2009:02 Sida Evaluation

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Evaluation of the Swedish-Norwegian Regional HIV/AIDS Team for Africa

Final Report

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Foreword

The HIV/AIDS epidemic is a major threat to development in Eastern and Southern Africa. Since 2001 the Swedish International Development Agency (Sida) and the Norwegian Ministry of Foreign Affairs (NMFA) have collaborated through a joint Swedish/Norwegian Regional HIV/AIDS Team ("the TEAM"). The overall objective of the TEAM is to contribute to poverty alleviation by strengthening regional organisations and embassies in relation to prevention and impact mitigation of HIV/AIDS in Sub-Saharan Africa. Since the start the TEAM's two main tasks have been to manage the regional HIV/AIDS program and to provide technical assistance to the embassies in the region. Gradually the TEAM has also become what could be described as a regional knowledge resource base on behalf of Sweden and Norway. In 2008 the TEAM handled a portfolio of 71 regional contributions, amounting to 318 MSEK.

The purpose of the evaluation was to assess relevance, effectiveness and efficiency of the HIV/AIDS Team by focussing on: the regional approach; the cooperation between NMFA/Norad, Sida and the TEAM; and coherence with the respective HIV/AIDS policy; the TEAM's organisation and management/implementation; and selected regional partners' activities.

The evaluation concludes that the TEAM has added vitality to regional responses to HIV and AIDS in Africa. The TEAM is identified as a unique regional resource, but could be more effective and better utilised. The Team's rather weak programme theory hampers the articulation and strategic interpretation of regionality. Important questions that still need to be answered concern at which level results are being achieved and if impact can be identified at country level. There is a risk that the Team's main approach, building 'regional platforms' becomes an end rather than a means to achieving the overall goal. This also reflects a more general challenge for regional cooperation.

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Head of Secretariat
for Evaluation

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Director of Department
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Abbreviations

ARASA	AIDS and Rights Alliance for Southern Africa
ARVs	Antiretroviral medication
CCF	Christian Childrens Fund
CSA	Centre for the Study of AIDS
EAC	Economic Commission for East Africa
ECOWAS	Economic Community of West Africa States
GART	Golden Valley Agricultural Research Trust
GIPA	Greater Involvement of People Living with HIV/AIDS
GFATM	The Global Fund To Fight AIDS, Tuberculosis and Malaria
ICASA	International Conference on AIDS and STIs in Africa
ICP	International Collaborating Partner
IDASA	Institute for Democracy in South Africa
IGO	Inter Governmental Organisations
INGO	International Non governmental organisation
IOM	International Organisation for Migration
JFA	Joint Financial Agreement
MSM	Men who have sex with men
NAC	National AIDS Council
NGO	Non governmental organisation
NMFA	Norwegian Ministry of Foreign Affairs
Norad	Norwegian Agency for Development Cooperation
NZP+	Network of Zambian People Living with HIV/AIDS
OP	Operational Plans
PLWAs	People living with HIV/AIDS
PMTCT	Prevention of Mother to Child transmission of HIV
REC	Regional Economic Community
REPSSI	Regional Psychosocial Support Initiative
RAANGO	Regional Network of African AIDS Non-governmental organisations
SADC	Southern African Development Community
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SADC PF	Southern African Development Community Parliamentary Forum
SAT	Southern African AIDS Trust
Sida	Swedish International Development Cooperation Agency
SMFA	Swedish Ministry for Foreign Affairs
TEAM	Swedish-Norwegian Regional HIV/AIDS Team for Africa

UNAIDSRSTESA	UNAIDS Regional Support TEAM for Eastern and Southern Africa
UNODC	United Nations Office on Drugs and Crime
VSO-RAISA	Voluntary Service Overseas/Regional AIDS Initiative of Southern Africa
ZARAN	Zambia AIDS Law Research and Advocacy Network

Executive Summary

Background

In 2000, the Swedish International Development Agency (Sida) established in Harare (later relocated to Lusaka) what would become the Swedish/Norwegian Regional HIV/AIDS Team (the TEAM). Since 2001, Sida and Norway have collaborated. In 2006 this collaboration was subsequently strengthened and formalised through a cooperation agreement. By 2008 the TEAM's annual budget amounted to SEK 264 million plus NOK 50 million, and it has a current programme portfolio of approximately 37 organisations and 57 projects.

The purpose of the evaluation is to assess the TEAM's relevance, effectiveness and efficiency by focusing on the following key dimensions underpinning the TEAM's work:

1 The 'regional approach'
2 The cooperation between the NMFA/Norad, Sida and the TEAM; and coherence with the respective HIV/AIDS policies
3 The TEAM's organisation and management/implementation
4 Selected regional partners' activities

It was requested by Sida and Norad (those members sitting in the evaluation's management group) that while *all* of the dimensions mentioned above should be covered, particular emphasis should be given to dimensions 1 *and* 4: namely, the regional approach and regional partner activities.

Methodology

Programme theory is the key analytical tool used to uncover the different levels at which the TEAM operates, and to identify intentions, outputs and outcomes of the work of the TEAM, and of the TEAM's partner organisations. *Sampling of organisations:* from 37 partner organisations, seven organisations were selected. Two of these were selected for in depth study in both Zambia and Tanzania, namely, the Regional Psychosocial Support Initiative (REPSSI) and the Southern African AIDS Trust (SAT). *Document analysis* was an initial step in assessing how the TEAM works. Other methods included: *Key informant interviews (*61); and *Group discussions* facilitated in workshop settings held with the TEAM's partners invited to events in Lusaka, Dar es Salaam, and Pretoria. *Participatory methods* with

beneficiaries, including people living with HIV/AIDS at a local level; and a web-based *Survey* of embassy support were additional data collection tools.

Field work took place over 4 weeks in May, 2009 (see Annex 5 and 6).

Validity and reliability. The use of such a variety of data collection techniques has ensured cross validation of the data and information that have been gathered. By triangulating the methods used, in this way cross checking for accuracy and consistency across the methods, both the reliability and overall validity of the data and findings were ensured.

Findings

The TEAM's Regional Approach is highly relevant to building regional capacity. The TEAM has demonstrated outcomes in several areas in terms of building regional networks that exchange information, set agendas, and build competence related to sensitive issues. The TEAM can rightly claim building regional platforms as a considerable achievement.
The TEAM is therefore found to have augmented the capacity of regional organisations, driving processes in specific instances and in initiating support to other organisations. Many of the regional partners are highly relevant for regional responses to HIV/AIDS. Many are contributing to strengthening local organisations through networking, capacity building and training. The communities visited demonstrate capacity that has been built through the TEAM's support to regional organisations.

Added value from the regional approach is identified more generally, particularly in terms of capacity building and political influence.

The cooperation between the NMFA/Norad, Sida and the TEAM and coherence with the respective HIV/AIDS policies. There is added value to a joint partnership in the collaboration. This cooperation can be used in the two countries' joint work on HIV/AIDS at a global level. But the terms of the current cooperation agreement are limited in terms of detail, the extent to which they are adhered to and are also less well managed from Sida. There is also concern that contrary to being a joint team, the TEAM in the view of many will remain a Sida team. Norway therefore needs to decide its ambitions in relation to the TEAM. A larger degree of Norwegian commitment would create better symmetry and be beneficial in terms of Norway getting more out of the TEAM's unique regional experience. The TEAM often refers to Swedish policies and strategies but rarely refers to Norwegian ones.

Embassy support. The embassy survey confirmed the asymmetry (for a number of reasons) between Swedish and Norwegian embassies and respective ownership of the TEAM. Because the support to the embassies is demand driven, however, the TEAM is found not to be proactive enough in dealing with the different country and organisational contexts in which the embassies find themselves. Most respondents valued the TEAM's contribution in several areas and wished for the TEAM support to be continued, albeit in a modified way. The majority, however, including Swedish embassy responses, also highlighted the relatively poor connection between the TEAM and embassy interests at national level. These circumstances limit the relevance and effectiveness of the TEAM's embassy support.

TEAM management builds on relatively good systems but it could improve its performance and internal management.

Prevention and Mitigation. The TEAM's highly informed understanding of both the immediate and structural dimensions of the epidemic is an asset to prevention work. Because prevention is a composite of many different factors influencing behaviour, the portfolio is judged to generally have good coverage and understanding of these different angles. Above all, the TEAM is credited for playing a proactive role in identifying cultural drivers of and political responses to the epidemic on the regional level. In particular, some of these deal with cultural issues, such as multiple concurrent partners, as well as the role of political leadership in the epidemic. A major challenge, however, is to translate regional agendas and national mechanisms on prevention into behaviour change at the sub-national level and in meeting the needs of local target beneficiaries.

Overall Conclusion

The TEAM has added vitality to regional responses to HIV and AIDS in a number of key areas. The TEAM is identified as a unique regional resource. But it is also one that could be more effective and better utilised. Better articulation and strategising of regionality, to include regional-national-local bottlenecks is hampered by the TEAM's rather weak programme theory. Whether regional mechanisms are actually implemented and impact is felt at country level raises important questions concerning at what level results are achieved. When the TEAM's main approach, building 'regional platforms', is placed in the context of these different levels of outcomes, it is apparent that it soon becomes an end rather than a means to achieving the overall goal. This is not a problem of the TEAM alone but rather reflects the challenges in regional cooperation more generally.

Recommendations

Sida, the NMFA, Norad, the TEAM and the SMFA (as the author of a new regional cooperation strategy)

- It is highly recommended that the new Swedish regional development cooperation strategy considers how regional interventions also require better linkage to local, national and global levels. In other words, greater awareness could be made of understanding and strategising across these different levels, especially regarding national implementation of regional accords and instruments.

The TEAM

- There needs to be a more consistent understanding of regionality across the TEAM, not only on a broad level, but also with respect to specific details and a more critical engagement. This need not become an excuse for inflexibility, but should rather involve a more rigorous application of this understanding, especially in assessment memos. This will particularly assist in rationalising the programme portfolio, which requires review.
- A more regular external reassessment of the TEAM's portfolio is necessary. The portfolio review should also consider changes that have taken place in organisations due to the TEAM's support.
- The TEAM's staffing numbers should be maintained. Should the future bring cuts in budgets and fewer projects, this will free more staff time for developing a leaner and more strategic focus in line with above recommendations.
- Overall, greater effort should be dedicated to improve the presentation of knowledge and experience possessed by the TEAM.
- A clearer change theory for prevention and mitigation would provide much better focus on the TEAM's programme. The TEAM should prioritise, for example, cultural drivers and political leadership as key strategic considerations that cut across its work on prevention. A more prominent advocacy strategy should be based on such key causal mechanisms.
- More generally, with respect to both Swedish and Norwegian embassies, support should now be better tailored to embassy needs. For example, it seems that both Swedish and Norwegian embassies want the TEAM to engage more on a national level. The TEAM should improve its external communication and information system, and an improved website with details of the national partners it supports would be useful.

- It is highly recommended that while revising its support to the embassies, the TEAM should make use of the opportunity to incorporate more strategic considerations at national and regional levels.
- Better utilisation of the TEAM's regional experience can perhaps take place through a specific regional theme focal point seminar. Working with the embassies to track specific issues of mutual interest from regional initiatives to national implementation, is another. One particular issue might be championed for a definite period of time to enhance synergy.

The TEAM and regional partners organisations

- The TEAM and its partners should hold a workshop to discuss critical areas of achievement in regional added value and emerging issues, and the need for strategising for future direction. A new Regional Strategy for Swedish development cooperation in Sub-Saharan Africa presents an opportune occasion on which to do so.
- The challenges for regional organisations, such as the new sub-contracting role, need to be discussed, and human rights, cultural and gender issues need local translation.
- Many of the regional NGOs need to increase their visibility at the country level through strategic advocacy campaigns that use regional instruments more directly.

The TEAM and Norway

- A more solid entry point for Norwegian embassies would be achieved by introducing the TEAM at a regional gathering of Norwegian Ambassadors (as they do currently with Swedish Ambassadors).

Sweden and Norway

- A new agreement will present an opportunity to rectify the limits of the original agreement with the inclusion of more specific details regarding planning and reporting lines, and to recommit to better adherence to requirements for annual meetings and minutes of meetings. A new agreement should also include more references to specific, relevant Norwegian policy documents.

Norway

- Norway needs to decide what it wants from the agreement. For example, a better balance in funding and the provision of staff from Norway for the TEAM would increase symmetry, ownership and benefits from the work, while simultaneously increasing the perception of this as a joint TEAM.

1 Introduction

1.1 BACKGROUND

In 2000, the Swedish International Development Agency (Sida) established in Harare what would become the Swedish-Norwegian Regional HIV/AIDS Team (the TEAM). Since 2001, Sida and Norway have collaborated, and in 2006, this was subsequently strengthened and formalised through a cooperation agreement.[1]

1.2 COMMENTS TO THE TERMS OF REFERENCE (TOR)

The specific purpose of the evaluation following the ToR, is to assess the TEAM's relevance, effectiveness and efficiency by focusing on the following key dimensions underpinning the TEAM's work:

1 The 'regional approach'
2 The cooperation between NMFA/Norad, Sida and the TEAM; and coherence with the respective HIV/AIDS policies
3 The TEAM's organisation and management/implementation
4 Selected regional partners' activities

A set of questions to develop each dimension was set out in the ToR (see Appendix 2), which provides useful guidance for the evaluation. In terms of which dimensions to prioritise or give different emphasis to, the ToR states: 'An assessment of effectiveness, i.e. of results that have been achieved in relation to the TEAM's objectives, is of particular importance and shall focus on the outcome level. The evaluation shall pay specific attention to outcomes of the regional partners'. Furthermore the ToR also recognised that while the evaluation 'may not be able to assess sustainability and impact of the TEAM's efforts, it is expected that the consultants in their report will, based on their findings, discuss potential sustainability and impact of the regional partners' activities'. The ToR also states that it is

1 "Agreement between the Norwegian Ministry of Foreign Affairs and the Swedish International Development Cooperation Agency concerning Regional Development Cooperation on HIV/AIDS in Sub-Saharan Africa through the Swedish/Norwegian Regional HIV/AIDS Team in Lusaka" (2006).

expected that the evaluation team report will offer lessons learned that link the findings from the evaluation of the TEAM to the on-going discourse on regional approaches in development cooperation, bilateral and multi-donor cooperation and support to prevention and mitigation of HIV/AIDS. In the Inception report meeting it was decided that particular emphasis should be given to dimensions 1 and 4: namely, the regional approach and regional partner activities.

1.3 METHODS AND DATA COLLECTION

The complexity of the TEAM's programme, given the broad geographic coverage, large number of recipient organisations and long chain of implementation (from regional to local level), demanded the use of a varied and complimentary set of *data collection tools* [2]:

- Sampling of organisations and country visits
- Document analysis
- Key informant interviews
- An electronic survey to selected Swedish and Norwegian embassies
- Field work, including interviews with selected organisations
- Facilitated group discussions in workshops
- Participatory methods at the local level

Validity and reliability. The use of such a variety of data collection techniques has ensured cross validation of the data and information that have been gathered. Statements made in individual interview settings, for example, could be compared to, and contrasted with, the anonymity of those expressed in a survey, or, the interactive dynamic of a peer group setting. The methods were complimentary and enabled a fuller range of responses to be captured than would be achieved by using a fewer number of tools. These methods were very important in order to contextualise the rather limited nature of the documentation received, to better understand the work of the TEAM.

The interviews, for example, were based on a similar set of questions, addressing common themes and with a high degree of transparency (see interview and workshop guides). A good range of interviewees (61), most of which had two researchers conducting them, along with debriefing and clarification, ensured an overall good degree of reliability. By using local consultants with knowledge of the communities and familiar-

2 For a more detailed presentation of methods and data collection, see Annex 5.

ity with local languages, the approach taken to participatory work minimised problems of reliability. The data generated was particularly important to gauge beneficiaries' own perceptions of project interventions. Although therefore subjective, it was internally rigorous and therefore reliable.

By triangulating the methods used, in this way cross checking for accuracy and consistency across the methods, both the reliability and overall validity of the data and findings was ensured.

Attribution and contribution. The programme theory approach, with its emphasis on identifying and documenting linkages between outputs (activities), outcomes and results is a methodology that is well suited to document linkages, and hence addresses the question of attribution. However, because Sida and NMFA pool their funding, no direct link can be attributed between their funding and outcomes, which means that Sida and Norad contribute to the outcomes of the work of the TEAM's partners in general.

Informed consent was a feature of all surveys, focus groups and other participatory methods used. Wherever necessary, the local language was used.

1.4 THE EVALUATED INTERVENTION: THE TEAM

The period for the evaluation is 2006–2008, but it is important to briefly locate the TEAM's purpose and logic within the original Sida project decision document to establish the TEAM (1999). In this document, the TEAM was envisioned in four key roles:

1 Increase consideration of the HIV/AIDS situation within Sweden's bilateral aid
2 Regional cooperation to complement bilateral contributions
3 Research
4 Multi-lateral cooperation – with relationships with some multilaterals described as 'excellent' partnerships but with UN cooperation less developed at the regional and country level

The decision document identifies how more systematic feedback on the experience of the UN system's work at country level was, at that time, lacking within development cooperation. A strengthened field office (through the TEAM) was expected to provide information and recommendations that would contribute to better Swedish governance of various UN

organisations. It was expected that the experience would be systematically used by the SMFA in policy dialogues with the respective organisation head quarters and enhance governance. A team was considered especially useful in terms of acting to strengthen the goals of the Swedish HIV/AIDS strategy. Reflecting concerns at that time, emphasis was placed upon linking bilateral and multilateral aid and intensifying dialogue with multi-laterals, rather than regional intergovernmental bodies. The regional element gained momentum, however, with the increasingly strong regional emphasis of Sweden's Regional Development Cooperation Strategy (2002–6), within which increased regional support with respect to HIV and AIDS was considered an integral component.

In terms of the growing significance attached to the TEAM, this can be read on one level through changes in human resources and budget allocations. When the TEAM started up in 2000, it consisted of 3 people and a small budget; by 2002, after the move to Lusaka, there were 5 staff members and a budget of 30 MSEK. In the intervening years, there was a rapid 10-fold expansion. By 2008, the TEAM had 13 staff members (8 sent out, 4 NPO, one administrative assistant), with an annual budget of 264 MSEK, plus 50 MNOK from Norway. This places the TEAM on a very different footing in terms of human resource capacity in relation to other key 'like minded' donors (Dfid, RNE, and Irish Aid in particular) who have a far smaller capacity. The dual mandate of supporting a regional portfolio and providing support to Norwegian and Swedish Embassies is also another key characteristic that differentiates the TEAM from other donors.[3]

1.5 THE GOAL AND OBJECTIVES OF THE TEAM

The overall goal of the TEAM is 'to contribute to poverty alleviation by strengthening regional organisations and embassies in relation to prevention and impact mitigation of HIV/AIDS in Sub-Saharan Africa'.

Two core objectives of the TEAM are:

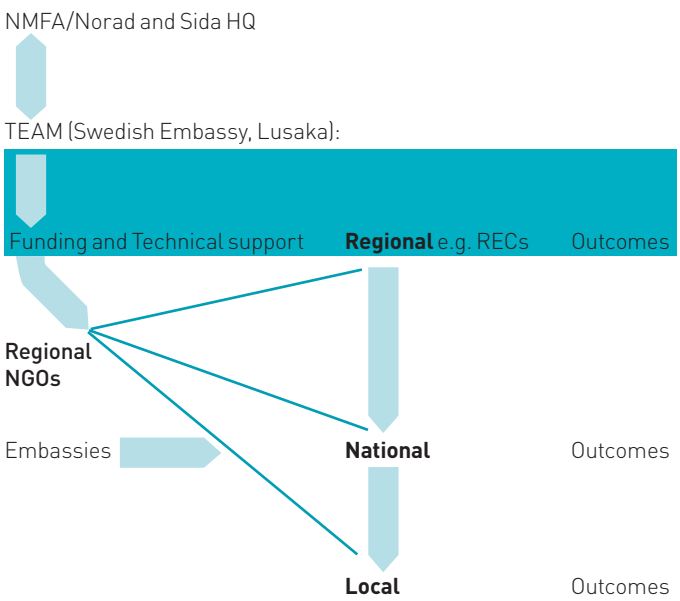
- To strengthen the organisational and thematic capacity of regional organisations, programmes and initiatives in relation to prevention and impact mitigation of HIV/AIDS, through capacity building, communication/dialogue and research.

3 With the RNE regional programme, for example, regional Dutch embassies are actually part of the RNE regional management structure.

- To support Swedish/Norwegian embassies in the region, in relation to prevention and impact mitigation of HIV/AIDS, through capacity building, communication/dialogue and the sharing of research.[4]

The TEAM has a very diverse portfolio of programmes supported. According to the TEAM's 'Operational Plan 2009–2011 Context Analysis', the programmes supported numbered approximately 67 (since changed, see chapter 5 and Annex 11 and 12 for the most recent numbers available). Some previous work raised issues concerning the TEAM's lack of measureable indicators and outcomes (for example, see Norad, 2007). For 2009–2011 the TEAM suggests that 'Consolidation, coordination and harmonisation' of the portfolio will be a 'major task' with the target of a reduction in the portfolio contributions by one third by 2011. The TEAM regards itself as an important regional actor, suggesting that 'the unique resource the TEAM represents in the region gives Sweden a strong voice and influence in the regional dialogue' (Annual report, 2008). The TEAM's leadership also wants the TEAM to be recognised as 'a Centre of Excellence'.

A basic starting point in assessing the TEAM's work is its depiction in the following simple diagram:



4 See 'Concept Note on Thematic focus' dated 17 February 2009, Embassy of Sweden, Lusaka, and ToR.

This shows the TEAM based at the Swedish Embassy, Lusaka, providing funding and technical inputs directly to regional organisations. The TEAM works through non-governmental organisations when it comes to working at the national and local levels. This means that there is long implementation chain: from Sida HQ (and NMFA/Norad) to the TEAM, to regional organisations, to national offices (where relevant) and to local Community Based organisations (CBOs) that are implementing partners for regional organisations. The regional non-governmental organisations therefore act as hubs connecting different levels of regional work (as depicted by the different lines connecting the regional non-governmental organisations to different levels).

Programme theory is the key analytical tool used to uncover the different levels at which the TEAM operates, and to identify intentions, outputs and outcomes of the work of the TEAM, and of the TEAM's partner organisations. Programme theory helps bring forth the assumed relations between the intentions or objectives of an intervention, the activities carried out and outcomes. Programme theory also helps in identifying the relations between the outcomes and the solution of the problems that the intervention seeks to reduce or solve (effectiveness). Programme theory, like other theories, suggests links between causes and effects: what outcomes are results of what mechanisms under what preconditions? The evaluation identifies and documents *outcomes* (particularly concerning recipient organisations), as well as describes and analyses *process/activities* which more specifically concern the Team's own organisation and activities.

In this way, the following questions may be posed:

- What is the vision and what are the objectives of the TEAM, or *what* did it intend to do?
- *How* does the TEAM intend to reach its objectives (with the help of what measures or activities)?

The TEAM intends to contribute towards prevention and mitigation of HIV/AIDS by means of the following activities:

- Funding and administering a regional portfolio of support to 37 regional organisations
- Technical support to embassies
- Capacity building of regional organisations, thematic as well as organisational
- Regional 'platforms' for dialogue/communication that bring together regional stakeholders; governments, civil society organisations, and regional institutions
- Research: funding of high quality research at regional universities

How the TEAM itself works directly at the regional level to implement its own activities is one key dimension. Another involves whether the TEAM adds organisations to its project portfolio that are in line with its objectives and that are capable of working at multiple levels: the regional, the national and the local.

What are the expected outcomes of the TEAM's work?
Improved organisational and thematic capacities of regional organisations are expected as outcomes of the TEAM's work. This aspect refers to institutional capacities at the regional level. Moreover, the ToR also asks for a discussion of the outcomes of the activities of the 37 organisations and 57 projects to which the TEAM provides funding. Outcomes of the work of the partners can be found at regional, national, community and individual levels. The evaluation will therefore address the contribution of the TEAM at different levels in terms of whether its own work and also that of its partners match expected outcomes.

1.6 THE EVALUATION TEAM

The Evaluation Team consists of four researchers from the Norwegian Institute of Urban and Regional Research (NIBR):

Peris Jones, PhD, human geography/development studies, was the team leader and took part in the overall management of the NIBR TEAM, design of the evaluation, all the field work and report writing.

Siri B. Hellevik, political scientist, took part in two of the workshops, some field work in Tanzania and South Africa and report writing.

Berit Aasen, sociologist, had the overall responsibility for the section concerning the relations between Norway and Sweden regarding the TEAM, and design of the report.

Aadne Aasland, PhD, social scientist, was responsible for the design and processing of the survey.

Consultants involved in the field work were Mwajuma Masaiganah, Equinet, Tanzania; Clara Mbwili, Equinet and the Department of Health, Zambia, with Charlotte Wonani, University of Zambia; Liya Mutale, consultant, Zambia; and Pierre Brouard and Rakagdi Mohlahlane at the Centre for the Study of AIDS, University of Pretoria.

The evaluation management group consisted of representatives from Sida and Norad.

2 The Regional Approach

2.1 POLITICAL AND SOCIAL CONTEXT

Countries in Sub Saharan Africa, which are home to 67 per cent of people living with HIV/AIDS (PLWAs) and where 75 per cent of all deaths globally related to AIDS occur, have seen reversals in post-independence development gains. It is now widely accepted that HIV/AIDS generates poverty, contributes to famine, consumes both household and government resources, and contributes to the social exclusion and discrimination associated with its stigma. The Southern African region, as the epicentre of the epidemic with 35 per cent of all PLWAs and 38 per cent of all AIDS-related deaths (UNAIDS, 2008) has a disproportionate burden.

Global mobilisation to combat HIV/AIDS has led to a dramatic increase in funding commitments – a twenty-eight fold increase in just under ten years, according to UNAIDS. In addition to global and bi-lateral programmes to strengthen national level systems and responses, it became increasingly recognised by stakeholders that an important contribution could also be made at the regional level through a r*egional approach* to the epidemic. An example is that as early as 1996 the European Union and SADC held a joint conference with the intention to prepare a SADC Plan of Action for adoption by the SADC Council of Ministers. This did not happen. But by 2003, the Maseru Declaration on the Fight Against HIV/AIDS in the SADC region signalled a renewed regional commitment.

2.2 DONORS' REGIONAL STRATEGIES

2.2.1 Sida/SMFA's regional approach

Sweden's 2002–2006 Regional Development Cooperation in Sub-Saharan Africa (SMFA 2002), currently being extended and updated, is the key document guiding regionality. This states that: "The aim is that, by the end of the five-year period, Sweden's support for regional cooperation should have helped to increase African capacity to cope with the following tasks: – reducing the spread of HIV/AIDS in a region…" (p. 8). It also

states that "Areas that should be particularly eligible for Swedish support for regional development cooperation that can afford added value for the parties are: …– cooperation to develop methods and exchange experience for efforts to combat HIV/AIDS" (p. 11). Although the TEAM is not mentioned specifically, all the citations point to work done by the TEAM. It seems like the TEAM has a defined role in the Swedish regional strategy, although we do not know how this will be formulated in the new strategy to be approved in 2009, except that AIDS will remain one of the core thematic areas of support.

Key issues in defining regionality are identified in this document. These include: *essentiality* –those aspects that can only be adequately met beyond the level of the nation state; *subsidiarity* – with the principle that where issues can be met at a lower level then this should always take precedent; *economies of scale* – the aggregate benefits of being in a bigger unit.

The Swedish policy framework understands regional added value as enabling: – "substantial gains [that] may be made if coordination and exchange of experience take place at the regional level between the actors involved. Here, regional cooperation affords added value for cooperation partners, compared with the situation of measures being taken in isolation at a national level. This applies, for example, to cooperation regarding skills and capacity development and to professional exchange of experience in various sectors of society" (SMFA, 2002:9).

2.2.2 Norway's regional approach

NMFA drew up an internal document in 2005 regarding the organisation of their regional support to Southern Africa (SADC), wherein support to HIV/AIDS is clearly identified as an important area. The responsibility for regional support to the energy sector was placed in the embassy in Mozambique; responsibility for HIV/AIDS, the TEAM and the other areas of support was placed in the embassy in South Africa (NMFA 2005a). This was communicated to the embassies in 2005 (NMFA 2005b). Norway has also developed a new "Platform for an Integrated African Policy" (NMFA 2008), where regional strategies are given high prominence while there is little reference to HIV/AIDS as a challenge to the region; the only reference is "Norway is also taking active part in the efforts to achieve MDG 6 on combating HIV/AIDS, malaria and other diseases (including tuberculosis)". (p. 23). One reason for the lack of HIV/AIDS visibility in this document is that it is perceived by the NMFA as a foreign policy document, and related less to development cooperation. The Norwegian HIV/AIDS Policy makes little reference to work on the regional level.

2.3 THE TEAM'S REGIONAL APPROACH

At the regional level, the TEAM provides funding and technical support. It regards its main role as building platforms for dialogue, enhancing regional cooperation and building the capacity of organisations to tackle the HIV/AIDS epidemic. The TEAM also consistently uses the Paris Declaration as a tool for working at the regional level, for example, working with the RECs and some regional organisations through Joint Financial Agreements (JFAs)[5] with other donors.

This approach is guided by some overall principles. For example, the TEAM stresses establishing South to South learning initiatives, regional democratic ownership and transparent and mutual responsibilities and coordination, both between regional programmes and international collaborating partners (TEAM, annual report, 2008).

Documented evidence of the TEAM's thinking on the regional approach is limited until 2009. A recent concept note from the TEAM on thematic focus does begin to define and set out its regional objectives (TEAM, February, 2009). The most recent TEAM document that discusses regionality is the 'Regional analysis of HIV and AIDS in sub-Saharan Africa' (TEAM, June, 2009), which provides a descriptive overview of regional impacts and responses to HIV/AIDS.

2.3.1 TEAM Activities and Outcomes

Activities

- The TEAM is regarded as an initiator of regional activities, such as the SADC Think Tank and therefore particularly through SADC, and more recently EAC support (see chapter five), but together with other donors. The TEAM sits within key fora such as the UNAIDS convened International Cooperating Partners forum and the non-formalised HIV prevention group; also in technical committees within SADC and the EAC.
- The TEAM finances key regional fora, such as the International Conference on AIDS and STIs in Africa (ICASA), the SADC Partnership Forum and Regional Network of African AIDS Non-governmental organisations (RAANGO). Many of its partners are active in these networks creating a range of synergies (see also chapter 5).
- The TEAM has organised several research-focused events, for example at the International HIV/AIDS conferences, where evidence-based findings are presented.

5 Joint Financial Agreements are agreements intended to harmonise donor support mechanisms, producing greater coherence and more simplified reporting systems for the recipient.

Outcomes

- Through this support certain policy 'milestones' have been achieved, including the Expert Think Tank on Prevention (May 2006) which for example highlighted the role of Multiple Concurrent Partners in the epidemic, but also resulted in member state commitments.
- TEAM has contributed to building the capacity of the HIV and AIDS Unit at the SADC (discussed later in the report).
- There have also been numerous examples of standard-setting through regional guidelines and protocols. A model law on HIV and AIDS has been developed through the SADC Parliamentary Forum. The definition of SADC Best Practices Criteria on HIV and AIDS, for example, helps to establish the characteristics of a 'good' intervention.
- The TEAM was influential, alongside other donors, in creating the 'Framework for regional support to HIV and AIDS in Southern Africa', which sets out a common vision of harmonisation by ICPs to strengthen support to Southern African regional institutions.[6]

The TEAM serves as the lead donor on at least four Joint Financing Agreements (JFAs) and has contributed to agreeing 11 of these. Long-term commitments have characterised the TEAM's approach to funding agreements.

The TEAM's approach is highly relevant to building regional capacity. In their outcome assessment, Devfin (2009) suggests that the TEAM appears 'well harmonised with the overall regional strategy' with respect to the TEAM's adherence to the regional development cooperation strategy. The TEAM is also regarded by several respondents as highly relevant and a critical ally in regional HIV/AIDS work, and as a significant regional player. The TEAM is regarded by UNAIDS as an initiator of activities. The TEAM has contributed in several areas in terms of building regional networks that exchange information, set agendas, and build competence related to sensitive issues. The TEAM can rightly claim building regional platforms as a considerable achievement. The TEAM is therefore found to have augmented the capacity of regional organisations, driving processes in specific instances (SADC, for example) and in initiating support to other organisations (e.g. ARASA).

The TEAM has initiated and strengthened the role of research in contributing to evidence-based findings to inform its own work, its partners and regional approaches to very contemporary issues. The TEAM's specific approach has also

6 Undated pamphlet publication, by UNAIDS, with Sida and several other donors, including NMFA.

contributed to ownership. One National AIDS Council (NAC), for example, lauded the TEAM's flexible approach, i.e. its tendency not to impose programmes on recipients, which, it was claimed, gives the TEAM programmes a distinctive character and credibility.

2.4 REGIONAL ADDED VALUE

The evaluators identified a list of dimensions identified from workshops and interviews as comprising 'regional added value', namely, benefits accruing from work at a regional level as distinct from work at only a national level.

2.4.1 Capacity building

Information sharing – according to beneficiary organisations, more valuable lessons and practices were shared between recipients than would otherwise have been the case had they been locked into a specific national or even local level of work.

Access to resources – smaller community-based organisations have used partnerships with regional organisations in order to leverage in financial resources that would not have been possible otherwise. The ARASA, for example, shared how many of its affiliates are finding it much easier to raise funds through the ARASA network than on their own.

There was added value found in *harmonising approaches* – regional model laws, protocols, guidelines, and common standards were all regarded as important in standardising responses to HIV/AIDS. Harmonisation allows for inter-country comparisons and tracking of impact at a regional level to identify genuine 'best practices'. For example, surveillance methods, which through SADC had for the first time enabled a common approach across a majority of the countries in the region, gave results that could be compared and contrasted.

Technical expertise – Technical expertise transfer is cited as very important due to the uneven capacity of different organisations. In this respect, training people from several countries at the same time was also deemed a more efficient method than holding several in-country workshops.

Networking – the benefits of belonging to a network as opposed to working alone were highlighted, e.g. for increasing the visibility of an organisation.

There was also a range of *less tangible* 'added value'. One organisation mentioned, for example, that through regional cooperation, laboratory equipment that was not available in Zambia was made available in South Africa for that organisation to use.

Much of this reflects the *'economies of scale'* mentioned – not only with respect to training more people, but also information materials concerning treatment or prevention could be mass-produced regionally.

More specifically, a regional approach was useful in tackling *'essential'* regional issues such as cross-border migration and transport corridors.

2.4.2 Political influence

Lobbying – ZARAN in Zambia mentioned the added value of having a network organisation – ARASA – involved in its lobbying activities, which lent its own organisation credibility and visibility in Zambia (for example in a joint newspaper article). This added political capital in some instances. ARASA, one of the TEAM's partners, had also been influential in creating a regional civil society statement of opposition to the criminalisation of HIV/AIDS in the region. Moreover, access to treatment and other *regional goods* were cited as things that were better coordinated and lobbied for at the regional level.

Political momentum – such as through the Maseru Declaration on Prevention, the Expert Think Tank meeting, again added political force aggregated at a regional level, where national responses had waned. The *peer pressure* on countries and competition generated at a regional level was deemed by several to be conducive to generating national leadership where previously little pressure was being exerted.

Sensitive issues – a number of issues were also highlighted that had been deemed too sensitive to approach at the country level. MSM, HIV prevention in prisons, sex work – all were issues that struggled to be placed on national agendas. Regional awareness and regional approaches to these issues proved able to enter into the national context and policy debate in a number of countries.

From the above, benefits of regionality are identified that actually go beyond those stated in SMFA (2002) and in the TEAM's own documentation. These benefits reflect valuable dimensions of the regional approach, in what can be identified as the *aggregated added value* of working at this level.

2.5 CHALLENGES

A number of challenges, however, are evident. Two overall inter-related challenges are identified here:

Poor discussion on regionality. The TEAM's documentation is descriptive and insufficiently elaborates upon regionality. The evaluators, however, are aware, based on interviews, that the TEAM has rigorous internal discussions in their 'project

assessment committees', where they discuss regionality amongst themselves. There appears to be broad agreement on what regionality is within the TEAM, but when it comes to the details, discrepancies and a degree of unevenness emerges. A review of some TEAM assessment memos of funding proposals by the evaluation team, for example, showed that discussion of regionality is very uneven from assessment to assessment. But a degree of confusion regarding understanding of and reporting on results of regionality also appears to permeate many of the TEAM's partners. Regionality was regarded by some as posing numerous challenges for NGOs. Some of these challenges include ascribing new roles to NGOs, with regards, for example, to acting as sub-contractors to other organisations. Other challenges identified include whether or not regionality brings with it a tendency to homogenise and hence simplify complicated national level differences (see South Africa workshop report, Annex 9). Critical engagement by the TEAM with such issues regionality raises appears to be missing.

Lack of detail on expected outcomes. There is a tendency for the TEAM to regard the emphasis on building regional platforms as an end rather than a means to preventing and mitigating HIV/AIDS. It is important to ask what then happens to all the guidelines, protocols, laws and so on, after that platform is created and developed regionally. On several occasions, the TEAM simply was unable to identify what had happened because these areas had not been followed-up. When national-regional linkages are evident, these are either lost or, at least, not always easily visible in the TEAM's documentation.[7]

While democratic governance and rights-based approaches, themes mentioned in the concept note, for example, are highly relevant at the regional level, both conceptually and operationally also clearly depend upon national political actors/duty bearers for implementation. The most recent TEAM 'regional' document (June, 2009) still does not respond to some of the problems with regional-national linkages raised more generally in regional cooperation by Devfin (2009) and this evaluation.

7 For example, the National AIDS Council in Zambia cited the important role facilitated by SADC in generating peer pressure between member state NACs. Good programmes in member states create competition and also a desire to improve less well performing programmes. These are important dimensions that are not being tracked or even adequately reported by the TEAM.

2.6 RECOMMENDATIONS

- The TEAM needs to better focus its programme theory. In particular, the TEAM should elaborate on its change theory and the causal mechanisms that lead to prevention and mitigation of HIV/AIDS. One way is to focus more clearly on programme objectives as something distinct from activities and especially to provide more detailed expected outcomes.
- There needs to be more consistent understanding of regionality across the TEAM, not only at a broad level but also in the specific details, and more critical engagement. This need not become an excuse for inflexibility, but rather a more rigorous application, especially in assessment memos. This will particularly assist in rationalising the programme portfolio.
- The evaluation team find the TEAM's emphasis on 'creating platforms for regional dialogue' important but in the face of bottle necks between regional and national level, inadequate. The issue of follow-up on some of these bottle necks, e.g. the model law on HIV and AIDS, should be pursued and requires discussion and strategising between the TEAM and Sida (and Norad) HQ, Embassy level and partners.
- The TEAM needs to further develop its result-oriented approach which will contribute a lot towards documenting outcomes rather than activities. It is still too vague and requires better focus on goals, objectives and activities.
- A more rigorous programme theory and regional methodology would help in revising the programme portfolio (a basic starting point is to map 'regional added value' against 'typology', see chapter 5 and recommendations concerning a workshop with partners).
- It is highly recommended that the new Swedish regional development cooperation strategy consider how regional interventions also require better linkage to other important levels. In other words, greater awareness could be made of understanding and strategising across these different levels, especially regarding national implementation of regional accords and instruments.

3 The NMFA/Norad, Sida and TEAM cooperation

3.1 MANAGEMENT OF THE TEAM IN Sida AND NMFA/Norad

Sida and the Norwegian Ministry of Foreign Affairs (NMFA) entered into an agreement, dated 4 December 2006, concerning the "Regional development cooperation on HIV/AIDS in Sub-Saharan Africa through the Swedish/Norwegian Regional HIV/AIDS TEAM in Lusaka" for funding the period 2006–2010 (Sida/NMFA 2006). The Agreement is in effect until the end of 2010, although funding commitments only run until the end of 2009. The total Norwegian budget is 180 million NOK, while the total Sida budget is 925 million SEK. The budget each year reflects a proportional distribution between the partners.

Although it is a jointly funded team, the Norwegian funding is delegated to Sida, and the management of the TEAM follows Sida rules and procedures as they are set out in "Sida at Work" (Sida 2005). It is, however, not a silent partnership, and the Norwegian voice should be registered through the annual meeting in issues relating to changes in administration and in policy concerns.

The TEAM is organised as a Sida unit, and as a section in the Swedish embassy in Lusaka. It presents its operational plans and budgets (OP) to Sida/Operations, Department for Long Term Cooperation, in the same manner as Sida sections in Swedish embassies, and receives its Letter of Allocation and the consolidated (Swedish/Norwegian) funding from them.

Norway provides funds to contract two staff positions, while the rest of the staff positions are funded by Sida. Norway, however, provides only one diplomatic staff position to the TEAM. The plans in 2005 were for Norway to make two diplomatic positions available to the TEAM. However, a new government came to power in Norway that froze the number of its diplomatic positions, and Norway was left with only one diplomatic position. A long and difficult process took place and resulted in a decision that Norway would fund a second staff position, but Sida would provide the diplomatic position for this staff member. According to information the evaluation team has received, in so far as a new agreement is signed, the issue of how Norway will fund and make available diplomatic staff positions needs to be clarified.

According to the rules for delegated aid (Sida at work 2005) the annual meetings of the partners shall be organised to approve plans and budgets. The Agreement set out the procedures for managing the joint partnership. An annual meeting is to be called by Sida in the 4th quarter of each year for the coming year. The documents for the meeting shall be forwarded by Sida at least two weeks ahead of the meeting, together with the Agenda. The documents shall include the plans and the budget for the coming year. Minutes of the meeting should be recorded and approved by the parties after the meeting. The disbursement rules are also set out in the agreement, whereby Norway pays in 6-monthly instalments, the first at the beginning of the year based on the information from the annual meeting and a second instalment after having received the full annual report and accounts in April for the preceding year. However, disbursement is also dependent on the cash balance and the need of the TEAM for new transfers.

These procedures are in line with the usual way of managing delegated aid in both Norway and Sweden, but they have not been followed. Sida has not called annual meetings in due time. The inception meeting was held in 2006, but there is no agenda or minutes from this meeting in the archives. The minutes do not seem to have been produced at all. An annual meeting which was supposed to be organised in 4th quarter 2007 was called very late, after reminders from the NMFA, and was eventually organised as late as in April 2008 (Sida 2008c) to approve the same year's plans and budgets. Due to illness this meeting was organised as a telephone conference, and only a very brief and informal minutes of this meeting exist (Sida 2008). The annual meeting for 2008, which should have been organised in the 4th quarter of 2008 was not called in due time, and finally took place as late as 3 June 2009.

The documents necessary for disbursement of funds have also been late. The annual report for 2007, which should have been forwarded to the NMFA, Norway, was still not available for the Annual Meeting in June 2008. Nor has it yet been made available to the evaluation team. The reason given for this is that in the latest reorganisation of Sida, reporting templates have been changed and the annual budget year for the TEAM is now from 1 September to 31 August.[8] The next annual report will therefore be from August 2008 to July 2009, and will be forwarded to the parties in September 2009, whereupon an annual meeting will be organised. However, these changes in reporting timelines were not reported to the NMFA until the latest Annual Meeting in June 2009.

8 These changes were presented by Sida to the NMFA and Norad at the latest annual meeting on 3 June 2009.

Given that Norway enters into a new agreement, management and follow up of the TEAM by the Norwegians might be moved from the Department for Regional Affairs and Development (Regional Department)/NMFA to Norad. This seems reasonable, as it is mainly policy and technical discussions that take place on strategic directions in the annual meeting. However, there would also be downsides to such a change. HIV/AIDS is less and less prominent in bilateral aid in Norway and in the embassies' aid programme portfolios. Having the responsibility for managing the TEAM would ensure some institutional responsibility and involvement of the Regional Department of the NMFA in HIV/AIDS work in the most affected region of the world. As long as the TEAM also serves the Norwegian embassies with advice, there should be a link to the regional department in the NMFA, as they are instructing the embassies on their annual activity plans and three-year rolling plans for development cooperation, even if the management of the TEAM is moved to Norad. Such a link is expected to be maintained, also in the event of moving the management to Norad, with overall responsibility remaining in the Regional Department.

3.2 SECTOR DEPARTMENTS' INVOLVEMENT

In Sida there is no formal note concerning how the various sector departments are involved in the management of the TEAM. Sida procedures for managing the TEAM follow the general management rules of bilateral development cooperation.[9] The TEAM is organised in parallel with the embassies' bilateral aid programmes, and present their annual plan, including a three-year rolling plan, to the Department for Long-term Cooperation in Sida HQ. Sida's management organises a week of peer review of all Operational Team Plans, including the HIV/AIDS Team's. All department directors in the Policy Pillar take part in the peer review exercise, including the Director for Human Development.

This scrutiny and feedback to the TEAM is where the various policy directors have an opportunity to comment on aspects pertaining to their field of expertise, and a window of opportunity to bring in non-HIV/AIDS themes such as gender, human rights, governance etc. This is also to ensure that the TEAM is informed about new policies and strategies. The AIDS advisor in the policy department is not directly

9 Sida was reorganised 1 October 2008. The description here is based on the procedures introduced at that time, and is only in effect for the year 2009 and onwards.

involved in this, but may be contacted informally by her director for comments. The Department of Long-term Cooperation then presents the comments in their letter of allocation to the TEAM for the next year. The TEAM reports back to Sida each trimester starting in 2009.[10]

The directors of the departments within the policy pillar are similarly involved in a week-long review of the reports from the embassies, including the one from the TEAM.

The Health and Social Security team in the Policy Department Human Development has regular informal contact with the TEAM, and is the contact point for the SMFA for HIV and AIDS related programming in Sida. The Health and Social Security team at Sida HQ has regular contact with the HIV and AIDS ambassador in the Swedish MFA (SMFA), takes part in preparatory meetings for global meetings and forms part of joint delegations to meetings in UNAIDS and The Global Fund (GFATM) etc., under the leadership of the SMFA. The Health and Social Security team at Sida HQ provides substantial information from the field through regular contact with the TEAM, which again is used in the SMFA comments to work in the UNAIDS and the GFATM. This includes Sweden's comments to the latest UNAIDS evaluation, which were informed by the TEAM's experience from the field.

There appears to be, based on information received by the evaluation team, some concern, in Sida that communication with the technical expertise (Policy Department) was weakened in the period between 2006 and the Sida reorganisation on 1 October 2008, when the Africa Regional Department handled the management of the TEAM. Since the reorganisation, this link has been strengthened again. The Policy Department for Human Development and its Health and Social Security team where the HIV and AIDS policy specialist is placed, has the overall responsibility for global dialogue, competence development, results – and portfolio analysis and policy development within the thematic area. The TEAM forms part of the Human Development Network, which means it is closely linked to these responsibilities.

In Norway, responsibility for the management of the support to the TEAM was transferred from Norad to the NMFA/Regional Department in April 2004, when bilateral aid was transferred from Norad to the NMFA. The entity within the NMFA responsible for HIV/AIDS policy is the Section for Global Initiatives and Gender Equality (GIL) in the Department for UN, Peace and Humanitarian Affairs. The Global

10 This is a simple excel sheet following the result matrix presented in the annual plan, where issues and problems are flagged.

Health and AIDS Department (AHHA) in Norad works closely with the NMFA and provides policy and technical advice. A memo dated 22 May 2008 from the NMFA set out the 'Communication between the Lusaka-TEAM and the NMFA/Norad/the Norwegian embassies'. It states that the TEAM should relate to the Regional Department, NMFA, for all administrative and management matters, to GIL (the AIDS ambassador and her staff), for policy matters, and to Norad for technical matters. The Regional Department sends the reports and plans to Norad for comments, and make consolidated comments back to Sida and the TEAM concerning these documents.

The TEAM also has a Reference Group with experts from the Region (see chapter 4). To gain better insight in the TEAM's work, and ease communication and understanding, it might be a good idea that policy advisors/specialists from the two countries join the Reference group meetings. There are two Reference Group Meetings a year. The idea of organising the annual meeting of the two donors in Lusaka back-to-back with one of the reference group meetings has been suggested to us, and we support that this option be discussed.

3.3 ALIGNMENT WITH SWEDISH AND NORWEGIAN HIV/AIDS POLICIES

Both Sweden and Norway have HIV/AIDS policies, which very much reflect mutual coherence. The two countries also work closely together in international fora. Both policies place great emphasis on the two objectives of the TEAM: prevention and mitigation. Both countries also link prevention to sexual and reproductive health and rights (SRHR), which has been introduced as one of the three thematic areas of work and results reporting of the TEAM. The support provided by the TEAM is clearly influenced by the HIV/AIDS policies and thinking in the two donor countries, and is in line with their strategies and policies at a general level. However, the Evaluation team is concerned that the work on prevention and SRHR is still weak in the TEAM's support to the regional NGOs, although it is present in the support to other regional organisations, such as the SADC.

Both Sweden and Norway have strongly emphasised the involvement of civil society in their HIV/AIDS policies, and also voice strong support for multilateral development cooperation to strengthen HIV/AIDS initiatives. The TEAM is a

relevant and useful instrument for strengthening the active participation of civil society in the region's HIV/AIDS work. The TEAM could play a stronger and more strategic role in relation to the global HIV/AIDS initiatives by providing evidence and learning from the field to the discussions in the global health fora, such as the UNAIDS, The Global Fund etc.

3.4 THE ADDED VALUE OF THE SWEDISH/NORWEGIAN COLLABORATION THROUGH THE TEAM

The added value of the joint collaboration beyond a larger budget for the regional support is that this collaboration may build a strong foundation for joint Swedish/Norwegian participation in the global HIV/AIDS arena. There is already strong collaboration between the two countries. This could be strengthened and given an even better knowledge base if the collaboration is better organised and integrated in the two respective countries. This might entail, for example, linking the Swedish AIDS ambassador closer to the TEAM's work.

This added value is, to some extent, already made use of, but it could be improved. The asymmetry has to be taken into account when discussing the added value. The Norwegian embassies have gradually closed down their bilateral HIV/AIDS support, in response to policy from the NMFA to reduce the number of programme areas[11], while this is not the case with the Swedish embassies, who are also instructed to use the TEAM as their technical advisors. The added value of linking embassy support with support to regional organisations will therefore differ between Sweden and Norway.

3.5 ASYMMETRY BETWEEN SWEDEN AND NORWAY IN THE USE AND 'OWNERSHIP' OF THE TEAM

The partnership between the two countries is affected by the asymmetry that exists between them in terms of their roles as donors and respective organisational structures. This affects the respective countries' 'ownership' of the TEAM. Norway provides approximately 18 per cent of the TEAM's funding

11 Arguments for decreasing bilateral support to HIV/AIDS have also been that the sector is crowded at country level, with many donors; and that Norwegian bilateral funding is providing better value for money in other areas.

and funds two out of eight expatriate staff positions. One reason for this asymmetry might be that at the time when the two countries signed the new agreement of 2006, Norway underwent a change of government. The new government did not place HIV/AIDS among the five highest priority areas, but promoted new areas such as climate change, gender equality, clean energy etc.[12] In Sweden during the same period there was a renewed interest and investment in an active HIV/AIDS policy and interventions, also at bilateral level.

Sida has delegated technical support to the Swedish embassies in Eastern and Southern Africa to the TEAM; Norway has not done so. No clear instructions have been given to Norwegian embassies on when to use the TEAM and when to use Norad. An internal note in the NMFA, which was never formalised and conveyed to the embassies, states that the embassies, for technical support to HIV/AIDS, should refer to their needs in their annual activity plans. Thereafter Norad would review these needs and discuss with the TEAM which of these assignments will be covered by Norad and which by the TEAM. Embassies tend to use Norad as priority source for technical support. Norad confirmed in interviews that the embassies make their needs for technical support known in their annual activity plans. Norad then discusses these on a case to case basis with the TEAM, when and if Norad deems it relevant to bring in the TEAM.

Norway has a substantial HIV/AIDS capacity and competence in its Global Health and AIDS Department (AHHA) team in Norad, and also more staff supporting the AIDS ambassador in the NMFA. Sida keeps only one HIV/AIDS policy advisor/specialist in Stockholm, and the AIDS ambassador and one additional global health advisor in the SMFA. There are, however, a number of health experts, who also work on HIV/AIDS in the Sida country teams, placed within both the embassies and in the Sida HQ.

According to the Agreement, the management of the TEAM shall follow Sida procedures and rules. Sida has in its latest plan (2009–2011) taken this to mean that it is sufficient to refer only to Sida policy documents (on HIV/AIDS and on regional strategy). While the NMFA disagrees with this, it is evident that the Agreement could have been more explicit on this issue. A new agreement should be explicit on what policy documents the TEAM should relate to.

12 One indicator is the lack of space allocated to the issue of HIV/AIDS in the new 'Platform for an integrated Africa Policy' (NMFA 2008) and in the latest White Paper 13 (2008/2009), 'Climate, Conflict and Capital' (NMFA 2009). Both these documents are seen as foreign policy documents, and giving directions for a broader Norwegian development policy discourse going beyond aid. HIV/AIDS seems, in this connection, to belong to the aid paradigm.

3.6 SHOULD OTHER LIKE-MINDED PARTNERS BE INVITED TO JOIN THIS COLLABORATION?

This question has been discussed for several years now, and an initial beginning of such collaboration may be seen in the Joint Financing Agreements (JFAs) that the TEAM has worked on. Taking the next step towards more formalised collaboration with and through the TEAM has not been discussed explicitly in the documents reviewed. It became evident through the field work that there is little basis for inviting other donors to join in the financing of the TEAM, as they all work in different manners and have differing opinions on what a regional approach entails. The evaluation team believes the JFAs may serve as a useful instrument for joint donor collaboration for specific organisations. It does not recommend inviting new, like-minded partners to join the collaboration. However, the evaluation team recognises that this might change in the future and that those other like-minded donors might approach Sweden and Norway on this issue.

3.7 RECOMMENDATIONS

- The division of labour and reporting and decision making that was made explicit in the Agreement of 2006 has not been followed up. Both donors are well aware of this, and ready to rectify the situation. Sida will inform the NMFA in a letter about the changes in management given the new reorganisation of Sida, and the reporting system will be adapted to this. One of the main changes taking place was that Sida, Long Term Co-operation only approve overall plans and budgets and that all other decision taking has been moved to the TEAM, and that the TEAM represents Sida at Annual Meetings. The evaluation team is concerned about this situation, as there is little supervision of the TEAM. With so much delegated power in the TEAM, there will be a need for more information, better reporting, and more analytical work to be presented to the annual Meeting and the Reference Group.
- The systems for involving sector departments and policy units need to be formalised and strengthened. The policy units may then benefit more from the knowledge generated within the TEAM and from their work, and the TEAM may benefit more from the policy divisions, also beyond HIV/AIDS specific policy issues.

- The work of the TEAM is in line with the two donors' policies and strategies at a general level. However, the evaluation team is concerned that there still is not enough support to prevention and sexual and reproductive health and rights (SRHR) in the TEAM's support to the regional NGOs. The TEAM should make a special effort to improve their project portfolio on prevention and SRHR. A regular portfolio review would be a useful instrument to ensure that the content of the support is better aligned to priorities in the two donor countries, and to the objectives of the TEAM.
- There is added value to a joint partnership in the collaboration in the support of the TEAM that can be used in the two countries' joint work on HIV/AIDS globally. This added value can be improved to depend on proper organisation and linking the knowledge base in the TEAM and the TEAM's work better to the two countries' joint efforts at the global level. There seems to be less scope for added value and joint efforts at the country level as the two countries pursue very different policies with respect to the embassies involvement in the bilateral funding of HIV/AIDS programmes.
- Norway is advised to be more ambitious in their use of the TEAM, and to put more energy into ensuring that there is a synergy and visibility in Norwegian development cooperation in their engagement with the TEAM. Norway needs to strengthen their 'ownership' of the TEAM. The best way of increasing the symmetry of the two countries' involvement in the TEAM, is for Norway to increase their funding to the TEAM, and be more active in their communication with the TEAM, by i.e. taking part in the some of the Reference Group meetings. This might be contradictory to the idea that one should delegate resources to simplify and lower the cost of management though harmonisation and division of labour. However, the TEAM is one of a kind, and offers unique knowledge and experience that are not provided through silent partnership, but only through active involvement.
- Given the asymmetry, there is a danger that the TEAM will remain in the perception of many a Sida TEAM. Norway needs to engage with Sida on this issue if a new agreement is formulated in 2010. A better balance of funding and sending out more Norwegian staff to participate in the TEAM (raising the latter from one to three for example) would also increase the symmetry and the perception of it as a joint TEAM. This should be encouraged as this is a unique and effective regional mechanism for HIV/AIDS support in the world's most affected region.

- It is recommended that Sweden and Norway enter into a new agreement for a new period of joint support to the TEAM. Such an agreement should clarify a number of issues that have remained problematic during the 2006–2009 period. The two countries need to agree on the type of partnership and delegation that will govern this collaboration. It is recommended that partnership should take precedence over delegation, i.e. that one strives for better symmetry between the two countries. It is recommended that reference is made explicitly to the need for adherence to both countries' policies and strategies; that planning and reporting lines are identified, and that the role and function of the annual meeting between the two countries is also stated explicitly in relation to decision taking residing in Sida's management system and procedures for the TEAM. Norway needs to decide what kind of delegated aid this will be; if this is not a silent partnership, how much involvement and investment will Norway provide to the management of the TEAM? The evaluation team is well aware that this is a decision that has to be taken by the partners, and where a balance must be struck between the capacity available and efforts to improve utility by engaging more in the TEAM's work. An alternative would be to move in the direction of a more silent partnership and delegate to Sweden even more of the management of the Norwegian funding of the TEAM. This is not recommended by the evaluation team, which believes that Norway will then miss out on important and valuable knowledge and experience by not being more involved in the management of the TEAM.
- The evaluation team advises against inviting other like-minded donors to the collaboration.

4 The TEAM's organisation and management

4.1 INTERNAL ORGANISATION

Overall, the internal management of the TEAM is found to be adequate. The TEAM has dedicated and competent staff. The level of staff and resources is deemed appropriate and, moreover, necessary for the TEAM to maintain its influence in the region. The TEAM is headed by a Director, who is also a regional counsellor and provides overall oversight and leadership, and a Deputy Director. Each programme officer is allocated, on average, approximately six partner portfolios. The allocation is based on a combination of interests, country and work expertise, and thematic relevance. Where a programme officer has specific country experience, then they can be allocated projects related to that country. Most staff has country or regional expertise from a Sub-Saharan African context.

In addition to portfolio allocations, each programme officer is given additional responsibilities. These include, among others, those for developing monitoring and evaluation; result-based matrix; TEAM regional strategy; work with RECs; and so on. TEAM programme officers have large workloads, which are exacerbated by a high number of travel duties and large project portfolios. Nevertheless, the in-country offices of regional organisations generally expressed a desire for more team contact and visits.

Some partner organisations, as well as TEAM members themselves, indicated that there is a problem of knowledge management. This is particularly in terms of the turnover of TEAM staff and sometimes in the poor overlap between the outgoing and the incoming TEAM members.

4.2 RESULTS-BASED MANAGEMENT (RBM) AND REPORTING

There is generally an overall absence of reference to the regional dimension in the projects/programmes assessed and documents reviewed. A lack of measurable results is therefore reflected in the TEAM's own reporting and planning system, although documentation from 2009 does indicate, as suggested, that better detail is being added. In terms of measuring

and documenting results, whereas the TEAM developed a results-based matrix by 2009 (see thematic strategy concept note, 2009), although very relevant, it is still to be operationalised and is therefore too soon to be of direct use for the evaluation. It does, however, still appear too vague and poorly linked to a better defined goal/objective hierarchy in relation to regionality.

The TEAM's annual reports have a very changeable and sometimes hard to follow format. A selected number of activities of various projects tend to be presented. These are often very descriptive highlights that do not constitute results-oriented reporting. Some of the documents received also appeared to have an unclear status in terms of the titles and whether they were drafts or finished documents. In some documents, sections were incomplete.[13] A degree of confusion over the TEAM's division of labour also seems to be reflected in the filing system.[14]

The refocusing and enhanced use of management tools in recent years –particularly from 2009, is a welcome addition to the TEAM's organisation. Under the previous director, and certainly up until at least 2006, it is not apparent that the TEAM worked from a work plan (interview, TEAM and former TEAM members, 2009). The use of indicators appears most recently in a nascent result-oriented log frame created in 2009. While an important step, these indicators and outcomes appear too vague.

RBM is a common problem also for the TEAM's partners. Most of the RNGOs met with stated how they encounter difficulties in capturing results at regional level. ARASA, for example, has only recently introduced a result-based log frame matrix due to problems with M & E being flagged up by the TEAM previously. An external evaluation in 2006 provided the impetus to strengthen internal systems and improve focus. Developing a RBM system was a precondition for the latest phase of funding. It is therefore difficult to draw upon specific measurable results.

13 For example, concept paper 2009, where a section on 'Accountability and Democratic ownership' is blank.

14 On the surface, the filing system appeared to be very organised, but one of the evaluators ended up spending an entire Saturday chasing documents. For instance, travel reports had not been filed where they should have been, or had not been filed at all. Other documents were not put in the master files. The Evaluation team's thanks go to the TEAM member who fortunately was at the office, for another purpose, but had it not been for his?her? help the evaluators would simply not have found the documents needed.

4.3 REFERENCE GROUP[15]

The reference group is comprised of regional experts and the TEAM. It meets every six months. Its purpose is to review the direction and overall plans of the TEAM and to give input on what happens in respective reference group member countries.[16] Reference group members also participate as presenters and discussants at workshops and conferences organised by the TEAM. The reference group does not comment on budget allocations. Nor does it comment on regional organisations to be funded, or selection of projects. Two members of the reference group are from organisations that receive funding from the TEAM. There is no evidence of any conflict of interest, especially as the reference group does not, as mentioned, discuss funding issues. On the contrary, it is an asset to the TEAM that they can draw on the capacity of experienced and important reference group members. One reference group member, however, clearly felt that the group was not used in a more proactive fashion – that it did not receive adequate information or time for more thorough discussion. Consultation took place after the TEAM had already taken decisions, it was felt. Another group member also raised the issue of the need for review of the TEAM's project portfolio. But beyond acting as a useful sounding board and for information exchange, the evaluation team sees the need for a more proactive use of the reference group.

4.4 PROGRAMME PORTFOLIO

Both the period of rapid expansion and now the budget cuts to the TEAM's programme make it particularly important that the TEAM undertake a reassessment of its portfolio.
The TEAM is responding to this need. A reassessment provides an opportunity to clearly identify which programmes currently fit less well within a regional approach and would have better coherence across thematic areas. The process of revising the portfolio is a very welcome development but the evaluators also recognise the complexity of reorganising the portfolio. It requires that the TEAM have guidelines for making strategic choices. According to the TEAM, such criteria for reducing the number of contributions are:

15 Current members (2009–2011) are: Ms Helen Jackson, UNAIDSRST-ESA, Prof Michael Kelly, University of Zambia, Prof Alan Whiteside, HEARD, University of Kwazulu Natal, Liz Mataka, the UN Special Envoy for AIDS in Africa, Noerine Kaleeba, the founder of The AIDS Support Organisation (TASO) in Uganda.
16 TEAM (2008) Memo, Reference Group for the Swedish-Norwegian HIV/AIDS team.

- That the programmes are in accordance with the new regional strategy and the new Swedish HIV and AIDS Policy as well as the current Norwegian one
- Strictly regional programmes
- Within the three focus areas
- Previous performance
- Donor harmonisation (other donors that can take over)[17]

These are clearly useful criteria in helping to focus the reassessment. But a problem still remains for the TEAM that concerns how the broad programme objectives, and now broadly defined thematic areas, are problematic for a tighter rationalisation of the portfolio. In other words, to avoid merely repackaging the portfolio, the programme theory needs to better link the outcomes stated under each thematic area to the TEAM's existing overall goal and objectives.[18]

An additional complication is that the TEAM has stated a rights-based approach will be integrated as part of new mainstreaming direction for the TEAM. However, the evaluators note, first, that the overall budget allocation for human-rights-based programmes has seen only a minimal increase. Second, the evaluators also find that there is a basic level of confusion about what a rights-based approach entails. For example, one TEAM report mentions that because food is a human right and food and nutrition exists in one programme area supported, this project is understood as reflecting a rights-based approach. For a genuine rights-based approach, however, the TEAM will require a very different level of understanding. This should foreground human rights principles, instruments and methodologies as a *process* that underpins all its work rather than an add-on to what it already does.

4.5 TEAM SUPPORT TO EMBASSIES

The support to embassies is one of the key activities of the TEAM and this was highlighted in the ToR for consideration by the evaluators. For a complete report on the survey process and findings please consult annex 3.

To determine the scope and nature of the TEAM's reach to embassies, the survey was directed towards all 34 Swedish and Norwegian embassies listed in Africa. Allowing for attrition of those embassies not interested in participating for vari-

17 Communication with TEAM's Deputy Director.

18 For example, the TEAM states that the theme of 'democratic governance', addresses leadership, participation and accountability, but clearly also cuts across all the other themes. How should programme theory be restructured to capture these linkages and, just as importantly, to map out the causal links to the TEAM's overall goal? In other words, how do all these themes relate programmatically to the goal and objectives?

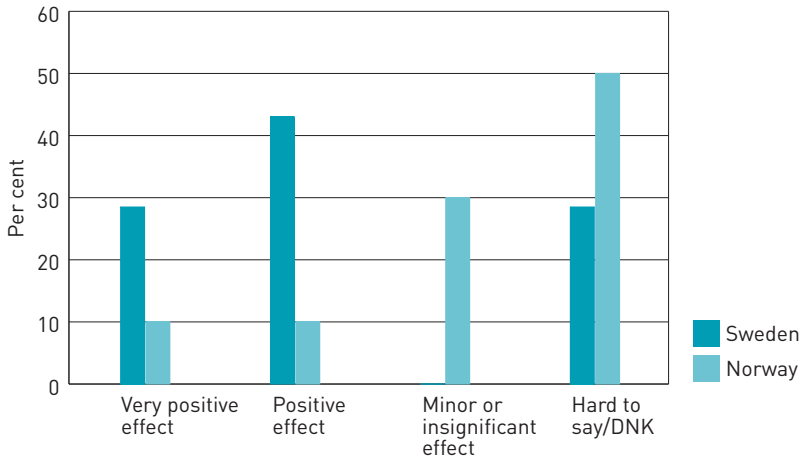
ous reasons, responses to the web-based survey were satisfactory, in that 25 persons from 22 different embassies (10 Swedish and 12 Norwegian) responded.

Familiarity with the work of the TEAM varied depending on geographic location and the category of employee responding. The findings are therefore intended to indicate trends, which, when also triangulated with other evaluation methods (such as follow-up interviews) are verifiable. The key findings are as follows:

- There are clear differences between Norwegian and Swedish embassies in terms of their respective AIDS work. These differences underpin the different country perceptions and use of the TEAM. These country differences are also reflected in responses to the amount of time dedicated to HIV/AIDS work among respondents at respectively Swedish and Norwegian embassies. While in Norwegian embassies hardly any respondents spend more than 10 per cent of their working time on HIV/AIDS, in Swedish embassies spend substantial amounts of time. The contrast between Norwegian and Swedish embassies in terms of participation in the TEAM activities is also great. Norwegian embassies tend to participate much less.
- Activity levels are clearly highest in Southern Africa, but also substantial in Eastern Africa, while in Western and Northern Africa the activity is virtually non-existent. This finding reflects the TEAM's resource allocations.
- In terms of satisfaction with the work of the TEAM, the survey revealed that there is general satisfaction with the work of the TEAM, but a moderately positive assessment prevails over overt praise. The more familiar the respondents are with the work of the TEAM, the more positive their assessments tend to be. Regardless of limited contact, there is still a perception of the usefulness of the TEAM
- Findings show that there is room for improvement in the communication between the embassies and the TEAM.

In terms of the perceived effect of the TEAM on embassy AIDS work, findings are as follows:

Figure 4.1 Perceived effect of the TEAM on the embassy's HIV/AIDS work by country (per cent). Based on a sample of 10 Norwegian and 7 Swedish respondents (n=17).

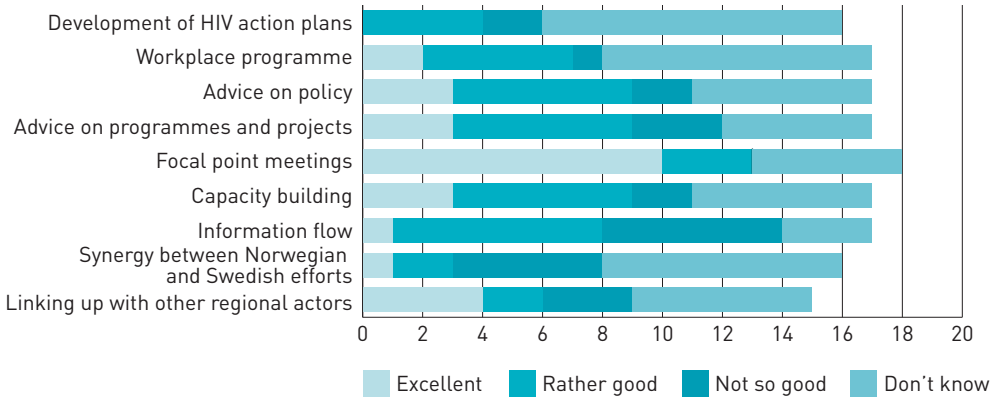


The majority of respondents claimed that the overall impact of the TEAM on the embassies' work was minor, insignificant or in the category 'hard to say' with some variation between countries as shown in Figure 4.1.

In terms of which aspects of the TEAM's work can be identified as most valued, the level of satisfaction amongst respondents is greatest when it comes to participation in the TEAM's focal point meetings (shown in Figure 4.2). Quite a few also think that the input from the TEAM is excellent in terms of linking up with other regional actors. For most items – advice on policy, capacity building, work place programme, advice on programmes and projects – the majority say the TEAM's input is rather good, but with about equal numbers indicating excellent and not so good.

Respondents are most critical when it comes to the TEAM's use of synergies in Swedish and Norwegian efforts (a majority of respondents consider the TEAM's input to be not so good in this respect). The information flow is also an item where respondents tend to be quite critical, while none of the respondents assess the TEAM's input in the development of HIV action plans to be excellent. A problem identified in the open-ended answer section of the survey and in interviews is also that respondents feel the TEAM is travelling so much that they are not able to assist embassies in their work. Some of the embassies indicated that they would like the TEAM to respond more to their requests and felt that these were not always dealt with.

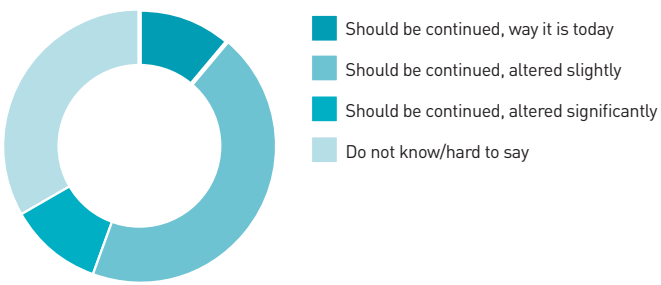
Figure 4.2 Assessment of TEAM's activities. Number of respondents with different responses (n=17).



A major finding for both countries is that the broad majority were of the opinion that the TEAM does not link sufficiently with in-country processes. Again, this was confirmed by interviews at both the Swedish and Norwegian embassies. Another aspect is that the TEAM had not followed-up on some of its activities at embassies and that mainstreaming and HIV/AIDS workplace plans – a core function of the TEAM – are dependent upon embassy prioritisation of these. It appears critical that the TEAM devise more tailored responses to meet the needs of the respective embassies.

When asked to be forward looking and to comment on the future role of the TEAM, a clear majority want the TEAM to continue. But they also want to see the TEAM alter its practices slightly (see Figure 4.3).

Figure 4.3 Responses to the question: "in your opinion, what should the role of the TEAM be in the future? Number of responses opting for each answer category (n=17).

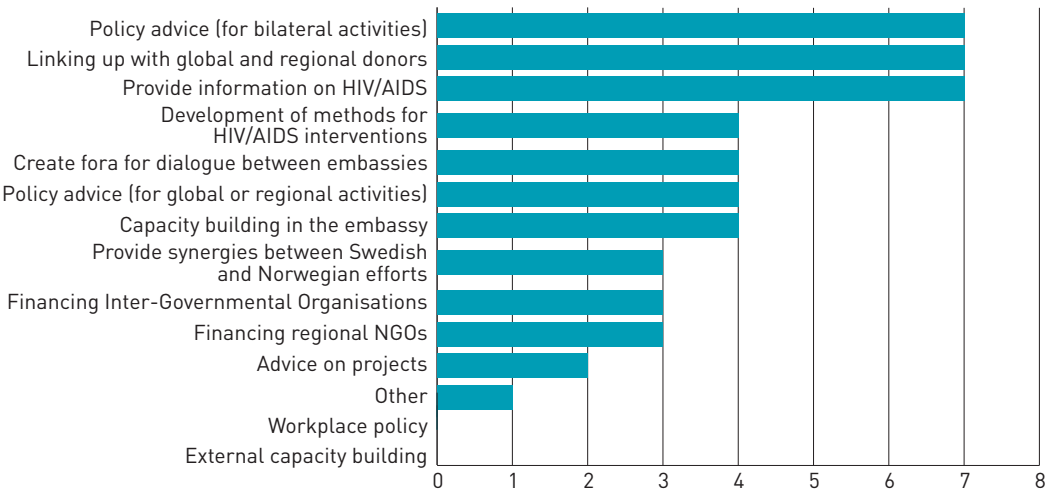


It also shows that the TEAM is perceived as a valuable regional resource. Some Norwegian embassies that were followed up by interviews indicated that although they might not use the TEAM very much, they nonetheless regarded its potential as the only regional mechanism that could function as a vehicle for enhancing Norwegian presence and visibility.

Future role

The respondents were also asked to express their opinion of what future priorities of the TEAM should be based on a set list. They were asked to indicate up to three alternatives. The results are presented in Figure 4.4.

Figure 4.4 Opinions with respect to the TEAM's future priorities for each of the listed items (n=18).



Three areas stand out with respect to identifying future priorities of the TEAM by embassy personnel:

- Policy advice for bilateral activities,
- Provision of information on HIV/AIDS, and
- Linking up with global and regional actors.

4.6 RECOMMENDATIONS

- The TEAM should develop a more rigorous template for reporting, especially for its annual reports. In particular, there should be a section providing a critical analysis of results and the regional added value in the entire project portfolio.
- The filing needs to be kept updated and travel documents should be filed.
- The TEAM should ensure that they have a consistent strategy for organising overlap periods.
- The TEAM needs to have a regular external review of its portfolio so that it is not left with a large number of residual programmes to support. The evaluation team hopes that the TEAM will use the large budget cuts as an opportunity to scrutinise the portfolio and eliminate those projects that fit less well (e.g. some of the multi-country programmes). Developing a more coherent programme theory to link new thematic areas to overall goals and objectives is fundamental in assisting the restructuring of the portfolio.
- It is recommended that staff numbers be maintained, which, if administering less funding and fewer projects, would therefore free more staff time for the development of a leaner, more strategic focus. And not least, efforts could be dedicated to improving the presentation of the TEAM's knowledge and experience.
- The TEAM should concentrate geographically on the regions with the highest prevalence of HIV: southern Africa and to a lesser extent eastern Africa. There is a danger that in spreading support to the IGOs into West Africa and elsewhere, the TEAM's scarce time and resources will be further stretched. The evaluators see particular strategic merit in working with existing IGOs, and also with the African Union (AU), but are less convinced about the need to support ECOWAS, for example.
- The TEAM should consider appointing staff with knowledge and experience in strengthening health systems; in advocacy; and in policy development expertise.
- One way to provide a better review of and feedback to the TEAM would be the inclusion of Sida and Norad policy people in the Reference group meetings, perhaps holding Reference group meetings back to back with the Annual meeting. The Reference group's role should be revisited.
- The nature and content of support to embassies needs to be reassessed by the TEAM. Mainstreaming and action plans at embassy level – this support depends for its implementation on how the embassies themselves prioritise it, or other-

wise. A more tailored approach to providing what the embassies want is therefore recommended. The TEAM needs to be more proactive in contacting and meeting embassies to ascertain needs.

- The TEAM should provide information about activities funded by the TEAM that are used by national organisations in the respective countries. A rapid and easily accessible system for information retrieval should be made available on the TEAM's web pages.
- There should generally be better, mutual sharing of information between the TEAM and the embassies. At a very basic level, updating mailing lists for the TEAM information news-sheet should be relatively straightforward. When meeting with Swedish embassies, the TEAM should also try to meet with their Norwegian focal point colleagues at the Norwegian embassy in the same city. Perhaps a more solid entry point for Norwegian embassies would be the introduction of the TEAM at a regional gathering of Norwegian Ambassadors (as is currently done in gatherings of Swedish Ambassadors).
- The decreasing focus on HIV/AIDS at Norwegian embassies does not mean that the TEAM is not wanted. On the contrary, even where funding for HIV/AIDS is being phased out, the expertise of the TEAM is still required for assessment of the long-term impact of AIDS on the economy and in different productive sectors. To repeat what was said above about a more tailored approach – other ways should now be found to service the embassies that are more in tune with current and shifting priorities and stages of the epidemic.
- To improve the strategic focus and impact of the TEAM one example might be to champion one issue for in-country tracking and follow up each year with embassies. For example, resourcing ART, or the right to treatment and prevention for mobile people at RECs, issues that emerge from the regional level, could then be pursued by the TEAM perhaps in conjunction with embassies in question. This would add synergy and momentum between in-country and regional levels.
- Sweden and Norway should consider two focal point meetings a year – with perhaps one addressing the epidemic per se and the other used as an occasion for more explicit coverage of the regional component and national-regional activities, and for national-regional synergies. The evaluators realise that this may not be feasible given current workloads, but it is nonetheless highly desirable and intended to stimulate discussion of future roles for the TEAM.

At the very least, a back to back meeting could be arranged to address bilateral and regional synergies and/or a focal point seminar meeting addressing regionality, for example.

- Similarly, in order to utilise the regional competence of the TEAM in those embassies which have responsibility assigned for following regional processes, an invitation to the focal point seminar could create a better linkage with the TEAM.
- In any case, it is highly recommended that the TEAM revise its support to the embassies, and do so in light of more strategic considerations at national and regional levels.

5 Outcomes of Regional Programmes, Inter-governmental organisations (IGOs), civil society and applied research[19]

5.1 INTRODUCTION

The TEAM's programme portfolio in 2009 consists of 37 organisations with a total number of 57 funded projects[20]. A list of recipients and volumes of the TEAM's financial allocations to each organisation can be seen in Annex 11 and Annex 12, respectively. The TEAM has been made attempts in recent years to structure the portfolio according to priority thematic areas. Annex 12, for example, shows that the recipient organisations are now grouped by the TEAM according to its three thematic areas: Sexual and Reproductive Health and Rights; Social Protection; and Democratic Governance. 'Innovative' projects is seen by the TEAM as an attempt to identify new, emerging forms of support (not shown in Annex 12). It can be seen from Annex 11 and 12 that the TEAM supports a diverse range of organisations consisting of intergovernmental organisations (IGOs), civil society organisations and applied research.

5.1.1 Typology of regional organisations

The evaluators sought to compile an elementary 'typology' of the TEAM's recipient organisations by schematising them in terms of how they work regionally, as depicted:

Regional Economic Commissions (RECs)
Regional organisations with offices in all countries they work in, having common systems, such as M & E, communications, materials (e.g. SAT).
Regional organisations with sub-regional offices, i.e. not physically in all the countries they work in (e.g. REPSSI).
Organisations that are more typically multi-country, e.g. they are based in one country and operate in other countries without standardising practices or approaches across countries or having strong linkages between the countries these organisations operate in (e.g. Olive Leaf).
Regional network organisations with formal membership (e.g. ARASA).

19 For a full list of outputs and outcomes of the selected organisations, see Annex 10
20 Based on information received from the TEAM in September 2009.

Regional networks, with informal membership – the network does not implement projects but has a specifically lobbying and strategic focus (e.g. RAANGO).

Research institutions which collaborate regionally (HEARD, University-based) and may also use the regional level as an entry point for national level political leadership (IDASA, NGO-based);

UN Organisations, such as UNODC, UNAIDS, and also similar, like ILO, and IOM, with country offices but within regional structures, regional HQs often based in South Africa.

This typology is especially useful in showing that when it comes to working regionally, the TEAM's recipients have different organisational structures. Whether an organisation's particular mode of working regionally has any bearing upon the ability to attain outcomes will be referred to wherever relevant in the case studies that follow.

5.2 REGIONAL ECONOMIC COMMISSIONS (RECS)

The outcome assessment of the Swedish regional development cooperation strategy shows that there has been an overall increase in Swedish support to the RECs and AU (Devfin 2009, p. 4). The TEAM also reflects this trend by giving greater priority to the RECs in its own work. This section evaluates the TEAM's support to the RECs in terms of the outputs and outcomes achieved. The evaluation of the support from the TEAM to the RECs is linked to the discussion of the questions outlined in the ToR on the TEAM's influence on regional dialogue, the TEAM as a regional player, support to IGOs and, later, RNGOs.

5.2.1 Support to SADC

The SADC JFA 2006–2008 (November 2005–March 2008) states its main objective as: "to strengthen the capacity of the SADC HIV/AIDS Unit to effectively manage and support the implementation of the SADC Business Plan on HIV and AIDS". The priority areas in the agreement were to develop and harmonise policies and protocols within the region, mainstreaming throughout SADC organisation.

In its own view, the TEAM has been an important player in developing the Maseru Declaration. The SADC Expert Think Thank meeting in Maseru in May 2006 identified the drivers of the epidemic in high-prevalence countries and produced a document to ensure political commitment by member states. SADC's new strategic plan, "Towards the Universal Access to HIV Prevention – SADC Strategic Plan (2008–

2010)" 'builds on the recommendations from the SADC Think Tank meeting in Maseru 2006' (TEAM 2008). The Declaration resulted from a consultative process with Governments, UN, donors and Civil Society. The strategy is intended to compliment the work of the Member States in order to achieve the shared goal of Universal Access to Prevention by 2010' (TEAM 2008, p. 10).

Outcomes

- Overall co-ordination between donors and SADC has greatly improved through the JFA (TEAM as lead donor).
- Surveillance across all countries, a survey according to this was undertaken in all SADC countries for the first time in 2008.
- HIV and AIDS Unit is now fully fledged, met its staffing target, and regarded as strong.
- Unit also interacts with Civil society, e.g. Partnership forum – used for proposal for Global Fund application, synergies on specific activities, for instance, REPSSI and SADC have funded a position in the SADC HIV/AIDS Unit together 'to ensure incorporation of children and young people' (TEAM 2008, p 7, and see section on synergies).
- Other interactions include SADC Parliamentary Forum – some areas of success but impact seems very dependent upon the domestic political situation and hostage to in-country party politics.
- The JFA has led to harmonisation and eased the administrative burden on SADC in terms of reporting, etc.

Relevance and challenges

The TEAM in-depth assessment in 2005 of the application from SADC for support to the Business Plan 2005–2009 argues that the support is highly relevant given that the SADC region is the worst affected in the world with regards to HIV/AIDS. Still, there is a need to discuss whether the SADC HIV/AIDS Unit has the most relevant focus in its activities. Given that the key mandate of SADC is to facilitate economic integration and decrease trade barriers among member states, Dfid (interview, 2009), for example, suggests that SADC, in the context of HIV/AIDS, should (re)focus on trade-related issues. The potential inherent in an economic community, with reference to economies of scale, engaging in drug procurement negotiations, condom purchasing, etc., would enable SADC to focus on concrete steps for the mainstreaming of HIV/AIDS throughout SADC. Also, the focus on harmonising surveillance indicators and M & E among member states may be seen as less relevant, given the UNGASS criteria and

other standard guidelines on reporting indicators developed by UNAIDS and WHO are already present.

There seems to be an imbalance between the HIV/AIDS Unit, which has been considerably strengthened, and other areas of SADC's Directorate of Social and Human Development that have not received this level of technical and financial support (see Chipamunga 2009:6). Bottle necks at the national level concerning an 'implementation gap' can be identified, with agreements not taken forward. One problem also identified by Chipamunga (2009:20) is that there is no clear strategy for dissemination and use of the various guidelines and frameworks produced. SADC also has no enforcement mechanisms at the national level to ensure implementation by member states. Harmonisation of treatment, testing, and PMTCT protocols should be linked back to national standards: communication and commitment gaps exist between the regional and national levels e.g. between the NACs and respective Ministry of Health, and regarding drug procurement, Ministries of Finance and Trade. In other words, the 'buy-in' of other departments is required. Challenges therefore lie at the national level, but the TEAM's mandate is regional.

One implication highlighted in interviews is that as the RECs are strengthened, the nature of the support requires adjustment. The TEAM's own strategising and prioritisation is key here. The SADC Parliamentary Forum, for example, called partners together – 3 or 4 MPs from each member states – but staff sent from TEAM were perceived as not having adequate seniority to engage with on strategic issues.

The JFA, in which the TEAM is the lead donor, funds all but two of the positions in the HIV/AIDS Unit, and there might be concerns about the sustainability. The informant in the SADC HIV/AIDS Unit (interview, 2009) did not see sustainability as a problem, arguing that the commitment from member states increases over time. This started with all staff being funded by the donors, now the member states fund two of the positions, and they believed that it will improve in years to come.

5.2.2 Support to EAC

The TEAM supports the 'East Africa Community implementation framework: Operationalising the EAC Regional Strategic Plan for HIV and AIDS' (2008–2012; SEK 27.5 million). The objective of the support is to provide capacity in order to implement the strategy. The strategic objectives of the framework (shortened here) are: 1. To enhance the institutional capacity of the EAC; 2. To mainstream HIV and AIDS; 3. To improve effectiveness of interventions through harmonisation; 4. To improve the design and management of national and regional responses regarding information and knowledge; 5. To scale up responses through strengthening political leadership and commitment; 6. To consolidate effective partnerships; and 7. To improve workplace environment regarding stigma through a workplace policy.

Since the EAC support was initiated recently in April 2009, it is very early to assess its output and outcomes. However, there are four outputs and one outcome identified as having taken place, where one of them is attributed to the TEAM.

Outcomes

- *EAC Regional HIV Prevention Experts Think Tank and Multisectoral Stakeholders Meeting in Nairobi, 24th–26th February, 2009*
  The meeting resulted in the EAC partner states commitment to "by 2015, reduce the number of new HIV infections by 50% compared with 2009".

Relevance and challenges

The support to the establishment of the HIV/AIDS Unit and the expected scale-up of focus on HIV/AIDS in the EAC is seen as highly relevant by the evaluators in terms of particular issues that should be dealt with at the regional level. The EAC provides the only inter-governmental forum for East Africa. The regional issues of mobile populations, economies of scale in terms of drug supply and transport across borders and tackling the high prevalence rates in border areas are important issues touching on prevention and impact mitigation in particular. Treatment is also highly relevant in terms of regional added value. Since the HIV&AIDS Unit within the EAC has not yet been set up, it is only possible to discuss two issues: a) the initiative on mobile populations and transport corridors and b) the effectiveness of the planning process that is to lead to the establishment of the HIV/AIDS programme and the HIV/AIDS Unit.

The evaluators find the transport corridor initiative relevant in terms of being an issue that benefits greatly from being addressed at the regional level. The EAC has been effective in

terms of organising a high-level meeting on this initiative in 2009, but the effectiveness in moving forward from the meeting to implementation is not possible to assess at the current stage.[21]

The actual establishment of the *HIV/AIDS Unit* lags behind by 2 years, and it is reasonable to question the effectiveness of the process leading to its establishment.

Given that the HIV/AIDS Unit has not been established yet, it is not possible to assess the overall sustainability of the EAC support given by the TEAM. However, it is possible to comment on a few issues. One of these issues is that the EAC counterpart to the JFA agreement only states that 'the EAC has committed itself to provide ten percent (10%) in counterpart funding to the EAC HIV/&AIDS Implementation Framework (2008–2012)' (EAC n.d., p. 2). Given the low political commitment that has been given to HIV/AIDS in the region by political leaders over the years, the evaluators question the sustainability of the HIV/AIDS work in the EAC.

5.3 REGIONAL NGOs

5.3.1 Regional Psychosocial Support Initiative (REPSSI)

REPSSI is a regional NGO with HQ in South Africa, working in 13 countries, but with sub-regional offices (i.e. not an office in every country it works in). It started in Zimbabwe in 2001 and is dedicated to capacity building and advocacy on psycho-social methods to carers and children to mitigate the impact of HIV/AIDS. REPSSI has been funded by the TEAM since 2002. The overall vision is that 'All children affected by HIV and AIDS, poverty and conflict access stable, affectionate care and support to enhance psychosocial wellbeing'. The objectives are to provide leadership, quality technical assistance and knowledge in psychosocial care and support for children and youth in communities affected by HIV and AIDS, poverty and conflict. The TEAM's objective is to strengthen the capacity of these organisations to build capacity in individuals and communities. In view of the impact of the epidemic on children being harsh, particularly the often 'hidden' psychological impact, the approach is very relevant. In 2008 REPSSI reported they reached over 2,355,649 children (Annual report 2008).

21 It resulted in a meeting called 'EAC Cross-Border Transport Corridor HIV and AIDS Multisectoral Stakeholders Meeting', held from 18th–22nd May, 2009 in Kisumu, Kenya, bringing together parliamentarians from the EAC countries, donors, civil society organisations, trade, custom and transport authorities, etc. The concrete output of the meeting was the recommendation of reviewing the EAC regional strategic plan on HIV/AIDS to ensure a strengthened focus on mobile populations, and high-risks groups were identified. Also, the field visits made the participants more aware of the problems in this region. The extent to which the meeting also discussed the North-South corridor initiative between SADC-EAC-COMESA is not known to the evaluators.

Outcomes[22]

- Psychosocial support has been effectively and unequivocally put on the agenda of civil society, development partners and governments in East and Southern Africa;
- REPSSI has developed several PSS tools that are widely used to respond to the PSS needs of children;
- Mainstreaming its tools and methods in education sector (South Africa);
- OVC initiatives at SADC have taken place e.g. Development of the Strategic Framework and Programme of Action for 2008 to 2015;
- From the evaluation's local fieldwork (see Annex 6 for more details): Use of tools such as memory books led to action, like making wills against property grabbing; the village was now sensitised to issues of child abuse, the problem of early child marriages was being addressed; underage drinking was banned; better communication, such as discussing illness and disclosure of status, and identifying problems had been achieved.

Relevance and challenges

A significant challenge raised in an evaluation of REPSSI (Matikanya et al., 2007) is the need 'to ensure appropriately *differentiated strategic responses to national priorities and country conditions'* (Matikanya et al., 2007). Each sub-regional office visited appears to adhere to national guidelines, including those for translation and works with national (and local) authorities. The increasing use of MOUs and liaison with local and national entities is beginning to address the 'one size fits all' tendency of regionality. Furthermore, the Technical officer at SADC was welcomed by all stakeholders consulted for a mid-term review in placing OVC issues at a regional level (Ndhlovu, 2008). And while REPSSI's role in advocacy is acknowledged in the 2007 evaluation, the mid-term of REPSSI's support to SADC also suggests that the regional initiatives now require advocacy so that member states ratify them. REPSSI have been effective in mainstreaming the tools into the education sector in South Africa and are doing the same in Zambia. This mainstreaming is an important avenue to influence country responses, and moreover, in a sustainable fashion.

One challenge in meeting their objectives relates to the typology of organisational structure mentioned earlier. REPSSI have sub-regional offices and not offices in all countries. This was evident in discussions in Tanzania (where they do have a sub-regional office) and it undermines the effective-

22 From Manikanya (2008), plus interviews and local field visits undertaken as part of the evaluation.

ness of REPSSI's regional approach. For example, it is linked to related challenges, in dealing with ministries in the countries where they do not have offices. In many instances, government officials simply do not always show up for meetings. Another challenge is that since they cannot be in all countries themselves, they rely on their country partners: who are supposed to represent REPSSI in meetings. However, instead of representing REPSSI, these country partners often may present their own agenda rather than REPSSI's. This uneven presence may be reflected in the unevenness of training observed. In the Tanzania case visited, it was evident that inadequate training had taken place (one week on the hero book and one week on memory book). But where capacity building has been thorough, significant outcomes were demonstrated (e.g. evaluation's field work in Zambia, annex 6).

Other challenges include the need to devise specific and objective criteria in partner selection. This is currently being responded to by the TEAM. Monitoring and evaluation challenges are especially important given the difficulty in capturing the achievements of training and children reached and, especially, the quality of this. During field visits, for example, it was not made clear what benefits of the training to carers, directly benefit the children. Part of the difficulty may be the long-term nature of the benefits, but also the previously limited nature of monitoring to capture results has an effect. The co-operation with Swiss researchers currently undertaken and feeding into improving M&E is particularly welcome given that the evaluators were unable to fully grasp whether there was a specific methodology used to identify organisations and children, and monitoring to capture the benefits of REPSSI support. REPSSI rather regarded their criteria as based on being interested in organisations that worked with children. They worked with local authorities in identifying OVCs. REPSSI is, despite these challenges, considered one of the leading advocates of psycho-social support. REPSSI has also become increasingly prominent in regional fora (see section on synergies).

5.3.2 Southern Africa AIDS Trust (SAT)

SAT started as a Canadian funded programme to provide capacity building to organisations. It has been receiving support from the TEAM since 2005. In 2003 SAT became an autonomous entity and hence a regional NGO. SAT's work is guided by two general approaches in its efforts to building the competence of communities to respond to the epidemic: 1) To broaden, increase and improve the regional responses to HIV/AIDS, and 2) To build the capacity of CBOs/NGOs.

Its reach is reflected in current support to over 125 partner organisations. More effective local and regional responses are stated objectives.

Outcomes

- SAT is achieving many of its goals. The total number of SAT beneficiaries receiving prevention, and counselling, and home-based care, has doubled in the period 2005–2008, at 1.1 million. Titus and Charo, in their evaluation, also reiterate that SAT is 'making a positive difference to the supported CBOs and how lives of the people reached and supported by the work of SAT's partners is changing for the better' (Titus and Charo, 2008:4) and identified 'significant development results'.
- The evaluation's local field visits (see Annex 6) confirmed that SAT has a very relevant role to play in capacitating CBOs on 'the frontline' of the epidemic. In an era previously characterised by huge increases in funding for HIV/AIDS initiatives, building the capacity of recipient organisations is critical for attempts to absorb funding in an effective manner. The evaluators were impressed with the good level of knowledge and resources that SAT's capacity building has leveraged into communities. SAT's intervention has undoubtedly given local organisations greater access to resources from other donors. Community level impact, for example, as observed by the evaluators, showed well-resourced and knowledgeable organisations:
- In one instance (field work, Zambia), extensive training on ARVs can be correlated with a huge increase in numbers of those accessing the medication in the local area. In 2006 this was 12 people, but is now 3221. This increase was also attributed to the advocacy capacity that the local CBO in question had to lobby – successfully – also for mobile clinics.
- Members interviewed also claimed they can now take treatment openly and stigma was decreasing.
- In follow-up group work with members of local organisations receiving support from NZP+, 4 representatives cited a range of benefits and improvements. Training had provided information of nutrition, ARV management, materials, and general openness about the disease.
- These beneficiaries interviewed had also acted as role models through testimonies and peer education.
- Support had also kick started income generation, with, for example, goats' milk considered very important substitute to breast feeding for HIV+ mothers regarding PMTCT.

Relevance and challenges

In terms of SAT as a regional actor and their own understanding of regionality, it was evident that country offices are now part of the regional management structure – thus ensuring better harmonisation as a regional entity. SAT also refers to key regional documents and processes. SAT was key in establishing the Regional Network of African AIDS NGOs (RAANGO) and also, like REPSSI, has good exposure in international and regional fora. Nevertheless, problem areas are:

SAT itself acknowledges that whilst it has 25 advocacy networks (2008) 'staff constraints do not allow extensive SAT staff participation at national levels' (SAT, 2008). This is an important omission and tends to explain how SAT is relatively invisible in at least two of the countries visited (Tanzania and Zambia).

Whilst appearing to be growing in use, it is still less evident, for example, the extent to which regional policy instruments and guidelines (such as Maseru Think Tank) are actually embodied in directing SAT's programme. A case in point is the emphasis in the work of a number of country partners on treatment rather than prevention. The Director was aware of this situation and identified that SAT and other organisations need to be better in discussing sexuality and prevention at the local level.

More specifically for SAT-the issue of graduation of partners, –when they no longer require financial and capacity building support from SAT, – appears to be a particular challenge. Granted that the issue is not clear cut, and that both SAT and the TEAM are aware of it, nonetheless, the evaluators wonder if there is adequate discussion taking place with partners and clear 'exit' strategies.

There are other challenging areas such as SAT's objective to integrate human rights and gender approaches into their overall direction. The evaluation's field visits showed a rather limited imprint of gender and human rights considerations at the local level.

Finally, the issue of income generation was raised by SAT partner beneficiaries as an increasingly significant part of their work, yet SAT did not appear to support this in their own programming. Income generation and the small stipend for the local organisation facilitators were considered very important in motivating them. A basic participatory exercise revealed progress since the intervention in terms of, for example, access to ARVs, but less progress in other areas, such as food security. In terms of stigmatisation of people living with HIV/AIDS, local participants also deemed little progress to

be made and identified the need to work with churches and local health workers.

5.4 REGIONAL NETWORKS

The AIDS and Rights Alliance for Southern Africa (ARASA) is a regional partnership of non-governmental organisations established in 2002 and working to promote a human rights approach to HIV/AIDS and TB in Southern Africa through capacity building and advocacy. ARASA's overall goal is to improve human rights in the context of HIV and TB leading to reduced vulnerability to infection and universal access to prevention, treatment, care and support. It has approximately 39 network partners in 15 SADC countries. Programme areas include advocacy and lobbying, both regionally and internationally; capacity building and training, and producing materials. It sees itself as enabling a platform or space for a common voice in the region.

Outcomes

- The evaluators suggest that the outcomes of ARASA's work lie in generating a critical mass and momentum to regional lobbying around rights and HIV/AIDS in the region. Some of this includes recent lobbying over concerns about testing, disclosure and criminalisation provisions contained in the West Africa Model HIV Law and deemed to be inappropriate. ARASA also worked with the SADC Parliamentary Forum (SADC PF) to provide technical input on the development of the SADC Model HIV Law and to facilitate civil society input on the draft model law.
- ARASA was central to a joint civil society statement on the criminalisation of HIV transmission and which also fed into SADC PF lobbying in a number of countries with MPs in order to reverse moves towards more punitive approaches. In addition, there are achievements in training, including Regional Capacity Building for Access to HIV/AIDS Prevention and Treatment and Advocacy Programmes in Botswana, Swaziland, and Lesotho.
- ZARAN, in Zambia, for example, described a situation in Zambia where previously 'nothing was happening on HIV and rights', ARASA's support had added to their efforts to raise the profile in this thematic area. One example given was the benefit of attending a 3-day meeting in Johannesburg on criminalisation, and then being able to train others back in Zambia on these issues. The partnership had, overall, been very useful and created a space to learn from others. Another example cited was a joint press release in

Zambia on the harmful effects of the criminalisation of HIV, and another on fake cures for AIDS. Both instances gave greater credibility than would have been the case alone. There was also a TV debate on criminalisation. On this basis, ARASA involvement created some space on the issue, which enabled ZARAN, for example, to write to ask the Attorney General to allow for debate and discussion before Parliament introduces criminalisation.

- Other organisations also highlight the aggregate results of 'scaling up' voices and action and the benefits of training and building knowledge on rights and the epidemic, sometimes culminating in joint civil society statements. According to the Director of ARASA, the intention is for stronger network partners to assist less strong organisations.

Relevance and challenges

For some of the network partners there is a challenge, however, of dealing with unequal relationships in the network. Another challenge concerns duplication of studies and material that ARASA and other HIV and human rights organisations have produced. But through better regional networking the problem of duplication is now better managed. Seeking accreditation for ARASA training is also an ongoing challenge. The evaluators therefore find that ARASA is proving effective in meeting its goals but that this is not necessarily readily translated into results-based indicators.

The ARASA network is extremely active and engaged in the regional and international context. The TEAM was one of the first donors to contribute to the early growth of ARASA. The evaluators find that as one of a few regional HIV/AIDS and rights organisations, ARASA is extremely relevant to regional and global endeavours to achieve a rights-based focus onto the epidemic. It is particularly salient to note that in an era when many of the NGOs are mainly acting primarily as service providers, that an organisation like ARASA is supported to lift other organisations to the level of providing more critical engagement.

5.5 RESEARCH INSTITUTIONS

The TEAM supports a range of research-related activities. Most notably, HEARD (the Health Economics and HIV/AIDS Research Division) receives TEAM funding through a JFA. The HEARD aims to increase systemic interpretations of the pandemic and also of the effects of vulnerability in Africa, specifically for children, women and families.

HEARD influence is reflected in the quality and range of its publications, presentations and also in its membership of key institutional structures. For example, HEARD was appointed as the Secretariat for the Economics Reference Group (ERG) for the World Bank and UNAIDS. ERG is an advisory body providing expert economic advice on policy and operations around HIV. The ERG serves as a forum for analysis and review, to inform UNAIDS, the World Bank, the UN and national policymakers on key findings and research trends.

Another major contribution concerns ''aids2031', which is a consortium of partners who have come together to look at what has been learned about AIDS. Based on innovative thinking, critical analysis and public debate, aids2031 will compile the report, An Agenda for the Future (see HEARD, 2008).

The HEARD collaborates increasingly with TEAM partners, something that is considered to be an important opportunity to anchor NGO programmes in evidence-based findings and especially to contribute to more rigorous M&E.

IDASA conducts research on the impact of the epidemic on democratic structures and processes. This work has been very significant to encourage member states of SADC to be aware of work on elections and to provide a stimulus for leadership. In relation to the issue of leadership, the TEAM funds a research programme on leadership based at the University of Cape Town, which can be considered an area of high relevance.

More generally, social science support to African researchers, especially through the African Association of Universities, ICASA, and the Africa Journal of AIDS, also underpins the TEAM's role in developing African-based ownership of research on the epidemic.

5.6 UN ORGANISATIONS

5.6.1 The UNAIDS Regional Support Team

The TEAM funds the UNAIDS Regional Support Team for Eastern and Southern Africa (UNAIDSRST-ESA) programme called "Accelerate HIV Prevention action in Eastern and Southern Africa, 2007–2010" (27 million SEK). The goal is to support the intensification of HIV prevention knowledge, understanding, partnerships and programming across 20 countries in East and Southern Africa. The programme aims to strengthen regional and country capacity for evidence-based HIV prevention planning and programming. A key focus of the TEAM funding is for the evidence-informed

national HIV prevention strategies. The wider package of objectives for the programme concerns aspects such as mobilisation of key stakeholders across the United Nations system, governments, regional organisations and institutions, civil society, faith-based organisations and people living with HIV in order to provide leadership for a stronger response to HIV prevention.

Outcomes

- The emphasis upon 'universal access' to services has encouraged engagement with national partners to monitor and review progress towards universal access. A number of countries are revising their national targets in other areas, to ensure a sharper focus on areas in need of additional support.
- Some of the modes of transmission studies (MOT) undertaken by UNAIDS/WB with TEAM support are being taken up by the UN Secretary General.[23] The MOTs describe changes and differences in epidemic patterns, and highlight the need for more priority on prevention and local, tailored programmes.
- The MOT studies in 5 countries are gaining popular media exposure and creating debate in-country. For example, in radio stations in Uganda, there was recently a one-hour call-in phone show discussing the implications of the findings in the MOT that married people are most at risk.
- Kenya and Botswana have launched new prevention strategies this year, and an additional nine countries should have these in place by the end of this year.
- Clearing house on social change communication

Relevance and challenges

The relationship with UNAIDS is highly relevant in the context of building global and regional governance on HIV/AIDS. It is particularly relevant for the regional agenda in terms of seeking to harmonise prevention initiatives ongoing in the region. The emphasis upon capacity building for evidence-based preventive programmes is also very relevant for informed prevention programmes and best practices. It is directly relevant to the TEAM's overall goals and objectives. According to the Head of UNAIDSRST-ESA, 'this work, as seen in the recent SADC Prevention meeting, – has had a significant impact on prevention thinking and action – from country to global levels'. Some challenges, however, include 'insufficient

23 The Analysis of Prevention Response and Modes of Transmission Study (MOT) is a multi-country initiative currently supported by UNAIDS and the World Bank Global HIV and AIDS Programme's Global HIV/AIDS Monitoring and Evaluation Team (GAMET).

capacity at regional and national levels to provide the required technical assistance to countries to translate improved knowledge into policy and programming' (UNAID-SRST-ESA, 2009). Other challenges involve the outcomes of mobilisation within countries, and especially, what advocacy outcomes have been achieved. Furthermore, the issue of how national strategies are or will be used requires follow-up and more detailed outcome analysis.

5.6.2 United Nations Office on Drugs and Crime

UNODC started a three-year programme, "HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings in Southern Africa", with TEAM funding in 2008. The overall objective of the programme is to support the development and implementation of an effective response to HIV/AIDS in prisons in Southern Africa. UNODC will work on three levels: policy, prison management and service provider level.
Two specific objectives of the Programme are: to reduce the risks of HIV transmission in prison settings in southern African countries and to reduce the HIV related mortality in prison settings in southern African countries. UNODC have country office presence, with regional Southern Africa HQ based in South Africa. Their regional system reflects cross-pollination across common systems, such as e-mail and joint information.

Outcomes

- MOUs signed at Ministerial level in 4 countries: Mozambique, Namibia, Swaziland and Zambia. Following one high profile event in Mozambique, for example, this resulted in a commitment made by the Minister of Health to improve health service delivery to prisons.

Relevance and challenges

Given that the issue of HIV in prisons has hitherto been taboo, or, at best neglected in the region, the evaluators find the topic to be extremely relevant. In terms of results, the programme only commenced in 2008. It is, however, already a project reflecting a high degree of complimentarity to regionality-harmonised systems, but it also rolls out of a common framework. The challenges of impact are reflected in dealing with competing jurisdictions at the national level, – and especially the immediate governmental department responsible for prisons, and which usually is a different jurisdiction from health. Achieving impact will be keenly reflected ultimately in prisoners accessing condoms and having better access to ARVs. Problematic barriers remain, including the overall low

status of prisoners. None the less, the UNODC has successfully initiated an important process addressing a highly marginalised group, and in a sensitive area previously neglected in the region. Using an emphasis upon partnership and capacity building of authorities and civil society, the skilful use of public health concerns, and close involvement of the TEAM, is already proving very effective.

5.7 SYNERGIES CREATED BETWEEN PARTNERS

5.7.1 RECs and NGOs

The SADC Partnership Forum is the main forum for interaction between SADC and regional organisations. Several of the regional organisations that the TEAM funds participate in this forum, including SAT, REPSSI, ARASA, RAANGO. This forum provides synergies among a substantial number of the recipients of TEAM funding. Moreover, there are synergies related to specific activities, represented by for instance that where for example REPSSI and SADC have funded a position in the SADC HIV/AIDS Unit together 'to ensure the incorporation of children and young people' (TEAM 2008, p 7).

Regional organisations are using SADC plans. VSO is rolling out SADC's plan for orphans and vulnerable children, and wish to pursue this regional approach in its work. Regional organisations influencing SADC's plans and frameworks, for instance REPSSI, persuaded SADC to include orphans and vulnerable children in the plan. REPSSI is also in discussions with UNODC regarding children in prisons. The evaluation of the JFA between development cooperation partners and SADC stated, however, that there are implementation bottlenecks at the national level.

5.7.2 SADC and NACs

Through SADC meetings and reporting on country measures, NACs stated that SADC is one of the most important partners. According to the Zambia NAC, for example, this support to SADC had enabled all NACs to meet twice a year with SADC, and to agree on a number of documents, including HIV surveillance reporting formats. In 2008, 14 countries did surveillance according to this reporting format, and this was the first time they obtained a regional surveillance overview. The overview is facilitated through the SADC Technical committee interface with the ministries, and was stated as an important mechanism to get the heads of states to see the

nature of the problems concerning the epidemic. The heads of states have created a regional fund, which shows their commitment. Consensus on the epidemic has shifted: it is now accepted wisdom to include certain things that must be addressed as a region, such as the cross-border issues.

5.7.3 UNAIDS RST-ESA and partners

The UNAIDS RSTESA funded prevention programme is interfacing with many of the TEAM's partners: including RECs, and regional NGOs. Due to the focus of the programme upon national and regional prevention, linkages between national level structures, such as National AIDS Councils and TEAM's partners can be enhanced across these different levels.

5.7.4 SAfAIDS

SAfAIDS, materials are widely used by many of the partners, e.g. collaboration with UNAIDSRST-ESA on certain materials. SAfAIDS has developed its training curriculum in alignment with various national AIDS authorities' guidelines and protocols. They have a tri-partite memorandum of understanding with NAC, the MoH and itself in Zambia.
Other partners, such as REPSSI increasingly cooperate with various government departments on MOUs.

5.8 INCLUSION OF PEOPLE LIVING WITH HIV/AIDS

With regards to the Greater Involvement of People Living with HIV and AIDS (GIPA) principle, the TEAM has a role to advocate for involvement of people living with HIV/AIDS as staff within partner organisations. The TEAM, however, recognises that it has been less than successful in this. The need to include PLWA organisations in their portfolio is fully acknowledged by the TEAM, and the difficulties in finding and supporting a strong regional PLWA organisation are evident. While this is ongoing, the evaluators nevertheless found a good level of representation of PLWA organisations either directly in the portfolio, and or indirectly, for example, in the work of SAT. Some partners are now increasingly operationalising PLWA participation in its activities, such as ARASA and its workshops.

5.9 RECOMMENDATIONS

- The TEAM prioritises one specific issue each year for following up, to enable the TEAM to champion the issue and strategise around it.
- The approach in working with EAC could be more incremental than the comprehensive approach which is currently being applied.
- The TEAM should prioritise the Eastern and Southern African regions where HIV/AIDS prevalence is highest and should therefore rethink their support and engagement with ECOWAS, IGAD. It is important to rethink its support, because it seems to be very time-consuming and not the most strategically appropriate support. AU support, however, is appropriate given the broader Swedish approach and strategic merit.
- The TEAM should refocus its support to SADC in terms of assessing what are the subsidiarity issues are that will be most appropriately addressed at the regional level, such as negotiations on drug procurement, drug manufacturing, licenses, transport corridor issues.
- In terms of better regional-national linkages, the TEAM could be present at the biannual meeting between the respective RECs and the NACs, and they could do this in their role by being the lead donor, presenting themselves and staying informed about the country situation.
- Better understanding of both regionality and how organisational structure may affect working regionally is required. This should be instigated by the TEAM with its partners in a joint workshop. The occasion of a new Swedish regional development cooperation strategy is a particularly appropriate opportunity for this. The TEAM should be more proactive and strategic in pointing out connections and linkages between regional and in country level.
- The TEAM should report better on analyses of 'making the money work' at national and local levels.
- Regional NGOs need to strategise on tackling difficult issues at a local level, such as how to tackle human rights and gender issues at this level.
- Some of the Regional NGOs need to be more visible at the national level, and more involved beyond service delivery. Specific action plans on advocacy should be encouraged by the TEAM.
- Many Regional NGOs are increasingly linking with research institutions to produce more evidence-based findings. This is particularly beneficial for improving M&E and should be strengthened.

- TEAM needs to review its portfolio. There may be scope for more innovative prevention programmes that more directly link to the community context and cultural issues.
- The TEAM requires a new approach paper reflecting upon the implications of an era of massive influx of treatment, and care and mitigation, and the implications of this at a local level for their focus upon 'prevention'.

6 Conclusions and Recommendations

6.1 CONCLUSIONS

Effectiveness of the regional approach

The TEAM is identified as a unique regional resource. But it is also a resource that could be more effective and better utilised.

The TEAM has added vitality to regional responses to HIV and AIDS in a number of key areas. Capacity has been strengthened in a number of regional organisations and by building various regional 'platforms'. These outcomes are even more significant when placed in a context previously characterised as having weak regional responses to HIV/AIDS. Several donors also see the regional level as highly relevant for tackling HIV/AIDS. Regional organisations can provide a 'helicopter view', as one described it, in which local level organisations can be scaled up to national, regional and even international levels by providing knowledge, resources, training and political support. Most organisations see the relevance of the regional level. The relevance of the regional level for the embassies was less clear, however. While many see the value of the TEAM in linking embassies to regional actors, embassy respondents were less likely to see the relevance for national level responses. The TEAM is particularly effective in providing consistency in support and in working with some of the most relevant regional partners that are enabled by being located in the region. It is doubtful that direct administration from HQs in Stockholm or Oslo or from the embassy level would be any more efficient.

The TEAM reports, however, do not document the valuable and interesting results achieved. Reporting on results at different levels is also a challenge that appears common to all stakeholders. This evaluation report provided several examples of the added value of the regional approach, which when combined, also constitute effectiveness in contributing to the goal of HIV/AIDS prevention and mitigation.

However, differences in interpretations of regionality exist. Whether regional mechanisms are actually implemented and their impact felt at the country level also raises important questions concerning the level at which results are achieved. What happens to all the guidelines, protocols, laws and so on, that have been developed at a regional level is not systemati-

cally followed-up by the TEAM. Many of the regional-national bottlenecks identified could be much better analysed. When the TEAM's main approach, building 'regional platforms', is placed in the context of these different levels of outcomes, it is apparent that it soon becomes an end rather than means to achieving the overall goal. This is not a problem of the TEAM alone but rather reflects the challenges in regional cooperation more generally.

Many of the TEAM's partner organisations are, to some extent, making use of the new standards and capacities that have been developed at the regional level to inform their work at the national and local levels. The seven organisations reviewed have either been strengthened through TEAM support or themselves contribute to capacity building of other organisations. In terms of sustainability, the encouraging signs are that some organisations demonstrate an increasing government involvement, even in mainstreaming some of their programmes. The SADC also plans to increase its member states financial contributions to HIV/AIDS. Several organisations now have basket funding from several donors, which lessens dependence on individual donors. Local level organisations have also been able to use the TEAM's support in order to leverage other sources of funding.

Prevention and mitigation of HIV/AIDS

The TEAM regards its core achievements as lying in the area of prevention. The TEAM's highly informed understanding of both the immediate and structural dimensions of the epidemic is an asset to prevention work. Because prevention is a composite of many different factors influencing behaviour, the portfolio is judged to generally have good coverage and understanding of these different angles. Above all, the TEAM is credited for playing a proactive role in identifying cultural drivers (e.g. concurrent partners) of and political responses (political leadership) to the epidemic on the regional agenda. In particular, some of these deal with cultural issues, such as multiple concurrent partners, as well as the role of political leadership in the epidemic. A major challenge, however, is to translate regional agendas and national mechanisms on prevention into behaviour change at the sub-national level and in local target beneficiaries. The evaluation's local field work showed that this is especially the case when local communities are particularly concerned with income generation, which may deflect attention from difficult local issues having to do with culture, gender and rights. The TEAM can maximise its impact in the years to come by more explicitly integrating cross cutting themes on political leadership, cultural factors

and local communities' demands for material support in a more holistic understanding of prevention and mitigation.

Programme Coherence
Better articulation and strategising of regionality to include regional-national-local bottlenecks is hampered by the TEAM's rather weak programme theory. It has overall goals and objectives that appear more like activities. These lead to poorly detailed outcomes, and, especially, poorly programmed explanations of what causal mechanisms lead to prevention and mitigation. The sub-objectives stated in the TEAM's new thematic areas begin to address the need for greater elaboration of objectives and change mechanisms, but these still require better integration and definition. Where the region remains the key level for organising support and intervention, any method addressing regionality must also recognise the need for a more strategic approach to 'jumping' levels to local, national (and sometimes global) levels when appropriate.

6.2 RECOMMENDATIONS

Sida, the NMFA, Norad, the TEAM and the SMFA (as the author of a new regional cooperation strategy)

- It is highly recommended that the new Swedish regional development cooperation strategy considers how regional interventions also require better linkage to other important levels. In other words, greater awareness could be made of understanding and strategising across these different levels, especially regarding national implementation of regional accords and instruments.

The TEAM

- There needs to be a more consistent understanding of regionality across the TEAM, not only on a broad level, but also with respect to specific details and a more critical engagement. This need not become an excuse for inflexibility, but should rather involve a more rigorous application of this understanding, especially in assessment memos. This will particularly assist in rationalising the programme portfolio, which requires review.
- A more regular external reassessment of the TEAM's portfolio is necessary. The portfolio review should also consider changes that have taken place in organisations due to the TEAM's support.

- The TEAM's staffing numbers should be maintained. Should the future bring cuts in budgets and fewer projects, this will free more staff time for developing a leaner and more strategic focus in line with above recommendations.
- Overall, greater effort should be dedicated to improve the presentation of knowledge and experience possessed by the TEAM.
- A clearer change theory for prevention and mitigation would provide much better focus on the TEAM's programme. The TEAM should prioritise, for example, cultural drivers and political leadership as key strategic considerations that cut across its work on prevention. A more prominent advocacy strategy should be based on such key causal mechanisms.
- More generally, with respect to both Swedish and Norwegian embassies, support should now be better tailored to embassy needs. For example, it seems that both Swedish and Norwegian embassies want the TEAM to engage more on a national level. The TEAM should improve its external communication and information system, and an improved website with details of the national partners it supports would be useful. An embassy link to the TEAM management system might also be beneficial.
- It is highly recommended that while revising its support to the embassies, the TEAM should make use of the opportunity to incorporate more strategic considerations at national and regional levels.
- Better utilisation of the TEAM's regional experience can perhaps take place through a specific regional theme focal point seminar. Working with the embassies to track specific issues of mutual interest from regional initiatives to national implementation, is another. One particular issue might be championed for a definite period of time to enhance synergy.

The TEAM and regional partner organisations

- The TEAM and its partners should hold a workshop to discuss critical areas of achievement in regional added value and emerging issues, and the need for strategising for future direction. A new Regional Strategy for Swedish development cooperation in Sub-Saharan Africa presents an opportune occasion on which to do so.
- The challenges for regional organisations, such as the new sub-contracting role, need to be discussed, and human rights, cultural and gender issues need local translation.

- Many of the regional NGOs need to increase their visibility at the country level through strategic advocacy campaigns that use regional instruments more directly.

The TEAM and Norway

- A more solid entry point for Norwegian embassies would be achieved by introducing the TEAM at a regional gathering of Norwegian Ambassadors (as they do currently with Swedish Ambassadors).

Sweden and Norway

- A new agreement will present an opportunity to rectify the limits of the original agreement with the inclusion of more specific details regarding planning and reporting lines, and to recommit to better adherence to requirements for annual meetings and minutes of meetings. A new agreement should also include more references to specific, relevant Norwegian policy documents.

Norway

- Norway needs to decide what it wants from the agreement. For example, a better balance in funding and the provision of staff from Norway for the TEAM would increase symmetry, ownership and benefits from the work, while simultaneously increasing the perception of this as a joint TEAM.

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Annex 2 Terms of Reference

Joint Evaluation of the Swedish/Norwegian Regional HIV/AIDS Team for Africa 2009-02-24

As stipulated in the "Agreement between the Norwegian Ministry of Foreign Affairs and the Swedish International Development Cooperation Agency concerning Regional Development Cooperation on HIV/AIDS in Sub-Saharan Africa through the Swedish/Norwegian Regional HIV/AIDS Team in Lusaka" of 2006, the cooperation is to undergo an evaluation.

1. INTERVENTION BACKGROUND

The HIV/AIDS epidemic is a major threat to development in Eastern and Southern Africa, as the epidemic is characterised as generalized in several countries. Since 2001 the Swedish International Development Agency (Sida) and the Norwegian Ministry of Foreign Affairs (NMFA) have collaborated through a joint Swedish/Norwegian Regional HIV/AIDS Team ("the Team"). The Team was first established in Harare, Zimbabwe, and then moved to Lusaka, Zambia, in 2002. Since the start the Team's two main tasks have been to provide technical assistance to the embassies in the region and to manage the regional HIV/AIDS program. Gradually the Team has also become what could be described as a regional resource base on behalf of Sweden and Norway. In 2008 the Team handled a portfolio with 71 regional contributions, amounting to 318 MSEK.

1.1 Previous evaluations' findings

An external evaluation[24] of Sida's implementation of the Swedish HIV/AIDS strategy "Investing for Future Generations" in 2005 looked at the Team as part of Sweden's response. In the report the Team was characterised as being highly competent on HIV/AIDS, and the Team's efforts to achieve synergy between the regional programmes and its collaboration with the embassies were stressed. Nevertheless, a lack of common understanding of the roles and functions of the Team was noted by the evaluators.

24 "Sida's implementation of the Swedish HIV/AIDS strategy" (2005).

In parallel, an internal review of the Team was conducted by Norad in 2005. At the time, it was found that the Norwegian embassies did not have the capacity to follow up on regional or sub-regional HIV/AIDS initiatives to the same extent as the Team and so there was little demand from the Norwegian embassies.

It was concluded that the cooperation had proven to be useful, and that the usefulness could be even further enhanced by appointing two more Norwegian positions and making the cooperation formalised through a delegated model for cooperation. In addition, the value added could be further strengthened by including the Team in the broader cooperation between Sweden and Norway in the HIV/AIDS area. Alternatives for future cooperation were considered (delegation, partnership, compatibility), as well as exiting the collaboration altogether.

1.2 Today's tasks and organisation

In 2006 Sweden and Norway signed a new agreement[25], constituting a framework for the partners in the area of HIV/AIDS. *The overall objective of the Team: to contribute to poverty alleviation by strengthening regional organisations and embassies in relation to prevention and impact mitigation of HIV/AIDS in Sub-Saharan Africa.*

In order to achieve this, the Team employs two strategies:

a. Support to the embassies (primarily demand driven)
b. Support to regional programmes, inter-government & civil society and applied research

According to the Agreement, Sida has committed to contribute with SEK 925 million during the period 2006–09, while Norway tentatively contributes with NOK 180 million for the same period. The Team reports directly to Sida/HQs. Norwegian financial support is provided by the Regional Department of the NMFA, while the technical cooperation with the Team is delegated to Norad's HIV/AIDS team.

The Team has a staff of 13 people, whereof Sweden finances 11 staff and Norway two. The Team is lead by a Regional Director and organised in three working groups. In addition an external Reference Group consisting of regional experts has been established, whose role is to provide advice and guidance on strategic issues to the Team through regular and more ad-hoc consultations.

25 "Agreement between the Norwegian Ministry of Foreign Affairs and the Swedish International Development Cooperation Agency concerning Regional Development Cooperation on HIV/AIDS in Sub-Saharan Africa through the Swedish/Norwegian Regional HIV/AIDS Team in Lusaka".

The structures are therefore somewhat different, as the contracting parties are an agency and a ministry. Furthermore the roles of the two contracting parties differ in the sense that Sida has taken on the responsibility of acting on behalf of the Ministry, and also makes the largest financial contribution and has most staff.

2. EVALUATION PURPOSE

In a recent inspection of the Swedish Embassy in Lusaka[26], the inspectors referred to this planned evaluation due to the need to consolidate and concentrate the work of the Team. They mention that it might even be necessary to consider a more geographic concentration. Other issues which should be considered according to the inspectors are the monitoring of results and the future organisation of the Team.

The purpose of the evaluation is to assess relevance, effectiveness and efficiency of the HIV/AIDS team by focussing on:

1 The regional approach
2 The cooperation between NMFA/Norad, Sida and the Team; and coherence with the respective HIV/AIDS policy
3 The team's organisation and management/implementation
4 Selected regional partners' activities.

The assessment of effectiveness, i.e. of results that have been achieved in relation to the Team's objectives, is of particular importance and shall focus on the outcome level. The evaluation shall pay specific attention to outcomes of the regional partners' work in the areas of prevention and mitigation of HIV/AIDS.

While it is recognised that evaluation may not be able to assess sustainability and impact of the Team's efforts, it is expected that the consultants in their report will, based on their findings, discuss potential sustainability and impact of the regional partners' activities

The matrix below illustrates which criteria the evaluation should assess for each dimension and to which extent.

26 "Rapport från inspektion av ambassaden i Lusaka", Regeringskansliet, Utrikesdepartementet, Promemoria 2008-10-29.

	RELEVANCE	EFFECTIVENESS	EFFICIENCY	SUSTAINABILITY	IMPACT
Regional approach	**	**	**		
Cooperation Norad /Sida & Team	*	*	**		
Team management & implementation	**	**	**		
Regional partners' implementation	**	***	*	*	*

Based on the findings from the above assessment, recommendations and lessons should be formulated for all four dimensions.

3. EVALUATION QUESTIONS

The evaluation shall cover the main goals, objectives and working areas of the Team since the Agreement was signed, i.e. from 2006 until end of 2008. The main elements to explore throughout the evaluation will be the Team's organisation and management, as well as its regional dimension.

As the overall objective is to contribute to poverty alleviation by strengthening regional organisations and embassies in relation to prevention and impact mitigation of HIV/AIDS, the assessment of results and achievements cannot be concentrated on the Team itself, but has to include and pay particular attention to the supported partner organisations and the outcomes of their work with the target groups.

It is expected that the evaluation team report will offer a comprehensive package of recommendations, as well as lessons learned that link the findings from the evaluation of the Regional HIV/AIDS Team in Zambia to the on-going discourse on regional approaches in development cooperation, bilateral and multi-donor cooperation and support to prevention and mitigation of HIV/AIDS.

Below are questions that the evaluation should discuss, but not necessarily be limited to:

1) The regional approach
- How is the regional dimension understood and embraced by the two bilateral partners and how does this regional dimension fit with the global and national "AIDS architecture"?
- What is the role of the team as a regional player?
- To what extent does the Team influence the regional dialogue on HIV/AIDS? Are there issues where the Team has changed the discourse?
- Which methods has the Team developed for working regionally?

– To what extent does the Team interface with national partners and mechanisms?
– What is the added value of a regional approach and what synergies have been created between supported activities at the regional level?
– From the evaluation, can one say that support t to HIV/AIDS programmes at the regional level strengthens work on HIV/AIDS at national and local levels?

2) The cooperation between NMFA/Norad, Sida and the Team; and coherence with the respective HIV/AIDS policy

– To what extent are the division of labour and the line of decisions between the Team and the different partners (Sida, NMFA, Norad, embassies and the embassy in Lusaka) clear and adequate?
– Which methods are used to involve sector departments at Sida HQ and/or NMFA/Norad in planning, assessment and follow up of support?
– To what extent is the support provided by the Team in line with Swedish and Norwegian strategies and policies on HIV and AIDS?
– What is the added value of the Swedish/Norwegian collaboration through the Team?
– Should other like-minded partners be invited to join this collaboration?

3) The team's organisation and management/implementation

a internal organisation

– How has the organization of the Team developed over time, what has triggered changes and is the organization (number of staff, line of management, competence and skills etc) adequate for the tasks today?
– Which managerial tools are applied by the Team, and to what extent are they (e.g. use of work plans, indicators, targets, outputs) appropriate for the goals of the Team?

b support to embassies

– How does the team support the embassies (technical advice, seminars, focal points etc.) and what are the outcomes of this support?
– How has the demand from the respective embassies developed over time and how has the Team responded to the requests?
– Are roles/responsibilities between the Team and Sida HQs and Norad HQs in matters related to HIV/AIDS clear to the Embassies?
– Could the approach and methods of the Team be changed in order to better support embassies in the region? (added skills, focus areas etc)

c regional activities
– What regional activities does the Team support and to what extent has the Team's portfolio changed over time?
– Which methods does the Team apply when identifying, assessing and following up the financial support to regional partners?
– To what extent has the Team contributed to capacity building of regional organisations? Which type of capacity building has been most important? Contributing + impeding factors.
– How does the Team assess if supported organizations meet their objectives, outcomes and outputs? If not met, how does if influence discussions and/or transfer of financial resources?
– What is the added value of channeling support through the regional team, as compared to other regional initiatives?
– Which recommendations can be made for the Team's role, organisation, partners, portfolio and scope, so that all the different partners can benefit?
– Could the role and visibility of the Team as a regional player be enhanced?

4) support to regional programmes, inter-government & civil society and applied research
– To what extent is there synergy between the regionally supported activities and bilateral programmes/projects at country level?
– Is the choice of partner organisations adequate given the focus on HIV prevention and impact mitigation?
– To what extent have the supported programmes reached their objectives? Are there differences between prevention and impact mitigation programmes?
– Can the different types of programmes that receive support be plausibly linked to results on HIV and AIDS at national and regional level?

4. METHODOLOGY

It will be part of the assignment to develop a detailed methodological framework for this evaluation, which should include but not be limited to the following methods:
– Document analysis (relevant policies and other regulatory documents, programme documentation, previous evaluations, etc.).
– Interviews of key stakeholders (the Team, Sida, NMFA, Norad, Swedish Ministry of Foreign Affairs, the members of the Team's reference group (including some of the previous members), some Norwegian and Swedish embassies

(including some of the HIV/AIDS focal points and development counsellors), UNAIDS, a careful selection of regional partners (including the GOs)
– Questionnaire survey (embassies)
– Field visit to Lusaka, Zambia and UNAIDS Regional Team in South Africa and probably one more country (It is expected that the consultants will spend ca. 2 weeks in Zambia and 2 more weeks in other countries in the region)
– Participatory methods of enquiry (regional partners' beneficiaries and members of the target group who have not been beneficiaries)
– Organise dissemination/discussion/information meetings with key stakeholders in the region as learning check points in the process

Guiding methodological principles shall be:
1. Triangulation and validation of information
2. Critical assessment of data quality and data gaps
3. Assessment based on factual findings, reliable data and observations
4. Transparency of methods, research tools and sources of information.

In order to ensure a strong learning element, the evaluation team shall apply participatory methods where possible, for example when organising workshops both in Lusaka, South Africa, Oslo and Stockholm at the outset of the evaluation.

5. EVALUATION TEAM

The evaluation team shall be a multi-disciplinary team combining competence and experience in the following areas:
– Development cooperation
– The HIV/AIDS epidemic, prevention and mitigation strategies
– Evaluation, in particular mixed methods and participatory approaches
– The Eastern and Southern African region

Knowledge and experience of Norad, Sida, and Swedish and Norwegian MFA and their respective policies and strategies would be a merit.

The assignment is estimated to require the services of two to four individuals, not including sub-contracted consultants for the field work, if any.

The team leader shall have experience in conducting and managing evaluations of similar magnitude. It is expected

that during field work at least part of the team is familiar with the local context and speaks the respective local language. This may imply sub-contracting consultants (individuals), in which case these shall be presented with heir CVs in the tender.

6. REPORTING, WORK PLAN AND SCHEDULE

Assuming that the contract is signed by 15th April 2009, the evaluation team shall submit the following reports according to the schedule below:

1. 30th April 2009: An *inception report* providing an interpretation of the assignment. This includes a detailed description of the methodological design to be applied such as sampling strategies, methods of investigation and data collection, and analytical approach. The inception report will be subject to discussions within the reference group and to the approval of the management group consisting of Sida and Norad.
2. Brief summary reports from the participatory workshops.
3. 1st June 2009: A *presentation of preliminary findings*. The presentation shall be subject for discussions with the reference group and other relevant stakeholders in Lusaka.
4. 15th June 2009: A *draft report*, which shall be discussed by the reference group. The management group will summarise and submit the comments to the evaluation team.
5. 15th August 2009: the *final report* shall be submitted. The final report shall include conclusions and recommendations, lessons learned, as well as an Executive Summary. The evaluation report must be presented in a way that directly enables publication.

All reports shall be written in English. The Consultant is responsible for editing and quality control of language. The final report should not exceed 50 pages, excluding annexes and follow the structure specified in Sida's Evaluation Manual, Annex B (here attached as Annex A).

The Consultant is expected to adhere to the OECD/DAC's Evaluation Quality Standards.

The budget and work plan must include sufficient time for presentations of conclusions and recommendations. The number of person weeks required for this assignment is estimated at 25.

Annex 3 Embassy Survey

Of the 34 Swedish and Norwegian embassies in Africa listed, we obtained e-mail addresses from 27 of them. The remaining seven of the embassies, particularly those in the northern part of the continent, responded that they were not interested in participating, largely due to the little relevance of HIV/AIDS work in their embassies. A second reason for not responding that was given, was the turnover at the embassies, with nobody being familiar or having experiences from working with the TEAM. Responses to the survey were nevertheless satisfactory, in that 25 persons from 22 different embassies (10 Swedish and 12 Norwegian) responded. One person was a previous employee at a Swedish embassy and is counted as a representative of Sweden in the analysis. From two Norwegian embassies we received responses from two respondents (e.g. both the counsellor and the HIV/AIDS focal point or a humanitarian/health officer). This was encouraged by us, as we were interested in the experiences and the opinions of different categories of employees, and these persons are also included in the analysis.

In order to keep the analysis simple and transparent, we have not computed weights to adjust for the slight overrepresentation of Norwegian embassies. A web-link to the survey was sent out in mid-May 2009, and the invited respondents had approximately 10 days to fill out the questionnaire. A total of 19 responded to the first mail. A follow-up mail was sent out the day before the deadline, adding 6 respondents. Naturally, the familiarity with the work of the TEAM varied between respondents, and those who early in the questionnaire responded that they were not familiar with the TEAM at all (7 respondents in total) only filled out a smaller part of the questions.

While the response rate must be considered quite high for this type of survey, the crude number of respondents is nevertheless low. Thus, many of the differences between groups that are commented upon in the text are based on a very small sample. We are not referring to statistical tests of significance, as the sample is too small. Thus, any conclusions about differences between countries, categories of employees and regions or other group differences should be interpreted with a certain amount of caution. We have nevertheless decided to report such findings, as they can give an indication of trends, and

especially when they are supported by evidence that has been found or reported in the field.

Figure Annex 3.1 gives the categories of respondents from respectively Sweden and Norway. As can be seen from the table, Norwegian embassies are represented with relatively more HIV/AIDS focal points, while there are more programme officers on HIV/AIDS or health from Sweden compared to Norway. [Whether this reflects a different personnel structure at Swedish compared to Norwegian embassies is hard to say.] Other positions include an Ambassador, a First and a Second Secretary, a regional humanitarian officer, while a few were unreported.

Figure Annex 3.1 Distribution of respondents by country and embassy position (in number and per cent).

	RESPONDENT'S POSITION AT EMBASSY				
	HIV/AIDS FOCAL POINT	COUNSELLOR	PROGRAMME OFFICER HIV/AIDS AND HEALTH	OTHER	TOTAL
Sweden	1	2	5	3	11
%	9	18	46	27	100
Norway	6	3	2	3	14
%	43	21	14	21	100
Total	7	5	7	6	25
%	28	20	28	24	100

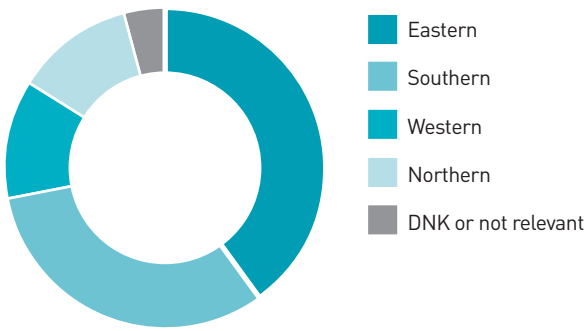
Figure Annex 3.2. shows the distribution of embassy personnel according to their status as diplomats or local employees. We see that among the focal points that responded, a majority have diplomatic status, while the programme officers tend to be locally employed. While among Swedish embassy respondents there are about the same number of diplomats and locally employed responding, a clear majority of the Norwegian embassy respondents have diplomatic status. Of the 8 locally employed respondents, 6 are citizens of the country where the embassy is located; one is a citizen of Norway/Sweden, while the final one is a citizen of a different country.

Figure Annex 3.2 Distribution of embassy personnel according to status by country.

		RESPONDENT'S POSITION AT EMBASSY				
		HIV/AIDS FOCAL POINT	COUNSELLOR	PROGRAMME OFFICER HIV/AIDS AND/OR HEALTH	OTHER	TOTAL
Sweden	Diplomat	0	2	1	2	5
	Employed locally	1	0	4	1	6
	Total	1	2	5	3	11
Norway	Diplomat	6	3	0	3	12
	Employed locally	0	0	2	0	2
	Total	6	3	2	3	14

The regional distribution of respondents reflects the target area for the work of the TEAM. The distribution of embassies is shown in Figure 3.3. A clear majority of respondents represent embassies from the Eastern and the Southern parts of the continent. The regional distribution is very equal for respondents from Swedish and Norwegian embassies.

Figure Annex 3.3 Regional distribution of respondents' embassies.



HIV/AIDS work at Swedish and Norwegian embassies

HIV/AIDS is not evenly spread throughout the African continent, and this is reflected in the response to a question on the significance of the HIV/AIDS pandemic in the countries for which the respondent's embassy is responsible. Nearly all the respondents in the southern part maintain it is a very significant issue, in the Eastern part it is largely seen as a significant issue, while in the Western and Northern parts of the continent, it is thought of as being of modest or little significance.

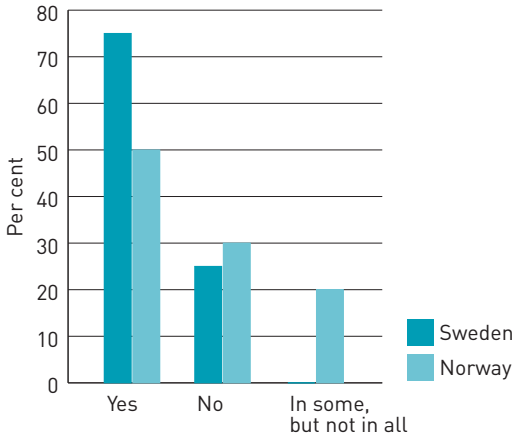
Figure Annex 3.4 Respondents' assessment of the significance of the HIV/AIDS issue in their country/ies of responsibility by region of Africa.

	EASTERN	SOUTHERN	WESTERN	NORTHERN	NO ANSWER	TOTAL
It is a very significant issue with high infection rates and great societal implications	2	7	0	0	1	10
It is a significant issue	5	1	1	1	0	8
It is of modest or little significance	1	0	2	2	0	5
DNK/hard to say	2	0	0	0	0	2
Total	10	8	3	3	1	25

Judged by our survey findings, HIV/AIDS does not have a very high priority at Swedish and, particularly Norwegian embassies in Africa. Only 16 per cent of the respondents say it is a core area with a high priority, while 28 per cent say it is an important issue but not among the core areas. An additional 20 per cent say it is an issue they deal with from time to time, while the remaining 36 per cent hold that the issue has a low priority at the embassy. There are, naturally, large differences between regions, with the highest priority indicated in embassies in Southern Africa, but with Eastern Africa not far behind, while the priority is unanimously low in embassies both in Western and Northern Africa.

More than six in ten of the respondents report that there is a donor group for HIV/AIDS in the country/ies for which they are responsible. Close to three in ten hold that there is no such group, while one in ten say that there is such a group in some but not in all the countries covered by their embassy. Seven respondents did not give a reply to this question, indicating a larger share having no donor group. Donor groups are found in all but one of the countries covered in Southern Africa, slightly fewer in the countries of Eastern Africa, and only rarely in Western and Northern Africa. Figure 3.5 shows that donor group membership is somewhat more common in Swedish than in Norwegian embassies for those who work in countries where such donor groups exist.

Figure Annex 3.5 Membership of donor group by country. Percentage of respondents reporting membership among those working in embassies where such groups are present.



In this section we have presented some of the context within which the employees responsible for HIV/AIDS at the embassies work. This context will undoubtedly influence the perceived need for support from the regional HIV/AIDS Team, as well as the type of support needed. The findings should therefore be kept in mind when interpreting the responses to questions more directly linked to the work of the TEAM in subsequent chapters.

Familiarity with and use of the TEAM

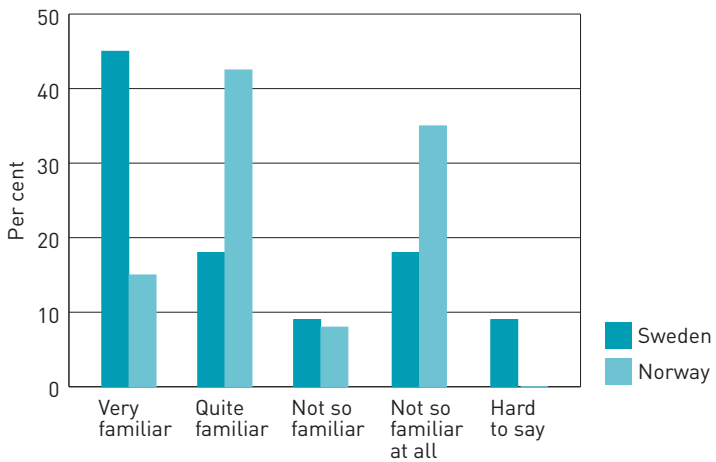
A majority of respondents in the survey are familiar with the work of the TEAM – 28 per cent are very familiar, 32 per cent quite familiar, while 8 per cent say that they are not so familiar. It is worth noting that 28 per cent are not familiar with the TEAM at all. We expected that familiarity would be strongly correlated with target area of the TEAM's activities, and this was confirmed: while 'very familiar' was the most common answer in Southern Africa and 'quite familiar' was most common in Eastern Africa, in Northern and Western Africa none of the respondents had opted for these alternatives.
There were a few respondents both in Southern and Eastern Africa who were not familiar with the TEAM. A reason could be that these respondents are new in their positions, but it could also indicate some country differences.

There are noticeable differences between respondents of Swedish and Norwegian embassies, as shown in Figure 3.6. While fewer of those working for Norwegian embassies say that they are very familiar with the work of the TEAM, the

percentage reporting no familiarity at all is higher among this group of respondents.

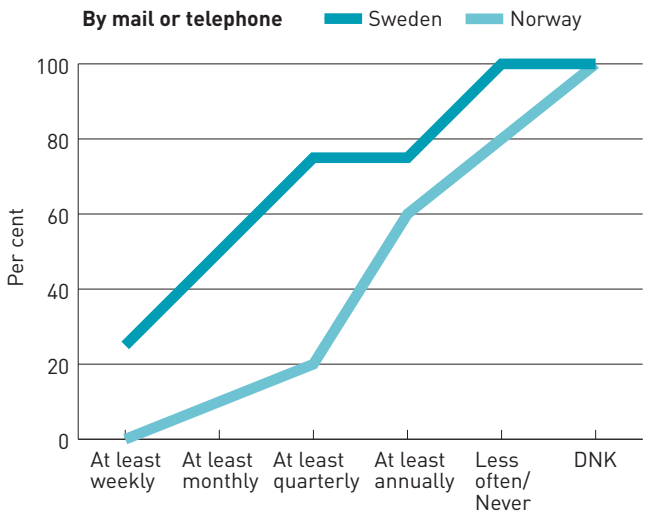
Since we in the subsequent analysis were mostly interested in the experiences and opinions of those who reported at least some familiarity with the TEAM, the number of respondents is somewhat reduced for the remaining survey questions – 18 in total, with exactly 9 respondents from each country, all but two from embassies in the Southern and Eastern parts of Africa.

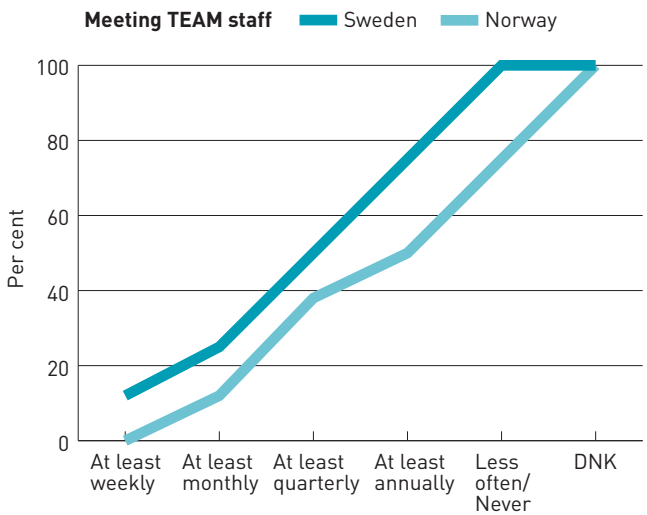
Figure Annex 3.6 Reported familiarity with the work of the TEAM by country (per cent).

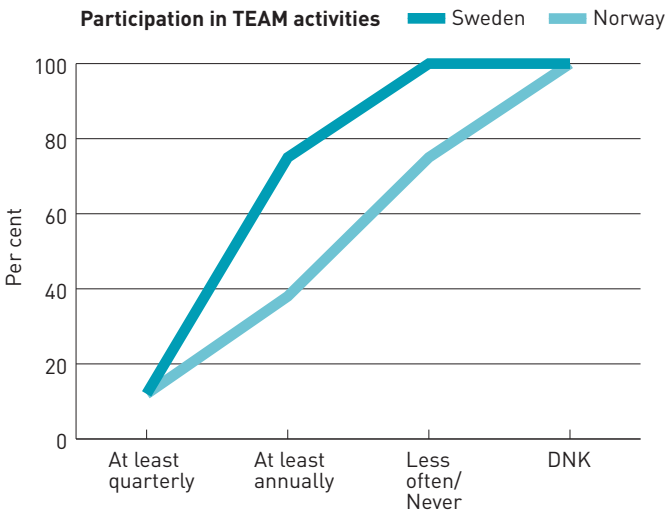


There is great variation in terms of frequency of embassy participation in TEAM activities. Figures 3.7a to 3.7c give clear indications that Swedish embassies have much more frequent contact with the TEAM than do Norwegian ones. For example, while three quarters of respondents representing Swedish embassies report that they communicate by e-mail of phone at least quarterly, the same is true of only one quarter of the Norwegian embassies. Differences are less marked when it comes to meeting TEAM staff, but the trend is the same. Participation in TEAM activities is not common for Norwegian embassy personnel according to this survey. Only 38 per cent participate annually or more often. The same is true of 75 per cent of Swedish respondents. In conclusion, it seems Swedish embassies have better access to or utilise the TEAM more frequently than Norwegian embassies.

Figures Annex 3.7a, 3.7b and 3.7c Frequency of communication with TEAM and participation in TEAM activities by country (cumulative percentage).



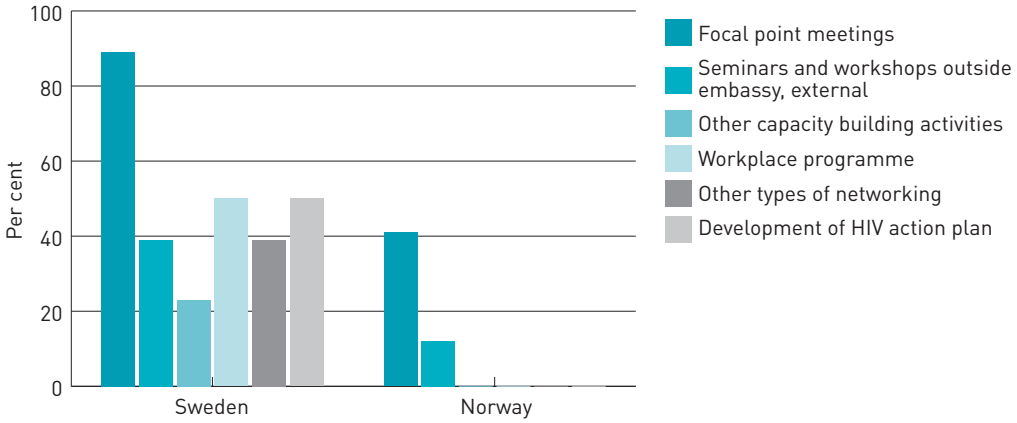




There are also systematic differences between embassies in Eastern and Southern Africa; respondents working in embassies in the South are much more likely to have frequent interaction with the TEAM than those in the East.

Differences between countries are even more revealing when it comes to frequency of participation in typical TEAM activities. Figure 3.8 shows the percentage of respondents from respectively Swedish and Norwegian embassies that have participated in a number of listed activities *frequently* or *sometimes*. As can be seen from the figure, respondents from Norwegian embassies have only participated in focal point meetings and seminars and workshops outside the embassy, and not even regularly so. For respondents from Swedish embassies almost all have participated in focal point meetings. A significant share has furthermore participated in the other types of activities listed as well.

Figure Annex 3.8 Frequency of participation in TEAM activities. Percentage reporting having participated 'frequently' or 'sometimes' by country.



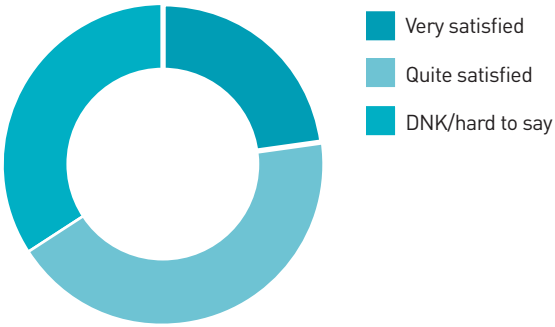
What then about participation in policy-related activities with assistance from the TEAM? Six per cent of the respondents have done so *frequently*, 39 per cent *sometimes*, the same percentage *rarely or never*, while 17 per cent are *unsure*. Country differences are less pronounced here than for the previous items: similar proportions at Norwegian and Swedish embassies have had at least some participation in policy-related activities with assistance from the TEAM. Such policy-assistance appears to be somewhat more common in Eastern than in Southern Africa, but differences are so small that one should not pay too much attention to them. The policy-activities that are most common are participation of TEAM staff in meetings with other regional actors and in donor group meetings, while participation in terms of joint financial agreements is virtually non-existent.

After this brief presentation of the use of the TEAM at Swedish and Norwegian embassies, we proceed to look at how the TEAM support is assessed by representatives of Swedish and Norwegian embassies.

Assessment of various aspects of the TEAM's work

There is general satisfaction with the work of the TEAM (see Figure 3.9), but there are more respondents who are *quite satisfied* (44 per cent) than *very satisfied* (22 per cent). None of the respondents report dissatisfaction with the TEAM's work, but a rather large percentage, 33 per cent, is undecided or don't know. While half the Swedish respondents are *very satisfied*, none of the Norwegian respondents opt for this alternative. The Norwegian respondents are evenly divided between *quite satisfied and don't know/hard to say*.

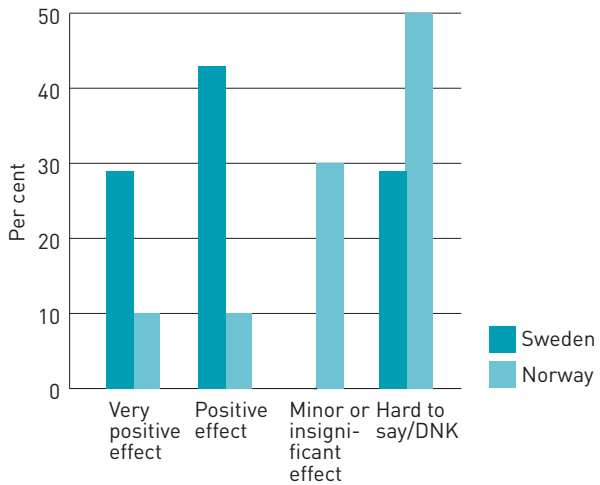
Figure Annex 3.9 Level of satisfaction with the work of the TEAM (per cent).



There are no differences in terms of satisfaction levels between the Eastern and Southern part of Africa. Those who are most familiar with the work of the TEAM are also those who are most satisfied. Status and position at the embassy does not appear to affect the level of satisfaction.

The survey also contained a question on the perceived influence of the TEAM on the HIV/AIDS work of the embassy. Only 18 per cent hold that the TEAM has a *very* positive effect, and another 24 per cent opt for positive effect. The remaining 59 per cent say that the effect is minor or insignificant (18 per cent), or that it is hard to say (41 per cent). Figure 3.10 shows that country differences are substantial, with personnel of Swedish embassies being considerably more positive in their assessment of the effect of the TEAM on the work of their embassies than Norwegian embassy personnel. Those employed locally are more likely to assess the effect more positive than the diplomatic corps. Differences between regions are minor, but with respondents in the Eastern part being more likely to be unsure of the effect.

Figure Annex 3.10 Perceived effect of TEAM on embassy's HIV/AIDS work by country (per cent).



Of those who have participated in seminars and workshops and have an opinion on their usefulness, all respondents have found them useful. The majority (71 per cent) found them *very useful*, while 28 per cent found them useful *to some extent*. The trend is similar for all groups, but with representatives of Swedish embassies and locally employed finding these events even more useful than others. Regional differences are small.

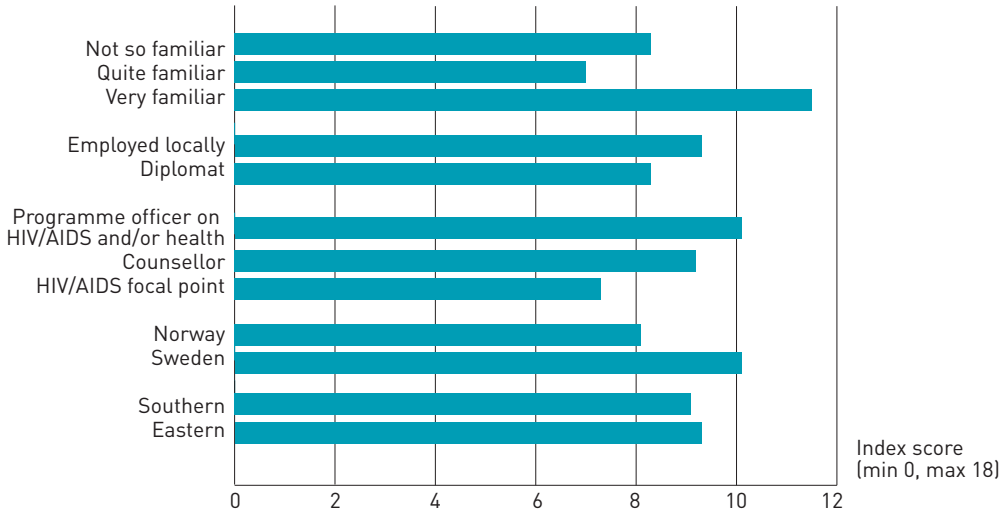
When asked to assess the input of the TEAM in regards to a number of areas where the TEAM is supposed to play a supportive role for the embassies, the responses differ greatly between the different items, as illustrated in Figure 3.10. It should be noted that those who have *answered don't know/hard to say* for each of the items (varying from 3 to 10 respondents) have been removed from the analysis, so that only those with a pronounced opinion are included.

An additive index was constructed to help us to compare the general assessment of the TEAM's input by country, region, position at embassy and familiarity with the TEAM's work. The index could vary from 0 (*not so good* for all items) to 18 (excellent for all).[27] The highest score reached was 13. Average scores for different groups of respondents are shown in Figure 3.11. As can be seen from the figure, satisfaction levels are somewhat higher among respondents from Swedish compared to Norwegian embassies. Differences are negligible

27 The index was constructed so that **not so good** is given the score 0, **rather good** 1 and **excellent** the score 2 for each item. The index score is computed by adding the score for each item, with a minimum of 0 and a maximum of 18. Since quite a few of the respondents did not answer all the questions, missing values were replaced by the average score for each item. The number of responses from Northern and Western Africa is so small that we have removed them from the figure.

between embassies in the Southern and Eastern parts of Africa. Programme officers and counsellors have a somewhat higher average score than HIV/AIDS focal points, while differences in terms of diplomatic status are very small. The highest average score is found among those who are very familiar with the work of the TEAM, while the most critical are those who are quite familiar. It is highly likely that there is co-variation between several of these background variables, but due to the low number of respondents, we are not able to control for these in a multivariate model.

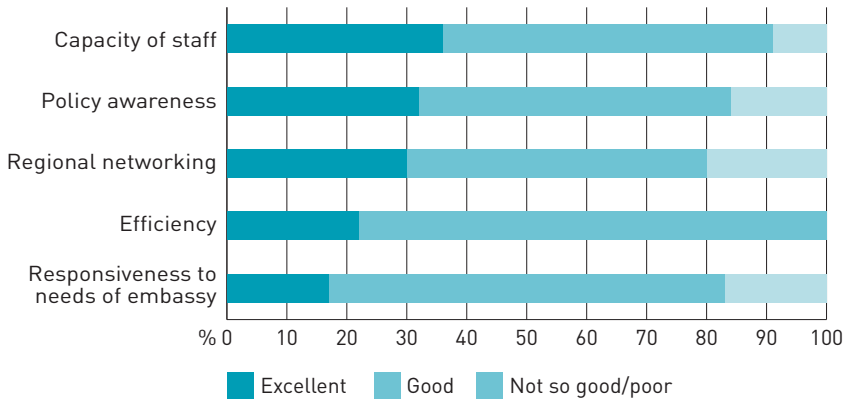
Figure Annex 3.11 Average index scores for assessment of various aspects of input of the TEAM by familiarity with the TEAM's work, diplomatic status, position in the embassy, Swedish or Norwegian embassy and region of Africa.



Respondents were also asked to evaluate the quality of the TEAM's work along a predetermined set of indicators, including the capacity of the TEAM staff, its responsiveness to the needs of the embassy, efficiency, regional networking and policy awareness. Responses are presented in Figure 3.12.
The first thing to note is the relatively large number of respondents answering *don't know/hard to say*, varying from 29 per cent to 47 per cent of the responses. In the figure only respondents with an opinion on each item have been included. A majority of respondents assess the work of the TEAM to be at least *good* for each item. The highest percentage of *excellent* is obtained for the capacity of staff, while the lowest share (0 per cent!) of *not so good/poor* are found for the TEAM's efficiency. The lowest share of *excellent* and with a noticeable share of *not so good/poor,* is the responsiveness of the TEAM to the needs of

the embassy. To identify differences in assessment of different categories of respondents, a similar index to the one presented in the previous paragraph (Figure 1.12) was constructed; this time the index could vary from 0 to 10, with an average of 5.8). The trends were the same as those presented above, with respondents from Swedish embassies giving slightly better average scores than those from Norwegian (6.0 vs. 5.5), and those familiar with the work of the TEAM being more positive than those quite or not so familiar (index scores of 7.1, 4.6 and 5.8 respectively). Respondents from Southern Africa (6.3) were slightly more positive in their evaluation than those from Eastern Africa (5.8). It should be stressed, however, that differences are quite small, and a few persons in a category with very positive or negative assessments would be enough to change the picture.

Figure Annex 3.12 Assessment of various aspects of the TEAM's work (per cent).

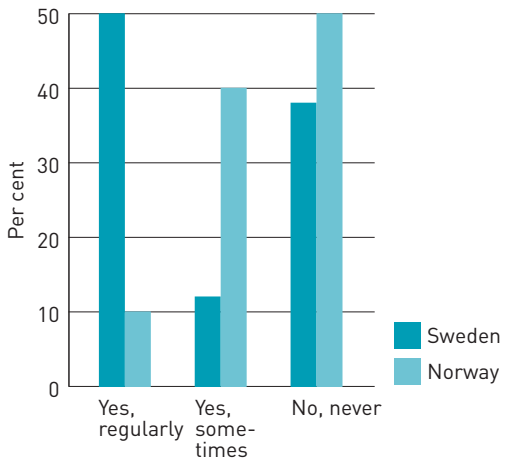


Communication between the TEAM and the embassies

We have already seen the frequency of communication between the embassy staff and the TEAM, and this section looks into some other means of communication and the embassy staff's assessment of the communication. One of the means of communication from the TEAM to the embassies is the TEAM newsletter (hiv@africa-digest). According to survey responses, however, only 28 per cent of the embassy staff receives this newsletter regularly, while the same percentage receives it sometimes. As many as 44 per cent – and remember that these are the people who normally are in charge of HIV/AIDS work at the embassies – claim that they *never* receive these newsletters. We should also be reminded that people who are not familiar with the TEAM are not included in these figures.

Embassies in the Southern part of Africa receive the newsletter considerably more often than those in the Eastern part; in the Eastern part 56 per cent of the respondents report never to receive it. Only 20 per cent of the HIV/AIDS focal points say that they receive the newsletter regularly, while 40 per cent claim that they never receive it. Respondents at Norwegian embassies are much more likely than at Swedish embassies to say that they receive it only *sometimes* or *never* (see Figure 3.13).

Figure Annex 3.13 Responses to the question "Do you receive electronic newsletters (hiv@africa-digest) from the TEAM?" by country (per cent).



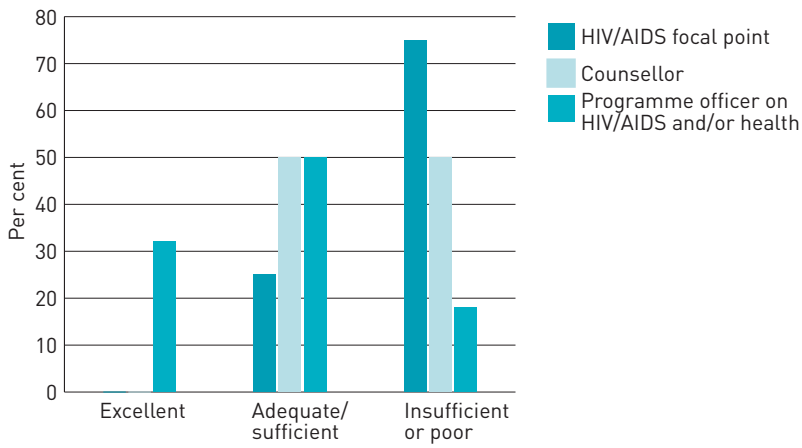
Of the respondents receiving the newsletter, half of them report that they read it regularly, three in ten read it sometimes while the remaining two in ten rarely or never read it. For this item responses are so few that it makes little sense to compare groups. Of those receiving the newsletter, 30 per cent find it *very useful*, the same percentage find it *somewhat useful*, while 20 per cent find it *not so useful*, and the same percentage opted for *don't know/hard to say*. None of the respondents reading the newsletter had acted upon or actively used the information received in the newsletter *to a large extent*. However, 40 per cent had done so *to some extent*, while 40 per cent had *rarely or not at all* done so. The remaining 20 per cent reported they did not know or found it hard to answer.

Findings thus far have hinted that there is room for improvements in the communication between the embassies and the TEAM. This is confirmed in the responses to a question where the respondents are asked to assess this communication. While 17 per cent assert that it is *excellent* and 28 per cent say that it is *adequate/sufficient*, the share indicating that it

is insufficient or poor reached 39 per cent. Another 17 per cent found it hard to answer this question.

After removing the undecided from the analysis, we checked to what extent a set of background characteristics are associated with satisfaction of dissatisfaction with the communication. Respondents from Norwegian embassies are more likely to be dissatisfied with the communication than those from Swedish embassies, 63 per cent compared to 29 per cent. Figure 3.14 shows the distribution of assessments made by people with different positions in the embassies. It is noteworthy that the HIV/AIDS focal points (almost all of whom are from Norwegian embassies in this sample) are more or less unanimously dissatisfied with the communication with the TEAM. The most satisfied are programme officers on HIV/AIDS or health.

Figure Annex 3.14 Assessment of communication between embassy and TEAM, by position at the embassy (per cent). Responses 'do not know/hard to say' removed.



The embassy, the TEAM and their policy framework

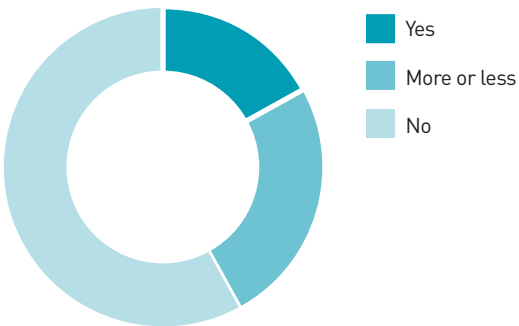
It was shown that many of the embassies use the TEAM for policy purposes. In this section we discuss the perception of the policy framework within which the embassies find themselves in HIV/AIDS work and how this relates to the use of the TEAM.

There appears to be very little tension between political guidelines from the home country and the initiatives made by the TEAM. Only one respondent reported such a tension, and even for this person it was not a regular feature. Quite a few respondents, however, were undecided (35 per cent) on this issue.

To a question on whether they see a value added of channeling funding through the TEAM instead of direct HIV/AIDS support through the embassies, many of the respondents (50%) were undecided. However, among those with an opinion on this issue, two thirds of the respondents see a *great added value*, 22 per cent opted for *a certain added value*, while only 11 per cent believe there is *minor or no added value*. None of the respondents thought that the effect is negative. The number of answers, however, is low, which restricts a further breakdown of respondents to see the relationship with background variables.

Respondents were more critical in their assessment of whether the links between the TEAM and the national level HIV/AIDS responses are sufficient. Of the two thirds of the respondents who had an opinion on this issue, respectively 17 and 25 per cent gave *yes* and *more or less* as their response to this question. The percentage answering *no* is as high as 58 per cent. Once again the number of responses is too low to make firm conclusions about the relationship with background variables, but there does not appear to be a large difference between responses from Norwegian and Swedish embassies in this respect.

Figure Annex 3.15 Assessment of the sufficiency of links between the TEAM and the national HIV/AIDS responses (per cent of those with an opinion, undecided removed).

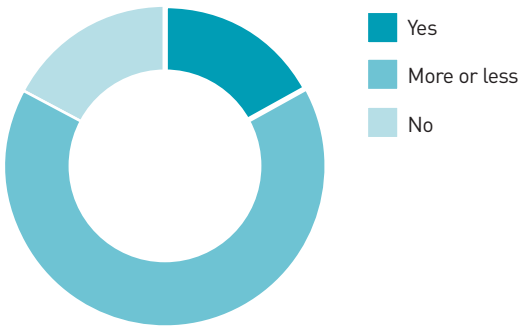


Suggestions for the future role of the TEAM

Respondents were not only asked to assess the present situation, but were also given questions on the possible future role of the TEAM. One third of the respondents did not have an opinion about whether or not the TEAM should continue in the future. Of those with an opinion, all respondents believe there is a place for the TEAM. The majority – two thirds of the respondents – think that the TEAM should be continued,

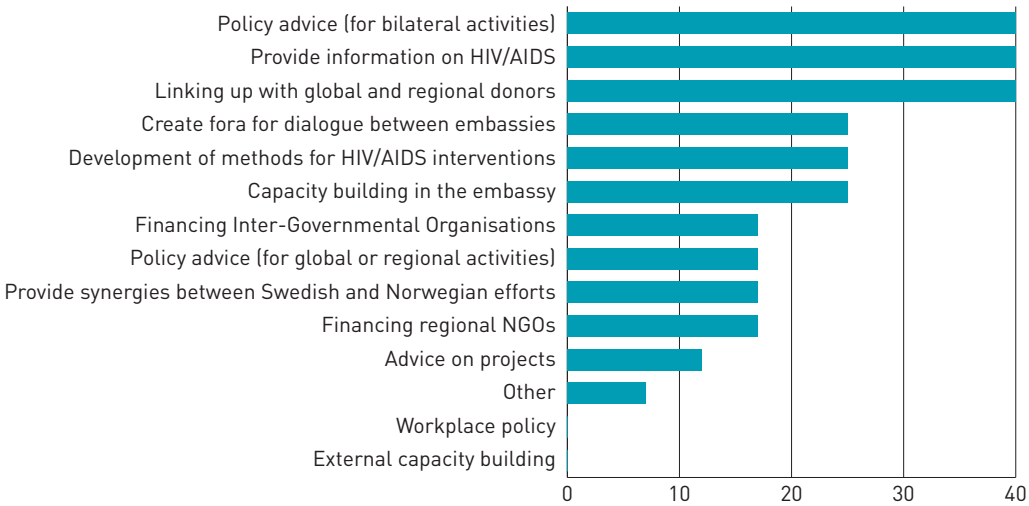
but altered slightly. The remaining respondents are divided equally between it should be continued the way it is today and it should be continued but altered significantly. The results are illustrated in Figure 3.16. Responses to the question were too few to present a meaningful breakdown on sub-groups of the survey population.

Figure Annex 3.16 Responses to the question "In your opinion, what should be the role of the TEAM in the future?" (per cent). Those answering "don't know/hard to say" have been removed.



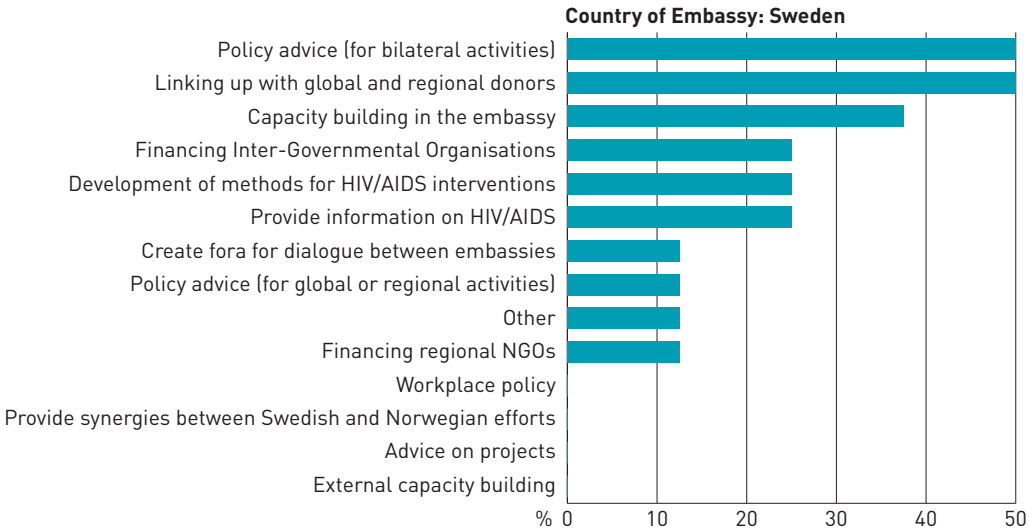
The respondents were also asked to give their opinion on what could be the future priorities of the TEAM based on a predetermined list. They were asked to mark up to three alternatives. Results (percentage opting for each of the items) are presented in the following figures. Three areas stand out as having the highest priority among embassy personnel. These are policy advice for bilateral activities, provision of information on HIV/AIDS, and linking up with global and regional actors. Substantial proportions furthermore believe that the TEAM should put emphasis on creating fora for dialogue between embassies, developing methods for HIV/AIDS interventions, and on capacity building in the embassies. Workplace programmes and external capacity building are not recommended to be among the three main future priorities by any of the embassy respondents.

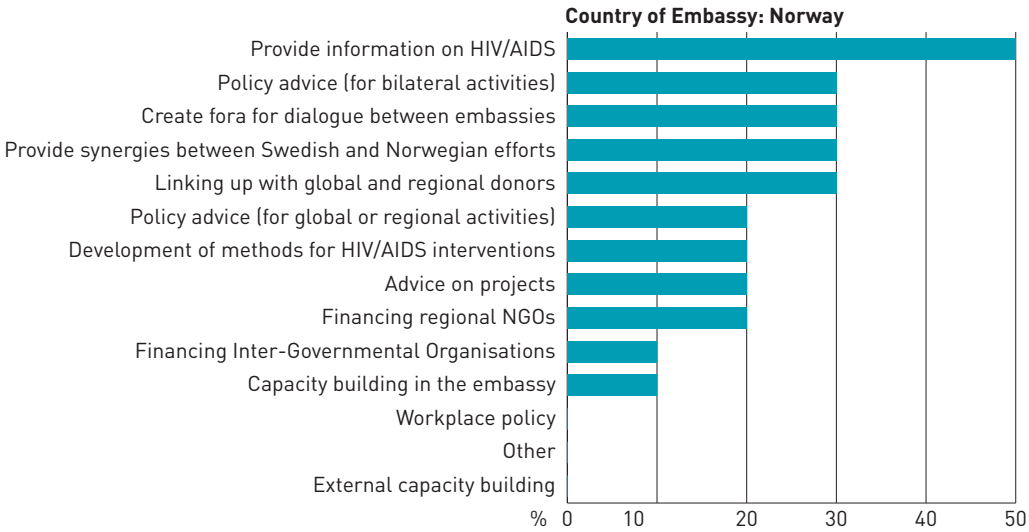
Figure Annex 3.17 Opinion on future priorities of the TEAM.
Percentage of respondents opting for each of the listed items.



These can be sub divided according to each Embassy:

Figure Annex 3.18a Sweden, 3.18b Norway





Questionnaire, embassy survey

Welcome to the survey on the Regional HIV/AIDS team
First some practical information:

1. In the following we will refer to the Regional HIV/AIDS team as the TEAM.
2. Use any Scandinavian language or English for the open-ended questions.
3. Use the available space for open-ended questions. If there is not enough space, and you have further comments, please send them by mail to peris.jones@nibr.no.

Click on next to continue.

Which country's embassy do you work at?

Country

Sweden ☐
Norway ☐
Other/Not relevant ☐

Which region of Africa does your embassy belong to?

Region

Eastern ☐
Southern ☐
Western ☐
Northern ☐
Central ☐

Don't know /not relevant ☐

What is your position at the embassy?

Position

- HIV/AIDS focal point ☐
- Counsellor ☐
- Programme officer on HIV/AIDS and/or health ☐
- Other ☐

What is your position at the embassy?

Pos Other

Do you belong to the diplomatic corpse or are you employed locally?

Diplomat

- Diplomat ☐
- Employed locally ☐
- Other ☐

What is your citizenship?

Citizen

- Citizen of country where embassy is located ☐
- Citizen of Norway/Sweden ☐
- Citizen of other state/non-citizen ☐

How much of your time at work do you spend on HIV/AIDS?

Worktime

- Almost all the time, more than 80% ☐
- Between 50% and 80% ☐
- Between 25% and 50% ☐
- Between 10% and 25% ☐
- 10% and below ☐
- Hard to say/don't know ☐

Are there other people at the embassy spending more time on HIV/AIDS related activities than you?

Moretime

- Yes ☐
- No ☐
- Hard to say/don't know ☐

How high is HIV/AIDS on the agenda of your embassy?

Priority

A core area with high priority	
An important issue but not among the core areas	
An issue that we deal with from time to time	
This issue has low priority at the embassy	
Hard to say/don't know	

Is your embassy engaged in the following HIV/AIDS-related activities?

Activities

	Yes	No	Don't know/ hard to say
Specific programmes			
Mainstreaming in other programmes			
Integrated into the context analysis for country activity plans/3-year rolling plans			
Civil society/NGO support			

How significant is the HIV/AIDS pandemic in the country/-ies that your embassy is responsible for?

Significance

It is a very significant issue with high infection rates and great societal implications	
It is a significant issue	
It is of modest or little significance.	
The significance varies between countries.	
Don't know/hard to say	

To what extent does your embassy engage in bilateral and regional activities to fight HIV/AIDS?

Bi_or_multi

Both bilateral and regional, approximately equally	
Both bilateral and regional, but with emphasis on regional	
Both bilateral and regional, but with emphasis on bilateral	
Only bilateral	
Only regional	
Little or no engagement with AIDS	
Don't know/hard to say	

Is there a donor group on HIV/AIDS in your country(ies) of responsibility?

Donor

- Yes ☐
- No ☐
- In some, but not in all ☐
- Don't know ☐

Is your embassy a member of the donor group(s)?

Donor_memb

- Yes ☐
- No ☐
- In some, but not in all ☐
- Don't know/not relevant ☐

How familiar are you with the work of the TEAM?

Familiar

- Very familiar ☐
- Quite familiar ☐
- Not so familiar ☐
- Not familiar at all ☐
- Hard to say ☐

In general, how satisfied are you with the work of the TEAM?

Satisfaction

- Very satisfied ☐
- Quite satisfied ☐
- Not satisfied ☐
- Very dissatisfied ☐
- Don't know/hard to say ☐

Could you please describe the main benefit(s) to your embassy related to the input of the TEAM?

_____

_____

Could you please describe the main challenge(s) or problem(s) in dealing with the TEAM?

_____

_____

To what extent does the presence of the TEAM influence on the HIV/AIDS work of the embassy?

Influence

Very positive effect	☐
Positive effect	☐
Minor or insignificant effect	☐
Negative effect	☐
Hard to say/don't know	☐

In the 2006–2009 period, how frequently have you interacted with the TEAM in the following ways?

Interact

	At least weekly	At least monthly	At least quarterly	At least annually	Less often /Never	Don't know
By e-mail or telephone						
Meeting TEAM staff						
Participating in Team activities						

Which of the following types of activities has your embassy engaged in with assistance from the TEAM?

Types_act

	Frequently	Sometimes	Rarely or never	Don't know/ not relevant
Seminars and workshops (internal at embassy)				
Focal point meetings				
Other seminars/workshops outside the embassy				
Other capacity building activities				
Workplace programme				
Other types of networking				
Advice and input on embassy's projects or programs				
Development of HIV action plan				

To what extent has your embassy engaged in policy dialogue or other policy-related activities with assistance from the TEAM?

Policy

Frequently	☐
Sometimes	☐
Rarely or never	☐
Don't know/not relevant	☐

What of the following policy-related activities has the embassy engaged in with assistance from the team?

Policy_act

	Frequently	Sometimes	Rarely or never	Don't know/ not relevant
Joint financial agreements				
Donor group meetings				
Meetings with other regional actors				

In your opinion, is the TEAM sufficiently linked into national level HIV/AIDS responses?

Linked

- Yes ☐
- More or less ☐
- No ☐
- Hard to say/don't know ☐

How could the TEAM be better linked into national level HIV/AIDS responses?

_____

_____

If your embassy has participated, has the participation in seminars or workshops with assistance from the TEAM benefited the work of the embassy on HIV/AIDS?

Benefit

- Yes, very much ☐
- Yes, to some extent ☐
- Not so much ☐
- Not at all ☐
- Have not participated ☐
- Don't know/hard to say ☐

Please describe why you have found it useful and how you have acted upon the results.

OR

Please describe why they were not useful, and how they could be improved to match your needs.

_____

_____

_____

How do you assess the input of the TEAM concerning...

Assessment

	Excellent	Rather good	Not so good	Don't know/ Hard to say
Relevance for Embassy's HIV/AIDS work				
Linking up with other regional actors				
Synergy between Norwegian and Swedishefforts				
Information flow				
Capacity building				
Focal point meetings				
Advice on programs and projects				
Advice on policy				
Work place programme				
Development of HIV action plans				
Mainstreaming of HIV/AIDS in embassy's work				

Do you receive electronic newsletters from the TEAM (hiv@africa-digest)?

Newsletter

- Yes, regularly ☐
- Yes, sometimes ☐
- No, never ☐
- Don't know/remember ☐

Do you read the newsletters?

Read

- Yes, always ☐
- Yes, sometimes ☐
- Rarely ☐
- Never ☐
- Don't know/not relevant ☐

Is the newsletter useful in your work on HIV/AIDS?

Newsl_useful

- Yes, very useful ☐
- Yes, somewhat useful ☐
- Not so useful ☐
- Completely unuseful ☐
- Don't know/hard to say ☐

Have you acted upon or actively used information received in the newsletter?

Acted_newsl

- Yes, to a large extent ☐
- Yes, to some extent ☐
- Rarely or not at all ☐
- Don't know/hard to say ☐

How would you assess the communication between the embassy and the TEAM?

Communic

- Excellent ☐
- Adequate/sufficient ☐
- Insufficient or poor ☐
- Hard to say/don't know ☐

What could, in your opinion, be done to improve this communication?

_____

_____

How do you evaluate these different aspects of the TEAM?

Aspects

	Excellent	Good	Not so good /poor	Hard to say /don't know
Capacity of staff				
Responsiveness to needs of embassy				
Efficiency				
Regional networking				
Policy awareness				

Do you ever feel there is a conflict or tension between initiatives and activities supported by the TEAM and the policy guidelines from Sweden/Norway?

Tension

- Yes, often ☐
- Yes, sometimes ☐
- Rarely or never ☐
- Don't know/hard to say ☐

In your opinion, is there a value added in channeling funding for HIV/AIDS through the TEAM instead of directly through the embassies or other regional/global funds?

Addedvalue

- Yes, a great value ☐
- Yes, a certain value ☐
- Minor or no added value ☐
- No, on the contrary, the effect is negative ☐
- Don't know/hard to say ☐

What, in your opinion, is the extra value added?

_____

_____

Why, in your view, is there no value added, and what would be a better way of channelling HIV/AIDS funding?

_____

_____

In your opinion, what should be the role of the TEAM in the future?

Future

- Should be continued the way it is today ☐
- Should be continued, but altered slightly ☐
- Should be continued, but altered significantly ☐
- Should not be continued ☐
- Don't know/hard to say ☐

What should, in your opinion, be altered as to the role of the TEAM?

OR

Why do you think the TEAM should be discontinued in the future?

_____

_____

_____

What should be considered the three main priorities of the TEAM in the future?

Three_prior

- ☐ Provide information on HIV/AIDS
- ☐ Linking up with global and regional donors
- ☐ Financing regional NGOs
- ☐ Financing Inter-Governmental Organisations
- ☐ Provide synergies between Swedish and Norwegian efforts
- ☐ Capacity building in the embassy
- ☐ External capacity building
- ☐ Policy advice (for bilateral activities)
- ☐ Policy advice (for global or regional activities)
- ☐ Advice on projects
- ☐ Create fora for dialogue between embassies
- ☐ Workplace policy
- ☐ Development of methods for HIV/AIDS interventions
- ☐ Other
- ☐ Don't know/hard to say

Are there issues related to the work of the TEAM that have not been covered in the questionnaire but that you believe are relevant to the present evaluation? Please comment in the space below. Feel free to send additional information to peris.jones@nibr.no

Name of Embassy (will not be used when presenting results, but will be used to check coverage)

Label 51

Would you be willing to answer a few questions in a follow-up telephone interview?

Phone

- ☐ Yes
- ☐ Perhaps
- ☐ No

Please provide your name and telephone number where you can be reached (include country code).

Phone_num _____

Thank you so much for your participation! We will send a link of our evaluation report, including survey results, to all Swedish and Norwegian embassies in Africa.

Annex 4 List of interviews and workshop participants

South Africa

Name	Organisation
Carmel Gaillard	REPSSI, 27th may, 2009
Noreen Huni	REPSSI, 27th may, 2009
Peter Masessa	REPSSI, 27th may, 2009
Phillip Melthuhi	REPSSI, 27th may, 2009
Margaret Mokhuane	Royal Norwegian Embassy of Norway, Pretoria, 29th May, 2009
Ntabeleng Motsomi	UNODC, 27th May, 2009
Stein Inge Nesvåg	HIV/AIDS Focal Point, Royal Norwegian Embassy, Pretoria, 29th May, 2009
Atieno Odenyo	Partnership Advisor, UNAIDS Regional office for Eastern and Southern Africa, 29th May, 2009
Anita Sandstrøm	Head of SAT (and former Director TEAM), 28th May, 2009
Doreen Sanje	SADC HIV/AIDS Unit, 26th May, 2009
Mark Stirling	Director of UNAIDS Regional office for Eastern and Southern Africa, 29th May, 2009
Ria Schoeman	HIV/AIDS Focal Point, Royal Swedish Embassy, Pretoria, 29th May, 2009

List of participants in workshop in Pretoria, South Africa, 26th May, 2009

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	Home Based Care (HBC) group, Umvumo, Morogoro
Titus A Lugendo	Programme Coordinator, TANOPHA
General Lupogo	Executive chairman, TANOPHA
Nyabasi Makori	Technical Officer, Tunjali, Morogoro
Peter Massesa	Sub Regional manager East Africa, REPSSI, Tanzania
Barabona Mubondo	Director, SAT, Dar es Salaam
Dr. Stanley Sonoiya	EAC, Arusha.
Florence Temu	Programme Officer, AMREF, Dar es Salaam
Joyce Tesha	HIV/AIDS Focal Point, Royal Swedish Embassy, Dar es Salaam
Levina	FHI, Dar es Salaam
Hanna	Royal Norwegian Embassy, Dar es Salaam (telephonic interview)

List of participants in workshop in Tanzania, Dar es Salaam, 15th May 2009

Leonard Peter	Bangonet
Tatu Kartala	BEDF
Anne-Kristine Bagger	FEMINA-HIP
Albert Magohe	Youth taskforce for realisation of Primary Health Care
Kruinge Evodiues	Savelife Club-Muhimbili
Keleyani Alphonce	Gender club MUHAS
Felician Adelphina	Savelife Club, MUHAS
Mwajuma S Masaiganah	Training and Research Support
HijaWazee	HelpAge International
Peter Massesa	REPSSI
Peris Jones	NIBR
Siri Bjerkreim Hellevik	NIBR

Zambia

Sebastian Chikuta	REPSSI Sub regional manager, Lusaka
Dr. Ben Chirwa	NAC
Barbara Ehrenreich	IOM CCF-peer educators meeting
Anne Fredriksen	Royal Norwegian Embassy, Lusaka
Dr Stephen Muliokela	GART Director
Amaya Gillespie	UNAIDS country co-ordinator, Lusaka
Audrey Mwendapole	Royal Swedish Embassy, Lusaka Mutamino Family Group, Chongwe
Linda Nonde	SAFAIDS
Sharon Lesa Nyambe	UNODC
Zoonadi Ngwenya	Country Programme Manager, SAT
Boemo Sekgoma	SADC PF
Clement Singangwe	Chapter Chair, NZP+, Mumbwa

List of participants in workshop in Zambia, 22nd May, 2009

Clara Mbwili	Consultant
Liya Mutale	Facilitator Zambian Red Cross representative REPSSI representative
Zoonadi Ngwenya	SAT
Sharon Lesa Nyambe	UNODC
Malala Mwondela	ZARAN, Director
Peris Jones	NIBR

The Regional HIV/AIDS TEAM, Lusaka:

Kristina Ramstedt, Director

Peter Iveroth, Deputy Director

Enoch Banda

Davis Chitundu

Paul Dover

Karolina Kvarnare

Eva Liljekvist

Anne Lindeberg

Eva Charlotte Roos

Chilamo Sinkala

Michael Twanda

TEAM reference group

Michael Kelly	Formerly University of Zambia
Alan Whiteside	HEARD

Other donors

Robin Gorna	Senior Health & AIDS Adviser, DFID

Oslo

Sigrun Møgedal	Norwegian HIV/AIDS Ambassador, NMFA
Tove Stub	Section for Southern and West Africa, Department for Regional Affairs and Development, NMFA, Assistant Director

Robert Hovde	Section for Southern and West Africa, Department for Regional Affairs and Development, NMFA Senior Advisor
Anne Skjelmerud	Global Health and AIDS Department (AHHA), Norad, Senior Advisor
Tale Kvalevaag	Global Health and AIDS Department (AHHA), Norad, Senior Advisor
Marit Berggrav	Global Health and AIDS Department (AHHA), Norad, Senior Advisor
Ingjerd Haugen	Section for multilateral banks and finance, NMFA, Advisor

Stockholm

Lena Ekroth	Policy Specialist SRHR/MDG5, former Head of the HIV/AIDS Secretariat Sida, 2002–2007, 4th May, 2009
Sofia Norlin	Programme Officer, Sida, previous TEAM member, 4th May, 2009
Barni Noor	Programme Officer, Sida, previous TEAM member, 4th May, 2009
Pia Engstrand	Policy Specialist HIV/AIDS (TEAM Health and Social Security), 5th May, 2009
Jan Bjerninger	Head of AKTSAM, Department for Long term Cooperation/Operations, Sida HQ, 5th May 2009
Kristina Kuhnel	Deputy Head of AKTSAM, 5th May 2009
Göran Paulsson	Head of TEAM Health and Social Security, 5th May 2009
Tomas Lundström	Programme Officer, TEAM for Regional Programmes Asia. 5th May, 2009

Annex 5 Methods and data collection

SAMPLING OF ORGANISATIONS AND COUNTRIES

Organisations. A decision had to be made by the evaluation team regarding which of the TEAM's 37 recipient organisations to select as case studies. Seven organisations were selected (EAC, SADC, REPSSI, SAT, ARASA, UNAIDSRST-ESA, UNODC, and in addition, in less detail, 'Research institutes'). The criteria for selection of the organisations were:

- To exemplify how the TEAM's partners work at multiple levels (regional, national and local) and therefore to enable the evaluators to identify the outcomes of the TEAM's work at these different levels (as also reflected in the ToR) and across a long chain of implementation
- The organisations selected represent a good spread in working across the TEAM's thematic areas
- The organisations also represent the different modes of working regionally (as per typology in chapter 5)
- For the Regional Economic Community organisations (RECs) the discussion only includes EAC and SADC as the cooperation with the other RECs are only in its planning stages
- The selection also had to fit with the country selection (see below)

Each of the organisations was therefore chosen in order to illustrate some key aspect of the TEAM's work. Sampling, however, by implication, raises issues concerning how representative the sample can be – in this case 7 organisations out of 37. It was particularly unfortunate for the evaluation that the TEAM, although requested by Sida HQ to prepare for the evaluation, did not give input into the selection of organisations until the field work had already commenced. For example, it was not always possible for the evaluation team to identify partner organisations according to all of the TEAM's thematic areas within the countries selected for field work (see below). While it can by no means be said to be exhaustive of the TEAM's wide geographic and thematic reach, based upon the criteria above, the sample of organisations is nevertheless considered a reasonably approximate representation of the TEAM's work.

From the seven, two were selected for in depth study, which included an assessment of the impact and sustainability of the partner organisations, especially at the local level. The two work in both Zambia and Tanzania, namely, the Regional Psychosocial Support Initiative (REPSSI) and the Southern African AIDS Trust (SAT). These were also chosen because they represent different modes of organisation (the former through sub-regional offices, and the latter, more standardised regionally). Furthermore, with their explicit emphasis on supporting training and capacity building at a local level, target beneficiaries could be identified to bring context to verify relevance, outputs and outcomes and so on, concerning interventions (see 'beneficiary work').

Countries. Three country field visits were requested in the ToR. The criteria for selection were as follows:

- Zambia was selected due to being the host country for the TEAM
- South Africa because that is where the majority of the organisations the TEAM funds have regional headquarters.
- The rationale for selection of the third country was a combination of having both regional organisations (some which were also present in Zambia) and, following input from the evaluation management group, where there was also Norwegian and Swedish bilateral presence on HIV/AIDS. Tanzania was selected.

In Zambia, the TEAM itself was visited on several occasions in Lusaka and also its country-level partner organisations. Local field visits took place to REPSSI's partner in the Chongwe area and the SAT local sub grantee, in Mumbwa.

In Tanzania, REPSSI's partner, Tunajali, in Morogoro, and SAT's partner, the Tanzania Network of Organisations of People Living with HIV/AIDS (TANOPHA), in Dar es Salam were visited. The EAC was visited in Arusha. Several of the TEAM's Tanzanian partners met with the evaluators.

In South Africa, several organisations were visited in Johannesburg and Pretoria.

An underlying consideration, as with selection of organisations, was that these countries would approximate a good representation of the TEAM's overall work.

DATA COLLECTION TOOLS

Document analysis was an initial step in assessing how the TEAM works, with documents collected such as TEAM annual reports and plans, key Norwegian and Swedish policy documents, and evaluations made of the TEAM's partner organisations. However, the less than optimal way the evaluation team received the TEAM's documents, particularly in terms of the evaluators receiving a disjointed and incomplete set of documents before field work had commenced, did prove a limiting factor. Furthermore, the documentation that was received from the TEAM did not capture its approach or results adequately at the regional level. This lack of detail, more generally, reflects that written documentation is particularly poor in relation to assessment of outcomes of regional cooperation (Devfin, 2009). Both these omissions –lack of documentation and poor reporting content – meant that the evaluators were not able to get a satisfactory overview of the TEAM's work prior to both sampling and the fieldwork.

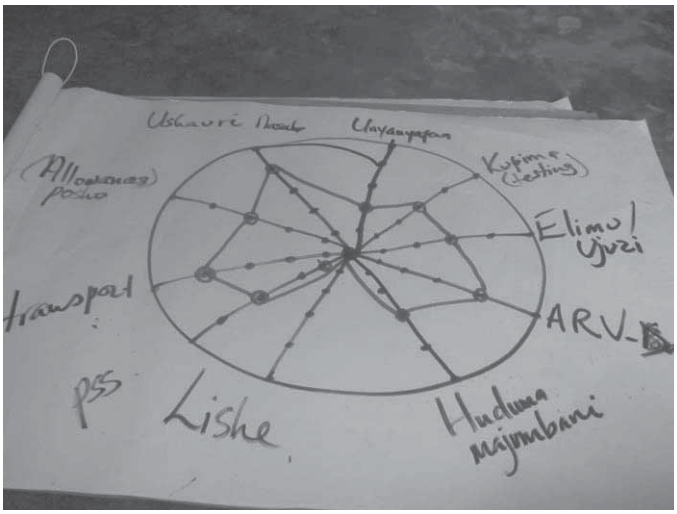
Key informant interviews enabled individual and detailed responses to specific aspects of the TEAM's work not available in written documentation. The majority of the interviewees were regional NGO and REC partners of the TEAM and local NGO and CBO beneficiaries; in addition to Sida/SMFA and Norad/NMFA HQs, interviews also took place with Swedish and Norwegian Embassy HIV/AIDS Focal Points. The views of Swedish and Norwegian donors were therefore well covered. In addition, other donors, such as DFID, were interviewed. The entire TEAM was also interviewed, along with two of the TEAM's reference group. A total list of interviewees (61) is provided in Annex 3. A semi structured interview guide was used (attached in this annex), intended to cover general themes required by the ToR, whilst open to adaptation depending on the specific interviewee. In general, the interviews with donor informants were candid and positively received by the evaluators for their degree of credibility. Interviews in the field were also generally open and frank, although a minority had their reliability compromised due to specific setting. Overall, the interviews filled in much of the detail concerning the work of the TEAM. To minimise any inaccuracies or biases based on these individual accounts of events and processes, cross referencing with other methods was required.

Facilitated group discussions. These were held with the TEAM's partners who were invited to workshop events in Lusaka, Dar es Salam, and Pretoria. The discussions were based upon organisation representatives being requested to share their experiences in working regionally and with the TEAM. The ToR was given in advance to participants, wherever possible, and with a brief presentation by the evaluation team of the aims and purpose of the evaluation. Participants' experiences were shared either through formal presentations or commentaries in relation to presentations and plenary sessions. Facilitation can be regarded as a method to encourage sharing of views. Not only did the three discussions enable direct comparison of similar issues in three different country contexts but they also generated a lot of information from an *in situ* peer group setting. In other words, by grouping organisations in such settings perceptions and attitudes towards working regionally may emerge amongst peers differently from those expressed in individual interviews. Group participants were able to share, compare, contrast and place themselves alongside the other views expressed. In this way, good levels of discussion were generated. In some instance there were more assertive reflections expressed than possibly had taken place in some interviews. Non-beneficiaries also attended the workshops, where possible, to include different viewpoints. In some specific instances, like with the Pretoria workshop, these were critical and thought provoking interventions. Otherwise, non-beneficiary views tended to be less informed about the TEAM and working regionally and were therefore considered less useful to the evaluation. Attendance of workshops was in general not as good in Tanzania and Zambia as South Africa (where the regional organisations also tend to have regional HQs). Indeed, the workshop in South Africa was considered particularly useful for the evaluation and a full report on it is included (in Appendix 7). One limitation of group discussions tends to be that only those more vocal get heard but the evaluators feel that good facilitation encouraged a high level of participation. A good level of complimentarity with key informant interviews also minimised biases inherent to group settings. Interviews provided important follow-up and verification of accounts from group work and vice versa.

Participatory methods with local beneficiaries. These methods were considered particularly important for assessing interventions from the point of view of the direct beneficiaries themselves, especially PLWAs, at a local level. Skilled facilitated discussions addressed the use of training and other support received by local recipients. Time and the particular settings allowed for one key participatory tool, the *Wheel chart*, which

was used in one group in Zambia and one in Tanzania.
The wheel chart is a simple tool used to gauge participants' own sense of change concerning key issues that they themselves identify. Group discussions are used, first, to identify key issues of concern to the community and in relation to the particular intervention taking place. A large circle is then drawn on a piece of paper (or, on the ground). The circle is divided by placing one line per issue identified, drawn from the centre point of the circle to the circumference. The idea is to depict change concerning the issue, for example, what has happened in terms of access to antiretroviral treatment, by asking participants to locate a point on the line -moving away from the centre outwards to the circumference – before the intervention, then, to a point after the intervention. The method is highly subjective rather than being in any sense scientifically objective. The importance of the method, however, lies more in terms of the process. The beneficiaries themselves discuss and identify issues, express their own perceptions of change and also can reflect on why the change has, or, has not, taken place. This method was very useful in reflecting on what beneficiaries regarded as relevant and what progress they felt had taken place. This method, at times, enabled views of local beneficiaries to contrast with the accounts provided in interviews with some NGO managers. The perception of change concerning the extent of stigma encountered by PLWAs, for example, differed between those of beneficiaries, and those of organisation representatives. Local beneficiaries were less likely to agree that widespread progress had been made.
In terms of judging the relevance of some interventions over others, a common theme identified by beneficiaries in both countries, for example, was the lack of access to food, and with limited improvement over time noted. In the photograph below, which shows one of the wheel charts, 'Lishe' (from the Swahili verb 'lisha', meaning to graze or feed), refers to food in this context, and it shows this as still a priority in this community, and one in which little or no progress had been achieved, in contrast, say, to access to ARVs.

'Wheel Chart, Morogoro'.



At the end of the exercise, lines are drawn to connect all the end points across each of the issues. In this way, how complete, or, 'full' the circle is helps to visualise progress and distance still remaining in relation to the issues/intervention in question.

These methods were also complimentary to the other methods, and especially in tracking the work of the TEAM across its very long implementation chain from the regional to the local level.

A survey was developed to cover aspects of the TEAM's work concerning interaction with Norwegian and Swedish Embassies. The survey questionnaire was standardised to allow ease of comparison but also included the possibility to provide more open ended responses and suggestions. It was conducted initially by e-mail with respondents directed to a web-based questionnaire and categorised by region (western, eastern or southern Africa) and nationality of embassy (Swedish or Norwegian). The response rate was good (see chapter 4 and Annex 3, for full details).

Informed consent was a feature of all surveys, focus groups and other participatory methods used. Wherever necessary, the local language was used.

Validity and reliability. The use of such a variety of data collection techniques has ensured cross validation of the data and information that have been gathered. In other words, similar questions posed in different ways (through different methods) and in very different organisational and country settings and to different stakeholders, enabled a satisfactory degree of consistency in the data. Statements made in individual one-on-

one interview settings, for example, could be compared to, and contrasted with, the anonymity of those expressed in a survey, or, the interactive dynamic of a peer group setting. The methods were complimentary and enabled a fuller range of responses to be captured than would be achieved by using a fewer number of tools. These methods were very important in order to contextualise the rather limited nature of the documentation received, to better understand the work of the TEAM.

The interviews, for example, were based on a similar set of questions, addressing common themes and using transparent methods (see interview and workshop guides). While the particular setting of some of the interviews compromised reliability, nonetheless a good range of interviewees (61), most of which had two researchers conducting them, along with debriefing and clarification, ensured an overall good degree of reliability. The specific nature of the themes covered, and range also ensured a high degree of validity (that is, the method measured what it set out to measure). The survey had highly transparent and standardised methods, with a generally high overall level of response, but large number of non-respondents *(n)* or those in the category 'do not know', to particular questions. The survey therefore reflects a high level of validity but possibly less high level in terms of reliability (although, again, interviews followed up survey findings, hence added to produce an overall reliability of the findings). On the other hand, the participatory work reflects subjective methods but with efforts made to minimise the problems of reliability by using local consultants with knowledge of the communities and familiarity with local languages. Due to its subjective tools and dependence upon particular settings it is considered less applicable to other settings, and therefore has a reasonable level of validity.

The use and, especially, the triangulation of a variety of data collection techniques has ensured cross validation of the data and information that have been gathered. These techniques therefore secured the consistency and overall reliability of the data. The evaluation was able to measure what it set out to measure, which means that beyond the specificities of different contexts, there is a more general applicability of the findings on the TEAM and the regional approach, which reflect a good degree of validity.

Attribution and contribution.
The programme theory approach, with its emphasis on identifying and documenting linkages between outputs (activities), outcomes and results is a methodology that is well suited to document linkages, and hence addresses the question of attribution. However, because Sida and Norad pool their funding, no direct link can be attributed between their funding and outcomes, which means that Sida and Norad *contribute* to the outcomes of the work of the TEAM's partners in general.

INTERVIEW AND WORKSHOP GUIDES

Questions: Sida-Norwegian Regional AIDS Team evaluation

Group Discussion, 22nd May, 2009, 10–14, Chita Lodge, Lusaka (used also for Tanzania group discussion).

For all

- What, if any, is your organization's experience and thoughts/visions about working regionally?
- What are the broader regional challenges/experiences of working regionally as civil society organizations or government?
- Is there an added value of regional organisations (like SAT, REPSSI, and the EAC, SADC, UNAIDS Regional Office)? Is so, please identify components of 'added-value'.
- Have you heard about the Swedish/Norwegian regional AIDS team? Do you see the Team as a significant regional player when compared to other regional actors?
- For those receiving support from Sida Team: briefly describe the support you receive from the Team. To what extent has your organisation managed to achieve the objectives set in the agreement with the Team? Why, or why not?
- How do you see the Team as a regional player as compared to other regional players? In considering your answer, why is this the case? (identify which players are regional; what makes them the same or different)?
- What should be the role of a regional AIDS Team, such as Sida, in the future? To what extent should it be linked to the national level HIV/AIDS challenges?

Interview Guide for field work: Zambia, Tanzania and South Africa, May, 2009

Broad themes/questions for organisations

- Briefly describe the support that …. receives from the Joint Swedish/Norwegian Regional HIV/AIDS team and the cooperation with the Team (reporting, visits, etc).
- What is the regional approach in the work of …. and what is the impact of your work in the region? Please specify results.
- What is the added value of working regionally of the organisation?
- What are some of the challenges in working regionally?
- What other organisations (not supported by the Team) that you know work regionally and do these have support from other donors?
- How do you perceive the Team as a regional actor?
- Where has the Team been most effective, and least effective?
- What future role would you like the Team to have?

Adapted to specific organisations, e.g. East African Community

- Briefly describe the support in terms of the objectives of the work you are carrying out with support from the Joint Swedish/Norwegian Regional HIV/AIDS Team.
- Describe the relationship that EAC has with the Team on its HIV/AIDS activities and the cooperation with the Team (reporting, visits, etc).
- What is the regional approach in the work of EAC?
- To what extent did the Team funded work at the EAC manage to reach its objectives? What were the challenges in reaching these objectives?
- What is the impact of your work in the region? Please specify outcomes.
- What are the challenges of making member states implement the HIV/AIDS strategic framework of EAC? Which countries, if any, have implemented the framework?
- What is the future of working regionally in terms of EAC cooperation within HIV/AIDS? What are the challenges?
- What is the relation, if any, between the work of EAC and SADC, AU, ECOWAS, IGAD, and UNAIDS East Africa and Southern Africa Regional Office on HIV/AIDS?

Annex 6 Fieldwork

In terms of local field trips, this section discusses local level organisations supported through SAT and REPSSI, which were visited, in two localities each in Tanzania and Zambia, and the national level workshops that took place in each country (plus South Africa).

ZAMBIA

REPPSI

REPSSI's partner in *Chongwe* area, sub-partners CCF, and locally supported carers organisation, Mutamino Family Group /Memory group (has 75 members, 18 were met) and in association, four members of a youth group. REPSSI does not give grants but provide training to CCF and affiliates. When the carers started, they did not think it would go anywhere, but now has helped children who are still alive and HIV positive. The group was mainly composed of grand parents who had lost their children and were caregivers. Carers and youth had received training in psycho-social methods and were clearly able to demonstrate their learning about these tools, how they had used them, and achievements in doing so. 20 trainers have been trained and they were told to go out in the community with these methods. 4–5 people were then trained by each trainer. The participants took particular pride in showing one of the tools, the memory book; with titles such as 'if I die today, at least my children will have a clear memory of me'.

The support group was formed and developed out of the training received. The training kick started other activities, such as a membership fee for the group and then monthly contribution which had been beneficial for income generating activities. In terms of results, the village now had been sensitised to issues of child abuse, the problem of early child marriages before the support group was established, and property grabbing. Some results were higher profile of children's issues; will writing, action concerning underage drinking, and fewer child marriages. Generally, through methods such as the memory book, and Tree of life, an enhanced ability to communicate with children, such as discussing illness and disclosure of status, and identifying problems had been achieved. In the event of death, these tools had also enabled children to

know where they come from, and to identify their goals and focus on shaping the future. Some of the youth group themselves had been in a vulnerable position – such as child marriage, but through support had been able to escape this. The group claimed no one in particular was excluded and if some could not afford membership fees then this was waived.

There were also committees formed, which through involvement of headmen (one of whom was present) and other key local stakeholders, such local government departments, appeared to be effective. Whilst of course difficult to ascertain this in the course of a few hours meeting, nonetheless, the evaluators gained a good overall impression as to the quality of the training and, above all, it use and role in this community. In particular, the community claimed that prior to intervention these problems were not being addressed. In total 500 people had been trained.

SAT

SAT local sub grantee, NZP+ and their district chapter in *Mumbwa,* was a local organisation representing PLWAs in the district. They received support from SAT in 2007, which was the first organisation to support them. On this basis, training received and financial support, the local chapter has used the support to lever in support from other organisations. They appeared now to be successful in working with at least five other organisations – SAFAIDS, IHAA, World vision and the Ministry of Health, amongst others.

Their reach is 43 support groups, with a total of 593 people. A main focus of the NZP+ chapter has been on ARV sensitisation and support, with the organisation having a group of treatment supporters who liaise with patients at clinic level. In terms of results, one readily identifiable impact has been the large increase in numbers on ARVs – in 2006 this was 12 people, but is now 3221. And through lobbying, mobile clinics will now service the rural locations. Members interviewed claimed they can now take treatment openly and stigma was decreasing. In follow-up group work with members of local organisations receiving support from NZP+, 4 representatives cited a range of benefits and improvements.

Training had provided information on nutrition, ARV management, materials, and general openness about the disease. They themselves acted as role models through testimonies and peer education. Support had also kick-started income generation, with, for example, goats' milk considered very important substitute to breast feeding for HIV+ mothers regarding PMTCT. A basic participatory exercise revealed progress since the intervention but also that stigma still per-

sisted, especially identifying the need to work with churches and local health workers. Income generation and the small stipend for the local organisation facilitators were considered very important in motivating them. Again, more detailed research would be required to ascertain if the most vulnerable get direct access to the benefits.

Workshop

The key findings based on discussion with 5 country partners of the TEAM is that the TEAM is relatively invisible in country and that the partners would like more direct contact with the TEAM. Generally, these organisations were one step removed from the regional level (being in country offices) but could still identity how they had benefited in terms of the regional added value identified in an early chapter. Furthermore, partners would like to see the TEAM more involved in national level context and structures (such as the NAC, in-country ICP) and to see their results in the field. Although this is not the mandate of the TEAM, these were nonetheless perceptions as described by in country partners, and, significant given that this is the country also were the TEAM in located.

TANZANIA

REPSSI

Tunajali, in *Morogoro,* is an organisation for PLWAs and carers supported via FHI and local beneficiary Umvumo. It was noticeable that the local care group met had a less obvious grip on the psycho social tools. The Memory books were much more variable in content and organisation. And some of the tools were clearly less understood compared to others. The technical officer at FHI expressed that she had not received sufficient training and did not understand all the tools that were to be passed on in training. This person was relatively new to her position and the finding illustrates that it takes time to build knowledge on some of these tools. Another issue is that perhaps only 25 per cent of the OVCs involved are infected or affected by HIV/AIDS. But it was claimed that the tools were important nevertheless for all OVCs and provided a basis for better communication between them and adults more generally.

Overall, the participatory work revealed progress on a number of issues since the intervention. What is particularly interesting is also how Tunajali also receives support from SAT. Again, similarities in progress in a number of areas with NZP+, the role of income generation, and especially the

renewed sense of hope that the organisation had brought to PLWAs, like in Zambia, were very apparent. The area of biggest improvement was deemed ARVs, whereas psycho social training, however, had the joint lowest sign of progress because the group said only 10 per cent of organisations had received training.

The overall lowest area of progress concerned food security and how this was affecting adherence to ARVs. Some recipients also identified how the tools helped tackle similar issues in the community. However, overall, the depth of the training was not on par with the example in Zambia. But the local group and FHI officer could still indicate some benefits but also clearly expressed a desire for more training and follow-up.

SAT partner, Tanzania Network of Organisations of People Living with HIV/AIDS (TANOPHA), Dar es Salam.

TANOPHA was established in 2001 and intended as a galvanising force for PLWA organisations in Tanzania. They received funding since 2003 for capacity building and salaries, and also training. What was most apparent about his visit was that TANOPHA had been very successful in attracting additional funding, most notably 400,000USD since 2005, which dwarfed the SAT grant of 18,000USD. They also receive funding from Rapid Funding Envelope. They claimed that the SAT grant was more important than the training which was received from other organisations.

TANOPHA see the next big stage of their work as being income generation and they really want SAT to contribute to this, which may be at odds with both in country and also HQ position. This sharpens the issue of graduation of SAT beneficiaries, and at what point they should graduate rather than continuing to receive the SAT grant. This was an issue that SAT HQ and the Tanzania office were fully aware. But it also does suggest where SAT has actually been very successful in kick starting the growth of organisations and building capacity to attract other funding. The issue of graduation may not also be so straightforward but the example of TANAPHO does suggest a need for more rigorous 'exit strategy' for SAT.

Workshop

This was attended by half a dozen or so TEAM country partners. It also highlighted parallel issues to the workshop in Zambia. The TEAM's visibility was also an issue, with recipients often unable to distinguish between Sida bilateral support and the TEAM itself. The evaluators also perceived the reach of regional HQs (mainly in South Africa) to be less felt in Tanzania. And the TEAM's reach was also much less apparent,

with some organisations saying they had only been visited once in 3 years. Regional HQs were considered by some to be an added layer of bureaucracy. Regarding visibility of partner organisations, quite often these were more known to communities through the local level partner rather than national level offices. Like Zambia, recipients desired a higher level of interaction and visits from the TEAM, as this, it was claimed, was also a motivation for better results. Nonetheless, some regional added value was also noted. Help the Aged, for example, had successfully lobbied with other TEAM partners, for inclusion of OVCs in the SADC prevention strategy and also provision for the aged in the AU policy 2005–15.

Fieldwork and workshop South Africa

A full list of HQs visited is mentioned in Annex 4. In addition, a workshop took place in Pretoria, with an opportunity for a mass discussion on regionality and the TEAM. This was very successful, and very well attended. The full report of the workshop is attached in the Annex because it is deemed integral to the evaluation as a whole and gave several very useful highlights as to both the advantages and also challenges of the regional approach.

Annex 7 Project proposal assessments

Upon receiving a proposal, if deemed in line with the TEAM's mandate, the Director appoints a programme officer or officers to look at the proposal. A significant characteristic of the TEAM is that it takes a highly collective team approach to projects. A high level of information exchange takes place on projects. This approach results in a strong collective ownership of the projects, which seems particularly unusual in the current era of development cooperation work. This collective effort makes the TEAM a collective enterprise – for both good and bad (see below).[28]

The TEAM meets every Monday to discuss new proposals, among other issues. If relevant, the proposal is recommended for further assessment. If rejected, applicants are notified. The applications that are continued are then presented to the relevant TEAM committee (TC), with the three TCs clustered according to each of the three thematic issues. The respective chairperson of the TC in question is responsible for the formation of a committee for each meeting.

There are usually two stages in the assessment process. One initially involves a preparation phase for the TC, to adjudicate on a decision to pursue further. If so, then a more in-depth phase takes place. The evaluation team has reviewed several of the in-depth project assessments. The assessments are found to be extremely thorough in addressing a good range of considerations. It is apparent that the TEAM adheres to the 'Sida at work' manual in their funding assessments, as throughout the project cycle more generally.

The assessments, however, are generally very descriptive and do not allow enough space to provide more critical analysis and engagement on substantive issues. It is therefore welcome that the assessment process is currently being revised by Sida. Furthermore, the recent decision to use auditors to conduct the organisational assessment of potential recipient organisations component should hopefully free up more time for such critical engagement. External, i.e. Sida HQ, relevant embassy staff or others, are only occasionally involved in these processes. A review of some of the memo assessments conducted by the TEAM programme officers confirms the tendency not to use external input – although this did occur in some cases.

28 As one member of the TEAM expressed this: 'each can contribute their own role'.

More recently, following this period of expansion, the last two years has seen a re-strategising of the TEAM's approach, particularly regarding the thematic focus of support. The evaluators gain the impression that there is a more rigorous application of the regional added value argument in assessments of project applications, but also in refocusing their portfolio. This appears to reflect an increasing Sida emphasis upon results-oriented development cooperation and policy changes. Interviews with the TEAM showed that they value this period of consolidation of the portfolio, because, they recognise that it provides a better focus.

The evaluation team was concerned only with seeing those projects accepted by the TEAM that were the end point of the selection process. We therefore requested that the TEAM compile a list of total applications received since 2006 to the current year, those rejected and those accepted. This reads as follows:

YEAR	NUMBER OF PROPOSALS RECEIVED	REJECTED	ACCEPTED
2006	89	78	11
2007	31	20	11
2008	23	5	12[29]
2009	14	12	02

On the one hand, the larger number of applications received and rejected in 2006 can be regarded as reflecting a rigorous selection process taking place. The then Director was described by the TEAM as being very proactive in seeking submission of applications. This large volume of applications allowed the TEAM the opportunity to pick projects that more closely adhered to the TEAM's goal and objectives. The decrease in the number of projects accepted, however, may indicate a potential problem in that the TEAM is left with a relatively rigid portfolio that is unsustainable. It nonetheless also indicates that the TEAM faces budget cuts and is cautious about signing new agreements. Documentation concerning individual application decisions was mainly limited to the rejection letter itself. In other words, specific reasons for rejection were not made readily available to the evaluators.

29 According to the TEAM, a number of proposals received in 2008 were taken forward to 2009; however, it is now doubtful that they can be supported due to budget cuts, currently estimated at 40 per cent of total budget.

Annex 8 Additional Description of RECs

SADC

The first substantial step towards focusing on HIV/AIDS in SADC was taken with the Extraordinary Summit in July 2003 when the SADC member states adopted the SADC Strategic Framework and Programme of Action, as well as the Maseru Declaration on the Combating of HIV and AIDS in the SADC.[30] However, the work on HIV/AIDS does not seem to have started until 2005/06 when the HIV/AIDS Unit was established. The TEAM has according to its own documents tried to engage with SADC for some time before entering into a JFA with SADC in November 2005.

The TEAM is the lead donor on this JFA which includes support to SADC HIV/AIDS Unit. The JFA is regarded by the TEAM as 'a pilot phase' and 'a first step towards long-term support' (The TEAM 2005, p. 3). The JFA was intended to 'kick-start' the implementation of the SADC HIV and AIDS Business Plan 2005–2009. This Business Plan is to facilitate the implementation of the SADC Strategic Framework 2003–2007 and the Maseru.

The overall approach towards HIV/AIDS by SADC member states as outlined in the 2003–2007 strategic framework, the HIV/AIDS Business Plan 2005–2009 and the Framework for Coordinating the National HIV and Aids Response in the SADC region adhere to the Abuja Declaration, the UNGASS 2001 Declaration, and put forward the multisectoral approach. The Three Ones principles, being agreed upon in 2004, are reflected in particular in the Framework for Coordinating the National HIV and AIDS response in the SADC region, which is natural, given that this provides inputs to work at the national level.

The main areas of focus for the SADC work are the following: mainstreaming – at policy, project, and activity level. Capacity-building, Workplace programs, facilitating technical responses, such as regional guidelines and best practices, PMTCT, OVCs, home-based care, research and surveillance,

30 See SADC 2005, p. 4, SADC 2003a, SADC 2003b]. With the Maseru Declaration, the member states commit to fighting HIV/AIDS and five priority areas are outlined: 1. 'Prevention and social mobilisation'; 2. 'Improving Care, Access to Counselling and Testing Services, Treatment and Support'. 3. 'Accelerating Development and Mitigating the Impact of HIV and AIDS'. 4. 'Intensifying Resource Mobilisation'. 5. 'Strengthening Institutional, Monitoring and Evaluation Mechanism'

access to treatment, etc, facilitating resource networks, mapping of national and regional resources and use and mobilise these resources to create networks for information exchange, creating networks, for example, network of national AIDS programs/NACs, facilitating the monitoring of regional and global commitments (e.g. Abuja, Maseru, MDG, UNGASS, etc), institutional framework to ensure the implementation of the regional multisectoral approach, such as the HIV/AIDS unit itself.

EAC

The original operational framework document dated February 2008 proposed a Joint Steering Committee on HIV&AIDS which did not include the International Cooperating Partners (donors). Instead, the donors were to be on the HIV/AIDS Multisectoral Technical Committee. The TEAM's in-depth assessment of the EAC application for support stated that this proposal regarding the organisational structure was inappropriate. Instead, the TEAM proposes in this document that donors are to be present on the JSC.

Later, the ICP and EAC agreed that the JSC was to be split into two committees, one overall committee where donors take part, called the Joint International Cooperating Partners HIV and AIDS Donors group, and then an internal EAC Project Steering Committee. The Joint ICP Group's role is then to review the plans, budgets, etc that have already been approved by the Project Steering committee, and not participate in decision-making and policy development as was the suggestion by EAC in the process of developing the organisational framework[31].

The output of the TEAM's work together with the other donors participating in the JFA is thus assessed in terms of their influence on the EAC in revising the organisational structure into one structure which the evaluators find more in line with the Paris Declaration principles on national ownership, or, in this instance, regional ownership. Being placed in a review committee, the ICPs do not have a stake in decision-making processes, but can still provide inputs, which seems to better ensure ownership of the EAC.

31 This suggestion was however not the same as in the original proposal of the framework dated February 2008, in which the Joint Steering Committee is not to include any ICPs at all, but that they were to participate in the Multisectoral Technical committee and thus, it seems, be more hands-on in developing the policies, etc, which was seen as 'inappropriate' by the team, possibly because it is too much work.

Even though it is not possible to attribute this influence to the TEAM alone, it is probable that the TEAM was leading in exercising this influence as it is the lead donor in the JFA. It may be expected that they have been the lead donor in the processes of developing the organisational structure which was to be funded under the JFA agreement with EAC.

As to outcomes of this particular influence, it has resulted in the changes that have taken place in terms of the division of the Joint Steering Committee into two committees, one internal EAC committee and one external committee with donor representation.

The commitments to reach this goal is centred round five areas, leadership, resource mobilization, prevention strategies, community mobilization and most at risk populations. Moreover, the themes discussed may be seen as highly relevant and reflecting a positive trend towards discussing issues which have been regarded as sensitive, such as Male circumcision, criminalisation, multiple and concurrent partnerships, prevention with positives, vulnerable populations (including 'sex workers, men who have sex with men, prisoners, intravenous drug users, fisher communities and other mobile populations in the Lake Victoria Basin area, and in other geographic areas with particularly high HIV prevalence, was also recognized as cost effective and important' (EAC, 2009, p. 5).

Furthermore, there seems to have been a clear acknowledgement of the key driver of multiple and concurrent partnerships, seen in the report by the following phrase:

'The Think Tank agreed that the greatest numbers of new infections are due to: *"Complex sexual networks that arise because of multiple and concurrent partnerships in which condom use is low and inconsistent and in populations where males are uncircumcised"*' (EAC 2009, p, 6).

The heads of national delegations signed a Consensus Statement for presentation to the Council of Ministers Meeting, 23–25th March, in Nairobi.

Annex 9 Report on the workshop in Pretoria

By Tsitsi B Masvaure and Menzi Hlongwa, the Centre for the Study of AIDS, www.csa.za.org

1. INTRODUCTION

1.1. Participants

On Tuesday the 26th of May 2009, the Centre for the Study of AIDS facilitated an evaluation of the 'regional approach' that the Norwegian Ministry of Foreign Affairs (NMFA) and the Swedish International Development Agency (Sida) have jointly adopted in their support of HIV and AIDS mitigation programmes in the continent. The evaluation meeting brought together 27 participants, who included the evaluation consultants, Peris Jones and Siri Bjerkreim Hellevik, representatives from the NMFA based in South Africa, representatives from Sida, as well as representatives from some of the regional organizations receiving joint support from the NMFA and Sida. Significantly, well over half of the participants representing regional organizations were directors or other highly placed individuals in their organizations.

The following 13 were represented at the meeting: the AIDS and Rights Alliance for Southern Africa (ARASA), the Centre for the Study of AIDS (CSA), the Embassy of Norway, Gender Links, the Institute for Democracy in South Africa (IDASA), the International Organisation for Migration (IOM), the Olive Leaf Foundation, the Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS), the Regional Psychosocial Support Initiative (REPSSI), the Swedish Red Cross, the Southern African Development Community (SADC), the Southern Africa AIDS Trust (SAT) and the United Nations Office for Drugs and Crime (UNODC).

1.2. Objectives of the meeting

The meeting was intended to examine the challenges and opportunities involved in working regionally. The organizations present were therefore invited to share their experiences and views with regards to the kind and level of support that they were receiving from 'the Team' that is based in Zambia and which administers the joint NMFA/Sida 'regional approach' to HIV and AIDS mitigation.

1.3. Format of the meeting

The meeting was held over one day. It commenced at 9am and concluded at 3pm. Pierre Brouard and Rakgadi Mohlahlane, both from the CSA, were the main facilitators. The meeting started off with a welcome and thank you note from Stein Nesvag from the Norwegian Embassy on behalf of 'the Team'. This was followed by a presentation from Peris Jones, who gave a brief overview of the evaluation exercise and NIBR (see TOR attached separately). This was then followed by a series of presentations from all the organizations present.
These presentations focused on the regional work each organisation was involved in as well as an assessment, by each organisation, of the value of 'working regionally'. The meeting concluded with a plenary session in which participants made recommendations on how best to strengthen the 'regional approach' to HIV and AIDS mitigation.

1.4. Outcomes of the meeting

There was consensus among the participants that the regional approach has many advantages and should therefore not be discarded. Some of the advantages highlighted were that regional approaches enable smaller, community-based organizations to access resources that they otherwise would not have been able to; they also give visibility to otherwise 'controversial' issues and interventions (e.g. MSM programmes) as well as create a critical mass for activism at a regional level.
The lack of a common definition of the concept of 'regionality' was unanimously identified as the major challenge.

2. KEY ISSUES RAISED AT THE MEETING

2.1. Defining 'regionality'

The definition of 'regional' programmes was topical at the meeting. In his presentation, Frans Viljoen, from the University of Pretoria's Centre for Human Rights, distinguished between 'regional' and 'sub-regional' programmes. He suggested that the former refers to continent-wide interventions, while sub-regional refers to working in a specific part of the continent (e.g. Southern Africa). He added that regional integration in Africa is often a top down approach leading to an inability to filter the message through to the masses.
The regional interaction between organisations should supplement a bottom up approach.

Examples of the CHR's regional work include: working with the African Commission on adopting an access to medicines policy and SADC on the adoption of the Model Law on HIV. The Model Law gives moral authority and enforces an obligation on the 14 states that are part of SADC. However, challenges around language, representation, specificities and standards remain when 14 states agree to homogenise policy or law. Although SADC does not have a human rights mandate, the translation adopted by the SADC tribunal has made it possible for SADC to affect a human rights mandate.

In contrast, Bongai Mundeta, from VSO-RAISA, distinguished between 'regional' and 'multi-country' programmes and she argued that the former entails working in a specific, geographically defined part of the world and often requires much standardization, while multi-country approaches are more flexible and cover those programmes that might be operating in just two countries. She stated that VSO had reflected on its activities in 6 countries and whether it should continue with its regional work in these countries. The organisation sees added valued to the regional approach as strategies can be harmonised and there can be a sharing of skills and an exchange of information.

Michaela Clayton from ARASA provided a perspective from a regional partnership. She explained how ARASA came to existence, and how there was a need for an organisation that focused on HIV and human rights – the partnership has been particularly effective in addressing contentious human rights issues. She stated that the idea behind ARASA is to have more developed partners assisting less developed organisations. The programming is designed to impact on both a regional and national level; they also focus on mobilising resources for their partner organisations

The ability to access regional policies and the creation of strong cross-border links was seen as another incentive of adopting a regional approach. Having a regional approach was seen to be cost effective and projects can be replicated across different countries, taking into account the relevant contexts and prevailing conditions. On the other hand issues of language, e.g. Portuguese translations, have proven to be a challenge both in terms of financial and capacity resources.

The lack of clarity on the definition of regionality was said to be of major concern because it ultimately affects how regional organizations are evaluated. For instance, will regional organizations be assessed in terms of the changes that take place at the national level or should they only be assessed in terms of the changes that occur at a regional level?

2.2. Why regionality now?

Mary Crewe, from the CSA questioned why there was this sudden interest within the donor community to work through regional partners where HIV and AIDS mitigation is concerned. She noted that while it is evidently more expedient for donors to manage a few, large grantees than it is for them to manage many, small ones, a regional focus can potentially detract from the efforts and interventions that are occurring at national and local levels. She also argued that regional funders tend to over simplify the postcolonial context, and the push for regional funding highlights a level of disengagement and cynicism. There is a sense of inequity when looking at the treatment consultants receive as apposed to the people who are from and work in the regions.

2.3. The value of a regional approach

Participants unanimously agreed that the regional approach adopted by the NMFA and Sida was adding much value to HIV and AIDS mitigation efforts in the continent. The following were identified as the key advantages of a regional approach:

Gives visibility to unpopular issues: A number of the participants indicated that when an issue has backing from a region, it makes it easier to introduce it to otherwise unwilling countries. One such issue is HIV prevention for prisoners, which is highly contentious in many African countries because it touches on homosexuality, injecting drug use and men having sex with men (MSM). However, organizations have found that their regional focus has made it possible to initiate dialogue around these issues in hostile countries. IDASA reiterated this view and explained that it had successfully introduced HIV and AIDS issues into the SADC leadership by using a form of 'positive peer pressure'. For instance, Members of Parliament and other political leaders in different countries were pressured into participating in IDASA activities because the latter had already secured buy-in from SADC. Lastly, some participants explained that it is easier for regional organizations to attend to emerging new issues because national governments are often reluctant to embrace new ideas.

Harmonisation of strategies: the second advantage of regional approaches given by participants was that it allows for the standardization of interventions that work. An example was given of the SADC Best Practices Criteria on HIV and AIDS, which clearly define the key characteristics of a 'good' intervention. Before the SADC Criteria were developed, different countries claimed that their interventions were 'best practices'; the criteria thus allow for minimum standards to be set vis-à-vis HIV and AIDS interventions. The Swedish

Red Cross noted that it had found an M&E approach that it likes and was therefore using the same indicators to assess progress in ten different countries. This not only allows for inter-country comparisons but makes it possible to track its impact at a regional level as well.

Mentoring: the third advantage of regional approaches was that they facilitate information and skills-transfer from bigger, well established and well resourced organizations to smaller, community-based, poorly resourced organizations. A participant from Gender Links explained that regional organizations help to amplify the voices of smaller organizations and isolated individuals who are doing brilliant work in their communities. He gave the example of the 'Let's Go' programme in Orange Farm, which saw Gender Links taking one of its smaller partners to the Committee on the Status of Women (CSW) held in New York earlier this year. The partner was given an opportunity to share her organisation's work at this international forum and she was able to establish linkages with potential partners. The work of SAfAIDS was cited as another example of the advantages of regionality. Most of the organisations represented at the meeting indicated that they were relying extensively on the materials produced by SAfAIDS because they are well researched, informative and easy to adapt to different contexts. Regionality therefore facilitates networking and learning between organizations.

Access to resources for community-based organizations was the last major advantage highlighted. ARASA shared that many of its affiliates are finding it much easier to raise funds through ARASA than on their own. This view was echoed by many of the participants who argued that many community-based organizations have accessed financial resources from particular donors only because of their partnerships with regional organisations. Many donors are reluctant to take on the huge administration demands that inevitably come with working directly with small, community-based organizations.

2.4. Key challenges of a regional approach

Although participants had many positive things to say about 'regional approaches', they highlighted the following key hallenges:

Governance: because of the lack of a clear definition of what regionality entails, participants indicated that they were increasingly under pressure from the donor community to play the role of sub-contractor to the smaller, community-based organizations. Furthermore, fitting regional programmes into donor logframes was said to be restrictive as it is often unclear which results to capture and how. For instance,

should indicators focus on changes that occur at the regional level or at the various national levels? Related to this was the question of how to determine if changes at the local and national levels were actually contributing to change at a regional level. Participants were of the view that greater clarity on what 'regional approaches' are would assist in addressing some of these ambiguities.

Creates/reinforces inter-country inequities: another concern raised was that the level of skills differs across countries, which makes it extremely difficult to determine salary scales. Participants noted that they typically have different salary scales for personnel. Inadvertently, therefore, regional approaches might actually perpetuate inequities. Related to this was the question of how partnerships are established and between who they are established. There was general consensus that partnerships are often between unequal partners, and that while this provides an opportunity for mentoring, it also reinforces inequities.

Homogeneity of responses: participants noted that while regionality facilitates inter-country and multi-country comparisons, it has tended more towards homogeneity and by doing, the uniqueness of each country's experiences are lost. This results in overly simplistic programmes. Other participants noted that there is also a tendency to view a 'region' as one monolithic structure, and yet, in practice, there are multiple regions. For instance, the 'sub-Saharan Africa' region encompasses countries from the south, east and west, which are vastly different from each other.

Bureaucracy: the last major challenge that participants highlighted was the issue of bureaucracy. Those participants whose work entails working with regional bodies such as SADC explained that it takes a long time to get any decisions acted upon by SADC, which in turn, adversely affects the effectiveness of certain aspects of interventions.

2.5. Participants' assessment of 'the Team' based in Zambia

Participants were invited to give feedback on their assessment of 'the team' based in Zambia. Overall, participants had very positive opinions of the team, which they said was very flexible in terms of trying out new and untested ideas; the team was also said to be efficient in the disbursement of funds as well as in reading reports and giving constructive feedback on them. The only negative thing that was reiterated throughout the meeting was the issue of high staff turnover; participants felt that the transition from one staff member to another is sometimes poorly managed. These issues are summarized below:

Participants flagged the following positive ways that the team has strengthened them:

Flexibility: there was consensus that the team is open to new ideas raised by partners, and does not force its own views and agendas on them. Participants were of the view that the flexibility exhibited by the team might be because the latter have been given great autonomy by their bosses in Norway and Sweden and they commended this approach as it has helped regional organizations to determine their own strategies and activities. Furthermore, the team leaves room for failure and only asks that organizations capture fully these failures in their reports.

Efficiency: the team was commended for its timely disbursement of funds. Participants' experiences were that the team honours its contractual agreement and always releases funds as agreed upon in the contracts. The team was also said to take rather seriously the reports that are submitted to it; this was evident in the thoroughness of the feedback that organizations got from the team on their respective reports. Participants explained that the interest shown by the team in this regard is very encouraging.

Basket funding: other participants appreciated the basket funding approach that has been adopted by the team. This has made it possible for organizations to enjoy longer-term funding, which, in turn, leaves enough scope to learn and readjust programmes as necessary. Related to this was the 'broker' role that joint funding has enabled; some participants indicated that basket funding means that they only deal with a few donors, which leaves them with enough time to attend to programmatic concerns, rather than administrative ones. For example, the SADC HIV and AIDS Unit representative, noted that instead of her organisation having to follow up with each donor when there are problems, such as the late disbursement of funds, they just contact the team, which then does the follow-up itself.

Active participation: finally, the team was commended for its passion in the work that regional organizations are doing. Participants noted that the team takes an active interest in what is happening at both national and regional levels and are more engaged on issues of policy development than other donors. The team has also initiated collaborations between the partners and like-minded organizations, which have proved to be very strategic.

Managing staff turnover: on this issue, participants explained that, in contrast to many donors, the transition between old and new staff is very well managed by 'the team'. This, participants further explained, translates to less inter-

ruption to their programmes, for which they were quite thankful for. Some participants shared how, with some donors, they often find themselves having to redo their proposals and reports because new staff have different views from their predecessors. This was said to be quite frustrating.

On the negative side, participants noted the following:

Communication: the only thorny issue flagged by participants was inadequate communication within the donor community, in general, as to the rationale behind particular approaches used. The current drive to move beyond reporting on activities to reporting on results was given as an example. Often, organisations find themselves under pressure to adopt particular approaches in their programmes, but there is never any conversation as to why this is so.

3. WAY FORWARD

The meeting concluded with a discussion of the next steps. Participants recommended that the following actions be taken, as a way of further strengthening the regional approach:

- Continued decision-making autonomy for the team. Platform to discuss and agree on what regionality is and is not; including a platform to agree on appropriate regional-level indicators.
- In light of the possibility of severe reductions in funding, due to the global economic crunch, organisations should revise their strategic plans and try to anticipate what will happen if their current budget is halved. This will assist organizations to re-prioritise and re-think existing strategies and approaches.
- In light of above, participants called for a meeting between the donor community and AIDS Service Organizations to plan for a 'severely reduced funding' scenario.
- Consultants who are invited to evaluate programmes should have a fair understanding of Africa and the HIV and AIDS epidemic in the continent.

Annex 10 List of partner output and outcomes

NAME	PROGRAMME FUNDED BY TEAM	OBJECTIVES	OUTPUTS	OUTCOMES
EAC	JFTCA[32]	Support to EAC HIV and AIDS implementation framework: 1. To enhance the institutional capacity of the EAC; 2. To mainstream HIV and AIDS; 3. To improve effectiveness of interventions through harmonisation; 4. To improve the design and management of national and regional responses regarding information and knowledge; 5. To scale up responses through strengthening political leadership and commitment; 6. To consolidate effective partnerships; and 7. To improve workplace environment regarding stigma through a workplace policy.	1. The TEAM has wielded positive influence in the process of developing the organisational structure for HIV/AIDS work in EAC. 2. The recruitment of a technical consultant from UNAIDS Uganda 3. EAC Regional HIV Prevention Experts Think Tank and Multisectoral Stakeholders Meeting in Nairobi, 24th–26th February, 2009. The meeting enabled sensitive, yet highly relevant themes, such as sexual networks, to be taken up for discussion. 4. The meeting on transport corridors in Kisumu (May, 2009). It is too early to see any results yet, but it must to be acknowledged that the EAC has moved one step forward on this theme, which we find to be appropriate and necessary to address at the regional level.	1. EAC Regional HIV Prevention Experts Think Tank and Multisectoral Stakeholders Meeting in Nairobi, 24th–26th February, 2009 The meeting resulted in the EAC partner states commitment to "by 2015, reduce the number of new HIV infections by 50% compared with 2009". Think tank meeting resulted in commitment to 50 per cent reduction in prevention and reaching regional consensus

32 Joint financing and Technical Cooperating Agreement – Sida TEAM, Irish AIDS, UNAIDS RSTESA. TEAM is lead donor.

NAME	PROGRAMME FUNDED BY TEAM	OBJECTIVES	OUTPUTS	OUTCOMES
SADC	The SADC JFA 2006–2008 (November 2005–March 2008).	The main objective is: 'to strengthen the capacity of the SADC HIV/AIDS Unit to effectively manage and support the implementation of the SADC Business Plan on HIV and AIDS'	1. The SADC Partnership forum established 2. A Regional Fund has been established with contributions from member states 3. A JFA among donors and the SADC has been established, providing what the Swedish/Norwegian Regional HIV/AIDS TEAM perceives as a 'platform for dialogue.'	1. Overall co-ordination between donors and SADC has greatly improved through the JFA (Sida as lead donor). 2. Surveillance across all countries, a survey according to this was undertaken in all SADC countries for the first time in 2008. 3. HIV and AIDS Unit is now fully fledged, met its staffing target, and regarded as strong. 4. Unit also interacts with Civil society, e.g. Partnership forum – used for proposal for Global Fund application, synergies on specific activities, for instance, REPSSI and SADC have funded a position in the SADC HIV/AIDS Unit together 'to ensure incorporation of children and young people' (TEAM 2008, p 7, and see section on synergies). 4. Other interactions include SADC Parliamentary Forum – some areas of success but impact seems very dependent upon the domestic political situation and hostage to in-country party politics. 5. The JFA has led to harmonisation and eased the administrative burden on SADC in terms of reporting, etc.

NAME	PROGRAMME FUNDED BY TEAM	OBJECTIVES	OUTPUTS	OUTCOMES
REPSSI	JFA – core funding to 'Strategic Framework (2006–2010) and Strategic Implementation Plan (2007–2011)'	1. To strengthen the capacity of governments, civil society and other institutions to respond to the psychosocial needs of children affected by HIV and AIDS, poverty and conflict; 2. To develop knowledge in the application of psychosocial care and support; 3. To facilitate knowledge, skills and information exchange on psychosocial care and support; 4. To strengthen the Monitoring and Evaluation system of REPSSI and partners.	1. Training of regional facilitators 2. Training of beneficiaries from partner organisations 3. Tools and best practices. 4. An extensive range of materials have been created, peer-reviewed by consultants, and are available for downloading from their website. 5. Certificated course modules with certificates in conjunction with the University of KwaZulu Natal aimed at training 800 students in the region. 6. REPSSI also sits in a range of relevant fora, such as RIATT, RAANGO, and has been allocated standing time in the SADC Partnership Forum, and has a good level of exposure in international fora. 7. REPSSI has established a technical officer within SADC Secretariat. 8. Co-operation with governments, MOUs, and local government coordination in identifying OVCs locally	1.[33] Psychosocial support has been effectively and unequivocally been put on the agenda of civil society, development partners and governments in East and Southern Africa.; 2. REPSSI has developed several PSS tools that are widely used to respond to the PSS needs of children 3. Mainstreaming its tools and methods in education sector (South Africa). 4. OVC initiatives at SADC have taken place e.g. Development of the Strategic Framework and Programme of Action for 2008 to 2015. 5. From local fieldwork: Use of tools such as memory books led to action, like making wills against property grabbing; the village was now sensitised to issues of child abuse, the problem of early child marriages was being addressed; underage drinking was banned; better communication, such as discussing illness and disclosure of status, and identifying problems had been achieved.

33 Taken from Matikanya et al (2007).

NAME	PROGRAMME FUNDED BY TEAM	OBJECTIVES	OUTPUTS	OUTCOMES
SAT	JFA[34] – Core funding for 'Strategic Framework 2008–2011'	To increase community HIV and AIDS competence re. prevention, treatment, care and mitigation: 1.Community competence 2. Knowledge base 3. Influence 4. Values e.g. rights based approach mainstreamed	1. Study visits, workshops, network meetings, mentoring e.g. 56 activities achieved 2007–08. 2. Training of Regional facilitators 3. Training of organisation members by Regional facilitators 4. Extensive range of materials 5. Involvement in regional fora, e.g. RAANGO, plus two other advocacy networks Research on 6. key drivers of the epidemic shared from regional level to national level partners; regional review workshops to reflect on research and how used 7. Media exposure e.g. Zambia radio slot 8. Coordination with national and local authorities, e.g. District AIDS Task Force 25 National Advocacy and Networking Organisations supported.	1. SAT is achieving many of its goals. 2. The total number of SAT beneficiaries receiving prevention, and counselling, and home-based care, has doubled in the period 2005–2008, at 1.1 million. 3. Titus and Charo, in their evaluation, also reiterate that SAT is 'making a positive difference to the supported CBOs and how lives of the people reached and supported by the work of SAT's partners is changing for the better' (Titus and Charo, 2008:4) 4. The field visits confirmed: In one instance (field work, Zambia), extensive training on ARVs can be correlated with a huge increase in numbers of those accessing the medication in the local area. In 2006 this was 12 people, but is now 3221. This increase was also attributed to the advocacy capacity that the local CBO in question had to lobby – successfully – also for mobile clinics. Members interviewed also claimed they can now take treatment openly and stigma was decreasing. In follow-up group work with members of local organisations receiving support from NZP+, 4 representatives cited a range of benefits and improvements. Training had provided information of nutrition, ARV management, materials, and general openness about the disease.

34 Joint Financing Agreement – core funding

NAME	PROGRAMME FUNDED BY TEAM	OBJECTIVES	OUTPUTS	OUTCOMES
				These beneficiaries interviewed had also acted as role models through testimonies and peer education. Support had also kick started income generation, with, for example, goats' milk considered very important substitute to breast feeding for HIV+ mothers regarding PMTCT.
ARASA	'Basket', i.e. joint-core funding for 'Implementation of Strategic Plan 2008–2012'	Improving human rights in context of HIV and TB leading to reduced vulnerability to infection and universal access: 1. HIV and Human rights Advocacy and Lobbying 2. HIV and Human rights training and capacity building 3. Regional Capacity building for access to HIV/AIDS treatment and prevention	1. ARASA co-hosted a regional civil society consultation meeting on 14 July 2008 in Pretoria with the Centre for the Study of AIDS and SADC PF on the draft SADC HIV Model Law, amongst many other events. 2. In 2008, ARASA initiated the first one-year regional Training of Trainers (ToT) programme for 28 participants (2 from each SADC country). 3. The joint ARASA and University of Cape Town course on 'Understanding Scientific Information, with the Infectious Diseases Epidemiology Group' in the School of Public Health	1. The evaluators suggest that the outcomes of ARASA's work lie in generating a critical mass and momentum to regional lobbying around rights and HIV/AIDS in the region e.g. recent lobbying over concerns about testing, disclosure and criminalisation provisions contained in the West Africa Model HIV Law; worked with the SADC Parliamentary Forum (SADC PF) to provide technical input on the development of the SADC Model HIV Law 2. ARASA was central to a joint civil society statement on the criminalisation of HIV transmission and which also fed into SADC PF 3. ZARAN, in Zambia, for example, described a situation in Zambia were previously 'nothing was happening on HIV and rights', ARASA's support had added to their efforts to raise the profile in this thematic area. 4. Contributed to joint civil society statement on criminalisation

NAME	PROGRAMME FUNDED BY TEAM	OBJECTIVES	OUTPUTS	OUTCOMES
UNAIDS	The TEAM funds the programme called "Accelerate HIV Prevention action in Eastern and Southern Africa, 2007–2010" (27 million SEK), i.e. the prevention component.	The goal is to support the intensification of HIV prevention knowledge, understanding, partnerships and programming across 20 countries in East and southern Africa. The programme aims to strengthen regional and country capacity for evidence-based HIV prevention planning and programming.	1. Recently convened a 'think tank' meeting of regional partners representing UN agency representatives, senior policy makers, academics, civil society and people living with HIV. The purpose was to engage in galvanising action for Universal Access. 2. Support provided to eight countries with National Strategic Plans and institutional frameworks review completed. 3. UNAIDS support to 3 regional meetings on MSM 4. Consolidation of Regional prevention Working Group 5. Dissemination of strategic information on HIV prevention 6. Advocacy events	1. The emphasis upon 'universal access' to services has encouraged engagement with national partners to monitor and review progress towards universal access. 2. A number of countries are revising their national targets in other areas, to ensure a sharper focus on areas in need of additional support. 3. Some of the modes of transmission studies (MOT) undertaken by UNAIDS/WB with TEAM support are being taken up by the Secretary General.[35] The MOTs describe changes and differences in epidemic patterns, and highlight the need for more priority on prevention and local, tailored programmes. 4. The MOT studies in 5 countries are gaining popular media exposure and creating debate in-country. For example, in radio stations in Uganda, there was recently a one-hour phone call-in show discussing the implications of the findings in the MOT that married people are most at risk. 5. Kenya and Botswana have launched new prevention strategies this year, and an additional 9 countries should have these in place by the end of this year. 6. Clearing house on social change communication

35 The Analysis of Prevention Response and Modes of Transmission Study (MOT) is a multi-country initiative currently supported by UNAIDS and the World Bank Global HIV and AIDS Programme's Global HIV/AIDS Monitoring and Evaluation Team (GAMET).

NAME	PROGRAMME FUNDED BY TEAM	OBJECTIVES	OUTPUTS	OUTCOMES
UNODC	Basket Sida: SEK 35 million	Three-year programme, "HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings in Southern Africa", with TEAM funding in 2008. The overall objective of the programme is to support the development and implementation of an effective response to HIV/AIDS in prisons in Southern Africa. UNODC will work on three levels: policy, prison management and service provider level.	1. UNODC appears creative in strategising around such events, and invites other UN colleagues to generate a 'high level' feel to meetings. 2. Regional meetings/seminars with the actors as well as UNODC strengthen the regional approach – in particular when it comes to lessons learned in training etc. effective in getting issues on to the agenda in meeting prison authorities and this appears to work to good effect. 3. For example, their country office in Zambia UNODC has cultivated relations with prison authorities	1. MOUs signed at Ministerial level in 4 countries: Mozambique, Namibia, Swaziland and Zambia. Following one high profile event in Mozambique, for example, this resulted in a commitment made by the Minister of Health to improve health service delivery to prisons.

Annex 11 List and Contacts of supported Organisations, September 2009

	ORGANISATION	CONTACT PERSON	E-MAIL ADDRESS	CONTACT PHONE NO	RESPONSIBLE OFFICER	SCOPE AND OBJECTIVES
1	AMREF(African Medical Research Foundation)	Dr Daraus Bukenya	darausb@amrefhq.org	25 420 605 220	Michael Tawanda	Addressing mobile induced vulnerabilities and gaps in harmonsied responses to HIV and AIDS in Lake Victoria Basin Region
2	ANERELA (African Network of Religious Leaders Living with or Affected by HIV& AIDS)	Reverand JP Mokgethi-Heath	jheath@inerela.org	27-11-8371523	Davies Chitundu	Support to the Strategic Plan (Establishing effective networks of religious leaders living with or personally affected by HIV/AIDS)
3	ARASA (AIDS & Rights Alliance for Southern Africa)	Michaela Clayton	mclayton@lac.org.na	264 61 223356	Michael Tawanda	Promote a human rights based response to HIV/AIDS in the SADC region.
4	Association of African University (AAU)	Justin Wyne	jwayne@aau.org	233-21774495	Paul Dover	Scaling-up its members' responses to the HIV/AIDS pandemic in sub-Saharan Africa; Develop university responses towards developing an 'AIDS competent society'.

	ORGANISATION	CONTACT PERSON	E-MAIL ADDRESS	CONTACT PHONE NO	RESPONSIBLE OFFICER	SCOPE AND OBJECTIVES
5	COMESA (Common Market for Eastern & Southern Africa)	Sindiso Ngwenya	secgen@comesa.int	260-1225898	Michael Tawanda	Planning grant towards proposal to contribute towards reduction of HIV transmission and prevalence rates in the COMESA region
6	EAC (East African Community)	Dr Njagu	njagu@eachq.org	255 -272504253/8	Michael Tawanda	Support to the "EAC HIV&AIDS Implementation Framework (2008–2012)
7	East African National Network of AIDS Service Organisations (EANNASO)	Lucy Ng'ang'a	eannaso@eannaso.org	255-272507521	Enock Banda	Strenthening Civil Society in East Africa through linkages, advocacy and representation, communication and management of resources
8	Gender Links	Colleen Lowe Morna	execdirector@genderlinks.org.za, clmorna@mweb.co.za	27-11-6222877	Chilamo Sikazwe	Media Action Plan on HIV/AIDS and gender policy leg
9	Golden Valley Agriculture Research Trust (GART)	Dr Stephen Muliokela	gart@zamnet.zm	260-211-213832	Davies Chitundu	Strengthening HIV/AIDS and food security mitigating mechanisms amongest small holder farmers in Botswana, Lesotho, Namibia and Zambia
10	HEARD (Health Economics and HIV/AIDS Research Division)	Jonathan Gunthorp	gunthorpj@ukzn.ac.za, jongun@mweb.co.za	27-312602333	Paul Dover	Support to the business plan
11	HelpAge	Nesta Hadendi	nhatendi@helpage.co.ke	254-204441052	Chilamo Sikazwe	contribute to the reduction of the impact of HIV/AIDS on older people in Sub-Sahara Africa

	ORGANISATION	CONTACT PERSON	E-MAIL ADDRESS	CONTACT PHONE NO	RESPONSIBLE OFFICER	SCOPE AND OBJECTIVES
12	Hope World Wide (Olive Leaf Foundation)	Rachel Kgeledi	rachel.kgeledi@hwwafrica.org	27-11-766 3528 /827751083	Carolina Simumba	strengthen the technical and organizational capacity of organizations and programmes at regional level to scale up their reach and effort to deliver high-quality and holistic OVC care
13	HRDI (Human Rights Development Initiative)	Asha Ramgobin	ARamgobin@hrdi.org.za	27-123422370	Michael Tawanda	increase Access to Justice for Vulnerable Groups in Africa/AIDS Discrimination
14	IDASA (Institute for Democracy in South Africa)	Kondwani Chirambo,	kchirambo@idasa.org.za	27-12-3920556, 0721711808	Michael Tawanda	Building AIDS resilient democratic societies in SubSaharan Africa
15	IHAA (International HIV/ AIDS Alliance)	Michelle Evans	mevans@aidsalliance.org	+44-1273 718 739/900	Davies Chitundu	Reduce stigma and discrimination faced by people living with HIV and vulnerable groups; increase the access of vulnerable and stigmatised populations to effective prevention interventions; and strengthen meaningful involvement of national and regional networks of PLHIV in HIV policy development and implementation
16	ILO (International Organisation on Migration)	Barbara Rijks	brijks@iom.int	27-124239631	Karolina Kvarnare	Support to the partnership on HIV/AIDS & mobility in southern Africa
17	KKCAF (Kenneth Kaunda Children of Africa Foundation)	Dr Waza Kaunda	wazadr@zamnet.zm	260-211291394	Davies Chitundu	Scaling up food security and nutrition/ART interventions for PLWA in Southern Africa

	ORGANISATION	CONTACT PERSON	E-MAIL ADDRESS	CONTACT PHONE NO	RESPONSIBLE OFFICER	SCOPE AND OBJECTIVES
18	Plus News	Obinna Anyadike	obi@IRINnews.org	27 11 890 1900	Chilamo Sikazwe	Support to production and dissemination of HIV related news
19	IFRC (International Federation of the Red cross)	Mikael Apelsten	mikael.apelsten@redcross.se	27-113039716 /27-828568327	Karolina Kvarnare	Support to the strategic plan – Southern Africa raising to the challenge)
20	REPSSI (Regional Pschosocial Support initiative)	Noreen Huni	noreen@repssi.org	27-119985820 /27-826564607	Carolina Simumba	Enhance existing psychosocial support programmes and service delivery to children affected by AIDS; Scale up psychosocial support activities to children affected by AIDS; and Strengthen the enabling environment for organisations assisting children affected by AIDS.
21	Safaids (Southern African HIV and AIDS DisseminationService)	Lois B Chingandu	lois@safaids.net	27 12 3610889	Chilamo Sikazwe	Support to the implementation of the 2007–2010 strategic plan
22	SAT (Southern Africa AIDS Trust)	Anita Sandstrom	sandstrom@satregional.org	27-113410660 /27-832671338	Carolina Simumba	Support to 2006–2009 Strategic Plan
23	UNAIDS	Mark Stirling	stirlingm@unaids.org	27 11 5171624	Peter Iveroth	Support to prevention workplan
24	UNODC (United Nations Office for Drugs and Crime)	Sylvie Bertrand	sylvie.bertrand@unodc.org	27-123422424 /27-716854885	Karolina Kvarnare	Support to development & implementation of effective responses to HIV/AIDS in prison settings
25	WFC (World Fish Centre)	Dr Stephen J Hall	s.hall@cgiar.org	60-46261606	Davies Chitundu	Investing in sustainable solutions

	ORGANISATION	CONTACT PERSON	E-MAIL ADDRESS	CONTACT PHONE NO	RESPONSIBLE OFFICER	SCOPE AND OBJECTIVES
26	ANHERTHA (African Network for Higher Education & research in Theology)	Dr Edwina Ward	edwina@njcmail.co.za	223-12017524	Davies Chitundu	Support of the African network for higher education in theology
27	CADRE (Centre for AIDS Development Research & Evaluation)	Dr Warren Parker	warrenparker@cadre.org.za	27-11-339-2611	Chilamo Sikazwe	Supporting AIDS development research and evaluation
28	SADC (Southern Africa Development Community)	Stephen Sianga	ssianga@sadc.int	263-3951863	Peter Iveroth	Support to implementation of the business plan on HIV&AIDS
29	VSO RAISA (Voluntary Service Overseas Regional AIDS Initiative of Southern Africa)	Stephen Bell	stephen.bell@vso.org.uk	44-2087807200	Carolina Simumba	Support to phase II strategic plan (capacity building in prevention, care and treatment and impact mitigation)
30	PACANET (Pan African Christian Network)	Edward Baralemwa	pacnet@it.bw	267-3162243	Davies Chitundu	Support to Christian response to HIV&AIDS
31	PANOS	Lilian Chigona	lilian@panos.org.zm	260-211-268411	Chilamo Sikazwe	Communicating HIV/AIDS in Southern Africa
32	RATN (Regional AIDS Training Network)	Kevin Storey	storeyk@ratn.org	254-203871016	Carolina Simumba	Support to the Regional AIDS Training Network Strategic Plan
33	RENEWAL (Regional Network on AIDS, Livelihoods & Food Security)	Joachim von Braun	j.vonbraun@cgiar.org	202-8626496	Davies Chitundu	Enhancing learning about the various interactions between HIV/AIDS, food and nutrition
34	International Gay Lesbian Human Rights Commission (IGLHRC)	Cary Alan Johnson	cjohnson@iglrc.org	27-73-505-9903	Karolina Kvarnare	Supporting the gay and lesbian initiative

	ORGANISATION	CONTACT PERSON	E-MAIL ADDRESS	CONTACT PHONE NO	RESPONSIBLE OFFICER	SCOPE AND OBJECTIVES
35	SADC PF (Southern African Development Community Parliamentary Forum)	Dr Kasuka Mutukwa	kmutukwa@sadcpf.org	264-61-2870000	Peter Iveroth	Support to the strategic plan
36	Population Council	Max Gill	mgill@popcouncil.org	212-339-0560	Paul Dover	Developing a multisectoral and comprehensive response to sexual and gender based violence in East and Southern Africa
37	ACHEST (African Centre for Global Health and Social Transformation)	Prof Francis Omaswa	omaswaf@achest.org	256-715268322	Peter Iveroth	Establishing African based "think tank and network" to promote evidence based and sond policies

Annex 12 The TEAM's Project Portfolio, September 2009

ORGANISATION (STATUS)	2009 A	2009 I+P	SRHR	SOCIAL PROTECTION	DEMOCRATIC GOVERNANCE
NIR Workplace policy II (A)	12 000 000	0			12 000 000
LGBT (I)	0	3 000 000	3 000 000		
ILO (A)	18 000 000	0			18 000 000
IOM PHAMSA II (A)	14 200 000	0		14 200 000	
UNODC Prev in prison (A)	15 000 000	0	15 000 000		
REPSSI (A)	10 640 000	0		10 640 000	
Hope World Wide (A)	300 000	0		300 000	
IFRC (A)	10 000 000	0		10 000 000	
SADC PF (A)	5 400 000	0			5 400 000
IGAD HIV/AIDS (P)	0	4 000 000			4 000 000
ARASA (A)	3 000 000	0			3 000 000
IDASA (A)	9 200 000	0			9 200 000
ECOWAS/UNAIDS (p)	4 500 000	0			4 500 000
AMREF (A)	18 500 000	0		18 500 000	
Comesa (I)	0				
EAC (A)	0				
HRDI (A)	400 000	0			400 000
PACANET II (P)	0	4 000 000		4 000 000	
PACANET (A)	2 000 000	0		2 000 000	
IHAA (A)	10 000 000	0	10 000 000		
RENEWAL (A)	4 000 000	0		4 000 000	
ANERELA (A)	1 600 000	0		1 600 000	
HIV/AIDS & Fisheries (A)	10 000 000	0		10 000 000	
ANHERTHA (A)	3 000 000	0		3 000 000	
GART (A)	14 000 000	0		14 000 000	
EANNASO (A)	3 000 000	0		3000000	
SANASO (A)	500 000	0			500 000
HELP AGE (P)	0	12 000 000		12 000 000	
SafAIDS (A)	7 000 000	0			7 000 000
Media Policy (A)	1 025 000	0			1 025 000
Cadre (A)	1 200 000	0			1 200 000

ORGANISATION (STATUS)	2009 A	2009 I+P	SRHR	SOCIAL PROTECTION	DEMOCRATIC GOVERNANCE
PLUS News HIV/AIDS (A)	5 800 000	0			5 800 000
SADC HIV/AIDS Unit (A)	9 500 000	0			9 500 000
Regional Conferences (A)	1 650 000	0			1 650 000
ICASA Conference (A)	50 000	0			50 000
Pol Leadership University of CT (A)	1 500 000	0			1 500 000
ACHEST (A)	3 000 000	0			3 000 000
EDCTP Vaccine Trail (A)	5 500 000	0	5 500 000		
HIV Prevention UNAIDS (A)	8 200 000	0	8 200 000		
PDF 2009 (A) 2008 (A)	7 700 000	0			
RATN (A)	750 000	0			750 000
RATN II (P)	0	3 700 000			3 700 000
SAT (A)	26 000 000	0		26000000	
SAT (A)	862 420	0		862420	
PLWHA NAP SAR (A)	3 000 000	0			3 000 000
VSO RAISA (A)	6 000 000	0	6 000 000		
Men Engage Seminar (P)	0	2 000 000	2 000 000		
HEARD 06–10 (A)	11 000 000	0			11 000 000
Pop Council (P)	0	6 000 000	6 000 000		
TASO/TEACH (A)	6 250 000	0	6 250 000		
INRUD	6 800 000		6 800 000		
AMNR	3 600 000		3 600 000		
Phasing out project in Health sector	13 000 000				
AUU HIV/AIDS II (A)	4 200 000	0			4 200 000
RFSU YMEP (A)	292 000	0	292 000		
	303 119 420	34 700 000	72 642 000	134 102 420	110 375 000

Evaluation of the Swedish-Norwegian Regional HIV/AIDS Team for Africa

The overall objective of the HIV/AIDS Team is to contribute to poverty alleviation by strengthening regional organisations and embassies in relation to prevention and impact mitigation of HIV/AIDS. The assessment of results and achievements can therefore not be concentrated on the Team itself, but has to include and pay particular attention to the supported partner organisations and the outcomes of their work with the target groups. The evaluation was to cover the main goals, objectives and working areas of the Team from 2006 until 2008. Other elements to explore throughout the evaluation were the Team's regional dimension as well as its internal organisation and management.

The collaboration of Sweden and Norway through the Team was found to have created added value. However, both partners could achieve more at bilateral and global levels by drawing on the Team's unique regional experience in a more strategic way. Added value from the regional approach was identified particularly in terms of capacity building and political influence. Many of the regional partners are involved in meaningful work in relation to regional responses to HIV/AIDS and are contributing to strengthening local organisations through networking, capacity building and training. The communities visited by the evaluators demonstrated capacity that had been built through the TEAM's support to regional organisations.

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