Donor policies and the allocation of aid by Dutch NGOs:
The changing importance of HIV and AIDS

Thesis

Wageningen, August 2010

By:	Maaike van Gameren
Study programme:	International Development Studies
Specialisation:	Sociology of Rural Development
Registration number:	850407 249120
E-mail address:	maaike_van_gameren@hotmail.com

Thesis code:	RDS-80733
Supervisors:	Dr Gemma van der Haar
	Prof. Dr Anke Niehof

Contents

Figures and tables

Figures

Tables

Abbreviations and acronyms

AIDS	acquired immunodeficiency syndrome
ART	anti-retroviral therapy
ARV	anti-retroviral drugs
CAB(H)A	children affected by (HIV and) AIDS
EU	European Union
FBO	faith based organisation
GDP	gross domestic product
GFATM (Global Fund)	Global Fund to fight AIDS, Tuberculosis and Malaria
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
IDU	injecting drug user
IOB	Policy and Operations Evaluation Department
LGBT	lesbian, gay, bisexual and transgender people
MDG	millennium development goal
MFS	co-financing system
MSM	men having sex with men
NGO	non-governmental organisation
ODA	official development assistance
OVC	orphans and vulnerable children
PEPFAR	US President's Emergency Plan for AIDS Relief
PLWHA	people living with HIV and AIDS
SRHR	sexual and reproductive health and rights
STD	sexually transmitted disease
STI	sexually transmitted infection
TB	tuberculosis
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
US	United States
WHO	World Health Organization
WRR	Scientific Council for Government policy

Acknowledgements

First and foremost I would like to thank the numerous respondents for their cooperation and generous invitations for interviews. Their input is the very fundament for this thesis. I hope I have done justice to them all in my translations and interpretations of the interviews and other study material. However, the conclusions are first and foremost my own responsibility.

I can't thank my supervisors Gemma van der Haar and Anke Niehof enough for their work and feedback on every nook and cranny of this research.

Furthermore, I am grateful to a number of fellow students at Wageningen University. Jackson Mbogela, Anne-Ester Varwijk, Harmke van den Dikkenberg and Annemarie Visser shared their experiences working for HIV and AIDS related programmes. Their stories were insightful and a continuous reminder of the reality hiding behind policy papers and statistics.

I thank Ineke Bijl and Willemijn Eindhoven for their feedback on the proposal of this research.

In my personal life, my thanks go out to Peter, who has been very patient and supportive while I was finishing this thesis. I am lucky to have him around.

Summary

Since the late 1990s, HIV and AIDS is a high priority for many actors in the development sector. Funding for the topics increased to unprecedented levels and many non-governmental organisations included projects on HIV and AIDS in their portfolios. Recently, discussion started about the importance of HIV and AIDS compared to other health problems. Criticism grew that diseases with an equal burden on global health were overlooked because of the 'popularity' of HIV and AIDS interventions.

This research aimed to find out more about how NGOs decide on which health topics they pick up. To find out how NGOs come to their priorities, HIV and AIDS was chosen as a case. One of the questions was if NGOs also preferred to implement HIV and AIDS related activities. Other important topics are the relations that NGOs have with their donors and the local partners that they support. The basis of the thesis are 18 interviews with employees from various NGOs and the Ministry of Foreign Affairs and the examination of published policy documents.

I found out that HIV and AIDS are no longer a top priority NGOs. The main reasons are a decrease in available funds and the possibilities to invest more in other topics like sexual and reproductive health and rights (SRHR). This showed that funding opportunities can steer the NGOs work indirectly. A striking trend is that more and more NGOs now aim to integrate and 'mainstream' HIV and AIDS in their other programmes.

These findings imply that NGOs do not set themes and approaches in isolation. They work within a sphere of various actors that bring about a certain consensus (or 'discourse', or 'paradigm') about what are the things to do. Both NGOs and the Ministry of Foreign Affairs operate in the same sphere and therefore their policies are alike. The severity of the health problem in question is important, but not decisive in decisions about what the content of the projects of NGOs is.

1 - Introduction and research questions

1.1 HIV and AIDS and development aid

UNAIDS (Joint United Nations Programme on HIV and AIDS) reported that in 2007 around 33 million people were infected with HIV (human immunodeficiency virus). 67 percent of all these people live in sub-Saharan Africa. The majority of infections occur in developing countries. Also in 2007, 2 million people died of the consequences of AIDS (acquired immunodeficiency syndrome) (UNAIDS 2008). Poverty and HIV and AIDS have become a perpetuating negative cycle; HIV and AIDS increase poverty and inequality, just as much as it makes people more vulnerable for infection (Parker and Wilson 2000). There are also some signs of hope, because the percentage of infections is stabilizing in some countries (UNAIDS 2008). Funding for HIV and AIDS programmes increased six-fold since 2001. Many NGOs have programmes for HIV prevention, against stigmatization, helping children that are orphaned by AIDS, etcetera (UNAIDS 2008). Other health problems cause similar burdens; also every year, one million people die from malaria and – a popular statistic in campaigns - one African child every 30 seconds. A further 1 in 22 African women do not survive giving birth to their child (Skolnik 2008). Recent estimates indicate that now approximately one billion people are chronically undernourished (FAO 2009). The list of health problems goes on and on and so do the efforts of the donor community and NGOs (non governmental organisations).

Recently, questions are raised about the priority given to HIV and AIDS. The government of Rwanda pointed out that in 2005 they received $47 million of development assistance earmarked for HIV and AIDS, in a country where prevalence of the disease is 3.1 percent. These generous donations exceeded the entire national health budget of the Rwandese government of $37 million in 2003 (Shiffman 2008). Health problems that cause much more loss of life and productivity, like respiratory infections, diarrhoea among children and undernutrition, gain significantly less attention from development organisations (Walt 2009). Others notice that donations for HIV and AIDS specific programmes can put pressure in the existing health care systems (Koch 2007; Levine and Oomman 2009; Pfeiffer 2008).

In many low- and middle income countries, the national health care system is unavailable for the poorest people. The hospitals and doctors may be too costly, distant or otherwise

inappropriate (for example because of cultural barriers). NGOs are important health care providers in such areas (Fuller 2006). Health care provision is one of the oldest branches of development work, tracing back to missionary hospitals (Green and Matthias 1997). Since then, the development sector has grown and so has the number and size of NGOs (Lewis and Kanji 2009). Despite the increase of development assistance, the list of diseases and health problems remains very long and every organisation in development aid has the task to decide where they want to direct their money and resources to. Heyse noted that every NGO has to select what projects they want to take up, because there will never be enough to cover everything (Heyse 2004).

HIV and AIDS are of great importance for the Dutch government and it takes up a large share of the attention and spending of the Dutch development assistance aimed at health. In 2009 €3.5 billion was allocated for HIV and AIDS related programmes (Ministry of Foreign Affairs 2010b). At the same time, the Dutch government currently spends about a quarter of the budget for development assistance on national and international civil society organisations. Conversely, up to 75 percent of a NGOs budget can be filled with government resources (Ministry of Foreign Affairs 2009). A change in the amount and allocation of the government's budget can therefore be expected to have a great impact on NGOs. The Ministry of Foreign Affairs changes policies on development aid regularly. Sectors that used to be cornerstones could be abandoned, cuts in overall budgets are made, ideas about how development organisations should operate change, etcetera.

However, NGOs are not merely 'contractors' for donors like the Ministry of Foreign Affairs. The NGOs are traditionally based on charitable funds and voluntarism. Every organisation aims for independence to work closely for and with the poor in local communities. Throughout the years, NGOs have also become more and more professional service providers, some with big organisations that stock large amounts of funding and human resources (Lewis and Kanji 2009). The preferences of donors can be different from the work that NGOs already do in their projects with the local community. Over time, new elements are introduced to donor policies, but how do NGOs respond to these kind of changes? Will they secure funding by adapting to the preferences of the donor or pursue the interest of the partner organisations they work with 'in the field'? The link between NGOs and local partners is an interesting one. Most NGOs seek a connection of some sort with the community, to make sure that development activities are aimed towards the actual

needs and context of the local community and involving local organisations in the planning and implementation is one way to establish such a connection (Lewis and Kanji 2009). Prior to starting this research, I did not hear of one organisation that does not work with local partners and does not proudly state that their objective is to work together with the poor and build capacity. On the other hand, some of the representatives have (sometimes on-, but mostly off-the-record) said that every NGO states this ideal, but in fact most decisions about what development priorities should be, are made by the funding partner. Could this also explain the out of proportion donations Rwanda receives for a disease that is not one of the most impactful in the country?

In Figure 1.1, the relation between donors, Dutch NGOs and their local partners is portrayed. The arrows indicate that all three actors have influence on each other. Institutional donors have influence on the Dutch NGOs (arrow downwards), but there is also an arrow upwards, meaning that NGOs themselves can also provide input and question the ideas of the donors. Between Dutch NGOs and their local partners there is also influence in both directions.

Figure 1.1: Relationship between different actors in development aid

Authors like Koch et al. (2009) have already pointed out how NGOs tend to follow their back donors and other NGOs when it comes to selecting countries they will work in. The question remains if the thematic priorities of NGOs also change along with donor preferences. This can be important because already in the brief introduction above appeared that the health problems with the highest mortality do not necessarily receive the most attention by means of development aid. One example is noted by Shiffman (2006), who calculated that of all non-communicable diseases, acute respiratory infections

comprise more than a quarter of the burden, but only 3 percent of direct aid is aimed at it. His research data only stretch the contributions of institutional donors and fall short of examining the NGOs, which play a huge role in health aid. In short, there are many important questions about what drives the thematic choices of NGOs.

In order to find out more about how thematic choices regarding HIV and AIDS are made, studying the internal process of decision making is very important. NGOs cannot operate in complete isolation, the organisations are influenced by and are accountable to various actors, like donors, local communities and partner organisations (Lewis and Kanji 2009). To find out how these influences are processed within the organisation, the 'black box' of NGOs has to be opened. Organisations are not entities that make decisions on their own; it is the people within the organisation that 'create' a decision (van der Krogt and Vroom 1995; Hilhorst 2003). Various factors can influence people; for example knowledge about the gravity of health problems, information from actors outside the NGO (the preferences of local partners and donors for example), constraints within the organisation (are there enough resources to start a new activity? Is the area safe enough to start a programme?), the history and culture of the NGO and finally the individuals own power and charisma to legitimize a decision (van der Krogt and Vroom 1995; Heyse 2004). Placed in between two other important actors (as shown in Figure 1), the activities of NGOs are not just a rational consequence of the input from both sides. Instead, the input gets handled and processed, leading to a strategy that is unique for the organisation.

1.2 Research objectives

In this research the allocation of development aid for health by Dutch NGOs is studied. The focus is on the position and importance of HIV and AIDS. The first main question is: do NGOs prioritize HIV and AIDS over other health problems? It is hypothesized that NGOs follow their donors in assigning priority to certain health problems. What I want to add with this research, however, is a broader perspective on donor-recipient influence than merely stating that 'he who pays the piper calls the tune.' That is why this study also pays attention to the way priorities come to life within organisations, how decisions are made and how organisations respond to a changing policy environment. Is it only the financial relationship that can divert a NGO away from their own priorities? Another reason could perhaps be that donors list their interests based on other reasons than what is needed from the perspective of an NGO. The context of people making policies is likely to be different

than the context of a given community in need of certain services. Assuming that NGOs have close relations with both, an important question is how the organisations balance these two interests. How do they find possibilities to make the 'two worlds' come together in their programming? Central in this study will hence be the planning and prioritization of HIV and AIDS related programmes and projects within Dutch NGOs. HIV and AIDS is chosen as a case, because of its position in global health and many NGOs have experience with activities in this area. Therefore, this case is suitable to examine the questions raised about NGO's responses to policy changes.

In short, NGOs are heavily depending on Dutch government funding and at the same time they are expected to provide aid in close partnership with local partners. In the current debate about the effectiveness of development aid it is useful to know more about how NGOs juggle these two aspects and come to coherent programming.

1.3 Research questions

The central research question posed at the start of the this research is:

How do NGOs respond to the prioritization of HIV and AIDS by donors, and what does that mean for the NGOs' allocation of aid to other health (care) problems?

Subquestions are:

1- Is the Dutch government – as a part of the larger donor community - indeed prioritizing HIV and AIDS over other health care issues?
2- How do Dutch NGOs allocate their funding to HIV and AIDS and what is the content and context of the activities?
3- How do NGOs react to prioritizing of HIV and AIDS and programme adjustments?
    a. Does budget allocation of NGOs follow the government's priorities?
    b. How do NGOs decide a specific problem is their key target and not something else?
    c. What role did assessments of local needs play in the prioritization?
4- Is there displacement of aid (a mismatch between needs for a certain service and allocation of money)? What aspects of decision making in NGOs makes this possible?

Soon after starting collecting the data, it was found that HIV and AIDS are no longer uncontested priorities for both donors and NGOs (see subquestion 1). This finding was unexpected and it drew the attention to studying the reasons NGOs gave for the decreasing investments in HIV and AIDS. The second subquestion changed subsequently. Instead of asking how Dutch NGOs allocated their funding towards large health problems, it is now only focused on the changes in the content and context of the HIV and AIDS programmes themselves. This change allowed to focus more on the 'life-cycle' of the topic HIV and AIDS. Subquestion 3 and 4 remained the same and are still valid, even though I started with the assumption that funding would still be rising.

1.4 Research methods in short

The purpose of this study is to better understand NGOs decision making processes in the light of a multitude of health problems by converging both quantitative and qualitative data. In the study, quantitative data will be obtained on the allocation of resources to HIV and AIDS by the Dutch government and a selected sample of Dutch NGOs. This is meant to address the relationship between donor prioritization of HIV and AIDS by the Dutch government and the allocation of aid by NGOs. At the same time, the context and process of decision making within NGOs will be explored using in-depth interviews and document analysis with three or four NGOs. The rationale for using both quantitative and qualitative data is that the –relatively straight forward- quantitative data will show the relevance and extent of the problem. In-depth qualitative data on the other hand will put the numeric results and broad trends in the proper perspective.
(Modelled after Creswell 2003)

2 - Theoretical framework

2.1 Health and development

Health and care are important aspects of development aid. People and organisations involved in development aid often stress the importance of health in poverty reduction. It is hard to establish the exact relation and the direction of the causal link, because both health and poverty are difficult to quantify and define. Nonetheless, researchers have frequently identified a clear correlation between health and poverty (Parker and Wilson 2000; Skolnik 2008).

- Illness decreases the ability to gain income, because people feeling ill usually do not work or work less. Health, on the other hand, increases productivity. When disease takes epidemic or endemic forms, the entire economy of a country or area can be destabilized. Poverty and low education also increases the chances that people are forced into jobs in unsafe work environments that carry health risks (e.g. working with chemicals or sex work) (Beaglehole and Bonita 2004).
- It is known that healthy children have higher school attendance and perform better. Proper education will also increase productivity and income later on in life. Educated people usually have more knowledge of hygiene and healthy behaviours, which is another determinant of health (Skolnik 2008).
- Undernutrition is a huge health problem and poverty can easily set off hunger. An inadequate diet means that the body is more vulnerable for infections and less able to fight off diseases. The effects of undernutrition strike children under five hardest. Because undernutrition also limits cognitive development, it means that children will learn less in school and be less productive later on in their life (Skolnik 2008).
- In many developing countries the health care system is itself underdeveloped or too expensive and therefore inaccessible for the poor citizens. Large payments for health care can also push people into poverty. Health care services can also literally be inaccessible and too far away, particularly for those in rural areas (Parker and Wilson 2000).
- Poverty usually comes with living circumstances that are negatively influencing health. Most important are a safe water supply and good sanitation (Beaglehole and Bonita 2004).
- Social status is also linked to health. Inequalities in society can mean that the health of for example women or ethnic minorities is compromised. Especially women are

confronted with unequal access to medical care and unequal distribution of food within the household (Beaglehole and Bonita 2004).

All these aspects of poverty clarify how intertwined health and development are; it is therefore not surprising that large parts of development aid are aimed at health and health care. Recently, the Dutch Scientific Council for Government Policy (WRR) questioned the investments in health and health care made by Dutch development actors. The council believed that poverty might reduce health, but that efforts to increase health will not lead to poverty reduction (WRR 2010).

2.2 HIV and AIDS

'HIV and AIDS' is the aggregate term for a complex sickness. In the 1980s, the human immunodeficiency virus (HIV) was identified and linked to the symptoms that we have come to call AIDS (acquired immunodeficiency syndrome). HIV causes a slow, but steady breakdown of the body's immune system, making it more susceptible and unable to fight off other infections. Within five to fifteen years after infected the patient will develop AIDS. AIDS is thus not a single disease, but a number of diseases that occur because the immune system fails. Because the body is no longer capable of fighting off opportunistic disease, the patient will die (Barnett and Whiteside 2002).

Compared to other infections, HIV is a virus that is relatively hard to transmit, because it can only spread through contaminated body fluids. The main route of transmission is through sexual intercourse. It can also be transmitted from mother to child during pregnancy, delivery and breastfeeding. Other ways of transmission are the use of contaminated blood, blood products or organs, sharing needles among injecting drug users and injuries with contaminated needles or other medical equipment (Davey and Hart 2002).

There is no cure for AIDS and it is also not likely that a vaccine against HIV infection will become available soon. The opportunistic diseases that occur (like tuberculosis and other common infections) however, can be treated with drugs (Davey and Hart 2002). In a later stage of infection, when the immune system starts deteriorating, treatment is possible in the form of anti-retroviral therapy (ART). These drugs suppress the HIV infection directly. Used properly they can prolong life and ward off opportunist infections (Barnett and Whiteside 2002). The two major problems with ART are the costs and adherence

problems. ART is expensive and requires not only the pills itself but also regular check-ups and laboratory testing. This means that this treatment is out of reach for many poor people. ART is a cocktail of up to 18 pills per day that all have to be taken at defined times of the day. This can be problematic because adherence to this very strict regimen is crucial for success. Another danger of missing pills is that drugs-resistant strands of the virus start occurring (Davey and Hart 2002).

Preventing the spread of the virus has been fairly successful for transmission trough contaminated blood, injuries and needle-sharing. Blood and organs are now widely (but not always) tested for HIV infection, needle-exchange programmes have reduced infections among injecting drug users. The chances of mother-to-child transmission during birth can be reduced by administering anti-retroviral drugs (Davey and Hart 2002). Breastfeeding enhances the risk of HIV transmission, but using formula-milk instead is not always a viable alternative for poor families. Most prevention programmes are now aimed at reducing sexual transmission. Reducing risks of transmission is sought through a variety of interventions; promoting good sexual health by treating sexually transmitted diseases (STDs) early, discouragement of unsafe sexual practices, using condoms (properly) and changing sexual behaviour (Barnett and Whiteside 2002) .

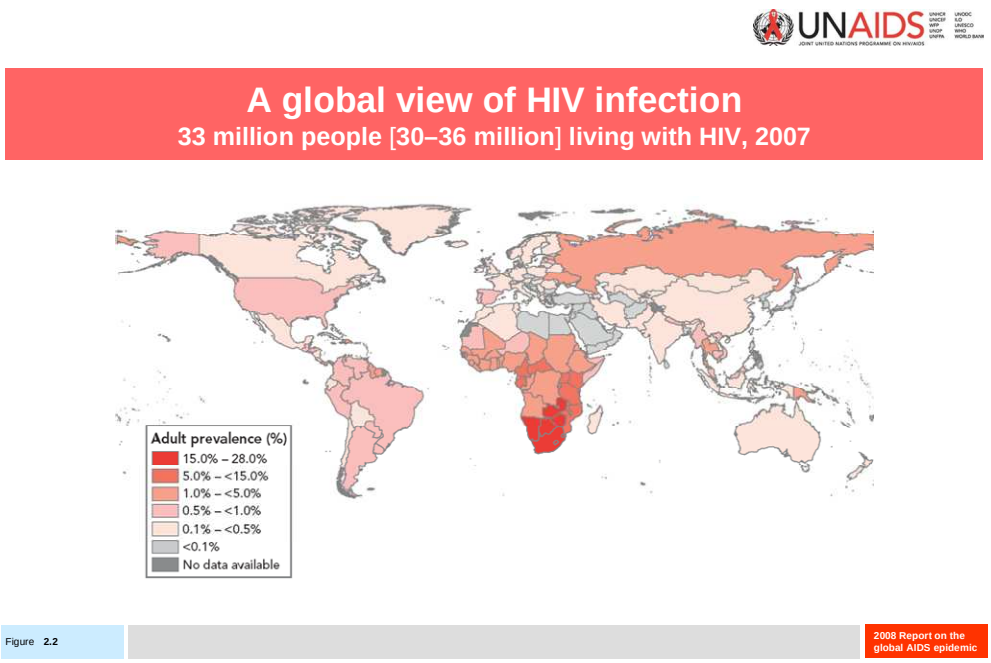
2.3 An overview of the epidemic

Table 2.1: The statistics on the global HIV and AIDS epidemic

Number of AIDS deaths to date	25 million
Number of AIDS deaths in 2007	2 million (of which 75% in Sub-Saharan Africa)
Number of people living with HIV and AIDS	33 million (of which 67% in Sub-Saharan Africa)
Number of new infections in 2007	2.7 million
Percentage of all new infections that are females	50% (in Sub-Saharan Africa 60%)
Percentage of all new infections that occur among people aged 15-24	45%
Children younger than 15 with HIV	2 million (of which 90% in Sub-Saharan Africa)
Number of HIV infected people on ART in low- and middle income countries	3 million (which is 31% of those who need medication)

Source: UNAIDS 2008

Figure 2.1: ‘A global view of HIV infection’



Source: UNAIDS 2008

2.4 Social and economic consequences of HIV and AIDS

The effects of HIV and AIDS reach far beyond the medical aspect of the problem. HIV and AIDS are health problems that have devastating effects not only for the individual patient but also for entire communities and societies (Barnett and Whiteside 2002). It is not coincidental that this chapter started with a elaborate description of the ways health and poverty are linked. The mechanisms and effects described there, are also relevant in studying HIV and AIDS;

- AIDS affects people in the prime of their lives, in their most productive years. The disease will render people unable to raise an income for themselves or their families. The other spouse will usually be taking care of the ill, often being infected or even sick themselves as well. In countries with high prevalence, economic growth will be lower because many productive employees are lost to aids (Barnett and Whiteside 2002).
- Children in the family can face several problems. They might be infected themselves, have to take care of their ill family members and in some cases raise the household income as well. For all these reasons their school attendance will be low. After the death of their parents, children are usually taken in by the extended family (JLICA 2009).

- Fear of discrimination and being stigmatized can shy people away from testing themselves or their relatives for HIV. In some areas HIV infected persons can get excluded from their jobs, schools, communities or even their own family. Stigma and inequality makes it hard for the patients and their family members to continue their roles in society, for example when widows are denied access to their husbands property (Hivos 2009)
- Treating the illnesses associated with AIDS is expensive. Effective drugs may not be available, it can cost too much, or there might not be enough supplies around. The health care system itself can be affected when productive personnel itself is struck with aids (Barnett and Whiteside 2002).

2.5 Linking poverty to HIV and AIDS

HIV and AIDS thus influence the social and economic fabric of a community, or even an entire country, but can these social and economic factors also influence HIV and AIDS? In its bi-annual reports on the epidemic, UNAIDS notes that HIV infection occurs in a social, economic and political environment. Living in poverty and under discrimination increases vulnerability for infection (UNAIDS 2004 & UNAIDS 2008). Stillwaggon explains the positive correlation between poverty and HIV infection rates by saying that –just like other infectious diseases- people are more susceptible for HIV infection when they are malnourished and the body's immune system is weakened by other parasitic infections. Both these factors, combined with little access to health care and poor general health, pave the way for HIV infection (Stillwaggon 2005). Illiteracy and lack of education, which are associated with poverty, can also mean that prevention interventions are out of reach. Poverty can be so acute that the time-horizon of a person shrinks to day-to-day survival. In those cases a long-term risk like HIV infection is not considered, because immediate survival can call for behaviour that increases the risk for infection (e.g. commercial sex work) (Fenton 2004). In all, this means that HIV/Aids is not an isolated health problem, treating and preventing it is therefore not just a matter for the health care sector in a country. It is intertwined with other development issues (Schoepf 2001).

Considering the correlation between poverty and HIV and AIDS, it might be bewildering that two of the wealthiest countries in Africa, notably Botswana and South Africa, are also the two countries with the highest HIV prevalence. However, the national figures may

‘cover up’ large inequalities within the countries (Barnett and Whiteside 2002; Stillwaggon 2002).

2.6 Development interventions for HIV and AIDS

Since the start and growth of the epidemic many organisations and governments are actively try to diminish its impact and limit the spread. Ranging from UNAIDS, which is the first and single organisation of the United Nations (UN) dedicated to one disease, to tiny organisations with budgets as limited as a couple of thousand dollars a year. While some organisations work with local communities, others prefer to work at different levels and want to change public and political opinions (Lewis and Kanji 2009). The interventions of all these different organisations and institutions can be aimed at treating as well as preventing HIV and AIDS.

Regarding treatment, most interventions are aimed at increasing the number of people on ART medication. Some larger institutions try to convince pharmaceutical companies to release the medication at prices affordable for poorer governments. Others focus on providing those who already suffer from AIDS with care and support (Barnett and Whiteside 2002).

The majority of all interventions are now aimed at prevention. Most commonly implemented are: voluntary testing and counselling (because many people are unaware of their HIV status and pass it on unknowingly), preventing mother-to-child transmission by administering ART to pregnant women, needle exchange programs, screening for and treating STDs (sexually transmitted diseases), stigma reduction and providing information and education about HIV and AIDS and how to reduce the risk of contracting it (Barnett and Whiteside 2002). Some prevention interventions are criticized, because having knowledge about AIDS and how to prevent HIV infection does not automatically mean that participants will adopt new – healthy – behaviour. Stillwaggon (2005) has argued that there is too much focus on the fact that HIV is spread through sexual intercourse. That focus shifts interventions towards behaviour change, but changing sexual behaviour is a sensitive and difficult topic to discuss. In her view, the policies on HIV and AIDS focus too much on the transmission and treatment of it and too little on the socioeconomic factors that make people susceptible for contracting and transmitting the virus (Stillwaggon 2005).

2.7 Global funding for health and HIV and AIDS

The Netherlands is the number one per-capita donor for HIV and AIDS, and the third international donor in absolute terms, right after the United States and the United Kingdom (Ministry of Foreign Affairs 2008). Overall, funding for health has increased enormously over the past decade. It is not certain by how much exactly and it is also impossible to estimate such figures because of the multitude of different actors (McCoy et al. 2009a). A rough estimate is that about a quarter of the global funds for health are now aimed towards HIV and AIDS (Shiffman 2008). This may seem contradictory, when compared to other diseases that may occur more often, but receive less attention. Elsewhere, Shiffman et al. (2002) and McCoy et al. (2009b) note that priority and funding for a certain disease does not just depend on its burden, but also on factors like the possibilities and technologies available to treat a disease, the likelihood of transmission and whether the disease can be a threat to the public health in donating country itself. Halmshaw and Hawkins (2004) acknowledge that the rise of HIV and AIDS can also be challenging for the community sector that receives the money. Not every organisation has the 'absorptive capacity' to channel the money appropriately create the highest impact for the beneficiaries. In such cases personnel is limited and organisations may feel pressured to scale-up interventions too quickly.

2.8 NGOs in health and medical aid

In some situations non-governmental organisations (NGOs) are the most important, if not only, providers of health care, for instance when a conflict or natural disaster has paralysed the existing health care system. Charitable organisations also have a long history in the health sector. Christian missionary organisations were present in developing countries from the 19th century onwards where they ran hospitals and provided primary care. The involvement of international NGOs like the Red Cross and Oxfam is relatively recent (Green and Matthias 1997). It is unknown what proportion of all the health care that people use is given by NGOs. It is however evident that the NGO sector is growing and that their activities are a significant element of the health care services in many developing countries (Green and Matthias 1997; Pfeiffer 2003). The NGOs provide a wide range of services, from emergency care right after a natural disaster to long lasting facilities for primary health care and health education. Some NGOs concentrate on eradicating one particular disease, for example through a vaccination campaign, while others focus on wider areas like preventing maternal death. Other NGOs find it more promising to invest in the health

care system. All these approaches have their own advantages and downsides and much debate goes on about what kind of interventions are most effective to achieve the common goal of a healthier population (Gellert 1996).

Throughout the years, trends can be discovered in what kind of interventions are favoured. In health, there has been a gradual shift from focusing on treating individual diseases ('selective biomedical interventions') towards more attention for health and heath care in general. This integrated approach created an upsurge of prevention programmes (Gellert 1996). In recent years 'community participation' and 'empowerment' have become key words in health development programmes (Lewis and Kanji 2009). A reoccurring criticism is that development aid aimed at health focuses too much on western ideas of what is healthy and what is not (Foster 1999). Pfeiffer (2003) also criticizes the way the expats working for NGOs, cooperate with local health care providers and authorities. Their conduct would undermine the establishment of a solid health care system for the local communities by seeing the local health care and government more as obstacles in the way of the NGO projects rather than partners.

2.9 NGOs between donors and beneficiaries

Many authors have commented on the organisational characteristics of NGOs and how the organisations work. There are also several attempts to categorize NGOs among characteristics like their relationships with partners, local governments or donors, their degree of independency or tasks that the organisation takes on (service delivery or capacity building for example) (Stoddard 2003; Green and Matthias 1997). In this setting it is important to know that all NGOs are private (i.e. not part of the government), not-for-profit organisations, whose aim it is to 'improve the quality of life of disadvantaged people', but that the variety among all the organisations that are called NGOs, is enormous (Lewis and Kanji 2009). According to the same authors, NGOs have broadly three roles. Firstly, as implementers; NGOs mobilize resources and with those they distribute goods and services to those in need. Secondly, NGOs can be 'catalysts'. This means that NGOs initiate change and action among the people or actors they work with. An important example is lobbying and advocacy work. Third and last, the NGOs role as partners in joint projects is emphasized (Lewis and Kanji 2009).

One of the important partners that NGOs have are their donors. Edwards and Hulme (1996) studied the relation between these two actors. At the time of writing the article, donors were enthusiastic about diverting their money through NGOs, because they were private actors and believed to be able to reach the poorest of the poor. Since then, this enthusiasm silenced (Lewis and Kanji 2009). Edwards and Hulme (1996) have the critique that NGOs are not necessarily the best service-providers and that when NGOs receive more of their funding from governments they will be less able to continue an independent relationship with these donors (Edwards and Hulme 1996). This assumption is important for this research because it would mean that Dutch NGOs that are heavily funded by the Ministry of Foreign Affairs or any other institutional donor, will be unable to define their own aims and priorities regarding health and HIV and AIDS in particular.

Studying the allocation of aid and the priorities of NGOs automatically means paying attention to decision making and policymaking in the organisation. Mosse (2004) believes that the practice of development is out of reach of the policy models that ought to describe that reality. Policy is important for NGOs because it mobilizes resources and attention, but it never functions as a guideline for action in the field. He further states that success of a programme does not mean that a policy model is turned into reality, but rather that the organisation has succeeded in framing the effects of the programme to fit in the policy model. He concludes that improving development aid is not just a matter adjusting and fine tuning policy models, but equal attention should be paid to understanding the actors in a programme (Mosse 2004). If indeed Edwards and Hulme (1996) above are right about the lack of independency of NGOs, that would mean that NGOs would show their dependency on a donor by displaying the results of a programme in such a way that it fits into the policy models that the donors set up.

In similar fashion, Schennink et al. (2006) state that NGOs usually operate in different ‘domains’. These domains can be the interaction and relation with local partners, international organisations, the home-country, internal culture, etcetera. What works for the NGO and is appropriate in one domain may not be in another. Regarding policy making this means that the plans have to be acceptable in all domains. Broad and vague policy goals can help NGOs in reconciling differing interest in various domains. Another interesting observation is that implementing actors make practical decisions not by applying the policy, but rather pragmatically (Schennink et al. 2006).

What all these authors seem to have in common is a degree of scepticism towards methodically defined policy plans and objectives and their use in practice. All seem to conclude that policy is a tool to negotiate different interests. Policy is also a ‘blank slate’ that can be filled in and used creatively to describe what the NGO chooses to. In the case of priorities of health topics this would imply that the preference to work on certain diseases is also negotiated and part of that creativity.

3- Research methodology

3.1 Research strategy

The main methods of data collection in this research were qualitative interviewing and examining quantitative data of NGOs on the content of their programmes. The first phase of the research was exploratory in nature; the aim was to find out more about the scope and field of HIV and AIDS and health development aid in general. Part of that was studying quantitative data on the allocation of resources by the Dutch government and a sample of Dutch NGOs. At the same time a series of in-depth interviews started. Beginning this research I set out to complement the second phase of the research with three to four case studies, but unfortunately this aim could not be met. The most difficult problem during this research was gaining access and trust in the organisations. The scope of this research did not allow for prolonged participatory research or fieldwork, so that particular possibility of gaining access was unavailable. To reduce this limitation, more variety of respondents was sought. So instead of having multiple interviews within one organisation that could have lead to lead to two or three very detailed case-studies, I opted for more individual interviews with a larger variety of different organisations.

Starting the research, there was little 'hard data' on the prioritization by NGOs of HIV and AIDS and how this is preceded by donor interests. The knowledge so far rests on case studies, anecdotal evidence and in-depth ethnographic data. The inclusion of quantitative aspects in this research shows the scope and relative importance of displacement of aid. Relying on statistical data only, on the other hand, would also be limited because then the opportunity to interpret the data in the highly complex context that is development aid by NGOs, would be missed. By bringing together strands of both research strategies, more sophisticated and nuanced conclusions can be drawn. Using multiple methods was a good option since I was able to put different data in perspective. Sometimes the interviews confirmed or contested data from other sources. These contrasting ideas and responses expanded my understanding of the research problem.

At first, the aim was to study the priority of HIV and AIDS compared to other health issues. During the research this appeared much harder than thought. Many NGOs do not consciously compare these priorities; at least it appeared that way during the interviews. This finding will be further analyzed other chapters, but it also meant that I got much more

into detail about the changing content of the HIV and AIDS activities (approaches, strategy, recurring topics, etcetera) and how they were organised within the organisation.

I started this research assuming that funding for and priority of HIV and AIDS were still rising. During the data collection phase I noticed that this was no longer the case. This new basis called for new questions: how and why did the attention get less? How does that change the approach to HIV and AIDS by NGOs? Hence the question how the priority of HIV and AIDS stands out against other health problems became less relevant.

3.2 Research methods

The first, exploratory, phase of the research consisted of two activities, taking place concurrently, at the same time. First, quantitative data on the allocation of resources by the Dutch government and a sample of Dutch NGOs, were collected and studied. The aim was to find out if there is really a correlation between the government's and NGO's priorities and to give an overview of the organisational characteristics and activities of the NGOs.
By examining resource flows and the topics of the programmes, a large deal can be learned about prioritization. The saying that 'action speaks louder than words' is kept close to mind. The option of gathering data first-hand (for example through a survey) was rejected from the onset, because collecting these kinds of data would be very difficult and time-consuming. That is why preference went out to collecting correct and representative secondary data, for example from annual reports.

During the research I found a number of studies that already collected and compiled data on the activities of Dutch NGOs regarding HIV and AIDS. These documents provided good background information but never a full and recent quantitative overview. Later on I found that even organisations themselves had difficulties assessing exactly how much is spent on each of their activities and themes. Most NGOs also have their own means and formats to release data, which made comparisons extra hard. For example, NGOs are required to report annually on the content of their programmes, but most of them do so in different ways. There are barely any uniform 'labels' that NGOs use to categorize the activities in their programmes. In practice collecting the data was not limited to the start of the research. Usually respondents from the interviews had extra information and explanations to use in this phase.

Second, I conducted a limited number of interviews to get familiar with the field and test ideas and assumptions I had established from the theory. These initial interviews also proved beneficial further along in the research, because they provided a ‘safe place’ to probe interview questions and techniques, which became more refined throughout the research period. Another benefit of these first interviews was that they could provide an entry-point for further research and interviewing within the organisation.

As the second phase of this research, I wanted to conduct three to four case studies. These would allow focus on one specific HIV and AIDS related programme of one organisation. Tracing back how projects start and end would give more insight in the process of decision making. In the case-studies I planned to use in-depth interviews with employees with various responsibilities and document analysis as the main methods of data collection. However, this phase rested totally on the possibilities and willingness of the organisations to cooperate. In practice, it was possible to arrange one interview, typically with an HIV and AIDS or health advisor, but this hardly led to possibilities for further investigation. The reasons listed were that a case study would take too much time. The requests for participation were prepared carefully, leaving no doubts about why I was approaching them, what my research is about, what I wanted to do in their organisation, if my activities would be disruptive, how I would deal with the (possibly sensitive) data and what the NGO itself could possibly gain from participating. I noticed that sometimes these detailed approaches possibly daunted people thinking this research would be much more intruding than it would probably be.

For the conduct of this research it meant that there could not be detailed case studies. I did manage for two organisations to interview a local counterpart as well, and in one organisation I conducted two interviews with people in different positions. Overall, I shifted to a broader focus: I conducted more ‘single’ interviews with different organisations, instead of more interviews within the same organisation. The advantage of this was that I got a more complete view of the HIV and AIDS activities of the Dutch NGO-sector as whole; this would not have happened if I had focused on a few cases. It also allowed me to compare organisations (for example secular and Christian-inspired NGOs) in how they arranged the HIV and AIDS related activities.

3.3 Data collection

I started with making a selection of Dutch NGOs that are involved in HIV and AIDS related activities. This period of desk research allowed me to collect available documents like annual reports, strategic plans, HIV and AIDS polices if available, etcetera. These documents and other information provided via the websites of organisations gave me a good basis to get a good view on how Dutch NGOs are organised and what they do related to health and HIV and AIDS. The desk research on Dutch NGOs also gave ideas on who I could approach for further research. By selecting actors with different backgrounds, different points of view will surface, which is helpful when getting to know the full field. I approached potential respondents an e-mailed request in which I gave information about my research plans and what I would like from them, accompanied with a letter of recommendation from Wageningen UR. In case I had no contact details or any idea who to contact within the organisation, I called to enquire who I could approach. Most times, my request was passed on to (one of) the programme officers or advisors in the NGO with HIV and AIDS in his or her portfolio.

In all, I approached 17 NGOs and three employees of the Ministry of Foreign Affairs (in two different departments). Of the NGOs I approached, four did not participate. In two cases I received no clear decision, despite regular efforts to get in touch. For two other NGOs it was easier to get contact with the right person but my request was declined. Both organisations indicated that they had not enough time to participate in this research. Within the Ministry of Foreign Affairs I approached various employees of the department Health and AIDS and one in the department Civil Society Organisations. One person did not want to participate and another one brought a colleague along to the interview. In all, I conducted 18 formal interviews; 15 with people who worked for 13 different NGOs. Within two organisations, I interviewed two different persons. Apart from these people, I had contact with three other persons, that do not work on HIV and AIDS directly, but are involved in another way. One respondent that was interviewed works for a research institution, another one is an independent consultant and the last works for Partos, the organisations that represents Dutch NGOs. With the last two persons, I did not have a formal interview.

Eleven of the interviews were conducted face-to-face, in the offices of the respondent. At the request of 5 respondents, the interview took place via phone or Skype. In two cases,

there were no possibilities to do an actual interview so that the questions were posed by e-mail and respondents wrote out their answers. A full overview of the respondents and conducted interviews can be found in Annex 1.

More than once a respondent was reluctant to agree on participation because they thought their organisation was not 'interesting enough', when it came to HIV and AIDS programming. When asked further it often appeared that these organisations used to have HIV and AIDS specific programmes, but that the theme gradually became less important or it was integrated in other programmes. The interviews with these respondents were useful to gain insight in *how* HIV and AIDS became less important and how this trend was perceived within the organisation.

The topics and questions of the interviews varied per organisation. Most of the time the specific characteristics of an organization or programmes prompted specific questions. For example a question regarding the religious identity of the NGO or a joint programme on HIV and AIDS with international partners. The employees of the Ministry of Foreign Affairs and respondents that worked for a local branch of an NGO were also asked specific questions. A topic list can found in Annex 2.

3.4 Data analysis

The phases of collecting and analyzing the data usually overlapped and were conducted at the same time. Initial analysis prompted new questions for the next phase of the research. This also happened the other way around when information gathered during an interview shed new light on earlier findings. Recordings and the notes taken during the interview were the basis of the analysis. Except two, all of the live interviews were recorded with consent of the respondents. These interviews were not transcribed, but were used during analysis to check the notes. In most cases, my memory and notes corresponded with the tapes. Most respondents appeared comfortable and confident answering the questions during the interviews. I anticipated the possible confidentiality of the data and that people may not want to speak openly about their experiences in sensitive cases and perhaps give 'politically correct' answers. In this report I chose to make all quotes anonymous and limited the chance that certain findings or anecdotes can be traced to one organisation.

4 – The global agenda on HIV and AIDS

4.1 Introduction

The aim of this chapter is to give an overview of the global trends and developments in addressing HIV and AIDS. The sources for this chapter are literature, policy documents added with the interpretation of these data from the expert interviews.

4.2 Origin and growth of the epidemic in US and Europe

Even though some researchers claim to have found cases of AIDS in the 1950s and 1970s, it is only in the 1980's doctors in the United States began reporting and ringing the alarm about unusual cases of illness and death among otherwise healthy young men (Iliffe 2006; Susser 2009). Researchers renamed the syndrome to its current name: Acquired Immunodeficiency Syndrome, in 1983 (Barnett and Whiteside 2002). Patients were discriminated because AIDS was discovered among already stigmatized groups; gay men, sex workers and injecting drug users. Fears and discrimination also delayed adequate responses from national governments to prevent the spread of AIDS. National authorities in the US ignored the problem and so did mass-media. In the UK, media enhanced stigma by portraying AIDS as sign of and punishment for sexual promiscuity and drug abuse (Davey and Hart 2002). Early prevention campaigns were sometimes even reinforcing stigma by explicitly mentioning the groups that were in danger of contracting AIDS and on the other hand urging the general population not to indulge in sexual promiscuity. Campaigns to promote safe sexual practices were deemed too explicit to apply for government funding in the UK (Davey and Hart 2002). This situation shaped the first response to HIV and AIDS in Europe and the US. Campaigns were initiated at grass-roots level and aimed at specific target groups and risk behaviours (like unsafe sex among gay men or using non-sterile injecting equipment) (Davey and Hart 2002).

At the beginning of the 21 century the majority of new infections were caused by unsafe heterosexual intercourse and HIV is no longer confined to certain groups in society (Singhal and Roger 2003). Even though treatment has been on the market since the late 1990's, these ARVs (anti retroviral drugs) could not cure the disease. (Davey and Hart 2002). The availability of these drugs in high-income countries led to a belief there that AIDS is treatable and no longer a 'death sentence'. Later on in the research, one respondent mentioned this trend to explain decreasing public support for HIV and AIDS

projects elsewhere in the world. It also became apparent that behaviour change does not automatically follow health education. Social norms are just as important in individual behaviour and can 'overrule' knowledge about safe-sex practice, for example. This is also one of the current and biggest difficulties in HIV reduction. The social and cultural context and perceptions of sexual activity and AIDS are enormously influential and also difficult to change (Singhal and Rogers 2003). In Chapter 7 will be shown that despite these challenges, many NGOs prefer to do activities that aim to change sexual behaviour.

4.3 From epidemic to pandemic

HIV and AIDS are global phenomena in the true sense of the word. Africa is the worst affected continent; two-thirds of all new infections occur here. In southern Africa there are countries in which over 15-20 percent of the population is infected and this has enormous implications for the social fabric, economic growth and life expectancy of the populations of those countries. By now, most new infections occur through heterosexual intercourse. Knowing that women are most likely to contract the virus that way, it also implies that women are now worst affected (Susser 2009). Unequal gender relations make women even more vulnerable for averse effects of HIV infection (Müller 2005). In situations like these, HIV and AIDS programmes by NGOs focus more on reducing the inequalities that underlie these vulnerabilities.

Much of the research and interventions in the field of HIV and AIDS rely on epidemiological data. This means that the epidemic is mapped by giving the number of people infected with HIV, those who have died of AIDS, etcetera. It is important to note that these data are not unambiguous truths. Instead, many uncertainties surround the estimates of HIV incidence and AIDS prevalence (Barnett and Whiteside 2002). In low-income countries, there is hardly any funding to screen anonymous blood samples for HIV, as is done in wealthier countries. HIV testing is done mostly voluntarily and can be expensive, so many cases of infection go undetected in countries where stigma and poverty play a role. Other difficulties occur in assessing the number of people living with AIDS, because AIDS is not single disease but an immunological inability to fight off other infections. The WHO has set up a definition of AIDS that consists of weight loss, diarrhoea, fever and one of the opportunistic infections that frequently occur in HIV-infected persons (Barnett and Whiteside 2002). In 1993 tuberculosis was added to the list of opportunistic infections that define AIDS and, as a result, suddenly the number of AIDS

cases seemed to explode. A weakness of interpreting these data might be that they are usually national percentages and these aggregated data may overlook regional differences. One area can hugely affected and another not, but this information will not show in national data. Another aspect is that large countries with relatively low percentages of infection still account for millions of affected persons lost lives. This is especially true for the HIV and AIDS epidemic in Asia (Barnett and Whiteside 2002; Davey and Hart 2002).

Since the nature of the epidemic and the specific situation can be different on each continent and in every country, or even community, NGOs cannot make uniform plans in their HIV and AIDS programming. Each of these specific situations need a good insight in the causes and drivers of the epidemic, for the projects to be effective (Salden 2009). At the same time, NGOs need to be cautious when relying on official epidemiological data only. Shortcomings in these data may obscure the real scope of the problems in the area where the NGO wants to intervene.

4.4 Governments and national strategies

The strong association of HIV and ADS with sexuality and illegal activities like drugs use and sex work can be the reason why some government hesitate(d) to formulate adequate policies in time. The stigma on the affected groups can lead to public notions that HIV itself is a 'punishment' for what are deemed immoral and illegal activities (Barnett and Whiteside 2002).

Singhal and Rogers (2003) state that a national strategy is effective when there are resources, political will and openness about the epidemic is of utmost importance. According to the same authors the government can help reducing HIV by several means, even in cases where government budgets are modest. First, governments can help by supporting and implementing prevention activities as soon as the epidemic is detected. Openness here can be crucial for reducing stigma. Second, it is important to explore the possibilities to provide treatment. Anti-retroviral drugs (ARVs) may be too costly to provide for the whole nation, but providing pregnant, HIV-positive women with drugs can greatly reduce the number of children born infected. Third, vulnerability for HIV infection can be reduced by addressing underlying problems of poverty and gender inequality. Last, efforts are required that reduce stigma and discrimination of people living with AIDS (Singhal and Rogers 2003).

In reality national AIDS programmes face several difficulties. Often there are not enough physical resources to meet all the needs. 'Involving communities' is not as easy as it seems, because it means having to reconcile many conflicting interests. Also the underlying social problems like inequalities and poverty cannot be changed overnight. De Waal (2006) gives a different explanation that centres around the lack of political will. He points at the absence of commitment from national governments in Africa to do something about HIV and AIDS. Despite the heavy burden, the topic does not rank high on the list of national priorities for government action. Even though not many people deny the very existence of an epidemic, awareness of it does not result in a demand for governments to do something about it, while at the same time demand for assistance by NGOs is increasing. An inactive government combined with stigma, make for challenging conditions for NGOs who want to be active in those countries. Some NGOs opt to advocate the governments in question to do more (or support local organisations and groups who do this), while others set up programmes more or less isolated from the national health system.

4.5 Responses to HIV and AIDS from international politics

HIV and AIDS gradually became a focus for the international community. The largest international health organisation, the World Health Organisation (WHO), set up a Global Program on AIDS in 1987 (Illiffe 2006). This global program supported national aids programs, but is criticized by Iliffe (2006) for imposing WHO's own ideas and strategies uniformly upon the local situation. In 1996 the Joint United Nations programme on HIV and AIDS (UNAIDS) was formed, a United Nations division assembled from nine UN organisations. In 2001, the UN General Assembly held a session on HIV and AIDS. At this occasion the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM, also known as 'the Global Fund') was founded. The funds come from participating UN member-states (Seckinelgin 2002). In the 2000s the WHO started to emphasize the link between development, poverty and health (Seckinelgin 2002). There is still a lot of debate about these linkages, but it did change the global perception of HIV and AIDS. It broadened the scope of the problem, that no longer was conceptualized and treated as merely a health problem, but also as a matter of human rights and poverty. These different views also meant that many more actors and organisations became involved in the response. It also meant that NGOs became involved that did not have a medical background. They also linked HIV and AIDS to broader development issues in their programming.

Apart from international member organisations, many states also have their own programmes against HIV and AIDS as part of development assistance. At the moment, the biggest donor worldwide in absolute terms, is the United States (US). Most notable is the in 2003 launched US President's Emergency Plan for AIDS Relief (PEPFAR). PEPFAR spends most of the money (55%) on treatment, thereby increasing access to ART for many (Levine and Oomman 2009). The programme is also controversial. First, some researchers question that half of the funds is spend within the US or Europe, for example on academic research. Second, the boundaries for funding are under heavy influence of US politics and in the programme's social prevention projects, restrictions were put on the content of the projects (Susser 2009).

In practice this meant that activities on harm reduction, sex workers, sex education for young people and reproductive health (abortion) were not eligible for funding. Instead the so-called ABC-approach (Abstain, Be faithful, use a Condom) was enforced. For certain target groups, this approach was stripped down. In projects for young people only the first part of ABC-formula was promoted ('abstinence-only' projects), for couples the second part (monogamy; Be faithful) was considered relevant and only to risks-groups one could promote the use of condoms. These restrictions met with much criticism, because without discussing all aspects of sexual behaviour, all three the ABC elements, the whole approach is regarded ineffective (Susser 2009). This approach became influential because it reduced the space for activity for a number of NGOs that received funding via this programme. Furthermore, the trend was followed by a number of other donors, that were also headed by conservative governments, much to discontent of the Dutch Ministry of Foreign Affairs. As will be explained further in Chapter 6, the Dutch Ministry prefers and promotes a more liberal/progressive outlook on things. Especially on topics like abortion, young people having sex, use of illegal drugs and contraception, the Dutch ministry promotes openness to discuss the topics at all levels.

The PEPFAR programme is an example of how national politics can have a far-reaching influence on how AIDS is targeted. Through funding relations, the vision of a government can be channelled towards the NGOs that receive funding and implement activities. During this research many respondents mentioned the election of a democratic president in the US in 2008 as a positive impulse for the way HIV and AIDS is targeted globally.

‘What’s very important is the new government in the US. They have a much more progressive look on things. Well, in the field you don’t see the changes at once… However, in PEPFAR you do; they stop with the ‘abstinence only’ and all that… Sure, we are still hopeful. […] Next week for instance, we’ll have a meeting chaired by the Americans about harm reduction. Health care for drug users. They never could have done that with Bush. Couldn’t even use the word.’

Part of this optimism was justified; policies became less restrictive and NGOs who apply for funding enjoy more freedom to set their own priorities (Avert 2010).

4.6 Treatment and prevention campaigns

Without a vaccine or cure available, most of the efforts in the response to HIV and AIDS go to preventing people from getting infected and mitigating the problems for those already infected. Availability of treatment was not an issue in the international debate, even at the time when ART (anti-retroviral therapy) was readily available for those who could afford it. The continued focus on prevention in development assistance was cynically dubbed ‘drugs for us, condoms for you’ by some (Seckingelin 2008). In the beginning of the 21st century the continuous lobby of people living with HIV and AIDS and NGOs who represented them paid of and several initiatives have been taken to increase ART access. It was also made a sub-target of Millennium Development Goal 6 (Reducing HIV and AIDS) (Seckinelgin 2008). The biggest barrier to treatment is its costliness and NGOs often favour to put more effort into prevention activities.

As mentioned previously, prevention of HIV is not a simple task. There is no ‘golden bullet’ for an effective approach. Some critics claim that there has been way too much focus on the sexual transmission of HIV. Authors like Stillwagon (2005) also agree that much more attention should be paid to underlying social problems that make people more vulnerable and susceptible for HIV-infection in the first place, like poverty. The key to prevention is changing behaviour, but behaviour is not only shaped by knowledge of health dangers. In the case of HIV and AIDS it gets even more difficult because it is about sexual behaviour, which is personal, private and often not discussed openly. HIV and AIDS also touch upon behaviour that might be illegal, stigmatized, discriminated against, moralized upon, takes place in unequal relations, is shaped by social and cultural traditions and subject to circumstances, emotions and simply chance (Singhal and Rogers 2003; Muller 2005).

4.7 Discussions of findings

In this chapter the start and growth of the HIV and AIDS epidemic was described, including the international responses to it. It shows that ideas about what constitutes a good HIV and AIDS approach, change throughout time and differ per region. These ideas are shaped by the 'technical' aspects of the disease itself, the history of the epidemic, earlier successful approaches, politics and in the severity of the problems itself. The international consensus also shapes the programmes and activities of NGOs. For example, the focus on prevention activities also shows through in the current activities of Dutch NGOs (this will be discussed further in Chapter 7 and 9. An important question remains how NGOs themselves perceive international trends and how these find their way in their HIV and AIDS related activities.

5 - Dutch development policy on HIV and AIDS

5.1 Introduction

In this chapter the role and activities of the Dutch ministry of Foreign Affairs are studied in more detail. The main sources of information here are the interviews held within the ministry, policy documents and reviews on the subject in other literature.

5.2 The Dutch Ministry of Foreign Affairs

5.2.1 Organisation

In the period 2007-2010, two Ministers worked for the Ministry of Foreign Affairs; one for foreign affairs, one for international development cooperation. In addition there is a Parliamentary Undersecretary for European affairs. Within the Ministry there is a Directorate General International Development Cooperation. It coordinates all the international development efforts of the Dutch government. The structure of this directorate has been revised in 2009. Before that time, HIV and AIDS was in the portfolio of the Social Policy Department, under the Social and Institutional Development Directorate, better known as the Health and Aids department and the Directorate for Health, Gender and Civil Society. Since then the directorate has been renamed into Social Development, including three departments; Health and Aids, Civil Society and Education and Research. The Health and Aids Department list three general priorities: basic health care, HIV and AIDS and sexual and reproductive health and rights (SRHR). The Civil Society Department supports Dutch and international civil society. It is also the department that manages the subsidy programs for Dutch NGOs. Both departments employ approximately ten to fifteen people (source: personal communication during interviews).

5.2.2 Expenditure

Overall, the Dutch government spent €4.614 billion on development cooperation in 2009, which is 0.82 percent of the national income, the gross domestic product (GDP). This percentage is important in the international arena, because in 1970 the member states of the UN agreed to reserve at least 0.7 percent of their country's GDP for development assistance. In 2002, EU member states reaffirmed this promise. The Netherlands is one of the few countries that adheres to this norm, along with countries like Sweden, Denmark, Norway and Luxembourg (Ministry of Foreign Affairs 2010a). On average, countries spend 0.3 percent on official development assistance (ODA). Governments can spend

ODA in different ways. Largely four categories can be distinguished; bilateral aid, multilateral aid, through civil society and others. The last category can for example be public-private partnerships or debt relief. In the Dutch budget for 2010, 27 percent is allocated to bilateral aid, which means that Dutch money goes to a another national budget directly, sometimes earmarked for specific activities. Most of the bilateral programs are set up by the Dutch embassies in the country concerned. Embassies are rather independent in deciding which sectors or themes they want to target. In 2009, the Netherlands had bilateral programs in 39 different countries, called 'partner countries'. In twelve of them, the programme supported HIV and AIDS related projects. 26 percent of the 2010 budget goes to multilateral aid, which are donations to membership organisations like the UN. Another 23 percent goes to the so-called civil society, which are mostly NGOs. Finally, 7 percent goes to public-private partnerships (i.e. cooperation with for-profit organisations) and 6 percent is reserved for debt-relief. The last 11 percent goes to various other posts (Ministry of Foreign Affairs 2010c). It is interesting to note that during the interviews employees of both the Ministry and of NGOs emphasized that The Netherlands channel a higher amount of donations through NGOs than other donors. Stoddard (2003) however calculated that 25 percent of the budget is average when it comes to humanitarian assistance.

At this point HIV and AIDS takes up approximately 8 percent of the Dutch ODA-budget, amounting to €3.5 billion in 2009 (HGIS 2010). However, this is a very rough estimate. For the year 2006, different official government publications give different absolute numbers, ranging between €350 and €450 million on the topics HIV and AIDS and reproductive health combined (IOB 2008). These differences are due to different ways of allocating funds towards themes, which makes it hard to assess exactly how much money goes to specific themes like HIV and AIDS and how it is divided over different channels. One respondent working for the Ministry of Foreign Affairs indicated some of the difficulties that arise:

'Well, we can do it, but it's… […] The structure of our own budget does not give a good insight in what we spend on AIDS. It has only two posts, HIV/AIDS and primary health care. And almost everything has to be put under that. It also means that things that are not AIDS or not specifically about reproductive health, have to be put under those two posts. So that is already a kind of pollution. […] So when you only look at those two posts, HIV and SRHR, you don't get a clear view of what we spend on HIV/AIDS, because other posts also contribute as well. Another problem is allocation; what do you allocate to what? Money that you give to

UNFPA will partly be used for commodities, condoms. That contributes to fighting HIV/AIDS. Do you allocate it to HIV/AIDS or SRHR and if you do it to both, in what ratio?'

Knowing that the figures are estimates and not uncontested truths, in 2009 the division over channels for HIV and AIDS, tuberculosis and malaria combined was as follows; 35 percent via bilateral aid, 49 percent via multilateral aid, 13 percent via support of Dutch NGOs and other posts covered 3 percent (HGIS 2010). In 2008, the inspection office of the Ministry of Foreign Affairs (IOB) evaluated the expenses for HIV and AIDS and reproductive health combined and came to the following division; 33 percent bilateral, 38 percent multilateral, 11 percent NGOs, 16 percent public private partnerships and 2 percent others (IOB 2008). Further back in time it gets even more difficult to trace how much has been spend on HIV and AIDS. Regardless of the calculation chosen, it is evident that NGOs are important, but also minor channels for the donations for HIV and AIDS. This may imply that NGOs rely on other sources of funding to set up the HIV and AIDS related activities.

Most accounts agree on the fact that the funding for HIV and AIDS has risen since 2003 . This is not surprising since in that year UNAIDS called for an intensification of HIV and AIDS efforts and the Dutch parliament followed up to this request by sending a motion to the government, asking it to double the spending on HIV and AIDS (source: personal communication during interviews). At this moment, the allocated funds are no longer increasing. Economic recession and decreasing public support mean that the ODA-budget no longer grows and cuts have to be made. The decision on what priorities is cut then becomes part of politics, as this respondent illustrated.

'Sometimes there is an attempt to keep HIV and AIDS out. But it's not really working. It is more like: "we will cut you a little less than the themes that are not a priority." […] Sometimes the parliament agrees and sometimes they do not agree. Then will put up a big mouth and it depends [if the minister says] "Okay, I will respond" and then they add something or make a cut a bit smaller.'

5.3 HIV and AIDS and SRHR policies of the Netherlands

Since the International Conference on Population and Development (ICPD) in Cairo in 1994 (known as 'the Cairo conference'), sexual and reproductive health and rights (SRHR) became a point of attention in development policies. The conference resulted in an ambitious action plan for 20 years, which is known as the 'ICPD Plan of action' or the

‘Cairo Agenda’, in which states are expected to raise access to reproductive health services. These services can for example be; primary health care and availability of methods for family planning (Meijer 2002). Declarations like the Cairo agenda do not come to life out of the blue. It is known that extensive lobbying by the European Union (EU) played a role in this. Dutch policymakers claim that also the Netherlands played a good part in preparing the minds of other nations before going to Cairo by supporting NGOs and women’s movements from across the world. The Cairo agenda became a marker in the policy debate about SRHR. HIV and AIDS were not extensively debated but regarded as a part of sexual health (IOB 2008).

In 2000 UN member states formulated eight millennium development goals (MDGs). One of them is directly aimed at combating HIV and AIDS. The signing member states pledged to achieve the targets for each goal by 2015. For MDG6 the targets are; ‘stopping and reducing the spread of HIV and AIDS by 2015’ and ‘stopping and reducing the spread of malaria and other diseases by 2015’. Later on another target was added: ‘universal access to anti-retroviral treatment by 2010’. Other health related MDGs are 4 and 5, aimed at reducing child mortality and enhancing maternal health, respectively. The Netherlands was one of the 189 signing states and made achieving MDGs central in its own development policy (Ministry of Foreign Affairs 2010d). Since then HIV and AIDS gained more attention on its own, no longer a sub-topic or attached to SRHR. For NGOs, the MDGs became equally important and many organisations set out their own aims an priorities against the MDGs.

The Netherlands followed the international trend and released a policy note exclusively dedicated to HIV and AIDS in development cooperation between 2004 and 2007. It included the promise to double the funds to €270 million in 2007. This target was easily reached (IOB 2008). Thematically, a number of principles were formally laid out, including the acknowledgment that HIV and AIDS is not merely a health problem, but that it is also a human rights issue, and that preventing HIV and AIDS overlaps with sexual and reproductive health and rights (Ministry of Foreign Affairs 2010e).

In 2008 the inspection office of the Ministry of Foreign Affairs (IOB) released an evaluation of the Dutch SRHR and HIV and AIDS policy. It praised the continuous efforts to keep the topics on the international agenda and also discussing the issues that are more

sensitive (like abortion and the rights of vulnerable (and often) stigmatized groups) (IOB 2008) Furthermore, the report concludes that the Dutch policies are completely in line with international agreements. This is not seen as surprising since they also note that most of these agreements were set up with Dutch input in the first place. On the whole, the IOB is positive and sees no need to change priorities (IOB 2008). It also appeared that the NGOs that received from the Ministry for HIV and AIDS and SRHR, focused on the same priorities as the Ministry did. Since that time, funding mechanisms did not change radically, so it can be expected that in this research there will also be alignment of the Ministry's and NGO's priorities.

By then, a new Minister had come into office of International Cooperation. He laid out his plans in a policy note called 'Een zaak van iedereen' (roughly translated 'Everyone's business'). In it he listed gender combined with SRHR as one of the four top priorities (Ministry of Foreign Affairs 2007). One of the reasons to put that topic in the list is earlier experience and knowledge about the topic within the Ministry which had been gathered in previous years. Another point was that it appeared that progress on MDGs 3 (equal rights and opportunities for women) and 5 (increasing maternal health) was lagging far behind compared to the other MDGs (Ministry of Foreign Affairs 2007). The following quote from an interview with one respondent within the Ministry of Foreign Affairs, shows that policy priorities can also be set quite pragmatically. Needs and progress on certain aims (like the MDGs) are important, but capacity within the organization and personal preferences play a role as well.

'He [the Minister] organized a quite broad discussion about it before and there is also an analysis made of 'where are we standing regarding the MDGs and which ones are really lagging behind?' It was clear that there was no progress with MDG5. That contributed to the fact that he said 'Okay, I will make that one of my priorities.' He could build on what was already there. On what the field is already doing and what it is good at.'

This finding already hints that policy is made not only based upon needs and assessments of the severity of problems, but, as described in 2.9, different factors like the earlier experience with the topic.

The priority was accentuated by formulating a new policy note in 2008 'HIV/Aids and sexual and reproductive health and rights (SRHR) in foreign policy'. This note is the follow-up for the AIDS note from 2004. In this document, SRHR gets more attention, which is not surprising since it is listed as a priority in other policy documents as well. More specifically, maternal health will receive more attention and funding. HIV and AIDS are regarded as important parts of sexual and reproductive health, just like in the Cairo agenda (Ministry of Foreign Affairs 2008b). Overall, the human rights approach is applied. Policymakers perceive the progressive, open attitude of the Netherlands as a comparative advantage among other donors in discussing sensitive topics and put them on the agenda.

5.4 The co-financing system

5.4.1 Introduction and history of the co-financing system

The co-financing system is the most important mechanism for the Ministry of Foreign Affairs to fund Dutch civil society organisations in development aid. Organisations can apply for available funds and the Ministry itself decides who has the best plans and receivers funds to carry out them out. During the interviews many NGOs noted that they financed HIV and AIDS related activities through this system, therefore any changes in it may have implications for those activities.

The co-financing system started in 1965 with four (still existing) NGOs; Cordaid, Icco, Hivos and Novib (now Oxfam Novib). Each organisation represented one pillar in the at the time rather segregated Dutch society (Derksen and Verhallen 2008). This variety ensured public support. The programme existed to full satisfaction until in the late 1980s, criticism of development aid grew. The effectiveness of the aid provided by NGOs was also questioned. With that criticism in mind the co-financing programme was reviewed in 1999. The recommendation that proved most important and influential was to open the program for more organisations. In 2006 the new programme was presented, which is now known as 'MFS-1' (Derksen and Verhallen 2008). All Dutch organisations were open to apply for a share of the funding available for the period 2007-2010. 58 Of the 115 applicants were accepted into the co-financing programme. In 2007, they collectively received €500 million, which is 11 percent of the total Dutch budget for development assistance (Derksen and Verhallen 2008). The MFS-1 system led to some criticism by the receiving organisations. First, they were frustrated by the amount of paperwork and bureaucracy that comes with participating in the application procedure. Second, the system

rewards effective organisations. This should not be problematic, but some NGOs fear that it encourages organisations to aim for quick, tangible results. Difficult and long term work, like supporting local civil society groups, does not produce those impressive quantifiable results (Derksen and Verhallen 2008). The NGOs that have HIV and AIDS related activities do exactly that 'difficult' long-term work like prevention and behaviour change, so the last fear might be unjustified.

5.4.2 'MFS-2'

In 2009, a new policy document on civil society was released that sketched the outlines of the co-financing programme from 2010 onwards, called MFS-2 (Ministry of Foreign Affairs 2009). A first fundamental difference with the earlier programme is that organisations are strongly encouraged to cooperate with others and form 'alliances'. In practice, alliances with other organisations were regarded as a prerequisite and all but two organisations applied for funding within one or more alliances. Second, the budget is limited. Only 30 applicants are going to receive the actual funding which is set at a total of €425 million annually. Most of the other small programs that existed beside the first co-financing programme will be incorporated in the second co-financing program. Third, the Ministry of Foreign Affairs has decided that they would like to see civil society's efforts more in line with their own programs (Ministry of Foreign Affairs 2009). In practice this means that organisations have to spend at least 60 percent of the MFS-2 funds they could receive in partners countries of the Netherlands. NGOs protested to this decision, because they fear this will limit their organisation's freedom and for some it would mean they would have to end existing partnerships (Partos 2009). On March 31st in 2010, the ministry released the names of organisations that passed to the next round of the MFS-2 scheme. This does not mean that funding is secured, but they are invited to hand in their project plans for the MFS-2 budget. 43 alliances applied in the first phase of MFS-2, of which only 20 passed to the second phase (Ministry of Foreign Affairs 2010f). Thus, many more proposals were rejected than anyone expected. The twenty alliances concerned consist of 74 individual organisations that apply for a total sum of €2.8 billion, meaning €560 million each year (Schulpen 2010). The final decisions on the allocation of the budget can be expected around November 1st 2010 (Ministry of Foreign Affairs 2009).

5.4.3 Thematic priorities in MFS-2

The Ministry of Foreign Affairs emphasized that there is no preference for topics or themes in assigning MFS-2 funds. Working within the four priorities of the Minister could lead to some 'bonus points', but people within the Ministry also feel that these priorities are broad enough to fit in any specific interest of the NGO. This broadness is supposed to encourage NGOs to come forward with new ideas and proposals. Indeed, in the assessment of the MFS-2 proposals in the first phase, themes did not play a significant role. Organisations and alliances were judged on their own quality and (expected) effectiveness (Ministry of Foreign Affairs 2009). And so it did happen that what is known and listed as a top priority for the Dutch government, notably HIV and AIDS, is not so well represented in the new co-financing scheme. Much to their own surprise, the consortium of 11 HIV and AIDS specific organisations was turned down in the first round of the procedure. From the reactions on the decisions, it appears that NGOs did expect and anticipated that their proposals would be judged for their thematic relevance (Broere 2010; Schings and Verweij 2010; Stop AIDS Now! 2010). The parliament questioned the Minister about the particular decision about the HIV and AIDS consortium, because they were concerned that HIV and AIDS projects would disappear. In his reply the Minister noted that the alliances were judged for their organisational qualities, not thematic relevance. Second, he noted that five other alliances that did pass to the next round also have HIV and AIDS projects, and that more money goes to HIV and AIDS through the multilateral channel than through civil society (Ministry of Foreign Affairs 2010g).

5.5 Discussion of findings

Despite the freedom that the Ministry of Foreign Affairs gives to organisations to determine their own priorities, the NGOs themselves feel restricted. Because MFS is an important source of funding, the NGOs will hand in proposals with the biggest chance of success. The NGOs know what the preferences of the Ministry are and are tempted to stay close to them in their own proposals. They also expect the Ministry to act according to these priorities, hence the surprise when the AIDS specific organisations did not qualify for MFS-2 funding. The defence of the Minister that HIV and AIDS is supported through the multilateral channel is right, but multilateral organisation usually have a different scope and approach than NGOs. It is also true that other NGOs have HIV and AIDS related activities, but it remains to be seen what the other organisations will actually do about HIV and AIDS. Most of them are broad organisations that started or may be about to

‘mainstream’ HIV and AIDS into other programs. In Chapter 8 will be shown that ‘mainstreaming’ is easier said than done this could mean that unintended and without anyone consciously making a decision about it, HIV and AIDS could slide of the agenda somewhat more. Here it seems that the absence of thematic preference of a donor has an immediate effect on the activities of NGOs. Furthermore, when asked how NGOs fund their HIV and AIDS related programmes right now, MFS-1 appears to be a major source. These programmes cannot be continued, however, respondents stated that the projects had a cycle of four years from the start, so they see the end of the funding more as a sign that projects should be ‘completed’, rather than ‘stopped’.

6 – Dutch NGOs working on HIV and AIDS

6.1 Introduction

This chapter gives an overview of the characteristics of Dutch NGOs and their health and HIV and AIDS related activities. The selection contains the following 17 Dutch organisations with activities related to HIV and AIDS (in alphabetical order); Amref, Artsen zonder Grenzen (AZG), Aids Fonds, Cordaid, Healthnet TPO, Hivos, ICCO, Oxfam Novib, Plan, Rode Kruis, Save the Children, Simavi, Stop Aids Now!, Tear, World Vision, Woord en daad, WPF. This list is by no means comprehensive and does not include all Dutch organisations active on this topic. The aim of this selection is to broadly sketch the Dutch NGO's responses to the HIV and AIDS epidemic and give the reader a general idea on what is been done by NGOs. In the selection I sought variety of organisational characteristics and different approaches to HIV and AIDS and practicing development aid. All the organisations are implementing activities themselves, or closely supporting implementing organisations (local partners for example). The following sections describe a variety of organisational characteristics and aspects of HIV and AIDS care and prevention of the organisations. Furthermore, the selection served as a starting point for data collection. Most of the organisations were approached to participate in interviews and/or case studies. The information presented in this chapter is therefore a mix between document analysis (website, annual reports, strategy plans, etcetera) and information gathered during interviews. Twelve of the seventeen organisations were interviewed. All data refer to the year 2009 unless these were unavailable at the time of writing.

6.2 Scope of the organisations

Of the NGOs in the selection, only two focused solely on HIV and AIDS. All other organisations were either health specific organisations or general development organisations. General development organisations work in several sectors (for example, education, emergency relief, agricultural) of which health is one. These organisations often linked their HIV and AIDS activities to programmes in these other sectors. Health specific organisations focus on health and health care only. These organisations did not necessarily have more HIV and AIDS related activities than broad development organisations. The findings here are similar to the trend described in Chapter 5, that HIV and AIDS are not only regarded as health problems only but have implications for other sectors as well.

6.3 Size of the organisations

All the organisations are relatively large and established, but there are substantial differences in size. The annual budgets, ranging from €5 to €190 million, are taken here as an indication of size. As it could be expected, the broad organisations also have the largest budgets. In the following table 6.1 only the size of the organisation in the Netherlands is taken into account.

Table 6.1: Annual budgets of a selection of Dutch NGOs working on HIV and AIDS

Size of the organisation	**Organisations**
Total income in 2009	
€ 0-10 million	Amref, WPF, World Vision, Simavi, Tear
€ 10-20 million	Stop Aids Now!, Healthnet TPO, Save the Children, Aids Fonds
€ 20-75 million	Woord en Daad, Plan, Red Cross
€ 75-120 million	
€ 120- 150 million	Artsen zonder Grenzen, Hivos, ICCO
€ 150- 190 million	Oxfam Novib, Cordaid

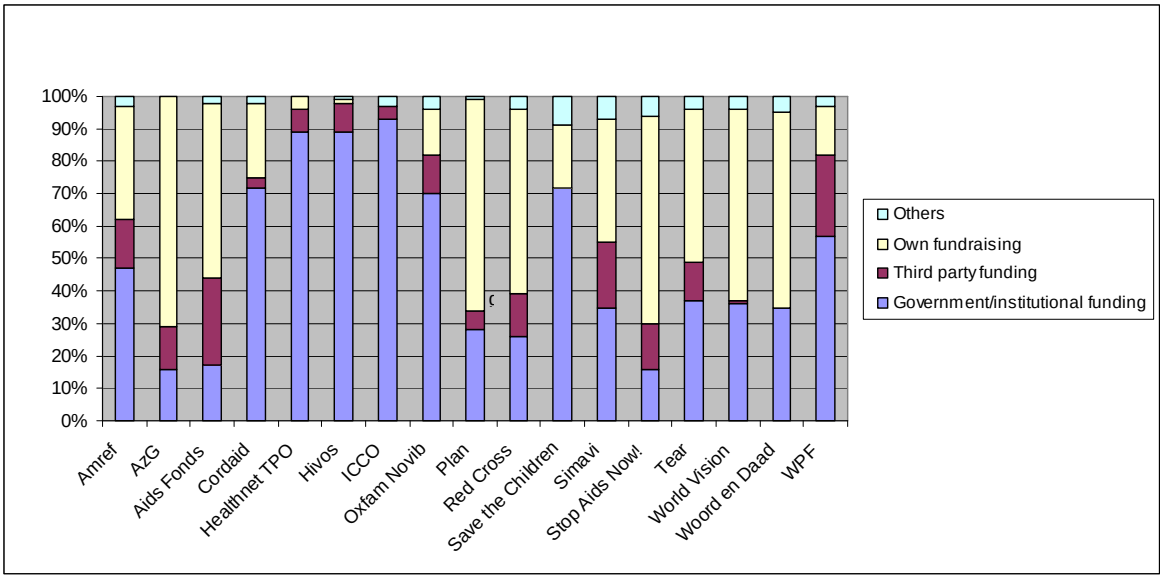
Source: Annual reports of 2009 of the organisations mentioned in the table

6.4 Funding

Figure 6.1 on the next page, gives the sources of NGO's incomes. The purple bar indicates what proportion of an NGO's income comes from institutional donors. The two major institutional donors are the Dutch government (subsidies from Ministries, co-financing program, incidental subsidies) and the European Commission. The proportion of institutional funding varies enormously. It is worth noting that the four biggest organisations in the first co-financing program (Cordaid, Hivos, Icco and Oxfam Novib) now rely for over 70 percent of their income on institutional funding. This could mean that their activities are also more in line with government priorities. Smaller organisations seem to be more able to find different sources. There are, of course, exceptions like Artsen zonder grenzen (a big organisation, but without extensive institutional funding) and HealthNetTPO (a small organisation, receiving funding from multiple Dutch Ministries). The pink bar shows how much funds are raised by third parties, i.e. not by the organisation itself. In a few cases, this part can be as much as 25 percent of the annual income. A good example of a third party raising funds is the 'Nationale Postcode Loterij', a national lottery in which part of the money participants put in, is divided over a number of good causes. The yellow bar indicates the proportion of income that is due to the organisations own

fundraising efforts. Generally these are gifts and subsidies from private parties and individuals. Sponsorship programs, sell of merchandise, benefit concerts are all examples of more creative ways of generating funds. For most organisations that receive less institutional funding (less than 50 percent), 'own fundraising' is the biggest source of income. The last category, a bar in blue on top consists of funding that is not otherwise specified, for example benefits from interest, investments or sale of assets.

Figure 6.1: Sources of funding



Source: Annual reports of 2009 of the organisations mentioned in the table

Sources of funding can indirectly be linked to the activities of an organisation. Each donor has its own requirements regarding their donations. For example, in the co-financing system as described in Chapter 5, there is a restriction that beneficiaries can only use 40 percent of the funds in countries that are not partner countries of the Netherlands. The larger the share of MFS funding is, the more restrictive this rule will be for an individual organisation. A variety of different sources of funding can mean that NGOs feel less bound to restrictions or preferences of those donors. A last comment is that not only institutional donors have preferences. Private donors increasingly earmark their donations for specific projects as well.

6.5 Countries of implementation

The following table 6.2 lists the number of implemented projects or programmes directly or indirectly related to HIV and AIDS, by all the NGOs combined, in certain countries. It is difficult, if not impossible, to find out the accurate data for all organisations. Only the projects that had traces of HIV and AIDS significance in its brief project descriptions are included in this table. The number of projects and programmes is set out against HIV prevalence in the country and whether the country is a partner country of the Netherlands. The source for the prevalence data is the UNAIDS 2008 report. The qualification low, moderate, high and very high is based on the categorization used in Rau et al. (2008). They give four categories: low prevalence: <2 percent, moderate 2,1-5 percent, high 5,1-15 percent and very high >15,1 percent. A full overview of countries of implementation can be found in Annex 3.

Table 6.2: The total number of HIV and AIDS related projects in countries

Prevalence	**Partner country**	**Not a partner country**	**Total**
Low <2%	39	34	73
Moderate 2,1-5%	14	8	22
High 5,1-15%	27	7	34
Very High >15,1%	15	6	21
n/a	2	1	3
Total	97	56	153

Source: Sources: UNAIDS 2008; Ministry of Foreign Affairs 2010h; Salden 2009; websites and annual reports 2009 of the NGOs listed in section 6.1.

Based on this table it appears that there are more projects in low-prevalence countries than in high-prevalence countries. These findings contradict the assumption that needs are leading the location of NGO's interventions. Possible explanations that NGOs gave for this discrepancy could be that:

1- Prevalence does not take into account the absolute severity of the problem. For example, in India a prevalence of 0.3 percent still means that several millions of people are infected.

2- No distinction is made for the size and depth of programmes. The only indication is whether there is one HIV and AIDS related project or not. It could be that the projects in low-prevalence countries are smaller than those in high-prevalence countries. That would mean that on the whole more attention goes to high

prevalence countries after all. However, most organisations do not have these data available for their own projects, so this hypothesis could not be checked.

3- Some programs in low-prevalence countries may be aimed at preventing escalation. This could have something to do with comparative advantage of prevention 'done' by NGOs. Some respondents thought that NGOs were better capable of setting up prevention projects in areas where HIV is still stigmatized.
4- Many organisations have programmes that integrate HIV and AIDS. Not all of those programmes are labelled as an 'HIV and AIDS project' by the NGO itself. Perhaps there is more need to integrate HIV and AIDS in everyday activities in those countries where prevalence is already high and so HIV and AIDS affects society as a whole.

What these data also show is that NGOs are significantly more active in partner countries of the Dutch Ministry of Foreign Affairs. The number of projects in partner countries resemble the 60 percent that is required for MFS-2 funding. However, the projects that do not take place in partners countries also taken place in low-prevalence countries. Therefore, it cannot be concluded that partner country policy 'steers' HIV and AIDS projects towards low-prevalence countries.

6.6 Perspective on HIV and AIDS

This section is about how organisations themselves perceive HIV and AIDS. Not very surprisingly, the majority of organisations consider HIV and AIDS to be a health problem. Most NGOs add to this viewpoint that HIV and AIDS should not be handled exclusively as a health issue but attention should also be paid to the social-economic origins and impact of the epidemic where they work. Here the background of NGOs as broad development organisations show through. A considerable number of organisations approach HIV and AIDS from a human rights perspective, paying more attention to inequality and discrimination. Noteworthy is also the trend that an increasing number of NGOs focus on sexual and reproductive health and rights (SRHR) and see HIV and AIDS as an important part of that. With this perspective they are in line with the priorities that were set by the Ministry of Foreign Affairs.

6.7 Target groups

Table 6.3 shows the target groups that the NGOs explicitly mention in the description of their HIV and AIDS related work. Regardless of any other characteristic, the most 'popular' target groups are young people, followed by women, people living with HIV and AIDS, and affected children. NGOs that focus on HIV and AIDS as a part of SRHR have women, but also young people as their primary target groups. Organisations working from a human rights perspective have a greater involvement with target groups that are more often stigmatized, such as: lesbian, gay, bisexual and transgender people, men who have sex with men, sex workers, injecting drug users, but also people living with HIV and AIDS. Lastly, it is noteworthy that all the organisations that identify religious and church leaders as their target groups are NGOs with a Christian background. For them, this identity provides an entry-point to discuss HIV and AIDS with local faith based organisations.

Table 6.3 Target groups of NGOs working on HIV and AIDS

Target groups	**Total number of organisations that explicitly mention this target group as relevant in their HIV and AIDS related work**
People living with HIV and AIDS	9
General public	8
Young people	14
Women	9
Young mothers (to be)	4
Children affected by HIV and AIDS / Orphans and vulnerable children	9
Care givers / Extended families	4
Religious and church leaders	5
Lesbian, gay, bisexual and transgender people	2
Men who have sex with men	2
Sex workers	5
Injecting drug users	4
Disabled persons	1
Labor migrants and transport personnel	1
Displaced and trafficked persons	2

Sources: websites and annual reports 2009 of the NGOs listed in section 6.1; Salden 2009.

6.8 Share and importance of HIV and AIDS related activities for the organisation

Table 6.4 is made on the basis of an interesting mix of different sources. For many organisations it is difficult to indicate how important HIV and AIDS is as a topic, because HIV and AIDS related activity is increasingly intertwined with programmes in other sectors. The first column of the table indicates what percentage of the total budget approximately goes to projects and programs directly related to HIV and AIDS. The

second column indicates how important the topic is perceived within the organisation. It is difficult to establish how importance of a topic as an outsider. However, observing how well the topic is represented in reports, strategic plans and how people respond to the question, one can give an indication if priority for HIV and AIDS is going up or down over the last five years. In the last column trends regarding the importance of HIV and AIDS in the projects an programs are noted.

Table 6.4: Share and importance of HIV and AIDS related activities

Organisation	**Share of total activity**	**Perceived importance**	**Going up or down**	**Trends regarding HIV and AIDS priority**
Amref	Unknown	Moderate	Down	HIV as part of SRHR
Artsen zonder Grenzen	15-20 %	Moderate- high	Under discussion	Integration HIV and tuberculosis activities
Aids Fonds	100%	High	No change	
Cordaid	4,6 %	Moderate, but it is a separate program	Going down	Mainstreaming and integration in vertical programs
Health Net TPO	Very small	Low	No change	
Hivos	4%	Unknown	Unknown	
ICCO	2,4%	Unknown	Unknown	Mainstreaming and integration in vertical programs
Oxfam Novib	+/- 4%	Moderate	Unknown	
Plan	8%	Unknown	Unknown	
Red Cross	4%	Moderate	Slightly down	Integration in health programs
Save the Children	0-2%	Moderate	Down	Integration in other programs, less funds available
Simavi	0-2%	Moderate – low	Down	Horizontal programming
Stop Aids Now!	100%	High	No change	Integration
Tear	20-40%	Moderate- High	Down	Less funds available
World Vision	17,7%	Moderate – high	No change	
Woord en Daad	5-6%	High	Up	Expectation to go down again
WPF	Unknown: +/- 4%	Low-moderate	No change	Accent on SRHR, HIV is part of that

Source: Interviews; Annual reports 2009.

It can be concluded that HIV and AIDS is still seen as a moderate and quite important topic. This does not mean that organisations automatically make more funding available for it. Despite the moderate to high importance many organisations see the attention for HIV and AIDS stabilizing or declining. Most of the NGOs that see the importance of HIV and AIDS going down also plan a further integration of HIV and AIDS in other programmes. In Chapter 7, more will explained about the integration and mainstreaming of HIV and AIDS. There the respondents also mention that the step towards integration and mainstreaming is often taken as a response to declining funds.

6.9 Activities and themes

In this section the activities and themes that organisations work on will be discussed. Table 6.5 gives an overview of the general themes of the HIV and AIDS related activities. The information is gathered from project descriptions given by the organisations themselves.

Table 6.5: Total number of NGOs that work on a specific theme

General theme	Prevention	Care	Support	Treatment	Poverty reduction	Awareness raising	Capacity building	Research
Number of projects	17	13	7	4	5	8	6	2

Source: Interviews; Annual reports 2009.

Prevention and care are by far the most implemented by these Dutch organisations. The preference to target children and young people also shows through in the activities of the organisation, since many NGOs have prevention programs like life skills, peer education and HIV prevention integrated in education, all of which are projects that are likely to reach young people. Broad development organisation more often engage themselves with 'broad' topics like poverty reduction, awareness raising and capacity building. Perhaps this is because these organisations already have the expertise and experience with broader programmes, so that it is easier to link HIV and AIDS to them. Only a few NGOs provide treatment for AIDS in the form of ant-retroviral treatment (ART) or medication for opportunistic infections. During the interviews many respondents noted that they considered provision of ART not something that their organisations was able to do, because of the costs. Prevention, care and support on the other hand is what many indicate as topics that their NGOs had a good 'comparative advantage' in providing. Care and support activities can for example be voluntary testing and counseling, home-based care

and prevention of mother-to-child transmission. When describing their approach to prevention, only the organisations with a religious background mentioned the ABC-approach. This reflects the findings in Chapter 4 that since the PEPFAR programme, the ABC-approach is associated with a certain conservancy regarding the content of prevention programmes. Furthermore, it is worth noting that prevention is such a popular topic, because in Chapter 4 appeared that prevention is a relatively difficult task. It is hard to assess the effectiveness of prevention programmes and takes a long time before results show. Still, NGOs automatically consider prevention programmes as a sustainable option and include in their activities.

7- Thematic shifts in HIV and AIDS programming of NGOs

7.1 Introduction

This chapter will describe some of the current debates about changes in HIV and AIDS programming. These cases can illustrate some of the challenges of policymaking. For each of these themes the views of NGOs, donors and – if possible and applicable - local partners will be discussed.

7.2 'Mainstreaming' HIV and AIDS in other programs

The selection of NGOs interviewed in this research also included a number of NGOs that more or less readily admitted that HIV and AIDS was becoming gradually less and less important for the organisation. The reason for HIV and AIDS sliding of the agenda were not always clear, sometimes not even to the organisation itself. They think it has to do with the success of other themes and projects, combined with an ability to raise funds for them. When at the same time funding for HIV and AIDS projects stagnates for a while, this can easily lead to vast decline of HIV and AIDS specific projects. Most NGOs are not blessed with an expanding budget, so raising the budget for a certain theme, almost immediately means cutting on another one. An often heard comment was, 'we cannot do everything'. This does not mean that these organisations are suddenly insensitive to the effects and impacts of HIV and AIDS in the areas they work in. Nor do they underestimate the gravity and severity of the problem. Stopping HIV and AIDS related activities altogether was not mentioned by any of the NGOs as a good option. Some organisations also mentioned how hard it is to find additional funding for HIV and AIDS 'exclusive' projects. In an attempt to find a middle way between lacking funds for directly linked activities and a wish to (continue) doing something, many organisations now aim at integrating or mainstreaming HIV and AIDS into their programmes.

According to the literature mainstreaming and integration can take different forms (Holden 2004; Stop AIDS Now! 2009). Integration of HIV and AIDS work has come to mean that organisations implement activities directly targeting HIV and AIDS alongside or within other projects, so that the activities are clearly linked (Holden 2004). Furthermore, two different kinds of mainstreaming have evolved. First, internal mainstreaming means that the organisation becomes more aware and sensitive of the consequence of HIV and AIDS for their own functioning. Chances are that NGOs and their partners employ people who

themselves are HIV-positive. Internal mainstreaming can then be that there are rules and policies in place on recruitment, sick-leave and termination of employment that do no discriminate against people living with HIV and AIDS (Stop AIDS Now! 2009). Second, external mainstreaming. This means that the 'core work' of the organisation, which is not HIV and AIDS related, is re-analyzed in the light of HIV and AIDS. It is about making sure that the activities of the organisation do not exclude or harm those living with HIV and AIDS. Ideally, people working on and in other sectors (for example; agriculture, education, water and sanitation services and microfinancing) ask what the influence on HIV and AIDS on their own work is and adjust their core work to that (Holden 2004).

During the interviews respondents mentioned these various approaches to mainstreaming and integration. Broad development organisations that run long-term projects in which a community is 'adopted', often integrated HIV and AIDS. Depending on the situation in that particular area, it will be part of the projects implemented there. Health care and education are popular sectors for external mainstreaming of HIV and AIDS. Sometimes this happens naturally: an NGO that has successful education programmes can make HIV and AIDS part of them. Whether it is called 'an HIV prevention programme for young people, taking place in educational setting' or 'an education programme that includes information about preventing HIV and AIDS', some people claim that in the end this boils down to the same thing: children attend school and learn about HIV and AIDS. Internal mainstreaming also happens, this is especially relevant for NGOs that work with independent local organisations in all kinds of sectors. These NGOs notice that HIV and AIDS affects the functioning and effectiveness of the development projects that are implemented, for example because personnel is on sick-leave often.

Despite the popularity of mainstreaming it is not something to be taken for granted. Experiences with mainstreaming of gender have shown that it can be unclear what should happen in practice after the decision to mainstream is made. Different interpretations of mainstreaming exist and attention for the topic can slowly disappear (Elsey et al. 2005). One guideline for fieldworkers on mainstreaming HIV and AIDS in emergency situations starts with the quotation: *My manager wants me to mainstream HIV and AIDS- how do I do it?* (Walden et al. 2007) This seems to suggest that mainstreaming is forced upon projects without any clear vision why or how this should be the case. Mainstreaming is not quite as easy at it seems, and NGOs realize that. Constantly keeping an eye on a topic

when all the energy in the organisation goes to something else and sustaining commitment, is difficult. In situations where HIV and AIDS specific activities are no longer funded, it can easily happen that experience, expertise and knowledge (embodied by partners and employees) disappear from the organisation.

This raises the question if 'mainstreaming' is only an elegant way for NGOs to push a topic from the agenda and a way to frame its decreasing priority. Some respondents state that the reason their organisation mainstreams HIV and AIDS, is because there is not enough funding to continue HIV specific activities. This implies that NGOs are sympathetic to the issue but that the lack of funding means nothing more can be done. Usually a formal structure is set up to make sure that HIV and AIDS are considered when programmes are set up. If necessary, small projects will be included. But it remains unclear what the organisations will and can do with the small funds allocated to a mainstreamed issue. Not all respondents are completely convinced that mainstreaming is the best way forward or the ultimate solution. The following quotations show just a few examples of respondents that are aware of the difficulties of mainstreaming:

'As I said, mainstreaming sounds very good. But to make it concrete is very difficult. You have to invest time in it. Often it stays with giving [health/sex] education. […] Usually we do activities that are not very expensive, easy to implement in any program; that's the least you can do.'

'And then it's our role to say yes, it's very good to mainstream, because we also favour an integral approach, because that's way more effective and efficient. But at the same time we have to make sure that HIV and AIDS does not disappear from the agenda. So we are a little hesitant.'

Another respondent explained with much confidence how HIV and AIDS were going to be mainstreamed within the organisations activities. But later on, expressed doubts about the way the Ministry of Foreign Affairs mainstreamed certain target groups (like children and women) in their policies. This respondent knows that processes of mainstreaming can in practice mean that the topic becomes invisible and that it becomes rhetoric to mask that it is no longer a priority for the NGO. But at the same time she explained her organisations AIDS mainstreaming policy as the right, obvious thing to do. This happened more often. I believe that NGOs are aware that mainstreaming can mean that a topic disappears. Some of the respondents saw something similar happen with other themes. Most of them are health or HIV and AIDS advisors. They may want to do more specifically on HIV and AIDS and

be able to convince their colleagues that the topic is important, but in everyday practice it is difficult to keep it a substantial part of the activities. It also appeared that a good deal of the commitment for a topic comes from people within the organisation who have the time, energy and advocating skills to convince their colleagues. Focus on a specific topic seems to thrive with an officer or advisor in head quarters with experience and determinedness in keeping it on the agenda. Staff turnover can mean that commitment disappears.

People in the Ministry of Foreign Affairs, acknowledge the problems of NGOs with mainstreaming, because they have experience with it themselves:

'When we talk to them [NGOs], when you are really being honest, you see that it's also difficult for NGOs to mainstream things. Because you have to invest a lot in it. A lot. And they don't always have the people for it, or the right persons. Mainstreaming means you have to involve others. It often happens like 'Oh, I'll do a workshop and I'll say, you are also affected by AIDS' and that's it. That is not enough. And of course we see that they try. Some a little bit better than others, but it takes time.'

These employees see in the field that real mainstreaming efforts take time and serious efforts, for example in reducing stigma around HIV and AIDS in the partner organisations and building a workplace policy around that. They also know that NGOs can give all kinds of different meanings to the concept mainstreaming and that some of these interpretations do not result in effective action.

Overall the respondents that work with or for local organisations and field offices do not seem to think about mainstreaming in the same conceptual way as respondents from the Netherlands did. They were able to mention various examples of how mainstreaming took place in their organisation, but also mentioned some critical observations. One respondent working for partners, mentioned that local organisations sometimes have difficulties with implementing mainstreamed or integrated programs. She noticed that in her work peer-to-peer education is a very effective way of preventing HIV transmission. On the other hand, it takes a lot of time and dedication to make this activity work, whereas in some integrated projects there is only time and resources to do a broad, population based project on awareness raising, for example through the mass media. The difficulties of measuring and actually seeing the effects of integrated and mainstreamed work can lead to disappointment among staff working for the organisation, because they would like to see the effects of

their efforts. Another respondent noted about internal mainstreaming that more resources are needed to make staff of the organisation more aware that HIV and AIDS is a cross-cutting issue and how it affects their own work. Overall, the respondents I spoke to found it difficult to compare the two approaches (specific or integrated), but list more 'challenges' when it comes to integrated or mainstreamed projects.

It appears that mainstreaming has an uncomfortable position. At first glance this is strange because rationally it is the best approach. In the discussion on the context of HIV and AIDS in Chapter 4 it appeared that this disease cannot be seen or treated as a biomedical problem alone. The same people that kept HIV and AIDS high on the agenda for many years did so by spreading the view that HIV and AIDS affect other sectors, that HIV and AIDS are not only a biomedical issues but also have a social and economic background and impact. So, in order to handle the problem, other sectors need to be involved too. No one can be against an integrated, comprehensive and holistic approach as is promoted with mainstreaming. The concept is also problematic because it is unclear what mainstreaming means in practice. This is also what I noticed during the interviews: respondents found it easier to explain *why* they mainstream than *what* actually happens. It takes time and effort to do mainstreaming right, but it must be done in situations where time and money for HIV and AIDS is lacking. In the field, the integrated or mainstreamed approach needs more time to prove its merit. Hence, 'mainstreaming' has become a vague and broad concept that is used in the policy debate over HIV and AIDS taking place within the Netherlands, similar to the way described in Mosse (2004) and Schennink et al. (2006). The concept mainstreaming can be used as a tool to negotiate and frame policy change. NGOs may not want to admit openly that they want or need to reduce the amount of HIV and AIDS related activity. In those cases mainstreamed projects are a good option to express that the topic itself is still important within the organisation.

7.3 The target group children: from orphans to family-members

As noted in Chapter 6, Dutch NGOs are most likely to be involved with young people and children affected by AIDS. This is based on the rationale that prevention and behaviour change efforts will be effective when the projects reach children before they become sexually active. NGOs providing care and support to children do this based on the impact of HIV and AIDS on children's lives. In 2007, an estimated 2 million children were living with HIV themselves, but many more see the effects of having one or more people in their

household suffering from AIDS. It can mean that children take on care-giving and income-raising roles.

Many Dutch NGOs now realize that the global response to children and AIDS was narrowly focused on 'AIDS-orphans' and providing care for them. This is happening in parallel to a global reconsideration of children and AIDS activities in development projects. Mid-2000s the definition of the term 'orphan' used in AIDS projects came under global discussion. UNICEF defined an orphan as a child 'who has lost one or both parents' (JLICA 2009). Many organisations then argued that in reality the word 'orphan' conjures up images of children who are isolated from any form of family care and are in a way in need of a new 'home'. This image has led to an upsurge of orphanages. But research showed that up to 90 percent of all children that are designated as 'orphan' under the UNICEF definition have a surviving parent and continue to live with their family. Besides, children affected by AIDS are in need of support long before one of their parents pass away (JLICA 2009).

NGOs took this criticism seriously. They helped address it through working groups and different kinds of interventions are implemented. Now there is much more focus on families and communities that care for children affected by HIV and AIDS. The care and support that they provide is taken more seriously. Any activity from an external NGO must reinforce and support that work. Those Dutch NGOs that are child-oriented on the whole, like Plan, World Vision and Save the Children, are also – not surprisingly - the NGOs that follow and feed the debate on children and AIDS closely. The response from NGOs could mean that part of the influence on their priorities and strategy (for example providing home-based care for families instead of building new orphanages) comes from the international 'mood' on a certain topics.

7.4 Partner countries

Organisations freely and frequently mentioned how the partner country policy of the Ministry of Foreign Affairs can be restrictive on their programming. This is interesting because on other occasions NGOs stressed their independence from the Ministry of Foreign Affairs. For organisations participating in the co-financing programme (MFS), the relation is obvious: they are required to spend at least 60 percent of the MFS funding on partner countries. This rule will also be strictly enforced in MFS-2. The Minister hopes that

thereby the efforts of NGOs reinforce and strengthen the Ministry's own bi-lateral programs in those countries (Ministry of Foreign Affairs 2009). The selection of partner countries is done at the Ministry. Currently there are 40 countries on the list, indicating which countries the Netherlands have a development relationship with (Ministry of Foreign Affairs 2010h). Each individual minister makes minor changes in the list, usually reducing the number of partner countries. One country that NGOs mentioned was South Africa. Some respondents foresaw they would have to close down projects when it is no longer a partner country. Checking if that was indeed the case at the Ministry, I noted that employees there were not sure and did have detailed knowledge. This could have something to do with their portfolio and work area. Regardless of the question if South-Africa is indeed a partner country and how the decisions about that are made, at the very least it can be concluded that the partner country policy is confusing and somewhat unclear for both NGOs and policymakers. It also has consequences because NGOs seem to anticipate these changes.

The Dutch Ministry of Foreign Affairs is not the only institutional donor steering the course of NGOs. One respondent at an NGO explained how the European Union also has preferences where their funds are spend.

'It's really looking at, where does the money come from? When you look at the EU… There are these periods… Sometimes they want to focus on western Africa and then it's southeast Asia and then it's the Caucasus. And that means that a lot of money is available for certain regions. What do you do? Are you not going there because it is not a priority country even though you can do a lot of work there and there is also a field office present? Of course you go there! So, sometimes you need to go with the wind and of course we have our own priorities. But when at a certain point you know, well there is money for it, but you know we cannot do it, we don't have the expertise, you just have to turn it down. We don't have to do it.'

What the quote also illustrates is that funding opportunities can be linked to location choice, but it is part of a broader comparison. Expertise, capacity, present knowledge of the area and the problems and needs in the area also play a role.

From Chapter 6 it already appeared that there are significantly more projects and programs in partner countries than in those who are not. The partner/no-partner division comes near the 60/40-equation required for MFS. Organisations that run projects in countries that are not on the Dutch partner list receive less MFS funding, but the difference is not

spectacular. So even though there is space to implement activities in countries other than partner countries of the Ministry (40 percent), the policy is still seen as restrictive and guiding. The NGOs also noted that it is much more difficult to finds new and other donors, so it might be that they are 'stuck' in the government priorities. With only a limited amount of partner countries the effect is clustering of NGOs in certain countries, similar as what Koch et al. (2009) concluded.

7.5 Cooperation with faith-based organisations

There is a lot of debate about the role of religion in development aid. In many parts of the world that are heavily affected by HIV and AIDS, religion is an important part of daily life. Religious beliefs can influence the way people think about HIV and AIDS and sexuality in both negative and positive way. Religious leaders emphasize norms, for example about sexual behaviour that followers adopt in their own life. These norms can be positive (e.g. the 'be faithful' norm), but also counterproductive when it comes to preventing HIV transmission (e.g. the Pope claiming that condoms do not prevent HIV transmission). On the other hand, religion is a basis for support that many people cannot do without. JLICA (2009) estimates that about 60 percent of the local organisations that provide care and support for people living with HIV and AIDS are based in a church or have another religious foundation.

In the sample of this research there were three organisations with an outspoken Christian identity. The people I spoke with in those organisations found that this outspokenness helps them in their work, because so many of the people they work with and for in the field are religious themselves. One respondent said that it is easier to establish contacts in communities, with faith-based organisations but also with religious leaders. There were more opportunities to influence churches from within and correct any incorrect ideas if necessary.

Secular NGOs apply the neutral approach, attaching greater importance to the possible limitations that religiosity can impose. They like to work freely on topics like abortion, sex work, drug use and sexual relationships. Whereas organisations with a Christian inspiration favour an approach focused more on changing (sexual) behaviour. In Chapter 6 I noted how the Christian oriented organisation more often use the ABC-approach in their prevention strategies.

‘That’s probably also why you asked about Christianity and HIV and AIDS and prevention… My organisation will be less inclined to put itself on the street corners to hand out condoms. We do use the ABC approach and c [condoms] are an essential part of that. So if a and b don’t work out, c is also fine. We don’t say ‘don’t use condoms’ because that’s nonsense. And unrealistic.

The Dutch Ministry of Foreign Affairs is known for its progressive viewpoints regarding HIV and AIDS and takes pride in advocating for issues that are sometimes too sensitive for other governments. One respondent felt that the Ministry had les attention for their ideas and that conservative organisations are easier overlooked. His assumptions seem correct when listening to a Ministry employee on the subject:

‘Yes, there are NGOs that have different opinions [on SRHR] but because we have always had progressive ministers so we don’t do anything with that. There are NGOs that take a conservative position on these matters because of their Christian inspiration. Well, we don’t do anything with them.’

This quote shows that ‘secular’ and ‘progressive’ has become the norm, which forces Christian organisations to ‘defend’ their strategy and approach when they are among other NGOs as well. On the other hand, the Christian organisations often noted that even though they receive less institutional funding, HIV and AIDS is an important topic for their private donors.

7.6 Treatment

Another finding from Chapter 6 is that the majority of the NGOs engage in activities aimed at prevention. In some literature and also among some NGOs the general consensus is that prevention is the best thing for them to do to tackle HIV and AIDS. Few respondents noticed the need to provide ART and the care associated with treatment, also observing that providing treatment (or assisting in doing that) was too expensive for them, but also ‘not their thing to do’. They considered other organisations would be better suited to ‘do’ treatment. Organisations working from a human rights perspective are involved with treatment in another way. They encourage civil society to advocate for better access to treatment, but the NGOs do not provide treatment themselves. Respondents working for broad development organisations often noted that a medical organisation would be best suited to provide treatment because of their specific expertise. One respondent noticed how the global ‘task-division’ is changing. Foundations like the Gates Foundation, the Global Fund and PEPFAR have always concentrated on treatment. They also have much more

funds available for it than NGOs. NGOs felt reassured that this part of HIV and AIDS care was handled by those who could afford it and concentrated on prevention. Since a couple of years, the big foundations are reorienting their activities towards prevention and integration of HIV and AIDS care, leaving activists and NGOs uneasy, because no other actor is picking up the treatment aspect. NGOs are not the only ones reluctant to start activities around treatment, the same goes for policymakers:

'Prevention was always important in our HIV policy. Then treatment, ARVs came up. We were hesitant at first. You know, can you make that sustainable, it's very expensive… Yes and then we kind of turned, more open to the possibilities, like 'yes, treatment is also important'. But now, now the accent lies more on prevention again. Mainly because of sustainability'.

Employees of local organisations give preference for treatment and care interventions. This is understandable, because they see the immediate impact that treatment has on peoples lives. With treatment and care, the people living with HIV and AIDS can be active and relatively healthy again, whereas for prevention it can take years, even decades before positive results show.

7.7 SRHR, mother- and child health initiatives (the 'new' themes)

When asked about the health related activities of their organisations, a good part of the respondents mentioned sexual and reproductive health and/or mother and child health as their new focus. These new priorities coincide with the Ministry of Foreign Affairs that also put SRHR to the forefront of its health policy. In an earlier section I already discussed the challenges of mainstreaming and integrating HIV and AIDS in other programs. SRHR is one of the broader themes that HIV and AIDS is put under. Two respondents found that HIV and AIDS projects can be 'used' to gain access to a community and make people more open to activities on SRHR. Where did the topic come from? And: did this replace other health issues like HIV and AIDS? The respondents did not mention the link explicitly but increasing attention for SRHR tends to accompany a decrease in HIV and AIDS activities. The reasons that NGOs give for putting emphasis on these topics range from idealistic: they point at the severe situation in the areas they work, to mundane: an increased amount of funds available. Some organisations joined in with a worldwide campaign against child mortality of the international organisation they belonged to.

7.8 Discussion of findings

In this Chapter I discussed various ways in which HIV and AIDS programmes are operationalized by NGOs. First of all, the shift towards more mainstreaming and integration of HIV and AIDS in other programmes. The NGOs are not always completely convinced that mainstreaming is the best approach in setting a programme, but for them it is a way to continue working on the topic with less funds. This trend shows how a broad concept is 'filled in' with various meanings. The uncertainty serves the NGOs because they can show their concern for an issue while at the same time another topic becomes more important, like SRHR.

The description of topics that become more or less important also shows that themes (like HIV and AIDS) have 'life-cycles'. In the case of HIV and AIDS, the topic become more and more important until at some point actors silently agreed that the priority of that theme is out of proportion compared to other topics. At that point, the attention starts to decline again. This growth and decline, however, have nothing to do with the severity of the problem.

It remains to be seen in how far the course of these life-cycles are driven by funding opportunities. From the section on partner country policies it shows that funding opportunities can be restrictive on NGO's activities, but perhaps that there is also more room to move than NGOs assume. In the case of partner countries: 40 percent of MFS budget can be used 'freely' in other areas. In reality, this room is not used on areas that are not a priority for the Ministry of Foreign Affairs. Instead, there is a certain nervousness and NGOs make assumptions about what might happen in the future (e.g. 'phasing-out' of South-Africa) and close down projects based on that.

8- How NGOs explain decision making

8.1 Introduction

The previous chapter described what has changed thematically, this chapter will list the reasons that organisations themselves give for those changes. It will describe how NGOs explain decision making from their own perspective.

8.2 Comparative advantage and capacity of the organisation

Prior to starting a project, organisations have certain expectations about their ability and capacity to bring about results. These possibilities always play a role in the decision whether to start or to support a project. There needs to be capacity to support the projects; a water and sanitation project by a NGO that never has done anything similar or without employees knowing something about the issue, has smaller chances of success. Respondents stated that an important reason to start or continue a project is that their organisation has something to contribute, like specific expertise. Apart from having the practical and organisational capacity to bring activities to a good end, the projects need to fit within the organisation's mission, vision and strategic plan. These provide the long-term aims and strategy of the organisation and new projects have be in line with them. It depends on the organisations how strictly the overall strategy is followed. However, it is important to most employees that their organisations do what they are good at. For example; a NGO that has a good understanding of and experience with educational projects, but less in providing basic health services will probably start an HIV and AIDS project within the school they already support. A proposal to include HIV and AIDS prevention in local health services will be likely be frowned upon by employees as they do not understand the added value of their organisation doing the project.

8.3 History

NGOs build up a history of projects throughout the years. Sometimes a decision to start up a new project is based upon that history. One example is the continuation of successful projects. After the successful completion an NGO can decide that the results were so promising that another project could be set up. It does not need to be the exact same kind but can also be a slightly different project. An example is the addition of a project on prevention of mother-to-child transmission of HIV, after a clinic for primary care has been set up. In this way, NGOs build a long-lasting relationship with a community. A similar

situation applies to organisations that are setting up long lasting projects for entire communities (Plan and World Vision for example). These programmes can last up to ten-fifteen years. The rationale behind them is that continuous commitment and concentration on one area can make more difference than scattered projects spread all over a country. NGOs can no longer take their portfolios for granted, they cannot state they support a certain project, because that is what they 'have always done'. NGOs are increasingly forced (by donors, general public, etcetera) to justify what they are doing and a lot of effort is put into strategic plans and policies for certain themes.

8.4 Identity of the organisation

NGOs realize that they are not able to do everything they want. Funding is limited and donors (both institutional as private) scrutinize the organisation's activities. This forces the NGOs to look inwards and think critically about their strategy. The result is that NGOs have a good sense of their identity, which they can present to the outside world. It also means that NGOs are making conscious decisions about their strategy, target groups, the role religious identity will play (if applicable) and the priority of certain sectors. These aspects find their way into the NGO's everyday activities, since all of them compare their plans (or the plan of their partners) against their identity and the priorities resulting from it. Respondents related to the vision of their organisation when they talked about specific aspects of the HIV and AIDS activities.

'We are an organisation that wants to protect human rights, so we support partners that advocate for the rights of people living with HIV and AIDS.'

'Care for widows and orphans is very important for Christians. We think that is important and you want to link concrete things to that. For example, for children with HIV... […] We try to do things in practice that are in line with our vision and mission.'

A few respondents thought that sometimes there is a gap between the mission and vision and the daily activities of NGOs. Therefore, it can remain unclear in some cases if the vision of the organisation is really driving the direction and activities or that the vision is 'used' to justify the choices made.

8.5 Local situation

8.5.1 NGOs own understanding of the local context

The local situation is one of the leading reasons why organisations state they work in a certain area. Severity of issues is assessed before action is taken. But if that is so, how come that in the results of Chapter 6 appeared that most HIV and AIDS projects do not take place in the countries where HIV prevalence is highest? It could be that NGOs see the necessity of prevention activities earlier on, as the following respondent explains.

'In Asia we work in areas where HIV and AIDS is not a really an acute big problem. I just returned from Indonesia, from an area on the border with Malaysia. The program started three years ago and since a year, the government is planning to open a new border post there, to Malaysia. That is so important for the people who live there. People from Malaysia will come in, but also because many will go to Malaysia to find a job. So the risk that HIV and AIDS will become a problem in the future is very high. So we have to work on that right now by educating and informing people.'

This example shows that, based on local context analysis, an HIV and AIDS project in a low-prevalence areas can make sense.

8.5.2 Input and requests from field offices or local partners

Some organisations actively search for partners in an area where they want to work in. Other NGOs let local organisations take the initiative to contact them with an initial proposal. In that case the partner has all the freedom to set up a plan of action for the causes they think are important. These proposals are then assessed against the NGOs own ideas and strategic plans. One respondent illustrated this point by showing that project plans 'have to make sense.'

'We see that a lot [of partners] like to do peer education. It is safe to teach children in their schools. It's not harmful, no one can disagree on it. It's also an activity that many organisations took on and have volunteers for. But when we are writing proposals… I first let them make a context analysis and then a logical framework. They make an excellent context analysis. They know what the main problem is, the root causes… It includes the returning soldiers, the truck drivers… A clear vision on everything. Then you see the logical framework and what does it say they want to do for prevention: peer education at schools. […] Now we have to tell them: that's fine but what is the link between the activities that you are doing now and the drivers of the epidemic that you listed in the context analysis?'

At the same time, the quote shows how the local partners are not only informed about the nature of the epidemic, but also have their own preference for activities (they are enthusiastic about peer education). Peer education in this case was also something that the organisation has done for while now, so perhaps they anticipated that their donors would like to fund peer education again. This hypothesis can however not be studied within this research, because there are only limited data about the internal workings of the local partners.

Local partners do seem to be more restricted by the possibilities to acquire funding for their projects.

'If there is no money for [inaudible] but there is money for HIV projects you simply go for it. Because it's simply available. The funding mechanisms these days are becoming more and more complicated, so sometimes you have to… take into consideration the interest of the donor. What can you prioritize because this particular donor has a call on sexual and reproductive health, or water and sanitation? […] It's a struggle, a dilemma and sometimes we simply don't apply because it's not what our organisation wants to do. So of course you don't get money [laughs] but that's the reality.'

It appears that local organisations have a complicated donor-partner funding relationship with their donors, similar to the relationship between Dutch NGOs and their donors. In both situations, the receiving party has to negotiate and 'work its way around' donor preferences. Like the following respondent, southern NGOs more often (and openly) mention 'creativity ' as a way of avoiding strict donor prescriptions, than the Dutch NGOs did when they speak about the wishes of their donors.

'Sometimes you have to adjust what you really want to do. So there is an SRHR call for example. How do you bring in the issue of HIV and AIDS in that? So we also have to be a bit creative. Sometimes you can be creative and tap resources and sometimes it is simply not a priority. […] From my experience and what I have seen, organisations seem to adapt to external changes around them. So one time, you miss out and another time you are [laughs] better prepared. So it's not one thing or the other.'

8.6 Input from international partners

Half of the respondents in this research worked for an NGO that belonged to an international group (for example Oxfam). These organisations also have to take the international NGO that they represent into account. The relationship with international

headquarters differs per organisation, as well as the degree of independence that national branches have. New international priorities of international head-quarters can mean that the Dutch organisations also have to 'do something with it'. In most cases respondents found it difficult to negotiate their own position between local needs, the activities and priorities of other branches of their organisation and the situation in the Netherlands.

8.7 Funding opportunities

8.7.1 Declining funds for HIV and AIDS

All NGOs invest a lot of time, money and effort in raising funds of various sources, it is one of the main tasks in many Dutch offices. The ability to raise funds for a certain issue can also steer the themes NGOs work on. Among AIDS activists there is now consensus that after years of growth, funding for HIV and AIDS starts to decline (UNAIDS 2010). In times of economic crisis, donors hold back their donations. This affects the entire development sector and also HIV and AIDS projects. Another reason for lagging donations for HIV related causes was called 'AIDS fatigue'. After initial enthusiasm it appeared to be more difficult to achieve results while at the same time the public has gone numb to the continuous alarming messages.

'There was a lot of initial optimism to treat HIV, like 'yeah, let's do it!' But it's extremely difficult. [...] This is a big organisation, with access to lots of funds and everything. We try to be as close as possible to emergencies, but for HIV that's impossible. So this realization plays an important role.'

Regardless of the reason that NGOs hold responsible for lagging interest for the theme, it leads to a real decline of funds available for HIV and AIDS related projects. Some of them said that declining funds meant that HIV and AIDS became less and less important for the organisation's portfolio. The ability to raise funds also has something to do with who the big donors on HIV and AIDS are, and if Dutch NGOs can get access to them. One respondent noted that the largest funds are usually American and, as a Dutch branch of an international organisation, it is 'not done' to raise funds in the 'territory' of the American branch.

8.7.2 Participation in MFS-2 subsidy programme

During this research, many NGOs were working on their applications for MFS-2 funding (co-financing system). Almost every organisation was extremely busy with these

applications. The NGOs that reached the second round were given three months time to write down their working plans for the coming years. This possibility of acquiring funding was so important that it seemed to consume entire organisations. (Potential) Respondents appeared to have no time for anything else, also working overtime to get the applications ready in time. It showed how crucial the funds of MFS are for the existence of many NGOs. One organisation interviewed made the conscious decision not to apply at all. Other NGOs reacted in disbelief to this decision, but according to the respondent, the organisation balanced that the efforts did not outweigh the possible benefits of MFS funding.

'MFS-2 asks a lot of time and energy of so many organisations and we decided that it's not worth it. Because we would have to invest so much time, work very hard, while the results of it are not even sure. We don't know who is going to be the next Minister, how much money will be left and you have to share all of it. […] We have discussed [our decision not to participate] with other organisations and they were all like "What? That's impossible! Are you crazy?" [laughs]'

This is one of the organisations that received relatively limited institutional funding beforehand, so they are used to managing with less subsidies from the Ministry of Foreign Affairs. Other NGOs are definitely not and for them MFS is almost a lifeline they simply have to keep. Especially the larger NGOs realized they would have to downsize or find additional funding.

Halfway into this research, on March 31st 2010, the news came that more than half of the applications were turned down (Ministry of Foreign Affairs 2010). Especially the HIV and AIDS consortium was disappointed when they heard that the themes did not play any role in the assessment. Employees agreed that the Ministry of Foreign Affairs encouraged NGOs to submit proposals in line with the ministry's own priorities but also thought that these priorities were broad enough to fit in any topic the NGOs might want put forward. This is interesting because it is almost like the policymakers expect NGOs to behave as Mosse (2004) described it. He sees development practitioners fitting policy to their reality, instead of doing what policy prescribes. For this research it means that steering on thematic content does not take place openly, but all the applicants know what the Ministry wants and fit their own preferences in with those policies, 'just to be sure'. But the question

remains if there is more potential for NGOs to become more independent from MFS funding.

8.8 Networks and knowledge

NGOs never work in isolation. Ongoing discussions about development aid, issues that need attention, new strategies and new scientific research all reach them and influence their work. First of all, there is the knowledge of the local situation. Most respondents thought that an orientating visit is the best way to find out about local needs. These observations are consequently translated into the work and priorities of the NGO. Furthermore, the organisations use their knowledge of local problems, NGOs and programmes in their communications with other NGOs and policymakers. Some respondents regularly visited conferences or seminars to stay updated and exchange information with their people in other organisations (who are often also former or future colleagues). The policies of donors and shifts on the global agenda are noticed and regarded as important. Perhaps NGOs work in line with the same priorities as the Ministry of Foreign Affairs because they both attune themselves to global, international ideas. The Ministry of Foreign Affairs also uses the input of Dutch NGOs and their partners to write its policies so it is not a coincidence that the two are alike. One respondent working for the Ministry explained this as follows.

'We need their [NGOs] expertise, their networks, contacts… And we can facilitate what they are trying to do. Because we come in places they don't.'

8.9 Cooperation with the partners

The local partner can also be a reason to start or stop a project. In assigning projects Dutch NGOs usually assess the local organisations using the following criteria; for some organisations it is important to know if there is an affiliated office in the country or region. Bigger NGOs have field offices and those NGOs attached to international organisations often prefer a situation where another branch is already present. Furthermore, the capacity of local personnel is important. NGOs want to know if the organisation can handle the project and make it a success in the long run. Most NGOs emphasized that both parties should be able to express their expectations beforehand.

'When there are problems you try to sort it out together. I notice that using Skype and the phone can lead to problems easier, when those are the only means of communication you use. When you are back in the field

and have more time to talk you get closer. So it is very important to have that face-to-face contact. To make really clear what we expect from a partner and they can express what expectations they have from us. Especially when a new relationship with an organisation and you don't know them that well… It's an investment.'

Furthermore, most NGOs working with partners stress that they want their counterparts to be independent from them. Dutch NGOs prefer not to be the only donor sponsoring a particular project, so they look for organisations that already have multiple sources of funding. The NGOs state that this is to ensure that their partners do not become too dependent on them and once funding stops, the project has to stop immediately as well. A downside to this approach is that it could lead to clustering of aid where multiple financing NGOs concentrate on a few receiving ones. Possibly the Dutch NGOs see other financing partners also as a kind of insurance; a local organisation with other funds must have done something well to earn their trust, so their own money is probably safe there as well.

8.10 Discussion of findings

What stands out from the previous sections is that the severity of a health problem or a need for assistance is one, but never the only reason that NGOs have to start up a project or programme. All the other discussed aspects, like earlier experience (in the form of projects on another topic or already having a good relationship with a partner) and funding opportunities, are also important and form the wider discourse or consensus on what is needed from an appropriate and effective programme. This consensus overarches individual actors, so various actors can interpret the different aspects in their own way and add their own ideas. For HIV and AIDS as a topic this means that attention for it depends on what is happening in the environment described above.

9 - Interaction of NGOs with institutional donors and local partners

9.1 Introduction

This chapter describes different aspects of interaction of NGOs with their biggest institutional donors (for most of them this is the Ministry of Foreign Affairs) and with local implementing partners and civil society. The concept 'interaction' is chosen on purpose because it is a broader concept than 'relation'; interaction refers to more than just direct contact. The following sections discuss how the two parties perceive and see one another and what the recurring discussions points are.

9.2 Interaction between NGOs and institutional donors

9.2.1 Task divisions

All respondents emphasized they are content with their relationship with the Ministry of Foreign Affairs. The other way round, Ministry employees note how special it is (compared to other donor countries) that the Dutch Ministry is very close with the NGOs. The donor-recipient relationship is a very important one. The Ministry claims they give freedom to the NGOs to decide for themselves how and on what they will spend that money within boundaries. These boundaries are strict and are mostly rules about transparency and reporting. At the same time, the Ministry and NGOs are direct colleagues, working on different levels but still on the same topics. For example: harm reduction (reducing risk of HIV transmission among injecting drug users) is a topic that is very important for policymakers; they put it on the international agenda and convince other donors and ministries they should do something too. Together with Dutch NGOs who work on the topic as well (for example through contacts with civil society), they participate in special platforms and working groups. On those occasions, the Ministry and NGOs are more like partners; experts exchanging ideas and reinforcing each other's strategy. This is happening for not just those organisations that work on harm reduction: discussion groups, workshops and platforms are good ways for the Ministry of Foreign Affairs and NGOs to make contact and discuss the content of the work they are doing. These contacts are more frequent when the NGOs work on topics that are a priority for the Ministry as well.

The Ministry of Foreign Affairs has formal contact with organisations that receive subsidies, by means of occasional field visits and regular meetings to stay in touch. Apart from the formal contacts, there is frequent contact to update each other and NGOs also

contact them when they have something to share. One employee of the Ministry describes this process.

'We need to know what is going on, what they [the NGOs] are doing. We discuss that, but it's more that we are asking questions and not so much telling them what to do or what we think they should.. […] We have a constant dialogue about the contents of their work.'

In all, employees of the Ministry of Foreign Affairs believe that there are enough possibilities for NGOs to come in contact with them and share their opinions and views. They appreciate this input because for them it is a way to get to know what is happening in the field. The contact with NGOs also serves as an input for their own policies. NGOs on their turn, not only acquire funding from the Ministry but also use these contacts to bring forward what they think is important (advocacy). The Ministry can also be an access to international politics. Concluding, the Ministry and the Dutch NGOs have a mutual relationship but also separate responsibilities.

The general satisfaction about the relationship does not obscure occasional problems and critique. Respondents did not go into much detail about how these are handled because it is sensitive information. However, most organizations felt free to express doubts about the Ministry's policies if certain topics came under discussion in the interview. This shows that NGOs follow closely what the Ministry is doing and what effects this could have on their own activities. Vice versa, the Ministry can be wary about the results that NGOs present them, as one respondents expresses.

'We don't walk around in the field all the time. So we don't really get a good view of how well they [NGOs] are doing there. We talk on the basis of the beautiful, glossy reports they produce. But some NGOs pioneer and let you have more insight in the day-to-day activities.'

The Ministry likes openness of NGOs and the freedom to 'look in the kitchen'. However, knowing that the organisation will be judged on how efficient it is working it is not surprising that few NGOs give their biggest donor insight in what is going wrong in the activities more than necessary.

9.2.2 Thoughts on HIV and AIDS

The Ministry of Foreign Affairs and Dutch NGOs generally have the same ideas about health topics. The NGOs interviewed, all but few exceptions, have the same ideas on HIV and AIDS, what priority it should get and what strategies could be used. Noteworthy is also the leap towards sexual and reproductive health and rights (SRHR) as a new field for attention and the 'mainstreaming' of HIV and AIDS. Regarding mainstreaming it is interesting that both NGOs and the Ministry have critical notes about each other on how mainstreaming takes place. It shows how difficult it is to make 'mainstreaming' successful. Most NGOs are glad that the Ministry pays attention to HIV and AIDS as a part of SRHR, because this is what they do themselves. Policy officers at the health department of the Ministry are pleased to see that so many NGOs put extra effort in SRHR activities.

9.2.3 Who shapes who?

Policymakers of the Ministry of Foreign Affairs emphasized that they do not steer NGOs on the content of their work. They do acknowledge that some regulations about reporting and registration can be a burden, but they always defend this: they are giving the money and are accountable for what is happening with it. The ministry has to be accountable for how they spend money. So, they believe it is fair to ask from NGOs to be transparent about what they do with government funding. The practical aspects of transparency (reporting and evaluations) are sometimes interpreted by respondents working for NGOs as bureaucracy distracting them from their 'real job'.

Another important trend is that, depending on the Minister, the NGOs are seen more or less as a channel that implements government policies. At this moment, the pendulum swings in favour of more alignment of Ministry's and NGOs' policies. One practical consequence is that 60 percent of the budgets that organisations receive via the co-financing system (MFS) should be spent in partner countries of the Netherlands.

Besides funding there are other contact moments allowing for influence and lobbying. Not every NGO uses those opportunities. Smaller organisations for example make less direct contact, because they do not have the capacity to do more, for example by joining a platform or discussion group on a certain theme. Most NGOs are also represented by Partos, the joint representative organisation that has formal and informal contact with the Ministry on behalf of their members.

Although Ministry employees say they give the NGOs space to work out their own thematic priorities, pressure is indeed subconsciously felt. All NGOs note that shifts in funding can have consequences for their own programmes. They are to some extent dependent on the Ministry for funding. Furthermore, some respondents noted that their organisation needs to 'keep up with trends and developments in the field', without specifying which trends and developments weigh heavy and are followed up upon. 'The field' for them is a mixture of experiences during fieldwork, research findings, the work of other NGOs, international trends, but also the policies of the Ministry of Foreign Affairs.

9.2.4 Discussion of findings

Regarding the relationship and interaction between NGOs and the Ministry of Foreign Affairs there is a mutual dependence. NGOs may rely on generous funding and the Ministry cannot spend as much time working in the field as the NGOs. Thus, civil servants use the NGOs as a source of knowledge and reflection on what is happening in the world and use these observations and other input from NGOs in policymaking. At the same time, it appears that the Ministry and NGOs focus on the same aspects like mainstreaming and sexual and reproductive health and rights.

It can be concluded that the Ministry of Foreign Affairs and NGOs have two different types of relations: one for funding and another one as experts on topics. The donor-recipient relationship is a very important one. It is also unequal, as expressed by one Ministry employee; 'As far as the NGOs work with government money they will have to put up with it; who pays, says'. The contacts on thematic issues are perceived to be an equal exchange of information. This is a completely different relation that the donor-recipient relationship. Almost all respondents notice these two roles; they receive institutional funding and also work together. They also notice more or less tension between these two roles; contact as experts supposes an equal relationship and having a funding relationship simultaneously can misbalance this equality.

9.3 Interaction NGOs and local partners

9.3.1 Partnerships

Most of the NGOs shape their cooperation with a local organisation in the form of a partnership. Ideally a partnership between two NGOs is based on mutual respect, exchange of ideas and sharing the decision making on the activities that will be implemented (Smillie

2001; van der Haar and Hilhorst 2009). In the literature the partnership between funding and receiving organisations is often defined along a scale of intensity and the time-horizon of the collaboration. Sometimes collaboration means that the funding organisation is looking for a local one to implement a project designed by the funder. In other circumstances there are series of projects of a longer term, with more space for 'capacity building' of the receiving organisation. Equality, in the form of mutual accountability and sharing decision making gets more and more important. In the end, a partnership can become so close that the partner becomes a branch of the same international network (van der Haar and Hilhorst 2009). Some of these varieties of 'partnerships' do not live up to the ideal type described above. Critical questions are asked if the local partners always have a say in policies or are just implementing the donors plans (Smillie 2001).

9.3.2 Task division and being partners

In this research the role of being a partner varies per organisation and also for each project. Sometimes the Dutch NGOs merely provides the funding for a project that is consequently implemented by the local partner. On other occasions, the Dutch NGOs help out more by providing specific expertise (for example on advocacy or communication strategies in prevention programmes). The relationship and task division is also dependent on what the aims of the collaboration are and the characteristics of the organization, as one respondent explained.

'We work with groups that are not very organised yet. When we work in an area where HIV is very stigmatized, then the organisation representing people living with HIV and AIDS will probably be a stigmatized group. Some of our partners are informal or clandestine organisations, which makes them fragile. Working with them is very different from working with a larger, established organisation.'

After a project or cooperation has started, NGOs have mechanisms to keep track of the progress. Regular field visits take place and usually there are formal evaluations every year. In between there are many informal contact moments via e-mail, phone calls and Skype. Sometimes local partners are invited to participate in strategy discussions or to join the Dutch NGOs at conferences or seminars.

Most respondents indicate they are generally satisfied with their relationships. A good partnership for them is based upon knowing each other working styles and what they can

reasonably (realistically) expect from each other. If things are not going well, this is expressed in mild terms such as; ‘we have had some hiccups, communication problems, misunderstandings.’ This could have been socially desirable answers. Most respondents felt that cooperation and communication with the partner is important, that it could be better in some cases and that it remains a point of attention. Some respondents also noted that their situation was not abnormal; they thought that all sorts of groups and organisations have similar problems at some point. So the problems in their work were seen more as a fact of ‘human life’ rather than a sign of ineffective working of the partners or themselves.

9.3.3 Who shapes who?

When it came to the topic ‘partnership’ all respondents note that there is various and continuous interaction. The aim of partners to share decision making may not always be achieved. One partnering organisation found that sometimes calls for proposals from their donors come with very short deadlines. In those cases there is not enough time, resulting in what this respondent called ‘proposals developed by technocrats only without involving the partners or communities’. But the same respondent also insisted that in most cases there is no pressure. It is noteworthy that respondents working for local organisations define ‘no pressure’ as knowing the conditions for funding so that everyone knows what they can expect. They do not mention unconscious, implicit steering in a certain direction; only the practical aspects of the relationship.

Dutch NGOs are also influenced by their partners. They get to know their partners’ way of looking at issues, get better insights in the real problems in the field and on the real possibilities and working style of the NGOs working there. Local partners on their turn appreciate it when their funders really make an effort to get to know the local context. Donor NGOs appreciate debate and critical dialogue with their partners. Sometimes these critical questions by donors are interpreted by the receiving organisation as ‘annoying’, but rarely as a sign of an unequal relationship.

The interaction about the content of HIV and AIDS related activities was usually about which interventions should be used in a specific context, or which target group should be aimed at in prevention programmes. Local partners did also more often express the need for interventions regarding the treatment of HIV and AIDS. None of the respondents

mentioned a situation where a Dutch NGO discussed the priority of the theme HIV and AIDS among other issues with their partners. This could have something to do with the way partnerships are formed; the broad directions and themes are first decided and then the discussion with partners about it starts. Other organisations select partners and projects based on incoming proposals and reject the ones they do not like immediately, this means there is no pressure, but neither an opportunity to debate new ideas and proposals.

9.3.4 The opinion of 'backdonors'

For the Ministry of Foreign Affairs, the relationship with local partners is an important criterion to assess the Dutch NGOs on. For the Ministry, 'independence of local partners' is not just that the partners have access to various resources. They value equality more: sharing decision making and having a genuine mutual relationship:

'It is a very important criterion and it comes back in the policy framework for civil society. How will there be invested in southern partners, to operate independently, to influence the application procedures, to put things on the agenda, to operate regardless of permission from headquarters in the Netherlands…'

This respondent knows that NGOs interpret partnership in a different way, but they would like to see that Dutch NGOs somehow strengthen local civil society. The employees of the Ministry also notice that what is called partnership can harbour various meanings:

'For some NGOs it is a matter of principle to work on empowerment and autonomy of their southern partners and they will have a partner policy. Others are more, ehmm, patronizing… […] We notice that during subsidy rounds. Applications come in and some organizations write about their southern partners but you can clearly see that they are not independent organizations, but merely satellites of headquarters. I don't think Dutch NGOs have that… Maybe a few...'

Another employee also confirmed that is difficult to assess the real value of a partnership during field visits:

'We ask [local organisations] how is their relationship with X? But that's their donor, so they will say; yes, we are fine.'

Also noted is that local partner organisations get more and more independent from their Dutch counterparts. The Ministry sees that empowerment and capacity building has paid

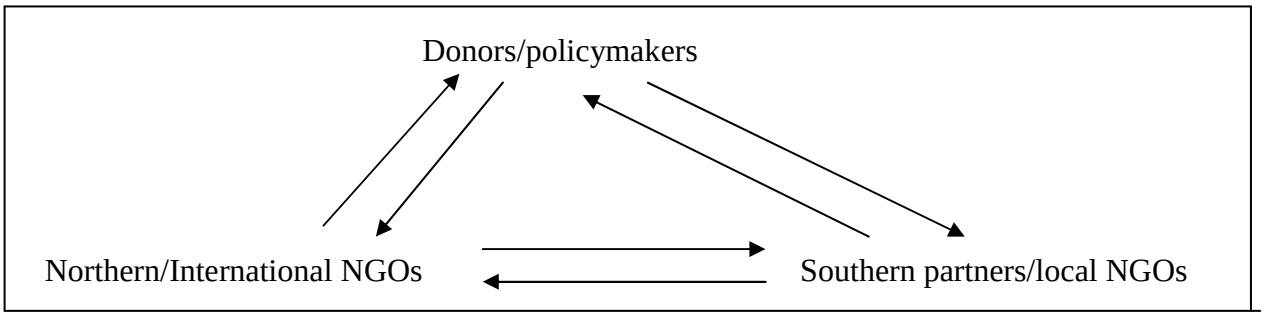
off in some situations and southern partners become equally strong, independent and skilled as their Dutch counterparts. The conclusion of the Ministry is that in those cases Dutch NGOs have to take on another role. Respondents also expected that Dutch NGOs will become a less important channel for funding and donors will fund local NGOs directly more often.

9.3.5 Discussion of findings

NGOs and their local partners seem to think about pressure and influence in different ways. Local partners point more at practicalities; they appreciate a donor who is clear about what they expect from them and takes the local context and needs into account. They do not show the same nervousness about acquiring funding than Dutch NGOs when they talk about their own donors and seem to be much more pragmatic.

The Ministry of Foreign Affairs finds the relationship of Dutch NGOs and their partners very important. Since local partners get stronger and more articulated, there is a tendency to question the function of Dutch NGOs as a financial channel. When referring back to Figure 1.1 in Chapter 1, it may be that in the future the direct relation between donors and southern partners gets more and more important. Figure 9.1 shows that the direct interaction between local NGOs and donors gets more important and the Dutch NGOs could lose its role a transfer point. This scheme only portrays the relations between NGOs and local partners and institutional donors like the Ministry of Foreign Affairs. The relation with a funding party is important, but it is not the only factor shaping policies of NGOs.

Figure 9.1: Relationship between different actors in development aid II



10 - Conclusion and discussion

This research started on the assumption that HIV and AIDS are still a high international priority. During the research it turned out this was no longer the case: at the international AIDS conference in Vienna this summer, this finding was confirmed. Global funding for HIV and AIDS is indeed declining. The NGOs in this research noticed this trend; they found it harder to acquire funding for HIV and AIDS and therefore the topic slipped to a lower priority. Some respondents acknowledged hesitantly that they thought that HIV and AIDS might have gotten too much attention in the past, compared to other health issues. They were also acutely aware that even though it is not of high priority anymore, this does not mean that the problem is solved. So it can be concluded that in this case, availability of funding plays just as much a role in deciding on priorities as the need for intervention in a certain area.

When talking about the declining attention for HIV and AIDS, many respondents fluently moved to their new fields of attention. Sexual and reproductive health and rights (SRHR) were mentioned as a broader way of approaching HIV and AIDS, there were some campaigns on maternal and child health, and often the NGOs planned to mainstream or integrate HIV and AIDS in their other programmes. These integrated programmes came to replace HIV and AIDS specific activities. Respondents knew about the pitfalls of mainstreaming and most of them were aware that it can mean that attention and funding for a topic can disappear altogether. Despite this hesitance, all of them seemed to support their organisations new approach.

The shift from HIV and AIDS to more complex issues like sexual and reproductive health and rights was unforeseen from the start of this study. With these topics, many health problems are now under the attention of development organizations. Is this a more equal allocation of funding. Shiffman (2008) and McCoy (2009a) suggested that ideally donors should assess what problems are the biggest and that is where funding should be directed to. Their conclusion was that too much funding is directed towards HIV and AIDS. However, I doubt that recent shifts have anything to do with a rational re-allocation of money to where it is most needed. Instead, NGOs operate in a varied and full field of different actors in which the NGOs have to set up their policies. The actors create a discourse or consensus on what the most important topics are and what is the best strategy

to work on them. Individual NGOs are sensitive to these issues and use this information to shape their own policies. A rational assessment and allocation of money only according to needs hardly ever takes place. I would not necessarily call this incompetence or displacement of aid, it is more likely that severity of issues, or epidemiology, does not play a huge role in global priority setting. Individual NGOs are required to position themselves and they use the internalized information to create policies that are in line with their vision and mission.

In this research the relationships with donors and beneficiaries (the local partners that they fund themselves) were also studied. There it appeared that discussion on themes and needs is important but most of the interaction and influence between Dutch NGOs and local partners is about the practical aspects of programmes. The overarching themes of the projects (for example HIV and AIDS, instead of any other disease) are discussed less often. It is difficult to assess to what extent that indicates steering of organisations and if the local partners feel 'done wrong'. Extensive fieldwork would be needed to answer that question properly, but from the interviews one could hypothesize in line with (Hilhorst 2003) that local NGOs are responding to the donor. Not necessarily by doing exactly as they say, but by 'being creative'. It means that the local organisations know what can be asked from a donor and if necessary are able to 'work your way around the requirements' of the donor. On the other hand there is a lot of open discussion between the Dutch and the local organisations on the approaches and strategies that are used in these HIV and AIDS activities (like, what do we do with orphans? Who is the most vulnerable group in this area? Is lobbying and advocacy an option in this area? Is the partner well equipped (money and expertise) to work on this?) These discussions take place often and openly and both sides appear to be knowledgeable about these issues.

During this research it appeared that NGOs themselves rarely discussed the questions I asked them about prioritization. More than one interview closed with a respondent saying that the topics were very interesting, but also 'quite philosophical' and therefore of low practical value. Priorities seem to have 'grown' out of everyday business. An explanation could be that decision making in organisations takes place on levels. It could be that I spoke to people in the organisation who do not belong to the upper management levels and therefore do not participate in 'philosophical' debates about the strategy and policy. This also depends on the character of the NGO; in some organisations there is an atmosphere

that welcomes debate and there is a lot of internal discussion about the work and the direction of the organisation, while others take pride in being ‘doers’, where more pragmatic choices are made. A downside of being pragmatic is there is no ‘philosophical’ debate about the HIV and AIDS programming. During this research only one respondent wondered for example why some many NGOs work on prevention of a disease, when medication is available for people in Europe. Other respondents discussed the future of HIV and AIDS projects based on more mundane topics, on how to enhance the effectiveness of the current HIV and AIDS projects.

One limitation on the results of this research is that there was not an extensive field work period. I noticed that it is difficult to assess what is really going on at the partner organisations. Even though these organisations were not the first focus of this research, it could be useful to know more about how these organisations organize the HIV and AIDS projects on a day to day basis and how they relate to their donors.

Bibliography

Annual Reports 2009 of Amref, Artsen zonder Grenzen, Aids Fonds, Cordaid, Healthnet TPO, Hivos, ICCO, Oxfam Novib, Plan, Rode Kruis, Save the Children, Simavi, Stop Aids Now!, Tear, World Vision, Woord en daad and WPF.

Avert. 2009. *President's Emergency Plan for AIDS Relief (PEPFAR).* Avert website, can be retrieved at http://www.avert.org/pepfar.htm

Barnett, T. & Whiteside, A. 2002. *Aids in the twenty-first century: Disease and globalization.* Hampshire and New York: Palgrave Macmillan.

Beaglehole, R. & Bonita, R. 2004. *Public health at the crossroads: Achievements and prospects.* Second edition. Cambridge: Cambridge University Press. [1997]

Broere, M. 2010. *Partos-directeur Alexander Kohnstamm: "De sector gaat het Waarmaken."* Vice Versa Online, can be retrieved at http://www.viceversaonline.nl/2010/03/partos-directeur-alexander-kohnstamm-%E2%80%98de-sector-gaat-het-waarmaken%E2%80%99/

Creswell, J.W. 2003. *Research design: Qualitative, quantitative, and mixed methods approaches.* Second edition. London, Thousand Oaks and New Delhi: SAGE publications. [1994]

Davey, B. & Hart, G. 2002. 'HIV and AIDS.' In: B. Davey & C. Seale (Eds.), *Experiencing and explaining disease,* 83-136. Buckingham and Philadelphia: Open University Press.

Derksen H. & Verhallen, P. 2008. 'Reinventing international NGOs: A view from the Dutch co-financing system.' In: A.J. Bebbington et. al (Eds.), *Can NGOs make a difference? The challenge of development alternatives,* 221-239. London and New York: Zed Books.

De Waal, A. 2006. *AIDS and power: Why there is no political crisis – yet.* London and New York: Zed Books.

Edwards, M & Hulme, D. 1996. 'Too close for comfort? The impact of official aid on nongovernmental organizations.' *World Development* 24(6):961-973.

Elsey, H. et al. 2005. 'Mainstreaming HIV/AIDS in development sectors: Have we learnt the lessons from gender mainstreaming?' *AIDS Care* 17(8): 988-998.

FAO. 2008. *The state of food insecurity in the world 2008: High food prices and food security – threats and opportunities.* Rome: Food and Agriculture Organization of the United Nations.

Fenton, L. 2004. 'Preventing HIV/AIDS through poverty reduction: the only sustainable solution?' *Lancet* 364:1186-1187.

Foster, G.M. 1999. 'Bureaucratic aspects of international health programs.' In: R.A. Hahn (Ed.), *Anthropology in public health: Bridging differences in culture and society,* 345-364. Oxford and New York: Oxford University Press.

Fuller, L. 2006. 'Justified commitments? Considering resource allocation and fairness in Médecins Sans Frontiers-Holland.' *Developing World Bioethics* 6(2):59-70.

Gellert, G.A. 1997. 'Non-governmental organizations in international health: Past successes and future challenges.' *International journal of health planning and management* 11:19-31.

Green, A. & Matthias, A. 1997. *Non-governmental organizations and health in developing countries.* London: Macmillan Press.

van der Haar, G. & Hilhorst, D. 2009. *Partners in crisis : Peer review of partnership in crisis-related interventions.* The Hague: PSO.

Halmshaw, C. & Hawkins, K. 2004. 'Capitalising on global HIV/AIDS funding: The challenge for civil society and government.' *Reproductive Health Matters* 12(24):35-41.

Heyse, L. 2004. *Choosing the lesser evil: Understanding decision making in humanitarian NGOs*. Leiden: Universiteit Leiden.

HGIS. 2010. *HGIS Jaarverslag 2009.* The Hague: Ministry of Foreign Affairs.

Hilhorst, D. 2003. *The real world of NGOs.* London and New York: Zed Books.

Hivos. 2009. *Aids policy.*

Holden, S. 2004. *Mainstreaming HIV/AIDS in development and humanitarian programmes.* Oxford: Oxfam GB.

Iliffe, J. 2006. *The African Aids epidemic: A history.* Athens: Ohio University Press.

IOB. 2008. *Beleidsdoorlichting seksuele en reproductieve gezondheid en rechten en hiv/aids 2004-2006.* The Hague: Ministry of Foreign Affairs.

JLICA. 2009. *Home truths: Facing the facts on children, AIDS and poverty.* Can be retrieved at www.jlica.org

Koch, D. et al. 2009. 'Keeping a low profile: What determines the allocation of aid by non-governmental organizations?' *World Development* 37(5):902-918.

Koch, H. 2007. *Aidspatient in Afrika is beter af dan andere zieke.* Trouw website, 19-07-2007. Can be retrieved at http://www.trouw.nl/nieuws/wereld/article1653596.ece

van der Krogt, Th.P.W.M. & Vroom, C.W. 1995. *Organisatie is beweging.* Utrecht: Uitgeverij Lemma BV.

Levine, R. & Oomman, N. 2009. 'Global HIV/AIDS funding and health systems: Searching for the win-win.' *Journal of acquired immunodefiency syndrome* 52(1)November: S3-S5.

Lewis, D. & Kanji, N. 2009. *Non-governmental organizations and development.* London: Routledge.

McCoy, D. et al. 2009a. 'Global health funding: How much, where it comes from and where it goes.' *Health policy and planning* 1-11.

McCoy, D. et al. 2009b. 'The Bill & Melinda Gates Foundation's grant-making programme for global health.' *Lancet* 373:1645-1653.

Meijer, W.A. 2002. 'Population and reproductive health: The state of the art.' In: *Global population issues: The human dimension*, 25-37. The Hague and Hilversum: NGIZ and WPF.

Ministry of Foreign Affairs of The Netherlands. 2007. *Een zaak voor iedereen: Investeren in een veranderende wereld.* The Hague: Ministerie van Buitenlandse Zaken.

Ministry of Foreign Affairs of The Netherlands. 2008. *Global financial architecture of the Aids responses.* Speech of Minister Koenders at the international Aids conference Mexico, August 25th 2008.

Ministry of Foreign Affairs of the Netherlands. 2008b. *Beleidsnotitie HIV/aids en seksuele en reproductieve gezondheid en rechten (srgr) in het buitenlands beleid: Keuzes en kansen.* The Hague: Ministerie van Buitenlandse Zaken.

Ministry of Foreign Affairs of The Netherlands. 2009. *Beleidsnotitie Maatschappelijke Organisaties: Samenwerking, maatwerk, meerwaarde.* The Hague: Ministerie van Buitenlandse Zaken.

Ministry of Foreign Affairs of The Netherlands. 2010a. *Hoeveel geven we uit?* Can be retrieved at http://www.minbuza.nl/nl/Onderwerpen/Ontwikkelingssamenwerking/Hoeveel_geven_we_uit

Ministry of Foreign Affairs of The Netherlands. 2010b. *Resultaten.* Can be retrieved at http://www.minbuza.nl/nl/Onderwerpen/Tegengaan_aids_en_malaria/HIV_aids/Resultaten#top

Ministry of Foreign Affairs of The Netherlands. 2010c.*Uitgaven per kanaal.* Can be retrieved at http://www.minbuza.nl/nl/Onderwerpen/Ontwikkelingssamenwerking/Met_wie_werkt_Nederland_samen/Uitgaven_per_kanaal

Ministry of Foreign Affairs of The Netherlands. 2010d. *Millennium Ontwikkelingsdoelen.* Can be retrieved at http://www.minbuza.nl/nl/Onderwerpen/Millennium_Ontwikkelingsdoelen

Ministry of Foreign Affairs of The Netherlands. 2010e. *Wat doet Nederland om hiv/aids te bestrijden?* Can be retrieved at http://www.minbuza.nl/nl/Onderwerpen/Tegengaan_aids_en_malaria/HIV_aids/Wat_doet_Nederland_om_hiv_aids_te_bestrijden

Ministry of Foreign Affairs of The Netherlands. 2010f. *Meer samenwerking tussen ontwikkelingsorganisaties door nieuw subsidiestelsel. Nieuwsbericht 31-03-2010.* Can be retrieved at http://www.minbuza.nl/nl/Actueel/Nieuwsberichten/2010/03/Meer_samenwerking_tussen_ontwikkelingsorganisaties_door_nieuw_subsidiestelsel

Ministry of Foreign Affairs of The Netherlands. 2010g. *Kamerbrief inzake beantwoording vragen schriftelijk overleg over MFSII d.d. 20 mei 2010. Kamerbrief 27 mei 2010.* Can be retrieved at http://www.minbuza.nl/nl/Actueel/Kamerstukken/2010/05/Kamerbrief_inzake_beantwoording_vragen_schriftelijk_overleg_over_MFS_II_d_d_20_mei_2010

Ministry of Foreign Affairs of The Netherlands. 2010h. *Drie categorien van aanpak.* Can be retrieved at http://www.minbuza.nl/nl/Onderwerpen/Ontwikkelingssamenwerking/Waar_is_Nederland_actief/Drie_categorieën_van_aanpak

Mosse, D. 2004. 'Is good policy unimplementable? Reflections on the ethnography of aid policy and practice.' *Development and Change.* 35(4):639-671.

Müller, T.R. 2005. *HIV/AIDS, gender, and rural livelihoods in sub-Saharan Africa.* Wageningen: Wageningen Academic Publishers.

Parker, M. & Wilson, G. 2000. 'Diseases of poverty.' In: T. Allen & A. Thomas (Eds.), *Poverty and development into the 21st century*, 75-97. Oxford: Oxford University Press.

Partos. 2009. *Reactie van Partos op de beleidsnotitie Maatschappelijke Organisaties.* Amsterdam: Partos.

Pfeiffer, J. 2003. 'International NGOs and primary health care in Mozambique: The need for a new model of collaboration.' *Social science and medicine* 56:725-738.

Pfeiffer, J. et al. 2008. 'Strengthening health systems in poor countries: A code of conduct for nongovernmental organizations.' *American Journal of Public Health* 98(12): 2134-2140.

Rau, B. et al. 2008. *The evolving contexts of AIDS and the challenges for food security and rural livelihoods.* Rome: FAO.

Salden, O. 2009. *The work of the Stop AIDS Now! Partners: A mapping study and general analysis.* Amsterdam: Stop AIDS Now!

Schennink, B. et al. 2006. 'Working on peace-building and conflict prevention: Reflection on the findings.' In: B. Schennnink & G. Van der Haar (Eds.), *Working on peace-building and conflict prevention: Experiences and dilemma of Dutch NGOs,* 203-217. Amsterdam: Dutch University Press.

Schings, J. & Verweij, M. 2010. *Aids sneuvelt op bijltjesdag hulpsector.* One World, can be retrieved at http://www.oneworld.nl/Nieuws/article/24958/?template=print

Schoepf, B.G. 2001. 'International AIDS research in anthropology: Taking a critical perspective on the crisis.' *Annual Review of Anthropology.* 30:335-361.

Schulpen, L. 2010. *MFS-II: Een eerste reactie op het nemen van de eerste horde.* Vice Versa Online, can be retrieved at http://www.viceversaonline.nl/2010/04/mfs-2-een-eerste-reactie-op-het-nemen-van-de-eerste-horde/

Seckinelgin, H. 2008. *International politics of HIV/AIDS: Global disease – local pain.* London and New York: Routledge.

Shiffman, J. et al. 2002. 'The emergence of global disease priorities.' *Health policy and planning* 17(3):225-234.

Shiffman, J. 2006. 'Donor funding priorities for communicable disease control in the developing world.' *Health planning and policy* 21(6):411-420.

Shiffman, J. 2008. 'Has donor prioritization of HIV/AIDS displaced aid for other health issues?' *Health Policy and Planning* 23:95-100.

Singhal, A. & Rogers, E.M. 2003. *Combating AIDS: Communication strategies in action.* New Delhi, Thousand Oaks and London: Sage Publications.

Skolnik, R. 2008. *Essentials of global health.* Sudbury: Jones and Bartlett Publishers.

Smillie, I. 2001. *Patronage or partnership: Local capacity building in humanitarian crises.* Bloomfield: Kumarian Press.

Stillwaggon, E. 2002. 'HIV/AIDS in Africa: Fertile terrain.' *The journal of development studies* 38(6):1-22.

Stillwaggon, E. 2005. *Aids and the ecology of poverty.* Oxford Scholarship Online

Stoddard, A. 2003. 'Humanitarian NGOs: Challenges and trends.' *HPG Briefing*. Number 12.

Stop AIDS Now! 2009. *Strategic Plan 2010-2015*. Amsterdam: Stop AIDS Now

Stop AIDS Now! 2010. *Ministerie van Buitenlandse Zaken stopt effectieve aidsprogramma's.* Stop AIDS Now! website.

Susser, I. 2009. *AIDS, sex and culture: Global politics and survival in Southern Africa.* West Sussex: Wiley-Blackwell.

UNAIDS. 2004. *Report on the global AIDS epidemic.* Geneva: UNAIDS.

UNAIDS. 2008. *Report on the global AIDS epidemic.* Geneva: UNAIDS.

UNAIDS. 2010. *Outlook report.* Geneva: UNAIDS.

Walden, V.M. et. al. 2007. *Humanitarian programmes and HIV and AIDS: A practical approach to mainstreaming.* Oxford: Oxfam GB.

Walt, V. 2009. *Diarrhea: The great zinc breakthrough.* Time website 17-08-09, can be retrieved at http://www.time.com/time/printout/0,8816,1914655,00.html

WRR. 2010. *Minder pretentie, meer ambitie: Ontwikkelingshulp die het verschil maakt.* Amsterdam: Amsterdam University Press.

Annex 1: List of respondents (alphabetical order)

Organisation	Conversation	Telephone	Questionnaire
Artsen zonder Grenzen	X		
HealthNet TPO		X	
Hivos	X		
KIT	X		
Ministry of Foreign Affairs	X		
Oxfam Novib		X	
Plan		X	X
Rode Kruis	X	X	
Save the Children	X		
Simavi	X		
Stop AIDS Now!	X		
Tear		X	
Woord en Daad			X
World Vision	X		
WPF / MyBody		X	

Annex 2: General topic list interviews with NGOs

1) Background of the organisation
2) HIV and AIDS related activities
3) Position and importance of HIV and AIDS within the organisation
4) Decision making about themes and projects
5) Financing: How are the HIV and AIDS projects funded?
6) Partners: What kind of cooperation and interaction?
7) Relation with the Ministry of Foreign Affairs

If applicable:

8) About mainstreaming and integration: What happens exactly?
9) Religious background of the organisation

Annex 3: Table with countries of implementation

The following table accompanies Chapter 6. It lists how many NGOs implement projects or program directly related to HIV and AIDS in the listed countries. A second column lists the number of organisations that have indirect/integrated projects in a country, meaning that HIV and AIDS are addressed in within a broad program or another project. It is difficult, if not impossible, to find out for all organisations if and how much of this indirect activity there is and how substantial its contribution in targeting HIV and AIDS is. Only the projects that had traces of HIV and AIDS significance in its brief project descriptions are included in this table.

For each country, HIV prevalence (percentage of HIV-positive adults in the population) is also listed. The source for these prevalence data is the UNAIDS 2008 report. The data are estimates for the year 2007. More recent data from a reliable source like the UN were not available at the time of writing.

The last column indicates if the country in question is a partner country of the Dutch Ministry of Foreign Affairs. Not every country on the world is in this list, only those who a.) are a partner country of the Netherlands, b.) have HIV prevalence over 5 % or where c.) there is a Dutch NGO present with a HIV and AIDS related project or program.

Country	**HIV Prevalence (in percentages)**	**Number of organisations that run a project or programme in the country**		**Partner country for BuZa**
		direct	indirect	
Africa				
Benin	1,2			Yes
Botswana	23,9			No
Burkina Faso	1,6	3		Yes
Burundi	2,0	2	1	Yes
Cameroon	5,1			No
Central African Republic	6,3		1	No
Chad	3,5	1		No
Congo, DR	3,2	5		Yes
Egypt	0,1			Yes
Eritrea	1,3	2		No
Ethiopia	2,1	6	1	Yes
Gabon	5,9			No
Ghana	1,9	1		Yes
Ivory Coast	3,9	1		No
Kenya	6,1	7	2	Yes
Liberia	1,7	1		No

Mali	1,5	1		Yes
Malawi	11,9	5	1	No
Mozambique	12,5	2		Yes
Namibia	15,3	2		No
Rwanda	2,8	2		Yes
Senegal	1,0	2		Yes
Sierra Leone	1,7	1		No
Somalia	0,5	1		No
Sudan	1,4	3	2	Yes
Tanzania	6,2	2	1	Yes
Uganda	5,4	8	5	Yes
Zambia	15,2	5	1	Yes
South-Africa	18,2	7	2	Yes
Zimbabwe	15,3	4	1	No
Asia				
Afghanistan	n/a	1		Yes
Bangladesh	0,1	3		Yes
Cambodia	0,8	1		No
China	0,1	1	1	No
Georgia	n/a	1		Yes
Indonesia	0,2	6	1	Yes
India	0,3	6	1	No
Yemen	n/a			Yes
Kazachstan	0,1	1		No
Kyrgyzstan	0,1	1		No
Mongolia	0,1			Yes
Myanmar	0,7		1	No
Nepal	0,5	1		No
Pakistan	0,1	2	1	Yes
Palestine territories (?)	n/a			Yes
Thailand	1,4	2		No
Vietnam	0,5	2	1	Yes
Europe				
Albania	n/a	1		No
Kosovo	n/a			Yes
Moldova	0,4			Yes
Latin America				
Bolivia	0,2	2		Yes
Belize	2,1	1		No
Brazil	0,6	2		No
Colombia	0,6	1		Yes
Costa Rica	0,4	1		No
Cuba	0,1	1		No
Dominican Republic	1,1	2		No
Ecuador	0,3	1		No
El Salvador	0,8	1		No
Guatemala	0,8	2		Yes
Haiti	2,2	5		No
Honduras	0,7	2		No
Nicaragua	0,2	3		Yes
Peru	0,5	2		No
Suriname	2,4			Yes

Sources: UNAIDS 2008; Ministry of Foreign Affairs 2010h; Salden 2009; websites and annual reports 2009 of the NGOs listed in section 6.1.