



PIONEERS, PARTNERS, PROVIDERS:

The Dynamics of Civil Society
& AIDS Funding
in Southern Africa

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**Research conducted for the HIV and AIDS Programme of the
Open Society Initiative for Southern Africa**

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ABOUT THE AUTHORS

The **Centre for AIDS Development, Research and Evaluation (CADRE)** is a South African non-profit organisation, founded in 2001, that conducts research into social aspects of HIV/AIDS in South and southern Africa. Its main areas of work include: qualitative and quantitative epidemiological, socio-behavioural and communication surveys; monitoring and evaluation of HIV/AIDS interventions; communications research and interventions; and research related to HIV/AIDS policies, strategies, models and interventions.

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About the Open Society Initiative for Southern Africa (OSISA)

OSISA is an advocacy organisation based in Johannesburg and operating in ten countries in

southern Africa: Angola, Democratic Republic of Congo, Lesotho, Malawi, Mozambique, Namibia, Swaziland, Zambia and Zimbabwe. OSISA's vision is that of a vibrant southern African society in which people, free from material and other deprivation, understand their rights and responsibilities and participate democratically in all spheres of life. OSISA works towards this vision through advocacy, capacity-building, networking and grant-making.

OSISA's HIV and AIDS programme supports the right to health through the promotion of civil society participation in policy-making processes related to HIV and AIDS; monitoring public expenditure on HIV and AIDS programmes; and amplifying the voices of communities living with and affected by HIV and AIDS.

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FOREWORD

For many years AIDS activists struggled for funding to carry out lifesaving programmes to educate and care for people living with and affected by HIV. Throughout the 1980s, in countries as disparate as Uganda and the United States, activists pioneered the struggle against stigma and discrimination, fought centuries-old taboos against speaking openly about sex and sexuality, and insisted that those affected by the virus were as worthy as any others in society of respect, dignity and the right to health.

Over the years, AIDS activists have shown a remarkable ability to adapt their modes of activism to suit the times. Once bureaucracies began to finally respond to the pandemic in the early 1990s, activists moved from the street-level protests and die-ins of the 1980s, to insisting on the greater involvement of people living with HIV and AIDS in institutions and policy spaces. AIDS activists have been adept at reading the political moment and crafting constructive approaches to ensuring that the voices of those most affected by AIDS are front and centre, guiding the collective global conscience.

The hard work has paid off: there is now money to fight AIDS. The establishment of the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the United States President's Emergency Plan for AIDS Relief, combined with significant increases in bilateral commitments by donor nations and higher levels of resource allocations to health by poor countries, have meant that although the resources are still insufficient, there is now more hope for scaling up programmes and interventions that work.

Yet this success brings with it challenges. In southern Africa, where HIV infection levels are highest, and where the impact of the epidemic has frayed and stretched the fabric of many communities, states and civil society actors are trying to find new ways to provide services on a wider and grander scale. Yet all too often, they are using systems and institutions that are unprepared for scale up.

Today we are faced with a paradox of plenty: there is more money for AIDS in circulation, but not always enough human capacity and resources to make the money work. This partially accounts for the sense amongst many people in the southern African region that money for AIDS is being wasted on groups who do not deserve it, and that it seems

not to be accessible to organisations that are doing good work. Indeed, in everyday conversation, many southern Africans will say that there is too much AIDS money out there. This, of course, is not factually correct – there is a globally acknowledged shortfall of resources to combat the epidemic. But there is no denying that the perception that there is too much money for AIDS points to systemic problems in AIDS funding modalities. It is plain to all of us who work at country level that there are real questions that need to be addressed by governments, donors and NGOs about how AIDS funds are used, by whom and to what end.

It is therefore useful that OSISA's HIV and AIDS programme, out of which this report emerged, focuses among other things on the tracking of resources that are allocated by governments or by donor agencies and intended for use in programmes that affect the lives of people. This report signals an attempt to begin to deal with some of these questions of the political economy of AIDS resources. Indeed, as one of the survey respondents for the study noted, it seems that there is a lot of AIDS money 'splashing around.' The imagery is appropriate: the money is landing in big drops in some places and missing other spots entirely. In some places the drops of money are useful, and in others, the money simply pools, collecting in puddles that seem to be 'evaporating.'

The challenge ahead is to refine and target funding more appropriately – bringing an end to the era of 'splashing money' and making sure that the right organisations access funds and have the capacity to manage these funds in ways that are appropriate. As this new frontier of 'getting the money right' is tackled, it will be critical to build partnerships between civil society actors, states and donors to ensure mutual accountability. Research of this kind, which monitors and provides corrective and constructive suggestions, will be crucial as we continue to develop sustainable and consistent streams of funding for groups acting as 'pioneers, partners and providers' at the forefront of AIDS responses in communities across this region.



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CONTENTS

Abbreviations and Acronyms.....	vii
OVERVIEW	1
PART I – INTRODUCTION	3
1 Rationale.....	5
2 Objectives.....	6
3 Approach and methods	7
3.1 Research team.....	7
3.2 Data collection.....	7
3.3 Limitations of the methodology	10
PART II – BACKGROUND AND CONTEXT	13
1 AIDS impact and response.....	15
1.1 AIDS impact in southern Africa.....	15
1.2 Structures of AIDS response.....	16
1.3 Strategies of AIDS response	20
2 Resourcing the response	26
2.1 Funding modalities.....	28
2.2 Bilateral and multilateral funding for AIDS in southern Africa.....	29
2.3 Foundation funding for AIDS.....	30
3 Trends in development assistance	31
3.1 More aid, better aid	31
3.2 Aid harmonisation and effectiveness.....	32
3.3 How aid is being delivered	35
4 AIDS and civil society responses	37
4.1 The concept of civil society	37
4.2 Civil society in AIDS response	40
PART III – CIVIL SOCIETY ACCESS TO AIDS FUNDS	45
1 Civil society and AIDS response	47
1.1 Location of CSOs.....	47
1.2 Organisational characteristics.....	47
1.3 CSO involvement in AIDS response	50
1.4 Human resources.....	56
1.5 Services provided.....	58
1.6 Beneficiaries of programmes	60
2 The resource environment for CSOs working on AIDS	62
2.1 How much are CSOs spending on AIDS?.....	63
2.2 What are the main sources of support for CSOs?	67
2.3 What are CSOs being funded to do?	78
2.4 What issues are CSOs facing in accessing support?	81
3 Donor funding for civil society and AIDS	84
3.1 The challenges of monitoring and interpreting funding for civil society.....	84
3.2 Donor perspectives and strategies on civil society and AIDS	85
3.3 Country analysis of funding for civil society	93
PART IV – CASE STUDIES	127
1 Ha Ramapepe, Lesotho	129
1.1 Description of the site.....	129
1.2 AIDS in Ha Ramapepe.....	130
1.3 Responses to AIDS in Ha Ramapepe	131

1.4 The evolution of SWAALES in Ramapepe.....	132
1.5 Issues around funding and resources.....	135
1.6 Achievements and challenges.....	136
2 Bangwe Township, Blantyre, Malawi	137
2.1 Description of the site.....	137
2.2 AIDS in Bangwe Township.....	138
2.3 Major challenges faced by the CBOs and NGOs in Bangwe.....	140
2.4 Funding and support for AIDS activities.....	141
2.5 Sustaining AIDS activities	142
3 Boane, Mozambique	143
3.1 Description of the site.....	143
3.2 AIDS in Boane.....	144
3.3 Responses to AIDS in Boane.....	145
3.4 CSO experiences in accessing funding	147
4 Epako, Namibia	151
4.1 Description of the site.....	151
4.2 AIDS in Epako.....	153
4.3 Responses to AIDS in Epako.....	154
4.4 Sources of funding for CSOs in Epako	160
4.5 The funding environment for CSOs.....	162
4.6 Implications	164
5 Motshane, Swaziland	166
5.1 Description of the site.....	166
5.2 AIDS in Motshane	167
5.3 Responses to AIDS in Motshane	168
5.4 Funding dynamics.....	173
6 Linda Compound, Lusaka, Zambia	174
6.1 Description of the site.....	174
6.2 Impact of AIDS in Linda Compound.....	175
6.3 Identification of the problem.....	175
6.4 The emergence of a community project.....	177
6.5 Structure of the project.....	179
6.6 Challenges and setbacks	179
6.7 Plans for the future	181
7 Perspectives from the ground	181
PART V – DISCUSSION	185
1 The growth of CSOs	187
2 Funding for CSOs, funding for services	189
3 Imbalances in the funding environment.....	191
4 Systematisation, but not at the expense of diversity and flexibility.....	194
5 Support needs go beyond money	196
6 Implications for the future.....	198
PART VI – RECOMMENDATIONS	201
1 Recommendations for optimising funding to civil society	203
2 Recommendations for civil society organisations and networks	204
3 Recommendations for further study	205
REFERENCES	207
APPENDIX	212

ABBREVIATIONS AND ACRONYMS

ART	Anti-retroviral therapy
ASO	AIDS service organisation
CANGO	Coordinating Assembly of Non-Governmental Organisations (Swaziland)
CBO	Community-based organisation
CCM	Country Coordinating Mechanism
CHAI	William J. Clinton Foundation's HIV/AIDS Initiative
CHAZ	Churches Health Association of Zambia
CIDA	Canadian International Development Agency
CNCS	Conselho Nacional de Combate ao HIV/SIDA (Mozambique)
CRAIDS	Community Response to HIV/AIDS (Zambia)
CSO	Civil society organisation
DAC	Development Assistance Committee of the OECD
DACC	District AIDS Coordinating Committee (Malawi)
DATF	District AIDS Task Force
DFID	UK Department for International Development
FBO	Faith-based organisation
FCAA	Funders Concerned About AIDS
GBS	General budget support
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater involvement of people with AIDS
GTZ	Gesellschaft für technische Zusammenarbeit
IGA	Income generating activity
INGO	International non-governmental organisation
JASZ	Joint Assistance Strategy for Zambia
JFA	Joint Financing Arrangement
LAPCA	Lesotho AIDS Programme Coordinating Authority
LENEPWHA	Lesotho Network of People Living with HIV/AIDS
MANASO	Malawi Network of AIDS Service Organisations
MANET	Malawi Network of People Living with HIV/AIDS
MAP	World Bank Multi-Country AIDS Program
MDG	Millennium Development Goal

MONASO	Mozambique Network of AIDS Service Organisations
MTP III	Third Medium Term Plan (National Strategic Plan on HIV/AIDS, Namibia)
M&E	Monitoring and evaluation
NACA	National AIDS Coordinating Authority
NAMACOC	National Multisectoral AIDS Coordination Committee (NAMACOC)
NANASO	Namibian Network of AIDS Service Organisations
NANGOF	Namibian Non-Governmental Organisation Forum
NERCHA	National Emergency Response Council on HIV/AIDS
NGO	Non-governmental organisation
NORAD	Norwegian Agency for Development Cooperation
NZP+	Network of Zambian People Living with HIV
ODA	Official Development Assistance
OECD	Organisation for Economic Cooperation and Development
OGAC	Office of the US Global AIDS Coordinator
OVC	Orphans and other vulnerable children
PAF	UNAIDS Programme Acceleration Funds
PATF	Provincial AIDS Task Force
PEPFAR	US President's Emergency Plan for AIDS Relief
PMTCT	Prevention of mother-to-child transmission
PRSP	Poverty Reduction Strategy Paper
RENSIDA	Rede Nacional de Associações de Pessoas Vivendo com HIV/SIDA (Mozambique National Network of People Living with HIV/AIDS)
Sida	Swedish International Development Agency
STI	Sexually transmitted infection
SWANNEPHA	Swaziland National Network of People Living with HIV and AIDS
SWAp	Sector-wide approach
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
USG	United States Government
VCT	Voluntary counselling and testing
ZNAN	Zambia National AIDS Network

OVERVIEW

This report examines the AIDS funding environment through a civil society lens. It presents and discusses findings from a six-country study of access to AIDS funding by civil society organisations (CSOs) in southern Africa. The study draws upon data from 439 CSOs conducting AIDS response activities, as well as community case studies and interviews with a selection of donor institutions in Lesotho, Malawi, Mozambique, Namibia, Swaziland and Zambia. It focuses on the period 2001 to 2005.

Civil society organisations have become a mainstay of AIDS responses in southern Africa. They exist in a multiplicity of forms, from community-based organisations (CBOs) such as support groups and income-generating projects, to large-scale, professional non-governmental organisations (NGOs) that work nationally and internationally. Civil society organisations are heterogeneous; the roles they play in relation to AIDS are not easily categorised and are often poorly understood. CSOs have often been referred to as pioneers of local-level responses to AIDS, bringing innovative approaches to HIV prevention, care and support in affected communities and mobilising around the rights of people living with HIV. More recently, they have come to be seen as partners in national AIDS programmes, acting as bridges between communities and external resources and frameworks. Perhaps most frequently, CSOs are conceived of as well-intentioned and altruistic providers of services and support to people who might otherwise not be reached by existing programmes. These varying and overlapping views of civil society organisations as 'pioneers,' 'partners' and/or 'providers' are influencing the positions which CSOs are assuming within the broader AIDS response environment and, in particular, the dynamics of resourcing and support for their efforts.

This research has explored the funding environment for local civil society organisations against a backdrop of rapid increases in funding for AIDS, as well as critical shifts in the way that international development assistance is conceived of and delivered. The Paris Declaration on Aid Effectiveness and the 'Three Ones' principles call for greater national ownership and control over development assistance and better harmonisation of donor activity at country level. These trends have important implications for CSOs in terms of how they access, utilise, and report on funding for AIDS and other development issues.

The research found evidence that there has been a dramatic increase in the number of civil

society organisations involved in AIDS responses, beginning in the early 1990s and intensifying since 1999, and that global increases in funding for AIDS are reflected in the spending patterns of the organisations surveyed. Between 2001 and 2005, CSOs' average annual expenditure on AIDS tripled. Spending grew most rapidly during the latter half of this period which corresponds to the introduction of Global Fund and PEPFAR funding in the region, as well as increases in other funding sources. By 2005, CSOs working on AIDS were receiving more funding, from a greater number of sources, than they had in 2001.

The bulk of funding for CSOs over the period examined went to a small proportion of leading organisations – many of which are urban-based – with prior programme delivery experience and financial capacity, while many smaller and less-developed organisations operated mainly on the basis of donations and in-kind support. However some of the trend data collected in the study suggests dynamics which may be mitigating against these imbalances. Average spending on AIDS among CBOs grew at a faster rate between 2001 and 2005 than it did among national and international NGOs.

Country-level funding architecture has become an important factor shaping CSO access to funding, especially for smaller organisations. Increased spending among CSOs between 2001 and 2005 can be traced in part to disbursements by sub-granting agencies – public or private institutions which act as funding conduits for one or more streams of external funding. While these accounted for only about 11% of the total volume of funding received by surveyed CSOs in 2005, they were the most frequently mentioned source of support. Their size, reach, degree of decentralisation, and relative efficiency in distributing funding shaped the extent to which small and medium CSOs were able to access support for AIDS.

During the period studied, the funding environment included a wide range of agencies channelling support to CSOs. Bilateral funders provided the greatest amount of money for CSOs, but access to bilateral as well as multilateral funds was highly concentrated among about 20% of surveyed organisations, and these were generally the most well-established national and international non-governmental organisations. International development NGOs also played a major role as conduits of international aid and this role became more prominent with the scaling-up of funding for AIDS over the five-year period.

Despite harmonisation efforts among donors, there was only limited evidence that the funding environment became more regularised or simplified from the perspective of CSOs. Fundraising has proven to be an increasingly time-consuming activity and many CSOs expressed that funding arrangements were not well-suited to their needs, were difficult to work with, and did not function efficiently.

The growth in overall levels of funding for CSOs has not translated into sustainable support, as almost half of organisations surveyed had 25% or less of their projected budgets funded for the following year. The case study research showed that funding flows were not reaching many smaller organisations trying to serve members of their community, and there was evidence of numerous local organisations functioning without access to any financial support.

Funding agreements were generally found to be short term and project specific, and the quality and sustainability of much CSO work was compromised by a lack of support for basic costs linked to organisational expenses and activities not directly related to funded services. Funding during the period was overwhelmingly directed at programme implementation and service delivery. There was relatively little funding awarded to CSOs for activities such as training, advocacy or rights-based work.

The study shows that the proportion of time spent on AIDS-related activities increased over time in those organisations that do not have an exclusive AIDS focus. However, at the same time, many of the younger organisations which have worked on AIDS since their founding were also involved in other community development and support activities not specifically related to AIDS. This was particularly true for small community-based organisations and NGOs which often adopt a holistic approach to addressing community needs and may be utilising 'AIDS funding' for activities which can be seen as more broadly developmental. In other words, there appears to be a certain coalescing of 'development' and 'AIDS interventions' at community level.

Based on these key findings, the study raises critical questions about the scaled-up involvement of civil society organisations in the planning and development of AIDS responses. The recent growth of CSOs in AIDS response is a phenomenon that is unfolding without a roadmap and there are many strategic questions which require attention and debate. It is not always evident whether funding for civil society organisations is being pursued strategically, based on an understanding of civil society's strengths and potential contributions to the epidemic, or largely instrumentally as a way to extend the reach of services. One clear possibility is

a shift away from the independence of civil society towards greater co-option into the role of service provider. The way funding for AIDS is structured is having clear effects on the type of work many CSOs are undertaking, the degree of ownership they feel over their work and the programme models they use, and their ability to plan for the future and grow as independent organisations. Scaling-up has often been achieved without adequate recognition of the operational limitations faced by many CSOs that make them ill-suited to meet some of the standard requirements that are attached to the receipt of funding.

The challenges of 'funding' AIDS responses and 'supporting' AIDS responses should not be conflated. Getting money to 'where it is needed most' is only part of what is required. The value of CSOs having money in hand is greatly dependent on other kinds of support, and the findings from this research suggest that this has not been given sufficient attention, or that the complexities of this process have been underestimated. If many of the emerging CSOs are to become viable and strong organisations, there is a need for enhanced country-level support for strategic planning, organisational development, and human resource development programmes. This cannot be ignored. Without attention to these capacity-building issues, strong and effective local responses to AIDS are unlikely to emerge.

This research has shown that critical appraisals of the global response to the HIV epidemic have resulted in significant shifts in the way that funding for AIDS is being conceptualised. To differing degrees, all six countries in the present study reflect efforts to move funding closer to the ground in order to better resource community-level responses to AIDS. A range of models and approaches are in evidence and it is clear that there is a growing amount of thinking – and a mounting evidence base, drawn from practical experience – about how to optimise support to civil society.

One of the major challenges that remains, however, lies beyond the problem of simply 'moving money' to communities more efficiently – it is about getting those resources to work in different and more effective ways. This is a much more difficult challenge, because it relates to the complexity of marrying external forms of support to local ideas, motivations and forms of activity in a way that enables them, rather than dictating to them. The report concludes with some recommendations to funding agencies, governments and AIDS coordinating authorities, and to civil society organisations themselves around how approaches to funding civil society organisations could be strengthened in line with these goals.

PART I

INTRODUCTION



This report presents and discusses findings from a six-country study of access to AIDS funding by civil society organisations (CSOs) in southern Africa. Drawing upon data from more than 400 CSOs involved with AIDS response activities, as well as community case studies and interviews with a selection of donor institutions in Lesotho, Malawi, Mozambique, Namibia, Swaziland and Zambia, the research has explored the funding environment for local civil society organisations against a backdrop of rapid increases in funding for AIDS, as well as critical shifts in the way that international development assistance is conceived of and delivered.

Part I introduces the rationale, objectives and methods employed in the research.

Part II of the report provides background and an overview of key issues relevant to the study, including national structures and strategies of response, trends in international funding for AIDS, important shifts in the international aid system that are affecting the way funding for AIDS is being delivered, and the role of CSOs in responses to the epidemic.

Part III presents key findings from the CSO survey and analysis of donor funding. The report focuses predominantly upon trends common across the six countries, although important distinctions between individual countries are highlighted where appropriate. Among the issues covered are:

- The organisational and programmatic profile of CSOs working on AIDS in the region, including the history of their involvement in AIDS response, organisational characteristics, main areas of activity and primary beneficiary groups;
- The financial profile of CSOs, including trends in expenditure and sources of funding;
- The general resource environment for CSOs, including their relative access to funding for different types of costs, the amount of time spent fundraising, and their relationships with donor institutions; and
- An analysis of donor funding, including rationales for supporting civil society to respond to AIDS, the proportions of funding being channelled to CSOs, and the channels through which funding flows.

Part IV presents local case studies conducted in each of the six countries and shows the community-level manifestations and implications of the funding trends highlighted in Part III.

Part V discusses the implications of these findings, while Part VI summarises key learnings and makes recommendations on how funding for civil society might be optimised.

1. Rationale

As the resources allocated to AIDS responses increase, growing attention is being paid to how funding is administered and used. Using a variety of approaches, studies that fall under the emerging discipline of resource tracking have investigated how funding for AIDS flows, the purposes for

which it is allocated, and how it is spent. Areas of emphasis in resource tracking have included:

- Analysing the channels and mechanisms through which AIDS funding is committed and distributed at a global level, and trends in the resources available for AIDS;¹
- Analyses of support for AIDS by particular donors, including overall levels of support, trends in funding modalities, and proportions of assistance that can be considered 'real aid';²
- Budget analysis: patterns of allocation and expenditure on AIDS by national governments;³
- National-level spending assessments that estimate total expenditure on AIDS by identifying all sources of AIDS funding (public and private, domestic and external) and providers of AIDS-related services;⁴
- Beneficiary analyses which investigate who is paying for AIDS-related goods and services and who is benefiting from allocated resources;⁵
- Investigations of spending bottlenecks and challenges to absorptive capacity;⁶
- Thematic analyses of AIDS funding, focusing upon the intervention areas for which funds are designated and the beneficiary groups that are targeted;⁷ and
- Institutional analyses of AIDS funding, exploring the types of institutions that are used to channel assistance.⁸

The present research, which was commissioned by the HIV and AIDS programme of the Open Society Initiative for Southern Africa (OSISA) in early 2006, was designed to explore impacts of the changing AIDS funding environment on CSOs engaging in AIDS response activities in southern Africa. At the time the research was conceptualised, several of the major new initiatives for AIDS, including the Global Fund to Fight AIDS Tuberculosis and Malaria (GFATM), the US President's Emergency Plan for AIDS Relief (PEPFAR) and the World Bank Multi-Country AIDS Program (MAP), were coming into force in countries in southern Africa, dramatically increasing the resources available for AIDS response. A number of studies had been published which examined broad trends in funding for AIDS and national government expenditure on AIDS in selected countries,⁹ but few if any investigations had been carried out which looked at the AIDS funding environment through a civil society lens.

2. Objectives

The research was aimed primarily at discovering and describing funding practices and strategies for supporting civil society responses to AIDS. It also had an evaluative element in that it sought to understand the comparative strengths and limitations of funding practices and strategies identified.

The objectives of the research were as follows:

- To determine the amount of funding being accessed from donor institutions over the period 2001-2005 by CSOs working on AIDS in Lesotho, Malawi, Mozambique, Namibia, Swaziland and Zambia;

Official responses to AIDS at national level are increasingly spearheaded by multisectoral, AIDS-specific structures.

¹ See Kates, J. & Lief, E. (2006); OECD Development Assistance Committee (2004 & 2006).

² See, for example, Bernstein, M. & Sessions, M. (2007); Daly, M. (2005); European HIV/AIDS Funders Group (2006); Funders Concerned about AIDS (2005 & 2006); Greenhill, R. & Watt, P. (2005); Janjua, H. (2003); Pratt, B., Adams, J. & Warren, H. (2006)

³ See Guthrie, T. & Hickey, A. (2004).

⁴ The National AIDS Spending Assessments are based on a methodology developed by UNAIDS and are used to develop country-level assessments of resource expenditure on HIV/AIDS. They use internationally accepted accounting methods and economic costing activities, where needed, to develop national-level estimates for use in planning and resource allocation.

⁵ Dmytracezenko, T. et al (2006).

⁶ See, for example, Foster, G. (2005).

⁷ Human Rights Watch (2005). See also 'Divine intervention: US HIV/AIDS policy abroad' on www.publicintegrity.org/aids and materials available at www.pepfarwatch.org.

⁸ Pratt, B., Adams, J. & Warren, H. (2006); Stockman, F. et al. (2006).

⁹ See, for example, footnotes 1-8.

- To identify the main funding channels through which civil society organisations access support and assess the extent to which these are well suited to the needs of civil society organisations;
- To explore the relationship between donor institutions and civil society organisations in each country, including donors' rationales for supporting civil society in their AIDS funding portfolios;
- To explore factors that mediate the ability of civil society organisations to access donor funding, including disparities in geographical location, sector of response, project orientation and institutional capacity; and
- To investigate, through case studies, how large increases in available funding for AIDS are being experienced by CSOs at community level.

3. Approach and methods

3.1 Research team

In each of the six countries CADRE worked with a consultant or local organisation who had been selected on the basis of previous experience in facilitating research related to AIDS or civil society, and their understanding of key dynamics related to civil society organisations in the AIDS sector. The country consultants were called together and briefed over a period of two days. Thereafter they implemented each of the three research components in their own countries with the guidance of the CADRE research team.

3.2 Data collection

The research was comprised of three main data collection components: a national survey of CSOs working in the AIDS sector; interviews with a selection of donor and intermediary institutions; and a community case study focusing upon funding dynamics at community level.

3.2.1 CSO survey

Data from civil society organisations were gathered through a self-administered four-page questionnaire which captured information on the organisational profile, staffing, budget, sources of funding and programme activities. The questionnaire was piloted with organisations in each country prior to finalisation. The survey instrument was identical in each country, with the exception of minor variations in the question pertaining to beneficiary groups. It was translated into Portuguese and Sesotho for use in Mozambique and Lesotho respectively. In all other countries the questionnaire was administered in English.

In each country a list of CSOs active in the AIDS sector was compiled on the basis of information held by AIDS coordination networks, National AIDS Coordinating Authorities (NACAs), and granting and sub-granting institutions. Efforts were made to include both non-governmental organisations (NGOs) and community-based organisations (CBOs) from all parts of the country. Both AIDS-specific CSOs and CSOs with a significant AIDS component to their work, but not exclusively focused on AIDS, were included in the master lists. Government and parastatal institutions, schools, clinics and private organisations were removed from the lists, as were regional or district-level branches of NGOs.

In Malawi, Mozambique, Namibia and Zambia, where the number of organisations in the consolidated list exceeded 300, 120 organisations were randomly sampled to receive the survey. In Lesotho and Swaziland where the total population of CSOs was less than 100, the questionnaire was distributed to the full list. Questionnaires were distributed by email, fax, hand, and post according to circumstances. In all six countries the consolidated lists were found to contain many organisations which no longer existed, which existed in name only, or which could not be reached due to changes in contact information. Each organisation to which the survey was originally distributed was contacted a minimum of three times to secure a response. If the organisation could not be contacted or did not return the questionnaire after three follow-ups, it was dropped from the list and replaced by the next randomly selected organisation. A 65% response rate was pursued.

A total of 439 surveys were returned (see Table 1). The questionnaires were checked for completeness and targeted follow-ups were made to verify information where necessary. Financial data provided in national currencies was converted into US dollars according to an average annual exchange rate. Data was captured and analysed using SPSS statistical software.

Table 1
Survey response rates

	Surveys Successfully Distributed	Surveys Completed	Return Rate
Lesotho	73	66	90%
Malawi	120	80	67%
Mozambique	120	87	67%
Namibia	120	77	64%
Swaziland	80	55	69%
Zambia	120	74	62%
Total	633	439	69%

3.2.2 Donor analysis

In each country 10 donor institutions were selected for investigation based on the significance of their funding for AIDS, either in terms of absolute amounts provided or a particular focus on civil society. Face-to-face semi-structured interviews were arranged with programme officers responsible for health and/or AIDS funding portfolios to collect information about the institution's funding for AIDS, the channels used to disburse support, funding provided to civil society organisations and the rationale behind this support, and issues related to civil society involvement with AIDS response in the country. Donor institutions were also asked to complete a data capture form with details of their funding for AIDS over the period 2001-2005, including committed and disbursed funds and the proportion of funding allocated to civil society organisations.

Representatives of the national AIDS coordinating authorities and key intermediary institutions were also interviewed in each country to provide further information about the architecture of AIDS funding as it relates to civil society recipients.

A total of 57 interviews were conducted. Not all donor and intermediary institutions availed themselves for interviews or provided data. A list of interviews conducted is included in the appendix.

Where interviews or data could not be secured, an Internet-based search was conducted for publicly available information on donor activity and strategies around AIDS support. Key documents included annual reports, programme documents and evaluations, AIDS strategies, and policy documents for engagement with civil society institutions. Some donor institutions make data about funding commitments and disbursements available on their websites; these were systematically downloaded and captured wherever possible.

3.2.3 Case studies

In each country a case study was undertaken to explore the dynamics of AIDS funding in a community context. The case study methodology was designed to go beyond the work of major donor agencies and funding mechanisms to look at smaller-scale forms of support that are important at community level, including the work of national and international NGOs, foundations, churches, the private sector, and contributions from community members themselves.

Sites were identified on the basis of several criteria, not all of which were met in each site: likelihood of illustrating interesting dynamics related to donor funding that had been identified in the other research components; the site was relatively accessible and conveniently situated for the research team, but not heavily researched in previous studies; the site was home to a particular population group that is seen as vulnerable or marginalised; specific funded programmes or interventions of interest have been carried out in the site; and there has been a change or shift in the character or profile of the site in relation to AIDS that is linked to economic or other developments.

The case study locations and their key features are summarised in Table 2.

Table 2
Case study sites and key features

Country	Case Study Site	Key Features
Lesotho	Ha Ramapepe Leribe District	Village in district with highest HIV prevalence rate in Lesotho. AIDS response activities in the village dominated by a group of local women who provide home-base cared and support to orphans and other vulnerable children. Case study allows for in-depth exploration of the 'support group' phenomenon, which is the dominant form of grassroots civil society AIDS response in Lesotho.
Malawi	Bangwe Township Blantyre	A township within the rapidly urbanising City of Blantyre. More than 70% of residents live below the poverty line. The case study looks at a number of organisations addressing community needs related to AIDS and provides an opportunity to understand the different funding and development needs of organisations at different stages of development.
Mozambique	Boane Boane District	A small town near Mozal, a large aluminum smelter which has introduced employment opportunities in an area where the only other economic opportunities link to the location of the town on the main route between Mozambique and South Africa. These two factors pose a high HIV threat to the local community. The case study looks in depth at the difficulties of local organisations obtaining funding for AIDS efforts and it examines in particular the efforts of KindliMuka, a village-level AIDS support organisation providing services to its members and other community members in need.

Country	Case Study Site	Key Features
Namibia	Epako Omaheke Region	Former apartheid-era township for Gobabis, the administrative centre of one of the poorest and most sparsely populated regions of Namibia. The community is located on the Trans-Kalahari Highway close to the border crossing with Botswana and is home to a significant San population. HIV prevalence rates in the region are low, but specific HIV risk factors in the community, as well as the remote and rural character of the region, make the site an interesting one to explore in terms of the mix of local, national and international AIDS responses.
Swaziland	Motshane community	A traditional rural area presided over by a chief and heavily affected by AIDS. The case study looks at the different ways in which AIDS needs are serviced at community level. It provides an interesting insight into the jigsaw-nature of community AIDS responses and the difficulties posed by piecemeal funding.
Zambia	Linda Compound Lusaka Province	Informal peri-urban settlement on outskirts of Lusaka with few public or private services and large numbers of orphaned and vulnerable children dropping out of school. In the absence of other forms of support, guardians and concerned community members organised themselves to address the problem. The resulting project is an example of a non-funded, grassroots self-help initiative.

The sites were visited for periods ranging from two to four days. Prior to the research visits, a list of key research questions was developed to guide the data collection process. These questions linked to the original reasons for selecting the case and were also shaped by country-specific issues that had emerged to date in the other components of the research.

Data collection involved a range of elements: interviews with key informants, focus group discussions, site visits to local organisations, and gathering key documents related to the community (from the media, official data sources, and other studies). Attention was paid to the physical environment and factors that may affect AIDS responses in the community, including access to transportation, the geography of the community, living conditions, and the availability of key services.

The case studies are presented in Part IV.

3.3 Limitations of the methodology

A number of inherent limitations to the research methodology need to be noted, apart from any limitations that may have arisen from problems of implementation.

- The study did not attempt to evaluate the ultimate achievements of funding, but rather to explore the structures and channels through which it flows to civil society organisations.
- Complete or updated lists of CSOs engaged with AIDS response were not available in any of the countries, and these had to be constructed from a range of sources in each country. The sources of information that were drawn upon may have resulted in a sample that is biased towards organisations that are funded and/or networked with other organisations.
- CBOs in rural areas were more difficult to reach than urban-based CSOs and their response rates to the survey were lower.
- Data collected from both CSOs and donor/intermediary institutions were self-reported and may contain gaps, inaccuracies

- and internal contradictions, although attempts were made to identify problems and correct them.
- Donor institutions use different terminology and categorisations for their funding, making the use of a standard data collection tool problematic, and leading to data that was fragmented and often difficult to interpret. Analysis of donor allocations to civil society required extensive triangulation against secondary sources.

In addition to these, the research was subject to the following problems of implementation:

- The research process took longer than expected at almost all stages.
- Initial response rates from CSOs were low and required extensive follow-up before targeted response rates were attained.
- High costs and difficulties of communication meant that rural responses to the survey in Lesotho had particularly high non-response rates and it is likely that rural responses from that country are underrepresented.
- Difficulty was experienced in accessing certain institutions for interviews and appropriate representatives were frequently unavailable or failed to respond to repeated attempts to set up appointments.
- Donors frequently did not provide promised information and in many instances appeared not to have past records available or accessible. There was considerable difficulty experienced in obtaining reliable and relevant information from donor organisations. These difficulties are further described in Part III, Section 3.1.

PART II

BACKGROUND AND CONTEXT



1. AIDS impact and response

Nearly a quarter century since it was formally identified in humans and given a name, AIDS has become one of the defining public health and social crises of our age. The epidemic has spread and intensified in many parts of the world, especially among poor, marginalised and otherwise disadvantaged populations. In 2006, an estimated 39.5 million people were living with HIV. It is estimated that 4.3 million of these individuals were infected during 2006 – a level which, compared with previous years, suggests that the HIV incidence rate continues to climb.¹⁰

Despite some important signs of progress in responding to the epidemic – expanded access to treatment, isolated examples of HIV-prevalence reduction, and increased political and financial commitment to respond to the epidemic – AIDS remains a monumental challenge.

1.1 AIDS impact in southern Africa

Southern Africa is often described as the epicentre of the global AIDS epidemic. In 2006 it was home to 32% of world's HIV-positive population and 34% of all AIDS-related deaths,¹¹ while accounting for less than 5% of the world's total population.¹²

The six countries investigated in this study are all heavily affected by AIDS (see Table 3), although their HIV prevalence rates vary significantly. The three smallest countries in terms of population – Lesotho, Namibia and Swaziland – have the highest estimated adult prevalence rates among the six countries (23%, 20% and 33% respectively). In all of the countries, HIV prevalence rates are higher in urban than in rural areas.

Table 3
Key indicators of HIV prevalence, impact and response

	Lesotho	Malawi	Mozambique	Namibia	Swaziland	Zambia
HIV PREVALANCE						
Population (thousands)	1 795	12 884	19 792	2 031	1 032	11 668
Adults and children with HIV 2005 ^a	270 000	940 000	1 800 000	230 000	220 000	1 100 000
Adults and children with HIV as proportion of population (%) ^a	15.0	5.7	9.7	11.3	21.3	9.4
Adult (15-49) HIV prevalence rate	23.2	14.1	16.1	19.6	33.4	17.0
Urban antenatal HIV prevalence (%) ^b	31	21	18	25	41	27
Rural antenatal HIV prevalence (%)	28	17	13	19	35	9
AIDS IMPACT						
Government funds spent on AIDS (US\$ thousands)	1 358	8 704	2 565	38 558	3 961	32 000
Orphans (0-17) ^{a,c}	97 000	550 000	510 000	85 000	63 000	710 000

¹⁰ UNAIDS (2006a).

¹¹ UNAIDS (2006a).

¹² United Nations Secretariat (1999). Based on 1999 population figures. Southern Africa defined as member countries of the Southern Africa Development Community (SADC).

	Lesotho	Malawi	Mozambique	Namibia	Swaziland	Zambia
AIDS IMPACT						
School attendance rates among orphans/non-orphans	79%/91%	81%/87%	63%/78%	83%/90%	79%/87%	73%/78%
AIDS deaths in adults and children during 2005 ^{a,d}	23 000	78 000	140 000	17 000	16 000	98 000
RESPONSE						
% of HIV infected men and women receiving ART	14	20	9	35	31	27
% of pregnant women receiving treatment to prevent MTCT ^{b,e}	5.1	2.3	3.4	25	11.9	4

a Source: UNAIDS (2006).

b Source: Asamoah-Odei, E., Garcia Calleja, J., Boerma, J. (2004). Data from 1997 to 2003.

c Definition: number of children (0-17) who have lost one or both parents to AIDS.

d Deaths during 2005.

Despite an overall expansion of availability of anti-retroviral therapy (ART) in the region, the majority of those who could benefit from ART in the countries in this study are still not being treated. The proportion of HIV-positive adults on ART is highest in Namibia (35%) and lowest in Mozambique (9%). All of the countries fare poorly in terms of the proportion of pregnant women receiving treatment to prevent HIV transmission to their babies, with only Namibia managing to treat a quarter of the relevant population.

Across the six countries, more than two million children are estimated to have been orphaned as a result of AIDS, with the highest proportions found in the smaller countries. School attendance rates among orphans are lower than non-orphans in all six countries.

1.2 Structures of AIDS response

The structures of AIDS response that have evolved over the past two decades to deal with these challenges are multi-faceted and highly differentiated. They comprise both planned, strongly hierarchical elements (vertical programming; channels for reporting, monitoring and funding; universal standards and 'best practice') and a host of fragmented, relatively small scale, dynamic elements (localised projects; volunteer-driven initiatives; forms of mutual support).

Official responses to AIDS at national level are increasingly spearheaded by AIDS-specific structures – often collectively referred to as National AIDS Coordinating Authorities – that have been established to plan, coordinate, resource, implement and/or monitor national strategic plans for controlling the spread of HIV and mitigating its impacts (see Table 4). International agencies and donor institutions look to NACAs for guidance in determining the needs and priorities for external financial and technical assistance related to AIDS.

While the first generation of national responses to AIDS in the late 1980s and early 1990s were generally driven by AIDS committees located within ministries of health, and were narrowly oriented on medical aspects of AIDS (e.g. blood screening, surveillance systems,

The structures of AIDS response that have evolved over the past two decades comprise both planned, strongly hierarchical elements and a host of fragmented, relatively small scale, dynamic elements.

In some countries, multiple coordination and consultation structures exist and overlap in membership and focus.

clinical management, public awareness campaigns around prevention), realisation of the scale of the epidemic and frustration with limited impact led to the emergence of more autonomous, multisectoral structures – NACAs – that would become focal points for comprehensive nationwide responses.¹³ The form, content and functions of both the early national AIDS programmes and the current multisectoral AIDS structures have been heavily influenced by best practice guidelines and templates promoted by international structures such as the World Health Organisation, UNAIDS (e.g. the ‘Three Ones’),¹⁴ and major AIDS funders such as the World Bank and the Global Fund.¹⁵ In a 2004 UNAIDS survey, more than 95% of countries reported having a national AIDS coordinating authority.¹⁶

One of the major roles of NACAs is to coordinate the growing scope and scale of AIDS response activities which emanate from all levels of society and involve an increasing number of international institutions.^{17 18} The universe of actors involved with AIDS response in any national context is complex and heterogeneous. Although it does not lend itself well to mapping or succinct description, the following broad categories can be distinguished:

- *Government and public sector institutions:* Ministries and departments and the sectoral institutions through which they work (e.g. schools, hospitals, clinics); provincial and local government structures; AIDS coordinating authority structures at sub-national level (e.g. task forces, committees, councils); the public sector workforce (teachers, police force, armed services);
- *Parastatal institutions:* national councils and similar structures (e.g. youth council, gender commission), universities and research institutions; laboratories; nationalised enterprises (e.g. utilities, transport);
- *Donor institutions:* bilateral and multilateral agencies that provide funding and technical assistance; development agencies (church-based and secular); private foundations; international projects and initiatives; embassies; international development volunteers;
- *International agencies:* UN agencies (non-funding), intergovernmental organisations, regional structures (e.g. SADC);
- *Civil society:* international NGOs (including humanitarian relief and development agencies), national NGOs and CBOs, networks of HIV-positive people, hospices, churches, professional associations, trade unions;
- *Private sector:* consultants and service providers, project management and fund management institutions, workplace programmes, corporate social responsibility projects; and
- *Individuals:* caregivers, volunteers, philanthropists, social entrepreneurs (both local and international).

Centralised programmes and channels – such as those led by government/NACAs and some large-scale donor programmes – are criss-crossed at all levels by a host of smaller-scale activities that may or may not be linked to the official response framework. In some countries, multiple coordination and consultation structures exist and overlap in membership and focus. While a certain hierarchy of authority can be said to exist – UNAIDS, NACAs, the national government and major donor institutions such as the World Bank, PEPFAR and GFATM frame the macro response context to a considerable degree – the AIDS response environment as a whole is crowded, vibrant and largely unsystematic.

¹³ See Iliffe, J. (2006) and Putzel, J. (2004) for important critiques of the evolution of early national response structures under the WHO/Global AIDS Programme and the more recent emergence of ‘organisational templates’ for multisectoral responses.

¹⁴ The ‘Three Ones’ principles promoted by UNAIDS call for countries to develop one agreed AIDS action framework, one national AIDS coordinating authority, and one country-level monitoring and evaluation system.

¹⁵ Putzel, J. (2004).

¹⁶ Of 66 countries responding to the survey. UNAIDS, (2005).

¹⁷ Many of the actors engaged with AIDS response are international, and the extent to which strategies and structures can be said to be locally owned and developed is an important underlying issue. See Swidler, A. (2006) for an important discussion of dynamics of AIDS governance in Africa. Swidler argues that the porousness of post-colonial African states has meant that AIDS governance has become deeply entwined with the modalities favoured by international actors, yet the way these play out on the ground is often conditioned by local patterns and understandings.

¹⁸ Although NACAs are unquestionably government institutions, in this report we regularly make distinctions between NACAs and ‘government’. In referring to ‘government’, particularly in relation to funding for CSOs, we are referring to government ministries and departments and the budgets which relate to them. NACAs, and the decentralised organs which feed into them, are understood as distinct AIDS-related authorities that are distinguishable from surrounding government structures by their explicit mandates in relation to AIDS.

The strong push towards systematisation of AIDS response – embodied in the Three Ones and the Paris Declaration of Aid Effectiveness (see Section 3.2) – is motivated by a desire to ‘align’ these diverse forms of activity for maximum impact and results. The trend is clearly in the direction of greater orderliness, yet for every effort to coordinate activity and streamline the flow of funding, there is an independent, ad hoc or parallel initiative which adds to the dense web. Many of the very institutions that most vigorously endorse systematisation also undercut it: UNAIDS country coordinators have noted that when donors are impatient with national AIDS authorities they bypass them by supporting vertical initiatives without reference to overall country efforts.¹⁹

UNAIDS country coordinators have noted that when donors are impatient with national AIDS authorities they bypass them by supporting vertical initiatives without reference to overall country efforts.

Table 4
Features of national AIDS response structures

	National institution	Institutional structure and composition	Role in financing
Lesotho	National AIDS Commission Statutory body since 2005 Autonomous body that reports to the Prime Minister's office	Tri-partite body responsible for coordinating the national response. It comprises a six-member Board responsible for policies and strategy; a Secretariat, which handles operational issues; and a Stakeholder's Forum comprised of 14 representatives from civil society, government and the community. District AIDS Task Forces, District AIDS Coordinators, and District Data Officers work at district level.	The NAC mobilises funding for AIDS from government and external sources. The NAC is establishing a financial management unit, which will allow it to play a greater role in channelling and administering AIDS funding.
Malawi	National AIDS Commission Statutory body since 2001 Falls under the office of the President and Cabinet	Led by a multisectoral Board of Commissioners and assisted by a secretariat of over 70 mostly professional staff. Other coordination structures include: (a) Principal Secretaries of the HIV and AIDS committee; (b) Multisectoral District AIDS Committees; (c) Civil Society Forums for international and local organisations; (d) Umbrella organisations for CBOs and small NGOs at district level; (e) Interfaith umbrella organisations; (f) Country Coordination Mechanism; (g) Malawi Business Coalition Against AIDS. All coordination structures are represented in the National Partnership Forum.	Existence of a functional basket fund (inclusive of the Global Fund) for AIDS resources managed by the National AIDS Commission. Fully functional HIV and AIDS Donor Development Group. One national integrated annual workplan funded by both pool and discrete donors. Participatory six monthly and annual reviews that produce an aide memoir signed by development partners and Government.
Mozambique	Conselho Nacional de Combate ao HIV/SIDA (CNCS) Statutory body created in 2002 Chaired by Prime Minister with Ministry of Health as vice chairperson	Comprises a board and secretariat, which is headed by a deputy secretary and four coordinators responsible for: advocacy and communication; planning, monitoring and evaluation; financial management; and administration. For each of the provinces there is a provincial nucleus representing the CNCS headed by a coordinator.	Takes responsibility for implementing the national strategic plan. Manages disbursement of funding from a number of bilateral donors, the GFATM, the World Bank and a Common (pooled) Fund.

¹⁹ UNAIDS (2005, pp. 31-32).

	National institution	Institutional structure and composition	Role in financing
Namibia	National AIDS Committee (NAC) Statutory body since 2001 Below cabinet	Comprised of cabinet ministers and regional governors. Highest policy decision-making body; initiates and approves policy; provides leadership; ensures political commitment. Advised on policy issues by National Multisectoral AIDS Coordination Committee (NAMACOC), which is comprised of permanent secretaries, regional and civil society participants, some donors institutions and is responsible for coordination and implementation; leadership on sectoral and regional implementation; resource management. National AIDS Executive Committee reports to NAMACOC and provides technical leadership for implementation, including monitoring the MTP III. The NAEC reaches down to Regional AIDS Coordinating Councils and Constituency AIDS Coordinating Councils.	MTP III is the costed national plan for AIDS response. Namibian National Planning Commission responsible for preparing, monitoring and overseeing the country's development budget, including for AIDS.
Swaziland	National Emergency Response Council on HIV/AIDS (NERCHA) Statutory body since 2003 Governed by a broadly representative Council accountable to the Prime Minister	Daily affairs of Council managed by a Director and secretariat. Coordinates and facilitates implementation of a national multisectoral plan for responding to AIDS. Convenes a number of coordinating and consultative committees. Centralised although attempts being made to decentralise to regions.	Principal recipient of Global Fund grants, money from government and a few other donors. Makes funds available to implementers and ensures that funds are spent in fulfilment of national objectives. Coordinates funding and implementation through a national monitoring and evaluation framework which includes a comprehensive output monitoring system.
Zambia	National HIV/AIDS/STI/TB Council Statutory body since 2002 Reports to committee of Cabinet Ministers	Council comprised of permanent secretaries in the ministries and representatives from various organisations and bodies. Chairperson appointed by Prime Minister from among the permanent secretaries. Main role is in developing policy and advising the Government. Secretariat implements the Council's decisions. 10 Technical Working Groups. Provincial AIDS Task Forces (PATFs) and District AIDS Task Forces (DATFs) extend down to provincial and district level.	The NAC is not a financing agency. It coordinates and mobilises resources; identifies institutions through which funding can be directed; and provides operational funding to PATFs and DATFs.

1.3 Strategies of AIDS response

1.3.1 A brief history of interventions: the road to comprehensive programming

Responses to AIDS have evolved over the past two decades, alongside changes in the epidemic itself, better surveillance and epidemiological data, medical and technological advances, and prevailing attitudes. The approaches used to control the spread of AIDS and mitigate its impacts have been a dynamic combination of top-down 'strategies' led by international institutions and national governments, and a heterogeneous set of practices and activities, such as home-based care and feeding schemes for children, that emerged from communities themselves. In this fluid context, there has been a tendency for certain interventions or areas of focus to rise to prominence – attracting heavy attention (and more recently, resources) – within a general move towards what is now termed a 'comprehensive response' of measures aimed at prevention, care, treatment and rights.

The history of official AIDS response interventions in Africa has been heavily shaped by the models used in Western countries to address AIDS among gay men and injecting drug users. In these countries, concern for confidentiality and individual rights were made paramount, which led to a particular form of response which did not treat HIV as a typical infectious epidemic (e.g. with mandatory testing, reporting and contact investigation) and a public health emergency, but which worked instead through individualistic approaches to behaviour change, support and public education with a strong view to protecting human rights and mitigating against stigma and discrimination.²⁰

This approach, which emerged out of a particular context of concentrated prevalence among stigmatised minorities, was transferred to Africa where the shape of the epidemic was markedly different. Debates continue over whether 'AIDS exceptionalism' – treating AIDS differently than other public health emergencies – contributed to the failure to curtail the epidemic in Africa at an earlier stage of its progression.²¹

During the 1980s, official responses to AIDS were largely medical in orientation – safeguarding the blood supply, establishing surveillance systems, expanding laboratory facilities and training medical staff in case management – and were run hierarchically and vertically.²² Basic public education campaigns and training in counselling for medical personnel occurred on a limited basis,²³ but concerns about preventing discrimination and protecting individual rights meant that routine HIV testing was not widely promoted or used as a preventative tool. Apart from some targeted programmes aimed at high-risk groups, such as commercial sex workers and truck drivers, awareness campaigns emphasised the notion of universal risk and were not targeted to particular population sub-groups with vastly differing HIV infection profiles.²⁴ During the late 1980s and early 1990s, as the first medium-term national AIDS plans were launched, surveillance systems began to be strengthened through sentinel sites at antenatal clinics, and mass condom distribution campaigns became a standard element of many programmes.

During the early 1990s HIV spread rapidly throughout many parts of sub-Saharan Africa and its impacts came to be seen more clearly through increasing illness and death. The main 'official' interventions at this stage focused upon prevention and limited epidemiological surveillance. The responsibility of caring for the sick and dying devolved to families

²⁰ De Kock, K., Mbori-Ngacha, D. & Marum, E. (2002); Iliffe, J. (2006).

²¹ See De Kock, K., Mbori-Ngacha, D., & Marum, E. (2002).

²² The term 'vertical' refers to activities which are managed separately from other related activities, usually by government departments, rather than 'horizontally' which by contrast would place emphasis on the management of programme of action involving the cooperation of different agencies.

²³ Iliffe, J. (2006).

²⁴ De Kock, K., Mbori-Ngacha, D., & Marum, E. (2002).

and communities, along with community organisations, welfare groups and NGOs. Long before 'home-based care' became a key component of official AIDS plans, it was being used widely in communities – first linked to hospitals and health system personnel (hospital-based home care) and then increasingly administered by trained lay people. Support groups, post-test counselling, community-based prevention education, peer educators, anti-discrimination campaigns, and outreach with sex workers all emerged from the grassroots²⁵ – often with minimal interface with the official response systems.

Impact mitigation' activities came to the fore shortly thereafter, again with their genesis at the level of communities. It has been noted that, 'International bodies other than UNICEF largely ignored the orphan problem during the 1990s, preferring to stress HIV prevention. National government also neglected what they saw as quintessentially a field for community and charitable action.'²⁶ National programmes for orphans and other vulnerable children (OVC) were only launched around the turn of the millennium, and social grants systems – to the extent these existed – generally did not reach children and their caregivers in a targeted way. However, unofficial support for orphans and affected households was occurring widely, if unsystematically, through NGOs, churches and welfare groups. The patchwork of assistance included material relief (donations of food and clothing), help with school fees, feeding schemes, income generating projects, and sheltered housing arrangements (community-based orphan care facilities) – activities which have since become incorporated formally under the rubric of 'OVC programmes.'

Although important medical advances in treatment had been made in northern countries by the mid-1990s, the notion of 'rolling out' prevention of mother-to-child transmission of HIV and antiretroviral treatment in Africa only took centre stage in the late 1990s and early 2000s following years of open scepticism that widespread treatment programmes could 'work' in Africa. Turning points included the discovery that Nevirapine was an effective and inexpensive alternative to the more costly AZT and the major cost breakthrough on ARVs that was achieved with the pharmaceutical industry in 2001.²⁷ The years since 2000 have seen a strong shift in attention to: campaigns for treatment access, resource mobilisation for treatment programmes, plans for treatment roll-out, investments in health systems and health personnel, expansion of voluntary counselling and testing (VCT), and broad-based treatment literacy and treatment support programmes. Advocacy efforts on the part of people with HIV were prominent during this period.²⁸

Over the past decade, following UNAIDS guidance, national AIDS plans have increasingly adopted 'comprehensive responses' to AIDS comprised of a relatively standard set of interventions that are situated along the continuum from prevention through to care and support, treatment and rights. From heterogeneous roots, a wide array of 'top down' and 'bottom up' responses to AIDS have become clustered into an ordered set of programmatic interventions²⁹ clustered under broad headings: prevention (VCT, behaviour change communication, prevention of mother-to-child transmission (PMTCT), activities targeted at high risk and vulnerable groups, control of sexually transmitted infections (STIs), blood safety, infection control, workplace interventions), care and support (home-based care, support groups, networks and associations of people with HIV, treatment of opportunistic infections, nutrition, psychosocial support), treatment, impact mitigation (support for orphans and other vulnerable children, income-generation projects, food security) and rights (anti-stigma and discrimination, enabling environment, leadership,

²⁵ Iliffe, J. (2006).

²⁶ Iliffe, J. (2006, p. 120).

²⁷ Iliffe, J. (2006).

²⁸ Escalating investments in biomedical research – into microbicides and an HIV vaccine – also characterise this late period. However this area of response is located at a global rather than national level.

²⁹ Swidler (2006) speaks of 'institutional isomorphism' in the way that similar 'organisational forms, professional titles and programme labels' have emerged within the AIDS sector.

human rights, and the 'greater involvement of people with AIDS' (GIPA) principles).

Reviews have found that many national plans contain these standard elements and do not differ strongly from one another. Despite widely varying epidemiological contexts, they rarely prioritise specific objectives or strategies.³⁰ The comprehensive response framework seems to leave little space for anything short of addressing all elements simultaneously. This is strengthened by the fact that core elements of these responses have been increasingly linked to global targets – e.g. the '3 by 5 campaign' and the campaign for universal access to prevention and treatment – which are structured around the same intervention categories.

1.3.2 Intensification of response and key concepts in implementation

The United Nations General Assembly Special Session on HIV/AIDS in June 2001 marked a turning point in terms of global political commitment to tackling AIDS. Heads of state committed their governments to meeting a number of key goals whose attainment would require a massive expansion in efforts. For example, by 2005, 90% of young people were supposed to have access to information, education and services that would help them to reduce HIV vulnerability and 80% of pregnant women seeking antenatal care were supposed to have access to information, counselling and services which would help them prevent transmission of HIV to their child.³¹

This intensification of AIDS response has had three main dimensions:

- *Scale of response:* 'Scaling up' responses to prevent infections, provide care and support and mitigate the social impact of HIV has required increasing the effectiveness of responses, increasing resource levels and the ability to deploy them, and systematising activities that have grown in a responsive, but uncoordinated and possibly inefficient way.
- *Scope of response:* The scope of responses relates to breadth and comprehensiveness, and ensuring that these are matched appropriately to needs within different populations and in different geographical areas and settings. Increasing scope generates new needs for information management, coordination and integration of activities, and a management infrastructure that can effectively harness the various responses into a society-wide concerted effort.
- *Rate of response:* Attempts to increase the speed of response have involved adoption of an emergency framework for thinking about AIDS response which bypasses usual mechanisms and attempts to create greater efficiency and speed. This in turn requires greater commitment to forward planning, multi-year resource commitments, creation of synergies, increased cooperation of complementary services, and making good of economies of scale. The rate of response can only improve when all needed systems increase simultaneously.

The drive to intensify and improve responses has required attention to strategies and systems for mobilising, managing and optimising AIDS responses. Some of the more prominent trends in thinking since 2000 are described below.³²

Reviews have found that many national plans contain standard elements and do not differ strongly, despite widely varying epidemiological contexts.

³⁰ Iliffe, J. (2006); Mullen, P. (2005).

³¹ United Nations General Assembly (2001).

³² African Development Forum (2000).

Multisectoralism and mainstreaming

'Multisectoralism' has meant attempts to involve a wide array of actors, both within and outside of government, in AIDS responses. 'Mainstreaming' refers to seeing AIDS response as a necessity in all social development and health initiatives, rather than as a special stand-alone programme.³³ In relation to AIDS, multisectoralism and mainstreaming have been the leading concepts in involving all sectors of society and all spheres and tiers of government in AIDS response. This has represented a strong break from early strategies which saw AIDS as a health issue and AIDS responses led predominantly by health departments. Multisectoral and mainstreamed approaches see AIDS as a broader development issue, with social and economic roots and impacts, which cannot be addressed effectively through health interventions alone.

The commonly cited risk of mainstreaming is a loss of focus on the specific requirements of AIDS response, and there are various views on the wisdom and success of mainstreaming. Evaluations of gender mainstreaming approaches, for example, have found them to be largely unsuccessful, in part because they are slow-moving, cumbersome, and rarely receive the attention and resource allocations that are promised.³⁴

Risks associated with multisectoralism include use of resources in poorly led and rationalised programmes, poor capacity, fragmentation and poor coordination of programmes, loss of urgency, and dilution of AIDS leadership in the context of other important development priorities. Advantages include sustainability, broader scope of involvement of sectors such as agriculture, education and community development, association of AIDS response with development concerns, and mobilisation of efforts to support partnerships.

Partnerships

The call for 'partnership' has been a rallying call in AIDS response, in recognition of the fact that different actors have different experience and skills to contribute, as well as different positioning in relation to affected communities. The language of partnership is sometimes used in a context where differences are recognised and need to be bridged. For example, governments may be uncomfortable working with socially excluded groups, such as commercial sex workers or men who have sex with men, while NGOs may not. Partnerships are often constructed across sectors – e.g. government, civil society, private sector, donor institutions – and within and across levels of society. Locally based organisations may work in partnership with national NGOs or with sub-national government structures.

While the positive benefits of partnership are evident, there are strong criticisms in the development literature about the way that partnership discourse masks power imbalances and differences in agendas between different types of partners at all levels of the aid chain. This includes between donor institutions – or 'development partners' as they are sometimes termed – and recipient institutions (governments and civil society alike), between government and civil society, and within civil society between international NGOs and their local counterparts.³⁵

Coordination and integration

It is well recognised that there is need for integrating HIV prevention with sexual and reproductive health services and, more recently, with

³³ The construct was first employed in the international development arena in response to the need to adopt gender-sensitive approaches in all programmes and sectors, rather than to deal with gender as a stand-alone issue.

³⁴ Clark, C. et al. (2006, pp. 25-26).

³⁵ See, for example, Fowler, A. (2001).

treatment, care and support activities. Services need to be linked from a user perspective and the relationship between different programmes needs to be considered, both from the perspective of minimising risks of negative programme interactions as well as capitalising on synergies through better integration. However, programmes are often vertically planned, leading to critical gaps and sometimes new risks associated with programme interactions. For example, there are risks in the success of ART programmes which could lead to diminished motivation to prevent HIV infection.

Aligning, rationalising and drawing together disparate AIDS response activities into a common framework has been strongly promoted through the set of principles broadly adopted by national and international agencies and known as the 'Three Ones',³⁶ but coordination remains a formidable challenge. One of the consequences of the proliferation of AIDS responses is an increasingly complex constellation of activities and programmes which cut across thematic sectors and levels of society and which are implemented by a confusing range of institutions. As a fuller range of social resources is mobilised, a major concerted effort is needed in the interest of creating better aligned and ultimately more integrated systems of response, both within and between sectors. This has required, among other things, encouraging better sectoral coordination, development of local service integration strategies, development of multisectoral monitoring and evaluation strategies, and the sharing of learning and knowledge about pioneering work.

Decentralisation

Most countries within their national strategic plans have moved towards the notion of a decentralised response to AIDS involving satellite coordinating authorities or task forces at sub-national level. This corresponds to a general trend in development thinking towards strengthening decentralised local government. Local government structures are situated closer to the people and, the logic follows, are therefore more responsive to citizen needs.

Local governments have been pushed forward as actors in multisectoral responses to AIDS, yet they must be viewed as an unproven force in this regard. The relatively young local government structures that have evolved in many sub-Saharan African countries do not necessarily have capacity or experience in relation to AIDS. In some countries it is evident that local government is incapable of meeting the specific and quite high demands involved in managing decentralised funding for AIDS and coordinating local level activity. District AIDS task forces and councils are strongly aligned vertically with NACA structures, and in some respects are more efficient than the local government structures that are meant to host them. The area of decentralised responses to AIDS requires significant further attention and investment.

1.3.3 Debates over AIDS exceptionalism

HIV has often been treated differently from other infectious diseases – a fact which has provoked no small amount of debate. The prioritisation of human rights – linked to concerns about stigma and protecting the confidentiality of HIV diagnoses – over traditional public health infection control measures was the first major example of what has come to be called 'AIDS exceptionalism'.³⁷ The merits of building up AIDS-specific policies, approaches and structures for treating and responding to the

One of the consequences of the proliferation of AIDS responses is an increasingly complex constellation of activities and programmes which cut across thematic sectors and levels of society and which are implemented by a confusing range of institutions.

³⁶ UNAIDS (2004).

³⁷ De Kock, K., Mbori-Ngacha, D., & Marum, E. (2002).

epidemic, as opposed to integrating these more seamlessly into existing health and other systems, have also been contested.³⁸ This strain of debate has become more pronounced recently with the dramatic escalation of AIDS-related funding and the rapid expansion of programmatic responses to AIDS both nationally and globally.

Proponents of the idea that AIDS is exceptional and needs to be dealt with accordingly argue that it ranks among a handful of global crises that holds the power, through its present and anticipated impacts, to threaten 'the survival and wellbeing of people worldwide.'³⁹ Given the unparalleled magnitude of the situation, exceptional responses are not just merited, but absolutely necessary. Elements of a sustained exceptional response would include, among others, maintaining political commitments at national and global levels to attend to AIDS as a matter of priority, ensuring full and sustained financing for AIDS responses, addressing structural drivers of the epidemic, and investing in research and biomedical innovations.⁴⁰

At a practical level, AIDS exceptionalism has often been linked to the idea that AIDS needs to be responded to as an emergency. This has translated into a greater willingness to roll-out programmes quickly, to mobilise and channel funding rapidly, and to short-circuit lengthy planning cycles in a spirit of 'act now, sort out details later.' The guiding premise is that there is an emergency to attend to and that 'business as usual' will not be adequate to the task.

Contrasting views have stressed that 'AIDS exceptionalism' runs the risk of longer-term failure by paying insufficient attention to structural factors underpinning the epidemic; by inadvertently feeding into HIV-related stigma by treating HIV differently from other diseases; by setting up parallel systems rather than investing in core (health) structures; by paying insufficient attention to the links between AIDS and other diseases such as TB and malaria; and by diverting limited health worker expertise away from health systems into AIDS-specific programmes.⁴¹

One of the core tensions in discussions around AIDS exceptionalism is the relationship between AIDS and other development challenges. It is now well accepted that AIDS compromises socio-economic development efforts and successes. Vulnerability assessments in the region indicate that adult illness and death at household level are accompanied by reduced food production and lower household income.⁴² It has been found that members of affected households tend to resort to short-term coping strategies that disable their long-term ability to manage adversity and to recover from crises.⁴³ The result is a vicious circle of socio-economic deterioration, dependency and heightened vulnerability to the effects of natural disasters and famine.

This realisation has led to calls for an emergency response to AIDS and for integrating AIDS programmes 'with broader development and humanitarian initiatives.'⁴⁴ There is a growing body of literature on AIDS and humanitarian assistance⁴⁵ which has established that humanitarian assistance programmes and AIDS programmes need to be linked. However, the implications of integrating AIDS response 'with broader development and humanitarian initiatives' is questionable, particularly since these two forms of intervention are notably different in approach.⁴⁶ The interface between humanitarian assistance and long-term AIDS development needs is not simple and certainly not without tensions and, in many national AIDS plans and programme documents where

³⁸ Casarett, D. & Lantos, J. (1998); De Kock, K., Mbori-Ngacha, D. & Marum, E. (2002); Garrett, L. & Rosenstein, S. (2005); Piot, P. (2006).

³⁹ Piot, P. (2006, p. 526).

⁴⁰ Piot, P. (2006).

⁴¹ See, for example, Garrett, L. and Rosenstein, S. (2005).

⁴² UNAIDS (2003).

⁴³ Baylies, C. (2002).

⁴⁴ UNAIDS (2003, p. 9).

⁴⁵ See literature review by Harvey, P. (2003).

⁴⁶ Holloway, A. (2003).

the language of development and emergency response is interwoven, due recognition is not always given to the fundamentally different methodologies for responding to emergency and development needs.

It becomes important to examine what this means for both programming choices and the funding models which support them. Of interest in this particular research is the extent to which AIDS funding is oriented on building a society's longer-term resilience to AIDS (a 'developmental' approach) as opposed to rapid efforts to respond to immediate needs (an 'emergency' approach), and the degree to which AIDS and its effects are seen as unique and therefore meriting of a prioritised response over other similar issues or situations which are not explicitly AIDS related.

2. Resourcing the response

The impacts of the HIV epidemic are exacerbating the already significant developmental challenges in the six countries examined in this research. Malawi, Mozambique, and Zambia are among the poorest countries in the world and the human development index⁴⁷ rankings of all of these countries, as reflected in Table 5, fall within the bottom third of world rankings from 1 to 177.

The annual per capita expenditure on health in the three poorest countries ranges from US\$16 in Malawi to US\$28 in Mozambique. Swaziland and Namibia stand out as having relatively high per capita government expenditure on health, although they are still low in terms of global standards.

Given this human development, socio-economic and fiscal background and the fact that these countries all fall within the top ten countries in the world in terms of adult HIV prevalence, it is highly likely that all of the six countries will continue to rely on the financial support of development partners for many years to come, not just in the field of AIDS but also in other areas key to development.

Between 1996 and 2005 the amount of available resources for AIDS response in low- and middle-income countries increased nearly thirty fold, reaching US\$8.3 billion in 2005.

Table 5

Key development indicators

	Human Development Index Ranking 2006 ^a	% living on less than US\$2 per day ^b	Per capita gross national income (US\$) ^c	Per capita gov't expenditure on health (US\$) ^d
Lesotho	149	56.1	3210	84
Malawi	166	76.1	620	16
Mozambique	168	78.4	1160	28
Namibia	125	55.8	6960	252
Swaziland	146	No data	4970	185
Zambia	165	87.4	890	26

a-c: Human Development Report (2006); d: UNAIDS Global Update (2006).

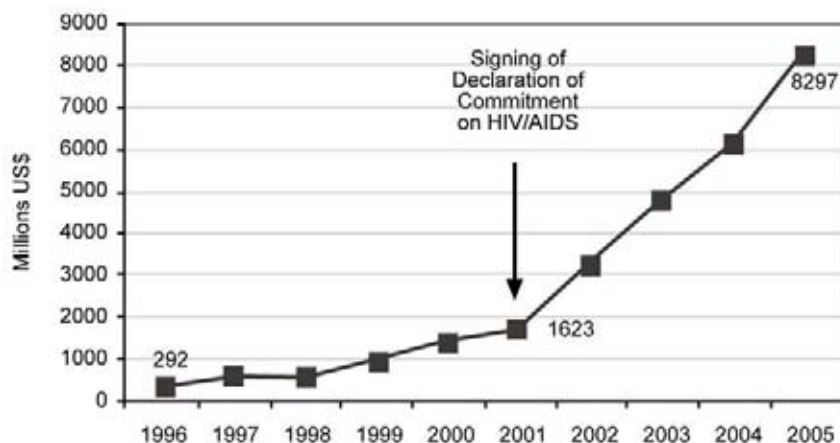
A major focus on resource mobilisation for AIDS during the late 1990s resulted in dramatically increased commitments of funds and the emergence of new financing mechanisms. Between 1996 and 2005 the amount of available resources for AIDS response in low and middle-income countries increased nearly thirty fold, reaching US\$8.3 billion in 2005 (see Figure 1).⁴⁸

⁴⁷ The HDI is a comparative measurement of quality of life in countries around the world, taking into account levels of life expectancy, literacy, education and standards of living.

⁴⁸ UNAIDS (2006a).

Figure 1

Estimated annual resources available for AIDS response, 1996 - 2005



Source: UNAIDS (2006)

Approximately 30% of global expenditure on AIDS is now provided by national government revenues, although this is heavily dominated by expenditure in middle- income countries.

On the basis of existing commitments, available funding for AIDS is estimated at US\$8.9 billion in 2006 and US\$10 billion in 2007. However, these amounts will fall short of the overall funding that is estimated to be needed to enact comprehensive prevention programmes, to achieve universal access to treatment, to support orphans and other vulnerable children, to build key human resource capacity, and to support policy development and programme implementation. These projected amounts, shown in Table 6, significantly exceed the currently committed funds. This 'financing gap' is used to support arguments for further increases in financial commitments as well as greater attention to the use and impact of existing funding.

The main sources of funding for AIDS are international donor institutions, national governments, and private sources, including foundations, private sector companies, international and national NGOs and churches. Household expenditure is known to be significant, but is difficult to measure.⁴⁹

Approximately 30% of global expenditure on AIDS is now provided by national government revenues, although this is heavily dominated by expenditure in middle income countries. Budget expenditure in low income countries is limited compared with external assistance. Bilateral and multilateral development assistance accounted for 69% of overall spending in 2005, with the small remainder attributable to other private sources.⁵⁰

Table 6

Estimated funding requirements for AIDS response in low and middle-income countries (US\$ billions)⁵¹

	2006	2007	2008	Total	%
Prevention	8.4	10.0	11.4	29.8	54%
Care and treatment	3.0	4.0	5.3	12.3	22%
Support for orphans and other vulnerable children	1.6	2.1	2.7	6.4	12%
Programme costs	1.5	1.4	1.8	4.6	8%
Human resources	0.4	0.6	0.9	1.9	3%
Total	14.9	18.1	22.1	55.1	

⁴⁹ Efforts to measure out-of-pocket expenditure on HIV/AIDS in Latin America and the Caribbean have found that, on average, 25% of spending on AIDS can be attributed to households, but that the level varies from country to country in relation to the extent of services provided by the health system. UNAIDS (2006a).

⁵⁰ UNAIDS (2006a).

⁵¹ UNAIDS (2006a, p. 225).

In 2005, the single largest source of funding for AIDS was the United States government, which committed US\$2.1 billion, followed by the governments of the United Kingdom (US\$688 million), the Netherlands (US\$265 million), and Canada (US\$237 million).⁵²

2.1 Funding modalities

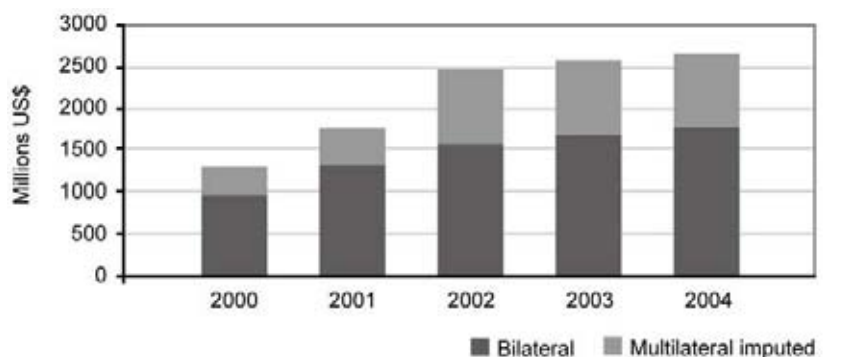
International development assistance – often referred to as Official Development Assistance (ODA) – originates primarily from the 22 member countries of the Development Assistance Committee (DAC) of the Organisation for Economic Cooperation and Development (OECD). Assistance comes in a variety of forms, from grants and loans through to the provision of technical assistance, procurement of commodities, and implementation of projects and programmes.⁵³

ODA is channelled bilaterally and multilaterally. Bilateral assistance is transferred directly from one government to another and is administered by one or more agencies or departments.⁵⁴ Donor nations can exercise control over bilateral assistance by attaching specific conditions about where and on what the funds are spent.⁵⁵ Multilateral assistance is channelled indirectly through an institution which combines resources from many donors and then allocates funds to recipient countries. Multilateral institutions that are important funders of AIDS include the Global Fund, the World Bank and the European Commission. United Nations agencies are also multilateral sources of funding, although much UN assistance is in the form of advocacy, information, facilitation and technical assistance.⁵⁶

Many DAC member countries fund both bilaterally and multilaterally, administering their own programmes in recipient countries as well as contributing funds to multilateral institutions. Overall, the majority of assistance for AIDS is channelled bilaterally, although some countries, such as Canada, France and Italy, provide most of their assistance for AIDS multilaterally through the Global Fund.⁵⁷ Both bilateral and multilateral commitments for AIDS grew steadily between 2000 and 2004, although the creation of the Global Fund has led to a greater percentage increase in multilateral assistance over this period (see Figure 2).

Figure 2

*OECD DAC countries' aid for AIDS, 2000-2004 (commitments)*⁵⁸



Linked to bilateral ODA, another funding channel that is particularly relevant to this research is the support provided by the official aid agencies of donor nations to large domestic NGOs that carry out relief and development work internationally. These arrangements are referred

⁵² Kates, J. & Lief, E. (2006).

⁵³ While attention is often paid to the amounts of ODA committed, it is equally important to consider the quality and nature of that assistance. In many southern African countries, donor institutions make available managerial and technical assistance aimed at supporting national capacity in areas such as monitoring and evaluation, developing workplans, costing out strategic plans, and organisational development (UNAIDS, 2005).

⁵⁴ For example, assistance from the United Kingdom is managed by the Department for International Development. American assistance for HIV/AIDS is overseen by the Office of the General AIDS Coordinator, but is administered by a range of agencies including the US Agency for International Development, the Centers for Disease Control and Prevention, the Department of Defense and others.

⁵⁵ See Kates, J. & Lief, E. (2006) for a detailed discussion of funding modalities for HIV/AIDS.

⁵⁶ UNAIDS (2006a). For example, Programme Acceleration Funds (PAFs) allow UN Theme Groups to play a catalytic and facilitating role in advancing the scope, scale and effectiveness of a country's response to AIDS. Amounts of funding are modest compared to the resources available through other donor channels and are intended to 'maximise the comparative advantage of the UN.' Funds can be used in one of five areas: to empower leadership for an effective country response; to mobilise and empower public, private and civil society partnerships and civil society engagement; to strengthen strategic information management; to build capacities to plan, track, monitor and evaluate country responses; and to enable access to, and efficient use of, financial and technical resources. See also, 'Guidance Notes for UNAIDS Programme Acceleration Funds (PAF) - 2004/05'. Available at http://data.unaids.org/UNA-docs/paf_guidance-notes-2004-05_en.pdf.

⁵⁷ Kates, J. & Lief, E. (2006).

⁵⁸ OECD Development Assistance Committee (2006).

to using varying terms – ‘block grants,’ ‘framework agreements,’ ‘cooperating agreements,’ and ‘partnership schemes’ – but are generally structured as multi-year agreements that support either specific project activities or a shared strategic vision between the donor and the NGO.⁵⁹ Many of the large international NGOs (INGOs) active in AIDS work in southern Africa receive this form of support from official agencies in their own countries.

2.2 Bilateral and multilateral funding for AIDS in southern Africa

In 2004, 57% of all ODA for AIDS was committed to countries in sub-Saharan Africa and nine of the top ten recipient countries were in sub-Saharan Africa.⁶⁰

The six countries examined in this research all fall within the top 15 recipients per capita of ODA commitments for AIDS in sub-Saharan Africa over the period 2000-2004 (see Table 7). Together they account for 18% of the overall ODA for AIDS committed to the region over this period.

Of particular note is Namibia’s status as the country with the highest per capital commitments of ODA for AIDS in sub-Saharan Africa – more than US\$45 per person.

Table 7
*Official development assistance for AIDS, 2000-2004*⁶¹

US\$ millions	Total bilateral ODA commitments for AIDS (2000-2004)	Total multilateral ODA commitments for AIDS (2000-2004)	Total ODA for AIDS (2000-2004)	Rank, overall ODA for AIDS (within sub-Saharan Africa)	ODA for AIDS per capita (US\$)	Rank per capita ODA for AIDS (within sub-Saharan Africa)
Lesotho	5,370	18,840	24,210	31	13.49	12
Malawi	101,590	79,070	180,660	9	14.02	11
Mozambique	166,450	94,010	260,920	8	13.18	13
Namibia	59,030	35,820	94,830	14	46.70	1
Swaziland	4,340	33,080	37,420	29	33.09	4
Zambia	236,370	116,540	352,910	5	30.25	5
Total	573,150	377,820	950,970			

⁵⁹ For a detailed discussion of trends in official agency funding of domestic NGOs, see Agg, C. (2006) and Pratt, B., Adams, J. & Warren, H. (2006).

⁶⁰ DAC member nations provide regular statistics to OECD on their ODA commitments through a Creditor Reporting System. All commitments are assigned a purpose code that indicates their main developmental focus. Data on HIV/AIDS are reported under the population/reproductive health sector and are related to two purpose codes: one which concerns activities related to sexually transmitted diseases and HIV/AIDS control (including education, testing, prevention, treatment and care) and, since 2005, another which relates to social mitigation of AIDS. 2004 is the latest year for which complete reporting data is available.

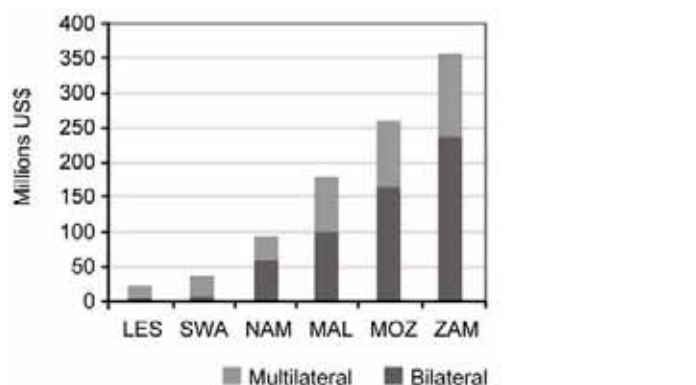
⁶¹ Data derived from OECD CRS Database.

⁶² This can probably be attributed to the fact that Lesotho and Swaziland are both small, lower-middle income countries with which many donor nations do not have separate bilateral programmes. Some donors fund activities in Lesotho and Swaziland through South Africa, and others through regional initiatives.

The proportions of assistance coming from bilateral and multilateral sources differ across countries (see Figure 3). On average 57% of assistance for AIDS comes through bilateral channels. However, this ranges from a low of 12% in Swaziland to a high of 67% in Zambia. Apart from Lesotho and Swaziland, all of the countries receive more bilateral than multilateral assistance. Lesotho receives three times more assistance through multilateral channels than bilateral ones, while in Swaziland the difference is more than ten-fold.⁶²

Figure 3

Commitments of bilateral and multilateral assistance, 2000-2004



2.3 Foundation funding for AIDS

AIDS grantmaking by private foundations has grown in recent years and a number of high-profile AIDS initiatives have been launched that blend grantmaking with technical assistance and programme implementation. While the financial value of these commitments is generally small compared to official development assistance, foundation initiatives are often narrowly targeted and adopt a catalytic approach to change which allows them to ‘punch above their weight.’

The European HIV/AIDS Funders Group, which is affiliated to the European Foundation Centre, and the US-based Funders Concerned about AIDS (FCAA), have begun undertaking resource tracking exercises to monitor levels of AIDS grantmaking. Their recent surveys have found that 68 US-based foundations committed US\$346 million to AIDS in 2004, with US\$239 million of this directed internationally.⁶³ In 2004-2005, 30 European donors contributed approximately US\$100 million for AIDS in developing countries.⁶⁴ These figures are not disaggregated by individual recipient countries, and it is therefore not possible to speak about the proportions of these funds that are directed to the six countries examined in this research.

The Bill and Melinda Gates Foundation is the world’s largest private grantmaking institution and has become a major funder for AIDS. From the start of its grantmaking in the 1990s, through the end of 2006, it made more than US\$2 billion in grants for HIV/AIDS, TB and Reproductive Health under its Global Health programme.⁶⁵ The Foundation has a strong orientation on HIV prevention, with investments in HIV vaccine and microbicide research, large-scale HIV prevention programmes, and models aimed at expanding access to new technologies.

According to these resource tracking studies, other major foundations by size of commitments to AIDS internationally include the Wellcome Trust (UK), Foundation Bettencourt Schueller (France), Ford Foundation, the Merck Company Foundation, and the Open Society Institute (all USA). AIDS-specific foundations or initiatives include the Elizabeth Glaser Pediatric AIDS Foundation, the Elton John AIDS Foundation, and the Bristol-Myers Squibb Secure the Future Initiative.

The William J. Clinton Foundation’s HIV/AIDS Initiative (CHAI) is an example of a catalytic model that works with limited financial resources,

While the financial value of commitments by private foundations is generally small compared to official development assistance, foundation initiatives are often narrowly targeted and adopt a catalytic approach to change which allows them to ‘punch above their weight.’

⁶³ Funders Concerned about AIDS (2004).

⁶⁴ European HIV/AIDS Funders Group (2006).

⁶⁵ The FCAA study found that the Gates’ Foundation commitments specifically for HIV/AIDS were US\$ 206 million in 2003 and US\$ 119 million in 2004.

but leverages high-level support and commitment to advance its goals. The Clinton Foundation works directly with national governments and provides technical assistance, financial resources, and expertise aimed at scaling up public health systems that can support integrated treatment and care programmes. It has also been instrumental in making ARVs more affordable through negotiated agreements with pharmaceutical companies. In sub-Saharan Africa, CHAI has concentrated its work in six countries, including Lesotho and Mozambique. Approximately US\$6 million was spent on the HIV/AIDS Initiative in 2004, rising to US\$14 million in 2005.⁶⁶

3. Trends in development assistance

3.1 More aid, better aid

Despite decades of international development assistance, there are few if any examples of countries where large numbers of people have been lifted out of poverty. Well-targeted development projects have been successful in tackling specific challenges, such as eradicating polio, but its overall promise has not been realised, particularly in sub-Saharan Africa.⁶⁷ Many have argued that the very structure of development assistance has helped to deepen the crisis, for example, through structural adjustment policies that have restricted spending on key developmental priorities such as education and health care.⁶⁸ Others have focused on structural 'pathologies' within the aid system itself that have worked against its performance and credibility with politicians and ordinary people alike.⁶⁹

By the end of the 20th century, it was evident that poverty had deepened in many parts of the world and the idea that economic globalisation and trade liberalisation would translate into broad economic growth had proven unfounded. The adoption of the Millennium Development Goals (MDGs) in 2000 became a catalyst for a series of further actions aimed at strengthening efforts to reduce poverty and improve quality of life for millions around the world. Eight broad MDGs – including one to combat HIV/AIDS, malaria and other diseases – were endorsed by heads of state and leading development agencies as a shared vision of the world's development priorities until 2015, but each country is responsible for developing its own targets and strategy for tackling the goals, as well as for monitoring progress towards them. These have been referred to as the 'benchmarks' of global collective action against poverty.⁷⁰

The United Nations Conference on Financing Development held in Monterrey in 2002 resulted in the so-called 'Monterrey Consensus,' which stressed the importance of country-led processes, involving both governments and donors, aimed at optimising the use of available resources for poverty reduction. The Monterrey Consensus became an important building block in the emerging development framework.

Although DAC member countries had long ago promised to reach a target of committing 0.7% of Gross National Income to ODA, by 2005 only five countries had reached this level, and many fell well short of this goal. Against the backdrop of the MDGs campaign, governments of developed countries came under increasing pressure to reaffirm this commitment and to dramatically scale up ODA. The 0.7% target was reiterated at the G8 Summit in Gleneagles in 2005 and ODA commitments have continued to rise.

⁶⁶ See <http://www.clintonfoundation.org/cf-pgm-hs-ai-home.htm>. Financial figures from William J. Clinton Foundation Annual Reports, available at <http://www.clintonfoundation.org/pdf/annual-report-2004.pdf> and <http://www.clintonfoundation.org/pdf/annual-report-2005.pdf>.

⁶⁷ Fowler, A. (2001).

⁶⁸ Poku, N. (2005).

⁶⁹ Among these, Fowler (2001) lists the dominance of Cold War political agendas over poverty and growth agendas; emphasis on disbursement, rather than performance; short-termism; aid that is 'tied' to donor countries; donor ce of ownership; and uneven power dynamics between donor and recipient countries.

⁷⁰ Rogerson, A. with Hewitt, A. & Waldenberg, D. (2004). Rogerson et al. (2004, pp.11-12) also raise an important limitation of the MDGs, which is that they have a 'natural shelf life,' having designated targets for attainment by 2015. 'As 2015 grows closer,' they note, 'the probable statistical outcome of these individual endeavours will become clearer.' It then follows that the MDGs 'will probably cease to be an effective reference point both for very successful and very unsuccessful countries, and may lose their potency for much of the undecided category.'

Alongside demands for increasing aid, there are also calls for improving the quality of the aid that is provided to ensure that it has the intended effects in reducing poverty – in other words, to redress ‘aid pathologies.’ Analyses of development assistance have revealed that a significant proportion of assistance does not reach its target, due to factors including expensive consultants and technical assistance, procurement conditions that require purchases from the donor country’s own companies (‘tied aid’), high administrative overheads, and the double counting of debt relief.⁷¹ As commitments of donor assistance increase, there is concern among activists, donor agencies, and governments that funding be used effectively and reach the people and communities that are most in need of help. Among the major shifts that can be observed are: the dominance of ‘poverty reduction’ as a framing concept (embodied in the MDG campaign); attention to appropriate policy frameworks and institutional capacities to support poverty reduction (linked, for example, to Poverty Reduction Strategy Papers); multisectoralism, partnerships, ‘participation’ and decentralised decision-making to promote greater ownership of development; and a more narrow targeting of donor assistance, accompanied by specific targets for measuring performance and demonstrating impact.⁷²

3.2 Aid harmonisation and effectiveness

Increased allocations of development assistance by donor nations have been accompanied by heightened attention to issues of accountability, efficiency, and measurement of impact. With the prospect of more aid flowing and the development field becoming ever more crowded, the challenge of administering aid effectively has attracted great attention in recent years. The 2005 Paris Declaration on Aid Effectiveness⁷³ outlines a set of principles for systematising the delivery and use of development assistance that are having a powerful effect on the development landscape. These include:

- Strengthening host countries’ capacity to develop and deliver results-driven national development strategies;
- Defining performance standards and measures for host countries’ financial management systems and other systems;
- Reforming and simplifying donors’ policies and procedures to make them as cost effective as possible, to reduce unnecessary duplication and bureaucratic burden on countries and to achieve progressive alignment with host countries’ policies and procedures;
- Providing more predictable, multi-year aid flows consistent with the sustainable development needs of host countries;
- Doing a better job of integrating global initiatives – including AIDS – into host countries’ broader development agendas; and
- Enhancing both donor and host countries’ accountability to their citizens and parliaments by making their policies, procedures and activities more transparent.

Donor nations that are signatory to the Paris Declaration are committed to integrating these principles into their national assistance policies, while recipient countries are expected to develop their national development plans in consultation with a wide range of domestic stakeholder groups, to be accountable to their own societies, and to be actively involved in coordinating donor assistance in support of development goals. The

⁷¹ Greenhill, R. & Watt, P. (2005).

⁷² Fowler, A. (2001).

⁷³ Paris Declaration on Aid Effectiveness (2005).

following categories and indicators were established to monitor progress in implementing the Paris Declaration:

- *Ownership*. Country partners having operational development strategies;
- *Alignment*. Reliable country systems for procurement or public financial management; aid flows aligned to national priorities; strengthened capacity by coordinated support; use of country public financial management systems; use of country procurement systems; strengthened capacity by avoiding parallel implementation structures; disbursement of aid is more predictable;
- *Harmonisation*. Use of common arrangements or procedures; encouragement of shared analysis;
- *Managing for results*. Results-oriented or performance measurement frameworks; and
- *Mutual accountability*. Mutual accountability involving mutual assessment reviews regarding commitments.

Traditional aid mechanisms, characterised by independent and unconnected project-based funding, are not well-suited instruments for attaining this type of aid effectiveness, and so-called ‘new aid modalities’ have been gaining in prominence alongside the harmonisation agenda. These are described in more detail in Section 3.3.

While harmonisation has now become a development buzzword, there is far from consensus that it is a good thing. Concerns have been voiced from the perspective of civil society and include the fact that national development plans are not always developed through consultation and may not reflect the views of key sectors of society; that harmonising development aid can make poor people increasingly vulnerable in instances where political changes or shifts in donor preferences mean that a state ‘falls out of favour’; that civil society’s role is not necessarily to align itself with national development plans as CSOs have very different types of constituencies with varied needs and interests; that civil society risks becoming an ‘instrument of the state’, rather than characterised by its own inherent diversity and independence;⁷⁴ and that funding for CSOs will ultimately decrease.

Harmonisation in relation to AIDS

The Paris Declaration sets forth the overarching framework for how development assistance in general might be made more systematic. Within the AIDS sector, complementary processes have been launched that seek to harmonise funding and support specifically related to AIDS.

While it had long been apparent that AIDS responses were occurring through a range of disconnected and parallel channels, calls for harmonisation grew louder around 2003 and 2004 as the three major funding initiatives began to come on stream. A fieldwork-based analysis of four countries’ experiences in applying for Global Fund support found that senior policy and technical staff were already consumed by negotiations with the World Bank, PEPFAR and the Clinton Foundation at the time that Global Fund Round One proposals were called for, and that the dominant pattern was one of governments ‘partially engaging with many (old and new) financing initiatives, in place of systematic and effective engagement with fewer initiatives and funding agencies’

While it had long been apparent that AIDS responses were occurring through a range of disconnected and parallel channels, calls for harmonisation grew louder around 2003 and 2004.

⁷⁴ Pratt, B. (2006).

– a reality that was attributed to the ‘perverse effect of too many poorly coordinated parallel financing mechanisms.’⁷⁵ According to the research findings, ‘there was no evidence...that these global initiatives were trying to promote a coordinated approach to the financing, planning and monitoring of HIV/AIDS control at the country level’ and that, apart from Mozambique where harmonisation was strongly supported by government respondents, ‘the attitude appeared to be: “Let’s first secure the funds and we’ll harmonise later.”’⁷⁶

In 2003, in recognition of these types of challenges, officials from African nations, multilateral and bilateral agencies, NGOs and the private sector met and reached consensus around three principles applicable to stakeholders in national-level AIDS responses.⁷⁷ These have become known as the ‘Three Ones’, and refer to the need for one agreed AIDS action framework that provides the basis for coordinating the work of all partners, one national AIDS coordinating authority with a broad-based multisectoral mandate, and one agreed country-level monitoring and evaluation system.

The Three Ones principles have garnered significant support and were endorsed and adopted by a high-level meeting of participants representing many countries and international support agencies in April 2004. This step served to bring the AIDS sector into line with agreed principles of the Paris Declaration and related frameworks. Donors, aid agencies and international NGOs are encouraged to work in concert with the national plans and national coordinating structures, and align with into national monitoring and evaluation frameworks.

The ‘Three Ones’ have become a powerful rhetorical force in the way that AIDS response strategies are framed and understood, both internationally and at country level. However significant questions need to be asked about the extent to which the principles are being employed in action. An assessment of progress conducted by UNAIDS in 2005 found that the majority of countries surveyed had met basic targets – for example, 82% had a national AIDS plan and 79% had at least begun work on developing monitoring and evaluation frameworks – but that there were significant weaknesses in the quality and comprehensiveness of these actions. Of particular relevance to civil society, the review found that even where consultative procedures have been put in place in relation to national plans, key stakeholder groups – such as those representing women, NGOs, faith-based organisations (FBOs) and people with HIV – are not fully engaged. ‘Agreement requires participation,’ the report noted, and ‘broad participation is the exception rather than the rule.’⁷⁸ Another finding was that 95% of countries had National AIDS Coordinating Authorities, but many did not have strong mandates and did not adequately cover all relevant sectors.

Another critique related to harmonisation and AIDS comes from those who question the way that ‘AIDS exceptionalism’ has resulted in the development of narrowly focused AIDS-specific programmes, interventions, and funding and coordination models – rather than integrating AIDS responses into existing systems and focusing on the interconnected nature of AIDS and other diseases. One result of this, they argue, is the absence of institutional mechanisms that can work *across* the many different health-related initiatives underway in countries. This leads to ‘consistent interagency conflict,’ duplication of one another’s work, competition for resources, competition for the limited pool of qualified health personnel, an ‘endless stream of donor-mandated forms,’

The ‘Three Ones’ has become a powerful rhetorical force in the way that AIDS response strategies are framed and understood.

⁷⁵ Brugha, R. et al. (2005, p. 8).

⁷⁶ Brugha, R. et al. (2005, p. 9).

⁷⁷ UNAIDS (2004).

⁷⁸ UNAIDS (2005, p. 17).

and multiple studies and evaluations to demonstrate implementation and offer accountability. 'Simply keeping track of the demands of divergent benefactors requires the time and professional skills of a small army of English-speaking paperpushers,' they conclude.⁷⁹

Finally, it is important to underscore the undeniable 'fact on the ground' that parallel funding and programming for AIDS continues to exist, and even to thrive, although it is now common for support of all kinds to now be described as aligned with national plans and priorities.⁸⁰ Two of the largest funding initiatives for AIDS – the Global Fund and PEPFAR – are structured in ways that are at odds with elements of the Paris Declaration and Three Ones principles. The Global Fund requires the establishment of parallel systems (Country Coordinating Mechanisms), insists on certain procedures being conducted by the Global Fund itself,⁸¹ and channels its funding directly to Principal Recipients. PEPFAR's Country Operational Plans are developed with little or no consultation with in-country institutions or stakeholders,⁸² funding earmarks for prevention activities limit programming choices,⁸³ restrictions on the purchase of generic drugs conflict with many national drug procurement systems, funding is channelled predominantly to non-state recipients, and monitoring and evaluation requirements specific to PEPFAR's own numerical targets⁸⁴ are an integral part of all PEPFAR awards.⁸⁵

3.3 How aid is being delivered

The principles of aid effectiveness outlined in the Paris Declaration require changes in the way development assistance is administered. If 'traditional' development assistance involved a multitude of individual development projects, funded and administered directly by a range of institutions, and not linked systematically into an overall development plan, 'new aid modalities' emphasise a much more streamlined approach to delivering aid which utilises country systems and structures and gives national governments much greater control over the way aid is used.

The 'new aid modalities' are oriented on increasing levels of direct budget support to governments – in other words, turning resources over to national government treasuries to manage and allocate through their own budgeting, allocation, procurement and monitoring systems. The rationale behind direct budget support is that it gives governments greater control over resources, strengthens their capacity to plan and manage development processes, promotes transparency and good governance, and will eventually result in governments that are more accountable to their citizens.

There are push and pull factors behind the trend towards new aid modalities. On the one hand, traditional forms of assistance have come to be seen as 'donor driven' in that they were often fragmented, did not address national development priorities in a systematic way, did not build national institutional capacities as they largely bypassed national structures, and resulted in 'islands of development' that ultimately may not have been sustainable.⁸⁶ The administration of multiple unrelated projects also generated high transaction costs for both donors and national governments. Yet beyond these concerns about the limitations of project-based development strategies, development assistance has shifted towards direct budget support largely because there has been a need to find ways to channel significantly increased resources. Governments are seen as potentially having the capacity to absorb the increased aid flows in a way that 'off budget' projects cannot.

⁷⁹ Garrett, L. & Rosenstein, S. (2005).

⁸⁰ However, as has been shown in reviews of national AIDS plans, these are often fairly generic and not prioritised (see Mullen, 2005), making it quite easy to describe activities of all types as being 'aligned' with them.

⁸¹ Bezanson, K. (2005).

⁸² Personal interviews conducted for this research.

⁸³ Peacock, D. & Msimang, S. (2007); Rawls, W. (2006).

⁸⁴ In the 15 focus countries, PEPFAR aims to prevent 7 million new HIV infections, make treatment available to 2 million people, and reach 10 million people with care and support.

⁸⁵ Despite this, PEPFAR frames itself as working in support of the 'Three Ones' which, 'rather than mandating that all contributors do the same things in the same ways...facilitate complementary and efficient action in support of host nations.' See www.pepfar.gov.

⁸⁶ Scanteam (2005).

3.3.1 General budget support and sector-wide approaches⁸⁷

The two main forms of direct budget support are general budget support (GBS) and sector-wide support (or sector-wide approaches – SWAp). General budget support refers to untied assistance that flows directly into government budgets and forms part of the overall resources available to government in its budgeting processes. GBS flows through government treasuries and is handled through the government's normal public finance management systems. It can be directed to national budgets or to sector-specific budgets.

General budget support generally involves more than simply the provision of resources, and is often directed at building up the capacity of the state institutions involved in its allocation and use. A typical GBS programme⁸⁸ usually includes: 1) policy dialogue between donors and the recipient governments pertaining to fiduciary risk assessments and public finance management systems; 2) the financing itself, which is disbursed in tranches in accordance with the attainment of agreed-upon conditions and objectives; 3) the conditions attached to the support and indicators for measuring performance; and 4) the provision of technical assistance and capacity-building to strengthen public finance and management systems.

Sector-wide approaches vary in form, but are generally aimed at reducing the amount of 'off budget' support that occurs within particular development sectors (e.g. health, education, water and sanitation) and consolidating development activity within an agreed-upon, sector-led plan and budget. It is a way of minimising the duplication of efforts by a number of different donors and institutions and unifying these activities under a government-led strategy and framework. SWAPs can take a variety of forms – some include pooled funds, while others do not – but the common elements include: an agreed programme for the sector, which is developed by government in a consultative fashion; agreement among donors working within the sector as to their respective roles and inputs; and funding commitments within the sector directed in support of the agreed programme.

3.3.2 Implications of 'new aid modalities'

Although budget support is often described as a 'new' aid modality, donor institutions have been providing support to governments and national treasuries to some extent for decades. The major change is the scale at which budget support is now being provided and the fact that it is being heavily championed by the bulk of donor institutions. This is leading to a tangible shift in overall aid delivery modalities in many sectors, including AIDS, and the implications of these shifts are being felt on the ground in terms of how funding is accessed by non-state actors in particular. Concern is being raised in some quarters about the lack of attention paid to date to the effects of the shift to budget support, as opposed to the extensive attention that is paid to technical issues related to donor coordination.⁸⁹ These issues are of direct relevance to the role and positioning of civil society organisations within development efforts in general, and within the AIDS sector in particular.

It is also important to note that shifts in preferred aid modalities are occurring gradually, with many donors employing a mix of 'complementary modalities'⁹⁰ in cases where it is deemed that the policy and institutional environment may not be sufficiently enabling for programme funding. The UK Department for International Development

The general budget support approach is leading to a tangible shift in overall aid delivery modalities in many sectors, including AIDS, and the implications of these shifts are being felt on the ground in terms of how funding is accessed by non-state actors in particular.

⁸⁷ Material in this section draws heavily upon background material in Scanteam (2005).

⁸⁸ From the Joint Evaluation of General Budget Support (University of Birmingham), cited in Scanteam (2005, p. 13).

⁸⁹ See Student Partnerships Worldwide (2006).

⁹⁰ The White Paper on Irish Aid (Government of Ireland, 2006, p. 72), for example, speaks of 'main modalities' in the form of SWAPs and General Budget Support, but the need 'to continue to support individual projects' in places where the policy or institutional environment is not deemed suitable for programme funding.

(DFID), for example, speaks of a 'hierarchy of actual and potential aid instruments' in its Country Assistance Plan for Zambia, which ranges from 'general budget support' through 'multi-donor sector investment programmes,' 'multi-donor pooled funding projects' and 'co-funded or stand-alone technical assistance and direct delivery projects.' The latter can be employed where the projects are in line with government priorities, the benefits outweigh the transaction costs, and there is a reason to expect significant innovation benefits or a more effective delivery of outcomes.⁹¹ In other words, the agenda set forth in the Paris Declaration remains a work in progress, rather than a reality.

4. AIDS and civil society responses

4.1 The concept of civil society

'Civil society' is an old concept that has experienced a major renaissance over the past 15 years. Despite years of unresolved debate about its precise meaning and definition, civil society has become "'the big idea" on everyone's lips' – a 'chameleon-like' concept employed enthusiastically by actors and thinkers on many points of the political spectrum.⁹² Ascendant during a period marked by the fall of communism and popular democratic revolutions, as well as growing disenchantment with both state-led models of development and neo-liberal economic globalisation, the idea of civil society has come to embody the promise and potentials of the space and/or institutions that fall outside the bounds of the state, the market and the family.

Two main theoretical understandings of civil society can be distinguished from amidst a complex set of debates. The first, which emanates out of the Enlightenment period⁹³ and is most closely associated with the writings of Alexis de Tocqueville, focuses upon the importance of independent, self-regulating citizen associations that can defend individual rights and freedoms against the encroachment of the state or dominance by any particular group. In this view, popular membership in civic bodies is an important guarantor of democracy and political stability. This intellectual tradition has been picked up strongly in recent years in the writings of Robert Putnam and has fed into the view of civil society which sees it as a part or 'sector' of society comprised of institutions and associations that are, by definition, non-governmental.⁹⁴ The emphasis here is on institutions and 'associational life.'

A second broad intellectual tradition draws upon the critical perspectives of writers such as Hegel, Marx, Gramsci and Habermas. Focusing more upon issues of power and resistance, it tends to see civil society as a dynamic social space or arena within society where ideas are debated and contested, where issues of concern can be taken up and pursued through popular action, and where human capacities can be employed in the creation of a democratic public sphere. In this reading, civil society has come to be seen as a potential site for progressive politics, embodying possibilities for emancipation and transformation. While it encompasses institutions, the emphasis here is on civil society as a force for social change and as a set of capacities for developing 'collective visions' around the shape of the societies in which people live.

The vigorousness of the debate over civil society – its meaning(s), its role(s), its recent re-emergence as a political, social and analytical construct – reflects efforts to make sense of the worldwide explosion of

⁹¹ DFID (2004b, p. 16).

⁹² Edwards, M. (2004).

⁹³ The term has its likely origins in 18th-century philosophy, notably in Adam Ferguson's 1867 *History of Civil Society*, and particularly its reference to the work of French philosopher Montesquieu who articulated a separation of government powers into executive, legislative and judicial arms.

⁹⁴ Edwards, M. (2004).

civil society organisations over the past two decades and the mounting pressures for greater 'citizen participation' in decision-making of all sorts. In what has been termed a global 'associational revolution,'⁹⁵ tens of thousands of non-governmental organisations, faith-based organisations, community-based organisations, social movements, social forums and citizen-led advocacy campaigns have emerged on local, national, regional and international stages around a wide range of issues and interests. Among the most visible of these have been large international development NGOs – such as Save the Children, Oxfam, World Vision, and ActionAid – and campaigning groups, such as Greenpeace, which gained in prominence, operational and policy expertise, and financial and programmatic magnitude throughout the 1970 and 1980s. By the early 1990s these had emerged as powerful players in shaping popular opinion on key issues, lobbying governments and international institutions, and delivering emergency humanitarian relief as well as providing non-emergency developmental services in many countries throughout the world.

Through the power of the work that these and smaller CSOs do, the generally high levels of trust they enjoy within many societies and, increasingly, their financial and political might, civil society organisations and the civil society 'sector' have been catapulted to the international stage as central players or 'partners' in addressing a range of political, economic and social challenges, including within the development sector. During the 1990s, donor agencies 'discovered' civil society and embraced it both rhetorically and programmatically.⁹⁶ Although development agencies in donor countries had long channelled some support to their own international development NGOs for work overseas,⁹⁷ the 1990s saw a major shift from 'support for NGOs' to the less clearly defined 'support for civil society.' Alongside reassessments of Structural Adjustment Programmes, given their deleterious effects in many low and middle income countries, and strong ideological aversions to the state as the leading economic and development actor, civil society came to the forefront as part of a package of normative concepts including 'good governance,' 'partnership' and 'participation'⁹⁸ that have since become centrally embedded in development thinking.

Following the end of the Cold War, which was characterised by largely peaceful popular uprisings against communist rule, many donor agencies saw civil society as both a 'site and an agency' of resistance to authoritarianism⁹⁹ – in other words, as a critical component of democratisation programmes – in the neo-Tocquevillian tradition. However the idea that a strong civil society could also contribute to economic development and poverty reduction also took root, based in the premise that civil society presents a space in which citizens – including the poor – can voice their interests and needs, thereby shaping public debates and policy, in addition to organising themselves to address these needs directly. In keeping with neo-liberal economic theory, a positive relationship was generally assumed to exist between economic development, poverty reduction and democratisation.¹⁰⁰ NGOs and other civil society institutions were 'valorised' by many as efficient, altruistic, honest, and close to the people, making them popular alternatives to the state, which was often seen as weak in terms of management capacity, unaccountable to its citizens, and either corrupt or mired in patronage.¹⁰¹

In what has been referred to as the 'trinity of State, civil society and the market,'¹⁰² the idea of multisectoral partnerships has become the guiding premise of development assistance strategies. The idea is

In what has been referred to as the 'trinity of State, civil society and the market,' the idea of multisectoral partnerships has become the guiding premise of development assistance strategies.

⁹⁵ Salamon, L. (1994).

⁹⁶ For a comprehensive look at the relationship between donors and civil society, see Howell, J. & Pearce, J. (2001).

⁹⁷ The international system of donor state NGOs (DOSTANGO) is often traced back to a US government initiative in the early 1960s, by which other OECD governments were asked to follow its lead in giving money to NGOs or private voluntary organisations to increase public support for official aid projects (Tvedt, 2004).

⁹⁸ Wickramasinghe, N. (2005).

⁹⁹ Howell, J. (2002).

¹⁰⁰ Howell, J. (2002).

¹⁰¹ Igoe, J. & Kelsall, T. (2005).

¹⁰² Howell, J. (2002).

that broad-based mobilisation of resources and actors is required for development programmes to be effective and that, through partnerships, the 'ownership' of development programmes can be spread more broadly across involved and affected groups. Although these partnerships are generally depicted as largely harmonious and mutually beneficial, with the three main 'sectors' and other 'partners' (e.g. external donors) pursuing broadly similar developmental objectives for the country, critical observers have noted that this masks the great differentiation, inequality and competing agendas that exist within civil society,¹⁰³ as well as the fact that the partnerships themselves exist in a context of vast power imbalances.¹⁰⁴

One forceful critique of donor support for civil society in developing countries¹⁰⁵ argues that donor agencies are deliberately manufacturing civil society in southern countries where the concept never existed as such in the past, in line with a specific version of the concept that has become hegemonic over the past two decades. Following this line of argument, the version of civil society that is now commonly applied within the development field has become 'Americanised' – that is, the institutional, associational strain of de Tocqueville and Putnam has triumphed over the vision of civil society as a public sphere for debate and action around a common vision. Support for 'civil society strengthening' tends to focus upon particular types of institutions – namely NGOs, which are often urban-based, elite-led and oriented on strengthening democratic institutions and the legitimate expression of dissent – at the expense of others; such as trade unions, ethnic and religious-based groups, rural and professional associations (e.g. farmers, fisherpeople), CBOs and groups led by linguistic or cultural minorities which have more limited resources and voice, but may also demand more fundamental changes or pursue their claims through methods that lie outside the formal political system.

The tendency to engage with a filtered stratum of civil society organisations has been termed 'the illusion of plurality and social inclusion.'¹⁰⁶ Donor definitions of civil society tend to be broad and include a wide range of types, but actual funding tends to be constrained to 'known' institutions (as opposed to more informal types of groups),¹⁰⁷ rather than being based on an informed understanding of the dynamics of change in a given country. There are fundamental power dynamics at play within civil society, just as there are anywhere, and donor support for civil society can perpetuate inequalities within civil society itself, through their choices about which institutions to support. Donor choices about what types of institutions to support effectively 'sanitises' and 'rationalises' what is a highly diverse and complex universe of forms; this is seen particularly clearly in efforts to create or establish particular types of CSOs where such do not exist, or to encourage the formation of 'representative bodies' or networks to speak for constituencies and with whom government and private sector partners can 'cooperate.'¹⁰⁸

In this view, donor institutions have instrumentalised support for civil society as means to an end, rather than as an end to itself. Support for civil society is oriented more on building up the sector as protection from the state and for the promotion of good governance, than as a space within society where thinking, debate, and action around common interests are pursued. Global institutions 'consume' local initiatives and formations; civil society can become depoliticised; and local CSOs struggle to define and sustain their own agendas in the face of financial dependency on external sources of funding.¹⁰⁹

¹⁰³ Fowler, A. (2001); Howell, J. (2002); Wickramasinghe, N. (2005).

¹⁰⁴ Fowler, A. (2000).

¹⁰⁵ Wickramasinghe, N. (2005).

¹⁰⁶ Howell, J. (2002).

¹⁰⁷ Others have also noted that 'civiness' has come to be associated with formal institutions only – a Western concept that misrepresents the diverse ways in which citizens interact with one another and forms of social configurations based in informal networks and trust-based relationships. See, for example, Fowler, A. (2000) and Wilkinson-Maposa, S. et al. (n.d.).

¹⁰⁸ Wickramasinghe, N. (2006).

¹⁰⁹ Howell, J. (2002); Wickramasinghe, N. (2006). Fowler, A. (2001), in his discussion of 'aid pathologies,' also focuses upon the unequal power relationship that characterises interactions between donors and recipient-country CSOs.

4.2 Civil society in AIDS response

4.2.1 CSO roles in development

The belief that a 'strong civil society' is linked to (democratic) political stability, good governance and economic growth led many donor agencies to launch 'civil society strengthening' programmes during the 1990s with the aim of supporting civil society as a sector. Such support often focused upon particular types of institutions and goals, such as strengthening the rule of law through legal and judicial reform, the consolidation of democratic elections, the promotion of decentralised government, and support for independent media and professional associations.

Compared to these types of support to the sector as a whole, however, proportionally more development assistance has been channelled to (and through) civil society organisations working on the ground as implementing agencies on a wide range of development-related issues. The past two decades has seen a steady deepening of the involvement of civil society organisations in the provision of social services, emergency and humanitarian relief, and development interventions in many countries. Although there is a long history of social service provision by non-governmental institutions,¹¹⁰ this role became much more pronounced and more mainstream during the 1980s, when Structural Adjustment Programmes severely curtailed levels of spending and constrained the capacities of the state. Fuelled in part by an economic and governance climate that favoured outsourcing roles to non-state 'service providers,' NGOs moved into this gap and began to take over the provision of services in certain sectors, such as health, sanitation, education and rural development – in some cases surpassing the role of the state itself.¹¹¹ During the 1990s, NGOs emerged as one of the main vehicles for delivering official development aid to its intended beneficiaries.¹¹²

While precise figures are difficult to come by, some estimates place the value of the non-governmental development sector at more than US\$1 trillion per year, putting it on par with some of the world's largest economies. International development NGOs in particular have come to rival the potency of many bilateral development agencies with the size of their budgets, their size of staff, and their operational presence around the world.¹¹³ Studies of funding trends in the 1990s have found that the proportion of funding directed to the CSO sector grew at a time when there was an overall contraction of development assistance and that direct funding of CSOs – at least during the 1990s – constituted a growing share of a shrinking overall pie.¹¹⁴

The same review found that CSOs spent most of the funding they received on the provision of services, as opposed to advocacy-related activities such as issue-specific mobilisations, lobbying, or other forms of rights-based claims making¹¹⁵ which extend along a spectrum from technical and relatively non-confrontational engagements within the parameters of the political system, to more radical claims for change that may challenge the basis of the prevailing order. Similar research among women's organisations has also found that technical approaches to development (for example, 'poverty alleviation' projects, as opposed to attention on changing the structural drivers of poverty) are favoured over political ones – a trend which poses particular challenges for CSOs that have adopted a rights-based approach to their work.¹¹⁶

Studies of funding trends in the 1990s have found that the proportion of funding directed to the CSO sector grew at a time when there was an overall contraction of development assistance.

¹¹⁰ For example, church-based health care systems in some sub-Saharan African countries date back more than a century.

¹¹¹ Clayton, A., Oakley, P. & Taylor, J. (2000).

¹¹² Fowler, A. (2000).

¹¹³ See Agg, C. (2006) for a discussion of the 'golden age' of NGOs.

¹¹⁴ INTRAC (1998).

¹¹⁵ INTRAC (1998).

¹¹⁶ Clark, C. et al. (2006).

In terms of its overall financial value, funding to CSOs is largely in support of service provision, yet the roles that civil society organisations are expected to play in the development sphere are multi-faceted and also include fostering social integration, building local capacity, acting as watchdogs of the public good, and promoting people-centred development.¹¹⁷ The growth in service provision by non-governmental actors over the past 20 years has dovetailed with the resurgence of the concept of civil society in development (see Section 4.1) in a way that has become mutually reinforcing, at least in the eyes of donors: a strong civil society sector is important for democratisation and growth; civil society is 'close to the people' and both reflects and addresses their needs and interests; and the involvement of civil society institutions in providing services should be encouraged as a way to ensure that those needs are met efficiently and effectively. The result, in some interpretations, is that funding and support for civil society as a sector has become blurred with development assistance support channelled to CSOs as non-governmental implementing institutions¹¹⁸ and that the diverse and complex universe of 'civil society' has become reduced down, for programmatic purposes, to NGOs with a development focus.¹¹⁹

4.2.2 CSOs as 'partners' in AIDS response

Civil society organisations have been at the forefront of responses to AIDS in many parts of the world, and some of the clearest successes in confronting the epidemic have been linked to the active role played by local level actors.¹²⁰ Civil society action on AIDS long predated the idea of 'comprehensive programming' and the large-scale funding which is now enabling its implementation. Many of the care and support and impact mitigation activities that have become institutionalised in national and global-level plans were in fact pioneered on the ground by NGOs, welfare organisations, churches and groups of infected and affected people.¹²¹ To the extent that it has happened – and there are varying views on how genuine versus rhetorical these steps have been – the official embrace of civil society organisations as 'partners' in multisectoral response, public acknowledgement of their contributions, and attention to the need to make funding and resources available to them have all lagged behind CSOs' practical involvement in AIDS response activities.

CSOs have commonly been cited as the leading forces in the evolution of community-based models of care and support to affected people and households, including to orphaned children.¹²² In the absence of strong social safety nets, associations of community members – usually women – have proliferated across the continent to meet social and material needs. Home-based care, income-generating activities, support groups, food gardens, peer education, pastoral and spiritual care, treatment support, and treatment literacy programmes have all been promoted from the 'bottom up' – partly outside structured frameworks and often in a holistic, cross-cutting way – and have gradually entered into programmatic discourses as discrete interventions.¹²³

Civil society groups have also played an important role in drawing attention to the epidemic, mobilising for the rights of HIV-positive people, and catalysing greater political and financial commitments to addressing the epidemic. This political strand of AIDS-related civil society advocacy has continued until the present day, and has primarily been visible in campaigns for the Greater Involvement of People Living with AIDS in policy, leadership and various forms of decision-making; in mobilisations around access to ARV treatment and systems

¹¹⁷ Fowler, A. (2000).

¹¹⁸ Clayton, A., Oakley, P. & Taylor, J. (2000).

¹¹⁹ As civil society has come to be applied in contradistinction to government initiatives and structures, the many diverse institutions of civil society have increasingly been reduced down to 'non-governmental organisations.' The terms are often used interchangeably, although, as this discussion has shown, they are conceptually distinct.

¹²⁰ Low-Beer, D. & Stoneburner, R. (2004a & 2004b); Panos Institute (2003); Rau, B. (2006); Thornton, R. (2003).

¹²¹ Rau, B. (2006).

¹²² Foster, G. (2002 & 2003); Iliffe, J. (2006); Rau, B. (2006).

¹²³ Iliffe, J. (2006); Rau, B. (2006).

for administering treatment; and in demands for greater resource commitments, including development assistance, to fight the epidemic.

As the number of CSOs working on AIDS has grown, umbrella structures and sector-wide networks have emerged to link together organisations with similar orientations in the interests of sharing information, creating synergies, enhancing access to resources and, ideally, advancing common interests. Among the most common types of networks have been those between organisations representing people with HIV, networks of AIDS service organisations, associations of traditional healers and traditional leaders, AIDS-related business associations, inter-faith networks, and networks of CSOs focusing on children's issues.

The first official call for civil society organisations and people living with HIV to be drawn more deeply into AIDS responses came at the 1989 World Health Assembly; the following year this was echoed by calls to strengthen women's involvement in AIDS strategies.¹²⁴ This was prompted in large part by the growing realisation that the centralised, health-focused responses that had been mounted to date were not turning the tide. A growing focus on vulnerability and on structural drivers of the epidemic led to a questioning of the narrow medical orientation that had been taken to date. It is probably not coincidental that the official calls for a greater role for civil society in AIDS occurred at the same time that the concept of civil society was making its resurgence.

As is discussed in greater detail in Part III of the report, some of the main rationales for drawing civil society into AIDS responses have included beliefs that civil society organisations represent, or are located close to, vulnerable and affected communities; they are more efficient, effective and innovative than the state in the way they work; they understand community needs; they can reach remote and marginalized populations; and they can give voice to the needs and concerns of affected communities.

Civil society organisations have been brought into the fold through both national AIDS plans and AIDS funding flows, and are seen as a crucial constituency for realising the 'Three Ones' principles. Roles are generally allocated to civil society organisations in national plans, which are almost always now 'multisectoral' in design. It is apparent that civil society is being strongly pushed to the fore as the solution to at least some of the problems of AIDS delivery, such as the practical challenges of reaching and providing follow-up services to people in remote and underserved areas, however there has been little critical discussion of this. There are differences in the extent to which these plans reflect genuine processes of consultation, draw upon civil society contributions strategically, and are sensitive to the diverse circumstances, constituencies and orientations of different types of civil society groups. As one observer has noted, such plans are often 'unrealistic and directive rather than collaborative' and 'presented in ways that take for granted that NGOs and CBOs will conform to a set of benign regulations or to HIV/AIDS approaches that do not fit civil society realities'¹²⁵ – for example, reporting and data collection requirements which may be onerous for many small CSOs. A review of progress on the Three Ones found that civil society is not an equal partner – particularly when it comes to reviewing and updating national plans – and that people with HIV, women's groups and FBOs are particularly under-involved.¹²⁶

Partnerships with civil society have also translated into the disbursement of significant funding to civil society organisations. Proportions of

¹²⁴ Iliffe, J. (2006).

¹²⁵ Rau, B. (2006, p. 291).

¹²⁶ UNAIDS (2005).

Global Fund grants to many countries are re-granted to NGOs in more than token amounts, and in World Bank and PEPFAR initiatives funding for CSOs is prioritised as a matter of principle.¹²⁷ Overall, civil society organisations *in general* have benefited, alongside other types of institutions, from the increased availability of funding for AIDS activities. However, as the findings from this report show, there are important differences among organisations that make this picture a highly uneven one. Other important limitations to the generally improved funding environment for civil society organisations working on AIDS include: development assistance trends in favour of general budget support that seem to be occurring at the expense of direct funding for CSOs; funding channels that tend to favour technocratic approaches to programming that require monitoring, evaluation and reporting in formats that do not align with the capacities of smaller organisations; and power imbalances between donors and recipients that result in CSOs being contracted as the implementers of programmes that are externally designed.

4.2.3 Civil society organisations: the taxonomic challenge

In this report we use the term ‘civil society organisation’ in its broadest sense to encompass the full range of non-governmental, non-commercial entities located in the public sphere. As such it embraces both large international NGOs and small community-based welfare organisations. It includes a range of societal interests ranging from churches and non-profit associations of professionals, to traditional healers and HIV support groups. It excludes all state and parastatal institutions, including educational institutions, donor agencies and local government committees, as well as private sector companies and for-profit enterprises.

However, even the quite general parameters of non-governmentality and non-commercialism are sometimes stretched. Some NGOs strain the bounds of non-governmentality as they are almost exclusively supported by national or foreign governments. There are non-profit organisations and community projects that are largely driven by entrepreneurial interests. CSOs also vary greatly in their connectedness to communities, with some established with the sole purpose of providing professional services to other organisations. Furthermore, some CSOs are barely ‘organisations,’ being little more than loose associations of community members united by charitable aims.¹²⁸ Other CSOs have multi-million dollar budgets and run major humanitarian operations.

Notwithstanding problems of definition, we have adopted the following mutually exclusive categories for distinguishing types of organisations within the general rubric of civil society:

- *Community based organisations* (CBOs): organisations working in one community or area only;
- *Non-governmental organisations* (NGOs): organisations that work in more than one community, but not in any other countries; and
- *International NGOs* (INGOs): organisations with branches or programmes in other countries.

Other organisational types referred to in the study are:

- *Faith-based organisations* (FBOs): organisations that identify themselves as associated with a church or as having a faith-based orientation;

¹²⁷ World Bank MAP and PEPFAR are both structured to ensure that significant funds go directly to communities and non-state actors.

¹²⁸ Wilkinson-Maposa, S. et al. (n.d.).

- *Umbrella organisations*: organisations that play the function of coordinating and/or funding a cluster of other organisations which may be branches of the umbrella organisation, which may have a common activity focus, or which may fall within a geographic demarcation; and
- *AIDS service organisations (ASOs)*: organisations that are focused primarily, if not exclusively, on the provision of services related to AIDS and distinguishable in particular from those organisations which provide a range of services in the development sector, some of which may be characterised as AIDS responses.

There are many other salient distinguishing characteristics of CSOs not captured by these fundamental distinctions; e.g. legal status and extent of formalisation, scope of operations, size of funding, membership, horizontal and downward accountabilities to constituencies, and the types of services provided. During data analysis and interpretation, a number of such distinctions are drawn out where relevant.

PART III

CIVIL SOCIETY ACCESS TO AIDS FUNDS



1. Civil society and AIDS response

This section presents key findings from the CSO survey and the research conducted with donor institutions. It is divided into three parts:

- A description of the involvement of civil society organisations in AIDS responses and its development over time;
- An analysis of the sources and uses of funding by CSOs; and
- Trends and patterns in donor support for CSOs, including country-level analyses.

1.1 Location of CSOs

The countries covered in this study are predominantly rural, with levels of urbanisation ranging from less than 20% (Lesotho and Malawi) to 35% (Mozambique, Namibia and Zambia).

In all the countries except Malawi, CSO activity around AIDS is concentrated heavily in towns and urban areas (see Table 8). Overall, 61% of CSOs surveyed are based in urban areas.

Table 8
*Levels of urbanisation*¹²⁹

	Urban % in survey	Level of urbanisation (2005)
Lesotho	80	19
Malawi	14	17
Mozambique	56	35
Namibia	68	35
Swaziland	69	24
Zambia	88	35

With the exceptions of Malawi and Mozambique, there is a high concentration of CSO activity in and around capital cities. Eighty-five percent of CSOs surveyed in Lesotho are based in Maseru district; 64% of Zambian CSOs are based in Lusaka province; 60% of Swazi CSOs are based in Manzini region; and 44% of Namibian CSOs are based in Khomas region.

The concentration of CSOs in urban settings, and particularly near capital cities, is likely to be a product of a number of factors, including higher HIV prevalence rates; greater access to information and resources; higher levels of mobilisation around AIDS; greater exposure to media and awareness campaigns; better access to available services; a higher concentration of educated people able to found and lead an organisation at a professional level; and proximity to key institutions involved with response activities, including government and donor institutions.

Rural areas, by contrast, are characterised by a lower density of organisational activity around AIDS, and the organisations that do exist have more limited access to resources and forms of support than their counterparts in urban areas.

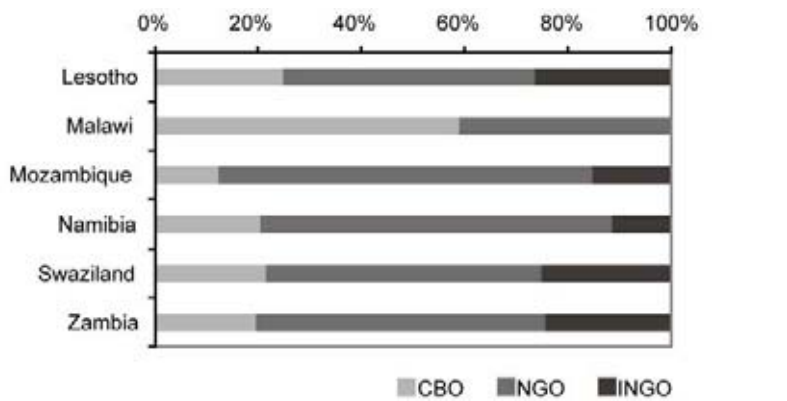
1.2 Organisational characteristics

Figure 4 reflects the proportion of civil society organisations, by type, that are involved in AIDS responses in each country.

¹²⁹ Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2004 Revision and World Urbanization Prospects: The 2005 Revision, <http://esa.un.org/unup>.

Figure 4

Types of CSOs involved with HIV/AIDS response, by country



The majority of CSOs working on AIDS in southern Africa are local organisations – in other words, CBOs and NGOs that have emerged and continue work within their country of origin.¹³⁰ These account for at least 75% of the CSOs surveyed in each of the six countries.

International NGOs also play a prominent role in AIDS activities. In Lesotho, Swaziland and Zambia, INGOs constitute at least 20% of the survey sample, while in Mozambique and Namibia they are less prominent and in Malawi they did not feature in the random sample.¹³¹ As will be seen throughout this presentation of findings, the scale of INGO programmes, budgets and operations, as well as the fact that they often play an intermediate funding and/or capacity-building role in relation to local CSOs, positions them as a distinct sub-set of civil society organisations in the region.

Across the countries there is a relatively similar distribution of CSOs by type, with the greatest proportion of organisations being local NGOs, followed by smaller proportions of both CBOs and INGOs. The exception is Malawi, where the majority of organisations are CBOs working only in one community.

Faith-based organisations

Approximately one-third (34%) of the CSOs in the survey report are affiliated with a religious institution or are faith-based in orientation. Faith-based organisations cut across organisational types, ranging from small church-based projects to national and international NGOs. Among INGOs, for example, 42% identify themselves as faith-based in orientation.¹³²

The highest proportions of FBOs are found in Namibia (51%) and Swaziland (47%), followed by Lesotho (37%), Malawi (29%), Mozambique (26%) and Zambia (22%). The religious affiliation of the FBOs in the sample is predominantly Christian.

Organisational infrastructure

The great majority of CSOs in the region (91%) work from an office or premises that can be visited by the public and a similarly high proportion have bank accounts. This level of organisational infrastructure is reasonably consistent across countries, although CSOs in Mozambique are less likely to have a bank account than are their counterparts in other

¹³⁰ For the purposes of this analysis, CBOs are considered to be those organisations that report working within one community or area, while NGOs are organisations that report working in more than one community or area, but do not work in other countries. INGOs are organisations that report having branches or programmes in more than one country.

¹³¹ This is a little misleading in the case of Malawi, as the five prominent international NGOs, which serve an important function as umbrella organisations to the NAC by supporting NGOs and CBOs at district level, were not included in the sample. They were considered to be serving a proxy function within the NAC decentralisation framework, rather than operating as CSOs in the usual sense, and hence were excluded from the CSO survey. The fact that other international NGOs working in Malawi did not fall into the sample may be a product of the sampling method, which relied heavily upon lists provided by MANASO, the national ASO network.

¹³² In this analysis, faith-based organisations are not considered a mutually exclusive category with respect to other types of CSOs. Where a faith-based orientation may be a relevant factor for the analysis, these findings are presented in addition to those on the basis of organisational type.

Overall, 85% of surveyed CSOs report that they are members of an AIDS network or coordinating body.

countries¹³³ – a finding which is in keeping with the less developed commercial banking infrastructure in Mozambique, along with significant challenges in the physical and service infrastructure.

The CBOs and rural CSOs surveyed are slightly less likely than NGOs/INGOs and urban CSOs to have office space and bank accounts. However the differences are not as great as might be expected. This finding underscores that those CSOs reached by the survey – sampled from lists compiled from networks, funding bodies and district-level entities – tend to have evolved to a relatively formal level. By contrast, the case study research revealed numerous examples of unsupported organisations that function without access to financial support and without bank accounts.

Membership in networks

AIDS-related networks and umbrella bodies have emerged in most countries as bottom-up efforts to link together individuals and groups active in AIDS response activities. These networks generally focus on sharing information, promoting access to training and resources, and amplifying the voices and concerns of affected individuals and communities. Networks representing people with HIV and networks of AIDS service organisations are probably the two most common forms at a national level, although in many countries sector-specific bodies, such as interfaith networks, associations of traditional healers, and business coalitions, also exist. In addition, district and provincial-level bodies often coordinate the activities of local organisations.

Malawi, Mozambique, Namibia and Zambia all have national ASO networks; in Lesotho the ASO network (LENASO) is inactive, while in Swaziland the role of ASO network is effectively played by a working group of the Coordinating Assembly of Non-Governmental Organisations (CANGO). All six countries have national networks representing people with HIV, and a number have more specialised AIDS-related networks.

Overall, 85% of CSOs report that they are members of an AIDS network or coordinating body.¹³⁴ The countries with the highest proportion of networked CSOs are Malawi (94%) and Namibia (93%), with the lowest proportion found in Mozambique (76%). Rural and urban CSOs are equally likely to belong to networks.

NGOs and CBOs are more likely than INGOs to affiliate to a network, which may reflect the relatively greater value of networks for local organisations in terms of access to information, resources and other opportunities.

Table 9 shows, by country, the AIDS-related networks most commonly cited by CSOs that report membership of an association.

Table 9
Membership of CSOs in AIDS networks

	National ASO Network	Networks of organisations representing people with HIV	Other
Lesotho (n=54)		Lesotho Network of People Living with HIV/AIDS (LENEPWHA) – 9%	NGO Coalition on the Rights of a Child – 11%; Lesotho Council of NGOs – 11%

¹³³ 80% of CSOs in Mozambique report having a bank account; in all other countries the proportion was over 90%.

¹³⁴ Given that network lists were partly used in identifying organisations to be surveyed, there is potential over-reporting of membership levels.

	National ASO Network	Networks of organisations representing people with HIV	Other
Malawi (n=73)	Malawi Network of AIDS Service Organisations (MANASO) – 77%	Malawi Network of People Living with HIV/AIDS (MANET) – 14%	
Mozambique (n=66)	Mozambique Network of AIDS Service Organisations (MONASO) – 58%	RENSIDA – 14%	Provincial Forum of NGOs – 23%; National Forum of NGOs – 5%
Namibia (n=71)	Namibia Network of AIDS Service Organisations (NANASO) – 56%		Namibian Non-Governmental Organisation Forum (NANGOF) – 6%
Swaziland (n=46)		Swaziland National Network of People Living with HIV and AIDS (SWANNEPHA) – 2%	Coordinating Assembly of Non-Governmental Organisations (CANGO) – 46%; Church Forum – 11%; Child Protection Network – 9%
Zambia (n=56)	Zambian National AIDS Network (ZKAN) – 43%	Network of Zambian People Living with HIV (NZP+) – 2%	

ASO networks are the most commonly cited in the four countries where these exist, ranging from 43% of CSOs in Zambia (ZKAN) to 77% in Malawi (MANASO).

Levels of affiliation to networks specifically representing people with HIV are low in all countries – between 2% and 14% of CSOs. One explanation for this relatively low level of affiliation is that networks representing people with HIV may tend to attract more individual members than institutional ones, or may be relevant for particular types of CSOs, such as support groups, that are comprised of people with HIV. Another explanation, however, may lie in the fact that such networks in many sub-Saharan African countries have struggled to evolve into strong institutions and that their presence in the countries in this study remains relatively weak.

The highest penetration of any network in the survey is the Malawian ASO network, MANASO, with more than three quarters of CSOs in Malawi affiliating to it. Taken together with the high levels of affiliation to District AIDS Coordinating Committees (DACCs) (28%), it appears that networking is more deeply embedded among Malawian CSOs than in other countries. This may reflect the prominent role played by DACCs in administering funding and capacity-building to CSOs alongside the five umbrella bodies (international NGOs) working with the NAC, as well as the relative strength of MANASO as an umbrella body.

1.3 CSO involvement in AIDS response

1.3.1 Rate of growth of CSO involvement in AIDS activities

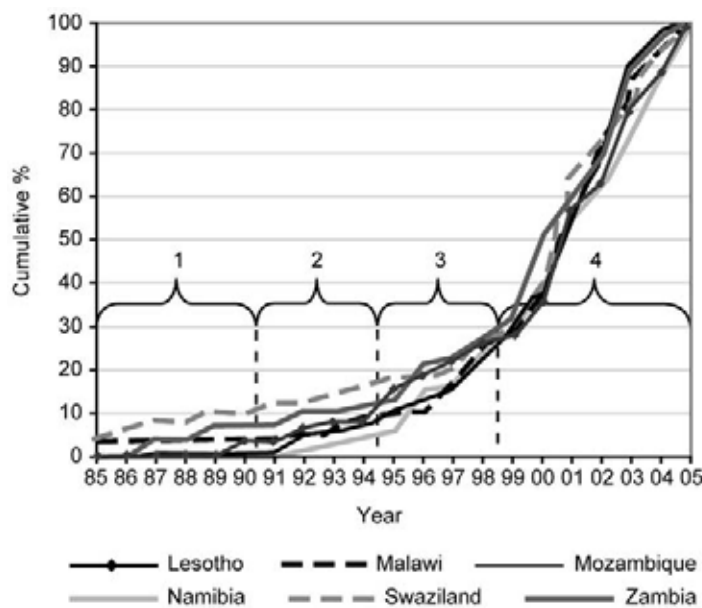
Organisations were asked to note the year in which they commenced AIDS activities. Some organisations started specifically in response to AIDS-related needs, while others existed previously and only later included AIDS responses among their organisational activities.

Levels of affiliation to networks specifically representing people with HIV are low in all countries.

The following chart represents all organisations in the study. It presents the cumulative percentage of organisations conducting AIDS response activities at any given year.

Figure 5

Year in which CSOs started AIDS activities



By 1999 only about 30% of CSOs in the survey were active in the AIDS field, meaning that the bulk of growth has happened since then.

There is notable consistency across countries in the rate of involvement of CSOs in AIDS-related activities. This growth may be divided into four stages: 1) before 1991; 2) 1991 to 1995; 3) 1996 to 1999; and 4) 1999 to 2005.

In Swaziland and Malawi there was some CSO involvement in the early days of the epidemic; by 1985 in both countries, 4% of the CSOs currently active in AIDS response were already involved. Zambian CSOs began to be active in 1987, but it wasn't until the early 1990s that CSOs were active in the other countries. Mozambique and Namibia were the countries where CSOs last became active. Growth in CSO involvement was gradual in these early stages – by 1995, in all countries, less than 20% of organisations currently active in AIDS responses were involved.

There was an acceleration of involvement around 1991 which was amplified around 1996. Even so, by 1999 only about 30% of CSOs in the survey were active in the AIDS field, meaning that the bulk of growth has happened since then.

From this point, the annual rate of CSOs becoming involved in AIDS responses was more or less equal across countries. Whatever factors had led to uneven growth rates of CSO involvement prior to 1991 appear to have been largely eradicated by 1999.

The growth rate has remained high, but has not accelerated since this time. In fact, since 2002 there is some suggestion of slowing of growth rates, especially in Mozambique (2002) and Zambia (2003).

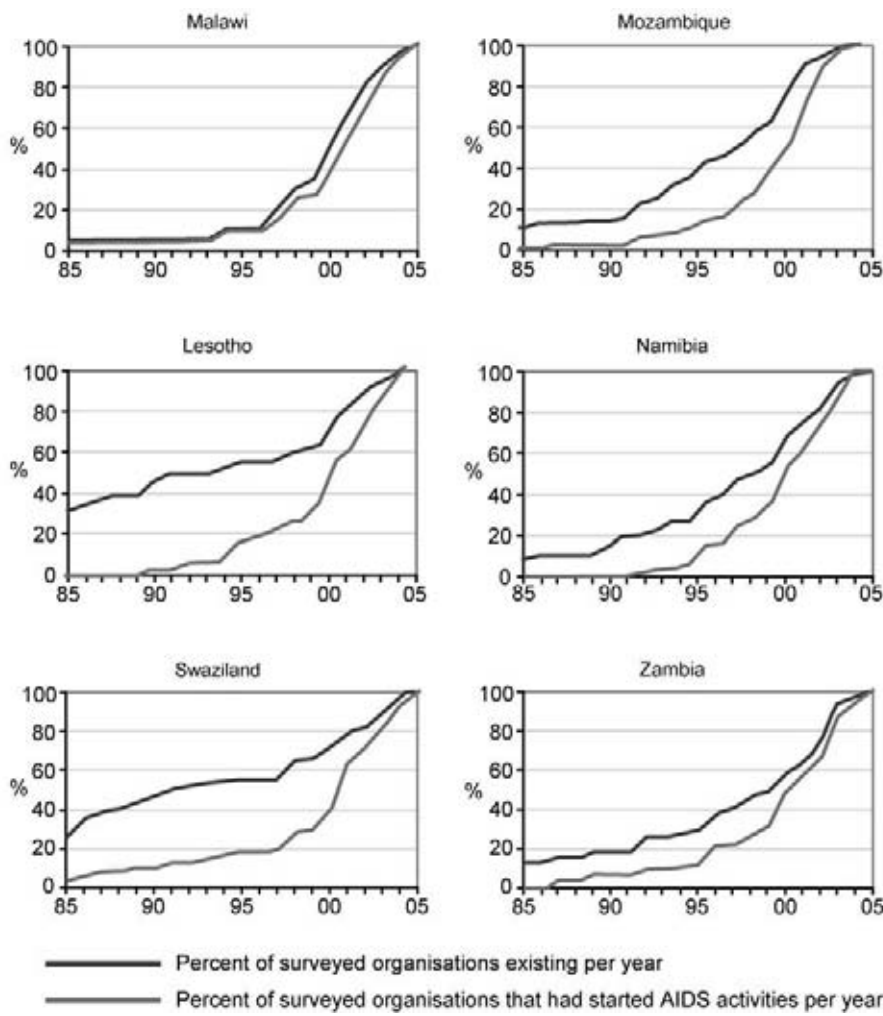
1.3.2 Country trends

As well as the year in which they commenced AIDS-related activities, organisations were asked to note the year in which they were founded as organisations. The cumulative percent of organisations active in AIDS response is presented in Figure 6, disaggregated by country, alongside the

cumulative percent of all organisations in the sample that existed *per year*, whether or not they were active in AIDS response at that time.

Figure 6

History of AIDS response activity in CSOs



The rate of growth of organisations' involvement with AIDS, as indicated by the light-coloured trend line, seems to follow a similar trajectory in each country. But there are notable differences across countries in the growth rate of organisations as reflected by their founding date (the dark trend line).

Visual comparison of the profiles in Figure 6 shows that Swaziland and Lesotho have similar patterns, with higher proportions of organisations now involved in AIDS activities already in existence in the early days of the epidemic. In Swaziland in 1996, 56% of the organisations currently involved in AIDS activities were already in existence, but only 18% of these were involved in AIDS activities. From about 1997 there was increasing uptake of AIDS by these organisations and this accelerated markedly after 2000. In Lesotho the acceleration starts only in 2000 after a period of more gradual growth commencing in about 1989.

Mozambique, Namibia and Zambia have similar profiles with rapid growth in the early 1990s of many AIDS-oriented CSOs that did not previously exist. This began slightly earlier in Zambia, where CSOs began to get involved with AIDS as early as 1986 and accelerated after 1991.

Malawi is a unique case and shows only very gradual growth in growth of CSOs in general until about 1996, after which there is a very close coincidence between the establishment of organisations and the involvement of organisations in AIDS activities. From this point there is a very steep rate of growth in the number of organisations which commenced with AIDS activities almost immediately after founding.

Each of the charts in Figure 6 could be interpreted in relation to specific country milestones in AIDS response – the formation of AIDS councils, development of country strategic plans, and initiatives to promote civil society engagement – as well as socio-political events in the countries, notably the end of independence struggles in Namibia and Mozambique which created an environment more conducive to growth of civil society generally.

1.3.3 AIDS specialisation

It is interesting to note that in 47% of cases, the founding year of the organisation is the same as the year in which it commenced AIDS activities. However, this does not mean that the organisations are ‘AIDS-focused.’ Most organisations (70%) report that they are not exclusively focused on AIDS-specific activities, but work also in other areas. This is reflected in Table 10 which shows that Malawi is the country with the highest number of AIDS-specific CSOs and Lesotho is the country with the lowest proportion of AIDS-specific CSOs. Many of the AIDS-specific CSOs focus on providing particular services such as HIV counselling and testing or home-based care for those sick with HIV-related illnesses.

Table 10
Percent of organisations exclusively involved in AIDS

All	Lesotho	Malawi	Mozambique	Namibia	Swaziland	Zambia
30%	17%	40%	32%	28%	28%	34%

The realities of AIDS impact are such that the types of activities engaged in by the majority of CSOs cannot readily be distinguished from more general forms of community development, such as extreme poverty relief, food gardening and income generating activities. These are not specific to AIDS response and organisations often do not strictly distinguish AIDS as a predisposing condition in the provision of assistance. The recent high incidence of new organisations may therefore be a result of funding made available for AIDS. There is no equivalent drive to increase funding for CSOs in any other area of community life.

However, we should not overlook the fact that, of the 70% of organisations that are not exclusively AIDS-focused, 67% started AIDS-related activities a year or more after they were founded. This indicates that AIDS was not a primary activity at start-up, but was soon adopted as an activity – for more than half of these organisations (54%), within 3 years. In 1996 only 41% of the organisations that existed at the time were involved in AIDS, meaning that at the time 59% had no involvement in AIDS. All of these organisations have subsequently become involved in AIDS activities. However, because the data is confined to organisations involved in AIDS activities we cannot conclude much more than to say that newly formed non-AIDS oriented organisations have a tendency eventually to become involved in AIDS.¹³⁵

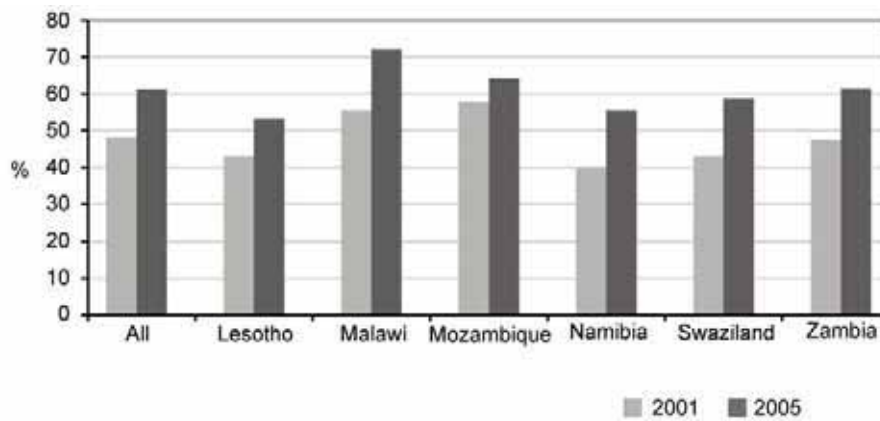
¹³⁵ To investigate this phenomenon it would be necessary to survey all CSOs rather than only organisations that are presently involved in AIDS.

Across countries, CSOs that do not have an AIDS-specific focus spent just over 60% of their time working on AIDS-related activities in 2005

(see Figure 7), up from slightly under half in 2001. It is evident that AIDS-oriented activities are increasingly absorbing the attention of those organisations that do not have an exclusive AIDS focus. Although CSOs in all countries have spent an increasing proportion of time on AIDS activities over this period, this tendency is least pronounced in Mozambique and Lesotho where other concerns have continued to hold attention.

Figure 7

*Proportion of time spent on AIDS 2001-2005:
CSOs that do not have an exclusive AIDS focus*



Of those organisations that existed prior to 1999, 30% are exclusively involved in AIDS activities, whereas of those started in or after 1999, 33% are exclusively involved in AIDS activities. This is not a significant difference – an interesting finding noting the large growth of organisations during and since 1999 (75%). These organisations have grown in the AIDS era and possibly in relation to AIDS needs, but like those that started earlier, most are additionally involved in activities apart from AIDS.

The above probably means that we are witnessing a general growth in civil society organisation activity and not only AIDS-related activity. This is likely being driven by increased opportunities for AIDS funding, but is oriented on more general purposes than simply the provision of services related to AIDS. AIDS impact mitigation needs and funding opportunities are fuelling other areas of development response and it is likely that funding opportunities are being seized on to mitigate the impacts of poverty. Each of these countries faces formidable challenges in almost all areas of social and economic development and the advent of AIDS by all accounts has exacerbated the challenges faced. The case studies reported in Part IV show in no uncertain terms the intensification of need created by AIDS, but in a context where the situation of communities in general is dire.

If funding for AIDS is leading to a growth in organisations that are able to receive development funding and deliver assistance where it is needed, this may be seen as a positive by-product. There is, however, some risk that CSOs grow into generalist organisations providing a range of forms of assistance, rather than developing specific expertise in particular areas. AIDS response at community level requires at least some level of expertise, both at the level of understanding the complexities of AIDS and in provision of specific specialised services for which training is necessary.

The issue of specialisation cannot be separated from the questions of organisational growth and development. Many CBOs and NGOs emerge at a small scale in response to a particular need and may hold to that core function over time or, as is often the case, add additional activity areas as the epidemic changes and as the interrelatedness of needs becomes apparent. For example, organisations that begin by providing home-based care to people with HIV-related illnesses often are drawn into work with OVCs as they witness the plight of children who are orphaned or at risk of being orphaned. Material support to OVCs can then lead to work with schools – for example, arranging bursaries and school fee waivers where applicable, ensuring that children have the requisite documentation to be enrolled, and promoting gardening projects in support of school feeding schemes.

This model of growth reflects a trend towards comprehensivity, whereby a single organisation grows larger in and of itself over time, offering more and more types of services. The alternative to this, complementarity, involves growth through increasing cooperation of more narrowly focused organisations. Rather than growing larger and broader, an organisation invests more deeply in a smaller number of activities. When it requires other services (e.g. HIV seroprevalence testing in workplaces where it conducts peer-education programmes), it works in partnership with other ‘specialised’ organisations that provide those services. In other words, an equivalent of comprehensivity is attained through organisations working together to complement and support each other’s efforts, rather than covering all of their needs independently. This requires good cooperation and development of working relationships and referral systems.

Figure 8

Average number of beneficiary groups, by year when AIDS programmes began

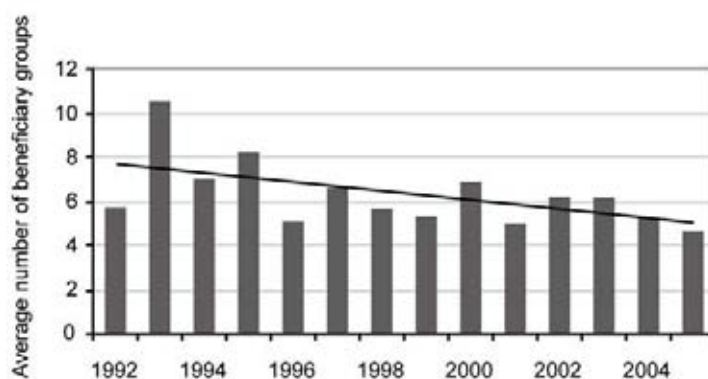


Figure 8 reflects the average number of beneficiary groups worked with per organisation, with organisations grouped according to the year in which the CSO began work on AIDS. It shows that those organisations which have been in existence longer tend to work with a greater number of beneficiary groups. This may be taken as a proxy measure of broadening of programme focus. In other words, organisations tend to become more comprehensive over time. Organisations that began working on AIDS in the early to mid-1990s work with a greater average number of beneficiary groups than those founded since 2000. The longer an organisation works in the field, the greater the range of groups it serves.

1.4 Human resources

It is of interest to understand the human resource profiles of CSOs to better appreciate their costs in responding to AIDS, but also the extent to which AIDS provides employment and a training ground for workers in the development sector. It is also interesting to note the involvement of unpaid volunteers, which can be regarded as an indicator of grassroots resources that have been mobilised for AIDS response.

CSOs as employers

Across all countries a total of 4,544 staff are employed full-time or part-time by the CSOs surveyed. However, more than half of CSOs (52%) have no salaried staff at all. It is also notable that some CSOs are large-scale employers with 2% having more than 20 employees.

Zambia and Swaziland employ full-time staff at a higher level than is the case in other countries, with 57% and 62% of CSOs in those countries having at least one full-time paid employee. Zambia has a notably higher proportion of larger organisations with more full-time staff, with half the organisations employing more than 2.5 full-time staff.

The above refers to staff who are citizens of the country in question. In addition to this, 9% of CSOs have one or more full-time international employee and 2% have one or more part-time paid international employee.

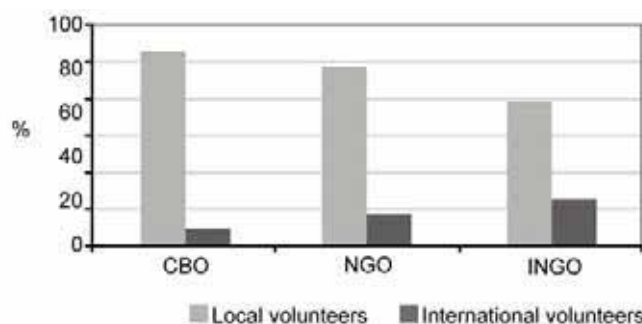
CSOs mobilising volunteers

CSOs also draw on the assistance of unpaid volunteers. Seventy-nine percent of organisations have at least one unpaid volunteer. The median number of volunteers is 11, meaning that half of all organisations have 11 or more volunteers. Malawi (median 13) and Mozambique (median 12) have higher numbers of unpaid volunteers per organisation. Lesotho, Namibia and Swaziland have relatively low numbers of unpaid volunteers per organisation. In addition to local volunteers, 11% of CSOs have one or more international volunteer.

This confirms that civil society organisations draw considerably on the assistance of unpaid volunteers in furtherance of their aims. In this regard it is notable (see Figure 9) that CBOs draw on local volunteers to a somewhat greater extent than NGOs and significantly more than INGOs. In contrast, INGOs draw on international volunteers to a greater extent.

Figure 9

Percentage of organisations with volunteers, per type of organisation



Half of all surveyed organisations have 11 or more volunteers.

In considering volunteers as assets provided by communities to assist AIDS responses, it is interesting to note the extent to which volunteers receive any financial or in-kind compensation for their efforts. Seventy percent of CSOs do not provide volunteers with stipends for their work. There is a greater likelihood of stipends being paid in Mozambique and Swaziland where 41% and 40% of CSOs provide their volunteers with stipends, as compared to the all country average of 30%. In Malawi only 13% of CSOs provide stipends.

Seventy percent of surveyed CSOs do not provide volunteers with stipends for their work.

There are strong differences between the types of organisations in respect of tendency to pay stipends to volunteers. Only 18% of CBOs pay their volunteers stipends, whereas 31% of FBOs pay stipends and 36% of INGOs do so. This attests to CBOs being supported by community members who receive no compensation for their efforts in contrast to INGOs which either can afford to or need to pay for the involvement of volunteers, because they are not community organisations so much as community service organisations. Many people receiving stipends are in effect providing services to organisations, but without this being regarded as an employer-employee relationship. Volunteers are often extremely poor and lack food and basic supplies. Many of them suffer the same problems being addressed by the organisation for which they volunteer and in this sense they are both beneficiaries and volunteers.

At other times, payment takes the form of 'per diems' or 'attendance fees' which are, in effect, ways of paying people for their time. Some CSOs that do not provide stipends attempt, where possible, to cover transport costs or distribute food parcels or other goods to their volunteers. Whatever the justification, there can be little doubt that there is some blurring of the nature of the relationship between CSO and volunteer, with the 'compensation' occupying a grey space between 'payment/employment' and 'covering costs'. As became evident in the case studies, compensation is a sole source of income for many volunteers and the work they do is seen as a 'job.'

CSOs as vehicles for self-empowerment

In the case studies a number of organisations were encountered which initially relied on small contributions from members in order to cover basic start-up costs. This allowed members to participate in income generating opportunities offered by these organisations, such as the use of sewing machines or marketing of services through community events conducted by the organisation.

The case studies showed a range of motives for being involved in AIDS, including employment, various economic opportunities, compassion, feelings of obligation to help the community, interest in giving back to the community, interest in gaining experience, desire to share experience and knowledge, belief in principles and causes, and opportunities for training and education.

Motives for involvement of individuals in AIDS CSOs are mixed and complex

In Bangwe, Malawi, a group of young people have formed an organisation that provides AIDS related services. The organisation provides voluntary counselling and testing as a professional service and it also conducts community HIV education campaigns. Yet the members of the organisation also offer specialised services unrelated to HIV/AIDS (including book-keeping, hair-dressing, carpentry). These services are marketed through the organisation. The organisation has

served as a professional development ground for the young people that run it and they have greatly benefited from various training opportunities and work experience gained through engaging with AIDS funders and partners. Their personal self-interest and the work of the organisation are intertwined.

In Boane, Mozambique a physically disabled retired school teacher has mobilized the largely unemployed and uneducated community near his home to develop coordinated support for people living with AIDS and orphans. His motive is philanthropic and he derives no material gain from involvement, and even incurs costs as do all members of the community organisation who contribute modestly to assisting those in need.

In Motshane, Swaziland, a Zambian priest and his wife have started an orphanage which is well integrated into its community. Its success is largely driven by the missionary vision of the couple who live as a family with a group of orphans in a community which otherwise receives little external support.

In the same community a group of women grow and cook food from shelter they constructed themselves with some external support, and they are motivated by community-mindedness. They have no ambitions to be an organisation, only to ensure that hungry children in their midst are fed.

The early beginnings of organisations are often not really distinguishable from the circumstances and people that gave rise to the organisation. When we speak of CBOs and NGOs, we often imply that these are institutions bound by external parameters and which, in some respects, exist apart from the people that constitute them. But in reality many of these organisations, particularly at earlier stages of development, are simply constellations of people with similar interests. They become shaped as institutions in relation to opportunities for growth and funding. It is important to appreciate this in supporting newer organisations which do not fit naturally into the expectations of funders and external agencies.

1.5 Services provided

The following definitions were used to elicit responses from CSOs about the different types of AIDS response activities they engaged in:

- *Prevention of HIV*: communication, condoms, education, PMTCT, VCT;
- *Treatment, care and support*: counselling, home based care, nutrition, support for people with HIV;
- *Impact mitigation*: income generation, poverty alleviation, work with orphans and others in need of social assistance;
- *AIDS response management*: capacity-building, coordination, M&E, systems development, training; and
- Policy development, advocacy, research.

Figure 10 reflects CSOs' areas of programme activity in 2005, rated on an indexed scale from 'little or no activity in an area,' through gradations of 'some activity,' 'much activity' and 'primary activity.' The data is presented as average ratings per activity, per country.

For each of the countries the activity with the highest 'engagement index' is prevention. This simply means that CSOs are most intensively engaged in prevention activities. 'Treatment, care and support' and 'impact mitigation' are less prominent as programme foci, and are rated

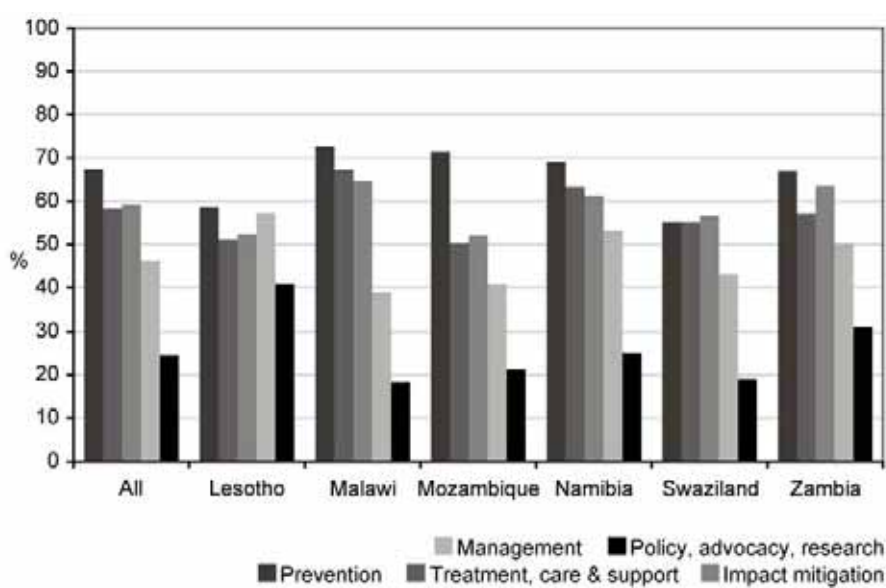
about equally. These three areas of activity are the main foci for the bulk of organisations. There are much lower ratings for 'AIDS management',¹³⁶ with aggregated responses for all countries falling between 'some' and 'much' activity. Within this category there are notably lower averages in Malawi and Mozambique.

Policy, advocacy and research are the areas of least activity across all countries, with responses falling between no activity and some activity. While this finding is not surprising, it does give support to anecdotal evidence that CSOs are more engaged in providing mainstream AIDS services than in shaping responses to the epidemic through other means, as they were at earlier stages of the epidemic. The general picture is of CSOs being most active in service delivery and least active in activities involved in directly shaping agendas.

Swaziland and Lesotho show a more even spread between the three main areas of activity than is found in the other countries, with relatively higher levels of impact mitigation response and less intensive focus on prevention. The generally lower levels in these two countries may reflect characteristics of the sample in these small countries where the entire population of AIDS-involved CSOs was targeted, leading to inclusion of more organisations that are only marginally involved in AIDS response. In other countries only those directly involved in AIDS activities would have been represented on national lists from which samples were drawn, leading to higher representation of those with a specialised involvement in 'primary activity' areas.

Figure 10

Levels of activity across programme areas in 2005



Organisations were asked to indicate if the proportion of time they have spent on different activities has changed over time. As Table 11 shows, there is no significant difference between countries in relation to this question, with countries ranging between 69% (Lesotho) and 78% (Zambia) of CSOs reporting change in the proportion of time spent on different types of AIDS activities. The high proportion of organisations reporting that their primary activities have changed over time is suggestive of a dynamic environment, although it is not possible to say what occasions the change from this data alone. It may be a response to funding opportunities, a response to changing needs or a response to directives or expectations of funding organisations.

¹³⁶ Representing training, coordination and capacity-building.

Table 11

Percent of CSOs reporting a change of activity emphasis over time

All	Lesotho	Malawi	Mozambique	Namibia	Swaziland	Zambia
73%	69%	70%	78%	66%	72%	78%

‘Treatment, care and support’ and ‘prevention’ are the activities expanding most substantially, followed by ‘impact mitigation.’ There has been relatively little growth in CSOs being involved in AIDS management and a net reduction of CSOs involved in ‘policy development, advocacy and research’. This may reflect the emergence of a small number of more specialised CSOs while the mass of CSOs engage in less specialised and mainstream activities.

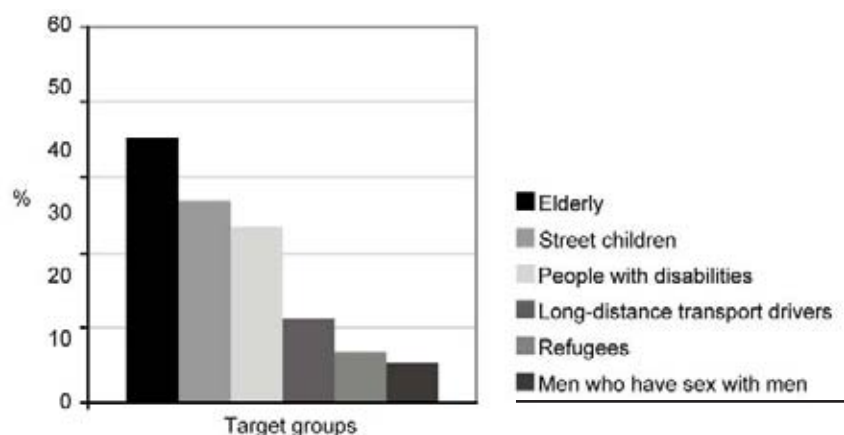
1.6 Beneficiaries of programmes

CSO activities in southern Africa reach thousands of people directly and many thousands more indirectly. Some CSO programmes are targeted at particular population groups – for example, interventions aimed at long-distance truck drivers in Mozambique or garment factory workers in Lesotho – while others have a broad orientation and are applicable to many types of people. While certain target groups have particular information and/or programmatic needs in relation to AIDS (e.g. ‘high risk groups’ like commercial sex workers, health workers and injecting drug users), there are also large categories of people who are directly affected by HIV (people with HIV and their families, OVC) and who are vulnerable to infection (women, youth). Because the AIDS epidemic in southern Africa is understood as ‘generalised,’ great attention has been paid to broad programmatic prevention and treatment/care/support initiatives aimed at the general population and at groups considered to be vulnerable, often at the expense of targeted interventions for high risk groups that are important contributors to the epidemic.¹³⁷

Against this backdrop, it is of interest to understand the types of beneficiary groups with which CSOs are working, as well as the degree to which they are specialising their efforts.

Figure 11

Proportion of CSOs working with selected beneficiary groups



Main beneficiary groups

Organisations were asked to indicate which beneficiary groups are specifically targeted in their programmes. The questionnaire included a

¹³⁷ See Mullen (2005). A review of National AIDS Plans in 23 African countries concluded that, in the absence of clear information about how responses were to be prioritised, the overall impression is that ‘more resources are to be devoted to interventions targeting the large vulnerable groups of youth and women than are to be assigned to those targeting high-transmission groups’ (p. 14).

list of populations from which to choose, all of which could be considered underserved, marginal, or difficult to reach.

Among these groups, the most commonly targeted were elderly people (42%), street children (32%), people with disabilities (28%), people working in the informal economy (28%), and farm workers (27%).

Some of the more specialised beneficiary groups are served by a smaller proportion of CSOs – for example, commercial sex workers (22%), prisoners and their families (16%), uniformed personnel (13%), long-distance transport workers (13%), and refugees and internally displaced people (8%).

Men who have sex with men are the least served target group, with only 6% of CSOs reporting work with this group.

From the above list, it appears that the more specific the group and the less easy it is to access, the smaller the proportion of organisations that target activities accordingly. Commercial sex work and homosexual activity are illegal in many African countries and these populations can be difficult both to identify and to work with openly because of the legal environment. Prisoners, uniformed personnel and refugees may be challenging to reach because of institutional barriers (e.g. correctional services system, law enforcement bodies, refugee camps). Targeted work with long-distance transport workers is geographically dependent (e.g. concentrated on main transport routes) and can require specific interventions that many organisations would not be in a position to undertake.

Some CSOs reporting working with very specific groups, including ex-combatants, polygamists, midwives, bicycle taxi drivers, rites of passage practitioners, illiterate people, San people, alcoholics, and abused people. Additional qualitative research would be required to understand the nature of these activities and the extent to which they are expressly designed with these populations in mind. In other words, it is not possible to assess from the present research whether these represent groups that happen to be reached by general CSO activities, or whether organisations have developed targeted approaches towards the particular needs of these groups of people.

Extent of beneficiary focus

Data on beneficiary groups provide insight into the overall proportions of CSOs that work with particular groups (discussed above), but can also inform understandings about the extent to which individual CSOs are specialising their activities in particular directions.

The survey data revealed that CSOs in the region target their activities at an average of 5.7 beneficiary groups, ranging from a high of 7.1 groups in Malawi to a low of 4.1 groups in Swaziland. Across the region, approximately 20% of CSOs report that they target their activities at only 1 or 2 beneficiary groups.

Men who have sex with men are the least served target group, with only 6% of CSOs in the survey reporting work with this group.

A lower number of beneficiary groups may suggest a CSO that is specialising its efforts relatively narrowly, compared with those which report working with a wide range of groups. Caution must be exercised, however, in over-interpreting the data as issues of organisational size and the type of beneficiary groups would need to be borne in mind.

For example, an established CSO with strong institutional capacity and working at a large scale could administer targeted interventions for 8-10 different target populations – working with a large number of groups does not, therefore, necessarily translate into an absence of specialisation.

Table 12 provides data on the average number of beneficiary groups worked with by different types of CSOs.

Table 12

Average number of beneficiary groups worked with, by type of CSOs¹³⁸

CBOs	5.5	INGOs	5.3
CSOs in rural areas	6.1	CSOs in urban areas	5.5
FBOs	6.0	Non-FBOs	5.5
CSOs that began working on AIDS in or prior to 2000	6.2	CSOs that began working on AIDS since 2001	5.8

It suggests that smaller, rural-based CSOs work with a greater number of beneficiary groups than do larger, urban-based organisations – a finding which could be interpreted to mean that CBOs in rural areas work in a more holistic and undifferentiated manner than their counterparts in urban areas, which tend to specialise their efforts slightly more. The table also indicates that older organisations – those working on AIDS in or prior to 2000 – tend to work with a greater number of beneficiary groups than do organisations which began work on AIDS since 2001.

There are clear differences between countries in terms of the average number of beneficiary groups with which CSOs work.¹³⁹ CSOs in Malawi work with a significantly larger average number of beneficiaries (7.1) than Lesotho (6.0), Mozambique (5.9), Zambia (5.4), Namibia (5.2) and Swaziland (4.1). In Malawi, CSOs working on AIDS are predominantly small and village based – a fact which may lead them to work in an integrated manner with many different population groups.

2. The resource environment for CSOs working on AIDS

The survey questionnaire solicited information about organisations' funding and financial profiles through a series of closed and open-ended questions. While organisations of all types are often sensitive about disclosing financial information, response rates to the financial questions were relatively high¹⁴⁰ and data gathered through the survey has allowed for the development of a 'bottom up' picture of patterns of expenditure and funding among and for CSOs working on AIDS. These findings are presented in the following sections.

¹³⁸ These differences are not statistically significant.

¹³⁹ $p \leq 0.001$

¹⁴⁰ Response rates ranged between 72-88% for open-ended questions asking for annual expenditure by year, and between 79-91% for closed-ended questions on other funding-related issues.

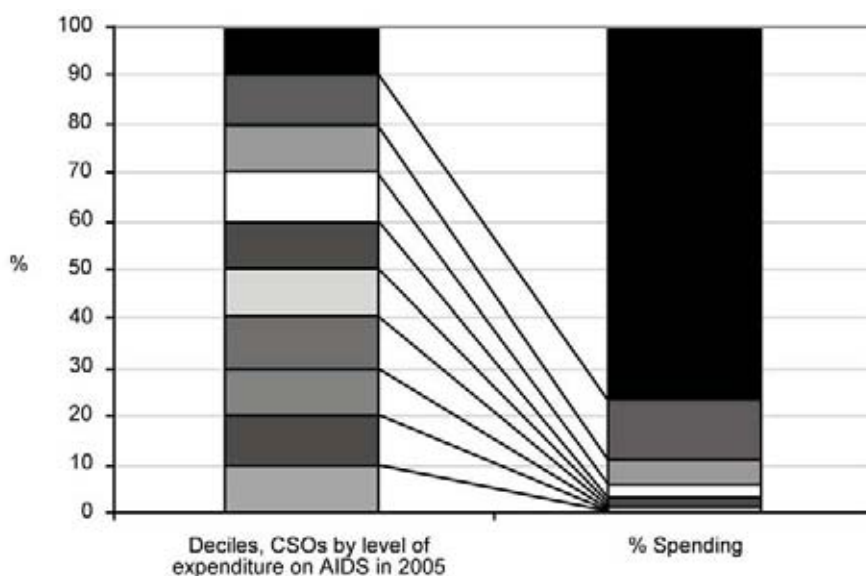
2.1 How much are CSOs spending on AIDS?

2.1.1 Overview of spending in 2005

The CSOs surveyed spent more than US\$56 million on AIDS in 2005. While this equates to an average expenditure of more than US\$145,000 per organisation, the organisational sample is highly differentiated and reference to average expenditure masks a strongly stratified spending picture. The median organisational expenditure on AIDS responses in 2005 was just over US\$16,000, meaning that half of the CSOs surveyed spent less than this amount and the bulk of spending was concentrated among a small proportion of CSOs.

Figure 12

The skewed distribution of spending among CSOs working on AIDS



As Figure 12 shows, 89% of all spending in 2005 was incurred by the top 20% of organisations, compared to less than 1% by organisations in the bottom 20%. The average expenditure of CSOs in the top decile was over US\$1 million in 2005; the highest-spending CSO reported US\$6 million in expenditure on AIDS programmes in 2005 alone.

Of organisations answering the question about expenditure on AIDS in 2005 (n=384), 91% reported having some monetary expenditure related to AIDS. Nine percent of organisations did not spend any money on AIDS activities, but did conduct programmes using donations or other in-kind support. Forty-two percent of organisations reported receiving some kind of in-kind (non-financial) support during 2005.

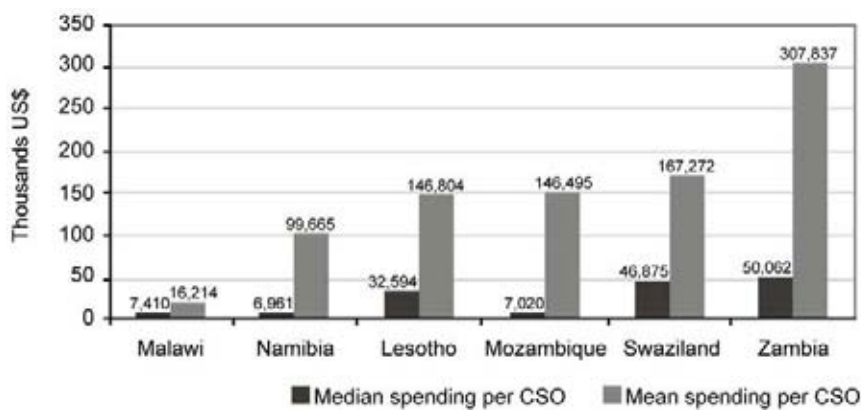
Patterns across countries

Average and median spending for CSOs per country are presented in Figure 13. In all six countries, median spending is significantly less than average spending, reflecting the fact that spending is concentrated among a small proportion of organisations with large budgets. The closer the average and median values, the closer funding in the country is to being evenly distributed across the sample of organisations.

Twenty percent of organisations surveyed account for 89% of CSO spending.

Figure 13

Average and median spending on AIDS by CSOs (2005), per country



Of the six countries in this study, Swaziland and Zambia have the highest median organisational expenditure – more than US\$46,000 and US\$50,000 respectively in 2005 – followed closely by Lesotho, where the median was over US\$32,000 in 2005. Half of the organisations surveyed in these countries had expenditure in 2005 in excess of these levels.

This contrasts strongly with Mozambique, Namibia and Malawi, where median organisational expenditure in 2005 in all three countries was approximately US\$7,000, meaning that half of the organisations surveyed in these countries had spent below this level.

The case of Malawi is distinctive and CSO spending there evinces a different pattern than is seen elsewhere. A large number of relatively small organisations in Malawi are accessing small amounts of funding, and the difference between median and average organisational expenditure in Malawi is significantly less than in the other five countries. As will be discussed in the following section, the use of umbrella bodies to sub-grant funds to CSOs at district level appears to have shaped the CSO funding environment in Malawi in specific ways.

Figure 14

Concentration of CSO spending on HIV/AIDS, by country

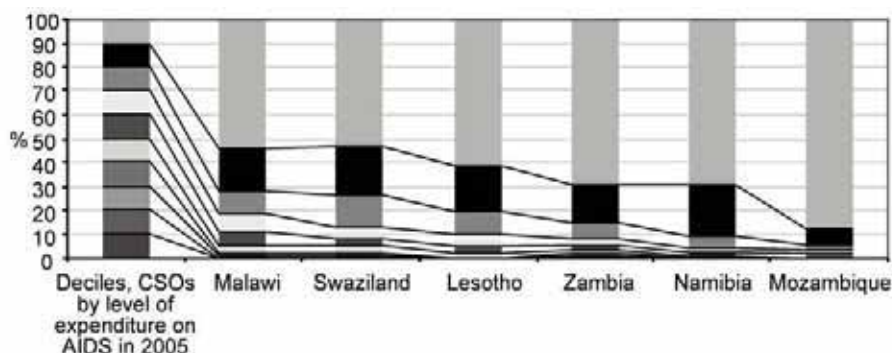


Figure 14 depicts the extent to which CSO spending on AIDS is concentrated among a small number of organisations across countries. Spending is most highly concentrated in Mozambique, with the top 10% of organisations accounting for 87% of spending. The distribution of spending is somewhat more differentiated in Zambia and Namibia, with the top 10% of organisations accounting for 70% of spending, and the next 10% for an additional 15–20%.

In Mozambique 10% of surveyed CSOs account for 87% of CSO spending.

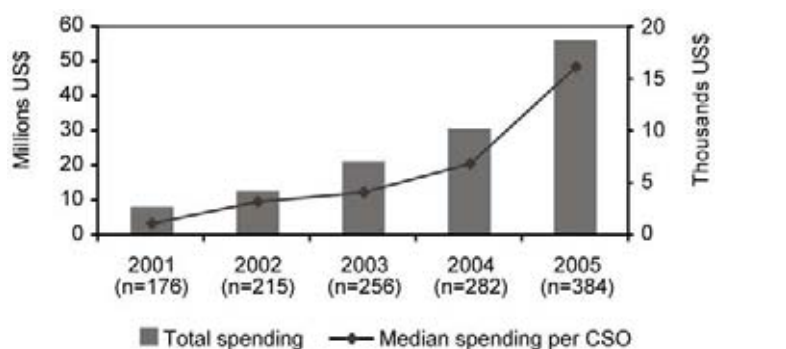
Total spending by CSOs in the survey grew by 168% between 2003 and 2005.

In Malawi and Swaziland, spending is notably less concentrated in the top ranks than is the case in the other countries, indicating more equitable access to funding by CSOs in these countries. The reasons for this may relate to the funding architecture – the aforementioned sub-granting umbrella organisations in Malawi, and the hybrid ‘coordination’ and ‘funding support’ mandates of NERCHA in Swaziland.

2.1.2 Trends in spending, 2001-2005

Total CSO spending on AIDS increased by more than 600% over the period 2001-2005. Median organisational spending grew more than ten-fold over this period, from US\$1,200 to more than US\$16,000.¹⁴¹

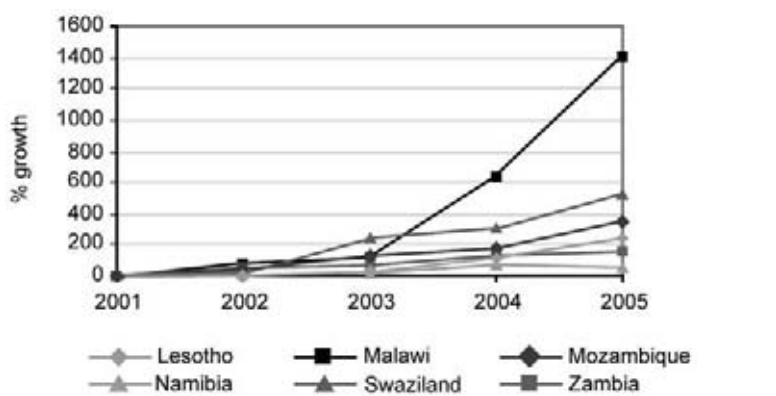
Figure 15
Trends in total and median spending, 2001-2005



Total spending by CSOs grew by 168% between 2003 and 2005, a period which coincides with the acceleration of funding disbursements by the Global Fund, PEPFAR and other major AIDS funding initiatives.

CSO spending on AIDS rose in all six countries over the five-year period (Figure 16), although there were differences in the rates of growth between countries.

Figure 16
Growth in CSO spending



Although the actual levels of spending among CSOs in Malawi are significantly lower than in other countries, spending grew at the fastest rate in this country – an increase of more than 1,400% between 2001 and 2005. The acceleration in spending began in 2004 and became more pronounced in 2005, which corresponds to the period of time when the national sub-granting mechanism for CSOs came onstream.

¹⁴¹ Of the surveyed CSOs, 237 were working on HIV/AIDS issues in 2001; 285 in 2002; 350 in 2003; 392 in 2004; and 421 in 2005.

After Malawi, Swaziland experienced the greatest increase in spending among CSOs (511%). The acceleration in spending began slightly earlier (2002-2003) than in Malawi, and may relate to the consolidation of NERCHA's funding role and the onset of Global Fund support to the country.

The lowest rate of growth in CSO spending occurred in Namibia, where it increased by only 50% over the five-year period.

The lowest rate of growth occurred in Namibia, where spending by CSOs increased by only 50% over the five-year period. The reasons behind this relatively muted growth in spending in Namibia need to be explored further; however, it should be noted that the country does not have any large-scale sub-granting mechanisms in place to support civil society organisations working on AIDS, which results in constrained access to funding on the part of smaller and younger CSOs.

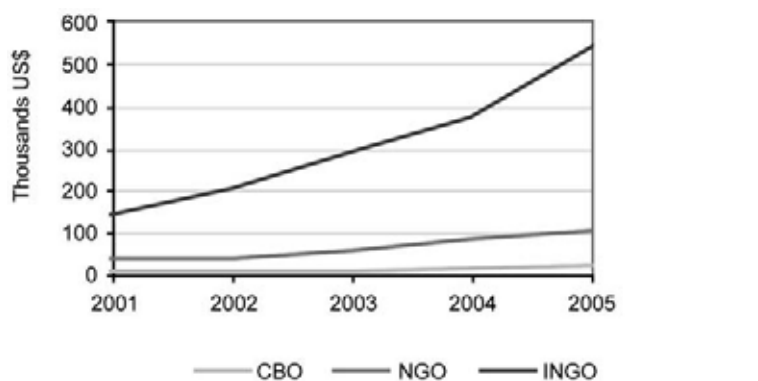
Patterns of spending vary widely by type of organisation

While aggregated figures about CSO spending provide useful insights into broad trends, they also mask important differences that exist between sub-types of organisations.

In 2005, the average spending on AIDS by INGOs was five times greater than that of NGOs and 25 times greater than that of CBOs (see Figure 17), providing further evidence of the extent to which large organisations with international links are dominating the AIDS funding environment in the region.

Figure 17

Changes in average annual spending, by CSO type



However, the picture is not a static one: over the period 2001-2005, average spending grew most rapidly among CBOs (377%) and the gap in spending between INGOs and CBOs narrowed slightly. Growth in spending was least pronounced among NGOs (174%), who 'lost ground,' relatively speaking, to both smaller CBOs and larger INGOs. This numerical evidence aligns with widespread anecdotal reports that national NGOs find themselves in a vulnerable position in the current funding environment, with sub-granting mechanisms catering primarily to small grassroots organisations and the shift to budget support by many bilateral donors resulting in more constrained access to funding for these established organisations.

CSOs based in rural areas and organisations that began working on AIDS since 2000 have lower average levels of spending than their older, urban-based counterparts. There is not a significant difference in average levels of spending between CSOs that identified themselves as faith-based and those that do not.

Over the period 2001-2005, average spending grew most rapidly among CBOs.

More than 300 different institutions and organisations were named by respondent organisations as sources of financial support in 2005.

2.2 What are the main sources of support for CSOs?

Despite movements towards the harmonisation of the development assistance sector at national level, and the establishment of centralised AIDS funding mechanisms in some southern African countries, this research has found little evidence to suggest that funding for CSOs working on AIDS is becoming more orderly or regulated in the region as a whole.

Sources of funding for CSOs in the region are numerous and diverse: more than 300 different institutions and organisations were named by respondent organisations as sources of financial support in 2005, and dozens more were cited as providing donations or in-kind assistance. These span the gamut from large international institutions – donor agencies, UN agencies, private foundations, development NGOs and churches – to private sector companies, trusts, and NGOs located in country.

The following section analyses the provenance of the US\$54 million in funding and support that was received by respondent CSOs for AIDS activities during 2005.

CSO Data on Sources of Support

The following analysis is based on the sources of funding as named by respondent CSOs and must be treated with caution. While most CSOs appear to have indicated the agencies or institutions from which they physically received funding (the immediate source of funding, whether this be an intermediary institution or an original source), in other cases organisations clearly named the original source of the funds, even though the funding itself was channelled through an intermediary institution. This phenomenon is particularly notable in the case of the Global Fund, which does not fund sub-recipient organisations directly, but rather through one or more designated principal recipients (which are government ministries or NACAs in all countries except Zambia). Despite this, many CSOs in receipt of Global Fund support as sub-recipients nonetheless named the Global Fund as a source of funding. This and similar examples from the questionnaires reflect the difficulty that can arise in delineating intermediary and original sources of funds, and the complexity of a context in which some funding retains the imprimatur of the original source while other funding does not.

It was not practicable within the confines of this research to verify and/or unravel the funding chains that may be embedded in some CSO responses. Data is therefore presented as reported and, in cases where there is reason to believe that the reported information may mask a different picture, this is noted.

Bilateral donors are the number one source of AIDS funding for CSOs in southern Africa, accounting for 42% of the total funds received by surveyed CSOs in 2005.

¹⁴² In this context, development agencies refer to institutions such as DanChurchAid, IBIS, Trocaire, and NOVIB, which receive development assistance funding from their own governments, as well as other sources, to conduct development work overseas.

¹⁴³ This figure reflects stated references to support received from multilateral institutions, including UN agencies. However it most certainly under-represents their financial significance for CSOs (see note on data in box above). Global Fund and World Bank support is generally channelled through intermediary institutions or basket-funding mechanisms and in this manner can easily 'lose' its original attribution.

2.2.1 Main sources of funding at regional level

Main sources by volume of funding

Bilateral donors are the number one source of AIDS funding for CSOs in southern Africa, accounting for 42% of the total funds received by CSOs in 2005. International NGOs, FBOs and development agencies¹⁴² comprise the second largest source of funding for CSOs (17%), while multilateral agencies account for another 16%.¹⁴³ Eleven percent of funds were accessed through country-specific sub-granting mechanisms which channel international funding.

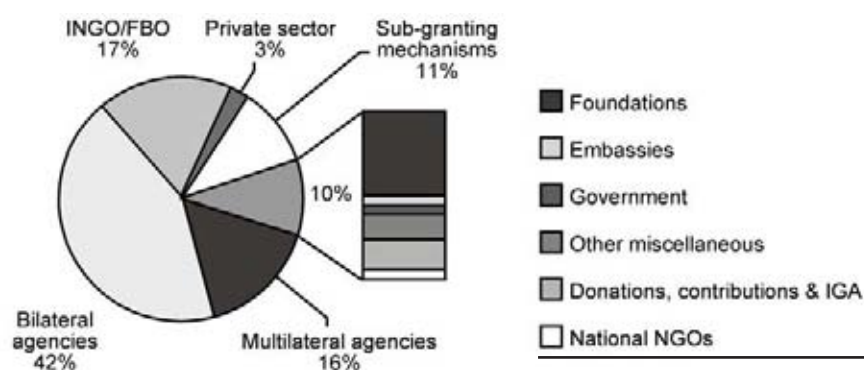
While 86% of funding was therefore accessed directly from international funders, from organisations that are themselves large recipients of ODA, or from structures that channel such funds, the remainder was accessed

through a combination of private foundations and trusts (5%), private sector companies (3%), individual contributions, membership fees and self-generated income (3%), national NGOs (<1%), embassies (<1%) and government departments (<1%).¹⁴⁴

This distribution of sources is broadly consistent with global estimates of resourcing for AIDS (see Part II, Section 2), in that it is heavily dominated by bilateral and multilateral funding. However spending by national governments, which is estimated at 30% of all expenditure globally, is very weakly reflected in the survey data, which suggests that CSOs are not receiving significant financial support from government budgets. In other words, grants to CSOs do not appear to be a major element in southern African governments' own domestic spending on AIDS. By contrast, various private sources such as businesses, foundations and trusts, donations by individuals (including CSOs members' own contributions) and income from income generating activities (IGAs) contribute upwards of 10% of all funding accessed by CSOs.

Figure 18

Sources of funding for CSOs in the region



The US Government's PEPFAR initiative was by far the largest single bilateral funder for CSOs in 2005, accounting for 47% of all bilateral funding accessed by CSOs. Other major bilateral donors included the Netherlands Ministry of Foreign Affairs (18%), Irish Aid (8%), DFID (5%), AusAid (4%), and Sida (2%). The average value of bilateral grants to CSOs in 2005 was over US\$250,000.

Given its enormous funding commitments in the region, it is not surprising that PEPFAR emerges as the leading source of support for CSOs. However it is important to note that its dominance in this survey is likely also related to the fact that US Government (USG) funds are almost exclusively channelled in the form of direct project support. Although some awards are made to government institutions, the majority of funds are directed to non-state actors: university and research institutions, NGOs, and various private contractors. By contrast, many of the main European bilateral institutions have begun to shift away from direct project support to pooled or budget funding, which may shape the extent to which they are reflected by name in the CSO survey. Finally, while PEPFAR funds are clearly considered to be 'AIDS funding,' many of the other bilateral agencies have relatively small AIDS-specific funding portfolios compared to their much larger sectoral support programmes for the health and education sectors.

The US Government's PEPFAR initiative was by far the largest single bilateral funder for surveyed CSOs in 2005, accounting for 47% of all bilateral funding accessed by CSOs.

The Global Fund, the European Union and the World Bank were the largest named sources of multilateral funding by CSOs, followed by a number of UN agencies led by UNICEF, UNDP and the World Food Program.

¹⁴⁴ Government sources include government departments, parastatal institutions, and decentralised local government bodies.

Although sub-granting mechanisms accounted for only 11% of the total volume of funds accessed by CSOs in the survey, they were by far the most frequently mentioned source of support.

International NGOs/FBOs and development agencies are a major source of funding for CSOs. This category comprises dozens of different groups, some with offices and operational presences in the region and others funding projects from overseas. The top sources of funding in this category – the Red Cross, Catholic Relief Services, Family Health International, and the Hope for African Children Initiative – together accounted for a more than a quarter of all funding for CSOs provided through this category of institutions. Other major players included Oxfam agencies,¹⁴⁵ IBIS, Trocaire, Southern African AIDS Trust, Save the Children, ActionAid and CARE. The average value of grants in this category was over US\$60,000.

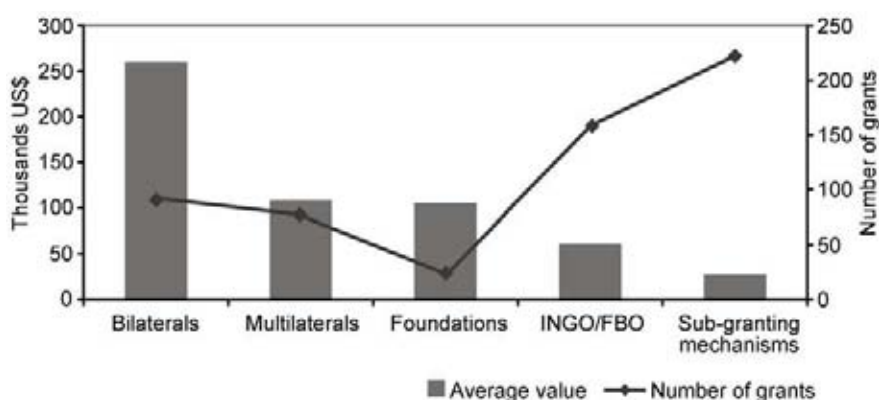
Sub-granting mechanisms take a variety of forms, from funding conduits administered as part of NACA structures (as in Malawi and Mozambique) or by the NACA (Swaziland), to NGO umbrella bodies (Zambia) and independently administered funding schemes (Namibia). These mechanisms, which act as funding conduits for one or more streams of external funding, exist in one form or another in all six countries except Lesotho.¹⁴⁶ Their size, reach and efficiency in disbursing funds can be taken as a rough proxy for the extent to which small and medium-sized CSOs are able to access AIDS funding in these countries. The average funding award in this category of support was approximately US\$25,000.

Although sub-granting mechanisms accounted for only 11% of the total volume of funds accessed, they were by far the most frequently mentioned source of support. The largest of these mechanisms by volume of funds awarded were the Zambian National AIDS Network, Swaziland’s National Emergency Response Council on HIV/AIDS, Mozambique’s Conselho Nacional de Combate ao HIV/SIDA (CNCS), Zambia’s Community Response for HIV/AIDS (CRAIDS), and Churches Health Association of Zambia (CHAZ).

Main sources by number of grants

As Figure 19 shows, there is an inverse relationship between the financial value of grants awarded by different categories of sources and the frequency with which the sources are mentioned. Although the average value of grants from bilaterals, multilaterals and foundations is over US\$100,000, by far the most frequently mentioned sources of support were international NGOs and FBOs and sub-granting mechanisms.

Figure 19
Main sources of funding by financial value and by number



¹⁴⁵ Although various Oxfam agencies are autonomous and fund independently, for the purposes of this analysis financing provided by various Oxfam chapters has been combined.

¹⁴⁶ There have been examples of sub-granting for AIDS in Lesotho (e.g. World Vision sub-granting GFATM funds to CSOs), but these have been time-bound initiatives rather than mechanisms that undertake sub-granting to CSOs on a continuous basis.

Almost half of all CSOs¹⁴⁷ received funding from a sub-granting mechanism in 2005, making this the most widely accessed source of support for CSOs in the region. Rates differed by country, ranging from a low of 23% of CSOs in Namibia to a high of 66% in Zambia. This provides evidence that sub-granting mechanisms are succeeding in disbursing funding to CSOs in a broad-based manner, and that the stronger and more decentralised these mechanisms, the greater their reach. This can be seen in the relatively weak penetration of sub-granting in Namibia, where there is one relatively small independently administered fund, compared Zambia where three large-scale conduit mechanisms (ZNAN, CHAZ and CRAIDS) sub-grant funds to CBOs, NGOs and FBOs nationwide.

Almost half of all CSOs in the survey received funding from a sub-granting mechanism in 2005, making this the most widely accessed source of support for CSOs in the region.

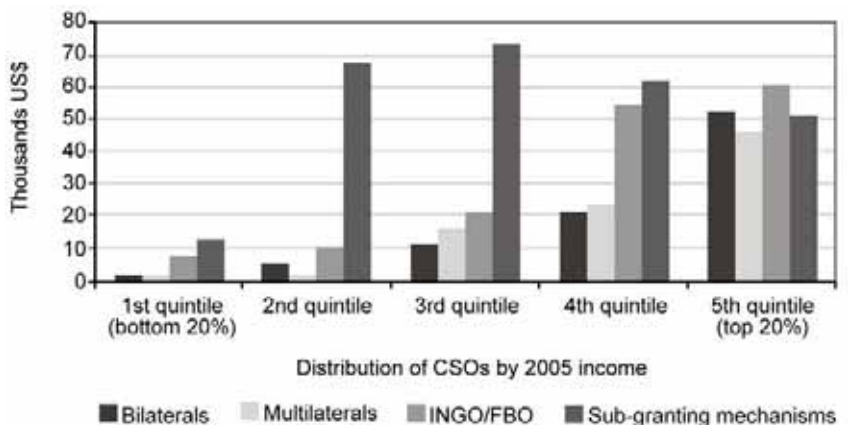
The survey provides evidence of the relative importance of different sources of funding for CSOs of various sizes (see Figure 20). Access to funding by the bottom 20% of CSOs (by size of annual income) is relatively constrained across all categories of support, while the top 20% of CSOs are accessing support from a range of sources in greater proportions.

Among the middle 60% of organisations, sub-granting mechanisms are by far the most commonly accessed type of support. Levels of access to these grants are many times higher than for other sources of support. While such mechanisms are commonly accessed by the largest organisations as well, their role is less pronounced given that access to funding for the top organisations is more evenly diversified across different types of support.

Among organisations with larger budgets, other types of funding – notably from international NGOs and FBOs – are accessed in greater proportions. However, direct access to bilateral and multilateral funding sources remains heavily concentrated among the top 20% of organisations.

Figure 20

Proportion of CSOs, by size of income, which accessed main sources of funds in 2005¹⁴⁸



2.2.2 Main sources of funding at country level

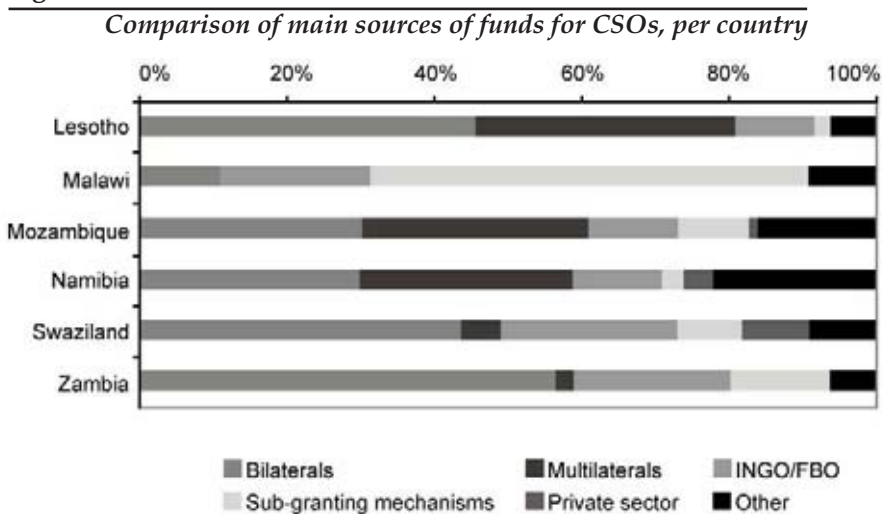
The funding and AIDS response architecture in individual countries strongly shapes the relative importance of different streams of funding for civil society organisations (see Figure 21). Major factors include: the extent to which the National AIDS Coordinating Authority plays a direct role in funding AIDS response; the presence or absence of a pooled or basket fund linked to sub-granting mechanisms; the functionality of

¹⁴⁷ Excluding the CSOs in Lesotho where there is no sub-granting mechanism for CSOs.

¹⁴⁸ n=439 for all categories except sub-granting mechanisms, where n=373.

this mechanism (in terms of rates of disbursement); the existence of other sub-granting mechanisms aimed at CSOs; the country's status as a PEPFAR focus country; and the active presence of international and/or development NGOs that channel large amounts of ODA funding.

Figure 21



Malawi is a clear example of a country where a centralised basket funding mechanism, linked to a sub-granting arrangement, has been used to disburse funding widely to civil society organisations (see Figure 22, Malawi). Sixty percent of all funding received by CSOs in Malawi in 2005 came in the form of sub-grants from the National AIDS Commission (NAC) or the five large international NGOs that act as umbrella bodies for funding and capacity-building of CSOs.¹⁴⁹ This is by far the number one source of funding for Malawian CSOs, and the relatively small proportion of funds received directly from bilateral and multilateral channels speaks to the dominance of the basket fund within the funding environment. The fact that Malawi is not a PEPFAR focus country also contributes to the relatively peripheral role of direct bilateral funding for CSOs in the country.

Where centralised basket funding mechanisms are in place but are performing sub-optimally in terms of rate of disbursement, funds continue to flow in large volumes through parallel streams – as is the case in Mozambique (see Figure 22, Mozambique). In 2005, CSOs were only accessing 10% of their funding through national and provincial AIDS structures despite the strong push from the top to consolidate AIDS funding in the common fund. Bilateral and multilateral donors remain the key sources of support for CSOs, along with the strong presence of international NGOs and FBOs in the country. PEPFAR is a dominant source of funding for CSOs in Mozambique (accounting for 13% of all funding received in 2005), which is designated a focus country under the scheme.

In Swaziland NERCHA is the lead AIDS response agency and significant external funding, including from the Global Fund, is channelled through it. NERCHA supports a wide variety of implementing partners who submit proposals to receive funding support for activities in fulfillment of particular national objectives. It also plays an active role in the direct procurement of goods and services for implementing partners. The relatively low proportion of funding that is attributed to NERCHA in the survey (9%) likely masks its actual financial significance for CSOs to the extent that its support takes the form of central procurement and

¹⁴⁹ For the purposes of this analysis, all funding reported received from the five international NGOs serving as umbrella bodies has been classified as funds derived from a sub-granting mechanism.

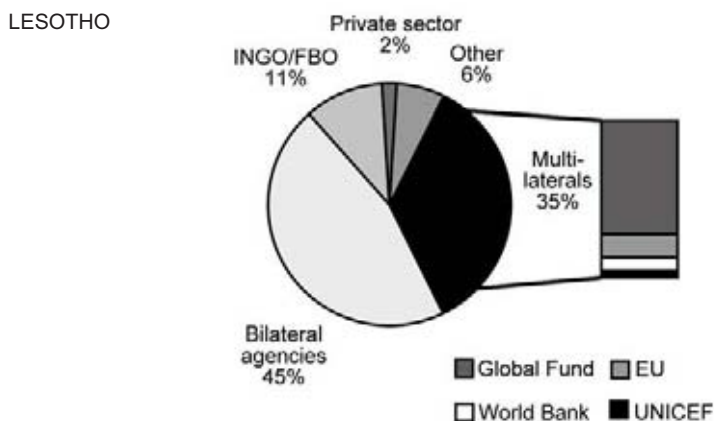
covering of costs for services, rather than direct allocations of funding. Bilateral support for CSOs in Swaziland is dominated by the US and the Netherlands, and a range of large international NGOs and development agencies, including the Red Cross, are active players (see Figure 22, Swaziland). The proportion of support from the private sector is higher in Swaziland than any other country and is largely attributable to grants from the Bristol-Myers Squibb corporation through its Secure the Future initiative.

In contrast to Malawi, Mozambique and Swaziland, the NACAs in Lesotho, Namibia and Zambia do not play a direct funding role, although they are active in directing flows of funding behind the scenes.

Lesotho does not have a large-scale sub-granting mechanism for CSOs or a centralised funding mechanism for AIDS response. The Ministry of Health and Social Welfare has awarded significant amounts of World Bank and Global Fund support to NGOs over the past five years, but there is no 'rolling' fund to which CSOs can apply for access.¹⁵⁰ CSO access to funding in Lesotho therefore continues to be fairly fragmented and CSOs access support where they can through direct relationships with donor institutions (Figure 22, Lesotho). Apart from sub-grants of multilateral funds, which, as noted above, are channelled largely through government, bilateral donors and NGOs are important sources of support. Financial support in the form of grants is directed predominantly at established NGOs, many of which are based in Maseru, while CBOs and community-level support groups tend to receive in-kind support in the form of food, supplies and other materials.

In Namibia (see Figure 22, Namibia), more than half of the funding received by CSOs in 2005 came from two sources - the Global Fund (28%), through sub-grants from the Ministry of Health and Social Services, and PEPFAR/Family Health International (23%).¹⁵¹ Foundations and international NGOs and FBOs emerge as more important sources of funding for CSOs than (non-PEPFAR) bilateral funding, which is in keeping with the recent trend for donors to scale down their support to Namibia and to channel funding through sector-wide programmes rather than direct project support. The Small Grants Fund accounted for only 3% of total funding received by CSOs, underscoring its modest financial reach in terms of the sector as a whole - a fact which stands in direct contrast to the importance attached to the fund by CBOs in the country (see box, Section 3.3.4).

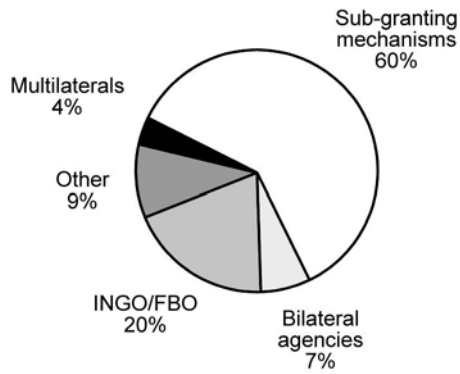
Figure 22
Sources of funding for CSOs, by country



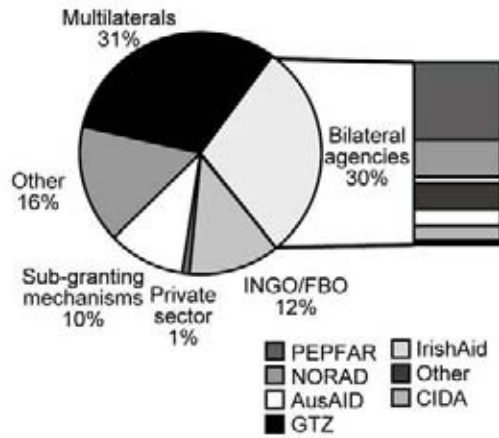
¹⁵⁰ With the reconstitution of the LAPCA into the NAC, it is likely that the NAC will assume a greater financial role in the future, leading to greater centralisation of AIDS resources.

¹⁵¹ Family Health International was a prime recipient of PEPFAR funding in 2005 and sub-granted large amounts of PEPFAR funding to local organisations.

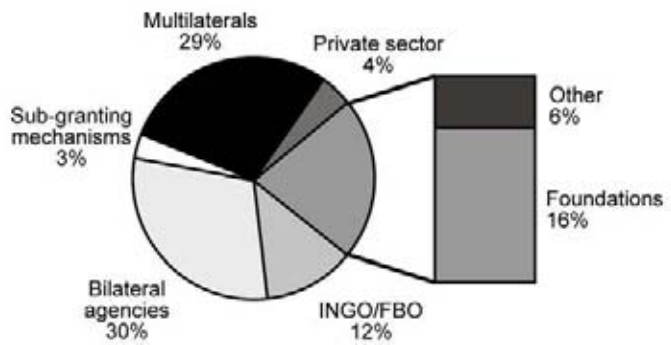
MALAWI



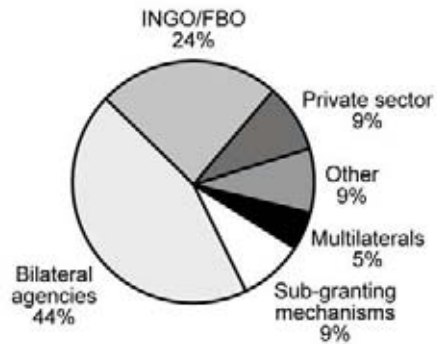
MOZAMBIQUE



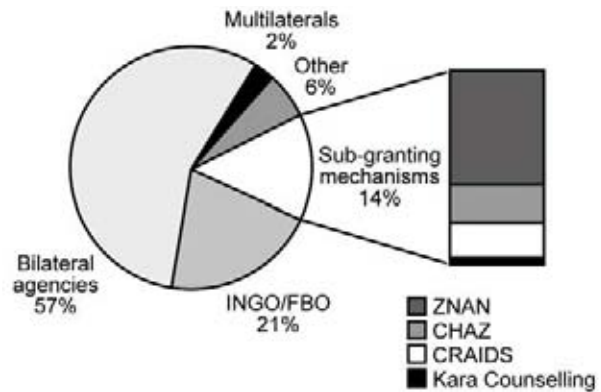
NAMIBIA



SWAZILAND



ZAMBIA



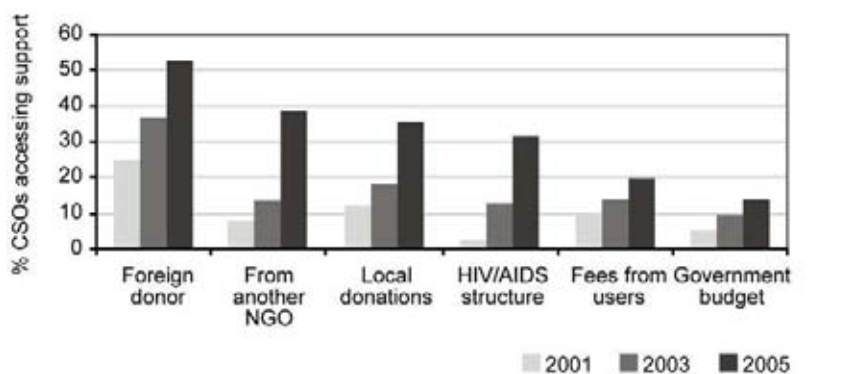
Funding for CSOs in Zambia is heavily dominated by bilateral funders (see Figure 22, Zambia); PEPFAR alone accounts for almost a third of all funding received by CSOs. Multilateral sources did not figure prominently in the survey, as most of these funds are channelled through the three main sub-granting mechanisms – CRAIDS (World Bank), ZNAN and CHAZ (Global Fund) – which also channel support from donors such as DFID, the Royal Netherlands Embassy, IrishAid and NORAD. Indeed, the prominence of these three mechanisms for small to medium-sized civil society organisations cannot be overstated. A wide array of international NGOs and FBOs – many based outside Zambia – provide direct project support to CSOs of all sizes and together represent a significant, if fragmented source of support for the sector.

2.2.3 Trends in sources of support, 2001-2005

As shown in Figure 23, over the five-year period 2001-2005 there was year on year growth in the proportion of CSOs that accessed funding from six main categories, or sources, of support: foreign donor or institution; another NGO; an HIV/AIDS structure; government budget; local donations; and fees from users. The rates of growth in the various categories differed, however, as did the overall proportions of CSOs benefiting from each category.

Figure 23

Trends in sources of support, 2001-2005



Foreign donors and institutions were the most commonly accessed source in 2001, 2003 and 2005: a quarter of CSOs received support from a foreign donor in 2001, increasing to more than half in 2005.

Close to 40% of CSOs reported receiving support from another NGO in 2005, an almost three-fold increase over 2003 levels. The particularly steep jump between 2003 and 2005 likely reflects the growing involvement of INGOs in channelling donor funding for AIDS activities, as it coincides with the acceleration of official development assistance for AIDS, including the launch of PEPFAR which channels significant proportions of funds to non-state actors such as NGOs. The exponential growth in this particular category – compared to the slower and steadier growth in access to foreign donors – provides further evidence that NGOs are assuming a leading role as conduits for external funding, as well as programme implementation in conjunction with local CSOs.

The most pronounced change in access to funding can be seen in relation to HIV/AIDS structures – understood as local, provincial or national bodies with a mandate to coordinate and support AIDS response activities. While these structures were not major sources of support in

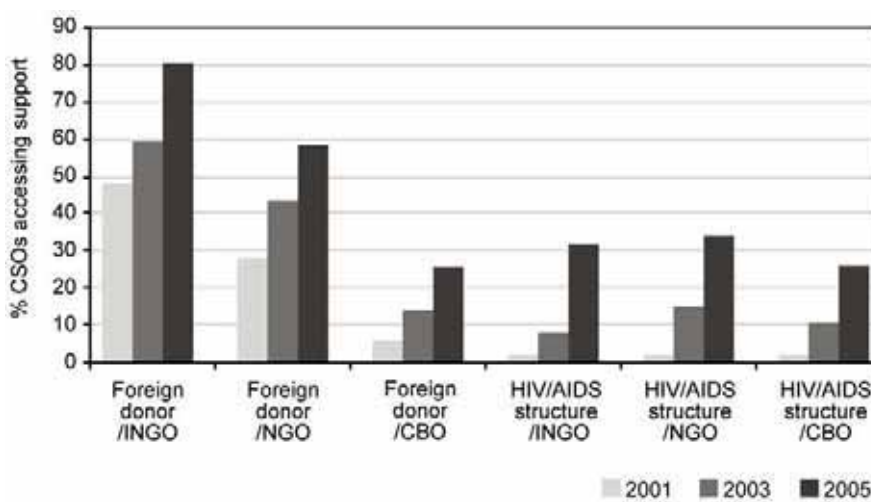
National bodies with a mandate to coordinate and support AIDS response activities grew rapidly after 2001 as the national architectures of AIDS response were consolidated.

2001, they grew rapidly in importance during succeeding years as the national architectures of AIDS response were consolidated. In 2005, approximately one-third of CSOs received support from such bodies – a level 16 times greater than in 2001.

The proportion of organisations receiving donations from businesses, churches and other local sources tripled over the five year period, from a relatively high starting point (12%) compared to other sources. The smallest degrees of change occurred in relation to income from user fees and support from government budgets; these two categories of support were also the least commonly cited among CSOs.

Access to foreign donor institutions is significantly greater for INGOs than for NGOs or CBOs, although the growth in access over the five-year period was greater for CBOs than for larger organisations. By contrast, access to funding through HIV/AIDS structures is less differentiated by organisational type, with a quarter to a third of all types of CSOs receiving support from such structures in 2005. The relatively similar patterns of growth in access over time suggest that this channel of support does not disfavour CBOs in relation to other types of CSOs.

Figure 24
Uneven growth in access to sources of funding



Approximately one-fifth of INGOs received support from the budgets of government departments or ministries in 2005 – a higher proportion than among CBOs (7%) and NGOs (15%). While still not high, this represents a three-fold increase over 2001 levels and may provide preliminary evidence that the trend for donors to direct funding through SWAPs and budget support is being felt in gradually increased allocations to civil society.

Urban and rural-based CSOs had similar patterns of access to funding from HIV/AIDS structures, NGOs and local donations over the period. However a greater proportion of urban-based CSOs received support from foreign donors (64%) and government budgets (18%), compared to rural-based organisations (34% and 7% respectively), which reflects the difficulty that can be experienced by organisations in more remote areas in securing access to support which may concentrate in urban nodes.

CSOs that began work on AIDS in or before 2000 had greater access to funding in all categories of support than did CSOs that began in or after 2001, although in all cases the differences in access between ‘older’ and

'younger' CSOs grew smaller with each successive year. In 2005, the older generation of CSOs accessed support from HIV/AIDS structures at only slightly greater levels than newer organisations (35% vs. 30%), although differences in access to foreign donors was more pronounced (66% among 'older' CSOs, compared to 43% among younger ones). This supports the general view that greater time is required to establish contacts and cultivate funding relationships with foreign institutions than with in-country AIDS structures, for example. In general, however, the data suggests that newly established CSOs, or those which added an AIDS component within the past five years, have generally succeeded in accessing funding quite quickly and are only at a minor disadvantage when compared with their older counterparts.

Greater time is required to establish contacts and cultivate funding relationships with foreign institutions than with in-country AIDS structures.

2.2.4 Diversification of funding

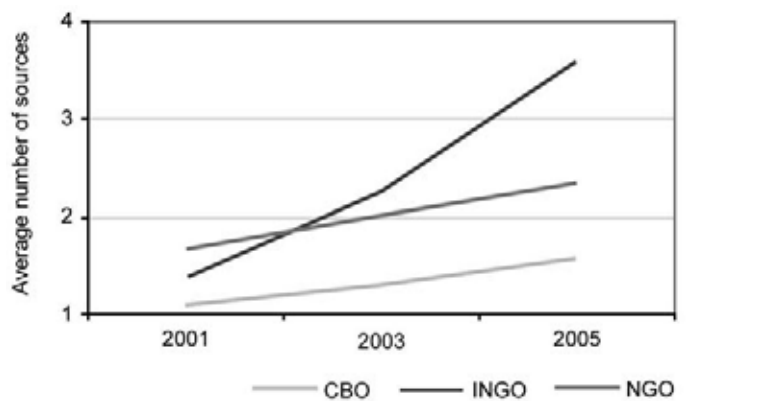
The number of sources of funding that an organisation has succeeded in accessing at any given time speaks to its level of financial diversification. Organisations with a diversified funding base may be less vulnerable to the instability that can be caused by the withdrawal of a donor's support or change in donor priorities and more able to chart their own programmatic course. Organisations reliant upon a small number of funders, by contrast, can be overly dependent upon the changing agendas and priorities of the funders.

The number of grants received by the average CSO in the region rose from 1.45 in 2001 to 1.89 in 2003 to 2.32 in 2005. It is apparent in Figure 25 that CSOs of all sizes diversified their funding sources over the period 2001-2005.¹⁵²

CSOs of all sizes diversified their funding sources over the period 2001-2005.

Figure 25

Diversification of support



The differences in average number of sources became much more pronounced over the five-year period.¹⁵³ By 2005, the average INGO had far outpaced NGOs and CBOs in terms of number of funders, despite starting with a lower average number of funders than national NGOs. This can be taken as another indicator of the enhanced access to funding among international NGOs in particular.

By country, Zambian CSOs had the highest average number of funding sources (2.97) in 2005, followed by Mozambique (2.59) and Lesotho (2.44). Malawi had the lowest number of sources (1.65) in 2005. Over the five-year period, the rate of funding diversification – that is, the percentage change in the number of sources of grants – was greatest in Lesotho and Zambia (a growth of 105% in both countries) and lowest in Swaziland and Namibia (11% and 16% increase respectively).

¹⁵² 'Grants' include all sources of external support from a named entity, with a designated financial value, that were reported by CSOs in the survey.

¹⁵³ 2005 figures are significant at $p \leq 0.00$. It was not significant for earlier years.

2.2.5 Donations and in-kind support

Donations of food, supplies, equipment, office space and assistance of various kinds are particularly important for small CSOs and can often constitute the main forms of support for organisations too small to access funding directly. Almost 10% of CSOs surveyed reported receiving *only* in-kind support in 2005. On average, these organisations had begun their work on AIDS within the past five years and had not accessed external support in the form of funding.

The five most frequently mentioned types of support included food, office space and equipment, educational and communications material, clothing, and medical supplies and drugs. Beyond these main categories the breadth and variety of support is remarkable. Among the donations mentioned by CSOs were sewing machines, maize mills, pigs and chickens, wheelchairs, building materials, carpentry tools, training programmes and workshops, donated labour, donated transportation or vehicles, subsidised fertilizer, sponsored excursions for children, and electricity credits.

The case study research found numerous examples of organisations that were running programmes on a regular basis without any external financial support (see Part IV). Village-level support groups in Lesotho, for example, are rarely registered in the 'modern' sense (they are recognised by village chiefs) and generally do not have bank accounts. However they access supplies from the Red Cross, the World Food Programme, the Office of the First Lady, local clinics and a handful of international NGOs in volumes large enough to sustain feeding schemes, home-based caregiving, and food gardens. In the urban fringes of Lusaka, the case study research found a well-developed women's project that has grown in size and reach without any external funding, relying upon small-scale income generation projects, food gardening, and volunteer input from local women, caregivers and guardians, concerned community members and the school principal.

Almost 10% of CSOs surveyed reported receiving only in-kind support in 2005.

In the urban fringes of Lusaka, the case study research found a well-developed women's project that has grown in size and reach without any external funding.

Donations of goods and supplies appear to be central to the operations of predominantly rural CSOs working on AIDS in Malawi.

The survey found that CSOs in Malawi are more likely than their counterparts in other countries to receive in-kind support. While the most commonly mentioned type of donation in all the other countries was food, in Malawi it was bicycles for use in home-based caregiving and transporting patients to clinics. The fact that in-kind donations play such a large role for Malawian CSOs is almost certainly not unrelated to the relatively low levels of financial support they receive (see previous sections). Donations of goods and supplies appear to be central to the operations of predominantly rural CSOs working on AIDS in Malawi. Many – such as maize mills, livestock, and sewing machines – are linked to poverty alleviation and income generation schemes.

At their earliest stages of development, civil society organisations most closely resemble small groups of individuals who have joined together to address a shared concern. These entities often engage in what can be termed 'horizontal philanthropy' in the way that they support one another and other community members with modest resources and direct forms of support. At this stage in organisational evolution, what CSOs need most are inputs of materials and supplies with which to work, a place from which to work, the ability to reach beneficiaries, and access to opportunities to increase and formalise knowledge and skills around the work they are doing.

While money is certainly useful, in many cases it is not the thing that is needed most, as the short organisational history in the box below demonstrates. The first monetary donation (which came almost two years after the organisation was founded and was worth US\$1,500) allowed the CBO to buy pots and other material required to start a feeding scheme, but it was not until they managed to get a refrigerator donated from a charitable trust during the following year that they could actually scale up the feeding scheme and make it more efficient. As the rest of the history shows, the CBO's successful growth can be attributed in large part to the mix of monetary and non-monetary support it received from a host of sources – inputs that addressed the right needs at the right times. It should be noted that funding from international development agencies – e.g. the German Development Service – appeared relatively late in the organisation's evolution.

Donations and in-kind support for young CSOs

The Early Development of the TOV Multipurpose Centre, Tsumeb, Namibia

Excerpt from an article entitled, 'TOV is Five Years Old'

"TOV comes from a Hebrew word which means Good. We started on 16 January 2001 with 3 kids in our pre-school; today the parents when they are looking for a pre-school come first to TOV. We have seen over the last 5 years 120 kids graduating from our pre-school...

Our first donation came from VSO [Voluntary Service Overseas] towards the end of 2002. Wow! Wow! That was really awesome.... This donation helped us to start the feeding scheme, purchasing pots and more.

We were buying soup bones per day. We did not have a fridge. It was expensive to do that and buying more would have meant that they just get rotten. [A private trust] came to our rescue, donating a fridge to the Centre. Wow! Wow! It helped us to save a lot of money...

The needs of TOV are just growing and the community starts to demand more from TOV.... We approached the Ministry of Land and Resettlement for land. We want to grow our own food and start to feed more children. We got the land and we are pleased to tell you that we are waiting for our first harvest. We want to thank the German Development Service (DED) and the Embassy of France in Namibia for investing in the farm and we are forever thankful. ...

There are so many good memories to mention, people and organisations that have given to make this project a success"

Source: NANASO

2.3 What are CSOs being funded to do?

Figure 26 shows the intended purpose of funding awards made to civil society organisations for AIDS in 2005. The chart presents the proportion of awards made by category of intended use, rather than the overall financial value of these awards.

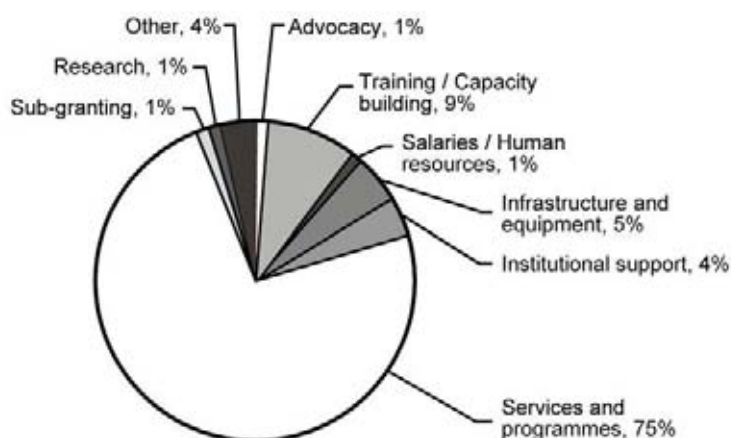
Each listed award's intended use was determined on the basis of the brief description provided of the activities and costs which the funding was meant to cover. When the description of a single funding award pointed to coverage of a range of costs – e.g. home-based care, training for caregivers *and* caregiver stipends – categorisation was done in accordance with the main thrust of the activity. In the example above, the award would be considered to be funding for 'programmes and services,' rather than for training or for salaries.

This funding analysis confirms CSO reports on the services they predominantly provide (see Figure 10, Section 1.5). AIDS-related funding being provided to civil society organisations is strongly directed at prevention, care and support, and impact mitigation activities. In 2005, 75% of all funding awards received by CSOs were for programme implementation or service delivery in areas such as home-based care; distribution of food, clothing and material support; education and awareness campaigns; operating places of safety, neighbourhood points and child care facilities; constructing maize mills; running income-generation projects; organising youth athletic associations; orphan and vulnerable children support programmes; and a wide range of other functions.

Funding for training and capacity-building comprised the next largest category of awards at 9%, followed by funding for equipment, vehicles, or infrastructure (including the construction of facilities) at 5%, and general institutional costs at 4%.

Just over 1% of all awards were linked to advocacy or rights-based campaigns.

Figure 26
*Funding awards received by CSOs in 2005,
by category of intended use*



Advocacy activities comprise a slightly higher proportion of awards in Lesotho (5%) and Swaziland (3%) than in the other countries. No CSOs in Mozambique or Namibia reported funding for advocacy work on AIDS.

Funding for service provision is most dominant in Mozambique and Zambia (both 84%) and lowest in Lesotho (57%) and Namibia (63%).

Funding for training and capacity-building programmes was significantly more common in Namibia (19%) than in any of the other countries. The reasons for this are not immediately apparent, although donor interviews pointed to an almost universal view that considerable capacity-building is needed for Namibian CSOs. In Lesotho, a significant proportion of funding awards (18%) were made for the purchase of equipment, vehicles or other infrastructure-related expenses. This may reflect a tendency for large NGOs based in the capital to embark upon decentralised operations at district level in areas that are remote and relatively difficult to access.

These findings provide support for anecdotal evidence about the strong emphasis on service delivery that is currently found within AIDS

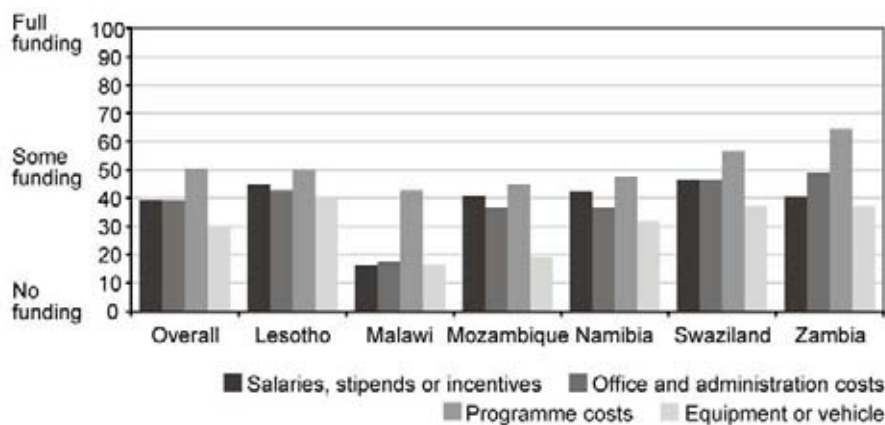
funding flows. Although many of the funding awards for services and programmes may also include coverage of specific costs linked to salaries, transportation, operational expenses and even an advocacy component, these are included in support of the larger programme goals and are not funded as stand-alone components or activities in their own right.

Funding for CSOs by types of costs

CSOs were asked to note the levels of funding received in 2005 for four different types of costs: salaries, stipends and incentives; office and administration costs; programme costs; and equipment and vehicles. The following chart (Figure 27) reflects the reported levels of funding received rated on an indexed scale from 'no funding', through 'some funding', to 'full funding'. The data is presented as average ratings per area of need, per country.

Figure 27

Funding coverage, by country and type of programme cost



The most notable finding is that in all areas of need funds received fall well below 'full funding' and averages for all categories of funding apart from 'programme costs' fall between 'some funding' and 'no funding.' Funding levels are particularly low in Malawi, although this may reflect greater recent mobilisation of smaller organisations in Malawi that remain only partially funded, rather than a paucity of civil society funding in Malawi in general.

The findings presented in Figure 27 echo the analysis of individual funding awards presented in Figure 26. It is apparent that donors in all countries are more willing to support programme costs than costs of salaries, administrative/office expenses or equipment. Funders are generally willing to pay for human resources directly associated with projects, but are reluctant to fund the existence of organisations by supporting salary costs associated with the day-to-day running of the organisation, including the salaries of staff not directly involved in project implementation.

Funding for 'salaries, stipends or incentives' is well below what is perceived as needed and the same may be said of 'office and administration costs.' Donors have traditionally been reluctant to fund recurrent costs, and especially the cost of administration. In the view of CBOs and NGOs, projects suffer as a result. One Zambian NGO surveyed noted, 'Some organisations like [bilateral funder name] do not meet personnel costs and administration cost which makes it difficult

In all areas of funding need, funds received fall well below 'full funding' and averages for all categories of funding apart from 'programme costs' fall between 'some funding' and 'no funding'.

to implement their projects on schedule and to acceptable quality.’ The failure to recognise the need for basic running costs can assume tragic proportions: in one organisation, volunteers in a small and underfunded Malawian CBO walked daily for 12 kilometres to deliver a service for which the organisation was paid a modest amount on a fee-for-service basis, but there was no coverage of transport costs because the service was deemed to be ‘in the community.’

Funding for equipment and vehicles has been difficult to secure, especially in Malawi and Mozambique. This is surprising given the challenging physical infrastructures in both of these countries which would suggest a legitimate need to invest in vehicles and facilities.

2.4 What issues are CSOs facing in accessing support?

The emergence of a large number of civil society organisations interested in responding to AIDS should not be thought of as a permanent phenomenon. Many of these organisations are largely unfunded and their responses to questionnaires reflect considerable difficulties in accessing funding. Many organisations report cutting back on areas of work as a result of delays or cuts in funding, and for the smallest organisations work may take place when there are resources available and simply stop when there are not. CSO operational plans are significantly underfunded. Forty-six percent of organisations reported that between 0% and 25% of their planned programme for the year ahead was currently funded. Only 10% reported that they were at least three quarters funded for the year ahead.

There is a strong prevailing perception, on the part of CBOs in particular, that access to funding is erratic and this is an impediment to effective functioning. In the words of a survey respondent from a CBO in Lesotho: ‘Funding application is a futile exercise and demotivates more than motivates. If funding gets through, activities start, but stop once funding is over. There is no long term commitment.’

CBOs are generally very dissatisfied with funding arrangements. The following box is but a sample of the many comments reflecting the inadequacy of the current situation in all countries and the perception that funding is not getting to CBOs at the necessary scale and for the right things.

Dissatisfaction with the current funding environment on the part of CBOs

‘Donors are not willing to fund small organisations. They opt for big organisations. It is not easy to access funding where there are no internet services.’ (Lesotho)

‘We work with people from rural areas but funding agencies do not help us.’ (Malawi)

‘We are very worried just because the CBOs are the ones which are doing job on HIV/AIDS pandemic, but they are not receiving grants at the right time and they are not even helped.’ (Malawi)

‘The organisation is not able to run or to perform its day to day activities due to funds, so immediate sources of funds are greatly needed for HIV/AIDS implementation.’ (Malawi)

‘Major donors expect too much sometimes and they are over complicated... Funders keep on changing the priorities and policies.’ (Swaziland)

Forty-six percent of surveyed organisations reported that between 0% and 25% of their planned programme for the year ahead was currently funded.

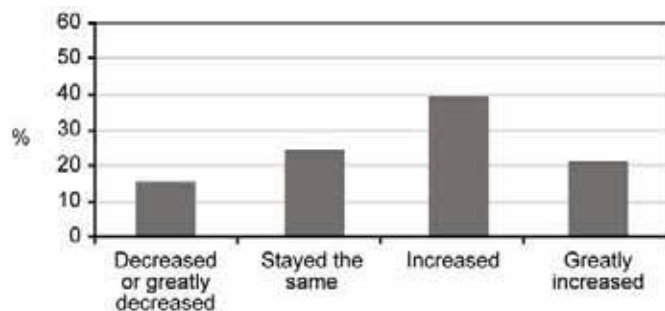
2.4.1 Amount of time spent fundraising

Figure 28 indicates the change in amount of time spent fundraising over the past three years. It is evident from this chart that the amount of time spent fundraising has increased or greatly increased for 60% of organisations. This is significant as it is counter to what might have been expected with the increasing attention paid at national and sub-national level to attempts to improve funding mechanisms. With the increase in general availability of funding, fundraising has become more rather than less time-consuming.

With the increase in general availability of funding, fundraising has become more rather than less time-consuming.

Figure 28

Change in amount of time spent fundraising in past three years



Some organisations submit a large number of proposals for funding, and this is time consuming. Fifty-two percent of organisations submitted four or more proposals in 2005, while 28% submitted six or more proposals and 14% submitted 10 or more proposals.

The average number of proposals submitted per organisation was five, while on average only three received any response from the agency to which it was submitted. The average number of successful proposals per organisation was only 1.5. This attests to a very inefficient way of obtaining funding, at least from the CSO side. Comments by CSOs on the funding process suggest that they struggle to write proposals and have difficulties in understanding what funders are looking for. They welcome interactive relationships with funders through which the funder gets to know the organisation and assists the organisation to develop its capacity where this is deficient. What seems to happen, though, is that smaller CSOs in particular often fail to meet funder requirements.

CSOs report that often no reasons are given for rejection. However when reasons are given, these frequently include: that funds were already committed; late submission; the proposal does not fit thematic or priority areas for funding; that the country already has a national body that is funded for the activities in question; that the proposal contains unallowable costs; that the proposal does not address monitoring and evaluation; that the organisation demonstrated inadequate experience; that funding is not available for short-term projects; and that the proposal was accompanied by insufficient documentation.

The research findings suggest that CBOs in particular are competing in a contest for which they are ill-prepared and where conditions for receipt of funding are often miles apart from their own institutional realities.

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2.4.2 Relationships with funding institutions

The definition of what constitutes a 'funder' often differs significantly from donor and CSO perspectives. In the CSO survey, many of the

agencies listed by CSOs as funders would not call themselves funders, for example, the national coordinating authority in Swaziland (NERCHA) and the international NGOs that serve as umbrella organisations for NAC funding in Malawi. From CSO perspectives, however, ‘donor’ or ‘funders’ are the agencies to which the CSO applies for funds and with which it has the most direct dealings, irrespective of the actual origins of the funds.

From the funding side of the relationship, conduit organisations are aware of the donor origins of funds and are all too aware that they as ‘funders’ are intermediary agencies expediting the expectations of the real donors, rather than being donors themselves. In fact, such organisations may be best understood as beneficiaries of donor funding who engage CSOs to fulfil their own contractual obligations.

CSOs were asked to name the funding agencies which they have found ‘easiest’ and ‘most difficult’ to work with. The most significant difference between the ‘easiest’ and ‘most difficult’ lists of funders is the large number of smaller donors and bilateral donors that are listed as ‘easiest,’ and the fact that these same agencies are also seldom listed among the ‘most difficult’ to work with.

The ‘most difficult’ lists are mainly populated by the US government agencies and its partners, UN agencies, the Global Fund (especially in Lesotho), and national AIDS coordinating agencies (especially Mozambique and Malawi). Umbrella organisations are also prominent among the ‘most difficult’ funders, especially in Malawi where five international NGOs serve as umbrella organisations and funding conduits for disbursement of funds to local organisations.

Comments made by CBOs express frustration at the perceived lack of opportunity for direct contact with funders: ‘We want serious funding agencies who will visit,’ noted one Namibian CSO. ‘We will take to the corners of Namibia – many agencies only end up in Windhoek. Let us go to Katima, Rundu, Ruacana, Kunene, Oshakati, Opuwo and other places.’ It was significant that many organisations included in their responses on questionnaires appeals to the researchers for help in engaging with funders. For example, ‘We ask you to sell us or advertise us to other donors who work on HIV/AIDS and human rights’ (Lesotho). Some of the expressed need for direct contact with funders seems to be premised on the understanding that this would diminish the delays that CBOs experience in dealing with intermediary organisations that are perceived to be slow in dealing with proposals and with national funding agencies that are perceived to be overly bureaucratic.

One Malawian CBO expressed a view that ‘International or national NGOs should directly work with local NGOs/CBOs,’ meaning that local government level district assemblies should be cut out of the current funding arrangements. The reality is that the NAC hopes ultimately to cut out the umbrella NGOs and for the district assemblies to take responsibility for the funding process. There is a perception on the part of funded organisations, however, that the funding architecture itself is an impediment and that direct lines of communication and accountability should be established with funders.

It is also apparent that there are few opportunities to discuss and address the problems experienced with funders. Many organisations felt that the questionnaire sent to them as part of the current research allowed them to clarify and conceptualise for themselves the problems that they

experience with funders. It is strongly apparent that they had not hitherto systematically looked at these issues, let alone sought to address them. For example, 'We want to argue the donor communities through you to assist us with funding, so that our programmes and activities should be carried on very successfully' (Lesotho).

Clearly, from the CSO perspective, the growth in numbers of organisations involved in AIDS response is small comfort. Their view is that the funding context is unsatisfactory and increasingly onerous. The existence of a large number of underfunded CSOs which are only partly active in AIDS response should not be taken as success. The emergence of a new stratum of AIDS response organisations poses considerable challenges at the level of managing funding relationships in the future. It would appear that, from the perspective of the organisations themselves, the current set of arrangements is far from satisfactory and there needs to be much more dialogue about these issues.

The existence of a large number of underfunded CSOs should not be taken as success. The emergence of a new stratum of AIDS response organisations poses considerable challenges at the level of managing funding relationships in the future.

3. Donor funding for civil society and AIDS

This section moves away from the bottom-up analysis of funding for civil society to an institutional and country-level exploration of AIDS funding patterns for CSOs.

3.1 The challenges of monitoring and interpreting funding for civil society

The information presented in this part of the report is derived from three primary sources: semi-structured interviews with donor representatives; financial data from donor representatives, where such were provided; and a wide array of written documents and reports (annual reports, programme evaluations, reports from other resource tracking exercises, national AIDS reviews, data provided on donor websites, donor matrices, etc.).

Significant secondary analysis and triangulation of data was required to build up a picture of donor funding to civil society at country level. It is important to underscore that the figures in this section should be taken as indicative only, given the extreme difficulty of mapping funding flows for AIDS.

The challenges involved in tracking the distribution and use of donor funding for AIDS have been well documented.¹⁵⁴ Many of these issues were encountered during the present research, including:

- *Identifying AIDS funding within donor portfolios.* Budgets for AIDS are not always distinguishable from other types of support, particularly when AIDS is treated as a cross-cutting issue, is 'mainstreamed' across programmes, or is embedded as a component of a larger project or programme. A number of donors fund AIDS directly as well as through sector support programmes – for example, in health or education. Focusing only on AIDS-specific funding, as was done in this research, can produce a misleading picture if the donor's AIDS budget is tiny in comparison with the sector support it provides.
- *Disaggregating the various channels of funding for AIDS.* In addition to the main bilateral and multilateral channels, a number of donors support AIDS responses through regional programmes

¹⁵⁴ See Guthrie, T. & Hickey, A. (2004); Kates, J. & Lief, E. (2006); Ndlovu, N. (2005).

and through grants to international NGOs based in their own country. This adds additional layers of complexity to efforts to track resource flows as these various streams are often managed separately from one another.

- *Comparing funding data from different donors.* Donors work according to different funding cycles and fiscal years, and provide information about their funding using a variety of categories, including obligations, commitments, disbursements, and allocations. As a rule, more information is available about commitments than actual expenditure.
- *Analysing recipients of funding.* Different methods are required for tracking funding that flows through a common pool versus directly to recipients. Where detailed information about recipients is available, these have to be categorised into types. Information is sometimes not disaggregated down to the level of individual recipients (but, for example, into consortia that could comprise both state and non-state institutions); in some cases it is therefore only possible to calculate a 'minimum' and 'maximum' range of support that goes to CSOs, as apart from other types of recipients.

Considerable difficulty was experienced in the process of collecting data about donor funding. The difficulties encountered included:

- Inability of donor representatives to generate data in the categories requested;
- Turnover among donor staff, coupled with poor institutional recordkeeping, resulting in difficulty accessing information about funding from previous years;
- Unwillingness of donor representatives to share data or to be interviewed in relation to the research. This included referral of information requests to individuals in regional or headquarter offices, or to websites;
- Discrepancies between data provided by donors and published information in annual reports, evaluations and review documents; and
- Provision of partial or internally contradictory information.

The analysis of bilateral funding has focused on country programmes only and generally does not attempt to describe funding for AIDS channelled through regional programmes or through international NGOs based in the donor's country of origin. It is acknowledged that these are significant streams of funding, however it was not possible within the scope of this research to document these channels of support.

3.2 Donor perspectives and strategies on civil society and AIDS

The following analysis was generated from donor interviews and donor strategy documents. It explores donor perspectives on the desirability of funding CSOs for AIDS response and briefly describes different funding strategies adopted by major donors in the region.

3.2.1 Perspectives on support for civil society

What reasons do donors give for wanting to support civil society? Why do they think it is a good idea, or not? How do they conceive the benefits and risks of funding civil society against alternatives? Many different and

overlapping rationales are provided in strategy and policy documents, and these can be clustered together under a number of broad points:

Conduit for carrying the benefits of funding to places it would otherwise not reach

There is a widespread prevailing belief that CBOs and FBOs are an underutilised resource for expanding the reach of services to the poorest of the poor and 'spending money where it most helps.' This belief is strongly voiced by bilateral and multilateral funders alike.¹⁵⁵ There is a growing awareness amongst donors that funding bottlenecks have often resulted in resources not reaching communities in adequate volumes, or reaching groups that are particularly vulnerable or high risk. For these reasons it is argued that, whereas government support and SWAps are important, there is need to 'continue to support individual projects in the programme countries where the policy or institutional environment is not suitable for using more programmatic assistance.'¹⁵⁶

Mobilising latent societal resources

Each of the six countries faces severe human resource constraints in the public sector, particularly in health and education,¹⁵⁷ including a shortage of adequately trained human resources, the flight of desperately needed human resources overseas, and the loss of human resources as a result of AIDS. In this context civil society is seen by donors as a force or latent resource that can be mobilised to complement public sector efforts. The World Bank MAP programme, for example, was designed to contribute to 'national mobilisations' that would overcome earlier obstacles within national AIDS programmes that included limited human and financial resources, amongst others. It incorporates an explicit focus on engaging communities in 'sharing the burden' of AIDS alongside health and social service institutions.¹⁵⁸

The public sector is overstretched and cannot cope without civil society engagement

Linked to the point above, as well as to the principle of multisectoralism, many donors express the view that the government alone is unable to meet the scale of need. The Global Fund, for example, has required the involvement of non-governmental actors in the development and administration of programmes as a way to accelerate the pace of implementation beyond what would be feasible through a public sector-driven model.^{159 160}

Efficiency

There is a strong belief on the part of some donors that CSOs are less bureaucratic and that it is easier to 'get things done' through them. For example, Sida's HIV/AIDS strategic policy document states that 'It is Sweden's view that...international NGOs working on HIV-related prevention and care are efficient conduits for channelling funds to support people living with, or affected by, HIV and AIDS, as well as affected communities.'¹⁶¹ Similar views are expressed by the World Bank, which sees CSOs as 'an economical and effective way of reaching and serving large numbers of beneficiaries.' In its operational guidelines for the MAP programme, it goes on to note that 'resources focused directly at community level can have far greater value than comparable resources directed to formal structures.'¹⁶² CSOs, it continues, 'can often respond more rapidly than other agencies.'¹⁶³

¹⁵⁵ UNAIDS (2006a); Norad's position on funding for civil society (www.norad.no); Irish Aid (2006, p.23), which speaks of the need to get resources to where they are needed. NGOs are seen as 'filling the gap' left by government services and donor programmes. This sentiment was also expressed in numerous interviews conducted for this research. See also OGAC (2005b); interview and background information on DanChurchAid; interview with DFID; Brown, J., Ayvalikli, D. & Mohammed, N. (2004).

¹⁵⁶ Government of Ireland (2006, p.72).

¹⁵⁷ This is apparent in descriptions of human resources in each of the countries' 2005 UNGASS reports.

¹⁵⁸ Brown, J., Ayvalikli, D. & Mohammed, N. (2004, p. 2). Ironically, this suggests that communities heretofore have been insufficiently burdened by HIV/AIDS.

¹⁵⁹ Schocken, C. (n.d.).

¹⁶⁰ The World Bank promotes a similar view. Brown, J., Ayvalikli, D. & Mohammed, H. (2004, pp.37-38).

¹⁶¹ Sida/Swedish Ministry for Foreign Affairs (1999, p.42).

¹⁶² Brown, J., Ayvalikli, D. & Mohammed, H. (2004, pp.37-38).

¹⁶³ See also DFID (2005, p. 13); Government of Ireland (2006).

Sensitivity and cultural appropriateness

CSOs have the trust of their communities and can therefore work effectively on personal and intimate issues.¹⁶⁴ This view is promoted particularly strongly by PEPFAR, which sees FBOs as possessing particular ability to 'influence the attitudes and behaviours of their community members by building on relationships of trust and respect.'¹⁶⁵ High levels of religious affiliation and the role of churches in delivering health services make them 'crucial delivery points for HIV/AIDS information and services.'¹⁶⁶

Local ownership and sustainability

From varying viewpoints, donors voice the idea that support for civil society organisations allows for greater national/local determination of priorities and funding allocations,¹⁶⁷ that funding 'indigenous' organisations will increase longer term sustainability of AIDS responses,¹⁶⁸ and that it will contribute to greater 'community ownership, leadership, and management of HIV/AIDS responses'.¹⁶⁹

Supporting innovation and new solutions

CSOs can be important 'sources of innovation.'¹⁷⁰ Several funders expressed misgivings about projects which they had previously funded, but had been forced to 'let go of' as institutional policy shifted in favour of funding government or national programmes. Misgivings were expressed by a number of donors about the fate of projects which were more experimental or innovative, as a strongly strategy-oriented focus is likely to stick to tried and tested interventions rather than to explore new interventions on a small scale. Some programmes have gathered such projects under the banner of technical assistance or research, and thereby continue to conduct them, in spite of strong commitments to budget support. An example is the World Bank's three-country Treatment Acceleration Programme which has one of its implementation sites in Mozambique. Another is Irish Aid, which maintains 'a mix of complementary modalities in each of our programme countries.'¹⁷¹ Complementarity balances the need to support tried and tested solutions with encouragement of innovation and new solutions. Civil society is seen to be a good testing ground for the latter.

Civil society support is consistent with development and poverty reduction priorities

Against the backdrop of poverty reduction as an overarching concept for development assistance, and as a framing concept for many AIDS strategies, CSOs are seen as good partners in poverty relief and development interventions. Bilateral donor discourse generally strongly promotes partnership with civil society as a vehicle for poverty reduction and meeting the MDGs. DFID, for example, sees three main roles for civil society in poverty reduction: a) Building voice and accountability in relation to the state through, *inter alia*, local and national-level policy formulation and monitoring services and budgets; b) Providing services and humanitarian assistance in times of crisis, delivering services in 'fragile states,' and developing innovative approaches; and c) Promoting awareness and understanding of development among constituencies in northern countries in particular.¹⁷²

¹⁶⁴ Brown, J., Ayvalikli, D. & Mohammed, H. (2004); OGAC (2005b).

¹⁶⁵ OGAC (2007).

¹⁶⁶ OGAC (2005b).

¹⁶⁷ Royal Netherlands Embassy (interview).

¹⁶⁸ OGAC (2005b).

¹⁶⁹ Brown, J., Ayvalikli, D. & Mohammed, H. (2004).

¹⁷⁰ Government of Ireland (2006, p 72). Similar views are expressed by the World Bank.

¹⁷¹ Government of Ireland (2006, p. 72).

¹⁷² DFID (2005).

Many donors refer to the need to support civil society for its ability to give voice to popular concerns, both in relation to AIDS and more broadly. Sometimes this is softly couched through endorsement of the value of supporting diversity of interests which are deemed to make up a healthy and robust society, and at other times more strongly in the form of promoting alternatives to government domination. Norad, for example, speaks of support for CSOs as complementary to assistance to governments, in that it is an 'important corrective to government policy' through its 'platform of values, alternative social analyses and development strategies.'¹⁷³ With specific respect to AIDS, donors such as Sida note that, 'Community organisations have a key role to play in stimulating government action through advocacy and assistance to people living with, and affected by, HIV and AIDS.'¹⁷⁴

3.2.2 Unspoken assumptions and tensions

It is important to articulate some of the assumptions that underpin these rationales, particularly in the absence of an evidence base that can substantiate some of the motivations that are expressed for supporting civil society. As was discussed in Part II of this report, the widespread involvement of civil society organisations in development is a relatively recent phenomenon. Although the issue of CSO impact and effectiveness has been taken up increasingly seriously since the late 1990s, there is little systematic empirical evidence that CSOs are more efficient than other actors in delivering services, that the changes brought about by their efforts are more sustainable, or that their operations are genuinely characterised by participation, social inclusion and empowerment.¹⁷⁵

Perhaps the rationale most commonly cited by donors is that CSOs are well-positioned to reach people most affected by AIDS. In many instances CSOs probably are, in fact, the best opportunity for reaching people in dire need who cannot be reached by limited government health and especially social services.¹⁷⁶ For example, orphans and people sick in isolated areas without transport would go without assistance if it were not for the reach of civil society agencies. They are also well placed to reach specific populations that are not always recognised as such within government planning frameworks,¹⁷⁷ for example, commercial sex workers, street children and migrant or seasonal workers. Furthermore, donor support for peer-group approaches recognises that access to particular kinds of communities, for example communities of young people, for the purpose of disseminating information or promoting programmes of action, is best achieved by these groups themselves. This may be particularly important in addressing problems which are embedded in community-level knowledge and attitudinal systems, such as stigma and discrimination and persistence of myths about AIDS.

However it is important to interrogate some of the assumptions embedded in rationales that are cited for supporting civil society in AIDS responses:

- *CSOs have a broad scope and reach.* Although it is commonly held that CSOs have emerged in such numbers that they 'blanket' countries in southern Africa, their coverage is in fact quite fragmented. For example, the CSO survey conducted for this research has found that CSOs are predominantly an urban phenomenon and many work at small scale. It also found that certain specific high-risk groups are only weakly covered by CSO services, if at all.

¹⁷³ See www.norad.no

¹⁷⁴ Sida (1999, p.44).

¹⁷⁵ Fowler, A. (2000); Agg, C. (2006).

¹⁷⁶ For some donors, such as the Dutch Government, NGOs are seen as an appropriate vehicle for fighting poverty in countries where the Netherlands does not wish to work with the government either because there isn't one (e.g. Somalia) or 'because the government pursues extremely bad policies.' See www.mibuza.nl/en/developmentcooperation. See also DFID (2005, p.13).

¹⁷⁷ Or are recognised in situational analyses, but not prioritised at the level of programming.

- *Local ownership.* There is a strong discourse framing the need for civil society responses as a way to build local ownership of AIDS-related activities and to enhance the effectiveness and impact of AIDS programmes overall. This is linked to the idea that CBOs in particular are 'sensitive to needs on the ground.' However in many instances, CBOs are not 'community institutions' as much as they represent particular interests that are often personal. Furthermore, the idea that CSOs operate and are often embedded in local communities is sometimes deceptive. Organisations tend to grow where there are some resources, often in towns and with the leadership of relatively empowered members of communities. Larger CSOs have often grown beyond their early roots and can perhaps better be described as community service organisations, than as community organisations, given their strong upwards – rather than downwards – accountabilities.
- *CSO activity complements that of the public sector.* There is little evidence to suggest that there are strong systems of cooperation and coordination between CSOs and public sector institutions at the local level in particular. Thus, while CSO contributions may fill gaps in what is available through the public sector, these are not necessarily joined up well with government services. Significant efforts are required to address these issues of programme integration at the local level.
- *Local civil society organisations can be strengthened and made 'fundable.'* The considerable growth of community organisations and the large number of CSOs that have applied for funding suggests that civil society is available and interested in joining national mobilisations. But ultimately, this resource needs to be engaged with and developed. While many donors recognise that not all CSOs are in a position to manage donor funding directly, there seems to be an assumption that it is ultimately possible to strengthen local civil society to a point where it is able to do this, and where its impact and effectiveness can be felt. However, all evidence from the case studies suggests that the development of CBOs involves a long and arduous process with many challenges faced and strategic redevelopment processes needed. The research found few examples where this was being strongly prioritised.
- *Channelling funding through CSOs is efficient.* There is a notion that support to CSOs is efficient in the sense that funding moves relatively directly to the places where it is most needed. However this may not take adequate account of the costs involved in getting funds to CSOs in the first place. The use of umbrella organisations to manage funding for civil society in Malawi, for instance, has decentralised the administrative burden from donors, but in ways that are proving burdensome and challenging to manage. The international NGOs that were designated to act as funding conduits have been drawn into extensive capacity-building work with little prospect that the District Assemblies will be in a position any time soon to take over their role. Similar examples have been noted in other countries.¹⁷⁸ Ultimately it is a significant burden to fund civil society at scale, and this needs to be born somewhere in the system.
- *Civil society organisations working on AIDS contribute to poverty reduction.* Civil society organisations in the AIDS field do indeed respond to poverty and are acutely aware of the need to combat the daily realities of poverty which they encounter. But they mainly provide only basic relief for the destitute: in the AIDS field,

There is a notion that support to CSOs is efficient in the sense that funding reaches places where it is needed, however this may not take adequate account of the costs involved in getting funds to CSOs in the first place.

¹⁷⁸ For example, donor agencies that are channelling support through CHAZ and ZNAN in Zambia, and the growing administrative burden upon these sub-granting agencies.

development-type work is generally limited to food gardening and modest income generating activities as a limited form of economic empowerment. It is probably true, as is often stated, that much development work is done not by governments but by NGOs.¹⁷⁹ For this reason, it is appropriate that funders should pin their hopes of integrating AIDS response and development on the civil society sector. But the reality is that this work is often led by large international development NGOs and the bulk of civil society organisations in the AIDS field do not have the capacity or experience to link AIDS response to long-term development work.

- *Countries with strong civil society activity around AIDS have achieved successes in curtailling the epidemic.*¹⁸⁰ This is a contested assumption, in the sense that it is based largely on experiences in Uganda and within the gay community in the United States. In both instances, civil society activity emerged organically and was not driven or resourced from above.

Although there are discernible funding trends unfolding in each country, the situations are dynamic and changing. Whereas many donors have a centrally developed strategy or approach that guides their funding for AIDS, these may differ in response to country conditions and are 'emergent' in the sense of being contingent upon changing conditions. In many cases, there is a distinction between 'ideals' and 'realities'. Donors resort to interim practices which are not in their terms ideal, but which are necessitated by the conditions in countries.

There is a set of tensions embedded within many donor strategies around support for civil society. These include:

- Commitment to channel greater support through government budgets, yet reluctance to end all direct project funding. Donors in some instances stray from their own fundamental commitments to budget support, pooled-funding and SWAps¹⁸¹ through discretionary decisions to provide stand-alone technical assistance or direct project funding. In some cases this appears to be linked to a desire or need to point to 'tangible' successes or to 'brand' particular interventions as their own.
- A belief in the advocacy role of civil society in pressuring and holding their governments accountable, yet firm commitments to channel aid through government. These are reconciled from the donor side by a belief that civil society and government are reconcilable through support for democratic processes. However in countries where government is sceptical of expanding civil society's role, particularly outside service delivery functions, there is little guarantee that these will be reconciled.
- Belief that civil society has unique attributes, in terms of its role in giving voice to popular needs, but endorsing strategies through government support and basket funding that position civil society primarily as a service provider.

3.2.3 How donors channel funding for AIDS

This research revealed a great diversity of approaches among donor institutions in terms of how support for AIDS is channelled. While specific details of country-level funding patterns are presented in Section 3.3 below, this section provides a brief overview of some of the key issues that relate to the way AIDS funding portfolios are structured and the implications of this for support to civil society.

'Ideally, civil society organisations should not be encouraged to build up parallel services, such as in the area of health, but should create incentives or pressure for improved performance from the state. However, in reality, because of the scale of need, they will continue to play an important part in the direct supply of these services.'

White Paper on Irish Aid,
Government of Ireland (2006)

¹⁷⁹ www.minbuza.nl/en/development-cooperation

¹⁸⁰ DFID (2004a, p.50). See also Brown, J., Ayvalikli, D. & Mohammed, H. (2004, pp. 37-38), citing behaviour change at community level among young girls in Uganda and Zambia.

¹⁸¹ It was interesting to note in donor interviews that many donors, off the record, disclosed their reservations about winding down bilateral assistance programmes in favour of budget support and pooled funding programmes.

Donor institutions differ strongly from one another in the extent to which funding for AIDS is understood as separate from broader development assistance in areas such as, for example, health, education, agriculture, and governance. In other words, AIDS funding can be understood as located along a continuum from support for AIDS-specific programmes and issues through to a mainstreamed approach where AIDS concerns are woven throughout a range of other thematic programmes.

Some donors, such as GTZ, lean heavily towards a mainstreamed approach, integrating AIDS into their technical assistance that is focused on governance reform, decentralisation, and support for local government. Sida also places a heavy emphasis on mainstreaming AIDS throughout its assistance portfolio. At the other end of the spectrum, major funding flows such as Global Fund, MAP and PEPFAR were created as AIDS-specific funding initiatives.

In between these extremes, many donors have a diversified portfolio of support at country level that mixes AIDS-specific funding with other elements that indirectly contribute to AIDS responses. Sometimes the AIDS-specific portfolio is relatively small in value compared with the other components. An example of this configuration is the Royal Netherlands Embassy in Zambia, where the AIDS budget in 2006 was approximately €1.2 million, but contributions to the health SWAp amounted to €15 million. As general support for the health sector flows into the development of systems, facilities and human resource capacity that contribute to responses to AIDS, as well as other health issues, this can also be understood as AIDS-related funding even though it is not earmarked as such.

This research focused exclusively on donors' AIDS-specific funding portfolios¹⁸² and found that donors rely upon a range of modalities for channelling their AIDS-specific support. Notably, many, but not all, donors retain a mix of funding strategies despite the overall push towards harmonisation of funding. Portfolios are often diversified to include a range of components including direct technical assistance to build the institutional capacity of the NACA, a small number of direct funding arrangements for civil society organisations or networks, joint-funding arrangements (JFAs) with other donors in support of sub-granting programmes, contributions to UN-led programmes (e.g. a national UNICEF programme in Namibia on adolescent life skills), and commitments to national basket funding arrangements.

A major distinguishing factor between donor institutions is the extent to which they pool their assistance with others. PEPFAR is particularly notable as an example of a self-administered vertical funding stream. On the other hand, many of the European bilateral agencies are more inclined to enter into pooled funding arrangements, either with one another or through nationally led processes. Smaller funders, including foundations, generally administer their own funding streams through direct project support.

How CSOs are funded

Funding for civil society organisations is reflected in donor AIDS portfolios both directly and indirectly. As noted above, many donors continue to provide direct funding despite moves towards budget support. Most bilateral agencies continue to fund a limited number of

¹⁸² Recognising that this, by definition, excludes large amounts of support that are being directed through health, education and other types of SWAps, as well as general budget support.

NGOs directly, although almost all of them noted that they are gradually reducing the number of direct projects in favor of funding through umbrella structures. This appears to be as much related to the need to curtail their own administrative and overhead costs as it is a reflection of other expressed motivations, such as promoting greater local ownership of funding decisions by channelling support through local sub-granting agencies.

Direct funding of NGOs is clearly used by some donors to support work on issues of particular concern. Irish Aid is a notable example in this respect. In Zambia, it has re-oriented its CSO support on OVCs in the Copperbelt region. In Lesotho, it has identified a small number of issues and populations it wishes to focus on – including, for example, female garment industry workers and migrant workers – and awards funding to NGOs accordingly.

On the whole direct funding relationships with individual organisations appear to be giving way to pooled funding arrangements that serve a greater number of beneficiaries. Examples of Joint Funding Agreements include the Small Grants Fund in Namibia, established by the Netherlands, Sweden and Finland and administered by UNAIDS, and agreements between the Netherlands and Norway in Zambia to jointly fund ZNAN, with the agencies alternating the ‘lead role’ between them. Such arrangements are seen as a way to reduce the administrative burden on the recipient organisation, as well as the donors, and appear to occur most frequently among the so-called ‘like-minded donors’ that comprise the Netherlands, Sweden, Ireland, Norway, Canada and sometimes the UK.

The exception to this trend is US government funding, which is channelled through direct project support. Large proportions of this are committed to non-state entities, including NGOs, universities and research centres, laboratories, government ministries, and private contractors.

A second variation on direct funding for civil society can be seen in a number of the World Bank grants for AIDS (both MAP and non-MAP) which designate that a specific proportion of the award be channelled to CSOs and/or support for community responses. The MAP programmes in both Zambia and Mozambique contain significant community components, and the Health Sector Reform Programme in Lesotho earmarked specific funds for sub-granting to NGOs. World Bank funding is channelled through government structures, but with clear earmarks around its use. A similar model prevails with many of the Global Fund awards, where funding is channelled through a government Principal Recipient, with the understanding that portions of the support will be distributed to sub-recipients, among whom are NGOs and other non-state actors.

CSOs also benefit indirectly from donor funding commitments in instances, such as in Malawi and Mozambique, where donors fund basket or ‘common’ funds that are drawn upon in support of multisectoral responses in the country. In these cases, the donor allocates its support not for civil society directly, but for the idea of a decentralised national response that will, by definition, include but not be limited to civil society organisations.

Finally, CSOs may also be benefiting indirectly from donor support that is being channelled through SWAs and general budget support, although

Apart from US government funding, direct funding relationships between donor institutions and individual organisations appear to be giving way to pooled funding arrangements that serve a greater number of beneficiaries.

there was little evidence from this research – either from the CSO survey or donor interviews – that this is happening at any scale. From those donor institutions that have shifted much of their assistance to sector and budget support, there was a clear view that decisions about the use and allocation of funding are in the hands of the government. While the donor may express a preference to see government and civil society work together more closely, it is ultimately up to the government to determine whether or not to engage civil society. This is an emerging channel of support for CSOs which needs to be monitored.

3.3 Country analysis of funding for civil society

3.3.1 Lesotho

Overview of AIDS funding environment in Lesotho

Although there has been an overall decline in development assistance to Lesotho over the past decade, external funding for AIDS response has increased strongly since 2003, coinciding with the adoption of *Turning a Crisis into an Opportunity* and the reorganisation of the Lesotho AIDS Programme Coordinating Authority (LAPCA) into the National AIDS Commission, both of which signalled to international partners that the Government of Lesotho had made a strong commitment to AIDS response.

The Government of Lesotho (GOL) designates that 2% of line ministries' recurrent budgets be allocated to AIDS expenditure. This amounted to 15.0 million Maluti (M) in 2003/2004 and 20.7 million in 2004/2005. Of these allocations, 58% (M8.7 million or US\$1.3 million) was spent in 2003/2004 and 43% (M8.8 million or US\$1.4 million) was spent in 2004/2005.¹⁸³ By contrast, more than US\$24 million in ODA for AIDS was committed to Lesotho by bilateral and multilateral donors over the period 2000-2004; 71% of this through multilateral channels.¹⁸⁴ Compared with earlier years when mobilisation of funding was the main challenge, an urgent priority is now seen to be the appropriate use and absorption of available resources. The large commitment made by the Global Fund (see below) has not been matched by a rapid absorption of funds, and a number of development partners in the AIDS field have since targeted their assistance at strengthening the institutional capacity of government, private sector and civil society groups within Lesotho to receive, manage and expend Global Fund resources.¹⁸⁵

At present there is not a basket funding mechanism in place in Lesotho that pools the contributions of external donors to AIDS response, although the newly established National AIDS Commission intends to promote basket funding among donors and is positioned to take on a larger financial management role in the future as its capacity and systems are developed. A ten-year Health Sector Reform Programme has been underway within the Ministry of Health and Social Welfare (MOHSW) since 2002, with significant support from the World Bank, Irish Aid, the European Union, the World Health Organisation, and the African Development Bank; complete pooling of these funds has not yet been attained, but is seen as a 'milestone' for the future. A Project Accounting Unit was set up within the MOHSW as part of the Health Sector Reform Programme and oversees the management of all external health related-financing. Funding is disbursed to recipient departments, programmes and institutions in accordance with an annual sector expenditure program that is approved by contributing partners.

¹⁸³ Government of Lesotho (2006). Based on reports from 17 of 19 line ministries; to date, Lesotho has not undertaken a National AIDS Spending Assessment.

¹⁸⁴ OECD Database.

¹⁸⁵ See, for example, the World Bank's US\$5 million HIV capacity-building grant; support from Irish Aid and DFID for the institutional strengthening of the NAC; and GTZ work on local government strengthening.

In the absence of a centralised basket funding mechanism, external funding for AIDS response in Lesotho is channelled in a variety of ways, including to the Government of Lesotho through the Ministry of Finance and Development Planning, to the National AIDS Commission, and directly to recipient institutions. The United Nations Expanded Theme Group was established in 2002 to act as the interface between external donor institutions and the Government of Lesotho in relation to the scaling up of AIDS response in the country. Coordination and tracking of resource flows has been cited as a challenge.¹⁸⁶

Main sources of funding for AIDS response in Lesotho, 2001-2005

This section overviews some of the major external funders of AIDS response in Lesotho and summarises how, if at all, they have supported civil society organisations in their funding portfolios. Where possible, this includes data about the amount or proportion of funding allocated to CSOs.

The Global Fund has approved a total of US\$69.7 million for HIV/AIDS in Lesotho (US\$29.3 million in Round 2 and US\$40.3 million in Round 5) to expand activities aimed at prevention of HIV transmission, ARV provision, and national management of AIDS service delivery. Of this total award, US\$39.3 million has been approved for disbursement, including US\$29.3 million through the end of 2005. The principal recipient of GFATM funding is the Ministry of Finance and Development Planning, which manages the funds. Funds are disbursed by the Project Accounting Unit of the Ministry of Health and Social Welfare under the guidance of the National AIDS Commission, GFATM Coordinating Office and the CCM.¹⁸⁷ Global Fund support began to flow to Lesotho in late 2003.

By the end of 2005, US\$8 million had been disbursed by the GFATM to Lesotho¹⁸⁸ and of this, approximately 25% had been sub-granted on to civil society organisations. The majority of recipient organisations were local NGOs, although by value of awards more than half of the funding went to INGOs. The single largest sub-grant to CSOs went to World Vision, which was tasked with re-granting funds in smaller amounts to other CSOs around the country.¹⁸⁹

The World Bank had two separate AIDS-related programmes underway in Lesotho over the period 2001-2005.¹⁹⁰ US\$2 million was earmarked for AIDS within a US\$6.5 million Health Sector Reform Programme that was implemented between 2001 and 2005. These funds were disbursed through sub-grants to eight organisations, including four local NGO and three international NGOs¹⁹¹ for prevention, impact mitigation, and treatment, care and support programmes. A US\$5 million HIV/AIDS Capacity Building and Technical Assistance grant to the GOL was approved in 2004, aimed at accelerating the absorption of GFATM funding, but only a small amount had been disbursed by the end of 2005. Close to a quarter of the overall grant is earmarked for capacity-building among civil society and private sector institutions to improve the quality of proposals, programme implementation and fulfilment of reporting requirements related to GFATM funding for Lesotho.¹⁹²

Irish Aid, previously Development Cooperation Ireland (DCI), is the largest single country donor to Lesotho.¹⁹³ Its major areas of support have been education, health, human rights, water and rural development, business development and public sector performance. Irish Aid has mainstreamed support for AIDS throughout its funding portfolio,

¹⁸⁶ Interviews with NAC CEO and UNAIDS Country Coordinator. Interview with Director of Health Planning and Statistics, MOHSW.

¹⁸⁷ Interview with Director of Health Planning and Statistics, MOHSW.

¹⁸⁸ Global Fund (2006).

¹⁸⁹ Calculated on the basis of information provided by MOHSW and NAC/GFATM unit about sub-grants made during 2004 and 2005.

¹⁹⁰ Committed funds. The World Bank (2000 & 2004).

¹⁹¹ Calculated on the basis of data provided by PAU of MOHSW and final report by Crown Agents on administration of HIV funding.

¹⁹² The World Bank (2004, p. 30).

¹⁹³ Development Cooperation Ireland (2004, p. 1).

particularly in health and education, but it has also funded AIDS directly since 1999.¹⁹⁴ Just over US\$4 million was committed to AIDS-specific programmes over the period 2001-2005,¹⁹⁵ including multi-year support to NGOs such as Lesotho Planned Parenthood Association, Positive Action, Lesotho Save the Children, and Women and Law in Southern Africa. CSO partners are identified on the basis of the work they undertake in relation to issues or population groups of interest, such as migrant workers, garment factory workers, gender issues, and cross-border activity. In 2005, close to half of Irish Aid's AIDS-specific funding (€900,000) went directly to civil society organisations, while the other half went to support of the National AIDS Commission. Irish Aid's new civil society policy may result in increased allocations to CSOs in 2006-2007, and Irish Aid is considering contracting an external funds manager that would administer the funding arrangements on its behalf.¹⁹⁶

Lesotho is not a focus country under the US Government's PEPFAR initiative, and USG funding for AIDS in Lesotho is more modest in scale than in other southern African countries. USG funding for AIDS in Lesotho is part of the Southern Africa Regional budget and is administered through USAID's Regional HIV/AIDS Program, the Centers for Disease Control, the Peace Corps and other agencies. US\$12 million was committed to Lesotho for AIDS during fiscal years 2003-2005.¹⁹⁷ In fiscal years 2004 and 2005, at least 60% of allocated funding was designated for civil society organisations, predominantly international NGOs such as Population Services International, Academy for Educational Development, Family Health International, and Pact.¹⁹⁸ USG funding in Lesotho has strongly emphasised prevention activities (VCT, PMTCT, condoms, partner reduction, abstinence, behaviour change communication, education), with 68% of funding in fiscal year 2004 and 54% in fiscal year 2005 being allocated to programmes in these areas.¹⁹⁹

From 1999/2000 to 2003/2004, DFID provided £11.2 million in bilateral assistance to Lesotho. HIV/AIDS was one of seven 'intermediate development outcomes' of the funding partnership; however only 2% of DFID's total bilateral expenditure in Lesotho went to AIDS during this period.²⁰⁰ Lesotho has also been involved in a number of regional activities led by DFID Southern Africa in Pretoria and implemented in countries across the region by SADC, Soul City and others. DFID continues to provide bilateral support to Lesotho from its Pretoria office and has committed US\$3.1 million (£1.7 million) to AIDS over the period 2005-2006. Priority areas include support for institutional development of the National AIDS Commission, AIDS mainstreaming in government ministries, responses to AIDS in the private sector, and general technical assistance funds.²⁰¹ DFID's AIDS funding portfolio in Lesotho has not featured significant support for civil society, although certain programmes, such as the Private Sector Coalition Against AIDS in Lesotho, have been implemented through non-governmental partners (in this case, CARE Lesotho).

The German agency GTZ (Gesellschaft für Technische Zusammenarbeit) has adopted a mainstreaming approach to AIDS in its decentralised rural development programme in Lesotho – the 'Gateway Programme' – which is worth approximately US\$7.2 million during its first phase, 2004 to 2007. The programme seeks to mainstream AIDS response throughout the public and local government services in four southern districts, as well as to scale up local government responses to AIDS.²⁰² No support is channelled to civil society organisations, although GTZ has contracted an NGO to conduct trainings as part of the Gateway Programme.

¹⁹⁴ Government of Ireland (n.d., p. 10). See also Development Cooperation Ireland (2004).

¹⁹⁵ Data provided by Irish Aid Maseru. Converted to US\$ at 1 Euro=1.24 US\$.

¹⁹⁶ Interview with Irish Aid, Maseru.

¹⁹⁷ Committed funds. OGAC (2005a, p. 132).

¹⁹⁸ US Government (n.d.).

¹⁹⁹ CADRE calculations based on allocations indicated in US Government (n.d.).

²⁰⁰ Gayfer, J., Flint, M. & Fourie, A. (2005, p. 65). Focus was on scaling up private sector responses to HIV/AIDS and on assisting GOL with its institutional review of LAPCA.

²⁰¹ Interview with DFID, Pretoria.

²⁰² GTZ (n.d.)

Since 2000, the Secure the Future initiative of the Bristol-Myers Squibb Foundation has made grants of close to US\$1.5 million to civil society organisations in Lesotho as part of its Community Outreach and Education programme. Approximately half of the funding has gone to local NGOs, with the other half channelled through international NGOs working in Lesotho.²⁰³ Secure the Future has also invested several million dollars in the establishment of an ART clinic and community-based treatment programme in the country.²⁰⁴

Many of the main UN agencies are represented in Lesotho and are involved with AIDS response:

- UNICEF addresses AIDS primarily through the health and nutrition division of its Child Survival Programme. The agency's budget for AIDS-related activities was US\$1.9 million over the period 2001-2005.²⁰⁵ It has supported the Churches Health Association of Lesotho (CHAL) and a number of other CSOs, although the total value of this support amounts to approximately 10% of overall spending over the period in question.²⁰⁶
- The World Food Programme provides food supplements to food insecure households in Lesotho, including those with chronically ill individuals. It also supports a school feeding programme. In 2005 the agency shifted from a focus on food insecurity linked to drought conditions and began to target AIDS-affected individuals more specifically. Direct operational expenditures in Lesotho totalled US\$81.7 million over the period 2001-2005, with 86% of this expenditure occurring from 2003 to 2005. Approximately 19% of expenditure in 2005 was targeted for AIDS.²⁰⁷ The WFP contracts five large INGOs and NGOs to distribute food at district level, comprising approximately 30% of its total spending.²⁰⁸
- The World Health Organisation plays a critical role in shaping policy in conjunction with Government of Lesotho and acting as a catalyst to action for other development partners. Its role as a funder is minimal; its support is provided primarily in the form of technical assistance, facilitating training and developing materials. As such, it does not fund CSOs directly.

Support for CSO responses to AIDS in Lesotho

Civil society organisations involved with AIDS response in Lesotho include INGOs, which tend to have their central offices in Maseru and district-level operations in some or all parts of the country; national NGOs that work in more than one district or community; and small CBOs whose activities are limited to one particular location.

While international and national NGOs, such as World Vision, CARE, Lesotho Red Cross, the Lesotho Planned Parenthood Association, and the Lesotho Association for Non-Formal Education are the most prominent CSOs in terms of the scale and visibility of their operations, the predominant form of civil society response to AIDS in Lesotho is the community-level 'support group.' A mapping and capacity assessment of CSOs working on AIDS in Lesotho in 2004 found that 74% of the CSOs identified in the selected districts (194 out of 263) were CBO support groups.²⁰⁹ In the context of this research, more than 450 support groups were reported by the country's 10 District AIDS Coordinators to be active in mid-2006 (from among a much larger number of groups that have formed across the country over the past years), compared to fewer than 100 INGOs and NGOs.²¹⁰

²⁰³ Bristol-Myers Squibb Company and Bristol-Myers Squibb Foundation (2004); Secure the Future website (<http://www.securethefuture.com>)

²⁰⁴ The exact value of this commitment is not known. US\$30 million has been committed to this programme across five countries, but it was not possible to confirm the exact value of the commitment in Lesotho. See Bristol-Myers Squibb Company and Bristol-Myers Squibb Foundation (2004).

²⁰⁵ According to a UNICEF official in Maseru, the agency began mobilising funding specifically for AIDS in 2005; however activities related to child protection and care, pediatric AIDS, PMTCT and HIV prevention have long been core to the agency's work.

²⁰⁶ Data provided by UNICEF representative, Maseru.

²⁰⁷ World Food Program, Annual Reports 2004 and 2005. Interview with WFP in Maseru.

²⁰⁸ Data provided by WFP representative, Maseru.

²⁰⁹ Support to International Partnership against AIDS in Africa, (2004, p.17).

²¹⁰ As part of the CSO survey research, DACs were contacted in each of the 10 districts and asked to provide a list of the support groups known to them in their districts.

Support groups in Lesotho are associations of 10-30 volunteers who have come together around a particular community need – often to care for the sick and vulnerable, but increasingly also to support one another.

Support groups are associations of 10-30 volunteers who have come together around a particular community need – often to care for the sick and vulnerable, but increasingly also to support one another (support groups for people with HIV) – sometimes of their own volition and sometimes in response to an external call for action. In some places support groups are drawn upon by INGOs and national NGOs as ‘implementing partners,’ although often they work autonomously on the basis of whatever materials and resources they can mobilise. These groups are rarely registered formally as organisations, but are recognised by their local chiefs (‘traditional registration’) and may be known to the District AIDS Coordinators. Support groups are often affiliated to one or more pillars: a church or religious institution, political parties (particularly the local MP’s wife, linked to the Office of the First Lady), the District AIDS Task Force, and/or the local clinic/MOHSW.

The sources of funding available to CSOs working on AIDS in Lesotho vary significantly depending on the type of CSO. As the previous section has suggested, the majority of donor funding flowing to civil society in Lesotho is channelled to INGOs and large national NGOs in the first instance. Support groups, by contrast, are often unaware of funding opportunities or are ineligible to receive funding because they are unregistered. A mapping exercise conducted by SIPAA in 2004 found that CBOs tend to be self funded through member contributions or funds raised through income generation activities. This finding was corroborated in the current research, which found that support groups – when they receive anything – tend to receive in-kind support of goods and supplies (HBC kits, food, paraffin, seedlings, and donations of blankets and clothing), but rarely funding per se.²¹¹ Only two cases of funding for support groups was encountered in the course of the research – the first through a small-scale CBO support project administered by CARE (involving six partnerships), and the second linked to a small grant provided by a Peace Corps volunteer to a local CBO. All were valued at US\$10,000 or less.

The main sources of support for support groups in Lesotho include:

- The Office of the First Lady – donations of food and clothing for orphans; access to training;
- World Food Program – food supplies for distribution to needy families and children;
- Other NGOs and INGOs (e.g. World Vision) – donations of food and clothing; office supplies; seedlings and income-generation supplies; access to training;
- Red Cross and local clinics – home-based care kits, training in home-based care; and
- District AIDS Task Forces (DATFs) – income-generation supplies via Global Fund funding.

Key issues in supporting CSO responses to AIDS in Lesotho

The research revealed a relatively consistent view from multiple vantage points that civil society in Lesotho is ‘weak’, has ‘limited capacity,’ does not have strong internal governance structures and practices, and does not play a strong advocacy role in relation to government institutions. This includes, but is not limited to, CSOs that work on AIDS.

The responsibility for this state of affairs was apportioned quite equally. On the one hand, the government is seen as uninterested in enabling

²¹¹ See Lesotho case study for a detailed discussion of the resourcing of support groups.

civil society in any meaningful way. There is not a clear framework for supporting CSOs (financially or otherwise) and one respondent expressed the view that government is 'avoiding this' altogether. The support that does exist is ad hoc.

On the other hand, the very structures of civil society that should support and propel its interests forward in relation to AIDS have not succeeded in filling the void thus far. The AIDS service organisation network, LENASO, exists primarily on paper and does not have a solid membership base invested in building a strong institution, and the Lesotho Council of NGOs (LCN), which is structured around thematic commissions, has not designated an AIDS commission, leading some observers to feel that it does not give AIDS the seriousness it deserves. The launch of a national umbrella network for people with HIV (LENEPHWA) in 2005, following years of competition and conflict between other associations for people living with HIV, was a major victory, but one that was made possible through the strong guidance of an outside institution.²¹² One respondent noted that CSOs in Lesotho do not develop around a specific agenda and structure themselves to drive forward that agenda; rather, they tend to respond to opportunities as they present themselves.

There are at least two major implications of this situation, as far as civil society access to funding is concerned. First, the relative weakness of civil society institutions themselves, in terms of internal capacity, systems and governance, means that donor institutions may be hesitant to fund them directly due to fears about unaccountability and failure to comply with requirements. Second, the absence of strong umbrella bodies representing the interests of AIDS service organisations means that there is limited or no advocacy on behalf of the sector, and limited CSO voice in discussions about policies, programmes and implementation strategies.

These issues must be considered against the broader context of increasing interest on the part of donors in budget support and other ways of channelling development assistance through the government.²¹³ The trend towards increased funding via government is occurring against a backdrop of political decentralisation in Lesotho, which has seen local government elections for the first time in the country's history. Although the governance arena is changing, local institutions remain relatively weak and there has not yet been devolution of resources to local level. District AIDS Task Forces established under LAPCA play a local coordination role, but were not intended to act as funding agents. Resources for AIDS response in Lesotho remain highly centralised, which is a factor hindering the financing of decentralised activities, including greater support for local level activities.

3.3.2 Malawi

Overview of AIDS funding environment in Malawi

Unless otherwise specified, information for this section derives from NAC Financial Management Agency (FMA) reports, Malawi UNGASS reports²¹⁴ and from information and documents supplied by donors.

Since 2000, the Government and major development partners have been committed to developing SWAps as a primary approach to development support. Appropriate procurement, disbursement, management and monitoring systems have had to be set in place and this has been slowed

²¹² LENEPHWA was strongly supported by ActionAid's SIPAA initiative in Lesotho.

²¹³ The US Government remains an important exception to this trend.

²¹⁴ Bowie, C. et al. (2005); Office of the President and Cabinet (2005); Panos (2006).

by the SWAp's strong reliance on relatively weak national administrative systems as well as the centralising effects of a single national funding system.

While there has generally been slow progress in developing SWAps run by government ministries (principally health and education), there has been notable success in pursuing SWAp-type thinking through the National AIDS Commission (formed in 2001). In keeping with the 'Three Ones' direction and the Paris Declaration, funders have increasingly aligned with government programmes under the banner of the NAC. The most significant development for civil society has been the development of the 'Pool Fund,' which many bilateral donors have agreed to support rather than directly supporting projects or specialised programmes.

The NAC has established a national grants facility, operated by an external, contracted Financial Management Agency, through which it supports multisectoral AIDS responses.

During the 2004-05 financial year there was considerable effort on the part of agencies and ministries funded by NAC to establish systems to effectively manage financial resources. This investment initially resulted in poor absorption of financial resources and programme slow-down in various agencies, because there were insufficient human resources in the major public sectors (principally health and education) to deal with these changes. However, corrective action was taken and by most accounts good progress and success have subsequently been achieved.

There is not only evidence of more organisations being engaged in AIDS response, but also better quality in implementation of planned action. The average time taken for processing funding applications decreased from April to November 2005. This reflects increased efforts on the part of the NAC and its partners to increase funding efficiency through improving systems for disbursement. By the end of 2005²¹⁵ it took on average not more than six months for a project to be funded from the time the proposal was received.

At this point, through the NAC, Malawi has developed the capacity to mobilise and effectively manage funds from a wide range of bilateral and multilateral donors, and to disburse these funds to a wide range of institutions and organisations, including government departments, parastatal organisations, the business sector and CSOs. Using available financial resources from NAC and other (non-NAC) funding agencies, numerous organisations, including government departments, non-governmental organisations, faith-based organisations, and the private sector, have been able to build and strengthen their capacity to implement AIDS-response activities. Ministries, government departments, and all other agencies have access to guidelines and policies to guide the implementation of sector-specific AIDS interventions.

Funders that have chosen not to fund through the NAC – particularly USAID – and the recipients they support, whilst not within the fold of NAC or other country-level management systems, are nonetheless increasingly complying with the requirements of funding and coordination being advanced by the national coordinating authority. Evidence is that they are increasingly yielding to the expectation of reporting into the national output reporting system for AIDS response programmes.

²¹⁵ The FMA Monthly Report, November 2005.

Funding of the national AIDS response comes from a large range of different sources, including the Government of Malawi, the Global Fund, the Pool Fund (comprising DFID, the World Bank, NORAD and CIDA), the United States Government, and a number of smaller donors.

There are two main parallel planning and implementing frameworks for AIDS response. One is the National AIDS Commission's Integrated Annual Work Plan and the other is the Sector-wide Approach Programme of Work within the health sector (see below). There is a lack of coordination and harmonisation between the two programmes of work and a recent evaluation²¹⁶ found that the inflow of funds from the GFATM exacerbated the lack of coordination as the NAC programme surged ahead of the SWAp programme. There are reportedly considerable pressures placed on human resources on the back of the injection of GFATM funds into the NAC pooled fund, with the increase in uptake of programmes not having been planned for. In accommodation of this, in the first year of the grant, emphasis was placed on systems strengthening. About 35% of NAC funding passed on to CSOs in 2004 and 2005.

The Global Fund grant (2003-2005) was for the amount of US\$41.4 million and contributed 69% of the total financing of the 2004/05 NAC Annual Programme of Work. NAC funds for 2005/06 were estimated at US\$100.4 million and more than 50% was to come from the GFATM,²¹⁷ with 30% from the Pool Fund major contributors to the pooled NAC fund in 2005/2006 included DFID, the World Bank, NORAD and CIDA. The Government of Malawi was set to contribute only 4% of the funds.²¹⁸ The total GFATM commitments to 2009 are US\$262 million. The Government and development partners have committed close to US\$600 million to AIDS through 2009.

Malawi has recently adopted a SWAp within its health sector which runs from 2004-2010. The estimated health sector expenditure on AIDS for 2005 is US\$26.4 million. Out of this, US\$1 million was allocated as 2% AIDS budget for each line ministry in the 2005 central government budget. The total Malawi government expenditure on AIDS in 2005 is estimated at US\$28.8 million.²¹⁹ This is made possible at least in part by the Highly Indebted Poor Country (HIPC) initiative. In 2004 the total external debt service to multilateral creditors (International Development Association, African Development Fund, and International Monetary Fund) for Malawi was US\$112.9 million. Since the year 2001, the multilateral donors have permitted the Malawi government to utilise 34-42% of its debt service funds towards social service sectors such as health and education. It is not clear what proportion has translated into budget support for AIDS activity, but certainly this is a sizeable support to the national budget which must at least indirectly underpin the government's AIDS expenditure.

A number of other bilateral donors - including Norway, Canada, Japan, and Germany - provide assistance in selected sectors. Multilateral donors include the various United Nations agencies, the European Union, the World Bank,²²⁰ the International Monetary Fund, and the African Development Bank, many of which work mainly in capacity-building and systems development. Donor coordination is widely proclaimed to be good in Malawi and helps to strengthen government capacity in many areas.

The United States Government has provided grants to a number of international non-governmental organisations (notably Family Health

²¹⁶ Mtonya, B. et al. (2005).

²¹⁷ The NAC is the principal recipient of the Global Fund grant.

²¹⁸ Panos (2006).

²¹⁹ 2003/04 - US\$ 0.1 million; 2004/05 - US\$1 million; 2005/06 and beyond - Committed to contributing annually approximately US\$2 million to NAC and 4% of the national AIDS funding.

²²⁰ The World Bank Multi-Country AIDS Programme contributed a total of US\$14.5 million between 2003 and 2005, out of a total of funds committed to date of US\$35 million.

The broad strategy of creating umbrella organisations and providing support for the funding process has worked well in Malawi, but there is little indication that district assemblies are ready to take over this role as intended.

International and Population Services International) that in turn give assistance to local NGOs and CBOs. USAID also provides technical assistance to the Ministry of Health as well as capacity-building to local NGOs. Some NGOs supported by USAID also provide technical assistance support on policy and design of programmes to key ministries. USAID does not channel its funds through government departments or ministries, but gives assistance directly to its implementing partners. Areas of intervention include impact mitigation, behavioural change interventions and support for services such as antiretroviral therapy, prevention of mother to child transmission and HIV testing and counselling. USAID favours competitive proposals and grants typically run from 3 to 5 years. Total commitments from 2001 to 2005 were approximately US\$66 million.²²¹

Support for CSO responses to AIDS in Malawi

It has been a concern of the NAC and its partners to simplify the process of accessing funding from the NAC to enable civil society organisations to successfully apply for and access the funds available. The interim mechanism for this was the creation of five umbrella facilities at district level, each run by a different international NGO (Save the Children USA, Canadian Physicians for Aid and Relief, Plan International, ActionAid Malawi and World Vision). Whilst it is clear that the broad strategy of creating umbrella organisations and providing support for the funding process has worked well, there is little indication that the district assemblies are ready to take over from the five INGOs, as intended. Although there have been improvements as indicated above, there remain some notable problems including protracted approval and delays in disbursement of grants, weak organisational capacities of CBOs as well as umbrella organisations, and the limited scale and scope of projects being funded. Many organisations are being funded for short-term, small-scale projects - a practice which raises questions about the future scale that might be achieved given current mechanisms.²²²

Some CSOs are supported directly through the NAC. The total amounts disbursed to them are reflected in data on proportions of funding to CSOs reported below. This data does not, however, distinguish between different ways in which the NAC directly and indirectly funds CSOs. The most important types are NGOs that receive grants directly from the NAC and the system for disbursing funds through umbrella organisations.

Twenty-four NGOs (umbrella organisations like the National Youth Commission and Malawi Network of AIDS Service Organisations) received grants directly from NAC to the total of US\$5.7 million in the year to March 2005, some of which would have subsequently on-granted funds to member or cognate implementing organisations. Some of these NGOs are themselves on-granting amounts received and it has not been possible in the scope of this research project to determine the proportions of money provided by NAC which is being spent by these organisations and what is being on-granted.

There are also umbrella organisations in the form of the five international NGOs mentioned above that are responsible for acting as funding conduits to CSOs in designated catchment areas. Their role is to manage the grants facility of the National AIDS Commission at district level. This is intended as an interim measure prior to District Assemblies assuming this function, which at this point has fallen behind target. There have been significant difficulties experienced in staffing these umbrella

²²¹ Figures for 2001-2002 taken from OECD DAC Database. For 2003-05, figures have been annualised from data provided in OGAC (2005a).

²²² Carlson, C. et al. (2006).

organisations appropriately and the lack of systems and processes or preparedness of local structures has been a major hindrance and source of dissatisfaction for the umbrella organisations. They have had to do considerably more systems building than anticipated. There is no strongly developed approach to capacity-building, and this must be seen as a considerable risk to the long-term growth of the programme. There has been some tension between the pressure to create grants and the need to build systems and structures at local level, including District AIDS Coordinating Committees. It is important to note that all of the NAC umbrella organisations used by NAC in Malawi are international NGOs, and two of the five are withdrawing from future commitments, whereas another two are not having their contracts renewed.²²³ Unanswered questions remain about how the capacity gap will be filled and whether and when it will be possible to phase out the umbrella NGOs and replace them with district-level government agencies.

Table 13 reflects the amount of funding received by NAC and disbursed to CSOs in 2004 and 2005 as proportion of all funds disbursed by NAC in 2004 and 2005.

Table 13

NAC disbursements to CSOs

Funding received by the NAC that was granted to CSO implementers in 2004 and 2005 ²²⁴				
	NGO US\$	CBO US\$	FBO US\$	All CSOs US\$
2004	13.8 million	4.4 million	0.5 million	18.7 million
2005	0.6 million	1.1 million	0.01million	1.7 million
2004-05	14.4 million	5.5 million	0.5 million	20.4 million
% of total funds NAC received 2004-2005 (US\$57,880,000)	25%	10%	1%	35%

The following are some key points relating to the above table:

- NGOs, CBOs and FBOs received a total of US\$20.4 million through NAC in 2004 and 2005;
- 35% of all funds received by NAC in 2004 and 2005 were disbursed to NGOs, CBOs and FBOs; and
- The bulk of the disbursed to money to NGOs, CBOs and FBOs went to NGOs.

The distribution of disbursed funds, by programme area, from June 2004 to October 2005 was as follows:

- Treatment, care and support – 40%
- Advocacy and prevention – 24%
- Capacity-building, partnerships and sectoral AIDS-response mainstreaming – 16%
- Leadership, coordination and programme management – 11%
- Impact mitigation – 6%
- Monitoring, evaluation and research – 3%.

It is not clear how these proportions may differ for CSOs, but it appears that CSOs assume a relatively high proportion of the burden for impact mitigation and care and support. Over 600 community organisations have been funded through the NAC Grants Facility and a high proportion of these reportedly target the needs of orphans.

²²³ Information supplied by interviewed INGO.

²²⁴ Bowie, C. et al (2005); NAC Financial Management Agency Report.

Questions must be raised about the sustainability of decentralised funding in Malawi given the sheer numbers of organisations involved.

There is strong evidence from the CSO survey that there are numerous other smaller funders that are directly supporting AIDS activities carried out by CSOs. These are often donors who do not have focused and large-scale AIDS portfolios. However, this phenomenon is much less pronounced in Malawi than in the other countries and there is a relatively low penetration of direct bilateral funding, as a result of the strongly centralised funding pools. There is evidence, however, of various international NGOs funded by foreign governments, but which operate independently of in-country bilateral government agencies. In other words, they are bilaterally funded but not through country offices. In some cases there are complex streams²²⁵ of funding to bypass rules and expectations regarding country support for pooled funding. It appears that these do not constitute large amounts and in some cases, at least, they are interim measures to sustain funding for existing projects.

The Malawi Social Action Fund (MASAF) funds impact mitigation activities which also cover AIDS impacts, but there is little information available to assist in understanding the extent to which MASAF funding is AIDS-specific. MASAF has a Community Development Programme which finances demand-driven community-based socio-economic projects managed directly by communities through the Community Managed Projects and safety net operations managed by Local Assemblies through the Local Authority Managed Projects. In order for a project to be eligible for funding from MASAF, it must have been identified through a Participatory Rural Appraisal process.

Malawi has developed a monitoring and evaluation system which promises, when it becomes fully operational, to capture the outputs of AIDS programmes throughout the country. This is much easier to achieve through funded programmes where conditions of funding include regular output reporting, but it is more difficult to capture where activities are undertaken without external support.

Key issues in supporting CSO responses to AIDS in Malawi

Malawi stands out amongst countries studied for the degree to which it has attempted to harmonise funding. An environment has been created which provides greater opportunity for planning national programmes aligned to national strategic frameworks. This has importantly led to a major initiative launched by the NAC to engage civil society which has been accompanied by significant institutional investment in funding architecture. However, there are significant problems associated with decentralising funding and Malawi illustrates this well.

Key questions must be raised about sustainability given the sheer numbers of organisations involved and also about the capacity to manage sub-granting at decentralised levels. It is conceivable that over time this capacity will be attained, and then the focus will need to move to improvement about decision making and coordination at local level, in terms of knowing who to fund and at what level. It is quite clear from case studies that there are a great many community organisations in Malawi that feel they are eligible for funding but are not receiving it. At first glance, a motivated group of people trying to assist their own community may seem well worth supporting, especially when it is apparent that their current efforts are hampered by lack of the most basic commodities. It is not a case of having to start community organisations, but rather supporting nascent organisations.

However, it may be the case that an expectation has been created that funding and support is available and since some organisations receive it,

²²⁵ Reported in interviews off the record.

it is unfair that all who need it should not receive it. Some organisations are more worth funding than others, because they will be more efficient and will achieve better results. Some activities may be more effectively funded when conducted by particular types of groups than others. It may be the case, for example, that an activity such as voluntary counselling and testing should be supported through a national NGO, but home-based care is more effectively supported through CBOs, or perhaps specifically women- or church-led CSOs, for argument's sake. The point is that this large scale funding initiative is an experiment and the next stage will require more nuanced understanding than is currently available.

Hopefully the monitoring and evaluation system being set in place will rapidly develop its evaluative capacities, because there is much to be known about effectiveness, sustainability and growth of these entities too easily grouped together under the rubric of 'CSO.' Using this information to good effect will also require improving district level funding architecture and programme support.

3.3.3 Mozambique

Overview of AIDS funding environment in Mozambique

Mozambique has made significant economic progress in the years since the end of its civil war, but it remains one of the poorest countries in the world and one of the 10 lowest in terms of human development. This notwithstanding, it is reported in the 2005 Mozambique UNGASS report that availability of funding is 'no longer the principal priority in Mozambique's fight against HIV/AIDS.'²²⁶

The CNCS (equivalent of a national AIDS council) is the main governmental channel for engaging with and supporting civil society responses to AIDS. Its five main responsibilities are coordination of the national multisectoral response; monitoring and evaluation; mobilisation and management of resources; addressing the epidemic in its public health and development aspects; and responding to the challenges of people with HIV.

Specifically regarding civil society, the CNCS oversees and manages a programme for supporting civil society organisations. The number of projects supported has evolved from 3 in 2003 to 664 in 2004 and 1,285 in 2005. However, there remain major challenges in organising the disbursement of funds and translating them into more and better services. Procedures are considered cumbersome by NGOs and CBOs, suggesting a need for simplification and improved efficiency. Steps taken by CNCS that appear to have improved the number of subprojects and the amount of financing flowing to civil society include: promotion of larger subprojects; removal of subproject ceilings; simplification of procurement; streamlining of the review process; development of a subproject guide; simplification of application forms; increasing the role of provinces in approval and supervision of subprojects; and training of civil society organisations.²²⁷

The CNCS recognised that the funding of subprojects conducted by CSOs was absorbing management time to the detriment of other CNCS functions and with the support of donors it subcontracted a Grant Management Agency (GMA) to manage the contracting of CSOs.

Partners' Forum meetings take place monthly between the CNCS and the bilateral and multilateral organisations that cooperate with it.

²²⁶ Mozambique UNGASS Report 2005

²²⁷ World Bank Aide Memoire, Mozambique. HIV/AIDS Response Project Mid-Term Review Mission. February 6-17, 2006.

Community-based AIDS service organisations in Mozambique have very little access to needed funds, even in contexts where distance is not a problem and where organisations are part of larger networks. A strong sense of discontent prevails.

Nonetheless there is a continuing need to help the CNCS assume its crucial coordinating responsibility for AIDS response in Mozambique and ensure that it becomes as efficient and effective as possible in its operations.

There has been much focus on developing systems for HIV funding, for instance development of the capacity of the CNCS to manage a pooled fund, and to strengthen links between discrete funding programmes like that of the GFATM with national planning processes. It is difficult to track the spending of donors in Mozambique and they appear to follow 'mixed' approaches to a greater extent than is the case in other countries. For instance, in 2004 DFID supported UNICEF to provide services to the CNCS, it supported implementation programmes through UNICEF, it directly supported NGOs to provide services, and it supported provision of technical assistance and financial support to NAC. There are many bilateral agencies which support the CNCS common fund and support CSOs directly, as well as providing funds to UN country programmes such as UNFPA and UNICEF. Examples are Sida, CIDA, Danida, and Irish Aid. This illustrates that the situation in Mozambique is in flux, and funders effectively tend to have comprehensive portfolios incorporating many directions rather than strongly focused programmes.

It is starkly apparent from the case study in Mozambique that community-based AIDS service organisations have very little access to needed funds, even in contexts where distance is not a problem and where organisations are part of larger networks. A strong sense of discontent prevails about what is perceived as the government's inability to devise appropriate mechanisms and processes for disbursing funds. There are high levels of skepticism about the value of participating in local government forums and much evidence of inefficiencies in responding to organisations even when their proposals and approaches have been called for.

Main sources of funding for AIDS response in Mozambique, 2001-2005

There have been significant inflows of funds for AIDS in Mozambique from 2003 to 2005.

There are many separate funders and many different funding mechanisms. Donors may fund both directly and through pools and SWAPs; the situation is in a state of flux. There are three common funds within the Ministry of Health (general, drugs and provincial) and in the interest of supporting a government with little internal revenue, there has been strong bilateral drift towards common funds. There was a 17% growth in 2006 in funds channelled through common funds and a corresponding growth of only 8% through 'vertical funds' channelled through intermediary agencies and NGOs.²²⁸ This has been with some reservations on the part of donors, recognising that the government has not historically supported civil society.

Some bilateral funders remain committed to direct funding, notably the United States, which has designated Mozambique as a PEPFAR focus country. More than US\$190 million has been committed to Mozambique under this initiative over the period FY2004 to FY2006.

The main sources of AIDS funding are the Global Fund, the MAP and TAP initiatives of the World Bank, the Clinton Foundation and PEPFAR. Important steps in coordinating AIDS funding have been made with the creation of the Common Fund of the CNCS, pooling the AIDS funds of a

²²⁸ Barcellos, N. (2005).

number of bilateral donor agencies, and the HIV/AIDS sub-committee of the Sector Wide Approach (SWAp) of the health sector.

The World Bank programme in Mozambique is comprised of two parts. The one is a MAP programme project and the other is part of an accelerated treatment programme. The objective is to improve institutional capacity for planning, delivery and monitoring of AIDS responses to decrease the growth of the infection rate. Actual implementation only started to pick up after the new government was installed and reaffirmed its active stance towards the National Response on HIV/AIDS. By 2006, 843 new civil society subprojects were being implemented in the area of prevention, care and treatment, mitigation, and advocacy.

Support for CSO responses to AIDS in Mozambique

Mozambique has a weak history of civil society organisations and civil society networks are not strong, although they are growing. It also appears that that government is reluctant to let go of its centrist orientation and this certainly is the perception of many of the organisations interviewed in Mozambique. It is apparent that there is much parallel direct and pooled funding by donors and it is difficult to talk in general terms about the ways in which CSOs are funded by their numerous donors.

The main pooled fund for CSOs is managed by the CNCS which transfers funds channelled by partners through the NAC Common Fund to civil society organisations implementing approved projects. Organisations are classified by size and legal status, and projects can be submitted up to certain budget ceilings for each category. The system for CSOs to submit proposals is intended to be decentralised with provincial nuclei performing the functions of the CNCS. The majority of projects request up to US\$1,000 over a period of six months to one year to perform prevention or care activities.

There has been widespread dissatisfaction about the functioning of the CNCS, although there is evidence of growing efficiency. From the civil society perspective, although the key national networks are represented in the CNCS decision-making structures, there is a "lack of recognition of civil society as a real and fundamental partner in all aspects of the national response to the HIV/AIDS epidemic."²³⁰

The Common Fund of the CNCS is supported by bilateral funders Irish Aid, Danida, Sida, DFID, and CIDA and it is also a recipient of a grant through GFATM.²³¹ To the end of June 2005 these sources had contributed US\$13.25 million. Most of this funding is intended to go directly to AIDS response activities, whereas the functioning of the CNCS is supported by the national budget. A total of 1,124 civil society grants were made to the end of June 2005. About 600 of these, totaling US\$10 million, had started implementation by mid-2006.

In this context the substantial increase in funding is a real test for the capacity of public sector management mechanisms in Mozambique, both ministries and the CNCS. Budget execution rates at the Ministry of Health in 2004 were low. Similarly, the CNCS has had difficulties in executing its budget, particularly in the allocation of funds to NGOs and local associations. This is a priority problem area in which the Mozambican government requires strong support from its development partners, and this has been widely recognised. There is currently much

*'Though a relatively large number of civil society actors are involved in the National Response, their capacity is relatively weak, coordination and collaboration are often lacking and interventions tend to be short term and at times ineffective... Grassroots mobilisation and advocacy by civil society actors is also weak as is their engagement in policy processes.'*²²⁹

²²⁹ Barcellos, N. (2005, p. 28).

²³⁰ Barcellos, N. (2005).

²³¹ By the end of 2005 the amount of US\$8.5 million had been disbursed by the Global Fund, making up 70% of the expected US\$12.1 million disbursement. Global Fund (2006).

*'While government might acknowledge the role that civil society could and should play in the fight against HIV/AIDS, and indeed other development-related fields, it can not be expected to champion the voice of civil society. Mozambique's development partners therefore have an opportunity – perhaps even a responsibility – to ensure that civil society organisations are capacitated and encouraged to become more active.'*²³²

activity in support of developing the CNCS's capacities and relationships with civil society and also in developing understanding of the expectations of funders providing money to a pooled fund. It is crucial that this challenge be met to ensure that funding mechanisms function efficiently and that increased donor support really does mean an increase in the quality and quantity of services.

More efficient coordination among all partners engaged in AIDS-related work is widely seen as a prerequisite for any improvement in the current situation which, from the perspective of civil society organisations, is dire. Effective coordination is challenging given the range of organisations involved and the lack of experience of government and CNCS in forming collaborative partnerships with civil society and other non-state actors. It is clear that, without better systems in place, pooling of funds is premature and poses significant risks for intensifying the fight against AIDS.

An important source of support which does not feed into government budgets or the pooled fund is the United States Government contribution. Between 2001 and 2005 this source committed US\$149 million.²³³ At least 25% of commitments in FY2005 have been designated for civil society recipients.²³⁴

The World Bank Multi-country AIDS Programme (MAP) committed a total of US\$9.8 million for the period of 2004 to 2005. A total of US\$9 million had been disbursed by the end of 2005.²³⁵ The total MAP commitment for 2003-2008 amounts to US\$55 million. Support to mid-2006 covered 447 sub-projects including: community and civil society initiatives – US\$28 million; capacity-building for Civil Society HIV/AIDS Response – US\$5.5 million.

Another small but significant initiative for supporting civil society capacity building was provided by the Southern Africa Regional AIDS Training Programme - Phase III. Between 2002 and 2007 an amount of US\$4.3 million has been provided for capacity-building programmes for strengthening and supporting community-based organisations providing AIDS services.

Key issues in supporting CSO responses to AIDS in Mozambique

There is considerable mistrust between civil society and government in Mozambique, with CSOs suspicious of governmental commitment to supporting non-state AIDS responses and government seemingly reluctant to hand state functions to non-state actors. There is also strong scepticism on the part of non-state actors regarding government capacity and efficiency.

The donor and international development community has made significant efforts to harmonise its funding approaches, but many have felt frustrated that government agencies have not made sufficient progress in fulfilling the requirements of government towards more harmonised action. If donors are to move away from bilateral and programmatic funding commitments towards pooled funding and SWAs, there needs to be the reassurance that government is going to be able to spend the money well and that this will be guided by an adequate management framework, including strong financial management and monitoring and evaluation. Whilst government agencies are certainly moving in the right direction from the perspective of the international community, many agencies opt to maintain some distance from

²³² Mozambique UNGASS Report 2005.

²³³ Figures for 2001-2002 taken from OECD DAC Database. For 2003-05, figures have been annualised from data provided in OGAC (2006a).

²³⁴ Conservative estimate based on calculations from publicly available commitments broken down by partners for FY2005 (OGAC, 2006d). These publicly available commitments total US\$47.7 million of the total US\$57.2 million commitments to Mozambique for FY2005. The actual proportion of funding going to CSOs may therefore be greater than 25%.

²³⁵ In addition the World Bank committed US\$20 million in 2004 for its Treatment Acceleration Programme, but this was not specifically targeted as a civil society initiative.

centralised funding approaches. For some it is a strategic decision based on wanting to fund specific types of activities and not wanting to have their relatively small contributions made insignificant in large pools. For others it is seen as preferable to wait until suitable CSO funding arrangements through government are tried and tested.

Given this context Mozambique poses an interesting challenge where a mixed model of harmonisation is arguably required, perhaps even in the medium to long term, rather than a more centralised model such as is the case in Malawi. Because of the prevailing culture of mistrust, weakness of the CNCS and its provincial agencies, and the geography and infrastructure of the country (which makes communication and coordination difficult), there are likely to be strong obstacles to the idea of one national funding agency.

The CSO networks are weak and need to be strengthened as part of a more general drive to support civil society activity and infrastructure as well as to support government attempts to drive development and AIDS responses in communities. It is not conceivable that the CNCS would be in a position to preside over and fund the development of civil society networks, and there are many community development issues that are likely for many years to need more direct external assistance. This does not rule out harmonisation and many funding agencies already have joint funding arrangements through which they cooperate, but without working through government. Alternative civil society funding arrangements also need to be explored alongside the CNCS funding mechanisms, and there is the need to begin actively developing national AIDS service organisation networks, which may in time become the equivalent of Malawi's international NGOs - umbrella funding organisations working in concert with a national authority.

3.3.4 Namibia

Overview of AIDS funding environment in Namibia

Namibia is classified as a lower-middle income country, despite the fact that 35% of its population lives on less than US\$1 per day. The country is characterised by stark disparities in wealth distribution, with a Gini coefficient (0.7) that is among the highest in the world.²³⁶

Like many middle-income countries, Namibia occupies a somewhat paradoxical position within the development universe. There has been a steady exodus of bilateral donors from Namibia in recent years, and overall per capita development assistance has declined from US\$110 per capita in the 1990s to US\$60 per capita in 2005.²³⁷ Yet at the same time, Namibia is one of the countries most heavily affected by AIDS in southern Africa – a situation with serious long-term development implications. Thus, while bilateral development assistance as a whole is declining, support for AIDS has grown strongly in recent years. Namibia has the highest per capita assistance for AIDS of all countries in sub-Saharan Africa.

This shifting landscape is being watched closely. Concerns have been expressed that the overall decline in development assistance for Namibia may undercut the effectiveness of AIDS control programmes. The UN family, for example, has granted Namibia an 'as if LDC' (less developed country) status in its development framework, believing that its historically disadvantaged population remains in a highly vulnerable situation. Another concern relates to the fate of civil society organisations

²³⁶ UNDP (2006).

²³⁷ Sasman, C. (2007).

While bilateral development assistance to Namibia is declining as a whole, support for AIDS has grown strongly in recent years.

focused on broad development issues, at a time when more and more funding is narrowly targeted at AIDS.²³⁸

The Third Medium Term Plan (MTP III) for AIDS control is a costed framework for the period 2004-2009; it follows upon the MTP II, which ran from 1999 to 2004. The MTP III is intended to be the guiding framework for all AIDS response activity in the country, including that by government, civil society and the private sector, and external funding for AIDS response should align with its priorities. External donors are encouraged to direct their support to areas in the MTP III where funding shortfalls still exist.

The National Planning Commission (NPC) is responsible for preparing, monitoring and overseeing the country's development budget, which is separate from its operational budget. The NPC handles negotiations with donors regarding development assistance and is meant to track all incoming development funds and their use in relation to the overarching National Development Plan, of which AIDS is a priority component. Some, but not all, development assistance flows to Namibia via the NPC, although it is reported anecdotally that the general tendency is now for donors to 'bypass' the NPC once negotiations about the assistance have been completed. This is due to concerns over the slow pace of the distribution of funds by the NPC and the use of funds for other than earmarked purposes. The two largest funders of AIDS in Namibia – the US government and the Global Fund – channel their funds directly to recipients, not through the NPC.

As the above suggests, at present there is not a basket funding mechanism in place in Namibia that pools the contributions of external donors to AIDS response. Significant amounts of funding are channelled through government ministries, but other streams of support go directly to implementing organisations. As in other countries, this has made the task of resource tracking extremely complex. However since 2002, UNAIDS in Namibia has coordinated a 'donor matrix' through the Partnership Forum which details all AIDS-related funding commitments, per donor, including their intended use in relation to the categories of MTP III. Although challenges and gaps remain in terms of the completeness of information and its comparability, the matrix is voluntarily supported by most major donors in the country and appears to be establishing its usefulness and credibility. For example, the matrix was heavily drawn upon in preparing the Global Fund Round 5 bid in 2005. The analysis presented in this section draws heavily upon information contained in the donor matrix.

Main sources of funding for AIDS response in Namibia, 2001-2005

More than US\$94 million in ODA for AIDS was committed to Namibia by bilateral and multilateral donors over the period 2000-2004; 62% of this was through bilateral channels.²³⁹

Expenditure of domestic revenues by the Government of Namibia (GRN) accounted for 49% and 42% of all expenditure on AIDS in 2004 and 2005 respectively, making it the single largest contributor to the national response.²⁴⁰ The government spent US\$35.0 million in national funds on AIDS in 2003, 38.6 million in 2004, and 45.3 million in 2005.

Following the GRN, the US government is the most significant funder of AIDS response in Namibia. Namibia has been designated one of the 15 focus countries under the PEPFAR initiative. A total of US\$67 million

²³⁸ Sida (2006a).

²³⁹ OECD Database.

²⁴⁰ Ministry of Health and Social Services (2005); Republic of Namibia (2006).

was committed to Namibia for FY 2004 and 2005 (US\$24.5 million and US\$42.5 million respectively).²⁴¹ This represents a significant increase over previous levels of USG support for AIDS in Namibia, which were approximately US\$1.5 million, US\$3.4 million and US\$11.2 million in FY 2001, 2002 and 2003 respectively.²⁴²

In 2003, the Global Fund approved a total of US\$104 million in Round 2 financing for HIV/AIDS in Namibia, including US\$26 million for Phase 1 (2004-2006). The principal recipient of GFATM funding is the Ministry of Health and Social Services (MOHSS) and funds are managed through a Programme Management Unit within the ministry. Although funding was approved in 2003, delays in grant negotiations meant that Global Fund support only began to flow to Namibia in early 2005, resulting in implementation delays. Implementation agreements have been drawn up between the MoHSS and more than 20 sub-recipient institutions.

Table 14

Main sources of AIDS expenditure in Namibia, 2004 and 2005

	% of expenditure on AIDS (2004)	% of expenditure on AIDS (2005)
Government of the Republic of Namibia	49%	42%
United States Government (PEPFAR)	30%	33%
Global Fund	---	11%
European Commission	7%	4%
Government of Germany	4%	3%
Others	10%	7%

Sources: MOHSS (2005, p.50); Republic of Namibia (2006).

The European Commission provides support to Namibia through two channels: European Development Funds (via bilateral agreements with GRN) and through European NGOs, working in partnership with Namibian organisations, that access funding through EC Budget line items. Over the period 2001-2005, total EC commitments for AIDS in Namibia were approximately US\$8.7 million (€7 million), split more or less evenly between the two channels. EDF support is channelled through the MOHSS, while EC Budget support has gone to PSI, Kindernothilfe and the German Red Cross.²⁴³ In addition, the EC is a major provider of education sector support, which contains a significant AIDS-related component.

German Development Cooperation in Namibia focuses on the issues of transport, sustainable management of natural resources, and economic development. AIDS is treated as a cross-cutting issue within this portfolio; commitments of funds for AIDS over the period 2001-2005 were at least US\$6 million.²⁴⁴ Assistance has been channelled through GTZ (technical support at sector level), Kreditanstalt für Wiederaufbau (KfW) development bank (support to the Namibian Social Marketing Association), and Deutscher Entwicklungsdienst (DED) (placement of skilled professionals).

DFID's bilateral programme with Namibia has been gradually phased out and the agency closed its office in Namibia in 2003. Support for AIDS has come largely through the Southern Africa Regional Programme administered out of Pretoria. Namibia was one of four countries involved in a large DFID-funded cross-border initiative through SADC that focused on behaviour change, treatment of STDs and condom distribution. It has also received support from DFID for health

²⁴¹ OGAC (2005a).

²⁴² Indicative figures of support channelled through USAID and the CDC prior to the launch of PEPFAR. OECD Database.

²⁴³ Interview with EC representative, Windhoek.

²⁴⁴ According to in-country representatives. Other sources of data suggest total value of German assistance for AIDS may have been as high as US\$8 million over this period.

management strengthening. DFID's funding commitment for AIDS in Namibia was approximately US\$3.1 million over the period 2004-2006.²⁴⁵ Namibia will also be part of a large regional initiative for orphans and other vulnerable children supported by DFID and led by UNICEF, beginning in 2006.

Sida supports AIDS in Namibia through contributions to the Small Grants Fund (see below), to programmes administered by UNICEF and UNFPA, and through sector support to the Ministry of Education. Some limited project-based funding for private sector responses is also provided. Sida will be closing its office in Namibia and administering support from its regional office in Lusaka, although it is expected that support for AIDS will not be scaled down. Sida has contributed approximately US\$5 million to AIDS control in Namibia between 2002 and 2005.²⁴⁶

Since 2000, the Secure the Future initiative of the Bristol-Myers Squibb Foundation has made grants of more than US\$1.5 million to organisations in Namibia as part of its Community Outreach and Education programme, and has also invested several million dollars in the establishment of an ART clinic and community-based treatment programme in the country.²⁴⁷

UNICEF's country programme for Namibia (2002-2005) had four major themes: young children's health, care and development; adolescent HIV prevention; special protection and disparity reduction; and cross-cutting programme support. Although the HIV prevention component focused specifically on AIDS, all of the themes incorporated attention to AIDS. The overall value of the country programme was US\$16 million, with US\$5.3 million budgeted for the adolescent HIV component.²⁴⁸

A Small Grants Fund (SGF) administered by UNAIDS, and supported by contributions from Sida, the Netherlands, and Finland, has been in operation in Namibia since 2002 (see box). More than 120 awards valuing approximately US\$800,000 were made to CBOs through eight rounds of funding over the period 2002-2005.²⁴⁹

Support for CSO responses to AIDS in Namibia

Namibian civil society organisations enjoyed significant external support during the country's pre-independence period, but, after an initial period of strong support for civil society in the early and mid-1990s, less development assistance has been channelled through CSOs. As noted above, many civil society organisations working on development issues in Namibia struggle to resource their work. The Namibian NGO Forum (NANGOF), which is the country's civil society umbrella organisation, is working to rebuild after a series of difficult years.

A large number of CSOs are involved with AIDS response in Namibia – many are newly formed within the past five years, while others have broadened their mandates to include AIDS. These range from large national NGOs with a countrywide operational presence down to small community-level organisations. A handful of international NGOs are involved with AIDS response in Namibia, although such organisations do not dominate the landscape in the same way that they do in some other countries in the region.

Defined roles for civil society organisations are woven throughout the MTP III framework. The Namibian Network of AIDS Service

²⁴⁵ UNAIDS Donor Matrix, Namibia. Figures for commitments prior to 2004 not available.

²⁴⁶ UNAIDS Donor Matrix, Namibia.

²⁴⁷ The exact value of this commitment is not known. US\$30 million has been committed to this programme across five countries, but it was not possible to confirm the exact value of the commitment in Namibia. See Bristol-Myers Squibb (2004).

²⁴⁸ Government of Republic of Namibia/UNICEF (n.d, p. 27). These figures include both Regular Resources (allocated by UNICEF headquarters) and Other Resources, which need to be mobilised separately by UNICEF from other donors.

²⁴⁹ Data provided by SGF, Namibia.

Organisations (NANASO), Lironga Eparu, the national network of people with HIV, and NANGOF are designated in the MTP III as the coordinating bodies for NGOs, CBOs and FBOs in AIDS response, and specific CSO implementing partners are named for each sub-component of MTP III. Namibia's UNGASS report (2006) cites the 'significant role' of civil society in meeting the needs of people infected and affected by AIDS.

Respondents commented that the relationship between the Government of Namibia and civil society looks good on paper, but could be much stronger in practice.

In the course of the research, respondents from both donor institutions and civil society commented that the relationship between GRN and civil society looks good on paper, but could be much stronger in practice. The view was expressed more than once that, although there is a robust discourse about the importance of civil society in AIDS response, the government remains intrinsically wary of granting too large a role to civil society. One respondent spoke about 'the presumption that government should be at the centre of things.' Representatives from two different donor agencies noted that, in negotiations with GRN around the delivery of assistance, the government rarely raises civil society involvement and that its preference is, in fact, 'not to use civil society.' When funding is being channelled through government, external donors have 'no mechanism to steer money to civil society if government does not accept the case.'

The mid-term review of MTP II, whose findings fed into the current MTP III, listed among the priority areas requiring attention within the national response: uncertain financial flows and pipeline blockages; lack of mechanisms to channel public funds to sub-regional level and to non-state actors; and unsystematic and unstructured support to regional and sub-regional level to enhance local responses.²⁵⁰ All of these areas can be seen as linked to the resourcing and support environment for civil society institutions.

The leading sources of support for CSOs in Namibia differ by type of organisation. Medium and large-sized NGOs in Namibia are heavily involved in program implementation and receive funding either directly from international sources or through sub-granting arrangements. Global Fund and PEPFAR financing are significant sources of support: Global Fund support is accessed through agreements with the Ministry of Health and Social Services (the GFATM Primary Recipient), while PEPFAR funding is typically accessed through sub-granting arrangements with Family Health International or PSI/Social Marketing Association. NGOs also access support through foundations, private initiatives (such as Bristol-Myers Squibb's Secure the Future), international NGOs, bilateral agencies and other overseas entities. The findings of this research suggest that there is a cohort of 12 to 15 NGOs in Namibia that receive funding from several of these sources simultaneously.

Funding opportunities for smaller CSOs in Namibia are significantly more constrained. The Small Grants Fund is one of the very few application-based nationwide sources of funding available to young and emerging organisations. Small-scale grants are also issued by Voluntary Service Overseas Regional AIDS Initiative of Southern Africa (VSO/RAISA) and some discretionary funding is available from embassies. To date, Regional AIDS Coordinating Committees have not had resources to distribute in the form of grants, although there are indications that this situation is shifting. National NGOs, such as those described above, sometimes partner with community organisations at a regional level for programming purposes, but this does not seem to extend to the provision of sub-grants.

²⁵⁰ NANASO (2005, pp. 11-12).

Many CBOs operate on the basis of their own membership contributions, sporadic funds from income generating projects, and small in-kind donations from businesses and churches.

Small Grants Fund

Since 2002, the Small Grants Fund (SGF) has been supporting NGOs and CBOs working on AIDS-related activities in Namibia. The SGF is a pooled funding mechanism comprising contributions from Finland, Sweden and the Netherlands. UNAIDS administers the fund on behalf of the contributing partners. Approximately US\$1 million had been committed to the fund through end 2005, with more than US\$800, 000 in awards being made to organisations over eight rounds of funding.

The idea for the Fund emerged in 2002 in discussions at the Partnership Forum on HIV/AIDS, which brings together donors and other institutions involved in AIDS response in Namibia. A need was identified to channel resources to grassroots organisations at a larger scale and in a more systematic manner to increase their involvement in the national response. At the time that the Fund was created, very limited support was available to CBOs.

The Fund's sole purpose is to fill the gap in resourcing for grassroots organisations. The average award is less than US\$10, 000, and funding is released in tranches pending satisfactory reporting. Criteria for accessing funding are relatively broad and the SGF has deliberately adopted a flexible approach. It sees itself as responding to needs as they are identified and understood on the ground: for this reason a wide diversity of activities is supported and there is no preferred model or format. To be eligible, organisations must be community based; must carry out work related to AIDS (broadly understood); and must be known to and endorsed by their Regional AIDS Coordinating Committees. Awards are generally issued for year-long projects. The SGF provides a certain amount of capacity-building support in the form of workshops and training for recipients.

An outcome evaluation conducted in 2004 concluded that the SGF model is appropriate to the needs of the organisations it targets, and is filling a critical gap in Namibia. The evaluation noted that the project is effective in supporting the involvement of people with HIV, given the high proportion of HIV-positive individuals involved in CBOs. Another strength is its commitment to funding organisations from all parts of the country, in contrast with a general tendency for funding to flow to the most highly affected regions in the north. Involving Regional AIDS Coordinating Committees in the application process also helps to build strong networks and linkages at regional and local level.

The SGF has been pointed to as a 'best practice' example of a funding mechanism for CBOs, and the present research has corroborated the importance of its role as the only significant source of financial support targeted at small organisations (see case study and CSO survey findings). However it is also important to draw attention to some of the key challenges the model faces. First, the organisations funded are small and often lacking in previous funding experience. The very process of applying for funds through a written application presents enormous challenges, as does managing and reporting on funding. The model is labour intensive and a lot of support is required from the Fund administrators and from Regional AIDS Coordinators, who are overworked and presently without support staff. Second, and related to the above, the rate of disbursement of funds appears to lag quite significantly behind awards. Complete records are not available but, for example, only 59% of Round Four funds (awarded in 2004) had been disbursed to recipients as of November 2005. Tranches of funding are only released when earlier funds have been fully accounted for, and this appears to be something of a sticking point. Third, many of the supported organisations have difficulty graduating on to other sources of support after the funding ends. The outcome evaluation detected that 'many of the projects either fold' or come to rely on members' own contributions to sustain themselves.

The SGF is a successful example of a relatively small-scale pooled funding mechanism which takes a flexible and needs-driven approach to funding. It is a model which could be appropriate in other countries where a gap in support for local-level initiatives has been identified.

Data on financial support to CSOs: Evidence from the Namibia donor matrix

Analysis of the donor matrix compiled by UNAIDS in Namibia, and last updated during 2005, suggests that between 35% and 43% of all commitments of development assistance for AIDS listed in the database are designated for civil society organisations.²⁵¹

Table 15 shows a breakdown of the 10 largest funders in the donor matrix, by commitments for the years 2004-2005, and the minimum proportion of their commitments that is indicated as going to civil society organisations.

It shows that the 10 largest funders of AIDS activities in Namibia committed US\$76 million in funding for the years 2004 and 2005, one-third of which was designated for civil society recipients. US Government funding accounted for 49% of all the funding going to civil society recipients, followed by the Global Fund at 16%.

Table 15

Commitments of AIDS funding to CSOs by 10 largest funders in Namibia

Donor institution	Amount committed, 2004-2005 (US\$ millions)	% to CSOs	Amount to CSOs (US\$ millions)
United States	33.6	37%	12.4
European Commission	15.0	10%	1.4
Global Fund	12.4	32%	4.0
Germany	4.0	50%	2.0
Sweden	3.4	10%	0.3
United Kingdom	2.1	59%	1.2
UNFPA	1.8	28%	0.5
UNICEF	1.5	84%	1.2
Denmark	1.2	100%	1.2
Italy	1.0	100%	1.0
Total	76	33%	25.2

The CSOs most frequently designated as recipients of funding included Family Health International, Catholic AIDS Action, Social Marketing Association, Lutheran Medical Services, Catholic Health Services, Johns Hopkins University, and Population Services International.

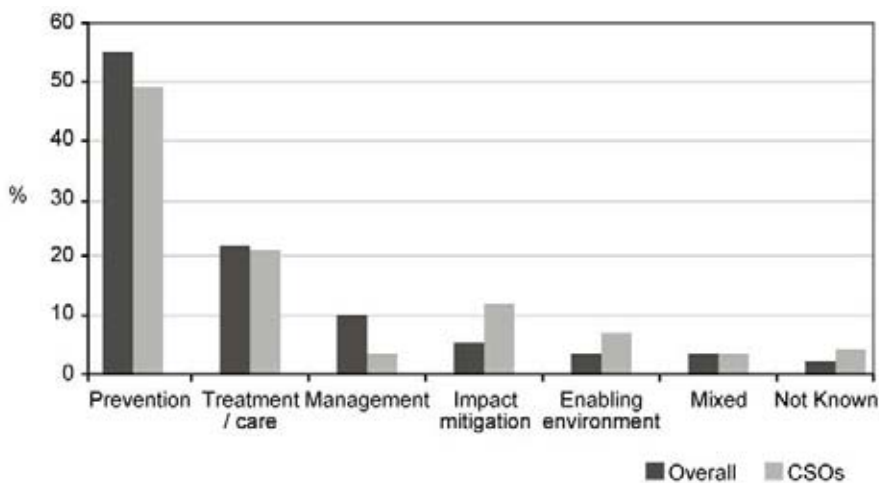
The donor matrix also allows for analysis of funding commitments by area of intervention. Figure 29 compares the areas of intervention among the overall funding commitments with those designated for civil society. While the differences are not extreme, it is of interest that funding for impact mitigation activities is particularly directed towards CSOs, as is funding for enabling environment activities such as anti-stigma and discrimination work, sensitisation, and support for people living with HIV.

²⁵¹ The matrix contains some information as far back as 2001, and projected forward as far as 2008. However the most complete data is for the years 2004 to 2006. Between 34% and 41% of the funding commitments for the years 2004 and 2005, which fall within the parameters of this study, are designated for civil society.

It is notable that more than half of committed funds in 2004 and 2005 were for prevention-related activities. This stands in stark contrast to the more diversified spectrum activities which Namibian CSOs report undertaking.²⁵² This suggests that funding streams are more sharply differentiated than the work of organisations on the ground, which tend to see AIDS holistically and orient themselves across a range of services despite the fact that external support is more narrowly focused.

Figure 29

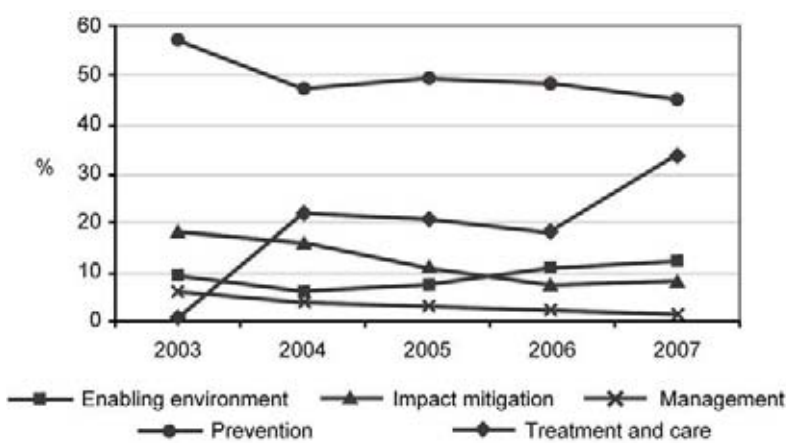
Distribution of donor commitments (2004-2005) by MTP III intervention areas: overall and for civil society organisations



Over time, trends in funding allocations to civil society organisations can be detected. Figure 30 shows that over the period 2003 to 2007 (projected), funding for civil society organisations in the area of treatment and care has risen, while funding for prevention, impact mitigation and management has declined.

Figure 30

Funding for civil society over time, by area of intervention (MTP III categories)



3.3.5 Swaziland

Swaziland is distinguished by being the country with the highest HIV prevalence rate amongst pregnant women in the world. It is a small country with a population of 1 million people and the impact of AIDS has been profound in almost all areas of social and economic life.

²⁵² See, for example, NANASO (2005).

AIDS has a prominent profile as an issue of societal concern in Swaziland. Whereas there has been some despondency about success in curbing new infections, too little is known about the situation currently to understand whether the country is finally turning the tide. It was encouraging that Swaziland met 89% of its WHO '3 by 5' targets in 2005, and this is indicative of the serious commitment of a broad range of actors working together under the umbrella of the National Emergency Response Council on HIV/AIDS (NERCHA), which was established by Act of Parliament in 2001.

Swaziland is a small country and the impact of AIDS has been profound in almost all areas of social and economic life.

Overview of AIDS funding environment in Swaziland

As the principal recipient of GFATM grants to Swaziland, NERCHA does not call for proposals but invites service providers to propose ways of implementing a set programme of action as defined in the national strategic plan and in keeping with the terms of the GFATM grants. NERCHA takes responsibility for all procurement and supports only operational costs, including human resource costs. A wide range of private sector, civil society, parastatal and governmental agencies are involved in implementing the national AIDS strategy with NERCHA's facilitation and coordination. They receive funds to render services and NERCHA pays for goods and services that they need to procure.

Allocations from the Government of Swaziland cover the running costs of NERCHA and surpluses are used to fill in the shortages in the Global Fund funding.

In order to improve coordination of the national response, NERCHA has established and/or strengthened umbrella bodies for each sector or special group. These sectors or groups are organisations serving youth, faith-based organisations, organisations of people with HIV, workplace, NGOs and the Ministry of Health and Social Welfare. Umbrella bodies include the Swaziland National Youth Council (SNYC), the Church Forum, Swaziland National Network for People with HIV/AIDS (SWANNEPHA), Business Coalition on HIV/AIDS (BCHA), Public Sector HIV/AIDS Committee (PSHACC), Swaziland National AIDS Programme (the Ministry of Health and Social Welfare programme), and the Coordinating Assembly of Non-governmental Organisations (CANGO). Through these structures, NERCHA provides technical and financial assistance to organisations to implement AIDS-related activities at all institutional and community levels. In addition, NERCHA has been able to expand Swaziland's response to AIDS through capacity-building and information sharing.

Main sources of funding for AIDS response in Swaziland, 2001-2005

Of funding received by NERCHA from 2002-2005, 97% was from two funders: the Swaziland Government (30%)²⁵³ and the Global Fund (67%). The remaining funds over this period were provided by 11 donors, the largest of which provided 2% to the national sum of funding available. NERCHA has received about US\$47.4 million during this period.

There are also a sizeable number of bilateral²⁵⁴ and multilateral donors²⁵⁵ that have funded AIDS activities separate from NERCHA. The total funding from other donors can only be estimated and for the period in question it appears to be about 80% of the value of that received by NERCHA, amounting to approximately US\$35-40 million.

²⁵³ Between April 2002 and March 2006 a sum of US\$14 million was contributed by the Government of Swaziland to NERCHA.

²⁵⁴ The bulk of bilateral donor support in the period from 2001-2005 was received from the following countries: United States, Netherlands, Italy, Japan, Norway, Ireland and Australia.

²⁵⁵ Multilateral support was received from UNICEF, UNFPA, and the United Nations Turner Fund Grant.

Table 16 provides some indication of the proportion of NERCHA's 2005 HIV/AIDS payments or procurements which went to civil society organisations, per area of intervention, as well as indicating changes in this over the period 2001-2005.

Table 16

Summary of NERCHA allocations to CSOs, 2005, by programme area

Programme Area	% of 2005 Expenditure	Changes in the proportion 2001-2005		
		Increased	Decreased	Remained the Same
HIV/AIDS awareness & prevention: Condoms, PMTCT, VCT, education, communication	17%		X	
HIV/AIDS treatment & care: Nutrition, home-based care, counselling, support for people with HIV/AIDS	10%		X	
HIV/AIDS impact mitigation: Work with orphans and others in need of social assistance, income generation, poverty alleviation	37%	X		
HIV/AIDS management: Training, coordination, capacity building, M&E, systems development	36%	X		
HIV/AIDS policy, advocacy, research	0%			X

The Global Fund is the most significant contributor to civil society responses to AIDS in Swaziland. Between 2003 and 2005 a total of US\$23.4 million was disbursed by the Global Fund,²⁵⁶ which amounted to 80% of expected disbursement of US\$29.6 million. Seventeen percent was paid to CSOs for services rendered or used for direct procurement of goods and services on behalf of CSOs. This covered a wide range of CSOs, including umbrella organisations, well-established and professionalised organisations with years of experience, and newly formed CBOs.

The HIV/AIDS Prevention and Care Programme (HAPAC) is a joint bilateral funding project of the Government and the European Commission which focused on improving access to VCT, provision of resources for home-based care and curtailing the high rates of sexually transmitted infections. The HAPAC programme supports the Ministry of Health and Social Welfare in assisting non-state actors to develop services for HIV/AIDS. Between 2003 and 2005 this contributed a total of US\$2.4 million, of which approximately 48% went to national and international NGOs. The EC also has a European Development Fund which has no specific budget for HIV. This programme was introduced at a time when the government was finding it difficult to work with CSOs. The money was principally spent through HAPAC (a specially created MOH unit) by subcontracting NGOs to provide specific services (e.g. VCT centres). The grant funds both human resource and programme costs. The EC funding procedures have been very difficult to complete and this has been a major obstacle.

²⁵⁶ Global Fund (2006).

Between 2003 and 2005 the United States Government²⁵⁷ provided an amount of US\$11.4 million for programmes focusing on capacity-building for local NGOs, CBOs, and FBOs, but with the bulk of funding going to international NGOs, including Pact, AED, Dream for Africa, and the CDC.

Recognising the need for organisational capacity-building among local NGOs, CBOs and FBOs, USAID's Regional HIV/AIDS Program has entered into an agreement with the international NGO Pact to provide organisational strengthening and grants management support. In June 2005, USAID, assisted by Pact, launched a call for proposals from NGOs, FBOs, and CBOs to deliver prevention, treatment, and care services focusing on community-based, community-owned approaches.

UNICEF's 2001-2005 country programme strategy aimed to identify potential solutions to the looming crisis for children affected by AIDS. An emerging concept has been that of 'neighbourhood care points' and US\$15 million was committed by UNICEF between 2001 and 2005 to establish and run these care points, as collaborations between CBOs and government ministries. About 33% of this funding went to CSOs either directly (payment for goods and services) or indirectly (capacity-building initiatives). This and a good many other programmes uniquely developed and implemented in Swaziland are strongly community-based and use existing traditional social structures²⁵⁸ to support programmes, with the assistance of CBOs, NGOs, INGOs and government partnerships.

UNDP spent an amount of US\$0.4 million between 2002 and 2005. This money was spent on capacity-building, rather than on direct disbursement to CSOs. The beneficiaries were NGOs and umbrella organisations including the coordinating assembly of NGOs, the Church Forum, SWANNEPHA (network of associations representing people with HIV) and the Swaziland National Association of Journalists.

The African Capacity Building Foundation has supported two civil society coordinating bodies: the Alliance of Mayors and Municipal Leaders on AIDS in Africa (AMICAALL) to build capacity of local authorities/municipalities to respond to the epidemic (2002 to 2005 - US\$1 million), and the Coordinating Assembly of NGOs in Swaziland (CANGO) and its members to promote local responses and professionalise the voice of civil society (2005 - US\$1 million). The latter programme aims at strengthening the interface between civil society and the government of Swaziland. In line with CANGO's strategic plan, the grant will facilitate activities which include strengthening the institutional capacity of CANGO, the promotion of good governance in the NGO sector, promotion of the contribution of NGOs to Swaziland's development, participation of non-state actors in the development policy-making process, as well as promotion of gender sensitivity in the NGO sector by encouraging and equipping NGOs to mainstream gender concerns in development programmes. Unlike most other funders in Swaziland, ACDF parameters are broad rather than prescriptive with much latitude given to funded programmes to craft their interventions as they see fit.

The Bristol-Myers Squibb Secure the Future programme committed US\$ 2.5 million from their Community Outreach and Education Fund to organise in Swaziland.²⁵⁹ Sub-grants went to local and international NGOs and university institutions in support of AIDS response programmes.

²⁵⁷ USG funding to Swaziland is channelled regionally and it was not possible to obtain amounts prior to 2003. 2003-05 figures were taken from the PEPFAR 2005 Operational Plan (OGAC, 2005b).

²⁵⁸ In particular, reviving chiefdoms as caretakers of the community.

²⁵⁹ Additional funding was provided for an NGO Institute and community-based treatment programme, but the exact value of these activities in Swaziland cannot be determined on the basis of available data.

Many civil society actors in Swaziland, from small initiatives to larger NGOs, feel 'left out.' NERCHA may be a product of its own success: the ideas of the national plan and national strategy are often in evidence, and in some respects civil society has become an implementation instrument rather than a constituency holding its own reigns and having its own voice.

Key issues in supporting CSO responses to AIDS in Swaziland

Perhaps the most notable issue in Swaziland is the role of NERCHA, which is a coordinating rather than implementing agency, but which is also a recipient of the largest block of money for AIDS response. It is responsible to the Global Fund in terms of reporting on the achievements of the grants it has received, and yet it achieves its objectives through partners.

These partners understandably see themselves as 'funded' by NERCHA, although what can be done with the money is closely prescribed. However, NERCHA consults with its partners at every turn and it cannot be said that it functions unilaterally. The national strategic plans which lay the foundations for NERCHA's 'mandates' were developed through an extensive consultative process.

It may seem surprising then, that many civil society actors, from small initiatives at community level to larger NGOs, feel 'left out.' NERCHA may be a product of its own success in some respects. AIDS response is truly widespread in Swaziland. Even where there is little or no funding, the ideas of the national plan and national strategy are often in evidence, and in some respects civil society has become an implementation instrument rather than a constituency holding its own reigns and having its own voice.

There is also another reason for disaffection, and this lies in the relative lack of independence of civil society. There are some limits on civil society freedom in Swaziland. Press freedom is limited and democracy is held at bay by a monarchy and a patriarchal system of chieftainships. In addition to this, the centralisation of funding may further limit the evolution of civil society in Swaziland. Most civil society actors stand to benefit from NERCHA-managed funds and hope to be partners and this mutes critical voices.

Some of the larger organisations, such as the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa, have felt that the centralisation of funding has limited their own discretionary ability to receive and disburse funding. This reflects an inherent disadvantage of 'Three Ones' thinking from the perspective of civil society. Whereas it gives civil society a place in a coherent multisectoral framework, it also limits independence. Strong harmonisation, or alignment, as has been argued above, reflects Paris Declaration thinking on development assistance. It may limit developmental thinking and limit the strength of civil society actors. In Swaziland financial control has been maintained by NERCHA, in the sense that money is not handed to CSOs, who then use it. NERCHA does not so much sub-grant to civil society, as use civil society to implement programmes in the national interest. This may limit the future role of civil society and possibly compromise what it has to offer, however, all things considered, the various initiatives to develop and support civil society identified above, have at least supported the continuation and strengthening of a small number of strong NGOs which uphold the idea of an independent civil society.

3.3.6 Zambia

Overview of AIDS funding environment in Zambia

AIDS is a national emergency in Zambia, and a vigorous effort is underway, involving a large and varied set of institutions, to combat

its spread and to mitigate its impacts. In many respects the situation in Zambia with funding for AIDS epitomises both the promise and the challenge of increased resourcing directed towards the epidemic. In addition to significant commitments of funding from the world's three largest initiatives – Global Fund, PEPFAR and MAP – Zambia is also home to a multitude of bilateral assistance programs, church-based initiatives, international development NGOs, and UN agencies. While the funding gap has not been closed, it has been eased in recent years and one of the main challenges related to AIDS response is how to absorb and utilise the increased funding with very limited human resource capacity. A second challenge is how to coordinate and optimise the many overlapping AIDS-related initiatives already underway in the country.

The 'Three Ones' principles are well-enshrined in Zambia. The National AIDS Strategic Plan 2002-2005 is the guiding framework for AIDS response in the country and the National AIDS Council, created in 2002 by an Act of Parliament, is acknowledged as the coordinating authority for the national response. A National M&E System is in its early stages of development and annual reviews of progress against the national strategic plan, which involve consultative processes, began to be carried out in 2004.

Zambia is one of the countries at the forefront of moves towards donor harmonisation and alignment. A 'Harmonisation in Practice' initiative, launched in early 2003 with the support of seven bilateral donors, led to the adoption of a Memorandum of Understanding on Coordination and Harmonisation of GRZ/Donor Practices for Aid Effectiveness in Zambia in 2004. The MOU has been signed by almost all of the major donor institutions working in Zambia and lays out a framework of action that includes movement towards the adoption of a Joint Assistance Strategy for Zambia (JASZ) in cooperation with the Government and the National Development Plan. The JASZ seeks to minimise duplication of efforts by multiple donors, to 'de-congest' crowded sectors, to bring about a simpler 'division of labour' by identifying 'lead donorships' within each sector.

A related element is the move towards greater levels of budget support. The European Commission has been at the forefront of this effort, approving €110 million in budget support for GRZ in late 2003, as well as additional technical support for public sector financial management and information systems.²⁶⁰ The EC's move has laid the groundwork for other institutions to follow suit, and many (but not all²⁶¹) donors are actively supporting this shift. Significant levels of sector-wide support are already provided by bilateral institutions in Zambia as part of a general trend of merging stand-alone projects into wider programmes of support.

Despite these moves towards greater harmonisation, funding for HIV/AIDS in Zambia remains a complex affair. It is anticipated that when the JASZ is operational, funding for AIDS will flow through the Ministry of Finance and National Planning, along with other ODA, but at present its delivery is far from systematic.

The National AIDS Council in Zambia does not channel funding. It plays a mobilisation, coordination and oversight role in relation to AIDS financing, helping to identify gaps where assistance is needed and institutions through which funding can be directed. In theory, the NAC should act as a broker between donor institutions and the National Strategic Plan, shaping how and where the donors 'buy in' to elements of the plan. In practice this role is only partially realised. While the NAC has

²⁶⁰ See Sida (2006b, 2006c, 2006d) for background discussion on changes in development partnership environment in Zambia.

²⁶¹ It is expected, for example, that the US Government, Japan, and the Global Fund will be unlikely to join the JASZ.

'In Zambia the HIV/AIDS arena is characterised by numerous local and international actors, including donors, UN agencies, international financial institutions, universities and research institutions, NGOs, FBOs, CBOs, etc. Much of the coordination efforts and coordination capacities of NAC are absorbed by managing numerous individual coordination processes associated with such a diverse group. The net result is that not enough action is realized on the ground.'

- Zambia UNGASS report (2006, p. 16)

strong links to and is aware of the details of particular funding initiatives (e.g. World Bank, Global Fund), it does not have the 'big picture' of the resource environment. Several attempts at resource tracking have been undertaken over the past decade, but these have been of only marginal usefulness and there is nothing resembling a comprehensive donor matrix or database. Some information is provided to the NAC by donors voluntarily, but in other instances the NAC is essentially informed after the fact what programming decisions have been made. The NAC has difficulty getting reports from certain donors about how much funding has actually been spent in country; blank sections in the Third Joint Annual Programme Review section on 'Finance and Budgeting' attest to the absence of a basic overview of the funding environment by its lead coordinating agency.²⁶²

The NAC itself is supported at an institutional level by a Joint Financing Arrangement (JFA) between DFID, Irish Aid, the Netherlands, NORAD and Sida. Some of the funds committed through the JFA are passed downwards to the Provincial and District AIDS Task Forces for operational (not programming) purposes. The JFA also includes support for capacity-building and institutional development of the NAC, which is seen as a high priority by many development partners. The NAC is accepted as the sole coordinating authority, but there is widespread concern that it has not been effective in carrying out its role. There have been a large number of vacant staff positions within the NAC, including some key posts, and limited oversight by the Cabinet Committee to which NAC reports. The World Bank has recommended changing institutional arrangements by relocating the NAC to the Office of the Vice President where it would be in a better and more independent position to coordinate the activities of other bodies.²⁶³

Main sources of funding for AIDS response in Zambia, 2001-2005

Zambia is heavily reliant upon international funding to support its AIDS response efforts. Expenditure of domestic revenues (support to NAC and line ministries) by the Government of Zambia (GRZ) totaled US\$32 million in 2005,²⁶⁴ while funding commitments from the three largest external funders alone was more than US\$170 million.

Zambia is one of the 15 focus countries under the US Government's PEPFAR initiative, which was launched in late 2003. More than US\$360 million has been committed for scaling up prevention, treatment, and support activities in Zambia during fiscal years 2004-2006 alone, making Zambia the fourth largest recipient of PEPFAR funding after South Africa, Kenya and Uganda.²⁶⁵ Prior to the PEPFAR initiative, USG funding in Zambia was provided primarily through USAID and the Centres for Disease Control.

Overall US Government funding commitments for AIDS in Zambia for the period 2001-2005 were close to US\$300 million.²⁶⁶ USG funding is channelled directly to recipient institutions, which include a combination of civil society organisations, research institutions and universities, government departments and health institutions,²⁶⁷ and private contractors that provide technical assistance and project management services. Many of these are US-based entities; some work in partnership with or sub-grant to local institutions. There is insufficient information available on amounts committed to specific recipient organisations over the period 2001-2005 to estimate the proportion of overall funding channelled to CSOs; however for FY 2005 at least 37% of total committed funds were channelled through CSOs.²⁶⁸ Of 43 prime recipient partners

²⁶² See Republic of Zambia (2006b, pp. 180-192). The NAC's Director of Programmes expressed in an interview that the decision to leave elements of the section blank was a deliberate one.

²⁶³ See World Bank report on institutional arrangements in Republic of Zambia (2006b, p. 206).

²⁶⁴ Republic of Zambia (2006a).

²⁶⁵ OGAC (2006a, p. 16).

²⁶⁶ Figures for 2001-2003 taken from OECD database; FY 2004-2005 figures taken from OGAC (2006a, p. 16), and annualised.

²⁶⁷ For example, the National Blood Transfusion Service.

²⁶⁸ Conservative estimate based on calculations from publicly available commitments broken down by partners for FY 2005 (OGAC, 2006c). These publicly available commitments total only US\$109 million of the total US\$130 million commitments to Zambia for FY 2005.

of PEPFAR funding in Zambia in FY 2005, 40% were international FBOs or NGOs such as World Vision, Pact, Christian Aid, Family Health International, Hope Worldwide, and Catholic Relief Services. There were 87 sub-partners, 90% of which were local FBOs and NGOs.²⁶⁹

Zambia has been awarded a total of US\$346.5 million for HIV/AIDS by the Global Fund in Round 1 and Round 4 applications; of this, US\$116 million has been approved for disbursement and US\$60 million had been disbursed to Zambia by the end of 2005.²⁷⁰ Zambia has four separate Principal Recipients of funding – the Ministry of Finance and National Planning, the Ministry of Health, the Zambian National AIDS Network (ZANAN), and the Churches Health Association of Zambia (CHAZ). ZANAN and CHAZ are responsible for sub-granting Global Fund support to civil society organisations and the private sector: NGOs/CBOs and the private sector, in the case of ZANAN, and FBOs in the case of CHAZ. Together, ZANAN and CHAZ account for 58% of the overall committed Global Fund support to Zambia and received 56% of the actual disbursements of funds made through end 2005.²⁷¹ At least 400 NGOs, CBOs and FBOs had been supported through sub-grants from ZANAN and CHAZ through the end of 2005.²⁷²

The World Bank MAP program has committed US\$42 million to the Zambia National Response to HIV/AIDS (ZANARA) program for the period 2003-2008. ZANARA has four main streams of activity: technical guidance for the National AIDS Council (6% of funds), support for mainstreaming AIDS activities in line ministries (23%), funds for impact mitigation and care programs through the Ministry of Health (28%), and the Community Response to AIDS (CRAIDS) initiative to support local activities (35%).²⁷³ By the end of 2005, the CRAIDS programme had supported 528 community-level NGOs and CBOs with more than US\$5 million in World Bank funding.²⁷⁴

DFID's multisectoral AIDS response program – Strengthening AIDS Response in Zambia (STARZ) – has committed £10.3 million (US\$18.9) to activities in Zambia over the period 2004-2008.²⁷⁵ The main components of STARZ include support for civil society responses (36%), technical assistance (53%), institutional support to the NAC, as part of the JFA (6%), and support for private sector responses (5%).²⁷⁶ The funds for civil society response are channelled through ZANAN and CRAIDS in the form of sub-grants for CBOs and NGOs. Over US\$1 million in STARZ funding had been disbursed to 147 organisations by the end of 2005.²⁷⁷

Many other bilateral donor agencies support AIDS in Zambia, and some fall into a 'like-minded group' of institutions that fund in a similar and compatible manner.

- *NORAD* has provided US\$14.5 million for AIDS from 2001-2005 through Norwegian NGOs, support to GRZ, ZANAN and the NAC.²⁷⁸ It channels its funding to ZANAN through a Joint Funding Arrangement with the Netherlands that minimises reporting requirements and streamlines donor oversight.
- *Irish Aid* has provided US\$11 million in direct project support, funding for ZANAN and CHAZ, and the NAC over the period 2001-2005. More than 80 organisations have been supported directly by Irish Aid, although it is now concentrating its support for civil society in ZANAN, where its funding is earmarked for projects targeting orphans and other vulnerable children in the Copperbelt region. Approximately 80% of Irish Aid's AIDS-specific funding went to civil society organisations in 2005.²⁷⁹

²⁶⁹ OGAC (2006b).

²⁷⁰ Global Fund (2006).

²⁷¹ Calculations based on publicly available information about commitments and disbursements. See Global Fund (2006).

²⁷² Sub-granting records provided by ZANAN; CHAZ progress reports to Global Fund and 2005 Annual Report.

²⁷³ The World Bank (2002b, p.16).

²⁷⁴ 147 projects were funded in 2004 (Ministry of Finance & National Planning, 2005, p. 6) and 381 projects were funded in 2005 (Ministry of Finance & National Planning, 2006, p. 15).

²⁷⁵ Information on DFID support for HIV/AIDS prior to the STARZ programme could not be obtained.

²⁷⁶ Personal correspondence with DFID representative, Lusaka.

²⁷⁷ 106 organisations were supported through ZANAN (US\$636,000) and 41 through CRAIDS (US\$404,000). ZANAN sub-granting records and CRAIDS annual reports.

²⁷⁸ Disbursements, as reported by NORAD Lusaka. This appears to include support channelled through Norwegian NGOs. See, for example, NORAD (2006, p. 21), for breakdown of funding delivery in 2005.

²⁷⁹ Data provided by Irish Aid, Lusaka.

- *DanChurchAid* provided US\$6 million in support for local FBOs and NGOs, including CHAZ, over the period 2002-2005. It works through multi-year partnerships with local NGOs, many of which are faith-based, and emphasises gender and poverty alleviation in the projects it supports. All of *DanChurchAid*'s AIDS funding in Zambia goes to CSOs.²⁸⁰
- The *Royal Netherlands Embassy* has spent US\$4.5 million on AIDS-specific projects between 2001-2005, including direct project support to CSOs, funding for ZNAN and CHAZ, and institutional support to the NAC.²⁸¹ In recent years the Netherlands has been scaling back on direct project funding in favour of support to ZNAN and CHAZ, however the great majority of the Netherlands' AIDS funding in Zambia continues to go to CSOs.
- *Sida* has adopted a mainstreaming approach to AIDS in its funding portfolio and provides only a limited number of direct grants to recipient institutions, most of which are youth organisations focusing on HIV prevention. *Sida* committed approximately US\$1.8 million to AIDS projects over the period 2002-2005.²⁸² *Sida* also contributes to the NAC Joint Financing Arrangement.

Thirteen UN agencies are present in Zambia and many of them work on AIDS. UNICEF and UNDP are among those that provide significant funding, as opposed to playing more technical roles. UNDP launched a US\$5 million multisectoral response initiative in 2003, and UNICEF's maternal and adolescent project (US\$3.2 million from 2002-2005) devotes significant attention to AIDS.

Support for CSO responses to AIDS response in Zambia

Civil society organisations have emerged relatively strongly in Zambia since the advent of multi-party democracy. Although relations between civil society and the state are not always smooth, the work of civil society organisations on development and humanitarian (as opposed to political) issues is generally valued by the government, which recognises the need for partners to realise its development strategies. Consultations surrounding the development of the PRSP were important in setting a precedent for civil society participation in policy discussions, and the Civil Society for Poverty Reduction network is beginning to emerge as an important forum for civil society input into pro-poor development strategies.

Civil society organisations are heavily involved in AIDS-related activities in Zambia and have been since the earliest stages of the epidemic. The CSOs themselves are varied in form, as are the roles they play. The 2006 UNGASS report cites the contributions of large international NGOs that are pioneering multisectoral programmes that draw together issues of AIDS, food security and income support; the work being conducted by other NGOs in support of decentralised planning and provincial and district-level structures; the important service provision role being played by church health services and FBOs in the areas of treatment, care, and prevention; and specialised projects targeted at niche groups and issues such as treatment literacy. There are also hundreds, if not thousands, of community-level CBOs and NGOs involved with prevention, care and support activities dotted across the country.

Zambia has a number of strong CSO networks and umbrella bodies that have taken on key roles in the national AIDS response. These include the Zambia National AIDS Network (ZNAN), the umbrella body for AIDS-

²⁸⁰ Interview with *DanChurchAid*, Lusaka.

²⁸¹ Significant sector support is provided to the Ministry of Health, but this is not considered part of the AIDS-specific budget.

²⁸² Committed funds, as reported by *Sida* Lusaka. See also Jansegers, P. (2005, p. 33), for list of *Sida*-supported projects on HIV/AIDS in Zambia.

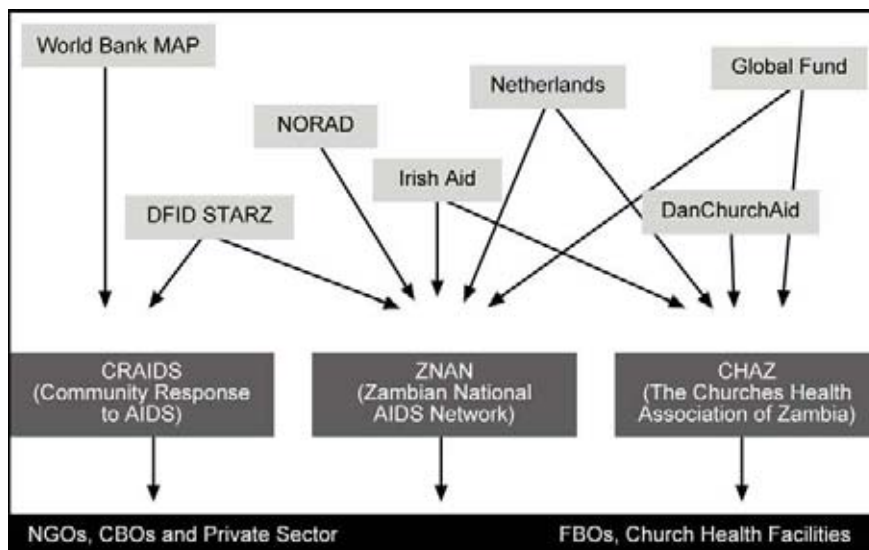
related organisations in Zambia; the Zambia Interfaith NGO Network (ZINGO) and the Churches Health Association of Zambia (CHAZ), which work with church health services and FBOs; and the Zambia Business Coalition on HIV/AIDS (ZBCA). There is also a national network of people living with HIV, called ZNP+, and a large network of traditional health practitioners.

In comparison with some other countries in the region, CSOs in Zambia benefit from the existence of three large-scale funding mechanisms specifically designed to move funding for AIDS down to the grassroots level: the sub-granting programs of the Zambian National AIDS Network, the Churches Health Association of Zambia, and the Community Response to HIV/AIDS component of the World Bank's ZANARA program.

As Figure 31 shows, there is considerable overlap in the funding sources for these three initiatives which, taken together, had sub-granted approximately US\$24 million in funds by the end of 2005.

Figure 31

Sources of funding for Zambia's civil society sub-granting bodies



ZNAN and CHAZ were designated as Principal Recipients of Global Fund funding in 2003; following this, a number of bilateral donors also began contributing funds for sub-granting. Irish Aid and the Netherlands, for example, which are moving their funding portfolios away from direct project support, have begun channelling their support through ZNAN and CHAZ instead. The Netherlands and NORAD have entered into a Joint Financing Arrangement and pool their contributions to ZNAN to minimise the administrative and reporting burden.

While CHAZ, which was founded in 1970 and is responsible for up to half of all health care provision in rural areas of Zambia, had some prior experience as a funding conduit, ZNAN had not previously acted as a conduit. For both organisations the sub-granting role has demanded major institutional changes: for example, a significantly larger staff, the introduction of an M&E unit, a grants management unit, and an internal audits department. Reporting requirements and timelines are not the same for all the donors, and this places a heavy administrative burden upon ZNAN and CHAZ. The funding streams essentially need to be managed separately, since donors place specific requirements on how or

Both ZNAN and CHAZ have met and even exceeded expectations in terms of their performance in disbursing large amounts of funding. However both are also working to maximum capacity and certain other functions may be suffering as a result of the pressures of the sub-granting role.

where their funds should be targeted. For example, Irish Aid's funding to ZNAN is earmarked for projects supporting OVC in the Copperbelt.

In addition to administering grants directly, both ZNAN and CHAZ utilise intermediary bodies to extend their reach into rural areas and to specialised target groups. ZNAN works through 'lead agencies' that re-grant funds in remote and underserved areas as a strategy for countering the urban bias that otherwise exists through the application process. CHAZ works through 13 sub-recipients - various religious 'mother bodies' for different faiths and denominations - to extend sub-grants to FBOs and institutions that are not members of CHAZ.

Both ZNAN and CHAZ have met and even exceeded donor expectations in terms of their performance in disbursing large amounts of funding quickly and efficiently, and reporting back on its use. However both organisations are also working to maximum capacity, or perhaps over capacity, and it is important not to ignore the fact that certain other functions may be suffering as a result of the intense pressures of the sub-granting role. An evaluation of ZNAN conducted in 2005 found that the grant-making role has put strain on its ability to carry out certain functions, such as technical support and M&E, and may have long-term implications for its original role as a network to facilitate collaboration and information sharing among AIDS service organisations.²⁸³

In contrast with ZNAN and CHAZ, which were existing membership organisations prior to becoming sub-granting agencies, CRAIDS is a newly established initiative set up as part of the World Bank MAP program. It is responsible for administering 35% of the overall MAP funding envelope of US\$42 million, and has also received funding from the DFID STARZ program. Working in close collaboration with DATFs, CRAIDS provides funding for community-based projects and a small number of private sector initiatives across the country. Proposals are first reviewed by DATFs and forwarded on to a CRAIDS selection committee; all applications over US\$20,000 require the approval of the NAC. Once funding has been awarded, UN Volunteers at district level work with the DATFs to monitor the projects.

Table 17

Overview of main sub-granting mechanisms for CSOs in Zambia

Funding Intermediary	Source of Funds	Number of CSOs funded to end 2005	Amount disbursed in sub-grants (ZMK)	Amount disbursed in sub-grants (US\$)
ZNAN ²⁸⁴	Global Fund	239	38.1 billion	8.4 million
	JFA (Netherlands/Norway)	124	11.1 billion	2.4 million
	DFID STARZ	106	2.8 billion	636,000
	Irish Aid	27	2.7 billion	608,000
CHAZ ²⁸⁵	Global Fund	160-250		6.2 million
	Other contributors (Netherlands, Irish Aid, DanChurchAid)			* Could not be determined
CRAIDS ²⁸⁶	World Bank	147 (2004) 381 (2005)	6.5 billion 18.9 billion	5.6 million
	DFID STARZ	41 (2005)	1.8 billion	404,000
<i>Minimum estimate of funds sub-granted to CSOs (2004-2005)</i>				US\$24 .2 million

²⁸³ Legend Consulting (2005).

²⁸⁴ Grant summaries provided by ZNAN.

²⁸⁵ Complete information was not available from CHAZ to document full extent of sub-granting per donor. Figure in final column should be taken as an estimate; data derived from CHAZ progress reports and disbursement requests to GFATM which detail issued sub-grants. Estimate of beneficiary organisations taken from CHAZ Annual Report 2005, and Republic of Zambia (2006b, p. 181).

²⁸⁶ Ministry of Finance and National Planning (2005); Ministry of Finance and National Planning (2006).

The sub-granting mechanisms described above are perhaps the most visible forms of support for CSOs in Zambia, but they are only one part of a complex picture. They are oriented on disbursing money to as many organisations as possible, as broadly as possible, and many of the grants are fairly small (for ZNAN, between US\$10,000 and 40,000). Funding at this scale is important to CSOs at a certain stage of development, but it is not sufficient as a sole source of funding for NGOs with larger-scale operations.

It is apparent that the funding environment for civil society in Zambia is changing. A number of bilateral donors are reducing their direct project-based funding for CSOs in favour of funding through conduits (such as the above) or through sector programmes. The US Government is the major exception to this trend and PEPFAR funding is one of the clear examples of large-scale project-based funding for civil society organisations. PEPFAR funding is channelled through US-based NGOs, universities and research institutions, and private contractors who often work in consortia with one another and enter into sub-granting arrangements with local NGOs and FBOs. World Vision International, Pact, Family Health International and Catholic Relief Services all sub-grant funds to local organisations in Zambia.

Other sources of direct project support exist for NGOs in Zambia, but the research found that mid-to-large-sized Zambian NGOs are getting 'pinched' in the current funding environment: community organisations are relatively well-catered for by ZNAN, CHAZ and CRAIDS, and international NGOs are able to access funds directly from donor agencies through their headquarters. Yet the traditional sources of support for national NGOs – from in-country bilateral agencies – are drying up with the shift towards budget support and funding through conduits.²⁸⁷ The Government of Zambia does not yet have the mechanisms in place – and possibly not the inclination either – to fund CSOs directly. Organisations are therefore being forced to expend ever greater energy and time on cultivating other sources of support – foundations, trusts, the private sector, international NGOs – with mixed success.

²⁸⁷ Student Partnerships Worldwide (2006).

PART IV

CASE STUDIES

ONDE ESTÁ A MULHER?
Foi traída pela SIDA.



The method for conducting the case studies is described in Part I Section 3.2.2.

It became apparent in writing up these case studies that each site tells a different story and highlights different issues. Accordingly, a uniform structure was not adopted for recounting all cases. The level and type of detail available about the community also differed greatly, and it was not possible to provide standard background information across all sites.

In compiling each of these studies we begin with a description of the place and the unique challenges facing each community in responding to AIDS. But beyond that we follow the lead of what appeared to us as most compelling and interesting about each community's responses to AIDS, with a view to appreciating and critiquing, as the case may be, existing attempts to build support for community-based efforts.

Having already developed a picture of each country from other components of the research process, there were inevitably preconceptions about what we would find. But we tried to set these aside in collecting narratives about community efforts to respond to AIDS in conversation with a large number of individuals and organisations, many of them well below the radar screen of 'national AIDS response.' What we found was in some senses refreshing, but also disturbing. It unravelled some of the official and usual accounts that we had heard at country level, and added a number of new perspectives to the picture.

Perhaps most notably, the case studies show that the interface of funders and CSOs has in some respects become a relationship conducted 'above the grassroots.' Our concern here is to consider the nature of the connection of community need and external assistance and to understand the emergence and role of CSOs in this context.

Through the case studies, the CSOs which we had previously encountered came to appear as an intermediary stratum representing communities in the activity of engaging with formal processes of seeking and receiving support. It became apparent to us in conducting these case studies that the reality of emerging attempts to tackle AIDS at community level also tells another story that never made it to our CSO survey and donor interview data collection efforts. To a large extent these stories are sobering accounts of the failure of authorities and funders literally to get to where they want to be – assisting struggling communities to cope with a scale of AIDS-related problems which is clearly much greater than existing resources are able address. But at another level they show the promise in supporting the attempts of community members to rally local resources and to provide assistance where there is often little or none from outside.

1. Ha Ramapepe, Lesotho

The case study was developed by Dr Mpolai Moteetee

1.1 Description of the site

The village of Ha Ramapepe is located in the lowlands, close to the foothills of the Maluti Mountains, about 20 km from Hlotse, the district centre of Leribe District. The village is situated 10 km along an all-

'To a large extent these stories are sobering accounts of the failure of authorities and funders literally to get to where they want to be.'

weather gravel road that splits off the main tarmac road from Hlotse in the direction of Pitseng/Katse. There is daily bus service from the village to Hlotse.



Winter in the foothills of the Maluti Mountains

Ha Ramapepe is one of three sub-villages that fall under the same chief. One of the other villages – Thaba Phatšoa – is home to an Outward Bound training centre that can host up to 50 people. Recent population statistics are not available for the village, but the 1986 Census placed the population of Ha Ramapepe at approximately 1,800 people.²⁸⁸

The village is comprised of separate homesteads, which are generally thatched rondavels or cinderblock buildings with corrugated roofs, surrounded by a fenced-in yard. The village is linked to a rural water supply system (a network of taps on the street). The toilets are primarily pit latrines.

The area is rich agriculturally, and farming and livestock are the main sources of livelihood. Most of the men who are formally employed are mineworkers, although retrenchments are now common. Economic opportunities for young people are limited. Fewer and fewer young men are finding employment in the South African mines.

While there are some local residents who pursue education up to tertiary level, most are reported to attend school up to secondary school level (Form C/3). Two primary schools (one government and one Anglican) and one secondary school are located within the village, as well as three primary health care facilities (one is a government clinic and the other two are run privately by nurses). Referrals are made to Motebang District Hospital in Hlotse. There are no other public facilities in the village.

1.2 AIDS in Ha Ramapepe

The national adult HIV prevalence rate in Lesotho, according to the 2004 Demographic and Health Survey, is 24%.²⁸⁹ Women overall have a higher prevalence rate than men (26% vs. 19%).

At 30%, adult HIV prevalence rates are higher in Leribe District than in any other district in Lesotho. Women in Leribe District have a

²⁸⁸ Sen, S. (1990).

²⁸⁹ Ministry of Health and Social Welfare (2005).

prevalence rate of 31%; prevalence among men is 28%. Prevalence rates among youth, while lower than adults, are also highest in Leribe District. Nationally, prevalence is also highest among people living in the lowlands (25% overall; 28% among women, 20% among men), where Ha Ramapepe is located. However, people living in rural areas have a lower HIV prevalence than those living in cities (22% vs. 29%).

HIV prevalence figures are not available at sub-district level in Lesotho and there is no way to know the HIV prevalence among residents of Ha Ramapepe. However, its location in the lowlands of Leribe District suggests that the HIV prevalence rate in the village could well be between 20 and 30%.

According to the area chief, who records deaths in his territory, there were 56 deaths in the village between July 2005 and June 2006. Twenty of these were believed to be AIDS-related.

Factors which may contribute to HIV prevalence in Ramapepe, according to community residents, include: the frequent use of alcohol in the village, particularly among youth (places where alcohol is sold are reported to be the main places of entertainment for young people); the fact that many men from the village had worked in the mines in South Africa; and the large number of widowed and/or separated women who became migrant workers within Lesotho.

1.3 Responses to AIDS in Ha Ramapepe

At the centre of responses to AIDS in Ramapepe is the work of the local branch of the Society for Women Against AIDS in Africa Lesotho (SWAALES, or simply SWAA). A local youth group, a support group linked to the office of the First Lady, and community health workers (CHWs) affiliated to the local clinic are also present in the village, although in most cases their activities appear to link closely with those of SWAA.

All respondents identified activities by SWAA as the key activities occurring within the village. The two main pillars of their work are home-based care and support for orphans and children.

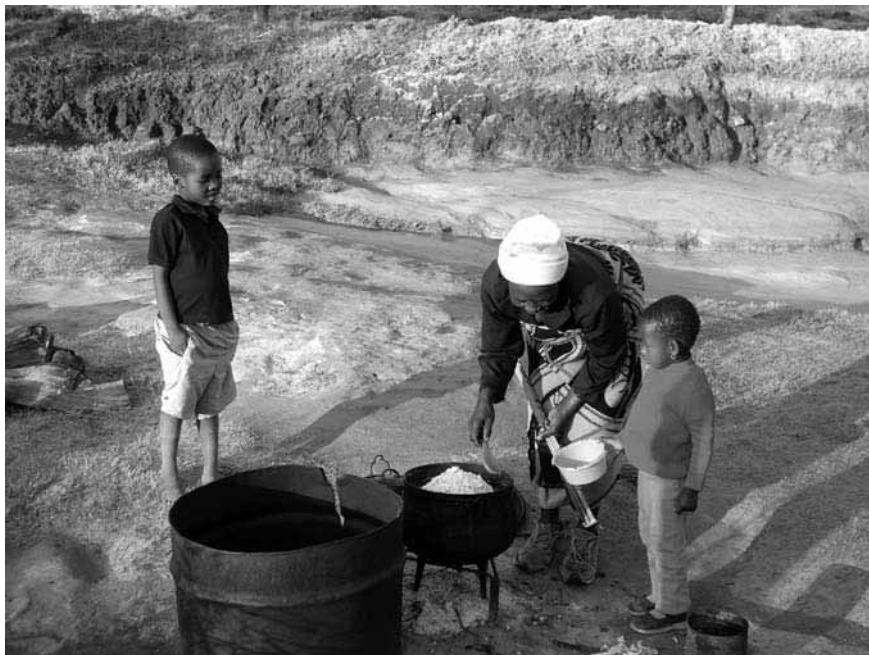
Home-based care activities include house-to-house visits where SWAA members support both the patients and family members/carers where these are present. They care for patients holistically, from bathing and cleaning patients to doing laundry, providing food, cooking for the patient and feeding them, providing basic medicines and drugs (pain killers, oral gels, disinfectants), and dressing sores. They also counsel HIV-positive individuals and members of the household.

Work with orphans emerged from the home-based care activities which heightened the women's awareness of the plight of children whose parents or caregivers had died. The women cook meals for children on a daily basis at the home of one of their members. When donations of second-hand clothing are received, they distribute these among needy children in the village.

According to the area chief, who records deaths in his territory, there were 56 deaths in the village between July 2005 and June 2006. Twenty of these were believed to be AIDS-related.

SWAA also engages in local awareness campaigns, including candle light ceremonies in remembrance of people who have died of AIDS and promotion of HIV testing. It has worked with the Lesotho Association of

Non-Formal Education (LANFE) to providing literacy classes in nearby villages.



Local women provide afternoon meals to orphaned and other vulnerable children in the village

With the support of SWAA, including mobilising limited resources to get them started, a local youth group has become involved in gardening and crop production as a form of income generating activity. Given the high unemployment rate in the area, this is seen as a strategy for keeping young people busy and productive. Some members of the group have been trained in peer education and HIV/AIDS education activities have been integrated into the group's work. The District AIDS Coordinator in Hlotse, through her familiarity with the SWAA group, has provided the youth group with seeds, fertilizer and tools for their gardening project.²⁹⁰

The local health centre offers HIV Testing and Counselling (HTC), among other health services, and has cooperated with SWAA to promote community-based HTC in Ramapepe. Community Health Workers affiliated to the health centre are equipped with home-based care kits, gloves, basic medicines and condoms for distribution. They also receive training from the nurses at the centre.

The Office of the First Lady of Lesotho supports community-level support groups linked to the wives of Members of Parliament in constituencies across the country. A support group linked to the wife of the local MP was set up in Ramapepe well after SWAA was already established in the community and was 'launched' at a ceremony attended by the First Lady. Its members were drawn from other women in the community who had not joined SWAA. However the group appears not to have taken root. Although it has distributed some second-hand clothes, it is not seen to be involved in home-based care, which is the typical focus area of support groups in Lesotho.

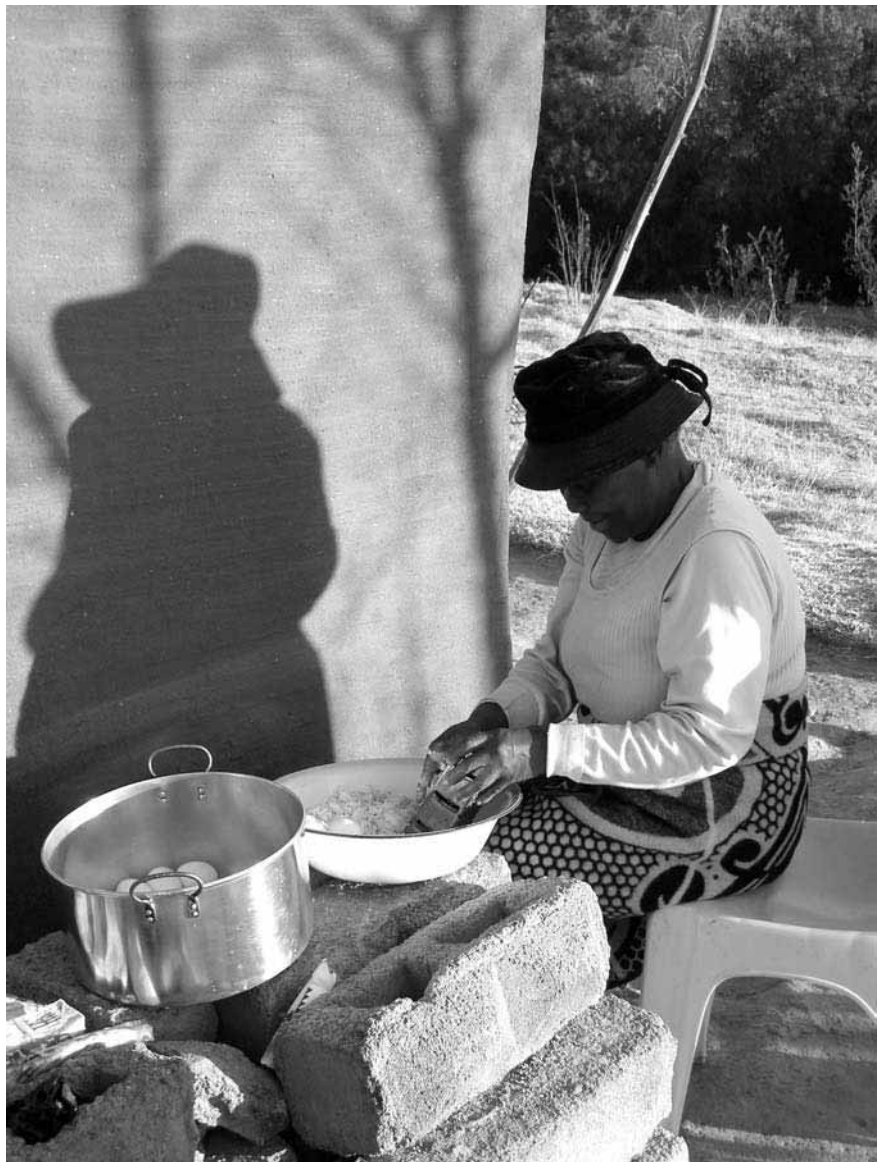
1.4 The evolution of SWAALES in Ramapepe

SWAA started its operations in the area in February 1997. The chair of the organisation took part in training conducted for members of the Anglican

²⁹⁰ Support for these supplies comes from Global Fund financing provided to each DATF in the country.

Church Mothers' Union in Maseru by someone who also happened to be the chair of SWAA and a medical doctor. The woman from Ha Ramapepe realised that AIDS was accounting for the high mortality and morbidity in the villages and that there was a contribution that could be made at the local level. Upon her return to the village, she spoke with other concerned women who then organised themselves into a local chapter.

SWAA Ramapepe approached the Ministry of Health and Social Welfare and the district hospital and requested to be trained in the care of chronically ill patients, including those with hypertension and diabetes, with the intention to care for and emotionally support the affected and infected. While their concern was for patients with AIDS, they decided to include other diseases because of the stigma associated with AIDS. The hospital provided them with training and they began to provide home-based care services.



Meals are prepared and served outside the home of one of the support group members

As they continued, the women of SWAA realised that there was an emerging problem of orphans in the village, linked to the many AIDS-related deaths. They decided to expand their work to support these orphans with whatever resources they had or could mobilise and focused especially on feeding them.

From the beginning, the basic model of SWAA in Ramapepe has been that of a volunteer-driven and supported organisation. SWAA members donated from their own households what essential goods they were able to – e.g. food, soap, supplies – and would pay out of pocket to help patients get to the hospital. They would also help families pay for burial costs. Many of them grew vegetables in their own plots and contributed these to the collective ‘food kitchen’ that was run out of the home of one of the women. The group never wrote a proposal for support to any external organisation.

The project gradually became known outside the village and SWAA Ramapepe began to network with other groups and institutions. Through these links it began to receive external resources and training. The Leribe District AIDS Coordinator in Hlotse heard about their activities and invited the leaders to attend the District AIDS Task Force meeting at which they shared information on their activities.²⁹¹ Through this link, they began to receive more HBC supplies and medicines/kits from LAPCA channelled through the DAC.

Through the Anglican Church, overseas visitors once came to the area and put on a play as part of a community development programme. Following this, they invited some of the local orphans to Maseru for another phase of their work. At the end of the visit, the children, accompanied by two adults from SWAA, were taken shopping and bought items that were identified by the adults to be priority needs.

Through the national SWAA office in Maseru, SWAA Ramapepe began receiving regular deliveries of food supplies to use in preparing daily meals for the local orphans.²⁹² This support began *after* the women had already set up a feeding scheme using their own supplies and resources.

More recently, SWAA Ramapepe has taken steps to get involved with a project based out of Hlotse and linked to the Ministry of Forestry which provides fruit tree seedlings and training to orphans on how to care for the trees. The project is intended both to generate income and to engage the children in a productive role in the community. SWAA Ramapepe has already undergone the necessary training and discussions to join the project, but a delay in allocation of land has stalled this project for the time being.

As the organisation grew, it received training from LANFE in basic project development, project management, record keeping and financial accountability. CARE Lesotho has also provided it with ‘capacity-building training.’ SWAA Ramapepe has also received donations from both private individuals and Lesotho Planned Parenthood Association.

The group in Ramapepe has become something of a local example in the district and a number of similar support groups have sprung up in seven nearby villages. The District AIDS Coordinator in Hlotse pointed to the group as an example of a well-established, well-trained local organisation that is starting to play a leadership role in relation to other emerging groups in the area. For example, SWAA Ramapepe represents support groups from its area at the DATF meetings and reports back to them on key decisions and issues.

²⁹¹ The DATF is a multisectoral committee that meets monthly for the purposes of sharing information and ensuring coordination of activities within the district. All types of CSOs active in HIV/AIDS are expected to participate in this committee.

²⁹² The funding for this support appears to originate with a US Government-funded agency, although the women in the village know only that it is ‘the Americans’ who are behind the food donations. A group of Americans visited Ha Ramapepe to assess the work of the group before committing to the support.

1.5 Issues around funding and resources

Over its nearly 10 year history, SWAA Ramapepe has gradually become known in its own district and beyond and has built up a variety of institutional linkages which have attracted new resources. Some of the inputs of training and resources described above have contributed to this growth and allowed the group to work at a greater scale.

However this expanded resource base has not been unproblematic. Members of the group have been thankful for the offers of support and the donations made to the group, but also expressed a certain frustration that they do not have more control over these resources and that there isn't more consultation *in advance* about what resources are most needed or how often certain types of supplies need to be replenished.

One example given pertained to the overseas visitors who took some orphans from Ramapepe to Maseru for a few days and then wanted to buy them some things to take back to their village. The overseas visitors wanted to buy the children toys and blankets, and it took the intervention of the SWAA chaperones to convince the hosts that what the children really needed most were shoes. Although a small example, it characterises the type of well-intentioned charity that a CBO like SWAA Ramapepe often finds itself receiving.



Women are at the heart of community-level support groups across Lesotho

Members of the group are thankful for offers of support and donations made to the group, but would prefer more control over the resources and more consultation in advance about what resources are most needed.

A more important example, however, relates to the donations of food received from the national office for orphan support. Although the women in Ramapepe have been told that they have been allocated funding for feeding orphans, they are not clear about how much funding has been allocated in their name, nor the duration of this funding. The organisation does not see any of the funding; supplies are procured centrally and delivered to them. The amount of food as estimated by the central office does not always match the amounts required, based on their own experience. Often the supplies that are provided run out before the end of the month and the difference has to be made up out of their own pockets or with supplies from their own households. However,

they believe that it is important to provide the meals consistently so as not to lose contact with the orphans who have come to depend on the food and for this reason they bridge the gap in supplies themselves. The organisation has received training from LANFE in project management and financial management and would prefer to receive and manage the funding directly, as it would give them greater control over purchases. However under the funding scheme, they appear to have been designated as a recipient of support through funding received and managed at a central level.

Another sign of this is the fact that, as a condition of receiving the food supplies, SWAA Ramapepe was required to designate two individuals to act as coordinators of the project. They did this, although the request itself suggested logic that was antithetical to the collective way in which the group had been working to date. At the meeting where this requirement was discussed, it was not necessary to nominate or designate anyone among them, as two people volunteered to act in that capacity, seeing it as a reflection of the volunteer ethos which pervades the organisation.

SWAA's members report that they work without any stipends or remuneration. There is a wish that some type of support could be available for them, particularly given how much and how often they have donated supplies from their own households for the benefit of others. The carers for the orphans are mostly elderly women and expressed a wish that the SWAA members/volunteers could receive a regular incentive given their devotion to a good cause.

1.6 Achievements and challenges

The most visible and most valued AIDS response activity in the community is the home-based care, provision of medicines, and feeding of children conducted by SWAA. The members were applauded for their empathy and assistance to people in need.



The support group's latest project: children from the village will be trained to care for fruit tree seedlings

'They help us a lot by feeding these children. We do not have any vegetables and the vegetables the children are consuming are from their gardens.'

- A grandmother in the village, speaking about the SWAA women

'Without their support the children would go to bed hungry, because I am old and can no longer be as economically active as I used to be.'

- Carer/grandmother of 5 orphans

There appears to be genuine support within the community for SWAA's work – a fact which may in part be attributed to their practice of informing the Chief and the local councillor of the activities they conduct and the forms of support being received from outside parties.

Interviews with community members suggest that the community as a whole is increasingly 'paying attention' to AIDS issues. In addition to the outreach work being conducted by SWAA, this may be linked to the HTC activities being conducted by the community health workers at the home of the SWAA president and the discussions about AIDS being initiated by the youth group.

SWAA continues to deepen and diversify the type of work it conducts. The fruit tree project, in conjunction with the Ministry of Forestry, will add a new dimension to their activities if the issue around the land allocation can be resolved. Everyone interviewed in the research agreed that there is a problem around the land allocation, but there were differing opinions about whether the Chief or the local councillor was ultimately responsible. The recent changes in local government in Lesotho, linked to the process of decentralisation, may have contributed to the confusion over jurisdiction for local land issues.

Apart from this issue, the organisation's other main desire at the moment is to move into some type of office space so that the members can separate their organisational affairs from their own households. Until now, SWAA Ramapepe essentially operates out of the homes and yards of its core members.

The organisation thus far has grown on the basis of local connections and word-of-mouth. The group has never applied for funding and does not necessarily know where or how to begin with this process. Although the organisation does not presently have a bank account, they know how to open one should it be required by a potential funder.

2. Bangwe Township, Blantyre, Malawi

The case study was developed by Alister Munthali

2.1 Description of the site

Blantyre is the most populous city in Malawi and occupies a geographical area of about 23,000 hectares. It was founded in 1800 by Scottish missionaries and over the next 100 years grew to a city of 6,000 people. With colonialisation and the subsequent introduction of a hut tax by the colonial administrators in the surrounding agricultural districts of Thyolo, Chiradzulu and Mulanje, people migrated in massive numbers to the City of Blantyre where they could work for wages. In addition to people from these surrounding districts, there was also a significant movement of people from Mozambique which contributed to population growth in the city.²⁹³ In the 1998 census, the population of the City of Blantyre was estimated at 500,000, up from 197,000 in 1977. The population of Blantyre more than doubled over the intervening 20 years and is projected to double again by the year 2020.²⁹⁴

According to the Integrated Household Survey, the proportion of people living below the poverty line is much higher than in Lilongwe, the capital

²⁹³ Chikhwenda, E. (n.d.).

²⁹⁴ National Statistical Office (2003).

city of Malawi.²⁹⁵ Within the City of Blantyre, it is estimated that 70% of the population of Bangwe Township, the focus of the case study, lives below the poverty line.



Along the main street of Bangwe Township

2.2 Responses to AIDS in Bangwe Township

Fourteen NGOs and CBOs were identified in Bangwe Township and the following were visited: Active Youth Initiative for Social Enhancement (AYISE), Umunthu Foundation, Samaritan Trust, Tithandizane CBO, Caring for Persons with Disabilities (CAPDI), the Salvation Army and Bangwe HIV/AIDS Self-Help Initiative (BAHASI). The majority were initiated by members of the community in the early 2000s. They generally operate within the confines of Bangwe Township although some, such as Samaritan Trust, are linked to larger organisations and operate in a wider catchment area that extends beyond Bangwe Township.

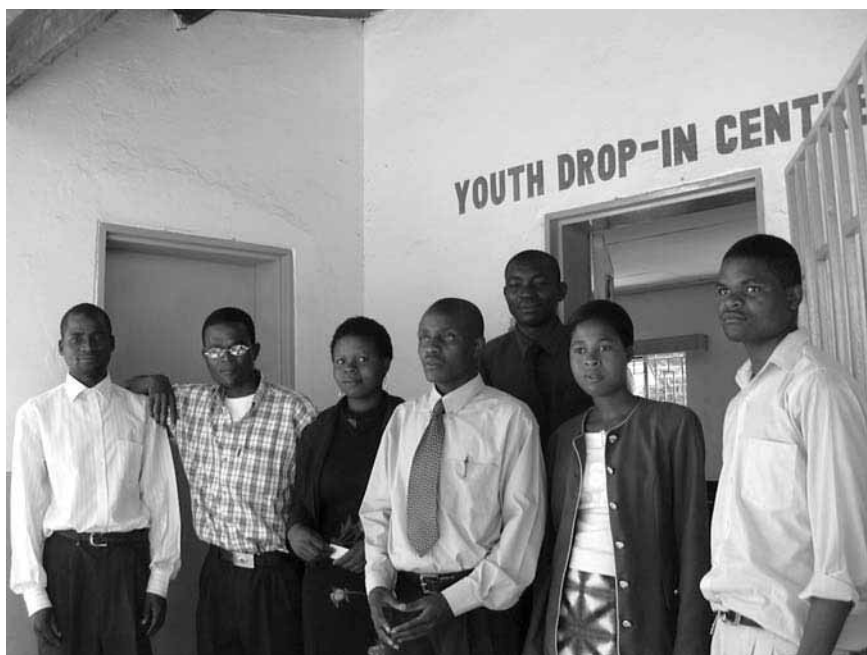
Some of these organisations are registered with the Office of the Registrar General and the District Social Welfare Office – a requirement of certain funding agencies and membership organisations such as CONGOMA (Congress of NGOs of Malawi). A few of the well-established organisations, such as the Samaritan Trust, Umunthu Foundation and CAPDI, have boards of trustees in addition to an executive management committee.

The most well-established organisations operate from their own offices, and others rent premises. However, the majority of organisations operate from premises donated by ‘well wishers,’ such as churches. There is much ‘under the radar’ and in-kind support for these organisations, apart from the official funding that some of them receive. Staff are comprised mostly of volunteers from the community working alongside a few formally employed staff members. Only AYISE and the Samaritan Trust have had expatriate volunteers work with them. During the interviews, it was found that most of the CBOs in Bangwe Township operate on a voluntary basis with limited or no external financial assistance.

The organisations target diverse groups of people, including street children, orphans, people with disabilities, chronically ill patients,

²⁹⁵ National Statistical Office (2003).

people living with AIDS, widows, young men and women, the elderly and other vulnerable groups in the community. The AIDS activities that are being implemented by these organisations at community level include the provision of HIV testing and counselling services, orphan care, distribution of information, education and communication using drama and sport to reach people, providing community home-based care and promoting behaviour change for prevention. Some organisations make referrals to health centres for sexually transmitted infections and other reproductive health issues. The organisations involved with home-based care for the chronically ill also provide food, soap, assistance with laundry and household cleaning, and prayer and spiritual support.



Youth taking a lead in AIDS responses and at the same time seizing opportunities for career development

Given the poor socio-economic conditions in this township it is not surprising that many of the activities are aimed at mitigating the impacts of AIDS rather than on AIDS-specific services related to prevention, support and treatment. For example, the Samaritan Trust works to reintegrate street children with their families and to get children back to school. It provides material support, such as food, clothing, blankets and soap, to the street children and their families. CAPDI is broadly oriented on disability issues and works to create awareness about disability and human rights. BAHASI is involved in crop and vegetable farming; at the time of the research, they had 700 heads of cabbages in the garden and had harvested 15 bags of maize in the previous growing season.

Given the poor socio-economic conditions in this township it is not surprising that many of the activities are aimed at mitigating the impacts of AIDS rather than on AIDS-specific services related to prevention, support and treatment.

Growth of CBOs

While some of the larger organisations, such as Samaritan Trust and Umunthu Foundation, have relatively well-established and stable operations, it was clear that the smaller organisations are still quite fluid in terms of the types of activities they conduct. There were accounts of organisations scaling up particular areas of work, while others were cutting back on activity. This can be attributed to a range of influences, not least of which is the resource environment – i.e. the funds available for particular kinds of activities, which has a strong moulding influence on what organisations undertake.

It is important to take stock of how these community-based organisations evolve. There are certainly some major differences between them. The Salvation Army is a national organisation and was initiated at a national level, although its programme was adapted to local community needs and staffed by community members. But as an institution it was conceived elsewhere and its organisational culture did not have to evolve in the community – it only needed to be adapted to it. CAPDI, by contrast, started out much like a club or informal association within the community. Its members would meet at various venues within the community and not necessarily on a regular basis. Over time, it has grown into a more formalised CBO and now has its own office space. It has made efforts to establish working relationships with other organisations and the church, which has helped it gain recognition and assistance from partners. BAHASI shows a different model of growth. It has changed its area of focus over time. Beginning with the needs of orphans, the organisation has since come to incorporate widows into its programmes. Its evolution has partly been a result of funding opportunities, but importantly it has been driven by its encounters with needs in the community. Another organisation, Tithandizane CBO, grew through focusing on orphans and child-headed households and then contracted its operations within Bangwe, as it scaled up its operations in other areas. AYISE grew from being a modest organisation on the basis of efforts by largely one person, into being an organisation employing several dozen people. Whilst still limited to operations in the area, it is now at the point of considering whether it should also operate as a conduit for donor funds.

Each of these initiatives has gone through a different growth trajectory. Important issues have faced organisations as they have become increasingly more established, started paying salaries, expanded their range of services and opened other branches. Some organisations have sought outside assistance in managing decision making in these areas and others have coped on their own. Such processes have contributed to the establishment of these organisations as independent entities which, whilst based in a community and related to it, have increasingly developed their own organisational cultures as they have grown.

2.3 Major challenges faced by the CBOs and NGOs in Bangwe

The major challenge faced by CBOs and NGOs in Bangwe Township is the general lack of material and financial resources to meet the needs of the communities that they are serving.

In many instances, members and volunteers use their personal resources in order to cover the operating costs of the organisation. This limits the scale and scope of what they are able to accomplish and prevents expansion into other districts and areas. A number of CBOs, for example, are involved in home-based care. One of their major concerns is the fact that many of their clients are malnourished and require more nutritious food. However the CBOs are not in a position to meet this need and they can see how the absence of food is undermining their patients' overall well-being. Many of these organisations have also been forced to limit the number of clients they support because they visit people on foot due to a lack of transportation.

The lack of financial resources has prevented some CBOs from renting offices, which has made it difficult for the CBOs to build up their

operations and to provide a space for members of the community to visit. One CBO has been granted the use of a local church, however when the church requires the use of the space they have no office. This CBO mentioned that some of its members are from other denominations – a fact which is problematic for some members of the church and has led to tensions.



Mapping and locating community services within the bigger picture of AIDS responses in Malawi

In the case of the better-established NGOs, small salaries are provided through the budgets of the projects they are implementing. However, in most of the organisations, members work on a voluntary basis and only occasionally receive small allowances.

Some of the younger organisations require access to training linked to the services they provide. Some CBOs are involved in support for orphans and the provision of home-based care, for example, yet have not ever received any specialised training in these areas.

2.4 Funding and support for AIDS activities

Access to funding varied amongst organisations. On one end of the spectrum is the Samaritan Trust, whose Bangwe Township office is not involved in fundraising as this is done in another office. However most organisations visited are located at the other end of the continuum – they are involved in on-going efforts to secure funding for their work and have found this to be a difficult and frustrating experience. Some organisations in this community have written and submitted proposals for funding through the National AIDS Commission and international funding agencies. While these have been successful in a few instances, the majority of organisations have not succeeded in accessing support through these channels. What emerged from the research was that a very few organisations, mainly the Samaritan Trust, AYISE and Tithandizane CBO, had relatively well-established sources of funding, while the rest of the organisations operate with little or no assistance.

There were a number of problems that were mentioned by organisations in accessing funding. Among the younger organisations, the main problems included a general lack of information about how funding for AIDS activities can be accessed, a lack of knowledge of the umbrella

organisations through which they can apply for funding, and a general lack of capacity and experience in proposal writing. It was noted that it is too expensive to hire consultants to assist with proposal writing, even though this option is known to exist. Among the more established organisations, such as Umunthu Foundation, there was greater familiarity with the procedures for applying for funding, but frustration with the bureaucracy involved in accessing funds. Even if projects are approved for funding, it sometimes takes a long time before the funds are actually disbursed. Other concerns include the fact that some funding agencies do not accept proposals directly, but require that they are submitted through an intermediary (e.g. requests for support from UNICEF must be submitted through the District Social Welfare Office). These procedures and requirements are not always well understood.

Registration appears to be a barrier to access to funding in some cases. Many agencies require proof of registration with either the Ministry of Women and Child Development or the Registrar General. One organisation felt that it had missed out on a number of possible funding opportunities due to delays in the registration process. It took nearly two years for them to be registered.

There were no funding agencies that were viewed as 'easy' to work with. Rather, the overall impression is that funding organisations are 'mean' and overly strict about details. The CSOs expressed the view that there is a *de facto* bias against small organisations who struggle to access small amounts of funding and to build a track record. They perceive a tendency for already funded organisations to continue to receive funding.

Major sources of funding

Even those CSOs that are relatively well-supported in Bangwe Township are accessing support from many sources that fall outside the main international funding flows. The Samaritan Trust has a relationship with some organisations and individuals in the Netherlands who send funds; locally they get assistance from private companies such as Illovo Sugar, Rab Processors, Bakhresa Grain Milling and Unilever South East Africa. Tithandizane CBO is funded by the Projects Office of the Synod of Blantyre and once in a while visiting church members from overseas also provide donations.

Most CBOs, however, are still struggling to be recognised and are operating on the basis of personal contributions, income generating activities, and ad hoc donations of clothes and medical supplies.

2.5 Sustaining AIDS activities

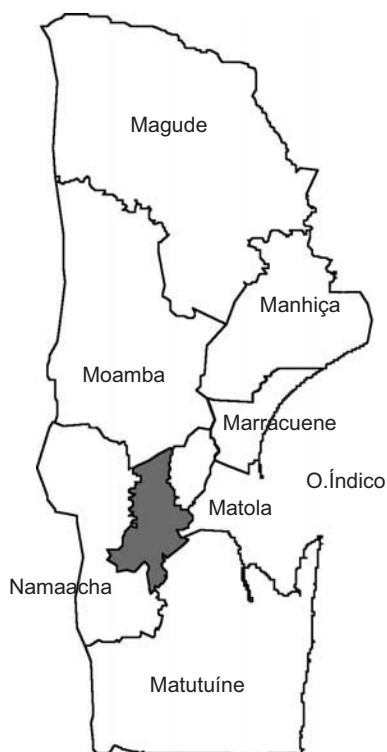
Larger CSOs face greater pressure in sustaining their activities. The Samaritan Trust, for example, noted that it is unlikely that they could sustain their activities without outside support. This reflects the greater professionalisation of this CSO, which has grown to a scale where it has come to depend on a particular level of resourcing and would be institutionally vulnerable to cutbacks. Smaller CSOs were more likely to feel that they could sustain their AIDS activities irrespective of funding flows. At Tithandizane CBO, for example, there was a belief that the home-based care work could be sustained as it was already heavily reliant upon locally available resources, including herbs and

CSOs in Bangwe Township expressed the view that there is a bias against small organisations who struggle to access small amounts of funding and to build a track record. They perceive a tendency for already funded organisations to continue to receive funding.

pain relievers from local sources and the contributions of neighbours and other community members. This was similar to what was reported at BAHASI, where it was expressed that home-based care and food gardening could continue without external funding.

The following is a summary of the needs expressed and suggestions made by the CSOs in Bangwe Township relating to how the funding environment could be improved:

- There is need to build CSO capacity to write proposals and to better promote available sources of funding. Financial management is an area of weakness among CSOs.
- Funding agencies should make their budget ceilings known to prospective beneficiary organisation so that they tailor their proposals accordingly.
- Funders should visit CSOs to hear some of the problems that they are facing in accessing funding. CSOs expressed that donors' reliance on umbrella organisations means that they are failing to fund organisations that could make impact on the ground.
- When funding is awarded, it is important that it is disbursed promptly so that activities can be implemented within the agreed period.



3. Boane, Mozambique

The case study was developed by Dirce Costa

3.1 Description of the site

The district of Boane is one of eight districts in Maputo Province. It is located approximately 30 km from the city of Maputo, and has a population of 81,000 inhabitants.²⁹⁶

According to 2005 estimates, 42% of the population of Boane is under the age of 15, 53% are women, and 68% live in urban areas. Illiteracy among women stands at 57%, compared to 35% among men. Overall school attendance in the district is 47%, although a significantly higher proportion of boys than girls attend school. It is not uncommon for marriages to occur among children as young as 12 years old.

In the early 1990s Boane benefited from an investment of US\$1.3 billion for an aluminum smelter, Mozal I. The area is the country's top-ranking producer of aluminum and maintains a strong position in the international market. The construction of Mozal II was completed in 2003, resulting in a doubling of production. In recent years, Boane has shown clear signs of economic growth linked to the aluminum industry.

The Maputo–South Africa highway that runs through Boane is an important infrastructural feature that has also contributed to the development of the region and presents another important source of local income.

Agriculture is the basis of the local economy. The main crops are vegetables, maize, cassava, beans, banana and citrus; cattle breeding and poultry farming are also important. The NGO Médicos sem Fronteiras

²⁹⁶ Metier – Consultoria & Desenvolvimento Lda. (2005).

(Doctors without Borders) estimates that 5% of the district's population is in a vulnerable situation regarding food security.

At the district level the state is represented by the Administrator, who is the head of the district. The government is organised into district directorates, each of which oversees a specific sector. The directorates dealing with AIDS-related issues are the Health and Women and Social Affairs Directorates and the District Aids Council (DAC). The main roles of these organisations are the coordination and control of the operations of all public bodies dealing with health, social affairs and AIDS.



A town located on the highway to South Africa, near a major factory

3.2 AIDS in Boane

Mozambique is not only one of the poorest countries in the world, but also one of the countries heaviest hit by the HIV epidemic. The national prevalence rate has risen from 3.3% in 1992 to an estimated 14.9% in 2004, placing Mozambique among the ten most-affected countries in the world.

There are an estimated 1.6 million people in Mozambique who were HIV-positive in 2005-2006,²⁹⁷ 58% of which are women. Widespread gender inequities in the country contribute to this pattern of HIV infection. The HIV pandemic has and will continue to have a significant impact on Mozambique's key human development indicators, such as health status and life expectancy, as well as on the social and economic outlook.²⁹⁸

In 2002 the estimated HIV prevalence for adults (aged 15-49) in Maputo Province where Boane is situated was 17.4%. This represents the third highest prevalence rate in the country after Sofala (26.5%) and Manica (19%), both in the central part of the country.²⁹⁹ The high mobility of people and goods along Beira Corridor is believed to be the main contributing factor spreading the epidemic in these other two regions. Maputo Province is relatively urbanised and its high prevalence typifies the elevated prevalence found in urban areas across the region.

There is no official information about the trends of the HIV epidemic in Boane district. However, data from HIV antenatal surveys by the Ministry of Health can be used to obtain estimates of the epidemic in

²⁹⁷ MISAU/INE (2004).

²⁹⁸ UNDP (2004).

²⁹⁹ MOH/NIE (2004).

the area. In Maputo Province where Boane District is located, there are two sentinel sites, in Manhiça and Namaacha districts. The table below presents the respective prevalence rates for the period 2000-2002:

Sentinel Post	HIV Prevalence (%)		
	2000	2001	2002
Health Centre Manhiça	15.7	15.0	14.7
Health Centre Namaacha		16.7	21.0

Namaacha is the district neighbouring Boane and has similar epidemiological vectors to Boane. Records from an extensive international NGO-led voluntary programme in Boane show growing numbers of people testing and rising prevalence in this voluntary sample.³⁰⁰ The table below presents annual data from VCT in the district.

Year	Tested	HIV Positive (%)
2002	1120	16
2003	1415	19
2004	2506	24
2005	3218	27
2006*	557	30

Source: ADPP monthly bulletin for 2002-2005; District Health Directorate for 2006.
*data for July, August and September

3.3 Responses to AIDS in Boane

While the emphasis of early responses to AIDS was strongly on prevention, the focus in the last few years has shifted to include care and treatment. In early 2002, the Ministry of Health adopted a policy to prevent mother-to-child transmission and treat opportunistic infections through the public health system.

District Directorate of Health (DHD)

The District Directorate of Health (DHD) is responsible for health in Boane district. It establishes the public health strategy for the district, as well as the specific programmes for primary health care. This level of care in the district is provided by five public health centres, each with a maternity ward, and two public and four private health centres without maternity wards.

The Ministry of Health began financing HIV tests, CD4 counts and ARV treatment in July 2006.³⁰¹ In October 2006, the DHD began providing anti-retroviral treatment to 35 people and a target was set of bringing 50 new patients on to treatment each month.³⁰²

Apart from these services a PMTCT programme financed by the Elisabeth Glaser Pediatric AIDS Foundation is in place in the public health units. Analysis of CD4 counts is undertaken at Hospital José Macamo, a secondary health facility, located in the city of Maputo.

District AIDS Commission (DAC)

Another public institution with direct responsibility for AIDS response at district level is the District Aids Commission (DAC), the equivalent body of the NAC at local level. The executive secretary of the DAC is the

³⁰⁰ Voluntary testing data does not necessarily reflect population trends, although in this instance given the general population outreach of the programme, and the numbers of people tested, it is probably broadly indicative of growing prevalence over the period; or at least lack of containment.

³⁰¹ The ADPP programme in place since 2002 was interrupted in December 2005. A big effort on the part of the DHD to get funds from different donors allowed the testing programme to start again in July 2006 with Mozal's support. However the testing used to be done at six posts and now is done at one health centre and three posts.

³⁰² According to the medical doctor in charge of ARV treatment at the MoH there is a limited quantity of ARVs available to be used through the Mozambican National Health Service. The provision of ART demands an organisational set-up and trained technical staff to provide the treatment. Experience has also shown that, due to stigma, patients do not enter ARV treatment despite its availability. In this context a quota was established in order to monitor its use. Changes in the quota will be introduced according to patient behaviour and improvements in the organisational set-up.

District Health Director. According to her, the DAC this year received instructions from the provincial AIDS coordinating authority to present proposals to implement AIDS activities for health personnel and to develop district AIDS programmes. The DHD has no funds available from the NAC for specific AIDS programmes and there is no district or provincial strategy in place.

District Directorate of Women and Social Affairs

The official role of the district Directorate of Women and Social Affairs is to support orphans and other vulnerable children and people with HIV. However, in practice, its role appears to be extremely limited. One of its main areas of activity is to assist people in need to obtain milk from the National Institute of Social Affairs.

Significant non-governmental groups involved in AIDS response

During the period 2001-2005, responses to AIDS were largely undertaken by local and informal organisations. Their role was particularly important because of the weak state response. There are a significant number of NGOs, CBOs and FBOs working in Boane to respond to the growing AIDS problem in the area. According to a list of projects provided by the District AIDS Commission there are 12 organisations operating in Boane. Data from other sources, however, refer to more than 24 organisations operating in the district, showing that there is a stratum of organisations that operates independently of official channels and coordinating mechanisms.

Information gathered in meetings and interviews with different actors operating in Boane led to the conclusion that many of the recognised organisations do not actually implement specific programmes and there were many claims and much suspicion that some of them mismanage funds or at least do not use them for their intended purpose. There is in general in Mozambique a high level of suspicion around management of funds, both in government and civil society.

The most significant non-governmental groups acting in the community are:

- *Centro de Esperança de Bebeluane*: Main activities include education and information activities through debates and film screenings, voluntary testing (approximately 75 people per month) and orphan support.
- *Pfukhani*: Main activities include education and information activities in the areas of prevention, advocacy, discrimination and stigma, impact mitigation and partnership with other organisations working on AIDS response.
- *Casa do Gaiato*: Main activities include education and information activities through debates, theatre, plays, and sport activities; training of activists, counsellors, and trainers; support to people with HIV and home-based care; nutrition and school material support. They focus in particular on young people (both in and out of school), orphans and other vulnerable children, and community members.
- *Kuphedza Association*: Main activities include distributing goods to orphans and people with HIV; home-based care; and transporting patients to health units for anti-retroviral treatment.

According to a list of projects from the District AIDS Commission, there are 12 organisations operating in Boane. Data from other sources, however, refer to more than 24 organisations in the district, showing that there is a stratum of organisations operating independently of official channels and coordinating mechanisms.

- *Kindlimuka*: Main activities include distributing goods to orphans and people with HIV; home-based care; and transporting patients to health units for anti-retroviral treatment.
- *Kulima*: implementation of an AIDS project to support people with HIV; information and education sessions on the disease; credit support for income generation activities; community education; and organisation of monthly workshops at community level to discuss different topics such as education, health, justice, security and AIDS.
- *Tembeka* is a faith-based organisation comprised of parish priests from 20 churches in Boane. Its main activities include spiritual and material support to 60 people with HIV and 400 orphans. Material support includes school material for children and food baskets provided every three months. A maximum of 20 orphaned children from each church are aided by the organisation.

The activities undertaken by local organisations³⁰³ are centred on prevention through sensitisation campaigns where different topics related to AIDS are addressed, including sexually transmitted infections, voluntary testing, home-based care, and orphans and vulnerable children. Organisations employ various methods to get the message across including presentations, theatre plays and sports activities. Training of activists is another area of activity.

Some organisations, such as Kindlimuka and Kuphedza, focus their activities on supporting orphans and vulnerable children and people living with AIDS through provision of food, cleaning materials, school materials and second-hand clothing.

There is no notable coordination between the activities of the various organisations in the district. This may be part of the reason why there are so many small organisations ‘doing everything’ and little evidence of either scale or specialisation amongst these organisations. There is also little evidence of linkages to government programmes, although these are themselves so limited as to offer little tangible benefit. It must be concluded that development of AIDS response CSOs in this area of Mozambique is still largely unsystematised, unsupported and limited in scale and civil society is barely supported by official government institutions and initiatives.

3.4 CSO experiences in accessing funding

The main sources of funding for AIDS activities in Boane District are Mozal (private sector factory), NPCS (the provincial AIDS coordination structure), Spanish Cooperation, ActionAid and Geração Biz (a government project to support youth health and education programmes). But these represent only limited funding sources and CSOs are largely at sea in terms of knowing how to and being able to access funds.

The relations with NPCS are reported to be very difficult due to the complexity of the forms which must be submitted for funding. A number of the organisations in the district say that they do not have the human resources to satisfactorily complete funding forms or proposals. CSOs also see the NPCS as bureaucratic and slow-moving and they say that it takes an excessive amount of time for them to review project proposals. For example, Casa do Gaiato, an organisation dealing with orphans and

³⁰³ The information presented here was obtained in a meeting organised by DAC on September 22, 2006 and through interviews with four local organisations: activists of Joaquim Chissano Secondary School, Pfulani, Casa do Gaiato, and Kindlimuka.

other vulnerable children, had a project approved by NPCS in 2005, but nothing had been disbursed by the latter part of 2006. This created significant problems as they had planned based on the project approval and urgently had to secure bridging funds.



No gloves: using plastic bags for home-based care

In this context, very few organisations have had access to AIDS funds. The volume of AIDS funding in Boane is irregular and small and this means that programme scale is also small. Some organisations have managed to access funds to implement activities, but few organisations have secure funding and amidst accusations and suspicions of mismanaging funding the entire funding environment is problematic. The result is that organisations tend not to have grown to the point of providing consistent services and there has been growth of many small initiatives which have little hope of making a significant difference apart from in their immediate surroundings.

Even in areas where support is relatively easy to provide, such as providing supplies for home-based care, there seems to be an absence of systematic support. Home carers at Kindlimuka use plastic bags for gloves when they care for bed-ridden patients and contributions from CSOs members, many of whom have very few resources, are an important element of support for the organisation in its efforts to support orphans and people with HIV. This organisation also has been promised support for renovating a building for its use from a local industry, but this kind of support is not systematic or at scale.

Views on NPCS/NAC from the CSO Survey

“NPCS is very bureaucratic. They take too long to analyse the reports and there are too many interruptions in the process.”

“The NAC is very bureaucratic. They take too long to provide the funds for project implementation; the funds are reimbursed just for short-term projects; they do not pay incentives to the project staff; they take too long to disburse the funds.”

“NPCS was the most difficult funding agency to work with because it

is very hard to get funds from them. In this context there is no way to implement projects.”

“The NAC is very bureaucratic. There are no clear instructions for project presentation and they often change the procedures along the implementation of projects. The approval of a proposal can take one year.”

“NPCS - they are very bureaucratic because their decisions and policies are established at the central level and are not operationalised at local level.”

“The NAC takes too long to approve the first project. Clarifications about access to funds are never correctly made and when the organisation gets the answers the project has to be reviewed because all the quotations are outdated.”

The case of Kindlimuka Boane

Kindlimuka Association was the first organisation of people living with HIV/ AIDS in Mozambique. It began its activities in 1996 and was legally established in 1998. Its main objective is to give moral and material support to people with HIV, people with HIV-related illnesses, orphans and relatives through the establishment of networks of social solidarity. The most important activities of Kindlimuka are counselling, advocacy, prevention, and sustainability of projects to help people with HIV and their relatives to deal with the disease in their daily life.

Kindlimuka has its national headquarters in Maputo. Since October 2002 a branch of Kindlimuka has also been operating in Boane District. Kindlimuka is one of the most active organisations in the district undertaking through the hard work of its members a considerable support to people with HIV and orphans in the district.



A support organisation in the midst of the community

It is comprised of 49 members. The organisation has an executive board comprised of the representative, executive secretary, the accountant, activists, the head of the sewing activities, trainees, the coordinator of orphan support, the counsellors, and the guard. Eighteen members are part of the working staff. All are volunteers who work without payment.

Kindlimuka Boane is a member of the District Aids Commission and of the Consultative Council of Boane's District. Since October 2006, it has been the president of NGOs and of the Associations Forum Against HIV/AIDS in the district.

With the support of the chief of the neighbourhood, Kindlimuka develops awareness sessions that are used to invite people to be tested for HIV. The Kindlimuka activists take those who test positive to a health unit for them to start treatment or receive appropriate care.

Through the work undertaken by the activists and counsellors, the organisation provides moral and material support to 444 orphans, 85 people with HIV and 188 affected women. The activists help the patients through home-based care: cleaning the houses, washing the patients and taking them to the hospital (although only cases where the patients have money to pay it); the counselors give them advice on how to inform the family of their status and how to deal with the disease. They support orphans with school materials and food.



Membership in a support organisation offers opportunities to help and to survive

Kindlimuka receives funding and material support from Kindlimuka headquarters, UNICEF and Southern African AIDS Trust. These funds consist of subsidies to pay the activists and counselors, school materials for orphans and food baskets. When the organisation has no funds available, the members of Kindlimuka (who are poor people without regular income) pay for urgent expenditures such as the transport of patients to hospital or needed materials for home-based care.

Kindlimuka also implements income generation projects in agricultural production, sewing and dress making, and in the production of mosquito nets as a means of sustaining its members.

A *machamba* (smallholding used for food production and traditionally managed by families) managed by the Kindlimuka headquarters and located at Boane is worked by the members of Kindlimuka Boane. Last year, however, there was no production due to lack of funds.

Kindlimuka is an exemplar of an organisation which has the leadership, community commitment and organisational culture to make a significant contribution, but this opportunity is largely lost due to the absence of a system for making funding available such that the organisation can undertake proper planning.

A project to open a new *machamba* was submitted to ActionAid and was expected to start in late 2006. One part of this *machamba* is to be used for food production to improve members' nutrition. This project will also provide funding for the medical assistance of 50 members and of 100 orphaned children of both members and non-members.

A dress making project is also in place; skilled members train other members in the basics of the work. Funding for the project came from NPCS. However the organisation currently has four sewing machines that are broken and there is little likelihood that they will be repaired due to lack of funds. Nonetheless, despite the fact that the trainees can not apply their knowledge, they consider the training very important.

Mozal supported the Kindlimuka project for mosquito net production by giving them an additional four sewing machines and materials for the training of its members. The training is already concluded, Mozal bought the product, and Kindkimuka is now using the income to continue the production.

On April 7, 2005, Kindlimuka was visited by Joana Manguera, the Executive Secretary of the NAC, who promised to provide funds for home-based care. By early 2007 nothing had been forthcoming.

According to the representative of the Boane branch of Kindlimuka, the organisation's needs are a vehicle to transport patients to hospital and materials for home-based care, such as gloves, soap and kits.

Kindlimuka is an exemplar of an organisation which has the leadership, community commitment and organisational culture to be a significant support in an area where this is hugely needed. But the opportunity is largely lost due to the failure of any viable system for making funding available such that proper planning can be done by the organisation. It exemplifies a true community organisation capable of making a significant and probably cost-effective contribution, but the experience of which flies in the face of prevailing rhetoric around national support for CSOs. The opportunity remains mostly unrealised.

4. Epako, Namibia

The case study was developed by Andrew Harris

4.1 Description of the site

Epako is a peri-urban mixed location on the outskirts of Gobabis, the market town and administrative centre of Omaheke Region in eastern Namibia. The population of Gobabis, including Epako, is approximately 15,000 people.

As a former township from the apartheid era, Epako is the residential centre for many of the poorer residents of Gobabis. Communities of all the main Omaheke groups are resident there – Hereros, Nama/Damara, San, Owambo, Tswana and Xhosa. The San, in particular, may be considered as a vulnerable group, being economically marginalised and educationally disadvantaged.

The ex-township status is reflected in the concentration of poor people in Epako. A recent series of village-level participatory poverty assessments in Omaheke identified Epako as one of the areas which should be included in a representative sample of poverty in Omaheke.



Informal housing in Epako

Gobabis is located 200 km from Windhoek on the Trans Kalahari Highway towards Botswana. It is thus the first (or last) stopping point in Namibia for traffic on the highway to Botswana, other than the border post. The highway brings its own risks: Epako is a place where truck drivers stay, and although prostitution is illegal and not talked about openly, it is known to exist along the highway. An army camp is located about 4 km away. Alcohol abuse is seen as a major factor in the spread of HIV, and the regional governor speaks about how the region is becoming more integrated due to greater levels of mobility.

Epako itself is a very mixed area that is described as dynamic and without a strong sense of community. Gobabis and Epako are growing as people move from the rural areas looking for work, even though there are no ready sources of employment. There is a transient element to Epako's population, with a number of people moving into and out of the informal settlements at the edge of the community. Epako is a place where many people live as their main residence, as well as a place in which people from other parts of the region stay when they come to Gobabis as the market town.

Omaheke Region

The Omaheke region is in the east of Namibia and covers an area of 84,612 sq. km. In 1991, the population of Omaheke was estimated at 52,000 (0.61 person/sq. km); by 2005, it is estimated that this has grown to 75,102 (1.13 person/sq. km) – still below half the average population density for Namibia as a whole (2.44 person/sq. km.). Centres (other than Gobabis itself) are small and the population is widely dispersed. Eighty percent of the population lives in the rural areas.

A general picture of Omaheke, as painted by the UNDP 2000 Human Development Index, is as follows:³⁰⁴

³⁰⁴ Source: 1996 ICS and UN Population Division (life expectancy); 1993/94 NHIES (income); 1996 ICS (literacy enrolment); NHDR 1999 (UNDP); national accounts 1993-1999. The HDI is a comparative measurement of quality of life in countries around the world, taking into account levels of life expectancy, literacy, education and standards of living.

	Life expectancy	% Adult literacy	% School enrolment	Income N\$	HDI 2000	HDI 1999	HDI 1998
Omaheke Region	44.3	67	74	3 944	0.607	0.644	0.706
Namibia (Overall)	43.1	81	84	3 608	0.648	0.683	0.770

In relation to poverty, the 1998 UNDP figures show:

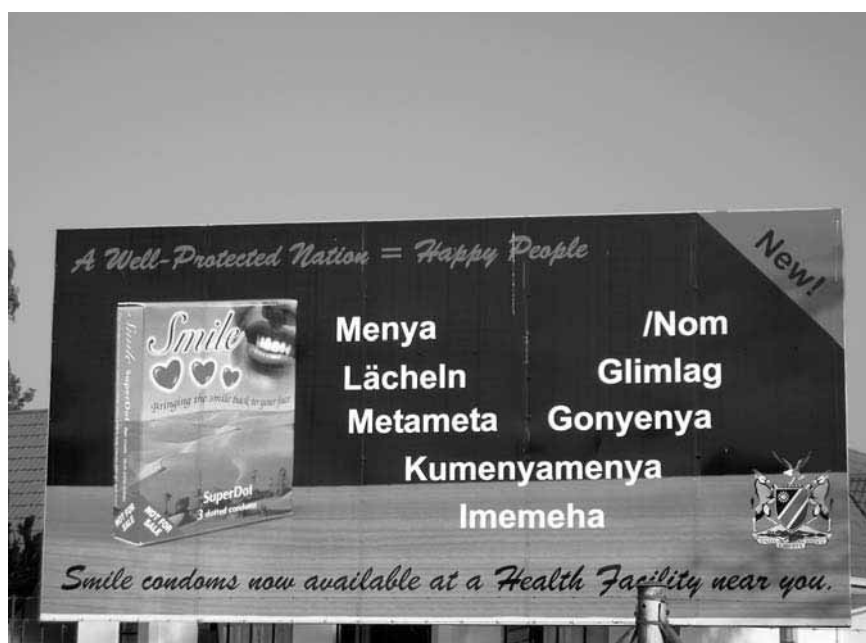
%	Non-survival 40 years	Illiteracy	Underweight children	No water supply	No health service	Poor living standard	Poor households
Omaheke Region	21.1	36	9	6	89	35	25
Namibia (Overall)	18.0	19	15	23	45	28	9

At 25%, the proportion of poor households in Omaheke is by far the highest for all regions of Namibia. This is not inconsistent with the average income figures for the region in the first table – these income figures are inflated by the relatively high incomes of farmers in the region’s commercial farming areas.

By language group, inadequate human development and poverty is heavily focused on the San community, whose human development index is only 0.28. Significant numbers of San live in the Omaheke region.

4.2 AIDS in Epako

Omaheke has a low HIV prevalence rate compared to other parts of Namibia. It is estimated that the HIV prevalence rate in 2004 was 13.8%, amounting to approximately 5,500 HIV-positive people in the region. This represents only 3% of the overall HIV-positive population in Namibia.



HIV prevention is one of top priorities in Omaheke Region, which has relatively low HIV prevalence levels

Given the relatively low prevalence rate, it follows that in Omaheke most attention is being paid to preventing new infections. However concern

was expressed during the case study research that the relatively low seroprevalence figures may actually mask the fact that HIV incidence is rising. A fair amount of skepticism was expressed about the accuracy of the prevalence rates in the region. Treatment and care services are on the increase in Omaheke and there is an emerging tension around the balance between prevention activities and those aimed at care and support.

The recent Participatory Poverty Assessment (PPA)³⁰⁵ carried out by the National Planning Commission in 2006, which included Epako as one of the six reference sites, produced a number of findings relating to AIDS, as seen by the community.

The pandemic always ranked lowest among identified community problems, with a wide range of misconceptions and misplaced beliefs about AIDS. Of particular concern was a strongly held view that only prostitutes and women who live 'loose lives' would be infected by the virus. The PPA showed that poverty and hunger may indeed force a number of women to render sexual services in return for food, commodities or money. The gender circumstances that women face, with more limited control over and access to productive resources, coupled with cultural practices that put women at risk of losing a large share of their assets to a husband's relatives if he dies, mean that women are more vulnerable to being forced to opt for risky survival strategies and more vulnerable to exposure to HIV infection. On top of this, women described how men in the region were still stubborn when it came to regular condom use.

4.3 Responses to AIDS in Epako

Research in Epako revealed a remarkable density of organisations and structures working on AIDS activities in the community. These fell into two main categories – governmental (the Ministry of Health and related institutions, the municipality, and the Regional AIDS Coordinating Committee (RACOC)) and civil society, including NGOs, CBOs and churches.

Respondents uniformly held the view that local businesses have not taken on a role in AIDS response in the community. This was consistently understood as a continuing reflection of patterns established during the pre-independence period. There is no 'culture of donations' among the predominantly white owners of businesses in the area, and the same was said of white church congregations.

4.3.1 Government activity

Department of Health

Until recently the district hospital in Gobabis has been the focal point for AIDS services in the region, although increasingly functions are being devolved to clinics as health workers are trained in procedures and protocols.

Most health workers in the region have been trained in HIV counselling and testing and there is a counselor based in every clinic in the region. Rapid HIV testing has been introduced at the hospital in Gobabis, the Epako clinic and one other clinic. By the end of 2006, it was expected that approximately half the clinics in Omaheke would be equipped to

Research in Epako revealed a remarkable density of organisations and structures working on AIDS in the community, including from government and civil society. To date, local businesses have not taken on a role in AIDS response in the community.

³⁰⁵ National Planning Commission (2006).

do rapid tests. Once this is in place, it will be possible for PMTCT to be provided at clinic level. Up until this point, blood had to be drawn in clinics and sent to Gobabis for testing. This was an undesirable situation, because of the challenges and time involved in transporting samples to Gobabis and sending back results. Post-exposure prophylaxis is available at all clinics in the region.



The Epako Clinic is located near the entrance to the community, just off the main road to Gobabis

At present, ARVs are provided at Gobabis Hospital, but doctors and nurses are being trained to administer ARVs so that this can be rolled out more broadly. All patients who test positive are registered at the clinics for screening to enter the ARV programme. In order to qualify they must have a designated treatment supporter. The majority of people receiving ARVs from the hospital live in Epako. One of the major challenges that has been experienced thus far is that people who are in the ARV programme move away and there is no systematic way for them to be reached for on-going support. There are clusters of ARV patients in the vicinity of other clinics; every Tuesday doctors from Gobabis travel to other clinics to reach these patients, but given the distances, this means that clinics are visited only once every one or two months. Transportation is a major problem. A doctor at the Gobabis Hospital noted that the condition of the roads means that vehicles are often 'grounded' after two or three months.

The Ministry of Health and Social Services in Omaheke works in close partnership with the Omaheke Health Education Project (OHEP) on TB and HIV services (see below). OHEP works in all the clinics in the region with the exception of one remote location. Otherwise there is not significant collaboration or interface between the formal health system and civil society organisations. A doctor at the Gobabis Hospital noted that there have been efforts to engage with civil society through community meetings and also through contacts with the Regional AIDS Coordinator, but other than with OHEP, these relationships have not solidified. He said that they do not have a good sense of which CSOs in the area work on AIDS and what types of roles they play.

The Regional Aids Coordinator (RAC) is responsible for coordination of AIDS activities through a multisectoral Regional AIDS Coordinating Committee (RACOC). Constituency and District AIDS Coordinating Committees are expected to coordinate at a more local level, although the RAC reported these are less well established. The overwhelmingly rural nature of the region means that constituency (or village) committees are more likely to be effective than district-level bodies which would span large territories.

The main role of the RACOC is stimulating and coordinating AIDS response activities in the region, although it is also involved, to some extent, in implementing activities. Main areas of focus include awareness campaigns and combating stigma, home-based care and family counselling, support to orphans and getting children into school, condom distribution, and promoting the ARV programme in the region. The RAC felt that it has been drawn into implementation because there are not sufficient strong organisations in the region to drive the work forward in some of these areas.

The RAC works closely with CSOs in the region; one function is providing assistance in developing proposals, endorsing proposals, and assisting groups that have accessed funds to manage them properly. Although the RACOC is shifting gradually towards more of a direct funding role and will be issuing small grants through its own budget, until now most funding for CSOs in the area has come from the Small Grants Fund (SGF) administered by UNAIDS. The RACOC endorses all proposals to the SGF that emanate from the region and has had a reasonably good success rate. Another source of funds, particularly in 2002-03 when there was a development worker working in RACOC, was Voluntary Services Overseas (VSO) grants. However the VSO money has still not been completely used because of capacity issues. The RACOC also offers capacity-building and skills training programmes, but these are limited because of the shortage of resources.

The RACOC holds quarterly meetings which are reportedly well attended by a variety of groups. The Regional AIDS Coordinator describes CSOs as the 'backbone' of participation in the meetings. Overall, groups within the region as well as external entities believe that the Omaheke RACOC is largely successful in its coordination role. Local organisations noted that 'it listens to our problems and will try to assist the organisations. It helps in revealing the gaps.'

Gobabis Municipality

Since March 2006 the Gobabis Municipality has employed an HIV/AIDS Coordinator whose position is funded by a Dutch NGO. The focus of the coordinator's work is principally on outreach with municipal employees, but is also oriented towards community needs. Her position is guided by a municipality HIV/AIDS committee and her workplan is aligned with priorities in the national strategic plan. The Municipality is a member of RACOC.

The key work areas of the HIV/AIDS coordinator are: education and awareness, including weekly health sessions with municipal employees; distribution of condoms to all municipal offices and training in proper

The Regional AIDS Coordinator describes civil society organisations as the 'backbone' of participation in the quarterly meetings of the Regional AIDS Coordinating Committee in Omaheke.

use; organising municipal-wide events, such as 'Gobabis Cares' day; promoting and making visible messages about AIDS, including on municipal stationery; promoting community engagement; and consolidating information about AIDS resources in the municipality through a directory of service providers.

The Municipality has funds to support income generating activities in the town and is able to distribute funds for projects that it believes could be self-sustaining. Other projects that are being considered are an orphanage trust, a multi-purpose centre, home-based care activities for employees and supporting people with HIV (including financial support). At the time of the research, the process of advertising this funding and making decisions about allocations was at an early stage.

The municipality's HIV/AIDS coordinator was familiar with the major civil society initiatives in the community and had already developed links with at least one of them as a back-up source of condoms at times when her supplies ran low. However there was little evidence that her workplan included any structured collaboration with CSOs in the community. If anything, the community outreach work that she undertook on behalf of the municipality, such as visiting shebeens to distribute condoms and teach people how to use them, duplicated other existing work and might well have been better undertaken in partnership with a local CSO, rather than drawing upon her limited time and resources.

4.3.2 Civil society activity

A total of 41 CSOs are listed on the NANASO database as operating in Omaheke region. Twenty of the organisations are classed as NGOs, 13 as CBOs and 7 as FBOs. Four of these are branches of larger organisations and, of the remainder, 17 are based outside the region – all in Windhoek. Thus 20 (50%) of the organisations are locally based in Omaheke.

A number of these CSOs are either based in Gobabis and work in Epako, or are from Epako itself.

CSOs with international links

Organisations that are internationally based and have invested heavily in the area include the Omaheke Health Education Project (OHEP) which was launched as a project of Oxfam Canada; Health Unlimited, a UK-based development organisation with a focus on marginalised groups in remote areas; and ACORD. In two of these three cases, the initiating organisations have formed, or are forming, independent, locally based agencies to continue the work that they have initiated.

OHEP has developed a model response to community health needs, with a particular focus on TB.³⁰⁶ This response is based on a close working relationship with the Ministry of Health through the hospital and clinics which refer people to OHEP. A nursing-based assessment is then undertaken and the referred person is taken into a community-based support programme. This includes field promoters, clinic health committees, village health committees (reporting to the clinic committees), and local support groups. The local support groups comprise the individuals who are identified to support people in the programme – typically a family member who is identified and then

³⁰⁶ OHEP has since been re-launched as Community Health Care Services Namibia.

trained to play an effective support role to the person receiving home-based care. At the time of the case study research, OHEP was undertaking a community survey in Epako to make contact with every person in the community who was known to have TB or to have developed AIDS. They were a visible and organised presence on the streets of the community.

Health Unlimited also has a strong programme of community health support which is not specialised on AIDS, although the epidemic is central to the work it is doing. It works closely with the Ministry of Health to provide primary health care in hard to reach areas, including by training community members to provide particular types of services. The organisation has worked extensively in Omaheke Region because of the significant San and Danara population living there. It reports that the shift of funds towards tackling AIDS has led to it becoming much more difficult to raise funds for general community health programmes. This in turn has led to recent cutbacks in its community health programmes in Epako.

Both Health Unlimited and Total Child/ACORD have done significant work on health promotion in schools, focusing on teenage pregnancy and vulnerable children. Both have adopted a holistic approach to issues affecting children in an attempt to prevent drop-outs; for example, Total Child links work in schools to visits to families. They see that many of the factors leading to school drop-out rates emanate from conditions in the home and the community.

The governor and Regional AIDS Coordinator both noted that Johns Hopkins University is expanding its activities in Namibia into Omaheke region and will be forming community action groups, particularly in the informal areas of Epako. This is a research-based programme that is directed towards developing local evidence-based AIDS strategies. However, the researchers did not come across any evidence of this programme during the case study research.

National CSOs

A number of Namibian NGOs that work nationally or in more than one region are reported to have activities in Omaheke. However the experience on the ground seems to be that nationally based NGOs are not particularly known in the community, apart from those that have regional offices in Omaheke.

Catholic Aids Action (CAA) and the Evangelical Lutheran Church AIDS Programme (ELCAP) are the most prominent examples of national NGOs. CAA runs soup kitchens for 300 orphans and other vulnerable children two times per week and oversees eight groups of home-based carers from its church offices in Epako. It trains youth peer educators and also oversees a group of volunteers who support children in an after-school programme. ELCAP's office is in Gobabis town and was not visited as part of the case study. ELCAP also provides home-based care services in the area.

There are strong relationships between the regional government and both CAA and ELCAP; the regional governor acknowledged that 'government can't do everything' and that there is a need to rely upon organisations that are closer to the people. They also find the churches to be disciplined

and organised in the way they work, and regard them as a 'good platform' for disseminating messages.

The Omaheke branch of Lironga Eparu, the national network for people with HIV, is based in a small office at the municipal office in Epako and receives extensive support from OHEP. The branch works with little or no support from the national office, which appears to be related to its failure to liquidate a grant that had been issued two years earlier. It was explained that the grant could not be closed out, because the person in Lironga Eparu Omaheke who had been responsible for the grant had died and the other members were not able to provide the national office with sufficient records or supporting documentation for the grant to be closed out. OHEP supplies Lironga Eparu with food parcels for its members and has also set up a poultry project in Epako to supply eggs along with the food parcels.

Although Lironga Eparu is the national network for people with HIV and ostensibly has an active presence in every region of the country, the network as a whole remains quite weak and its branches are under-resourced and under-capacitated. The assistance that Oxfam/OHEP provides to Lironga Eparu in Omaheke is the primary source of support for the network locally, and the fact that the assistance is largely oriented on provided food for Lironga Eparu members also reflects the desperate situation in which many HIV-positive people in Epako find themselves.

Local CSOs



A local project to support children, Save the Children was initially set up by residents of Epako, but has since attracted sporadic assistance from international volunteers and benefactors

The Regional Aids Coordinator explained that the largest number of groups in the region are CBOs, FBOs, farming organisations and youth groups that emerge from the community itself. During the research in Epako, a number of small-scale, volunteer-run CBOs working on AIDS were identified.

- During the time of the case study research, a group of young British volunteers affiliated to Raleigh International were

constructing a playground in Epako in partnership with Light for the Children, a local CBO led by the pastor a nearby church. Light for the Children works with 150 children in Epako.

- A volunteer-run theatre group, which has been in existence for eight years and has received training from the National Theatre of Namibia, puts on plays for the community on a variety of social and development issues, including gender, AIDS, environmental issues and discrimination.
- The theatre group is based out of a small child care centre – ‘Save the Children’ – that provides orphaned and other vulnerable children who are approaching school-going age with supplementary support to ‘bridge’ them into school. The children also receive a meal every mid-day.

4.4 Sources of funding for CSOs in Epako

The main sources of funding for CSOs in Epako differ markedly by type of organisation.

Some of the more prominent organisations active in Epako are there as a result of action by international development organisations. These had secured and sustained their presence through access to international grant sources. Health Unlimited and OHEP are both perceived by other civil society organisations as being very successful, but part of their success is attributed to the fact that they have regular and significant levels of outside funding. This allows them to have broad community outreach; they have the physical means to get into the community (eg. vehicles); and they provide community workers who are well trained. They also have skilled managers, some of whom are expatriates, to oversee programme implementation. Moreover, the regular external funding means that staff have fewer fundraising responsibilities than do the leaders of other CSOs. This undoubtedly allows them to focus more attention on the content of the work they are conducting.

Local branches of national NGOs tend to receive significant core support from their national headquarters, and then supplement that support through local resource mobilisation. The larger research findings show that these agencies are often effective in securing a significant proportion of funds from international sources on a bilateral basis. For example, both CAA and ELCAP receive significant amounts of PEPFAR and Global Fund funding through their central headquarters which allows them to carry out programmes across the country. Other national NGOs such as YWCA Namibia, which carries out projects in schools in Omaheke, also source their support centrally through a national office, largely from international sources.

While support from a central office allows some stability, it does not mean that the local branches are without resource pressures. Catholic AIDS Action in Epako runs a soup kitchen twice a week, but has no financial resources to support this activity. They cover the costs in a variety of ways – for example, by cutting into their home-based care budget and, more recently, by convincing a local Pentecostal church to take on responsibility for the soup kitchen one week per month. A Peace Corps volunteer based at CAA has worked with its local volunteers to solicit donations from businesses in Gobabis – they are asking for pledges

of N\$1/week – yet despite visiting local businesses in person, this approach has secured only a handful of responses.

The Small Grants Fund, administered by UNAIDS, is the most important source of open, competitive funding for local CBOs and NGOs. Since the start of the scheme in 2003, a total of N\$958,462 (approximately US\$150,000) has been allocated to 14 Omaheke organisations. The largest grant made was N\$69,000 (approximately US\$11,000) and the smallest was N\$11,000 (approximately US\$1700).SGF applications are submitted through the RACOC, which endorses them and passes them on to the secretariat in Windhoek. The SGF awards funds for one-year projects, so even this scheme has its limitations as it can be difficult for recipient organisations to sustain themselves after only one year of support.

Evergreen Theatre Company

The Evergreen Theatre Company, based in Epako, was established in 1998 and has been trained by the National Theatre of Namibia as a community theatre group. It develops and puts on plays on issues such as gender, discrimination, AIDS and the environment in school halls and community centres.

The group works on a voluntary basis. It has never received any funding; its members contribute what they can to prepare and stage the plays. Applications it has submitted for funding have been turned down. It asks for contributions from people who attend its plays and once received a donation from a Dutch woman who visited the project.

Two of the original members are still with the group, but over the years many members have come and gone. According to the director, people come to the group because they see an opportunity, but then leave in search of paid employment.

According to the director, the position of the National Theatre is that the regional theatre groups need to become 'self-reliant.' It remains in contact with the groups, but does not provide them with any resources.

Apart from the SGF, there were few other sources of financial support that had been accessed by CBOs and NGOs in Epako. Most of the other CBOs received limited in-kind assistance through linkages they had established with national and international sources: for example, the National Theatre Company of Namibia (training and workshops), and links with international volunteers and individuals overseas who make once-off donations to support project costs. The case study research found that this can place CBOs in vulnerable positions – not just in terms of sustainability, but also in terms of the ownership of their activities. One CBO related an instance when an individual from Gobabis reportedly secured a donation from a donor overseas in the name of the project in Epako, but did not transfer the funds to the project as claimed, essentially embezzling the resources. At a later stage, a foreign woman became heavily involved with the same project and, in the eyes of the original founders, began to steer the project in her own way on the basis of the argument that she had succeeded in securing funds from abroad to finance the project's work. A conflict emerged between the original founders from the community and the foreign woman over the direction of the project that remained unresolved at the time of the case study research.

Although some of the organisations that were active in Epako had strong working links with government, there was no evidence of funds being

The Small Grants Fund, administered by UNAIDS, is the most important source of open, competitive funding for local CBOs and NGOs in the area. Apart from this fund, there were few other sources of financial support that had been accessed by local organisations in Epako.

made available to civil society from government directly. Indeed, direct funding from government for mitigation of AIDS was seen to have declined, with the tightening up of the application of the disability grants and the discontinuance of drought relief programmes. The municipality, similarly, was not seen as a source of funds, although the municipality was seeking to develop a funding source for income generating projects.

Note has already been made of the perceived lack of support from local businesses and individuals, said to be the result of strong inclinations (or dis-inclinations) left over from pre-independence days. It was noted that local churches were beginning to awaken to the idea of support for local projects, but this remains at the level of sporadic, once-off events. As the RAC put it, the idea is 'still getting into their minds.'

4.5 The funding environment for CSOs

Every respondent in the case study research held strong opinions about the funding situation for AIDS in Epako. The most commonly expressed views were that there is insufficient funding available for CSOs in the area and that the funding that is available is directed at the wrong priorities.

Many respondents felt that donors and NGOs direct their attention to other parts of the country where HIV prevalence rates are higher. The Regional AIDS Coordinator noted that donors are 'being directed by government to other areas' and that low prevalence in Omaheke meant that 'the money doesn't come here.' This was indirectly corroborated by the UNAIDS Country Coordinator who noted that there has been a tendency for donors in Namibia to 'go North' where the highest prevalence and deepest levels of deprivation are.

While national NGOs and international organisations receive significant funding from their headquarters, there are few funding options available to local organisations and CBOs apart from the Small Grants Fund. This has a direct effect on their ability to sustain regular activities. Many of the CBOs interviewed carry out activities sporadically, if and when they have access to resources. There is very limited assistance available for core costs such as transportation. As one larger NGO representative commented, CBOs – particularly those in outlying areas – use donkey-drawn carts to do the 'running around' work that is required to organise and conduct activities.

The general consensus was that the Small Grants Fund and the limited support available through the RACOC were helpful, but extremely limited. This results in a situation where 'there are only three or four big NGOs which are doing the work' in the area, even though there are many entities in the community itself that wish to be involved.

Organisations were aware that Namibia has received large disbursements from the Global Fund, but the perception in Epako is that Global Fund support mostly reaches towns and larger NGOs. As the Principal Recipient, the Ministry of Health and Social Services allocates funds to civil society organisations, but 'civil society is big' and there are many organisations that need support. None of the organisations in Epako had any direct experience with Global Fund financing.

A different challenge was expressed by one of the large development NGOs working in Omaheke. This organisation focuses on extending

'The funders will give money for activities, but not the organisational modalities and the logistics. The resources are in the wrong form. There need to be resources to enable an organisation to survive, otherwise there will simply be a process of organisations starting and collapsing.'

- Respondent from a large NGO working in Omaheke

'When you write a proposal that includes all these things [food and poverty], it is too wide for a donor. My conscience does not allow me to just write a proposal on home-based care. [Why can't we write proposals] through HIV/AIDS funds that are about poverty alleviation? We need to tackle the bottom that bubbles underneath the formal programmes of home-based care or whatever.'

- NGO working on health promotion in Omaheke

primary health care services in underserved communities, and has lost funding in recent years due to the narrow targeting of funds for AIDS only. The NGO previously ran a large-scale community-based health promotion programme in Epako, but this programme was eventually terminated because they could not attract continued funding for a generic health care programme that was not specifically targeted at AIDS. This was a source of great frustration for the head of the organisation, who felt that the earmarking of funding was counterproductive, as AIDS is inextricably linked with patterns of health-seeking behaviour and other underlying issues within communities.

Capacity issues

A number of issues related to capacity were cited as factors that hamper that ability of local CSOs to access funds. It was noted that local organisations do not have much experience with recordkeeping, monitoring and evaluation, proposal writing, and tracking expenses. Low levels of literacy among CSO personnel are also an issue.

The Regional AIDS Coordinator commented that CSOs are eager to work, but sometimes can 'lose focus' during the dry spells when resources are not available. He observed that 'they have the capacity to deliver a message,' but that this doesn't mean they can do the 'process stuff.' Tasks that shouldn't be complicated – like putting together a workshop programme or making arrangements to hold an event – are in fact very challenging and organisations need outside support to learn to administer certain kinds of activities.

Comparing local CSOs to those based in Windhoek, he observed that there is a greater 'professionalism' in evidence among CSOs in the capital, which have learned to package and sell their activities in a more sophisticated way. He used an example related to funding proposals – the 'Windhoek NGOs' use research and attach supporting materials to their proposals to bolster their applications. CSOs in Omaheke, he said, 'don't know what else to attach to proposals.' They lack confidence around how to do certain basic things.

AIDS and poverty

'Poverty in Omaheke is the basis for all the problems we see.' This comment by one respondent was echoed by many others. Hunger and poverty are major underlying factors exacerbating the situation with AIDS in Epako, and poverty is at the centre of people's thinking. On the surface Omaheke may appear wealthier than it is because it is rich in cattle and commercial farms. However, this obscures deep poverty. A doctor at Gobabis Hospital noted that the ARV programme is compromised due to the fact that patients on ARVs do not have enough food to eat. He commented that 'the ones who own cattle aren't the ones who are sick.'

'The biggest problem is when our members die. Not all can afford to buy coffins.'

- Representative of Lironga Eparu

Local response mechanisms to deal with poverty have in the past been to access the drought relief programmes; however, this support is not currently available. Another mechanism was to register for disability grants. However, a circular from the MOHSS in 2005 reminded officials that the disability grants could only be given to those who were able to prove to a medical practitioner that they were unfit, wholly or partially for work. This immediately led to the withdrawal of a number of

previously given grants and, as the ARV programme takes effect, the ability to gain the relevant certification becomes progressively more difficult.

The increased international focus on AIDS was seen by some to be diverting attention and resources away from a broader developmental agenda, which would include a more balanced approach to community health programmes and social and economic welfare in the region.

Beyond the recently launched Participatory Rural Poverty Alleviation Programme, which has yet to translate into tangible programmes on the ground, there seemed to be little resolution available to the problems raised. Through Lironga Eparu Oxfam delivers maize meal to people on ARVs, but the broader government mechanisms that were previously available had been withdrawn. Moreover, in the search for adequate responses to the problems being faced, local organisations were facing the same dilemmas that have faced other rural development agencies in Omaheke in the past, namely that sustainable income generation projects or food programmes are not, in the end, sustainable in and of themselves because of the arid nature of the environment and because of competition from South African producers. The comparative advantage of Omaheke lies in cattle, not in small scale poultry (or similar) projects. This is not to say that the projects are not worthwhile in a larger social sense (when the value of local engagement of individuals and communities is factored into the cost benefit analysis). But such a message is not, typically, acceptable to donors who emphasise sustainability and cost effectiveness.

4.6 Implications



*Concrete block houses in the formal area of Epako.
Few streets in the community are paved*

Overall, there was a strong awareness of AIDS on the ground in Epako. While stigma is still strong and much more needs to be done in relation to awareness and prevention, there is also recognition of the impact of AIDS in the community that was not there before. Despite this, AIDS does not feature much in the list of poor people's perceptions of the important issues facing them; here poverty issues, particularly food, dominate.

The focus of the discussions in and around AIDS organisations centred on the lack of resources to do as much as the organisations felt was needed. There was a perception that resources were going to other parts

of the country because the problems in Omaheke were not seen to be as pressing. CSOs argued that there should be as many resources going to Omaheke 'because we need to prevent the problem.' The fact that the region has a relatively low prevalence rate was not seen as a good reason for not funding the region.

There was very little perception of the larger flows of funding coming into Namibia. These are translating into Omaheke through, for example, the roll out of ARVs throughout the region. The ability of some of the larger NGOs to come and work in the region is also reflective of the increasing flow of funds, and the Small Grants Fund itself is supported by donations from several bilateral European donors who are part of the general resource scale-up.

But the underlying sense is that flows are not coming into the region in ways that the community response to AIDS can utilise. There has been a significant growth of local organisations, sometimes in response to education and training programmes and sometimes as a response to a growing awareness of the problems presented by AIDS on the ground. However these organisations are not succeeding in locking into the larger funding flows.

Some of the reasons for this relate to capacity. Community-based and smaller organisations are not geared up to the funding obligations required by the larger donor. While there was a great deal of discussion of the need to rectify this, through capacity-building and infrastructure support, the underlying question of whether smaller organisations should have to build themselves in this way was not sufficiently addressed. Nor is there clarity about whose responsibility it is, ultimately, to undertake this capacitation. There is an alternative response which suggests that the smaller and community-based organisation should be capacitated to do what it can do best on the ground, with funding structures that recognise this.

This need to think hard about funding systems was highlighted by the case of the local Lironga Eparu branch, which was working with little or no funding for itself as it had failed to liquidate a grant given to it two years before. Although the branch was being helped by other organisations with 'in kind' support, there seemed to be no constructive way forward to resolve the initial failure and to find mechanisms by which funding could be resumed, and in a way that might prevent a repeat of the original failure.

There was, in the light of all of the need to support local organisations, widespread endorsement of the Small Grants fund administered by UNAIDS. This mechanism was seen to work and a good proportion of smaller, local organisations had benefited from it. As may be seen from the larger study of which this case study is a part, the key problems faced by this popular mechanism were the small number of donor sources who were using the mechanism and the lack of transferability, with stronger recipients of Small Grants funding failing to move on to larger-scale funding sources.

Alongside the challenges of securing adequate funding, the challenges of coordination featured prominently in the discussions. Some of the mechanisms, such as those managed through OHEP, were seen as exemplary. More generally, despite a high opinion of the RACOC and

the RAC, much more was felt to be needed in relation to coordination. Interestingly, the churches were said to be taking this seriously, at least in Epako. But the Constituency AIDS Committees, which are seen in MTP III as the sub-regional mechanism for coordination, were still to prove their worth.

The importance of coordination in funding was highlighted by the Regional Governor, who argued that where funds went through the regional coordination mechanism, funding and funding flows worked well. But where the funding is coming from elsewhere it does not work as well.

On coordination, the RAC indicated that there is competition between civil society groups in the region: 'We have not learned that we are working for one people. Collaboration is poor.' The result is a lot of gaps. It was felt that civil society organisations will work together when necessary or when coordinated by an outside agency, but there have been problems of coordination in home-based care, with volunteers and clients moving from organisation to organisation according to the terms of resources offered to the volunteers. This has been a particular problem in Epako and Gobabis. In the rural areas, the work is more easily linked and coordinated around the clinics and local support groups.

Respondents note that Epako is a difficult community in which to mobilise people: meetings are called and people don't attend. Willingness to participate in community events is limited and turnout depends on whether the event is seen as 'attractive.' The head of one CBO noted that the atmosphere in Epako is very difficult in terms of working for change: people are 'passive' and 'no one is complaining;' donor organisations and resources are concentrated in Windhoek, which is far away; there are tensions in the area between some of the major ethnic groups, which plays out politically and may effect the way available resources are allocated; and low levels of education and employment lead to a sense of stagnation.

5. Motshane, Swaziland

The case study was developed by Alfred Mndzebele

5.1 Description of the site

Swaziland has the highest HIV prevalence rate in the world. HIV prevalence among pregnant women in all age groups stood at 43% in 2004, but among pregnant women age 25-29, as many as 56% were HIV-positive in 2004.³⁰⁷ The impact of the epidemic is being felt in many forms. For example, it is estimated that there are currently 150,000-180,000 orphans and other vulnerable children in Swaziland as a result of AIDS. Children are taking on greater domestic, agricultural and income generating responsibilities; are dropping out of school temporarily or permanently; go hungry or without meals for days; and are at risk of abuse, sexual violence and losing family assets.

Positioned along the highway from the Oshoek (Ngwenya) border gate with South Africa, Motshane community is located 15 km northwest of Mbabane, the capital of Swaziland. Given its proximity to Mbabane and the Ngwenya border post, Motshane receives a high volume of traffic. Its

The local Lironga Eparu branch was working with little or no funding as it had failed to liquidate a grant given to it two years before. Although the branch was being helped by other organisations, there seemed to be no constructive way forward to resolve the initial failure and to find mechanisms by which funding could be resumed in a way that might prevent a repeat of the same situation.

³⁰⁷ UNAIDS (2005).

highway is flooded by trucks, tourist buses and motor vehicles that enter and leave the country for South Africa on a daily basis.



A rural landscape may veil widespread and severe AIDS impacts

In 1999 a large-scale construction process was initiated to expand the road from Ngwenya to Mbabane into a highway. Motshane was seen as a suitable place to house the contractors' offices and also provided residential quarters for the employees, some of whom came from South Africa. The ongoing construction of the highway has added to the volume of people living in and around the community, especially Motshane centre, where a temporary compound that houses migrant workers has been set up. This highway also links to the northern part of Swaziland through another road which connects to South Africa on the north, at Matsamo border gate.

Motshane is a rural area under the control of a chief who is assisted by his council in governing the people. In 1997 the population of Motshane was 1,353 people. Motshane's location makes it an affordable residential place for people employed in Mbabane and Ngwenya industrial area.

The highway and the new Ngwenya industrial area, which is about 7km away, render Motshane vulnerable to HIV as it is regularly crossed by people in transit and provides a home to workers who have money in a community where there is widespread poverty. Like other parts of the country, Motshane has many unemployed residents and faces a severe AIDS problem.

5.2 AIDS in Motshane

The problem of AIDS has grown in Motshane like any other part of Swaziland. One community member lamented that there is an increasing number of funerals and these are largely for young people. The elderly are left to care for children as the parents pass on. In the primary school, it was reported that some of the children are HIV-positive, and deaths among pupils have been experienced in the past. A school teacher estimated that at least six children at that time were showing signs and symptoms of opportunistic infections associated with AIDS. Parents of some of the children were also sickly or had died. The Rural Health Motivator (RHM) and community carers both observed that there are a growing number of homes in Motshane that are headed by grandparents or children as the parents have died.

5.3 Responses to AIDS in Motshane



Women play the central role in organising community responses in Motshane

Communities and families – including children – are attempting to take care of affected children in many parts of the world where the epidemic has matured. This is also the case in Motshane community. A number of community structures and initiatives were identified in Motshane including:

- *Hope House* is a facility that provides a home for orphans and other vulnerable children. A new, expanded centre is currently being built.
- *Feeding kitchens*: There are about seven points in the area where children can access food.
- *Caregivers* include women who have volunteered to cook meals for the children.
- *Youth groups*: There are two youth groups in the area.
- *Rural Health Motivators*: These are community volunteers who play a major role in promoting health and other social programmes in the community.
- *A primary and a secondary school* that enroll children from Motshane, Ekupheleni and other adjacent areas.
- *Community fields*: These are community fields that are planted by

community members with maize and beans to support affected children in Motshane.

- *The community clinic.*

The clinic

Many people are infected and affected by the HIV epidemic in Motshane, according to the nurse at the Motshane Clinic. The clinic is one of the main institutions in Motshane that is involved with AIDS. It collaborates with Population Services International (PSI) in its New Start Programme, which provides counselling and testing every Wednesday at the clinic. Individuals testing positive who may need ARVs are referred to Mbabane Government Hospital, which is about 15 km from Motshane. On Mondays and Fridays, the clinic provides prevention of mother to child transmission services. Due to logistical constraints, including transport, clinic personnel seldom visit clients at their homes. Those patients who are sick and require specialised care are linked with Hospice at Home, a civil society organisation that provides services in Motshane to about 10 patients once a week. The rural health motivator who participated in the case study noted that it is not uncommon to see patients being transported to the clinic in wheelbarrows in cases of emergency, as the clinic nurses are not able to check patients who are sick at home.

The clinic has collaborated with the Ngwenya branch of Swaziland Positive Living (SWAPOL) to form a support group for people living with HIV. The support group has close to 20 members. Since its formation the support group has had two planning sessions, but does not yet have a formal programme. The support group’s priority needs are to know more about AIDS issues related to treatment and to learn how to care for those already suffering from AIDS.

School fee support for children

The illness and deaths of parents has had major consequences for the lives of children in Motshane. Over 100 children who attend the Motshane Primary School have been identified as vulnerable and required support with school fees during 2006. The children were identified through an assessment done in collaboration with Rural Health Motivators among needy households in the community. The Rural Health Motivators and a community team used specific criteria to classify the children into distinct groups of vulnerability and non-vulnerability. The Government of Swaziland could only support 30 of the eligible children with a bursary for school fees - 70% less than in 2005. This decline in government support for school fees is caused by the increasing number of children that have been classified as orphaned or vulnerable countrywide.

The table below summarises the number of children who received support from the government for school fees in Motshane from the years 2003 to 2006.

Year	Number of children supported
2003	32
2004	85
2005	111
2006	30

In addition to government, other independent institutions and individuals have been providing support for children's school fees. In 2006, according to the Motshane Primary School, the following institutions and individuals provided support for 48 children. This included Hawane Lighthouse (14 children), Motshane Hope House (11), Mr J. Borrell (6), Father J. Dobson (16), and Compassion in Abundance (1).

In 2005, the primary school introduced a feeding scheme in view of the number of children that came to school with empty stomachs. The food is provided on a daily basis to all children, five days a week, when the school is open. The government through the National Emergency Council on HIV/AIDS (NERCHA) provides maize and beans. Parents also contribute towards this feeding scheme by paying a flat fee for each child at the beginning of the academic year.

Community kitchens



Hunger and malnutrition must be dealt with at a community level

Seven community kitchens currently exist in Motshane community. These kitchens were started as a result of a directive by the Motshane leadership to address the problem of children who did not have food. A number of women, known as caregivers, were selected to do the work at a community meeting. They started the community kitchens by cooking their own food for the children; later three bags of mealie meal, oil, soya, peas and beans were received from UNICEF by each of the kitchens. The kitchens are now also supported by the harvest of mealie meal and beans from the community fields.³⁰⁸ The community fields receive maize and bean seeds from NERCHA each season.

The Esibovini Kitchen has also been assisted by a couple from the United States who have donated 10 kilos of rice, 10 kilos of beans, bread and 5 litres of cooking oil on a weekly basis. This support came about after the couple visited the Motshane Hope House and were exposed to the work of the kitchen.

The caregivers report that there have been occasions when supplies run out and they have to contribute their own food to cook for the children.

³⁰⁸ Community fields are fields located in each chiefdom in the country and which are used by the communities to plant crops that are distributed to vulnerable children in the area. All chiefdoms with fields receive seeds from NERCHA each planting season. This initiative is a nationwide response to address the food situation faced by orphans and other vulnerable children.

'Lomtfwalo sewaba kitsi banakekeli' ['It is now our burden to see to it that the children are fed']. Cooking and feeding utensils are also provided by the caregivers as no support has been received thus far to purchase such utensils from any organisation or from the community leadership. The commitment by the women of Motshane and their selfless attitude towards the challenge of children in the community reflects how the burden of AIDS is being shouldered largely by women. The caregivers were all volunteering their services without any allowance. For the caregivers the children's need for food is the most important motivating factor: 'If we were not to cook, the situation for the kids will be worse,' said one of the caregivers.



A community-built kitchen to cook and distribute food

At the time of the research, only one kitchen had been constructed, with stick and mud. In the other six places volunteers cooked from their homes and then brought the food to meeting sites. The most pressing issue for these kitchens is to have physical structures in place. Two male community members were donating their labour by cutting logs to be used to build a kitchen structure.

The kitchens play a very important role within the community, but they are not well linked with other services and structures. Caregivers report that there are sick children who come to the kitchens, but they aren't able to help them directly. The lack of linkages between the kitchen and the clinic leads to missed opportunities.

Although the kitchens play a very important role within the community, they are not particularly well linked with other services and structures. Caregivers report that there are sick children who come to the kitchens, but because they don't have any medical supplies (or the required training), they are unable to help them directly. The lack of linkages between the kitchen and the clinic leads to missed opportunities to assist children in need. When the initiative for the community kitchens was started, there reportedly was collaboration with the RHMs, however this stopped over time – reportedly as a result of lack of coordination and undefined responsibilities between the two groups. According to the recollection of the caregivers it was sometime in 2004 when the collaboration between the two groups stopped.

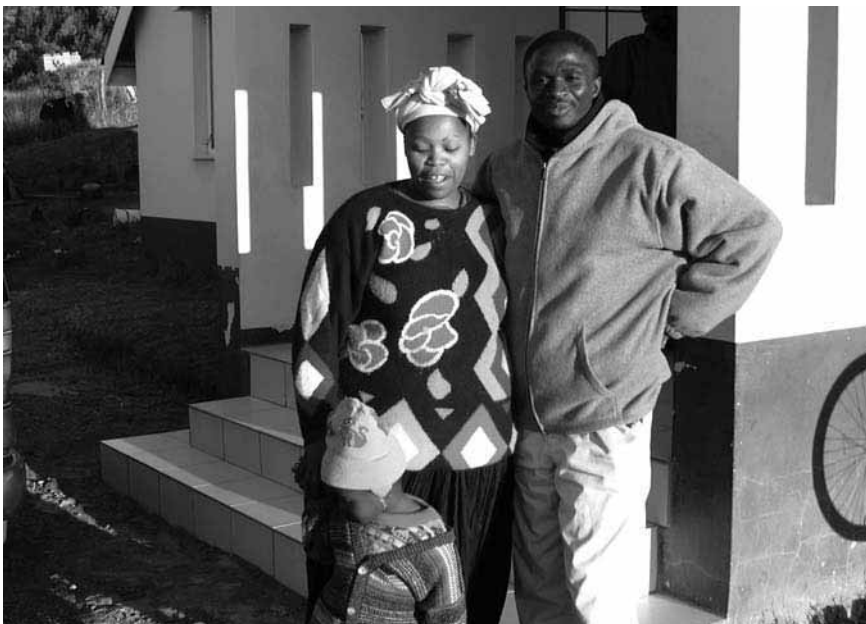
On occasion, the caregivers meet with their counterparts from other kitchens, particularly during workshops hosted by UNICEF. Apart from this, there is no apparent coordination of the community feeding kitchens. UNICEF officers conduct supervisory visits to the kitchen sites

in order to check and weigh children on a regular basis. There does not appear to be any specific focus on children who are HIV-positive, as the programme is broad in orientation.

Motshane Hope House

Motshane Hope House is a Christian faith-based organisation that supports 21 orphans and other vulnerable children in Motshane. The Hope House project initially partnered with Hawane Light House in providing a home for children in Motshane. However, as the initiative grew, more and more children came on board and independent funding was secured. The programme has evolved into a free-standing organisation.

The Hope House is run by directors who are not from Motshane Community, and is sponsored by patrons in the United States and the United Kingdom. It supports orphans and other vulnerable children by providing residential support, clothing, toiletries and food. It provides support for school fees, books and uniforms for children that are not resident in the home. There are four caregivers who work with the children residing at the centre. These children are referred by residents of Motshane, the government Social Welfare Department, the police, and Save the Children.



A Christian couple from Zambia dedicated to the well-being of orphans in Swaziland

'We came from Zambia to this country with 3 children and we were most welcomed and we have lived here as residents, it is our country. We are giving back what the country gave us.'

- Mrs. Borella, whose family provides school fees for children in 4 nearby primary schools

According to the pastor who is the director of the Hope House, all the financial support for running their programme comes from friends in the USA and the UK. In 2002, NERCHA provided support for setting up a chicken project. Local shops like the Spar and Woolworth provide food parcels and church members also give food and money. The organisation sent a number of proposals to local donors and funding institutions in the past, but has not received any support and the pastor has stopped submitting proposals for local funding. He noted great frustration in trying to follow the specified procedures, the long waiting time for the responses, and the fact that negative responses were never accompanied by explanations. 'If we had a steady income, we would be doing much more. Currently we are moving at a snail's pace as funding is unpredictable,' he noted.

The chief of Motshane donated land to be used to build the centre, as well as land to plant maize for the children residing in the centre. The community members help in ploughing and weeding the fields. The pastor attributed the village leadership's commitment to supporting the Hope House programme to its understanding of the vision of the Hope House.

Motshane Alliance Initiative on HIV/AIDS – A youth initiative

The response to the HIV epidemic in Motshane has not been restricted to the adult population. In 2001, a youth group called Motshane Alliance Initiative on HIV/AIDS was formed. This was the second youth group to emerge in Motshane to address the epidemic. To date the initiative has about 34 active members. Its focus is on educating the youth about sexually transmitted diseases and visiting the sick at their homes. The activities of the group include distribution of condoms, visiting schools for educational purposes and visiting children once a week at the community kitchens. The group members meet twice per month. Support for activities of the youth group has largely been from donations by the founding member who is an adult resident of Motshane.

The members of the youth group volunteer their services and need support for an office and salaries for two staff members who can provide counselling and coordinate the group's activities on a daily basis.

The group has received small donations from individuals, as well as from the United States Embassy, in the past. Swaziland Positive Living has provided training to some of the group's members on home-based care, counselling, ARVs and good nutrition. The youth group is also collaborating with the Motshane Support Group in some of its activities, including home visits.

According to the group leaders, NERCHA does not support activities that already exist and the group is facing a big challenge in funding its activities. The youth group wished that the local leadership would increase its commitment to AIDS responses by analysing what is happening in Motshane as a result of the HIV epidemic and supporting the different initiatives that are emerging. They noted that:

- Most of the youth are not involved in any income generating projects, nor are they employed;
- The Mbabane-Ngwenya highway does not allow for pass-bys by tourists who might be in a position to support a livelihood initiative in Motshane; and
- There is a growing problem with the use of intoxicating substances, particularly alcohol, as a pastime among the residents of Motshane.

5.4 Funding dynamics

The different initiatives that have emerged in Motshane appear to be benefiting from resources either originating from within the local community itself or from outside the country. Little support appears to be coming from funding institutions in Swaziland, apart from support to farming, supplies for meals and a limited number of scholarships to cover school fees.

The causes for the current resource deficiencies in supporting the AIDS responses in Motshane could be summarised as follows:

- Insufficient information of the scale of need in the absence of a coordinating mechanism for the AIDS problem within the Motshane Community;
- Insufficient expertise and information on the part of community groups in terms of accessing resources controlled by in-country institutions;
- Lack of expertise in advocacy, resource mobilisation and partnership building;
- There are few non-governmental organisations involved in social and development work in Motshane, despite it being a rural area and not too far away from Mbabane; and
- The challenging history of Motshane CBOs not receiving funding in the past from the country's funding institutions has made them hesitant to request funding for future projects and activities.

There is a sense among the residents of Motshane that the traditional authority could be overseeing a better response towards the epidemic and general development of the area. Also, the lack of involvement of men in the community response to the epidemic is viewed as a drawback, shifting more responsibility to women who find themselves overburdened with the responsibility of caring for the orphans and vulnerable children with little support from their male counterparts.

Whilst the responses to the AIDS epidemic are coming from different role players in the Motshane community, there is lack of coordination of these responses. The different role players ranging from the school, the clinic, volunteers, community kitchens, youth groups and the Hope House are convinced that if there could be better coordination of responses, initiatives would be more effective and more resources could be mobilised.

The responses that have emerged in Motshane community are very important and crucial to the beneficiaries, but lack synergy, collaboration, coordination and systematic monitoring, which might also be the reason why the resources that have been attracted from funding institutions in the country have been limited.

6. Linda Compound, Lusaka, Zambia

The case study was developed by Chandiwira Nyirenda

6.1 Description of the site

Linda Compound is a peri-urban settlement located approximately 10 km south of Lusaka. The compound has a population of approximately 20,000 inhabitants and borders on the relatively affluent Buckley Estates, which is a farming block made up of small holding farming units. The compound's proximity to this farming block makes it a strategic source of farm labour. Apart from being a source of labour, the compound has no other economic activities of significance as the majority of its inhabitants are engaged in work as casual labourers.



Having originally come into existence as an illegal settlement, the compound has received minimal attention from government in terms of social services and other programmes. Although the compound is now officially recognised as a peri-urban settlement, it lags far behind other similar settlements in Lusaka in terms of access to support from the state.

6.2 Impacts of AIDS in Linda Compound

Like most high density peri-urban areas in Zambia, Linda Compound has been seriously affected by AIDS. Data from the 2004 Sentinel Survey found an overall national HIV prevalence rate of 18.7%, but a mean prevalence rate in urban areas of 25%. The absence of a comprehensive AIDS awareness and education programme, as well as widespread alcohol abuse in the compound, has contributed to the high HIV infection rate.

In recent years there has been an escalation in AIDS-related deaths among adults and adolescents in the compound. One consequence of this is a deepening of household poverty due to a reduction in income earning capacity. Another immediate consequence has been the increase in the number of widows, widowers and orphans. In Linda Compound it is not uncommon for children who have lost both parents to simply shift next door because they have nowhere to go.

The high prevalence of HIV in Zambia and general poor performance of the economy has had severe repercussions for children's welfare. The loss of parents and guardians through AIDS-related deaths has placed a heavy burden on households that have taken on the responsibility of meeting the needs of these children. It is estimated that more than 1.1 million of the 5.1 million children under 18 in Zambia are orphans. This number is so overwhelming that it is now being considered a national disaster.

Given its origins as an illegal settlement, Linda Compound has not been well-reached by government services that might support orphans and other vulnerable children. While there is a national child policy that provides for a safety net for orphans and other vulnerable children,³⁰⁹ there is little evidence to show that Linda Compound is benefiting from the provisions of this policy. Government supported programmes for children are not visible in the area, and there are no donor-supported NGO activities responding to the plight of vulnerable groups.

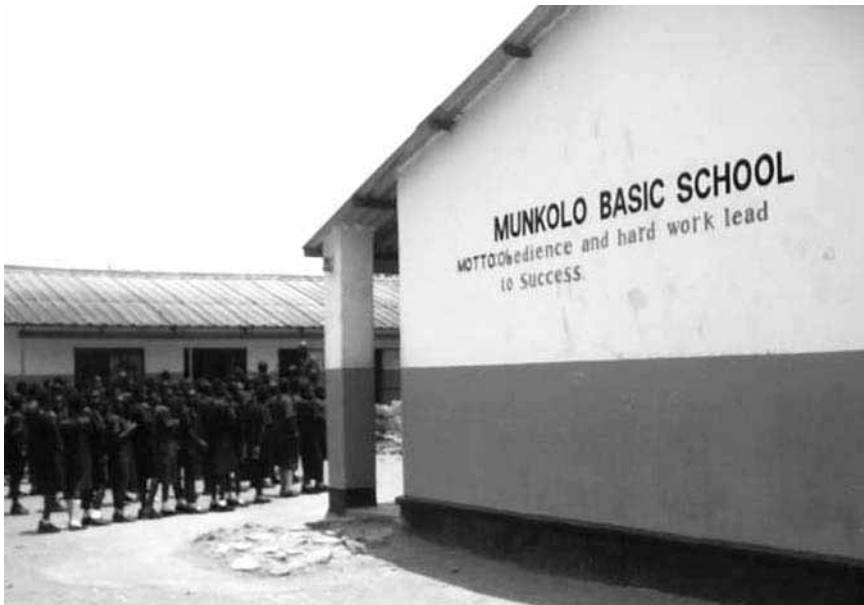
6.3 Identification of the problem

While there are government schools in the neighbouring areas of Chilanga and Lilayi, most children from Linda attend school at Munkolo Basic School, in Buckley, which enrolls about 1,800 pupils in grades one to nine. The administration of the school observed that a growing number of children were missing classes for prolonged periods of time, or were dropping out altogether. Prompted by the increasing rate of absenteeism among her pupils, a teacher at the school decided to investigate the whereabouts of the missing pupils.

In the neighbouring Buckley Township, a local resident who is a development worker had also observed over a period of time that a number of children from Linda Compound were spending time playing near his home during times that they were supposed to be in school.

³⁰⁹ The safety net programme includes a bursary for orphans and other vulnerable children through the Ministry of Education and provision of a food security pack to households looking after children.

After speaking with several of them, he learned that they were orphans who had dropped out of school following the deaths of their parents or guardians. His investigation traced these children to very poor households run by widows or old women with no means of providing any form of livelihood to the children, let alone meeting their education needs.



Growing absenteeism among pupils at the local school prompted community action

He visited Munkolo School to learn more about the magnitude of the problem. There he met the teacher, who shared with him her findings on the plight of these children. Their subsequent joint visits to the homes from which the children came revealed a willingness among their guardians to engage in community activities that would help them alleviate their problems, most important of which was that of sending the children back to school.

The teacher and the local activist encouraged the guardians, who were primarily women, to meet and talk together. During one of their meetings, the guardians agreed to negotiate with the school administration to re-admit the children to school and to allow them to attend classes without wearing uniforms.

With the intervention of the teacher and the activist, the school administration responded favourably to the request and offered to provide the children with basic school requisites, such as books. The readmission of the children into school was on the understanding that the guardians would mobilise themselves to secure financial resources to buy uniforms for the children and pay for the requisites that had been provided by the school.

During this initial phase, 30 households with orphans and other vulnerable children were identified. In each of these households one child was selected for support with enrolment, giving preference to those children who had dropped out. While the guardians recognised the magnitude of the challenge of sending the children back into school, they also acknowledged that with virtually no resources at their disposal they could only assist a limited number of children at the beginning. For this reason, they unanimously agreed on supporting one child per household in order to attain a reasonable spread of households being reached.

'I stopped school when I was in grade three following the death of both my parents. I stayed at home for two years until I was followed by my teacher who eventually helped me to get back into school. During the two years that I was at home I was doing nothing and never imagined that I would get back into school. I even forgot how to read and write. Now that I am back in school and doing grade 8, I can be certain that my future is secured.'

- Pupil, 15 years old

6.4 The emergence of a community project

The Chipego Women's Project was born out of the need to reintegrate orphans of Linda Compound into school. In Tonga, which is one of the languages spoken in the southern province of Zambia, *chipego* means gift. The name of the organisation symbolises the motivation of its founding members to give the gift of education to the children of Linda Compound.

The project began with 25 members who contributed 20,000 kwacha (approximately US\$5) apiece to start up income generating activities. The original members included teachers from Munkolo School, widows, other guardians of orphans and vulnerable children, and some interested residents of both Buckley Township and Linda Compound. Members of the group identified specific skills among them which had a potential to generate income for the project. This guided the choice of initial activities they undertook: making peanut butter, which they sold to a local supermarket, and producing tie-dyed material for dresses.

With income from the two activities, the members were able to put some children back into school and over time they have increased the number of children they have supported from 30 to 70. Some of the children who were brought back into school became reference cases and were a source of encouragement for other children to seek help from the project.

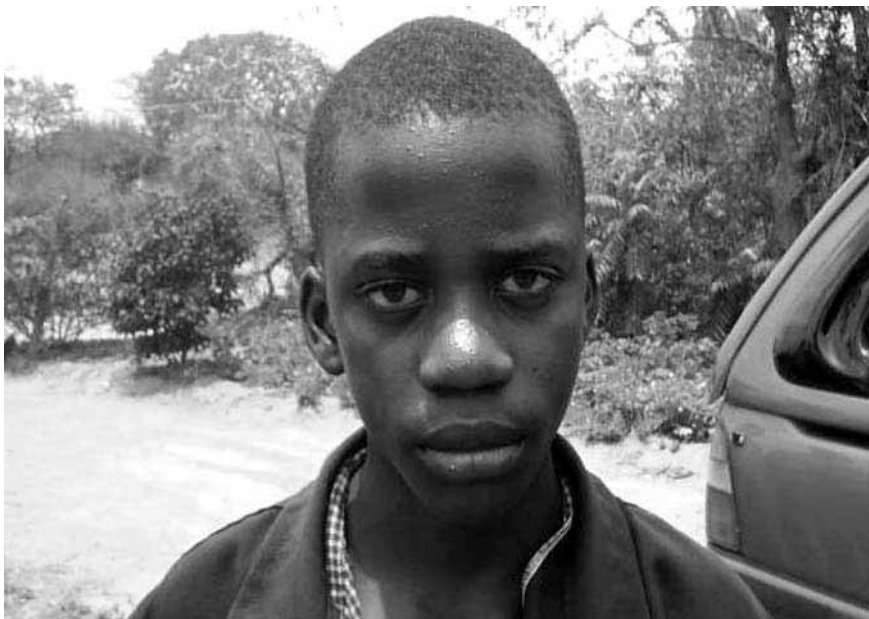
In the early stages of the project, some members of the community had misgivings about the work the women were doing. At that time, rumours circulated in Lusaka about 'satanic' organisations that would target destitute children and lure them away from their guardians by providing them with things that their guardians couldn't afford. Over time, however, the work being carried out by the project came to speak for itself and its reputation within the community was consolidated.

In 2002, the project was registered as a CBO to fulfil the requirements of the Registrar of Societies, which stipulates that any organisation that engages in community work must be registered as a legal entity. This legal status facilitated the project's links with other women's organisations and its membership with the Women Entrepreneurs Association, which supports its members through training and product promotion. Through this connection the project has recently enjoyed the benefits of exhibiting its products at trade shows.

In 2003 the Chipego Women's Project was introduced, through the local activist, to Communities without Borders (CWB), a US-based consortium of local churches in the Boston area that provides small-scale support to a handful of community development projects overseas. CWB provided the project an initial grant of US\$3,000 to purchase school books and uniforms, and later loaned the project money to increase its production of tie-dyed material. Communities without Borders also helps the group sell its material in the United States. With the income from these sales, the project repaid its loan to CWB and reinvested in more production of the tie-dyed material.

The relationship between the Chipego Women's Project and CWB is largely informal, and the main thrust of CWB's efforts is to assist the women to access the American market for their tie-dyed material. The material and the proceeds are sent back and forth between the US and

Zambia via visitors and individual travellers. The income from the sale of the material is transferred to the local CWB contact person, who in turn transfers the money to the Chipego Women's Project account.



One of the children being supported by the Chipego Women's Project

Through a participatory process, the women decide on how the money will be split. Part of the money is kept aside for the school feeding programme (see below), while the other part is given to the women who reinvest it in the income-generating projects and use a portion to meet their own domestic needs. This arrangement for sharing the money ensures that there is an incentive for the women to continue supporting the project.

The Chipego Women's Project began by focusing on providing school uniforms and books for children who had returned to school. Yet the women came to realise that most of these children were poorly nourished or not fed at all and as a result, their performance in school was badly affected. Given that almost all the children that had been put back in school came from impoverished households, providing them with school uniforms and books meant that only half of their problems were solved. Nutrition was equally important for their active participation in school activities.

In 2004 the Chipego Women's Project started a school feeding programme for children under its care, supported by income generated through the IGAs. To support this programme, the school administration allocated a piece of land where vegetables started to be grown. However, the lack of adequate water at the school posed a major obstacle to the success of the initiative. With this problem of erratic water supply, the production of vegetables was seriously hampered.

The local activist who was involved with the project from the beginning approached UNICEF to find out if it could offer any support to the feeding scheme. UNICEF responded with the offer to sink a borehole for the school to improve water supply at the institution. Once this happened, the feeding programme was scaled up from two lunchtime meals per week per child to five meals. Although most schools in Zambia

'I am not a widow, but I made myself available because I noticed that the Chipego Women's Project had a noble cause which needed to be supported.'

- Volunteer/Vice Chairperson

receive support for meals through the World Food Programme, the feeding programme at Munkolo School does not receive external support. The meals are all provided through the efforts of the women who grow and prepare the food.

6.5 Structure of the project

The Executive Team of the Chipego Women's Project comprises seven people: the Chairperson, Vice Chairperson, Secretary, Vice Secretary, Treasurer, Vice Treasurer and the Coordinator. The team meets regularly – at least weekly – to discuss and make decisions on issues affecting the children under their organisation's care and to discuss reports on the performance of the children in school. The team also makes follow-up visits to households where the children live as part of the continuous assessment of the living conditions of the children.

Overall, the project is anchored in the premise that the community has to take responsibility for addressing the challenges of children in Linda Compound. The members have maintained a participatory approach to decision-making; planning for activities and the allocation of resources are handled with the involvement of all members. The local activist who was instrumental in the formation of the project remains involved, but mostly acts in an advisory capacity.

From the start, the project saw itself as a community-based organisation that would focus on generating its own income rather than surviving on 'handouts' from donor organisations. Members of the group have maintained this position over the years. They feel that externally driven support for children is often not sustainable, as exemplified by numerous cases of NGOs that have collapsed following the withdrawal of donor support. Within Buckley Township, for example, an orphanage that provided support to children there recently closed down following the decision by its main donor to withdraw support to it after three years.

This incident has been repeatedly referred to by the Chipego Women's Project members as an example of the institution they don't want to be. The members strongly hold on to the philosophy of self-reliance and are committed to supporting their services through earned income. The vision of being a self-sustaining CBO has been the major binding factor among the members of Chipego Women's Project and for this reason they pay great attention to managing the income generating projects well, rather than focusing on devising strategies for sourcing funding from donors. In order to improve their skills in managing the project, the members have undergone basic training in business management and budgeting.

6.6 Challenges and setbacks

Initially, the project attracted a lot of volunteers, but over time some members have left the project, resulting in a drop in membership from 25 to 15. The remaining members attribute this decline in membership to disillusionment among some of the members who felt they were not personally benefiting from their contributions to the project and were unhappy carrying on as volunteers. One member of the project expressed that volunteerism is difficult because the Chipego members themselves have personal problems that make them vulnerable to poverty and illness. Some of them struggle to carry on with Chipego activities in the

face of other pressing problems. It should be noted, however, that the members who have left the organisation all joined the project after its formation and that the core founding team is still in place.

Another setback occurred in 2004, when a woman from the US collected tie-dyed material from the project with the promise that she would help them broaden their market base for their product in the US. They never heard from the woman again. At the stage at which this occurred, it was a major loss of income for the project. The women struggled for some time to re-establish the project's income base from the sales of the tie-dyed materials.

The project has discovered that the extent of deprivation that exists in the community is so great that it sometimes undermines the contributions they are making. As part of its support to the project, UNICEF donated blankets to be distributed to children who did not have bedding at home. The project disseminated the blankets, however during follow-up visits it came to light that in many households the blankets had been sold for money or traded for food.

During a visit to the project by a representative of CWB in 2005, it was observed that only 2 out of the 60 children being assisted by the Chipego Women's Project were wearing uniforms, despite the fact that CWB's support was aimed at ensuring that the children had uniforms for school. It is not certain whether the donated uniforms are also being sold, however it is likely that many children may have worn out their uniforms because they don't have alternative clothing to wear when they are at home. Members of the project note that children are often seen wearing their uniforms even on Saturdays and Sundays.

Members of the Executive Committee of the project feel that the level of poverty in households which they support directly undermines their efforts to put the children back into school. While they understand that many of those households cannot afford to provide the children with alternative clothing, they also feel that children's readmission into school should be protected by ensuring that they always have decent uniform to wear in school.

With meagre resources the Chipego Women's project is making significant strides in meeting the basic education and nutrition needs of the children under its care. Yet its members struggle with the realisation that there are many children who need help that they are not able to reach. The overwhelming problem in Linda Compound prompted one of its members to start teaching children at her house, as a way to go beyond the work that the project was doing:

'I am also a widow who has been having problems sending my children to school and feeding them. I joined the Chipego Women's Project so that I could contribute to addressing the problem of orphans in our midst. I realised that networking with other widows and guardians of orphans to be the most effective way of helping our children to attend school and have something to eat. I also noticed that even children who have both parents alive were not able to attend school due to poverty in their households. Because of this, I even tried to start teaching children at my house as a way of supplementing the efforts we are making in the project. I had 65 children who were learning at my house, but I had to abandon this because I could not find dedicated volunteers to help me. Abandoning these children was a very painful thing to me because it was like killing their future altogether.'

From the start, the Chipego Women's project has seen itself as a community-based organisation focused on generating its own income rather than surviving on 'handouts' from donor organisations. Members of the group feel that externally driven support for children is often not sustainable, as seen in cases where NGOs have collapsed following the withdrawal of donor support.

In the end, she abandoned this initiative because it became clear that her energies were better invested in the collective work of the group, rather than trying to initiate a complex activity on her own with limited support.

6.7 Plans for the future

Within Linda Compound and in the neighbouring Buckley Township, the Chipego Women's Project has won the respect of many who recognise the good work it is doing in sending disadvantaged children to school and providing nutrition support through the school feeding programme.

With contributions from well-wishers, the project has embarked on the construction of a feeding centre on the school premises. This centre, once completed, will provide an all-weather shelter where meals can be served. At the moment, the children are fed in the open space surrounding the teacher's house. During the rainy season, these arrangements are particularly unsuitable and feeding the children outside becomes problematic.

The problem of orphans and other vulnerable children in Linda Compound remains an enormous one. While the Chipego Women's Project is a useful intervention by the community to alleviate the problem, the members acknowledge that this initiative is only addressing a small fraction of the problem. For this reason the women in the project are seeking ways in which they can scale up their support to children. One of the approaches being considered is to co-opt community members who have different skills that can be exploited to start other IGAs, for example, dress making using their tie-dyed materials. However, they are aware that this activity will require them to invest in sewing machines, for which they do not presently have resources. Moreover, they are also aware that they cannot necessarily count on large-scale volunteerism, as community members want to engage in activities that will give them a source of livelihood.

7. Perspectives from the ground

Having looked through the lenses of a number of community AIDS initiatives and sought to explore the relatedness of CSOs to communities, we are in a better position to articulate some aspects of the role of CSOs as 'intermediaries'³¹⁰ between communities and external support.

There has been relatively little study of forms of social support and crisis response at community level that pre-date external assistance efforts and how these relate to official and organised sources of support. The term 'philanthropy of the poor'³¹¹ has been coined as part of an appreciative enquiry into how communities help themselves. A key question raised by the case study research is the extent to which organised forms of support in response to AIDS relate to or grow out of indigenous forms of support.

In addressing this question it must be noted that community life, at least in some of the communities studied, is so lacking in resources that there is no real 'bedrock' on which to build. Political leadership and whatever traditional forms of leadership exist seem to be uneasy bedfellows, perhaps with the exception of Swaziland, and communities tend to have little united vision or coherence. In some sites, migration, urbanisation and other forms of social displacement have contributed to fragmented

³¹⁰ Naute, W. (2004).

³¹¹ Wilkinson-Maposa, S., et al. (n.d.).

communities. The wisdom of elders does not seem to be drawn on or believed in in any meaningful ways. Local knowledge is largely about bare survival in environments which are either inadequate for meeting the basic resource needs of growing populations, or where infrastructure prevents optimal use of these environments for creating sustainable communities.

Having said this, there are clearly some forms of community support that are integral to community life and upon which individuals and families within these communities have traditionally relied in times of need. These have been significant resources for AIDS responses, prior to and parallel to any forms of support reliant on external assistance. Notable among these are various church structures and women's groups. Support within extended families is also evident, and has saved numerous children from abandonment. There is also a rallying spirit within some of the communities based on ideas of community connectedness and responsibility which creates a moral and ethical prerogative to support each other to do something about those in dire need, even when one's own circumstances are not good. This seems to apply particularly to children.

It is interesting to note that some of these forms of support, and perhaps even the most foundational, are difficult to 'capitalise' on. They cannot be funded. One cannot fund community spirit, the care of a grandmother, the commitment of a church to uplifting people or commitment to providing company to a bed-ridden neighbour. But what of supporting such phenomena, or making it easier for them to happen?

Here we find that the external modes of contact and support have had to work through official structures, and because these are limited, there have been attempts to reach communities through those points of access that have been easier to mobilize. On the difficulties of working through official structures, it is quite apparent that local government and traditional leadership structures have sometimes been an impediment to be 'worked through' rather than a ready vehicle for supporting community structures. Newly created local structures such as DACCs in Malawi (and equivalent examples in other countries) have often not been up to the task of really connecting with communities. But even traditional structures, such as are evident in Swaziland and Lesotho, have not been able to step to the fore in making links between community response mechanisms and external assistance. They seem to have functioned best when they step out of the way and 'allow' things to happen, or act within their own realms of authority by providing access to communal land, for example.

In such contexts the primary response has been the invention and introduction of modes of assistance that can be parachuted into communities by service providers which can provide baskets of particular services: e.g. counselling and testing; food parcels; particular health services; assistance with clothes and school fees. Because decentralised government is not well developed in any of the countries, CSOs have been promoted and used to fulfill these functions.

This has not been achieved without sensitivity to community needs, especially in consideration of 'how' services are delivered. But making contact with communities and building support at scale has introduced dynamics that are additions or 'constructions' in the community context.



There are clearly forms of community support that are integral to community life and upon which individuals and families have traditionally relied in times of need. However some of these forms of support are difficult to 'capitalise' on. They cannot be funded. One cannot fund community spirit, the care of a grandmother, the commitment of a church to uplifting people.

Perhaps the most notable example has been the involvement of young people in CSOs responding to AIDS. This has been promoted as a way of reaching young people, given that many new infections occur in young people. Some of the CSOs we encountered were formed by young people. But young people have career and other personal development interests that have been an important element of their engagement in forming and developing CSOs. Their interests in forming and managing CSOs are different to those, for example, involving a church serving its congregation.

These agencies of AIDS response are shaped by the opportunities offered by AIDS funding as much as they are compelled by needs to respond to AIDS. They stand between communities and funders. They are mostly new social institutions and perhaps even a new stratum of social organisation that is being increasingly strongly supported from outside.

It seems essential to appreciate this, to begin to differentiate this world of CSOs into its parts and types and to differentiate the backing and aspirations which underlie their development. There has been insufficient understanding of this world. It is hard to imagine that large-scale support programmes that are underway – albeit in different forms – can grow and be sustained without much more nuanced understanding, and indeed scholarship, that throws light on the structures and processes that underlie and drive the evolution of these CSOs. They cannot be adequately supported without being better understood.

PART V

DISCUSSION



1. The growth of CSOs

This research has documented a dramatic increase in the number of civil society organisations involved in AIDS responses in southern Africa. Patterns of growth are remarkably similar across the six countries: notable accelerations in involvement in AIDS responses occurred around 1991 and 1996, but the bulk of organisations have begun work on AIDS since 1999. CSOs working on AIDS in the region include both newly established and previously existing organisations, although the greatest growth in activity has been found among small, recently established CBOs that began working on AIDS either immediately from the time of their founding or shortly thereafter.

The scale of this growth is such that it must be regarded as a notable socio-political phenomenon, involving large numbers of paid people and volunteers and taking on a myriad of organisational forms, some of which are clearly unique products of the HIV epidemic. How can this growth be explained and what does it mean? Are we witnessing an AIDS-specific 'associational revolution'?

The findings from this research point to a number of factors that are underpinning this growth. First among these is the epidemic itself: close to half of the CSOs surveyed across the region began working on AIDS in the same year that they were founded as organisations. In the most extreme case, Malawi, there is almost no difference between the year in which organisations were founded and the year they began working on AIDS. Such findings seem to suggest that a desire to respond to AIDS and AIDS-related impacts has been driving a process of civic association and organisation across the region. One could interpret from this that nationwide social mobilisations around AIDS are underway – the 'exceptional' response to AIDS that is often called for.

At the same time, however, 70% of the CSOs surveyed report that they carry out work that is not related to AIDS. Community organisations often form and operate with a holistic orientation to community needs. Many that work on AIDS are also engaged with activities that are oriented at general poverty relief and community development – food gardening, training in income-generation activities, the construction and operation of maize mills, efforts to keep children in school – that are becoming increasingly needed against a backdrop of AIDS, but which are not, strictly speaking, AIDS-related. The case study research in all six countries showed clearly that the presence of AIDS in a household is rarely a prerequisite for the provision of assistance by community organisations: many home-based care groups, for example, are oriented on support for the chronically ill and disabled, whether this is related to diabetes, TB, AIDS, or a severe disability. It can be difficult to draw distinctions between children who are poor and needy as a result of general poverty, and those who are poor and needy as a result of AIDS. Taken in this light, the research findings seem to point towards a general growth in civil society action in the region that may be closely linked to AIDS – and to some extent driven forward by it – but that is also broader in orientation.

The dramatic increase in funding for AIDS in southern Africa is another factor. Funding for AIDS is reaching civil society organisations in ever

greater volumes and it is plausible to assume that the high incidence of new organisations may be linked to the perception (and reality) that there are resources available for AIDS work in the region. There has been no other equivalent drive to increase funding for CSOs in any other area of development.

Various motivations propel people into work on AIDS and these may also help to explain the rapid emergence of civil society organisations. These motivations are often a complex mix of altruism, concern for the well-being of others, and a desire for self-empowerment and upliftment. In contexts of high unemployment and extreme poverty, CSOs can be seen as possible avenues to change, opportunity, employment or access to resources, education and training. They are also a vehicle for giving back to the community and helping others. In some selected cases, CSOs are also linked to political or patronage networks.

The reasons why individuals join together – often informally, at first – under the banner of community development and AIDS response work are multi-layered. The case study research, which highlighted the activities of many largely non-funded CSOs, suggests that, in the first instance, motivations are as much about compassion and community activism as they are about any type of financial or personal opportunism. However there is also evidence to suggest that CSO members and volunteers may drift away from organisations when other opportunities present themselves, especially if the work is not remunerated and there is no prospect of this coming to pass.

The growth of CSO activity on AIDS over the past decade seems generally to have been regarded as a desirable phenomenon. It has been encouraged at country level, by the donor community and by civil society umbrella organisations themselves. Seemingly civil society organisations are thriving, as evidenced by their growth in numbers. This occurrence has been encouraged in AIDS strategic plans and is seen as an outgrowth of the need for multisectoral engagement and mobilisation of societies as a whole.

However the way in which this growth proceeds has significant implications at a number of levels. It has raised civil society and community expectations of support, it has created particular areas of responsibility for national AIDS authorities, and it has witnessed a growing role for non-state actors in providing AIDS-related services that would otherwise be seen as the responsibility of the state. It has also intensified the engagement between civil society organisations and the state, a process which has involved both hope and optimism around such concepts as partnership and multisectoralism, as well as tensions and frictions around the state's power and control over policy and resources. The recent growth of CSOs in AIDS response is a phenomenon that is unfolding without a roadmap and there are many strategic questions which, surprisingly, appear to be attracting little attention: Is it desirable that there should be an ever proliferating number of civil society organisations in the AIDS field? Is it envisaged that CSOs will ultimately professionalise as they become more proficient? What is the envisaged service delivery framework five years hence? Will current developments ultimately erode the independence of CSOs as they are progressively preoccupied in service of national plans?

The recent growth of CSOs in AIDS response is a phenomenon that is unfolding without a roadmap. It poses many strategic questions which, surprisingly, appear to be attracting little attention.

2. Funding for CSOs, funding for services

This research has found that global increases in funding for AIDS are reflected in the spending patterns of civil society organisations in southern Africa. Between 2001 and 2005, CSOs' average annual expenditure on AIDS activities tripled. Spending grew most rapidly during the latter half of this period which corresponds to the introduction of Global Fund and PEPFAR funding in the region, as well as increases in other funding sources. By 2005, CSOs working on AIDS were receiving more funding, and from a greater number of sources, than they had in 2001.

The increased funding for CSOs in the region is a product of expanding international commitments for AIDS. More than 85% of funding received by CSOs in 2005 can be attributed to external sources; government budgets remain a relatively minor source of support. Bilateral assistance agencies are the largest source of funding for CSOs working on AIDS in the region, followed by international NGOs, multi-lateral agencies, and intermediary funding institutions that channel external assistance. PEPFAR is by far the largest source of financial support for CSOs in the region by total volume of funds committed.

The comparative nature of this study has provided important insights into the extent to which the specific AIDS funding architecture that is evolving in each country is shaping patterns of access to funding amongst CSOs. Across the region, the growing spending on AIDS on the part of small and medium-sized CSOs can be attributed to the emergence of intermediary agencies that act as conduits for external funding and sub-grant funds to CSOs through decentralised structures. Although these account for only 11% of total funding received by the surveyed CSOs in 2005 in terms of absolute financial value, nearly half the CSOs surveyed had accessed support from one of these institutions. Over the five year period, this was the fastest growing source of support for CSOs across the region.

'We are not interested in just doing activities, as the donors wish. Rather we want to do something towards positive outcomes. For example, if we conduct research into the causes behind the growth of lucrative sexual activities, the results will show us what should be implemented towards the reduction of young girls opting for this activity – maybe giving them the possibility of new activities. But if we carry on just distributing condoms and taking those who acquire STDs to health centres, then we are not eliminating the bad from its root, we are just covering the holes.'

– Mozambican CSO

Sub-granting mechanisms have emerged as particularly important in Malawi and Zambia, where 60% and 14% of all funding received by CSOs in 2005 in the respective countries was accessed through such channels. In both cases, this reflects a strong commitment to see funding disbursed broadly to community organisations as part of a national mobilisation around AIDS: in Malawi the process is centrally administered by the NAC in conjunction with five international NGOs acting as umbrella bodies; in Zambia it is implemented independently of the state through two existing civil society associations and one new coordinating agency. In countries where the national sub-granting activities are more limited (Swaziland), less efficient in disbursing funds (Mozambique) or do not exist (Namibia, Lesotho), funding for CSOs is more concentrated among a smaller number of relatively large NGOs that are in a position to access support directly from donors or through sub-recipient agreements with government (e.g. for Global Fund support).

An analysis of the funding portfolios of some of the largest AIDS funders in the region has found that, in many cases, the proportions of funding being channelled through CSOs are not insignificant. For example, more than half of Global Fund support to Zambia and one-third of funding to Namibia between 2001 and 2005 went to civil society organisations.

World Bank MAP includes a community support component in both Zambia and Mozambique that accounts for 35% and 51% of the total commitments in these country programmes respectively. PEPFAR support to non-governmental organisations ranges from a quarter to more than half of overall commitments in countries across the region.

Many donors examined in this research have diversified AIDS portfolios in which support is channelled through a mix of modalities, including AIDS-specific pooled funding, budget support, SWAPs, and direct project funding. In almost all cases, some support flows to civil society organisations either directly or indirectly. The rationales given for directing support to civil society are wide ranging, but tend to cluster around a core number of points. The most dominant reasons relate to CSOs' positioning 'close to the ground' and their ability to ensure that funding reaches 'those who need it most.' This is linked to the complementary notion that 'government cannot do it alone.' There are also efficiency concerns – the idea that CSOs can move rapidly, with limited overheads, and minimal bureaucracy – as well as a view that CSOs represent the needs and concerns of those most affected by the epidemic. These justifications also blur into broader rationales about the involvement of CSOs in poverty reduction programmes, in which many donor AIDS strategies are embedded.

There are many assumptions embedded in these rationales and it is not apparent how thoroughly these have been questioned and whether there is, in fact, sufficient evidence to support them. For example, there is little systematic empirical evidence that CSOs are more efficient than other actors in delivering services and the notion that CSOs are locally 'owned' and accountable to community members needs to be treated with caution as many cannot truly be considered community institutions.

Some donor representatives noted that, despite a general trend away from project based funding (including direct support to civil society recipients), donor institutions find themselves under pressure to point to the tangible effects of their work, particularly to constituencies at home. Because it is very difficult to convey the successes of providing general budget support to governments, some donors will retain a small number of directly funded projects which can be used to showcase results – for example, how many meals have been provided to orphaned children and how many women have been trained in income generating projects. Support to civil society may therefore also be motivated in part by the need to retain direct links with development activities that are visible and concrete.

While donors voice a mix of rationales for supporting civil society in AIDS response, most of these ultimately link to CSOs' perceived positioning at community level and their ability to implement needed services vis-à-vis the broader national AIDS plan. By contrast, expressions of support for civil society's voice and advocacy roles are more muted, at least in comparison with the core role of service delivery. This orientation is reflected in the purposes for which funding is awarded to CSOs: three quarters of funding received by surveyed CSOs in 2005 was for direct programme costs linked to prevention, care and support, and impact mitigation work. Less than two percent of all funding was awarded for advocacy or rights-based work. CSOs report that it is significantly more difficult to mobilise resources to support general organisational

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operations – such as salaries, stipends for volunteers, office equipment, and office space – than it is to access funding to cover direct project costs.

Funding for CSOs tends to be awarded in short-term funding cycles: almost half the CSOs surveyed had only mobilised a quarter or less of the funds required for the following year. Reports of delays and interruptions in funding disbursements were not uncommon. These findings suggest that the significant overall increases in available funds, as well as a growing willingness to channel funding to CSOs, have not been accompanied by planning for consistent, multi-year funding strategies that allow for the systematic growth of CSOs at community level. This research has found that funding for CSOs is largely project-based and that organisations' management and development needs are regarded as of secondary importance, if at all.

The survey revealed that a large majority of organisations have bank accounts through which to receive funds and premises from which to work, but operate in the absence of any financial cushion that would allow them to sustain and grow their operations outside the recurring project funding. This convergence of conditions leaves many organisations – and not only the young and emerging ones – in vulnerable positions: they are heavily dependent upon external financial support, donor priorities for funding are reported to change in ways that are often perceived to be non-transparent, and the focus of capacity-building efforts is largely on compliance with financial and reporting requirements. Funders with a significant commitment to long-term investment in civil society organisations – such as Southern African AIDS Trust – stand apart in terms of the approaches they have adopted, but also, it must be acknowledged, in the smaller scale of their work.

There is little question that civil society as a sector has been embraced as an implementing partner in AIDS responses, but this appears to have been done instrumentally, rather than strategically, on the basis of grounded understandings of the strengths and potential contributions of civil society to AIDS response efforts. Linked to this, there has not been adequate recognition of the operational limitations faced by many CSOs that make them ill-suited to meet some of the standard requirements that are attached to the receipt of funding.

3. Imbalances in the funding environment

Civil society organisations involved with AIDS response are heterogeneous and patterns of access to funding vary widely. The research findings have revealed strong differences between organisations located at the 'centre' and the 'periphery' of the funding environment, but also point to some trends which may be mitigating against these imbalances.

Spending on AIDS is highly concentrated among a small proportion of organisations. Twenty percent of surveyed organisations accounted for almost 90% of all CSO spending on AIDS in 2005, while 10% of organisations received no monetary support at all in 2005 and functioned solely on the basis of donations and contributions from their own members. The research has shown clearly that there are still many people and communities that desperately require assistance and are not being reached by the funding architecture in its current form.

'All donor agencies want you to be in operation for three years or more and must have an active bank account before considering funding. I think they should also tell you how you are supposed to achieve that as well.'

– Zambian CSO

*'Needy people increase, yet
there is no funding'*

- Namibian CSO

The organisations with the largest income in 2005 had relatively high levels of access to all the major sources of funding: bilateral and multi-lateral agencies, funding from international NGOs and FBOs, and sub-granting mechanisms. By contrast, smaller organisations (those in the bottom 60% by income in 2005) depended heavily upon grants from sub-granting mechanisms; only a small proportion access support from the other channels directly. Access to funding from bilateral and multi-lateral agencies is strongly concentrated among the largest organisations and the average value of these awards was more than US\$250,000 in 2005. Over half of the international NGOs surveyed in the research fell within the top 20% of organisations by level of 2005 expenditure. Compared with NGOs and CBOs, INGOs were found have much higher levels of annual spending on AIDS and a greater number of funders.

Geographical location is a strong factor influencing organisations' access to funding. The survey found that rural organisations are disadvantaged in comparison to their urban counterparts in relation to all of the funding indicators: they have a significantly lower average expenditure on AIDS, they submit fewer proposals for funding and have fewer sources of funding, and they have lower average levels of support for all types of costs than do organisations in urban areas.

These financial figures suggest that CSOs in rural areas are on the periphery of the funding environment, and the case study research conducted in rural locations underscored this in no uncertain terms. In these communities, we found only limited evidence that large scale funding is trickling down to smaller organisations. In Namibia (Epako, Omaheke Region) and Lesotho (Ha Ramapepe, Leribe District), for example, community organisations that had succeeded in accessing support generally did so on a very limited scale, through donations of supplies from clinics or other NGOs or in the form of small-scale support channelled through local/regional AIDS councils. In Ramapepe, the local support group was on the bottom rung of a lengthy 'aid chain' that extended from the original donor through a national NGO based in Maseru. Although the group was a designated beneficiary of funding, it did not receive any money directly. Rather, it implemented a set of activities - home-based care and an orphan feeding scheme - using supplies provided by the national NGO; when the supplies ran short, as they often did, the women in the support group would supplement them with purchases from their own pockets. Although the group directly controlled the way it conducted its work, it did not control the funding itself, nor the purposes for which it was allocated. In Epako, where there was a greater density of civil society activity on AIDS, the imbalances between 'resourced' national NGOs and local CBOs were strongly apparent. Funding options for small local organisations were extremely constrained, apart from a limited number of one-year awards through the Small Grants Fund which, while gratefully received, also created sustainability problems as they were often not renewed for a second year.

The picture that has emerged from this research is of an imbalanced and top-heavy distribution of funding that in shape seems to resemble a funnel. Funding is reaching a certain segment of large organisations in sizable volumes and is increasingly penetrating the ranks of small and medium-sized NGOs in more modest amounts through sub-granting mechanisms. However there is still a significant population of grassroots community organisations that are marginalised in this environment: they

are trying to serve a large number of people with acute and complex needs, but have very little funding and capacity to do this effectively. Such organisations often tend to have little information about where they can turn for funding, do not have experience writing proposals, and have limited formal understandings of how an organisation can grow and develop in line with a particular vision. Because many of these organisations are located in remote and underserved areas, the people they are working with are effectively at a double disadvantage: formal services are limited in their reach, and the community organisations that seek to fill these gaps are under-capacitated.

The research has shown the important role being played by international NGOs as conduits for bilateral AIDS funding, yet there is mixed evidence about the extent to which their collaborations with local CSOs are resulting in strengthened capacity or greater access to funding on the part of organisations in these peripheral areas. Interviews conducted for this research encountered a frequently expressed view across the region that large national and international NGOs access significant funding to implement specific programmes across a particular area or geographic territory, but that the bulk of the resources still tend to remain concentrated in regional capitals and towns. In other words, AIDS funding and programme ‘arteries’ are not yet linked into an adequate system of ‘capillaries’ that can carry support to more distant areas. One respondent from a national ASO network noted that the people who are supposedly leading and monitoring the programmes (large NGOs and the government) don’t actually want to work in the places where they are most needed, which may be remote or uncomfortable. As a result, they continue to cluster around points of ‘civilisation’ and outsource roles and functions to locally based entities which are seen to be ‘on the ground’ across regions. Programme implementation in more remote areas is often done through ‘partnerships’ with local organisations in those communities – CBOs, churches, traditional leaders – who are brought into short-term implementing agreements and may or may not be compensated for their time and efforts. The lines of accountability between these groups and the centre are reported to be weak and, in some cases, the outsourced organisations may not be appropriate partners for the task at hand, but simply the ones that are best positioned to be drawn in for purposes of implementation.

In countries where investments have been made in sub-granting mechanisms, these are proving successful in expanding access to funding among small and medium-sized CSOs. They are helping to level an uneven playing field by making support available in appropriate amounts to organisations that would otherwise remain on the periphery of the funding environment.

The above description suggests that the general thrust of growth in AIDS funding and responses thus far has benefited those located at the centre of the funding environment: larger organisations, based in urban areas, with prior programmatic and financial experience. However some of the trend data collected in the study suggests that there are dynamics at play which may be mitigating against these imbalances. Most notably, average spending on AIDS among CBOs and smaller organisations grew at a faster rate between 2001 and 2005 than it did among NGOs and INGOs. Linked to this, decentralised AIDS structures, including sub-granting mechanisms, were the sources of funding which recorded the strongest increases in access among CSOs over the five-year period, and it is known that these are particularly significant for smaller organisations.

Together this suggests that, in countries where investments have been made in sub-granting mechanisms, these are proving successful in expanding access to funding among small and medium-sized CSOs. In other words, they are helping to level an uneven playing field by making

support available in appropriate amounts to organisations that would otherwise remain on the periphery of the funding environment. This is nowhere more evident than in Malawi, where CSOs have undergone an explosive rate of growth in terms of spending on AIDS since the roll-out in 2004 of a national sub-granting mechanism linked to the NAC. This is not to downplay the significant challenges being experienced in this model – nor the serious questions about its sustainability – but rather to underscore that, at the level of moving funding in a decentralised manner, such approaches appear to be meeting with some success.

4. Systematisation, but not at the expense of diversity and flexibility

Under the ‘Three Ones,’ concerted efforts are underway to regularise the AIDS funding environment, but powerful forces are working against the harmonisation of support and this research has found only limited evidence that the funding environment for CSOs is becoming more regularised. While the dominant trends within development assistance financing can be felt at country level – e.g. shifts towards budget support and sector-wide funding approaches, the consolidation of funding through basket mechanisms, the alignment of external assistance behind national plans – a mix of funding modalities continue to prevail across the region and the largest AIDS funding initiatives remain the least harmonised. The implications for CSOs of the systematisation of funding for AIDS are mixed, and in some respects, CSOs *benefit* from an un-harmonised funding environment where a diversity of parallel sources continues to exist. Because civil society is so internally heterogeneous, only a highly differentiated centralised funding system would be in a position to meet the needs of CSOs at different stages of institutional development and it is unlikely that such a system could embody the flexibility and tolerance of funding risk that is probably required to fund CSOs at a broader scale than at present.

The findings from the research suggest that there is a fine balance that needs to be struck between systematising some channels of support in a way that benefits smaller CSOs, on the one hand, and maintaining a diversified funding environment where organisations can continue to pursue independent direct funding relationships with donors, on the other. This is essentially about the need to ensure greater equity of access to funding for a broad spectrum of organisations, while not over-regulating the environment such that it constrains the ability of larger organisations to continue working at scale or limits some of the innovative and path-breaking work that is often supported through direct funding relationships.

The findings from this research are replete with examples of the dangers of under and over-regulation of funding, linked both to centralised control over AIDS finances as well as non-harmonised funding streams, from the vantage point of civil society organisations. In countries where there is strong central control over funding – such as in Malawi and Mozambique – CSOs note frustrations with excessive bureaucracy and the slow pace of funds disbursement, but there is a clear and ostensibly transparent mechanism in place to which all CSOs in the country may apply and theoretically access support. These ‘centrally planned’ AIDS

‘There are too much of technical requirements for issues that do not require them.’

– Malawian CSO

economies are constructed in a way that seemingly favours broad and equitable access to funding by a wide range of CSOs. In Malawi, this has been shown to work in the sense that spending on AIDS amongst surveyed CSOs is the least concentrated of all six countries in the study. By contrast, the failure of these mechanisms to work as intended in Mozambique has resulted in the country having the most concentrated CSO funding profile in the region. This appears to be attributable to the significant parallel project funding that continues to flow from donors to compensate for the slow pace of fund distribution through the central structures.

In Lesotho, Namibia and Swaziland, the NACAs do not act as funding agents directly, but exercise control over the allocation of available funding, often through calls for proposals, direct procurement of services, or other methods for identifying partner organisations. Such systems are geared less to 'equitable access' and more to identifying institutions that can perform certain roles, including non-state actors. As such, they tend to gravitate towards larger more established NGOs, sometimes with the proviso that these work in partnership with smaller CSOs, sometimes not. There are no sub-granting mechanisms of any scale in these countries, apart from the Small Grants Fund in Namibia which is targeted at CBOs but whose reach remains limited. Funding for CSOs in Swaziland and Lesotho is somewhat less concentrated than in Namibia, where PEPFAR and Global Fund support dominate the funding environment and funding is heavily concentrated among a small tier of predominantly national NGOs that implement programmes on a large scale. Yet in all three countries, the funding needs of small community organisations cannot be described as well catered for.

'There is excessive bureaucracy.... The request for funds from the CNCS is based on filling out forms. After one fills out the forms properly and submits them, they ask to specify details not accounted for in the forms. Subsequently, they ask us to give them three quotations for each proposed item, and for each correction made, they ask for another three quotations. After four to five months our plan has not yet been approved. Once the plan is approved we return to the same cycle regarding the refunding, and after eight months the costs have changed, and everything has to be done anew.'

- Mozambican CSO, on applying for funding to the national common fund

Zambia stands apart as a distinctive case and provides an interesting alternative to the decentralised and concentrated funding models in the other countries. The NAC in Zambia plays a relatively hands-off role in funding and 'parallel' funding for AIDS continues to enter the country despite the fact that Zambia is at the forefront of aid harmonisation in the region. Large NGOs and INGOs – of which there are many, given Zambia's profile as a low-income country with a large international development presence – clearly benefit from these sources of support. Yet the three independent sub-granting agencies which disburse Global Fund and other donor support to CSOs and FBOs across the country have evolved into sizable operations that are seen to be making a significant dent in the funding needs of CBOs and small NGOs. In Zambia, the predominant concerns about funding within civil society relate to the 'squeeze' being experienced by large national NGOs who require greater levels of funding than the sub-granting mechanisms are in a position to provide, and who are losing their traditional support from bilateral agencies which are increasingly funding through budget support.

Different organisations require very different types of funding and although the present un-harmonised funding environment may be disorderly and difficult to keep track of from the perspective of a central coordinating agency, its jumbled diversity may in fact be important for maintaining civil society's robust and vibrant role. National AIDS plans have been shown to embody fairly uniform strategies for what are in fact complex and heterogeneous epidemics, and some of the large funding initiatives are driven by a relatively standard programme model that emphasises rolling out key services, mainstreaming AIDS into line

ministries, and strengthening the government's institutional capacity, rather than being developed in response to the particular epidemiology of a given country. These types of tendencies are leading to an official homogenisation of AIDS responses into named programme areas and vertical interventions which dominate over more holistic approaches. There is a danger that CSOs, which are predominantly being funded to help implement these programmes, become overly dependent upon externally defined activities and approaches.

This research has found that many smaller funding institutions – among them independent development agencies, church-based projects and initiatives, and foundations – tend to be less beholden to some of the prevailing categorisations of intervention and therefore more able to support interdisciplinary or cross-cutting forms of activity. Although they work on a smaller scale and tend to develop longer-term partnerships with a small handful of organisations, the CSOs that do succeed in linking with such partners often commented that the funder understood the community and its needs, that the funding relationships were 'easy,' and that reporting requirements were straightforward. These individualised funding arrangements – where they exist – provide positive examples of how development and support can be channelled directly and individually, albeit on a limited scale.

The shift towards general budget support is beginning to be felt by CSOs in some countries in southern Africa, although on the basis of data gathered in this research it is not possible to say how much of this is anticipatory and how much of it is actual. There are clear concerns that government procurement systems are not presently geared to work on a larger scale with CSO 'contractors,' apart from the bigger question of how inclined governments in the region are to expand partnerships with CSOs. This provides another strong argument in favour of a diversified funding environment. This study has found that advocacy and rights-based work is presently funded at a very low level, and it is unlikely that this would increase under a scenario where more funding is channelled through government. In fact, where donors do target particular support to the needs of marginalised groups, to strengthening networks and institutions, and to promoting the voices of affected populations, this is often done through direct project funding arrangements which continue to flow in parallel to the larger streams of support which are channelled through SWAps, pooled funds, and budget support.

5. Support needs go beyond money

The challenges of 'funding' AIDS responses and 'supporting' AIDS responses should not be conflated. By increasing 'absorptive capacity' and channelling money to 'where it is needed most' only part of what is needed is achieved. The value of CSOs having money in hand is greatly dependent on other kinds of support, and the findings from this research suggest that this has not been given sufficient attention.

The most comprehensive attempt to build institutional systems for supporting CSOs in AIDS response that we have found in this study is the Malawian national grant facility. The grants facility has been designed and carefully planned from a blank slate, rather than being an adaptation

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or redevelopment of existing arrangements. It is therefore particularly meaningful that it has overlooked to such an extent the support needs of civil society organisations apart from funding. Although an excellent financial management and project monitoring system has been set up for grants, the actual usage of funds remains low. Part of the problem is technical, involving protracted approval and disbursement processes for grants, but capacity problems in umbrella organisations and in recipient CSOs have proved to be significant obstacles to the success of the grants facility.

As an outcome of limited capacity to plan and manage complex programmes, the grants facility has turned to funding a large proportion of small-scale, short-term projects which can immediately be put into place and which do not require extensive preparation and development within organisations. Admittedly, there have been attempts to build capacity and to provide guidelines on writing project proposals, on procuring goods and services, and on accounting for funds received. But the experience in Malawi has shown that there remains a critical capacity problem within recipient CSOs even to use such guidelines. The need for support involves much more than guidance on how to deal with money – it extends into planning and programme management, assessing needs in the community, basic skills in formative evaluations, organisational governance – yet these elements of support have been neglected. The result is that the system, despite being ‘excellently’ structured, is underperforming.

Those umbrella organisations managing the facility at district level report that they have been far more involved in the direct capacity-building of organisations than was anticipated and have been overstretched in their efforts to provide support, to the point of becoming less effective in their mainstream functions. They had not resourced themselves in preparation for meeting this need. This has significantly delayed further development of the grant facility system which is overdue in being handed over to the management of district assemblies.

Malawi is not exceptional, but is a large-scale exemplar of a situation that pertains in all of the countries studied. There is little evidence of systematised programmes to develop CSOs to the point that they are able to manage what they are targeted to achieve. While all of the sub-granting mechanisms encountered in the research incorporate some elements of training and capacity-building, these are inevitably slotted into supporting rather than leading roles, given the dominant emphasis on disbursing funds. As CBOs in particular are largely funded to provide services in keeping with expectations of funding agencies and national plans, existing capacity-building efforts tend to focus on developing organisations into better and more accountable service providers, rather than building them into independent self-governing organisations guided by their own vision and unique strengths.

CSOs need a mix of different inputs at different stages to be able to scale up and grow sustainably. Organisations tend to grow in different ways, sometimes becoming more comprehensive and other times expanding by offering such services in more contexts and with increasing expertise. Yet on the whole, the same rules tend to be applied to organisations irrespective of their relative capacities, accountabilities and development needs. For example, in Malawi, procurement and reporting requirements

are universal, meaning that the same rules apply to institutions of all types and sizes, and these are onerous and create problems of reporting. While adjustments could no doubt be made to these procedures, this seems to work against the drive to scale up sub-granting through standardised, bureaucratised practices.

Part of the problem has been a failure to tease apart the varying roles being played by civil society actors and to tailor support accordingly. We have referred to discourses around the promise of CSOs as pioneers, partners and providers in AIDS response, focusing on CSOs as innovative, efficient, close to people in need, service oriented, accountable and part of a sustainable national response. In reality, CSOs are often diffuse and polymorphic. Their boundaries with informal associational life are often blurred. They change. In many cases they may stagnate or collapse. The motivations which underpin their emergence, the needs and interests they serve, and their capacities to evolve are varied. Engaging these actors and optimising their roles means understanding what they are, what they can do and the various forms of support they need in their development.

Supporting the sustainability and development of such entities inevitably involves shaping them in a way that builds on their unique characteristics and strengths, to a point where they have the possibility of entering into a self-learning trajectory, yet this requires intensive inputs and is time consuming. Building capacity of CSOs requires working closely with them and staying close to them as they develop. Ultimately the cost of this may not be warranted as an AIDS response strategy and strategic debates need to grapple with this question. There has been a high degree of overestimation of the capacity of CSOs to fulfil the expectations that have been imagined upon them, in light of their ability and willingness to join national mobilisations.

If many of the emerging CSOs are to become viable and strong organisations, there is need for country-level support for strategic planning, organisational development assistance, human resource development and management development. This cannot be ignored. There is a thriving private sector industry in this area, but little evidence of this kind of support activity under national funding programmes.

6 Implications for the future

The patterns of access to funding that have been explored in this research suggest a number of possible implications – both worrisome and promising – for the future of civil society responses to AIDS.

One clear possibility is a shift away from the independence of civil society towards greater co-option into the role of service provider. The way funding for AIDS is structured is having clear effects on the type of work many CSOs are undertaking, the degree of ownership they feel over their work and the programme models they use, and their ability to plan for the future and grow as independent organisations. We have found that CSOs are being funded to work largely within the context of national plans on activities which link to a defined set of services, which is often in contrast with their more holistic approaches to work and understandings of the epidemic. Short-term funding cycles that

emphasise direct project costs appear to slow or even undermine the development of the institutional skills and capacities that are essential for organisations to grow and become viable structures. There is a danger that many smaller organisations that are funded directly or through implementing partnerships with larger NGOs are becoming proficient in delivering programme services in a particular way, but may not be capable of growing or even of surviving if funding flows change or are cut off.

The overlapping trends of increasing funding for AIDS and growth in CSOs have resulted in a great deal more money flowing to a greater number of organisations. Yet many CSOs remain underfunded in their own terms and growth in numbers of CSOs active in AIDS responses is not accompanied by consistent or long-term funding which allows for planning and systematic growth of CSOs at community level. Shifts towards general budget support may introduce new institutional vulnerabilities for civil society organisations. Yet despite great dissatisfaction among many CSOs in the region about the funding environment in which they are operating, there is little evidence to suggest that CSOs involved with AIDS responses are coming together as a movement around a shared agenda. While national and sector-wide networks do exist, these do not appear to be active in representing the interests of the sector in relation to donors and government policymakers in the way that treatment access, for example, has galvanised many in the AIDS field. Competition for funding may be undermining the formation of alliances among CSOs around issues of common interest.

Alongside these concerns, however, it is important not to lose sight of some of the promising changes within the current environment in which civil society organisations are responding to AIDS. This research has clearly shown that critical appraisals of the global response to the HIV epidemic have resulted in significant shifts in the way that funding for AIDS response is conceptualised. To differing degrees, all six countries in the present study reflect a range of efforts to move funding closer to the ground in order to better resource community-level responses to AIDS. A range of models and approaches are in evidence and it is clear that there is a growing amount of thinking – and a mounting evidence base, drawn from practical experiences – around issues of how to optimise support to civil society.

The present funding environment for AIDS appears to be seeding broad-based community development work that goes beyond AIDS and its immediate impacts. At the grassroots level, development is being 'mainstreamed into AIDS,' as funding for AIDS responses is used to address a range of community needs that are more broadly related to poverty, marginalisation and exclusion.

Another hopeful aspect of the present funding environment for AIDS is that it appears to be seeding broad-based community development work that goes beyond AIDS and its immediate impacts. At the grassroots level, development is being 'mainstreamed into AIDS', as funding for AIDS responses is used to address a range of community needs that are more broadly related to poverty, marginalisation and exclusion. Some of the most promising examples of community activity encountered in this research were the CSOs that had evolved integrated approaches to addressing AIDS – that saw problems and challenges holistically and attempted to address them through a spectrum of related actions, rather than in narrow categories of intervention. These cases appeared as genuine examples of 'locally owned' development, where top-down approaches had given way to more collaborative forms of work that build on local strengths, motivations and insights.

Indeed, one of the major challenges that remains lies beyond the problem of simply 'moving money' to community level more efficiently – it is

about getting those resources to work in different and more effective ways. This is a much more difficult challenge, because it relates to the complexity of marrying external forms of support to local ideas, motivations and forms of activity in a way that enables them, rather than dictates to them. The case study research vividly revealed the many ways in which community life and forms of solidarity are manifesting themselves in activities that reach out to people in need of assistance. In many instances, these feeding programmes, home visits, and support for affected children are only minimally reliant upon external funding and resources and seem poised to carry on regardless of the presence or absence of outside assistance. As the systems for disbursing funding are further developed and refined, it is critically important not to lose sight of the effects of those mechanisms upon the communities they reach and the types of impacts they introduce into community settings. As funding channels stretch closer to the ground, the systems, methods and approaches they employ must increasingly be oriented on supporting locally defined priorities and approaches, and on enabling community responses rather than driving them.

PART VI

RECOMMENDATIONS

SAVE THE CHILDREN PROJECT OMAHEKE





This study has focused on the intersection of donor funding for AIDS, country strategies for responses to the epidemic, and the growing role of civil society organisations in AIDS-related activities. We have described a strong growth in numbers of civil society organisations involved in such work, as well as increasing levels of funding that have been made available to CSOs to address needs associated with AIDS. The research has directed attention to the need to better understand the significance of this phenomenon and to critically question and debate its future directions.

Making recommendations needs to be approached with caution because so much about the current context remains fluid. We have described a dynamic situation in which prevailing practices for funding CSOs have evolved through the interplay of international trends linked to thinking about development assistance and a myriad of country-specific situations, inclinations and opportunities. Any recommendations must be seen as tentative in the sense that the phenomena in question are newly emerged and it is not yet apparent what will remain in place as rapid growth turns into consolidation. However, interventions are likely to have greater impact if conducted before the growth of current trends run too far, and it is apparent that there are imbalances within the funding environment that require redress.

The recommendations presented below are divided into three main sections: recommendations for optimising funding for civil society in AIDS responses, recommendations for civil society organisations and networks, and recommendations for further study.

1. Recommendations for optimising funding to civil society

As this research has shown, there are many parallel and overlapping approaches in use for funding civil society organisations in AIDS response. Specific recommendations could be made for optimising the functioning of each of these various models, however these would be more appropriately formulated on the basis of thorough evaluations, rather than broad situational research such as that undertaken in this study. Without going into the specific details of individual funding arrangements and systems, the following general recommendations are made to donor institutions, national AIDS coordinating authorities, and other government agencies that bear responsibility for the shape of funding allocations for AIDS:

- *A strategic approach to funding and support for civil society is required.* Support for civil society needs to be approached strategically, with cognisance of the particular strengths, capacities and limitations of civil society organisations, as well as the range of roles they are suited to play. To the greatest degree possible, strategies need to be based on empirical evidence and research, as well as a participatory process involving civil society organisations themselves.
- *Support for civil society organisations must recognise the heterogeneity of the sector* and be sufficiently differentiated in approach to be able to cater for the needs of different types of CSOs. One-size-fits-all models are unlikely to be successful and a graduated approach to ‘funding risk’ may be required.

- *Capacity-building must be an integral component of funding strategies, not an add-on element. Funding for civil society organisations is only as useful as CSOs' ability to utilise funding effectively.*
- *Decentralised responses to AIDS should be supported, yet these require significant investment in local government institutions, decentralised AIDS structures, and other local entities. Support for decentralised governance systems has generally not paid adequate attention to AIDS.*
- *There needs to be a greater willingness to support CSOs as institutions. Current project-based, short-term funding cycles are not conducive for building the long-term sustainability of organisations. Support for institutional, administrative and human resource costs need to be provided alongside project funding.*

For donor institutions, these recommendations might involve:

- Maintaining some direct funding of CSOs alongside harmonised forms of support;
- Increasing allowable levels of support for administrative and institutional costs in grant awards;
- Reviewing and revising procedures and reporting requirements to make them less onerous for small organisations;
- Re-visiting standard 'risk' thresholds for funding allocations, particularly for small CSOs;
- Providing support to national civil society networks and umbrella bodies that can draw together small CSOs for greater collective significance and action; and
- Promoting and supporting small grants funds for civil society organisations, particularly in those countries in the region where they do not presently exist.

For NACAs/governments, this might involve:

- Prioritising funding and support for CSO networks within national plans and budgets;
- Increasing the proportions of funding available for cross-cutting projects that fall outside vertical programme categories;
- Investing in capacity-building programmes, at both a national and decentralised level;
- Promoting opportunities for funding and support more clearly and proactively at local level; and
- Initiating consultative processes with civil society organisations around long-term plans for AIDS response funding and support.

2. Recommendations for civil society organisations and networks

Civil society organisations working on AIDS have been shown to work relatively independently and have not as yet joined together into a strong and viable force. Individually they stand in a disempowered position in relation to donor and government institutions that heavily influence

the funding environment. Yet CSOs are not passive entities and there are many basic things that even individual organisations can do to act upon the context in which they are operating.

Civil society organisations should:

- Recognise the importance of networking, not only for accessing information and resources, but as the foundation of a strong sector that can begin to advocate around its interests;
- Participate in the work of thematic and sector-wide associations that can represent concerns of the sector;
- Think beyond the day-to-day focus on programme implementation and identify issues around which to advocate for change;
- Contribute actively, including at the local level, to multisectoral forums that exist on AIDS-related issues; and
- Use opportunities to voice concerns about donor practices and requirements that are onerous or constrain effective work.

3. Recommendations for further study

This study is part of a growing body of research literature on the involvement of civil society organisations in AIDS response. Many areas of this field remain under-studied and further research should be encouraged, with linkages to the well-established fields of research on civil society, social movements, development studies and organisational development.

Recommendations for further study are clustered under two main areas of focus: tracking trends that have on-going significance for civil society organisations in AIDS response, and conducting work related to under-researched areas and gaps in knowledge.

Tracking emerging trends

Broad trends of relevance to CSOs in AIDS response include:

- The changing aid architecture and its impact on the growth and consolidation of civil society organisations;
- Impacts of general budget support on civil society organisations, including access to funding, relationships with the state, and advocacy/critical voice;
- The evolving role of international NGOs as conduits for bilateral assistance; and
- The roll-out and institutionalisation of the 'Three Ones' and their implications for CSOs.

Under-researched areas

Areas that have been under-researched and require focused attention include:

- *The basis of 'partnerships' between national-level CSOs and international NGOs in the AIDS sector.* International NGOs are

becoming increasingly important vehicles for the delivery of development assistance. One effect of this may be the 'juniorisation' of national CSOs who are drawn into implementing arrangements on uneven terms.

- *The impact of funding on the value systems of civil society organisations.* There has been little attention paid to the value systems that underpin civil society organisations and the ways in which these may be lost or eroded in the drive to partnership through service delivery funded by donors or the state.
- *The cost-effectiveness of delivering basic AIDS-related services through CSOs.* Important issues needing attention are: the cost-effectiveness of different models of funding disbursement; the costs of CSOs of different sizes and types providing basic services as compared to government; and the costs of capacity-building.
- *Effects of the trend towards centralisation and homogenisation of AIDS responses.* There is a need to critically examine the costs of growing AIDS bureaucracies and bureaucratic requirements, not least those of fast developing national monitoring and evaluation systems, and their implications for civil society organisations in particular.
- *Patterns of growth of CSOs.* There is a need to better understand different patterns of growth of CSOs working in AIDS, including tendencies towards increasing specialisation or towards increasing comprehensivity of services.

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APPENDIX

List of individuals interviewed

Country	Institution	Individual	Position
Lesotho	ActionAid International/SIPAA	Abraham Opito	Technical Advisor
	CARE Lesotho	Abigail Dreyer	LETSEMA HIV & AIDS Organisational Development Coordinator
	DFID	Tim Martineau	Senior HIV & Health Adviser, DFID Southern Africa (Pretoria)
	Global Fund	Nkhala Sefako	GFATM Coordinator, NAC
	GTZ	Kirsten Röttcher	Advisor, Community Development
	Irish Aid	Phinny Hanson 'Mawinnie Kanetsi	Programme Advisor
	Lesibe District	'Mamotheo Marumo	District AIDS Coordinator
	Lesotho Council of NGOs	Seabata Motsamai	Executive Director
	Ministry of Health and Social Welfare	M. Makhakhe	Director, Health Planning and Statistics
	National AIDS Commission	Keketso Sefeane	Chief Executive
	National AIDS Commission	Senate Molapo	Data Officer, Lesibe District
	Office of the First Lady	'Mathato Mosisili	First Lady, Kingdom of Lesotho
	Secure the Future (Bristol Myers Squibb)	Beryl Mohr Archie Smuts	Community Outreach Manager Research Project Manager (Johannesburg)
	Strengthening Civil Society in Lesotho (SCIL) Project	Lineo Nketu	Programme Manager
	UNAIDS	Tim Rwabuhemba	Country Coordinator
	UNICEF	'Mapaseka Selikane	Assistant Programme Officer, Health
	United States Government	Joan Atkinson	HIV/AIDS Programme Coordinator
	WHO	Angela Benson	WHO Representative
World Bank	Muhammad Ali Pate	Health Specialist	
World Food Programme	Adam Weimer	HIV/AIDS Coordinator	
Malawi	ActionAid	Boniface Msiska	Regional Manager, Southern Region
	CIDA	Johannes Lebede	HIV/AIDS Coordinator
	DFID	Comfort Khembo	Programme Officer, Rural Livelihoods
	GTZ	Huzeifa Bodal	National HIV/AIDS Coordinator
	NAC/FMA	Dave Runganaikaloo	Financial Officer, NAC
	NORAD	Agnes Muvira Kiromera	Programme Officer
	PLAN	Rex Chapota	Programme Officer

Country	Institution	Individual	Position
Malawi	UNDP	Fred Mwanthengere	Programme
	USG/CDC	John Aberle-Grasse	Epidemiologist
	USG/USAID	Sosten Chilumpha	HIV/AIDS Specialist
	World Bank	Susan Kraemer	Programme Advisor
Mozambique	CIDA	Marcia Colquhoun	
	European Commission	Rui Ferreira	Social Sector & Thematic Budget Lines Support
	Global Fund	Gertrudes Machatine	National Director for Planning and Cooperation, Ministry of Health
	MONASO	Ana David	Coordinator
	RENSIDA	Júlio Mujujo	National Executive Secretary
	Royal Netherlands Embassy	Annie Vestjens	Primary Secretary for Health and HIV/AIDS
	Sida	Maria Aguiar	Programme Officer for HIV/AIDS
Namibia	Catholic Aids Action (Omaheke)	Dollene Mouton	Administrator
	Children of the Light Foundation	Pastor Hank Olwage	Coordinator
	DFID	Tim Martineau	Senior HIV & Health Adviser, DFID Southern Africa (Pretoria)
	European Commission	Jutta Pomoell-Segurola	NGO and HIV/AIDS Programme
	Family Health International	Lucy Steinitz	Senior Technical Officer, Faith-based Programmes
	German Development Cooperation	Stephan Sckell Kathrin Lauckner	Counsellor for Development Cooperation Programme Manager, GTZ
	Gobabis Municipality	Detlivine Katamelo	HIV/AIDS Coordinator
	Ministry of Health and Social Services	Dr Ikandi	Physician, Omaheke District Hospital
	NANASO	Eliezer Hamburee	Monitoring & Evaluation Officer
	NANGOF	Daphne de Klerk	National Coordinator
	Omaheke Regional Council	Laura McLeod	Governor
	Regional AIDS Coordinating Committee (Omaheke)	Reinhardt Kavendjii	Regional Aids Coordinator
	Secure the Future (Bristol Myers Squibb)	Beryl Mohr Archie Smuts	Community Outreach Manager Research Project Manager (Johannesburg)
	Sida	Ylva Lindstrom	First Secretary
	Small Grants Fund	Salvator Niyonzima	UNAIDS Country Coordinator
	UNICEF	Eiichima Shimuzu	M&E Officer
USG/PEPFAR	Aaron Daviet	Emergency Plan Team Coordinator	

Country	Institution	Individual	Position
Swaziland	AMICAALL	Bongani Motsa	Finance Manager
	DFID	Tim Martineau	Senior HIV & Health Adviser, DFID Southern Africa (Pretoria)
	European Commission	Sharon Moynihan	
	HAPAC	Nhlanhla Nhlabatsi	
	Italian Cooperation	M. Almaviva	Programme Director
	NERCHA	Dumisani Kunene	Finance & Administration Manager
	Secure the Future (Bristol Myers Squibb)	Beryl Mohr Archie Smuts	Community Outreach Manager Research Project Manager (Johannesburg)
	UNDP	Harinder Janjua	Programme Officer
	UNICEF	Zodwa Mtetwa	Monitoring and Evaluation
Zambia	Church Health Association of Zambia (CHAZ)	Charles Byemba	Executive Director
	DanChurchAid	Niels Vestergaard	Junior Programme Officer
	DFID	Terri Collins	Civil Society Advisor, STARZ
	Dialogue Africa	Rueben Lifuka	Chief Executive Officer
	Irish Aid	Patricia Malasha	HIV/AIDS Advisor
	National AIDS Council	Alex Simwanza	Director of Programmes
	NORAD	Dorothy Hamwele	Programme Officer
	Royal Netherlands Embassy	Petra Staal	Programme Assistant, Health & HIV/AIDS
	Sida	Njakwa Nkandu	Assistant Programme Officer
	UNAIDS	Catherine Sozi	Country Coordinator
	UNDP	Dellia Yerokun	
	UNICEF	Christine Muntanga Joanna Nikulin	Project Officer Assistant Programme Officer, HIV/AIDS
	USG/PEPFAR	Cristina Garce (Provided written answers to questions)	PEPFAR Coordinator
	World Bank	Agatha Shula	Regional Coordinator, CRAIDS
	Zambia National AIDS Network (ZNAN)	Barnabas Chiboboka	Grants Manager