PART III

CIVIL SOCIETY ACCESS TO AIDS FUNDS

1. Civil society and AIDS response

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

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

1.1 Location of CSOs

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

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

Table 8

Levels of urbanisation[129]

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

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

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

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

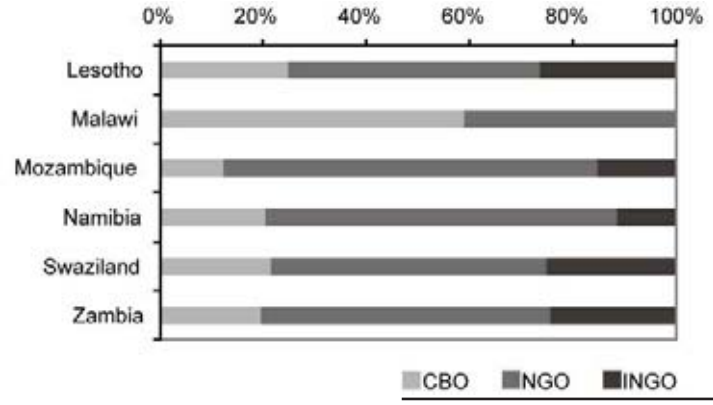
[129] Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2004 Revision and World Urbanization Prospects: The 2005 Revision, http://esa.un.org/unup.

1.2 Organisational characteristics

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

Figure 4

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



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

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

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

Faith-based organisations

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

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

Organisational infrastructure

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

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

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

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

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

countries[133] – a finding which is in keeping with the less developed commercial banking infrastructure in Mozambique, along with significant challenges in the physical and service infrastructure.

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

Membership in networks

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

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

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

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

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

Table 9

Membership of CSOs in AIDS networks

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

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

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

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

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

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

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

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

1.3 CSO involvement in AIDS response

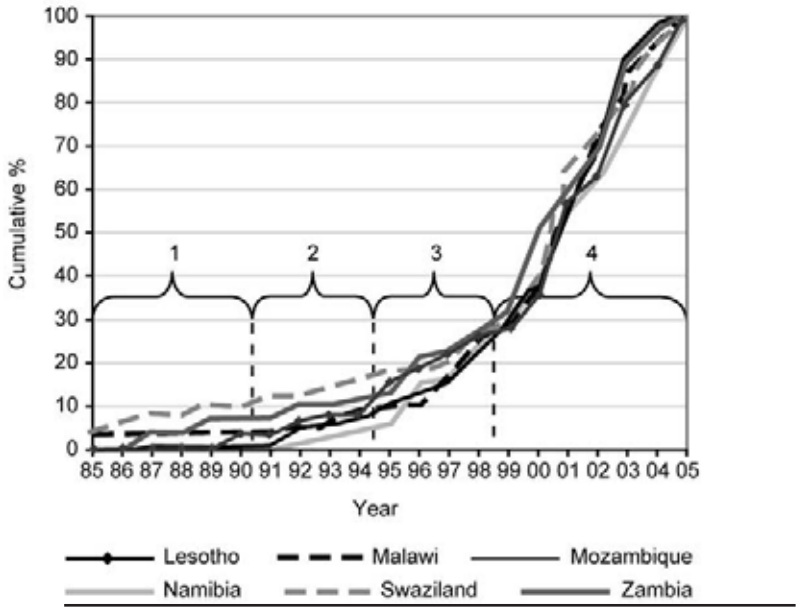
1.3.1 Rate of growth of CSO involvement in AIDS activities

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

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

Figure 5

Year in which CSOs started AIDS activities



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

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

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

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

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

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

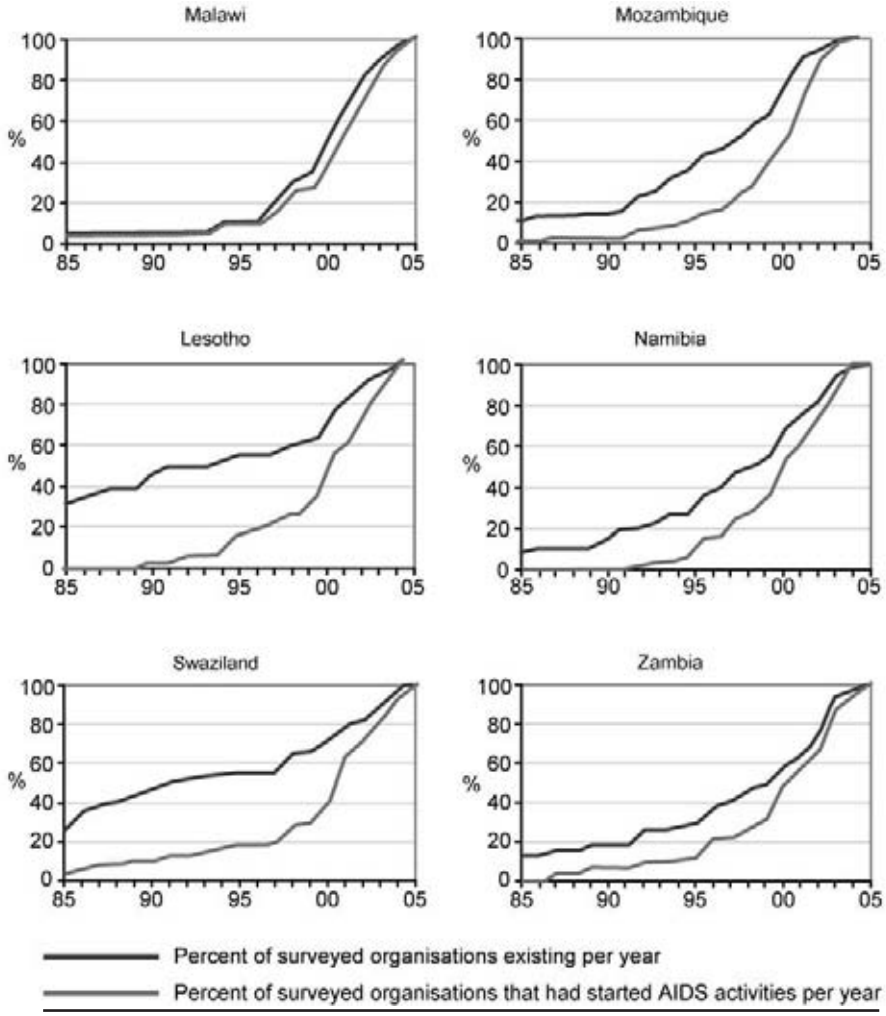
1.3.2 Country trends

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

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

Figure 6

History of AIDS response activity in CSOs



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

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

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

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

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

1.3.3 AIDS specialisation

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

Table 10

Percent of organisations exclusively involved in AIDS

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

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

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

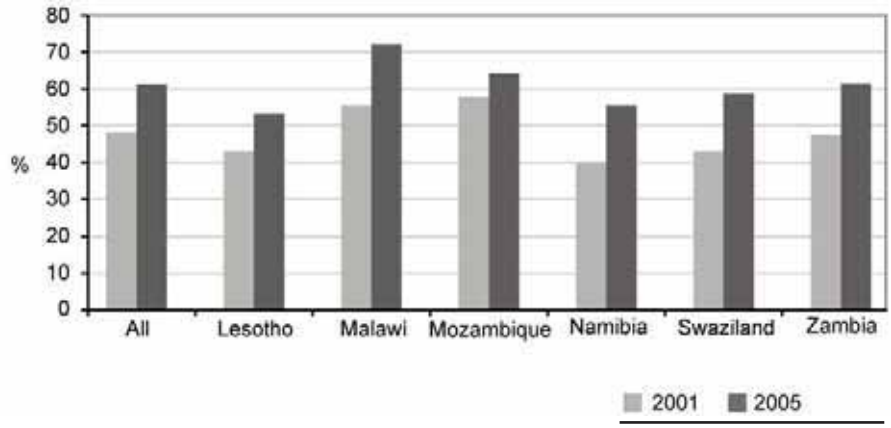
Across countries, CSOs that do not have an AIDS-specific focus spent just over 60% of their time working on AIDS-related activities in 2005

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

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

Figure 7

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



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

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

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

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

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

Figure 8

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

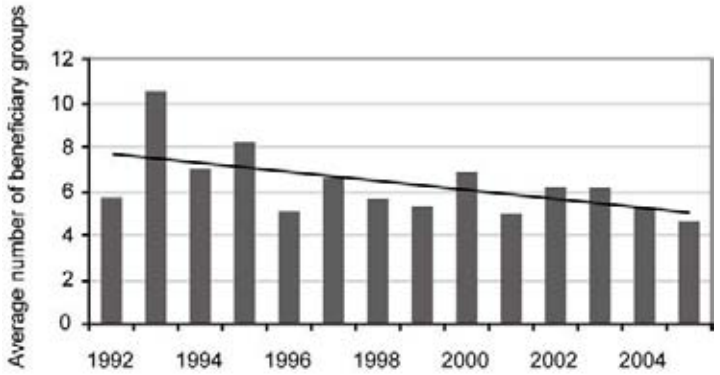


Figure 8 reflects the average number of beneficiary groups worked with per organisation, with organisations grouped according to the year in which the CSO began work on AIDS. It shows that those organisations which have been in existence longer tend to work with a greater number of beneficiary groups.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

1.4 Human resources

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

CSOs as employers

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

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

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

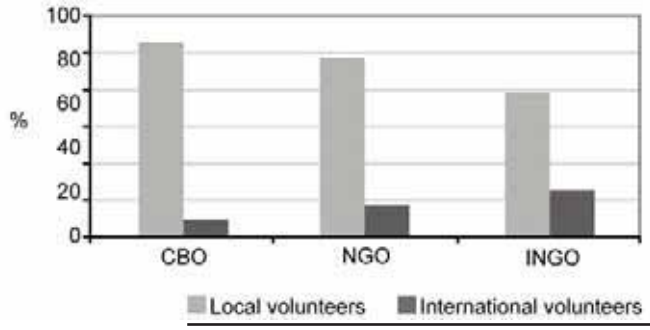
CSOs mobilising volunteers

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

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

Figure 9

Percentage of organisations with volunteers, per type of organisation



Half of all surveyed organisations have 11 or more volunteers.

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

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

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

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

CSOs as vehicles for self-empowerment

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

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

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

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

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

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

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

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

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

1.5 Services provided

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

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

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

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

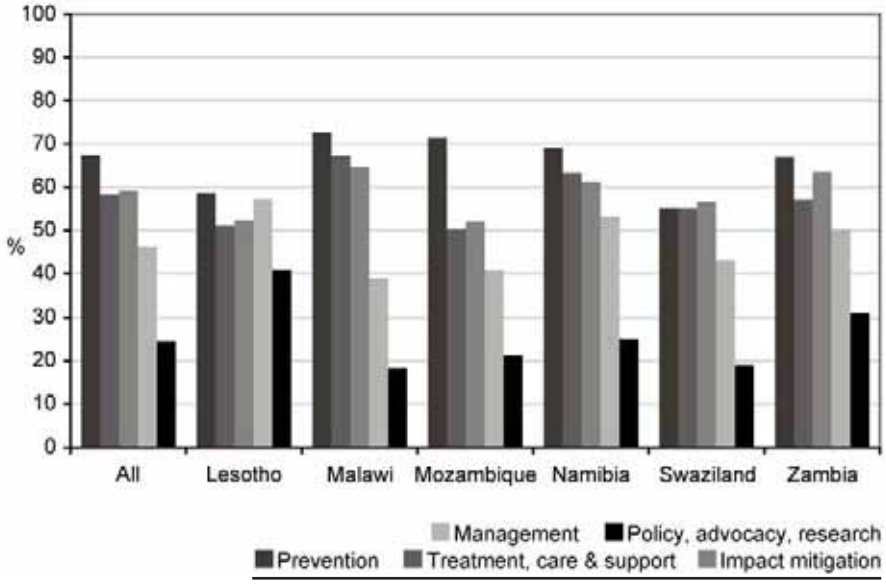
about equally. These three areas of activity are the main foci for the bulk of organisations. There are much lower ratings for 'AIDS management,'[136] with aggregated responses for all countries falling between 'some' and 'much' activity. Within this category there are notably lower averages in Malawi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

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

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

Figure 10

Levels of activity across programme areas in 2005



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

[136] Representing training, coordination and capacity-building.

Table 11

Percent of CSOs reporting a change of activity emphasis over time

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

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

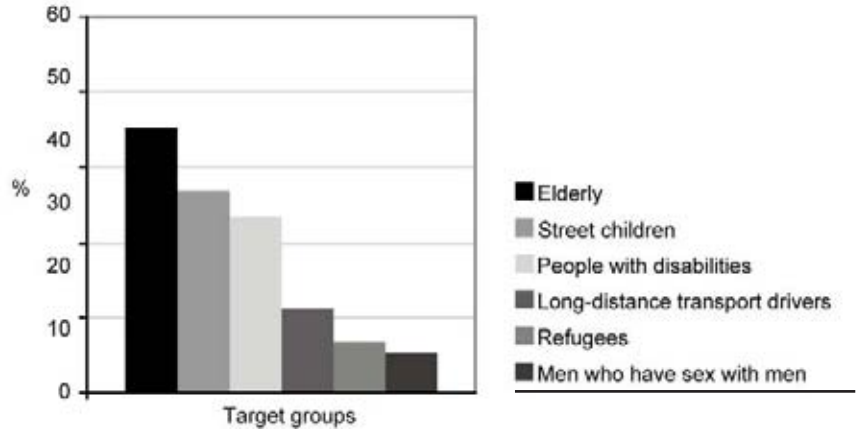
1.6 Beneficiaries of programmes

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

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

Figure 11

Proportion of CSOs working with selected beneficiary groups



Main beneficiary groups

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

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

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

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

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

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

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

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

Extent of beneficiary focus

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

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

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

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

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

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

Table 12

Average number of beneficiary groups worked with, by type of CSOs[138]

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

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

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

2. The resource environment for CSOs working on AIDS

The survey questionnaire solicited information about organisations' funding and financial profiles through a series of closed and open-ended questions. While organisations of all types are often sensitive about disclosing financial information, response rates to the financial questions were relatively high[140] and data gathered through the survey has allowed for the development of a 'bottom up' picture of patterns of expenditure and funding among and for CSOs working on AIDS. These findings are presented in the following sections.

[138] These differences are not statistically significant.

[139] $p \leq 0.001$

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

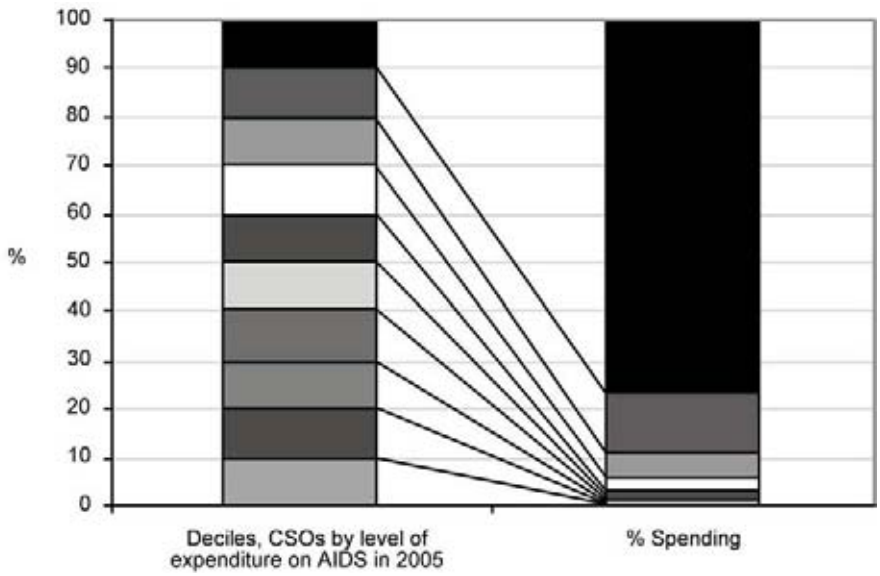
2.1 How much are CSOs spending on AIDS?

2.1.1 Overview of spending in 2005

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

Figure 12

The skewed distribution of spending among CSOs working on AIDS



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

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

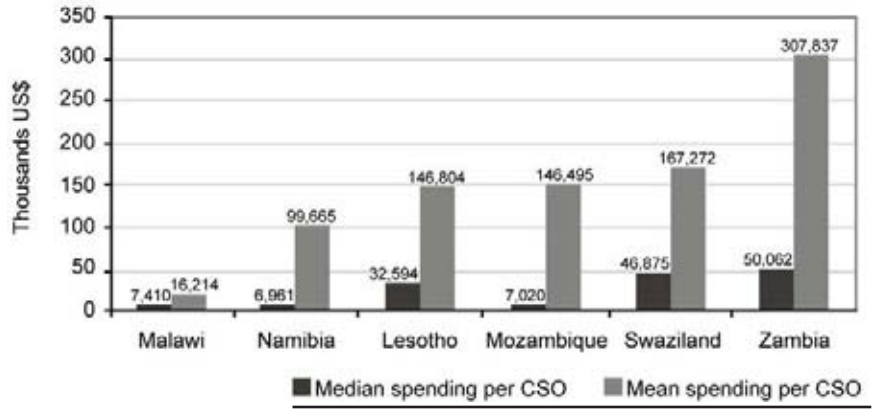
Patterns across countries

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

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

Figure 13

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



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

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

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

Figure 14

Concentration of CSO spending on HIV/AIDS, by country

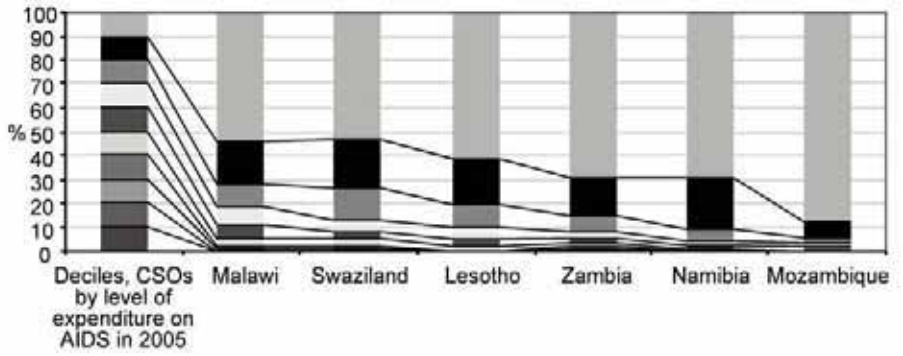


Figure 14 depicts the extent to which CSO spending on AIDS is concentrated among a small number of organsations across countries. Spending is most highly concentrated in Mozambique, with the top 10% of organisations accounting for 87% of spending. The distribution of spending is somewhat more differentiated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

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

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

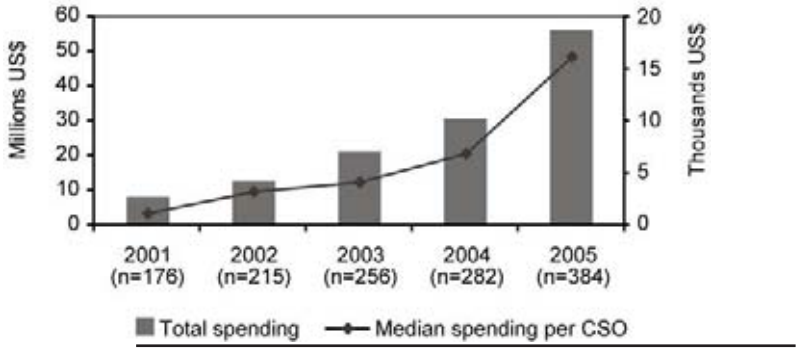
In Malawi and Swaziland, spending is notably less concentrated in the top ranks than is the case in the other countries, indicating more equitable access to funding by CSOs in these countries. The reasons for this may relate to the funding architecture – the aforementioned sub-granting umbrella organisations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

2.1.2 Trends in spending, 2001-2005

Total CSO spending on AIDS increased by more than 600% over the period 2001-2005. Median organisational spending grew more than ten-fold over this period, from US$1,200 to more than US$16,000.[141]

Figure 15

Trends in total and median spending, 2001-2005

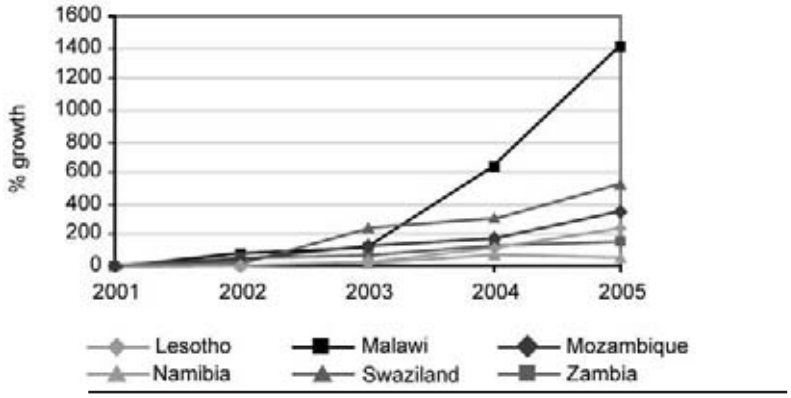


Total spending by CSOs grew by 168% between 2003 and 2005, a period which coincides with the acceleration of funding disbursements by the Global Fund, PEPFAR and other major AIDS funding initiatives.

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

Figure 16

Growth in CSO spending



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

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

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

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

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

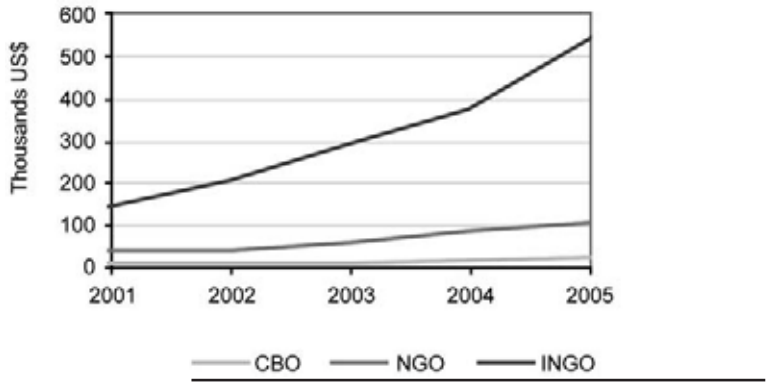
Patterns of spending vary widely by type of organisation

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

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

Figure 17

Changes in average annual spending, by CSO type



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

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

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

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

2.2 What are the main sources of support for CSOs?

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

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

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

CSO Data on Sources of Support

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

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

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

2.2.1 Main sources of funding at regional level

Main sources by volume of funding

Bilateral donors are the number one source of AIDS funding for CSOs in southern Africa, accounting for 42% of the total funds received by CSOs in 2005. International NGOs, FBOs and development agencies[142] comprise the second largest source of funding for CSOs (17%), while multilateral agencies account for another 16%.[143] Eleven percent of funds were accessed through country-specific sub-granting mechanisms which channel international funding.

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

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

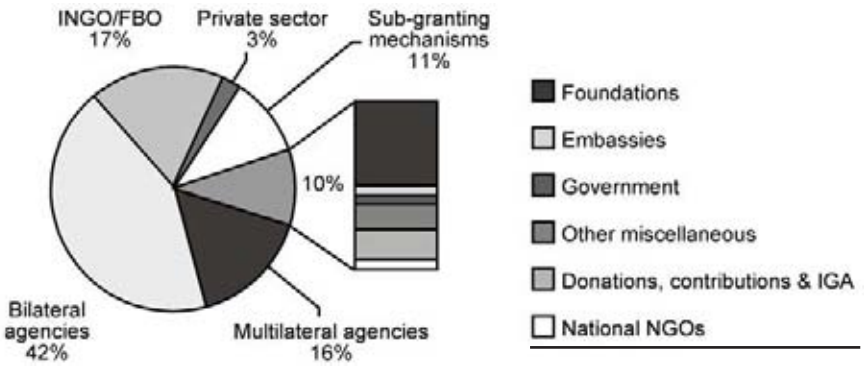
[143] This figure reflects stated references to support received from multilateral institutions, including UN agencies. However it most certainly under-represents their financial significance for CSOs (see note on data in box above). Global Fund and World Bank support is generally channelled through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

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

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

Figure 18

Sources of funding for CSOs in the region



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

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

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

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

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

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

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

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

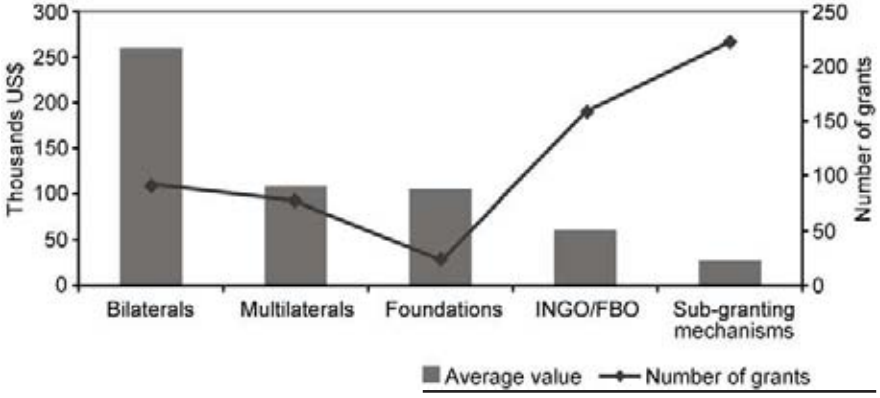
Although sub-granting mechanisms accounted for only 11% of the total volume of funds accessed, they were by far the most frequently mentioned source of support. The largest of these mechanisms by volume of funds awarded were the Zambian National AIDS Network, Swaziland's National Emergency Response Council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

Main sources by number of grants

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

Figure 19

Main sources of funding by financial value and by number



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

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

Almost half of all CSOs[147] received funding from a sub-granting mechanism in 2005, making this the most widely accessed source of support for CSOs in the region. Rates differed by country, ranging from a low of 23% of CSOs in Namibia to a high of 66% in Zambia. This provides evidence that sub-granting mechanisms are succeeding in disbursing funding to CSOs in a broad-based manner, and that the stronger and more decentralised these mechanisms, the greater their reach. This can be seen in the relatively weak penetration of sub-granting in Namibia, where there is one relatively small independently administered fund, compared Zambia where three large-scale conduit mechanisms (ZNAN, CHAZ and CRAIDS) sub-grant funds to CBOs, NGOs and FBOs nationwide.

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

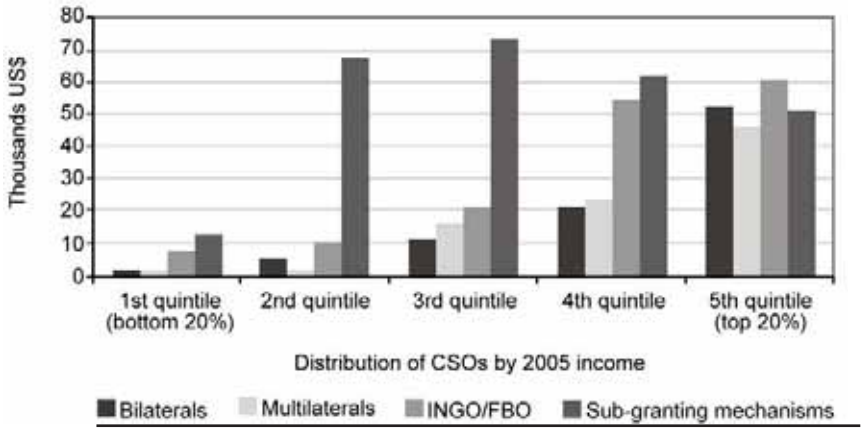
The survey provides evidence of the relative importance of different sources of funding for CSOs of various sizes (see Figure 20). Access to funding by the bottom 20% of CSOs (by size of annual income) is relatively constrained across all categories of support, while the top 20% of CSOs are accessing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

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

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

Figure 20

Proportion of CSOs, by size of income, which accessed main sources of funds in 2005[148]



2.2.2 Main sources of funding at country level

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

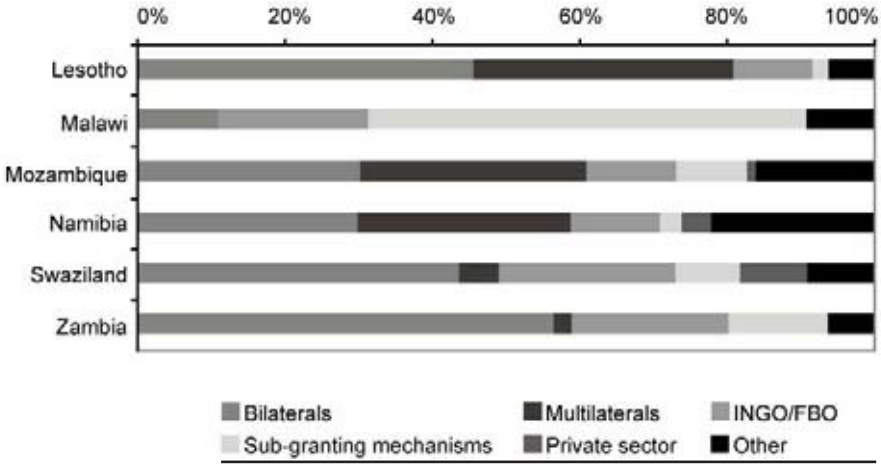
[147] Excluding the CSOs in Lesotho where there is no sub-granting mechanism for CSOs.

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

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

Figure 21

Comparison of main sources of funds for CSOs, per country



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

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

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

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

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

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

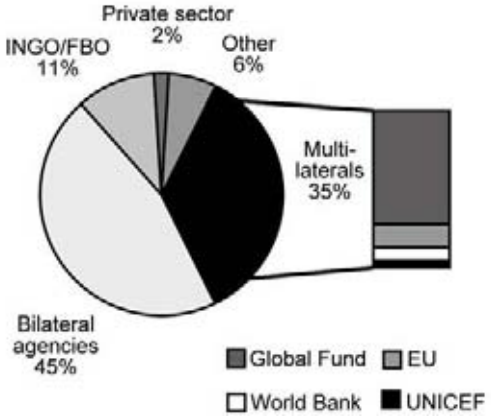
Lesotho does not have a large-scale sub-granting mechanism for CSOs or a centralised funding mechanism for AIDS response. The Ministry of Health and Social Welfare has awarded significant amounts of World Bank and Global Fund support to NGOs over the past five years, but there is no 'rolling' fund to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

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

Figure 22

Sources of funding for CSOs, by country

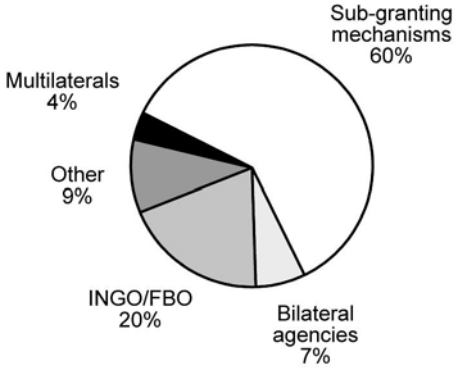
LESOTHO



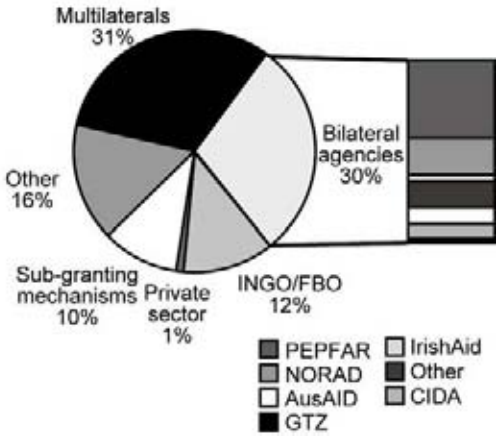
[150] With the reconstitution of the LAPCA into the NAC, it is likely that the NAC will assume a greater financial role in the future, leading to greater centralisation of AIDS resources.

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

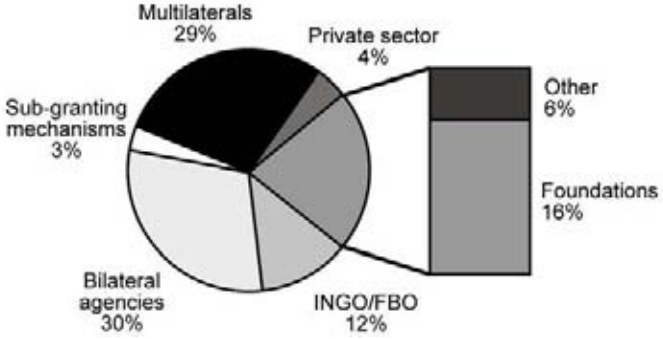
MALAWI



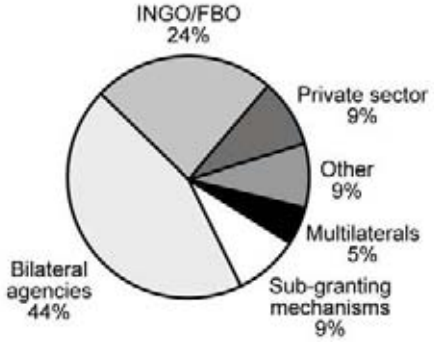
MOZAMBIQUE



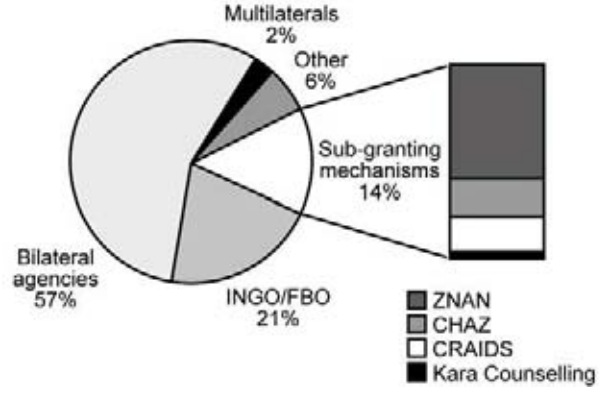
NAMIBIA



SWAZILAND



ZAMBIA



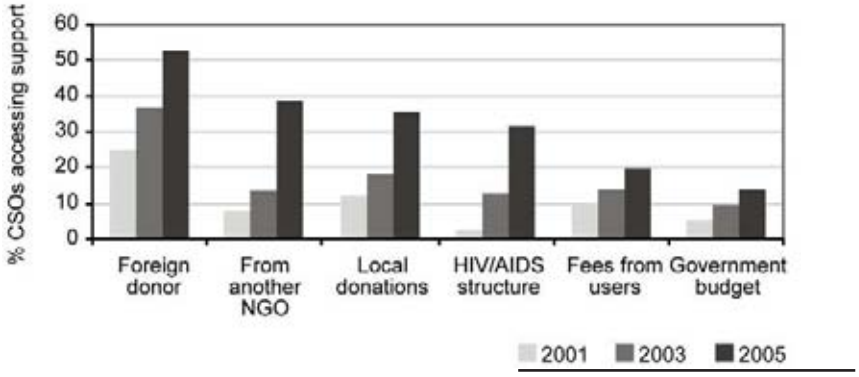
Funding for CSOs in Zambia is heavily dominated by bilateral funders (see Figure 22, Zambia); PEPFAR alone accounts for almost a third of all funding received by CSOs. Multilateral sources did not figure prominently in the survey, as most of these funds are channelled through the three main sub-granting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

2.2.3 Trends in sources of support, 2001-2005

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

Figure 23

Trends in sources of support, 2001-2005



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

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

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

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

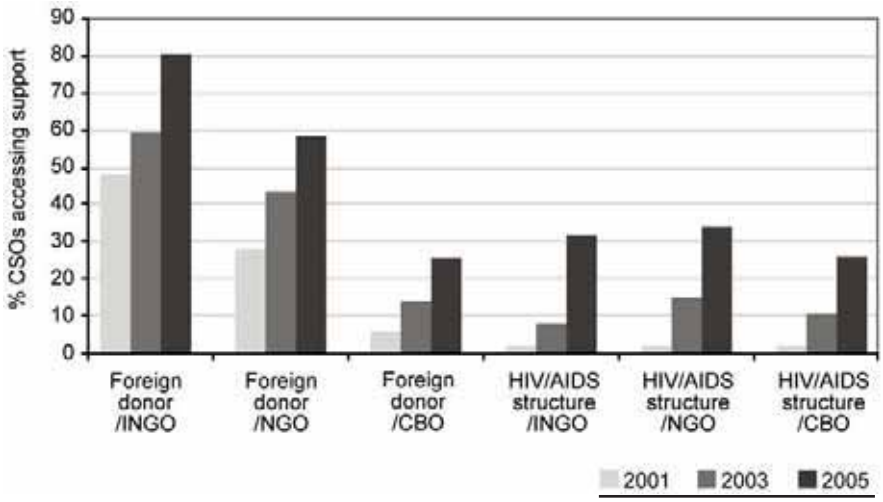
2001, they grew rapidly in importance during succeeding years as the national architectures of AIDS response were consolidated. In 2005, approximately one-third of CSOs received support from such bodies – a level 16 times greater than in 2001.

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

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

Figure 24

Uneven growth in access to sources of funding



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

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

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

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

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

2.2.4 Diversification of funding

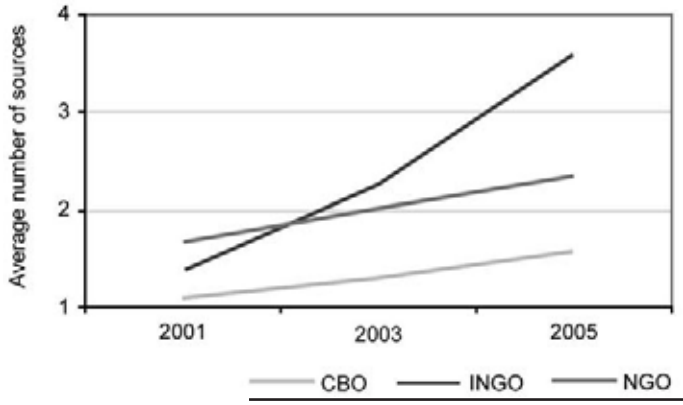
The number of sources of funding that an organisation has succeeded in accessing at any given time speaks to its level of financial diversification. Organisations with a diversified funding base may be less vulnerable to the instability that can be caused by the withdrawal of a donor's support or change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

The number of grants received by the average CSO in the region rose from 1.45 in 2001 to 1.89 in 2003 to 2.32 in 2005. It is apparent in Figure 25 that CSOs of all sizes diversified their funding sources over the period 2001-2005.[152]

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

Figure 25

Diversification of support



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

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

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

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

2.2.5 Donations and in-kind support

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

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

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

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

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

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

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

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

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

Donations and in-kind support for young CSOs

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

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

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

Our first donation came from VSO [Voluntary Service Overseas] towards the end of 2002. Wow! Wow! That was really awesome…. This donation helped us to start the feeding scheme, purchasing pots and more. We were buying soup bones per day. We did not have a fridge. It was expensive to do that and buying more would have mean that they just get rotten. [A private trust] came to our rescue, donating a fridge to the Centre. Wow! Wow! It helped us to save a lot of money…

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

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

Source: NANASO

2.3 What are CSOs being funded to do?

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

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

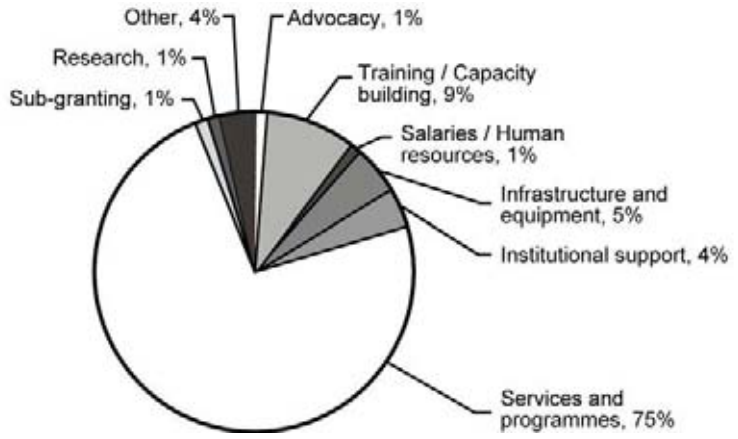
This funding analysis confirms CSO reports on the services they predominantly provide (see Figure 10, Section 1.5). AIDS-related funding being provided to civil society organisations is strongly directed at prevention, care and support, and impact mitigation activities. In 2005, 75% of all funding awards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

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

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

Figure 26

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



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

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

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

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

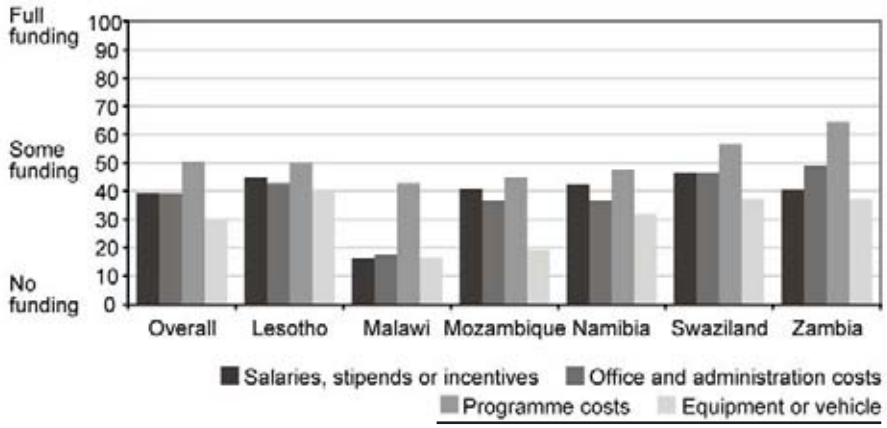
funding flows. Although many of the funding awards for services and programmes may also include coverage of specific costs linked to salaries, transportation, operational expenses and even an advocacy component, these are included in support of the larger programme goals and are not funded as stand-alone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

Funding for CSOs by types of costs

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

Figure 27

Funding coverage, by country and type of programme cost



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

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

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

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

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

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

2.4 What issues are CSOs facing in accessing support?

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

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

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

Dissatisfaction with the current funding environment on the part of CBOs

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

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

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

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

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

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

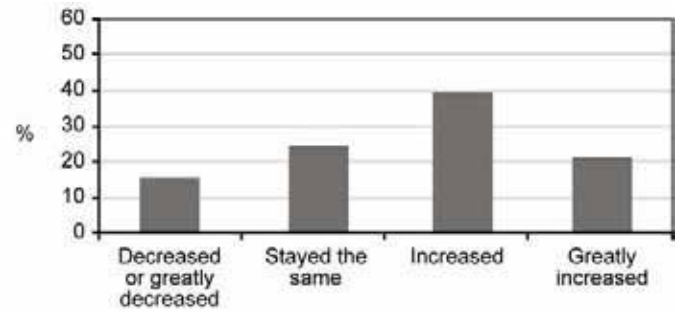
2.4.1 *Amount of time spent fundraising*

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

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

Figure 28

Change in amount of time spent fundraising in past three years



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

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

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

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

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

2.4.2 *Relationships with funding institutions*

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

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

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

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

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

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

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

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

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

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

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

3. Donor funding for civil society and AIDS

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

3.1 The challenges of monitoring and interpreting funding for civil society

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

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

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

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

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

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

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

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

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

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

3.2 Donor perspectives and strategies on civil society and AIDS

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

3.2.1 Perspectives on support for civil society

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

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

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

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

Mobilising latent societal resources

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

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

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

Efficiency

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

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

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

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

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

[159] Schocken, C. (n.d.).

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

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

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

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

Sensitivity and cultural appropriateness

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

Local ownership and sustainability

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

Supporting innovation and new solutions

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

Civil society support is consistent with development and poverty reduction priorities

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

[164] Brown, J., Ayvalikli, D. & Mohammed, H. (2004); OGAC (2005b).
[165] OGAC (2007).
[166] OGAC (2005b).
[167] Royal Netherlands Embassy (interview).
[168] OGAC (2005b).
[169] Brown, J., Ayvalikli, D. & Mohammed, H. (2004).
[170] Government of Ireland (2006, p 72). Similar views are expressed by the World Bank.
[171] Government of Ireland (2006, p. 72).
[172] DFID (2005).

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

3.2.2 Unspoken assumptions and tensions

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

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

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

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

[173] See www.norad.no

[174] Sida (1999, p.44).

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

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

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

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

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

- *Civil society organisations working on AIDS contribute to poverty reduction.* Civil society organisations in the AIDS field do indeed respond to poverty and are acutely aware of the need to combat the daily realities of poverty which they encounter. But they mainly provide only basic relief for the destitute: in the AIDS field,

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

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

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

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

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

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

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

- Commitment to channel greater support through government budgets, yet reluctance to end all direct project funding. Donors in some instances stray from their own fundamental commitments to budget support, pooled-funding and SWAps[181] through discretionary decisions to provide stand-alone technical assistance or direct project funding. In some cases this appears to be linked to a desire or need to point to 'tangible' successes or to 'brand' particular interventions as their own.
- A belief in the advocacy role of civil society in pressuring and holding their governments accountable, yet firm commitments to channel aid through government. These are reconciled from the donor side by a belief that civil society and government are reconcilable through support for democratic processes. However in countries where government is sceptical of expanding civil society's role, particularly outside service delivery functions, there is little guarantee that these will be reconciled.
- Belief that civil society has unique attributes, in terms of its role in giving voice to popular needs, but endorsing strategies through government support and basket funding that position civil society primarily as a service provider.

3.2.3 How donors channel funding for AIDS

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

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

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

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

Structure of AIDS funding portfolios

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

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

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

This research focused exclusively on donors' AIDS-specific funding portfolios[182] and found that donors rely upon a range of modalities for channelling their AIDS-specific support. Notably, many, but not all, donors retain a mix of funding strategies despite the overall push towards harmonisation of funding. Portfolios are often diversified to include a range of components including direct technical assistance to build the institutional capacity of the NACA, a small number of direct funding arrangements for civil society organisations or networks, joint-funding arrangements (JFAs) with other donors in support of sub-granting programmes, contributions to UN-led programmes (e.g. a national UNICEF programme in Namibia on adolescent life skills), and commitments to national basket funding arrangements.

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

How CSOs are funded

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

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

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

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

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

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

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

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

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

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

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

3.3 Country analysis of funding for civil society

3.3.1 Lesotho

Overview of AIDS funding environment in Lesotho

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

The Government of Lesotho (GOL) designates that 2% of line ministries' recurrent budgets be allocated to AIDS expenditure. This amounted to 15.0 million Maluti (M) in 2003/2004 and 20.7 million in 2004/2005. Of these allocations, 58% (M8.7 million or US$1.3 million) was spent in 2003/2004 and 43% (M8.8 million or US$1.4 million) was spent in 2004/2005.[183] By contrast, more than US$24 million in ODA for AIDS was committed to Lesotho by bilateral and multilateral donors over the period 2000-2004; 71% of this through multilateral channels.[184] Compared with earlier years when mobilisation of funding was the main challenge, an urgent priority is now seen to be the appropriate use and absorption of available resources. The large commitment made by the Global Fund (see below) has not been matched by a rapid absorption of funds, and a number of development partners in the AIDS field have since targeted their assistance at strengthening the institutional capacity of government, private sector and civil society groups within Lesotho to receive, manage and expend Global Fund resources.[185]

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

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

[184] OECD Database.

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

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

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

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

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

By the end of 2005, US$8 million had been disbursed by the GFATM to Lesotho[188] and of this, approximately 25% had been sub-granted on to civil society organisations. The majority of recipient organisations were local NGOs, although by value of awards more than half of the funding went to INGOs. The single largest sub-grant to CSOs went to World Vision, which was tasked with re-granting funds in smaller amounts to other CSOs around the country.[189]

The World Bank had two separate AIDS-related programmes underway in Lesotho over the period 2001-2005.[190] US$2 million was earmarked for AIDS within a US$6.5 million Health Sector Reform Programme that was implemented between 2001 and 2005. These funds were disbursed through sub-grants to eight organisations, including four local NGO and three international NGOs[191] for prevention, impact mitigation, and treatment, care and support programmes. A US$5 million HIV/AIDS Capacity Building and Technical Assistance grant to the GOL was approved in 2004, aimed at accelerating the absorption of GFATM funding, but only a small amount had been disbursed by the end of 2005. Close to a quarter of the overall grant is earmarked for capacity-building among civil society and private sector institutions to improve the quality of proposals, programme implementation and fulfilment of reporting requirements related to GFATM funding for Lesotho.[192]

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

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

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

[188] Global Fund (2006).

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

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

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

[192] The World Bank (2004, p. 30).

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

particularly in health and education, but it has also funded AIDS directly since 1999.[194] Just over US$4 million was committed to AIDS-specific programmes over the period 2001-2005,[195] including multi-year support to NGOs such as Lesotho Planned Parenthood Association, Positive Action, Lesotho Save the Children, and Women and Law in Southern Africa. CSO partners are identified on the basis of the work they undertake in relation to issues or population groups of interest, such as migrant workers, garment factory workers, gender issues, and cross-border activity. In 2005, close to half of Irish Aid's AIDS-specific funding (€900,000) went directly to civil society organisations, while the other half went to support of the National AIDS Commission. Irish Aid's new civil society policy may result in increased allocations to CSOs in 2006-2007, and Irish Aid is considering contracting an external funds manager that would administer the funding arrangements on its behalf.[196]

Lesotho is not a focus country under the US Government's PEPFAR initiative, and USG funding for AIDS in Lesotho is more modest in scale than in other southern African countries. USG funding for AIDS in Lesotho is part of the Southern Africa Regional budget and is administered through USAID's Regional HIV/AIDS Program, the Centers for Disease Control, the Peace Corps and other agencies. US$12 million was committed to Lesotho for AIDS during fiscal years 2003-2005.[197] In fiscal years 2004 and 2005, at least 60% of allocated funding was designated for civil society organisations, predominantly international NGOs such as Population Services International, Academy for Educational Development, Family Health International, and Pact.[198] USG funding in Lesotho has strongly emphasised prevention activities (VCT, PMTCT, condoms, partner reduction, abstinence, behaviour change communication, education), with 68% of funding in fiscal year 2004 and 54% in fiscal year 2005 being allocated to programmes in these areas.[199]

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

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

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

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

[196] Interview with Irish Aid, Maseru.

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

[198] US Government (n.d.).

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

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

[201] Interview with DFID, Pretoria.

[202] GTZ (n.d.)

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

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

- UNICEF addresses AIDS primarily through the health and nutrition division of its Child Survival Programme. The agency's budget for AIDS-related activities was US$1.9 million over the period 2001-2005.[205] It has supported the Churches Health Association of Lesotho (CHAL) and a number of other CSOs, although the total value of this support amounts to approximately 10% of overall spending over the period in question.[206]
- The World Food Programme provides food supplements to food insecure households in Lesotho, including those with chronically ill individuals. It also supports a school feeding programme. In 2005 the agency shifted from a focus on food insecurity linked to drought conditions and began to target AIDS-affected individuals more specifically. Direct operational expenditures in Lesotho totalled US$81.7 million over the period 2001-2005, with 86% of this expenditure occurring from 2003 to 2005. Approximately 19% of expenditure in 2005 was targeted for AIDS.[207] The WFP contracts five large INGOs and NGOs to distribute food at district level, comprising approximately 30% of its total spending.[208]
- The World Health Organisation plays a critical role in shaping policy in conjunction with Government of Lesotho and acting as a catalyst to action for other development partners. Its role as a funder is minimal; its support is provided primarily in the form of technical assistance, facilitating training and developing materials. As such, it does not fund CSOs directly.

Support for CSO responses to AIDS in Lesotho

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

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

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

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

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

[206] Data provided by UNICEF representative, Maseru.

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

[208] Data provided by WFP representative, Maseru.

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

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

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

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

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

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

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

Key issues in supporting CSO responses to AIDS in Lesotho

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

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

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

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

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

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

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

3.3.2 Malawi

Overview of AIDS funding environment in Malawi

Unless otherwise specified, information for this section derives from NAC Financial Management Agency (FMA) reports, Malawi UNGASS reports[214] and from information and documents supplied by donors.

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

[212] LENEPWHA was strongly supported by ActionAid's SIPAA initiative in Lesotho.

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

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

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

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

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

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

There is not only evidence of more organisations being engaged in AIDS response, but also better quality in implementation of planned action. The average time taken for processing funding applications decreased from April to November 2005. This reflects increased efforts on the part of the NAC and its partners to increase funding efficiency through improving systems for disbursement. By the end of 2005[215] it took on average not more than six months for a project to be funded from the time the proposal was received.

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

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

[215] The FMA Monthly Report, November 2005.

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

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

There are two main parallel planning and implementing frameworks for AIDS response. One is the National AIDS Commission's Integrated Annual Work Plan and the other is the Sector-wide Approach Programme of Work within the health sector (see below). There is a lack of coordination and harmonisation between the two programmes of work and a recent evaluation[216] found that the inflow of funds from the GFATM exacerbated the lack of coordination as the NAC programme surged ahead of the SWAp programme. There are reportedly considerable pressures placed on human resources on the back of the injection of GFATM funds into the NAC pooled fund, with the increase in uptake of programmes not having been planned for. In accommodation of this, in the first year of the grant, emphasis was placed on systems strengthening. About 35% of NAC funding passed on to CSOs in 2004 and 2005.

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

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

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

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

[216] Mtonya, B. et al. (2005).

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

[218] Panos (2006).

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

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

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

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

Support for CSO responses to AIDS in Malawi

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

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

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

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

[221] Figures for 2001-2002 taken from OECD DAC Database. For 2003-05, figures have been annualised from data provided in OGAC (2005a).
[222] Carlson, C. et al. (2006).

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

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

Table 13

NAC disbursements to CSOs

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

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

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

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

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

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

[223] Information supplied by interviewed INGO.

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

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

There is strong evidence from the CSO survey that there are numerous other smaller funders that are directly supporting AIDS activities carried out by CSOs. These are often donors who do not have focused and large-scale AIDS portfolios. However, this phenomenon is much less pronounced in Malawi than in the other countries and there is a relatively low penetration of direct bilateral funding, as a result of the strongly centralised funding pools. There is evidence, however, of various international NGOs funded by foreign governments, but which operate independently of in-country bilateral government agencies. In other words, they are bilaterally funded but not through country offices. In some cases there are complex streams[225] of funding to bypass rules and expectations regarding country support for pooled funding. It appears that these do not constitute large amounts and in some cases, at least, they are interim measures to sustain funding for existing projects.

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

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

Key issues in supporting CSO responses to AIDS in Malawi

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

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

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

[225] Reported in interviews off the record.

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

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

3.3.3 Mozambique

Overview of AIDS funding environment in Mozambique

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

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

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

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

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

[226] Mozambique UNGASS Report 2005

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

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

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

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

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

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

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

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

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

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

[228] Barcellos, N. (2005).

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

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

Support for CSO responses to AIDS in Mozambique

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

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

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

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

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

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

[229] Barcellos, N. (2005, p. 28).

[230] Barcellos, N. (2005).

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

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

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

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

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

The World Bank Multi-country AIDS Programme (MAP) committed a total of US$9.8 million for the period of 2004 to 2005. A total of US$9 million had been disbursed by the end of 2005.[235] The total MAP commitment for 2003-2008 amounts to US$55 million. Support to mid-2006 covered 447 sub-projects including: community and civil society initiatives – US$28 million; capacity-building for Civil Society HIV/AIDS Response – US$5.5 million.

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

Key issues in supporting CSO responses to AIDS in Mozambique

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

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

[232] Mozambique UNGASS Report 2005.

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

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

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

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

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

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

3.3.4 Namibia

Overview of AIDS funding environment in Namibia

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

Like many middle-income countries, Namibia occupies a somewhat paradoxical position within the development universe. There has been a steady exodus of bilateral donors from Namibia in recent years, and overall per capita development assistance has declined from US$110 per capita in the 1990s to US$60 per capita in 2005.[237] Yet at the same time, Namibia is one of the countries most heavily affected by AIDS in southern Africa – a situation with serious long-term development implications. Thus, while bilateral development assistance as a whole is declining, support for AIDS has grown strongly in recent years. Namibia has the highest per capita assistance for AIDS of all countries in sub-Saharan Africa.

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

[236] UNDP (2006).
[237] Sasman, C. (2007).

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

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

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

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

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

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

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

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

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

[238] Sida (2006a).
[239] OECD Database.
[240] Ministry of Health and Social Services (2005); Republic of Namibia (2006).

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

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

Table 14

Main sources of AIDS expenditure in Namibia, 2004 and 2005

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

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

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

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

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

[241] OGAC (2005a).

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

[243] Interview with EC representative, Windhoek.

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

management strengthening. DFID's funding commitment for AIDS in Namibia was approximately US$3.1 million over the period 2004-2006.[245] Namibia will also be part of a large regional initiative for orphans and other vulnerable children supported by DFID and led by UNICEF, beginning in 2006.

Sida supports AIDS in Namibia through contributions to the Small Grants Fund (see below), to programmes administered by UNICEF and UNFPA, and through sector support to the Ministry of Education. Some limited project-based funding for private sector responses is also provided. Sida will be closing its office in Namibia and administering support from its regional office in Lusaka, although it is expected that support for AIDS will not be scaled down. Sida has contributed approximately US$5 million to AIDS control in Namibia between 2002 and 2005.[246]

Since 2000, the Secure the Future initiative of the Bristol-Myers Squibb Foundation has made grants of more than US$1.5 million to organisations in Namibia as part of its Community Outreach and Education programme, and has also invested several million dollars in the establishment of an ART clinic and community-based treatment programme in the country.[247]

UNICEF's country programme for Namibia (2002-2005) had four major themes: young children's health, care and development; adolescent HIV prevention; special protection and disparity reduction; and cross-cutting programme support. Although the HIV prevention component focused specifically on AIDS, all of the themes incorporated attention to AIDS. The overall value of the country programme was US$16 million, with US$5.3 million budgeted for the adolescent HIV component.[248]

A Small Grants Fund (SGF) administered by UNAIDS, and supported by contributions from Sida, the Netherlands, and Finland, has been in operation in Namibia since 2002 (see box). More than 120 awards valuing approximately US$800,000 were made to CBOs through eight rounds of funding over the period 2002-2005.[249]

Support for CSO responses to AIDS in Namibia

Namibian civil society organisations enjoyed significant external support during the country's pre-independence period, but, after an initial period of strong support for civil society in the early and mid-1990s, less development assistance has been channelled through CSOs. As noted above, many civil society organisations working on development issues in Namibia struggle to resource their work. The Namibian NGO Forum (NANGOF), which is the country's civil society umbrella organisation, is working to rebuild after a series of difficult years.

A large number of CSOs are involved with AIDS response in Namibia – many are newly formed within the past five years, while others have broadened their mandates to include AIDS. These range from large national NGOs with a countrywide operational presence down to small community-level organisations. A handful of international NGOs are involved with AIDS response in Namibia, although such organisations do not dominate the landscape in the same way that they do in some other countries in the region.

Defined roles for civil society organisations are woven throughout the MTP III framework. The Namibian Network of AIDS Service

[245] UNAIDS Donor Matrix, Namibia. Figures for commitments prior to 2004 not available.

[246] UNAIDS Donor Matrix, Namibia.

[247] The exact value of this commitment is not known. US$30 million has been committed to this programme across five countries, but it was not possible to confirm the exact value of the commitment in Namibia. See Bristol-Myers Squibb (2004).

[248] Government of Republic of Namibia/UNICEF (n.d, p. 27). These figures include both Regular Resources (allocated by UNICEF headquarters) and Other Resources, which need to be mobilised separately by UNICEF from other donors.

[249] Data provided by SGF, Namibia.

Organisations (NANASO), Lironga Eparu, the national network of people with HIV, and NANGOF are designated in the MTP III as the coordinating bodies for NGOs, CBOs and FBOs in AIDS response, and specific CSO implementing partners are named for each sub-component of MTP III. Namibia's UNGASS report (2006) cites the 'significant role' of civil society in meeting the needs of people infected and affected by AIDS.

Respondents commented that the relationship between the Government of Namibia and civil society looks good on paper, but could be much stronger in practice.

In the course of the research, respondents from both donor institutions and civil society commented that the relationship between GRN and civil society looks good on paper, but could be much stronger in practice. The view was expressed more than once that, although there is a robust discourse about the importance of civil society in AIDS response, the government remains intrinsically wary of granting too large a role to civil society. One respondent spoke about 'the presumption that government should be at the centre of things.' Representatives from two different donor agencies noted that, in negotiations with GRN around the delivery of assistance, the government rarely raises civil society involvement and that its preference is, in fact, 'not to use civil society.' When funding is being channelled through government, external donors have 'no mechanism to steer money to civil society if government does not accept the case.'

The mid-term review of MTP II, whose findings fed into the current MTP III, listed among the priority areas requiring attention within the national response: uncertain financial flows and pipeline blockages; lack of mechanisms to channel public funds to sub-regional level and to non-state actors; and unsystematic and unstructured support to regional and sub-regional level to enhance local responses.[250] All of these areas can be seen as linked to the resourcing and support environment for civil society institutions.

The leading sources of support for CSOs in Namibia differ by type of organisation. Medium and large-sized NGOs in Namibia are heavily involved in program implementation and receive funding either directly from international sources or through sub-granting arrangements. Global Fund and PEPFAR financing are significant sources of support: Global Fund support is accessed through agreements with the Ministry of Health and Social Services (the GFATM Primary Recipient), while PEPFAR funding is typically accessed through sub-granting arrangements with Family Health International or PSI/Social Marketing Association. NGOs also access support through foundations, private initiatives (such as Bristol-Myers Squibb's Secure the Future), international NGOs, bilateral agencies and other overseas entities. The findings of this research suggest that there is a cohort of 12 to 15 NGOs in Namibia that receive funding from several of these sources simultaneously.

Funding opportunities for smaller CSOs in Namibia are significantly more constrained. The Small Grants Fund is one of the very few application-based nationwide sources of funding available to young and emerging organisations. Small-scale grants are also issued by Voluntary Service Overseas Regional AIDS Initiative of Southern Africa (VSO/RAISA) and some discretionary funding is available from embassies. To date, Regional AIDS Coordinating Committees have not had resources to distribute in the form of grants, although there are indications that this situation is shifting. National NGOs, such as those described above, sometimes partner with community organisations at a regional level for programming purposes, but this does not seem to extend to the provision of sub-grants.

[250] NANASO (2005, pp. 11-12).

Many CBOs operate on the basis of their own membership contributions, sporadic funds from income generating projects, and small in-kind donations from businesses and churches.

Small Grants Fund

Since 2002, the Small Grants Fund (SGF) has been supporting NGOs and CBOs working on AIDS-related activities in Namibia. The SGF is a pooled funding mechanism comprising contributions from Finland, Sweden and the Netherlands. UNAIDS administers the fund on behalf of the contributing partners. Approximately US$1 million had been committed to the fund through end 2005, with more than US$800, 000 in awards being made to organisations over eight rounds of funding.

The idea for the Fund emerged in 2002 in discussions at the Partnership Forum on HIV/AIDS, which brings together donors and other institutions involved in AIDS response in Namibia. A need was identified to channel resources to grassroots organisations at a larger scale and in a more systematic manner to increase their involvement in the national response. At the time that the Fund was created, very limited support was available to CBOs.

The Fund's sole purpose is to fill the gap in resourcing for grassroots organisations. The average award is less than US$10, 000, and funding is released in tranches pending satisfactory reporting. Criteria for accessing funding are relatively broad and the SGF has deliberately adopted a flexible approach. It sees itself as responding to needs as they are identified and understood on the ground: for this reason a wide diversity of activities is supported and there is no preferred model or format. To be eligible, organisations must be community based; must carry out work related to AIDS (broadly understood); and must be known to and endorsed by their Regional AIDS Coordinating Committees. Awards are generally issued for year-long projects. The SGF provides a certain amount of capacity-building support in the form of workshops and training for recipients.

An outcome evaluation conducted in 2004 concluded that the SGF model is appropriate to the needs of the organisations it targets, and is filling a critical gap in Namibia. The evaluation noted that the project is effective in supporting the involvement of people with HIV, given the high proportion of HIV-positive individuals involved in CBOs. Another strength is its commitment to funding organisations from all parts of the country, in contrast with a general tendency for funding to flow to the most highly affected regions in the north. Involving Regional AIDS Coordinating Committees in the application process also helps to build strong networks and linkages at regional and local level.

The SGF has been pointed to as a 'best practice' example of a funding mechanism for CBOs, and the present research has corroborated the importance of its role as the only significant source of financial support targeted at small organisations (see case study and CSO survey findings). However it is also important to draw attention to some of the key challenges the model faces. First, the organisations funded are small and often lacking in previous funding experience. The very process of applying for funds through a written application presents enormous challenges, as does managing and reporting on funding. The model is labour intensive and a lot of support is required from the Fund administrators and from Regional AIDS Coordinators, who are overworked and presently without support staff. Second, and related to the above, the rate of disbursement of funds appears to lag quite significantly behind awards. Complete records are not available but, for example, only 59% of Round Four funds (awarded in 2004) had been disbursed to recipients as of November 2005. Tranches of funding are only released when earlier funds have been fully accounted for, and this appears to be something of a sticking point. Third, many of the supported organisations have difficulty graduating on to other sources of support after the funding ends. The outcome evaluation detected that 'many of the projects either fold' or come to rely on members' own contributions to sustain themselves.

The SGF is a successful example of a relatively small-scale pooled funding mechanism which takes a flexible and needs-driven approach to funding. It is a model which could be appropriate in other countries where a gap in support for local-level initiatives has been identified.

Data on financial support to CSOs: Evidence from the Namibia donor matrix

Analysis of the donor matrix compiled by UNAIDS in Namibia, and last updated during 2005, suggests that between 35% and 43% of all commitments of development assistance for AIDS listed in the database are designated for civil society organisations.[251]

Table 15 shows a breakdown of the 10 largest funders in the donor matrix, by commitments for the years 2004-2005, and the minimum proportion of their commitments that is indicated as going to civil society organisations.

It shows that the 10 largest funders of AIDS activities in Namibia committed US$76 million in funding for the years 2004 and 2005, one-third of which was designated for civil society recipients. US Government funding accounted for 49% of all the funding going to civil society recipients, followed by the Global Fund at 16%.

Table 15

Commitments of AIDS funding to CSOs by 10 largest funders in Namibia

Donor institution	Amount committed, 2004-2005 (US$ millions)	% to CSOs	Amount to CSOs (US$ millions)
United States	33.6	37%	12.4
European Commission	15.0	10%	1.4
Global Fund	12.4	32%	4.0
Germany	4.0	50%	2.0
Sweden	3.4	10%	0.3
United Kingdom	2.1	59%	1.2
UNFPA	1.8	28%	0.5
UNICEF	1.5	84%	1.2
Denmark	1.2	100%	1.2
Italy	1.0	100%	1.0
Total	**76**	**33%**	**25.2**

The CSOs most frequently designated as recipients of funding included Family Health International, Catholic AIDS Action, Social Marketing Association, Lutheran Medical Services, Catholic Health Services, Johns Hopkins University, and Population Services International.

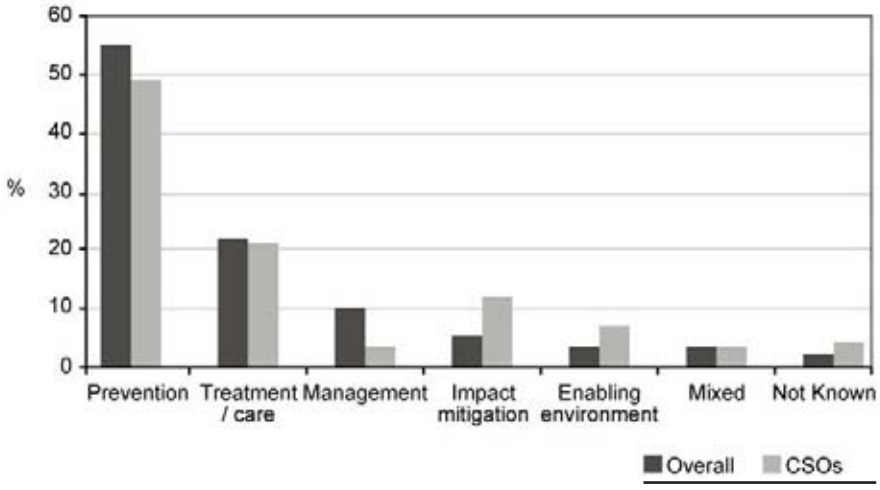
The donor matrix also allows for analysis of funding commitments by area of intervention. Figure 29 compares the areas of intervention among the overall funding commitments with those designated for civil society. While the differences are not extreme, it is of interest that funding for impact mitigation activities is particularly directed towards CSOs, as is funding for enabling environment activities such as anti-stigma and discrimination work, sensitisation, and support for people living with HIV.

[251] The matrix contains some information as far back as 2001, and projected forward as far as 2008. However the most complete data is for the years 2004 to 2006. Between 34% and 41% of the funding commitments for the years 2004 and 2005, which fall within the parameters of this study, are designated for civil society.

It is notable that more than half of committed funds in 2004 and 2005 were for prevention-related activities. This stands in stark contrast to the more diversified spectrum activities which Namibian CSOs report undertaking.[252] This suggests that funding streams are more sharply differentiated than the work of organisations on the ground, which tend to see AIDS holistically and orient themselves across a range of services despite the fact that external support is more narrowly focused.

Figure 29

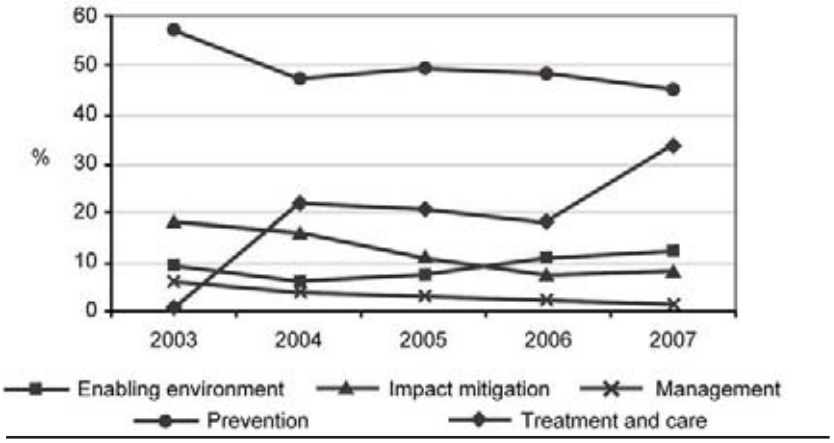
Distribution of donor commitments (2004-2005) by MTP III intervention areas: overall and for civil society organisations



Over time, trends in funding allocations to civil society organisations can be detected. Figure 30 shows that over the period 2003 to 2007 (projected), funding for civil society organisations in the area of treatment and care has risen, while funding for prevention, impact mitigation and management has declined.

Figure 30

Funding for civil society over time, by area of intervention (MTP III categories)



3.3.5 Swaziland

Swaziland is distinguished by being the country with the highest HIV prevalence rate amongst pregnant women in the world. It is a small country with a population of 1 million people and the impact of AIDS has been profound in almost all areas of social and economic life.

[252] See, for example, NANASO (2005).

AIDS has a prominent profile as an issue of societal concern in Swaziland. Whereas there has been some despondency about success in curbing new infections, too little is known about the situation currently to understand whether the country is finally turning the tide. It was encouraging that Swaziland met 89% of its WHO '3 by 5' targets in 2005, and this is indicative of the serious commitment of a broad range of actors working together under the umbrella of the National Emergency Response Council on HIV/AIDS (NERCHA), which was established by Act of Parliament in 2001.

Swaziland is a small country and the impact of AIDS has been profound in almost all areas of social and economic life.

Overview of AIDS funding environment in Swaziland

As the principal recipient of GFATM grants to Swaziland, NERCHA does not call for proposals but invites service providers to propose ways of implementing a set programme of action as defined in the national strategic plan and in keeping with the terms of the GFATM grants. NERCHA takes responsibility for all procurement and supports only operational costs, including human resource costs. A wide range of private sector, civil society, parastatal and governmental agencies are involved in implementing the national AIDS strategy with NERCHA's facilitation and coordination. They receive funds to render services and NERCHA pays for goods and services that they need to procure.

Allocations from the Government of Swaziland cover the running costs of NERCHA and surpluses are used to fill in the shortages in the Global Fund funding.

In order to improve coordination of the national response, NERCHA has established and/or strengthened umbrella bodies for each sector or special group. These sectors or groups are organisations serving youth, faith-based organisations, organisations of people with HIV, workplace, NGOs and the Ministry of Health and Social Welfare. Umbrella bodies include the Swaziland National Youth Council (SNYC), the Church Forum, Swaziland National Network for People with HIV/AIDS (SWANNEPHA), Business Coalition on HIV/AIDS (BCHA), Public Sector HIV/AIDS Committee (PSHACC), Swaziland National AIDS Programme (the Ministry of Health and Social Welfare programme), and the Coordinating Assembly of Non-governmental Organisations (CANGO). Through these structures, NERCHA provides technical and financial assistance to organisations to implement AIDS-related activities at all institutional and community levels. In addition, NERCHA has been able to expand Swaziland's response to AIDS through capacity-building and information sharing.

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

Of funding received by NERCHA from 2002-2005, 97% was from two funders: the Swaziland Government (30%)[253] and the Global Fund (67%). The remaining funds over this period were provided by 11 donors, the largest of which provided 2% to the national sum of funding available. NERCHA has received about US$47.4 million during this period.

There are also a sizeable number of bilateral[254] and multilateral donors[255] that have funded AIDS activities separate from NERCHA. The total funding from other donors can only be estimated and for the period in question it appears to be about 80% of the value of that received by NERCHA, amounting to approximately US$35-40 million.

[253] Between April 2002 and March 2006 a sum of US$14 million was contributed by the Government of Swaziland to NERCHA.

[254] The bulk of bilateral donor support in the period from 2001-2005 was received from the following countries: United States, Netherlands, Italy, Japan, Norway, Ireland and Australia.

[255] Multilateral support was received from UNICEF, UNFPA, and the United Nations Turner Fund Grant.

Table 16 provides some indication of the proportion of NERCHA's 2005 HIV/AIDS payments or procurements which went to civil society organisations, per area of intervention, as well as indicating changes in this over the period 2001-2005.

Table 16

Summary of NERCHA allocations to CSOs, 2005, by programme area

		Changes in the proportion 2001-2005		
Programme Area	% of 2005 Expenditure	Increased	Decreased	Remained the Same
HIV/AIDS awareness & prevention: Condoms, PMTCT, VCT, education, communication	17%		X	
HIV/AIDS treatment & care: Nutrition, home-based care, counselling, support for people with HIV/AIDS	10%		X	
HIV/AIDS impact mitigation: Work with orphans and others in need of social assistance, income generation, poverty alleviation	37%	X		
HIV/AIDS management: Training, coordination, capacity building, M&E, systems development	36%	X		
HIV/AIDS policy, advocacy, research	0%			X

The Global Fund is the most significant contributor to civil society responses to AIDS in Swaziland. Between 2003 and 2005 a total of US$23.4 million was disbursed by the Global Fund,[256] which amounted to 80% of expected disbursement of US$29.6 million. Seventeen percent was paid to CSOs for services rendered or used for direct procurement of goods and services on behalf of CSOs. This covered a wide range of CSOs, including umbrella organisations, well-established and professionalised organisations with years of experience, and newly formed CBOs.

The HIV/AIDS Prevention and Care Programme (HAPAC) is a joint bilateral funding project of the Government and the European Commission which focused on improving access to VCT, provision of resources for home-based care and curtailing the high rates of sexually transmitted infections. The HAPAC programme supports the Ministry of Health and Social Welfare in assisting non-state actors to develop services for HIV/AIDS. Between 2003 and 2005 this contributed a total of US$2.4 million, of which approximately 48% went to national and international NGOs. The EC also has a European Development Fund which has no specific budget for HIV. This programme was introduced at a time when the government was finding it difficult to work with CSOs. The money was principally spent through HAPAC (a specially created MOH unit) by subcontracting NGOs to provide specific services (e.g. VCT centres). The grant funds both human resource and programme costs. The EC funding procedures have been very difficult to complete and this has been a major obstacle.

[256] Global Fund (2006).

Between 2003 and 2005 the United States Government[257] provided an amount of US$11.4 million for programmes focusing on capacity-building for local NGOs, CBOs, and FBOs, but with the bulk of funding going to international NGOs, including Pact, AED, Dream for Africa, and the CDC.

Recognising the need for organisational capacity-building among local NGOs, CBOs and FBOs, USAID's Regional HIV/AIDS Program has entered into an agreement with the international NGO Pact to provide organisational strengthening and grants management support. In June 2005, USAID, assisted by Pact, launched a call for proposals from NGOs, FBOs, and CBOs to deliver prevention, treatment, and care services focusing on community-based, community-owned approaches.

UNICEF's 2001-2005 country programme strategy aimed to identify potential solutions to the looming crisis for children affected by AIDS. An emerging concept has been that of 'neighbourhood care points' and US$15 million was committed by UNICEF between 2001 and 2005 to establish and run these care points, as collaborations between CBOs and government ministries. About 33% of this funding went to CSOs either directly (payment for goods and services) or indirectly (capacity-building initiatives). This and a good many other programmes uniquely developed and implemented in Swaziland are strongly community-based and use existing traditional social structures[258] to support programmes, with the assistance of CBOs, NGOs, INGOs and government partnerships.

UNDP spent an amount of US$0.4 million between 2002 and 2005. This money was spent on capacity-building, rather than on direct disbursement to CSOs. The beneficiaries were NGOs and umbrella organisations including the coordinating assembly of NGOs, the Church Forum, SWANNEPHA (network of associations representing people with HIV) and the Swaziland National Association of Journalists.

The African Capacity Building Foundation has supported two civil society coordinating bodies: the Alliance of Mayors and Municipal Leaders on AIDS in Africa (AMICAALL) to build capacity of local authorities/municipalities to respond to the epidemic (2002 to 2005 - US$1 million), and the Coordinating Assembly of NGOs in Swaziland (CANGO) and its members to promote local responses and professionalise the voice of civil society (2005 - US$1 million). The latter programme aims at strengthening the interface between civil society and the government of Swaziland. In line with CANGO's strategic plan, the grant will facilitate activities which include strengthening the institutional capacity of CANGO, the promotion of good governance in the NGO sector, promotion of the contribution of NGOs to Swaziland's development, participation of non-state actors in the development policy-making process, as well as promotion of gender sensitivity in the NGO sector by encouraging and equipping NGOs to mainstream gender concerns in development programmes. Unlike most other funders in Swaziland, ACDF parameters are broad rather than prescriptive with much latitude given to funded programmes to craft their interventions as they see fit.

The Bristol-Myers Squibb Secure the Future programme committed US$ 2.5 million from their Community Outreach and Education Fund to organise in Swaziland.[259] Sub-grants went to local and international NGOs and university institutions in support of AIDS response programmes.

[257] USG funding to Swaziland is channelled regionally and it was not possible to obtain amounts prior to 2003. 2003-05 figures were taken from the PEPFAR 2005 Operational Plan (OGAC, 2005b).

[258] In particular, reviving chiefdoms as caretakers of the community.

[259] Additional funding was provided for an NGO Institute and community-based treatment programme, but the exact value of these activities in Swaziland cannot be determined on the basis of available data.

Many civil society actors in Swaziland, from small initiatives to larger NGOs, feel 'left out.' NERCHA may be a product of its own success: the ideas of the national plan and national strategy are often in evidence, and in some respects civil society has become an implementation instrument rather than a constituency holding its own reigns and having its own voice.

Key issues in supporting CSO responses to AIDS in Swaziland

Perhaps the most notable issue in Swaziland is the role of NERCHA, which is a coordinating rather than implementing agency, but which is also a recipient of the largest block of money for AIDS response. It is responsible to the Global Fund in terms of reporting on the achievements of the grants it has received, and yet it achieves its objectives through partners.

These partners understandably see themselves as 'funded' by NERCHA, although what can be done with the money is closely prescribed. However, NERCHA consults with its partners at every turn and it cannot be said that it functions unilaterally. The national strategic plans which lay the foundations for NERCHA's 'mandates' were developed through an extensive consultative process.

It may seem surprising then, that many civil society actors, from small initiatives at community level to larger NGOs, feel 'left out.' NERCHA may be a product of its own success in some respects. AIDS response is truly widespread in Swaziland. Even where there is little or no funding, the ideas of the national plan and national strategy are often in evidence, and in some respects civil society has become an implementation instrument rather than a constituency holding its own reigns and having its own voice.

There is also another reason for disaffection, and this lies in the relative lack of independence of civil society. There are some limits on civil society freedom in Swaziland. Press freedom is limited and democracy is held at bay by a monarchy and a patriarchal system of chieftainships. In addition to this, the centralisation of funding may further limit the evolution of civil society in Swaziland. Most civil society actors stand to benefit from NERCHA-managed funds and hope to be partners and this mutes critical voices.

Some of the larger organisations, such as the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa, have felt that the centralisation of funding has limited their own discretionary ability to receive and disburse funding. This reflects an inherent disadvantage of 'Three Ones' thinking from the perspective of civil society. Whereas it gives civil society a place in a coherent multisectoral framework, it also limits independence. Strong harmonisation, or alignment, as has been argued above, reflects Paris Declaration thinking on development assistance. It may limit developmental thinking and limit the strength of civil society actors. In Swaziland financial control has been maintained by NERCHA, in the sense that money is not handed to CSOs, who then use it. NERCHA does not so much sub-grant to civil society, as use civil society to implement programmes in the national interest. This may limit the future role of civil society and possibly compromise what it has to offer, however, all things considered, the various initiatives to develop and support civil society identified above, have at least supported the continuation and strengthening of a small number of strong NGOs which uphold the idea of an independent civil society.

3.3.6 Zambia

Overview of AIDS funding environment in Zambia

AIDS is a national emergency in Zambia, and a vigorous effort is underway, involving a large and varied set of institutions, to combat

its spread and to mitigate its impacts. In many respects the situation in Zambia with funding for AIDS epitomises both the promise and the challenge of increased resourcing directed towards the epidemic. In addition to significant commitments of funding from the world's three largest initiatives – Global Fund, PEPFAR and MAP – Zambia is also home to a multitude of bilateral assistance programs, church-based initiatives, international development NGOs, and UN agencies. While the funding gap has not been closed, it has been eased in recent years and one of the main challenges related to AIDS response is how to absorb and utilise the increased funding with very limited human resource capacity. A second challenge is how to coordinate and optimise the many overlapping AIDS-related initiatives already underway in the country.

The 'Three Ones' principles are well-enshrined in Zambia. The National AIDS Strategic Plan 2002-2005 is the guiding framework for AIDS response in the country and the National AIDS Council, created in 2002 by an Act of Parliament, is acknowledged as the coordinating authority for the national response. A National M&E System is in its early stages of development and annual reviews of progress against the national strategic plan, which involve consultative processes, began to be carried out in 2004.

Zambia is one of the countries at the forefront of moves towards donor harmonisation and alignment. A 'Harmonisation in Practice' initiative, launched in early 2003 with the support of seven bilateral donors, led to the adoption of a Memorandum of Understanding on Coordination and Harmonisation of GRZ/Donor Practices for Aid Effectiveness in Zambia in 2004. The MOU has been signed by almost all of the major donor institutions working in Zambia and lays out a framework of action that includes movement towards the adoption of a Joint Assistance Strategy for Zambia (JASZ) in cooperation with the Government and the National Development Plan. The JASZ seeks to minimise duplication of efforts by multiple donors, to 'de-congest' crowded sectors, to bring about a simpler 'division of labour' by identifying 'lead donorships' within each sector.

A related element is the move towards greater levels of budget support. The European Commission has been at the forefront of this effort, approving €110 million in budget support for GRZ in late 2003, as well as additional technical support for public sector financial management and information systems.[260] The EC's move has laid the groundwork for other institutions to follow suit, and many (but not all[261]) donors are actively supporting this shift. Significant levels of sector-wide support are already provided by bilateral institutions in Zambia as part of a general trend of merging stand-alone projects into wider programmes of support.

Despite these moves towards greater harmonisation, funding for HIV/AIDS in Zambia remains a complex affair. It is anticipated that when the JASZ is operational, funding for AIDS will flow through the Ministry of Finance and National Planning, along with other ODA, but at present its delivery is far from systematic.

The National AIDS Council in Zambia does not channel funding. It plays a mobilisation, coordination and oversight role in relation to AIDS financing, helping to identify gaps where assistance is needed and institutions through which funding can be directed. In theory, the NAC should act as a broker between donor institutions and the National Strategic Plan, shaping how and where the donors 'buy in' to elements of the plan. In practice this role is only partially realised. While the NAC has

[260] See Sida (2006b, 2006c, 2006d) for background discussion on changes in development partnership environment in Zambia.

[261] It is expected, for example, that the US Government, Japan, and the Global Fund will be unlikely to join the JASZ.

'In Zambia the HIV/AIDS arena is characterised by numerous local and international actors, including donors, UN agencies, international financial institutions, universities and research institutions, NGOs, FBOs, CBOs, etc. Much of the coordination efforts and coordination capacities of NAC are absorbed by managing numerous individual coordination processes associated with such a diverse group. The net result is that not enough action is realized on the ground.'

- Zambia UNGASS report (2006, p. 16)

strong links to and is aware of the details of particular funding initiatives (e.g. World Bank, Global Fund), it does not have the 'big picture' of the resource environment. Several attempts at resource tracking have been undertaken over the past decade, but these have been of only marginal usefulness and there is nothing resembling a comprehensive donor matrix or database. Some information is provided to the NAC by donors voluntarily, but in other instances the NAC is essentially informed after the fact what programming decisions have been made. The NAC has difficulty getting reports from certain donors about how much funding has actually been spent in country; blank sections in the Third Joint Annual Programme Review section on 'Finance and Budgeting' attest to the absence of a basic overview of the funding environment by its lead coordinating agency.[262]

The NAC itself is supported at an institutional level by a Joint Financing Arrangement (JFA) between DFID, Irish Aid, the Netherlands, NORAD and Sida. Some of the funds committed through the JFA are passed downwards to the Provincial and District AIDS Task Forces for operational (not programming) purposes. The JFA also includes support for capacity-building and institutional development of the NAC, which is seen as a high priority by many development partners. The NAC is accepted as the sole coordinating authority, but there is widespread concern that it has not been effective in carrying out its role. There have been a large number of vacant staff positions within the NAC, including some key posts, and limited oversight by the Cabinet Committee to which NAC reports. The World Bank has recommended changing institutional arrangements by relocating the NAC to the Office of the Vice President where it would be in a better and more independent position to coordinate the activities of other bodies.[263]

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

Zambia is heavily reliant upon international funding to support its AIDS response efforts. Expenditure of domestic revenues (support to NAC and line ministries) by the Government of Zambia (GRZ) totaled US$32 million in 2005,[264] while funding commitments from the three largest external funders alone was more than US$170 million.

Zambia is one of the 15 focus countries under the US Government's PEPFAR initiative, which was launched in late 2003. More than US$360 million has been committed for scaling up prevention, treatment, and support activities in Zambia during fiscal years 2004-2006 alone, making Zambia the fourth largest recipient of PEPFAR funding after South Africa, Kenya and Uganda.[265] Prior to the PEPFAR initiative, USG funding in Zambia was provided primarily through USAID and the Centres for Disease Control.

Overall US Government funding commitments for AIDS in Zambia for the period 2001-2005 were close to US$300 million.[266] USG funding is channelled directly to recipient institutions, which include a combination of civil society organisations, research institutions and universities, government departments and health institutions,[267] and private contractors that provide technical assistance and project management services. Many of these are US-based entities; some work in partnership with or sub-grant to local institutions. There is insufficient information available on amounts committed to specific recipient organisations over the period 2001-2005 to estimate the proportion of overall funding channelled to CSOs; however for FY 2005 at least 37% of total committed funds were channelled through CSOs.[268] Of 43 prime recipient partners

[262] See Republic of Zambia (2006b, pp. 180-192). The NAC's Director of Programmes expressed in an interview that the decision to leave elements of the section blank was a deliberate one.

[263] See World Bank report on institutional arrangements in Republic of Zambia (2006b, p. 206).

[264] Republic of Zambia (2006a).

[265] OGAC (2006a, p. 16).

[266] Figures for 2001-2003 taken from OECD database; FY 2004-2005 figures taken from OGAC (2006a, p. 16), and annualised.

[267] For example, the National Blood Transfusion Service.

[268] Conservative estimate based on calculations from publicly available commitments broken down by partners for FY 2005 (OGAC, 2006c). These publicly available commitments total only US$109 million of the total US$130 million commitments to Zambia for FY 2005.

of PEPFAR funding in Zambia in FY 2005, 40% were international FBOs or NGOs such as World Vision, Pact, Christian Aid, Family Health International, Hope Worldwide, and Catholic Relief Services. There were 87 sub-partners, 90% of which were local FBOs and NGOs.[269]

Zambia has been awarded a total of US$346.5 million for HIV/AIDS by the Global Fund in Round 1 and Round 4 applications; of this, US$116 million has been approved for disbursement and US$60 million had been disbursed to Zambia by the end of 2005.[270] Zambia has four separate Principal Recipients of funding – the Ministry of Finance and National Planning, the Ministry of Health, the Zambian National AIDS Network (ZNAN), and the Churches Health Association of Zambia (CHAZ). ZNAN and CHAZ are responsible for sub-granting Global Fund support to civil society organisations and the private sector: NGOs/CBOs and the private sector, in the case of ZNAN, and FBOs in the case of CHAZ. Together, ZNAN and CHAZ account for 58% of the overall committed Global Fund support to Zambia and received 56% of the actual disbursements of funds made through end 2005.[271] At least 400 NGOs, CBOs and FBOs had been supported through sub-grants from ZNAN and CHAZ through the end of 2005.[272]

The World Bank MAP program has committed US$42 million to the Zambia National Response to HIV/AIDS (ZANARA) program for the period 2003-2008. ZANARA has four main streams of activity: technical guidance for the National AIDS Council (6% of funds), support for mainstreaming AIDS activities in line ministries (23%), funds for impact mitigation and care programs through the Ministry of Health (28%), and the Community Response to AIDS (CRAIDS) initiative to support local activities (35%).[273] By the end of 2005, the CRAIDS programme had supported 528 community-level NGOs and CBOs with more than US$5 million in World Bank funding.[274]

DFID's multisectoral AIDS response program – Strengthening AIDS Response in Zambia (STARZ) – has committed £10.3 million (US$18.9) to activities in Zambia over the period 2004-2008.[275] The main components of STARZ include support for civil society responses (36%), technical assistance (53%), institutional support to the NAC, as part of the JFA (6%), and support for private sector responses (5%).[276] The funds for civil society response are channelled through ZNAN and CRAIDS in the form of sub-grants for CBOs and NGOs. Over US$1 million in STARZ funding had been disbursed to 147 organisations by the end of 2005.[277]

Many other bilateral donor agencies support AIDS in Zambia, and some fall into a 'like-minded group' of institutions that fund in a similar and compatible manner.

- *NORAD* has provided US$14.5 million for AIDS from 2001-2005 through Norwegian NGOs, support to GRZ, ZNAN and the NAC.[278] It channels its funding to ZNAN through a Joint Funding Arrangement with the Netherlands that minimises reporting requirements and streamlines donor oversight.
- *Irish Aid* has provided US$11 million in direct project support, funding for ZNAN and CHAZ, and the NAC over the period 2001-2005. More than 80 organisations have been supported directly by Irish Aid, although it is now concentrating its support for civil society in ZNAN, where its funding is earmarked for projects targeting orphans and other vulnerable children in the Copperbelt region. Approximately 80% of Irish Aid's AIDS-specific funding went to civil society organisations in 2005.[279]

[269] OGAC (2006b).

[270] Global Fund (2006).

[271] Calculations based on publicly available information about commitments and disbursements. See Global Fund (2006).

[272] Sub-granting records provided by ZNAN; CHAZ progress reports to Global Fund and 2005 Annual Report.

[273] The World Bank (2002b, p.16).

[274] 147 projects were funded in 2004 (Ministry of Finance & National Planning, 2005, p. 6) and 381 projects were funded in 2005 (Ministry of Finance & National Planning, 2006, p. 15).

[275] Information on DFID support for HIV/AIDS prior to the STARZ programme could not be obtained.

[276] Personal correspondence with DFID representative, Lusaka.

[277] 106 organisations were supported through ZNAN (US$636,000) and 41 through CRAIDS (US$404,000). ZNAN sub-granting records and CRAIDS annual reports.

[278] Disbursements, as reported by NORAD Lusaka. This appears to include support channelled through Norwegian NGOs. See, for example, NORAD (2006, p. 21), for breakdown of funding delivery in 2005.

[279] Data provided by Irish Aid, Lusaka.

- *DanChurchAid* provided US$6 million in support for local FBOs and NGOs, including CHAZ, over the period 2002-2005. It works through multi-year partnerships with local NGOs, many of which are faith-based, and emphasises gender and poverty alleviation in the projects it supports. All of DanChurchAid's AIDS funding in Zambia goes to CSOs.[280]
- The *Royal Netherlands Embassy* has spent US$4.5 million on AIDS-specific projects between 2001-2005, including direct project support to CSOs, funding for ZNAN and CHAZ, and institutional support to the NAC.[281] In recent years the Netherlands has been scaling back on direct project funding in favour of support to ZNAN and CHAZ, however the great majority of the Netherlands' AIDS funding in Zambia continues to go to CSOs.
- *Sida* has adopted a mainstreaming approach to AIDS in its funding portfolio and provides only a limited number of direct grants to recipient institutions, most of which are youth organisations focusing on HIV prevention. Sida committed approximately US$1.8 million to AIDS projects over the period 2002-2005.[282] Sida also contributes to the NAC Joint Financing Arrangement.

Thirteen UN agencies are present in Zambia and many of them work on AIDS. UNICEF and UNDP are among those that provide significant funding, as opposed to playing more technical roles. UNDP launched a US$5 million multisectoral response initiative in 2003, and UNICEF's maternal and adolescent project (US$3.2 million from 2002-2005) devotes significant attention to AIDS.

Support for CSO responses to AIDS response in Zambia

Civil society organisations have emerged relatively strongly in Zambia since the advent of multi-party democracy. Although relations between civil society and the state are not always smooth, the work of civil society organisations on development and humanitarian (as opposed to political) issues is generally valued by the government, which recognises the need for partners to realise its development strategies. Consultations surrounding the development of the PRSP were important in setting a precedent for civil society participation in policy discussions, and the Civil Society for Poverty Reduction network is beginning to emerge as an important forum for civil society input into pro-poor development strategies.

Civil society organisations are heavily involved in AIDS-related activities in Zambia and have been since the earliest stages of the epidemic. The CSOs themselves are varied in form, as are the roles they play. The 2006 UNGASS report cites the contributions of large international NGOs that are pioneering multisectoral programmes that draw together issues of AIDS, food security and income support; the work being conducted by other NGOs in support of decentralised planning and provincial and district-level structures; the important service provision role being played by church health services and FBOs in the areas of treatment, care, and prevention; and specialised projects targeted at niche groups and issues such as treatment literacy. There are also hundreds, if not thousands, of community-level CBOs and NGOs involved with prevention, care and support activities dotted across the country.

Zambia has a number of strong CSO networks and umbrella bodies that have taken on key roles in the national AIDS response. These include the Zambia National AIDS Network (ZNAN), the umbrella body for AIDS-

[280] Interview with DanChurchAid, Lusaka.

[281] Significant sector support is provided to the Ministry of Health, but this is not considered part of the AIDS-specific budget.

[282] Committed funds, as reported by Sida Lusaka. See also Jansegers, P. (2005, p. 33), for list of Sida-supported projects on HIV/AIDS in Zambia.

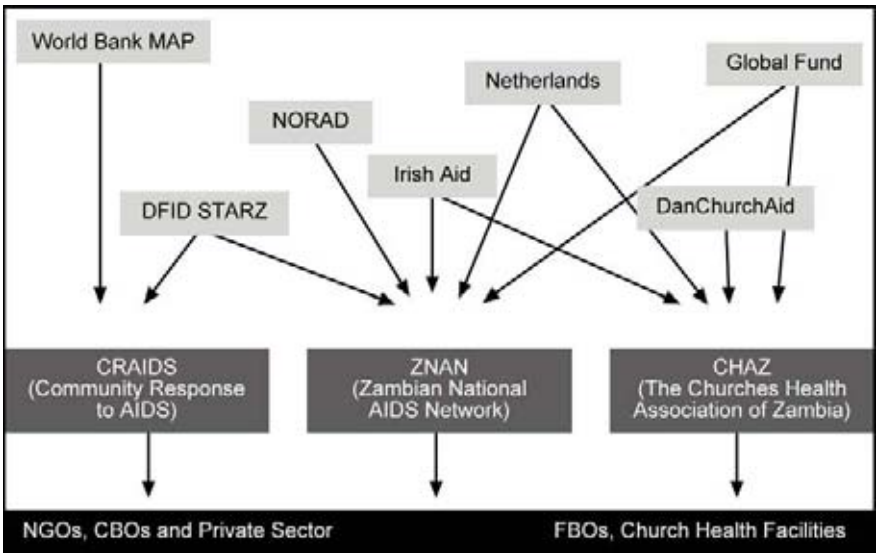
related organisations in Zambia; the Zambia Interfaith NGO Network (ZINGO) and the Churches Health Association of Zambia (CHAZ), which work with church health services and FBOs; and the Zambia Business Coalition on HIV/AIDS (ZBCA). There is also a national network of people living with HIV, called ZNP+, and a large network of traditional health practitioners.

In comparison with some other countries in the region, CSOs in Zambia benefit from the existence of three large-scale funding mechanisms specifically designed to move funding for AIDS down to the grassroots level: the sub-granting programs of the Zambian National AIDS Network, the Churches Health Association of Zambia, and the Community Response to HIVAIDS component of the World Bank's ZANARA program.

As Figure 31 shows, there is considerable overlap in the funding sources for these three initiatives which, taken together, had sub-granted approximately US$24 million in funds by the end of 2005.

Figure 31

Sources of funding for Zambia's civil society sub-granting bodies



ZNAN and CHAZ were designated as Principal Recipients of Global Fund funding in 2003; following this, a number of bilateral donors also began contributing funds for sub-granting. Irish Aid and the Netherlands, for example, which are moving their funding portfolios away from direct project support, have begun channelling their support through ZNAN and CHAZ instead. The Netherlands and NORAD have entered into a Joint Financing Arrangement and pool their contributions to ZNAN to minimise the administrative and reporting burden.

While CHAZ, which was founded in 1970 and is responsible for up to half of all health care provision in rural areas of Zambia, had some prior experience as a funding conduit, ZNAN had not previously acted as a conduit. For both organisations the sub-granting role has demanded major institutional changes: for example, a significantly larger staff, the introduction of an M&E unit, a grants management unit, and an internal audits department. Reporting requirements and timelines are not the same for all the donors, and this places a heavy administrative burden upon ZNAN and CHAZ. The funding streams essentially need to be managed separately, since donors place specific requirements on how or

Both ZNAN and CHAZ have met and even exceeded expectations in terms of their performance in disbursing large amounts of funding. However both are also working to maximum capacity and certain other functions may be suffering as a result of the pressures of the sub-granting role.

where their funds should be targeted. For example, Irish Aid's funding to ZNAN is earmarked for projects supporting OVC in the Copperbelt.

In addition to administering grants directly, both ZNAN and CHAZ utilise intermediary bodies to extend their reach into rural areas and to specialised target groups. ZNAN works through 'lead agencies' that re-grant funds in remote and underserved areas as a strategy for countering the urban bias that otherwise exists through the application process. CHAZ works through 13 sub-recipients – various religious 'mother bodies' for different faiths and denominations – to extend sub-grants to FBOs and institutions that are not members of CHAZ.

Both ZNAN and CHAZ have met and even exceeded donor expectations in terms of their performance in disbursing large amounts of funding quickly and efficiently, and reporting back on its use. However both organisations are also working to maximum capacity, or perhaps over capacity, and it is important not to ignore the fact that certain other functions may be suffering as a result of the intense pressures of the sub-granting role. An evaluation of ZNAN conducted in 2005 found that the grant-making role has put strain on its ability to carry out certain functions, such as technical support and M&E, and may have long-term implications for its original role as a network to facilitate collaboration and information sharing among AIDS service organisations.[283]

In contrast with ZNAN and CHAZ, which were existing membership organisations prior to becoming sub-granting agencies, CRAIDS is a newly established initiative set up as part of the World Bank MAP program. It is responsible for administering 35% of the overall MAP funding envelope of US$42 million, and has also received funding from the DFID STARZ program. Working in close collaboration with DATFs, CRAIDS provides funding for community-based projects and a small number of private sector initiatives across the country. Proposals are first reviewed by DATFs and forwarded on to a CRAIDS selection committee; all applications over US$20,000 require the approval of the NAC. Once funding has been awarded, UN Volunteers at district level work with the DATFs to monitor the projects.

Table 17

Overview of main sub-granting mechanisms for CSOs in Zambia

Funding Intermediary	Source of Funds	Number of CSOs funded to end 2005	Amount disbursed in sub-grants (ZMK)	Amount disbursed in sub-grants (US$)
ZNAN[284]	Global Fund	239	38.1 billion	8.4 million
	JFA (Netherlands/ Norway)	124	11.1 billion	2.4 million
	DFID STARZ	106	2.8 billion	636,000
	Irish Aid	27	2.7 billion	608,000
CHAZ[285]	Global Fund	160-250		6.2 million
	Other contributors (Netherlands, Irish Aid, DanChurchAid)			* Could not be determined
CRAIDS[286]	World Bank	147 (2004) 381 (2005)	6.5 billion 18.9 billion	5.6 million
	DFID STARZ	41 (2005)	1.8 billion	404,000
Minimum estimate of funds sub-granted to CSOs (2004-2005)				**US$24 .2 million**

[283] Legend Consulting (2005).

[284] Grant summaries provided by ZNAN.

[285] Complete information was not available from CHAZ to document full extent of sub-granting per donor. Figure in final column should be taken as an estimate; data derived from CHAZ progress reports and disbursement requests to GFATM which detail issued sub-grants. Estimate of beneficiary organisations taken from CHAZ Annual Report 2005, and Republic of Zambia (2006b, p. 181).

[286] Ministry of Finance and National Planning (2005); Ministry of Finance and National Planning (2006).

The sub-granting mechanisms described above are perhaps the most visible forms of support for CSOs in Zambia, but they are only one part of a complex picture. They are oriented on disbursing money to as many organisations as possible, as broadly as possible, and many of the grants are fairly small (for ZNAN, between US$10,000 and 40,000). Funding at this scale is important to CSOs at a certain stage of development, but it is not sufficient as a sole source of funding for NGOs with larger-scale operations.

It is apparent that the funding environment for civil society in Zambia is changing. A number of bilateral donors are reducing their direct project-based funding for CSOs in favour of funding through conduits (such as the above) or through sector programmes. The US Government is the major exception to this trend and PEPFAR funding is one of the clear examples of large-scale project-based funding for civil society organisations. PEPFAR funding is channelled through US-based NGOs, universities and research institutions, and private contractors who often work in consortia with one another and enter into sub-granting arrangements with local NGOs and FBOs. World Vision International, Pact, Family Health International and Catholic Relief Services all sub-grant funds to local organisations in Zambia.

Other sources of direct project support exist for NGOs in Zambia, but the research found that mid-to-large-sized Zambian NGOs are getting 'pinched' in the current funding environment: community organisations are relatively well-catered for by ZNAN, CHAZ and CRAIDS, and international NGOs are able to access funds directly from donor agencies through their headquarters. Yet the traditional sources of support for national NGOs – from in-country bilateral agencies – are drying up with the shift towards budget support and funding through conduits.[287] The Government of Zambia does not yet have the mechanisms in place – and possibly not the inclination either – to fund CSOs directly. Organisations are therefore being forced to expend ever greater energy and time on cultivating other sources of support – foundations, trusts, the private sector, international NGOs – with mixed success.

[287] Student Partnerships Worldwide (2006).