Mapping of funding mechanisms and main sources of funding for the community response to HIV and AIDS

International HIV/AIDS Alliance

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Executive summary

The study's primary goal was to map and describe funding mechanisms and main sources of funding of the community response to HIV and AIDS. The specific objectives were to:

(i) Identify the main sources of global funding of the community response;

(ii) Document different funding mechanisms for the community response to HIV and AIDS;

(iii) Describe the flow of funds from key funding sources;

(iv) Identify the percentage of the budgets of civil society organisations (CSOs) covered by each of the main sources of funding; and,

(v) Describe the allocation of funds across the continuum of prevention, treatment and support, care, mitigation, policy and advocacy.

This study is descriptive in nature. The purpose was not to analyse the relative efficiency of different channels (e.g. CSOs versus government agencies) or provide a cost-benefit analysis of interventions.

The following are key conclusions.

1. Increased funding has reached civil society to respond to AIDS.

As a result of donors prioritising both the scale-up of AIDS responses and the involvement of multiple sectors of implementers in developing countries, new and important funding flows have reached civil society in the past nine years. From 2001, the World Bank Multi-Country AIDS Program for Africa emphasised a community response as part of country and regional projects, with likely funding commitments to CSOs in Africa averaging $55 million annually from 2001 through 2013. MAP's efforts resulted in an apparent mobilisation of local CSOs, with relatively small individual funding amounts spread through a large number of civil society organisations.

From early 2003, the Global Fund has also prioritised civil society involvement within its model of scaling up responses in developing countries. By June 2010, 18 percent of Global Fund disbursements for AIDS grants have been through civil society Principal Recipients (PRs), or more than $150 million on average per year. Most CSO PRs have exceeded performance targets. Indigenous organisations, rather than international NGOs, have managed 57 percent of Global Fund disbursements received by civil society PRs. Geographically, the funding flow through CSO PRs is not aligned with global funding patterns, and this has been addressed by the Global Fund by encouraging systematic inclusion of CSO PRs in all proposals.

From 2003, US PEPFAR has largely relied on partners with demonstrated capacity to deliver the top priority of rapid scale-up. While most funding passes through relatively large international organisations, it is also estimated that 11 percent of the funding flow reaches indigenous civil society organisations (net of clinical activities for treatment and blood safety), amounting to an annual average of approximately $270 million a year.

From 2004, DFID's first AIDS strategy committed the UK government to spend $2.5 billion on AIDS in developing countries, and in 2008 its second AIDS strategy committed $11 billion to more general strengthening of health systems. DFID's support to civil society engagement in AIDS responses is estimated at $55 million on average per year.

There are some challenges in putting this funding in context, but it is possible to say the annual average when all four donors have been active has been almost $500 million a year for civil society AIDS activities across all countries. While certainly higher in some years, it is still a relatively modest contribution to effective AIDS responses when compared to the funding needs for AIDS responses in low- and middle-income countries – estimated at $22 billion for 2008 – and the amounts being made available from different sources.

2. Despite growth, there have been important signs of funding uncertainty and these continue

On the ground, as indicated by country profiles, it is only in recent years that positive developments in civil society AIDS funding have been effectively in place. In Peru, India and Kenya funding continues to be subject to change: there are relatively recent examples of successes in involving more CSOs in the AIDS response, alongside examples of funding fluctuations or funding stream close-out. Both positive and negative developments for recipients reinforce long-standing complaints from civil society regarding the predictability of funding beyond the short term.

There are indications of changes in donor priorities that have occurred and are continuing. Examples include a reduction in the World Bank MAP's relative contributions, although its funding is still important in some countries. The Global Fund continues to change aspects of its funding system. While PEPFAR has made attempts to broaden the number of partner organisations, it also has a new emphasis on country government ownership for programme sustainability, and its most recent HIV/AIDS budget has been flat-lined in 2010 after more than doubling every two years since 2005. DFID's more recent emphasis on health systems strengthening has replaced AIDS-specific priorities. The effects of these various changes on civil society's access to funding flows, and on its contributions to AIDS responses in low- and middle-income countries, are not yet known.

During the past nine years the role of CSOs within AIDS responses has been positively influenced by donor priorities, including the World Bank's and the Global Fund's systematic prioritisation of funding community responses. It will be important to understand the impact of future changes in donor priorities, especially on advances that have been made in funding the involvement of indigenous civil society organisations in AIDS responses.

3. Country level funding mechanisms are important for civil society responses

From the recipients' level there are clear indications of the importance of country funding mechanisms that are accessible to civil society organisations. Indigenous CSOs in particular appear to be well-served by these funding streams, including the

Global Fund grants through PRs and other country funding mechanisms. While some information from country profiles shows concentration of funding among a small number of recipients (in Kenya and Peru), some funding streams have successfully strengthened dispersal through country mechanisms (Peru and India). There are examples of funding that has expanded the number of CSOs involved, and indigenous organisations in particular, while data on the resulting AIDS activities indicate these mechanisms are funding community responses.

A CSO survey reached a fairly homogenous sample of indigenous organisations involved in AIDS at grassroots level, and showed country level funding mechanisms provide on average 37 percent of annual revenue for AIDS activities. This includes 21 percent from the Global Fund and 16 percent from country based funding mechanisms and government contracts. Another fifteen or sixteen percent average annual revenues are from each of three other categories: the organisations' own private fundraising, funds from "other" bilaterals and multilaterals (i.e. not the "big four" reviewed here), and unspecified foundations or charities. At the same time, while country funding mechanisms were individually important to average annual income, they do not often dominate budgets. This is consistent with findings in the literature: when funding mechanisms are strong and decentralised they are more successful in reaching organisations in a broad-based manner.

4. The findings confirm that civil society organisations fill certain roles

The country profiles and survey results confirm the main rationales for funding civil society and its complementary role in AIDS responses. In Kenya, national AIDS spending was dominated by treatment and care, but half of CSO funds were allocated to prevention. In India, some larger prevention programmes fully rely on local CSO implementers, while Global Fund financing to CSO PRs appears to have increased the use of different funding channels, filled gaps in delivering the national strategy, and diversified AIDS activities. In Peru, a third of CSO projects targeted key populations such as transgender people, men who have sex with men and sex workers, which have not been the focus of Governmental prevention activities.

The survey respondents were mostly indigenous organisations, and most of these are small, voluntary CSOs. The bulk of their annual prevention spending – 71 percent on average – was for work with key populations at high risk and targeted prevention for groups such as women, youth and migrants. Treatment spending was focused on support to people living with HIV (72 percent) rather than drug procurement (14 percent). Most care and support funds deliver programming for adults living with HIV (52 percent on average) and for orphans and vulnerable children (another 22 percent).

5. There is an important gap in regular data

Despite certain stakeholders' recognition of the importance of the community response, regular monitoring systems have not specifically tracked its funding or its outputs. This appears to be true both at donor and country levels. This lack of regular information could be a risk for ensuring continued funding of CSOs' contributions to AIDS responses, especially while donor priorities for AIDS continue to be discussed and funding flows continue to change.

1. BACKGROUND AND FINDINGS FROM THE LITERATURE

Summary of key points

The following are four main areas of background and findings relevant to involvement of civil society in AIDS responses and funding issues.

- *The role of civil society in HIV/AIDS responses*

There are multiple rationales given for funding civil society organisations (CSOs) for community AIDS responses. The most common is that CSOs are capable of reaching priority populations and those most affected. There is a view among some that evidence about CSO effectiveness is lacking, while others argue that sufficient evidence exists about priority HIV interventions and that these are key to prioritising funding flows.

- *Funding of civil society for AIDS*

Funding of civil society AIDS activities has grown significantly in the past decade. There have been new and larger funding streams from different sources. This has increased the number of CSOs involved, as well as CSO spending on AIDS.

- *Reaching the community level and priority populations*

Programming for marginalised populations is insufficient. There is also a need for further data on the effects of active funding streams on expanding priority, targeted programming. There are indications that CSO participation in networks and in stakeholder coordination committees can increase their access to financing that would support community responses.

- *Allocating resources and tracking donor funds*

While AIDS funding has increased, this has not necessarily translated into financing of the most relevant AIDS programming priorities, including efforts to reach priority populations.

1. The role of civil society in HIV/AIDS responses

The most commonly given rationale for funding civil society organisations is that they are well positioned to reach the people most affected, such as vulnerable populations and remote communities (Alliance, 2007; Birdsall and Kelly, 2007; Drew and Attawell, 2007; Homedes and Ugalde, 2006; ITPC, 2008; Middleton-Lee, 2007; Noack and Campioni, 2006; Sidaction, 2005; World Bank, 1999). This view often holds that civil society organisations have strong links with, or are composed of, marginalised and hard to reach populations, and further that they have greater expertise in understanding and responding to the needs of these groups. This is particularly important in contexts where governments resist developing programmes for vulnerable and affected populations.

In addition to their access to populations affected by AIDS or those at risk, in some settings CSOs are perceived to be less corrupt and inefficient than governments

(Doyle, 2008). Some also argue that government approaches tend to be more standardised compared to the innovative approaches of CSOs, many of which work in difficult environments and with few resources (Halmshaw and Hawkins, 2004; Middleton-Lee, 2007). Finally, broader development considerations could inform the rationale for supporting civil society engagement in AIDS responses, such as: improving service delivery in developing countries; empowering communities or marginalised populations; mobilising political support for the AIDS response; contributing to democratic pluralism; and developing local ownership and longer term sustainability of AIDS responses (Ainsworth et al., 2005; Birdsall and Kelly, 2007).

While the literature provides multiple reasons for funding CSOs, some state the evidence base concerning the effectiveness of civil society AIDS responses is less developed (Birdsall and Kelly, 2007; Doyle and Patel, 2008). Others have said this is a generalised issue: the ability to evaluate the impact of both government and civil society AIDS responses is limited by the absence of strong information systems at country level and a lack of programmatic evaluations (Ainsworth, 2006; Cáceres and Mendoza, 2009).

On the other hand, some feel there is ample understanding of the effectiveness of HIV interventions, and the central problem "is not lack of evidence but failure to bring to scale programming that addresses the major drivers of HIV infection in specific national settings" (Global HIV Prevention Working Group 2008: 6). In such a case, civil society's role as part of a multisectoral approach should include strong advocacy for scaling up of prevention and treatment simultaneously, participating in development of national targets, monitoring national progress, and pushing for strategies that deliver evidence-based interventions for key populations.

2. Funding of civil society for HIV/AIDS

Funding for civil society activities on HIV/AIDS has grown significantly in the past decade, starting in 1999 and intensifying from 2001 (Birdsall and Kelly, 2007). A number of studies gauged that overall resources for AIDS responses in developing countries increased from US$1.6 billion in 2001 to US$10 billion in 2007 (Lieberman et al., 2009). For civil society, the result was greater levels of AIDS funding made available from an increased number of sources, and in some cases CSO revenues increased three-fold (Birdsall and Kelly, 2007). In this funding context, the World Bank's MAP for Africa programme, the Global Fund and the US PEPFAR initiative have been among those making efforts to raise stakeholder participation and to increase CSO access to financial resources (Biesma et al., 2009).

In parts of sub-Saharan Africa, the number of civil society organisations has increased and some existing organisations have shifted their missions to place a greater emphasis on AIDS due to available funding in this area (Kelly and Birdsall, 2008). From 2001 to 2005, total CSO spending on AIDS increased by more than six hundred percent.[1] In this study, local community-based organisations (CBOs) gained increased access to funding, reflected by the fact that their average spending on AIDS grew at a faster rate than it did among national and international NGOs. The main sources of CSO revenue found by Birdsall and Kelly (2007) were bilateral

[1] Based on a study of 439 CSOs in six sub-Saharan African countries

donors (providing 42 percent of funding to civil society), followed by international NGOs, multilateral agencies, and sub-granting mechanisms.[2] Smaller amounts of funding derived from: private foundations and trusts; private sector companies; individual contributions, membership fees and self-generated income; and national NGOs, embassies and government departments.

Although the average value of grants from bilateral donors, multilateral agencies and foundations were larger, the most frequently mentioned sources of support were international NGOs and sub-granting mechanisms. This southern Africa study noted that by 2005 sub-granting mechanisms were the most accessed source of CSO funds and disbursed funds broadly (ibid). In more recent years, national sub-granting mechanisms have continued to replace bilateral funding to CSOs in many countries (Kelly and Birdsall, 2008).

3. Reaching the community level and priority populations

Due to epidemiological variations, different regions of the world will prioritise different populations, such as men who have sex with men in Latin America or injecting drug users in Central and Eastern Europe and Central Asia (Kelly et al., 2006). However, programming for marginalised populations is often lacking. For example, organisations working in countries where sex work is criminalised face formidable barriers to reaching sex workers or receiving funding to work with them (Dorf, 2006). A study of 13 World Bank projects in Latin America showed more than half did not provide adequate support to CSOs to reach key populations – sex workers, men who have sex with men, and transgender people – despite initial plans to do so. Among the perceived obstacles were discriminatory laws that undermine interventions aimed at key populations, overly ambitious planning and lack of subsequent strategic guidance, insufficient funding of CSO core costs, and over-estimation of CSO capacity to implement and evaluate key population interventions (Alliance, 2007).

Biesma et al. (2009) highlighted the need for studies to assess whether marginalised populations are benefiting from global health initiatives such as the Global Fund, PEPFAR, and MAP. One study of key populations in the Latin American and Caribbean region found a direct correlation between participation in Global Fund Country Co-ordinating Mechanisms and resource allocation to key population organisations (Alliance, 2009). Another study of key population CSOs in Latin America found that joining national or international networks provided greater access to financial resources (GTZ and CITC, 2008).

4. Allocating resources and tracking donor funds

With the increase in funding flows for HIV/AIDS, there have been concerns about the spending priorities and the beneficiaries reached by funded programming. In many countries HIV and AIDS resources are not being allocated in ways that are likely to achieve the greatest impact (Forsythe et al., 2009; Hester et al., 2009). Forsythe et al. describe the need for an evidence-based allocation strategy “in which resources are spent in a way that is, based on the best currently available evidence, likely to achieve the greatest possible result” (8).

[2] These three sources provided a further 44 percent: international NGOs 17 percent, multilateral agencies 16 percent, and sub-granting mechanisms 11 percent.

The study also noted that neighbouring countries with similar prevalence of HIV often allocate resources very differently (4). Despite the fact that 90 percent of the required financial resources were generated from donors, only 61 percent of the target number of sex workers and 37 percent of injecting drug users were actually reached (6). Half of all donor prevention money in China was aimed at the general population, even though 90 percent of HIV transmission is attributable to injecting drug users and men who have sex with men (12). These and other examples suggest that either initial targets were too optimistic, or that spending in practice did not turn out to be as efficient or effective as was originally assumed (6).

Several studies state that evidence is lacking in areas that could support more efficient and effective fund allocation and programme design: programme evaluations, cost-effectiveness research, and programme costing studies, particularly those associated with interventions for priority populations (Forsythe et al., 2009; Hester et al., 2009; Kelly et al., 2006; Schenk, 2009).

It is also difficult to gauge to what extent programming is reaching priority populations in the absence of robust data on funding and expenditure (Dmytraczenko et al., 2006; Foster, 2005; Hester et al., 2009; Renton, 2005; Save the Children, 2006; UNDP China, 2008). One study highlighted that out of 147 countries, approximately two thirds provided expenditure data in the 2008 UNAIDS Report on the Global AIDS Epidemic, and of these countries only one third reported expenditure on programmes for populations that are most at risk for HIV infection (Hester et al., 2009). The absence of reported expenditure in this area may be due to a lack of collected data; however, it may also “reflect strong political reluctance to acknowledge or support these groups, particularly with public funds” (Hester et al., 2009: 13). Improved data collection can aid in identifying where spending on priority populations is deficient, and can lend itself to advocacy efforts to increase resource allocation for programming that reaches key populations.

Lastly, without adequate tracking systems, it is difficult to monitor whether donor earmarked money has actually reached target populations, such as funding pledged by DFID, USAID and Irish Aid for OVC programming (Renton, 2005; Save the Children, 2006). Similarly, UNDP China (2008) reported a lack of expenditure reported by international NGOs and donors for programmes reaching men who have sex with men, and Birdsall and Kelly (2007) confronted similar challenges in collecting data on donor funding to civil society organisations in general.

2. DONOR FUNDING FLOWS

The World Bank's Multi-Country HIV/AIDS Program for Africa

The Africa MAP first phase

Approved in the fiscal year ending June 2001, the Africa Multi-Country AIDS Program was, in different ways, a new approach for the World Bank. Countries had to meet four criteria to secure MAP funds – have a national AIDS strategic plan in place; have a high-level AIDS coordinating body; use arrangements for accelerated implementation (which reduced the average 18-month approval period for Bank projects by half); and channel some project support to non-governmental actors, including NGOs, community and faith-based organisations, and the private sector (Görgens-Albino, Mohammad, Blankhart, Odutolu, 2007). This phase-one report also cited MAP's positive outcomes for the Bank as an institution. The authors felt MAP was the first significant HIV/AIDS programme whose support went beyond prioritised HIV interventions by also making strategic and system investments, that it set an example as a swift response to the AIDS health emergency in Africa through a large-scale programme, and that it established the Bank's reputation for addressing HIV/AIDS after "sustained neglect" in the 1990s.

In this period between 2001 and 2006, the Africa MAP led to almost $1.3 billion in AIDS funding commitments, or 47 per cent of the Bank's allocations to AIDS (ibid:13). From the end of phase one in 2006 to the end of 2009, a further $545 million in commitments brought the total across all sectors to almost $1.9 billion for the 2001-2013 period (World Bank, "Multi-Country HIV/AIDS Program" and "Projects and Programs"). Key informant feedback also indicates that by 2009 MAP funding as a proportion of total AIDS resources had declined, although it is still relatively important in a few countries where Global Fund grants are not large.

In addition to Africa MAP, the Bank provided financial or technical support to Botswana, Lesotho, Swaziland and Namibia – countries where HIV prevalence rates are among the highest globally but were ineligible for MAP funds because of national income levels (Görgens-Albino et al.:17). MAP style funding approaches were also replicated in other regions, such as the Caribbean and Central Asia (61).

Community involvement was an explicit component among the main priorities of the MAP design. Overall, the Africa MAP intended to catalyse or support the following:

- a strong political and governmental commitment to the AIDS response;
- an environment conducive to national scale-up;
- increased community participation and ownership through funding and capacity building; and,
- a multisectoral response including governmental and non-governmental stakeholders, improved national coordination, and decentralisation to sub-national government bodies.

The approach was informed by a recognition that "Initial efforts to respond to HIV were too narrowly focused on the health sector" which could not by itself address "the complex social and individual behaviors involved in HIV transmission, and the multifaceted impact of AIDS" (ibid:15). As one example of programming not focused

solely on health system delivery, MAP supported community-based care including nutritional support and income generation for people living with HIV and those directly affected such as family members. Furthermore, after five years of MAP the Bank's Global HIV/AIDS Program cited some evidence of funding reaching key populations through civil society, such as people living with HIV and sex workers, while it was felt the multisectoral and multi-partner approach contributed to a pro-poor focus, reaching people outside of capitals and in particularly impoverished groups (51). Oomman, Bernstein and Rosenzweig (2007) also noted that n many individual country projects more than half of funds flowed to district and community level, where the main recipients are often district governments, NGOs and CBOs.

Oomman et al. (57) also concluded that MAP's focus on involving sectors of recipients, rather than funding specific AIDS activities, resulted in increased capacity. At the same time, funding was slow and unpredictable due to bottlenecks encountered by first-level government recipients; and MAP's procedures indicate that it prioritised accountability over quick implementation.

The funding flow

Guidance for MAP disbursement procedures (The World Bank, undated) highlights certain elements of the funding flow's architecture. The intended primary recipient of funds is the National HIV/AIDS Council (NAC). NACs can be funded by multiple donors. A multi-layered structure is used to reach a large number of beneficiaries dispersed throughout a country. Because of this, funds flow to community-level implementers through intermediaries, which can include district and local governments, NGOs, private sector service providers, and line ministries. Most of the intermediary organisations are also implementers of their own HIV/AIDS activities supported by these funds. This system also typically involves numerous small transactions that require carefully designed accounting procedures. The guidance also notes these arrangements can vary.

Mapping of the funding flow

The visual map offered here puts a specific emphasis on channels that reach civil society and community responses (fig. 2.1). In terms of the flow of funds, Oomman et al. notes variances on the basic model citing the MAP programmes in Mozambique, Uganda and Zambia:

- Alternative models that have come about in different countries were based on parameters set out as part of the MAP programme, and a process of design led by the government with close involvement of World Bank staff.
- The NAC could be considered the "default" principal national recipient, but in some cases they play an oversight role and approve disbursement decisions proposed by others, notably the Ministry of Health. Exceptions can also include funding flowing through both the NAC and Ministry of Health, as in Mozambique.
- Sometimes the NAC does not handle funds but in such a situation the NAC would normally approve all sub-grants across sectors, as in Uganda.
- Some countries, such as Madagascar and Zambia, set up MAP project units to process proposals and disburse funds within the national oversight process.

Figure 2.1. World Bank MAP's funding flow

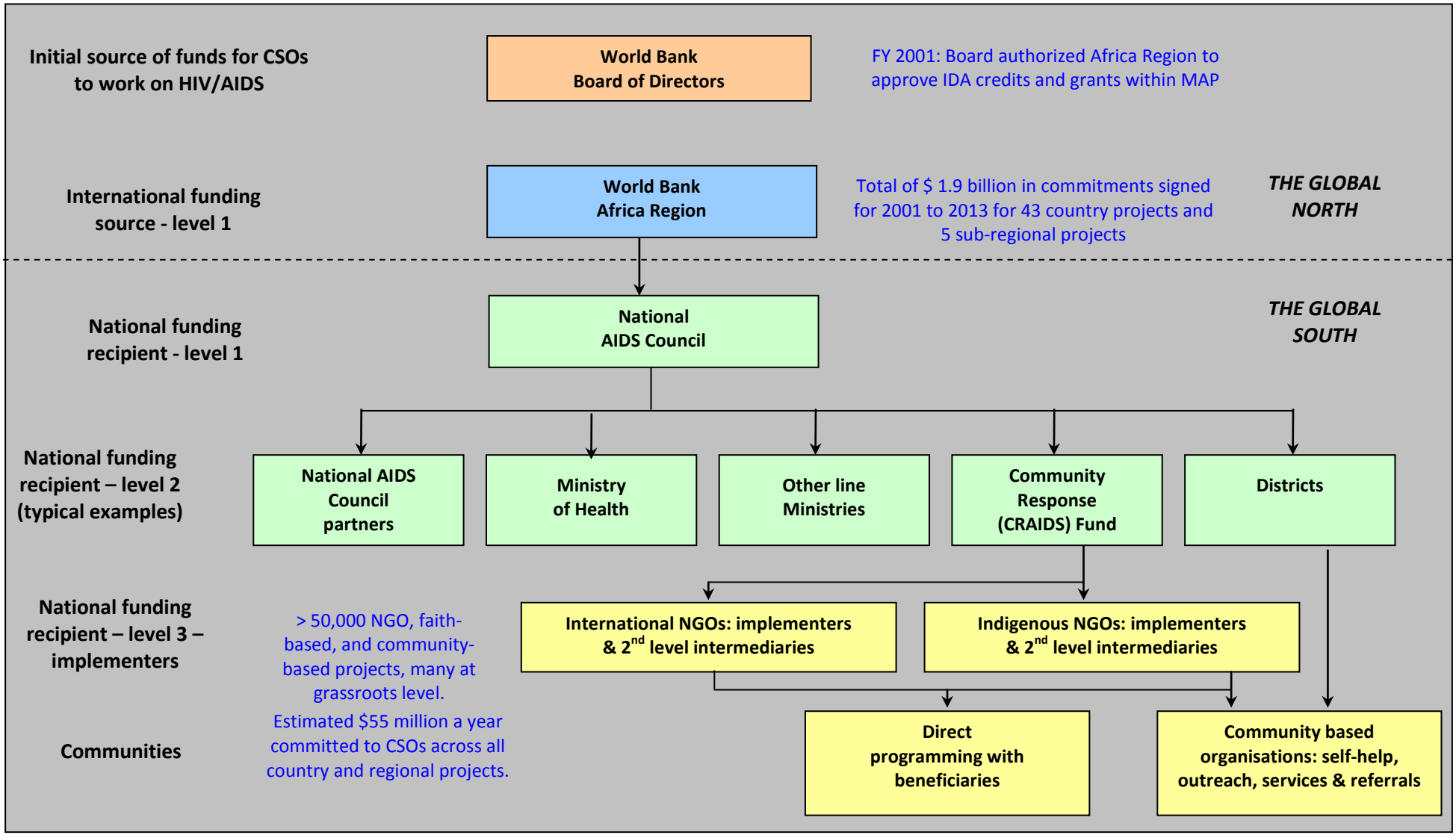
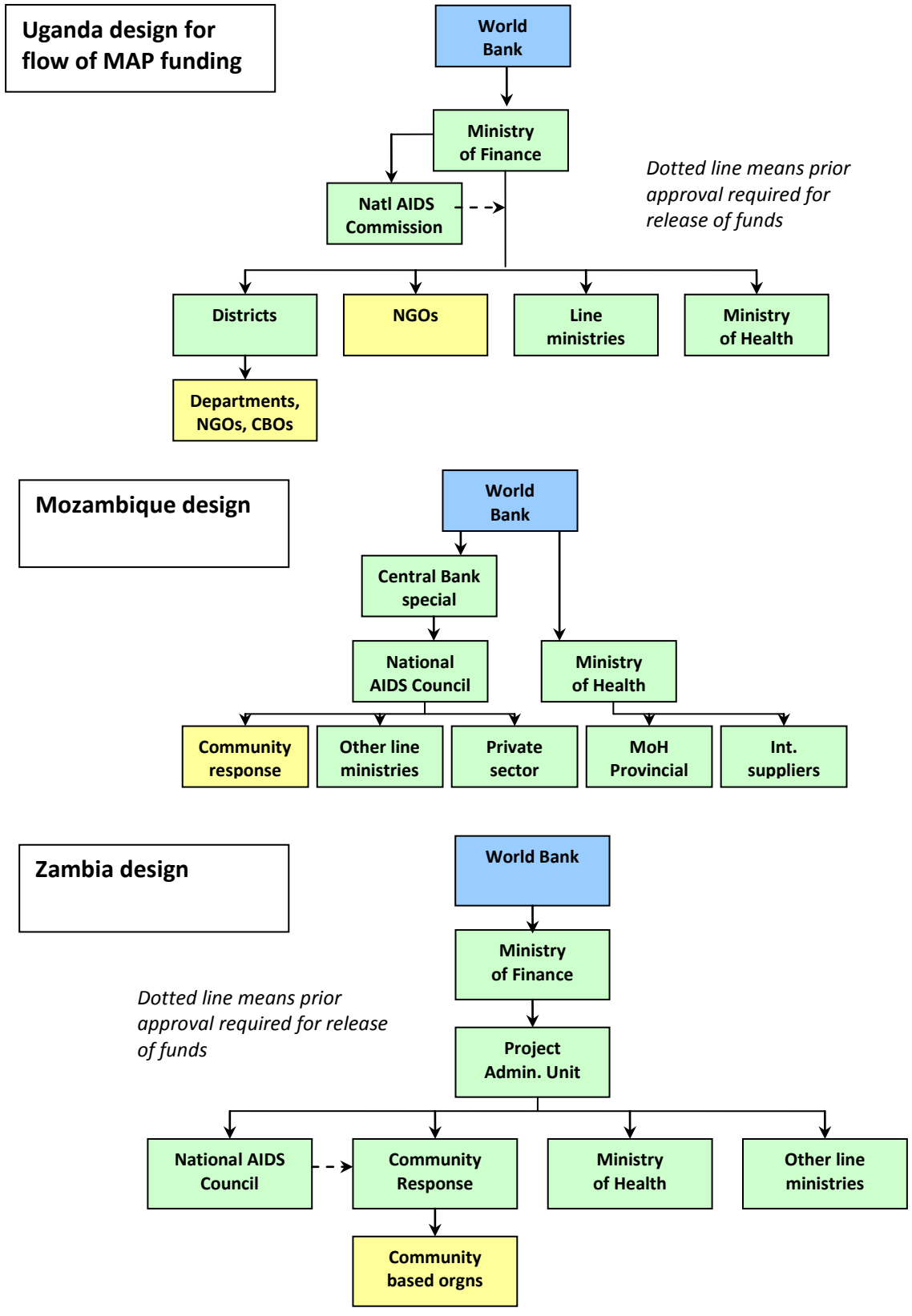


Figure 2.2 presents varied designs of country level financing structures that Oomman et al. found in three settings.

Figure 2.2. Variations on MAP structures in three countries.



Source: Oomman et al. 2007

The funding flows in these system designs imply somewhat different relationships. The National AIDS Council is involved in approving civil society funding in each case, and sometimes in managing disbursements. In Uganda funds to civil society actors are released at the central project level and decentralised to administrative districts.

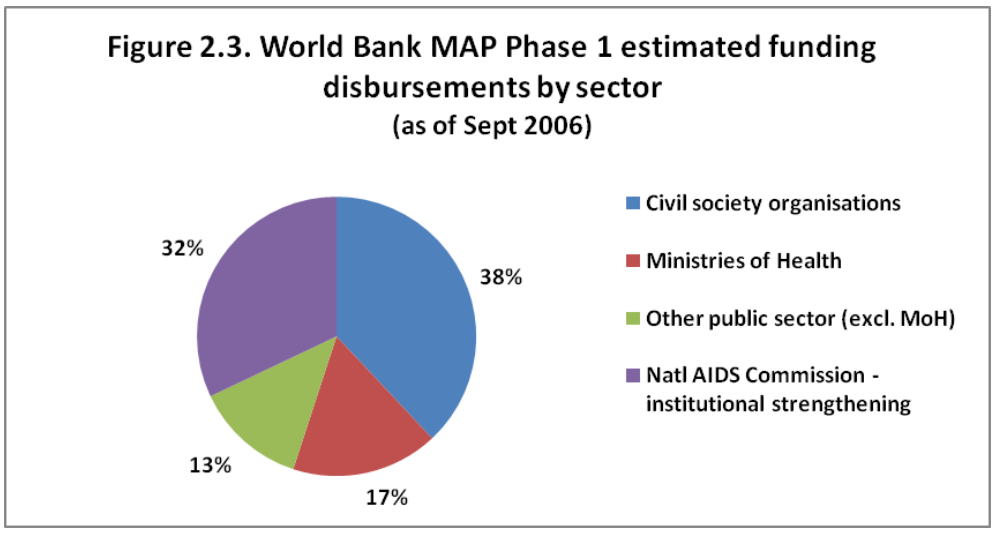
Tracking the funding flow

The 2007 Bank report was written when the first MAP projects were reaching completion, and presented data on sectoral funding flows allocated to National AIDS Councils, Ministries of Health, other line ministries and civil society.[3]

Funding to civil society and other sectors

Funding intended for CSOs was estimated to be $306 million (38 percent) of the first $805 million disbursed by MAP up to September 2006. A further $196 million of allocations were in the pipeline, bringing the total committed and disbursed funds intended for civil society implementers to $502 million, across the 31 countries and four multi-country projects in sub-Saharan Africa that had been approved (ibid:3).

The recipients included more than 66,000 civil society organisations (CSOs) and 234 line ministries (ibid:44). The dispersed nature of these CSOs, and the typical size of their funded AIDS efforts, is underlined by the average amounts of money managed by agencies in each sector. A significant variability is likely among recipients, but the report's figures mean an average line ministry received just over $1 million by September 2006, and the average CSO was allocated slightly more than $4,500.



Source: Görgens-Albino et al.

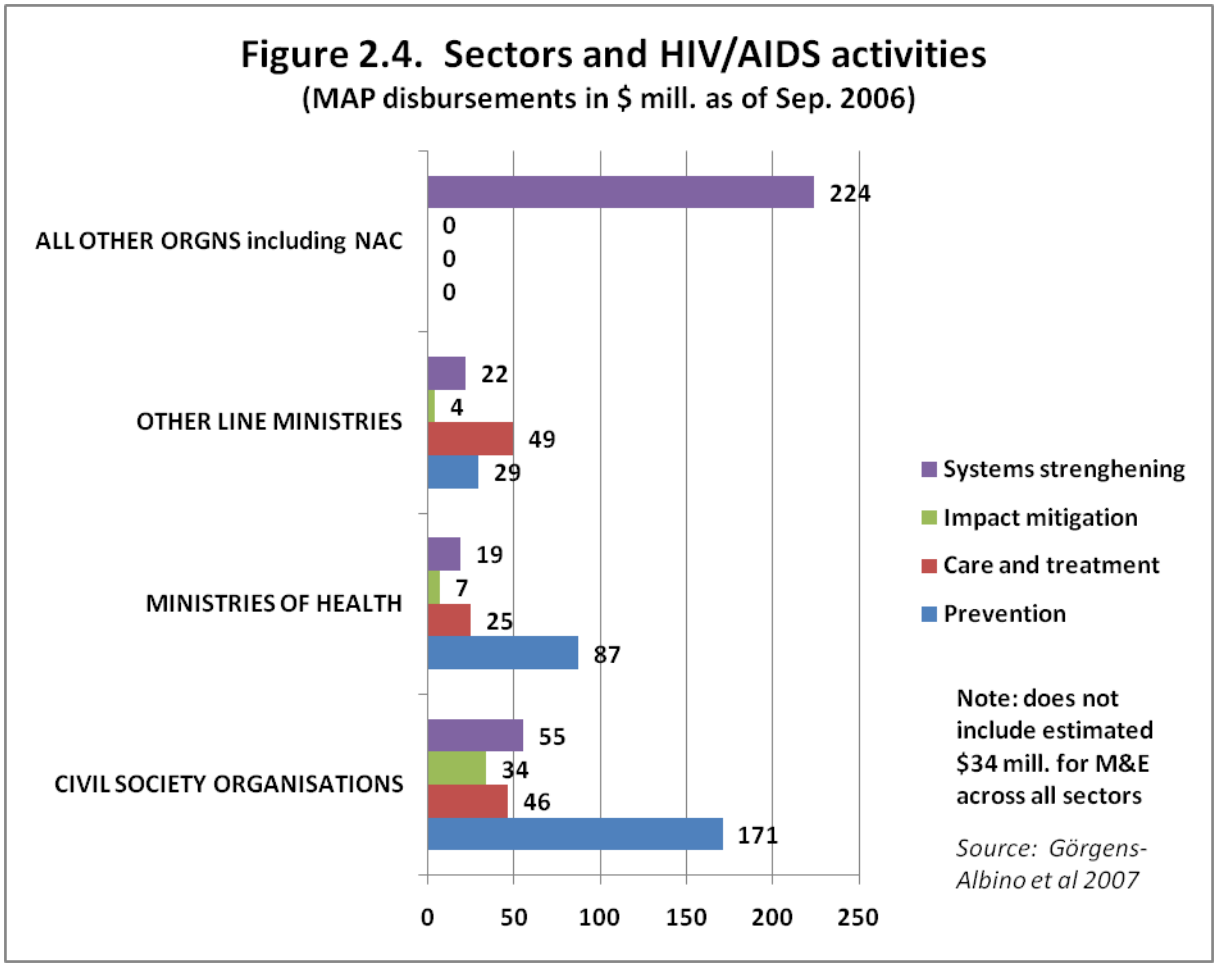
An extrapolation of the phase one estimate to MAP funding agreed in subsequent years (World Bank, "Projects and programs") indicates that commitments to civil society could have reached $709 million (out of a total of $1.865 billion in all agreements) for the 2001-2013 period, or $55 million per year on average.

[3] This was not collected through routine monitoring but from the MAP's annual survey of country and regional projects and by making extrapolations from project planning documents.

Expenses on HIV/AIDS activity areas by sector

The Bank's 2007 report gave a sense of sectoral spending in different activity areas. An estimate of the first $800 million in disbursements, by activity area for each sector, is shown in figure 2.4.

- Health ministries allocated 62 percent of funds to prevention, often for clinical services (HIV testing, management of sexually transmitted infections, and prevention of maternal-child transmission), and 19 percent for treatment.
- CSOs were allocated most of the total prevention funding, for activities such as peer education, promotion of condom use, and promotion of testing for HIV and other sexually transmitted infections. A quarter of all the disbursements to CSOs were for activities focused on care, treatment and impact mitigation.
- Non-health ministries were given allocations mostly for prevention and for care activities, often aimed at government employees.
- National AIDS Commissions used funding for institutional strengthening, coordination, research, monitoring and evaluation, capacity building and operational costs.



The report showed typical roles differentiated among the various sectoral actors, as shown in table 2.1.

Table 2.1: HIV service delivery areas typically undertaken by different sectors

	Prevention
Civil society organisations	Peer education, information campaigns, and communication efforts about HIV to increase condom use, and increase the use of services for voluntary counselling and testing (VCT) and sexually transmitted infections (STIs).
Ministries of Health	Services for: VCT, STI treatments, prevention of mother-to-child transmission (PMTCT), and other HIV prevention interventions
Other line Ministries	Funds typically used to run HIV prevention programs for employees
	Care and treatment
Civil society organisations	Home-based care and support by CSOs, and NGOs providing ARVs or treatment for opportunistic infections (OIs)
Ministries of Health	Setting up ARV facilities, ARV treatments, etc.
Other line Ministries	ART programs of ministries that run their own clinics, e.g., Ministry of Defence and police
	Impact mitigation
Civil society organisations	Income generation activities, support for orphans and vulnerable children, and access to community-level health schemes
Ministries of Health	Nutrition support and counselling for people on ARV treatment.
Other line Ministries	Mitigate the impact of HIV for employees living with HIV and those directly affected (such as family members).
	Systems strengthening
Civil society organisations	Support, training, and capacity building for NGOs. Umbrella organizations fund smaller NGOs, build capacity, supervise and mentor.
Ministries of Health	Building capacity to provide HIV services, including infrastructure development
Other line Ministries	Internal impact assessments, planning, and capacity building
National AIDS Councils and partners	NACs & partners including decentralised structures, training institutions, and consultants (for M&E, capacity development etc) are responsible for the following: build capacity, set up decentralized coordination structures, review the national strategic plan, improve supply chain management, design HIV policies, set up private sector coalition against HIV/AIDS, etc.

Source: Görgens-Albino et al., 2007

Conclusion

– *Funding flow*

The World Bank's MAP for Africa programme plans during phase one (2001-2006) included 38 percent of allocations to civil society organisations. This resulted in estimated funding disbursements to civil society of $84 million a year, on average, out of a total of $502 million in estimated funding commitments to civil society. Extrapolating across the periods covered by all signed project agreements, commitments to civil society implementers from MAP could amount to $709 million from 2001 to 2013, or an annual average of $55 million per year agreed to date.

The amounts provided to individual CSOs have been small and, at the same time, the number of CSO recipients has been relatively large, which could distinguish MAP's priorities from many "traditional" health projects. In addition, the programme's inclusion of different sectors of implementers including the community response, and funding of institutional strengthening in addition to health activities, were characteristics of MAP from its inception. It was an early programme with these particular areas of focus, and while its relative contribution to financing of AIDS responses has declined it is still important in certain countries.

– *Expenditure by civil society on HIV/AIDS activity areas*

The data also indicates funding has been allocated to complementary roles among different sectors of implementers. Across the different activity areas – prevention, care, treatment, impact mitigation and institutional strengthening – there was a clear delineation between the activities that were the main focus of civil society, Ministries of Health, and other line ministries.

– *Data availability and limitations*

The Bank's own estimates of the funding flow to civil society and the use of funds for different activities were based on planned rather than actual expenditure, and covered the period 2001 to 2006. At the time of this estimate there had been $805 million of disbursements (across all sectors), while total MAP commitments signed for the 2001-13 period total almost $1.9 billion.

When considering the availability of data covering donor funding of civil society, this 2007 estimate was a rare attempt to disaggregate a global programme's HIV/AIDS financing by different sectors of implementing agencies. In particular, the estimation exercise tried to look beyond first-level recipients, and also disaggregated both recipient types as well as their expenditure on different AIDS activities.

The Global Fund to Fight AIDS, Tuberculosis and Malaria

The principal purpose of the Global Fund, as clearly stated in its inception framework, is to act as a financing mechanism for scaling up responses to the three diseases (Global Fund, undated), and its main HIV-related funding focus has remained the scale-up of anti-retroviral treatment. This is simply explained by recalling that in 2002, when the Global Fund was founded, there was increasing global awareness of the HIV/AIDS burden in developing countries while recent, lifesaving treatment was inaccessible to 90 percent of the people who needed it (Global Fund, "History of the Global Fund"). At that time of extremely limited treatment access, it was estimated that almost 30 million people were living with HIV, mostly in sub-Saharan Africa, and almost 2 million people a year were dying of AIDS (UNAIDS, 2008),

In addition, the Global Fund's financial support for the AIDS response is spread in various ways: geographically, across different HIV/AIDS activities, and through different sectors of funding recipients and implementing agencies. In its 2009 results report, The Global Fund stated that it disburses 23 per cent of international funding for HIV (The Global Fund, 2009d).

Civil society

The Global Fund cites various benefits of supporting a multi-sectoral approach: reaching more people by raising awareness of service availability; scaling up delivery of services to more populations and regions; accelerating access, including for those currently excluded and key affected populations; and promoting sustainability by increasing capacity of a broad range of implementing agencies. Civil society also helps ensure accountability of implementers to citizens (Global Fund 2009d).

Civil society organisations have been involved in the Global Fund from its design phase, and played an early role in ensuring donor government financing (International HIV/AIDS Alliance and The Global Fund, 2008). Early pressure on governments came from Northern and Southern civil society organisations, and resulted in the first round of GFATM funding in 2002. A sense of ownership of the Global Fund by CSOs is attributed to the fact that civil society helped to create, fund and govern this initiative (The Global Fund, "NGOs and Civil Society").

While civil society organisations have been eligible for grants since its establishment, over time the Global Fund felt the process of generating proposals through national stakeholders did not result in sufficient disbursements to civil society (Global Fund, 2008a). One study also reported there has been reluctance by governments in many countries to work with civil society, and this has obstructed both effective proposal design before funding and the management of grants once they are awarded (International HIV/AIDS Alliance and Global Fund, 2008). Equally, there are barriers among CSOs, particularly local ones, in terms of understanding what they can propose to the Global Fund. Members of the Country Coordinating Mechanisms also do not always understand the Fund's rules and procedures, for instance believing that funding ceilings prevent the submission of more ambitious proposals that might include civil society service providers and people in need.

In response, from 2008 the Global Fund did not require, but recommended, that all country proposals routinely include both governmental and non-governmental Principal Recipients (Global Fund, 2008a).[4] Due to the time required for project development and approval, grants under this "dual track financing" condition were signed starting in 2009. Previously, non-government agencies were 23 per cent of the Principal Recipients (PRs) worldwide, even though more than 80 per cent of civil society PRs exceeded performance requirements of their grants (Global Fund 2009b). In the last two funding rounds, since dual track financing has been implemented, 48 percent of PRs have been civil society organisations.

In addition to this, there have been recent modifications to an original design feature of the Global Fund that focused the operation almost exclusively on channelling financial support to outputs rather than funding of technical support that might be required by recipients. The organisation's inception framework states that country proposals could consider capacity building, but specifically for ensuring delivery of programme outputs and monitoring (Global Fund, undated).[5] In parallel to the Global Fund's dual track financing at Principal Recipient level, from 2008 the Global Fund also sought proposed activities for strengthening civil society systems (Global Fund, 2008a) as well as starting to finance health systems strengthening (Global Fund 2008b).

The Global Fund (2009b) has presented a combined rationale for both of these funding adjustments:

- The scale-up of responses requires unprecedented efforts from both public and private sectors in order to turn community level needs into demand.
- Sustainable scale up of implementation needs to focus on those working at community level, including local governments
- Implementers at community level are challenged by capacity gaps, such as resources to roll out community support activities, human resources and M&E.

The Global Fund felt the subsequent response in country proposals demonstrated commitment to community systems strengthening. In 2009, at least 70 percent of proposals for each funding stream – AIDS, tuberculosis and malaria – included community systems strengthening, with 94 percent of HIV/AIDS applications incorporating it (ibid). Across all countries and different funding streams, between 50 percent and 80 percent of the proposals submitted in 2009 proposed reinforcing capacity in the following five areas: (i) scaling up or strengthening programming; (ii) monitoring and evaluation; (iii) partnership building; (iv) strategic planning and management; and (v) financial management and reporting.

[4] It was a recommendation rather than a requirement, but the Global Fund further stipulated that applications without a CSO proposed as a Principal Recipients should give reasons for this, and discuss alternatives for ensuring both governmental and non-governmental implementation.
[5] Various other agencies have since been involved in technical support to Global Fund projects: UNAIDS and US PEPFAR now support this area, for instance.

The funding flow

The Global Fund's processes are recent, relatively different, and well described elsewhere. From a recipient's perspective, however, the funding flow includes several notable characteristics. Country proposals can include more than one top-level Principal Recipient. Programming plans are often developed by different actors, then tied together as a single proposal that in its entirety is accepted, provisionally approved pending changes, or rejected. However, once funding agreements are signed each PR is responsible for its own programme's performance.

The Country Coordinating Mechanism decides which organisation(s) it will put forward as PRs, whether from government, civil society, or other sectors. However, each PR later signs a grant agreement directly with the Global Fund, and submits further disbursement requests directly to the Fund's Secretariat. Many PRs both manage programme implementation themselves, as well as managing onward grants to other organisations (Global Fund, "Principal Recipients and Sub-Recipients").

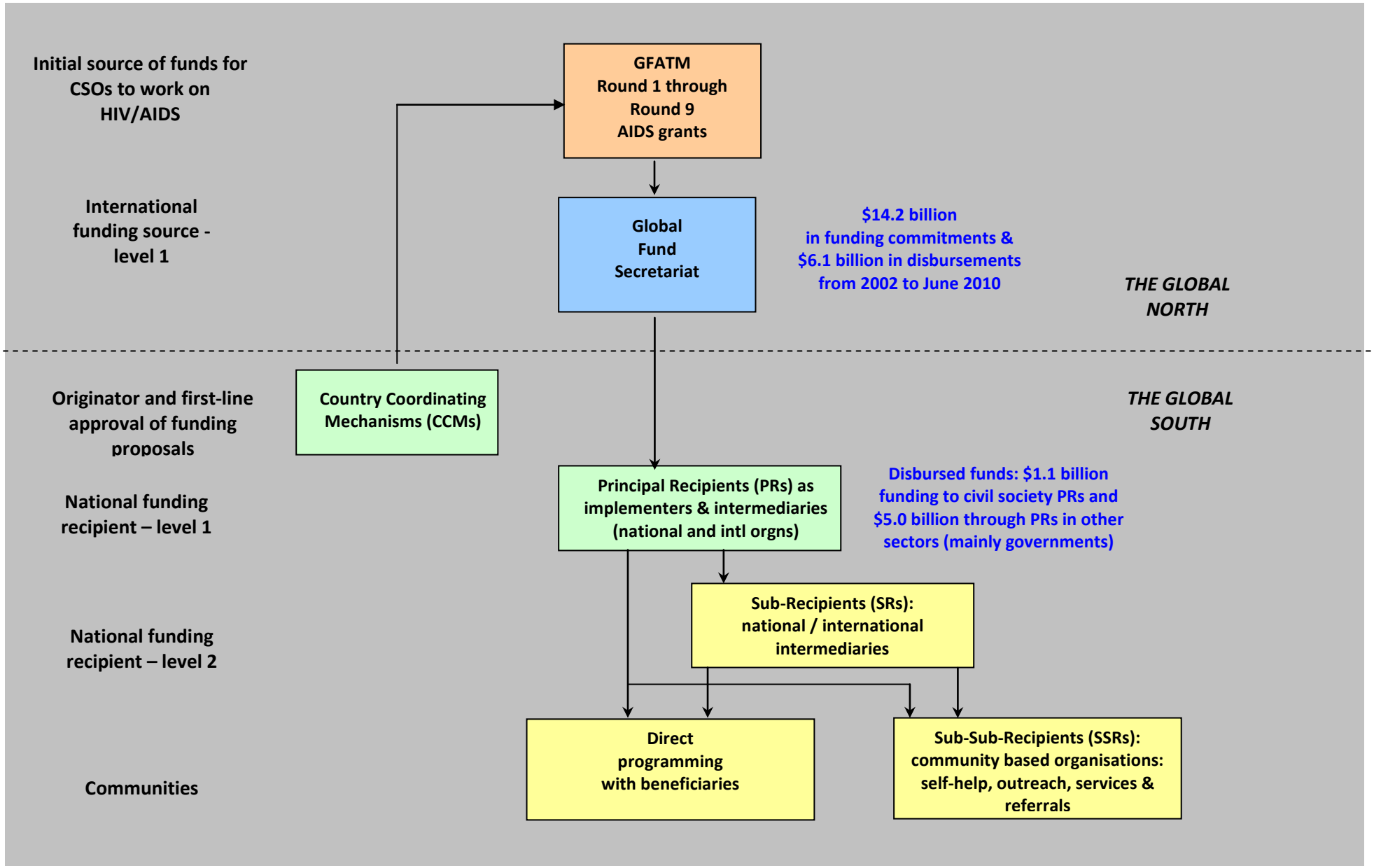
The visual map of the Global Fund (fig. 2.5) accurately demonstrates the funding flow, but does not fully capture important processes that take place before grant signature and once grants are signed. This is also true to some extent for the other donor maps included in this report. However, it is a notable aspect of Global Fund financing, given its relatively new and largely country-driven practices for grant development and management, and its various procedures that are implemented by the Global Fund Secretariat as well as Local Fund Agents.

For instance, the application process normally takes two years, including multiple stages of approval by Country Coordinating Mechanisms, the Technical Review Panel, the Global Fund Board, and the Local Fund Agent. The post-signature funding does not directly involve the Country Coordinating Mechanisms (CCMs), whose oversight role usually focuses on the proposal stages rather than once the funds start to flow. In 2008, following a review of CCM functioning, the Global Fund Secretariat concluded country-level committees lack sufficient financial resources to meet increasing demands on their role as a multi-stakeholder body that originates funding requests. Specifically, the Secretariat concluded that CCMs need further resources devoted to three areas: grant oversight, engagement of civil society and the private sector, and stronger harmonization with other national bodies (The Global Fund, 2009c). Among other things, this is relevant to issues of tracking the funding flow that reaches different sectors of implementers.

The funding is systematically performance-based. The first phase lasts two years, and the second phase's approval and subsequent funding level is directly dependent on phase one performance: outputs, numbers of beneficiaries, and the rate of spending against the original budget.

Importantly from the point of view of recipients, the Global Fund has continued to review and modify its funding process. For instance, in 2006 the GFATM Board approved a mechanism for simplified renewal of high-performing grants after their usual five-year funding, but suspended it in 2009 due to lack of available funds. In addition, there are plans in the next two years to introduce single funding streams,

Figure 2.5. The Global Fund's funding flow



consolidating multiple grants for the same Principal Recipient (Global Fund Observer, 2009). National Strategy Applications (NSAs) were introduced as a pilot "learning wave" in 2009. While the Global Fund plans to retain specific funding rounds, NSAs are intended as an alternative to grant-by-grant funding by applying criteria to a national strategy rather than a proposal (Global Fund, 2009a).

Funding through and to civil society

It is possible to look at CSOs' involvement as first-line recipients of the Global Fund. The table below was compiled for this study from Global Fund data, and shows 69 civil society organisations have acted as Principal Recipients.[6] With some further research into the identity of organisations named in the data, Principal Recipients were classified as either as international NGOs, or as nationally or regionally based organisations.

The average multi-year grant signed by CSO PRs has amounted to $17 million. Although the financial management responsibilities of being a Principal Recipient are significant, 57 percent of disbursements to civil society PRs have been to indigenous organisations while international NGOs have received 43 percent of these transferred funds. In addition, country and regional CSOs have handled most of the funding through CSO PRs in five of the Global Fund's eight regions.[7]

Table 2.2. Funding flows through civil society Principal Recipients of the Global Fund's HIV/AIDS grants (February 2003 to June 2010)

	Number of civil society PRs	Number of grants	Total approved grants (USD)	Disbursements (USD)
Active grants	50	53	$947,091,699	$601,002,612
Closed grants	26	34	$541,202,898	$473,799,555
Lifetime grants	69	87	$1,488,294,597	$1,074,802,167

Source: Global Fund grants - progress details. Report generated June 2010.

Civil society recipients' funding flow as a proportion of all PRs is 10 percent of all approved Global Fund AIDS grants ($14.2 billion in total) and 18 percent of disbursements to date ($6.1 billion in total).

This analysis did, however, find regional variations in the funding flows through civil society organisations as PRs of the Global Fund. Civil society PRs are more often found in the following regions: Latin America and the Caribbean; East Africa; West and Central Africa; and Eastern Europe and Central Asia.

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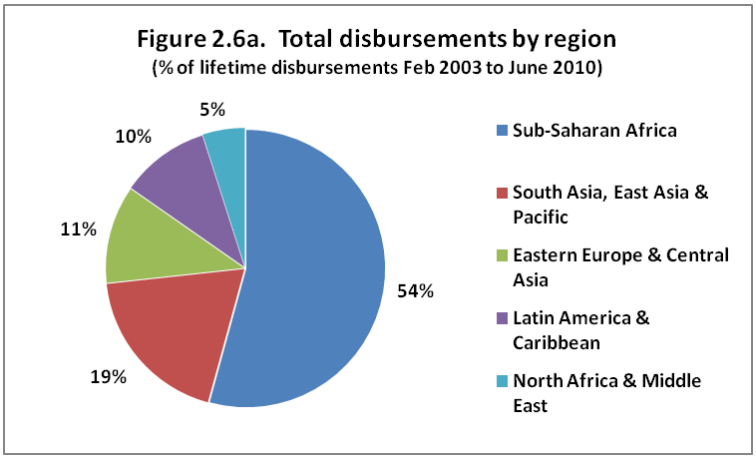
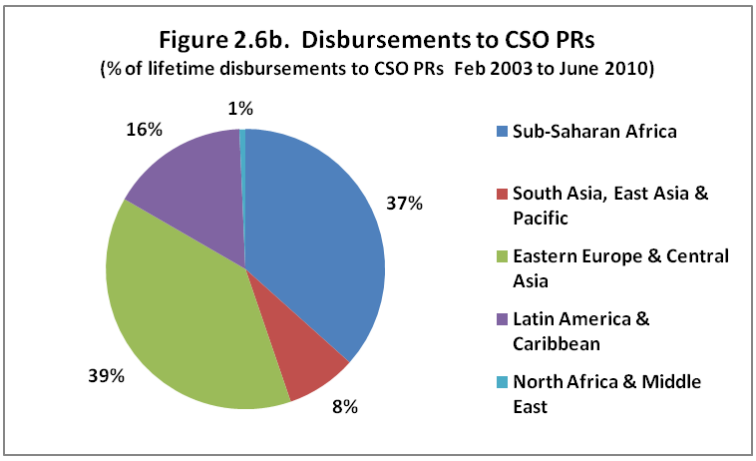
[6] Notes: a) For this study we considered "active grants" to be those signed with PRs and scheduled to last beyond March 2010. b) This data does not include grants awarded in 2009 since the Principal Recipients had not been confirmed awaiting grants signature in mid-2010.

[7] The three exceptions have been: Latin America and the Caribbean (76 percent of CSO PR funds through international NGOs); Eastern Europe and Central Asia (75 percent); and Central and West Africa (55 percent)

The overall distribution of disbursed funds, from the inception of the Global Fund in 2002 to the end of January 2010, is shown in figure 2.6a. This is substantially different from the regional distribution of disbursements that have gone through civil society organisations as first-level Principal Recipients, as shown in figure 2.6b.



While 54 percent of all Global Fund disbursements are to programmes in sub-Saharan Africa, it accounts for only 37 percent of disbursements through civil society PRs. The contrast is even greater when these programmes are combined with disbursements in South Asia, East Asia and the Pacific – together these countries represent 73 percent of Global Fund disbursements, but only 45 percent of disbursements through civil society PRs.



Source: Global Fund grants - progress details. Report generated June 2010.

Within Sub-Saharan Africa, CSO PRs receive a smaller proportion of total disbursements in East Africa and Southern Africa. While in West and Central Africa the proportion of disbursements through civil society PRs is similar to the global average (19 percent), in East Africa CSO PRs have received 13 percent of the regional funding flow. In Southern Africa a small number of CSO first-line recipients have received half the global average: 8 percent of the total funding disbursed.

Expenses on HIV/AIDS activity areas by sector

The Global Fund's regular systems cannot provide information about funded activities that are implemented by civil society organisations as compared to other sectors of implementers. An analysis below the level of regular grant reports would be required to identify the ways civil society spends Global Fund resources on specific AIDS activities, by asking each PR across all sectors and in different countries for further information that is not currently aggregated by type of implementing agency.

Conclusions

– *Funding flow*

The Global Fund's principal founding purpose was the scale-up of lifesaving drugs. In addition to funding health ministries and technical bodies, however, from its inception the Global Fund has funded a range of AIDS activities, and involved civil society from both the global south and the global north within its scale-up models. By June 2010 the Global Fund had committed $1.5 billion to civil society Principal Recipients, and disbursed $1.1 billion to them. Five-year total funding through CSO PRs has been 10 percent of the Global Fund's AIDS grant commitments and 18 percent of disbursements. As of 2008, more than 80 percent of CSO PRs had exceeded their grant performance requirements.

The average multi-year grant to each CSO PR has been $17 million. Indigenous organisations have managed 57 percent of funding that has been disbursed to all CSO PRs with AIDS grants. The annual average funding has been just over $200 million in commitments and $150 million in disbursements to all of the CSOs that have acted as PRs, many of whom manage both implementation and sub-grants to other organisations.

Globally, the geographic distribution of funding through civil society PRs has not aligned with the total distribution of funds. This is likely due to the method of choosing PRs within the country proposal development. This is undertaken at the level of national stakeholders, including the Country Coordinating Mechanism and others who attempt to influence programme priorities or the identification of Principal Recipients, and as such the process is at the same time both technically-based and political. The Global Fund has addressed the relative shortfall of CSO PRs during the past two years by encouraging their inclusion all proposals, and since then the proportion of civil society PRs has increased.

Other examples of changes to the Global Fund include: the closing in 2009 of a simplified renewal process for high-performing grants, due to insufficient funds; plans to consolidate PR grants into single funding streams; and piloting National Strategy Applications as a possible alternative to grant-by-grant funding. The effects of these on funding to civil society are not yet apparent.

– *Expenditure by civil society on HIV/AIDS activity areas*

The regular Global Fund reporting system does not collect disaggregated data related to spending on AIDS activity areas by sectors of implementers. This information could be found beyond the first-level recipient, but is not currently available at the global level and would require further detailed analysis.

– *Data availability and limitations*

Global Fund data is highly transparent and accessible. For instance, all first-line recipients' grant performance reports are updated at key implementation points and publicly available.

Available information on civil society recipients is restricted to the 69 CSO PRs, which are used here as a proxy of funding to CSOs. It is a step removed from data that could show specific funding flows to community responses, but which are located at the level of individual grants. It is clear that some CSO sub-recipients are funded by public sector PRs, and some CSO PRs fund public sector implementation. However, this precise financial breakdown is not readily available because the Global Fund's regular systems require information beyond the first-level recipient to be reported in an aggregated fashion. Similarly, it is also not possible to tell with accuracy the types of AIDS activities for which civil society recipients spend their funding. The data exists, but it is located at multiple PRs across countries and not reported regularly.

However, during this study key informant feedback indicated that in the past year the Global Fund's Portfolio and Implementation Committee decided sub-recipient reporting should be as transparent and accessible as PR reporting, and that sub-recipient data should be made available on CCM websites in each country. This is still at proposal stage, and rollout across different countries likely would take a few years.

US President's Emergency Plan for AIDS Relief (PEPFAR)

PEPFAR was authorised by the US Congress in 2003 and re-authorised in 2008 (US PEPFAR 2009a). Spending more than doubled between the end of FY2005 and FY2007, and more than doubled again by the end of FY 2009 (US PEPFAR 2006, 2008b, 2010). This has resulted in significant funding flows with almost $25 billion made available through various Congressional appropriations and $17 billion spent in the six years to the end of September 2009

As a global health programme, PEPFAR strongly orients programme management – by staff of US Government agencies as well as implementing organisations – towards outputs and the number of people these outputs reach. As Oomman et al. (2007:ix) state, PEPFAR is an emergency response that is focused on achieving targets, with most funds transferred to organisations that have few capacity constraints and can be relied upon to make sure that funds flow quickly. In addition, they characterise the distribution of funds as "strikingly similar" across countries due to Congressional spending requirements, with the bulk of funds spent on anti-retroviral treatment. The following summary of results released on World AIDS Day 2009 also gives a good sense of PEPFAR's focus on outputs and people reached (US PEPFAR 2009e).

Table 2.3. PEPFAR results

- **Supported antiretroviral treatment for more than 2.4 million men, women and children, more than half the estimated 4 million people in low and middle-income countries on treatment.**
- **Through September 2009, supported care for nearly 11 million people affected by HIV/AIDS, including 3.6 million orphans and vulnerable children.**
- **In FY 2009, supported programmes for prevention of mother-to-child transmission allowing nearly 100,000 babies to be born HIV-free, adding to nearly 240,000 babies born without HIV due to PEPFAR support during 2004-2008.**
- **In FY 2009, PEPFAR supported HIV counselling and testing for nearly 29 million people as a critical entry point to prevention, treatment, and care.**

Source: World AIDS Day 2009: Latest PEPFAR Results

The original Congressional authorisation of PEPFAR included earmarking at the top level for the US Government to provide AIDS funding, and also included lower level earmarking for specific programming. Notably, these earmarks called for 55 percent of funds to be allocated to treatment, 20 percent to prevention (a third of which was earmarked for abstinence and faithfulness promotion), 15 percent to care, and 10 percent to programming that supports orphans and vulnerable children. In its first review of PEPFAR, the Institute of Medicine (2007) called for a removal of these specific provisions since, it felt, it is not effective to have common budget allocations across all countries where PEPFAR money is used.

While PEPFAR continues, it is also being incorporated into the US Global Health Initiative or GHI (The White House, 2009). This intends to broaden funding to include

reduction of mortality of mothers and children under the age of five, averting unintended pregnancies, and eliminating some neglected tropical diseases. As announced in May 2009, the Administration's intention is for PEPFAR financing for HIV/AIDS and tuberculosis to constitute more than 70 percent of the GHI funds during a six-year period. The White House announcement also included specific projected figures through September 2014, as shown in the table below.

Table 2.4. Projected US global health funding (2009 to 2014, $ billions)

($ in billions)	FY 2009 Enacted	FY 2010 Budget	Change FY10 from FY09	Six-Year Total (FY09 – FY14)
PEPFAR (Global HIV/AIDS & TB)	$6.490	$6.655	+$0.165	
Malaria	$0.561	$0.762	+$0.201	
PEPFAR & Malaria Subtotal	$7.051	$7.417	+$0.366	**$51 billion**
Global health priorities subtotal	$1.135	$1.228	+$0.093	**$12 billion**
Global Health Initiative total	$8.186	$8.645	+$.459	**$63 billion**

Source: White House 2009

The GHI is a new initiative, but it brings together several existing funding streams emanating from different Congressional appropriations (Kates 2009). Kates undertook a historic analysis to show what the GHI would have looked like over the past decade if earlier disease-specific funding had been considered part of an overall government strategy, and examined the relative annual funding of different streams as a proportion of total US spending on global health priorities. Between 2001 and 2008 fiscal years, overall funding to these different components rose from $1.7 billion to $8.4 billion, or almost five hundred percent. The largest change was in AIDS funding, which increased during the decade from a third of US government financing for global health to almost two-thirds. This drove most of the global health budget increase, largely due to PEPFAR funding. The Global Fund has been included in PEPFAR since 2004, and was the second largest share of funding during the subsequent five years (ibid:4-5).

While funding for PEPFAR more than doubled every two years since its inception, this budgetary scale-up is currently slowing. Congressionally approved AIDS funding was essentially flat-lined for FY2010 from the previous year, within an overall annual increase of about 5 percent for the various components now making up the Global Health Initiative[8] (Henry J Kaiser Family Foundation, 2010).

[8] As well as HIV/AIDS, this now includes: tuberculosis, malaria, the Global Fund, child survival and maternal health, vulnerable children, family planning and reproductive health, avian flu and neglected tropical diseases.

PEPFAR and civil society involvement

PEPFAR's latest annual report restated its focus on results through engagement with organisations across different sectors:

> The success of PEPFAR is firmly rooted in a commitment to results. Through partnerships between the American people and the people of the countries in which we are privileged to serve — governments, non-governmental organizations (NGOs) including faith-based organizations (FBOs) and community-based organizations (CBOs), and the private sector — we are building sustainable systems and empowering individuals, communities, and nations to battle HIV/AIDS (US PEPFAR 2009a:8).

PEPFAR's individual country programmes prioritise the role of CSOs in a variety of ways. For instance, in the Caribbean PEPFAR planned to "strengthen a multi-sectoral response involving government, NGOs, civil society, and the private sector" and focus on policy development, gender equality and human rights (US PEPFAR 2009a:80). In Senegal, the plan states that PEPFAR funds would strengthen both health system and local NGO capacity for quality prevention and treatment services reaching sex workers, men who have sex with men, military personnel and mine workers (ibid:91). Reach and access to communities are commonly given as reasons to involve CSOs. For example, in Botswana civil society participation in PEPFAR programming led to increased coverage, linkages with the National TB program, and increased numbers of people living with HIV receiving care and support (ibid:55).

As PEPFAR has developed since 2003, there have been attempts to adjust the overall programme's partnership portfolio (ibid: 30-31). Notable among these are two central level actions. First of all, single organisations can receive a maximum of 8 percent of a given country programme's funding.[9] As well, centralised reviews of country operational plans undertaken by the Office of the Global AIDS Coordinator have, among other things, evaluated efforts to increase the participation of indigenous organisations. PEPFAR cites this as resulting in an increase in total partner organisations from roughly 1,600 in FY2004 to almost 2,700 in FY2008. Furthermore, roughly 2,300 of these were locally based organisations. Although not broken down further, it could be fair to assume that most of these 2,300 local PEPFAR partners are indigenous CSOs (rather than, for instance, a large number of individual government entities).

In addition, in December 2005 the New Partners Initiative was launched, which is intended to help locally based organisations to move from being a sub-contractor to a manager of first-line PEPFAR funding (ibid).

Another change to funding architecture that is currently being developed could have further effects on the involvement of civil society. A "substantially new focus for PEPFAR" emanates from the requirement for Partnership Frameworks to be developed with country governments, as mandated in PEPFAR's 2008 re-authorisation legislation. Agreed frameworks are to result in five-year plans at

[9] Three exceptions to this rule are: funding to the government, to an organisation procuring commodities including treatment, and to organisations managing umbrella funds to smaller organisations.

country level, with the expectation that developing countries "will be better positioned to assume primary responsibility for the national responses to HIV/AIDS in terms of management, strategic direction, performance monitoring, decision-making, coordination, and, where possible, financial support and service delivery" (US PEPFAR 2009d:3-6). PEPFAR guidance states that Partnership Frameworks "should be established with transparency, accountability, and the active participation of other key partners." If the government feels it is appropriate, the Partnership Framework's development, implementation and monitoring "may also include a multi-sectoral partnership," with stakeholders such as civil society, the private sector, and international partners (ibid).

In addition to the prioritisation of sectoral involvement that takes place through country operational plans, as well as adjustments to overall funding architecture, partnership with PEPFAR is influenced by broader considerations related to CSO capacity to abide by fairly significant US government compliance demands. Some of these are legislated requirements that are quite specific, including regulations about air travel on US carriers and the well-known "anti-prostitution pledge" requirement that was enacted with the original PEPFAR authorisation.

Other factors affecting access to US-supported funding streams include contracting mechanisms for international development funding, which have undergone significant changes in recent years with a move toward Task Order contracting. Some stakeholders feel these could have a negative effect on funding flows that will reach smaller organisations in particular. For instance, organisations are often required to belong to consortia that pre-qualify to compete inside specific funding streams. US Government staffing roles have also changed, and designated civil servants make decisions such as completing a Task Order's description of work, and shifting the emphasis among tasks (USAID 2009:11). There appears to be very little literature related to this experience, although Challand (2009:104-105) describes contracts as much more prescribed with implementation details "carefully defined" by the USG agency managing the award, and quotes a USAID representative as indicating that (previously common) grants allowed USAID to "buy the organisation's programme" but not tell them to "do this and this," while with a contract, "We define the service and we make sure the service is delivered."

PEPFAR funding flows

US PEPFAR funding is transparently and regularly reported at the top level, particularly concerning income and spending by US Government agencies, country level spending, and by 19 activity areas across the categories of treatment, prevention, care and "other".

When attempting to answer specific questions, however, PEPFAR data can be less clear. First, PEPFAR does not regularly release information about spending by recipients. Individual allocations to external organisations could normally be found only on an individual basis or in separate country plans, with one exception that has been used here.[10] In addition, to get a picture of PEPFAR funding including civil

[10] Aggregated data on spending by recipient types is not normally published, but results from PEPFAR's Country Operational Plan and Reporting System were released for one period: FY2004 to

society recipients it is necessary to triangulate information from different sources, covering different time periods, as shown in table 2.5.

Table 2.5. Different sources of relevant PEPFAR information

Type of information	Data source	Period of available data
Funding commitments – Proportional funding plans by US agencies – Allocation plans by activity type: treatment, prevention and care	Fiscal Year 2009: PEPFAR Operational Plan	Oct 2008 – Sep 2009
Total PEPFAR spending – Actual outlays	Summary Financial Status as of September 30, 2009	Oct 2003 – Sep 2009
Funding to different sectors – Recipient types, including CSOs	Dataset of FY2004-06 obligations for PEPFAR focus countries	Oct 2003 – Sep 2006

Sources: US PEPFAR 2008, US PEPFAR 2010, Center for Global Development

In addition, the funding flow can be difficult to understand, between the US Administration's budget requests, Congressional authorisations, specific funding commitments made by the civil service, as well as actual disbursements. For example, appropriations voted by Congress allocate most of the funding to the State Department. However, most PEPFAR funds are then passed on and managed by other government bodies, which are noted in reports as the "implementing agencies" on behalf of the US government. The latest available annual plan showed 85 percent of the total allocated to the State Department, but also showed 96 percent of all funds to be managed by USAID and by the Department of Health and Human Services (US PEPFAR 2008).

Furthermore, funds managed by US government agencies generally do not result in those agencies implementing AIDS activities, but managing the funding through awards to external agencies, especially non-governmental organisations, universities and private contractors. Funds to first-level recipients are mostly awarded to US-based organisations that implement HIV/AIDS activities directly (e.g. through field offices), sub-contract to others, or do both. Sub-awards can go to a variety of organisations for activities in the field, including international NGOs or private contractors as well as indigenous civil society organisations in developing countries. The latest publicly available PEPFAR operational plan, related to FY 2009 (US PEPFAR 2008), shows incoming funding to different accounts, and designated for US government agencies by Congressional authorisations. The top row in table 2.6 indicates both the names of the recipient agencies and the various funding accounts.

2006. The AIDS Monitor project supplemented this information by classifying recipients as international or domestic organisations and also added information on centrally awarded funds. The information published by AIDS Monitor, and some further analysis of the dataset, are used here to drill down concerning a few questions. The release of this data is described at page 18 of Oomman et al (2008).

The breakdown of the $5.6 billion available is also shown: by country operations, headquarters plans, and transfers to the Global Fund and UNAIDS.[11]

Table 2.6. Approved PEPFAR funding plans for FY2009 by authorised account, total of $5.58 billion					
	State Dept Global Health and Child Survival	**Health and Human Services** CDC Global AIDS Program - Natl Institutes of Health	**USAID** Global Health and Child Survival	**Dept of Defense** HIV/AIDS Prevention Program	**All accounts**
Total of included programmes	**84.7%**	**7.5%**	**7.8%**	**0.1%**	**100.0%**
Field programmes	61.6%	1.6%	2.2%		**65.4%**
Central programmes	3.7%				**3.7%**
Other country programmes	0.3%	0.1%	1.2%	0.1%	**1.7%**
Headquarters plans	7.6%	0.4%	2.5%		**10.5%**
Global Fund	10.7%	5.4%	1.8%		**17.9%**
UNAIDS	0.7%				**0.7%**

Source: Fiscal Year 2009: PEPFAR Operational Plan

Most of these funds were then distributed to various agencies according to approved country and headquarters operational plans, which are coordinated by the Office of the Global AIDS Coordinator. For FY2009, almost $3.9 billion of the $5.6 billion was decentralised into country operational plans, the bulk of which was allocated for management to different offices within the Department of Health and Human Services (HHS) and USAID. Both agencies manage a significant amount of onward funds to partner organisations.

HHS funding includes medical research, for instance related to HIV treatment outcomes in the field. It also includes the Centers for Disease Control and Prevention's Global AIDS Program, whose mandate focuses on strengthening laboratory, epidemiology, surveillance, public health evaluation and workforce capacity. Its staff work directly with ministries of health on policy, services and capacity (CDC, "A Partner in the Global Fight against HIV/AIDS"). USAID is a lead manager of overall US AIDS programmes in developing countries, and most of its staff work with host country governments, NGOs, indigenous groups, and the private sector (USAID, "HIV/AIDS Leadership Rooted in Development").

[11] The $5.6 billion is an accumulation of approved plans for FY2009 (as of late 2008), and differs from the total of $6.5 billion of 2009 enacted funding shown in the earlier table of US global health funding. It is one example of challenges in comparing PEPFAR data from different stages of the funding flow.

Spending by activity type

Table 2.7 shows the breakdown of funding by activity across all country spending plans. Treatment comprised 37 percent of planned expenditures for FY2009 ($1.4 billion), including purchases of anti-retroviral drugs, laboratory infrastructure, and adult and paediatric treatment delivery. Roughly a quarter of funds were planned to be spent on prevention ($1 billion), and a fifth on care ($800 million).

Excluding the "other" category, the breakdown of FY2009 funding was: 44 percent for treatment, 31 percent for prevention and 25 percent for care. This breakdown can serve as a comparison to some of the other donors' planning and approaches to making allocations for specific HIV/AIDS activity areas.

Table 2.7. Approved activity funding for FY2009 Country Operational Plans

	$ millions	% of category	% of planned spending
TREATMENT			
Adult treatment	703.5	49.8%	18.2%
Antiretroviral drugs	392.4	27.8%	10.2%
Laboratory infrastructure	210.2	14.9%	5.4%
Paediatric treatment	105.3	7.5%	2.7%
Sub-total	**$1,411.4**		**36.6%**
PREVENTION			
Prevention of mother to child transmission	225.6	22.5%	5.8%
Abstinence, be faithful	207.6	20.7%	5.4%
Counselling and testing	206.7	20.6%	5.4%
Other sexually transmitted prevention	233.4	23.3%	6.0%
Blood safety	55.4	5.5%	1.4%
Male circumcision	33.8	3.4%	0.9%
Injection safety	22.5	2.2%	0.6%
Injecting and non-injecting drug use	17.9	1.8%	0.5%
Sub-total	**$1,002.9**		**26.0%**
CARE			
Orphans and vulnerable children	320.3	39.4%	8.3%
Adult care and support	308.3	37.9%	8.0%
TB/HIV	140.3	17.3%	3.6%
Paediatric care and support	43.9	5.4%	1.1%
Sub-total	**$812.7**		**21.1%**
OTHER			
Health systems strengthening	227.3	36.0%	5.9%
Management and staffing	224.3	35.5%	5.8%
Strategic information	180.7	28.6%	4.7%
Sub-total	**$632.2**		**16.4%**
Total	**$3,859.2**		**100.0%**

Source: Fiscal Year 2009: PEPFAR Operational Plan

Map of the funding flow

The visual map of the funding flow shows actual outlays from PEPFAR's start-up in October 2003 through the end of September 2009. This includes $14.2 billion spent from funding accounts (the top level) and $9.6 billion of outlays for PEPFAR country activities (the second level) (US PEPFAR 2010). The balance was financing of the Global Fund and of health research.

- USAID and CDC are presented separately in the map as the agencies most likely to manage funding of civil society activities in the field.
- Some elements are not reported separately in summary financial status reports, notably at the level of US Government agencies. This includes CDC's Global AIDS Program, which is part of the $4.6 billion for Health and Human Services country activities, but separate from HHS's research outlays of $1.8 billion.

The amounts of funding at lower levels, particularly funding of civil society organisations, is based on extrapolations of estimates by Oomman et al. (2008) for FY 2004-06 of planned spending in 15 focus countries.[12]

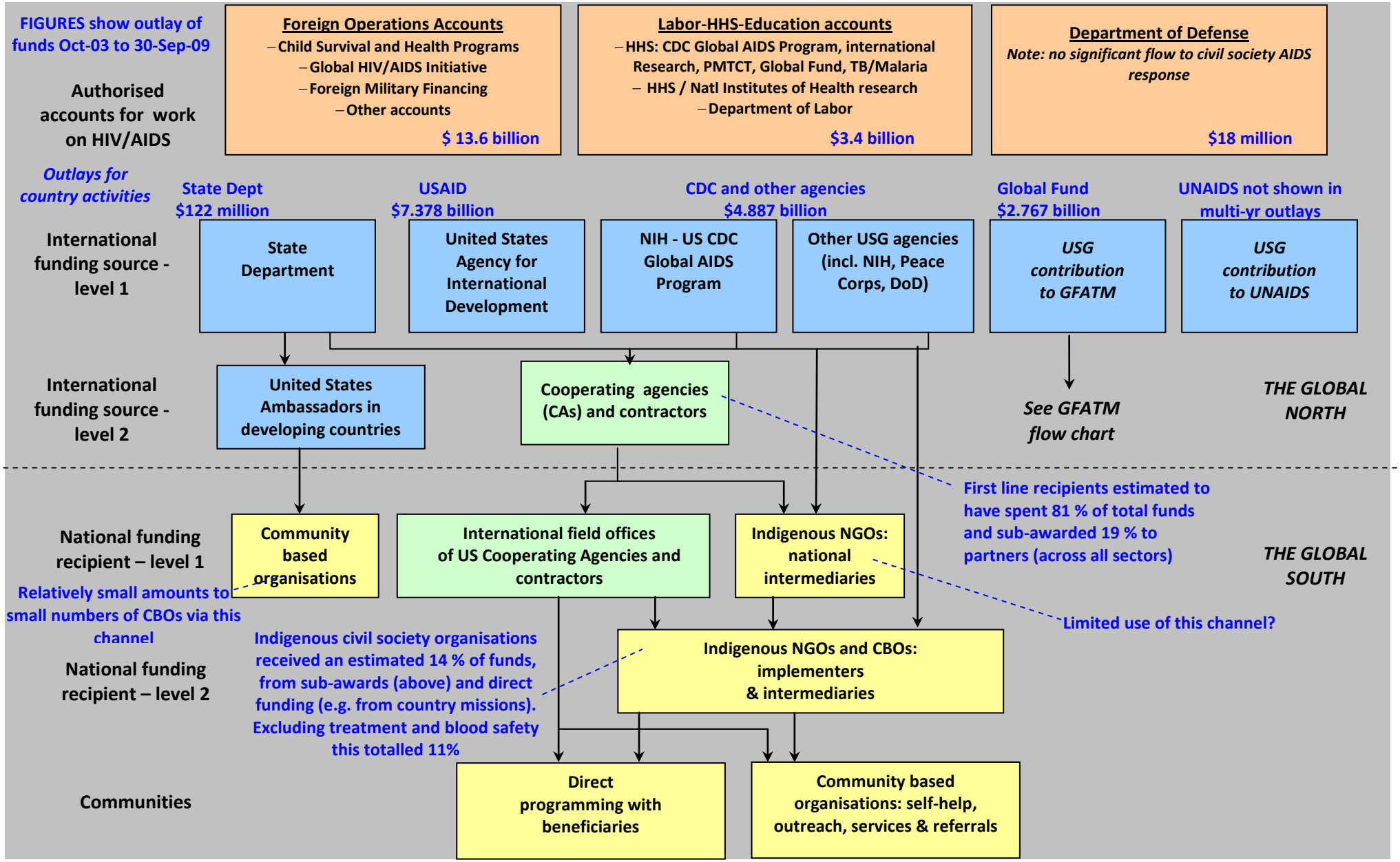
- We do know that some elements shown on the map are relevant to civil society, but not very large or used as frequently as other funding mechanisms. Some informants felt that few indigenous organisations act as intermediary managers of PEPFAR funds, so although this channel exists there is a question about its significance for the flow of US funds.
- In addition, US ambassadors make small grants – examples were found of funding in the range of twenty thousand dollars per CBO, given to half a dozen organisations at a time, sometimes linked to Peace Corps support in local communities.
- Some informants indicated a relatively small amount of PEPFAR funds are given to developing country governments, and this could further flow to CSOs. This was not explicitly included in the map of US PEPFAR flows to civil society or community responses given the lack of examples of this actually occurring, as well as other data showing domestic government spending on AIDS flat-lined alongside PEPFAR flows (Oomman et al 2007).[13]

These estimates of CSO funding flows are further explained below – see "funding to civil society organisations".

[12] These include thirteen countries in Africa – Botswana, Côte d'Ivoire, Ethiopia, Guyana, Kenya, Mozambique, Namibia, Nigeria, Rwanda, South Africa, Tanzania, Uganda, and Zambia – plus Haiti and Vietnam.

[13] This has been included without similar evidence in the map of DFID, but key informants did point out that significant amounts of its funding is made up of government-to-government budget support.

Figure 2.7. PEPFAR funding flow



In terms of funding flow, the following were some of the main findings reported in Oomman et al. (2008).

- Across all sectors, international organisations appeared to meet the requirements to quickly handle large sums of funding. Four country programmes where local organisations are perceived to already have significant capacity were exceptions to the trend of the majority of implementation led by international organisations.
- The report also cited PEPFAR planning guidance indicating perceived bottlenecks for funding many indigenous organisations with insufficient capacity in financial management, specifically: accounting, managerial and administrative skills, and auditing practices.
- Overall, only 19 percent of funds awarded to first-line recipients ("primes" in US government terms) were subsequently sub-awarded to second-line recipients ("subs"). On average in these 15 countries slightly more than half of these second-line recipient funds were granted to domestic organisations across all sectors. However, given the small total amount of sub-awards this amounted to only 11 percent of the total funds that were received by primes.
- On average, 30 percent of funds were obligated to locally based recipients across the PEPFAR focus countries (again, across all sectors and not just civil society). This proportion is higher than the sub granted funds passing from primes to domestic organisations because of direct funding from US agencies (such as USAID and CDC field offices). This proportion to domestic agencies also varied considerably across countries. In four countries – Botswana, South Africa, Namibia and Uganda – PEPFAR's obligations to domestic institutions ranged from 45 to 55 percent of the total.
- International and domestic faith based organisations received a small proportion of PEPFAR funds, with only 12 percent of funding obligated during 2005. About half of these funds were for treatment. Overall, more than 70 percent of funds obligated to faith-based CSOs went to three organisations: the US-based NGO Catholic Relief Services, the Mission for Essential Drugs and Supplies in Kenya, and the international NGO World Vision.

Funding to civil society organisations

For this report a further analysis of the AIDS Monitor data set gives indications of funding flows specifically to indigenous civil society organisations. These have been estimated at an annual average of $227 million.

- Spending plans for FY2004-06 included obligations of almost 70 percent to be allocated to civil society organisations. These included international CSOs (mostly US-based) as well as domestic NGOs, universities and faith-based organisations (FBOs) based in developing countries. This large proportion of total funding through various types of non-profit organisations reflects the reliance on Cooperating Agencies and contractors to implement United States spending of development assistance.
- The actual outlays for PEPFAR country activities from October 2003 through September 2009 were more than $12 billion. Extrapolating previous obligations to CSOs results in an estimate of $8.4 billion conferred for management to

international and indigenous civil society organisations involved in all funded PEPFAR activities. This includes clinical services run by non-profit organisations or their implementing partners. When these are excluded, the total funding handled by CSOs can be estimated at $7.4 billion – or $1.2 billion per year.

– Similarly, a total of 14 percent of PEPFAR obligations were intended for indigenous civil society organisations during FY2004-2006. However, excluding clinical activities of treatment and blood safety, the flow to indigenous CSOs can be estimated at 11 percent of spending plans.

Therefore, extrapolating to spending to September 2009, funding of indigenous CSOs for non-clinical activities amounted to roughly $227 million a year.

Table 2.8. Sources of PEPFAR funding flow information		
Funding flow and subsets: FY04 –FY09	**Total six-year outlay**	**Average per year**
Total to country HIV/AIDS activities	$12.386 billion	$2.064 billion
Estimate of above through all types of CSOs: NGOs, universities and faith-based organisations	68% of country programming	$1.404 billion
Estimate of above net of treatment and blood safety	60% of country programming	$1.238 billion
Estimate of above to indigenous civil society organisations	11% of country programming	$227 million

Distribution of funding among types of CSOs

There are various ways of analysing the parameters that are included in this data (as explained in the annex on methodology), and these result in some minor variations notably in the amounts allocated to international and indigenous CSOs. However, analysis of allocations by type of civil society organisation (table 2.9) shows 78 percent of the total funding to CSOs allocated to international NGOs, universities and faith-based organisations, and 22 percent to domestic organisations.

Table 2.9. Distribution of total CSO funding among different types of organisations Spending plans for FY2004-06			
CSO recipient type	**International**	**Domestic**	**All CSOs**
NGOs	**48%**	**12%**	**60%**
Universities	**18%**	**4%**	**22%**
Faith based organisations	**11%**	**6%**	**17%**
Sub-total	**78%**	**22%**	**100%**

Source: PEPFAR obligations, from AIDS Monitor project, Center for Global Development.

Expenses on HIV/AIDS activity areas by different CSOs

To get a further sense of funding flows for types of HIV/AIDS activities implemented by CSOs, data was selected to show only known net funding obligations for treatment, prevention and care activities carried out by international and domestic non-profit organisations.[14]

Table 2.10. Distribution of CSO funding by activity type
Spending plans for FY2004-06

AIDS activity type	International CSOs	Domestic CSOs	All CSOs
Treatment	**48%**	**42%**	**47%**
Prevention	**27%**	**26%**	**27%**
Care	**25%**	**32%**	**26%**
Total obligations to types of CSOs	**100%**	**100%**	**100%**

Source: PEPFAR obligations, from AIDS Monitor project, Center for Global Development.

In terms of the general picture, these priority activity areas were consistent with overall PEPFAR funding: treatment was the most important, representing almost half of these funds, followed by prevention and care. Compared to international organisations, indigenous CSOs were allocated a higher proportion of their funding for care activities and a lower proportion for treatment.

Conclusions

– *Funding flows*

In its first six years PEPFAR has prioritised the use of funding for scaling up AIDS responses. It has also done so using traditional US funding architecture, with first-level recipients largely composed of US-based international organisations. An estimated 70 percent of funding commitments have been managed by CSOs. US-based international CSOs have received most of the funding allocated to Cooperating Agencies and contractors.

As an attempt to get a better picture of civil society financing that could be a closer proxy of community responses to HIV, the estimate of CSO funding annually (net of treatment services and blood safety) is almost $1.5 billion. Of this, funding specifically to indigenous CSOs was roughly $227 million a year.

[14] Net obligations are allocations received by an agency and not onward granted. The distribution of AIDS activity budgets by type of CSO is based on net obligations to known recipient types coded both by geographic origin of the recipient and by activity area, and these total $1.29 billion. Although a sub-set of the total data, it was the portion that was most clear in its allocation by both geography and activity areas.

PEPFAR funding management has included some attempts to limit the amount of money flowing through large partner organisations and to increase the total number of partners, in part to reduce reliance on larger international organisations. An emerging development includes Partnership Frameworks which are designed to contribute to sustainable AIDS responses owned by developing country governments. At the same time, PEPFAR AIDS funding has been flatlined for FY2010 after several years of significant growth. The eventual impact of these different changes on civil society implementers is not clear.

- *Expenditure by civil society on HIV/AIDS activity areas*

Civil society expenditure for AIDS activity types has been consistent with PEPFAR spending priorities which, in order of importance, are the categories of treatment, followed by prevention and then care. Indigenous CSOs, however, were allocated somewhat more than the norm for care activities and less for treatment.

- *Data availability and limitations*

Estimates of types of funded organisations and their HIV/AIDS activities were based on spending plans rather than actual expenditure. In addition, it is from a specific period (2004-06) and then extrapolated to all PEPFAR spending for the six years through September 2009. PEPFAR has grown significantly since its initial three years of implementation, but further breakdown of data by recipient types is not available.

None of the donors covered in this review have complete data that is readily available and that would provide a full report of AIDS funding spent by all civil society recipients. However, PEPFAR data has fairly important limitations for attempting to answer this specific question.

- Available data is largely focused on PEPFAR's principal priorities of scaling up AIDS activity types, rather than the issue of sectors of implementers and their particular inputs into the overall effort.
- Civil society organisations, taken as a whole, are also likely to be a weaker proxy of community responses in the case of US funding architecture, which relies to a large degree on relatively sizeable international non-profit organisations. These act as both implementers of a broad spectrum of types of programming types, and as funding managers that provide grants or contracts to partner organisations (both international and domestic).

In the case of PEPFAR, therefore, funding of the community response might be better understood with further data on funds that both flow through specific types of civil society organisations and are used for various AIDS activity types. At the same time, such a breakdown of current is also not available for the other donors.

Department for International Development, United Kingdom

In recent years the United Kingdom became the second largest bilateral donor for HIV/AIDS, after the United States. Its first AIDS strategy, Taking Action, was launched in 2004 and committed the UK to spending at least $2.5 billion in three years.[15] By early 2006, DFID was spending about $500 million to $700 million annually on HIV in developing countries (Drew and Attawell, 2007:xxii).

At the same time, DFID became a significant donor for the Global Fund, UNAIDS and UNFPA. Its efforts to influence other sources for greater funding resulted in the G8 and EU increasing financial commitments in 2005, including to new funding mechanisms such as UNITAID, whose mission is to achieve price reductions for diagnostics and medicines in developing countries (ibid).

In 2008 the UK updated its AIDS strategy, now called Achieving Universal Access – the UK's strategy for halting and reversing the spread of HIV in the developing world. In this new framework the Department for International Development de-linked AIDS and vertically tracked funding by committing to spending $11 billion on health systems and services in the period to 2015 (DFID, 2008). The DFID strategy also noted that this sits alongside development funding commitments to other sectors: up to $15 billion on education in the ten years to 2015, as well as $375 million over three years for social protection programmes which, in part, are intended to contribute to better access to child nutrition, health and education that will benefit orphans and vulnerable children.

DFID's rationale for modifying its strategy included the need to take a long-term approach across a range of health interventions and services in order to achieve universal access. Such health areas include sexual and reproductive health and rights, maternal health services, as well as addressing other diseases such as TB and malaria. These would be supported in order to prevent HIV transmission or reduce the impact of AIDS, as well as general strengthening of health systems that "provide for everyone" (ibid).

Tracking the overall strategy

In October 2009, DFID released a baseline for measuring its new AIDS strategy commitments. This document stressed DFID's structure and business model, which includes work through international partners, managed by DFID's International Secretariat in the UK as well as through decentralised decision making by country offices. Three regional divisions oversee and support country offices, each of which in turn has responsibility for funding decisions. For each country where DFID spends at least £20 million, a country plan defines how DFID intends to contribute to poverty reduction and to achieving Millennium Development Goals (DFID, 2009).

The baseline includes the following top-level priorities to meet the commitments included in the Achieving Universal Access AIDS strategy.

[15] The actual commitment was £1.5 billion. Unless otherwise noted, this and other DFID funding figures are converted for this report at $1.85 per British pound, the average interbank rate for FY2004-05 to FY2008-09, and rounded.

Table 2.11. DFID priorities (summarised)	
Priority 1:	**Increase effort on HIV prevention; sustain momentum for treatment; increase effort on care and support**
• Work with others to reduce by 50% the unmet demand for family planning by 2010. • Work with others to increase to 80% the coverage of HIV-positive pregnant women receiving ARVs, to prevent mother-to-child transmission, by 2010.	
Priority 2:	**Respond to the needs and protect the rights of those most affected**
• Increase the coverage of HIV and AIDS services for injecting drug users. • Increase by at least 50% funding for development of AIDS vaccines and microbicides during 2008–2013.	
Priority 3:	**Support more effective and integrated service delivery**
• Spend £6 billion on health systems and services to 2015. • Spend more than £200 million to support social protection programmes over the next 3 years. • Support countries with health worker shortages to provide at least 2.3 doctors, nurses and midwives per 1,000 people	
Priority 4:	**Making money work harder through an effective and co–ordinated response**
• Work with others to reduce drug prices and increase access to more affordable and sustainable treatment. • Ensure the Global Fund implements the Paris Declaration target on use of common arrangements and procedures, including programme–based approaches. • Work with partners within and outside the International Health Partnership to ensure sector–wide approaches to health strengthen AIDS responses and that targeted AIDS programmes also strengthen the wider health system.	

Source: Achieving Universal Access – A 2008 Baseline (DFID, 2009)

The required outcomes to support these four priorities are specified in this baseline. For instance the unmet need for family planning in developing countries is estimated to be 29 percent of those requiring services, which should to be reduced by half. The unmet coverage for prevention of mother to child HIV transmission in low and middle-income countries is 68 percent, to be reduced to 20 percent.

The baseline also notes that DFID has some relevant regional performance indicators – for instance, in Africa at least 14 of 22 countries should report reductions in adult HIV prevalence, and in at least 3 countries in South Asia there should be a

decline in HIV prevalence in high risk groups. As well, certain country-level monitoring frameworks include specific AIDS performance indicators, and/or performance indicators for health systems strengthening and sexual and reproductive health.

Funding flows

The challenge of HIV/AIDS funding data specifically related to civil society was noted in the 2007 interim evaluation of the Taking Action strategy, which stated that it is difficult to obtain accurate information on UK funding of civil society for international development efforts in general, and in particular for HIV/AIDS. Citing the National Audit Office, the evaluation further stated that data at that time was available on direct funding of international NGOs, but two-thirds of UK funding for CSOs was estimated to go through country programmes (Drew and Attawell:70).

– *Civil society and other sectors receiving DFID funds*

The UK has increased ODA in the last five fiscal years, including DFID's budget which rose 66 percent from $7 billion in 2004/05 to $10 billion in 2008/09 (DFID, 2009c). DFID's total spending on bilateral assistance consistently represented 40 percent of this, and from 2004/05 through 2008/09 averaged $5 billion per year.

Also during this period, DFID's annual direct funding of civil society organisations averaged 12 percent of the total bilateral programme expenditure.[16] This average of $610 million a year is classified into two principal categories: $160 million granted to 30 organisations with Partnership Programme Agreements, and $450 million channelled through a number of central and country based funding mechanisms that reach civil society partners (ibid).

Apart from its bilateral aid, for several years DFID has consistently spent 40 percent of its annual programme funds, or $3.5 billion on average per year, through its multilateral programme (ibid). Some of this has funded HIV programming undertaken by CSOs. For the five years to April 2009 it included DFID's average annual contributions to the Global Fund (for all three diseases) of $120 million (DFID, 2009b). Similarly, DFID funded UNAIDS by $20 million a year in this period.

– *Civil society spending on HIV/AIDS*

As yet, there is no available dataset for a given period that provides information specifically on AIDS spending by civil society recipients. However, DFID recently released a projects database that includes $38 billion of projects that were active in August 2009 or have started since then.

This indicates that HIV is a principal focus for 6.8 percent of the budgets of CSO first-line recipients. Extrapolated to DFID overall expenditure through CSOs in past years, this amounts to spending on HIV-focused projects of roughly $42 million a

[16] This was alongside 20 percent of bilateral spending through budget support to developing country governments, 20 percent through multilateral agencies (as managers or channels of specified bilateral aid), and the balance through other channels including humanitarian assistance, technical cooperation (specialists, training, research), and other financial and bilateral aid.

year on average for the years 2004/05 through 2008/09.[17] This is based on an estimate of current and recent project budgets found in the database, extrapolated backward to previous annual spending, as shown in 2.12.

Table 2.12. Extrapolation of current CSO budgets with principal or significant HIV focus		
	Applied to CSO funding in FY2004-05 to FY2008-09	**Average per year**
CSO funding with "principal" HIV focus	**$207.9 million**	**$41.6 million**
CSO funding for mixed projects: with "significant" focus & "HIV" in title or project description	**$72.9 million**	**$14.6 million**
Total	**$280.8 million**	**$56.2 million**

Sources: DFID Project Information (report generated 7 June 2010), and DFID and Gross Public Expenditure on Multilateral Contributions 2004/05 – 2008/09.

In addition, another 14 percent of CSO budgets in the recent database have coded HIV as a "significant" part of their efforts (rather than either "principal" or "not targeted"). However, the overall contribution of this funding to the HIV effort and its allocation to community responses would require a detailed analysis of individual project budgets.[18] For this estimate, CSO projects that also include "HIV" in their title or description were included. They represent another 2.4 percent of CSO budgets in the database, which if taken as a whole would add almost $15 million per year to the overall estimate of CSO funding for AIDS activities.

Map of the funding flow

The visual map of DFID's funding flow is presented on the next page.

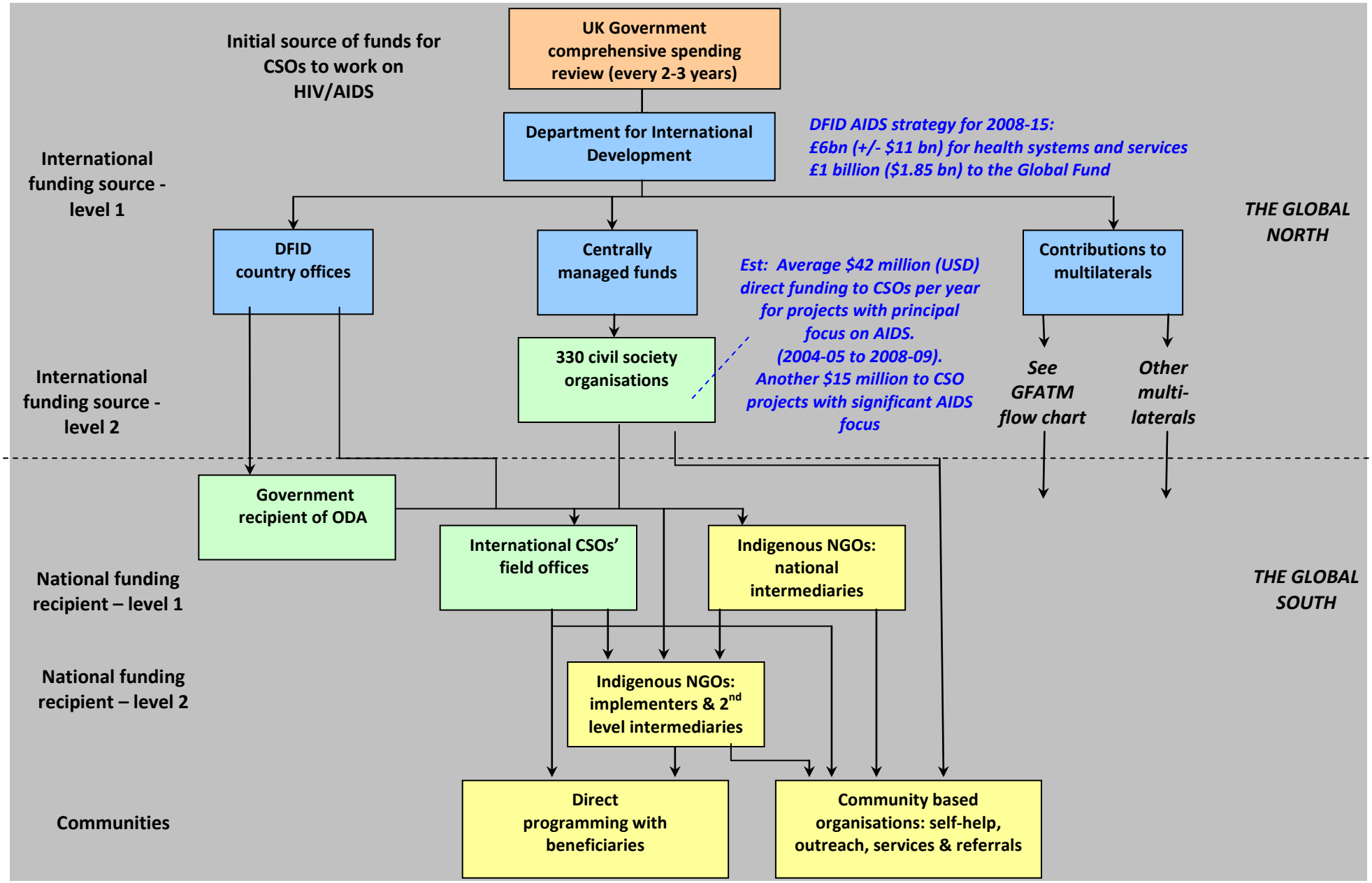
International and decentralised funding channels accessible to civil society

From its UK offices DFID channels centrally managed funds through approximately 330 civil society organisations. DFID, both in the UK and through country offices, has multiple channels that can be used to provide funding to civil society. As one illustration of this, at central level there is a global Civil Society Challenge Fund that is ongoing, and which requires the sponsoring applicant to be a UK-based NGO (which can also name partners in developing countries). In addition, country offices have launched a range of their own Challenge Funds that can be open to UK as well

[17] In this case, the annual DFID expenditure of bilateral aid to CSOs was converted for each fiscal year to US dollars at the annual average interbank rate.

[18] Barring a detailed analysis that would show their specific contribution to AIDS activities, a decision was made to not include all the 14.1 percent of funding for CSO projects (or $86 million per year on average) currently reported as "significantly" rather than "principally" focused on the HIV goal.

Figure 2.8. DFID funding flow



as non-UK civil society organisations, and these usually have a fixed duration (incorporating a few opportunities to apply, or even a single funding round).

The most significant single channel of direct DFID financing to civil society, by volume, is felt to be the Partnership Programme Arrangements, which provide funding that is largely unrestricted in its use to 30 civil society organisations. Other centrally managed funding mechanisms include the Common Ground Initiative supporting African development through UK-based small and diaspora organisations, as well as conflict and humanitarian funding (DFID website, "Funding schemes").

Both country offices and DFID in the UK can also channel funds through civil society via supply contracts, by tendering for specified services or deliverables. Country offices have also supported basket fund programmes, which are country-based financing mechanisms intended to increase development assistance harmonisation in line with the Paris Declaration on Aid Effectiveness. (From the point of view of civil society funding recipients, these mechanisms are defined by the fact that several donors contribute to pooled funds to which CSOs can apply from within the country, rather than directly through individual bilateral donor headquarters or country offices.)

Specifically in terms of bilateral support, although DFID does not prioritise countries as such the bulk of its bilateral assistance is channelled to 22 countries with Public Service Agreements. For these countries, DFID tracks achievements towards Millennium Development Goals.

Financing mechanisms at country level include: general support to the government's budget, sector budget support (e.g. for health or education), as well as support to multilateral agencies and civil society organisations.

DFID notes that while spending on health including AIDS is due to increase from 2008 for three years, much of this funding will be channelled either to general budget support to recipient governments, through pooled funding arrangements, or through multilateral and global funding streams (DFID, 2009).

Conclusions

– *Funding flows*

DFID has a history of funding civil society organisations as partners in development, and all first-line CSO recipients received an average of approximately $600 million a year from 2004-05 to 2008-09. DFID has also supported HIV/AIDS responses through its own funding channels and by supporting multilateral institutions including the Global Fund. DFID's 2004 AIDS strategy included a commitment to spend $2.5 billion on AIDS activities. The follow-on 2008 strategy committed $11 billion to more general support for health systems strengthening.

DFID's funding flow to first-line civil society recipients for AIDS efforts is estimated at $56 million a year on average for 2004-05 to 2008-09. This is based on an extrapolation of current reported project budgets to DFID expenditure over these five years.

This includes an estimate of almost $42 million a year on average for CSO first-line recipients' projects that are principally focused on AIDS. In addition, an estimated $15 million a year represents a proportion of CSOs' mixed projects that report a significant HIV focus.

– *Expenditure by civil society on HIV/AIDS activity areas*

Individual examples of DFID's support to CSO efforts on AIDS can be cited. However, overall DFID funding data is not available on the types of AIDS activities carried out by civil society partners. This limits the ability to judge the extent to which DFID funding supports activities associated with community responses. This would require a detailed analysis at the level of individual projects.

– *Data availability and limitations*

The DFID project funding database was less than a year old at the time of this analysis, so it provided budgets for projects that were active in August 2009 or started since then. As a group they did not cover any given period, although they do give some proportional information. A percentage of budgets for CSOs and for HIV can be determined from this sample of about $38 billion of multi-year funding for DFID programmes.

Among other limitations, this average percentage extrapolated back over five years cannot take into account upward or downward trends in annual allocations to CSO AIDS efforts from 2004-2005 to 2008-09, for which more detailed information is not readily available.

Without an analysis of activity types, there are some limitations in using CSO first-line recipients as a proxy of "typical" CSO spending on community AIDS responses.

Funding from four key donors, and its context

Estimated funding flow to civil society from three key donors

Table 2.13 provides a recap of the estimated CSO and AIDS funding flow by the four donors that were reviewed, along with a summary of the different bases of calculation.

Table 2.13. Summary of four donors' funding flows to civil society for AIDS responses

Donor	Nature of the funding data	Basis of the estimate of CSO funding for AIDS	Resulting proxy for the funding of community responses to AIDS	Period	Multi-year estimate ($ mill)	Estimate: average per year ($ mill)
World Bank MAP	Funding commitments agreed through end of 2009	Extrapolate the estimate of 2001-06 commitments to total MAP commitments	Estimate of CSOs funded by MAP	**2001-2013: 13 years**	**$709m**	**$55m**
Global Fund	Disbursements	Funds disbursed to CSO first-line Principal Recipients (PRs)	AIDS grant disbursements managed by CSOs as first-line PRs	**2003-2010: 7 years**	**$1,075m**	**$154m**
US PEPFAR	Mixed: part allocations and part expenditure	Extrapolate estimate of 2001-06 obligations for CSOs to the total outlays for country programmes	Estimate of funds for non-clinical activities reaching indigenous CSOs	**2004-2009: 6 years**	**$1,362m**	**$227m**
DFID	Mixed: part allocations and part expenditure	Extrapolate recent CSO budgets to previous annual DFID expenditure through CSOs (first-line funding recipients)	Estimate of funds to CSO first-line recipients with AIDS as a major project priority	**2005-2009: 5 years**	**$281m**	**$56m**

Conclusions

The estimate of these donors' support for civil society AIDS responses is estimated at $3.4 billion, for multiple years and across all the countries involved in the funding flows.

However, this lacks more detailed breakdown of these multi-year estimates, and the individual donor estimates cover different time periods. Therefore, it is not possible to provide any accurate annual totals that would encompass all four donors. As well, it is not possible to show increases and decreases through the different years that are covered.

At best, it is possible to say that the annual average, during those years when all four donors were active, was almost $500 million funding to civil society's contributions to AIDS responses. This would certainly have been higher in certain years, particularly as the larger funding flows scaled up at similar moments.

It is also important, if somewhat challenging, to try putting this in a larger AIDS funding context. Kates, Lief and Avila (2009:1) described the need to ensure financing of a sufficient and sustained response to the epidemic as "one of the world's greatest health and development challenges. and one that will be with us for the foreseeable future." Kates et al. (:9) estimated that in 2008, $15.6 billion of the $22.1 billion needed for AIDS in developing countries was made available from all sources: multilateral, private and domestic.

Therefore, even if the estimate of average annual funding from these key donors is an underestimate of the higher funding years, at an annual average of $500 million across all countries it still appears to be a relatively small contribution to the total amount that is needed for AIDS responses in low- and middle-income countries.

3. COUNTRY FUNDING PROFILES: KENYA, PERU AND INDIA

Introduction

The three countries included in this review were chosen as important in different ways to the global HIV/AIDS epidemic, and possibly presenting contrasts in terms of responses and involvement of civil society.

- One country was included from each of Africa, Asia and Latin America. As well, in terms of HIV/AIDS epidemics and responses each is relatively important in its own region.
- Kenya has a severe and generalised epidemic, and is the recipient of important AIDS-related funding. There are an estimated 1.2 million people currently living with HIV in Kenya, and more than 75,000 new infections occurred in 2009 (UNAIDS, “Kenya Launches 3rd National AIDS Strategic Plan”).
- India has a national adult prevalence rate of about 0.4 percent, but also includes six states with high HIV prevalence rates, and it is estimated that 2.4 million people in India are living with HIV (UNAIDS, “India”).
- Peru has a focused AIDS epidemic affecting key populations. For instance, while pregnant women (a proxy of the general adult population of reproductive age) have an HIV prevalence rate of 0.2 percent, it is estimated that men who have sex with men have a national prevalence rate of 14 percent (Peru, Ministerio de Salud, 2010). Peru is also the largest Global Fund recipient in Latin America and the Caribbean.

Kenya

Donor funding for civil society AIDS activities

The national AIDS response in Kenya has received significant financing from the United States' PEPFAR, the World Bank, UK's DFID, the United Nations and several other donors (Kenya CCM, 2007). The latest UNGASS report from Kenya indicates total AIDS funding increases in the latest three years: from $418 million in FY2006-07, rising to $660 million in FY2007-08 and $687 million in FY200-09 (Kenya National AIDS Control Council, 2010).

For civil society, data from the Kenya National AIDS Spending Assessment indicates two-year revenue of $21.3 million for 60 Kenyan and international organisations: $13.0 million in 2007 and $8.3 million in 2008.[19] This was a year-on-year reduction of 37 percent. In addition, this would indicate that reported CSO funding varied from 2 to 3 percent of the total AIDS funding in Kenya. Funding for indigenous civil society organisations each year was approximately 1 percent of the total.

The reported data indicates the bulk of funding received by CSOs came from the United States through various channels.[20] The United Kingdom was also an important individual donor of Kenyan CSOs during this period. The data also shows US funds to CSOs decreasing by almost half, and almost all funding from UN agencies not continuing from 2007 to 2008.

Table 3.1. Sources of funding to civil society (USD, 000s)

Donor	2007	2008	Total	% of funding
United States	$8,283	$4,522	$12,805	60.1%
United Kingdom	$1,411	$1,206	$2,617	12.3%
UN agencies	$1,064	$24	$1,087	5.1%
Germany	$288	0	$288	1.3%
Ford Foundation	0	$206	$206	1.0%
Global Fund	$7	0	$7	0.0%
Other sources	$1,981	$2,315	$4,296	20.2%
Total	$13,034	$8,273	$21,307	100.0%

Source: Kenya National AIDS Spending Assessment

Global Fund financing is next-to-absent from this table because of its grant history in Kenya. The grant running from 2003 to 2009 performed well in important clinical areas, but its planned funding of CSOs only reached a fifth of the intended

[19] For this report data in Kenya shillings was converted at 68 KSH per USD.
[20] In arriving at donor totals for this report, a few assumptions were made about individual entries and ultimate sources of funds. For instance, Family Health International and FACES were listed as donor agencies but likely received PEPFAR funds principally

beneficiaries during the five-year period (Global Fund 2008c). The follow-on Round 7 grant includes planned involvement of 34 civil society organisations alongside government implementers (Kenya CCM, 2007). However, this grant started in 2009, while national funding data is only available up to 2008.

Civil society recipients of AIDS-related funding

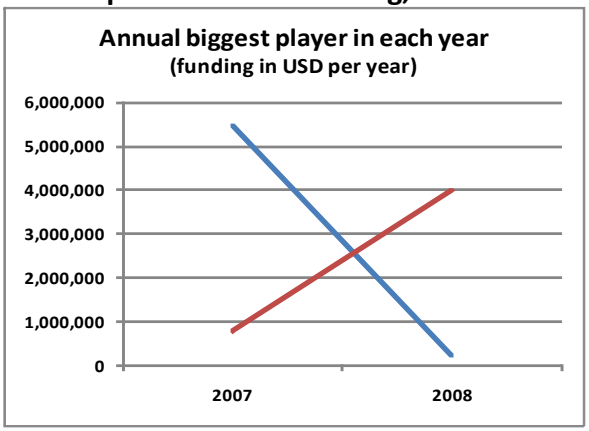
Roughly half of the 60 CSOs receiving HIV/AIDS funding were development organisations, while a quarter of these CSOs were AIDS service organisations formed specifically to implement HIV-related interventions. Other organisations specialise in health care services, while CSOs for people living with HIV comprised less than 10 percent of the recipient organisations. These numbers were relatively stable in both years.

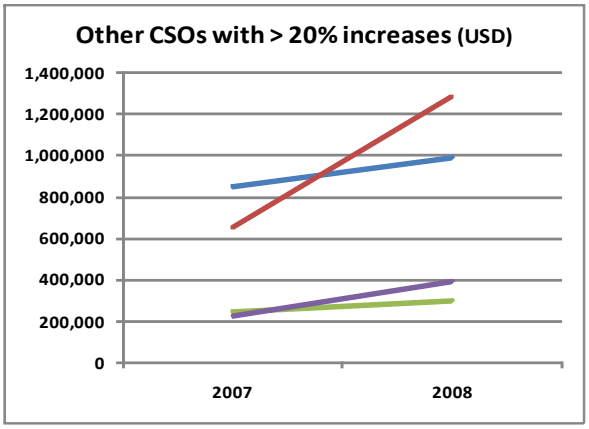
A fifth of the organisations included in this data also acted as funding intermediaries by providing onward grants to other CSOs. Most of these implemented their own activities as well as managing onward funding.

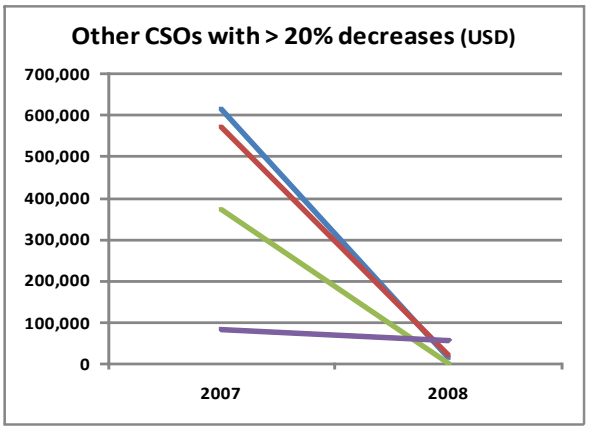
Distribution of funding among organisations

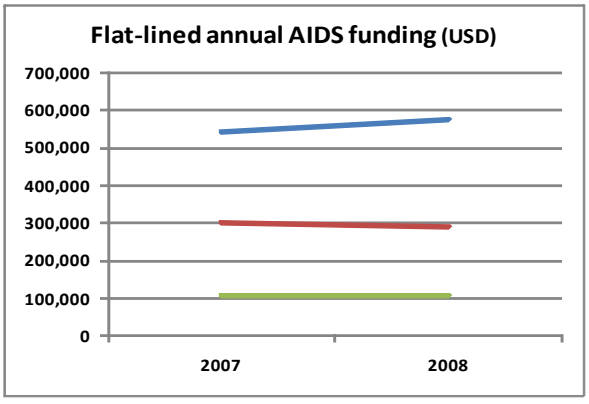
The bulk of the reported funding was received by a small number of the 60 organisations included in the NASA dataset. In each year, most of the funds destined to civil society organisations went to only five organisations. The top thirteen recipients of funds included in the dataset received

Figure 3.1: annual changes for the top CSO recipients of AIDS funding, 2007-08









Source: Kenya National AIDS Spending Assessment

$19 million or 89 percent of the CSO funding flow. All other CSOs, combined, received less than $2.3 million.

Shifts in CSO funding

While recognising that there are some possible errors at the level of individual entries, the Kenya data is presented on an annual basis which allows for an illustration of possible changes in CSO funding. Each line in figure 3.1 represents one of the 13 top recipient organisations' HIV/AIDS funding in 2007 and 2008.[21]

Of the top CSO recipients, ten saw AIDS funding increase or decrease by more than 20 percent between the two years, and only three had relatively stable funding. The biggest annual recipient each year was two different organisations. The top recipient in 2007 was a US-based international NGO that received $5.5 million, or 42 percent of the CSO funding flow in 2007. This dropped to roughly $200,000 the following year. In 2008, a Kenyan NGO that originated in an international project received $4 million, an increase of four hundred percent from the year before and almost half the CSO funding flow. Other CSOs with significant annual increases include organisations whose budgets grew by 16 to 96 percent, reaching new totals of between $300,000 and $1.3 million. CSOs with substantial annual decreases include three organisations appearing to have seen most of their HIV funding disappear in 2008.

The funding by type of CSO varied greatly during these two years (table 3.2). Together, AIDS service organisations and development-focused CSOs received 84 percent of funds. However, there was a notable shift between these two categories, with funding to development NGOs dropping dramatically while AIDS service organisations as a group had a fairly large increase. Health care organisations also saw a decline. The PLHA organisations saw their funding increase from less than one percent of the total in 2007 to 2.3 percent of the CSO funding flow in 2008.

Table 3.2. Annual funding by CSOs with different types of programmes

	2007	2008	Difference	% change
Development NGOs	$8,259,500	$3,384,481	-$4,875,019	-59.0%
AIDS service organisations	$2,756,642	$3,558,214	$801,571	29.1%
Health care delivery NGOs	$1,921,178	$1,139,191	-$781,987	-40.7%
PLHA organisations	$96,450	$191,106	$94,656	98.1%
Total reported CSO funding	$13,033,770	$8,272,992	-$4,760,778	-36.5%

Source: Kenya National AIDS Spending Assessment

[21] The individual organisations' names are not included because their permission was not sought.

The proportion of the annual funding flow to international or Kenyan civil society organisations changed dramatically during these two years, with international organisations receiving two-thirds of the 2007 funding ($8.5 million) but only one-third in 2008 ($2.6 million). While Kenyan organisations therefore received two-thirds of the funds in 2008, this was an absolute increase of only $1.1 million, within an overall annual decline in the funding flow to civil society of $4.8 million.

Table 3.3. Year-to-year changes in funding to Kenyan and international organisations

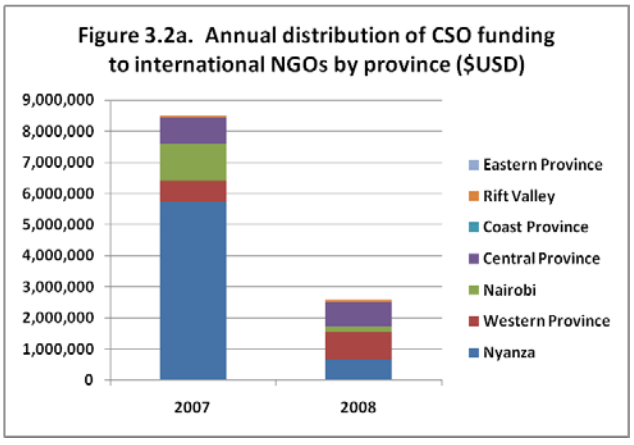
	2007	2008	Yearly change	
Kenyan organisations	$4,535,752	$5,675,273	$1,139,521	25.1%
International organisations	$8,498,018	$2,597,719	-$5,900,299	-69.4%
Total funding to CSOs	$13,033,770	$8,272,992	-$4,760,778	-36.5%

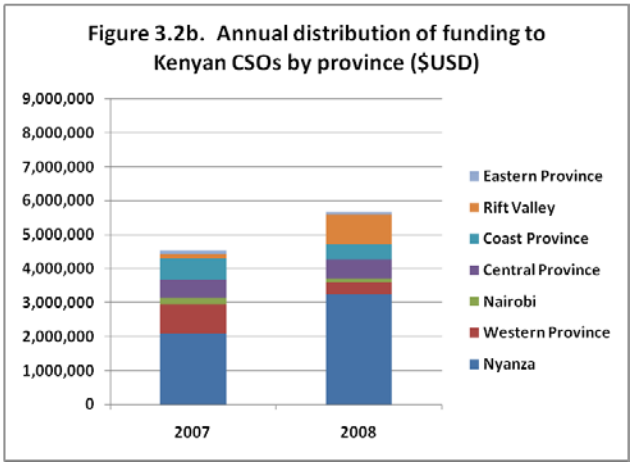
Source: Kenya National AIDS Spending Assessment

This fluctuation is further demonstrated when looking at regional distribution of funds to CSOs. The civil society funding flow broken down by province can mostly be accounted for by the significant shifts in funding to international and Kenyan organisations.

Funding of international organisations decreased by more than 80 percent in Nyanza and Nairobi provinces, or more than $6 million in total. International CSO funds in Western Province increased by almost 40 percent, bringing the annual flow there to $900,000.

For Kenyan civil society organisations, there was an increase of funds of more than 50 percent in Nyanza Province from $2.1 to $3.2 million per year. There was also more than a five-fold yearly increase in funding reaching CSOs in Rift Valley Province, from just under $150,000 to almost $900,000. These was also a decrease of almost half a million dollars to Kenyan CSOs in Western Province, from $860,000 to $372,000.





Source: Kenya National AIDS Spending Assessment

Main activities of civil society organisations

Spending on different AIDS activities are shown in table 3.4. [22] Half of CSO funding was allocated to prevention. This contrasts with national spending patterns as described in the latest UNGASS report (Kenya National AIDS Control Council, 2010): excluding programme management, prevention efforts represented 29 percent of total AIDS expenditure across all sectors.

National expenditure was dominated by treatment and care – 69 percent of total HIV/AIDS spending across all sectors, and 28 percent for civil society actors. Support for orphans and vulnerable children was 8 percent of national expenditure but 11 percent of CSO spending.

The data also indicates variability among types of CSOs. National-level Kenyan NGOs spent most of their funds on anti-retroviral treatment, while locally based community organisations were more likely to spend funds on social protection, such as financial support to people directly affected by AIDS, and on home-based care.

Table 3.4. Estimated expenditure by civil society organisations for AIDS activities (2007-08)

HIV/AIDS activities	Expenditure	% of total
Prevention	$10,570,271	50%
Treatment and care	$5,876,286	28%
Orphans and vulnerable children	$2,260,864	11%
HIV research	$1,076,612	5%
Social protection	$974,934	5%
Enabling environment	$547,795	3%
Total activity spending	$21,306,762	100%

Source: Kenya National AIDS Spending Assessment

CSO spending on different activity areas also varied from one year to the next. There were large decreases in funding for CSO activities in prevention, treatment and care, and support for orphans and vulnerable children. The relatively small amount budgeted for improving the enabling environment also decreased. Social protection and HIV research were each increased from a relatively low base.

[22] The NASA data reports human resources and programme management as separate line items, which were distributed pro-rata across these activities although it is not clear if some activities are, for instance, more labour intensive.

Table 3.5. Changes in annual expenditure for CSOs' AIDS activities				
HIV/AIDS activities of civil society organisations	**2007**	**2008**	**Difference**	**% change**
Prevention	$6,709,982	$3,841,959	-$2,868,022	-43%
Treatment and care	$3,875,780	$1,979,381	-$1,896,399	-49%
Orphans and vulnerable children	$1,402,999	$856,364	-$546,635	-39%
HIV research	$375,713	$722,154	$346,441	+92%
Social protection	$223,517	$779,436	$555,919	+249%
Enabling environment	$445,780	$93,698	-$352,082	-79%
Total activity spending	$13,033,770	$8,272,992	-$4,760,778	-37%

Source: Kenya National AIDS Spending Assessment

Conclusions

– *Funding flow*

Kenya has a severe and generalised epidemic, and is the recipient of important AIDS-related funding. Within the total funding flow to Kenya, bilateral assistance is especially important with US PEPFAR the largest single donor. This is true for CSO funding as well. Kenya has a relatively large sector of very local community-based organisations as well as Kenyan NGOS (based in provinces and nationally), and a fairly significant presence of international NGOs. For 2007 and 2008, the funding flow to civil society reported in the National AIDS Spending Assessment is about $10 million per year. This is 2-3 percent of the total HIV/AIDS funding, and for Kenyan CSOs it is about 1 percent of the national total.

The data on funding to civil society shows important annual fluctuations, especially where the flow is greatest, seemingly as funding for large projects gets unplugged and plugged in. Fluctuations are found in the overall annual funding received by civil society organisations, which declined by 37 percent from one year to the next. The flow to international versus indigenous CSOs, the flow to CSOs by province, and the total available to civil society for different categories of AIDS activities also all saw fluctuations. Further enquiries would be needed to understand the reasons for these funding changes, and how they might fit into longer term CSO funding patterns.

– *Expenditure by civil society on HIV/AIDS activity areas*

Expenditure on activities indicates distinctions between the efforts of all sectors that are involved and those specifically of civil society. Proportionally more of the CSO funds were allocated to prevention efforts (half of CSO spending compared to 29 percent for all sectors), and somewhat more to support for orphans and vulnerable children, while less CSO spending was dedicated to treatment and care (28 percent for CSOs and 69 percent for all sectors). There was also a distinction between types

of CSOs, with international NGOs more focused on treatment, and local organisations more focused on social protection and home-based care

Due to the apparent changes in projects and annual funding, CSO spending on specific activity areas was quite variable within this short period of time.

- *Data availability and limitations*

The specifics within the dataset raised a few questions about definitions of the funding flow to civil society, as well as about data accuracy when drilling down to this sector. Indeed, several revisions were made after questioning the data at the level of individual organisations and projects. Below are some examples of questions raised during this closer analysis:

- The total of 60 organisations appears very low given that, for instance, the Kenya AIDS NGOs Consortium consists of almost a thousand local member CSOs. Many of those are small organisations, so it was felt the data represents the vast majority of CSO funding in the country.
- Individual errors are more easily spotted when analysing sector-specific data. For instance, one organisation listed as receiving 5 percent of the 2007 funding flow to civil society was not a CSO, but rather a private sector organisation with a DFID contract to support the Government of Kenya.
- Similarly, the practical status of some large NGOs as recipients of funds or donors is not always clear. International NGOs that handle donor funding can sometimes be found in the donor data – presumably since the funds they bring into Kenya are clearly contributions to the AIDS response – but sometimes these are included in the CSO data. Given the relatively significant amounts of these funds, and without information on their use by these international organisations – spent by themselves, passed on to other CSOs, or used to support public sector activities – these entries could potentially affect a large proportion of the reported CSO funding flow.

Given the purpose and timeframe of this study, it was decided not to pursue individual enquiries with each of these organisations, but rather adjust the data where obvious and note such possible anomalies.

India

Unlike the presentation of funding flows in Kenya and Peru, there is no available dataset in India upon which this report's analysis can be based. However, below there is an attempt to bring together the parts of relevant information that are available.

Funding sources for civil society

There are funding streams in India that reach civil society organisations in important ways. Several of these date back only a few years and their significant evolution has continued, notably: the third National AIDS Control Programme's expansion of the AIDS response since 2007, Avahan's scale-up of focused prevention up to 2009, and the expansion of Global Fund support of civil society PRs. In addition, support from bilateral and multilateral sources have continued with some changes in emphasis, notably alignment with government funding schemes that reach CSOs.

– *National AIDS Control Programme*

The National AIDS Control Programme for 2007 to 2012 (NACP-III) is implemented by parastatal State AIDS Control Societies, with India-wide coordination by the National AIDS Control Organisation. Its budget for this period is $2.5 billion, or $500 million per year (National AIDS Control Organisation, 2010). NACP-III is supported by the Government of India (which contributes 15 percent of the funds), as well as donors such as the World Bank, the UK's DFID, the Global Fund, UNDP and USAID.

The main NACP-III programming that involves civil society consists of interventions for outreach to key populations and targeted prevention. Through these schemes the government involves CSOs as implementers of standardised interventions, and attempts to achieve national presence of activities (while prioritising districts based on epidemiological factors). Programming is widespread, and the individual amounts of funding to partner CSOs are smaller than is the case with other sources of funding. In addition to focused prevention, a number of CSOs are also funded under NACP-III for community care centres, treatment management, drop-in centres for people living with HIV, and for capacity building. With some exceptions the CSOs funded at the state level and are almost entirely indigenous NGOs and CBOs, organisations of people living with HIV, and technical and academic institutions.

– *Bill and Melinda Gates Foundation*

Avahan is the India HIV/AIDS initiative of the Bill and Melinda Gates Foundation, started in 2003. It funds civil society organisations to support and implement a standardised set of interventions to scale up focused prevention. The objective is saturation coverage of outreach and services for sex workers, their clients and partners, men who have sex with men, *hijra* and transgender people, and injecting drug users. Activities are in six high-prevalence states and along major trucking routes. The overall funding flow to civil society has been relatively large. Although CSOs were involved in such activities in India before Avahan started, and indeed were supported for groundbreaking projects with sex workers among others, Avahan

was the first major donor initiative to provide such significant financing of prevention with key populations. The total Avahan budget is $338 million from 2003 to 2014.

– *The Global Fund*

The Global Fund has made several grants to India that have included civil society funding streams. Supported activities have included promoting access to care and treatment, community based care and support with an emphasis on children and families directly affected, and specific initiatives for academic institutions to build capacities of counsellors and nurses. From 2005 to the beginning of 2010, different Global Fund grants have disbursed $54 million through civil society organisations acting as first-line Principal Recipients.

– *Other bilateral, multilateral and charitable sources*

The key bilateral and multilateral donors undertaking direct CSO funding are the European Commission, UNDP and other UN agencies, USAID and, until a few years ago, UK's DFID.

There are some other funds from foundations, charities and international NGOs that finance civil society activities, but usually at levels that are felt to be significantly smaller than the donor flows cited above.

The funding flow

It is difficult with the available information to provide an estimate within one given time period of the total funding flow that actually reaches civil society. Most of the available AIDS budgeting data is disaggregated by programme area but not sorted by implementing agencies. For instance, a complete list of government-funded CSOs is not available at the national level or on websites, but would have to be compiled through direct contact with each of the 35 State AIDS Control Societies.

We do know the following:

– The overall funding flow to CSOs is composed of (i) a portion of some of the National AIDS Control Plan's budget lines, and (ii) direct funding from donors which is classified by the government as extra budgetary resources.

– The Indian Government's total budget for the National AIDS Control Plan is almost $2.6 billion for five years (2007 to 2012), although the portion reaching civil society implementers is not clear. The main category from which civil society organisations are involved is targeted interventions for prevention, which are funded at approximately $500 million for the five-year period. This has increased three-fold from the previous national plan, which ran from 1999 to 2006.

– Extra budgetary resources for AIDS are estimated to have totalled $500 million in recent years, with different funding streams coming and going during the past decade. Much of this is used to fund CSOs. Some donors such as USAID and UNDP divide their funds, giving a larger share to government pool funds, while others such as the European Commission and Gates Foundation's Avahan do not use the government channel, funding CSOs directly but ensuring alignment in

goals and objectives. Several donors have a defined geographic area where their directly funded activities are concentrated, and this is usually planned in consultation with the Government.

- By far the largest single source of extra budgetary support that has flowed directly to CSOs is the Gates Foundation, whose Avahan programme spent more than $200 million from 2003 to 2009 and plans to spend another $100 million to 2014. During Avahan's current stage, the Gates Foundation is phasing out its direct support to AIDS prevention in India. Targeted interventions will continue to be implemented by Indian CSOs but the financing will be progressively handed over to the government. From an annual budget of $50 million in 2007, Avahan funds are expected to go down to $40 million in 2010 and less than $3 million in 2013.

- UNDP annual commitments have increased from roughly $15 million under the previous NACP-II to $20 million under NACP-III, but the funding patterns have become much more aligned to NACP priorities which limits the flexibility of direct funding for CSOs.

- USAID's envelope has increased significantly, from $11 million to $15 million annually under NACP-II, to $22 million under NACP-III. Approximately two-thirds of this funding flows to CSOs, although now a significant portion is routed through the National AIDS Control Organisation programmes. The programme focus of USAID has also expanded from prevention to include care and support and increased technical assistance.

- DFID resources for NACP-III have increased but are now part of the pooled funds apart from a small portion for a capacity building project. Under NACP-II DFID made 58 grants to CSOs under its Civil Society Challenge Fund, which provided about $7 million from 2005 to 2007 but has now ended.

- Global Fund financing has expanded over several years to include more civil society involvement. While the government was the sole first-line recipient of the first two AIDS grants to India, civil society organisations have been included in subsequent rounds and the more recent ones appear to continue a trend to spread funds more widely through different CSO channels. The Global Fund has to date committed a total of up to $76.5 million through five CSOs that have acted as first-line funding managers. The latest Global Fund grant will be signed in 2010, and aims to fill gaps in achieving the current national strategy. Civil society will be involved in expanding focused prevention with men who have sex with men and harm reduction with injecting drug users, alongside government efforts for prevention aimed at informal labourers.

Civil society recipients of AIDS-related funding

There is a perception that official donors are increasingly funding indigenous civil society organisations, both because of increased capacity for managing grants and because donors wish to align themselves to National AIDS Control Plan costing guidelines. Some informants see international NGOs as adding value in terms of management and monitoring support, research, and information management. At the same time, several Indian NGOs undertake management of direct funding.

Donors have invested in capacity building of local CSOs for increased independent management of projects, with an increased share of funds for technical support. The National AIDS Control Organisation has encouraged donors to fund Technical Support Units at national and state levels, with the intention of shifting away from the use of international technical agencies.

There is no single database of civil society organisations in India, and estimates of their number vary widely – between one million and two million, or even more. Even with regards to CSOs working on HIV/AIDS there are several databases, but none of them could be considered truly exhaustive.

Information obtained from a sample of key donors allowed for an identification of 73 CSOs that have received direct funding, with varying types of projects and funding. Of these, 41 are Indian organisations and 32 are international NGOs. Because this is direct funding, the number of recipients for each donor varied as did their roles. For instance, UNDP cited 32 directly funded organisations, most of which were locally-based Indian NGOs. By the end of 2009, the Global Fund had signed agreements with four CSOs – two Indian academic institutions, one larger Indian NGO, and one international NGO – to act as Principal Recipients.

In addition, information from this sample of donors plus the government funding channel suggests that HIV/AIDS funding is widely dispersed among a large number of CSOs. This estimate includes CSOs funded directly by the donors or indirectly through intermediary organizations.

Table 3.6. First- and second-line CSO recipients of key AIDS funding flows

Name of donor	Types of organisations	No. of CSOs
National AIDS Control Organization (NACO) and State AIDS Control Organizations (SACS)	– Local NGOs and CBOs implementing targeted prevention interventions	**1,300**
	– NGOs implementing Link Worker outreach scheme (15 at State level and 125 at district level)	**140**
Global Fund	– Mostly Indian NGOs and CBOs, some international NGOs	**430**
Avahan / Gates Foundation	– Larger Indian and international NGOs, – Academic institutions – Local NGOs and CBOs implementing targeted prevention interventions	**160**
USAID	– Larger Indian and international NGOs – Local NGOs and CBOs	**150**
European Commission	– Indian and International NGOs	**45**
UNDP	– As above	**35**
Total funded CSOs		**2,120**

Despite the popular notion that international donors are the lead funders for CSOs, the government supports the largest number of organisations with funded AIDS activities, especially smaller CSOs at the district and state level. While these grassroots organisations are numerous and widely spread across the states, there is a relatively small pool of larger Indian and international NGOs receiving direct funding from donor agencies. Several of these NGOs act as intermediaries, providing sub-grants to grassroots organisations that work with a smaller constituency in one district or a cluster of districts. Through these various channels, implementation on the ground is almost entirely carried out by local NGOs and CBOs.

Expenditure on AIDS activities

While it is not possible to obtain data that disaggregates expenditure by both activity areas and civil society organisations, feedback was elicited from a small sample of ten of the more prominent and active Indian and international NGOs. This indicates that at least half, and probably more, of civil society's AIDS funds are likely spent on prevention. This is in line with the government's overall budget for the National AIDS Control Plan, of which two-thirds is devoted to various types of prevention activity (including targeted interventions for key populations, prevention of parent to child transmission, IEC, and blood safety) while another 17 percent is allocated to care, support and treatment and a further 17 percent on other activities such as capacity building, programme management, surveillance and programme monitoring.

Important funding streams involving CSOs are aimed at reaching specific population groups, such as the government-funded Targeted Interventions programme, Gates Foundation's Avahan, and parts of the Global Fund financing for populations such as men who have sex with men and injecting drug users. There is also some CSO activity in care and support to those directly affected, and some impact mitigation work. There are two programmes for community-based care and support focusing on children and families directly affected by HIV, one financed by the Global Fund and the other by the private Children's Investment Fund Foundation. Key informants also reported civil society advocacy activities, although spending in this area appears relatively small.

Conclusions

– *Funding flows*

India includes specific states with high HIV prevalence rates, has important focused epidemics within a large population, and is home to the largest number of people living with HIV in any country outside of Africa. There are several notable funding streams, which in various ways support at least two thousand NGOs and CBOs working in communities. In recent years indigenous CSOs have played a more important role as direct recipients of donor funds. At local level, there is widespread presence of Indian NGOs and CBOs that have become involved in the AIDS response.

Larger funding streams, whether from the government or delivered through CSO intermediaries, focus on standardised packages of programming for the purposes of

geographic coverage or saturation of key populations. In parallel, bilateral and multiateral donor support is shifting to align with or pass through government channels. In addition, India proposals to the Global Fund have added funding that is managed by civil society Principal Recipients. These appear to have helped increase the use of different funding channels, fill gaps in delivering the national strategy, and diversify AIDS activities.

There have been important changes in the last few years and these continue. With increasing alignment of donor flows to government-managed AIDS programming as well as the phase-out of the Gates Foundation's significant financing, the National AIDS Plan and the Global Fund could eventually be the dominant streams supporting CSOs. This would mean that CSO influencing of AIDS funding priorities would be located less at the level of writing individual proposals or interacting with individual donor representatives. Instead, it would require getting involved in attempts to shape funding priorities at the national level, or soliciting to become a sub-contractor of pre-specified deliverables at the local and state level.

– *Expenditure by civil society on HIV/AIDS activity areas*

Although spending data across CSOs is not available, it appears from a sample of organisations that half or more of civil society expenditure is for prevention, following the national strategy's spending in which prevention comprises two-thirds of AIDS activity expenditure. In addition, civil society has played a role in ensuring complementary programming such as child-focused care and support, and in securing external resources for expanding the national programming for gaps such as services for injecting drug users and outreach to men who have sex with men.

– *Data availability and limitations*

Available information is clear about AIDS programming priorities and donor channels. It is less clear about CSO funding, either as a total amount in itself or as a proportion of national AIDS spending. There is no available dataset covering all CSO funding for AIDS, or for expenditure for different activity areas. Available data and key informant feedback did provide information about funding priorities and modalities.

Peru

Donor funding for civil society AIDS activities

From 2006 to 2008, the total financing for AIDS in Peru across all sectors averaged $37.4 million per year, or a three-year total of roughly $112 million (Peru, Ministerio de Salud (2008) and (2010)). [23] During this period, eleven external donors provided $30 million for CSO AIDS-related activities as reported by Peruvian organisations to APCI, the government's agency for international cooperation. However, in the case of Peru we should note that almost half of this funding flow was for health research projects carried out by NGOs. Funding for activities that would be considered as more typical of community AIDS responses was approximately $17 million, or an annual average of $5.7 million for all CSOs. This represents 15 percent of the national funding flow for HIV/AIDS during this time.

The Global Fund has been the largest funding source for civil society organisations responding to the HIV/AIDS epidemic, representing almost 35 percent of revenue for all civil society's externally-funded projects, or 62 percent of the funding of the community response to AIDS excluding health research. As shown in table 3.7, the next most important donors were three of the four health research funders. All of these are based in the US and, presumably, were principally channelling centrally-awarded US government research funding.

Table 3.7. CSO AIDS funding in Peru from external sources (2006-08)

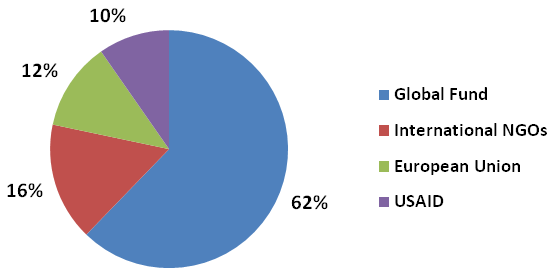
Source of funds	All CSO funding	Funding net of health research projects
Global Fund	35%	62%
J David Gladstone Institutes	17%	-
University of Washington	15%	-
US Natl. Institutes of Health	7%	-
European Union	7%	12%
USAID	5%	10%
Social and Scientific Systems	5%	-
HIVOS	4%	6%
CORDAID	3%	5%
Intl. Planned Parenthood Fedn	1%	3%
Terre des Hommes	1%	2%
Total main donors	100%	100%

Source: Records of APCI (Peruvian Agency of International Cooperation)

[23] Reported as 110 million to 132 million nuevos soles per year in 2006-08, converted at 0.32 / USD

Apart from the Global Fund, the European Union and USAID are the other two official donors active in the country, providing almost a quarter of non-research funds during this period. According to USAID Peru, approximately US$1.5 million is granted annually, with resources channelled through US organisations or contractors that have included Peruvian organisations as partners within their proposals. Some international development NGOs also provide direct funding to Peruvian CSOs. This includes two NGOs based in the Netherlands – HIVOS (the Humanist Institute for Development Cooperation), and Cordaid (the Catholic international development organisation) – as well as the International Planned Parenthood Federation (with a sexual health focus) and Terre des Hommes (a network of child-focused international NGOs). Excluding health research, sources of donor support for community responses to AIDS are shown in figure 3.3.

Figure 3.3. CSO funding for community AIDS responses (2006-08)



Source: APCI records

Trends in donor funding

International funding that reaches CSOs in Peru, for all types of development work, has increased slightly compared to a period of 5 to 7 years ago. In parallel, the creation of the Global Fund clearly represented a significant change in financing of AIDS responses in Latin America, and Peru has received more Global Fund commitments than any other country in the region. This totalled almost $59 million in three rounds for all sectors of implementers. Between 2005 and 2006, the Global Fund increased its financing by 90 percent, from $7.3 million to $14 million per year (APCI 2005), across the different sectors of recipients and for all AIDS activities.

Table 3.8. The Global Fund's multi-year AIDS grants to all sectors in Peru

	Round 2 (start: 2003)	Round 5 (start: 2006)	Round 6 (start: 2007)	Totals
Approved	$21.6 million	$12.9 million	$24.2 million	$58.6 million
Disbursed	$21.6 million	$9.3 million	$21.2 million	$52.0 million

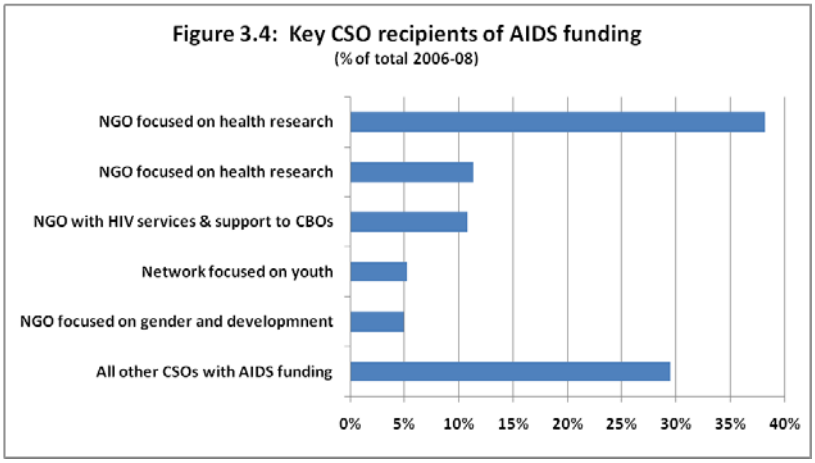
Source: The Global Fund

The last two rounds of funding have explicitly included civil society organisations, with significant funds to strengthen activities reaching vulnerable populations and for country-wide implementation. Indeed, some stakeholder feedback indicated that these recent funding developments change the overall picture of the CSO response to the extent that ACPI data through 2008, which was only reported in the past year, no longer represents the extent of the community response.

Civil society recipients of AIDS-related funding

Analysis of the 2006-08 APCI data show 26 civil society organisations receiving funding for AIDS activities, although about 70 percent of the funding was concentrated in only five organisations (figure 3.4).. The CSOs receiving significant funding are seen as having experience in project implementation and service provision. They received on average $1.4 million each year, within a range of $490,000 to $3.8 million annually per organisation. The higher amounts were allocated to NGOs with health research activities. Another 21 organisations, many of them relatively new, received a total of $8.8 million over three years, or on average of $140,000 annually per organisation.

The top two recipients are heavily involved in health research projects. The others are: an organisation providing community level AIDS services and supporting smaller organisations in communities; a national network for youth-focused activities; and a long-established organisation working on gender and development.



Source: APCI records

The following are further relevant points about civil society organisations involved in the Peruvian AIDS response:

- APCI records show implementation of CSO AIDS activities in 2006-08 was basically carried out by national organisations. For HIV/AIDS, international CSOs are involved mainly as funders of Peruvian CSOs. This is different from the profile in other development areas: about 140 international CSOs work in the country, generally both directly implementing their own activities and also working with Peruvian NGOs and grassroots CBOs. However, their work scope is mainly in social development, economic development, the environment, humanitarian aid and disaster prevention.
- Most of the CSOs receiving AIDS funds – 17 out of 26 – focus on development issues. The others specialise in one of the following areas: PLHA associations, provision of health services for PLHA and for more general health issues, health and development, and health research related to HIV/AIDS.
- There is not a long history of Peruvian CSOs acting as intermediary organisations. Out of all CSOs working on AIDS only one provides small prevention grants to CBOs. Other organisations work with grassroots groups, but the responsibility for managing financial resources, logistics and supplier contracts is kept within the NGO while the CBOs only carry out agreed activities.

- Most recipient civil society organisations in this period were based in Lima but carried out activities across the country. Only two organisations were located in the northern regions of Piura and Lambayeque, and they jointly received 4 percent of the 2008 funding. However, since funding was reported to ACPI for 2008, Global Fund support has emphasised the decentralisation of projects.
- Data for 2006-08 does not show community grassroots organisations as first-line funding recipients. During interviews, NGO and donor representatives agreed that CBOs lack capacity to produce project proposals and for administrative management except for experienced organisations such as the Movimiento Homosexual de Lima and, more recently, the Self-help Support Program for Seropositive Persons. More CBOs started to become Global Fund sub-recipients once the Round 5 grant started in 2006, which required at least one community-based organisation in each recipient consortium (see "the flow of funds," below).

Expenditure on AIDS activities

Most of Peruvian civil society organisations' non-research activity in 2006-08 was dedicated to prevention. The 26 organisations implemented 90 projects in this period, of which 60 were prevention projects and 14 were health research. Five or six projects were dedicated to each of the following: care and support to people affected by AIDS, support for treatment access and adherence, and advocacy.

This emphasis among CSOs on prevention is in contrast with the proportional expenditure across all sectors. In this period, 44 percent of national AIDS spending was for care and treatment and 29 percent for prevention.[24]

While the epidemiological profile in Peru would indicate focused prevention for key populations as a priority – notably for men who have sex with men, sex workers and transgender people – the government does not intervene in this area and the CSO sector represents the main actors. At the same time, focused prevention is not generalised across CSOs as a sector: of the projects reviewed in this study, only 30 percent are working with key populations.

In terms of the public sector, the Ministry of Health has gradually taken over funding of anti-retroviral therapy, which has been made available for free since 2004, and currently almost all of these drug costs are provided by the government (Visser-Valfrey, Cassagnol and Espinel 2009). For prevention, the government's expenditure is oriented to three activity areas: antiretrovirals for pregnant women living with HIV to prevent mother-to-child transmission; awareness for school groups (although not nationwide); and prevention campaigns oriented to the general public.

The flow of funds

Apart from the Global Fund, civil society financing for AIDS activities usually flows on a project basis directly from an international source to one of several national CSOs. This part of the funding flow appears to have been almost $2 million per year on

[24] Other country-level spending (excluding management and human resources) included 18 percent for HIV research, 6 percent for enabling environment, 2 percent for social services and social protection, and 1 percent for orphans and vulnerable children.

average in 2006-08. Most of these funded projects do not include onward granting to other civil society organisations.

Peru has received three Global Fund AIDS grants with CARE acting as Principal Recipient for each. As an international NGO, CARE has therefore managed the funding for public sector and CSO activities. The Global Fund projects are aligned with the strategic objectives of Peru's Multisector Strategic Plan, which include reducing by half the number of new cases of HIV nationally and the prevalence of sexually transmitted infections among men who has sex with men, sex workers and prisoners (Health Ministry of Peru, "Peruvian Response to the HIV/AIDS Epidemic").

While Peru's first grant from the Global Fund started at the end of 2003, NGOs and CBOs were explicitly included in Peru's funding flow starting at the end of 2006. Four CSO consortia were formed and include a total of 17 CSOs. Each consortium focuses on one of the following objectives: decreasing STI transmission; comprehensive care for men who have sex with men and sex workers; reducing social impact, stigma and discrimination; and strengthening PLHA organisations.

Additional efforts to decentralise CSO funding started in late 2007. This included an attempt to increase the number of organisations acting as fund managers and as implementers. The process started with CARE assessing institutional capabilities in a dozen regions. Eventually CSO consortia were formed for each of the programmatic objectives in the north, central-south and the east of the country, for a total of 9 civil society consortia involving 24 CSOs. This evolution in the objectives of CSO efforts was proposed by stakeholders in the Peru proposal for Round 6. The Global Fund's subsequent grant to Peru includes civil society to address the following: closing the funding gap for prevention with men who have sex with men, sex workers, and transgender populations; STI prevention for the general population and young people; and scaling up prevention of mother-to-child HIV transmission.

Perceived issues related to the main funding flow

Key informants felt the positive aspects of the Global Fund financing in particular include the following: the coordination mechanism allows for stakeholder discussion and prioritisation; its inclusion of populations directly affected by HIV allows for better inclusion of their needs and strengthens their organisations as institutional stakeholders; the possibility of joint work with other CSOs helps expand coverage of activities; and, there has been a learning process that has resulted in strengthening of capacities related to project management.

Negative aspects include: the large number of reporting requirements require dedicated staff; technical support is not provided for donor compliance; there is a need to strengthen capacities for better implementation; the focus on quantitative monitoring does not allow for qualitative assessments; staff salaries, set in the country proposal, are below market prices; and, staff are mobilised exclusively to achieve project goals and CSOs cannot engage in additional resource mobilisation, generating uncertainty about the future once Global Fund financing ends.

Conclusions

– *Funding flow*

Peru has a focused epidemic with important HIV prevalence affecting key populations in particular. The funding for more "traditional" CSO activities amounted to 15 percent of the total AIDS funding flow in 2006-2008, or an average funding of $5.7 million per year. More than 60 percent of this came from the Global Fund. Most of the rest came from two official donors and four international NGOs as direct funding of individual CSO projects.

There is a diverse profile of civil society organisations and activity portfolios among a relatively small number of CSOs that are involved in AIDS work. Funding is concentrated among a few organisations. As well, intermediary support through CSOs is less common than elsewhere. Recently, management of the Global Fund grants has started to expand the practice of onward granting through intermediaries, as well as ensuring wider dispersal of CSO funding through more organisations and by decentralisation to regions. This began in late 2006 with 17 CSOs starting to receive Global Fund sub-awards, and another 24 multi-year sub-awards were made toward the end of 2007.

In addition to the above, there is a relatively large amount of health research funding to some Peruvian CSOs. This underlines the lack of homogeneity of civil society as a sector, and the fact that a review of CSO funding does not automatically equate with an analysis of community responses.

– *Expenditure by civil society on HIV/AIDS activity areas*

CSO activities appear to be complementary to those of other sectors. Most of the individual CSO projects were focused on prevention. By contrast, across all sectors care and treatment was the highest area of spending (44 percent) followed by prevention (29 percent). As well, roughly one-third of CSO projects targeted key populations who are most significantly at risk in Peru: transgender people, men who have sex with men and sex workers. Governmental prevention activities have not focused on prevention for key populations.

– *Data availability and limitations*

Some informants felt the decentralisation of Global Fund sub-awards and the increased number of CSOs with AIDS activities, even in recent months, has made the 2006-2008 data somewhat outdated and that it underestimates the extent of community action on AIDS.

Two datasets were used to compare funding CSOs and the national picture. The legally required ACPI records of external aid from all donors are felt to be a complete information source for CSOs' own activities, budgets and spending, and were reviewed in late 2009. The 2010 UNGASS report gives data on the national picture across sectors.

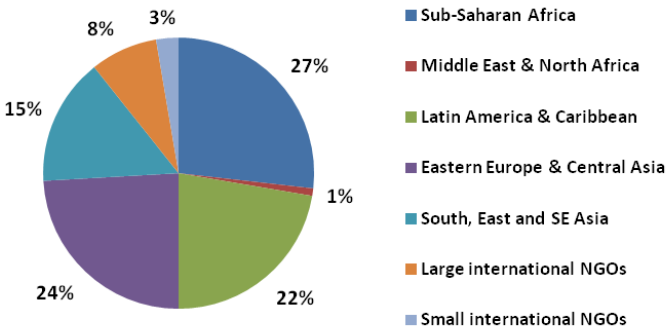
4. SURVEY OF CSOS INVOLVED IN AIDS RESPONSES

Responding organisations

A total of 146 civil society organisations answered the online survey. The profile of responding organisations was quite homogenous: 89 percent are indigenous civil society organisations, including 18 percent working at national level and 71 percent at sub-national level (i.e. in local communities or districts). They are relatively small: two-thirds have less than 20 staff members. They also rely on volunteers: 66 percent of the organisations have volunteers making up at least a third of the workforce.

The 27 percent of organisations located in sub-Saharan Africa almost equally divide between Southern Africa, Eastern and Central Africa and West Africa. The relatively large responses from Latin America and the Caribbean as well as Eastern Europe and Central Asia may be attributable to the fact the survey was available in five languages, including Spanish, Portuguese and Russian.

Figure 4.1. Geographic base of the organisations
(n=112)



Almost three-quarters of all the responding organisations are public benefit NGOs or CBOs, a tenth are peer organisations of people living with HIV, while slightly smaller percentages are either faith-based organisations or advocacy organisations. More than half (58 percent) work mainly on HIV/AIDS but also on other health or development issues, while 22 percent are focused solely on HIV/AIDS. Another 20 percent have some activities in AIDS but mostly in other development work.

Sources of CSO funding for HIV/AIDS activities

The frequency of funding shows the proportion of organisations receiving at least some AIDS-related revenue from different sources. The sources cited most often were three categories – the organisation's own private fundraising, national funding mechanisms or government contracts, and foundations or charities. The fourth was the only named donor, the Global Fund, and it was more important than the category of smaller bilateral donors and "other" multilaterals (34 percent).[25]

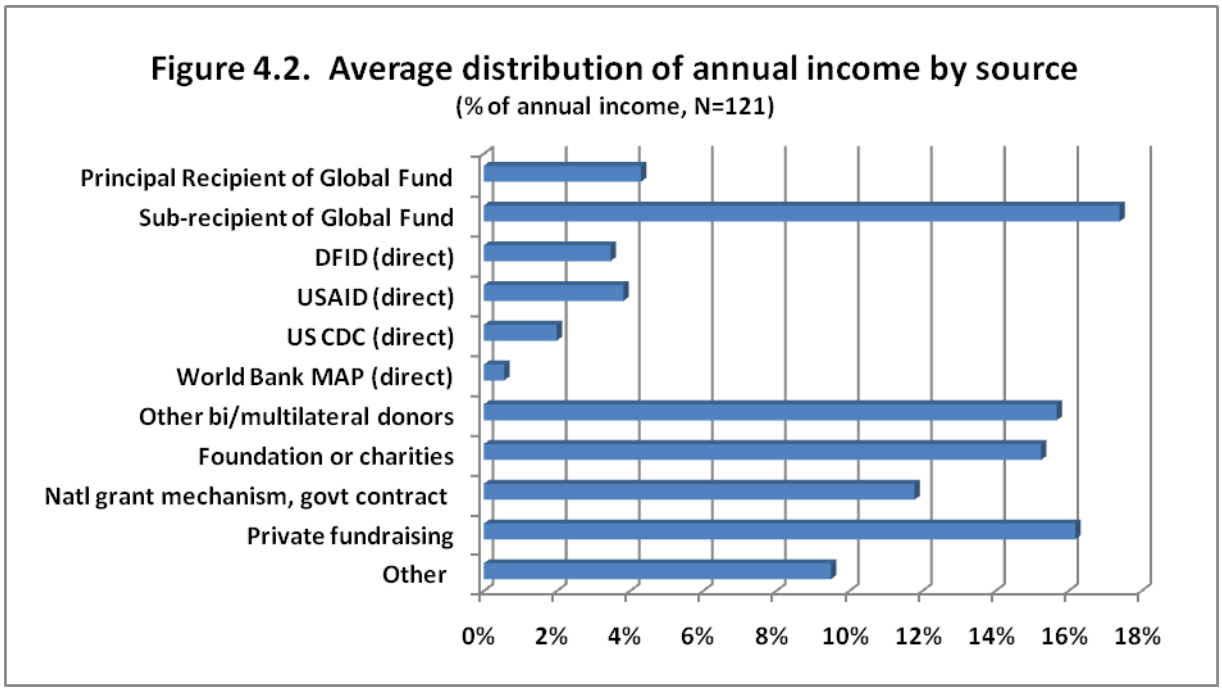
Overall, institutional sources provide half or more of annual income in 77 percent of cases. The top sources, based on the average distribution of funding reported by respondents, are shown in the following table.

[25] To increase the response rate, the survey did not ask for actual income but percentages from different sources. Also, given the range of possible donors and channels, organisations were asked if they receive are a direct recipient of the larger donors, and also if they receive funds from categories of other funding sources (such as "private fundraising" and "other bilaterals or multilaterals").

Table 4.1. Frequency and average distribution of annual funding among CSOs		
Most important annual income sources in last financial year	**Organisations receiving some funding from this source**	**Average proportion of income from this source**
The Global Fund	**38 percent**	**21 percent**
Private fundraising	**55 percent**	**16 percent**
Natl grant mechanism, govt contract	**42 percent**	**16 percent**
'Other' bilaterals or multilaterals	**34 percent**	**16 percent**
Foundations or charities	**42 percent**	**15 percent**

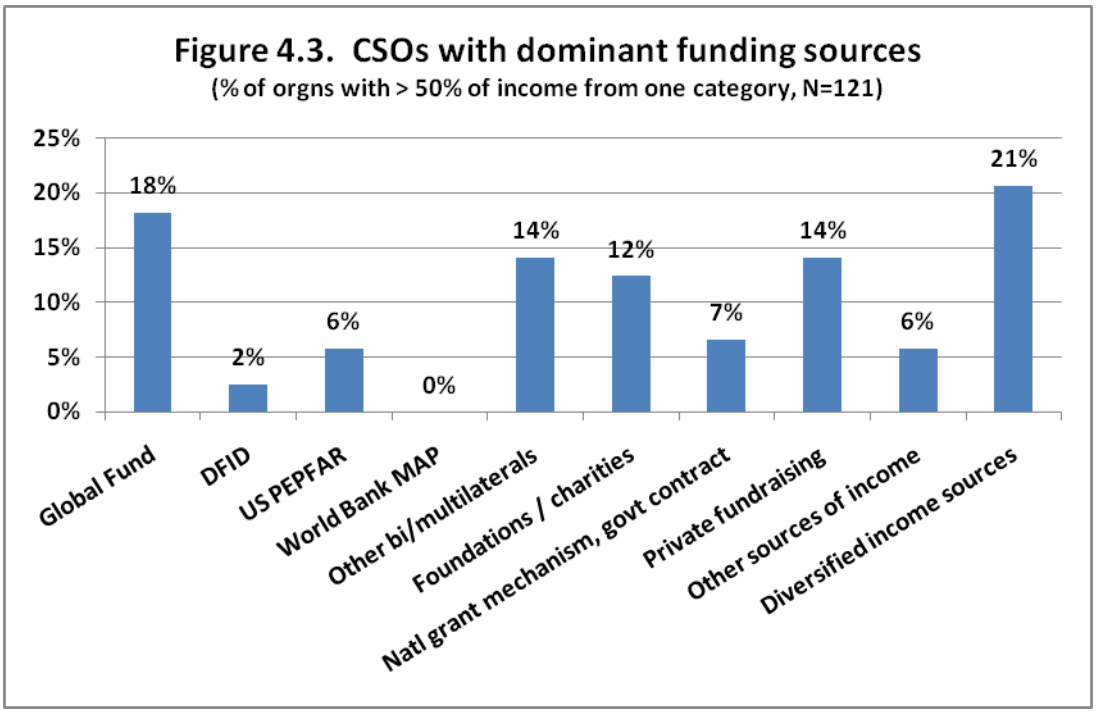
There survey indicates further points about the major named donors:

- For these CSOs, the Global Fund did not on average finance a majority percentage of annual budgets, but it was on average the largest single contributor.
- There were relatively small percentages coming directly from other named donors. The two US government agencies (USAID and CDC) represented a total of 6 percent of funding on average, and the World Bank's MAP was one percent. This relatively small average contribution from large international donors could reflect a couple of scenarios: the funding was more significant than this but passed through intermediaries and cited, for instance, as national funding mechanisms; or this funding does not significantly reach these particular types of small and usually local organisations working at the grassroots.



Reliance on major donors

The number of donors per organisation, as well as the proportion of annual income from any single source, helps to show CSOs' reliance on donor funding streams. Just over half the organisations indicated they had two to four institutional donors in the past year. More than a quarter received institutional funding from a single donor. Dominant funders were deemed to be those providing more than half an organisation's annual income. The named large donors are dominant funders of a quarter of these organisations, and within this the Global Fund is dominant for 18 percent of organisations.



A further 14 percent cite other bilaterals or multilaterals as a dominant donor category, with 12 percent naming "foundations or charities." Again, as categories it is not clear if each of these usually consists of one or more donors for these sorts of local NGOs. However, if "other bilaterals or multilaterals" and "foundations or charities" were often a single donor, then up to about half of organisations would be largely dependent on a single dominant institutional donor.

A third of organisations are not heavily reliant on income from single donor sources: 21 percent have no single source providing more than half of annual income, and an additional 14 percent rely mostly on private fundraising.

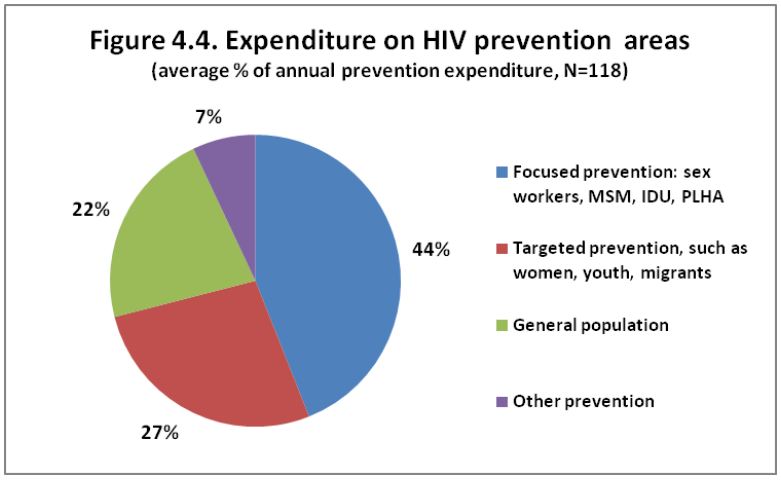
Expenditures by HIV/AIDS activities

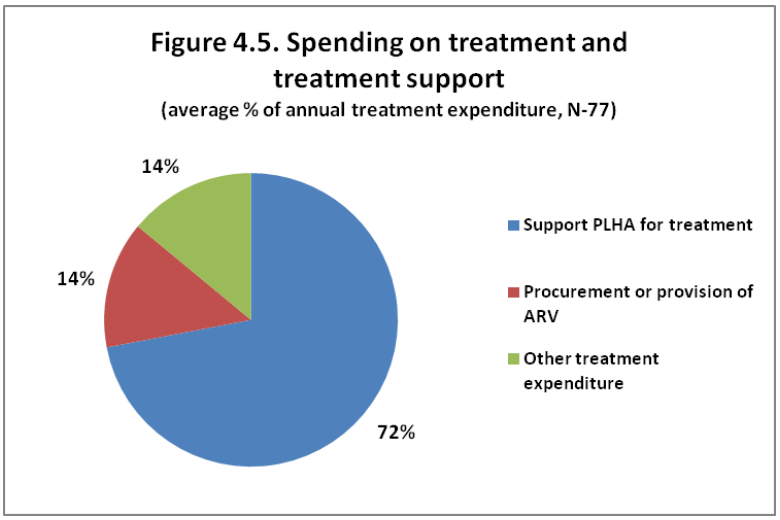
Prevention activities are the largest area of annual expenditure: 42 percent on average. Care and support represented almost a fifth of annual expenditure on average, as were activities to improve the enabling environment. While treatment is a large focus of major donor funding, notably from PEPFAR and the Global Fund, for these organisations an average of only 15 percent of annual expenditure was devoted to both treatment and support for treatment access and adherence. Finally,

impact mitigation – defined in the survey as “food assistance, income generation, material and welfare support, savings and credit, vocational training, legal support, etc.” – accounted on average for only 6 percent of annual expenses.

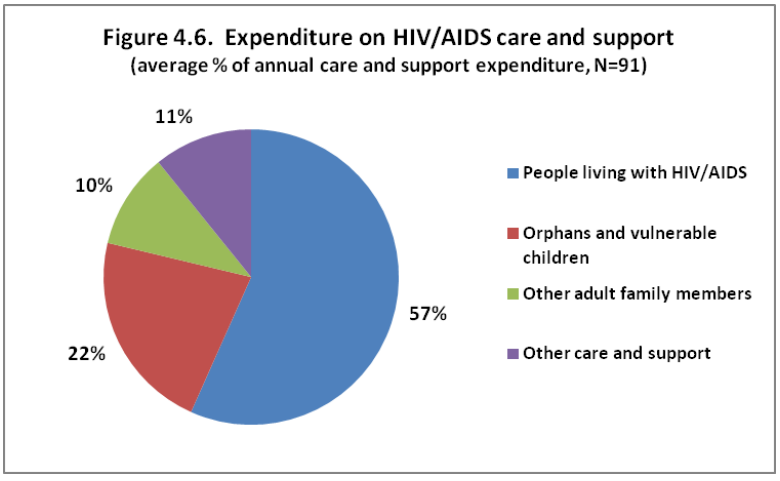
The survey also asked for a further breakdown of spending within three categories.

Prevention: CSOs spent an average of 44 percent of annual prevention funds on focused prevention for sex workers, men who have sex with men, injecting drug users, and/or people living with HIV and their partners. A quarter of prevention spending, on average, went to targeted prevention for groups such as women, youth or migrants, and a fifth for general population awareness and prevention.





Treatment: expenditure by these organisations is dominated by community activities that support people living with HIV to gain access or adhere to treatment, rather than procurement or drug provision.



Care and support: expenditure was largely focused on people living with HIV, with a fifth used for support to orphans and vulnerable children and 10 percent for other adult family members.

Responses were analysed to see whether organisations spent more than half their money in any one category of activity type. Prevention spending was dominant for 41 percent of these organisations. Another 20 percent reported dominant activity spending in one of three categories: improving the enabling environment (8 percent), treatment and treatment support (6 percent),

and care and support to people affected by HIV/AIDS (6 percent). Economic impact mitigation did not figure among these. Finally, 40 percent reported relatively diversified expenditure.

Opinions about funding, CSOs and the AIDS response

The survey also asked for opinions on ten specific issues. The answers rely on the views of participating individuals, but it was felt they could provide an insight into some current thinking among CSOs. The strongest reactions were the following:

- 74 percent believe more funding needs to be allocated to activities reaching vulnerable and most at risk populations.
- Most report that there has been pressure on HIV budgets since the global financial situation started (73 percent of those who expressed an opinion).
- CSO respondents are fairly confident in the quality of community action in their countries (64 percent agree and 35 percent disagree), but somewhat less confident about its comprehensiveness (51 percent agree, 49 percent disagree).
- There is also relative confidence in collaboration among civil society organisations (59 percent agreed while 38 percent disagreed). However, there is somewhat reduced confidence in CSO-government collaboration (51 percent agreed and 46 percent did not agree).
- A majority (57 percent) think there is insufficient technical support and capacity development available to CSOs working on AIDS.

In addition, asked whether they think key donors participate in a single country level M&E system, almost as many said they did not know or did not have an opinion (27 percent) as those who disagreed (30 percent), while 43 percent agreed. In terms of funding, 51 percent agreed that there is “a good match between available funding and what our organisation wants to do regarding HIV/AIDS” and 47 percent disagreed. As well, 48 percent are “confident that during the next five years, donor funding for civil society organisations involved in HIV/AIDS activities will continue at the same level as now or it will increase,” while 43 percent did not agree.

Conclusions

- *The survey appears to largely provide information about the income and expenditure of smaller, indigenous civil society organisations working at the grassroots*

Responses to the CSO survey differ from the comparison of the profiled donors and the specific results of three country profiles.

- The profile of CSOs was quite specific, and more homogenous than the funding recipients that would be reflected in other parts of this report: 89 percent are from CSOs based in developing countries. Respondents are mainly from small and voluntary organisations, sometimes working at national level but more often at sub-national and local level.

- They are civil society organisations that usually receive some support from official donor sources and mechanisms (77 percent of the total) and therefore are part of the international donor funding flows.
- The geographic spread was quite diverse, including similar numbers of organisations based in sub-Saharan Africa, Latin America, and Eastern Europe and Central Asia.
- Respondents were asked to report on funding only in their latest financial year, i.e. after funding developments have been rolled out during recent years.

Given the diverse nature of civil society as a whole, the sample is also clearly not representative of all CSOs involved in AIDS. There were few larger and international NGOs. Equally, the survey did not reach un-staffed CBOs, such as voluntary village groups providing community support in places that have severe epidemics.

At the same time, in contacting intermediaries that could reach CSOs to participate in the survey, several people warned of the difficulty they perceived in eliciting responses about organisational income and expenditure, since they felt it is not an area respondents would feel comfortable disclosing. However, the response from 146 organisations is adequate to produce trend data, particularly since the profile of participating organisations is fairly homogenous and specific.

So the survey does offer a view into current funding and expenditure that is mostly related to local civil society organisations, for which little data exists.

The following appear to be significant findings:

- *Indigenous CSOs in particular appear to be well-served by country level funding streams, including the Global Fund grants through PRs and other country funding mechanisms*.

An average of 37 percent of annual income came from country level funding programmes. The Global Fund was the most important source of average annual CSO revenues, representing on average a fifth of last year's income for AIDS activities. For 18 percent of organisations it was also the source of most of their resources for work on AIDS. So while its funding was relatively widespread and important relative to other donors, Global Fund financing does not appear to monopolise revenues of CSOs that are mostly involved in local and national AIDS responses. There was a similar pattern for other national funding mechanisms and government contracts, but at lower levels of financing. These provide on average 16 percent of annual income, and are dominant for 7 percent of organisations.

- *Civil society organisation expenditure fits into profiles that confirm their complementary role in AIDS responses.*

The ways in which these CSOs spend their money generally portray local and national organisations as filling an appropriate civil society niche.

For prevention, we could presume that there might potentially be important differences between organisations (for instance, their use of specific prevention

approaches and messages). However, among survey respondents the average CSO prevention expenditure was highest for focused activities reaching sex workers, men who have sex with men, injecting drug users, or people living with HIV and their partners. The next most important expenditure area was targeted prevention with populations such as women, youth or migrants. Together these represented the bulk of annual expenditures on prevention (71 percent on average).

In addition, an average of 72 percent of treatment-related expenditure was used to support people living with HIV – for instance, help to gain access to clinical services or support to understand treatment adherence – rather than actual drug procurement or provision (14 percent). Also, care and support funds are mostly used to deliver programming for adults living with HIV (representing 52 percent of average annual care spending) and support for orphans and vulnerable children (a further 22 percent).

Prevention activities dominate spending for 41 percent of organisations. There is almost an equal number of CSOs that report diversified spending, with no single activity category taking up most of annual spending. Small numbers of organisations focus most of their spending on improving the enabling environment, treatment and treatment support, or care and support for people directly affected. No responding organisations spend most of their funds on mitigating socio-economic impact. Its average 6 percent of annual expenditure would indicate it is not an area commonly addressed by these types of CSOs.

- *CSO opinions provide an additional insight into implementers' issues, and areas where more stakeholder dialogue is needed*

Concerns such as the use of funds to reach vulnerable and most at risk populations, and pressure on civil society HIV budgets since the start of the global financial situation, give some insight into the reality of this level of civil society actor and, with further investigation, could help shape effective donor support. They can also serve as examples of issues that could more frequently be addressed – especially through multi-sectoral partnership discussions between civil society and other AIDS actors at country or local levels – to improve performance of overall responses.

5. STUDY CONCLUSIONS

This rapid review attempted to triangulate existing and new information to answer questions about funding flows to the community AIDS response. Its largely descriptive and "snapshot" approach helps answer some study objectives in particular: identifying main funding sources of the community response, documenting funding mechanisms that reach civil society organisations (CSOs), and describing the funding flow. There is information on CSO income from different sources, and about funds allocated to different types of activities carried out by civil society. The following are key conclusions.

1. Increased funding has reached civil society to respond to AIDS

As a result of donors prioritising a scale-up of AIDS responses in developing countries and the involvement of multiple sectors of implementers, new and important funding flows have reached civil society in the past nine years. A review of support for civil society involvement in AIDS responses from four key donors finds the following:

- From 2001, the World Bank Multi-Country AIDS Program for Africa emphasised a community response as part of country and regional projects. In its first phase, through 2006, estimated funding of CSOs represented 38 percent of MAP project commitments. Extrapolated to planned funding through 2013, this would amount to $700 million, or an average of $55 million annually, committed to civil society AIDS efforts in African countries.

  MAP's funding efforts resulted in an apparent mobilisation of local CSOs to work on AIDS. By 2006, relatively small individual amounts of funding were spread through a large number of civil society organisations.

- From early 2003, the Global Fund has also prioritised civil society involvement within its model of scaling up responses in developing countries. By June 2010, 18 percent of Global Fund disbursements for AIDS grants have been through civil society Principal Recipients (PRs). This totalled almost $1.1 billion, or more than $150 million on average per year.

  Most CSO PRs have exceeded performance targets. Indigenous organisations (rather than international NGOs) have managed 57 percent of the disbursements received by civil society PRs. Geographically, however, the funding flow through CSO PRs is not aligned with global funding patterns, likely due to variances in country proposal development. This has been addressed by the Global Fund in the past two years by encouraging systematic inclusion of CSO PRs in all proposals.

- From 2003, US PEPFAR has largely relied on partners with demonstrated capacity to deliver the top priority of rapid scale-up. Most funding to first-line recipients passes through relatively large, international non-profit organisations for undertaking or managing the range of PEPFAR-supported AIDS activities. It is also estimated that 11 percent of the funding flow reaches indigenous civil society organisations (for activities other than treatment and blood safety). As a

stronger proxy measure for funding community responses, this amounts to an annual average of approximately $270 million a year.

- From 2004, DFID's first AIDS strategy committed the UK government to spend $2.5 billion on AIDS in developing countries, and in 2008 its second AIDS strategy committed approximately $11 billion to more general strengthening of health systems. It is estimated that DFID's support in the past five years to civil society's engagement in AIDS responses has been $55 million on average per year.

There are some challenges in putting this funding in context,[26] but it is possible to say the annual average when all four donors have been active has been almost $500 million a year for civil society AIDS activities. This would certainly have been higher in some years. Even at an increased level, this can be compared to 2008 estimates of the need for $22.1 billion annually for AIDS responses in low- and middle-income countries, and of $15.6 billion of this being made available from all sources (multilateral, private and domestic). In these circumstances, it appears to be a relatively modest contribution to effective AIDS responses.

2. Despite growth, there have been important signs of funding uncertainty and these continue

On the ground, the country profiles indicate how recently the positive developments in civil society AIDS funding have been effectively in place. They also show how funding continues to be subject to change.

- In Peru, donor funding flows have expanded the small number of involved CSOs and decentralised the community response, but with reported effects only becoming significant in the past two years.
- In India, Global Fund grants to civil society have expanded only since 2005, and important government funding streams involving CSOs are about three years old. The important Gates Foundation funding in India that started in 2003 is now being phased out.
- In Kenya, where bilateral assistance was particularly important, AIDS funds spent by all CSOs represent 2 or 3 percent of annual national AIDS spending, and for indigenous Kenyan organisations it amounted to one percent of the total. In addition, funding underwent severe fluctuations in the two years for which data is available: between 2007 and 2008, overall reported CSO AIDS spending in Kenya declined by 37 percent while the country spending increased. The fluctuations were most significant where the funding was largest, with shifts in individual organisations' AIDS spending as projects seemingly got unplugged and plugged in, as well as important fluctuations in CSO spending by province and by AIDS activity type.

Both positive and negative developments for recipients reinforce long-standing complaints from civil society regarding the predictability of funding beyond the short

[26] For example: these funding estimates do not provide annual breakdowns or reflect annual changes, and they cover different periods. It is difficult to fully compare between them, or to add them together in a given period and compare them with total annual AIDS funding.

term. There was also a strong response in the survey of CSOs regarding the effects of the financial crisis on their budgets for HIV/AIDS activities. Whether perceived or actual, this also questions the consistency of the funding flows that are reaching community level.

In addition, while the donor funding estimates noted above do not capture annual increases and decreases in funding flows, either during recent years or going forward, there are indications that donor priorities have experienced changes and that these are continuing. In recent years the World Bank MAP has agreed fewer stand-alone AIDS projects, and although it is still important in some countries the relative financial contribution of the MAP programme has declined. In 2009, the Global Fund closed a simplified process for renewing high-performing grants due to insufficient funds, and current plans include other funding architecture changes such as national strategy applications. US PEPFAR has made attempts within the past few years to broaden the number of funded partner organisations. However, it also has a new emphasis on country government ownership for programme sustainability, and the HIV/AIDS budget has been flat-lined in 2010 after more than doubling every two years since 2005. DFID's more recent emphasis on health systems strengthening has replaced AIDS-specific priorities. It remains to be seen what effects these various changes will have on civil society's access to funding flows and its contributions to AIDS responses in low- and middle-income countries.

During the past nine years the role of CSOs within AIDS responses has been positively influenced by donor priorities. For instance, the World Bank MAP's design, from its inception, explicitly ensured funds reached community organisations within an increased governmental involvement in AIDS responses. The Global Fund continued this systematic prioritisation, and has since made adjustments to increase the number of first-level recipients from civil society. It will be important to understand the impact of recent and future changes in donor priorities, especially on the advances that have been made in funding indigenous civil society's involvement in AIDS responses.

3. Country level funding mechanisms are important for civil society responses

From the recipients' level there are clear indications of the importance of country funding mechanisms that are accessible to civil society organisations, and particularly indigenous CSOs. On one hand, some information from country profiles shows a concentration of funding among a small number of recipients (in Kenya and Peru). On the other, specific country level funding streams have successfully strengthened dispersal through country mechanisms (Peru and India). There are examples of funding from official donor mechanisms, government and the private sector that have expanded the number of CSOs involved in AIDS work, and indigenous rather than international civil society organisations are common beneficiaries. The available data on the resulting AIDS activities further indicate that these mechanisms are funding community level responses.

The survey of CSOs involved in AIDS, most of which are grassroots organisations, also reinforced this point. Country level funding mechanisms provide on average 37 percent of annual revenue for AIDS activities, including 21 percent from the Global

Fund and 16 percent from country based funding mechanisms and government contracts. This was alongside another fifteen or sixteen percent average annual revenues from each of the following three sources: the organisations' own private fundraising, funds from "other" bilaterals and multilaterals (i.e. not the "big four" reviewed here), and unspecified foundations or charities.

At the same time, while country funding mechanisms were individually important to average overall income they were not often dominant: the Global Fund provided more than half the annual budgets of only 18 percent of organisations, and other country funding mechanisms and government contracts were the source of more than half annual income of another 7 percent of CSOs. This is consistent with Birdsall and Kelly's finding (2007:70) that while bilateral funding was very important to the budgets of a small number of organisations, when funding mechanisms are strong and decentralised they were more successful in reaching organisations in a broad-based manner.

4. The findings confirm that civil society organisations fill certain roles

Each of the country profiles and the survey results confirm the main rationales stated in the literature for funding civil society and its complementary role within AIDS responses.

- In Kenya, while national AIDS spending was dominated by treatment and care, half of civil society funds were allocated to prevention.
- In India, some larger standardised interventions such as targeted prevention fully rely on locally based CSO implementers. In addition, Global Fund financing through CSO PRs appears to have increased the use of different funding channels, filled gaps in delivering the national strategy, and diversified AIDS activities.
- In Peru, a third of CSO projects targeted key populations who are most significantly at risk – transgender people, men who have sex with men and sex workers – which have not been the focus of Governmental prevention activities.
- The survey respondents were mostly small, voluntary grassroots CSOs. The bulk of their annual prevention spending – 71 percent on average – was for work with key populations at high risk and targeted prevention for groups such as women, youth and migrants. Treatment spending was focused on support to people living with HIV (72 percent) rather than drug procurement (14 percent). Most care and support funds deliver programming for adults living with HIV (52 percent on average) and for orphans and vulnerable children (another 22 percent).

There are questions remaining. The country profiles and the survey findings consistently confirmed that many CSOs focus largely on prevention activities. It is unclear how these priorities get set: because organisations decided they need to prioritise prevention, specifically for key populations, or because funding opportunities for local CSOs are determined by donor programmes and the first-line funding recipients that lead proposal development. In other words, is funding matching both population needs and CSOs' potential? It is an interesting question when comparing, for instance, the level of funds CSO spend on prevention with lower

amounts for care and support activities, and extremely small expenditures on mitigation of economic impact.

5. There is an important gap in regular data.

Despite certain stakeholders' recognition of the importance of the community response, regular monitoring systems have not separately tracked its funding or outputs. In a general fashion, disaggregated data is lacking on the combined question of funding for AIDS and funding flows that reach civil society. There is also a lack of complete information on types of AIDS activities implemented by different sectors of implementers. This is true at both donor and country levels. For donors, it was necessary in this study to use different proxy measures to better understand their funding of CSOs involved in community AIDS responses. In addition, each of the donor estimates was made on a different basis, and each country profile gathered available CSO data in a different way.

There is competition among the priorities for collecting data on funding and programme implementation. However, it would appear that lack of regular monitoring information could be a risk for ensuring continued funding of CSOs' contributions to AIDS responses, especially while donor priorities for AIDS continue to be discussed and funding flows continue to change.

Annex: sources of data and methodology

The following show both the sources of data and some of their limitations.

1. Donor funding flows

Visual mapping and descriptions of donor flows were based on available existing data and feedback from key informants, with some additional data analysis of available datasets for DFID, the Global Fund and PEPFAR. Actual funding disbursements were used when available, although this was not frequent and budget plans and estimates were also used.

- Data on the World Bank MAP's funding of civil society principally came from estimates included in a review of its first phase, from 2001 to 2006, with the following limitations. An initial estimate of the average percentage of funding to each recipient type was derived from expenditure amounts included in project planning documents or the legal financial agreement for each country project or regional project. These planning percentages were then applied to the total funds that were committed by projects and actually disbursed.

  The actual amounts were not readily available for two reasons: countries receiving MAP funds are not required to track expenditure by project component; and, the Bank tracks expenditure by category, such as training, operating costs and goods. The mapping also relied on some additional secondary data about the funding flow and its architecture.

- The Global Fund's priorities concerning civil society and its funding arrangements were sourced from a range of reports, minutes of Board decisions and information on websites. Data on its funding flow to civil society was analysed for this study from available Global Fund data on disbursements. It shows volume of funding from 2003 to 4 June 2010 that was transferred to international and indigenous CSOs acting as first-line recipients. Disaggregated data on second-line recipients is not available, although it exists, since it is held by the first-level recipients in each country receiving a Global Fund grant but not reported to a further level.

  First-line government recipients sometime fund civil society and, equally, first-line CSO recipients sometimes support public sector expenditure. This limits the ability to see specific types of second- and third-line recipients, and the types of AIDS activities they carry out. Therefore, the funding provided to civil society principal recipients can only be used as a proxy measure of CSO funding.

- The US PEPFAR map was largely based on key informant feedback. Published and grey literature provided information on funding modalities. Data on funding flows in general, and specifically to civil society, had to be triangulated from sources covering different aspects of funding and different time periods. This included the most recently available annual summary of country programme plans for the year ending in September 2009, providing a breakdown of funding allocated to different US government channels as well as its allocation to activity types. In addition, total disbursed funding over the life of the initiative came from

PEPFAR's summarised financial status, covering five-year expenditure from October 2003 to the end of September 2009.

Additional data on US government funding came from a released dataset of planned obligations in PEPFAR focus countries from 2004 to 2006, and covering 15 PEPFAR focus countries. This remains the only source of information for answering certain questions, such as money that is obligated to the first-line recipients of funds and to their second-line partners (including both international and indigenous organisations working in developing countries). This was previously reported by the AIDS Monitor Project, highlighting aspects such as the amount of indirect funding flow from first-line recipients to their partner organisations.

For this study, the dataset was further analysed to give a picture of funds reaching indigenous civil society organisations, as well as the distribution of treatment, prevention and care funding across international and indigenous CSOs. The dataset includes more than 17,000 individual entries of reported obligated funding, and also includes some anomalies. The Center for Global Development noted that reported sub-awards sometimes exceed the first level recipients' total awards, but felt the overall integrity of the dataset is acceptable. Drilling down further, these anomalies start to appear more important, notably when looking at AIDS activity areas undertaken by different types of recipient organisation. Therefore, international and indigenous civil society expenditure was based on a subset of "net obligations." This is the only publicly available data covering these specific issues and the overall trends are likely to be relevant.

- DFID's map of funding channels was drafted from information provided by key informants and found on websites, and further validated with a DFID representative.

  The description of its AIDS funding and objectives came from a 2007 evaluation of DFID's first AIDS strategy, the publication of the new AIDS strategy released in 2008, and a baseline that DFID will use to measure its new strategic commitments, published in October 2009. The estimate of CSO funding focused on AIDS was generated from DFID's recently released projects database. The extrapolation to total annual funding to first-line CSO recipients used DFID's *Statistics on International Development* published in 2009.

- The estimate of funding to civil society from three key donors was based on the Global Fund's disbursements to first-line recipients (a proxy measure of civil society funding), and an extrapolation of the estimates of DFID, PEPFAR and World Bank MAP funding reaching civil society in 2004-06. While limitations are clear, these were the best available sources for estimating the overall flow to civil society.

2. Estimating the donor funding flows

The following considerations, specific to each donor's available data, were used to estimate the donor funding flows.

World Bank MAP

- 38% of estimated funding reaching the civil society sector.
- This estimate is based on planning documents for one period: 2001 to 2006.
- Total funding commitments of $1.865 billion gives an estimate of $709 million reaching CSO implementers from 2001 to 2013.
- During phase one (2001-06), estimated disbursements through CSOs are $55 million per year on average. However, this did not include commitments still in the pipeline, and there is no further available information on actual disbursements that passed to different sectors of implementing agencies, or used for spending on AIDS activity types. After phase one, the MAP programme stopped gathering specific information, e.g. through surveys, that the Bank's regular systems do not capture.

Global Fund

- Disbursements data available for first-line recipients by sectoral type (early 2003 to June 2010).
- Assumptions: in absence of an answer to the question of how much government recipients fund civil society and CSO recipients fund public sector activities, use the CSO Principal Recipients funding as a proxy.
- Some CSO first-line recipients fund drug procurement (the Global Fund's largest expenditure area) and other health care activities not typically associated with the community response. Equally, some public sector Principal Recipients fund civil society organisations. However, the actual amounts of these funds would need analysis of individual grants.
- Disbursements of $1.075 billion through CSOs from early 2003 to 4 June 2010.

US PEPFAR

- Data available on total outlays by the US government reported for October 2003 to end of September 2009. Further estimate of funding flows by recipient types is based on a dataset of obligations for 2004 to 2006.
- Assumptions: reliance on contracting large NGOs and sometimes faith-based organisations and universities to roll out clinical services, notably treatment, PMTCT and blood safety, distorts the usual picture of civil society responses to AIDS. Country operational plans from 2009 indicate 50.2 percent of funding flow to all implementers is for these clinical activities, roughly in line with 2004-06 dataset showing 47 percent for treatment activity obligated to CSOs.
- Further limitations: the 2004-06 estimate is based on spending plans not actuals, and only for the PEPFAR focus countries. PEPFAR has grown significantly since these initial three years of implementation, but further breakdown of data by recipient types is not available.
- The AIDS Monitor dataset covers $3.544 billion of obligations over the three years. Of this amount, a total of $2.951 billion was planned for a type of recipient such as NGOs, private contractors, or in some cases US agencies. (The rest was "to be determined" or "unknown".) Of this, 71 percent ($2.098 billion) was intended for international recipients and 29 percent ($853 million) for domestic recipients of this across all sectors: government, private sector contractors and civil society. Slight adjustments to clarify specific entries resulted in this being 1 percent different from the figures reported by the AIDS Monitor project
- The distribution of AIDS activity budgets by type of CSO is based on net obligations to known recipient types coded both by geographic origin of the recipient and by activity

area, and these total $1.29 billion. Although a sub-set of the total data, it was the portion that was most clear in its allocation by both geography and activity areas.
- Total PEPFAR outlays of $12.386 billion for country activities (net of funding for medical research and contributions to the Global Fund), or $2.477 billion on average per year.
- Extrapolation: disbursement to civil society for all activities estimated at $1.685 billion per year. When excluding certain clinical activities (treatment and blood safety), CSO funding is estimated at $1.486 billion per year on average.
- Disbursement to indigenous civil society (excluding treatment and blood safety), funding is estimated at $273 million per year on average.

DFID

- The DFID project funding database was less than a year old at the time of this analysis, so it provided budgets for projects that were active in August 2009 or were started since then. As a group they did not cover any one period. However, they do give proportional information.
- Out of funding to first-line recipients, projects with AIDS as a principal focus were 6.8 percent of the total CSO budgets recorded in the database as of 7 June 2010. This was consistent when searched by projects with "HIV" as a term in the title or project description. This budgeting figure was then applied to DFID's reported expenditure on CSO funding for the five fiscal years ending in April 2009 to arrive at total estimated spending of $281 million or $56 million per year.
- An additional amount of projects in the database was checked off as having "significant" HIV focus and their total budgets were roughly double those with HIV as a principal focus. A total of 65 CSO projects with "principal" AIDS focus amounted to £147 million in budgets, while 108 projects with "significant" AIDS focus totalled £302 million.
- However, when adding the term "HIV" in the project title or description, there remained a similar number of projects with principal AIDS focus – 62 projects with budgets of £144 million – but a much reduced number with significant AIDS focus – 44 projects with budgets of £51 million.
- All figures in the DFID section are converted at USD $1.85 / pound, except annual DFID expenditure to CSOs which was used to calculate the estimate of funding to CBO for AIDS. This used the average annual interbank rate for each of the 5 years.

3. Country funding profiles

Country profiles of AIDS and civil society funding were developed for Kenya, India and Peru based on available data and through key informant interviews with representatives from civil society, government and donors.

- In Kenya the main source of data was the government's National AIDS Spending Assessment that covers 2007 to 2008. Limitations when drilling down to data on civil society are noted in this report.

- In India there is information about existing programming and funding architecture, but there is little available data on funding amounts that reach civil society for AIDS activities. Information that is available is presented here to give a picture of civil society's involvement in the AIDS response.

- In Peru data was compiled from the Peruvian Agency for International Cooperation (APCI), reported by CSOs on a yearly basis. Relevant APCI records of AIDS projects were analysed for the latest period (2006 to 2008) to look at CSOs' organisational types, their donors and activity areas.

4. Survey of civil society organisations involved on AIDS

The confidential internet-based survey relied on self-reported information.

- There were 146 CSOs responding to the survey. The survey was made available online in English, French, Spanish, Portuguese and Russian. It used a targeted, cascade contact method. Several agencies sent information to their lists of CSOs involved in AIDS, and it is estimated this reached between 3,000 and 4,000 e-mail addresses. Notices were also placed on relevant e-forums.
- To increase the response rate, the survey did not ask for actual income but percentages from different sources. Also, given the range of possible donors and channels, to avoid confusion organisations were asked if they are a direct recipient of the larger donors, and also if they receive funds from categories of other funding sources (such as “private fundraising” and “other bilaterals or multilaterals”).

Annex: key informants

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