EVALUATION

META-ANALYSIS OF DEVELOPMENT COOPERATION ON HIV/AIDS

2009:4

Evaluation

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MINISTRY FOR FOREIGN AFFAIRS OF FINLAND

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Minna Tuominen
Martin Taylor
Dirce Costa

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MINISTRY FOR FOREIGN AFFAIRS OF FINLAND

This evaluation was commissioned by the Ministry for Foreign Affairs of Finland to Liverpool Associates in Tropical Health Ltd and Austral/Cowi Lda. The Consultants bear the sole responsibility for the contents of the report. The report does not necessarily reflect the views of the Ministry for Foreign Affairs of Finland.

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[1)] Annexes 2-7 are non-edited and contained in the attached CD.

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PREFACE

HIV/AIDS has been an important theme in Finnish development policy for several years. Since 2007, HIV/AIDS has been highlighted as a cross-cutting issue within the Finnish development policy. The HIV/AIDS is thus recognised as a crucial challenge to efforts aiming at reducing poverty. Finland has emphasised a comprehensive approach to HIV/AIDS, with prevention and human rights as principal themes.

To tackle the multifaceted problem of HIV/AIDS, the Ministery for Foreign Affairs of Finland (MFA) decided to carry out a meta-analysis of the strategies and key development interventions of other development actors related to HIV/AIDS. The main objective of the meta-analysis was to assess whether a separate evaluation of the Finnish policy and strategy in the sector is needed. Before the actual evaluation there was a preparatory phase during which background material was collected from various sources. The meta-analysis is based on literature review and key informant interviews.

Through a competitive bidding process the meta-analysis was commissioned to Liverpool Associates in Tropical Health Lta and Austral/Cowi Lda and carried out by Minna Tuominen, Martin Taylor and Dirce Costa.

The main conclusion of the analysis of HIV/AIDS related strategies and key interventions of 25 development partners funding the HIV/AIDS related activities is that the Ministry for Foreign Affairs of Finland (MFA) should not conduct a separate evaluation of the Finnish HIV/AIDS policy and response. Firstly, the HIV/AIDS has been evaluated in recent years by several donors, for example by UNAIDS and GFATM. Secondly, according to the evaluators, the priorities expressed in the Finnish HIV/AIDS policy document are still coherent with the Finnish development policy and with those of like-minded donors. However, the evaluation team recommends the MFA to review its internal organization, systems and capacity. The team recommends the MFA to develop a detailed implementation and monitoring plan and upgrade the total fi nancial commitment to HIV/AIDS towards the OECD average level.

Helsinki, 30 August 2009

Aira Päivöke
Director
Development Evaluation

ACRONYMS

AfDB	African Development Bank
AfDF	African Development Fund
AfT	Aid for Trade
ARV	Antiretroviral Treatment
CBO	Community Based Organisation
CIDA	Canadian International Development Agency
CCM	Country Coordination Mechanism
CNCS	Conselho Nacional de Combate ao HIV/SIDA
CPA	Community Partners in Action
CSO	Civil Society Organisation
DANIDA	Danish International Development Agency
DFID	Department for International Development UK
EC	European Commission
EU	European Union
GFATM	Global Fund to fi ght AIDS, Tuberculosis and Malaria
GIST	Global Implementation Support Team
GNI	Gross National Income
GNP+	Global Network of People Living with HIV and AIDS
GTT	Global Task Team
HAPS	HIV/AIDS Partnership Scheme
HIV/AIDS	Human Immunodefi ciency Virus/Acquired Immune Defi ciency Syndrome
HNP	Health, Nutrition and Population
IAVI	International AIDS Vaccine Initiative
ICASO	International Council of AIDS Service Organisations
IDA	International Development Association
IHP	International Health Partnership
ILO	International Labour Organisation
LCF	Local Cooperation Funds
LMD	Like-minded Donor
MAP	Multi-Country AIDS Programme
MAPS	Multi-Annual Programme Scheme
MARP	Most-At-Risk-Population groups
MDG	Millennium Development Goals
MFA	Ministry for Foreign Affairs of Finland
M&E	Monitoring and Evaluation
MSF	Medecins Sans Frontieres
NAC	National AIDS Commissions/Councils
NGO	Non-Governmental Organisation
NORAD	Norwegian Agency for Development Cooperation
ODA	Offi cial Development Assistance

OECD/DAC	Organisation for Economic Cooperation and Development / Development Assistance Committee
PCB	Programme Coordinating Board
PEPFAR	President's Emergency Plan For AIDS Relief
PLWHA	People Living With HIV and AIDS
PMTCT	Prevention of Mother To Child Transmission
PROSAUDE	Programa Nacional de Reorientação da Formação Profi ssional em Saúde
PRSP	Poverty Reduction Strategy Papers
SAAT	Southern African Aids Trust
Sida	Swedish international development cooperation agency
SRH	Sexual and Reproductive Health
SWAp	Sector-wide Approach
TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
TRIPS	Trade-Related aspects of International Property rights
UM	Ulkoasiainministeriö/ Utrikesministeriet
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientifi c and Cultural Organisation
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Offi ce on Drugs and Crime
USAID	United States Agency for International Development
USD = US$	USA dollar currency
WHO	World Health Organisation
WFP	World Food Programme
YK	Yhdistyneet Kansakunnat

Meta-analyysi HIV/AIDS Kehitysyhteistyöstä

Minna Tuominen, Martin Taylor ja Dirce Costa

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TIIVISTELMÄ

Tämä meta-analyysi pohjautuu analyysiin 25 hiv/aids-kentällä työskentelevän kehitysyhteistyökumppanin HIV/AIDS-työhön liittyvistä strategioista sekä keskeisistä toimenpiteistä. Analyysin tarkoituksena on tarjota asiantuntevaan tietoon perustuva lähtökohta, jonka avulla voidaan selkiyttää ja paremmin kohdentaa suomalaisten HIV/AIDSin vastaiseen työhön sekä HIV/AIDSin eri ulottuvuuksiin keskittyvien kehityshankkeiden vaikutusalaa. Analyysi perustuu kirjallisuuskatsaukseen sekä keskeisten tietolähteiden kanssa tehtyihin haastatteluihin.

Suomi hyväksyi HIV/AIDS-toimintaohjelman vuonna 2004 ja määritteli vuonna 2007 HIV/AIDSin koko kehityspolitiikkaa koskevaksi monialaiseksi kysymykseksi. Suurin osa Suomen HIV/AIDSin vastaiseen työhön menevästä tuesta annetaan YK:n järjestöjen kautta. Sen lisäksi neljännes tuesta kanavoidaan kansalaisjärjestöjen kautta.

Tämän meta-analyysin perusteella voidaan todeta, että Suomen ei ole tarvetta erikseen arvioida HIV/AIDS-työtään. HIV/AIDS-toimintaohjelmaa koskevan asiakirjan painopisteet ovat edelleen yhteneväiset suomalaisen kehityspolitiikan sekä samoin ajattelevien avunantajatahojen kanssa. On suositeltavaa, että Suomi laatii yksityiskohtaisen työn toteutukseen ja seurantaan liittyvän suunnitelman; tarkastaa HIV/AIDS-sitoumuksen kokonaismäärän ja vertaa sitä OECD-maiden keskiarvoon; tarkastaa toimintojen rahoittamiseen tällä hetkellä käytetyt kanavat; lisää sisäistä johtoa sekä henkilökuntaa maksimoidakseen tukensa vaikutuksen ja luo parhaiden käytäntöjen suuntaviivat aiheen valtavirtaistamista varten.

Avainsanat: meta-analyysi, HIV/AIDS, strategia, toiminta-ohjelma, kehitysyhteistyö

Meta-analysis av HIV/AIDS Utvecklingssamarbete

Minna Tuominen, Martin Taylor och Dirce Costa

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ABSTRAKT

Denna meta-analys baseras på en analys av strategierna i samband med HIV/AIDS och de centrala biståndsinsatserna av 25 utvecklingssamarbetspartner i HIV/AIDS-fältet. Syftet med analysen är att bereda en faktabaserad utgångspunkt utifrån vilken man kan förtydliga och skärpa verksamhetsfältet av finländska utvecklingsprojekt för bekämpningen av HIV/AIDS och dess olika dimensioner. Analysen baseras på en litteraturöversikt och intervjuer med centrala informanter.

Finland godkände en HIV/AIDS-policy år 2004 och förklarade år 2007 HIV/AIDS som en övergripande fråga i hela utvecklingspolitiken. Största delen av Finlands HIV/AIDS-stöd tillhandahålls via FN:s system och därtill styrs en fjärdedel av stödet via icke-statliga organisationer.

På basis av metaanalysen finns det inget behov för Finland att utföra en separat utvärdering av landets HIV/AIDS-aktiviteter. Prioriteringarna som lyfts fram i policydokumentet för HIV/AIDS är fortfarande samstämmiga med den finländska utvecklingspolitiken och likasinnade givares politik. Det rekommenderas att man i Finland utarbetar en detaljerad genomförande- och uppföljningsplan; granskar de sammanlagda åtagandena för bekämpningen av HIV/AIDS i jämförelse med OECD-ländernas genomsnitt; ser över kanalerna som för närvarande används till finansieringen av aktiviteterna; investerar i intern ledning och personal för att få ut maximal verkan av det stöd som ges och sätter upp riktlinjer för bästa tillvägagångssätt för att integrera jämställdhetsaspekten.

Nyckelord: metaanalys, HIV/AIDS, strategi, policy, utvecklingssamarbete

Meta-Analysis of Development Cooperation on HIV/AIDS

Minna Tuominen, Martin Taylor and Dirce Costa

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ABSTRACT

This meta-analysis is based on an analysis of the HIV/AIDS-related strategies and key interventions of 25 development partners working in the HIV/AIDS arena. The purpose of the analysis is to give an informed basis to clarify and sharpen the scope of Finnish development projects responding to HIV/AIDS and its various dimensions. The analysis is based on literature review and key informant interviews.

Finland endorsed its HIV/AIDS policy in 2004 and in 2007 declared HIV/AIDS as a crosscutting issue in overall development policy. Finland provides most of its HIV/AIDS support through UN system with an additional fourth of the support channelled through NGOs.

On the basis of the meta-analysis, there is no need for Finland to carry out a separate evaluation of its HIV/AIDS activities. The priorities expressed in the HIV/AIDS policy document remain coherent with the Finnish development policy and those of like-minded donors. It is recommended that Finland develops a detailed implementation and monitoring plan; reviews the total commitment to HIV/AIDS in comparison to OECD averages; reviews the channels currently used to fund activities; invests in internal management and personnel to maximise impact of its support and implements best practice guidelines to deliver mainstreaming.

Keywords: meta-analysis, HIV/AIDS, strategy, policy, development cooperation

YHTEENVETO

Suomen ensimmäinen panos maailmanlaajuisessa HIV/AIDSin vastaisessa toiminnassa oli vuonna 1996, kun Suomi alkoi tukea Yhdistyneitten kansakuntien AIDS-ohjelmaa (UNAIDS). Vuonna 2004 Suomi julkaisi HIV/AIDS-toimintaohjelmansa ja vakiinnutti hiv/aidsin kehityspoliittisena painopistealueena. Vuonna 2007 HIV/AIDS nostettiin esiin monialaisena kysymyksenä Suomen kehityspolitiikassa. Vuonna 2007 72 % Suomen tuesta HIV/AIDSin vastaiseen työhön jaettiin YK:n järjestöjen (pääasiassa UNAIDS:n) sekä Hiviruksen ja AIDSin sekä tuberkuloosin ja malarian torjuntaan liittyvän maailmanlaajuisen terveysrahaston, GFATM:n kautta. 26 % tuesta kanavoitiin kansalaisjärjestöjen kautta.

Analyysin tarkoituksena on tarjota asiantuntevaan tietoon perustuva lähtökohta, jonka avulla voidaan selkiyttää ja paremmin kohdentaa suomalaisten HIV/AIDSin vastaiseen työhön sekä HIV/AIDSin eri ulottuvuuksiin keskittyvien kehityshankkeiden vaikutusalaa. Analyysin tavoitteena on arvioida HIV/AIDSin vastaista toimintaa kokonaisuudessaan ja tämän arvion perusteella ratkaista, onko Suomen toimintoja tarpeen arvioida erikseen vai antavatko meta-analyysin tulokset riittävän tuen Suomen toimintaohjelman sekä tähän sektoriin kohdistuvan strategian tarkistamiseen.

Tämä meta-analyysi pohjautuu analyysiin 25 HIV/AIDS-kentällä työskentelevän kehitysyhteistyökumppanin HIV/AIDSiin liittyvistä strategioista sekä keskeisistä toimenpiteistä. Ensimmäisessä vaiheessa konsultit keräsivät ja laativat perustietoja osapuolten toiminnasta (julkistetut painopisteet, rahoitustavat, julkinen kehitysapu (ODA) sekä HIV/AIDS-varojen osuus siitä). Tältä pohjalta voitiin luoda yleiskuva HIV/AIDSin vastaisen työn osa-alueiden painotuksista. Toisessa vaiheessa konsultit kävivät läpi olemassa olevat arviointiraportit sekä muun oheismateriaalin ja arvioivat kuinka laajasti HIV/AIDSin vastainen työ on integroitu muihin tämän sektorin valittuihin toimintaohjelmiin. Lisäksi konsultit haastattelivat muutamia keskeisiä tietolähteitä kartuttaakseen ymmärrystään toimintaohjelmien tekemiseen liittyvistä prosesseista. Koska tehtävä kuitenkin koski meta-analyysin laatimista, pääasiallisena tietolähteenä käytettiin olemassa olevia kirjallisia aineistoja.

Yleisesti ottaen HIV/AIDS on toimintaohjelman tasolla tärkeä kysymys. Suurin osa arvion kohteina olleista elimistä nostaa sen esiin joko ensisijaisena painopistealueena tai jonkin ensisijaisen painopistealueen osa-alueena. Toimintaohjelman tasolla toteutunut painotus ei kuitenkaan automaattisesti muutu määrärahoiksi. Vaikka HIV/AIDS on Suomessa nostettu monialaiseksi kysymykseksi, maan taloudellinen panos on alle Taloudellisen yhteistyön ja kehityksen järjestön / kehitysapukomitean (OECD/DAC) keskitason. Yhtä lukuun ottamatta kaikki tarkastelun kohteena olleet kahdenväliset elimet ovat julkaisseet toimintaohjelman/strategian HIV/AIDSin vastaista työtä varten, ja osalla niistä on apuvälineitä toimintansa parempaa kohdentamista varten. Tästä huolimatta vain neljä tutkituista elimistä on antanut strategiansa ulkopuolisen tarkastelun kohteeksi.

Neljällä monenvälisellä toimijalla ei ole ollenkaan julkaistua toimintaohjelmaa/strategiadokumenttia, mutta ne osallistuvat silti aktiivisesti maailmanlaajuiseen toimintaan. Kirjal-

lisen strategian puute ei näytä olevan este aktiiviselle ja selkeälle HIV/AIDSin vastaiselle toiminnalle, ja selkeän strategian olemassaolo ei välttämättä takaa sitä, että toiminnassa noudatetaan toimintaohjelman ohjeistusta.

Kaikki tutkitut elimet käyttävät monenvälisten ja kahdenvälisten kanavien yhdistelmää. Kahdenvälisten ja monenvälisten sitoumusten osuus ei suoraan korreloi avustajatahojen koko julkisen kehitysavun ja HIV/AIDSin-sitoumuksen koon kanssa. Suomi on siitä poikkeuksellinen, että se käyttää enimmäkseen monenvälisiä kanavia. Kahdenväliset avustajatahot tukevat HIV/AIDS-toimintoja useiden monenvälisten organisaatioiden, erityisesti UNAIDS:n ja GFATM:n kautta. Ensin mainittua käytetään maailmanlaajuiseen ja yksittäisten maiden tasolla tehtävään yhteistyöhön, avustukseen ja tekniseen apuun, kun taas viimeksi mainittua käytetään rahoitusvälineenä, jolla tuetaan maiden tasolla tapahtuvaa täytäntöönpanoa. Suomi on erityistapaus kahdella tapaa: kaikista avustajatahoista se antaa suurimman osan HIV/AIDS-tuestaan UNAIDS:lle ja alhaisimman osuuden GFATM:lle.

Avustajatahot käyttävät erilaisia tukitapoja kahdenvälisessä avussa, ja useimmat samoin ajattelevat avunantajatahot (LMD) antavat rahoitusta budjettituen/alakohtaisen tuen muodossa sekä yhteisten rahastojen, hallitustenvälisten hankkeiden ja kansalaisjärjestöjen kautta. Samoin ajattelevat kahdenväliset avunantajatahot eivät yleensä määrää eri välineiden kautta kanavoitavien varojen jaosta yksityiskohtaisesti, mikä lisää joustavuutta paikallisella tasolla. Tavallisimpia avustusvälineitä ovat alakohtaisen tuen tai yhteisten rahastojen alaisuudessa toimivat kohdennetut HIV/AIDS-hankkeet.

Kaikki kahdenväliset ja monenväliset elimet ovat julkaistuissa strategioissaan sitoutuneet valtavirtaistamaan HIV/AIDS-teemaa, mutta tämä ei useinkaan ole toteutunut erityisen tehokkaasti laajemmassa mittakaavassa. Tärkeimpiin valtavirtaistamista estäviin tekijöihin kuuluvat määritelmän sisältöön sekä ilmiön tarkoitukseen liittyvä hämmennys, puutteellinen ymmärrys valtavirtaistamisen tarpeesta silloin, kun epidemiat ovat vähemmän esillä, sekä kilpailu useiden muiden toimintaohjelman painopisteiden sekä muiden monialaisten kysymysten kanssa. Muihin esteisiin lukeutuvat riittämättömät henkilö- ja taloudelliset resurssit, organisaatioiden sisäiset hallintojärjestelmät, panostukset johtajuuteen ja edistysaskeleiden valvontaan.

Monet avunantajat käyttävät kolmea erillistä kansalaisjärjestöjen kautta toimivaa rahoituskanavaa: sopimuksenvaraiset monivuotiset kumppanuudet, kansalaisjärjestöjen esittämät hanke-ehdotukset ja harkinnanvarainen rahoitus suurlähetystöille tai maakohtaisille toimistoille. Jotkin toimijat kannustavat apurahajärjestelmiensä kautta aktiivisesti kansalaisjärjestöjä nostamaan HIV/AIDS-toimintoja etusijalle. Kansalaisjärjestöille annettu rahoitus ei kuitenkaan ole sidottu yleisiin HIV/AIDS-strategioihin, koska painopisteitä ja strategiaa eivät määrittele rahoittajat, vaan rahoitusta hakevat kansalaisjärjestöt itse.

Suomen HIV-toimintaohjelmassa painotetaan neljää temaattista aluetta: (i) proaktiivinen tartuntojen ehkäisy, (ii) kansalaisyhteiskunnan toiminnan tukeminen, (iii) ihmisoikeudet sekä (iv) sukupuolten välinen tasa-arvo ja nuorten kanssa tehtävän työn vahvistaminen.

Nämä painotukset ovat yhteneväisiä Suomen tuottamana lisäarvona yleisesti pidetyn linjan kanssa. Toimintaohjelmassa ei eritellä toteutukseen liittyviä suunnitelmia eikä valvontaan liittyvää toimintakehystä. Toimintaohjelman mukaan suurin osa Suomen hiv-varoista kanavoidaan YK:n järjestöjen kautta, mutta siinä ei yksityiskohtaisesti selvitetä hiv-rahoituksen tasoa, kanavia tai välineitä.

Vuosina 2006-07 Suomen keskimääräinen vuosittainen sitoumus HIV/AIDSin vastaiseen työhön oli 23,4 miljoonaa Yhdysvaltain dollaria. Tämä vastaa 2,6 % julkisesta kehitysavusta. Määrä on tuntuvasti pienempi kuin OECD-maiden keskiarvo (4,1 % julkisesta kehitysavusta) ja samoin ajattelevien avunantajatahojen keskiarvo (5,5 %).

Maailmanlaajuista HIV/AIDSin vastaista yhteistyötä ja koordinaatiota on useasti yritetty kehittää. Tähänastiset arviot osoittavat kuitenkin, että tältä osin tehtävää on edelleen erityisesti yksittäisten maiden tasolla, mihin monet hankkeet tällä hetkellä keskittyvät.

Tässä analyysissa vertailtiin Suomen toimintaohjelmaa samoin ajattelevien avunantajatahojen toimintaohjelmiin, ja analyysi osoitti, että: (i) Suomen toimintaohjelman HIV/AIDSin vastaiseen työhön sijoitettuja varoja koskevat perustelut ovat verrattain puutteelliset ja vähemmän systemaattiset kuin muissa ohjelmissa, (ii) sen painopisteet ovat perusteltuja ja tärkeitä, (iii) osa painopisteiden saavuttamiseen käytetyistä toimintatavoista tulee tuoda ajan tasalle, (iv) toimintaohjelmassa ei luoda päämääriä ja mittareita sisältävää seurantakehystä, jota vastaan täytäntöönpanoa voidaan mitata, sekä (v) toimintaohjelmassa ei jäsennellä toimintaohjelman toteuttamiseen tarvittavia sisäisiä järjestelmiä, henkilöstöä, tai koulutukseen ja johtamiseen liittyviä toimenpiteitä.

Tällä perusteella tämän analyysin ensimmäinen suositus on, ettei Suomen ulkoasiainministeriö (UM) erikseen ryhdy arvioimaan Suomen HIV/AIDS-toimintaohjelmaa ja HIV/AIDSin vastaista työtä. Tällaisen arvion tuoma arvo olisi vähäinen, koska Suomen HIV/AIDSin vastaisen työn keskeiset elementit on arvioitu yksittäin lähivuosina (esim. UNAIDS, GFATM ja Suomen monialaiset kysymykset). UM:n tulisi kuitenkin tarkastaa sisäinen organisaationsa, järjestelmänsä ja suorituskykynsä.

Toinen suositus on, että UM:n tulisi kehittää yksityiskohtainen toimeenpanosuunnitelma, johon sisällytetään tehtävään kohdennettavat resurssit sekä kehityksen mittaamiseen ja seurantaan tarkoitettu toimintamalli. Keskustelun ja sopimusten keskeisiä alueita ovat: (i) HIV/AIDSin vastaiseen työhön varattujen varojen tarkoituksenmukaisuus, (ii) kahdenvälisten ja monenvälisten toimintatapojen yhdistelmä sekä käytetyt tukivälineet, (iii) kuinka maksimoida tulokset, jotka saavutetaan monenvälisten ja kahdenvälisten kanavien kautta annetulla tuella monialainen sekä kansalaisjärjestöille annettu tuki mukaan lukien sekä (iv) HIV/AIDS-toimintaohjelman toimeenpanon vaatimat järjestelmät ja voimavarat sekä sisäinen organisaatio.

Kolmas suositus on, että UM tarkastaa Suomen HIV/AIDSin vastaiseen työhön suunnatun kehitysavun kokonaisuudessaan, koska se on ristiriidassa sen kanssa, mitä toimin-

taohjelman painotuksesta on lausuttu julki, ja tuo sen lähemmäksi OECD-maiden keskiarvoa.

Neljännen suosituksen mukaan Suomen toimintaohjelma ei vaadi pikaista uudelleenarviointia, koska sen painopisteet ovat vakaat ja yhteneväiset Suomen kehitysavun yleisten painotusten kanssa, ja koska ne perustuvat Suomen tuomaan lisäarvoon (sukupuoli, ihmisoikeudet, naiset). Siten on epätodennäköistä, että painotukset tarkastuksen tuloksena muuttuisivat.

Viides suositus on se, että Suomen on järkevää tarkastaa tämän rahoituksen osalta käyttämänsä monenväliset organisaatiot ja kahdenväliset avustusvälineet. Vaikka analyysi päätyy esittämään, ettei ole olemassa todisteita, joiden mukaan Suomen kehitysavun jakautumista monenvälisten ja kahdenvälisten kanavien kautta tulisi muuttaa, on hyvä varmistua siitä, että käytetyt kanavat sopivat hyvin yhteen julkistetun toimintaohjelman kanssa.

UM:n mahdolliset päätökset varojen laajuudesta ja monenvälisten organisaatioiden sekä kahdenvälisten avustusvälineiden valinnasta voidaan tiivistää seuraaviin neljään vaihtoehtoiseen malliin uudesta HIV/AIDS-toimintaohjelmasta.

Vaihtoehto 1:	Säilytetään nykytilanne.
Vaihtoehto 2:	Pidetään resurssit ennallaan, uudistetaan toimintatapojen yhdistelmä.
Vaihtoehto 3:	Lisätään resursseja, pidetään toimintatapojen yhdistelmä ennallaan.
Vaihtoehto 4:	Lisätään resursseja, uudistetaan toimintatapojen yhdistelmä.

Jos sovitaan resurssien lisäämisestä tai muuttamisesta, vaihtoehtoja ovat: lisätään GFATM:lle annetun tuen määrää, lisätään UNAIDS:lle annetun tuen määrää, aloitetaan tuen antaminen muiden YK:n erityisjärjestöjen kautta, annetaan tukea YK:n aids-ohjelmalle UNAIDS:n kautta jossakin Suomen painopistemaassa, annetaan tukea kansalaisjärjestöille näiden HIV/AIDS-toimintoja ja palveluita varten jossakin Suomen painopistemaassa tai -alueella, annetaan tukea jonkin kansallisen hallituksen työlle jossakin Suomen painopistemaassa.

Kuudes suositus on, että UM ryhtyy keskeisiin toimenpiteisiin, joilla lisätään sitoumuksista saatavia tuloksia. Proaktiivinen sitoutuminen ja hallinto mahdollistaisivat sen, että Suomi saisi enemmän aikaan pyrkimyksissään kohdata HIV/AIDS monialaisena kysymyksenä ja UNAIDS:lle, GFATM:lle sekä kansalaisjärjestöille antamansa tuen kautta.

Seitsemäs suositus on, että UM toteuttaa toimenpiteitä, jotka ovat yhteneväisiä tuoreen monialaisista kysymyksistä tehdyn arvion ja valtavirtaistamista koskevan ohjeen kanssa, ja parantaa näin sisäistä hallintoaan. Näihin toimenpiteisiin kuuluisivat: (i) HIV/AIDS-lähettilään tai -esitaistelijan nimittäminen johtamaan UM:n HIV/AIDSin vastaista työtä, (ii) yleisen seurantakehyksen kehittäminen Suomen HIV/AIDS-toimintaohjelmaa varten,

(iii) vuosittaisen kehitysraportin tuottaminen UM:lle, (iv) järjestelmien ja vertailukohtien valmistelu, joiden avulla voidaan riittävästi seurata ja valvoa HIV/AIDSin vastaiseen työhön varattuja ja käytettyjä varoja sekä kohdentaa näiden toimenpiteiden täytäntöönpanoa varten enemmän henkilöstöä.

SAMMANFATTNING

Finlands första insats i det globala arbetet mot HIV/AIDS gjordes år 1996 då man började stödja Förenta Nationernas (FN):s program för HIV/AIDS (UNAIDS). År 2004 publicerade Finland en HIV/AIDS-policy och hiv/aids etablerades som en tyngdpunkt som bör utvecklas. År 2007 lyftes HIV/AIDS fram som en övergripande fråga i den finländska utvecklingspolitiken. År 2007 utbetalade Finland 72 % av sitt HIV/AIDS-stöd via FN:s system (huvudsakligen UNAIDS) och GFATM, den globala fonden för bekämpning av HIV/AIDS, tuberkulos och malaria. Av stödet går 26 % via icke-statliga organisationer.

Syftet med analysen är att bereda en faktabaserad utgångspunkt utifrån vilken man kan förtydliga och skärpa verksamhetsfältet av finländska utvecklingsprojekt för bekämpningen av HIV/AIDS och dess olika dimensioner. Analysens mål är att utvärdera insatserna i bekämpningen av HIV/AIDS i sin helhet och att sedan på basis av denna utvärdering avgöra huruvida det behövs en separat utvärdering av de finländska aktiviteterna eller om slutsatserna från metaanalysen ger ett tillräckligt stöd för granskningen av den finländska policyn och strategin för detta verksamhetsfält.

Metaanalysen baseras på en analys av HIV/AIDS-strategierna och de centrala biståndsinsatserna av 25 utvecklingssamarbetspartner. I den första fasen samlade och upprättade konsulterna grundläggande fakta om parternas insatser (inklusive prioriteringar som man hade uttalat sig om, finansieringssätt, det offentliga utvecklingsstödet (ODA) i allmänhet samt andelen av medlen för HIV/AIDS). På basis av detta kunde man skapa en samlad bild av prioriteringarna i samband med HIV/AIDS. I den andra fasen gick konsulterna igenom tillgängliga utvärderingsrapporter och övrigt stödmaterial samt bedömde graden av integrering av HIV/AIDS i andra utvalda policyn i denna sektor. Därtill utförde konsulterna några intervjuer med centrala informanter för att bättre förstå processerna vid utarbetandet av strategier. Eftersom uppgiften emellertid var att utföra en metaanalys utgjorde den huvudsakliga informationskällan existerande skriftligt material.

Generellt sett har HIV/AIDS en hög prioritering på policynivå. De allra flesta organen som utvärderades lyfter fram ämnet antingen som främsta prioritet eller som ett delområde i ett högprioriterat område. Prioritering på policynivå omvandlas dock inte automatiskt till finansiella anslag. Även om Finland anser HIV/AIDS vara en övergripande fråga är landets finansiella bidrag mindre än genomsnittet i Organisationen för ekonomiskt samarbete och utveckling / Kommittén för utvecklingsbistånd (OECD/DAC). De undersökta bilaterala organen har alla, med undantag av ett organ, publicerat en HIV/AIDS-policy eller -strategier och en del har stödinstrument för att skärpa sina insatser. Trots detta har endast fyra undersökta organ överlämnat sin strategi för extern utvärdering.

Fyra multilaterala organ har inget publicerat policydokument/strategidokument, men de deltar trots detta aktivt i de globala insatserna. Bristen på en skriftlig strategi verkar inte hindra aktiviteter eller klarheten av insatserna i bekämpandet av HIV/AIDS, och befintligheten av en tydlig strategi betyder inte nödvändigtvis att man vid åtagandena följer de i

policyn angivna anvisningarna.

Alla undersökta organ utnyttjar en kombination av multilaterala och bilaterala kanaler. Det fi nns ingen direkt korrelation i förhållandet mellan de bilaterala och multilaterala åtagandena och storleken av bidragsgivarens totala offentliga utvecklingsstöd eller HIV/AIDS-åtaganden. Finland är ett undantagsfall som i huvudsak utnyttjar multilaterala kanaler. Bilaterala bidragsgivare stöder HIV/AIDS-aktioner via olika multilaterala organisationer, speciellt UNAIDS och GFATM, den förstnämnda för koordinering, förfaranden och tekniskt stöd globalt och på enstaka länders nivå och den sistnämnda som ett fi nansieringsinstrument för att stöda genomförandet på enstaka länders nivå. Finland är en utböling på två sätt; bland alla bidragsgivare är andelen av landets bidrag till HIV/AIDS via UNAIDS störst, andelen av bidrag som går via GFATM minst.

Bidragsgivarna utnyttjar en kombination av bidragsinstrument för sitt bilaterala stöd och fl ertalet av de likasinnade givarna (like-minded donors) ger fi nansiering via budgetanslag/sektoralt understöd, gemensamma fonder, projekt mellan olika länders regeringar och icke-statliga organisationer. I allmänhet föreskriver de likasinnade bilaterala givarna inte exakt fördelningen av resurser som ska kanaliseras via de olika instrumenten, vilket ger den lokala kontexten ökad fl exibilitet. Det vanligaste bidragsinstrumentet är målinriktade HIV/AIDS-projekt inom ramen för sektorstöd eller gemensamma fonder.

Alla bilaterala och multilaterala organ förbinder sig i sina publicerade strategier till att integrera jämställdhetsaspekten till arbetet mot HIV/AIDS men detta har sällan varit särskilt effektivt i mer omfattande synvinkel. De huvudsakliga hindren för integrerandet av jämställdhetsaspekten är att det råder förvirring över innebörden i och syftet med begreppet, bristande förståelse för behovet av att ta med jämställdhetsaspekten då epidemierna inte är särskilt synliga samt konkurrens med ett fl ertal policyprioriteringar och andra övergripande frågor. Utöver detta bildas det hinder på grund av att de mänskliga och fi nansiella resurserna samt interna förvaltningssystemen, ledningen och skyldigheten att övervaka framstegen i organisationerna är otillräckliga.

Många bidragsgivare förvaltar tre separata fi nansieringskanaler via icke-statliga organisationer: förhandlade fl eråriga partnerskap; projektförslag som icke-statliga organisationer har lagt fram och prövningsberoende fonder för ambassader eller verksamhetsställen i olika länder. Några organ uppmuntrar aktivt icke-statliga organisationer att prioritera HIV/AIDS-aktiviteter genom sina biståndssystem. Finansieringen av icke-statliga organisationer är emellertid ofta inte bunden till de generella HIV/AIDS-strategierna eftersom prioriteringar och strategier sätts upp av de icke-statliga organisationerna som söker fi nansiering i stället för att anges av de fi nansierande organen.

I Finlands HIV-policy prioriteras 4 tematiska områden: (i) proaktivt förebyggande av infektering, (ii) stöd till medborgarsamhälleliga aktiviteter, (iii) mänskliga rättigheter och (iv) könsjämställdhet samt stärkandet av arbetet med unga människor. Dessa prioriteringar är likriktade med det som allmänt anses vara det fi nländska mervärdet. I policyn anges inga

detaljerade genomförandeplaner eller ramar för uppföljningen. Policyn pekar på att de mesta av Finlands medel för bekämpningen av HIV går via FN:s system, men inga detaljerade uppgifter på nivåer, kanaler eller instrument för hiv-fi nansieringen anges.

Åren 2006–07 var Finlands årliga åtaganden för bekämpningen av HIV/AIDS i genomsnitt 23,4 miljoner USD, vilket motsvarade 2,6 % av det offentliga utvecklingsstödet. Detta är betydligt mindre än genomsnittet i OECD-länderna (4,1 % av det offentliga utvecklingsstödet) och hos likasinnade givare (5,5 %).

Man har fl era gånger eftersträvat att förbättra koordinationen av den globala bekämpningen av HIV/AIDS men hittills visar utvärderingar att ytterligare arbete återstår i synnerhet på landsnivå dit fl era initiativ koncentrerar sig för närvarande.

I denna analys jämfördes Finlands policy med likasinnade givares motsvarande och slutsatsen var att: (i) den är mindre systematisk och förhållandevis bristfällig då det gäller att lägga fram gångbara grunder för att investera i insatser för bekämpningen av HIV/AIDS, (ii) dess prioriteringar är hållbara och relevanta, (iii) en del försök att uppnå de uppsatta prioriteringarna behöver uppdateras, (iv) i policyn etableras inga mål och indikatorer för en ram för uppföljning mot vilken man kunde mäta upp genomförandet, och (v) i policyn struktureras inte de interna systemen, mänskliga resurserna, utbildningen och åtgärderna för ledningen som behövs för att bidra till dess genomförande.

På basis av detta är den första rekommendationen av denna analys att Finlands utrikesministerium (UM) inte bör utföra en separat utvärdering av den fi nländska HIV/AIDS-policyn och bekämpningen av HIV/AIDS. Detta skulle medföra enbart marginellt värde eftersom nyckelelementen i det fi nländska arbetet mot HIV/AIDS har utvärderats separat på senare år (t.ex. UNAIDS, GFATM och fi nländska övergripande teman). UM borde dock utvärdera sin interna organisation, sina system och sin kapacitet.

Den andra rekommendationen är att UM borde utveckla en detaljerad genomförandeplan i vilken man inkluderar resurserna som man vill allokera till uppgiften samt en ram för uppmätandet och uppföljandet av framstegen. Till de centrala områdena för diskussion och överenskommelse hör: (i) lämpligheten av de sammanlagda medlen för HIV/AIDS, (ii) kombinationen av bilaterala och multilaterala tillvägagångssätt och de bidragsinstrument som används, (iii) hur man kunde maximera resultaten som uppnås genom multilaterala och bilaterala kanaler, inklusive det övergripande stödet och stödet till icke-statliga organisationer, och (iv) den interna organisationen samt systemen och resurserna som krävs för att genomföra HIV/AIDS-policyn.

Den tredje rekommendationen är att UM bör granska Finlands utvecklingsbistånd för bekämpningen av HIV/AIDS i sin helhet eftersom det skiljer sig från den uppsatta prioriteringen samt föra det närmare OECD-ländernas genomsnitt.

Den fjärde rekommendationen är att Finlands policy inte är i brådskande behov av en granskning eftersom dess prioriteringar är stabila, likriktade med Finlands generella prio-

riteringar för utvecklingsbiståndet och baserade på det fi nländska mervärdet (kön, mänskliga rättigheter, kvinnor). Därför är det osannolikt att en granskning skulle leda till en ny uppsättning av prioriteringar.

Den femte rekommendationen är att - även om slutsatsen från denna analys är att det inte fi nns några bevis som tyder på att man behöver ändra på Finlands uppdelning i multila teralt och bilateralt stöd - det är rådligt att Finland inom denna fi nansiering granskar de specifi ka multilaterala organisationerna och bilaterala biståndsinstrumenten som används för att säkerställa att man uppnår bästa möjliga förenlighet med den uppsatta policyn.

Besluten som UM fattar på resursskalan och vid valet av multilaterala organisationer och bilaterala biståndsinstrument kan sammanfattas i de följande fyra alternativen för utformningen av en ny HIV/AIDS-policy.

Alternativ 1:	Man bibehåller den rådande situationen.
Alternativ 2:	Man bibehåller resurserna på samma nivå och för in en ny-kombination av tillvägagångssätt.
Alternativ 3:	Man utökar resurserna och bibehåller de nuvarande tillvägagångssätten.
Alternativ 4:	Man utökar resurserna och för in en ny kombination av tillvägagångssätt.

Alternativen som uppstår om man kommer överens om att öka eller ändra resurserna är följande: att stödet till GFATM ökas, att stödet till UNAIDS ökas, att man inleder stöd via andra specialorgan inom FN, att man ger stöd till FN:s program för HIV/AIDS via UNAIDS i något av de länder som Finland prioriterar, att man ger stöd till icke-statliga organisationer för deras biståndsinsatser och tjänster i samband med HIV/AIDS i något av de länder eller någon av de regioner som Finland prioriterar och att man ger stöd till en nationell regerings insatser i något av de länder som Finland prioriterar.

Den sjätte rekommendationen är att UM vidtar en uppsättning av centrala åtgärder för att öka resultaten från sina åtaganden. Proaktiva insatser och proaktiv ledning skulle möjliggöra att Finland uppnår mera med sitt stöd till UNAIDS och GFATM, med sin strävan att bemöta HIV/AIDS som en övergripande fråga och med sitt stöd till icke-statliga organisationer.

Den sjunde rekommendationen är att UM tillämpar en uppsättning av åtgärder som överensstämmer med den färska utvärderingen av de övergripande frågorna och guiden för integrerandet av jämställdhetsaspekten för att förbättra den interna ledningen. Till dessa åtgärder skulle följande aspekter höra: (i) anställandet av en HIV/AIDS-ambassadör eller en förespråkare som ledare för UM:s insatser, (ii) utvecklingen av en generell ram för uppföljningen av Finlands HIV/AIDS-policy, (iii) framställandet av en årlig rapport över framstegen för UM, (iv) utarbetandet av system och premisser med hjälp av vilka man kan tillbörligt följa upp och övervaka de fi nansiella resurserna som har anslagits och utdelats för arbetet mot HIV/AIDS, samt allokering av ökade mänskliga resurser för genomförandet av dessa aktioner.

SUMMARY

Finland's first contribution to the global HIV/AIDS response was in 1996 when it started providing support to the Joint United Nations Programme on HIV/AIDS (UNAIDS). In 2004, Finland published an HIV/AIDS policy and established HIV/AIDS as a development priority. In 2007, HIV/AIDS was highlighted as a crosscutting issue in Finnish development policy. In 2007 Finland disbursed 72% of its HIV-support through the UN system (mainly UNAIDS) and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM); with 26% through NGOs.

The purpose of the analysis is to give an informed basis to clarify and sharpen the scope of Finnish development projects responding to HIV/AIDS and its various dimensions. The objective of the analysis is to assess the totality of HIV/AIDS response and based on this assessment; decide whether a separate evaluation of Finnish activities is needed or whether conclusions of the meta-analysis give sufficient support to the review of the Finnish policy and strategy in the sector.

The meta-analysis is based on an analysis of the HIV/AIDS-related strategies and key interventions of 25 development partners. At the first stage, the consultants gathered and compiled basic information related to the partners' response (including expressed priorities, funding approaches, overall official development assistance (ODA) and the proportion of HIV/AIDS funds). On this basis it was possible to form an overall picture of the HIV/AIDS related prioritization. At the second stage, the consultants looked through available evaluation reports and other support material and assessed the extent to which HIV/AIDS is integrated within other selected sector policies. In addition, the consultants conducted few key informant interviews to gain understanding of policy making processes. However, given that the assignment was a meta-analysis, existing literature material formed the main source of information.

In general HIV/AIDS is highly prioritised at the policy level. The vast majority of the assessed agencies highlight it as either a top priority, or sub-area of a top priority. However, policy level prioritization does not automatically translate into financial allocations. While Finland has HIV/AIDS as a cross-cutting priority, its financial contribution is below the Organization for Economic Cooperation and Development/Development Assistance Committee (OECD/DAC) average. All but one of the sample of bilateral agencies have a published HIV/AIDS policy/strategy and some have supporting instruments to sharpen their response. However, only four of the sample agencies have submitted their strategies to external evaluation.

Four multilaterals do not have any published policy/strategy document yet participate actively in the global response. The lack of a written strategy does not appear to hinder activity or clarity of the HIV/AIDS response and the presence of a clear strategy does not necessarily ensure that activities follow policy guidance.

All sample agencies utilize a mix of multilateral and bilateral channels. There is no direct correlation between the proportions of bilateral to multilateral commitments and the size of the donors' total ODA or HIV/AIDS commitment. Finland exceptionally utilizes mostly multilateral channels. Bilateral donors support HIV/AIDS actions through a range of multilateral organizations, in particular UNAIDS and GFATM, the former for global and country level coordination, facilitation and technical assistance, the latter as a funding instrument to support country level implementation. Finland is an outlier in two ways; it provides the largest proportional of its HIV/AIDS commitment of all donors to UNAIDS and the lowest proportional level to GFATM.

Donors utilise a mix of aid instruments for their bilateral assistance, and most of the like minded donors (LMD) provide funding through budget/sectoral support, pooled funds, government to government projects and NGOs. The like-minded bilateral donors generally do not prescribe the precise allocation of resources to be channelled through the different instruments allowing flexibility to local contexts. The most common aid instrument is targeted HIV/AIDs projects within sectoral support or pooled funds.

All bilateral and multilateral agencies make a committment to mainstreaming HIV/AIDS in their published strategy but rarely has it been particularly effective on a widescale. The main factors which hinder mainstreaming include confusion over the definition and purpose of mainstreaming, lack of understanding of the need to mainstream when epidemics are less visible and competition with a multiplicity of policy priorities and other cross-cutting issues. Further barriers include insufficient allocation of human and financial resources, internal organisation management systems, leadership and accountability to monitor progress.

Many donors manage three separate NGO funding channels: negotiated multi-year partnerships; project proposals submitted by NGOs; and discretionary funds for embassies or country offices. Some agencies actively encourage NGOs to prioritise HIV/AIDS activities through their grant schemes. However funding to NGOs is often disconnected from overall HIV/AIDS strategy as priorities and strategies are set by the NGOs requesting funding rather than the funder.

Finland's HIV policy prioritises 4 thematic areas: (i) proactive prevention of infection, (ii) support to civil society activities, (iii) human rights, and (iv) gender equality and strengthening the work with young people. These priorities are in line with what is commonly considered as the Finnish added value. The policy does not provide detail of implementation plans or a monitoring framework. The policy indicates that Finland will provide most of its HIV funds through the UN system but does not provide detail on HIV funding levels or channels and instruments.

In 2006-07 Finland's annual average commitment for HIV/AIDS was USD 23,4 million, which corresponded to 2,6% of ODA. This is considerably smaller than the OECD average (4,1% of ODA) and the average of LMD (5,5%).

There have been numerous efforts to improve coordination and cooperation in the global response to HIV/AIDS but evaluations to date show that there is still more to do particularly at the country level where many initiatives are currently focused.

This analysis compared Finland's policy with LMD and found that: (i) it is less systematic and comparatively short in laying out a compelling case for investing in the response to HIV/AIDS, (ii) the priorities are valid and relevant, (iii) some of the approaches employed to achieve the stated priorities require updating, (iv) the policy does not establish targets and indicators in a monitoring framework against which implementation can be measured and (v) the policy does not outline the internal systems, human resource, training and management measures that are needed to contribute to its implementation.

On this basis, the first recommendation of this analysis is for the Ministry for Foreign Affairs of Finland (MFA) not to conduct a separate evaluation of the Finnish HIV/AIDS policy and response because there would be only marginal value in doing so; the key elements of the Finnish response have undergone separate evaluations in recent years (e.g. UNAIDS, GFATM and Finnish cross cutting themes). However, the MFA should review its internal organization, systems and capacity.

The second recommendation is that the MFA should develop a detailed implementation plan to include the resources it will allocate to the task, and the framework for measuring and monitoring progress. Key areas for debate and agreement include: (i) the appropriateness of the total funds dedicated for HIV/AIDS, (ii) the mix of bilateral and multilateral approaches and aid instruments used, (iii) how to maximize the outcomes through multilateral and bilateral channels, including cross-cutting and NGO support, and (iv) internal organization and systems and resources required to implement the HIV/AIDS policy.

The third recommendation is that MFA review the total of Finland's development assistance for HIV/AIDS because it is inconsistent with the stated level of policy priority, and bring it closer in line with the OECD average.

The fourth recommendation is that Finland's policy does not require urgent revisiting because the priorities are sound, in line with Finnish overall development priorities and based on the Finnish added value (gender, human rights, women). Thus, it is unlikely that a new set of priorities would emerge from a review.

The fifth recommendation is that whilst this analysis concludes there is no evidence to suggest that Finland's multilateral-bilateral split should be changed; it is advised that Finland reviews within this funding the particular multilateral organizations and bilateral aid instruments it utilizes to ensure best fit with its stated policies.

The decisions MFA takes on the scale of resources and the choice of multilateral organizations and bilateral aid instruments can be summarized in the following four options for the shape of a new HIV/AIDS policy.

Option 1: Maintain the status quo.
Option 2: Resource level with new mix of approaches.
Option 3: Resource increase with current approaches.
Option 4: Resource increase with new mix of approaches.

The options that exist if increased or altered resourcing is agreed include: increasing support to GFATM, increasing support to UNAIDS, starting support through other UN specialist agencies, support to Joint UN Programme through UNAIDS in one of Finland's priority countries, support to NGOs to deliver HIV/AIDS interventions and services in one of Finland's priority countries or regions, and support to a national government response in one of Finland's priority countries.

The sixth recommendation is that the MFA undertakes a set of key measures to increase outcomes from its commitments. Proactive engagement and management would enable Finland to achieve more from its support to UNAIDS and GFATM, its efforts to address HIV/AIDS as a cross-cutting issue and its NGO support.

The seventh recommendation is that the MFA implements a set of measures in line with the recent evaluation of the cross-cutting issues and the guide on mainstreaming to improve internal management. These measures would include: (i) appointing an HIV/AIDS ambassador or champion for leading the MFA response, (ii) developing an overall monitoring framework for Finland's HIV/AIDS policy, (iii) produce an annual progress report for MFA, (iv) prepare systems and baselines to adequately track and monitor fi nancial resources committed and disbursed for HIV/AIDS response, and allocation of increased human resources to implement these actions.

EVALUATION OF FINLAND'S RESPONSE TO HIV/AIDS GLOBALLY		
Findings	**Conclusions**	**Recommendations**
The key elements of the Finnish response have undergone evaluations in recent years and there is unlikely to be little to add to this to justify the allocation of resources. UNAIDS has undergone two 5 year evaluations, the GFATM has recently undergone a 5 year evaluation, Finland's implementation of cross-cutting themes has been formally evaluated (with some reference to HIV/AIDS) and the Finnish Partnership Agreement Scheme and support to Finnish NGO Foundations were both evaluated in 2008.	We conclude that there is no compelling reason for Finland to conduct an evaluation of its response to HIV/AIDS because the different elements of Finland's response have been evaluated in recent years. These evaluations combined with the findings of this meta-analysis of the similarity and relevance of the priorities of Finland's policy with those of other like-minded donors render a formal evaluation of marginal additional benefit. The one exception is the MFA internal organization in support of its HIV/AIDS response which has not been evaluated.	The MFA should not conduct an evaluation of the Finnish HIV/AIDS response. The MFA should review its internal organization, systems and capacity to implement its HIV/AIDS policy.

DEVELOPMENT OF NEW POLICY OR IMPLEMENTATION PLAN		
Findings	**Conclusions**	**Recommendations**
The priorities in Finland's HIV/AIDS policy are relevant and in line with the overall development policy and thus appropriate but other elements in the policy on approaches, internal resource allocation and management, and a monitoring framework are lacking or now out of date.	Finland's HIV/AIDS policy does not require urgent revisiting because the priorities are sound and still relevant (gender, human rights, women). It is unlikely that a new set of priorities would be chosen because of the continued importance of	The MFA should develop a detailed strategy or implementation plan that lays out how it will achieve its stated HIV/AIDS priorities, the resources it will allocate to the task, and the framework for measuring and monitoring progress. It should set targets with indicators for what Finland intends to achieve, re-consider the mix of multilateral and

	existing priorities and coherence with the global consensus on important issues. However, the implementation of the policy requires reconsideration.	bilateral approaches and aid instruments it utilizes to achieve these priorities, and give serious consideration to the internal management and reporting systems and human and financial resources required to implement its policy.
FINANCIAL RESOURCES COMMITTED TO ADDRESSING HIV/AIDS		
Findings	**Conclusions**	**Recommendations**
Finland's annual average commitment to addressing HIV/AIDS was USD 23,4 million per year, 2,6% of Finland's official development. assistance. The average contribution of the OECD countries in 2006-07 was 4,1% and the median 3,4%.	Finland's resources committed to addressing HIV/AIDS are lower than the OECD DAC average and lower than the other like-minded donors. The level is also low for a donor which states in its HIV/AIDS policy and general development policy that HIV/AIDS is a priority.	The MFA should review the total of Finland's development assistance for HIV/AIDS and increase it to bring it closer into line with the OECD average.
FINLAND'S PRIORITIES IN ITS HIV/AIDS RESPONSE		
Findings	**Conclusions**	**Recommendations**
The priorities in Finland's HIV/AIDS policy are basically still relevant and appropriate.	There is no urgent need for MFA to revise its HIV/AIDS priorities.	The MFA should keep its present set of priorities and focus its attention on the more systematic and effective implementation of those priorities.
FINLAND'S APPROACHES IN ITS HIV/AIDS RESPONSE		
Findings	**Conclusions**	**Recommendations**
There is no strict correlation between the size of a bilateral donor ODA or commitments for responding to HIV/AIDS and its relative allocation of resources through	Finland's allocation of two thirds of its HIV/AIDS assistance through multilateral channels is not unusual and is	Whilst this analysis concludes there is no evidence to suggest that Finland's multilateral-bilateral split should be changed; it is advised that Finland reviews

bilateral and multilateral channels. Similarly there is no one pattern amongst the like-minded donors although all the other like-minded donors do allocate a higher proportion of resources through bilateral channels than Finland does.	consistent with Finland's strong commitments to the UN, the EU, to the Paris Declaration and reflects the relatively small staff the MFA can afford to maintain to manage bilateral development programmes.	within this funding the particular multilateral organizations and bilateral aid instruments it utilizes to ensure best fit with its stated policies. Unless increased human resources, this study recommends MFA channel any additional resources through multilateral channel, particularly UNAIDS.
EFFECTIVENESS OF FINLAND'S POLICY IMPLEMENTATION		
Findings	**Conclusions**	**Recommendations**
The implementation of Finland's HIV/AIDS policy has been mixed. There has been strong support to UNAIDS, reasonable but reactive support through NGOs that priorities HIV/AIDS but not necessarily the MFA's HIV/AIDS priorities, and insufficient cross-cutting in bilateral programmes.	The fourth major conclusion of this meta-analysis is that there is scope for MFA to increase the achievements and get greater returns from its financial support for responding to HIV/AIDS irrespective of the policy priorities chosen and the approaches and aid instruments utilized.	The MFA should enact a set of key measures to increase the outcomes from its existing set of commitments for addressing HIV/AIDS and ensure that the parts of its HIV/AIDS response contribute to achieving higher objectives than the sum of those parts. This should focus on (1) connecting the multilateral contributions, bilateral mainstreaming, and NGO contributions (2) achieving more from its support to UNAIDS and GFATM through prioritised active working at board level, in committees and working groups, to pursue, by working with these organizations on shared technical or policy priorities, (3) implementing a set of actions designed to make mainstreaming of HIV/AIDS more systematic and less random, and (4)

		explicitly making Finland's HIV/AIDS policy priorities a priority for its support for NGOs and seeking synergies with its support through other channels – in particular with UNAIDS at country level.
MFA LEADERSHIP, RESOURCES AND MANAGEMENT SYSTEMS FOR IMPLEMENTING ITS HIV/AIDS POLICY		
Findings	**Conclusions**	**Recommendations**
There is a lack of internal systems to lead, manage, coordinate and monitor the MFA response to HIV/AIDS. The evaluations of Sida, UNESCO and UNICEF found similar lack of internal systems, staffing and resources to ensure that the organization was adequately equipped to implement their HIV/AIDS policies.	Finally we conclude that the MFA would benefit from reviewing its internal human resource and management systems relating to HIV/AIDS whether the MFA updates its policy or maintains the same priorities and approaches.	The MFA should implement a set of measures to improve its internal management of its support for addressing HIV/AIDS. These would include: (1) Appointing an HIV/AIDS ambassador or champion with responsibility for high level external representation, leading and coordinating the MFA HIV/AIDS response and reporting on progress. (2) Developing an overall monitoring framework for Finland's HIV/AIDS policy with a clear set of targets and indicators, and responsibilities in different MFA departments for implementing them, (3) Producing an annual progress report for MFA leadership based on the monitoring framework. (4) Preparing systems and baselines to adequately track and monitor financial resources committed and disbursed for HIV/AIDS response, and (5) Allocating increased human resources to implement these actions.

1 INTRODUCTION

Each year approximately 2,5 million people become infected with HIV, half of them under 25 years of age. Two million die of AIDS. The total number of estimated cases worldwide is 33 million, with Sub-Saharan Africa being the most affected region, home to 67% of people living with HIV/AIDS (PLWHA) or 22 million. Lives of many families and communities are deeply affected by the pandemic as it affects people in their most productive years (24-45), predominantly women who are at increased risk often due to reduced decision making power (UNAIDS 2008a). The virus is mainly spread through unprotected heterosexual sex in Africa while in other regions of the world is use of intravenous drugs, men who have sex with men, sex workers or contaminated blood products. The epidemic continues to evolve and in parts of Asia married women increasingly are becoming infected with HIV.

The escalation of the epidemic has been matched by political commitment and unanimity on the need to join forces to address the disease. All parts of society and global organisations have increased attention to the epidemic and its impact. Major landmarks in the global response over the past 10-15 years include:

- The Joint UN Programme on HIV/AIDS (UNAIDS) established in 1996.
- The Millennium Summit (2000) set the response to AIDS, malaria and other diseases as the sixth Millennium Development Goal (MDG).
- The 2001 UN General Assembly Declaration of Commitment to respond to HIV/AIDS renewed in 2005 through the UN Political Commitment.
- In 2004 UNAIDS launched the *Three Ones* principle to enhance a more effective country response.

The response entered a new phase at the new millennium, as the price of AIDS drugs began to fall. The 2001 Doha Declaration introduced new flexibility in trade-related aspects of intellectual property right (TRIPS) and made it possible for the least developed countries to purchase generic drugs. This resulted in dramatic falls in the cost of antiretroviral drugs (ARV) and an increase in access to treatment.

The creation of the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) in 2001 resulted in massive increases in resources for the three interrelated public health problems. In 2003 UNAIDS and the World Health Organisation (WHO) launched the ambitious *3 by 5* initiative to provide treatment for 3 million people in low and middle-income countries by 2005. This was succeeded in 2006 by the UN General Assembly Political Declaration on Universal Access to Prevention, Treatment, Care and Support, which has helped establish country-specific coverage targets.

1.1 The Purpose, Objective and Scope of the Work

The Finnish Ministry for Foreign Affairs (MFA) wishes to review and, if indicated, update its HIV/AIDS policies and practices. The purpose of the meta-analysis is to give an informed basis to clarify and sharpen the scope of Finnish development projects addressing HIV/AIDS and its various dimensions.

The objective of the analysis is to assess the totality of HIV/AIDS response and based on this assessment decide whether a separate evaluation of Finnish activities is needed or whether conclusions of the meta-analysis might give sufficient support to the review of the Finnish policy and strategy in the sector. This meta-analysis is an analysis of HIV/AIDS related strategies and key interventions of 25 bilateral and multilateral development agencies: the sample agencies. The consultancy was conducted from March to July 2009.

1.2 Sample

During the inception meeting, the study sample was discussed with representatives of the MFA Evaluation Unit and the HIV/AIDS Adviser. It was agreed to revise the sample agencies included in the original Terms of Reference (TOR) to include important organizations such as the EU and United Nations Children's Fund (UNICEF) and donors of comparable size to Finland such as Belgium; The final sample included:

- **Bilateral organizations:** Sweden, Norway, Denmark, Netherlands, UK, Ireland, USA, Canada, Japan, Belgium and
- **Multilateral organizations:** UNAIDS, GFATM, UNICEF, United Nations Population Fund (UNFPA), United Nations Development Programme (UNDP), WHO, World Food Programme (WFP), United Nations Educational, Scientific and Cultural Organisation (UNESCO), World Bank, United Nations Office on Drugs and Crime (UNODC), United National High Commission for Refugees (UNHCR), International Labour Organization (ILO) and EU.

The rationale for the selection was the most relevant set of comparator bilateral donors (like-minded or largest volume of aid) and availability of relevant HIV/AIDS strategies, policies or plans. In addition, the team also analyzed the Finnish response to HIV/AIDS. Like-minded donors include Sweden, Norway, Denmark, Netherlands, UK, Ireland and Canada and are subsequently referred to as LMD.

1.3 The Methodology and Evaluation Process, Analytical Framework, Data Collection and Analysis

As per the TOR, the meta-analysis should "construct an overall picture of the HIV/AIDS response of main donors globally and that carried out with Finnish

development funds, considering:

- strategies, projects/programmes and their objectives;
- results, effects and impacts of strategies and projects as reflected in evaluations;
- corrective measures and new approaches taken after the evaluations; and
- future plans and strategies for future based on earlier experience."

The TOR also requested that the analysis should map both covered and uncovered areas in HIV/AIDS work and identify possible synergies with Finnish development cooperation and the global response. The analysis should recommend whether a separate evaluation of the Finnish HIV/AIDS response is needed. If not, the analysis should draw broad HIV/AIDS policy directions for future Finnish development cooperation.

The meta-analysis was mainly based on literature review and analysis. The MFA compiled relevant material in 2008. As per the TOR, "[t]he compiled material forms a fair cross-section of the HIV/AIDS response of various donors during last decade and should thus form a sufficient basis for a meta-analysis." The consultant team added to this selection with strategy documents for the agencies added to the sample and additional evaluation and overview documents. Although, the TOR indicated that the analysis should cover strategies for the past ten years (1996-2007), it was agreed at the onset of the assignment that the focus should be on the most recent strategies and the analysis should be forward-looking. A summary of the core materials used for the meta-analysis is provided in Annex 3.

Consultants first compiled basic information on the sample agencies' response, including expressed priorities, funding instruments and approaches, availability documentation on lessons learnt, evaluations, and assessments of agencies' comparative advantages/roles in the international response. The consultants mapped the sample agencies' overall development policy priorities and gathered information on overall ODA and the allocation to HIV/AIDS. This information was compiled as a datasheet for each sample agency and translated into a simple database to facilitate analysis. This built up an overall picture of HIV/AIDS prioritization.

The consultants expanded the analysis to include available evaluation reports and other relevant support material. They also assessed the extent of integration of HIV/AIDS within other selected development cooperation policies (mainly gender, education and health sector policies). Document review was complemented with few key informant interviews, limited to selected informants from the MFA Finland and of LMD, the latter to gather further insight on the context and factors influencing strategic priority setting. However, given that the assignment was a meta-analysis, key informant interviews were only used as a supplemental source of information. Contacting LMDs proved somewhat more challenging than expected due to difficulties in the identification and contact of the right informants as those individuals who had informed the priority setting process had often moved on leaving behind limited institutional memory. When necessary utilising personal contacts, consultants managed to interview face-to-face, by phone or e-mail key individuals in four LMD: Denmark, Norway, Netherlands and Canada.
As two of the three consultants are based in Mozambique interviews were carried out

with Finnish embassy staff in Maputo and with a few other sample agencies in-country. The Geneva-based team member, interviewed staff of UNAIDS and GFATM at their respective headquarters.

The total information was analyzed using qualitative content analysis. Because the meta-analysis is largely based on qualitative data, the results are sensitive to interpretation. This was particularly an issue when mapping priority areas and funding approaches, which were not stated systematically by some sample agencies and required interpretation. Although information was triangulated there is the possibility that some aspects have been misunderstood or overlooked.

2 PRIORITY SETTING

2.1 HIV/AIDS at Development Policy Level

Table 1 Prioritization of HIV/AIDS.

High	Medium	Low
Denmark	Canada	Belgium
Ireland	Finland	ILO
USA	Netherlands	
UNAIDS	Sweden	
UNDP	UK	
UNFPA	EU/EC	
UNICEF	UNESCO	
WHO		
WFP		
UNODC		
UNHCR		

Source: Development policies as listed in Annex 3

The TOR for the meta-analysis asked "To what extent is HIV/AIDS seen as a priority [by development agencies]". To answer this question, the team used two indicators. First whether HIV/AIDS appeared in the development policy as high priority (clearly mentioned as a priority area), medium (as a sub-area of a main priority) or low (not specifically reflected as a priority). Secondly, the team analysed the proportion of official development assistance (ODA) allocated for HIV/AIDS. However, this latter analysis only included bilateral agencies as there was no comparable data readily available for the multilateral agencies.

The analysis of development policies only included 21 out of 25 sample agencies as there were four whose policies could not be accessed: Japan, Norway (not in English), the World Bank and GFATM. There was no consistent pattern between multilateral and bilateral

agencies, or between LMD and other agencies. Table 1 shows the level of prioritization by agency. Whilst Finland mentions HIV/AIDS within its development policy, it is as a cross-cutting issue and therefore not considered by this study as one of the main priorities.

Table 2 HIV/AIDS funds as percentage of ODA.

Partner	% **ODA on HIV (2006 – 07)**
Austria	0,8
Portugal	1,0
Switzerland	1,2
Japan	1,9
Spain	2,3
Germany	2,3
Greece	2,6
France	2,6
Finland	2,6
Belgium	2,6
New Zealand	2,7
Luxembourg	3,4
Netherlands	3,6
Denmark	3,8
Canada	4,4
Norway	4,5
Sweden	4,5
Australia	4,6
Italy	5,2
UK	6,9
Ireland	11,1
US	16,2
Average	4,1
Median	3,4

Source: OECD/DAC 2009

The financial data is based on the *Measuring AID to HIV/AIDS Control* paper (OECD/DAC 2009) and DAC net official development assistance calculations. The data used is the 2006-07 annual average unless otherwise stated. In order to calculate the proportion of HIV funds, the annual ODA data for 2006 and 2007 were converted into annual averages for the same period.

The analysis highlighted that most OECD/DAC members committed between 0,8 and 5,2 percent of their overall ODA for HIV/AIDS control in 2006-07 (Table 2). There were three exceptions: the UK committed 6,9%, Ireland 11,1% and the USA 16,2%. The LMDs

average was 5,5% and the median 4,5%. Finland's commitment was 2,6% of ODA. Comparing the prioritization of HIV/AIDS and the percentage of ODA spent on HIV/AIDS – it is evident that 2 of the 3 bilateral partners who gave high level importance to HIV/AIDS in overall development policy also committed the largest proportion of funds to HIV: Ireland and USA. Whilst Denmark prioritised HIV/AIDS it allocated a comparatively smaller share of the ODA funds to HIV. Thus, it appears that policy level prioritization does not automatically translate into high proportional financial allocations. Ireland and UK have set targets for their spending to address HIV/AIDS and they contribute the 2nd and 3rd largest proportions of ODA. Evidence from the UK suggests that "the spending target and requirement to report on activities to Ministers have encouraged DFID staff to keep HIV and AIDS high on the agenda" (Social & Scientific Systems Inc 2007).

2.2 Development Partners' HIV/AIDS Strategies

In this section we analyse the content of sample agencies' HIV/AIDS strategies which are variously reflected in documents labelled strategies, policies, programmes and plans. The consultant team included all the relevant documents in the analysis. In order to simplify the language, all these documents are hereafter called strategies.

The mapping exercise showed that nearly all the bilateral agencies, except Japan, have an HIV/AIDS strategy. Japan considers its added value so limited in the area of HIV/AIDS that it has not defined a specific strategy but includes it within its infectious diseases strategy. Yet Japan still contributes nearly 2% of its ODA to HIV/AIDS. Of the assessed bilateral partners Sweden, Ireland, Denmark, Canada and UK were the first partners to elaborate an HIV/AIDS strategy with documentation produced between 1999 and 2001. Finland, Netherlands and Norway were the only LMD countries who prepared their first HIV/AIDS strategies after UNGASS in 2001.

Most HIV/AIDS strategies have not been updated regularly. Only Denmark and Sweden have revised and updated their original strategies once (Denmark after 4 years, Sweden after 9 year) and US and UK twice (USA after 1 and 5 years, UK after 3 and 4 years). The USA expressed its initial strategic vision through the 2002 International Mother and Child HIV Prevention Initiative. A year later, the USA adopted a more comprehensive approach through the President's Emergency Plan for AIDS Relief (PEPFAR), which was updated and reauthorized in 2008.

In addition to the main strategy document, some bilateral partners have adopted other supporting instruments to sharpen their response. The Netherlands has one overall strategy for HIV/AIDS and a separate strategy for harm reduction, which is the main priority area for the Netherland's response. Sweden has developed a number of tools, including a manual to guide the integration of HIV/AIDS into country level strategies, HIV-related thematic information updates, and evaluations of different areas of the response. Whilst

Canada does not have a formal updated HIV/AIDS strategy at central level, it is said to define priorities locally through its country level development frameworks.

Of the assessed multilateral donors the World Bank first planned an HIV/AIDS response in 1999. Since then, the World Bank has elaborated at least four strategies on HIV/AIDS (two on Multi-country AIDS Programme (MAP), one for the Global HIV/AIDS Program and one for the African region). However, such a volume of HIV strategic plans is exceptional among multilateral and bilateral agencies.

In fact, the concept of HIV/AIDS strategy is less clear for multilateral agencies. Some multilateral agencies have no published policy/strategy document on HIV/AIDS. This is the case for ILO, UNICEF, UNFPA and UNODC who are all UNAIDS cosponsors, and thus share the accountability for UNAIDS strategies. Yet, they do not have strategies of their own. ILO has developed a code of practice to orient workplaces to deal with HIV/AIDS and has more recently developed international standards for the workplace. Both UNICEF and UNFPA give high priority to HIV/AIDS in their respective medium term strategic plans. Also, UNICEF has been running a multi-year campaign called "Unite for Children, Unite against AIDS" and advocates care and protection for orphans and vulnerable children, and treatment for HIV-infected children. UNFPA promotes the relationship between HIV/AIDS and reproductive health and leads, within the UN system, prevention efforts targeting women, girls and young people. UNODC leads the UN prevention efforts targeting injecting drug users and prisoners. The fact that these organizations have not written down their HIV/AIDS strategies does not mean that they were not active or that they lack clarity in their HIV/AIDS response. Conversely the fact that a partner has an HIV/AIDS policy/strategy document neither ensures that it is active, or that the document guides its activities.

2.3 Priority Areas

In this section, we look at thematic areas that the agencies identify as their priorities within their HIV/AIDS strategies. The framework for the thematic areas follows loosely the structure defined by UNAIDS (www.unaids.org/en/PolicyAndPractice consulted 15.05.2009). The analysis is based on the priority areas as stated in the agencies' HIV/AIDS strategy documents. Within these the level of specification of the priorities varies greatly with some strategies only stating that they support HIV/AIDS-related prevention and/or care and/or treatment. Whilst the analysis has endeavoured to follow the agencies' own definitions, the consultants have sometimes had to interpret the strategies in order to carry out the analysis. The results of this interpretation are compiled in the agencies' data sheets in Annex 7. A summary of the stated priorities per agency can be found in the Annex 6.

The results do not provide evidence of which thematic areas are well covered and which are not. While the partners define the priorities at the policy level, they are not always able

to ensure that their investment reflects the same priorities. This is especially the case for multilateral funding modalities. Even if funds are earmarked for identified priority areas it is impossible to confirm whether these areas are sufficiently covered or not. Thus, what follows is an analysis of the priority areas from the agencies' strategies.

2.3.1 Prevention

The analysis shows the vast majority of bilateral and multilateral sample agencies support prevention related activities in general. HIV-related education and Prevention of Mother to Child Transmission (PMTCT) are clearly the areas that get most support. The prevention areas that have been mentioned by three or less agencies include post-exposure-prophylaxis, male circumcision, harm reduction and blood safety.

2.2.2 Care and Support

Support for care and support was highlighted by nearly half the agencies, although often this was a general commitment without reference to the specific interventions. This was somewhat more commonly highlighted amongst bilateral agencies. Those who were more specific, prioritised care, nutrition and food security. Areas such as palliative care, psychological support or carer support were practically absent in all the strategies. Home-based-care and impact mitigation were rarely mentioned.

2.3.3 Treatment

More than one third of agencies prioritise treatment. In most cases, this equated to support to adult and paediatric antiretroviral treatment (ARV). Whilst only a few agencies explicitly state treatment of opportunistic infections, it is assumed that this area is covered as these services normally go hand in hand with ARV treatment. Only WHO indicates support for traditional/alternative medicine.

2.3.4 Other

More than half of the agencies prioritise promotion of greater gender equality and human and social rights. More than one third of the agencies, mostly bilateral, prioritise HIV-related scientific research and development of new tools. Nearly two thirds of the agencies prioritise strengthening of national level response mechanisms, including national strategic planning and implementation. Health system strengthening was often stated as a priority. In contrast very few agencies mention HIV counselling and testing, strengthening community involvement, private sector involvement or action to reduce drug prices.

Many agencies prioritise the targeting of most-at-risk-population groups (MARPs). The most common MARPs were: children and orphans, young people and women and girls. Injecting drug users and commercial sex workers and clients are mentioned by some agencies.

Analysis of expressed priorities shows limited or no targeted support for a range of at risk groups. These are listed in Box 1. Surprisingly few agencies (4) specifi cally included PLW HA among their priorities. Whilst men who have sex with men are only seldom included within the priority areas, other sexual minority groups are mentioned even less often.

Box 1 List of less prioritised Most-at-risk-Population groups.

- Men who have sex with men and other sexual minorities
- Migrant/mobile people
- Refugees and internally displaced people
- Indigenous people
- Disabled people
- People in prison settings
- Uniformed services
- People in education sector
- People in health sector
- Rural communities
- People at workplace
- People living with HIV/AIDS

Source: HIV/AIDS strategies of the respective development partners as identifi ed in Annex 3

It is recognized that some priority areas are both socially as well as politically more sensitive than others. This is the case of commercial sex workers, injecting drug users and men who have sex with men. Due to the volume of its funds, the USA government has perhaps more infl uence than other partners on the way these groups are addressed. In order to ensure that sensitive issues and target groups are adequately addressed, those development partners who prioritise these groups should keep vigilant and undertake active advocacy work for keeping these issues on the agenda.

In general, there are no signifi cant differences between bilateral and multilateral agencies. However, the priority areas of the multilateral agencies are clearly related to their particular mandate.

Box 2 Least Prioritised responses to HIV/AIDS.

Prevention
- Post-exposure-prophylaxis
- Male circumcision
- Harm reduction
- Universal precautions and blood safety

Care & Support
- Palliative care
- Psychological support
- Carer support

Treatment
- Traditional/alternative medicine

Others
- HIV counseling and testing
- Community involvement
- Strengthening the role of private sector
- Reduce drug prices

Source: HIV/AIDS strategies of the respective development partners as identified in Annex 3

Analysis of the LMD alone shows no common pattern of prioritization. The thematic areas prioritised by most of the LMD include prevention, care and treatment, health system strengthening, linking with sexual and reproductive health and rights and targeting young people and women and girls. These are common priorities for the whole sample. Least prioritised responses are listed in Box 2.

For the European Commission, HIV/AIDS is both a cross-cutting theme and a priority area on its own. The European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Aid foresees significant efforts to be taken at country level. At the global level, the EU promotes affordable pharmaceutical products; seeks to expand the capacities to perform scientific and regulatory tasks with respect to the evaluation and marketing and authorisation of pharmaceutical products at national, regional and global levels; and attempts to respond to the human resource crisis for health providers. In addition, EU supports research and development of new tools to accelerate the development of new vaccines, drugs, microbicides and diagnostic tools for resource-poor settings.

On the basis of the information provided in the strategy documents and on the basis of

the small number of interviews conducted, it is understood that the priority setting of bilateral partners' strategies is usually a result of a consultative process that involves public as well as non-governmental sectors in the home country. This was the case for example in Norway and Finland. Typically, the first draft is prepared by the agency on the basis of overall development policy and priorities. Often changes in government also result in changes in development policy. Reflections are also made on the added value the agency can deliver and where they may have a specific comparative advantage. The Netherlands' decision to prioritise harm reduction for injecting drug users was influenced by the recognition that this area was given insufficient global attention (key informant interview). It is likely that the Netherlands' liberal policy on drug use facilitated this decision. Denmark's decision to prioritise strengthening health systems came as a result of analysis of critical long term constraints to the response, and their focus on women, girls and youth because they were identified as a vulnerable population group.

The draft strategy is then circulated among stakeholders whose opinions are likely to be influenced by the status of the global epidemic and by trends in the global response. For example, after drug prices started dropping significantly post-2001, treatment became a dominant focus at global and national level. A few years later, UNAIDS and other global level actors started to express a renewed concern for prevention as the mainstay of the response to the epidemic. Today's trends support a more comprehensive prevention, treatment, care and impact mitigation approach. Even when the focus is only on prevention, it is now recommended to combine behavioural, structural and biomedical approaches (Merson, O'Malley, Serwadda & Apisuk 2008). Overall health system strengthening, donor coordination and aid harmonization have become increasingly common HIV/AIDS priorities.

2.4 Evaluation of HIV Strategies

Few of the many HIV/AIDS-related evaluations have focused on the agencies' strategy document. On the basis of the pre-study conducted by the MFA and subsequent searches by the consultants, only Sweden, Norway, UK and the World Bank have had an external evaluation of their strategies. In addition, both UNAIDS and GFATM have had broad evaluations of their overall performance in meeting their institutional mandates. As most agencies do not systematically measure the results or impact of their HIV/AIDS strategies it is not possible to draw conclusions about the impact of different strategic approaches.

Other partners, such as UNESCO and UNICEF, have had evaluations of their overall HIV/AIDS response despite not having a specific HIV/AIDS strategy. UNESCO had an evaluation for 1987-2003, i.e. before it had elaborated its HIV strategy. The lack of readily accessible information means that it is not possible to document to what extent the recommendations of evaluations have been acted upon and a systematic follow up of evaluation recommendations is beyond the scope of this study. Sweden, the UK and

the World Bank have updated their original HIV/AIDS strategies following external evaluation although the latest Swedish strategy, for example, does not explicitly reflect the evaluation recommendations.

The team studied a wide range of available evaluation reports both specific to HIV strategies and more general development policy. Some issues, such as mainstreaming, are addressed in several reports; others, such as cost-effectiveness of different funding modalities are not covered at all. The six major themes identified within the different reports are summarized below.

2.4.1 Need for Action at Country Level

Global level policies/strategies need to be translated into action at the country level. It is important to show flexibility and responsiveness towards national priorities and to understand the impact of civil society organizations (CSOs) and how to effectively support and monitor their contribution (Vogel, Skjelmerud, Jansegers, & Forss 2005; Social & Scientific Systems Inc 2006; Irish Aid 2007; Poate & Ogunlayi 2008).

2.4.2 Need for Coordination and Harmonization

The overall HIV/AIDS resource envelope is theoretically adequate and the main challenge is to make best use of these resources, supporting countries and regions to strengthen their own responses to scale up prevention, treatment and care and mitigation activities in a coordinated and structured way. The progress in aid harmonization has not been reflected in coordination of work by CSOs. Yet, the important role CSOs play in covering hard to reach areas and vulnerable groups means it is important to continue supporting their work (Vogel *et al* 2005; Social & Scientific Systems Inc 2006; Sepulveda, Carpenter, Curran, Holzemer, Smits, Scott, & Orza 2007; Poate & Ogunlayi 2008).

2.4.3 Mainstreaming

HIV mainstreaming is the route to ensuring an effective multisectoral response. Mainstreaming is much documented but there is little evidence of its effective implementation and little hard evaluation data. HIV/AIDS focal points within the headquarters of agencies are major assets for incorporating HIV/AIDS issues into technical work. However individuals often lack sufficient technical and programmatic knowledge to mainstream HIV/AIDS. Some agencies have a steering committee, composed of heads of key departments/divisions to regularly monitor implementation across different sectors of the organisation (Vogel *et al* 2005; Social & Scientific Systems Inc 2006; Irish Aid 2007; Poate & Ogunlayi 2008).

2.4.4 Organization and Staff Issues

Strategic focus and adequate funding will not produce results by themselves. Sufficient competent people are needed to advocate and develop responses inside the agency and, even more importantly, in the co-operation countries. At head office level HIV/AIDS expertise should be given permanence within the structure of the agency (Vogel *et al* 2005; Social & Scientific Systems Inc 2006).

2.4.5 Monitoring and Evaluation

Lessons learnt
Very little is documented on agencies' experience in dealing with HIV/AIDS as a technical and programmatic issue. It is important to develop a plan to document lessons learned, to produce evidence on approaches including mainstreaming and to conduct operational research. The results of these efforts should be widely disseminated to help determine the most appropriate and effective interventions.

Monitoring
Many agencies do not have a clear policy on monitoring progress. Operational targets should be set and regularly monitored by top management.

Need for Good Evaluations
In general, the number of evaluated interventions is low. Most programmes rely on desk studies and stakeholder interviews and lack systematic and solid evidence of the results – only rarely do programmes include systematic collection of quantitative and/or qualitative information before and/or after implementation. The financing of interventions should include sufficient funds for research and robust evaluation.

Remaining at Output Level - not Assessing Impact
Almost all M&E efforts focus on programme outputs. Even when evaluations find an increase in outputs and intermediary outcomes, they often do not establish a causal link to impact, nor are analyses of cost or cost-effectiveness provided. Overall very little is known about the effect that individual programmes have on, for example, knowledge about HIV/AIDS and behaviour.

Not addressing Cost and Cost-effectiveness
Programmes and interventions should provide evidence on efficiency, cost-effectiveness and sustainability. Yet, the cross-cutting nature of interventions makes it difficult to assess total funds allocated rendering cost-benefit analysis complicated.

The synthesis of HIV/AIDS evaluations indicates that the international community lacks robust evidence on how to spend the considerable funds raised to maximum effect. The extensive on the ground knowledge is not systematically collected or analyzed (Vogel *et al* 2005; Social & Scientific Systems Inc 2006; Sepulveda *et al* 2007; Ministry of Foreign Affairs of Denmark 2008).

2.4.6 Support to Programmes Addressing MARPs

Despite the heterogenous nature of agencies involved there is broad consensus on the need to deliver effective interventions to the poorest countries and to the poorest populations within these countries.

Gender
Need to empower women and girls by increasing attention to the reasons that place them at greater risk of HIV/AIDS, and support improvements in their legal, economic, educational and social status (Social & Scientifi c Systems Inc 2006; Sepulveda*et al* 2007; Ministry of Foreign Affairs of Denmark, 2008).

2.5 Comparative Advantages of Development Partners

In the context of harmonization and donor coordination, division of labour between international development partners becomes an issue. Defi ning a comparative advantage, which justifi es a specifi c role in the context of the global response to HIV/AIDS is espe cially challenging for bilateral agencies. Most defi ne their roles through the priority areas or broad lines of action that they support. Defi ned this way, there is plenty of duplication and it is diffi cult to distinguish the role of one from another. The only exceptions are the US and Japan. The US identifi es itself as 'the leader of the international campaign against HIV/AIDS' which, considering the volume of funds it provides can be considered a fair judgement. Japan, in contrast, considers its comparative advantage so limited that it focuses on the wider infectious diseases agenda and not specifi cally on HIV/AIDS.

There are two different emphases in the way the LMD defi ne their comparative advantages. Ireland and UK emphasize their role in supporting country-led processes and their commitment to enhance donor coordination and aid effectiveness. Both Sweden and Norway promote sexual rights particularly to specifi c vulnerable groups such as youth, sexual minorities, marginalized groups, PLWHA. Canada, Denmark and Finland do not clearly specify their roles or comparative advantages.

The division of labour is most marked among UN agencies. With UNAIDS assistance, the UN agencies have their specifi c roles leading the response in the areas that are based on their agency mandates (see Annex 4 for the UN technical support division of labour). UNICEF leads support to orphans, vulnerable children and PLWHA, UNESCO leads support to HIV prevention among in-school-youth, UNFPA leads on prevention for out-of-school youth. Other agencies may also contribute to these areas (UNAIDS 2005).

According to its latest strategy for Africa, the World Bank is to increasingly adopt a role of a facilitator and knowledge contributor and reduce its financing role to complement efforts of others (World Bank 2008a). The division of labour on technical support already reflects this new role. In contrast, GFATM will maintain

its leading role as a financer for HIV/AIDS, tuberculosis and malaria programmes.

2.6 Conclusions on HIV-related Priority Setting

In general HIV/AIDS is highly prioritised at the policy level. The vast majority of the assessed agencies highlight HIV/AIDS as either a top priority, or a sub-area of a top priority. However, policy level prioritisation does not automatically translate into financial allocations. While Finland has HIV/AIDS as a cross-cutting priority, its financial contribution is below the OECD/DAC average. All but two of the sample bilateral agencies have a published HIV/AIDS policy/strategy or a similar document and some have adopted supporting instruments to sharpen their response. However, only four of the sample agencies have submitted their HIV strategies to external evaluation.

Several multilateral agencies have published strategies which are more geared towards the international community than the agency itself; with only half having strategies which contain explicit targets and responsibilities for the agencies themselves. Some multilaterals do not have any published policy/strategy document yet participate actively in the global response. The lack of a written strategy does not appear to hinder activity or clarity of the HIV/AIDS response and the presence of a clear strategy does not necessarily ensure that activities follow policy guidance.

3 APPROACHES IN ADDRESSING HIV/AIDS

In pursuing their policy priorities bilateral and multilateral agencies use a range of funding approaches including sectoral and budget support, pooled funds, targeted projects, mainstreaming HIV/AIDS, and funding international or local NGOs. Bilateral agencies commit resources through both bilateral and multilateral channels.

3.1 Bilateral Agencies Funding Channels for HIV/AIDS Control

Bilateral agencies provide resources for HIV/AIDS control through commitments to UN and other international and multilateral agencies and through bilateral channels to governments, NGOs and technical cooperation projects. The proportion of funding through these two channels varies considerably. France provides 98% of its commitments through multilateral channels; the US gives 88% of its resources through bilateral channels (based on 2006/7 data). The commitment data reported to OECD shows that there is no linear relationship between the total HIV/AIDS assistance and the multilateral-bilateral split. Portugal, the smallest DAC donor has a similar pattern to France, the fourth largest, whilst New Zealand, the second smallest donor is mostly a bilateral supporter, as are the USA and the UK, the two largest HIV/AIDS donors (Figure 1).

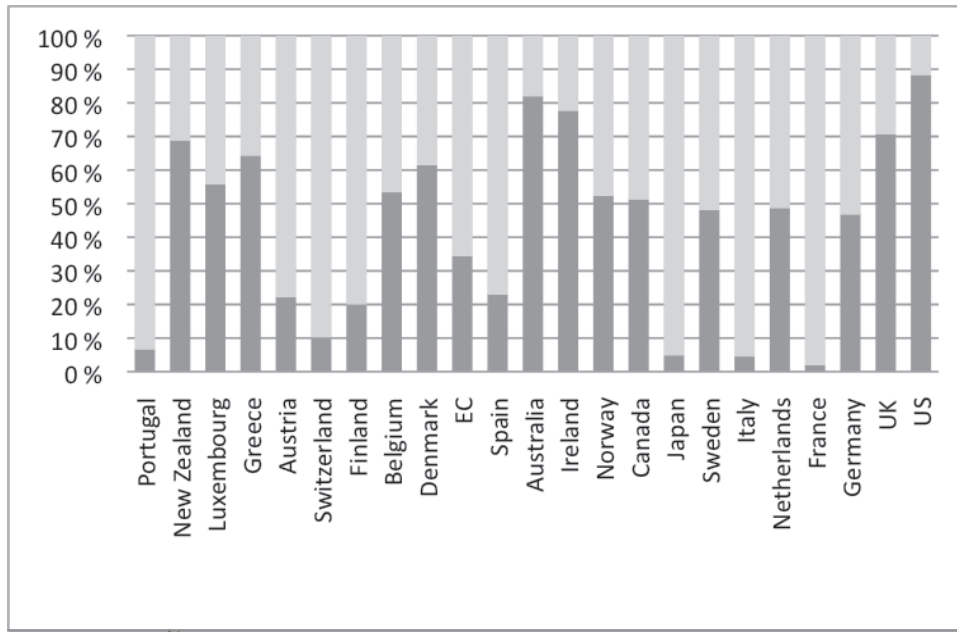

Figure 1 Bilateral and multilateral HIV/AIDS commitments as per centage of total ODA. Annual average 2006-07. Dark columns, bilateral funding; light columns, multilateral funding.

Source: Calculated from OECD/DAC 2008; 2009

Table 3 shows that agencies can be grouped into 3 sets: mostly multilateral, mixed and mostly bilateral commitments. Finland is in the mostly multilateral group, as are most of the other lower ODA countries. The LMD are split between mixed (Norway, Canada, Sweden, and Netherlands) and mostly bilateral (Denmark, Ireland and UK). Finland is therefore a slight outlier in the LMD with the largest multilateral proportion. It is worth noting that the US commits the largest actual funds to multilateral channels (mostly GFATM) of all donors because its overall HIV/AIDS fi nancing commitment is so high.

Table 3 Bilateral agencies by mix of funding commitments for HIV/AIDS.

Type	Funding channel %	Countries
Mostly multilateral	>60% multilateral	Portugal, Austria, Switzerland, Finland, EC, Spain, Japan, Italy, France
Mixed	60%>bilateral/multilateral>40%	Luxembourg, Belgium, Norway, Canada, Sweden, Netherlands, Germany
Mostly bilateral	>60% bilateral	New Zealand, Greece, Denmark, Australia, Ireland, UK, US

There are many UN agencies, multilateral and international organisations to channel resources through. The OECD has data on bilateral donors contributions to International Development Association (IDA – World Bank), African Development Fund (AfDF – African Development Bank), EC, UNICEF, UNFPA, UNAIDS and GFATM, see Figure 2. OECD does not have data on commitments to WHO.

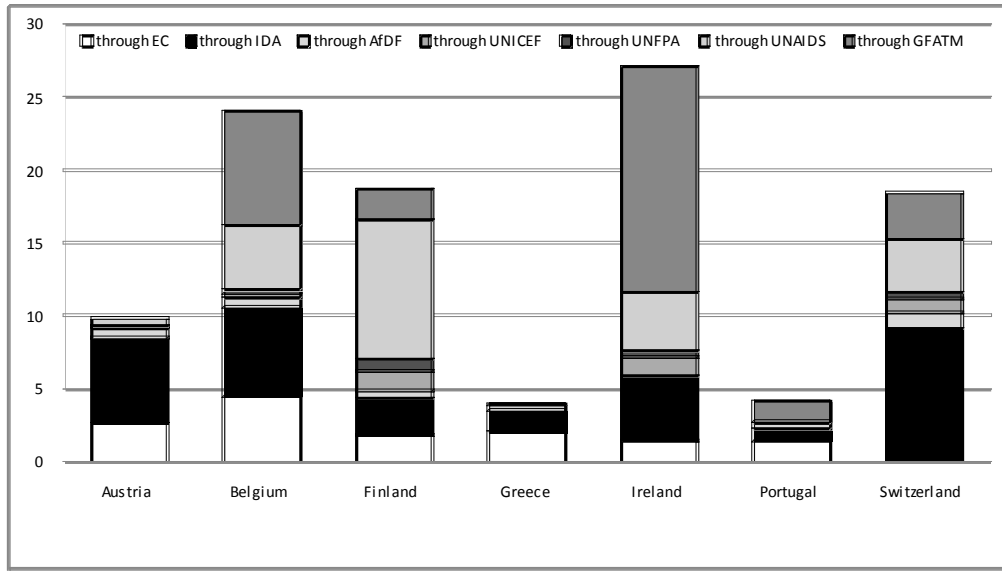

Figure 2 Imputed multilateral commitments (HIV/AIDS): countries with similar ODA. Annual average 2006-07, USD million, 2007 constant prices.
Source: Calculated from OECD/DAC 2008; 2009

Comparison of the relative contributions to these agencies shows that the largest variations are in contributions to UNAIDS and GFATM where the decision to fund these agencies is directly related to HIV/AIDS prioritization. For the other multilateral channels the decisions on commitments are made on broader developmental objectives of which HIV/AIDS is only one factor. There is no overall pattern to the multilateral commitments of the group of similar size bilateral agencies, nor the LMD. Finland provides the greatest proportion of its multilateral support (51%) through UNAIDS. Sixteen of the 22 OECD/DAC donors provide a higher proportion of their funding through GFATM than through UNAIDS: the six exceptions are Austria, Finland, Greece, Luxembourg, New Zealand and Switzerland.

Bilateral agencies make multilateral contributions as un-earmarked or earmarked. Earmarked funding is targeted on specifi c priority issues that the agency wants the multilateral to focus on. The data available on the split between earmarked and non-earmarked commitments is very limited. GFATM does not accept earmarked funding, UNAIDS does. Finland has provided its funding to UNAIDS as 100% un-earmarked since 2007 and in 2006 provided 87,5 % un-earmarked with 12,5% earmarked for the Global Coalition on Women and AIDS. In 2006, 100% of Netherlands funding for UNAIDS was un-earmarked, 65% for UK, 75% for Sweden, 88% for Norway, 91% for US (Social & Scientifi c Systems Inc 2007).

3.2 Aid Instrument Choice for Addressing HIV/AIDS

The documentation of development agencies generally is not prescriptive on the allocation of resources through different aid instruments. They outline the range of available aid instruments and emphasise the need for a country and context specific analysis of the most appropriate aid instrument. We found two exceptions. The Netherlands HIV/AIDS policy note is unusual in that it does outline an indicative distribution of bilateral at 15%, multilateral at 35%, civil society organisations 20% and public-private partnerships (including GFATM, IAVI etc) at 30% (Dutch Ministry for Foreign Affairs 2004 www.minbuza.nl/binaries/en-pdf/aids-dutch-policy-nste.pdf consulted 17.06.09). The evaluation of the DFID HIV/AIDS strategy attempted to disaggregate HIV/AIDS commitment and expenditure data to enable this analysis but found it so difficult that they wrote an annex explaining why the results need to be used with care and describing the methodological problems (Social & Scientific Systems Inc 2006; 2007).

Most bilateral donors utilise a mix of aid instruments including budget and sector support, pooled funding, targeted HIV/AIDS projects and cross-cutting interventions. The LMD utilise all four instruments. The USA only support targeted HIV/AIDS projects and cross-cutting interventions.

Donors vary the mix of instruments according to the country context. For example, Norway provides support through multilateral agencies, research institutes and CSOs in Ethiopia but not direct bilateral cooperation because of the "difficult political situation" and in Malawi it supports a large bilateral programme working through government and NGOs (Poate & Ogunlayi 2008). Whereas, in Tanzania, Norway supports the government through a Rapid Fund Envelope and NGOS, but also provides general budget support and finances the health basket fund.

The European Commission supports primarily general budget support, but also some health sector budget support and HIV/AIDS projects (European Court of Auditors 2008). This report found that EC project support enabled involvement by a wide range of government and civil society actors, that it had made little use of sectoral support in the health sector and that its general budget support had weak links to health sector outcomes. It also noted an EC comparative advantage of supporting fragile states where there tends to be less EU member state presence.

There is little data available to show trends over time in the allocation of bilateral funding for HIV/AIDS. An exception is the evaluation of DFID HIV/AIDS strategy which shows a significant increase in the number of large size projects (over £10 million) and of projects with a policy dialogue element (Social & Scientific Systems Inc 2006). Most DFID funding has traditionally been technical cooperation, however, since 2003 DFID has increased the proportion of financial aid for HIV/AIDS and decreased the proportion for technical cooperation. It is interesting that DFID, a strong advocate of budget and sector support mechanisms, provides only 30% of its bilateral funding for HIV/AIDS as

financial aid. This study could not find comparative evaluations of the effectiveness of the different aid instruments, however, the evaluations of the DFID and Sida strategies discuss the pros and cons of providing support through country led approaches, primarily budget support. Addressing HIV/AIDS through budget support has helped its perception as a cross-sectoral issue in Mozambique and increased levels of on-budget funding in Tanzania (Social & Scientific Systems Inc 2007). The Sida evaluation highlights the opportunities of providing support through country led approaches including the possibility for better coordination with other development partners, harmonisation between donors to reduce workload on the country partner, several donors speaking with one voice to strengthen advocacy and putting the government 'in the driver's seat' (Vogel *et al* 2005). Disadvantages of budget support include the difficulty of obtaining rapid results, the relative weakness of institutions, the difficulty of supporting innovation, pilots and civil society, and that many vulnerable populations may be marginalised by government and political processes (Social & Scientific Systems Inc 2007). The Sida evaluation highlights that a particular risk of sectoral support is the requirement of a national strategic framework consistent with Sweden's principles and approach; but as a relatively small agency it is "often not in a position to substantially influence agendas" (Vogel *et al* 2005).

Two multilateral agencies provide finance for HIV/AIDS control: the World Bank and GFATM. Many UN agencies primarily provide technical assistance to government, advocate, run projects particularly pilots, and in some instances provide financial assistance. These include the UNAIDS Secretariat and all their cosponsors.

The World Bank uses a range of instruments including its lending portfolio, IDA grants and analytical work. It supports budget and sectoral funding to countries, targeted HIV/AIDS projects, and pooled funds for HIV/AIDS and mainstreams components into other sectoral programmes (health, population, social protection, education and transport programmes). The World Bank has modified some of its standard procedures to enable a more rapid process of developing and implementing programmes and in 2002 the Bank began providing IDA grants, rather than loans (Ainsworth 2005). The GFATM's main approach is through targeted HIV/AIDS projects developed through a country-led process and approved by a technical review panel. GFATM supports HIV/AIDS as a cross-cutting theme only in other TB and Malaria projects because it does not operate in other sectors. GFATM provides support to pooled funding if its fiduciary conditions are met and if the country requests it to do so, but it does not provide general budget support. To date GFATM has only contributed to pooled funds in Malawi and Mozambique (but recently the country requested this to stop because of the unpredictability funds).

UN agencies, funds and organisations addressing HIV/AIDS generally operate through projects, and provision of technical advice and support to government. UNHCR for example manages projects and programmes to address HIV/AIDS, these are often joint projects with other UN agencies. UN projects are implemented by government organisations, contracted NGOs and the agencies own staff. Only UNDP, UNICEF, UNESCO and UNFPA are empowered to provide sectoral support by their governing bodies. They

do so in some countries in the health and education sector with relatively low levels of fi nancing. These agencies also use funding to develop global public goods, for example new knowledge and new tools.

In summary, development agencies utilise a mix of aid instruments with most LMD provide funding through sector support, pooled funds, targeted projects and cross-cutting approaches. Bilateral agencies generally allow fl exibility for a country by country assessment of the most appropriate mix. The most common aid instrument is targeted HIV/AIDS projects supplemented by sectoral support and funding HIV/AIDS as a cross-cutting issue. Bilateral agencies differ in predominantly supporting budget /sectoral support or standalone targeted projects which refl ect their development philosophy. Smaller scale donors' greater reliance on multilateral channels suggests the lack of a country presence suffi cient to manage signifi cant bilateral projects. The challenge for smaller donors is to access country knowledge to enable infl uencing of the multilateral organisations they support (OECD/DAC 2003). Ireland achieves this fi rstly by working with other LMDs, and secondly by initiating strategic studies, (for example the Global Fund Tracking Study which was subsequently co-fi nanced by Ireland, Netherlands, Norway and UK) to inform decision making .

3.3 Supporting NGOs Efforts to Address HIV/AIDS

There is little available data to enable analysis of the proportions of funding for addressing HIV/AIDS that development agencies commit to NGOs. All bilateral agencies and the two fi nancing multilaterals (World Bank and GFATM) provide support through NGOs, although some (Japan and Belgium) do not explicitly state this in their strategy or policy. Many donors manage three separate NGO funding channels:

- negotiated multi-year partnerships with selected NGOs (Finland, Ireland, UK and Sweden);
- project proposals submitted by NGOs, (Finland, UK and Ireland); and
- delegated resources for the discretion and management of embassies or country offi ces to fund NGOs (Finland, Sweden, Norway and UK).

Many bilateral agencies, like Sweden, Denmark, Norway and UK, have departments in their headquarters which are responsible for managing their NGO partnerships.

Irish Aid has supported Irish NGOs through two mechanisms: the MAPS (Multi-Annual Programme Scheme) and HAPS (HIV/AIDS Partnership Scheme). Ireland launched MAPS in 2003 to provide long-term predictable support to fi ve Irish NGOs. HIV/AIDS was one of three cross-cutting themes in MAPS and the evaluation found that it had been most effective in mainstreaming HIV/AIDS (Development Cooperation Ireland 2006). However, it did note that four of the fi ve NGOs receiving MAPS funding also received HAPS funding and therefore success in mainstreaming could be attributable to both or either sources of funding.

Development agencies use incentives and eligibility criteria to encourage NGOs to address HIV/AIDS. Sida "decided to actively stimulate the integration of HIV/AIDS interventions by offering NGOs 100% funding (instead of requesting the usual 10–20 % of own contribution) if they include HIV/AIDS activities in their projects" (Vogel *et al* 2005). NGOs that did not include HIV/AIDS in their applications had to justify the decision. The evaluation does not provide a judgement on the degree to which NGO action on HIV/AIDS increased and whether the actions were effective in addressing HIV/AIDS. The World Bank MAP programme included as eligibility criteria for the governments to agree to "use multiple implementation agencies, especially NGOs". The evaluation of the World Bank HIV/AIDS response concludes "Bank assistance has encouraged governments to enlist NGOs in their response to AIDS" (Ainsworth 2005).
GFATM is a very strong supporter of NGOs and CSOs and uses the leverage of its grant eligibility criteria to ensure that national CSOs and NGOs are represented on the Country Coordination Mechanism and written into grant proposals as recipients or sub-recipients. GFATM has had considerable success in promoting and supporting the role of civil society in the response to HIV/AIDS in many countries and makes the partnership involving civil society a key element in its business model (GFATM and International HIV/AIDS Alliance 2008).

Norway's support to Norwegian NGOs is mostly managed by NORAD's department for civil society. The evaluation of Norway's HIV/AIDS strategy includes assessment of the positive achievements of Norwegian NGOs in four country case studies (Poate & Ogunlayi 2008). Development agencies highlight many benefi ts from supporting NGOs including: achieving greater coverage of essential HIV/AIDS prevention, treatment and care services; building local civil society; and more effective coverage of vulnerable populations. However, the evaluations suggest that there are issues in the way in which funding operates which can limit the effectiveness of the support. The World Bank evaluation suggests that "the lack of political will, low capacity of NGOs and CBOs, and the Bank's cumbersome procedures were often major impediments to enlisting civil society" (Ainsworth 2005). The evaluation of Norwegian support for NGOs concludes that despite positive achievements, the "Norwegian NGOs have been operating more or less independently of the Norwegian country representatives that know the national contexts and might otherwise guide NGOs towards better adherence to the national response" (Poate & Ogunlayi 2008).

3.4 Mainstreaming HIV/AIDS as a Cross-cutting Issue

All sample agencies state in their published HIV/AIDS strategy/policy that they support mainstreaming of HIV/AIDS. This study will follow the defi nitions provided in the Evaluation of Cross-cutting Themes in the Finnish Development Cooperation which stated that "if 'cross-cutting issue' describes the theme that should be taken into account across the board, 'mainstreaming' is the act or tool through which the cross-cutting issue should be considered in all policies, strategies and operations at all levels" (Kääriä, Poutiainen,

Santisteban, Pineda, Chanda, Munive, Pehu-Voima, Singh & Vuorensola-Barnes 2008). This study uses the UNAIDS definition that "Mainstreaming AIDS is a process that enables development actors to address the causes and effects of AIDS in an effective and sustained manner, both through their usual work and within their workplace" (UNAIDS 2004b).

Most development agencies do not exclusively address HIV/AIDS as a cross-cutting issue but support this in addition to other targeted projects, and in this sense Finland is slightly unusual. Given this oft stated commitment to mainstreaming, HIV/AIDS is remarkably invisible in other published sector strategies, and references are often contextual rather than analytical, outlining commitments or intentions for action.
HIV/AIDS as a cross-cutting issue features highly in the transport sector, but we found no transport strategy for any bilateral agency. Safe Clean and Affordable Transport for Development: The World Bank Group's Transport Business Strategy 2008–2012 has a short section on HIV/AIDS recognising that improved transport can increase spread of disease (World Bank 2008b). It suggests increasing the use of transport corridors "as means and focus for providing active awareness, prevention and treatment services to corridor users, truck drivers and border communities".

A review of LMD gender strategies found that few addressed HIV/AIDS as a substantive issue rather than just to provide contextual information. CIDA 1999, Sida 2005 and DFID 2007 have only one contextual reference to HIV/AIDS in their gender strategies (CIDA 1999, Sida 2005, DFID 2007). Denmark's gender strategy (2004) has a few references highlighting the importance of HIV/AIDS for gender work; but has only one concrete indication of work on HIV/AIDS and gender (Ministry of Foreign Affairs of Denmark 2004). UNAIDS is not listed as one of the UN agencies to work with. Sida's gender strategy (Sida 2005) states "as the spread of HIV/AIDS is closely linked to imbalances in gender relations, Sida will give priority to actions oriented towards openness on men's and women's roles and responsibilities towards safer sexual behaviour, including their sexual and reproductive rights, giving priority to young people". It is the only reference to HIV/AIDS, but it is at least a statement of intent. CIDA's gender strategy (1999) and DFID's gender equality action plan (DFID 2007) have only one contextual reference to HIV/AIDS each. The new GFATM gender strategy is an interesting and different type of gender strategy because it is exclusively about addressing HIV/AIDS, TB and Malaria and gender in an integrated way and builds from the mandate and business model of the GFATM to identify specific actions that can be encouraged by the fund within its grant making operations.

Education is a sector in which one might expect some treatment of HIV/AIDS as a cross-cutting issue but again the findings are disappointing. DFID girls education strategy (DFID 2005) included a recognition that education can help prevent spread of HIV/AIDS and a commitment to "take appropriate measures to tackle abuse and violence towards girls and prevent the spread of HIV." Sida's education for all strategy (Sida 2001) has no references to HIV/AIDS. This study reviewed a range of other bilateral agency

sector strategies including environment, water and sanitation and sustainable development and found nothing on HIV/AIDS.

Many UN agencies routinely address HIV/AIDS as a cross-cutting issue given that their core mandate is in other sectors. For example UNESCO does not have an education strategy as such, but it does have an HIV/AIDS strategy for the education sector. UNDP, UNAIDS and WB have been working together on integrating HIV/AIDS into national processes for developing Poverty Reduction Strategy Papers (UNDP, UNAIDS, and World Bank 2007). They have identified four key challenges to effectively integrating HIV/AIDS in PRSPs. Firstly they identify "insufficient participation in PRSP formulation by local government, the private sector, civil society organizations (CSO), and people living with HIV … and the need for enhanced coordination of and support to AIDS mainstreaming efforts by the national AIDS coordinating authority". Secondly there is insufficient analysis of the impact of AIDS on macroeconomic development and poverty reduction. Thirdly there is "weak prioritization of AIDS in the PRSP and in sectoral plans" and finally a weakness of HIV/AIDS indicators in PRSPs and inadequate coverage of HIV /AIDS in poverty monitoring processes.

The contrast between the priority attached to mainstreaming HIV/AIDS and the relative invisibility of HIV/AIDS in other sectoral strategies raises the question of how effective the development agencies have been in addressing HIV/AIDS as a cross-cutting issue. The overall conclusion of the few existing evaluations is that they have not been particularly effective.

Sweden is the only country to commission a review of its progress in mainstreaming HIV/AIDS, gender and the environment. It found that "Sida has not managed to effectively implement any of the policies" (Uggla 2007). The reasons are similar for all three issues: namely "an overload of different policies and guidelines, an absence of clear guidelines and goals, lack of systems for follow-up and learning, and deficits in staff competence to perform the necessary analyses". The review recommends: "clarification of goals and responsibilities, specification of synergies and relations between different policy areas, enhancement of systems for follow-up and learning, and allocation of staff resources to match policy priorities". Likewise the evaluation of Sida's HIV/AIDS policy concluded that staff thought the policy did not spell out "what Sida could do to incorporate HIV/AIDS issues into their other priorities of development cooperation" (Vogel *et al* 2005). The evaluation concluded that almost no-one "… has so far documented an HIV/AIDS mainstreaming experience, despite the fact that some initiatives are definitely worth reporting." The evaluation notes one exception in a Sida supported agriculture project in Zambia.

The evaluation of cross-cutting issues in Finnish development cooperation comes to similar conclusions as the Sida synthesis paper. It found that there are "a large variety of values, principles, issues, goals, objectives, and cross-cutting themes" in Finnish cooperation which makes it difficult for staff members to take the issues into account (Kääriä*et*

al 2008). It also concluded that there was a lack of training and guidelines on mainstreaming. It also stated that the guidelines on project and programme development "treat cross-cutting themes as a separate issue which does not encourage mainstreaming". It concluded that "implementation of cross cutting themes is difficult without human and financial resources".

There are a few good examples of HIV/AIDS mainstreaming. Norway had successful initiatives in the agriculture sector in Malawi and road construction in Tanzania; although there is a "need for Norway to plan for HIV mainstreaming into Norway's current development priorities now that programmes focus more on good governance, environment and natural resources, media and culture, energy and infrastructure and maternal and child health" (Poate & Ogunlayi 2008).

The World Bank has published Lessons Learned from Mainstreaming HIV/AIDS in Transport Sector Projects in Sub-Saharan Africa which summarises lessons learned but does not explore internal World Bank organisational and systems factors that led to successful mainstreaming in the transport sector. The flagship good practice example is the HIV/AIDS Project for the Abidjan-Lagos Transport Corridor which was designed to include transport and HIV/AIDS interventions from the start. Most other projects had HIV/AIDS interventions mainstreamed during implementation. Contrary to the Sida and Finnish evaluations cited above it appears that within the World Bank there is clarity on the objectives for mainstreaming HIV/AIDS in the transport sector which are "(a) to prevent road construction projects from being vehicles of HIV infections; and (b) to help client countries better define their HIV/AIDS prevention strategies in the transport sector" (World Bank 2008b). While the World Bank has clearly had some success there were some limitations. There have been challenges in monitoring and evaluating the HIV/AIDS components in other sectoral programmes because they are "rarely large enough to become a formal project component that can be monitored" and the components are rarely supervised (Ainsworth 2005). A brief summary of 34 transport and education projects found that "AIDS was rarely mentioned in the development objectives. Fewer than 40% reported on the status of AIDS activities and less than a third had AIDS indicators" (Ainsworth 2005).

Even if HIV/AIDS being adequately addressed as a cross-cutting issue in project designs this is still not a guarantee of success. A synthesis of road project evaluations for Danida concluded that "HIV/AIDS is included in policies and project design, but there are gaps between intentions and implementation" (Nordic Consulting Group 2008). In particular mechanisms were not in place to ensure that HIV/AIDS objectives were implemented and contractors lacked in-house expertise and were reluctant to contract in specialist knowledge unless it was mandatory.

Other sectoral evaluations have surprisingly little to say on HIV/AIDS. Local Solutions to Global Challenges: Towards Effective Partnership in Basic Education Joint Evaluation of External Support to Basic Education in Developing Countries (Freeman & Faure

2003) has a few references to the impact of HIV/AIDS on reducing the teaching and middle management cadre thereby creating a human resource problem in Zambia (Freeman & Faure 2003). The evaluation of Belgian cooperation in the education sector and DFID gender strategies both have a few contextual references to HIV/AIDS, the joint Sida-EU evaluation of integrating gender equality into development cooperation has one contextual reference (COWI 2006). The evaluation of DFID's education support from projects to sector wide approaches (SWAps) and the evaluation of CIDA's gender strategy have no HIV/AIDS references. However the 2007 first progress report on the implementation of the new DFID gender action plan includes considerable examples of work on HIV/AIDS including gender disaggregation of data and focus on gender equality issues in HIV/AIDS work.

In conclusion all donors aim to mainstream but evidence from evaluations demonstrates none have yet got it right, with a few notable project exceptions. There is remarkable similarity in the conclusions of the evaluations on the reasons for lack of effectiveness and what needs to be done to improve it. These are perhaps best summarised in the Sida evaluation as: confusion over definition and purpose of mainstreaming, lack of understanding of need for mainstreaming in countries with less visible epidemics, competition with multiplicity of cross-cutting issues, and tendency to think that mainstreaming issues do not require specific resources (human and financial) resulting in under-resource (Vogel *et al* 2005).

3.5 Factors Influencing HIV/AIDS Response of Agencies

Recent history shows a significant increase in HIV/AIDS funding, but the next few years may show a bleaker picture as the implications of the global economic crises begin to affect the volumes of development assistance provided. An interesting point in previous years has been the use of public HIV/AIDS spending commitments as a tool to increase spending, as by DFID (Social & Scientific Systems Inc 2007).

The evaluations of implementation of HIV/AIDS strategies point mostly to internal organisational factors as being particularly important factors behind successful or slow implementation. The Sida strategy evaluation is very clear that internal organisation factors are important and that after the strategy was published there was little change in action for two years (Vogel *et al* 2005). It was not until 2004 that there began to be a significant increase in organisational prioritization of HIV/AIDS and higher human and financial resources allocated. The evaluation utilises the concepts of "carrots, sticks and sermons" developed by Kruse and Forss (2001) to explore other factors which influence the HIV/AIDS response. The evaluation suggests that initially implementation of the policy was slow because of a lack of "sticks" to compel action, "carrots" to act as incentives and "sermons" to provide influence and leadership. Real changes in the scale of Sida's response came after some time with the establishment of a secretariat, a team in Lusaka, regional action plans and instructions from the Ministry of Foreign Affairs. The evalua-

tion states that policy evolves over time and cannot be captured in one published HIV/AIDS policy; it also includes a range of related policy documents, speeches by politicians and senior officials, and management board meeting notes.

The evaluation of UNESCO's HIV/AIDS policy also points to key limitations on implementation being internal; in this case lack of resources allocated to HIV/AIDS, insufficient management systems, and lack of human resources dedicated to HIV/AIDS (Forss & Kruse 2004). The UNICEF HIV/AIDS policy evaluation found that the response had been slower than expected in taking off because of an over reliance on sermons in the form of pronouncements from leadership, rather than consistent and high level use of both carrots and sticks, incentives in the form of staff or financial resources, and formal organisation requirements (Kruse & Forss 2001). The evaluation of Norway's HIV/AIDS response indicates a structural constraint within the organisation that "despite the strengths of the multiple channels adopted by Norway in responding to the HIV/AIDS epidemic, these channels are not well connected at country level" and that "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 contribution" (Poate & Ogunlayi 2008). A number of evaluations point to lack of sufficient staff knowledge and awareness, including in the World Bank where staff had not read the relevant strategy or guidance documents (Ainsworth 2005).

The evaluation of NORAD's HIV/AIDS policy demonstrates how country level political factors can influence the HIV/AIDS response for example Norway does not have a bilateral technical cooperation arrangement in Ethiopia because of concerns regarding the political situation (Poate & Ogunlayi 2008). High levels of decentralisation can lead to disconnect of activities to overall policy for example DFID's continued fragmented support to UN agencies in variance to the strategy of supporting joint UN teams and programmes (Social & Scientific Systems Inc 2007).

'The performance of the HIV/AIDS portfolio [of the World Bank] has been much lower than that of other HNP projects' according to the World Bank's recent evaluation (World Bank 2009). This evaluation suggested that the complexity of HIV/AIDS projects and the fact that they tend to be implemented by many partners and new (multi-sectoral) institutions with weak capacity (compared to for example existing TB institutions) are factors behind this relative under-performance. The evaluation of World Bank HIV/AIDS programmes indicated a number of country level factors which affected implementation, notably the lack of adsorptive capacity of NGOs, the insufficient prioritization in national strategic plans and the lack of attention paid to implementing M&E components in HIV/AIDS projects (Ainsworth 2005). It also pointed out that a historical factor constraining the World Bank's response was a lack of demand by borrowers for HIV/AIDS loans in the 1990s combined with an internal lack of recognition by health sector managers of the future impact of HIV/AIDS (Ainsworth 2005). For GFATM a critical external constraint at country level derives from its partnership model which relies on

other organisations to provide Technical Assistance (TA) and the evaluation states that it "is in urgent need of systematic and strategic arrangements to secure reliable, timely and high quality technical assistance" (Mookherji, Ryan, Ricca, Bize & Dye 2008).

3.6 Conclusions on Approaches in addressing HIV/AIDS

In summary, there are a number of other factors that influence the actual HIV/AIDS response of development agencies including internal organisation, allocation of human resources, and motivation of staff with incentives, demands and high quality leadership. Policies and strategies evolve over time and are best seen as a collection of documents, policy statements and guidance notes, rather than one published document, although this can act as a focal point.

4 THE FINNISH HIV/AIDS RESPONSE

Finland acknowledges the UN system as the most prominent agent in international development policy but also supports the strengthening of the role of the EU (Ministry for Foreign Affairs of Finland 2007b). Finland is one of the signatory countries of the Paris declaration and is committed to enhance aid effectiveness through improved donor coordination and cooperation.

Since 2004, the main objectives of the Finnish development assistance have been to eradicate extreme poverty and to promote socially, economically and ecologically sustainable development in line with the Millennium Development Goals (MDGs). Human rights and gender equality have also been emphasized. In 2004 HIV/AIDS was stated to be one of the many focus areas in the implementation of the MDGs.

In 2007, Finland's new Government issued a new Development Policy. Although the main objectives remained much the same, eradication of poverty in line with the MDGs, there was now a stronger emphasis on environmental issues and sustainability. Except for the reference to MDG 6, the first drafts of the new policy did not mention HIV/AIDS at all. Consultations with CSOs and other stakeholders resulted in a demand for the inclusion of HIV/AIDS as a cross-cutting issue. Consequently, the final development policy programme (Ministry for Foreign Affairs of Finland 2007a) recognizes HIV/AIDS as one of the three cross-cutting issues that should be supported throughout all Finnish development policy. The other two cross-cutting themes are promotion of gender equality and promotion of the rights of easily excluded groups (such as children, persons with disabilities, indigenous populations).

In 2008, Finnish ODA totalled USD 1 139 million, or 0,43% of GNI (OECD 2009). Both in absolute terms and in proportional terms, the Finnish contribution is below the average of OECD countries. Finland has pledged to increase the proportion of ODA to 0,5%

by 2010 and to 0,7% by 2015 (Ministry for Foreign Affairs of Finland 2007b). Finland allocates ODA through regional and bilateral mechanisms (28,5%), multilateral channels (21,3%), EU-led interventions (17,3%), civil society initiatives (9,6%), humanitarian interventions (7,5%) and other development initiatives (15,8%) (Julkisen kehitysyhteistyön määrärahojen osuudet vuonna 2008: www.formin.fi nland.fi /public/download.aspx?ID=42267&GUID={2F7FBA96-F57B-4A00-B2A1-945EA209790} Consulted on 23.05.2009). Figure 3 shows Finnish overall ODA has always prioritised bilateral initiatives, but there is no clear trend in the relative proportions.

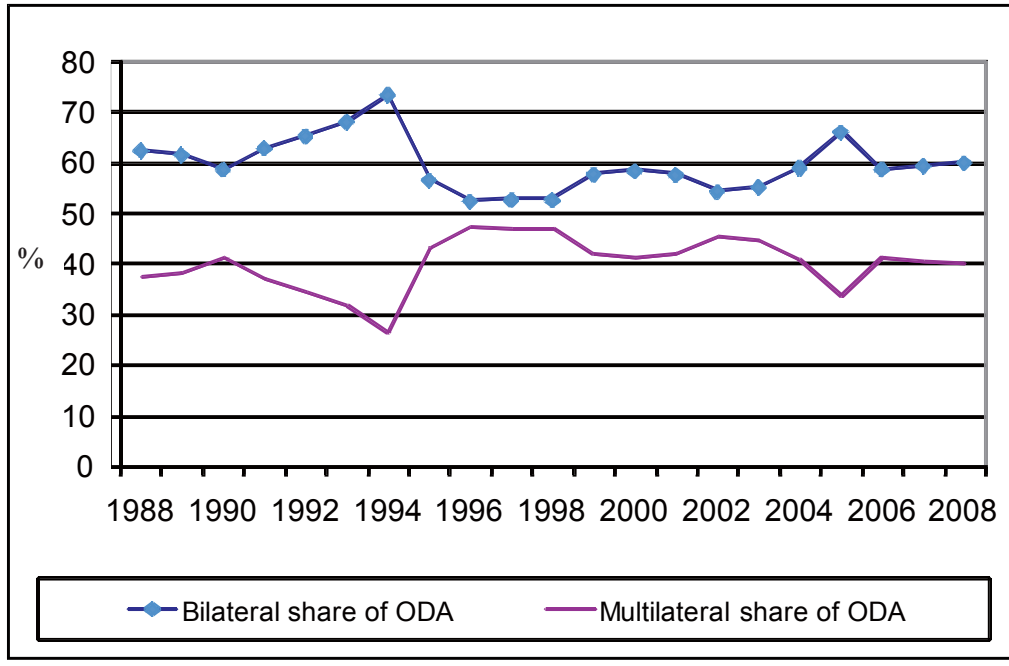

Figure 3 Bilateral and multilateral share of Finnish ODA.
Source: Ministry for Foreign Affairs of Finland, undated.

With globalization, the importance of multilateral cooperation has increased, and also the current focus on ecological sustainability requires more effi cient multilateral cooperation. Finland intends to keep the shares of fi nancial allocations to multilateral and bilateral channels at their current levels (Ministry for Foreign Affairs of Finland 2008b). However, according to several key informants, the current tendency at the Finnish MFA is to increasingly provide the support to social sectors through multilateral channels and through NGO cooperation whereas new upcoming sectors including environment, forestry, climate change, innovation and technology are increasingly getting bilateral support.

4.1 HIV/AIDS Priority Setting

According to some MFA informants in 1996 Finland was excited by the fact that UNAIDS was a first ever joint program that brought together seven UN agencies (currently 10) for one cause and thus it started promptly providing support to UNAIDS. UNAIDS is led by a Programme Coordinating Board (PCB), which includes 22 member states and a rotating chair. In 2000-2001 Mr Osmo Soininvaara, then the Finnish Minister of Health and Social Service, chaired the PCB. During this one year period, the global response to HIV/AIDS took several important steps forward: the framework for the International Partnership against AIDS in Africa was endorsed, the Contact Group on Accelerating Access to HIV/AIDS Related Care was established, and the framework for Global Leadership on HIV/AIDS was endorsed. During this same period it was decided that the UN would hold a special session on HIV/AIDS (UNGASS) and the proposal was made to establish a global fund to strengthen the response to HIV/AIDS (UNAIDS/PCB 2001).

In 2001, the world leaders signed a declaration of commitment to respond to the global epidemic of HIV/AIDS (UNGASS). The president of the UN General Assembly was Mr Harri Holkeri who also played a key role in ensuring consensus on the Declaration of the Commitment. It was in this context that Finland issued its first white paper on HIV/AIDS in early 2002 (Ministry of Foreign Affairs of Finland 2002). The white paper established the framework for the type of support that Finland has provided to the present day. Finland adopted a broad approach that encompassed support to social sectors, mainly health and education, emphasizing HIV-preventive measures and the importance of providing support to women and children.

Two years later Finland issued a policy on HIV/AIDS (Ministry for Foreign Affairs of Finland 2004b). The policy document continues the same broad approach defined in the white paper. Finland wants to ensure that the overall health system is simultaneously strengthened whilst responding to HIV/AIDS. Through overall support to health sector, Finland seeks to ensure the sustainability of care provision in general and the availability of HIV/AIDS-related care and treatment in particular. Furthermore, Finland considers the provision of comprehensive and diversified services for SRH of particular importance and pledges to increase funding for this area. Finland also considers universal access to primary school a precondition for halting or reversing the spread of the epidemic (Sack, Cross & Moulton 2004).

In its HIV/AIDS policy document Finland reiterates its commitment to the MDGs and the UNGASS Declaration of Commitment. The policy emphasizes the importance of protecting human rights, especially women's rights and gender equality, and fighting against discrimination in the context of HIV/AIDS. The

thematic areas that Finland prioritises comprise:

- proactive prevention of infection;
- support to civil society activities;
- human rights; and
- gender equality and strengthening work done among young people.

The development process of the 2004 HIV/AIDS policy involved not only MFA staff but also individuals from the Ministry of Health and NGOs. At the time it was deemed important to treat HIV/AIDS as a broad social problem, and not only as a health issue. The final priority setting reflects the consensus reached with the stakeholders. In fact, the priorities are in line with overall Finnish development cooperation policies, which emphasize human rights and gender equality. Prioritizing prevention is not only the principle of the Finnish overall approach to public health; it is also the mainstay of the global HIV/AIDS response.

Apart from the priorities, the Finnish HIV/AIDS policy does not provide many details on how Finland intends to put in practice its HIV/AIDS response, or how it will monitor the results of its efforts in this area. There are no targets, actions or indicators specified. While the policy indicates that Finland will provide most of its HIV/AIDS funds through the UN system, particularly UNAIDS, it does not provide any indication of the HIV/AIDS funding levels nor does it provide guidance on what other funding channels and instruments should be used.

Most of the policy documents endorsed by Finland's development cooperation appear equally broad and unspecific. By comparison all the LMD define more concretely how their policies will be translated into practice. Both UK and Sweden included a whole section to explain how they will put their strategies in action. Sweden has also developed a manual specifically guiding the integration of HIV/AIDS into Sida's country level strategies. Denmark, Norway and Netherlands identify concrete activities for each of their priority areas. Canada's document is in fact an action plan with specific targets and areas of action. Ireland specifies the goals and the objectives of its strategy. The strategies of UK, Ireland, Netherlands and Denmark include plans for building internal HIV/AIDS capacities of their staff.

The Finnish HIV/AIDS policy priorities are in line with what is commonly considered as Finnish added value. Most of the key informants who were interviewed identified social and gender equality, human rights–based approach and transparency as the main dimensions of Finnish added value in the area of HIV/AIDS. In addition, Finland was considered as one of the prominent advocates of SRH and rights. All of these aspects are reflected in HIV/AIDS policy, which therefore can be considered both relevant and appropriate for Finland.

Although the Finnish HIV policy is very broad and unspecific, it is acknowledged that

Finland follows it literally at least in one aspect: it channels a lion's share of funds through UNAIDS. In addition there are also other factors that influence the Finnish response to HIV/AIDS. Some key informants mentioned that the Finnish HIV/AIDS response follows the path marked by the EC. Indeed, both EC and Finland have adopted a broad-based approach to HIV/AIDS programming. Similarly to Finland, EC emphasizes the need to support the overall health sector as part of the HIV/AIDS response and promotes strong linkages with sexual and reproductive health and rights. EC also advocates for greater gender equality and equity and emphasizes the importance of ensuring girls' education, as does Finland. (Boyle & Garay Amores 2006). However, the EC position was formulated a few years after Finnish policy was issued. Thus, it is more probable that Finland and other member countries have marked the path chosen by EC.

Some key informants think that the international development cooperation operates in thematic cycles – the current cycle being dominated by climate change and environmental concerns – and these cycles have also an impact on the thematic areas that are prioritised within Finnish development policy and cooperation. Some key informants also expressed their concern in relation to the likely impact of the current financial crisis on development cooperation and HIV/AIDS funds in particular.

The Finnish development cooperation did not employ any HIV/AIDS specialists until 2006. Until then the Health Adviser at the MFA also covered HIV/AIDS. In 2006, simultaneous to Finland holding the EU presidency, Finnish development cooperation started providing support to GFATM and the MFA appointed the first HIV/AIDS Adviser at Ministry level; but so far there are no other HIV/AIDS–related technical staff working at the central, regional or country level.

4.2 Approaches

DAC members' average annual commitments for HIV/AIDS control in 2006-07 range from USD 4,5 million (Portugal) to USD 3 597,5 million (United States of America). During the same period, Finland's annual average commitment to tackling HIV/AIDS was USD 23,4 million, which corresponded to 2,6% of Finland's ODA. It should be noted that these figures include imputed multilateral contributions through EC, IDA, AfDF, UNICEF, UNFPA, UNAIDS and GFATM. The average contribution of the OECD countries in 2006-07 was 4,1% and the median 3,4%. While there are several OECD countries, whose HIV/AIDS share of the ODA is even lower than Finland's, all the LMD contribute more than Finland both in proportional terms and in absolute terms – the average being 5,5% (OECD-DAC 2009: www.oecd.org/dataoecd/60/8/42843897.pdf).

Table 4 HIV/AIDS funding of countries with similar ODA.

Country	Total ODA (USD million) 2006-07 Annual average	HIV/AIDS Control commitment (USD million) 2006-07 Annual average	HIV funds as % of ODA
Portugal	431	11,4	2,65
Greece	443	4,5	1,02
Finland	**904**	**23,4**	**2,59**
Ireland	1 095	121,5	11,10
Switzerland	1 666	20,6	1,24
Austria	1 661	12,6	0,76
Belgium	1 961	51,7	2,64
Average	**1 166**	**35,1**	**3,14**
Medium	**1 095**	**20,6**	**2,59**

Source: OECD 2007; OECD/DAC 2009

One should also compare Finland with similar sized donors in terms of ODA. The only donor that has very comparable overall ODA is Ireland. Ireland provides a signifi cantly higher proportion compared not just with this group but against most DAC members. Other countries shown in Table 4 provide overall ODA almost 50% more or less than Finland. Finland's share of ODA on HIV/AIDS is below average for this group but at the same level as the group median.

4.2.1 Multilateral Support

The HIV/AIDS-related white paper (Ulkoasiainministeriö 2002) and subsequent policy (Ministry for Foreign Affairs of Finland 2004b) stated that Finland should channel its support mainly through the UN system, particularly UNAIDS, to strengthen international coordination, and through UNFPA and UNICEF to support the rights of women and children and reproductive and sexual health service provision. The possibility of supporting HIV/AIDS work through WHO and ILO was also mentioned. In addition to these multilateral mechanisms, it was decided that funds should also be channelled through international non-governmental organisations to complement the efforts of governments and expand international information work (Ulkoaisianministeriö 2002). In addition to the UN system and NGOs, the policy document previews a possibility of providing support also through international fi nancial institutions and the EU.

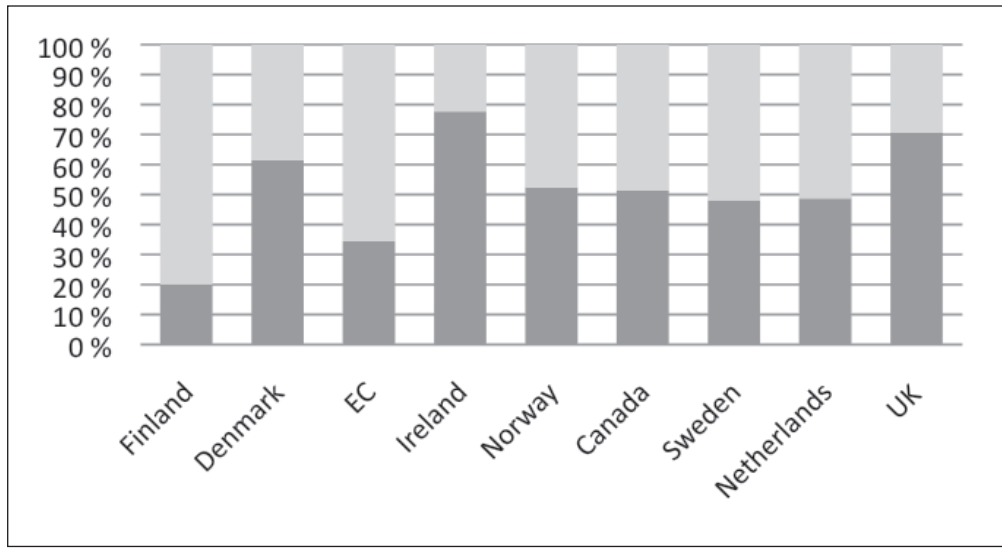

Figure 4 Like-minded agencies´ HIV/AIDS commitments as per centage of total. Annual average 2006. Dark columns, bilateral aid; light columns multilateral aid.
Source: OECD/DAC 2009 annual average 2006. Dark columns, bilateral aid; light columns multilateral.

Figure 4 shows the proportion of LMD funding between bilateral and multilateral channels. Following this guidance,Finland has always prioritised multilateral cooperation in its response to HIV/AIDS.This is in striking contrast to Finland's overall development cooperation approach, which commits more funds through bilateral channels (see Figure 3). In 2006-07, some 80% of Finnish HIV/AIDS funds were provided through multilateral channels. Of all LMD and EC member agencies, Finland puts the highest proportion of its HIV/AIDS fi nancing through multilateral channels.

In comparison to similar size agencies there are two others with a similar approach: Switzerland and Austria. Switzerland has higher ODA than Finland, but provides marginally less HIV/AIDS assistance, and has a very similar bilateral-multilateral profi le. Ireland is exceptional in this group not just for the volume of its HIV/AIDS fi nance but for the mostly bilateral approach it takes. Belgium has a more even split between bilateral and multilateral channels.

According to the policy paper on Finland's multilateral cooperation it opens up an opportunity to participate in and contribute to the norms and guidelines orienting international development cooperation. A multilateral approach also enables countries to maximise their comparative advantage in knowledge and thus provide added value (Ministry for Foreign Affairs of Finland 2008b). The management of such funding requires less fi nancial and human resources than bilateral funding and if fi nancial commitment is limited are considered cost-effective. However, none of the evaluation reports provided a comparative analysis of cost-effectiveness of bilateral and multilateral approaches.

Finland provides the highest proportion of its multilateral assistance for HIV/AIDS through UNAIDS (51%) compared with an average of 25% for LMD and the lowest proportion through the GFATM, 11%, compared with an average of 49% for LMD (OECD/DAC 2009). Finland, Switzerland and Luxemburg are the only three OECD countries who provide a greater share of funds to UNAIDS than to GFATM.

During interviews with representatives of both UNAIDS and GFATM informants expressed appreciation of Finland's consistency and predictability as a donor. GFATM considers Finland a rather silent partner often letting the EC represent it. In contrast, UNAIDS considers Finland an active, supportive and engaged donor. Finland takes part in UNAIDS through four different forums: (i) the Nordic group; (ii) Geneva group of friends of UNAIDS; (iii) Programme Coordinating Board; and, (iv) ad hoc bilateral forums. According to UNAIDS, Finland uses its political influence to advocate its priorities. For example, Finland actively advocated for prevention to be included in the new Executive Director's strategic objectives.

UNAIDS considers Finland's specific strengths to be: proximity to and good relations with Russia and Baltic states – especially on harm reduction and other sensitive issues; successful sexual reproductive health experience in Finland and mobilizing civil society.

Finland's challenges as a donor to multilateral organisations include:

- A lack of senior HIV/AIDS staff to lead within the organisation to ensure prioritization, and also to participate at the policy discussion at global level.
- Disconnect between the expertise of MFA, Ministry of Health and Social Affairs and the National Public Health Institute. Better coordination of available expertise could strengthen technical engagement with UNAIDS.

Both GFATM and UNAIDS identified opportunities for strengthening Finland's engagement. These include:

- Utilising experience gained in NGO support to provide technical support to NGOs implementation of GFATM programmes.
- Take an active role in the GFATM development of a strategy for technical assistance by GFATM partners for implementation of grants in countries.
- Engaging with GFATM on implementation of its recent gender strategy (which links with one of Finland's priority areas).
- Engaging with the Baltic States which are new supporters for GFATM.
- Engaging Finland's private sector in HIV/AIDS work and GFATM.
- Support to UNAIDS in providing technical assistance at country level in support of implementation of GFATM projects.
- Engage with and support UNAIDS Performance and Evaluation Monitoring Framework which will strengthen reporting of UNAIDS cosponsors and therefore demonstrate value for money, including of Finland's money.

4.2.2 Bilateral Support to NGOs

Approximately, 26% of Finnish HIV/AIDS funds are disbursed through NGOs compared to approximately 12% of overall ODA (unpublished database "HIV-rahoitus" 2006-2007). Apart from few exceptions, most of the NGOs receiving HIV funds are Finnish. Finland classifi es NGOs into four categories: partnership, foundations, small and medium based in Finland, international and local. Partnership NGOs include ten important long-term NGOs who run three-year programmes supported by the MFA. NGO foundations include three organizations (Abilis, KIOS and Siemenpuu) that channel support to local organizations in developing countries. Local NGOs in developing countries may obtain support through LCF managed at embassy level. All other support is provided directly by MFA.

Support to NGOs is usually provided on a demand basis. Once a year, the MFA launches a call for NGO project proposals open to any thematic area. However MFA meets with Finland based NGOs annually to inform them of current MFA priorities. In developing countries, embassies may defi ne strategies for funding NGOs although these should follow policy but adapt it to local circumstances.

To apply for funds, NGOs need to have in place effective administrative and fi nancial management systems. The application process involves extensive presentation of the intended project, its objectives, target groups, other funding sources, local partners, etc. Applicants complete a check list to measure the impact of the project on Finnish priority cross-cutting issues. The check list used in 2009 appears more in line with the priorities of the development policy 2004 than with those of 2007. The check list completely excludes HIV/AIDS.

Although, in principle the NGO proposals should be in line with the Finnish development policies, MFA does not require or encourage project proposals with any specifi c thematic focus. NGOs proposals are based on their own prioritization and may not contribute to the priority areas defi ned in the HIV policy.

Finland's NGO support – both HIV-related and other – extends beyond the 8 long-term partnership countries. According to MFA and NGO key informants, it is deemed politically incorrect for MFA to try to limit the geographical focus of the NGOs. In 2009, Finland provides HIV support through NGOs in 22 countries, of which 15 are in Africa, 3 in Asia and 4 in rest of the world. Financially, some 80% of the resources are to be invested in Africa, 13% in Asia and 7% in other countries. (Unpublished database "HIV hankkeet 2009").

4.2.3 HIV/AIDS as a Cross-cutting Issue

HIV/AIDS was clearly addressed with a vertical development approach until the new development policy (Ministry for Foreign Affairs of Finland 2007a) defi ned it as a cross-cutting issue. Finland's rural development strategy of 2004 made only a superfi cial refe rence to the impact of the HIV/AIDS epidemic on the rural labour supply, but took no active stance (Ministry for Foreign Affairs of Finland 2004a). Although education is one

of the key sectors in the prevention of HIV/AIDS, the Finnish strategy for education sector did not mention HIV/AIDS (Ministry for Foreign Affairs of Finland 2006).

The 2007 development policy heightened the profile of HIV/AIDS as a cross cutting issue and HIV/AIDS should thus be mainstreamed into other sector policies and programs. This thinking was already reflected in the new health sector policy, endorsed in 2007. The policy prioritises six mutually reinforcing components, of which one is HIV/AIDS. Other components include strengthening of the overall health system, comprehensive SRH services and preventive health care and health education – all of which also enhance the sustainability of HIV/AIDS-related care and treatment provision. The health policy also emphasizes the promotion of women's rights and gender equality as prerequisites for achieving the health related MDGs (Ministry for Foreign Affairs 2007a). Considering that some 50% of Finnish development assistance for the health sector is provided for the area of SRH, which is closely related to HIV/AIDS, there could be more conscious attempts to build synergies between these two priority areas.

The very recent Aid for Trade (AfT) strategy 2008-2011 hardly mentions HIV/AIDS. It plainly states that the cross-cutting themes, such as HIV/AIDS, are 'essential' in the Aid for Trade cooperation. The check list for AfT cooperation projects includes one question about the potential impact of the project on HIV/AIDS. However, HIV/AIDS is not reflected within the AfT thematic priorities or sectoral priorities even though the epidemic poses serious obstacles to the development of all the stated priority areas (Ministry for Foreign Affairs of Finland 2008a).

One striking feature in Finnish development cooperation is the lack of an accountability mechanism for cross-cutting issues. In practice, it means that the cross-cutting issues are either addressed or ignored depending on the officers who are in charge of the different programs. While there is one Technical Advisor who counsels and gives advice on HIV/AIDS related programming, nobody has a formal responsibility to mainstream HIV/AIDS. Although, the MFA has a quality assurance group to ensure that the planned interventions are in line with policy (in Finnish "laaturyhmä"). This group only assesses the proposals at the end of the planning period. Thus, should the group recommend mainstreaming into any given plan, it is likely that this will be an isolated component added on too late in the planning cycle.

The situation is even more critical at country level, where there is nobody to provide specialized advice. In theory the central level Technical Adviser assists the staff at the embassies on request but in practice these requests are rare and if they were to increase significantly would have difficulty in being met. This explains, for example, how it is possible that HIV/AIDS is not part of the priorities of the LCF strategy in a high prevalence country such as Mozambique (Box 3).

Box 3 Case study: Local cooperation funds in Mozambique.

Mozambique is one of Finland's long-term partner countries. The Embassy manages the LCF in line with LCF strategy 2008-2010. According to the strategy, the LCF should be used for 6 target areas: (i) democracy and human rights, (ii) gender, (iii) prevention of climate changes, (iv) cultural identity, (v) private sector support, (vi) collaboration in research. In 2008 over €800 000 was committed for LCF, of which €414 000 was disbursed to 10 projects. Only one of the ongoing projects is related to HIV/AIDS providing counselling and home-based-care services in Maputo and surrounding areas. As the objective of the project is to involve men in HIV/AIDS prevention and care, it was approved for LCF under the area of gender. Since HIV/AIDS is not included in the 6 target areas, a pure HIV/AIDS-related project proposal could be turned down by the Embassy. In 2008 it was decided by the LCF steering committee that 10% of the LCF could be used for thematic areas not included in the strategy. However, given that this rule was later questioned by auditors, this possibility was no longer included in the 2009 action plan.

While interviewing MFA staff, several key informants expressed doubts about how HIV/AIDS should be mainstreamed; some feeling it was easier to mainstream women's rights and gender equality than HIV/AIDS. Perhaps this lack of clarity and capacity is the reason behind the low level of mainstreaming. The MFA organizes training courses for its newly recruited staff members, especially for those who are going to work overseas, but HIV/AIDS has not been part of the training curriculum.

The recent evaluation of cross-cutting issues carried out by the Evaluation Unit discovered the same problem: cross-cutting issues are addressed at the policy level but seldom in practice. The report noted that in many cases a decision to address, for example, gender equality as a cross-cutting issue has led to reduced funding of targeted programs seeking specifically to address women's rights. Yet the report concludes, both kinds of approaches are needed. The evaluation report calls for a 'cross cutting strategy' to identify how to mainstream at central and at country level. The report also stresses the need for human and financial resources to this end (Kääriä*et al* 2008). Practically all the recommendations of the cross-cutting issues evaluation report are applicable also to HIV/AIDS.

Until very recently, the MFA did not have any guidelines on mainstreaming HIV/AIDS. However, simultaneously to this study the MFA Technical Advisers for cross-cutting areas elaborated a guide defining the steps for implementation of the recommendations of the evaluation. Each step will need be formally institutionalized to make cross-cutting issues truly part of Finnish development cooperation.

4.3 Conclusions on the Finnish Response to HIV/AIDS

HIV/AIDS is one of the three cross-cutting issues within the Finnish development policy program. These priorities are well in line with what is commonly considered as the

Finnish added value. Finland's HIV/AIDS contribution is considerably smaller than both the OECD and LMD average. Finland is the only one of the LMD who relies so much on multilateral funding channels. Other LMD either prioritise bilateral channels or use an even mix of bilateral and multilateral channels.

Apart from the priorities, the Finnish HIV/AIDS policy is rather vague does not specify how it will translate the policy into practice. The policy lacks concrete commitments or activities, specified targets and indicators. It does not orient the funding approaches apart from stating that the majority of the funds are to be channeled through the UN system. There are currently no accountability mechanisms in place to ensure that policy is acted upon or that HIV is mainstreamed. A recent external evaluation on implementation of cross-cutting issues did not include HIV, but the recommendations should be applied also to HIV.
There is only one specialist HIV/AIDS staff member who provides assistance and technical advice to staff at different levels, but has no decision making authority.

5 COORDINATION AND COOPERATION

The founding of UNAIDS was the first major step toward international cooperation recognizing the need for global leadership, and to coordinate the efforts of the many engaged UN agencies. UNAIDS took up the international leadership role and took international cooperation to a new level with the UNGASS Declaration of Commitment in 2001 which achieved unprecedented consensus on the urgency of HIV/AIDS, the need for political leadership and the key principles of a global response. However, the declaration made almost no reference to country level coordination. One of the commitments was to the establishment of a 'global AIDS and health' fund to increase resources to tackle HIV/AIDS. GFATM has become the largest multilateral financial mechanism for addressing HIV/AIDS, bringing together the finances of 26 OECD donors, 19 other countries with foundations, private sector and individual contributors. GFATM's other significant contribution has been in bringing civil society, the private sector and recipient governments together with donors and UN agencies which has "produced a paradigm- and power-shift in the international and national discourse on human health. This model has opened spaces for dialogue and participation that would not otherwise have existed" (Mookherji *et al* 2008).

With HIV/AIDS high on the international political agenda and the mobilization of greater resources, the international community turned its attention to more effective country ownership and leadership of the response. In 2004 emerging bets practice helped define the '*Three Ones* concept': one agreed HIV/AIDS Action Framework to coordinate all partners; one National AIDS Coordinating Authority with a broad based multi-sector mandate; and one agreed country level M&E System (UNAIDS 2004a). The international community quickly turned its attention to the difficult challenge of improving how it

effectively delivers assistance. In 2005 the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (GTT) published *On Improving AIDS Coordination Among Multilateral Institutions and International Donors* (Global Task Team 2005). Its recommendations were strongly linked to the Paris Declaration issues of country leadership and ownership, harmonization and alignment. The GTT spawned a range of activities of which the most notable was the Global Implementation Support Team (GIST; 2008) as an inter-agency rapid response mechanism for addressing country level issues that were raised to the global level. In 2007 the international community concerned at the slow progress on the MDGs but unwilling to launch a new financing mechanism, launched the International Health Partnership (IHP) to improving the effectiveness of assistance for health in support of country leadership.

5.1 Coordination and Cooperation at the International Level

5.1.1 GTT Impact on Global Coordination

The GTT made 10 broad recommendations focusing on improving the multilateral system in support of country-led action (Box 4).

Box 4 Recommendations of the Global Task Team (GTT).

Empowering Inclusive National Leadership and Ownership
1. Countries develop prioritised AIDS action plans that drive implementation
2. Ensure that countries macroeconomic and public expenditure frameworks prioritise the implementation of national AIDS action frameworks and plans

Alignment and Harmonization
3. Multilateral institutions and international partners commit to working with NACs to align support to national strategies, policies, systems, cycles, and plans.
4. GFATM, the World Bank, and other multilateral agencies, and international partners shift to programme fi nancing based on national frameworks..

Reform for a more Effective Multilateral Response
5. Establish a Joint UN team on AIDS in each country with a joint programme.
6. Establish joint UN system – GFATM problem-solving team.
7. UNAIDS and GFATM establish functional division of labour.
8. Financing for technical support by UN be considerably increased.

Accountability and Oversight
9. UNAIDS assists NACs to lead reviews of performance of partners
10. Development partners assist NACs to strengthen M&E mechanisms.

Source: Global Task Team 2005

The independent assessment of the implementation of GTT recommendations focused on the TA provided and harmonization and alignment of international partners. It judged progress to be mixed (Attawell & Dickinson 2007). Most progress was found in establishing a UN division of labour for technical support, establishing Joint UN Teams on AIDS, and improving the harmonization of UNAIDS secretariat and cosponsors, although even in these areas the review questioned whether the UN division of labour is actually being applied. Mixed progress was found in the development of Joint UN Programmes, in national ownership of technical support efforts and of Global Fund and World Bank work on harmonization and alignment. The evaluation qualifi ed its assessment of progress in these areas by noting that the recommendations of a study on World Bank and Global Fund comparative advantages had not been acted on, and that the Joint UN Programmes tended to be a collection of existing agency programmes rather than a jointly developed programme. The evaluation found a lack of progress effective technical support plans, technical support mechanisms and harmonization and alignment. The evaluation identifi es a considerable list of existing and on-going challenges for the successful implementation of the GTT recommendations.

There was some good analytical work, early progress in attempts to clarify divisions of labour and comparative advantage, and efforts to establish technical assistance coordination mechanisms. However it is clear that there has been limited progress in some of the tougher recommendations which require development agencies to change what they do, or the way they do it. The Global Fund evaluation stated that 'the main problem is not in the design of the GTT recommendations but in the slow pace of follow-through (Mookherji *et al* 2008). This is highlighted by the lack of progress in efforts by bilateral donors to harmonize and align and their support for fragmented UN work, by the lack of progress in improving World Bank and Global Fund harmonization and alignment and by the lack of real change in UN planning and provision of TA. The evaluation of GFATM supports this assessment when it concludes that "progress has been limited in defi ning the place of the Global Fund in the global architecture relative to other major actors, such as the World Bank, WHO, UNAIDS and AfDB", particularly in the fi nancing and supply of technical support and health systems strengthening initiatives (Mookherji *et al* 2008). The GTT evaluation concluded that a key issue with implementation is a lack of accountability. "It is unclear what mechanism is responsible for holding Co-sponsors to account globally for their part in implementing the GTT recommendations" (Attawell & Dickinson 2007). The same could be said for bilateral donors and GFATM.

The GTT evaluation suggested that the GIST had encouraged multilateral institutions to address wider systemic issues at global level (Attawell & Dickinson 2007). The GIST evaluation concluded that it is an important link between GFATM and the UN system and that "there is little doubt it has catalyzed action and solved problems in some countries" (Moodie 2007). It had also faced many challenges including a lack of clarity and agreement on its mandate and lack of clarity on who the GIST reports to. The report raises many questions about the appropriate role of the GIST and whether it should be closed, modifi ed or left as is. The GIST continued after the review with a re-focused objective

of "working together and holding each other mutually accountable to harmonize and coordinate technical support to address implementation bottlenecks, disseminate lessons learnt and identify good practices" (Global Implementation Support Team 2008)

IHP is the latest in a line of initiatives aiming to improve coordination, this time specifically coordination of the multiple initiatives and flows of donor resources to the health sector in line with the Paris Declaration. It was launched in 2007 with high level political support. It is interesting to note that the IHP puts considerable emphasis on mutual accountability of all development partners. The GTT evaluation noted a lack of accountability as a significant issue that reduced the incentive and urgency for implementation of GTT recommendations. However the IHP, despite the rhetoric, also lacks an accountability mechanism.

5.1.2 UNAIDS Impact on Global Coordination

"The rationale for the creation of the joint [UNAIDS] programme was the development of a more coherent and intensified response of the United Nations System" (UNAIDS 2002). After a slow start it "established itself as a leader in tackling HIV/AIDS, and a centre of knowledge about the disease" concluded its first five year evaluation (UNAIDS 2002). This was despite the low level of coordination and mobilization that existed when it was founded. "At the outset, UNAIDS was a joint programme in name only. The cosponsors were unenthusiastic" (UNAIDS 2002). It has forged a consensus on a global agenda and established the best practice collection with global 'name recognition' (UNAIDS 2002). UNAIDS achievements in improving coordination included: agreement on the UNGASS declaration in 2001; UN political declaration in 2005; establishment of first UN wide strategic plan on HIV/AIDS in 2001; and, progress on establishing a division of labour at global level. UNAIDS has coordinated the UN system response, including mobilizing greater agency activity and human resources focused on HIV/AIDS. The Unified Budget and Workplan process and the role of the Committee of Cosponsoring Organizations has developed over time from competing for turf and defense of roles to a more constructive agreed global division of labour based on mandates and utilizing the concept of "convening agencies" to lead on particular technical issues.

At the time of writing the second five year evaluation of UNAIDS is underway and a consultation document is available with preliminary findings (ITAD & HLSP 2009). This paragraph is based on these findings and the reader should be aware of the tentative nature of the conclusions. UNAIDS has responded well to the rapidly evolving global context that it operates in, for example building a good partnership with the Global Fund. There has been little progress on improving the governance of UNAIDS, a major coordination mechanism involving cosponsors, national members and civil society. There has been little impact on the way that UNAIDS operates as a result of the GTT and external initiatives like the Paris Declaration. The focus of efforts, for example, in the division of labour work, has been on "what" the cosponsors do, rather than "how" they do it.

What can we conclude overall on the role of UNAIDS in global coordination and cooperation? Firstly it is hard to imagine the global consensus, the UNGASS declaration, and the high level of mobilization within UN agencies if the UNAIDS joint programme had not existed. These are considerable achievements. The evaluations suggest that there is still much to be achieved to improve coordination at the level of technical support and cooperation, and that in this area there is little or no value added in having UNAIDS as a joint programme. Evaluations suggest that the UNAIDS secretariat is relatively good at implementing recommendations from the first evaluation and the GTT that are within its control, but are less able to do so for important recommendations which require joint action by all the cosponsors.

5.1.3 NGOs in International Coordination and Cooperation

International NGOs play a very active role in international coordination and cooperation of the global HIV/AIDS response through their role on the boards and committees of international organizations like GFATM and UNAIDS, as well as their advocacy work. There are no published evaluations available that assess their role or effectiveness. This section will outline the objectives of some of the major organizations and networks (drawing on the information on their websites). The International AIDS Society is the world's leading independent association of HIV/AIDS professionals. It convenes the International AIDS Conference and other scientific conferences for presenting new research and it promotes dialogue and education. The International Council of AIDS Service Organizations' (ICASO) mission is to mobilize and support diverse community organizations to build an effective global response to HIV and AIDS. This includes building community sector capacity to advocate, advocating for the effective implementation of universal access to comprehensive HIV and AIDS services. The Global Network of People living with HIV and AIDS (GNP+) advocates improving the quality of life of all PLWHA. GNP+ is the only worldwide network representing all PLWHA. It has six fully independent regional networks. The International Community of Women living with HIV/AIDS is an international network run for and by HIV+ women that promotes their voices and advocates for changes that improve their lives. There are also technical or thematic networks including for example the International Harm Reduction Network and the Global Business Coalition on HIV/AIDS.

5.1.4 Coordination and Cooperation at the Country Level

The major challenge of coordination at the country level is of multiple donors, UN agencies, multilateral development partners, global funds and NGOs providing assistance in countries with low coordination capacity. Resulting in:

- diversion of scarce government human resources away from tackling HIV/AIDS and towards managing development agency relationships;
- significant transaction costs in preparing multiple proposals and reports in different formats;

- fragmented and unpredictable financial flows hampering government efforts to develop comprehensive planning;
- uncoordinated technical assistance; and,
- inequitable geographical coverage of interventions.

This section will review progress in country level coordination using the framework of the Three Ones, with the addition of two extra issues: coordination of multiple channels of financial assistance governed by different fiduciary, management and reporting requirements with unpredictable resource flows to countries, and fragmented, supply driven, un-coordinated technical assistance to governments.

There has been good progress in supporting governments to put in place one national strategic framework or plan for the response to HIV/AIDS. UNAIDS report that 97% of countries have a multisectoral HIV/AIDS strategy in place (UNAIDS 2008b). These have provided two benefits of an "improvement in donor coordination and cooperation, and plan for capacity development of national structures, especially in the health system" (UNAIDS 2002). According to the World Bank evaluation many country strategies and plans do not cost or prioritise activities and do not focus strategies on public goods and reducing high risk behaviour. "In terms of overall strategic direction, with a lack of clear statements of priorities, the strategies are so similar that a generic package of HIV/AIDS areas of focus and interventions could have served just as well" (Ainsworth 2005).

UNAIDS reports that 92% of countries have a national HIV/AIDS coordinating body (UNAIDS 2008a). Many National AIDS Commissions or Councils (NACs) were established in the late 1990s or early 2000s, some encouraged by World Bank conditionality and by the agreement of the Three Ones in 2004. They are positioned outside the health sector, usually under the Office of the President or equivalent to give clout and neutrality when dealing with other ministries. They tend to have decentralized structures replicated at provincial and district level. They are also generally committed to ensuring civil society representation and participation. Most have a grant management function. The one comparative review of NACs finds evidence that "some NACs were experiencing problems with delivering their core mandate to lead and coordinate a multisectoral response, especially mainstreaming HIV and AIDS in other sectors" (Dickinson & Mundy 2007). Ministries and members can be unclear of their role and at sub-national level there is often insufficient capacity. In addition there can be disincentives for sectors to address AIDS when resources are scarce and controlled by the NAC. According to the GFATM evaluation, one key issue that has arisen is a problem with the Country Coordinating Mechanism (CCM) fitting into the in-country aid architecture on coordination and planning, especially with regards to NACs (Mookherji *et al* 2008). This evaluation also found that in many countries "CCMs were created exclusively to meet [GFATM] requirements and, however useful, would cease to operate if the [GFATM] funding stopped." UNAIDS reports that 92% of countries have a national M&E plan in place or in development. This review could not find any evaluations or comparative studies of the progress on establishing national M&E.

There has been some progress in countries on the coordination of financial assistance for addressing HIV/AIDS but it has been mixed. The review of NACs found that there were initiatives underway to align the multiple channels of funding to national priorities (Dickinson & Mundy 2007). Many of the seven countries studied receive support from PEPFAR, GFATM and World Bank. There are good examples of pooled funding in Uganda, a common fund in Mozambique which integrated GFATM funds, and pooled funding in Malawi into which GFATM and WB contribute. There are no evaluations available on the effectiveness of these mechanisms. The challenges to coordination of financial assistance remain. The two largest donors, PEPFAR and GFATM, generally finance vertical projects and are not part of pooled funding mechanisms (with the exception of Malawi and Mozambique for GFATM). There is still a lack of predictability in the delivery of finance, with PEPFAR providing funding outside of government frameworks and only on the basis of annual commitments of funds. GFATM has had considerable problems with in-year predictability of timing of disbursements but has recently started a longer term rolling continuation channel. However the GFATM evaluation concluded that "while there are clearly some examples of (GFATM) activities aligning with country programs and systems, the overall picture presented by the 16 CPAs is one of the (GFATM) channeling through stand-alone systems, often duplicating in-country efforts and existing structures, and not adequately embracing national alignment and global harmonization agendas" (Mookherji *et al* 2008).

There has been some progress on improving coordination of technical assistance, but not as much as had been hoped for. UNAIDS has not met the expectations of reducing the duplication of effort within the UN system and had not provided governments with a clearer, more comprehensive view of the financial and technical support available from UN agencies (UNAIDS 2002). "Few cosponsors were able to report clear evidence of changed way of working as a result of UNAIDS" (UNAIDS 2002). The evaluation concluded that the integrated work plans of the UN Theme Groups were generally not valuable and little more than a collection of existing agency plans rather than an "integrated" work plan. Moreover they do not relate well to government's own plans, do not analyze comparative advantage of UN agencies, and lack assessment of national demand and gaps. These were the findings of the first five year evaluation of UNAIDS, and unfortunately the preliminary findings of the second five year evaluation suggest that there has not been any improvement. "UNAIDS Secretariat and cosponsors have provided appropriate, timely and valued technical support. There is limited evidence of the added value of the joint programme. Joint teams have improved information sharing, but have not functioned as an entry point for, or noticeable strengthened coordination of, technical support" (ITAD & HLSP 2009). Challenges to improving coordination on technical assistance include a lack of guidance from headquarters, achieving a shift from UN agencies delivering assistance to brokering assistance, lack of joint planning, programming capacity and expertise and slow response times to request (Attawell & Dickinson 2007). There is also a serious lack of coordinated technical assistance plans linked to GFATM projects and CCMs rarely have the capacity or the resources to fulfill this role (Mookherji *et al* 2008).

This study could not find any evaluations of efforts by bilateral donors to improve coordination between bilateral agencies at the country level. There are the widely known strategies of pooling funds, sector support, organizing donor groups to speak with one voice, and working as silent partners. However there is little analysis of the extent to which these are working well and really improving coordination and cooperation. For example Mozambique has thirteen bilateral donors in the partners group for HIV/AIDS, most of them providing support outside the pooled funding arrangements and often through stand alone projects.

5.1.5 Joint Projects and Joint Evaluations

Donors and multilaterals have multiple types of joint projects although there are fewer published joint evaluations. The two main variables in joint projects are the number of donors and the number of implementing agencies. There are a range of joint projects to tackle HIV/AIDS:

- Two or more donors or multilaterals finance a joint project to be implemented by government, or a UN agency or NGOs. For example Nweti is a health communication project in Mozambique jointly supported by Irish Aid, EU, DFID, the Netherlands, British Petroleum and the Soul City Institute.
- Silent partnership where two donors support the same project or pooled fund but one is silent in the management and oversight dialogue – for example Sweden and Netherlands support to the health SWAp in Zambia.
- Two or more bilateral or multilateral agencies provide joint finance into a pooled fund to support a national AIDS programme led by government, for example the Common Fund managed by CNCS in Mozambique.
- Single agency provides support to an NGO or UN agency to implement a project where there is joint oversight.
- Two or more UN agencies work together to implement a joint project.

Evaluations of the relative effectiveness and merits of these joint projects are not available, and possibly do not exist. There are some evaluations of jointly funded projects or joint donor evaluations of the work of a particular NGO overall and there are few joint evaluations of NGO projects. The joint evaluations of projects include an evaluation of the Southern Africa AIDS Trust (SAAT) in 2008 and of the International HIV/AIDS Alliance Africa Regional Programme in 2007 (Machawira & Moyo 2007; Titus & Chari 2008). SAAT started as a CIDA funded project in 1990, became an autonomous entity in 2003, and in 2005 began to receive support from the Swedish-Norwegian Regional HIV/AIDS Team (Titus & Chari 2008). In 2006 the Royal Netherlands Embassy also began funding. The evaluation found that SAAT is filling a niche that no one else is in reaching the community level through supporting community based organizations and as a networking organization at the national and regional level. It concluded that SAAT needs to capacity building to strengthen its systems. The mid-term review of the Inter-

national HIV/AIDS Alliance Africa Regional Programme was commissioned by the Alliance for the programme funded by Sida, DANIDA and the Dutch Ministry of Foreign Affairs (Machawira & Moyo 2007). The evaluation concluded that the programme was coherent and had added value to country programs and that it should be considered for continuation. It made recommendations to strengthen the focus and management of the programme as well as its coordination with country programs.

In 2006 there was a Joint Donor evaluation of the International HIV/AIDS Alliance's Organisational Performance (ITAD 2006). This evaluation was commissioned due to interest from NORAD, Sida, DFID and USAID to inform their decision making about future funding. The evaluation covered governance, core functions, policy functions, knowledge management and finally its strategy. It provided a range of recommendations. Overall it concluded that the Alliance has "supported an impressive scaling up of community action against HIV and AIDS".

In many countries the main focus is on annual reviews of the national AIDS response rather than on project evaluations. Joint annual reviews are usually led by government. Sometimes an independent team is contracted to conduct a review which is used by the joint review as the basis for their review. UNAIDS has published guidance on good practice for joint annual reviews (UNAIDS 2008c).

5.1.6 Case Study: Country Coordination in Mozambique

In Mozambique the national response to HIV/AIDS is coordinated and implemented by the National AIDS Council (CNCS) and by the Ministry of Health. Two planning instruments are used: the national Strategic Plan to fight HIV/AIDS – PENII and the Health Sector STI/HIV/AIDS strategic plan. Seven donors (CIDA, Denmark, Ireland, DFID, Sida, GFATM and World Bank) contribute resources into and un-earmarked common fund that is managed by the CNCS for implementation of the HIV/AIDS Annual Operational Plans. The Government and these seven Common Fund Partners agreed a memorandum of understanding which governs the management arrangements of the common fund. There is a Code of Conduct between government and a wider group of partners (including the Embassy of Finland) which establishes the rules and mechanisms for coordination of the national response led by CNCS. Coordination takes place through monthly Partners Forum meetings. CNCS organizes an annual joint evaluation review with the involvement of the donors. A recent review of the Partners Forum concluded that the code of conduct was not known or abided by and that the quality of meetings could be improved. In addition there was no systematic feedback from technical working groups, some of whom operated without terms of reference. An additional mechanism is the pre-partners' forum which only involves the donors and NGOs without government agencies and where, in theory, the donors agree upon one voice. Mozambique used to have a CCM that was established for the purpose of overseeing GFATM grant applications but is now subsumed within the broader SWAp forum.

There are also health coordination mechanisms in Mozambique that are relevant for HIV/AIDS. The MoH has adopted a Sector Wide Approach (SWAp) with 17 partners governed by a Code of Conduct. Some donors contribute funds to the three common baskets – PROSAUDE, Common Fund for Drugs and the Provincial Common Fund. There is a memorandum of understanding between the government and the development partners which is the framework for the SWAp and the common funds. There are three levels of dialogue, a Sectoral Coordination Committee of the Minister, donor ambassadors and NGOs which meets twice a year, the Joint Coordinating Committee is more operational and meets every month and there are health SWAp working groups focusing on specifi c technical issues.

Mozambique is considered to have a relatively well organized and structured aid management system compared to other countries. Nevertheless progress in improving coordination is diffi cult and in some instances progress has been reversed. An evaluation of the CNCS Partners Forum in 2008 found a decrease in harmonization and alignment although it also found an increase in the proportion of partners who reported only using the national monitoring and evaluation indicators.

5.1.7 Summary of Existing Coordination Mechanisms

Most countries have multiple mechanisms to coordinate their HIV/AIDS response- overlap and duplication remain problems (Table 5).

Table 5 Key country level coordination mechanisms.

	Membership	**Function**	**Financial coordination**
National AIDS Councils or Commissions	Government ministries, civil society, private sector. Attached to President's office	National policy Coordinate domestic multisectoral response	Sometimes
UN Partners Forum/Expanded Theme Group	UN, donors, multilaterals, government, civil society, private sector	Information exchange Advocacy General coordination	No
UN or Joint Team on AIDS	UN agencies	Unified UN support through Joint UN plan	Sometimes – of UN TA funds
Country Coordination Mechanisms	Government, UN, donors, multilaterals, civil society, private sector	Prepare and oversee implementation of GFATM grants	Yes
HIV/AIDS or Health Partners' Group	Government, donors, multilaterals and UN, sometimes civil society and private sector	International support to policies, programmes, SWAPs and sector support	Sometimes – for pooled fund or sector support

5.1.8 UNAIDS and GFATM: Country Level Coordination

The first five year evaluation of UNAIDS concluded that its "country level coordination has been less effective. A number of institutional features contribute to this judgment: the uncertain accountability of the theme groups; the absence of objectively measurable targets for the theme groups; the limited influence of the PCB over country-level activities and the lack of any incentives for the cosponsors to develop a genuinely integrated approach" (UNAIDS 2002). The evaluation did note that UN Theme Groups had worked 'quite well' in supporting 'government in developing national strategies'. However it did state that "shifting the focus of effort onto the country level is the primary message from this evaluation" (UNAIDS 2002). This seems to have only partially been acted on according to the preliminary findings of the second five year evaluation. It found that UNAIDS Secretariat and Cosponsors had provided high quality, timely TA but that there appeared to be no added value from this happening in the context of a Joint UN programme (ITAD 2006). It found that many country level recommendations of the first evaluation had not been implemented. These included governance, transparency of cosponsors budgets and promoting stronger evaluation and research at country level. A significant factor is that cosponsors funding is outside the control of UNAIDS and there is little incentive for joint working. UNAIDS has developed a range of tools to improve country level coordination, including the Proposed Working Mechanisms for Joint UN Teams on AIDS at Country Level, the Second Guidance Paper on Joint UN programmes and teams on AIDS and the Guidance on Joint Reviews of AIDS programmes (UNAIDS 2008b; UNAIDS 2008c; UNAIDS 2006).

GFATM has made a major contribution to country level coordination through the establishment of CCMs, although many believe they add an additional mechanism into the already complex architecture creating increased transaction costs. CCMs have been an innovation that has "spawned a range of partnership with governments, international and local NGOs, faith-based organizations, the private sector, and organizations of persons living with HIV/AIDS" (Mookherji *et al* 2008). CCMs have had the greatest impact on developing grant proposals, but at implementation recipients have often not had sufficient coordinated oversight. The evaluation states that while GFATM made significant achievements in scaling up coverage these had generally been outside existing coordination frameworks and run through parallel management processes. It judged that despite its commitment to the Paris Declaration, the GFATM model "often contributes directly to the problems of overlap and duplication at the country level" (Mookherji *et al* 2008).

5.1.9 Summary Coordination and Cooperation

Some progress has been made but there is still much to do. There have been some notable achievements at the global but there have been notable failures including the ability of donors and development partners to work together at country level to support national programmes and reduce the transaction costs to a government of having to deal with a broad fragmented range of development partners, each with its own systems and

procedures. The fi ve year evaluation of GFATM (Mookherjee *et al* 2008) outlined the following four existing outstanding challenges in the global aid architecture. Firstly, the lack of global governance. Secondly, the lack of overall coherence and delineation of mandates and roles Thirdly, some inappropriate governance lacking adequate representation of low income countries and lack of accountability and transparency. Finally, the lack of predictable and stable funding which is particularly acute for the UN.

6 KEY FINDINGS

Across the bilateral and multilateral partners, HIV/AIDS is prioritised at the policy level. The vast majority of the sample agencies mention HIV/AIDS either as a top priority, or as one sub-area of a top priority for development cooperation. The vast majority of sample agencies support prevention related activities in general. Nearly half stated support for care and support and more than one third prioritise treatment. Most of the LMD prioritise prevention, health system strengthening and targeting young people and women and girls. This mix is also typical for all sample agencies. Thematic areas that are seldom or never mentioned among the priorities include post-exposure-prophylaxis, male circumcision, harm reduction, universal precautions and blood safety in the area of prevention; palliative care, psychological support and carer support in the area of care; and traditional/alternative medicine. Strengthening the role of private sector, community involvement and the reduction of drug prices are also rarely mentioned.

All agencies employ a mix of multilateral and bilateral funding channels. There is no direct correlation between the proportions of bilateral and multilateral commitments and the size of total ODA or HIV/AIDS commitment. Large donors like the UK and US, and small donors like New Zealand and Greece use mostly bilateral channels, with other large donors like France and Italy and other small donors like Portugal and Austria using mostly multilateral channels. LMD either use a balanced mix of approaches or are mostly bilateral with the exception of Finland utilizing mostly multilateral channels. Bilateral agencies support HIV/AIDS actions through a range of multilateral organizations, the main ones being UNAIDS and GFATM, the former for global and country level coordination, facilitation and technical assistance, the latter for country level action. Of all bilateral agencies Finland provides the largest proportion of its multilateral resources through UNAIDS; this is signifi cantly higher than other LMD. Compared to other bilateral agencies and to other LMD Finland is a low level supporter of GFATM.

Agencies utilize a mix of aid instruments for their bilateral assistance, and most of the LMD provide funding through budget/sectoral support, pooled funds, project support, and technical cooperation on government to government projects and through NGOs. With the exception of the Netherlands, the LMD generally do not prescribe the precise allocation of resources to different aid instruments, but allow fl exibility for country by country assessment of the most appropriate mix. The most common aid instrument

utilized by agencies to address HIV/AIDs is targeted HIV/AIDs projects with sectoral support or pooled funds. These are supplemented through addressing HIV/AIDS as a cross-cutting issue, and through project and core funding support to NGOs. There is however little data that provides an accurate breakdown of donor support through these various aid instruments. The choice of aid instrument is related more to overall donor development philosophy rather than to HIV/AIDS specifi c issues.

All bilateral and multilateral agencies state in their published HIV/AIDS strategy that they support mainstreaming of HIV/AIDS. Evaluations of mainstreaming conclude that it has not been particularly effective and could be improved to achieve much greater impact. The main factors which hinder mainstreaming include confusion over defi nition and purpose, lack of understanding of the need for HIV/AIDS mainstreaming in countries with less visible epidemics, competition with a multiplicity of policy priorities and other cross-cutting issues, and insuffi cient allocation of human and fi nancial resources. These barriers are compounded by internal organization and management systems including the lack of both leadership and accountability for progress.

Many donors manage three separate NGO funding channels: (i) negotiated multi-year partnerships with selected NGOs, (ii) project proposals submitted by NGOs and (iii) discretionary funds for embassies or country offi ces to fund NGOs. Some LMD actively encourage NGOs to prioritise HIV/AIDS activities in their grant schemes. Emerging issues for bilateral donors include a disconnect between support through NGOs and overall policy. In developing countries key obstacles to support through NGO channels include a lack of political will and limited NGO adsorptive capacity to effectively utilize resources.

This analysis compared Finland's policy with those of other LMD and found that: (i) it is brief and less systematic at laying out a compelling case for investing in the response to HIV/AIDS, (ii) the priorities are still basically valid, relevant and similar to LMD, (iii) the policy requires updating as it does not refer to Finland's support for GFATM, (iv) the policy does not outline targets with indicators in a monitoring framework against which implementation can be measured and (v) the policy does not outline internal systems, human resource, training and management measures that will need to be taken to ensure effective implementation.

The implementation of Finland's HIV/AIDS policy has been mixed. There has been strong support to UNAIDS, reasonable but reactive support through NGOs that prioritises HIV/AIDS but not necessarily the MFA's priorities, and insuffi cient mainstreaming in bilateral programmes. There is a lack of internal systems to lead, manage, coordinate and monitor the MFA response. Responsibility is fragmented; the HIV/AIDS adviser has no management or coordination function.

There have been a large number of efforts to improve coordination and cooperation in the global response; but more remains to be done. Efforts to improve country level coor-

dination have been relatively successful in putting in place the *Three Ones*, improving information exchange and expanding partnerships to include new partners. They have been less successful at improving the harmonization and alignment of fi nancial and technical assistance behind national strategies. At the global level UNAIDS has been relatively successful at bringing global political consensus on the urgency, approaches and best practice to address HIV/AIDS.

7 CONCLUSIONS

In the broader global response the signifi cant developments since 2004 include the consolidation of the GFATM as the largest multilateral donor, the reduction of ARV prices and massive increase in access to treatment changing the nature of the previous prevention versus treatment debate, the establishment of PEPFAR as the largest donor funding and the growing coordination efforts including the GTT and IHP. At the national level Finland has seen a change of government, started contributions to the GFATM and developed a new development policy which focuses on sustainable development while listing HIV/AIDS as a cross-cutting issue.

An HIV/AIDS policy lays out the priorities that the agency intends to address, and a strategy or implementation plan lays out the measures that the agency intends to take to address the stated policy priorities. The current Finnish prioritisation is based on what is considered Finnish added value (gender, human rights, women) and is in line with its overall development policy. Therefore, the current prioritisation can be considered adequate and relevant. Should the MFA opt for revising its HIV policy, these priorities are not likely to be changed. However, should a revision process take place, the MFA could generate synergies emphasizing the prioritisation of sexual and reproductive health and rights, which is also prioritised within health sector policy. Finland could also sharpen its targeting and focus for example on women/girls and easily marginalized groups (such as children, persons with disabilities, indigenous populations) in line the development policy. Should Finland consider adding new areas, this could include harm reduction, which is considered as a Finnish strength particularly in relation to Russia and Baltic countries. The decision making on priorities should be essentially based on i) available resources, ii) Finnish comparative advantage, and iii) available skills – in this order. Finland should not add on new priority areas unless it signifi cantly increases its HIV funding

However, this analysis concludes that the MFA would benefi t from developing a detailed strategy or implementation plan that lays out how it will achieve those priorities, the resources it will allocate to the task, and the framework for measuring and monitoring progress.

We conclude that there is no compelling reason to conduct an evaluation of the Finnish response to HIV/AIDS because the different elements of the response have been evaluated in recent years. These evaluations combined with the fi ndings of this study render

an evaluation of marginal benefit. The one exception is the MFA internal organization in support of response which has not been evaluated.

As a result of these developments this analysis concludes that there are five main questions which would determine whether the MFA is to update and publish a new HIV/AIDS policy. The first is the level of HIV/AIDS prioritisation in overall development cooperation, the second is the priorities in the policy, third is the balance between the various multilateral and bilateral channels available, the fourth is the level and nature of engagement of MFA staff to maximize the value of each of its bilateral and multilateral commitments, and fifth is the internal management systems and human resources required to implement any HIV/AIDS policy.

Finland's financial commitment to address HIV/AIDS is lower than the OECD DAC average and lower than the other LMD. The level is also low for an agency which states in its HIV/AIDS policy and general development policy that HIV/AIDS is a priority. Finland's allocation of two thirds of is HIV/AIDS assistance through multilateral channels is not unusual and is consistent with Finland's strong commitments to the UN, the EU, to the Paris Declaration and to the relatively small staff the MFA can afford to manage bilateral programmes. The opportunity cost of Finland's strong and highly valued support to UNAIDS is that it allocates less resources to on the ground activities implemented by country governments and NGOs in responding to HIV/AIDS. This is not necessarily a bad thing – but it is a policy choice for the MFA to make. The argument for maintaining or further strengthening support for UNAIDS at either global or country level is that there is still much to be work to be done to improve coordination and cooperation and countries still request TA from UNAIDs. On the other hand plenty of publications highlight the additional resources required globally to scale up HIV/AIDS prevention, treatment and care and the MFA has options through GFATM, bilateral (or silent partner) arrangements or its NGO programmes.

The fourth major conclusion is that there is scope for MFA to obtain greater returns from its financial support irrespective of the policy priorities chosen and the approaches and aid instruments utilized. Firstly, the multilateral contributions, bilateral mainstreaming of HIV/AIDS, and NGO support could be better coordinated. Different MFA departments manage these different channels and there does not appear to be shared strategic objectives, synthesis is not sought, and there is no common or unified internal reporting that outlines the total impact. Secondly, Finland could achieve more from its support to UNAIDS and GFATM, without increasing its financial contributions, by working with these organizations on shared technical or policy priorities. Thirdly, Finland has achieved little from its efforts to address HIV/AIDS as a cross-cutting issue and could achieve significantly more by implementing a set of actions designed to make this more systematic. Finally the value of NGO support could be increased by explicitly making HIV/AIDS priorities criteria for funding and seeking synergies with other funding at country level.

Finally we conclude that the MFA would benefit from reviewing its internal human resource and management systems whether or not the MFA updates its policy. Firstly

there is an absence of an HIV/AIDS leader or champion with responsibility for leading the various parts of the response and for high level external representation. The HIV/AIDS adviser fulfils a technical advisory role to other departments but is not in a position to coordinate and cajole. Secondly, each of the multilateral, cross-cutting and NGO channels would benefit from additional staffing working to a set of objectives are reported on annually. The conclusions of other agencies' evaluations on mainstreaming HIV/AIDS provide clear recommendations on what is needed internally to ensure mainstreaming is effectively implemented.

8 RECOMMENDATIONS

The first recommendation of this meta-analysis is that the MFA should not conduct an evaluation of the Finnish HIV/AIDS response and the implementation of the Finnish HIV/AIDS policy because there would be only marginal value in doing so. The MFA should, however, conduct a review of its internal organization, systems and capacity to implement its HIV/AIDS policy.

The second recommendation is that it would be timely and worthwhile for MFA to put in place an implementation plan for its HIV/AIDS policy to reconfirm its priorities, verify the multilateral and bilateral approaches it utilizes to achieve those priorities, set targets with indicators for what Finland intends to achieve, re-consider the mix of multilateral and bilateral approaches and aid instruments it utilizes to achieve these priorities, and give serious consideration to the internal management, reporting systems and human and financial resources required for implementation.

It is recommended that in compiling this plan the following key areas should be debated and agreed within the organization to maximize buy in:

- The appropriate total of Finland's development assistance for HIV/AIDS.
- Confirmation of the policy priority issues and implications for MFA.
- The mix of bilateral and multilateral approaches and aid instruments utilised and the relative allocation of resources through these instruments.
- Improved approaches to maximise outcomes of existing and future support through all channels, including cross-cutting and NGO support.
- Internal organisational systems and resources required to action the policy.

The third recommendation of this analysis is that MFA review the total of Finland's development assistance for HIV/AIDS and increase it to bring it closer into line with the OECD average.

The fourth recommendation is that there is no compelling reason for Finland to change its policy priorities, as these are in line with overall development policy and also in line with what is commonly considered as Finnish comparative advantages.

The fifth recommendation is that whilst there is no evidence that the overall multilateral-bilateral split of funds Finland provides should be significantly changed; this study does, however, recommend that Finland reviews the specific multilateral and bilateral channels through which it provides resources to ensure consistency with policy priorities. There is insufficient data to provide an evidence base to determine the most effective options, but the options can be assessed against Finnish priorities, consistency with development approach, and the level of human resources available.
The decisions MFA takes on the scale of resources and the choice of multilateral and bilateral channels can be summarized in the following four options for the shape of a new HIV/AIDS policy all of which should be supported by efforts on internal human resource and management systems to achieve greater outcomes from multilateral, NGO and cross-cutting support.

Option 1: Maintain the status quo. The total volume of financial assistance and the mix of aid instruments and proportion of resources allocated through each would remain the same as at present.

Option 2: Same resource level with new mix of approaches. The total volume of financial assistance would remain as at present but the mix of preferred aid instruments would be revised with a new set of approaches contributing to an updated set of strategic objectives and priorities.

Option 3: Resource increase with current approaches. The total volume of financial assistance would be increased (to be closer to LMD or OECD average) and the current mix of aid instruments with resource allocations would be maintained.

Option 4: Resource increase with new mix of approaches. The total volume of financial assistance would be increased (to be closer to LMD or OECD average) but the mix of aid instruments with resource allocations would be revised with a new set of approaches contributing to an updated set of strategic objectives and priorities.

The options that exist for increased resourcing include:
Increasing support to GFATM. This would support country responses to HIV/AIDS, require zero or marginal additional human resource cost to MFA, and be consistent with the LMD (and OECD members more generally). It would not of itself enable Finland to prioritise particular issues or population groups and it would not enable Finland to maximize its own comparative advantage.

Increasing support to UNAIDS. This would support global and UN coordination, lesson learning, best practice generation and country level assistance to governments. It would require zero or marginal additional human resource costs and it would build upon Finland's current prioritization and recognized support to UNAIDS and the UN. Finland should observe how the new Executive Director leads the organization in response to the second five year evaluation. Again, it would not of itself enable Finland to prioritise par-

ticular issues or population groups and it would not enable Finland to increase resources to the response on the ground.

Starting support to other UN agencies. This would be consistent with Finnish development policy of supporting the UN and enable Finland to select an agency or agencies to support which directly address the areas of Finland's own policy priorities for addressing HIV/AIDS. This would suggest UNFPA or UNICEF. There would be some transaction costs in establishing the agreement and Finland would require time to establish itself as an infl uential and supportive donor.

Support to Joint UN programme through UNAIDS in one of Finland's priority countries. This would aim to improve UN coordination at country level, support technical assistance to governments and NGOs and be consistent with Finland's support for UNAIDS and UN. It would require human resources to negotiate and monitor the agreement and would not signifi cantly support HIV/AIDS interventions on the ground. The volume of resources would need to be suffi cient to ensure that it is supporting a Joint UN programme and not perpetuating a fragmented UN programme.

Support to local NGOs to deliver HIV/AIDS interventions and services in one of Finland's priority countries. This would directly support interventions on the ground, would strengthen civil society, and would enable Finland to focus on its priority issues and populations. It would have potentially high human resource costs for MFA unless a Finnish, international or local NGO with suffi cient capacity could act as an umbrella NGO to manage the programme.

Support to a national government response in one of Finland's priority countries. This would directly support interventions on the ground and strengthen national leadership and ownership. It could have high human resource costs to MFA (unless supported as a silent partner or through existing pooled funds), it might not allow explicit focus on Finland's priority issues or populations, and depending on the capacity of the national government response it might not be the most effective means of supporting HIV/AIDS interventions in the short term.

There are also the options of increasing support through Finnish NGOs, and through addressing HIV/AIDS as a cross-cutting theme in other programmes. These are not outlined in more detail here because they would require high human resource allocation which is unlikely.

This meta-analysis suggests that the current balance of multilateral and bilateral support that Finland provides does not require radical amendment. We recommend that unless Finland strengthens its human resources any increase in resources should be channeled to GFATM and UNAIDS with a clear strategy for what Finland intends to achieve and how it will engage. This is because human resource capacity constraints within MFA would limit effective management of an expanded bilateral programme, and support for UN-

AIDS in particular would build on Finland's history of strong and highly valued support. This should be supplemented with a strong policy dialogue together with LMDs to work with UNAIDS to focus on improving country level coordination.

The sixth recommendation of this analysis is that the MFA takes a set of key measures to increase the outcomes from its existing set of commitments for addressing HIV/AIDS. These could include:

1 With LMDs pursue policy and technical objectives with UNAIDS and GFATM through active engagement at board level, committees and working groups.
2 Maximise outcomes from GFATM by engaging in partnership discussions and plan ning technical assistance to support implementation of grants.
3 Focus on pursuing Finland's policy priorities (human rights, gender, women and children) by identifying opportunities to work with GFATM and UNAIDS to sup port them to take forward their strategies in these areas.
4 Maximise outcomes from UNAIDS by supporting technical assistance at country level in support of implementation of GFATM projects and engaging with and sup port UNAIDS Performance and Evaluation Monitoring Framework to demonstrate value for money, including of Finland's money.
5 Develop a strategy to explicitly work with LMDs to engage and infl uence multilate ral organisations. This could include joint studies and reviews of how the multila terals address Finnish policy priority issues at the country level to provide evidence for evidence based promotion of Finnish priorities.
6 Develop an MFA wide plan for addressing HIV/AIDS as a cross-cutting issue, iden tify a high level cross-cutting champion, and ensure that annual progress reports are prepared for MFA senior management. The plan would include identifi cation of targets and indicators for mainstreaming, prioritization of the most appropriate sec tors to focus mainstreaming, HIV/AIDS mainstreaming training for key staff (this could be contracted in). The Swedish and Swiss (SDC 2004) HIV/AIDS mainstrea ming guidelines may be useful models.
7 Maximise outcomes from support to NGOs by (i) explicitly making the MFA HIV/ AIDS priorities a criteria for NGO funding, (ii) encouraging focus on key priorities in the HIV/AIDS policy, and (iii) ensuring that NGO reporting includes focus on HIV/AIDS so that this information can be aggregated.
8 Develop an implementation plan which brings together Finland's sup port for addressing HIV/AIDS in one framework with targets and indica tors, which links the multilateral, cross-cutting and NGO support to a shared overall objective, and which seeks synergies between the different approaches.

These would also be relevant if MFA increases funding or changes the proportion through the different channels.

The seventh recommendation is that the MFA implements a set of measures to improve its internal management of its support for addressing HIV/AIDS. These would include:

1. Appointing an HIV/AIDS ambassador or champion with responsibility for high level external representation, leading the MFA response, for coordinating all elements of the MFA HIV/AIDS response and reporting on its progress.

2. Development of an overall monitoring framework for the policy with a clear set of targets and indicators, and responsibilities for implementing them.

3. Produce annual progress reports for MFA leadership based on the monitoring framework.

4. Preparation of systems and baselines to adequately track and monitor financial resources committed and disbursed for HIV/AIDS response.

5. Allocation of increased human resources to implement these actions. Depending on the scale of the decisions taken by the MFA this may require recruiting additional staff, but at the very least it will require existing staff explicitly allocating time for HIV/AIDS either to mainstream it, manage NGO or multilateral work and to report and track progress.

9 LESSONS LEARNED

There are few readily available evaluations of the implementation by a development agency of their HIV/AIDS strategy and there are even fewer revised HIV/AIDS strategies which demonstrate lesson learning. There are also few readily available evaluations of joint projects, of NGOs work either on specific projects or on the full range of work of an agency. There are probably many evaluations that are not in the public domain which would be a particularly useful resource for anyone wishing to learn lessons in effective implementation. The OECD/DAC Evaluation Resource Centre is useful but could benefit from availability of a higher number of evaluations.

Development agencies need to commit human and financial resources, provide leadership and put in place a framework for monitoring the progress of implementation of their strategies to ensure that action happens. There is a striking similarity between the findings of a number of evaluations about the lack of progress after a strategy was published until these building blocks were put in place. The key lesson here is that the work begins, not stops, once the strategy is published, and this requires departments and individuals knowing their responsibility for implementation and having the resources and skills to do so.

The global response has seen some very successful attempts at improving coordination and cooperation and some areas of little progress despite much effort. Improved coordination should make a real difference to the workload of governments. One lesson from this study is that initiatives and political statements of improving aid effectiveness and coordination have not had the desired impact. The reasons are

less clear but evaluations suggest that there is a fundamental lack of accountability for delivering support at country level, and perhaps a focus on coordination between agencies distracts attention from focusing on the important issue of how agencies deliver their development assistance.

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ANNEX 1 TERMS OF REFERENCE

Ministry for Foreign Affairs of Finland

Terms of Reference

Meta-analysis of Development Cooperation on HIV/AIDS (89851702)

1. Background

HIV/AIDS is one of the greatest threats to human development worldwide. The problem cannot be dealt with only as a health issue - it must be treated more broadly as a crucial issue with economic, social, security and other dimensions. Finland is committed to a comprehensive, long term HIV/AIDS response through the Millennium Declaration and the Declaration of Commitment adopted at the UN General Assembly's special session on HIV/AIDS in 2001.

The Millennium Development Goals also guide the work for reducing HIV/AIDS, including the following particular operational aims:

- improving the equitability of treatment
- investing in health-care systems and extending HIV/AIDS care services
- strengthening proactive prevention work
- concentrating particularly on vulnerable groups.

Response to HIV/AIDS is enshrined in the 2005 Joint Development Policy Statement: the European Consensus for Development as one of the main dimensions of poverty eradication, an area for Community action and a cross-cutting issue that must be mainstreamed in other sectors. The EU Programme for Action to Confront HIV/AIDS, Tuberculosis and Malaria through External Action (2007-2011) launched in May 2005 is being implemented and a progress review is coming up in 2009.

Finnish support to HIV / AIDS response

HIV/AIDS has been an important theme in Finnish development policy for several years. In 2002, the Finnish Ministry for Foreign Affairs prepared the first white paper on issues related to HIV/AIDS. This white paper was updated in 2004. In the 2004 policy HIV is described as an extensive, multisectoral development challenge. In the 2007 policy for development co-operation HIV/AIDS is included as one of the three cross-cutting themes. The epidemic was thus recognised as a crucial challenge to efforts to reduce poverty. Finland has emphasised a comprehensive approach to HIV/AIDS, including the importance of prevention and human rights as principal themes. In the area of human

rights, the challenge has particularly been seen in gender equality and women's and girls' special vulnerability to HIV infection. It is important to note that HIV/AIDS is not only meant to be mainstreamed in all interventions, but that the epidemic is also to be addressed through targeted interventions.

Finland participates in the HIV/AIDS response mainly through support to multilateral organisations and non-governmental organisations. The main multilateral organisations supported are UNAIDS and the Global Fund to fight against HIV/AIDS, tuberculosis and malaria (GF). About one third of the Finnish support to HIV/AIDS work is channelled through NGOs based in Finland and a small proportion is extended to organisations in partner countries through local cooperation funds. Finland does not provide bilateral support for HIV/AIDS specific governmental projects/programmes in partner countries.
Finland has supported UNAIDS since its establishment in 1996. In 2008 Finnish funding to UNAIDS was MEUR 7,5. Finland joined the Global Fund in 2006. In 2008 the Finnish share to Global Fund was MEUR 2,5. In addition the Ministry for Foreign Affairs supports HIV/AIDS related work in Russia through the neighbouring area cooperation.

In the Ministry for Foreign Affairs HIV/AIDS was part of the Health Adviser's portfolio until 2006, when an HIV/AIDS Adviser was recruited to provide expertise on HIV/AIDS-issues and to promote a broad approach to the epidemic and its integration in all sectors. Collaboration with other relevant Ministries and Institutes and the civil society is regular. There is no permanent HIV/AIDS network within the Ministry in Helsinki or with the Embassies. Finland does not have HIV/AIDS Advisers in the field.

Reasons for the meta-analysis

To tackle the multifaceted problem of HIV/AIDS, MFA will carry out a meta-analysis on the strategies and key development interventions (multilateral, bilateral, NGO support, INGO support, local funds) of main donors to combat HIV/AIDS. Several international initiatives have been taken in order to mobilise and join forces in the response to the HIV epidemic, but despite rather extensive experience on what works, there is still an ongoing discussion regarding priority-setting. Therefore the need has arisen to review and possibly update the Finnish HIV/AIDS policies and practices of development cooperation. As numerous donors already struggle with these issues, it is considered useful to view the existing deliberations before deciding on the need for an independent evaluation of Finnish efforts.

2. Purpose and objective of the meta-analysis

The purpose of the meta-analysis is to give an informed basis to clarify and sharpen the scope of Finnish development projects combating HIV/AIDS and its various dimensions.

The objective of the analysis is to assess the totality of HIV/AIDS response and based on this assessment, decide whether a separate evaluation of Finnish activities is needed or whether conclusions of the meta-analysis might give sufficient support to the review of the Finnish policy and strategy in the sector.

3. Scope of the meta-analysis

The time frame for the meta-analysis will be the years 1996 - 2007. As a preparatory phase for the meta-analysis, a compilation of material on HIV/AIDS in development cooperation was carried out in August - September 2008. The material includes HIV/AIDS strategies and interventions funded by Finland and by major international donors (governmental development cooperation: Canada, Denmark, France, Germany, Japan, Ireland, Netherlands, Norway, Sweden, UK, USA and
international / intergovernmental organisations: UNAIDS, UNESCO, UNDP, UNFPA, UNHCR, UNODC, GF, ILO, IPM, WB, WFP, WHO).

The compiled material forms a fair cross-section of the HIV/AIDS response of various donors during last decade and should thus form a sufficient basis for a meta-analysis.

5. Task of the meta-analysis team

Based on the material collected in the preparatory phase, the experts shall collate and analyse the information, and synthesise it into a well-structured and concise report. The steps in the work of the team are as follows:

- to construct an overall picture of the HIV/AIDS response of main donors globally and that carried out with Finnish development funds, considering:
    - the strategies, projects / programmes and their objectives,
    - the results, effects and impacts of these strategies and projects as reflected in evaluations
    - corrective measures and new approaches taken after the evaluations
    - future plans and strategies for future based on earlier experience

- considering the multiple dimensions of the impact of HIV/AIDS, to chart the covered and uncovered areas in HIV/AIDS work and possible synergies of the strengths of Finnish development cooperation that could be linked to HIV/AIDS

- to make recommendations for the need of a possible further evaluation to be carried out; or if the conclusion of the meta-analysis is that there is adequate available information and experience for the drawing of lessons learned applicable to the Finnish development aid context, propose elements and an outline of a policy on HIV/AIDS in development cooperation of Finland.

6. Specific questions for the meta-analysis

- Priority-setting:
  - What considerations are taken into account in the process of priority-setting?
  - To what extent is HIV/AIDS seen as a priority?
  - On what basis are decisions and priorities made?
  - Do the priorities / themes / strategies promoted vary depending on the channel of funding (multilateral, bilateral, NGO, ...)?
  - To what extent has there been systematic follow up and implementation of recommendations of various evaluations related to HIV/AIDS?
  - Is there a specifi c focus in HIV/AIDS work in the development cooperation of like-minded countries?
  - For each donor to be assessed, what is perceived to be its current and future role and comparative advantage with regards to HIV/AIDS, and why?

- Approaches:
  - For each donor to be assessed, is there a policy / strategy on HIV/AIDS? If yes, to what extent is it being applied?
  - How relevant is the policy for the work with HIV/AIDS?
  - How often have the policies been updated?
  - Besides the policy, what other factors infl uence the work on HIV/AIDS?
  - In practice, to what extent is HIV/AIDS seen as a cross-cutting issue?
  - To what extent is mainstreaming seen as a tool when dealing with the epidemic?
  - To what extent are targeted interventions preferred?
  - How does coherence and complementarity of bilateral and multilateral cooperation work in the area of HIV/AIDS?

- Coordination and cooperation:
  - How is the HIV/AIDS response coordinated among the various actors at internatio nal level and at country level?
  - What characterises cooperation with external actors in the area of HIV/AIDS?
  - Have there been joint projects of different actors? Joint evaluations?
  - What is the extent of cooperation of local actors (governmental, non-governmental) in different partner countries?
  - To what extent have organisations learnt from the experiences of other organisations and partners?
  - To what extent do they follow their guidelines and programmatic good practices related to HIV/AIDS?

7. Methodology and work plan

The evaluation is carried out as a desk-study based on the material collected in the background study and possible other materials that the evaluation team identifi es / fi nds rele

vant and that the Ministry may provide during the course of the work.

The desk study will be complemented by interviews of a sample of desk officers and advisors of MFA and other relevant experts, who participate in the planning and administering of development projects on HIV/AIDS.

Based on the desk study and interviews a final draft report is prepared with well-formulated and evidence-based conclusions and recommendations for the dual purpose of the meta-analysis.

8. Expertise required

The evaluation team consists of two senior experts with profound experience in different dimensions of HIV/AIDS in development. One of the two experts shall preferably come from a developing country.

The two members of the team shall complement each other's qualifications. The team shall have

- relevant academic qualifications;
- sound and proven background in different dimensions of HIV/AIDS effects in society, national and international;
- familiarity with Finnish and international development policies, principles and modalities;
- experience in relevant development issues and proven theoretical and practical experience in evaluation of international development interventions;
- (for the Team Leader) substantial prior experience as a Team Leader of evaluations and other type of missions;
- good communication and interpersonal skills;
- gender balance is an asset.

As part of the material is in Finnish, at least one team member has to be fluent in Finnish language.
The Team Leader will have the overall responsibility for the report writing and its quality and other arrangements, including communication with the MFA.

9. Reporting and time schedule

The meta-analysis will be started during the first quarter of 2009 and it will take approximately three months.

The evaluation shall be carried out in accordance with the Evaluation Guidelines, Between Past and Future (2007) of the Ministry. These guidelines include outlines of different reports.

The final report shall clearly and concisely present the findings, conclusions and recommendations. The analysis and results presented must be evidence-based. The list of projects / programmes included in the evaluation will be annexed to the report.

The report has to be submitted in pdf and word format in the electronic form and the final report also in five hard copies. All reports shall be written in English; the language (already in the final draft) has to be proof-edited, and written in a clear and concise manner, suitable for use in public communication. A professional editor and language checking must be used, if the evaluation team does not have the competence for copy-editing. The text of the final report has to be ready-to-print. A recent copy of an evaluation report of MFA must be consulted for layout and style. The Ministry also provides some instructions to facilitate the finalisation of the evaluation report. The abstracts and the executive summaries must be included in Finnish, Swedish and English exactly as they will be printed. Only the ISBN and ISSN numbers shall be inserted by the Ministry.

The quality of the final report has to be checked against the EU Quality Criteria for development evaluations: http://ec.europa.eu/europeaid/evaluation/methodology/index_en.htm .
The evaluation team shall complete a self-evaluation of their report against the above EU evaluation report quality criteria. This self-evaluation sheet shall be appended to the report.

The OECD/DAC Evaluation Quality Standards shall be used as reference in report writing to assure the quality of the evaluation report. The team shall fill in the OECD/DAC quality criteria matrix in the course of the work, and surrender it at the end of the assignment to MFA. These guidelines can be found in the web page of the organization http://www.oecd.org .

10. Mandate

The evaluation team members are entitled and expected to discuss with pertinent persons and organizations the above and any other matters relevant to the assignment. However, they are not authorized to make any commitments on behalf of the Government of Finland. The final report shall be subject to approval by the Ministry.

Helsinki 18.12.2008

Aira Päivöke
Director
Evaluation and Internal Auditing of Development Cooperation

REPORT 2005:5 Evaluation of the Service Centre for Development Cooperation in Finland (KEPA)
ISBN: 951-724-523-8, ISSN: 1235-7618

REPORT 2005:4 Gender Baseline Study for Finnish Development Cooperation
ISBN: 951-724-521-1, ISSN: 1235-7618

REPORT 2005:3 Evaluation of Finnish Health Sector Development Cooperation 1994–2003
ISBN: 951-724-493-2, ISSN: 1235-7618

REPORT 2005:2 Evaluation of Finnish Humanitarian Assistance 1996–2004
ISBN: 951-724-491-6, ISSN: 1235-7618

REPORT 2005:1 Ex-Ante Evaluation of Finnish Development Cooperation in the Mekong Region
ISBN: 955-742-478-9, ISSN: 1235-7618

REPORT 2004:4 Refocusing Finland's Cooperation with Namibia
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REPORT 2004:2 Evaluation of Finland's Development Cooperation with Bosnia and Herzegovina
ISBN: 951-724-446-0, ISSN: 1235-7618

REPORT 2004:1 Evaluation of Finnish Education Sector Development Cooperation
ISBN: 951-724-440-1, ISSN: 1235-7618

REPORT 2003:3 Label Us Able – A Pro-active Evaluation of Finnish Development co-operation from the disability perspective
ISBN 951-724-425-8, ISSN 1235-7618

REPORT 2003:2 PART 2 Evaluation of Finnish Forest Sector Development Co-operation
ISBN 951-724-416-9 ISSN 1235-7618

REPORT 2003:2 PART 1 Evaluation of Finnish Forest Sector Development Co-operation
ISBN 951-724-407-X, ISSN 1235-7618

REPORT 2003:1 Evaluation of the Finnish Concessional Credit Scheme
ISBN 951-724-400-2, ISSN 1235-7618

REPORT 2002:9 Evaluation of the Development Cooperation Activities of Finnish NGOs in Kenya
ISBN 951-724-392-8, ISSN 1235-7618

REPORT 2002:8 Synthesis Study of Eight Country Programme Evaluations
ISBN 951-724-386-3, ISSN 1235-7618

REPORT 2002:7 Review of Finnish Training in Chemical Weapons Verification
ISBN 951-724-378-2, ISSN 1235-7618

REPORT 2002:6 Kansalaisjärjestöjen Kehyssopimusjärjestelmän arviointi
ISBN 951-724-376-6, ISSN 1235-7618

REPORT 2002:5 Evaluation of the Bilateral Development Co-operation Programme between Kenya and Finland
ISBN 951-724-373-1, ISSN 1235-7618

REPORT 2002:4 Evaluation of Bilateral Development Co-operation between Nicaragua and Finland
ISBN 951-724-372-3, ISSN 1235-7618

REPORT 2002:3 Evaluation of the Bilateral Development Co-operation between Ethiopia and Finland
ISBN 951-724-370-7, ISSN 1235-7618

REPORT 2002:2 Evaluation of the Bilateral Development Co-operation between Mozambique and Finland
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EVALUATION

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2009:4

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ISSN 1235-7618

Ministry for Foreign Affairs of Finland

ANNEX 2 PEOPLE INTERVIEWED NON-EDITED

Staff of the Ministry for Foreign Affairs of Finland

Blumenthal, Gisela, Health Sector Adviser, Department for Development Policy/Unit for Sector Policies, Ministry for Foreign Affairs of Finland

Forslund, Maria, Inspector, Unit for Southern Africa, Ministry for Foreign Affairs of Finland

Keisalo, Lasse, Counsellor, Unit for Latin America and the Caribbean, Ministry for Foreign Affairs of Finland

Kolehmainen, Ismo, Counsellor, Department for Development Policy/Unit for UN Development Issues, Ministry for Foreign Affairs of Finland

Kullberg, Gunilla, Adviser, Department for the Americas and Asia, Ministry for Foreign Affairs of Finland

Kääriäinen, Matti, Ambassador/Development Policy Adviser, Department for Russia, Eastern Europe and Central Asia, Ministry for Foreign Affairs of Finland

Leino, Vesa, Adviser, Department for Development Policy/Unit for Sectoral Policy, Ministry for Foreign Affairs of Finland

Mikkola, Heli, HIV/AIDS Adviser, Department for Development Policy/Unit for Sector Policies, Ministry for Foreign Affairs of Finland

Olasvirta, Leo, Director, Unit for Non-Governmental Organizations, Department for Development Policy, Ministry for Foreign Affairs of Finland

Pihlatie, Heidi, Senior Evaluator, Evaluation and Internal Auditing of Development Cooperation, Ministry for Foreign Affairs of Finland

Päivöke, Aira, Director, Evaluation and Internal Auditing of Development Cooperation, Ministry for Foreign Affairs of Finland

Väänänen, Hanna, Second Secretary, Unit for Southern Africa, Ministry for Foreign Affairs of Finland

Maputo based interviews

Hill, Eleanor, Coordinator for Pre-partners' Forum, UNAIDS Mozambique

Hiltunen, Eeva, Adviser for Health, Education and Innovation & Technology, Embassy of Finland in Maputo, Mozambique

Larsen, Dennis, Communication Officer, UNAIDS Mozambique

Martins, Alexandra, Coordinator for Local Cooperation Funds, Embassy of Finland in Maputo, Mozambique

Parviainen, Ritva, Former Coordinator for Local Cooperation Funds at the Embassy of Finland in Maputo, Mozambique

Pincince, Luc, First Secretary (Development), High Commission of Canada, Maputo, Mozambique.

Geneva and HQ based interviews

Christiansen, Thea, Ministry of Foreign Affairs, Denmark (formerly responsible for HIV/AIDS)

Armstrong, Christopher, Counsellor, Cooperation – Health & HIV/AIDS, High Commission of Canada, Dar es Salaam, Tanzania.

Elo, Olavi, Senior Advisor to the Director, Partnerships and External Relations, UNAIDS, Geneva, Switzerland

Ferazzi, Silvia, Manager, Donor Governments Team, Resource Mobilization Unit, The Global Fund to Fight AIDS, Tuberculosis and Malaria, Geneva, Switzerland

Lary, Tanya, Senior Policy Advisor, HIV/AIDS Policy, Coordination and Programs
Division, Public Health Agency of Canada.

Ryan, Sinead, Bilateral and Multilateral Team, Partnership Unit, The Global Fund to Fight AIDS, Tuberculosis and Malaria, Geneva, Switzerland

Skjelmerud, Anne, Senior Adviser/ Coordinator HIV and AIDS, Global Health and AIDS Department (AHHA), Norwegian Agency for Development Cooperation, Oslo, Norway (written comments)

Spreeuwenberg, Johanna, Senior Policy Advisor HIV/AIDS, Health, Gender and Civil Society Department, DSI, Ministry of Foreign Affairs, The Netherlands

Szabo, Sylvia, Donor Relations Officer, Donor Governments Team, The Global Fund to Fight AIDS, Tuberculosis and Malaria, Geneva, Switzerland

Ussing,Morten, Advisor to the Deputy Executive Director, Management and External Relations, UNAIDS, Geneva, Switzerland

Wangerin, Merle, External Relations Officer, Resource Mobilization, Partnerships and External Relations, UNAIDS, Geneva, Switzerland

Other people interviewed

Hakulinen, Maija, Programme Coordinator, Southern Africa, Finn Church Aid

Rantakari, Birgitta, Director, International Affairs, Deaconess Institute

Rinne-Koistinen, Eva-Marita, Adviser, Socio-cultural rights, Finn Church Aid

Tuomi, Marja, Project Manager, Cuaha-Project, International Affairs, Deaconess Institute

NON-EDITED

ANNEX 3 MATRIX OF AVAILABLE DOCUMENTS

	HIV/AIDS strategy, policy or plan	HIV/AIDS evaluation	HIV progress reports	Health strategy/policy	Health evaluation	Development policy / strategy	Annual development plan	Related sector strategy/policy	Related sector evaluations
Belgium	1				1			1	
Canada	1					1		1	1
Denmark	1	1				2			
EU	1								
Finland	2			1	1	2		5	3
Ireland	2		1	1		1			
Japan		1							
Netherlands	2	1				1			
Norway	1	1						2	
Sweden	2	3	1	1	2	3			
UK	3	1		1		1		3	3
US	3		5	1		1			
GFATM	1		5						
ILO									
UNAIDS	3	1							
UNDP	1								1
UNESCO	1								
UNFPA						1			
UNHCR	1					1			
UNICEF	1	1	2			1			
UNODC						1			
WFP	1					1			
WHO	1	1	1						
World Bank	2	1	2	1				1	1

NON-EDITED

ANNEX 4 UN TECHNICAL SUPPORT DIVISION OF LABOUR

Technical support areas	Lead Organizations	Main Partners
1. STRATEGIC PLANNING, GOVERNANCE AND FINANCIAL MANAGEMENT		
HIV/AIDS, development, governance and mainstreaming, including instruments such as PRSPs, and enabling legislation, human rights and gender	UNDP	ILO, UNAIDS Secretariat, UNESCO, UNICEF, WHO, World Bank, UNFPA; UNHCR
Support to strategic, prioritized and costed national plans; financial management; human resources; capacity and infrastructure development; impact alleviation and sectoral work	World Bank	ILO, UNAIDS Secretariat, UNDP, UNESCO, UNICEF, WHO
Procurement and supply management, including training	UNICEF	UNDP, UNFPA, WHO, World Bank
HIV/AIDS workplace policy and programmes, private-sector mobilization	ILO	UNESCO, UNDP
2. SCALING UP INTERVENTIONS		
Prevention		
Prevention of HIV transmission in healthcare settings, blood safety, counseling and testing, sexually-transmitted infection diagnosis and treatment, and linkage of HIV prevention with AIDS treatment services	WHO	UNICEF, UNFPA, ILO
Provision of information and education, condom programming, prevention for young people outside schools and prevention efforts targeting vulnerable groups (except injecting drug users, prisoners and refugee populations)	UNFPA	ILO, UNAIDS Secretariat, UNESCO, UNICEF, UNODC, WHO
Prevention of mother-to-child transmission (PMTCT)	UNICEF, WHO	UNFPA, WFP
Prevention for young people in education institutions	UNESCO	ILO, UNFPA, UNICEF, WHO, WFP
Prevention of transmission of HIV among injecting drug users and in prisons	UNODC	UNDP, UNICEF, WHO, ILO
Overall policy, monitoring and coordination on prevention	UNAIDS Secretariat	All Cosponsors
Treatment, care and support		
Antiretroviral treatment and monitoring, prophylaxis and treatment for opportunistic infections (adults and children)	WHO	UNICEF
Care and support for people living with HIV, orphans and vulnerable children, and affected households	UNICEF	WFP, WHO, ILO
Dietary/nutrition support	WFP	UNESCO, UNICEF, WHO
Addressing HIV in emergency, reconstruction and security settings		
Strengthening HIV/AIDS response in context of security, uniformed services and humanitarian crises	UNAIDS Secretariat	UNHCR, UNICEF, WFP, WHO, UNFPA
Addressing HIV among displaced populations (refugees and IDPs)	UNHCR	UNESCO, UNFPA, UNICEF, WFP, WHO, UNDP
3. MONITORING AND EVALUATION, STRATEGIC INFORMATION, KNOWLEDGE SHARING AND ACCOUNTABILITY		
Strategic information, knowledge sharing and accountability, coordination of national efforts, partnership building, advocacy, and monitoring and evaluation, including estimation of national prevalence and projection of demographic impact	UNAIDS Secretariat	ILO, UNDP, UNESCO, UNFPA, UNHCR, UNICEF, UNODC, WFP, WHO, World Bank
Establishment and implementation of surveillance for HIV, through sentinel/population-based surveys	WHO	UNAIDS Secretariat

acquired over the last 100 years. Profits generated by LATH are donated back to LSTM and therefore are reinvested in supporting the School's pioneering work in international health. www.lath.com

Austral-COWI has strong internal capacity in the design and performance of research programmes, including the design of qualitative and quantitative instruments for data collection. Austral-COWI has gained particular experience in performing KAP (Knowledge, Attitude and Practices) studies, workplace interventions, and the designing of HIV/AIDS related implementation strategies. AC also undertakes HIV/AIDS related project evaluations and has implemented several long-term projects in this field.. www.australcowi.co.mz

Minna Tuominen has worked some 4 years as the senior consultant of Austral in the area of HIV/AIDS and gender. Previously worked nearly 3 years with UNAIDS in Mozambique as HIV/AIDS Program Officer. Assignments that she has undertaken include: analysis of policies and practices of donors; analysis of gender policies and practices in policies of donors; design of workplace HIV/AIDS programme; study of knowledge and practices of young people; evaluation of HIV/AIDS IEC materials; mobilizing the private sector to address HIV/AIDS; development of HIV/AIDS strategies; HIV/AIDS in the transport sector.

Martin Taylor has had a particular specialism in HIV/AIDS strategies **i**n over 10 years working for the Department of International Development, UK (DFID) In 2000 he developed a framework for the first UN Strategic Plan for HIV and AIDS and in 2001 he was a key member of the team who founded the GFATM. He was the DFID representative for UNAIDS and principal author and led multi-sectoral team that produced DFID's first HIV/AIDS Strategy in 2001. Between 2003-2007 he was responsible for all of the £180m DFID spending in China to address Health and HIV/AIDS.

Dirce Costa: 2001-2008 Principal researcher in a regional project evaluating which element of donor funding (Global Fund, World Bank MaP and PEPFAR) is most effective in the response to the HIV/AIDS epidemic in a given country context. The evaluation includes looking at aspects of gender, reproductive health policy and the labour market. Lead a study into the effect of HIV/AIDS donor funding on civil society organizations. Also has completed a number of assignments in relation to workplace HIV/AIDS programmes in Mozambique.

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ANNEX 5 CONSULTANCY TEAM

Liverpool Associates in Tropical Health is an independent international health consultancy and programme management company. It is wholly owned by the Liverpool School of Tropical Medicine (LSTM), an internationally recognised centre of excellence devoted to research, education, training, programme management and consultancy in the field of international health. LATH delivers sustainability through capacity development, continually putting issues of equity and vulnerability at the fore. LATH is able to benefit from the rich experience that LSTM has

acquired over the last 100 years. Profits generated by LATH are donated back to LSTM and therefore are reinvested in supporting the School's pioneering work in international health. www.lath.com

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ANNEX 6 STRATEGIC PRIORITIES PER AGENCY

Nr.	Development partner	Prevention	Condoms	EC	PEP	Male circumcision	PMTCT	Behavior change	Universal precautions & blood safety	Harm reduction	STI treatment	Care, support, social protection	Home and community based care	Palliative care	Psychological support	Carer support	Nutrition, food security	Mitigation of impact	Treatment	Paediatric treatment	Traditional/alternative medicine	Treatment of opportunistic infections	ARV treatment	Key populations	OVCs	Indigenious people	MSM	Migrants & mobile populations	Disabled people	People in prison settings	People in education sector	People in health sector	PLWHA	IDU	Refugees & IDPs	Rural communities	CSW & clients	Uniformed services	Women & girls	Workplace	Youth	Testing & counselling	SRHR	Gender	Human rights	Stigma & discrimination	Science, research, biomedical vaccines, microbicides	Nat. planning & implementation / national level leadership	Strengthening surveillance system	Coordination/harmonization	Multisectorial capacity	Development / Health system Strengthening/health worker crisis	Involvement of civil society	Community involvement	Involvement of private sector	Reduction of drug prices
1	Belgium	x		x			x					x					x		x				x		x																				x								
2	Canada	x	x	x			x				x						x						x		x										x			x		x			x	x					x		
3	Denmark	x										x						x	x					x	x													x							x					x		x
4	EU	x		x			x	x					x				x	x	x	x		x	x		x							x		x				x					x	x					x		
5	Finland	x																																				x														
6	Global Fund																																																				
7	ILO																																						x				x									
8	Ireland	x										x							x																								x									x
9	Japan																																																			
10	Netherlands	x	x								x		x										x		x							x	x		x								x									x
11	Norway	x					x																	x			x					x		x			x					x	x								
12	EU																																																			x
13	Sweden	x		x								x												x	x														x				x									
14	UK	x					x					x							x					x	x	x	x	x		x				x			x					x									x
15	UNAIDS	x										x							x					x									x			x															
16	UNDP																																	x																		x
17	UNESCO	x		x				x																																x	x				x									
18	UNFPA	x	x	x			x	x			x														x										x			x														
19	UNHCR	x	x	x	x		x		x	x	x						x		x			x	x	x										x				x				x									
20	UNICEF	x					x												x	x				x																												
21	UNODC	x																											x				x																	x		
22	USA	x	x	x	x	x	x	x	x			x							x	x				x									x		x			x					x									
23	WFP	x					x					x	x				x							x													x															
24	WHO	x			x		x		x	x	x	x		x			x		x	x	x	x	x																												
25	World Bank	x										x												x	x			x											x		x	x			x	x	x			x		x	

ANNEX 7 DOCUMENTS CONSULTED

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