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[a,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.

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.

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,

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]

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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 grassroots[25] – 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 interventions[29] 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 standard elements and do not differ strongly, despite widely varying epidemiological contexts.

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]

[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.

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.

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

[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 assistance[45] 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

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.

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 index[47] 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.

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).

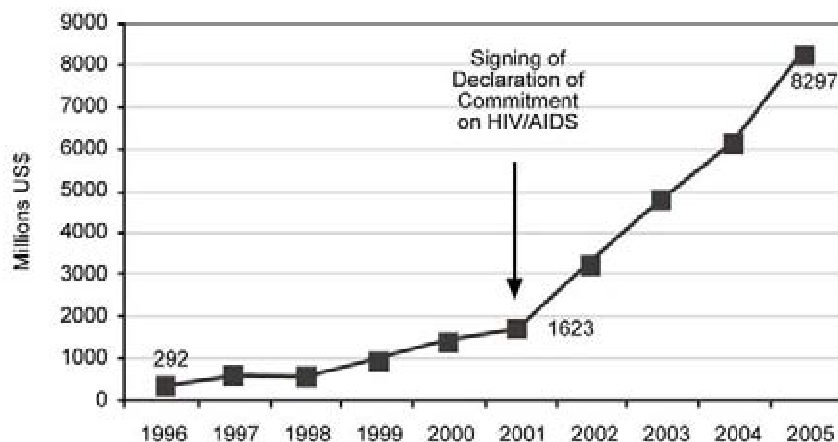
A major focus on resource mobilisation for AIDS during the late 1990s resulted in dramatically increased commitments of funds and the emergence of new financing mechanisms. Between 1996 and 2005 the amount of available resources for AIDS response in low and middle-income countries increased nearly thirty 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

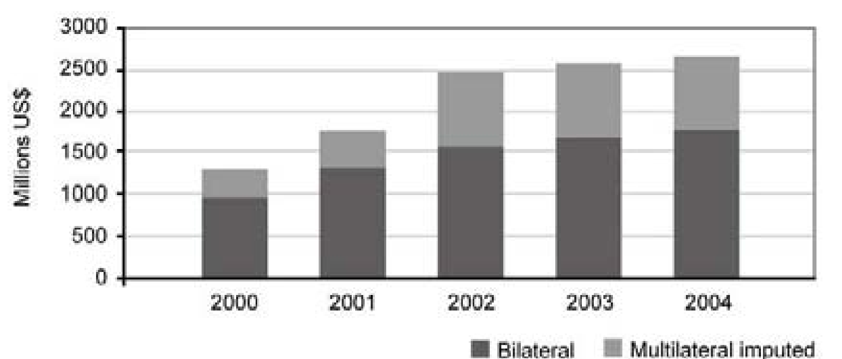
International development assistance – often referred to as Official Development Assistance (ODA) – originates primarily from the 22 member countries of the Development Assistance Committee (DAC) of the Organisation for Economic Cooperation and Development (OECD). Assistance comes in a variety of forms, 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			

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]

[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).

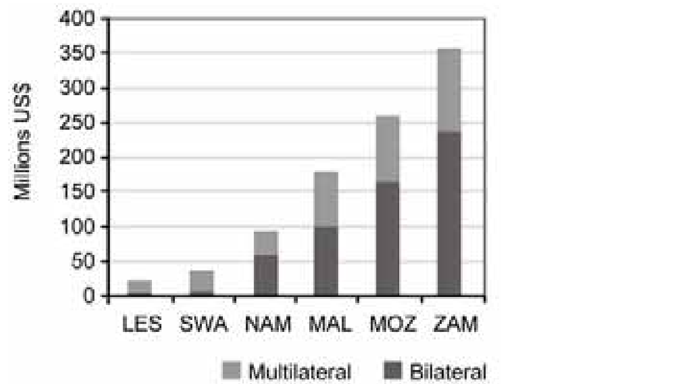
[60] DAC member nations provide regular statistics to OECD on their ODA commitments through a Creditor Reporting System. All commitments are assigned a purpose code that indicates their main developmental focus. Data on HIV/AIDS are reported under the population/reproductive health sector and are related 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.

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.'

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.'

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,

[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]

Background & Context

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 centu ry, 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 Effectiveness[73] 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.

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.

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'

[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.

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

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,'

[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 targets[84] 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 approaches[87]

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 programme[88] 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.

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.

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

[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 period[93] 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.

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.

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 authoritarianism[99] – 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

[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 countries[105] 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 'civic-ness' 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

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.

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 making[115] 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]

[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 became 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 institutions[118] 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 are 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.