Evaluation Department

Norad

Evaluation of Norwegian HIV/AIDS Responses

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Executive Summary

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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

Executive Summary: Country Report Malawi

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.

Executive Summary: Country Report United Republic of Tanzania

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[12], 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[13]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)[14].

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

12 TACAIDS – Tanzania Commission for AIDS
13 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
14 United Republic of Tanzania (2005). The National Strategy for Growth & Reduction of Poverty.

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 400,000 cases of PLWHA since 2003 (which was 1.6 million), and an increase of about 1 million orphans in the same period[15].

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[16] 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.

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

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. 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)[17] 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

17 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.

Executive Summary: Global Paper

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)[18], the Three Ones concept[19], the 3 by 5 initiative[20] and the Universal Access initiative[21], 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.

18 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.

19 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.

20 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.

21 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.

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