified informants in institutions and agencies that Norway interacted with or supported during the period. Factual data about events, actions, achievements; and opinions and perceptions about why events occurred in the way they did and the outputs generated. The team used interview topic guides to guide the direction of the interviews.

The face to face interviews were conducted with key informants in multilateral agencies in Geneva – WHO, the UNAIDS Secretariat, UNITAID & GFATM, and UNICEF, UNDP and UNFPA in New York.

Email / Web Survey – We utilized email survey to gather opinions and perceptions of stakeholders in agencies and institutions that could not be reached for face to face interview using concise and limited set of questions. The responses from the email survey were analysed and information were used to buttress and triangulate information synthesized from documents reviewed and key informant interviews conducted. Twenty – seven respondents were reached using the email survey covering the multilateral and bilateral agencies, private institutions working and supporting HIV/AIDS responses, educational institutes and non-governmental organizations.

Telephone Interviews – For flexibility reasons, we requested stakeholders that cannot respond to the email survey to contact us for telephone interviews. Telephone interviews were also conducted for a number of stakeholders who preferred to talk to us rather than responding to the email survey.

The mix of methods utilized for the review were selected carefully in order to reach the key stakeholders that would provide us with the necessary information to ensure conduct of an objective and independent review.

1.2 Methodological Challenges

No single source of information was able to provide a coherent overview, so it was challenging to review hundreds of documents made available from various sources and synthesise appropriate information useful for the study. At an early stage it was clear that the nature of work that Norway has engaged with at this level required sensitive approaches of diplomacy and advocacy, and such efforts in most cases are not documented. The evaluator has to rely on oral information from the key persons involved and the team triangulated such information with other sources for confirmation. In addition, there are few or no systematic

procedures for reporting (annual, program report) like in other development cooperation because of the nature of the work in this context.

Movement of key informants from one agency to another or out of the system also posed some challenges. To overcome this, the informants were followed up to the new agencies where they currently serve in order to reach them for face to face interview or email surveys. Those who have moved out of the system were reached through their personal email contacts or telephone numbers that were made available to the team. In terms of getting the necessary documents as promised by the informants, the team was persistent in following up with the required agencies on many occasions to obtain the documents.

2 Norwegian Main Contributions

Norwegian contributions during the period 2000–06 include multilateral financing, support to development of international and national policies, and country level programmes to halt the epidemic. The 'Policy positions to guide Norwegian participation in an intensified effort to combat HIV/AIDS' (2000) forms the main policy guidance for Norwegian contributions throughout the period. The main features of the policy were: international coordination with UNAIDS as the major agency; support to contextually developed national plans under national leadership and linking HIV/AIDS to national development planning across sectors and on all levels; donor coordination; public-private-civil society partnerships; addressing gender and age dimensions; and social exclusion.

The actual contributions by Norway during the period have generally been in accordance with these positions when it comes to general policies and institutional set-up. Although the policy paper also mentions affordable treatment and drug prices, its priority at the time was on prevention, care and coping; during the period there has been much more focus on treatment and on health systems capacity, in particular health personnel more recently. These changes can be seen as reflecting adaptation to global developments rather than a shift in policies.

Norwegian contributions on harmonisation and coordination have perhaps also changed in some forums during the period, from a policy focus to more technical approach, which may also be seen as adaptation to a changing context; during the latter part of the period the need for harmonisation and coordination was acknowledged by most other institutions and agreed in the Paris Declaration.

During the period under evaluation, Norwegian contributions to the global HIV/AIDS response may be characterised by relative generosity compared to own GDP; medium absolute volume of financial support compared to other donors; more flexibility than most other donors; and a very proactive role in attempting to build and shape the international aid architecture towards greater harmonisation. Towards some institutions, like UNAIDS and WHO, Norway is among the major donors.

2.1 Reference to Timelines

Annex 3 presents a timeline of major events concerning the global fight against HIV and AIDS. Only major initiatives are shown, but even so, the diagram conveys how much effort has been made by international institutions, both directly, such as the creation of the Global Fund and promotion of the Three Ones and in support, such as the declaration of access at the World Trade Organisation (WTO) Doha round.

2.2 Financial Contributions

Norway has been a substantial financial contributor to international organisations with programmes to tackle HIV and AIDS. Owing to the ways in which expenditure is categorised and the fact that programmes to tackle HIV/AIDS are often subsumed within broader programmes of the multilateral organisations, it is not easy to get a single overall summary of the resources that have been committed. The tables in Annex 4 present the information made available by the Ministry of Foreign Affairs, from three complementary but overlapping perspectives for the period from 2000-2006:

- Expenditure to support multilateral organisations, part of which was used to fight HIV/AIDS
- Expenditure categorised by DAC Sector code, relevant to HIV/AIDS
- Expenditure that was coded as having a main or significant objective to fight HIV/AIDS

The findings from those tables are summarised here in Table 1.

Table 1 Summary of Norwegian development assistance expenditure by various recipients and programme categories 2000-2006

			NOK '000
Expenditure on multilateral organisations			6,922,661
	Of which major contributions to:[6]		
	African Development Bank		
	World Bank		
	World Health Organisation		
	UNAIDS		
Expenditure by objective to tackle HIV/AIDS			925,560
	Significant objective to tackle HIV/AIDS	27%	
	Main objective to tackle HIV/AIDS	73%	
	Of which:		
	UNICEF	19%	
	Global Fund to fight HIV/AIDS, TB and Malaria	15%	
	UNFPA	12%	
Expenditure by DAC Sector code for SRH and HIV/AIDS[7]			366,114
	Of which:		
	UNICEF	26%	
	UNFPA	24%	
	IPM - International Partnership for Microbiocides	15%	
	IAVI - International AIDS Vaccine Initiative	11%	

The information in Annex 4 shows some clear trends. Firstly, that total expenditure to multilateral organisations for broadly HIV/AIDS and closely related purposes over the period has been high, in excess of the NOK 7 billion shown in the table. Expenditure has been concentrated in four organisations with a clear emphasis on Africa and health. Almost NOK 1 billion in programme expenditure was marked as being directed towards HIV/AIDS as a main or significant programme objective. Of this, close to half (46%) was to just three organisations: UNICEF, the Global Fund and UNFPA. Funding categorised by DAC sector code shows again the concentration of funding, with 50% split between UNICEF and UNFPA, and 26% to the specialist programmes IPM and IAVI.

2.3 Norway's Support to and Engagement in International AIDS Architecture

Aid architecture could be defined as the set of rules and institutions governing aid flows to developing countries. While aid has architecture, it has no single architect.[8] Aid architecture has evolved over time, much of it without a pre-defined blue print. Burall et al (2006) noted that one of the key features of the international aid architecture is that there is no forum that brings together all of the key players to discuss and ultimately make binding decisions. But the situation has changed as there have been a number of developments that offered some opportunities to advance the debate and increase political pressure on the different actors in the system.

The Paris declaration for aid effectiveness offers perhaps the most potential for short term improvements to the way aid is delivered; and the process of UN reform is moving towards the stage of UN system-wide coherence in the areas of development assistance, aiming to streamline the UN's development architecture. Reform of the international aid architecture requires the active engagement and agreement of many different actors, bilateral and

6 Exact details have not been made available. The data in Annex 4 Table 3 omits some channels of support such as IDA replenishment and is not comprehensive. The total quoted is a guide only.
7 DAC – Development Assistance Committee of the OECD, which has the lead role in documenting and reporting flows of development assistance.
8 International Development Association Resource Mobilisation (2007) AID Architecture: An Overview of the main trends in ODA flows.

multilateral donor agencies as well as national governments within the donor and recipient nations. In addition, for reform effectiveness and legitimacy, civil society and the private sector will have to understand and agree with the proposed direction, thus presenting problem of a complex collective – action, especially on building consensus and trust that would allow significant and meaningful reform to happen.

To move this forward especially in relation to HIV/AIDS, Norway played a significant role in building consensus at international and national level – in efforts to ensure that various flows of aid yield impact required in halting the epidemic. Diagrams showing three time periods are presented below to illustrate the evolution of the global AIDS architecture in relation to HIV/AIDS (Figures 1, 2, & 3).

Figure 1 AIDS architecture prior to creation of UNAIDS

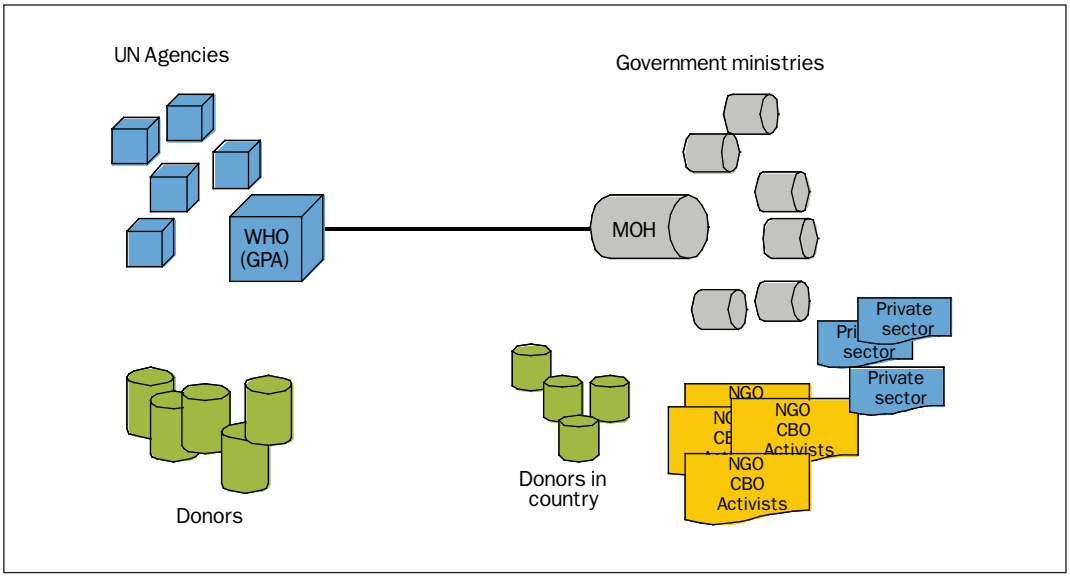
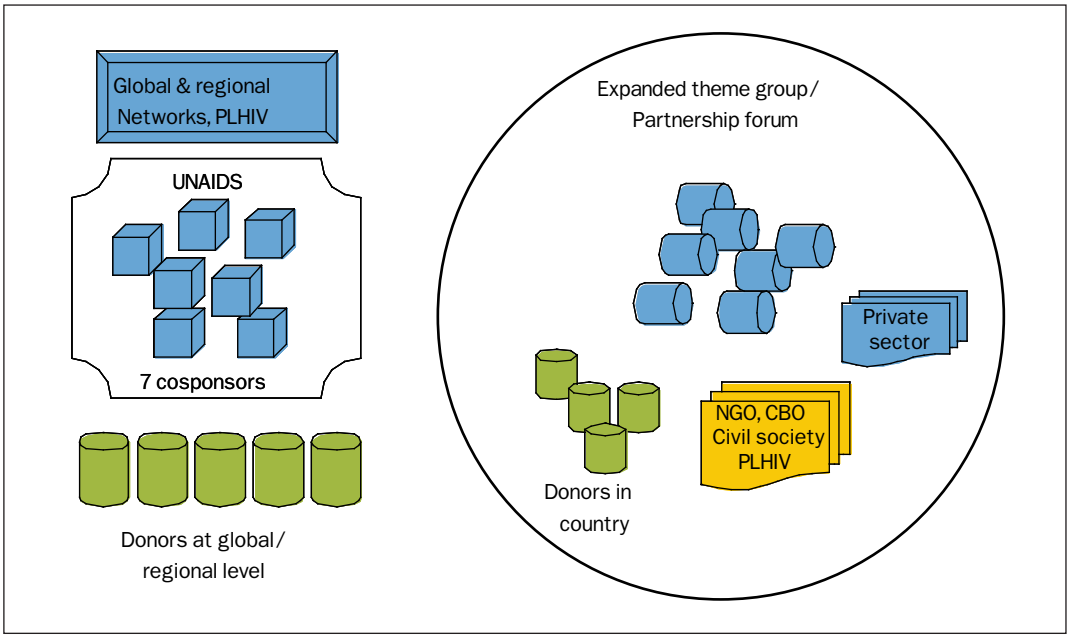


Figure 1 shows that prior to the creation of UNAIDS the response was fragmented with the strongest links between WHO and national Ministries of Health through the Global Programme on AIDS (GPA). Other government ministries were not on board and rarely were there multisectoral responses, although the impact of AIDS was felt in other sectors such as education, agriculture, etc. There was little coordination and limited involvement of non-governmental organisations and the private sector. Response was delivered unilaterally as the situation arose.

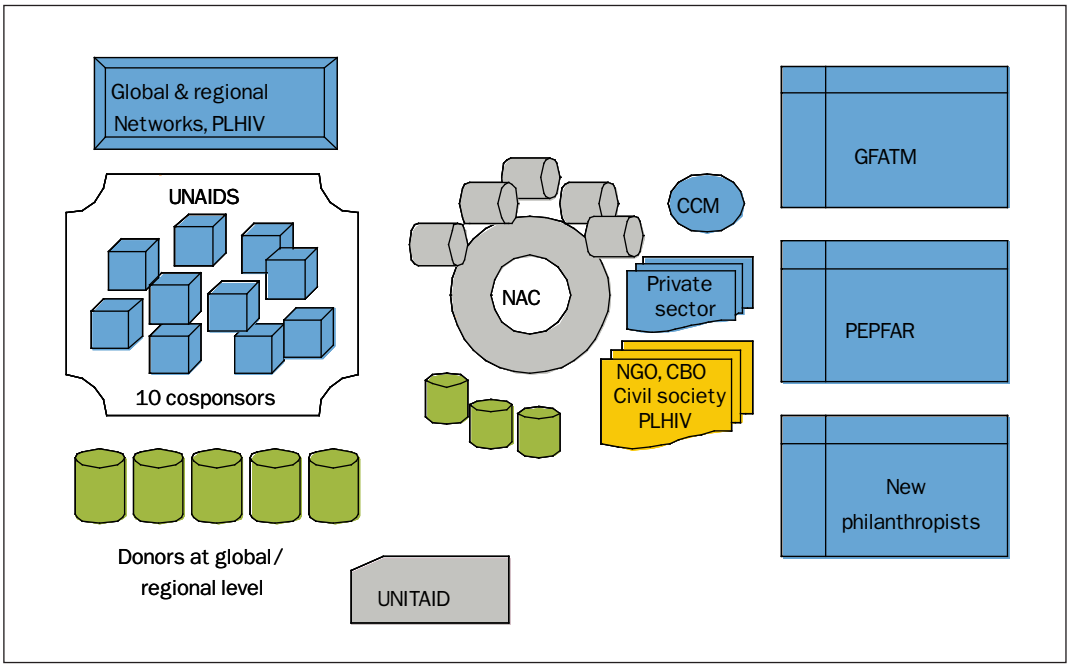
Figure 2 AIDS architecture circa 2001



A major change came during the first five years of UNAIDS as donors unified behind the joint UN programme. An expanded response started to develop around better coordination in country, increasing involvement of non-governmental partners including PLHIVs, and the UN cosponsors started to adopt a more coherent approach (Figure 2). UNAIDS helped achieve a critical mass of consensus towards an expanded approach but major weaknesses remained. Core problems included:

- A massive shortfall in funding, especially for treatment and care
- Poor planning and coordination at national level
- Overlaps in the work of international agencies
- Crises in health care systems amid the pressure to cope with vertical programmes

Figure 3 AIDS architecture after 2001



These issues have to a large extent been tackled, if not fully resolved, such that by the time portrayed in Figure 3 UNAIDS has an expanded complement of cosponsors, country programmes have largely adopted the NAC structure with the implementation of the Three Ones concepts – one coordinating body, one national framework and one monitoring and evaluation. New large scale funding has becomes available through global funds and with active involvement of the private sector, new philanthropists and emergence of bodies such as UNITAID.

Norway had a visible and active role in many of the decisions and organisational reforms that led to these improvements. It is impossible to list all the actions that were taken, but four stands out and are explored further in later sections of this report:

- Solid support for UNAIDS as the lead UN joint programme
- Support to the establishment and operational procedures of the Global Fund
- Development of a pivotal sector policy for WHO
- Promotion of the concept of the Three Ones

The next sections look at aspects of Norway's support to specific organisations and to some important themes.

2.3.1 UNAIDS

Norway has been a key donor since the beginning of UNAIDS and board member of UNAIDS Programme Coordinating Board from 2000 to 2002 and from 2006 onwards. Norway also seconded personnel to UNAIDS head office and has also frequently engaged through participation as member and chair in committees and working groups, and roles as facilitator to various processes, including the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, and the Global

Steering Committee on Scaling up Towards Universal Access (including chair of subgroup on health personnel and capacity).

From 2002-2004, Dr. Sigrun Møgedal[9] was seconded as Senior Policy Adviser on a part-time basis to the UNAIDS Secretariat with responsibility for the country level coordination of the HIV/AIDS response. In particular, Dr. Møgedal was in charge of a broad consultation process in a range of countries, that contributed to the establishment of the Three Ones concept, whose principles have later dominated the AIDS architecture at international as well as national level in most countries (see separate case study in Chapter 3).

The Norwegian positions and inputs in UNAIDS have been characterised by:

- A focus on national coordination and ownership;
- Donor coordination;
- Marginalised groups, scientific and evidence based (rather than normative and ideological) approach to prevention in controversial issues;
- The links between AIDS and health sector capacity in general;
- Universal access to treatment; and
- Keeping a focus on prevention when the international effort shifted towards treatment.

2.3.2 The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

Following the initiative for a global fund, Norway has, in addition to funding, contributed to the institution since prior to establishment through the transitional working group, in which Norwegian inputs reflect an insistence on harmonisation. Subsequent formal involvement has been via board membership as part of the Point 7 group (of countries aiming to provide more than 0.7 percent of GDP in aid). 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 representative in 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; coordinate with other funding mechanisms; adhere to the Three Ones concept by supporting one national strategy with one set of indicators and pool resources on country level; and closely integrate with health sector and development strategies in general. Norway has also engaged in procurement and supply management (including key role in formulating procurement policies) issues and the monitoring system (by chairing the M&E and finance committee), and generally in organisational and governance issues. Among the specific Norwegian positions are that GFATM should not broaden its role but continue as a funding mechanism only; not establishing representation in recipient countries.

Although Norway's financial contributions to GFATM are relatively small (around 1.5 percent according to an internal note from MFA, sources indicate that Norway has had a role in mobilising resources from other donors, in part because of the active involvement, commitment and direct participation of Norwegian political leaders (including the Prime Minister) in fundraising (replenishment), which lead to a more positive climate among public donors and private sector that may have led to more financial contributions from others.

2.3.3 Norway's contributions and support to other multilateral agencies.

Norway is generally one of the top five most important donors to the World Health Organisation. In addition to funds earmarked for HIV/AIDS, Norway was engaged with WHO on issues relating to HIV/AIDS including TRIPS and the WHO Global Health Sector Strategy for HIV/AIDS 2003-2007 (see separate case study in Chapter 3).

Norway worked since early in the period with the World Bank to put HIV/AIDS on the agenda. Measures include setting up a Trust Fund that supported AIDS Campaign Team for Africa (ActAfrica), which was crucial in establishing and enabling support for the Multi-Country AIDS Program (MAP) launched in 2000. ActAfrica also served to mainstream the World Bank's operations in various sectors and countries. Norway has also supported some country level monitoring and support to ActAfrica, and direct support to MAP. Norway used

9 Dr Sigrun Mogedal was seconded as a Policy Advisor to UNAIDS in 2002, and UNAIDS requested for a year extension in February 2003.

various occasions on different levels in the World Bank to highlight the links between HIV/AIDS and development.

Norway has supported follow-up of the Security Council Resolution 1308 on HIV/AIDS in peace keeping programmes, and supported the follow-up by UNAIDS of the resolution.

Norway took an active part in the UNGASS 2001 and follow-up meetings in 2006. Norway has also supported and funded UN agencies - UNDP, UNICEF, UNFPA at country level to support implementation of the national plans.

Norway had key roles in the processes that led to the establishment of the Global Health Workforce Alliance, e.g. in hosting two conferences prior to start-up and funding other conferences, in joining the Alliance from the start; and in committing to funding operational costs for the first year (USD 3.5 mill).

Norway has also engaged with WTO regarding the TRIPS agreement, arguing that life threatening diseases like TB and AIDS justifies exemptions from patent rules. A conference hosted by Norway in Oslo in 2001 raised the issue through participation in WTO negotiations.

Norway has provided financial support to research on vaccines through IAVI and development of prevention options for women through IPM. These institutions have, however, been given less priority in policy dialogue and technical assistance.

2.4 Cross-Institutional Support to Specific Objectives

Norway has, in addition to engaging widely with the various institutions, applied a thematic approach that has also contributed to cross-institutional cooperation in general. These are described below (with some overlap to the text above).

2.4.1 Drug prices

During first parts of the period under evaluation, Norway was engaged in the challenges of TRIP and other trade related agreements affecting patent issues, which had led to higher prices on antiretroviral drugs. Initiatives were taken in WTO, and Norway hosted a conference in 2001 with WTO and WHO, considering the importance of linkage of these institutions and putting the issue on the agenda. After the patent issue was partly resolved, another issue related to affordable drugs was financing, for which Norway engaged with other institutions, in particular GFATM. Towards the end of the period, it was internationally recognised that functioning drug purchase mechanisms were lacking, and Norway engaged with other four countries to come up with the International Drug Purchase Facility which subsequently led to the establishment of UNITAID (see case study in Chapter 3).

2.4.2 Harmonisation and coordination

A major priority of Norway has been harmonisation and coordination at national and international level. Norway's support for development of the Three Ones initiative is a particular case (see case study). Norway has also contributed to harmonisation through its involvement in the various institutions, normally insisting on coordination between international agencies and supporting development of mechanisms to enable better coordination at national level (e.g. harmonised reporting systems). Several of the processes in which Norway has been a key agency have also served to link various multilateral organisations closer to each other. Examples include World Bank and UNAIDS through ActAfrica; UNAIDS and UN Security Council through UN Office on AIDS, Security and Humanitarian Response, UNAIDS and WHO on Health Sector and most institutions through Three Ones.

2.4.3 Health systems strengthening

In the area of health systems strengthening Norway has worked within a range of institutions. The challenge of strengthening health systems were put on the international agenda through, amongst others, the G8 (in 2003 and 2005) and later UNGASS 2006, and it became the explicit priority under the international commitment for Universal Access. Norway took a proactive role on one of the components; health personnel. An "Oslo consultation" hosted by Norway in February 2005 may be seen as one of the starting points for a broad engagement

involving a wide range of institutions, and for which Norway was one of the catalysers. The issue of health personnel was linked to and integrated in various other international structures and initiatives including WHO, MDGs, World Bank, GFATM and others. The Global Health Workforce Alliance was established, in which Norway joined and supported the first year of operations. Within WHO Norway worked with the departments of HIV/AIDS and health systems cluster, promoting an awareness of the issues to ensure both had a shared agenda. Within GFATM Norway was among those pushing for the GFATM to support strengthening of health systems in addition to directly targeting the three diseases. The principle was agreed, although applicants to GFATM grants must justify that strengthening health systems is effective in combating one of the three diseases.

Summary of Norwegian main contributions

- Norwegian contributions during the period under evaluation include multi-lateral financing, support to the development of international and national policies, and country level programmes to halt the epidemic.
- Total expenditure to multilateral organisations for HIV/AIDS and closely related issues over the evaluation period is in excess of NOK 7 billion.
- About NOK 1 billion was expended on programmes marked HIV/AIDS as significant, 46% of the fund was directed to UNICEF, UNFPA and the GFATM.
- Norway played a significant role in global aids architecture through building consensus at international and national level. This has resulted in unifying efforts of stakeholders to coordinate responses to HIV/AIDS to yield the impact required, although there are still challenges.
- Norway's active involvement in many decisions and organisational reform that resulted in improved global aid architecture include solid support to the establishment and operational procedures of UNAIDS and the GFATM, promotion of the Three Ones concept and support to pivotal sector policy in WHO.

3 Presentation of Sample Case Studies

Norway was involved in many international actions as stated in the previous chapter. Three sample case studies have been selected to illustrate Norway's contribution and they include the Three Ones, Global Health Sector Strategy (GHSS) and the establishment of UNITAID. The justifications for the selection of these three cases out of many others are:

- The three occupied key milestones in the period reviewed. For example, the Three Ones discussion started in 2002, GHSS was approved in 2003 with other updates arising from it and UNITAID was established in 2006.
- The Three Ones concept has contributed immensely in shaping the development aid architecture for HIV and AIDS, and the role of Norway is well recognized by stakeholders at international and country levels.
- The GHSS is unique for WHO and vital considering the role of the health sector within the multisectoral response, and the emergence of PEPFAR and other targeted programme initiatives.
- UNITAID is about drug purchase to respond to the three key diseases – Malaria, HIV/AIDS and Tuberculosis. UNITAID was formed at the latter period of the evaluation and has received criticisms from many informants to this study. Hence the need to consider the value added and any lessons learned.

The three case studies follow in the subsequent sections.

3.1 Development of the "Three Ones" Concept

3.1.1 Background

The initiative of developing the concept of the Three Ones[10] was first presented at a side meeting to the International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) in Nairobi in 2003.[11] The ICASA side meeting was a follow-on to the meeting held in July 2002 at the International AIDS Conference in Barcelona which focused on National AIDS Councils (NAC) and the coordination of national responses to HIV/AIDS.[12] Stakeholders at the Barcelona meeting requested the UNAIDS Secretariat and the World Bank to harmonise their efforts and activities in strengthening NACs. In addition, they also requested UNAIDS to develop guidelines that could be used by countries as they establish their national coordination structures and mechanisms, especially given that Country Coordination Mechanisms (CCMs) were being introduced by the Global Fund (GFATM). Based on these demands, UNAIDS Secretariat, World Bank and Global Fund worked with UNDP to prepare for the ICASA side meeting. Prior to this meeting, a survey of country experiences in relation to National HIV/AIDS responses was prepared as background material.

The side meeting at ICASA reaffirmed that the initiative was not about creating new structures, but to ensure that existing structures are utilised effectively, considering the environment in which there was substantially more funding becoming available and a growing interest in public/private partnerships. Hence, the need for more effective and efficient coordination of national responses to avoid duplication, confusion and wastage of resources. The meeting noted the opportunities and challenges of a growing diversity of funding mechanisms and partnerships for HIV/AIDS action, and also underlined the need to understand coordination challenges at many levels, the urgency of the local action and the imperatives of an enabling policy environment.

10 A note from Sigruns archive: The Three Ones Concepts and the Global Task Team Recommendations – Fostering Country Ownership and Leadership: From ICASA 2003 to Rio 2005,

11 ICASA side meeting report: The Coordination of National Response to HIV/AIDS – Sunday, 21st September, 2003

12 Report, Satellite Meeting on National Aids Commissions, Barcelona, July, 2002

Six key principles were presented and deliberations led to strong consensus over three key and urgent messages emanating to all stakeholders at country level:

- One national authority, with a broad-based multi-sector mandate
- One agreed HIV/AIDS Action Framework that drives alignment of all partners
- One agreed country level Monitoring and Evaluation System.

The principles were later endorsed at a Washington Consultation on Harmonization of International AIDS Funding, in April 2004. In addition, the London high level meeting of March 2005 that established the Global Task Team on improving AIDS coordination also further promoted the development and implementation of the Three Ones.

The Three Ones came about owing to the marked shift in global response to the crisis of AIDS, new acknowledgement of urgency and stronger and more consistent actions required to fight the epidemic, the need to deal with and manage risks of duplication, overlap and fragmentation of the response, particularly where the capacity to coordinate is weak.

3.1.2 Role of Norway

The Policy Advisor seconded by Norway to the UNAIDS Secretariat from 2002 to 2004 played a central role taking forward the various tasks of making the Three Ones a reality. The Policy Advisor led the country level consultations and synthesised the outcomes in the form of the six key principles presented at ICASA. The Three Ones have now become the guiding principles used worldwide in organising national responses to HIV/AIDS. It is fair to say that the Three Ones to a large extent benefitted strongly from Norway's contributions to UNAIDS. Norway also actively promoted the endorsement of the Three Ones concept, among others in preparation for the Washington Consultation.

3.1.3 What has been the effect of the Three Ones on country level responses?

In all the three countries studied for this evaluation, it is very clear that the Three Ones are operational and supported by stakeholders involved. If the Three Ones had not been in place, the scenario at country level with the proliferation of funding could have been chaotic. The national coordinating authority is in place coordinating the responses and unilateral framework to guide responses across all sectors. In other words, the establishment of Three Ones has been a direct boost to the implementation of true multisectoral responses. Most donors including Norway also structure their financial support behind the implementation of the national framework – hence the framework acts as a road map to guide responses in the countries. Implementation is not without problems and in general terms countries have faced a bigger challenge to establish one Monitoring and Evaluation system (M&E). But, despite challenges with the implementation, the M&E framework is contributing to the visibility of achievements and progress recorded in many countries today and stakeholders are working with partners to see how this could be made more functional.

The Three Ones has enabled donor governments and other external partners to have a major role in ensuring that their funding and support enables a nationally owned and led AIDS response. The Three Ones concept for coordination have achieved effectiveness, speed and results that could be a showcase for efforts put into HIV and AIDS and also is a practical manifestation of the principles of the Paris Declaration on Aid Alignment and Harmonisation.

3.2 The WHO Global Health Sector Strategy (GHSS) for HIV/AIDS 2003-2007

3.2.1 Background

The need to define and strengthen the health sector in responding to HIV and AIDS within the broad multi-sectoral response informed the World Health Assembly (WHA) resolution in May 2000. This requested WHO to develop a Global Health Sector Strategy (GHSS) for responding to the epidemics of HIV/AIDS and sexually transmitted infections as part of the United Nations system-wide effort to combat the epidemic. This mandate resulted in wider consultations amongst stakeholders involving the regional offices of WHO and significant number of countries. For the first time in WHO, the GHSS stated the action points specific for the health sector in responding to the epidemic. The GHSS document was endorsed by the World Health Assembly (WHA) in May 2002. It has four core components:

- Prevention and Health Promotion
- Treatment
- Health Standards and Health Systems
- Informed Policy and Strategy Development

In addition, the GHSS document contains explicit strategies and key action points for WHO and Health Ministries for the implementation of the core components.

Development of the GHSS responded to a clear need at country level and some countries adopted the use of the GHSS even before final endorsement by WHA. Tanzania, for example realized at the consultation stage that the GHSS was a pillar and the guide needed for the implementation of the health sector response especially the AIDS treatment programme. The example of Tanzania was reinforced during interviews with stakeholders consulted during the field visit for the evaluation in Tanzania.[13]

"We have started the plan for treatment programme before the commencement of 3 by 5 initiative here in Tanzania, but the initiative only pushed forward the momentum on ground" – NACP & WHO, Tanzania.

In May 2003, the leadership in WHO changed. Momentum was retained in driving forward the health sector response to HIV and AIDS and to push the balance between prevention and treatment, especially in Sub-Sahara Africa. As a way of implementing the treatment component of GHSS, the 3 by 5[14] initiative was launched with clear reference to the strategy.[15] The 3 by 5 initiative contributed to and served as the spring board for Global Fund focus on treatment as requested by countries and which subsequently led to the 2005 commitment to Universal Access to HIV prevention, treatment, care and support by 2010.

Subsequently, various other sub-components of the strategy were picked for implementation but the strategy was never implemented in a holistic way. Also, to address the implementation, some advocacy efforts were embarked on to call global attention to the human resource crisis which was clearly documented in the GHSS and resulted in the establishment of the Global Health Workforce Alliance. The issues at country level still remain owing to weakness in the health system and have resulted in a strategic approach adopted by GFATM in collaboration with WHO in approving funds for health system strengthening to enhance the productivity and performance of GFATM grants at country level.

Efforts are now being directed at reclamation of HIV-positive health workers and creation of incentives to retain them, thus resulting in another initiative of Treat, Train and Retain (TTR). Norway provided financial and technical support to the development of the TTR guideline and to build on this, the US government has announced $1.2 billion to implement the TTR initiative in 15 PEPFAR countries.

The TTR is in line with the international consensus that without urgent improvements in the performance of health systems, including the significant strengthening of human resources for health, the world will fail to meet the MDGs for health or to achieve universal access to HIV services by 2010[16]. The TTR includes a task shifting approach that involves a rational redistribution of tasks among health workforce teams whereby specific tasks are moved where appropriate, from highly qualified (and more scarce) health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of available human resources. The task shifting approach is expected to represent a return of the core principles of health services that are accessible, equitable and of good quality.

Although the four core components of the GHSS have not been comprehensively implemented, the strategy is good and comprehensive in addressing HIV/AIDS and related issues within the health sector and some of the components have been led forward through other institutional settings.

13 The comment boxed in the paragraph was made by senior officials interviewed in NACP and WHO Dar es Salaam office.
14 The 3 by 5 initiative means having 3 million people on treatment by 2005. This is WHO initiative to address mortality resulting from AIDS by improving access to treatment.
15 Discussion with Dr. Winnie Mpanju – Shumbusho, Senior Adviser to the Assistant Director General HIV/AIDS, TB, Malaria and Neglected Tropical Diseases – April 30 2008.
16 WHO (2008) TTR Task Shifting – Global Recommendations and Guidelines.

3.2.2 Role of Norway

Norway provided leadership to the development of GHSS. The sound technical knowledge of Norway's representative and her ability to influence other donors and countries contributed to the success of the development of the strategy. It is not clear how much money Norway put into this, but the Norwegian representative chaired the Global Reference Group[17] and participated in the wide regional consultations for the development of the document. In terms of implementation, Norway also played a key role in the sub-components that have been picked for implementation especially the 3 by 5 and the TTR initiatives.

3.2.3 Emerging issues

The GHSS is a comprehensive and well accepted document especially at global level with the endorsement of WHA. But there are issues and challenges with implementation at a full scale as contained in the strategy. Considering Norway's recognition as one of the five leading donors supporting WHO, the leadership role that Norway played and the amount of time invested in getting this strategy developed, it is unclear why Norway did not direct the weight of it's influence, as acknowledged amongst stakeholders, in ensuring implementation of the strategy irrespective of change in leadership of WHO.

In addition, opportunities appear to have been missed for better interaction among organisations. Norway also serves on the board of the Global Fund and it might have been expected that the GHSS would have been the basis for support to achieve health system strengthening at country levels to effectively address the three diseases from the inception. The GHSS was a pivotal exercise for WHO and the process was valuable to the member countries, but it is not clear why only sub-components have been selectively picked and promoted. The extent to which the strategy has had an impact is not possible to judge at the present time, but clearly this important initiative merits a comprehensive and independent evaluation.

3.3 Establishment of UNITAID

3.3.1 Background

A group of 44 countries agreed in September 2004 on the need for additional stable resources to deliver the three health goals in the MDGs as a way of eradicating poverty, through commitment to working on innovative funding mechanisms. Two years later France, Brazil, Chile, Norway and United Kingdom decide to create an international drug purchase facility which subsequently informed the establishment of UNITAID[18] that will be financed with sustainable predictable resources. The need to get drugs to the world's poorest people was identified as a primary target especially in scaling up access to medicines and diagnostics facilities for HIV/AIDS, TB and Malaria. Hence the birth of UNITAID was to fill a critical gap in the global health landscape using purchasing power and an understanding of the market to drive long term reduction in prices of drugs and diagnostics. The establishment draws funds primarily from a levy on air tickets.

The mission of UNITAID is to reinforce access to treatments against HIV/AIDS, malaria and tuberculosis for the poorest populations in developing countries by reducing prices of quality medicines and diagnostics and speeding up their availability.

The justifications for the establishment of UNITAID were to:

- Address issues of making medicines available for children and provision of second line treatments for HIV/AIDS
- Provide support to the worst affected and most vulnerable countries through operation of a global forecasting that ensures comprehensive approach to addressing demand and supply factors
- Use innovative mechanisms for financing treatment that is long term and attractive to the drug manufacturers
- Adopt multi-dimensional approaches to address quality, regulation, IPR, pricing, and provide support to in-country supply systems

17 Email correspondence between WHO and Sigrun Møgedal, June 10 2002.

18 UNITAID is an international drug purchasing facility established to provide long-term, sustainable and predictable funding to increase access and reduce prices of quality drugs and diagnostics for the treatment of HIV/AIDS, malaria and tuberculosis in developing countries.

3.3.2 Achievements

UNITAID is currently housed in WHO, managed by a small secretariat and has an independent executive board. UNITAID works through partners, namely GFATM, RBM, WHO, Stop TB, Global Drug Facility, UNICEF, UNAIDS, and Clinton HIV/AIDS Initiative (CHAI)[19] to provide drugs, diagnostics and treatment to those in need. UNITAID tries to play a role in influencing manufacturers and has been able to achieve the following:

- In 2006 the first significant price reductions of 30–65% on ARVs for positive children were achieved. This was done in collaboration with CHAI.
- UNITAID has provided support to 53 recipient countries on paediatric ARV, second line ARV and PMTCT, 22 countries have received Malaria ACT drugs and 58 recipient countries have received first line TB drugs, paediatric TB drugs and MDR-TB.
- Improvements to enable user-friendly medicines to reflect the situations in recipient countries. For example, dosages adapted for children's use, fixed dose combination of drugs, heat stable products and avoidance of dilution with water considering poor access to drinkable water in some countries.

In response to this progress, the donors to UNITAID have grown from the initial five founding countries to 27 member countries plus the Gates Foundation. Three countries aimed to implement budget contributions and 23 countries adopted implementation of taxes.

3.3.3 Norway's role and support to UNITAID

Norway is one of the founding countries of the initiative of International Drug Purchase Facility (IDPF) now transformed to UNITAID and provides financial support for the implementation of the initiative. Norway serves on the board of UNITAID and UNITAID has enjoyed political support from Norway. This was demonstrated by the attendance of the Norwegian Prime Minister at the launch of UNITAID in New York in September 2006. 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 should be committed and implementation of the initiatives. In addition the UNITAID board benefits from the technical and political expertise of Norway's representative.

3.3.4 Emerging issues

The establishment of UNITAID has proved to be one of the innovative approaches in improving access to essential medicines especially with increase in funding through the Global Fund to address the three diseases.

The need for the functions performed by UNITAID was long acknowledged[20] and the various prior initiatives talked about the need for such a facility. But there is no evidence of an institutional appraisal to demonstrate the need for a new organisation. During interviews for this review, respondents repeatedly questioned the wisdom of creating a new organisation rather than providing a new facility to an existing body.

Arguments have been heard that without Norway's support the initiative would have stayed a 'French' facility, but Norway's early participation and promotion gave it much broader and better legitimacy as an international initiative. To the extent they are true the outcome of Norway joining and supporting the initiative at an early stage may have had the outcome of transforming an otherwise smaller initiative by France and a few other countries into being a global and multilateral mechanism.

Participation of Norway in the board membership of UNITAID has raised some criticisms that Norway is very loyal to France as a board member, e.g. in not supporting requests by NGOs to elect a non-French chair. The issue of conflict of interest has also been raised considering Norway's role as board member of both GFATM and UNITAID, and concerns about objectivity in taking decisions as regards the two organisations. Although, respondents recognise the potential for complementarity and connectedness that might have arisen which ordinarily would be expected to enhance achievement of results.

19 The purpose of establishing CHAI is to expand access to life-saving medicines and help developing countries systematize their approach to HIV/AIDS treatment.

20 Keith A. Bezanson : Replenishing the Global Fund: An Independent Assessment. GFATM (2005)

UNITAID was established during a period when most donors and development agencies were committed to harmonisation and coordination, and repeated warnings were heard against competition and overlap of roles between institutions. There are of course arguments to establish UNITAID as a separate institution – just as there are similarly arguments for almost any other single-purpose missions to be anchored in a separate institution. There is however a degree of overlap in functions with other institutions, mainly GFATM, WHO and Clinton Foundation (although none of these carry all the functions of UNITAID) and the functions could be carried out by other institutions (as suggested for GFATM as late as January 2006[21], only few months before launching UNITAID).

The question of whether the benefits of establishing UNITAID as a separate institution outweigh the costs of adding another body to the already too complicated international AIDS architecture, is beyond the mandate and data availability of this study. However it is difficult to reconcile Norway's support against the otherwise active role of Norway over years in insisting on harmonisation, coordination and in effect simplification of international aid. One may read some of UNITAIDS work and communication as an indication that the institution itself is concerned about its own role in a context in which other institutions provides overlapping functions, and some observers have made reference to UNITAID as having an "identity problem". If this is true, it may also be seen as an indication that the need for a separate institution is not fully justified and believed.

Summary on presentation of sample case studies

- Norway was involved in many international actions shaping HIV/AIDS responses as reflected in the three sample cases studied. They include the Three Ones, the Global Health Sector Strategy (GHSS), and the establishment of UNITAID.
- The three cases occupied key milestones in the period reviewed.
- Norway played a central role in making the Three Ones a reality as the guiding principle in organising national responses. Without the concept of the Three Ones guiding responses at country level, the scenario would have been chaotic with proliferation of funds meant for tackling HIV/AIDS.
- Norway was also active in the development of the GHSS which has four components namely: prevention and health promotion, treatment, health standards and health systems, informed policy and strategy development.
- Although the GHSS was not fully implemented, but implementation of some of the sub-components served as springboard for the 3 by 5 and Treat, Train and Retain (TTR) initiatives.
- The establishment of UNITAID is an innovative approach in improving access to essential medicines in tackling HIV/AIDS, Tuberculosis and Malaria. Despite the acknowledgement of functions performed by UNITAID, the organisation lacked evidence of an institutional appraisal to demonstrate the need for a new establishment especially at a period when most donors are committed to harmonisation and coordination, as their functions overlap with other existing agencies.

21 Alexander Shakow: Global Fund – World Bank HIV/AIDS Programs Comparative Advantage Study, GFATM and World Bank, January 2006.

4 Possible Outcomes

This short paper has shown that Norway has supported the global development assistance architecture to fight HIV/AIDS in several ways: partly through financial support, but mainly through policy and technical advisory support. Norway's contributions have been diverse and extensive, and review of three specific cases has shown specific examples of the process and implications.

As there are several agencies involved in all the processes and Norway has never worked alone towards the multilateral institutions, the actual outcomes of Norwegian contributions are in most cases neither possible nor feasible to document. Most of the ideas and initiatives that have come up in the international HIV/AIDS response during the period are believed to have developed in a range of interactions between different institutions and persons of which Norway has been a part, often a catalytic part, but where it is impossible to point to one particular origin. It is, however, clear that Norway has to a greater or lesser extent been part of the processes that have led to the major achievements throughout the period, including establishment of the GFATM, the Three Ones, 3 by 5 and Universal Access, and in these cases have supported the processes without having any identifiable negative influence.

There is also little doubt that Norway's active contributions towards greater harmonisation has led to better effectiveness and efficiency of the global HIV/AIDS response in general; although the actual contributions cannot be measured precisely. Consequently it can be said that Norway, in addition to making own funds available, has served to better outcomes of most other international funds made available for HIV/AIDS.

Some contributions by Norway have led to little or no direct outcome so far, including the support to research on vaccination or biocides. This is a well known risk in support to research and development and the lack of positive outcomes does not mean that the research was not worthwhile.

Other contributions have led to lower outcomes than anticipated, including the WHO Global Health Sector Strategy for HIV/AIDS, from which only a few sub-components have been implemented. Some of the outcomes are not yet seen, such as most of those related to health sector strengthening; while a strengthening of the health sector is seen in some countries with Norwegian bilateral support, the outcomes of the international focus is still probably relatively small, but likely to grow significantly in future.

In some cases it is possible to see that "seed funding" from Norway has led to other donors taking over and hence multiplying Norwegian efforts. One example is that Norway is one of the donors that financed the "Treat, Train, Retain" (TTR) guideline developed by WHO, following which upon completion and presentation, the US government announced $1.2 billion to scale-up in 15 PEPFAR countries.

The establishment of UNITAID, of which the international legitimacy may be attributed to the early support from Norway, may be seen as having contributed to a more complex international architecture that may serve to undermine outcomes from other Norwegian contributions.

4.1 Review and Discussion about Linkages Across the Various Actions

The Norwegian contributions are generally well connected and in line with a consistent policy as reflected in the 2000 policy paper. Deviations from the policy paper are mostly in priorities, not in general policy choices and can be read as adaptation to a rapidly changing context.

As shown in Chapter Two on Norwegian contributions, there are generally good linkages across the various actions and also across institutions. Norway seems to be consistent in working on the same issues in different institutions, and insisting on a coherent approach. This linkage is also reflected in the country level responses. For example, the Three Ones are operational in the three countries studied for the evaluation. The national strategic framework is the pillar to which the evaluation of Norwegian responses to HIV/AIDS was anchored in Malawi and Tanzania because of the nature of support provided in these countries. The World Bank MAP and the GFATM were identified as two major resources financing HIV/AIDS at country level. Aside the above, Norway also channelled resources through the multilaterals, government and Norwegian NGOs to implement interventions in line with the country HIV/AIDS national strategy.

Norwegian contributions are in most cases consistently aligned to multilateral processes and Norway can be seen as operating on a mandate by the multilateral system. For example, development of the Three Ones was mandated by the International AIDS Conference in Barcelona, and the WHO Health Sector Strategy for HIV/AIDS was mandated by the World Health Assembly; and Norway was requested by WHO to take a leading role.

A relatively small number of personnel in Norad and MFA have been involved in HIV/AIDS during many years. This is atypical in Norwegian development cooperation, which is otherwise characterised by relatively frequent shifts in tasks and functions. The stability in personnel is perhaps one factor behind the seeming consistency in the HIV/AIDS approach and linkages of the various actions to achieve maximum impact on the epidemic.

A particular case is Dr. Sigrun Møgedal who has been the key person during the period. She has been involved in Norad, MFA, and the government as state secretary, and later as Norwegian HIV/AIDS Ambassador. She has been closely involved in a major proportion of Norwegian HIV/AIDS contributions variously as politician, technical expert, policy adviser, and diplomat. While this anchoring in one particular person undoubtedly has led to better consistency and linkages in Norwegian efforts, it also involves substantial risk, and some sources have suggested that Norway should consider delegation of the role to a wider group of people to help create the capacity to meet all the expectations from partners.

4.2 Conclusion

The key issues emanating from this review revealed that Norway is seen as a donor with:

- Consistent, predictable high level sources of finance
- Active approach to policy engagement with institutions through participation in committees and chairing governing bodies
- Focused primary engagement with stakeholders and effective in the provision of technical support especially in providing speedy and high-quality comments to policy and strategic papers of development partners
- Flexible interaction and provision of advisory roles especially when it comes to linkages of the global policies to country programmes for implementation

Norway's efforts have been relevant against what is needed in the international architecture as acknowledged as acknowledged by the institutions themselves or as considered by the team. Having stated the above, some of the major contributions by Norway may be seen as a result of Norway seeing needs, trends and initiatives and responding fast to them. Norway rarely launch its own initiatives, but quickly follows up when others do (and is probably also part of the processes that lead to others launching initiatives).

Some of Norway's success can hence be explained by ability to:

- identify needs arising on national level and the international context (arising from a mixture of technical and political skills, and resources to monitor),
- provide the necessary inputs to relevant institutions in developing ideas and initiatives (depends on good diplomatic relations), and
- quickly support initiatives when launched (depends on flexibility as donor)

Furthermore, the fact that Norway does not claim the "honour" of initiatives itself probably makes it easier for others to take initiatives and allow more ownership to other institutions.

Many of the contributions and their outcomes can be explained by the role played by Norwegian representative. The excellent personal qualifications as a technical expert and good politician of the representative – and in particular the fact that she is both technically and politically skilled and able to communicate well with both technical and political issues - are probably one but not necessarily the key reason for the success. In some cases the personal qualifications and the ability to influence may be the main factors for her involvement in the roles she has played.[22] In other cases the success is better explained by her association to Norway, known as a generous donor and occasionally demonstrating high level political commitment.

Most of the leaders do not understand the technical components of these issues, so her participation at high levels fora enhanced such discussion as she was able to explain the technical issues. Based on this, she commands a lot of respect and they listen to her. Such steps would have guided some of the decisions at such high level fora. - WHO

Summary of possible outcomes

- The global development assistance architecture to fight HIV/AIDS was supported by Norway through financial, technical and advisory support.
- Actual outcomes of Norway's contributions are in most cases not possible to document as Norway has never worked alone towards multilateral institutions.
- Norway's active contributions towards greater harmonisation have resulted in better effectiveness and efficiency of the global HIV/AIDS response. Although some have resulted in little or no direct outcome. Example includes support to research on vaccination and biocides.
- There is good linkage in Norway's support across institutions and various actions as Norway is consistent in working on the same issues in different institutions and insist on a coherent approach.
- Key issues emanating from the review revealed that Norway is a consistent donor, active in their approach to policy engagement with institutions including provision of technical support, and flexible in their approach to achieve results.

22 The comment boxed in the paragraph was made by senior officials interviewed in WHO.

Annex 1: References

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Annex 2: List of Stakeholders Consulted

NO	NAME	DESIGNATION	ORGANISATION	CONTACT
1.	Sissel Hodne Steen	Norway's delegation to Geneva		
2.	Dr Winnie Mpanju-Shumbusho	Senior Adviser to Asst. DG HIV/AIDS, TB, Malaria & Neglected Tropical Diseases	World Health Organisation	+41227914645 mpanjuw@who.int
3.	Gargee Ghosh	Senior Program Officer Global Health Policy & Finance	Bill and Melinda Gates Foundation	Gargee.Ghosh@gatesfoundation.org +1202 662 8114
4.	Dr. Badara Samb	Advisor Health Systems Partnership and Coordination	World Health Organisation	+41227914452 sambb@who.int
5.	Kebe Mohammed Amine	Planning, Resources Coordination and Performance Monitoring.	World Health Organisation	kebea@who.int
6.	Morten Ussing		UNAIDS	ussingm@unaids.org
7.	Luiz Loures		UNAIDS	louresl@unaids.org
8.	Christoph Benn	Director, External relations	GFATM	christoph.benn@theglobalfund.org
9.	Silvia Ferazzi	Manager, Donor Relations	GFATM	Silvia.Ferazzi@theglobalfund.org
10.	Pauline Mazue	Special Assistant to the Director of External Relations	GFATM	Pauline.Mazue@theglobalfund.org
11.	Philippe Duneton	Deputy Director	UNITAID	dunetonp@who.int
12.	Gavin McGillivray	Head, Global Funds & Development Finance Institutions Department	DFID	G-McGillivray@dfid.gov.uk +44 (0)20 7023 0155
13.	Carole Presern		DFID/GAVI	cpresern@gavialliance.org
14.	Gargee Ghosh	Senior Program Officer, Global Health Policy & Finance	Bill & Melinda Gates Foundation	Gargee.Ghosh@gatesfoundation.org; +1 - 202.662.8114
15.	Susan Stout		World Bank	sstout@worldbank.org
16.	Jim Kolker	Head, HIV/AIDS Department UNICEF		Jkolker@unicef.org
17.	Purnima Mane	Deputy Executive Director (Programme)	UNFPA	pmane@unfpa.org 212-297-5115
18.	Carlton P Evans	Policy and Programme Manager Global Funds and DFIs Department	DFID	c-evans@dfid.gov.uk +44 (0) 207 023 0937
19.	Dr Doreen Mulenga,	Senior Adviser, HIV and AIDS	UNICEF	
20.	Jessica Koehs	Project Officer PARMO	UNICEF	
21.	Henriette Ahrens	PARMO	UNICEF	

NO	NAME	DESIGNATION	ORGANISATION	CONTACT
22.	Mary Otieno		UNFPA	motieno@unfpa.org
23.	Kebedech Ambaye Nigussie		UNFPA	knigussie@unfpa.org
24.	Gary Conille		UNFPA	gconille@unfpa.org
25.	Alain Sibenaler		UNFPA	asibenaler@unfpa.org
26.	Dr. Mohga Kamal-Yanni	Senior Advisor, Health & HIV Policy	Oxfam GB	mkamalyanni@oxfam.org.uk

Annex 3: Timeline

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

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

Annex 4: Financial Resources

Tabell 1 Multi-bilateral bistand med DAC-sektor 130.40 og 160.64 fordelt på avtalepartner, 2000-2006

DAC Main sector (code+na	DAC Sub sector (code+name)	Agreement partner	2000	2001	2002	2003	2004	2005	2006	Total	%
130 - Population policies/ programmes and reproductive health	40 - STD control including HIV/AIDS	IAVI - International AIDS vaccine initiative					15,000		25,000	40,000	11%
		IBRD - International Bank for Reconstruction and Development	5,679	8,252						13,932	4%
		IDB - Inter-American Development Bank		848						848	0%
		IPM - International Partnership for Microbicides					10,000	20,000	25,000	55,000	15%
		PAHO - Pan American Health Organisation	1,586	4,222	1,607					7,414	2%
		UNAIDS - UN Programme on HIV/AIDS	1,485	500	2,300	2,183	6,148	-350		12,266	3%
		UNDP - UN Development Programme			7,700		5,000		1,500	14,200	4%
		UNFPA - UN Population Fund	202	18,695	17,250	19,400	8,497	11,771	10,604	86,419	24%
		UNHCHR - Office of the UN High Commissioner for Human Rights	750	750						1,500	0%
		UNHCR - UN Office of the UN High Commissioner for Refugees		1,000						1,000	0%
		UNICEF- United Nations Children's Fund	6,050	26,915	8,538	9,160	10,161	11,129	23,105	95,059	26%
		WB/IBRD							5,000	5,000	1%
		WFP - World Food Programme					638	738		1,377	0%
		WHO				2,800	2,000	2,600		7,400	2%
130.40 Total			15,752	61,182	37,395	33,543	57,444	45,888	90,210	341,414	93%
160 - Other social infrastruc	64 - Social mitigation of HIV/AIDS	UNICEF- United Nations Children's Fund			10,000		7,700	4,000	3,000	24,700	7%
160.64 Total					10,000		7,700	4,000	3,000	24,700	7%
Grand Total			**15,752**	**61,182**	**47,395**	**33,543**	**65,144**	**49,888**	**93,210**	**366,114**	100%

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Tabell 2 Multi-bilateral bistand med Policy makrer HIV/AIDS fordelt på avtalepartner, 2000-2006

PM - HIV/Aids	Agreement partner	2000	2001	2002	2003	2004	2005	2006	Total	%
Main objective										
	CGIAR - Consultative Group on International Agricultural Research				1,000				1,000	0%
	FAO - Food and Agricultural Organization of the United Nations			575	4,501	1,850	3,600		10,526	1%
	GAVI - Global Alliance for Vaccines and Immunization			862					862	0%
	GFATM - Global Fund to Fight AIDS, Tub and Malaria				138,300				138,300	15%
	IAVI - International AIDS vaccine initiative				12,500	15,000		25,000	52,500	6%
	IBRD - International Bank for Reconstruction and Development	5,679	8,252						13,932	2%
	IDB - Inter-American Development Bank		848						848	0%
	IOM - International Organisation for Migration			1,093					1,093	0%
	IPM - International Partnership for Microbicides					10,000	20,000	25,000	55,000	6%
	PAHO - Pan American Health Organisation	1,586	4,222	9,607	7,417	7,021	8,837	8,632	47,320	5%
	UNAIDS - UN Programme on HIV/AIDS	1,485	3,863	2,300	2,745	6,148	5,850	500	22,891	2%
	UNDCP - UN Drug Control Programme			385	500	665			1,550	0%
	UNDP - UN Development Programme		1,139	9,069	5,000	5,000		2,000	22,208	2%
	UNFPA - UN Population Fund	202	18,695	35,550	19,400	8,497	14,771	10,604	107,719	12%
	UNHCHR - Office of the UN High Commissioner for Human Rights	750	750						1,500	0%
	UNHCR - UN Office of the UN High Commissioner for Refugees		1,000						1,000	0%
	UNICEF- United Nations Children's Fund	6,050	32,065	39,738	25,780	25,361	21,779	26,105	176,879	19%
	UNIFEM - UN Development Fund for Women			1,500	1,500	1,500			4,500	0%
	WB/IBRD							5,000	5,000	1%
	WFP - World Food Programme		207			638	738		1,584	0%
	WHO				5,238	2,000	2,600		9,838	1%
	World Bank							15	15	0%
	Main objective Total	15,752	71,042	100,679	223,881	83,679	78,176	102,856	676,064	73%
Significant objective	EBRD			637					637	0%
	FAO - Food and Agricultural Organization of the United Nations				4,500		3,270	2,000	9,770	1%
	IBRD - International Bank for Reconstruction and Development		8,500		11,500	0	3,391	4,515	27,906	3%
	ILO - International Labour Organisation			3,000					3,000	0%
	IOM - International Organisation for Migration				275	52			327	0%
	UN - Dept of Political Affairs			6,000					6,000	1%
	UN diverse					20			20	0%
	UNAIDS - UN Programme on HIV/AIDS		603						603	0%
	UNDCP - UN Drug Control Programme				4,000				4,000	0%
	UNDP - UN Development Programme			30,700	1,500	8,000	8,500	12,300	61,000	7%
	UNFPA - UN Population Fund			10,000	11,500	7,000	1,500		30,000	3%
	UNHCR - UN Office of the UN High Commissioner for Refugees				6,000	4,000			10,000	1%
	UNICEF- United Nations Children's Fund		4,500	18,529	4,012	11,470	500	2,000	41,011	4%
	UNIFEM - UN Development Fund for Women							4,000	4,000	0%
	UNO - UN Organisation						1,300		1,300	0%
	UNOCHA - UN Office of Co-ordination of Humanitarian Affairs			10,000	7,700		9,961		27,661	3%
	UNODC - United Nations Office on Drugs and Crime					1,940			1,940	0%
	WFP - World Food Programme						4,000	15,000	19,000	2%
	WHO				350	971			1,321	0%
	Significant objective Total		13,603	78,866	51,337	33,453	32,422	39,815	249,496	27%
Grand Total		**15,752**	**84,645**	**179,545**	**275,218**	**117,133**	**110,597**	**142,671**	**925,560**	100%

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Tabell 3 Multilateral bistand fordelt til utvalgte organisasjoner, 2000-2006 (NOK 1000)

Agreement partner	Agreement title	2000	2001	2002	2003	2004	2005	2006	Total	%
AFDB - African Development Bank	1st contribution the 10th replenishment Afr DF						443,436		443,436	6%
	2nd Contribution:10th Replenishment, Afr Dev Fund							443,436	443,436	6%
	3rd Instalment Afr. Development Bank					346,000			346,000	5%
	5th Capital Replenishmnt of Afr. Dev. Bank						5,862		5,862	0%
	5th General Capital AfDB					5,561			5,561	0%
	Afrikas Developent Fund				346,149				346,149	5%
	General Contribution	303,650	303,500	322,000					929,150	13%
	QMA/The African Development Bank, 8th instalment.							5,619	5,619	0%
AFDB - African Development Bank Total		303,650	303,500	322,000	346,149	351,561	449,298	449,056	2,525,214	36%
GFATM	Global Fund, Fight Aids, TB & Malari					125,000			125,000	2%
GFATM - Total						125,000			125,000	2%
IBRD - International Bank for	Add Contribution to HIPC TF IDA						114,400		114,400	2%
Reconstruction and Development	Consultative Group to Assist the Poor CGAP III						3,000		3,000	0%
	Contribution to HIPC Trust Fund						44,300		44,300	1%
	Contribution to HIPC Trust Fund IDA						65,310		65,310	1%
	Contribution to IDA Debt Reduction Facility						89,397		89,397	1%
	Dept Sustainability IBRD					7,000			7,000	0%
	Gender mainstreaming in WB			4,000					4,000	0%
	General contribution WB GEF II	57,335	37,080	42,810					137,225	2%
	Global Fund, Fight Aids, TB Malaria			130,000					130,000	2%
	Global Fund, Fight Aids, TB & Malaria						151,541	271,041	422,582	6%
	Grant to the World Bank, The Norweg			5,000					5,000	0%
	Multilateral Debt Relief - regional creditors-IBRD							40,000	40,000	1%
	Multilateral Debt Relief IDA 14 period - IBRD							65,310	65,310	1%
	Norway´s CG contribution 2003				9,941				9,941	0%
	PRGF HIPC	14,075	163,102	200,000					377,177	5%
	TF for Private Sedctor/Infrastructur				50,166				50,166	1%
	Trust Fund Env./Soc. Sustainable Dev				101,000				101,000	1%
	WBI Governance Prgm			2,819					2,819	0%
IBRD - International Bank for Reconstruction and Development Total		71,410	200,182	384,629	161,107	7,000	467,948	376,351	1,668,627	24%
UNAIDS - UN Programme on HIV/AIDS	Additional contribution to UNAIDS							40,000	40,000	1%
	Efforts impl Sec Council Res 1308			7,946					7,946	0%
	General Contribution	70,800	112,374	100,000					283,174	4%
	UNAIDS Core contrib. 2006							160,000	160,000	2%
	UNAIDS Norwegian Annual Contribution				100,000	115,000	125,000		340,000	5%
	UNAIDS Security/Human Respons				7,500				7,500	0%
UNAIDS - UN Programme on HIV/AIDS Total		70,800	112,374	107,946	107,500	115,000	125,000	200,000	838,620	12%
World Bank	ABCDE Conference			5,784					5,784	0%
	African Prog for Onchocerciasis ctl			6,200					6,200	0%
	CGAP - Phase 2			3,000					3,000	0%
	Developmen of Education in Africa			56,500					56,500	1%
	Environment and social dev			42,000					42,000	1%
	MUL-participants High Level Forum Aid Effetivenes						350		350	0%
	Private dev sectors and infrast			53,000					53,000	1%
World Bank Total				166,484			350		166,834	2%
WHO	Assessed Contribution to WHO							14,124	14,124	0%
	Contribution IPCS 2002			4,200					4,200	0%
	GAVI (Glob Alliance Vaccin & Immun)	10,000	20,000	20,000					50,000	1%
	General Contribution	15,620	16,330	16,839					48,789	1%
	Global Fund for AIDS TB and Malaria		1,209		11,922				13,131	0%
	Norw.contb. to WHO				20,000				20,000	0%
	Norwegian progr. support 2003				214,500				214,500	3%
	Research TDR and HRP	36,500							36,500	1%
	Voluntary contribution WHO 2006-2007							215,500	215,500	3%
	WHO		160,990	215,500	991	229,150	248,272		854,902	12%
	WHO GAVI activites 2005						20,000		20,000	0%
	WHO Programmes and initiatives	86,720							86,720	1%
	WHO/GAVI: Global Alliance for Vacc.					20,000			20,000	0%
WHO Total		**148,840**	**198,529**	**256,539**	**247,413**	**249,150**	**268,272**	**229,624**	**1,598,366**	23%
Grand Total		**594,700**	**814,585**	**1,237,598**	**862,168**	**847,711**	**1,310,869**	**1,255,031**	**6,922,661**	100%

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Annex 5: Email Survey Questions

ITAD has been contracted by Norad to evaluate Norway's support for HIV/AIDS in Ethiopia, Malawi and Tanzania. As part of that study, we have also been asked to prepare a paper describing Norway's contribution at global level to the institutions and approaches being used. This part of the work is intended to complement the country studies already conducted and explain Norway's work at global level.

We have worked closely with Dr Sigrun Møgedal on the assignment and your name has been given to us as a key informant who is thought to be familiar with Norway's contribution and can help us document and understand the contribution that has been made. This questionnaire will only take a short amount of your time and will be a valuable contribution to the study.

With the agreement of Norad we have decided to concentrate on (3) key issues where we know Norway has played a distinctive role. These are:

- Support to UNAIDS/ The Three Ones/ GTT
- The WHO Global Health Sector Strategy for HIV/AIDS 2003-2007
- The establishment of UNITAID

First of all, could you indicate which, if any of these you feel you are in a position to comment about? Then for each one please answer the following questions.

(If you would prefer to talk to us rather than write a response, please reply to this email with your contact number and indicate a date and time between receipt of this message and close of business on Wednesday 14th May when we could telephone you).

1. In what ways did Norway interact and provide support for this specific issue? For example, was it mainly financial, political interaction at a high level, work through committee structures, appointment of a special adviser, funding technical assistance? etc.

2. What was the level of effort - routine donor interaction or something out of the ordinary? How did Norway engage with and interact with other development partners.

3. Are there any distinctive characteristics of Norway's support, such as harmonisation with other development partners, advocacy of a human rights perspective, gender awareness, involvement of people living with HIV/AIDS, etc. which make Norway's contribution different from other donors?

4. What was the outcome of Norway's contribution? Was the original problem adequately tackled or resolved? Has the outcome made a difference to the global aid architecture to fight HIV/AIDS?

5. Lastly, please add any further general comments that you think might be relevant to our study.

Thank you for your assistance. Your contribution will be acknowledged in a list of respondents but individual replies will be treated anonymously in the report.

Appendix 1: Terms of Reference of the Evaluation of Norwegian HIV/AIDS Responses in Three African Countries: Ethiopia, Malawi & Tanzania.

1 Background[1]

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[2] were developed as a response. Concrete steps to achieve the Three Ones principles were presented through the report of the Global Task Team[3]. 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 VCT in an early phase in Uganda and the national AIDS control programme in Tanzania.

1 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.
2 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)
3 Global Task Team on Improving AIDS Coordination Among Multilateral Institutions and International Donors 2005

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 priorites, 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[4]. 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 outcomes[5] 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[6]. 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: *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.

4 The evaluation unit was moved to Norad in February 2004.
5 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).
6 "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.

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[7]. 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[8]). 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, refering to the *three core impact indicators* defined by UNAIDS for generalized epidemics:

- 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).

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7 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.

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

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[9].

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 being reported on, such as country level reporting on "*National Commitment and Action*" [10]. 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

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

10 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).

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 interlinkages 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 and 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 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*[11] 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 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

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

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-sectorial 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[12]. 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*[13]. 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.

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 Ethiopia Country Report Final	September 2007 November 2007
Malawi Country Report Draft Malawi Country Report Final	December 2007 February 2008
Tanzania Country Report Draft Tanzania Country Report Final	February 2008 April 2008
Draft paper on Norway's contribution to the global HIV/AIDS architecture Final paper on Norway's contribution to the global HIV/AIDS architecture	March 2008 April 2008

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

ACTIVITY	DEADLINE
Synthesis Report Draft Synthesis Report Final	April 2008 May 2008
Publication, distribution	June 2008
Final presentation seminars (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[14].

7.2 Budget

Number of person weeks stipulated: 60

7.3 Reporting[15]

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[16], as well as the Norad Evaluation Guidelines[17].

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.

7.4 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 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.

14 Dates should be specified by tenderer in the proposals for tender.
15 See attached Report Specifications.
16 http://www.oecd.org/dataoecd/43/54/35336188.pdf
17 See. http://www.norad.no/items/4620/38/6553540983/Evalueringspolitikk_fram_til_2010.pdf

8 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.

EVALUATION REPORTS

2.94 Evaluation of the Norwegian Junior Expert Programme withUN Organisations
1.95 Technical Cooperation in Transition
2.95 Evaluering av FN-sambandet i Norge
3.95 NGOs as a Channel in Development aid
3A.95 Rapport fra Presentasjonsmøte av «Evalueringen av de Frivillige Organisasjoner»
4.95 Rural Development and Local Govemment in Tanzania
5.95 Integration of Environmental Concerns into Norwegian Bilateral Development Assistance: Policies and Performance

1.96 NORAD's Support of the Remote Area Development Programme (RADP) in Botswana
2.96 Norwegian Development Aid Experiences. A Review of Evaluation Studies 1986–92
3.96 The Norwegian People's Aid Mine Clearance Project in Cambodia
4.96 Democratic Global Civil Governance Report of the 1995 Benchmark Survey of NGOs
5.96 Evaluation of the Yearbook "Human Rights in Developing Countries"

1.97 Evaluation of Norwegian Assistance to Prevent and Control HIV/AIDS
2.97 «Kultursjokk og Korrektiv» – Evaluering av UD/NORADs Studiereiser for Lærere
3.97 Evaluation of Decentralisation and Development
4.97 Evaluation of Norwegian Assistance to Peace, Reconciliation and Rehabilitation in Mozambique
5.97 Aid to Basic Education in Africa – Opportunities and Constraints
6.97 Norwegian Church Aid's Humanitarian and Peace-Making Work in Mali
7.97 Aid as a Tool for Promotion of Human Rights and Democracy: What can Norway do?
8.97 Evaluation of the Nordic Africa Institute, Uppsala
9.97 Evaluation of Norwegian Assistance to Worldview InternationalFoundation
10.97 Review of Norwegian Assistance to IPS
11.97 Evaluation of Norwegian Humanitarian Assistance to the Sudan
12.97 Cooperation for Health DevelopmentWHO's Support to Programmes at Country Level

1.98 "Twinning for Development". Institutional Cooperation between Public Institutions in Norway and the South
2.98 Institutional Cooperation between Sokoine and Norwegian Agricultural Universities
3.98 Development through Institutions? Institutional Development Promoted by Norwegian Private Companies and Consulting Firms
4.98 Development through Institutions? Institutional Development Promoted by Norwegian Non-Governmental Organisations
5.98 Development through Institutions? Institutional Developmentin Norwegian Bilateral Assistance. Synthesis Report
6.98 Managing Good Fortune – Macroeconomic Management and the Role of Aid in Botswana
7.98 The World Bank and Poverty in Africa
8.98 Evaluation of the Norwegian Program for Indigenous Peoples
9.98 Evaluering av Informasjons støtten til RORGene
10.98 Strategy for Assistance to Children in Norwegian Development Cooperation
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12.98 Evaluation of the Development Cooperation between Norway and Nicaragua
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Norad
Norwegian Agency for
Development Cooperation

P.O.Box 8034 Dep, N0-0030 Oslo
Visiting adress:
Ruseløkkveien 26, Oslo, Norway

Telephone: +47 22 24 20 30
Fax: +47 22 24 20 31
Postmottak@norad.no
www.norad.no

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