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Aid for AIDS: How do Community Groups and Other Stakeholders Negotiate the New Financial Architecture in Kenya, Malawi and Zambia?

Jerker Edström and Hayley MacGregor

With: Netsayi N. Mudege, Ireen Namakhoma, Chishimba Mulambia, Joseph Simbaya and the assistance of Rebecca Cassidy, Kate Hawkins, Naomi Vernon and Jan Boyes

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Summary

In the past decade global health resources for AIDS have increased dramatically. What have these investments meant to responses of communities affected by HIV and AIDS? To explore this issue, research was conducted in Kenya, Malawi and Zambia and this report describes the findings, analysis and questions arising for policy.

The qualitative methodology used provides a rich and triangulated analysis. Based on a review of the literature, four sets of critical debates were identified, focusing on: (i) the effects of disease-specific funding; (ii) its effects on national sovereignty; (iii) issues of flow-through and 'aid effectiveness'; as well as (iv) whether this aid facilitates civil society engagement and holding governments to account. The conceptual framework ensured that issues raised at national level were tracked down to local sites to consider how local groups negotiate the aid architecture. In total 109 structured in-depth interviews were carried out, at all levels, and 21 focus group discussions were conducted in local sites. The analysis triangulates perspectives from: local community members and community groups; local government staff; national civil society organisations; government officials; and staff of international NGOs and donor agencies.

Findings show that the influence of donors is seen as determining, whilst their own agendas are set 'at home' and their interactions are seen as poorly coordinated. National governments appear challenged in leading national responses, but results speak against further centralising funding and power. The complex (and often complicated) aid systems continue to be beset with a range of problems in terms of effectiveness, coordination and local access, but a plurality of channels appears important to the survival of local groups' and civil society's capacity to respond. Key recommendations centre on the need for donors and governments to both harmonise and simplify multiple systems of support down to community level, as well as strengthening indigenous support structures.

Keywords: HIV; AIDS; aid; global health transfers; Global Health Initiatives; community based organisations; civil society organisations.

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Country Reports

Netsayi N. Mudege and Jerker Edström (with George Mgomella, Sixtus Otumbe, Eva Nderu, Rebecca Cassidy, Kate Hawkins, Rose Oronje and Bridie Phillips) (2010) 'Aid for AIDS: Kenya Country Report', *Field Research Report*, Nairobi: African Population and Health Research Center (APHRC) and Brighton: Institute of Development Studies (IDS)

Ireen Namakhoma, Hayley MacGregor and Jerker Edström (with Kumbukhani Kuntiya, Mtisunge Chibambo, Grace Bongololo, Rebecca Cassidy, Kate Hawkins and Bridie Phillips) (2010) 'Aid for AIDS: Malawi Country Report', *Field Research Report*, Malawi: Research for Equity and Community Health (REACH) and Brighton: Institute of Development Studies (IDS)

Chishimba Mulambia, Joseph Simbaya and Hayley MacGregor (with Joseph Tembo, Mbiko Msoni, Richard Bwalya, Elizabeth Mills, Kate Hawkins and Rebecca Cassidy) (2010) 'Aid for AIDS: Zambia Country Report', *Field Research Report*, Zambia: Institute of Economic and Social Research (INESOR) and Brighton: Institute of Development Studies (IDS)

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
APHIA	AIDS Population and Health Integrated Assistance
ART	Anti-retroviral Therapy
ARV	Anti-Retroviral
CAC	Constituency AIDS Committees (Kenya)
CACC	Constituency AIDS Control Committees (Kenya)
CATF	Community AIDS Taskforce (Zambia)
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism
CDC	Centre for Disease Control
CHAK	Christian Health Association Kenya
CHAM	Christian Health Association Malawi
CHAZ	Churches Health Association of Zambia
CHW	Community Health Workers
CIDA	Canadian International Development Agency
CRAIDS	Community Response to HIV/AIDS (World Bank programme in Zambia)
CSO	Civil Society Organisation (which can be NGO, CBO or FBO)
CSW	Commercial Sex Workers
DA	District Assembly (Malawi)
DACA	District AIDS Coordination Advisor (Zambia)
DACC	District AIDS Coordinating Committee (Malawi)
DASCO	District AIDS/STD Coordination Officer (Kenya)
DATF	District AIDS Task Force (Zambia)
DDCC	District Development Coordinating Committee (Zambia)
DFID	Department for International Development
DHMT	District Health Management Team
DOD	Department of Defence (US)
DOS	Department of State (US)
FAO	Food and Agriculture Organization of the United Nations

FBO	Faith Based Organisation
FGD	Focus Group Discussion
GAP	Global AIDS Program
GF	Global Fund
GFATM	The Global Fund to fight AIDS Tuberculosis and Malaria
GHIs	Global Health Initiatives
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (German Society for Technical Cooperation)
HIV	Human Immunodeficiency Virus
IDI	Individual In-depth Interview
JAPR	Joint HIV/AIDS Programme Review (Kenya)
JICA	Japanese International Cooperation Agency
JICC	Joint Interagency Coordination Committee (Kenya)
KANCO	Kenya AIDS NGOs Consortium
KENWA	Kenya Network of Women with HIV/AIDS
KI	Key Informant
KNASP	Kenya National HIV/AIDS Strategic Plan
M&E	Monitoring and Evaluation
MAP	Multi-Sectoral AIDS Project (Malawi)
MASAF	Malawi Social Action Fund
MFNP	Ministry of Finance and National Planning (Zambia)
MIAA	Malawi Interfaith AIDS Association
MOF	Ministry of Finance
MOH	Ministry of Health
MPF	Malawi Partnership Forum
NAC	National AIDS Commission/Council (Malawi/Zambia)
NACC	National AIDS Control Council (Kenya)
NAF	National AIDS Framework (Malawi)
NAPHAM	National Association of People Living with AIDS (Malawi)
NASCOP	National AIDS/STD Control Programme (Kenya)
NGO	Non-Governmental Organisation
NNEPOTEC	Network of Post-Test Clubs (Kenya)

NORAD	Norwegian Agency for Development Cooperation
NZP+	Network of Zambian People living with HIV/AIDS
OECD	Organisation for Economic Co-operation and Development
OPC	Office of President and Cabinet (Malawi)
OVC	Orphans and Vulnerable Children
PACA	Provincial AIDS Coordination Advisor (Zambia)
PATF	Provincial AIDS Taskforce (Zambia)
PC	Peace Corps
PEPFAR	President's Emergency Plan for AIDS Relief
PLHA	People Living With HIV
PLWHA	People Living With HIV/AIDS
PR	Principle Recipient
PRG	Project Review Group
PRGF	Poverty Reduction and Growth Facility
SH	Stakeholder(s)
Sida	Swedish International Development Cooperation Agency
STI	Sexually Transmitted Infection
SWAp	Sector-Wide Approach
TOWA	Total War against AIDS (Kenya)
UNAIDS	The United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WB MAP	World Bank Multi-Country HIV/AIDS Program for Africa
WB	World Bank
WFP	United Nations World Food Programme
WHO	World Health Organization
YMCA	Young Men's Christian Association
ZANARA	Zambia National Response to HIV/AIDS Project
ZNAN	Zambia National AIDS Network

Executive summary

In the past decade global health resources for AIDS have increased dramatically. Yet what impacts do these investments have on communities affected by HIV and AIDS? How do local groups access these resources? And how have these funds shaped their responses? To explore these issues, the study titled ‘Aid for AIDS’ was conducted in three African countries – Kenya, Malawi and Zambia. Aid for AIDS was a research project organised by the Institute of Development Studies (IDS), the African Population and Health Research Center (APHRC) in Kenya, the Institute of Economic and Social Research (INESOR) of the University of Zambia and the Research for Equity and Community Health (REACH) Trust (Malawi). Developed as an independent research study, the project was proposed to, and financially supported by, the Swedish International Development Cooperation Agency (Sida). This research report describes the findings, analysis and questions arising for policy from a comparative analysis of three country-level studies conducted by in-country and IDS researchers during 2009. The research is based on findings from structured in-depth interviews with a wide range of stakeholders drawn from: community groups and organisations; local government staff; national civil society organisations; national government officials; international donor agency officials and staff of international NGOs. Issues raised at national level are tracked down to consider how local groups and other stakeholders experience and perceive the aid architecture.

Debates within this field have been extensive and four areas were reviewed for the purposes of this study. First is a set of interlinked questions over the basic logic of how to resource health internationally – i.e. whether a specific disease focus is inefficient, divisive and/or undermines, rather than strengthens health systems in recipient countries. Second, a related set of debates asks questions about a potential erosion of national sovereignty resulting from shifts in the roles of different kinds of national and international actors and arrangements, which are said to skew priorities. Third, significant attention has been given to issues of ‘aid effectiveness’. These include capacity constraints, inefficiencies and blockages or corruption associated with these flows and moderated by complex global funding arrangements. Last, whilst there exists a broad consensus on community action as central to effective AIDS responses, debates have evolved as to whether these new aid practices aimed at facilitating civil society engagement, actually strengthen responses and their governance, or not. Much of this theorising has taken a view from above, but there are several substantial gaps in existing research. Important questions arise if one takes a view from below and foregrounds the perspective of grassroots organisations and service providers, juxtaposing these with the perspectives of other stakeholders. This study has aimed to address the central question: ‘What are the perspectives of community groups and other stakeholders on the new financial architecture in the three countries?’

The methodology employed qualitative techniques to provide a rich, contextually relational and triangulated analysis. Based on a review of the general literature on global health financing and governance, four sets of critical debates were identified (as described above) around which to formulate detailed research

questions on 'vertical' and 'horizontal' dimensions. The fieldwork design involved: (a) following the flows of resources from the main international health initiatives down to community level; as well as (b) a triangulation of perspectives across sectors, both locally and nationally. A desk review was carried out to map significant funding architectures nationally at the first stage of fieldwork in each country. The study then used structured in-depth key informant interviews with national level actors from government, donor and civil society sectors. At community level, structured in-depth interviews were carried out with stakeholders from different sectors, utilising the national level mapping to follow resource flows 'down' the structures, in two local sites per country. Stakeholder interviews were carried out with actors in community organisations, public sector officials and service providers, in addition to semi-structured focus group discussions with beneficiaries of the organisations. In total, 109 interviews were carried out with stakeholders at all levels across the three countries, and 21 focus group discussions were conducted in the local sites with beneficiaries.

The methodology has certain limitations to consider. As is common in qualitative studies, the relatively small number of field sites and respondents per site, along with potential biases in the purposive sampling method employed, place limitations on the degree to which results may be generalised. They should rather be seen as providing detailed information of perceptions of a variety of stakeholders in the countries. Comparisons with findings from other research can mitigate these limitations to a certain degree. The method of triangulating perspectives also mitigates subjectivity to some extent. Further bias might be expected from certain respondents' potential impressions that researchers might leverage resources to their organisations and the personal views of researchers may also privilege certain perspectives. To mitigate such biases, the independent nature of the research was explained in connection with seeking informed consent and interview teams were set up as pairs, in order to cross-check and discuss impressions and scripts after interviews.

The findings can be summarised under the key analytical themes:

The influence of global funders on priorities and structures for resourcing the national response

- √ Major international funding programmes strongly influence national agendas and priorities, but do so in distinctive ways.
- √ In all countries, the US government influence is highly visible and significant, and is often seen to undermine national government control of strategies.
- √ Despite governments leading the elaboration of national strategies, these are often described as derivative of the basic programme categories of global agencies.
- √ Many donors are seen simply to invest in their own priorities within this.
- √ Government stakeholders generally argue for a need for greater government control, but major donors show concern over governments' capacities to administer large amounts efficiently or equitably.
- √ National civil society formations often feel their influence on overall priorities is negligible and many see national agendas as being *set* internationally.

Local access to services and influence over agendas

√ Local access to HIV and AIDS services is generally seen to have improved over recent years in all countries, particularly treatment. Nevertheless, many still feel access to basic health services remains limited and geographically inequitable.

√ In all countries, processes of decentralisation in health are underway, but success is seen as hampered by low investment in infrastructure, human resources and capacity building.

√ Community organisations tend to feel they have very little influence or bargaining power with respect to donor funding priorities.

√ Groups' size and capacity shapes their ability to negotiate agendas.

√ Resource availability is driven by donor-targets, which makes it difficult for groups to develop and sustain programmes meeting community needs.

The flow of support: blockages, leaks and delays

√ Sufficient amounts of money are not seen to be getting through to district and local levels for various reasons, such as: low capacity; ill-adapted systems; corruption; and political interference.

√ Centralised government funding of civil society was seen as fraught with difficulties.

√ Major donors resort to various complex parallel systems to disburse funds.

√ Many community groups survive on opportunistic accessing of funds from a diversity of sources, with both positive and negative effects.

√ For some CBOs access to a multiplicity of sources can be a life-line and improve overall sustainability.

√ However, multiple donor systems filter down to local level in the form of diverse application, reporting and accounting procedures, which restricts the kind of organisations that can obtain funding.

Intermediary structures: move support down, but at what price

√ Various 'intermediaries' between the donor and the final recipient organisations fulfil functions such as disbursement of money, capacity building and monitoring.

√ Most government representatives are not particularly in favour of using NGO intermediary organisations and want more flow of donor money through government.

√ Opinions about International NGO intermediaries were complex, both positive and negative but they were usually seen as costly.

√ Community groups and some government representatives favoured money going to national NGOs as intermediaries, but experiences varied.

Donor coordination

√ There is a general sense amongst most stakeholders that the majority of donors aim to coordinate between themselves and with government, but in different ways.

√ National governments are seen by many as challenged to adequately play a role in leading donors, which appears to be connected to both lack of

coordination between certain donors, the perception that most donors are led primarily by their headquarters, and lack of accountability (or unity) within government.

√ Governments hardly contribute financially, making leading coordination a challenge.

√ Many felt that global donors tend to undermine the governments' autonomy, but they are also seen by some to strengthen governments' abilities to implement policies.

Civil society coordination and influence

√ Several donors (especially PEPFAR and the Global Fund) feel that civil society is essential in taking community responses beyond a medical and public sector implemented approach as well as in holding government to account.

√ In most countries there are formal mechanisms for civil society engagement (most notably the CCMs and various technical working groups) and some civil society networks do influence government, if not always in highly visible ways.

√ Civil society's autonomy and ability to hold governments to account is sometimes felt to be undermined, both by tokenistic – but ineffective – representation and by relationships of dependency.

√ Shifts and tensions between diverse roles in service provision, onward granting, capacity building, representation or advocacy can compromise the integrity, credibility and effectiveness of 'independent' civil society voices.

√ Civil society networks' engagement with grassroots constituencies is variable and divisions within the civil society sector are a constraint to influence effectively national agendas.

Local level coordination

√ Whilst international donors often have less awareness of the substance of community level initiatives, national level players from all sectors (e.g. UN, government, donors, civil society) often idealise community level responses and the notion that 'the community knows best'.

√ Structures exist in all countries for district level coordination, and community groups generally looked favourably on *the idea* of coordination, whilst some saw the reality more as an exercise in control, with little useful coordination resulting from it.

√ The degree of local coordination between groups in an area appeared to vary and often different actors took the lead, *de facto*, depending on actors and context.

√ The nature of different donor systems can discourage coordination and the linking up of similar or related services across different civil society groups.

√ Many community-based organisations felt unable to provide holistic linked-up services even within their own organisations due to the constraints of this complex resourcing architecture.

In conclusion, the findings call for further reflection on existing debates:

'Vertical' vs 'horizontal' approaches to health and HIV: new perspectives on an old debate
The polarised old debate over vertical vs horizontal approaches is becoming increasingly obsolete, since – as noted by many – health systems do indeed need strengthening if we are to respond to HIV effectively, as well as to other health needs. In addition, certain health crises require responses well beyond the health sector itself. HIV programmes have to some extent shown that health services can be strengthened through a disease-focused approach, which can be applied to cross-learning in other areas such as chronic disease care. Whilst disease-specific programming is valuable and leads to specific outcomes, it needs to be integrated with other issues and priorities. HIV provides a good example of yet another reason for why a specific disease focus can be beneficial. That is, the epidemic requires a broader national response across sectors and line ministries, which may be relevant to other health and development issues more broadly. This needs to be effectively elaborated and coordinated at local level, with systems to support such coordination at all levels.

Reconsidering the concept of 'national sovereignty' in relation to global financing for HIV and health
Debates over national sovereignty have tended to assume a Westphalian framework relating rights-bearing citizens to a sovereign nation-state.Thus they have focused on questions of governments autonomously leading the response on self-reliance and on sustainability. In some ways these assumptions are all called into question by the influx of resources and influence in aid for AIDS. The study has found fairly widespread concern on the part of many civil society organisations about the effect of external funding on governments' own financial inputs to the AIDS response in-country and a high dependence on foreign aid to continue existing programmes, with resultant concerns about longer term sustainability. Sustainability concerns increase pressures for more strategic resource allocation (including towards better prevention strategies with the most vulnerable and marginalised sections of societies) and more creative and efficient resourcing of responses. Prevention, in particular, requires a response well beyond the formal government health sector to engage strategically with civil society, media and education sectors.

Findings from the study do not suggest a universal desire for governments to control all the resources. In particular, such a situation would not likely be in the interests of community groups and local responses in the countries studied. Both evidence on the budgetary effects of aid for AIDS and the increased recognition of the need for more strategic investments in prevention speak clearly for strengthening support to civil society alongside assistance to strengthen the *governance* of national public sector services and responses (rather than international funding for public sector budgets). On the basis of our findings, we argue that government roles of leadership and coordination in policy processes should be clearly distinguished and separated from state control of resources or implementation. Whilst the former is perceived to be essential for strong national responses, the latter is often seen as problematic, particularly by those in civil society.

Aside from direct government control over resources, notions of national sovereignty often involve interconnected ideas of legitimacy and *ability to lead*, in turn involving abilities to convene, consult and coordinate effectively with different actors and interest groups to build an overall strategic and complementary response. For several different reasons, governments in the three countries studied are seen as severely challenged in trying to lead the donors and national responses more broadly. The study suggests that the role and structural positioning of national AIDS councils or commissions (NACs) appear quite important in terms of the effectiveness of this institution. Multi-sectoral NACs would appear better placed to link into government structures outside and above line ministries, as this allows for both more neutral cross-sectoral priority setting (within and beyond government) and authority to lead. The institution of the Global Fund's Country Coordinating Mechanisms (CCMs) is typically viewed differently by different stakeholders and it would be foolish to draw general conclusions. What is clearer is that the CCM has to a significant extent changed the 'name of the game' and moved discussions of national sovereignty from a focus on governments to multi-sectoral national responses and therefore a more up-to-date and less state-centric notion of 'the national'.

Aid effectiveness and harmonisation at the local level
A key dilemma remains that sufficient amounts of resources are not seen to be getting through to district and local levels for various reasons and that local perceptions of aid for AIDS is often one of a chaotic or disjointed system. Flow-through in the public sector was also a widely reported problem in this study. However, this conclusion should not be seen as sufficient or universal, as we also found additional explanations for the limited flow-through and constraints, through bottlenecks arising from lack of capacity and ill-adapted systems, in line with findings of other researchers.

Our study vividly describes two typical responses to these dilemmas: the one being a common use of a range of intermediary task-focused structures and, the other, an argument for greater government control of resources along with strengthening centralised public health systems. By privileging a community perspective, we would argue that local harmonisation needs to be de-linked from the notion of government control of resources. Thus, in the question of whether a monopoly or diversity of funding channels is preferable, diversity is actually to the benefit of local groups and responses, as well as to donors and others concerned with enabling scaled-up community level action.

A key issue emerging is the ill-adapted orientation and design of current donor and funding systems for enabling locally driven responses. Current output-target-driven donor approaches to funding a narrower range of readily quantifiable activities do risk shaping the nature of the kinds of community level responses that evolve. Aside from addressing the current 'output countability bias' of many donors, which limits funding for areas vital to sustainability and militates against a holistic response, there is a need to redress bureaucratisation as well as multiple different reporting and accountability requirements. Currently these are typically passed down to community level and restrict many local groups' access.

Whilst multiple intermediary structures can increase the sense of parallel systems and sense of waste, they can also make procedures and requirements more appropriate to the needs of local groups (as well as provide guidance and

capacity building). The study has registered strong arguments for using – and strengthening – national NGOs, platforms and organisations to act as such intermediaries, particularly in light of the almost universally acknowledged need for building local and national capacity.

A strong momentum behind donor harmonisation has emerged with the Paris Declaration (OECD/DAC 2005), but this remains framed in (i) too state-centric terms and (ii) too generically focused at national level. Donor and cross-sectoral harmonisation at local levels remain underexplored and problematic. We would suggest one way forward would be for a range of the big global health initiatives to engage with each other, with donor- and recipient governments as well as with local stakeholders to develop far more coherent and user-friendly systems 'down to community levels'. This might be done best with agreeing a focused – but open and structured – pilot process in a few countries, to begin with, but with clear timetable and process for developing a joint Donor Code of Practice.

Leveraging the multiple contributions of civil society in local and national responses

The 'big three' programmes – the President's Emergency Plan for AIDS Relief (PEPFAR), the World Bank's Multi-country HIV/AIDS Program (MAP), the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) – have increased stakeholder participation and the involvement of civil society actors. Whilst cross-sectoral consultation in national HIV and AIDS strategies has increased – given a particular boost by the processes and structures set in place by the Global Fund – national civil society formations often felt that their influence on overall priorities remained negligible. Many still saw national agendas as being set internationally and saw governments as intent on controlling their activities. The study suggests that there is a real need for more meaningful representation of key civil society actors in national and local structures. The roles that different civil society groups can play need to be acknowledged in planning and coordinating a truly 'national' response that goes beyond a health focus. A cross-sectoral strategic response is also likely to be less vulnerable to political shifts and more resilient to short-term shocks and the concomitant interruptions.

Governments have been challenged for greater transparency and accountability, which is being responded to in different ways (proactively and defensively). The ability of civil society to 'hold government to account' is often constrained by various factors. A diversity of funding sources for civil society potentially mitigates concerns about government control.

The advent of funding has diversified the roles of some CSOs, for example in taking on the disbursement of funds in an intermediary capacity. The aim of greater national ownership can be aided by a move away from a heavy reliance on international NGOs as intermediaries, except in a time-limited and outcome-oriented support role. Donors and governments need to prioritise an investment in the capacity of national civil society structures to fulfil the disbursement role and to act as intermediary NGO/CBO supporters.

The incorporation of CSOs into granting structures can have the effect of a diffusion of aims (or 'mission creep'). This is a further potential constraint to fulfilling effectively more 'traditional' roles of HIV-related advocacy work and even

service delivery. A periodic evaluation of the range of effects of HIV funding on the actual work conducted by NGOs is important to ensure that a diverse spread of activities exists nationally and locally. Such strategic evaluation and planning requires civil society to work together and build and maintain active networks for coordination at all levels. In this respect, the 'community systems strengthening' agenda could be valuable if carefully applied.

The recommendations from the study are as follows:

- √ Link the HIV response to other health sector issues and beyond the health sector to more strategically include public, private and civil society sectors;
- √ Maintain or strengthen diversity of funding structures and plural ways of operating;
- √ Ensure key national stakeholders, including key populations, are positioned and enabled to partake in the national response, through:
  - Placing the main national coordinating bodies outside and above line ministries to enhance their authority, and;
  - Ensuring architectures and coordinating body constitutions (a) clearly separate coordination from control of resources and (b) meaningfully involve the relevant stakeholders;
- √ Engage with global evidence on 'what works' and strategically focus efforts and resources on curbing and sustainably controlling the epidemic with longer-term perspectives in mind;
- √ Build on and expand structures and processes for a diverse and strategic cross-sectoral national response to build ownership and resilience;
- √ National intermediary organisations need strengthening, specifically to reduce dependency and transaction costs, and to build shared national ownership;
- √ The potential benefits of intermediary structures should be strategically and sustainably harnessed, by building on a range of local resources and capacities for NGO/CBO support;
- √ Minimise the range and detail of local level restrictive targets and indicators for specific outputs, and instead build participatory systems to enable holistic responses and capacity to monitor broader outcomes at community levels;
- √ Make the different funding systems more appropriate and less burdensome to the capacities of small local organisations;
- √ Focus efforts at checking corruption proportionally according to levels of finance and carefully consider cost-efficiency on the degree of financial monitoring at different levels;
- √ Rather than new blue-prints from above, enable community strengthening through harmonising and simplifying donor systems at the community beneficiary level;
- √ To support all these aims, develop a joint '*donor code of practice*' down to community level, setting appropriate and non-duplicative standards for qualification, application, reporting, and accountability.

1 Introduction

This report describes the results of a collaborative field study entitled ‘Aid for AIDS: How do community groups negotiate the new financial architecture?’. The study has focused on local and other stakeholders’ perspectives and responses to international financing for HIV and AIDS in Kenya, Malawi and Zambia. It has aimed to uncover unintended negative consequences of funding programmes at a local level, as well as positive effects and new initiatives that might open opportunities for local engagement and strengthening of local responses.

The past decade has witnessed a change in the public health funding landscape with the rise of global health programmes as well as simultaneous increases in bilateral funding for health sector development. In the arena of HIV/AIDS in particular, a number of vertical initiatives and other kinds of funding partnerships now exist that aim to make resources available to alleviate the mortality and morbidity due to the disease in sub-Saharan Africa. The potential impact of these programmes is wide-ranging. These may range from empowering local communities, by making a diverse range of funding options accessible in any one location, or – conversely – compromising collaboration, locally driven solutions through competing priorities, guidelines and/or approaches.

A view from above has prompted substantial amounts of theorising about the extent to which these initiatives constitute a new form of ‘global sovereignty’ that can bypass state authority. Another line of enquiry aims at tracking the flow of funds through the various management structures in order to determine the proportion that reaches the end target. There are, however, also several substantial gaps and important questions that arise if one takes a view from below and foregrounds the perspective of grassroots organisations, those dependent upon the receipt of funding. The different impacts of vertical funding programmes on local level activities and the evolution of local level responses to HIV/AIDS, need more critical analysis and – in particular – the combined impacts of their local interactions need closer scrutiny. Similarly, what might be the effect of such programmes operating alongside other bilateral government funding initiatives on district-level responses to the epidemic? This study has been designed to provide a ‘bottom up’ perspective on a range of issues related to funding for HIV, which is intended to provide community-rooted recommendations for policy and donor coordination.

The study has aimed to answer the central question: ‘What are the local experiences of multiple major global and bilateral international financing structures for HIV and AIDS on local and district-level responses in selected communities in Kenya, Malawi and Zambia?’ The central purpose of this report is to inform policymakers, stakeholders and international assistance agencies with identified challenges and recommendations for strengthening coordinated and/or complementary support to local HIV and AIDS responses in selected countries of the region. The study was led by the Institute of Development Studies (IDS) and has been based on field-level research planned and carried out with three African partner institutions: African Population and Health Research Center (APHRC), Kenya; Research for Equity and Community Health Trust (REACH), Malawi and;

Institute of Economic and Social Research (INESOR), Zambia. The focus has been primarily on recipients of support from major global and bilateral international funding programmes for HIV (especially the World Bank, Global Fund and the President's Emergency Plan for AIDS Relief (PEPFAR)), but the study has also considered perspectives of other selected stakeholders and groups of community members, benefiting from AIDS responses.

2 Background to international aid for AIDS

This chapter contextualises the study by providing an overview of the literature and research on global health financing and development assistance for HIV responses. We highlight, in separate sections below, some key issues and debates which have informed the study design.

2.1 A new era of funding, actors and architectures

The architecture of global funding for health has changed substantially in the last decade, with a seismic shift from primarily bilateral, state-centred, to multilateral, global structures for health funding, or Global Health Initiatives (GHI). Ravishankar *et al.* (2009) review development assistance for health transfers from 1990 to 2007, charting this shift alongside a four-fold increase in funding during this period. HIV funding makes up a major part of this and by 2005 the 'big three' – the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), the World Bank Multi-Country AIDS Programme (WB MAP), and PEPFAR – were dispersing $3 billion annually, PEPFAR accounting for 70 per cent (Bernstein and Sessions 2007).

We are not proposing a strict definition of 'Global Health Initiatives' and we recognise that the term 'global' has many connotations. For example, whilst PEPFAR is technically a fund under US bilateral aid, it brings together several US agencies, and the United States' global influence (as a recognised global superpower) taken together with the large amounts of resources involved, makes it comparable to other major Global Health Initiatives. For recipient countries the vast sums involved, for disease specific programmes, can outstrip the total health budget (Brugha *et al.* 2005). Whilst it is very likely that extensive provision of treatment for HIV in much of sub-Saharan Africa would not be occurring without such external funds, there is also some concern that these resources can shift the balance of power within countries, undermining national sovereignty and encouraging corruption and inefficiency. Similarly, such practices can also run through the webs of partnerships and, with or without the money, reach all sectors of society.

Current debates within this emerging field of global funding for health are diverse and four areas deserve particular attention for the purposes of this study. First is a set of inter-linked questions over the basic 'logic' of how to resource health – i.e. whether a specific disease focus is inefficient, divisive and undermines rather than strengthens otherwise under-funded health systems in recipient countries. Second, a related set of debates asks questions about national sovereignty and

who drives priorities in the context of such massive flows of money. Third, significant attention has been given to questions of aid effectiveness – e.g. capacity constraints, inefficiencies and/or corruption associated with these programmes. Last, whilst a broad consensus on community action as central to effective AIDS responses exists, debates have evolved as to whether these new aid practices facilitate such engagement and to what extent they strengthen civil society responses. These four areas are briefly summarised below.

2.2 Critiques of 'vertical funding'

It has been argued that disease-focused programme structures and significant earmarked resources of donors shape the response on the ground, distorting overall health priorities in services, programming and research. For many critics, debates around the governance of Global Health Initiatives (GHIs) and international AIDS funding centres on a charge of 'exceptionalism' for HIV and linked to that, ring-fencing of funding and programming. Whilst these debates often conflate the 'exceptional' nature (or relative seriousness) of HIV and a disease-focused or 'vertical' logic in developing and resourcing responses to health problems, the former is often said to justify the latter. Hence, GHIs are sometimes criticised for a 'disease-focused' approach at the expense of health systems (England 2007) and many such critiques bring into question the whole architecture, often on the basis of 'principle' rather than on evidence of how best to improve health.

Whilst certain international funding programmes for AIDS are criticised in the literature for a 'vertical' or 'disease-focused' approach potentially weakening national health systems, counter-arguments claim that many health systems were already struggling and that programmes have instead strengthened these, particularly in certain related areas of health care. The point is sometimes made that certain programmes would not have been possible without these new structures and flows of aid – most prominently the international roll-out of Anti-Retroviral (ARV) treatment. An exceptionalist argument does not necessarily go against systems strengthening, but can support the call for multi-sectorality in health. Piot and colleagues, for example, combine the point about exceptional health crises needing strategic society-wide approaches (far beyond the health sector) with a call for strengthening and holding public (health and other) systems to account against clearly defined objectives, such as HIV prevention:

> … the much-needed strengthening of health services in developing countries might only be marginally beneficial for HIV prevention… the debate in some public-health and political circles that polarises so-called vertical HIV/AIDS programmes versus horizontal strengthening of health services is the wrong agenda... The needs of individuals or communities do not come packaged into sectoral boxes, and an activist HIV/AIDS movement, focused on meeting real needs effectively, will not only be the strongest weapon against the inefficiencies of 20th century verticality, but also a corrective to system strengthening without clearly defined objectives.
> (Piot *et al.* 2008: 854)

Essentially, these debates often treat 'vertical funding' as a single concept and can tend to set up a 'straw man' to knock down, whilst global or international funding actually covers a great diversity of architectures for resourcing national and local AIDS responses and many go well beyond a health sector focus. What is also worth noting is that different structures to some extent reflect distinct ideological approaches and assumptions. This may be characterised in very broad terms as follows:

- The Global Fund supports a 'country response'. It requires government to involve other sectors in planning and coordination through its specified Country Coordinating Mechanism (CCM). Resources are channelled through Principal Recipients (PRs) and sub-PRs. The PRs vary by country but typically include a government department or a National AIDS Commission and sometimes separate civil society PR/s (supporting projects by non-governmental organisations).
- The World Bank typically supports the national government to lead and requires it to borrow resources as well as to fund civil society in service delivery and community responses.
- PEPFAR engages an array of private sector actors (many US-based) as partners and sub-partners down to community level, effectively bypassing in-country government channels with a US-led plan. However, they do consult with governments and provide some public sector institutions with inputs and support.
- Other prominent bilateral donors (such as the UK, Sweden or Canada) tend to support government leadership and health sector strengthening through a sector-wide approach (SWAp). In addition, they often support civil society separately to 'hold government to account'.

2.3 Questions about national sovereignty

The literature points to the influence of donors being felt in a number of ways: as direct conditions imposed on the receiving state (as well as other local actors); as setting constraints around which programmes and organisations can effectively access funds; as leading to competition over resources between the state and civil society (as well as within civil society). Key debates centre on questions like, 'Does the power of "aid" undermine governments' abilities to lead?', 'Who drives the principles and goals behind such massive funds?' and 'Who holds the global donors to account?' Yet, it is also clear that the situations in different countries are complex and that different architectures have different influence. Reflection on the literature and debate also raises the question that the principle of '3 ones' (a coherent AIDS response guided by one national authority, one strategic plan, and a single monitoring and assessment framework) assumes a particular kind of government (as democratic, bureaucratically efficient and transparent), which is often called into question in practice.

A central question in debates on sovereignty and HIV funding revolves around 'political will', 'national ownership' and 'government leadership' (see, for example De Waal 2006). For example, governments are sometimes accused of substituting

donor AIDS funding for their own investment in HIV and even in health more broadly. In a recent analysis of government expenditures on domestically and externally financed public health costs in developing countries, researchers found that shares of government expenditures to health decreased in many sub-Saharan African countries over 1995 to 2006 (Lu *et al.* 2010). Their findings suggest that development assistance for health to governments had a negative and significant effect and for every US$1 of such assistance, government health expenditures from domestic resources were reduced – in some places almost 'dollar for dollar'. Surprisingly, whilst other factors (such as debt relief) had no detectable effect on domestic government health spending, assistance to the *non-governmental sector* actually had a positive and significant effect on domestic government health spending.

The concept of 'political will' may be naïve and misleading, while pointing instead to the power of 'political incentives' may be more pertinent, since the control of significant amounts of additional resources for AIDS can be seen to have strengthened the hand of some governments (De Waal 2006). These resources create incentives and opportunities for politicians to consolidate the support of strategic power-bases through chains of patronage and access. The international funding of AIDS programmes through governments as well as through civil society, in parallel, can set up tensions as well as complex inter-dependencies, which defy simple notions of nation-state sovereignty:

> As political power becomes distributed in a permeable transnational system of national and foreign governments, multilateral organisations and international NGOs, it makes sense for African citizens to find mechanisms for accessing those networks to secure protection, funds and influence… But this involves a consensual charade… The more consistent outcome is that donors obtain the cooperation of local actors in their intrusion into Africa…
> (*ibid*.: 59)

2.4 Aid effectiveness

Debates on aid effectiveness and harmonisation attempt to grapple with perceived constraints and benefits of this diversity in funding architectures, in terms of effectively and accountably resourcing local AIDS responses. Debates have questioned whether the multiplicity of donor effort actually results in effective, complementary responses. Some argue that the influx of money for HIV and AIDS into the country sets up divisions within and across government agencies and sectors. Such divisions are said to be deepened further through corruption, as funds 'leak' out of official channels (Tayler 2006), or where some are seen to benefit financially from engagement in HIV work. One argument is that the dominant form of political accountability in Africa is not universalistic bureaucratic rule, but is more based on patron-client ties. Swidler (2009) further suggests that one can consider whether international engagement in African contexts increases the accountability of traditional modes of power on the one hand, or makes these less responsive and inclusive.

In addition, some point to the complexity of funding systems combined with capacity constraints as creating 'bottlenecks' which prevent funds moving

smoothly, compromising aid effectiveness (Foster 2005; Birdsall and Kelly 2007). Aside from corruption, other issues arise around the routes and speed of the transfer of funds, from donor, to in-country partners (government or other PR or recipient), to intermediary or implementing partners, to community beneficiaries of programmes. Foster (2005) identifies the 'bottlenecks and drip-feeds' which prevent sufficient funds moving smoothly or predictably through these chains. These include a lack of awareness and capacity to apply for and account for funding, a lack of capacity to absorb funding, or conversely a short-term donor approach which gives short repeated rounds of funding but no long-term security. The problem of limited 'flow-through' in the case of public sector channels is a pervasive issue noted in the literature.

Whilst it has been noted that larger NGOs have tended to absorb the lion's share of AIDS funding for civil society, the relative increase in spending on AIDS by smaller CBOs has been faster than for larger NGOs between 2001 and 2005 (Birdsall and Kelly 2007). The authors link these relative increases in part to increasing use of, and disbursements by, sub-granting agencies. Such intermediaries can include either public or private institutions acting as funding channels for various donors and governments. Yet, private and/or parallel channels are often critiqued for duplication, high transaction costs and for undermining national government efforts and oversight. A key response of the international community has been to develop a broad consensus in the Paris Declaration on the need for harmonisation of efforts to improve aid effectiveness through agreed mutual commitments between donors and national governments (OECD/DAC 2005). Whilst rhetoric commonly reflects these principles and commitments, the question as to whether they are translating into more effective and harmonised responses remains underexplored, and particularly the impact on local community level responses.

2.5 Civil society access and autonomy

Recent research (Birdsall and Kelly 2007) into funding patterns for civil society organisations in six countries of southern Africa (including Tanzania) found evidence that there has been a major increase in civil society organisations involved in HIV and AIDS, particularly since 1999. It was also found that between 2001 and 2005, their average annual expenditures on AIDS-related activities roughly tripled and that the number of sources of their funding increased (*ibid*.). For local groups there can be many knock-on effects from an influx of funding and Grebe (2009) notes that a resulting bureaucratisation of CBOs can separate them from the community they set out to serve, and bring them more in line with meeting donor priorities than local conceptions of what programmes may be necessary. Earlier research by Foster (2005) found that for CBOs to grow and develop effectively in the wake of international AIDS funding requires their striking a difficult balance between keeping a rootedness within the community and gaining the capacity and skills to expand and receive more funding. A common observation is that many donors are keen to support 'grassroots' organisations, seen as legitimately representative of a community, in order to confer both legitimacy and signify ideals such as participation and ownership. Some caricature donor interest in – and support of – CBO activities as mere window dressing, to

enhance their credibility without recognising or engaging with the valuable experiences and competencies within community organisations (Rau 2006). From different perspectives, community organisations are seen as co-opted by donors; as playing a go-between role between donors and communities; or as working at the forefront of HIV programming. Seckinelgin (2005) argues that most NGOs tend to lack the agency to withstand the ideological and programmatic aims of international donors and points to the difference between claimed and actual agency to carry out work in the field of HIV.

On the side of the international donors, Birdsall and Kelly (2007) note tensions embedded within many donor strategies for support for civil society, such as: a commitment to channel greater support through government budgets, against a reluctance to end direct project funding (which they see as partly linked to a need to point to successes or 'branding' particular interventions as their own); a common belief in the advocacy role of civil society in holding governments to account, against the commitment to channel aid through government and; a view that civil society has a unique role in giving voice to popular needs, but yet promoting strategies of government support and basket funding that posit CSOs primarily as service providers. The Global Fund structures, in particular, privilege and encourage civil society involvement explicitly in this way, although many have argued that such involvement has been difficult to achieve in practice (Birdsall and Kelly 2007).

Grebe (2009) identifies three major 'risks' in the way of donor facilitated civil society engagement in effective HIV coalitions: (a) Donors may dominate the AIDS response agenda, inhibiting the ability of domestic actors to build locally appropriate institutions and coalitions; (b) financial assistance may be used to advance a particular ideological agenda driven by the domestic politics of the donor country, and; (c) donors may be overly concerned with maintaining their partnership with the state, and consequently fail to support and perhaps even unintentionally undermine, the development of an independent and critical civil society sector.

In summary, debates in this have focused on questions such as; 'To what extent is the space for civil society growth shaped by in-country donor funds?', 'How independent are civil society groups from government and can they "hold government to account" if they become service providers?', or 'Is diversity of funding for civil society (e.g. through government or multiple channels) better or worse for a national response?'. Some points to note which have influenced the research questions in this study include, firstly, the fact that civil society organisations are overwhelmingly framed as representative of 'communities' and key to effective responses, arguably an over-generalisation. Secondly, the notion of a distinct sector appears to be an over-simplification. Lastly, international NGOs are not necessarily independent themselves, as many depend on bilateral funding and have close links with the governments in their countries of origin (e.g. Oxfam-DFID in the UK, or Pact-PEPFAR in the US).

3 Conceptual framework and study design

The field research on which this report is based complements other research concerned with 'tracking' the flow of funding, by uncovering how social and political dynamics associated with *multiple* international health initiatives interact and are *experienced* at the local level. We investigate the effects of funding directives and modes of delivery on the experiences, perceptions and responses of local actors. The study also analyses perceived impacts of global financing for AIDS on sovereignty, coordination, local governance and accountability.

3.1 Objectives and scope

The study set out to explore the overall impact of multiple major global and bilateral international structures for funding in HIV and AIDS on local and district level responses in selected communities. To address this we were guided by the following objectives:

i. To determine the influence of funding directives on local agendas, for example the framing of AIDS responses and the perception of their appropriateness;

ii. To explore the effect of funding on local politics and power bases;

iii. To determine the combined effects of funding structures on the coordination of efforts and the mechanisms of accountability.

In order to achieve the objectives, the team designed a qualitative study of local perspectives and responses to the new financial architecture, to supplement existing literature and provide a 'richer' picture and to identify potentials for improving international HIV support. The study is therefore intended to provide useful information for international HIV initiatives, African civil society networks, African governments, bi- and multilateral development organisations and funding programmes.

At the conceptualisation stage, three countries of sub-Saharan Africa were chosen according to the following criteria: (a) Countries with significant investments from a number of different vertical and bilateral international funding programmes for HIV and AIDS (in particular World Bank MAP, Global Fund and PEPFAR) and (b) countries where IDS has good local research contacts.

3.2 Conceptual framework

Based on a review of the general literature on global health financing and governance, four sets of critical debates were identified in the areas of: (i) critiques of 'vertical funding', (ii) questions about national sovereignty, (iii) aid effectiveness and (iv) civil society access and autonomy. In crude terms these can be characterised as focusing on 'vertical' or 'horizontal' axes or issues, as described in Figure 3.1, below.

Levels: Whilst pertinent issues come up relating to global, national, intermediary and local levels (in a sense along the vertical axis), there are both 'functional'

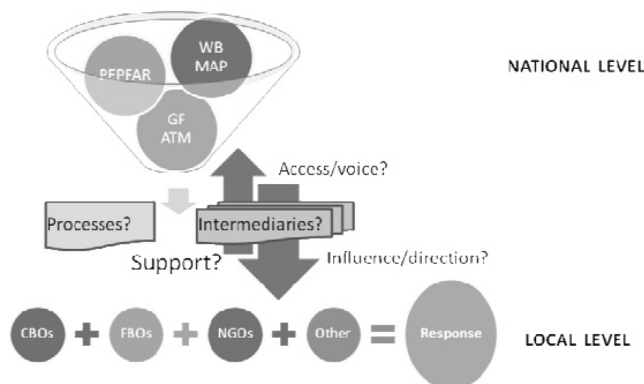
Figure 3.1 **Vertical and horizontal issues for analysis in the study**

Source: Authors' own.

levels (such as intermediary NGOs or programmes) and levels of geo-spatial aggregation (including regional and provincial). Interview questions touched on issues at many levels in these respects, but the study design focused interviews at two geo-spatial levels – 'national level' key informants (KIs) and 'community/ local level stakeholders' (SHs), as illustrated schematically in Figure 3.2.

Triangulation: It is clear that judgement on these issues is influenced by respondents' positions within resourcing structures and that many actors and stakeholders are involved at many levels. Hence, a fundamental premise of the design became one of triangulating perspectives on the questions across sectors *and* types of stakeholders, and doing this at two geo-spatial levels. At national level KIs were interviewed on the same questions from government, international agencies and national level civil society organisations (with minor adaptations in questionnaires for relevance to the category of informant). At local level, stakeholders were interviewed from community and faith-based organisations, government offices and clinics, churches and local branches of NGOs, with similar structured questionnaires. In addition, project beneficiaries were consulted in focus group discussions.

Figure 3.2 **Conceptual schematic of questions for the study**



Source: Authors' own.

Table 3.1 **Triangulating perspectives on research themes in the study**

Triangulating perspectives at the analysis stage →	**Civil Society**	**Public sector**	**International donors**	**Beneficiaries view**
↓ **Themes for coding interview scripts for facilitating analysis**	*Networks, NGOs, CBOs, FBOs Intl. NGOs*	*Ministries Departments Clinics Officials*	*Multilaterals Bi-laterals*	*Youth, women, sex workers, etc.*
Vertical				
→ Global–National: influencing priorities, including views on structure				
→ Local–District: Access, influencing and politics				
→ Local–District–National: Blockages, leakages, transaction costs				
→ Intermediary structures: bypass or 'monopoly resistance'				
Horizontal				
→ Donor–donor-government coordination/complements/ conflict?				
→ Govt–civil society networks coordination/dissonance				
→ Local level coordination				

Source: Authors' own.

Following the resource flows: Since the interactions between different funding programmes and actors operate in complex ways up and down the resource chains or 'stove pipes', a third important aspect to the design was one of following the resource flows, or 'veins', from national to local levels. Focusing primarily on the 'big three' (PEPFAR, the Global Fund and the World Bank) as well as some significant bilateral donors, the team mapped significant pathways of resource flows using reports and the internet during a tools design and fieldwork planning workshop. Figure 3.3 below, provides visual snap-shots of a rapid mapping of the main recent funding flows of the three largest global donors in Kenya. This (and more detailed) information was then used to select sites as well as informants to connect together donors, intermediaries and recipients.

3.3 Methodology

The study employed a qualitative methodology, using interview-based primary data collection, with purposive identification of informants. The design and methodology was fundamentally uniform across countries, with flexibility for adaptation according to respective national funding architectures and contexts.

As indicated above, the study explored the context and issues in funding in AIDS at the global or international level through a general desk review of available

Figure 3.3 **Rapid mapping of AIDS funding flows from the 'big three' in Kenya**

Source: Author's own.

literature, which informed the development of specific research and interview questions.

At *national level* ('in-country'), we carried out a desk review and rapid mapping of significant funding architectures at the first stage of fieldwork in each country. At this level, the study also utilised structured key informant interviews with national level actors from different sectors as described above. Interview guides were adapted for different types of stakeholders in each country.

At *community level*, the methodology involved identification of stakeholders to interview from different sectors and services, building on the rapid mapping at national level, to identify groups linked to particular donors further 'down' the funding structures. It also included a local mapping of actors and services, which complemented the former rapid mapping. The primary data-collection method at community level was structured stakeholder interviews (with a range of community-based civil society actors and public sector officials/workers). Facilitated semi-structured focus group discussions with project/programme beneficiaries in communities provided additional experiences and helped put into context the claims made by key individuals interviewed in the different community organisations.

Site selection: Six community level sites were selected across the three countries, and the three national capitals were treated as sites for national level key informants. The two community level sites per country were identified on the basis of a set of criteria agreed at a methods development workshop in Malawi with researchers from all three countries, as:

- Sites where funding from several big funding programmes reach community groups;
- One in or near the capital and one in a different district or province;
- Sites with a mix of NGOs, CBOs and FBOs.

Table 3.2 **Number of interviews by type and by country**

	Kenya	Malawi	Zambia	Total
National KIs (CSO, Donors, Govt)	18 *(10, 5, 3)*	18 *(10, 5, 3)*	17 *(6, 6, 5)*	**53**
Site level SHs (CBO/FBO, Govt)	16 *(11, 5)*	17 *(14, 3)*	23 *(20, 3)*	**56**
Local FGDs	4	9	8	**21**
Totals	38	44	48	130

The sites chosen were: Lilongwe/Likuni and Nkhotakota in Malawi; East Nairobi/ Kayole and Nakuru in Kenya and; Lusaka/ M'tendere and Kabwe in Zambia.

Informant selection: Respondents were selected through purposive identification, following the rapid mapping and contacts made in sites, in order to generate a balance across sectors and levels and sites, as well as to be able to trace linkages of funding flows between levels. The definition of types of respondents can be characterised by level, as below:

- National level key informant (KI)
  - Government
  - International development partners/donors
  - Civil society organisations and networks
- Local level stakeholders (SH)
  - District health and AIDS coordination staff
  - Community and faith-based organisations and NGOs (typically the head)
- Project beneficiary groups – selected for focus group discussions (FGDs)

Three types of questionnaires

- Key Informant questionnaires, in three versions each tailored to a specific sector (government, civil society and donor)
- Local level Stakeholder questionnaires
- Focus Group Discussion facilitation guides

The research methodology, selection criteria and questionnaire outlines were first developed jointly by all country partners at a planning workshop in Malawi in order to ensure comparability of the approach and analysis across the countries. Questionnaires were subsequently adapted slightly for Kenya and Zambia in national planning workshops, in light of specific features and priority issues in these national contexts.

Data management and analysis: Country teams took down detailed hand-written notes during the interviews. Data entry comprised of typing up notes from the FGDs and Individual In-depth Interview (IDIs), including verbatim quotes. FGD question guides were translated into the local language and in Malawi local stakeholder question guides, likewise. Otherwise, all KI interviews and SH interviews were in English and typed up from hand-written notes.

Interviews were not tape-recorded for a number of reasons, including: engendering a positive interview dynamic to prevent potential concerns about confidentiality; encouraging engagement with the substance of the information on the part of

interviewers who were asked to type up notes following interviews and; savings in time and cost by avoiding additional steps and media for data processing.

The analysis of the interview and focus group discussion data was conducted via a two-tiered process. Initially, first-level coding was conducted by reading the field notes, and coding text as per the broad identified themes listed in Table 3.2, above. Subsequently, sub-themes were identified to inform country-specific analyses. In the planning of the fieldwork and subsequent analysis, specific protocols for handling, checking and tracking transcripts were developed in order to ensure quality and comparability between countries.

Consultation and identification of implications for policy: Following analysis, preliminary findings were presented in stakeholder consultation workshops in Kenya, Malawi and Zambia, as well as at a regional meeting in Pretoria, South Africa. The emphasis of these meetings was to validate findings in a shared public setting involving stakeholders from all sectors and levels (with the exception of Pretoria which was confined to policymakers, regional actors and peer researchers), as well as to jointly explore the potential implications for policy development and future research.

Ethical considerations: Prior to the start of the research, the project was reviewed and checked for ethical considerations through IDS' Project Review Group (PRG) and each country research team obtained ethical clearance from a relevant National Ethics Review Committee.

Prior to each interview, the researchers obtained consent from the study participant. To obtain consent interviewers described the research in full to the respondents, assured them of confidentiality, if they elected to take part but remain anonymous. Consequently, most quotes reproduced in this report are anonymised. It was explained to all the respondents that they had the right to refrain from answering any question posed by the interviewer. Respondents were also made to understand that they were at liberty to refuse to participate in the study, or end the interview at any point, with the understanding that there would be no sanctions for such refusals. Respondents were required to read the informed consent form and sign it if they were willing to participate in the study.

Whilst light refreshments were provided in focus group discussions, no payment or remuneration was provided to any interviewees and the independent nature of the research was made clear as part of the informed consent explanation and form.

3.4 Study limitations

As with many qualitatively rich and detailed field studies, the small number of field sites per country and respondents per site, along with potential bias in the purposive sampling method employed, place limitations on the degree to which results may be generalised within and across the three countries. Furthermore, certain types of stakeholders proved to be much harder to access and secure interviews with, than others; government actors in particular were hard to access. Comparison and resonance with findings from other research (see for example, Foster 2005; Birdsall and Kelly 2007) can mitigate these limitations to a certain degree.

This study, which was reflecting different stakeholders' subjective perceptions, did not set out to track and quantify resource flows or verify allegations of blockages, inefficiencies or corruption specifically. The triangulation of perspectives mitigates this subjectivity to a certain extent and the results may benefit from being considered in conjunction with more quantitative research on funding for HIV.

The study did not attempt to access more general views of community members in the respective sites regarding funding for HIV and AIDS. The interviews with local stakeholders focused primarily on key individuals involved in local organisations. The focus group discussions drew participants from the beneficiaries of such organisations and opinions quoted from these groups do not thus specifically reflect a more general 'community voice'.

A certain amount of bias, or over-representation, might be expected from certain respondents, in light of their own relative position and access (or lack of access) to resources and influence, as well as by a potential impression that researchers might leverage resources to their organisations. Explanations in connection with informed consent aimed to clarify the independent nature of the research. As with any field study, the positionality of field researchers and analysts may privilege certain perspectives or insights. To mitigate this potential bias, interview teams were set up to pair researchers to observe, cross-check and discuss impressions and scripts after interviews, which was intended to reduce bias and ensure greater objectivity.

4 Overview of the HIV and AIDS funding architecture in the study countries

In order to contextualise findings from different countries and facilitate the interpretation of findings across the settings, it is useful to first briefly review the broad outlines of AIDS funding architectures in Malawi, Kenya and Zambia, before delving into the substantive field research findings across the countries. Readers with a good knowledge of the financing arrangements in these three countries may want to skip to Chapter 5.

4.1 Overview of the HIV and AIDS funding architecture in Kenya

UNAIDS data on Kenya show that gains have been made as prevalence has dropped; however, the prevalence remains high; dropping from 10 per cent in 1996/97 to 5.1 per cent in 2006 (National AIDS Control Council 2008). Some 98 per cent of available HIV funding is accounted for by international donors and is 'off-budget', with absorptive capacity, coordination, national ownership and sustainability being significant challenges (UNAIDS 2008). The post-December 2007 election resulted in a power-sharing government and a split of the Ministry of Health, creating a separate Ministry of Public Health and Sanitation. The latter now houses the National AIDS/STD Control Programme (NASCOP), whereas the

National AIDS Control Council (NACC) is located in the Ministry of Health and the two health ministers are from separate political parties.

PEPFAR is the largest funder of HIV programmes in Kenya; providing millions of dollars in AIDS programmes since 2004, in 2008 putting in $534.8 million (PEPFAR 2010a). Funding is distributed to a number of partners, and through them sub-partners focusing on different areas from treatment and care to prevention and education programmes. These partners include a variety of international and local NGOs, FBOs and community groups.

Kenya received funding for HIV programmes through Rounds 1, 2 and 7 through the Global Fund. Four Principle Recipients are listed: Two local NGOs (Sanaa Art Promotions and Kenya Network of Women with AIDS, or KENWA, in Round 1), the Ministry of Finance (Round 2) and CARE International (Round 7). Through the latter, two funds are dispersed to Sub-Recipients. The Kenya AIDS NGO's Consortium (KANCO) was a significant sub-recipient in Round 2, which provided onward grant-making and training to local NGOs, CBOs and FBOs. A total of $201,417,822 was granted up to Round 7 – signed 2007, but as yet not fully dispersed (GFATM 2010a).

The World Bank's Multi-country AIDS Programme (MAP) supports the national government's 'Total War Against AIDS' (TOWA) programme to expand targeted HIV and AIDS prevention and mitigation activities through: 'sustaining the improved institutional performance of the National AIDS Control Council (NACC)' and 'through supporting the implementation of the Kenya National HIV/AIDS Strategic Plan (KNASP)'. The project has two components; one to strengthen governance and coordination capacity and the other to build capacity of beneficiaries in using grant funds (World Bank Group 2010a).

Further funds are channelled through bilateral agreements, the UN and various smaller NGO programmes. Kenya's health system reforms through the 1990s have looked to decentralise health provision to the district level, in a situation where resources are insufficient and government budgets exceeded available funds. These reforms also promoted a public-private model of service provision, with NGOs and the private sector taking over services which government could not provide (Oyaya and Rifkin 2003).

Jensen focuses on the 'macroeconomic policies and targets laid out in Kenya's recent IMF programme, the Poverty Reduction and Growth Facility (PRGF), [which] were overly restrictive, limiting the government's options for fighting health crises like HIV/AIDS and tuberculosis, address the massive health worker shortage faced by the country, and have the flexibility to respond to the current economic crisis' (2009: 1). Thus although massive funds have been made available through international funding these constrictions inhibit government spending, and impact significantly on issues such as staffing of the health sector.

Issues around delays in disbursement of funding are also highlighted as a barrier to providing HIV services in Kenya. In 2006 FBOs involved in the treatment programme criticised the government's record on payments, and also the risk to further funding in failing to provide accounts to the GF (Wakabi 2007).

For people living with HIV in Kenya social support and services from various organisations is recognised to be vital, but often lacking. As in other countries

incomplete knowledge about HIV, as well as poverty and the 'double-stigma' experienced by marginalised groups also affected by HIV contribute to the spirals of poverty and vulnerability to HIV (re)infection (Amuyunzu-Nyamongo *et al.* 2007; Nyambedha *et al.* 2003; Donahue *et al.* 1999; Chiao *et al.* 2009; Nyambedha *et al.* 2001; Skovdal *et al.* 2009).

4.2 Overview of the HIV and AIDS funding architecture in Malawi

Malawi has an HIV prevalence rate of approximately 11.9 per cent (OPC 2007) and HIV programmes supported by a variety of international donors, including the World Bank, Global Fund, PEPFAR, other multilateral and bilateral agencies. Multilateral organisations include the GFATM, the African Development Bank, the World Bank and other United Nations system agencies including the Food and Agriculture Organization (FAO), The Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), the United Nations World Food Programme (WFP) and the World Health Organization (WHO). Bilateral partners are the Canadian International Development Agency (CIDA), the German Society for Technical Cooperation (GTZ), The Japan International Cooperation Agency (JICA), the UK Department for International Development (DFID), Norway and the United States programme, PEPFAR. In total, about US$724 million had been committed by the Malawi government and donors to finance the National HIV and AIDS Action Framework up to 2009. The Framework is seen as strongly led by the National AIDS Commission (NAC), which holds an elevated position reporting to the Office of the President and Cabinet (OPC), outside and above the structure of line ministries.

The Global Fund is the major HIV and AIDS funding agency in Malawi. On HIV and AIDS the Global Fund has approved funding amounting about $375 million through the National AIDS commission in Global Fund Round 1, 5 and 7. The Round 5 grant focus was on orphan care and support. Out of the total amount granted, about $232 million has been disbursed. The Global Fund also approved a Round 5 grant for Health systems strengthening to the tune of $52 million; a total of $21 million has already been disbursed (GFATM 2010b). In earlier years GF money was distributed from government to civil society through international NGO intermediaries, but this arrangement has now been phased out in favour of channelling the resources through government structures to local levels.

The United States government funds Malawi under PEPFAR, which in Malawi collaborates with government and other partners, although funding does not pass through the government programme. PEPFAR support to Malawi is primarily through USAID and CDC. From 2004–07 PEPFAR has provided grants in excess of $65 million, with a further $23.9 million for 2008, and $25.2 million for 2009 (PEPFAR 2010b). In line with this transfer of support PEPFAR has set up a Partnership Framework, as a means of promoting national ownership of sustainable HIV programmes. In 2008, USAID received $17 million for essential HIV and AIDS programmes and services in Malawi. CDC operates the Global AIDS Program (GAP) with an emphasis on establishing long-term working relationships with the Malawi government, notably the National AIDS Commission (NAC) and the Ministry of Health (MOH). The United States government had in

May 2009 doubled its financial support to $45 million per year to fight against HIV and AIDS in Malawi and signed its first Partnership Framework with the Malawi government. The new agreement focuses on reducing new infections while continuing to improve the quality of treatment and care, while fostering close alignment of the Partnership Agreement with the National AIDS Framework.

The World Bank approved $35 million in funding through its Multi-country AIDS Programme for a Multi-Sectoral AIDS Project in Malawi (MAP) from 2004 to 2008, which includes funding for schemes to increase HIV and AIDS related activities in the education sector. Recently, a three year extension of the MAP has been signed for 2009–12 and additional support will continue to support the national response in line with the National AIDS Framework (NAF). The World Bank has dedicated $30 million for the period (World Bank Group 2010b).

DFID provided £4.5 million between 2003 and 2008 to Malawi NAC for the HIV and AIDS response. Over a period of six years (2005/06 to 2010/11) a total of £100 million has been committed to the health sector. Out of this, 45 per cent is to support the Essential Health package. In addition, DFID also supports the HIV programmes in the education sector. From 2005 to 2008, DFID committed a total of £600,000.

Other bilaterals also support a government led approach, such as the GTZ, which supports a joint programme by the Malawian government, donor countries and partner organisations – the sector wide approach, SWAp – by advising the Ministry of Health, improving the medical provision and facilitating human resource development. The assistance is intended to support the availability of health services and ensure satisfactory primary medical care for the population. Finally, the United Nations agencies provide substantial funding amounts to the HIV response in different ways.

In general, much of these funds have been channelled through government, to local and international NGO partners, with the main exception of large portions of PEPFAR's funding. Schou addresses the issue of CBOs in Malawi within this structure: 'One of the major findings… is that the project-rich areas were already blessed with many supporting NGOs/CBOs and pro-active community leaders, while in the project-poor areas there were few signs of this kind of backing. A further finding is that most of the funded CBOs, for various reasons, were unable to facilitate collective action' (2009: 162). Here the issue of possible cooption of communities and funds by elites skews funding towards areas with capability for applying for and channelling donor funds, rather than communities or programmes accessing funding due to a greater need. Schou's study also highlights the need to scrutinise CBO claims to community representativeness or ownership, as well as the potential effects of large funding streams on CBO formation.

In Malawi the extent of the HIV epidemic focuses attention on the coping strategies for families and communities affected by HIV and AIDS. Within this context the role of NGOs and FBOs in HIV work as well as social support has increased, as have mutual assistance associations and CBOs, either as a direct response to HIV or to shifts in cultural norms influenced by the epidemic (Munthali 2002). In recent years funding to such local groups increased particularly through the use of international intermediary NGOs providing a sub-granting function

under various programmes of the national response, but – significantly – this arrangement has ended with funding now being centralised through government channelled through local branches of the public administration. This shift of strategy was seen as risky in terms of local groups' access to resources several years ago (Birdsall and Kelly 2007) and this study explores this question further.

4.3 Overview of the HIV and AIDS funding architecture in Zambia

Since 2003, funding for HIV/AIDS from the government and donors has increased dramatically in Zambia. The HIV response in Zambia is mainly financed from external sources, which account for more than 80 per cent of HIV/AIDS expenditure in the country. For example, in the 2006 fiscal year (January to December), Zambia reported an expenditure of US$203,825 million, 85 per cent of which came from external sources (Ndubani *et al.* 2009). The three main Global Health Initiatives (PEPFAR, GFATM, World Bank MAP) have been the main source of funding, accounting for 76 per cent of HIV funding between 2003 and 2006. Whilst the NAC reports under the Ministry of Health, donors fund both this ministry and other channels for the AIDS response, as described below.

PEPFAR is the largest funder of the HIV/AIDS response and most of its funding is channelled through United States (US) based international NGOs (Oomman *et al.* 2007). Some local NGOs and CBOs also receive PEPFAR funds through the 'prime partners'. PEPFAR has been funding HIV/AIDS interventions significantly since 2004, providing $82 million, $126 million, $147 million and $216 million in 2004, 2005, 2006 and 2007 respectively (Oomman *et al.* 2007; Ndubani *et al.* 2009). In Zambia, PEPFAR brings together five US Government agencies to endorse a single strategy and implement one programme. These are the Centre for Disease Control (CDC), the United States Agency for International Development (USAID), the Department of Defense (DOD), the Department of State (DOS) and the Peace Corps (PC). In 2006, for example, PEPFAR supported more than 148 partners including 95 local organisations. It has been working directly with civil society, the private sector, as well as various other ministries and organisations. Under its Ambassador's Small Grants Fund, PEPFAR provides funds for smaller organisations working within Zambia at community level.

The Global Fund to fight AIDS, Tuberculosis and Malaria has been providing HIV/AIDS funding to Zambia since 2003 (Oomman *et al.* 2008). Its funding is disbursed through four Principal Recipients (PRs). These are the Zambia National AIDS Network (ZNAN) for civil society organisations, Churches Health Association of Zambia (CHAZ) for faith-based organisations, the Ministry of Health (MOH)/NAC for national health services and the Ministry of Finance and National Planning (MFNP) for line ministries. Zambia qualified for Round 1 ($90 million in 2003), Round 4 ($236 million in 2005) and Round 8 ($144 million to be signed) (Donoghue *et al.* 2005). Round 8 of the global fund will be disbursed through the UNDP.

In 2003, Zambia received a US$42 million grant from the World Bank MAP to implement HIV/AIDS prevention and care activities throughout the country. The WB MAP funds were channelled through the Zambia National Response to HIV/AIDS Project (ZANARA). The overall project was based on an approach for addressing HIV/AIDS by supporting and strengthening community-based

responses to the epidemic and had four components: (1) support for community response to HIV/AIDS (CRAIDS), through financing activities by community-based organisations (2) support to the National AIDS Council and secretariat, (3) support to the line ministries, in order to mainstream HIV/AIDS related activities into their work programmes, and finance the Ministry of Health for support implementation activities, and (4) programme administration.

HIV/AIDS service providers have over the last decade received support, both technical and financial, from various sources to support the HIV/AIDS response since early 2000. Literature (Oomman *et al.* 2008) shows that since 2003, HIV/AIDS funding in Zambia has increased more than ten-fold. However, lack of strong coordination has resulted in different structures and models of funding HIV/AIDS interventions. For example, international NGOs and agents both implement directly and fund local NGOs and CBOs, whilst the Global Fund supports both government and NGOs through a national process. However, the Global Fund processes in Zambia have been described as problematic, with weak communication and confusion as to roles and processes of the CCM in planning and implementing funding bids. On the whole the pressure of reporting not just to GF structures and timelines, but also to the competing interests of PEPFAR and WB exacerbated problems with capacity and human resources throughout the health system, from central bodies to district level (Brugha *et al.* 2005). Further issues have been highlighted around the coordination of donors and debt relief, even where this was specifically targeted at providing funding for HIV work (Cheru 2002).

4.4 Similarities and differences between the three countries

The three countries in this study were selected as highly relevant and comparable countries, with key similarities, whilst they also have a number of significant differences. In terms of similarities all three are medium-sized low-income countries. They are all situated in Anglophone east and southern Africa and they have: similar systems of government; cultural similarities; significant levels of poverty; similarly serious HIV epidemics; and other similarities in health burdens and health service access. In addition, all three countries have had significant investments over time by the ‘big three’ global AIDS funding initiatives (World Bank MAP, PEPFAR and GFATM), as well as fairly similar presence of other bilateral and UN aid agencies. Finally, these countries have experienced some challenges with absorptive capacity and accountability for funds.

There are also a number of significant differences. All three countries have, or have had, civil society intermediary organisations for disbursing pooled (or ‘national’) resources, but Malawi has discontinued NGO intermediaries and centralised disbursement through NAC for the Global Fund or other pooled funds under the National AIDS Framework. Kenya and Zambia also use national and local public sector disbursement systems for some pooled funds, including World Bank funds, but have relatively more ‘plural’ funding systems in place for other sectors.

In the case of the Global Fund, technically we should distinguish between ‘split principal recipients’ (PRs) and ‘intermediary sub-recipients’. However, in the popular understanding any civil society organisation operating as PR or

sub-recipient in order to disburse funds to others is considered a broker or ‘intermediary organisation’. Whilst GFATM principal recipients are divided (or ‘split’) between government and civil society in Kenya and Zambia, Malawi has one government principal recipient only and distributes resources through government structures, although previously the Malawi government contracted international NGOs as intermediary sub-recipients.

The role, status and position within government of the main governmental AIDS coordination institutions also differed in each country. In Kenya, the NACC and the NASCOP sit in two different Ministries of Health, following a split in the wake of a difficult election with a power-sharing government emerging. This is seen by some as posing challenges in providing a strong and united government leadership on AIDS.

In Zambia, the NAC reports in to the Ministry of Health, but has limited control of resources. Consequently, it is seen as relatively disempowered by many and its structural position would not seem to lend itself well to having a great influence on resource allocation decisions.

In Malawi, on the other hand, the NAC is attached to the Office of the President and Cabinet (OPC), outside and above the line ministries, which gives the Malawi NAC a more elevated position and, likely, more power to lead processes and policy across departments and sectors.

5 Findings

The findings from the study are presented below in seven substantive sections: the first four address essentially vertical dynamics of resource flows, influence and visibility between international donors and local communities; the last three sections address issues of horizontal coordination between donors, sectors and actors – at national and local levels.

5.1 The influence of global funders on priorities and structures for resourcing the national response

The first and overriding finding is that the vast majority of respondents interviewed expressed the view that major international funding programmes strongly influence national agendas and priorities. The following quote from a respondent in Zambia makes this point in stark terms:

> *We actually are still colonised. White people are the ones who know how long we will live and how far they can go in helping us. All the nurses and doctors are now working for NGOs because there is no money in the government. How can the government lead the fight when they can’t pay the health workers?* (local level support group, Zambia)

Ultimately there was a widespread sense that ‘debates are influenced by external forces – donors’, in the words of a respondent from an international FBO operating in Malawi, who went on to explain; ‘Much power is by donors. Priorities

are sometimes already dictated'. The common explanation for this perceived overwhelming influence wielded by international donors is put down to their provision of resources for the response, which may or may not fit well with official national priorities, as illustrated by the following quote: 'When donor priorities are not the priorities of the country, people just apply because it is being funded' (National Level Organisation, Kenya). Even government representatives, often spoke freely about the strong influence of donor resources on priorities and what gets funded, such as in this quote:

> *In essence, yes, you can say that donor resources influence our agenda. There are subtle ways in which they drive the agenda and typically us Zambians we do not want to talk about it... In most instances donors insist on their priorities. For example PEPFAR is in prevention and condoms are part of prevention and they insist that their money will not be used to distribute condoms in schools but it is our national priority to invest in condoms as a prevention strategy but the Americans say you can't use our money for that.*
> (NAC Zambia)

There were also some differences between the countries and some overall recent shifts in Malawi in particular. Here there was a sense that the government's role in driving the agenda has become markedly stronger in the last few years. Several CSOs were of the opinion that government is now leading the national setting of priorities with less donor influence, as one respondent explained that 'government has more power, though funding comes from other countries' donors' (NAPHAM, Malawi). This was also related by donors and by a key representative of the National AIDS Commission:

> *During the Structural Adjustments… we lost direction. We were just doing what the donors wanted. For example during the first years of the NAC money they gave us a person to manage the money. But with the coming in of this office we stopped this. We moved out donor influence and we are slowly moving forward to independence.*
> (Principal Secretary in the HIV/AIDS and Nutrition Office of the President and Cabinet, Malawi)

The impact of donors' own agendas on overall responses and synergies is seen as negative in terms of disjointed programmes and priorities, and the focus of efforts not being driven by local needs: 'At times these donors end up breaking the synergies instead of strengthening the ties … and one wonders if it is really coming from Malawi' (Oxfam, Malawi). A related effect on donors driving their own priorities was described by some more precisely as certain needs being left out, exemplified in the following quote:

> *The other thing that is lacking in donor priorities is the issue of multi-drug resistant TB; this is a disaster. At the moment in the entire country they are about 500 people suffering from this but no one is on treatment. There is also a notable increase in cervical cancer among HIV positive people but nothing is being done in these areas. These things are not in the call for proposals so we cannot even include them when we are developing our proposal.*
> (NNEPOTEC, Kenya)

Interviews showed that many stakeholders and informants felt that different donors influence agendas in different ways, although there are key similarities in how particular donors operate across countries. In all countries, the US government influence is highly visible and significant and often seen to undermine national government control of strategies, although PEPFAR is sometimes said to increasingly operate within national frameworks. A respondent from USAID in Malawi (funding under PEPFAR) said that 'USAID supports the National Framework and the Paris Declaration principles, and support Treatment, Care and Support, along with strengthened health systems'.

The Global Fund was sometimes perceived to be different since the Country Coordinating Mechanism is in place to ensure inputs from different sectors in the proposal development stage, as described in these terms: 'Most donors come with their own agenda… with Global Fund money there are some differences since the rounds are negotiated where a consensus is reached' (Oxfam, Malawi).

Despite governments officially leading the elaboration of national strategies, these national plans and strategies are often described as 'generic' and derivative of the basic programme categories of global agencies, such as (i) HIV Prevention, (ii) care and treatment and (iii) support and mitigation. In discussing the Kenya National HIV/AIDS Strategic Plan (KNASP), a respondent from Christian Health Association Kenya (CHAK) explained that 'the KNASP [document]… [may] be identical to others in other countries. The operating processes are driven by donors'. Many international donors are seen to simply invest in their own priorities within these general frameworks, as described by one civil society respondent: 'The donors could refuse the funds if they do not agree with an emphasis. This is done indirectly. So in this way they do shape agendas' (The Malawi Interfaith AIDS Association (MIAA) Malawi).

Government stakeholders generally argue for a need for greater government control of resources, but major international donors show concern over governments' capacities to administer large amounts efficiently or equitably. Some donors who are normally inclined to funding government programmes were also cautious because, in the words of one European bilateral donor representative in Kenya, 'African baskets have holes thus we don't give funds to institutions like NACC but can only support if NACC put proper policies in the running of its institution'. Donors respond to this through: (i) investing in government capacity or (ii) bypassing government structures (or sometimes both).

At this level of setting priorities and agendas, national civil society formations often feel their influence on overall priorities is negligible, as most see national agendas as being set internationally as funding drives what can be done. A respondent of a local CBO in Nakuru, Kenya, explained that 'as an organisation we have what we want to do, however at times we will do what the donor wants to keep the funds coming'. A representative from an International recipient organisation in Kenya similarly described the tendency to follow the money: 'It also depends on donors' rules and regulations. You can see where your proposal fits. You also have to spend money based on the proposal.'

5.2 Local level access to services and influence over agendas

In all three countries, respondents at all levels feel that, in general, access to health services for HIV and AIDS has improved over recent years. This is particularly noted as being the case for access to treatment. However the impression remains that access to basic health services at local level remains limited, as the following quote describes:

> *People may not know that services exist or may know but do not know how to get them. Sometimes drugs can only be found at the provincial hospitals... People at grassroots should be able to get ARVs at local level and not at the provincial level.*
> (Representative of national CSO, Kenya)

A commitment to processes of decentralisation in health care as a means to improve services is evident in all countries and mechanisms are underway to achieve this. However, respondents perceive the success of this endeavour to be hampered by constraints such as a low investment in essential infrastructure (e.g. transport, computers), lack of human resource capacity (e.g. people to dispense drugs) and the need to build essential skills (e.g. knowledge about ARVs). For example, in Malawi there are still concerns about services being equitably distributed on account of such problems:

> *... a lot has been done to scale up ART in terms of numbers... the missing pieces are where are those numbers? What are the challenges that people face to access treatment, how much time do they spend to access treatment? It is not known if they are getting quality treatment or not, then there is the issue of follow up especially for those who react to the first line regimen. In short I would say beyond the numbers I am not satisfied.*
> (Large international NGO, Malawi)

District level health staff tend to report a sense of being dictated to by higher levels of management and would like more autonomy in decision-making. As stated by a member of a District Health Management Team (DHMT) in Kenya:

> *For us basically when they come, they come with decisions which influence the policies made. Their aims are discussed at a higher level therefore the decisions will be based on their policies.*
> (DHMT, Nairobi)

Community organisations across the board feel that they have very little power to influence the agendas of the donors to whom they are looking to fund their activities, as typified by these quotes from Zambia and Malawi:

> *We decide and we plan. In planning we consult the community. The government and donors have their own conditions. We don't decide. CRAIDS [Community Response to AIDS] tell us. They show us the forms. We identify the gaps ourselves and then we write the project proposal. But then they come with their own conditions and guidelines.*
> (medium-sized FBO, Kabwe, Zambia)

> *We wanted to rear chickens but did not instead we were told to rear goats but the donor can just change our priorities. It dictates us on what we should do in the end we do not achieve what we want. This makes us to be where we were before the grant.*
> (FBO, Likuni, Malawi)

The degree of influence that a community group can leverage to negotiate with donors in terms of what activities they would like funding for, depends on the size of the group and their capacity to apply for funds – learn of opportunities, write proposals, demonstrate an ability to meet the financial accountability demands. Smaller funders are perceived to be more flexible and open to negotiation. Community groups do not feel that they have voice to speak to large donors – both in terms of having opportunities to speak, and in terms of having a sense that they are heard. The feeling is that agendas have been decided and they must fit in and find funding according to the respective donor priorities of the day, as expressed here about priority-setting:

> *This is influenced by donors and these don't reflect what the community would have preferred to be done. They should involve the locals in decisions making [sic].*
> (FGD of peer educators, Kayole, East Nairobi, Kenya)

Thus there are clearly difficulties noted to be consequent to these donor-driven agendas and targets: groups repeatedly expressed a difficulty in developing and indeed sustaining programmes that could meet their sense of the community needs.

5.3 The flow of support from global to local levels: blockages, leaks and delays

As found in other research (Foster 2005; Birdsall and Kelly 2007), our findings broadly confirm the view that the flow-through of support into meaningful services and resources at community level remains constrained, and this despite the fact that virtually all informants at all levels felt that affected people in communities are the first and most crucial agents in the response. The 'flows' often appear to be held up and blocked, whilst much is said to be wasted and 'leaked' to unaccountable brief-case groups, as reflected typically by these local level respondents:

> *I would not say it's going through the wrong people. It's the amount we are given that's not enough… what is released is not what we get. It's not 100% maybe 60%... No active groups here received the money, briefcase groups get more money… [For the] TOWA fund you write a proposal, the money is released but you can never trace it. There are brokers in between.*
> (CBO, Nakuru, Kenya)

> *... the disbursement of funds is difficult because stoppages are cumbersome. Money should come straight to the community... Money is blocked somewhere and as it trickles down it becomes very little...*
> (CBO, Kabwe, Zambia)

> *… when they clumped funds together… which was run and controlled by the government, it failed to reach where it was supposed to reach.*
> (District AIDS official, Nakuru, Kenya)

Several big funders (most notably PEPFAR and the Global Fund with civil society PRs in some cases) bypass centralised government funding systems to avoid blockages, whilst others invest in strengthening government systems to disburse (for example, some bilaterals and the World Bank). The World Bank will typically fund through government, but also insist on funding to civil society and communities, often via specific programmes and intermediaries, like CRAIDS in Zambia or MASAF in Malawi. A key concern in these arrangements is one of leakages and potential corruption in general government structures, as related in this quote:

> *Government is the owner of the programmes but in reality they are not. Everything has been left to the donors. Government has no control and they* [the donors] *have stopped pumping in money because of so much corruption.*
> (CBO, Zambia)

Concern about poor financial controls and limited capacity to disburse or monitor funds also appears to favour certain stronger and well-known civil society groups over others. 'Boutique projects' (often based near main urban centres) are often seen to access a disproportionate amount of money and many also feel that entrepreneurial 'briefcase' organisations (often lacking community legitimacy) 'steal' resources. It is not uncommon to speak to members in organisations of people living with HIV, or sex worker beneficiaries of CBOs, who have a perception that their status is being used instrumentally by others to access funding which is siphoned off in the process of accessing donor funds:

> *What I think is that they use us people who are positive to get money and then very little goes down to the community. These organisations apply for funding claiming to support PLWHA but in the end we get nothing no matter how many proposals you write. These people use the money themselves instead of giving it to us.*
> (People Living with HIV (PLHA) Support Group, Zambia)

In Kenya, access to resources or services at community levels is seen as constrained by lack of capacity, ill adapted systems and political interference. In particular, political interference and nepotism are generally perceived as key problems, as described in the following quote:

> *What usually happens is that if I come from coast province I will direct all the funds to coast. Even organizations with only one certificate will get the money. That is why they were unable to account for the Global Fund funds because they just gave the money to these organizations and even to individuals... Organizations that received money in 1990 are still the same organizations that are being funded. There is no diversity.*
> (PLHA organisation, Nairobi, Kenya)

In Malawi, by contrast, there seemed to be more faith (particularly amongst donors) in the potential of government systems and some advocated the need to strengthen those for funding local responses through a 'pooled fund' under government control. However, most CBOs felt it was more complicated to get

funding locally from the pooled basket than from discrete funders, such as the intermediary umbrella organisations which had previously disbursed funding for the NAC. National stakeholders concurred that the decentralisation process had not worked well, in part because of low capacity in government structures, as reflected by a Norwegian FBO funding local groups:

> *CBOs are unable to access this money. The problem is the system used. The CBO writes a proposal to NAC, NAC responds and conditions have to be fulfilled. Formats, forms used are quite complex.*
> (International FBO, Malawi)

Some local stakeholders in Malawi also noted that the increased government monopoly in disbursing funds to civil society, now using the structures of the public administration, have also increased nepotism and political interference:

> *The first one* [INGO umbrella structure] *was better... But, the government – TA* [Traditional Authority] *Chiefs, District Assemblies, District Commissioners, NAC, etc. – all these want to be involved, but it was better when CARE did it. Government just go around and get their allowances. I have lost trust in them. We have not seen the fruits and we are all complaining. I wish they could reverse the situation, or – if not – if they could at least support us and give us training like before… since CARE pulled out – and CARE was neutral – people seem to think that there is political influence... the Chief thinks his own CBO – which he formed himself – should get funded. The District Commissioner is the direct boss of the Chief, so he would be favoured. It is confirmed that he is getting funding, but we have been told we are not. The Chief's CBO doesn't have any trainings or activities. It is too political.*
> (CBO, Likuni, Malawi)

In Zambia, which experienced a recent corruption scandal in the Ministry of Health, donors across the board see difficulties with the flow of resources. Flow is seen as constrained by lack of capacity in government structures, with weak financial management systems and resulting corruption especially highlighted. A lack of trust in government funding structures exists on the part of donors and community groups alike. This common view was reflected by a leader in a local community group: 'The worst is putting the money passing through the ministry. It will enrich the first person who is there, then the second person', (CBO, Kabwe, Zambia). Beyond corruption and weak financial systems, political interference was also mentioned:

> *... If not well handled, political party ward chairmen for both ruling and opposition parties can create confusion. They will always try to bring in Political Party politics in the running or distribution of resources to the client community... in some instances, the areas of operation fall in chiefdoms; as such the chiefs, especially where they don't understand your role or work, will always want to interfere in the activities of the Organizations.*
> (FBO, Kabwe, Zambia)

Yet, several bilateral donors in Zambia rely on the government structures to get their money to district and community level. District level government officials stressed the lack of capacity at district level as a real constraint in disbursement. National level key informants praised the recently discontinued World Bank CRAIDS programme as a good model for disbursement to CBOs at a large scale, connected

to and supporting the government system. National government respondents, however, focused more on blockages in getting money from the international donors (e.g. delays with Global Fund) and several government respondents argued for government having more control. The government recently passed a bill requiring all civil society organisations to register and to declare all incomes. The level of trust in the government is however extremely low amongst many local groups:

> *…We don't even see where the tax payer's money goes. In fact the government is even in the forefront of misusing donor money. When this money comes government ministers share amongst themselves and misuse it.* (CBO, Kabwe, Zambia)

PEPFAR has consistently bypassed governments in its funding strategies, but even other bilateral donors are also typically bound by their own requirements for accountability, which can force them to block funding to government (as was the case in the recent corruption scandal in Zambia) or to opt for alternative routes to funding civil society. They often recognised the weaknesses of many government systems, as the following quote from Kenya describes:

> *NACC cannot provide independent leadership even if you put the very best people… the existing culture* [is one of] *of self interest first, communal interest last.* [There are] *institutional problems* [and the] *political setup rewards bad deeds and punishes good deeds. Use of resources is not channelled to where people know will give the best results. Transaction cost is high.* (European bilateral donor, Kenya)

The Global Fund has over the last few years increasingly favoured separate Principal Recipients for civil society disbursement rather than giving governments monopolies as sole principal recipients. Kenya and Zambia have followed this split PR model, whilst Malawi has, in a sense, reinforced government monopoly by discontinuing the earlier civil society sub-PR umbrellas and putting funds through the government structure.

Across all three countries, major donors resort to various complex parallel systems to disburse their respective funds and, even where some use centralised systems more, there are others who fund through alternative structures – including PEPFAR and several smaller donors. On the positive side, many community groups survive on accessing of funds from a greater diversity of sources, including small lesser known funders even outside of these large donor programmes. For larger NGOs and CBOs with strategic skills, it can also allow for more choice in accessing funding appropriate to particular goals. On the negative side, short-term programmatic funding means unpredictable income flows and a lack of sustainability of responses. Community groups also complain frequently about burdensome and parallel reporting and accountability requirements, which bring a pressure to bureaucratise (with very little resources).

Although government controlled funding programmes are often cumbersome and unpredictable for local CBOs, not all discrete funders were seen as perfect either. For example, some CBO respondents cited the system used by USAID as too demanding, although more predictable and long-term, as a national level NGO respondent describes:

> *USAID does a lot of arm twisting but the beauty of it is that it's long-term. USAID funded programs are heavily supported in a big way. Our facilities supported by US have the very best compared to those supported by Global Fund.*
> (CHAK, Kenya)

Many local groups rated donors who work directly with CSOs as more flexible and less burdensome. These, which include sub-granting NGOs or smaller private charities, often do site visits and engage personally, as was described by one CBO leader in Malawi:

> *CARE* [a former INGO umbrella for Malawi's pooled fund] *came in 2005 and helped us train VCT promoters and in Home-Based Care… They came down to us, were listening and they were flexible and changed things to meet our needs… Pendulum* [a smaller private charity] *even more so. They were not as strict and more flexible, as long as we reported to them.*
> (Local CBO, Likuni, Malawi)

It was evident in all the sites that many community organisations saw it as essential to be engaged in their own income generating activities in order to sustain the organisation and their community work. Several of these were in fact receiving no regular grant income at the time. Examples encountered included selling water from a municipal tap on the project site, charging people to watch football matches on an old television, and selling food.

5.4 Intermediary structures: move support down, but at what price?

In all the countries, various 'intermediary' organisations and structures exist that occupy a position between the donor organisations or central government disbursing institutions and final grant recipients. They are typically contracted to fulfil functions such as the disbursement of money, capacity building and monitoring of local-level organisations. These intermediary organisations include international NGOs, or their national offices, and national NGOs. These national examples are either pre-existing, such as the Kenya AIDS NGO's Consortium (KANCO) and the Christian Health Association (CHAM) in Malawi, or have at times been set up specifically to perform these functions for a specific donor organisation, such as ZNAN for the Global Fund in Zambia. At times these new organisations have a close connection with government structures, such as CRAIDS in Zambia. PEPFAR in particular utilises highly complex tiers of intermediary structures and organisations.

Most government respondents interviewed were less in favour of the use by donors or government of NGO intermediaries. In contrast, they favoured a system where more donor money was given first to central government to flow down through government structures (existing, or created expressly for the purpose). For example, in Malawi, the government has discontinued the previous use of international intermediary organisations, which is not welcomed by many CBOs, as exemplified in the following quote:

> *We had to stop… because there was no more money. CARE stopped in 2006, but handed over our new proposal to the District Assembly, though the DA said they didn't have it, so I resubmitted it to them. I never got any replies… CARE*

> *were doing a fine job, because they were trying to find out what we need.*
> (CBO, Likuni, Malawi)

A distinction was often made by many respondents between international NGO intermediaries and those seen to be national or 'indigenous'. Opinions varied. For example, international NGOs were seen as costly, but some also found them efficient in disbursing funds and supporting organisations. Community groups and some government respondents rather favoured the use of national NGOs as intermediaries, as the employees were more likely to be nationals and the funds less likely to be absorbed in funding offices back in northern countries. This preference for national organisations was expressed both by a central government official and by a PEPFAR coordinator in Kenya:

> *… conditionalities slow down the flow of funds. They should find ways of disbursing the funds like using people like KANCO to disburse the funds and report on behalf of the CBOs.*
> (NASCOP, Kenya government)

> *We want to move from funding international organization[s] to local organizations. Supporting local organisations directly will provide a saving because there will be no overheads.*
> (PEPFAR, Kenya)

In Zambia, national organisations were being used to disburse the global fund money. In fact, ZNAN has been set up for this purpose. Representatives of these organisations expressed the opinion that they could act as brokers between donors and community organisations, so that the priorities expressed at local level could be communicated to donors. However heads of community organisations did not feel that this was in fact happening, and also did not have the impression that the flow of funds was more efficient. Indeed, at local level there was very often a sense that inserting intermediary organisations, and specifically many tiers of structures (be they government or other) between the origin of the funds and the final recipients, was wasteful. The following opinion is typical:

> *They should organise so the money doesn't remain with the NGOs, but so it gets to community groups. I know they use it for nice documentation, their costs and nice big vehicles.*
> (CBO, East Nairobi)

Many community organisations feel that most major disbursement mechanisms fail to bring big donors closer to the communities:

> *Seeing what is really happening is the best and donor projects operating like that have done really well… Let me give you an example. We have a community school here in Makululu run by the Swedes and they come here so often to see for themselves what is happening on the ground… but you have people like the World Bank; they give money to other people who are not end users and this money gets cut a lot in the process. I wonder if they even go to the community to see what is happening* [,] *they just get reports which is not enough.*
> (CBO, Kabwe, Zambia)

However, the intermediary organisations themselves felt that they had a good capacity to disburse money, and that it was simply not realistic to expect that donor money could come directly to local organisations:

> *I can say that it is good to have intermediaries because they have the absorptive capacity. Donors are big and they do not have the time to work with small organisations in the community. Intermediaries for sure consume time and money, and probably that money would have gone toward some projects in the communities but there is a risk of giving money straight to the community because the communities do not have the capacity. Moreover the intermediary can oversee the program over a large scale though there is a cost, a small group would not cover the country but an intermediary would.*
> (International NGO, Lusaka)

5.5 Donor coordination

There is a general sense amongst most stakeholders that donors aim to coordinate between themselves and with governments, but in different ways. However the degree of coordination is often assessed as inadequate. Various fora for meetings between groups of donors exist in the three countries. In particular, the activities of the UN organisations are often felt to be coordinated amongst themselves. The mid-sized bilaterals are seen as engaged in coordination between themselves and with government, and mention was made by a few stakeholders of the 'like-minded' bilaterals coordinating their activities. The World Bank is seen to work with government. The Global Fund is recognised for implementing a range of coordination processes, such as the Country Coordinating Mechanism. In the case of PEPFAR, government and civil society stakeholders see the in-country staff to engage in the first instance with the central authorities in Washington. However there is mention of PEPFAR also establishing active dialogue with government and national stakeholders. At times, the approach of PEPFAR was harshly criticised:

> *Donors do harmonize except for PEPFAR, which does its own things deliberately to cause chaos and confusion.*
> (Government representative, Kenya)

In all three countries, governments are seen by many as challenged in leading donors to coordinate an appropriate national response. This was seen to undermine the ability for a coordinated response as this statement from Kenya illustrates:

> *One of the challenges is from the government, because government leadership is not there, and…* [it] *intentionally tries to undermine the coordination alignment we have planned.*
> (Bilateral donor, Kenya)

Several reasons are suggested for inadequate leadership. Some feel that at the end of the day, the donors such as PEPFAR and the GFATM are led by the priorities of their headquarters in the first instance. At a national level, lack of accountability or divisions within governments were cited, or the fact that the NAC did not have a clear role or enough authority. This provoked considerable comment in Zambia:

NAC works very hard, but so often they are seduced into implementation. There are specific roles for MoH vs NAC and so often they overlap. This causes duplication. The capacity of NAC should match its functions. People at NAC get seduced in technical functions.
(Respondent from a UN agency, Zambia)

It is noted by several stakeholders in civil society and the donor community that the governments contribute very little from their own coffers to the AIDS response, which makes their authority weak. As the head of the local office of a national NGO in Zambia put it:

It feels very weak on the Zambia side. The donors dictate. They give direction at every level; even the DACA and PACA are employed by donors… The government has been too comfortable. The government has not given to NGO's like in other countries. They give us 0.xx %, basically nothing. We are a third world country and Zambia is one of the least developed so we are cheating ourselves if we start saying government can do this or that. Maybe in a hundred years.
(NGO, Zambia)

The relationship between governments and donors evoke complicated responses. Many nationals of the countries feel that the global donors tend to undermine the government autonomy, but it is also acknowledged by some that at the same time the inflow of money does strengthen governments' abilities to implement. Whilst there is a widespread belief amongst community organisations and NGOs about donors coordinating closely at a national level, there is a common perception that this does not translate into coordination of inputs at local levels.

5.6 Civil society coordination and influence

Several donors (especially PEPFAR and the Global Fund) feel that civil society is essential in taking community responses beyond a medical approach as well as in holding government to account. In most countries there are formal mechanisms for civil society engagement (most notably the CCMs and various technical working groups) and some civil society networks do influence government, if not always in highly visible ways. The three countries have different complex histories of emerging civil society, in the wake of colonialism and post-colonial development assistance, and these may to some extent shape differences found in our study. In certain instances the mechanisms for involving civil society in decisions were not seen to operate effectively. For example, in Kenya, civil society engagement in developing the Kenya Strategic Plan was seen as positive, but short-lived:

However, apart from that [referring to the KNASP III process] *we don't have a real national mechanism to involve civil society. Even as NGOs we are not united… For example, the HIV/AIDS act of 2006 – we only read about it in the papers… We can't repeal this law unless as civil society we are united and challenge it.*
(PLHA Network, Nairobi)

In Malawi, with a relatively young civil society movement, mention was made of bureaucratic limitations and hierarchies that limited effective preparation and involvement by civil society groups in the CCM:

> *We are not able to speak at meetings and usually communication about meetings comes two to four days before the meeting, which means that we cannot contribute when setting up agendas because by the time they communicate about the meeting agendas of the meeting are already set.*
> (PLHA Network, Malawi)

The funding structures available to civil society and the degree to which the state controls their access to donor funding, is also significant. Some expressed the view that receiving funding from the government can limit CSOs' independence and that they can become reluctant to bite the hand that feeds them. One respondent said; 'I strongly believe that if CSO were getting funds directly from donors, it could have had a voice.' (NAPHAM, Malawi)

The situation in Zambia is interesting in that the government was, during fieldwork, in the process of passing a bill in order to require CSOs to register and share information about their funding. Some were uncomfortable with this and saw it as a potential instrument for greater state control, whilst others felt that it could improve coordination of the national response. This ambiguity is evident in the following assessment:

> *It* [recent Zambian NGO Bill] *might be good thing. But with ongoing corruption now in government, how do they aim to do this?... Of course the government will be involved, as money is coming into the country. But then it must come direct to us implementers.*
> (Large CBO, Zambia)

In some instances civil society organisations have been given the role of disbursement of funding, in addition to other important tasks, such as capacity building of smaller groups or direct service provision. Concern was expressed that the challenges of disbursement, and the associated reporting and monitoring, were limiting the capacity of such groups for other activities and in particular for activism. It is important to underline the wide variation in experiences, including that the degree of engagement of civil society networks with grassroots constituencies appears to be variable and that divisions within the civil society sector were often reported as a real constraint to effectively influencing national agendas.

5.7 Local level coordination

Whilst some international donors have less awareness of the substance of community level initiatives, national level players from all sectors (UN, government, donors, civil society) often idealise community level responses and the notion that 'the community knows best', as described by this national representative of a small European bilateral agency:

> *Local level community based initiatives are more important than government – much more important… For example, there is a case of fishing communities in Nkhotakota, who… are coming up with their own solutions. The communities monitor themselves and it's not forced on them. They can easily link across sectors locally. The national level gets too generalised. They came up with local by-laws to stop young girls selling fish after dark, for example.*
> (Bilateral European donor, Malawi)

Structures exist in all countries for district level coordination of the AIDS response. These often link into broader structures for decentralised health management or local government generally (as in the Constituency AIDS Control Committees, CACCs, working with District Health Management Teams, DHMTs, and reporting to the NACC, in Kenya; or, the District AIDS Task Force, DATF, working with the DHMT, the District Development Coordinating Committee, DDCC, and District Assemblies, whilst reporting to the National AIDS Council, NAC, in Malawi). Community groups and local health officials generally looked favourably on *the idea of* coordination, whilst some saw the reality more as an exercise in control from the top, with little coordination resulting, as illustrated by this perspective from Kenya:

> *I wish they would be involving us. They later inform us when they are on the ground and they didn't involve us with the planning. If we were involved then we would guide them on areas to venture.*
> (DHMT, Kayole, East Nairobi, Kenya)

The nature of different donor systems and how they intersect with national bureaucratic structures can discourage coordination and the linking up of similar or related services across different sectors and civil society groups. Even within government controlled programmes, such as the Total War against AIDS (TOWA) in Kenya, the systems employed can impose serious burdens at local levels, as described by one PLHA organisation in Nairobi, Kenya: 'There is also a lot of bureaucracy. NACC has five agencies implementing TOWA. It is hard and cumbersome to bombard communities with all these different agencies…'

The challenges of inter-sectoral coordination within governments was commonly reported to be difficult to overcome nationally and they were broadly seen as very difficult to translate from theory into reality at the local level in particular, as described for Zambia in these terms:

> *The Ministries of Zambian Government… operate in isolation. The link* [is] *maybe there but very thin, at times nonexistent.* [It] *arises when a workshop or conference is to be held. Their lack of coordination has led to no or minimal coordination and fragmentation of the whole system of providing HIV/AIDS based interventions.*
> (DHMT, Lusaka, Zambia)

Whilst competition for sources of funding and increased CSO involvement was seen, by some, to be undermining coordination, it was seen by others as improving the sharing of information. A fairly common perspective was that '…there is a lot of duplication of activities' (FBO, East Nairobi), but the degree of local coordination between groups in an area appeared to vary and often different actors took the lead, *de facto*, depending on actors and context. An example of a positive perspective on this is provided by a faith-based group in Zambia:

> *Coordination is there among the groups through each group providing a specific intervention. In this community, the groups that operate there have tasked themselves different activities and will not do what the other is doing. Thus duplication of both task and client patients is avoided at all costs.*
> (FBO, Kabwe, Zambia)

In Nakuru, Kenya, local groups felt that certain intermediary actors played useful roles in coordinating locally 'APHIA II [a USAID funded programme] is good, since it has brought together stakeholders to share ideas… [and] KANCO offers meetings sometimes to help know new organizations in town and open up linkages' (CBO, Nakuru).

Local stakeholders' views on donors' roles in coordination varied, however. For example, in Nakuru, Kenya, local government staff felt donors do indeed coordinate, although there was also a feeling that 'there are areas they have left out due to their regulations' (DASCO, Nakuru). In Kayole, East Nairobi, local health staff felt less informed about donor coordination and amongst CBOs and FBOs in both sites the more common view was that they do not coordinate well. Perspectives included: 'No, they are not coordinated, because we would have felt the effect. Because, no, you can't be working for seven years and involve with all in the communities and not notice anything!' (CBO, East Nairobi)

For a range of reasons imposing constraints in this complex resourcing architecture, many community-based organisations felt unable to provide holistic linked services even within their own organisations. Some constraints mentioned include: short-term funding; reluctance to fund current or capital costs; having to keep separate accounts and avoid pooling donor funds even if for the same/similar activities; unpredictable continuity and; disparate burdensome targets and reporting requirements. An intermediary NGO support actor reflected on problems of continuity and shifting donor preferences as undermining the sustainability of certain programmes in Zambia:

> *What is causing all this is the limitation of donor support. You find that the money allocated to orphans is very little to support e.g. orphans. Consistent donor support* [is needed] *to help continue with activities in these organizations that are community based. They start with a bang but end up in a poor state.* (District level branch of FBO intermediary to PEPFAR, Kabwe, Zambia)

6 Discussion

Here we discuss our findings in relation to major current debates as highlighted in Chapter 2, above, in order to consider implications and recommendations for policy in Chapter 7. We do not discuss the findings in detail, as these are summarised at the end of each section in Chapter 5.

6.1 'Vertical' vs 'horizontal' approaches to health and HIV: new perspectives on an old debate

This study has found the reality of 'vertical funding' to be rather more complex than many debates imply and we would argue that the notion of vertical funding is itself not a particularly useful analytical tool. Several positive effects can be seen from these various global health programmes for AIDS. Disease-specific objectives and resources have strengthened services, results and saved lives. On the more negative side, we would argue that funding is seen as displacing domestic budgetary commitments, potentially distorting priorities through donors'

investment concerns and therefore also compromising national ownership, leadership and potentially – if indirectly – contributing to corruption.

The polarised old debate over vertical vs horizontal approaches is becoming increasingly obsolete, since – as noted by many – health systems do indeed need strengthening if we are to respond to HIV effectively, as well as to other health needs, but also that certain health crises require responses well beyond the health sector itself (for example, Piot *et al.* 2008, WHO 2009). Global health financing is increasingly incorporating additional health problems (including those related to HIV, such as tuberculosis, maternal and child health, cancer or sexually transmitted infection (STI) services) and research has estimated that funding for HIV has been accompanied by increases in other areas of health (Ravishankar *et al.* 2009). Rather than the zero-sum view of HIV 'taking money away from other health programmes', it seems more plausible that the response to the epidemic has actually increased support for investing in health more broadly, if in complex and contested ways. HIV programmes have to some extent shown that health services can be strengthened though a disease-focused approach, which can be applied to cross-learning in other areas such as chronic disease care. Whilst disease-specific programming is valuable and leading to specific outcomes, it needs to be integrated with other issues and priorities in a 'diagonal' fashion (Ooms *et al.* 2008). This would involve integrating issues of 'vertical' delivery and outcomes with 'horizontal' interactions and trade-offs. Stakeholders would need to consider both relative burdens of diseases and interactions between them.

HIV provides a good example of yet another reason for why a specific disease focus can be beneficial. That is, the epidemic requires a broader national response across sectors and line ministries. Our findings suggest that local groups do attempt to respond to a range of problems and issues related to HIV beyond narrowly defined health issues. Yet, their experience of the funding architecture and of donor priorities and practices suggests that the current environment somewhat militates against their developing and sustaining holistic responses. The factors involved in constraining the responses of community groups include narrowly-defined and compartmentalised output indicators and systems for resourcing. It seems clear that responses need to be more effectively elaborated and coordinated at local level, with systems to support such coordination at all levels. Not only does this help us to understand how to link specific services for an effective response in this particular case, but it could also provide an approach for holistically addressing other pressing public health concerns and the local interactions between them more broadly.

6.2 Reconsidering the concept of 'national sovereignty' in relation to global financing for HIV and health

Debates over national sovereignty have tended to assume a framework relating rights-bearing citizens to a sovereign nation-state (a formal government) with duties, obligations and significant powers of control. Thus, they have focused on questions of governments autonomously leading the response, on self-reliance and on sustainability. In some ways these are all called into question by the influx of resources and influence in aid for AIDS.

At a basic level, this often gets reduced to 'who controls the money' and – therefore – who can plan and implement the response over the longer term with the people's interest at heart. At a community level, funding channelled largely through government structures (such as the Global Fund resources in Malawi) was often talked about as 'government money', so one might argue that this arrangement strengthens people's view of government as taking measures to relieve the effect of the epidemic. However, the study has found fairly widespread concern on the part of many civil society organisations about the effect of external funding on governments' own financial inputs to the AIDS response in-country and a high dependence on foreign aid to continue existing programmes, with resultant concerns about longer term sustainability. Indeed, other research has found that many recipient governments appear to have substituted domestic health funds for international assistance to the government, which may in part be due to IMF conditions on public sector spending ceilings (Lu *et al.* 2010).

However, it has also been found that support to civil society from development assistance in particular appears to have had a surprisingly positive effect of increasing government health spending from domestic resources (*op cit.*). Funding of civil society might circumvent public sector spending ceilings, as it can resource additional responses outside of the formal health or other government systems, which can further complement government efforts and spending with net gains effects. It may also increase people's ability to hold governments to account and for influencing the national response. Sustainability concerns increase pressures for more strategic resource allocation (including towards better prevention strategies with the most vulnerable and marginalised sections of societies) and more creative and efficient resourcing of responses. Prevention, in particular, requires a response well beyond the formal government health sector to engage strategically with civil society, media and education sectors. Findings from the study do not suggest a universal desire for governments to control all the resources, but rather that such a situation would not likely be in the interests of local responses in the countries studied. Both evidence on the budgetary effects of aid for AIDS and the increased recognition of the need for more strategic investments in prevention speak clearly for strengthening support to civil society alongside assistance to strengthen the governance (rather than international funding) of national public sector services and responses.

Aside from direct government control over resources, notions of national sovereignty often involve interconnected ideas of legitimacy and *ability to lead*, in turn involving abilities to convene, consult and coordinate effectively with different actors and interest groups to build an overall strategic and complementary response. For several different reasons, governments in the three countries studied are seen as severely challenged in trying to lead the donors and national responses more broadly, despite the pressures and approaches promoted by international actors. It has been argued elsewhere that global pressures to elevate NACs outside of Ministries of Health have not been particularly successful and that the addition of the Global Fund CCM has created overly complex and unclear coordination challenges (England 2006). Our findings broadly confirm this complexity, although we found the

positioning of the Malawi NAC as likely having rather strengthened its position in Malawi, where the NAC is attached to the Office of the President and Cabinet (OPC), outside and above the line ministries.

Generally, however, different donors appear to approach coordination in their own respective ways and, indeed, several different fora typically exist for this, whilst how they interrelate (when and if they do) is often a little unclear. Aside from national political and 'institutional architecture' constraints, the fact that governments are said to hardly contribute financially, partially explains their difficulties in acquiring the authority or perceived legitimacy to lead effectively. On the other hand, services have actually been strengthened in many areas and governments do play active roles, sometimes taking on increased leadership. The institution of the CCM is typically viewed differently by different stakeholders and it may be foolish to draw general conclusions, as situations vary by country and as views also differ within different sectors in-country. What is clearer is that the institution has to a significant extent changed the 'name of the game' and moved discussions of national sovereignty from a focus on governments to multi-sectoral national responses and therefore a more up-to-date and less state-centric notion of 'the national'.

Most local and civil society respondents want their *governments* to lead better and involve all sectors to build shared ownership, whilst not necessarily controlling all the resources. This focuses attention on the question of what it might mean to 'lead better'. On the basis of our findings, we argue that roles on coordination and policy process should be clearly distinguished and separated from central control of resources or implementation. Multi-sectoral NACs would indeed appear better placed to link into government structures outside and above line ministries, as this allows for both more neutral cross-sectoral priority setting (within and beyond government) and authority to lead. Governments appear to be more engaged where civil society is empowered and holding it to account and governments may contribute more public resources to health where civil society is better funded separately, which may create virtuous dynamics of legitimacy and transparency.

On balance, it appears that international aid for HIV and AIDS can both strengthen and/or severely challenge governments and national health systems, but the notion of national sovereignty is also complicated by multiple global-to-local dynamics via both public and private channels. The notion of the sovereign nation state, as represented purely by a national government, seems insufficient in negotiating the relationship between local people responding to AIDS in African countries and the global community today. International donors and agencies predominantly take the national government as the rightful locus of national sovereignty. Consequently, frameworks, discourse and high-level agreements and declarations – such as the 2005 'Paris Declaration' on harmonisation and alignment by the Organisation for Economic Co-operation and Development (OECD) (OECD/DAC 2005) – often take on and reflect state-centric governance frameworks, with little explicit mention of how civil society is to engage nationally or internationally, let alone locally. The main exception to this rule has been the Global Fund, which is itself a global public-private partnership. Yet, in practice, many international donors and global health initiatives engage directly with civil society at many levels, which can both strengthen and challenge governments in recipient countries.

6.3 Aid effectiveness and harmonisation at the local level

A key dilemma remains that sufficient amounts of resources are not seen to be getting through to district and local levels for various reasons and that local perceptions of aid for AIDS is often one of a chaotic or disjointed system. Our findings suggest that major aid inflows through complex multiple global systems do appear to be predicated on efficient bureaucracies, whereas the local political culture is often more patron-client based, as suggested in debates (for example, De Waal 2006; Swidler 2009), and they are also consistent with the notion that this can deepen or entrench divisions and corruption in society (*op cit.*). This perspective is lent additional credence by the fact that flow-through in the public sector was also a widely reported problem in particular in this study. However, this conclusion should not be seen as sufficient or universal, as we also found additional explanations for the limited flow-through and constraints, through bottlenecks arising from lack of capacity and ill-adapted systems, in line with findings of other researchers (for example, Foster 2005; Birdsall and Kelly 2007). Typical explanations included different procedures, requirements and time scales of different funders and pressures on CBOs to become more professional, like NGOs, which may also reorient their accountability and direction to meet the needs and interests of donors rather than communities, as also noted by others (for example, Grebe 2009).

Our study vividly describes two typical responses to these dilemmas: the one being a common use of a range of intermediary task-focused structures and organisations, as also documented by other researchers to have increased recently (Birdsall and Kelly 2007), and, the other, an argument for greater government control of resources along with strengthening centralised public health systems. As in the literature (for example, England 2006), private and/or ‘parallel’ intermediaries sometimes appeared to be criticised almost ‘on principle’ for adding to complexity and duplication or ‘waste’. On the whole, however, our evidence does not appear to support this contention, particularly when set against more commonly levelled charges against inefficiencies and corruption in government-based solutions. By privileging a community perspective, we would argue that local harmonisation needs to be de-linked from the notion of government control of resources and that – in the question of ‘monopoly or diversity of funding channels?’ – diversity is actually to the benefit of local groups and responses (see especially findings in section 5.3), as well as to donors and others concerned with enabling scaled-up community level action.

Furthermore, the question of ‘complexity’ in the architecture also needs to be separated from the fact that the associated opportunities and procedures for access can be overly ‘complicated’ for local groups: we would argue for a need to acknowledge complexity in systems whilst aiming for their becoming less complicated to use. At an overarching level, our findings lead us to concur with the recommendation to move towards a ‘diagonal’ approach (Ooms *et al.* 2008) discussed above, but at a more concrete level we suggest a few elements for strengthening complex architectures – i.e. make them more sophisticated and well-adapted, whilst less complicated.

A key issue emerging is the ill-adapted orientation and design of current donor and funding systems for enabling locally driven responses. Current output-target-

driven donor approaches to funding a narrower range of readily quantifiable activities do risk shaping the nature of the kinds of community-level responses that evolve. Indeed, Birdsall and Kelly (2007) also argue that this has occurred. In our study, groups reported difficulties in getting support for work on income generation and that it was very difficult to get donors to fund infrastructural investments, salaries or transport requirements necessary. Such inputs were said to be essential to providing a sustained response and achieve real outcomes over time. Yet, several initiatives were relying entirely on membership contributions and their own income generating activities, whilst it may not be realistic to expect extensive community responses that rely entirely on a spirit of volunteerism to be sustainable. We must acknowledge that a community might not always know best, but it is significant and worrying that they do not even feel consulted, which may also impact on their sense of ownership of programmes. They clearly value systems which give them some voice and actually welcome monitoring, as it is seen as a way of having personal engagement. Aside from addressing the current 'output countability bias' of many donors, limiting funding for areas vital to sustainability and militating against a holistic response, there is a need to redress bureaucratisation as well as multiple different reporting and accountability requirements down to community level, which restricts many local groups' access. This has also been argued with respect to development aid more broadly, such as by Natsios (2010).

Whilst multiple intermediary structures can increase the sense of parallel systems, they can also make procedures and requirements more appropriate to the needs of local groups (as well as provide guidance and capacity building). These benefits and systems are seen to have substantive 'transaction costs', although the building of local capacities is often also argued to be an important outcome – and 'value added' – in its own right. Whether seen as transaction costs for scaled-up funding and responses or/and as valid investments for improving local (and national) responses in more complex ways, intermediary functions are often seen as very costly, particularly when delivered by international NGOs. The study has registered strong arguments for using – and strengthening – national NGOs, platforms and organisations to act as such intermediaries, particularly in light of the almost universally acknowledged need for building local and national capacity. Intermediaries are, however, also held back by the constraints and limitations of donor systems and approaches of funders and other stakeholders need to converge better on allowing for more enabling systems to support local responses.

A strong momentum behind donor harmonisation has emerged with the Paris Declaration (OECD/DAC 2005), but this remains framed in (i) too state-centric terms and (ii) at a too generic national level, with donor and cross-sectoral harmonisation at local levels remaining underexplored and problematic. The new emphasis on Community Systems Strengthening by the Global Fund and some civil society networks (International HIV/AIDS Alliance and GFATM n.d.) provides a further ground for recognition of some of these capacity and sustainability issues (including specific 'dual-track' financing arrangements with civil society principal recipients) to improve aid effectiveness to better enable local responses. There most likely remains a need for critically assessing 'community systems' strengthening (for example, to what extent it may be 'old wine in new bottles' in response to the recent push for 'health systems' strengthening, or to what extent

community responses are amenable to systematic categorisation as systems in any truly useful way). Furthermore, whilst very significant, the Global Fund is only one of several donor initiatives, so such an approach would seem to need broader buy-in from a wider range of programmes. We would suggest one way forward would be for a range of the big global health initiatives to engage with each other, donor- and recipient governments as well as local stakeholders to develop far more coherent and user-friendly systems 'down to community levels'. This might be done best with agreeing a focused – but open and structured – pilot process in a few countries, to begin with, but with a clear timetable and process for developing a joint Donor Code of Practice.

6.4 Leveraging the multiple contributions of civil society in local and national responses

The 'big three' programmes have increased stakeholder participation and the involvement of civil society actors. Whilst cross-sectoral consultation in national HIV and AIDS strategies has increased – partly as a result of global health initiatives and given a particular boost by the processes and structures set in place by the Global Fund – national civil society formations often felt that their influence on overall priorities remains negligible. Many still saw national agendas as being set internationally and governments as intent on controlling their activities. However, we would suggest that there is a real need for more meaningful representation for members of civil society in national and local structures and for the roles that different civil society groups can play to be acknowledged in planning and coordinating a truly 'national' response that goes beyond a health focus. A cross-sectoral strategic response is also likely to be less vulnerable to political shifts and more resilient to short-term shocks and the concomitant interruptions. It is also noteworthy that in all three of these countries very little attention is given to the perspectives of, and representation for, marginalised (and often criminalised) groups, whose involvement in prevention programmes is now suggested internationally to be crucial to addressing drivers of the epidemic.

Governments have been challenged for greater transparency and accountability, which is being responded to in different ways (proactively and defensively). In Malawi, national civil society organisations felt limited in their ability to provide an independent voice as significant proportions of their funding came from government. In Zambia, the inclination of the government to want more control of the civil society sector (for example, in terms of registration and declarations of funding sources) could have a detrimental effect on the independence of the sector. Thus the ability of civil society to 'hold government to account' is often constrained. A diversity of funding sources for civil society potentially mitigates concerns about government control.

The advent of funding has diversified the roles of some CSOs, for example in taking on the disbursement of funds in an intermediary capacity. This granting role clearly requires considerable skills, given the amounts of money involved. Our research suggests that existing national intermediary organisations in Zambia and Kenya have encountered difficulties and we suggest that they need additional strengthening, specifically to reduce dependency and transaction costs, and to build shared national ownership. This aim of greater national ownership can be aided by a move away

from a heavy reliance on international NGOs as intermediaries, except in a time-limited and outcome-oriented support role. Donors and governments need to then prioritise an investment in the capacity of national civil society structures to fulfil the disbursement role and to act as intermediary NGO/CBO supporters.

The incorporation of CSOs into granting structures, involving new roles, can have the effect of a diffusion of aims (or ‘mission creep’). This is a further potential constraint to effectively fulfilling more ‘traditional’ roles of HIV-related advocacy work. A periodic evaluation of the range of effects of HIV funding on the actual work conducted by NGOs is important to ensure that a diverse spread of activities remain nationally and locally. Furthermore, there is a need also for monitoring to ensure a spread of funding to a range of organisations in terms of size, roles and geographic location. Such strategic evaluation and planning requires civil society to work together and build and maintain active networks for coordination at all levels. In this respect, the ‘community systems strengthening’ agenda could be valuable if applied across local government and CBOs, but it may also inadvertently divert attention and resources from strengthening civil society’s independent capacity for advocacy. Service delivery also remains a core role for civil society organisations, and here the potential of community responses to encompass a holistic set of interventions beyond a narrow health focus needs to be fostered and funded. Again, attention must be paid to ensure that systems strengthening initiatives do not in fact force local responses into blue-print service delivery frameworks. The true value of community responses must not only be paid lip service, but given space to grow.

7 Policy recommendations

Health systems need strengthening in order to respond to HIV effectively, as well as to other health needs. Global health financing is increasingly incorporating additional health problems to HIV and AIDS (including those related to HIV) and in order to strengthen systems for health and HIV, countries need to consider both relative burdens of diseases and interactions between them. HIV programmes have to a large extent shown that health services can be strengthened though a disease-focused approach, but it also needs to be integrated with other issues and priorities in a ‘diagonal’ fashion (integrating issues of ‘vertical’ delivery and accountability for outcomes with ‘horizontal’ interactions and trade-offs). Equally importantly in this is that AIDS requires a broader national response across line ministries and sectors (beyond the government) and one that can be effectively coordinated and driven at local levels. One key recommendation emerges from these debates:

√ Link the HIV response to other health sector issues and beyond the health sector to more strategically include public, private and civil society sectors

Governments and certain donors favour government control and centralisation as a means of coordination and governments are developing legislation with new powers of control over civil society in some countries. Our findings do not support such a view or approach and, on balance, plurality is a benefit for local responses, rather than a constraint.

√ Maintain or strengthen diversity of funding structures and plural ways of operating

Strong national leadership is essential to better responses to AIDS, but what this means often needs updating and working out with a range of local stakeholders. The CCMs have moved the idea of 'national ownership' beyond the idea of government implemented national responses, to include civil society and private sectors. Roles on coordination and policy process should be distinguished from central control of resources or implementation. NACs appear better placed outside and above line ministries, and governments appear to be more engaged where civil society is empowered and holding it to account, and contribute more resources to health where civil society is better funded.

√ Ensure key national stakeholders, including key populations, are positioned and enabled to partake in the national response, through:

- Placing the main national coordinating bodies outside and above line ministries to enhance their authority, and
- Ensuring architectures and coordinating body constitutions (a) clearly separate coordination from control of resources and (b) meaningfully involve the relevant stakeholders

Very little is invested in AIDS by national governments, as donor investments (for example in sector-wide approaches to health sector strengthening) tend to reduce allocations from domestic coffers. This leads to concerns over sustainability of long-term support from global donors, which increases pressures for more strategic resource allocation (including towards better prevention strategies) and for more creative and efficient resourcing of responses. A cross-sectoral strategic response is likely to be less vulnerable to political shifts and more resilient to short-term shocks with resulting interruptions. Two recommendations can be formulated to enhance sustainability of responses:

√ Engage with global evidence on 'what works' and strategically focus efforts and resources on curbing and sustainably controlling the epidemic with longer-term perspectives in mind

√ Build on and expand structures and processes for a diverse and strategic cross-sectoral national response to build ownership and resilience

Our findings show that intermediary organisations and programmes play important roles in strengthening multiple local responses at scale, with real costs and trade-offs. International NGOs often do this well, but are costly and there is a very strong case for investing seriously in capacity building of national civil society structures to do this (with time-limited and outcome-oriented support roles for international groups). We recommend that:

√ National intermediary organisations need strengthening specifically to reduce dependency and transaction costs, and to build shared national ownership

√ The potential benefits of intermediary structures should be strategically and sustainably harnessed, by building on a range of local resources and capacities for NGO/CBO support

Blockages, leaks and corruption continue to restrict intended resource flows and support to communities responding to AIDS. In addition, a 'countability bias' of

many donors limits potentials for funding areas seen as vital to the sustainability of local groups and inadvertently militates against a holistic response. A current bureaucratisation of AIDS, with multiple reporting and accountability requirements down to community level restrict many local groups' access. 'Community systems strengthening' is needed across local government and CBOs, but this (potentially being a reactive civil society response to the health systems strengthening agenda) may also inadvertently divert attention and resources from strengthening civil society's independent capacity for advocacy and it may force local responses into blue-print service delivery frameworks. Whilst a good starting point, the principles of the Paris Declaration remain limited to national-international interactions for harmonisation as well as heavily focused on government; donor and cross-sectoral harmonisation at local levels remain problematic. We propose the following recommendations on the basis of the study findings and the above considerations:

- √ Minimise the range and detail of local level restrictive targets and indicators for specific outputs, and instead build participatory systems to enable holistic responses and capacity to monitor broader outcomes at community levels
- √ Make the different funding systems more appropriate and less burdensome to the capacities of small local organisations
- √ Focus efforts at checking corruption proportionally according to levels of finance and carefully consider cost-efficiency on the degree of financial monitoring at different levels
- √ Rather than new blueprints from above, enable community strengthening through harmonising and simplifying donor systems at the community beneficiary level
- √ To support all these aims, develop a joint '*donor code of practice*' down to community level, setting appropriate and non-duplicative standards for qualification, application, reporting, and accountability

Annex 1 Aid for AIDS: communications report

The communications for this research project were guided by a strategy that was prepared by IDS and signed off by each of the research partners. The communications strategy was coordinated from the Institute of Development Studies and delivered in partnership with the researchers in Zambia, Malawi and Kenya drawing on their existing communications capacity, knowledge and contacts. Our target audiences were: civil society and participating community members in Kenya, Malawi and Zambia; policymakers at national, regional and international level (including donor organisations); and academics who are active in this field of study. In order to reach these audiences we created targeted outputs and hosted four dissemination meetings in the participating countries and South Africa.

Aims of the communications strategy

The aims of our communications strategy were to:

- Provide support so that community level stories on how AIDS funding affects coordination, local governance and accountability reach a national, regional and international audience;
- Inform donor policy and the way that financing is delivered to community-based organisations based on the evidence that we generate; and
- Contribute to debates and understandings on the effectiveness of global health initiatives.

Outputs

We prepared bespoke communications products for each of our target audiences which included:

- An IDS news story which announced the launch of the study (www.ids.ac.uk/go/news/aid-for-aids-how-do-community-groups-negotiate-the-new-financial-architecture, accessed 19 February 2011) which was featured on the STEPS Centre blog 'The Crossing' (http://stepscentre-thecrossing.blogspot.com/2009/06/aid-for-aids-how-do-community-groups.html, accessed 19 February 2011)
- A write-up on the Aid for AIDS project can be found on the APHRC website (www.aphrc.org/insidepage/?articleid=416, accessed 19 February 2011)
- Short research briefings that covered emerging findings and analysis from Kenya, Malawi, Zambia and across the countries. These were used to feed back to research participants and provided a basis for discussions with policymakers
- Workshop presentations which guided the discussion at each of the feedback meetings

- Press releases which were targeted at national media in Kenya, Malawi and Zambia
- An IDS published report which targets an international audience of researchers and development practitioners
- An IDS published brief as part of the 'In Focus' series which targets policymakers at international, regional and national level

Feedback meetings

Feedback meetings were held in Kenya, Malawi, Zambia and South Africa in late 2009/early 2010 and attracted around 50 participants, each of which were comprised of research participants, researchers and policymakers. The purpose of these meetings was to communicate the findings of the research and the analysis, get feedback on the findings and validate them and engage with policymakers and donors regarding the research. The meetings also acted as a platform for dialogue between community members, researchers and policymakers.

Efforts were made to embed policymakers in the structure of the meetings. In Kenya the meeting was opened by Dr. N Muraguri, the Director of the National Aids and Sexually Transmitted Diseases Control Programme (NASCOP) and hosted by the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ). In Malawi the Principal Secretary for HIV/AIDS and Nutrition in the Office of the President and Cabinet (OPC), Mary Shawa, spoke. The meeting in South Africa was hosted by UNDP.

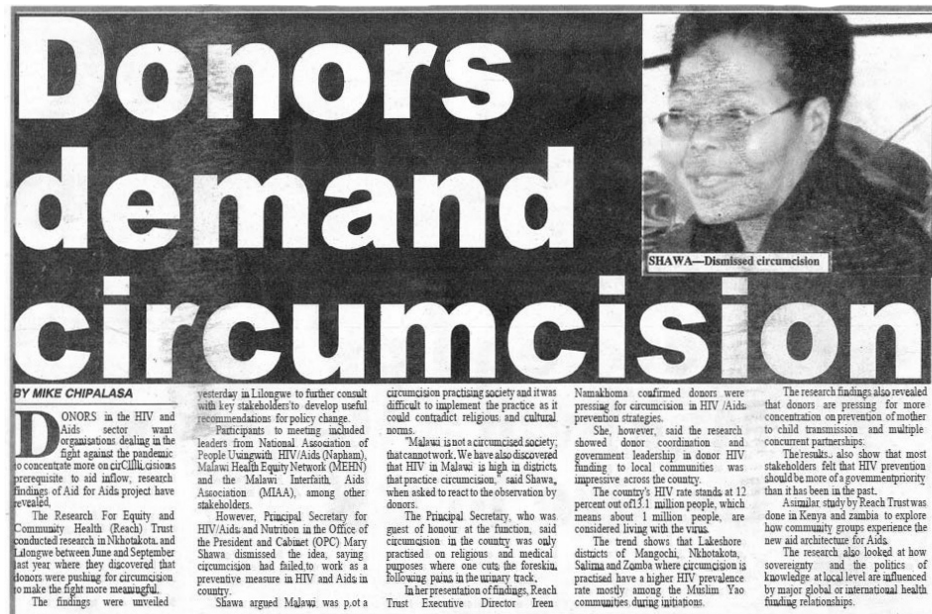
International policymakers and donors were represented in the meetings from organisations such as: PEPFAR, CDC, the Swedish/Norwegian Regional HIV/AIDS Team for Africa, the Netherlands Embassy, UNDP, the Embassy of Sweden, UNAIDS, DFID, the World Bank, UNESCO, UNICEF, Irish Aid, UNFPA, UNAIDS, USAID, WHO, the Global Fund to fight AIDS, TB and Malaria. A similar mix of national policymakers engaged with the meetings.

Media engagement and reporting

In Zambia, Malawi and Kenya representatives from the media were invited to the dissemination meetings with a view to them acting as a multiplier and communicating the study findings and associated discussion to the public. Media releases were also prepared and circulated. We were also mindful that policymakers use the media as a source of information.

In Kenya the study and the dissemination meeting were covered on K24 (a local TV station) and Voice of America. An article on the study by Elizabeth Kahurani of APHRC appeared in *The Standard* (a national daily newspaper) on Wednesday 2 December.

In Malawi four representatives from the media houses, radio and print media attended the dissemination meeting. The media reporting was more challenging. On Friday 19 February *The Daily Times* newspaper made the meeting a headline; however, the story put a lot of emphasis on one small point from the briefing that was fleetingly mentioned in the meeting discussion (see below). As a result of the



Donors demand circumcision

SHAWA—Dismissed circumcision

BY MIKE CHIPALASA

DONORS in the HIV and Aids sector want organisations dealing in the fight against the pandemic to concentrate more on circumcisions prerequisite to aid inflow, research findings of Aid for Aids project have revealed.

The Research For Equity and Community Health (Reach) Trust conducted research in Nkhotakota and Lilongwe between June and September last year where they discovered that donors were pushing for circumcision to make the fight more meaningful.

The findings were unveiled yesterday in Lilongwe to further consult with key stakeholders to develop useful recommendations for policy change.

Participants to meeting included leaders from National Association of People Uwingwith HIV/Aids (Napham), Malawi Health Equity Network (MEHN) and the Malawi Interfaith Aids Association (MIAA), among other stakeholders.

However, Principal Secretary for HIV/Aids and Nutrition in the Office of the President and Cabinet (OPC) Mary Shawa dismissed the idea, saying circumcision had failed to work as a preventive measure in HIV and Aids in country.

Shawa argued Malawi was not a circumcision practising society and it was difficult to implement the practice as it could contradict religious and cultural norms.

"Malawi is not a circumcised society; that cannot work. We have also discovered that HIV in Malawi is high in districts that practice circumcision," said Shawa, when asked to react to the observation by donors.

The Principal Secretary, who was guest of honour at the function, said circumcision in the country was only practised on religious and medical purposes where one cuts the foreskin following pains in the urinary track.

In her presentation of findings, Reach Trust Executive Director Ireen Namakhoma confirmed donors were pressing for circumcision in HIV /Aids prevention strategies.

She, however, said the research showed donor coordination and government leadership in donor HIV funding to local communities was impressive across the country.

The country's HIV rate stands at 12 percent out of13.1 million people, which means about 1 million people, are considered living with the virus.

The trend shows that Lakeshore districts of Mangochi, Nkhotakota, Salima and Zomba where circumcision is practised have a higher HIV prevalence rate mostly among the Muslim Yao communities during initiations.

The research findings also revealed that donors are pressing for more concentration on prevention of mother to child transmission and multiple concurrent partnerships.

The results also show that most stakeholders felt that HIV prevention should be more of a governmentpriority than it has been in the past.

A similar study by Reach Trust was done in Kenya and zambia to explore how community groups experience the new aid architecture for Aids.

The research also looked at how sovereignty and the politics of knowledge at local level are influenced by major global or international health funding relationships.

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story the lead researcher was asked to meet with the NAC to explain more about the findings. Zodiac Broadcasting Corporation also covered the meeting on their news programme.

Dissemination

From engagement with research participants and the feedback meetings we created a targeted contact database for each of the participating countries and for regional dialogue to use for dissemination purposes. This augments IDS' existing extensive list of contacts for dissemination of the final report and briefing. The reports will be uploaded to online resource guides such as the AIDS Portal and Eldis (one of a family of knowledge services from IDS) and the pdf versions will be circulated using relevant electronic mailing list servers. The final report and briefing will also be circulated by the participating research organisations. The findings from this study will help to inform future IDS teaching curricula and will be available through the IDS website.

References

Amuyunzu-Nyamongo, M.; Okeng', L.; Wagura, A. and Mwenzwa, E. (2007) 'Putting on a Brave Face: The Experiences of Women Living with HIV and AIDS in Informal Settlements of Nairobi, Kenya', *AIDS Care* 19.1: 25–34

Bernstein, M. and Sessions, M. (2007) *A Trickle or a Flood: Commitments and Disbursement for HIV/AIDS from the Global Fund, PEPFAR, and the World Bank's Multi-Country AIDS Program (MAP), Center for Global Development*, Washington DC: HIV/AIDS Monitor

Birdsall, K. and Kelly, K. (2007) *Pioneers, Partners, Providers: The Dynamics of Civil Society and AIDS Funding in Southern Africa*, Johannesburg: CADRE/OSISA

Brugha, R. with Donoghue, M.; Cliff, J.; Starling, M.; Fernandes, B.; Walt, G.; Nhatave, I.; Ssengooba, F.; Ndubani, P. and Pariyo, G. (2005) *Global Fund Tracking Study: A Cross-Country Comparative Analysis*, Final Draft 2 August www.theglobalfund.org/documents/library/studies/integrated_evaluations/IE13_full.pdf (accessed 20 August 2010)

Cheru, F. (2002) 'Debt, Adjustment and the Politics of Effective Response to HIV/AIDS in Africa', *Third World Quarterly* 23.2: 299–312

Chiao, C.; Mishra, V. and Sambisa, W. (2009) 'Individual- and Community-Level Determinants of Social Acceptance of People Living with HIV in Kenya: Results from a National Population-Based Survey', *Health & Place* 15: 742–50

De Waal, A. (2006) *AIDS and Power: Why There is No Political Crisis – Yet*, London: Zed Books

Donahue, J.; Hunter, S.; Sussman, L and Williamson, J. (1999) *Children Affected by HIV/AIDS in Kenya: An Overview of Issues and Action to Strengthen Community Care and Support*, Report of a Combined USAID/UNICEF Assessment of Programming in Kenya for Children and Families Affected by HIV/AIDS, USAID

Donoghue, M.; Brugha, R.; Walt, G. and Ndubani, P. (2005) *Global Fund Tracking Study, Zambia Country Report*, London School of Hygiene and Tropical Medicine

England, R. (2007) 'Are we Spending too Much on HIV?', *British Medical Journal* 334: 344

—— (2006) 'Coordinating HIV Control Efforts: What to do with the National AIDS Commissions', *The Lancet* 367: 1786–89

Foster, G. (2005) *Bottlenecks and Drip-Feeds: Channelling Resources to Communities Responding to Orphans and Vulnerable Children in Southern Africa*, London: Save the Children Fund www.savethechildren.org.uk/en/docs/Bottlenecks_Full_Report.pdf (accessed 20 August 2010)

GFATM (2010a) *Grant Portfolio, Kenya, The Global Fund to Fight AIDS, Tuberculosis and Malaria*, http://portfolio.theglobalfund.org/Country/Index/KEN?lang=en (accessed 20 August 2010)

—— (2010b) *Grant Portfolio, Malawi, The Global Fund to Fight AIDS, Tuberculosis and Malaria*, http://portfolio.theglobalfund.org/Country/Index/MLW (accessed 20 August 2010)

Grebe, E. (2009) *Leaders, Networks and Coalitions in the AIDS Response: A Comparison of Uganda and South Africa*, CSSR Working Paper 241, Cape Town: Centre for Social Science Research

International HIV/AIDS Alliance and GFATM (n.d.) *Civil Society Success on the Ground: Community Systems Strengthening and Dual-track Financing: Nine Illustrative Case Studies*, Geneva: GFATM www.theglobalfund.org/documents/publications/progressreports/Dual-Track_Report_en.pdf (accessed 20 August 2010)

Jensen, P. (2009) *The IMF in Kenya: Implications for Health and Development*, Results/CEGAA

Lu, C.; Schneider, M.T.; Gubbins, P.; Leach-Kemon, K.; Jamison, D. and Murray, C.J.L. (2010) 'Public Financing of Health in Developing Countries: A Cross-National Systematic Analysis', *The Lancet* 375: 1375–87

Munthali, A. (2002) *Adaptive Strategies and Coping Mechanisms of Families and Communities Affected by HIV/AIDS in Malawi*, UNRISD project on HIV and Development, Geneva: UNRISD

National AIDS Control Council (NACC), Office of the President, Kenya (2008) *UNGASS 2008 Country Report for Kenya*, Nairobi: NACC http://data.unaids.org/pub/Report/2008/kenya_2008_country_progress_report_en.pdf (accessed 20 August 2010)

Natsios, A. (2010) *The Clash of the Counter-Bureaucracy and Development*, Center for Global Development Essay, Washington DC: Center for Global Development. www.cgdev.org/content/publications/detail/1424271 (accessed 11 January 2011)

Ndubani, P.; Simbaya, J.; Walsh, A.; Dicker, P.; Kamwanga, J. and Brugha, R. (2009) *Tracking Global HIV/AIDS Initiatives and their Impact on the Health System in Zambia*, Final Report: Global HIV/AIDS Initiatives Network, London School of Hygiene and Tropical Medicine

Nyambedha, E.O.; Wandibba, S. and Aagaard-Hansen, J. (2003) 'Changing Patterns of Orphan Care Due to the HIV Epidemic in Western Kenya', *Social Science & Medicine* 57: 301–11

—— (2001) 'Policy Implications of the Inadequate Support Systems for Orphans in Western Kenya', *Health Policy* 58: 83–96

OECD/DAC (2005) *The Paris Declaration of Aid Effectiveness and the Accra Agenda for Action 2005*, www.oecd.org/dataoecd/11/41/34428351.pdf (accessed 20 August 2010)

Office of the President and Cabinet (OPC) (2007) *Malawi HIV and AIDS Monitoring and Evaluation Report 2007: Follow up to the UN Declaration of Commitment on HIV and AIDS*, http://data.unaids.org/pub/Report/2008/malawi_2008_country_progress_report_en.pdf (accessed 20 August 2010)

Oomman, N.; Bernstein, M. and Rosenzweig, S. (2008) *Seizing the Opportunity on AIDS and Health Systems: A Comparison of Donor Interactions with National Health Systems in Mozambique, Uganda and Zambia, Focusing on the US President's Emergency Plan for AIDS Relief, the Global Fund to Fight AIDS, TB and Malaria, and the World Bank's African Multi-Country AIDS Program*, Washington: Center for Global Development

—— (2007) *Following the Funding for HIV and AIDS: A Comparative Analysis of the Funding Practices of PEPFAR, the Global Fund and World Bank MAP in Mozambique, Uganda and Zambia*, Washington: HIV and AIDS Monitor and Centre for Global Development

Ooms, G.; Van Damme, W.; Baker, B.K.; Zeitz, P. and Schrecker, T. (2008) 'The "Diagonal" Approach to Global Fund Financing: A Cure for the Broader Malaise of Health Systems?', *Globalization and Health* 4.6

Oyaya, C.O. and Rifkin, S.B. (2003) 'Health Sector Reforms in Kenya: An Examination of District Level Planning', *Health Policy* 64: 113–27

PEPFAR (2010a) *Partnership to Fight HIV/AIDS in Kenya*, US Government interagency website managed by the Office of US Global AIDS Coordinator and the Bureau of Public Affairs, US State Department www.pepfar.gov/countries/kenya/index.htm (accessed 20 August 2010)

—— (2010b) *Partnership to Fight HIV/AIDS in Malawi*, US Government interagency website managed by the Office of US Global AIDS Coordinator and the Bureau of Public Affairs, US State Department www.pepfar.gov/countries/malawi/ (accessed 20 August 2010)

Piot, P.; Bartos, M.; Larson, H.; Zewdie, D. and Mane, P. (2008) 'Coming to Terms with Complexity: A Call to Action for HIV Prevention', *The Lancet* 372 .9641: 845–59

Rau, B. (2006) 'The Politics of Civil Society in Confronting HIV/AIDS', *International Affairs* 82.2: 285–95

Ravishankar, N.; Gubbins, P.; Cooley, R.J.; Leach-Kemon, K.; Michaud, C.M.; Jamison, D.T. and Murray, C.J.L. (2009) 'Financing of Global Health: Tracking Development Assistance for Health from 1990 to 2007', *The Lancet* 373: 2113–24

Schou, A. (2009) 'Who Benefits from Demand-Driven Distribution of HIV/AIDS Services? An Analysis of the Emerging CBO Sector in Malawi', *Public Administration and Development* 29.2: 155–66

Seckinelgin, H. (2005) 'A Global Disease and its Governance: HIV/AIDS in Sub-Saharan Africa and the Agency of NGOs', *Global Governance* 11: 351–68

Skovdal, M.; Ogutu, V.; Aoro, C and Campbell, C. (2009) 'Young Carers as Social Actors: Coping Strategies of Children Caring for Ailing or Ageing Guardians in Western Kenya', *Social Science & Medicine* 69.4: 587–95

Swidler, A. (2009) 'Dialectics of Patronage: Logics of Accountability at the African AIDS-NGO Interface' in D.C. Hammack and S. Heydemann (eds), *Globalization, Philanthropy, and Civil Society: Projecting Institutional Logics Abroad*, Bloomington IN: Indiana University Press: 192–222

Tayler, L. (2006) ‘Corruption and AIDS – an Overview of the Issues’, *HLSP Institute, Technical Approach Paper*, Transparency International report February 2006

UNAIDS (2008) *Country Situation: Kenya*, July, http://data.unaids.org/pub/FactSheet/2008/sa08_ken_en.pdf (accessed 20 August 2010)

Wakabi, W. (2007) ‘Kenya’s Mixed HIV/AIDS Response’, *The Lancet* 369.9555: 17–18

World Bank Group (2010a) *Total War Against HIV and AIDS (TOWA) Project, Kenya*, http://web.worldbank.org/external/projects/ main?Projectid=P081712&theSitePK=40941&piPK=64290415&pagePK=64283627&menuPK=64282134&Type=Overview (accessed 20 August 2010)

—— (2010b) *Multi-Sectoral AIDS Project (MAP), Malawi*, http://go.worldbank.org/LW3YH77350 (accessed 20 August 2010)

World Health Organization (WHO), Maximizing Positive Synergies Collaborative Group (2009) ‘An Assessment of Interactions between Global Health Initiatives and Country Health Systems’, *The Lancet* 373: 2137–69