The Swedish Aid Response to the HIV Epidemic: An Overview

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List of Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ARASA	AIDS and Rights Alliance of Southern Africa
ART	Antiretroviral Therapy
CCM	Country Coordinating Mechanism
CDC	Centres for Disease Control
CPA	Combination Prevention Approach
CSO	Civil Society Organisation
EBA	Swedish Expert Group for Aid Studies
EC	European Commission
EDCTP	European and Developing countries Clinical Trials Partnership
EU	European Union
EUR	Euro
HAART	Highly Active Antiretroviral Treatment
HEARD	Health Economics and HIV and AIDS Research Division
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening
IAS	International AIDS Society
IAVI	International AIDS Vaccine Initiative
IFFG	Investing for Future Generations – Sweden's International Response to HIV/AIDS
IOM	International Organisation for Migration
IPM	International Partnership for Microbicides
IPPF	International Planned Parenthood Federation
IVI	International Vaccine Institute

KIT	Royal Tropical Institute
LGBTQI+	Lesbian, gay, bisexual, transgender, intersex, queer, asexual and other sexually or gender diverse people
LMIC	Low- and middle-income countries
MDGs	Millennium Development Goals
MFA	Ministry for Foreign Affairs (of Sweden)
NGO	Non-governmental Organisation
OECD	Organization for Economic Co-operation and Development
OVC	Orphans and vulnerable children
PDP	Product Development Partnership
PEPFAR	The President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission
SABCOHA	South African Business Coalition on HIV/AIDS
SADC	Southern African Development Community
SAREC	Swedish Agency for Research Cooperation with Developing Countries
SDGs	Sustainable Development Goals
SEK	Swedish Kronor
Sida	Swedish International Development Cooperation
SRC	Swedish Research Council
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SWHAP	Swedish Workplace HIV and AIDS Programme
TANSWED	Tanzanian and Swedish HIV/AIDS programme
TWG	Transitional Working Group
UN	United Nations

UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
UNRISD	United Nations Research Institute for Social Development
USAID	United States Agency for International Development
USD	United States Dollar
WHO	World Health Organization
WHO/GPA	World Health Organization's Global Programme on AIDS

Foreword

In the late 1970s the first cases of a new, unknown disease began to appear, that would quickly develop into one of the modern world's largest public health and development crises. Acquired Immuno Deficiency Syndrome (AIDS) has killed millions of people over four decades, most of them in low- and middle-income countries. It has challenged already weak health systems and haltered economic development in large parts of the world. Approximately 40 million people are living with Human Immunodeficiency Virus (HIV) today, but with access to proper care, HIV can now be managed as a chronic disease, which is a remarkable achievement by the global public health community.

As the world became exposed to yet another devastating global public health and development crisis, COVID-19, The Expert Group for Aid Studies (EBA) commissioned a report on the Swedish aid response to the HIV epidemic. The world will continue to face a variety of health threats in the future, including new pandemics and other challenges such as climate change, conflicts, antimicrobial resistance (AMR) and non-communicable diseases. It is essential that we make efforts to learn from previous experiences in responding to health threats. The purpose of this report was to describe the Swedish HIV response over time, distilling what has characterized the response, and what we can learn from that. To our knowledge, there has not been such a comprehensive attempt before.

We hope that this report will find its audience among the Swedish Ministry for Foreign Affairs, embassies, Sida and other government agencies, as well as policymakers, civil society organizations and the general public interested in the Swedish aid response to HIV. The study has been conducted with support from a reference group chaired by Julia Schalk.

The authors are solely responsible for the content of the report.

Stockholm, March 2024

Torbjörn Becker, EBA Chair

Julia Schalk

Sammanfattning

Acquired Immuno Deficiency Syndrome (AIDS) dök upp i slutet av 1970-talet och sjukdomen utvecklades snabbt under 80-talet till en internationell epidemi. Vissa länder i Afrika har drabbats särskilt hårt, med en stor andel smittade i befolkningen. Det internationella utvecklingssamarbetet har varit betydelsefullt i arbetet mot Human Immunodeficiency Virus (HIV) och AIDS, och Sverige har spelat en viktig roll i det arbetet. På uppdrag av Expertgruppen för biståndsanalys (EBA) har nu Royal Tropical Institute (KIT) och Technopolis Group genomfört en deskriptiv studie av Sveriges internationella respons på HIV-epidemin, från mitten av 1980-talet fram till idag. Studien bygger på en omfattande granskning av dokumentation och litteratur samt på fokusgruppsdiskussioner och intervjuer med nyckelpersoner.

HIV-epidemin har förändrats och utvecklats i hög grad över tid, och har genomgått olika faser, vilket återspeglas i den globala och svenska responsen. Den svenska responsen har över tid till exempel inkluderat budgetstöd, stöd till civilsamhället och till multilaterala organisationer, samarbete med den privata sektorn och stöd till forskning. Sverige har haft bilateralt samarbete med flera länder, inklusive Botswana, Etiopien, Kenya, Moçambique, Namibia, Tanzania, Uganda, Zambia och Zimbabwe i Afrika samt Bangladesh och Vietnam i Asien. Sida har genomgående prioriterat stöd till de värst drabbade länderna i Afrika söder om Sahara. År 2000 etablerade man ett regionalt HIV/AIDS-team i Afrika. Det multilaterala samarbetet har bland annat inkluderat ett omfattande stöd till den Globala fonden, UNAIDS, Unicef, Världshälsoorganisationen (WHO) och Europeiska unionen (EU).

Några av de främsta dragen i det svenska bidraget till den globala HIV-responsen har varit:

- Ett övergripande fokus på prevention och ett progressivt angreppssätt med betoning på kondomanvändning. Sverige har varit en pionjär inom sexuell och reproduktiv hälsa och rättigheter (SRHR), vilket varit tydligt i HIV-responsen, där Sverige har förespråkat preventiva åtgärder som ansetts kontroversiella av vissa andra länder.
- Ett fokus på strukturella och socioekonomiska faktorer som bidrar till en persons risk för att bli smittad av HIV, såsom fattigdom, ojämlikhet och diskriminering.
- En bred systemansats. Detta har inkluderat att främja och stärka nationella hälso- och sjukvårdssystem, samt integration av HIV-responsen i den bredare SRHR-agendan.
- Jämställdhet och rättigheter för HBTQI+-personer[1] har varit prioriterade områden för Sverige. På grund av nationell svensk lagstiftning kring sexarbete och personer som injicerar droger (PWID) så har dock Sverige delvis avstått från att aktivt stödja vissa åtgärder som rör dessa två grupper.
- Sverige har varit en stark förespråkare för evidensbaserade interventioner och har bidragit med mycket stöd till HIV-forskning. När behandling mot HIV introducerades ansåg inte Sverige omedelbart att en storskalig satsning på antiretroviral behandling (ART) i låg- och medelinkomstländer var genomförbar. Med tiden blev Sverige dock alltmer involverat i arbetet med att säkerställa tillgången till ART.
- Trots att Sverige är en liten aktör har man lyckats få inflytande i det multilaterala samarbetet. Detta har skett tack vare tillgången på kompetenta och erfarna experter och diplomater med både tematisk kunskap och kunskap om den globala biståndsarkitekturen. Detta har varit avgörande för hur Sverige

[1] Homosexuella, bisexuella, transpersoner, personer med queera uttryck och identiteter och intersexpersoner.

har lyckats förespråka sin ståndpunkt inom många av den globala HIV-responsens områden.

Summary

The first cases of acquired immunodeficiency syndrome (AIDS) appeared in the late 1970s and the disease rapidly developed into an international epidemic. Some countries in Africa have been particularly affected, with large shares of the population being infected with Human Immunodeficiency Virus (HIV). Development cooperation has played a vital role in the international response to HIV, and Sweden has been a significant contributor to this. In order to provide an overview and basis for reflection and learning in relation to current and future health aid and crises, The Expert Group for Aid Studies (EBA) commissioned the Royal Tropical Institute (KIT) and Technopolis Group to conduct a descriptive study of the Swedish international HIV response. The overview is based on a desk study, scoping discussions and interviews with key informants. The time period covered spans from the mid-1980s until the present day.

The HIV epidemic has evolved substantially over time, as has the global and Swedish HIV response. The Swedish response has included multiple components, such as bilateral aid, support to civil society and multilateral agencies, private sector collaboration and research. Overall, Sida's HIV response has focused on the worst affected countries in sub-Saharan Africa. In 2000, Sweden established a regional HIV/AIDS team in Africa. Multilateral aid has primarily been channelled through The Global Fund, The Joint United Nations Programme on HIV/AIDS (UNAIDS), The United Nations Children's Fund (UNICEF), the World Health Organization (WHO) and the European Union (EU).

Some of the main features of the Swedish contribution to the global HIV response include:

- A strong focus on comprehensive prevention. Sweden has played a pioneering role in sexual and reproductive health and rights (SRHR) and has promoted prevention strategies considered controversial by other countries.
- Addressing social health determinants, including focus on structural and socioeconomic factors that underlie a person's vulnerability to HIV, such as poverty, gender inequality or stigma.
- A broad health systems approach, including the strengthening of national health systems in low- and middle-income countries (LMICs). This approach also includes the integration of HIV prevention into the broader SRHR agenda.
- Gender equality and the rights of lesbian, gay, bisexual, transgender, intersex, queer, asexual and other sexually or gender diverse people (LGBTQI+) have been priority areas for Sweden, at least in later stages of the response.
- Domestic policies and legislation on sex work and persons who inject drugs (PWID) has meant that Sweden has sometimes refrained from supporting actions related to these two vulnerable groups.
- As a strong advocate of evidence-informed interventions Sweden has provided extensive support for HIV research and evidence-informed actions. Initially, Sweden did not consider large-scale roll out of antiretroviral therapy (ART) in low- and middle-income countries (LMICs) feasible, but eventually, Sweden got more involved in scaling up access to treatment.
- Despite being "a small fish in a big pond", Sweden has managed to be influential within the multilateral cooperation. This has been instrumental in the way Sweden has managed to provide leadership and to advocate for its position in many of the areas of the global HIV response.

1 Introduction

Around the late 1970s the first cases of what would become known as acquired immunodeficiency syndrome, or AIDS, began to appear. This previously unknown disease would quickly develop into one of the modern world's largest public health crises. By the mid-2000s, the number of deaths due to AIDS reached more than 2 million per year. Parts of Africa were particularly hard hit. In some countries, up to a quarter of the population was infected with Human Immunodeficiency Virus (HIV), the virus causing AIDS (UNAIDS, 2005). The arrival of low-cost treatment and increased awareness have helped to significantly reduce mortality and the number of new infections, but prevalence remains high in some countries and global goals such as Agenda 20230 for ending the epidemic may not be reached.

Development assistance has played a crucial role in the global fight against HIV. It is estimated that between 2000 and 2015, around USD 110 billion in development assistance was spent on addressing HIV (Schneider et al., 2016). New global mechanisms were created specifically to mobilise and channel an unprecedented influx of resources, and to assist countries with the implementation of their national responses. Many countries contributed to the global HIV response through a combination of support for multilateral organisations and through their own bilateral programmes for development cooperation.

Sweden was among the countries that joined the response early on and has, over the following four decades, contributed significant resources to it. Against this background, EBA commissioned the Royal Tropical Institute (KIT) and Technopolis Group to describe and analyse the Swedish international HIV response through development cooperation from the mid-1980s until the present day, and to extract reflections and lessons learned from that response, considering how policy and implementation have adjusted to the continuous transformation of the HIV epidemic and the response.

The initial objectives included assessments of the effectiveness of the response, but during the work, the parties agreed to limit the task of the study to comprise an overview of the response, due to methodological challenges to measure the impact of the Swedish response. Thus, this study does not attempt to evaluate the outcomes and effects of the Swedish HIV support, but it can nonetheless contribute to the understanding of how the support evolved and of what the main features of the Swedish response were.

The "Swedish international response to the HIV epidemic" has been defined broadly as explicitly formulated strategies, managerial decisions on projects and programmes, decisions on financial allocations, capacity development activities, institutional reforms, policy decisions in multilateral organisations and other platforms for international collaboration. In terms of scope and limitations, the study only includes Sweden's international response, thus excluding the domestic response. Sweden's contributions to research and research capacity building with support from international development funds have been included when these could plausibly be linked to the HIV response. The Swedish HIV response cannot be isolated from the wider global response. It has taken place alongside other initiatives, as well as through other (bi- and multilateral) initiatives. This study primarily focuses on describing the Swedish response over time, choices made and evidence to support these, with reflections about Sweden's contribution to the global HIV response.

An aim with the study was to provide insight into complex connections, achievements and lessons learned within the Swedish international HIV response, to inform future policy development and institutional commitments to ending HIV as well as addressing other public health burdens. The study was initiated during a time when the world was experiencing yet another devastating public health crisis, the COVID-19 pandemic.

The report is organised as follows. After describing the methodology in chapter 2, chapter 3 offers a description of the global response to

HIV over time. Four distinct (but partly overlapping) phases can be identified. Chapter 4 provides a brief description of the overall structure of Sweden's HIV response. Chapter 5 describes the Swedish HIV response focusing on its bilateral and regional cooperation, while chapter 6 summarises Sweden's work with multilateral agencies. Chapter 7 presents Sweden's support to HIV research. Chapter 8 outlines the main features of Sweden's HIV response, as a principled rights-based approach, with a focus on structural factors and strengthening of systems. Finally, chapter 9 provides some concluding comments.

1.1 Aim and objective

While the initial objectives included assessments of the effectiveness of the response, due to methodological challenges, EBA and the authors agreed to limit the task of the study to comprise an overview of the response.

The objectives were:

- To describe and analyse the Swedish international response to the HIV epidemic since the 1980s until the present day and to paint a broad picture of some of its results, based on stakeholder experiences and existing knowledge.
- To extract reflections and lessons learned from that response, considering how policy design and implementation have adjusted to the continuous transformation of the HIV epidemic and the response.

2 Methodology

This study has used a combination of primary qualitative data that has been collected, and secondary data, obtained from a review of relevant documentation (Appendix A).

In-depth analyses have been made of three components of the Swedish response, namely the support to the Global Fund, the regional support to Sub-Saharan Africa and the bilateral cooperation with Zimbabwe.

2.1 Data collection

The following data sources have been used:

- A desk study with a review of over 400 documents, including policy and strategy documents, evaluations, budgets, websites and scientific articles (Appendix A.2);
- Seven scoping discussions with key informants: for rapid insight into the composition and focus of the Swedish response, its added value, and its strengths and challenges, and to discuss possible angles for analysis (Appendix A.3);
- In-depth interviews with 42 key informants connected to specific aspects of the Swedish response (Appendix A.4).

Information from all sources was extracted and coded using a high-level coding framework, derived from the research questions. The coded information was then analysed and synthesised using a study framework (Appendix A.1). Triangulation of different sources was done to internally validate and contextualise study findings.

To anchor findings into context, the research team also constructed a timeline of significant events within the global HIV response and the Swedish development cooperation. This timeline is depicted in Figure 1. In Figures 2–5, events like changes in policy priorities, introduction of a new type of intervention, a significant change in

resources allocated, or formation of new partnerships have been plotted in chronological order.

2.2 Limitations and transferability

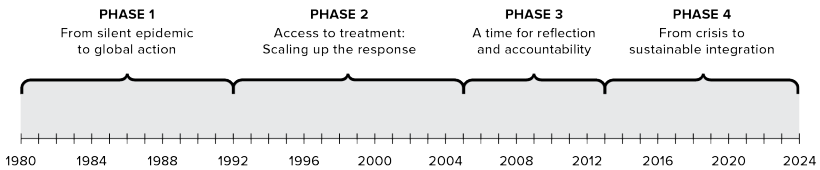
As in any study, there are several limitations and potential sources of bias (Appendix A.5). In particular, the following apply:

- Recall bias: The long period covered by this study means that informants may not always have remembered events fully or correctly.
- Response bias: Informants may have tended to overemphasise positive aspects of the response for which they are/were (co)responsible or from which they benefit(ted).
- Representativeness: A relatively small selection of included informants means that certain stakeholder groups may be underrepresented.

3 The evolution of the global HIV epidemic

To understand the Swedish response to the HIV epidemic, one must consider its evolution in the context of its time and against the backdrop of developments in the rest of the world. In this chapter, we give an introduction to the global HIV epidemic over time. Roughly, the epidemic can be divided into four phases, depicted in Figure 1.

Figure 1. Timeline with four phases within the global HIV response



The timeline was developed by the authors and has been modified afterwards for printing.

We have called the initial phase of learning and mobilisation to combat AIDS *Phase 1: "From silent epidemic to global action"* (Figure 2). The second phase was characterised by the development of Anti-Retroviral Treatment (ART), including the debate, campaigns and negotiations about availability and affordability of treatment; *Phase 2: "Access to treatment: Scaling up the response"* (Figure 3). The next phase included the integrating of HIV programmes into national health systems, as well as critique of how funds were used; *Phase 3: "A time for reflection and accountability"* (Figure 4). *Phase 4 "From crisis to sustainable integration"* is defined by HIV becoming a manageable chronic disease, and being challenged by new epidemics and public health challenges as competing priorities (Figure 5).

Each of these phases are characterised by key events, both at the global level and within the context of Swedish development assistance. They are described on more detail in the sections below. Figures 2–5 describe each phase in more detail and discuss some of the key events that occurred during that phase. Global key events are described above the timeline (in blue), and key Swedish events are described below the timeline (in red).

3.1 Phase 1 – From silent epidemic to global action

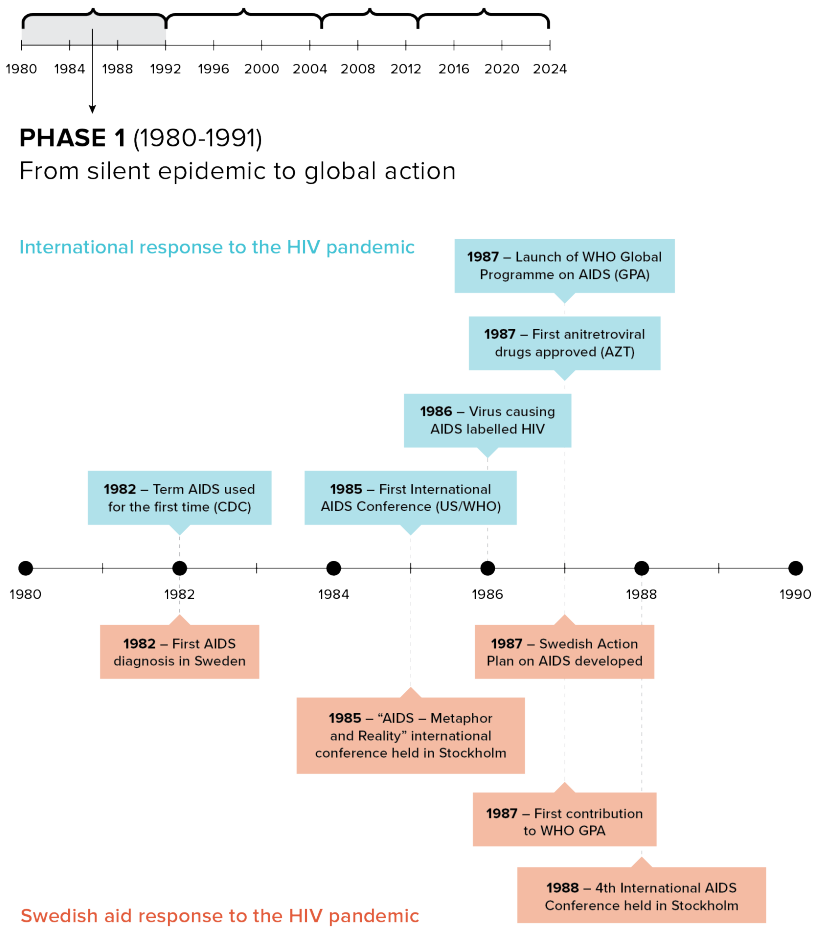
In the late 1970s and early 1980s, when the cause of AIDS was still unknown and the epidemic appeared to be isolated to the gay community in the United States, most countries paid little attention to this new disease (Avert, 2020). In Sweden, the first official case of AIDS was diagnosed in 1982 and three years later, there were still only a handful of confirmed cases (Karolinska Institutet, 2020). In 1986, the virus causing AIDS was isolated and officially named Human Immunodeficiency Virus (HIV) (Sharp and Hahn, 2011). By the second half of the 1980s, the full scale and impact of the epidemic became evident (Mann, 1987; Mann and Kay, 1991). The world began mobilising substantial amounts of funding to combat AIDS, especially in sub-Saharan Africa which by now was heavily hit. In the absence of effective treatment options, programmes were introduced that focussed mostly on provision of education, prevention, care and impact mitigation services (Kagaayi and Serwadda, 2016; U.S. CDC, 2006).

Alongside national initiatives in heavily affected countries, the multilateral response to HIV was gathering steam. In 1987, the World Health Organization's Global Programme on AIDS (WHO/GPA) was established to help coordinate the global response (Mann and Kay, 1991). Not only governments reacted, but action was also taken by civil society, academia, and health professionals. Movements arised among different stakeholders to

unite around common interests, to advocate, raise awareness etc. For instance, the International Steering Committee for People with HIV/AIDS, which would later become the Global Network of People Living with HIV/AIDS (GNP+), was established in 1986 (GNP+, 2023).

The 1987 approval of the first antiretroviral therapy (ART) by the United States Food and Drug Administration helped fuel a global civil society movement to bring down the cost of treatment (Treatment Action Campaign, 2020). The globalisation of the issue also precipitated the formation of the International AIDS Society (IAS), at the 4th International AIDS Conference in 1998 organised in Stockholm. The IAS Secretariat remained based in Stockholm until 2004, when it moved to Geneva (International AIDS Society, 2022b).

Figure 2. The first phase of the pandemic with key events



Source: The timeline was developed by the authors and modified afterwards for printing.

3.2 Phase 2: Access to treatment: scaling up the response

The development of highly active antiretroviral therapy (HAART) and subsequently more affordable generic treatments raised hopes of finally being able to tackle the HIV epidemic and drove the momentum to scale up access to treatment for all. The arrival of HAART in 1996 marked a turning point in the global HIV response. Compared to previously available ARTs, HAART significantly increased life expectancy (Zuniga et al., 2008). The cost was, however, prohibitive, and along with the perceived complexity of managing patients on HAART, it initially remained out of reach for populations in low- and middle-income countries (LMIC). Over the next few years, pressure would mount on pharmaceutical companies to make HAART more affordable. In 2000, UNAIDS, the WHO and other global health groups were able to negotiate a price reduction with five major pharmaceutical manufacturers for use of HAART in developing countries (Yamey, 2000). Further price reductions were enabled by the introduction of generic versions soon after and by the adoption of the Doha declaration (t'Hoen et al., 2011; WHO, 2014).[2]

A major signal of the global commitment to fight HIV came with the adoption of the Millennium Development Goals (MDGs) in 2000, with its stated target of halting and reversing the spread of HIV by 2015 (World Health Organization, n.d.). A meeting of G8 leaders that same year helped lay the foundations for the Global Fund to fight against AIDS, Tuberculosis and Malaria (Section 7.1.2). The Global Fund was established in 2002.

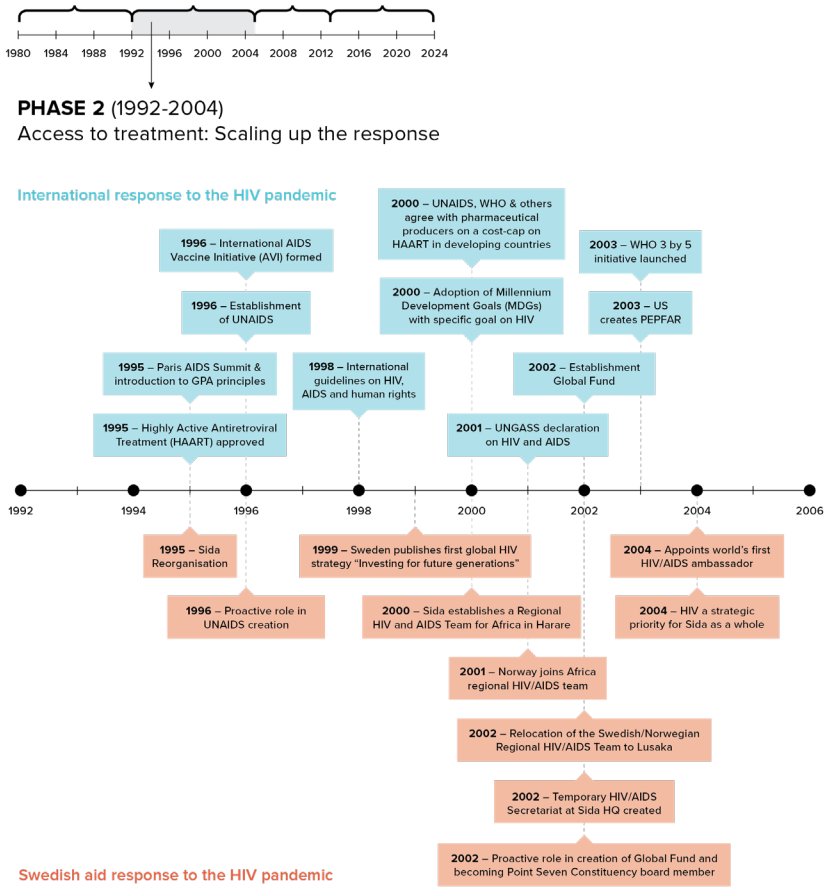
[2] The Doha Declaration was adopted at the World Trade Organisation (WTO) Ministerial Conference in Doha, Qatar, in 2001, in response to concerns expressed that the Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement should not undermine the legitimate right of WTO members to formulate their own public health policies to protect public health. It established mechanisms for supply of affordable medicines and provided additional relief for the least developed countries.

In 2001, the United Nations General Assembly Special Session (UNGASS) on HIV/AIDS took place, attended by high level government representatives and almost a thousand civil society organisations (Gruskin, 2002).

In 2003, UNAIDS and the WHO further raised the ambition for a scale-up of access to ART through its '3 by 5 initiative', which aimed to have 3 million people in LMIC on treatment by 2005.

In 2004, the United States announced the creation of another initiative, the President's Emergency Plan for AIDS Relief (PEPFAR) (United States Department of State, 2023).

Figure 3. The second phase of the pandemic with key events



Source: The timeline was developed by the authors and was modified afterwards for printing.

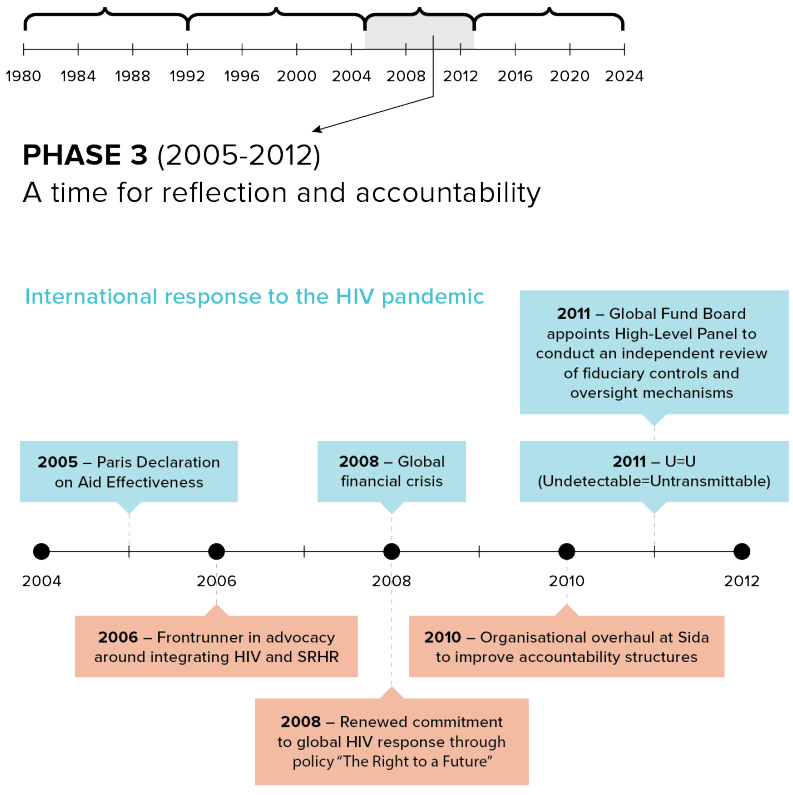
3.3 Phase 3: A time of reflection and accountability

Worldwide, the second half of the 2000s saw a shift in tone around international development cooperation in general and with regard to the enormous amounts of funding being poured into the HIV response globally in particular. Concerns were growing about the

increasing 'verticalisation' of global health. Whilst the targeted response to HIV could be considered to have been helpful in the initial stages of the epidemic, when resources needed to be mobilised and deployed quickly, it had also drawn away resources from already weak health systems. This mode of service delivery had led to duplication of systems and blurred the lines of responsibility, with HIV programmes sometimes functioning almost entirely outside of national health systems (Atun RA et al., 2008; Biesma et al., 2009; Msuya, 2005). Many in the global health community pushed for better integration of HIV programmes into wider health systems and a greater focus on health systems strengthening (HSS)(De Maeseneer et al., 2008).

Meanwhile, the demand to demonstrate impact of development assistance became stronger among donors (Center for Global Development, 2018; Eckhard Deutscher & Fyson, 2008). As the world had opened its coffers at an unprecedented scale, questions were mounting about whether public funds were being spent in an efficient and effective manner. At the Second High Level Forum on Aid Effectiveness in 2005, OECD donors endorsed the Paris Declaration on Aid Effectiveness. This outlined principles around country ownership, accountability, harmonisation, alignment and results measurement to make aid more effective (OECD, 2022). Then in 2008 the global financial crisis hit. This put many donor countries under heavy pressure at home to justify their spending on aid, and funding for HIV treatment and prevention programmes provided by the international community flatlined (International Treatment Preparedness Coalition, 2010).

Figure 4. The third phase of the pandemic with key events



Source: The timeline was developed by the authors and was modified afterwards for printing.

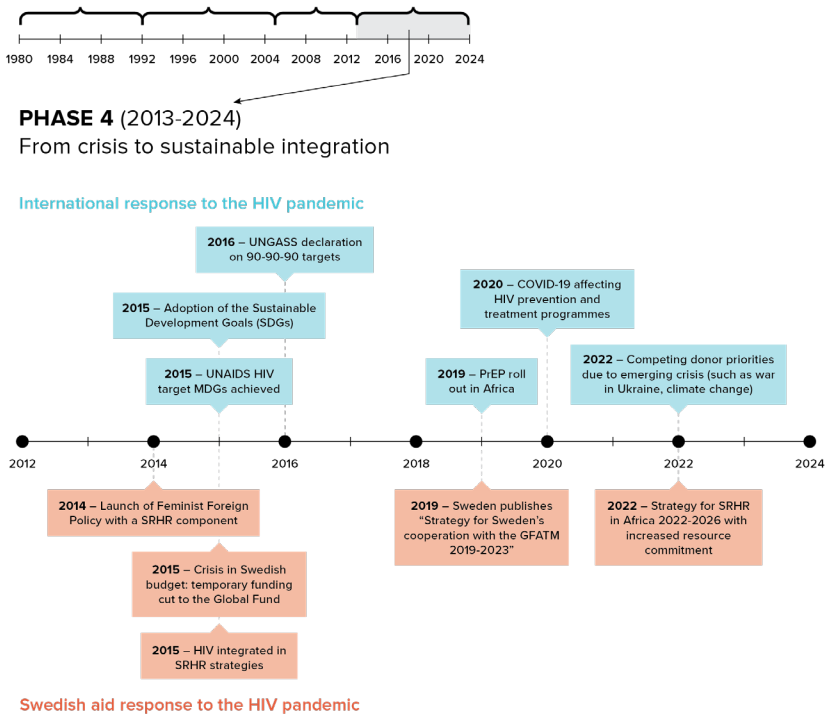
3.4 Phase 4: From crisis to sustainable integration

Further advances in ART have helped to transform HIV from a guaranteed death sentence into an infection that, with access to proper care and treatment, can be managed as a chronic disease (Patel et al., 2008). The effectiveness of the new generations of ART, along with new strategies for prevention of transmission of infection, in particular Prevention of Mother-to-Child Transmission (PMTCT), have further helped bring down infection rates (UNAIDS 2011; WHO 2015).

Although the HIV epidemic is by no means over, these positive developments have removed much of the urgency that characterised the first three decades of the response. Many countries have moved away from purely HIV-centric strategies and programmes, towards an integrated HIV control into broader health and development agendas. Whilst communicable diseases, including HIV, still make up a large part of the disease burden in LMIC, attention has also turned towards non-communicable diseases and other health and social issues (Reubi et al., 2016). This trend is reflected in the Sustainable Development Goals (SDGs) adopted in 2015 by UN member states. SDG 3 includes a target to achieve the end of AIDS by 2030 (target 3.3), but it is no longer a goal in itself (WHO/EURO, 2017).

In the face of these shifting approaches, UNAIDS issued a warning in 2022 that the SDG target of eradicating HIV by 2030 may not be achieved (UNAIDS, 2022). The COVID-19 pandemic has also reduced access to key HIV treatment and prevention services and increased unprotected sexual activities, resulting in increased HIV vulnerability and gender-based violence, especially of those most marginalised (UNAIDS, 2022).

Figure 5. The fourth phase of the pandemic with key events



Source: The timeline was developed by the authors and was modified afterwards for printing.

4 General Swedish response to the global HIV epidemic

This chapter briefly describes the overall Swedish support to the global HIV response, including collaboration with civil society and the private sector. The character of the support has changed over time, in response to the different phases of the pandemic.

4.1 Policies and strategies

In 1985, the Swedish government introduced the first bill outlining various strategies to combat AIDS, focusing on both the domestic and international situation (Sida & Swedish Ministry for Foreign Affairs, 1999a). An AIDS Delegation was appointed to coordinate actions. From the onset, Sweden emphasised not only the medical, but also the social, cultural and political dimensions of the epidemic.

When treatments became available, policies changed. In 1999, Sida and the Swedish Ministry for Foreign Affairs published the strategy "Investing for future generations (IFFG)" (Sida and Swedish Ministry for Foreign Affairs, 1999b). It had a strong focus on structural factors affecting HIV, such as poverty, rights violations and gender. Gender equality has long been one of the thematic priorities in Swedish development assistance. In the IFFG strategy, gender inequality was highlighted as one of the systematic causes of women being more vulnerable to HIV infection than men, due to their lack of ability to negotiate safe sex. The strategy also stressed that women are most impacted by AIDS due to care responsibilities for sick family members and stressed that interventions need to focus on gender equality, and challenge traditional gender structures and norms (Sida & Swedish Ministry for Foreign Affairs, 1999a). Over the years, Sweden has supported numerous programmes and initiatives to deal with gender inequality as an underlying cause of HIV transmission.

4.1.1 HIV Secretariat and HIV Ambassador

In 2002, Sida created a dedicated HIV Secretariat as a three-year project to mainstream HIV into general development cooperation (Sida and the Ministry for Foreign Affairs, 2002). A year later, Sweden became the first country to appoint an HIV ambassador, Lennart Hjelmåker. The function of the ambassador was to build more recognition of the magnitude of the HIV crisis through high-level advocacy, especially towards settings where those in charge were not yet willing to acknowledge this. In 2004, Sida made HIV a strategic priority for the entire organisation for the period 2005–2007 (Sida & Swedish Ministry for Foreign Affairs, 2004).

Sweden's experience with and knowledge on harmonised coordination of stakeholders within the HIV response was acknowledged early on. Sida was asked to disseminate lessons learned in various fora, such as at OECD/DAC meetings (Sida, 2005), and Sweden took an active role in different donor coordination meetings.

Sweden also used its embassy network to promote strategic knowledge sharing between countries (Nilsson et al., 2013). Particularly in Southern Africa, this emphasis on promoting dialogue and knowledge sharing has contributed to increased information exchange between beneficiary organisations, and more harmonised approaches. This allowed for development of joint standards, inter-country comparisons, better tracking of impact and identification of 'best practises' (Jones and Hellevik, 2012).

4.1.2 "The Right to a Future"

In 2008, the policy 'The Right to a Future' was adopted. This was at a time with increasing questioning of the 'verticalisation' of global health. The combined focus on social, cultural, political, and medical aspects that Sweden had promoted since the start of the epidemic became widely adopted. The 'Right to a Future' policy consequently

underlined poverty reduction, and the incorporation of rights and gender approaches (Government Offices of Sweden, 2008).

Since around 2015, when HIV could be managed as a chronic disease, Sweden has mainly integrated HIV in its general SRHR agenda.

4.2 Collaboration with civil society

Around three quarters of Sweden's bilateral assistance has been channelled through several hundreds of local and international NGOs and civil society organisations (CSOs) to implement projects and programmes in countries with high HIV prevalence rates. This includes organisations in recipient countries, as well as those based in donor countries or internationally. Only around 5% of activities involve appropriations directly to governments in recipient countries. Most funding has been allocated to organisations in South Africa, Zimbabwe, Tanzania, Uganda, Kenya and Zambia (Sida, 2002; Sida, 2003; Sida, 2004; Sida, 2005; Sida, 2006; Sida, 2007; Sida, 2022).

Sida's allocations to CSOs in general are either given directly to country-based organisations or to umbrella organisations that, in turn, channel funds to national organisations (Nilsson and Jassey, 2009). Examples of the latter have included Frontline AIDS[3] and Safaids. Both these organisations support national NGOs or AIDS service organisations working at community level.

Many organisations initially received institutional "core" funding. This changed to more of "project funding" around 2013. Some implementing partners suggested that this shift has posed challenges, in cases when recipient organisations did not have the required capacity to manage funds and report on activities in the ways that were required.

[3] Formerly, the HIV/AIDS alliance.

> "This shift from institutional to project funding can be a big shock [....]. It would be valuable to prepare the grantee or the CSO [and] take them through some kind of skills building to be able to cope and adjust operationally to the new mechanism and style." (Implementing partner stakeholder 5, based in sub-Saharan Africa).

Over time, capacity building initiatives to CSOs have enabled some national and local organisations to take on more responsibilities. For instance, some stakeholders in Zimbabwe indicated that, with Swedish support, a number of community-based organisations have matured to the level that they now receive larger amounts of funding directly rather than through an umbrella organisation.

In selecting its civil society partners, Sweden has tended to choose organisations that take on a more systemic perspective, rather than those that are singularly focused on HIV. However, according to a Swedish government stakeholder, 'that balance was not always easy".

Sweden has sought to engage with people living with and affected by HIV both through organisational support and more directly, to incorporate their experiences into policy and co-create initiatives. However, such efforts have not always been successful. A 2005 evaluation of Sida's work on HIV found that people living with HIV not been sufficiently involved, despite this being explicitly recommended in the IFFG Strategy and by international policy guidelines (Vogel et al., 2005). An evaluation of the regional programme in 2009 also concluded that, while organisations for people living with HIV were well represented, the regional team had been less successful in advocating for involvement of people living with HIV as staff within their partner organisations (Jones et al., 2009). A 2005 study furthermore reported that Sweden could have given more attention to the vulnerability of key populations through, for instance, working with LGBTQI+ representatives, have an LGBTQI+ inclusive gender policy and invest in statistical data with

a special reference to LGBTQI+ people (Samlius & Wagberg, 2005). A report from 2021 stated that more coordinated efforts could also be put in place to target and support the most marginalised, for instance LGBTQI+ people, as many small grassroots organisations are not yet in a position to access Sida funding (Ismail and Lesinko, 2021).

4.3 Private sector collaboration

Within the HIV response, Sida has worked not only with the public sector and non-governmental organisations but also with private sector actors. Additionally, it has supported private sector development in affected countries. Sweden's private sector engagement has aimed not only at local businesses and networks but also at Swedish companies active in Africa. This has been done to promote the development of workplace policies that protect the rights of workers living with HIV and provide HIV prevention, care and treatment services. As such, it can serve as an example of the broader holistic approach to the epidemic. For instance, the Swedish-owned Sandvik Mining and Construction multinational company received support to develop a comprehensive HIV/AIDS workplace policy for its site in Zambia, and with the implementation of activities to end stigma and discrimination of employees living with HIV (Embassy of Sweden, 2011).

In 2004 Sida supported the Swedish Workplace HIV and AIDS Programme (SWHAP), a joint initiative by the International Council of Swedish Industry and the Swedish Industrial and Metalworkers' Union. It focussed on the provision of HIV testing and on awareness raising, as well as on providing counselling and access to treatment for employees. Companies that partook in the SWHAP scheme had a notably higher average uptake in counselling and testing (over 70%), than the national average in the participating countries (Hinds, 2013).

Box 1 Working with the private sector to fight HIV

The South African Business Coalition on HIV/AIDS (SABCOHA) focussed on implementing programmes and empowering workplaces, as well as on collecting HIV-related data from the private sector to show how the sector contributed to national HIV targets. In 2013, SABCOHA received a Partner Driven Cooperation grant (SEK 1.5 million) from Sweden. This grant established a relationship between Gothenburg University in Sweden, Wits University in South Africa and SABCOHA. Over the years, SABCOHA worked with a range of Swedish-funded organisations such as Trucking Wellness/CEP and SANAC. This helped to provide support to private sector wellness and HIV programmes, as well as to collect and contribute data to the project of monitoring the response to understand the situation within South Africa (P.-U. Nilsson & Jassey, 2009).

RISE (formerly the HERproject), worked in collaboration with the Business for Social Responsibility. The education programme targeted young women working in factories in Africa and Asia, while focussing on topics such as maternal health, family planning and sexually transmitted infections (Hinds, 2013). Sida funded the HERproject for two project periods; in 2010–2011 (SEK 7.1 million) and in 2012–2013 (SEK 7.6 million) (Sida, 2014).

5 Bilateral and regional collaboration

Sida is the main agency to manage and disburse funding for Sweden's bilateral and regional development cooperation. A significant amount of 'multi-bi' support is also channelled through Sida.

Tracking the amount of funds dedicated to the HIV response through bilateral cooperation is challenging because the specific allocation for work on HIV and AIDS ceased in 1993. Since then, funding for HIV-related activities has been integrated into other activities (Sida and Swedish Ministry for Foreign Affairs 1999). However, at least 700 activities funded by Sida between 1998 and 2021 can be clearly linked to HIV. Together, they represent a contribution of over SEK 1.5 billion. The integration of HIV with other activities means that the true contribution may be substantially higher.

Although Sweden's bilateral and regional financial contributions collectively are lower than its multilateral contributions, it has targeted more specific priorities of the Swedish development cooperation, closely linked to SRHR. In the early 2000s, Sida had a strong focus on bilateral support Bilateral programmes became Sida's main route for development cooperation with countries, particularly in Africa (Eduards K., 2006; Sida, 2006b; Sida Regional Team, 2006). While the focus has varied over time, Sweden has been particularly active in Botswana, Ethiopia, Kenya, Mozambique, Namibia, Tanzania, Uganda, Zambia and Zimbabwe in Africa and in Bangladesh and Vietnam in Asia.

Sweden has consistently taken the position that countries should be empowered to take full responsibility for addressing HIV. Sweden has viewed its own role as promoting that this is done in an integrated and multisectoral fashion. This is in line with the health systems approach, as well as with the integrated perspective of HIV prevention. Country ownership has been pushed in strategic

discussions at the Global Fund, including inclusive financing mechanisms and discussions on Country Coordination Mechanisms (CCM).

> "We have also been working very much on the financing model as such to ensure that the country voice [and] the local ownership is coming in stronger. […] I don't think we were completely successful in that regard: it is still quite complacent, but that was the intention at least." (MFA/Sida stakeholder 9)

5.1 Bilateral collaboration with Zimbabwe – a case study

The case study of Sweden's bilateral engagement with the HIV response in Zimbabwe and how it has shifted over the years may offer insights into how Swedish high-level policy priorities and strategies on HIV and donor assistance have been translated into a specific country context.

Box 2 Zimbabwe – A case study of bilateral collaboration

Zimbabwe has been among the countries hardest hit by HIV. It is estimated that, by 2000, two out of every eleven Zimbabweans were living with HIV and that around 780,000 Zimbabwean children had lost one or both parents due to AIDS-related illnesses (UNFPA, 2015). HIV also placed a heavy toll on the health system as 50% of all patients in hospital wards were infected with HIV (UNAIDS, 2002). High-risk behaviour due to cultural attitudes and practices and socio-economic inequalities are believed to have facilitated the rapid spread in Zimbabwe (Mugurungi et al., 2007).

Despite the devastating consequences of the epidemic, recognising HIV as a societal problem was a challenge throughout the 1990s (Jovonna Rodriguez, 2007; O'Brien & Broom, 2011). As in many other countries, HIV-infection was associated with severe social stigma and Zimbabwean policy was openly hostile to people in the LGBTQI+ community and those engaged in sex work. Such factors helped fuel a culture of denialism and non-disclosure of HIV-

status that allowed the rapid spread. Although by 1990 President Robert Mugabe had publicly declared that HIV placed the country in great jeopardy, the government still failed to prioritise a response to HIV. The governmental vacuum was partly filled by non-governmental and faith-based organisations focused on HIV prevention counselling and offering care to those infected.

Sweden began supporting the Zimbabwean HIV response in 1998. Under a bilateral agreement, a Strategic Planning Fund was formed, financing projects focused on HIV prevention, home-based care for people living with HIV, care for orphans and gender-focused interventions (Sida, 2004). In recognition of the broad impact of the disease, the Ministry of Health of Zimbabwe received support to mainstream HIV through the health sector programme (Muhwava et al., 2007; Mupindu et al., 2005). Reduction of poverty and general inequalities was integrated in this approach(Killick et al., 1998).

Soon after, the relationship between Sweden and Zimbabwe changed significantly. In 1999, due to political unrest and instability in the country, the collaboration with the government in Zimbabwe was suspended (Goliber, 2004). The same happened with other international donors. Swedish funding was reduced by approximately 50%, with just two main areas remaining, namely HIV and good governance (Muhwava et al., 2007). Support to the HIV response was from here on channelled exclusively through non-governmental and civil society organisations, which to this date continues, as confirmed by stakeholders. Given the need to build capacity on the ground, and in the absence of collaborative mechanisms with the Government of Zimbabwe, building NGO capacity remained central to the Swedish approach.

In 2017, the Swedish Ministry for Foreign Affairs produced a new strategy for development cooperation with Zimbabwe (Government Offices of Sweden, 2017). It included SRHR [1], but HIV was no longer explicitly prioritised. Currently, Sida's focus in Zimbabwe is economic development; environment, climate and sustainable use of resource, and strengthening of human rights, democracy and gender equality including SRHR.

5.2 Regional collaboration in Africa

In general, Sida has focussed its attention on the worst affected countries, notably in sub-Saharan Africa. For a short period in 2002–2005, Sweden also supported the strengthening of community-based prevention and care efforts in Asia. This was motivated by the notion that Asia was home to 60% of the global population, which implied large numbers of people living with HIV and that similar HIV scenarios as in sub-Sahara Africa should be prevented there.

> "[2004] was the time when HIV affected everything and there was a big fear that what we saw happening in Africa would also happen in Asia…" (MFA/Sida Stakeholder 5)

However, after a few years, Sida refocussed its attention on high-prevalence countries in sub-Saharan Africa, particularly on key and vulnerable populations there. Due to lower HIV prevalence and language limitations of staff, the regional collaboration never expanded into Western Africa. Sweden has however provided support to the Economic Community of West African States.

The main flagship of a regional approach to the HIV response is the Swedish regional HIV/AIDS team in Africa, described in more detail below. The fact that much of Sweden's bilateral and regional SRHR support continues to be centred on sub-Saharan Africa is further motivated by the limited progress in the region related to SRHR outcomes (including HIV) (Kågesten et al., 2021).

> "[Sweden]... is one of the few donors that have been consistent in this region around supporting HIV and recognising that it's still at crisis levels for communities in this region, particularly adolescent girls and young women and key populations." (Implementing partner stakeholder 3, with focus on Southern Africa)

In addition, there are some examples of regional collaboration related to pooled funding. Pooled donor funding is an example of donor alignment in practice, easing recipients' administrative burden in terms of reporting, negotiations over contracts, and other administrative issues. From 2006 until 2009, Sweden and Norway led several regional Joint Financing Agreements with a group of donors including the Netherlands, the United Kingdom, Canada, Denmark, Finland and Ireland (COWI, n.d.)(Ministry for Foreign Affair of the Netherlands, 2007).

5.2.1 The Swedish Regional HIV/AIDS team in Africa

Sweden strengthened its presence in Africa already in 2000, during the second phase of the HIV response when treatments first became available. It did this as part of its IFFG strategy by establishing a regional HIV/AIDS team (hereinafter called "the team") and implementing a regional programme. The team was initially based in Zimbabwe but moved to Zambia in 2002.

Between 2001– 2013, this programme was a Swedish – Norwegian collaboration. When Sweden decided to set up the regional office, it could draw on the presence and expertise of a network of embassies across Africa. Norway did not have a similar network of experts in the region. By joining the Swedish initiative, Norway was able to work in the region as an equal partner with comparatively limited resource investments. Still, the team was mostly recognised as being Swedish, with more references to Swedish policies and strategies than Norwegian ones (Jones et al., 2009). After Sweden's decision to change the HIV programme into a SRHR programme, and with continuously decreasing presence of the Norwegian team and their overall political reorientation in the health aid sector, Norway terminated its contribution to the regional team in 2013. (Jones et al., 2009).

Initially, the team's main responsibility was to link bilateral and multilateral aid and intensify dialogue between multilateral organisations working in the region (Jones et al., 2009). This included helping to strengthen regional policy discussions at the level of the African Union and the Eastern Africa Community. The team has participated in several key fora, such as the UNAIDS convened International Cooperating Partners Forum and the non-formalised HIV prevention group. The team furthermore has taken part in the technical committee of the Southern African Development Community (SADC) and financed the SADC's Partnership Forum.

> "I really particularly appreciated the support that they gave to SADC in terms of supporting their role as a convener of Member States, to harmonise policies around HIV responses in the region. And also, to create a platform for a multistakeholder response at the regional level. […] I think that many of the successes that we've seen in Southern Africa can be attributed to support and approaches like that […]." (Implementation partner stakeholder 3, based in Southern Africa)

Some interviewees highlighted the usefulness of Sida's regional approach for country-to-country learning and for the creation of peer pressure to adopt international commitments and strategies.

From 2005 and on, the team's strategic focus shifted towards supporting regional intergovernmental and civil society organisations[4]. A comprehensive implementation chain was created: from Sida's headquarters to the regional team, to regional

[4] Supported organisations include: the Regional Network of African AIDS Non-governmental organizations (RAANGO), the Southern African AIDS Trust (SAT), ARASA, Southern Africa AIDS Dissemination Service (SAfAIDS), and INERELA+ (a global network of religious leaders living with or personally affected by HIV).

organisations, to national offices (where relevant) and to local implementing partners. This enabled different implementation levels to inform each other and to feed grassroot experiences back to the regional or headquarter teams, from where they could be taken forward into global health decision-making fora, like UNAIDS and the Global Fund (Jones et al., 2009). Interviewees emphasised that, through these relationships, Sweden was able to amplify local voices and encourage joint action.

In 2015, as the fourth phase of the global response emerged, the team's focus evolved further, with HIV becoming part of a broader SRHR agenda. This was influenced by multiple factors, such as the adoption of the SDGs which no longer had a stand-alone goal on HIV, the successes in the response so far, and the global economic downturn. Nonetheless, the programme has maintained attention for HIV prevention, key populations, young people, PMTCT and HSS, including resource mapping for HIV (Government Offices of Sweden, 2015).

Sida's most recent strategy (2022–2026) for the team focuses strongly on adolescents, for whom in many countries HIV is the most common cause of mortality. LGBTQI+ issues are also a priority, for which health services have been an effective entry point. PMTCT is no longer explicitly on the agenda, as the regional team does not feel it can offer sufficient added value in this area. Instead, the team aims to focus on difficult issues that lack full political support from a regional perspective.

The added value of Sweden's regional approach and the regional team has been recognised by stakeholders, in particular in capacity strengthening of local organisations (e.g. through training on rights and HIV) and fostering the exchange of knowledge and expertise amongst actors. The regional collaboration has furthermore increased the ability of community-based organisations to raise funds, as well as increased power of advocacy efforts, particularly on sensitive issues, by elevating discussions from the local or country level to the regional level. According to stakeholders that have been

interviewed, the core funding provided through the regional programme to regional and local organisations has helped to significantly advance the regional response.

Reference Group of Experts advising the Team

To ensure the relevance of Sweden's regional programme, the team has been advised on strategic issues by a reference group of experts drawn from different disciplines, organisations and countries in the region. Reference group members have often been very valuable facilitators in capacity building seminars/workshops (Vogel et al., 2005). The regional team's tendency not to impose programmes, and to work with a reference group added to its credibility (Jones and Hellevik, 2012).

Interviewees considered them a crucial element of the regional programme, demonstrating its participatory nature, but also suggested that the rotation and diversity of group members could have been higher.

> "That advisory team who came to these meetings, I think for them it was a brilliant platform. (…) But perhaps they should have rotated this a bit more often to have new people on board." (Development partner stakeholder 11, Global but previously regional focus)

6 Multilateral collaboration

Bilateral development cooperation with partner countries has been an essential part of Sweden's HIV response, as described above. But equally important has been the support to, and normative influence on, the multilateral system. Sweden has long been a backer of the UN system and has contributed substantial funding to UN organisations and other multilateral organisations that have been important in the global HIV response over the years. Decisions about core contributions to UN organisations are made by the Ministry for Foreign Affairs (MFA), but the transferral of funds is administered by Sida.

"AIDS control" is explicitly mentioned for the first time in the Swedish national budget proposal of 1990.[5] Funding was then allocated from the budget area 'Special Programmes' to WHO, bilateral cooperation and individual organisations. "Special Programmes" were designed to provide broad support for AIDS control, "with the aim of preventing the spread, reducing incidence and mortality, and alleviating the social and economic consequences of HIV transmission" (Regeringen, 1990).

Sweden has been funding various multilateral organisations, most notably the Global Fund, UNAIDS and UNICEF, as detailed in the following paragraphs. Other multilateral agencies such as the WHO, UNDP, UNFPA, the World Bank and other development banks have also received substantial funding. The World Bank has a unique capacity to carry out large-scale bilateral and global initiatives and are an important partner for Swedish development assistance (Sida, 2021). At country level Sida has, for instance, supported the World Bank in its efforts to increase knowledge about the social and economic consequences of HIV (Sida, Tanzania 1990–1995, National archives). However, it is difficult to estimate how much of Sweden's contribution to these organisations has been used in

[5] Sweden funded HIV-related activities prior to 1990 but this was not identified in the national budgets under the explicit heading of AIDS control.

support of the HIV response, as this funding has not been earmarked for HIV.

Although it is challenging to estimate the aggregated amount of multilateral funding Sweden has provided to the global response for HIV over time, it can safely be assumed to be more than SEK 10 billion. This amount is a testament to both Sweden's commitment to the fight against HIV and to its emphasis on working through multilateral cooperation.

6.1 The Global Fund

The Global Fund was established in 2002, when the global HIV response was being scaled up. The Global Fund is a worldwide partnership to tackle three diseases: HIV, tuberculosis (TB) and malaria. It´s mission is to raise and pool funds, and invest in countries, to fight these diseases, strengthen health systems and pandemic preparedness in the hardest hit countries. In 2000, AIDS, TB and malaria appeared to be unstoppable, despite being preventable and treatable. But solving the problem requires the commitment not only of world leaders and decision-makers, but also of those working on the ground to support the men, women and children living with these diseases (History of the Global Fund, 2023).

The idea of the Global Fund originated from grassroot organisations involved in political advocacy coming face-to-face with the imperatives of global leadership. In 2001, then-UN secretary Kofi Annan called on world leaders to increase their commitment to the fight against HIV. Subsequently, a Transitional Working Group was set up to develop the organisation that was to become The Global Fund. Sweden was herein represented by Anders Nordström, who had come from Sida. When the Global Fund formally began operations in 2002, he was elected its interim executive director. Within the new organisation, Sweden received a seat on the board as part of the 'Point Seven' constituency. Until 2004, this seat was held

by Sweden's newly appointed HIV ambassador Lennarth Hjelmåker. Multiple interviewees, both from within and from outside the Swedish government, indicated that the presence of two well-respected Swedes in key positions during the Global Fund's formative period gave Sweden real influence on its strategic direction and priorities. This influence was visible, for instance, in Sweden's successful push for the Global Fund to extend its mandate beyond HIV and focus on health systems strengthening. Other issues Sweden has continuously advocated for within the Global Fund include gender equality, human rights, poverty alleviation and SRHR more broadly.

> "I think they were the first to really bring gender into the equation. We did not have gender as part of our grant proposals." (Development partner stakeholder 7 (Global focus))

Sweden's strategy for cooperation with the Global Fund for the period 2019–2023 states that Swedish funding clearly contributes to gender equality, as HIV is a major cause of ill health and death among women and girls. One of the four goals of this strategy concerns the promotion and protection of gender equality (Swedish Government Offices, 2019).

Beyond the role that key individuals played, Sweden appears to owe much of its influence on the Global Fund to that, within the donor community, it is viewed as a knowledgeable, credible, and honest partner. Interviewees generally consider Swedish representatives to the Global Fund to have a good understanding of the issues at hand. It was furthermore said that Sweden uses the power of persuasion by providing reasoned arguments, rather than that of its financial contribution to affect change.

> "Sweden was an honest broker, and they did that through their integrity; they did that through knowledge and their own experiences. […] Unlike the US that had the money: its influence was the

> money. […] Whereas Sweden would come to the table with really good ideas, without the threat of 'we're going to take the money away'." (Development partner stakeholder 7 (Global focus))

Although the impact of such knowledge-based soft power may not always be visible to the outside world, it can be as effective, or even more so, as leverage exerted through formal voting power. Several Swedish interviewees confirmed that they and their colleagues often use background diplomacy to help move things in the system.

When the Global Fund was established, Sweden was among the first countries to pledge funding, and has remained a key donor. With each consecutive replenishment round, Sweden has maintained or increased its contribution, from 1.026 billion SEK in the first round to 2.650 SEK in the 7th round (The Global Fund, 2023). In deciding on its funding pledge, Sweden has typically followed the investment case prepared by The Global Fund. Only in the most recent, seventh, replenishment round did Sweden not commit the requested amount in full due to competing demands on the budget.

The Swedish contribution to the Global Fund exceeds that to UNAIDS in absolute terms (The Global Fund, 2023). To date, Sweden has pledged SEK 16.8 billion to The Global Fund (Appendix B). Whilst contributions are not earmarked, data from the Global Fund indicate that, of all funds allocated between 2014 and 2025, around half (US$25.8 billion out of US$50.72 billion) have been made available for HIV (The Global Fund, n.d.).

In 2011, there were reports of corruption and fraud with grants within the Global Fund. Sweden was then quick to demand action from the Global Fund's leadership. In an unusual move, the Swedish government announced it would withhold its contribution until sufficient safeguards had been put in place (The Local, 2011; Usher, 2010). Germany and Ireland followed suit. Once Sweden was confident that appropriate oversight mechanisms had been put in

place, it released its contribution in October 2011 and subsequently pledged SEK 2 billion for the Fund's third replenishment round (Gostin, 2014; TB Online, 2014).

The Global Fund publishes annual reports with results achieved in countries. The 2022 report highlights that considerable progress has been made in reducing AIDS-related deaths and preventing new HIV-infections through investments in prevention, care and treatment services. An independent assessment for the period 2017–2021 found that, despite the COVID-19 pandemic, the Global Fund "has demonstrated that its use of funds has indeed maximised its impact against HIV, tuberculosis, and malaria" (MOPAN, 2022).

6.2 UNAIDS

The Swedish government has funded the World Health Organization's Global Programme on AIDS (WHO/GPA) since its inception in 1987 (Regeringen, 1992). In 1990, the WHO/GPA received the largest single contribution under the Swedish budget area for Special Programmes. Sida also provided flexible funding to WHO/GPA to support the establishment of National AIDS control Programmes in many countries (Sida, Lao 1987–1989, National archives).

In 1996, at a time when HAART first arrived, the WHO/GPA was succeeded by The Joint United Nations Programme on HIV/AIDS (UNAIDS), and Sweden became one of UNAIDS' largest and most stable donors. It was the second largest donor, after the United States, with the Swedish contribution accounting for 16% of total voluntary contributions (UNAIDS, n.d.). Thus far, Sweden has contributed over SEK 4.6 billion to UNAIDS. Nearly all of this is provided as core funding. In its national budget proposal for 2006, the Swedish government emphasised that "in multilateral work, UNAIDS is the cornerstone of all HIV/AIDS work" (Regeringen, 2005). Sweden also supports the work of UNAIDS through joint projects and pooled funding mechanisms (UNAIDS, 2019).

By funding UNAIDS, Sweden has also co-financed technical support for in-country implementation of grants from the Global Fund (UNAIDS, 2021). When The Global Fund became operational in 2002, Sweden was among the first countries to pledge funding to the new fund, and also stepped up its contributions to UNAIDS, clarifying that "the collaboration with the newly formed Global Fund against AIDS, Tuberculosis and Malaria will also place increased demands on UNAIDS. All this speaks in favour of increased Swedish support for UNAIDS" (Regeringen, 2002).

Sweden is an active member of the United Nations system, providing technical, political and financial support to the UN organisations including UNAIDS (Irwin, 2019).[6] This allows Sweden to contribute to global policy development and assist countries, including those which Sweden does not have a bilateral arrangement (Sida, 2020).

Sweden played an active role in the creation and development of UNAIDS and advocated for its establishment as a joint programme rather than as a separate UN agency. Sweden considers UNAIDS as an example of UN reform in practice, focused on maximising strategic coordination between UN agencies (Sida, 2005b; Sida & Swedish Ministry for Foreign Affairs, 1999a; Vogel et al., 2005). Interviewees have stressed that Sweden strongly encourages such interagency collaboration.

> "There is quite a bit of overlap in what we do as UN agencies; sometimes we can create waste. The support that we are getting from Sweden makes us work more collaboratively together. […] They specify which organisation is responsible for what,

[6] This includes, for instance, Sida's technical inputs to the development of UNAIDS Global strategy on Prevention of HIV/AIDS; the Swedish Strategy framework 2005–2008 "Working in partnership with UNAIDS"; contribution to the UNAIDS report "AIDS in Africa: three scenarios to 2025"; technical inputs to the Swedish participation at the board meeting of UNAIDS, UNFPA and UNICEF; input to UNICEF's medium-term strategy plan, 2006–2009; and core support to several of the International AIDS conferences (Sida, 2006).

> utilising their strength. They want us to work jointly." (Development partner stakeholder 8, based in Zimbabwe)

A key role of the UNAIDS is advocacy and leadership. Especially the Secretariat is a strong global advocate, influencing the international agenda. In its 2005–2008 strategic plan for cooperation with UNAIDS, Sida stated it supported the leadership role of UNAIDS in advocacy and the provision of strategic information on the epidemic and its impact (Sida, 2005). Sweden views UNAIDS as a global forum within which agreement can be reached concerning guidelines, standards, ethics, and evidence informed recommendations (Sida & Swedish Ministry for Foreign Affairs, 1999a). It has also encouraged the UNAIDS Secretariat to initiate and organise international research efforts and conduct advocacy (Sida, 2005b).

In 2020, UNAIDS established its "90-90-90" target, meaning that at least 90% of all people living with HIV would know their status, at least 90% of all people diagnosed with HIV would receive ART, and at least 90% of all people receiving ART would have viral suppression. With Swedish core support, UNAIDS has been able to contribute – in collaboration with other actors – to fully achieving those objectives in eight countries. The countries in eastern and southern Africa, which are the regions most affected by the pandemic, achieved results close so the 90-90-90 target (Government Offices of Sweden, 2022).

6.2.1 The '3 by 5 Initiative'

In December 2003, the WHO and UNAIDS announced the "3 by 5" Initiative, which aimed at reaching three million people in low- and middle-income countries with ART by the year 2005. It has been one of the most visible global programmes to scale up access to ART in LMICs. The UNAIDS Secretariat played a leading role in all aspects of the Initiative's policy development and implementation

on country level and globally (WHO & UNAIDS, 2006). Sweden contributed 28.5 million USD to the Initiative. This enabled WHO to recruit professional staff at country and regional levels to assist in scaling up treatment in 41 of the Initiative's 49 focus countries (WHO & UNAIDS, 2006). The Initiative significantly helped accelerate the roll-out of ART in LMICs. It was endorsed in May 2004 by all 192 WHO Member States at the 57th World Health Assembly. The '3 by 5 Initiative' fell short of its target but helped to increase the number of people on treatment from around 400,000 in 2003 to 1.3 million by the end of 2005. Hence, it demonstrated the feasibility of providing ART in resource-constrained settings (Ines et al., 2006).

Initially, when the '3 by 5 Initiative' was announced, Sweden was doubtful over whether such a large-scale roll-out of treatment was feasible. In the Swedish HIV global response strategy "Investing for Future Generations" (IFFG Strategy), Sweden had indicated that it considered it unlikely that HAART would soon be available for low-income countries due to their weak health systems (Sida and Swedish Ministry for Foreign Affairs, 1999b). In its bilateral support, Sweden thus focused more on care and support, including support for caregivers of people living with HIV, orphans and vulnerable children. Sweden also focused on research and legal reforms required to facilitate a roll out (Sida and the Ministry for Foreign Affairs, 2002; Sida & Swedish Ministry for Foreign Affairs, 2004; Sinclair & Aggarwal, 2008). Nonetheless, Sweden contributed to the massive scale-up of access to ART through its contributions to and engagement with UNAIDS and The Global Fund (Sida, 2005b, 2006b; The Global Fund, 2023; UNAIDS, 2019).

6.3 UNICEF

Sida is among UNICEF's largest public funders. Relatively little of Sweden's contributions have been thematically earmarked, and none specifically for HIV and AIDS. Therefore, Swedish response to HIV

through UNICEF is indirect. Between 1980 and 2022, the Swedish government appropriated at least SEK 12.9 billion to UNICEF. Most of this has been given as core support, enabling UNICEF to direct funds to areas of greatest need. UNICEF also allows financing partners to allocate or "earmark" funding thematically. Between 2018 and 2020, for instance, thematic contributions for HIV and AIDS was USD 23 million in total (2% of all thematic contributions) (UNICEF, 2021). By 2021, however, this contribution had declined to USD 1 million (0.13%). Data was not found on the total amount of funding allocated to HIV programmes by UNICEF over time, neither through thematic funding or core support.

UNICEF's contribution to the global HIV response centres on ensuring access to HIV prevention, treatment, care and support for babies, children, adolescents, and mothers (UNICEF, 2022). HIV prevention activities also include tackling some of the key drivers of HIV infections such as poverty, gender inequality and lack of access to education. UNICEF is a co-sponsor of UNAIDS as well.

6.4 European Union Joint Assistance

Sweden's entry in the EU in 1995 meant that Sweden could no longer be as independent in foreign policy and began to practice a "quieter diplomacy" (Dahl, 2006). Sweden also redirected some of its development funding and actions through the EU's joint assistance. In general, Sweden uses the EU as a platform to push for poverty reduction, gender equality, environment protection, democratic development and human rights (Danielson et al., 2003) and all socio-economic and cultural factors affecting HIV vulnerability.

As an EU Member State, Sweden is committed to playing an active role and ensuring that the European Commission's development work complements that of other international organisations. This includes promoting the integration of HIV issues into other EU development programmes (Sida & Swedish Ministry for Foreign Affairs, 1999a).

Through the Ministry for Foreign Affairs, Sweden also participates in multiple EU expert groups and committees linked to development cooperation.[7]

Using funding from the EU, under delegating agreements, Sida currently supports SRHR and HIV interventions in Africa (Sida, 2021). Moreover, in 2020, Sweden has teamed up with other bilateral donors in the Team Europe Initiative on SRHR together with the European Union and the renewal process of commitments on Comprehensive Sexuality Education (European Union, 2023).

[7] For instance, since 2015, Sida has been a member of the Practitioners' Network for European Development Cooperation, consisting of development cooperation agencies from several EU Member States. This network aims to improve aid effectiveness, to promote closer cooperation and to exchange experiences between development agencies in Europe.

7 Supporting HIV research

Throughout the 1980s, learning more about the causes and transmission of AIDS was crucial to inform an effective response. Many countries thus invested heavily in research to improve the understanding of the disease and support the search for new treatments and prevention methods. From the beginning of the epidemic, Sweden too recognised the important role that research could play in halting HIV. Research into the causes and consequences of AIDS and the development of strategies to prevent, diagnose and treat the disease soon became an important pillar of the Swedish response.

Around 1986, Sweden started funding a special research programme on HIV for Swedish scientists working in collaboration with scientists in Africa. The programme provided long-term support for projects focussed on preventive measures (including vaccines), on halting infection transmission from mother to child, on development of diagnostics and on epidemiology of infection patterns (Sida, 2004). Sweden has invested substantially in HIV-related research and the development of innovations for use in the HIV response. This includes biomedical and public health research as well as wider sociological research (Lazarus et al., 2010). Initially, the Swedish Agency for Research Cooperation with Developing Countries (SAREC) was the responsible agency for supporting Swedish development research (Eduards, 2006). In 1995, this agency was integrated into Sida and became a research department.

The special research programme on HIV was an important component of Sweden's development research cooperation. Under this programme, Sweden disbursed SEK 186 million up until 2004 (Sida, 2004a). Funding has been channelled to 1) research on HIV and related sexually transmitted diseases (through Sida and the Swedish Research Council (SRC)), to 2) research capacity development, and 3) HIV-related Product Development Partnerships. Between 2016 and 2021 alone, SRC funded 146

research projects on HIV[8] for a total of SEK 570 million (Adam et al., 2020). Furthermore, between 2014 and 2019, Sweden invested around SEK 450 million in virus research, of which a major share was allocated to research into retroviruses, including HIV (Swedish Research Council 2020).

Challenges related to how data have been categorised make accurate tracking of the Swedish funding contribution to HIV research difficult (Appendix A.4.2). Where estimates are available, these have been included in the estimates. They likely, however, underestimate the true extent of Swedish contribution to HIV-related research.

Subsequent Swedish directives and strategies for research cooperation have aimed at contributing to strengthened research of high quality and of relevance to poverty reduction and sustainable development. Whilst the strategies have provided support to research in different thematic areas, including health generally as well as HIV-related research, no explicit mention of HIV or SRHR has been made (Government Offices of Sweden, 2014).

7.1 The TANSWED HIV Research Programme

In 1986, Sweden initiated the TANSWED programme, a collaboration between the Swedish Karolinska Institutet and the Muhimbili University College of Health Sciences in Dar es Salaam, Tanzania. The programme has supported projects in the fields of clinical medicine, biomedicine, epidemiology, and social sciences. Initially, TANSWED was a results-oriented thematic programme but, in 1990, as it was transformed into a broader bilateral programme for research cooperation between Sweden and Tanzania, a component of strengthening research capacity within Tanzania through training and institutional development was added. Sida

[8] Identified through 'HIV' in project title/abstract.

furthermore provided financial support to a UNAIDS-led multi-centre study on PMTCT.

The capacity building programme with Tanzania continues. By the end of 2022, it had produced over 40 Tanzanian PhD graduates. New funding for the 2023–2028 period include research into PMTCT, HIV vaccine development, HIV drug resistance and the COVID-19 response (Karolinska Institutet, 2022). The TANSWED programme is a prominent example of Sweden's bilateral support. No information was found on the total allocation to the programme since its inception. Various figures[9], covering the period 1986 to 2007, suggest a total contribution of more than SEK 100 million (Cohen, 2000; Mellander & Sewankambo, 2002; Sida, 2004a; Rika, 2016).

7.2 HIV Research within multilateral collaboration

Also, in the context of HIV research, Sweden has prioritised multilateral engagement. Sweden has provided core financial support for HIV research initiatives embedded in multilateral organisations, such as the United Nations Research Institute for Social Development (UNRISD) and the Alliance for Health Policy and Systems and Research (Eduards & K., 2006; Irwin, 2019). Several Swedes[10] have served on the UNRISD Board. The Alliance was established in 1999 with the support of the Swedish government and individual Swedish experts (Irwin, 2019).

[9] Available estimates for specific (overlapping) time periods include: USD 8 million between 1986-2000 (Cohen, 2000); SEK 60 million between 1995–2004 (Sida, 2004); SEK 18 million between 2001–2003 (Mellander & Sewankambo, 2002); and USD 1.9 milion between 2006–2007.

[10] In 1997, Swedish Thandika Mkandawire was appointed as director of UNRISD.

Sweden´s most notable contributions are those to the European and Developing Countries Clinical Trials Partnership (EDCTP). EDCTP had been created in 2003 as a partnership between EU Member States and countries in sub-Saharan Africa to support the clinical development of products in the area of poverty-related infectious and (re-)emerging diseases, including HIV (EDCTP, 2015). Member State contributions, both cash and in-kind, to EDCTP are matched by the European Commission.[11] This creates a multiplier effect on the Swedish contribution.

The purpose of the EDCTP is to reduce the individual, social and economic burden of poverty-related infectious diseases in sub-Saharan Africa. A primary scope has since the beginning been HIV and HIV-related infections. The organisation works by supporting collaborative research to develop accessible, suitable, and affordable medical interventions. Sida has provided in-kind and monetary support to EDCTP since the start. Under the partnership's first programme (EDCTP1), which ran from 2003 until 2015, Sweden was one of only two countries to provide unrestricted cash contributions. Together with restricted cash and in-kind contributions, Sweden's direct contribution to EDCTP1 was EUR 15.6 million, making it the second biggest direct contributor (Mostert et al., 2014) (EDCTP, 2015). Under EDCTP1, participating states were able to put forward research activities within the scope of EDCTP for which the value is then matched from the budget of the European Commission. In this way, Sweden indirectly contributed a further approx. EUR 40 million.

The second programme (EDCTP2), which was launched in 2014 and runs until 2024, saw a considerable expansion of both its budget and the scope of the partnership. 17 percent of its ongoing work during EDCTP2 concerns HIV and HIV-related infections. This portfolio includes projects focusing on diagnostics, drugs, and

[11] The partnership is additionally funded by non-EU governments, non-governmental organisations (including several PDPs) and some pharmaceutical companies. These contributions are not matched.

vaccines, with drugs the most common type of intervention being investigated. EDCTP2 has a total budget of EUR 2 billion, of which EUR 175 million is provided as cash contributions by EU participating states. This includes a contribution of EUR 18.3 million by Sweden (between 2014 to 2021), making it the third largest contributor (The European & Developing Countries Clinical Trials Partnership, 2021).

According to an independent evaluation, Sida's support to EDCTP has been particularly valued for its flexibility. As it is provided into EDCTP's central funding allocation, Sida's money has enabled the continuation of EDCTP's activities at times when funding from the EC or other funders was yet to be received (Hanlin et al., 2020).

Swedish research institutes have, in turn, received grants through EDCTP's work programmes. Under EDCTP1, three Swedish institutes jointly received EUR 3.37 million (Mostert et al., 2014). Despite this bidirectional movement of funds, Sweden is a net donor to EDCTP.

7.3 Building research capacity

One of the 1999 IFFG strategy's eight guiding principles was that it should help "facilitate the development of national research and research capacity". This principle did not mark any significant change in Sweden's approach to HIV-related research. Rather, it reaffirmed Sweden's view on its importance to fighting the epidemic. The strategy furthermore emphasised the need to involve scientists from affected countries and develop national research programmes and strengthen research capacity in areas of local priority. It also provided a framework for implementation at the country, regional and multilateral levels. To support the strategy operationally, Sida developed guidelines for research support and cooperation (Sida & Swedish Ministry for Foreign Affairs, 1999a).

The focus on research capacity development and demand-led research has been visible in the continued support for the TANSWED programme. An evaluation in 2006 concluded that the support through Sida in Tanzania had facilitated direct links between the researchers and ministries to research specific societal problems and to develop solutions. The same evaluation also found that this support had helped enhance the reputation of the research institutions involved in Tanzania amongst private and public bodies (Boeren et al., 2006). A similar focus can be seen in later initiatives with national governments, research institutions and NGOs across Africa (For examples, see Box 3).

Box 3 Examples of Swedish initiatives for research capacity development

The HEARD Project 1999–2017

Sida provided core funding and additional funds to help establish a PhD programme at the University of KwaZulu-Natal, South Africa (Greaser, 2017), The Health Economics and HIV and AIDS Research Division (HEARD).

Strengthening research capacity in Zambia

A joint project supported by Sweden and Norway, that started in the early 1990s. It involved a partnership between the University of Zambia, the Central Statistical Office (CSO) of Zambia and the Centre for International Health at the University of Bergen (Michelo and Fylkesnes, 2016; Sida, 2004a). It focussed, among other things, on conducting epidemiological studies on HIV to offer insight on transmission dynamics in Zambia and trends (Michelo and Fylkesnes, 2016).

Research in Malawi and Uganda

In Malawi, Sweden supported the government with a study in 2005 to explore the impact of HIV on the economy, on livelihood and on poverty (Arrehag et al., 2006).

In Uganda, Sweden supported applied research in collaboration with The AIDS Service Organisation in Uganda (Sida, 2005).

The Swedish Regional HIV/AIDS team in Africa provided intensive support to African research networks. One example was a research

programme that promoted capacity building for applied research on the epidemic and related social science research by African scholars (Boeren, 2006). Support was provided to several regional African organisations [12] (Rath, 2006; Rath et al., 2009; Sida, 2022a; Sida, 2022; Rath, 2006). For more than ten years, Sida supported the African Journal of AIDS Research to promote research dissemination (Sida, 2005b; Sida Regional Team, 2006).

> "Sida was very, very strong in pushing on stronger capacities through research: for organisations to be learning organisations, and to do that with a discipline and a rigor that could then translate that into compelling evidence and cases for others to consider." (Development partner stakeholder 12 (global focus))

7.4 New partnerships for global health research

Around 2001, a new research and development model began to emerge in the global heath field: the Product Development Partnership (PDP) model (De Pinho Campos et al., 2011). PDPs are not-for-profit intermediary organisations to develop and market diagnostics, treatments, vaccines, and other prevention methods. The first major global health PDP to be created was the International AIDS Vaccine Initiative (IAVI), established in 1996 (UNAIDS, 2002). In the decade thereafter, several more PDPs of this kind were formed, including the International Partnership for Microbicides (IPM) which was established in 2002 (International Partnership for

[12] For example, the Council for the Development of Social Science Research in Africa (CODESRIA), which remains ongoing, the Organization for Social Science Research in Eastern and Southern Africa (OSSREA), Social Science and Medicine Network Africa (SOMA-Net), and Union for African Population Studies (UAPS).

Microbicides, 2023). Both IAVI and IPM are aimed at HIV prevention, through the development of methods that could halt infection and transmission of HIV.

The PDP model has proven popular among international development agencies for its capacity to pool resources and de-risk product development. Many donor countries have contributed significant amounts of funding to PDPs. Initially, Sweden joined other funders in channelling funding for HIV-related research to dedicated PDPs. These investments were consistent with Sweden's previously stated beliefs that vaccines could "ultimately offer the best possibility of controlling the epidemic" and that there was a role for development of "women controlled preventive methods such as vaginal microbicides". In the 1999 IFFG strategy, Sweden even declared that research in these areas should be given strategic support at the global level (Sida and Swedish Ministry for Foreign Affairs, 1999). Jointly, IAVI and IPM received SEK 82 million between 2006 and 2008 (Regeringskansliet, 2006; Policy Cures Research, 2020). However, from 2009 onwards, Sweden ceased its contributions to both IAVI and IPM (HIV Vaccines & Microbicides Resource Tracking Working Group, 2011). Sweden's withdrawal of support to IAVI and IPM can be traced, at least in part, to the restructuring of Sida and concurrent staff reduction at its research support unit, which resulted in a rationalisation of the organisations to which it contributed.

Sweden's rather short-lived investment in these HIV-focussed PDPs contrasts with that of some like-minded donors. For instance, although Norway has also gradually stepped down its contributions, it continued to support IAVI until 2015 and IPM until 2016. As of 2020, Denmark and the Netherlands were still supporting both (International AIDS Society, 2022a). The decision was further influenced by Sweden's view on the need to develop holistic research capacity. Rather than funding single-disease focussed PDPs, Sweden opted to channel resources through the European and Developing countries Clinical Trials Partnership (EDCTP).

EDCTP funds interventional trials and invests in sustainable development of the necessary research capacity to conduct such trials, regardless of disease. As such, Sweden's commitment to EDCTP is in line with its emphasis on systems strengthening and integration, seen also in other parts of the response.

> "Why microbicides and vaccines only for HIV when there are so many other needs? The same research that you do for HIV can be used for other viruses or other [diseases]. […] the support that Sweden gives makes a very big effort for diminishing verticalisation and increasing coherence between programmes." (MFA/Sida stakeholder 7)

Whilst Sweden no longer supports IAVI or IPM, it remains a key supporter of the International Vaccine Institute (IVI) (Sida, 2021). IVI was established in 2000 as an initiative of the United Nations Development Programme (UNDP). Since 2022 it has a regional office in Stockholm (IVI, 2023). The focus of IVI is more general on infectious diseases of global health importance. At present, IVI does not conduct research on a possible HIV vaccine.

Sweden also supported the African Aids Vaccine Programme, a network of African scientists and stakeholders formed to "promote the development of and future access to HIV vaccines suitable for use in Africa" through research, advocacy, partnership, capacity strengthening and policy development. The programme was created in 2000 with support from WHO and UNAIDS. (Kaleebu et al., 2008; Sida, 2006a).

Sida's current work on research and innovation includes continued support for vaccine development through IVI and support for the Social Innovation in Health Initiative, which works on issues of maternal and child health (Sida, 2021. As in the previous period, however, there is no longer an explicit prioritisation of research and innovation in the fields of HIV or SRHR.

8 Main features of the Swedish HIV response

The previous chapters have already given some glimpses into Sweden's policy priorities within the HIV response, and how it has aligned with or differed from those in the global response, but it is worthwhile delving deeper into the principles that have consistently underpinned the Swedish response. This chapter outlines the main features that have characterised the Swedish approach over time.

8.1 A rights-based approach to HIV and AIDS

A core principle of Sweden's HIV approach is the emphasis on supporting continued democratic developments and increasing respect for human rights in target countries. This support has mainly been channelled through civil society organisations (Kruse, 2016). In 2004, the regional team initiated a collaboration with the AIDS and Rights Alliance of Southern Africa (ARASA) to promote a human rights-based response to HIV. Other examples of this thematic focus include the support to the AIDS Legal Network (A. Nilsson et al., 2013) and the Institute for Democracy in South Africa (Idasa) for projects on the effects of HIV on electoral processes (Embassy of Sweden Lusaka, 2006). In India, support to the Lawyers Collective involved the promotion of human rights and fighting stigma and discrimination related to HIV through capacity building of different legal actors and the empowerment of communities to respond to HIV and seek legal service (Sida, 2006b).

The protection of human rights, and particularly those of marginalised and vulnerable populations, has been a cornerstone in all areas of Swedish development cooperation, including in the HIV response. This focus has been evident not only in Sweden's policies

for regional and bilateral cooperation, but also in the advocacy role it has played at the multilateral level (Botman, 2003; Sida and the Ministry for Foreign Affairs, 2002; Sida & Swedish Ministry for Foreign Affairs, 2004; Sida & Swedish Ministry for Foreign Affairs, 1999a; Swedish Government Offices, 2019; Vylder, 1999, 2001). The strong focus on rights was echoed by all stakeholders interviewed in this study.

> "Human rights have been very big for them [Sweden], and it has remained quite central to most of the grants that they have been supporting in terms of addressing legal bottlenecks, criminalisation and so forth. […] Human rights are cross-cutting, but I think issues of democracy and governance have also been important for them." (Implementing partner 5, CSO focussed on sub-Saharan Africa)

One area where this focus on protecting vulnerable populations has been visible is in Sweden's large-scale support to orphans and vulnerable children (OVC) in high-prevalence countries. Sweden has, for example, funded efforts to facilitate school attendance and provide psycho-social support (Sida and Swedish Ministry for Foreign Affairs, 1999). Sweden has also been a consistent donor to the United Nation's Children's Fund (UNICEF) and has worked extensively with locally based organisations[13] that focus on OVC and young people (UNICEF, 2016, 2021; Sida, 2006b). The Sida HIV regional team has furthermore worked with the Regional Psychosocial Support Initiative to strengthen capacity of organisations in psychosocial support programming and with Hope for African Children Initiative to provide technical, management, programmatic and financial support to alliances and networks that assist OVC (Sida, 2005a).

[13] For instance: Frontline AIDS, RUDO's Village Based Support for HIV/AIDS and Catholic Relief Services Zimbabwe (CRS/ZW).

In cooperation with the International Organisation for Migration (IOM), Sida has also paid attention to enhancing health rights and conditions for migrant workers and refugees, groups that are among those most vulnerable to HIV infection (Embassy of Sweden Lusaka, 2006). The regional team has supported initiatives in southern Africa focussed on prevention and impact mitigation in vulnerable communities along main transport routes.

Whilst Sweden has focussed primarily on LMIC countries, it has also financed programmes involving vulnerable populations in upper-middle income countries. For instance, recognising that the combination of overcrowded spaces, widespread HIV infection, and injecting drug use increases the spread of HIV, Sweden was among the first donors to focus on prisons. A large programme financed by Sida, implemented by AIDS Foundation East West (in cooperation with the Russian Ministry of Justice, focussed on developing HIV-centric training curricula for medical, psychological, security and training staff in Russian prisons (Sida, 2006b).

Sweden has also advocated for The Global Fund to increase its investments in actively ensuring that LGBTQI+ people, who are among the most discriminated against groups, can enjoy their human rights (Swedish Government Offices, 2019).

8.1.1 Domestic policies on persons who inject drugs and sex work may have influenced the Swedish aid response

Some interviewees have highlighted that, within the Swedish priorities on HIV prevention, there has been relatively little focus on activities directed at people who inject drugs (PWID) and on sex workers, despite these being key populations with high vulnerability to HIV. With regards to harm reduction and people who inject drugs, only activities geared towards reduction of demand for illicit drugs were directly supported (Sida, 2000). This aligned with

Swedish national drug policies, which focussed largely on the attainment of a drug-free world and strengthening of the police in drug control models instead of on preventive measures and treatment. Provision of harm reduction measures was not prioritised, neither domestically nor abroad, although a needle- and syringe exchange programme was introduced in Sweden in 1986 (Lenke & Olsson, 2016; Karlsson et al, 2021). Over time more support for a needle and syringe exchange programme in Sweden came about evidenced by a revision of the needle and syringe exchange programme law in 2017. However, this revised law goes hand in hand with the continued restrictive view on drugs (Karlsson et al, 2021).

With regards to sex workers, Sweden has not had a liberal permissive approach to transactional sex. It effectively views sex work as a choice that is not made freely and therefore considers sex workers in need of protection from the practice (Levy, 2015). This has resulted in criminalising sex purchases, whilst decriminalising the selling (Waltman, 2011). Still, sex work is considered abuse and therefore to be discouraged. This perspective has made the issue somewhat sensitive and has meant that Sweden has refrained from supporting actions that could be considered as enabling sex work. Both Swedish and non-Swedish interviewees have suggested that this position has resulted in lost opportunities for the prevention agenda.

> "Sweden, given their national policies with some of the elements of key populations, always had a hard time. They were fine and strong on LGBTQ populations, but on sex workers and people injecting drugs, they have always been in a much more difficult position given their domestic policies. […] I think they missed an opportunity to have more influence there because of their national policies being so restrictive." (Development partner stakeholder 14, Global Focus)

For instance, in 2012 Sida came under heavy fire from Swedish women's rights organisations and politicians about providing funding to Mama Cash[14], as the organisation advocates for the rights of sex workers. In Sweden, this was seen as supporting sex work (Scaramuzzino & Scaramuzzino, 2018). In response to questions in parliament, Sida stated that it would not cooperate with the organisation on any activities regarding prostitution or "advocacy work around 'sex workers'"[15] and that in their agreement, there was a clause prohibiting the Swedish contribution from being used for the decriminalisation of sex purchases (Global Network of Sex Work Projects, 2015).

Stakeholders interviewed confirmed that, whilst domestic policies prevented Sweden from actively supporting harm reduction strategies or activities aimed at sex workers, it never opposed initiatives in this area at the multilateral level. Instead, the Swedish global response took a rather pragmatic approach: it largely refrained from participating in discussions on these issues and Swedish support to multilateral organisations was never earmarked to exclude these activities from being funded. For instance, Sweden has not opposed funding from The Global Fund from being used for setting up mobile clinics for sex workers.

> "They wouldn't oppose harm reduction but were also not the biggest promotors of that." (Development partner stakeholder 6, Global focus)

8.1.2 Fighting stigma and discrimination

Because of the association of HIV with sexual transmission, marginalised populations and death, the HIV epidemic has a history

[14] An international women's fund based in The Netherlands, supporting the rights of women, girls and trans persons.
[15] Sweden has resisted the labelling of prostitution as "commercial sex work".

of widespread discrimination, stigma, and denial. This is commonly acknowledged to be a key obstacle to successful HIV prevention and care. For instance, in Africa, in the past, preventive therapies were not made more widely available because it was assumed people living with HIV might not want to use these for fear of being stigmatised (Brown et al., 2017; Merson et al., 2008). It is also acknowledged that stigma and discrimination are very persistent and challenging to change (Viiv Healthcare, 2020).

Sweden has supported stigma and discrimination reduction interventions in its international development cooperation. For instance, the International Federation of Red Cross and Red Crescent Societies has received Swedish funding to, among other things, fight stigma and discrimination in Southern Africa and South Asia (Sida, 2006b)(Sida, 2007a).

8.2 Progressive approach to HIV prevention

It can be argued that Sweden had a progressive approach to HIV prevention in different ways. Sweden's HIV response has been characterised by a progressive attitude towards sexual and reproductive rights. This position has at times placed Sweden at odds with other countries, where issues around sex, gender and sexual orientation are viewed differently.

By drawing attention to structural factors like poverty, gender inequality and discrimination that underlie a person's risk of being infected with HIV, Sweden helped pave the way for the 'Combination Prevention Approach' (CPA) that UNAIDS introduced in 2010. This approach acknowledges the complex challenges when addressing prevention, and the need to address specific, but diverse needs of key populations with high vulnerability to HIV at different levels (e.g., individual, community, societal) (UNAIDS, 2010).

8.2.1 Sweden´s progressive attitude towards SRHR

Sweden has used the SRHR framework to address HIV and was early in doing so. Linking HIV and SRHR can lead to more consistent condom use, better HIV testing outcomes, improved quality of care, a potential for better use of scarce human resources and for reduction of HIV-related discrimination and stigma. Moreover, HIV and SRHR linkages may improve access to, coverage and uptake of better HIV and SRHR services for key populations (Hopkins & Collins, 2017).

Sweden has played a pioneering role in the area sexual and reproductive health and rights. In 1992, the first Swedish position paper on sexual and reproductive health (SRH) was published, which encompassed the idea of an integrated and coordinated action plan to prevent unintended pregnancies and make abortions safer with measures to prevent HIV and other sexually transmitted diseases (Swedish Government Offices, 2013).

At the 1994 International Conference on Population and Development, Sweden was advocating for prevention of HIV transmission, in the face of opposition from some countries that were uncomfortable with the introduction of some prevention and family planning tools, particularly condom use (Swedish Government Offices, 2013). Sida's SRH Action Plan had been published only months before the conference and the event would serve as a platform to launch actions within the international HIV response (Geisler et al., 2004). While the Action Plan focussed on SRH in general, control of sexually transmitted diseases, including HIV, was presented as a priority area for Swedish development aid. It also highlighted Sida's commitment to the promotion of research and development (R&D) related to HIV prevention (Sida, 1994).

In 1997, Sida's "Strategy for Development Cooperation – Sexual and Reproductive Health and Rights" (SRHR) was launched. This included the second "R", making Sida a frontrunner in including the concept of sexual and reproductive *rights*. Eight sub-areas were prioritised in the strategy, one of them being HIV and other sexually transmitted infections. These priorities were soon integrated into several Sida policy documents, including a handbook on gender equality and health, the 1999 IFFG strategy, and strategies guiding the work in other countries and with UN organisations (Sida & Swedish Ministry for Foreign Affairs, 1999a). In the 1999 IFFG strategy, reduction of HIV transmission through prevention was listed as the number one priority and as the strategic goal of Sweden's global HIV response. The strategy set two main directions for prevention; 1) Enabling people to protect themselves against HIV through and 2) Encouraging greater political commitment to HIV prevention programmes. The first direction highlighted greater acceptance of safer sexual behaviours, especially among youth, with a focus on gender equality, as well as the provision of condoms and other forms of protection. (Sida and Swedish Ministry for Foreign Affairs, 1999)

In 2006, Sida increased its support to the International Planned Parenthood Federation (IPPF) to continue working for a comprehensive prevention agenda where SRHR and HIV are integrated (Sida, 2006b).

In 2008, the IFFG strategy was complemented by a newly formulated "*The Right to a Future*" policy (Government Offices of Sweden, 2008). It called prevention a crucial component of an effective global HIV response and focussed on the prevention of transmission by strengthening the response to human rights and increasing gender equality. Priority areas including promoting access to information about HIV and SRHR, access to contraception, non-discriminatory legislation, and support for democratic processes were identified.

Much of Sweden's support to civil society and advocacy groups has had the strategic goal of reducing the HIV prevalence and incidence through providing information on HIV prevention. Stakeholders interviewed for this study acknowledged that this approach to prevention still holds true until today, especially in relation to vulnerable groups such as LGBTQ or through efforts on comprehensive sexuality education.

During the early 2000s, when the global discourse became intensely focussed on the scale-up and roll-out of ART in high-prevalence countries, Sida used its multilateral engagement to strongly push for keeping prevention high on the global agenda.

> "Of course, prevention, prevention, prevention. […]. Depending also on what the priorities were on the other side of the Atlantic. It was more of a struggle when they were more focusing on the treatment agenda. We did what we could to ensure that prevention was not forgotten and ensured that it also received financing." (MFA/Sida stakeholder 9)

In 2014, Sweden became the first country to adopt a Feminist Foreign Policy, with SRHR as one of its six focus areas. This reinforced Sweden's international engagement in normative progress, in preserving agreements in the area and in preventing the undermining of SRHR, while advocating for effective financial support for the implementation of SRHR initiatives at the global, regional and country levels (Government Offices of Sweden, 2019). Although the policy was retracted in 2022, the commitment to SRHR as a priority area in Swedish development cooperation has remained.

Throughout the past four decades, the Swedish HIV response has emphasised the role of prevention (Government Offices of Sweden, 2015; Sida, 2005b; Sida & Swedish Ministry for Foreign Affairs, 1999a; Vogel et al., 2005). The Swedish approach to prevention has

been controversial to some. For instance, whilst Sweden advocated for sexuality education and distribution of protection methods for young people, Sweden faced opposition by countries who only accepted abstinence-only interventions. Various stakeholders confirmed that, when direct engagement with governments and public authorities on such issues was not possible, Sweden would regularly opt to work with civil society organisations instead. Sweden has faced considerable obstruction, when trying to get specific prevention issues on the global agenda, (Sida & Swedish Ministry for Foreign Affairs, 1999a; Swedish Government Offices, 2013). Sweden's attempts to raise issues related to sexual matters in international fora have regularly been voted down.

8.2.2 Holistic approach and strengthening health systems

In its 'HIV prevention 2025 road map', UNAIDS stated that countries that have directed their resources towards high-impact combination HIV prevention programmes have been most successful (UNAIDS, 2022a). The WHO Global Health Sector Strategy on HIV 2022–2030 also stresses that comprehensive prevention packages, including "biomedical, behavioural and structural interventions" are needed (World Health Organization, 2022). Studies have furthermore suggested that poverty alleviation can be one of the most powerful interventions in fighting HIV (Kalichman, 2023). Sweden's early leadership in this area has been widely recognised by stakeholders.

> "Sida was ahead, looking at determinants and gaps in addressing these. […] Instead of looking at HIV services, testing and PrEP, [we should be] looking at drivers of the epidemic and addressing those." (Development partner stakeholder 15, based in Zimbabwe)

Bilateral and regional programmes have been Sweden's main vehicles for funding structural prevention interventions. However, since the introduction of the Combination Prevention Approach (CPA), multilateral organisations including The Global Fund have also actively been funding combination prevention programmes (Swedish Government Offices, 2019; The Global Fund, 2022; UNAIDS, 2022b). Thus, at all levels of the response, Sweden has been contributing to the implementation of structural and comprehensive prevention activities that, based on available evidence, are considered highly effective.

Sweden's support for structural interventions has also helped to fill a gap in the funding landscape. Key stakeholders have described that even after the introduction of CPA, many other donors remain more eager to fund biomedical interventions, rather than structural HIV prevention interventions.

Early on, Sweden recognised that people affected by HIV have fewer opportunities to participate in economic processes and that the subsequent loss of income, as well as increasing healthcare related costs, can push affected people and their families deeper into poverty (Sida & Swedish Ministry for Foreign Affairs, 1999a). Poverty, in turn, can result in behaviours that increase the risk of contracting HIV, creating a vicious cycle. It has been argued that HIV has posed a unique threat to humankind in that its economic impact has been greater than that of other diseases, because of its incurability and surrounding stigma (Durevall & de Vylder, 2006).

In the 1999 IFFG strategy, Sweden reaffirmed the notion that HIV was not simply a health problem but had to be addressed from multiple angles and in multiple sectors. This included a focus on poverty reduction and on addressing the consequences of HIV in countries with a high HIV prevalence. In 2000, the global community, including Sweden, prioritised LMIC and scaled up prevention programmes (Björk, 2019).

Sweden has long recognised the importance of strong health systems for the effective and efficient delivery of healthcare to all people, including those living with HIV. Although health systems strengthening (HSS) was not explicitly referred to in official policy documents prior to 2012, Sweden had already been implementing programmes related to the health system building blocks.[16]

The need for HSS as part of the HIV response was explicitly mentioned for the first time in Sweden's policies, programmes, and projects in 2012. This coincided with a growing call in the donor community for improving the integration of HIV (see section 3.4). From then on, more explicit HSS initiatives were funded, including on health financing, migrant health systems and health economics research capacity for HIV.

Stakeholders interviewed strongly favoured Sida's focus on HSS.

> "If you don't build a system and an emergency strikes, you are done. […] Verticalising doesn't solve the problem: it only lets you get the low hanging fruit. Strengthening systems is more important." (Development partner stakeholder 17, based in Zimbabwe)

Further investments in HSS were made as part of broader SRHR programmes that included HIV. An example of this was the bilateral support provided to Zambia between 2015–2020 for the '*Improved health for women, children and adolescents*' programme. One of the programme's stated objectives was strengthening of health system capacity to enable effective delivery of reproductive, maternal, neonatal, child and adolescent health services at national level and in two target provinces (Embassy of Sweden, 2022).

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[16] The health system "building blocks" refer to a framework developed by the World Health Organisation that aims to contribute to the strengthening of health systems in different ways. The six building blocks are: service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership and governance (WHO, 2010)

Sweden has also pushed for attention to HSS within The Global Fund. Initially, this was met with some resistance from other countries but, from 2007 onwards, the Fund began to address strategic support to HSS more prominently. In 2008, it opened a call for stand-alone HSS grants. The experience was not entirely positive and the approach was not continued in that form, but Sweden continued to advocate within the Global Fund for allocating funds to HSS activities in recipient countries (Weber, 2011).

> "We have always pushed the Global Fund to view HIV as something broader than an illness, to consider systems and rights and the need for Health Systems Strengthening. […] Even in The Global Fund, the fight for a broader perspective was not always that easy, there was a tendency to think along lines of those 3 diseases." (MFA/Sida stakeholder 6)

Sweden's comprehensive approach to HIV has stood in clear contrast, particularly at the start of the epidemic, to that of several other donors who were more commodity-driven and often neglected addressing structural factors. This also meant that Sweden was more willing to fund complex interventions, even when their impact was hard to measure.

> "With Swedish support, we were able to do more around the high-level issues, around advocacy, around things that may not directly or immediately result in countable input [but that] take away barriers to cultural norms, harmful practices. [These issues can be] sometimes difficult to argue [for] when running after delivery and disbursement linked indicators all the time." (Development partner stakeholder 16, based in Zimbabwe)

8.2.3 Mainstreaming and integration

In parallel to the 1999 IFFG strategy, Sida's Health Division issued a paper calling for increased 'mainstreaming' of HIV prevention across the different areas of Sida's development aid. In 2003, Sida produced a manual on incorporating HIV prevention in all of Sida's activities and sectors. This was part of an approach to integrate HIV prevention into a macroeconomic and sectoral policy of Swedish development aid. It targeted all projects directed at the alleviation of poverty and the improvement of infrastructure in countries where Sweden was engaged in development cooperation, virtually making HIV prevention a central theme not only for Sida's Department of Health but in all other parts of the organisation (Uggla, 2007).

In 2006, Sida published a paper that called for all aspects of their HIV response in high-prevalence countries to be reflected and by focussing on all people (Sida, 2006b). In low-prevalence countries, however, Sida stated that priority should be given to prevention within SRHR, with an emphasis on young people. It was felt that, to reach as many people as possible with prevention interventions, it would be imperative to increase linkages between the SRHR and HIV agendas. Mainstreaming HIV prevention continued to be a strategic priority for Sida's regional team in Africa (Embassy of Sweden Lusaka, 2006).

In recent years, the Swedish focus on HIV prevention has been succeeded by a more holistic integration of HIV prevention into the SRHR agenda. As highlighted by several of Sida's global and regional strategies, gender equality and SRHR are now key priorities for Sweden's international development cooperation. SRHR is prioritised at all levels of official development assistance in addition to being primarily covered under Sida's thematic area of health equity (Kågesten et al., 2021). The Swedish SRHR support includes multiple interconnected areas, including a focus on prevention of HIV via strengthened capacity and resource allocation. Moreover, provision of SRHR services is seen by the Swedish government as the number one tool for HIV prevention.

Sweden's current SRHR strategy for Africa 2022–2026 builds on its Regional SRHR Strategy for Development Cooperation 2015–2019. This emphasised how Sweden's work around HIV integration should contribute to increased respect for and enjoyment of SRHR for all. It also focused on social norms and values that promote SRHR, as well as on increased accountability for SRHR (Regeringskansliet, 2022).

Some stakeholders indicated that the Swedish focus on prevention, especially when paired with SRHR components, has been particularly valuable during the period of the Mexico City Policy.[17]

> "Sida really helped us when we decided not to sign the Mexico City policy. Under [U.S. President] Trump, the situation was quite severe. [...] they provided more funding to help us through." (Implementing partner stakeholder 4, focussed on sub-Saharan Africa)

8.3 Evidence-based interventions

Over the years, interventions have become more and more informed by the best possible evidence of what works best to effectively address HIV both in high prevalence countries (mostly sub-Sharan African countries) and in concentrated epidemic settings. UNAIDS has played a major role in gathering this evidence and translating it into crucial guidance for effective approaches. As a critical yet steadfast supporter of UNAIDS, Sweden has contributed to these global efforts to increase the evidence base for designing impactful approaches to the HIV epidemic.

[17] The Mexico City Policy, a USA policy, required foreign NGOs to agree that they would not perform or promote abortion as a family planning method (including with funding from non-USA sources) as a condition to obtaining funding for family planning interventions from the USA. Under the Trump administration, this condition was extended to funding for most other health interventions.

Additionally, Sweden has used its bilateral development assistance and programmes for research cooperation to directly support the generation of such evidence. The use of formal evidence, as well as of contextual insight from affected countries by having presence in the region, has been said to have benefited Sida's response.

> "Sida had a very comprehensive and good total view of what was required in the HIV response and was much more sensitive to the call for better understanding of what was driving this epidemic or these epidemics: how are they differentiated in different contexts, why and what needs to be done, [and of] what are the policy and other implications of that." (Development partner stakeholder 12, global focus, previously sub-Saharan Africa focus)

8.3.1 Sweden initially slow in realising the feasibility of rolling out HAART

Before ARTs were developed, Sweden's support to care and treatment for HIV mainly focused on the development of social support systems for people living with HIV and their families, addressing stigma and care and supporting treatment of opportunistic infections. This aligned with Sida's broader policies for development cooperation in the health sector and on poverty reduction (Sida, 1997; Sida & Swedish Ministry for Foreign Affairs, 1999a). The 1999 IFFG strategy aimed at working towards "enabling people infected and affected by HIV/ AIDS to pursue their lives with quality and dignity". When HAART was introduced in the mid-1990s, Sweden did not initially consider large-scale introduction in LMIC feasible. Instead, Sweden called for more research and negotiations to find new and cost-effective ways to provide treatment to people living with HIV (Sida and Swedish Ministry for Foreign Affairs, 1999). The same position was taken in the IFFG

Strategy. Sida saw its role as supporting the review of laws, policies and guidelines to accommodate ART and opportunistic infections treatment and to commission analytical and systematic studies (SODECO – Social Development Consultants, 2002). This position put Sweden somewhat out of step with other donors in the global HIV response.

> "Sida would maintain we first need to build systems before we can roll out treatment. […] I remember the Swedish AIDS ambassador, being involved in all these international discussions, speaking with people at the country level in countries in sub-Saharan Africa who no longer accepted that they would not have access to treatment. He was in that difficult position where part of the system did not support [roll-out of] treatment in sub-Saharan Africa. (Development partner stakeholder 14, Global focus).

With funding from Sida, the Karolinska Institutet led various studies to test different types of antiretroviral treatments for PMTCT and study the effects of combining two types of ARTs and the relationship between breastfeeding and ART (Egerö et al., 2003; Sida, 2004a). Several of these stressed the urgency of enhancing ART roll-out in low-income countries to address the growing inequity gap and the related rights violation causing millions of people who could have been on ART to die prematurely (Sida & Swedish Ministry for Foreign Affairs, 2004; Sida/UNRISD, 2002; Geisler et al., 2004).

Around 2004, Sida shifted its position on the feasibility of large-scale ART roll-out in LMIC. In policy documents it began mentioning how it was contributing to directly making ART accessible, mostly through its multilateral engagement. In its 2004 strategy, Sida emphasised how Sweden's contributions to UNAIDS and WHO but also to UNFPA and UNICEF, were supporting the '3 by 5 Initiative' to roll-out ART, negotiate price reductions and develop guidelines for HIV treatment in resource limited settings (Sida, 2005c) (Sida &

Swedish Ministry for Foreign Affairs, 2004; Sida, 2005f). Especially through UNICEF, support was provided to ART roll-out within PMTCT interventions (Urwitz & Nyman, 2002).

Bilaterally, Sweden also started to directly support increased access to ART. For instance, in 2004, Sida entered into an agreement with Tanzania to support its National Care and Treatment plan for HIV (Sida, 2005a). It was Sida's first ever supported national programme where ART was included (Sida, 2005b). Alongside this, Sida supported the TANSWED HIV programme with assessing laboratory tests and tailormade testing strategies as a basic requirement for ART (Sida, 2004a). In 2007, Sida reported that this programme had helped make care services available to 103,000 patients and treatment to 490,000 people with HIV (Sida, 2007).

To facilitate ART roll-out a range of health systems strengthening activities were funded. These included training of health staff and technicians, strengthening of laboratories, development of policies on the supply and use of antiretroviral treatments, development of guidelines on PMTCT and creation of stronger linkages between health services and civil society (Arrehag & Sjöblom, 2005).

Meanwhile, Sida continued its support for legal changes and advocacy to help create an enabling environment for ART scale-up. It, for instance, supported the AIDS Law project, which successfully negotiated better access to ART throughout sub-Saharan Africa on behalf of the Treatment Action Campaign and 12 other organisations (Chigudu & Gerntholtz, 2006; Marock, 2007; Sida & Swedish Ministry for Foreign Affairs, 2004).

Sweden continued to advocate for prevention to remain the cornerstone of the HIV response and that there was a need "to balance investment in treatment with investment in HIV prevention" (Sida & Swedish Ministry for Foreign Affairs, 2004). In 2005, the HIV/AIDS secretariat began differentiating between high- and low-HIV prevalence countries (Sida, 2005b). While the first group would receive a combination of treatment and prevention

support, the focus in low-prevalence countries would be on HIV prevention as part of SRHR. It justified this with the estimation that approximately only 11 percent of those in need in sub-Saharan Africa were receiving ART and called for increased commitment to support these activities (Sida, 2005b). Sida continued to stress the need to not define treatment too narrowly and argued that a stronger focus on livelihood vulnerabilities, as well as stigma and discrimination reduction, which all affect treatment outcomes was needed.

Over the years, Sida has supported a range of activities to complement ART in high-HIV prevalence countries, such as by strengthening home-based care through community based HIV-service providers, improving food consumption to facilitate ART intake, promoting uptake of and adherence to ART, improving treatment literacy, making ART more available for children, strengthening social support systems for people living with HIV, strengthening psychosocial support, especially for children, and combatting stigma and discrimination (Machawira & Moyo, 2007).

8.4 "A small fish in a big pond"

While the Swedish contribution to the HIV response has been significant, compared to that of, for instance, the United States it has naturally been relatively small. Also, the number of staff at Sida has been small compared to that of other donor agencies. A 2005 evaluation already flagged Sida's limited staff capacity as its biggest bottleneck, something that has been confirmed as a persisting problem by several stakeholders (Vogel et al., 2005).

Considering Sweden's size, it has been a challenge to live up to the ambitions and wide engagement in the HIV response, with limitation related to human resources. One way of dealing with this has been to channel much of Swedish development cooperation through multilateral channels rather than through bilateral programmes, which require more management capacity at Sida.

In the international policy arena, being "a small fish" can make it harder to be influential.

> "[The Americans …] are so big in themselves. So, they have their own bilateral programmes and they know exactly how to use the multilaterals. That creates conflicts within the Global Fund and it creates conflicts between different constituencies and also an imbalance as some are more equal than others. […] I think for the Swedes now […] they do struggle with it: they are not recognised because they are still too few." (MFA/Sida stakeholder 11)

Nonetheless, Sweden seems to have been successful in leveraging its influence in policy discussions, thanks in large part to its strong reputation as a knowledgeable and reliable partner, as confirmed by stakeholders interviewed.

9 Concluding remarks

Some aspects of the HIV epidemic have been unique. For example, HIV is foremost sexually transmitted, which adds high levels of stigma and discrimination, particularly in cultures where sexuality – and homosexuality specifically – is taboo. This has increased the need for culturally sensitive interventions. This has also required attention to be paid to social and legal contexts that exclude people from claiming their rights and accessing services.

Another factor is the epidemiological characteristics of the HIV virus. HIV has a very long incubation time, so it usually takes a long time before people realise that they are infected. This created a different dynamic in comparison with, for instance, the COVID-19 or the Ebola outbreak, which became visible much quicker, enabling the development of effective measures to prevent infection or transmission (e.g. vaccination or isolation of affected persons). Also due to the characteristics of the virus, there is to date no effective vaccination against HIV on the.[18]

The Swedish HIV response must be understood and viewed against the specific background of the disease as well as the context of its time. Nonetheless, the Swedish HIV response offers valuable insights for future international aid responses to health crises or emergencies.

Even though all health crises are unique, there are also common features. Sweden's general approach to acknowledge and address underlying determinants of disease and health is relevant, both as part of epidemic preparedness and for other health threats, as well as for a sustainable societal development in general. Many of the identified strengths and lessons learnt can be transferred to other contexts. A system thinking, strong leadership, consistency, reliance

[18] https://www.gavi.org/vaccineswork/how-close-are-we-workable-hiv-vaccine?gclid=CjwKCAiAx_GqBhBQEiwAlDNAZp-M0EWJj2Tm-fV_6TSGePOnPt9fU9JRUhxyGfYGOVblLCBTGQ-9LBoC0PcQAvD_BwE

on evidence, strong partnerships and country ownership all are qualities that are likely to benefit any type of crisis response.

Swedish global health aid in general as of today is largely focused on two areas: health systems strengthening and SRHR. This is a result of Swedish priorities, and to some extent also a result of knowledge gained through the HIV response.

The comprehensive approach to HIV has also meant that Sweden was more willing to fund complex HIV-interventions, even though the impact of such interventions is more difficult to measure and evaluate. Sweden's willingness to look beyond short-term gains and quantifiable results has allowed the country to position its response in the broader context of fighting inequality and protecting human rights. This approach has been widely appreciated and may be considered a key enabling factor behind Sweden's ability to deliver an impactful response.

Sweden has focused strongly on health systems strengthening, on addressing underlying determinants of health, and on risk factors for HIV contraction as part of its response. During the recent COVID-19 pandemic, the need for strong systems to deliver essential health services effectively and efficiently in emergency conditions, and a comprehensive approach to disease prevention and response were underscored. As part of the pandemic response, Sida and the Ministry for Foreign Affairs supported several activities directed at health systems strengthening and essential health care. The EBA report "Swedish aid in the time of the pandemic" (Schwensen et al., 2022),[19] finds that Sweden "played an important role in keeping a holistic view of the support to the health sector" during the pandemic.

When HIV was new, there was a strong vertical focus on HIV, and probably rightly so. Later however, this narrow, disease specific approach was criticised and revised, in favour of a more horizontal

[19] https://eba.se/en/reports/eba-reports/swedish-aid-in-the-time-of-the-pandemic-2/19663/

approach to disease prevention and response. Some reflections on the trade-offs associated with these different approaches are needed, related to vertical vs. horizontal programmes. In recent years, HIV has largely been integrated in the SRHR portfolio – but is SRHR becoming another silo? SRHR and health systems strengthening are often addressed and reported separately in Swedish aid policies, strategies, and programmes, as for example in the annual report on health aid[20]. Many issues within the SRHR frame are sensitive and controversial, requiring earmarked funding and "champions". There is even concern today that HIV is becoming a "neglected disease", though it is not classified as such. Sweden´s strong position as an SRHR champion, with a progressive stance and a strong rights-based approach to SRHR and health in general, has been a key element of the HIV response. One lesson from the Swedish HIV response could be that these two areas – health systems strengthening and SRHR – benefit from being addressed jointly, as they reinforce each other. A conclusion might be that there is a need for broad, horizontal approaches, but in parallel, there is also a continued need for vertical activities in areas that are either emerging, neglected or threatened because of shrinking democratic space or violation of rights.

Finally, the report shows that, despite having been a relatively small actor in the global HIV response, Sweden has had an influence beyond its financial contributions. Sweden has, both in the global arena and in its interactions with regional and local development partners, played the role of strategic influencer and knowledge broker. Sweden has managed to add value through its continued support to regional institutions, which has provided significant political capital. Through this, Sweden helped create political pressure at the regional level, which could be leveraged against countries where national responses had waned (Jones and Hellevik, 2012).

[20] Sveriges hälsobistånd 2022

Several factors have played a role for Swedish influence, as demonstrated in the report. Influential individuals in key positions were able to help shape global policies and strategies, due in large part to their personal commitment, technical knowledge, strong networks, and ability to navigate bureaucratic and diplomatic processes. For a small country to be influential at the international level, there is a need for national expertise in global health. Having skilled and experienced experts and diplomats with both thematic knowledge and knowledge of the global aid architecture has been instrumental for Sweden's leadership and influence the global HIV response.

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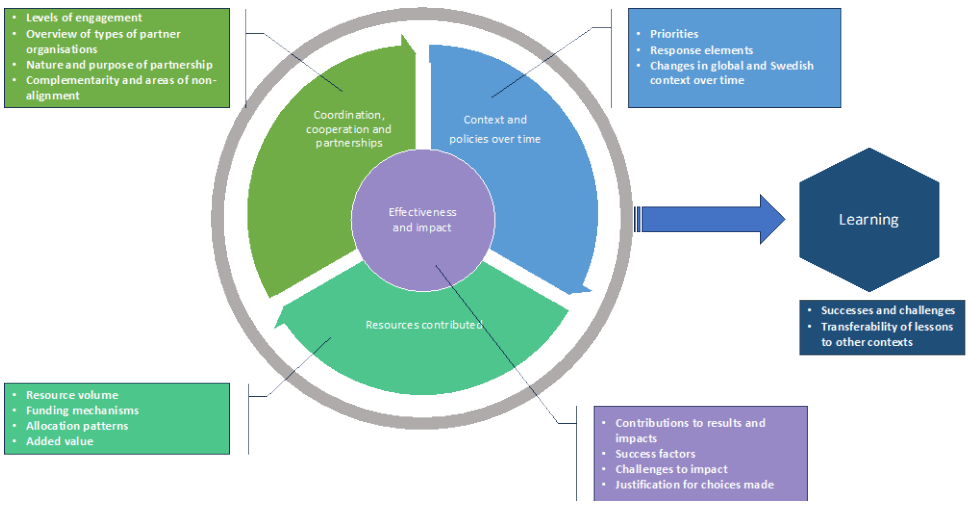
Appendix A Methodology

A.1 Study framework

The uniquely long period covered in this report allows for findings to be considered in the broader context of Swedish development cooperation and global developments over time. Based on the objectives of the study and informed by document review and scoping interviews, the research team developed a study framework that guided the data collection and structure of this report.

Figure A1 Study framework



A.2 Desk study

A review of documents and literature published since the 1980s in English or Swedish was conducted. The following data sources were consulted:

- Sida website: "Publications on development cooperation"[21] (Sida, 2023)
- Google / Google scholar
- PubMed

Searches were conducted using strings of key terms, with the syntax adapted as needed to each source. The main string, developed for PubMed, was as follows:

> (HIV OR HIV/AIDS OR AIDS) AND (Sweden OR Sida OR Swed* OR global) AND (priorit* OR focus areas OR strategy OR intervention* OR response OR mainstream* OR approach* OR policy OR prevention OR treatment OR care OR support OR impact mitigation OR research OR health system* OR gender OR "human rights" OR equity OR pledges OR SEK OR resources OR "development partner* OR cooperation* OR UNAIDS OR "Global Fund" OR "regional programme" OR Zimbabwe OR evaluation* OR effective* OR impact OR lessons learn* OR "added value")

Around 190 documents were initially identified. A further targeted search was done to fill potential data gaps. This yielded over 250 additional information sources. In total, 446 relevant sources were reviewed (**Fel! Hittar inte referenskälla.**). A high-level framework, derived from the evaluation questions, was used to code all relevant

[21] https://www.sida.se/en/publications/?term=&page=1&sortBy=score

document. The coded information was analysed and synthesized into a description of the Swedish response over time.

Table A1 Overview of documents in the desk review

Type of document	1979–1989	1990–1999	2000–2009	2010–2022	Total
Policies, strategies		3	7	16	**26**
Evaluations, studies		4	84	65	**153**
Budgets/plans/reports	10	11	40	27	**88**
Journal articles	3	7	38	51	**99**
Websites/newspapers		2	13	65	**80**
Total	**13**	**27**	**182**	**224**	**446**

A.3 Scoping discussions

To rapidly gain insight into the composition and focus of the Swedish response, its added value, and its strengths and challenges, as well as to discuss possible angles for analysis, a set of 7 scoping discussions was done (6 Swedish individuals; 1 non-Swedish). Interviewees were identified with inputs from the EBA and members of the Reference Group. Interviewees had typically fulfilled multiple, often influential, roles within the HIV response at different times.

The scoping interviews were conducted as open, in-depth interviews to allow maximum flexibility to explore issues. Interviews were recorded and transcribed. All transcripts were coded and analysed in line with the evaluation framework. Findings from initial interviews were fed back into subsequent interviews to further explore, verify and complement these.

A.4 Case studies

A.4.1 Selection of cases

Sweden's contributions to the global HIV response have been channelled through a combination of bilateral, regional and multilateral support, aiming to achieve a balance between acting directly on Sweden's own policy priorities (through bilateral and regional initiatives) and supporting the wider global response (through multilateral support). The different levels of support are complementary, but each serve their own purposes within Sweden's HIV response and, as such, can offer a distinct set of lessons. Therefore, these three levels were used as the basis for the selection of the cases. Specific case selection within these levels was done on the basis of:

- Importance of the case within the overall context of the response
- Availability of documentation and other supporting data
- Access to key informants (including willingness to participate)
- Particular points of interest for learning

The following three cases were selected:

1. **Swedish multilateral engagement with The Global Fund.** The Global Fund to fight against HIV, Tuberculosis and Malaria (hereafter: The Global Fund) is an international partnership, created in 2002 to help affected countries fund and implement responses against the three diseases. It has since become the main funding instrument in the global fight against HIV. During scoping interviews, several interviewees suggested that, in the formative phase of the Global Fund, Sweden played an important role in shaping the Global Fund's initial strategy,

policies and organisational structures. Additionally, Sweden's financial contributions to the Global Fund are indicative for the importance Sweden accords to multilateral engagement in the global HIV response. As such, this case study was expected to illustrate Sweden's position in the global HIV arena as a policy influencer and knowledge broker, while simultaneously outlining how Sweden's domestic priorities aligned with the global response.

2. **The Swedish regional HIV programme,** managed from the regional office in Zambia. Throughout, the Swedish response has primarily focussed on countries with a high HIV prevalence, largely concentrated in sub-Saharan Africa (Swedish Government Offices 2019). In creating a regional programme for Africa, Sweden sought to foster collaboration and knowledge exchange between stakeholders across the region. This case study was thus expected to allow for a more in-depth exploration of Sweden's role as a knowledge broker and connector between development partners and implementing organisations within the region.
3. **Sweden's bilateral support to Zimbabwe**. Non-governmental organisations (NGOs) and civil society organisations (CSOs) have played a large role in the implementation of the Swedish HIV response in sub-Saharan Africa (Bigsten et al., 2016). The role of such organisations was particularly important in Zimbabwe, where the political situation at the time prevented the Swedish government from engaging with the national government. An in-depth analysis of Sweden's bilateral support in Zimbabwe was therefore expected to enable deeper study of the way in which Sweden has engaged with such organisations.

A.4.2 Data sources and interviewee selection

All case studies included, to the extent possible, a review of the financial resources involved, policy priorities and their evolvement over time, stakeholder interactions, observable results and impacts, and lessons learned for policy formulation and management in times of crisis.

Initial interviewees for each case study were identified with the help of the EBA and EBA Reference Group. This included staff at the Sida regional office in Zambia and embassy staff in Zimbabwe. Additional interviewees were subsequently identified through 'snowballing', i.e. by asking interviewees to suggest others. For an overview of key stakeholders interviewed, see Table A1.

Interviews were conducted in a semi-structured manner, entailing the flexibility to add, remove or amend questions depending on participants' scope of experience. Topic guides were designed around the study framework. Interviews were recorded and transcribed. All transcripts were coded and analysed in line with the study framework, to identify the main findings and lessons learned. Findings from this analysis, together with those from the desk review, were subsequently synthesised.

In line with ethical guidance, all stakeholders have been anonymised as follows:

- Interviewees (previously) working for Sida, SAREC or the Swedish Ministry for Foreign Affairs have been classified as 'government stakeholder'.
- Interviewees (previously) working for multilateral organisations or non-Swedish donor agencies have been classified as 'development partner stakeholder'.
- Interviewees (previously) working for a non-governmental organisation, civil society organisation, regional implementation partner organisation or research organisation have been classified as 'implementing partner stakeholder'.

Table A1 Overview of interviewees by category

Stakeholder category	Number of interviewees
Swedish government stakeholder	20
Scoping interviews	*7*
Global Fund (case study)	*4*
Regional programme (case study)	*6*
Zimbabwe (case study)	*3*
Development partner stakeholder	19
Scoping interviews	*1*
Global Fund (case study)	*8*
Regional programme (case study)	*6*
Zimbabwe (case study)	*4*
Implementing partner stakeholder	10
Regional programme (case study)	*7*
Zimbabwe (case study)	*3*
Total	49

A.5 Study limitations

As any study, this study has a number of limitations and potential sources of bias. In particular:

A.5.1 Recall and response bias and representativeness

It has been recognised that in the study of historical processes, only certain elements or aspects of all that has happened can be brought together, which may become abstracted from the context in which they took place to create a subjective perception of social reality (Azarian, 2011). This is particularly challenging when there is a large

amount of information around some time periods but less information concerning others.

In this study, such an uneven distribution of information applied to both documentation and interviews. Some key informants who were most active during the first decades of the response were no longer available or willing to participate in interviews. Others had doubts about their ability to speak meaningfully or accurately about events that took place over 20 years ago. They also feared viewing past events through today's lens without proper consideration of the context at that time. Nonetheless, research suggests that major events can have a reasonably good recall (Buka et al, 2004). To mitigate recall bias, several interviewees had extensively prepared themselves by reviewing key documents, including personal notes, from the past.

Another potential source of bias is that interviewees may have overemphasised positive aspects, as they were either (co)responsible for specific actions or benefitted from them. Particularly if people are still involved in or benefitting from the current response, they may be more likely to share only positive information and withhold criticism for fear of losing out on future benefits. To mitigate this risk of bias as much as possible, information from different data sources (primary and secondary) and from different groups of stakeholders was triangulated.

In the absence of a comprehensive list, with current contact details, of key stakeholders from across the whole duration of the response, a representative sample of interviewees could not be achieved. In particular, the lack of field-based organisations and governmental representatives from recipient countries in the sample is noteworthy.

It should furthermore be recognised that the case of Zimbabwe is not representative for all Swedish bilateral HIV support in sub-Saharan Africa. Due to political turmoil, Swedish bilateral support to the Zimbabwean government was halted in the early 2000s and only support through multilateral channels and CSOs continued, unlike

in other countries where Sweden continued working directly with national governments. While this created a unique situation, the Zimbabwean case is nonetheless useful as an in-depth exploration of how Sweden engaged with partners on the ground to further its policy priorities.

A.5.3 Confounding

As mentioned earlier, the effects of defined interventions under the Swedish contribution cannot be isolated from the global HIV response (USAID, 2018). Furthermore, it is difficult to assess what would have happened if Sweden would have taken a different approach. This is firstly due to the absence of a counterfactual or case-control studies, but also due to the absence of methods to accurately measure the impact of complex public health interventions (McGill, 2021). This is especially true when these are hypothetical in nature and take place in a setting where multiple donors and actors have influenced the response. Furthermore, in such a complex and multi-stakeholder environment, it is important to recognise the importance of complementarity and synergies.

A.6 Ethics

A waiver for full ethical review was obtained from the KIT Research Ethics Committee. For all interviews', informed consent was obtained, and permission was asked for recording.

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