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**Future Strategies for HIV/ AIDS Policy - Recommendations  
for the German Federal Health Ministry  
in the Ukraine, the Russian Federation and Estonia**

Katri Kemppainen- Bertram, Research Associate (Hertie School of Governance)

Foreword by Prof. Stein Kuhnle (Hertie School of Governance)

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***Foreword***

This report represents a concise, shortened version of Katri Kemppainen-Bertram's Master thesis. The project was carried out in cooperation with The German Federal Health Ministry. Katri Kemppainen-Bertram graduated in May 2007 as one of 28 students in the first class of the Master of Public Policy program at the Hertie School of Governance. Her Master thesis was considered to be among the best of her class and she was invited to prepare the shorter version for the HSoG Working Paper Series. We are glad to make her work available to a wider audience in this form. The complete Master thesis is available for download from the homepage of The Hertie School of Governance:

[http://www.hertie-school.org/binaries/addon/278\\_student\\_project\\_kemppainen\\_bertram.pdf](http://www.hertie-school.org/binaries/addon/278_student_project_kemppainen_bertram.pdf).

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***Abstract***

This study provides recommendations to the German Federal Health Ministry (BMG) for positioning itself with respect to the multitude of actors involved in international HIV/AIDS policy in Eastern Europe, in particular in the Ukraine, the Russian Federation and Estonia. A particular focus is placed on different coordination mechanisms, whereby the benefits and costs of the coordination strategies are analysed in terms of their *effectiveness, efficiency and sustainability*.

The study concludes that different countries not only require different HIV/AIDS policies, but also require different coordination strategies. Estonia, Russia and the Ukraine require not only different policies in terms of the comprehensiveness of policies. Engagement in the three countries also needs to differ with regard to the time horizon (short or long term) and whether existing networks can or should be used. The most comprehensive engagement of the BMG is recommended for the Ukraine, the least for Estonia.

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## 1 Introduction

HIV/AIDS policy is complex, encompassing medical, behavioural and socio-economic aspects. A multitude of actors are involved in planning and implementing HIV/AIDS policy, ranging from health and education ministries to international organizations, and from local NGOs to global faith-based initiatives. The consumers of HIV/AIDS policy, mainly those infected or at risk, include as broad a spectrum, ranging from youth to prisoners and from pregnant women to migrant workers. HIV/AIDS policy arguably rides at the forefront of transnational cooperation and multi-level governance initiatives, yet despite the establishment of e.g. the Global Fund to Fight Tuberculosis, AIDS, and Malaria (GFTAM), UNAIDS and policy cooperation via e.g. the Millennium Development Goals (MDGs), much that is envisioned on paper is far from what takes place in reality. This study aims to provide recommendations to the German Federal Health Ministry (*Bundesministerium für Gesundheit*, henceforth BMG) for positioning itself with respect to the multitude of actors involved and in defining an *effective, efficient and sustainable* HIV/AIDS strategy in Eastern Europe.

The criterion of effectiveness is defined as achievement of policy objectives or as a significant contribution towards their achievement. Efficiency is defined as minimizing a waste of resources and time. Sustainability is defined as avoiding the creation of negative effects in the long term. Policy effectiveness is seen as the primary criterion,<sup>1</sup> as efficiency and sustainability are not ends in themselves.<sup>2</sup>

The three case countries for this study have been selected by the BMG based on the severity of their problems: the Russian Federation has the highest absolute number of HIV/AIDS cases in the Eastern European and Central Asian region (in 2006 totalling 940,000 cases out of a population of 143m); the Ukraine has the highest number of new infections in the past years (410,000 cases out of 46m); and Estonia, providing a case example not only from the border but inside the EU, witnessed a worrying increase of HIV/AIDS prevalence at the turn of the millennium (10,000 cases out of a population of 1,3m).<sup>3</sup> Although the HIV/AIDS situation in the three countries is interlinked, illustrating some of the negative effects of globalization, each country has unique problems.

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<sup>1</sup> See also: UNAIDS (2006c: 254).

<sup>2</sup> See: OECD (2004b: 2).

<sup>3</sup> Figures based on UNAIDS (2006c: Country Profiles).

The study begins with an actor-centred approach (Ch.2), and then discusses the context of the three Eastern European case countries (Ch.3). In Chapter 4, three actor coordination approaches will be outlined, and used to introduce four possible alternative coordination strategies (Ch.5). Finally, Chapter 6 will provide a conclusion and specific policy recommendations for the BMG.

## ***2 The Actors: The German Federal Health Ministry (BMG) and Other National and International Actors***

### ***The BMG's Mandate***

Germany works in and together with almost 50 countries on HIV/AIDS,<sup>4</sup> and is one of the largest HIV/AIDS bilateral donors and contributors to IGOs.<sup>5</sup> The mandate for international HIV/AIDS projects is shared by the BMG together with the Federal Ministry for Economic Cooperation and Development (BMZ), the German Technical Cooperation Agency (GTZ), the Robert Koch Institute (RKI), the Federal Centre for health Education (BzGA), the foreign office (AA),<sup>6</sup> various NGOs,<sup>7</sup> as well as indirectly through supranational and international organizations.<sup>8</sup> There is an abundance of projects in the field where Germany is an active participant or donor. However, the problem is that, although German HIV/AIDS policy is well-coordinated on the national level,<sup>9</sup> projects on the international level are highly uncoordinated in nature<sup>10</sup> and the role of the BMG has so far been minor.

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<sup>4</sup> Germany's international HIV/AIDS budget for bilateral, multilateral (IGO) and supranational (EU) contributions totals €300m per annum. BMG (2005e).

<sup>5</sup> Its bilateral contributions totalled €500m by 2003 and it is, e.g., the third-largest contributor to the WHO with US\$41m in 2004. See: BMG (2005e and 2006g respectively).

<sup>6</sup> See: BMG (2005f).

<sup>7</sup> There are more than 60,000 NGOs active in HIV/AIDS policy. Garret, Laurie(2007).

<sup>8</sup> Such as the EU, G8, the United Nations, UNAIDS, the World Health Organization (WHO) and the Global Fund (GFTAM). An estimated 20% of all international finances for HIV/AIDS, TB and malaria are channeled through the Fund, out of which 56% are used for HIV/AIDS. 61% went to governments and, important for this study, 9% to Eastern Europe. UNAIDS (2006c: 74 and 242 respectively).

<sup>9</sup> The actors involved are the BMG, BZgA, RKI, PEI, DIMDI, DAH, and the German AIDS Foundation. The main actors are the BZgA, which coordinates mass campaigns for the general public, and DAH, which carries out interpersonal contacts and is an umbrella organization of 120 local health groups. See: BMG (2005e).

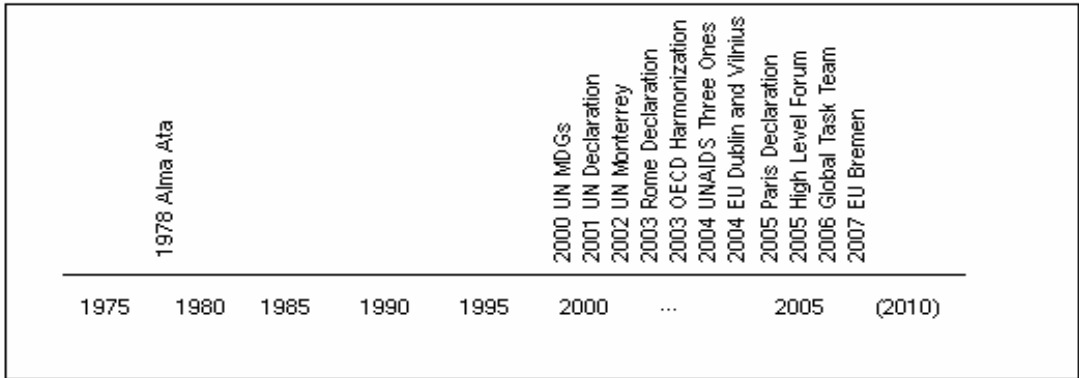
<sup>10</sup> Although the 2005 strategy notes that an interministerial working group has been planned at the federal level, such a group has not yet been formed. See: BMG (2005a) and BMG (2005f). However, formal cooperation does take place between the BMG and the BZgA, which the BMG supervises, with the RKI, and on an ad hoc basis with the BMZ.

The BMG’s small role can be explained in that it has one of the smallest budgets of all federal ministries, at €1925m in 2007.<sup>11</sup> This is partly due to the fact that in Germany, health policy is mainly a state (*Länder*) task. Having a small budget, the BMG does not carry out its own projects in HIV/AIDS internationally, but works bilaterally with its international counterparts<sup>12</sup> as well as with and through supra- and international organizations. Germany also works through the EU,<sup>13</sup> although these activities are qualified by the 1992 Maastricht and 1999 Amsterdam Treaties, in particular the latter’s Article 152 which defines that EU health policy is only to “complement national policies...fully respect[ing] the responsibilities of the Member States for the organisation and delivery of health services“.<sup>14</sup>

**International Agreements**

The BMG not only works together with various national and international actors, but it also operates within a framework of international agreements.

*Graph 1: Timeline of International Agreements Directly and Indirectly Relating to HIV/AIDS*



These agreements frequently not only list qualitative or quantitative targets for states to strive for, but also deal with cooperation approaches, which is a focus of this study. They also frequently trigger policy shifts, e.g. changing the policy focus from comprehensive to disease-

<sup>11</sup> The budget was decreased from €4598,42m in 2006 (out of a total governmental budget of €61600,00m) to €1924,95m in 2007 (out of a total budget of €67600,00m), i.e. by 58.1%, due to a cut in financing the national health insurance of €2.7b. BMF (2006).  
<sup>12</sup> Currently, it has bilateral treaties with Bulgaria, China, Hungary, Kazakhstan, Poland, Romania, South Korea and, out of this study’s three case countries, with the Ukraine (planned in 2007) and Russia (from 1987, 1997, and 2004).  
<sup>13</sup> As party to the Rapid Action Plan that expired in 2005 (See EU. 2004a), the Action Programme that runs from 2007-11 and as signatory of the 2004 Dublin and Vilnius declarations, and as the organiser of the 2007 Bremen Conference and through the European HIV Task Fore (DG SANCO). See: European Union (2005).  
<sup>14</sup> European Union (1999).

specific approaches.<sup>15</sup> The disease-specific approach has since the 1980s remained dominant, exemplified also in the 2000 United Nations Millennium Declaration, where health goals are defined in a selective and disease-specific way. Most declarations and agreements from this decade are based on the MDGs.<sup>16</sup>

Since 2002, several conferences and agreements have also focused directly on international coordination issues.<sup>17</sup> The main coordination strategy in HIV/AIDS has been the *2004 UNAIDS Three Ones*, which call for “one agreed AIDS action framework” (to coordinate the work of all key stakeholders) “one national AIDS coordination authority” (recognized in law with a strong mandate), and “one agreed country-level monitoring and evaluation system”<sup>18</sup> (using standardized indicators and informing authorities where to use resources to respond effectively and quickly).<sup>19</sup> In line with these agreements, the EU has produced its own agreements to improve coordination and cooperation both within and external to the EU, resulting in the *2004 EU Dublin and Vilnius Declarations*,<sup>20</sup> as well as the *2007 Bremen Declaration*.<sup>21</sup> In these documents, Germany (and the EU) pledged to work together with Eastern European and Central Asian states.<sup>22</sup>

### ***The BMG in Eastern Europe***

In general, the BMG evaluates that “Eastern European countries have functioning health care institutions”.<sup>23</sup> However, there is seen to be “insufficient coordination among numerous

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<sup>15</sup> The 1978 Alma Ata Declaration of Health promoted a comprehensive and participatory approach (See: Sanders, David. 2003: 1.). This was challenged by e.g. the World Bank in the 1980s, which pushed developing countries to adopt fiscal limits for health, a transition which was further emphasized by UNICEF, which began to advocate the more narrow GOBI (growth monitoring, oral hydration, breastfeeding, immunization) approach, targeting specific health factors in a disease-specific, top-down and vertical manner. See: UNICEF (2007).

<sup>16</sup> For example, the *2001 United Nations Declaration of Commitment on HIV/AIDS*. See: UN (2001).

<sup>17</sup> The *2002 United Nations Monterrey Consensus* (See: UN. 2002), where the promotion of donor country-led leadership was reiterated by the *2003 OECD Harmonizing Donor Practices for Effective Aid Delivery*, the *2003 Rome Declaration on Harmonization*, the *2005 Paris Declaration on Aid Effectiveness*, the *2005 High Level Forum on the Global Response to AIDS* and the *2006 Final Report of the Global Task Team*. See: OECD (2003), Rome Declaration (2003), UNAIDS (2006c: 256), UNAIDS (2006c: 268-9) and the Global Task Team (2005: 5, 20 and 11, respectively).

<sup>18</sup> UNAIDS (2005b: 7).

<sup>19</sup> See: UNAIDS (2005b: 12), and UNAIDS (2006c: 56, 58 and 256).

<sup>20</sup> In Dublin, and seven months later in Vilnius, the EU held two conferences to improve “coordination, cooperation and partnership” and to “help avoid duplication of efforts and maximise synergies” in HIV/AIDS policy. See: BMG (2005f).

<sup>21</sup> See: European Union (2007).

<sup>22</sup> See: BMG (2006e).

<sup>23</sup> BMG (2005f).



actors in the health care system.”<sup>24</sup> Several groups are underrepresented in policy making, and are furthermore stigmatized, lack access to medical facilities, and lack programs specifically tailored to their needs.

The BMG’s aims in Eastern Europe are to promote solidarity; encourage the provision of low-threshold services, in particular for high-risk groups; raise the awareness of governments affected; and support the transfer of knowledge through cooperation and exchange of experts.<sup>25</sup>

As mentioned above, however, nearly all of the BMG’s international HIV/AIDS projects are financed from budgets external to the BMG.<sup>26</sup> The consequence is that the BMG’s projects are very few in number, specific in nature and rather small in scale. An exception is a slightly broader technical cooperation project aiming at developing a prevention strategy in four regions (*oblasts*) of the Ukraine, which was initiated in 2006 together with the BMZ and has a budget (from the BMZ) of €1.5m (2006-9), to which the BMG plans to contribute €50-60,000. The project is also supported by UNAIDS and ILO.

The main foci of the BMG’s own projects lie in promoting health education, disease prevention and research. It cooperates actively with the BZgA in several countries in Eastern Europe (including Russia and the Ukraine) in its educational “In Circuit” program.<sup>27</sup> In 2004 the BMG also organized, together with the WHO, a workshop for self-help groups on HIV/AIDS prevention. In the same year, it organized a conference in the Balkans to bring together different stakeholders in HIV/AIDS. The BMG also financed travel costs and technical equipment for a project in the Saratow/Wolga region in Russia to train doctors to become aware of HIV/AIDS and TB, carried out by the Johanniter International.<sup>28</sup>

The BMG’s main strengths lie in the expertise it has accumulated through its experience with the successful German national HIV/AIDS strategy and in its membership and weight, via the German government, in a multitude of IGOs. However, the BMG continues to face the

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<sup>24</sup> BMG (2005f).

<sup>25</sup> See: BMG (2005f).

<sup>26</sup> See: BMG (2006g).

<sup>27</sup> “In Circuit” combines HIV/AIDS education with group tasks and discussions. It is targeted especially for young persons, but circuits have also been carried out for e.g. military personnel or prisoners. See: Gesellschaft für Technische Zusammenarbeit (2006).

<sup>28</sup> BMG (2001a).

challenges that its role viz. e.g. the BMZ and GTZ internationally is disputed, and it lacks its own funding. This is a problem which is exacerbated by the fact that the BMG is not actively involved in institutionalized HIV/AIDS policy partnerships or networks, resulting in lacking harmonization and coordination of strategies and policies.

### **3 The Context: HIV/AIDS in Eastern Europe and in the Ukraine, Russia and Estonia**

#### ***HIV/AIDS in Eastern Europe***

Eastern Europe has been claimed to be “on the brink of an AIDS disaster”.<sup>29</sup> Some argue that the epidemics “may come to rival that of sub-Saharan Africa in scope”.<sup>30</sup> Although the region experienced a slow start due to Soviet travel restrictions and strict social control, since the mid-1990s infections began to spread from drug-users in Ukraine to Russia and the rest of Eastern Europe at a time of severe socio-economic crisis and when drug trafficking routes from Afghanistan ran through Central Asia and Eastern Europe.<sup>31</sup> The speed of the spread of the epidemic has been argued to be its most worrying facet, with a twenty-fold increase in less than a decade<sup>32</sup> and a 70% increase of infection rates in 2005 alone (see Graphs 2 and 3).<sup>33</sup> The rise in rates runs counter to the global trend, where new infections peaked globally in the late 1990s.<sup>34</sup> The prevalence rate lies at 0.8% for Eastern Europe and Central Asia,<sup>35</sup> compared with the German rate among the population aged 15-49 of 0.1% and the Western European average between 0.2 and 0.5%.<sup>36</sup>

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<sup>29</sup> Quoting UNICEF, Spiegel Online (2006).

<sup>30</sup> UNAIDS (2006c: 3).

<sup>31</sup> See: Hamers, Françoise and Downs, Angela (2003).

<sup>32</sup> UNAIDS (2006c: 33-34).

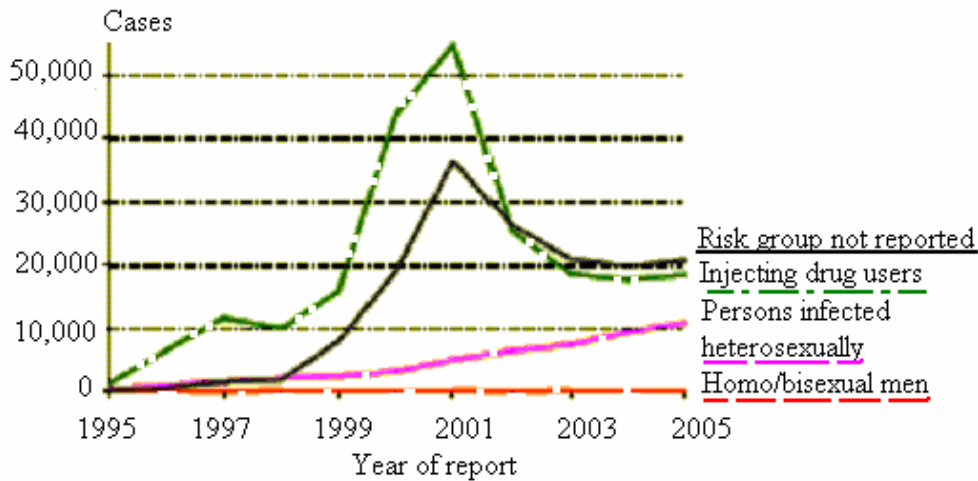
<sup>33</sup> Or 270,000 people. Spiegel Online (2006).

<sup>34</sup> *A note on data measurement: HIV/AIDS data is measured either in a generalized or a concentrated way. Generalized prevalence means that HIV infections exceed 1% of the general population and transmission is mostly through heterosexual intercourse. Concentrated data means that HIV is measured in high-risk groups, and this data is gathered through studies among these high-risk population groups. HIV risk is defined as “the probability of an individual becoming infected by HIV either through his or her own actions, knowingly or not, or via another person’s actions.”* UNAIDS (2006c: 105). Both generalized and concentrated testing may, however, fail to provide early warning for potential infection, as only infections that have already taken place are recorded. Behavioural monitoring (e.g. having unprotected sex with multiple partners or using contaminated or non-sterile injecting equipment) and biological marker testing (e.g. the presence of STDs or TB) could provide such information. See: UNAIDS (2006c: 9 and 278-9).

<sup>35</sup> These figures are argued to be gross underestimates of true cases, in particular among subgroups, as e.g. stigmatization of homosexuals in the region results in lacking testing among this group. UNAIDS (2004d). See also: Hamers, Françoise and Downs, Angela (2003).

<sup>36</sup> BMG (2005e).

Graph 2: HIV Infections Newly Diagnosed (1995-2005) by Transmission Group, Eastern-Europe



Source: Adapted from Eurohiv (2005).

A particular focus on certain subgroups of the population, such as sex workers, homo- and bisexual men, prisoners or sex workers is useful for several reasons. First, broader AIDS epidemics tend to start from these subgroups,<sup>37</sup> and they may act as an early warning for broader epidemics. Second, a focus on subgroups helps to understand the causes and conditions for the initial spread of HIV/AIDS.<sup>38</sup> Third, if HIV/AIDS begins to spread amongst subgroups, a viable HIV/AIDS strategy should ensure that these groups receive sufficient prevention, treatment and care, as such targeting has proven to be the most cost-effective and successful measure to slow down or even stop epidemics.<sup>39</sup> Although this study will focus on the five most-at-risk subgroups: *injecting drug users, sex workers, homo- and bisexuals, prisoners, and the youth*, other high-risk populations should not be forgotten.<sup>40</sup>

The average age of those newly infected is startlingly low in Eastern Europe. More than 80% of those infected are under 30 years of age, in contrast to 30% in Western Europe.<sup>41</sup> Behavioural factors - mainly drug use and unsafe sex - are the main drivers of infections.<sup>42</sup> Drug-users, mostly young, account for the highest number of new HIV/AIDS infections in

<sup>37</sup> UNAIDS (2006c: 258).

<sup>38</sup> UNAIDS (2006c: 69).

<sup>39</sup> UNAIDS (2006c: 104).

<sup>40</sup> E.g. women, girls and migrant workers. See: UNAIDS (2006c).

<sup>41</sup> UNAIDS (2004d: 4).

<sup>42</sup> UNAIDS (2004d: 3).

Eastern Europe, yet the figures for e.g. homosexual and sex worker transmission should be regarded with some caution,<sup>43</sup> as due to social stigmatization and legal penalization, infected persons may not identify themselves as such (see Graph 4).

One reason why the Eastern European epidemic among drug-users is argued to be so rapid and severe is that Eastern European countries have been reluctant to adopt harm-reduction measures (e.g. sterile needles), and many countries continue to marginalize drug-users from prevention and care services by societal and legal discrimination.<sup>44</sup> Prisons in Eastern Europe are argued to be “incubators of HIV infection”,<sup>45</sup> as prisoners tend to combine all problems of the other subgroups noted here. Importantly, heterosexual transmission is also increasing, implying that Eastern European epidemics are moving from being concentrated to generalized epidemics.<sup>46</sup>

### ***The Ukraine, Russia and Estonia***

The HIV/AIDS prevalence rates for case countries of this study lie above Eastern European and even global averages, with the Ukraine at 1.4%, and Russia and Estonia at 1.1% respectively (see Graph 2 above).<sup>47</sup>

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<sup>43</sup> See: Hamers, Francoise and Downs, Angela (2003: 1035). Homo- and bisexual men and sex workers are also rarely targeted by services and outreach programs, as in 2005, whereas 36% of sex workers were reached on a global level, this was the case for only 8% in Eastern Europe; 1 to 4% of homo- and bisexual men were reached in Eastern Europe compared to 9% globally. UNAIDS (2006c: 57 and 70 respectively).

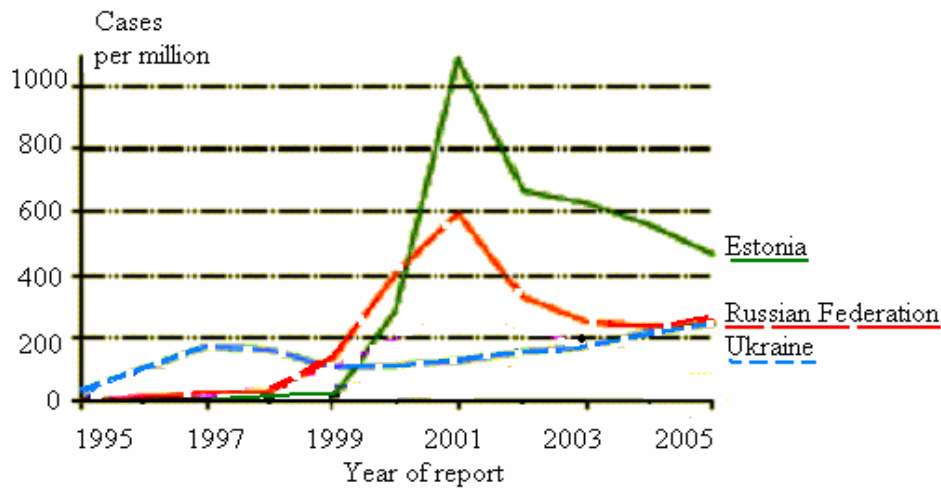
<sup>44</sup> See: Hamers, Francoise and Downs, Angela (2003: 1039).

<sup>45</sup> Hamers, Francoise and Downs, Angela (2003: 119).

<sup>46</sup> Hamers, Francoise and Downs, Angela (2003: 1038). See also Fn 34 for definition of concentrated and generalized epidemics.

<sup>47</sup> BMG (2005e).

Graph 3: HIV Infections Newly Diagnosed per Million Population by Year (1995-2005), Selected Countries, Eastern-Europe



Source: Adapted from Eurohiv (2005).

The particular problem of *the Ukraine* is that new annual HIV/AIDS diagnoses keep rising at a rapid rate. From 1988, when the first two cases were documented, new infections remained single or double-digit until 1996, when 159 new cases were found. Within three years, this figure had increased more than 60-fold, to 10,009 registered new cases in 2003.<sup>48</sup> The current annual doubling of new infections is not only worrying as such, but in particular because official figures are estimated to be gross underestimates, as they cover only official tests.<sup>49</sup> Furthermore, HIV/AIDS has now spread into the general population, with increasing heterosexual and female infection.<sup>50</sup> Although absolute numbers of HIV/AIDS are lower than in Russia, Ukraine's prevalence rate – the rate of infection out of the population - is the highest of all three case countries, lying at 1.4%.<sup>51</sup> Although now a generalized epidemic, the epidemic is to a large extent concentrated geographically.<sup>52</sup>

The main subgroup with HIV/AIDS infections and at the greatest risk of infection in the Ukraine is injecting drug users, accounting for 72% of officially registered HIV/AIDS cases.<sup>53</sup> In the Ukraine drug users are very young – 20% are still in their teens<sup>54</sup> - and drug-

<sup>48</sup> UNAIDS (2004c: 2).

<sup>49</sup> See: UNAIDS (2006c: 36).

<sup>50</sup> See: UNAIDS (2006c: 36).

<sup>51</sup> 410,000 HIV cases out of a population of 46,5m, of which 200,000 are women. UNAIDS (2006c: 437).

<sup>52</sup> In the regions of Dnipropetrovsk, Donetsk, Odessa, Mykolaiv and Crimea. UNAIDS (2006c: 2).

<sup>53</sup> UNAIDS (2004c: 2).

<sup>54</sup> UNAIDS (2004d: 5).

use often overlaps with sex work or imprisonment. Already marginalized in society and as no national information or prevention programs for most-at-risk populations exist, only a minority of high-risk persons are knowledgeable about transmission methods and are reached by prevention programs.<sup>55</sup> Furthermore, programs are conducted in a piecemeal manner, and the Ministry of Health, which so far heads the national HIV/AIDS policies in the Ukraine, does not have sufficient program management and coordination capacities.<sup>56</sup>

*Russia* has the biggest absolute number of HIV/AIDS cases in all of Europe.<sup>57</sup> 940,000 persons had HIV/AIDS in 2005 out a population of 143.2m, with a prevalence rate of 1.1%.<sup>58</sup> The epidemic emerged in the 1990s when political and economic turmoil resulted in economic and social dislocation of large parts of the population.<sup>59</sup> The epidemic in Russia peaked in 2001, when 88,422 new cases were recorded, and annual infection rates have remained relatively stable in recent years.<sup>60</sup> Although detected in 88 of Russia's 89 administrative territories, 10 of these territories account for 60% of HIV/AIDS infections, with St. Petersburg at the core.<sup>61</sup> Because some parts of the territory have above high prevalence (at 24% of the population), Russia's HIV/AIDS epidemic is not considered generalized but concentrated.<sup>62</sup>

As in the Ukraine, unsafe drug injection is the main cause of HIV/AIDS infection in Russia. 80% of HIV/AIDS cases were due to unsafe injecting drug use, mostly among men under 30 years of age.<sup>63</sup> The main problem is the illegality and stigmatization associated with drug use and with HIV/AIDS in general.<sup>64</sup> Drug users are deterred from HIV/AIDS testing and treatment facilities because their drug use is officially registered with government authorities.<sup>65</sup> Homosexual epidemics may also be taking place in Russia, but due to the considerable stigma associated with homosexuality, most cases are not reported. The Ministry

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<sup>55</sup> 39% of prisoners could identify transmission methods. UNAIDS. 2006c: 121. 21.2% of injecting drug users and only 8.1% of sex workers could identify transmission methods. 38.4% of drug-users, 33.7% of sex workers, and only 5% of homosexuals are reached with prevention programs. AIDS (2006c: 578 and 437 respectively).

<sup>56</sup> See: UNAIDS (2005b: 42).

<sup>57</sup> See: UNAIDS (2006c: 8).

<sup>58</sup> Women accounted for 210,000 of these cases. See: UNAIDS (2006c: 437).

<sup>59</sup> See: UNAIDS (2006c: 35).

<sup>60</sup> See: UNAIDS (2006c: 34).

<sup>61</sup> UNAIDS (2004d: 6).

<sup>62</sup> UNAIDS (2004b: 2).

<sup>63</sup> UNAIDS (2004d: 5).

<sup>64</sup> Outreach programs reach only 4.9% of drug users, 15.6% of sex workers, and 1% of homosexuals. Funding for harm reduction measures for drug users actually decreased by 29% between 2002 and 2004. UNAIDS (2006c: 437 and 115 respectively).

<sup>65</sup> See: UNAIDS (2006c: 117-8).

of Health, responsible for coordinating all programs, only spends a meager US\$ 0.28 per capita on HIV/AIDS.<sup>66</sup>

*Estonia* has one of the highest HIV/AIDS prevalence rates in Europe. The epidemic spread at an alarming rate in Estonia in the late 1990s, with single digit new cases in the 1990s rising to 390 new cases in 2000 and 1,474 in 2001. In 2002, however, new cases declined to 899 and in 2003, 258 new cases were reported.<sup>67</sup> Delayed but swift government reaction, with the help of the Global Fund, using prevention and harm reduction programs, has contributed to this decline.<sup>68</sup> In 2005, 10,000 persons out of a population of 1,33m had HIV/AIDS, resulting in a prevalence rate of 1.3%.<sup>69</sup> The Estonian epidemic is mainly concentrated among Russian-speaking Estonians who inject drugs, in particular in border regions located close to St. Petersburg.<sup>70</sup>

Two other risk groups are sex workers, who tend to come from St. Petersburg,<sup>71</sup> and prisoners, which accounted for 26% of new cases (the overlap with drug use is frequent).<sup>72</sup> However, whereas programs are uncoordinated and meager in the Ukraine and Russia, Estonia offers services free of charge to everyone in Estonia, albeit restricted to those with health insurance<sup>73</sup> and still neglecting border regions with Russia.<sup>74</sup> However, all programs are coordinated by the social ministry, with strong involvement from the justice, interior, defence and education ministries, as well as NGOs.<sup>75</sup> Following the rapid rise of infection rates, the government has reacted swiftly, targeting in particular drug users with needle exchange and methadone detoxification programs.<sup>76</sup>

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<sup>66</sup> In comparison, India spends US\$ 0.59 and Burkina Faso US\$ 1.87. UNAIDS. 2006c: 234. Russian per capita spending on health in general was US\$ 454 in 2001. UNAIDS (2004b: 3).

<sup>67</sup> UNAIDS (2004a: 6).

<sup>68</sup> See: Nemeth, Zsofia (2006).

<sup>69</sup> UNAIDS (2006c: 354).

<sup>70</sup> AIDS Prevention Centre. 2007. Most infections are in the regions of Narva, Kahtla-Jaerve and Tallinn UNAIDS (2004a: 2).

<sup>71</sup> Hamers, Françoise and Downs, Angela (2003: 1041).

<sup>72</sup> UNAIDS. 2004a: 2 and AIDS Prevention Centre (2007).

<sup>73</sup> Services are furthermore offered bilingually in both Estonian and Russian. See: AIDS Prevention Centre (2007).

<sup>74</sup> AIDS Prevention Centre (2007).

<sup>75</sup> Nemeth, Zsofia (2006: 70).

<sup>76</sup> AIDS Prevention Centre (2007).

## **4 The Processes: Conceptual Insights**

### ***Selection of Approaches***

Public sector agencies can no longer today expect to be able to be the sole providers of public policies.<sup>77</sup> They can not cope with the complexity and interdependencies of issues alone, even if they try to improve their performance through internal reforms. Such internal reforms may enhance efficiency, but do not ensure that effectiveness is improved.<sup>78</sup> To capture both efficiency and effectiveness gains, public sector agencies need to think about partners and networks.<sup>79</sup>

Specific theoretical research on international health policy coordination has not been conducted. There is, however, research on actor constellations at a more general level - e.g. on advocacy coalitions (Sabatier 1987), policy-learning (Sabatier and Jenkins-Smith 1993), institutional analysis and development (Ostrom *et al* 1994), and actor-centered institutionalism (Mayntz and Scharpf 1995).<sup>80</sup>

To offer a comparative evaluation of what could constitute best practice for HIV/AIDS actor coordination on a national and international level, the main findings of three different approaches have been selected for this study. These approaches are not mutually exclusive, but all offer different insights and thus complement each other. They have been selected because they most comprehensively cover what is required to define an effective, efficient and sustainable strategy.

### ***Network Theory***

Networks are defined as “structures of interdependence involving multiple organizations or parts thereof, where one unit is not merely the formal subordinate of the others in some larger hierarchical arrangement”.<sup>81</sup> Networks are formed because there is a belief that they offer

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<sup>77</sup> See: Pattberg, Philipp (2004: 2).

<sup>78</sup> On, e.g. performance-based-management (pbm), see: OECD (2004b).

<sup>79</sup> See: O’Toole, Laurence (1997: 45).

<sup>80</sup> For an overview of theories, see: Scharpf, Fritz (2000).

<sup>81</sup> O’Toole, Laurence (1997: 45).



efficiency advantages.<sup>82</sup> They can serve several different functions, such as exchange, cooperation, information sharing, joint problem solving or production, or reciprocity.<sup>83</sup> Just as there are several functions, networks can also take several forms.<sup>84</sup>

The main lesson from network theory is that different types of networks have different compositions, functions and also effects. For one, a network often does not only involve an actor who enters a network relationship with a partner (direct), but often also extends to the partners' partners (indirect). Loose networks with many indirect ties, providing for information, may be more beneficial to an actor if he already has several direct ties, which can provide both resources and information.<sup>85</sup> Second, networks can be either temporary (project-based) or involve longer-term resource-exchanges (program-based).<sup>86</sup> Because of longer-term resource commitments, program networks usually require the involvement of state agencies or international organizations, which have sufficient "finances, information and expertise".<sup>87</sup> Finally, the size of a network has implications. Large networks may have more political weight and legitimacy, but with increasing size, coordination costs increase and poor coordination and duplication may arise as a result.<sup>88</sup> The empirical finding is that stable and effective networks have "a limited core of agencies",<sup>89</sup> as these provide for higher levels of trust and coordination effectiveness.<sup>90</sup> In other words, indirect networks may be large, but the number of members in direct networks should be small.

Networks are argued to be useful for public sector agents because they "offer a way to provide services effectively while still maintaining acceptable levels of organizational and professional autonomy".<sup>91</sup> They may result in more cost-effective economies of scale, foster a greater sense of community,<sup>92</sup> and enhance shared norms and behavior.<sup>93</sup> Particularly in

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<sup>82</sup> The efficiency argument stems from game theory, where Axelrod (1984) argued that cooperation will produce outcomes that are more favorable to both parties than when the parties compete. See: Podolny, Joel and Page, Karen (1998: 58). On game theory and networks, see also O'Toole, Laurence (1997: 49).

<sup>83</sup> See: Agranoff, Robert and McGuire, Michael (1998: 69) and Ahuja, Gautam (2000: 432).

<sup>84</sup> Such as formal or informal, intra- or inter-sectoral, coordinative or collaborative, cohesive or disconnected, or single-issue or multiplex. On these types, see Agranoff, Robert and McGuire, Michael (1998: 69 and 89); Ahuja, Gautam (2000: 425); and Provan, Keith and Millward, H. (2001: 69).

<sup>85</sup> Ahuja, Gautam (2000: 448-9 and 431).

<sup>86</sup> See: Agranoff, Robert and McGuire, Michael (1998: 71-2).

<sup>87</sup> Agranoff, Robert and McGuire, Michael (1998: 87).

<sup>88</sup> See: Provan, Keith and Milward, H. (2001: 418).

<sup>89</sup> Provan, Keith and Milward, H. (2001: 418).

<sup>90</sup> See: O'Toole, Laurence (1997: 49).

<sup>91</sup> Provan, Keith and Milward, H. (2001: 415).

<sup>92</sup> See: Podolny, Joel and Page, Karen (1998: 66).

<sup>93</sup> See: Ahuja, Gautam (2000: 432).

health policy government agencies operate not only in one but in several networks,<sup>94</sup> “due in part to categorical funding streams that pay for one type of service but not another and in part to traditions of service organized around a single, narrowly defined problem or illness.”<sup>95</sup> However, public sector involvement in networks raises accountability questions, due to resource sharing and more non-transparent provision of services.<sup>96</sup> Participation may also require time, financial and human resource contributions that agencies can not justify. Enduring networks also require that partners share an “ethic or value-orientation”<sup>97</sup> and that there is compatibility between “organizational cultures, and commonality of organizational goals”.<sup>98</sup> Incompatible organizational interests or procedures may result in political turf battles, resource sharing problems, and eventually policy incoherence. The most important finding is that for networks to be effective, a network administrative organization (NAO) is necessary, which takes a leading role in network governance. Without it, commitment levels of participants to the network goals and coordination among participants has been found to be low, resulting in poor network outcomes.<sup>99</sup>

### ***Epistemic Communities***

Epistemic communities are less institutionalized and formal than networks, although there is a great deal of overlap between the two concepts. An epistemic community is defined as “a network of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue area”.<sup>100</sup> The main factors that bind these communities together are “a shared set of normative and principled beliefs” and “shared causal beliefs”,<sup>101</sup> which differentiate them from other forms of networks, such as interest or issue groups or professions, where knowledge but not necessarily normative values may be shared.<sup>102</sup> These normative values are narrowly defined, which means that epistemic communities have relatively few members.<sup>103</sup> The main function

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<sup>94</sup> See: Agranoff, Robert and McGuire, Michael (1998: 84).

<sup>95</sup> Provan, Keith and Sebastian, Juliann (1998: 435).

<sup>96</sup> See: O’Toole, Laurence (1997: 50), Agranoff, Robert and McGuire, Michael (1998: 89), and Provan, Keith and Milward (2001: 420).

<sup>97</sup> Podolny, Joel and Page, Karen (1998: 60).

<sup>98</sup> Podolny, Joel and Page, Karen (1998: 72).

<sup>99</sup> See: Provan, Keith and Milward, H. (2001: 419).

<sup>100</sup> Haas, Peter (1992: 3).

<sup>101</sup> Haas, Peter (1992: 3).

<sup>102</sup> See: Thomas, Craig (1997: 223).

<sup>103</sup> See: Haas, Peter (1992: 27).

of epistemic communities is to act as “channels through which new ideas circulate from societies to governments as well as from country to country”.<sup>104</sup>

As with different types of networks, there can be different types of epistemic communities. The main differences in types are determined by the scope, strength and duration of cooperation.<sup>105</sup> In particular the strength of cooperation, which is dependent on the positions that the community members hold within agencies and governments, has been found to be important. Hereby a community’s strength is determined not only by who the participants are, but where they are located.<sup>106</sup>

As epistemic communities are based on shared values and beliefs, an entire agency or even department is unlikely to form an epistemic community. This means that members of epistemic communities may be employed in the public sector, but they tend to be spread across several agencies, and possibly across several countries. The most important, but also most debatable argument in the literature is that communities cannot be formed in a top-down manner, and that “politically imposed committees typically provide little more than the appearance of coordination”.<sup>107</sup> Political actors can, however, use ideas of existing epistemic communities to legitimate or justify policies, or delineate or clarify policy alternatives, as they can provide information on complex interlinkages and probability statistics.<sup>108</sup> The finding has indeed been that more powerful decision makers tend to accept only technical advice that enables them to pursue preexisting ends.<sup>109</sup> In other words, they can ignore or react in different ways to consensual evidence provided by experts and thus mere “learning does not necessarily lead to policy coordination”.<sup>110</sup>

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<sup>104</sup> Haas, Peter (1992: 27).

<sup>105</sup> See: Thomas, Craig (1997: 236).

<sup>106</sup> In particular “political infiltration” into government agencies, which are seen as more legitimate and official, is seen as enhancing strength. See: Haas, Peter (1992: 27).

<sup>107</sup> Thomas, Craig (1997: 224-5). Whether shared values and interpretations cannot be formed in a top-down manner is debatable. As is evident from network theory, findings point to an opposite view. A successful example of such a case could be argued to be the World Bank’s institutionalized ‘Thematic Groups’ (also called ‘Communities of Practice’) See: World Bank (2007b).

<sup>108</sup> World Bank (2007b: 15-6).

<sup>109</sup> See: Haas, Peter (1992: 14).

<sup>110</sup> Haas, Peter (1992: 30).

## ***Donor Partnerships***

Although most of the literature on donor partnerships is normative in nature,<sup>111</sup> this section aims to provide a more comprehensive overview on different forms of donor partnerships, drawing mainly on the Soros Foundation's practical handbook "Building Donor Partnerships." Donor partnerships can be very broadly defined as a cooperative relationship between "two or more individual organizations [who] find it in their common interest to work together toward a specific outcome".<sup>112</sup> This definition illustrates that there are "many ways to achieve a partnership – different structures of partnership, different partners, and different ways of forming them".<sup>113</sup>

Donor partnerships are most frequently categorized in terms of actor constellations, e.g. whether they are multi-donor, bilateral or some other form (e.g. NGO). These differ in complexity and formality, but what is common to all is that to endure and be effective, partnerships require a lead partner or coordinator. Although multilateral coordination frequently receives more attention, the bilateral model is more frequently viewed as more practical by governments. Multilateral partnerships are seen as less transparent, slower, and inefficient. Because bilateral aid can, however, according to research, lead to fragmentation and duplication, a compromise of "bilateral aid within a multilateral framework"<sup>114</sup> has been proposed, and also adopted in some circumstances.<sup>115</sup> Donor partnerships can be also classified in terms of whether they provide program or project-based aid. Programs are more comprehensive and sustainable in form, involving a multi-year commitment from donors in terms of financial and non-financial resources.<sup>116</sup> Projects, on the other hand, are more short-term and directly target some particular policy aspect. Although donors appear to prefer projects because they can bypass national strategies – if these exist - in order to provide a more transparent and direct effect, research on sustainable policy effectiveness shows that the "program approach rather than a project approach should be applied"<sup>117</sup> to ensure that a coherent overall strategy is followed.

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<sup>111</sup> For example, debates include whether aid should be given or not and whether actors with for-profit interests should be involved.

<sup>112</sup> Bassler, Terrice and Wisse Smit, Mabel (1997: 1).

<sup>113</sup> Bassler, Terrice and Wisse Smit, Mabel (1997: foreword).

<sup>114</sup> Rosenstein-Rodan, Paul (1968: 224-5). Italics from original removed.

<sup>115</sup> The MDGs could be argued to be such a case.

<sup>116</sup> Rosenstein-Rodan, Paul (1968: 43).

<sup>117</sup> Rosenstein-Rodan, Paul (1968: 223).

## **5 Analysis: Four Alternative Strategies**

This section will outline four alternative strategy options that the BMG faces in terms of positioning itself in international HIV/AIDS policy. The conclusion and policy recommendations that follow from the strategy options aim to provide clarity and give guidance at a time of “strategic uncertainty”<sup>118</sup> in international HIV/AIDS policy.

### **Strategy One – Vertical Cooperation**

Vertical cooperation is the simplest form of cooperation outlined in this study. An even simpler strategy would be for an actor not to cooperate at all, but to implement its own policies. This alternative is not seen as viable for the BMG internationally, neither politically or economically, as it would have to build its own field capacities, expertise, and acquire significant new resources.

Vertical cooperation here means that the BMG would bilaterally cooperate with one other actor in a target country, most likely with the health ministry or its equivalent. Although some information is provided by the target country into the cooperative relationship, most information and resources flow from the BMG to the country. In terms of the typologies of cooperative relationships outlined in Chapter 4, this type of vertical cooperation tends to have the following characteristics: First, it is more narrow than comprehensive in its policy objectives, and hence rather project than program-based. Second, it is more top-down than bottom-up, and thus formal in nature. Third, the relationship is direct and the group of participants is *per se* small.

A vertical cooperation strategy has potential benefits in terms of compatible working cultures, transparency, control and costs. Health ministries may share more interests and values across countries than they do with other national ministries or organizations. Funds and work flows can be monitored more transparently, thus enhancing accountability. And costs can be kept in control, as there is a formal agreement, a clear policy objective and a pre-determined budget. However, although efficient in terms of cost and time, vertical cooperation has significant weaknesses in terms of effectiveness and sustainability. It can be effective in the very narrow

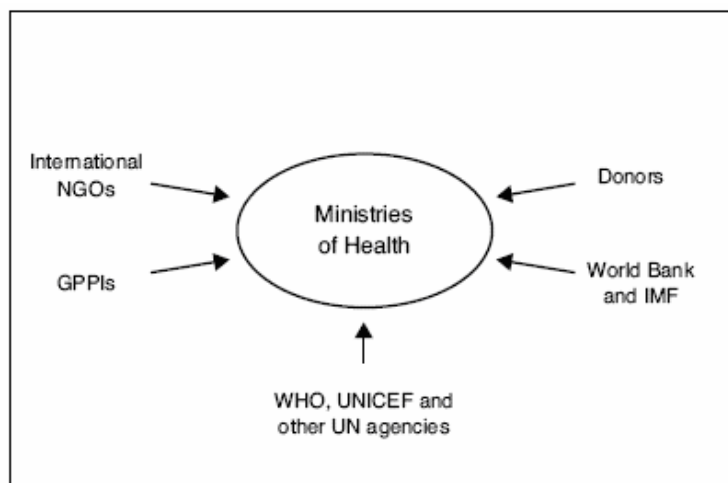
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<sup>118</sup> Garret, Laurie (2007).

foci of its projects, but if an HIV/AIDS strategy aims to be not only medical (e.g. focusing on treatment), but also tries to tackle behavioural aspects driving the epidemics,<sup>119</sup> not to mention the socio-economic roots thereof, vertical cooperation reaches its limits, not only in terms of mandates, but also with regard to expertise required and financial and human resource costs. Many important interconnections and facets of the HIV/AIDS problem are therefore often left unaddressed, resulting in an ineffective outcome overall.

The main problem with vertical cooperation is that it is not sustainable for the target agency or country, which not only has to deal with one cooperation partner, but all other international cooperation partners as well (see Graph 5). It has to plan and negotiate with a multitude of actors and has to produce separate financial and program reports for each external partner.<sup>120</sup> This not only results in a combination of inefficient duplication and serious gaps in responses,<sup>121</sup> but is a severe administrative burden and a drain on scarce human resources and time.<sup>122</sup> This situation exacerbates already difficult economic situations, in particular in the Ukraine and Russia. The donor agency also wastes resources, expertise and time by not coordinating with other donors.

*Graph 5: Problem with Vertical Coordination: The Circus of External Agencies and Initiatives*



*Source: Global Health Watch (2005-6), p.78.*

<sup>119</sup> Behavioral programs include e.g. information provision, risk assessment, and negotiation skill development. UNAIDS claims they are the most cost-effective interventions available. Garret, Laurie (2007: 127).

<sup>120</sup> See: Global Task Team (2005: 13).

<sup>121</sup> See: UNAIDS (2006c: 254).

<sup>122</sup> See: UNAIDS (2005b: 34).

## ***Strategy Two – Horizontal Donor Cooperation***

Horizontal donor cooperation means that international donors coordinate their HIV/AIDS policies in some form, before recipients are targeted with narrow disease-specific programs (vertically). In terms of the conceptual framework of this study, such a strategy is top-down, and can include both projects and programs, although these are narrow rather than comprehensive in nature. Cooperative relationships among donors are more informal, as the general agreements and declarations that are signed in this context are by no means binding. The size of networks is usually very large.

Donor coordination attempts through global alliances, such as UNAIDS and the Global Fund, have mushroomed recently.<sup>123</sup> Currently, over 70 global health partnerships (GHPs) exist.<sup>124</sup> However, the horizontal coordination approach has several problems. First, agreements and declarations are not binding, and often include over-ambitious goals that are difficult to coordinate and implement in practice. Reality is therefore not always what it appears to be on paper.<sup>125</sup> In HIV/AIDS policy specifically, it is argued that “information is not systematically shared by multilateral institutions and international partners”,<sup>126</sup> a problem that exists even within such agencies such as UNAIDS<sup>127</sup> and between agencies such as the Global Fund and the World Bank, resulting in a great deal of duplication.<sup>128</sup> Steering such vast alliances, or coordinating the work of 60,000 NGOs working in HIV/AIDS policy is, of course, a nearly impossible task. The improvements in efficiency and effectiveness are therefore highly questionable. And if coordination is not really taking place in reality, the same sustainability problems arise as noted with regard to the first strategy.

Even in theory, coordination has costs, as someone has to take time and be paid for coordinating activities.<sup>129</sup> Second, coordination rarely commences from a blank slate, making

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<sup>123</sup> Such as UNICEF’s GOBI, mentioned above.

<sup>124</sup> Department for International Development’s Health Systems Resource Centre (2005: 23).

<sup>125</sup> Alma Ata is not the only declaration that seems to have been forgotten and replaced by others, more recent declarations such as the Cairo Declaration on Population and Development (ICPD), focusing on sexual and reproductive health services, has not been compatible with rigid and fragmented donor policies. See: Mayhew, Susannah (2002: 221-2).

<sup>126</sup> Global Task Team (2005: 14).

<sup>127</sup> Global Task Team (2005: 14).

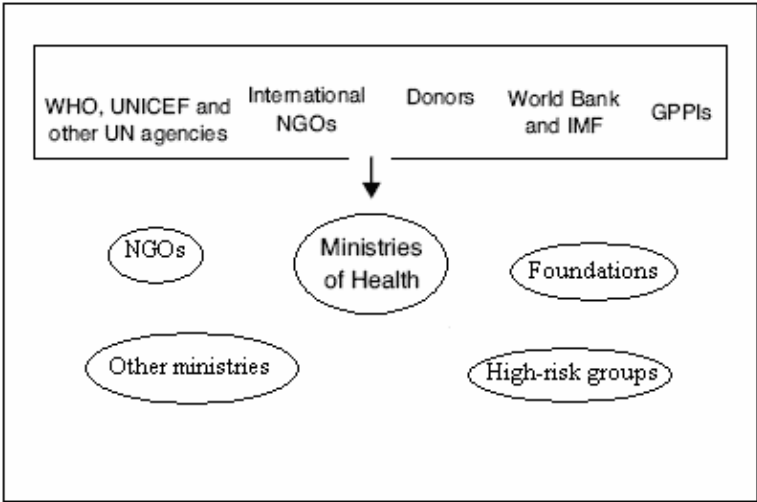
<sup>128</sup> Global Task Team (2005: 8).

<sup>129</sup> On whether cooperation is seen as necessary, one survey respondent answered that these efforts “have to be financially supported. Additional personnel is needed.” See also the findings from the conceptual section in Chapter 4.

coordination difficult when “donors have already developed their own programs and established their own ways of working within a given area”.<sup>130</sup> And finally, too much coordination may harm fruitful competition. Perhaps it is beneficial that some duplication takes place and that there is some choice on offer in terms of strategies, projects and partners. Even if efficiency and sustainability are not optimized, it could be that effectiveness is attained.

The main drawback of this strategy, however, lies not in whether coordination is truly taking place on the donor level or not, but that it assumes that the target recipient is sufficiently representative, knowledgeable and powerful to implement the project or program effectively. It could well be that the recipient, here the health ministry, is only a small, or not a representative stakeholder at all (see Graph 6). The effectiveness of this strategy therefore mainly depends on the choice of the recipient stakeholder and its capacities.

*Graph 6: The Problem of Donor Coordination: Donor coordination without Target State Level Coordination*



**Strategy Three – Horizontal Cooperation at the Target State Level**

Horizontal donor cooperation at the target state level means HIV/AIDS policies are coordinated between all relevant national stakeholders in the country which receives aid. Ensuring coordination on a national level in the target state has been argued to be essential for policy efficiency, effectiveness and sustainability. The entire Three Ones strategy, outlined

<sup>130</sup> Bassler, Terrice and Wisse Smit, Mabel (1997: 5).



above, is based on this premise.<sup>131</sup> Without a harmonized national strategy or a coordinated framework, important stakeholders may be left out, and information and resources are not distributed or targeted effectively, resulting in contradictory policies, duplication and shortages. The willingness of donors to engage is also argued to be undermined if a national AIDS framework is lacking, as “time-consuming efforts are needed to determine who does what, when, and where”.<sup>132</sup>

Not only must there be a national strategy, but key stakeholders, including international actors, need to be involved in its development and implementation. However, international stakeholders are to play a secondary role, as it is argued that “countries must lead and bilateral and multilateral organizations must follow”.<sup>133</sup> This leadership role, played by a national AIDS authority, is argued to lead to efficiency and sustainability gains for the target country. Involving stakeholders such as NGOs in the planning and particularly in the implementation of the strategy also ensures higher policy effectiveness, as NGOs can “reach under-served areas or groups or geographically remote areas”.<sup>134</sup>

However, as with donor coordination, horizontal coordination at the target country level may ensure effectiveness, efficiency and sustainability on paper, but not in practice, and even in theory there are several caveats. In many developing countries, the national AIDS authority often lacks the political authority, capacity or will to coordinate activities,<sup>135</sup> and little coordination thus takes place.<sup>136</sup> This is in combination due to domestic political turf wars, cultural mistrust between sectors and organizations, unclear or lacking mandates and legislation,<sup>137</sup> international power relationships, and a general unwillingness to reform rigid models and procedures.<sup>138</sup>

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<sup>131</sup> The Three Ones strategy, which envisages “one framework, one authority and one monitoring and evaluation system” is similar to the concept of sector wide approaches (SWAPs), whereby “all significant funding for the sector supports a single sector policy and expenditure programme.” Global Health Watch (2005-6: 78).

<sup>132</sup> Global Health Watch (2005-6: 11).

<sup>133</sup> UNAIDS (2006c: 254).

<sup>134</sup> Department for International Development’s Health Systems Resource Centre (2005: 17).

<sup>135</sup> See: Global Task Team (2005: 13 and 15).

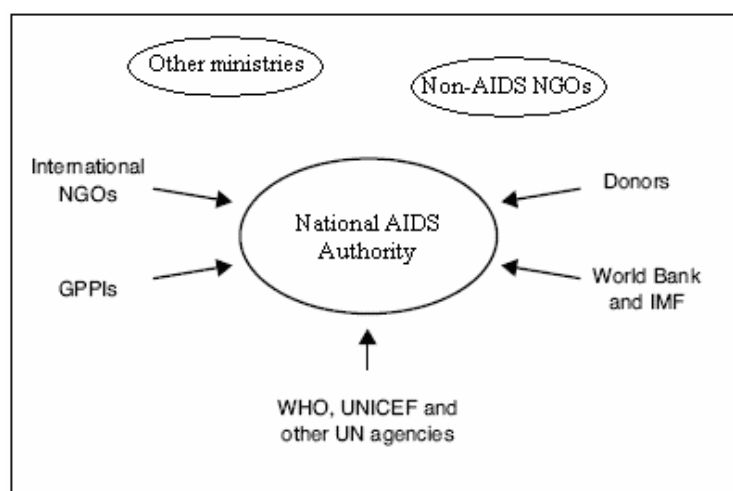
<sup>136</sup> The consequences of a weak national AIDS authority were predicted by network theory, the findings of which showed that if a network administrative organization (NAO) is missing or too weak, coordination does not take place and policy outcomes are poor. See also: UNAIDS (2005b: 17); Global Task Team (2005: 12); and Global Health Watch (2005-6: 74).

<sup>137</sup> See: Global Task Team (2005: 9). This was confirmed in a telephone interview with a German ministerial employee, who stated that “we are not keen to work with NGOs, they only want funding from us”

<sup>138</sup> See: Global Task Team (2005: 12-3) and Global Health Watch (2005-6: 78).

What exacerbates the problem is that, as HIV/AIDS problems frequently interlink with drug policies, other health and education policies and socio-economic contexts, inclusion of stakeholders “beyond special HIV/AIDS projects”<sup>139</sup> would also be vital, but is often not taking place in practice (see Graph 7). Lack of coordination is not only inefficient and ineffective, but is also unsustainable in the long run, as parallel projects drain scarce human resources, e.g. from primary health care.<sup>140</sup>

*Graph 7: The Problem with Target State Level Coordination: Partial Target State Level Coordination without Donor Coordination*



#### ***Strategy Four – Horizontal Donor Cooperation and Horizontal Cooperation at the Target State Level***

In this fourth strategy, donors coordinate their activities, as in strategy two, and in parallel target country level actors coordinate their own actions, as in strategy three, resulting in two levels of coordination. Coordination between the two levels can occur either in a top-down or bottom-up manner, although resources are transferred mainly top-down. Ties between the two vertical levels are direct and formal, whereas ties between the horizontal actors can be a combination of both direct and indirect.

The aim of such a strategy is to include all important stakeholders, both national and international, into planning and implementation. This aim arises from the finding that target

<sup>139</sup> The BMG defines this group broadly, as “all actors and sectors involved in development of a country need to be included” BMG (2005f).

<sup>140</sup> McCoy, David et al.; 3 and Global Task Team (2005: 13).

“governments feel they are left out of the various now-institutionalized donor forums where donors harmonize their efforts and set agendas *for* developing countries rather than *with* developing countries”.<sup>141</sup> The strategy is based on the assumption that each partner has unique perspectives and resources that it can contribute.

Such comprehensive coordination is argued to result in efficiency gains, as parallel systems resulting in wasteful duplication are eradicated. Improvements in effectiveness arise as broad stakeholder involvement ensures that all subgroups are taken into account. And sustainability is ensured in that national AIDS authorities and coordinators receive continuing support and resources over time. The MDGs could be seen as such a cooperation strategy.

However, as with strategies two and three, full coordination has its problems. The theoretical arguments against coordination will not be repeated here again, but they are of course exacerbated as coordination is taken a step further. More practically, the problems with this approach can be illustrated when looking at the MDGs. The MDGs give rise to a collective action problem as it is not clear whether states or donors should be taking the lead.<sup>142</sup> Parallel to this problem, there is no clear coordinator (in terms of network theory, an NAO). Without an NAO, as noted above, networks have been found to be highly inefficient and ineffective – and here the networks concerned are truly vast in size.

Furthermore, narrow targets can result in duplication and distortion, as resources are channeled to a few select sources. Effectiveness may be undermined if the approach chosen does not include important causal factors that might require a more comprehensive approach.<sup>143</sup> And sustainability may be undermined if, e.g., workshops that aim to coordinate the work of health sector employees lead to health workers spending nearly all of their time and resources on coordination activities, rather than on trying to implement HIV/AIDS policies (see Graph 8).<sup>144</sup> Effectiveness in itself may also be undermined directly if the consensus or compromise strategy reached through coordination is not the optimal strategy. For example, the MDG foci on treatment and cure<sup>145</sup> may be a suboptimal relative to a focus on prevention and a more comprehensive policy.

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<sup>141</sup> UNAIDS (2005b: 35). Italics in original.

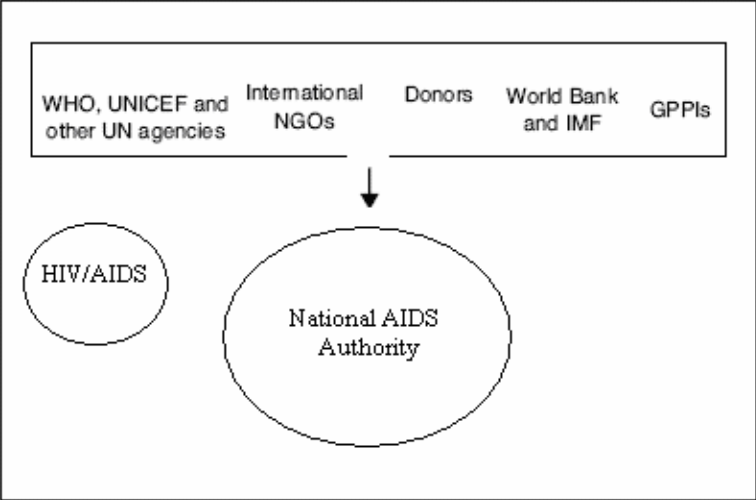
<sup>142</sup> See: Global Task Team (2005: 14).

<sup>143</sup> See: Travis, Phyllida et al. (2004: 903).

<sup>144</sup> Travis, Phyllida et al. 2004: 903 and Garret, Laurie (2007).

<sup>145</sup> See: Department for International Development’s Health Systems Resource Centre (2005: 3).

*Graph 8: The Problem with Donor and Target State Level Coordination: Donor and Target State Level Coordination that Does Not Effectively Deal with HIV/AIDS*



## **6 Conclusion and Recommendations**

From the analysis of the four strategies outlined above, it becomes evident that each strategy has effectiveness, efficiency and sustainability benefits as well as costs. Instead of being able to tick off boxes in a matrix as to which strategy is the most effective, which the most efficient, and perhaps which proves to be the most of all three criteria, a realistic choice of strategy is based on the acceptance that both costs and benefits will always be involved. This study has tried to make more explicit these benefits and costs, both in theory and in practice.

The effectiveness criteria is, however, as noted in the introduction, believed to be the most important criteria, although it cannot be divorced from the other two. All three criteria therefore need to be considered, unless a purely short-term approach is desired – this is, however, not believed to be the case.

This study has found, first, that the BMG can make a valuable contribution to Eastern European HIV/AIDS policy. It can do so, first, membership and weight, via the German government, in a multitude of international organizations. And second, it can use its expertise in developing and implementing the successful German national HIV/AIDS strategy. Many elements of the German strategy are transferable also to other countries, as the strategy both targets high-risk groups (which is needed in all three case countries) and the general population (increasingly needed in the Ukraine). The transferability of the German HIV/AIDS and national coordination strategy to other contexts is possible in theory, but a precondition in practice is that there is sufficient political will and physical and human resource capacities in the target country. As the BMG on its own cannot ensure sufficient political and financial clout, it needs to rely on and cooperate with other German and/or international actors.

A second finding of this study is that the Ukraine is the most problematic case of all three countries, as infection rates continue to rise and the epidemic is also beginning to spread into the general population. The BMG's capacities should therefore concentrate on this case, with the BMZ and BMG project in the Ukraine therefore being a step in the right direction. This does not, however, rule out the option of engagement in the other two countries, if the BMG feels that it has sufficient capacities and resources for such parallel undertakings. Indeed, the geographical interrelatedness of the three cases would encourage such an approach.

The added-value of this study for the BMG, and hopefully also other actors engaged in international HIV/AIDS policy, is that policy coordination can provide vast efficiency, effectiveness and sustainability advantages, but also has costs. The findings from network theory and donor partnership literature clearly show that it is important to design networks in a manner suitable to the policy aims, partners and contexts. The epistemic community approach helps to keep in mind that coordination may not always be effective if designed in a top-down manner, and that using existing epistemic communities may be a better starting point.

These findings have been expanded on in the analysis of four alternative strategies for HIV/AIDS coordination. Vertical coordination (strategy one) has been found to be the most viable option, in particular for a ministry, and may be an effective strategy in terms of reaching narrow, single-issue policy objectives. However, it has vast efficiency and sustainability costs, as well as broader effectiveness costs if several fragmented projects do not add up to a coherent and comprehensive whole. It is therefore a viable strategy only as a starting point, e.g. to initiate pilot projects, or if no other strategy is available.

To ensure long-term effectiveness, horizontal coordination must take place at the target state level (strategy three). This means that the activities of all relevant stakeholders at the national level should be coordinated. However, as in particular network theory findings have shown, such coordination is very costly. A framework for coordination must be defined in a precise and viable manner (e.g. in terms of size and the nature of institutional linkages) in order to ensure that efficiency advantages outweigh costs and that such a network is sustainable in the longer run. This strategy should not, however, be taken too far, as strategy four has illustrated that vast coordination activities may become too costly, ineffective and a mere end in itself.

The final conclusion of this study is that different types of coordination for HIV/AIDS policy can take place in different contexts, and with different timeframes. In the short run, vertical coordination might be the most realistic strategy where a comprehensive strategy is lacking and where coordination mechanisms are not yet in place. As HIV/AIDS is still a deadly infection, wasting time to find more viable options is not an alternative. This case applies to the Ukraine out of the three case countries in this study. However, where target state and donor coordination is more developed (as is the case especially in Estonia), an actor must choose whether it can offer value-added expertise or resources to such structures (if not, it can

continue to pursue strategy one also in the long run), or whether it could contribute to improving these structures from within (strategies two, three or four).

The following table outlines policy recommendations for the BMG for its HIV/AIDS policy, in particular with regard to prevention activities in the Ukraine, Russia and Estonia.

*Table 2: Policy Recommendations*

	<b>Need for BMG engagement?</b>	<b>Priorities</b>	<b>Proposed coordination mechanism SR</b>	<b>Proposed coordination mechanism LR</b>
<b>Ukraine</b>	Yes (SR and LR)	Comprehensive: High-risk groups and universal prevention.	Vertical coordination.	Improving target-level coordination.
<b>Russia</b>	Yes (LR)	High-risk groups, lesser focus on universal prevention.	Indirectly through existing donor coordination.	Improving target-level coordination.
<b>Estonia</b>	Yes (SR)	Selective: Russian-speaking minorities, in particular IDUs, along the border region to Russia.	Indirectly through existing donor and target-state coordination structures.	No engagement proposed for LR (only indirect with border-states).

\* *SR=short run (2-4 years), LR=long run (5-10 years)*

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## **List of Abbreviations**

AA	German Foreign Office
AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti-retroviral treatment
BMBF	German Federal Ministry of Education and Research
BMG	German Federal Ministry for Health
BMI	German Federal Ministry of the Interior
BMU	German Federal Ministry for the Environment, Nature Conservation and Nuclear Safety
BMZ	German Federal Ministry for Economic Cooperation and Development
BZgA	German Federal Centre for health Education
DAC	Development Assistance Committee of the OECD
EU	European Union
EU SANCO	Directorate General for Health and Consumer Affairs
GFTAM	The Global Fund to Fight Tuberculosis, AIDS, and Malaria
GHP	Global Health Partnership
GNI	Gross National Income
GPPI	Global public-private initiatives
GO	Governmental Organization
GOBI	UNICEF Program for Growth monitoring, Oral rehydration, Breastfeeding and Immunization
GTZ	German Technical Cooperation Agency
HIV	Human Immunodeficiency Virus
IGO	International Governmental Organization
ICPD	Cairo International Conference on Population and Development
MDG	Millennium Development Goal
MOH	Ministry of Health
MSM	Men who have sex with men
NAC	National AIDS Council
NGO	Non-Governmental Organization
OECD	Organization for Economic Cooperation and Development
PEPFAR	The United State President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
RKI	Robert Koch Institute
STD	Sexually Transmitted Disease
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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