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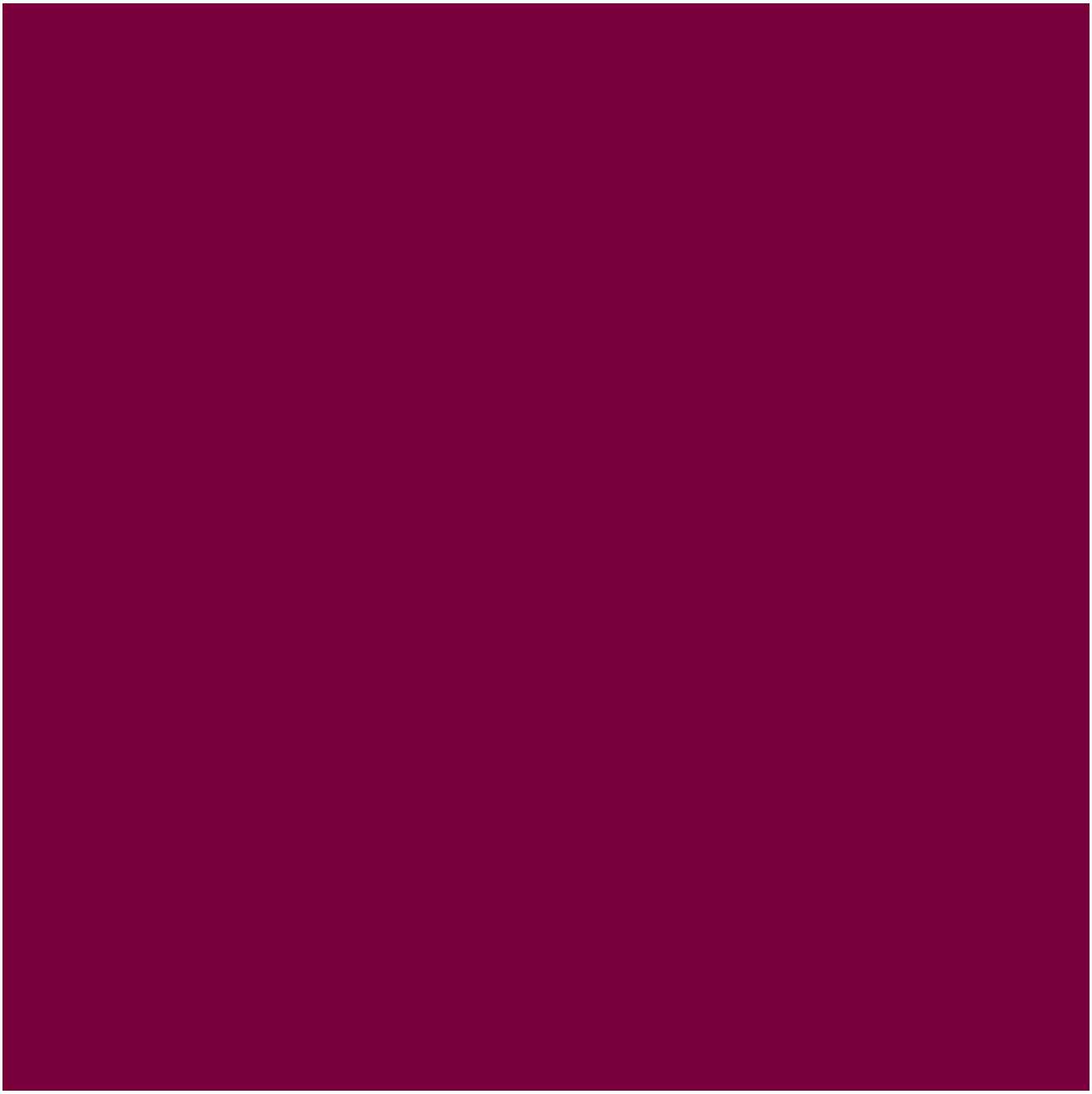
Annual Report 2006

# The Regional HIV and AIDS Team for Africa



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# List of Abbreviations

| | |
|---|---|
| AAU | Association of African Universities |
| AfDB | African Development Bank |
| AIDS | Acquired Immunodeficiency Syndrome |
| ARASA | Aids and Rights Alliance of Southern Africa |
| AMREF | African Medical and Research Foundation |
| ANERELA+ | African Network of Religious Leaders Living with or Affected by HIV/AIDS |
| ARV | Anti-retrovirals |
| ART | Anti-retroviral Treatment |
| AU | African Union |
| BOCAIP | Botswana Christian AIDS Intervention Project |
| CADRE | Centre for AIDS Development, Research and Evaluation |
| CIDA | Canadian International Development Agency |
| CODESRIA | Council for the Development of Social Science Research in Africa |
| DfID | Department for International Development, the UK |
| DRC | Democratic Republic of Congo |
| EAC | East African Community |
| EANASAO | Eastern Africa Network of AIDS Service Organisations |
| ECOWAS | Economic Community of West African States |
| Equinet | Regional Network for Equity in Health in Southern Africa |
| FAO | Food Agriculture Organisation |
| FBO | Faith Based Organisation |
| FCM | Family Care Model |
| FEMINA-HIP | FEMINA-Heath Information Project |
| GART | The Golden Valley Agricultural Research Trust |
| GBS | General Budget Support |
| GDP | Gross Domestic Product |
| GLIA | Great Lakes Initiative on AIDS |
| HACI | Hope for Africa Children Initiative |
| HDI | Human Development Index |
| HEARD | Health Economics and AIDS Research Division at University of KwaZulu Natal |
| HIV | Human Immunodeficiency Virus |

| | |
|---|---|
| HRDI | Human Rights Development Initiative |
| IAS | International AIDS Society |
| IAEN | International AIDS Economics Network |
| ICASA | International Conference on AIDS and STDs in Africa |
| IDASA | Institute for Democracy in South Africa |
| IFRC | International Federation of the Red Cross |
| IGAD | Intergovernmental Authority on Development |
| IHAA | International HIV/AIDS Alliance |
| IMF | International Monetary Fund |
| IOM | International Organisation for Migration |
| IPC | Initiative Privee et Communautaire |
| IPPF | International Planned Parenthood Federation |
| JAS | Joint Association Strategy |
| JFA | Joint Financial Arrangement |
| KK-Foundation | Kenneth Kaunda Foundation |
| KKCAF | Kenneth Kaunda Children of Africa Foundation |
| MAP | Media Action Plan |
| MDG | Millennium Development Goals |
| MLG | Ministry of Local Government |
| MoFA | Ministry for Foreign Affairs |
| MOU | Memorandum of Understanding |
| MTEF | Medium Term Expenditure Framework |
| NAC | National AIDS Council |
| NACA | National AIDS Coordinating Authority |
| NGO | Non Governmental Organisation |
| NORAD | Norwegian Agency for Development Cooperation |
| NIR | International Council of Swedish Industry |
| OSSREA | Organisation for Social Science Research in Eastern and Southern Africa |
| OVC | Orphans and Vulnerable Children |
| PEPFAR | US President's Emergency Plan for AIDS Relief |
| PHAMSA | Partnership on HIV/AIDS and Mobile Populations in Southern Africa |
| PLWHA | People Living With HIV and AIDS |
| PMTCT | Prevention of Mother to Child Transmission |
| PRSP | Poverty Reduction Strategy Paper |
| PSG | Project support Group |
| RATN | Regional AIDS Training Network |
| REC | Regional Economic Community |
| RENEWAL | Regional Network on HIV/AIDS, Rural Liveli hood and Food Security |
| REPSSI | Regional Psychosocial Support Initiative |
| RFSU | Swedish Association for Sexuality Education |
| RIATT | Regional Inter-Agency Task Team on Children and AIDS |
| RRD | Sida Resource Centre for Rural Development based in Nairobi |
| SADC | Southern Africa Development Community |
| SAfAIDS | Southern Africa HIV/AIDS Information Dissemination Service |
| SANASO | Southern Africa Network of AIDS Service Organisations |
| SAT | Southern Africa AIDS Trust |
| SAREC | Department for Research Co-operation, Sida |

| | |
|---|---|
| SEK | Swedish Kronor |
| SEKA | Cooperation with NGOs, Humanitarian Assistance and Conflict management, Sida HQ |
| Sida | Swedish International Development Agency |
| SOMA-Net | Social Science and Medicine Africa Network |
| SRHR | Sexual and Reproductive Health and Rights |
| STI | Sexually Transmitted Infection |
| STEPS | Social Transformation and Empowerment Projects |
| SWAP | Sector Wide Approach to Programming |
| TASO | The AIDS Service Organisation, Uganda |
| TARSC | Training and Research Support Centre |
| UN | United Nations |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNDP | United Nations Development Programme |
| UNECA | United Nations Economic Commission for Africa |
| UNFPA | United Nations Population Funds |
| UNGASS | United Nations General Assembly Special Session on HIV/AIDS |
| UN-HABITAT | United Nations Human Settlements Programme |
| UNICEF | United Nations Children's Fund |
| UNZA | University of Zambia |
| VCT | Voluntarily Counselling and Testing |
| WHO | World Health Organisation |
| WB | World Bank |
| YMEP | Young Men as Equal Partners |

# 1. Summary

Over the last decade the epicentre of the global epidemic has moved from eastern to southern Africa. Today, SADC is the hardest hit sub-region with half of all persons living with HIV on the African continent, and about one third of all positive people on the globe. Simultaneously the prevalence rates are levelling off in some countries, while the silent impact is moving from illness to death and increasing numbers of orphans, with the brunt of the impact on society still to come. In a study covering four countries in sub-Saharan Africa the IMF showed that the poverty incidence and the poverty gap increases when HIV and AIDS hits livelihoods, acknowledging that this disease "can throw a considerable share of the population into poverty even in cases where researchers do not expect a significant fall in income per capita."

Response to the heterogeneity of the epidemic in a context of global funding mechanisms and vertical policies is challenging. In 2006, the African year of prevention, recognition of this diversity is essential for effective prevention, and opens up for discourse on more specific evidence-based interventions, looking at micro-epidemics amongst Injecting Drug Users and Men having Sex with Men both in the general population and in prisons.

In Southern Africa SADC has taken an increasingly prominent role with the think tank meeting on prevention and coordination meetings for heads of National AIDS Coordinating Agencies. A build up of capacity within the organisation was made possible through a Joint Financing Arrangement where a group of bilateral donors and the UNAIDS have joined forces under the leadership of the Swedish-Norwegian Team.

The experience from regional programming and comparative studies funded by the Team provided a solid platform for support to Swedish and Norwegian Embassies. An IDASA-study concluded that the epidemic creates a democratic deficit when parliamentarians pass away, and delayed by-elections see the ruling parties in the region winning in most cases. CADRE studied prevention communication in a number of countries to conclude that it has had an impact, but a more focussed strategy with well targeted and researched campaigns would be much more effective. Again, heterogeneity needs attention. Seminars on HIV and AIDS in Conflict Settings, Mainstreaming in the Water Sector, how to work with HIV and AIDS in Broader Cooperation and a Focal Point Meeting that brought together Swedish, Norwegian and Irish colleagues from 13 African countries were highlights of the embassy support during 2006.

In response to the Paris Declaration the Team, together with UNAIDS and six bilateral colleagues developed a Joint Framework for Regional Support to the HIV and AIDS response. The framework was used as input to the Swedish Regional Strategy currently with the Government for approval. Further harmonisation was achieved late in the year when the Norwegian Government signed an agreement with Sida to become a full partner in the Team proving funding and planning to step up the Norwegian staff to two advisors.

At the UNAIDS PCB Meeting in Lusaka in December, the Team organised field visits for the delegates and an exhibition for regional partner organisation to provide an opportunity for global level decision makers to learn from local and regional actors.

The Team's bilateral responsibility grew to include Swedish financed interventions in both Botswana and Angola by the end of the year.

# 2. Strategic Development Trends and Key Issues for Dialogue

## 2.1 HIV and AIDS and its Impact in Sub-Saharan Africa

*Sub-Saharan Africa* is still the region worst affected by HIV & AIDS. In 2005 60% of all persons living with HIV, 79% of all orphans due to AIDS, 71% of AIDS-related deaths, and 66% of all new infections were in the region (Table 1)[1]. At the same time, the average adult HIV prevalence rate for Sub-Saharan Africa continues to level off, but at the relatively high level of 6.1%. Rather than indicating any generalized trend towards decline in rates of infection however, this stabilization reflects the balancing out of new infections with AIDS-related deaths.

**Table 1. HIV and AIDS in Sub-Saharan Africa: Selected Indicators**

| Global/Region | adults & children living with HIV | | adult prevalence (%) | Adults & child AIDS-related deaths | Orphans (0–17) | HDI score |
|---|---|---|---|---|---|---|
| | 2005 | | 2005¤ | 2005 | 2005 | 2004* |
| | Total | % women¤ | | | | |
| Global | 38 600 000 | 48 | 1.0 | 2 800 000 | 15 200 000 | 0.741 |
| Sub-Saharan Africa | 24 500 000 | 59 | 6.1 | 2 000 000 | 12 000 000 | 0.472 |
| Central | 1 128 900 | 59 | 6 | 90 700 | 571 600 | 0.501 |
| EAC (East) | 4 040 000 | 58 | 5.1 | 405 000 | 3 530 000 | 0.451 |
| IGAD (Horn) | 1 603 000 | 58 | 2 | 179 300 | 691 000 | – |
| SADC (Southern) | 13 354 100 | 59 | 20.7 | 1 011 000 | 5 275 000 | 0.487 |
| ECOWAS (West) | 4 772 000 | 61 | 2.6 | 452 600 | 2 058 800 | 0.414 |

*Unweigthed averages, Source: Derived from UNAIDS 2006 Report on the global AIDS epidemic

There are wide sub-regional variations in the epidemic; The sub-regional breakdown employed here follows membership[2] of the Regional Economic Communities (RECs). Some of the divergence is due to differences in the pathogenesis of the *HIV-1 and HIV-2* sub-types of the virus[3]. The more virulent and transmissible HIV-1 has been consistently identified in Southern Africa, while HIV-2 is more likely to be found in Western and central Africa.

[1] Data cited are from the UNAIDS 2006 Report on the global AIDS epidemic.

[2] As far as possible, dependent upon data availability.

[3] ADF 2000 "HIV/AIDS and Economic Development in sub-Saharan Africa" UNECA

*SADC*[4] (excluding Tanzania, Mauritius, Seychelles and Madagascar), the global epicentre of the pandemic, is home to 55% of all persons living with HIV. Prevalence also appears to have stabilized in this sub-region, but at the very high level of 20.7%. Based upon data from sites on the major trucking routes to Malawi, South Africa, and Zimbabwe, there is some evidence however that the epidemic may be expanding in Mozambique and South Africa suggesting a possible causal link to the epidemics in those countries.

Zimbabwe experienced an apparent behavioural-change related decline in adult prevalence, from 22.1% in 2003 to 20.1% in 2005. A significant part of that fall is attributable to high AIDS-related mortality. The long-term impacts of ongoing food shortages and impoverishment in that country are not yet evident, but the vulnerabilities created have implications for the future course of the epidemic.

The data for *Central Africa*[5] (excluding Angola, DRC, Sao Tome & Principe) indicate a stable but relatively high adult prevalence rate of 6%. This level is second only to the SADC region.

HIV prevalence in the *EAC* (including Burundi, Kenya, Rwanda, Tanzania and Uganda), also shows evidence of stabilization, at 5.1%. But in Uganda, increases in some rural prevalence rates could signal a breakdown in the prevention efforts which facilitated the gains made in the 1990s: A 2004/05 survey found erratic condom use and a resurgence in multiple sexual partnerships[6]. In Kenya and Tanzania there are also disturbing signs of increasing Intravenous Drug (heroin) Use, especially amongst Commercial Sex Workers. In Tanzania, users have been observed practising "flashblood" or "backloading" – drawing blood by syringe from one user, and re-injecting the same blood into another user.

Only in the *IGAD* countries[7] (excluding Kenya and Uganda) is the HIV prevalence rate (2%) lower than in the *ECOWAS* sub-region[8] (2.6%). While prevalence in Senegal is low (0.9%) high infection levels have been observed among Men who have Sex with Men (MSM). In Mali, increasing prevalence has been observed among pregnant women, suggesting that the epidemic may be expanding in that country.

**Table 2. Trends in the Human Development Index (HDI)[9] in the SADC Region**

| | DRC | Angola | Malawi | Mozambique | Zambia | South Africa | Namibia | Zimbabwe | Lesotho | Botswana | Swaziland |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **adult HIV prev. rate 2004** | 3.2 | 3.7 | 14.1 | 16.1 | 17.0 | 18.8 | 17.0 | 20.1 | 23.2 | 24.1 | 33.4 |
| **2000 HDI rank** | 155 | 161 | 163 | 170 | 153 | 107 | 153 | 117 | 132 | 126 | 125 |
| **2004 HDI rank** | 167 | 161 | 166 | 168 | 165 | 121 | 165 | 151 | 149 | 131 | 146 |
| **+/-** | **-12** | **–** | **-3** | **-2** | **-12** | **-14** | **-12** | **-34** | **-17** | **-3** | **-21** |

[4] Angola, Botswana, DRC, Lesotho, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, Zambia, Zimbabwe

[5] Cameroon, Central African Republic, Chad, Congo, Equatorial Guinea, Gabon

[6] MoH 2005 Uganda HIV/AIDS sero-behavioral survey 2004–2005, Preliminary Report

[7] Djibouti, Eritrea, Ethiopia, Somalia, Sudan

[8] Benin, Burkina Faso, Cote d'Ivoire, Gambia, Ghana, Guinea, Guinea-Bissau, Mali, Níger, Nigéria, Senegal, Sierra Leone, Togo.

[9] Composite measure of life expectancy at birth; adult literacy; and per capita GDP (UNDP 2005). The HDI ranges from 0 (negative) to 1 (positive).

The UNDP HDI is a useful tool for assessing the impact of HIV & AIDS on the quality of life. Analysis of the HDI trend within SADC suggests a debilitating link between HIV and AIDS and the quality of life. Between 2000–2004, 11 countries[10] fell by an average 11 places in their HDI rank (Table 2).

The pandemic is having a serious impact on the *demographic structure* of Sub-Saharan Africa, where deaths to 20–49 year olds constituted 60% of all deaths in 2005, compared to 20% between 1985–1990. This has serious negative implications for *economic growth, household structure, and the development of human capital.* AIDS-related morbidity and mortality compounds the negative growth effects of the brain-drain of skilled and professional staff, depletes institutional continuity, places additional pressure on an already overburdened health system, and increases the direct *(health-care)* indirect *(reduced productivity)* costs to both government and business.

By 2005 the number of *orphans due to AIDS* had escalated to 12 million in Sub-Saharan Africa. Approximately 9% of children under 15 were living without 1 or both parents, and 1 in 6 households cared for at least one orphan. The impact is greatest in the SADC sub-region, which has about 44% of Sub-Saharan Africa's orphans due to AIDS. These orphans face impoverishment, malnutrition, and loss of educational opportunities: this is especially true of girls, but also of boys. The plight of orphans, and their caregivers, is exacerbated by the fact that the burden of care often falls to elderly grandparents and female-headed households, the most vulnerable in the community. Women already bear the brunt of the disease – approximately 60% of adults living with HIV are female – yet female-headed households taking care of people with HIV-related illness support a larger number of orphans than male-headed households.

*Sex between men* is banned in every country except South Africa. It is therefore difficult to obtain accurate data on HIV infection among men who have sex with men (MSM) in the general population. The paucity of comprehensive data is acute for *prisons* which are high risk environments for infection, yet underserved by prevention, treatment and care interventions. Infection may occur from unprotected sex between men, often associated with violence and intimidation, and in the presence of STIs, and from unsafe injecting practices, (UN 2003)[11]. Related facilitating factors are overcrowding, shortages and consequent transactional sex, and the presence of juveniles alongside adult prisoners. In women's prisons the risk of infection arises from unprotected sex between male prison staff and inmates. There are a few country-specific studies which do give some indication of the extent of the problem. In Cameroon's New Prison and South Africa for example, HIV prevalence rates of 12.1% and 41%, respectively, have been found amongst the prison population (UNAIDS 2006).

## 2.2 Poverty Situation

Poverty is a cause, a symptom or a consequence of situations which have arisen as a result of insufficiencies with regard to: respect for human rights, democracy and good governance, equality between women and men, sustainable use of natural recourses and protection of the environment, economic growth, social development and social security and peace and human security[12].

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[10] South Africa, Namibia, Botswana, Madagascar, Zimbabwe, Zambia, Malawi, Mozambique

[11] UN 2003 un Office for the Coordination of Humanitarian Affairs

[12] Sida's Position Paper – Poverty Reduction Strategies, 2005

HIV & AIDS is one of the greatest obstacles to development in Africa. In some of the worst affected countries, life expectancy at birth has declined by more than 20 years. The impact on society at large comes in waves – maturation of the epidemic; illness, death; and, a stark increase in the number of orphans. The cost to the wider society is potentially enormous. Simulation analysis based on household data confirms earlier evidence that the impact of HIV & AIDS on poverty indicators often goes beyond its impact on average incomes. A recent IMF working paper[13] shows that poverty incidence and the poverty gap increases more than would be expected from the decline in income per capita. Thus, the disease can throw a considerable share of the population into poverty even in cases where researchers do not expect a significant fall in per capita income.

Higher HIV prevalence rates for women and girls compared with boys and men, demonstrates the underlying gender inequalities within poverty that are fuelling the epidemic.

Sub-Saharan Africa is the poorest region in the world. 313 million people live below the poverty line. The improved growth[14] in recent years is welcome, but still falls well short of the 7% annual growth rate needed to meet the Millennium Development Goal (MDG) of halving poverty by 2015 (and Sub-Saharan Africa is not on target to meet the other MDGs either)[15]. This in a situation where more resources are required to scale up HIV & AIDS prevention activities, care and treatment, and impact mitigation.

## 2.3 Macro-Economic Development

HIV & AIDS undermines economic growth by negatively affecting the quantity and quality of labour, savings and investment, and the effectiveness of government. The HIV & AIDS-development link is complex, and difficult to model. Available evidence nevertheless, does suggest significant HIV & AIDS impacts on economic growth. In terms of GDP[16] growth Sub-Saharan African economies, which grew by an average of 5.1%, performed somewhat better than the global economy, which grew by an average of just over 5% (IMF 2006)[17]. But this performance was not evenly distributed across the region:

[13] HIV/AIDS: The Impact on Poverty and Inequality, Gonzalo Salinas and Markus Haacker

[14] Expected at 5.2 percent 2006

[15] IMF:s World Economic Outlook, Sept. 2006

[16] The intra-national (mal)distribution of income/wealth is not factored into this measure.

[17] MF 2006 World Economic Outlook, Database, September 2006

**Table 3. Economic Performance 2004–2006: Global and Sub Saharan Africa**

| | economic growth rate (%)* | | | HIV prev. rate 2005 | Contributory factors[18] |
|---|---|---|---|---|---|
| | 2004 | 2005 | 2006 | | |
| **Global** | 5.3 | 4.9 | 5.1 | 1 | + *domestic demand* in US, Canada and Asia (China, India) |
| **Sub-Saharan Africa** | 5.6 | 5.8 | 5.2 | 6.1 | + high *commodity prices* (oil, gold, platinum, diamonds, copper, tea, coffee arabica); ODA and debt relief (HIPC[19], MDRI[20]); FDI; tourism; lower inflation; improved fiscal balances |
| **EAC** | 5.2 | 5.1 | 5.2 | 5.1 | + strong *agricultural production* (Tanzania, Rwanda, Uganda, Kenya); continued *donor support* (Burundi, Uganda; tourism) |
| **ECOWAS** | 3.3 | 5.6 | 5.2 | 2.6 | + strong tertiary sector growth<br>– negative growth in Liberia<br>– political tensions in Togo, Cote d'Ivoire, and Guinea Bissau |
| **IGAD**** | 6 | 6.2 | 5.9 | 2 | + *oil* production (Sudan)<br>+ strong *agricultural performance* (Ethiopia)<br>+ investments in new *port facilities* (Djibouti) |
| **SADC** | 4.8 | 4.7 | 4.8 | 20.7 | + strong *South African* economy; rising *oil* production and prices (Angola); *agriculture* (Mozambique); *service sector* growth (Botswana, Mauritius); *minerals* (DRC, Zambia); donor support (DRC, Madagascar)<br>– social and political tensions in Zimbabwe |
| **Lesotho** | 2.7 | 1.3 | 1.6 | 23.2 | |
| **Swaziland** | 2.1 | 1.9 | 1.2 | 33.4 | |
| **Central Africa** | 7.7 | 4.2 | 3.6 | 6 | + rising oil production and prices (Chad, Equatorial Guinea) |

Source: IMF 2006 World Economic Outlook, Database, September 2006 and UNECA 2005, 2006 Economic Reports on Africa.
*Unweighted average
**Excluding Somalia

The following is a simple ranking of RECs by general growth trend over the three (3) years:

a) IGAD ≈ 6% per ann. – influenced by strong performances in agriculture (Ethiopia), and oil (Sudan)
b) ECOWAS – generally above 5% per ann. if the negative growth impact of Liberia in 2004 is removed
c) EAC – just above 5% per ann., influenced by strong performance in agriculture (Tanzania, Rwanda, Uganda, Kenya), donor support to Burundi, and tourism
d) Central Africa – affected by decelerated growth in Cameroon, Chad, Equatorial Guinea, Sao Tome and Principe
e) SADC.

The SADC sub-region, which is the epicentre of the HIV & AIDS pandemic, performed poorly. This status cannot be attributed entirely to Zimbabwe's negative growth, which is counterbalanced by the strong South African economy; the oil boom in Angola; strong agricultural performance by Mozambique; service sector growth in Botswana and Mauritius; minerals marketing in the DRC and Zambia; and, continued donor support to the DRC and Madagascar. Instead, the impact of HIV

[18] UN Economic Commission Africa (UNECA) 2005 and 2006 Economic Reports on Africa.

[19] Highly Indebted Poor Countries

[20] Multilateral Debt Relief Initiative.

and AIDS on agricultural performance in some of the hardest hit countries has been for suggested as a contributory factor in the SADC region's low economic performance (Annan 2005)[21].

In agriculture, HIV&AIDS destabilizes production by reducing the quantity and quality of labour. Areas of land under cultivation and crop diversification may decline as people die, or become too ill to work. Similarly, livestock production may also fall. Wages may increase as labour supply falls, thereby altering the relative prices of commodities on local and international markets, and reducing their competitiveness.

With the loss of entire generations of teachers, health workers, civil servants and other skilled and professionals, AIDS mortality also diminishes the nation's capacity to manage both the epidemic, and economic development. ILO and UNECA estimate that in 2004, HIV&AIDS reduced the rate of economic growth in Southern Africa by about 0.9%[22].

## 2.4 Political Development, Good Governance and Human Rights

### 2.4.1 Commitment, coordination and regional initiatives

In March 2006 high level representatives from governments and multilaterals from all over Africa met in Brazzaville for a continent-wide consultative meeting on scaling up HIV prevention, treatment, care and support in Africa towards Universal Access[23]. The AU later endorsed the outcome of the Brazzaville meeting at their special summit on HIV/AIDS Tuberculosis and Malaria in Abuja in May[24]. At the same meeting the AU also declared 2006 the year of prevention. SADC subsequently organised an Expert Think Tank on HIV Prevention in Maseru later in May[25], defining the key drivers of the epidemic in Southern Africa to be "Multiple and concurrent partnerships by men and women with low consistent condom use, and in the context of low levels of male circumcision." Contributing factors were defined as male attitudes and behaviours, intergenerational sex, gender and sexual violence, stigma, lack of openness and untreated viral STIs, all set within a virally conducive social structure, high population mobility, inequalities of wealth, cultural factors and gender inequality.

At the global level the five year follow-up to UNGASS 2001 took place in New York in late May. The declaration reiterated many of the commitments from 2001, and acknowledged that "national and international efforts have resulted in important progress in the areas of funding, expanding access to HIV prevention, treatment, care and support and in mitigating the impact of AIDS, and in reducing HIV prevalence in a small but growing number of countries, and also acknowledged that many targets contained in the declaration of 2001 had not yet been met.[26] Unfortunately the well prepared joint agenda from the African constituency was not fully utilised, as Gabon and Egypt, who represented the continent in the meeting, did not completely agree with the document. This was most probably due to the Egyptian government objections to a rights based approach to SRH in the universal access agenda.

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[21] Kofi A. Annan, United Nations Secretary General, Letter of appeal for Humanitarian Assistance for Southern Africa, August, 2005

[22] ILO&UNECA 2004 Employment-friendly macroeconomic policies

[23] http://www.afro.who.int/press/2006/pr20060306.html

[24] www.africa-union.org Universal access to HIV/AIDS, Tuberculosis and Malaria Services by A United Africa by 2010

[25] Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa REPORT, SADC, May 2006

[26] UN 2006 High-Level Meeting on AIDS

At regional level the Team participates in an informal coordination group of donors and UN agencies working at regional level. The group developed a Joint Framework in 2006, in response to the Paris Declaration of 2005. By late 2006 it was presented to SADC for their consideration.[27] The work has already contributed to an increasing number of JFAs. By the end of 2006 six JFAs were signed with partners.

On the initiative of UNICEF, a Regional Inter-Agency Task Team (RIATT) on Children and AIDS was formed in October to bring together stakeholder in four key working areas – tracking of resources, social protection, advocacy and coordination. The formulation of RIATT was a direct follow up to the Global Partner Forum for children affected by HIV and AIDS that took place in London in February.

### 2.4.2 Human rights and gender

There is an increasing acknowledgement of a gradual shift in the human rights agenda. From being focused on confidentiality and protection of the rights of infected people, the trend is now a wider human rights based approach, taking into consideration the rights of non-infected, when applicable[28]. More accessible testing, care and treatment[29] and commitment towards universal access[30] are important reasons behind the shift[31]. Increased numbers of civil society organisations, PLHIV, medical staff etc want a normalisation of testing, highlighting the urgent need to treat HIV as any other disease if the region shall come to terms with stigma and denial. Some claim that the previous tendency not to treat HIV and AIDS as any other disease, has added to stigma and discrimination. Laws against intentionally spreading the virus are on the increase in the region. In addition, legislation to promote the human rights of PLHIV, women and children, and vulnerable groups need to come into effect.

The region is moving towards a strengthened agenda around sexual and reproductive health and rights. The African Union's 2005 decision on an action plan to strengthen the access to sexual health is a big step forward. AU states that "today, by any measure, less than one third of Africans have access to reproductive health (RH)", and declares these rights key to reaching the MDGs. The decision calls for strengthening of the health sector component by increasing resource allocation to health, in order to improve access to services. Mainstreaming gender issues into socio-economic development programmes and SRH commodity security are also addressed[32].

Most people living with HIV are unaware of their status. By 2004 merely 10% of persons in need of testing in low- and middle- income countries actually had access to testing[33]. To come to scale with testing and treatment, in line with the "3-by-5 programme"[34] initiative, more countries are practising routine opt-out testing. This has generated

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[27] Joint Framework on Donor Coordination, U11 Ya22.3/20 3/12

[28] UNAIDS and OHCHR International Guidelines on HIV and Human Rights, consolidated 2006

[29] 1 million in the region is currently on treatment

[30] Member states of the African Union promised that by the end of 2006 every country will have set targets, defined actions and costs to guide a scaling-up of HIV prevention, treatment, care and support to reach Universal Access by 2010. By the end of 2006 many member states still had to fulfil their promise.

[31] UNAIDS and OHCHR Guidelines on HIV and Human Rights, consolidated 2006

[32] Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa – Maputo Plan of Action for the operationalisation of the continental policy framework for sexual and reproductive health and rights 2007–2010, September 2006

[33] UNAIDS/WHO Policy Statement on HIV testing, 2004

[34] 3 by 5 was instituted in 2003 meaning that 3 million people globally should be on ARV's by 2005

debate among human rights organisations, which claim that confidentiality might not be guaranteed. It is important to closely follow the trends in testing, to see how the regional level can contribute to policy development and good practise for increased testing in the region.

The feminisation of the epidemic in eastern and southern Africa is particularly evident, and worsening. 59% of people living with HIV in sub-Saharan Africa are female. By age of 24[35], young girls in parts of Africa are six times more likely to be HIV positive than their male counterparts. Limited access to resources and decision-making power puts females at greater risk, fuelled by poverty, unfavourable cultural practises and sexual and gender-based violence. Gender inequality leaves women with less control than men over their bodies and their lives. Women and girls have less information about how to prevent HIV, and fewer resources to take preventative measures[36]. Services are still not responding to these gender dimensions[37].

At the 2006 High Level Meeting on AIDS, all member states of the United Nations have pledged "to eliminate gender inequalities, gender-based abuse and violence" and to "increase the capacity of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and services, including, inter alia, sexual and reproductive health, and the provision of full access to comprehensive information and education".

### 2.4.3 Prevention, care and treatment

Globally as well as regionally there is an increased commitment and identified need to intensify HIV prevention efforts. Increased availability of testing is crucial for the roll-out of treatment, but also an important opportunity for prevention[3839]. In search for a strong regionally owned agenda SADC and UNAIDS held consultations on Social Change Communication with Southern African Editors Forum and at the SADC National AIDS Council Directors meeting. There was a consensus that reduced concurrent partnerships will be the focus of communication campaign interventions in SADC for the next one to two years. A similar process is planned for East Africa.

Communication is an important tool in any prevention intervention, a fact increasingly recognised in the region. A Sida commissioned study[40] concludes that, in order to have any impact on HIV incidence, prevention campaigns need to clearer follow the epidemical heterogeneity, like variations within geographical areas countries, gender, age, religion, cultural groups etc.

Anti-retroviral therapy has expanded dramatically in sub-Saharan Africa with approx. 1 million people receiving treatment[41], a tenfold increase since December 2003. Yet still only about a quarter (23 per cent) of the people in need of treatment receive it[42]. Constraints to a wider roll-

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[35] UNIFEM: Transforming the National AIDS Response, mainstreaming gender equality and women's human rights into the "three ones", 2006

[36] www.genderandaids.org

[37] www.unaids.org

[38] "Standing up for HIV prevention" conference in Stockholm in May 2006

[39] "Intensifying HIV prevention, UNAIDS policy position paper and UNAIDS Action Plan on Intensifying HIV prevention 2006–2007

[40] HIV/AIDS Communication in selected African Countries – Interventions, responses and possibilities, 2007

[41] WHO/UNAIDS, June 2006

[42] Seven countries in southern and eastern Africa, one third, achieved more than 20% treatment coverage. Three of sixteen countries in the region, one fifth, achieved the "3 by 5 target", UNAIDS

out, apart from political commitment and access to the actual drugs are limited availability of testing and the human resource crisis in the health sector.

During 2006 the lethal combination of HIV and TB was clearly evident when the drug-resistant tuberculosis (XDR-TB) was detected in South Africa. It was found mainly in HIV positive persons who are more vulnerable to develop drug resistance. The spread of XDR-TB constitutes a severe complication that increases the pressure for scale-up of routine testing, among other interventions. An emergency action plan has been decided to prevent a further spread[43]. The Team needs to closely follow developments in this area.

Male circumcision and its links to HIV is now a hot topic. Trials in Kenya, Uganda and South Africa have all shown that male circumcision significantly reduces a man's risk of acquiring HIV. The three sets of trials have shown circumcised men are up to 60% less likely to acquire HIV during heterosexual intercourse[44]. The latest research findings are driving potential change in the way male circumcision is practiced and implemented. Male circumcision is not to be viewed as a complete protection, and thus presents a communication challenge in order not to replace known prevention methods. WHO and UNAIDS outlines a few areas to take into account, including culture and human rights; safety and procedure; and the potential to undermine existing prevention strategies[45]. At the regional level the Team should follow further developments in the area and identify needs in policy, programming and research.

Each day, 1,800 children become infected with HIV, the vast majority of whom are newborns[46]. Access to the cheap and simple protocols for Prevention of Mother to Child Transmission (PMTCT) services varies considerably throughout the region. In four countries more than half are able to utilize services, whereas in eight countries less than 10% of women have access to ARVs to prevent mother-to-child transmission[47]. High cost has previously been a hindrance of large scale roll-out. However, recent studies show that single dose Nevirapine given to the mother during labour and to the child within 72 hours of birth costs as little as USD 4 per mother-child pair[48] and reduces the risk by more than 40 per[49]. When appropriately implemented, PMTCT has the potential to prevent infection in the 15–35% of babies who would otherwise be born HIV-positive[50].

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43 WHO meeting of a Global XDR-TB Task Force, 9–10 October 2006

44 Orange Farm Intervention Trial in South Africa 2005; Kisumu, Kenya; and Rakai in Uganda, both in 2006.

45 WHO/UNAIDS statement on Male Circumcision, 3 December 2006 and Male Circumcision and Comprehensive HIV Prevention Programming, Human Rights Ethical Legal Guidance. Geneva, 2006

46 UNAIDS, webpage: www.unaidsrstesa.org

47 ibid

48 AIDS in the 21st century, 2006

49 UNAIDS, webpage www.unaids.org

50 UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS, this Resource Pack aims to strengthen the impact of national HIV/AIDS programmes by tackling a key underlying factor that fuels the epidemic: gender inequality, 2006

# 3. Swedish Development Cooperation – Overall Assessment

## 3.1 Strategic Assessment and Considerations

In 2006 the Team was an important driver in drafting a Joint Framework for bilateral and multilateral organisations working regionally with HIV and AIDS[51]. The framework emphasises that ICPs decisions should be informed by evidence and strategic information and ensure relevance to an often rapidly changing epidemic and policy environment. The draft was utilised as input to the Swedish Regional Strategy for Development Cooperation with Africa currently with the Swedish Ministry for Foreign Affairs for consideration in anticipation of a Cabinet decision.

In the latter part of the year, the Reference Group[52] and an independent consultant performed a participatory capacity assessment of the Team. The report concluded that the Team had accomplished a great deal during the years of its existence, but that the Team should set up a log-frame to strengthen its results-based management, and to initiate discussions with other bilaterals on setting up a separate Team in West Africa, funded and supported by another bilateral agency. The process of developing the LFA for the Team has already started with the recruitment of a Monitoring and Evaluation officer in late 2006. In 2007 the new management will develop a full management response to the assessment.

In December 2006 Norway and Sida signed an agreement in which Norway commits to channelling regional funds for the HIV and AIDS response through the Team.

## 3.2 Key Issues on Dialogue

Through participating in SADCs Prevention Think Tank, in support to embassies and in other regional fora, the focus in dialogue has been on broad based prevention in order to reclaim it on the national and regional agendas. The human resources crisis has also stimulated dialog on flexible support in order to build national and regional systems to complement and mitigate the strong verticalisation of the response. In the dialogue with Swedish Embassies the directive to mainstream all contributions in high prevalence countries was important.

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[51] Joint Framework on Donor Coordination, U11 Ya22.3/20 3/12

[52] The Swedish-Norwegian HIV/ADIS Team for Africa has a reference group of African experts that are regularly consulted on strategic issues, decision HIV 74/2006.

## 3.3 Volumes and Disbursements

In 2006 the Team disbursed 198.65 MSEK out of the delegation of 200 MSEK from the budget allocation for regional development co-operation on HIV and AIDS.

The team also handled delegated funds from SAREC, Lake Victoria, and Burkina Faso and from these allocation accounts, 4.7 MSEK were disbursed during the year. In addition, the team disbursed 20 MSEK to bilateral HIV/AIDS programmes in Botswana and Angola. The Regional Advisor for culture, who is placed at the team, handles regional programmes for culture, totalling 11.5 MSEK for 2006, and out of the 8 MSEK delegated to the team, the entire amount was disbursed.

# 4. Thematic Overview of the Programme

## 4.1 Livelihood and Food Security

The work on food security and HIV/AIDS during the year focused on getting evidence-based data to reinforce the importance of integrating nutrition in care and support and how this translates into prolonged positive living. The Kenneth Kaunda Children of Africa Foundation (KKCAF) demonstrated that targeted nutrition saves and prolongs life. In particular, the use of locally cultivated food crops with essential nutrients proved effective. The conclusions drawn thus far are that: a) with improved nutrition, combined with ARVs, patients recover much faster with minimal stigma and are able to be productive again, b) training in nutrition provides a good entry point for interventions particularly with regard to VCT, PMTCT and ART administration, c) several local foods have been identified as immune enhancers, d) patients on ARVs combined with mushroom diet resulted in an improvement in CD4 count and e) a significant change was observed in full blood count in patients on ARVs and mushroom diet.[53] The technical and political dissemination strategy is now being developed to ensure that the findings benefit more countries in the region. The Golden Valley Agricultural Research Trust (GART) produced traditional seed crops with appropriate nutrients essential for PLWHA as recommended by the KKCAF and through NGOs made them available to communities. GART also promoted labour saving technologies and the utilisation of low input sustainable agricultural technologies in mitigating the impact of HIV and AIDS in households severely affected and infected by the pandemic. A regional workshop was convened to provide a forum for the exchange of experiences and to forge professional strategic alliances among food security projects supported by the Team. The outcome was the RENEWAL project under the International Food Policy Research Institute (IFPRI) commencing the process of compiling experiences by various projects with the aim of developing a dialogue matrix to positively influence food and nutritional security policies at country and regional levels.

The UN 2006 High-Level Meeting on AIDS declaration article 28[54] expressed political commitment on the need to incorporate food support as an integral part of a comprehensive response to HIV and AIDS.

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[53] Food Security and Nutrition Among PLWHA in Southern Africa (A Zambian Experience) U11 Ya 22.3/42

[54] UN 2006 High-Level Meeting on AIDS declaration

The article states that "all people at all times, will have access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life as part of a comprehensive response to HIV/AIDS". This recognition is of great significance as it falls well in line with team activities in the area of support to food security.

During 2006 the Regional Team entered into an agreement with Hope World Wide, to build organisational capacity to improve quality of services, effectiveness and efficiency amongst organisations working with children. The evaluation[55] of the Regional Psycho-Social Support Initiative (REPSSI) shows that REPSSI has built capacity and develop tools for psycho-social support utilised by 78 partner organisations in 13 countries over the last four years. The latest annual report from REPSSI shows that a total of more than 800 000 children have been reached through the network of the member organisations over the last five years.

The Team's support to mobile and migrant populations during 2006 was through IOM and the Project Support Group (PSG). The first phase of the IOM project on repatriation of Angolan refugees from Zambia came to an end, and preparations for a new phase was initiated. The project on the vulnerabilities of migrant workers in West African countries is ongoing. Within the extended agreement with PSG, the organisation has increased the level of research activities in order to improve its on-going activities, as well as to share best practices among the partner organisations.

On delegation from the Sida/Lake Victoria Initiative the Team prepared support to AMREF for their capacity-building and policy harmonization on mobile populations within the Lake Victoria Basin. The project will start in 2007.

An experts' meeting on regional public goods was organised to tease out potential areas of intervention at regional level[56]. As a result of the expert workshop on Regional Public Goods the idea of a Regional Observatory on HIV and AIDS related to commodities in Africa came up. Many HIV commodities are in short supply in the region. It often depends on the erratic demand and sometimes on the constraint on the supply side. There are also a number of quality issues that many countries with limited capacity have to handle. The Regional Team has entered into an agreement with WHO to conduct a study on HIV commodities related to supply, quality, procurement planning and funding. The aim is to create transparency on costs in the region and in the long run a better market situation on HIV commodities.

The impact on older people is reaching crisis point as traditional Africa extended family coping mechanisms are stretched to the limit. Few governments are incorporating older people issues in their national HIV and AIDS responses. In 2006, the Team started to support HelpAge international – Africa regional office. This collaboration so far made it possible for the organisation to make inroads in collaborating, for advocacy purposes, with intergovernmental bodies such as AU, SADC and the AfDB on ageing and the HIV and AIDS scourge.

[55] Sida's Evaluation Report series, 06/20

[56] Sida-Regional Public Goods Meeting, U11 Ya22.3/66

## 4.2 Impact on Systems; Workplace, Intergovernmental Organisations

In the role as lead ICP to SADC the Team participated in the Swedish delegation to the 2006 SADC Consultative Conference that resulted in a specific paragraph on mainstreaming of HIV and AIDS in the final Communiqué[57]. Dialogue with Swedish, Norwegian, British and Dutch representatives at the African Development Bank in Tunis has resulted in an improved alignment and harmonisation of an intended AfDB HIV and AIDS support to SADC. The HIV and AIDS Unit at SADC was by the end of the year fully staffed and a work plan was to be presented early 2007.

An initial support was given to an HIV and Gender workshop at ECOWAS. As a follow-up the organisation is working on a concept note for an HIV and AIDS Strategy to be submitted to the Team. Communication has also started with EAC, where the Team worked with UNAIDS and the Regional UNDP project on HIV and AIDS[58] to support the organisation in coming up with a strategic plan on HIV and AIDS the implementation of which the Team will later consider contributing towards. Together with the Swedish Embassy in Addis Ababa, initial contact has been made with the AU on formulating an operational plan to implement their strategy.

In the world of work the Team supports workplace policies at Swedish-linked companies in Kenya, South Africa and Zambia. The NIR (International Council of Swedish Industry) programme focused on conducting exploratory studies at workplaces which ultimately resulted in focused training for workers. In the majority of cases the training was followed by Voluntary Counselling and Testing (VCT) which provided information on prevalence rates at workplaces. This information was key in designing interventions at individual workplaces. During the year the programme was expanded to Tanzania and Uganda. The World Economic Forum received a smaller support for which they have defined good practises in promoting workplace policies down the supply chains of a number of large multinational member companies in Africa.

The 4-year support to ILO presented its first results in better mainstreaming HIV and AIDS in the organisation and a number of established programmes. The labour courts is one of the focus areas, where labour judges have been trained to better understand the procedural issues on HIV and AIDS cases which will improve the application of relevant laws. ILO is using its tripartite structure as a vehicle to improve the response to the epidemic. In Mozambique, Malawi, Ethiopia and Zimbabwe tripartite committees on HIV and AIDS are now in place and working. For small and medium sized enterprises and the informal sector a training of trainers manual has been developed.

In continuing to provide critically needed intellectual leadership in the response HEARD has influenced policy development at a national, regional and global level. For example – in the global arena – HEARD was requested to act as secretariat to the Global UNAIDS/World Bank Economics Reference Group. In addition, at the International AIDS Conference in Toronto, HEARD organized the International AIDS Economics Network (IAEN). HEARD has also conducted regional training courses on mainstreaming and on monitoring and evaluation.

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[57] Rapport från SADC:S konsultativa konferens den 26–27 april, Windhoek, Namibia

[58] Supported by the Team

The Regional Team has taken the lead donor role in terms of the JFA. One of the key issue as the lead donor has been to conduct an organizational assessment. Except that several organizational improvements have taken place within HEARD, the organisation has also moved from a project- to a more programme-based research agenda.

At the UNAIDS PCB meeting in Lusaka in December the Team took the opportunity to organise field visits for delegates and an exhibition with a number of regional partners to provide an opportunity for board members to experience the heterogeneity of the epidemic, as well as the response. Earlier in the year, in conjunction with the launch of Global Health Work Force Alliance, the Team organised a seminar on testing, counselling and implications for stigma and discrimination by health care staff. Needs for comprehensive workplace policy programmes in the sector were identified.

## 4.3 SRHR, Gender, Communication, Human Rights and Stigma

The Team kept up the mainstreaming efforts in the area of gender. Young Men as Equal Partners, through RFSU/IPPF, continue to be the largest supported gender programme. During 2006 all the four participating countries have carried out baseline surveys for monitoring and evaluation purposes. Findings show generally low knowledge among young boys/men of contraceptive methods (only condoms widely known) and the importance of faithfulness as a preventive measure. Still only half of 15–24 year olds practise "safe sex". To reach the target group, out-of school activities are essential, including working with gender attitudes as well as providing information on condoms to young groups (before the sexual debut). A regional training of trainers has been organized to strengthen the capacity for an effective roll-out.

A study on Trafficking and HIV and AIDS in Southern and East Africa was commissioned through IOM[59]. The findings of the study were reviewed at the Team's reference group meeting which concluded that the links between HIV and AIDS and trafficking in the sub-Saharan region did not warrant regional approaches, but should be integrated into trafficking interventions at national level.

Gender-based inequalities and violence, combined with poverty, are main underlying factors for HIV infection in sub-Saharan Africa and mostly require a national response. However, in 2006 the Team started to support the Population Council, an international NGO, for a project on sexual and gender based violence in Kenya, South Africa and Zambia, with planned follow-up of seed grants to Zimbabwe, Ethiopia, Malawi and Senegal. The focus is on practical inputs for support to survivors, prosecuting perpetrators and community and family work against violence. The aim at regional level is to strengthen and broaden response mechanisms, create policy guidelines and good practise towards scaling-up.

Sida has supported pilot projects on prevention communication including Femina HIP and STEPS for the future, using magazines, talk-shows and video screening to get positive messages out in the area of SRHR, targeting youth. A Sida commissioned study on prevention communication was finalised by CADRE during the year[60]. The study does not encourage large scale campaigns, no "one size fits all" approach

[59] Breaking the cycle of vulnerability - responding to the health needs of trafficked women in eastern and southern Africa, IOM 2006

[60] HIV/AIDS Communication in selected African Countries – Interventions, responses and possibilities, 2007

but rather communication that follows the specific epidemic and the situation of the target group. The support to Panos SA does already partly use this concept, also engaging the people themselves in designing the communication they need, via the radio listener clubs pilot project in Zambia, Malawi and Namibia.

The Team takes a holistic approach on prevention and made a joint initial assessment of the area[61], outlining communication, capacity building and research as suitable areas for regional interventions. UN-AIDS regionally has been identified as an important partner in the prevention efforts as well as some civil society organisations.

Close to this area is also media, which plays an important role in the response to HIV and AIDS. Media Action Plan on HIV/AIDS and gender has continued to successfully roll out policy processes in the media industry, so far 57 media house in the region have started working on policies, of which 13 have already been finalized and adopted[62]. Together with support to Panos SA, SAfAIDS and IRIN Plus news the Team is using different approaches to give journalists in the region better understanding of the impact of HIV and AIDS, thus providing better informed news to its citizens, human interest stories and lessen stigma.

In the area of Human Rights the Team continued support to the Human Rights Development Initiative (HRDI) in order to work on legal precedent on discrimination against HIV positive people. The project has now reached the stage when a few legal cases have been prepared by legal students. The support to AIDS Rights Alliance of Southern Africa, ARASA, came to an end 2006 and the organisation was evaluated[63]. ARASA is a network of 14 organisations promoting human rights in the area of HIV and AIDS, providing training, advocacy etc. The organisation has mainly fulfilled planned activities but weak systems for monitoring and evaluation make it difficult to systematically assess possible impact. The organisation will develop a strategic plan to more clearly outline values, mission, vision, goals and strategies for the next five years. Sida will thereafter consider continuation.

Greater involvement of people living with HIV and AIDS is key to combating stigma and discrimination, along with measures of "normalising" testing, care and treatment. In a religious setting such as sub-Saharan Africa it is important to work with some of the main communicators with people, the churches. Support to ANARELA+ and PacaNet, both networks of religious leaders, are efforts to strengthen an evidence-based approach by the leaders to the epidemic and address it among their parishes.

In collaboration with the Secretariat at Sida HQ and the advisors in Asia, the Team published three issues of the EYES on AIDS newsletter as part of their information work. The format was slightly changed whereby the newsletter was to be published focusing on major global events whenever they take place. An example is the issue that focused on the Toronto AIDS conference.

At the Toronto AIDS conference, the Team had a booth in which several information materials were exhibited. The booth was a joint effort with the secretariat.

2006 saw the Team establish its own web site (www.Sida.se/hivteamafrica). This site is intended to facilitate quick and up-dated

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[61] Initial Assessment of a Sida programme on HIV Prevention in Southern Africa, dated 2006-11-10, U11 Ya 22.3/79

[62] MAP Policy Review Meeting with Sida, March 2007

[63] Sida Evaluations 43/06

information exchange and links to other sites of major players in the HIV/AIDS arena.

## 4.4 Capacity Building, Comparative Research and Networking

The support to the field of capacity building is regarded as one of the key areas to improve effective use of resources, quality of services and their scaling up in the region.

The collaboration within a joint financial arrangement is guiding the new agreement with RATN (Regional AIDS Training Network) with Sida as the lead. A mid-term review (MTR) concludes that there is evidence of significant progress in linking the training institutions and facilitating regional collaboration when training for prevention, treatment and management of STIs/HIV/AIDS.

A bridging fund has been agreed with Edusector AIDS Response Trust (former Mobile Task Team, MTT/ART) for mainstreaming HIV/AIDS in the Ministries of Education in Sub-Saharan Africa. Discussions on a more long term continued support have not yet been concluded.

The support to the International AIDS Alliance (IHAA) has resulted in strengthening of 16 NGOs/CBOs working with border populations in West Africa. Within the programme a Men-having-sex-with-Men training is under development by the programme.

The Teach experiental training programme of TASO is proving very popular with applications far exceeding the regional placements available for this 2006. The UNHabitat Urban Management Programme pilot project on building local municipalities' capacities to respond to the epidemic, is ongoing in 5 cities. The project is behind schedule, with just one (1) city (Blantyre, Malawi) well advanced in implementation.

The Association for African Universities is in the second year of the programme to support the development of workplace policies, curricula and research among its member institutions.

The Team is delegated responsibility to follow-up SAREC support to CODESRIA, OSSREA, SOMA-NET, and UAPS for applied social science research in Africa. A preliminary assessment of the research results, presented at an international conference in November/Addis Ababa indicates that the programme has enhanced the capacity of African scholars for research. However, no new research findings and applied results that can feed into policy and practice were identified.

The Governance and AIDS component of the Idasa "Measuring the impact of HIV/AIDS on electoral processes and national budgets in Africa" has already produced interesting results: AIDS mortality has increased both the number of necessary parliamentary by-elections and related costs to governments in the region; and, both potential and elected representative are in denial about their HIV status for fear that it would be used against them.

The regional team prepared and agreed three year support to the Southern Africa AIDS Trust (SAT) by end of 2006. The support aims to enable SAT to scale up capacity building for national and regional organisations to improve their community participatory approach as well as services when working in the field of HIV and AIDS. The annual monitoring report concludes that SAT has achieved most of its planned program outputs and activities for 2006.

As a follow-up to the seminars on the New Aid Architecture the Team commissioned a study on HIV and AIDS indicators in SWAp and

GBS frameworks[64]. The study identified relevant indicators that are readily available in Malawi, Mozambique, Tanzania and Zambia. Possible fora and issues for dialogue were also identified. The results will be used in the work with embassies as a tool in mainstreaming HIV and AIDS in GBS and sector-wide approaches.

SAA has yet to submit reports on support provided for the ICASA conference held in Abuja, 6–10 December 2005. SAA has arbitrarily proceeded with organization for the next conference, without consulting IAS, and IAS is suspending its relations with ICASA.

## 4.5 Embassy Support

The support comprises of thematic seminars, visits and mini-seminars at embassies as well as HIV and AIDS guidelines, second opinions on programme documents and participation in reviews. Focus in supporting Swedish Embassies has been on the directive to mainstream all contributions in high prevalence countries, plus the directive to increase direct support and to operationalize the workplace policy.

In 2006 the Team organised the following seminars:

- Annual Focal Point Meeting, gathered colleagues from Swedish, Norwegian and Irish Embassies in 13 African countries. The sessions included updates on recent developments in the region, country specific updates, a mainstreaming exercise and discussions on the relations between the global, regional and national levels.[65]
- A seminar to develop methods for HIV & AIDS interventions in the context of broader cooperation, targeted participants from the Swedish Embassies in Angola, Botswana, Namibia and South Africa.[66]
- HIV and AIDS Mainstreaming in for the Water Sector - a support to the Sida Regional Water Team in Mozambique and Zimbabwe.[67]
- A seminar aimed at investigating the interaction between HIV/AIDS and tension, conflict and post-conflict settings through practical, theoretical and academic input, identifying current responses as well as gaps that needed to be filled. The attendees were composed of representatives from Sida and Norway HQ, NGOs working in conflict settings and a few representatives from Embassies.[68]

*Examples of bilateral support to Norwegian Embassies in 2006:*

- Abuja – introduction of the Team and the concept of Workplace Policy
- Kampala –Introduction of the Tea and discussion on support to HIV & AIDS response in Northern Uganda, which later led to a direct advisory mission from the Team to National Committee on AIDS in Emergency Settings (NACAES)
- Nairobi – Joint mission with NORAD to map out relevant organisations for a HIV and AIDS intervention in Kenya.
- Lusaka – A mini-seminar on mainstreaming with a programme from the embassy's portfolio as an example was held.
- Maputo – A brief introduction of the Team and up-date on the portfolio.

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[64] HIV and AIDS Indicators, Oliver S Saasa

[65] Report from Focal point Meeting 2006. Swedish-Norwegian HIV/AIDS Team

[66] HIV and AIDS in Broader Cooperation – way forward, U11 Ya 22/24

[67] Travel Report 80/2006, Davies Chitundu

[68] Workshop on HIV/AIDS in Conflict and Post-Conflict Countries in sub-Saharan Africa -REPORT

*Examples of bilateral support to Swedish Embassies in 2006:*

- Luanda – An annual review meeting took place between the Sida representative in Angola, UNICEF and the regional team in June. The visit to the Swedish Embassy also continued the discussions on activities for the work place.
- Kinshasa – The regional team has been assisting the Sida team at the Swedish Embassy for support to a HIV and AIDS intervention during 2006. The preparation was targeting possible support to the IHAA. The DRC team finally decided to reject the proposal as they found that the costs were to high in comparison with their available budget.
- Ouagadougou – The team has supported the SDC with technical inputs in relation to the ongoing support to Initiative Privee et Communitaire contre le lutte de VIH/Sida (IPC). Part of the support was to assist in the preparation for an evaluation of the support to IPC. The evaluation concluded that IPC is doing a professional job but that the organisation needs to concretise their objectives, criteria and indicators.
- Windhoek – Support in planning days and design of snap-shot review of the epidemic and the response in Namibia in preparation for the possible continued bilateral support in response to HIV and AIDS after the phase-out of traditional development cooperation.
- Harare – Contributions in the preparation of the new position paper on Swedish development cooperation in Zimbabwe, and ongoing support to the design of the Expanded Support Programme (ESP), a joint donor effort in response to the epidemic in Zimbabwe.
- Pretoria – Support in planning for continued HIV and AIDS programming after the phase-out of traditional development cooperation.
- Uganda – Support on mainstreaming in programmatic work. the programme officer took the opportunity of coming to the Team to draw on different competencies.
- Abuja – Mini-seminar on the virus, the epidemic and the Swedish workplace policy.
- Lusaka – Work on localized strategy focussing on mainstreaming in the three focus-sectors for the new country strategy.
- Maputo – Discussions on mainstreaming with a focus in GBS, and a follow-up on HIV and AIDS in the country strategy process.

## 4.6 Support to Swedish and Norwegian NGOs

Sida/SEKA has for some years encouraged the Swedish NGOs in framework agreements with Sida to scale-up their HIV and AIDS responses. As from 2006 a SEKA financed Associate Expert/BBE joined the Team to focus on Civil Society and the strengthening of the Swedish NGOs' response to the epidemic. In May a start-up meeting was held in Lusaka with 9 of the 15 heads of these framework organisations. To follow up a joint exploration on capacity-building opportunities has been undertaken and dialog on the best ways to forge strategic partnerships initiated. In order to better understand common challenges individual meetings and field visits have been carried out, and in Härnös a general meeting exploring the role of Swedish civil society was held in July. In August, Sida/SEKA and the Team agreed that Norwegian NGO's also be included in the capacity-developing activities and networking struc-

tures. The participation of several Norwegian NGO's at the HIV and AIDS and Conflict seminar in Kampala in November constituted the starting point of this expanded collaboration.

## 4.7 Botswana and Angola

The Ministry of Local Government initiated a restructuring process. The inertia and uncertainties created by the process of restructuring affected the proposed support to scaling- up the Family Care Model. The model promotes targeting the household as a unit. The continued work in mainstreaming of HIV and AIDS in the planning process was also affected.

The National AIDS Coordinating Agency (NACA) initiated the mid-term review of the National Strategic Framework on HIV and AIDS to which Sida contributed financially. The process is on-going and is expected to inform future Sida support to NACA.

Work with the San people relocated from their traditional dwelling place in the Kalahari Game Reserve was initiated. The Sun people who for long have been a hard to reach community have now been integrated into the mainstream society. The integration has resulted in several social complications for the Sun fuelling drug abuse and gender based violence. The project has put in place activities aimed at disseminating targeted information on HIV for the Sun people.

Towards the end of the year an agreement was signed with Forum Syd to act as an umbrella organisation for Sida support to the civil society in Botswana.

As from mid 2006 the bilateral allocation for HIV and AIDS support to Angola was delegated to the Team. The programme with UNICEF (2005–2008) focusing on children and young people has begun its implementation in 2006. As from 2007 the allocation for Angola will be delegated from AFRA to the Team. Late 2006 an initial assessment was made of a UNFPA proposal on SRHR for adolescents in the Luanda district.

# 5. Office and Administrative Issues

The team is working as a division within UM-Lusaka although the regional mandate is the whole sub-Saharan Africa. After entering the year with severe staff constraints the Team have during 2006 received additional staff members. Effectively, the team has increased its capacity to perform its mandated tasks – both in relation to Embassy Support and the regional portfolio. The administrator employed at the beginning of the year has taken on the roll as financial controller, allowing the Head of the Team more time to work on quality assurance and thematic issues. In August the new Norwegian Seconded advisor took up his position, and in October a monitoring and evaluation officer was employed who is assisting team members in monitoring and evaluation at project level. The monitoring and evaluation officer is also responsible for creating a model for a results-based follow-up of the overall work of the team.

In December, both the the Head of the Team and the Deputy, left their positions. A new head has been recruited and was in Lusaka for a hand-over in December. A new deputy has also been appointed who will be the acting head of the team until the new head takes up her position at the beginning of 2007. One of the regional advisors will be on maternity leave for the first six months of 2007 and a short-replacement has been hired from mid January to July. During 2007, an additional NPO will be hired as from July. Also, according to the agreement that was signed between Sida and the Norwegian Ministry of Foreign Affairs on the 4th of December, the second Norwegian secondment will be placed with the team during 2007 in addition to the first Norwegian secondment who started with the team in August 2006. The agreement also states that Norway will contribute financially as a silent partner to the Team. Initially 30 million NOK was transferred to Sida by the end of 2006 for use during the first half of 2007.

| Position | Name | End of contract |
|---|---|---|
| Sent-Out Staff: | | |
| Head of team | Anita Sandström | 2007-01-20 |
| | | 2006-12-31 |
| Regional Advisor/Deputy | Paul Dover | |
| Administrator | Eva Liljekvist | 2008-08-15 |
| Sent-Out Regional Advisors | Anna-Carin Kandimaa | 2008-08-15 |
| | Ulf Källstig (new deputy) | 2008-08-15 |
| | Anne Lindeberg | 2008-08-15 |
| | Anette Widholm-Bolme (50% culture) | 2007-08-15 |
| Associate Expert/BBE | Barni Noor | 2007-05 |
| Associate Expert/BBE | Marilyn Josefsson | 2007-05 |
| Secondment from Norway | Michael Tawanda | 2009-07 |
| Locally Employed Staff: | | |
| Regional advisor/Food Security | Davies Chitundu | |
| Communication Officer/Regional Advisor | Bright Phiri | |
| Monitoring & Evaluation Officer | Enock Banda | |

The following HIV & AIDS experts have agreed to serve in the Team's reference group that has been functioning since the beginning of 2003. The group gives advice on strategic thematic issues and assists with peer review of projects and programmes. Reference group members are also a great asset as facilitators for seminars and meetings.

| Reference Group Member: | Affiliation | Area of special competence |
|---|---|---|
| Dr Alex Coutinho | Director, TASO, Uganda | Public health and work with prevention, care and treatment, PLWHA |
| Helen Jackson | Regional HIV/AIDS Advisor, UNFPA, Zimbabwe | Prevention, Information and Communication, Gender |
| Prof Michael Kelly | Prof. Emeritus at University of Zambia | HIV/AIDS and development, education, FBOs |
| Prof Alan Whiteside | Health Economics & HIV/AIDS Research Division (HEARD), University of Kwa Zulu Natal | Socio Economic impact of HIV and AIDS |
| Dr Adebayo Olokushi | Director, CODESRIA, Dakar | Social Science research, Political Science |
| Alan Ragi | Kenya AIDS Network of Civil Society Organisations | Civil Society Response. |

## CONTRIBUTION PORTFOLIO 2006

**Delimitation:**

**Status: I, P, A and C** (Agr end > 200600 or Outcome2006 <> 0)
**Region/Country:**
**Main sector:**
**Alloc account: 155027**
**Other criteria:**
**Department:**

| | |
|---|---|
| **Country** | (All) |
| **Resp Unit** | (All) |
| **Resp Officer** | (All) |

| | | | | Data | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Country Alloc** | **Alloc Account** | **Contribution** | **Status** | **DAA Total** | **Outcome up to 2005** | **Outcome 2006** | **FC 2006** | **FC 2007** | **FC 2008** | **FC 2009** |
| OUTSIDE | Hiv & Aids Secretariat | | | | | | | | | |
| | | 21500000 Enhanced Capacity - KKF | A | 4 002 657 | 4 002 657 | 0 | 0 | 0 | 0 | 0 |
| | | 21500002 CADRE AJAR journal | A | 758 087 | 526 013 | 232 075 | 232 075 | 0 | 0 | 0 |
| | | 21500005 GART HIV Food Security | A | 16 000 000 | 5 964 965 | 5 000 000 | 5 000 000 | 5 035 035 | 0 | 0 |
| | | 21500006 TASO Reg Training Centre | A | 16 000 000 | 4 007 803 | 5 400 000 | 5 400 000 | 6 592 197 | 0 | 0 |
| | | 21500008 SADC HIV/AIDS Unit | A | 12 000 000 | 3 000 000 | 5 000 000 | 5 000 000 | 4 000 000 | 0 | 0 |
| | | 21500009 HEARD - Univ. of Natal | C | 3 111 152 | 3 111 153 | 0 | 0 | 0 | 0 | 0 |
| | | 21500010 NIR/SMF workplace policy | A | 30 912 500 | 12 022 500 | 6 000 000 | 6 000 000 | 12 890 000 | 0 | 0 |
| | | 21500011 IOM Refugees | C | 9 299 153 | 9 299 152 | 0 | 0 | 0 | 0 | 0 |
| | | 21500012 AAU HIV/AIDS | A | 7 500 000 | 2 202 923 | 2 800 000 | 2 800 000 | 2 497 077 | 0 | 0 |
| | | 21500013 Program development 2004 | C | 1 051 809 | 1 006 809 | 45 000 | 45 000 | 0 | 0 | 0 |
| | | 21500016 ARASA - Aids och MR | A | 5 031 405 | 4 031 405 | 1 000 000 | 1 000 000 | 0 | 0 | 0 |
| | | 21500017 ICASA conference 2005 | A | 2 001 493 | 2 001 493 | 0 | 0 | 0 | 0 | 0 |
| | | 21500019 UNICEF mainstreaming CR | A | 20 000 000 | 20 000 000 | 0 | 0 | 0 | 0 | 0 |
| | | 21500020 Renewal-Food security | A | 5 800 000 | 5 700 000 | 100 000 | 100 000 | 0 | 0 | 0 |
| | | 21500021 ACORD/HASAP | A | 10 000 000 | 2 000 000 | 4 000 000 | 4 000 000 | 4 000 000 | 0 | 0 |
| | | 21500023 ANERELA+ | A | 1 873 231 | 1 073 231 | 800 000 | 800 000 | 0 | 0 | 0 |
| | | 21500024 HIV/AIDS Program developm | C | 1 195 757 | 781 403 | 414 354 | 414 354 | 0 | 0 | 0 |
| | | 21500025 HIV/AIDS Team Activities | C | 638 420 | 609 984 | 28 436 | 28 437 | 0 | 0 | 0 |
| | | 21500026 Femina-edutainment-region | A | 3 000 000 | 0 | 1 000 000 | 1 000 000 | 1 000 000 | 1 000 000 | 0 |
| | | 21500028 Secondment UNAIDS TL | A | 3 500 000 | 3 368 884 | 0 | 0 | 0 | 0 | 0 |
| | | 21500031 Food Security Initiative | I | 10 000 000 | 0 | 0 | 0 | 4 000 000 | 6 000 000 | 0 |
| | | 21500032 Media Policy HIV/AIDS | A | 4 700 000 | 530 252 | 2 169 748 | 2 169 748 | 2 000 000 | 0 | 0 |
| | | 21500034 PLUS NEWS HIV/AIDSService | A | 3 800 000 | 1 900 000 | 1 900 000 | 1 900 000 | 0 | 0 | 0 |
| | | 21500038 RFSU-YMEP | A | 45 700 000 | 10 000 000 | 11 000 000 | 11 000 000 | 12 700 000 | 12 000 000 | 0 |
| | | 21500039 Panos HIV/AIDS S Afrika | A | 4 400 642 | 1 350 642 | 950 000 | 950 000 | 900 000 | 1 200 000 | 0 |
| | | 21500040 Beat It, Swahili transl. | A | 750 000 | 500 000 | 0 | 0 | 250 000 | 0 | 0 |
| | | 21500041 Train & research (TARSC) | A | 1 805 000 | 669 419 | 615 000 | 615 000 | 535 000 | 0 | 0 |
| | | 21500042 SATSouth.AfricaAIDSTrust | A | 5 000 000 | 5 000 000 | 0 | 0 | 0 | 0 | 0 |
| | | 21500043 UNICEF, ESARO-OVC | I | 24 000 000 | 0 | 0 | 0 | 8 000 000 | 8 000 000 | 8 000 000 |
| | | 21500045 HelpAge Africa HIV/AIDS | A | 15 128 957 | 0 | 5 128 957 | 5 128 957 | 5 000 000 | 5 000 000 | 0 |
| | | 21500046 STEPS for the future | A | 9 000 000 | 0 | 3 000 000 | 3 000 000 | 3 000 000 | 3 000 000 | 0 |
| | | 21500048 UNHABITAT Shelter/AIDS | I | 9 000 000 | 0 | 0 | 0 | 3 000 000 | 3 000 000 | 3 000 000 |
| | | 21500050 IOM Prevention W. Africa. | A | 14 000 000 | 0 | 6 000 000 | 6 000 000 | 4 000 000 | 4 000 000 | 0 |
| | | 21500051 Support to PACANET | A | 13 000 000 | 0 | 5 000 000 | 5 000 000 | 4 000 000 | 4 000 000 | 0 |
| | | 21500052 Nutrition Support- KKCAF | A | 15 000 000 | 0 | 5 000 000 | 5 000 000 | 5 000 000 | 5 000 000 | 0 |
| | | 21500053 Renewal Support | P | 15 000 000 | 0 | 0 | 0 | 3 000 000 | 3 000 000 | 3 000 000 |
| | | 21500054 RATN capacity development | A | 10 500 000 | 0 | 3 500 000 | 3 500 000 | 3 500 000 | 3 500 000 | 0 |
| | | 21500057 HRDI, Aids discimination | A | 6 931 547 | 1 781 547 | 250 000 | 250 000 | 2 000 000 | 2 900 000 | 0 |
| | | 21500058 HEARD 06-10 | A | 35 720 000 | 0 | 7 058 173 | 7 058 173 | 6 639 573 | 7 000 000 | 7 000 000 |
| | | 21500059 WEF Supply Chain | A | 780 119 | 780 119 | 0 | 0 | 0 | 0 | 0 |
| | | 21500060 Social Science Workshop | C | 450 000 | 450 000 | 0 | 0 | 0 | 0 | 0 |
| | | 21500061 IDASA workshop ICASA | C | 300 000 | 300 000 | 0 | 0 | 0 | 0 | 0 |
| | | 21500062 IPPFAR workshop at ICASA | A | 310 000 | 310 000 | 0 | 0 | 0 | 0 | 0 |
| | | 21500064 PSG Assessment | C | 950 000 | 950 000 | 0 | 0 | 0 | 0 | 0 |
| | | 21500066 IOM Refugees Ext. | A | 6 700 000 | 0 | 6 700 000 | 6 700 000 | 0 | 0 | 0 |
| | | 21500071 SATSouthAfricaAIDSTrust | A | 36 500 000 | 0 | 10 500 000 | 10 500 000 | 12 000 000 | 14 000 000 | 0 |
| | | 21500074 HIV team activities 2006 | A | 889 620 | 0 | 837 553 | 837 551 | 52 067 | 0 | 0 |
| | | 21500075 PDF HIV team 2006 | A | 4 145 017 | 0 | 2 071 017 | 2 071 016 | 2 074 000 | 0 | 0 |

| Country Alloc | Alloc Account | Contribution | Status | DAA Total | Outcome up to 2005 | Outcome 2006 | FC 2006 | FC 2007 | FC 2008 | FC 2009 |
|---|---|---|---|---|---|---|---|---|---|---|
| OUTSIDE | Hiv & Aids Secretariat | 26000250 RATN Reg Cap Development | C | 6 000 000 | 5 967 409 | 0 | 0 | 0 | 0 | 0 |
| | | 26003014 STEPS - distribution | A | 16 755 685 | 15 105 685 | 1 650 000 | 1 650 000 | 0 | 0 | 0 |
| | | 26003016 Plan Sverige - HACI | A | 18 000 000 | 18 000 000 | 0 | 0 | 0 | 0 | 0 |
| | | 26003023 UNDP Reg HIV-program | C | 14 000 000 | 14 000 000 | 0 | 0 | 0 | 0 | 0 |
| | | 26003024 SAFAIDS - core support | A | 9 979 021 | 5 979 022 | 4 000 000 | 4 000 000 | 0 | 0 | 0 |
| | | 26003026 Femina-youth HIV/AIDS | C | 16 628 250 | 13 128 250 | 3 500 000 | 3 500 000 | 0 | 0 | 0 |
| | | 26003029 Idasa - ABU and GAP | A | 11 987 042 | 7 987 042 | 4 000 000 | 4 000 000 | 0 | 0 | 0 |
| | | 26003032 IHAA Africa wp 2005-8 | A | 18 000 000 | 5 354 494 | 6 000 000 | 6 000 000 | 6 645 506 | 0 | 0 |
| | | 26003034 SANASO 2004 Phase out | C | 693 525 | 693 525 | 0 | 0 | 0 | 0 | 0 |
| | | 26003035 SAfAIDS-AIDS in Africa | A | 3 829 137 | 3 829 138 | 0 | 0 | 0 | 0 | 0 |
| | | 26003045 HABITAT-UMP HIV/AIDS | A | 6 443 128 | 6 443 128 | 0 | 0 | 0 | 0 | 0 |
| | | 26003046 OVC Rapid Asessment | C | 1 200 000 | 1 200 000 | 0 | 0 | 0 | 0 | 0 |
| | | 27000187 REPSSI Regional OVC | A | 27 040 811 | 23 972 811 | 3 068 000 | 3 068 000 | 0 | 0 | 0 |
| | | 27000201 PSG - mobile populations | A | 24 526 132 | 17 026 132 | 7 500 000 | 7 500 000 | 0 | 0 | 0 |
| | | 27000203 ILO-Aids SubSahara Africa | A | 43 000 000 | 0 | 13 000 000 | 13 000 000 | 12 000 000 | 10 000 000 | 8 000 000 |
| | | 27000204 IOM-Phamsa | A | 16 400 000 | 10 495 729 | 5 900 000 | 5 900 000 | 4 270 | 0 | 0 |
| | | 27000250 IFRC/SRC Home-based Care | A | 30 000 000 | 23 995 550 | 6 000 000 | 6 000 000 | 0 | 0 | 0 |
| | | 21500103 Observatory RPG | A | 1 040 000 | 0 | 1 040 000 | 1 040 000 | 0 | 0 | 0 |
| | | 21500094 HIV/AIDS and fisheries | P | 36 000 000 | 0 | 0 | 0 | 12 000 000 | 12 000 000 | 12 000 000 |
| | | 21500077 MTT/ART - Capacity dev. | P | 22 640 000 | 0 | 0 | 1 | 5 660 000 | 5 660 000 | 5 660 000 |
| | | 21500096 Idasa ABU and GAP | I | 18 000 000 | 0 | 0 | 0 | 6 000 000 | 6 000 000 | 6 000 000 |
| | | 21500080 Anerela (core supp.06-08) | P | 5 600 000 | 0 | 0 | 1 600 000 | 2 000 000 | 2 000 000 | 0 |
| | | 21500081 UNDP Regional HIV/AIDS | A | 39 000 000 | 0 | 10 000 000 | 10 000 000 | 29 000 000 | 0 | 0 |
| | | 21500018 SAT microbicides meeting | C | 572 195 | 635 695 | -63 500 | -63 500 | 0 | 0 | 0 |
| | | 21500079 PLWHA, NAP+ SAR | I | 8 000 000 | 0 | 0 | 0 | 2 000 000 | 3 000 000 | 3 000 000 |
| | | 21500097 SAFAIDS core support | I | 15 000 000 | 0 | 0 | 0 | 5 000 000 | 5 000 000 | 5 000 000 |
| | | 21200004 Communication HIV NPO | A | 2 167 917 | 938 910 | 579 007 | 579 007 | 650 000 | 0 | 0 |
| | | 21200047 Monitoring and evaluation | A | 734 282 | 0 | 134 282 | 134 282 | 600 000 | 0 | 0 |
| | | 21200005 Food Security HIV NPO | A | 2 090 312 | 768 939 | 621 372 | 621 372 | 700 000 | 0 | 0 |
| | | 21200055 NPO HIV/AIDS | A | 505 000 | 0 | 0 | 0 | 505 000 | 0 | 0 |
| | | 21200003 HIV/AIDS team | A | 55 999 015 | 18 380 313 | 11 105 565 | 11 081 703 | 13 000 000 | 13 100 000 | 0 |
| | | 21500088 ARASA -HR/AIDS network | P | 6 000 000 | 0 | 0 | 1 | 2 000 000 | 2 000 000 | 2 000 000 |
| | | 21500095 REPSSI - OVC and HIV/AIDS | A | 45 560 000 | 0 | 3 000 000 | 3 000 000 | 10 640 000 | 10 640 000 | 10 640 000 |
| | | 21500083 Pop. Council GBV | A | 10 800 000 | 0 | 2 600 000 | 2 600 000 | 6 400 000 | 1 800 000 | 0 |
| | | 21500086 HIv Prevention S Africa | I | 22 000 000 | 0 | 0 | 0 | 5 000 000 | 7 000 000 | 10 000 000 |
| | | 21500078 Reference Group | A | 1 200 000 | 0 | 394 603 | 394 603 | 400 000 | 400 000 | 0 |
| | | 21500099 SANASO - core support | I | 4 500 000 | 0 | 0 | 0 | 1 500 000 | 1 500 000 | 1 500 000 |
| | | 21500101 PSG JFA | P | 18 000 000 | 0 | 0 | 0 | 6 000 000 | 6 000 000 | 6 000 000 |
| | | 21500084 ECOWAS HIV/GENDER Wshop | A | 600 000 | 0 | 600 000 | 600 000 | 0 | 0 | 0 |
| | | 21500087 HIV/AIDS Communication SA | I | 15 000 000 | 0 | 0 | 0 | 5 000 000 | 5 000 000 | 5 000 000 |
| | | 21500102 IOM PHAMSA II | P | 45 500 000 | 0 | 0 | 0 | 15 500 000 | 16 000 000 | 14 000 000 |
| | | 21500098 PLUS NEWS HIV/AIDS Servic | I | 6 000 000 | 0 | 0 | 0 | 2 000 000 | 2 000 000 | 2 000 000 |
| | | 21500093 Social Science Conference | A | 2 400 000 | 0 | 2 100 000 | 2 100 000 | 300 000 | 0 | 0 |
| | | 21500082 New SANASO | A | 1 000 000 | 0 | 1 000 000 | 1 000 000 | 0 | 0 | 0 |
| | | 21500085 FAO Nutrition Support | A | 2 300 000 | 0 | 2 300 000 | 2 300 000 | 0 | 0 | 0 |
| | | 21500100 EAC Aids Plan | I | 14 000 000 | 0 | 0 | 0 | 3 000 000 | 5 000 000 | 6 000 000 |
| | | 21500090 Hope WW - OVC | A | 18 500 000 | 0 | 4 500 000 | 4 500 000 | 6 000 000 | 8 000 000 | 300 000 |
| | | 21500104 IFRC- HIV Home-Based Care | P | 30 000 000 | 0 | 0 | 0 | 10 000 000 | 10 000 000 | 10 000 000 |
| | | 21500107 AMREF Mobile Populations | P | 47 000 000 | 0 | 0 | 0 | 17 500 000 | 17 500 000 | 12 000 000 |
| | | 21500105 ASSITEJ theater AIDS | A | 625 000 | 0 | 625 000 | 625 000 | 0 | 0 | 0 |
| | | 21500106 SADC PF AIDS-prog | P | 14 000 000 | 0 | 0 | 0 | 4 000 000 | 5 000 000 | 5 000 000 |
| | | 21500108 Norway's contribution H/A | A | -188 350 000 | 0 | 0 | 0 | -88 350 000 | -50 000 000 | -50 000 000 |
| | **Hiv & Aids Secretariat Total** | | | **1 036 603 018** | **303 134 125** | **198 654 641** | **200 230 780** | **220 319 725** | **187 200 000** | **95 100 000** |
| **OUTSIDE Total** | | | | **1 036 603 018** | **303 134 125** | **198 654 641** | **200 230 780** | **220 319 725** | **187 200 000** | **95 100 000** |
| **Grand Total** | | | | **1 036 603 018** | **303 134 125** | **198 654 641** | **200 230 780** | **220 319 725** | **187 200 000** | **95 100 000** |

# Annex 2:
# List of Strategic Documents

- Investing for Future Generations. Sweden's International Response to HIV/AIDS. March 1999.
- Turning Policy into Practice: Sida's implementation of the Swedish HIV/AIDS Strategy. Sida Evaluation 05/21.
- Swedish Strategy for development co-operation with regional and sub-regional organisations in Sub Saharan Africa 2002—2006.
- Working in Partnership with UNAIDS. A Swedish Strategy Framework for 2005–2008.
- Intensifying Prevention. UNAIDS Policy Position Paper. August 2005.
- The "Three Ones" in action: where we are and where we go from here. February 2005.
- The global Response to AIDS: 'Making the Money Work' The Three Ones in Action. Communiqué from the High-Level Meeting, 9 March 2005.
- Global task Team on Improving AIDS Co-ordination Among Multilateral Institutions and International Donors. June 2005.
- AIDS in Africa: Three scenarios to 2025. UNAIDS 2005.
- Sweden's International Policy for Sexual and Reproductive Health and Rights. December 2005.
- Sida's Gender policy, 2006
- Expert Think Tank Meeting on HIV Prevention in High-Prevalence Countries in Southern Africa REPORT, SADC 2006
- Report from Focal Point Meeting 2006, Swedish-Norwegian HIV/AIDS Team
- HIV and AIDS in Broader Cooperation – way forward, Swedish-Norwegian HIV/AIDS Team
- SIDA-Regional Public Goods Meeting, Swedish-Norwegian HIV/AIDS Team
- Workshop on HIV/AIDS in Conflict and Post-Conflict Countries in sub-Saharan Africa, Swedish-Norwegian HIV/AIDS Team
- Rapport från SADC:S konsultativa konferens den 26–27 april, Windhoek, Namibia, UD Stockholm

- HIV/AIDS Communication in selected African Countries – Interventions, responses and possibilities, CADRE
- UN 2006 High-Level Meeting on AIDS declaration
- Joint Framework on Donor Coordination, Swedish-Norwegian HIV/AIDS Team
- Intensifying HIV prevention, UNAIDS policy position paper and UNAIDS Action Plan on Intensifying HIV prevention 2006–2007
- HIV and AIDS Indicators, Oliver S Saasa
- UNAIDS and OHCHR Guidelines on HIV and Human Rights, consolidated 2006
- HIV/AIDS: The Impact on Poverty and Inequality, Gonzalo Salinas and Markus Haacker

*Halving poverty by 2015 is one of the greatest challenges of our time, requiring cooperation and sustainability. The partner countries are responsible for their own development. Sida provides resources and develops knowledge and expertise, making the world a richer place.*


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