Sida Evaluation 05/21:1

Turning Policy into Practice: Sida's implemention of the Swedish HIV/AIDS strategy

A Review of Country Strategies and Organisational Arrangements

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List of abbreviations

ADG	Assistant Director General
CA	Country Analysis
CS	Country Strategy
DESO	Department for Democracy and Social Development
DG	Director General
FP	Focal Point
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
HÄLSO	Health Division
HO	Head Office (Sida's Stockholm office)
IFFG	"Investing for Future Generations"
INEC	Department for Infrastructure and Economic Cooperation
MFA	Ministry of Foreign Affairs
NATUR	Department for Natural Resources & Environment
NGO	Non-governmental Organisation
PO	Programme Officer
RA	Result Analysis
SAREC	Department for Research Cooperation
SEKA	Dept for Cooperation with NGOs, Humanitarian Assistance and Conflict Management
UNAIDS	Joint United Nations HIV/AIDS Programme
UTV	Department for Evaluation and Internal Audit

1. Introduction

In 1999, Sweden launched its strategy on HIV/AIDS: "Investing for Future Generations" (IFFG). In 2000, the Department for Evaluation and Internal Audit at Sida (UTV) decided that the implementation of the IFFG should be evaluated. In order to prepare for a future evaluation, a desk study was commissioned to provide a baseline on the situation in relation to HIV/AIDS in Sida's work from 1999.[1]

In 2004, Sida launched the evaluation of IFFG. Part 1 of the evaluation would repeat the baseline study as a comparative desk study, followed by an analysis of possible changes over time since the launch of the IFFG strategy in 1999.

The present desk study focuses mainly on the strategic key documents for the bilateral cooperation, and also discusses the organisation within Sida. More in-depth country case studies will not be included, as that belongs to a different part of the evaluation.

1.1 Background: Addressing HIV/AIDS in Sida

The Situation before 1999

As the "Baseline Study" of 2001 noted, the responsibility for HIV/AIDS work in Sida from mid-1980s to the end of 1990s rested overwhelmingly with the Health Division (HÄLSO). Inside the HÄLSO, one programme officer was assigned to the task, and acted as the knowledge and technical focal point in the entire organisation.

For some years from the last part of 1980s, the Ministry of Foreign Affairs (MFA) gave a special budget line to Sida for allocation to HIV/AIDS projects. However, this special arrangement was phased out after some years in the early 1990s.

Strategic policy papers on HIV/AIDS were not in place at this point. However, HÄLSO had included HIV/AIDS into their "Sexual and Reproductive Health and Rights" strategy and the Department for Research Co-operation (SAREC) developed a research strategy in 1999.[2] At the country/embassy level, health and/or social sector officers would be promoting HIV/AIDS issues. This would happen either as a result of expressed country needs, the special attention or awareness of staff in the country, or other local circumstances. In Zambia, a regional adviser on HIV/AIDS was based. It seems that there was no systematic, centrally directed effort in building capacities neither at Stockholm nor at country level, however.

Despite the fact that there was no group of staff focussing particularly on HIV/AIDS at the head office, substantial project and programme activities took place. (see Lists of Targeted Interventions in 1999, Appendix 4 of Baseline Study 2001). It seems however that up to 1997/98, divisions and departments responsible for planning country support did not emphasize HIV/AIDS work.

The process of developing the IFFG started in 1997. It seems that the pressure for such a coherent and comprehensive policy for Sweden/Sida came very much from the African field. A project group composed of staff from different departments and divisions was created, and it accompanied and steered the process until "Investing for Future Generations" was published in 1999. With the IFFG, HIV/AIDS was given a higher formal status on the agenda for the development co-operation. The IFFG gave a framework for the work on HIV/AIDS, and underlined that AIDS cannot be seen as purely a health issue,

1 Peck, Lennert et al., "HIV/AIDS – Related Support through Sida – A baseline study " (Sida Studies in Evaluation 01/02)

2 SAREC, Sida's Department for Research Co-operation, like the Department for Co-operation with NGOs and Humanitarian Assistance (SEKA) has a special status in the organisation, as they have their own budgets and their work is not directly integrated into the country development co-operation process.

but must be seen as a development issue. HIV/AIDS should therefore be integrated with development co-operation, and interventions should be analysed in relation to HIV/AIDS.

The Situation 1999–2004

After the strategy was launched, a project for implementing the strategy was established at Sida's head office. The HÄLSO division continued its technical work on HIV/AIDS, and focal points for HIV/AIDS were appointed in some divisions and departments. Moreover, staff training seminars on HIV/AIDS with international experts were organised to promote and deepen the understanding of IFFG.

In 2000 an "African HIV/AIDS Team" was established in Southern Africa (first in Harare, then moved to Lusaka, Zambia). The team 'belongs' to the African Department and is financed out of its budget. Its main focus is to give advice to embassies and their focal points, especially on "mainstreaming" of HIV/AIDS in development cooperation.[3]

In order to strengthen the HIV/AIDS competence at the head office, the HIV/AIDS Secretariat at Sida Stockholm was created in July 2002 as a temporary project for three years. The HIV/AIDS Secretariat was placed at DESO, and the head of the secretariat reports to the director of that department. The secretariat cooperates with the focal points (FP) in the different divisions/departments, and is responsible for the FP meetings.

At the same time as the creation of the HIV/AIDS Secretariat at Stockholm, the position of an HIV/AIDS adviser for South Asia in New Delhi was established with responsibilities to support Sida's activities in Bangladesh, India, Sri Lanka and (to a lesser degree) Afghanistan and Myanmar. This position is funded through the Asia Department. A similar position for South-East Asia has been created in 2004 and staff is expected to be in place by early 2005.

1.2 Evaluation of the implementation of the IFFG

The baseline study for the evaluation was carried out in 2001, and it included four different areas:

1. Analysis of country strategy documents from 1999
2. Inventory of interventions targeted to HIV/AIDS
3. Analysis of how HIV/AIDS has been integrated into Sida's general projects and programmes
4. Sida's organisation and methods for working with HIV/AIDS

The baseline study was performed as a desk study reviewing key documents. Four countries were selected for case studies, in which the study team also looked more closely at project documents. In addition to the document reviews, persons in the regional and sector departments of Sida were interviewed.

In the present evaluation, the desk study uses 2003 as the year of comparison, and consists of the same main components as the baseline study, separated into studies of content and organisational structure of Sida's work with HIV/AIDS. The terms of reference state that this part shall do the following:

a) *"Content:* A study of country strategies (no 1 of the baseline study) and programming, including targeted and non-targeted interventions (no 2 and 3 of the baseline study). Underlying questions include: Compared with 1999, what did Sida do in 2003 with regards to the four strategic areas of support stated in IFFG at the various levels of co-operation? In what ways have the preconditions for Sida's work with HIV/AIDS changed since 1999 (e.g. the development of the epidemic, political circumstances, changes of the global agenda)?

3 Further assessment of the role of the African team with regard to promoting/implementing the IFFG will be done as part of the in-depth country study in Zambia.

b) *Organisation and methods:* A study of organisation and working methods (no 4 of the baseline study) providing input to the recommendations for the future organisation of Sida's work with HIV/AIDS which will be developed in part IV. Underlying questions include: How has the internal governance with regards to HIV/AIDS developed since the IFFG strategy? What are the lessons learned? And how could this work be organised in the future? What development of methods has taken place? What kind of capacity building has been provided?"

The criteria used for the selection was to include countries that had produced country strategies in 2003. The initial list of 13 countries underwent some modifications to ensure regional representation, and twelve countries were finally selected; four in Africa, three in Asia, three in Europe and two in Latin America.[4]

Results from a recent desk study on mainstreaming of HIV/AIDS will also be taken into consideration.[5]

1.3 Methodology for this desk study

The study has been primarily a desk study, combined with interviews at the Sida office in Stockholm. The interviews were particularly important for the issues raised in chapter 3 on "Organisational structures to promote HIV/AIDS related issues in Sida".

For each of the countries, the team went through the country analysis, result analysis,[6] country strategy, and also annual or semi-annual reports from the embassies. In the baseline study, a set of questions was used for the analysis. This study was asked to use the same questions, and it has done so with few modifications:[7]

- one question was added, as to whether HIV/AIDS was given priority as a dialogue issue or a cross-cutting issue,
- some questions were added in relation to gender mainstreaming, to be able to see how gender is mainstreamed, as compared to, or in relation with HIV/AIDS.

The countries are in very different situations with regard to the HIV/AIDS epidemic, which will have a direct bearing on the necessity to include HIV/AIDS action in development work. We have therefore also included a brief analysis of the importance of addressing HIV/AIDS in each particular country. In order to allow for comparison between the actual attention given to HIV/AIDS issues in the country strategy and the estimated importance of addressing HIV/AIDS in the prevailing country situation, both the country strategy and the country situation are rated as follows:

a) Mainstreaming score:[8]

0 = no mention of HIV/AIDS in the country strategy

1 = HIV/AIDS is mentioned, but no significant targeted interventions

2 = HIV/AIDS is prominent among the objectives, but not mainstreamed

3 = HIV/AIDS is mainstreamed and integrated in most development work

b) The country score is based on the appreciation of two separate factors:

4 Two of the Asian country strategies (Laos and Vietnam) are more recent than the rest of the sample, as they are from 2004.
5 Lise Munck, "Mainstreaming of HIV/AIDS – What happened in Sida during 2003?", Konsultbyrån Tres, 12 January 2004.
6 For some countries, separate country or result analyses are not available. In such cases, when available, the summary of the analyses in the country strategy was considered.
7 The questions for the analysis and the results can be found in Appendix 3 and 4 respectively
8 Adapted from Munck: "Mainstreaming of HIV/AIDS – What happened in Sida in 2003?", op. cit.

1. How serious was the HIV/AIDS situation in the country (not only concerning the stage of advancement of the epidemic, but also taking the likelihood of a rapid spread into account)?
2. How strong are the links between HIV/AIDS and the sectors in which Sida projects/programmes are considered?

We assigned the following ratings to those two aspects:

Seriousness of HIV/AIDS situation	Link between HIV/AIDS epidemic and sector concerned
0 = low	0 = none
1 = moderate	1 = likely
2 = high	2 = strong

A combined country score between 0 and 3, highlighting the importance of including HIV/AIDS in all the development efforts, is obtained by multiplying the two scores above, as follows:

Combined score

0 for either of both aspects, whatever the other → 0

Seriousness = 1, and link = 1 → 1

Seriousness = 1, and link = 2
Seriousness = 2, and link = 1 } → 2

Seriousness = 2, and link = 2 → 3 (instead of 4, to facilitate comparison with mainstreaming score)

One could say that any development cooperation strategy in a country with a combined score of three, i.e., with a serious HIV/AIDS situation and a strong link between the HIV/AIDS epidemic and cooperation sectors concerned, should definitely have mainstreamed HIV/AIDS issues, while a country for which either factor is zero, and thus has a combined score of zero, would not necessarily need any HIV/AIDS action. To put it in a more simple way, matching figures for both scores would mean that the country strategy in that country does exactly what is needed.

This analysis will also allow us to somehow correct the findings of the January 2004 study, which appeared to us overly severe (see Appendix 6: "Mainstreaming of HIV/AIDS – What happened in Sida in 2003?"). We have also used it to put the evaluation of the twelve country strategies in a more nuanced perspective.

The analysis of the twelve countries will be presented by region, and the result from each region will be discussed in relation to the baseline study. Four countries were included in both studies, and a direct comparison will be made on the basis of them.

It is important to note that this study has not gone back to the documents that were analysed from 1999. There is always room for different interpretations of a set of documents, even when concrete questions are asked. Even though we believe that there have not been major differences in the ways of interpreting, it is still important to read the results with caution: This part of the evaluation only deals with documents, and impressions from documents and reality on the ground may not be the same thing.

The country strategies should be concerned with both analysing HIV/AIDS in relation to the challenges in the country and the ongoing work; and at the same time describe how to do mainstreaming in Sida supported projects. In addition it should describe what kind of interventions to be undertaken in relation to HIV/AIDS.

For the analysis of projects, the team has been given two lists of projects which received support in 2003: one including all projects directly targeted to HIV/AIDS,[9] and the other with projects of which certain components are related to HIV/AIDS. This second list thus contains projects in other sectors than health, which integrate HIV/AIDS in some of their components. A brief analysis of these lists of projects will be done under section four.

For assessment of how Sida organised the HIV/AIDS related work, a questionnaire was sent out to all the focal points. In addition, a number of interviews were conducted with key informants within Sida in Stockholm. These issues are presented in Chapter 3.

2. Attention to HIV/AIDS in the country strategies and accompanying documents.

For each of the countries included in the analysis, the team has been asked to look at three key documents; the country analysis (CA), the result analysis (RA) and the country strategy (CS). The country analysis and result analysis are background documents giving key input to the country strategy, which is the important document that will guide the development cooperation by Sida in a country. For some countries, the team also reviewed country reports and other analyses (such as conflict analysis). Appendix 1 lists the countries that were included in this review, and the documents used in the analysis.

There may be an accidental bias in the current country sample as a majority of the countries are in a state of conflict/civil war or in rebuilding the country in a conflict/post-conflict situation. This is the case in all the Balkan states, in Colombia, Sri Lanka, Somalia and Angola, that is, in seven of the twelve countries. The political and conflict analysis therefore dominates the country documents. Also, in a situation of conflict it is often difficult to obtain good data in relation to HIV/AIDS.

Appendix 4 presents the summary of the analysis, similar to what may be found under Appendix 3 in the 1999 desk study. From an immediate superficial view, one may want to count the number of 'Y' (YES) as positive and 'N' (NO) as negative, but this is too simplistic. In countries with a very low prevalence rate, not all areas are equally important to address at the present stage. In such cases, what we see as required is for the analysis to reflect on the situation, and to conclude that the full range of activities may not be needed at this point, but only limited interventions. That is what the scoring system for the importance of including HIV/AIDS in the development work has tried to highlight.

In most country strategies there is a list of key statistics/data from the country. The guidelines for how to work out a country strategy suggest the data that should be included in such a list, and it is remarkable that the list has no reference to the HIV-situation in the country.

2.1 The HIV/AIDS situation in the countries included in the study.

The HIV-infection rates vary tremendously between the countries and the regions in which they are located. There are also large differences on how well the epidemic is surveyed in the different countries. For the same country there may be different estimates provided by different institutions. Comparison must therefore be done with caution, as the figures are uncertain. It is also important to keep in mind that the epidemic may be very large in certain areas of the country, or among certain groups, and much less in other areas. In countries with many inhabitants, low prevalence rates may still mean very high numbers of persons infected.

9 In fact, the selection criteria for this list was the sector code 2112, i.e. Sexual Health and Rights (SHR), including HIV/AIDS. Almost all of the projects included in this code target HIV/AIDS.

Below is a list of key data on HIV/AIDS for the countries and regions included in this study. All the figures are taken from the 2004 Report on the Global AIDS Epidemic by UNAIDS/WHO.

Table I Estimates on HIV/AIDS from UNAIDS, from end of 2003

Country	People living with HIV	Adult prev. rate	Deaths in adults & children
Angola	240 000	3.9	21 000
Ethiopia	1 500 000	4.4	120 000
Somalia	?	n.a.	n.a.
Zambia	920 000	16.5	89 000
Laos	1 700	0.1	<200
Sri Lanka	3 500	<0.1	<200
Vietnam	220 000	0.4	9 000
Bolivia	4 900	0.1	<500
Colombia	190 000	0.7	3 600
Bosnia-Herzegovina	900	<0.1	n/d
Kosovo (no data)			
Serbia-Montenegro	10 000	0.2	<100
Macedonia	<200	<0.1	<100
Regional data			
Sub-Sah. Africa	25 000 000	7.5	2 200 000
South & South-East Asia	6 500 000	0.6	460 000
Latin-America	1 600 000	0.6	84 000
Eastern Europe & Central Asia	1 300 000	0.6	49 000

2.2 Africa

By the end of 2003, Sub-Saharan Africa alone, with just over ten per cent of the world's population, had about two-thirds of all people living with HIV, that is 25 million people out of a total of 37.8 million globally. Of the global total of 4.8 million new HIV infections in 2003 alone, an estimated three million occurred in this region.

With an overall HIV infection rate among adults (15–49 years old) of 7.5 per cent, and nearly all countries with infection rates above the one per cent threshold (except for the notable exceptions of Mauritania and Senegal), Sub-Saharan Africa has no country where HIV/AIDS may be said to be marginal, or where the impact of the epidemic on overall development can be ignored.

Sub-Saharan Africa is also the region where the HIV/AIDS epidemic has become predominantly feminized, due to the higher vulnerability of women to hetero-sexual transmission of HIV, and to a number of other factors that still increase that vulnerability, such as lower socio-economic status, genital mutilations, sexual violence, in particular in the context of conflict situations, etc.

Poverty reduction being the primary objective of Swedish overall development cooperation, the demonstrated vicious circle between poverty and HIV/AIDS, an HIV infection rate among adults seven times higher than the global average, and an overwhelmingly feminized HIV/AIDS epidemic, are all factors that strongly argue for a very clear focus on HIV/AIDS in Sweden's support to Africa, not only for an increase in explicitly targeted interventions, but also for mainstreaming HIV/AIDS into all development work.

Country analyses

At a first glance, the comparison between the summary tables of data from the baseline study and the present desk study seems to indicate that the country analyses back in 1999 did much better in assessing the HIV/AIDS situation than those in 2003! For Africa, however, it is almost impossible to compare the two studies. As a matter of fact, out of the four countries selected for this study, three (Angola, Ethiopia and Somalia) were until recently involved in long-standing violent internal and/or external conflicts, while only one of the six countries selected for the baseline study in 2001 was in that situation. Although these countries have a substantial HIV/AIDS problem, they have their attention much more focused on peace-building and reconstruction.

In that perspective, analyzing the importance of addressing AIDS in the various countries, as we have done, will enable us to give a more balanced answer to the question of whether HIV/AIDS issues were given the appropriate attention in the country analyses, and subsequently in the country strategies.

There was no separate country analysis for Somalia, and the country situation was briefly summarized at the beginning of the country strategy document. The section pays little or no attention to HIV/AIDS: *none* of the questions from the framework for analysis could be answered by "Yes"![10]

The country analysis for Angola mentions AIDS briefly, for instance in relation to the problems with orphans. In the conclusion, AIDS is highlighted as a probable threat to the development. The other two country analyses provide information on the HIV/AIDS epidemic, but this is typically limited to the recognition of the epidemic as a "major threat for development", while the issue is generally not discussed in any depth.

For instance, if there is some information on the current spread, underlying causes and immediate effects of the epidemic in Ethiopia and Zambia, it is only in the latter case, where indications are given on the potential spread of the HIV, and long-term effects of the epidemic analyzed.

Gender issues are discussed in the Angola, Ethiopia and Zambia documents, although not in much depth, but not at all in the analysis of Somalia.

Result analyses

Attention to HIV/AIDS in the result analyses is even less than in the country analyses: For Zambia is there some information about HIV/AIDS interventions, and for Angola it is mentioned that the regional HIV/AIDS team in Lusaka has assisted in making recommendations for mainstreaming HIV/AIDS in the Sida-supported health programme. It is also remarked that the support to NGOs for HIV/AIDS projects has been reduced in the previous period. The issue is not considered at all for the two others (besides the remark, for Somalia, that "HIV/AIDS issues can only be addressed at regional level"). Zambia is the only country for which gender issues were assessed in different sectors of development cooperation. In the document on Angola there is a separate section on gender equity.

The remark made above, on the post-war situation of the three countries concerned, is of course all the more valid here: development work during the war period has been very limited indeed.

10 The framework questions used are found in Appendix 3.

Country strategy documents

Here again, the consideration that three of the four countries are in a post-conflict situation seems to have greatly determined the orientation of future development cooperation, which essentially goes to reconstruction and humanitarian assistance.

In two countries (Angola and Somalia), the only type of support considered for HIV/AIDS interventions is through multilateral agencies (Angola) or from a regional perspective (Somalia). The mainstreaming score for the country strategy in those two countries is therefore one (1).

Even for Ethiopia, where HIV/AIDS is mentioned as an issue that must be given attention in all support areas, it does not appear among other issues to be mainstreamed (which gives the country a mainstreaming score of two (2)).

One can say that only the country strategy for Zambia has given maximum attention to HIV/AIDS issues, including their integration to a certain extent in other development work (which gives the country a mainstreaming score of three (3)).

As for the combined country scores, there is an established link between the HIV/AIDS epidemic and the sectors in which Sida has chosen to work. Therefore, it was considered that HIV/AIDS should need the highest attention (combined score of three in our appraisal for the relevance of special attention to HIV/AIDS) in Angola, Ethiopia and Zambia, where the seriousness of the HIV/AIDS epidemic is a fact. As for Somalia, given the lack of HIV/AIDS data, but in view of the high HIV prevalence in neighbouring countries, a country strategy for development cooperation should not ignore this issue.

In conclusion (see Table II, for a summary of the ratings for all twelve countries), for the countries of the African region, with the exception of Zambia, the country strategies fall short of reaching the objectives of the IFFG: to increase the focus on HIV/AIDS, and to mainstream the issue in overall development work. That is particularly true for Ethiopia, a country with extreme poverty and with the third largest population of persons living with HIV/AIDS in Africa.

Except for Angola, the problem of gender equality is addressed in all country strategies. The Ethiopia document even discusses the issue in relation with HIV/AIDS.

Some comments on each country[11]

Angola

The Swedish policy "Investing for Future Generations" has not been applied to the country strategy for Angola, despite the fact that this is a country where the HIV/AIDS situation is serious, and where Sweden has development cooperation in sectors that offer the possibility to include specifically HIV/AIDS targeted interventions, and to mainstream HIV/AIDS in other projects.

A number of arguments are implicitly invoked to limit development cooperation with Angola to a certain amount and to certain sectors:

- the lack of transparency in the central government budget
- the state's inability to supply social services
- the insecurity, in particularly the risk due to the "continuing presence of countless landmines"
- the scarcity of good data on HIV/AIDS, gender, etc.

11 Most data on HIV/AIDS in this section were taken from the "2004 Report on the global AIDS epidemic" by UNAIDS.

- the fact that (given its oil production and other resources) "Angola should eventually be able to finance its development".

AIDS is discussed in the result analysis, and that document recommends that HIV/AIDS should be an important component in the future support. However, in the country strategy this consideration is not reflected, it is "business as usual": "financing [for humanitarian assistance] is to be distributed to the same areas as before, e.g. healthcare, education and functioning schools, water and sanitation, infrastructure, mine clearance, rehabilitation of the agricultural sector, air transport and programme coordination". HIV/AIDS is not considered in relation to these very relevant sectors, which is not in line with the IFFG. The mention that "support for the efforts of multilateral bodies to prevent and combat the HIV/AIDS epidemic is to be given special priority" does not make up for this deficiency, as there does not seem to be any further practical implication of that stated priority in the document. The absence of any disbursement during 2003 for HIV/AIDS projects confirms the validity of that concern.

Ethiopia

Although it is recognized in the country strategy document that Ethiopia has the third largest number of people living with HIV/AIDS in the world, and that it has a paradigmatic vicious circle where the HIV/AIDS epidemic and poverty fuel each other, HIV/AIDS does not get much attention, besides a very general statement on its importance and the "efforts [that] must be made to find points of contact between the various sectors in order to fight the epidemic effectively".

Targeted interventions towards HIV/AIDS in the area of social development are allocated a budget of 70 MSEK for the years 2003 to 2005, out of a total of 1,504 MSEK for the entire development cooperation.

Even though it is mentioned that "HIV/AIDS is a crucial part of the war on poverty in Ethiopia and must be given priority in all support areas", there is no mention of mainstreaming HIV/AIDS issues in development work, even at places where cross-cutting issues such as gender and environment are brought to the attention.

Obviously, the conclusions of the country analysis, as far as HIV/AIDS is concerned, have not been taken into account for the development of the country strategy document. At the same time, the case of Ethiopia very evidently illustrates the gap between the IFFG strategy and its effective implementation, at least down to the level of the country strategy document.

Somalia

The data on HIV/AIDS for Somalia are so scarce that no definitive rating can be given to the country with regard to the seriousness of the epidemic. However, high HIV prevalence in Somalia's two main neighbours (Kenya and Ethiopia) should incite caution. UNAIDS warns that "the existence of diverse risk factors and determinants that may lead to a rapid escalation of the epidemic".

Although Sweden's support is primarily focused on conflict management and peace building, basic health and education remain two important sectors for support. Both offer excellent opportunities for integrating HIV/AIDS issues, which would have deserved more attention.

Zambia

Zambia has one of the world's most advanced HIV/AIDS epidemics, with an adult prevalence rate of 16.5 per cent at the end of 2003 (more than 20 per cent among young pregnant women), and a very high adult mortality rate due to AIDS. As a result, there were close to one million AIDS orphans in the country by the end of 2002, for a total population of hardly more than 10 million people. According to UNAIDS, HIV/AIDS today, is Zambia's most critical development and humanitarian crisis: "households with chronically ill adults, recent deaths and orphans, suffered marked reductions in agricultural production and income generation".

On the other hand, two thirds of Sweden's development support goes to health care (including HIV/AIDS measures) and agriculture, two sectors for which the links with HIV/AIDS are very obvious. For those two reasons, Zambia gets the highest combined score for the importance of including HIV/AIDS in all development efforts.

It is hence encouraging to see that HIV/AIDS takes a very visible place in the country strategy, not only by the volume of directly targeted interventions (for the years 2003 to 2005, the budget foreseen for health-care including HIV/AIDS is 240 MSEK, out of a total of 600 MSEK for the entire development cooperation), but also by the fact that the need for mainstreaming HIV/AIDS into all sectors is very much underlined. Concrete references to HIV/AIDS mainstreaming can be found in the document, for instance for support to the private sector, and to agricultural development. In addition, the document clearly expresses the will to better align development work with the national agenda, with a view on increasing ownership by the government, and to better coordinate with other development partners.

This very prominent place of HIV/AIDS in the country strategy comes in a surprising contrast with the relative lack of hard data and in-depth analysis in the country analysis. It is also interesting to note that, according to the result analysis, HIV/AIDS was not considered as one of Sweden's overall development objectives for the period 1999–2001(only democracy, poverty reduction and gender equality were listed), although it was recognized that "HIV/AIDS has had a negative impact on goal achievement within the projects supported by Sweden and, more importantly, on poverty reduction".

2.3 Asia

Next to Africa, Asia is the region with the highest number of people living with HIV/AIDS. The modes of transmission are more diversified than in Africa, as injecting drug use plays a major role, not least in South-East Asia. Sexual transmission is increasing, often representing a second wave of the epidemic after an increase in infection among drug users. In some areas of Asia, commercial blood transfusion has also contributed significantly to the epidemic.

From 1999 to 2003, Sida has increased its focus on HIV/AIDS in Asia. Sida arranged a conference on HIV/AIDS in Asia together with UNAIDS in Stockholm in November 2001, and all the embassies in Asia were instructed by the Ministry of Foreign Affairs to report on the HIV/AIDS situation in their country. The embassies were also instructed to mainstream HIV/AIDS into the development cooperation, and to include the issue in policy dialogue with the government at different levels.[12] It should also be noted that the country strategies for Laos and Vietnam are newer than those for the rest of the sample, as they are both from 2004.

Country analyses (CA)

In this study, three countries from South and South-East Asia are included; Sri Lanka, Vietnam and Laos, the last two were also included in the 1999 strategy. All the three country analyses give information about the epidemic in the country, and there is some discussion on risk factors that may contribute to a further spread. In each of the CA there is a separate chapter or section discussing HIV/AIDS, but the discussion is rarely brought forward in relation to other areas analysed in the document, the positive exception is to some extent Laos.

This is in contrast to gender, which is discussed at many points during the CA, and thus appears to be quite well mainstreamed in the document.

Compared to the situation in 1999, there is a real improvement, in the sense that HIV/AIDS is discussed at some length in each CA. However, it still does not appear to be mainstreamed into the different sector analyses.

12 The instructions to the embassies in Asia were sent out in April 2002, in a letter from the State Secretary Gun-Britt Anderson.

Result analyses (RA)

The result analyses do not say much with regard to HIV/AIDS, reflecting that Sida is not active in the field of HIV/AIDS. There is no analysis of the outcome of different programmes and projects in relation to HIV/AIDS. The discussion regarding gender is more extended, with the exception of Sri Lanka.

In the road sector in Laos, there is a component on HIV/AIDS, which is meant to be a pilot project for how HIV/AIDS components may be included in other sectors and programmes. There is however no analysis or discussion on how that project has worked or how the success is measured (there is only a footnote with reference to other documents). It is not discussed how experiences of this project may be included in other programmes, for instance in the educational sector, where Sida is quite active.

In the other RAs, there is hardly any mentioning of HIV/AIDS. For Vietnam it is said that there are too many donors already involved in HIV/AIDS, and their work is not coordinated. The government has asked Sida to play a coordinating role, but the embassy suggests that Sida should not play such a role without a portfolio in that area.

The only mentioning of HIV/AIDS in the RA for Sri Lanka is that an organisation that works with human rights has included rights for people living with AIDS.

Country strategies (CS)

The country strategies are of course the most important documents, as the other two act as background documents, while the political and strategic direction is given in the CS. Here one may see a clear improvement compared to 1999. In all the CS, the overall objectives are very broad and at a high level, related to poverty reduction, and democratic governance and not specifically mentioning HIV/AIDS. For all the countries however, HIV/AIDS is mentioned as a cross-cutting issue that will be included in the dialogue with the government.

The issues linked to HIV/AIDS are best integrated in the CS from Laos, where integration of HIV prevention activities will be carried out in projects in the education and transport sector, and also in the law programme, in order to secure the rights of people living with HIV/AIDS and reduce stigmatisation and discrimination. The Laos document is also strong on gender mainstreaming, although concrete interventions are rarely spelled out.

In the combined score for the relevance of special attention to HIV/AIDS, all the Asian countries included get a combined score of two on the scale from 0 to 3. It is very important to make use of existing knowledge to prevent a future large epidemic in the region. Even though notable improvements are seen in the CS compared to 1999, both in relation to integrating components in ongoing projects and in relation to dialogue, Sida still needs to be more proactive on that arena.

Laos appears to be the best case among the three countries. It is clearly stated that HIV/AIDS components will be integrated in different sectors, but it does not demonstrate full mainstreaming. In the mainstreaming score, Laos is thus rated as two (2). Integration of HIV/AIDS issues in the various sectors seems to get less attention in Vietnam, and even less in Sri Lanka, although it is mentioned as a dialogue issue. Both Vietnam and Laos are therefore ranked one (1) in the mainstreaming score.

Some comments on each country

Sri Lanka

Sri Lanka is a country where the conflict situation dominates the development agenda. The situation for HIV/AIDS is probably not very serious at the moment, with a prevalence rate of less than 0.1 per cent.

However, there are many risk factors present, so there is good reason to start taking HIV/AIDS activities into consideration.

In Sida's annual report from 2002–2003, there is no mention of HIV/AIDS, and it is hardly mentioned in the result analysis. There is however a section in the country analysis strongly advocating for more focus on HIV/AIDS, and this is followed up as a dialogue point in the CS. However, there is no mentioning of HIV in relation to the focus on youth and children and human rights. There is also no mention of interventions on HIV to be supported by Sida.

Vietnam

According to UNAIDS estimates from the end of 2003, 220 000 persons are living with HIV in Vietnam. The adult prevalence rate is 0.4 per cent. The spread in Vietnam started mainly through injecting drug use, but has since spread through unprotected sex. The situation is most serious in urban areas, but as development leads to increased urban-rural mobility, this may increase risk of spread to rural areas. Human trafficking and migration are also risk factors.

Sida has been engaged in many areas of development in Vietnam, and wants to consolidate these efforts. Sida therefore seems to be reluctant to engage in HIV/AIDS.[13] The discussion about HIV/AIDS seems well informed, but the question of how AIDS relates to the other areas of cooperation is not addressed. The CS states that HIV shall be integrated, but no examples are given on where and how it will be done.

Laos PDR

According to UNAIDS estimates from 2003, 1 700 persons or 0.1 per cent of the adult population live with HIV. The country strategy points out the special location of the country, close to areas with high infection rates, such as Thailand, Cambodia, Yunnan (China), and Myanmar, and this places the country at risk as there is a lot of cross-country migration.

Despite the very low HIV prevalence rate, HIV/AIDS issues are being addressed in Laos. More concrete reflections on how to integrate HIV/AIDS in development sectors could have been done, not least in relation to the educational sector. However, the general message of the document is that it is not quite business as usual; HIV/AIDS interventions will be integrated in the important programmes and will play a role in how Sida develops its cooperation in Laos.

2.4 Latin America

Latin America has a similar estimated adult HIV-prevalence rate as Asia, 0.6 per cent. There is not one dominant mode of transmission. HIV is transmitted through men who have sex with men, heterosexual unprotected sex and injecting drug practice. There are concentrated infections at very serious levels (such as 60 per cent of injecting drug users in certain cities), but the epidemic is not generalised in the population as a whole.

Two countries are included in this sample, Colombia and Bolivia. Bolivia is said to have the lowest level of HIV-infection on the continent, 0.1 per cent, while Colombia with an estimated 0.7 per cent adult prevalence rate has a larger epidemic than average for the continent.

Country analyses

In the country analysis for Colombia, HIV is not mentioned at all. There is a chapter on gender, describing how women are affected and victimised by the conflict, rape being a huge problem. Trafficking and prostitution are also mentioned as problems in the country, but no reference is ever made to HIV vulnerability. For Bolivia on the other hand, despite having a lower level of infection, the CA mentions HIV, and discusses the

13 This is sometimes justified with the argument that there are so many other donors involved in HIV/AIDS in the country.

problems linked to illegal abortions and low contraceptive use, and underlines that education is needed in those areas. It also states that in the education reform, gender and sexuality are among "transversal themes".

Gender is discussed at some length in both documents, in a separate chapter in the Colombian CA. In the Bolivian CA, gender is discussed in relation to health, poverty and education, and it is stated that gender is a crosscutting issue in the PRSP.

Result analyses

There is no mention of HIV in any of the result analyses. Several projects aiming at women are discussed in Colombia. For Bolivia, a separate evaluation looks at Swedish (and Dutch) strategies for promotion of gender equality, but there is not much in the rest of the RA. In a country report for Bolivia, a pilot project on sexual and reproductive rights for adolescents is mentioned, and it will continue, not least as an HIV preventive project (The project is carried out with UNFPA and other agencies), but there is no comment on this project in the result analysis.

Country strategies

HIV is not mentioned in any of the country strategies. This is particularly striking in Colombia where the prevalence rate is quite high. Gender is prominent in both strategies, in Colombia in relation to participation in peace-building activities. Both countries get a low mainstreaming score. Even though the CS never mentions HIV/AIDS, Bolivia still gets a score of one (1), as Sida is involved in a project that sounds very relevant, and which should have been reflected in the CS. Colombia should have demonstrated more clearly some thinking in relation to HIV/AIDS, so they score zero (0).

Some comments on each country

Colombia

With a 0.7 per cent HIV prevalence rate in Colombia, it is estimated that 190 000 persons are living with HIV. The predominant mode of transmission is through sex between men, but heterosexual transmission has increased significantly in recent years.

HIV is not mentioned once in any of the documents from Colombia. This is disturbing seen in relation to the dramatic threats faced by women in relation to rape, trafficking and domestic violence. Children are also in a very vulnerable position, as they are often exploited in different ways.

Conflict resolution and peace building are the key areas of cooperation for Sida in Colombia, and participation of youth and women is underlined. Democracy, human rights, children's right and gender equality are key areas.

In the combined score for the importance of addressing HIV/AIDS, Colombia is given a two (2), to underline the importance of this issue as part of the effort to build a peaceful and democratic country in a situation with a relatively high infection rate.

Even if the Swedish support is not in health or education, HIV/AIDS could and should have been discussed as an element that needs attention, and which may further aggravate the situation in the country.

Bolivia

Bolivia is the country in South America with the lowest level of HIV-infection (0.1 per cent and 4 900 persons estimated to live with HIV).

The country strategy never mentions HIV, despite the fact that according to the country report, Sida will contribute SEK 25 million over five years to a new project on adolescent reproductive health, in cooperation with UNFPA, Danida and several Bolivian municipalities.

Given the fact that Bolivia is a very poor country with many important challenges, one can accept the fact that HIV/AIDS is not high on the list. In the combined country score, Bolivia is scored at one (1), meaning that some attention should be given to HIV/AIDS work, to try to maintain the low infection rate. The above mentioned project is therefore appropriate, as it seems to address current problems linked to reproductive health and to see it in a perspective of HIV-prevention.

The fact that the result analysis did not mention this project, nor did the country analysis, may give an indication that those responsible for writing the strategies have not been concerned with aspects linked to HIV/AIDS. The country report describing the project does not say where the initiative for the project came from; whether it was driven locally from the embassy or through multilateral level through cooperation with UNFPA, or upon initiative from Sida's head office.

2.5 Europe – Balkan

Sida is engaged in three countries/areas in former Yugoslavia: Bosnia-Herzegovina, Macedonia and Kosovo. The UNAIDS estimates for the area is that the infection level for Bosnia-Herzegovina and Macedonia is less than 0.1 per cent. There is no estimate specifically for Kosovo, but the estimate for Serbia and Montenegro is 0.2 per cent. The work of Sida in the area focuses mainly on post-conflict rehabilitation, and building of peace and democracy. For Macedonia, there is no country analysis or result analysis; however, there is a conflict analysis document, as well as semi-annual reports.

Country and result analysis documents

For both Kosovo and Bosnia-Herzegovina, HIV or AIDS is never mentioned in any of the documents, which focus more on assisting the countries in becoming European democratic countries with market economies. Emphasis is therefore on political and economic analysis.

Gender is discussed to some extent, not least in relation to Kosovo. Human trafficking is seen as an important challenge to address, but this is not linked to HIV/AIDS. In a semi-annual report from 2002, the possible spread of HIV is raised as a concern.

UNICEF implements a specific HIV/AIDS prevention project in Macedonia, funded by Sida, and this is described in two semi-annual reports. In the conflict analysis from Macedonia, problems linked to human trafficking and mafia-type activities are raised as a concern, as well as the fact that groups of unemployed youths in the border areas are involved in criminal activities, but there is no discussion of HIV in that relation. HIV/AIDS is actually never mentioned in any part of the conflict analysis.

Country strategies

A separate regional HIV/AIDS prevention project has been started, and that is mentioned under health care in each of the strategies. There is not much information given about the project in any of the strategies, and it is also unclear who will actually run the project (or projects, as there seem to be several). HIV/AIDS is not discussed in relation to projects aiming at key issues such as unemployed youth, domestic violence and women, or human trafficking. In Macedonia, an organisation for gay rights is mentioned, but there is no reference to HIV/AIDS as part of that work. In other words, there is no real discussion about HIV/AIDS, and the mainstreaming score for the three countries is set to one (1), as HIV/AIDS is mentioned, but not discussed in relation to even very relevant interventions.

2.6 General observations related to the country strategies

The countries reviewed here are in different positions in relation to the HIV/AIDS challenge. It is important to acknowledge that one should not use or expect a "one size fits all"-measure.

There is certainly more need to actively address HIV/AIDS through any intervention in most African countries than in other regions. However, as the epidemic is presently in all countries, it is always relevant to mention HIV/AIDS in any country document, to demonstrate that it has been considered.

We have given each country a "country score" based on the importance of addressing the HIV/AIDS issue to indicate the level that each country in our opinion should have been at. The "mainstreaming score" sums up how we rate the achievement of each country strategy in that perspective, as seen in Table II below.

Table II.

	AFRICA				ASIA			LATIN AMERICA		EUROPE		
	Ang	**Eth**	**Som**	**Zam**	**Laos**	**Viet-nam**	**Sri L**	**Bol**	**Colo**	**Bos-H**	**Koso**	**Maced**
Country score[14]	3	3	2	3	2	2	2	1	2	1	1	1
Main-streaming score	1	2	1	3	2	1	1	1	0	1	1	1

As explained before, one could be satisfied with the documents analysed when the two scores match each other. However, as we have stated in the more detailed comments in this chapter, there is room for improvement in all twelve countries.

According to Table II, six out of twelve, or half the countries have a satisfactory rating. It is worth noting that among those six countries, four are in low-prevalence areas. When some HIV/AIDS-related activities are in place, the countries have been given a mainstreaming score of one (this relates to Europe and Bolivia). In general, the discussion on mainstreaming is weak in all the country strategy documents. With few exceptions, the documents do not demonstrate that HIV/AIDS aspects have been considered for in-depth analysis, and subsequently for key interventions in the countries. The country that has performed best is Zambia, but also Laos and Bolivia have demonstrated, despite their low prevalence rate, that HIV/AIDS concerns can be reflected and relevant interventions implemented.

For some countries, such as Bolivia, Kosovo and Macedonia, the important information about HIV/AIDS in the country was neither to be found in the country strategy, the country analysis nor in the result analysis, but rather in annual (or semi-annual) reports from the countries. It may be that some staff at embassy level are more aware of the need to address HIV/AIDS than those who finalise and approve the country strategy.

The fact that AIDS is discussed to a relatively large extent and highlighted as a dialogue issue in Vietnam and Laos, may be an indication of a positive change in relation to how HIV/AIDS is included in the country strategies, as they are newer strategy documents compared to the other documents.

14 For more information on the country score for each country, see the list of data in Appendix 4. For explanation of the score, see section 1.3 above.

3 Organisational structures to promote HIV/AIDS related issues in Sida

As mentioned in the introduction, a number of organisational structures have been established to implement the IFFG within Sida:

- The HIV/AIDS project inside Sida (from 1999–2002)
- The Lusaka HIV/AIDS team for Africa (from 2000)
- The HIV/AIDS secretariat, as a temporary structure (2002–2005)
- The Delhi HIV/AIDS adviser for South Asia (from 2002)
- The Cambodia HIV/AIDS adviser for South East Asia (from 2005)
- A network of focal points has been developed, comprising members from the different departments and divisions within Sida.

The Ministry of Foreign Affairs has created the position of an "HIV/AIDS ambassador".

In addition, the implementation of IFFG has not only been promoted through the creation of specific posts, but also through working out a set of documents and reports, and – to a certain extent – staff training.

3.1 Function and work of the secretariat

3.1.1 Functions of the secretariat:

There are three main functional areas[15]

1. The first priority (estimated at a total of 37 per cent of its work load) is technical support to Sida staff at head office and the embassies on issues in development cooperation: mainstreaming, country processes, project cycle, policy and information/communication.
2. The second priority (with 23 per cent of work time) consists of methodological development; involved in capacity and competence building in Sida and other Swedish actors.
3. The third priority (at 15 per cent) is international dialogue in policy work with international forums (UNAIDS, bilateral, international organisations, etc.) In dealing with UNAIDS, the GFATM etc., other Sida staff (of the Health division) also have some responsibilities as focal points for the entire organisation.

The remaining 25 per cent are for internal and administrative processes.

In October 2004, there was three staff at head office:

a) Anders Molin (Head, July 2002)

b) Lena Ekroth (since September 2002)

c) Eva-Charlotta Roos (since August 2002; seconded between September and December 2004 to the South Asia team)

15 See flyer on IFFG, June 2003, see also the percentages attached to each area in the outline of functions from 2004.

It is worth noting that the different cross-cutting issues have different structures. The most extended structure seems to be for the environmental issues, where there are five full-time staff-persons, and in addition there is an external 'help-desk'. The HIV/AIDS secretariat will establish a contract with a 'help-desk' in 2005.

3.1.2 Methods of work of the secretariat

The HIV/AIDS secretariat focuses on a process of "bottom–up" moving the HIV/AIDS concerns through discussion and motivation in all divisions and departments. This "bottom-up" approach corresponds, in the eyes of the secretariat, to the general organisational culture of Sida, which is characterized by consensus-building rather than hierarchical instructions. However, members of the secretariat like other Sida staff were aware that both "the carrot and the stick" are important for moving and motivating staff in relation to prioritisation and change. From 2002 the MFA instructed the embassies to report on HIV, and this means that the bottom-up approach is now supported by instructions from 'above', which has made a change in the attention devoted to AIDS from the embassies. The previous lack of guidelines and instructions from 'above' on how the divisions and departments are expected to implement the IFFG, made efforts of the secretariat to get changes inside the organisation more difficult. With support from instructions and prioritisation, the work is now easier.

The secretariat has addressed Sida's management committee. The head of the secretariat is part of the weekly meeting of directors of the departments with the director general (DG) at several occasions. The secretariat was also invited by the DG to present developments on the epidemic and Sida's response directly to her.

Monitoring

There is no coherent and systematic system for monitoring progress in the implementation of the IFFG. In the absence of that, the secretariat tries to keep informed about how HIV/AIDS concerns are integrated into Sida's work through:

- Members of the secretariat take part in the preparation and review of country strategies, and from 2004 they are members of the working group for each CS.
- The secretariat reviews statistics of disbursements to assess financial commitments of regions and divisions.
- Through informal and personal contacts and information sharing.

With the instructions to the embassies to report about HIV/AIDS in the country and about the work of the embassy, it has become easier to monitor part of the work.

3.2 The HIV/AIDS network and focal point system

The network was created to bring representatives from departments and divisions together. It is not a formalised structure within Sida, and no formal terms of reference exist.[16] Although each department/division was invited to have an HIV/AIDS focal point (FP), not all divisions have appointed one. While there are 14 departments and 33 divisions in Sida,[17] there are only 19 members (apart from the secretariat). Some departments have only "contact persons for HIV/AIDS" a kind of "second-rate" FPs, who do not participate in the meetings of the network.

16 A draft of generic terms of reference for the FPs has been circulated and discussed in the network since 2002/3, but has not been formally adopted.

17 There are several divisions in the finance and human resources department, altogether nine. In addition, there are other entities like Civil Society Centre, Unit for Multilateral Affairs etc.

In October 2002, the network had 22 members. In addition to the three staff of the secretariat, the other members are focal points nominated by their department/division. The director of the Africa Department participates as one of the focal points. The network is supposed to meet every two months for information exchange and discussions. Minutes of most meetings are available.

The functioning of the FP Network[18]

There are ten departments and 16 divisions represented in the network. The Department of Policy and Methods, the Human Resources Department and the Information Department are not represented at all. The network comprises directors of departments, vice-directors, and senior as well as junior staff; some have worked in Sida for more than ten years, while a good number has joined the organisation only recently. FP positions often remain vacant for several months.

Some FPs have been in that capacity since the beginning of the structure (2002), some have just joined a couple of months ago or even last week. The great majority volunteered for the job and/or was asked by her/his supervisors. For a few the nomination was work-related.

Except for one person who basically drafted her own job description, the FPs do neither have a terms of reference nor a job description giving any indication of how much time they should dedicate to HIV/AIDS-related work. The amount of time spent on HIV-related issues varies from a maximum of 25 per cent of total working time to 1 hour in the last two working months (except for one person who is professionally occupied with HIV/AIDS issues).

Preparation and introduction as FPs has been very limited. There is no specific training organised for them; many had long discussions with members of the secretariat, but half of them also mentioned that their preparation was either self-studies or nothing at all.

Partially as a consequence of this, the self-appreciation of being 'AIDS–competent' is critically challenged by two thirds. Many FPs think that they are not sufficiently equipped to do their work as a FP.

The meetings of FP are seen as useful information exchange and sometimes as enriching its own professional capacity, but hardly much more. Some feel they have lacked practical discussions, or clear orientation on what should be achieved by the group.

HIV/AIDS is rarely an agenda item in division or department meetings. While all the FPs are convinced that HIV/AIDS should be part ("mainstreamed") in overall development work, only a few felt that this was already sufficiently done in their department/division. Overall, the FPs felt that the network was not really sufficient in achieving a proper implementation of the IFFG.

There are other networks based on what may be termed cross-cutting issues in Sida. However, there is also no evaluation or analysis of the strong and of the weak aspects of these networks which seem to be quite common in the organisation. (Some informants assume that there are around ten different types of informal and formal networks throughout the organisation.)

3.3 Regional HIV/AIDS advisers

As mentioned above, a regional team was established in 2000 to assist the embassies in Sub-Saharan Africa in implementing the IFFG. The team also entered in cooperation with NORAD, which has seconded one member to the team. The team gives advices to the Norwegian and Swedish embassies in the region, in addition to its responsibility for regional projects. These embassies have appointed HIV/AIDS

18 These observations and comments are based on nine personal interviews with FPs at Stockholm and the outcomes of 14 questionnaires received (out of 19). The survey was sent to all network members minus the HIV/AIDS Secretariat. In Appendix 8, a more extensive summary of the questionnaires is provided together with the original questionnaire (which can be found in appendix nine).

focal points, which have the main contact with the team. The team arranges seminars and meetings for different groups of staff and in relation to a variety of themes, in order to build competence and discuss important issues.

For 2004, the team presents the following main tasks:

The long-term implementation of the Swedish strategy Investing for Future Generations will continue with the integration of HIV/AIDS in Sweden's development co-operation and in all Sida's processes.

The sub-goals for the Regional HIV/AIDS Team are:

1. HIV/AIDS should be integrated in Sida's processes and projects and in the dialogue with cooperating countries.
2. Good knowledge about and a broad view on HIV/AIDS as a development issue within Sida and regional actors,
3. An increased African capacity to reduce the spread of HIV/AIDS through regional development cooperation, and strengthening other regional cooperation in this respect, and
4. A strengthened Swedish profile and position in the regional and international dialogue.

The main tasks to reach these goals are:

- support to the embassies in Sub Saharan Africa
- regional programmes,
- multilateral monitoring, and
- information/communication and research.

In South Asia there is a regional HIV/AIDS adviser based at the embassy in New Delhi in a part-time (70 per cent) position, and in 2004 a similar post was created in South East Asia, based in Cambodia. These regional advisers shall perform similar tasks as the Lusaka Team; assist the embassies in competence building, integration of HIV/AIDS in the work and dialogue, and cooperation at regional level with organisations and agencies such as UN agencies and NGOs.

3.4 Instruments of Work

In the end of 2002, two important documents were published by Sida: *"How to Invest for Future Generations"* Guidelines and *"HIV/AIDS and Sida's Country Strategy Process – a Manual"*. Both were written by SODECO, a consultancy firm which worked closely with HÄLSO/DESO. These two documents were produced to fill the gap produced by the absence in the IFFG of sufficiently concrete details on how the new strategy can and should be incorporated into the development cooperation process at Sida at different level (regions/thematic divisions). Both documents were commissioned before the HIV/AIDS secretariat was appointed. Even though the intention from Sida as well as from the authors was to develop a document that would have broad ownership in the organisation, participation by different departments and divisions seems to have been weak.

Some comments on the two documents:

- *HIV/AIDS and Sida's Country Strategy Process – a Manual*

This is a key document as it situates the HIV/AIDS issue in the context of the development of a country strategy, which is the main process in which Sida/Sweden organises its development cooperation. The

document describes the process leading to a country strategy and indicates where, when and how HIV/AIDS concerns have to be assessed, reviewed and incorporated. We would therefore make some comments on the document:

a. The manual does not underline the importance of cooperation with the national AIDS programmes and consulting the national AIDS plans and in the recipient countries, or to contact UNAIDS for information and consultation, despite the fact that having a "dialogue with cooperation partners" seems to be a very important role for Sida (see, for instance, "Sida at work"). This may to some extent reflect the fact that national plans and programmes were not very well developed at the time this document was produced. Even so, however, there were structures in place in most countries.

b. The manual seems quite (over-)ambitious in its perspective to research and integrate HIV/AIDS concerns at country level. It does not seem adequate to invest so much resources for instance in countries with very low prevalence, where simpler methods would be sufficient.

- *How to 'Invest for Future Generations' – Guidelines for Integrating HIV/AIDS in Development Cooperation*

The 'How to IFFG' document is a valuable resource and is being used in training workshops and meetings (e.g. the meeting of African focal points in 2003). It is an important reference document, and we will limit ourselves to very few comments:

a. These guidelines review the interrelations between HIV/AIDS and seven key sectors of development cooperation, and possible actions to be undertaken in each of them. However, it does not underline the importance of looking at the local context and condition, and does not explain in general terms the linkages between the HIV/AIDS issues and the general development issues, poverty, human rights, gender or the situation of children.

b. the guidelines do not refer explicitly to analyses and work already done in the different country contexts, which should be the starting point of any additional investigation or intervention.

Other Materials

The HIV/AIDS secretariat has produced or commissioned a number of studies and issue papers on various issues linked to HIV/AIDS. These documents are meant to assist in the implementation of the IFFG, but will however not be assessed independently in this report.

Training

Training is a key issue in order to implement a strategy. There are various training programmes in Sida, and HIV/AIDS is integrated in several of the courses, for instance in the mandatory training for all staff who are assigned to work at an embassy. There is also a basic course on HIV/AIDS offered to all newly employed staff, but that is not mandatory. The basic course has been held twice since 2002 (one was a full day and the second was half a day). In addition training is provided for the different departments upon request, and there has been a mini-workshop of 30 to 60 minutes in each department/unit. Special workshops of a half or a full day have been arranged for divisions such as NATUR, UND, KULTUR and the SEKA department, plus for Swedish NGOs. The SEKA project for NGOs also comprised training in Africa as well as a three days' training programme in Sweden (Härnösand).

There has been a half day training workshop with the focal points in 2003, and there are some training elements in each network meeting.

Embassy staff may also take the Nordic e-learning course on HIV/AIDS, which so far taken place twice. The HIV/AIDS secretariat has been involved in designing the course.

Despite these efforts, it seems that training is not sufficiently systematic and comprehensive in order to meet the ambition of having a better integration of HIV-aspects in the various sectors.

4. Interventions and components relating to HIV/AIDS

Appendix 5 contains two lists of Sida's interventions that had disbursements in 2003:

A. those specifically targeting HIV/AIDS, and

B. overall development projects which have HIV/AIDS components.

Both lists were provided by Sida's "Plus system" data base, by using the following additional selection criteria:

- for the first list: by applying sector code (2112) (Sexual health and rights, including HIV/AIDS)
- for the second list: by applying financial code (A05) (HIV/AIDS contributions), in sectors other than 2112.

Note
A comparison with the baseline study is limited by the fact that the lists produced by the Plus system do not provide all the information gathered for the baseline study, e.g. (for the targeted interventions) the distribution of interventions among Sida departments, and their objectives and content. For the non-targeted interventions, the baseline used a case study of eight selected projects (which were said "not [to be] statistically representative"), while the entire list of such projects was used in the present desk study.[19] Those limitations will be largely made up for by the four in-depth country case studies, which constitute the third part of the present evaluation.

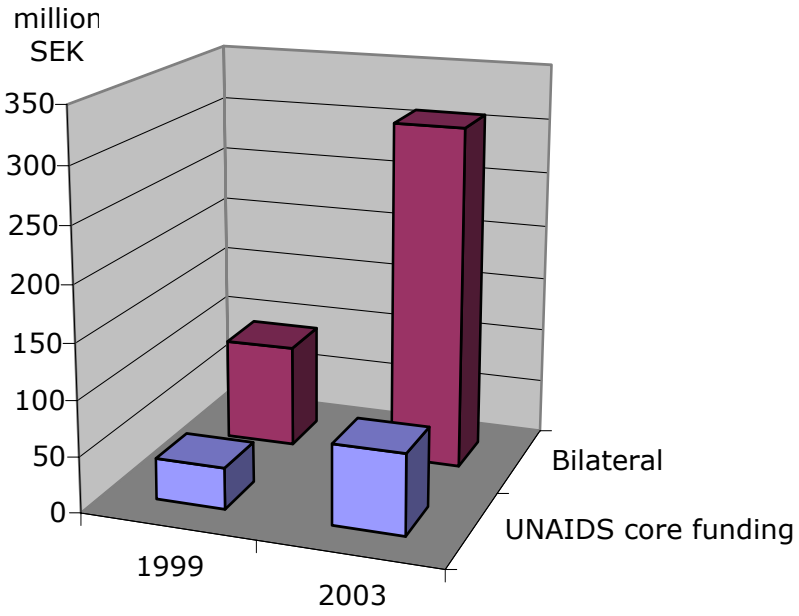
4.1 Sida's targeted HIV/AIDS interventions

Number of projects
The total number of projects directly targeting HIV/AIDS, and which received funds from Sida in 2003, is 130. This is an almost 50 per cent increase as compared with the number in 1999 (N = 90).

Funding
The increase is even more striking when the amounts of contributions are compared: total disbursements for those interventions in 2003 amounted to slightly more than 310 million SEK. To compare this amount with 1999, one should take into consideration that the baseline study included in their inventory of 37 MSEK core funding, and an additional 10 MSEK for strategic planning to UNAIDS, a contribution that was made by the MFA. The corresponding MFA contribution for 2003 (i.e. 72 MSEK) is not included in the 310 MSEK, which therefore compares with 93 MSEK for 1999, instead of 130. That means a more than three-fold increase, over just four years, and an almost doubling of the core contribution by the MFA to UNAIDS. The latter will again double in 2004. The graph here below clearly illustrates the trends in Sida's support to HIV/AIDS targeted interventions (bilateral) and core funding to UNAIDS.

19 It should be stressed though, that the list does not necessarily include all interventions which contain HIV/AIDS related components. That, indeed, depends on the appreciation by the persons who entered the data into the "Plus system".

Fig. 1 Evolution of Sweden's contribution to the fight against HIV/AIDS, for bilateral and UNAIDS core funding.



4.1.1 Geographical distribution of Sida support

For the reasons explained above, the distribution of interventions between Sida departments, and according to objectives and content is difficult to grasp from the information provided in the list. Some indications on the responsibility of the projects within Sida will be given below, according to the geographical distribution.

The geographical distribution is illustrated in the table and the graph below:

Table III: SHR (including HIV/AIDS) projects (code 2112)

	Number of projects	Total disbursed in 2003	% of total
Global	*7*	*75 447 371*	*24%*
Regional Africa	37	61 144 776	
Bilateral Africa	53	85 424 809	
Total Africa	*90*	*146 569 585*	*47%*
Regional Asia	3	12 037 270	
Bilateral Asia	8	26 933 873	
Total Asia	*11*	*38 971 143*	*13%*
Regional Latin America	4	4 905 342	
Bilateral Latin America	4	5 328 184	
Total Latin America	*8*	*10 233 527*	*3%*
Regional Europe	5	13 379 081	
Bilateral Europe	9	11 215 031	
Total Europe	*14*	*24 594 112*	*8%*
Direct NGO support		14 236 638	5%
TOTAL	**130**	**310 052 376**	**100%**

Support at the global level, which is about one quarter of the total, is constituted essentially of a 70 MSEK contribution to International Planned Parenthood Federation (IPPF).

Quite logically, almost half of Sida's total support, or 146.6 MSEK (47 per cent of total), goes to Sub-Saharan Africa, where it is more or less equally distributed to regional and country activities. Most of the regional projects (23 of 37 interventions, at a total of 46 MSEK) fall under the direct responsibility of the regional team in Lusaka.

An overwhelming majority of the bilateral support goes to countries of South-East Africa: Malawi (15.4 MSEK), Mozambique (9.2 MSEK), Namibia (6.0 MSEK), Tanzania (23.8 MSEK), Uganda (8.8 MSEK) and Zimbabwe (13.8 MSEK) absorb together over 90 per cent of all bilateral support. A notable difference with 1999 is Mozambique, which in 1999 was pinpointed as receiving minimal support, but which received 9.2 MSEK in 2003. Zimbabwe remains a country with numerous relatively small grants to NGOs: 22 projects with a total of 13.8 MSEK, while in Malawi, an agreement was made with NORAD for not earmarked support to four sectors: health, HIV/AIDS, good governance, and support to macro-economic reforms.[20]

The rest of the geographical distribution also seems to be more or less in line with the importance of the HIV/AIDS pandemic in the world, with predominant attention to Asia, before Eastern and Central Europe, and Latin America.

Finally, five per cent of the support was directly channelled to NGOs by the SEKA Division for NGOs.

4.1.2 Distribution of Sida support among cooperation partners

Table IV

Cooperation partner	Number of projects	Disbursed in 2003	% of total
International NGO	10	85 872 520	28%
Municipalities & counties	7	6 302 948	2%
NGO	55	70 846 553	23%
Private enterprise	6	2 071 322	1%
Private individuals	5	1 077 086	0%
Public service, organisations	20	43 650 977	14%
State universities, schools	7	18 710 497	6%
UN	7	29 365 975	9%
unspecified	13	52 154 498	17%
Grand Total	**130**	**310 052 376**	**100%**

Note

The channels used for 17 per cent of all funding remained unspecified. This proportion is quite large, and unfortunately introduces some uncertainties in the analysis of the distribution patterns. It would take but little effort to improve on that weakness in the Plus system.

As shown in the table, the majority (51 per cent of 2003 disbursements) of Sida's support for HIV/AIDS targeted interventions is channelled to international (28 per cent) and national NGOs (23 per cent). Another 14 per cent goes to government agencies in the countries concerned, and nine per cent goes to various UN

20 Therefore, the amount mentioned is probably not devoted entirely to HIV/AIDS.

agencies. Given the ever increasing role and equally growing expertise of NGOs in the area of HIV/AIDS, and taking into account that much support from multilateral agencies (including non-earmarked funding by Sida) goes to government bodies, this significant support to the civil society is certainly welcome.

4.2 HIV/AIDS components in overall development interventions

The only information from the search in the Plus system data base that can be used for the present study is that at least 61 overall development projects integrated HIV/AIDS components in their activities. Here again, a large majority of those projects (45 out of the 61 mentioned) were in Sub-Saharan Africa, and another ten in Central and Eastern Europe.

The amounts in the table below are only indicative, since they refer to the disbursements made for the overall development projects, and not necessarily to their HIV/AIDS component. It is remarkable though, that overall development projects for a total amount of close to half a billion MSEK integrated HIV/AIDS among their activities. It is also interesting to see that almost all those projects are carried out by either local NGOs (17 out of the 61) or government agencies (28), which hopefully are hereby reminded of the necessity of considering HIV/AIDS as an issue that goes beyond general health considerations. The four in-depth country assessments will of course need to validate this finding.

Table V: Geographical distribution of Sida support to overall development interventions which include HIV/AIDS components

	Number of projects	Disbursed in 2003
Global	2	3 032 929
Africa	45	404 003 442
Asia	3	30 254 684
Latin America	1	17 251
Europe	10	51 034 613
TOTAL	**61**	**488 342 919**

5. Concluding remarks and issues for further discussion

Since the launching of the IFFG in 1999, Sida has put in place a range of structures and other measures to implement the strategy. In comparison with other bi-lateral development agencies, these efforts are considerable. Sweden and Sida are very active on the international HIV/AIDS 'arena', as an important donor to UNAIDS and other multilateral organisations, as well as having had a substantial increase in project support on different levels and through a range of channels. The Swedish presence is very visible, for instance during the 2004 International AIDS conference in Bangkok, where Sweden arranged satellite meetings, distributed documents from their own exhibition stand, and had sponsored a video that was shown in the opening ceremony.

Considering all the different efforts that have been made to integrate HIV/AIDS into Sida's development co-operation, one might have expected, after four to five years of implementation, more tangible results in the various country strategies. It is however important to note that country strategies discuss priorities, and when HIV/AIDS is not given priority in a country, the document may not discuss why a different choice has been made or how mainstreaming HIV may have been discussed in the process.

One could have expected a more consistent integration of HIV/AIDS concerns throughout the different departments and divisions of the organisation. However, four years is a short time in organisational development, and things are starting to change in the last half of 2004, since HIV/AIDS have become a priority issue by Sida's top management as well as by the MFA.

It is difficult to establish what has been the main influence on the changes and the prioritisation of HIV/AIDS issues by the political leadership in the MFA and Sida's management board. It is quite likely that the fact that there has been a HIV/AIDS project, regional team, secretariat, and network has contributed to such changes, in addition to the HIV/AIDS ambassador. In addition, there has been an increasing attention to HIV/AIDS on the international agenda. It is also quite obvious that a political expression of priority would have been more difficult to implement if the above mentioned structures and experiences were not in place in Sida.

The main approach during the first years after the publication of the IFFG was based on a peer approach characterised by bottom-up thinking, with networking, training and motivation as primary tools. In an organisation with conscious professionals this makes a lot of sense. However, Sida is also a bureaucracy with its hierarchy, and in a busy schedule, the staff first of all has to deliver what the management requires. Over the past year, however, both the political leadership as well as the Sida top management has given priority to AIDS, and this seems to have changed the way that the organisation operates in relation to the issue. Providing information, guidance and training options have in other words not alone produced the desired results. Directives from management has strengthened the efforts in the different departments, and it remains to be seen how this increased attention translates into "outputs" in relation to the mainstreaming and integration of HIV/AIDS into the ongoing work. In sum, it seems that important changes are possible only when a combination of the metaphorical "carrots, sticks and sermons" is used.

Moreover, conferring a more systematic monitoring task to the HIV/AIDS secretariat could have a positive impact on the effective implementation of the IFFG, and could also strengthen the internal learning process and competence building.

In conclusion, the following elements are essential; staff should:

a) be motivated and helped to understand of the importance of integrating HIV/AIDS,

b) be given access to knowledge and competence,

c) receive instructions and (administrative) recognition from the political and organisational leadership on the importance of prioritising the issue.

In relation to this, one should note that Sida has adopted very different ways for managing cross-cutting issues like gender, environment, or HIV/AIDS, etc:

1. "Gender" has two advisers who are organisationally located in DESO (previously in the Policy Department)

2. "Environment" has a mandatory impact assessment system for all projects, and an Environmental Policy unit with five staff members to work with it, and

3. "HIV/AIDS" has a secretariat with three members, located in DESO.

We have not attempted to compare how well the different cross-cutting issues are mainstreamed in Sida, but we have "glanced" at gender in the documents we have reviewed, and the general impression is that Sida has come quite far when it comes to mainstreaming gender in the country strategies, compared to HIV/AIDS, even though more can be done in that area as well. Considering how many years gender has been on the agenda, and also the fact that as men and women are present in more or

less equal number in any society, it is probably easier for a Nordic person to acknowledge the importance and relevance of including gender as part of any analysis or intervention. But even that has taken many years to accomplish![21]

The question: "How will Sida become 'AIDS-competent?" has not been clearly answered by the Sida management. What would have been needed with regard to the implementation of the IFFG was a clear organisational analysis on how to proceed:

a. in terms of human/organisational resources and

b. in methods and instruments.

A number of documents have been prepared on how to build competence, also on how to integrate HIV/AIDS in development assistance. However, it seems that HIV/AIDS is not well integrated into other key documents in Sida, so that people will have to read both the general documents (like "Sida at work" or "Perspectives on Poverty") and the more specialised documents on HIV/AIDS.

Some informants told the evaluation team that "In Sida we are better at working out policies than in implementing them". Indeed, from the country document reviews as well as from the interviews, the overall HIV/AIDS competence level in Sida may appear insufficient.

The issues linked to the HIV/AIDS pandemic evolve rapidly, and it is important to ensure that the organisation can follow these developments. The existing elements – the policy as well as the structures and instruments to implement it – will need a critical revision and adjustments to optimise them.

Some key questions for further discussions may be:

- How can training be organised to address the various cross-cutting issues in relation to each other, and to receive sufficient attention in the organisation?
- What are the linkages to poverty reduction as the overarching goal? How can the different policies create synergies and support each other?
- Is there a need to establish clear and measurable goals (with indicators) on what Sida would like the IFFG to accomplish in the next three to four years? If yes, what should these goals and indicators be?
- How does an increased focus on the "Field Vision"[22] impact on procedures, preparation, training, and monitoring of work at HO level?

21 Gender mainstreaming has also not been smooth in Sida. The evaluation of the implementation of the Gender Action Programme 1997–2001 in 2001 found only one project with a well-developed mainstreaming strategy. Mikkelsen, B. et al, 2001, "Mainstreaming Gender Equality", page 65.

22 The "field vision" means that more decisions on project funding and administration should be made at the embassy level.

Appendix 1: Documents reviewed for the desk study

Country	Country Analysis	Results Analysis	Country Strategy	Other documents	Incl. in Baseline?
Angola	2003	2002	2003–05	Sida Country Report 2003	yes
Ethiopia	Feb. 2003	1996–01	2003–07	• Health Profile (1995) • Country Gender Profile (Feb.03) • Strat. Environm. Analysis • Country Plan for 2003 (Dec.02) • Country Plan 2004–06 (Jan.04) • Country report 03 (Mar.04) • Country report Jan-Aug.04 • Structures and Relations of Power • Survey of Culture and media	no
Somalia			2003–05		no
Zambia	Nov. 2003	Nov. 2003	2003–07		yes
Sri Lanka	2002	1998–01	2003–07	Ann.rep 02–03	no
Vietnam	2003/4?	2003/4?	2004–08		yes
Laos	2004	2003	2004–08		yes
Bolivia	03–07	97–02 (in Swedish)	2003–07	Country rep 03	no
Colombia	03–07 (in Swedish)	1998–02 (in Swedish)	2003–07	Country rep 03	no
Bosnia-Herze-govina	X (in annex)	X (in annex)	2003–05	Conflict A. (annex)	no
Kosovo	May 04	02–04	2003–05	Untitled doc Semi-an.rep 03	no
Macedonia			2003–05	2 Semi-ann.rep 03 memo:priority tasks 03 Conflict analysis	no

Appendix 2: List of persons met

Sida/Stockholm

Ms. Bruzelius, Marie-Louise	PO, Dept. for Cooperation with NGOs, Humanitarian Assistance and Conflict Management, Focal Point
Ms. Ekroth, Lena	HIV/AIDS Secretariat. DESO[23]
Ms. Ericsson, Malin,	PO, Division for Democratic Governance, DESO, Focal Point
Mr. Essner, Jan	Vice Director, Division for Asia, Dept. for Asia, Focal Point
Mr. Gerremo, Inge	Senior Adviser, Multilateral Affairs, Dept. for Natural Resources and the Environment,
Ms. Hagström, Britt F	Director, DESO
Mr. Hessel, Martin	PO Ethiopia, Dept. for Africa,
Dr Molin, Anders	Head, HIV/AIDS Secretariat, DESO
Ms. Lien, Molly	Adviser, Dept. for INEC, Focal Point
Ms. Lindqvist, Helen	PO, Dept. for Latin America, Focal Point
Mr. Lundström, Tomas	PO, HÄLSO, DESO, Focal Point
Ms. Otterstedt, Annika	PO, Environment Policy Unit, Dept. for Natural Resources and the Environment
Ms. Palmberg, Johanna	PO, Agriculture Dept. for Natural Resources and the Environment, Focal Point
Ms. Petterson, Mirja	PO, Ukraine, Dept. for Europe
Mr. Ronnas, Per	Chief Economist, Dept. for Policy and Methodology
Ms. Rylander, Berit	PO, Division for Culture, DESO
Ms. Sörman Nath, Ylva	Gender Adviser, DESO
Ms. Sylwander, Lotta	Head, Dept. for Africa, Focal Point
Mr. Uggla, Fredrik	PO, Division for Evaluation and Internal Audit, Focal Point

Ministry of Foreign Affairs

Mr. Herrström, B.G.	Deputy Director
Mr. Hjelmaker, Lennarth	Ambassador, HIV/AIDS.

23 DESO stands for the Department for Democracy and Social Development.

Others

Ms. Lise Munck,	Consultant, Ex-Sida (by phone)
Mr. Mikael Hammarskjöld,	Consultant

Appendix 3: Framework for analysis

Country analysis

Content	Yes/No	Specify
The epidemic		
Information about the current spread of the epidemic in the country?		
Indications regarding the future spread of the epidemic?		
Causes		
Analysis of the immediate causes of the epidemic (unprotected sex, transmission from mother to child, shared blood and blood products etc.)?		
Analysis of underlying causes of the epidemic (poverty, gender inequalities, population movement, lack of political will etc.)?		
Effects		
Analysis of immediate effects of the epidemic (at household level, on children and young people, on the health sector etc.)?		
Analysis of long-term effects of the epidemic (demographic impact, inter-generational consequences, macro-economic impact, sectoral impact etc.)?		
Analysis of how the epidemic has changed the need for international support?		
Response		
Information about political commitment, policies and actions taken at national level in response to the epidemic?		
Information about response to the epidemic from the international community (which actors, type of support etc.)?		
Approach		
Is the analysis of the HIV/AIDS situation linked to Sida's overall objectives (poverty reduction, economic growth, social equality, economic and social independence, democracy, gender equality and natural resources)?		
Is the epidemic treated as a general development issue and not only as a health issue in the analysis?		
Gender		
Is gender included as part of the analysis or discussion?		

Result analysis

Content	Yes/No	Comments
Type of reported interventions		
Information about interventions where the objective has been to reduce the spread of HIV and/or mitigate effects of the epidemic?		
Effectiveness of interventions		
Analysis of which type of intervention has been effective (in relation to HIV prevention, care and support, political commitment and coping strategies)?		
Analysis of which channels have been most effective for HIV/AIDS interventions?		
Analysis of how HIV/AIDS interventions contribute to the overall objectives of Sida support?		
Side-effects		
Analysis of how the epidemic has influenced the results in Sida's overall development co-operation with the country?		
Analysis of possible negative side effects on the epidemic from Sida interventions and overall development co-operation with the country?		
Gender		
Are outcome of interventions analysed/discussed in relation to gender?		

Country strategies

Content	Yes/No	Comments
Objectives		
Does the strategy include objectives related to reduction/mitigation of HIV/AIDS?		
Does the strategy include interventions that aim to enable people to protect themselves against HIV infection?		
Does the strategy include interventions that aim to encourage greater political commitment to HIV protection programmes?		
Does the strategy include interventions that aim to enable people infected and affected by HIV/AIDS to pursue their lives with quality and dignity?		
Does the strategy include interventions that aim to develop coping strategies to alleviate long-term effects?		

Is HIV/AIDS mentioned as an issue or cross-cutting theme for policy dialogue?		
Does the strategy recognise the need to adjust Sida's overall development co-operation with the country to the HIV/AIDS situation?		
Does the strategy recognise the need to mitigate possible negative side effects of Sida's general interventions on the epidemic?		

Co-operation		
Does the strategy include information about the compatibility of Sida's strategy and the national strategy in relation to HIV/AIDS?		
Does the strategy include information on how planned Sida support complements other donor support in relation to HIV/AIDS?		
Does the strategy include information on which channels should be used for HIV/AIDS interventions?		
Gender		
Does the strategy include interventions or components addressing gender issues and/or promoting gender equality?		
Are issues related to gender and HIV/AIDS ever discussed together in the document?		

Seriousness (and perhaps stage) of the HIV/AIDS situation

General comments & reflections:

How is the overall impression of the response in relation to the situation in the country?

Appendix 4: Overview of country data

COUNTRY ANALYSES

	AFRICA				ASIA			LAT. AMER.		EUROPE		
	Ang	**Eth**	**Som**	**Zam**	**Laos**	**Vietnam**	**Sri L**	**Bol**	**Colo**	**Bos-H**	**Koso**	**Maced**
The epidemic												
Information about the current spread of the epidemic	N	Y	N	Y	Y	Y	Y	Y	N	N	N	
Indications regarding the future spread of the epidemic?	Y	N	N	Y	Y	N	Y	N	N	N	N	
Causes												
Analysis of immediate causes of the epidemic?	N	Y	N	N	Y	Y	Y	Y	N	N	N	
Analysis of underlying causes of the epidemic?	N	Y	N	Y	Y	N	N	N	N	N	N	
Effects												
Analysis of immediate effects of the epidemic?	N	Y	N	Y	N	N	N	N	N	N	N	
Analysis of long-term effects of the epidemic?	N	N	N	Y	N	N	N	N	N	N	N	
Analysis of how the epidemic has changed need for international support?	N	N	N	N	N	N	N	N	N	N	N	
Response												
Information about political commitment, policies and actions taken at national level?	N	Y	N	Y	Y	Y	Y	N	N	N	N	
Information about response to epidemic from the international community?	N	Y	N	N	N	N	N	N	N	N	N	
Approach												
Is the analysis of the HIV/AIDS situation linked to Sida's overall objectives?	N	N	N	Y	Y	N	N	N	N	N	N	
Is the epidemic treated as a general develop-ment issue and not only as a health issue?	N	Y	N	Y	Y	Y	N	Y	N	N	N	

Gender												
Is gender included as part of the analysis or discussion?	N	Y	N	Y	Y	Y	Y	Y	Y	N	Y	

RESULTS ANALYSES

	AFRICA					ASIA		LAT. AMER.		EUROPE		
	Ang	**Eth**	**Som**	**Zam**	**Laos**	**Viet-nam**	**Sri L**	**Bol**	**Colo**	**Bos-H**	**Koso**	**Maced**
Type of reported interventions												
Information about interventions that aim to reduce the spread/ mitigate effects of HIV/AIDS	Y	N	N	Y	N	N	N	N	N	N	N	
Effectiveness of interventions												
Analysis of which type of intervention has been effective	N	N	N	Y	N	N	N	N	N	N	N	
Analysis of which channels have been most effective	N	N	N	N	N	N	N	N	N	N	N	
Analysis of how HIV/AIDS interventions contribute to the overall Sida objectives	N	N	N	N	N	N	N	N	N	N	N	
Side-effects												
Analysis of epidemic's effect on results in Sida's overall co-operation with country	N	N	N	N	N	N	N	N	N	N	N	
Analysis of possible negative side effects on the epidemic from Sida interventions and overall development co-operation with the country?	N	N	N	N	N	N	N	N	N	N	N	
Gender												
Are outcome of interventions analysed/discussed in relation to gender?	N	N	Y	N	Y	Y	N	Y	Y	N	Y	

COUNTRY STRATEGIES

	AFRICA					ASIA		LAT. AMER.		EUROPE		
	Ang	**Eth**	**Som**	**Zam**	**Laos**	**Viet-nam**	**Sri L**	**Bol**	**Colo**	**Bos-H**	**Koso**	**Maced**
Objectives												
Does the strategy include objectives related to reduction/ mitigation of HIV/AIDS?	N	Y	Y	Y	N	N	N	N	N	N	N	N
Are interventions that aim HIV prevention included?	N	Y	N	Y	Y	N	N	N	N	Y	Y	Y
Are interventions that aim to encourage greater political commitment to HIV included?	N	Y	N	Y	Y	Y	Y	N	N	N	N	N
Does the strategy include interventions that aim to enable people infected and affected by HIV/AIDS to pursue their lives with quality and dignity?	N	N	N	Y	N	N	N	N	N	N	N	N
Does the strategy include interventions that aim to develop coping strategies to alleviate long-term effects?	N	N	N	Y	N	N	N	N	N	N	N	N
Is HIV/AIDS mentioned as an issue or cross-cutting theme for policy dialogue?	N	Y	N	Y	Y	Y	Y	N	N	N	N	N
Side-effects												
Does the strategy recognise the need to adjust Sida's overall development co-operation with the country to the HIV/AIDS situation?	N	N	N	Y	N	N	N	N	N	N	N	N
Does the strategy recognise the need to mitigate possible negative side effects of Sida's general interventions on the epidemic?	N	N	N	N	N	N	N	N	N	N	N	N
Co-operation												
Information about the compatibility of Sida's strategy and the national strategy on HIV/AIDS?	N	N	N	Y	N	Y	N	N	N	N	N	N

Information on how planned Sida support complements other donor support in HIV/AIDS?	N	Y	N	Y	N	N	N	N	N	N	N	N
Information on which channels should be used for HIV/AIDS interventions?	N	N	N	Y	Y	N	N	N	N	N	N	Y
Gender												
Does the strategy include interventions or components addressing gender issues and/or promoting gender equality?	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Issues related to gender and HIV/AIDS discussed together in the document?	N	Y	N	N	N	N	N	N	N	N	N	N
Strategy (mainstreaming) score	**1**	**2**	**1**	**3**	**2**	**1**	**1**	**1**	**0**	**1**	**1**	**1**

RELEVANCE OF SPECIAL ATTENTION TO HIV/AIDS

	AFRICA				ASIA			LAT. AMER.		EUROPE		
	Ang	**Eth**	**Som**	**Zam**	**Laos**	**Viet-nam**	**Sri L**	**Bol**	**Colo**	**Bos-H**	**Koso**	**Maced**
Seriousness of the HIV/AIDS situation	2	2	2	2	1	1	1	1	1	1	1	1
Aggregated link between HIV/AIDS epidemic and sectors concerned by country strategy	2	2	1	2	2	2	2	1	2	1	1	1
Combined country score	**3**	**3**	**2**	**3**	**2**	**2**	**2**	**1**	**2**	**1**	**1**	**1**
Health	2	2	2	2	1	2					1	
Education	2	2	1		2			2				
Agriculture		1		1				1				
Democratic governance & human rights	1	2	1	2	2	2	2	2	2	1	1	1
Infrastructure		1			2						1	
Trade, industry, energy				1		1	2	1		1	1	1

Urban development				2								
Balance of payment support		1						1				
(post-)conflict management	1		1				1		1	1		1
Other												

Appendix 5: Sida's interventions in 2003, in relation with HIV/AIDS

A. Specifically targeted to HIV/AIDS

Sexual Health & Rights (incl. HIV/AIDS) projects in the Health Sector, which made disbursements in 2003

	Number of projects	Total disbursed in 2003
Global	7	*75 447 371*
UN	*0*	*0*
Global Fund	*0*	*0*
Regional Africa	37	61 144 776
HÄLSO Health Division	6	7 699 625
HIV/AIDS Secretariat	3	153 105
SAREC Thematic Programmes	5	7 369 879
Zambia (Africa regional team)	23	45 922 167
Bilateral Africa	53	85 424 809
Angola	0	0
Botswana	3	3 092 818
Ethiopia	4	1 121 957
Malawi	1	15 364 473
Mozambique	4	9 205 256
Namibia	3	6 032 845
Somalia	0	0
South Africa	4	2 224 928
Tanzania	6	23 766 780
Uganda	3	8 796 000
Zambia	3	1 990 029
Zimbabwe	22	13 829 722
Regional Asia	3	12 037 270
ITP Int'l Training	1	764 382
Administration	1	1 788 952
HÄLSO Health Division	1	9 483 936
Bilateral Asia	8	26 933 873
India	4	16 581 891
China	2	176 990
Laos	1	174 991
Myanmar	1	10 000 000

	Number of projects	Total disbursed in 2003
Regional Latin America	4	4 905 342
HÄLSO Health Division	3	4 836 017
HIV/AIDS Secretariat	1	69 325
Bilateral Latin America	4	5 328 184
Bolivia	1	2 000 000
Guatemala	0	0
Honduras	1	3 000 000
Nicaragua	2	328 184
EECA E Europe & C Asia	2	622 737
HÄLSO Health Division	3	12 756 344
Bilateral Europe	9	11 215 031
Albania	0	0
Bosnia Herzegovina	1	1 736 000
Macedonia	1	2 170 000
Montenegro	1	1 054 000
Kosovo	0	0
Ucraina	2	2 195 399
Serbia	1	1 240 000
Russia	3	2 819 632
Direct NGO support		14 236 638
TOTAL	**130**	**310 052 376**

Distribution according to Cooperation partner

Cooperation partner	Number of projects	Disbursed in 2003
International NGO	10	85 872 520
Municipalities & counties	7	6 302 948
NGO	55	70 846 553
Private entreprise	6	2 071 322
Private individuals	5	1 077 086
Public service, organisations	20	43 650 977
State universities, schools	7	18 710 497
UN	7	29 365 975
unspecified	13	52 154 498
Grand Total	**130**	**310 052 376**

B. Overall development projects including HIV/AIDS components

	Number of projects	Disbursed in 2003
Global	*2*	*3 032 929*
DESA Democratic Governance	1	3 000 000
Environment Policy Division	1	32 929
UN	*0*	*0*
Global Fund	*0*	*0*
Regional Africa	*5*	*25 843 293*
SAREC Thematic Programmes	2	12 800 000
Zambia	3	13 043 293
Bilateral Africa	*40*	*378 160 150*
Malawi	13	45 356 373
Mozambique	7	149 222 517
South Africa	12	33 642 507
Tanzania	6	145 624 095
Zambia	1	3 064 657
Zimbabwe	1	1 250 000
Regional Asia	*0*	*0*
Bilateral Asia	*3*	*30 254 684*
India	1	2 254 684
Sri Lanka	2	28 000 000
Regional Latin America	*0*	*0*
Bilateral Latin America	*1*	*17 251*
Colombia	1	17 251
Regional Europe	*3*	*46 950 000*
EBC Baltic States & Central Eu	1	450 000
HÄLSO Health Division	2	46 500 000
Bilateral Europe	*7*	*4 084 613*
Estonia	2	451 509
Latvia	2	737 374
Lithuania	3	2 895 730
Direct NGO support	*0*	*0*
TOTAL	**61**	**488 342 919**

Distribution according to Cooperation partner

Cooperation partner	Number projects	Disbursed 2003
International NGOs	1	1 250 000
Interest & membership organisations	1	6 038 812
Municipalities & counties	4	18 253 415
NGOs	17	53 981 538
Other multilateral organisations	1	450 000
Private enterprises	2	2 552 515
Public service organisations	28	367 230 262
State enterprises	1	7 702 546
State universities, schools	3	13 857 251
UN agencies	3	17 000 000
Grand total	**61**	**488 316 339**

Appendix 6: Mainstreaming

"Mainstreaming of HIV/AIDS – What happened in Sida in 2003?"

(January 2004)

This study comes four years after the introduction of the IFFG. It is a desk study of 21 projects (16 country- and five regional/global). 18 of these projects were in Sub-Saharan Africa.

The study rated the projects as follows for mentioning/integrating/mainstreaming HIV/AIDS:

0 = no mention

1 = HIV/AIDS mentioned in Assessment Memo

2 = direct HIV/AIDS activities included

3 = HIV/AIDS issues mainstreamed

The results of the study are the following:

Score	0	1	2	3	
Country projects	2	1	8	5	16
Reg./Global	2	3	0	0	5
Totals	4	4	8	5	21

These results do not look very good: 4 years after the introduction of the IFFG, which insists on the "strong relationship between HIV/AIDS and poverty, gender inequality, human rights and sustainable development", one could expect that about 100 per cent of the African projects would score the maximum, i.e. three, or at least two. Yet, eight out of 21 projects score either zero or one; and *none* of the regional/global project does better than one (1)!

However, the study has directly focused on the *actions* undertaken, without looking at the actual context in which they occur:

1. How serious was the situation of the country/region with regards to HIV/AIDS, for the projects to require special attention to HIV/AIDS?
2. What are the links between the HIV/AIDS epidemic and the sector(s) in which those projects operate?

If we assign the ratings here below for those two aspects,

Seriousness of HIV/AIDS situation	Link between HIV/AIDS epidemic and sector concerned
0 = low	0 = none
1 = moderate	1 = likely
2 = high	2 = strong

The following combined scores (by multiplication of the two individual scores) could be used for rating the importance of mainstreaming HIV/AIDS in the projects studied:

Combined score

0 for either of both aspects, whatever the other → 0

Seriousness = 1, and link = 1 → 1

Seriousness = 1, and link = 2
Seriousness = 2, and link = 1 } → 2

Seriousness = 2, and link = 2 → 3 (not to exceed the maximum score given by the study)

One could say that any development project with a combined score of three, i.e. with a serious HIV/AIDS situation and a strong link between the HIV/AIDS epidemic and the sector concerned, should definitely have mainstreamed HIV/AIDS issues.

Assigning those ratings and scores, we could re-examine the 21 projects:

Country	Project	Seriousness	Link	Need	Study result
Burkina Faso	Appui aux district sanit.	2	2	*3*	*0*
Kenya	Primary Education	2	2	*3*	*0*
Mozambique	Regional Roads management	2	2	3	2
Mozambique	Rural Electrification	2	2	3	3
Mozambique	Civil society support	2	2	*3*	*1*
Namibia	Education Sector support	2	2	3	3
South Africa	Urban Development & housing	2	1	2	2
South Africa	Education project	2	2	3	2
Tanzania	District developt programme	2	2	3	2
Tanzania	Education Sector	2	2	3	3
Tanzania	Photovoltaic market developt	2	1	2	2
Uganda	Health Sector support	2	2	3	2
Uganda	Rural water & sanitation	2	2	3	3
Uganda	Justice Law & Order Sector	2	1	2	2
Uganda	Inter-Agency Appeal	2	1	2	2
Zambia	Agriculture support Programme	2	2	3	3
Regional	Democratic Governance – E.A.	2	2	*3*	*0*
Regional	African-Swedish museum netw.	2	0/1	1	1
Global	Unesco capacity building	2	2	*3*	*1*
Global	Int. Institute for Educ. Planning	2	2	*3*	*1*
Global	R. Wallenberg Institute	2	2	*3*	0

Taking the actual country situations into account, the study results look a bit better: ten projects (i.e. those – underlined – for which the numbers in the last two columns match) out of 21 have done exactly what was needed.

But still, seven projects, for which it was estimated that the highest level of mainstreaming was needed, scored only one (three projects) or zero (four projects). For those projects *(scores in italic)*, the question may be asked as to how such projects could be accepted for funding, as they did not at all or hardly integrated HIV/AIDS issues, in a situation where the importance of integrating HIV/AIDS was rated at the highest level.

Appendix 7: Sida's HIV/AIDS Network October 2004

Name	Department/Division
1. Lotta Sylwander	AFRA
Head of department	Department for Africa
2. Jan Essner	ASIEN
Desk officer	Division for Asia
	Department for Asia
3. Helen Lindquist	RELA
Desk officer	Department for Latin America
4. Florence Ahlberg	RELA/MULTI
Administrative assistant	Unit for Multilateral Affairs
	Department for Latin America
5. Henrik Norberg	EUROPA/EECA
Desk officer	Divison for Eastern Europe and Central Asia
	Department for Europe
6. Berit Rylander	DESO/UND
Desk officer	Divison for Education
	Department for Democracy and Social Development
7. Tomas Lundstrom	DESO/HÄLSO
Desk officer	Health Division
	Department for Democracy and Social Development
8. David Holmertz	DESO/KULTUR
Desk officer	Division for Culture & Media
	Department for Democracy and Social Development
9. Malin Ericsson	DESO/DESA
Desk officer	Division for Democratic Governance
	Department for Democracy and Social Development
10. Molly Lien	INEC/AL
Investigator	Department for Infrastructure and Economic Cooperation
11. Ervor Edman	INEC/INFRA
Desk officer	Division for Infrastructure and Financing
	Department for Infrastructure and Economic Cooperation
12. Anna George	INEC/KTS
Desk officer	Divison for Contract-financed Technical Cooperation
	Department for Infrastructure and Economic Development

13. Ola Sahlen	INEC/Marknad
Desk officer	Division for Market Development
	Department for Infrastructure and Economic Development
14. Johanna Palmberg	NATUR
Desk officer	Division for Rural Development
	Department for Natural Resources and the Environment
15. Pär Svensson	SAREC
Research officer	Department for Research Cooperation
16. Marie-Louise Bruzelius	SEKA/EO
Desk officer	Division for Non-Governmental Organisations
	Department for Cooperation with NGOs, Humanitarian Assistance and Conflict Management
17. Anna-Klara Berglund	SEKA/Hum
Desk officer	Division for Humanitarian Assistance and Conflict Management
	Department for Cooperation with NGOs, Humanitarian Assistance and Conflict Management
18. Alex Muigai	SEKA/Härnösand
Subject responsible	Sida Civil Society Center
	Department for Cooperation with NGOs, Humanitarian Assistance and Conflict Management
19. Fredrik Uggla	UTV
Evaluation officer	Department for Evaluation and Internal Audit
20. Eva Charlotte Roos	HIV/AIDS-SEKR
Desk officer	
21. Lena Ekroth	HIV/AIDS-SEKR
n.a.	
22. Anders Molin	HIV/AIDS-SEKR
Head of unit.	

Appendix 8: Analysis of Questionnaires sent to Members of the HIV/AIDS Network of Sida at the Head Office in Stockholm

Introduction:

Questionnaires were sent out to all 22 members of the network.[24]

As three of them are the team of the HIV/AIDS secretariat, their answers are not taken into consideration here as they are full-time professionally concerned with HIV/AIDS issues.

Of the other 19 members, the evaluation team met with nine of them for interviews. Some of the colleagues interviewed referred to these interviews and did not specify some of their comments as they had already expressed their views.

15 questionnaires (79 per cent of total) were received by October 25, 2004 after the second reminder; one person did not answer the questionnaire but instead referred to her interview with the evaluation team, two colleagues were on duty travel during the days, and one did not answer at all.

Summaries of the Responses:

1. Which Division/Department are you working?

The 19 members of the network (except the HIV/AIDS secretariat) represent ten departments and 15 divisions of Sida head office.

2. How long have you been in Sida?

The range of experiences in Sida is enormous. While a few colleagues have entered Sida only recently and are already 'promoted' to FPs, eight FPs have worked in Sida between 10 and 30 years.

3. How long have you been a Focal Point for HIV/AIDS?

While occasionally a FP has already had exposure and experience in HIV/AIDS (as a FP) in his or her assignment at country level and one occupies a post where HIV/AIDS is the main concern (HÄLSO), most of the FPs have been in their position between one and five years. However, a fair number have been active less than one year, occasionally even starting 'yesterday'. Six of the answers are referring to months (and not years); one volunteered only a week ago.

4. How did you become a FP?

Most FPs got in that position as through a mixture of having volunteered and being asked by their supervisors. Some had a strong work relation to HIV/AIDS issues and therefore were nominated FPs. There is also the case that someone was just present to replace a member leaving.

5. As a Focal Point, were you provided with…?

While it seems that there are no official 'generic' terms of reference for a FP in Sida (a draft has been discussed and circulated for some time), one or two FPs seem to have received this draft and/or have incorporated their FP work in their respective job descriptions.

However, more than 50 per cent of the respondents mentioned that they neither had ToRs, nor job descriptions nor an indication how much of their time should be spent on HIV/AIDS.

24 The questionnaire can be found in Appendix 9.

6. In your last two working months, how much of your work time have you spent on HIV/AIDS?

The actual amount of time spent on HIV/AIDS issues in the last two working months varies considerably: while the highest answer is 25 per cent of total there are also colleagues who spend around 1 per cent of their time on related issues. (The exception is the HÄLSO member whose post mainly deals with HIV/AIDS).

7. How was your preparation/introduction for the FP work?

None of the FP had a formal preparation (there is not such a system or specialized training). Some had discussions with the HIV/AIDS secretariat. But two thirds of the answers provided (ten of fifteen) mentioned that they had either done some personal reading or had no preparation at all!

8. As a FP on HIV/AIDS what do you perceive as your main role/function?

The overwhelming majority of colleagues stressed the functions like the link to the HIV/AIDS secretariat and to raise/promote the issues in their respective divisions/departments as the most relevant ones.

However, the functions help desk and providing technical advice although received positive answers.

It was also mentioned that the FP function should be seen in the support to programme officers at country level as well as participating in strategic issue development and following up on issues discussed in the department/division

9. Are you familiar with the Policy "Investing for Future Generations" (IFFG)?

If yes, what do you think of that Policy?

Of course, all FPs were familiar with the IFFG!

Most think it is a good policy summarizing important aspects, some think it is a bit outdated (in its facts) and that is also not practical enough for the needs of Sida but needs complementation through other documents.

It was also mentioned that there are too many policies in Sida and their relationship is not always clear.

10. Have you participated in 2004 in HIV/AIDS FP meetings?

Only four FPs had participated in 2004 in FP meetings at department level;

Only four have participated in the two FP-meetings at Sida level in 2004, five in one meeting and six had not yet participated in any meeting.

11. What do you think of the meetings?

The highest score was received by the answer that the meetings are useful exchange of information; nobody thought it was a waste of time; some thought it could be more practical, more intensive, more focused on the FP work. It was even suggested that the network should establish a work plan for its activities on a yearly basis. It was also mentioned that the work as a FP needs more recognition (by colleagues, division?). That would also affect the character of the meetings.

12. How often were HIV/AIDS related issues discussed in your staff meetings at division/department level in 2004?

Very few divisions (three) have the issues of HIV/AIDS as a regular item on their agenda; in the majority of divisions HIV/AIDS was "not at all", "rather seldom", or "sometimes" on the agenda.

13. Do you feel "AIDS-competent?"

While a strong minority (five) of the FP respondents felt that they were "AIDS competent", the majority (ten) was 'unsure' or negative in their answers.

14. Do you feel confident in your assignment/work as FP?

The answers were divided: half of them felt competent in their work as FPs, the other half was unsure about it. The insecurity relates evidently also to the lack of ToRs and job-description.

15. Do you think that mainstreaming HIV/AIDS into overall development work is important?

Nearly 100 per cent of the answers said "Yes"

16. Do you think that mainstreaming HIV/AIDS is done sufficiently in your division?

Only a few colleagues feel that this is already sufficiently done in her/his division/department.

- FPs mentioned that there are too few practical guidelines and tools,
- that 'mainstreaming' is still a somehow controversial concept for colleagues
- that mainstreaming should most of all happen at country level in the ministries and organizations and be supported by head office staff via the programme officers at the embassies.
- The FP new in their departments/divisions had, of course, not yet a clear picture.

17. Please include any comment/suggestion you would like to make on the issue of IFFG and HIV/AIDS work in Sida which may not be dealt with in the above questions but which you feel is important

Only a few FP provided additional comments (as mentioned in the introduction, the Evaluation team had direct interviews with nearly 50 per cent of them).

- Next to the country focus it was stressed that there is a need for more practical approaches but which are harder to develop and not so 'sexy'.
- The need for updates on international and Swedish initiatives was also stressed.
- The HIV/AIDS interventions should also be careful to "do no harm". Often outside interventions weaken the local capacity to respond.
- The need for donor 'harmonization' was stressed.
- A feeling was that Sida staff in general and FPs in particular need more skills/experience in dealing with the sensitive issues around HIV/sexuality.

Appendix 9: Questionnaire for HIV/AIDS Focal Points in Sida

1. Which Division/Department are you working?

2. How long have you been in Sida?

3. How long have you been a Focal Point for HIV/AIDS?

4. How did you become a FP?

a. volunteered ()

b. suggested by Head/Director of Div/Dept. ()

c. other; *pls specify* () .....

5. As a Focal Point, were you provided with

a. Terms of Reference ()

b. Job description ()

c. An indication how much of your time should be spent on HIV/AIDS

(pls specify hours or %) ()

6. In your last two working months, how much of your work time have you spent on HIV/AIDS? *(hours or percentage)*

7. How was you preparation/introduction for the FP work

a. formal training ()

b. discussion with HIV/AIDS Secretariat ()

c. own studies/reading ()

d. none ()

8. As a FP on HIV/AIDS what do you perceive as your main role/function

(multiple answers are possible)

a. Help desk ()

b. Link to HIV/AIDS secretariat ()

c. raise/promote issue in division/department ()

d. providing technical advice on mainstreaming ()

e. other, *pls specify* () .....

9. Are you familiar with the Policy "Investing for Future Generations" (IFFG)?

If yes, what do you think of that Policy?

a. not familiar ()

b. it is a good policy summarizing important aspects ()

c. it is good but a bit out of date ()

d. it is too much based on Swedish conditions/experiences ()

e. it is not practical enough for Sida's work ()

f. other comments ……

10. Have you participated in 2004 in HIV/AIDS FP meetings

a. at department level; *how many* ()

b. at Sida level; *how many* ()

11. What you think of the meetings?

a. useful exchange of information ()

b. useful for my competence building ()

c. relevant for my work ()

d. could be more practical ()

e. waste of time ()

f. other comments ……

12. How often were HIV/AIDS related issues discussed in your staff meetings at division/department level in 2004

a. sometimes ()

b. rather seldom ()

c. not at all ()

d. was introduced by my initiative ()

e. is a regular item on my meeting agenda ()

13. Do you feel "AIDS-competent"

(AIDS competency includes a. that you have a good understanding of the dynamics and challenges of the epidemic in general, b. you can assess the relevance of the epidemic in your (thematic/geographical) area of work and c. you feel secure that you can deal with the challenges as a person).

a. Yes ()

b. No ()

c. Unsure ()

d. Other comments ……

14. Do you feel confident in your assignment/work as FP?

a. Yes ()

b. No ()

c. Unsure ()

15. Do you think that mainstreaming HIV/AIDS into overall development work is important?

a. Yes ()

b. No ()

c. Other comment ……

16. Do you think that mainstreaming HIV/AIDS is done sufficiently in your division?

a. Yes ()

b. No ()

c. Other comment ……

17. Pls include any comment/suggestion you would like to make on the issue of IFFG and HIV/AIDS work in Sida which may not be dealt with in the above questions but which you feel is important

THANK YOU FOR YOUR PARTICIPATION

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