Evaluation of
Finnish Health Sector Development
Cooperation
1994 - 2003
Final Report

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>ACP</td>
<td>African, Caribbean and Pacific countries</td>
</tr>
<tr>
<td>AKF</td>
<td>Aga Khan Foundation</td>
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<tr>
<td>ARIVAC</td>
<td>The Filipino-Finnish-French-Australian investigation of effectiveness of the 11-valent pneumococcal conjugate vaccine</td>
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<tr>
<td>CC</td>
<td>Concessional credits</td>
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<td>CSO</td>
<td>Civil society organisation</td>
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<tr>
<td>DAC</td>
<td>OECD’s Development Assistance Committee</td>
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<td>DDP</td>
<td>Department for Development Policy</td>
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<td>DIDC</td>
<td>Department of International Development Cooperation</td>
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<tr>
<td>DPC</td>
<td>Development Policy Committee</td>
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<tr>
<td>EC</td>
<td>European Commission</td>
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<td>EDF</td>
<td>European Development Fund</td>
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<td>EHG</td>
<td>Euro Health Group</td>
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<td>EU</td>
<td>European Union</td>
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<td>FIDIDA</td>
<td>Finnish Disabled People’s International Development Association</td>
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<tr>
<td>FINNIDA</td>
<td>Finnish International Development Assistance (Now Department for International Development Cooperation)</td>
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<tr>
<td>GAVI</td>
<td>Global Alliance for Vaccines and Immunisation</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
</tr>
<tr>
<td>GNI</td>
<td>Gross national income</td>
</tr>
<tr>
<td>HEDEC</td>
<td>Health and Development Cooperation (Unit of STAKES)</td>
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<td>HIPC</td>
<td>Highly Indebted Poor Country initiative</td>
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<td>IAC</td>
<td>Inter-African Committee</td>
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<tr>
<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<td>IDC</td>
<td>International Development Collaboration (Unit of STAKES)</td>
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<tr>
<td>IDP</td>
<td>Internally displaced person</td>
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<tr>
<td>IDS</td>
<td>Institute for Development Studies</td>
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<tr>
<td>IEC</td>
<td>Information, education and communication</td>
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<tr>
<td>IFI</td>
<td>International financial institution</td>
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<tr>
<td>ILO</td>
<td>International Labour Organisation</td>
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<tr>
<td>INGO</td>
<td>International non-governmental organisation</td>
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<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
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<tr>
<td>KEPA</td>
<td>Service Centre for Development Cooperation</td>
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<td>KESU</td>
<td>Development Policy Committee</td>
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<tr>
<td>KTL</td>
<td>National Public Health Institute</td>
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<tr>
<td>LCF</td>
<td>Local Cooperation Fund</td>
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<tr>
<td>LDCs</td>
<td>Less developed countries</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and evaluation</td>
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<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MERGY</td>
<td>Monitoring and evaluation reference group</td>
</tr>
<tr>
<td>MEURO</td>
<td>Million Euros</td>
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<tr>
<td>MFA</td>
<td>Ministry for Foreign Affairs</td>
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<tr>
<td>MIP</td>
<td>Meeting of Interested Parties</td>
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<tr>
<td>MSAH</td>
<td>Ministry of Social Affairs and Health</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organisation</td>
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<tr>
<td>NORAD</td>
<td>Norwegian Agency for Development Cooperation</td>
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<tr>
<td>ODA</td>
<td>Official Development Assistance</td>
</tr>
<tr>
<td>OECD</td>
<td>Organisation for Economic Cooperation and Development</td>
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<tr>
<td>PAHO</td>
<td>Pan American Health Organisation</td>
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<tr>
<td>PHC</td>
<td>Primary health care</td>
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<tr>
<td>PLWHA</td>
<td>Person living with HIV/AIDS</td>
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<tr>
<td>PMC</td>
<td>Project Management Committee</td>
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<tr>
<td>PRSP</td>
<td>Poverty Reduction Strategic Paper</td>
</tr>
<tr>
<td>PVO</td>
<td>Private voluntary organisation</td>
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<tr>
<td>SARED</td>
<td>Reproductive Health, Equity and Rights Programme (Nicaragua)</td>
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</table>
SAREM ............Support to Reproductive Health and Women’s Empowerment (Nicaragua)
SIDA ...............Swedish International Development Assistance
SRHR ...............Sexual and reproductive health and rights
STAKES .............National Research and Development Centre for Welfare and Health
STIs ................Sexually transmitted infections
SWAp ................Sector-wide approach
TA ..................Technical assistance
UCCK ................University Clinical Centre of Kosovo
UNFPA ..............United Nations Population Fund
UNICEF ..........United Nations Children’s Fund
UNGASS ..........United Nations General Assembly Special Session on HIV/AIDS
UNMIK ............United Nations Interim Administration Mission in Kosovo
WHO ................World Health Organisation
WIDER ..........World Institute for Development Economics Research
EXECUTIVE SUMMARY

“Somehow, health seems to be at the bottom of the drawer for Finland.” (Senior respondent at the WHO)

This first-ever evaluation of Finland’s health development cooperation covers the years 1994-2003. Finland considers health to be one of its main development cooperation sectors and its new Development Policy focuses on poverty reduction and the Millennium Development Goals. Both are areas for which health is very important.

Policies and strategies: Finland has no health development cooperation policy or strategy. The White Papers and policies governing development cooperation in general make little specific mention of health. The absence of a health policy or strategy made it difficult for the evaluation team to review and compare Finland’s achievements in health development cooperation. To compensate, the evaluation team examined public domain documents on key Finnish positions. Our aim was to see whether these would provide a clear expression of a unified position by the government of Finland. We found the statements neither comprehensive nor focused enough for this purpose.

Resource allocation: The examination of multilateral funding levels over the evaluation period shows that UNFPA, UNAIDS, UNICEF and WHO (excluding membership contribution), which are the major multilateral partners, received a relatively stable percentage of the annual allocation to health-related contributions (approximately 11%). The absolute amount increased, particularly to UNFPA and UNAIDS. This is in line with Finland’s commitment to follow up on the ICPD conference.

The bilateral funding of health sector development contains direct state-to-state health sector programmes/projects, projects financed through local cooperation funds and bilateral programmes implemented through multilateral organisations, such as PAHO or UNFPA. The share of bilateral funding to long-term partner countries decreased continuously during the evaluation period. A significant increase occurred both in the number of non-long-term partner countries receiving bilateral health support and in the quantity of small projects. This trend runs counter to the government’s stated priorities. The growth in projects was mainly due to concessional credit schemes, particularly in China. Within the NGO financial frame, both the resources allocated to health and the number of NGO health projects increased significantly, notably between 1997 and 2001.

Involvement in key areas: The main thematic areas that the evaluation team could identify in Finnish multilateral and bilateral health cooperation are very appropriate. They include strengthening health systems, capacity building, population and reproductive health, disability and HIV/AIDS. Finland has been a leading donor in supporting disability internationally. Its active role in promoting women’s rights and a broad perspective on sexual and reproductive health is particularly important at a time, when some other donors are reducing their support to these areas.

The MFA has no official HIV/AIDS strategy, but there is ample evidence that HIV/AIDS is understood to be a multisectoral problem, with strong causal and outcome linkages to national poverty. There do not, however, seem to be any ‘White Papers’ with thorough analyses of the implications of HIV/AIDS for development cooperation and the less developed countries. There is no collection of all the position statements by Finnish spokespersons (in all sectors and international arenas) regarding HIV/AIDS. No intersectoral or interministerial networks focused on HIV/AIDS could be identified. In spite of
its multisectoral scope, programming for HIV/AIDS is left to the health sector. The Ministry for Foreign Affairs does not have an HIV workplace policy, a surprising finding for a ministry that sends its staff overseas on a regular basis.

**Aid mechanisms:** Finnish funding to *multilateral organisations* is principally provided as non-earmarked ‘core funding’ with some additional thematic support. The share of core funding appears to be declining, but the amount has increased in absolute terms. The mechanism the MFA uses for discussion and engagement in active dialogue in relation to the multilateral funding programmes is not clear. An increasing amount of funding has been earmarked for themes of particular relevance to the Finnish development assistance in the health sector. While the selected themes are important, the criteria and strategic considerations that led to the choice of these thematic areas are not obvious.

Finland’s *bilateral* state-to-state grant assistance is shifting from a project approach to a SWAp approach. While the move to a SWAp is a positive one, steps must be taken to ensure that gains made by past programmes are not lost. One option is to maintain earmarking of a smaller part of the Finnish support for areas of particular concern to Finland. Finnish assistance has been in line with the needs and priorities of the recipient countries - although not necessarily at the core of them. Finland’s flexibility and ability to provide some un-earmarked support has provided it with much influence beyond what its level of financial support justifies. By its choice of sub-sectors, Finland has supported those quarters of government that are willing to put slightly contentious health-related issues on the agenda and work for changing the health of vulnerable groups. Several informants in Nicaragua credited Finland for helping keep important issues, such as the disabled people, reproductive health and family violence, higher on the agenda than they would otherwise have been.

Non-government organisations (NGOs) are a varied group from large Finnish and international organizations to small local ones. About two hundred Finnish NGOs implement over 500 projects in almost 70 countries. The MFA has partner agreements with eight large, experienced NGOs; they receive approximately 50% of the total NGO support. No database lists all NGOs working in the health sector, which makes it difficult to assess NGO funding as an aid mechanism toward better health. Anecdotal information on the value of their contribution in health is quite positive, as they are often in a better position to address critical and potentially controversial issues than government authorities. The evaluation team is concerned, however, that NGO work appears to be isolated from the mainstream work of the MFA’s other Departments.

*Local Cooperation Funds* (LCFs) are a good mechanism to reinforce health development assistance at a country level. The availability of a LCF could also be an avenue for empowering civil society to engage meaningfully in the SWAp discussions. The evaluation team supports allowing embassies to plan the use of LCFs as part of a country specific plan. The team found a great deal of apprehension regarding the use of *Concessional Credits* (CCs) in the health sector. Consistency between social impact and the use of CCs will have to be ensured through careful preparation and monitoring of projects. CC could also be an instrument for gradually withdrawing from countries, where health sector support is being phased out.

**Key implementation strategies:** The evaluation team found little evidence of *mainstreaming*, either in relation to gender or HIV/AIDS. A process toward *participatory ownership* has been initiated, though stakeholder participation is still limited. *Capacity building* has long been considered an important part of development cooperation in Finland. Namibia represents Finland’s most consistent experience with both health system strengthening and capacity building. Many valuable lessons can be learned from Namibia, but the evaluation team was unable to find any evidence that these ‘lessons learned’ would have been applied to Finnish
health development cooperation efforts elsewhere. Finland is generally poorly prepared for any form of transition, be it a phase-out from countries or from sectors. Guidance on phase-out is thin on the ground and there appears to be no collection of relevant MFA experiences with phasing-out in various situations.

**Management capacity:** The evaluation team is very troubled by the seeming incongruence between Finland’s stated importance of health in development cooperation and its current lack of systems and processes to assure appropriate attention to health within the government structures. The team members were surprised – frankly, even startled – by the extent of weakness in the MFA’s management capacity as it relates to Finland’s health development cooperation. Many of the management issues are not specific to the health sector nor is the MFA unaware of them.

The evaluation team found it difficult to identify what management systems and processes Finland uses now to define its health sector cooperation policies and priorities and operationalise them through its aid modalities. No department or unit in the Ministry for Foreign Affairs maintains a comprehensive picture of Finland’s health development cooperation. There is no Finnish health development cooperation policy or strategy to guide strategic and resource allocation decisions. There are no clearly defined health sectoral or thematic goals that would be commonly understood and accepted by the MFA staff managing multilateral, bilateral and NGO support to health in their separate departments and divisions. And there is no easily accessible repository of key documents on health to inform these staff (as well outside consultants and evaluators) about the government’s stance regarding issues of health development.

The approach to approving new health projects is haphazard and unstrategic. The Sectoral Policy Unit of the MFA has no statutory role in enforcing sectoral policies. The sectoral health adviser has very little influence on bilateral funding decisions. The MFA’s information system is totally inadequate for evidence-based decision making about health development cooperation. It does not allow for the identification of all projects with health as a component. It focuses on funding, not outcomes or results, and appropriate disaggregation of data is not possible without considerable additional manual effort. The documentation of achievements and lessons learned is also very weak.

A disconcerting finding of this evaluation is the unsystematic manner in which Finnish bilateral health projects and programmes are monitored and evaluated – or not! Guidelines on management and evaluation are not complete, and the process for reviewing and updating them is unclear. *Baseline studies* have, in general, not been a feature of bilateral projects. Where they were undertaken, they do not appear to have been followed up. Even mid-term reviews are sometimes ad hoc decisions and tend to yield information only about project processes and not outcomes. *End-of-project evaluations* are rarely done.

The evaluation team was struck by the extreme vulnerability of the MFA’s and embassies’ staffing situation in regard to health expertise. The technical skills of both present health advisers are highly praised, but the fact that required skills and experience lie in only a few individuals, overloaded with work, makes Finland’s capacity to competently address the myriad health-related issues most precarious.

The evaluation team is very concerned about the apparent lack of planning for “growing” the next generation of Finnish health development expertise. Most of the experienced health and development experts are likely to retire within the next 10-15 years. The Ministry for Foreign Affairs does not consider building capacity in health development cooperation to be its role. In fact, it appears that no ministry or institution sees this as their responsibility.
Measurable achievements: The evaluation team was expected to examine measurable achievements of Finland’s health sector support. Putting it quite squarely, this part of the Terms of Reference proved unrealistic and unachievable, given the state of information management in the MFA. Relevant information to measure achievements was simply not available – not just to the evaluation team, but even to the MFA itself. The evaluation team heard complaints about the absence of statistics and data bases from a number of senior officials in various departments of the MFA, and from officials in the field. We fully agree - all members of the evaluation team were shocked to find that there is no data base of evaluations, not even a register of them that would go back ten years.

The evaluation report includes an analysis of gaps in information about achievements and a listing of significant (but not necessarily measurable) achievements that were highlighted during the evaluation.

Faced with the dearth of data and documentation, the evaluation team struggled to assess the relevance, effectiveness and impact of Finland’s health sector development cooperation. In reference to relevance, the Finnish development assistance to health is generally in line with the objectives in the general development principles and related statements of Finland. The relevance of the portfolio mix at a more detailed level is, however, difficult to assess due to the absence of a health policy. Regarding specific bilateral programmes, the ones examined were found to be relevant to the country needs and priorities. The effectiveness of Finnish multilateral development assistance to health is difficult to assess and cannot easily be distinguished. At the bilateral programme level, the evaluation team assesses the programmes as having been fairly effective overall in reaching their objectives. The effectiveness in mainstreaming gender and HIV/AIDS has, however, been low. Finnish assistance has probably made an impact on the lives and health of target beneficiaries. The absence of documentation, however, makes it difficult to assess in which health areas and target groups such impact would be most notable.

Finland’s strengths: This evaluation calls attention to a number of challenges facing Finland, as it seeks to strengthen its development cooperation in the health sector. But the evaluation also revealed several areas of particular strength. These include Finland’s choice of thematic areas of support; its focus on often marginalised but important areas, such as disability and sexual and reproductive health and rights; the dependability of Finland’s ‘core support’ to multilateral partners and the good alignment between Finnish bilateral support and recipient countries’ priorities. These are valuable strengths to build on, as Finland tackles the challenges confronting the operationalisation of its new Development Policy with respect to the health sector.

Recommendations and opportunities analysis: The evaluation report concludes with a detailed list of recommendations, as well as an opportunities analysis. Many of the most vexing issues affecting health development cooperation require action at a government level higher than the MFA. The opportunities analysis is presented as an input to the debates and discussions – within the MFA itself and between the MFA and its partners - on priority actions to improve the focus and management of Finland’s future health development cooperation.
### SUMMARY OF RECOMMENDATIONS
*(See 4.1. for the expanded list)*

<table>
<thead>
<tr>
<th>Policy and strategy development</th>
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<tbody>
<tr>
<td><strong>Health sector policy, strategy</strong></td>
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<tr>
<td>1. MFA should urgently develop a health sector policy and a health sector strategy.</td>
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<tr>
<td>2. MFA should develop a comprehensive database of “de facto” position statements about ‘health’ and about ‘HIV/AIDS’.</td>
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<tr>
<td><strong>Aid mechanisms</strong></td>
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<tr>
<td>3. MFA should ensure greater coherence between the different aid mechanisms in support of a health cooperation strategy</td>
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<tr>
<td><strong>Bilateral support</strong></td>
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<tr>
<td>4. MFA should keep a mixed portfolio in health cooperation with some project activity that is designed strategically, at least for an extended transition period.</td>
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<tr>
<td>5. MFA should continue to work toward budget support but also carefully consider the institutional capacities and the need for channelling more funds and TA to systems strengthening.</td>
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<tr>
<td><strong>Multilateral support</strong></td>
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<td>6. MFA should develop a strategy for multilateral cooperation that is specific by organisation.</td>
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<td>7. MFA should strengthen the consultation mechanisms on multilateral health projects.</td>
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<tr>
<td><strong>NGO support</strong></td>
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<td>8. MFA should consider preferential treatment of NGOs working in priority countries and priority sectors (such as health) that supplement other development assistance.</td>
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<tr>
<td><strong>LCF support</strong></td>
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<tr>
<td>9. MFA should use the LCF to support civil society organisations and agendas related to the sector focus in the country.</td>
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<tr>
<td><strong>Operational research to inform decisions and advocacy</strong></td>
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<tr>
<td>10. MFA should commission operational research studies to document lessons learnt and emerging good practices in its long-term partner countries</td>
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<tr>
<td>11. MFA should, with urgency, articulate a workable strategy to improve its phasing out practices.</td>
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<tr>
<td><strong>Cross-cutting issues</strong></td>
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<tr>
<td><strong>Mainstreaming (HIV/AIDS and other themes)</strong></td>
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<tr>
<td>12. MFA should develop and articulate an HIV/AIDS mainstreaming strategy with the utmost urgency.</td>
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<tr>
<td>13. MFA should undertake or commission the preparation of analytical ‘White Papers’ on HIV/AIDS in all of its long-term partner countries</td>
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<tr>
<td>14. MFA should improve its information management regarding cross-cutting issues in the health programme it funds.</td>
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<tr>
<td><strong>Attention to equity and complexity</strong></td>
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<tr>
<td>15. MFA should strengthen support for continually testing and improving stakeholder participation in the changing environment of health cooperation for poverty reduction.</td>
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<tr>
<td><strong>Management</strong></td>
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<td><strong>Annual planning for health sector</strong></td>
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<td>16. MFA should undertake a ‘small’ review of the development assistance to health in its totality, i.e., across all aid mechanisms, on an annual basis.</td>
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<tr>
<td><strong>Human resources</strong></td>
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<tr>
<td>17. MFA should use lessons learnt to develop suitable hiring criteria and job descriptions for decentralised health sector advisers.</td>
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<tr>
<td>18. MFA should prepare a short and long range plan for human resource development that particularly addresses the need for development staff in health (and other sectors).</td>
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<tr>
<td>19. MFA should recruit and support a specific HIV/AIDS adviser to promote HIV/AIDS issues effectively with all of MFA’s partner countries, priority sectors, and partner organisations.</td>
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<tr>
<td><strong>Information support and management</strong></td>
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<tr>
<td>20. MFA should urgently refine and improve the utility and performance of its information system to allow sector-specific analyses of all projects and their components.</td>
</tr>
<tr>
<td>21. MFA should improve the archiving of documents in the headquarters and at all embassies and diplomatic missions/liaison offices.</td>
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<tr>
<td>22. MFA should revise its project/programme evaluation guidelines and develop a quality assurance mechanism to ensure they are followed.</td>
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1 INTRODUCTION

Finland has declared health to be one of its main development cooperation sectors, stating that it sees better health both as a goal in itself and as an essential ingredient to improving a country’s economic and social status.¹ The role of health in Finnish development cooperation has recently become even more prominent than before. The focus of the Government’s new Development Policy is on poverty reduction and the Millennium Development Goals (MDGs).² Poverty and ill health are closely linked and three of the eight MDGs directly target better health.

Following the adoption of the new Development Policy and cognizant of changes occurring in the international development arena, the Ministry for Foreign Affairs (MFA) commissioned an evaluation of Finland’s development cooperation in health covering the period 1994-2003. Such an evaluation had never been done, though individual health projects have been evaluated. The evaluation was awarded through an international tender to the Euro Health Group (EHG), a Copenhagen-based consulting company. The EHG fielded a four-person team of consultants, composed of Dr. Riitta-Liisa Kolehmainen-Aitken (team leader), Dr. Tom Barton, Dr. Ulrika Enemark and Ms. Hope Chigudu.

The evaluation was conducted between September 2004 and March 2005. The study methodology consisted of an extensive review of documents, interviews with key informants, an in-depth study of Finnish health development cooperation in Mozambique, Nicaragua and Kosovo and an examination of Finnish support to WHO and UNAIDS.³ After reviewing a preliminary set of documents from the MFA, the consultants visited Helsinki, where they met with the MFA staff, interviewed key informants and collected additional documents. The initial, very ambitious terms of reference were revised during this visit. (See Annex 1 for terms of reference and Annex 2 for methodology.) The bilateral countries/areas and multilateral organisations to be studied in more depth were selected shortly afterwards in collaboration with the MFA. The evaluation team used the country and multilateral visits to verify preliminary findings, capture stakeholder perspectives and examine data that were only available at the local level. Following the country studies and before drafting the final report, the evaluation team met to compare individual findings and achieve consensus on recommendations.

This evaluation report is first and foremost intended for the Ministry for Foreign Affairs (MFA) and the Development Policy Committee (DPC). The MFA is charged with operationalising the new Development Policy, while the DPC holds the oversight responsibility for it. The report is also written for the other government ministries and institutions, non-governmental organisations and private sector entities that are committed to seeing Finland give the much needed and appropriate attention to health as an essential ingredient of development.

The context in which Finnish health development cooperation works influences both its strategic directions and operating reality. The report starts by briefly discussing Finland’s overall development policies and the human, financial and institutional setting, in which these policies are put into action. Recommendations of previous health-related evaluations are reviewed briefly. A look at the important international trends that affect health development aid globally concludes the context chapter. The main body of the report focuses on the findings. The chapter starts by examining Finnish health development

policies, strategies and thematic areas of support, followed by the allocation of financial resources for health sector support. Finland’s involvement in key priority areas - poverty, vulnerability, disability and HIV/AIDS - is addressed next. An analysis of the different aid mechanisms precedes a review of key implementation strategies (e.g., mainstreaming and phase-out). Findings related to management capacity are discussed under the headings of human resources and management systems. An assessment of measurable achievements in Finland’s health sector support concludes the chapter on Findings.

The report presents both a detailed list of recommendations and an opportunities analysis. While the MFA itself can take action on several recommendations, many of the most vexing issues require action at a higher government level. The evaluation team offers the opportunities analysis as an input to the debates and discussions on priority actions that should be taken to improve the focus and management of Finland’s health development cooperation.

The evaluation examined Finnish health development cooperation funded through the ODA budget. Thus, the report does not cover Finnish support to strengthening the health sector in Russia and the Baltic States. It excludes a detailed examination of concessional credits, humanitarian aid and development research. These areas have either been evaluated recently or were being evaluated at the time of this evaluation. Gender is discussed in the report under the MFA’s mainstreaming strategies. An in-depth analysis of gender issues is not attempted, however, since a separate gender evaluation was getting underway as this evaluation was going on. The evaluation also did not look at private sector contributions to international development cooperation from Finland, e.g., funds raised through Finnish NGOs, whether used in partnership with the MFA or independently.

The expansive scope of work for the evaluation meant that the team has not been able to examine all the myriad issues to the same depth. The notable lack of documentation and unavailability of relevant statistical information at both the central and country levels further constrained the evaluation team’s work.

Two comments regarding the use of language are in order. First, this report uses the term, ‘HIV/AIDS,’ for the sake of simplicity and coherence with the existing documentation from the MFA and its partners. The evaluation team does recognise that some debate exists at the international level about the use of ‘HIV/AIDS’ versus ‘HIV and AIDS.’ Second, the team uses the word ‘policy’ to denote the official position of a government (or an organisation) on a particular issue. The word ‘strategy’ is used to signify the approach and means by which the policy goals and development objectives are reached. The evaluation team has noticed that these two terms are used inconsistently in some Finnish documents, when they are translated into English. Furthermore, the team was not always clear, whether the Finnish term ‘linjaus’ is intended to mean ‘policy’ or ‘strategy.’ Individuals and documents appear to vary in the way they use this term.

Finally, the evaluation team would like to thank the MFA Unit for Evaluation and Internal Audit. Its staff guided the evaluation team’s work, responded promptly to its many requests, and greatly facilitated interaction with other MFA staff and Finnish embassies. The team is very grateful to MFA’s advisers for health, social policy and gender, who graciously made time to meet with the evaluators in spite of their busy schedules. We also owe our gratitude to the many individuals in the Ministry of Social Affairs and Health (MSAH), other government ministries and institutions, Finnish embassies, consulting companies and NGOs, who so openly shared their perspectives with us. Most importantly, the team would like to acknowledge the numerous individuals in Finland’s partner countries, with whom the team members met in the field. They were generous with their time in providing their perspective on Finnish development cooperation in health. Suuret kiitokset!
2 CONTEXT

Living conditions in many less-developed countries are deteriorating, even while some developing countries have progressed over the past few decades. Especially in Africa, the multiple negative outcomes of the HIV/AIDS pandemic are seen in shorter life expectancies, loss of qualified human resources, and a burgeoning drain on the national economies. The world remains very unequal with deep gaps in the standard of living, despite all the development efforts and achievements of concerned citizens and governments around the globe. As noted in Finland’s 1996 Decision in Principle, the motives for development cooperation, solidarity and the moral imperative to aid people in need are thus as valid as ever.

Finland has engaged in international development cooperation since 1961. In the past ten years in particular, it has progressively clarified its development principles and country partner selection criteria. Development cooperation has been guided by a series of policy documents and partnering arrangements. Coherence of policies and the movement toward harmonisation of development endeavours with other donor partners have been key aims.

2.1 Finnish overall development policies

2.1.1 Coherent policies

Finland’s goal is to support political and economic reform and manageable change in developing countries, and thereby create conditions for peaceful, sustainable development and well-being. A more unified foreign policy approach is replacing the aid-fixed scope of development cooperation of early years. Development cooperation is seen as a means to provide long-term support for improving the capacity of societies to deal peacefully and effectively with the root causes of poverty. An important concurrent effort is the work toward coherence between policies that address the various dimensions of globalisation. The positions taken by Finland and other like-minded governments - whether about development, health, social security, finance or trade - should be informed by common thinking and common values, seeking to promote more equitable, rule-based globalisation.

The latest Development Policy (2004) makes a clear call for policy coherence for development. It states that development policy refers to coherent activity in all sectors of international cooperation and national policy that have an impact on the status of developing countries. These include security, human rights, trade, environment, agriculture and forestry, education, health and social welfare, immigration, and information society policies. Development cooperation is seen as a key instrument of development policy.

MFA officials working in development co-operation see a need for enhanced capacities to identify, prioritise and address issues in policy coherence, as well as to handle the complexities and conflicts that often characterise policy coherence considerations.

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5 Ministry for Foreign Affairs, Finland. (1996) Decision-in-Principle on Finland’s Development Cooperation by Department of International Development Cooperation.
6 The Cabinet (1998) Finland’s Policy on Relations with Developing Countries, October.
7 OECD (2003). DAC Peer Review Finland.
2.1.2 Development priorities for partnering

2.1.2.1 Bilateral cooperation

The 1993 Development Cooperation Strategy stated that the priorities in Finland’s bilateral development cooperation were the cumulative result of choices made over nearly thirty years. They reflected one distinct, and still valid, basic principle, namely that development cooperation should concentrate on the poorest countries (in terms of per capita GDP).

In the 1996 Development Cooperation Decision-in-principle, the MFA articulated partner countries of choice as two main categories, either countries suffering major political-economic crises (e.g., being at war or just emerging from conflict) or impoverished but politically stable countries. The document also opened the scope for pursuing a more flexible policy in the choice of partners and a capacity to react to rapid political and economic changes in developing countries.

The plan for operationalising the 2001 Development Cooperation Decision-in-principle laid out a more detailed set of criteria for long-term partner countries. The essential principles for long-term partners expressed a sharp focus on poverty, but also expected a partnership commitment by the developing country. Finland emphasized that the developing countries are responsible for their own development and that the donor’s role is always merely a supportive one. Work in countries other than the limited set of long-term partners would be based on thematic cooperation. It would largely rely on modalities other than direct government to government cooperation, e.g., through NGOs and multilateral agencies.

At the international level, Finland has followed the lead of many other development donor countries in limiting the number of partner countries. In the next few years, Finland plans to focus on eight to ten long-term partner countries. Finland focuses its bilateral ODA on Africa (46%) and least developed countries (43%). The aid is, however, relatively widely dispersed.

Since the mid-90s, Finland has maintained the option to respond flexibly with aid, when an acute situation warrants support outside of its long-term programme. A commentary in 2000 on Finland’s patterns of cooperation pointed out that

"Traditional long-term partnership with a relatively small number of selected primary recipient countries continues to attract the main emphasis of Finland’s bilateral development co-operation. …The flexibility concept, included in the (1996) decision-in-principle, has the potential to extend the geographical range and strengthen the overall effectiveness of aid through greater policy coherence. Examples of activities that come under the concept of flexibility are co-operation for a limited period with some countries, trilateral co-operation, thematic multi-bi-co-operation with certain UN agencies, funds for democracy and human rights managed by the Finnish embassies as well as foundations established by Finnish NGOs in the fields of human rights, environment and assistance to the disabled. While providing for opportunities to assist in achieving short-term goals with this approach, the concept of flexibility does not change Finland’s principles of commitment to long-term partnership and programmes, but is complementary to them." (Carlsson et al., 2000)

2.1.2.2 Regional cooperation

The MFA stated in the 1996 Development Cooperation Decision-in-principle that some of its development cooperation can be carried out through regional cooperation projects. In the

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1998 Policy on Relations with Developing Countries, Finland underlined the role of regional integration and the importance of regional trade and networking in reducing marginalization and the threat of growing poverty in the developing countries and planned to support the developing countries in enhancing integration.

2.1.3 Sectoral orientation priorities

In the 1993 Development Cooperation Strategy, the MFA considered that the choice of regions and countries had first priority. The choice of sectors was second, based on local need and development priorities and Finland's ability to offer quality resources in the key sectors selected.

2.1.3.1 Project versus sector support

Geographic area-based focus has been a guiding influence on many Finnish provincial or sub-national projects and programmes. Development cooperation agencies in general have long been attracted to the concept of area focused development work. It makes combining (or integrating) inputs from multiple sectors more feasible, thus providing a stronger push for development. Targeting interventions to specific poverty groups (like squatters, small farmers and female-headed households) also becomes much easier. (Carlsson et al., 2000)

In the late 90s, the trend in bilateral support was moving away from pure investment projects towards integrated technical assistance and institution and capacity building. As a way of enhancing poverty reduction, Finland has, however, increasingly become fully committed to utilizing the new aid modalities, such as basket funding and budget support, as well as to harmonisation of procedures. As noted by the DAC peer review (2003), analytical capacity for the sectoral basket funding and budget support strategies is still limited in the MFA. The guideline for budget support was developed only recently.

2.1.3.2 Priority sectors

Regarding Finland’s choice of programmes and sectors, the 2001 policy states that these will be based on the priorities set in the poverty reduction strategies of partner countries on the one hand and on Finnish policies on the other. In line with the development goals set out in the Millennium Declaration, Finland’s development cooperation aspires to emphasise the sectors and themes in which Finland can exert an influence based on the experience and know-how that has been accumulated. Finland has committed itself to the achievement by 2015 of the Millennium Development Goals (MDGs). Like most DAC members, it is struggling to develop appropriate mechanisms to ensure that the entire aid programme is engaged in the promotion of MDGs.

2.2 Human resources

“...with a substantial increase of Finnish ODA in prospect, concerns are surfacing as to sufficiency of development co-operation policy and administration skills in the MFA, and the perceived lack of development specialists in the Ministry.” Saana Consulting (2004)

In the last decade, the Ministry for Foreign Affairs has coped with growing expectations for its services within stagnant budget and staffing levels. The Ministry’s organisational structure has undergone several major reforms and minor adjustments. A key structural change was merging the separate diplomatic and development career tracks in the second half of 1990s after FINNIDA was abolished. Staff in permanent development track positions were moved to the diplomatic track or placed in general career posts until retirement.
The MFA's current staffing structure is marked by a very rapid turnover of country desk officers and heavy reliance on motivated but inexperienced young staff, many on short-term and temporary contracts. Most of the 65 development officers still on the MFA payroll will be lost through retirement in the next 10 years.\textsuperscript{10} There is increasing concern that the MFA's current staff capacity does not match the demands of implementing the new Development Policy, either in the number of staff with development expertise or in the skill mix. The recent evaluation by Saana Consulting of the MFA's administrative and resource development needs, referenced above, addresses these issues in more detail.

Sectoral or thematic advisers, working in the MFA’s Unit for Sectoral Policy, provide specific development expertise in their respective sectoral and thematic areas. The advisers are hired on a contract basis with varying contract terms. The MFA in Helsinki employs one health adviser. A second health adviser works in the Finnish embassy in Mozambique through a recent pilot experiment, with the adviser hired through the MFA’s Department for the Middle East and Africa. A third health adviser will reportedly be placed shortly in the Nicaragua embassy under a similar arrangement.

2.3 Overall financial resources

The Finnish official development assistance decreased following the economic crisis in the early 1990s. A significant downward trend occurred over the period 1990-94, partly as a result of slightly decreasing GNI, but mainly due to reprioritisation of the public budget during the economic crisis. The percentage allocation to development assistance dropped from a high of 0.73\% of GNI in 1990 to 0.38\% by 1994, and then stabilising around 0.34\% of GNI over the period 1997-2003. This corresponds to the EU average, but is far below the average for the other Nordic countries. However, Finland still ranks ninth among the OECD/DAC countries in terms of % of GNI allocated to development assistance. In absolute terms, there has been a positive real growth in development assistance because of the increasing GNI.

There seem to be no clear criteria or guidelines for prioritisation of resources within MFA and between sectors. In 1994, the share of multilateral assistance was low (26\%), mainly due to the need for maintaining funding levels in bilateral projects combined with a smaller overall portfolio. Over the period 1995-2003, the development assistance to multilateral ranged between 42-48\%. This was consistently higher than the DAC average.

The government of Finland is committed to increasing development cooperation funds to 0.44\% of GNI in 2007 and aiming at 0.7\% in 2010. According to the new Development Policy, most of the funding will be channelled through bilateral assistance focussing on programme countries. An increase in NGO funding (reaching 14\% in 2007) is also envisaged. Further, 5\% of the annual increase in operational development funds can be allocated to administrative expense appropriations.

The reviewed period has thus been one of relatively stagnant resources for development cooperation, characterized by a need to adapt to the drastic reduction in aid just a few years earlier. There is scope for considerable expansion of development cooperation in all sectors for the coming period. It will be important to consider how to prioritise the expansion.

2.4 Institutions and organisations

The oversight of Finnish development cooperation belongs to the Development Policy Committee. It was established by the Cabinet in October 2003 as advisory to the whole government. The Committee’s mandate is to steer Finnish development policy

implementation, evaluate its quality and effectiveness and monitor levels of public funding going to development aid. It is also charged with promoting the coherence of Finnish development policy and ensuring that the policy supports the MDGs. The Committee’s membership represents the composition of the Finnish parliament and society. The DPC presented its first annual report on the state of Finnish development policy in February 2005.

The Ministry for Foreign Affairs plans, manages and supervises Finland’s development cooperation as an integral part of Finnish foreign policy. The MFA’s current organisational structure is a matrix of policy and operational departments. Its Department for Development Policy (DDP) includes a Unit for Sector Policy, whose role is to set sector or thematic policies and advise the geographic (i.e., operational) departments of the MFA. The Unit for Non-Governmental Organisations in the same Department is responsible for development cooperation through NGOs. Geographical Departments manage the bilateral projects, while the Department of Global Affairs is responsible for multilateral development cooperation.

The Ministry of Social Affairs and Health (MSAH), the National Research and Development Centre for Welfare and Health (STAKES) and the National Public Health Institute (KTL) are the Finnish government health institutions of most importance for health development cooperation. The MSAH pays Finland’s assessed contribution to the WHO’s regular budget and cooperates widely at both multilateral and bilateral levels. The Ministry oversees STAKES, an expert agency that produces information and know-how in health for decision-makers. The International Development Collaboration (IDC) unit of STAKES is a Finnish expert organisation in international health and social sector development. It provides technical assistance, training and other consulting services. The KTL, another expert body under the Ministry of Social Affairs and Health (MSAH), has research, training and public health service functions. It also collaborates internationally.

The first health sector strategy paper for Finnish health sector development cooperation was approved by the MFA in 1986, and emphasised the importance of supporting primary health care and its components. The strategy was prepared by representatives of the MSAH, the Finnish National Board of Health and the MFA. In order to implement this strategy, it was necessary to systematically develop Finnish human resources for health sector development cooperation on a long-term basis. The strategy was supported by establishing a library that gathered international sectoral guidelines and "lessons learned" information on health sector projects and helped ensure dissemination of this information.

HEDEC (Health Development Cooperation Group) was founded in 1990 as a unit within the National Board of Health. The founding document stated that the main aim of HEDEC was to work on a long-term continuous basis to improve the quality and contents of the Finnish health sector development cooperation. The Ministry for Foreign Affairs originally established the HEDEC unit based on a four-year project funding, but the funding was discontinued later in order to open up the tender process. Two key external events convinced STAKES (the successor to the National Board of Health and the parent body of HEDEC) to retain the functions of HEDEC as a self-sustaining unit. The first was Finland’s eligibility to apply for development funds through the European Union after it joined the EU. The second was the need to respond to the health needs of neighbouring Russia after the disappearance of the Soviet Union. HEDEC subsequently started to implement neighbouring area interventions - in collaboration with MSAH - and EU projects in both health and social welfare sectors, changing its name to International Development Collaboration at STAKES.

The IDC has over the years formed into a valuable centre of Finnish expertise in health development cooperation. Though it functions as a consulting company, it has a special
advisory role to the MFA under a three year contract, ending in December 2005. Given this advisory role, it does not currently generally bid on projects funded with Finnish ODA funds. The IDC maintains close links with the MFA and the MSAH. It remains self-financing, a requirement that can threaten its organisational sustainability. Another potential threat is the outcome of an emerging debate about the future of its parent organisation, STAKES. The recently released Huttunen report on the development of Finnish government’s sectoral research capacity recommended merging most of STAKES into a new entity that would combine several existing government health institutions.11

Consulting companies and non-governmental organisations are other organisations of relevance to health development cooperation. Finnish consulting companies with past or present health projects are few in number; even fewer work exclusively in health. The NGOs include small NGOs in Finland and some local NGOs in partner countries, large long-established Finnish NGOs with MFA partner contracts and Finnish-supported international NGOs. The Finnish NGOs are a large and varied group, implementing a widely varied set of projects, many with health as one component. KEPA (the Service Centre for Development Cooperation) is the umbrella organisation of Finnish NGOs.

Universities and research institutions undertake development related research. The most prominent are the Institute for Development Studies (IDS) in the University of Helsinki and the World Institute for Development Economics Research (WIDER) of the United Nations University. It is interesting to note that when asked which institutions conduct health development research, several respondents mentioned the IDC in STAKES. The IDC itself does not see research as being its role and does not have funding for it.

2.5 Previous recommendations

While the present evaluation is the first overall health sector evaluation for Finnish development cooperation, there have been some smaller evaluations of Finnish assistance to health sector projects and programmes. Unfortunately, the majority of these evaluations have been mid-term reviews, which means that they have focused on processes and output targets, and not included any review of outcome level changes, e.g., effects and impacts. The output targets are usually physical or institutional. No information exists about results of those achievements on the population, either in terms of service utilisation or deeper changes in disease and poverty patterns. These evaluations have also noted a lack of indicators for monitoring health sector effects/impact on poverty reduction.

The past evaluation reports also indicate that much less attention has been paid to cross-cutting themes, i.e., the ‘soft issues’ related to ownership and participation, disability, HIV/AIDS and gender. Finnish development policy has become more explicit in its concern to mainstream gender in all sectors, including health. However, past evaluations note that operationalising and integrating a gender strategy has not been systematically pursued within the health sector.

Another critical and recurrent issue in the evaluation reports has been a concern about human resources. Part of the criticism was levelled at the Ministry headquarters, where there has been a long-standing problem of rapid staff turnover in the desk officer positions, contributing to loss of institutional memory. Desk officers are in a crucial support role to the field operations, but they are always on a learning curve trying to catch up to the projects and staff in the field. Concern has also been expressed about the quality of persons recruited as technical advisers on projects, with examples of both ‘good’ and ‘bad’ staff at

different times and phases in both of the present long-term partner countries for health – Nicaragua and Mozambique.

Annex 6 shows some selected health-related recommendations from past evaluations and comments on their current implementation status. Even if most of the recommendations are country specific, they have wider implications for the whole health sector programme support.12

2.6 International trends affecting health development aid13

2.6.1 Policy focus

Over the evaluation period, especially in the early 1990s, some major shifts took place in the international development arena. The World Development Report 1993 focused on the need to concentrate scarce public financing on a cost-effective basis and develop affordable health services. The emphasis on strengthening district health services to improve health was broadened. Increasing recognition was given to strengthening the management of government health services in order to improve effectiveness and efficiency in service delivery. Such improvements would require fundamental changes across the health sector. This brought the emphasis on health sector reform to enhance performance of health care systems and work towards sustainable health care financing.

In the same time period, WHO and the various UN world conferences on the social sector increasingly highlighted and promoted human rights, including the emerging consensus on health as a human right.14 The Cairo International Conference on Population and Development (ICPD) in 1994, in particular, made the linkage between human rights, reproductive rights and health. It thereby broadened the scope of reproductive health beyond population control and refocused the work of UNFPA, for example. These conferences also resulted in an increasing focus on the importance of gender in health.

The international financing institutions (IFIs), especially the World Bank, have been key players in setting the broader development agenda that also affects the health sector. The role of the IFIs has changed from a focus on strict structural adjustment measures with a view to improving the macroeconomic situation with little regard to the negative social effects to a broader, comprehensive focus on poverty reduction, recognising the importance of the social sectors. The World Development Report 2000 recognised social development as having intrinsic value, as well as being instrumental in achieving economic growth. Poverty reduction became the main focus for development assistance. Its definition became increasingly broad, relating no longer solely to income, but to general access to financial and

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12 Although efforts were made to find as many relevant documents as possible, it is unavoidable that some relevant reports or documents have not been studied.
human resources. This placed the education and health sectors in a key role. The World Bank and IMF proposed the Highly Indebted Poor Country initiative (HIPC), which aims to make debt service burdens manageable through a mixture of sound policies, generous debt relief and new inflows of aid. The debt relief would free resources for higher spending targeted for poverty reduction, including spending in the health sector. Some countries also emphasised the link between poverty reduction and security, encompassing social, environmental and military security.

At the World Summit in 2000, most governments adopted and signed the Millennium Development Goals. The major IFIs have now also committed to the MDGs. Three of the seven main goals pertain to health - reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases.

### 2.6.2 Aid mechanisms

In the beginning of the evaluation period, individual donor views on health sector reform were the main determinants for strategic choices. In several countries, donors balkanised the country by adopting different provinces, to which they applied their specific model for health systems development. Several donors, the Nordic countries in particular, soon engaged in a strategy of active multilateralism, with a view of influencing policies and strategies. Towards the end of the 1990s, there was a revival of multilateral initiatives to work on health systems development. The small donors tended to emphasize the importance of the UN system and fund a relatively large share of the multilateral budget. The period also saw increased coordination among the group of like-minded donors vis-à-vis the multilateral organisations.

A big new multilateral organisation emerged with the creation of UNAIDS in 1995, as did several large public/private international funding mechanisms. As the health sector reform agenda worked to integrate efforts and eliminate vertical disease control programmes, new vertical funding mechanisms emerged. The Global Alliance for Vaccines and Immunisation (GAVI) was established in 1999 and the Global Fund to Fight Aids, Tuberculosis and Malaria in 2002.

The EU Treaty of 1992 included development assistance. In Northern Europe, the European Development Assistance and the European Development Fund have become an increasingly important channel for funding.

In striving towards greater effectiveness in bilateral aid, donors were increasingly selective in choosing whom to support and in terms of concentrating efforts. Several donors are now concentrating their aid on a lesser number of countries and fewer sectors, resulting in fewer and larger health sector programmes. The main country selection criteria, in principle, seem to relate to good governance. In practice, history also plays an important role.

### 2.6.3 Resource allocation

OECD/DAC has developed a common reporting system for statistics on development assistance in order to facilitate a comprehensive picture and comparisons between countries. The DAC statistics definition of “aid to health” includes two DAC sectors, Health (code 120) and Population policies/programmes and reproductive health (code 130). This

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15 Two important High Level Forum Meetings on Health MDGs took place after the evaluation period (January and December 2004). They focused on the health workforce and health sector aid financing.

16 The group consists of Finland, Denmark, Norway, Sweden, Netherlands, UK and Ireland. It is also sometimes referred to as the 7+ group, because others are involved in various settings.

17 DAC sector 120 includes health-general and basic health; DAC sector 130 includes population policy and administrative management, reproductive health care, family planning, STD control including HIV/AIDS and personnel development for population/reproductive health.
evaluation is concerned with the health sector broadly defined, thus including sexual and reproductive health and HIV/AIDS (covered under code 130). One limitation with the DAC statistics is that currently each activity can only be assigned to one sector/purpose code, and the statistics only capture activities with health/population and reproductive health as their main purpose. This is particularly a problem when multi-sectoral approaches are used, for example in addressing HIV/AIDS or where a programme contains elements under several headings. Thus, the DAC system may sometimes underestimate or overestimate the amounts effectively made available.

Among DAC countries, about 7% of the total bilateral ODA and multilateral bank lending for ODA was directed to health in 2000. This share remained more or less unchanged over the past 10 year period. The share of bilateral ODA allocated to health between 1990 and 1998 among the like-minded donors ranged from 6% for Norway to 10% for UK and Denmark.¹⁸ According to DAC, about one-third of bilateral aid to health (DAC sectors 120 and 130) is used for basic health, one-third for general health and one-third for population health programmes.

### 2.6.4 Aid implementation strategies

Sustainability problems of project support and the recognised need for local ownership and broader health systems development resulted in a general shift from projects to sector programme support. Recipient countries under programme support are responsible for priority setting, planning and implementation of the development aid - guided by an active dialogue among development partners. The development partner provides the financial and technical resources needed for implementation and monitors resource use against objectives.

A recognition of the fungibility of funds and the need for increased effectiveness in aid has led donors to call for a broader view on health sector expenditure programmes and for overall consistency in health sector priorities. Increasing numbers of donors and recipient governments have started working towards the sector-wide approach (SWAp). In a SWAp, all significant funding supports one single sector policy and expenditure programme of the recipient government. This process moves the donor/recipient partnership towards common approaches and reliance on government procedures for disbursement and accounting for all funds. The SWAp is increasingly being combined with new funding modalities, such as sector budget support and pooling of donor funds, in small or large pools. The guidelines for budget support are very similar in the Nordic countries. While Denmark started shifting its assistance toward SWAps earlier, Sweden and Finland appear to be headed more towards pure budget support.

Capacity building has been a key implementation strategy for improving sustainability and enhancing self-reliance. Capacity building as a concept has evolved over the period from merely meaning necessary training of relevance to the project in question to being a much broader range of support, targeted at institutional and systems development and with financial resources and TA as the main input. Concerns about the large share of technical assistance in development aid, as well as increasing capacities in developing countries, resulted in downsizing the use of technical assistance and a shift from international to local TA.

There has been a lot of rhetoric about mainstreaming cross-cutting issues, e.g., gender, into the implementation of health sector support. In reality, the operationalisation is generally lagging behind. In addition, and perhaps quite importantly, although several issues are thought to cross-cut through health (gender, disability, elderly, HIV/AIDS), there does not

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seem to be any pattern or capacity to consider how health cross-cuts other sectors, including education, forestry, governance, etc. The use of Health Impact Assessments (parallel to Environmental Impact Assessments) in appraisal of aid across sectors is being discussed.

### 2.6.5 Aid management

Quality of aid matters as much as its quantity. By second half of the 1990s, there was an emerging consensus about the need for sound preparatory analysis in areas that had not traditionally been in focus in health project development, e.g., economic, socio-cultural and institutional analysis. The inclusion of such analyses in bilateral cooperation plans became increasingly important, as the focus of support was health sector reform broadly.

In line with the shift from project to programme assistance, programme management tended to move from parallel project implementation units to integration with the government system. The like-minded donor group has been especially active in driving the move towards improving quality in aid through aid harmonisation, alignment of priorities and strategies and coherence in aid activities. OECD/DAC has played an increasingly important role in working towards improving the development assistance of the member countries through development of norms and guidelines for effective assistance, monitoring of development assistance of member countries (peer reviews, cross-cutting reviews) and collection of statistics. Recently, the Rome Declaration on Harmonisation in 2003 further strengthened the push towards common management structures and a unified format, at least for the donor group.

While the aim is for management structures to be in line, as much as possible, with recipient government planning, accounting and monitoring systems, governments are at various stages of development. Some progress has taken place, in particular over the past 3-4 years. A few donors have also started entering into an active-passive partnership, where one donor manages aid on behalf of the other donor, e.g., NORAD and SIDA in Malawi and Laos, DFID and the Dutch Government in Nicaragua and Ghana.

All donors have intensified the work to improve measurement of achievements in development assistance in the longer term. There is a trend towards results-based management with more focus on the achievement of objectives and monitoring of impact indicators. Likewise, there is a trend away from project evaluations towards sector evaluations, country evaluations and joint evaluations. Evaluation results are increasingly used as basis for decisions on how to maximise health sector achievements by linking development assistance to interventions that bring the best results.

### 3 FINDINGS

"Somehow, health seems to be at the bottom of the drawer for Finland." (Senior respondent at the WHO)

Diseases and health risks have become issues of common concern for all countries in the world in the face of increasing globalisation. In Finland, public support for development and cooperation on health are strong. A recent public opinion survey found that 99% of a
sample of 1,000 Finns generally supports development assistance, and 69% favours giving priority to expenditures on health. (PAI, 1998) Finland does not, however, have a health development cooperation policy, and the White Papers and policies governing development cooperation in general have made little specific mention of health (or of other sectors). Finland’s overriding focus has been poverty reduction and general development of poor countries. The choice of regions and countries in which to work has been given more importance than the choice of sectors.

The latest Development Policy (2004) places a strong emphasis on the importance of the health sector to development. It recognises that improved health is an integral part of poverty reduction and essential for reaching the Millennium Development Goals. The new Development Policy of 2004 is very committed to working towards the MDGs. Its main health focus is on combating global health risks, curbing the HIV/AIDS pandemic, and improving preventive primary health care in developing countries.

3.1 Policies and strategies

3.1.1 Absent health policy

Background
Some respondents reported during the present evaluation that there had been little interest in a health policy since the mid-80s. Apparently there used to be a health strategy paper in the days of FINNIDA, but it was an internal document and not printed for wider circulation. In the early years, there were also guidelines that were prepared to improve the health sector data base, and an annual list of projects was circulated. These efforts were undertaken to raise the standard of the sector, and to enable discussions about health sector issues with politicians.

Present status
Several respondents reported that a full and comprehensive picture of Finnish contributions to international health is not in the hands of anybody. There is also no person or programme advocating strongly for health development cooperation in the country, despite favourable public attitudes. In part, this may be a reflection of only having one health adviser, who is considerably overburdened, but it is also a reflection of the lack of a cohesive position on health. Although there is a sector policy on forestry, it seems that some senior ministry staff appear unwilling to be bound by a health policy.21

One respondent was moved to comment on a perceived difference between the rhetoric and the reality by stating that the MFA “keeps saying that health is a priority, although not entirely honestly.” Another respondent felt “crushed” by the status of the Finnish international health sector – no annual plan, no policy or strategy, and no good source of new projects.

On the other hand, one respondent with long experience in the MFA said that the total funds for development are low. Funds for health are so low overall that “they don’t amount to a hill of beans, so how much policy is actually needed?” The evaluation team also heard opinions that a Finnish health strategy “is there, but not written down”, e.g., that it is clear in commitments made at Cairo.

Some of the concern about having a “full-blown” policy and strategy stem from worries about the amount of work and resources needed to develop them. In particular, some respondents were recalling the difficulties in working on the big development strategy document of 2004.

21 Some informants at the MFA told the evaluation team that there is also a sector policy in education, but this was disputed by others.
Preparing that document was evidently a major challenge to the MFA and required a lot of time and work to reconcile all the disparate views and arrive at shared views.

Consequences
The absence of a health policy means that it is hard to review and compare achievements in the health sector. MFA staff working with multilaterals acknowledged that the absence of a health policy or strategy made their life more difficult. They said there are some issues where it would help to have a statement and not just be making ad hoc decisions. They conceded that the ever-changing rotation of staff means that there is little or no memory of the institutional decisions and position statements. For that, a policy would help.

“In dealing with the multilaterals, we have to deal with this all the time. We have to clarify for ourselves and have to learn these issues.”

Some respondents believed that the bilateral side needs the support of a health strategy even more than the multilateral side, and that it would even help in financing the sector. As the ambassador stated in one of the countries visited, “The lack of a policy leads to situation with new people who want to start over or to start fresh with ‘new’ (but ill-informed) ideas. It is hard for me as an ambassador to provide support without a clear policy.” He also pointed out that it is hard for the desk officers, who are changing frequently, to provide good support to bilateral projects in health without a policy.

‘De facto’ policy – Finnish position statements
The evaluation team followed up the suggestion that there may actually be a number of documents in the public domain that represent or present key Finnish positions on health and HIV/AIDS in international development. Requests were made to the MFA for such documents, but the MFA was able to provide only one or two examples. An extensive search on the Internet did yield more examples (see Annex 7 - Documents of/about position statements on health and/or HIV/AIDS by Finland), but these statements are neither comprehensive nor focused enough to be useful in the ways suggested or required by the respondents mentioned earlier. They could offer a starting point for the development of a policy or strategy, but certainly cannot be taken as a clear expression of such a unified position by the government of Finland.

3.1.2 Thematic areas of support in health
Finland’s main thematic areas of support in health have included capacity building, strengthening of health systems, especially in primary care, population and reproductive health and HIV/AIDS. Finland stresses the enhancement of developing countries' own primary health care systems, social services, and social protection organisations. As noted in the Development Policy (2004), primary health and social service systems must be of good quality, comprehensive and easily accessible to all.

In addition to primary health care services, women’s rights and equality are key prerequisites for achieving the three health-related goals of the Millennium Declaration. In this regard, Finland is active in promoting women’s rights, and a broad perspective on sexual and reproductive health. Gender and health are also linked to the MDG on sustainable development. As stated at the World Summit for Social Development (1995), Finland believes that it is of the utmost importance to improve the status of women in order to foster sustainable development. In tackling the feminisation of poverty, all efforts must be taken to assure that women and girls have the right to health and education. Finland committed itself to the Draft Declaration that equality between women and men is a necessary precondition for social development. (Huuhtanen, 1995)

Health and human rights; poverty and vulnerability
Finland believes that it is essential to act cohesively and concurrently on services and
policies in the entire social sector, including reproductive and sexual health, education, gender equality and the protection of minorities, and on democracy and good governance. In a statement to the UN for the five-year review of the ICPD, Finland affirmed that population policy must be integrated into the wider context of social policy. More specifically, reproductive and sexual health services must be integrated in primary health care. (Lintonen, 1999)

Reduction of maternal and child mortality is directly connected with the promotion of human rights. National poverty reduction programmes need to address sexual and reproductive health and rights. Development cooperation is frequently needed to help support services in these areas. As noted by Holkeri (2003), such financing is particularly important, because the USA has withdrawn its support from this sector.

Finland supports population programmes mainly through the multilateral UN system. In particular, it provides funding through the United Nations Population Fund (UNFPA), primarily as core (non-earmarked) support. Finland is in fact one of the ten largest donors to the UNFPA. One important function of the UNFPA is to promote the implementation of the reproductive and sexual health and rights goals, set at the Cairo conference.

Finland is striving to implement its gender strategy for the economic and social empowerment of women in numerous bilateral projects. Educational programmes are promoting access to schooling for girls in particular. Such action increases the knowledge of women and girls concerning their own rights and also contributes indirectly to the improvement of their reproductive health.

Many NGOs receive financial aid for population and reproductive health projects from Finland’s development cooperation funds. Issues involving reproductive health and HIV/AIDS are also aspects of projects in the areas of primary health care, maternity centres, village communities and schooling. (MFA, Finnish support, 2001)

3.1.3 Alignment with international trends

Finland’s latest Development Policy (2004) is very much in alignment with international trends. The following table highlights the main principles of the new development policy with comments from a policy and health perspective regarding alignment:
<table>
<thead>
<tr>
<th><strong>Main points in Development Policy 2004</strong></th>
<th><strong>Comments / observations</strong></th>
</tr>
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</table>
| Commitment to the values and goals of the UN Millennium Declaration | ► Three of the 8 MDG goals are specifically about health (4,5,6), and two others rely on health related indicators (1,7) to track performance  
► International performance monitoring of development is increasingly being drawn to use of the MDGs by UN agencies and donor countries, including the like-minded group |
| Broad national commitment and coherence in all policy areas | ► Finland does not have a separate health policy or strategy for development cooperation  
► There is a Development Cooperation HIV/AIDS Policy (2002), which emphasises the importance of poverty, gender, education and economic approaches as well as health, especially prevention |
| Commitment to a rights-based approach. This means that the realisation of the rights of the individual as defined by international human rights agreements is taken as the starting point in Finland's development policy. | ► As early as the 1993 Development Strategy, Finland was already using development cooperation to address human rights issues. |
| The principle of sustainable development | ► The policy links sustainable development to poverty reduction, environmental protection, education, and human security. There are no specific comments about linkages to health, but these can be construed through concerns for capacity building in partner countries and the shift to participatory development, including sector and budget support.  
► Sustainable Development also overlaps with one of the MDGs (7). |
| The concept of comprehensive financing for development | ► Although this concept is not linked with health in the policy, it is strongly in line with other international donors. |
| Partnerships for development. Partnerships based on participation by the public and private sectors and civil society, both at the national level and internationally, are a sine qua non for development. | ► Finland has already been demonstrating increased commitment to programme-based cooperation in the health sector, progressively shifting to sector wide approaches and budget support in its long-term partner countries with health as a primary sector (Mozambique and Nicaragua). This is in line with the like-minded group of countries, the EU, and, gradually, the UN agencies. |
| Respect for the integrity and responsibility of the developing countries and their people. States themselves bear responsibility for their own development. Finland's contributions are directed towards supporting each country's own efforts. | ► This statement is very much in line with multiple international accords and commitments, emanating originally from human rights declarations. |
| Long-term commitment and transparency. Finland adopts predictable long-term solutions, and communicates all activities and plans in a transparent manner. This applies both to the financing and the contents of policy. | ► There is no health strategy per se for development cooperation, even though all of the policy documents on development cooperation mention health. This weakens Finland’s stance about commitment and transparency in regards to health. (See discussion below about the implications of this point.) |

### 3.1.4 Cautionary notes

One side of alignment is Finland’s congruence or harmonization with other international donors and agencies. As noted above, the core elements of the new Development Policy are largely in line with international trends. Meanwhile, the other side of alignment is Finland’s role in influencing the alignment of other donors and agencies. Finland can exert an important advocacy role in pushing certain positions in the international arena, even though it is a relatively small donor, as several authors have pointed out in the past few years.

**Monitoring the UN**

One of the MFA’s own papers (Deacon et al., 2003) observes that the UN’s own long-term cross-cutting policies and values, such as the “Health For All” policy, are expected to guide its work in health. Finland has long endorsed these policies, as this statement from the World Summit for Social Development (1995) demonstrates

*We share the view of the World Health Organisation that health has undeniable capacity to enhance people’s participation in the development process. The Health for All Principles launched by the WHO already in the 70's are still valid and should*
Concerns are emerging, however, that global vertical technological solutions are overriding these horizontal policies. This policy direction is not caused solely by the public/private partnerships (e.g., the Global Fund for HIV/AIDS), but they are certainly promoting it. International coherence is at risk, if policy-making on essential public health matters does not remain within the auspices of the UN, but becomes divided up among various structures outside it. Such fragmenting is detrimental not only at the global level. It is also regressive in pushing national health policy-making back into vertical programming (Deacon et al., 2003).

Critically reviewing health care reforms
A MFA evaluation (Saasa et al., 2003) pointed out that despite universal acclaim for the ‘Health for All’ agenda set in 1978, various political influences are still preventing countries from building health services based on universal access. In opposition to the principles of re-distribution and development, the health sector in developing countries is increasingly influenced by private interests and by the principles of ‘willingness to pay’. Saasa et al. argue that the reality of health care reforms is actually the growth of a private health sector, serving the affluent while limiting public provision to selective basic services to the poor. Reforms that allow some people to opt out of the public health system result in segmentation and inequality of access. They also cause deterioration of quality by subsidizing private provision by the public sector alongside the general shrinkage of public resources. In this way, the reforms resemble “a return to the colonial era when elite and minority classes enjoyed access to supposedly international ‘quality’ services, while the rest of society went without or depended on the services of charities and churches.”

3.1.5 Coherence with other national policies and strategies
Coherence is essential
The latest Development Policy (2004) recognizes that health is one of the most important factors affecting development. The policy expresses strongly that the coherence of Finland’s inputs and policies affecting health, social and labour development are essential for realising the goals of the Finnish development policy.

Addressing globalization - International support to equitable development
Recognition by the Finnish government that underdevelopment and health are linked at many levels is one of the issues that has informed the new development policy. Not only is there need to improve public and preventive health, but also to ensure broader access to life-saving drugs. Meeting this need implies connections with the WTO-related policies concerning intellectual property rights in countries facing health and environmental emergencies. From there, it is crucial to talk of human needs and rights having a priority in designing international trade and investment policies, i.e., aiming ultimately for equal rights for everyone. In that regard, coherence on issues related to poverty reduction and social development is critical to achieving a quality of globalization that will support equitable and sustainable development. (Väyrynen, 2003)

Interministerial collaboration – WHO support
Finland participates with multiple other agencies, both Finnish and international, in cooperating for international health. One of the key agencies is the World Health Organisation (WHO), which has an important normative role in setting standards and measuring quality in health. Finland’s support to the WHO is dependent on collaboration between the Ministry for Foreign Affairs and the Ministry of Social Affairs and Health. As presently structured, the MSAH pays the core annual fees for membership in WHO. The MFA, in turn, pays any development cooperation costs, i.e., extra-budgetary thematic or programmatic contributions.
The strength of extra-budgetary funding is the potential to support neglected themes or programmes within WHO’s portfolio. In recent years, Finnish extrabudgetary money to WHO has gone to mental health, anti-tobacco, strengthening health systems and vaccine activity. There are, however, several weaknesses. The extra-budgetary funds are allocated on a resource-available basis, rather than a needs basis. Thus they tend to come after the year in question and are only annual. Both aspects constrain WHO’s capacity for long-term planning for the funds.

As a specialised agency within the UN system, WHO has key responsibilities for concentrating on norms and standards. Some project work is needed, e.g., for pilot testing or concept development, but probably not to the extent that actually takes place. Meanwhile, everybody in WHO is reported to “sell their pet project” to the MFA funding team and they are said to generally succeed, ensuring that all available resources get used. In practice, the leftover from the bilateral support goes to extra-budgetary support to the multilaterals, just to keep the annual cooperation expenditures up. The scale and application of the extra-budgetary funds are largely prioritized by non-health personnel and the choices made in the absence of a guiding health policy for the MFA. Frustration with these arrangements prompted one senior respondent at WHO to comment on health being “at the bottom of the drawer for Finland.”

Looking at how other countries deal with WHO reveals some alternatives for consideration in Finland’s effort to provide quality cooperation in international health. Several European countries are using rolling and/or multi-year budgets for WHO. A number of countries have very large health departments within their MFAs, e.g., the UK, which enable them to have a much stronger technical interaction with WHO. At least one country, Japan, has delegated all of their health cooperation work to its Ministry of Health, recognising where their limited human resources for health are concentrated. (For more specific details about the support to WHO, see Annex 8—WHO collaboration issues.)

3.2 Resource allocation for health sector support

3.2.1 Avenues of funding

The Finnish government funds health sector development broadly through multilateral organisations working to a varying extent in the area of health. Some organisations like WHO work only in health, UNFPA works predominantly in health and UNICEF works partly in health. Some of the other UN agencies work somewhat or indirectly in health, e.g., ILO (occupational health, social health insurance), UNDP (HIV/AIDS) and UNHCR (refugee health). Similarly, part of the contributions to the international financing institutions, such as the World Bank, the regional Banks and the Nordic Development Fund, and to the EU is used for health. One feature in common to all of these funding channels is that the exact Finnish contribution to health is not easy to pinpoint. The Finnish support to multilateral organisations mostly takes the form of core contributions, although there is also some extra-budgetary funding and secondment of staff.

The bilateral funding of health sector development contains direct state-to-state health sector programmes/projects, projects financed through local cooperation funds and bilateral programmes implemented through multilateral organisations, such as PAHO or UNFPA. It also includes more indirect cooperation in the form of general budget support, of which the partner country will spend a specified or non-specified amount on health.
Finally, some health sector support is funded by MFA through national or international NGOs working at least partly in the health sector. A number of the NGOs work on multisectoral projects and some of the framework NGOs work in several sectors.

While acknowledging the many different ways in which the Finnish government supports health sector development, the focus in the following analysis will be on the main direct support to the health sector.

### 3.2.2 Resource allocation for health

**Multilateral funding:** Focusing only on the major multilateral agencies working in health in developing countries - UNFPA, UNAIDS, UNICEF (weighted for share allocated to health) and WHO (excluding membership contribution) - the annual percentage allocation to health-related contributions was relatively stable over the ten year period. It amounted to approximately 11% of total multilateral assistance. The contribution in absolute amounts increased, however, mainly to the benefit of UNFPA and UNAIDS. Support to UNFPA doubled over the period 1994-97 (from 6.2 to 12.8 MEURO). Since 1997, the tendency has been a steady but small increase in support. UNAIDS started receiving small funding in 1996, but except for 1997-98, the contributions have doubled from year to year reaching a high of 6.8 MEURO in 2001, but stabilising around 3.0 MEURO thereafter. The peak was allegedly due to large unspent bilateral funds and a need for funding in relation to the UNAIDS Special Session of the UN Assembly in 2001, when Finland chaired the UNAIDS Executive Board.

**Bilateral funding:** The percentage of bilateral aid allocated to health and population has not stayed as stable over the years, cf. Figure 1. The relative allocation for health appears volatile, but with an overall increasing trend. This has, to some extent, been due to an increasing allocation for population programmes. According to the DAC database, this development pattern is not unique to Finland. The phenomenon has also been observed in the rest of the like-minded group of donors.

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22 Getting an overview of the expenditures in development assistance to health has not been easy. A number of the sources consulted have conflicting figures. The main sources used for this section are statistics reported by Finland to the OECD/DAC; International Development Statistics; Online Databases on aid and other resource flows; the Ministry for Foreign Affairs, Finland’s Development Cooperation, years 1999-2003; Finland’s Official Development Assistance in Statistics (global.finland.fi/v2/English/tietopankki/tietotytot.shtml); UNFPA Annual Reports 1995-2003; UNICEF Annual reports 1995-2003; UNAIDS. Core Contributions 1995-2004 (www.unaids.org); and a data extract from the NGO database.

23 According to UNAIDS, this peak in contributions is in 2002. However, the MFA reports the peak to be in 2001.

24 Ireland and the UK are allocating a relatively larger share of their bilateral ODA for health. The Nordic countries are at a similar, but a slightly lower level. They allocated 7.5% of ODA for health, on average, over the evaluation period.
For most of the evaluation period, Finland had 11 long-term partner countries. They are now in a transitional phase. Only three long-term partner countries have had health as a priority sector and one of them (Namibia) is among the ‘transition’ countries being phased out. Few truly new projects are being developed. Most “new” projects are in fact continuations, especially when it comes to major projects. The bilateral aid for health sector development has mainly been aimed at long-term partner countries. The share of the health sector development aid allocated to long-term partner countries has, however, continuously decreased since 1997, cf. Figure 2. In 2002, less that 50% of the bilateral aid to health was channelled to long-term partner countries. This phenomenon could be partly due to changing reporting and registration practices in the DAC database. However, it is also related to the use of new instruments in bilateral development assistance that target a different set of countries (concessional credits) or do not target anything in particular (NGOs).


25 Egypt, Ethiopia, Kenya, Mozambique, Namibia, Nepal, Nicaragua, Peru, Tanzania, Vietnam and Zambia

26 Egypt, Namibia and Peru
Figure 2. Percentage of bilateral aid to health by category of recipient.

Note: Details on 1995 missing.


The decline in the percentage of funding allocated to long-term partner countries is linked to the development in the number of countries that receive some kind of health sector support, cf. Figure 3. It is also a result from the increase in actual number of health sector projects, cf. Figure 4. One must recognise that a significant increase took place in the number of non-long-term partner countries receiving some kind of bilateral health support, especially during the period 1999-2001. Much of the increase in the number of projects was due to the growth in concessional credit schemes, mainly in China. Such trends are in contrast with the overall intentions of the MFA to enhance effectiveness through concentration on fewer and larger efforts.
Figure 3. Number of countries receiving some kind of bilateral health sector support.

Note: Details on 1995 missing.

Figure 4 Number of bilateral projects in health and population.

**Non-governmental organisations:** The resources allocated for health projects in the NGO financial frame have significantly increased. This is especially notable over the period 1997-2001, cf. Figure 5. The number of NGO projects has followed a similar trend.

**Figure 5. Disbursements in NGO projects in health.**

![Figure 5](source.png)

Source: List provided by NGO unit, MFA.

**Figure 6. Number of NGO projects in the health sector.**

![Figure 6](source.png)

Source: List provided by NGO unit, MFA.
3.2.3 Does resourcing reflect priorities?

The Finnish development policy does not come out very strongly on the priorities given in development assistance to the health sector. The importance of the health sector for overall development is, however, stated with increasing clarity. The actual priority given to health sector development in terms of the proportion of government expenditure for development assistance allocated seems to have been in line, to some extent, with this increasing recognition of the health sector in the overall policy up to this point.

The increase in multilateral funding to UNFPA and UNAIDS is well in line with Finland’s commitment to follow up on the Cairo conference. The bilateral support to health sector development has focused mainly on relatively few major programmes in three countries. Meanwhile, an increasing number of smaller projects have emerged over time, in contrast to the stated intentions of the MFA. The fact that no new major projects or programmes have been developed could be interpreted as health lacking status in Finnish development assistance. It could also merely reflect a general lack of resources, combined with a history of a rather haphazard and unstrategic approach to approving a large number of new, widely dispersed and small projects.

NGO development assistance in the area of health has increased over the period, both in absolute and relative terms. This development is in line with the overall policy trend in Finland (and the world in general). However, this consistency is merely coincidental, because the Finnish government has not been willing or able to set any sectoral priorities for NGOs.

It is too early to say, whether the MFA’s current institutional weaknesses, discussed later in this report, will affect the way health is prioritised and funded in the future within Finnish development cooperation. Given the recognized importance of health sector development in relation to poverty reduction, the MFA could consider putting a target figure for resource allocation for health, in order to ensure an appropriate future funding level.

3.3 Involvement in key areas

3.3.1 Poverty, vulnerability, disability

Health linked to poverty reduction

Poverty reduction is an overriding principle of MFA’s international cooperation agenda, as stated in all of their policy documents since the early 1990s. The 1996 Decision-in-principle affirmed that Finland would “emphasise basic education and health services, which are crucial to enabling poor people to participate; support efforts to improve family planning and reproductive health as a part of basic health services.” The 1998 Decision-in-principle also emphasised support for basic services in education and health care, food security, advancement of participation by women and girls and consideration of the status of the disabled as critical means of reducing poverty.

The current Development Policy (2004) continues to urge that the promotion of good health is a crucial and essential element in national poverty-reduction programmes. The policies of the MFA are explicit, stating the intention as improving the health status of the most vulnerable groups, with an emphasis on women and children. The policy notes the strategic value of health cooperation by citing a World Health Organisation report on national economies and health, showing that investing in health pays for itself many times over through economic growth.
Multilateral support – As noted in an earlier chapter, many of the UN agencies supported by the MFA include health activities. All the UN agencies have signed up to the Millennium plan in support of the MDGs. Finland actively lobbyed for this commitment in the run-up to the Millennium session. In addition, special attention has been directed to specific health problems, such as HIV/AIDS (e.g., by supporting UNAIDS) during the period of the evaluation.

Bilateral support - The main entry point for MFA bilateral support to the health sector has been the health system of a partner country. The MFA has supported primary health care (PHC) principles and contributed to bringing health closer to the people (e.g., in the Engela area of Namibia, Beni Suef in Egypt, Kenya and Mozambique). MFA funding has been used to support the renovation of community level infrastructure and the expansion of PHC services. The MFA has supported the training and capacity building of health personnel in most countries, where MFA has health related programmes (e.g., Kosovo). The aim has been to improve access of vulnerable groups to health care.

In some of their most challenging work, the MFA has responded to the poverty-related social connections between health and domestic violence. In Nicaragua, where there is a high incidence of domestic violence, a Finnish-supported reproductive and sexual health rights project sensitively and successfully confronted issues of gender-based violence and health inequities. It was an important and even unique project, addressing vulnerability. It has, however, not been well documented and widely shared with other key stakeholders.

NGO support - In Tanzania, Finnish NGOs have funded multiple primary health care projects in remote and poor villages. An evaluation carried out in 1996 indicated that the health care projects had brought about positive changes in people’s lives and communities.27 The MFA also supports some international organisations that focus on specific vulnerable groups, e.g., HelpAge that focuses on issue of the aged. The Lutheran World Federation and the International Red Cross (funded through the Red Cross Finland), have been active in training traditional birth attendants in countries such as Ethiopia and Mozambique. NGOs, such as Finnish Refugee and Finland Federation for Mental Health, have provided financial support for improving care and living conditions in psychiatric hospitals. The NGOs working with disability, and they are many, have been instrumental in keeping disability on the agenda of many countries. Finland has, in fact, been a leading donor in supporting disability internationally.

Embassy level support - Local cooperation funds have frequently been used to support very vulnerable groups. This has been particularly true in the past few years, after greater discretion in their allocation was ceded to the Embassies. In Mozambique, for example, Meninos de Mozambique, one of the organisations supported by the embassy, is working with street children on the prevention of STIs and HIV infection. The project is operating on a small pilot scale compared to the size of the country, but its successes suggest there is potential for scaling it up to cover many more urban and peri-urban areas.

Challenges
A choice must be made between short-term curative services and a preoccupation with the deeper causes and prevention of ill health and poverty. The MFA's support to the public health care strategy and related preventative health services has placed Finnish support to health in line with the longer-term poverty reduction objective. At the same time, some interventions, such as AIDS counselling, clearly fit a short-term alleviation perspective. Should Finnish NGOs concentrate more on short-term curative services, while the bilateral support concentrates on long-term measures?

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27 Nkya, L. et al. (1994) Finnish NGOs Development Cooperation Projects In Morogoro Area, United Republic of Tanzania: Evaluation Impact Report. MFA.
Reviews of highly technical projects, such as the maintenance project in Mozambique, have indicated that the allocation of funds does not always correspond to the intention of increasing equity in the delivery of health services. A mid-term review carried out in 2001 revealed that there had been a bias towards high tech equipment in centralised hospitals built in big cities. Meanwhile, the majority of the poorer segments of the population live in the rural areas with little access to the new equipment.

There is a shortage of specialist skills to address the multi-dimensional aspects of poverty. Staff performance, management, and training are yet to be sufficiently linked with incentive and reward systems for poverty reduction and other cross-cutting issues. Decentralising decision-making and ensuring adequate staffing in the field also continue to be major challenges.

Listening to the poor remains a problem. The beneficiaries of the Tanzanian NGO-funded projects complained that their priority needs, such as severe incidence of malaria, worms, typhoid and diarrhoea, lack of an ambulance, insufficient basic medicine and lack of rural roads to link them to the city and villages, were not addressed. Can addressing health needs alone reduce poverty? The need to adopt a participatory approach, based on joint identification of issues, cannot be overemphasised.

3.3.2 HIV/AIDS

3.3.2.1 Recognising the seriousness and multisectoral nature of HIV/AIDS

There is ample evidence in documents and speeches by representatives of the MFA that HIV/AIDS is understood to be a multisectoral problem, with strong causal and outcome linkages to national poverty. For example,

*The prevention of the spread of the HIV is an illustrative example area where developmental and humanitarian concerns meet. The spread of the virus is shown to accelerate whenever social networks are uprooted, families are separated and populations are displaced to other regions or countries under poor conditions of health care and under conditions liable to change sexual behavioural patterns. After complex emergencies a surge in HIV/AIDS can be traced to the resettlement of ex-combatants.* (Backström, 1999)

*The spread of HIV/AIDS constitutes a serious threat to the goal of poverty reduction as well as to other important objectives in the health and education sectors. The disease also directly affects countries' economic growth.* (Holkeri, 2003)

In recognition of this situation, there are multiple calls for action, with most of the emphasis on prevention. For example,

*Sub-Saharan Africa is the worst-affected region for the HIV/AIDS epidemic and needs to be the focus of action. We lost many important years in prevention because of shame to call things by their correct names. We do not have any other alternative than to overcome our taboos, like people in Africa have done in recent years. How can prevention be successful if we do not identify the vulnerable groups and call them by their correct names?* (Soininvaara, 2001)

*It (is) essential that all people, especially the young, learn how to avoid infection. Regarding human rights, overcoming discrimination against victims and removing the stigma of infection (are) important in the fight against HIV/AIDS. Also tied to the fight against the disease (is) the theme of poverty reduction. After all, countries (have) to

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address the fact that the pandemic (is) having an immense impact on economies throughout the world. (Tuomioja, 2003)

Meanwhile, there do not seem to be any 'White Papers' by the MFA with thorough analyses of the implications of HIV/AIDS for development cooperation and the LDCs. Likewise, there is no collection of all the position statements by Finnish spokespersons (in all sectors and international arenas) regarding HIV/AIDS. (See also chapter 3.5.1 about mainstreaming HIV/AIDS and the current status of the MFA in regard to mainstreaming)

3.3.2.2 Link to education

There are multiple references to the importance of collaboration with the education sector in working on HIV/AIDS. For example,

According to the HIV policy (of the MFA), the HIV/AIDS epidemic should be taken into consideration when planning all Finnish sectoral and macro-economic development cooperation. In the work against the epidemic, Finland especially emphasises prevention, the development and strengthening of comprehensive primary health care and the importance of basic education. Gender issues, women's rights and sexual and reproductive rights are also placed high on the agenda. (STAKES, 2003)

Despite the number of statements bringing up education in the context of HIV/AIDS, it has not been possible to find an education policy or strategy on the MFA websites, although one may exist. In the absence of a policy or strategy for education, it is difficult to know to what extent HIV/AIDS is being integrated into the planning and monitoring of bilateral activities in the education sector.

3.3.2.3 Linking HIV/AIDS with human security

In the years since September 11, it has become increasingly common to find the terminologies of security and conflict prevention used as part of the justification for development cooperation. In the same vein, links are now being drawn between HIV/AIDS and security. For example,

HIV/AIDS issues are no longer regarded as health problems, but are important questions for security, societal and development policies. The basic education and education systems have a central role in preventive work, but also in handling of the consequences. (MFA, HIV policy, 2002)

As people become more mobile, the risk of the spread of contagious diseases also increases. HIV/AIDS is threatening social development, particularly in Sub-Saharan Africa, where most of the world's AIDS victims live...In addition to health effects, epidemics are also having a growing economic impact. HIV/AIDS and tuberculosis are a particular problem in Finland’s neighbouring areas. (Finland Security and Defence Policy, 2004)

HIV/AIDS is barely mentioned in the new Finnish Security and Defence Policy (only three times and all in the paragraph extracted above). Moreover, the policy still speaks in the somewhat outdated terminology of “AIDS victims”, which has been rejected by many people living with HIV/AIDS as stigmatizing. The policy does not have any content about workplace aspects of HIV/AIDS for the peacekeeping forces. In fact, the word ‘sex’ does not even appear in the policy, either in terms of protection or abuse – though the word ‘drugs’ does appear several times.

3.3.2.4 HIV/AIDS - policies and strategies

HIV/AIDS policy for development cooperation

In 2002, the Finnish Ministry for Foreign Affairs prepared a development cooperation policy for issues related to HIV/AIDS. At approximately the same time, the HIV Expert Group appointed by the Ministry of Social Affairs and Health to promote the national coordination of
HIV/AIDS work drafted a national HIV/AIDS policy for 2002-2006. The summary for the National HIV/AIDS policy states that key objectives have been defined for each priority area as a way of tracking whether the desired aims are being achieved or not. (HIV working group, National HIV policy - summary, 2002).

The MFA HIV/AIDS policy is not time bound, despite the rapidly evolving nature of the pandemic and its consequences. It also does not include any statements about how or when it will be reviewed and updated. The evaluation team was informed that the policy was being reviewed and updated at the time of the present evaluation, but an official copy was not yet available. The existing international cooperation HIV/AIDS policy includes some broad aims, but does not include specific objectives or indicators for tracking achievements.

**HIV/AIDS Strategy (de facto)**

At the time of the evaluation, there was no official HIV/AIDS strategy for the MFA. Several statements, made to the evaluation team by senior officials in the MFA, indicated that in reality, programming for HIV/AIDS is left to the health sector. For example,

“At the present time, HIV is only a health issue in the MFA.”

“MFA recognises that HIV is a shared issue with social policy (and other sectors), but interventions have been led by health.”

This medical focus to HIV/AIDS-related interventions can also be seen in some of the Finnish international position papers. For example,

*Prevention of the further spread of the pandemic should be the major focus of our response. Quality primary health care structures are the key issue here. A sound, universally accessible health care system, including sexual and reproductive health as well as social and psychological support and care, is a cornerstone of prevention and the basis for treatment.* (Soininvaara, 2001)

As noted earlier, there is a policy paper on HIV/AIDS for the MFA, but it is not able to serve as a strategy. As noted by some of the respondents in the MFA, the policy does not give enough information for making specific decisions about funding amounts.

The focal point for HIV/AIDS is the health adviser, and much of the emphasis on HIV/AIDS by MFA officials or documents is within health – but there is no health policy or strategy that can back up the HIV/AIDS policy. Documentary support for HIV/AIDS involvement, prioritisation, focus and consistency are weak or absent. In the words of a senior MFA official involved with making decisions about multilateral support priorities,

“This is where a health sector strategy would help, including sexual and reproductive health.”

**Networking on HIV/AIDS**

The latest Development Policy (2004) raises the issue of networking on HIV/AIDS, and says that progress is being made.

*Finland emphasises the need for the prevention of HIV/AIDS on a broad basis, cutting across different sectors. The formation of networks among different ministries, organisations and groups is being intensified.* (MFA, Development Policy, 2004)

The reality of these ‘intensified’ networks is difficult to find. On the positive side, the evaluation team did hear that the health adviser was consulting outside the MFA on the HIV/AIDS paper. However, it was also reported that the institutions being consulted have been only the health-related ones, i.e., MSAH, the Public Health Institute and STAKES.

In Geneva, Finland does belong to the “Friends of UNAIDS”, which is comprised of the top
16 donors. The representative who comes to the meetings of the ‘Friends’ is the attaché with the permanent Finnish mission in Geneva. The ‘Friends’ sit with the UNAIDS secretariat about five times per year – generally in the period from October to June, with a recess after that. It is a low-key advisory forum, and it does not keep any formal minutes.

No intersectoral or interministerial networks focused on HIV/AIDS were identified to the team during this review. If they exist, they are not active or vocal; nor is there evidence of them (in English) on the web. Some consultation does take place by the health adviser, but only with other health institutions to the best of the available information, and not on a regular, formalised basis, like a network.

**Resource implications at country level**

As noted in the MFA policy on HIV/AIDS, the epidemic does not affect all regions and countries in the world equally. Where it is at its worst, it contributes dramatically to national poverty crises.

> The HIV/AIDS epidemic increases the resource demand in social and health sectors, resulting thus in a need to shift resources within the development cooperation framework. Supportive actions targeted against HIV/AIDS should be in an appropriate relation to the extent and the profile of the HIV/AIDS problem in each country. (MFA, HIV policy, 2002)

Despite these good words in the policy, as noted in the earlier section of this report on policies and strategies, the MFA is not currently preparing or using country strategies. Implementing this point from the HIV/AIDS policy is either not happening, or it is not being done through an evidence-based decision making process.

### 3.3.2.5 Mainstreaming HIV

Extensive checking was done by the evaluation team on the Internet, at MFA offices in Helsinki, Geneva and in the countries visited. It was confirmed in all of these areas that there is no HIV workplace policy for the MFA. Some information about HIV is given as part of the training programme for new employees.

In the words of one senior MFA officer in Helsinki,

> “There is no clear campaign for mainstreaming HIV in development work.”

The evaluation team also heard concerns that even if the HIV/AIDS strategy gets accepted by the MFA, there is no system or structure to ensure that any mainstreaming or HIV/AIDS programming is monitored. Again, to quote an MFA official,

> “If there is no health sector, then the countries are not doing much on HIV.”

Mainstreaming is thus clearly only rhetorical at this point.

### 3.3.2.6 UNAIDS and other multilateral support to HIV/AIDS

Finland’s main area of financial contribution on HIV/AIDS is through the United Nations. The principal recipient is the United Nations Programme against HIV/AIDS (UNAIDS); followed by support to the UN Population Fund (UNFPA). UNFPA's assistance is aimed more broadly at promoting reproductive health, while UNAIDS is only focused on HIV/AIDS. The support to UNAIDS and UNFPA is given as ‘core support’, i.e., non-earmarked funding that the agencies can use as per their annual plans, including support for their core administrative and operating costs. This kind of open donorship is very much appreciated by the UN agencies.

> Finland – they have no special reporting requirements; no earmarking; no negotiations, no pledge sessions; and no special requests. They are a nice, neat, well-behaved donor. (UNAIDS)
Another organisation, supported by Finland, is tied to UNAIDS, but also acts as an umbrella organisation to support other AIDS prevention organisations. It is the Global Coalition on Women and AIDS. UNAIDS runs the programme and acts as a donor.

"Finland finances this project aimed at improving the status of girls and women with two million euros a year in 2005-2006", says Finland's Minister for Foreign Trade and Development Paula Lehtomäki. (MFA press release 2004)

This looks like earmarked funding, but it is not clear whether it is included within the UNAIDS budget of the MFA or not. Interestingly, this project was not discussed with the evaluation team member, who visited UNAIDS in Geneva. (That may, of course, have been an accidental omission in a short, tight programme of meetings.)

Monitoring
Finland is appreciated for non-earmarked donorship. There were, however, concerns in Geneva at UNAIDS headquarters that there is no feedback from Finland on any of the reporting or information flowing to the MFA from UNAIDS. Meanwhile, most of the donor community as a whole wants clearer and simpler reporting. For example, UNAIDS praises the UK for having criteria on investing in the UN system that rely on an effectiveness frame, with investments conditioned by their strategy paper. The Australians have also used an evaluation to make their decisions about commitments. (UNAIDS)

Regarding opportunities for participation, UNAIDS has an M&E reference group (MERG) that meets one time per year for a 2-day meeting. The meetings are open for donor participation, but it is hard to get donors involved – except USAID, DFID and GTZ. (Many Scandinavian ministries reportedly say they are not “technical”.) At present, UNAIDS is mildly concerned that the MERG is overly dominated by the Americans. (UNAIDS)

Peter Piot comes one or two times per year to the Nordic country alliance for a meeting and discussions. At these Nordic consultations, the UNAIDS priorities are reviewed. These meetings are open, informal – and UNAIDS can receive comments from Finland.

In Helsinki, there were some unsettled voices, mostly expressing concerns related to the large unstructured support to UNAIDS and feeling that they cannot “see where the money goes.” In Geneva, UNAIDS presented information about their new system to link resource tracking and activities monitoring, i.e., following where the money goes. They have now developed a new tracking system, which was presented at the XV International AIDS Conference in Bangkok in 2004, to address this issue.

In summary, Finland is not taking up the opportunity for dialogue, nor for expressing their concerns to UNAIDS about where the money goes on HIV/AIDS and helping UNAIDS look for credible evidence.

Advocacy
Finland was chair of the PCB (programme coordinating board for UNAIDS) during 1999-2000, which meant that it was the chair for the United Nations General Assembly Special Session on HIV/AIDS (UNGASS). (Holkeri) According to UNAIDS, Finland was heavily involved in that meeting and contributed to the international debates about HIV/AIDS at the time. Finland will be a full member of the PCB meeting in June 2005 and will coordinate the views of the Nordic countries.

A question remains: Finland has capitalised on opportunities at some international fora to promote HIV and human rights related issues. What will it do with the opportunity that the coming EU presidency presents?
Global Fund

The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was created in July 2000. The GFATM is a funding instrument, not an implementing organisation. It has an independent secretariat housed by WHO in Geneva. The World Bank manages the money as a trustee. A 17-member technical review panel, consisting mainly of experts in the three diseases, reviews the proposals. Much of the Fund’s focus to date has been on pharmaceuticals to prevent and treat these diseases. (Deacon et al., 2003)

Representatives in the MFA said that there has been a lot of pressure to have Finland join the Global Fund. (They are the only 'old EU' country not to join.) The evaluation team was told that as a relatively small donor, Finland would prefer to channel all its resources for HIV/AIDS through one avenue. The MFA policy on HIV/AIDS lists specific criteria about the conditions that should prevail for Finland to participate in the Global Fund:

► To decide on participation in the fund only when the ODA eligibility of the funding, the management structure, statutes and funding basis of the fund have been cleared.
► The evaluation will take into account, among others, whether the fund meets the Finnish policies for development cooperation and whether it acknowledges sufficiently the role of the basic services.
► Will the fund be able to raise significant new resources from the private sector, or is it based only on development funding from the governments, which might reduce the money available for other development goals?
► In addition, the relationship of the fund to other UN agencies working in the sector will be evaluated; is the fund complementary or competitive to them? (MFA HIV policy, 2002)

In reality, no paper documents the collection of this evidence. Reportedly, however, there are some internal MFA briefing papers on GFATM, but NONE of these were shared with the evaluation team, either in Finnish or in English. Therefore, the evaluation team cannot comment on whether these papers do, in fact, report or use such evidence. Only one person concentrates on dealing with HIV/AIDS; she is overwhelmed by also being the only health adviser. It is not surprising if the choices taken minimize the number of organizations to deal with and the amount of administrative workload.29

► The most thorough review of any MFA documents regarding the Global Fund is found in an MFA review of Global Social Governance by Deacon et al., 2003. Their concerns about the GFATM do not appear to have become widely known among the sections of the MFA responsible for health, HIV/AIDS and multilateral support. It is worth reiterating these concerns about the Global Fund:
► Democratic accountability is less clear than in UN-hosted programmes. The role of UNAIDS and WHO, the UN organisations on whose mandate the three diseases primarily fall, are relegated to non-voting board members. Industry is represented in policy-making and agenda setting positions.
► No substantial new funding for development aid has been forthcoming. About 95% of the pledged funds are from public resources, mostly taken away from other

29 In the interviews with UNAIDS in Geneva, additional issues were identified, which were not mentioned by MFA officials in Helsinki. The Global Fund does not provide any technical assistance at country level, unlike UNAIDS. The Global Fund has had a problem with absorptive capacity, and a big need for capacity building. It is now changing back into focusing on the management of chronic care. Moreover, the Global Fund is supposed to be only “additional” to other pre-existing contributions on HIV/AIDS. Finally, Finland does not have too much possibility to do additional funding. (UNAIDS)
Funds are directed towards three selected diseases, which may compromise the possibilities for the development of more comprehensive health systems.

GFATM is a funding body. The necessary technical assistance at country level should be ensured at all stages of the programme (but only UNAIDS has a country level presence).

Proper policies and mechanisms still not in place (as of 2003).

There is concern that too much emphasis will be placed on funding purchases of medical products.

GFATM with its resources, policies and implementation mechanisms may have a big impact on existing health systems, particularly on primary health care structures and capacities. This should be carefully monitored.

The focus on clear and measurable results may limit activities to selected interventions and give less emphasis to initiatives with intersectoral working methods and long-term goals.

3.3.2.7 Development cooperation support for HIV/AIDS

The exact amount targeted directly at HIV/AIDS is difficult to estimate. Finland participates in the work against HIV/AIDS especially through multilateral development assistance, which is to be increased in the next few years. In the future, a big portion of the aid will be channelled through UNAIDS. STAKES has pointed out that Finland does not presently have any bilateral projects focusing directly to HIV/AIDS. Many projects on the social sector are, however, involved (to some extent) with HIV/AIDS work. (STAKES, 2004) In this regard, some officials of the MFA said that Finland would have to decrease the commitment to UNAIDS if they also opted to support the Global Fund.

The team has not been able to see any documentation on the amount of funds that are or should be available for HIV/AIDS.

Bilateral support and HIV/AIDS

HIV/AIDS is perceived to be “a tough, difficult issue”. It seems that the MFA has been reluctant as an organisation to get on board with specific projects and funds. One of the big concerns for Finland about HIV/AIDS, expressed in interviews and in the HIV/AIDS policy (see quote below), was worry about Finland getting involved with treatment and the huge, long-term expenditures that implies.

HIV/AIDS is also a difficult problem for social security. Finland is keen to search for, and to support - in cooperation with others - new innovative forms of community-based and public social security. (MFA, Development Policy, 2004)

This is still an unresolved question, and one that needs research, whether desk review and extracting best practices from the international literature or through a field study.

According to consulting companies and MFA officials, mainstreaming HIV/AIDS and fully integrating it into Finnish programming is not really happening in bilateral projects. For example,

“In Mozambique, it was a maintenance project so HIV was not much of an issue.”

(Consulting company)

The MFA appears to be getting more serious about the issue of HIV/AIDS now than it was in the past. However, this example from Mozambique shows a lack of creative thinking either by the MFA and/or the consulting company. Maintenance projects involve occupational exposure to blood/blood products. They also involve travel for the maintenance staff. As
most of them are males, such travel can lead to casual or unprotected sex if the issue is not confronted and discussed as a risk. This gap in thinking may be related, at least in part, to the absence of a mainstreaming strategy document or a workplace HIV/AIDS policy. Both of these would help desk officers, embassy staff and project officers to follow through on these issues.

There are positive examples elsewhere, including in Mozambique, where HIV/AIDS has been thoroughly mainstreamed for health workers in training, e.g., in the Manica Training Centre. In addition, it is reassuring to note that the Mozambican Maintenance/Health Technology programme, which has now been taken over by the Ministry of Health, has integrated occupational HIV safety into its programmes.

**Limitations of the present review**
The evaluation team had minimal contact with other sector advisers, or with projects in other sectors regarding the mainstreaming of HIV (or for other ‘mainstreamed’ themes, such as gender and disability).

### 3.4 Aid mechanisms

This section will assess the role and relevance, benefits and challenges for the various aid mechanisms, as well as the coordination and synergy effects. Its focus is on the *directly* health-related multilateral assistance (except the brief discussion of support through EU) and on the bilateral development cooperation in health. LCF, CC, humanitarian aid and research funding channelled through the Academy of Finland are touched upon, but not examined in depth. All have been or currently are subject to a separate evaluation.

#### 3.4.1 Multilateral cooperation with a health focus

*3.4.1.1 Background*

As already mentioned in this report, Finland is in line with the other like-minded donors as a strong supporter of the UN system and in supporting the development and maintenance of the normative role of the UN agencies. Participation in the work of decision-making bodies and contribution of financial and other resources are the instruments Finland uses in multilateral cooperation. Its main partners in the area of health are UNFPA, UNICEF, UNAIDS and WHO. UNAIDS has been supported since its establishment in 1996.

Funds are channelled to the UN organisations principally as non-earmarked general appropriations (so-called ‘core funding’) and some as so-called thematic support, which is designated for either a specific programme or a particular theme (also called ‘extra-budgetary funds’). The core funding is used for country programmes, for specific programme support and for management and administration of the organisation, as well as for maintaining core capacity for effective global presence. Core funding (in contrast to fragmented and projectised extra-budgetary funding) enhances efficiency in planning and management.

The proportion of Finnish contribution given as core funding appears to be declining, even though it is still high. Funding is increasingly designated to special themes. In 2003, for

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30 For development assistance channelled through institutions and organisations with a broader portfolio, it is particularly difficult to pinpoint the Finnish influence on how these institutions and organisations work with health sector development. It would to some extent amount to assessing the general interface between the MFA and these institutions. This is deemed to be beyond the scope and resources available for this evaluation. However, since the TORs asked for support to EU to be covered in general descriptive level, a brief discussion on EU support to health is included.
example, 85% of funding from Finland to UNFPA was in the form of core funding. This is a reduction from earlier years, when the core funding accounted for over 90% of the Finnish contribution to UNFPA.\textsuperscript{31} The core funding has increased in absolute terms. The increase in thematic funding is additional, reflecting the increased overall funding level. Adolescent sexual and reproductive health was the main thematic area supported by earmarked funding for UNFPA.

Appropriations used to be granted on an annual basis. Recognising the problems that this causes for planning and efficient use of resources in the organisations, MFA recently (2002) started making multi-year provisions (through a so-called authorisation decision) for the contribution of core funds with UNFPA and UNICEF. WHO still suffers from the fact that Finland does not allow a rolling budget.

UNFPA, UNICEF and UNAIDS fund programmes based on voluntary contributions. WHO, like other UN special agencies, is mainly financed by the line ministry. The Ministry of Social Affairs and Health deals with WHO's general activities and the member state contribution to WHO is financed through its budget. In contrast, support for WHO's development activities is financed by the MFA budget for development cooperation. The member state contribution paid through MSAH in 2003 was 1.97 million euro\textsuperscript{32}. The relatively low level of core funding is based on the view that WHO should concentrate on normative functions, as opposed to implementing funded programmes. The contribution from the development cooperation budget for thematic areas amounted to 1.6 million euro. These funds were aimed at anti-tobacco, health systems development, mental health, polio and pneumococcus eradication programmes and country specific programmes. Part of the extra-budgetary funding from MFA is contributed as non-earmarked funding for use to be decided by the Director General of WHO.

3.4.1.2 Decision making and consultation mechanisms in Finland

The responsibility for cooperation with UNFPA, UNAIDS and UNICEF lies with the MFA Department for Global Affairs. The evaluation team is not clear what mechanism the MFA uses for discussion and engagement in active dialogue about health development issues in relation to these funding programmes. The yearly financial contributions related to the health sector are reportedly discussed in a meeting with the MSAH, in which the health adviser of the MFA normally participates. The health adviser is not often consulted on technical aspects in relation to the UN funding programmes in health. The multilateral projects also do not often go through the MFA Project Management Committee (PMC), for screening and coordination.

As regards WHO, the MSAH deals with WHO's general activities. The MFA cooperates with the MSAH on general and overriding policy issues, including those of an organisational nature. The MFA also deals with health issues related to development countries. The health adviser participates frequently in technical meetings regarding health sector issues in developing countries. She does not, however, often participate in policy discussions, as this is the jurisdiction of the MSAH. There are diverse views on how well this cooperation works. There is, however, common agreement about the limitations in terms of time constraints and the lack of sufficient human resources (cf. Chapter 3.6. on Management Capacity).

Funding requests for WHO extra-budgetary projects are developed in WHO/Geneva. They are forwarded to the head of the UN Unit in the Finnish Ministry for Foreign Affairs through the Finnish Permanent Mission in Geneva. The Unit consults with the health adviser, but not always with the MSAH. Prioritisation is made in Helsinki by the MFA. The selection criteria

\textsuperscript{31} UNFPA. Annual reports 1996-2003.
are not clear, especially in the absence of a health policy or strategy. On the other hand, the experience from WHO is that Finland is flexible regarding reallocation within the budget.

Soft monitoring of WHO takes place through the personnel in Geneva, Board meetings and annual reports and Meetings of Interested Parties (MIP) for Member States and other partners that contribute voluntary resources. The annual reports are of varying usefulness, as they tend to report on activities rather than outcomes. Finland does not place any special reporting requirements on WHO.

No systematic consultation or feedback mechanism on the performance of multilateral partners in the health sector exist from the embassies or health sector programmes. Such sharing of field experience could be very useful for discussions on the role and future development strategies for the multilateral partners, active in health. SIDA, for example, has been very proactive in getting UNFPA into a new role in relation to the SWAps, after it identified a gap in attention to reproductive health in many SWAps.

### 3.4.1.3 Role and relevance of Finnish multilateral cooperation in health

Finland sees the main function of the multilateral organisations to be a normative one. This is clearly more so for the specialised agencies (such as UNFPA) and less for the operational ones (such as UNAIDS), whose main focus is on implementation. Multilateral cooperation in the health sector offers an opportunity to complement the bilateral support with development of universal norms and standards, setting the international agenda and sharing and learning from each other. This view has consistently been put forward over the years in policy documents. No major change in the policy towards multilateral organisations working with health is evident. On one hand, the shift to active multilateralism appears to have resulted in more targeted assistance, insisting on pursuing Finnish interests. On the other hand, these interests have been poorly defined thus far.

As mentioned previously in this report, no overall health policy or sector strategy exists, against which the relevance of Finland’s multilateral cooperation can be measured. The general policy documents do reveal a Finnish focus on basic health services, including sexual and reproductive health and rights and to a lesser extent, HIV/AIDS (cf. section 3.1.2. on thematic areas of support). In that context, the considerable increase in funding over the years to UNFPA and UNAIDS (cf. Section 3.2.2.) is well in line with the view that UNFPA should champion the implementation of the ICPD Programme Action Plan. It is also in line with the recognised need to strengthen the fight against AIDS in a coordinated manner.33

As part of policy oriented multilateralism, an increasing amount of funding has been earmarked for themes of particular relevance to the Finnish development assistance in the health sector. While the selected themes - adolescent reproductive health (UNFPA), mental health, tobacco and health systems strengthening (WHO) - are important and the relevance well-recognised, the criteria and strategic considerations that led to the choice of these thematic areas are not clear. There may be strategic considerations well-known to those vested within the system, but not documented and thus available to those coming from outside, be it partners, civil society, new employees or external evaluators.

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33 UNFPA did not originally have reproductive health as the core issue. Its priorities were reoriented following the ICPD in 1994. They now include reproductive health and rights and family planning, as well as establishment and evaluation of population and development strategies. UNFPA is the lead on the implementation of the ICPD Programme of Action and the ICPD+5. In 2003, more than 60% of its expenditures were used in the areas of reproductive health and family planning, according to its 2004 Annual Report. WHO has a key normative role at the global level, as centre of excellence at country level and for research and information-sharing. UNAIDS is important for HIV/AIDS advocacy, coordination and learning from global efforts.
3.4.1.4 **Key benefits**

One benefit of multilateral collaboration is the opportunity to influence the development policies of international organisations and participate in setting the agenda for development work internationally. Indeed, Finland was a member of the Executive Board of WHO 1994-97, a member of the joint UNDP/UNFPA Executive Board 2001-2003, and chair of UNAIDS Executive Board from May 2000 to end of 2001. It has also participated as observer. Finland has been active on discussions on policies towards MDGs, good governance of the agencies and harmonisation of work among agencies. It is, however, difficult to pin-point any particular achievements to the Finnish contribution.

Finland has collaborated closely with the group of like-minded donors in influencing the policy dialogue and priorities. This, combined with a major part of support being given as core funding, raises the issue of visibility. As a group, the like-minded donors have been able to stimulate improved governance and get reproductive health and rights higher up on the agenda of UNFPA. The core funding has in turn enabled UNFPA to manifest itself as a core organisation for promoting reproductive health and rights and for standard setting for improved implementation.

3.4.1.5 **Problems and challenges**

Some concerns were raised to the evaluation team about the lack of predictability in multilateral funding from Finland. Extra-budgetary funds are not all part of long-term planning, but to some extent depend on unspent amounts in the bilateral budget. Some of the extra-budgetary funds arrive only by the end of the year, which exacerbates the problem of annual grants and no rolling budget. The multi-year commitments that have been made with some agencies may solve part of this problem.

Finland intends to increase funding for AIDS-related activities and is under pressure to start contributing to the Global Fund (c.f. 3.3.2.6. Global Fund). The reasons why Finland has opted not to do so were not clear to a number of the persons interviewed, and there is no documented strategy.

There are also some concerns about the increasing ‘verticalisation’ of the multilateral cooperation, i.e., the tendency to increasingly earmark support for thematic areas. The concern is parallel to the discussion in bilateral aid, where the trend is a move away from earmarked support towards general budget support for the implementation of a comprehensive plan. While Finland has also increased its proportion of earmarked funding, UNFPA and UNAIDS still see it as a strong supporter. As a strong supporter, Finland could raise the issue of earmarking among all donors, possibly with a view to agreeing on a target percentage allocation for unearmarked core support. Finland may also want to signal its own minimum target proportion of core funding.

The increased funding for multilateral organisations increases the need for a more explicit strategy for cooperation in health. While there are clear priorities for which UN organisations to support, there is no strategy for cooperation with the individual organisation. The other Nordic countries either already have (e.g., Denmark) or are preparing (e.g., Sweden) such an organisation-specific strategy for more targeted and effective collaboration. The lack of strategy also raises some very concrete concerns, for example as to what extent the areas supported are related to Finns being employed in particular units of a multilateral

34 WHO board members were elected as individuals in the early part of the evaluation period, whereas they now represent member states. Finland worked actively for this change.

35 The 2002 evaluation of UNAIDS (covering 5 years of the programme) was fairly positive, especially of the work of UNAIDS at global level. It was less favourable in its assessment of country level work.

organisation and to what extent programmes can expect to continue receiving Finnish support when that person is transferred.

3.4.2 EU cooperation and health

3.4.2.1 Background

Development cooperation was included in the EU Treaty in 1993. According to Article 130u, the community development policy shall be complementary to the development policies of the member states. Article 130x states that community and member states shall coordinate their development cooperation policies and consult each other on their development cooperation programmes. In practice, EU plays a dual role as bilateral donor and coordinating framework for member states.

Finland has contributed to EU's development activities through EU's general budget since 1995 and through the European Development Fund (EDF) since 1998. The EDF provides development assistance under the Lomé Conventions and recently the Cotonou Agreement for the 9th EDF. Each EDF covers a five year fund period and is aimed at supporting the ACP (African, Caribbean and Pacific) countries. The EDF has been earmarked for increased flows. EU's general budget contains allocations for development assistance in non-ACP countries. About 55% of EU's development assistance is financed by the member countries’ compulsory contributions to EU’s general budget, whereas 45% is financed by the (in principle) voluntary contributions to the EDF.\(^{37}\) The share of development assistance funded by the ordinary budget is, however, increasing.

The two funding channels have different governance structures and administrative rules. The EDF is governed by the Member States meeting in a specific Management Committee, under the chairmanship of the European Council. Development assistance funded over the general budget is governed by a set-up of Management Committees that are made up of Member States. It comes under the oversight of Parliament in the budget discussions. The European Parliament considers only the EU general budget, not the EDF.

In Finland, the general contribution to the EU appears on the budget of Ministry of Finance. The contribution to EDF appears under development assistance as contributions to multilateral organisations. It was recently given its own budget line.

3.4.2.2 Role and relevance of EU assistance in health

The health sector was one of EU's initial focus areas for coordination. This resulted in a resolution on the fight against HIV/AIDS in 1993 and another resolution on health in 1994. A regulation on support to population policies and programmes in developing countries was adopted in 1997. The first general development policy framework that places poverty reduction as the overall objective was developed only in 2000.

The first single policy framework to guide investment in health, HIV/AIDS and population within the context of overall European assistance to developing countries came in 2002. It proposed four objectives for future support:

1) Improve health, AIDS and population outcomes at country level, especially among the poorest

2) Maximise health benefits and minimise potential negative health effects of EU investments in other sectors

3) Protect the poorest and most vulnerable from poverty through support for equitable and fair health financing mechanisms and

4) Invest in the development of specific global public goods.

In July 2003, the European Parliament and the Council issued a policy document on development aid for policies and actions on reproductive and sexual health and rights in developing countries.38

At country level, the role of EU is less clear. It supports bilateral health programmes in a number of countries, e.g., in Mozambique. The purpose of the Mozambique programme is to support the development of a SWAp in health and to improve the delivery and quality of basic health services, particularly those related to the treatment and prevention of STDs and HIV/AIDS. The programme is implemented nationally, but with a focus on Zambézia Province. In many ways, this programme is similar to that of Finland and Denmark, leading one to wonder about the added value of EU involvement. Indeed, the member states, rather than the EU, often take the lead at country level in health sector development assistance. (Conversely, one may, of course, also speculate about the added value of several EU member states running parallel health sector programmes, when the EU can do so.)

The EU may have a comparative advantage in bringing European health development policy preferences onto the global agenda. The EU, however, appears to have failed to attain visibility commensurate with its contribution.39 It is not yet regarded as a major player, despite being a major ICPD donor. The lack of visibility is attributed to human resource constraints, rather than structural problems.

EU’s approach to population and development, as well as health sector development, has been coherent with the Cairo ICPD and with the approach taken by major international donors.40 In 2000, the share allocated to the health sector, including population, was, however, only 5% of total bilateral development assistance.41 It is further notable that basic health receives only the 2% and population programmes 1%. Overall population and development programmes are roughly estimated to account for 5% of total external assistance. This is surpassed only by Finland in terms of the preference accorded to this area of support.42 The indirect Finnish health sector development assistance through EU is relevant in relation to global needs and largely in line with Finnish priorities.

3.4.2.3 Key benefits of Finnish assistance through EU

EU’s development assistance to health has shown progress in development of the coordinating framework. Also, progress has been made at a more general level in increasing efficiency. (Many evaluations in the 1990s found that EU procedures related to project identification, design, implementation and monitoring were highly centralised, complicated and time-consuming.) Finland has participated since 1995 and contributed through the management structures, but it is not possible to credit any of these achievements specifically to the Finnish contribution.

38 Key EU documents for the period under review include: Communication on the fight against HIV/AIDS, COM (93) 479; Communication on Health, COM(94) 78; Regulation 550/1997 on HIV/AIDS-related operations in developing countries; Regulation 1484/1997 on aid for population policies and programmes in developing countries; Communication on accelerated action targeted at major communicable diseases within the context of poverty reduction, COM(2000) 585; Communication on accelerated action on HIV/AIDS, malaria and TB in the context of poverty reduction, COM(2001) 96; Communication on health and poverty reduction in developing countries, COM(2002) 192; Regulation 1567/2003 on aid for policies and actions on reproductive and sexual health and rights in developing regions; Regulation 1568/2003 on aid to fight poverty diseases (HIV/AIDS, tuberculosis and malaria) in developing countries.
40 Ibid.
3.4.2.4 Problems and challenges

The European Parliament has raised concerns about the insufficient poverty focus in EU’s sectoral allocations of bilateral aid. The Parliamentary Development Committee has suggested a percentage allocation target for all social sector spending, expecting this to translate into higher allocations to the basic social services. This assumption may, however, not be met. Further, many of the member states, including Finland, do not themselves have a specific allocation target.

A key challenge for EU in the future will be how to improve its visibility and efficacy in the international health policy dialogue. A central question is also to elaborate the role of EU health sector programmes vis-à-vis health sector programmes of member states. For Finland, a key challenge will be how to contribute to and influence the content and quality of EU’s health development cooperation through active strategic involvement, rather than wait for guidance.

Finland has continued to play its part in the EU funding of NGO projects. Some Finnish NGOs, including KEPA, indicated that the process of applying for EU funds is very laborious. Along the same lines, Finnish consulting companies tend to find the tendering procedures time-consuming and far from transparent.

3.4.3 State-to-state health sector support

Bilateral health sector cooperation includes state-to-state grant-based assistance, assistance through NGOs and international NGOs (INGOs), as well as through Local Cooperation Funds (LCF) and Concessional Credits (CC). Finland also collaborates on projects with UNFPA and UNICEF as part of its bilateral cooperation. Bilateral state-to-state health projects, funded during the evaluation period (1994-2003) are listed in Annex 9.43

3.4.3.1 Background

As discussed earlier, the number of purely grant financed health sector programmes of significance are decreasing. In 1993, recipients of major health sector support included Kenya, Mozambique, Namibia, Egypt and Nicaragua. The programme in Kenya closed for political reasons (but has been to some extent continued by NGOs); Namibia and Egypt are phasing out. The few health projects that have been developed include ones in Kosovo, Kyrgyzstan and Vietnam, ARIVAC in the Philippines and a PAHO implemented project in Guatemala.

The purely grant-based state-to-state support has shifted from infrastructure provision to systems and institutional development and towards larger emphasis on integration of cross-cutting themes. For example, the Manica Province Integrated Health Project shifted from an initial focus on infrastructural development to health care management issues in the second phase. Likewise, the early projects in Namibia and Nicaragua included hospital equipment and maintenance elements, whereas the later Finnish development assistance increasingly focused on systems development and capacity building. In addition, however, Finland has increasingly engaged in a number of hospital and laboratory equipment projects, partly through the concessional credit scheme, cf. Section 3.4.6.

Finland’s commitment to development cooperation based on a partnership, new funding modalities and increased aid effectiveness is also reflected in the state-to-state grant-based support to health sector development. In the long-term partner countries, support is shifting

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43 The table was developed based on Annex G of the tender for this evaluation. It was cross-checked with the DAC database. The disbursed amounts were excluded; the two data sources were inconsistent both as to the disbursed amounts and the years in which disbursement occurred.
from a projectised approach to a more programmatic approach. The programmes are at various stages of moving towards new funding modalities for health sector support. The examples of Kosovo, Nicaragua and Mozambique are illustrative in this regard (cf. Annex 10).

In Kosovo, which is not a long-term partner country, the project approach is still used. In Nicaragua, the approach is shifting. The 1997-2001 Support to Reproductive Health and Women’s Empowerment project (SAREM) used a project approach with a separate project implementation unit. Its continuation, the 2002-2006 Reproductive Health, Equity and Rights Programme (SARED) uses a programmatic approach, in which the Ministry of Health is responsible for the implementation. In 2003, Finland joined SIDA, DfID and the Dutch Government in supporting a fund for the development of a health SWAp. In Mozambique, the SWAp process has been going on for some years and pooled funding arrangement has already been developed. Finland has played a key role in the development of the SWAp. It used its many years of experience working in a provincial health sector programme in Manica Province constructively and completed its term as lead donor for the SWAp process last year. Finland has been highly praised for its efforts, initiatives and team work.

The Finnish development cooperation has thus far been characterised by a fairly heavy technical assistance (TA) component in terms of the financial resources allocated. The proportion of TA in general was about a third of Finland’s bilateral development assistance in 2001. In Mozambique, the Manica Province Integrated Health Project phase II (1994-98) included 19% expenditures for TA, whereas the Finnish Programme Framework for the Finnish Support to the Health Sector in Mozambique (2003-2005) operates with an allocation of 16%. The two Namibia health programmes had budget allocations of 45-48% for TA. Nicaragua shows the largest recent change in strategy. While the SAREM project allocated 47% to TA, only 5% is budgeted under SARED. A strong involvement of consultancy companies is another feature of Finnish development cooperation. The consultancy companies have typically been responsible for providing the long and short term TA and taken the responsibility for disbursing funds and financial management. In the past, the desire to achieve quick and effective results appears to have resulted in some cases in parallel ad hoc implementation structures.

3.4.3.2 Role and relevance of bilateral assistance to health

The bilateral state-to-state grant assistance has been relevant. It is in line with the needs of the recipient countries, as well as in line with the government priorities, although not necessarily at the core of them. In Nicaragua, for example, Finland is providing support focused on the disabled people and on reproductive health and family violence. Both are areas at risk of being marginalised, even though they appear on the government’s priority list. Several informants in the country credit Finland for helping keep these issues higher on the agenda than they would otherwise have been.

Finland has shown willingness and flexibility to adapt its assistance, as recipient countries have shown interest in increasing efficiency in aid and worked towards comprehensive planning under the umbrella of Poverty Reduction Strategy Plans. It has even taken bold moves, such as the shift at an early stage to government implementation in Nicaragua or the move to some level of budget support in Mozambique, despite a simultaneous need for capacity building and systems strengthening in the recipient government. Finland is, thus, participating in spearheading the new approaches. Based on the Nicaragua case, however, the evaluation team is concerned that Finland may not have fully recognised the need for

44 The figures in the following examples are taken from relevant expenditure statements, when available, otherwise from budgets in programme documents.
undertaking a comprehensive institutional analysis and then tailoring the capacity building and technical assistance to the findings. The team’s experience with health sector programmes and SWAps in other countries demonstrates that the initially envisaged diminishing need for TA does not necessarily materialise and not as quickly as expected.

### 3.4.3.3 Key benefits

Its flexibility and ability to adapt to changes and provide some un-earmarked support have provided Finland with much influence beyond what its level of financial support justifies. In Mozambique, the continuous presence of the health sector adviser has been pivotal in allowing immediate participation in policy dialogue, based on a level of information and personal relations that gives a lot of credibility. Similarly, the long-term commitment of Finland has added to the mutual trust and credibility in its participation in the policy dialogue. By its choice of sub-sectors, Finland has managed to support those quarters of government that are willing to put slightly contentious issues on the agenda and work for changing the health of vulnerable groups.

The lack of systematic documentation, such as base line studies and programme evaluations, makes the identification of Finnish programmes’ impact difficult, however. This is not a problem particular to Finland, but also to many other donors. (See Chapter 3.7. Measurable achievements of health sector support.)

### 3.4.3.4 Problems and challenges

The shift to programme support or participation in SWAps and pooled funding raises concerns about the capacity on both the donor and the recipient side. These concerns centre on monitoring, policy dialogue, appropriate accounting and achieving value for money. Weakening the link between donor support, activities and visible results is another area of concern to some staff, especially in relation to mobilisation of resources for development assistance in Finland.

An obvious challenge with participating in SWAps or pooled funding, in particular, is that Finland becomes part of the overall sector development in the recipient country. This will include any “white elephants” - typically hospital infrastructure development projects - that could so easily be disregarded in a projectised approach. It does, of course, also present an opportunity to confront such potential “elephants” through a joint effort by donors and government quarters interested in change. However, the issues raised are likely to be uncomfortable for the Finnish public. On the plus side, Finland may also take credit for achievements by joint efforts of a magnitude that it could never muster on its own. Any sector budget support is support for the general implementation of the overall health sector strategy. One option is to earmark a smaller part of the country support for areas of particular concern to Finland. These could include development of new approaches and/or issues at risk of being marginalised, e.g., maintenance or family violence.

The key characteristic of the SWAp process is that all resources (government, development partners, users, earmarked and unearmarked funds) are planned for and used to implement one comprehensive strategic plan for the sector that is balanced and prioritised in view of the combined resources available. As the SWAp matures, some of the development partners may seek to stimulate further administrative efficiency gains by providing some, or sometimes all, funding as sector budget support through pooled funding arrangements. Any sector budget support is support for the general implementation of the overall health sector strategy. To maintain some distinct Finnish visibility, one option is to maintain earmarking of a smaller part of the Finnish support for areas of particular concern to Finland. These could include areas in need of development of new approaches and/or issues at risk of being marginalised, e.g., health technology maintenance or family violence. In a transitional period such holding aside of a small part of the Finnish support outside the core sector support.
could also be used for phasing out of earlier projects and gradual phasing in of budget support. It could also be used for maintaining some ground level activities that would provide knowledge and credibility, when raising issues about the problems on the ground. Alternatively, the Finnish concerns could to some extent be addressed through alternative avenues of support, e.g. a focused NGO strategy or strategic use of the Local Cooperation Funds.

There is a risk that central level discussions on the SWAp, in particular in its initial phases, will focus on administrative, financial and management issues only. The risk is increased, if and when donors shift funding to sector budget support and lose contact with the problems that emerge for service delivery at ground level. Developing monitoring and evaluation systems is important, but maintaining some kind of minor presence on the ground, at least in a transitional phase, may also well be wise. This will also contribute to the credibility with which Finland can participate in the policy dialogue.

While the move to a SWAp is a positive one, steps must be taken to ensure that gains made by past programmes are not lost. Staff trained and facilities built and equipped should be taken over properly. Lessons learnt, especially with respect to the quality of care, should be documented so that they can convincingly be shared. Some activities may need special protection during a transition period. It cannot be assumed that those in charge of health sector reform will necessarily from the beginning understand or recognise the need for prioritising (e.g., maintenance) or appreciate the importance of matching a phased adaptation to changing circumstances. In the long run, such priority setting should result from the policy dialogue, in which Finland as one partner can contribute to the agenda. Finally, moving to SWAp and pooled funding arrangements also raises the issue of how to phase-out of the existing support, cf. Chapter 3.5.

A potential clash exists between decentralisation processes at the country level and the SWAp. A SWAp to some extent is a very centralised approach. Donor agencies may prefer sectoral financing, as opposed to the integration of grants into the decentralised government system. It is obviously easier for a donor to agree with one Ministry of Health or one Ministry of Finance about resource allocations to the health sector and priority spending areas than to agree with a large number of local administrative units receiving block funding. In countries where decentralisation is further developed than in Mozambique and Nicaragua, the Ministry of Local Government is a key stakeholder. A donor has the alternative of refraining from providing direct health sector support, and providing only general budget support through ministries of finance, with a requirement for overall health sector spending in accordance with the poverty reduction strategy plan. This could, however, result in the donor country losing its credibility in the more technical health policy discussions taking place in ministries of health. As decentralisation takes off in any of the partner countries, Finland will have to consider which strategy to adopt.

The role of NGOs and civil society was raised as a concern in Nicaragua and Mozambique, as well as in other countries adopting a SWAp. When development assistance is concentrated in a SWAp, funds will invariably be channelled through the government system. Non-governmental stakeholders are not necessarily part of the SWAp process and may feel alienated from the decision-making. Further, there is a risk that funding will only benefit the government, if the government does not recognise its stewardship role or where there is a certain apprehension between sectors. Designing the SWAp to become inclusive of all stakeholders, while maintaining a manageable size and a balanced representation, is a challenge, particularly since vulnerable groups are often not well-organised. Furthermore, resources may be needed to promote a change in culture and bridge the gap of mutual understanding between some stakeholders. If NGOs or other private service providers are to benefit from contracts with the government on service provision, resources may be
needed to strengthen them as partners in the policy dialogue and in terms of management skills and improved quality of care.

3.4.4 Non-governmental organisations

3.4.4.1 Background

The strengths and benefits of supporting NGOs are recognised at the official Finnish government level. NGOs are seen as forerunners in dealing with sensitive issues, such as reducing unwanted pregnancy and unsafe abortion. The Decision-in-principle on Finnish Development Co-operation set a target to channel 10-15% of the total Finnish development assistance through NGOs. Self-financing of NGOs is to be decreased from 20% to 15%.

The MFA has been, for a number of years, an important funding agency for many NGOs involved in international development. It provides both institutional and programme funding. Institutional funding has been critical to the survival of these NGOs. Currently, NGOs take about 11% total Finnish aid. More than 90% of these resources go to projects run by Finnish NGOs. The balance is for projects run by international NGOs.

The Unit for NGOs Support is within the MFA’s Department of Development Cooperation. There is no NGO policy as such, but the MFA does have a comprehensive manual that gives guidelines on funding for NGOs.

3.4.4.2 Role and relevance of NGOs working in health

About two hundred Finnish NGOs implement over 500 projects in almost 70 countries. Unfortunately, there is no data base, where all NGOs working in the health sector would be listed with information on their performance, size, geographical coverage, target group and the various strategies used. An evaluation of NGOs done in 1997 indicated that about 33% of all the NGOs supported by the MFA work in the health sector. The majority of Finnish NGOs that work in the international health sector are church-related.

The support to NGOs seeks to widen relations past official aid channels to incorporate people-to-people cooperation. This creates space for grassroots initiatives that strengthen the roles and capabilities of the most vulnerable people as a basis for long-term and sustainable development. Some Finnish NGOs, for example, support psychiatric programmes in various countries.

In 1993, the MFA agreed on a Framework Agreement System (known as partner agreements since 2003) with some large, experienced NGOs. The MFA believes that financing the most professional NGOs improves the overall quality of projects and reduces the administrative burden on the NGO unit, as application and report screening are less frequent. Partner agreements define the principles and project-specific frames for a four-year period at a time. If necessary, funds may be transferred between projects within the approved overall frame, which provides more flexibility in the NGO’s operations. Otherwise, the NGOs with partner agreements must follow the same requirements for project plans and monitoring and reporting procedures as other NGOs. The progress of the NGO programme and disbursements are discussed in annual meetings between the MFA and the partner NGOs.


48 See a report, entitled 2002:6 Evaluation of framework NGOs in Finland (in Finnish), indicating that this might not be the case. The most time consuming tasks in the administration of NGO funds are related to verification of technical appropriateness of the project applications and reports.
The volume of work and geographical coverage of partner NGOs are big, compared to most other Finnish NGOs. The support for the partner NGOs amounts to approximately 50% of all the support given to NGOs (FIM 80 million in 2002 for a total of 180 projects). By the year 2002, the Ministry had partner agreements with seven NGOs; this increased to eight in 2003. The eight partner NGOs are:

- Suomen Lähetysseura (The Finnish Evangelical Lutheran Mission)
- Kirkon Ulkomaanapu (FinnChurchAid)
- FIDA International
- Suomen Punainen Risti (Red Cross Finland)
- Kansainvälinen Solidaarisuussäätiö (International Solidarity Foundation)
- Suomen Ammattiliittojen Solidaarisuuskeskus (Trade Union Solidarity Centre of Finland)
- Suomen World Vision (World Vision Finland) and
- Frikyrklig Samverkan (Free Church Aid)

Most partner NGOs are active in community development with health as one of the components. With their established presence, multi-donor-funding and broad legitimacy, the partner organisations (such as the Red Cross Finland) are uniquely placed to play an important role in health care at community level. The inputs of the Red Cross Finland, for example, have resulted in the Gjilane regional hospital in Kosovo being considered now the country’s best managed hospital. The vertical organisational nature of many partner NGOs may pose a challenge to their integration in a SWAp. Their approach may, however, lend itself well to future operational research.

The Service Centre for Development Cooperation (KEPA) is the umbrella organisation for approximately 200 Finnish NGOs. In 2001, the MFA gave EUR 4.54 million for KEPA’s member activities in 11 countries in Asia, Africa and Latin America. KEPA provides capacity building for its members in various areas, including project management. It administers and coordinates a voluntary services programme for young people and disseminates information to the Finnish public on development issues. The capacity building offered is not health specific, although many NGOs could benefit from such support. Some NGOs, for example, are struggling to understand human rights issues in the health sector. KEPA is well placed to build the capacity of NGOs working in the health sector, especially in mainstreaming cross-cutting issues, as well as to maintain a data bank of such organisations.

MFA also funds international NGOs to tap into their extensive experience and well established links with developing countries. Examples of international NGOs working in health that the MFA funds include:

- IPPF, funded under the Cairo Population Plan, works in most developing countries. It is the largest NGO working in the field of sexual and reproductive health.
- The Inter-African Committee (IAC) promotes the health and human rights of African women and children. It also aims to change attitudes regarding harmful habits and customs through training and information, targeting religious leaders. Finnish support was used to fund activities in Cameroon, Uganda, Ethiopia and Kenya.
- IPAS, which gives professional support in abortion issues to national healthcare systems, received funding to advance access to safe abortion care in Africa.
- Aga Khan Foundation (AKF) was given funding to improve knowledge of health and nutrition among students in Tadzhikistan through training, information and
The health programmes of international NGOs are often innovative, bold and cutting edge in terms of addressing issues that would probably not be addressed by governments. They have tried, for example, to break the silence on physical abuse and other forms of domestic violence by moving such issues into the public debate through campaigns, advocacy, counselling and training. A lot can be learnt from their approaches and strategies.

3.4.4.3 Benefits

The added value of funding both international and Finnish NGOs working in the health sector is clear. NGOs address issues that governments normally do not address in bilateral development cooperation. They lobby and advocate and have in fact been effective in convincing some governments to start addressing oppressive customs with a bearing on health, such as circumcision of women. Most of their activities are at grassroots level, reaching the vulnerable people in society. The MFA should consider documenting some of the methods used and lessons learnt, and then sharing these widely.

The role of men in sexual and reproductive rights is an example of a critical issue that some NGOs have addressed. A case in point is the work of Väestöliitto, the only Finnish NGO promoting the ICPD Programme of Action. Väestöliitto strives to promote the sexual and reproductive health of men and women, gender equality, balanced population development and alleviation of poverty through the projects it has had in India, Malawi and Mexico.

Another good practice worth highlighting is bringing together Finnish and overseas NGO counterparts to share ideas and best practices. For example, the 2002 Helsinki workshop, organized jointly by the MFA, Finnish Save the Children’s Fund and KEPA, was important for promoting synergy and ‘harvesting’ lessons learnt pertaining to sexual and reproductive health.

3.4.4.4 Challenges

The NGO unit staff are not necessarily specialists in development work and there is limited activism; the staff do not have time to identify innovative NGO initiatives that could enrich and amplify the work of the MFA. Networking and alliance building are hampered by the day-to-day workload and short-term strategies. NGO work tends to be isolated from the mainstream work of the MFA’s other Departments. In fact, it seems to be marginalized. The NGO unit is understaffed and vulnerable to high staff turnover, eroding continuity and capacity for effective reflection and networking.

An outsourcing experiment is being carried out with FIDIDA, an umbrella organisation for the disabled. FIDIDA receives all the applications related to disability for screening, before final prioritization by the NGO unit. A similar experiment with KEPA was not continued because of concerns about conflicting interests. The NGO unit has commissioned a thorough study on the possibility of outsourcing some other aspects of its work. Interestingly, other MFA units appeared unaware of this study.

NGOs are required to send comprehensive reports to the MFA. The evaluation interviews showed that the NGOs, however, perceive the MFA as more interested in monitoring expenditure than actual activities or outcomes. Monitoring through KEPA has been suggested. This, however, is difficult, because members do not currently send information to KEPA voluntarily. Some large NGOs, such as Red Cross Finland, do have monitoring systems in place, but a majority of the small ones do not. Most of the NGOs do not collect baseline data either.
NGO expertise is more advanced in sexual and reproductive health, and experts from NGOs are said to be involved in bilateral projects. However, sharing of lessons learnt between Finnish bilateral programmes and NGOs working in health is limited. It is not clear how the NGO expertise of sexual and reproductive health, for example, has been used in the development of bilateral programmes. Meanwhile, the NGOs also do not use the presence of a bilateral programme in the country as a channel for sharing their experiences. An improved flow of information, consultation and dialogue between the NGO Unit, bilateral state-to-state programmes, embassy and NGOs, especially on innovative projects, could be very beneficial.

Finally, the majority of local NGOs, which the Finnish NGOs support, suffer from a lack of staff skills. Investing in capacity building is thus crucial for a successful implementation and sustainability of programmes that local NGOs implement with their Finnish counterparts.

3.4.5 Local Cooperation Funds

The Local Cooperation Funds (LCFs) were created in 2000, when they replaced the small projects, human rights and democracy and cultural funds, previously available for the embassies. The LCF should complement Finnish development cooperation objectives by providing small funding to promote development of civil society addressing social and gender equality, local cultural identity, transparency and participation of civil activities and the rights of disabled people. The LCF was evaluated in 200349. The LCF was generally found to be a good instrument in the Finnish development portfolio, allowing a rapid and flexible response in innovative areas and linkages with civil society. The evaluation, however, found a lack of clarity in the objectives and uncertainty about the sectors in which it can be used. Large differences in quality of management and use of funds were also identified.

In Nicaragua, the Finnish embassy and the MFA have chosen a strategy to fund projects from sectors other than the bilateral cooperation. They mainly funded projects focusing on human rights and democracy and those contributing to the improvement of women's and children's rights.50 In 2004, support was given to a local NGO, working in reproductive rights and family violence, as well as provision of health care. While the support was for the rights-related work, the work was well in line with the areas of support in the health sector. In Mozambique, the LCF has mainly been applied to democratisation and human rights, elderly/disabled and culture. Some support has been given to NGOs that have included work in health, though they have had a narrow range of health activity, working mostly with disability, HIV/AIDS and mental health.

The LCF evaluation proposes to develop the system for partner countries further. The recommendation is to allow a larger Local Cooperation Fund with no ceiling and no restrictions on sectors, but as one part of overall country specific planning (jointly by the embassy and the MFA). Embassies in non-partner countries would maintain smaller LCF with a ceiling in the country specific plan, leaving the actual planning to the embassies.

The evaluation team finds that this proposition would provide a good opportunity to reinforce the development assistance in health in partner countries. The move towards SWAps raises concerns about diminishing resources for NGOs, cf. Section 3.4.3. The NGO sector and other private sector stakeholders are likely to need strengthening to allow them to participate as partners in the health policy dialogue and in improving the management and quality of health services. The availability of a Local Cooperation Fund could be an avenue for empowering civil society to engage meaningfully in the SWAp discussions. Broadening the

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50 Ibid.
definition of civil society to include professional associations (like associations of traditional birth attendants), would provide scope for comprehensive health sector development. At the same time, it would strengthen the purchaser, provider and consumer sides.

3.4.6 Concessional Credits

Concessional credit (CC) is a financial instrument, in which an interest subsidy from official development assistance supports an export credit. It may include a combined loan and grant element, e.g., in the form of TA. It is mainly a commercial instrument, but as it contains a grant element, it has to comply also with development objectives. The concessional credit scheme was evaluated in 200251.

The health sector accounted for 18% of approved credits (Euro 31,4 million) for the period 1993-2001. The CC Evaluation included a review of four health sector projects in China, the largest recipient of Finnish concessional credits overall. The projects were found to subsidize delivery of equipment to big-city hospitals with poor implementation and maintenance. The main findings of the review of the four Chinese health projects were that:

► Social impact of several health projects was left in doubt. The objectives were not realistically dimensioned in view of the hospital setting and the general institutional environment in the public health sector. The outcome therefore remained below expectations.
► The sustainability of three out of four health sector projects is questionable.
► Development impact in the health sector is ambiguous, because the improved services enabled by the project equipment are not necessarily available for poor people due to high user fees and other access costs.

One problem with CC is tying to domestic purchases in the donor country. In 2000, the required domestic purchase was reduced from 80% to “a considerable proportion”, in practice a minimum of 50%. With a fairly small market for hospital equipment in Finland, this raises some concerns about whether truly competitive prices can be obtained. Further, the tying may cause problems for obtaining spare parts (due to limited availability in local markets and higher prices), thus creating problems for maintenance and sustainability. This indeed appears to have been part of the problem. It should be an issue for concern when developing, appraising and deciding on new projects.

Likewise, the question of social impact should be a key concern, when developing new projects. Unfortunately, there has been a tendency to regard concessional credits solely as a loan (disregarding the grant element) with few requirements on the borrower, and primarily as a vehicle for strengthening trade. Therefore, the tradition of thorough analysis, of for example social impact, and the use of the results in the process of negotiation has not been so well-developed. Following the evaluation of the CC scheme, it appears, however, that there are some positive changes with increasing emphasis on the development aspect of the scheme.

Some respondents expressed to the evaluation team a great deal of apprehension regarding the use of CC in the health sector. They were particularly concerned about the use of CC for hospital projects with no social impact. The evaluation team recognises that there were problems with the particular projects in China in relation to equity (financial access barriers), efficiency and sustainability. The team would, however, like to warn against making a general assumption that support to hospital equipment in big-city hospitals does not have a social impact, and should therefore not be targeted for concessional credits.

Consistency between social impact and the use of CC will have to be ensured through careful preparation and monitoring of projects. Urban health services are not well-developed in many cities. Poor people and others rely on run-down public hospitals for all types of health care. These hospitals have increasing difficulties to cope with the population increase from rural to urban migration. Furthermore, they are often part of a referral chain that needs a certain level of functionality in order to provide the necessary back-up for improving service quality at lower levels. User payments can be used to cross-subsidise services. Quality improvements in turn can be pivotal to legitimise financing health services through increased taxes or having an urban middle class pay a disproportionate share of health insurance. Hence, there is not necessarily any inconsistency between urban hospital equipment projects and social impact – as there is also not necessarily any consistency! It all depends on design.

CC is mainly targeted at low and lower-middle income developing countries. Relevant projects for credits will often lift the health care system to a higher level of sophistication by strengthening the referral system and quality of care. CC may be an instrument for gradually withdrawing from countries, where health sector support is being phased out.

3.4.7 Other aid mechanisms

3.4.7.1 Humanitarian aid

A separate evaluation, conducted at the same time as this evaluation, will provide a more detailed analysis of Finland’s contribution to humanitarian aid. Finland allocates 10–15% of its development budget to this area each year. It spent 42 million EUR in 2003 on humanitarian aid and an additional 5 million EUR on humanitarian mine action. General non-earmarked support to humanitarian organisations amounted to 12 million EUR. Almost 60% of the earmarked funds were for Africa.

Finnish support to humanitarian aid is channelled through several organisations, many of them active in the health sector. In Finland, they include the Red Cross Finland, FinnChurchAid and Fida International. The United Nations High Commissioner for Refugees (UNHCR), the International Commission of the Red Cross (ICRC), the International Federation of Red Cross and Red Crescent Societies (IFRC), the World Food Programme (WFP), the United Nations Relief and Works Agency for Palestinian Refugees in the Middle East (UNRWA), and UNICEF are the most important international organisations that Finland has supported through humanitarian aid.

3.4.7.2 Research Funding

The MFA funds development research through two mechanisms: a research grant to the Finnish Academy (which the Academy itself manages) and direct funding from the MFA. Both a recent evaluation of development research via the Finnish Academy and internal discussions in the MFA have focused on examining the role of research in supporting the new Development Policy. Health-related development research is, however, notable by its absence both in the Finnish Academy’s development research portfolio and in research directly funded by the MFA. At the country level, Finland appears to have funded very little operational research in health. (Even "cutting edge" work that would qualify for operations research, e.g., the very positive team approaches to the SWAp in Mozambique, has been poorly documented.) At international level, Finnish money did contribute to a WHO study of mental health promotion, and the development of normative guidelines for prevention of mental health problems in emergency situations.

\(^{52}\) Finnish Academy research evaluation. Mimeo. Undated (?2004).

\(^{53}\) The evaluators’ queries about health development related research during the course of the evaluation revealed very little information. Prior to finalising this report, the evaluation team was given a list of such research
The ARIVAC project in the Philippines is a notable exception to the practice of not devoting Finnish development funds for health research. Since 1999, Finnish bilateral and NGO funds have been used to support ARIVAC, a research project aimed at prevent childhood pneumonia through pneumococcal conjugate vaccines\(^5\). It is important to note, however, that the ARIVAC project did not result either from an MFA decision to allocate the funding toward its research priorities or from its decision to fund a particular priority area in the Finnish bilateral portfolio with the Philippines. Rather, the project is said to have originated from previous NGO experience and a personal connection between a senior staff member of the Finnish National Public Health Institute and the then-incoming Finnish Ambassador to the Philippines.

### 3.4.7.3 Coordination and synergy effects

Different types of aid mechanism have different strengths. Multilateral organisations have much more resources. They can operate on a much larger scale and have much better opportunities to collect information, learn from experiences worldwide, set standards and influence the global agenda based on such evidence. The bilateral state-to-state cooperation can provide tailor-made programmes that take into account the country-specific context, e.g., local health needs, the institutional and economic setting and the available human resources. They also offer an opportunity to engage meaningfully in local policy review and development. Finnish, national and international NGOs on the other hand are close to communities. They can react promptly and target very specific local needs, often spearheading the development of innovative ideas.

Complementarity and synergy are important for the provision of comprehensive health sector development assistance. Finnish government’s policy is to use several channels of support to achieve such synergy. Little synergy, however, was found in reality in the health development portfolio. This is similar to the difficulties with mainstreaming (c.f. 3.5.1. below).

**Multilateral-bilateral interaction**

Decisions on proposed budgets, including considerations of coherence in bilateral and multilateral spending, go through the MFA’s Board of Development Policy Guidance Group. In principle, all projects should be presented for discussion to the Project Management Committee, which would provide an opportunity for seeing possible areas for synergy. The multilateral projects, however, tend not to go through the PMC. There is no systematic feedback of experiences or sharing of technical resources from the bilateral programmes that could help develop issues for improvement to take to the multilateral organisations. Interviews with multilateral organisations showed that their staff members would welcome a much more active dialogue with Finland.

**Bilateral state-to-state projects**

No particular coordination or systematic interaction between programmes could be found in Nicaragua, where several bilateral state-to-state health programmes are implemented simultaneously. If such synergy occurs, it is by coincidence. The recent, simultaneous implementation of the reproductive health programme (SARED) through the government system and the support to developing a SWAp appears to provide scope for some interesting synergy effects. The coordination and interaction with other sector programmes in Nicaragua also appears to be limited. It is not unusual that sector programmes work in

\[\text{\textsuperscript{funded since 2000. (See Annex 11.) It was not possible to assess the relevance of this research to operationalising the new development policy.}}\]

\[^{5}\text{The ARIVAC project is now a joint collaboration between the KTL and a number of international research institutions. It is funded by international and Finnish funding sources.}\]
different geographical areas. Potentially, however, there could be synergistic effects from working with agriculture, education and other sectors.

**Bilateral state-to-state and NGO/civil society**

Finnish bilateral state programmes have not systematically shared experiences with Finnish NGOs. Similarly, the experiences from NGO projects do not, in general, appear to be “harvested,” when new state-to-state health programmes are developed. The ARIVAC project in the Philippines is, however, said to build on long-term NGO cooperation in this field and NGO experts are reported to have been used in reproductive health programmes in Nicaragua and Afghanistan.

In accordance with Finnish government policy, no requirements are placed on Finnish NGOs in terms of in which sectors and countries to work in, despite the MFA providing 80% of their project funding. A large number of NGOs therefore operate in countries, in which there is no possibility for synergy effects. While the evaluation team agrees that civil society should not be unduly regulated, the team wonders whether it would be conducive to give some kind of preferential status to some key NGOs working in prioritised sectors and countries.

Development cooperation with local NGOs or other civil society organisations using local cooperation funding has not been used to complement the state-to-state health sector programmes in the reviewed period. The LCF, however, provides a very good instrument to develop a comprehensive multi-faceted approach to health sector development, cf. Chapter 3.4.5.

### 3.5 Key implementation strategies

#### 3.5.1 Mainstreaming themes related to vulnerability

**3.5.1.1 MFA and vulnerability**

Health is structurally very closely linked to ‘social policy’ in the MFA. This appears at the central level, where the health, social policy and gender advisers are expected to share many responsibilities. It is also true at the level of the “priority sectors” for the ministry’s international development cooperation (see Chapter 3.2. Policies and strategies). This cluster of advisers, in particular, is the home for the MFA’s cross-cutting themes, i.e., the expressions of concern about particular categories of vulnerable persons – people who are socially or economically marginalised on the basis of gender, HIV, disability or old age.

In the opinion of the evaluation team, the MFA seems to assume that this proximity will be enough to ensure widespread and adequate attention to these categories through a process of ‘mainstreaming’. However, the MFA does not appear to have an operational definition for mainstreaming. Nor does it have any clear objectives and indicators for action and monitoring the achievements of the mainstreaming.

Two of the cross-cutting issues – mainstreaming HIV/AIDS and gender - will be dealt with here. Both are critical issues for the MFA at the present time. (The issue of the elderly is only at a nascent stage of development, and disability was already reviewed recently as a separate issue.)

**3.5.1.2 Mainstreaming HIV/AIDS – what is it?**

Few governments and donors give any useful definition of what they mean by HIV/AIDS mainstreaming, even though many are talking more and more about the term. To further
confuse matters, ‘mainstreaming’ is often used interchangeably with phrases such as ‘the multi-sectoral response’ or ‘integrating HIV/AIDS.’

The same large working group on mainstreaming HIV/AIDS that made the above observation said that HIV/AIDS mainstreaming can be defined as the process of analysing how HIV and AIDS have an impact on all sectors now and in the future, both internally and externally, and using the information to determine how each sector should respond based on its comparative advantage. This definition emphasizes that each sector may need to approach mainstreaming in somewhat different ways.

Mainstreaming HIV/AIDS into the operations and programmes of organisations across the world is a challenge that requires creativity and commitment. Bringing HIV/AIDS to the centre of the development agenda requires change at the individual, departmental and organisational levels. The following definition stresses that mainstreaming requires serious organisational change and lateral (rather than vertical) thinking, planning and acting.

Mainstreaming HIV/AIDS is about change and it starts at the individual level where it must be internalized by the people in the institution. The process of change is from a vertical to a horizontal process, from a lack of action towards a push, demand and request for support, to integration, based on increasing ownership. It is about a growing organisational consciousness and culture towards integrating HIV/AIDS

Key organisational mainstreaming responses can include the following:

<table>
<thead>
<tr>
<th>Action</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workplace and human resource HIV policies</td>
<td>► Putting in place policies and practice that protect staff from vulnerability to infection and support staff who are living with HIV/AIDS and its impacts, whilst also ensuring that training and recruitment take into consideration future staff depletion rates, and that future planning takes into consideration the disruption caused by increased morbidity and mortality</td>
</tr>
<tr>
<td>HIV policy, strategy and detailed (or annual) implementation plan</td>
<td>► Refocusing the work of the organisation to ensure those infected and affected by the pandemic are included and able to benefit from their activities</td>
</tr>
<tr>
<td>Critical review of development ethics</td>
<td>► Ensuring that the sector activities do not increase the vulnerability of the communities with whom they work to HIV/STIs, or undermine their options for coping with the affects of the pandemic ◄ Participatory review of plans (and results), ideally involving members of all stakeholder groups, including PLWHAs</td>
</tr>
</tbody>
</table>

As will be noted again in more detail below, the MFA has no workplace policy on HIV. A general MFA HIV/AIDS ‘policy’ exists, but there is no strategy or action plan. There is also no evidence of any ethical review of the MFA’s development work in any sector from an HIV/AIDS perspective.

3.5.1.3 Specifics – mainstreaming HIV/AIDS in the health sector

At this point there are many international papers, reports, and presentations about HIV/AIDS mainstreaming, including some that are specific to mainstreaming HIV/AIDS into the health

sector. The table on the next page presents a very cogent outline of these ideas as organized by the UNDP. The table is presented here, because it offers a ‘checklist’ against which the HIV mainstreaming performance of the MFA can be assessed. It also provides some ideas about specific steps in a way forward.

On the positive side, most partner governments the MFA supports, such as Mozambique and Namibia, have HIV/AIDS policies and programmes of their own. It is not possible, however, to identify the extent to which any Finnish contributions helped achieve those plans. Most NGOs with a partner agreement have HIV/AIDS as one of their components. They take up the issue in combination with their core business and undertake activities, such as awareness raising and home-based care and nutrition. In Mozambique, for instance, the Red Cross is helping infected women live positively with HIV/AIDS through education. The main problem is that HIV/AIDS is being added on to the programmes without a rigorous analysis of how it is affecting people’s lives and of its links with poverty.
### UNDP classification for mainstreaming HIV/AIDS into the health sector

| Analysis |
|------------------|--------------------------------------------------|--------------------------------------------------|
| **Stage I - Awareness/Experience** |
| Sector HIV/AIDS plan with the following elements: |
| ► Analysis of AIDS-related morbidity on health sector work |
| ► Identified aspects of health sector work enhancing the spread of HIV |
| ► Identified aspects of health sector work inhibiting the spread of HIV |
| ► Analysis of AIDS-related mortality on health sector work |
| ► Sector workers’ AIDS risk analysis done |
| ► Development of evidence based communications for behaviour change |
| ► Condom promotions |
| ► Focal point persons designated |
| ► Financial resources made available |

| Action |
|------------------|--------------------------------------------------|--------------------------------------------------|
| No evidence that a risk analysis has been done – no White Paper for the MFA |
| Some IEC materials, but they have been project specific and not generic for the MFA, either for internal or external use |
| Condom promotion is being done |
| Some focal point persons, but unclear if they have any ToRs or scopes of work |
| No evidence of any budget for HIV/AIDS mainstreaming in the MFA; only HIV/AIDS funds going to multilaterals and some to LCF and NGOs |

| MFA Finland status |
|------------------|--------------------------------------------------|--------------------------------------------------|

| Analysis |
|------------------|--------------------------------------------------|--------------------------------------------------|
| **Stage II - Reflection/Processing** |
| Sector HIV/AIDS plan now includes the following additional elements: |
| ► Understanding of implications of AIDS related morbidity and mortality on health sector work |
| ► Understanding of implications of aspects of health sector work inhibiting or facilitating the spread of HIV |
| ► AIDS sector impact analysis conducted |
| ► Specific policies, strategies and actions developed, based on evidence |
| ► Actions to mitigate impact implemented |

| Action |
|------------------|--------------------------------------------------|--------------------------------------------------|
| No evidence that a risk analysis has been done – no White Paper for the MFA |
| There is an ‘HIV/AIDS policy’ (version 2002) that is currently under review; not clear about the evidence used for it. There is no strategy or implementation plan. |
| Very little action toward mitigation, and that only by small projects |

| MFA Finland status |
|------------------|--------------------------------------------------|--------------------------------------------------|

| Analysis |
|------------------|--------------------------------------------------|--------------------------------------------------|
| **Stage III - Decision/Generalization** |
| Sector HIV/AIDS plan now includes the following additional elements: |
| ► Analysis of sector policies, strategies and actions, and their negative or positive influence on the spread of HIV in the communities they serve |
| ► Policies developed to respond to AIDS related morbidity and mortality on health sector work |
| ► Policies developed to minimize aspects of health sector work that facilitate the spread of HIV, and encourage those that inhibit the spread of HIV |
| ► Organisational changes that will ensure above policies are implemented |
| ► Adequate financial resources made available to achieve policies |
| ► Appropriately skilled human resources made available. |
| ► Monitoring and evaluation framework |

| Action |
|------------------|--------------------------------------------------|--------------------------------------------------|
| No evidence of sector policy analysis in partner countries, though there has been some contribution to the health sector HIV/AIDS policy, but very little to the national HIV/AIDS policy in Mozambique |
| No workplace policy on HIV/AIDS for the MFA |
| No budget for HIV/AIDS activities within the MFA (As for development cooperation, there is only the large external support to UNAIDS and other UN agencies, and limited support to NGOs and LCF. No bilateral HIV/AIDS projects.) |
| The point person on HIV/AIDS in the MFA is also the only health adviser and has very little time for HIV/AIDS |
| There is no M&E framework for HIV/AIDS, and no specific objectives or indicators |

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Stage IV-Action/Applications

- Analysis of evidence showing lessons learnt through implementation of policies, strategies and actions
- Plan revised to incorporate stage III
- Plan implemented
- Learning plan for health sector

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<tr>
<th>Analysis</th>
<th>Action</th>
<th>MFA Finland status</th>
</tr>
</thead>
<tbody>
<tr>
<td>This is a consolidation stage that would include the following additional elements:</td>
<td></td>
<td>Of the new elements in this list, there is no learning plan on HIV/AIDS for the health sector</td>
</tr>
</tbody>
</table>
In addition to the ideas in the table on the previous page, it is also worthwhile to point out some of the specific opportunities for HIV/AIDS mainstreaming in the SWAp approach, listed below. These are important, considering the very strong push toward SWAps within the MFA. Meanwhile, the items on this list have not been part of either the HIV/AIDS or SWAp discourse in the MFA that was shared with the evaluation team.

**Opportunities for HIV/AIDS mainstreaming within SWAps:**

- Rewriting policies and plans with a focus on poverty and equity
- Redesigning systems and structures
- Bottom up planning
- Monitoring and reviewing systems
- Coordination structures
- Human resource restructuring
- More opportunities for the involvement of CSOs
- Greater sustainability within government sector

**Pitfalls to avoid in mainstreaming**
Looking at what HIV/AIDS mainstreaming is not can help understand what it actually is. The following are some examples of what HIV/AIDS mainstreaming is NOT:

- It is NOT simply providing support for a Health Ministry’s programme.
- It is NOT trying to take over specialist health-related functions.
- It is NOT changing core functions and responsibilities - instead, it is viewing them from a different perspective and refocusing them
- It is NOT business as usual – some things must change.

The usual form of ‘mainstreaming’ is just adding on some IEC. This may have been the total effort of the MFA so far. It appears that the following critical issues have not been looked at:

- Impact (now and future) on a specific sector (staff and work)
- Whether the sector’s work actually increases anyone’s vulnerability and
- Whether programmes exclude those who are HIV infected/affected.

### 3.5.1.4 Mainstreaming gender

**Conceptual background**
The term ‘gender mainstreaming’ really came into common usage with the adoption of the Beijing Platform for Action in 1995. Mainstreaming gender signalled that the issue was not just women as a separate ‘vulnerable group’, but that there was a more far-reaching goal of gender equality. Achieving this goal requires that:

> Governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes so that, before decisions are taken, an analysis is made of the effects on women and men, respectively. (Beijing Platform for Action, 1994, cited in Derbyshire 2001).

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Mainstreaming gender in health means that gender should be considered at every stage of health care planning and provision. It should not be considered only as an afterthought or just seen in separate ‘women in development’ or ‘women centred projects’. Interventions need to take into account the way in which gender influences the degree to which men and women have access to and control of the resources needed to protect their own health and that of family and community members. Preventive and public health interventions must take into account both women’s and men’s needs and priorities.62

**Gender and development in the MFA**

In general terms, the MFA is trying to strengthen its commitment to mainstreaming gender in several ways. For example, the MFA prepared a Strategy and Action Plan for Gender Equality for 2003-2007, using a participatory process. An evaluation and baseline of gender issues was taking place concurrently with the present health sector evaluation.

Capacity building in gender mainstreaming is provided through gender training and support, organised by the MFA for development NGOs, consultants and staff of the Ministry. KEPA also trains its members in gender mainstreaming.

Meanwhile, the gender adviser in the MFA is not a member of some of the key decision-making bodies in the MFA, e.g., the Development Policy Management Group and the PMC. In her absence, there are no reliable mechanisms or incentives for promoting gender responsiveness within these very strategically important bodies.

**Current state of gender mainstreaming in health for the MFA**

The Ministry has some gender tools, but most of these tools are generic and not health specific. For example, *Navigating gender: a framework and a tool for participatory development* is a useful gender handbook, but it has very little to say about health.

As mentioned earlier in this report, the majority of Finland's support to sexual and reproductive health is multilateral cooperation, channelled mainly through the UN system. Finland is one of the ten largest donors of the UNFPA. Within the bilateral programmes, the MFA has supported projects in sexual and reproductive rights. These include Reproductive Health and Women’s Empowerment (SAREM) 1997-2001 and the Reproductive Health, Equity and Rights Programme (SARED) 2002-2006 in Nicaragua. (See Nicaragua country report.) In Kosovo, Phase 1 of a Finnish-funded health programme dealt with training for primary health care, while Phase 2 trained nurses from secondary and tertiary care institutions. The support strengthened the nurses’ role in decision-making and hospital management. The majority of the trainers and trainees were women. Local cooperation funds have also been used to support some health related programmes and emphasise the importance of gender mainstreaming.

At the policy level, the countries visited were found to have included gender concerns in their Ministry of Health policy documents. These documents clearly spell out the need to collect and analyse sex-disaggregated health data. The gender component ‘evaporates’ in departmental plans and their operationalisation. Sex disaggregated data are available in some of the HIV/AIDS monitoring tools, as is the case in Mozambique. Generally, however, most available data are not disaggregated.

**Challenges**

The MFA acknowledges that building gender awareness within the Ministry and partner organisations presents its own challenges. Various evaluations since 1990 have shown a

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persistent gap between policy and practice within the Ministry and among the partner organisations. MFA staff have a positive attitude toward gender issues, but the enormous understaffing fosters a feeling that there is no time to acquire gender skills. It is difficult, therefore, to deliver on gender policy commitment.

Gender training is not properly ‘contextualised’. It is often an end in itself, going no further than the ‘awareness’ stage. The new ‘gender experts’ return to work within the existing structures and operational systems, unable to identify important gender issues within health programmes. In Nicaragua, for example, staff members were unclear as to what aspects of gender inequality, poverty and human rights should be dealt with in the provision of services to women and men.

3.5.2 Participatory ownership/engagement

Participation and ownership are - and have long been - key values in the planning and delivery of Finnish development assistance. Stronger local ownership and better partnerships have been realised through more responsive programme design and multiyear budget commitment, decentralisation of aid and management, by keeping the number of country programmes manageable and by providing long-term support. Long-term partnership is required for building up trust, learning about the environment and local culture and ensuring local ownership.

Finnish bilateral aid projects are now much more 'ownership-friendly' than in the 1980. An evaluation of ownership in 1996 noted that the MFA was able to report progress in this area.63 Aid recipients were being permitted a greater role in the formulation and management of Finnish-funded projects. There was a greater willingness to involve ordinary people at the grassroots in project design and implementation, and to adapt Finnish practices and procedures to those of recipient institutions. However, practices varied considerably within the MFA, and the heavy budget and staffing cuts of that era impeded its capacity to adapt wholeheartedly to new ways of working.

Current status

Discussions with some key stakeholders in the countries visited indicated that a process towards local ownership has been initiated. This should continue to be supported. Some of the respondents said that Finland is one of the most participatory of donors. It is modest, flexible and respects partners' policies. For example, in Kosovo, it was indicated that Finnish health projects have been very transparent and involved key stakeholders.

The MFA emphasises adaptation to the local context, making links to the partner country’s Poverty Reduction Strategic Paper (PRSP) and other national processes and policies. This has been the case in all long-term partner countries where health was a priority sector, i.e., Nicaragua, Namibia and Mozambique. Development plans are drawn up in the target country. Responsibility for generating funding proposals rests mostly with the country's authorities and the stakeholders, while implementation utilises the country's existing administrative structure.

The technical assistance provided by the MFA ensures that ownership lies with the recipient country. The advisers are taking a more supportive and advisory role than an implementing and supervisory one. In principle, national counterparts are the decision makers for bilateral projects, rather than the technical advisers. The Namibia Engela Health Project was planned and implemented in such a way that local ownership was a core element in its success. In Manica province of Mozambique, Finland has supported an Integrated Health Project since 1992. There is evidence of a progression to decentralisation and local

ownership in both planning and implementation at provincial level. A study on local cooperation funds in Tanzania\textsuperscript{64} found a strong ownership and participation at community level. (This was, however, on a very small scale.)

The move from project to sector-wide support is a key new strategy that most like-minded donors support. Undoubtedly, this move will increase local ownership by partner countries. The Finnish government is a supporter of this change and partners in Mozambique acknowledged the constructive role of the Finnish government in donor deliberations and national policy development.

**Limitations of participation and ownership**

Stakeholder participation is still limited. Discussions in Mozambique revealed that little use has been made of stakeholder analyses to identify actual and potential stakeholder roles in projects, whether bilateral, NGO or LCF. There are also hardly any ownership and participation indicators in operational plans of partner countries.

The increased emphasis on SWAps is shifting attention from the immediate users and beneficiaries to stakeholders at higher levels, policy-makers and health management staff. The assumption is that national ownership of health sector policies and strategies will in the long run improve the performance of the health sector. There is some fear that this might not be the case, as most partner countries are still struggling with decentralisation issues. Concern is also expressed that the importance of ownership and participation will be diluted by a preoccupation with purely technical, administrative and financial matters, the limited social mobilisation skills of health service managers and providers (both local and technical assistance), and a lack of real participatory planning.

While MFA has strategy papers and guidelines for some issues, such as gender, there are none at all concerning participation. Systematic approaches to community participation and documentation of experience and lessons learned on this issue are exceedingly few.

**3.5.3 Capacity building**

Capacity building has long been considered an important part of development cooperation in Finland as well as in other countries. The nature and scope of capacity building has broadened, as the scope for development cooperation has changed from isolated projects to sector-wide approaches. Ten years ago, capacity building was more or less synonymous with training, with training focused on the needs of each individual project, e.g., early health infrastructure projects in Nicaragua. More recently, capacity building has come to imply much more than just training, focusing in a much broader way on the overall systems needs of the sector.

Namibia represents Finland’s most consistent experience with health system strengthening and capacity building in the health sector. Strengthening planning skills was a strong element already in the Engela Area Integrated Health Project. The first phase of the Health and Social Sector Support Programme (HSSSP I) built on this experience. It focused on strengthening both the national Ministry of Health and Social Services (MOHSS) and Regional Management Teams. The follow-on HSSSP II also seeks to improve management capacity. It includes a key component of strengthening a training network to support pre- and in-service training. The Namibia projects have been well-conceived and important initiatives that have confronted a number of challenges to capacity building that arise from decentralisation and severe local staff shortages. Many valuable lessons can be learned from Namibia, but the evaluation team was unable to find any evidence that these ‘lessons

learned’ would have been applied to Finnish health development cooperation efforts elsewhere. No document, for example, could be found that examined the lessons from Namibia and analysed how they might apply in different contexts and situations in other countries.

In Mozambique, the Finnish support to the health sector in Manica Province has received praise for including the development of training centres and for implementing training that supports the needs of the province, as well as national needs. The capacity building has been broad in scope. It has included development of capabilities in health technology and maintenance, as well as policies and manuals. A number of the manuals, however, are only available for the district level. This has created a gap at the provincial level, leading to a potential problem with sustainability. Post-training follow-up appears to be weak and non-systematic.

In Nicaragua, the sustainability of some capacity-building efforts has been questioned, as trained staff leave their positions. Such training may still benefit the sector, even though it may create a sustainability problem for the particular project.

The health project in Kosovo is focused on capacity building. It is very comprehensive with support to training, library and curriculum development. The impact may, however, not be as large as one would wish, because no attention has been given to policy development for human resources in health that would address issues related to health worker careers. Such policies are pivotal for the future recruitment and deployment of human resources trained by the Finnish project.

3.5.4 Transitions: Phasing out and handing over

This section discusses phase-out under four headings. The first type of phase-out takes place, when Finland makes the decision to pull out or transition out of a development cooperation relationship with a long-term partner country. The second is phasing out of a particular sector, such as health, that Finland previously supported. The third type is from project to programme or sector support, which is now beginning in a few of Finland’s long-term partner countries. The final form of phase-out occurs at the end of an individual project, when Finland hands it over to the host government. The evaluation team’s assessment is that Finland is generally poorly prepared for any form of phase-out.

3.5.4.1 Country phase-out

After long-term cooperation

The increased dispersion of Finnish aid has been criticised. Finland now plans to concentrate its long-term bilateral cooperation to a cluster of 8-10 countries. As stated in 2001:

In the course of the next 3 to 7 years, long-term bilateral grant assistance in the form of projects will be phased out in middle-income countries such as Egypt, Namibia and Peru. (MFA, Decision in Principle, 2001)

The ‘phase-out’ is not going to be a ‘complete phase-out,’ however. Instead, it will be a transition from grant aid through bilateral projects to alternative forms of diversified cooperation and partnering. The 2004 Development Policy states that the change (involving countries such as Egypt, Namibia and Peru) “will take place in 2004 to 2007 in a controlled and sustainable manner, with the help of the implementation of transition strategies.” There is, however, very little documentation about specific plans or guidelines for going from partner country to transition country that would be helpful to ambassadors, desk officers, project managers or consulting companies, or to the counterpart ministries in the partner countries. It also appears that the timing for the ‘transition’ is possibly slowing down. This perhaps reflects an issue, mentioned by one diplomatic leader in the field,
“MFA has no development experience with ‘soft landings’, e.g., for country phase-outs.”

It is pertinent here to look at some other country experiences. Sweden is another Nordic country with many values and practices shared with Finland. Swedish bilateral programmes have had a similar tendency to run on for many years.

It is in the nature of development cooperation that it takes time to change societies and institutions, and the old SIDA was known for staying on until the job was done, even if this took several decades. If the project went well, none of the parties wanted to terminate a successful joint undertaking. If the project went very badly, SIDA wanted to put it on an even keel before leaving it. Whatever the outcome, the preference was always to continue. Very often, the content of the programme changed even though the cooperating partners were the same. Projects which started as a limited operation expanded into sectoral programmes and went on for decades with no serious discussion between the parties as to how and when the external resource inputs should be phased out. (Carlsson and Wohlgemuth, 2000)

Issues involving donors, recipients, implementing consultants and technical experts were among the contributing factors affecting this state of affairs for the SIDA programmes. In very aid-dependent economies, as is common in Africa, civil servants and their ministries rely heavily on incentives from donors, rather than designing models for raising domestic financing. There are also pressures from the donor country to disperse funds. This leads to a co-dependent relationship between recipient and donor, making it difficult for both sides to envision and realistically plan for phase-out.

After ‘short term’ cooperation

The 1996 Decision-in-principle included a clause authorizing the MFA to flexibly extend short term development cooperation to countries in urgent situations, particularly those involving human rights, mitigating conflicts, and supporting national reconciliation. By 2001, cooperation based on this principle of flexibility had been extended to include the Republic of South Africa, the Palestinian Autonomous Territories, Kosovo and other parts of the Federal Republic of Yugoslavia, Bosnia and Herzegovina and East Timor.

The cooperation in these situations is generally, although not entirely, linked to humanitarian support. Given the separate evaluation of humanitarian aid, the evaluation team did not try to identify all current ‘short-term’ countries and their situation vis-à-vis phasing out.

Kosovo is one example of longer term bilateral development cooperation in a non-core partner country that the evaluation team did assess. As will be noted elsewhere in this report, the project in Kosovo is an interesting and useful one that responds to a real need in the country. However, it is also an example of aid dispersion and lack of clear exit criteria and strategy with the country.

3.5.4.2 Sector choices

Finland is not only concentrating the number of development partner countries. It is also focusing on fewer sectors and larger efforts by narrowing down to a maximum of three sectors or three development programmes in any one country. The 2001 Decision-in-principle provides some information about the prioritisation process for these sectors.

The sectors or programmes of cooperation will be chosen through dialogue with the partner country. The choice of programmes and sectors will be based on the priorities set in the poverty-reduction strategy adopted by the partner country, on the one hand, and on the Decision-in-principle on Finland’s Development Cooperation and Finland’s Policy on Relations with Developing Countries, on the other. The final decisions will be made on the basis of an analysis about the added value that may be obtained from Finland’s participation in the development processes. (MFA, Decision-in-principle, 2001)
This discussion does not, however, reveal much about the potential for change. Bilateral discussions happen every two years with the partner countries. How frequently will the countries (or Finland) be allowed to revisit and reprioritise the sectors for that country? For example, there are now only two long-term partner countries with health as a priority. What would be the process, if more of the long-term partner countries wanted to have health as a priority sector, or if either Mozambique or Nicaragua wanted to drop health in favour of some other needed sector?

3.5.4.3 Transitions – goodbye to projects?

Finland is increasingly shifting to budget and sectoral programme support, partly in an effort to promote local ownership and sustainability, and partly to reduce the administrative overheads on development cooperation. Although Finland does not (yet?) have specific guidelines on sector or budget support, there are a number of such documents available, e.g., from the EU, Denmark and others in the like-minded country group.

At the same time, Finland’s own experiences in Mozambique suggest that there is insufficient documentation and learning of lessons about issues related to the process of changing from project to programmatic support. In Mozambique, many difficulties are arising, as the Manica project is being moved toward a “phase over” from a geographical project to integration with national systems of programme support. There are no guidelines or plans, e.g., on how to deal with the investment plan, ensure sufficient continuity and depth of institutional capacity, create and use rollover budgets, address gaps in felt ownership, and secure transparency and accountability.

As noted in a review of Finland’s rural development cooperation (Eskola, 2003), there can also be problems of resource concentration at the central ministries and urban areas. That review suggests that the phase-out of projects should not be abrupt, but instead comments that there is value to having a mixed portfolio of project and programmatic support.

In the future, local projects will have important roles to play as means for reality checks and as sources of new best practices. (Eskola, 2003)

3.5.4.4 Bilateral project phase-out issues

Issues arising – MFA

It was quite evident from early stages in this evaluation that phase-outs and exits from projects are problematic for the MFA. The whole concept of phasing out is not well understood or ‘mainstreamed’, despite how often it is mentioned in passing. The following table presents selected key issues about project phase-out/exit strategies identified in documents\(^{65}\) and field discussions during this evaluation.

\(^{65}\) Useful documents from MFA include: Eskola, 2003; Seppälä, 2000.
## Phase-out strategy guidelines – essential issues to be covered

<table>
<thead>
<tr>
<th>Issue</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase-out plans</strong></td>
<td>▶ Need to prepare phase-out plans/exit strategy early in the course of a project/programme to avoid failure to phase-out and cost extensions</td>
</tr>
<tr>
<td></td>
<td>▶ Need to prepare plans carefully to avoid public circulation of misinformation and/or flight/departure of key staff before the end of the phase</td>
</tr>
<tr>
<td><strong>Ownership</strong></td>
<td>▶ Need to plan early for management decentralisation, i.e., timely handing over of responsibility for planning, implementing and monitoring/evaluating project/programme activities to ensure empowerment and commitment to sustainability</td>
</tr>
<tr>
<td></td>
<td>▶ Need to plan early for appropriate handing over of project/programme assets (infrastructure, equipment, data)</td>
</tr>
<tr>
<td><strong>Financial sustainability</strong></td>
<td>▶ Need realistic and viable strategies for continued financing after external funding is phased out</td>
</tr>
<tr>
<td></td>
<td>▶ Need to ensure that the incentive structure of the project/programme is sustainable within resources that can be mobilized locally in order to maintain human resources and programme activities</td>
</tr>
<tr>
<td><strong>Programmatic sustainability</strong></td>
<td>▶ Need to ensure capability of the programme or organisational/institutional partner to independently carry on with all programme activities and services without dependency on foreign influence</td>
</tr>
<tr>
<td></td>
<td>▶ Need to ensure that adequate qualified human resources are in place with systems for transfer of institutional memory in the event of staff transfers or departures. This has the implication that staff capacity building is done well before the actual date of phase-out</td>
</tr>
<tr>
<td><strong>Institutional memory</strong></td>
<td>▶ Need to ensure that institutional memory (hard and soft copies of documents and data) and lessons learnt have been well documented and organized in accessible and secure way for all stakeholders prior to project closure</td>
</tr>
<tr>
<td><strong>Political sustainability</strong></td>
<td>▶ Need to ensure that the programme or organisation/institution is well integrated with civil policies and regulations to ensure sustainability</td>
</tr>
<tr>
<td></td>
<td>▶ Need to ensure that the programme/organisation/institution is well integrated with civil structures to minimize the funding problems of parallel systems</td>
</tr>
<tr>
<td><strong>Networking and learning capacity</strong></td>
<td>▶ Need to promote relevant networking, institutional cooperation and twinning before closure, with Nordic and local/regional institutions</td>
</tr>
</tbody>
</table>

Project duration and project transitions are two issues not highlighted in the above list.

*Project duration* - As pointed out by Eskola (2003) and others, sustainability of results is likely to be very much in doubt if the duration is too short. However, if the process goes on too long, then co-dependency between recipient and donor becomes the problem. The following quote aptly raises some key questions in this regard for projects:

> Given the complexity of many development matters, it often takes two years simply to identify the problems, and another two years to win the confidence and get properly established. At this stage, when the project is reaching a productive phase, it is often given a first warning about the termination of activities, and the financial resources start to decline. Could one increase the political sustainability of projects simply by means of increasing the length of intervention? Or is it true that lengthy interventions tend to create their own patron-client relationships and dependencies which, although functional on a temporary basis, are deficient in terms of sustainability in the post-intervention period? (Seppälä, 2000)
Project transitions – many bilateral projects go through multiple changes during their lifespan, particularly at the point of phase changes, e.g., change of focus, change of activities, change of implementing organisation, and change of technical advisers (and advice!). As these changes are not correlated with the actual ‘end’ of the project, they are often not well planned, documented or coordinated with any overall system for monitoring the effects (and side-effects) of all the changes over the life of the project. This pattern has been noted before, e.g.,

Individual projects have been characterised by discontinuity: sudden termination of activities or changes in orientation. The word discontinuity also describes well the ‘historical memory’ of aid interventions: new projects are planned without proper analysis of past experiments. For the recipient administration and citizens, the impact of shifts in orientation must have been bewildering. (Seppälä, 2000)

In view of this issue, one of the consulting companies interviewed during the evaluation felt that the MFA could have a larger role in preparing recipients ahead of the project, both before and after signing the project agreement. In this way, the consultant (company) would be able to implement an agreement that is clear and well understood between governments. Now it is at times caught in the middle, trying to explain decisions that were taken at a much higher level before the company was involved.

The relative frequency of turnovers and transitions in projects throws institutional memory into jeopardy. In one health project visited during this evaluation - in operation for more than 10 years - no copy could found of the baseline done in the first phase. The project had therefore been unable to assess project outcomes against the baseline measures. Another project had no handover report from the end of one phase to the start of another. Another had no record of how the project had started or where the project concept had originated. Diplomatic officers in the field are also frustrated by the lack of standard phase-out and handover practices. As one officer put it, such practices are often not there at all, or if they are there, they are ad hoc and tailor-made in the moment.

“The lack of sector policies (including health) and phase-out strategies is a problem. It is important to have flexibility, but need a common line and to be consistent.”

As mentioned earlier, the experiences of the sister Nordic countries provide some important lessons for Finland. A review of Swedish projects notes a serious weakness regarding project risks/assumptions and exit strategies. Very few projects include any risk triggers (critical indicators or indicator values for identified project risks) that would lead to modifying or terminating the implementation of the projects. Many project proposals trivialise the risk of failing any tests of financial sustainability. Exit strategies are generally weak or nonexistent, and often lack a meaningful strategy for transferring responsibility for the activity to the host organisation.

When it comes to the exit strategy, it is most likely that the project proposal authors are aware that their project design is unsustainable, and that they count on the funding agency to continue supporting the project for decades before any serious thought is given to the question of terminating the support. Their assumption is based on long empirical study of donor behaviour and it could hence be said that it is the result of organisational learning. A period of deliberate ‘unlearning’ will be necessary before financial sustainability becomes part of the project culture in SIDA. (Carlsson and Wohlgemuth, 2000)

3.5.4.5 Guidelines for phase-out

Several documents available on the MFA websites give a little bit of guidance for phasing out. (See Annex 12.) Overall, however the suggestions are thin on the ground, compared to the amount of detail on other project/programme design issues in the same guidelines. This
issue was clearly recognized by senior officials in the MFA as a cross-cutting problem, not limited to health alone.

“Phase-out planning is not required in the manual, but it should be.”

“There are some very general directions on phase-out in the guidelines, but no clear criteria.”

In fact, the problem is even more widespread. The MSAH also does not have any guidelines on phase-out strategies. Even the partner countries do not. Mozambique, for example, has no Ministry of Health criteria or guidelines for phasing out – despite the frequency with which that issue is discussed, debated and promoted, according to an interview with a senior MoH official.

There appears to be no collection of relevant MFA experiences with phasing out in various situations. An evaluation study of phasing out could result in understanding better the critical issues for planning phase-out at different levels of development cooperation. It could thereby lead to better quality guidelines for all dimensions. The Evaluation Unit of the MFA reported that the last Nordic meeting proposed to study ‘phasing out.’ Such a study could apparently be done as an internal evaluation that would fit the mandates of the Unit. Such a phase-out study could possibly be combined with some ex post assessment about the quality of phase-outs and the sustainability of plans and/or achievements for selected projects (in health or for other sectors as well). Several health projects have recently or will soon be phased out in Sri Lanka, Vietnam, Egypt, Namibia, Mozambique, and Nicaragua.

3.6 Management capacity

“If Finland would have identified institutional weaknesses of the same magnitude in a partner country ministry that the MFA itself has, it would have demanded adding an institutional strengthening component to its aid portfolio for that country!”

The management challenges affecting health development cooperation are part of a much larger set of management issues that the MFA confronts. These are explored at length in the recent Saana study. This section focuses on the most important management capacity issues as they relate to health development. Finland’s capacity to manage its health development cooperation portfolio effectively requires both competent and sufficient human resources and well-functioning management systems and processes. The human resources aspect of management capacity is discussed first. This is followed by a review of management systems and processes. They include defining and operationalising health development cooperation policies and priorities, ensuring information for evidence-based decisions, assuring the quality of funded projects, and documenting results and lessons learned.

The evaluation team was surprised – and even startled – by the extent of weakness in the MFA’s management capacity as it relates to Finland’s health development cooperation. The Ministry for Foreign Affairs is certainly not unaware of the weaknesses in its management capacity, and has already embarked on initiatives to address many of them. Solving the most severe human resource and management system challenges, however, cannot be done by the MFA alone. It will require decisions at a higher political level, as well as consensus building across ministries. The coherence and quality of Finland’s current and future development cooperation depends on making sound decisions regarding

66 Comment made by one of the evaluation team members
67 Study on the administrative and resource development needs of the Ministry for Foreign Affairs of Finland to ensure efficient and effective implementation of the White Paper on Development Policy of the Government of Finland. Saana Consulting Oy (Ltd), Helsinki. 30 September 2004.
management capacity strengthening for development cooperation in general and health development cooperation in particular. The evaluation team’s wish is to provide a helpful input to such decisions.

### 3.6.1 Human resources

Scarcity of human resources together with the skills problem has been pointed out in practically all major evaluations of Finnish Development Policy and Co-operation, e.g., in DAC peer reviews of 1998 and 2003. (Saana Consulting)

Competent management of Finland’s health development cooperation portfolio requires an adequate number of well integrated staff with technical expertise in health and excellent skills in project and programme management. New skill demands have arisen with the move from project support to SWAps and direct budget support. Technical expertise in preventive, promotive and clinical health services alone is no longer sufficient. The MFA also needs access to expertise in areas such as health policy analysis and formulation, health systems strengthening, health sector reform and health economics.

The evaluation team was struck by the extreme vulnerability of the MFA’s and embassies’ staffing situation in regard to health expertise. Required skills and experience often lie in only one or two individuals, making Finland’s capacity to competently address the myriad of health-related issues most precarious. The team is also concerned about the apparent lack of planning for “growing” the next generation of Finnish health development expertise.

**Human resources at the MFA**

The MFA staffing situation is marked by extremely rapid rotation (particularly of desk officers); filling many posts with young, eager, but inexperienced employees on very short-term contracts; and the increasingly serious loss of development expertise through retirement.

The MFA currently has one acknowledged health expert in a health adviser position, located at Ministry headquarters. This position, however, has not been staffed consistently during the evaluation period. At the beginning of the 1990s, the MFA employed two health advisers in Helsinki, but these positions were left vacant between 1994 and 1997. The functions were then carried out by HEDEC. In addition to the single health adviser in Helsinki, one health adviser is now based in the Mozambique embassy on a pilot basis. Another will reportedly be posted soon to the Nicaragua embassy.

The evaluation team would like to stress that the technical skills of both of the present health advisers were praised by those interviewed for this evaluation. Many informants observed, and the evaluation team agrees, that the workload of the MFA’s health adviser is unrealistic and overwhelming for a single individual. The demands on her time seem particularly onerous, when one considers that she is the technical point person for the whole portfolio of health cooperation activities. Although her time is reportedly prioritised for bilateral support, which takes her out of the country at least 30% of her time, she also has responsibilities for advising on health related NGO cooperation and multilateral cooperation. Moreover, the same individual is also the point person for the Ministry’s HIV thematic support and mainstreaming. It is no surprise in these circumstances that her attention is not able to be given equally and fully to all areas. As discussed earlier in this report, the coherence of the MFA’s health and HIV/AIDS commitment is further compromised by the lack of a health policy and strategy and a specific plan for HIV/AIDS mainstreaming.

In a parallel example of questionable commitment to fundamental aims, the MFA also employs only one gender adviser. Her workload is said to be similarly excessive, leaving little capacity to ensure gender mainstreaming in health projects and programmes.
Outsourcing is used to lighten the MFA health adviser’s workload by procuring external expertise in health, population and social development. The current consultant contract, the third of its kind, is executed by the IDC of STAKES and runs from 1 April 2003 to 31 December 2005. The MFA does not appear to have used the contract as part of an overarching strategy, however. An examination of the consulting assignments during the first two years shows a scattered set of tasks, many of short duration. The bulk of the assignments have been the preparation of background papers (33.6% and 28.1% in 2003 and 2004, respectively), appraisals (24.6% and 21.9%) and document reviews (17.9% and 23.4%). Notably, the organisations that have implemented the advisory contracts also report that they have at times been asked to comment on Finnish policy on a particular topic, even though they do not represent the Finnish government.

The very frequent turnover of desk officers shows up in poor institutional memory and weak backstopping of health projects at country level. Every one of the field visits highlighted this as a critical issue that has affected project or programme implementation at some stage. Nicaragua, for example, at one point had four desk officers in one year, while Mozambique had eight in three years. Some desk officers’ lack of sufficient language ability and understanding of country and development issues have also hampered the MFA’s ability to provide competent backstopping of projects and programmes. The 2002 Nicaragua bilateral evaluation, for example, spoke of “scarcity of human resources, and at times of a good insight into Nicaraguan development issues, and of language ability...due to high staff turnover and limited staff.”

The MFA’s Unit for NGO support is particularly understaffed and subject to high staff turnover. Its staffing situation was reported to be “close to desperate.” Nine out of the 13 staff were young people on short contracts finishing at the end of 2004. The average age of the remaining four staff members is around 50 years. A staff turnover of this magnitude erodes continuity and capacity for effective reflection and networking.

In 2003, the NGO unit tried a pilot experiment in which it outsourced the appraisal of 29 NGO projects to KEPA. The experiment was not continued, but in 2004, a second outsourcing experiment was underway with FIDIDA, an umbrella organisation for the disabled. FIDIDA appraised 24 project proposals, receiving all the applications related to disability and screening them before passing them on to the NGO Unit. The NGO Unit has commissioned a thorough study on the possibility of continuing to outsource some of its work.

**Human resources at the embassies:** The 2003 DAC review found that “In most of Finland’s field missions, the shortage of aid personnel is affecting the quality of aid delivery and the capacity for donor co-ordination and co-operation.” The shortage of health expertise is particularly acute in most Finnish embassies. Only the Mozambique embassy has a health adviser presently. The position is a recent pilot experiment and paid for by the MFA’s Africa Department. The current health adviser’s short-term contract expires in 2006. The evaluation team was informed that the experiment has been well received and the current adviser will be replaced at the end of her contract. The Nicaragua embassy is also expecting to have a health adviser, who will monitor sector development and participate in the SWAp policy dialogue.

For a donor that is serious about supporting the SWAp approach, active participation in the numerous meetings where decisions are made, is essential. In Mozambique, when Finland was the highly respected lead donor for the Mozambique SWAp, approximately 90% of the Finnish health adviser’s time was consumed by the SWAp process. The Finnish adviser is

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not supported by a local hire co-adviser or assistant. The Finnish and British advisers in Mozambique have adopted an innovative local arrangement to cope with the high workload. It stems from their similar assignments to cover two sectors (each responsible for both health and education). They have arranged reciprocal coverage of the two sectors, with the Finnish adviser covering the health sector on behalf of both countries, while her British counterpart covers the education sector. The Finnish adviser has no regional responsibility, confining her work to Mozambique.

In the Nicaragua embassy, one local hire adviser covers the whole social sector. While technically capable, she lacks decision making authority. The centralized decision making of the Finnish MFA means that a number of key decisions can only be authorized from Helsinki. This is in contrast to other development partners working with toward the SWAp in Nicaragua (e.g., Sweden and the Netherlands). The embassy has felt the centralized decision making to be a barrier to full Finnish participation in the SWAp. This constraint was also remarked upon by some of the development partners.

Building health development expertise for the future: The evaluation team is troubled by the lack of long-term strategic thinking about building a pool of international health resource persons for the future. Most of the experienced health and development experts are likely to retire within the next 10-15 years. Where will the expertise to fill their shoes come from?

Competence in health development cooperation requires both classroom teaching and practical, hands-on experience. The health policy and system strengthening skills that are now in demand cannot be developed in classroom alone. There appears to be a lot of enthusiasm among the younger generation of health professionals for acquiring international health skills. The efforts to provide such training are, however, feeble and the possibilities for acquiring practical experience even fewer.

The Ministry for Foreign Affairs does not consider building capacity in health development cooperation to be its role. In fact, it appears that no ministry or institution sees it as their responsibility. The MFA did provide limited grant funding for the first three Finnish Diploma Courses in Global Health, but recently indicated its reluctance to continue funding the course, at least in its present format. The Global Health course has been a joint effort by several Finnish health professional associations, organisations, universities and collaborating academic institutions, in partnership with organisations overseas. It aims to increase awareness of global public health and promote teaching and research in international health issues. The course combines a four week theoretical section with a four week practical part. Thus far, it has been offered to medical students from Finland and a few developing countries. Finnish participants paid their travel and per diem expenses during the field placement and the course organisers relied on hours of volunteer labour by the teaching faculty. While a useful introduction to issues of international health, neither the Global Health course nor the periodic training sessions that the David Livingstone Society has organized are a substitute for a planned and conscious effort to develop the next generation of Finland’s health cooperation expertise.

3.6.2 Management systems

3.6.2.1 Defining and operationalising Finnish health development cooperation policies and priorities

“The Ministry for Foreign Affairs says that health is a priority, but the comprehensive picture on Finnish health development cooperation is not in the hands of anyone.”
(Senior health official)
After the disappearance of FINNIDA and until 2003, most of Finland’s development cooperation was managed by the MFA’s Department of International Development Cooperation (in English - DIDC, in Finnish - KYO). The DIDC had operational geographic divisions, a multilateral development cooperation division and an NGO and Information Division. In 2003, the geographic divisions were upgraded to separate departments and multilateral functions transferred to a Department of Global Affairs. The units for NGO support and international recruitment remained as the DIDC’s only operative units.

The Saana study of MFA’s administrative and resource needs emphasises that “...in modern development cooperation, ‘policy’ and ‘operations’ need to be organically connected and constantly learning from each other. They can never be treated, or staffed, as stand-alone functions.” 69 In reference to the MFA’s organisational reforms, the Study warns about a looming risk to coherence between Finnish bilateral and multilateral policies, as well as between geographical regions.

The 1998 DAC Peer Review emphasised the importance of policy guidance on the *sector level* to achieving coherence in the Finnish approach. Yet, the evaluation team found it difficult to identify what management systems and processes Finland uses now to define its health sector cooperation policies and priorities and operationalise them through its aid modalities.

Priority setting for health development cooperation is fragmented, even haphazard. This finding is not limited to health development cooperation. Many informants, both inside and outside the MFA, made the same general observation about Finland’s decision making about development cooperation in general. One informant commented, “Decisions are based on what is picked up and interpreted, rather than on evidence.” Others observed that “much happens unsystematically” and “too much depends on individual judgement.” This is mentioned as evidence of a flawed occupational culture in the MFA, rather than gaps in the performance of any individual, like the health adviser.

The *Development Policy Committee’s* recent report, *The State of Finland’s Development Policy 2005*, points out that “the implementation of the development policy has been slow and is faltering up to this point” and that more coherence is needed in its implementation. Sectoral development issues have not yet featured on the Committee’s agenda. 70 Thus, it has played no role yet in overseeing and assessing Finnish health development cooperation. The Committee chairperson acknowledged recently that pressure to examine sectoral development has increased and the Committee might consider taking up the issue. 71

No *Ministry for Foreign Affairs* department or unit maintains a comprehensive picture of Finland’s health development cooperation. The MFA has no health development cooperation strategy to guide strategic and resource allocation decisions. There are no clearly defined health sectoral or thematic goals that are commonly understood and accepted by the MFA staff who now manage multilateral, bilateral and NGO support to health in their separate departments and divisions. 72 The Sectoral Policy Unit of the MFA is purely advisory to the geographical departments and has no statutory role in enforcing sectoral policies. Even its role in setting sector and thematic policies, previously one of its main activities, is reported to be "under development" after Finland joined the EU. (A few

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69 Study on the administrative and resource development needs of the Ministry for Foreign Affairs of Finland to ensure efficient and effective implementation of the White Paper on Development Policy of the Government of Finland. Saana Consulting Oy (Ltd), Helsinki. 30 September 2004.

70 http://global.finland.fi/kesu/suomi/kesu_vuosilausuntoseminaari.html


72 A recent internal MFA memo proposed increasing funding for maternal and child mortality and HIV/AIDS.
informants even wondered whether there was a need to develop Finnish policies at all, saying “Should we not just follow EU policies?”

The 2004 Saana study saw the lack of a clear logic for allocating financial resources between the MFA departments as one of the Ministry’s main problems. The basis for decisions on allocating funding between different international organisations within the multilateral portfolio is not clear either. Finland’s bilateral programme is agreed every two to three years in consultations with long-term partner countries and a technical review meeting held annually at the local level. No comprehensive country strategy papers are prepared to guide the bilateral negotiations, which proceed on the basis of a negotiating ‘mandate’ and a supporting background memorandum. As the 2003 DAC Peer Review commented, “The mandate, memorandum and agreed conclusions of annual consultations do not constitute a country strategy.” No wonder that the 2002 bilateral evaluation of Nicaragua stated that “Finnish development cooperation could be described as rather ad hoc, since there has been no country strategy on which to rely in the long run...”

The sectoral advisers, such as the MFA health adviser, are reported to have very little influence on bilateral funding decisions. According to the MSAH, the MFA does not consult them either on bilateral decisions regarding health development cooperation. The 1998 DAC Peer Review pointed out that the MFA has no management tool to prioritise sectors and their associated policies. The technical basis for selecting sectors and sectoral areas for bilateral support in a particular country is thus not transparent. The evaluation team is left to wonder, whether Finland defers passively to the selection of sectors and priority areas that the partner country has made. If this is the case, important but potentially controversial areas of support in which Finland could make a particularly valuable contribution (e.g., reproductive health and rights or family violence), may not get properly included in Finland’s future bilateral aid portfolio. Informants at the country level stressed to the evaluation team the donor’s responsibility in bilateral negotiations to push for such critical but neglected areas, because they are otherwise commonly ignored by governments.

In summary, there is now a clear contradiction between Finland’s public declaration of health as one of its most important areas of development cooperation and the lack of clear management systems and processes to define and operationalise a coherent set of health development policies and priorities. Such ad hoc decision making is unlikely to ensure that health receives its proper prominence in Finnish development cooperation as an essential ingredient of poverty reduction and meeting the MDGs.

3.6.2.2 Information for evidence-based decisions

“The MFA has almost no institutional memory.” (Senior health official)

Evidence-based decision making requires ready access to appropriate statistical data on inputs, outputs, outcomes and results. But raw data alone are not sufficient. An institutional memory of past and current projects and key decisions related to them is essential for interpreting what the numbers mean and turning them into useful information for decision making.

In its review of the MFA, the Saana study pointed out that “…there is no integrated information system or database containing information on both spending of financial resources (commitments and payments) and performance (level of goals and objectives achieved). This makes it extremely difficult for the headquarters and embassies to keep
track of performance achievement and their connection to development policy goals.” This evaluation team is in full agreement, as it, too, found the MFA’s information system inadequate for evidence-based decision making about health development cooperation.

Many problems plague the MFA’s current information system. First, it is not possible to identify all projects that have health as a component, because the DAC reporting system, used by Finland, provides only one primary purpose code for each project. While some countries have modified the DAC system and included additional purpose codes, Finland has not done so. As one informant observed, “Finland only changes if the DAC changes!” Second, the data base is focused on disbursements, budgets and expenditure, not on evaluating outcomes or results. Tracing outcome indicators of health projects, for example, cannot be done. Third, appropriate disaggregation of data is not possible without considerable additional effort of pulling old files from the archives and going through them manually. The data base does not allow a manager to see, for example, how much was spent on technical assistance by Finnish personnel in a particular health project year or how much of a health project’s budget was devoted to services, how much to materials and so on. The lack of a well-functioning information system has meant extra effort to hunt down needed information. As an informant commented “UNFPA asks the MFA how much was spent on population. The MFA phones the IDC, which phones projects!”

It is interesting to note that in the early 1990s, HEDEC regularly prepared country profiles of health and social sectors. These were distributed widely and much appreciated by those involved in development cooperation. The first outsourcing contract between the MFA and HEDEC included updating data on all bilateral and multilateral projects, as well as maintaining a list of all NGOs working in health and population. The current advisory contract, however, does not include any requirement to maintain or update data.

The MFA has no easily accessible repository of key documents that would inform the MFA staff, as well as outside consultants and evaluators, about the government’s stance regarding issues of health development. Such documents would include, for example, Finnish government’s position statements in important international conferences and other similar fora. The lack of such a repository is particularly regrettable, given the serious deterioration in the MFA’s institutional memory from the rapid staff turnover.

Country visits also showed a need to improve archiving systems. Documents were not archived according to an uniform system, important documents were at times missing and some filed documents were undated. The Liaison office in Kosovo, for example, had two loose folders, containing a scattering of project reports from various times and sources. This made identifying and accessing key project documents very difficult.

3.6.2.3 Assuring the quality of Finnish-funded projects

“The MFA definition of quality is whether financial management is OK and gender is reflected.” (NGO representative)

The quality of Finnish health development portfolio depends on ensuring the soundness of proposed projects and programmes, monitoring their implementation and evaluating the results. Quality assurance of project and programme proposals, in theory, is the task of the MFA’s Project Management Committee. In practice, this does not work satisfactorily. With no statutory role, the PMC is only advisory and all health-related proposals are not channelled through it. Projects that originate at the multilateral side and small projects are unlikely to come to the PMC’s attention. The PMC tends to get the projects late, at the project paper stage, when making changes is usually no longer possible. The PMC is

75 For example, the programme document for the Nicaragua Hospital Maintenance Project could not be found in the embassy archives.
reported to use certain criteria to assess project proposals (such as political criteria and the inclusion of cross-cutting themes). Furthermore, several interviewees noted that the MFA is not clear about how it defines and assesses the quality of health projects.

The recent experience in Nicaragua in moving from projects, managed by consultant companies, to implementation through a government’s own management systems indicates that project and programme preparation may have to be rethought. Both reproductive health initiatives (SAREM and SARED) had very long inception phases, leading to delayed implementation. An overestimation of the capacity of the Nicaraguan Ministry of Health and confusion about management responsibilities in moving toward a programmatic approach resulted in a one year gap between the two initiatives and later implementation problems with SARED. A more thorough institutional analysis as part of the preparation might have mitigated some of these problems.

### 3.6.2.4 Monitoring and evaluation

Respondents seem to be especially critical on poor performance monitoring, follow-up and vague performance indicators. (Saana Consulting)

A disconcerting finding of this evaluation was the unsystematic manner in which Finnish bilateral health projects and programmes are monitored and evaluated – or not! Guidelines on management and evaluation (M&E) are not complete and the process for reviewing and updating them is unclear. (See Sections 3.5.4. and 3.7.1. on phase-out and measurable achievement for similar issues.) The monitoring role of the MFA, the embassies and the consulting firms implementing a bilateral project is unclear. The lack of guidelines and the unclear roles have led to very different M&E approaches among bilateral projects, depending on the health adviser and the desk officer.

Finland uses the logical framework approach in project preparation. While objectives and indicators are developed for each project and included in the project document, outcome indicators cannot generally be traced. Indicators for gender mainstreaming do not yet exist.

**Baseline studies** have, in general, not been a feature of bilateral projects. Where they were undertaken, they do not appear to have been followed up. In Nicaragua, the baseline study of SAREM, for example, was never repeated. In Mozambique, the one done for the Manica project in the early 1990s cannot be found either in hard copy or in an electronic version! Reportedly, **mid-term reviews** are usually conducted for “larger projects.” It is not clear, what is considered a “larger” project. Even mid-term reviews are sometimes ad hoc decisions. Importantly, mid-term reviews, by their nature and timing in the project cycle, tend to yield information only about project processes and not outcomes.

A final report is prepared at the end of a multi-year project. **End-of-project evaluations** are, however, rarely done. A review of the embassy files in Nicaragua, for example, showed that the archives mostly held final project reports. The decision to conduct an end-of-project evaluation is separate from a monitoring decision. The lack of proper evaluations appears to contrast with the MSAH, which reports evaluating its projects regularly.

Despite the existence of NGO guidelines, the implementation and monitoring of NGO reporting, evaluation, learning and baseline data collection are not institutionalized yet. NGOs are expected to send comprehensive reports to the MFA, but report that the MFA prefers monitoring expenditure over actual activities. The majority of NGOs do not collect baseline data. Some big NGOs, such as the Red Cross Finland, do have monitoring systems in place, but the majority of the small ones do not. Monitoring through KEPA has been suggested. This, however, is difficult, because member NGOs do not voluntarily send information to KEPA.
3.7 Measurable achievements of health sector support

3.7.1 Information about achievements

Putting it quite squarely, this part of the Terms of Reference (ToRs) for the evaluation has proven to be unrealistic and unachievable, given the state of information management in the MFA.

Prior to travelling to the MFA offices in Helsinki, members of the evaluation team identified some basic information that would be necessary to answer the point in the ToRs regarding measurable achievements. (See Annex 13.) This information was not available – not just to the evaluation team, but even to the MFA itself. There is no data base of evaluations, not even a register of them that would go back ten years – facts that literally shocked all members of the evaluation team. The team heard complaints about the absence of statistics and data bases from a number of senior officials in various departments of the MFA, and from officials in the field. It was also repeatedly told about the need for a systematic data base/information system. As one person put it,

"The lack of information in the MFA – it is shameful." (Respondent in the MFA)

External partners, such as consulting companies and research institutions, also commented that the MFA is very poor on statistics. This sad lack of usable information has many causes: weak design for information gathering, poor data handling and entry at the MFA, gaps in the information system design, weak information sharing and limited independent problem solving and poor institutional memory. It is obvious that Finland’s commitment toward a policy shift into sector and budget support has not been paralleled by a careful analysis of its information needs and capacities. This evaluation team is not the first group to run into these problems. (For more details, see Annex 14.)

3.7.2 Impressions about achievements

Although hard comparative data about measurable achievements were difficult to come by, the evaluation team did have some impressions about achievements and positive outcomes. It might be possible to document them by a rigorous and time-consuming search in the MFA archives – or possibly with some operational research.

3.7.2.1 Multilateral support

As noted repeatedly in this report, most of the multilateral cooperation funds are going to core support for the agencies. The results are therefore not disaggregated by funder. Two UN agencies that appear to have some information about what happens to the received funds are UNAIDS and WHO.76 It cannot be construed that the other agencies are lagging, as these are the only agencies that were visited in person as part of the present evaluation. Note that the documents mentioned, however, were only cited by the agencies and not by the MFA staff dealing with those agencies.

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Discussions in person with representatives of WHO departments in Geneva elicited the following information regarding specific achievements:

► Finnish money has contributed to the development of normative advice for mental health in emergency situations (e.g., being used in the Darfur crisis); Finland’s contribution is acknowledged in the documents produced by the Mental Health unit on this issue.

► Polio eradication: The specific achievements of the polio eradication effort are generic for WHO and documented on the WHO website, although funds from the Finnish MFA have been used to support a key reference laboratory in Helsinki. Interestingly, Finnish Rotarians generated more than twice as much funds for the polio eradication drive and completely from the private sector than the funds provided by the MFA. This has come about despite the fact that the Finnish MFA does not use a ‘matching fund’ strategy to encourage private sector contributions, unlike some other MFAs.

3.7.2.2 Bilateral support

Three countries with bilateral cooperation projects in the health sector were visited during the evaluation. Many positive achievements were identified in the course of site visits and interviews, including discussions with national officials, embassy staff, and project advisers. The bulk of these achievements were ‘outputs’, meeting targets that had been set for the projects. There were some outcome/effect level changes and a few low level impact changes. (For details, see Annex 15.)

4 CONCLUSION AND RECOMMENDATIONS

The evaluation team has prepared both recommendations and an opportunity analysis. Both are presented below. The list of recommendations is longer than the team would have wished. The importance of the issues it addresses, however, is such that the team was unwilling to cut the list any shorter.

The evaluation team also prepared an opportunity analysis for the many issues and concerns that the evaluation revealed. Clearly, the MFA has neither the resources nor the time to act on all of them. Furthermore, different strategies can be applied to address a single issue, each strategy with its own considerations of political and economic feasibility. The MFA will have to define the priority issues to address first, and then consider alternative actions to address them. The opportunity analysis is intended to help the MFA and its collaborators in this process.

Faced with the dearth of data and documentation, the evaluation team struggled to assess the relevance, effectiveness and impact of Finland’s health sector development cooperation. The following judgements are thus presented with full recognition that better data in the future may lead the next evaluator to reach different conclusions.

Relevance: The emphasis on poverty reduction, the linking of poverty and health and the subscription to the Millennium Development Goals reflect the global recognition of the persistent health needs in developing countries. Finland shares these global concerns. It is therefore clearly relevant that Finland provides development assistance to health. Given the prominence of health in relation to poverty and in the MDGs, it is, however, surprising that the Finnish development assistance to health has not increased more.

The main areas identified in the MDGs include maternal and child health as well as HIV/AIDS, malaria and tuberculosis. The scaling up of Finnish multilateral support to
UNFPA and UNAIDS is in line with the increasing global efforts to address these globally recognised needs. The Finnish bilateral programmes also provide substantial support in these areas.

The Finnish development assistance to health is also generally in line with the objectives in the general development principles and related statements of Finland. The relevance of the portfolio mix at a more detailed level is, however, difficult to assess due to the absence of a health policy to relate the assistance to. Regarding specific bilateral programmes, the ones examined were found to be relevant to the country needs and priorities.

**Effectiveness:** Finland has consistently been working towards donor coordination and harmonisation to increase the effectiveness and efficiency in aid. The effectiveness of Finnish multilateral development assistance to health is difficult to assess and cannot easily be distinguished. Together with the like-minded group of donors, Finland has managed to influence the multilateral agencies. It has also provided earmarked support to internationally recognised important areas, such as mental health. Whether this has been effective in achieving the objectives of Finnish development assistance is hard to say. As emphasised before, the objectives of health sector development assistance are only very broadly defined in the general development policy statements. Mental health, for example, is not mentioned in them. The choice to focus the multilateral support on few organisations and larger amounts is likely to be an efficient approach, as is the collaboration and coordination with the like-minded group of donors.

At the bilateral programme level, the evaluation team assesses the programmes as having been fairly effective overall in reaching their objectives. The effectiveness in mainstreaming gender and HIV/AIDS has, however, been low. The relatively high input of expensive technical assistance in the past has raised some concerns about efficiency. It should be recognised that while some reductions in the input of technical assistance may be relevant, such resource inputs are still needed.

The effectiveness of the development assistance to health could increase, if more coherence was applied in the use of the various aid mechanisms, if interaction and feedback mechanisms were improved, monitoring and evaluation systematically utilised and overall management capacity in the MFA strengthened.

**Impact:** The overall assessment of the team is that the Finnish assistance has probably made an impact on the lives and health of target beneficiaries. However, the absence of documentation makes it difficult to assess in which health areas and target groups such impact would be most notable.

This evaluation has called attention to a number of challenges facing Finland, as it seeks to strengthen its development cooperation in the health sector. But the evaluation also revealed several areas of particular strength. These include Finland’s choice of thematic areas of support; its focus on often marginalised, but important areas, such as disability and sexual and reproductive health and rights; the dependability of Finland’s ‘core support’ to multilateral partners and the good alignment between Finnish bilateral support and recipient countries’ priorities. (See Annex 16.) These are valuable strengths to build on, as Finland tackles the challenges confronting the operationalisation of its new Development Policy with respect to the health sector.
### 4.1 Recommendations table

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<tr>
<td><strong>Policy and strategy development</strong></td>
<td></td>
<td><strong>MFA should urgently develop a health sector policy and a health sector strategy.</strong></td>
<td>a) Preparation through the health advisers (at MFA and Mozambique) together with the Sectoral Policy Unit</td>
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<tr>
<td><strong>Health sector policy, strategy</strong></td>
<td>No formal health sector policy, strategy or plan in the MFA</td>
<td>Qualities of the policy and strategy:► They should be evidence based ► They should be flexible ► They should carefully present the specific nature of the linkages to the cross-cutting themes and how attention to equity, gender equality, poverty reduction, etc. will be included and implemented in the health sector ► They should include attention to controversial issues where decisions are being made by non-technical people, e.g., NGO/CSO involvement; mixed models ► They should give adequate enough information to enable annual implementation planning</td>
<td>b) Review by the Department for Development Policy</td>
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<td></td>
<td>Contributes to lack of coherence and consistency, difficulties with support, inefficient use of resources, and gaps in monitoring</td>
<td></td>
<td>c) Review by the Department of Global Affairs</td>
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<td></td>
<td>Contributes to difficulties in allied areas, e.g., with mainstreaming of cross-cutting themes (HIV/AIDS, disability, gender, poverty, participatory ownership, human rights, poverty reduction, etc.)</td>
<td></td>
<td>d) Review by key stakeholders (e.g. MSAH)</td>
</tr>
<tr>
<td></td>
<td>MFA should urgently develop a health sector policy and a health sector strategy.</td>
<td>a) Preparation through the health advisers (at MFA and Mozambique) together with the Sectoral Policy Unit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Qualities of the data base:► It should be accessible, searchable, and regularly updated. ► It should be as comprehensive as possible, i.e., including statements from major international fora, press releases, and White Papers ► If possible, it should have a segment that is interactive so that it can include critiques and debates about the position statements</td>
<td>b) Review by the Department for Development Policy</td>
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<td></td>
<td>MFA should develop a comprehensive database of “de facto” position statements about ‘health’ and about ‘HIV/AIDS’.</td>
<td>c) Review by the Development Policy Committee</td>
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<td></td>
<td>Lack of coherence between modalities means that many opportunities are lost, e.g., for reinforcement, policy development, stakeholder engagement, and pilot testing of good ideas for scaling up</td>
<td></td>
<td>d) Review by key stakeholders (e.g. MSAH)</td>
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<td></td>
<td>MFA should ensure greater coherence between the different aid mechanisms in support of a health cooperation strategy. Aspects to be clarified:► It should include guidance on facilitating and strengthening the capacity of NGO and civil society partners as appropriate ► It should be build coherence, but also include flexibility ► It should specifically identify and recognise comparative advantages of</td>
<td>e) Review by the Development Policy Committee</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Review of existing strategies, guidelines and mechanisms by the Department for Development Policy – exploring opportunities and means to more effectively promote coherence b) Review of results by field personnel, diplomatic corps, desk officers, legal</td>
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<tr>
<td></td>
<td><strong>Aid mechanisms</strong></td>
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<td>e) Review by the Development Policy Committee</td>
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<td></td>
<td>The MFA currently supports the health sector in selected long-term partner countries through multiple aid mechanisms (bilateral, multilateral, NGO, LCF), but without evidence of coherence between them</td>
<td></td>
<td>a) Review of existing strategies, guidelines and mechanisms by the Department for Development Policy – exploring opportunities and means to more effectively promote coherence b) Review of results by field personnel, diplomatic corps, desk officers, legal</td>
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<td>Lack of coherence between modalities means that many opportunities are lost, e.g., for reinforcement, policy development, stakeholder engagement, and pilot testing of good ideas for scaling up</td>
<td></td>
<td>e) Review by the Development Policy Committee</td>
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77 Suggested responsibilities only; to be refined by the MFA internally and in consultation with other stakeholders, as indicated
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| Bilateral support                                                       | At the present time, the MFA has a mixed portfolio in its long-term partner countries that have health as a priority sector—though there is increasing pressure to drop all bilateral projects in favour of SWAp and budget support. The move to sector and budget support is revealing institutional weaknesses in the Ministry’s partner countries.                                                                 | MFA should keep a mixed portfolio in health cooperation with some project activity that is designed strategically, at least for an extended transition period. Qualities of the bilateral portfolio for health sector support in a partner country:  
   ➢ It should fit/support MFA health sector strategy and country strategy  
   ➢ It should include a strategy for phasing in budget support  
   ➢ It should include guidance on monitoring and evaluation issues and  
   ➢ It should include guidance on issues related to collaboration in the development partners-MOH group and priority issues for policy dialogue with a Finnish perspective.  
MFA should continue to work toward budget support but also carefully consider the institutional capacities in the partner countries and the need for channelling more funds and TA to systems strengthening.                                                                 | Issues to be incorporated in health sector policy and strategy development; see responsibilities for first recommendation in this table. Participation/review with geographic departments (including the Dept of Global Affairs). |
| Bilateral support                                                       | Project and programme designs have not always given adequate consideration to the institutional capacity building needed in order to make SWAps and budget support successful.                                                                                                               | MFA should develop a strategy for multilateral cooperation that is specific by organisation  
Aspects to include in the strategy:  
   ➢ It should include priority issues to pursue by organisation  
   ➢ It should include instruments for effective influence in that particular organisation  
   ➢ It should include means for systematic monitoring and follow-up.  
MFA should strengthen the consultation mechanisms on multilateral health projects. Examples of steps that could be taken include:  
   ➢ Ensure such projects are presented to Project Management Committee  
   ➢ Ensure adequate consultation with other relevant ministries  
   ➢ Develop system for feedback of experiences related to multilateral organisation activities, gaps and strategic options from the country level to MFA headquarters  
   ➢ Commission ‘White Paper’ analyses (e.g., review of public/private groups).                                                                 | Issues to be incorporated in health sector policy and strategy development; see responsibilities for first recommendation in this table. Participation/review with geographic departments (including the Dept of Global Affairs). |
| Multilateral support                                                     | The MFA’s approach to multilateral contributions for health sector related support is historical and ad hoc. There is increasing pressure to use this modality as it contributes positively internationally and minimises administrative costs for the MFA. Lacking a strategy contributes to poor institutional memory, lack of coherence, inability to monitor. It also means that Finland is missing opportunities to effectively promote Finnish health sector concerns in the international arena. | MFA should develop a strategy for multilateral cooperation that is specific by organisation  
Aspects to include in the strategy:  
   ➢ It should include priority issues to pursue by organisation  
   ➢ It should include instruments for effective influence in that particular organisation  
   ➢ It should include means for systematic monitoring and follow-up.  
MFA should strengthen the consultation mechanisms on multilateral health projects. Examples of steps that could be taken include:  
   ➢ Ensure such projects are presented to Project Management Committee  
   ➢ Ensure adequate consultation with other relevant ministries  
   ➢ Develop system for feedback of experiences related to multilateral organisation activities, gaps and strategic options from the country level to MFA headquarters  
   ➢ Commission ‘White Paper’ analyses (e.g., review of public/private groups).                                                                 | Participants prepare decision guidelines by Sectoral Policy Unit, with health advisers and the Department for Global Affairs. Participants review the guidelines and decisions by the Project Management Committee. White papers to be commissioned via the Evaluation Unit. |
| Multilateral support                                                     | Decisions about multilateral health support are not always transparent and lack documentation about evidence used in decision making. The MFA’s internal consultation systems for multilateral support have not been institutionalised, weakening the framework for sharing experiences, identifying gaps and considering strategic options. | MFA should develop a strategy for multilateral cooperation that is specific by organisation  
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   ➢ It should include priority issues to pursue by organisation  
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   ➢ Ensure adequate consultation with other relevant ministries  
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   ➢ Commission ‘White Paper’ analyses (e.g., review of public/private groups).                                                                 | Participants prepare decision guidelines by Sectoral Policy Unit, with health advisers and the Department for Global Affairs. Participants review the guidelines and decisions by the Project Management Committee. White papers to be commissioned via the Evaluation Unit. |
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<tr>
<td>NGO support</td>
<td>At the present time, the MFA’s approach to NGO support for health is historical and ad hoc, and lacks focus related to policy priorities</td>
<td>There is increasing pressure to use this modality and the amounts are scheduled to be increased. Lack of prioritisation means the loss of opportunities for coherence and enhancement of aid effectiveness.</td>
<td>MFA should consider preferential treatment of NGOs working in priority countries and priority sectors (such as health) that supplement other development assistance. Potential strategies:</td>
</tr>
<tr>
<td>LCF support</td>
<td>The utilisation and effectiveness of this strategy for health issues has improved in recent years, but its application is inconsistent and not linked to a health sector strategy</td>
<td>Decisions are largely made by non-technical people; and in the absence of a strategy, resulting at times in decisions to avoid the sector rather than support it</td>
<td>MFA should use the LCF to support civil society organisations and agendas related to the sector focus in the country. The team also supports the recommendation of the Local Cooperation Fund evaluation.</td>
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Operational research to inform decisions and advocacy

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<tr>
<td>Finland has supported some very successful efforts in the health sector in its long-term partner countries, but these successes and ‘good practices’ are not being documented and shared effectively</td>
<td>The lessons learnt are not being captured and used effectively by Finland or other stakeholders and partners for decision-making or policy advocacy. There are also important lessons from international and national NGOs that have been supported by the MFA that are going undocumented and are not being shared well.</td>
<td>MFA should commission operational research studies to document lessons learnt and emerging good practices it its long-term partner countries. Specific examples for study include:</td>
<td>a) Preparation of ToRs for studies by Sectoral Policy Unit (with support of health advisers), and input from other units in the Department for Development Policy, together with MSAH b) Implementation of the studies via the Evaluation and Internal Auditing Unit c) Dissemination and review of results widely internally within the MFA and with external partners/stakeholders; also posting on website</td>
</tr>
<tr>
<td>The MFA has been very weak on phase-out and transitions related to health at all levels – with countries, sectors, programmes, and projects. There is very little guidance (e.g., to ambassadors, desk officers, project managers or consulting companies, or to the counterpart</td>
<td>The lack of standard phase-out and handover practices is a big problem. Institutional memory is compromised, the quality of phasing out has been poor or it is put off indefinitely, even when there have been specific recommendations to phase-out of certain activities, projects, sectors or countries. The MFA Evaluation Unit reports that the last Nordic meeting suggested to study ‘phasing out’; and that such a study could be done as an internal evaluation study internal</td>
<td>MFA should, with urgency, articulate a workable strategy to improve its phasing out practices. Strategies to achieve this objective include:</td>
<td>a) Evaluation study and White Paper to be commissioned via Evaluation Unit b) Preparation of decision guidelines by Sectoral Policy Unit, with health advisers, and in discussion with the MSAH; consider for incorporation in Health Sector Policy and Strategy c) Review of guidelines and decisions by Project Management Committee d) Post guidelines on the website and internally</td>
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### Findings

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<tr>
<td>Ministries in the partner countries for the phase-out/transition processes and objectives.</td>
<td>Fitting MFA mandates</td>
<td>Out/transition practices in the health (and other) sector</td>
<td>Circulate widely</td>
</tr>
</tbody>
</table>

#### Mainstreaming (HIV/AIDS and other themes)

- **MFA staff and stakeholders lack guidance and clarity on what is meant by HIV/AIDS mainstreaming, how it can be done, how it can be funded, and how it can be measured.**

  - In the absence of clarity about mainstreaming, little or nothing is being done about HIV/AIDS, meaning opportunities are being missed for effective interventions, and staff are not being well protected.

  - **MFA should develop and articulate an HIV/AIDS mainstreaming strategy with the utmost urgency.**

    - Elements to include in the HIV/AIDS strategy:
      - It should lead to the development of an HIV/AIDS workplace policy for the MFA very urgently.
      - It should have a clear and workable definition for the concept of ‘HIV/AIDS mainstreaming’.
      - It should contain a plan for monitoring and evaluation of the HIV/AIDS strategy.
      - It should contain a mechanism for identifying, documenting and sharing ‘good practices’ of mainstreaming.
      - It should contain enough information to be used for creating annual implementation plans for HIV/AIDS by the MFA.

  - **MFA should undertake or commission the preparation of analytical ‘White Papers’ on HIV/AIDS in all of its long-term partner countries.**

    - Examples of content to be analysed:
      - Implications of HIV/AIDS for development cooperation.
      - Development cooperation practices that influence (positively or negatively) the prevention of HIV/AIDS, its care and management, or the mitigation of its effects for communities, agencies, organisations, and society at large.

    - **MFA should improve its information management regarding cross-cutting issues in the health programme it funds.**

      - Aspects to be strengthened include:
        - It should develop indicators to monitor its progress in promoting the cross-cutting issues and the outcomes of that promotion.
        - It should strengthen the sharing and application of the resulting knowledge in programming and decision-making.

  - The MFA has not been producing or commissioning analytical ‘White Papers’ on health related topics, including HIV/AIDS.

    - The evidence base for HIV/AIDS mainstreaming is not present; HIV/AIDS related activities are absent or ad hoc, lacking prioritisation, focus and consistency.

  - **MFA should undertake or commission the preparation of analytical ‘White Papers’ on HIV/AIDS in all of its long-term partner countries.**

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    - Examples of content to be analysed:
      - Implications of HIV/AIDS for development cooperation.
      - Development cooperation practices that influence (positively or negatively) the prevention of HIV/AIDS, its care and management, or the mitigation of its effects for communities, agencies, organisations, and society at large.

    - **The MFA says that it is mainstreaming cross-cutting themes, but it has very little information about its performance on those themes.**

    - Mere inclusion of vulnerable groups, disabled and poverty issues in policy documents is not enough. Gathering and analysing disaggregated data will aid in better assessing the degree to which activities are benefiting the poor.

    - During the transition to SWAs, there is a risk that the MFA’s contribution and efforts towards cross-cutting issues could be diminished or lost, e.g., concern for gender, vulnerable groups, poverty reduction, equity in access to health services, etc.

  - **MFA should improve its information management regarding cross-cutting issues in the health programme it funds.**

    - Aspects to be strengthened include:
      - It should develop indicators to monitor its progress in promoting the cross-cutting issues and the outcomes of that promotion.
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      - It should develop indicators to monitor its progress in promoting the cross-cutting issues and the outcomes of that promotion.
      - It should strengthen the sharing and application of the resulting knowledge in programming and decision-making.
### Findings
- The progressive shift to SWAps is enhancing ownership of health at a national level in the partner countries, but seems to be drawing attention away from local ownership and participation.

### Implications & challenges
- The principle of community participation needs to be reinforced - involving communities, women and other vulnerable groups in decision-making, particularly in cost-recovery mechanisms to strengthen the operationalisation of adequate health interventions, including quality of care. The complex nature of poverty requires a coordinated response that is multi-faceted, multi-levelled and multi-sectoral. A coordinated response to poverty should involve actors from a variety of backgrounds.

### Recommendations
- **MFA should strengthen support for continually testing and improving stakeholder participation in the changing environment of health cooperation for poverty reduction.**
  - There are several cautions to this process:
    - Care should be taken that ownership remains with national stakeholders; it must not be taken over by outside agencies.
    - The responses to poverty need to ensure that they include goals of empowerment and transformation and address the needs of all groups, especially those who are likely to be most marginalised and lacking a ‘voice’, including women, people with disabilities, adolescents and the elderly.
    - Strategies need to include service delivery, capacity building, advocacy and research.

### Responsibility
- a) Preparation of strategy and decision guidelines by the Sectoral Policy Unit, with health advisers, and in discussion with the MSAH; consider for incorporation in Health Sector Policy and Strategy
- b) Review of guidelines and decisions by the Project Management Committee
- c) Any White Papers or evaluation studies to be commissioned via the Evaluation Unit

### Management

#### Annual planning for health sector
- The MFA currently lacks information about the relevance of resource allocations against policy priorities and strategy targets in the health sector.
- The MFA has outsourcing arrangements with institutions capable of generating information about its performance in health. It also has a statistical unit that is willing to consider alternative coding (with justification and as long as the DAC procedures are not interfered with)
- Annual reviews of the sector could facilitate coherent annual planning for the sector, rather than the present uncoordinated planning.

#### Human resources
- The MFA currently has one field/country based health adviser, and this has been very successful
- Lessons from the health adviser experience are not yet well captured for informing the process of hiring more such positions, yet that hiring process is already underway
- The MFA is facing dire shortages of skilled and experienced development staff in the next few years, affecting health and other development sectors. No plan to address these issues was shared with the evaluation team
- The MFA is already short staffed and using underskilled persons in important roles, having to rotate persons through too many posts in too short of a time, leading to loss of informal ‘how to’ knowledge and experience, also resulting in compromised institutional memory

#### Recommendations
- **MFA should undertake a ‘small’ review of the development assistance to health in its totality, i.e., across all aid mechanisms, on an annual basis.**
  - Qualifiers:
    - The review should be supported by annual monitoring, i.e., there should be data and evidence organised ahead of time for the review group, whoever they are.
    - The review should be closely linked to the annual budget and activity planning for the sector

- **MFA should use lessons learnt to develop suitable hiring criteria and job descriptions for decentralised health advisers.**
  - Such advisers need a special skill set in the contemporary world of development cooperation, especially in light of the move to SWAps. They should have:
    - People skills, language competence, negotiating skills, organizational skills and technical skills.

- **MFA should advocate for and contribute to a short and long range plan for human resource development that particularly addresses the need for development staff in health (and other sectors).**
  - Important steps in the plan should include:
    - Raising the issue to the Permanent Secretary level with Ministry of Education, MSAH and MFA
    - MFA support to Finland’s universities to revise curricular content in

### Qualifiers:
- a) Preparation of review guidelines by Sectoral Policy Unit, with health advisers, the Evaluation Unit, and in discussion with MSAH; consider for incorporation in Health Sector Policy and Strategy
- b) Review to include participation of the Project Management Committee
- c) Any White Papers or evaluation studies to be commissioned via the Evaluation Unit
## Findings

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| preservice training programs, more in-depth post-basic courses, develop 'apprenticeship' programmes. | MFA should recruit and support a specific HIV/AIDS adviser to promote HIV/AIDS issues effectively with all of MFA’s partner countries, priority sectors, and partner organisations. | a) Department for Development Policy  
b) Department of Administrative Affairs  
c) Review by the Development Policy Committee |
| The HQ health adviser (one individual) is also the point person for HIV/AIDS for the whole organisation | The HQ health adviser (one individual) is also the point person for HIV/AIDS for the whole organisation. | a) Department for Development Policy  
b) Department of Administrative Affairs  
c) Review by the Development Policy Committee |
| HIV/AIDS is a multisectoral, multi-faceted issue that is being under-resourced, underanalysed, and weakly addressed by the present arrangement in the ministry. | HIV/AIDS is a multisectoral, multi-faceted issue that is being under-resourced, underanalysed, and weakly addressed by the present arrangement in the ministry. | a) Department for Development Policy  
b) Department of Administrative Affairs  
c) Review by the Development Policy Committee |
| Information support and management | Information support and management | Lead by the Dept. for Development Policy, General Development Policy and Planning Unit, with support from the the PMC, advisers, desk officers, field staff, consulting companies, NGOs, and the Evaluation Unit. |
| The present information system of the MFA is woefully inadequate and unable to support health and other development sectors effectively. | The present information system of the MFA is woefully inadequate and unable to support health and other development sectors effectively. | Lead by the Dept. for Development Policy, General Development Policy and Planning Unit, with support from the the PMC, advisers, desk officers, field staff, consulting companies, NGOs, and the Evaluation Unit. |
| Staff and partners of the MFA are widely frustrated with the MFA information system and the lack of analysis possible, using only the DAC primary purpose codes. Without secondary codes, it is impossible to follow all of MFA’s contributions, e.g., to health. | Staff and partners of the MFA are widely frustrated with the MFA information system and the lack of analysis possible, using only the DAC primary purpose codes. Without secondary codes, it is impossible to follow all of MFA’s contributions, e.g., to health. | Lead by the Dept. for Development Policy, General Development Policy and Planning Unit, with support from the the PMC, advisers, desk officers, field staff, consulting companies, NGOs, and the Evaluation Unit. |
| Diplomatic, technical staff, and partner agencies also expressed frustration about the documentation system of the MFA. Institutional memory is being heavily compromised, e.g., by missing all copies (hard or soft) of an important project baseline from 12 years ago. This makes tracking achievements very difficult. | Diplomatic, technical staff, and partner agencies also expressed frustration about the documentation system of the MFA. Institutional memory is being heavily compromised, e.g., by missing all copies (hard or soft) of an important project baseline from 12 years ago. This makes tracking achievements very difficult. | Lead by the Dept. for Development Policy, General Development Policy and Planning Unit, with support from the the PMC, Advisers, Desk Officers, Field staff, Consulting companies, NGOs, and the Evaluation Unit. |
| Project evaluation guidelines at present are equivocal about what is absolutely needed regarding evaluation. | Project evaluation guidelines at present are equivocal about what is absolutely needed regarding evaluation. | a) Lead by the Dept. for Development Policy, the PMC, with support from advisers, desk officers, field staff, consulting companies, NGOs, and the Evaluation Unit.  
b) Review of strategies and guidelines for M&E of quality assurance by these and other stakeholders, including Ministries of Health in partner countries. |
| Many projects are implemented with little or no evaluation processes; indicators are designed for log frames but not tracked and used | Many projects are implemented with little or no evaluation processes; indicators are designed for log frames but not tracked and used | a) Lead by the Dept. for Development Policy, the PMC, with support from advisers, desk officers, field staff, consulting companies, NGOs, and the Evaluation Unit.  
b) Review of strategies and guidelines for M&E of quality assurance by these and other stakeholders, including Ministries of Health in partner countries. |
### 4.2 Opportunities analysis table

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<tr>
<th>Issue/problem to be addressed</th>
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<tr>
<td><strong>Advocacy</strong> - Finland will have responsibility as EU president for last half of 2006 – how can this opportunity be used to the advantage of any key health concerns of Finland?</td>
<td>► Chance to mainstream some key issues with the EU (e.g., in health) ► Also opportunity to bring some of these issues more forward within the MFA.</td>
<td>► Finland has some important background experiences for this role, including provision of the chair for the UNGASS ► Other EU countries have used the same opportunity to greater or lesser effect when it was their turn.</td>
<td>Development Policy Committee, MFA HQ</td>
<td>► See comments below on the topic of information (position statements and cohesiveness) ► Do a critical analysis of EU positions on key health issues for Finland to assess where there are differences and the possible reasons for those differences ► Use the impetus of this event to develop a policy and strategy for the health sector in Finnish international development cooperation</td>
<td>► Preparation needs to start early to have a coherent position and advocacy plan</td>
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<td><strong>Advocacy</strong> - Level of engagement with multilaterals is relatively low and non-technical; missed opportunity</td>
<td>► Promote more active engagement of MFA representatives on both technical and non-technical issues with the multilateral agencies it is supporting, i.e., respond to the interest and encouragement of these agencies for greater Finnish involvement</td>
<td>► Although Finland is not always among the top 10 donors for the multilaterals, they are generally within the top 20 and thereby are accorded significant attention by the recipient agencies ► UNAIDS - Opportunity to be more involved in M&amp;E reference group (MERG – it has one meeting per year) and contributing to the development of useful indicators that people can and do want to sign up to. ► WHO wants both MoH and MFA to come to annual meetings – to help promote dialogue (Geneva)</td>
<td>MFA HQ, missions in Geneva, NY and Brussels, Development Policy Committee, MSAH</td>
<td>► Advisers who are technically capable would not all have to be based in the MFA/Helsinki, but there could be an understanding that selected field advisers could/should also have some multilateral responsibilities, e.g., participating in international meetings one time per year; participating in critiquing MFA position statements, contributing to MFA sectoral policy and strategy ► Could even consider interministerial collaboration arrangement, with international health staff from MSAH seconded to MFA for a specified period of time or other alternative arrangements for sharing responsibilities for the international health cooperation with the MSAH. ► See comments below on the topic of information (position statements and cohesiveness)</td>
<td>► May need more technical advisers; ► Need a committee of advisers and a strategy for effective information sharing and development of common positions among the advisers ► Need a health strategy, an HIV strategy, a population strategy that are clearly articulated and shared for common understanding and consistency (while retaining flexibility)</td>
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<td><strong>Financing mechanisms</strong> - Current multilateral funding arrangements make long-term planning difficult for the agencies, especially WHO</td>
<td>► Develop sustainable long-term financial arrangements with multilaterals</td>
<td>► WHO would prefer 2 year pledges; some countries are already doing this, e.g., 2 yr – Netherlands, Norway; 3 yr – Ireland; 4 yr – Belgium; rolling – Germany.  ► Some policy statements of Finnish government already indicate willingness to use this approach. The Finnish government has recently signed long-term agreements with UNFPA and UNICEF.  ► Better funding arrangements would enhance Finnish leverage with the multilaterals for advocacy and engagement on sector issues, e.g., in health</td>
<td>MFA HQ, missions in Geneva, NY and Brussels, Development Policy Committee, MSAH</td>
<td>► Do a operational research or evaluation study on the funding arrangements in place by other countries; focus on the nature of the arrangement, assumptions and risks, constraints, and strategies to minimise risk. Also assess the comparative advantage of this approach for advocacy and leverage with the agencies</td>
<td>► Would be strong challenge to high level political commitment, but would also be in line with recent Development Policy Committee report</td>
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<td><strong>Financing mechanisms</strong> - Difficulty mobilising funds to meet 0.7% for ODA, as well as funds for specific health initiatives</td>
<td>► Refine MFA’s strategy for working with private sector partners in Finland in support of international development cooperation</td>
<td>► Canada and Australia are using ‘matching fund’ strategy to help mobilise public/private partnership support (WHO, Geneva).  ► Finnish Rotarians have contributed twice as much as the MFA to the polio eradication effort of WHO.</td>
<td>MFA HQ, NGO unit, Development Policy Committee</td>
<td>► Develop ‘new’ models (for Finland) for mobilising private sector funds in support of international development cooperation. Make part of the public advocacy efforts of the MFA  ► Develop strategies to identify amounts mobilised and how they can be added to MFA funds for ‘leveraged’ development cooperation funds  ► If no local experience with such approaches is available, then consider study tour or evaluation study of how other countries are managing these approaches</td>
<td>► Might require greater flexibility and creativity in preplanning funding arrangements</td>
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<td><strong>Human resources</strong> - shortages of development oriented staff (particularly in health)</td>
<td>► Need to generate capacity and build competency for the future  ► Shortage of new persons</td>
<td>► The technical adviser position for health based in Mozambique has been a big success – due in part to local positioning, and in part to the good qualities of the person in the role, but overall it is resounding very much to the credit of Finland.  ► The Global Health exchange programme created by PSR in Finland</td>
<td>MFA HQ, consulting companies, MSAH, research institutes, universities; possibly also the Development Policy Committee</td>
<td>► To develop and fund ‘junior expert posts’ linked to supportive supervision and career development. (See, for example, Danida’s programme for bilateral JPOs)  ► To collaborate with MSAH and the MoE in supporting activities linked to international health careers, e.g., international health courses, research</td>
<td>► Change of attitude (and possibly policy) needed in the management of MFA regarding capacity building  ► Some budget, but not necessarily large</td>
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<td>coming up through the development ranks in the MFA</td>
<td>History of MFA reluctance (or stronger) to support capacity building for its own needs</td>
<td>triggered a lot of interest in international health, but MFA was unwilling to do more than nominal support</td>
<td>studies on international health in partner countries, student run health projects in partner countries (see example run by Danish medical students in the Upper West Region of Ghana)</td>
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<td>Increasing need for technical strengths in sector and budget support</td>
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<td>Possibly use an already existing committee, like the Project Management Committee, to oversee the selection of activities to encourage or support; or create a new inter-ministerial committee to take up this function. Recognise that a significant part of the role may be doing advocacy with universities, institutes and consulting companies</td>
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<td><strong>Human resources</strong> - Extensive use of outsourcing with inadequate quality controls</td>
<td>Limited technical capacity relative to workload in some sectors (e.g., health), resulting in extensive use of outsourcing</td>
<td>Insufficient systems for monitoring quality of the outsourcing</td>
<td>Develop and establish a transparent process for monitoring and evaluating the outsourcing process and results.</td>
<td>Develop a review process for monitoring and evaluating the outsourcing using the above criteria, e.g., a committee that periodically assesses a sample of outsourcing encounters and products, an articulated grievance procedure for persons or agencies challenging the process or outcomes of the outsourced work</td>
<td>Minimal budget implications</td>
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<td>There are already some committees within the MFA beginning to address quality issues, e.g., one that is reviewing bilateral project proposals.</td>
<td>Participatory development of criteria for ‘quality’ in both process and results of outsourcing</td>
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<td>There is a cultural concern within the MFA about getting ‘value for money’</td>
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<td>MFA HQ, sector advisers, consulting companies</td>
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<td><strong>Information - MDGs not being tracked</strong>&lt;br&gt;► Would like to track the contribution of Finnish support to MDGs&lt;br&gt;► Many questions arising about performance of the MFA with regard to its contribution to poverty reduction, and regarding prioritisation of countries for involvement</td>
<td>► Develop a system for monitoring (and sharing) MDGs in partner countries</td>
<td>► MFA does have or is setting up a database capable of yielding MDG information. There are also the country joint evaluations and PoA/national indicators&lt;br&gt;► MFA’s increasing involvement in sector and budget support is providing more push to use higher level indicators of outcomes and impacts&lt;br&gt;► There have been several evaluations that have criticised the MFA’s lack of impact information</td>
<td>MFA HQ, regional and country level, Development Policy Committee</td>
<td>► Ensure that the MDG information is updated regularly, that it includes source links for people who want to cross check it. Also ensure that it is readily downloadable for people who want to analyse it; preferably include it in a package that is capable of generating some simple tables and graphs (e.g., as UNDP has been doing in Tanzania) so that policy makers and planners can more easily use the information&lt;br&gt;► Link the information to amounts and proportions of Finnish support to the partner countries, overall and by sector</td>
<td>► Will probably need technical assistance with information management</td>
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<td><strong>Information - Weak documentation of MFA ‘positions’ (i.e., de facto policies and strategies on topics where there are no formal policies or strategies, such as health)</strong>&lt;br&gt;► Insufficient compilation of position statements, by sector or theme&lt;br&gt;► Contributes to MFA problem of institutional memory loss</td>
<td>Improve assembly and access to information about MFA ‘positions’ on key issues, e.g.,&lt;br&gt;► Improve self-directed access to MFA ‘position statements’, whether White Papers, press releases, public speeches in international fora, ‘mandate’ papers prepared before bilateral/multilateral negotiations, etc.&lt;br&gt;► Improve the cataloguing of the MFA ‘position statements’ by sector, cross-cutting theme, geographical region, etc.&lt;br&gt;► Use the information to trigger the development of White Papers and evidence based policies and strategies that can support greater clarity</td>
<td>► There is an area of the MFA web site that does include some press releases and public statements (but it is only organised in a chronological way without cataloguing, poorly accessible/downloadable, and not searchable from the web)&lt;br&gt;► There are complaints about the lack of policies and strategies for some of the MFA’s key target sectors, e.g., health.</td>
<td>MFA HQ, Development Policy Committee</td>
<td>► Redesign the relevant area of the web site&lt;br&gt;► Redesign strategies for capture of relevant types of information&lt;br&gt;► Retrospectively compile and catalogue this information by sector, theme, geographic region&lt;br&gt;► Periodic review of position statements on different sectors, themes, etc. to be done by compiling a set of consolidated statements on an issue, and using a suitable committee within MFA (and possibly including external representatives and representatives from the Development Policy Committee) to critically review the consistency and appropriateness of the current and emerging position of the MFA on that issue (from the overall human rights and poverty reduction lens of the MFA)</td>
<td>► Budget, human resources for the retrospective collection, collation and cataloguing&lt;br&gt;► Technical assistance to improve the website&lt;br&gt;► Political will and commitment from senior management to address the gaps in formal sector policies and strategies</td>
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<td><strong>Information</strong> - Weak information sharing</td>
<td>Improve knowledge management practices in the MFA, e.g.,</td>
<td>Already have a web site</td>
<td>MFA HQ</td>
<td>Expand the inventory of e-documents by the MFA that are available</td>
<td>Budget, human resources</td>
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<td>► Many key documents not easily available (on the web site or elsewhere)</td>
<td>Improve self-directed access to MFA documents</td>
<td>Have some documents available in hard copy (e.g., at the evaluation unit)</td>
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<td>Include key documents retrospectively that are not on the present web site – do by scanning and saving as pdf files if original e-files are not available</td>
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<td>► Weak design and utilisation of the ministry’s web site</td>
<td>Improve the web site – more user-friendly, more MFA content, more clarity about internal pages vs. external web links</td>
<td>Have an intranet in place (though not all countries are linked to it)</td>
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<td>Proactive notification of new postings on the web, e.g., by e-mail/e-newsletter, or by a special area on the web site.</td>
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<td>► Statistics not readily available for external analysis</td>
<td>Improve architecture of the MFA information system, including selection of information for entry, quality controls, and analyses that can be supported</td>
<td>Have an information system that is currently under revision</td>
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<td>Consider an e-journal/e-newsletter with highlights of new documents, either on the ‘intranet’ or on the open web</td>
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<td>► Contributes to loss of institutional memory</td>
<td>► Already have a web site</td>
<td>Strong culture of transparency</td>
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<td><strong>Partnering</strong> – the Local Cooperation Fund (LCF) strategy is extremely broad and not linked to country strategies (since they don't exist), or the health sector strategy (which also does not exist)</td>
<td>Use the LCF in more innovative ways to address civil society aspects of the broad priority sectors in the partner countries</td>
<td>The LCF support is currently de-linked from sector support, which is a missed opportunity to promote local involvement in the private and civil society sector.</td>
<td>MFA HQ, regional and country level</td>
<td>Consider operational research or an evaluation study to explore good practices and innovations by other donor countries using LCF, e.g., hiring a local consultant to identify NGOs to recruit involvement with in priority areas (as done by the Dutch)</td>
<td>Budget, human resources</td>
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<td>► Use the LCF in more innovative ways to address civil society aspects of the broad priority sectors in the partner countries</td>
<td>► Would also provide opportunity to address sensitive or marginalised issues within the sector that are outside of the core support to the MoH in the partner country</td>
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<td>Refine, improve systems for documenting the outcomes of LCF support</td>
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<td>► The LCF support is currently de-linked from sector support, which is a missed opportunity to promote local involvement in the private and civil society sector</td>
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<td>Build LCF support planning into the process of developing country strategies</td>
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<td>► To be most effective, this will require having an expressed health policy and strategy</td>
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<td>It will also be more effective if there is a country strategy</td>
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## Issue/problem to be addressed | Opportunity (response to the issue) | Supporting information about opportunity | Implementation level | Strategy for using the opportunity | Implications |
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**Partnering** - the current NGO/CSO strategy is delinked from the bilateral support and even from the sectoral support strategies | ► Engage the NGO sector more effectively in addressing civil society aspects of the broad priority sectors in the long-term partner countries | ► Would fit the mandate of the Development Policy (2004)  
► Would provide a critical and participatory opportunity to address sensitive or marginalised issues within the sector that are outside of the core support to the MoH in the partner country | MFA HQ, NGO unit, Development Policy Committee, partner organisations | ► Prioritise certain focus areas (while not excluding a proportion of support being self-defined by the NGOs).  
► Use participatory approaches to develop a coherent strategy for NGO/CSO focus work, e.g., on critical issues from a public/private partnership model, especially with sensitive, marginalised issues in priority sectors (such as health) in partner countries – i.e., being able to cover, address issues that are locally or internationally defined needs but outside of the mainstream work of the sectoral support programmes.  
► Involve NGOs in health programmes (at national level) with clear guidelines for their involvement | ► Potentially very sensitive politically, and would need a well-planned advocacy approach, not ad hoc or only top downward as it has been so far  
► Would need to build in or retain a element of flexibility, but possibly within certain limits  
► To be most effective, this will require having an expressed health policy and strategy  
► It will also be more effective if there is a country strategy |
**Policy engagement** - Health career ladder is a problem in the recipient countries affecting capacity and sustainability - especially with the transfer to the local public sector of increasingly technical responsibilities in SWAps and budget support strategies | ► Promote active engagement of Finnish representatives with policy dialogue on health sector career ladders in all partner countries | ► Many complaints and concerns in all partner countries about the problems associated with poorly designed and implemented health career ladders, in part because they are an issue of ministries of public service as well as health, and sometimes education, with many colonial residues and inequities; results in brain drain for the sector – not always leaving the country but also internally, as in Mozambique;  
► Also contributes substantially to institutional memory problems | MFA HQ, regional and country level | ► Need assessment of all the opportunities to get involved at policy level, e.g., in SWAp groups, in bilateral country negotiations, through bilateral projects, advocacy efforts linked to LCF, etc.  
► MoHs in partner countries acknowledge need to work on public sector at same time as health sector  
► SWAp may provide an opportunity for more coherence in funding through bilateral and multilateral funding. Opportunity to provide and use networking and policy dialogue arising from engagement in SWAp and budget support. | ► Requires policy analysis and advocacy skills |
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<tr>
<td><strong>Research</strong> - Research agenda not well defined; unclear if health has any assigned allocation within the programme</td>
<td>Promote operational research in development assistance to health for clarifying and sharing lessons learnt in ‘successful’ programmes and ‘good practices’</td>
<td>MFA is doing/sometimes does a research ‘bid’ – as an open call for proposals. Opportunity to allocate a proportion of the research to assessment of the effectiveness of health ODA issues (and, of course, a proportion to each of the other key sectors and cross-cutting themes)</td>
<td>MFA HQ, institutes, universities, sector advisers, regional and country advisers</td>
<td>Research studies on change of behaviour in practitioners. Case studies as examples of ‘good practices’, e.g., the health SWAp in Mozambique. Use research topics/agenda for development of international health studies by junior researchers; contribute to capacity building needs of the MFA.</td>
<td>Budget. Strategic thinking about allocation of research endeavours (A health sector strategy would be a helpful supporting document).</td>
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<td><strong>Strategic planning</strong> - Trend toward regionalisation of aid, but lack of an articulated strategy</td>
<td>Explore and develop a realistic and useful regionalisation strategy that can help address regional problems without overextending MFA’s capacity</td>
<td>Supporting info: other agencies (WHO, Danida, SIDA, UNAIDS) are involved with such an approach; MFA has an interest to move in this direction for development support as indicated in several policy statements On the other hand, some PVOs have dropped regional posts; may be an issue of inadequate design, planning for how to use. Budget – HR, office, travel (with possible decrease in demands for assistance from MFA in Helsinki). There has been an increasing development of regional clustering of countries with the capacity to address regional policies and strategies, e.g., the East African Parliament.</td>
<td>MFA HQ, regional and country level, Development Policy Committee</td>
<td>Review regional programmes and management structures of other agencies. Investigate the possibilities of regional health adviser, management and technical support to various forms of health sector ODA/support in region. Backstopping and resource centre. Cross-pollination of Finnish support efforts and MoHs and MFA. Networking and strengthening of bridging support for weaker organisations. Support to cross-border policy engagement and research projects. Advocacy and information sharing. Consideration needed for criteria affecting placement of sectoral advisers, e.g., based on regional ‘need’ or regional Finnish involvement.</td>
<td>Human resources are in short supply in the MFA. Partner countries are widely dispersed and not in ‘natural’ regional groupings.</td>
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<td><strong>Strategic planning</strong> - absence of country strategies, despite considerable rhetoric about their value and use</td>
<td>Develop country strategies in all partner countries (short or long-term)</td>
<td>Many policy statements speaking of the value and existence of these strategies – but they are not in place. Have been criticised for their absence by the DAC peer review</td>
<td>MFA HQ, regional and country level, Development Policy Committee</td>
<td>Review country strategy approaches of other donor countries, particularly among the Nordic and like-minded countries. Develop guidelines and, if necessary, capacity building for the key staff to be involved in preparing the country strategies. Use the strategies as part of the.</td>
<td>Will require high level management commitment to a more coherent planning process.</td>
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<td>Transitions - Need to maintain a certain amount of project activity for credibility, pilot testing, validation, i.e., need a strategic portfolio</td>
<td>Maintain a mixed portfolio rather than full shift to sector/budget support</td>
<td>Would permit health sector to continue to collaborate with local partners in small scale trial interventions – pilot approaches, working in underprioritised areas, testing phase-out strategies, developing good practices that can be ‘scaled up’ in the core support</td>
<td>Regional and country level, MFA HQ,</td>
<td>Support health sector development through a mixed modality approach: supply side through the sector programme, and demand side through civil society.</td>
<td>To be most effective, this will require having an expressed health policy and strategy</td>
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ANNEX 1 - Terms of Reference for the evaluation of the Finnish health sector development cooperation

(Issues to be studied revised with and approved by the MFA)

1. Introduction

Good health is a human right and essential contribution to economic and social development of a country. Health is both a goal in itself, and a key input towards development. Good health is critical in the chain of events that allow countries to break out of the vicious circle of poverty, high population growth, poor health, and low economic growth.

Finland acknowledges the importance of health in the achievement of development goals and considers health as one of the main sectors in Finnish development cooperation. Due to the changes in Finnish and international development policy context, there is a need to evaluate the health sector to meet the future needs of the Finnish health development cooperation and consider the need for a specific health strategy for health cooperation.

Although several Finnish bilateral health sector projects have been evaluated, an overall evaluation of Finnish health cooperation has never been done. The Ministry for Foreign Affairs has therefore decided to carry out such an evaluation during 2004.

2. Background

Finland’s health sector development cooperation has no specific sectoral cooperation policy. Thus the work is guided by the general policies of Finnish development cooperation (See: ITT p.6) and international agreements and commitments like the Global Agenda. Finnish health sector policy is consistent with the development principles, where health is considered vital for human development, and access to basic health services is a human right, which must be especially guaranteed for poor, vulnerable and disadvantaged people.

Finland emphasises a public health approach, based on sustainable and functional health systems focusing on health prevention, promotion and multi-sectoral approach. Sexual and reproductive health and HIV/AIDS prevention and care are seen as a part of the primary health care. On the attainment of a better health system, human resources development plays a key role.

The proportion of Finnish support allocated to health and social sectors (incl. Population sector activities) represents approximately 12. (53,50 million EUR) of the total ODA. The top five recipient countries in the health sector are Mozambique, Nicaragua, Namibia, China and Bosnia & Herzegovina. In 2001 the regional contributions were: Africa 44%, Asia 32%, Europe 13%, and Central and South America 9%.

In 2001 more than 65% of the support allocated to health and social sectors was channelled through multilateral assistance while 22% was channelled through official bilateral assistance, and the rest through national and international NGOs. Currently, some 200 Finnish NGOs are running around 500 projects in 70 countries, many of these related to health. In 2002, the Finnish NGOs received 37 million EUR funding and the international NGOs (INGOs) were supported by 4 million EUR.

The UN system and EU receive the majority of funds in the multilateral cooperation, and
a minor share is provided to international financing organisations. In the health sector UNICEF and UNFPA are the UN agencies receiving the main share of the contribution. However, in the last few years the contribution to UNAIDS has increased ten times reaching from 0.7 million EUR in 1999 up to 6.7 million EUR in 2001.

Finnish bilateral development assistance is mainly project or programme assistance. Sector-wide approaches (SWAp) are being developed in Mozambique and Nicaragua. Bilateral health projects are carried out in Egypt, Kenya, Mozambique, Namibia, Nicaragua, Guatemala, Afghanistan, the Philippines, Kyrgyzstanz, Vietnam and Kosovo (p.6).

In addition to above mentioned aid instruments, assistance in health sector development cooperation is also channelled through research, humanitarian aid, concessional credits and local cooperation funds in partner countries.

3. Objectives

The main objective of the evaluation is to review and assess the Finnish health sector cooperation, to improve the planning of future support and interventions, and to help the sectoral work to support better the attainment of Finland’s development objectives. The evaluation may also provide input to formation of a health sector strategy.

The purpose of the evaluation is to provide the MFA with an evaluation report, where Finnish health sector development cooperation is briefly described, results and impacts of interventions assessed, and lessons learnt and best practices clearly analysed. The report must have a rigorously analytic view, and concrete recommendations for further development of health sector cooperation will be clearly outlined.

The results of the evaluation will be used by the MFA for the further development of Finnish health sector development cooperation policy and interventions. Users of the report are (mainly) the MFA development cooperation policy makers, but the report should also benefit the policy making bodies in respective partner countries and other interested parties.

4. Approach

The evaluation of the Finnish health sector development cooperation will cover the period of 1994–2003. The evaluation will be concerned with the health sector broadly defined, thus including sexual and reproductive health and HIV/AIDS.

The evaluation should focus on assistance to multilateral organisations and bilateral cooperation including assistance through NGOs and INGOs. The health sector projects funded through the concessional credit scheme and the use of Local Cooperation Funds (LCF) should also be covered, making full use of the recent evaluation reports (see: ITT p.6).

Humanitarian aid, assistance to research, support to EU, trade policy and agreements should be covered in general descriptive level, to enable the reader to understand the full context. (Humanitarian aid and the research funding channelled through the Academy of Finland will be evaluated separately and need therefore not to be covered in deep in this evaluation).

The evaluation must be carried out within the framework of the available policy document and the MFA Guidelines for programme design, monitoring and evaluation (see: ITT p.6)
5. Issues to be studied

The evaluation will assess the general evaluation issues as relevance, effectiveness, efficiency, impact and sustainability and compatibility of the Finnish health sector development cooperation. In addition, the evaluation will assess several specific issues.

1. Role and status of health sector - Analyse the development of the role and the current status of the health sector in Finnish development cooperation. This will be principally qualitative, with supporting quantitative analysis based on allocation data.

2. Measurable achievements of health sector - Describe measurable achievements of Finnish health assistance to the extent that objectives, indicators and data are available for such analysis – from selected countries, regions, and internationally. Identify and discuss key supporting and constraining issues affecting either the achievement of outcomes or the analysis of intended and unintended outcomes.

3. Relevance of resourcing - Analyse the relevance of Finnish health assistance resourcing from both short and long-term perspectives. Discuss decision-making (use of evidence, objectives, priorities, etc.) and consequences for the overall Finnish contribution to international health and for selected countries.

4. Policies and strategies - Describe the Finnish development policies and strategies in relation to:
   a) External context – briefly review major international trends affecting health and Finland’s role in health, plus the influence of political, economic and social setting in selected partner countries.
   b) Existing Finnish policies – review trends in the Finnish policy environment affecting Finland’s development activity, especially for international health assistance
   c) Absent health policy – examine the effects, positive or negative, of not having a documented health assistance policy and strategy

5. Key areas of involvement - Examine the processes by which Finnish health development cooperation engages with selected key thematic areas – vulnerability, poverty, disability, and HIV/AIDS. What kinds of information from what sources are used to make which kinds of decisions by which stakeholders, both centrally and in selected countries?

6. Key implementation strategies – examine the influence and outcomes of key implementation strategies and policies in the Finnish development cooperation, including gender mainstreaming, participatory ownership, and alternative forms of budget support.

7. Management capacity and systems - Analyse the relevance of the Finnish administrative and management capacity, describe the procedures and different roles, and assess the synergy, coordination and complementarity between the MFA (including embassies and liaison offices) and partner organisations (e.g. Ministry of Social Affairs and Health, National Public Health Institute). Examine oversight and accountability arrangements. Assess the influence of the management systems at headquarters and in the field on realisation of the health development cooperation. Assess the readiness and responsiveness of health cooperation practices to adjust to external and internal changes.

8. Aid mechanisms - Assess the role, relevance, achievements, benefits, potential conflicts and problems of the following aid mechanisms. Analyse the coordination, synergy and complementarity between the mechanisms.
   • Multilateral cooperation - Describe the related decision making and consultation mechanisms in Finland and assess the Finnish contributions, including technical assistance.
Bilateral cooperation, including local cooperation funds and NGOs. Analyse the proposal evaluation procedures and decision making mechanisms. Assess the synergy and complementarity between interventions implemented by the MFA and NGOs. Identify the advantages and disadvantages of NGO projects. Compare quality of work of NGOs under long-term framework contracts with that of other NGOs.

INGOs. Analyse the proposal evaluation procedures and decision making mechanisms. Analyse the utility of using INGOs as an alternative funding channel to deliver official bilateral aid allocations.

Assistance to EU. Analyse the decision making mechanisms and volume of funding.

Plus short descriptions for background on the following aid mechanisms that are or will be covered by other assessments

- Humanitarian aid, shortly on general descriptive level.
- Concessional credit scheme (based on evaluation from 2002).

Research funding to Academy of Finland (shortly on general descriptive level) and institutional support to other research organisations and ad hoc funding to individual research projects (shortly on general descriptive level).

9. Way forward – prepare a concluding analysis, assessment of opportunities and make recommendations about a way (or ways) forward
ANNEX 2 - Methodology

The evaluation methodology consisted of document review, interviews with key informants in Helsinki, a comprehensive search of relevant documents on the web and field visits to three partner countries and two multilateral organisations.

The evaluation team’s Terms of Reference were revised and the revision approved by the MFA during the team’s visit to Helsinki. The team then submitted an Inception Report to the MFA, following which the MFA and the team selected Kosovo, Mozambique and Nicaragua for the field study countries. Geneva was chosen as the location for visiting multilateral partners, because it allowed the evaluation team to interview staff in both UNAIDS and WHO. Dr. Tom Barton visited the multilateral organisations, as well as Kosovo and Mozambique. Ms. Hope Chigudu joined him in Mozambique. Drs. Ulrika Enemark and Riitta-Liisa Kolehmainen-Aitken conducted the Nicaragua field visit.

Prior to the field visits, the evaluation team undertook a desk study of relevant key documents. The field visits focused on verifying preliminary findings and identifying and assessing any new data that were only available at the local level. Key informants were interviewed in-depth and locally available data on financial and technical performance of projects and programmes reviewed. The field visits also allowed the evaluation team to capture the perspectives of local stakeholders. These included Finnish embassies and representative missions, implementing agencies (including Finnish, international and local NGOs), national policy makers, donors and beneficiaries. After the field visits, the team met again to compare findings and agree on recommendations.

The list below is representative (but not exhaustive) of the type of inquiry that the evaluation team pursued during its field visits. The questions are grouped under the main headings of the team’s Terms of Reference.

Key issues and questions for field studies

*Role and status of the health sector in Finnish development cooperation*

How important is health sector support in the overall Finnish development cooperation in the country? Has this changed over the ten year study period? If yes, how?

*Policies and strategies*

Has Finnish assistance been in line with the country’s own health sector priorities? Is Finnish assistance synergistic and complementary with the work of the partner organizations? Is Finnish health assistance well coordinated with assistance by other donors?

Were sustainability and cost-effectiveness considered in project planning? When Finnish-funded health projects have ended or the funding modality has changed, has the partner country’s government allocated sufficient resources to continue the activities?

To what extent has budget and expenditure information been shared with partners? Has the reporting format been compatible with the country’s planning, monitoring and evaluation system? If not, do the recipients perceive the Finnish government to be willing and able to adjust the required reporting format?

How well has Finland collaborated with other donors in the health sector? What have been the main driving forces or constraints to such collaboration?
**Involvement in key areas**

Does Finnish-funded health development cooperation in the country target vulnerable groups (i.e. the poor, disabled, etc.)? What shows it, and how is it monitored?

To what extent is Finland’s commitment to women’s health and reproductive issues at international conferences (such as Cairo and Beijing) understood and translated into action at the country level? To what extent is HIV/AIDS linked to gender and poverty issues in bilateral and NGO health projects?

**Management capacity and systems**

Do the Finnish embassies have sufficient capacity to plan and manage projects and programmes supporting the health sector? What are the biggest capacity gaps?

Where funding modalities have changed, has the capacity (e.g., skills and resource inputs) of the Finnish embassy adapted well to the change? What is the embassy staff’s perception about the capacity of the MFA to support them in adapting to the change? What challenges have the human resource gaps and frequent rotation of staff in the MFA created for the Finnish embassies? How are the embassies responding to these challenges?

What data are available to the Finnish government at the country level and how are they used for planning health sector projects or programme support and for monitoring and evaluating performance?

How detailed are locally available data on project or programme expenditures? What mechanisms are used to hold partner organizations or countries accountable?

**Key implementation strategies**

How consultative or participatory are the processes that Finland uses to define the policy priorities and strategies that it will support? To what extent are issues of ownership discussed and indicators of ownership included in Finnish-funded NGO health projects?

How is technical assistance (TA) used in Finnish health development cooperation (i.e. is it administrative or technical, capacity-building or implementation)? Has the TA input been adequate, relative to other resource inputs?

Are both strategic gender interests and practical needs addressed in Finnish-supported health projects?

Are NGO staff implementing Finnish-funded health projects competent in gender mainstreaming? Are NGOs that work in health with Finnish funding allowed to promote controversial issues, such as sexual rights?

Are NGOs provided core funding for capacity strengthening to improve their ability to address health issues?

**Aid mechanisms**

Have the funding modalities changed in the country over time generally and in regard to Finnish support? If joint financing arrangements exist, what is the role of Finland? If there has been a shift from earmarked to budget support, what has been the strategy to hand over previously earmarked health activities? How has the shift in funding modalities been perceived by the recipients and by the Finnish embassy staff? What benefits or problems have arisen from the shift? How prominent are Finnish-funded NGOs working in health in SWAp-related discussions and how critical are their voices?

Has the balance between the different aid mechanisms changed over time? How is
this change perceived? Are there any experiences with synergy effects or conflicts that affect the health sector? Is there a structure for coordination of Finnish support to the health sector across aid mechanisms (i.e., bilateral, NGO support, multilateral)?

Are local cooperation funds used for health projects? If yes, what is the size and role of this support in relation to other health sector support? What criteria are used to select projects, funded through local cooperation funds? How are these projects monitored and evaluated?

**Measurable achievements of health sector support**

What evidence exists of measurable achievements in health projects and programmes (i.e., data on indicators measuring process, output, outcome or impact)? What are the most important constraints to better performance? What are the main supporting factors?
ANNEX 3 - References

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ANNEX 4 - Persons interviewed

Helsinki, Finland

Ministry for Foreign Affairs, Helsinki
Gisela Blumenthal.............. Social Development Adviser, Department for Development Policy, Unit for Sectoral Policy
Leena Haapaniemi-Castellanos López ......................................................... Programme Officer, Unit for Southern Africa
Vuokko Heikkinen .......... Counselor (Development Cooperation), Unit for Economic and Social Development
Matti Jaskari ....................... Department for Global Affairs, Unit for Economic and Social Development
Ritva Jolkkonen .................. Director General
Kari Kontio ..................... Development Cooperation, Evaluation and Internal Audit
Gunilla Kullberg ............... Department for the Americas and Asia
Satu Lassila ...................... Socio-economic and Gender Adviser, Department for Development Policy
Anna Perttula .................... Project Assistant, Unit for Latin America and the Caribbean
Pekka Puustinen ............... Director, Department for Development Policy, Unit for Sectoral Policy
Tarja Reponen ................... Director, Department for Global Affairs, Unit for Economic and Social Development
Kari Salermo ..................... Chief Auditor, KEO-08, Evaluation and Internal Audit
Leena Storgårds ................. Chief Administrator, Unit for General Development Policy and Planning
Elsi Takala ....................... Counsellor (Development Cooperation), Unit for Non-Governmental Organisations
Pirjo Virtanen .................... Counsellor, Development Cooperation, Evaluation and Internal Audit
Timo Voipio ..................... Social Development and Social Protection Adviser, Department for Development Policy, Unit for Sectoral Policy
Anneli Vuorinen ................. Counsellor, Unit for General Development Policy and Planning
Inger Wirén ....................... Counsellor, Department for Global Affairs, Unit for Economic and Social Development

Development Policy Committee
Suvi Virkkunen .................. Secretary-General

Ministry of Social Affairs and Health
Kimmo Leppo ..................... Director General
Liisa Ollila ....................... Ministerial Adviser, Head of Section for UN and Multilateral Cooperation, International Affairs Unit
Merja Saarinen ................. Ministerial Counsellor, Health/Medical Affairs, Health Department

National Public Health Institute
Hanna Nohynek ................. Senior Scientist, Department of Vaccines

STAKES/IDC
Marja Anttila ..................... Senior Expert, International Development Collaboration
Ali Arsalo ......................... Director, International Development Collaboration
Regina Montell ...................... Senior Expert, International Development Collaboration
Anika Pohto-Annanpalo .......... Senior Expert, International Development Collaboration
Timo Sorsa ......................... Senior Expert (Finance), International Development Collaboration

STAKES
Meri Koivusalo ..................... Senior Researcher, Globalism and Social Policy Programme

Ramboll Finnconsult Oy
Tauno Kääriä ....................... Managing Director
Markku Leppävuori ............... Deputy Managing Director
Katarina Nybergh ................. Consultant
Satu Pehu-Voima ................. Senior Consultant
Ruth Santisteban-Siltanen .... Director, Latin American Region

Helsinki Consulting Group
Martina Jägerhorn ............... Project Director
Maija Kaltakari .................... Project Director
Marja Laine ......................... Project Director

PSR Consulting, Ltd
Patrick Sandström ............... Managing Director

KEPA
Simo Granat ....................... Project Coordinator and Board Member of Physicians for Social Responsibility/Finland
Anja Onali ......................... Programme Adviser
Auli Starck ......................... Coordinator for Member Organisations

Finnish Disabled People’s International Development Association
Tuija Halmari ....................... Director

The Family Federation of Finland
Hellevi Hatunen .................... Head of Development Cooperation

The Finnish Evangelical Lutheran Mission
Leo Huostila ....................... Development Coordinator

FELM
Marja-Leena Salin ............... Development Coordinator

KPMG
Lisbet Kontula ..................... KHT
Jussi Sovasto ...................... Advisory services

Red Cross Finland
Kaisa Koistinen ..................... Programme officer, International Aid
Pentti Tamminen ................... Programme officer, International Aid

Others
Niilo Hallman ................. Professor of Paediatrics (emeritus)
Håkan Hellberg ................. Consultant (ex-Director, Primary Health Care, WHO)
Kari Lankinen ..................... Consultant in International Public Health and Pharmaceutical Medicine
John Telford ...................... Team Leader, Humanitarian Aid Evaluation
Geneva, Switzerland

Finnish Permanent Mission in Geneva
Tanya Gren .......................... Second secretary, Permanent Mission of Finland
Salla Sammalkivi ................... Attache, Permanent Mission of Finland

UNAIDS
Paul De Lay ........................ Director, Monitoring and Evaluation, Executive Office
Päivi Kannisto ...................... External Relations Officer, Office for Advocacy, Leadership and Resource Mobilisation, Executive Office
R. Glenn Mittermann ............... Chief, Planning and Performance Monitoring Programme Development, Coordination and UN System Relations
Ross L. Noble ...................... Senior Advisor - Donor Relations, Office for Advocacy, Leadership and Resource Mobilisation, Executive Office

WHO
Robert Beaglehole ............... Director, Chronic Diseases and Health Promotion, Non-communicable Diseases and Mental Health
Derrick Deane ...................... Coordinator, Governmental Agencies and Foundations, Department of Government and Private Sector Relations
Linda Muller ........................ Head of External Relations, Polio Eradication Initiative
Jukka Sailas ....................... Resource Coordinator, Planning, Resource Coordination and Performance Monitoring
Benedetto Saraceno ............... Director, Department of Mental Health and Substance Dependence
Shekhar Saxena .................. Coordinator, Mental Health: Evidence and Research, Department of Mental Health and Substance Dependence

Kosovo

Finnish Liaison Office
Markku Laamanen .................. Finnish Liaison Officer

Ministry of Health, Kosovo
Arben Cami .......................... Chief of Dept of Health Services
Barbara Jeffs ....................... Core Advisor to MoH, DfID project, “Strengthening capacity in the MoH, Kosovo"
Minera Kazazi ...................... Administrative Assistant (Nursing Division)
Pleurat Sh. Sejdiu .................. Permanent Secretary
Genc Ymerhalili ...................... Director, Centre for Development of Family Medicine

Current bilateral project (Finnish Support to Continuing Nursing Education)
Niman Bardhi ...................... PHC training coordinator, Dep. Chief of Nursing Division
Fidaim Gashi ........................ Interpreter
Fekrije Hasani ..................... Co-ordinator, Centre for Continuing Nursing Education (CCNE), MoH
Elvane Kukalaj ..................... Nursing Training Coordinator
Raiji Kurki ......................... Nursing Training Adviser
Baize Mucaj ......................... Education Planner
Kaisa Rouvinen .................... Project Team Leader
Raija Taavela ....................... Education Planning Adviser
International Federation of Red Cross and Red Crescent Societies
Matti Finnilä ..................... Head of office
Vjosa Macula ..................... OD and Youth Manager

HANDIKOS (Local NGO for persons with disability)
Halit Ferize ......................... President
Julia Palao ......................... CBR Co-ordinator

UNICEF
Agron Gashi ......................... Programme Officer, Health and Nutrition Unit

WHO
Skender Syla ......................... NPO, Public Health; Acting WR

Main Family Health Centre, Obiliq
Mentor Preniqi ......................... Director
Mevlyde Restelica ..................... Head nurse
Makfire Sylejmani ..................... Trainer

Mozambique

Embassy of Finland
Markku Kauppinen ..................... Ambassador
Ritva Parvainen ..................... Programme officer
Olli Sotamaa ......................... Counsellor
Kirsi Viisainen ..................... Counsellor for health

Ministry of Health, Mozambique
Bonifacio Cardoso David Cossa ... Technician of Cooperation (translator)
Elias Guambe ......................... Deputy National Director of Planning and Cooperation
Gertrudes Machatine .................. Head of finances (Prosaude)
Filipa Mariano ......................... Officer, Gender Unit
Ernesto Mazivila ..................... National director of Department of Administration and Finance
Anders Naucler ......................... Advisor in HIV-programme
Maria Manuela Rico .................. Officer, Gender Unit
Francelina Pinto Romao .......... Gender Unit Coordinator
Momade Sumalgy .................. Chief of Central Department of Maintenance

Donor partners, Maputo
Marcia Colquhoun ..................... Senior Development Advisor, Canadian High Commission
Giorgio Dhima ......................... Director Residente Adjunto, Swiss Agency for Development and Cooperation
Alison Milton ......................... Attache, Embassy of Ireland
Lise Stensrud ......................... Counsellor, Royal Norwegian Embassy
Paul Wafer ......................... Human development adviser, DfID

Manica Province
Francois Kisumbule Biombe .... Chief medical officer and clinical director, Hospital Rural de Catandica
Ilda Maria da Conceicao .......... Surgical technician, Hospital director, Hospital Rural de Catandica
Lidia Antonio Domingao .... MCH nurse, Macate Health Unit
Goncalves Fortes ..................... Medical Director, Gondola District hospital/health centre
Firmino Vidadi Jaqueta .......... Chief Medical Officer, Manica province
Alexandre Julai ..................... Basic nurse, Unit Head, Macate Health Unit
ACRIDEME
Abu Aftit Muze.................. Association of Parents and Friends of Mentally Retarded Children

FAMOD
Francisco Manuel Tembe ..... Forum for Mozambique Association of Disabled

Hospital Psiquiatrico de Influene
Inacio Mondlane................. Director

KEPA Service Centre
Katja Kari ........................ Project Advisor

Lutheran World Federation
Ana Maria Fumane .............. Administrator
Beatriz Nhamoneque .......... Nurse

Meninos de Mocambique
Abdul Faquir...................... Director

Monaso
Ana David ......................... Director

SANT'Egidio
Massimo Magnano............... Director

UNFPA
Jan Harnmeijer.................. Technical Adviser (Assessor Tecnico Chefe)
Petra Lanz........................ UNFPA Representative

Nicaragua

Finnish Embassy
Marja Luoto...................... Charge d’Affairs
Rosemary Vega ................. Social Sector Advisor

Ministry of Health
Stanley Atha Ramirez ........... Director General de I Nivel de Atención
Héctor Collado Hernández.... Proyecto Equiparación de Oportunidades para Personas con Discapacidad
Representatives of the disability sector
Eliseo Aráuz Palacios ........ Director General, División General Planificación y Desarrollo
Jorge María Bautista
Maria José Amador
Glisco Aranz
Ariel Espinoza
SILAI\textsuperscript{S} Carazo
Maria Auxiliadora Palacios,... SILAI\textsuperscript{S} Carazo
Rosa María Méndez........... SILAI\textsuperscript{S} Carazo
Brenda Castellón ............... Municipal Health Director, Municipality of Dolores
María José Pérez ............... Municipal Health Director, Municipality of San Marcos
Zeleada Divinosa ............... Municipal Health Director, Municipality of ?
Oscar Castillo................ Municipal Health Director, Municipality of La Conquista

SILAI\textsuperscript{S} Chontales
Diego Calvo ...................... Director, SILAI\textsuperscript{S} Chontales
Jaime Vanegas Ferrey .......... Municipal health director, Juigalpa
Other municipal health directors involved in SARED
Representatives of traditional midwives
Representatives of a youth club

Casa de la Mujer, Carazo
Elizabeth Vanegas and her team

Centro de Mujeres Ixchen, Managua
Argentina Espinoza............. Directora Ejecutiva
Karla Rodríguez Rocha .......... Coordinadora de Educación y Capacitación

Dutch Embassy
Jan-Kees Verkooijen.......... First Secretary, Macroeconomics and Health
María Jesús Largaezpa .... Health Adviser

KEPA/Nicaragua
Rene Hooker...................... Apulaiskoordinaattori
Margarita Antonio............... University of URACCAN

Movimiento Paula Mendoza, RAAN
Alejandra Centero

Mujeres en Defensa de la Vida, Siuna, RAAN
Marina Siles Moreno

Swedish Embassy
Mikael Elofsson.................... Counsellor

USAID/Nicaragua
Alonzo Wind........................ Chief, Office of Human Investments
Claudia Evans Baltonano...... Reproductive health adviser

WHO/OPS
Patricio Rojas.................... WHO Country Representative
Armando Vasquez
Manuel Cruz
ANNEX 5 - Organogram of the Finnish Ministry for Foreign Affairs

Organogram of the Department for Development Policy in the MFA
## ANNEX 6 - Summary of past recommendations

<table>
<thead>
<tr>
<th>Issue</th>
<th>Specific recommendations</th>
<th>Comments on status at present</th>
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</table>
| Human resources and capacity issue | ► Increased staffing in the embassies and better training, tools, techniques, approaches and methods are required to improve programme impact and sustainability.  
► Staffing of the Finnish embassy in Maputo should be strengthened in order for it to be more active in following the policy and strategic discussions and developments in the health sector.  
► The division of labour between embassy, sectors and desks needs to be clarified. | ► Locally available technical skills at the embassy improved dramatically with the assignment of a health adviser (KV)  
► Finland is now strongly represented in policy and strategic dialogue  
► The division of labour is now clearer than it was in the past, though there are issues on the horizon with the increasing shift from project to sector support | Mid term review -Manica Province Integrated Health Project (Phase 11) |
| Aid mechanisms - SWAP | ► Given that two of Finland’s cooperation sectors are moving to SWAPs, a single adviser at the head office will not be sufficient. The SWAPs will require that sectoral specialists follow their implementation closely, particularly if Finland wants to have any influence on the process of the SWAPs. A SWAP specialist or rather a non-sectoral specialist overseeing the SWAPs will not be able to bring that influence about. Similarly sectoral specialists not posted in Mozambique (posted say in Finland) will not likely be able to build sufficient rapport with other donor participants in the SWAPs or in the government. If Finland is going to continue supporting sectors with developing SWAPs, the sectoral specialists for each sector should be appointed to the embassy.  
► To be able to administer SWAPs effectively, the administrative capacity at all levels must be sufficient both in the sectoral ministries and in the central bodies of state administration. | ► A health adviser with strong background on SWAPs was recruited and is performing very well, addressing the issues identified in these recommendations  
► There is some concern to clarify the recruitment criteria for her replacement, which will become necessary next year.  
► The centralised decision-making authority is sometimes a hindrance for fast response to policy issues arising, e.g., in relation to the SWAP | As above |
| Key implementation strategies | ► There is a need to develop a three fold strategy for improving nurses’ status: vis-à-vis the health system and doctors, the administration and political decision makers, and the public and clients. Implementation of the strategy should be a wide based effort in which the project can have a catalytic role. The approach should be based on introducing family medicine and the family health teams, underlining the vital new role of nurses. | ► These agendas are being addressed in the current phase of the project  
► There is concern arising, however, that constraints to health careers in the MoH and public service need to be addressed for the sustainability of the project. | The Mid-Term Review of the Finnish Support to the Development of Nursing in Kosov, November 2001 |

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<th>Specific recommendations</th>
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<th>References</th>
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<td></td>
<td>► Department for international Development Cooperation should require stakeholder analysis as a routine part of the project preparation process, and do its best to equip local partners involved in project identification and preparation with an understanding of what stakeholder analysis is and how it may be used.</td>
<td>► Mozambique consulted widely during the process of formulating its HIV and AIDS strategic plan.</td>
<td>Evaluation of Health and Social Sector Support Programme, Namibia Report, 1998</td>
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<td>► Re-writing the country strategy papers should be reviewed as an opportunity to develop the analytic capacity of staff and to test and refine the use of such tools as stakeholder analysis.</td>
<td>► NGOs participated in the development of the recent programme in reproductive health in Nicaragua, thinking that they would be part of the programme, and were very disappointed to find they were not.</td>
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<td>► It is important to get a whole picture of the work of NGOs which work in the health sector.</td>
<td>► In Nicaragua, Finland had (through KEPA) supported other NGOs working in reproductive health, but information on their experiences was not sought when developing the new bilateral programme</td>
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<td></td>
<td>► There is need for more community participation and mobilization to enhance and foster a feeling of ownership of the project by the community. Finland should strengthen support to test different 'models' of stakeholder participation. Mobilise broader representation of all stakeholders, including those who are otherwise likely to be left out such as vulnerable groups, traditional healers and women's groups. The principle of community participation needs to be reinforced - involving communities in decision-making, particularly in cost-recovery mechanisms to strengthen the operationalisation of adequate health interventions.</td>
<td>► No site visit made to Tanzania</td>
<td>Evaluation of the Finnish Development Cooperation Activities of Finnish NGOs and Local Cooperation Funds in Tanzania. 2004.</td>
</tr>
<tr>
<td></td>
<td>► Finland should continue the support to rehabilitation of disabled in Nicaragua, but recommended a modification in the program to directly support the organisations of the disabled.</td>
<td>► Subsequently a project was developed to strengthen organisations of the disabled.</td>
<td>Mid-term evaluation of SIREH, 1998</td>
</tr>
<tr>
<td></td>
<td>► The Ministry for Foreign Affairs should make a policy statement in which disability issues are clearly seen to be human rights and development issues and an integral part of the poverty reduction agenda.</td>
<td>► Difficult to find: seems there is no formal disability policy statement.</td>
<td>Milen A et al. Label us Able: A pro-active evaluation of Finnish development co-operation from the disability perspective. 2003.</td>
</tr>
<tr>
<td>Measurable achievements of health sector support</td>
<td>► Finland should attempt to gather information based on available or additional data sources to assess the impact of Finland’s health supported programmes on beneficiaries. While measuring the impact on health status and other outcome indicators may remain too cumbersome, pilot projects and operation research in the catchments areas may help to ascertain changes in health-seeking behaviour, access, coverage and utilisation rates, quality of care and client satisfaction. They are essential, for example, to explore ways to reach the poor, to assess the impact of user fees on the behaviour of the community, to strengthen major stakeholders’ involvement in the design and implementation of health interventions, and to design and provide appropriate packages of health interventions at the different levels of care.</td>
<td>► A continuing problem, reiterated by the present evaluation (see Section 3.7. Achievements)</td>
<td>Nikya L et al. Finnish NGOs Development Cooperation Projects in the Morogoro Area, United Republic of Tanzania. Impact Evaluation Report. 1996.</td>
</tr>
<tr>
<td>Issue</td>
<td>Specific recommendations</td>
<td>Comments on status at present</td>
<td>References</td>
</tr>
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</table>
|       | ► Enhance the focus on quality of patient care at the peripheral services. Efforts to improve the quality of care should also include the non-technical aspects of quality, such as affordability, counselling/interaction, supervision, efficiency, and service environment. In areas with few qualified staff, establishing a supportive enabling environment and creating internal incentives will help foster quality of patient care. The issue of staff incentives are crucial with regard to good services. | ► Mozambique: This issue is being addressed to some extent in the provincial project, but it is blocked by changes needed in public service policy  
 ► Kosovo: Similarly, there are positive activities being done by the project, but policy changes are needed in support of health career improvements  
 ► Nicaragua: Quality of care was addressed in the reproductive health project, but not in relation to the work of NGOs. Concerns were raised about the focus on administrative and finance issues at central level, rather than service development at the peripheral level. | Evaluation of the Development Cooperation Activities of Finnish NGOs and Local Cooperation Funds in Tanzania. 2004. |
<table>
<thead>
<tr>
<th>What document</th>
<th>Year</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statement by Mr. Jorma Huuhtanen, Minister of Social Affairs and Health, Finland.  World Summit for Social Development. Tuesday 9 March 1995</td>
<td>1995</td>
<td>Comments on gender equality</td>
</tr>
<tr>
<td>Statement by Mr. Lars Backström, Director, Humanitarian Assistance, Ministry for Foreign Affairs of Finland, 14th July, 1999. Economic and Social Council Substantive Session of 1999, Geneva, Switzerland, Humanitarian Segment, Agenda item no. 5: Special Economic, Humanitarian and Disaster Relief Assistance International cooperation and coordinated responses to the humanitarian emergencies, in particular in the transition from relief to rehabilitation, reconstruction and development. The Permanent Mission of Finland to the United Nations</td>
<td>1999</td>
<td>Comments on HIV/AIDS, health, humanitarian emergencies</td>
</tr>
<tr>
<td>Statement by Mr. Glen Lindholm, Director-General, Department for Development Cooperation, Ministry for Foreign Affairs of Finland, 16th July, 1999. Economic and Social Council Substantive Session of 1999, Geneva, Switzerland Coordination Segment, Agenda item no. 4: Development of Africa: Implementation and coordinated follow-up by the United Nations system of initiatives on African development. The Permanent Mission of Finland to the United Nations</td>
<td>1999</td>
<td>Comments on HIV, Africa</td>
</tr>
<tr>
<td>Statement by Ms. Kirsti Lintonen, Under-Secretary of State, Development Cooperation, Ministry for Foreign Affairs of Finland, 2nd July 1999. Special Session of the General Assembly for the review and appraisal of the implementation of the Programme of Action of the International Conference on Population and Development; The Permanent Mission of Finland to the United Nations</td>
<td>1999</td>
<td>Comments on SRHR and health, links to Cairo conference</td>
</tr>
<tr>
<td>Statement by H.E. Mr. Harri Holkeri, President of the General Assembly, at the conclusion of the general debate of the 55th General Assembly, New York. The Permanent Mission of Finland to the United Nations. 22nd September 2000</td>
<td>2000</td>
<td>Comments on HIV</td>
</tr>
<tr>
<td>General Assembly Plenary; Twenty-sixth Special Session; 4th Meeting (AM). Affordable treatments, expanded access to care, urgent need for resources are major issues as special session on HIV/AIDS continues. Press Release GA/9885. 26/06/2001</td>
<td>2001</td>
<td>Comments on HIV/ AIDS</td>
</tr>
<tr>
<td>Finnish support for population and reproductive health programmes. 02.04.2001 global.finland. Ulkoasianministeriö. Kehitysyhteistyö.</td>
<td>2001</td>
<td>Comments on SRHR, links to Cairo commitments</td>
</tr>
<tr>
<td>Council of the Baltic Sea States, 10th Ministerial session (Hamburg, 7 June 2001). Statement by Mr. Erkki Tuomioja, Minister for Foreign Affairs of Finland. Cross-border cooperation, the Finnish experience.</td>
<td>2001</td>
<td>Comments relevant to Baltic region</td>
</tr>
<tr>
<td>Sexual and reproductive health and rights. 02.04.2001 global.finland. Ulkoasianministeriö. Kehitysyhteistyö.</td>
<td>2001</td>
<td>Comments on SRHR, links to Cairo commitments</td>
</tr>
<tr>
<td>Office of the President of the Millennium Assembly; 55th session of the United Nations General Assembly. Opening Statement by H.E. Mr. Harri Holkeri, President of the General</td>
<td>2001</td>
<td>Comments on HIV/AIDS</td>
</tr>
<tr>
<td>What document</td>
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<td>Comments</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
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<tr>
<td>Assembly, to the special session of the General Assembly on HIV/AIDS. 25 June 2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11th Ministerial Session of the Council of the Baltic Sea States (Svetlogorsk, Kaliningrad Oblast, 5-6 March 2002). Statement by Mr. Erkki Tuomioja, Minister for Foreign Affairs of Finland. Ten years of co-operation in the Baltic Sea region; Experiences, expectations and challenges ahead</td>
<td>2002</td>
<td>Comments relevant to Baltic region</td>
</tr>
<tr>
<td>Declaration concerning the establishment of a Northern Dimension Partnership in public health and social wellbeing. Adopted at the Ministerial Meeting in Oslo on 27 October 2003.</td>
<td>2003</td>
<td>Comments on health, HIV, Baltic region; partnership.</td>
</tr>
<tr>
<td>Memo on the follow-up activities for the Helsinki conference 2002 on “Searching for global partnerships” Helsinki Process on Globalisation and Democracy (Draft) May 27, 2003</td>
<td>2003</td>
<td>Comments on public/private issues</td>
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<tr>
<td>Statement by the Under-Secretary of State of Finland, Mr. Jaakko Laaja before the Commission on Human Rights, 59th Session. Geneva, 19 March, 2003</td>
<td>2003</td>
<td>Human rights and health</td>
</tr>
</tbody>
</table>

**Notes**

All of these documents were downloaded as files from the Internet. Any of them can be searched out from the web using the information in the ‘what document’ column.

The files listed here represent the full set that was able to be identified on/from the internet. No comparable or more extensive set was able to be provided by the MFA during the course of the evaluation.
<table>
<thead>
<tr>
<th><strong>Issue</strong></th>
<th><strong>MFA (Finland)</strong></th>
<th><strong>MSAH (Finland)</strong></th>
<th><strong>WHO preference</strong></th>
<th><strong>Other countries</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health policy</strong></td>
<td>None</td>
<td>Internal health policy paper Has guidelines on international health (publ. in 2000, in Finnish); consulted with MFA, NGOs, Min. of Labour</td>
<td>Finland should have a health policy with broad principles, but not too tight or restrictive on multilateral support</td>
<td>Many donor countries have health policies; helps with consistency, reference point for discussion</td>
</tr>
<tr>
<td><strong>Health advisers</strong></td>
<td>Two - one at central level in Helsinki, and one at country level in Mozambique</td>
<td>International Affairs Unit Several persons with international health experience, including one posted in Brussels working with the EU</td>
<td>Have more contact with representatives from both ministries at annual meeting</td>
<td>Some have whole departments with multiple staff</td>
</tr>
<tr>
<td><strong>Link to WHO</strong></td>
<td>Link via attaché in Geneva, desk officer in Helsinki and health adviser. Geneva mission listens and advises, but avoids having a strong view.</td>
<td>No officer in Geneva; some link through officer attached to EU in Brussels, and with the International Health Unit in Helsinki</td>
<td>Would prefer more formal interaction and feedback; more challenge around politics, decisions and performance of the organization</td>
<td></td>
</tr>
<tr>
<td><strong>Funds for WHO</strong></td>
<td>Extra-budgetary allocations for WHO (earmarked funds for thematic or programmatic use) Resource-based funding (varies with amount available) There is a standard agreement format for the money with the WHO Core support to WHO (annual fees) Prior to recession in early '90s, MSAH provided more support to WHO Fixed funding, based on criteria (GDP, population, etc. of Finland) Also pays EU cooperation</td>
<td>Have larger amount Have extra-budgetary funds allocated or committed sooner (now do not arrive until end of year or after) Change to a rolling budget, e.g., 2-4 years at a time, which would give the organization more security in planning Earmarking by broad theme is okay, but not ‘specified’ (or tied)</td>
<td>Some considering increase in core funding with less extrabudgetary (e.g., UK, Germany) Some with rolling budgets, 2-4 years at a time Norway, Sweden, Netherlands do 2 years; Ireland does 3 years; Germany is rolling; Belgium does 4 years. Some have consolidated all within MoH (e.g., Japan – the central government devolved all health issues to MoH, so MoH deals with WHO, both core and earmarked funding.</td>
<td></td>
</tr>
<tr>
<td><strong>Consultations on WHO funds</strong></td>
<td>Does not send representative to attend annual global review meeting MFA consults with MSAH about WHO extra-budgetary funding, but makes own decisions Attends annual global review conference at European level Makes plans for WHO, but depends on funds from MFA</td>
<td></td>
<td>Would prefer joint interaction of ministries at the annual review meetings Finland has generally a supportive attitude, and by being consistent, WHO can go to them to target</td>
<td>Other countries have tried to have ‘effective dialogue’ between MFA and MoH – Netherlands is pretty good; Canada is not bad.</td>
</tr>
</tbody>
</table>
### Decisions on WHO funds

| Decisions based on discussion between Helsinki and Geneva. Key parties – Desk officer and health adviser in Helsinki, attaché in Geneva | Plans, recommendations made on the basis of annual meeting in Geneva | Negotiations are done between MFA and MSAH in Finland. The MFA has development aid bureaucrats, but WHO feels that the MSAH could be more helpful if they had more voice. |

- Decisions made in the autumn, and may be handled electronically without a visit from Finland.
- Prioritization among all UN multilateral support requests

### Constraints

- When they have used a broad thematic approach, it was not enough. The money tended to disappear within WHO. Raised question of what to call it so that it would go to where it was wanted.
- There are problems with ministers who make promises outside of the budget.

| Politicians are opposed to raising the amount to WHO; say they have a budget already. International Unit would like WHO to be better resourced to support developing countries. Would be cost-effective, able to get more feedback and able to co-ordinate Wants budget to be net, rather than separated |

| Finland used to come and discuss at mid-year but it was frustrating because those discussions seemed to have no relation to the actual contributions that came in December. |

### Consultations and decisions for other issues

| No consultations with MSAH about health policy No consultations with MSAH about bilateral projects Some consultation with MSAH on HIV (see HIV chapter) |

### Note

Responsibility for workplace/occupational health is with the Ministry of Labour

Respondents: In Helsinki: with MFA, MSAH; external; in Geneva: with MFA, WHO, UNAIDS.

This table of state-to-state bilateral health projects specifies the country, name of project/programme and implementation period, as the evaluation team has been able to identify from documents supplied by the MFA and the DAC database. The table excludes NGOs and LCF projects, but includes (some) concessional credit projects. The implementation period is assumed to be the period during which disbursements were made.

<table>
<thead>
<tr>
<th>Region, country and projects</th>
<th>Project code</th>
<th>Implementation period within 1994-2003</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AFRICA</strong></td>
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<tr>
<td>Ethiopia</td>
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<td>Black Lion Hospital: Renovation</td>
<td>23808701</td>
<td>1995</td>
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<tr>
<td>Kenya</td>
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<td>Primary Health Care Project in Western Province</td>
<td>24801604</td>
<td>1993-95</td>
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<td>-Phase IV 1993-1995</td>
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<tr>
<td>Support to Health Sector</td>
<td>24811201</td>
<td>1996-97, 2001-02</td>
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<tr>
<td>Mozambique</td>
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<tr>
<td>Manica Primary Health Care Project</td>
<td>25906501</td>
<td>1992-1999</td>
</tr>
<tr>
<td>-Phase I</td>
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<tr>
<td>-Phase II</td>
<td>25906502</td>
<td>1999-2003</td>
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<td>Health Sector Maintenance</td>
<td>25908901</td>
<td>2001-2003</td>
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<td>Health Sector Programme</td>
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<td>2002-2003</td>
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<tr>
<td>Namibia</td>
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<td>Health and Social Sector Support Programme</td>
<td>28106602</td>
<td>1995-2000</td>
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<td>- Phase I</td>
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<td>- Phase II</td>
<td>28111602</td>
<td>2000-2003</td>
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<td>Zambia</td>
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<td>Endod Project: prevention of bilharzia</td>
<td>28807301</td>
<td>1997</td>
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<td>Sub-Saharan Africa</td>
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<td>TV programs on AIDS in Southern Africa</td>
<td>28920601</td>
<td>2001-02</td>
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<td><strong>MEDITERRANIAN AND MIDDLE EAST</strong></td>
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<td>Egypt</td>
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<td>Beni Suef Primary Health Care Project</td>
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<td>-Phase II</td>
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<td>Support to Health Sector</td>
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<td>1997, 1999-2003</td>
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<td><strong>ASIA</strong></td>
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<td>Afghanistan</td>
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<td>Health Services Project</td>
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<td>China</td>
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<td>Feasibility study for mammography equip.purchase, incl. training</td>
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<td>1994, 1996-2002</td>
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<td>Region, country and projects</td>
<td>Project code</td>
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<td>Pre-feasibility study for dental equipment purchase programme</td>
<td>73006201</td>
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<td>Shanghai Blood Center Project</td>
<td>73007601</td>
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<td>Dental Units</td>
<td>73006202</td>
<td>1998-2002</td>
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<td>Dalian Medical Equipment</td>
<td>73008401</td>
<td>1998-2002</td>
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<td>Modernization of Hospital Equipment, Guangxi province</td>
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<td>2000-03</td>
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<td>Delivery of Hospital Equipment, Hebei province</td>
<td>73010601</td>
<td>2000-03</td>
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<td>Modernization of Hospital Equipment, Shougang General Hospital</td>
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<td>CPR Huai Nan Hospital Equipment Modernisation</td>
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<td>Renovation of hospital equipment</td>
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<td>India</td>
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<td>Kyrgyzstan</td>
<td>Adult Lung Health Project</td>
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<td>Pakistan</td>
<td>Dental Equipment Project</td>
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<td>Upgrading of the Diagnostic Laboratory Equipment</td>
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<td>Philippines</td>
<td>Medical research: Vaccinations Programme</td>
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<td>Sri Lanka</td>
<td>The General Hospital Colombo</td>
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<td>Vietnam</td>
<td>Children's Hospital</td>
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<td>EUROPE</td>
<td>Kosovo</td>
<td>Support to Health Sector Development</td>
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<td>LATIN AMERICA</td>
<td>Guatemala</td>
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<td>Nicaragua</td>
<td>The Rehabilitation of the Disabled</td>
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<td>Development of equal opportunities for disabled</td>
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<td>Strengthening of Hospital Equipment and Maintenance System</td>
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<td>Reproductive Health and Women's Empowerment</td>
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<td>Reproductive health, equity and rights programme</td>
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<td>Support to the fund for SWAp development</td>
<td>36418601</td>
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</table>
ANNEX 10 - Country case studies

Kosovo

Tom Barton

1. Introduction

Finland has been involved with humanitarian and other support to Kosovo from the days immediately after the end of the conflict in 1999. Health has been one of the three priority sectors for involvement (along with education and human rights). A 3½ day visit was made to the country in late November of 2004 by a member of the evaluation team (Dr. Barton). Arrangements were very capably arranged for the visit by the Evaluation Unit of the MFA, the Liaison office of the MFA in Pristina, and by the Finnish supported Nursing Project in Pristina.

2. Context

When Finland went to Kosovo in 1999, the country was very much in a state of post-war reconstruction. There had been enormous displacements of people, and large scale destruction of homes. The system of government for the previous 10 years had been Serbian, run from Belgrade, and had severely displaced/marginalised the ethnic Albanians.

As stated by a former senior WHO staff person, “The basic premise early on was that the war had done some damage, but that basically the health system was not damaged all that badly; however, it was an archaic eastern bloc system that needed to be reformed, and that starting reform during the post-war phase when there was a lot of money made good sense. The effort was to help Kosovo develop a health policy and system that would fit into the European norm.”

3. Policies

As Kosovo was essentially starting from a blank page to develop their Ministry of Health and health policies in 1999/2000, they went through several early draft policies with varying degrees of participation in their development. The current health policy, issued in 2001, addresses the main problems of Kosovo’s health care system:

► Poor health status of the population when compared to the rest of Europe,
► Sub-standard qualifications of some health professionals,
► Old-fashioned organization,
► Neglected and poorly maintained infrastructure and equipment and
► Lack of management skills.

The Health Policy gives direction for developing a health care system that is more in line with similar systems in Europe. This involves a shift of resources from hospital-based, specialist care to community facilities with an emphasis on Primary Health Care (PHC) and referrals. The goal is to ensure full health potential for all by promoting and protecting health, reducing disease and injury, and alleviating suffering. Nurses and midwives are key professionals of the Kosovo health care development strategy. They account for more than 50 per cent of all
health professionals and their role is fundamental to the achievement of Kosovo’s health goals.\textsuperscript{78}

According to approved health policy of the Department of Health and Social Welfare, the future primary health care in Kosovo will be based on family medicine teams consisting of doctors and nurses. These teams are expected to solve 80 – 90% of arising problems in health care without a need to refer the patients to secondary or tertiary care. The training of doctors in family medicine already started in June 2000.\textsuperscript{79}

Nursing reforms in Kosovo are directed by a desire to achieve European standards. The health policy states that ‘Secondary Medical Schools’\textsuperscript{80} will be closed and nursing education will take place at post-secondary school level. The establishment of a Department of Nursing and Midwifery within the Medical Faculty of the University of Pristina regarding basic nursing education is in progress, and the first graduates are expected in 2005. In the meanwhile, the urgent need for complementary education of the thousands of nurses already in the workforce remains.\textsuperscript{81}

4. Human resources

\textbf{Status of nurses}

Nursing in Kosovo is still underdeveloped compared to other countries in Europe. It has low status and has suffered from many years of neglect. Until recently, Kosovo nurses have been under-represented in decision-making about health services. This has largely been due to their lack of leadership roles and to their low status. There is no standard for education or practice, no legal framework and prior to 2001, no professional association. Wages are low and working conditions poor.

The low status of nursing is very much reflected in education. Up to 2003/2004, the basic education of nurses took place in ‘Secondary Medical Schools’ after only eight years of general education. There were no training programs for advanced or specialised nursing practice and opportunities for professional development were (and are) limited.\textsuperscript{82}

There was a 10 year gap in professional support and development during the Serbian occupation. Ethnic Albanian nurses were unable to work in the public sector during the period of Serbian governance. While some worked in a parallel system of private clinics, large numbers were either underemployed or unemployed. Albanians were ejected from all health worker posts. They had to set up privately or work with some charity groups – outside the system and without formal continuing education. Many Albanian nurses returned to the nursing workforce in 1999. When they started coming back, they compared the education system in Kosovo with that of other countries, where nurses count for more and they were eager to upgrade their skills.\textsuperscript{83}

There were a number of short term trainings of nurses by NGOs in the post-conflict ‘emergency’ period, but they lacked consistency and follow up. They were scattered, not linked to any quality control, and not coordinated with national policy.\textsuperscript{84}

\textsuperscript{78} MFA/MoH-Kosovo, phase 2 proj doc, 2003
\textsuperscript{79} HCG, Finnish support to nursing in Kosovo, 2000
\textsuperscript{80} Students enter secondary medical schools at the age of 14 after eight years of general education. They graduate four years later. This form of nursing education is common in many eastern European countries and former communist states.
\textsuperscript{81} MFA/MoH-Kosovo, phase 2 proj doc, 2003
\textsuperscript{82} Ibid.
\textsuperscript{83} Chief of Health Services, MoH; MFA/MoH-Kosovo, phase 2 proj doc, 2003
\textsuperscript{84} Chief of Health Services, MoH; former Head of Health, UNMIK; former senior health adviser, WHO
Standards of practice
Unlike most of the countries in Europe where nursing is a legally recognised profession, nurses in Kosovo have had to practice under the supervision of a physician. They have lacked skills in independent thinking, problem solving and decision-making. Many lack clinical skills due to long periods out of the workforce or training programmes. The basic wage for nurses is low. New graduates and experienced nurses are paid the same wage for the same job. Head nurses and nurses with post basic education are paid slightly more.

The MoH working groups established in June 2003 are working to unify the job descriptions in the health sector. Generic job descriptions have been developed for hospitals and health houses. Some hospitals are making good progress in writing more specific job descriptions for different areas of practice. More work is needed in all areas to differentiate levels of complexity and responsibility for compensation purposes. Benefits are inadequate, e.g., maternity leave is short and there is no retirement plan.85

4.1 Institutions and organisations
The Ministry of Health of Kosovo established the Centre for Continuing Nursing Education (CCNE) in 2003.86 This Centre functions under the Nursing Division and Department of Health Services; and the director of the CCNE is the former national counterpart for the phase 1 Finnish project. The primary purpose of the CCNE is to organize and coordinate upgrading training of nurses in the process of improving the health care in Kosovo. The CCNE coordinates the training activities both in the primary as well as in the secondary and tertiary level health care. It is also the home for the current, phase 2, Finnish-supported nursing project.

In June 2001, the MoH established a Nursing Working Group with a mandate to develop a strategic plan for the development of nursing in Kosovo, including education reforms and professional regulation. The Finnish Project for the Development of Nursing in Kosovo has been an active participant in this group. The task of the working group is to develop policy framework and process that gives direction for future investment in programs, projects and activities, to develop effective nursing and midwifery services. Moreover, the group will make recommendations to the MoH concerning the development of nursing in basic education, in-service and continuing professional development and education/training requirements for specialised clinical practice, teaching and management roles.87

4.2 International trends
In most countries, education of nurses and midwives has undergone major reforms in recent years. These reforms are driven mainly by a growing awareness on the part of national and international policy makers that nurses are a key resource in health care system reform strategies. Overall the trend has been a shift from hospital-based apprentice training and training on institute level to college and university education programs leading to academic degrees. Nurses are expected to be long-life learners and to show evidence of their continuing competence.88

4.3 National status
The health status of the people of Kosovo is still among the poorest in Europe. Many communicable diseases are endemic in the region. High tuberculosis incidence is particularly worrisome. Water and food borne diseases, such as Hepatitis A, are endemic. Kosovo still shows a relatively high level of infant, child and maternal mortality, as compared to the rest of Europe.

85 MFA/MoH-Kosovo, phase 2 proj doc, 2003
86 UNMIK, Info circ 2, 2004
87 MFA/MoH-Kosovo, phase 2 proj doc, 2003
88 Ibid.
Almost all infants have bacterial infection either when they are admitted or acquire it shortly after admission. One of the key recommendations by UNFPA is focusing on improving the hospital hygiene practices like hand washing by the staff and proper cleaning and maintenance of the equipment. 89

5 Findings – Finnish support to health in Kosovo

5.1 NGO support

NGO support – humanitarian
In the immediate post-war emergency period, support was provided through the Red Cross Finland to provide and improve services in certain assigned areas, i.e., Viti and Gjilane, given as ‘humanitarian’ aid. The work included some training and upgrading of staff, including nurses, but only in these small areas. As this project was humanitarian, reports were not being made to the nascent MoH (at that stage it was called the DHSW, and was located within UNMIK). Apparently there was some confusion at that time between the legitimacy of the Thaqi Interim Government and UNMIK; and being registered with one did not carry over to the other.90

NGO support – hospital upgrading
In August, 1999, UNMIK requested the Red Cross Finland (RCF) to take over the administrative responsibility for the hospital in Gjilane. The RCF refused to do the administrative role, but did accept to run the reconstruction project for the hospital.91

The Red Cross Finland inputs included remodelling and rehabilitating the structure of the hospital, but it also supported improvement in the management of hospital, including health information, emergency service, and developing a culture of management meetings. It is reported that the hospital has been very well maintained since then92 (but a site visit was not possible during this evaluation).

5.2 Bilateral project support – development of nursing

There has been ‘one’ bilateral health project in Kosovo supporting the development of nursing. It is currently in phase 2. The following discussion outlines some key steps in the process of Finnish support to the health sector in Kosovo.

Origin of the nursing project (late 1999)
The origin of the Finnish project has been traced to the visit of the then Minister for Foreign Affairs (now President of Finland) to Kosovo in October/November of 1999. The person in charge of health with UNMIK was Finnish and had worked years before with the Minister in the Finnish Federation of Student Unions (she was the full-time social secretary, he was the vice-President in charge of social affairs) and as he wanted to request Finnish support for the health field, he asked the Head of the Finnish Liaison Office to arrange an appointment with the Minister. He obliged and arranged for the UNMIK health director to accompany the Minister during a trip from Pristina to the Finnish camp at Lipljan.

During that trip, the UNMIK health director briefed the Minister on the health care situation in Kosovo highlighting, among other things, the poor nursing situation and pointing out possible areas for Finnish support. Given the high standard of nursing education in Finland, one of his priorities was nursing education. The Minister was very interested but was initially insisting that the possible Finnish support should focus on midwifery. The UNMIK health

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89 MFA/MoH-Kosovo, phase 2 proj doc, 2003
90 Former Head of Health, UNMIK
91 Ibid.
92 IFRC staff and Finnish adviser
director tried to convince her that the scope should be broader. Although the Minister he was speaking to was not the Minister in the MFA in charge of development aid, she had in her entourage just the right person, the head of the Department dealing with development aid, and she was present during the discussions. Often, when the Minister expresses interest in something, the civil servants oblige. This is what happened with the nursing project, and rather soon thereafter, the mission to study nurse education and develop the nursing project was launched.93

**Tendering process**
The MFA went forward to tender the project in February, 2000. There were visits to Kosovo by at least two companies involved in bidding. Apparently, the MFA health adviser accompanied the two of the companies on the visit and attended their meetings. After submitting tenders, MFA interviewed the bidders but no representative from Kosovo was present in this process. The tender packages include 'project proposal' documents.94

**Phase 1 project, Inception stage** (Second half of 2000) (Implemented by HCG)
The initial concept of the project was to have a project based on a pilot area, rather than a project covering the entire country. At the beginning, it was targeted at Gjilane because the Red Cross Finland project had given the Finns a good reputation there. The nursing project could also count on cooperation with the Red Cross project.95

At the start of the project in June 2000, there existed a project proposal for the development of PHC, which was fairly general, but included the proposals of targeting mental health as well as Gjilan region as a pilot area. The ToR requested the consultant to spend 6 months planning and designing the project. The situation in Kosovo had been changing rapidly after June 1999, especially in the health sector. Various donors were earmarking projects for themselves, sometimes without consulting the Department of Health and WHO, who were supposed to be in charge of donor coordination.

The refocusing of the project (compared to the original project proposal) was the outcome of a participatory process. It included individual consultations with experts, as well as two workshops (the first one in Gjilan and the second one in Pristina). At the time, it was clear that the biggest needs were in supporting the status and upgrading training of nurses. Discussions were held about whether the given amount of funds should be targeted entirely for the Gjilan region (in which case all nurses in that region could be trained) or whether it would be better to target all geographical regions (in which case only a proportion of the nurses could be trained).

The Kosovo-wide approach was supported by several persons, but it was never a condition imposed on the project. Strong arguments supporting the Kosovo-wide approach included the following:

- Several scattered, at times overlapping, training events had been conducted by several NGOs in various localities, and their coordination and lack of impact were frequently criticised. (There were, e.g., cases of donors having money for a training of trainers course, but not for further support to training).

- The family doctors training had a Kosovo-wide approach, and the project intervention was seen as an opportunity for training family health care teams, consisting of doctors as well as nurses.96

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93 Former International Health Adviser to UNMIK; story confirmed by other informants
94 Former International Health Adviser to UNMIK; former technical adviser and team leader in Kosovo
95 Former International Health Adviser to UNMIK
96 Former technical adviser and team leader in Kosovo
Phase 1 – Upgrading of PHC nurses, implementation (Implemented by HCG)
The project was designed to diminish the gap between doctors and nurses and to create well-functioning primary care teams. In so doing, the project set out to upgrade the skills and knowledge of Kosovar nurses. The project was financed by the Ministry for Foreign Affairs of Finland, managed by UNMIK, and supported by Helsinki Consulting Group Ltd. A six-month-long Training of Trainers (ToT) course for 40 future trainers was run in 2001. Thereafter, the project aimed to train 1,120 primary health care nurses during four six-month upgrading courses. The courses were set to closely follow the training programme for doctors in family medicine, in order to create true family medicine teams. The aim was to provide the nurses working in primary health care with the knowledge, skills and attitudes necessary to provide good care in cooperation with other professionals in primary health care. The participants of the ToT-course were given basic teaching skills, which they used to conduct the upgrading courses for other nurses.97

Transition – bridging phase
There was an offer from Finland to continue the project, but the choice to do so was a joint decision. It was based on the findings that the first phase was successful, so the MoH requested to continue it.98

Since it was known that there would be a phase 2 of the Project, the project was actually never phased out, instead there was a six-months long bridging phase. The handing over protocol transferred not only equipment but also teaching material. There was a closing ceremony in June of 2003 in which all the trainers received their certificates.99

During the bridging phase, the MFA commissioned a project-planning mission for developing nurse training in Kosovo in January 2003; the National Research and Development Centre for Welfare and Health (STAKES) was assigned the task. The planning mission had two main objectives:

► To provide support to the Nursing Unit of the Ministry of Health in developing an overall comprehensive training strategy for nurses with special emphasis on the secondary and tertiary care to upgrade nurses’ knowledge and skills both for general and specialized practice, as well as in planning the new structures of nurse pre-service and in-service training
► To draft a project plan for a project on continuing nursing education in secondary and tertiary care.100

It seems that there was a project research or appraisal done during this period. However, it was not well documented, and thus not so useful as a baseline, despite some expression of intent that it should be so.

Phase 2 - Trainers of Nursing Education Programme (SOCON)
The new programme focuses on the training of the nurses in secondary and tertiary level health institutions. The MFA Finland has granted funds for support for four years, 2004 - 2008. The programme began by starting to train trainers of nursing in October 2004. In 2005, the trainer students will start teaching in upgrading courses for nurses in the University Clinical Centre of Kosovo (UCCK) and in the regional hospitals

The aim of the Trainers of Nursing Education Programme (ToT education) is to prepare Kosovar nurses to be professional and qualified trainers of nursing. The training is a comprehensive educational programme that is based on professional evidence-based

97 From: HCG, Finnish support to nursing in Kosovo, 2000
98 Permanent Secretary, MoH
99 Former technical adviser and team leader in Kosovo
100 MFA/MoH-Kosovo, phase 2 proj doc, 2003
theoretical knowledge and practical skills both in nursing and learning and teaching methods. During the 2½ year education as nursing trainers, the trainees will acquire theoretical knowledge and practice as trainers and gain a competence to teach nurses in the upgrading courses in the regional training centres.

The trainers of nursing are expected to commit themselves to work as trainers in the continuing nursing education programme in their respective hospitals (through coordination, observation and monitoring from the Nursing Division, CCNE- MoH).\(^{101}\)

In this second phase project, special emphasis is put on institutional and capacity building, in order to support the development of a continuing nursing education system in Kosovo. The immediate objectives of the project is to support the Ministry of Health in establishing a Centre for Continuing Nursing Education, as well as to support in planning and implementing a training program for continuing nursing education. The training program is mainly targeting nurses already working in the secondary and tertiary care sector, of which there are more than 5,000 – most of whom will not be going back to university to qualify for the new degree programme of nursing. Meanwhile, the new university-based basic nursing education program will, however, not produce trained nurses for some time and cannot fulfil the needs of Kosovo in the near future. In the interim, the urgent need for complementary education and training of the nurses in the workforce remains.\(^{102}\)

**Projected need for a third phase**

The project document for the current (second) phase notes that it might be unrealistic to build a permanent structure for providing complementary education to nurses in a sustainable way within a time-span of four years. In order to increase the sustainability and success of the project, a consideration should be made regarding an extension of the project with a feasible period of time. This would provide an extended period of phasing out of the Finnish support to the development of human resources in the health sector in Kosovo. It would also make a comprehensive follow-up of activities possible.\(^{103}\)

**Ensuring sustainability**

As in many other countries, there are serious problems in ensuring sustainability of inputs to capacity building of health workers. This is due in a major part to constraints in the career ladders, which are partly within the MoH and partly lodged with the civil service system of the country.

At the time of the evaluation, the career ladder was still an issue. The Nursing Board has not responded to requests for recognition of the curriculum. The Board (for licensing and accreditation) started in 2003, and is under the MoH. The PHC trainer’s job description is not yet accepted, and in fact, is not yet completely formulated. The working group has not developed any job descriptions yet for the secondary and tertiary level nurses. There is no specific budget in this phase from the MoH for the CCNE/nursing development project. It is included in the budget for the nursing division, but those funds are fungible. There is a problem with salary, and potentially, therefore with sustainability. In phase 1, the CCNE coordinator was a local hire employee of the project. Now she is under MoH, which means her salary is less than half of what it was, when she was a project employee.\(^{104}\)

The MoH has not yet solved the career ladder problem, though it is hoping that the new PHC strategy will help. There has been weak capacity to change/reform the situation in the working place. More attention has to be paid to ensuring the use of the newly acquired skills after completion, and in the right place – not allowing reassignment to other areas where the

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101 UNMIK, Info circ 2, 2004
102 MFA/MoH-Kosovo, phase 2 proj doc, 2003
103 Ibid.
104 Project team leader and CCNE coordinator
skills cannot be applied. However, this means that many actions are needed at the same time – doctors, nurses, legislation, etc.\textsuperscript{105}

5.3 Resource allocation for health sector support

The Kosovo annual budget is about 660 million Euros; of this, the Finnish contribution is only about 4 million for all sectors. Meanwhile, the EU provides at least 60 million. The Finnish contribution to health amounts to less than 1\% of the total budget.\textsuperscript{106}

5.4 Involvement in key areas

Gender
Most of the nurses in Kosovo, like in almost all countries in the world, are female. Enhancing the knowledge and skills of nurses will increase the respect for the profession. Complementary training in a variety of fields, e.g., teaching and management, will open new opportunities in the profession. The project will also strive to promote representation and participation of women in the planning and development of health services.\textsuperscript{107}

Meanwhile, although the project has these noble aims, there is almost no mention of gender or gender-related issues, including gender-linked health conditions, in the training materials for the courses. This was pointed out to the project. It seems that some discussions are organized on these issues, but they are not documented.

Marginalised groups
The project was too ambitious in pursuing the complete integration of Serbians and Albanians at the beginning. This led to problems and the project had to rethink its strategy and provide segregated trainings. It should not be a policy to fail the project on the basis of lack of equal involvement. There are problems on both sides – Albanian and Serbian.\textsuperscript{108}

HIV
There is very little mention of HIV/AIDS in the project document or the curriculum materials for the students. In reviewing other documents, including the national HIV strategy paper, it seems that there have only been 48 cases reported for a population of 5 million persons. Qualitatively, the contributing factors for these HIV cases have been drug abuse and prostitution, but there have been no studies on these issues. Several informants also reported during the evaluation mission by that denial of HIV is very strong in this society.

Disability
Finland has been supporting a local NGO, Handikos, which has been very energetic – both in terms of its efforts at local advocacy and services, but also in terms of national and international networking.

6 Aid mechanisms

Bilateral support
It was reported that even the strongest sector (education) is not ready for sector support in Kosovo. The present government is still too new, and still going through too many developmental stages to be able to handle the technical requirements of sector support very well. With limited funds, it has been a good idea to do capacity building in Kosovo.\textsuperscript{109}

Leveraging other resources
The second phase of the nursing project is focused on secondary and tertiary nurses.

\textsuperscript{105} Chief of Health Services, MoH
\textsuperscript{106} Liaison officer, Pristina
\textsuperscript{107} MFA/MoH-Kosovo, phase 2 proj doc, 2003
\textsuperscript{108} Permanent secretary, MoH
\textsuperscript{109} Liaison officer, Pristina
There was still substantial need to continue training more of the thousands of PHC nurses who had not yet been trained in the first phase of the project. The CCNE (which has been substantially supported by Finland) was able to work with the MoH and leverage funds from UNICEF to carry on with the PHC upgrading courses in the regional training centres.\textsuperscript{110}

6.1 Key implementation strategies

**Participatory ownership**

Finland has been praised by Kosovar leaders for their participatory approach.\textsuperscript{111} Examples of participation have included:

- At the beginning of the Phase 1 project, the Ministry of Health was invited for the first time to be part of evaluating the candidate companies for implementation of the project.
- The Finnish projects have been very transparent with stakeholders' meetings. No problems with activities of the Finnish project.
- Criteria were used transparently in the selection of beneficiaries/trainees in both phase 1 and phase 2. This was an important innovation for Kosovo, both in developing and in using them.

On the other hand, the evaluator did hear some criticism that the Kosovo institutions have only been weakly active in their participation, probably because they are still young as organisations.

6.2 Management capacity

The Liaison Office has been operating since the end of 1999; and the present Officer is the fourth one since it opened. There are three staff – one Finnish, two local; one does political, one does development, and one does immigration. The Liaison Office says it is doing as much business as a full embassy with 7 staff, but because of being so thin on personnel, it cannot do things as deeply. It has had to depend on the existing health project in Kosovo for the health sector link. This office is outside the Formin information system, which is also a problem. The Officer is only able to collect some of his electronic mail when he goes to Belgrade – about every two months. The mail is not forwarded to his Kosovo address.\textsuperscript{112}

**Monitoring and evaluation**

In this four-year project, there is a plan for an external mid-term review (MTR) at the end of the first two years. The costs of a MTR have been taken into account in the project proposal.\textsuperscript{113} Whether a final evaluation should be carried out after the completion of the project or an ex post evaluation some years after the project has terminated has been left to a decision of the Steering Committee with no action as yet.

There were links with desk officers in Helsinki, with some of the usual complaints that their turnover was too rapid for proper institutional support. It was also reported that there had been no visits from the health adviser for more than two years.

The project has operated with the usual panel of Monitoring Meetings for Finnish projects:

- Supervisory Board annual meetings
- Steering Committee quarterly meetings
- Project Management Team weekly or (at least) biweekly meetings

When this is probed in more detail, however, it appears that the external meetings may be

\textsuperscript{110} UNMIK, Info circ 2, 2004

\textsuperscript{111} Permanent Secretary, MoH

\textsuperscript{112} Liaison officer, Pristina

\textsuperscript{113} MFA/MoH-Kosovo, phase 2 proj doc, 2003
rather cursory. The Steering committee meeting lasts about 1½ hrs, and does occur quarterly. The Supervisory board meeting happens one time per year, and lasts about 2 hrs. It decides on work plan, budget and staffing issues. It takes place at end of January or early February so that it can be related to the work of the coming year.114

The filing system for the health projects at the Liaison Office was quite inadequate, indicative of the limited capacity of that office, which is thin on staff and stretched in covering multiple sectors.

7 Measurable achievements

Evidence base – research and monitoring

There has been a question of evidence of success – there have been no research based studies on change of behaviour in practitioners. The WHO informant thinks that the project could now be better documented than it has been, considering that the country is no longer rated as being in an emergency phase.115 In that regard, the CCNE has already started an observational study on how nurses are working, together with their job descriptions. It has also conducted a training needs assessment with more than 300 nurses that can be repeated as a follow up after training.116

The overall objective of the project is to contribute towards the improvement of the quality of nursing services and by that to contribute to the health and wellbeing of the population in Kosovo. The indicators for this objective can be grouped into the following categories:

- Patient satisfaction (e.g. patient-client feedback)
- Health indicators
- Quality indicators (e.g. infection rates)
- Efficiency indicators (e.g. length of hospital stay)
- A plan for continuing nursing education available

Some of the data needed to measure the indicators are not presently routinely collected in all districts in Kosovo. However, the development of a health information system is presently in process and will eventually involve all the districts.117

Contribution to policies and strategies of emerging government

The nursing project did not contribute directly, but it has had an undeniable indirect impact on the health policy. The project shared offices with the UNMIK health section, met almost daily, and discussed issues in office context and socially. The Finnish project had a particularly big impact on two persons: the Ministry’s Chief Nursing Officer and the Director of Health Services. They had very close contacts with the nursing project and adopted many ideas from the project. They, in turn, shaped the “Yellow Book” and the Kosovo Health Law.118 This project “has established the concept of continuing education and professional development – which was not there for many years.”119

As part of its aim to increase the status of nursing, the project was also involved in other supports to nursing, facilitating nursing coordination meetings, preparing minutes of the Nursing Working Group meetings, outlining draft job descriptions and presenting them to the nursing unit for further processing, participating in the drafting of a nursing strategy for Kosovo, and participating in the preparations for the establishment of the nursing college.120

114 Liaison officer, Pristina
115 Acting WR, WHO
116 Project advisers, phase 2
117 MFA/MoH-Kosovo, phase 2 proj doc, 2003
118 Former International Health Adviser to UNMIK
119 Chief of Health Services, MoH
120 WHO, Health Action in Kosovo, #50, 2002
Qualitative strengths of phase 1

It was reported to the evaluator that there has been an improvement in the standards of nursing practice, quality of care, and better quality of family nursing. There has been improved communication with patients, other professionals and in teaching. The professional upgrading has been linked to better teamwork and improved interpersonal cooperation with staff/doctors. “Nursing is not in the situation it was. Nurses’ voices now heard in other levels. Better cooperation. Increased effectiveness of nursing. All related to the training.”  

Staff at a family medicine clinic with several nurses trained by the first phase of the nursing project say that there are positive changes in the nurses trained through the project. The nurses are now closer to the patient and are able to give advice. As seen in a patient satisfaction study at this unit, the clients report that they are not waiting as much as before, and the changes in nurses’ attitudes are good.

Phase 1 training achieved

a) ToT for 6 months – trained 42 as trainers, and they became the principal trainers for the upgrading courses
b) Upgrading in PHC – for 5 months, 6 modules, 4 rounds – trained a total of 779 nurses

Infrastructure

“The hospital in Gjilane is now the best regional hospital in Kosovo, due to the inputs from the Finnish Red Cross; it is also the best managed hospital.”

8 Conclusions and recommendations

The nursing project in Kosovo has been and continues to be an important capacity building resource for the young Ministry of Health in this emerging country. In addition to the improved training and establishment of a continuing education culture, the project has been instrumental in institutional strengthening, through establishment of the CCNE and considerable support to policy and strategy development, particularly for human resources in health.

While the level of trainees was somewhat less than projected (close to 800 trained compared to a proposed level of more than 1100), this has still been a positive and remarkable achievement in the fluid and sometimes tense environment of the post-conflict period in Kosovo. It has gone a long way toward establishing a higher standard for quality of care in a substantial proportion (close to 10%) of the nurses in the country.

At the same time, documentation and the management of information within and about the project has not always been optimal. To a great extent, this is being rectified in the current phase of the project with an operational research component. However, it took considerable effort on the part of the evaluator to trace the origins of this project, which only dated back five years at that point.

The project came on board for the MFA under an extension of the ‘flexibility’ clause in the 1998 Decision-in-principle. However, subsequent to that time, there has been increasing pressure on the MFA (by the DAC, by KESU) to realign its actual commitments with its stated priorities. This potentially means that the Kosovo project would not be allowed to

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121 PHC training coordinator, CCNE/MoH
122 Family medicine centre, Obiliq
123 Project team leader and CCNE coordinator
124 Programme officer, UNICEF
extend to another phase, despite a creditable record of success and a tangible impact on the health care system of Kosovo.

In addition, the evaluation team heard about (though was unable to get any documentation about) a coming move toward regionalisation in the Western Balkans/Ilyric Peninsula region. On the one hand, this could have a reinforcing effect on the project, e.g., if their training approaches and even training programmes/trainers were to be involved in supporting the training for other similarly poor nursing programmes in the region. However, it could also be a factor withdrawing Finnish attention and resources from the nursing and health sector in Kosovo. In either case, there is no specific regionalisation strategic plan as yet, nor is there any commitment as to which sectors would be chosen for any regional projects. The gap in a regional strategy is another reflection of the widely observed and described problem of lacking country strategies.

**Recommendations**

- This project should continue to make every effort possible, both as a project, and as a member of various advocacy groups, to address the career ladder issue for nurses (and other health workers)
- The research results of this project should be shared early and widely within Kosovo and Europe, partly to help garner respect for the nurses of Kosovo, but also to enable various kinds of support to continue to flow toward the nursing profession and health providers in Kosovo – technical advice and project support.
- MFA should clarify its position on longer term support or not (see comments in strategy section above), and regional support or not (see below) as early as possible for both the project and the MoH of Kosovo.

**Opportunity issue – regionalisation**

The evaluator was informed that the MFA will be shifting from a bilateral approach in Kosovo to a regional approach after 2008. Activities will then come under the West Balkans unit – responsible for Croatia, Kosovo, Serbia, Montenegro, Macedonia, Albania and Bosnia. Respondents in Kosovo were probed about what might be some of the advantages and disadvantages of the regionalisation strategy; and how could it be a useful opportunity. Several gave very interesting answers, synthesised below.

**Advantages** - Some of the interesting ideas are listed here:

- Health services, e.g., Kosovo is already working on some border health issues with some of their neighbours, and this could support that activity.
- Quality standards
- Professional development – continuing education, family medicine training centre
- Research in PHC
- Larger pool of possible sites for posting newly qualified doctors for internship
- Using materials that have been already translated and produced as part of the nurse training programme – not many other materials available in both Serbian and Albanian.

**Disadvantages** - Following are the main concerns that were stated:

- The countries involved are not at the same level. Albania has bad infrastructure (more war), but good attitude to development. Macedonia has good infrastructure (little war),

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125 Liaison officer, Pristina
126 Chief of Health Services, MoH; Permanent Secretary, MoH, Programme officer, UNICEF; acting WR, WHO
but poor attitude. Will need agreements between the countries for what to do together

► The future of the region is unclear. Need for countries in region to move at the same
tempo and to be at the same level, which is very difficult. If it can happen, regional
approach would be okay.

► Should clearly indicate mechanisms that will ensure that Kosovo obtains some
benefits/is a beneficiary of the strategy.
Mozambique

Tom Barton and Hope Chigudu

1 Introduction

A one week visit was made to Mozambique in late January 2005 by two members of the evaluation team (Ms. Chigudu and Dr. Barton). Arrangements were very capably arranged for the visit by the Evaluation Unit of the MFA, the embassy of Finland in Maputo, and by the Finnish supported team in Manica Province. A range of relevant background papers, project reports and evaluation reports were studied. Many categories of stakeholders were interviewed, including government officials at the MoH HQ and in Manica Province, representatives of NGOs, donor community and embassy staff. At the end of the visit, a debriefing session was held with the embassy.

2 Background

2.1 Justification for Finnish intervention:

Mozambique became independent in 1975 and was immediately thrown into a quagmire of civil conflict, which inflicted extensive damage to infrastructure and the delivery of services. The civil war led to massive displacements and dislocation of people as IDPs and refugees. The health sector was not spared, and was, in fact, a frequent target of the wanton destruction of property and life. This left large numbers of people exposed to poor health services and generally impoverished. After the resolution of conflict, the return of refugees to their former home areas led to a rapid increase in the demand for health services that could not be met by the depleted infrastructure and human resources. Rebuilding the health system (and other sectors needing professional and technical expertise) has been hampered by the low levels of education and poor rate of literacy, estimated at 38%. The collapsed health sector resulted in an increased prevalence of communicable diseases such as cholera. This situation has been further exacerbated by the rising prevalence of HIV/AIDS.

The Human Development Index of 2003 produced by the United Nation ranked Mozambique the 173rd poorest country in the world out of the 175 countries studied and analysed. The severity of the poverty situation in Mozambique qualified it for development assistance from Finland in line with the Finnish development cooperation principle of prioritizing poverty reduction in its recipient countries. Mozambique also qualified to receive development aid from Finland because it fell into the category of “Poor but politically stable countries, requiring long-term support channelled into reinforcing human resources and national institutions, and fulfilling the basic prerequisite for development.”

Mozambique is heavily aid dependent; over the last thirteen years, development partners (donors) have provided approximately 60% of health sector budget in Mozambique.

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127 Finland’s Development Cooperation by Ministry for Foreign Affairs of Finland, 2003, page 54.
129 Improving Effectiveness of Finnish Development Cooperation Perspectives from the South by O.S. Saasa et al., 2003, page 91.
2.2 Scope of Finnish support to the health sector in Mozambique

**Bilateral support - project and programme**

Since 1991 to the present, Mozambique has received development assistance from Finland averaging 11.686 million Euros per annum\textsuperscript{130}. This aid has been targeted towards poverty reduction principally through support to education, health and infrastructure development. Finnish support to the health sector in Mozambique, which began in 1992 and is still ongoing, was characterized in the first two phases by a project approach. In the present (third) phase, it has been progressively shifting to a sector wide approach (SWAp).

The assistance provided through the bilateral assistance framework has focused on the following areas in the health sector:

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<tr>
<th>Project</th>
<th>Dates</th>
<th>Location</th>
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<tr>
<td>Manica Province Integrated Health Project</td>
<td>Phase 1 – 1992-1998 Phase 2 – 1998-2002</td>
<td>Manica Province</td>
<td>To enhance the functioning of the system of health services in order to improve the health of the population of Manica province</td>
</tr>
<tr>
<td>Health sector maintenance</td>
<td>1999-2002</td>
<td>Countrywide</td>
<td>To improve overall health administration and decentralization To improve management skills of Maintenance department at HQ and peripheral levels; attain integration into the MoH, and improve financial administration system of the MoH</td>
</tr>
<tr>
<td>Health sector support programme</td>
<td>2003-2005</td>
<td>Countrywide, also component in Manica province</td>
<td></td>
</tr>
</tbody>
</table>

Finland has provided technical assistance to the MoH in Mozambique to assist in the implementation of the projects and the sector wide support programme included in the development cooperation framework.

Presently, the following advisers are based in Mozambique:

<table>
<thead>
<tr>
<th>Title</th>
<th>Number, nationality</th>
<th>Located</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health sector adviser</td>
<td>1 expatriate - Finnish</td>
<td>At the Finnish embassy, Maputo</td>
<td>Coordinating activities related to the Finnish health sector support; also responsible for advising on education sector</td>
</tr>
<tr>
<td>Manica province advisers</td>
<td>2 expatriates – 1 is Finnish 1 national</td>
<td>At the Provincial Health Directorate, Chimoio (Manica province)</td>
<td></td>
</tr>
<tr>
<td>Maintenance adviser</td>
<td>1 expatriate</td>
<td>At MoH, Maputo</td>
<td></td>
</tr>
<tr>
<td>HIV adviser</td>
<td>1 expatriate</td>
<td>At MoH, Maputo</td>
<td></td>
</tr>
</tbody>
</table>

On the whole, Mozambique is happy with the contribution of the Finnish government, and that of some TAs, who have been supportive of the local initiatives without imposing their views on various aspects of their work. The MoH has been particularly impressed with the health sector adviser’s technical and people skills, and have appreciated her services and support to the health SWAp development.

**Support through Finnish NGOs**

Some of the Finnish development cooperation support goes to Mozambique via Finnish NGOs. Most of this support has been channelled to organisations helping persons with disabilities. From 1991 to 2001, the Mozambican disability sector has received approximately 27 million FM, with about 60% provided for by KEPA (umbrella organization

\textsuperscript{130} Ibid, page 95.
for Finnish NGOs) and the balance coming from other Finnish disability NGOs. In addition to the services for members of the organizations, this support has contributed directly to the formulation of the national disability policy.

Finnish organisations supporting activities in Mozambique have included KEPA, which has an office in Mozambique. KEPA provides financial support to local Mozambican NGOs working with persons who are disabled. The Finnish Mental Health Association, Red Cross Finland and the Finnish Association for Mental Retardation have all been working in Mozambique in the last ten years. Federation for Mental Health Finland supports psychiatric hospitals, the Finnish Association for International Development Cooperation of the Disabled (FIDIDA) supports the national association of the disabled in Mozambique (FAMOD) and the Abilis Foundation supports deaf students.

Support through Local Cooperation Funds
The Finnish embassy in Mozambique has been able to support local NGOs through the Local Cooperation Fund. They have about 1 million EU per year that is able to be used at the discretion of the embassy. Some goes to democratisation and human rights (HIV is considered to be part of this); some to culture; some to ICP/economic support for the most vulnerable (including elderly and disabled). This fund system with local decisions has been present for three years. Before, there were funds for themes and the embassy had to submit each grant proposal to Finland.

2.3 Policies and strategies
The Finnish development assistance to Mozambique has been anchored on joint consultation and operating on mutually agreed guidelines and principles dictated by both countries’ development ethos and priorities. There is evidence that the government of Mozambique has been the instigator of major new commitments particularly with regard to poverty reduction and improved management of the health sector.

The following are key Mozambican policies that guide the operations of Finnish development cooperation in the health sector in Mozambique.

Poverty reduction policy
A poverty reduction strategy (PARPA) was approved by government is 1999 and was endorsed by the IMF and the World Bank in 2001. This is regarded by the donors and government as a basis for their prioritisation.

Strategic Plan for the Health Sector in Mozambique (PESS)
The government of Mozambique has a strategic plan for the health sector. It sets out policies and strategies to achieve improvements in health care and the ways in which the health system works. The PESS guides all internal and external partners to:

► Support the Ministry of Health in managing the sector more coherently. This will entail reform of the health sector with minimum disruption to health care provision.
► Clarify and attribute the priorities of the health sector in line with the national policy for poverty alleviation.
► Provide an agenda for the next five years to guide collaboration between the Ministry of Health and its partners to implement the process of national health development.

HIV/AIDS strategy
Mozambique has both a National Strategic Plan on HIV/AIDS and a specific National Health Sector Strategic Plan to Combat Sexually Transmitted Infections and HIV/AIDS, 2004–2008.

The Action Plan sets out a number of key actions to tackle HIV/AIDS over the next three
years. The Ministry of Health’s mandate within the context of STI/HIV/AIDS health sector and the guiding principles are clearly defined in the documents. The main objective of the health sector is to offer an adequate combination of preventive and curative health services, as a means to reduce sexual and mother to child transmission, avoid transmission of HIV in health units and prolong the length and quality of life of people living with HIV/AIDS, including the health care workers themselves.

Meanwhile, there is a serious gap in capacity. The National Health Sector Strategic Plan proposes to provide treatment to 21,000 people living with HIV/AIDS by the end of 2005 and 132,000 people by the end of 2008, with the support of bilateral and multilateral agencies. In the meantime, the WHO estimate of the number of people requiring ARV treatment by end 2005 is already 190,000.131

3 Findings

3.1 Finnish support to the health sector

Finnish support to the health sector in Mozambique has contributed to reforms of the sector at national, provincial and local levels in relation to infrastructural development, human resources development and skills training, hospital equipment maintenance and repairs, management capacity building, and the development of national and provincial strategic plans for the sector. The success of this support has been particularly evident in Manica province, where direct assistance has supported improvements in health care services delivery.

Annual joint consultations and evaluations have formed the basis for negotiations for Finnish support to the sector. The Mozambican health officials have appreciated the participatory approach of Finnish officials in dealing with health issues, thereby leaving them to determine the course of action regarding the activities in the health sector.

Infrastructural development

Finland has supported infrastructural development and repairs in the health sector in Mozambique, especially during the first two phases of development assistance that were concentrated in Manica province. The extensive rehabilitation of health infrastructure in Manica province has brought about marked improvements in the provision of health services, as confirmed by national client satisfaction survey results.

Equipment maintenance

Finnish assistance helped support the development and operationalisation of a national maintenance policy. It helped develop a training/capacity building programme and create maintenance units in all the provinces. The maintenance department’s role and profile were thereby enabled to shift from crisis maintenance to become a programme for health care technology management.

Human resources development

Mozambique suffers from an acute shortage of requisite human resources in all the professional categories of the health care delivery system, including doctors, nurses, technologists and paramedics of all kinds. Finnish support has been used in enhancing human resources availability at national and international training institutions. A training centre has been established in Manica province at Chimoio to train medical personnel using local resources and inputs, thereby making the training appropriate and relevant to local needs.

Health sector SWAp
Although not the largest or the first donor to be involved with pooled funding in Mozambique, Finland has become a major contributor both economically and technically to the health sector SWAp. During 2004, Finland was the ‘lead donor’, i.e., the point agency among all the development partners for negotiating and steering the SWAp process for the year. It received high kudos from both the Government of Mozambique and all the development partners for the quality of work it achieved in this year. Achievements during the year included developing a code of conduct relating to the SWAp and preparing memoranda of understanding between government and partners to guide and manage the various funding pools.

In line with current international development strategies, Finnish assistance to the health sector in Mozambique is shifting from a direct project support approach to the sector wide approach. This requires consensus by all stakeholders on a common vision; sector policies and strategies; transparency in priority setting and resource allocation and common management arrangements among others. The adoption of the SWAp has necessitated the establishment and consolidation of the common fund for the health sector in Mozambique with provision for common funding for provincial and local health needs. However, concern has been raised regarding the accessibility of financial and other resources at local authority levels from the common fund.

The adoption of the SWAp has also emphasized the need for strengthening the decentralization process to empower local authorities to provide health care services with support from the MoH. Some resistance to decentralization has been noted. It is hoped this will be overcome effectively in order to enhance the quality of health care services in the country for the benefit of the majority of the population.

3.4 Involvement in key areas
Poor and vulnerable groups
Working at community level in Manica province has made it possible to reach many vulnerable persons. However, this was not targeted toward any specific vulnerable groups but was addressing the larger needs of the whole province. Finnish NGOs have assisted local NGOs and CSOs to support particular poor and vulnerable groups, such as the disabled, displaced children and the deaf. Local cooperation funds have supported some Mozambican organizations that target street children and pregnant women living with HIV/AIDS.

Gender mainstreaming
Gender mainstreaming remains a challenge to the Mozambican health sector despite the fact that a gender unit has been set up in the MoH. Some efforts have been made to encourage the participation in skills and human resources development. Notable gains have been made in the reduction of maternal mortality rates. UNFPA has been resolute in attempting to assist in the mainstreaming of gender in the health sector, particularly with regards to reproductive health and rights. There is one female engineer with the Maintenance programme, but there have been multiple missed opportunities to engage more actively in promoting gender equality in recruitment and training programmes. The training centre in Chimoio has had one of the most assertive efforts toward gender equality in recruitment. But stereotypes are strong and there are fewer women with even minimal education in this society. The Manica project team noted that there have been missed opportunities in promoting gender equality with contractors implementing construction projects – missed because the contracts were signed before the current stage of increased sensitivity to gender issues.

HIV/AIDS
Finnish development assistance has contributed to the development of a national HIV/AIDS action plan and the establishment of National HIV/AIDS Council responsible for the coordination strategies to combat HIV/AIDS. The Finnish government has contributed by providing a technical adviser (TA) who is working with the Ministry of Health to develop HIV/AIDS IEC and training materials. The adviser also participated in the elaboration of the national HIV/AIDS strategy. Other funds from Finland for the HIV/AIDS component are now being channelled through the common pool fund, i.e., the main instrument of the SWAp.

3.5 Management capacity and systems

From the beginning, Finnish development assistance focused on management capacity building in recognition of Mozambique’s limited professional and technical capacity. Human resources development through skills training and upgrading has contributed to the enhancement of management capacity, especially in Manica province where Finnish assistance was largely directed. Training for doctors, nurses and other health professionals was enhanced, resulting in the improvement in health services delivery.

National and provincial strategic plans were developed, adopted and implemented to provide a framework for the efficient delivery of health services in the country and in Manica Province in particular. Technical assistance also facilitated the improvement in the performance of the health sector. The capacity to deal with hospital equipment maintenance was improved through training at national, provincial and local levels and through the development and adoption of an equipment maintenance policy.

While government has appreciated the benefits of the SWAp, including greater MoH autonomy, there are also greater demands being made on the Ministry of Health. To meet these demands, the MoH has to strengthen its core functions, improve financial systems, quality of reporting and information dissemination. All these demands require extra hands and skills.

3.6 Key implementation strategies

Participatory ownership

One of the key implementation strategies for Finnish development assistance to the health sector in Mozambique has been the promotion of participation and improved ownership of processes by all stakeholders. The participatory approach has permeated all levels of project planning and implementation including training programs at provincial and district levels.

Management capacity building was also used to enhance the performance of the health care services delivery. Training aimed at human resources development at national, provincial and district levels has underpinned the capacity building program. Also the programme on health care technology management has contributed significantly to capacity building in the sector. The support has resulted in the development of a maintenance policy, emphasizing management of equipment care and repairs maintenance contracts. Officials of the MoH particularly appreciated the facilitative approach, as opposed to a dictatorial approach. Some concern was raised, however, regarding the capacity of some of the technical experts.132

Equity

The development and adoption of national and provincial strategic plans for the health sector, the code of conduct and national HIV/AIDS program and policies including the disability policy are important implementation strategies, as they provide frameworks for

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132 For example, the maintenance department was not really happy with technical background of the current TA, as he did not have the required skills mix for their current stage of development.
addressing health problems with a view to improving the quality of life for Mozambicans. Finnish development assistance directed to public and NGOs health promotion activities is well appreciated in this regard in Mozambique.

**Sector wide support**

In the next phase, it is expected that Finnish development assistance to health will shift even further toward funding being channelled through sector wide and budget support mechanisms, modes that are increasingly adopted by most of the bilateral donors in the country.

It is believed that the SWAp provides flexibility in utilization of donor funds by the recipient country with the underlying assumption that there will be increased transparency and accountability through the establishment of common procedures of financial management. The shift to SWAp may entail the need to bring in more TA in order to develop and put in place adequate and appropriate management systems that promote transparency, accountability and equitable allocation of resources to all levels of health care service delivery systems. The introduction of the SWAp may require further management capacity building at all levels of health care services delivery.

Harmonisation has been enhanced by the shift to a SWAp and is already reducing transaction costs in the country. Finnish support has also contributed to a drug support pool – for centralised purchase and distribution of drugs. This will be phased out in 1-2 years and become part of the general common fund, if conditions for good management are met.

The government appreciates the move to SWAPs on ground of ownership and reduced transaction costs. Most donors consulted appreciated a ‘coordinated policy dialogue’ based on the government’s poverty strategy, the development of single accounting and disbursement mechanisms of financial management with improved government mechanisms. Government officials appreciated the respect to poverty reduction papers and poverty reduction strategy as frameworks for prioritization of donor funding mechanisms.

However, with these advantages come the additional costs of conversion and the demands of donors on the Ministry for deeper reform and better reporting. Associated with this is the degree to which the Finnish government is prepared to bear the problems of accountability for risk. The question of capacity continues to be a challenge. The Ministry of Health seems to be overloaded, although they described the process as a ‘building blocks’ approach where eventually confidence and capacity will be built.

There is also fear, especially among NGOs, that moving to SWAPs might mean marginalization of the poor populations, since donors may not be in touch with the vulnerable groups. The space for innovative and experimental approaches, generating lessons for some of the activities, e.g. on reproductive rights, might be limited within a SWAPs funding framework. It is also feared that donors will lose contact with grassroots.

Concern and reservations have been expressed at provincial and district levels as to how their concerns and needs will be provided for from the common fund, despite the fact that there is provision for local funding in the common fund. This is an issue that needs to be addressed through discussion between the SWAp group, which includes Finland, and the MoH of Mozambique to reassure local authorities regarding funding, as they are responsible for providing health services to the majority of the population in the country.

**3.7 Coordination, synergy and potential conflict of aid mechanisms**

Several modalities were employed to enhance coordination and synergy regarding Finnish development assistance in relation to parallel bilateral assistance from other donors and the MoH at different levels. Finland participated actively in the various SWAp groups of donors,
working on different themes affecting the operationalisation of the SWAP. These working groups are aimed at creating synergy and building a common approach to the provision of development assistance to the health sector in Mozambique. Regular meetings are held with government on the SWAp to ensure that both government and donors are on the same wavelength regarding the SWAp.

A joint annual evaluation of the health sector programs is conducted using Terms of Reference developed by the Ministry of Health and agreed upon by all interested parties. The recruitment of the consultants to carry out the evaluation is also a joint effort of bilateral partners and government.

At provincial and district levels coordination and synergy is promoted through the establishment of committees on special health related issues such as training where stakeholders including representatives of communities are involved.

However, representation of views and interests of different stakeholders and primary target groups has been limited. Most CSOs interviewed did not have access to information on SWAPs priorities. They were not part of SWAPs. The government on its part is wary of involving stakeholders, especially NGOs, whose constituency is not always clearly defined.

3.8 Measurable achievements

Several notable achievements, both quantitative and qualitative were attributed to the Finnish development assistance for health in Mozambique. These include the following:

**SWAPs**

- Leadership within a team - Last year, the Health Advisor based at the Finnish embassy in Mozambique was the spokesperson for the whole donor group; she succeeded in bringing synergy among donors.
- Partnership with the government - facilitating the stated plan of work of government; supporting financial management by the government
- Empowerment of the Ministry - by reorienting aid from project assistance to more sectoral assistance, and supporting leadership by government in the change process
- Harmonisation - Using the same procedure as other donors, who were already in SWAPs

**Improved health status of the population (Manica province)**

- Increase in institutional births
- Improvements in antenatal attendance, outpatient care utilisation, and immunisation levels; all are higher than in other provinces

**Provision of essential services**

- Supply of trained health workers - The training centre in Chimoio is based in Manica province. Its training programme is based on the needs of the people of the province in addition to serving national needs. Training offered includes both basic and MCH nursing, which were in short supply.
- Improved conditions in Manica province, especially infrastructure, working conditions and capacities. For example, Catandica district (Manica) now has a rural hospital built with Finnish support that is serving a catchment area of about 250,000 people
- A national maintenance policy has improved the operations of the whole health care
technology department. ‘We are now more focused on health care technology management than just crisis maintenance.’

Promotion of ownership and participation

► 1997-98 MPIHP project was designed with a greater emphasis on decentralisation and local ownership. In the current phase, decision making is by the Provincial Health Directorate team, relying on their own strategic plan.

► The SWAp approach is strongly oriented to national ownership of the health sector with a drastic reduction in vertical programmes.

Human resources development

► Chimoio was the first training institution to teach a medium level course; other training institutions have now started to also do so.

► Many civil servants working in the health have had their skills upgraded, hostels for students have been built and accommodation improved.

► The Chimoio training centre uses an annual self evaluation of the training centre and training programme to improve their practices.

4 Conclusion

Civil war in Mozambique destroyed most of the health infrastructure. In the immediate post-conflict period, many people were left maimed, ravaged mentally and physically and extremely poor. They badly needed care. Therefore, during phase one of MPIHP, rehabilitation of health infrastructure was high on the agenda. The 1997 evaluation recognised the importance of rehabilitating the infrastructure. In the years since then, Finland has helped strengthen the process of decentralisation and prepare the province for the integration of the project to a general budget support framework.

The government of Mozambique officials at head office and in the MOH in Manica province and donor partners and others interviewed for the purpose of this evaluation praised and acknowledged the very important role of the support that the Government of Finland provided to the Government of Mozambique to upgrade health services in the country in general and in Manica province in particular. The assistance helped in improving the quality of health services and the fight against poverty.

The following are some of the salient features of Finnish aid to Mozambique:

► Informants in the evaluation felt that the assistance has been provided genuinely to improve the performance of the health sector. It has immensely contributed to the development of the health sector policy and the production of a five year health strategic plan at the national level. This has cascaded to the provincial level in Manicaland where a health strategic plan has been produced and attempts at reinforcing its implementation are visible.

► An important feature of the Finnish support to the sector has been the adoption of the participatory approach, which allowed the Ministry of Health at national and provincial levels to determine their project priorities and allocate resources as they saw fit. The Finns were praised for flexibility, consistency in contributions and involvement and ‘humility’.

► Finland has actively pursued a collaborative strategy with other bilateral donors operating in the health sector in Mozambique. The overall national budget for the

133 Interview with the director of maintenance, MISAU
The health sector was estimated to be USD 190 million, inclusive of national contribution to the sector. The shift in approach from funding projects to SWAPs is appreciated. This is in line with current perspectives on donor support in most countries.

- The Finnish regular follow-up to assess the performance of their support to the health sector at national and provincial levels was noted and appreciated, as it has helped to keep the project activities on track. Terms of reference for the project evaluations were developed by both the MoH based on national indicators and the Finnish government.

- The presence of a health adviser was appreciated and her special technical and human relations skills acknowledged. She was particularly praised for her role in leading the SWAP team last year. Her lobbying skills and team spirit were attributes that were highlighted.

- The Manica project support was praised for its major contribution to reconstruction of health infrastructure, development of the training centre, implementing training programmes, supporting the needs of the province, as well as national needs. The Finnish government was also praised for its flexibility in the reassignment of funding use as needed within the budget, for regular support, and for changing from tied support within the province to budget support of the provincial strategic plan.

- With regard to the Maintenance project, the Finnish government’s support to development of health technology capability and preventive maintenance was acknowledged.

- The Finnish government was also praised for keeping issues of disability on the agenda.

**Areas that require improvement**

- Manica Project: Need for coherent, ethical phase-out or phase-over into the national programme or pooled support. There is also need to start documenting lessons learnt and share them widely, as there is likely to be high staff turn-over at the provincial directorate level. In any case, Finland’s experiences of supporting an integrated project are worth documenting.

- With regard to gender mainstreaming, HIV/AIDS and disability, there have been some notable achievements but more could be done. It is particularly important to understand, for example, that gender issues are everywhere and in everything, including technical projects such as maintenance.

- Participatory ownership has been achieved more at the Ministry head office level, but needs to improve at the community level. There has been limited consultation of civil society organizations in the sector.

- There has not been much dialogue between the various stakeholders involved in health, even those supported by the Finnish government.
1 Background

Nicaragua is one of Finland’s long-term partner countries. It is one of the poorest countries in Latin America. It is estimated that 80% of Nicaraguans cannot meet their nutritional requirements. The Reinforced Strategy for Economic Growth and Poverty Reduction was published in 2001. Two of its four pillars are investment in the human capital of the poor and better protection of the vulnerable.

1.1 Finnish Support to the Health Sector

The Finnish support to the health sector in Nicaragua has a long history starting in early 1980s. In 2002, Finland provided 1.9% of the total donor funding to the health sector, corresponding to 4.2% of the total bilateral assistance to health. During the period 1994-2003, covered by the review, Finland’s bilateral state-to-state support has shifted in nature over time, both in terms of content and in terms of modality of support.

Projects in hospital equipment maintenance and rehabilitation of disabled people started in 1990 and continued up until the late 1990s. Finnish development assistance in the area of reproductive health and women’s empowerment started in 1997. Support to the development of a SWAp started in 2003.

In the beginning of the period, a multilateral agency, i.e. PAHO, was used as implementer of the projects (SIREH I, Maintenance Hospital Project). In the late 1990s, the implementing agents were Finnish consulting companies (SIREH II, SAREM). In the most recent support, there is a shift to a more programmatic approach in which MINSA is responsible for the implementation.

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In addition to the bilateral support directly to the health sector, Finland has granted general budget support to Nicaragua (2 million EUR in 2003) towards enhancing the implementation of Nicaragua’s poverty reduction strategy. The support is channelled through the social development fund of the state budget and is primarily used for the social sectors, e.g. in the health sector for refurbishing of hospitals and procurement of equipment.

The embassy has Local Cooperation Funds available for funding of smaller projects in the cross-cutting areas. LCF has been increasing from 137,972 EUROs in 2000 to 200,000 for 2003. In the period covered, none of these have been related to the health sector. The embassy and MFA have chosen a strategy to fund projects from other sectors than the bilateral cooperation and to fund mainly human rights and democracy and projects that contribute to the improvement of women’s and children’s rights. Majority of funds (77%) are indeed spent in the area of human rights and democracy. However, in 2004 support has been provided to a local NGO working with women’s right and provision of health services for women, with the emphasis of the support on the rights issue. It is expected that this support will continue. An open application procedure has been used in 2002, but the workload was rather high. The embassy is considering reverting to the strategy in which key actors are identified in the chosen sectors and cooperation initiated.

The umbrella organisation for Finnish NGO’s, KEPA, has an office in Managua. The first relationship between KEPA and the local NGOs was through Finnish voluntary development workers, e.g. doctors and nurses who came to work in local health centres. However, usually they did not speak Spanish. They first had to spend 4-5 months in language training, and furthermore learn to use Spanish as a working language. This resulted in very little effective working time. The local NGOs, however, praised the receptiveness of KEPA as it was approached with a request to shift from in-kind support of non-Spanish speaking Finnish volunteers to financing of Nicaraguan health staff.

KEPA has supported two projects in Siuna:

- A community change agent programme in which community health was a central

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**Box 1. Areas of bilateral support directly to the health sector**

- **Hospital Equipment Maintenance**
  - Maintenance Hospital Project Phase I 1990-93, bridging 1994;
  - Maintenance Hospital Project Phase II 1995-97, extension 1997-99

- **Disability**
  - Rehabilitating disabled people in Nicaragua – Development of the system of rehabilitation for the disabled (SIREH) 1990-98;
  - Development of equal opportunities for disabled people (2003-2006)

- **Reproductive health and rights**
  - Reproductive Health and Women’s Empowerment (SAREM) 1997-2001;
  - Reproductive health, Equity and Rights Programme (SARED) 2002-2006

- **SWAp**
activity parallel with a kitchen garden programme to improve nutrition. The projects were supported with 41,000 EURO and were implemented in 2001-2003 by the Movimiento Paula Mendoza, RAAN. It is estimated that 25% of the support was for community health care.

- A project to purchase equipment for health centre to improve access to services for women (but at the same time also for men) combined with a project to revive the use of traditional medicine. This project, implemented 1998-2000 by the Mujeres en Defensa de la Vida, Siuna, RAAN, was cofinanced with other donors, e.g., Oxfam, Health Unlimited. KEPA’s contribution was 10,000 EURO. The project was followed by a phase-out agreement for 2001. The phase-out project had a strong gender element and included a health component aimed at reproductive health, maternal mortality and cervical cancer. The support amounted to 9,000 EURO of which approximately half was spent on the health component.

During the implementation of SAREM, local NGOs were used for implementation of part of the project. So far NGOs have no role in the implementation of SARED, although they did participate in the development of the programme.

According to DAC statistics there are a few other small NGO projects in health in Nicaragua. These were unknown to KEPA, as well as to the Finnish embassy.

1.2 Methodology
The team visited Nicaragua 9th to 15th January. They visited Chontales and Carazo and met with key informants from MINSA, SILAIS and municipality level, NGOs, other donors and embassy staff. Further, the team had the opportunity to review some of the documentation available at the Finnish embassy.

2 Findings

2.1 Role and status of the health sector in Finnish support
Annual consultations between the governments have been the basis for deciding Finnish-Nicaraguan development cooperation since the beginning of the 1990s. Health has remained high on the agenda on both sides throughout the period.

Finland does not have a country strategy for Nicaragua that guides the choice of sectors, the financial emphasis on the sectors and the aid mechanisms to be applied in the chosen sectors. There were attempts to develop a Nicaragua country strategy around 1993-95, but the preparations stopped, because of a review of the Finnish policy on development assistance in its totality.

2.2 Policies and strategies
The choice of sub-sectors is in line with the needs in Nicaragua, as well as with the priorities of the government, although not necessarily at the core of government priorities. The Finnish support may have contributed to putting issues related to disability and reproductive health and family violence higher on the agenda. It is likely to have contributed to the development of these areas, which, although on the government’s priority list, would be at risk of being marginalised.

The shift from a project to a more programmatic approach is in line with the international trends. In the context of Nicaragua, the Finnish programme SARED is said to be the first of its kind in the country and therefore innovative and a learning experience of value also to other SWAp partners (this was however perceived more so by the Finnish side than by the other partners). Likewise, the strategic decision to support the development of the SWAp is
in line with trends among the likeminded donors, as well as the strategy entailed in the
general development policy of Finland to move towards budget support wherever possible.

The lack of a sector policy or country strategy is particularly problematic for local staff who
are likely to have a less clear perception of the general Finnishness and Finnish views. But
even for Finnish staff and for dealing internally with the MFA headquarters, as well as
externally with other development partners, informants found that it would have been useful
to have a Finnish policy for development assistance to the health sector as a reference
framework and tool for guiding focus areas.

2.3 Involvement in key areas

Poor and vulnerable groups
The geographical areas chosen for support in the area of reproductive health are not overall
among the poorest. Poverty is, however, still prevalent and in particular there are pockets of
severe poverty. The support is, however, clearly targeted to vulnerable groups with one
series of projects targeting the disabled and another series of projects targeting women and
victims of family violence. Both of these areas are difficult to address in the Nicaraguan
culture.

HIV/AIDS
Both SAREM and SARED address sexual and reproductive health. Both include awareness
raising and have adolescents among their target groups. In SAREM, a number of
adolescents have been trained on STD/AIDS in order to work as promoters of sexual and
reproductive health.

HIV/AIDS is, however, not an integral part of the other health programmes nor an issue that
is addressed in the Finnish projects/programmes in other sectors.

The Finnish embassy itself does not have an HIV/AIDS workplace policy.

2.4 Management capacity and systems

The preparation of programmes has not all been optimal. Despite most of the support being
long-term with programmes building successively on each other, bridging arrangements or
gaps in support are common phenomena. For example, the second reproductive health
programme (SARED) is a continuation of the first reproductive health programme (SAREM),
but SAREM ended in 2001, while SARED did not start until late 2002. Further, in both of the
programmes in reproductive health, the inception phases have been very long, indeed much
longer than planned. This has resulted in delays in implementation, leaving a gap from end
of implementation of SAREM to start of implementation of SARED of, de facto, more than
two years.

The preparation of SAREM was not sufficiently detailed. The scope of the programme did
not conform to the resources available. During the inception phase, the programme had to
be substantially scaled down from three SILAIS to one and from three components to two.
According to the health staff interviewed, however, no expectations had been created, so the
harm of abolishing that component was not so big. The component was aimed at a micro
credit scheme and would not have affected the work of the health staff much anyway. The
team did not meet with people from the two SILAIS that had to be excluded from the
programme.

136 Implementation starts only after the inception phase.
SARED has experienced a number of problems, which seem mainly to be due to an underestimation of the capacity at MINSA and confusion about the change in management set-up and division of responsibilities, when moving to a programmatic approach. A more thorough institutional analysis as part of the preparation might have resulted in initiatives to mitigate some of the problems. The development of a procedures manual and authority matrix could also be a tool for clarifying roles and responsibilities.

The current staffing at the Finnish embassy for managing the support to the health sector consists of one Nicaraguan social sector adviser. This is particularly problematic in relation to the Finnish participation in the development of the SWAp. Contrary to other partners working with the SWAp (e.g., Sweden and the Netherlands), a number of key decisions cannot be made locally. They have to be authorized from Helsinki, where staffing is also thin and time constraints an issue. This often results in delays and is a barrier to full participation of Finland in meetings on health sector development and on the development of the SWAp in particular.

The constraint by centralised decision-making is not only felt by the embassy, but also remarked upon by some of the development partners. The capability of MFA staff is not questioned; in fact, it is praised. Due to the thin staffing, the time constraint is a major concern as regards the one and only health adviser in Helsinki. As for the country desks, the lack of continuity presents an additional problem as the constant change in desk officers means that things have to be explained and discussed, understood and also agreed several times. One cannot help thinking that a similar vulnerability found in the recipient system would most likely give rise to considerations about assistance needed for capacity building and systems strengthening to mitigate risks.

One international health adviser will be posted in the embassy. This is important especially in view of the need to monitor sector development and participate in the policy dialogue with the government as part of the development of the SWAp. For future effective participation in policy discussions and in the SWAp, there is a need to strengthen the decision making authority at the embassy level. It should be noted that the current plans for delegation of decision-making authority from the country desks to the embassies do not encompass decisions regarding funding. Such decisions are bound with the Policy Department and can therefore not be delegated from the Country Desk.

Combinations of time constraints, lack of priority given to documentation and poor archiving system at the embassy (or MFA generally?) result in difficulties tracing the history of projects. This is, of course, a frustration for the odd consultant, but even more of a problem for those who work in the system, as newcomers or transferred to new positions or other tasks.

### 2.5 Key implementation strategies

Participation appears to have been important in the process of developing programmes, at least in the latter years. It has not necessarily been absent in earlier years, but it is simply difficult to assess.

Capacity building has been a key strategy, the main instruments being training and technical assistance. The programmes implemented in the late 90s had very large TA components, which consumed large shares of the budget. Some discontent with the quality of the TA was expressed. The recent programmes have much less TA input - possibly too little. The problems with the use of TA could also be due as much to the difficulties in understanding the new role of TA in relation to the programmatic approach, in which the administrative function is the responsibility of MINSA and the role of the TA is capacity building. In the past the TA has had more responsibility for programme implementation and administrative matters. With the programmatic approach, the role is changing into more focus on capacity
building. However, it appears that the need for capacity building at both central and regional level may have been underestimated. The embassy has taken steps to rectify this problem.

It is sometimes assumed that the need for TA is reduced with the SWAp. The general experience in other countries has, however, been that a substantial capacity building and TA input may be needed for systems development.

The decision to support the development of the SWAp with fairly flexible funding seems to be providing Finland with a relatively large voice for the amount contributed.

Phasing out strategies were considered in the NGO projects, but not in the bilateral projects as such. However, the bilateral projects were generally envisaged as long-term support with several phases. In practice, a third phase for various reasons did not materialise in case of SIREH (although support was continued in the same area years later). There was an unfortunate gap between the two phases of support in the area of reproductive health.

For the future: As the Finnish support moves towards sector budget support (or even general budget support), there will be a need to think about how to phase-out of the regional support. A strategic decision could be to channel additional funding from the increased development cooperation budget into budget support and maintain some or all support at the regional level and/or for specific health issues at risk of being marginalised. This would provide Finland with a voice and input at the overall health policy level (because of the budget support), as well as with knowledge and credibility in the discussions because of the work at ground level\(^ {137}\).

The FODINIC project to strengthen the organisations of the disabled is implemented in collaboration with the Danish PRODINIC project, using the same administration and procedures.

2.6 Coordination, synergy and potential conflicts of aid mechanisms

**Multilateral-bilateral:** There appear to be no multilateral projects with Finnish funding. No system for feedback on performance of multilaterals to MFA.

**NGO-bilateral:** There has been no systematic or regular exchange of information on Finnish bilateral and Finnish NGO support. The experience of NGO support has not generally been used in the development of the bilateral programmes. NGOs do not take the opportunity to use the presence of the bilateral programme as a channel for voicing their experiences. Some NGO projects do not seem to have been known by either KEPA or the Finnish embassy.

**Bilateral-bilateral health sector:** The maintenance hospital project and the rehabilitation project for the disabled (SIREH) took place at the same time and MINSA was involved in both. Towards the end of these two projects, the reproductive health project, SARED, started. The bilateral projects have been seen as separate projects. There appears to be no particular collaboration with a view to creating synergy effects between assistance in the supported areas (hospital maintenance, disability, reproductive health). This is a pity, as for example, persons with disabilities in most societies are more prone to being victims of violence and sexual abuse. Also, equipment has been part of the output in all projects. Useful lessons could potentially have been gained by interaction with the maintenance hospital project. Recently, though, the support to the development of a SWAp appears to benefit from the experiences in the reproductive health programme.

137 Danida has health sector programmes at various stages of development towards SWAp and with various portfolio mixes, ranging from Kenya at a very early stage to Ghana and Bhutan being at the most advanced stage. The programme documents are available online and may be useful for ideas. [http://www.health.dccd.cursum.net/client/CursumClientViewer.aspx](http://www.health.dccd.cursum.net/client/CursumClientViewer.aspx) .
In a longitudinal perspective, the projects build on past experiences and to a large extent the support to the key areas are coordinated over time.

**Bilateral-bilateral other sectors:** There has been limited coordination with projects supported by Finland in other sectors, as these have chosen other regions for implementation. A new approach is an attempt to work in the same regions. Potentially, there could be synergy effects from working with rural development, education, as well as other sectors in the same regions.

**Bilateral-Local Cooperation Funds:** While the current support has mainly been with a view to women’s rights, it is in line and supplements the focus adopted in the reproductive health programme (SARED).

### 2.7 Measurable achievements

Programme documents generally include objectives and indicators. (The programme document for the Maintenance Hospital Project could, however, not be found.) The indicators are of varying quality. Indicators for impact in terms of sustained changes in the population at large were not available. A baseline survey was carried out in SAREM, but it was never followed up and nobody knew where it was. The planned baseline survey for SARED is yet to be undertaken.

Mid-term evaluations were available in some cases. Interestingly, the mid-term evaluation of SIREH is dated May 1998, the last year of the second four year phase of the project. A final report, the only one found, is available for SAREM, while monitoring mission reports exist for SARED and FODINIC.

**Hospital equipment maintenance**

The main outputs are reported to have been minor hospital equipment, instruments and tools for maintenance in place and staff trained for maintenance. The availability of functional equipment is reported to have improved. However, no data are available. Problems with the trained maintenance staff drifting to the private sector have been noted. It can be questioned whether the gains have been sustained. Measurement of impact of the specific project is further difficult, because of the many donors working simultaneously in similar projects.

**SAREM**

The main outputs have been a substantial awareness-raising with 80% of health staff trained on sexual and reproductive health issues and intra-family violence. A lot of IEC material has been developed. Further, basic equipment has been provided for health centres targeting women and adolescents. A quality assurance system has been established to further enhance the quality of services. Adolescents have been trained as facilitators for discussions on family planning and prevention of STD/AIDS. A quite innovative approach with training of facilitators to raise awareness among men on sexual and reproductive health and domestic violence has been adopted.

A significant contribution has been made in facilitating the collaboration among several institutions involved with cases of domestic violence. This has resulted in the establishment of an inter-institutional referral system for victims of domestic violence. In an environment, where domestic violence is relatively prevalent and accepted, this is an important achievement.

The Finnish support to sexual and reproductive health, both in SAREM and SARED, has contributed to bringing these issues higher onto the agenda of MINSA. While sexual and reproductive health is part of the government health policy, it is a controversial issue and at
risk of being sidelined by the government, as the Catholic Church has a strong influence in the country.

The completion report for SAREM reports some measurable changes in indicators:

- A 13% increase in number of users of sexual and reproductive health services (1999-2001)
- Increased access to PAP smears with coverage increasing from 6% of target group to 15% (1998-2001), where 15% is for the first six months only
- Increase in family planning coverage from 19% to 23% (1999-2001)
- Increase in ANC (IV) attendance from 67% to 73% (1998-2000)
- Increase in institutional deliveries from 85% to 89%
- Diversification in sexual and reproductive health services to include more than just treatment
- Number of reported cases of domestic violence increased by 10.5%, from 200 in 1999 to 222 in 2001, in the municipalities covered.

The monitoring mission report of SARED notes that results achieved in SAREM do not appear to have been sustained. This conclusion is based on the observation that a number of the staff trained during SAREM is no longer there for SARED to build on. This could perhaps to some extent have been avoided, had there been a more smooth continuation from SAREM to SARED. With uncertainty and delays, the temptations to leave for better places and jobs increase. This is not to say that there would have been no brain drain, but it might have been less. As long as people remain working in the sector, the increased capacity is not lost. It could contribute to overall sector development in other ways, although the particular project that produced them could, of course, face a sustainability problem.

Rehabilitation of the disabled
The Finnish support has contributed to the establishment of the rehabilitation programme for the disabled in MINSA. A key contribution has been the capacity development in terms of training specialists and technicians in methods for rehabilitating the disabled, while at the same time constructing and equipping rehabilitation units throughout the country. In the second phase of SIREH, the scope was broadened somewhat and more focus was put on a cross-sectoral approach. Towards the end of the second phase of the SIREH, support was given to strengthening the organisations for the disabled.

During the period of Finnish support, the Law 202 for Prevention, Rehabilitation and Equalisation of Opportunities for the Disabled passed (1995) and the National Council of the Prevention, Rehabilitation and Providing Equal Opportunities for the Disabled was formed (1997). While they cannot be specifically attributed to the Finnish support, it is the impression of the team that the Finnish support has helped bring the important area of disability higher on the political agenda. The Finnish support was instrumental in putting various stakeholders together for an inter-institutional analysis, resulting in the formulation of the National Policy for Integrated Attention to Persons with Disabilities.

Further, the methodology applied in Nicaragua for rehabilitation of the disabled has been considered so successful that representatives from other countries have come to learn from the Nicaraguan experience. Even within Nicaragua, other ministries have learnt from MINSA and have attempted to improve the situation for the disabled.

Towards the end of the second phase of SIREH, a mid-term evaluation recommended that Finland should continue the support to rehabilitation of the disabled in Nicaragua, but that the program could be targeted directly at strengthening the organisations of disabled to enable them to advocate and present their needs and demands to authorities. The Finnish government followed the advice and developed such a project.
There are no impact indicators available for improvements in the quality of life of people with disabilities. A large national survey of people with disabilities was carried out in 2003 as the first of its kind.

3 Overall assessment

The support provided by Finland in the health sector in Nicaragua 1994-2003 has clearly been very relevant for the needs of the country. Maternal mortality is high, access to reproductive health services poor and domestic violence relatively frequent. Because of the civil war, disability is also fairly prevalent.

Overall, it is the impression of the team that the projects, in spite of problems, have been fairly effective in delivering what they were intended to deliver, e.g. SAREM. The cost-effectiveness and efficiency have been questioned. The extensive use of TA is one of the main factors contributing to lower efficiency. In the earlier projects, the input of TA has been fairly high, constituting 40-50% of the support, and difficulties have arisen due to high turnover, problems with language and other skills. An example of a cost-effective approach is the decision to let FODINIC collaborate with the Danish PRODINIC.

The impact is difficult to measure due to absence of data. It is, however, the impression of the team that the Finnish support, especially as regards sexual and reproductive rights and rehabilitation of the disabled persons, has had an impact on the policy agenda. It is also likely that it has had an impact on the lives of many women and families living in Carazo and Chontales, but this cannot be documented.

The sustainability of the capacity building has been questioned, but if a sector-wide perspective, rather than a project perspective is used, then the concern is less. The long-term involvement with rehabilitation of the disabled in some ways seems to have resulted in the development of a sustainable organisation and contributed to some milestones, such as the disability law and policy. These are still in place, although they may not be used to the extent one would hope.
ANNEX 11 - Health-related studies funded through the Academy of Finland since 2000

Routine Iron Prophylaxis during Pregnancy - Effects on Maternal and Child Health
Hemminki Elina
STAKES

Coping with the HIV/AIDS Pandemic in African Communities: The Case of North-Central Namibia
Notkola Veijo
University of Helsinki

Male Involvement in Reproductive Health Programmes in rural India and Malawi
Kulmala, Teija
University of Tampere
157 000 EUR

Child Nutrition Study
Ashorn Per
Lungwenan, University of Tampere
01.01.2003 - 31.12.2005
180.010 EUR

Effekten av D-vitaminsupplemering på benmineraltätheten och 25-hydroxi-D-vitaminkoncentrationen
Lamberg-Allardt Christel
01.01.2003 - 31.12.2005
150.000 EUR

Child Health Study
Ashorn, Per
Lungwena, University of Tampere
01.01.02-31.12.04
898.200 FIM

Exposure of infants in Egypt to a flatoxin M1 in breast milk
Mykkänen, Hannu
Kuopio University
01.01.02-31.12.04
868.700 FIM

HIV, KNOWLEDGE AND POWER "African Aids" as represented in HIV activism and medical discourses
Oinas, Elina
Åbo Akademi
01.01.02-31.12.04
576.000 FIM

Lungwena Child Nutrition Intervention Study - A Dietary Supplementation Trial in Rural
Malawi
Ashorn, Per
University of Tampere
167 000 FIM

The Vitamin D Status of Bangladeshi Women: Prevalence of Deficiency in Different Subject Groups
Lamberg-Allardt, Christel
University of Helsinki
01.01.2001-31.12.2002
475 000 FIM

Ecological and Health-related Changes in the Threatened Rainforest of Madagascar
Niemelä, Jari
University of Helsinki
01.01.2001-31.12.2003
1 445 000 FIM

Socioeconomic Status and Cardiovascular Risk Factors in an Urban Chinese Population
Nissinen, Aulikki
Kuopio University
48 000 FIM

Therapeutic Authority and the Realm of Healing in the Advent of Twenty-first Century
Nisula, Tapio
University of Tampere
01.01.2001-31.12.2003
840 000 EUR

AIDS in the Namibian Society
Notkola, Veijo
University of Helsinki
01.01.2001-31.12.2003
1 512 000 EUR
<table>
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<tr>
<th>Document</th>
<th>Advice</th>
<th>Evaluation comments</th>
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| Guidelines for project planning, monitoring and reporting. 26.5.2000. FTP International Oy, Finnconsult Oy | ► Time programme - The time-schedule of the project is clear and realistic and covers its whole lifetime. Sustainable results must be reachable within the project’s planned lifetime; it must be possible to phase-out the project in such a manner that the respective local organisations are able to take over the improved systems and continue the operations without further external support.  
► Contents of a project plan – Should include a section on “Risk assessment and key assumptions”, which are supposed to consider ‘sustainability factors’  
► Sustainability factors - Sustainability is one of the most important guiding principles that should be tested and cross-checked during the project preparation. Usually, projects aim at sustainable results and impacts. This means that improved systems and actions should not remain dependent on external support, after the project has been phased out. The foundation for sustainability is established already during the planning phase. Mistakes made during the planning process are hard, often even impossible, to repair. Instead, they tend to duplicate during the implementation process. | ► No requirement for a phase-out plan as a component in the project plan, only that there be some discussion of sustainability factors.  
► No discussion of phase-out plans to be part of the routine reporting and preparation leading up to the final report; and the final report does not ask for any information about what happened with the phase-out process. |
| Guidelines for Programme Design, Monitoring and Evaluation. MFA (nd)       | ► Glossary – includes a list of key terms relevant for programme design                                                                                                                                                                                                                                                                | ► No mention of phase-out and exit strategy in the glossary list  
► No sections on phase-out or exit strategy in the body of the guidelines.                                                                                                                                                                                                                     |
| Preventing Corruption: A Handbook of Anti-Corruption Techniques for Use in International Development Cooperation; Ministry for Foreign Affairs of Finland, 2003 | ► Handing over - The completion of the project is a critical stage that is vulnerable to corruption. The project’s final stage must be carefully prepared so that the operations that have been started during the project period continue to be undertaken by the implementing organisation. When the project is handed over, there must be an inventory of the assets that belong to the project. The inventory should specify the value, nature and quality of the assets. Where necessary the inventory can also show the present use of the assets and their specific maintenance requirements. Handing over the assets before the final completion of the project itself may help to prevent the project’s assets being transferred into the private ownership of officials in the implementing organisation.  
► The handing over of the project should also include the transfer of the project’s financial assets as a whole to the implementing organisation, the dismantling of the project’s separate accounting system and the complete integration of the project operations into the functions of the implementing organisation. It is obvious that this integration cannot be achieved overnight. Handing over the project therefore requires a transfer phase of a year or two. During this period, the operations are handed over and at the same time the transfer of sufficient administrative capacity to deal with them is also ensured. Guidelines for transferring project are to be found in Annex IX of the Finnish Ministry for Foreign Affairs “Guidelines for Programme Design, Monitoring and Evaluation”. | ► This content is focused on the management and transfer of assets, and does not give guidance about all the other issues related to an effective exit strategy that might be relevant even to a discussion focused on corruption and closure – rumour management, human resources management, data management, transfer of clientele, and so on.  
► The annex referred to is only in Finnish. When translated, the contents amount to useful questions for a terminal evaluation, but they are definitely not guidelines for transferring the project. |
| Development Co-operation of Finnish NGOs Manual 2003. MFA                | ► Time programme - The schedule of the project is clear and realistic and covers its whole lifetime. Sustainable results must be reachable within the planned duration;  
► Ownership and participation - It must be possible to phase-out the project in such a manner that the respective local organisations are able to take over the developed systems and continue the operations without further external support, after the project has been completed. Sustainability requires participation. Sufficient resources | ► Contains some general principles, but thin on detail (especially compared to other parts of the same guideline) about how to handle this important issue. |
<table>
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<tr>
<th>Document</th>
<th>Advice</th>
<th>Evaluation comments</th>
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<tr>
<td>Thinking Strategically about Democracy Assistance: MFA, 2001</td>
<td>and time are needed to secure participation of all groups, some of which may require special measures of support.</td>
<td>► Sustainability factors - Selection of the approach: When the alternatives (for project design) are assessed, it is also important to consider available strengths, resources and opportunities. It is especially useful to identify the beneficiaries' own resources and potentials. The more the approach is based on already existing resources, the better the possibilities to achieve sustainability. If a project is completely based on the use of external technology, expertise and funding, it will be difficult to phase-out in a sustainable way, as the operations have become dependent on external resources.&lt;br&gt;► Handing over - Operation and maintenance (O&amp;M) costs must in the long run be borne by the local stakeholders. Only in the start-up phase may O&amp;M costs be covered by the Ministry's financial support. However, already at this stage a clear and realistic plan on how to transfer the O&amp;M costs to the local stakeholders must be presented. The plan must also include a clear handing-over schedule.</td>
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ANNEX 13 - Preparatory analysis work to facilitate the evaluation

Date: September 2004 (slightly edited for inclusion in this report)

Here are some suggestions about some preparatory information collection and analysis that could be quite helpful to the team – both in terms of selection of projects to visit, but also as an overview of the MFA’s attention to monitoring, evaluation, and analysis.

Note that the request here is to identify the presence (or absence) of these elements, their dates and the availability of documentation. The sub-columns for each of these are:

a) Has such a study or evaluation been done in this project (or not)
b) If yes, what date (or dates if there were multiple rounds for different serial project cycles)
c) Is the report available in English/Finnish/other?

Monitoring and evaluation elements
These elements will usually appear as separate free-standing reports and evaluations, but they might sometimes be integrated as chapters in project documents and terminal evaluations.

**Baseline study** – initial benchmarking study gathering information about specific indicators to be used for reporting in this project (not the same as a situation analysis or context assessment)

**Endline study** – a final study at or near the end of a project cycle that uses the same methodology and indicators as the baseline study

**End of project cycle evaluation** – terminal evaluation for a project cycle, often referred to as a ‘summative’ evaluation, and usually done by an external team

**Ex post evaluation** – a follow-up evaluation done several years after project support has ended; carried out to assess the sustainability of changes brought about by the project

Analysis elements
These analyses may appear as separate free-standing analytical papers and evaluations, but they are also more likely than the monitoring and evaluation elements above to be integrated as chapters in project documents and terminal evaluations.

**Policy analysis** – an analysis of national policies relevant to the intended or actual outcomes of the project in the country of operation. E.g., is there a national HIV/AIDS policy? How is the project going to support or work with that policy, including advocacy for change in the policy? Do the outcomes of the policy lead to specific policy recommendations, or policy advocacy efforts?

**Gender analysis** – an analysis of gender issues as influences on the design and operation of the project; ideally, it would also include an assessment of how the outcomes of the project have influenced any gender issues. The gender issues in this analysis are likely to include gender-specific roles and responsibilities, equality of access to and control over resources and services, and participation in decision making on different levels for both sexes within the project and/or within the health sector that the project is supporting.
**MDG analysis** – an analysis of whether the project is influencing any of the specific MDG goals, and if so, which of the indicators for the MDGs are being monitored in the project. This might also be substituted by an analysis of the “pro-poor” aspects of the project and the health sector that it is working with/within.

**Participation analysis** – an analysis of the participation and involvement of the project and sector stakeholders, both at government level and in communities, in planning and implementation of health activities in selected partner countries. This might also be covered under the terminology of a ‘partnership’ analysis or an ‘ownership’ analysis. See table below for a possible format to use in organising this information.

### Monitoring and evaluation elements

<table>
<thead>
<tr>
<th>Project</th>
<th>Baseline study</th>
<th>Endline study (repeat of baseline study at end of project cycle)</th>
<th>End of project cycle evaluation</th>
<th>Ex post evaluation study</th>
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<td>Yes/no</td>
<td>Date(s)</td>
<td>Report lang.</td>
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<td>Yes/no</td>
<td>Date(s)</td>
<td>Report lang.</td>
<td>Yes/no</td>
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</table>

### Analysis elements

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<tr>
<th>Project</th>
<th>Policy analysis</th>
<th>Gender analysis</th>
<th>MDG analysis</th>
<th>Participation analysis (or partnership, ownership analysis)</th>
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<td></td>
<td>Yes/no</td>
<td>Date(s)</td>
<td>Report lang.</td>
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<td>Yes/no</td>
<td>Date(s)</td>
<td>Report lang.</td>
<td>Yes/no</td>
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Logically, the next step would be the extraction of relevant indicators of outcomes/results and impacts – assuming the above information is available.

Information about national level data on health and poverty indicators, including MDGs, is likely to be available from other sources, either from the Internet, or in-country from the MoH, or possibly from the Finnish embassy or Project officer/Technical Adviser.
## ANNEX 14 - Gaps in information about achievements

<table>
<thead>
<tr>
<th>Document</th>
<th>Issues</th>
<th>Related recommendations</th>
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| Rural Development Cooperation: Learning from Finland’s International Projects and Programmes, E. Eskola. MFA 2003 | ► The possibility of drawing conclusions about the development of the programme and the lessons learned is considerably weakened by the fact that the Project Documents for all phases, the Mid-term Reviews for the first and second phases, and the Final Reports for all phases were unavailable for this report.  
► It is still not sufficiently common practice to conduct a thorough baseline study at the very beginning and a comprehensive final evaluation after the programme has ended, despite the fact that identifying failures and successes and analysing the reasons for them is invaluable for other current and future programmes. | ► In order to facilitate learning from experience in future projects, more emphasis should be put on carrying out thorough baseline studies in the very beginning and final evaluations after the programmes have ended. Identifying the failures and successes and following up with analyses of the reasons for them would certainly be valuable when designing new programmes or reviewing and reorienting current ones. Taking even failures as valuable possibilities for learning after the reasons have been analysed would enhance the creation of the open learning environment that should be a part of common practice in the future. Lessons learned should also be openly disseminated to all the project and programme stakeholders.  
► Even though an increase in the budget would be required to conduct more thorough evaluations, if this produces more constructive recommendations it is well worth while. The timing of evaluations should be considered, too, so that each one takes place long enough after the end of the aid programme for the sustainability of the activities to be analysed, but not so long afterwards that the impacts of the programme can no longer be separated from changes that have occurred for other reasons. |
| Effects or Impacts? Synthesis Study on Evaluations and Reviews 1988 to Mid 1995. J. Koponen, P. Mattila-Wiro. MFA, 1996. | ► Impact was the major unknown factor. It was astonishing to find how little information on the impact of Finnish bilateral development projects was conveyed by the evaluation and review reports discussed in this study.  
► Underlying all these problems was a poor knowledge base: insufficient, poor or missing data, especially a lack of socio-economic baseline and cultural background data, and poor monitoring systems; a lack of thorough understanding of social and cultural factors; and inadequate understanding of the implications of policies, as well as inflexibility in adapting to changes in them.  
► The major limitations of the study lie not so much in the coverage of the activities as in the scope and quality of reports on which it is based. The majority of the project-specific reports were mid-term reviews, or other interim evaluations, of ongoing projects and programmes, although there were also some post-evaluations undertaken after the completion of the project or a distinct phase of it. Ex-post evaluations concentrating on long-term impacts were very few. | ► Knowledge bases and their use must be improved. This requires adequate monitoring and more research. Especially social and cultural factors need much more detailed attention. Before producing more data it must be made sure that the existing data are used.  
► Concerning evaluations, it is important to raise their quality by the following means, among others: more resources, new guidelines, increasing involvement of the partners from developing countries, more social and cultural expertise, and more broader thematic and other such evaluations as well as ex-post evaluations. The consultancy company mode of delivering assistance would warrant a major evaluation of its own. Evaluation results should be made more accessible in compact and timely publications, and through other more innovative and interactive forms of feedback. |
<p>| Improving Effectiveness of Finnish Development Cooperation: | ► Despite the positive changes that the SWAp approaches introduce in the area of development cooperation, perhaps the biggest challenge regards actual outcomes and impact that have generally been disappointing or difficult to measure. It is increasingly becoming clear that SWAp | ► Finland should support the periodic evaluations, including post-project impact assessments, of its development undertakings and draw lessons for the future. |</p>
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<th>Document</th>
<th>Issues</th>
<th>Related recommendations</th>
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<tr>
<td>Perspectives from the South. O.S. Saasa, G.C. Gurdian, Z. Tadesse, and G.S. Chintan. MFA 2003</td>
<td>advocates, particularly donors, have grossly underestimated the institutional constraints of the government system and the importance of the need to build and, perhaps more importantly, retain human resource capacities that is so pivotal in the planning and implementation of very complex SWAp approaches to service delivery. The policy and institutional limitations of the recipient governments often receive scant attention in donor’s efforts to improve aid effectiveness.</td>
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<td>DAC Peer review, Finland Development Assistance Committee, OECD, 2003</td>
<td>► In 2002, the MFA commissioned a study that evaluated eight country programmes (Effects or Impacts? Koponen et al.). Although the resulting judgements are somewhat inconclusive, the study states that project objectives have been achieved in many cases but that overall impact and sustainability were largely unknown or unimpressive, especially regarding poverty reduction. Such findings are similar to those of previous evaluations concerning Finnish projects in the 1980s and early 1990s.</td>
<td>► It would be of interest to the DAC to hear Finland’s plan of action on the findings, especially regarding how to increase its impact on poverty reduction.</td>
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<td>Searching for Impact and Methods: NGO Evaluation Synthesis Study. S-E. Kruse, T.Kyllönen, S.Ojanperä, R.C.Riddell, J.Vielajas, A.Bebbington, D.Humphreys, and D.Mansfield. Report for the OECD/DAC Expert Group on Evaluation May 1997</td>
<td>► If there is one consistent theme to come out of the majority of the country case studies it is that for the sheer numbers of evaluations that have been carried out, there are very few rigorous studies which examine impact: improvements in the lives and livelihoods of the beneficiaries. Most studies are dominated by a documentation of outputs, some merely describe a number of project activities. ► There are two types of reasons why it is necessary to 'flag' the issue of quality. Firstly, a common feature of most (and until recently the vast majority of) NGO development interventions has been the failure to provide baseline data, the failure to monitor and assess projects and programmes on an ongoing basis against the original position, and the failure to try to disentangle the contribution of the project and/or programme inputs to the outcomes achieved. As a result, most of the 'better quality' impact studies which have included visits to project sites (and by no means all have done this) have had to use a variety of proxy techniques (focus-group discussions, recall, comparative static analysis) to try to assess impact. Relatedly, the bulk of impact assessment studies, often those with larger budgets and more professional evaluators, highlighted weaknesses caused by the shortage of time within which to conduct their analyses.</td>
<td>► Donors to enhance their internal data-capture mechanisms; ► Encouragement to examine rigorously the whole area of methods of assessing nonproject development interventions, not least those focused on capacity-building, advocacy and development education. This work ought to have the discussion of suitable indicators as a major focus.</td>
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</table>
### ANNEX 15 - Significant achievements highlighted during the health sector evaluation

<table>
<thead>
<tr>
<th>Country</th>
<th>Project/support</th>
<th>Output</th>
<th>Outcome/effect</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kosovo</td>
<td>Bilateral support – now in second phase of nursing capacity building project</td>
<td>Almost 700 nurses trained Have now started training of nursing trainers</td>
<td>Positive changes in quality of care provided where the trained nurses are working Reinforced/reinstituted culture of professional development and continuing education for nurses</td>
<td>Baseline and operational research programme instituted with second phase</td>
</tr>
<tr>
<td>Kosovo</td>
<td>NGO support – IFRC; completed</td>
<td>One hospital with major rehabilitation of infrastructure</td>
<td>Improved staff performance after capacity building</td>
<td></td>
</tr>
<tr>
<td>Mozambique</td>
<td>Bilateral support – maintenance/health care technology; completed</td>
<td>Provinces all have small maintenance units Established a training section</td>
<td>Staff have a preventive maintenance culture, not just crisis repair orientation</td>
<td></td>
</tr>
<tr>
<td>Mozambique</td>
<td>Bilateral support – now in third phase of provincial health system capacity building</td>
<td>Rehabilitation or new construction on all health units in the province; rehabilitation of training centre; improved working conditions Training capacity built; have trained and deployed multiple cadres of health workers for the province Better access to care Provided small libraries in all districts in the province</td>
<td>Improved performance of health workers (though still to do a quality of care assessment) More job satisfaction among health workers and better patient satisfaction (on surveys) Reinforced culture of professional development and continuing education for nurses</td>
<td>Reportedly there were positive changes in some low order impact indicators in the target province, e.g., decreased institutional mortality, improved immunisation levels, increased institutional deliveries Baseline not available so comparative study not yet done</td>
</tr>
<tr>
<td>Mozambique</td>
<td>Local cooperation support – AIDS project; on-going</td>
<td>Number of seropositive women on treatment increased</td>
<td>Number of seropositive women on treatment increased</td>
<td></td>
</tr>
<tr>
<td>Mozambique</td>
<td>NGO support – via KEPA, on-going</td>
<td>Enabled organisations of persons with disability to formulate a policy that was accepted by government</td>
<td>Number of seropositive women on treatment increased</td>
<td></td>
</tr>
<tr>
<td>Nicaragua</td>
<td>Local cooperation support – street children project</td>
<td>Health education materials and activities, service provision</td>
<td>STDs among street children reduced</td>
<td></td>
</tr>
<tr>
<td>Nicaragua</td>
<td>Hospital equipment maintenance</td>
<td>Minor hospital equipment, instruments, spare parts and tools. Training of personnel in maintenance.</td>
<td>Reported to have improved the conditions of equipment. However, no data available.</td>
<td>Impact indicators unavailable. Many donors were working in this area.</td>
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138 These indicators are heavily dependent on the services being provided, and some are even measures of the services rather than sustained changes in the population at large. They were also presented to the evaluation team in qualitative terms of comparison to other provinces even more than comparison with the past situation in the same province – due to lack of documentation about trends and limited institutional memory over the long history of this project. Language was also an issue, as the bulk of the documentation was in Portuguese, and thus not accessible to the evaluation team.
<table>
<thead>
<tr>
<th>Country</th>
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<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicaragua</td>
<td>Bilateral support to reproductive health and rights – SAREM</td>
<td>Awareness-raising by training 80% of health staff. Provision of basic medical equipment. Quality assurance system developed. Training of adolescents as promoters on prevention of STD/AIDS. Training of facilitators for male groups. Development of IEC material on sexual and reproductive health and domestic violence. Inter-institutional referral system for victims of domestic violence established. Training of workers in Casas de la Mujer on ways to deal with victims.</td>
<td>Improved attitude of MoH personal on gender topics and topics of intra-family violence and sexual abuse. Local collaboration on intra-family violence has been established. Intra-family violence and sexual and reproductive health are reported to have been put higher on MINSA’s agenda.</td>
<td>A baseline study was undertaken in SAREM, but never followed up; cannot be found. 13% increase in number of users of SR services (1999-01); family planning coverage increased from 19% to 23%; coverage PAP smears increased 6% to 15%. 11% increase in number of reported and treated cases of domestic violence</td>
</tr>
<tr>
<td>Nicaragua</td>
<td>Bilateral support to development of the system of rehabilitation for the disabled - SIREH</td>
<td>Establishment of the MINSA rehabilitation program for the disabled. Training of specialists and technicians. Rehabilitation units constructed and equipped in the whole country. Organisations for disabled people strengthened in promoting, defending and analysing human rights.</td>
<td>Needs and assistance for the disabled promoted and put higher on the government agenda than would otherwise have been the case. Law 202 for Prevention, Rehabilitation and Equalisation of Opportunities for the Disabled passed in 1995. National Council for the Prevention, Rehabilitation and Providing Equal Opportunities for the Disabled formed in 1997. Inter-institutional analysis and formulation of the National Policy for Integrated Attention to Persons with Disabilities. Reorientation towards a multisectoral approach. Exporting concept of rehabilitation team to other countries. Also a cascading effect to other ministries.</td>
<td>No impact indicators for improvements in the quality of life of people with disabilities are available. A large national survey on disability was undertaken in 2003.</td>
</tr>
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</table>
ANNEX 16 – Strengths of Finnish health development cooperation

► Development policy of Finland
The role of health in Finnish development cooperation is being expressed more strongly over the evaluation period. Finland considers health to be one of its main development cooperation sectors. The new Development Policy’s focuses on poverty reduction and the Millennium Development Goals - both areas for which health is very important. Finland has also consistently been working towards donor coordination and harmonisation to increase the effectiveness and efficiency in aid.

► Thematic areas within health cooperation
The main thematic areas that are identifiable in Finland’s health cooperation are very appropriate. They include capacity building, strengthening of health systems, population and reproductive health and HIV/AIDS. Finland stresses the enhancement of developing countries’ own primary health care systems, social services, and social protection organisations.

As noted in the Development Policy (2004), primary health and social service systems must be of good quality, comprehensive and easily accessible to all. Finland believes that it is essential to act cohesively and concurrently on services and policies in the entire social sector, including reproductive and sexual health, education, gender equality and the protection of minorities, and on democracy and good governance.

► Gender and health
Women’s rights and equality are key prerequisites for achieving the three health-related goals of the Millennium Declaration. In this regard, Finland is active in promoting women’s rights, and a broad perspective on sexual and reproductive health. This is particularly important at a time when some other donors are reducing their support to these areas.

In some of their most challenging work, the MFA has responded to the poverty-related social connections between health and domestic violence. For example, in Nicaragua, where there is a high incidence of domestic violence, a Finnish-supported reproductive and sexual health and rights project has sensitively and successfully confronted issues of gender-based violence and health inequities.

► HIV and health
The evaluation team found ample evidence that Finland understands HIV/AIDS to be a multisectoral problem, with strong causal and outcome linkages to national poverty. There is a Development Cooperation HIV/AIDS Policy (2002), which emphasises the importance of poverty, gender, education and economic approaches, as well as health, especially prevention. There are also multiple references to the importance of collaboration with the education sector in working on HIV/AIDS.

Finland was chair of the PCB (programme coordinating board for UNAIDS) during 1999-2000, which meant that they were the chair for the UNGASS (Holkeri). According to UNAIDS, Finland was heavily involved in that meeting and contributing to the international debates about HIV/AIDS at the time.

There are positive examples elsewhere, including in Mozambique, where HIV/AIDS has been thoroughly mainstreamed for health workers in training, e.g., in the Manica Training Centre. In addition, it is reassuring to note that the Mozambican Maintenance/Health
Technology programme, which has now been taken over by the Ministry of Health, has integrated occupational HIV safety into its programmes.

► Multilateral support and health
As already mentioned in this report, Finland is in line with the other like-minded donors as a strong supporter of the UN system and in supporting the development and maintenance of the normative role of the UN agencies. Our examination of multilateral funding levels over the evaluation period showed that UNFPA, UNAIDS and UNICEF (the major multilateral partners) received a relatively stable percentage of the annual allocation to health-related contributions. Finland has also contributed to EU's development activities through EU's general budget since 1995 and through the European Development Fund (EDF) since 1998.

The support to UNAIDS and UNFPA is given as 'core support', i.e., non-earmarked funding that the agencies can use as per their annual plans, including support for their core administrative and operating costs. This kind of open donorship is very much appreciated by the UN agencies.

The strength of extra-budgetary funding is the potential to support neglected themes or programmes within WHO's portfolio. In recent years, Finnish extrabudgetary money to WHO has gone to mental health, anti-tobacco, strengthening health systems and vaccine activity. Finnish money has contributed to the development of normative advice for mental health in emergency situations (e.g., being used in the Darfur crisis).

Finland’s flexibility and ability to provide some non-earmarked support to multilateral organisations has provided it with much influence beyond what its level of financial support justifies in setting the agenda for development work internationally. Finland was a member of the Executive Board of WHO 1994-97, a full member of the joint Executive Board of UNFPA 2001-2003, and chair of UNAIDS Executive Board from May 2000 to end of 2001. Finland has been active on discussions on policies towards MDGs, good governance of the agencies and harmonisation of work among agencies.

► Bilateral support and health
MFA’s bilateral state-to-state grant assistance has been in line with the needs of the recipient countries, as well as their governmental priorities. The purely grant-based state-to-state support has shifted from infrastructure provision to systems and institutional development and towards larger emphasis on integration of cross-cutting themes. By its choice of sub-sectors, Finland has managed to support those quarters of government that are willing to put slightly contentious health-related issues on the agenda and work for changing the health of vulnerable groups. Finland has been acclaimed for helping keep these issues higher on the agenda than they would otherwise have been.

Finland has shown willingness and flexibility to adapt its assistance, as recipient countries have shown interest in increasing efficiency in aid and worked towards comprehensive planning under the umbrella of Poverty Reduction Strategy Plans. Finland has already been demonstrating increased commitment to programme-based cooperation in the health sector, progressively shifting from project support to sector wide approaches and budget support in its long-term partner countries that have health as a primary sector. This is in line with the like-minded group of countries, the EU, and, gradually, the UN agencies.

Its flexibility and ability to adapt to changes and provide some un-earmarked support have provided Finland with much influence beyond what its level of financial support justifies. In Mozambique, the continuous presence of the health adviser has been pivotal in allowing immediate participation in policy dialogue, based on a level of information and personal relation that gives a lot of credibility.
► **NGO support and health**
The NGOs are a varied group from large Finnish and international organizations to small local civil society groups. NGO development assistance in the area of health has increased over the period, both in absolute and relative terms. This development is in line with the overall policy trend in Finland (and the world in general).

Finnish NGOs, such as Finnish Refugee Council and Finland Federation for Mental Health, have provided financial support for improving care and living conditions in psychiatric hospitals. Other Finnish NGOs working with disability have been instrumental in keeping disability on the agenda of many countries. An evaluation carried out in 1996 indicated that Finland-supported NGO health care projects in Tanzania had brought about positive changes in people’s lives and communities. The MFA also supports some international organisations that focus on specific vulnerable groups, e.g., HelpAge for the aged.

Another good practice worth highlighting is bringing together Finnish and overseas NGO counterparts to share ideas and best practices. For example, a 2002 Helsinki workshop, organized jointly by the MFA, Finnish Save the Children’s Fund and KEPA, was important for promoting synergy and ‘harvesting’ lessons learnt pertaining to sexual and reproductive health.

► **Local cooperation funds**
Local cooperation funds, distributed by and through Finnish embassies, have frequently been used to support very vulnerable groups. This has been particularly true in the past few years, after greater discretion in their allocation was ceded to the embassies.

► **Participatory ownership/engagement**
Participation and ownership are - and have long been - key values in the planning and delivery of Finnish development assistance. Stronger local ownership and better partnerships have been realised through more responsive programme design and multiyear budget commitment, decentralisation of aid and management, by keeping the number of country programmes manageable and by providing long-term support. Long-term partnership is required for building up trust, learning about the environment and local culture and ensuring local ownership.

► **Human resources**
The technical skills of both of the present health advisers (at MFA and in Mozambique) were highly praised.

► **Impact**
The overall assessment of the evaluation team is that the Finnish assistance has probably made an impact on the lives and health of target beneficiaries.