Sida

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Sida's contributions 2006

Progress in health development

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Preface

The Health Division at Sida has previously published annual statistics of disbursements under the name "Facts and Figures". This year we have decided to increase our level of ambition to include more results and analysis and this is the result of our efforts.

Why have we done this? Partly for ourselves. In our efforts to improve quality and introduce results-based management, statistical facts and reports and analysis of results are necessary. Secondly we believe that a solid presentation of what we achieve can serve as an important input for both Sida management and the Ministry for Foreign Affairs (MFA). Thirdly, we direct this information to our partners in development, academic institutions, government agencies, NGOs and an interested Swedish public.

The analysis is divided into two main parts. The overview contains the overall statistics of disbursements and an analysis of trends over the period 2000-2006. In the second part we describe and analyse individual projects and programmes, by region and country. We have not been able to include all projects. The material has been produced by many different individuals from the Embassies, and from Sida's departments in Stockholm, including Sida's Department for Research Cooperation (SAREC), and Sida's Department for Cooperation with NGOs, Humanitarian Assistance & Conflict Management (SEKA).

We hope and believe that the process itself has increased our capacity to analyse results and that others can use our facts and figures to form their own opinion. We hope that we can stimulate an analytical discussion on the Swedish contribution to improved global health.

When looking at the total picture of Sida's contributions (we have included multilateral disbursements directly from the MFA for comparison) there are a few facts that stand out.

One example is that the amount going to programme support in 2006 was about SEK 500 million, representing about 25 percent of Sida contributions in the health sector. If all health support is included (including research, humanitarian and multilateral through MFA) only about 12 percent goes through programme support to governments. This gives rise to several questions. What should be the balance between support directly to governments and through other channels, such as the UN system, global partnerships or NGOs? What proportion should programme support in health have three years from now, considering the targets in the Paris agenda? If we want programme support to increase, how do we go about it?

This is one example of an important discussion on the future of Swedish health development cooperation, and we hope that this document will stimulate and contribute to this discussion and many others.

Anders Molin
Head, Health Division
DESO
Sida

Introduction

The Millennium Development Goals

Three of the UN's Millennium Development Goals (MDGs) directly address health problems: those relating to child health (MDG 4), maternal health (MDG 5), and HIV/AIDS, malaria and other diseases (MDG 6).

With the present development it is unlikely that MDGs 4-6 will be reached. Sub-Saharan Africa is the region with the highest morbidity and mortality, and where progress is also slowest. The global health gap is widening.

Child survival has improved markedly in Latin America, the Caribbean, Southeast and East Asia and Northern Africa. But sub-Saharan Africa, with only 20 percent of the world's young children, accounted for half of the total deaths, a situation that has shown only modest improvement. Overall, 10.5 million children died before their fifth birthday in 2004, mostly from preventable causes.

Maternal mortality has not been substantially reduced in regions where most deaths occur – sub-Saharan Africa and Southern Asia.

The number of people living with HIV has continued to rise, from 36.2 million in 2003 to 38.6 million in 2005. The number of AIDS-related deaths

also increased 2005 to 2.8 million, despite greater access to antiretroviral treatment and improved care in some regions.

The epidemic remains centred in sub-Saharan Africa. Rates of new HIV infections in the region peaked in the late 1990s, and prevalence rates in Kenya, Zimbabwe and in urban areas of Burkina Faso show recent declines. HIV prevalence among people aged 15 to 49 in sub-Saharan Africa appears to be levelling off, though at extremely high levels.

The number of new tuberculosis cases is growing by about 1 percent per year, with the fastest increases in sub-Saharan Africa.

Sexual and Reproductive Health and Rights (SRHR) continues to be highly controversial, with strong controversies around issues such as abstinence only, condom use, access to contraceptives and safe abortion.

Maternal mortality has not been substantially reduced during the last 20 years.

Of the 20 countries with the highest maternal mortality ratios in the world, 19 are in Africa and only one – Afghanistan – in Asia.

The African Region accounts for about one-tenth of the world's population and 20 percent of the global births, yet nearly half of the mothers who die globally as a result of pregnancy and childbirth are in this region.

Trends in health development cooperation

The global health architecture has changed dramatically over the last 30 years. In the 1970s the emphasis was on primary health care, in the 1980s focus was largely on health reforms, while the 1990s was characterised by the emergence of a great number of global health initiatives, many of them private-public partnerships. In the 2000s, the Paris agenda has added a strong emphasis on alignment and harmonisation and today we see on one hand a development towards programme support among several bilateral donors and on the other hand a number of large global health initiatives often organised around specific diseases, the most important being HIV and AIDS. The resource mobilisation for HIV/AIDS has been highly successful to the point that some countries receive resources for HIV and AIDS that exceed the resources for their entire health sectors.

Health is today high on the global development agenda. There is a growing realisation of the importance of health as a broad development issue, not only as a human rights issue. The HIV/AIDS pandemic has of course been the driving force for this, but there are other pandemics, such as SARS and Avian Influenza that also illustrate the global nature of health and disease.

Swedish priorities

The Government defines health priorities on the development agenda, for example, through its instructions in its annual directive and letter of appropriation for Sida and the budget bill to Parliament. There have been strong references to SRHR and HIV/AIDS in recent years, and there is now a Swedish policy on SRHR and a special programme for infectious diseases. In the letter of appropriation for 2006, there are specific reporting and financial conditions for SRHR and infectious diseases.

Swedish health development cooperation – an overview

Sida's total disbursements for the main Health[1] sector amounted to SEK 1,912 million for 2006. In addition, health research disbursement amounted to SEK 207 million (main sector Research), emergency health programmes and refugee health came to SEK 536[2] million (main sector Humanitarian assistance). This means a total of SEK 2,669 million from Sida in 2006, an increase of more than 25 percent from 2005 (SEK 2,096 million).

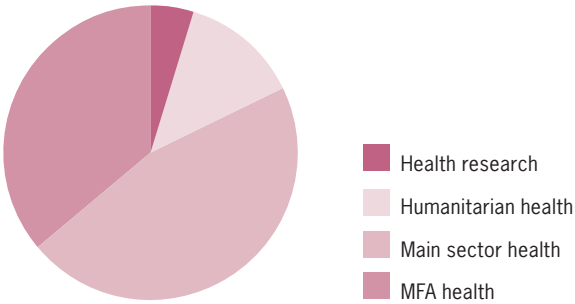

Figure 1: Total disbursement for Health 2006

MAJOR PROGRAMMES/ COMPONENTS	DISBURSEMENT 2006
UNICEF (not all defined as health)	440 000 000
UNFPA	400 000 000
UNAIDS	200 000 000
Global Fund against HIV/AIDS, TB and Malaria	600 000 000
International AIDS Vaccine Initiative (IAVI)	15 000 000
International Partnership for Microbicides (IPM)	15 000 000
Population Council	15 000 000
WHO; 3 by 5 support to ARV treatment (continuation of 3 by 5 support)	80 000 000
Contribution to WHO's Commission for Social Health Determinants	2 000 000
Support to UNAIDS budget	40 000 000
Swedish Institute for Inf. Diseases	10 000 000

Table 1: Health disbursements from MFA[3]

[1] Sida classifies contributions in "main sectors". The disbursements to the different sectors can be seen in Fig. 2.
[2] Swedish Humanitarian assistance amounted to SEK 2.2 billion and approximately SEK 536 million was dedicated to Emergency and Refugee Health (statistical codes 72014 and 72034 respectively). It has not been possible to include Refugee Health in the tables of this report.
[3] MFA disbursed SEK 1.824 million in 2006, including support to UNICEF of SEK 440 million, of which only a part should be counted as health support.

The Ministry for Foreign Affairs (MFA) contributions went primarily to the UN system (UNAIDS, UNICEF, UNFPA, WHO) but also to global health initiatives: Global Fund (SEK 600 million), International AIDS Vaccine Initiative (IAVI, SEK 15 million), International Partnership for Microbicides (IPM, SEK 15 million).

The proportion of health support from MFA has increased from 24 percent in 2003 to about 35 percent in 2006.

Sida health cooperation compared with other sectors

Health cooperation - counting only main sector Health – amounted to 12 percent of total Sida disbursements in 2006 and has oscillated around 10 percent for the last 10 years. A downward trend was reversed in 2002 and we have then seen health cooperation increase every year. The most rapidly growing sector at Sida is Human Rights and Democratic Governance, which now accounts for nearly one-quarter of Sida disbursements.

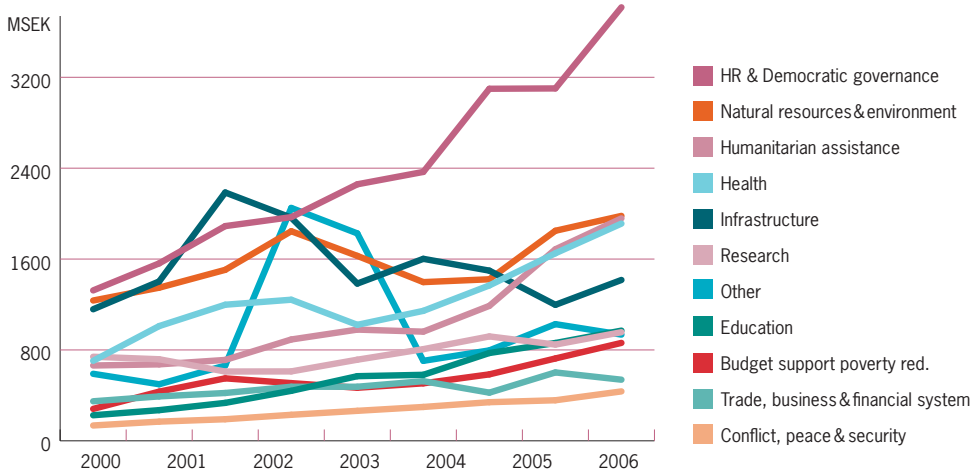

Figure 2: Total disbursement from Sida 2006, main sectors

By region

Distribution of health cooperation among regions (see figure 3) shows that Africa gets the lion share, or about 50 percent, followed by Asia with 21 percent.

Health cooperation with Africa has increased tremendously and nearly trebled since 2000. Emergency health has increased over the last two years from a relatively stable level of SEK 100 million per year to more than SEK 400 million in 2006, mainly due to the worsening humanitarian crisis in Africa.

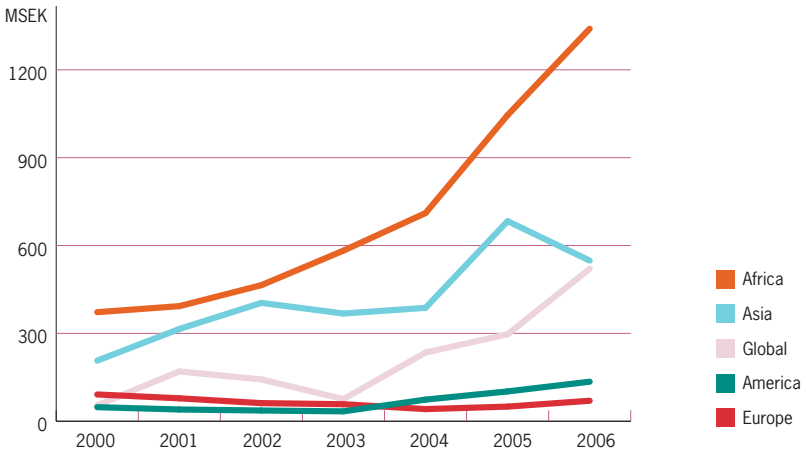

Figure 3: Total Sida Health disbursement by region 2000–2006

Bilateral – regional – global health cooperation

A total of 65 percent of the funds for health cooperation channelled through Sida goes to bilateral health cooperation, 15 percent to regional programmes and 20 percent to global programmes.

Figure 4 shows that the major part of the increase in health over the last seven years is an increase in bilateral health cooperation. Regional programmes have increased mainly due to increased support to HIV/AIDS programmes in Africa through the HIV/AIDS secretariat in Lusaka. Global health cooperation has remained at about the same level. The increase in support to multilateral organisations and the international health initiatives comes under the Ministry for Foreign Affairs and is not included in the figures.

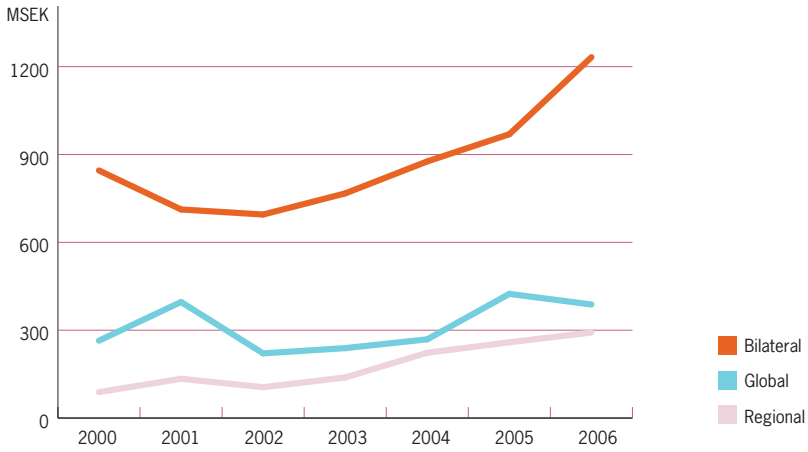

Figure 4: Disbursement by regional, bilateral and global programmes/projects

Programme support – project support

Sida has programme support in five countries in Africa (Zambia, Uganda, Mali, Burkina Faso, and Malawi) one in Asia (Bangladesh), one in Latin America (Nicaragua) and in one country in Central Asia (Kyrgyzstan).

Programme support has almost doubled between 2005 and 2006. Now 33 percent of all Sida programme support is in the health sector (29 percent education). However, programme support still only accounts for 25 percent of health cooperation, and most of the increase over the last five years is in traditional project support that still accounts for 64 percent of all support.

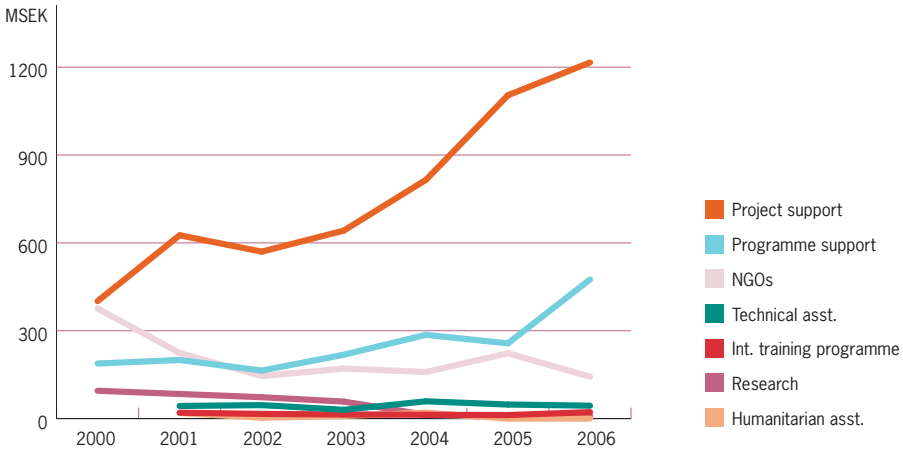

Figure 5: Health disbursement by type of support

In health programme countries, the volume of Sida support differs greatly, from just under SEK 19 million in Honduras to SEK 153 million in Zambia. In Bangladesh, Uganda and Zambia, Sida has made deliberate efforts to substantially increase contributions, responding to needs and increased absorption capacity in those countries. In other programme countries there are possibilities to increase the Swedish contributions to make them more cost-effective.

COUNTRY	2006
Bangladesh	108 068 343
Burkina Faso	22 268 607
Ethiopia	34 130 515
Guatemala	20 961 232
Honduras	18 899 537
India	32 736 964
Kyrgyzstan	21 186 163
Mali	35 133 790
Mozambique	33 263 179
Nicaragua	55 626 349
Palestinian Administrated Area	73 905 169
Uganda	86 153 388
Viet Nam	31 065 787
Zambia	153 365 643

Table 2: Disbursement by main partner country

Channels

The main channels in 2006 (not including research and humanitarian support) were to governments, followed by the UN System and International organisations and institutions. Support through these three channels has more than doubled since 2002 while support through Swedish institutions, NGOs and consultancies has remained at the same level. This means that if support through MFA is included, the UN system is the main channel for Swedish Health support, almost double what goes directly to governments. It is also noteworthy that four global partnerships (GFATM, GAVI, IAVI, IPM) amount to SEK 730 million, which is more than goes to governments directly.

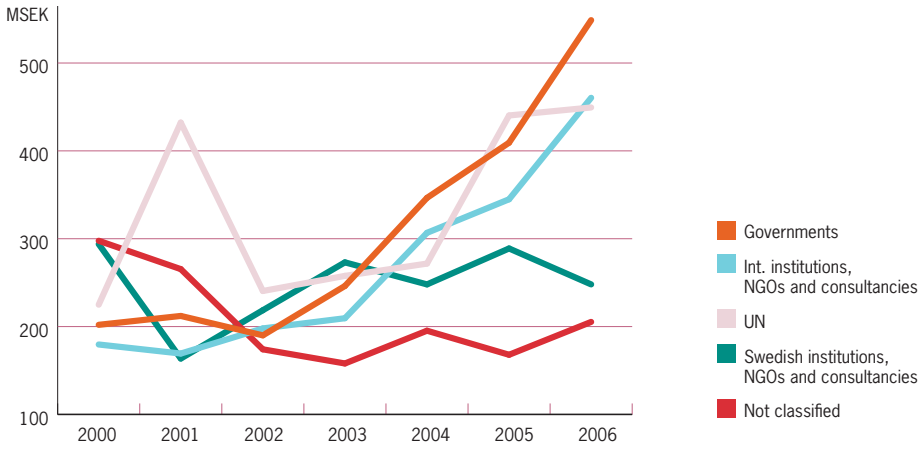

Figure 6: Disbursement by channel

NGO support

The NGO budget line is the general instrument within Swedish development cooperation to promote the development of a vibrant and democratic civil society through partnerships between Swedish NGOs and their partners in developing countries. A little less than 10 percent of the total Swedish bilateral development cooperation is allocated to this instrument. Sida has framework agreements with 14 major Swedish NGOs, some of which are umbrella organisations channelling funds to smaller NGOs, and thus reaches thousands of local civil society organisations in developing countries.

Until some ten years ago the budget line had a very broad focus, which implied rather general development programmes with the common denominator that they were organised by NGOs. At that time a lot of the resources were spent on educational or health programmes. The programmes were often public or mixed between government and civil society. When the budget line started to focus more clearly on the development of the civil society, many of the traditional NGO programmes in the health sector changed. Instead of specific health programmes, the NGOs included health components in broader civil society programmes. That explains in some sense why the statistics show a dramatic drop of Swedish NGO support to the health sector since 2000. It is basically because instead of broad traditional health programmes (i.e. running hospitals, supporting education of nurses, etc.), Swedish NGOs now support local CSOs with integrated programmes, including health components.

Examples of the current funding through NGOs are support to different popular health activities, like grassroots' education programmes or preparation of local health volunteers. With the increasing and devastating effects of the HIV/AIDS pandemic, more and more of the activities are concentrated in this field, especially when it comes to prevention programmes or social support to persons living with HIV/AIDS.

Thematic areas

Looking at distribution of Sida health cooperation among sub-sectors, figure 7 shows that health systems receive most support, followed by HIV/AIDS and emergency health. This is also illustrated in the figure below. Support to health systems includes sector or programme support, e.g. the SWAP support.

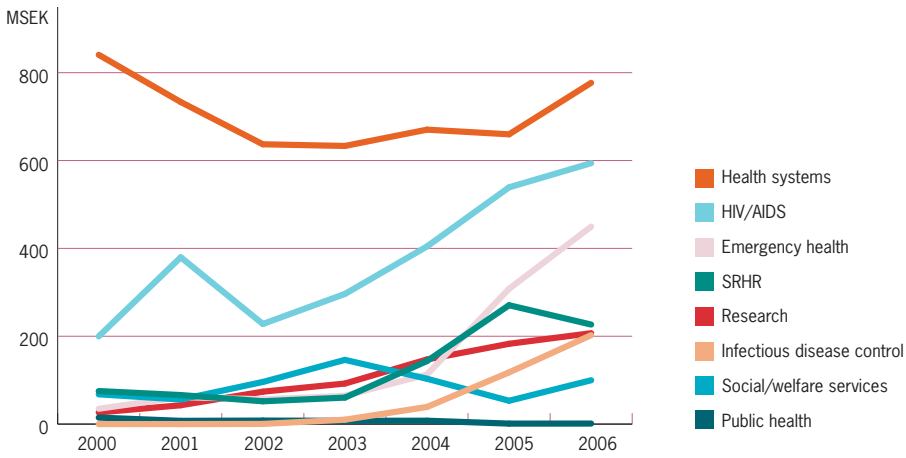

Figure 7: Disbursement by sub-sector

Health systems and infectious diseases

Strengthening health systems is one of Sida's core activities in terms of development cooperation in health.

Bilateral support to build up capacity in countries to improve health service delivery is provided to twelve countries: Bangladesh, Vietnam, Albania, Tajikistan, Kyrgyzstan, Malawi, Mali, Kenya, Burkina Faso, Uganda, Zambia, Nicaragua, Honduras and Guatemala. The most commonly used aid modality by Sweden in terms of health support is some sort of Sector Programme support (either through Sector Budget support or pooled funding). Amounting to SEK 776 million in 2006, Health Systems Strengthening is the largest thematic area for the Health division in financial terms. From analysing the different types of health systems supported by Sida through programme or sector support, it is clear that there has been a lack of thorough analysis to guide Swedish support. Instead other factors have guided us in our decisions on support (both in terms of modality and geographically). Overall political directives are one such factor.

More than 60 percent of the burden of disease in low-income countries is attributed to infectious diseases. Most of these diseases are preventable and curable with affordable drugs, simple standard regimes and preventive

measurements. The main problem in Sida development cooperation countries is that health services delivered by health systems are underfunded, understaffed and systems are far too often on their way to collapsing. The strategic action plan 2006-2008 for Sweden's contribution to the global fight against communicable diseases identifies health systems strengthening as a prioritised area of support. The action plan is well in line with Sida's current strategy on bilateral health sector support.

Regional programmes supported by Sida focus on equity aspects and health financing as fundamental aspects contributing to poverty alleviation from a human rights perspective. By supporting HEPNET, Sida contributes to building health economics and political capacity in the sub-Saharan African (SSA) Region by creating a critical mass of individuals and institutions with extensive knowledge in the field. Another Sida-supported regional network, EQUINET, aims at influencing and supporting national and regional policies and practices of countries in Eastern and Southern Africa to promote equity in healthcare.

The global programmes in the area of health systems supported by Sida are strategically chosen to improve and develop knowledge, norms and policies in this field. The specific task for the Health Unit in this process is to transfer this knowledge and programmes into action in our cooperation countries.

Priorities

"Health systems and communicable diseases" is a prioritised focus area for the Health division and the area is divided into four themes: health financing, human resources in health, vaccines and immunisation and drugs.

One indicator used for measuring achievements is the vaccination rate.

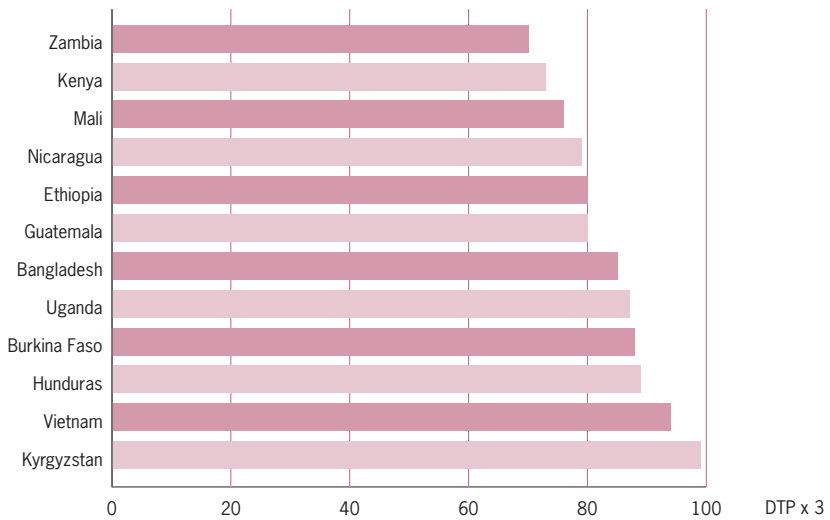

Figure 8: Vaccination coverage

Sida has only a very small part of support to disease specific programmes. This has been a deliberate strategy to move away from this type of fragmented programmes to more of systems support. The diseases for direct programme support by Sida are HIV/AIDS, Tuberculosis and Avian Flu. Mainstreaming HIV/AIDS activities in all other development cooperation programmes is also a key priority to Sida. The TB programmes focus on multi-drug resistant (MDR) Tuberculosis in Eastern Europe and Central Asia. The WHO programme on Avian Flu concentrates on mitigating the effects of the spread of a pandemic influenza.

A challenge for the future is to analyse and assess the characteristics of health systems presently supported by Sida and to decide what health systems should be supported through programme/sector support, looking at specific priority aspects areas, such as equity. Another challenge for Sida will be to make continued and strengthened efforts to utilise the knowledge and experience generated in global and regional programmes by creating clearer linkages and added value to health programmes supported at the national level.

Sexual and reproductive health and rights, SRHR

Sexual and Reproductive Health and Rights (SRHR) is a long-lasting priority area for Sida and Sweden. Important points of departures for the international work are the results from UN international conferences, such as the International Conference on Population and Development (ICPD) in Cairo 1994, together with Sweden's International Policy on SRHR launched in 2006. Sida's position is to safeguard what was achieved at these conferences and to implement Swedish policy in the dialogue at global, regional and bilateral levels.

In 2006, Sida reported SEK 280 million being used for SRHR in accordance with the letter of appropriation, which equals 8.7 percent of the total amount of the health sector support channelled through Sida. This sum excludes HIV and AIDS activities that are not directly linked to SRHR, support through SEKA and support to UN organisations funded through the Swedish MFA. In addition this figure does not include bilateral health sector programme support that is channelled through different funding mechanisms that does not always allow SRHR to be reported separately. The trend is a slight increase for SRHR with a peak in 2005 which was due to an extra allocation of funds for SRHR (SEK 95 million).

The large proportion of sexual and reproductive ill health globally has a negative effect on development in particular in poor countries. A large part of the SRHR agenda needs to be dealt with as well as in other sectors as in the health sector. Without improvements to maternal and neonatal care the Millennium Development Goals for children under the age of five and maternal survival will not be met. A well functioning health system with a strong primary healthcare that deliver a full range of reproductive health services is a necessary precondition for improvement of SRHR together with a skilled and trained health workforce, including trained midwives. Work with SRHR is thereby closely linked to health systems development and cannot be regarded in isolation.

A major challenge is to further link up the global and regional contributions with the bilateral support and use the experience and knowledge in the dialogue of global and regional intervention sat bilateral levels.

In 2006 Sida's health division identified focus areas for SRHR where Sweden can contribute and has comparative advantages. The areas are maternal healthcare for an increase of maternal and neonatal survival, breast-feeding, trained midwives, access to affordable and safe contraceptives, safe and legal abortions and sexuality education. In addition there is lesser support to other important areas, such as female genital mutilation (FGM) and trafficking and its close linkages to human rights.

Bilateral support

Bilateral health sector support is increasingly channelled through different funding mechanisms together with other donors. The dialogue has therefore increasingly become an important tool where Sida has identified SRHR as an important dialogue issue, which is the case in Mali, Burkina Faso, Ethiopia, Uganda, Kenya and India. In addition to programme support there are examples of direct bilateral support for SRHR such as midwifery training in technical collaboration with a Swedish institute in Nicaragua, emergency obstetric care in Ethiopia and a broad SRHR programme based on partnership between Indian and Swedish institutions in India.

Regional support

Health division's support for SRHR channelled to regional activities in Africa is SEK 10.9 million, which is 18.5 percent of the total amount for Regional Africa, and the figures for Latin America are SEK 3.3 million, or 13.5 percent. The Regional Programme in Asia in 2006 was mainly directed to support HIV/AIDS related SRHR interventions and to trafficking interventions. There is a trend to decrease the number of regional projects and to increase the focus on bilateral programme support. However, there is a need to draw attention to how the regional programmes can support the development of the broad SRHR agenda at the bilateral level. For example, the Ipas organisation is an active partner in policy development for safe abortion at the African regions' high level fora for the African Union's development of the Maputo Plan of Action to be implemented in the African countries. Advocacy work by Ipas has lead to liberalisation of abortion laws in Ethiopia, Ghana, Mozambique and Nepal, to mention a few countries.

For improved maternal care the African Midwives Research Network (AMRN), initially supported by Sweden, has contributed to improved and appropriate technologies as part of midwifery training in the participating countries, as well as improved midwifery care routines. The World Alliance for Breastfeeding Action (WABA), IBFAN-Africa and IBFAN-Asia promote and protect women's rights to breastfeed their infants and encourage their fathers to increase their partner's breastfeeding and actively participate in their child's development and care. Adolescent sexual health is supported by MAMTA/RFSU in India and Young Men as Equal Partners YMEP/RFSU in Africa.

Priorities

The areas are maternal healthcare for an increase of maternal and neonatal survival, breast-feeding, trained midwives, access to affordable and safe contraceptives, safe and legal abortions and sexuality education. In addition there is lesser support to other important areas such as female genital mutilation (FGM) and trafficking and its close linkages to human rights.

The figure below shows the use of contraceptives in health programme countries. It is one important SRHR indicator that differs greatly among countries.

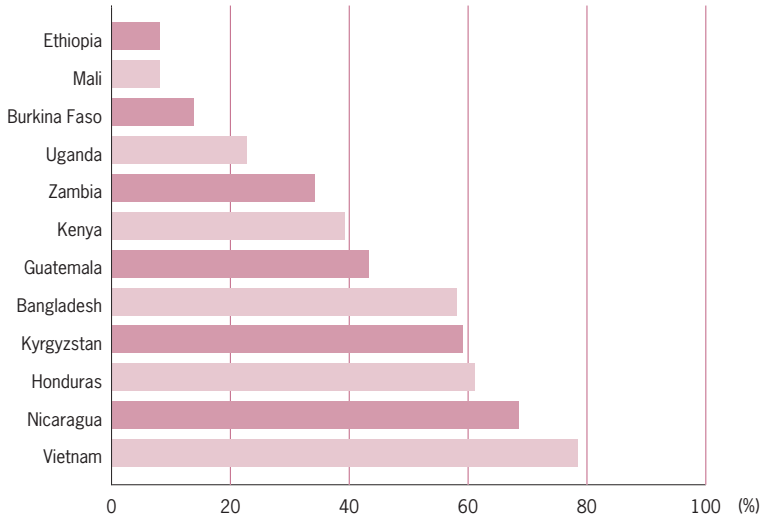

Figure 9: Contraception prevalence (%)

The majority by far of the Swedish global support for SRHR is channelled through UNFPA with SEK 400 million (most of this via MFA but also project support from Sida to the Campaign to End Fistula), International Planned Parenthood Federation (IPPF) with SEK 100 million, and WHO with SEK 45 million for Making Pregnancy Safer (disbursed in December 2005 with activities in 2006). Lesser amounts have been channelled through other organisations like FIGO for maternal health and to the in Safe Abortion Action Fund, established in 2006. Other examples are the worldwide dissemination of research results for medical abortion that is being made by the International Consortium for Medical Abortion (IMCA) and Gynuity Health Projects conducting research, which resulted in instructions for use that are used globally. The World Bank is conducting a synthesis of what is currently known about the cost of treatment of clients with post-abortion complication in sub-Saharan Africa, and estimates of the costs of providing contraceptive services to help women prevent unintended pregnancies.

HIV & AIDS

Globally, the HIV&AIDS epidemic is growing and changing character. Even though there are some good examples, there are only a few countries that have been able to reverse the spread. Women and young girls are more vulnerable and are at greatest risk. Young people account for half of all new HIV infections.

The HIV&AIDS epidemic is a severe obstacle for development, affecting all geographical regions and all sectors of society. The complexity calls for a multi-sectoral response at all levels. In recent years, the global response and the available resources to HIV&AIDS have increased markedly and money in the short term is no longer a major concern. Rather, the problem is to coordinate, prioritise and effectively utilise resources. Harmonisation and alignment are main principles for work on HIV&AIDS at the country level. The figure below shows the HIV/AIDS prevalence in Sida health programme countries.

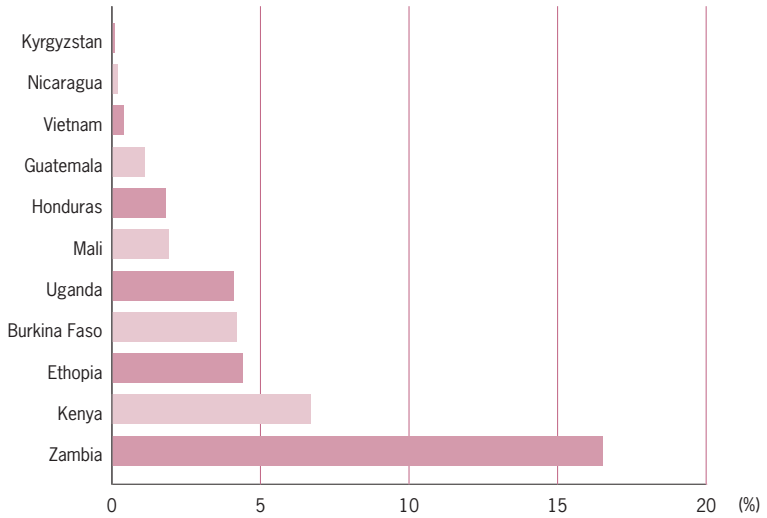

Figure 10: HIV prevalence

Since the launching of the Swedish HIV&AIDS strategy "Investing for Future Generations" in 1999 Sida has scaled up its engagement and addressed HIV&AIDS in a balanced approach, responding to all elements of HIV&AIDS: prevention, care & treatment and impact mitigation.

Priorities

The main focus is on supporting, advocating and initiating dialogue on prevention in all its aspects, including underlying determinants as well as immediate causes of HIV&AIDS. Gender inequality, poverty reduction and sexual education for young people have been central element in Side's efforts, including strengthening the linkages between Sexual and Reproductive Health

and Rights (SRHR) and HIV&AIDS. Mainstreaming in all sectors of development cooperation is one of the main strategic tools, as is increased support to targeted HIV&AIDS activities.

For the year 2005–2006 HIV&AIDS has been recognised as strategic priority for Sida's development cooperation. The disbursements through Sida earmarked to HIV&AIDS increased from SEK 551 million in 2005 to SEK 594 million in 2006. Of this, SEK 219 million was disbursed to regional programmes in Africa. In addition, the Swedish Ministry for Foreign Affairs disbursed SEK 840 million through the Global Fund to fight AIDS, Tuberculosis and Malaria, and through UNAIDS.

In Africa Sida is working both at the regional and bilateral level. Sida supported 40 non-governmental organisations, UN organisations and inter-country organisations such as SADC. Sida has been active in the policy dialogue between intergovernmental organisations in the region. At a SADC consultation in Namibia, HIV&AIDS were included in the final document as a result of Swedish influence.

In 2006 the Regional HIV/AIDS Team in Lusaka disbursed SEK 198.65 million out of the allocation of SEK 200 million from the budget allocation for regional development cooperation on HIV and AIDS. The team also handled delegated funds from SAREC, Lake Victoria, and Burkina Faso and from these allocation accounts, SEK 4.7 million were disbursed during the year. In addition, the team disbursed SEK 20 million to bilateral HIV/AIDS programmes in Botswana and Angola. The Regional Advisor for Culture, who is placed with the team, handles regional cultural programmes, totalling SEK 11.5 million for 2006, and out of the SEK 8 million allocated to the team, the entire amount was disbursed.

There are clear connections between HIV&AIDS and democratic governance. In Zambia Sida is supporting the national AIDS Council which aims at increasing democratic insight. Sida has supported research on how the epidemic affects democratic systems and how HIV&AIDS are dealt with within the national budget systems.

Treatment and care are central in many of the bilateral programmes; in Tanzania 49,315 infected people received treatment through a Sida-supported initiative.

To reach out at grassroots levels in many countries, the support is channelled through civil society. In Kenya's western province several grassroots organisations receive support for HIV&AIDS initiatives through the Manisha programme. In Ethiopia Sida supports 45 organisations work actively with HIV&AIDS.

Today the majority of the infected persons are women. To address this problem Sida is actively supporting imitative dealing with male involvement and masculinity. One example is the project Young Men as Equal Partners, which aims to get young men to increasingly adopt safer sexual practices and make better use of sexual and reproductive services in the communities.

In India, support for the Lawyers Collective involves the promotion of human rights and fighting stigma and discrimination related to HIV&AIDS. Components include capacity building of legal actors and empowerment of communities to respond to HIV&AIDS and to seek legal services. The primary

target groups are women, PLWHA, men who have sex with men, sex workers and IDUs. It is also actively involved in the campaign for access to affordable medicines and treatment campaign.

Sida and the Asian Development Bank (ADB) have collaborated in setting up a Trust Fund for HIV&AIDS at the Bank with a two-fold aim: that HIV&AIDS becomes an important component in all programmes that are being supported by the ADB and to strengthen and increase the capacity to address HIV&AIDS in the Asia and Pacific region.

One example of prevention is the Sida support to the international HIV&AIDS organisation AIDS Foundation East-West (AFEW) that cooperates with the Russian Ministry of Justice in training prisoners and prison staff in HIV prevention.

In Nicaragua, Sida supports the Center for AIDS Education and Prevention (CEPRESI), an organisation working with HIV&AIDS from a rights perspective focusing on men who have sex with men (MSM). Through this initiative young men and policemen have access to information on sexuality and HIV&AIDS.

Public health

A few major risk factors account for the majority of non-communicable disease morbidity and mortality. These include alcohol abuse, tobacco use, unhealthy diets and physical activity. The potential for improving health by health promotion and disease prevention is still largely untapped. Road traffic injuries kill an estimated 1.2 million people annually, injuring as many as 5.2 million. It is estimated that the number of killed and injured persons will have increased by 65 percent in 2020. The need for a better understanding of what will improve people's health highlights the need for cross-sectoral action in sectors beyond the control of the health sector.

Priorities

In 2006 the Health division emphasised identifying focus areas in public health most needed to be developed and elaborated in the years to come. These are alcohol and tobacco use, road safety/injuries and gender-based violence. Smoking is very high in countries like Bangladesh and Vietnam and a component against tobacco is part of the Sida support to Vietnam.

In some of these areas Sida has been working for many years (tobacco, injuries) and some are new to us (alcohol and gender-based violence). Road safety/injuries and gender-based violence are areas that will be dealt with inter-sectorally, since the responsibility is shared between divisions and units within Sida. Collaboration between the health division and INEC started in 2006 in road traffic safety. The intention is to create a global "Vision Zero Academy" in collaboration with the Swedish Road Administration that will constitute a platform for the development of system-orientated road safety work in low-income countries.

On a regional level Sida is contributing to two Swedish NGOs, Diakonia and IOGT-NTO, whose work in Southeast Asia aims at prevention to reduce

drug abuse and its related ill health consequences. In Cambodia, Laos, Vietnam, Thailand and Burma the support targets poor minority people living in the Golden Triangle in their efforts to improve their social life.

Bilateral cooperation under the Vietnam-Swedish Health Support has led to the Ministry of Health developing a tobacco policy and an injury prevention strategy that began being implemented a few years ago. Collaborating partners are the World Health Organisation (WHO) and Karolinska Institutet (KI). In 2006 work to develop an alcohol policy was initiated with support from the Swedish National Public Health Institute.

In the Kyrgyz Republic, Sweden has signed a delegated cooperation agreement with the Swiss Agency for Development and Cooperation (SDC) for the development of a community health promotion strategy for rural areas, called Community Action for Health. Health actions with population involvement are developed and implemented to address alcohol abuse, cardiovascular diseases, reproductive tract infections, anaemia, and promotion of vegetable gardens, iodised salt, and brucellosis control. Actions on research are also being done on hypertension and tobacco consumption.

All the member countries of World Health Organisation (WHO) adopted an historic tobacco control treaty, the Framework Convention on Tobacco Control (FCTC) in 2003. Since then, Sida supports a global alliance (The Framework Convention Alliance) made up of more than 250 organisations representing over 90 countries around the world to develop, ratify and implement the FCTC. The aim of the Sida support is to assist the implementation of the Convention in poor countries.

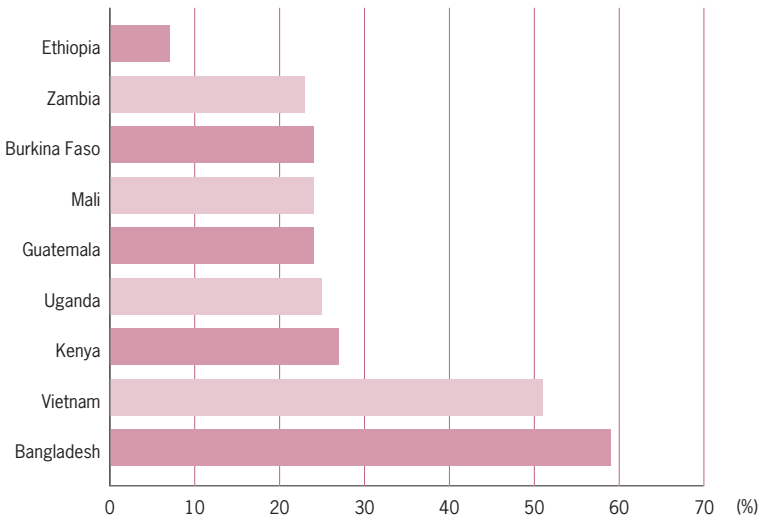

Figure 11: Smoking (% of population)

Social welfare

A policy shift has been underway recently to redefine the social sector within development cooperation to cover what is traditionally included in the social policy and welfare areas, i.e. social security systems, social insurance, social services, support to especially vulnerable groups and employment and labour market issues. There are a number of factors that form the background to this discussion. One important point of departure is the UN World Summit for Social Development in Copenhagen 1995 and reaffirmed 2000 and 2005, with three overarching goals: to eradicate poverty, employment for all and to foster social inclusion with the aim to create 'a society for all'. In articles 22, 23 and 25 of the UN International Bill of Human Rights, the right to social security, protection against unemployment and a satisfactory standard of living including the necessary social services is established. This is confirmed in the International Covenant on Economic, Social and Cultural rights that came info force in 1976.

Another point of departure is the UN Millennium Declaration with its overall goals of reducing extreme poverty by half by 2015 and creating fair and sustainable distribution of wealth in the world. All MDGs exert great influence on social welfare and social development. Recent research by the United Nations Research Institute for Social Development (UNRISD) suggests that social policy should be conceived as involving overall and prior concerns with social development, and as a key instrument that works in tandem with economic policy to ensure equitable and socially sustainable development. The building of social policy, including social welfare and social security systems, is ongoing in various degrees in all parts of the world. According to ILO, only 20 percent of populations enjoy adequate social security. In low-income countries more then 90 percent of the population is not covered, while in middle-income developing countries this percentage ranges from 20 to 60 percent.

Sweden's Policy for Global Development emphasises that Sweden's own modern history and experiences justifies a special Swedish commitment to, and an active involvement in, strengthening the building of social security systems as part of social development. The policy states that good health, education and social security increase opportunities for people to escape poverty, to permanently improve their living conditions and to actively participate in discussions and decisions of importance to their lives.

In 2006, Sida carried out a mapping of Sida's activities including Swedish actors in the area of social policy and social security. The survey shows that a large number of such activities are underway, especially in Eastern and Southeast Europe, where cooperation within this area has been well developed and well documented for a considerable period of time. In 2006 Sida also started drafting a position paper on social development and social security that will guide Sida's future direction in the area. Since the area of social welfare and social protection is a fairly new arena for development cooperation, there is a strong need for policy development. At a global level Sida's support is aiming at strengthening the policy and methodological development in this area.

Sida is supporting the International Council on Social Welfare (ICSW) to support the participation of civil society in the policy dialogue at global, regional and national levels. Sida is also supporting the Women in Informal Economy: Globalizing and Organizing (WIEGO) to influence the need for social protection in the informal sector through dialogue with ILO, ESCAP and The High Level Commission for the Legal Empowerment of the Poor.

Sida organised an international seminar in cooperation with UNRISD, called "Social policy in a development context – How to translate research into policy and action" with the aim of disseminating research findings for policymakers at different levels within the social sectors.

Operational Areas

Africa

Nowhere in the world is poverty as prevalent as in Africa. The population of the African region represents about 10 percent of the world's population but one-third of the world's poor people live in Africa. The health challenges facing the continent are enormous. Nearly half of the mothers who die as a result of pregnancy and childbirth are in the African region. Of the 20 countries with the highest maternal mortality ratios in the world, 19 are in Africa. More than 60 percent of all people in the world living with HIV infection are in Africa. In 16 countries on the continent, at least 10 percent of the population is infected and the majority of those are women. Of the children who die before the age of five, 43 percent are concentrated in Africa.

The key challenge confronting the health in Africa today is that most diseases and conditions are preventable, treatable or both. Most deaths in the region could be avoided if basic healthcare services were widely available and affordable to those that need it the most. A major concern are the weak, poorly performing and largely underfunded health systems with inadequate numbers of health workers, lack of infrastructure and basic equipment and medicines. Expenditures on health rarely exceed 5 percent of an African country's GDP and government per capita expenditures on health ranges between USD 5 to USD 10. An estimate of the cost of providing minimum healthcare to people in Africa is about USD 34 per person. In comparison, about USD 2,000 are spent per person and year in high-income countries.

Considering the fact that Africa has the world's highest burden of disease and 45 percent of the world's poor people live in the region, it is not surprising that Africa is the largest recipient of Sida's health support compared to other regions. Close to 50 percent of the total disbursement of SEK 2615 million that constitutes Sida's health support in 2006 is directed to Africa. Health cooperation with Africa has nearly tripled since 2000. In addition, 75 percent of Sida's emergency and humanitarian health-related assistance targets Africa and 44 percent of total Sida support to NGOs went to Africa. Programmes and projects that are of regional character – support to regional organisations and networks in Africa – amounted to SEK 238 million in 2006, excluding emergency assistance, the main part being HIV/AIDS programmes administered by the regional HIV/AIDS team in Lusaka, Zambia.

Sida's bilateral health support to Africa is concentrated in a number of countries, most of with which Sweden has longstanding partnerships. Zambia was by far the largest recipient of health sector support in 2006, followed by Tanzania, Uganda, Malawi, Kenya, Mali, Ethiopia and Burkina Faso. In these countries, Sida provides funding to national health sector plans and programmes, which in practice means that there is a formal agreement with the government in each country. In Tanzania, however, health support is specifically earmarked for national ARV treatment programmes only, and is not government-to-government support.

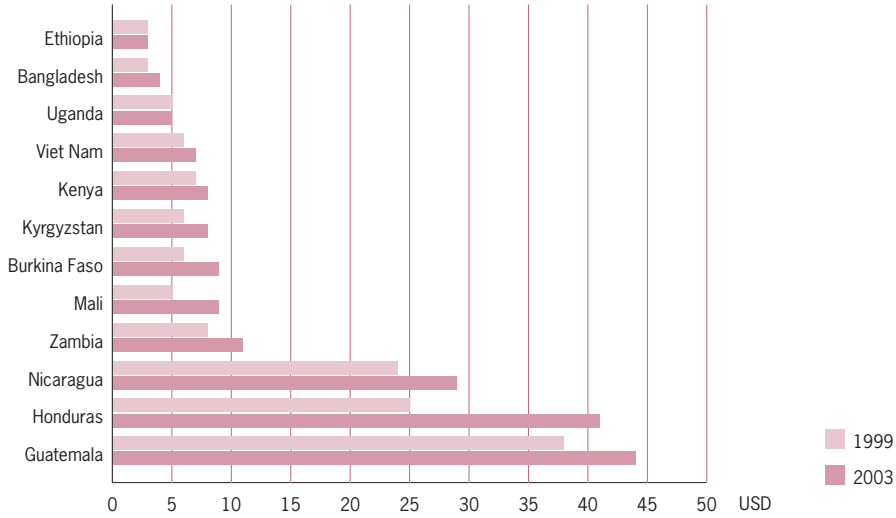

Figure 12: Government expenditure on health per capita (USD) 1999 and 2003

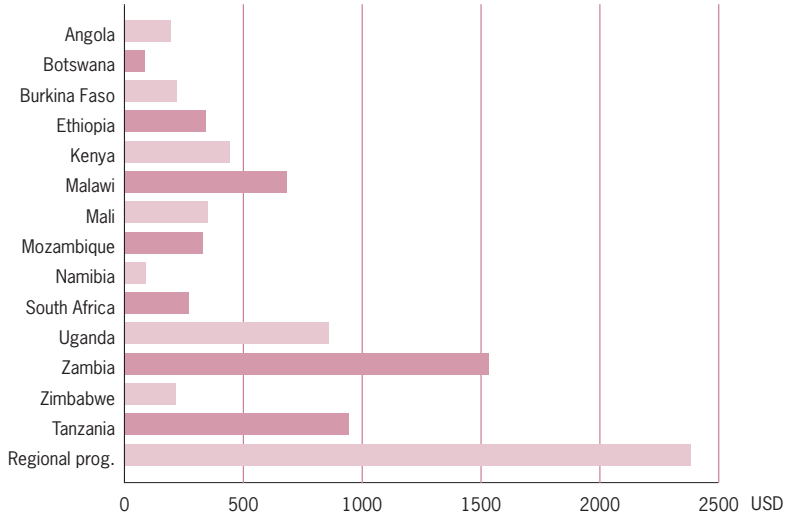

Figure 13: Africa, disbursements by country

The main aid modality for funding the health sector in Africa is through a programme-based support mechanism, such as sector budget support or pool funding. Programme support is in place in Zambia, Uganda, Mali, Burkina Faso and Malawi. However, In Mali and Burkina Faso, Sida has entered into a delegated partnership with the Netherlands, thereby handing over the responsibility for disbursing funds as well as programme monitoring and reporting. Sida also renounces the opportunity to conduct a sector dialogue with the health ministries in those countries. In Malawi, Sida has a delegated partnership with Norway in much the same way. In countries such as Mozambique, South Africa and Zimbabwe, Sida does not have formal bilateral agreements with the governments but gives project support, mostly related to HIV/AIDS and primarily to the civil society through NGOs, universities, research networks and other non-state actors.

The trend to move away from traditional project support to programme-based support, including general budget support, sector budget support and pool funding has increased over the last few years. Sida-funded sector programmes as a whole are increasing where the health sector represents one-third of these. Programme-based support mechanisms are predominantly used in Africa. The African share of Swedish general budget support disbursements was 90 percent in 2006.

In 2006, 25 percent of the total amount of health support to Africa, excluding humanitarian assistance, was channelled through a programme-based support aid modality. Programme support has almost doubled in real terms between 2005 and 2006 (SEK 257 million and SEK 475 million, respectively). Even though programme-based aid modalities are on the rise, it is clear that project support still prevails in real terms. Project support includes all earmarked bilateral support going through multilateral organisations such as the UN, non-governmental organisations and to governments. Government-to-government support is encouraged in the Paris Declaration and will most likely continue to represent a large share of total health support in the near future.

Total health cooperation with Africa was SEK 1 260 million in 2006, with HIV/AIDS as the most important sub-sector with SEK 490 million followed by health systems, mainly SWAP support, SEK 360 million and emergency support with SEK 330 million.

In Figure 14, any figures for infectious disease control and sexual and reproductive health and rights refer only to disease-specific or programme-specific support to these sub-sectors, while a fair share of the support to health systems has been provided both to the control of infectious diseases and to sexual and reproductive health services.

Bilateral health cooperation with Africa included support to 14 countries, programme cooperation with eight countries and health projects, mainly HIV/AIDS to another six countries. Nearly 70 percent of bilateral cooperation was programme cooperation. Health cooperation also included support to regional programmes, mainly HIV/AIDS.

SWAP programmes in Zambia, Uganda, Malawi, Mali and Burkina Faso receive the biggest support together with the HIV/AIDS support to Tanzania through the Clinton foundation.

Regional programmes include mainly support to HIV/AIDS, having increased from SEK 50 million in 2000 to SEK 500 million in 2006.

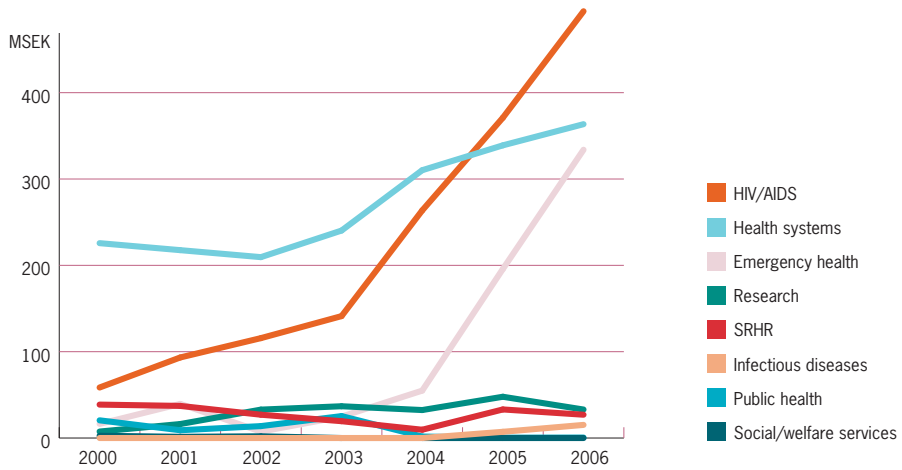

Figure 14: Africa, disbursement by sub-sector

Asia

Two out of every three poor men and women live in Asia; most of them are women and children. Studies show that the Millennium Development Goals (MDGs) in the social sectors are the hardest to reach. There is, for example, an extensive need for enhanced health services for poor people. Asian economic growth has created large unbalances and growing disparities between rich and poor. Natural catastrophes, conflicts and wars have added to the problems for poor people. Differences within many of the countries in Asia are growing with a growing middle-class and an enormously large impoverished class, for example in India. This tendency is also present in Vietnam.

Prioritised areas for development cooperation is, according to the Asia Strategy, good governance, promoting human rights and democracy including enhancing gender equality, women's and girls' rights to SRHR services, sustainable environment, combating HIV&AIDS and prevention of conflicts. Sida has two regional HIV/AIDS advisors, one in India for South Asia and one in Cambodia for Southeast Asia. Sida supported a few regional HIV/AIDS interventions in 2006.

According to the UNAIDS Report 2006 AIDS Epidemic Update, an estimated 8.6 million people were living with HIV in Asia in 2006. Two-thirds of them in India, which by the end of 2005 had approximately 5.7 million people living with HIV, of which 5.2 million were adults aged 15–49 years.

The South Asia region has many local concentrated severe epidemics among

groups at risk, such as female sex workers (FSW) and their clients and injecting drug users (IDUs) and their partners. In addition, recent information suggests that serious epidemics among men who have sex with men (MSM) are evolving in India, Nepal and Pakistan. Women account for a growing proportion of people living with HIV. In India around 38 percent of all people living with HIV in 2005 are women.

An underlying factor such as gender inequality amplifies the HIV transmission. In South and South-East Asia, 30 percent of adults and 40 percent of young people living with HIV/AIDS are women and girls. The number of infected women is growing in the region and HIV transmission between spouses has become a more prominent cause of new infections in countries like Cambodia, Myanmar and Thailand – countries which, like parts of India, are already contending with serious epidemics.

Asia regional programmes

The health division is handling regional programmes combating HIV/AIDS, drugs and human trafficking. These programmes are channelled through UNIAP, ADB and two Swedish NGOs (IOGT and Diakonia). The UNIAP support is directed to combat trafficking in developing regional and national capacity of institutional building in the Greater Mekong Sub-region. The support to UNIAP, IOGT and Diakonia all ended in 2006.

Asia bilateral cooperation

There are two large health programmes in Vietnam and in Bangladesh and project support to India, West Bank/Gaza and Burma.

In 2006 there was an evaluation of the Swedish support in the health sector Vietnam. The Sida support has been particularly positive in relation to policy development. Efforts are made in Vietnam as well as donors to the health sector

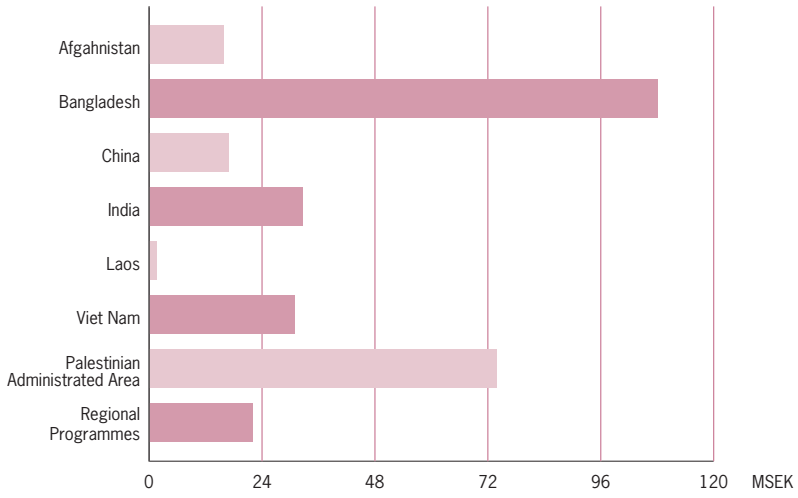

Figure 15: Asia, disbursements by country 2006

to move away from project support to sector programme support (SWAP).

The Health Division participated in the preparation of the new Development Cooperation Strategy for Bangladesh in 2006. The major Sida intervention in Bangladesh is a SWAP, a large DESO support including health and education sectors, covering 80 percent of the country allocation.

The cooperation with India exemplifies how the Swedish Policy on Global Development can be applied in elaborating a model for future cooperation with broader exchange of knowledge and experiences between Sweden and India. Partnerships based on mutual knowledge and experience exchange started their implementation phase in 2006 in the area of Sexual and Reproductive Health and Rights (SRHR), with broad-based interventions.

The Health Division prepared a new health support to West Bank/Gaza in 2006, together with the GC in Jerusalem.

The Health Division and the regional advisor for HIV/AIDS in New Delhi have been preparing a new support to Burma to combat HIV & AIDS, TBC and Malaria in 2006, the 3D Fund that will be implemented over a period of five years.

Total health cooperation with Asia was SEK 370 million in 2006, with health systems as the most important sub-sector with SEK 180 million.

In the table below, any figures for infectious disease control and sexual and reproductive health and rights refer only to disease-specific or programme-specific support to these sub-sectors, while a fair share of the support to health systems has been provided both to the control of infectious diseases and to sexual and reproductive health services.

Bilateral health cooperation with Asia included support to six countries, programme cooperation with two countries and health projects to another four countries and support to the Palestinian Administrated Area. Programme cooperation was 37 percent of bilateral cooperation. Health cooperation also included support to regional programmes, mainly HIV/AIDS.

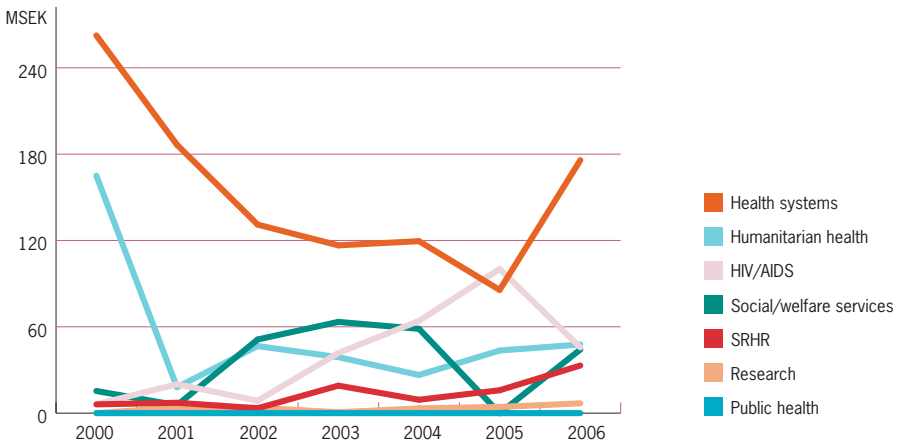

Figure 16: Asia, disbursement by sub-sector

Latin America

Poverty and social problems continue to generate a number of health hazards in Central America. This is reflected by indicators such as maternal mortality, infant mortality and life expectancy. Although figures have improved over the past few years and reforms in the health sector are under implementation in Central America, enormous differences still remain within countries and between groups of people.

The spread of HIV/AIDS has increased in the region and Honduras and Haiti are particularly affected by this problem. Intra-family violence seriously affects women and children and preserves oppressive attitudes and conditions. Gender inequality also affects women's health when it comes to nutrition, sexual and reproductive health and rights and access to health services. The region is experiencing epidemiological polarisation, i.e. communicable and non-communicable diseases are affecting the mortality profile simultaneously. Thus, chronic degenerative diseases as well as disability, violence and lifestyle-related diseases arise and coexist with emerging and re-emerging communicable diseases (malaria, tuberculosis, dengue fever, etc.).

One of the main objectives of Sida's support to health in Central America combating inequality and contributing to people's access to preventive healthcare and services based on a rights perspective – as well as supporting democratic and peaceful development. Within this context, regional support is envisaged as a mechanism to strengthen health sector reforms in Honduras, Guatemala and Nicaragua. The bilateral health sectors support and regional programmes complement each other and have synergy effects which increase the effectiveness of the regional programme. Due to similarities in health indicators among most Central American countries, Sida also wishes to promote systematic exchange of experience within the region, sharing results,

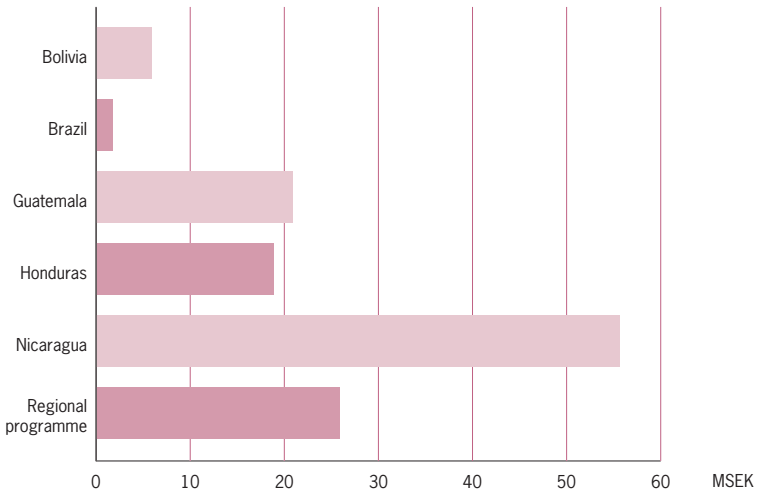

Figure 17: Latin America, disbursements by country

ideas and best practices. Regional cooperation is also promoted through regional NGOs as well as multilateral organisations, particularly in order to combat shared health hazards such as HIV/AIDS.

After an overview in 2004 the portfolio has turned into a more focused regional support with the spotlight mainly on SRHR, gender and social protection. An assessment of regional health programmes in 2006 assessed that the concentration had been effective but recommended that more focus on SRHR in the future. It also concluded that the regional programmes have a synergy effect on country level and bilateral programmes.

Sida has continued to promote the efficiency of cooperation through Sector Wide Approach Processes (SWAP) and increased donor harmonisation. The long-term goal of support in Honduras, Guatemala and Nicaragua is to establish a single, consolidated National Health Plan, a plan that will also constitute the basis for establishing SWAPs in each country.

The implementation of the health programme in Guatemala improved significantly with utilisation of 97 percent of the programmed funds. The agreement between the Guatemalan Ministry of Health and PAHO was extended through December 2007. Swedish support is directed towards 69 municipalities within five regions: Alta Verapaz, Huehuetenango, Ixcán, Ixil, and Quiché. One of the main results was a decrease in maternal mortality in the five regions compared to a maternal mortality baseline study done in 2000.

The health support programme in Honduras has contributed to the management of health services at local governments, promoted collaboration with local authorities and encouraged the participation of local communities in the planning and implementation of health services. The implementation of the programme has also contributed to improving planning in general and has generated ideas for local development projects. The health support has contributed to higher levels of equity in terms of access to health services in poor municipalities. In addition, the programme has facilitated the participation of other health actors as a means of effectively implementing the healthcare reform and decentralising care by bringing health services to the population in need.

In Nicaragua, Sweden and six other donors support the Five-Year Health Plan (2005-2009) through a SWAP arrangement with pooled funding. In total, the external cooperation represents some 12 percent of the total investments in the health sector. The national health policy supports the PRSP by focusing on maternal and child healthcare, increased access to nutrition and family planning as well as institutional capacity strengthening.

In 2006, the fairly new support to Intercambios and the Alan Guttmacher Institute started to show results. Intercambios is an alliance of organisations and networks in Latin America working against gender-based violence (GBV) from within the health sector. Intercambios has created conditions for exchange and learning about GBV between institutions and organisations – using their current work and processes.

In 2006, concrete work at the country level has included: capacity building of national authorities, such as judges, police, and staff at ministries of health in Nicaragua, Honduras and Guatemala, advocacy and information strategic work with NGOs targeting young people, scaling-up of already existing

products, tools and IEC material, joint campaigns on male involvement and responsibility, and collaboration with research institutions on the link between HIV/AIDS and GBV. Intercambios is closely collaborating with and is complementary to organisations such as PAHO, UNIFEM, UNFPA, IPPF and others. The conclusion is that Intercambios has produced a low-bureaucracy, cost-effective and synergy-building model of work at the regional level that produces visible results at the country level.

During the third year of project implementation SALTRA grew into a broader and more occupational health programme. Some of the main achievements of project implementation in 2006 were the positive impact on working conditions in some sectors addressed by SALTRA and the increased university presence in the political arena.

Sida supports PAHO Family and Community Health Programme for young people who participate in human rights advocacy programmes. Strong advocacy was done on adolescent pregnancy prevention using data from the Alan Guttmacher Institute. El Salvador is conducting an impact evaluation of the Empowerment of Adolescent Girls project to be disseminated in the region. Further, Sida in partnership with units as Health Policy Unit (HP), the Gender, Ethnicity and Health Unit (GE) in PAHO has developed and tested policy evaluation tools to mainstream gender equity in health sector policies, and to measure and impute value to unpaid care within the framework of National Accounts. Also, with HP inputs, GE is executing a capacity building initiative for the Central American Commission of Ministers of Women's Affairs (COMMCA). This initiative is directed to producing policy-orientated information and strengthening advocacy skills to mainstreaming gender equality issues in sub-regional Central American policy-making bodies.

PAHO is also working with development of social protection in the region and organised a seminar for high level policymakers.

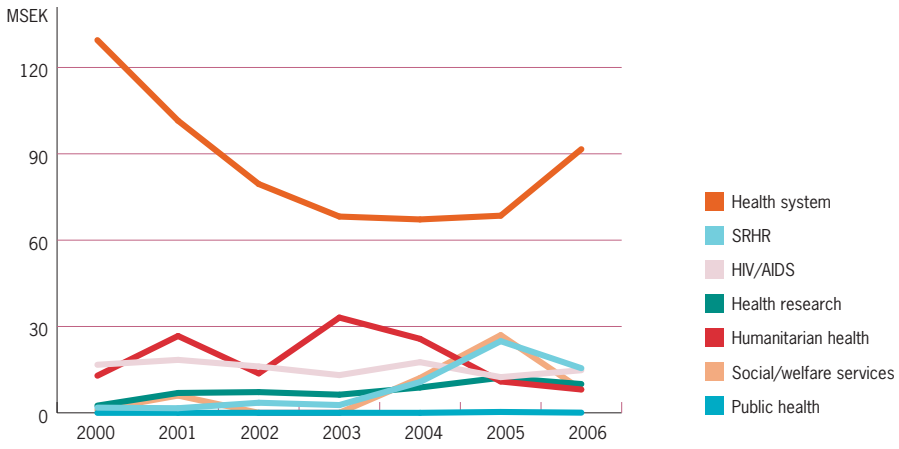

Figure 18: Latin America, disbursements by sub-sector

Total health cooperation with Latin America was SEK 149 million in 2006, with health systems as the most important sub-sector with SEK 92 billion. In the table below, the figures for sexual and reproductive health and rights refers only to disease-specific or programme-specific support to these sub-sectors, while a fair share of the support to health systems has been provided to reproductive health services.

Bilateral health cooperation with Latin America included support to five countries. Health cooperation also included support to regional programmes, mainly HIV/AIDS.

Eastern Europe and Central Asia

Income poverty and deterioration in health has spread to affect about half of the population in some countries. Poverty and under-funded health services create a double burden of diseases for those countries. Important inequalities in health status result from the increase in the incidence of communicable diseases such as HIV/AIDS and tuberculosis in Eastern Europe, largely related to the deterioration of the socioeconomic situation, and the persistence of malaria in some areas in the southeastern part of the region. Nevertheless, cardiovascular diseases, cancer, diabetes mellitus and other non-communicable diseases account for most of the burden of ill health and the east-west gap in life expectancy in Europe. Most of these diseases are associated with common risk factors related to lifestyles and the socioeconomic environment.

Health systems and services are undergoing major transformations in Eastern Europe, Russia and Central Asia. Structural changes are taking place to reduce the systems dependency on hospitals and specialists and give priority to primary healthcare and family medicine as the first level of care. Countries are striving to better balance sustainability and solidarity in financing. There is an increasing trend towards strategic purchasing as a way of allocating resources to providers to maximise health gain, including separating provider and purchaser functions, moving from passive reimbursement to proactive purchasing, and selecting providers according on their cost-effectiveness. Contracting mechanisms and performance-based payments become central to effective purchasing.

Health cooperation with Central Asia includes support to a health SWAP and community health in Kyrgyzstan and support to health reforms in Tajikistan. In Eastern Europe support goes to Albania for reforming health and mental health. Sida is giving support to a number of countries for HIV/AIDS control and prevention and to social assistance programmes, often to improve the situation of children.

Health cooperation with Russia goes through the East Europe Committee of the Swedish Health Care Community, SEEC. The activities of SEEC have progressed from initially small-scale consultations and contact-building to extensive, strategic reform-orientated projects. For the coming three-year period a new framework agreement has been worked out. SEEC has made a three-year work plan and proposal for funding for 2006-2008. An exit strategy

for all projects in Russia and Ukraine is presented in this programme. The projects are to be phased out and mainly replaced by programmes in Belarus. A total of 59 projects were funded by SEEC in 2006, the majority (51) in the northwestern regions of the Russian Federation.

Total health cooperation with Eastern Europe and Central Asia was 122 SEK million in 2006, with health systems as the most important sub-sector.

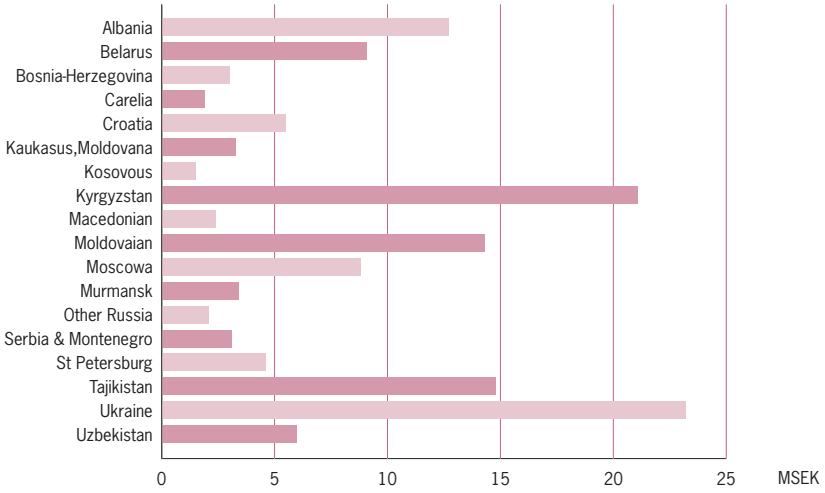

Figure 19: Europe and Central Asia, disbursement by country 2006

Global cooperation through Sida

Through global cooperation Sida contributes to the development of international policies, methods, capacity, institutions and communication. It also makes it possible to increase the proportion of qualified Swedish personnel to work in the international and regional organisations given priority by Sweden, and to extend, train and develop the Swedish resource base for international development cooperation. In the health sector there are several areas where global policy and methodology discussions are of significant importance for the development of efficient and effective health strategies in the partner countries.

WHO as a global normative organisation needs to have a leading role both at the global and country levels for strengthening technical and policy development and is therefore supported with a significant contribution from Sweden. The contributions for global cooperation are to a large extent guided by Sida's Letter of Appropriation. For 2006 infectious diseases including health systems and sexual and reproductive health and rights are in focus, which is reflected in large contributions to WHO, GAVI, UNFPA and IPPF.

To support health systems and infectious diseases, contributions focus on strengthening equity in health and human resources in health by earmarking support to WHO and support to GEGA, for example. To tackle contagious diseases the main focus is on immunisation through support to GAVI, and to

strengthen the area of drugs, support to Health Action International and REACT are examples of contributions.

To step up the issue of safe abortions on the global agenda and to improve the knowledge and availability of safe abortions, a couple of important but smaller organisations have received support such as Ipas, Gynuity Health project, The Safe Abortion Fund, and the International Consortium for medical Abortion (ICMA).

A major public health issue has been support to prevent tobacco use, through support to the Framework Convention Alliance.

Social policy and security is a rather new area for development aid and the main focus is on policy and methodology development by supporting global research policy networks such as Women in Informal Employment and the International Council on Social Welfare.

Several secondments to WHO have been made in important areas such as midwifery, tuberculosis and health systems. More secondments are in the pipeline. An SRHR expert is seconded to the World Bank. Apart from the experts there are several JPOs working at WHO, UNAIDS and UNICEF. Another way Sida has contributed to the Swedish resource base is by support to training courses for health personnel working in low-income countries and Swedish doctor's residence training based in Tanzania, Ethiopia and India.

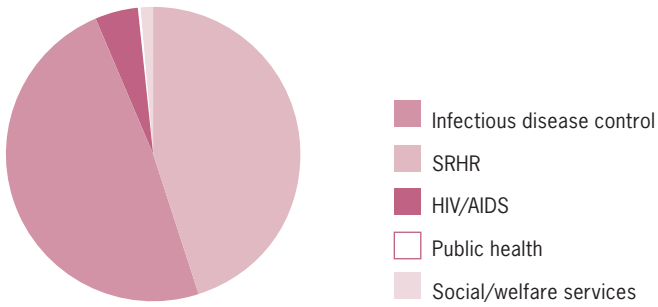

Figure 20: Global programmes, sub-sectors

As a conclusion, the support to multilateral and global organisations is in line with the Swedish priorities. The main challenge is to implement the policies and methods developed by global organisations at country level and to make use of the accumulated global knowledge in the countries. Another challenge is how to get the country experiences and knowledge back into the global organisations, and good practices and norms disseminated to and implemented by other countries. Sida is continuously trying to improve the use of evidence-based findings and experiences from global organisations in dialogue with partner countries.

Research cooperation

The specific objectives formulated by the Government for Sida research cooperation through its Department for Research Cooperation, SAREC, are as follows:

Sida shall contribute to strengthen research capacity in developing countries and promote research which contributes to combating poverty and to an equitable and sustainable global development. Furthermore, Sida shall contribute to strengthen development relevant research in Sweden.

The Government further states that continued support shall be directed:

- to poor developing countries for their building of good research environments; training of researchers; development of methods for planning, prioritising and funding research
- in the form of financial and scientific resources for the purpose of supporting the production of new knowledge and promoting the use of research findings of importance for the development of developing countries;
- to promoting scientific cooperation between researchers in Sweden and in developing countries and the participation of Swedish researchers in development relevant research and research cooperation

Several interesting scientific projects have been funded in 2006. For instance, one project has identified that the snake venom from vipers has bactericidal effects on both Salmonella and Staphylococcus bacteria. Physiological mechanisms are being identified and the project may lead to new antibacterial drugs. Another project has identified the extent of penicillin-resistance of nasopharyngeal bacteria in Nicaraguan children.

In 2006 SAREC managed a research cooperation budget of SEK 925 million. Out of this, around 20 percent was channelled to health related research. Support is generally distributed in the following way: 30 percent as direct support to research in partner countries, 30 percent to regional research cooperation that focuses both on knowledge and capacity development and 30 percent to international knowledge development. The remaining 10 percent goes to grants for Swedish development research.

In order to have proper impact, Sida research funding is concentrated to a limited number of geographic and thematic areas. The funding is aligned with national and organisational strategies for research. Sida may support the development of such strategies where these are weak or non-existent. Sida shall promote the utilisation of research findings into innovation, as well as promote links between national, regional and international research. Sida shall also promote harmonised research funding along these lines among development cooperation agencies and mobilise Swedish high quality research for development issues.

Emergency health

Health interventions make up a substantial share of Swedish humanitarian assistance. About a quarter of Swedish humanitarian assistance in 2006 went to

Emergency Health and Refugee Health.[4] Although all emergencies should be considered unique it is possible to identify common patterns in man-made and natural disasters and when it comes to the affected populations four categories of causes of death can be established: acute respiratory diseases, diarrhoea, malaria and malnutrition. Sida's Guidelines for Humanitarian Assistance in the Health Sector stipulate that humanitarian health interventions should give special priority to public health. Thus, in addition to primary healthcare, contributions include components dealing with water, sanitation, nutrition and food. The current Guidelines from 2001 is currently under review to more explicitly also cover issues of HIV/AIDS and to accommodate the changing landscape of humanitarian action. The changing humanitarian aid architecture features the Good Humanitarian Donorship (GHD) initiative and the cluster formation, where Health is chaired by WHO and Water, Sanitation and Hygiene is chaired by UNICEF.

It is worth noting that about one-quarter of Swedish humanitarian assistance is programmed within the Consolidated Appeals Process (CAP), which is a coordinated endeavour under the leadership of Office for the Coordination of Humanitarian Affairs (OCHA). Here lies a substantial share of health-orientated humanitarian responses, without necessarily being labelled as such for statistical purposes. For example, much of the Swedish contribution (SEK 85 million) to UNRWA CAP for the Occupied Palestinian Territories (OPT) was devoted to health interventions. Also part of the GHD agenda is the piloting of basket funding of the humanitarian response in the cases of Sudan and the Democratic Republic of Congo (DRC). In the latter case, an evaluation concluded that the Pooled Fund had led to significant changes in the thus far under-funded clusters, such as Health and Water and Sanitation. The following table shows emergency health disbursements by region.

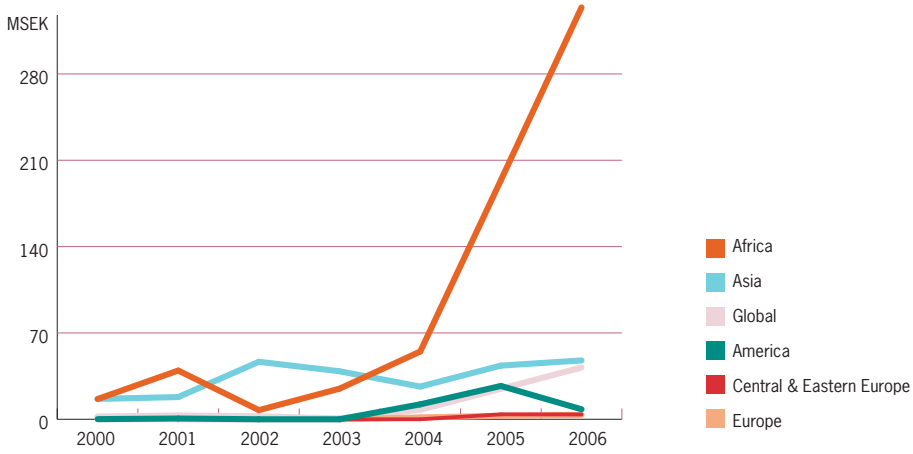

Figure 21: Emergency Health, disbursement by region

[4] Swedish Humanitarian assistance amounted to SEK 2.2 billion and approximately SEK 535 million was dedicated to Emergency and Refugee Health (statistical codes 72014 and 72034 respectively). A word of caution on the statistics is in place; some contributions are coded as health as they are predominantly health-orientated although not completely, while others are not reflected in these numbers but may contain health components (but not predominantly).

Health Programme Countries

Burkina Faso

Since July 2003, Sida supported the PADS (Program d'appui de développement sanitaire) programme in Burkina Faso. The current amount of SEK 80 million allocated to PADS II was granted for the period 1 January 2005 to 31 December 2008. The funds are granted via a delegated partnership. Sida disburses funds to the Netherlands, which then transfers the Swedish support together with its own contributions to the Ministry of Health in Burkina Faso. There are other several donors supporting PADS: France, UNFPA and the World Bank. Individual bilateral agreements as well as a joint financing arrangement between the Ministry of Finance & Budget of Burkina Faso and the donors regulate and define the roles and responsibility of the various actors.

PADS was created to help improve coordination and administration of financial resources in the health sector in order to implement the National Health Development Plan (PNDS) for 2001-2010. The overall goal of PNDS is to decrease the population's morbidity and mortality. PNDS has eight sub-objectives that are built on the PRSP, the policy for combating HIV/AIDS, the MDGs and the health chapter in the partnerships for Africa development. The main objective of PADS is to increase the capacity at the regional and district levels. At least 50 percent of financing of action plans are expected to be based on the process of decentralised performance-based management. Funding should also by at least 85 percent more than was allocated during the first phase and distribution of resources should be done according to rational criteria. Target groups are all levels of the health system: the 55 districts, the 13 regions, all central MoH directorates, the nine regional hospitals and three university hospitals, as well as NGOs and associations assuring care and treatment of people living with HIV/AIDS.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
21500070	Burkina Faso, IPC, HIV/AIDS	3 200 000
72300280	Burkina Faso Health	19 270 934
Total		19 270 934

In November 2006, the Netherlands submitted a short progress report, which was the first since PADS Phase II began in January 2005. It states that PADS is progressing well; the level of execution of planned activities is 85 percent in 2005 and 86 percent in the first half of 2006. PADS funding is timely available at decentralised level and procedures for utilisation are adhered to. A gradual improvement has been made on key indicators, but at present pace the MDGs will not be achieved. The following are several 2005 indicators: the vaccination coverage for children for preventable diseases is well above 80 percent, prenatal control 63 percent for at least two visits, 43 percent of women delivering with qualified assistance, and contraceptive prevalence is 22 percent.

	BURKINA FASO	LATEST YEAR	
HEALTH AND DEVELOPMENT	Life expectancy at birth (males)	47 (2004)	
	Under five mortality rate males	193 (2004)	
	Under five mortality rate females	191 (2004)	
	Human development index (value, ranking)	0.342/174 (2004)	
	IMR	97 (2004)	
	GDP/Capita PPP USD	1169 (2004)	
EQUITY	Under five mortality rate lowest/highest quintile	1.4 (2003)	
	Gini coefficient	48.2 (1998)	
SRHR	Maternal mortality ratio	1000 (2000)	
	HIV prevalence 15–49 (%)	4.2 (2003)	
	Antenatal care coverage, one visit (%)	7.2 (2003)	
	Births attended by skilled health personnel (%)	56.5 (2003)	
	Contraceptive prevalence rate (%)	13.8 (2003)	
	Total fertility rate (per woman)	6.6 (2004)	
	Adolescent fertility proportion (%)	10.1 (2002)	
	Neonatal mortality rate (per 1000 births)	36 (2000)	
	Deaths due to HIV/AIDS (per 100 000)	29 (2003)	
HEALTH SYSTEMS	Physicians per 1000 population	0.06 (2004)	
	Nurses per 1000 population	0.41 (2004)	
	Total expenditure on health (% of GDP)	5.6 (2003)	
	Government expenditure on health (% of government spending)	12.2 (2003)	
	External resources for health (% total)	7.4 (2003)	
	Per capita government expenditure on health	9 (2003)	
	Vaccination (3 x DPT)	88 (2004)	
	Midwives per 1000 population	0.13 (2004)	
INFECTIOUS DISEASES	Years lost to communicable diseases (%)	86.8 (2002)	
PUBLIC HEALTH	Years lost to non-communicable diseases (%)	6.6 (2002)	
	Years lost to injuries (%)	6.6 (2002)	
	Prevalence of tobacco smoking (males)	24 (2003)	

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The information systems have improved and the annual statistics for 2005 for health are available and detailed. However, there are still a number of major challenges ahead that must be met in order to make additional progress in the health sector:

1) improving efficiency by strengthening and adjusting the planning mechanisms by developing district health accounts with tools for budget and expenditure analysis linked to health impact interventions, and
2) the need to develop a comprehensive multi-annual and costed investment plan for infrastructure, equipment and logistics for the health sector and set priorities for implementation; for PADS:
3) further mobilisation and advocacy among donors for alignment and harmonisation with PADS procedures instead of specific project funding,
4) redefining the resource allocation criteria with increase of funding (with UNFPA & WB funding the budget will almost double in 2007),
5) improving coherence and quality of progress and financial reports by simplifying and rationalising them,
6) improving the institutional capacity of central and regional level directorates and identifying areas for technical assistance at all levels, and
7) integration of PADS into the directorate for administration and finances of the MoH.

Trends

SECTOR	2003	2004	2005	2006
Health systems	13 000 000	19 000 000	21 000 000	19 271 000
Inf. diseases, HIV/AIDS			3 000 000	3 200 000
Grand Total	13 000 000	19 000 000	24 000 000	22 471 000

Ethiopia

Sweden has supported the Ethiopian health sector since the late 1950s. The first support was to a paediatric clinic in Addis Ababa, followed by training of middle and lower level health staff, with a focus on midwives. Over the years, Sweden has contributed a large amount for continued training in integrated mother and child healthcare as well as to the establishment of training programmes for health assistants and midwifes throughout in the country.

Due to the political situation in Ethiopia and restrictions on aid Sweden can provide to the Government of Ethiopia, Sweden only provides assitance to the health sector via a few umbrella organisations that in turn support sub-grantees. The support is furthermore, concentrated on sexual and reproductive health and rights, including HIV/AIDS.

According to the latest Demographic and Health Survey (DHS), the fertility rate (2005) in Ethiopia has declined from 6.4 births per women in 1990 to 5.4 in 2005, a drop of one child per woman in the past 15 years. The trend analysis of HIV/AIDS prevalence in Ethiopia indicates that the infection rate in urban

	ETHIOPIA	LATEST YEAR	
HEALTH AND DEVELOPMENT	Life expectancy at birth (males)	49 (2004)	
	Under five mortality rate males	175 (2004)	
	Under five mortality rate females	158 (2004)	
	Human development index (value, ranking)	0.371/170 (2004)	
	IMR	110 (2004)	
	GDP/Capita PPP USD	756 (2004)	
EQUITY	Under five mortality rate lowest/highest quintile	1.1 (2000)	
	Gini coefficient	30 (2000)	
SRHR	Maternal mortality ratio	850 (2000)	
	HIV prevalence 15–49 (%)	4.4 (2003)	
	Antenatal care coverage, one visit (%)	27 (2000)	
	Births attended by skilled health personnel (%)	5.6 (2000)	
	Contraceptive prevalence rate (%)	8.1 (2000)	
	Total fertility rate (per woman)	5.7 (2004)	
	Adolescent fertility proportion (%)	9.4 (1998)	
	Neonatal mortality rate (per 1000 births)	51 (2000)	
	Deaths due to HIV/AIDS (per 100 000)	120 (2003)	
HEALTH SYSTEMS	Physicians per 1000 population	0.03 (2004)	
	Nurses per 1000 population	0.21 (2004)	
	Total expenditure on health (% of GDP)	5.9 (2003)	
	Government expenditure on health (% of government spending)	9.6 (2003)	
	External resources for health (% total)	26 (2003)	
	Per capita government expenditure on health	3 (2003)	
	Vaccination (3 x DPT)	80 (2004)	
	Midwives per 1000 population	0.01 (2004)	
INFECTIOUS DISEASES	Years lost to communicable diseases (%)	81.7 (2002)	
PUBLIC HEALTH	Years lost to non-communicable diseases (%)	12.3 (2002)	
	Years lost to injuries (%)	6 (2002)	
	Prevalence of tobacco smoking (males)	7 (2003)	

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areas (12.6 percent) seems to have levelled off while the rural epidemic (2.6 percent) is gradually increasing. The overall prevalence rate is estimated at 4.4 percent, a reduction from the 6.6 percent estimate in 2004 and 2005. However, although a decline in the HIV/AIDS prevalence has been observed, this is not considered to be robust or widespread enough to diminish the impact of the epidemic because the infection rate in rural areas is likely to continue the increase the overall national rate. There are over 1.5 million people in Ethiopia living with HIV/AIDS. Most of those infected come from the most vulnerable segments of the population – around 58 percent are women and 96,000 are children below the age of 15. HIV/AIDS is therefore still a serious threat to the overall socio-economic development of the country. The spread of poverty, the escalation of commercial sex, migration from urban to rural areas, low literacy levels, gender disparities and the stigma and discrimination associated with the disease are some of factors underlying the uncontrolled spread of the epidemic

The Swedish Embassy received a proposal from UNICEF to help increase access to skilled birth attendants during pregnancy and delivery and during the post-delivery period. After an initial assessment, Sida decided to conduct a more in-depth evaluation. The discussion with UNICEF is still ongoing and the in-depth assessment has not yet been finalised.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
29000227	Pathfinder Intl-Ethiopia	10 600 000
29000230	CRDA/CSO	6 000 000
29000231	CORHA/CSO	2 540 000
29000255	CSO Direct Funding	670 651
29000264	HIV AIDS through UNICEF 1	14 003 502
29000309	Audit NGO YADA 2006	3 069
Total		33 817 222

With Sida support, UNICEF has worked with the target regions to ensure that the programme is implemented as planned. The selected 21 target areas in the respective four regions (Oromia, Tigray, Afar and Somali) have carried out planning workshops, defined their respective action plans and began interventions. The regional HIV/AIDS Prevention and Control Offices have been active players. Other government staff working in offices such as Bureau of Labour & Social Affairs and Bureau of Youth & Sports have received orientation on HIV/AIDS prevention, care and support. Trainers have been educated about facilitating dialogue as well as life skills training for youth leaders. Follow-up activities within local communities have also been identified. UNICEF is also utilising Sida's contribution to work with partners to incorporate a strong focus on adolescents at all stages. Technical assistance has been commissioned to assist with implementation.

Civil Society Organisations

One of Sida's major contributions to the fight against HIV/AIDS in Ethiopia has also been through vivil society organisations. Sida allocated around SEK 70 million over three years. Three of the specialised umbrella organisations (SUOs) – Christian Relief & Development Association (CRDA), Pathfinder International-Ethiopia (PI-E) and Consortium of Reproductive Health Associations (CORHA) – have been selected to directly implement the HIV/AIDS allocation through sub-grantee NGO/CSO/CBOs working at the grassroots level. Another SUO, Pact-Ethiopia, also has some sub-grantees targeting women with HIV/AIDS. In total, there are 76 sub-grantee CSOs working on HIV/AIDS throughout the country through the four SUOs.

The involvement of the various sub-grantees in prevention initiatives as well as care and support of people living with HIV/AIDS has been one of the major outcomes. In particular, youth groups and volunteer home-based care providers have taken care of bed ridden patients in their respective communities. HIV orphans and the other orphans and vulnerable children (OVCs) have also been cared for. Contributions from Sweden through the umbrellas organisations have only been seed money to start up programmes and create other income generating activities. These groups have been recognised as successful youth projects that help affected community members and youth to avoid risky behaviour.

Behavioural changes among ex-prostitutes have also been observed. They have, with support from associations formed under the SUOs, participated in awareness-creating activities and learned about HIV prevention methods. Support from Sida gave them the possibility to improve their situation. Through Sida support via the SUOs, they have organised themselves, strengthened their associations and participated in other income-generating activities. One such group has a small multi-purpose kiosk, a café, a pool table, income from fees for video film shows and a weaving centre where they make traditional clothes to sell. Other income-generating initiatives include bee-keeping, poultry, and handicrafts. Quite a number of former commercial sex workers have been rehabilitated and others have testified how their lives and their children's lives have changed due to the Sida/sub-grantee interventions. These associations have been recognised by their communities and receive support from local administrations as well.

Trends

SECTOR	2000	2001	2002	2003	2004	2005	2006
Health Systems	17 228 042	5 301 280	7 274 236	902 175	624 250	471 695	84 291
SRHR	142 120	0	0	5 000 000	0	3 500 000	10 667
HIV/AIDS	123 390	217 137	1 680 923	1 352 378	15 011 159	33 238 197	34 035 558
16010 Social/ welfare services	1 037 056	705 598	1 925 665	2 141 798	37 178	-2 793	0
Total	18 530 608	6 224 015	10 880 825	9 396 351	15 672 587	37 207 099	34 130 515

Kenya

Health and HIV/AIDS cooperation with Kenya includes a Health Sector Bridging Plan, HIV/AIDS support, secondment of a health specialist to the World Bank office and Health and Children's Right programme. A SWAP process to support the Kenya National Health Sector Strategic Plan, NHSSP II was initiated late 2005 and developed in 2006. The Swedish Embassy actively supported the SWAP process and made an initial assessment about the possibility of ongoing support from Sweden through the SWAP modality. The "Rural Integrated Health Services Program" (RIHS) provided support to the district level and the Ministry of Health reform programme. The district support component was terminated in December 2005, whereas the support to MoH continued until the end of June 2006. The Swedish Embassy assessed a bridging plan that is supported from July 2006 to September 2007. The bridging plan is a continuation of the support to the MoH for capacity development related to the implementation of the Second Annual Plan of Operation of the NHSSP II and for preparations related to the SWAP.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
31000116	Health/childrens' rights	725 685
31000127	HIV/AIDS 2004-2006	36 569 638
31100028	ETC Technical Assistance for the SWAP	2 733 845
31102011	WB Kenya Secondment	2 418 277
Total		44 278 368

Results for the health cooperation are related to the development of the SWAP. The process rapidly expanded in 2006. The Kenyan government took ownership of the process and Denmark, Germany, Sweden, the UK and the World Bank provided intial support. A Joint Programme of Work and Funding, which is an important part of the SWAP, was developed outlining priorities for service delivery and increasing the capacity of the NHSSP II's implementation and funding systems for 2006-2010. Other achievements by MoH in the SWAP process in 2006 are the development of a Community Strategy, the Annual Operation Play (AOP) 2 for 2006-2007, based on district, provincial and headquarter plans, a Procurement Improvement plan, a Draft Human Resources for Health Plan, a Draft Performance Monitoring Framework, Draft Referral Guidelines and Health Norms & Standards. A Code of Conduct and a draft Joint Financing Arrangements have also been developed. It is expected that donor funding will start to flow through the SWAP mechanism in July 2007 in order to support the AOP 3.

	KENYA	LATEST YEAR	
HEALTH AND DEVELOPMENT	Life expectancy at birth (males)	51.0 (2004)	
	Under five mortality rate males	129 (2004)	
	Under five mortality rate females	110 (2004)	
	Human development index (value, ranking)	0.49/152 (2004)	
	IMR	78.0 (2004)	
	GDP/Capita PPP USD	1140 (2004)	
EQUITY	Under five mortality rate lowest/highest quintile	1.6 (2003)	
	Gini coefficient	44.5 (1997)	
SRHR	Maternal mortality ratio	1000 (2000)	
	HIV prevalence 15–49 (%)	6.7 (2003)	
	Antenatal care coverage, one visit (%)	88 (2003)	
	Births attended by skilled health personnel (%)	41.6 (2003)	
	Contraceptive prevalence rate (%)	39.3 (2003)	
	Total fertility rate (per woman)	5.0 (2004)	
	Adolescent fertility proportion (%)	11.7 (2002)	
	Neonatal mortality rate (per 1000 births)	29 (2000)	
	Deaths due to HIV/AIDS (per 100 000)	150 000 (2003)	
HEALTH SYSTEMS	Physicians per 1000 population	0.14 (2004)	
	Nurses per 1000 population	1.14 (2004)	
	Total expenditure on health (% of GDP)	4.3 (2003)	
	Government expenditure on health (% of government spending)	7.2 (2003)	
	External resources for health (% total)	15 (2003)	
	Per capita government expenditure on health	8 (2003)	
	Vaccination (3 x DPT)	73 (2004)	
	Midwives per 1000 population	–	
INFECTIOUS DISEASES	Years lost to communicable diseases (%)	81.4 (2002)	
PUBLIC HEALTH	Years lost to non-communicable diseases (%)	11.1 (2002)	
	Years lost to injuries (%)	7.5 (2002)	
	Prevalence of tobacco smoking (males)	27.2 (2003)	

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HIV/AIDS

AMREF Kenya, with support from Sida, is implementing the "Manisha" Community-Focused Initiative to Control HIV/AIDS in the Lake Victoria region covering Nyanza and Western Provinces. The programme started in January 2004 and was designed to cover all 20 districts within the two provinces. The objective of the programme is continued reduction in the infection rate of HIV/AIDS in Lake Victoria Basin. Specific objectives are capacity-building of CSOs/FBOs and private sector organisations to design and implement quality HIV/AIDS interventions, to promote safer sexual behaviour and practices among "at risk" and vulnerable groups, to establish coordination mechanisms in partnership with CSOs/FBOs networks and GOK structures and to support CSOs/FBOs to improve access to quality home-based care (HBC) and referral services for PLWHAs. An evaluation took place in January/February 2007.

Trends

SECTOR	2000	2001	2002	2003	2004	2005	2006
Health systems	10 169 709	17 705 281	16 266 587	22 015 842	30 166 910	49 432 095	5 954 006
Reproductive healthcare	1 419 972	341 496	0	0	0	0	0
HIV/AIDS	46 000	184 089	37 222	382 879	13 835 466	2 829 394	38 324 362
Social/welfare services	1 565 696	514 732	695 196	387 938	12 032	-1 784	0
Total	13 201 377	18 745 598	16 999 006	22 786 659	44 014 408	52 259 705	44 278 368

Malawi

Sweden supports Malawi's health sector programme through a delegated partnership with Norway, which has taken the lead.

CONTRIBUTION	PROGRAMME	DISBURSEMENTS 2006
	Health sector programme	68 090 000

The annual meeting between Sweden and Norway was held in Oslo in November 2006, and concluded that positive achievements included decreased infant mortality. There have also been slow improvements in making a central medical store functional and in implementing the "road map" for reproductive health. There has been an extreme shortage of health workers but fewer staff has resigned than previously. The number of HIV-positive patients receiving ARV treatment has also increased.

The programme is proceeding according to plan (AP).

Trends

SECTOR	2002	2003	2004	2005
Health systems	23 000 000	29 000 000	34 000 000	37 000 000
Inf. diseases, HIV/AIDS	11 000 000	14 000 000	17 000 000	18 000 000
Grand total	34 000 000	43 000 000	51 000 000	55 000 000

Mali

The "Program Développement Sanitaire et Social," PRODESS II, is the second five-year operational outline of Malis national ten-year Health and Social Development Plan. PRODESS is the main national programme for the expansion and improvement of the country's basic health and social services. The main objectives are to improve the health of the population and to create necessary prerequisites for poverty alleviation. The health plan specifically focuses on improvments in maternal and child health services. PRODESS II consists of two components: health (85 percent) and social development (15 percent). The latter focuses on improved social protection of the poorest and disadvantaged groups.

The funding modality is sectoral programme support and support from Sweden is thereby visible in the Malian national state budget. Disbursements are linked to macro-economic indicators and specific health and social indicators. The collaboration continues as a delegated partnership with the Netherlands as the lead partner.

CONTRIBUTION	PROGRAMME	DISBURSEMENT 2006
72300217	Mali PRODESS II	35 026 530

The four-year agreement for PRODESS II was signed in December 2006. Sexual and reproductive health and rights are a priority for both the Netherlands and Sweden and will be an important dialogue issue with the Ministry of Health. A study on SRHR and the next generation of demographic health survey will be released in mid-2007 and will provide the basis for further dialogue.

All 2006 indicators had been achieved when the first disbursement was made shortly after the agreement was signed in late December 2006. Some indicators even exceeded the targets, such as the improved geographic coverage of health centre facilities. However, much more emphasis is needed to improve the number of curative visits. Based on previous results, it is expected that PRODESS II will achieve additional results through its harmonisation efforts. The indicators for disbursements covers distance to a health centre number of attended deliveries and ante natal visits, DPT coverage, curative visits and use of modern contraceptives. The disbursements are made twice a year and the

	MALI	LATEST YEAR	
HEALTH AND DEVELOPMENT	Life expectancy at birth (males)	44 (2004)	
	Under five mortality rate males	230 (2004)	
	Under five mortality rate females	208 (2004)	
	Human development index (value, ranking)	0.338/175 (2004)	
	IMR	121 (2004)	
	GDP/Capita PPP USD	998 (2004)	
EQUITY	Under five mortality rate lowest/highest quintile	1.7 (2001)	
	Gini coefficient	50.5 (1994)	
SRHR	Maternal mortality ratio	1200 (2000)	
	HIV prevalence 15–49 (%)	1.9 (2003)	
	Antenatal care coverage, one visit (%)	53 (2001)	
	Births attended by skilled health personnel (%)	40.6 (2001)	
	Contraceptive prevalence rate (%)	8.1 (2001)	
	Total fertility rate (per woman)	6.8 (2004)	
	Adolescent fertility proportion (%)	13.7 (2000)	
	Neonatal mortality rate (per 1000 births)	55 (2000)	
	Deaths due to HIV/AIDS (per 100 000)	12 (2003)	
HEALTH SYSTEMS	Physicians per 1000 population	0.08 (2004)	
	Nurses per 1000 population	0.49 (2004)	
	Total expenditure on health (% of GDP)	4.8 (2003)	
	Government expenditure on health (% of government spending)	9.2 (2003)	
	External resources for health (% total)	15.3 (2003)	
	Per capita government expenditure on health	9 (2003)	
	Vaccination (3 x DPT)	76 (2004)	
	Midwives per 1000 population	0.04 (2004)	
INFECTIOUS DISEASES	Years lost to communicable diseases (%)	85.9 (2002)	
PUBLIC HEALTH	Years lost to non-communicable diseases (%)	7.7 (2002)	
	Years lost to injuries (%)	6.4 (2002)	
	Prevalence of tobacco smoking (males)	24 (2003)	

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first disbursement is 60 percent of the amount agreed on for 2007.

However, it is difficult to estimate whether or not the the social development targets have been achieved, as the number of people in need of support is unknown. The targets are based on the availability of funds rather that on meeting the needs of a target group. The 2006 operational report will be finalised in April 2007.

The Ministries are working on improved administration and progress has been made on the implementation of the decentralisation process.

The performance of the programme is going according to plan (AP).

Uganda

The main programme is the Health Sector Budget Support for the implementation of Uganda's Health Sector Strategic Plan 2 (HSSP2). The HSSP2 aims to meet Uganda's poverty reduction strategy goals within the health sector. Areas covered include maternal and child mortality, fertility, HIV/AIDS, tuberculosis and malaria. The emphasis of HSSP2 is on the delivery of a minimum healthcare package. Through its support for policy development, Sida also supports the health Swap Partnership Fund, which aims to support the functionality of the Swap as well as to improve alignment and harmonisation. Outside of the health sector programme, Sida's focus is on sexual and reproductive health and rights and HIV/AIDS.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
33000045	Health sector programme	65 000 000
33000046	Straight Talk	2 093 810
33000047	Naguru Teenage Centre	2 145 129
33000048	Technical advisors	2 923 656
33000049	Mbarara University	1 207 536
33000050	MUST-LU Collaboration	846 439
33000051	Policy development	2 061 548
33000052	Health Economics	2 390 683
33000067	TASO Strategic plan 03-07	6 911 001
Total		85 579 802

Sweden continued to chair the Health Development Partner Group (HDPG) in the first half of 2006. In addition to facilitating internal coordination of development partners and leading the dialogue with GoU related to the health sector, Sida supported a number of activities aimed at strengthening collaboration and improving alignment and harmonisation within the health sector. This support included initiatives to rationalise the health Swap structures and working groups and to harmonise support to capacity development.

Sweden also supported activities aiming at improving the internal efficiency of health development partners. The Embassy prepared a documentation and analysis of the Swedish chairmanship to provide experiences and to support future Swedish lead agency roles. In the areas of improved efficiency and anti-corruption, Sida supported a public expenditure review of the health sector and preparations for a value for Money Study.

The performance of Sida's Sector Programme Support for the implementation of Uganda's Health Sector Strategic Plan is primarily monitored through the Joint Health Sector Review and the Annual Health Sector Performance Report. The performance of the FY 2005/06 was mixed in relation to expected results. Good results were achieved in relation to malaria and tuberculosis treatment and malaria prevention. The roll-out of antiretroviral treatment was also successful. The proportion of the deliveries in public and NGO health facilities, the contraceptive uptake and pentavalent vaccine coverage improved slightly. However, the utilisation of the public and NGO health facilities, measured by outpatient attendances, stagnated. Key indicators showing decline included the percentage of GoU health sector budget allocation, which declined from 10.8 percent to 8.9 percent. The financial situation is further aggravated by very high population growth, increased drug costs due to changes in drug regime and the creation of many new districts. The proportion of health facilities without stock of essential drugs decreased from 35 percent to 27 percent during the year. Finally, the national sero-prevalence survey indicates that HIV infections are increasing in Uganda, which constitutes a reversal of decline in HIV infection that has been achieved during the last decade. Recent data on progress towards the achievement of health outcomes is pending the completion of the demographic health survey.

Straight Talk Foundation

Straight Talk Foundation targets adolescent SRHR through publication of newspapers, radio programmes and sensitisation campaigns. Planned activities for 2006 were generally achieved, including teacher sensitisation in adolescent sexual health and radio shows for adolescents in 11 different languages.

Naguru Teenage Information and Health Centre

Naguru Teenage Information and Health Centre provide sexual and reproductive health services – voluntary counselling and testing, counselling and medical services to young people. In 2006, 45,000 young people were received, which is a 23 percent increase from the previous year. An evaluation of Sida's support to Naguru was carried out in 2006. The evaluation concluded that Naguru is among the most comprehensive and best-performing centres providing Adolescent Sexual and Reproductive Health and Rights (ASRHR) education in Uganda.

Technical advisors

Support is provided for two technical advisors at the Ministry of Health – a management advisor and a financial management advisor. In 2006, capacity

	UGANDA	LATEST YEAR	
HEALTH AND DEVELOPMENT	Life expectancy at birth (males)	48 (2004)	
	Under five mortality rate males	144 (2004)	
	Under five mortality rate females	132 (2004)	
	Human development index (value, ranking)	0.502/145 (2004)	
	IMR	81 (2004)	
	GDP/Capita PPP USD	1478 (2004)	
EQUITY	Under five mortality rate lowest/highest quintile	1.8 (2001)	
	Gini coefficient	43 (1999)	
SRHR	Maternal mortality ratio	880 (2000)	
	HIV prevalence 15–49 (%)	4.1 (2003)	
	Antenatal care coverage, one visit (%)	92 (2001)	
	Births attended by skilled health personnel (%)	39 (2000)	
	Contraceptive prevalence rate (%)	22.8 (2001)	
	Total fertility rate (per woman)	7.1 (2004)	
	Adolescent fertility proportion (%)	13.6 (1999)	
	Neonatal mortality rate (per 1000 births)	32 (2000)	
	Deaths due to HIV/AIDS (per 100 000)	78 (2003)	
HEALTH SYSTEMS	Physicians per 1000 population	0.08 (2004)	
	Nurses per 1000 population	0.61 (2004)	
	Total expenditure on health (% of GDP)	7.3 (2003)	
	Government expenditure on health (% of government spending)	10.7 (2003)	
	External resources for health (% total)	28.5 (2003)	
	Per capita government expenditure on health	5 (2003)	
	Vaccination (3 x DPT)	87 (2004)	
	Midwives per 1000 population	0.12 (2004)	
INFECTIOUS DISEASES	Years lost to communicable diseases (%)	83.6 (2002)	
PUBLIC HEALTH	Years lost to non-communicable diseases (%)	7.9 (2002)	
	Years lost to injuries (%)	8.5 (2002)	
	Prevalence of tobacco smoking (males)	25 (2003)	

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development focused on improving planning, the establishment of district monitoring teams, and the development of a fiscal decentralisation strategy and financial monitoring of drug procurement.

Mbarara and Lund University institutional collaboration

Mbarara and Lund University institutional collaboration aims at improved access and quality of healthcare for the poorer sections of the local communities through student and staff exchange programmes and development of short courses in community health. Achievements in 2006 included web-based MPH graduates and training of peer educators in SRHR.

Support to health economics consisted of *secondment of a health economist* to WHO Kampala. In 2006, the emphasis was on supporting the Government of Uganda's budget process in the health sector assisting the MoH with health financing. There was limited progress in 2006.

TASO

The AIDS Support Organisation, TASO, focuses on HIV/AIDS care and support by providing counselling and medical services to HIV/AIDS-infected individuals. TASO also undertakes capacity building of government institutions and NGOs and works to improve the rights of people living with HIV/AIDS. In 2005, 23,000 new clients registered and 56,000 clients received medical services. The concept of home-based counselling and testing was also introduced.

Joint Inter-Agency Emergency Health Programme

Through the humanitarian support in 2006, Sida supported the Joint Inter-Agency Emergency Health Program in northern Uganda. The innovative and co-coordinated approach builds on the comparative advantage of each UN agency and targets the main health-related mortality causes in the northern part of the country. Sida belongs to the programme steering committee.

Trends

SECTOR	2000	2001	2002	2003	2004	2005	2006
Health systems	39 443 896	52 831 842	9 822 011	54 857 469	80 028 570	78 357 062	74 442 345
SRHR	0	0	0	0	2 043 123	2 001 858	2 093 810
HIV/AIDS	3 640 900	7 728 718	7 709 760	9 029 387	6 582 659	9 847 786	9 617 233
Social/ welfare services	1 092 125	170 146	610 180	312 621	53 884	-3 491	0
Grand total	44 176 921	60 730 705	18 141 951	64 199 478	88 708 236	90 203 214	86 153 388

Zambia

Sweden provided new support to the health sector in August 2006. The overall objective of a Swedish support to Zambian health sector is to reduce poverty and to strengthen people's right to attain highest possible health. Experiences from previous support to the sector show that the Sector Wide Approach and the basket funding have contributed to an increased and reliable funding of the districts, based on the implementation of the Basic Health Care Package. The development of systems such as financial and information systems have started to pay off, and healthcare delivery indicators are improving.

Nevertheless, Zambia faces significant challenges. A high disease burden including HIV and AIDS, critical shortages of health personnel, increasing maternal mortality and structural issues such as inadequate sectoral funding have significant implications on health service delivery and thus the health of the population.

In order to address these challenges in the sector, the new Swedish support was designed as a Sector Programme Support for the implementation of the National Health Strategic Plan (NHSP) 2006-2011. It amounts to SEK 635 million, which is about 6 percent of the total health budget. Sweden has a leading role in the sector and has entered into a delegated partnership with the Royal Netherlands Embassy as their representative in the sector. The new agreement takes over from the previous health support, which was directed to the districts through the district basket. The health support to Zambia is a long-term investment for improved health throughout the country. The support is monitored through the Swap arrangement. The Swedish Embassy uses the health indicators agreed on in the Poverty Assessment Framework (PAF) for monitoring and follow up.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
26002002	Aid finance prog off social	1 978 428
26002011	Health sect. npo	502 360
26003007	Health Economics	403 211
26003010	Policy & Planning MoH	113 830
26003011	Unallocated & Follow-up	115 320
26003036	NAC Capacity Building	2 997 300
26003037	Edusport	1 010 520
26003043	Trendsetters prog support	1 013 704
26003047	Health Sector Support	69 217 510
26003048	ZMB Support to PPAZ	2 819 216
26003049	HRH crisis response	38 434 511
Total		118 605 910

The outcome assessment of the previous health support covering the country strategy concluded that the performance in the health sector is somewhat contradictory. Some indicators are improving; some are not improving or even declining. Over the past five years basic healthcare delivery indicators have improved. However, the disease burden in Zambia is still high with a high prevalence of infectious diseases such as HIV/AIDS, malaria, respiratory tract infections (RTI), and diarrhea. Zambia is also a long way off from meeting the MDGs. The relatively good progress torwards meeting the key healthcare delivery indicators can to some extent be explained by the focus on basic healthcare at the district level. It is generally believed that a sustained and predictable funding of the districts has paid off in improved health services. On the other hand the relatively poor performance in terms of health outcomes such as child mortality and maternal mortality most likely has other explanations such as high poverty and high prevalence of infectious diseases such as HIV and AIDS.

A challenge during the strategy period has been the low number of staff at health facilities and problems with staff retention, especially of clinical staff in rural areas. During the strategy period, a human resources for health strategic plan was developed to address the increasing migration of staff from rural areas to urban areas, from the public sector to the private sector, and overseas. Programmes to retain staff have been launched and have so far been successful, although these have only targeted a very limited group of staff, i. e. doctors in rural areas.

The HR Crisis response supports the implementation of the HRH Strategic Plan. The support consists of three components, basket funding of the HRH strategic plan, monitoring the implementation of the plan, and technical-assistance support to the Ministry of Health. So far, the support has lead to the reopening of training institutions, increasing the retention of and incentive schemes for health workers, and strengthening of human resources information systems.

Trends

SECTOR	2000	2001	2002	2003	2004	2005	2006
Health systems	66 275 577	57 276 298	67 157 638	61 006 008	92 669 179	62 733 457	145 350 201
HIV/AIDS	6 383 982	5 198 175	3 273 762	2 061 979	3 201 064	6 982 885	8 015 442
Grand total	72 659 559	62 474 473	70 431 400	63 067 987	95 870 243	69 716 342	153 365 643

	ZAMBIA	LATEST YEAR	
HEALTH AND DEVELOPMENT	Life expectancy at birth (males)	40 (2004)	
	Under five mortality rate males	190 (2004)	
	Under five mortality rate females	173 (2004)	
	Human development index (value, ranking)	0.407/165 (2004)	
	IMR	104 (2004)	
	GDP/Capita PPP USD	943 (2004)	
EQUITY	Under five mortality rate lowest/highest quintile	2.1 (2002)	
	Gini coefficient	52.6 (1998)	
SRHR	Maternal mortality ratio	750 (2000)	
	HIV prevalence 15–49 (%)	16.5 (2003)	
	Antenatal care coverage, one visit (%)	94 (2002)	
	Births attended by skilled health personnel (%)	43.4 (2002)	
	Contraceptive prevalence rate (%)	34.2 (2002)	
	Total fertility rate (per woman)	5.5 (2004)	
	Adolescent fertility proportion (%)	13.7 (2000)	
	Neonatal mortality rate (per 1000 births)	40 (2000)	
	Deaths due to HIV/AIDS (per 100 000)	89 (2003)	
HEALTH SYSTEMS	Physicians per 1000 population	0.12 (2004)	
	Nurses per 1000 population	1.74 (2004)	
	Total expenditure on health (% of GDP)	5.4 (2003)	
	Government expenditure on health (% of government spending)	11.8 (2003)	
	External resources for health (% total)	44.7 (2003)	
	Per capita government expenditure on health	11 (2003)	
	Vaccination (3 x DPT)	70 (2004)	
	Midwives per 1000 population	0.27 (2004)	
INFECTIOUS DISEASES	Years lost to communicable diseases (%)	92 (2002)	
PUBLIC HEALTH	Years lost to non-communicable diseases (%)	6 (2002)	
	Years lost to injuries (%)	2 (2002)	
	Prevalence of tobacco smoking (males)	23 (2003)	

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Non-health Programme Countries

Angola

Sweden has supported the health sector in Angola since 1977. In the last few years, support has been channelled to the child and maternal health programmes run by the Provincial Directorate for Health in Luanda province. The last bilateral agreement covered the period June 2004 – March 2006 with a total amount of SEK 44.5 million. The focus of this agreement was to build sustainable systems and capacity so that Angola can take over responsibility for the the programmes. In accordance with the Country Strategy, the long-term development cooperation, including within the health sector, to Angola was phased out by the end of 2006.

The maternal health component included operational support for family planning activities, antenatal care, primary level delivery wards, and maternities at a secondary level as well as limited support to the national maternity ward. The child health component focused on both preventive and curative aspects and included support to primary-level child healthcare centres as well as support to child healthcare at a secondary and tertiary level in Luanda. Particular attention was given to nutrition and immunisation at the same time the WHO-based Integrated Management of Childhood Illnesses (IMCI) was applied. Support has also been given to an 18 month national midwifery education.

MAJOR CONTRIBUTIONS	PROGRAMME COMPONENTS	DISBURSEMENTS 2006
21500069	UNICEF, Angola HIV/AIDS	10 000 000
28004001	Institutional support DPS	3 301 541
28004002	Reproductive health Luanda	379 512
28004003	Child health Luanda	717 777
28004004	Midwifery training Ang	494 950
28004006	Consult InDevelop Angola	3 140 082
28004007	Follow-up & eval Ang health	1 495 899
Total		19 529 761

The quality of healthcare has increased and the accessibility and the proximity of health posts are considerably better today than compared to only a few years ago. The number of peripheral maternal centres has doubled from 11 in 2001 to 22 in 2005. Deliveries at these centres have during the same period gone up by 56 percent, while at the same time the overall number of institutional deliveries went up by 27 percent. A total of 92 midwives have passed the exams at the midwifery school in Luanda. The education has now been expanded to other parts of the country, namely Malanje in the north and Huíla in the south. New courses started in 2006, thereby doubling the number of midwives participating in training.

It has been decided to carry out two different evaluations in connection with the phase out of support from Sweden. The "Study of the Sida's Support to the Health Sector in Angola 1977-2006" was published in January 2007. The programme has gone according to plan. A slight implementation delay during the final year led Angola to ask for a three-month no-cost-extension (January – March 2006). This delay was due to a 2005 outbreak of the Marburg virus, which caused many activities to come to a standstill for several months.

Botswana

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
21500035	Support to NACA - BWA	2 950 000
21500067	Forum Syd Support - BWA	600 000
21500068	Forum Syd/Bonaso	5 000 000
Total		8 640 027

Mozambique

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
23000158	NPO PSD/HIV/AIDS	593 843
23000165	Save the Children Alliance	4 000 000
23000172	Cont. HIV Niassa	2 023
23000183	Programme Dev Fund 2005-2006	673 414
23000185	UNFPA Ger Biz HIV/AIDS	14 000 000
23000195	HIV/AIDS Niassa06	7 016 964
23000196	CNCS- Nat. AIDS Council	7 000 000
Total		33 286 244

Save the Children Alliance

Support was given to the Save the Children Alliance (Save the Children UK, US and Norway) to implement a programme addressing OVC from a children's rights-based perspective, using a holistic approach to promote interventions that improve various aspects of children's lives. The programme focused mainly on building the capacity of community groups, CBOs and NGOs to respond adequately and appropriately to OVC-related issues. In 2006 the three organisations assisted more than 18,000 children, providing them with things such as community activities, birth registration and school material.

Technical support was provided to the Provincial Directorate of Social Action in all provinces involved in the programme aiming at strengthening their capacity to respond to OVCs problems.

UNFPA

The UNFPA programme for Adolescent Sexual and Reproductive Health *(UNFPA Ger Biz HIV/AIDS)* has the overall objective of improving adolescents' sexual and reproductive health by reducing the incidence of premature pregnancy and the infection rates of STIs and HIV/AIDS. The programme aims to give young people between the ages of 10 and 24 years (in and out of school) knowledge and access to quality health services in order to modify behaviour related to their own sexual and reproductive health. The programme expanded to eight of the ten provinces of Mozambique and increased the number of young people attending Youth Friendly Services from 39,000 in 2002 to 140,000 in 2005.

Stamps and Concern Universal

Estamos and Concern Universal are organisations working in Niassa and supported by the Swedish Embassy since 2001 *(HIV/AIDS Niassa 06)*. The organisations presented an innovative integrated approach combining prevention, care and mitigation to the Embassy for funding for 2006-2007 in eight districts of Niassa. The general objective of the programme is to support the communities of these districts in the prevention of HIV/AIDS and other STIs and in the alleviation of the impact of HIV/AIDS in different components through a more integrated and participative approach.

CNCS – National AIDS Council

The main objective of the support to the National AIDS Council of Mozambique (CNCS) is to reduce the impact of HIV/AIDS in Mozambique by supporting the Annual Strategic Plan 2006 and 2007 designed by CNCS as part of the National Strategic Plan 2005-2009. The Swedish contribution is channelled through a common fund established between the Government of Mozambique and other donors [Canada, UK Department for International Development (DFID), Development Cooperation Ireland, World Bank, Denmark and Global Fund] in the framework of the MOU. CNCS manages the fund for the implementation of the HIV/AIDS National Response

The general rating of the programme's implementation is satisfactory.

Namibia

Namibia is not a programme country for health support. Contributions are mainly for HIV/AIDS prevention.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
21000435	Secondment UNDP Namibia	1 277 982
24003853	HIV-prevention	4 600 000
24003854	HIV-prevention	2 202 574
24003855	Small Grant Fund	1 008 654
Total		9 089 210

South Africa

South Africa is not a programme country for health support. Contributions are mainly for HIV/AIDS prevention. Dialogue with government, other donors and civil society have been scaled up. The Donor Coordination Forum on HIV/AIDS has been reviewed to ensure harmonisation. All donors participated.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
25000277	AIDS Law Project	2 419 408
25000278	AIDS Legal Network	1 250 000
25000280	AIDS Consortium	1 222 999
25000285	Treatment Action Campaign	4 698 848
25000286	AIDS Foundation of SA	510 000
25000287	SA Football Players Union	1 600 000
25000288	South African Cities Netw	450 000
25000291	Engender Health	1 200 000
25000292	Masimanyane III	2 961 427
25000294	Road Freight NBC	964 376
25000297	Vuka Violence Project	2 230 174
25000312	RADAR / WITS	2 055 031
25000321	Zivikele Training	2 520 423
25000342	RRF - 16 Days	999 142
25000344	World AIDS Day 2006	25 517
Total		25 107 345

RADAR/WITS

The mainstreaming of HIV/AIDS in the Small Enterprise Foundation's HIV/AIDS Image project (RADAR/WITS) in the Limpopo province reached 4,800 clients in 83 villages in Sekukuneland. More than 200 clients received training. Media coverage and publication in scientific journals disseminated the results. *The South African Cities Network* and the South Africa Local Government Association (SALGA) co-facilitated the drafting, dissemination and implementation of the Guidelines for HIV and AIDS at the Municipal Workplace. A web-based resource tool was developed and implemented to provide information to the participating cities.

Road Freight NBC

The scaling up of direct support focuses on areas where Sweden has the comparative advantage, but also recognises gaps in South African programmes. The long distance trucking industry's HIV/AIDS project, Road Freight NBC, operationalised two new clinics and three mobile clinics in 2006. The Wellness Centres treated 7,010 truck drivers and 634 commercial sex workers in 2006 for minor ailments and sexually transmitted infections. The workplace based AIDS policy was updated and promoted among operators.

Vuka Violence Project

Vuka uKahaye in the Vuka Violence Project held training workshops for guardians of orphaned children and 136 received training in 2006. The feeding scheme identified over 500 children in need but only 150 could be placed in the programme due to staffing and funding constraints. The Departments of Education and Social Development collaborate closely with Vuka to ensure minimum standards are adhered to. In 2006, a total of 902 victims of domestic and gender-based violence received legal assistance, shelter, counselling and medical services.

SAFPU

The South African Football Players Union (SAFPU) developed and implemented an HIV/AIDS Workplace policy and promoted it among all premier league football clubs. Awareness raising and education on prevention of transmission of new HIV infections among football players has started. Three premier league football matches have been used to promote awareness among football fans. Five players on the national football team have been identified and trained as AIDS Ambassadors.

Zivikele Training

Zivikele Training focuses on training government service providers to help improve the response of healthcare workers, police, prosecutors and social workers in cases of gender-based violence. Thirteen training workshops were held in the Eastern Cape, North West Province, KwaZulu-Natal and Gauteng. A total of 481 people from the Departments of Health, Social Development,

Justice, the South African Police Services as well as NGOs and faith-based organisations (FBOs) received multi-sectoral training. The training material was based on WHO's manual and is currently being accredited by the Health and Welfare Sector Education and Training Authority (SETA).

The AIDS Foundation of South Africa

The AIDS Foundation of South Africa (AFSA) strengthens community-based care for people affected or infected by HIV/AIDS through training to ensure access to high quality healthcare and community-support service. In 2006, AFSA provided financial support and capacity building to 52 CBO partners – this enabled them to provide vital services to their communities and facilitate access to essential health and welfare services.

Tanzania

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
32010046	HIV/AIDS Fund I	3 237 700
32000048	Tesha, Joyce	22 443
32010106	HIV/AIDS Care & Treatment	75 242 131
32010124	FEMINA HIP	11 295 521
32010126	SPW Tanzania	3 430 291
Total		93 228 086

HIV/AIDS Care and Treatment Program

The National HIV/AIDS Care and Treatment Program for 2006 showed quantitative progress in procurement of ARV drugs, laboratory equipment, training of health workers and expanded anti-retroviral treatment (ART) sites. By the end of 2006, there were 200 sites providing ART. STI drugs and other supplies – including gloves, cotton wool, syringes and needles – were distributed to health facilities providing STI services. Health-seeking behaviour has been promoted for youth-friendly HIV/AIDS/STIs services through radio and television programmes. National STIs/RTIs Guidelines have also been disseminated. The National AIDS Control Program (NACP) reviewed and upgraded its assessment and certification procedure. This should help to more easily evaluate all health facilities involved with the start-up and expansion of ART services. It will also certify health facilities that have met a set of minimum criteria required to provide care to people living with HIV/AIDS (PLHA). Furthermore, in collaboration with WHO and other partners, the monitoring and evaluation system was revised to capture more data and improve patient tracking. The rollout plan of the revised monitoring and evaluation tool was developed. Three regions were proposed as starting points. In counselling and social support, the guidelines and training materials for provision of Provider

Initiated Testing and Counselling (PITC) services were finalised. The overall performance rating is MDP. The programme has had implementation problems, such as overly optimistic targets regarding enrolment rates in the ARV programme.

YOFAHE

The Youth Friendly Approaches to HIV/AIDS (YOFAHE) by Save the Children in Zanzibar was evaluated in Jul –Aug 2006. The key lesson is that there is strong sense of denial about the intensity of the HIV epidemic. It was recommended that life skills for young people are promoted and that Youth Friendly Information Centre should be linked with VCT and STI services. SCF YOFAHE has submitted a proposal for Phase II and an initial assessment was done.
An in-depth assessment has been recommended.

FEMINA

The Swedish Embassy signed a three-year agreement (2006-2009) with FEMINA Health Information Project Multimedia Initiative. The total amount allocated to the cooperation is SEK 34 million. The goal is to enable youth and their communities to enjoy freedom of expression, as well as their rights to access information and services in order to improve their sexual and reproductive health as well as overall social well-being.

UNICEF Adolescent and Young People

The Swedish support to the UNICEF programme – Working with Adolescent and Young People and Reaching out for the Most Vulnerable Children was evaluated in March and April 2006. UNICEF implemented the project with the Ministry of Labor and Youth Employment and the Department for Social Welfare of the Ministry of Health and Social Welfare. Some of the major findings were that the projects have: district focus; enhanced youth visibility: promoted community participation, mobilisation and organisation; and helped families provide better care for most vulnerable children. UNICEF submitted a proposal request for Phase II that will focus on increasing resilience and livelihood chances through life skills, protection and participation of Tanzania's most vulnerable children.

SPW Tanzania

The Student Partnership Worldwide (SPW Tanzania) started a new project known as Kijana Ni Afya. Development Cooperation Ireland (DCI) and Sida are both funding the project. Educated young Tanzanians volunteer as peer educators to work in rural schools and communities across the Southern Highlands of Tanzania in the Mbeya and Iringa regions. The progress report is positive in terms of collection of behavioural surveillance surveys (BSS) from in and out-of-school youth, volunteer debriefing workshops, community action group's workshop and health service provider's supervisory training. An initial evaluation of the Kijana ni Afya Strategic Plan 2007 – 09 was conducted and an in-depth assessment was recommended.

Forum Syd

A mid-term review of the HIV/AIDS programme implemented by the Forum Syd was carried out in July 2006. Forum Syd works in cooperation with local NGOs and CBOs. The beneficiaries saw the support as very useful to their organisation. Major constraints identified include inadeaqute measurability of the targets and activities, poorly defined qualifications and number of human resources, poorly defined geographical coverage and inadequate monitoring and evaluation.

The third National Multisectoral HIV/AIDS conference took place in December 2006. Sida contributed SEK 300,000 towards its organisation. This was an exceptional opportunity for all involved to gather and share new research findings, best practices and experiences in order to help reduce the number of new HIV/AIDS infections. A second goal was to critically analyse the successes and failures of interventions in order to improve the programme in the future.

Trends

SECTOR	2002	2003	2004	2005	2006
Health systems	8 000 000	4 000 000	2 000 000	4 000 000	0
SRHR	1 000 000	1 000 000	1 000 000	2 000 000	15 000 000
Inf. diseases, HIV/AIDS	30 000 000	24 000 000	44 000 000	61 000 000	79 000 000
Grand total	39 000 000	29 000 000	47 000 000	67 000 000	94 000 000

Zimbabwe

Zimbabwe is not a programme country for health support. Contributions are mainly for NGOs and/or HIV/AIDS prevention.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
27000124	Deseret Int. Foundation Z	1 447 796
27002056	CADEC 2	4 367 090
27002057	Catholic Relief Services	4 500 000
27002058	PSZ youth HIV/RH	1 100 000
27003250	ZAPSO	851 503
27003256	PACT- phase II	1 983 087
27003259	ZAN 03-05	740 646
27003261	Mashambanzou	1 147 088
27003268	NRZ HIV/AIDS/STDs Programme	232 429
27003274	HIV NPO	471 265
27004382	FOST support to CABA	4 586 653
Total		21 427 557

Africa Regional Programmes

Health systems

MAJOR CONTRIBUTIONS		PROGRAMMES	DISBURSEMENTS 2006
72300236	Health systems	Budg Supp AMREF 05-09	5 000 000
72300237	Health systems	HEPNET 06-10 UnvCapeTown	2 000 000
72300325	Health systems	GEGA African Network	1 000 000
72300329	Health systems	Evaluation-AMREF	165 199
72300357	Health systems	Equinet 2006-2009	3 000 000
Total			11 165 199

AMREF

The regional support to African Medical & Research Foundation (AMREF) aims at increasing regional capacity, support networks and institutions for exchange of knowledge as well as building professional skills and institutional capacity. Sida has supported the AMREF Organisational Strengthening Plan (OSP) since 2003. AMREF was already a major health development organisation with a positive reputation, especially in terms of implementation. It also has a strong track record of influencing policy and practice.

GEGA

The Global Equity Gauge Alliance (GEGA) consists of 12 national African groups working for health equality and access to health services. Its main objectives are to increase access to health and health services and to link research and information to concrete action for policy change.

In Zimbabwe, a report was prepared from research detailing community health needs from the perspective of communities, health and local authorities. It also looked at the actions and health sector interventions responding to the priority health needs and how key resources for health are distributed across different health sector providers and programmes. As a result of the report, dialogue on health resource allocation between communities and health authorities was strengthened in districts. Health Centre Committees and other community structures are increasingly utilising findings about community preferences in District Budget processes.

A community-based monitoring and evaluation tool was developed in South Africa in three languages. Capacity-building workshops were also held with clinic committees and over 300 people from six villages participated in completing and assessing the monitoring and evaluation tool.

In Kenya, Equity Gauge mobilised parliamentarians as advocates on family planning and reproductive health issues through workshops and presentation of research findings. As a result, members of parliament formed a Parliamentary

Network on Population and Development in Kenya in 2006. They have since been actively engaged with the Regional Parliamentary Forum.

The overall rating of GEGA is AP.

EQUINET

The Network for Equity in Health in Southern Africa (EQUINET) promotes health equity by influencing and supporting national and regional policies and practices of the countries of eastern and southern Africa. This is done through developing networks of professionals, civil society members, policy makers and state officials. The main countries involved are Zambia, Zimbabwe, South Africa, Tanzania and Malawi.

In 2006, Sida and EQUINET signed a new contract for 2006-2009 after the final report for the previous agreement period was completed.

The main achievements in 2006 are the development of a framework for country-level equity analyses and pilot equity analyses initiated in Malawi (through NGO Reach Trust Malawi) and Zambia (NGO Chessore). Malawi and Zambia also participated in the WHO EIP programme on monitoring equity in health systems with particular focus on ART.

The overall rating of the project is AP.

HEPNET

The Health Economics and Policy Network in Africa (HEPNET) is administered by the University of Cape Town's Health Economics Unit, a training and research institution active in health economics. The unit heads the regional network NEPNet, which promotes health economics and policy development in five countries in sub-Saharan Africa: Tanzania, Uganda, Zambia, Zimbabwe and South Africa. Sida has supported the unit since 1999 with the objective of developing regional capacity and assisting governments and ministries of health in using research in health economics as a basis for health policy decisions. The previous support programme was evaluated in 2005. It evaluation concluded that the support has improved the HEU's capacity to train health economists and undertake policy-relevant research for pro-poor and equity-orientated health systems in the region. The support has also helped improve HEPNet's institutional capacity in member countries, which in turn helps it to influence policy decisions.

A new five-year programme was initiated in 2006. There is a great need for qualified health economists in sub-Saharan Africa to start to play a role in policy development. This is especially important in light of the new development aid environment, including the switch to general budget support. A heavy reliance on overseas consultants and the need for local capacity development also make this need acute. Support from Sweden has involved a wide range of regional actors. It has focused on capacity building and strengthening of local research institutions. The proposed programme is considered to be highly relevant and more scientific-based policy decisions, leading to pro-poor and equity-orientated health systems, are expected to be among the outcomes of the programme.

Since the programme has just begun, its performance has not been rated.

Infectious diseases

MAJOR CONTRIBUTIONS	PROGRAMMES		DISBURSEMENTS 2006
72300309	Inf. diseases	EPN drugs supply of FBOS	1 200 000
72300310	Inf. diseases	INRUD adherence to ARV	3 000 000
Total			4 200 000

EPN

The Ecumenical Pharmaceutical Network (EPN) works with the non-profit health sector to increase access to medicines through enhancing the capacity and sustainability of faith-based drug supply organisations.

INRUD

Sida supports the International Network for the Rational Use of Drugs (INRUD) to address adherence to anti-retro viral (ARV) drugs for HIV. The problem with adherence has not been addressed in any of the programmes now being scaled up in Africa. There is no common method of measuring adherence and the different ARV programmes have not been evaluated according to their ability to address adherence. Management Sciences for Health (MSH) – a reputable non-profit organisation with offices in more than 100 countries – has taken a lead in this area and proposed an applied research agenda. The ARV programme in five African countries (Tanzania, Uganda, Kenya, Rwanda, and Ethiopia) will be evaluated. A model ARV programme with the best adherence rates will be chosen and piloted. This programme will then become the golden standard in terms of adherence. It will be introduced as policy and applied in the national AIDS programmes in participating countries. The programme will be supervised by a specially formed Technical Advisory Group (TAG) with experts from WHO, Karolinska Institutets Division for International Health (IHCAR), Harvard Medical School and Management Sciences for Health.

The overall performance has not been rated since the programme is newly established and there are no reports available.

Sexual and reproductive health and rights

MAJOR CONTRIBUTIONS		PROGRAMMES	DISBURSEMENTS 2006
72004200	Public health	IBFAN-Africa 2003-2008	1 500 000
72500141	SRHR	AMRN 2002-2006	2 690 190
72300221	SRHR	IPAS Safe abortion	4 690 000
72300224	SRHR	Rainbo Support	2 000 000
Total			10 880 190

IBFAN-Africa

IBFAN-Africa has achieved increased awareness about appropriate infant and young child feeding practices amongst health workers, mothers and the general population. The last IBFAN regional conference primarily focused on community support for pregnant, lactating and HIV-positive mothers. Participants left with proposals for national action plans within these areas.

SAMOUZA

The SAMOUZA project is built on collaboration between Karolinska Institutet and the institutes for gynaecology and obstetrics in South Africa, Mozambique, Zambia, Angola and Uganda. The overriding goal is to create a regional exchange for sharing of best practices to decrease maternal morbidity and mortality.

Seven workshops were held in five countries, where a total of 216 participants were trained. Doctors and midwifes were introduced to problems and effective solutions in neighboring countries that face almost identical situation regarding maternal ill-health. This was one of the most important features of the programme. The innovative approach of this project brought together midwifes and obstetricians together, and gave them hands-on training where they learned appropriate live-saving skills. This led to increased delegation of duties to mid-level providers, such as midwives. The project clearly demonstrated the complexity and challenge of managing illness related to reproductive health. There is also . It also highlighted growing recognition about HIV as a major contributing factor to maternal death and the scarce human resources available to combat this issue. The SAMOUZA project started in 1999 and the second and last phase of the project covered here (2003-2006) ended in December 2006. The number of seminars has exceeded the target.

The performance of the project exceeded plans (EP).

AMRN

Sida provides support to the African Midwives Research Network (AMRN) to strengthen communication within the network, to improve research methodology and to expand knowledge within the midwifery profession. AMRN collaborates with Karolinska Institutet. One of the goals of the project is to increase the role of midwives in delivery healthcare and to promote evidence-based delivery healthcare practices. Support is provided to evidence-based research to encourage midwives to think critically, to provide analytical tools for problem solving and to increase consciousness of and interest in applied research. KI implemented a national-level research methodology course connected to evidence-based midwifery practices in Mozambique in 2006.

Ipas

The overall objective of Africa Safe Abortion (Ipas) is to reduce unsafe abortion, which is often a cause of maternal mortality and poor reproductive health of African women, especially among the poor. The purpose of the programme is to increase sustainable access to safe abortion care and help foster African women's ability to exercise their sexual and reproductive rights. The programme includes awareness activities and advocacy training as well as

human resources training. The result of these activities should be better services and abortion care, including improved technical and material resources. Sida visited the regional offices in Kenya and Ethiopia in 2005 and 2006.

Ipas provided technical support for the implementation of the Plan of Action for of Sexual and Reproductive Health and Rights, drafted by the African Union at Maputo, Mozambique. The action plan addresses unsafe abortion. Mozambique strengthened its efforts to achieve legal reform and Ipas assisted the MoH in drafting a new abortion law. With assistance from Ipas, Ethiopia also drafted guidelines on safe abortion services in accordance with the newly revised law approved by the Ministry of Health. The Ministry of Health in Zambia developed standards and guidelines for comprehensive abortion care services. With support from Ipas, it provided stakeholders with information about the Termination of Pregnancy Act. In Ghana, efforts were taken to improve the implementation of abortion training and services to the fullest extent of the law.

To improve advocacy skills, Ipas held values clarification workshops in South Africa and Ghana. A Southern Africa regional advocacy workshop was completed to help build participants' advocacy ability. Participants included women's advocates, female lawyers, parliamentarians, and Ministry of Health officials from Botswana, Malawi, Mozambique, Zambia and Zimbabwe. In Francophone Africa, Ipas supported the establishment of the first abortion care model service delivery centres in Benin and Burkina Faso. These centres also serve as training sites. Clinical training was held in Kenya, Botswana, and Zimbabwe. For the first time, comprehensive abortion care was integrated into pre-service training of mid-level healthcare providers at the Women's University in Africa, which is located in Zimbabwe.

Due to a flexible approach for moving efforts to where results can be achieved, the project has exceeded plans (EP).

RAINBO

Regional support was provided to RAINBO, which works against female genital mutulation/cirumcision in Africa. Sida provided support for a small grant project for local NGOs and also supported the Amanitare iniative, which is a network of African professionals that advocate women's empowerment, including the prevention of female genital mutilation.

International Training Programme

Lund University held the Sida International Training Programme, "Sexual and Reproductive Health and Rights,"in 2006. This was the first time it focussed on Africa. Participants worked in national teams of obstetricians and midwives, with the goal of implementing processes of change at home. There was great interest in the programme in terms of the number and quality of applications. Due to this, and the high relevance of SRHR activities in Africa, the programme was subsequently duplicated for the same region later in the year. The regional follow-up seminars indicated very encouraging results from many of the teams. These include improved efficiency of service delivery due to managerial reforms in Nigerian clinics and extended provision by low-cost methods in rural areas of Malawi.

HIV/AIDS

(Taken from the Regional HIV and AIDS Team for Africa Annual Report 2006:) Over the last decade, the centre of the global epidemic has moved from eastern to southern Africa. Today, southern Africa is the hardest hit sub-region with half of all persons living with HIV on the African continent, and about one-third of all HIV positive people in the world. At the same time that the infection rates are levelling off in some countries, the silent impact is no longer just illness but also death, leaving behind increasing numbers of orphans. The brunt of the social impact is 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 with HIV and AIDS, 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."

In the context of global funding mechanisms and vertical policies, it is challenging to properly respond to the heterogeneity of the epidemic. In 2006, the African year of prevention, recognition of this diversity was essential for effective prevention, and opened up a discourse on more specific evidence-based interventions, looking at micro-epidemics amongst injecting drug users and men that have sex with men, both in the general population and in prisons.

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

The experience from regional programming and comparative studies funded by the team provided a solid platform for support from the Swedish and Norwegian Embassies. An IDASA study concluded that the epidemic creates a democratic deficit when parliamentarians pass away, and delayed by-elections mean that ruling regional parties usually win. The Centre for AIDS Development, Research and Evaluation (CADRE) studied prevention communication in a number of countries and concluded that although there has been some impact, a more focused strategy with well-targeted and researched campaigns would be much more effective. Again, heterogeneity needs attention. Seminars were held on HIV and AIDS in conflict settings, mainstreaming in the water sector and how to work with HIV and AIDS in broader cooperation. A focal point meeting brought together Swedish, Norwegian and Irish representatives in 13 African countries. There were the highlights of embassy support in 2006.

In response to the Paris Declaration, the Swedish-Norwegian team – together with UNAIDS and six bilateral partners – developed a Joint Framework for Regional Support to the HIV and AIDS response. The framework was used as input to the Swedish Regional Strategy. Further harmonisation was achieved later in the year when the Norwegian Government signed an agreement with Sida to become a full partner in the team by providing funding and planning increase the Norwegian staff to two advisors.

CONTRIBUTIONS	HIV/AIDS PROGRAMMES	DISBURSEMENTS 2006
21500054	RATN capacity development	3 500 000
21500071	SATSouthAfricaAIDSTrust	10 500 000
21500095	REPSSI – OVC and HIV/AIDS	3 000 000
21500025	HIV/AIDS Team Activities	28 436
21500016	ARASA - AIDS och MR	1 000 000
26003026	Femina-youth HIV/AIDS	3 500 000
21500034	PLUS NEWS HIV/AIDS Serv.	1 900 000
21500045	HelpAge Africa HIV/AIDS	5 128 957
26003024	SAFAIDS - core support	4 000 000
21500005	GART HIV Food Security	5 000 000
21500010	NIR/SMF workplace policy	6 000 000
21500051	Support to PACANET	5 000 000
21500052	Nutrition Support- KKCAF	5 000 000
21500076	Support to Kuru Org.	1 500 000
21500058	HEARD 06-10	7 058 173
21500066	OM Refugees Ext.	6 700 000
21500013	Programme development 2004	45 000
21500024	HIV/AIDS programme development	414 354
21500074	HIV team activities 2006	837 553
21500075	PDF HIV team 2006	2 071 017
21500078	Reference Group	394 603
21500006	TASO Reg Training Centre	5 400 000
21500021	ACORD/HASAP	4 000 000
21500090	Hope WW - OVC	4 500 000
21500012	AAU HIV/AIDS	2 800 000
21500083	Pop. Council GBV	2 600 000
21500093	Social Science Conference	2 100 000
21500081	UNDP Regional HIV/AIDS	10 000 000
21500032	Media Policy HIV/AIDS	2 169 748
21500039	Panos HIV/AIDS S Afrika	950 000
21500105	ASSITEJ theater AIDS	625 000
21500038	RFSU-YMEP	11 000 000
21500041	Train & research (TARSC)	615 000
21500046	STEPS for the future	3 000 000
21500082	New SANASO	1 000 000
26003014	STEPS – distribution	1 650 000
21500020	Renewal -Food security	100 000
21500085	FAO Nutrition Support	2 300 000
27000250	IFRC/SRC Home-based Care	6 000 000
21500073	Seminar Malawi, Pilotstudy	83 659
21500008	SADC HIV/AIDS Unit	5 000 000
21500026	Femina-edutainment-region	1 000 000
26003032	IHAA Africa wp 2005-8	6 000 000
27000187	REPSSI Regional OVC	3 068 000
21500057	HRDI, AIDS discimination	250 000
21500072	HRDI, AIDS discrimin LVI	1 500 000
21500002	CADRE AJAR journal	232 075
21500023	ANERELA+	800 000
21500103	Observatory RPG	1 040 000
27000201	PSG - mobile populations	7 500 000
27000204	IOM - Phamsa	5 900 000
26003029	IDASA - ABU and GAP	4 000 000
27000203	ILO-AIDS sub-Sahara Africa	13 000 000
74002795	SwRedCross HIV/AIDS05-06	4 860 000
Total		187 621 575

In 2006, the Regional HIV/AIDS team entered into an agreement with Hope World Wide, to build organisational capacity for improved quality of services, effectiveness and efficiency amongst organisations working with children. The evaluation of the Regional Psycho-Social Support Initiative (REPSSI, Sida's Evaluation Report series, 06/20) shows that REPSSI has built capacity and developed tools for psycho-social support that were used by 78 partner organisations in 13 countries over the last four years. REPSSI's more recent annual report 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 in 2006 was through International Organisation of Migration (IOM) and the Project Support Group (PSG). The first phase of the IOM project on repatriation of Angolan refugees from Zambia ended and preparations for a new phase began. The project on the vulnerabilities of migrant workers in West African countries is ongoing. Within the extended agreement with PSG, the organisation has increased its research efforts to improve its performance, as well as to share best practices with partners.

On delegation from the Sida/Lake Victoria Initiative, the team prepared support AMREF for their capacity-building and policy harmonisation on mobile populations within the Lake Victoria Basin. The project will begin in 2007.

An experts' meeting on regional public goods was organised to tease out potential intervention areas at the regional level (SIDA – Regional Public Goods Meeting, U11 Ya22.3/66). As a result of this workshop, the idea of a commodity-related regional observatory on HIV and AIDS was proposed. Many HIV commodities are in short supply, often depending on erratic demand and sometimes constraints on the supply side. There are also a number of quality issues with which many countries with limited capacity face. 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 cost transparency in the region and in the long run a better market situation on HIV commodities.

The impact on older people is becoming critical as traditional African extended family coping mechanisms are stretched to the limit. Few governments are taking older people into account in their national HIV and AIDS responses. In 2006, the team started to support Help Age international – Africa regional office. This collaboration has thus far made it possible for the organisation to make inroads in collaborating ageing and AIDS with intergovernmental bodies such as the African Union (AU), SADC and the African Development Bank (AfDB).

Initial support was provided for an HIV and gender workshop at ECOWAS. As a follow-up the organisation is working on a concept paper for an HIV and AIDS strategy to be submitted to the team. Communication has begun with EAC, where the team worked with UNAIDS and the Regional UNDP project on HIV and AIDS 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 was 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 worker training. In the majority of cases, training was followed by Voluntary Counseling and Testing (VCT), which provided information on prevalence rates at workplaces. This information was a key factor in designing interventions at individual workplaces. This year the programme was expanded to Tanzania and Uganda. The World Economic Forum received a smaller amount of support, which they used to define good practices in promoting workplace policies down the supply chains of a number of large multinational member companies in Africa.

The four-year support programme to ILO presented its first results in better mainstreaming HIV and AIDS in the organisation and a number of established programmes. The labor courts is one of the focus areas, where labor judges have been trained to better understand the procedural issues on HIV and AIDS cases. This 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. For small and medium-sized enterprises and the informal sector, a training manual for trainers has been developed.

The team continued mainstreaming efforts in the area of Gender, Communication, Human Rights and Stigma. Young Men as Equal Partners, through RFSU/IPPF, continues to be the largest supported gender programme. In 2006, all four participating countries carried out baseline surveys for monitoring and evaluation. Findings show that young boys/men generally have little knowledge about contraceptive methods (only condoms are widely known) and the importance of faithfulness as a preventive measure. Only half of 15-24 year olds practice "safe sex". To reach the target group, out-of -school activities are essential, including working with gender attitudes as well as providing information about condoms to young groups (before they have sex for the first time). A regional training programme for trainers was organised 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[5]. 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 the national level.

Gender-based inequalities and violence, combined with poverty, are the main underlying factors for HIV infection in sub-Saharan Africa. For the most part, this requires 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. Seed grants to

[5] Breaking the cycle of vulnerability – responding to the health needs of trafficked women in eastern and southern Africa, International Organization for Migration, 2006

Zimbabwe, Ethiopia, Malawi and Senegal are planned as a follow-up. The focus is on practical inputs for support to survivors, prosecuting perpetrators and community and family work against violence. The aim at the regional level is to strengthen and broaden response mechanisms, create policy guidelines and good practice towards scaling-up.
Sida has supported pilot projects on prevention communication including Femina HIP and STEPS for the future. The projects targets youth, using magazines, talk-shows and videos to deliver positive messages about SRHR. A Sida-commissioned study on prevention communication was finalised by Cadre during the year[6]. The study does not encourage large scale campaigns since there is "one size fits all" solution. Communication is rather targeted at the specific epidemic and the situation of the target group. The support to Panos SA already partly uses this concept. It also engages the target group in designing the communication they need via the radio listener clubs pilot project in Zambia, Malawi and Namibia.

Media, which plays an important role in the response to HIV/AIDS, is also closely related to these projects. The Media Action Plan on HIV/AIDS and Gender has continued to successfully roll out policy processes in the media industry. Thus far, 57 media houses in the region have started working on policies, of which 13 have already been finalised and adopted[7]. Together with support to Panos SA, SAfAIDS and IRIN Plus news, the team employes different approaches to help journalists in the region better understand the impact of HIV and AIDS. This in turn provides better informed news and human interest stories to citizens. This can lessen the stigma.

In the area of Human Rights, the team continued support to the Human Rights Development Initiative (HRDI) in order to develop a legal precedent on discrimination against HIV-positive people. The project reached the stage when a few legal cases have been prepared by legal students. The support to AIDS Rights Alliance of Southern Africa (ARASA) ended in 2006 and the organisation was evaluated[8]. ARASA is a network of 14 organisations promoting human rights in the area of HIV and AIDS through training and advocacy activities, among others. The organisation has mainly fulfilled planned activities but weak monitoring and evaluation systems make it difficult to systematically assess possible impact. The organisation will develop a strategic plan to more clearly outline its values, mission, vision, goals and strategies for the next five years. Sida will thereafter consider continued support.

Greater involvement of people living with HIV and AIDS is a key factor 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 interlocuters, the churches. The African Network of Religious Leaders Living with or Personally Affected by HIV and AIDS (ANARELA) and PacaNet are both networks of religious leaders.

[6] HIV/AIDS Communication in selected African Countries – Interventions, responses and possibilities, Sida, 2007
[7] MAP Policy Review Meeting with Sida, March 2007
[8] Sida Evaluations 43/06

Support was given to encourage religious leaders to take an evidence-based approach to the epidemic and how they address it among their congregations. In collaboration with the Secretariat at Sida headquarters and the advisors in Asia, the team published three issues of the 'EYES on AIDS' newsletter as part of their information campaign. The format was slightly changed whereby the newsletter was to focus on major global events whenever they take place. An example is the issue that focused on the Toronto AIDS conference. 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 guides the new agreement with RATN (Regional AIDS Training Network) with Sida as the lead agency. A mid-term review concludes 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.

The Teach experimental training programme of TASO is proving very popular with applications far exceeding the regional placements available for this 2006. The UN-HABITAT Urban Management Program pilot project on building local municipalities' capacities to respond to the epidemic is ongoing in five cities. The project is behind schedule, with just one 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 in Addis Ababa indicates that the programme has enhanced the capacity of African scholars for research. However, no new research findings and applied results were identified that can feed into policy and practice.

The Governance and AIDS component of the IDASA study "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 parliamentary by-elections and related costs to governments in the region. And both candidates and elected representatives are in denial about their HIV status for fear that it would be used against them.
The regional team prepared and agreed a 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 programme 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[9]. 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 organisation for the next conference, without consulting IAS, and IAS is suspending its relations with ICASA.

The support to the field of capacity building, comparative research and networking 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 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 more long-term continued support have not yet been concluded.

[9] HIV and AIDS Indicators, Oliver S Saasa

Public health

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
72300138	ALI occup health SADC	5 000 000
72300361	Conferences injury prev	1 200 000
Total		6 200 000

WAHSA

The overall aim of the SADC regional programme on occupational health, Work and Health in Southern Africa (WAHSA), is to contribute to the reduction of poverty and promotion of human rights in Southern Africa, through improvements to occupational health and safety and the empowerment of workers. The long-term goals of the programme will be addressed through ten Phase I projects, some of which will continue in subsequent phases. Three projects address common and important occupational health issues in Southern Africa: the health effects of silica, pesticide exposure and work in the informal sector. The remaining projects are concerned with research into current health and safety conditions, the development of a regional strategy on the training of health and safety professionals and the promotion of advocacy for and awareness of workers' health and safety in the region. Interventions are carried out in areas such as silica, silicosis and TB and health impact on pesticides. The project will develop regional resource cooperation links primarily among Tanzania, South Africa and Zambia. The partner in Sweden is the Swedish National Institute for Working Life (ALI). In 2006 there was a discussion between ALI and Sida regarding the fact that ALI will dissolve in July 2007. The project will be turned over to the National Institute for Public Health.

The Main results in 2006 include the establishment of three resource complexes on occupational safety and health in Zambia and Tanzania. A Resource Complex workshop was held in Dar-es-Salaam, Tanzania in March. Country profiles were compiled in Mozambique, Botswana, Malawi and South Africa. A website was created for WAHSA-related as well as occupational health and safety issues of relevance to Southern Africa. Two protocols in the area of surveillance were developed and research was done in the areas of hazard communication and risk perception. Data collection on documenting information on pesticides usage and effects in SADC also began. Risk assessments and reports regarding dust control were carried out at quarries in Lesotho, Mozambique and Zambia.

In general, the projects were delayed and planned activities were to a large extent postponed and re-scheduled. The overall rating is MDP.

Health Programme Countries

Bangladesh

The Swedish country strategy for development cooperation with Bangladesh prioritises support to the health sector with focus on primary healthcare as well as Sexual and Reproductive Health and Rights (SRHR) through a sector-wide approach. The Health Nutrition and Population Sector Program (HNPSP) led by the Ministry of Health and Family Welfare (MOHFW) encompass the entire sector activities and accounts for almost all the government and development partner resources. HNPSP aims to accelerate progress on the MDGs and is aligned to the Government Poverty Reduction Strategy. The dialogues issues in health sector mainly emerge from the agreed Results Framework of HNPSP.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
42000084	HNPSP	90 000 000
42000160	HIV / AIDS-Brac	2 089 795
42000164	RHSTEP	3 372 108
42000165	BAPSA	1 428 230
42000166	BWHC	2 380 384
42000168	Second UPHCP	7 000 000
Total		106 270 517

Health in Bangladesh has improved significantly over the last few decades. Bangladesh is well on track to meet the Millennium Development Goals (MDGs) related to Child Health and Communicable Disease and has made impressive gains in fertility reduction. However, much remains to be done. Every year, there are more than 12,000 maternal deaths and 70,000 deaths from tuberculosis. The burden of death, ill health and malnutrition fall disproportionately on the poor and the poor are not benefiting fully from publicly subsidised healthcare.

The Annual Programme Review (APR) of HNPSP took place in April 2006. An Independent Review Team conducted the APR. Information was collected on six indicators to serve as a baseline for the programme. The hiring of three technical assistance bodies, Programme Support Office (PSO), Management Support Agency (MSA) and the Performance Management Agency (PMA) was delayed. The responsibility lies with both the World Bank and the Ministry of Health and Family Welfare (MOHFW).This has delayed the start-up of the 'Diversifying Service' provision component of the programme.

	BANGLADESH	LATEST YEAR	
HEALTH AND DEVELOPMENT	Life expectancy at birth (males)	62 (2004)	
	Under five mortality rate males	81 (2004)	
	Under five mortality rate females	73 (2004)	
	Human development index (value, ranking)	0.530/137 (2004)	
	IMR	56 (2004)	
	GDP/Capita PPP USD	1870 (2004)	
EQUITY	Under five mortality rate lowest/highest quintile	1.7 (2004)	
	Gini coefficient	31.8 (2000)	
SRHR	Maternal mortality ratio	380 (2000)	
	HIV prevalence 15–49 (%)	–	
	Antenatal care coverage, one visit (%)	39 (2000)	
	Births attended by skilled health personnel (%)	13.2 (2004)	
	Contraceptive prevalence rate (%)	58.1 (2004)	
	Total fertility rate (per woman)	3.2 (2004)	
	Adolescent fertility proportion (%)	22.6 (2003)	
	Neonatal mortality rate (per 1000 births)	36 (2000)	
	Deaths due to HIV/AIDS (per 100 000)	–	
HEALTH SYSTEMS	Physicians per 1000 population	0.26 (2004)	
	Nurses per 1000 population	0.14 (2004)	
	Total expenditure on health (% of GDP)	3.4 (2003)	
	Government expenditure on health (% of government spending)	5.8 (2003)	
	External resources for health (% total)	12.4 (2003)	
	Per capita government expenditure on health	4 (2003)	
	Vaccination (3 x DPT)	85 (2004)	
	Midwives per 1000 population	0.18 (2004)	
INFECTIOUS DISEASES	Years lost to communicable diseases (%)	60 (2002)	
PUBLIC HEALTH	Years lost to non-communicable diseases (%)	27.9 (2002)	
	Years lost to injuries (%)	12.1 (2002)	
	Prevalence of tobacco smoking (males)	59 (2003)	

Sida's assessments: Positive development Negative development

Second Urban Primary Health Care Project (UPHCP – II), June 2005 to December 2011

UPHCP – II is a part of HNPSP and led by the Ministry of Local Government and Rural Development. The project is decentralised via NGOs. It helps ensure the delivery of a package of preventive, promotional and curative health services to the poor in six city corporations and five municipalities. The services are designed to reduce child and maternal mortality and morbidity, and help the country achieve the MDGs. The project continues to contract out primary healthcare (PHC) services to NGOs through partnership agreements. Nutritional supplements will be given to moderately to severely malnourished women and children. Community-run latrines and community-based solid-waste disposal will be piloted to improve environmental health, and clinical waste management (CWM) will be supported. User fees will be charged to people who can afford them. Free and easily accessible PHC services will be made available to the poor. The project will improve the health status of the urban population, especially of the poor, in these areas. At least 30 percent of all the services provided under the Project will be targeted at the poor.

National Menstrual Regulation (MR) Program

The programme is part of the Essential Service Delivery (ESD) package of HNPSP, implementing a three-year programme, July 2004 to June 2007. As part of the advocacy programme, three NGOs held a dialogue on the *Role of National MR Program for the Promotion of Sexual and reproductive Health and Rights in Bangladesh on* 19 February 2006. The dialogue was addressed by the Ambassador of Sweden, senior government officials, NGO and civil society representatives and the media. The Embassy has also brokered partnerships between the Swedish Association of Sexuality Education (RFSU) and three NGOs based on common interests regarding SRHR.

Vietnam

The Embassy agreed with the Ministry of Health to extend the Vietnam-Sweden Health Cooperation (VNM-SWE) on Health Policy and System Development (VSHC/HPSD) up to 31 December 2007 with additional funding of SEK 14.6 million. The extension intends to consolidate the VSHC programme. Preparations for possible cooperation in the future will also be included in the extension.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
46000100	VNM05-Health	2 077 679
46000171	NPOs	342 415
46000207	VNM-SWE Prog Mgt and Coor	2 334 146
46000208	VNM-SWE Comm. health dev	1 824 731
46000209	VNM-SWE Drug Mgt	1 206 000
46000210	VNM-SWE Tobacco Control	1 560 000
46000211	VNM-SWE Accident & Injury	849 000
46000212	VNM-SWE Sida Follow up	1 515 293
46000213	SIPU	5 480 384
46000261	Co-financing ADB health	6 500 000
46000281	NA leadership on HIV/AIDS	6 400 000
46000342	VN health study 2006	506 500
Total		30 596 148

In the ADB/Sida Health Care Program in the Central Highlands, all five selected programme provinces commenced disbursements of the allowances for food, travel allowance, referral to high-tech medical services and mobile outreach health services at the municipal level. The absorption capacity remains relatively low and will be followed up in the bi-annual review mission in March 2007.

The MoH has been selected as a pilot ministry for implementing the Hanoi Core Statement (HCS) principles. The Embassy financed a MoH-study[9] jointly with the Netherlands on programme approach that concludes that Vietnam has relative strong public finance management (PFM) system. There is scope to introduce a health sector programme approach, but not all features could be applied at this stage. Actual implementation of sector budget support would greatly depend on prompt and supportive regulatory action on the parts of the MoH and MoF. MoH will establish a Health Sector Working Group with members from relevant ministry departments and health sector donors, headed by the MoH Planning and Finance Department, The goal of the group is to improve sector coordination and create the conditions for a health sector programme in the future.

The Action Plan for HIV/AIDS mainstreaming was developed in the Embassy in 2006. Each project or programme is required to provide information on what has been done, its current programme or project activities as well as planned activities for next two years.

[9] "Feasibility of the program approach in the health sector in Vietnam", Sjölander et al, Sida, April 2006

	VIETNAM	LATEST YEAR	
HEALTH AND DEVELOPMENT	Life expectancy at birth (males)	69 (2004)	
	Under five mortality rate males	24 (2004)	
	Under five mortality rate females	22 (2004)	
	Human development index (value, ranking)	0.709/109 (2004)	
	IMR	17 (2004)	
	GDP/Capita PPP USD	2745 (2004)	
EQUITY	Under five mortality rate lowest/highest quintile	–	
	Gini coefficient	36.1 (1998)	
SRHR	Maternal mortality ratio	130 (2000)	
	HIV prevalence 15–49 (%)	0.4 (2003)	
	Antenatal care coverage, one visit (%)	70 (2002)	
	Births attended by skilled health personnel (%)	85 (2002)	
	Contraceptive prevalence rate (%)	78.5 (2002)	
	Total fertility rate (per woman)	2.3 (2004)	
	Adolescent fertility proportion (%)	5.9 (2001)	
	Neonatal mortality rate (per 1000 births)	15 (2000)	
	Deaths due to HIV/AIDS (per 100 000)	9 (2003)	
HEALTH SYSTEMS	Physicians per 1000 population	0.53 (2001)	
	Nurses per 1000 population	0.56 (2001)	
	Total expenditure on health (% of GDP)	5.4 (2003)	
	Government expenditure on health (% of government spending)	5.6 (2003)	
	External resources for health (% total)	2.6 (2003)	
	Per capita government expenditure on health	7 (2003)	
	Vaccination (3 x DPT)	94 (2004)	
	Midwives per 1000 population	0.19 (2004)	
INFECTIOUS DISEASES	Years lost to communicable diseases (%)	39.9 (2002)	
PUBLIC HEALTH	Years lost to non-communicable diseases (%)	44.5 (2002)	
	Years lost to injuries (%)	15.6 (2002)	
	Prevalence of tobacco smoking (males)	51 (2003)	

Sida's assessments: Positive development Negative development

India

Support from Sweden is mainly focused on sexual and reproductive health and rights including HIV/AIDS and local government partnerships, including ICT. The Swedish input has been expanded to develop partnership projects between Swedish and Indian actors. In addition to these, direct support is provided to two Indian organisations and UNAIDS.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
72004205	RFSU-MAMTA Network	7 500 000
43100014	PC-Fund 2006	2 225 922
43199336	Strengthening Midwifery	6 366 700
43199337	Lawyers Collective	2 193 815
43199410	Safe Abortion	4 500 000
43199416	RCHR/IMCH Raj. Phase II	3 132 749
43199418	NE HIV/AIDS-UNAIDS	1 000 000
43199420	PMT-Linköping Collaboration	3 902 691
43199421	Naandi Foundation	1 500 000
Total		32 321 877

Health indicators are improving, but according to the progress report for the fulfilment of the Millennium Development Goals, India has made limited progress in halving the number of hungry people, lowering the rates of child and maternal mortality (87 of 1000 and 5.4 of 1000) and providing sanitation facilities in urban areas. The country is, however, likely to meets its targets in halving the number of people living in poverty, gender parity in primary education and universal access to clean drinking water. HIV/AIDS is increasing but is still considered to be low (prevalence below 1 percent).

The strategy in India is to work with partnership projects:

- The MAMTA/RFSU project, Young people's health and development
- The Indian Institute of Management/Karolinska Institutet collaboration project, Developing inter institutional collaboration between institutions in India and Sweden for improving midwifery and emergency obstetric care services in India
- The Ipas-IMCH, Uppsala University consortium project, Increasing access to comprehensive abortion care services in India,
- The Pravara Medical Trust-Linköping University Hospital project, Developing a multi-sectoral approach model to sustainable health and development
- The Rajasthan network in institutional collaboration with IMCH, Integrating social support for reproductive and child health and rights focus on reproductive and adolescence health, safe abortion and strengthening midwifery.

These projects are based on mutually developed mechanisms for knowledge and technology exchange as well as the promotion operational research and capacity development. The idea is to establish models in India based on Swedish expertise that can be replicated in other parts of the country. The Swedish partners mainly benefit from access to the Indian research environment as well as internationalisation of their organisations. Three of these partnership projects were agreed by the end of 2005 and the implementation only started in 2006. Therefore, it is premature to report on the outcomes. However, the projects proceeded according to plans and the main achievements during the year included the initiation of a process to establish model Centres for Advanced Midwifery Training within the government nursing colleges in three states. The Ipas consortium project completed its facility survey to develop a district-level model to expand the provider base for comprehensive abortion care. The consortium members were invited by the Government to be part of the national expert committee for amendments to the Medical Termination of Pregnancy Act. The multi-sector project also increased healthcare access by upgrading six rural health centres, established seven e-health centres and five mobile clinics in Loni, Maharashtra.

Mamta-RFSU

The Mamta-RFSU significantly contributed in the preparation of the Government's 11th Plan Document and the National AIDS Control Program III (NACP) with regard to young people's health, which shows that Mamta has developed into a recognised organisation participating in planning of national strategies. A mid-term evaluation was made in 2006 confirming that Mamta with support from RFSU has built up a very strong base to promote youth SRHR issues at the national level. The results are particularly striking in the areas of research, documentation and advocacy but progress was more uneven in the area of networking. The midwifery project trained master trainers in Sweden in its process to establish model Centres for Advanced Midwifery Training within the government nursing colleges in three states. The Ipas consortium project completed a facility survey to develop district-level model to expand the provider base for comprehensive abortion care. The consortium members were invited by the Government to be part of the national expert committee for amendments to the Medical Termination of Pregnancy Act. The multi-sector project has increased access to health by upgrading six rural health centres, established seven e-health centres and five mobile clinics in Loni, Maharashtra.

Within the *PMT-Linköping Collaboration,* a model of institutional collaboration between India and Sweden has been developed. The broad objective of the collaboration is conceiving a Multi Sectoral Approach Model to Sustainable Health and Development of the vulnerable sections of the society in underserved areas by involving all stakeholders, Government, Non Government, Academic and Research Institutions and Civil Society. The project has five strategic areas - (1) Improving Access to Quality Medical & Health Services on Swedish pattern Of Primary Health Care (2) Gender Equality, Sexual and Reproductive Health Rights, HIV/AIDS, Socio-cultural aspects, (3) Awareness generation, Behavioural Change Communication, Socio-economic Security, (4) Nutrition, Biotechnology,

Eco-farming, Poverty alleviation, and (5) e-health and Empowerment.

In the Ahmednagar district, Maharashtra, over 400,000 people spread over 235 remote and rural villages, of which 100 are hilly and tribal, are expected to benefit from the project.

Some of the results from the project are six upgraded and fully equipped rural health centres and five fully equipped mobile clinics in strategic, remote and underserved locations of the project area – Rahata, Bahbhaleswar, Kolhar, Pathare, Zarekathi (tribal) and Shendi (tribal), providing services to general patients, mothers, children and adolescents.

The Faculty from Linköping University and Hospital trained project staff twice for two weeks in 2006. The training covered gender-sensitive maternal and child health, youth clinics and computerised online registration and tracking of pregnant women and children according to the Swedish model. Activities in 2006 include regular testing of drinking water, development and dissemination of information and training material and the establishment of seven e- health centres in the project villages.

Integrating Social Support for Reproductive and Child Health Rights, Phase-II (RCHR/ IMCH Raj.) project sanctioned for five years started in June 2005. Various activities are being implemented in 180 villages of Rajasthan State with ten partner NGOs to execute programme activities. The project's goal is "sustained and gender equitable improvement in reproductive and child health rights in rural areas" with significant reduction in maternal mortality, infant mortality, total fertility rate, sexually transmitted diseases and considerable improvement in the survival of girls up to five years old. Key programme strategies include community participation in local governance, institutional linkages, advocacy and strengthening the network of NGOs for influencing policy environment to improve the access of quality and gender-sensitive health services.

The project started in June 2005. Most of the time has been utilised for carrying out a baseline survey with the help of IMCH, Sweden. The project has developed systems in its start-up phase, built capacity of project personnel, developed information systems for regular reporting and developed information and communication activities.

Naandi Foundation

Collaboration with the *Naandi Foundation* is about quality healthcare and education in the tribal region of Paderu. The Naandi Foundation recognises that quality health and education go hand in hand in improving the quality of life. Poor tribal mothers with little or no access to healthcare facilities, deliver babies with low birth weight. The cycle of undernourishment impedes a child's mental and physical development and affects his or her performance at school. This leads to high dropout rates from school, ensuring that the child remains on the margins of society. The key, therefore, to Naandi's strategy is the promotion of quality health and education for neonates, infants and children. The project works in three different areas:

To enhance *maternal and neonatal health* in remote tribal areas by facilitating the provision & convergence of services, awareness, education and training of public and private health service providers through: Health service delivery

for pregnant women and children below one year at primary, secondary and tertiary levels and through greater awareness regarding best practices during pregnancy, communicable disease, and sexually transmitted diseases.

Access to pre-primary education for children under six in remote tribal areas. Most children in the 3-6 year old group, who are first generation learners, are denied the opportunity to access basic pre-school facilities that provide early stimulation, and the scope to develop cognitive and social skills, which facilitates their integration into the formal school system. Older children often share the burden of sibling care, which deters them, especially girls, from entering school. Presently Naandi is running 100 centres in Paderu region of Andhra Pradesh. Around 500 children have 'graduated' from the centres into primary schools and absenteeism is low and the dropout rate so far is nil.

The primary objective of the third component is to ensure *children learning and attaining grade-specific competences* through teacher training and improving the learning environment in schools. Naandi is presently working in 150 primary schools, with over 8,000 children. Until now, 1,700 children from Naandi's schools have been admitted through a competitive test into the government's residential schools. Of all the new entrants in the residential schools so far, 45 percent are from Naandi's school. The school dropout rate in the region is 46 percent. In the Naandi schools, however, the drop out rate has decreased to 5 percent. This is due to involvement of parents and active presence of the Village Education Monitoring Committee. The monthly assessment shows that there is significant improvement in learning levels of all the children.

Lawyers Collective (LC)

LC is the only NGO on the Government's National Task Force that makes recommendations on the laws affecting vulnerable communities. Their interventions have led to some landmark judgments that established HIV-positive persons eligible for recruitment in the Police Department. They are the lead facilitators in the civil society on (a) opposition to patents for affordable medicines, (b) amendments to the Immoral Traffic (Prevention) Act, and (c) amendments of the law affecting the MSM community.

Sweden has been an active dialogue partner to the National AIDS Control Organisation (NACO) in the appraisal of the new phase of the National AIDS Control Programme (NACP-III, 2006 – 2011). Among others, Sweden was instrumental in proposing Development Partnership Arrangements between the Government of India and development partners outlining the principles of cooperation.

West Bank/Gaza

The Swedish Country Strategy for development cooperation with West bank and Gaza states the necessity to continue support in the health sector. The current cooperation in the health sector has a long history, but in May 2005 it was decided to phase out the support by mid-2007. The reason was the very long period that Sweden had been providing support through non-governmental organisations and it was considered more strategic to support the strengthening of the governmental health system.

The year 2006, however, witnessed an even further deterioration of living conditions and rise in poverty in the West Bank & Gaza, especially among the Palestinians living in the Gaza Strip. Due to the worsening humanitarian crisis, and recognising the very progressive character of the currently supported NGO health services, in combination with the EU contact policy towards the Hamas-led government, the decision was reconsidered. The current support to the health sector through the NGOs was continued. The programmes are considered to be relevant also when the political situation will change and also within a future framework of a comprehensive National Health Sector Plan.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
72300102	PGS/UPMRC PHC 2001-05	14 707 000
72300103	Diakonia Rehab 2006-07	6 500 000
72300104	PGS/GCMHP Mental Health 2002-05	7 885 000
47000057	EESP II/06	45 000 000
Total		74 092 000

PGS/UPMRC phc

Palestinian Medical Relief Society (PMRS) gives support through the programme *(PGS/UPMRC phc)* to primary healthcare in the West Bank and Gaza through the *Palestinagrupperna* in Sweden. 2006 has been another tough year in Palestine, with continued colonisation of the West Bank, renewed outbreak of violent conflict in the Gaza Strip, and a Palestinian financial crisis due to the international boycott of the elected government. Since the Ministry of Health runs 62 percent of all primary healthcare centres and hospitals, the boycott puts a heavy burden on the NGO sector, including PMRS. Despite this grave situation, PMRS has been able to adapt its service provision, and has produced primary healthcare services in line with plans and agreements. In the Gaza Strip, activities like blood donation campaigns, outreach medical clinics in areas affected by conflict, and distribution of food parcels to families in the hardest-hit areas have been necessary. In cooperation with the Institute of Community and Public Health at the Bir Zeit University, data collection has been performed throughout the West Bank and Gaza Strip concerning anaemia among pre-school children and patient flows in primary and secondary care, and analysis has begun in both projects.

Community Based Rehabilitation Programme (CBR)

The Diakonia Rehab 2006-07 Community Based Rehabilitation Program (CBR) supports community-based rehabilitation in the West Bank and Gaza through Diakonia. Sida has assessed and prepared an extension of the contribution. In 2006, the programme has focused on implementing the conclusions and recommendations from the follow-up study conducted by Sida at the end of 2005 as well as the evaluation from a user perspective document conducted during the same period. Both sets of recommendations have, in participation with our partners, been incorporated into a three-year strategic plan to guide the future. The results have been grouped into three categories: adjustment of the programme to the prevailing context; its organisational development as well as the development of specific areas within the programme. The CBR programme has developed emergency plans and because of its decentralised structure is more able to continue to provide primary rehabilitation services at the local community level, in coordination and support from the local structures and networks. Its work now solves partly the problem of access of disabled people to services. In addition, during 2006 two intermediate level services were piloted at the district level, one in Nablus and one in Hebron. The skills of community workers have been strengthened through the continuing education programme focusing on psychosocial needs of disabled persons, gender sensitisation, LFA training, response to autistic children and so on. At the management level, the Norwegian partner has committed to support the programme financially (50 percent) for three years and Diakonia is committed to seeking funds in case Sida phases out its support to the programme in the mid-2007.

The programme has achieved very positive results despite a difficult situation.

PGS/GCMHP Mental Health 2002-05

The PGS/GCMHP Mental Health 2002-05 – Gaza Community Mental Health Programme works with mental health of the children of the Gaza strip, supported through Palestinagrupperna in Sweden. Sida has assessed and prepared a new contribution to the programme and has followed up the programme in Gaza. Since the removal of Israeli settlements from the Gaza Strip in the fall of 2005, Gaza's dependency on Israel and its isolation from the outside world has increased radically, as well as the ongoing deterioration of the economic and social conditions. Despite this, the Gaza Community Mental Health Programme has been successful in generating results in training of school counsellors and intervention and counselling services for children in Khan Younis (south), Deir Al-Balah (middle) and Gaza City (north). Of particular interest has been the attempt to establish a non-violent environment for children in response to the rising phenomenon of violence and trauma. The newly started School Mediation Project has resulted in a significant decrease in violent behaviour, estimated to be between 40-50 percent, in the piloted schools.

The rating is exceeding plans (EP).

Non-health Programme Countries

Afghanistan

MAJOR CONTRIBUTION	PROGRAMME	DISBURSEMENTS 2006
72400031	Swedish Committee for Afghanistan	16 000 000

Burma/Myanmar

MAJOR CONTRI-BUTIONS	PROGRAMMES	DISBURSEMENTS 2006
72300417	Health Economist3-D Burma	314 414
72300442	Three Diseases Fund Burma	0
72300395	Burma - HIV/AIDSphase 2	0
Total		314 414

A consortium of six donors (AusAID, DFID, EC, Netherlands, Norway and Sweden) has established a fund managed by UNOPS to provide support to programme activities for HIV and AIDS, TB and Malaria in Burma/Myanmar. Sida has been active in establishing the mechanism and has assessed and agreed on the programme from 2007 and a health economist was contracted in the preparation during 2006.

Overall performance has been according to plans (AP), with some significant over-achievements against planned indicator targets.

Joint Programme for HIV/AIDS in Myanmar

Sweden is supporting a *Joint Programme for HIV/AIDS in Myanmar 2003-2006* with the purpose of strengthening the enabling environment and support capacity for prevention and care of HIV patients in Myanmar. Is based around five components: i) reducing individual risk of sexual transmission; ii) reducing individual risk of HIV transmission among injecting drug users and their partners, iii) improving knowledge and attitudes regarding HIV/AIDS among the general population, particularly young people; iv) increasing access and quality of care, treatment and support for people living with HIV; and v) strengthening essential elements of the enabling environment for an effective expanded national response.

In 2006, the fourth year of operations for the Fund for HIV/AIDS in Myanmar (FHAM), implementing partners continued expanding the coverage of services for prevention of HIV and for care and support for people living with HIV. FHAM funding supported an intensified response to HIV in Myanmar in several crucial areas including outreach to key populations at higher risk of infection, voluntary and confidential counselling and testing, anti-retroviral treatment, and support for people living with HIV and their families.

China

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
71001893	CHN Project form MOLSS	92 889
71001903	CHN ToR Ningxia	54 000
71006118	CHN Iodine phase 4	4 414 243
71300007	CHN UNICEF Maternal health	2 500 000
71300030	CHN WHO HIV Prevent Care	6 000 000
71300034	CHN Marie Stopes HIV	1 857 164
71300150	CHN HIV Prevent Care	1 970 035
Total		16 888 331

Laos

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
44000061	Inst of NDP impl	1 649 833
44000030	Road 8	50 977
Total		1 700 810

Asia Regional Programmes

Sexual and reproductive rights and health

MAJOR CONTRIBUTION		PROGRAMMES	DISBURSEMENTS 2006
78100263	SRHR	MAMTA	1 872 302
72700003		Conference MSM in Asia	717 432
Total			2 589 734

MAMTA

The MAMTA *International Training Programme "Young People's Sexual and Reproductive Health and Rights"* is a specific cooperation between RFSU and the Indian organisation MAMTA, as a complement to the long term bilateral project "Young People's Health and Development - A Reproductive and Sexual Health Centred Action Approach", implemented by the same organisations. The target region is South and South East Asia. Participants in 2006 came from Cambodia, Philippines, Lao PDR, Thailand, Nepal, Bangladesh, Sri Lanka, Vietnam and India. The purpose is to promote a better regional understanding of young peoples Sexual and Reproductive Health and Rights (SRHR) through experience sharing in the context of South and South East Asian Countries, to enhance the capacities of individuals/institutions to work

and network effectively, to address, act and advocate for young peoples sexual and reproductive health, with a rights perspective and to facilitate formulation of policies, programmes, strategies and interventions that are positively responsive to the health needs of young people.

In 2006, a two-week training program was held, for the fourth time, in September 2006 and a four-week training program, carried out by RFSU and IHCAR, was held for the third time.

HIV/AIDS

MAJOR CONTRIBUTION		PROGRAMMES	DISBURSEMENTS 2006
74002681	HIV-AIDS	ASIA/SRC/HIV-AIDS	10 000 000
41002722	HIV-AIDS	Reg post HIV/AIDS	1 942 907
Total			11 942 907

ADB HIV/AIDS

The trust fund agreement between the Asian Development Bank (ADB) and Sweden for the *ADB Cooperation Fund for Fighting HIV/AIDS in Asia and the Pacific* was signed in February 2005. The goal of the fund is to assist countries in their fight against HIV and AIDS through programmes that will build a knowledge base and capacity in countries and at ADB level, to make ADB have mainstreamed HIV programmes in all ADB core activities and strengthen ADB's internal capacity to implement this program. The work plan was agreed upon in October 2005 and the first instalment to the fund was effectuated in November the same year. Then the program was restructured more coherently in a Technical Assistance frame program. A new HIV/AIDS unit was created under the RSGS (Gender, Social Development and Civil Society Division). The unit consists of the health specialist in charge of the unit and two new TA staff to be recruited, plus one HIV/AIDS senior policy advisor. There is also an ADB HIV/AIDS Steering Committee. It will be chaired by the RSGS director and comprise the chair of health community of practice and the regional departments social sector leaders. The different projects are then within this framework TA program.

The new more coherent TA program has been approved by the board in June 2006. This first work plan is now a plan for altogether USD 8.67 million out of the total trust fund of about USD 13 million. Up till now only one of the projects in the work plan has been started and this is the NGO initiative to prevent HIV/AIDS. So it will actually be in September when the program will get of the ground. This is one and a half year later than planned. The delay is not all together negative, the new framework TA program is more coherent and the HIV/AIDS unit is strategic and could be more sustainable. Also the prolonged process leading up to this new organisation is reflecting a better ownership by the bank. ADB has suggested extending the agreement by 12 months to the 31 of December 2009 and that the next instalment is to be made in April 2007 after the first progress report has been delivered in March 2007.

Public health

CONTRIBUTION			DISBURSEMENTS 2006
72300251	Public health	Diakonia Golden Triangle	2 447 000
72300279	Public health	IOGT regional program	3 835 000
Total			6 282 000

IOGT-NTO

Sida Health Division provides support through the *Illicit drugs programmes, IOGT-NTO and Diakonia* for controlling illicit drugs in the Golden Triangle. Countries that are supported are Cambodia, Laos, Vietnam, Thailand and Burma/Myanmar. The main target groups in these countries are the ethnic minority groups in the countryside. These groups are considered especially vulnerable to becoming involved in drug production, trafficking and use of illicit drugs. The project aims at creating better living conditions through prevention and rehabilitation. In order to create good conditions for poverty reduction, the project works in areas such as: treatment and rehabilitation, guidance in how to apply for citizenship, prevention of HIV/AIDS, access to SRHR services and support of alternative agricultural growth.

Diakonia has been able to get greater access to vulnerable communities inside Burma/Myanmar. The numbers of organised communities have increased with village structures, such as Village Development and Health Committees and Self Help Groups. More than 5000 households have been involved in activities to address long-term food security. Positive impact in these committees has been monitored in the increase of food security, improved health and increased number of children sent to school[10].

Local ethnic minority partners in Thailand have been assisting communities affected by illicit drugs with alternative livelihood projects and legal aid. More than 30 ethnic minority communities have been involved in income-generating activities for alternative livelihoods. People have been assisted to get access to citizenship and legal aid when affected by the government's War on Drugs. Drug prevention networks have been formed and people have been assisted to get access to drug rehabilitation.

In 2006 Diakonia sponsored two community based research studies, in cooperation with selected target communities in Burma/Myanmar and Thailand. The studies show how problems related to poverty, lack of rights, migration/trafficking, HIV/AIDS and the negative effects of drugs are linked to each other and affect the population in the target areas. The surveys are also revealing successful and unsuccessful attempts to address the problem situation in the target communities. In 2007 Diakonia will be able to disseminate the findings of the study carried out in Thailand. The two governments' policies on illicit drugs and a discriminatory attitude towards the ethnic minority

[10] All the figures are from 2005 as final figures were not available for 2006. But the trend in 2006 is similar to 2005.

population are major obstacles for the local partners to carry out their programmes and address the problems in the most effective way. The Burmese regime is limiting access to the most vulnerable communities and putting a lot of limitations on INGOs and community based organisations.

Rating: Minor deviations from plans (MDP) – mainly due to political and external policy changes. The Thai government's "War on Drug" and the recent military coup d'état has also affected the work of partners and communities.

SEA Regional Drug and Drug-related issues prevention program

The program includes community-based drug abuse control (CBDAC) in communities with drug problems, and the youth-based Media package. A CBDAC model was developed in Northern Thailand, and has been introduced to Viet Nam and Cambodia with good results. It is a cost effective method and community participation has promoted understanding, support and care for the drug abusers while reducing potential HIV/AIDS vulnerability. Project results are impressive with a 100 percent drug rehabilitation rate in Thailand, 90 percent in Cambodia and slightly lower figures in Vietnam. The media (radio, video and theatre) projects disseminate information on illicit drugs, HIV/AIDS and related issues to the youth in schools and communities through youth participation.

UNIAP

The *UN Inter-Agency Project (UNIAP) on Human trafficking in the Greater Mekong Sub-region* (Thailand, Cambodia, Burma, Vietnam, Lao PDR, and Yunnan Province of China) brings together six governments, 13 UN agencies and NGOs. It was established in 2000 as an overarching mechanism to combat trafficking in women and children and implementing program in prevention, repatriation, rehabilitation and law enforcement. The project has been monitored by the Sida human rights advisor in Bangkok who participated during the year in anti-trafficking raining activities for national program officers. The project has been reviewed by an independent consultant. Health Division has received a copy of the report. The report is positive to the work and achievements of the project but has also identified certain shortcomings. The project has sent a draft proposal for a third phase.

The rating is minor deviation from plans (MDP): performance falls somewhat short of targets and work plans in terms of mainly quantity, time and cost, but is still on track.

Health Programme Countries

Guatemala

Support from Sweden is directed towards 69 municipalities within five health regions: Alta Verapaz, Huehuetenango, Ixcán, Ixil, and Quiché.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
61000673	Health sector GUA III	19 355 780
61000703	Swap-fund health sector	1 500 000
Total		20 855 780

The implementation of the health programme improved significantly with utilisation of 97 percent of the programmed funds. The agreement with the Ministry of Health and PAHO was extended until December 2007 and the outcome of an evaluation in 2007 will decide if the programme will be extended if the funds are not used during the year.
The main results in the programme areas were:

- Maternal mortality has decreased in the five health regions compared to the maternal mortality baseline study done in 2000.
- Child mortality has decreased between 6.0-25.0 percent compared to data registered by INE in 2001.
- The access to essential drugs has increased in 43 municipalities through the opening of small drug shops and pharmacies. This meant that 450,000 inhabitants have access to basic drugs at more affordable prices.
- The average per capita expenditure on basic healthcare has increased from GTQ 35.00 in 2003 (baseline study) to GTQ 57.20 – Q 72.47 (depending on the health area) in 2006.
- The Integrated Financial Administration System (SIAFI) has been implemented in 83 health units with improvements in management of human and financial resources.
- The health service network has been strengthened in 44 different health facilities with more personnel, increased opening hours, improved or new buildings and more supplies.
- Costumer satisfaction studies carried out in three of the five regions show positive results.
- Traditional medicinal therapy has been used in the five health regions and a national medicinal plant volume has been published.
- In 41 municipalities, there are local health plans in place and all five health regions have implemented human resources plans.

Other developments in the health sector are the drafting of the national health agenda (ANS), which should be presented and hopefully implemented in 2007. The Guatemalan Ministry of Health also initiated a health sector coordination group that meets monthly. At the end of 2006, Sweden signed an agreement with the Ministry of Health regarding support for a fund intended for the emerging Swap process.

	GUATEMALA	LATEST YEAR	
HEALTH AND DEVELOPMENT	Life expectancy at birth (males)	65 (2004)	
	Under five mortality rate males	45 (2004)	
	Under five mortality rate females	45 (2004)	
	Human development index (value, ranking)	0.673/118 (2004)	
	IMR	33 (2004)	
	GDP/Capita PPP USD	4313 (2004)	
EQUITY	Under five mortality rate lowest/highest quintile	2.0 (1999)	
	Gini coefficient	48.3 (2000)	
SRHR	Maternal mortality ratio	240 (2000)	
	HIV prevalence 15–49 (%)	1.1 (2003)	
	Antenatal care coverage, one visit (%)	86 (1999)	
	Births attended by skilled health personnel (%)	41.4 (2002)	
	Contraceptive prevalence rate (%)	43.3 (2002)	
	Total fertility rate (per woman)	4.5 (2004)	
	Adolescent fertility proportion (%)	12.1 (1997)	
	Neonatal mortality rate (per 1000 births)	19 (2000)	
	Deaths due to HIV/AIDS (per 100 000)	5.8 (2003)	
HEALTH SYSTEMS	Physicians per 1000 population	0.9 (1999)	
	Nurses per 1000 population	4.05 (1999)	
	Total expenditure on health (% of GDP)	5.4 (2003)	
	Government expenditure on health (% of government spending)	15.3 (2003)	
	External resources for health (% total)	3.8 (2003)	
	Per capita government expenditure on health	44 (2003)	
	Vaccination (3 x DPT)	80 (2004)	
	Midwives per 1000 population	–	
INFECTIOUS DISEASES	Years lost to communicable diseases (%)	60.1 (2002)	
PUBLIC HEALTH	Years lost to non-communicable diseases (%)	26.8 (2002)	
	Years lost to injuries (%)	13.1 (2002)	
	Prevalence of tobacco smoking (males)	24 (2003)	

Sida's assessments: Positive development Negative development

With a comprehensive health plan (ANS), a strong administration in planning and budgeting and better coordination in the health sector as a whole (including IGSS), the Guatemalan Ministry of Health has taken the lead in sectoral reform as well as work towards developing a Swap outlining clear guidelines about the Paris Agenda.

The positive developments within the Sida-supported programme, the planned evaluation, the above mentioned recent Swap process and a new decision in Sweden regarding its strategy for Guatemala in 2007 makes the situation ideal for a thorough assessment of a future health support in Guatemala.

Honduras

Swedish support to the health sector has been directed to Acceso programme since 1995. The current agreement covers 2003-2007. The main purpose of the programme is to increase access to healthcare in targeted regions, which include 40 percent of the Honduran population. The starting point of the programme is that healthcare is a human right, and should be of good quality and equally distributed among the population.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
65000040	Access to health	16 853 656
65000048	National AIDS Forum	2 031 419
Total		18 885 075

According to a 2005 evaluation, the program has increased access to primary healthcare services and thereby contributed to a reduction in morbidity and mortality related to common diseases and health problems.

"Acceso" has contributed to better management of health services by local governments, promoted collaboration with local authorities and encouraged the participation of local communities in the planning and implementation of health services. The implementation of the programme has also led to better overall planning and has generated ideas for local development projects. Practical coordination between Acceso and other programmes at the local level has been developed, as well as coordination at the national level. Despite increased poverty levels in many municipalities, Acceso has contributed to higher levels of equality in terms of access to health services. In addition, the Acceso programme has facilitated the participation of other health actors (outside of the public sector) as a means of effectively implementing healthcare reform and decentralisation of care by bringing health services to the population that needs it.

Due to the change in government in Honduras in 2006 and the subsequent staff change at the Ministry of Health, the execution of the program was very weak during the first eight months of the year. However, in July 2006, a new Minister of Health took office and the institutional capacity is subsequently being re-built.

	HONDURAS	LATEST YEAR	
HEALTH AND DEVELOPMENT	Life expectancy at birth (males)	65 (2004)	■
	Under five mortality rate males	42 (2004)	■
	Under five mortality rate females	40 (2004)	■
	Human development index (value, ranking)	0.683/117 (2004)	
	IMR	31 (2004)	■
	GDP/Capita PPP USD	2876 (2004)	
EQUITY	Under five mortality rate lowest/highest quintile	–	
	Gini coefficient	55 (1999)	■
SRHR	Maternal mortality ratio	110 (2000)	■
	HIV prevalence 15–49 (%)	1.8 (2003)	
	Antenatal care coverage, one visit (%)	–	
	Births attended by skilled health personnel (%)	55.7 (2001)	
	Contraceptive prevalence rate (%)	61.8 (2001)	
	Total fertility rate (per woman)	3.6 (2004)	■
	Adolescent fertility proportion (%)	13.7 (1994)	
	Neonatal mortality rate (per 1000 births)	18 (2000)	■
	Deaths due to HIV/AIDS (per 100 000)	4.1 (2003)	■
HEALTH SYSTEMS	Physicians per 1000 population	0.57 (2000)	■
	Nurses per 1000 population	1.29 (2000)	
	Total expenditure on health (% of GDP)	7.1 (2003)	■
	Government expenditure on health (% of government spending)	16.8 (2003)	■
	External resources for health (% total)	9.6 (2003)	■
	Per capita government expenditure on health	41 (2003)	■
	Vaccination (3 x DPT)	89 (2004)	■
	Midwives per 1000 population	0.03 (2000)	■
INFECTIOUS DISEASES	Years lost to communicable diseases (%)	51.8 (2002)	
PUBLIC HEALTH	Years lost to non-communicable diseases (%)	35.3 (2002)	
	Years lost to injuries (%)	12.9 (2002)	
	Prevalence of tobacco smoking (males)	–	

Sida's assessments: ■ Positive development ■ Negative development

Nicaragua

Sweden, in conjunction with six other donors, supports the Five-Year Health Plan (2005-2009) through the *Sector program support to Nicaragua's Health Plan 2005-2009*, an arrangement with pooled funding. In total, external cooperation represents around 12 percent of total investments in the health sector. The national health policy supports the PRSP by focusing on maternal and child healthcare, increased access to nutrition and family planning as well as institution building.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
62000169	Social Programme Officer	1 889 029
62000198	Local Programme Officers	1 060 798
62000102	PROSILAIS III	65 983
62000309	UNICEF-support	8 100 000
62000310	Health sector support	40 315 186
62003856	Midwife training	3 599 111
Total		55 030 107

In the past five years, Nicaragua has experienced ongoing high levels of maternal mortality and infant mortality, as well as high morbidity due to transmittable diseases. The maternal mortality has been rather stable over the last 13 years, although there have been great regional differences. The rural areas and the Caribbean Coast constitute the highest rates due to lack of access to health services, low school attendance and high poverty levels. High levels of pregnancies among adolescents giving birth at home and having abortions also keep the maternal mortality high. On average, four out of ten Nicaraguans do not have access to public health services.

The conclusion is the need of MoH starting the implementation of the new Integrated Model for Health Attention – MAIS, the main pillar of the Five Year Health Plan. This is planned to start 2007, aiming to improve access, intersectoral coordination, social participation, efficiency, quality, sustainability and civil responsibility. PAHO is concluding that Nicaragua will not reach the MDGs in health if not financing and providing services will be improved. Some indicators are improving, but still improvements in health services for the most vulnerable groups fail to materialise. In order to reach the MDGs in heath, education, nutrition, water and sanitation also need to improve.

2006 was a particularly challenging year for the Nicaraguan health sector. A six-month strike among health workers and a new law to reform public finances considerably delayed the implementation of the Five-Year Health-Plan.

	NICARAGUA	LATEST YEAR	
HEALTH AND DEVELOPMENT	Life expectancy at birth (males)	67 (2004)	
	Under five mortality rate males	41 (2004)	
	Under five mortality rate females	35 (2004)	
	Human development index (value, ranking)	0.698/112 (2004)	
	IMR	31 (2004)	
	GDP/Capita PPP USD	3634 (2004)	
EQUITY	Under five mortality rate lowest/highest quintile	3.3 (2001)	
	Gini coefficient	55.1 (2001)	
SRHR	Maternal mortality ratio	230 (2000)	
	HIV prevalence 15–49 (%)	0.2 (2003)	
	Antenatal care coverage, one visit (%)	85 (2001)	
	Births attended by skilled health personnel (%)	66.9 (2001)	
	Contraceptive prevalence rate (%)	68.6 (2001)	
	Total fertility rate (per woman)	3.2 (2004)	
	Adolescent fertility proportion (%)	18.5 (1999)	
	Neonatal mortality rate (per 1000 births)	18 (2000)	
	Deaths due to HIV/AIDS (per 100 000)	–	
HEALTH SYSTEMS	Physicians per 1000 population	0.37 (2003)	
	Nurses per 1000 population	1.07 (2003)	
	Total expenditure on health (% of GDP)	7.7 (2003)	
	Government expenditure on health (% of government spending)	11.7 (2003)	
	External resources for health (% total)	11.2 (2003)	
	Per capita government expenditure on health	29 (2003)	
	Vaccination (3 x DPT)	79 (2004)	
	Midwives per 1000 population	–	
INFECTIOUS DISEASES	Years lost to communicable diseases (%)	46.2 (2002)	
PUBLIC HEALTH	Years lost to non-communicable diseases (%)	36.5 (2002)	
	Years lost to injuries (%)	17.3 (2002)	
	Prevalence of tobacco smoking (males)	–	

Sida's assessments: Positive development Negative development

Karolinska Institutet technical collaboration on training of obstetric nurses

The KI collaboration is aiming at institutional development of the training of obstetric nurses in Nicaragua at several training schools in collaboration with the Ministry of Health (MINSA) and the University (POLISAL).

Visits for joint planning of 2006-2007 activities took place in 2006. An evaluation of the quality of care at the delivery clinics involved in the project was performed as a self-evaluation and a joint analysis was made of the strengths and weaknesses in the project in order to develop improved strategies and working models.

Participatory education was the methodological starting point used in the technical collaboration meetings also building on a joint philosophy of care including working in accordance with evidence-based knowledge, humanising of the care through a professional attitude and ethical aspects. The participants have reached awareness of teamwork and what positive outcome can be reached through extensive sharing, open communication and discussion.

So far 30 obstetric nurses have been trained within the Swedish supported project and most of them are now practicing as clinical tutors/teachers. At the seven training schools there are 118 obstetric nurse students who will complete their degrees in 2007. The training must now be integrated in the Swap in order to be sustainable. The obstetric nurses must get a clear acknowledgement as a professional category of health staff in order to contribute fully to bring down the high rate of maternal and newborn mortality in Nicaragua.

Non-health Programme Countries

Bolivia

MAJOR CONTRIBUTION	PROGRAMME	DISBURSEMENTS 2006
63000058	SRH Youth UNFPA Bol 03-07	5 684 012

Brazil

MAJOR CONTRIBUTION		DISBURSEMENTS 2006
72300437	"Against human trafficking"	270 000

Latin America Regional Programmes

Poverty and inequality remain key issues in Central America. Three of out of five Central Americans live in poverty. Nicaragua has the largest proportion of the population living below the international poverty line. The region has the greatest socio-economic inequalities in the world. There has been very little change in income distribution between 1990 and 2002. This partly explains why many countries are lagging behind in their efforts to meet the poverty reduction targets laid out in the millennium Development Goals (MDGs) for 2015.

The sub-region of Central America has not made much progress towards fulfilling the MDGs in the areas of HIV prevention and maternal mortality. None of the health-related MDGs are likely to be met in Guatemala, Honduras or Nicaragua. Structural disparities affect access to and control over resources that influence health status and access to appropriate care. Significant inequalities, for instance between men and women, are the predictable result. Even though awareness of gender inequality in health has increased considerably in many countries, there is still a lack of political will. Governments have not sufficiently taken gender into account when allocating funds or making policy within the health sector.

In Guatemala, Honduras and Nicaragua, one out of five persons is between the ages of 15 and 24 years[11]. Half of all women in these countries marry before age 20 and at least two out of five have had their first child by age 20. Early marriage and early childbearing are particularly widespread among women living in rural areas and those with less formal education. Among 15-year-old girls in Honduras, 10.7 percent have been pregnant. Premarital sexual activity is fairly low among young women in these three countries. Nevertheless, one in four women in Guatemala will have had intercourse outside of marriage by the age of 24. The prevalence of HIV/AIDS in the region is also increasing. One of the reasons women have a higher infection rate is due to their inability to negotiate safe sex and the high rate of gender-based violence (GBV), including sexual violence. Inequality between women and men is one of the underlying factors of both the spread of HIV/AIDS and GBV in the region.

Sida has provided a sub-regional health sector support to Central America since the 1980s. Up until 2004, support was mainly provided via the Pan-American Health Organisation (PAHO) to address occupational health, tobacco control, intra-domestic violence, strategic health development and social protection, gender equality and reproductive health. In the past three years, the scope of the regional health support has been narrowed to a limited number of areas: occupational health, sexual and reproductive health and rights (SRHR), youth health and gender as well as HIV/AIDS.

In 2004, Sida entered two new strategic partnerships with the Guttmacher Institute (GI) and the Programme for Appropriate Technology in Health (PATH), the latter which is a Latin American consortium on gender-based Violence. In 2005, Sida entered into new agreements with PAHO, the Latin American and Caribbean Women's Health Network (LACWHN) and the Swedish National Institute for Working Life (NIWL) in collaboration with the Central American Integration System (SICA).

[11] Sida's Assessment Memo AGI, 2004

In accordance with Sida's overall policies, the sub-regional health support aims to reduce poverty. One of the main goals is to fight inequalities and enhance access to preventative healthcare and services based on a rights perspective. Another aim is to contribute to a democratic and peaceful development of the sub- region. Sida also promotes systematic intra-regional exchange of experiences through the sharing of results, ideas and best practices. Sub-regional cooperation is promoted through regional non-governmental organisations (NGOs) and multilateral organisations, particularly to combat common health risk such as HIV/AIDS.

Sida expects the sub-regional programme to strengthen the ongoing health reforms in the sub-region at the same time it reinforces bilateral Swedish health support in the following programmes:

- Honduras: "Acceso" programme of the Honduran Ministry of Health, 1995-2002 and 2003-2005 extended to 2007, SEK 67 million.
- Guatemala: "Modelo Integral de Salud" of the Guatemalan Ministry of Health, 2003-2006 extended to June 2007, SEK 55 million.
- Nicaragua: sectoral programme support to the Nicaraguan Ministry of Health for the implementation of the Five-Year Health Plan, 2005-2009, SEK 203 million.

Another long-term goal for Sida's support is the creation of a consolidated national health plan (NHP) in each country. This should also pave the way for establishing sector wide approach processes (SWAPS).

Health systems

MAJOR CONTRIBUTIONS		PROGRAMME	DISBURSEMENTS 2006
72300370	Health systems	Overview Health CA	415 947

Pan American Health Organisation, PAHO

Sida's support to PAHO consists of support to i) Strategic Health Development, for work on strengthening the member countries health policies and systems of social protection; ii) programme support to the unit of Gender, Ethnicity and Health for its work to integration of gender and ethnic policies in research, policies and programmes; iii) programme support to Family and Community Health which includes activities relating to nutrition, child, adolescents health, immunisation, women and maternal health and HIV/AIDS and; iv) a Health System Development Course, reaching managers on mid to high level officials from Central America. The above contribution is an assessment of the regional programmes as part of the work with a new strategy for cooperation with Latin-American. The other PAHO programme components are described below.

Sexual and reproductive health and rights, SRHR

MAJOR CONTRIBUTIONS		PROGRAMMES	DISBURSEMENTS 2006
72300294	SRHR	PAHO Youth gender equity	11 437 086
72300298	SRHR	LACWHN 2005-2007	1 000 000
72300323	SRHR	AGI SRHR studies	2 300 000
72300324	SRHR	Intercambios GBV	4 150 000
Total			18 887 086

PAHO Youth gender equity

In the Family and Community Health Program, young people participate in human rights advocacy programmes. Strong advocacy was done for adolescent pregnancy prevention using data from the Alan Guttmacher Institute. El Salvador is conducting an impact evaluation of the project Empowerment of Adolescent Girls to be disseminated in the region. In partnership with the managerial areas such as Health Policy Unit (HP), The Gender, Ethnicity and Health Unit (GE) developed and tested policy evaluation tools to mainstream gender equity in health sector policies, and to measure and input value of unpaid care within the national accounts framework. International workshops were held as part of the latter efforts in collaboration with the UN Economic Commission for Latin America and the Caribbean. A resultant publication is being edited, and a time-use survey is being planned in Chile. Also, with HP inputs, GE began executing a capacity-building initiative for the Central American Commission of Ministers of Women's Affairs (COMMCA). This initiative is directed at producing policy-orientated information and strengthening advocacy skills in order to mainstream gender equality issues in sub-regional Central American policymaking bodies.

Latin American and Caribbean Women's Health Network (LACWHN) 2005-2007

LACWHN is a regional network of organisations and individuals in Latin America. Their mission is to promote gender equity in health. The basis of their actions is a rights perspective in international agreements regarding sexual and reproductive health and rights. Sida has supported the network since 1998.

Several results were achieved as part of LACWHN's advocacy strategy in 2006. Examples of healthcare implemented by LACWHN member organisations that took into account the the Cairo and Beijing International conference agreements were identified. This activity was carried out at the local, national and regional levels by promoting access to information that allows women to make free, informed decisions. It denounces and draws attention to violations of women's human rights and impacts the design of public choices and urges governments to fulfil their role as guarantors of comprehensive health. LACWHN produced status reports on maternal mortality in seven countries in Latin America (Brazil, Colombia, Chile, Nicaragua, Mexico, Peru and Surinam). These were transformed into communication strategies for advocacy on behalf of the women's health movement. These reports will help to convince political decision makers to live up to the commitments they have made in

sexual and reproductive health. Moreover, LACWHN member organisations have participated in more than 20 international events, allowing them to strengthen ties and coordinate joint action with other organisations.

Rating: According to plans (AP)

Guttmacher Institute: Ensuring sexual and reproductive health and rights for the next generation in Guatemala, Honduras and Nicaragua

The overall aim of the project is to identify and document the key sexual and reproductive health needs of adolescents and young adults in Guatemala, Honduras and Nicaragua and in Central America as a whole. These findings should be communicated to a wide range of stakeholders to improve provision of information and services to young people.

In 2006, Guttmacher and its partners made great strides in analysing available data and documenting new findings in a series of publications, Research in Brief, at the same time they prepared the ground for a second series of briefs and a regional monograph. The Institute convened a project workshop that was attended by regional and domestic research partners, as well as country-level policy and communications partners. This workshop allowed Guttmacher to build the research and advocacy capacities of partners. It also provided a forum for strategic planning and cooperation. In Guatemala, Honduras and Nicaragua, communications partners have already undertaken a range of activities to communicate findings to key audiences and identify important constituencies. In the meantime, the Guttmacher Institute has taken advantage of opportunities to disseminate findings at the regional level, including presenting to a high-level audience at PAHO's Regional Planning Workshop on Empirical Evidence for the Prevention of Adolescent Pregnancy.

Rating: According to plans (AP)

Intercambios

Intercambios is an alliance of organisations and networks in Latin America working against gender-based violence (GBV) within the health sector. Intercambios consists of experienced organisations with solid networks. Their collaboration partners are NGOs all over Latin America, but they also have strong ties with multilateral organisations, ministries of health and renowned universities and research institutes.

Four priority areas of work have been identified: research and the promotion of evidence-based information on GBV-related issues, the improvement of methods and material, the strengthening of joint strategic advocacy and the sharing of experiences. Intercambios functions as the link between policymaking and information-disseminating institutions (such as PAHO, IPPF, UNIFEM) and the national authorities and local organisations that need this information and guidance on a day-to-day basis. These actors include NGOs, police organisations, ministries of health, local health services, attorneys and ombudspersons, and municipal human rights commissions, among others. In Honduras, there was capacity building within the Ministry of Health as well as in GBV prevention health services. A high-quality manual produced by International Planned Parenthood Federation was translated and adapted and now functions as reference material. An NGO in the Dominican Republic that has had long-established working relationship with its national Ministry of Health expanded its activities to neighbouring countries. It has motivated

decision-makers and staff to integrate GBV into policymaking at the Ministries of Health in Guatemala and Nicaragua.

With support from USAID, Centres for Disease Control (CDC) and Johns Hopkins University, the Women's Network in Nicaragua incorporated questions concerning gender and violence and the relation between GBV and HIV/AIDS in the Nicaraguan and Guatemalan Demography and Health studies (DHS). They also trained researchers about ethical methods for data collection on these sensitive issues and they are now analysing the results of the study.

NGOs in Nicaragua, Guatemala and Brazil are working with the Johns Hopkins School of Public Health and Universidade Federal de São Paulo in a research programme aimed at creating reliable data on the relation between HIV/AIDS and gender-based violence. The objective is to be able to use scientific data as an advocacy tool. The International NGO PATH has been one of the main actors in the team around the extensive multi-country study on gender-based violence coordinated by the World Health Organisation. Through a Nicaraguan NGO, an 80-episode popular education series called "Sexto Sentido" was broadcast in four Central American countries. The shows addressed many issues related to sexual and reproductive health and rights and reached a very large audience.

Public health

MAJOR CONTRIBUTIONS		PROGRAMMES	DISBURSEMENTS 2006
72300080	Public Health	Work/Health/SICA	5 000 000
72300347	Public Health	Seminar illicit drugs LAC	61 123
Total			5 061 123

SALTRA Programme on Occupational Health in Central America

The overall aim of the programme is prevent ill health and promote economic and social development in programme countries by raising awareness about occupational health and safety. The programme includes promotion, prevention and information activities and will hold interventions within various strategic sectors (including the informal sector). The first four-year phase of the programme is between 2003-2007.

During the third year of the project, SALTRA grew and matured. Improved working conditions in some sectors targeted by the programme and the increased influence of universities in the political arena were some of the main achievements in terms of implementation in 2006. Considerable progress was made in many but not all of SALTRA's projects. The limited experience that regional SALTRA coordinators have with project management and administration is a major challenge. In terms programme rationality, evaluations indicate that SALTRA has added value to the region by creating the conditions for mutual learning and inter-country support. Another crucial advantage from the regional cooperation between SALTRA countries is that the south-south collaboration strategy considerably accelerates capacity building in the poorest countries and thus benefits disadvantaged income groups.

Rating: According to plans (AP)

Health Programme Countries

Kyrgyzstan

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
72300334	Swap prep Indevelop	859 406
72300383	Swap Health Kyrgyzstan	13 000 000
72300384	SDC Health Promotion	5 519 720
76003345	KIR Children at risk	605 776
76003677	KGZ Children at risk fas2	1 072 039
Total		21 056 941

SWAP health sector reform programme

In 2006, Sida undertook an in-depth assessment of support to the SWAP health sector reform programme in Kyrgyzstan. In December, Sida formally entered the group of joint financiers. The other donors are the World Bank, DFID, Swiss Agency for Development and Cooperation (SDC) and the German Development Bank (KFW). As the support was only initiated in December 2006, progress can not be reported.

SDC Health Promotion project

Sida supports the SDC Health Promotion project, a model of community action for health through delegated partnership with Switzerland. Its main features are village health committees in each village, elected by the people, acting on health problems analysed and prioritised by the population and closely linked with the local primary healthcare providers. The primary healthcare providers are trained to facilitate this process and thus learn a new approach to health promotion that is centreed on people's initiatives. Through combined support from SDC, Sida and ZDravPlus, funded by USAID, nationwide coverage of the project will be reached. Sida support started only in December 2006 so no results can be reported.

Children at risk and disabled children

Sida's support to children at risk and disabled children has continued with Stockholm University as the implementing partner in cooperation with the Association of Social Workers of Kyrgyzstan and the Ministry of Labor and Social Protection (MLSP). The project has worked with two pilots for the two target groups.

New and better premises have been arranged for children at risk by the local administration at the Sokuluk centre in Rostok. The staff was trained in practical social works methods and networking, and they received information about the psychological aspects on social work and learned how to carry out home visits. Today, the staff trains other employee groups. Fewer children are

	KYRGYZSTAN	LATEST YEAR	
HEALTH AND DEVELOPMENT	Life expectancy at birth (males)	59 (2004)	
	Under five mortality rate males	72 (2004)	
	Under five mortality rate females	63 (2004)	
	Human development index (value, ranking)	0.705/110 (2004)	
	IMR	58 (2004)	
	GDP/Capita PPP USD	1935 (2004)	
EQUITY	Under five mortality rate lowest/highest quintile	2.0 (1997)	
	Gini coefficient	29 (2001)	
SRHR	Maternal mortality ratio	110 (2000)	
	HIV prevalence 15–49 (%)	0.1 (2003)	
	Antenatal care coverage, one visit (%)	88 (1997)	
	Births attended by skilled health personnel (%)	98.1 (1997)	
	Contraceptive prevalence rate (%)	59.5 (1997)	
	Total fertility rate (per woman)	2.6 (2004)	
	Adolescent fertility proportion (%)	7.1 (2000)	
	Neonatal mortality rate (per 1000 births)	31 (2000)	
	Deaths due to HIV/AIDS (per 100 000)	–	
HEALTH SYSTEMS	Physicians per 1000 population	2.51 (2003)	
	Nurses per 1000 population	6.14 (2003)	
	Total expenditure on health (% of GDP)	5.3 (2003)	
	Government expenditure on health (% of government spending)	5.3 (2003)	
	External resources for health (% total)	17 (2003)	
	Per capita government expenditure on health	8 (2003)	
	Vaccination (3 x DPT)	99 (2004)	
	Midwives per 1000 population	0.52 (2003)	
INFECTIOUS DISEASES	Years lost to communicable diseases (%)	35 (2002)	
PUBLIC HEALTH	Years lost to non-communicable diseases (%)	50.7 (2002)	
	Years lost to injuries (%)	14.3 (2002)	
	Prevalence of tobacco smoking (males)	–	

Sida's assessments: Positive development Negative development

now placed into institutional care and instead stay in their homes with support from the centre. New attitudes towards children and families at risk can be seen. This has impacted how children at risk are received.

The staff working with disabled children gained more confidence in networking methods. They have taken the initiative and are now running training courses for other staff members. The staff group has been further trained regarding habilitation methods. An integration has started and the staff now brings the children into the society and the staff visits the children at home to follow up treatment plans. The role of the families in the habilitation process has been enhanced. Maksat centre has networked with relevant institutions in the neighborhood and the work at Maksat centre has impacted small villages around in the country regarding attitudes towards disabled children.

Albania

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
72300254	UNFPA SRHR/HIV youth Alb	3 000 000
72300390	OPTO-Albanien	497 220
76003107	WHO mental health Albania	2 000 000
76003112	Maintenace hospitals equi	7 295 074
Total		12 792 294

UNFPA

Sida supports UNFPA for the project *Healthy Lifestyles education of young people* in Albania. Sida supports the project with SEK 6 million from October 2004 to December 2007. Up to end of 2006, Sida disbursed SEK 4.5 million.

The purpose of the project is to enhance the quality of life of young people in Albania through improved family life education and behaviour change by creating an enabling environment for the promotion of young people's health and healthy lifestyles. To achieve set objectives and outputs the project has assisted the Albanian government (the Ministry of Health and Institute of Public Health) in developing a National Information Education and Communication strategy focusing on young people and their need for information and services. The production and dissemination of IEC material has assisted in family life education in secondary schools and promoted peer education programmes that respond to young people's needs. The project has further provided training of healthcare providers in communication skills, peer educator trainers and advocated for adolescent sexual reproductive health and rights. The project collaborates and coordinates with several NGOs in Albania.

Rating: According to plans (AP)

Strengthening the Management & Maintenance System for Albanian Health Services

Sida supports the Albanian Ministry of Health to carry out the project by contract with a Swedish consulting firm, Swedish Health Care (SHC), which will implement the project. The present contract period is 15 October 2004 to 30 June 2008. The allocated amount is SEK 30 million The project contains three parts: training clinical engineers, developing clinical engineering units in regional hospitals and assisting the MoH in adjusting policies and regulations with regard to hospital clinical engineers.

Sida has received biannual progress reports from SHC and has had a number of follow-up meetings with the implementing consultants and Ministry of Health staff. In the first quarter of 2006, Sida assigned two external consultants to assess the health situation and the health sector in Albania and to evaluate Sida-funded health support. The consultants also conducted a training workshop in collaboration with SHC on project cycle management and logical framework planning for each component of the SHC-managed project. The evaluation stated that the start up of project was delayed there is a lack of managerial capacity and skills within the organisation. A number of planned activities and outputs were delayed, but in 2006 the project caught up.

Mental health

Sida has supported development and restructuring of Albania's community mental health services since 1999 via WHO. The present project received Sida funds from July 2004 to September 2007. The allocated amount for the project is SEK 6.8 million. The total amount was disbursed by the end of 2006.

The purpose of the project is to support the Ministry of Health in consolidating its community mental health system through implementation of the mental health policy and plan. Activities to reach the set objectives and outputs have increased capacity within the MoH Mental Health Unit, assistance to the monitoring system, assistance to training of mental health nurses and primary care workers and support to establishment of Community Mental Health Systems. Through a de-institutionalisation process and establishment of protected apartments, support was given to the development of income-generating activities run by the recipients of mental health services as well as families associations.

Tajikistan

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
72300335	CBHP health WB Taj	12 000 000
72300337	Tajikistan InDevelop	814 383
72300411	ACTED Health Taj	500 000
72300464	Mercy Corps health Taj	430 000
72300465	Aga Khan Health Taj	1 100 000
Total		14 844 383

Community and Basic Health Project (CBHP)

Sida entered an agreement to support a health sector reform programme, Community and Basic Health Project of the Ministry of Health in Tajikistan in April 2006. The programme is currently being implemented in 41 pilot districts in two oblasts (regions), Sughd and Khatlon, with a total population of 4.5 million (65 percent of the country's total population). The programme is funded by the World Bank with USD 10 million USD, Sida with USD 6 million and Swiss Development Cooperation with USD 1.2 million.

Thus far the CBHP has achieved the following results:

- A new family medicine curriculum, as a six-month retraining courses for the medical personnel was developed and approved by the MoH. Since programme began in April 2006, 111 medical staff, including 36 doctors and 75 paramedical personnel have graduated and started to work.
- A website for the MoH was developed and is currently being redesigned.
- A field survey inventory of the primary healthcare facilities in the pilot districts was completed.
- With support of experts and international partners, a new model for per-capita financing was developed and approved by the MoH.
- Six persons from the MoH staff attended a training course organised by the World Bank on "Accelerating progress towards achieving MDGs for Central Asian countries."
- A set of technical normative frameworks was developed to increase the efficiency of primary healthcare facilities.
- Estimation for the rehabilitation and capital repair of the existing and building of new primary healthcare facilities was completed.
- In the context of building managerial capacity of the MoH staff, six persons attended the World Bank training on financial management and expenditure procedures of the World Bank projects; two in Italy, two in Almaty, and two in Bishkek. Three persons attended Sida's International Training Programme on Health Systems Development.
- A procurement and tender committee was established. It includes representatives from the MoH, Aid Coordination Unit under the President Office and Oblast/regional governments.

Rating: According to plans (AP)

NGO support

Another component of the sector reform programme is funded by Sida in parallel to the CBHP. It is the Strengthening of Primary Health Care Services and Outreach Programme, which is implemented by three NGOs. The programme started in November 2006 and is in its inception phase during which the implementing organisations are mobilising staff, conducting baseline surveys and coordinating their work plans with the MoH.

Rating: Not rated, since the programme just started.

Non-health Programme Countries

Belarus

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
76003195	HIV/AIDS	2 000 000
72300422	SEEC 2006 - 2008	4 000 000
76003475	Young against drugs ph 2	1 500 000
76003553	Orphan children ph 2	2 000 000
Total		9 144 548

Bosnia – Herzegovina

MAJOR CONTRIBUTION	PROGRAMME	DISBURSEMENTS 2006
72300348	UNICEF HIV prev youth SEE	2 900 000

UNICEF HIV-Prevention

Sida supports UNICEF in the implementation of a three-year long regional HIV/AIDS prevention project, HIV-Prevention with Especially Vulnerable Young People in South-eastern Europe between 31 May 2005 to 31 May 2008. The allocated amount is SEK 25 million, and up to the end of 2006 Sida had disbursed SEK 16 million.

The purpose of the project is to increase knowledge and skills among especially vulnerable young people (EVYP) so that they are able to protect themselves against HIV/AIDS. It has four objectives: 1) to increase the capacity of government to develop appropriate policies that ensure a comprehensive approach to HIV prevention; 2) to contribute to the amount of information available (nationally and locally) about the situation, behaviours and priorities of vulnerable groups of youth; 3) to increase the capacity of ministries of health to establish youth-friendly services and collaborate with NGOs and CBOs (Community-Based Organisations) in ensuring outreach activities; and 4) to ensure that young people have access to opportunities for participation,

learning and skill development in the communities where they live. The main target group is young, especially hard-to-reach vulnerable youth in Serbia, Montenegro, Bosnia –Herzegovina, Kosovo and Macedonia with particular emphasis on Roma youth, men having sex with men (MSM), commercial sex workers (CSW) and injecting drug users (IDUs).

Sida received the progress report for the first year of the project (June 2005-December 2006). It shows that the partnership between UNICEF and Sida has provided the opportunity to focus funding to complement other regional HIV prevention activities in the SEE sub-region by supporting governments in strengthening their HIV prevention policies, improving local and regional databases, increasing access to and availability of youth-friendly services and increasing participation opportunities for EVYP. Databases and monitoring and evaluation systems were established in all five countries. The Rapid Assessment and Response and Multiple Indicator Cluster Surveys were completed. More than 4,200 young people accessed voluntary counselling and testing (VCT) services throughout the five countries. Health professionals were trained in VCT and VCT standards and training modules were developed. Outreach activities were undertaken by more than 300 young people and professionals, reaching more than 8,500 young people with information and referral. The first year of the Sida funded project has laid the ground for scaling up HIV and AIDS prevention services in the five programme countries. There have been implementation delays of certain activities in all countries, but activities will be scaled up by provision of increased technical assistance and strengthened partnerships within and beyond the UN Theme Group on HIV/AIDS, and increased capacity building and training efforts with government and other partners.

Croatia

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
76003501	WB: Social welfare	3 500 000
76003592	Fostercare II, CRO	1 936 000
76003665	LFA workshop, fosterc II	74 450
Total		5 510 450

Caucasus Central Asia, Moldova

MAJOR CONTRIBUTION	PROGRAMME	DISBURSEMENTS 2006
78100265	Health system dev	3 335 398

Kosovo

MAJOR CONTRIBUTION	PROGRAMME	DISBURSEMENTS 2006
72300348	UNICEF HIV prev youth SEE	1 600 000

Moldova

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
76002210	Children at Risk III	466 238
76002225	Elderly & Disabled III	576 297
76003031	Migration 2004-2007 IOM	2 500 000
76003150	Safer sex and solidarity	2 000 000
76003223	Social service development	10 000 000
Total		15 542 535

Macedonia

MAJOR CONTRIBUTION	PROGRAMME	DISBURSEMENTS 2006
72300348	UNICEF HIV prev youth SEE	2 400 000

Russia

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
MOSCOW		
72300268	WHO WB TB/HIV Russia	2 800 000
72300305	WHO TB through SMI	438 676
76003043	HIV in prisons, AFEW	620 000
76003068	School networks in Russia	1 800 000
76003113	Mur Ret.children ph 3	2 734 334
76003462	Network for children IV	3 539 698
76003627	Safe return & recovery II	1 427 584
76003629	Disabled apatity	700 000
Total		14 060 292
REGIONAL NORTH WESTERN RUSSIA		
72300365	SEEC 2006 - 2008	31 040 500
72300366	WHO TBC prog Kaliningrad	2 700 000
76003100	Photo exhibition, drug pr	1 000 000
76003103	Reproductive health/NWRuss	2 000 000
76003497	Assistive technology	4 600 000
76003631	Trafficking Barents kvinn	508 862
Total		41 849 362
ST PETERSBURG		
76002078	Drug prevention Kronstadt	746 362
76003338	Process & Contract	1 000 000
76003392	CRIS in S:t Petersburg	199 396
76003498	CRIS Phase 2	1 500 000
76003506	ECAD Anti drug management	1 237 636
Total		4 683 394
CARELIA		
76002905	Child habilit. Karelia	567 530
76002931	Alcab workpl Petrozavodsk	305 399
76002939	Health way living TACIS	600 000
76003763	Karelia Alc.work pl.2	442 427
Total		1 915 356
TOTAL RUSSIA		62 508 404

TB and AIDS Control

The overall goal of the support to TB and AIDS Control in Russia is to ensure technically sound and effective implementation of the TB and AIDS control project in accordance with the internationally approved TB control strategy. Objectives outlined for the project include: assistance with developing a core training curriculum for regional and district TB specialists based on international standards; educate national and federal trainers at the national and in all components of modern TB control (organisation of TB control, laboratories, treatment, monitoring and TB/HIV control); strengthening the capacity of the federal TB research institutes to manage TB; monitoring the implementation of basic (DOTS) and enhanced (DOTS-Plus) packages in the regions; and finally, monitoring the strengthening of laboratory services.

At the estimated mid-point of the project, October 2006, a mid-term review gave the project the highest World Bank ranking and was considered successful while the AIDS component was viewed as marginally successful. As a result of the review, amendments to the Project performance indicators have been proposed by WHO and accepted by the WB and MoHSD.

Rating: According to plans (AP)

Tuberculosis control in Kaliningrad

Support for the continuation of activities to strengthen tuberculosis control in the Kaliningrad region and prevention of tuberculosis epidemic in the Sea Region (2006-2008) started the second phase in March 2006. Within the reported period, the programme continued with progress.

Rating: According to plans (AP), with good performance indicators.

Europe Committee of the Swedish Health Care Community, SEEC

Sida has supported SEEC, which is a non-governmental organisation consisting of key actors from the Swedish healthcare community. The objective of SEEC is to promote public health and assist in the strategic development of healthcare systems and services in Northwestern Russia and Eastern Europe.

The activities of SEEC have progressed from initially small-scale consultations and contact-building to extensive, strategic reform-orientated projects. SEEC made a three-year work plan and proposal for funding for 2006-2008. An exit strategy for all projects in Russia and Ukraine is presented in this programme. The projects in these countries are to be phased out and mainly replaced by programmes in Belarus. A total of 59 projects were funded by SEEC in 2006, the majority (51) in the northwestern regions of the Russian Federation. All projects are implemented by joint partnerships between the Swedish and the recipient country cooperation partners.

Within the area of primary healthcare, the projects in Vologda and Kaliningrad can be noted for their ability to promote the development of family medicine (FM) regionally. In Vologda, a post-graduate programme for FM doctors and nurses was established, and the SEEC project contributed decisively to the preliminary decision to make Vologda into a pilot region for a new national financing system for the healthcare sector. In Kaliningrad, a regional centre for FM post-education is being created. In a successful project

to promote health management, hospital directors responsible for specialist care and primary healthcare primarily in the Leningrad area received training in healthcare organisation and financing.

The SEEC efforts to counter sexually transmitted infections (STI) have resulted in the creation of two network projects for sexually reproductive health in Northwest Russia. The SEEC projects for the prevention of hospital infections have come to encompass a network of hospitals in Pskov, Novgorod, Vologda, Petrozavodsk and St. Petersburg. A project to improve the quality of laboratory medicine in Northwest Russia managed to introduce quality control and quality assessment at Murmansk hospitals. The post-graduate educational project, St. Petersburg International School of Perinatal Medicine and Reproductive Health, contributed to the introduction of evidence-based routines at birth clinics in St. Petersburg. The project Reproductive health and sexology, educational and clinical aspects 2004 – 2006 has been instrumental in establishing an academic course at the Medical Academy of Postgraduate Studies (MAPS) for staff at St Petersburg youth clinics that were established by previous Swedish-Russian projects. The project, Teenagers Our Future, involved teachers and school managers in the development of school curricula for sexuality in St. Petersburg. The SEEC projects within adult psychiatry continued to contribute to the development of psychiatric open-care, mainly in St Petersburg and Kaliningrad. In St Petersburg, the project Implementation of Integrated Psychiatry created a network encompassing most psychiatric hospital directors to further improve the work with seriously ill patients.

Rating: According to plans (AP), programmes and planning have been well implemented.

Serbia and Montenegro

MAJOR CONTRIBUTION	PROGRAMME	DISBURSEMENTS 2006
72300348	UNICEF HIV prev youth SEE	3 100 000

Ukraine

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
72300421	SEEC 2006 – 2008	1 000 000
76002272	Vulnerable children pha 1	1 196 490
76003055	SocStandards ProcureCnslt	91 086
76003610	Convictus HIV project	1 500 000
76003696	UN HIV prevention	4 300 000
76003708	Social system reform	9 000 000
76003745	Monitoring soc.mod.ass.	140 939
Total		17 228 515

Uzbekistan

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
76002272	Vulnerable children pha 1	1 196 490
72300353	TB support MSF in Uzbekis	6 000 000
76002723	Ukrainian social inv fund	5 896 015
76003055	SocStandards ProcureCnslt	91 086
76003610	Convictus HIV project	1 500 000
76003696	HIV prevention	4 300 000
76003708	Social system reform	9 000 000
76003745	Monitoring soc.mod.ass.	247 131
Total		28 230 722

Multiresistant TB

The TB project Multiresistant TB in Karakalpakstan/Uzbekistan implemented by MSF (Doctors without boarders) focuses on treatment of multiresistant TB through in Karakalpakstan. The catchments area is two districts and one hospital for multiresistant TB including operational research.

Re-establishment of the Republican DOTS centre as well as retraining of DOTS healthcare workers and MoH supervisors were the focus in 2006. Continuous enrolment of DOTS+ patients (multiresistant TB) is the main focus and so far 65 new patients have been admitted in 2006. This is below target but is explained by the malfunctioning of the DOTS programme and the tight political situation. The programme is rated minor deviation from plans (MDP).

Baltic Sea Region

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
76002210	Children at Risk III	466 238
76002225	Elderly & Disabled III	576 297
76002272	Vulnerable children pha 1	1 196 490
76002536	Health project phase II	511 158
76002723	Ukrainian Social Inv Fund	0
76003031	Migration 2004-2007 IOM	2 500 000
76003055	SocStandards ProcureCnslt	91 086
76003150	Safer sex and solidarity	2 000 000
76003223	Social service development	10 000 000
76003610	Convictus HIV project	1 500 000
76003696	UN HIV prevention	4 300 000
76003708	Social system reform	9 000 000
76003745	Monitoring soc.mod.ass.	140 939
Total		32 282 208

Eastern Europe and Central Asia Regional Programmes

West Balkans

MAJOR CONTRIBUTION	PROGRAMME	DISBURSEMENTS 2006
72300229	Project HOPE- HIV/AIDS	0

Western Balkans Programme to fight HIV and AIDS

Sida has given financial support to the NGO Foundation Partnerships in Health (FPH) to implement a Western Balkans Programme to fight HIV and AIDS from 1 November 2003 to 31 December 2006. Countries involved in the programme were Albania, Bosnia-Herzegovina, Croatia, Kosovo, Macedonia, Montenegro and Serbia. Sida's contribution amounted to SEK 30 million. That amount was disbursed by October 2005.

The overall goal of the programme was to contain the spread of HIV/AIDS in the Balkans, and to create conditions allowing countries to prevent the current situation from escalating into major AIDS epidemics. The purpose was to strengthen the various interdependent factors that are indispensable for the effective and sustainable containment of HIV/AIDS. The programme consisted of two major components: 1) Prevention and 2) Care and Support. Activities to meet the objectives and set outputs were assistance to local NGOs to increase technical and managerial capacity to implement HIV/AIDS prevention education and VCT programmes, training of health personnel in topics crucial for HIV/AIDS prevention, diagnosis and care & treatment.

FPH has to date trained 3,782 PHC providers (doctors and nurses) on HIV, stigma and discrimination, patient confidentiality and workplace safety. It has supported 18 NGO projects reaching thousands of intravenous drug users, men having sex with men, migrants and Roma populations. It has supported MoH and NGOs in establishing 10 centres for counselling and HIV testing. It has also supported the establishment of several support groups for people living with HIV/AIDS (PWHA) and Roma peer support groups. FPH has arranged two Western Balkans Regional HIV conferences (in 2005 and 2006) with the aim of building multi-sectoral partnerships. Both conferences had many participants and were well executed and highly appreciated.
The project has been implemented according to plans and is firmly on track (AP).

Health Systems

The sub-sector, health systems, includes health services, human resources, equity, private sector and financing. Strengthening health systems in health development cooperation is one of the core activities financed by Sida. Bilateral support to build up capacity by improving health service delivery is given to 14 countries: Bangladesh, Vietnam, Albania, Tajikistan, Kyrgyzstan, Malawi, Mali, Kenya, Burkina Faso, Uganda, Zambia, Nicaragua, Honduras and Guatemala. Most commonly, this means sector-wide support or programmatic support to the health sector. It is the largest thematic area for the health division, amounting to SEK 776 million.

The global programmes in the area of health systems supported by Sida are strategically chosen to improve and develop knowledge, norms and policies in this field. The specific task for the health unit is to transfer this knowledge and put programmes into action in bilateral cooperation countries. The two focus areas in health systems are human resources for health and health financing. An important global player in health systems is WHO.

WHO

The total agreed contribution from Sida of SEK 270 million for the period 2006-2007 has the following components:

• *Core support (*SEK *60 million)*
Swedish contribution to WHO shall move towards an un-earmarked contribution. This is in line with the global harmonisation agenda as well as with the internal reform process at WHO. This is also in line with the Swedish development strategy with WHO (2002-2005). Fifty percent of the core support should be directed towards regions and countries and spent in accordance with OECD Development Assistance Committee (DAC) rules.

• *Support to thematic issues (*SEK *50 million)*
The appropriation letter for 2006 states that Sida shall focus on sexual and reproductive health and rights, communicable diseases and health systems. Sida will report back to the government on these issues. Since WHO is the leading normative body, it is natural that the funding be channelled through WHO on these thematic issues. WHO will decide how this contribution will be divided among the areas of work that deal with these themes.

• *Secondments (*SEK *10 million)*
Consensus exists regarding the value of Swedish expertise on both the Swedish and WHO side and it is proposed that WHO will handle the procedure for hiring the experts. The contracts will be valid for a maximum of 11 months at a time.

• *Support to Health Action in Crises (HAC) (*SEK *20 million)*
The contribution to HAC (from SEKA) is to support the role of WHO in assessing health priorities as well as coordinate health stakeholders in emergency situations. The contribution is the same as in the previous agreement.

• *Contribution to health research through SAREC (*SEK *110 million)*
This is a complement to the above-mentioned support and will be included in the agreement. It is assessed in a separate memo and is decided by the Sida Research Board.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
72300072	Private sector providers	2 050 000
72300412	WHO voluntary contribution	70 000 000
78100260	Health system development	1 664 346
78101289	OSHD	1 853 775
78600009	CEDC	357 623
Total		75 925 744

Sida participated in the meeting of the Executive Board (EB) and the World Health Assembly (WHA) in 2006.Good progress was made in strengthening the planning and renewing the results-based managerial framework of WHO. Work on the 11th General Program of Work (GPW) was completed during the year and provided a ten-year (2006-2015) global health agenda. The GPW provides an overview of key challenges and gaps, including a seven-point health agenda and describes the core functions of WHO.

Work on the first WHO six-year, Medium-Term Strategic Plan (MTSP) is also nearing completion and will be presented at the May 2007 WHA for approval. The MTSP provides WHO with a longer planning horizon (six years) and is expected to foster greater horizontal collaboration by structuring programmes for 13 strategic objectives (instead of the 36 areas of work previously relied on). Work towards developing an integrated Global Management System (GSM) with results-based management and work planning at its core has progressed well, with roll-out at headquarters and in one region scheduled for early 2007.

The Human Resources for Health area has received a distinction this year for its World Health Report 2006: Working Together for Health, a publication coordinated by the Human Resources for Health Department at headquarters. The report highlighted the worldwide crisis in human resources for health, inter alia expressed by an absolute shortage of approximately four million health workers in 57 countries, the majority of which are in sub-Saharan Africa and Asia. The report presented an overview of potential interventions and proposed a ten-year action plan to begin solving this crisis. In a similar vein, this year's World Health Day was dedicated to the health workforce, which triggered significant advocacy efforts across all regions. Commitment to this area of work was also marked by the passing of two World Health Assembly resolutions; one on strengthening nursing and midwifery; the other on the rapid upward scaling of the health workforce. The latter urges member states to accelerate efforts to rapidly expand the workforce, so that the global shortage of approximately four million workers is diminished.

The area of workforce development is seen as particularly complex as it requires interventions from many stakeholders. Therefore, establishing effective partnerships and alliances was one major goal for this area this year. Good progress was reported at the mid-term of the biennium. As a result of this and previous advocacy efforts, the Global Health Workforce Alliance (GHWA) was launched as a global partnership in May 2006, aimed at strengthening advocacy of the health workforce and sustaining these issues on the international agenda.

The GHWA, in conjunction with WHO and its partners, works towards implementing effective interventions to reduce the shortages of health workers in countries most affected, and building up a well-performing health workforce worldwide. Additional regional alliances and partnerships were also developed, such as the Asia-Pacific Action Alliance for human resources for health, the Africa Observatory for the health workforce, and the south-east Asia network of nursing and midwifery education institutions.

Technical work – developing and testing frameworks, tools, guidelines and other technical instruments – progressed during the mid-term. Achievements at mid-term included a consensus framework on action in health workforce strengthening (HRH Action Framework) developed in partnership with USAID/ Capacity Project, Intra-Health and Management Sciences for Health, which will be tested in several countries.

Furthermore, a web-based survey tool for HRH policy dialogue and decision making (SOftPoDD) was developed in collaboration with Clemson University, which will be tested in countries. Additional instruments for assessing the capacity of training institutions to scale up production of nursing and midwifery tutors were also tested in three countries. Furthermore, at the request of regional and country offices, regular provision of country technical cooperation to develop HRH policies and plans was provided on an on-going basis.

Foundations for a more active, effective and coordinated approach were set in 2006, with global partners to begin tackling the health workforce crisis. The coming years will have to build on this foundation, by paying more attention to further strengthening partnerships and the knowledge base on effective interventions that build a well-performing health workforce.

Reports are not yet available for other thematic areas, the results of which will be presented at the WHA in May 2007. The overall performance rate stands at N/A (not available) until the WHO report is available.

Private sector – role of non-governmental health care

The Private Sector Program (PSP) is a collaborative research programme involving research institutions in Sweden (IHCAR, Karolinska Institutet), the USA (IHSP, Harvard) China, Vietnam, Laos, India, Uganda and Zambia. The programme seeks to strengthen the performance of health systems and improve their health outcome by exploring how the non-state (private) health sector can be involved in providing adequate healthcare to the population, and in particular, to those most in need, The programme has received support since 2002. Large-scale studies of the private sector are either on-going or have been completed in the programme in the six low- and middle-income countries that are involved in PSP. Results were presented at conferences in San Francisco (2003), Stockholm (2004) and Barcelona (2005).

Research on the private sector will be completed in 2006-2007. Private providers will seek ways to disseminate findings and explore the start-up of a second phase. Interventions for working with the private sector for improved health will be evaluated in this phase. Such interventions may be initiated by the research institutions themselves or by other actors. The Centre for Health Management and Policy in Jinan, China hosted a PSP conference in 2006 where key issues concerning public-private sector collaboration were analysed and discussed. Participants concluded that private healthcare providers make up a significant part of national health systems in most low- and middle-income countries today.

Private sector providers already account for a large share of access to basic healthcare services and contribute significantly to public health outcomes. Public-private partnerships have emerged as one of the main areas of innovation in health development; such partnerships can be created for healthcare provision, research, technology and communications, as well as other relevant fields of work. In light of this, participants at the meeting jointly called for governments in low- and middle-income countries to give greater recognition to the role the private health sector plays, as well as develop clear policies that can guide the work of national and local governments with the private sector, as strategic partners in healthcare delivery, in strengthening public health and access for all to health services.

The overall performance rating for this programme is according to plan (AP).

Health financing

Sida supports the World Bank Strategic Resource Allocation and Purchasing of Basic Health Care for the Poor (RAP 2) and Good Practice in Health Financing. RAP 2, one of four cooperative projects with the World Bank, has been designed to pilot ways to make public spending on healthcare more efficient and equitable in developing countries. The focus is on strategic purchasing and the contracting of services from non-governmental providers. Its two components include support for two regional meetings on RAP arrangements aimed at senior policymakers and development partners, and integration of lessons learned from RAP 1 in two or more pilot countries where the government is undertaking RAP-type reforms in both the public and private sector.

The Good Practice in Health Financing component seeks to build upon the World Bank's previous work in health financing. A review of country cases showing "good practice" in health financing will be conducted, with a view to assessing opportunities and challenges faced by countries implementing various approaches, and providing insights for countries considering reforms. Areas addressed in the review will include the country's economic, social and political environment, descriptions, chronologies, and an evaluation of financing reforms, including key conditions for success and lessons for other countries. The review will be practical and multi-audience, and will serve as a guide for decision makers and other development partners.

Owing to slow implementation and reporting, the overall performance rating was minor deviation from plans (MDP).

National Health Accounts (NHA)

The purpose of this project is to facilitate an increased use of National Health Accounts (NHA) in developing countries by supporting the process of institutionalisation, with a special focus on sub-Saharan Africa. The programme will focus on activities aimed at finding ways to increase the use of NHA at the country and regional level, and improve network activities with the ultimate goal of increasing the use of NHA in policy decisions. The major actors involved in NHA met in Lund in October 2006. At this meeting, the main objectives and targets for future work concerning the institutionalisation of NHA was agreed upon. Preparations for the global NHA meeting in Lund in 2007 are being made.

In view of the implementation plan, the overall performance rating for this programme is AP.

Training course for health personnel working in low-income countries

This three-year programme, in collaboration with the Health University in Linköping and the Futurum Akademin with Jönköpings Läns Landsting, aims to provide 3 six-week courses in 2006, 2007 and 2008 for Swedish health workers going abroad to work in low income countries. This is regarded as catalytic support to broaden the resource base for teaching in the area of healthcare services delivery in poor countries. The specific educational goal for the course is divided into three sections:

- maternity and delivery care, and child healthcare with nutrition
- tropical medicine and parasitology
- public healthcare, water and sanitation, and drugs epidemiology and prevention.

A training course for 22 participants was held at Ryhov Hospital in 2006, in collaboration with the Health University in Linköping. An evaluation will be done once the final course has run its course in 2008.

Infectious diseases

More than 60 percent of the disease burden in low income countries consists of infectious diseases. Most of these diseases are preventable with simple standard regimes and measures, or are curable with affordable drugs. The main problem in development cooperation countries is that the systems delivering health services are under-funded and under-staffed. In fact, in many countries, they are on the verge of collapse. The strategic action plan of 2006-2008 – Sweden's contribution to the global fight against communicable diseases – identifies the strengthening of health systems as one of the main areas of support. This coincides exactly with Sida's current strategy on bilateral health sector support.

Sida's support in fighting infectious diseases has changed from specific support – individual, disease-specific programmes – to broader health systems support. Diseases receiving direct programme support from Sida are HIV/AIDS, tuberculosis (TB) and Avian Flu. A top priority for Sida is to mainstream HIV/AIDS activities in all other development cooperation programmes. The TB programmes receiving support are focusing on multi-drug-resistant (MDR)

tuberculosis in eastern Europe and central Asia. The WHO programme on the Avian flu is concentrating on mitigating the effects of the spread of a pandemic influenza.

Global programmes dealing with the prevention of infectious diseases also include supporting essential drugs and immunisation. Support has been strategically selected to improve and develop knowledge, norms and policies.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
72300064	Support to HAI	1 000 000
72300248	PSP Conference	524 872
72300315	GEGA Equity in health	1 000 000
72300339	Health systems research SAREC	2 000 000
72300374	WHO Avian Flu	20 000 000
72300378	Training HW going abroad	1 300 000
72300381	RBM Forum V Yaoundé	1 000 000
72300396	GAVI 2006	100 000 000
72300402	Network REACT	6 000 000
72300403	NHA work through IHE	1 144 320
72300405	IHCAR tracking study planning	514 240
72300408	Health syst dialog quest	377 027
72300420	WHO/Apoteket AB Chemicals	4 000 000
Total		138 860 459

WHO Collaborating Centre for Chemical Reference Substances

The work of the WHO Collaborating Centre for Chemical Reference Substances focused on WHO 's high priority diseases in 2006. These included HIV/AIDS, malaria and tuberculosis. In the course of the year, work has been performed on International Chemical Reference Substances (ICRS) required to support the monographs for quality control of drugs in The International Pharmacopoeia. Three new ICRS for monographs on anti-retroviral, anti-malarial and anti-tuberculosis drugs have been established. The Centre has also developed a thin-layer chromatographic screening test for five different anti-malarials to prevent the use of counterfeit medicines in developing countries.

The Centre has participated in meetings at WHO headquarters regarding the development of draft monographs for anti-retrovirals. The establishment of these new monographs is very important for controlling the quality of anti-retrovirals in developing countries. Furthermore, work has been performed to guarantee the quality of the Centre's stored ICRS. About 50 ICRS, including five anti-malarials, have been re-examined. Three replacement batches for depleted ICRS have been established, as well as two new ICRS. The Centre increased the distribution of antiretroviral ICRS to African countries in 2006.

The work described will be presented in more detail in their "Report on the Work in 2006".

The performance is in accordance with the plan (AP); the report for 2006, however, is not yet available.

Avian Flu

Sida gives special support to the WHO programme on Avian Flu. This work is part of the "Strategic Action Plan for Pandemic Influenza." As part of the action plan, WHO maintains a continuous surveillance system that monitors influenza strains worldwide by a network of laboratories and trained personnel in member countries. WHO also works individually with each member country on building capacity and maintaining an updated action plan in the event a mutated Avian flu pandemic occurs.

The overall performance rating is not available (N/A), since the WHO report is not yet available.

GAVI

The GAVI Alliance was formed in 2000 in response to stagnating immunisation rates and high prices for new vaccines. In its first five years, GAVI committed almost USD 1.5 billion and disbursed over $800 million to support 72 of the poorest countries with new vaccines, funding for immunisation services and injection safety support.

In its second phase, 2006-14, GAVI will aim to further strengthen the health systems as a basis for immunisation and other health interventions as well as support the introduction of new vaccines that will become available in the next few years (most probably rotavirus and pneumococcal vaccines). Sweden has supported GAVI since 2001 and currently occupies a seat on its board.

Sida has increased its contribution over the years. Last year, Sweden contributed SEK 100 million, as was stipulated in the letter of appropriation for that year. The Government placed a focus on infectious diseases in 2006 through the launch an action plan for Sweden's contribution to the global fight against epidemic diseases. The support to strengthen national immunisation programmes to reach the 90 percent target coverage of basic childhood vaccines in all districts in low income countries is a key element of this strategy. Also, part of the strategic action plan is to support the development and introduction of new and under-utilised vaccines through innovative financing mechanisms. A special programme on health systems strengthening, very recently introduced by GAVI and eagerly supported by Sweden's presence on the board, is also exactly in line with the action plan on infectious diseases. The GAVI Alliance Progress Report of 2006 showed that:

- GAVI Phase 1 resulted in rapid disbursements to countries
- GAVI provided new vaccines to over 99 million children who otherwise would not have been protected against hepB, Hib or yellow fever
- hepB vaccine coverage in developing countries increased from 17 to 49 percent in the year 2000

- GAVI provided over 1.2 billion auto-disable syringes
- Over 15 million additional children were reached with the traditional EPI vaccines , with slow but continually increasing routine immunisation coverage in developing countries
- GAVIs showed a willingness to review, learn and adapt, for example, by including more developing country representatives on the Board and strictly maintaining focus on the poorest countries (below USD 1,000 GNI/capita)
- GAVI had administrative structures and demands on countries with a relatively light touch
- GAVI successfully introduced innovation; for example, in its form of performance-based support and Immunisation Data Quality Audits (DQAs).

The overall performance rating for GAVI Alliance is exceeding plans (EP), due to the good results shown in performance indicators.

Health Action International (HAI) – Global program of work 2002–2006

HAI is an informal network of approximately 160 member organisations and individuals. HAI, in collaboration with WHO, works in the essential drugs area. More than 90 percent of diseases are curable with the 350 drugs on the WHO essential drug list. HAI works in three areas: access to medication, rational use of medication, and drug policy formulation. A major achievement in 2006 was the "Medicines and Prices" publication, created in collaboration with WHO. The manual will simplify the procurement of essential drugs and lower drug prices.

The overall performance rating for this programme, in view of the implementation plan, is according to plan (AP).

EPN

The Ecumenical Pharmaceutical Network (EPN) is a network WHOse members are involved in the supply of drugs in over 30 countries. Each year, members meet to network and discuss emerging drug, health and policy development issues. The EPN has developed country focal points (CFPs) at the country level, which serve to facilitate information exchange and communication among country members and the rest of the network. The EPN organisation consists of a seven-member board and has its office in Nairobi.

The purpose of this project is to build capacity in member organisations to increase sustainability through training in planning, management and drug supply, and distribution routines. The result for 2006 was the creation of a self-assessment tool to be used to monitor progress vis-à-vis the characteristics of a functioning drug supply organisation (DSO). This work was carried out in a participative manner, with staff from the DSOs that designed the questionnaire. The EPN introduced the use of survey tools and methodologies to measure access to medicine in 2006. Using the tools developed in the access programme, DSO-staff were trained to carry our access studies to measure both factors impacting their own access to medicine and those factors impacting their clients.

The overall performance rating for APN is according to plan (AP).

ReAct

The Action on Antibiotic Resistance (ReAct) is a network organisation that receives core support from Sida for an initial period of five years. The support goes to the coalition's secretariat and core functions, as well as to its work involving five key objectives:

- Identify and remove critical evidence gaps that block action to contain antibiotic resistance
- Develop strategic options that remove barriers to innovation of new antibiotics and diagnostics
- Advocate better access to and use of effective and affordable antibiotics for those in need
- Promote global consensus for a new paradigm on the use of antibiotics
- Increase awareness of antibiotic resistance as a threat to global public health and involve key stakeholders actively.

The core functions supporting the work of ReAct will be supportive of the coalition as such, for its activities and its capacity to do preparatory work. The profound changes sought by ReAct will, in all likelihood, occur through interaction among social movements that involve civil society, community and consumer organisations, health policy reformers and those individuals, networks and institutions that generate and analyse health-related information. React will catalyse and coordinate action in ways that are most likely to bring about these changes. The React coalition is a brokering agreement among groups to work together through greater coordination to break through the inertia surrounding the issue of bacterial resistance. React's efforts come from the combined weight of its members and partners, as well as from extended networks and contacts of each of the groups in the coalition to involve many WHO are concerned about the issue. ReAct, in conjunction with the EU Commission, put together a fact sheet on disease burden of antibiotic resistance for hospital and neonatal infections in June 2006.

Even though the programme is newly established and full reporting is not yet available, the overall performance rating is according to plan (AP).

Sexual and Reproductive Health and Rights

Global programmes

The majority of Swedish global support to Sexual and Reproductive Health and Rights (SRHR) is mainly channelled through UNFPA, which received SEK 400 million (via MFA) in 2006, International Planned Parenthood Federation (IPPF) receiving SEK 100 million, and WHO which received SEK 45 million for Making Pregnancy Safer (disbursed in December 2005 with activities in 2006).

A smaller amount was channelled through other organisations, such as FIGO for maternal health, and the Safe Abortion Action Fund, established in 2006. Other examples include the International Consortium for Medical Abortion (IMCA), which disseminated research results worldwide for medical abortion, and Gynuity Health Projects for conducting research, which resulted in

instructions for use that are used globally. The World Bank is conducting a synthesis of current knowledge concerning the cost of treatment for clients with post-abortion complications in sub-Saharan Africa, and estimates of the costs that provide contraceptive services to help women prevent unintended pregnancies.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
72004201	IBFAN-GIFA 2003-2008	750 000
72004203	IBFAN-Asia Pacific Region	500 000
72300291	Ipas global abortion	11 000 000
72300344	IPPF 2005-2006	100 000 000
72300346	SCMIOG medical abortion	500 000
72300356	Safe motherhood FIGO	5 000 000
72300387	UNFPA Fistula	9 000 000
72300392	QWEB Project Support	792 110
72300397	GHEN Seminar Stockholm	366 603
72300406	Evaluation IPPF	1 879 351
72300430	Part UNFPA consultation	51 336
72300432	SRHR Global Safe Abortion fund	10 000 000
72300463	UNFPA-ICM works midwifcom	700 000
72800004	DAWN	500 000
72900016	IWHC: Compact Network	1 000 000
78100259	227 SRHRA	2 503 070
78101292	245 SRHR	3 606 406
78600003	245b SRHR	1 890 703
Total		150 039 579

IBFAN

The key achievement for the IBFAN Asia & Pacific Regional Program in 2006 was strengthening its partnership with key stakeholders. Five south Asian governments were represented for the first time at the South Asia Breastfeeding Partners Forum 2 in Kathmandu, Nepal and preparations for Forum 3 are ongoing. Nearly every government in southern Asia is involved in conducting the national assessment of the global strategy.

For the first time ever, the international building training course on national level capacity was conducted for developing national trainers in 'Infant and Child Feeding Counselling.' The course received global appreciation and interest. The work of the sub-regions was strengthened through the organisation of new actions, work on infant feeding during emergencies, the constitution of a task force and the development of the `State of the World's Breastfeeding South Asia Report Card', and its impact. National interests are growing as is witnessed from national level actions, workshops or assessments.

Ipas

Sida supports the overall objective of Ipas, which is to reduce unsafe abortion as a cause of maternal mortality and poor reproductive health among women in developing countries. Ipas regards this objective as essential in achieving the millennium development goals, including poverty reduction – a goal requiring an improvement in maternal health outcomes. The annual meeting took in Stockholm in May 2006.

Over 7,000 health facility workers were trained globally and over 3,200 in the focus countries of Ipas through clinical training courses and orientations in 2006 (from July 2005 to June 2006). Ipas also donated manual vacuum aspiration instruments to 30 countries and disseminated the Safe Abortion Presentation Package globally, based on the safe abortion guidance of WHO.

The project is performing according to plan (AP).

IPPF

The International Planned Parenthood Federation (IPPF) worked through a federation of 151 member associations in 183 countries with 5, 286 service clinics and 53, 184 non-clinical service delivery outlets in 2006. Over 30 million services were provided. IPPF also produced a major publication 'Death and Denial', which highlighted the global reality and consequences of unsafe abortion. The publication led to the establishment of the 'Safe Abortion Action Fund'. This fund will be managed by IPPF and will provide financial support to NGOs working towards increasing access to safe and legal abortion services as well as raising awareness about the socio-economic consequences of unsafe abortion in developing countries. The governments of Norway, Sweden, Switzerland and the United Kingdom are supporting this fund.

In September, the IPPF was a leading civil society organisation at the African Union Ministers of Health Conference in Maputo and was responsible for contributing to the development of the continental policy framework on sexual and reproductive health and rights. IPPF also worked closely with civil society organisations to advocate for 'universal access to reproductive health services' to be included as a target in the MDG framework, under MDG 5. This target has been taken note of by the UN General Assembly and, as such, the General Assembly has adopted four new targets for the MDGs, including one that focuses on universal access to reproductive health services. 2006 was the first year for IPPF to publish global indicator data, giving a global and federation-wide view of results as well as the status of IPPF member associations. IPPF also developed a framework for good practice in peer education in 2006. This publication was disseminated to a variety of NGOs and all member associations.

FIGO

The goal of the International Federation of Gynaecology and Obstetrics (FIGO) is to reduce maternal and newborn morbidity and mortality, and contribute to the achievement of MDG goals 4 and 5 in nine low-income countries. Specifically, the project will build and sustain the capacity of the obstetric/gynaecology (ob/gyn) and midwifery societies in Kenya, Kosovo,

Moldova, Nigeria, Pakistan, Peru, Haiti, Uruguay, and Uganda to conduct essential projects relevant to promoting safe motherhood and improving maternal health in these countries.

The project will be implemented by the FIGO and the International Confederation of Midwives (ICM) through twinning mechanisms between ob/gyn societies of developed countries with those in the implementing countries. An assessment was done by Sida and an agreement on the project was signed in 2006.

A number of activities were implemented during the project. A meeting of project coordinators was held in London in April 2006 and a meeting of project coordinators, FIGO officials and the SMNH Committee – also held in London in June 2006 – agreed on the format for monitoring and evaluating the projects, using the logical framework analysis (LFA) method, along with the development of a list of indicators/outcomes measures. A follow-up meeting of the FIGO and the SMNH Committee with some of the project teams in Kuala Lumpur, Malaysia was held during the FIGO World Congress to review project execution progress in the individual countries.

To date, all nine participating countries have developed acceptable LFAs for their projects. Contracts have been signed, funds transferred and activities initiated for six countries, with Kosovo, Nigeria and Uganda at various stages of contract execution and funding transfer.

In the overall assessment, performance fell somewhat short of the targets, or minor deviations from plan (MDP).

UNFPA

Due to the delays in program start-up, funding for the United Nation's Population Fund's (UNFPA's) Reproductive Health Commodity Security Global Program to Enhance RHCS was not utilised in 2006. Selecting "Proof of Concept" countries for which program implementation was set to begin in the following months took longer than expected. The decision to delay implementation was made in broad consultation and those consulted agreed that it was important to build consensus on country selection and involve the national authorities in question.

Global program implementation is moving forward in a number of "Proof of Concept" countries. A national RHCS multi-year plan of action is to be defined, based on the definition of mutual commitments and undertakings, and implementation is to begin in the coming months in these countries.

In 2006, a total of 39 countries were active in the UNFPA fistula campaign, and an increasing number of countries moved from the planning to the implementation phase of the campaign. In the Africa region, where the campaign is currently active in 30 countries, there were numerous country level results in 2006. For instance, a new advocacy film, developed by CNN correspondent Khalil Gueye, in collaboration with the UNFPA, inspired Senegalese President Abdoulaye Wade to make fistula treatment free for all women in the country and to officially ban early marriage.

In the Democratic Republic of the Congo (DRC), 12 healthcare providers were trained in the provision of quality maternal healthcare and the use of

referral systems in the case of pregnancy-related complications, and 185 community health workers were trained in methods and mechanisms that identified women with fistula so that they could be referred to treatment facilities.

In Cameroon, the UNFPA provided equipment to the three provincial hospitals to strengthen their capacity for fistula treatment, and an international surgeon and two national surgeons conducted a training workshop on fistula repair for medical staff at the three provincial hospitals.

In the Asia region, fistula prevention, treatment, and rehabilitation activities were further expanded in 2006. This also included enhanced evidence-based advocacy and further integration of fistula prevention and national maternal mortality and morbidity reduction efforts.

The regional highlight for 2006 was the second Asia and Pacific regional workshop, 'Strengthening Fistula Elimination in the Context of Maternal Health' in Islamabad, hosted by UNFPA in April 2006.

In the Arab region, with some of the countries having the highest rates of fistula prevalence in the world, significant results were noted as well. For instance, in Somalia, a needs assessment was finalised and shared with the government, and is now available to the public through the campaign's website.

In Sudan, two fistula repair workshops were conducted in El Fasher and Juba, and resulted in treating 60 women, training three surgeons and 14 nurses, and a new facility in Zalingei, dedicated to fistula repair and giving shunned women, living under stark conditions in surrounding Darfur, a special opportunity to regain their health and dignity.

GHEN

Sida supported Gender and Health Equity Network (GHEN) and the international conference it held at Sida in Stockholm in October 2006. GHEN is a partnership of national and international organisations concerned with developing and implementing policies to improve gender and health equity, and in resource-constrained environments in particular. Activities included organising and hosting the international seminar in Stockholm in 2006, disseminating findings from the Sida-supported GHEN project and discussing innovative methods for improving gender and health equity in poor environments in India, China and Mozambique.

The results were very positive, and reached an international audience of about 100 persons. A summary of the seminar was published and widely distributed.

The project went according to plan (AP) and had very good effects on project continuation.

Safe Abortion Action Fund

The Safe Abortion Action Fund was initiated by the UK DFID and created in 2006, with the purpose of attracting, managing and disbursing resources to NGOs working in developing countries in any area along the abortion continuum currently struggling with loss of funds. IPPF administers the fund on behalf of civil society groups and NGOs worldwide. A board and a technical review panel have been appointed. The number of applications received in the first round was 165, of which 50 came from Africa, 50 from Asia, 14 from

Europe, and only 1 from the Arab world. About 60 percent of the applications came from lower-income countries. Performance is going according to plan (AP); however, due to the unexpected high number of applications, the timetables for the release of funds will be slightly delayed.

WHO Making Pregnancy Safer

The objective of supporting 'Making Pregnancy Safer' is to contribute to the WHO work plan behind this initiative. Funds have been used to strengthen WHO's technical capacity in regional and country offices by recruiting national programme officers. Furthermore, capacity building and training workshops were carried out in all regions and global meetings were conducted from WHO headquarters for the purposes of joint programme planning and review, Stockholm-based partner development meetings, and technical meetings on post-partum bleeding and newborn health.

Center for Reproductive Rights

Sida's grant supported the collaborative work of the 'Center for Reproductive Rights' with the Network of East-West Women (NEWW) and the Bulgaria Gender Research Foundation (BGRF) in designing, directing and implementing the Women's Human Rights Training Institute (WHRTI).

The WHRTI trained 17 women lawyers from the East Central Europe (ECE) region in a two-year, four-session series workshops, with the last session held in April 2006. Its goal was to build capacity in litigating women's human rights cases in three focus areas at the national, regional, and international levels: violence against women, reproductive rights, and employment discrimination. The centre continued to support cases throughout 2006, with a total of four reproductive rights cases resulting from the training. With Sida's support, WHRTI made a significant step in establishing a network of lawyers in the East Central Europe region, committed to advancing reproductive rights through legal advocacy.

Gynuity Health

The 'Gynuity Health' project is a newly established research and technical assistance organisation, and is based in the USA. Its main focus is on sexual and reproductive health (SRH) and believes that all people shall have access to modern medical science and technology development in this field. The project aims to conduct evidence research, training and introducing the drug Misoprostol in reproductive health regiments. Misoprostol has proven to be effective, cost-effective, as well as easy and safe to implement in low-resource settings. Sida visited one of the research sites in Burkina Faso in September 2005 at the time research for treating some forms of emergency obstetrics at village level was ongoing.

The research findings on post-partum haemorrhage, post-abortion care and medical abortion were disseminated in journal publications and presentations in scientific meetings worldwide. In addition, Gynuity hosted a series of regional meetings for the dissemination of the results. Research supports that Misoprostol is safe, effective and as acceptable a standard as any other treatment in use today.

The instructions for guidelines on usage were developed by Gynuity and have been distributed and used worldwide. As a direct result of the studies, Malaysia's reproductive health guidelines include indications for use of Misoprostol for post-abortion care (PAC). Gynuity is the main author of a chapter in WHO guidelines, describing the use of Misoprostol for treatment of PAC.

The project is proceeding according to plan (AP).

ICMA

The International Consortium for Medical Abortion (ICMA) brings together key players in the field from all regions of the world and promotes medical abortion within the framework of support for safe abortion worldwide. It focuses on the needs of women in developing countries, including those countries where abortion is unsafe or non-accessible. The consortium seeks to increase awareness of the option for medical abortion among key players in developed and developing countries. It also seeks to facilitate dialogue and networking among health service providers and policymakers for increased service for medical abortion care.

As final support to ICMA, Sida plans to prolong the agreement for one year so as to cover funding for the conference in March 2007.

ICMA developed and disseminated information on medical abortion relevant to developing country settings in 2005 and 2006. Furthermore, a website was launched, and a network of organisations is being established, consisting of individuals WHO support access to medical abortion and are involved in its safe provision. ICMA is organising an international conference to raise the profile of medical abortion worldwide in March 2007.

The project is performing according to plan (AP).

HIV/AIDS

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
72300033	Arrow core support	400 000
72300401	WHO 3 by 5 Committee Meet	61 837
72300419	Investing in Future gener	122 400
72002138	Helpdesk HIV/AIDS	245 304
72700004	UNODC HIV AIDS	6 000 000
72300301	HIV/AIDS Alliance	2 500 000
72900012	Help desk HIV/AIDS	3 305
74300026	Save the Children/Rädda Barnen frame 2005-7	744 736
Total		10 077 582

ARROW

The Asian-Pacific Resource & Research Centre for Women (ARROW) focused on the expansion of capacity building and partnership development for evidence-

based advocacy on sexual and reproductive health and rights in 2006. ARROW's key results included setting up the south Asian GO-NGO task force on sexual and reproductive health and rights (SRHR), initiating dialogue with human rights commissions from the south-eastern Asia sub-region on developing monitoring tools for violations of women's SRHR, and building strong partner-ships for advocacy of monitoring progress of improving women's access to quality, affordable SRHR services. ARROW also continues to provide innovative information tools and conceptual frameworks that enable partner NGOs to increase the efficacy of advocacy of women's health and rights in the region.

The overall performance rating is minor deviations from plan (MDP), mainly due to the very slow start-up phase.

Public Health

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
72004202	WABA 2003-2007	1 024 000
72300277	Tobacco prevention-global	3 000 000
Total		4 024 000

FCA

The objective behind supporting the Framework Convention Alliance (FCA) is to support the ratification, implementation and monitoring of WHO FCTC in low-income countries. The FCA influenced the WHO Framework Convention on Tobacco Control (FCTC) by ensuring the participation of NGOs and delegates from low-income countries at all official WHO FCTC negotiations such as at the first Conference of Parties in February 2006 and expert group meetings.

The FCA hired regional coordinators in the Americas, Western Pacific, and African regions, all of WHOm have begun targeted tobacco control efforts in their respective regions. The FCTC Monitor – the FCA's independent shadow monitoring report on the implementation of the FCTC – is fully underway, with a full-time project manager coordinating the project.

The first edition of the Monitor will be released at the second Conference of Parties in July 2007 and will include implementation data from the first 40 ratifying parties. The FCA has conducted an independent evaluation in order to assess effectiveness. It is also finalising its strategic plan, which prioritises its aims and objectives over the course of the next three-year score support to FCA to develop an internal monitoring system to gear up and fulfil its task: to organise national and regional capacity-building workshops which focus on advocacy and legislation control regarding tobacco use. The FCA has initiated an independent evaluation and involvement of consultants to develop a strategic work plan.

Performance is in principal accordance with targets and work plans in terms of quality, quantity, time and costs. The performance rating is according to plan (AP).

Social policy/security

A policy shift has recently been underway to re-define the social sector within development cooperation to cover what is traditionally included in the social policy and welfare areas; i.e. social security systems, social insurance, social services, support to especially vulnerable groups, as well as employment and labour market issues. A number of factors form the background to this discussion.

One important point of departure is the UN World Summit for Social Development in Copenhagen in 1995 (re-affirmed in 2000 and 2005), with three overriding goals: poverty eradication, employment for all and the fostering of social inclusion, with the aim to create `a society for all'. Articles 22, 23 and 25 of the UN International Bill of Human Rights establishes the right to social security, protection against unemployment and a satisfactory standard of living, including the necessary social services. This is confirmed in the International Covenant on Economic, Social and Cultural rights that entered into force in 1976.

Another point of departure is the UN Millennium Declaration with its overall goal of reducing extreme poverty by half by 2015, and creating fair and sustainable distribution of wealth in the world. All MDGs exert great influence on social welfare and social development.

Recent research by the United Nations Research Institute for Social Development (UNRISD) suggests that social policy should be conceived as involving overall and prior concerns with social development, and as a key instrument that works in tandem with economic policy to ensure equitable and socially sustainable development.

The building of social policy, including social welfare and social security systems, is ongoing to various degrees in all parts of the world. According to the ILO, only 20 percent of populations enjoy adequate social security. In low-income countries, more than 90 percent of the population lack coverage, while in middle-income developing countries, the percentage ranges between 20 and 60 percent.

Sweden's policy for global development emphasises that Sweden's own modern history and experience justifies a special Swedish commitment to and active involvement in the area of strengthening the building of social security systems as part of social development. The policy states that good health, education and social security increase opportunities for people to escape poverty, to permanently improve their living conditions and to actively participate in discussions and decisions of importance to their lives.

Sida carried out a mapping of Sida's activities in 2006, including Swedish actors in the area of social policy and social security. The survey shows that a large number of such activities are underway, especially in eastern and southeastern Europe, where cooperation in this area is well developed and well documented for a considerable period of time.

Sida started drafting a position paper on social development and social security in 2006, which will guide Sida's future direction in the area.

Global support

Since the area of social welfare and social protection is a fairly new arena for development cooperation, there is a strong need for policy development. At a global level, Sida's support is aiming at strengthening the policy and methodological development in this area.

Sida supports the International Council on Social Welfare (ICSW), which in turn supports the participation of civil society in the policy dialogue at global, regional and national levels.

Furthermore, Sida supports the Women in Informal Economy: Globalizing and Organizing organisation (WIEGO), which influences the need for social protection in the informal sector through dialogues with ILO, ESCAP and The High Level Commission for the Legal Empowerment of the Poor.

Sida, in cooperation with UNRISD, organised an international seminar entitled "Social Policy in a Development Context – How to Translate Research into Policy and Action", which had the aim of disseminating research findings for policymakers at different levels within the social sectors.

MAJOR CONTRIBUTIONS	PROGRAMMES	DISBURSEMENTS 2006
72100002	VB konf social policy 05	800 000
72300350	ISCW core support	2 300 000
72300349	WIEGO core support	1 500 000
72300363	Social policy consultant	96 600
72300399	Position paper social protection	97 500
72300400	Seminars social policy	513 155
Total		5 307 255

WIEGO

Women in Informal Employment: Globalizing and Organizing (WIEGO) is a global research-policy network that seeks to improve the status of the working poor, especially that of women in the informal economy. Social protection is one of WIEGO's programme areas. Sida's activities have been focused on drawing on WIEGO's expertise for seminars and input to relevant Sida documents, particularly social protection for women and men in the informal economy. Results of the programme are in line with the objectives.

In the social protection programme, WIEGO has been working with ILO in The International Alliance for the Extension of Social Protection. A consensus document about extending social protection to all workers including informal workers has been approved.

In the statistics programme, WIEGO is, amongst other things, involved in the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) project on measuring informal sector and informal employment.

WIEGO is also involved in planning research projects and is participating in the international research conference, Social Security and the Labour Market: A Mismatch?, in Poland in 2007. The programme has been very successful and is exceeding plans.

Much attention was placed on employment and the informal economy in 2006, as well as putting these issues on the international agenda. Organisations such as ILO, ESCAP and the High Level Commission for the Legal Empowerment of the Poor, are involving WIEGO in their work.

ICSW

Sida's core support to the International Council on Social Welfare (ICSW) will support dialogue for input to the UN Commission for Social Development and the Kellokoski Expert meeting on "Comprehensive Social Policies for development in a Globalising World" and "The Organisation of ICSW 32nd International Conference on Social Welfare" in Brazil in 2006. ICSW is also giving important input from a global civil society organisation, globally, regionally and at country level, particularly trying to influence PRSPs. Furthermore, a web-based paper was disseminated and the "Global Social Policy" published.

The programme is in line with the plans for 2006 (AP).

UNRISD

The aim of the joint seminar by Sida and the United Nations Research Institute for Social Development (UNRISD), entitled "Social Policy in a Development Context", was to disseminate findings from the latter's flagship project "Social policy in a development context" and to discuss the promotion of social policies in the developing world. A seminar for about 100 international participants was organised and hosted at Sida – leading into an expert meeting in Kellokoski, Finland directly afterwards. These meetings were fed into the process of the UN Commission for Social Development.

The programme has had very positive results. A book from the Kellokoski and Stockholm seminars has been published and there are many references to them at the International Development Agenda, working with social development and social policies.

The programme has been performing according to plan (AP), and has had far more positive effects in the aftermath than expected (exceeding plan, or EC).


DE FEMMES ET DEVELOPPEMENT
"AGUN" DE DOSSOUHOUE

CONTINENT	2000	2001	2002	2003	2004	2005	2006
Africa	110 055 258	163 062 171	262 900 526	238 624 230	244 142 788	282 917 261	251 886 469
America	29 825 000	48 710 329	50 976 676	48 190 304	74 717 229	77 577 121	101 406 451
Asia	51 638 487	59 010 111	74 762 187	66 850 024	90 323 934	82 876 411	89 506 239
Central & Eastern Europe	0	0	0	0	0	0	1 667 000
Europe	0	0	1 000 000	1 159 000	210 629	123 713	1 884 294
Global	143 259 170	170 091 199	179 854 149	226 634 820	364 504 266	417 810 163	524 124 378
Grand Total	334 777 914	440 873 809	569 493 537	581 458 380	773 898 845	861 304 669	970 474 832

Bilateral Research Cooperation

Global funding for research in and by developing countries is often low. In addition, many developing countries lack national funding for research and the experience to organise national health research.

Capacity for research is essential if countries are to be in charge of formulating and implementing their development strategies. Research provides tools for analysis, for directing change and for evaluating the impact of internal and external efforts intended to reduce poverty and develop resources.

Decision makers can turn to the local research community for advice. Researchers have access to the international community and its existing knowledge. They may identify, evaluate, develop and apply knowledge relevant to local conditions and possibly influence the direction of international development-orientated research, where Northern perspectives dominate.

Sida's efforts for strengthening research capacity are directed at low-income countries that have a weak basis for research. Efforts are aligned with the priorities of the countries and support may be directed at the three main areas of reform and management, research capacity strengthening and research collaboration, which involves Swedish universities.

A central portion of support is targeted at central university structures for the development of the university research environment. This may include support for research management, information and communication technology, core laboratories and libraries. In addition, support to competitive research grants is given. The majority of support is directed at research collaboration and research training activities, with the overall objective of addressing important development issues. Sida currently gives support to medical schools in Bolivia, Ethiopia, Honduras, Mozambique, Nicaragua, Sri Lanka, Tanzania, Uganda and Vietnam.

Bolivia (SEK 1.6 million)

Bilateral research cooperation with Bolivia involves two national universities: Universidad Mayor de San Andres (UMSA) in La Paz and Universidad Mayor de San Simon (UMSS) in Cochabamba, but only UMSA is currently involved in health research. At UMSA, two programmes are currently active: acute diarrhoeal diseases and new therapeutic strategies.

Acute diarrhoeal diseases represent a major public health problem in Bolivia and are the leading cause of high morbidity and mortality rates among young children.

To contribute to prevention in Bolivia, the present project will address the aetiology of acute diarrhoeal diseases and pathogenesis among children hospitalised with diarrhoea, children seeking care at outpatient clinics and healthy children as a basis for comparison. Research efforts are focused on the characterisation of main diarrhoeal pathogens and include the establishment of a national rotavirus network at the Ministry of Health. Swedish collaborating institutions are Lund University and Göteborg University.

In terms of capacity building, several courses have been held at UMSA and other Bolivian universities, and three graduate theses and one licentiate thesis have been completed and defended. Two new licentiates were initiated. Two doctoral students are successfully involved in the programme in a sandwich model with Swedish counterpart universities.

The programme on new therapeutic strategies focuses on infectious diseases, which, in general, represent a severe public health problem in Bolivia. The problem of infectious diseases is mainly concentrated in the tropical regions that are economically depressed and where living conditions are poor. Leishmaniasis is a major problem in the tropical area surrounding La Paz, and exerts a high social and economic toll on the population.

The first phase of this project was devoted to work on Leishmaniasis. Molecular and immunological methods were used for diagnostic and therapeutic evaluations and subsequent experimental treatment using Evanta alkaloids (Galipea longiflora) was initiated. UMSA is now producing the drug in order to develop both efficient and economic alternatives for treatment against the different types of Leishmaniasis.

The project is a good example of how indigenous plants and traditional knowledge can be exploited and developed through science. Two PhD students enrolled in the sandwich model between UMSA and Stockholm University are progressing very well and are planning to defend their theses in 2009.

Honduras (SEK 1.8 million)

Health research cooperation with Honduras is targeted at the National Autonomous University of Honduras. The programme involves molecular epidemiology of HIV and TB, and Swedish counterparts are found at the Swedish Institute for Infectious Disease Control (SMI). In addition, a second project is being planned with Karolinska Institutet and involves identification and characterisation of an asymptomatic reservoir of malaria in an endemic region of Honduras, Central America.

AIDS and TB are moderate but emerging problems in Honduras. The molecular epidemiology is not well defined but is required for improved public health. The project on molecular epidemiology of HIV and TB has as its main objectives to build research competencies in molecular epidemiology to meet the needs of Honduras and to make epidemiological management more efficient at a regional level. In addition, the programme will increase the capacity to undertake educational initiatives, perform research and support

national and regional authorities in coping with the infectious-related problems.

Asymptomatic human malaria is problematic in controlling and developing resistance to the disease. It provides an interesting opportunity to identify pathogenic and protective mechanisms.

The aim of the asymptomatic malaria project is to identify and characterise a reservoir of asymptomatic malaria in Honduras. The study will first provide baseline information in two communities. In addition, it will identify the characteristics of the reservoir (risk factors, parasite genotyping and magnitude). If the reservoir is treated, this might prove to be an important method of malaria control. The project will strengthen the National Malaria Programme by linking the academic institutions to important health problems in the field.

Ethiopia (SEK 1.9 million)

Support to health research in Ethiopia is three-fold. First is a PhD training programme at the Faculty of Medicine at Addis Ababa University (AAU-FM) The programme aims to strengthen the Faculty's pre-clinical departments and promote basic science through MSc and Ph.D. training. The programme is conducted in collaboration with Karolinska Institutet. PhD training started in 1998 and involved three PhD students in 2006. One resulting thesis was successfully defended. Research areas included studies on toxin extracts from Ethiopian endemic species and studies on bio-active compounds of Aloe-Vera and possible effects of wounds.

The second area receiving support involves the Butajira Rural Health Program, which focuses on surveillance of socio-economic indicators. Results show that the population is undergoing a demographic and epidemiological transition that is important to understand in relation to interventions to reduce premature or avoidable deaths. Four PhDs are involved in the program. Academic staff will act as local supervisors for PhD students and will develop necessary skills to launch a local PhD training program. The program has four different research areas: mortality patterns in different gender and age groups, HIV, maternal and newborn health interventions, and impact of changing healthcare provision.

The third area is core support to the Armauer Hansen Research Institute, which is a biomedical research institute that initially focused on leprosy. Established in 1969, it has generated international cutting edge findings on leprosy. Due to the decline in the prevalence of leprosy, the research emphasis today has shifted to the field of tuberculosis. Scientists at the institute are trained in relevant epidemiological and clinical trial skills through short-term courses and workshops. Current research comprises different areas of tuberculosis such as vaccine and diagnostics research, localisation of bacilli, immunological and epidemiological studies, detection of drug resistance, clinical trials to improve the Directly Observed Treatment Short-course (DOTS) strategy, health systems and services research, and well as some studies on leprosy and visceral leishmaniasis.

Mozambique (SEK 3.2 million)

Sida's support is primarily directed at building research capacity at Eduardo Mondlane University, the public institution responsible for most of the nation's research capacity in quantity as well as diversity. The programme receiving support at the Faculty of Medicine is HIV Infection And Maternal And Child Health In Mozambique. The main objectives is to evaluate interventions to prevent mother to child transmission of HIV by antiretroviral treatment in women and children in Maputo, and to estimate the prevalence of predominant categories of severe obstetric morbidity and mortality, as well as analyse avoidable factors associated with these. The new agreement started in 2006 and seven PhD students are currently enrolled in the programme.

Nicaragua (SEK 7.3 million)

Health research cooperation with Nicaragua comprises three main research programmes at UNAN-León and was initiated in 1995. The areas are demographics and health research, infectious diseases, and occupational and environmental health. The Demographics and Health Research Program is located at the Epidemiological Institute for Health Research and Demographic Investigation (CIDS) which was created in 1995. Swedish collaborators are located at Umeå University and Uppsala University. The programme utilises a demographic health survey system to carry out research on reproductive and sexual health, child and adolescent health, as well as adult health and environmental health. There were two active PhD students, of which one presented his thesis in 2006.

The Infectious Diseases Programme has received support since 1982. Long-term collaboration with mostly Karolinska Institutet has resulted in a build-up of scientific competence as well as laboratory infrastructure to handle the most common infectious disease problems that affect the Nicaraguan population. The programme, through the identification of the aetiology, distribution and prevention of infectious diseases in families and across populations, has contributed to Nicaraguan society. Research areas are vector-borne diseases, anti-microbial resistance, enteropathogens and parasitic infections. The proposed programme has a multidisciplinary approach to increase the cost-effectiveness of the cooperation and envisages the creation of a local master and research projects in collaboration with CIDS. The programme had four active PhD students in 2006.

The Occupational and Environmental Health Program was created in 1987 and focuses on the health effects of exposure to pesticides. It is a multidisciplinary programme that encompasses research issues such as occupational exposures associated with increased neuropsychiatric symptoms and affective disorders– in particular depression – improved sampling methods for biological sampling and identification of metabolites in urine, intervention research to reduce pesticide use and exposure, and suicide rates. It frequently interacts with the working population and trade unions. A new method for detecting pesticide skin contamination was published in 2006. Four PhD students were active in the programme in 2006.

Rwanda (SEK 0.15 million)

Sida has been supporting bilateral research cooperation in the areas of peace and conflict, environment, education and information and communication technology (ICT) since 2002. In the area of health, the National University of Rwanda (NUR) has declared its interest in building health research. A planning phase was therefore supported in 2006 and the medical faculty at NUR selected the following three research areas: psychiatry/psychology, maternal and child health, and malaria/TB/AIDS.

The latter will be developed as PhD training projects starting in 2007. Sida has also initiated a process to assist NUR in selecting collaborating partners in Sweden.

Sri Lanka (SEK 0.85 million)

Research support to Sri Lanka comprises only one programme entitled Health and Social Care for the Socially Marginalised People. The programme is multidisciplinary and attempts to carry out research on low-income groups in societies in conflict. Sri Lanka has a comparatively well developed healthcare system but the system faces new challenges when war-torn areas in the north and east will be incorporated into the national programme for healthcare.

Emphasis is on gender equity, violence against women and children, social issues related to middle-eastern female migrant workers, and issues related to war widows and orphans. The project includes studies on the planning and implementation of healthcare in conflict areas. These issues related to the provision of services are carried out in collaboration with the Department of Women's and Children's Health, Uppsala University and the Ministry of Social services in Sri Lanka.

Sida's support will be phased out in the next two years. Involved in the programme are 12 PhD students, one of whom completed a PhD degree in 2006. The thesis is based on a questionnaire instrument to assess the mental health of adolescents in a conflict-affected area. The questionnaire was translated into Tamil and validated. The results showed that 30 percent of school children were having mental health problems, which is high when compared to other Sri Lankan and international studies using the same instrument.

Tanzania (SEK 14.3 million)

Health research cooperation with Tanzania involves the Muhimbili College of Health Sciences (MUCHS) and consists of three programmes: reproductive health, malaria, and HIV-TanSwed.

The Reproductive Health Program is multidisciplinary and involves scientists from obstetrics and gynaecology, nursing, community health, sociology and epidemiology and biostatistics. The four main research areas are: clinical obstetric research, using an established obstetric data base; health systems research in antenatal care in Rufiji district; domestic and sexual violence against women and children; and experiences and improvement of post-partum care. Six PhD students are enrolled in the programme, which is carried out in collaboration with Uppsala University and Umeå University.

The Malaria Program focuses on the case management improvement of children under five years of age. The project is multi-disciplinary, involving

pharmacology, paediatrics, parasitology, epidemiology, public health and social sciences. In addition, scientists from the National Institute of Medical Research and the National Malaria Control Program, as well as the Ministry of Health are participating.

Swedish collaborators are located at Karolinska Institutet. Two PhD students are enrolled in the programme and one will be registered during the coming year. Areas of research include disease management, development of diagnostic methods and tools, drug efficacy, effectiveness and metabolism, and disseminating findings to policy makers.

The project uses twinning arrangements between Swedish and Tanzanian PhD students, technicians and assistants to foster international collaboration with Karolinska Institutet – in this case. A study, finalised in 2006, showed that community health workers were able to correctly use rapid diagnostic tests and distribute the drug. The test contributed to a reduced rate of prescription of Coartem malaria treatment by almost 45 percent, which significantly reduces treatment costs.

The TANSWED HIV Programme emphasised intervention research and completed 20 years of collaboration in 2006. There is also a multidisciplinary program with scientists from medicine, microbiology and immunology, obstetrics and gynaecology, pathology, paediatrics, epidemiology, biostatistics and public health. In addition, the Ministry of Health is included via the National AIDS Control Program. The programme is carried out in collaboration with Karolinska Institutet, the Swedish Institute for Infectious Disease Control and Umeå University.

The overall aim of the programme is to obtain information about clinical manifestations, epidemiology, virology, immunology and immunopathology of HIV-1 infection in Tanzania and social behavioural factors related to HIV infection, and introduce and evaluate interventions for prevention and control of HIV infection.

Six PhD students are currently enrolled and six more will join. Two PhD theses were defended in 2006. One studied the aetiology of genital ulcers with special reference to Haemophilus ducreyi and association with HIV infection. The second studied the natural history of HIV-1 infection and preparations for HIV vaccine trials in Tanzania. Furthermore, very promising results have come from an HIV vaccine phase 1 trial in Sweden and preparations are taking place for a vaccine trial in Dar es Salaam. Staff has been recruited and trained, as well as police officers who will be the subjects for study. National ethical clearance has also been received for the trial.

Uganda (SEK 10.1 million)

Bilateral health research cooperation is connected to Makerere University and includes the following six sub-programmes: Molecular Biology of Plasmodium Falciparium Strains, Clinical Pharmacology of Anti-Malarial and Anti-Retroviral Drugs, Degenerative Disease, Collaborative Sub-Program in Reproductive Health/HIV, Mental Health: Profiles of Depressive Illness in Lake Victoria Basin, and Molecular Biology of Tuberculosis. At present, 19 doctoral candidates are participating and pursuing their PhDs in collaboration with co-supervisors from Karolinska Institutet and Uppsala University.

Two dissertations were defended in 2006. One studied domestic violence and another explanatory models of depression. The defence of the dissertation on domestic violence was the first public defence ever at Makerere University. This was a greatly supported by the university leadership and was very much appreciated by all involved.

Research cooperation is gradually expanding by providing research training opportunities at the PhD as well as MSc and Master of Medicine level. Besides capacity objectives to build a strong and sustainable human resource development programme with an emphasis on research quality and productivity, there is the additional objective of developing the Faculty of Medicine into a leading research institution in sub-Saharan Africa.

Vietnam (SEK 30 million)

In Vietnam, two research programmes are supported: one for health systems research and one for the pathogenesis, diagnosis, epidemiology and treatment of common diseases.

The health systems research programme, initiated in 1992, has the overall aim to promote rational decision-making about priority health problems. This will be achieved by strengthening research capacity at different institutions in Vietnam, namely Hanoi Medical University, Health Strategy and Policy Institute and the Ministry of Health, in collaboration with Swedish researchers from Karolinska Institutet and University of Umeå.

The programme has been focusing on multi-disciplinary research studies in priority areas such as reproductive health, healthcare for elderly people, tuberculosis and gender, healthcare utilisation, equity in health, accident and injury, epidemiology of malaria, private health sector reform, rational drug use and perinatal mortality.

The key unit in the project is the Epidemiological Field Laboratory of Bavi (FilaBavi). At present, activities related to 14 groups are supported. Ten PhD students were active, of which three presented their PhD thesis in 2006. In addition, nine students were in the process of registering as PhD students, and training at master's level was provided as well as support to four postdoctoral students.

The research findings have been useful to health planners and policymakers at both local and central levels. New policies and strategies have been proposed and implemented by the Ministry of Health where the programme has assisted with information and helped develop recommendations in several key areas such as user fees, health insurance, and equity in healthcare. The programme has a special impact different from others, in that it is involved in directly improving living conditions.

The programme on pathogenesis, diagnosis, epidemiology and treatment of common diseases started in 2000 and has the aim to modernise bio-medical research in Vietnam in selected fields of public health importance. The programme is run by the Hanoi Medical University in collaboration with Karolinska Institutet. The programme comprises six projects: pharmacology of diabetes, H. pylori and E. coli, Epstein Barr virus related to cancer, rheumatology, and public health aspects of suicide. A total of 14 PhD students were active in 2006, of which three presented their PhD thesis. In addition,

postdoctoral activities were funded for 14 students. The research results are directly applied to examination, diagnosis, and monitoring, which brings immediate benefit to patients. The research cooperation programme funded by the Swedish Government is considered a standard model for the build-up of other international cooperation at Hanoi Medical University.

Thematic Research Cooperation

Health is a strong indicator of welfare. It is no coincidence that three of the eight internationally adopted Millennium Development Goals relate to health. Several diseases are caused by or aggravated by poverty. Populations hit by ill health are also weakened in their capacity to combat poverty. The relationship between health and economics has been clearly demonstrated.

Sida is involved in health research in areas closely related in the fight against poverty and in efforts to address the Millennium Development Goals through its support to regional and international organisations. These organisations may be linked to the UN system (WHO) or have a broad-based constituency in other ways. They contribute to the creation of global public good in their respective fields of research and provide an overview of ongoing research. They identify under-researched knowledge gaps and channel support for addressing such issues. Normally, Sida contributes in the form of core funding to an agreed research agenda.

The following principles guide Sida in its funding for health research: it should promote capacity building for research in low-income countries and linkages between national and international research; it should address the major health problems of low-income countries, focus on prevention, and promote equity in health and ethical conduct of health research.

Sida's support to health research focuses on the following main areas: tropical and other infectious diseases; vaccine research; HIV/AIDS; sexual and reproductive health and rights; child health; health systems research and organisation of health research. The main areas are supported through bilateral and regional programmes as well as through international thematic programmes.

WHO research activities (SEK 55 million)

The purpose of Swedish contribution to research activities within the World Health Organisation (WHO) is to increase the opportunities of the organisation to maintain contact with relevant research of importance to the advisory and normative functions of WHO, and in particular, of importance to improving the health of poor and disadvantaged groups.

The aim is also to support the promotion of research in neglected areas and the identification of knowledge gaps, as well as provide support to individual research training opportunities, and involvement in specific and neglected multi-country research activities.

The contribution is channelled as open support to research programmes. The majority of support is directed at special research programmes on tropical diseases and reproductive health. A minor portion of the Swedish contribution to research activities is directed at the initiative for vaccine research, and research activities in technical programmes for child and adolescent health,

non-communicable diseases, and research policy and coordination.

Several research findings were achieved in 2006. For instance, the tropical disease research programme successfully coordinated the testing of a simple rapid identification procedure of communities with loaloa (eye worm) infelicity, which is important to identify in order to avoid severe adverse reactions to ivermectin treatment of onchocerciasis (river blindness).

Furthermore, the reproductive health research programme successfully promoted, coordinated and supported research on how to best utilise the prostaglandin Misoprostol which now is known to be one of the most important lifesaving drugs in obstetrics and gynaecology thanks to its effectiveness in situations such as uterus evacuation for various medical reasons, including missed abortion, incomplete abortion, and for labour induction and post-partum haemorrhage.

Research activities at WHO have gradually increased over the last decades. However, apart from the special research programmes, there has been no comprehensive overview of research activities within WHO. In addition, it has been unclear what role WHO wants to play in research and how WHO wants to organise and manage research.

Therefore, Sida initiated and supported an overview study of research functions at WHO. This overview study served as the basis for the resolution on "The Role and Responsibility of WHO in Health Research" at the 59th World Health Assembly in 2006. In relation to this resolution, Sida proposed a strategy on the management and organisation of research within WHO to the World Health Assembly. The idea of a strategy started to receive support from both WHO and member states in 2006.

Sida has also successfully contributed to the Swedish policy dialogue with WHO within the area of sexual and reproductive health. For some years, WHO has not paid necessary attention to sexual and reproductive matters, partly as a cause of the influence from conservative member states. WHO has, for instance, refused to publish a report from the research programme on reproductive health on preventing unsafe abortion. Therefore, Sweden released an official statement during the 117th Executive Board meeting in 2006 which emphasised that WHO did not give appropriate attention to these issues. After the statement, the Director General made official apologies, but the report had to be published outside WHO.

The Alliance for Health Policy and Systems Research was initially a separate initiative under the Global Forum for Health Research to which Sida has been instrumental and a faithful supporter. One purpose of the Global Forum has been to fill the global gap but also to put pressure on WHO to take the responsibility in the area of global research issues (see below). In 2006, the Alliance was formally included under WHO as a partnership programme, partly as a result of the Mexico City Ministerial Conference on Health Research in 2004. The overall aim of the Alliance is to promote health policy and systems research as a tool for improved decision making.

Activities in 2006 included the synthesis and improved availability of health policy and systems research, and support to the strengthening of capacity of

developing countries to generate and utilise research. In addition, the Alliance strengthened methodologies for research and dissemination, and tested approaches to make evidence available to decision makers.

Council on Health Research for Development (SEK 3 million) **and the Global Forum for Health Research** (SEK 3 million)

The Council on Health Research for Development (COHRED) and the Global Forum for Health Research are international organisations located in Geneva. The main task of COHRED has been to promote, facilitate and evaluate the development of national health research in developing countries as well as promote an increased active participation of the south in global health research contexts. The core activity of Global Forum is the yearly Forum meetings. The Global Forum also conducts analytical work of relevance such as monitoring resource flows on health research.

The idea behind both COHRED and the Global Forum was to fill the gaps in areas not shouldered by WHO, and at the same time put pressure on WHO to take care of research issues and proposals that received a weak response. As health research activities are now shouldered by initiatives such as COHRED and the Global Forum, WHO has become increasingly interested in the area of health research in recent years.

At the same time, Sida does not yet consider research to be a centrally placed issue for WHO and the strategy on how to organise research within WHO is still pending. Thus, the mission for COHRED and the Global Forum still remain valid. Furthermore, the activities of COHRED and the Global Forum are increasingly overlapping. Sida has therefore given final grants to COHRED and the Global Forum 2005-06 as separate organisations with the implicit suggestion to elaborate on a potential merger. Discussions on merging the two organisations have been initiated and Sida may consider continued support once a joint organisation is established.

Important accomplishments of COHRED in 2006 include policy briefs and working papers, such as National Health Research Systems Development: Perspectives from Cameroon, Central Asia, China, Gulf Cooperation Council States, Laos, Trinidad and Tobago, and Vietnam as well as Poverty Reduction Strategy Papers: Review of the Health Research Perspective of the 49 Existing Preps. COHRED also contributed to one chapter of Global Health Watch, the "alternative" world health report. The Global Forum arranged for the Forum 10 meeting in Cairo where several donor meetings were arranged to discuss how greater donor harmonisation and alignment to national priorities in line with the Paris agenda can be achieved in the area of health research. In relation to this meeting, the Global Forum publication Monitoring Financial Flows for Health Research 2006 was launched.

EDCTP (SEK 10 million)

The European and Developing Countries Clinical Trials Partnership (EDCTP) is a partnership between 14 EU countries, Switzerland and Norway on the one hand, and African countries on the other. It aims to join relevant European

national research programmes and their African partnerships to develop new clinical tools against AIDS, malaria and tuberculosis (TB). The European Commission (EC) is co-funding this joint programme.

The mission is to accelerate the development of new or improved drugs and vaccines against these diseases, with a focus on phase II and III clinical trials as well as on sub-Saharan Africa. Research and training activities support clinical trials and strengthen research capacities in the developing countries. Performing clinical trials takes laboratory-based research to the next stage of testing in the human host. Clinical trials are expensive and adequate achievement, requires concerted efforts of several countries and organisations.

Waiting for industry to take the initiative has not proven to be a viable alternative. EDCTP has initiated and continued support to several clinical trial projects in 2006. These have been in the areas of AIDS, including mother-to-child transmission (MTCT) and microbicides, tuberculosis, including vaccine trials and interaction with anti-retroviral treatment (ARV), and malaria drug trials.

In addition, in conjunction with WHO, numerous training and capacity-building activities have been carried out in African countries. These focused on strengthening regulatory capacity through health and bioethics workshops, fellowships and PhD training.

INDEPTH (SEK 4.5 million)

The International Network of Demographic Evaluation of Populations and Their Health (INDEPTH) in developing countries currently comprises 39 Demographic Surveillance Sites (DSS) in developing countries that collect large data sets on population demographic parameters in a longitudinal manner. INDEPTH has a vision to harness the collective potential of these sites in order to provide a better empirical understanding of health and social issues and apply this understanding to alleviate the most severe health and social deterioration.

The Network is growing and has representation from 19 countries in Africa, south-east Asia and Latin America, and covers a wide range of health areas including HIV/AIDS, malaria, TB, other infectious diseases, maternal health, sexual and reproductive health, non-communicable diseases, migration, health systems research, behavioural and socio-economic research, adult health and aging. The network is generating large quantities of highly relevant data to underpin novel health policies and strategies. The data is being taken up and used by local policymakers to an increasing extent.

International Vaccine Institute (SEK 3 million)

The International Vaccine Institute (IVI) is an international training and research institute located in Seoul, in the Republic of Korea. Its mission is to contribute to the reduction of disease caused by vaccine-preventable diseases in developing countries by collaborative research to generate the evidence needed for rational introduction of new vaccines. The evidence is generated through programmes of basic and applied laboratory research, product development, training and technical assistance.

IVI gives priority to vaccines against two diseases: diarrhoeal diseases, such as cholera, shigellosis and typhoid, enterotoxigenic Escherichia coli and

rotavirus, and respiratory diseases, such as bacterial meningitis, pneumonia and Haemophilus influenzae. These two groups of diseases contribute to five million deaths globally every year, of which the majority are children. Thus, the activities of IVI clearly relate to achieving MDG 4. Japanese encephalitis and dengue are also included in their portfolio.

Important accomplishments in 2006 include the finalisation and publication of a population-based surveillance study of over 600,000 people of all ages living in low-income study sites in six Asian countries. Shigellosis was found to be more widespread among poor populations in Asia than previously thought. For instance, children under five years of age were found to be six times more prone to infection. Furthermore, a disease burden study coordinated by the IVI found that 70 percent of all strains of Shigellosis were resistant to the most common antibiotics.

ICDDR,B (SEK 14 million)

The Centre for Health and Population Research (ICDDR,B) is an international research and training institute located in Bangladesh. Its mission is to develop and promote realistic solutions to the major health, population and nutrition problems facing the poor people in Bangladesh and in other settings.

As of 1 July 2006, ICDDR,B no longer certifies compliance with the USA Mexico City Policy or the Trafficking Policy. As a result of this decision, ICDDR,B no longer receives funding for many of its projects that were previously supported by USAID. Respecting ICDDR,B's decision to not abide by conservative policies preventing the Centre from doing research on issues related to abortions and prostitution, Sida decided to increase the Swedish funding level to the Centre in 2006.

Important accomplishments in 2006 include research on an oral rehydration solution. Over a period of 25 years, one formula for an oral rehydration solution as treatment for patients with diarrhoea has been recommended by WHO and UNICEF. Despite great success, research for an improved formula has continued. In 2002, WHO and UNICEF recommended a reduced osmolarity and indicated that the new proposed formula should be monitored for safety. A hospital-based phase 4 trial in developing countries has now concluded that the risk of symptoms associated with hyponatremia after treatment with the new reduced osmolarity formula is minimal.

International health-related research on HIV and AIDS (SEK 32.4 million)

A functional vaccine or microbicide would strongly contribute to decreasing the AIDS incidence. Sida increased its support to basic frontline research on AIDS in 2006 to intensify research and development of preventive tools such as vaccines – more specifically, identifying new ways on how to best construct preventive and treatment tools, such as vaccines and microbicides, medicines, and how to best utilise them.

Long-term support brought about interesting results in 2006. For instance, a vaccine candidate proved to be surprisingly efficient in activating the immune system to a much higher extent than other candidates. In addition, the candidate did not give any side effects. The project, possible due to sufficient

research capacity in Tanzania as a result of longstanding support to bilateral research collaboration, is based on a unique collaboration between researchers in Tanzania and Sweden. The project plans to test if the candidate is protective against transmission in Tanzania.

Other interesting projects include studying the development of resistance against anti-retroviral medicines, and coming up with ways of how to best prevent mother-to-child transmission, how to best construct microbicides, and how to handle sexually transmittable infections. In previous years, support to health-related research focused on biomedical research. In 2006, support was extended to include research on public health and health systems aspects.

Regional Support – Africa

Medical faculty network in eastern and southern Africa (SEK 0.2 million)

Sida has supported health-related research and research capacity build-up at medical faculties in Ethiopia, Rwanda, Tanzania, Uganda and Mozambique for a number of years. To improve future support to medical faculties in eastern and southern Africa, Sida initiated a process whereby representatives from the faculties are being provided the opportunity to meet and discuss the current situation, analyse common problems and needs for health research at national and regional levels, discuss possible forms for collaboration, and develop a concrete strategy for support.

In a series of three meetings that were held in Stockholm and in the region, representatives from the medical faculties agreed on the purpose and agenda of the network. In 2002, a term of reference for self-assessment was agreed on and a subsequent assessment of needs and desires was performed by the individual faculties. Self-assessments were then presented and discussed later that year.

In addition, action plans for the separate faculties were written, and serve as a background document for continued Sida support. In 2005, five recommendations for the network were agreed on, with each recommendation to be addressed by one specific faculty. The five recommendations were as follows: strengthening medical faculties for capacity building, improving research administration, exchanging experiences and knowledge for seminars and conferences, improving research supervision, and improving bioethics. Progress on the five recommendations and concrete action plans were presented in 2006. A memorandum of understanding was also presented for signing.

Research on children in Africa (SEK 19 million)

Sida supported representatives from African countries in their participation in the Colloquium on the Status of Child Research in sub-Saharan Africa that was held in Dakar, Senegal in November 2006. The colloquium was arranged by the Council for the Development of Social Science Research in Africa (CODESRIA) and Childwatch International Research Network, in collaboration with The Child and Youth Research and Training Program at the University of the Western Cape, the Children's Institute at the University of Cape Town and Kenyatta University.

The colloquium facilitated a dialogue among researchers, policymakers and practitioners. Its aim was to contribute to more relevant and accessible child research for governments and organisations working towards the realisation of children's rights and well-being. To achieve this, finding more effective ways of increasing the child research capacity in the region and promoting greater involvement between policymakers and researchers is necessary.

The objectives were to query the current child research capacity in the region, demonstrate the potential of African research especially for promoting children's rights through policies and practice, work towards closing the research-to-policy/practice gap, and establish a more permanent forum for linking research and policy development.

Network for research on sexual and reproductive health in southern and eastern Africa (SEK 0.31 million)

Sida supports African research in the area of sexual and reproductive health, through bilateral research collaboration with Sweden (see below). There are rational reasons for believing that national efforts could be complemented by regional initiatives, since the countries in the region have common needs and problems. Sida continued its efforts in 2006 to see how to best support regional activities.

A part of this effort was to invite African researchers and Swedish collaborating partners to a seminar in order to outline needs for improving research and to discuss how national efforts could be complemented by regional activities.

The researchers underlined several common problems such as an extensive workload, weak infrastructure and poor career incentives. They expressed the need for improved leadership and skills, research management and research utilisation. Several areas for improvement were identified.

The researchers also underlined the potential for regional collaboration as well as the importance of building capacity at the national level. It was emphasised that regional networks shall build on the existing capacity at the national level. Added values of regional activities were identified to be facilitation of networking, improvement in research skills, international exposure and broadening of the scientific basis for research. Seminar participants were invited to submit an application for support to regional activities.

Regional Support – Central America

NeTropica

At a certain level of development, a regional funding mechanism –in the form of a functional research council for objective and peer-reviewed grant disbursement – would retain researchers in developing countries and stimulate the development of regional and national research capacity. In addition, it would be a complement to national structures, in particular when health problems are common in a region and when the national basis for research project applications is too limited for genuine competition. However, experience on how to operate such regional research councils in the best way is limited in developing countries.

The regional network for research and training in tropical diseases in Central America (NeTropica), which has gradually evolved from being a research training programme in Sweden, is today such a regional research council-like body, with the capacity and knowledge to handle a peer-reviewed open call for research funding in Central America. A number of research grants were disbursed to regional projects in 2006. The regional research projects served as an academic environment for young researchers with the possibility to receive scientific mentorship. NeTropica also arranged seminars and workshops during the year.

Several interesting scientific projects were funded in 2006. For instance, one project identified that the snake venom from vipers has bactericidal effects on both Salmonella and Staphylococcus bacteria. Physiological mechanisms are being identified and the project may lead to new anti-bacterial drugs. Another project identified the extent of penicillin-resistance of nasopharyngeal bacteria in children in Nicaragua.

Swedish Development Research (SEK 25.875 Million)

The Council for Swedish Development Research funds researchers at Swedish institutions in the area of global development. The aim is to establish and maintain a knowledge base of relevance to development issues as well as build capacity for developing country research in Sweden.

All applications are reviewed by a committee comprising scientists in relevant fields. The funding of 67 proposals was approved in 2006 – encompassing support to projects, PhD students, a few networks and institutions. The majority of applications concerned communicable diseases, including HIV/AIDS. Another large area was sexual and reproductive health and rights. An area with an increased number of applications was non-communicable diseases. Of all proposals granted, 50 percent were from Karolinska Institutet (including the Swedish Institute of Infectious Disease Control) followed by Uppsala University (22 percent) and Göteborg University (10 percent).

In a thesis presented at Uppsala University, the uptake of the national Prevention of Mother-to-Child Transmission of HIV programmes (PMTCT) in South Africa was assessed. The findings highlight the low uptake of PMTCT interventions and inappropriate infant feeding choices. The experience of women with HIV provide an important insight into the difficulties of implementing WHO/UNICEF HIV and infant feeding recommendations in real settings, where rates of HIV disclosure are low and mixed feeding is the norm. Interventions to improve infant feeding need to include improving the quality of counselling and support provided by health workers, with more structured assessments used to guide infant feeding choices.

The lion's share of health interventions in Swedish humanitarian assistance is support that saves lives and alleviates suffering, thus focusing on interventions that immediately decrease mortality and morbidity that result from an onset event. What follows is a rather exhaustive account of an attempt to put some meat on the bone by highlighting some discrete interventions. Many different interventions appear under this heading, ranging from directly saving lives and alleviating suffering to the more indirect work of capacity building.

WHO

In the latter category, we find support to WHO's Health Action in Crises (HAC) programme (with Swedish contribution amounting to SEK 10 million a year). This three-year programme was borne out of the insights that WHO needed to strengthen its capacity to provide guidance for consistent and predictable response to health aspects of humanitarian crises. Thus, it aims at strengthening the crisis competence within WHO, making sufficient resources for immediate and effective responses available and concrete, and ensuring predictable support to countries for crisis preparedness, response and recovery.

A mid-term evaluation, well into the second year of implementation, was carried out in 2006. On a positive note, it was concluded that WHO/HAC made notable achievements in taking on a stronger and more leading role in recent acute onset emergencies and that the capacity in general has improved and is on track with the work plan.

WHO also channels support directly, touching upon secondary beneficiaries. In response to the earthquake in Pakistan in October 2005, Sida contributed SEK 15 million for emergency activities that were implemented over one year. The support went to emergency medicine, medical equipment, clinical expertise and endeavours to control and combat epidemics.

Furthermore, in response to the earthquake in Yogyakarta in May 2006, Sida contributed to WHO's work. A SEK 3 million contribution went to coordinating the response to the disaster, and the following objectives: coordination and monitoring of the local health situation, evaluation of the response to the earthquake, establishment of a local early warning and response system for communicable diseases, strengthening of information and supply management to address local emergency and rehabilitation needs, and facilitation of emergency medical aid and preventative and rehabilitative services.

International Red Cross and Red Crescent Societies and the International Committee of the Red Cross (ICRC)

This is a substantial channel for Sida. Through the Swedish Red Cross, approximately SEK 70 million was channelled to the International Red Cross and Red Crescent Societies in 2006. The funds went to IFRC and national Red Cross Societies throughout the world. The contribution was used to combat malaria, polio, measles and TB, and to roll back HIV and AIDS, with a particular focus on Africa.

Sida also supported ICRC health interventions around the world. ICRC deals mainly with emergency surgery and primary healthcare in emergency situations. The joint ICRC-Swedish Red Cross health-related work in Sri Lanka, Abkhazia and Ethiopia benefited from Sida support as well.

Médecins sans Frontières

Médecins sans Frontières (MSF) is actually the 10th largest channel for Swedish humanitarian assistance (more than SEK 50 million in 2006) and the main International Non-Governmental Organisation (INGO) channel. A number of MSF interventions received Sida funding in 2006: DRC (emergency health assistance to the population in Katanga and an HIV/AIDS project for commercial sex workers in Kinshasa); Sudan (emergency health care in Darfur); and India (basic health care for Internally Displaced Persons (IDPs) in Assam).

In addition, MSF is a partner within the 'smaller humanitarian frame' for Sida; that is, certain organisations have a framework agreement that enables a swift response in the event of sudden onset needs. This means that within 24 hours of a request, Sida will enable the use of the funds pre-disbursed to the organisation. This aid modality enabled MSF to respond in Ethiopia, Kenya and Niger in 2006.

Primary Health Care for Internally Displaced Persons in Khartoum State (Medair)

The contribution of SEK 1.643 million to Medair is of utmost importance as it is the only health actor with access in the area. The project aims to improve the health status of 25,000 Internally Displace Persons (IDPs) targeted in Khartoum State, mitigate the effects of re-location or disease outbreaks and an appropriate response to return. The IDPs are exposed to poverty-related diseases including diarrhoeal diseases, respiratory infections, malaria, anaemia, skin diseases and STIs. Medair runs a clinic in the Omdurman El Salaam camp and has a mobile clinic and community health promoters that serve 25,000 beneficiaries. Results as of June 2006: medical assistant consultations numbered 2,080 a month; 1,600 children were vaccinated through the EPI programme; an average of 375 women a month received tetanus immunisation and malaria prophylaxis in the antenatal clinic; 73 percent of the births in the target area received birth assistance at home by trained traditional birth attendants; community health promoters visited every household approximately once every two to three months, lecturing on health and promoting good hygiene.

Examples of Health Projects/ Programmes in Budget Line 2006

Peru

The project is an effort to recreate a common and efficient intervention model to confront Sexually Transmitted Diseases (STI), HIV, and problems particular to teenagers and young people. The project's results are linked to our mission, which is to empower teens and young people through formative activities in order to promote civic participation and the respect for their rights and duties, aiming for the development of a healthy and safe and healthy life Activities include street theatre and workshops.

Afghanistan

The Hazarajat Community Health Project, located in the remote mountainous region of Afghanistan, concentrates on four areas: community health worker training, community development activities, basic health-care services in village-based, nurse-run clinics, and comprehensive health services in a central hospital/clinic.

To support these services, the project trains local nationals in health education, community development and nursing, with the goal of improving the holistic health and livelihood of many families in the communities of the Lal-Wa-Sarejangal district. Target groups include patients receiving care at the CHC/RC 2, community health workers and communities receiving health education, advice or treatment, and water and sanitation services.

Iraq

The Helena Centre for Handicapped Children is a project that aims to expand the provision of a comprehensive service to disabled children in order to prevent loss of mobility and function as well as facilitate the children's development to full potential.

Comprehensive services for disabled children are being carried out in Erbil, Suleimania, and Dohuk and will be expanded to the Kirkuk and Mosul Health Departments. Target groups include children 0 to six years of age and some adolescents as well as 24 health staff members selected from the health authorities in Kirkuk and Mosul region. It is hoped that a more precise target group analysis will be available once the initial survey is completed.

Mali

The main goal of this programme is to improve the living conditions of the Segou population by building capacities in literacy, health practices (including HIV/AIDS and risks with feminine genital mutilation), civic responsibility and organisations for problem solving. Village committees have been established to take part in the planning and organisation of educational activities. The objective is literacy training, health education, and organisational development.

APPENDIX I: Total health disbursement all countries and global programmes 2000–2006

Countries with 2006 disbursements of more than SEK 1 million included.

COUNTRY	2000	2001	2002	2003	2004	2005	2006
Global	264 342 445	396 350 388	220 918 046	238 822 101	268 870 249	424 048 883	387 841 172
Zambia	72 659 559	62 603 234	70 431 400	63 438 762	95 866 223	69 716 341	153 365 643
Bangladesh	94 711 345	46 219 926	57 604 818	52 814 986	64 607 788	22 532 424	108 068 343
Reg South of Sahara	16 285 196	4 947 435	3 942 792	17 965 732	66 167 624	77 583 992	107 375 092
Tanzania	16 208 940	7 490 619	30 873 288	21 754 639	41 386 459	55 487 300	94 355 917
Uganda	44 176 921	60 730 705	18 141 951	64 199 478	88 708 236	90 203 214	86 153 388
Palestinian Administrated Area	23 306 012	21 336 763	65 763 038	70 650 682	68 751 288	23 199 549	73 905 169
Malawi	3 582 917	16 354 000	34 750 076	43 256 934	50 962 691	55 911 214	68 213 803
Reg Africa	40 936 141	79 917 363	68 678 857	68 010 670	52 619 986	54 182 478	58 751 616
Nicaragua	34 205 682	25 521 203	28 824 914	46 301 140	46 827 574	58 665 876	55 626 349
Reg South Africa	1 245 663	5 806 106	13 512 690	17 508 455	25 853 403	43 880 417	52 595 622
Kenya	13 201 377	18 745 598	16 999 006	22 786 659	44 014 408	52 259 705	44 278 368
Reg North Western Russia	1 135 908	2 651 033	2 918 731	1 684 047	36 375 888	39 673 906	41 801 000
Mali	645 400	438 695	444 523	348 248	121 008	35 236 694	35 133 790
Ethiopia	18 530 608	6 224 015	10 880 825	9 396 351	15 672 587	37 207 099	34 130 515
Mozambique	3 369 769	2 388 009	2 058 556	11 028 894	14 447 623	25 023 597	33 263 179
India	55 931 689	10 354 676	8 161 052	20 912 583	12 012 067	20 050 973	32 736 964
Viet Nam	36 136 910	63 765 106	27 424 387	28 553 810	28 508 695	39 469 567	31 065 787
South Africa	16 834 046	7 118 485	5 200 842	11 788 245	21 331 974	32 337 600	27 135 500
Reg Central America	16 179 817	30 508 008	14 743 982	16 537 739	28 377 083	32 353 690	24 556 894
Ukraine	246 648	500 040	5 812 608	3 564 814	5 897 276	4 076 639	23 241 497
Burkina Faso	313 144	45 646	560 287	12 895 803	19 117 298	23 962 166	22 268 607
Zimbabwe	16 568 191	11 339 281	11 524 870	15 653 408	15 910 165	38 061 527	21 572 569
Kyrgyzstan	0	205 998	1 702 866	982 521	950 912	2 807 837	21 186 163
Guatemala	16 092 501	15 757 514	12 011 493	13 718 652	6 912 117	2 704 738	20 961 232
Angola	37 390 832	29 945 308	28 258 880	18 761 894	16 117 715	27 849 911	19 540 053
Honduras	12 573 081	16 196 070	19 321 207	12 301 013	24 545 215	10 618 028	18 899 537
China	23 742 346	26 059 865	4 270 762	1 933 914	15 562 227	14 694 999	17 052 648
Afghanistan	5 179 499	1 190 150	3 537 770	22 427 451	11 824 697	2 076 620	15 880 445

COUNTRY	2000	2001	2002	2003	2004	2005	2006
Tajikistan	0	0	0	700 000	600 000	987 295	14 844 383
Moldova	4 000 000	1 967 180	13 423 736	6 105 791	4 836 387	33 562 369	14 394 640
Albania	0	5 800 037	5 257 370	9 420 886	3 766 763	8 372 045	12 792 294
Reg Asia	14 638 449	14 448 525	11 209 873	6 781 556	3 404 063	52 660 871	12 589 734
Reg West Africa	0	0	0	191 644	-10 011	632 772	12 446 935
Belarus	185 825	167 673	2 008 166	917 298	11 484 448	8 163 073	9 144 548
Namibia	5 851 214	6 043 133	7 387 353	6 976 770	6 877 439	5 661 466	9 069 898
Moscow	687 115	455 435	961 049	-101 096	13 000 000	2 984 927	8 825 958
Botswana	2 151 904	2 510 327	3 454 811	3 092 818	2 053 890	1 935 898	8 640 027
Reg Southeast Asia	3 556 227	15 055 000	950 892	9 507 717	16 071 071	6 454 352	6 220 611
Uzbekistan	379 500	-22 363	135	71 478	147 293	6 056 448	6 059 173
Bolivia	21 584 586	33 013 150	6 948 843	3 674 935	5 128 659	1 927 912	5 864 226
Croatia	350 000	1 216 250	2 033 677	3 904 684	1 500 000	600 000	5 508 652
Reg Eastern Africa	3 250 000	5 341 000	2 838 013	115 714	2 349 378	3 825 348	5 022 906
St Petersburg	834 837	677 821	524 735	1 221 824	3 072 623	1 991 439	4 683 394
Murmansk region	2 873 571	1 644 214	2 742 954	1 640 162	2 986 908	3 797 584	3 434 334
Kaukasus,Central Asia,Moldova	0	0	1 386 760	367 804	160 481	3 059 804	3 335 398
Serbia & Montenegro	0	0	92 400	0	32 560	1 859 163	3 100 000
Bosnia-Herzegovina	10 092 500	9 228 586	2 531 004	4 858 020	2 111 575	1 867 362	3 045 228
Macedonia	28 400	0	221 200	2 181 026	1 684 976	1 881 370	2 407 830
Reg South Asia	0	0	444 415	1 768 693	1 602 134	2 312 828	2 295 433
Other Russia	1 267 809	5 326 574	939 273	3 110 422	2 990 167	2 869 640	2 103 602
Reg Lake Victoria	0	0	0	0	38 943	10 188 087	1 993 659
Carelia	1 847 756	223 449	475 792	1 203 410	1 670 472	3 011 783	1 915 356
Brazil	3 045 275	2 587 363	2 379 476	2 074 718	1 676 071	1 765 966	1 718 454
Laos	6 218 264	5 083 791	9 191 057	2 811 643	106 227	591 728	1 712 074
Kosovo	0	5 835 345	1 812 402	2 860 643	88 770	978 160	1 547 104
Reg South America	1 000 000	1 000 000	1 000 000	57 857	2 114 133	3 639 303	1 343 886
Total	969 575 819	1 088 313 729	869 489 903	1 005 516 042	1 279 865 896	1 589 515 977	1 897 016 599

APPENDIX II: Sector distribution

Two classificiation systems compared

HEALTH DIVISION SECTOR	SIDA STATISTICS SECTOR
Health Systems	12110 Health policy and admin. 12191 Medical services 12220 Basic healthcare 12230 Basic health infrastructure 12261 Health education 12281 Health personnel development
Infectious disease control	12250 Infectious disease control
SRHR	13020 Reproductive healthcare 13010 Population policy and admin
HIV/AIDS	16064 Social mitigation of HIV/AIDS 13040 STD control incl HIV/AIDS
Public Health	12240 Basic nutrition 16063 Narcotics control
Social/welfare services	16010 Social/welfare services

In this document we have combined the Sida statistical classification in six groups that better reflect and correspond with our priorities. In the table below the relationship between the two classification systems is seen, and in the second table the disbursements according to Sida statistics sector are shown.

Disbursements according to Sida statistical sector classification

SECTOR	2000	2001	2002	2003	2004	2005	2006
12110 Health policy and admin.	250 920 911	339 255 926	338 133 718	301 559 296	325 438 508	253 718 642	236 488 197
12191 Medical services	99 621 262	118 726 642	82 018 883	81 898 047	62 254 578	43 306 034	30 552 934
12220 Basic healthcare	457 333 679	230 047 016	200 397 897	230 559 542	263 770 726	327 343 645	481 943 483
12230 Basic health infrastructure	25 026 912	30 278 983	6 467 693	5 043 852	1 568 278	5 461 620	8 041 797
12240 Basic nutrition	13 545 998	7 483 324	7 792 828	6 030 919	4 765 528	4 400 132	5 438 243
12250 Infectious disease control	0	0	400 000	1 000 000	39 000 000	117 773 583	202 449 135
12261 Health education	900 000	3 243 200	5 236 794	6 521 414	4 770 952	19 146 539	13 330 573
12281 Health personnel development	6 904 331	11 771 020	4 769 875	7 634 685	12 556 700	10 767 238	6 548 878
13010 Population policy and admin	5 675 628	4 337 723	4 305 646	12 887 699	4 729 960	8 999 995	8 342 753
13020 Reproductive healthcare	69 541 485	61 764 405	47 666 621	47 434 299	138 798 472	261 613 865	218 338 728
13040 STD control incl HIV/AIDS	199 764 350	379 868 474	222 248 226	285 524 592	351 323 503	467 244 866	494 293 840
16010 Social/welfare services	67 897 664	56 041 633	95 958 108	146 208 964	103 276 766	53 158 048	99 842 453
16063 Narcotics control	1 300 000	0	207 949	1 476 718	3 021 203	6 922 109	6 867 519
16064 Social mitigation of HIV/AIDS	0	0	5 692 000	10 862 983	53 140 402	71 825 290	99 724 881
Total	1 198 432 220	1 242 818 345	1 021 296 239	1 144 643 011	1 368 415 575	1 651 681 606	1 912 203 413

APPENDIX III: Sida health cooperation by department

DEPARTMENT	2000	2001	2002	2003	2004	2005	2006
AFRA	1 159 476	21 465 597	67 359 528	98 902 358	161 608 482	217 361 444	282 702 494
ASIA	827 399	110 000	40 000 000	450 000	0	0	-800 000
DESO	305 218 605	523 710 761	278 050 823	369 954 920	438 595 104	679 980 916	646 239 167
EUROPÉ	112 209 941	104 176 723	107 084 589	45 357 362	64 600 582	71 000 558	77 120 978
INEC	31 550 473	27 779 005	6 412 704	6 004 324	17 130 311	16 945 414	23 502 302
PEO	14 804 571	17 856 143	15 704 191	14 074 013	13 371 244	12 345 933	17 083 622
POLICY/METHOD	0	0	1 190 000	959 590	769 080	0	0
RELA	8 953 733	10 054 439	12 753 999	9 047 358	8 820 865	10 354 143	9 395 694
SAREC	93 717 560	84 299 862	69 535 256	56 270 715	4 525 089	-275 361	0
SEKA	257 262 540	104 180 740	122 176 191	142 012 334	92 621 650	104 235 724	51 034 280
UM AFRICA	163 393 145	180 102 638	176 465 975	219 602 794	342 977 083	404 146 879	501 047 260
UM ASIA	168 049 867	115 336 223	88 704 579	117 019 533	143 164 408	65 755 008	206 311 672
UM LATIN AMERICA	41 284 910	53 351 430	35 858 405	64 987 710	80 231 678	69 830 948	98 565 944
Grand Total	1 198 432 220	1 242 818 345	1 021 296 239	1 144 643 011	1 368 415 575	1 651 681 606	1 912 203 413

Swedish delegated embassies made disbursements of around SEK 800 million in 2006, or 42 percent. Health division disbursed SEK 646 million or 34 percent. The regional departments, primarily Sida's Department for Africa (AFRA) (15 percent) and EUROPE (4 percent) are also responsible for health projects. Support to NGOs through the SEKA department also concerns health.

APPENDIX IV: List of frequently used acronyms

AAU-FM	Faculty of Medicine at Addis Ababa University
ACTED	Agency for Technical Cooperation and Development
ADB	Asian Development Bank
AFEW	AIDS Foundation East-West
AFRA	Sida's Department for Africa
AFSA	AIDS Foundation of South Africa
ALI	Swedish National Institute for Working Life
AMREF	African Medical & Research Foundation
AMRN	African Midwives Research Network
ANARELA	African Network of Religious Leaders Living with or Personally Affected by HIV and AIDS
ANS	National Health Agenda (Guatemala)
AOP	Annual Operation Plan
AP	According to plan
APR	Annual Programme Review
ARASA	AIDS Rights Alliance of Southern Africa
ARROW	Asian-Pacific Resource & Research Centre for Women
ARV	Anti-retroviral treatment
ASRHR	Adolescent Sexual and Reproductive Health and Rights
AU	African Union
BSS	Behavioural surveillance surveys
CADRE	Centre for AIDS Development, Research and Evaluation
CAP	Consolidated Appeals Process
CBDAC	Community-based drug abuse control
CBHP	Community and Basic Health Project
CBO	Community-based organisation
CBR	Community Based Rehabilitation Programme (West Bank and Gaza)
CEPRESI	Center for AIDS Education and Prevention
CFP	Country Focal Point
CIDS	Epidemiological Institute for Health Research and Demographic Investigation
CNCS	National AIDS Council of Mozambique
CODESRIA	Development of Social Science Research in Africa
COHRED	Council on Health Research for Development
COMMCA	Central American Commission of Ministers of Women's Affairs
CORHA	Consortium of Reproductive Health Associations
CRDA	Christian Relief & Development Association
CSO	Civil society organisations
CSW	Commercial sex workers
CWM	Clinical waste management
DAC	OECD Development Assistance Committee
DCI	Development Cooperation Ireland
DESO	Sida's Department for Democracy and Social Development
DFID	UK Department for International Development
DOTS	The internationally-recommended TB control strategy
DPT	Diphtheria, Pertussis, Tetanus
DRC	Democratic Republic of Congo
DSO	Drug supply organisation
DSS	Demographic Surveillance Sites
EAC	Expert Advisory Committee on HIV Therapies
EB	Executive board meeting
EC	European Commission
EDCTP	European and Developing Countries Clinical Trials Partnership

EP	Exceeded plans
EPN	Ecumenical Pharmaceutical Network
EQUINET	Equity in health in Southern Africa
ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
ESD	Essential Service Delivery
EVYP	Especially vulnerable young people
FBO	Faith Based Organisation
FCA	Framework Convention Alliance
FCTC	Framework Convention on Tobacco Control
FGM	Female genital mutilation
FHAM	Fund for HIV/AIDS in Myanmar
FIGO	International Federation of Gynecology and Obstetrics
FSW	Female sex workers
GBV	Gender-based violence
GEGA	Global Equity Gauge Alliance
GHD	Good Humanitarian Donorship
GHWA	Global Health Workforce Alliance
GI	Guttmacher Institute
GSM	Global Management System
HAC	Health Action in Crises
HAI	Health Action International
HCS	Hanoi Core Statement
HDPG	Health Development Partner Group
HEPNET	Health Economics and Policy Network in Africa
HNPSP	Health Nutrition and Population Sector Program
HP	Health Policy Unit
HPSD	Health Policy and System Development
HRDI	Human Rights Development Initiative
HRH	Human Resources for Health Plan.
IAVI	International AIDS Vaccine Initiative
ICDDR-B	Centre for Health and Population Research in Bangladesh
ICDP	International Conference on Population and Development
ICM	International Confederation of Midwives
ICMA	International Consortium for Medical Abortion
ICRC	International Committee of the Red Cross
ICRS	International Chemical Reference Substances
ICSW	International Council on Social Welfare
IDP	Internally Displace Person
ID	Injecting Drug User
IEC	Information, Education & Communication
IGSS	International Graduate Student Services
IHAA	International AIDS Alliance
ILO	International Labour Organization
IMCA	International Consortium for Medical Abortion
IMCH	International Maternal and Child Health
IMCI	Integrated Management of Childhood Illnesses
INE	Instituto Nacional de Estadísticas
INGO	International Non-Governmental Organisation
INRUD	International Network for the Rational Use of Drugs
IOM	International Organisation of Migration
IPA	Africa Safe Abortion
IPM	International Partnership for Microbicides

IPPF	International Planned Parenthood Federation
ITS	Illness Transmitted Sexually
IVI	International Vaccine Institute
KFW	German Development Bank
KI	Karolinska Institutet
LACWHN	Latin American and Caribbean Women's Health Network
LFA	Logical framework analysis
M&E	Monitoring and Evaluation tool
MAIS	Integrated Model for Health Attention
MAPS	Medical Academy of Postgraduate Studies
MDG	Millennium Development Goal
MDP	Minor Deviation from Plans
MDR	Multi drug resistant
MFA	Ministry of Foreign Affairs
MINSA	Ministry of Health in Nicaragua
MoH	Ministry of Health
MOHFW	Ministry of Health and Family Welfare
MSA	Management Support Agency
MSF	Médecins sans Frontières
MSH	Management Sciences for Health
MSM	Men who have sex with men
MTCT	Mother-to- child transmission
NACP	National AIDS Control Program
NEWW	Network of East-West Women
NGO	Non-governmental organisation
NHA	National Health Accounts
NHP	National Health Plan
NHSP	National Health Strategic Plan
NHSSP II	Kenya National Health Sector Strategic Plan
NIR	International Council of Swedish Industry
NIWL	Swedish National Institute for Working Life
OCHA	Office for the Coordination of Humanitarian Affairs
OPT	Occupied Palestinian Territories
OSP	Organisational Strengthening Plan
OVCs	Orphans and vulnerable children
PAC	Post-Abortion Care
PADS	Program d'appui de développement sanitaire
PAF	Poverty Assessment Framework
PAHO	Pan-American Health Organisation
PATH	Programme for Appropriate Technology in Health
PFM	Public Finance Management
PHC	Primary Healthcare
PI-E	Pathfinder International-Ethiopia
PITC	Provider Initiated Testing and Counselling
PLHA	People living with HIV/AIDS
PMA	Performance Management Agency
PMRS	Palestinian Medical Relief Society
PMTCT	Prevention of Mother-to-Child Transmission of HIV programmes
PNDS	National Health Development Plan
PPP	Purchasing power parity
PSG	Project Support Group

PSO	Programme Support Office
PSP	Private Sector Programme
PWHA	People living with HIV/AIDS
RATN	Regional AIDS Training Network
REACT	Action on Antibiotic Resistance
REPSSI	Regional Psycho-Social Support Initiative
RFSU	Swedish Association of Sexuality Education
RIHS	Rural Integrated Health Services
RSGS	Gender, Social Development and Civil Society Division
SALGA	South Africa Local Government Association
SAPS	South African Police Services
SAREC	Sida's Department for Research Cooperation
SAT	Southern Africa AIDS Trust
SDC	Swiss Agency for Development and Cooperation
SEEC	East Europe Committee of the Swedish Health Care Community
SETA	South African Education and Training Authority
SHC	Swedish Health Care
SIAFI	Integrated Financial Administration System
SICA	Central American Integration System
SPW	Student Partnership Worldwide
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
SUO	Specialised Umbrella Organisation
SWAP	Sector Wide Approach Process
TA	Technical Assistance
TAG	Technical Advisory Group
TASO	The AIDS Support Organisation
TB	Tuberculosis
TBC	Tuberculosis
UMSA	Universidad Mayor de San Andres
UMSS	Universidad Mayor de San Simon
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	Programme for Adolescent Sexual and Reproductive Health
UN-HABITAT	United Nations Human Settlements Programme
UNICEF	United Nations Children´s Fund
UNIFEM	United Nations Development Fund for Women
UNRISD	United Nations Research Institute for Social Development
UNRWA	United Nations Relief and Works Agency
UPHCP II	Second Urban Primary Health Care Project
VCT	Voluntary Counselling and Testing
WABA	World Alliance for Breastfeeding Action
WAHSA	Work and Health in Southern Africa
WB	World Bank
WHA	World Health Assembly
WHO	World Health Organisation
WHRTI	Women's Human Rights Training Institute
WIEGO	Women in Informal Employment: Globalizing and Organizing
YMEP	Young men as equal partners in Africa
YOFAHE	Youth Friendly Approaches to HIV/AIDS

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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