‘BEING REGIONAL’:
AN ANALYSIS OF THE CONCEPTUALISATION, OPERATIONS AND EMBEDDEDNESS OF REGIONAL NON-GOVERNMENTAL ORGANISATIONS RESPONDING TO HIV AND AIDS IN SOUTHERN AFRICA

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ABSTRACT

This thesis offers an original sociological analysis of regional Non-Governmental Organisations (RNGOs) responding to the HIV epidemic in the Southern African Development Community (SADC) in respect of their emergence, constitution, role, function, embeddedness, accountability and practice of *being regional* in the HIV response. In doing so, it offers propositions on the conceptualisation of RNGOs and the concept *being regional* in clarifying regional HIV programming in the context of regionalisation. It also highlights the nexus between regional HIV work, and country and global HIV governance and programming as components of the global architecture of development regime under the tutelage of the United Nations as influenced by the dominant powers.

The analysis is based on a hybrid of social systems, actor systems dynamics, institutional and network theoretical analytical frameworks. A triangulation of these frameworks provides a comprehensive grounding on which it is possible to identify and analyse RNGOs as social systems, institutions, actors and nodes that constitute part of the global architecture of the HIV response. This also facilitates the conceptualisation of *being regional* as both a programmatic typology and state of existence of RNGOs, thus locating these regional actors in the framework of the global HIV governance and programming. It locates them in the resultant web of social relations connecting various development agents in hierarchical and institutionalised structures constructed around HIV governance and responses. Social embeddedness and hence accountability of RNGOs is thus presented as determined by this complex context.

Based on an extensive use of organisational documents as well as key informant interviews, the thesis reveals the dominance of funding organisations in determining regional and national HIV programme design and content as well as structuring the organisational practices of RNGOs and other development agents in the HIV response. Because of the demands by donors for accountability on the part of RNGOs for funds received, upward accountability becomes a major preoccupation of RNGOs and becomes privileged compared to downward accountability to their programme beneficiaries. However, RNGOs still enact agency in seeking to manoeuvre their way through the worldwide development system in order to advance the HIV response while also ensuring their own organisational sustainability.

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- The Southern African AIDS Trust (SAT),
- Africa Capacity Alliance (ACA), formally known as the Regional AIDS Training Network (RATN),
- AIDS Rights Alliance of Southern Africa (ARASA),
- Disability HIV and AIDS Trust (DHAT),
- The Network Of African People Living with HIV and AIDS in the Southern Africa Region (NAPSAR+),
- Regional African AIDS NGOs of southern Africa (RAANGO),
- The Regiona Psycho-Social Initiative of southern Africa (REPSSI),
- The Southern African AIDs Information Dissemination Services (SAfAIDS).

In addition, the Joint United Nation Programmed for HIV and AIDS (UNAIDS) and the Southern African Development Community (SADC) along with three donor organisations, whose publicly available information was also utilised:

- The Global Fund for HIV, TB and Malaria (GFHTM),
- HIVOS,
- The Swedish International Development Cooperation Agency (Sida), and representatives of regional donor teams.

These organisations were rich sources of valuable data that facilitated the analysis of their interface with RNGOs, regional programming and funding in the global architecture of the HIV response.

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I dedicate this thesis to the fond memories of my late parents: Mr Tarwechirango Josphat, (Tiki) and Mrs Grace Mushonga.

ACRONYMS	
ACSM	Advocacy, Communication and Social Mobilisation
ARASA	AIDS and Rights Alliance for Southern Africa
AIDS	Acquire immune deficiency syndrome
ASO	AIDS Service Organisations
AU	African Union
BONELA	Botswana Network on Ethics, Law and HIV/AIDS
COTs	Country Office Teams
CBO	Community based organisation
CBV	Community-based organisations and community-based volunteers
CIDA	Canadian International Development Agency
CPHA	Canadian Public Health Association
CPDP	Civil participation and democracy programmes
CO	Country Office
COMs	Country Office Managers
CSO	Civil society organisations
DED	Deputy Executive Director
DHAT	Disability HIV and AIDS Trust
DHSH	Data for health systems for health
DPOs	Disabled people's organisations
EAC	East African Community
ECOSOC	UN Economic and Social Commission
ED	Executive Director
ESA	Eastern and Southern Africa
FBO	Faith based organisation
GBV	Gender-based violence
GFATM	Global Fund to Fight HIV, Tuberculosis and Malaria
GPS	Good Practice Strategy
HBC	Home base care
HEARD	Health Economics and HIV/AIDS Research Division
HIV	Human acquire immune deficiency virus
HIVOS	Humanistic Institute for Development Cooperation
IDRC	International Development Research Centre
IEC	Information Education and Communication

INGO	International non-governmental organisation;
JFA	Joint financial arrangement
KII	Key informant interview
LAC	Legal Assistance Centre, (Namibia);
LGBTI	Lesbian, gay, bisexual, transgender and intersex
MCP	Multiple and concurrent sexual partnerships
MNCs	Multinational companies
M&E	Monitoring and evaluation
MoU	Memorandum of understanding
NAC	National AIDS Council
NAPSAR+	Network of African People Living with HIV and AIDS, Southern African Region
NGO	Non-governmental organisation
NGO	None Governmental organisations
NNGO	National non-government organisation
PLHIV	People living with HIV
OD	Organisational development
OECD	Organisation for Economic Co-operation and Development
ORD	Operations research and documentation
OVC	Orphans and vulnerable children
PCB	Programme Coordinating Board
PLHIV	People living with HIV
PMTCT	Parent to child transmission
PSS	Psycho-social support
PWD	People with disabilities
RAANGO	Regional African AIDS NGOs Forum
REPSSI	Regional Psycho-social Initiative
RDO	Regional donor organisations;
RIAT	Regional Inter-Agency Taskforce
RNE	Royal Netherlands Embassy
RNGO	Regional non-governmental organisation
RO	Regional Office
ROTs	Regional Office Teams
SAfAIDS	Southern Africa Information Dissemination Services

SAT	Southern African AIDS Trust
SADC	Southern African Development Community
SALC	South African Litigation Centre
Sida	Swedish International Development Cooperation Agency
SRHR	Sexual reproductive health and rights
STI	Sexually transmitted infection
TB	Tuberculosis
ToT	Training of Trainer
UN	United Nations
UNAIDS	Joint United Nations Commission on HIV and AIDS
UNGASS	United Nations General Assembly
UNDP	United Nations Development Programme
USAID	United State
WHO	World Health Organisation
WWF	World Wildlife Fund
ZARAN	Zambia AIDS Law Research and Advocacy Network

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CHAPTER ONE: INTRODUCTION AND METHODOLOGY

1.1 Introduction

This thesis is a sociological analysis of the emergence and work of regional non-governmental organisations (RNGOs) working in human immune virus (HIV) and the acquired immune deficiency syndrome (AIDS) programming in Southern Africa. It focuses particularly on the framing, practice and value of the concept of 'being regional' in the response to the epidemic. This chapter introduces the thesis by first identifying the research problem against the current research on civil society organisations (CSOs) and especially non-governmental organisations (NGOs) responding to HIV and AIDS in Southern Africa. It also outlines the methodological framework addressing ontological and epistimological issues relevant to the analysis before discussing the data collection and analysis tools adopted for this study. The chapter also discusses the framing of NGOs, their role and importance in development, and progresses to analysing the context in which RNGOs emerged. The concluding section of this chapter provides a general outline of the rest of the thesis, highlighting the key issues and findings of the research and arguments in each chapter relating to the framing of RNGOs and *being regional*, and their function and contribution to the HIV and AIDS response.

1.2 Research Problem and Context

When the human immune deficiency virus (HIV) and its attendent acquired immune deficiency syndrome (AIDS) were discovered in the early 1980s, HIV related civil society organisations (CSOs) emerged to complement medical efforts in responding to the epidemic (Kelly and Birdsall, 2010:1580). Webb (1997: 159, 160), USAID (2008) and Rodriguez-Garcia et al. (2011:4, 7) describe community responses as actions that community members, community-based organisations (CBOs) and non-governmental organisations (NGOs) take in response to HIV. In southern Africa, local NGOs (LNGOs) categorised by Cornman et al. (2005:1) as inclucive of indigenous national NGOs, faith-based organisations (FBOs) and CBOs, deliver HIV services and advocate for the health rights of people living with HIV (PLHIV).

International NGOs (INGOs) such as ActionAid, Plan International and World Vision, with donor funding, provide technical support in organisational capacity development, programming and grant-making, and act as intermediaries between LNGOs and donors (Kelly, 2009:9, Kates, 2013:10-11). However, according to Lee et al. (1996:345), in the

1990s, some larger LNGOs then directly involved in HIV service-delivery began to offer intermediary functions such as information dissemination, technical support, grant-making, networking for smaller organisations and linking them with INGOs and funders. At this stage, vertical relations spanning from donors to INGOs through larger LNGOs to the smaller NGOs, FBOs and CBOs began to emerge, as donors and INGOs endeavoured to improve their reach and effectively serve communities affected by HIV (Mercer, 2014:324).

While these organisations were crystallising their dual functions, organisations like the Southern African AIDS Trust (SAT) emerged. SAT was established in 1990 by the Canadian International Development Agency (CIDA) to provide technical support to HIV LNGOs and promote HIV specific South-South learning in southern Africa (SAT, 2004a:ii; CPHA, 2008:7, S42), becoming one of the first RNGOs in southern Africa. Many similar NGOs also emerged assuming different roles and operating in more than one country, with or without offices in every one of their programme countries. Currently, NGOs operating in more than one country proliferate in SADC, all calling themselves regional NGOs (RNGOs), and are similarly known by donors and other players in the HIV response.

However, there is limited analysis and conceptualisation of RNGOs and their work at the regional level; hence SAT coined the term '*being regional*' in an attempt to describe RNGO work (SAT, 2004). In that process arose a need to understand the concept as well as compare and contrast it with the notion *multi-country.* Jones and Hellevik (2012:1) observe that although "regional HIV responses have become vogue much less is known about the specific substance of regional responses to HIV/AIDS". They describe *'regional'* as "an abstract created for convenience", and ignore its objective reality rooted in delimited territory (Riggirozzi, 2010:4; Zyks, 2013:6). This leaves room to offer a more nuanced analysis of the concept 'regional' and hence regional bodies like RNGOs.

RNGO operations are located in countries that belong to territorial contexts. Riggirozzi (2010:4) regards these territories as international society, social systems, communities and institutionalised polities. These elements constitute the analytical context for RNGOs and *being regional*. The term *regional* implies a vertical alignment stretching from the local to the international level, implying top-down and bottom-up relations, as well as an intermediary positioning of RNGOs between the global and local spheres in the HIV response. The dynamics of the resultant relations constitute a core component of this analysis.

The concept *regional organisation* (RO) has also not been analytically and theoretically scrutinised in relation to RNGOs. The 'NG' in RNGO is the distinguishing mark between CSOs and the state (Albertyn and Tjønneland, 2011) but the 'RO' has not been

unpacked. Research on this subject has focussed on inter-governmental outfits (Zyke, 2013; Goertz, and Powers, 2011; Laruelle and Peyrouse, 2012). Zyks (2013:5) states that the term 'RO' has been used not only without sufficient clarity but largely to refer to inter-governmental organisations such as those based on treaties (e.g. North Atlantic Treaty Organisation), trade pacts (e.g. SADC Free Trade Area), continental bodies such as African Union (AU) including Southern Africa Development Community (SADC), resource specific bodies such as the Nile River Initiative, and identity-based bodies such as the Islamic Cooperation (also Laruelle and Peyrouse, 2012:5-6). Laruelle and Peyrouse (2012:5) define regional organisations (RO) as institutions that are "established to foster mechanisms of cooperation among states seeking common belonging to a geographical space, a geopolitical entity, or an economic bloc". For Zyks (2013a:6; 2013b:2), these organisations are characterised by substantial geographic proximity or connectedness, an official inter-governmental status enshrined in some legal instrument, a cooperative or collaborative mandate and a multi-sectoral focus that defines how members cooperate. This thesis questions whether these are the only forms of ROs, and where and how to locate RNGOs and their typologies.

Existing analyses such as Anamela et al. (2010) and Jones and Hellevik (2012) do not examine RNGOs as they do with regard to ROs, so they do not establish the extent to which, conceptually and operationally, RNGOs mimic or differ from ROs. RNGOs have existed for nearly two and half decades, yet conceptually they remain indistinctly sculptured in relation to form and role, relations among themselves and with other regional organisations, and their location in the architecture of the HIV response. Albertyn and Tjønneland (2011:3) state that to "speak of 'roles' requires the identification of normative frameworks" or institutions (Hodgson, 2006:2; De Pina-Cabral, 2011:480) that govern relations such as those regulating CSOs and citizen participation, development service provisions and social empowerment. This emphasises the significance of contextualised analysis of NGOs (including RNGOs) for better comprehension.

The current data on RNGOs comprises reviews of different regional HIV responses (Anamela et al., 2010; Jones et al., 2009; Jones and Hellevik, 2012; Sordobaum, 2016) rolled out by donors such as Swedish Sida, Norwegian NORAD and Irish Aid, focussing on the performance of their regional HIV strategies. In these reviews, RNGOs such as SAT, ARASA, SAfAIDS and REPSSI have been discussed alongside SADC, as participants in and beneficiaries of the donors' regional HIV programmes. In these writings, the term *regionality* is used to refer to HIV programming at the regional level and the concept *added value* is also

introduced to refer to the *comparative advantages* of operating at the regional level. However, there is no theoretical engagement with these concepts to distil their meaning and establish whether or not the '*comparative advantages'* are deliverable equally effectively at the lower national levels or through the SADC route that formally links with national governments and LNGOs through National AIDS Councils (NACs).

This thesis discusses the advent of RNGOs as contextualised in the United Nations (UN), various donor driven regional HIV strategies and SADC's HIV frameworks to guide the regional HIV response (SADC, 2013), including the realities of people living with HIV (PLHIV) in the region. It also examines the conceptualisation and typologies of RNGOs in relation to their organisational forms and functions linking this to the nature, extent and purpose of RNGOs' entrenchment in global, regional and country networks (as well as lateral relations), in order to demonstrate how all this facilitates and/or constrains RNGO added value and accountability to PLHIV in SADC.

1.3 NGOs in Development

Existing literature (Eades, 2000; Lee et al., 1996; Rau, 2010; Rodriguez-Garcia et al., 2011) testify to the role and significance of NGOs in development. However, the current recognition of NGOs as significant development players emerged only from the early 1990s as, hitherto, NGO work was mainly humanitarian and considered peripheral to mainstream development. Their recognition as key development players resulted from the appreciation of their effective delivery of services in the humanitarian sector against the frustrating bureaucratic and often ineffective and inefficient government to government aid programmes (Brett, 1992). As a result, donors began to redirect development aid to the NGO sector and expand their involvement in development.

Investment in NGOs' work was an attempt to improve the modernisation project through "improving structural relationships and economic incentives" as the major means for creating prime conditions for development, characterised by the existence of "the right rules of engagement and incentives" for NGOs to operate as part of a tripartite institutional arrangement of development agents (Lewis and Kanji, 2009:16). In this case, there was a refocus on and reformulation of institutional relations; defining the roles of economic actors, state actors and civil society actors in socio-economic development. Under these circumstances, NGOs began to emerge as one of three centre actors in development.

The creation of these favourable conditions gave NGOs comparative advantages over their counterparts in delivering development services resulting in NGOs being christened the

'magic bullet' (Vivian, 1994) "that could unblock the disappointment, disillusionment and deadlock that had characterized the world of development" (Lewis and Kanji, 2009:24). Donors presented them as the most favoured and trusted agents in development for their greater potential to reach poorer and under-served communities, as well as for their innovation and flexibility. Discussing the role/s NGOs play, their embeddedness and relations with other development players, is useful in order to further enhance the understanding of NGOs.

1.3.1 NGO Roles, Embeddedness and Susceptibility to External Influence

A review of development (Brett, 1993; Frank, 1969; Riddell and Robinson, 1995; Eades, 2000; Willis, 2011:27; Rostow, 1960) and NGO literature (Vivian, 1994; Lewis and Kanji, 2009; Smith, and Bornstein, 2001:6) reveals that NGO roles are defined by a collection of five mutually enforcing role-categories:

a. Implementer – mobilising resources and rolling out programmes in response to existing challenges;
b. Catalyst – inspiring groups and communittees to respond to a challenge and intiate change,
c. Partner – working with others (individuals, groups, communities etc) to respond and resolve existing problems,
d. Intermediary – connecting other players or levels of operation, and
e. Resource distributor – mobilising and distributing resources where they may be needed the most.

Each of these role-categories subsumes a variety of specific activities, and rarely do NGOs focus primarily on a single one. In fact, NGOs usually embrace a major role area and subsidiary ones (Eade, 2000; Seckinelg, 2005). One of the key roles of NGOs both in the global North and South is the mobilisation of funding and its transfer to needy communities, an activity which is closely connected to NGOs' roles as implementers, partners, intermediaries and resource distributers.

International NGOs bring funding to their beneficiaries either distributing directly to projects in the form of cash and material resources or invest it in capacity strengthening of local community groups, and at times they also sub-grant to southern partner NGOs to enable the beneficiary organisations to rollout their programmes for community benefit (Seckinelg, 2005). Southern NGOs also mobilise resources including funding from INGOs, donors (both local and foreign), UN agencies and embassies of foreign governments in seeking to support

their community-targeted programmes (Coscia et al., 2013). For southern NGOs, resource mobilisation is usually a core component of capacity development facilitated by INGOs and other similar technical support organisations. As such, it is a well-entrenched competency required for organisational sustainability and programme implementation (Eade, 2000:12).

These roles reveal that NGOs exist and operate as components of social systems and network relations of development actors, demonstrating a high level of embeddedness and interdependence among development actors. All NGO activities are performed in relation to, for and in partnership with other social actors. This points to different levels at which NGOs connect in the process (with local groups, communities, other NGOs, donors and governments) and demonstrates NGOs' intermediary position and function in the process. In other words, NGOs exist in mutually dependent relations either as dominant or lesser partners.

According to Edwards (2014) NGO dependence on donor resources makes them susceptible to their funders' influences on programme choice, design, duration and coverage. He further explains that dependence on donor funding, and hence exposure to their influences, is inescapable in a context of limited alternative funding for NGOs to finance their organisational programmes and sustainability. This thesis problematises the extent to which RNGOs are also susceptible to these influences and their impact on organisational configuration, social agency, programming and accountability. It argues that social agency is shaped by its contexts; therefore, the fusion of external ideas into RNGOs' programmes has to be understood in that context and not necessarily as a fault of the social agent, as it is only reflective of the power dynamics in the development partnerships (which actors develop in each instance relative to other agents). Thus discussing NGOs and their partnerships in development is of some significance.

1.3.2 NGOs and Development Partnerships

The foregoing discussion revealed that NGOs work in conjunction and partnerships with other development players. Williams (2013:17) defines parterships in the context of development as "a formal relationship with a local civil society organisation" that a donor organisation "supports or collaborates with" whose purpose is "to achieve mutually-agreed objectives that serve the needs and/or rights of poor, vulnerable or marginalised people in developing countries." In this sense, a partnership is a purposive relationship based on specific terms of reference. Development players establish partnerships to maximise on accruable advantages such as access to funding and other resources, and legitimation (Odén

and Wohlgemuth, 2006). These advantages may arise from the position and nature of the roles of each partner, location and proximity to community beneficiaries and knowledge of the local environment. Donors, UN agents, governments and the private sector seek partnerships with NGOs to benefit from their better knowledge of, and reach and legitimacy in, local communities as such a link with communities is considered to be a real asset for policy making and implementation (Seckinelg, 2005). In this position, NGOs more easily work as intermediaries, partners and implementers, as they are usually viewed as more flexible in adapting their work to accommodate new projects. Nilsson et al. (2013:19) define an implementer in this sense as an organisation that "directly implements development cooperation or humanitarian assistance with (or without - presumably only in humanitarian assistance) local cooperation partners in developing countries" (also Williams, 2013). Their link with local communities and legitimacy enhance programme sustainability **(**Odén and Wohlgemuth, 2006)**.**

According to Matei and Apostu (2013:143), NGOs collaborate with donors for three main reasons; first, NGOs receive "massive and systematic support" from international assistance programmes which they need to enhance their organisational and programmatic sustainability. Secondly, they receive material support such as office equipment, vehicles and medical supplies, as well as food packs which they distribute to their beneficiaries. Thirdly, donor support usually comes with technical support delivered either directly by the donor or funded by the donor to enhance management and programming skills which ensure that the material and funding support received is effectively and efficiently utilised, thus enhancing organisational sustainability. Technical support can be in the form of skills training for organisational personnel, secondment of a person with skills requisite in the organisation or facilitation of organisational processes such as strategic planning, work planning and budgeting, and programme/project monitoring and evaluation (SAT, 2005).

The main motivation for NGOs to engage and work with governments is to acquire legitimacy through registration, which enables them to legally operate and access local resources and support available through government structures where they may serve as subcontractors (Matei and Apostu, 2013:143). Under the new Global Fund Funding mechanism, National AIDS Councils (NAC) are the main recipients of the HIV, TB and malaria funding, and are entrusted with the responsibility to disburse to sub-recipient NGOs. In this regard, working closely with national governments enables NGOs to attract government recognition and increases chances to qualify as sub-recipients. Communities are critical for NGO legitimation as well as logistical support to access its members; but, more

importantly, they are the beneficiaries of NGO programmes without whom there can be no programming. Seckinelg (2005:357) observes that "NGOs and community organizations are brought in to localize global policies as free agents, although they will frequently represent the global frameworks." This thesis engages these issues in the analysis of the work of RNGOs in the HIV response in the SADC region to enhance the comprehension of partnership arrangements and their role, and the impact on development actors and development generally.

1.3.3 Framing NGOs and their Role in Development

The concept 'non-governmental organisations' (NGOs) has existed in development literature since the advent of modernisation. An NGO is viewed as a particular sub-species of civil society organisation (CSOs) (Banks et al., 2015) often defined as a sector by what they are not (non-governmental, not profit-driven organisations and separate from the private sphere of society), rather than by what they are (Eade, 2000:12; also Banks and Hulme, 2012:3). The term 'NGO' acquired its meaning from the United Nations (UN) which since 1945 has used it to denote non-state actors that could be consulted in UN business through the Economic and Social Commission (ECOSOC) (Lewis and Kanji, 2009). However, the initial UN definition conflates for-profit entities and humanitarian/development bodies. While the former are concerned with profit-making and distribution (businesses and related associations), the latter are not-for-profit making and not-for-distribution for private benefit, but are designed to benefit the public good, including if only through charity works.

Diamond (1999:221) defines CSOs (and implicitly NGOs) as formal and non-formal, non-state and non-market organisations above parochial society (individuals and family) aimed at delivering services and holding other development actors accountable (see also Onsander, 2007:11; Sida, 2004: 8). While Diamond echoes the non-state characteristic, there is a failure to recognise the fact that some non-state actors are actually state-driven and propel state agendas. Some NGOs are thus state-sanctioned and operate as state-sponsored development agencies (Onsander, 2007) as discussed later in this section.

Apart from defining CSOs (also NGOs) by what they are not, the second challenge relates to attempts to restrict CSOs to the non-market sphere. Existing literature (and as this thesis demonstrates as well) highlights that there also exists CSOs within the market sector such as employers' and business confederations and associations that serve the interests of the market. In other words, the defining line between market and non-market bodies tends to be thin, illustrating the integrated nature of the social world. In addition, CSOs such as

foundations and trusts are established by families as a mechanism for systematic and continued engagement and participation in and influence on public life. These non-state actors propel the agendas, values, principles and morals cherished by the founding families and/or for whom they are constituted. The Ford Foundation, Nelson Mandela Foundation and Melinda and Bill Gates Foundation serve as quick illustrative examples in this regard. In this case, some CSOs do not quite exist above parochial society but are driven by the visions, beliefs and values of the founding families and/or individuals. There is thus the need to narrow down the discussion to NGOs.

Martens (2002:279, 282) defines an NGO as a formal, non-profit CSO with a mission, vision, clearly stated goals and modalities for achieving its goals. In other words, an NGO is a form of corporate body and, as such, a social actor capable of social action to the extent that it sets and pursues goals, and has mechanisms of achieving its goals. In this case, not only are NGOs institutionalised, but they are social actors predisposed to engage in social relations, and forming and maintaining networks of these relations in seeking to fulfil their missions (Burns, 2006:417). These social relations are vital sources of social capital that facilitate access to relevant inputs into organisational processes (Fukuyana, 1999) as later discussed in the thesis.

Martens (2002) states that the non-profit differentiating dimension has been challenged on the basis that some NGOs make money from the donations they receive (in the form of interest) and others invest in income generating activities that earn them profit (Lewis and Kanji, 2009:10), making them profit-making entities. However, scholars such as Salamon and Helmut (1996:3) argue that such profit is still not for distribution to individual organisational directors but to support the charitable work of the NGO. For this reason, they rephrase the non-profit component to 'non-profit distributing'. In other words, some NGOs may make profit but such profit is for the support and expansion of their charitable work.

Sunkin et al. (1993:108) define NGOs as "privately constituted organizations (companies, professional, trade and voluntary organizations, or charities) that may or may not make a profit." Charnovitz, (1997:185). from a similar perspective, describes NGOs as "groups of individuals organized for the myriad of reasons that engage human imagination", highlighting the non-state character as the key defining element. Table 1.1 itemises some of the key defining elements of NGOs. While these elements capture the formal and non-governmental characteristics, it presents the profit aspect modified to emphasise *non-distribution* rather than *making*. However, Lewis and Kanji (2009) make a distinction between market NGOs (which are for-profit distribution) and non-market NGOs (that do not

distribute profit), adding aspects of self-control and management as well as volunteerism that link them to the concepts of civil society and charity work. This way it provides a more comprehensive conceptualisation of NGOs that resonates with the focus of this thesis.

Table 1.1: Defining Characteristics of NGOs

Characteristic	Elaboration
Formal	*Is institutionalised in that it has regular meetings, office bearers and some organisational permanence*
Private/ Non-governmental	*Is institutionally separate from government, though it may receive some support from government*
Non-profit distributing	*Generated financial surplus does not accrue to owners or directors (often termed the 'non-distribution constraint')*
Self-governing	*Is able to control and manage its own affairs*
Voluntary	*A spirit of volunteerism characterises the organisation (including voluntary participation in organisational activities, management and governance - e.g. a voluntary board of governors or volunteer staff)*

Source: Compiled from Lewis and Kanji (2009:10); Martens (2002:279, 282).

Against this background, the nature and character of NGOs tends to lend them into possible sub-categories that relate to some of their key characteristics, and the heterogeneus nature of the category. The next section explores some of these sub-categories to further augment the framing of these organisations.

1.4 NGO Typologies

NGOs are as diverse as their origins, location, their roles/function, and issues and fields of development they pursue. This lands them in varied typologies that emphasise certain aspects of their identity, and demonstrate the diversity of the NGO phenomenon and its agency in the global development architecture discussed in later chapters of the thesis. It also serves to illustrate that they come in all shapes and sizes, with some pursuing agendas and actions that are at times diametrically opposed to those adopted by others as characterised in the next subsections.

1.4.1 The Sector-based Typologies

In defining NGOs, we have noted that the 'N' differentiates NGOs from government bodies (Diamond 1999; Onsander, 2007), creating the impression that there are no government-related NGOs. However, there are government-sponsored or related NGOs, which Willetts (2010:29) calls government organised NGOs (GONGOs). In the global North, an organisation like Humanistic Institute for Development Cooperation (HIVOS) is an illustrative example.

The organisation is mostly sponsored by the Dutch government to deploy development projects in line with its international development policy. The for-profit sector also has a wide range of its own NGOs that include for example Confederations of Industries and Farmers Unions. But the largest variety of these non-state actors fall in the non-state and not-for profit-distribution subcategory, within which is located NGOs and RNGOs analysed in this thesis. These organisations are also discussed in development literature in terms of their location within the international development system.

1.4.2 Northern vis-à-vis Southern NGOs Dichotomy

Northern NGOs (NNGO) emerged as part of transnationalisation and globalisation of development (Batliwala, 2002). Lewis and Kanji (2009:12) define NNGO, as "organizations whose origins lie in the industrialized countries" while Southern NGOs (SNGOs) originate "from the less developed areas of the world" in the global South. Most SNGOs have been established by local communities or other social agents independently or with external support in response to local challenges (Mann and Tarantola, 1996) and hence they have a greater proximity and knowledge of the southern communities and local contexts of development generally.

With the advent of the HIV epidemic, NNGOs were the first to support emergent community support groups and organisations offering grassroots responses to the pandemic (Kelly, 2009:9; Kates et al., 2013:10-11; Morton, 2013:325). Their work had started in the global North in the form of humanitarian support during the second world war period, enduring through the post 1945 era when, for some, their efforts expanded to include supporting liberation movements (Onsander, 2007). In some literature (Shivji, 2006; Lee et al., 1996), these NGOs are called international NGOs (INGOs) in an attempts to capture the expanse of the coverage of their work.

While NNGOs initially performed their work directly within affected communities, a lack of adequate knowledge and difficulties in effectively reaching communities forced them to enlist the services and fund SNGOs' programmes to improve their reach and effectiveness. For SNGOs, NNGOs were and continue to be conduits of bilateral and multilateral aid raised from donors in the global North and channelled to the southern and eastern countries. In analysing the role of NNGOs in South Africa, Smith and Bornstein (2001:6, 8) note that "there are at least 75 internationally-based NGOs that either implement their own programmes in the country (SA) directly or fund local organisations to implement programmes." This trend is typical in both the eastern and southern parts of the world.

1.4.3 Member-serving vis-à-vis Other- serving NGOs

While all NGOs are created to serve a purpose, a key differentiating factor is their main clientele. There are NGOs established by and for serving a particular population segment to resolve challenges the group faces; including women, youth, sex workers, lesbians, gays, bisexuals, trans-genders and intersexes' NGOs. The primary focus of the NGOs' work is to serve their beneficiaries ('members') – the purpose for which they are created. Other NGOs serve non-members – they are other-serving NGOs. They are created as service providers to other organisations or anyone who may benefit from their services. Their work is largely externally focussed and geared towards providing services that would enhance the capacities of client organisations to deliver their own programmes. These organisations may include advocacy organisations that support a cause which may not directly affect them. A more nuanced discussion of these organisations is offered later in the thesis with particular reference to case examples in chapters 6 to 9. Subsumed in these two main typologies are other sub-categories such as activity-based models.

1.4.4 Activity-based Typologies

There are innumerable activity-based subcategories (Eades, 2000:12). These include those performing high-profile international advocacy, and those advocating and working in different areas such as women's rights and mainstreaming of gender, mainstreaming of HIV, HIV treatment access and sustainable development. There are also service delivery sub-categories related to organisational capacity building and development, information services and grant-making/sub-granting. Others work in and provide direct services to communities, including in home-based care, HIV testing and counselling, educational support among others, and carrying out community level advocacy for their areas of operation.

Activity-based typologies comprise largely of NGOs directly involved in programme implementation, usually at the community level. Some of those in the area of advocacy mount programmes across all levels (community, district, province, country, region and global), depending on the manner in which their work is structured and targeted, and the level at which they are designed to operate and the nature of challenges they have to address. As well, as noted below, some community-based groups that emerged at the advent of HIV became transformed into regional outfits.

1.4.5 Community-based Operators and Regional NGOs

With the advent of the HIV pandemic globally, the first civil society responses were initiated by groups of people affected and infected by HIV and local CSOs located in particular communities (Rodriguez-Garcia et al., 2011). Such organisations are usually referred to as community based organisations (CBOs) and, among them, some were secular while others were faith-based organisations (FBOs) (Lee et al., 1996; Rau, 2010). FBOs and CBOs have developed into large NGOs offering support beyond the local community and serve at district, provincial and country levels offering a wide range of services which can be located in the categories of member and other-serving organisations. Some of these NGOs advocate for the creation of conducive environments for the effective rollout of the services and/or the rights of their constituency members, serving various population groupings viz., men, women, youth; lesbians, gays, bisexuals, trans-gender and intersex (LGBTI); and sex workers and drug users.

Along the same lines of service, but with a greater focus on technical support, representation and advocacy, there has emerged (from the 1990s) regional level NGOs whose services focus both at regional and national spaces. As a new social phenomenon, regional NGOs (RNGOs) are yet to be adequately analysed, and hence the relevance of this thesis in contributing to a greater and better analysis, conceptualisation and understanding of these organisations.

1.5 Thesis Objectives

The study assumes that a comprehensive conceptualisation of RNGOs and their work in SADC may be better facilitated by locating it in the architecture of the HIV responses as enshrined in the following:

a. The donor aid strategies at all levels;
b. The regional bloc (SADC) and its coordinative instruments which facilitate regional relations among various development actors; civil society, intergovernmental organisations and donors;
c. The UN system that provides the global framework for development including the response to HIV and AIDS; and finally
d. The concerns and aspirations of people living with HIV.

These key contextual factors influence the nature and structure of RNGOs, their operations, role and importance in the HIV response in the SADC region and more broadly. As such, theoretically framing RNGOs as social systems, elements of social systems, institutions and

nodes in social networks provides the theoretical grounding necessary for this analysis (see chapter two).

The main objective of the thesis is *to analyse the conceptualisation, operations and embeddedness of RNGOs responding to HIV and AIDS in SADC, and the impact of embeddedness on RNGO operations, accountability and relevance*. This involves examining the concept *region* and the advent of RNGOs as contextualised in various donor-driven regional HIV strategies, SADC's priorities of regional integration, coordination, freedom of movement of population and people-centred sustainable development (SADC, 2013:12), in addition to the realities of PLHIV in the region. It also entails interrogating the conceptualisation and typologies of RNGOs in relation to their organisational forms and functions as linked to the nature, extent and purpose of RNGOs' entrenchment in global, regional and country networks and lateral relations, in order to demonstrate how that facilitates and/or constrains RNGOs' added value and accountability to PLHIV in SADC. The subsidiary objectives of the thesis include the following:

i. To define RNGOs and highlight contextual factors influencing their emergence and existence.
ii. To establish how *'being regional'* is defined, practiced and adds value to the HIV response in southern Africa in relation to the country, regional and global design of the response.
iii. To establish the impact of RNGOs' entrenchment in their operational contexts on their HIV work, conceptualisation and practice of *'being regional'*.

1.6 Research Methodology

The main methodological debates that characterise social enquiry relate to different philosophical traditions in sociology, most notably positivism, constructionism and realism (namely, the Marxist version). The points of difference berween these traditions relate to questions around ontology (what can be said to exist in the world) and epistemology (how to understand and explain the world as it exists). I do not position my thesis neatly into any one of these traditions. Certainly, though, I do not seek to offer positivist-type causal relations of the social phenomena (della Porta and Keating, 2008; Collier, Brady and Seawright, 2004a; Schwaninger, 2004) under investigation in the thesis.

Insofar as the thesis seeks to establish relations of determination between social phenomena, I draw upon the more Marxian notion of structural conditions which determine (in a soft sense) other social phenomena (as the conditions of existence for these phenomena).

Structure is central to the thesis as the focus is on the organisational arrangements which underpin the worldwide development system; however, I do not delve into the deep structural powers animating capitalism as Marxism does. But, in line with the views of constructionism, I recognise the significance of the ways in which agents within the worldwide system construct discursively their location and role within the system and how, through their agency, they engage in organisational practices (Bhattacherjee, 2012; Howitt, 2010; Dey, 2005; Creswell, 2014). In this way, the thesis is sensitive to both structure and agency as it seeks to undertand RNGOs and being regional in the HIV response within the southern African region in the context of the broader international development system.

As is the case with the combination of different research methodologies outlined, I recognise the significance of both quantitative and qualitative research methods as a useful basis for pursuing this study. Quantitative and qualitative methods are each known to have their strengths and weaknesses (Marshall and Rossman, 1999; Sandelowski, 2000; Pearce, 1971; Wolcott, 1994). Burg (2001:233) argues that the controversy is now "less about quantitative versus qualitative, and more about how research practices lie on a continuum between the two". As Creswell (2003:4) likewise states, the "best that can be said is that studies tend to be more quantitative or qualitative in nature" (see also Newrnan and Benz, 1998). Though there is some quantitative analysis in the thesis, the main focus is qualitative research so as to be able to identify and understand the structured practices of being regional amongst the RNGOs investigated.

1.6.1 Methods, Procedures and Techniques

This thesis is a qualitative analysis of RNGOs that employs a qualitative multiple case study research design (Hancock, 2002:6; Tellis, 1997:3; Kish, 1986). As Blatter (2008:68) informs us, "a case study is a research approach in which one or a few instances of a phenomenon are studied in depth." According to Burg (2001:225), a case study involves "systematically gathering sufficient information about a particular person, social setting, event, or group to permit the researcher to effectively understand how it operates or functions." Multiple case analyses involve the study of more than one case example, to provide an opportunity for comparison and contrast of the cases.

In the case of organisational analysis, the case study approach allows the investigator to collect "rich, detailed and in-depth information" about the organisation to gain insight into the life of that organisation (Burg, 2001, Blatter, 2008). The analysis, among other things, focuses on how the organisation emerged, is constituted, its role, purpose, relations with its

operating environment and, in that context, the way in which it is embedded in social relations with other entities which shape its disposition and social actions at various locations in social development processes such as responses to HIV.

The application of multiple case examinations in this thesis does not only provide an opportunity to collect in-depth information about RNGOs but facilitates comparison and contrast of the organisational case examples to further enhance the understanding of the unit of analysis – the RNGO phenomenon in the HIV response. Such enhancement is achieved through focussing on specific aspects such as RNGO emergence, configuration, focus, purpose, added advantage, life and the forces that shape them and how they endeavour to influence the operational contexts in pursuit of their visions and mission. In this way, a better opportunity arises in seeking to frame the concept *'being regional*'.

The main critique levelled against case studies by positivism relates to generalisability of findings but this has been dismissed by some scholars as based on a misconception of the purpose of a case examination. A case study as earlier noted is intended to obtain context- and case-specific data (Hancock, 2002:7). As such, case studies have proven to "have a strong comparative advantage with respect to the 'depth' of the analysis, where depth can be understood as empirical completeness and natural wholeness or as conceptual richness and theoretical consistency" (Blatter, 2008:69). In other words, case studies offer opportunities for a thorough and deeper examination of all aspects of the subject of analysis contextually, resulting in enhanced understanding of social phenomena. Multi-case studies further deepen our knowledge by presenting opportunities for comparison and contrast of cases.

Within the case study design, a variety of data collection techniques are employable: sampling and interviewing, observation, review of organisational documents and other archival material, whose triangulation ensures the gathering of thick descriptions of the case (Tichy, 1979:510). This thesis utilised a variety of these data collection methods namely: review of secondary data, archival material and grey literature reviews, and interviews, to permit triangulation of sources and data to enhance reliability and validity (Barbour, 2001:1117). As Zina (2010:114-115) puts it, employing a combination of data sources and methods facilitates triangulation and heightens the rigour, profundity and objectivity of the analysis thus enhancing reliability, validity and credibility of data. In this study, this was achieved through methodical sequencing and structuring of data collection.

1.6.2 Sequencing and Structuring of Data Collection

Data gathering for this thesis was sequenced and structured to allow for methodological reinforcement, and for thorough and targeted information collection as informed by triangulation of methods and sources. This involved first: the review of primary and secondary data which provided an informed entry into key informant interviews. However, for this process to be delivered more efficiently, a schedure of key themes/variables was drawn up against which specific questions were raised (Table 1.2) on the basis of the goals of the study. This schedule was a checklist against which data was methodically extracted in trying to answer the key goals of the research.

Equipped with this research guide, it was easier to design and conduct key informant interviews that did not only further delve into the details of the operations of the RNGOs but provided an opportunity for cross checking of reviewed data from organisational reports. In this way, information drawn from organisational websites, internal operational documents, interviews and reports from other partners could be collected, analysed, cross examined and checked for consistency, thus enhancing reliability, objective analysis, and understanding of the origins and nature of the sampled RNGOs (including their operations, relevance and practice of *being regional*). While general and publicly available organisational documents were gathered as part of the initial literature review, internal documents were collected after interview sessions as a follow-on to the interview discussions that were conducted in 2015 and 2016. The next subsection discusses each of the procedures employed in this thesis in relation to the specific aspects of the case organisations.

Table 1.2: Theme-based Data Collection Guide

Variable/theme	Operationalisation	Research Tool
RNGO emergence and organisational bio data	1. Name of the organisation? 2. When established? 3. What was it established to do? 4. Where it work?	Primary and secondary data reviews and Interviews
RNGO structuring/ institutionalisation	1. What is the organisational's vision, mission, goals and strategy? 2. How is the organisation structured and operated, and why?	Primary and secondary data reviews and Interviews
RNGO programming and partnership	1. How is the organisation's work organised? 2. Who and what informs its programmes? 3. Who does it work with and how? 4. What does it do with each of them?	Primary and secondary data reviews and Interviews
RNGO accountability	1. How you define accountability in relation to your work? 2. Who do you account to? 3. How do you account to them? (list of those you account to and what you do to account) 4. What do you account for? 5. Who demands the most of your work on accountability (rank and explain?)	Primary and secondary data reviews and Interviews
RNGO understanding of the region and regional work (being regional)	1. How do you define a region operationally? 2. What does working at the regional level involve (what you do and expect to do)? 3. Do you have/follow any rules/guidelines that help you define regional work as opposed to work at other levels? 4. What separates regional work from work at other levels? 5. How do you compare and contrast regional against multi-country work?	Primary and secondary data reviews and Interviews
RNGO partnerships and embeddedness: work relations with other regional and international players	1. How does your organisation relate and work with regional bodies e.g. SADC, EAC, AU etc.? 2. How does your organisation link and work with other regional NGOs? 3. How does your organisation link and work with UN bodies/agencies? 4. How does your organisation relate and work with global civil society structures? - Specify the structures. 5. What input does your organisation feed into these regional and global structures? 6. What inputs does your organisation draw from these structures and for what use?	Primary and secondary data reviews and Interviews,

1.6.3 Sampling

Sampling generally relates to the identification and selection of a group of representative elements for study on the basis of which generalisable results can be obtained to apply on the primary population. In the social sciences, this has evolved to include selecting key informants or units that lead to a closer understanding of a phenomena rather than for purposes of generalisation. In these cases, different methods of sampling such as stratified, incidental and purposive sampling have been applied effectively. In this study (Marshall, 1996:523, Barbour, 2001:1115-1116), purposived sampling was utilise as it has the capacity to yield a targeted sample to provide the requisite input in the study. Two categories of sample organisations were chosen: RNGOs and other organisations directly involved in the HIV response both globally and regionally, constituting a total sample of 13 organisations.

A purposive sample of RNGOs was preferred as the researcher already knew which respondents were likely to provide the relevant information for the different aspects of the study. Two RNGOs from four categories of RNGOs were sampled for further analysis leading to re-categorisation, based on roles defined in their websites and internal documents. The RNGOs were chosen for their mix across apparent typologies, and their exposure not only to the regional HIV response but discussions regarding the concepts *being regional*, *regionality* and *added value* of regional responses (SAT, 2004b:3-4; Jones and Hellevik, 2012). Some of the RNGOs had also participated in an original 2004 meeting organised by SAT and UNAIDS. The purposive RNGO sample included: SAT, SANASO, SAfAIDS, NAPSAR+, ARASA, DHAT, SAT, ARC (RATN) and RAANGO. The targeted individual key informants in these RNGOs were senior management officers, some of whom had participated in the SAT meeting of 2004 where *being regional* was initially mooted. These respondents could provide both strategic and operational information about their organisations relevant for this study. Table 1.3 presents the total number of RNGOs and key informants for this study.

Besides RNGOS, three donors, one regional governmental organisation and one UN subsidiary organ were also purposively selected for study due to their critical role in the HIV and AIDS response globally and within southern Africa (Table 1.4). While the Global Fund for HIV, TB and Malaria (GFHTBM) represents a global and UN-related joint funding arrangement for HIV, TB and Malaria, HIVOS mirrors the role of a primary receipient (PR) of GFHTBM funding. HIVOS has been implementing the newly launched GFHTBM Key Populations Representation, Evidence and Advocacy for Change in Health (KP REACH) Programme for southern Africa.

Table 1.3: Sample of RNGOs by Major Activity and Constitution

RNGO	Type of RNGO					Key informants
	Network/ Umbrella bodies	Capacity building	NGO Coordinating bodies	Information dissemination	Alliance	
ACA/RATN	-	x	-	-	X	*
ARASA		X	-	-		1
SAT	-	X	-	-		1
DHAT	X	X	-	-		1
NAPSAR+,	X	X	X	-		1
SAfAIDS	-	-	-	X		1
RAANGO	-	-	X	-	X	1
REPSSI		X				1
Total	**3**	**3**	**1**	**1**		**8**

Source: Own compilation.

The Swedish Agency for International Development (Sida) was chosen for its leadership of a southern Africa HIV response team that includes donors, civil society and government organisations.

While the Joint Programme of the UN on HIV, TB and Malaria (UNAIDS) represents the UN framework and technical support mechanisms for the HIV response at all levels, the Southern African Development Community (SADC) provided the regional component of the architecture of the HIV response.

Table 1.4: Donors and Other Organisations

Organisation	No	Names	%
Bilateral donors	2	➢ Sida: Swedish Agency for International Development ➢ HIVOS:	40
Multilateral donors	1	➢ GFHTBM: Global Fund for HIV, Tuberculosis and Malaria	20
UN Organs	1	➢ UNAIDS: Joint United nations Programme on HIV and AIDS	20
Regional governmental organisations	1	➢ SADC: Southern African Development Community	20
Total	**5**		**100**

Source: Own compilation.

Collectively, these organisations provide a context within which RNGOs operate and provide an avenue for analysing the interface between RNGOs and their environments (local, regional and global), including the extent of their embeddedness and its influence on their operations and accountability processes.

1.6.4 Review of Secondary Data and Archival Material and Other Grey Literature

Secondary and archival materials (grey literature) comprise a main source of data for reviews of pre-existing phenomenon such as organisations. Grey literature constitutes a record from which various patterns of social behaviour can be drawn and compared with current activities to better comprehend a social phenomenon (Hancock, 2002:12). The main criticism levelled against it is the accuracy and relevance of the data in relation to the purpose for which it was compiled vis-à-vis the needs of the research study drawing from such a source. However, its impact on this research was limited to the extent to which other supplementary methods (primarily, key informant interviews – Appendix 1 and 2) were utilised to enhance the accuracy of the research findings. In other words, a mixed methods approach has overcome this shortfall and maintained the relevance of grey literature in social analysis. Based on this strength, the analysis of grey literature has been utilised in this study as a lucrative source of both historical and current data about the RNGOs studied.

Interpretive analysis of accessible published and unpublished materials and other desktop literature on respondent RNGOs, UN organs, donors and SADC was conducted, to gain insights into the nature of work of these organisations, their reach and coverage, and how they were organised; as well as the relations and partnerships that emerged between RNGOs and other players in the HIV response. The documents that were reviewed collapse into four main categories:

- **i.** Strategy, which spelt out the vision, mission, goals, objectives and key working modalities of the RNGOs;
- **ii.** Policy, procedure and operating guideline documents, which provided substantial details on organisational operational models and implementation modalities;
- **iii.** Organisational management and governance structure documents, which also inllustrated organisational conceptualisation and modelling; and
- **iv.** Reports (annual, biannual, quarterly, workshop, monitoring and evaluation (M&E)) as applicable to each sample organisation. Documents provided an overview of the implementation of programmes and their reach, partners and

partnerships forged with various other players in the HIV response, as well as funding arrangements and the results achieved.

The analysis of these documents was guided by a predrawn thematic framework (Table 1.1) based on the objectives of the study as earlier intimated.

1.6.5 Interviews

Interviews are utilised to solicit information from respondents either about themselves, or an issue, situation or an entity, as the interviews seek both opinions and facts about social phenomena which is believed to be known by the respondent. They are known to come in three main forms; structured, unstructured and semi-structured (Hancock, 2002). In this study, targeted semi-structured in-depth interviews (Bhattacherjee, 2012:76-77) were utilised to draw data from a convenient and purposive sample – Appendix 1 (Marshal, 1996:523; Barbour, 2001:1115-1116) of eight RNGOs. From each organisation, an organisationally well informed (about the organisational strategy, structure, operations and partnerships) respondent was interviewed.

The interviews were conducted on a one-on-one basis to seek greater understanding of the RNGOs, *being regional* (its practice and benefits to the HIV response), RNGOs' operations, the networks within which they operated, and how that influenced their identity and work. They also contributed to the further understanding of each RNGO in terms of its conceptualisation, implementation and perceived impact of *being regional* in the response to HIV and AIDS in southern Africa, RNGO partnerships, operational relations, and the resultant embeddedness and its implication for accountability to their stakeholders and beneficiaries. In addition they sought to establish if experience (based on organisational learning processes) has facilitated new thinking about the *being regional* model and its implementation since the initial discussions in the early 2000s, as well as providing clarity on the model's facilitation of HIV and AIDS responses, and its sustainability within the changing donor priorities regarding HIV and AIDS.

Each interview schedule (Appendix 2) was specifically tailor-made to solicit information that particular respondents (Appendix 1) could provide and/or verify, given their position and experience in their organisation. To facilitate the interview process, and ensure the collection and capture of all relevant data, and with permission from respondents (Devers et al., 2000:268), note-taking and audio tapes were combined during the interview process to ensure the accurate and detailed capturing of data.

1.6.6 Data Analysis

Grey literature from the sample RGNOs was categorised according to each thematic area (Table 1.2) against which the key questions were directed to guide the research. Data amenable to tabulation and statistical culculations were so treated to establish patterns and trends. Such data largely worked as a foundation for interviews and thus sharpened probbing during interviews.

Interview data was first transcribed from each interview tape and integrated with the notes collected during that interview in the field. It was then subjected to thematic analysis to identify and examine responses as a basis for offering explanations to perceived patterns of outcomes in answering the key questions of the study as guided by the objectives (following the pre-classification of the interview schedule of questions (Appendix 2) guided thematically as illustrated in Table 1.2). This involved identification and classification: grouping and regrouping data; comparisons and interpretation of frequencies, trends and opinions; and tallying, tabulation and computation of data to generate descriptive statistics, including averages, percentages and frequencies where necessary (Sandelowski, 2000:338) and the development of socio-grams to illustrate inter-organisational relations. The analysis also included the comparison of definitions and determining the different aspects that constitute key concepts such as *being regional*.

Data analysis co-occurred with collection to allow re-focusing, re-examining and re-drawing of the study parameters in order to enhance enquiry and analysis (Onwuegbuzie and Leech, 2007:117). This was particularly useful in linking the document review processes and outputs to interview preparations, data checking and verification during and after the interviews. All confirmatory and emerging trends were categorised as with the document review data. The triangulated analysis of interview data ensured heightened clarity on results that did not seem complete or were contradictory to the general emerging patterns. This resulted in increased validity of data obtained and enhanced the analysis.

1.6.7 Observation of Research Ethics and Protection of Informants' Rights

Due to the sensitive and confidential nature of individual and organisational information, this research complied to the principles of informed consent, confidentiality and anonymity that apply to social science research ethics. In practice, this involved first seeking permission to involve the organisations and individual key informants in the research. As part of that process, due explanation was offered in writing to respondents (Appendix 3) supported by a letter from my supervisor (Appendix 4) confirming the authenticity and purpose of the study.

Any additional clarification sought was provided by any convinient means of communication. In addition, respondents signed a consent form (Appendix 3) or sent an email confirming their willingness to participate in the study.

1.6.8 Limitations of The Study

While substantial data was collected and analysed to produce this thesis, it must be noted that it was not always possible to utilise uniform sources for all organisations. In particular it was possible to interview only seven of the eight RNGOs, as it was not constantly possible to secure interviews or responses to request for interviews from all intended respondents. Requests to two organisations were not responded to and, in some cases where permission to utilise organisational material from the internet was granted, interviews of key respondents were not eventually offered largely due to workloads or other reasons that were not shared with the researcher. This meant that at times the research had to rely on publicly available documents. However, publicly available organisational documents yielded sufficient content to not make the absence of interviews a significant prejudice in the analysis, except with regard to the definition of the concept *being regional* which sometimes needed respondents' input as there was no standard definition of the term for all organisations. In all cases, even where interviews were offered, this had to be extrapolated from a collection of activities and practices to build up its content and character. It is notable that the concept *being regional* is evolving and still in its early theoretical infancy. While the findings of this study make ground-breaking contributions in this regard, and provide a practical guide to donors and CSOs in framing regional work, these remain tentative, thus beckoning further research and analysis. I present the general outline of the thesis in the next section.

1.7 Thesis Outline

The next chapter (chapter two) discusses the worldwide development system, including in relation to DNGOs, and then offers a blended theoretical framing for undestanding this global system. Chapter three looks more specifically at the global architecture of development governance, as constructed under the tutelage of the United Nations. It has a particular focus on the HIV response within the international development system, including in relation to regional level governance in southern Africa and with respect to the UN's rules of engagement. Chapter four addresses the history and existence of RNGOs in the context of discussions around regional programming and being regional, and seeks to identify key distinguishing factors and characteristics of regional organisations and regional programming. After this, chapter five turns to a close examination of donors and RNGOs with reference to

the HIV response in southern Africa (and specifically SADC). In discussing examples in SADC, it brings to the fore the type of funding mechanisms in existence, including joint funding arrangements, and the broader relationship between donors and RNGOs in the case of HIV funding. In this context, the following four chapters (chapters six to nine) each discuss, in turn, two case studies of RNGOs in the SADC region operating within the development field of HIV, including membership-serving and other-serving RNGOs. In each case, questions around governance, partnerships, embeddedness and accountability are considered, as well as the ways in which these RNGOs frame the notion of being regional. In the concluding chapter (chapter ten), I offer an overaching understanding of the case-study RNGOs, relating this back to the theoretical framing of the thesis.

CHAPTER TWO: THEORY, DEVELOPMENT AND REGIONAL NON-GOVERNMENTAL ORGANISATIONS

2.1 Introduction

This chapter offers the theoretical framing of the thesis. I first though focus on certain issues and debates concerning the international development system, including its historical background, organisation and development actors, which is detailed more fully in later chapters with specific reference to the case studies of regional non-governmental organisations (RNGOs), HIV and AIDS, and the southern African region. This contextual overview provides the basis for then going on to discuss more explictly the theoretical framing of the thesis, as it is used in relation to RNGOs in the international development system. The chapter discusses theory in relation to NGOs as organisational forms and how they are grounded and embedded within broader, hierarchical institutional and network-based arrangements. This theoretical framing, by treating NGOs as agents, facilitates the scrutiny and understanding of NGOs as development actors and considers the implications of this for their development practice and accountability. In this way, the thesis is able to investigate sociologically the complexities and dynamics of the location, role and programmes of NGOs within the worldwide development architecture and system, and the overall influence of this on their practices. This has direct relevance, as the thesis illustrates, for an examination of RNGOs and the concept of *being regional*.

2.2 Worldwide Development System

The concretisation of the concept ‘development’ as currently understood is typically traced back to the formation of the United Nations (UN) in 1945 as influenced by developed nations in the global North (Eades, 2000). This occurred in the context of post second world war reconstruction in Europe (notably, the Marshal Plan from 1948 to 1952) and the disintegration of colonial empires and subsequent nation-building in the post-colonial era in Africa and elsewhere, and in the context of the international dynamics and needs of global capitalism. On this basis, the worldwide development system, or even sometimes called industry, has grown and proliferated over a number of decades (Anievas and Nişancıoğlu, 2015:8, 9). International development assistance and cooperation, involving a range of financial, technical and institutional support systems, became “an explicit policy issue” (Coscia et al., 2013:2) for advanced capitalist nations and it has served to integrate

undeveloped/underdeveloped nations more firmly into the global political economy of capitalism for better or worse.

Following the end of World War II, the founding members of the United Nations highlighted the importance of both global security and socio-economic development (UN Charter, 1945 Article 1:3). The UN designated one of its principal organs, the Economic and Social Council (ECOSOC), as the agency responsible for international cooperation for development among all its Member States, with the underlying argument being that Member States had a collective responsibility to assist particular nations in the global South to enter onto a pathway of development in a sustained manner – what became known as modernising or becoming modern (Willis, 2011; Ogborn, 2005). The development challenges for these nations, it was claimed, existed internally, such that – as Coscia et al. (2013:3) put it – "the initial intellectual interpretation of the obstacles to development focused on the availability of capital and infrastructure" within these nations. Hence, advanced capitalist nations, as developed nations, were said to be in a strong position to assist other nations in modernising (through capital transfer and infrastructural enhancement, for instance) so that these latter nations could 'catch-up' and eventually reach a higher stage of development.

The UN Charter's (Chapter III, Article 13. 1b) notion of development encapsulated international development cooperation, technical assistance and financial aid through the various UN organs and agencies under the tutelage of the United Nations Economic and Social Commission (ECOSOC). As part of this process, not only did the UN begin to establish subsidiary organs under the ECOSOC to operationalise its global development agenda (Schrijver, 2006:18), as it also facilitated the establishment of the Bretton Woods Institutions. The International Monetary Fund (IMF), the World Bank (WB) and its five subsidiary organs, along with the World Trade Organisation (WTO), were the key institutions established to independently facilitate post World War II economic recovery, reconstruction and development (Milner, 2005:833), and they continue to function to this day. While the IMF and the WB are mechanisms for development funding, the WTO provides the framework for trade regulations internationally.

In the spirit of the UN framework, and in pursuit of America's own interests in global capitalist development, the United State of America (USA) President Truman, in his inaugural speech, as informed by the post World War II dispensation, declared the key role of the United States as rising to "the supreme need of our time" by "aiding the development of the economically underdeveloped areas." The avowed modus operandi of the USA included "making available technical resources" and "fostering capital investment", while also seeking

to “advance the cause of freedom and democracy in the world” (US Department of State, 1949:1). The USA, like other advanced capitalist nations later, was to pursue its own development ambitions while simultaneously recognising its commitment to the UN Charter. This entailed the formation of bilateral arrangements between particular developed nations (involving official state-driven development agencies) and particular undeveloped/underdeveloped nations, along with the interventions of multilateral development agencies such as the World Bank and IMF. The more contemporary manifestations of the worldwide development system (Brenner and Theodore, 2002; Sacks, 2004; Faist, 2006; Baliwala, 2002), which have arisen from various reforms, tweaking and refining of the system over a number of decades, are discussed in later chapters in relation to RNGOs and the global response to the HIV pandemic.

Clearly, the emerging worldwide development system was premised on a spatial dichotomy of the world, in which history it seems was forgotten. A crucial dimension of the international development regime has been thus the establishment and perpetuation of a dichotomised world (discursively and materially) characterised by the developed nations on the one hand and undeveloped nations on the other hand. The latter are seen as lagging behind the former, but would develop with the support and assistance of the former (Bartsch and Kohlmorgen, 2007:6). The condition of ‘undeveloped’ seemed to exist outside of the history of empire-building and colonialism of the past, as if this was an initial condition which could only be addressed by the developed nations in seeking to modernise the undeveloped nations. This formed the basis for (liberal) modernisation theory (Brett, 1992). I do not offer an overview of modernisation theory for reasons noted below.

Certainly, though, its basic premise (of undevelopment somehow not being conditioned by external and global forces) seems deeply problematic as many scholars have noted (Bellù, 2011; Lewis and Kanji, 2009). More critical perspectives (from within Marxism broadly) began to emerge which spoke about ‘underdevelopment’ rather than ‘undevelopment’. This involved the claim that former colonies (such as in Africa) had been underdeveloped by the empires ruling over them (i.e. had suppressed development in the former colonies), and that to expect developed nations to now develop these nations through a worldwide development system (rather than to further underdevelop them) would be an impossibility (Rodney, 1973; Ake, 1978). This led to all sorts of schools of thought such as underdevelopment theory, unequal exchange theory, world systems theory and dependency theory. Again, I do not offer an exposition of these Marxian analyses. Their main point is that underdeveloped nations are in a relationship of dependency vis-à-vis developed nations, and

that they are integrated into the global political economy in a deeply subordinate manner (Frank, 1969; Chilcote, 1974; Dos Santos 1971; Lall, 1975).

The reason for noting these contrasting theories, but not detailing them, is because of an important distinction between two ways in which the term 'development' is used in the scholarly literature, and sometimes in a manner which conflates them. More specifically, a distinction has been made between 'little d' and 'big D' development (Hart, 2001) which is closely related to what Cowen and Shenton (1998) call, respectively, 'immanent and unintentional development' on the one hand and 'intentional development' on the other. The particular aspect of development being examined in this thesis is 'big D' development or 'intentional development'. In their analysis, Cowen and Shenton (1998:50) speak of immanent development as "processes of structural, political and economic change such as the expansion of capitalism". This thesis, as implied already, makes no attempt to provide any kind of analysis of the expansion of global capitalism historically (either via modernisation or Marxist theory), including its uneven development. Rather, the focus is on the intentional development which is embodied in the worldwide development system (or industry), with all the diverse development agents located within this system – from multilateral financial institutions to local or national NGOs.

At the same time, it is acknowledged that the analysis (from a particular perspective) of the structural unfolding of global capitalism historically ('little d' development) tends to lead to a particular analysis of 'big D' development or of the international development system. Certainly, any Marxist criticism of 'big D' development emerges from the analysis of 'little d' development (with claims about inter-nation global inequality highlighting exploitation, subjugation and domination); likewise, more liberal views (notably, modernisation theory) on global capitalism would normally lead to mostly sympathetic accounts of the worldwide development industry.

Intentional development, as Bebbington (2004:726) argues, involves "international aid: public and other agencies implementing 'development' projects, programmes and policies with specific ends" (Bebbington, 2004:726; Bebbington et al., 2008). Hart (2001:650) as well defines 'big D' development as "the project of intervention in the third world that emerged in a context of decolonization and the cold war". Others, like Willis (2011) and Mitlin et al. (2006), have also sought to distinguish between the two forms of development in similar ways, with 'big D' development being in large part conceptualised, planned, pursued and driven by development agents in the global North. There is no doubt that multi-lateral financial institutions as well as state-sanctioned international development

agents (IDAs), such as the US Agency for International Development (USAID) and Department for International Development (DIFID) in the case of Britain, drive international development in the context of contemporary globalisation (Granstrom, 2008; McArthur and Pach, 2008; Yang and Qiu, 2010; Rothenberg, 2003; Al-Rodhan and Stoudmann, 2006:3; Tien and Talley, 2012; Tong and Cheung, 2010).

Further, as post-development theory (Clark, 1991; Green, 2003) demonstrates, there is a development discourse underlying 'big D' development which seeks to mask the causes of underdevelopment and to justify development interventions in a manner which also hides the hierarchical structures underpinning the international development system. In this context, Lie (2008: 122) argues that 'intentional development' is "a bureaucratic force and a global reach programme with an explicitly pro-capitalist agenda, operating as a tool of regimes that seek to perpetuate relations of inequality and dependence between the West and the rest" of the world. It is this bureaucratic machine that is unpacked in the thesis with reference to RNGOs.

Although the bureaucratic development system appears unidirectional, and ultimately this is the dominant tendency, this is not to deny the possibility of particular development agents lower down the hierarchy using their location (and their capacities and resources) to enact agency in a manner that offers space for maneouvring; power differentials do not imply absolute power (Checkland, 1999; Burns, 2006; Tamas, 2000), as many have argued within globalisation and development studies (Sucháček, 2011; Douglass, 2005:1). Certainly, as components of the development system, NGOs actively seek and engage in social relations to further their interests including achieving organisational goals.

The point of the thesis then is to examine the structures and processes constituting the worldwide development system, with a particular focus on RNGOs. 'Little d' development, though not discussed in any significant manner at all, is always there in the background and is recognised implicitly in describing, detailing and analysing 'big D' development. There is a recognition that 'little d' development and 'big D' development are both based on hierarchies, inequalities and subordination, but it would be crude to claim (and indeed un-sociological) to assert that 'big D' development is a totalising system based on unilateralism as if complete subordination exists.

In considering development specifically as an intentional and deliberate structured process, social agency is brought to the fore, along with organisational arrangements, social relations and networks between development agents (including RNGOs), and institutional and regulatory mechanisms. This entire development edifice is often channelled into programmes

and projects which are implemented in the global South, with NGOs being central to implementation. In this respect, Mitlin et al. (2006:7) argue that, within the international development system, NGOs are located and participate "as project implementers, knowledge generators or political activists all involved in interventions" but they are "also part of the societies and political economies in which they operate". This means that NGOs are both exogenous and endogenous to processes of intentional development. The emphasis on programmes and projects does not only imply fixed term processes but also raises questions of targeting, particularity, relevance, participation, roles (of local and external development agents), effectiveness, efficiency, sustainability and accountability. The ways in which RNGOs are embedded in 'big D' development, which is a deeply hierarchical structure, is central to this thesis, including the ways in which they enact agency despite their subordinate location in the international development structure.

2.3 Theoretical Framing

The previous section has spoken about the worldwide development system (in which RNGOs are located) as a complex institutionalised system of social relations. This section, which discusses a range of theories in a somewhat eclectic fashion, seeks to provide the analytical basis for examining – later in the thesis – RNGOS and HIV responses in southern Africa in the context of this development system.

Generally, the thesis draws on social systems theory (Checkland, 1991). As conceptualised by von Bertalanffy (1968, 1972), a system, at the most basic level, is "a set of elements standing in [relations of] interaction" implying the existence of socially binding features among them (Gharajedaghi, 2004). The various elements of the system constitute sub-systems that also have constituent elements (such as a single NGO in the HIV response) which interact with other elements (such as other development agents in a HIV intervention). All the various elements and related activities in a single sub-system exist and take place relationally, in the context of the overarching system, such as the international development system. It is up to the analyst to identify the overall system under investigation which, in the case of the thesis, is the world-wide development system and the many sub-systems existing within it, notably those centred around RNGOs.

The scheme itself has boundaries which define it as a system in its own right and delineates its bounded cohesiveness, as an institutional line "which determines what is inside and what is outside of a system" (Tamas, 2000:2). Social systems are open systems with porous boundaries in relation to wider social structures and processes (i.e. systems) within

which they exist. At times, it appears that social systems are almost self-reproducing in a sustainable manner (i.e. homeostasis) but certainly they are subject to change including revitalisation but even processes of decline, either because of factors outside the system or within the system. The international development system continues to be sustained through constantly attracting funding, just as it is also sustained through generating (at least as claimed) a range of development successes. In a similar way, the sub-system of NGOs is organisationally sustained by continuing to attract donor funding and providing development assistance at local levels, thereby contributing to the continuation and relevance of the overarching system.

Clearly, exchanges take place across sub-systems within the system and between the system (including the development system) and the broader social environment. To ensure homeostasis, some kind of boundary management is necessary so that only the best inputs are sourced and absorbed into the system as a whole and only the mostrelevant outputs are released out of the system. This is also the case with sub-systems, with other sub-systems and the overall system representing their immediate social environment. The challenge however is that sub-systems may not be in complete harmony with each other, and what is appropriate for one sub-system may be inappropriate for another. Thus, at times, what donors expect and require may go contrary to what RNGOs see as necessary for their sustainability.

The actor-system-dynamics theory (Baumgartner, et al., 1975) is a 'neo-systems' theory which seeks to show how systems theory remains relevant to sociological analysis but in a reconfigured manner, including becoming embodied in institutional and organisational theories among others. It also incorporates the significance of human agency and institutionalised rules of social conduct (including mutual expectations) as central components which structure social interaction, networking and transactions within systems and their sub-systems. Sub-systems are not objectified but are seen as comprising of instititutional formations which enact agency. Further, in and through their interactions, sub-systems "acquire new properties and are transformed, resulting in the reconfiguration of the agents and their social and physical environment" (Burns, 2006:412).

The actor-system theory conceptualises human agents (including organisations) as intentional, self-reflective and consciously self-organising (Long, 2001:16). In exercising their agency, "social agents may choose to deviate, oppose, or act in innovative and even perverse ways relative to the norms, values, and social structures of the particular social systems within which they belong, act and interact" (Burns, 2006: 413). In this regard, while organisational sub-systems with the capacity to act make up the system and are reproduced by

it through the seeming logic and imperatives of the overall system (or at least by way of being orientated towards the values, norms, goals and expectations of the system), social agents also actively transform the system through their actions.

An illustrative example in the development arena is when NGOs in the HIV field pursue the global HIV response as components of the development system located at various levels (global, regional, national and community levels) – they may simply appear to be implementing the Joint United Nations Programme on HIV (UNAIDS) global framework for fighting the epidemic. However, and consistent with the earlier argument about room to maneouver within the development system, RNGOs for instance may in fact influence the content of the programmatic framework (arising through feedback from their own experiences in the HIV response) while also altering the governance structure through which the programme is pursued.

While it seems important to frame the study within social systems theory and particularly the actor-system theory, there is some advantage in also drawing upon an institutional analysis approach (De Pin-Cabral, 2011). This is the case because, after all, the agents under investigation – notably RNGOs – are notably institutional actors expressing organisational behaviour and practices. Hodgson (2006:2) defines an institution as "a system of established and prevalent social rules that structure social interactions", with these structured social interactions taking place between and within organisations; in this sense, institutional rules are embodied in organisational forms.

Institutional rules, as socially constructed and reaffirmed, create conditions of expectation and hence the production of reasonably predictable social action. As Burns (2006:417) states, "a rule regime organizes people in a complex of relationships, roles, and normative orders that constitute and regulate recurring interaction processes among participants." Baba et al. (2013) call this the constraining effect of institutionalisation which, according to Scott (2001, 2008:52 – 59), involves three main dimensions: first, the regulatory dimension of institutions which involves rule-setting, monitoring, and sanctioning activity; secondly, the normative domain that involves prescriptive, evaluative, and obligatory aspects; and, thirdly, the cultural-cognitive component which includes shared conceptions about system goals and system governance.

Conceptualising NGOs as institutional arrangements or organisations complements the social agency framing as well as the understanding of NGOs as components of an institutionalised global governance system of development generally, especially of the HIV and AIDS response. Constituted under the auspices of the United Nations (UN), development

is driven through institutional frameworks and institutional agents – UN agencies, donors, national governments, regional organisations (state and non-state), NGOs and other non-state actors. The institutional framework recognises the capability of social action on the part of organisations, not only because of adherence to (or deviations from) the rule-based regime, but also because of organisational imperatives and interests aligned with the overall purpose of the organisation (North, 1994). Each organisation (such as a RNGO) acts out its agency within the broader system (for example the system of development) based as well on its own set of operational rules, resources, and mechanisms for reaching decisions and acting on them (Hodgson, 2006). As institutional agents, RNGOs become integrated into the larger development institutional setting and navigate their way through the system based on broader institutional imperatives and its own set of organisational imperatives.

Like in the actor-system theory, organisations (including development agents) are seen as institutional actors embodying purposive social agency which is operationalised within a broader system (Hindess, 1989). Organisations as components of larger institutional arrangements seek to achieve and continuously adjust and strengthen their capacities in interaction with their external environment (donors for instance in the case of RNGOs) and in pursuance of organisational goals. To add further complexity to the matter, it is also crucial to consider the hierarchical, network-based and multi-layed character of a system such as the international development system (Harary and Batell, 1981; Moliterno and Mahony, 2011).

A focus on the notion of networks allows for a focus on the arrangement, type amd content of social relations, as well as on the levels of resultant embeddedness within networks and the role of network relations in the work of development agents such as NGOs (Tichy et al., 1979). In this way, RNGOs as organisational entities reside in 'nested arrangements', where a particular RNGO is nested in the RNGO sector, which is nested in the NGO sector and the NGO sector is nested in a multi-layered overaching development system (Hitt et al., 2007). Conceptualising organisation-based social actors as nodes in a system of social networks ensures a relational understanding of NGOs, as an NGO is then seen as existing in and through its relations with other social actors within networks (Borgatti et al., 2009; Borgatti et al., 2014; Brass et al., 2004; Borgatti and Foster 2003; Dacin et al., 1999; Granovetter, 1985). Social actors as connected nodes also can be plotted graphically to illustrate the connections as well as their density from one node to another, with explanations sought to account for identified patterns through the examination of organisational processes.

In this regard, the complexity of the relations that regional non-governmental organisations (RNGOs) have in the HIV response in the SADC region are analysed from

systems-informed institutional and network frameworks. The gist of the social network analysis (like in actor-system-dynamics theory) is that "actors are embedded in networks of inter-connected social relationships that offer opportunities for and constraints on behaviour" (Brass et al., 2004:795; Burns, 2006:412). Like in systems and institutional theories, these social actors exist as components of a larger organisational setup, as nodes within systems of social networks where they connect to other development actors through social relations, and exercise their agency as nodes in development networks.

Of course, social agents do not just find themselves in social relations but actually "invest in social relations" for "expected returns." (Lin, 1999:31). Lin (1999) observes that these returns may include information, collegial and moral support, respect, recognition, legitimacy, trust, and material resources which, if mutual returns exist, facilitate the maintenance of homeostasis both in individual sub-systems (for example, RNGOs) and the entire system (of, for instance, the HIV governance structure and response). This, according to Folke at al. (2005:451), entails social capital (Fukuyuna, 1999), which is "the glue for adaptive capacity and collaboration – built by investing in social relationships, and the networks that emerge can either focus on horizontal or vertical collaboration." Because of this, Lin (2005:11) further asserts that social networks "provide the necessary condition for access to and use of embedded resources. Without networks, it would be impossible to capture the embedded resources." (also Portes, 1998). Lin (2005:4) continues to argue, in a manner similar to Alder and Kwon (2002), that "[t]hrough such social relations or through social networks in general, an actor may borrow or capture other actors' resources (e.g., their wealth, power or reputation) to then generate a return".

This notion of capturing, as a war-like metaphor, implies the existence of inequalities, power differentials and hierarchies within systems, which has yet to be touched upon. Typically, social systems are characterised by a hierarchical order. As Burns (2006:417) argues, "an institution defines and constitutes a particular social order with positions and relationships, defining in part the actors (individuals and collectives) that are the legitimate or appropriate participants (who must, may, or might participate) in the domain, their rights and obligations vis-à-vis one another, and their access to and control over resources." However, to reiterate, RNGOs are not mere instruments of totalising powers which impose development programmes and projects devoid of all negotiation and contestation (Kaplan, 1999). The content and character of networks, and the nodal points constituting them, speak to the form and extent of embeddedness and the ways in which organisational agents are subject to constraints. But these are also factors which might facilitate the possibilities of agency (and

hence contestation) on the part of development agents such as RNGOs, which find themselves in an intermediatory location within the development system. Yet, it is indeed the case that social systems, institutional arrangements and network-based relations (including with reference to the worldwide development system) are infused with power relations and differentials.

2.4 Conclusion

This chapter has offered a conceptualisation of development, and specifically of the worldwide development system as 'big D' development. While the modernisation theory of 'little d' development is problematic and also tends to treat intentional development as almost devoid of power differentials, the more Marxian analyses of 'little d' development tends to treat the world-wide development system as a totalising system marked by unilateralism. Undoubtedly, this world-wide system is characterised by inequalities and subordination, but it is not a totalising system as there is space for maneouvering and contestation. In this context, the chapter went on to offer an eclectic or blended theoretical framing (based ultimately on systems theory) for purposes of analysing the world-wide development system and, in particular, the locations and practices of RNGOs in this system in relation to the HIV response in the southern African region.

This framework conceptualises NGOs and specifically RNGOs as organisational forms capable of social agency within an institutionalised social system of development. The system is marked by multi-layered social networks, with the multi-layered character implying the prevalance of some sort of hierarchical arrangement. The RNGO sector represents one sub-system within the overaching system with each and every RNGO embedded or nested as a node within social networks of both a horizontal (for instance, within the RNGO sector) and vertical kind (including upward relations with donors and downward relations with the beneficiaries of their programmes). Central to the vertical forms of social networks is the question of accountability and, with specific regard to upward social relations, is the issue of the capacity of RNGOs as development agents to express some degree of autonomy vis-à-vis the demands of donors.

CHAPTER THREE: LOCATING NON-GOVERNMENTAL ORGANISATIONS IN THE ARCHITECTURE OF DEVELOPMENT GOVERNANCE

3.1 Introduction

International development, framed as big D development, as discussed in the foregoing chapter, is a process that occurs within frameworks and locations, and it involves specific social actors and is intended for achieving certain ends. Such a process can either be a result of deliberate attempts at progress through outside interventions, or through people's own efforts to improve the quality of their lives within specific contexts (Thomas 1996). In other words, such development is not a shambolic but a guided process. For this reason, it is critical to discuss the architecture of development governance to provide a context within which to understand development actors and their work, particularly regional non-governmental organisations (RNGOs), the subject of analysis in this thesis. The analysis seeks to demonstrate how there is a hierarchical structure and frameworks that provide a context within which development activities occur at different levels. In addition, it demonstrates how layered development actors are positioned and coordinated through principles that govern operations at different levels: global, regional and national. In this process, the influences of both local and global philosophies of regional programming are debated to arrive at some picture of a region and regionalisation, and how they link to the HIV response in the Southern African Development Community (SADC).

3.2 Framing Global Development Governance

The HIV and AIDS response has to be understood in the context of a vertical system of social relations and a hierarchy of policy influence obtaining from a gradation of three main institutional arrangements located at the global, regional and national levels. It is my submission in this regard that institutional arrangements at these levels constitute the main context of development policy influence, thereby determining resource flows from richer nations of the world to those needing development assistance. In other words, even though there may be spontaneous and less regulated/compliant processes of development, a global development governance structure exists that determines the course of development and the nature and distribution of its product. In this context, I examine the concept of global governance generally and link it to the HIV response in the SADC region.

3.2.1 Defining governance

The concept governance is defined in different ways, but it is not the intention to enter into the elaborate debates, save to simply offer a conceptual framework that enables the examination of development governance especially in the HIV response at different levels – global, regional and country. The analysis is intended to further locate NGOs and especially RNGOs in the spaces, structures and processes of development, and illustrate their embeddedness and how that influences their operations and practice of *being regional*.

Folke et al. (2005:444) define governance as "the structures and processes by which people in societies make decisions and share power" to resolve issues they confront in their life. They add that it involves a triumvirate of activities: providing a vision and direction for sustainability, management of operations to operationalise the vision, and monitoring and evaluation to obtain feedback and synthesise the observations into "a narrative of how the situation has emerged and might unfold in the future" (also Boyle et al., 2001). Hence, governance involves structures, relations and processes that are not only negotiated among those involved but intended for a purpose, thus becoming the "locus of active production of certain agency in relation to an actor" (e.g. an NGO) "through a dynamic process of engagement" (Seckinelg, 2005:353). This means that governance is a framework for social agency as earlier defined in chapter two.

However, social agency depends on various other resources such as social capital and the ability to mobilise and manage the resources for the exercise of power (Bellucci, 2002:16). In this sense, governance is presented as a process of organising and controlling both resources and structures to effect some form of authority over social groupings, processes and their outcomes. The exercise of such authority is determined by the participation of different social actors who, according to Millstein (2015:7), may be CSOs actively raising "issues at the regional level to put pressure on their national governments, and concurrently influencing the character of regional decision-making with national interests and identities." The underlying assumption in this case is that governance structures are inclusive, and where they are less so, social actors actively seek spaces to participate in these structures and influence the decision-making processes.

Bartsch and Kohlmorgen (2007:8) add that in the case of global governance, the process would embrace both "normative aspects that relate to how global governance should be and empirical-analytical ones which try to describe and understand the origins, complex characteristics and the dynamics of global politics and regulations." In this case, they view global governance as comprising "non-hierarchical forms of regulation and cooperation" (as

in some bilateral arrangements), "but also power structures and hierarchical top-down processes" (such as is the case with the United Nations (UN) system of international development). The global system of development governance, including health governance, is political to the extent that it involves social actors' engagement over focal issues, as well as actors' socio-economic and relative positions in terms of proximity to the centre or periphery in the governance structure, elements which for Thomas and Wilkin (2004: 243) say determine actors' say in global affairs (also Schrijver, 2006:9).

In addition, not only does this create hierarchies and power structures but it leads (first of all) to the development of a tiered order (global, regional, national, local) (Rosenau 1997; Jessop 2004; Hooghe/Marks 2004). Secondly, it begets a new configuration of social actors (UN agencies vis-à-vis regional and national state bodies, regional vis-à-vis national state bodies, donors vis-à-vis recipient organisation state or non-state organisations, and international NGOs (INGOs) and southern NGOs (SNGO) (Bartsch and Kohlmorgen, 2007:8). In other words, governance represents an inter-play, of not only different actors, structures and power relations, but interests and resource bases which determine issues that are discussed and whose ideas will prevail in policy development and implementation. It is characterised by contestations, even within the formal structures, as those involved leverage on their resources to determine policy directions and outcomes at the global, regional and national levels. I now explore the architecture of governance at the global level to illustrate this point and turn to other levels later.

3.2.2 Global Governance Architecture

From 1945, not only was international cooperation for development initiated but, in doing so, a global governance system (within which development took place) arose and became entrenched. This provides a critical context for development processes comprised of policy frameworks, financial assistance and trade regimes, administered by the UN through its Economic and Social Council (ECOSOC) (1945, UN Charter), but as influenced by its Member Countries including a wider range of non-state actors. These Member Countries, especially from the global North, are the key financiers of the organisation. These social agents converge to seek solutions to development challenges.

Bartsch and Kohlmorgen (2007:8) describe global governance as "a process of dealing with problems and – if possible – of problem-solving," (also Tully (2002:539). This resonates with the UN mandate as spelt out in its 1945 Charter which incorporates solving problems of war and peace through the security council, addressing matters of justice through the

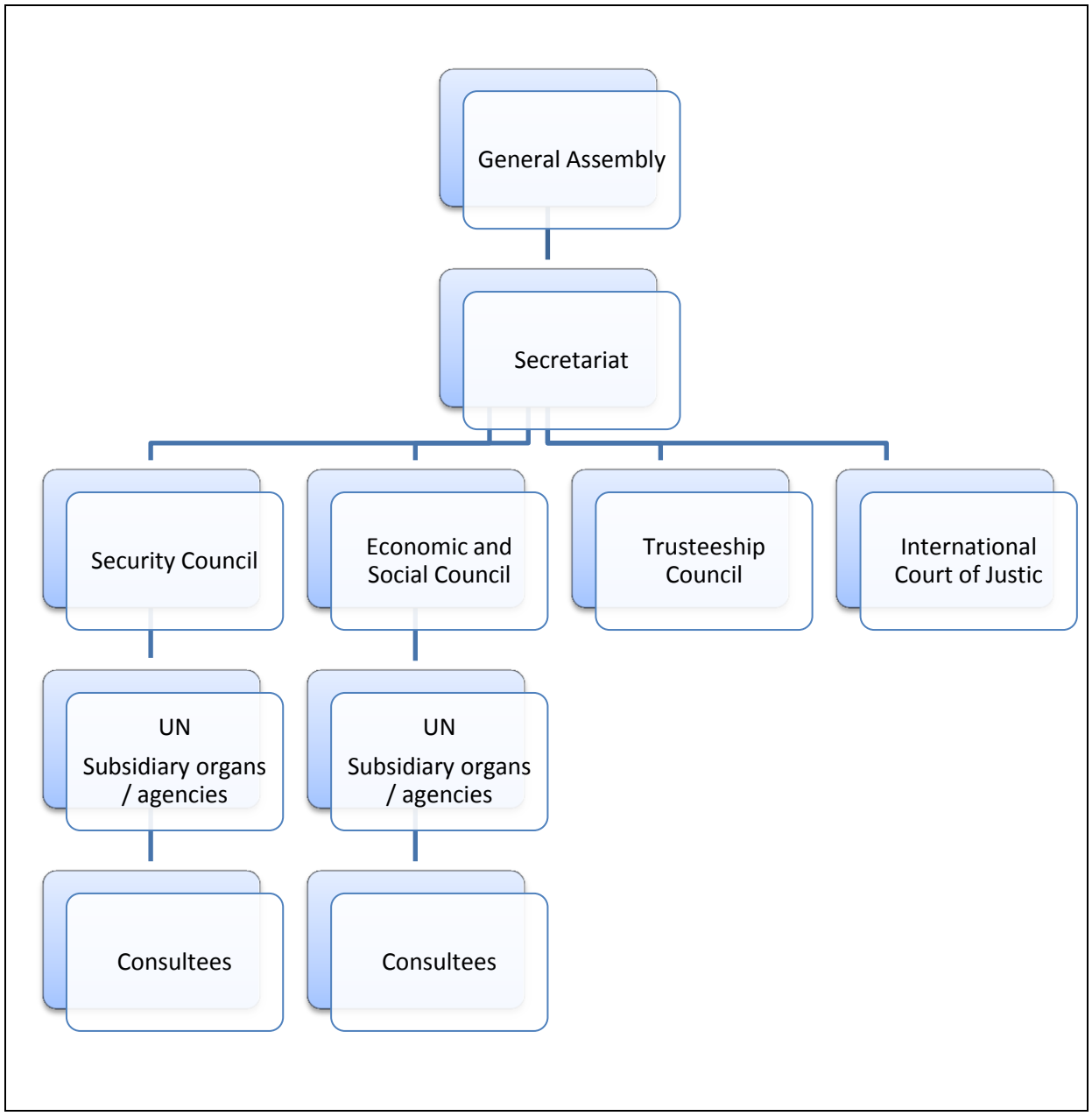
international court of justice, and resolving economic, social and cultural challenges globally through the ECOSOC generally. In addition, it also speaks to the idea of development governance conceptualised as a process of transforming economies and societies through local and foreign capital investments, technological transfers and elimination by substitution of 'decadent' cultural practices in less developed countries (Lall, 1975:800). As a result, development governance and actors are systematically located in webs of hierarchical and lateral social relations within which social transactions for development occur.

The UN Charter (1945) and subsequent UN declarations establish and institutionalise a global governance regime, making it the core and compelling fact of international relations and development in all spheres of human life globally. The degrees of conformity to the dictates of the UN Charter and associated constraints may vary markedly among Member States and sectors of society, but the influence is omnipresent, ordering development matters including the management of public health challenges generally and HIV and AIDS specifically.

The UN, as the world governing body constituted by 192 Member Countries, is an embodiment of the commitments of its members after World War II. These commitments are to maintain international peace and security in conformity with the principles of justice and international law, based on respect for the principle of equal rights and self-determination of peoples (Article 1.1-2). In addition, UN efforts are directed to "achieve international cooperation in solving international problems of an economic, social, cultural, or humanitarian character, and in promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion" (UN 1945 Charter, Chapter 1, Article 1. 3). These objectives broadly set the global agenda for governance and development and a framework for engagement on human development. Specific reference will be made to health but especially HIV in later parts of this chapter.

The UN structure as constituted in Article (7.1-2) and illustrated in Figure 3.1 is one-step towards operationalising these broad objectives. It enshrines the principles of engagement and devolution of rights, authority and prerogatives between the UN and its four principal organs which operate under the General Assembly through the UN Secretariat, the administrative and coordinating arm of the organisation. The General Assembly is the supreme governing body of the organisation comprised of its Member States, who deliberate and take policy decisions on all UN business tabled through the Secretariat from agencies through the principal organs of the UN.

Figure 3.1: The UN Governance Structure



Source: Compiled from the UN Charter (1945).

There are four principal organs: the Security Council (SC), the International Court of Justice (ICJ), the Economic and Social Council (ECOSOC) and the Trusteeship Council (TC). Operating under each of these principal organs is a set of subsidiary organs/agencies that work with a whole range of development partners, state and non-state. Table 3.1 illustrates the agencies that operate under the ECOSOC, including a wide range of organisations that can be engaged by the UN system as both consultees or contracted as development partners.

Table: 3.1: Illustration of UN System Actors Alignment

Principle organ	Subsidiary organs or UN agencies	Consultees		
		Intergovernmental organisations	***International NGOs***	***Regional NGOs***
Economic and Social Council (ECOSOC)	✓ UNAIDS, ✓ UNDP, ✓ WFP, ✓ UNESCO, UNICEF, ✓ UNFPA, ✓ UN Women, ✓ WHO, UNESCO	➢ African Union (AU) ➢ North Atlantic Treaty Organisation, (NATO) ➢ European Union, (EU)Southern Africa Development Community (SADC)	✓ RED CROSS ✓ Plan International ✓ Action Aid ✓ Voluntary Services Overseas (VSO) ✓ Save the Children	○ Africa Capacity alliance (ACA) ○ Southern Africa AIDS Trust (SAT) ○ Regional Psycho-social Initiative (REPSSI) ○ AIDS Rights Alliance for Southern Africa (ARASA)

Source: Own compilation.

The UN Economic and Social Council (ECOSOC) leads and coordinates development and socio-cultural matters. It is the custodian of Article 1.3 of the Charter that provides for the management of international socio-economic cooperation for development and reports to the UN General Assembly, constituted under the UN Charter (Chapter X). This is a sector-specific arrangement, and primarily an international development technical assistance and policy guidance mechanism to serve UN Member States, as informed by the UN General Assembly (Coscia et al., 2013).

In addition to the UN subsidiary agencies, there are various auxiliary yet critical organisations that have been created to support international development, and they have a direct influence on world-wide development. In line with the post-world war II development agenda, the International Monetary Fund (IMF), the World Bank (WB) (formally International Bank for Reconstruction and Development) and later with specific reference to HIV, the Global Fund for AIDS TB and Malaria (GFATM) – a funding mechanism for financing the HIV response globally – were established by UN Member States (Coscia et al., 2013). The World Trade Organisation (WTO) (hitherto the General Agreement on Tariffs and Trade (GATT) was established (Willis, 2011:40) to provide the framework for regulating the flow of goods and services globally (including HIV medication) and patents rules that govern the reproduction of branded technologies including cheaper generic drugs and their distribution to poorer and needy countries (Milner, 2005:533).

According to Batliwala (2002:394), these institutions have great and "growing influence on the economic, health, development agenda[s], and policies of individual nations —especially poor nations". More importantly, owned and driven by UN Member States, these organisations are linked to the UN development system, usually providing technical assistance to UN bodies through contractual arrangements such as is the case with the WB and UNAIDS discussed later in this chapter. In other words, they serve as consultees as well and offer sector specific technical support to the UN agencies.

In addition, the UN subsidiary organs engage various regional organisations (ROs) – state and non-state – to address matters specific to their operational location or specialty (Zyck, 2013; Riggirozi, 2012). The UN Charter (1945) recognises regional organisations (ROs) as potential partners (specialised agents) in UN business in relation to the operation of the UN Security Council under Article 57, as well as the ECOSOC in terms of Article 63.

The existing definitions of ROs as discussed in chapter one exude the influence of the UN's concerns with peace and security and its state-centric approach to global governance. It focuses largely on inter-governmental organisations (IGOs) which were deemed the key players in dealing with matters of international peace and security, and later extending into socio-economic matters (Schrijver (2006). As noted in chapter one, these organisations are legally established supra-national bodies intended for fostering cooperation "among states seeking common belonging to a geographical space, a geopolitical entity, or an economic bloc", (Laruelle and Peyrouse, 2012:5; Zyck, 2013a:6; 2013b:2). From this perspective, a regional organisation is a regional inter-governmental organisation (RIGO) such as SADC, as listed in Table 3.1.

The legal instruments establish the *de jure* regional bloc (usually called by the name of the supra-state body) and also set the basic operating principles of *supremacy* and *subsidiarity* as with the UN system. These RIGOs are complex inter-state institutionalised social systems to the extent that they include a governance structure and system of rules of membership, internal and external operational processes in relation to Member States and significant other players. The regional bloc over which they preside is a nucleated social network system that comprises an amalgamation of states and people (Nathan, 2010).

Nonetheless, this is a limited conceptualisation of ROs to the extent that it refers only to RIGOs and excludes a whole range of other ROs currently involved with the UN in terms of the UN Charter Articles 57 and 63, and related provisions under the ECOSOC. RIGOs are only part of diverse typologies of ROs recognisable by the nature of their composition, function, role, location and relations with the world system of social organisation. Literature

on regional organisations (Laruelle and Peyrouse, 2012:5; Zyck, 2013:10; Nathan, 2010; Zyck, 2013:11) restricts the definition of ROs to RIGOs, excluding many other bodies that emerge to operate and address issues at the regional level. The majority of these organisations are non-governmental, constituted separately from RIGOs. They encompass international NGOs (INGOs), a variety of donor regional teams, market related entities and regional NGOs, (RNGOs).

The largest variety of ROs is non-governmental organisations (including INGOs), academic research service organisations, market related bodies such as employer associations (not industrial concerns) and CSOs as defined in chapter four. They represent diverse interests for which they seek regional level solutions, and/or provide services to both international and country levels, only possible from the regional level, as shown in more nuanced discussions in chapters seven to nine based on the case studies for the thesis.

Among ROs there are both state and non-state actors largely focussed on regional issues or general inter-state matters and challenges. The intergovernmental organisations are largely engaged (separately from the proceedings of the UN General Assembly) on specific regional matters or indeed inter-regional matters that affect them. Although the UN structure was largely designed as a mechanism for engaging state actors, the UN Charter (1945:13-14) Article 71 provides for the engagement of NGOs as follows:

> *The Economic and Social Council may make suitable arrangements for consultation with nongovernmental organizations which are concerned with matters within its competence. Such arrangements may be made with international organizations and, where appropriate, with national organizations after consultation with the Member of the United Nations concerned.*

International NGOs are registered for consultative purposes and engaged through the ECOSOC (UN Charter, 1945) to contribute to sector-specific debates on responses to development challenges, but they do not have the right of participation in the UN General Assembly where UN global declarations and policies are made. These non-state actors are also engaged by UN subsidiary organs (usually separately and for their expertise) including major INGOs (some of which are listed in Table 3.1). These are organisations that operate development and humanitarian assistance programmes throughout the world, some of whom are also engage directly with the ECOSOC in its consultative processes.

In addition to these international non-state agents, there are RNGOs which emerged in the HIV response from the 1990s. These serve as both consultees and implementers of programmes initiated, funded and/or coordinated by the UN subsidiary organs. They are

organisations that have direct contact with community implementers or are themselves implementers of intervention programmes at the regional and community levels as illustrated later in the thesis (Chapters 7 - 9). Some of these organisations, in the case of those in the HIV sector, are consulted by the UN subsidiary organs directly in programme coordinating boards such as the UNAIDS PCB discussed later in this chapter.

According to Schrijver (2006:18), by the late 1940s, the UN was already establishing its first programmes for technical aid and programmes of grants in pursuit of this objective. Some of the first ECOSOC subsidiary organs established to undertake operational activities and address developing countries' concerns under its newly formulated programmes were the World Food Programme (WFP), United Nations Conference on Trade and Development (UNCTAD), United Nations Development Programme (UNDP), and United Nations Industrial Development Organisation (UNIDO) (Schrijver, 2006). There is also the Joint United Nations Programme on HIV/AIDS and AIDS (UNAIDS), United Nations Education Scientific and Cultural Organisation (UNESCO), United Nations Population Fund Agency (UNFPA), United Nations Women (UN Women), United Nations Children's Fund (UNICEF) and the World Health Organisation (WHO). Table 3.2 presents a larger list of the existing UN ECOSOC subsidiary organs all of which are thematically focussed.

Table 3.2: Subsidiary Organs by Focus Area

Principal organ	Subsidiary organ	Focus area
Economic and Social Council (ECOSOC)	UNDP	Coordination of global development
	UNFPA	Global population matters
	UN Women	Gender, women's right and developemnt
	UNICEF	Children's rights, education and development
	UNESCO	Education, Science development and culture
	WFP	Global food and food security
	UNCTAD	Trade and development issues
	UNEP	United Nations Environment Programme
	UNIDO	Global industrial development
	WHO)	Global health matters
	UNAIDS	Global response to HIV and AIDS

Source: Own complilation.

These subsidiary organs function as technical support in their areas of expertise and provide policy directions on development throughout the world (Spicer et al., 2010). They interact with inter-governmental and non-governmental organisations at different levels engaged in different UN development programmes and in various capacities depending on their competencies and expertise in addition to direct engagement with member countries

bilaterally. As part of that engagement, UN subsidiary organs are the principal implementers and monitors of UN work at all levels, accounting to the UN General Assembly through the respective principal organs (Coscia et al., 2013).

In other words, they receive and carry out respective UN policy directives with relevant social actors down to the regional and country levels where intervention programme implementation occurs. This does not only create a hierarchical governance structure but also a largely state-centric development regime: providing for engagement with Member States through its principal and subsidiary organs at the regional and country levels, and in the UN General Assembly. Its principal organs either engage directly with Member Countries or through inter-governmental bodies such as the African Union and SADC.

However, the organisation also engages NGOs as peripheral components of the structure and processes of the General Assembly where Member States engage the UN directly. NGOs are engaged through the ECOSOC at the highest level and by the latter's subsidiary organs at the regional level only to serve in consultative processes (Lewis and Kanji, 2009) and as programme implementers in areas of their competence as illustrated by the UNAIDS discussed later in the chapter.

The participation of RNGOs in these processes is only as old as the beginning of their efforts to define their niche in regional programming and governance structures. The engagement trajectory in terms of the operations of the ECOSOC is more direct with international NGOs (which are largely from the global North) than it is with RNGOs (largely from the global South), yet some of the RNGOs actually have grassroots constituencies and therefore could provide better linkage with issues at that level. Much of UN/NGO engagement has been characterised by advocacy and demand for greater participation and influence on the structures of the UN system globally.

Gradual changes in levels of NGO participation have, however, began to occur following the UN Conference Decade which affirmed "the right of non-governmental actors to participate in shaping national and global policies on the environment, population, human rights, economic development and women" (Batliwala, 2002:394). Seckinelg (2005) and Abbott and Gartner (2012) among others state that even though greater efforts are being made especially within the HIV field to provide for non-state actors' participation, the process remains variable and mostly peripheral and limited to NGOs serving as donor subcontractees for service delivery. Jönsson (2009) observes that NGOs are unequal partners without voting rights in UNAIDS but they have equal status on the Global Fund's board where, on the other hand, UN agencies are non-voting.

This further illustrates how NGO spaces for participation in global development governance process are still emerging and being defined as opposed to state actors that have clear spaces and lines of engagement as noted earlier. In this context, I discuss the Joint United Nations Programme on HIV/AIDS (UNAIDS) not only to further illustrate this point and elaborate on the governance structures, but do so with a specific turn to the HIV and AIDS response, the main focus of the thesis.

3.2.2.1 The Joint United Nations Programme on HIV/AIDS

The Joint United Nations Programme on HIV/AIDS (UNAIDS) is the UN ECOSOC specialised organ on HIV and AIDS, that is, a combination of efforts from various UN subsidiary organs desribed as co-sponsors for their primary contribution in the organisation to fight HIV. UNAIDS is the only UN subsidiary organ constructed around a specific health issue – HIV (Ellison and Porter, 2013). Established in 1994 through a resolution of the UN ECOSOC and made operational in January 1996, the UNAIDS was born out of the UN's recognition that the HIV and AIDS epidemic was a global problem affecting all countries and needing an immediate and coordinated response (ECOSOC Resolution 1994/24). Its role is to provide a framework, leadership and mobilise resources for the global HIV and AIDS response at all levels: country, regional and globally. In pursuit of this mission, UNAIDS functions are constructed around six specific objectives presented in Box 3.1.

Thus, the global architecture of the HIV response is not only rooted in the UN global development system but is driven by a specialised UN subsidiary organ that provides an international framework, leadership and technical support to the UN system and national governments, and mobilises human and material resources for coordinated global responses to the epidemic.

Box 3.1: UNAIDS Objectives

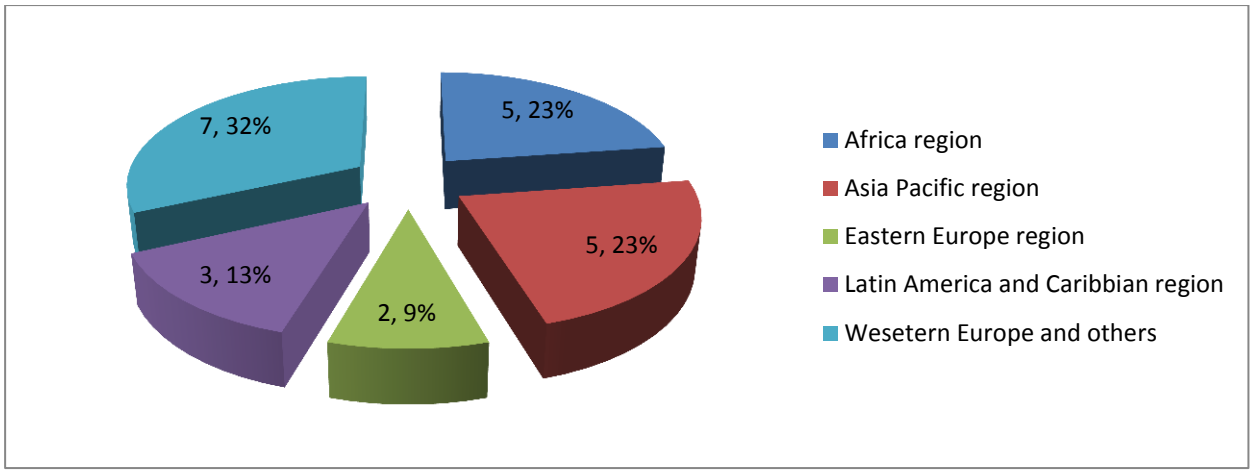
1. Provide global leadership in response to the epidemic;
2. Achieve and promote global consensus on policy and programmatic approaches;
3. Strengthen the capacity of the United Nations system to monitor trends and ensure that appropriate and effective policies and strategies are implemented at the country level;
4. Strengthen the capacity of national Governments to develop comprehensive national strategies and implement effective HIV/AIDS activities at the country level;
5. Promote broad-based political and social mobilization to prevent and respond to HIV/AIDS within countries, ensuring that national responses involve a wide range of sectors and institutions;
6. Advocate greater political commitment in responding to the epidemic at the global and country levels, including the mobilization and allocation of adequate resources for HIV/AIDS-related activities.

Source: http://www.unaidspcbngo.org/about/un-and-unaids/ accessed on 15-08-2016.

3.2.2.1.1 Composition, Structure and Function of the UNAIDS

The UNAIDS is comprised of a secretariat that runs the administration of the organisation and a Programme Coordinating Board (PCB) that presides over and coordinates 22 Member States (government representatives) that are drawn from five regions (Figure 3.2) to represent the rest of the 192 UN member states throughout the world. Of the 22 regional representatives of the UNAIDS, the largest groups (32%) are in 'Western Europe and others', while only 23% each are in the African and Asia Pacific regions. Each of the regions comprise the specific areas of operation for the UNAIDS team globally, from which it launches its contextualised leadership and coordination as well as policy and programme technical support efforts. In addition to deploying its support to these regions, the UNAIDS collects inputs from these regions to feed into the work of a technical committee of co-sponsors established in terms of ECOSOC Resolution 1994/24. Initially only the top six co-sponsoring UN agencies in Table 3.3 were mobilised into the PCB, but the list expanded to the current eleven between 2002 and 2012, as greater understanding of the epidemic revealed the need to incorporate players from other sectors (including labour, nutrition and food security, displaced people and gender) to strengthen the response.

Figure 3.2: Regional Distribution of PCB members



Source: Compiled from http://www.unaidspcbngo.org/about/un-and-unaids/ accessed on 15-08-2016.

These organisations are called co-sponsors because their mandate is not only to urgently and fully mobilise and coordinate all UN system organisations and other development partners in the global response to HIV/AIDS (UNAIDS, 2016), but to provide technical support, raise and provide resources for the HIV response.

Table 3.3: The UNAIDS PCB Co-Sponsors by Year of Admission to the PCB

Co-sponsor	Admission
UNICEF: United Nations Children's Fund	1995
UNDP: United Nations Development Programme	1995
UNFPA: United Nations Population Fund	1995
UNESCO: United Nations Educational, Scientific and Cultural Organization	1995
WHO: World Health Organization	1995
WB: The World Bank	1995
UNODC: United Nations Office on Drugs and Crime	1999
ILO: International Labour Organization	2002
WFP: United Nations World Food Programme	2003
UNHCR: United Nations Refugee Agency	2004
UN Women	2012

Source: http://www.unaidspcbngo.org/about/un-and-unaids/ accessed on 15-08-2016; Seckinelg, (2005:353).

These are mobilised according to the comparative advantages of each organisation, to provide technical support to countries and to divide leadership around technical support areas in working together with UNAIDS.

Each co-sponsor holds a continuous seat on the PCB. According to the UNAIDS, the co-sponsors have "full rights of participation" in the PCB, but do not have voting rights on matters debated by the PCB as they only provide technical support and mobilise various

sectors to deliberate on the epidemic and the responses at different levels. In addition to the committee of co-sponsors, there is a group of five NGOs chosen every year (including those representing people living with HIV) to represent civil society in the PCB consultative processes. Like the co-sponsors, NGOs on the PCB do not have the right to vote, but do actively participate in debates and make proposals at the Board's meetings to contribute to the PCB annual meeting that decides on the content and strategies for the response to tackle HIV.

As noted by Ellison and Porter (2013:4-5), the structure of UNAIDS is intended to create a comprehensive global approach to prevention and treatment of HIV/AIDS. UNAIDS' conceptualisations and structure also reflect the exceptional nature in which the epidemic was understood in terms of its spread in various sectors, intensity in affected areas, and the panic it induced throughout the world, what Seckinelg (2005:353) calls the 'globality' of HIV. However, like in all structures of the UN, civil society participation in the UNAIDS remains consultative and peripheral to the actual decision-making process; for example NGOs are not only few (five only) on the PCB but are denied the right to vote.

Therefore, although spaces for engagement and interface with other development players (the state representatives and co-sponsors) are provided, NGOs remain restricted to consultative processes rather than decision-making, even though they work directly with the grassroots and are celebrated as a more efficient 'third sector' as earlier noted (Vivian, 1994). Seckinelg (2005:361) states that even though NGOs are considered important as a 'link' with communities for policy implementation, "this link becomes disarticulated in the policy context" for HIV governance. This means NGOs do not (but regional state representative) determine absolutely the content of the HIV responses that the PCB produces and utilises as guidelines to the intervention in the areas of its operations. It is important therefore to explore (in the next subsection) some of the ideas which come packaged as key components of the response as delivered by the UN system generally but UNAIDS specifically.

3.2.2.1.2 The UNAIDS Frameworks for the HIV Response

According to Seckinelg (2005:356), the UN General Assembly meeting on HIV in June 2001 placed the disease prominently in the international policy agenda for development and human rights. In so doing it directed international focus on HIV and paved a way for policy frameworks to guide global interventions through the UNAIDS. The UNAIDS approach to the HIV epidemic is informed by the panic which characterised the initial days of the pandemic and takes a largely medical approach which gives greater emphasis to testing, treatment and prevention, leaving aside the social components that characterise community

HIV responses. It is largely geared towards managing and eliminating HIV medically and hence the emphasis on the three 90s treatment targets for 2020: "90% of people living with HIV know their HIV status, 90% of people who know their HIV-positive status are accessing treatment and 90% of people on treatment have suppressed viral loads." (UNAIDS, 2018:20) These targets are intended to contribute toward ending AIDS by 2030.

In terms of prevention, the organisation emphasises voluntary testing and counselling, treatment for viral suppression, medical male circumcision, male and female condom use, microbicides, and it promotes other technologies to prevent the spread of the epidemic, (UNAIDS, 2015). As well, because more than ever before, experience and research have demonstrated the link between behaviour and the transmission of the virus as well as the management of treatment (SADC, 2006), the organisation now promotes and applies a multi-dimentional approach that has seen increased investment in the social sector to provide supportive services (home-based care and support, and behaviour change programmes that address issues of culture and rights for example) in prevention and treatment. It promotes human rights in relation to the eliminating of HIV related stigma and discrimination, and gender equality in addition to the support for treatment of those infected and affected by HIV.

Some of the specific instruments utilised to address the social issues driving the spread of HIV and/or undermining HIV prevention, treatment and care are listed in Table 3.4. These instruments cover matters that in some countries become centres of contestation between civil society and the state (gender rights, gay and lesbian rights for instance) and hence create a niche for regional NGOs which can make use of the broader regional platforms, such as SADC. At these fora, RNGOs engage both the regional governmental organisation and its member-states, and other regional players to seek changes in the areas of cultural practices, human, gender and sex, and sexuality related rights to facilitate the delivery of health services.

Table 3.4: UN Commitment to Resolving the HIV Crisis

Year	Declaration/framework	Initiator	Key focus area
2001	Declaration of Commitment on HIV/AIDS, adopted by the General Assembly at its 26th special session;	UN General Assembly/UNAIDS	Global commitment to resolve the HIV crisis
2006	Political Declaration on HIV/AIDS, adopted by the General Assembly in resolution 60/262;	UN General Assembly/UNAIDS	Political Commitment to fight HIV
2011	Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV/AIDS (A/RES/60/262).6	UN General Assembly/UNAIDS	Commitment to intensify fighting HIV
2015	The UN Sustainable development Goals	UN General Assembly/UNDP	Commitment to reduce infection and eliminate some of the drivers
2016	Political Declaration on HIV and AIDS	UN General Assembly/UNAIDS	Commitment to reduce HIV infection and end AIDS

Source: Ellison and Porter, (2013:5); UN General Assembly, (2001, 2006, 2011 and 2015).

The 2006 joint UNAIDS/SADC sponsored Maseru Think-Tank Meeting is one such regional forum that was used to identify the key drivers of HIV in SADC and to develop a road-map for addressing the drivers of the epidemic (SADC, 2006). The road-map document became a guide for SADC countries to facilitate changes in areas of cultural practices, human, gender and sex and sexuality related rights. At the regional level, and within the context of this global framework, HIV responses reflect the spirit of these political commitments to resolving the HIV pandemic.

The frameworks are tailored to the demands of the HIV situations in each context, to the extent that it is possible to incorporate the contributions of regional representatives in the PCB consultative meetings and the adoption of the contextual issues in the response programmes. Some of the specific contextual factors include multiple and concurrent sexual partnerships in the context of inconsistent and incorrect use of prevention technologies such as male and female condoms, and negative gender dynamics that make women vulnerable to sexual abuse and fail to prevent themselves against HIV (SADC, 2006).

In addition to these HIV specific instruments (Table 3.4), the UNAIDS' work is guided by issue-specific instruments that facilitate the creation of a favourable HIV programming environment. The issue-targeted instruments provide frameworks for addressing socio-economic, cultural and political challenges that hinder the roll out of

effective HIV interventions, or facilitate the transmission of the virus – this is done with the support of technical support from relevant UN co-sponsors presented earlier in Table 3.3. Table 3.5 presents some of the specific international guidelines that are utilised in advocacy to tackle inequalities in HIV responses including stigma and discrimination.

These instruments form a framework for UNAIDS' advocacy work on various forms of rights in the HIV response. The instruments also constitute the basis on which NGOs, at different levels, engage governments, intergovernmental organisations, donors and other stakeholders on issues of rights in the response at the country, regional and international levels to demand representation in various HIV governance structures, motivate for equal access to funding and medication, and seek to provide opportunities in respect of specific constituencies such as women, sex workers, the disabled, lesbians, gays, bisexual, trans-gender and the intersex (LGBTI).

Table 3.5: UN Auxiliary Instruments for Dealing with HIV Related Discrimination

Year	Declaration/framework	Initiator	Key focus area
1948	The Universal Declaration of Human Rights (UDHR) as well as a range of human rights and health-related instruments	UN General Assembly	Universal Human Rights – all areas
1966	The International Covenant on Economic, Social and Cultural Rights	UN General Assembly	Economic, social and cultural specific rights
1966	The International Covenant on Civil and Political Rights	UN General Assembly	Civil and political rights
1979	The Convention on the Elimination of All Forms of Discrimination against Women	UN General Assembly	Gender rights with specific reference to women

Source: Ellison and Porter (2013:5).

As later chapters (7-8) will illustrate, a number of RNGOs are focused around the advocacy for and representation of these social groups.

In this light, Ellison and Porter (2013:13) states that "the central concept in the existing human rights framework is the idea of non-discrimination, which, together with equality before the law and equal protection of the law without any discrimination, constitutes a basic and general principle relating to the protection of human rights." Consequently, "the discrimination of persons with HIV is therefore a violation of human rights that should be addressed as such within international and domestic law." In this case, the major preoccupation of regional state and non-state actors in the HIV response is to have these

frameworks signed and domesticated by UN member states in order for them to be implementable in-country.

National governments choose international frameworks they domesticate depending on their national considerations arising from their local contexts; this includes their prevailing local cultural practices and their impact on the spread of HIV as well as the prevailing economic situation. The domestication of UN frameworks is on the level of a policy interface between the global body and regional and national bodies. The various NGO and community campaigns based on these frameworks and their mainstreaming into HIV programming constitute a lower level operationalisation of the instrument translating into NGO and community HIV programming. This confirms Seckinelg's (2005:356) observation that in terms of the policy context, "the role of civil society is to act as a conduit between policy structures and the people", implementing policies formulated at the higher echelons of the HIV governance structure. Nonetheless, it may be beneficial to examine what rules of engagement the UN utilises in its interfaces within the overall governance structure, which I now address.

3.3 The UN Principles of Engagement

This section first discusses the UN principles of engagement in relation to its interface with state and state-related bodies in the context of problem resolution. This is intended to demonstrate when and how engagement at each level, regional or country, is deemed necessary in the operations of the UN system; but this is also applicable to the work of other development agents especially regional NGOs (RNGOs). The discussion also leads to the comprehension of the determination of what constitutes regional work as discussed later in the thesis.

The UN institutionalised the principles of *supremacy* and *subsidiarit*y as the basis for the management of international and inter-country relations, and the devolution of power and responsibilities in the management of peace and security and development within the UN framework (Article 52 and 53). There is debate regarding the origins of these principles with some scholars attributing it to the UN while others dig deeper into history and locate it in the Catholic Church particularly the papa encyclicals (Moller, 2005).

3.3.1 The Principle of Subsidiarity

According to Moller (2005:3) the principle of *subsidiarity* originated from papal encyclicals *Rerum Novarum* (Leo XII, 1891) and *Quadragesimo Anno* (Pius XI, 1931); with Tsagourias

(2011:5) taking it back to Aristotle. In its original conception (Pius XI, 1931), the principle meant that "a community of a higher order should not interfere in the internal life of a community of a lower order, depriving the latter of its functions, but rather should support it in case of need and help to coordinate its activities with the actions of the rest of society, always with the view to the common good" (Moller, 2005:3), (also Kritzinger, 2005:8; Zyck, 2013:9). Following its practice in the Catholic Church, the principle was adopted and incorporated as a key governing principle for the United Nations Security Council regarding its peace and security work and engagement with specialised agencies (intergovernmental organisations) and Member Countries (Chapter VIII of the UN Charter).

The principle of subsidiarity is defined and provided for in the UN (1945) Charter which stipulates that:

a) *Nothing contained in the present Charter shall authorize the United Nations to intervene in matters which are essentially within the domestic jurisdiction of any state or shall require the Members to submit such matters to settlement under the present Charter; but this principle shall not prejudice the application of enforcement measures under Chapter VII.* (Article 2.7)

In other words, this Article restricts the authority of the UN to matters that are beyond the domestic domain. In the provision for the powers of the Security Council, the UN further devolves its powers and authority to regional arrangements as follows:

a. *The Security Council shall, where appropriate, utilise such regional arrangements or agencies for enforcement action under its authority* (Article 53.1)
b) *The Members of the United Nations shall make every effort to achieve pacific settlement of local disputes through such regional arrangements or by such regional agencies before referring them to the Security Council* (Article 52.2)

In these three Articles, (2.7; 52.2 and 53.1), the UN positions itself as the institution of last resort, following the exhaustion of regional and sub-regional efforts in dispute resolution.

It thus devolves responsibility and authority to lower level organisations and establishes a hierarchical structure for intervention in matters concerning peace and security, as well as coordination and collaboration mechanisms for maintaining peace and avoiding conflict. Regarding economic, social and cultural matters, this involved providing policy framework guidance and support to facilitate development as provided in Articles 57 and 63 of the UN Charter (1945). Interpretations of this principle abound in existing literature as different scholars position themselves to understand its application in international relations as well as development.

In the case of the UNDP (1999), and in terms of this principle, the responsibility for addressing a crisis should rest with the most 'local' level possible and a "central government should not take on a situation which provincial authorities have the ability to resolve, and a

regional organisation should not address crises which national authorities are able to address." According to Tsagourias (2011), the United Nations would be the final actor to intervene once all subsidiary layers, including regional organisations, have proved incapable of providing a suitable solution. Tsagourias (2011:7) adds that as part of the application of the principle of subsidiarity in the UN Security Council system (SC Resolutions 1373 and 1540), the UN helps "in the establishment of Committees to assist states in the implementation of their obligations." We see this reflected in the SADC in the form of the establishment of SADC National Councils (NC) established in terms of its Constitutive Act to assist national governments to meet their obligations at the national level and for SADC (Nzewi, and Zakwe, 2009:9).

3.3.2 The Principle of Supremacy

Unlike the principle of subsidiarity, there seems to be no other historical genesis to the principle of supremacy except the UN Charter, and the fact that the principle of subsidiarity actually implies it to the extent that it recognises prerogatives of lower arrangements. The UN Charter (1945) provides for the principle of *supremacy* as follows:

> *b. In order to ensure prompt and effective action by the United Nations, its Members confer on the Security Council primary responsibility for the maintenance of international peace and security, and agree that in carrying out its duties under this responsibility the Security Council acts on their behalf.* (Article 24.1).
> *c. The Members of the United Nations agree to accept and carry out the decisions of the Security Council in accordance with the present Charter.* (Article 25).

In these provisions, Member Countries subject themselves to the UN and agree to abide by its rules, perform duties that may be assigned by the UN and carry out its decisions.

In analysing the application of this principle at different levels, Zycks (2013:9) states that the UN principle of supremacy "holds that higher-level decisions or norms, where determined to be necessary, take precedence over lower-level commitments," adding that theoretically such decisions "supersede those of a regional organisation or individual state." In other words, the supra-national and supra-regional roles of the UN have precedence over lower level arrangements. In this regard, 'subsidiarity' and 'supremacy', even if not labelled as such, play a role in shaping the remits and work of regional organisations in the context of global development. This leads to examining regional level governance, not only to illustrate how it connects to the global but to locate RNGOs and their work.

3.4 Regional Level Governance

The analysis focuses first on the UN and proceeds to discuss the Southern African Development Community (SADC). The discussion narrows down to HIV governance and it links to RNGOs in both cases. The UNAIDS engagement with regional level bodies (like SADC, EAC etc.) is outlined and guided by the UN Article 52.1 which provides for the establishment and engagement of non-UN bodies, and arrangements at the regional level, in pursuit of matters consistent with its "purposes and principles." Such purposes are the pursuit of peace and security, as well as international collaboration for economic and social development as provided under Articles 57 and 63. The UN organs engage inter-governmental organisations (IGOs) as provided in terms of these Articles, and they utilise IGOs for as long as such agencies have relevant competencies related to their functions and are brought into a relationship with the UN (UN Charter, 1945).

Regional governance structures are subsidiary to the international level and are an intermediary juncture between the global and the national levels. At this level, there is not only an interplay between the global and regional actors but frameworks are crafted based on the externalities that characterise the region as well as on the priorities agreed on at that level by regional Members Countries, inclusive of both state and non-state social agents. Regional frameworks for development are crafted by regional inter-governmental organisations (RIGOs) which are the governing authorities in regional economic communities (RECs) mandated by their Member Countries with a specific focus on the critical regional externalities that bring them into cooperation, and as shaped by civil society actions.

Like the UN, RIGOs largely seek to exert policy influence on Member Countries to adopt agreed upon set standards and pursue specified regional objectives, politically, economically and socially. In doing so, RIGOs work closely with UN agencies in various areas (including science, health, education, labour, food and agriculture) and they encourage their Member Countries to adopt and domesticate international frameworks and standards set by the UN to guide development including HIV response as earlier noted. In this process, there are variant levels of involvement, participation and influence from stakeholders by different sectors as earlier noted in the case of UNAIDS.

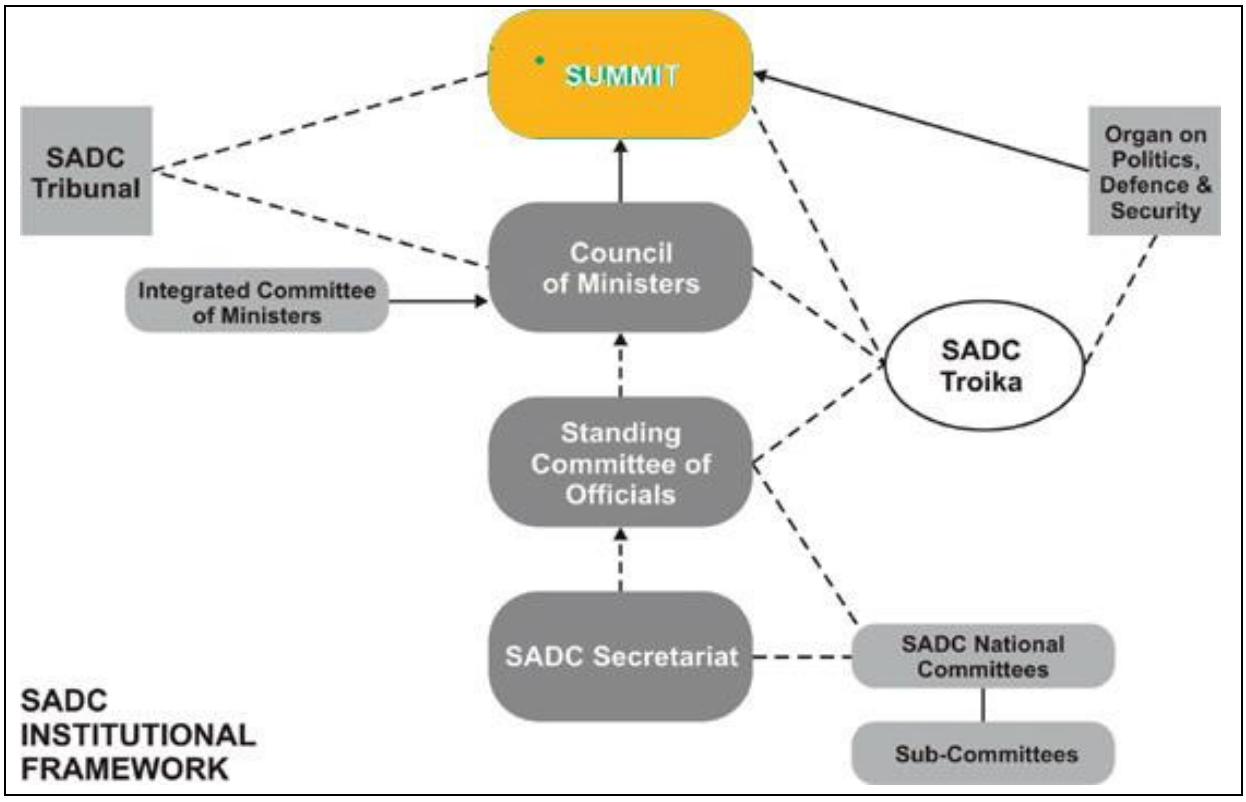
In the Health and HIV sectors specifically, Spicer et al. (2010:2) inform us that there was initially a governance gap at the regional level in the 1990s which pushed regional blocs like SADC to provide mechanisms for engaging Member States and civil society organisations on HIV as part of its development programmes. SADC had identified HIV as a major hindrance to the realisation of the bloc's socio-economic goals that needed to be

resolved (Peter-Berries, 2010:83, Taylor, 2003:7). This brings me to an examination of the SADC governance structure to highlight the mechanisms that exist especially for engagement with NGOs and other non-state actors.

3.4.1 The SADC Governance Structure

The Southern African Development Community (SADC) (the inter-governmental organisation and not the territory) is essentially a state-centric structure designed to facilitate regional governance processes in pursuit of regional integration for peace and development. As such, the engagement mechanisms are largely directed at state actors; at heads of state and government, through the Council and the Integrated Committee of Ministers. There are also four Directorates for: Trade Industry and Finance; Food, Agriculture and Natural Resources; Human and Social Development; and Infrastructure and Development as illustrated in Figure 3.3 (SADC, 2008; Peter-Herries, 2010:74). The Secretariat is SADC's administrative and implementation organ under which are the four Directorates and the Gender Unit. National level structures of the organisation include SADC National Committees and Sub-committees that are intended to ensure that SADC business is carried through.

Figure 3.3: The SADC Structure



Source: Adopted from Peter-Herries (2010:74); SADC (2008).

The organisation operates primarily on two main principles with regards to engagement with national authorities and at the national level. Like the UN, SADC operates on the basis of the principle of subsidiarity (and implicitly supremacy) as earlier discussed and variable geometry. According to Peter-Herries (2010:82), the principle of variable geometry "allows for a differentiated speed of regional integration according to the ability and willingness of member states to comply with a set of economic and political requirements". Some countries might be able and willing to implement these requirements faster than others but, instead of waiting for the 'slower' countries to catch up, the concept of "variable geometry" allows the 'faster' countries to move ahead. By this, "they are setting benchmarks and providing practical experiences." This therefore advocates for leadership by example among member states but also for differentiated levels of integration which may become a refuge for non-performers or those not so willing to change in relation to specific matters (for example gender norms and women's rights).

Generally, SADC engagement with Member States is primarily through its formal structures; through the Summit at the top, Council of Ministers, Standing Committee of Officials and various other committees, the SADC Tribunal and the SADC Organ on Politics, Defence and Security, depending on the issues at stake. Much of its work, though coordinated by the Secretariat, is carried out through the various committees, within which NGOs have an opportunity to participate. Under the SADC Treaty (1992:10) Chapter 7 Article 23 (1-2), SADC acknowledges the importance of NGOs in driving a successful process of regional integration and provides for their engagement in processes of development. It provides semi-institutionalised mechanisms for NGO engagement and participation except through the SADC Council of CNGOs (SADC CNGOs) to the extent that civil society participation in critical technical committee meetings remains at the discretion of the SADC Secretariat.

Box 3.2: SADC Engagement Provisions for NGOs

ARTICLE 23

NON-GOVERNMENTAL ORANISATIONS

1. In pursuance of the objectives of this Treaty, SADC shall seek to involve fully, the peoples of the Region and non-governmental organisations in the process of regional integration.
2. SADC shall cooperate with, and support the initiatives of the peoples of the Region and non-governmental organisations, contributing to the objectives of this Treaty in the areas of cooperation in order to foster closer relations among the communities, associations and peoples of the Region.

Source: SADC Treaty (1992) Chapter 7.

In addition to recognising the significance of NGOs in driving the regional development agenda, the supra-national body provides a variety of instruments to guide development in the region. Like the UN, and as an implementer of UN declarations, treaties and other frameworks, SADC provides leadership to its member states in various areas of development such as economic, social, health, education, political, human rights, peace and security and conflict resolution. I focus however only on SADC leadership directly related to HIV and the work of NGOs.

Like the UN, the SADC, in consultation with its Member States and non-state actors, has developed and deployed a wide range of instruments to deal with the HIV epidemic. Table 3.7 presents illustrative examples that the supra-national body has developed and deployed to guide the response to the pandemic. These instruments capture the spirit and focus of the UN instruments discussed earlier in this chapter. They were developed and deployed in the context of the global and UN guided response to the epidemic, but with special consideration of the epidemic in the region as informed by regional (state and non-state) stakeholders' inputs.

Kasambala and Zakeyo (2014:13, 16) highlight that SADC has various mechanisms of engagement with non-state actors including mainly the SADC Council of NGOs (SADC CNGO). Established in 1998, SADC CNGO is an apex body formally recognised by SADC as the mechanism through which civil society organisations can interact with SADC. In addition, there are several other fora such as the Regional Policy Dialogue meetings organised at the discretion of the SADC Secretariat, and Secretariat

Taskforce/Expert/Ministerial committees through which CSOs can contribute to the policy processes of the supra-national body.

Table 3.7: The SADC Health Sector – Guidelines and Documents

Year	Document	Type	Focus issue	Themes
1999	Protocol on Health	Protocol	HIV/AIDS	Risk management, Health, Pharmaceuticals, Communicable diseases, non-communicable disease, Social and Human development
2003	Maseru declaration on the fight against HIV and AIDS	Documents & Publications, Declarations	HIV/AIDS	Health and communicable diseases
-	Gender mainstreaming guidelines for HIV and AIDS, Tuberculosis and malaria	Leaflet	HIV/ AIDS	Health and communicable diseases
-	Gender mainstreaming guidelines for HIV and AIDS, Tuberculosis and malaria	Documents & Publications, SADC Technical and thematic Reports	HIV/AIDS	Health and communicable diseases
	Checklist for measuring implementation of the gender mainstreaming guidelines in HIV and AIDS, tuberculosis and malaria programmes	Documents & Publications, SADC Technical and thematic Reports	HIV/AIDS	Health and communicable diseases
2009	Regional minimum standards for harmonised approaches to prevention of mother-to-child transmission of HIV in the SADC region - leaflet	Documents & Publications, SADC Technical and thematic Reports	HIV/ AIDS	Health and communicable diseases
2009	Regional minimum standards for harmonised approaches to prevention of mother-to-child transmission of HIV in the SADC region - leaflet	Documents & Publications, SADC Technical and thematic Reports	HIV/AIDS	Health and communicable diseases

Source: SADC at http://www.sadc.int/documents-publications/themes/health/ accessed 22 June 2016.

However, like in the case of the UNAIDS PCB, these are consultative processes that are consolidated by the Secretariat with the upper levels of the organisation's structures particularly the SADC Integrated Committee of Ministers/Sectoral-Cluster Ministers which work in consultation with the SADC Council (Peter-Herries, 2010:77).

3.5 Country Level Governance

The country level is the operational level where higher-level frameworks are operationalised and transformed into time-bound strategies, implementable programmes and plans. It is normally the operational domain of country level NGOs and less so of RNGOs. However, as this thesis later demonstrates, and as earlier stated in chapter 1, some RNGOs do operate at the country level as well. According to the Regional Psychosocial Initiative (REPSSI – an RNGO) Advisor for Resources Mobilization: "There is very little that happens only at the level of the region, it only becomes real when it becomes country and even district where it is being implemented" (KII,13-6-2016). In fact, most service delivery-oriented RNGOs tend to have country level operations executed through their country offices as this thesis illustrates in chapters six to nine. For this reason, this section briefly reviews the country level governance system to locate and explain RNGO work.

Country-level operations, including those performed by RNGOs, are guided by national frameworks. The development of these frameworks is the preserve of national governments who are the designated authorities that preside over national structures and processes of development, in consultation with national stakeholders. At this level, governments respond to both the challenges in their countries in the context of both regional and global pressures/realities regarding the availability of investment capital, commodity markets, and externalities (negative and positive) that require collective effort and partnership to resolve. Individual governments preside over, provide frameworks and participate in national development processes variously, at the national, provincial, district and community levels. In other words, they assume the roles of referee and player, providing policy and strategic plans as well as carrying out development projects at different levels nationally.

With specific reference to HIV, country level governance structures are also constructed around the state in consultation with the private and regional and local NGOs operating in the country but as informed by the UN and regional (e.g. SADC) frameworks on the response to the epidemic. The SADC (1992), in its Constitutive Treaty, places great emphasis on the participation of especially civil society organisations (NGOs) in national governance and development processes, providing for such as noted in the foregoing discussion.

According to Spicer et al. (2010:2), from the late 1980s, national governments with the support of the UNAIDS and the World Bank began to establish the current National AIDS Commissions/Councils to coordinate the national level HIV response (Jönsson, 2009:13). The 2002 Global Fund Country Coordination Mechanisms (CCMs) buttressed these earlier efforts

to promote national level HIV governance structures and processes (Patterson, 2005). CCMs were established to coordinate country funding proposal development for submission to the Global Fund, as well as to broaden the cooperation and participation in decision-making of national stakeholders – state and non-state (including local and regional NGOs with in-country operations), and especially people living with HIV. Jönsson (2009) thus notes that NACs and CCMs were encouraged to cooperate and boost national stakeholders' (especially civil society organisations) participation in governance processes in relation to the epidemic.

However, with specific reference to CSOs, Seckinelg (2005:357) observes that "NGOs and community organizations are brought in to localize global policies." In this way, the governance structures are crafted in a manner that ensures the dominance of global policy frameworks, thus consigning lower level players (both state agents and NGOs - local and regional) to the position of implementers. It also embeds and predisposes these players into varying positions, roles and responsibilities as well as accountability burdens and mechanisms that relate back to who these social actors are and what they do in development. In this context, I briefly discuss accountability as part of governance and development relations to highlight the fact that development actors cannot operate as independent agents as they are components of a system to which they must account.

3.6 Accountability

Accountability is a major component of governance that arises from the fact that social actors who constitute governance structures and network relations 'owe' each other because institutional or network structures are based on social transactions. Social transactions occur in the context of social institutions, described by Burns (2006:417) as outlining and constituting "a particular social order with positions and relationships." The social order "defines in part the actors (individuals and collectives) that are the legitimate or appropriate participants (who must, may, or might participate) in the domain, their rights and obligations vis-`a-vis one another, and their access to and control over resources." In other words, matters of accountability originate from social structures and the accompanying social exchange processes within them, as network members are obliged to explain their utilisation of allocated resources or lack of it.

It is not my intention to offer a nuanced definition of accountability, except for laying a foundation for understanding the relations between RNGOs and donors in the HIV response (as discussed earlier in this chapter, and as illustrated later in the thesis) .Bendell (2006:1) defines accountability as "a state of being obliged" or "willing to accept responsibility" for

one's actions in a relationship between social actors. In this case, accountability is presented as both a requirement and a voluntary process depending on the nature of the relationship and the positions of each social agent. In this sense, AIDSpan (2015:3) elaborates that accountability "involves measures to ensure that the person or organization with the authority to provide a service actually delivers that service i.e. that providers and policy-makers are answerable for their actions, and to demonstrate that they have delivered" (also Edwards and Hulme, 1996, 8). Hence, accountability is directly linked to role, purpose, mandate and function in respect of the relationship between benefactors and beneficiaries in social transactions.

As such, Jönsson (2009) states that private and public institutions (as social actors) have a responsibility to account among themselves and to the social systems to which they belong and provide services – governments to the electorate, and private management to investor/shareholders. Internally, their members account to different levels of authority; civil servants to government leaders for instance; in the case of NGO staff, it would be to management and board. Accountability thus becomes a central aspect of the architecture of governance with the purpose to orient action and monitor performance in relation to purpose.

Viewed from a social systems and network perspectives, and as components and nodes, social agents (both institutional and individual persons) do not only have social statuses but roles they perform as they pursue organisational missions. In that process, they have to account to other members of their development fraternity and within their internal structures. Table 3.7 presents the various components that constitute the content of accountability for the individual development players as adapted from AIDSpan (2015).

The orientation of each of these forms of accountability would relate more to some types of relations than others. In the case of the HIV response, *fiscal accountability* would define more the accountability between a donor and its beneficiary. *Administrative* or *managerial accountability* and *horizontal accountability* would characterise more intra-organisational accounting processes in any organisation between different authority levels. *Political accountability, vertical accountability* and *social accountability* subsume a large array of organisations' social responsibilities arising from statuses and roles.

Table 3.7: Types of Accountability

Type	Definition
Fiscal Accountability	monitoring and reporting on allocation, disbursement and utilization of financial resources, using the tools of auditing, budgeting and accounting i.e. the verification of income and expenditure
Administrative or Managerial Accountability	answerability of those with delegated authority for carrying out tasks according to agreed performance criteria, using mechanisms that reduce abuse, improve adherence to standards and foster learning for improved performance
Political Accountability	ensuring that government delivers on electoral promises, fulfils the public trust, aggregates and represents citizens' interests, and responds to on-going and emerging societal needs and concerns
Social Accountability	the broad range of actions and mechanisms beyond voting that citizens can use to hold the state to account, as well as actions on the part of government, civil society, media and other societal actors that promote or facilitate these efforts
Horizontal Accountability	measures introduced internally within an organization, for instance, supervisory systems or mechanisms for financial control
Vertical Accountability	where external actors hold individuals or organisations to account e.g. community leaders complain about poor service delivery or corrupt practices at their local health facility

Source: Compiled from Aidspan (2015:3).

This thesis examines RNGO accountability in the context of their embeddedness as illustrated both in this and later chapters of this thesis. The primary focus is to reveal the dominant influences and practices in RNGO accountability.

3.7 Conclusion

This chapter has offered an analysis of the architecture of global development governance under the auspices of the United Nations (UN) as constituted following the end of the Second World War in 1945. In examining the overall governance architecture and the location of NGOs in development governance, the chapter demonstrates how NGOs are nodes in an international system of global governance that spans from the global and regional levels down to the country level, becoming subjected to various levels of authority. It also highlights the mechanisms that are utilised at different levels and within different sectors in relation to the exercise of authority and how some development agents influence the governance structures to respond to their needs. More significantly, such a process is negotiated through established principles of engagement and along various types of interfaces which help refine the position and role of each development agent in the overall development architecture. Inevitably, this involves the positioning of development agents within various social networks which facilitate their involvement in development processes as well as their own organisational perpetuation. Consequently, development agents (including RNGOs) have to account to their

benefactors and the overall governance structure as a basis for ensuring their ongoing existence and relevance.

CHAPTER FOUR: REGIONAL NON-GOVERNMENTAL ORGANISATIONS, REGIONAL PROGRAMMING AND BEING REGIONAL

4.1 Introduction

One of the key objectives of this thesis is to conceptualise regional non-governmental organisations (RNGOs), and trace their emergence in the context of the rising significance of the regional space as a level of global governance. In this context, regional organisations are the key drivers of regional processes. Chapter 3 identified these organisations as both state and non-state, and this chapter focuses on RNGOs, which belong to the non-state sector. With specific reference to HIV, the chapter examines the rise of regional HIV programming in the Southern African Development Community (SADC), defines it, and identifies and highlights the significance of regional work vis-à-vis work at other levels. The chapter concludes by offering a conceptualisation of *being regional*, a key term coined in the emergence of regional HIV programming in southern Africa.

4.2 Conceptualising a Region and Significance of Regional Level in Development

An analysis of the development literature indicates that the focus on *regions* is not a new phenomenon, notwithstanding varying understandings of the concept. There are those who emphasise the geographical aspect (Taylor, 1992), those that place greater weight on community characteristics (Zyck, 2013) while others see regions as social systems (Meinig 1956). Chngono and Nakana, (2008:397) and Kacowicz, (1998:8) take a more encompassing approach viewing a region as definable in a variety of ways: by geography, economic interaction, institutional or governmental jurisdiction, or by social and cultural characteristics. This section analyses the concept *region* in respect of these various defining characteristics to try to offer a more comprehensive picture of the phenomenon.

Hettne and Söderbaum (2000:461) define a region as "a geographic area, delimited by natural, physical barriers" that is "objectively rooted in territory" (also Soderbum, 2004:5). This definition focuses on natural regions such as continents and islands that are separated by such natural and physical barriers as seas, rivers or mountain ranges, which create natural geographical areas such as Africa, the Americas, Europe and Australasia.

In terms of global development, Varynen (2003:27) states that the key characteristics of a region "centre around the division of the world by levels of analysis and by the physical-functional distinctions." This means that analysis can be directed to the country, regional and international levels, including examining how they link, their interactions and impacts on the

entire global system and its functioning. Such analysis would enhance the comprehension of the phenomenon 'region' contextually, and how it fits and contributes to the world order and global socio-economic development. In this light, this thesis seeks to define and locate the regional level in the global order and international development architecture to contextualise the work of regional NGOs and facilitate the definition of regional work and being regional.

Physically, a region is a specific geographical space (De Wet, 2014) with explicit physical characteristics and endowments (climate, rivers system, soils, minerals, mountains, valleys) which distinguish it from other areas (Mansfield and Milner, 1997). Its endowments also facilitate the occurence of specific socio-economic activities among resident groups and between them and external actors. In other words, regional endowments attract different social actors to engage in various activities intended to utilise shared opportunities, and indeed seek to deal with existing and emerging challenges in the area. These challenges include those arising from various internal and external social relations that emerge from social transactions. According to Riggirozzi (2010:4) and Zyck (2013:6), regions have an undeniable objective reality rooted in delimited territory (i.e. the area of domicile for populations of Member Countries) within and from which these countries perform their socio-economic transactions. In other words, a region should be understood in terms of its physicality as well as its social reality.

Human intervention in the physical geographical area gives rise to formal social organisations and legally constituted structures and regulative systems, as well as more spontaneous networks and social relations that involve non-state actors; what Hettne and Söderbaum (2000:461) call *de jure* and *de facto* organisational forms. In other words, it includes grouping of inhabitants and their formalised activities and location in territorially-based social structures that stretch from community and country to regional structures and systems of governance (which provide frameworks for structured interactions), as well as more informal arrangements and networking. Overall, a region can also be viewed as a social construct.

According to Meinig (1956), "social construction" of regions means "that regions are shaped by the collective perception of identities and meanings with blurred and ever shifting boundaries." Hence, regions are created by people through their interactions beyond the limits of the initial emerging of a nation-state. There exists several common characteristics such as: "a certain amount or degree of social and cultural homogeneity; similar political attitudes or external behaviour toward third parties; common political institutions, as an expression of political interdependence; a certain degree of economic interdependence; and common

behavioural criteria, such as the identification of norms pertaining to conflict management and resolution," (Kacowicz, 1998:8). But regions are far from being one homogeneous community as they are characterised by the merger of different nationalities that do not necessarily share the same cultural values. Diversity in regional communities necessitates the creation of supra-national spaces for engagement, structures and authorities such as the Southern African Development Community (SADC), and the amalgam of component states and social groups constituting the regional community and the regional inter-governmental organisation - the supra-national body responsible for giving directions and coordination within the region (Marshall, 2013:1).

In this sense, a region can be viewed as a social system to the extent that it incorporates sets of constituent elements – social and physical (Checkland, 1991, also Zyck, 2013), and these are institutionalised in so far as they are formally constituted through a governance regime. Checkland (1991:119, 120) broadly defines a social system as any grouping of people who are aware of and acknowledge their membership of the group, accept responsibilities as a result of their membership, and have certain expectations of other members. The generation of awareness suggests institutionalisation which tends to lead to compliance rules that facilitate and/or constrain certain actions. North (1995:15) and Bruton et al. (2010:422) define institutionalisation in this sense to refer to the constraints that human beings impose on human interaction, in order to direct interaction in a manner beneficial for a certain common good specific to a social entity, such as a region.

In other words, institutionalisation provides a framework for legitimation of structures, participants and processes. The acceptance of and compliance to the regulative, normative and cultural-cognitive effects of institutionalisation lead to the formation of a polity (Scott, 2001), and indeed its function. Marshall (2013:1) defines a polity as "a political or governmental organisation" charged with the responsibility of giving direction and ensuring conformity to directives. Eckstein and Gurr (1975:26) state that giving direction "involves the definition of its goals, the regulation of conduct of its members, and the allocation and coordination of roles within it." These processes do not only indicate institutionalisation but confer social agency to the region as both a polity and international community. For Zyck (2013:5-9), in order for such agency to occur, a region "as a community takes shape when a stable organisational framework facilitates and promotes social communication and the convergence of values, norms and behaviour throughout the region,", creating "a transnational civil society characterised by social trust at the regional level."

The regional governance system directs a community or society which Doda (2005:62) defines as "a relatively large grouping or collective of people who share a more or less common and distinct culture, occupying a certain geographical locality, with the feeling of identity or belongingness, having all the necessary social arrangements to sustain itself." From this emerges the functional aspect of a region which can be linked back to the conception of the UN (1945) international governance structure discussed in chapter 3. In that structure, the regional level is intended to offer intermediary functions to global governance in relation to the international and country level operations in global development. Viewed this way, Whiting (1993:20) states that the region can be conceived as an "intermediate form of community, between the national community of the state and the potential global community of humankind." This conception describes how those operating at regional level contribute upwards to the global and downwards to the country levels as part of global integration in which "fewer and fewer 'problems' are in fact domestic or confined to the nation-state, meaning that they have to be solved or managed through international and regional cooperation and governance" (Söderbaum, 2008:6).

Regional players (state and non-state) constitute the phenomenon *region* through collective social enterprises. Vayrynen (2003:25) states that "regions appear to arise either through the dissemination of various transactions and externalities or as protection against the hegemony of capitalist globalization and great-power politics" (also Hettne et al., 1999; Chngono and Nakana, 2008:397). In this case, these externalities (common problems) justify the emergence and perpetuation of regional cooperation to the extent that they necessitate collective action. These actions serve common purposes thus becoming a rallying point not only for the formation of regions but participation in regional processes. A more nuanced discussion of externalities is offered later in this chapter to demonstrate how they are the driving force behind not only the formation of regions but regional programming through the actions of regional players.

As already noted in the foregoing chapter, the rise of the significance of the regional space as an operational zone was first formally recognised by the UN in 1945 through the acceptance of both regional inter-governmental organisations (RIGOs) and non-state bodies as potential partners in UN business in relation to the operations of both the UN Security Council under *Article 57*, and the Economic and Social Council (ECOSOC) in terms of *Article 63.* With specific reference to state bodies, Laruelle and Peyrouse (2012) state that regional inter-governmental organisations (RIGOs) are institutions that are created to buttress inter-state cooperation within a specific polity (also Zyck, 2013; de Wet, 2014); their

functions are illustrated in the operations of bodies like SADC as earlier noted. In this sense, they present themselves as attractive partners for the UN in its pursuit of international peace, security and development.

Alongside the operations of RIGOs are regional non-governmental organisations (RNGOs), civil society organisation operating on the regional level. Chapter one briefly notes that these organisations emerged in the HIV responses as southern NGOs (responding to HIV) began to extend their reach across a number of countries engaging broader issues affecting countries in the region. In doing so, they provided intermediary, coordinative and technical support functions at the international and regional levels, while others also focused on country level service delivery. Regional civil society regional organisations (RCSOs) are a relatively new phenomenon especially in the HIV response, hence the relevance of this thesis in providing a nuanced analysis that also highlights their role and interface with other development players. This section offers a scrutiny of regional organisations (ROs), a term used here to describe all formally constituted regional organisations that operate at the regional level; the aim is not to give an exhaustive list of these organisations, but to provide illustrative examples of the diversity of regional organisations and locate RNGOs in this context.

Table 4.1 presents a variety of organisations that are operating at the regional level within the Southern African Development Community (SADC). They comprise nine categories that range from UN organs' regional branches, a variety of intergovernmental bodies, international NGOs (INGOs), a variety of donor regional teams, market related entities, and NGOs. A description and examples of each category has also been offered to demonstrate the roles and diversity of these organisations. In effect, this illustrates how limited the discussion on ROs has been and how much has not been analysed.

The largest variety of regional organisations is non-governmental organisation; i.e. international non-governmental organisations (INGOs), academic research service organisations, market related bodies such as employer associations and civil society organisations. This group constitutes a category, which by virtue of being non-governmental and operating at the regional scale, should be called regional non-governmental organisations (RNGOs). These regional organisations are non-state actors but represent diverse interests for which they seek regional level solutions, and/or provide services to both international and country levels, which are only possible from the regional level as shown in a more nuanced discussion of case examples in chapters six to nine.

Table 4.1: Types of Regional Organisations

Type	Description	Examples
1. UN organs regional branches	Regional branches of UN organs	✓ UNAIDS RST ESA
2. Intergovernmental organisations	Regional bodies constituted by a collection of governments in common regional area	✓ Africa Union (AU) ✓ Southern African Development Community (SADC) ✓ East African Community (EAC)
3. Sponsored quasi-CSOs	Established by intergovernmental statutes as a mechanisms for engaging civil society organisation.	✓ SADC Council of NGOs ✓ SADC NGO Forum
4. Branches of INGO	Regional branches of international NGOs	✓ Plan international Southern Africa ✓ Red Cross Africa region
5. Branches of donor orgs.	These are regional offices of donor organisations, bilateral or multilateral	✓ Irish AID Southern Africa ✓ Sida Southern Africa
6. Employer Associations	These represent the interest of capital and or market related research	✓ Confederation of Zimbabwe industries (CZI)
7. Academic research institutions	Offer research and documentation support on sector specific issues	✓ Health Economics and HIV/AIDS Research Division (HEARD)
8. Civil society outfits	These are different types of civil society organisations operating at the regional level focussing on different thematic areas in a variety of fields.	✓ Trade unions ✓ Medical support NGOs ✓ Human rights organisations ✓ Networks of PLHIV ✓ HIV support and service organisations ✓ Economic rights NGOs ✓ Environmental NGOs ✓ Migration NGOs ✓ Cultural NGOs ✓ Faith based NGOs ✓ Humanitarian NGOs

Source: Own compilation.

However, within the non-governmental category, the civil society subgroup constitutes the largest component comprising eleven subcategories. Table 4.2 offers a further investigation of the CSO category of these regional players. This, by far, does not comprise an exhaustive compilation on regional CSO in operating in SADC, but serves to illustrate the diversity of CSO regional players and the areas of their operation.

Table: 4.2: CSO Typologies in Southern Africa

Category	Type	Description	Example
1. Workers' association	i. Migrant workers ii. Mining workers	Formed around specific migrant works issues common to a specific category.	✓ Southern Africa Miner's Association (SAMA)
2. Human rights organisations	i. Women's rights ii. LGBTI rights iii. PLHIV rights iv. Migrant rights v. Health rights vi. Economic rights vii. Gender rights viii. Legal support	Address human rights, empowerment, participation and access issues generally, and specific to certain categories of people and at times generally.	✓ AIDS & Rights Alliance of Southern Africa (ARASA) ✓ AFRODAD ✓ WILSA
3. Networks of PLHIV	i. Positive women ii. Positive youth iii. Positive men iv. People with disabilities v. Sex workers vi. Religious leaders	Member-based and driven; address issues specific to each network type.	✓ NAPSAR ✓ Disability HIV and AIDS Trust (DHAT) ✓ ANARELA ✓ Southern Africa Network of AIDS Service Organisations (SANASO)
4. HIV support and service organisations	i. Programme support and sub-granting ii. Organisational capacity building iii. Specialised services	CSO technical support and sub-granting organisations whose role is to strengthen the programme delivery and organisational capacity of HIV implementing CSOs	✓ SAT ✓ SAfAIDS ✓ RATN ✓ INGOs ✓ REPSSI ✓ MSF
5. Associations of NGOs	i. Think tanks ii. Mobilisation platforms	Made up of CSO and are focussed on mobilisation for policy and programming influence	✓ Regional Association of African NGOs (RAANGO)
6. Environmental NGOs	i. Climate change ii. Animal conservation	Concerned with the protection of the environment; including pollution, animal conservation, nature conservancies	✓ World Wildlife Fund (WWF) ✓ Green Peace
7. Medical support	i. General medical	Provide free medical services for vulnerable populations	✓ MSF (Doctors Without Borders)

Source: Own compilation.

The term CSO has already been defined and discussed and linked to NGOs (in chapter one) as inclusive of all non-state actors encompassing the private sector (Hassan 2009:70; Witter, 2004:9), thus dichotomising civil society and the state. Others such as Onsander (2007:11) view civil society as also exclusive of the economy (private sector) and parochial society (individuals and family) (Diamond, 1999:221) as noted earlier in chapter 1. Within

the CSO camp, however, there is extensive decernable differentiation which gives various typologies as illustrated in Table 4.2.

The categorisation of CSOs in Table 4.2 is based on their perception as exclusive of both the state and the private sector and as constituting a third component of a tri-format of social organisation comprising the state, private sector and civil society. In this instance, Ibrahim's (1999:31) definition of CSOs as all non-governmental organisations that occupy the public space between the institutions of the economy, the family and the state, and entail the voluntary participation of their members in promoting a common cause, is adopted.

This thesis and thus Table 4.2 focus largely on formally constituted entities in terms of organisational establishment. There is an enormous variety of CSOs operating at the regional level focussing on a wide range of thematic areas and fields ranging from human, economic and social rights, the environment, medicine, HIV and worker's rights among others. These broad categories encompass numerous issue-specific typologies (for instance, women and migrant workers) and others that are at times descriptive of the nature of the organisation (such as networks). The overall and predominant category is the HIV CSO sector that demonstrates the nature of the footprint that the epidemic has made on Southern Africa and globally. Its multi-sectoral nature is imposing. In this regard, it can be safely argued that failing to acknowledge the existence of these numerous players and limiting the analyses of regional organisations to inter-governmental outfits falls short of capturing this diversity at the regional level and the significance of these organisations in regional processes including responding to HIV, one of the common threats that confront SADC.

Confronting common threats occurs at three fronts: the state, private sector and civil society. What Zyck (2013) and others have offered is a state-centric approach to the significance of regional organisations and is limited to the role of intergovernmental organisations. In addition, a host of non-state actors play varied and significant roles, and make important contributions at the regional level. If we refer back to Tables 4.1 and 4.2, a whole host of roles of regional non-governmental organisations become apparent: addressing issues of human rights, health (including HIV), generating new ideas and providing coordination mechanisms in various sectors, and providing technical support for capacity enhancement in various specialised areas to facilitate the resolution of some of these challenges. In other words, the importance of regional organisations to national, regional and international level work cannot be over emphasised. However, it is critical to examine the issues of mechanisms and rules of engagement between these regional bodies and national level players as understood in the context of regional HIV programming within the region.

The next section looks at how regional HIV programming started, to set a basis for examining the question of being regional.

4.3 Regional HIV Programming in SADC

Regional HIV programming was occasioned by a set of compelling factors that necessitated collective action with due recognition of the principles of supremacy and subsidiarity where a supra-national mechanism is in place. Within SADC, and as part of global efforts to focus on hot spots of the epidemic, a collective decision was made for regional programming to be initiated (Jones et al., 2010). In an evaluative report of the Irish Aid regional HIV programming, Jones et al. (2010:24) observe that: "In addition to global and bi-lateral programmes to strengthen national level systems and responses (to HIV), it became increasingly recognised by stakeholders that an important contribution could also be made at the regional level through a regional approach to the epidemic." In that Report, a note is made that "as early as 1996 the European Union and SADC held a joint conference with the intention to prepare a SADC Plan of Action for adoption by the SADC Council of Ministers. This did not happen; but by 2003, the Maseru Declaration on the fight against HIV/AIDS in the SADC region signalled a renewed regional commitment" to provide a unified regional response to the epidemic.

In the Sida programme evaluative report (Jones and Hellevick, 2012:3), it is noted: "The rationale for a regional approach to HIV/AIDS must lie in assumptions about inherent negative externalities to HIV/AIDS at the regional level, externalities that are better handled at this level than at any other level." For Sida, one such important negative externality that justified a regional approach to HIV/AIDS was "the regional concentration of HIV/AIDS in the Sub-Saharan Africa region," that registered "35 percent of all PLWAs and 38 percent of all AIDS-related deaths".

In this case, a focus on the Southern African region became essential in the global response to the epidemic to the extent that the region had emerged as the epicentre of the pandemic. However, externality relates to essentiality as discussed later in the chapter. If the epidemic was not confronted within Southern Africa, it posed a global public health threat. Regional programming in this case was viewed as necessary in containing the epidemic within a manageable regional area rather than allowing it to be more generalised and logistically and financially over-stretching. At another level, common and appropriate strategic responses based on the level of knowledge of the epidemic (know your epidemic) makes it easier to organise more effectual responses. Ideally, commonalities (similar

challenges, opportunities, cultures, levels of resources, and skills) within the region should make it easier to mobilise for collaboration and coordination for an effective response.

In other words, regional programming tends to focus primarily on the region – it is an intra-regional process meant to deal with issues in the region but contribute to global processes for containing regional threats with the potential for global impacts. Because of this, there tends to be a more elaborate approach to understanding all aspects of the epidemic and the response within the region, including the various socio-cultural factors that drive the epidemic. In the case of SADC (southern Africa), heterosexual sex practiced in a context of low use of protection (condom use), multiple and concurrent sexual partnerships, unequal power between men and women to negotiate condom use are the key drivers of the epidemic (SADC, 2006:5-6).

In this case, the regional level HIV response provides an opportunity for dealing with common issues (HIV prevention, human rights, gender, key populations) in the region and provide mechanisms for mobilisation, collaboration and coordination; thus creating a common culture of mutual support (social capital) for member countries and communities. It builds a platform for dealing with common and critical issues such as the impact of migration and HIV, homosexuality and sex work in the HIV response. Along the same vein are also issues of human rights, particularly gender equality as well as those relating to minority populations such as the lesbians, gays, bisexuals, trans-gender and intersex (LGBTI).

4.3.1 Defining Being Regional and Regional HIV Programming

This sub-section examines the historical framing of the concept *being regional* drawing from the initial 2003/4 SAT/UNAIDS led meetings, which coined the concept, and reflections on the concepts as expressed in commentaries from donors and the UNAIDS at that stage. This will provide the initial sketch of the concept, and lay a basis for comparison with practices in illustrative case examples in chapters 6 to 9. The discussion also draws from RNGO inputs as there is little documentation on the concept.

The concept *being regional* traces its origins in the practices of regionalisation and transnational activity to the extent that it describes a process and practice that involves regional and transnational actions. These latter concepts have been defined earlier in the thesis (chapter 3). I now contextualise the understanding of *being regional* as it arose and became applicable in the work of RNGOs involved in the HIV and AIDS response in the SADC region. It is a new and less explored construct invented by the Southern Africa AIDS Trust (SAT) and a consortium of donors including the UNAIDS in 2004.

According to SAT (2004:3-4), the Netherlands embassy, UNAIDS and SAT, seeking synergy and better coordination at the regional level, held a meeting whose major aim was to provide leaders and senior staff of regional initiatives (including ACTIONAID, RATN, REPSSI, SAfAIDS, SAT, SCF-UK and regional donor teams, Swedish and Netherlands, focussing on HIV and AIDS) with the opportunity to reflect on what '*being regional*' meant (SAT, 2004a:3-4). The Harare (22-23 March 2004) *Being Regional Meeting* brought together a number of regional bodies in southern Africa working in the area of HIV and AIDS "to conceptualise what it meant to be regional and what defines us as *being regional.*" It also sought to identify the niche role of RNGOs in the epidemic, explore issues of complementarity, lesson sharing and interfacing between RNGOs and other agents in the response at different levels; national as well as international including the involvement of and with other stakeholders (SAT and UNAIDS, 2005:9). Although the meeting could not offer a definition of the concept *being regional*, it provided a menu of activities and propositions of what could constitute work at the regional level as now discussed.

4.3.2 Characteristics of Operating as a Regional Organisation

According to the Report of the SAT/UNAIDS (2005:33) facilitated meeting on '*being regional*' (which focused specifically on prevention), regional organisations are divided into three service categories as listed in Table 4.3. Concerned about duplication of efforts among regional RNGOs, participants to the meeting agreed on this menu of activities as a mechanism to decrease duplication and to maximise on benefit of collaboration and coordination. In addition, it was meant to encourage the achievement of the best outcome areas where each RNGO was strongest. In each of these specialised areas (information services, capacity building and advocacy), various forms of technical support were proposed for national and community partners.

Presented in this manner, the concept *being regional* seems to suggest a quest to identify not only the activities but possible principles that can be applied in defining regional work and working regionally as opposed to programming at other levels. The activity categories constitute the role of the RNGO while, in part, executing them would define *being regional*. Below I further explore the characteristics that distinguish regional programming from work at other levels.

Table 4.3: Proposed RNGO Roles

Information Exchange & Dissemination. Challenges	Capacity Building. Challenges	Advocacy Challenges
✓ Increase scale up by collaborating more effectively with National bodies. ✓ Regional bodies can encourage/ facilitate resource mobilization and fundraising where appropriate. ✓ Can facilitate skills transfer through capacity building workshops. ✓ Can serve as distribution points. ✓ Promoting south to south experience sharing. ✓ Working with governments to provide important and relevant information. ✓ Provide leadership in materials production & dissemination – setting standards. ✓ Collaborate with non HIV/AIDS bodies to integrate HIV/AIDS in their programmes ✓ Provide templates for national bodies on Codes of Good Practice, HR, grant writing etc. for small CBO/NGOs.	1. Identify capacity needs of regional bodies (UNAIDS to assist). 2. Develop a list of regional organisations of who is doing what at the regional level (in progress). 3. Hold regular forums to share and discuss. 4. Finding ways and networking of how to scale up, expand, and accelerate interventions. 5. Identification of effective country based partners to increase and implement capacities.	1. Identify organisations that are doing advocacy work and support them to do it better. 2. Play intermediary role between global and national advocacy issues and support where appropriate. 3. Identify emerging advocacy issues. 4. Encourage new prevention methodologies – technical & micro. **5.** Regional bodies to create "Advocacy Desks".

Source: SAT (Regional Meeting Report) (2005a:33).

In this process, first discussed are the principles of supremacy and subsidiarity (Zyck, 2013, Kritzinger, 2005, Anamela et al., 2010) as applied in international relations and examine the application of the concept of externalities (Mankiw, 2001) as justifications for a collective response; I then zero in on issues of essentiality and economies of scale (Jones and Hellevik, 2012). These aspects provide both a description and justification of regional programming.

4.3.3 Distinguishing Factors of Regional Programming

Regional matters usually involve issues of inter-state relations and/or of national and supra-national characteristics and relations and, as such, involve protocols of engagement applicable at that level. The term protocol of engagement is used here to mean a set of norms and rules that govern relations between a regional body and a national level organisation. Viewing RNGO work from this perspective seems prescriptive and rigid, but this seemed to be the focus of the SAT 2004 meeting, making it significant to examine the relevance of principles like *subsidiarity* and *supremacy* which apply in relations between local and supra-national bodies. These principles are critical from both inter-state relations and operational perspectives. They are intended to define entry points, and allocate responsibilities and avoid

conflict and/or neglect regarding the exercise of necessary actions at appropriate levels: global, regional, sub-regional and country. How donors began to apply them in the HIV response in Southern Africa is elaborated in the following discussions.

4.3.3.1 The Application of the Principle of Subsidiarity in Regional Programming

Taking a cue from the UN perspective as discussed in chapter 3, Anamela (2010:9) in evaluating the Irish Aid Regional HIV Programme states that subsidiarity is the principle, with "specific reference to regional organisations", where issues which "can be met at a lower level then this should always take precedent." Kritzinger (2005:8) likewise claims that subsidiarity means that regional institutions should be responsible only for those activities that are not better handled at the national level (also Moller, 2005:6). This, he argues, prevents the "overloading of limited sub-regional administrative capacity and resources and assures sufficient commitment and trust so that the key sub-regional agencies will be given the authority and the means to implement the sub-regional agenda while leaving opportunity for lower level actors to play their roles." Kritzinger (2005) thus calls for thrift in the creation of regional organisations and initiatives supporting only the establishment of those that will add value without duplicating national level efforts.

There are numerous programmes in the HIV response that posture as local level specific, with a home-based care programme being one typical activity that community-based players would execute best of all, thus ensuring the spatial separation of agents and respect of jurisdictions. Other players will only do their best supporting these efforts. Zyck (2013:9) argues that from an operational perspective, subsidiarity is "bolstered by the perception that lower-level stakeholders better understand problems (e.g. the drivers of HIV) and may thus be able to address them in a way which is more contextually or culturally appropriate" (also OSCE, 2011). However, Moller (2005:5) contends that subsidiary can be used as justification for 'buck-passing,' i.e. neglecting responsibility in taking requisite action.

4.3.3.2 Applying the Principle of Supremacy in Regional Programming

The principle of subsidiarity implies that of supremacy. By establishing a hierarchical structure of authority and responsibility, the principle of subsidiarity also creates levels of authority where some actors have higher level of authority than others. The essence of the principle of supremacy is "that higher-level decisions or norms, where determined to be necessary, take precedence over lower-level commitments," and "theoretically supersede those of a regional organisation or individual state," (Zyks, 2013:9).

Applied to public health programming, this means that a regional organisation (SADC or an RNGO) can only run programmes that are deemed of collective benefit to the SADC community and which can be delivered effectively only by a regional organisation at the regional level. Such a programme could be one of harmonisation of anti-retroviral treatment regimens for HIV positive migrant populations or bulk procurement of HIV medicines for the region. These programmes would require a mandate from Member States, which once secured, establishes rules and operational processes observed by all parties as agreed, for they become decisions of a supra-state body and process.

In relation to the operations of donors vis-à-vis their implementing partner (state and/or non-state), the principle implies that, even though donors pursue their own objectives to resolve development issues at the regional and country levels, their projects can only be implemented by and through partners positioned at these levels. These are the development agents that have the right to implement intervention programmes at these levels. The donors' roles remain those of facilitating and influencing the design and implementation of the local response programmes. The interface between donors and NGOs generally, and RNGOs specifically, is discussed in greater detail in chapter 5 with additional illustrations in chapters six to nine, where regional NGO work is also discussed further.

4.3.3.3 Applying Other Concepts to Regional Work

Additional elements or concepts also characterise regional work. In terms of the principles supremacy and subsidiarity, a regional organisation like SADC (or an RNGO) can intervene to resolve any issue at the national level only when the local level has no capacity to resolve it. The issue of capacity in this case does not only relate to availability of requisite resources and skills, as these can be provided by regional players as support, but should be of such proportion and complexity that the local level alone would not be able to resolve any challenge. In its regional review of southern Africa as background to its 2002-2006 Regional Strategy, the Swedish Sida (2002) used the concept of *externalities* to qualify matters for regional programming albeit without clarifying the concept. There is no intension in this thesis to provide a nuanced description or theoretical conceptualisation of externalities beyond clarifying the concept for the purposes of this analysis.

Borrowed from the field of economics and put simply, the term *externality* refers to "a person's activity that affects the well-being of an uninvolved person" and it obtains from the fact that someone *external* to the action or transaction is affected by the outcome of such activity or action (Mankiw, 2001; Vatn and Bromley, 1997:137). External impacts of actions

or activities can be both negative and/or positive (Helbling, 2010:48; Carande-Kuli et al., 2007:229). Verhoef and Nijkamp (2003:4) describe externalities as "unpriced effects that actors impose on other actors." This means there is usually no measurement of the actual monetary cost (negative effect) or benefit (positive effect) of externalities though they are critical and impose a certain response on those affected, individually or collectively.

A *negative externality* occurs when an activity creates discomfort or harm for people external to the activity. According to Carande-Kuli et al., (2007:229) and Koomey and Krause, (1997) such harm or cost is usually not adequately compensated as is the case in environmental pollution. On the other hand, a *positive externality* occurs when an external activity creates opportunities or benefits those who are uninvolved. Applied to the field of public health, Gubb and Meller-Herbert (2009:34) state that a *positive externality* may occur when "people who are not immunised will benefit from others being so because it minimises contagion." In addition, they state that "there are also positive externalities associated with the treatment of disease. Treating someone with an infectious disease such as tuberculosis or swine flu should minimise the risk of it spreading to others." In the same example, a negative externality occurs when lack of vaccination and treatment in an affected community leads to the spread of the disease to hitherto unaffected populations.

In these examples, there are apparent shared benefits obtaining from disease prevention and control, and therefore sufficient motivation for intercommunity coordination and collaboration to deliver mutually beneficial and effective public health programming. In other words, negative or positive, an externality triggers and imposes certain responses, usually to the effect that reactions can no longer be localised or, where localised, action cannot yield maximum benefits or effective resolution of the matter.

Focussing back on regional HIV work, a matter for regional programming must therefore sufficiently comply with the concept of *externality* and the principles of *supremacy* and *subsidiarity*. In other words, regional programmes either must focus on capitalising on accruable positive externality or should provide the only sustainable way of dealing with negative public health externalities within the region. The process of application of these principles is a matter for negotiation by regional and national parties affected by the matters.

In SADC, a number of issues can be identified as either positive or negative externalities (or both) and such a designation raises the profile of the issue to a relevance for regional programming. Table 4.4 is a illustrative list of some of the externalities drawn from a cross section of regional matters. Designating externalities as positive or negative is in some cases determined by prevailing conditions in each case.

Table 4.4: Some Externalities in SADC

Issue	Positive externality	Negative externality
HIV		√
HIV prevention	√	√
HIV treatment	√	√
Conflicts and wars		√
Commodity markets	√	√
Communication networks	√	
Common resource management	√	√
Human rights abuse in the region		√
Gender based violence in the region		√
Homophobia		√
Migration	√	√

Source: Own compilation.

This is true in cases where there may be both a gain and a loss and therefore a need for striking a balance in the interest of all affected. Migration is illustrative of a double-edged externality, as skilled labour flight may ease unemployment in the source country while availing additional and needed skills in the receiving country; and, in the course of time, such labour mobility may need to be balanced in the interest of the source and receiving countries.

Besides externality, another key concept is essentiality. Although the principles of supremacy and subsidiarity remain overarching on all work considered to be regional, not all issues comply with the dictates of either positive or negative externalities to qualify as a regional programming matter. Other considerations such as *essentiality* become more compelling and further refine our understanding of the range of regional activities and functions.

In their evaluation of the Sida Regional HIV Programme, Jones et al. (2010:25) coined the term *essentiality* to describe "those aspects (of HIV programming) that can only be adequately met beyond the level of the nation state." (also Jones and Hellevik, 2012:3). For them, from a Sida perspective, HIV/AIDS could be viewed as an essential aspect, but "a negative externality that knows no territorial boundaries and easily spreads across borders with migration and commerce." For this reason, the effective management of HIV/AIDS is only possible with inputs beyond the nation states; at the regional and global levels.

Analysed further, for Sida, "the negative externalities of HIV/AIDS involve issues such as mobile populations, economies of scale in terms of drug supply and transport across borders, and tackling the high prevalence rates in border areas" (Jones and Hellevik, 2012:3). These are matters that cannot be effectively managed at the country level because of their

intricacy and geographical extent which necessitates the involvement of international relations. As such they require inter-state mobilisation for the creation of common understanding and vision, to facilitate cooperation, policy alignment, coordination and harmonisation of interventions on issues such as migration, sex-work and HIV prevention and treatment. Matters of policy alignment, coordination and harmonisation of interventions arise from the existence of divergent approaches to contextual issues and their perception as drivers of the HIV epidemic. They also arise from the perceived or definite accruable benefit of such actions at the regional level in the response to HIV.

SADC member states do not have a common understanding and single mind on how to deal with issues of sex workers and homosexuals in relation to HIV. If anything, all SADC Members States criminalise sex work and only the South Africa government recognises homosexual union notwithstanding intense reprisals against gay couples in South Africa (ARASA, 2009). In the context of HIV and AIDS, and given that sex workers and homosexuals have been identified as vulnerable groups (UNAIDS, 2015:22), it has become important for these issues to be engaged; not at the lower national level (where there are either repressive laws or cultural practices) but at the regional level, among regional leaders who may hope to prevail over their national situations – and the usual entry point is RNGO activism and legal reforms as is the case in South Africa. However, this is by no means an attempt to ignore the work of NGOs in communities at the national level**.** It only serves to underscore the significance of the regional scale as the appropriate platform for the initiation of requisite legal reforms on these matters, and setting a basis for national level changes.

Regional integration, coordination and harmonisation are matters that involve interstate relations. By their very nature, they are matters more amenable to the principles of supremacy and subsidiarity to the extent that they are facilitative of the creation of a regional culture of co-existence and cooperation on matters of mutual interest. In addition, regional coordination, harmonisation and integration are inter-state aspects which require the involvement of a supra-state or regional organisations. Organisations such as SADC and relevant RNGOs are better positioned to engage on these matters and take relevant action. As such, these activities define regional work and working regionally, but arising from HIV externalities viewed regionally, and hence the necessity (essentiality) of regional level intervention. From an Irish AID perspective, HIV programming that is considered "regional work is preferred when it presents a clear comparative advantage over national or global programming" (Anamela, et al., 2010:9). In other words, regional programming is considered relevant when it presents the best results in the response relative to other levels of

engagement; national and global, but how do the best results arise? In this regard, I now discuss another concept or dimension of regional work, namely the influence of the considered benefit of economies of scale.

The notion of *economies of scale* is one criterion that the Irish Aid has employed to determine whether or not there is benefit in operating at the regional level. There is no intention to analyse the concept in any detail except as would make its application in regional programming comprehendible. The term *economies of scale* is borrowed from the discipline of economics where it is used to refer to a situation in production where "the greater the quantity of goods produced, the lower the per-unit fixed cost because these costs are shared over a large number of goods: (Clark, 1988, Allen and Liu, 2005). According to Farsi et al. (2006:3), these cost advantages arise in two circumstances: internally – within company, or externally which may be linked to industry size. In both cases, cost reduction occurs per unit because of operational efficiency or synergies. In other words, in the bigger environment where there are similar operators (companies), those in the same industry benefit from common sources of raw materials and infrastructure, among other things, resulting in reduced production costs.

Applied to the health sector, regional organisations accrue benefits through developing synergies and collaborating on specific health challenges. The area of HIV is huge; comprising of various focus areas which are all relevant for effective management of other epidemics, and no single organisation can do it single-handedly. Medical doctors across the region need each other to manage the epidemic given the nature of its externalities. In addition, to do that efficiently, they also need the non-medical support from the regional states, donor agencies and civil society organisations, at various levels; from the community through the country, regional to the global level. Such a huge community of players makes possible and easier the management of the epidemic.

In evaluating the Irish Aid HIV Programme in southern Africa, Anamela et al. (2010:25) highlight *economies of scale* as a key concept underpinning the Irish Aid Regional HIV Programming as well as defining regionality. For the Irish Aid, *economies of scale* describes 'the aggregate benefits of being in a bigger unit' – the regional block such as SADC where it is possible to draw benefits from various resources and contributions of other players in the field of HIV, but there must be a "clear comparative advantage over national or global programming" for an activity to qualify as a regional activity (Anamela et al., 2010:9). In this regard, Anamela et al. (2010) emphasise essentiality combined with subsidiarity as complementary to economies of scale in determining regional programming. But how is

regional work as defined in the foregoing subsection different from or similar to other types of programming at the regional level, and indeed are there other variants of regional work? The ensuing subsection explores this question in an effort to deepen the comprehension of regional work in the HIV response in Southern Africa.

4.4 Defining the Multi-country

The previous section has provided criteria for distinguishing regional programming from other variant scales; it therefore sets the basis for contrast with other scales. This subsection identifies the other levels of programming and attempts to demonstrate how regional work links, relates or is different from the other scales. In particular, the term *multi-country* needs to be defined and contrasted with regional programming to clarify the meaning of both terms in relation to each other, and whether or not those elements that characterise regional work similarly describe *multi-country programming*. As well, as noted in chapter five, different regional blocs in Africa intersect and share Member Countries. An inspection of some donor and regional NGO programme documents indicates that some of these organisations run programmes that straddle over regions. This is similarly analysed in this section to clarify the concept of regional programming and indeed provide inputs into the framing of the concept '*being regional*.'

Both regional and multi-country programming involves work that occurs in more than one country. However, as earlier illustrated, regional programming occurs within a specific region; and is justified by a set of five principles; of subsidiarity, supremacy, externality, essentiality and economies of scale. These principles remove regional programming from the country scale. In other words, like in the UN application of the principle of supremacy and subsidiarity, there is work that only country or regional scales can do. When one applies these principles to the international level vis-à-vis the regional level, the same picture emerges. However, multi-country programming activities are distinguishable by a number of elements that are directly opposite to the characteristics of regional programming.

Table 4.6 compares and contrasts regional and multi-country programming. While both programming typologies occur in more than two countries, the primary differentiating factor is the principles of *supremacy* and *subsidiarity*, which define the relationship between target countries and external social agents.

Table 4.6: Differentiating Regional from Multi-Country

Regional	Multi-country
• More than two countries • Same territorial and geographical location is a requirement • Many countries of the same region • Share of same geographical proximity • Subordination to governing principle of the regional sphere • Single coordinating framework for the region which harmonises varying approaches • Principles of supremacy and subsidiarity apply – operations take the form of technical support	• More than two countries • Same territorial and geographical location is not a requirement. • Many countries from different parts of the world • Geographical proximity not a necessary consideration • Varying governing principle which may be influenced by different regional frameworks • Unique frameworks oriented to local realities • Principles of supremacy and subsidiarity not necessary – operations may be directed to any level, including direct service delivery to communities.

Source: Interview data – (KII, 2015 -2016).

In regional programming, external social agents are engaged in technical support complementing local efforts without direct services delivery. The agent's programmes are designed with a regional focus and not necessarily tailored to community level issues – if so, the programme target would be to strengthen in-country CSOs to be able to address the issue rather than the external regional social agent (RNGO) to do so directly. In other words, service delivery is not the call of RNGOs. Operating at the regional level means running programmes in a specific territorial and geographical location such as SADC, where an RNGO operates at the same level as SADC to address issues of concern for the entire region. Such programmes are either run to support local efforts (technical support – the *partner role*) or to pave way for the implementation of relevant programmes otherwise difficult without the intervention of a regional agent like an RNGO – the *catalytic role*. These concepts have already been discussed in chapter one.

Regional programming offers greater opportunity for knowledge and skills transfer and has greater potential for the empowerment of in-country CSOs and their communities, as they are up-skilled to deal with their local issues. There is therefore better ownership and hence sustainability of in-country programmes as knowledge and skills circulate through those who receive support. There is also less likelihood of animosity between national players (the beneficiaries) and the RNGO, provided the terms and frameworks of partnerships are shared and operate for mutual benefit.

In multi-country programming, the design of programmes could be focussed on an issue of interest (e.g. psycho-social support) for both the external agent and the in-country beneficiary, and such a beneficiary could be located at country or community level, and may be the ultimate end user of the service. Such programmes do not need to have any orientation to any coordinative principles, and certainly not to those of supremacy and subsidiarity; and such operations usually straddle over regions and do not need to focus on the same issues but to any issue that is relevant in each context.

The RNGO (an external agent) can roll-out any intervention in-country directly for end-users of its services, with or without intermediaries. In this case, an intermediary is a social agent who would make the connections between two or more other actors. This means that being a multi-country operator involves running programmes anywhere in the world as the need arises without being driven by a single strategy or pursuing activities intended to respond to a common externality, such as HIV, across all intervention locations.

Work in the selected countries occurs albeit without full orientation to principles of supremacy and subsidiarity as there is direct intervention by the external agent. In this way, programming can be executed within a country and directly with community groups but not necessarily through higher-level NGOs within the country (organisations that usually provide that connective tissue recognised by the principles of subsidiarity and supremacy). In addition, the programmes are not necessarily in support of in-country agents as they directly deliver services where beneficiaries need them the most.

Multi-country operations, by virtue of the fact that they neither necessarily comply with principles of supremacy and subsidiarity nor those of common externality or economies of scale, have a potential for inducing competition with local CSOs who legitimately should be the custodians of local solutions, unless partnerships are forged with local CSOs operating in communities. There is likely to be limited effective transfer of knowledge and skills and programme sustainability especially where local CSOs view external agents' solutions as competing or taking over domestic responsibilities. In this case, the external agent tends to operate on a project basis hoping that communities will continue after the project ends. There is less likelihood of the development of local structures to ensure sustainability of initiatives.

Another variant of multi-country operations involves partnerships between country level operator and external agents. These partnerships are forged in terms of the external agent's (donor, RNGO or INGO) strategic objectives regarding the local challenge, and the desires of the local actors to find solutions to the challenge such as food aid in a drought stricken rural community. Plan International deals with these challenges often and they relate

directly to the strategy of ensuring food security. In situations like this, however, the challenge (hunger at community level) does not carry sufficient externality for regional action until it leads to emigration that affects neighbouring countries; hence, it remains a country level problem. In other words, multi-country programming and partnerships can be viewed as a mechanism for mutual advantage even as the quantum of such benefit may not be equal in intervention areas.

Further analysis of documentary and interview data revealed that regional programming as distinguished from multi-country is also different from another practice which involves inter-regional activities. The following subsection explores this phenomenon in further attempts to clarify what constitutes regional work and being regional/operating at the regional level.

4.5 Inter-regional/Multi-regional Programming

In the review of donors, SADC and RNGOs' documents, I noticed a pattern of donor programming that straddles over two regions including a tendency to then combine the regions involved into one programme site. Irish Aid rolls out its HIV programme in two regions: Southern Africa (SADC) and Eastern Africa and, in its reports, it refers to this as a combined programme site or the Eastern and Southern Africa region (ESA) (Anamela et al., 2010). Sida also does the same even though it has single-region programmes such as those specific to southern Africa or eastern Africa (Jones and Hellevick, 2012). Examining the Sida Eastern and Southern Africa HIV programme reveals that it incorporates a collection of theme-based strategic intervention areas such as HIV and AIDS, sexual and reproductive health and rights (SRHR), and human rights of lesbian, gay, bisexual and trans-sexual (LGBT) persons. All of this is intended to contribute to the prevention and management of the epidemic in both Eastern and Southern Africa (Sida, 2014). In this case, the bi-regional programme is treated as a single regional programme and evaluated as such even though it is rolled out in two regions. This constitutes a variant of regional programming to the extent that it occurs in two regions.

Some regional NGOs also extend their work and operate in more than one region, under a single strategy. An analysis of the work of the Regional Psychosocial Initiative (REPSSI - an RNGO) also shows the same characteristics as the Sida regional HIV programme. In the case of REPSSI, the HIV response is to a well-defined and consistent set of externalities (theme-based strategic intervention areas) arising from psychosocial challenges confronted by HIV positive people, which have a bearing on the effective

management of the epidemic and hence relevant in all the regions. REPSSI, and similar organisations, are discussed in more detail in chapters six to nine.

Against this analysis, it would seem that regional programming and working regionally occurs in different patterns but the key defining factors relate to, first of all, issues of a common externality such as HIV and the application of the principles of supremacy, subsidiarity, essentiality and economies of scale in considering and rolling out interventions as earlier discussed. Secondly, and as earlier noted, usually a common strategy applies which pronounces a common goal in response to a shared problem such as HIV and its attendent challenges. The consequences of these challenges may vary in their significance in each programming area, and hence the diversity of theme-based intervention activities; but all are directed towards the prevention, management and possible elimination of HIV. On this basis, unlike multi-country operations, inter-regional programming is a variant of regional work and working regionally – *being regional*.

4.6 Conclusion

This chapter has presented a conceptualisation of regional organisations, regional non-governmental organisations, regional programming and being regional, as defined by the crucial principles of supremacy, subsidiarity, externalities, economies of scale and essentiality. Regional organisations are all organisations operating at the regional level, both state and non-state. RNGOs are distinct civil society organisations that operate in the HIV response at the regional level. Regional HIV programming is seen as arising from the quest in the HIV response to provide mechanisms of dealing with issues that would require regional cooperation, and which are not possible to resolve in isolation at the national level. The quest to deal with regional externalities gave rise to both RNGOs and the practice of *being regional*, which emerges as a new concept describing how RNGOs configured themselves and aligned their activities in the response to HIV and HIV related matters, while operating in partnership with donor agencies and within the various UN and donor frameworks. In this regard, *being regional* emerges as performing, at the regional scale, those activities that comply with one or more identifiable principles (supremacy, subsidiarity, externalities, economies of scale and essentiality) within a region, by a supra-national level body. This chapter has therefore tendered an initial impression of the concept *being regional*.

CHAPTER FIVE: DONORS AND REGIONAL NON-GOVERNMENTAL ORGANISATIONS IN THE HIV RESPONSE IN SOUTHERN AAFRICAN DEVELOPMENT COMMUNITY

5.1 Introduction

The argument that I have consistently presented in this thesis is that understanding regional NGOs (RNGOs) is contextual to the extent that there are constituent elements of the environment within which they exist, and with which they interact in implementing their development programmes. To this extent, understanding RNGO programming also requires examining the donor context of their work as the later are active agents in the development arena. This chapter therefore examines and highlights the donors in the SADC region, how they have configured the HIV response and hence the flow of HIV funding to their partners in the response, including implications on RNGO operations. This analysis opens by examining the need for donor funding in the region, donor organisations and strategies for responding to the epidemic, giving illustrative examples of how they condition the work of RNGOs (The World Fish Centre, 2008:80)

5.2 The Context and Donors in the HIV Funding in Southern Africa

From the onset of HIV, funding has always been a problem for those responding to the epidemic in the global South (Mushonga, 2014). Chikwendu (2004) attributes this challenge to denialism that characterised southern authorities, both private and public sector players. Southern African governments in particular viewed the epidemic as a "helpless problem that could not be addressed by public policy" (Chikwendu, 2004:245) which also meant that no public funding could be availed for the response to the epidemic from the national fiscas. In general the culture for funding the response did not emerge soon enough and remains underdeveloped.

On the other hand, northern national governments, UN agencies, philanthropic organisations and private sector players had a much earlier entry into HIV funding, and were expanding their work into the global South through their international development assistance programmes (Mercer et al., 2014). In addition, with the advent of HIV, and its perception as an exceptional epidemic and threat to humanity (Whiteside, 2006), these social actors were mobilised to spearhead the response to the epidemic through the UN systems to act collectively (through the Global Fund) and individually through their international development programmes to support the response in the global South. In this way, not only did external funding became dominant in HIV funding in the global South but also did

northen approaches to the responses to HIV, as northern actors sought not only to fund the response but to develop the organisational and programmatic capacities of their southern counterparts. In pursuit of these efforts, they targeted areas that were determined as hot-beds of the epidemic, zones of greatest need and hence of strategic significance in the global response to the pandemic.

As the epi-centre of the HIV epidemic, SADC has attracted global attention and focus (UNAIDS, 2015). Many stakeholders are interested in the nature and dynamics of HIV. Among many, these development agents include the UN system (as the global coordinating and technical support structure), international NGOs, local NGOs at various levels, private sector outfits, and donor organisations (bilateral and multilateral). These development agents are united around a single goal, to manage HIV, end AIDS by 2030 and possibly eliminate it. In this section, I examine how donors organised and structured their responses to HIV, interface with RNGOs and impact on their work and existence. The majority of these donors operate programmes in general development including the HIV response in southern Africa.

5.2.1 Bilateral and Multilateral Donors in Southern Africa

There are several bilateral donors involved in development and HIV and AIDS work in southern Africa. Bilateral donors are those that offer funding on a direct one-on-one basis with an implementing organisation rather than as part of a collective arrangement. According to Giffen and Judge (2010:5), most of the donors involved in development work in southern Africa have long-standing relationships with their local partners providing larger core funding or programmatic grants. They largely originated from the global North and have their roots in the foreign policies of their home countries. I have listed some of the countries funding development including HIV in Table 5.1.

Table 5.1: Some of the Main Bilateral Development Donors in Southern Africa

Austria	Belgium	Canada
Czech Republic	Denmark	European Union (EU)
Finland	France	Germany
Greece	Italy	Japan
Ireland	Luxembourg	Netherlands
Korea	Norway	Portugal
New Zealand	Sweden	Switzerland
Spain	United States	United Arab Emirates
United Kingdom	Irish AID	USAID
PEPFAR		

Source: Compiled from Kates et al. (2013:8).

Unavoidably, these donors are drivers of international development policies of their home governments and they interface directly with development agents in destination countries of their aid programmes. In this way, development agents in these target areas inevitably interface with these external agents and the foreign policy priorities of their parent governments as entrenched in their aid packages on a bilateral basis.

There are also several multilateral donors operating in southern Africa providing development, HIV and HIV related funding as well as technical support. I have listed some of the multilateral donors in Table 5.2.

Table 5.2: Some of the Multilateral Development Donors in Southern Africa

Category one	Category two
i. African Development Fund (AfDF)	i. UNAIDS
ii. Asian Dev. Bank Sp. Fund (AsDB)	ii. UN Development Programme (UNDP)
iii. Global Fund	iii. UN Family Planning Agency (UNFPA)
iv. World Bank/IDA (IDA)	iv. UNICEF
v. Inter-American Development Bank (IDB)	v. World Food Programme (WFP)
vi. OPEC Fund for Int'l Development (OFID) IMF, ADF	vi. World Health Organisation (WHO)

Source: Kates et al. (2013:8).

Giffen and Judge (2010:5) observe that multilateral donors usually have more limited funds for civil society work (than bilateral donors), but are mostly distributed via country offices. The only exception is the Global Fund which is set up to provide funding for the HIV response and support the work of NGOs in that process. The UN agencies for example are not, strictly speaking, donors but technical support agencies responsible for specific development focus areas. However, they are usually listed as such because they coordinate huge sums of funds from many donors to facilitate programme delivery in specific intervention areas. In this regard, they double as donors and technical support organisations. In the case of HIV, the UNAIDS is the lead support structure for the response working on a technical support basis with all social agents involved (UNAIDS KII, 2015).

Although both bilateral and multilateral donors have their own funding structures and mechanisms, there has been growing cooperation between the two camps especially between bilateral donors and the UN structure such as the Swedish International Development Cooperation Agency (Sida) led RAP programme discussed later in this chapter. Both bilateral and multilateral donors are part of the southern African HIV response programme, over and above the funding they provide on a bilateral basis. I briefly discuss the role of these donors in the HIV response in the region to highlight how they frame regional HIV work, design it

and interface with their implementing partners; state and/or non-state, focussing especially on RNGOs.

5.2.2 Donors and the HIV Response in Southern Africa

From the 1990 onwards, there has been increasing interest in regional AIDS programmes (RAPs). RAPs started as an initiative of donors funding the HIV response who believed that there could be some value in regional work accruing from joint working arrangements. Kates et al. (2013:13-15) define RAPs as "HIV programmes that are organised and executed as part of a regional response to the epidemic, programmes that respond to the priorities of the entire region, addressing the epidemic on the basis of the characteristics it displays within the region." In other words, the response seeks to also target those broader issues that influence the epidemic (migration, similarity of cultures, gender, sex work, key populations etc.) in relation to the pandemic.

Greater interest in these broader issues led to the initiation of concretised regional programmes led by donors with the technical support of the UN system. These regional responses were rolled out within the jurisdiction of regional economic communities (REC) such as SADC, thus providing territoriality context to harness the juridical powers of regional governmental authorities. As a result, since 2000, there exists in southern and eastern Africa, donor regional HIV programmes around which donor interventions have been organised (Anamela et al., 2010:4). The programmes are a product of bilateral donors (Irish Aid, Sida, HIVOS, NORAD, USAID) working with UN agencies which, seeking synergy and better coordination among themselves, have since initiated and run the programmes.

According to Anamela and Hamilton (2010:16), the donor regional programme "pays great attention to harmonisation, co-ordination and alignment. Individual donors like Irish Aid maintained flexibility to adapting their programmes to accommodate joint working". The programme was initiated to give effect to the Paris Declaration principles of harmonisation, co-ordination and alignment of development financing (Birdsail and Kelly 2007). Table 5.3 presents the defining elements of donors working regionally in the HIV response, outlining the purposes of donor engagement among themselves as well as the kind of work they support among their implementing partners.

The programme is geared towards promoting collaboration and coordination to generate *added value* of regional work. In the next subsection, I examine the Sida led regional programme to highlight the mobilisation of the teams around the programme objectives and

hence explore the embedding and orienting effects of such configurations on implementing RNGOs.

Table 5.3: Defining Elements of Regional Programming

Element	*Description*
1. **Promote comparative advantage of regional approach**	*Mobilise for collaboration, harmonised approaches to achieve the best in regional programming*
2. **Donor harmonisation**	*Encourage donor harmonisation to ensure availability of funding and effective support for HIV programming in the region and avoid duplication of funding.*
3. **Foster global and country linkages**	*Establish linkages between global and country response to ensure coordinated effort for effective HIV funding, technical support and programming*
4. **Promote mainstreaming**	*Ensure HIV is covered in all areas of programming*
5. **Strengthen monitoring and evaluation**	*Checking on progress and impact of regional approaches to demonstrate added value of regional approaches*
6. **Technical assistance**	*Ensure technical support to regional and country CSOs, SADC , government and others in the response*
7. **Strengthen bilateral and regional links**	*Enforce links between bilateral and regional responses and clarify the role of respective advisors*
8. **Prioritise thematic areas**	*Prioritise programming on stigma and discrimination, children, women and young girls, food security and nutrition, and prevention.*
9. **Expansion**	*Expanding support to other regions to ensure the application of regional responses on population scale in Africa. (East Africa).*

Source: Anamela et al. (2010:7), my own compilation and presentation.

5.2.3 The Sida-led Regional HIV Response in Eastern and Southern Africa

Sida is one of the bilateral donors financing the HIV response in southern Africa. It occupies a critical position in the response as it has mobilised a regional team of development agents to respond to HIV and AIDS, and to roll out a multifaceted regional response – thus taking a lead in defining the regional response and working regionally in southern Africa (SAT, 2004). As a bilateral donor, the Swedish government directly funds Sida's work. Sida implements and delivers on Sweden's foreign policy on international development (Sida, 2002:9, Sordabum, 2016). Sida's work straddles over various issues that include governance, human rights, gender, regional integration, economic transformation and health, within which it has constructed a regional strategy for HIV and AIDS intervention for Eastern and Southern Africa (ESA) (Sida, 2002). The concept 'region' has already been problematised in earlier chapters (chapters 3 and 4). However, in terms of Sida's work, while recoginising territoriality, it identified 'region' as an operational area defined in terms of the spread of the HIV epidemic and the commonality of its drivers. As a result, the east and southern Africa

regions are usually conflated and regarded as a single region: the Eastern and Southern Africa region.

A review of online material revealed that the Sida HIV regional HIV team comprises of 27 member organisations that includes international non-governmental organisations (INGOs), UN agencies, state bodies (e.g. Southern African Development Community SADC) and non-state agencies.

Table 5.4: The Sida Regional HIV Team

Objective	Nature/type of Key Activities	Key Partners	Total partners
1. Decreased number of HIV infections	HIV Prevention, treatment, care and support, including issues of access to treatment care and support	○ Organisational capacity development organisations, ○ Gender justice organisations, ○ Research institutions, Population Services organisations, ○ Information and advocacy outfits, ○ Children and youth organisation, ○ Workers' organisations, specialised UN agencies – UNICEF, UNAIDS, UNODC, UNESCO.	**16** (57%)
1. Improved living conditions for women and girls affected by HIV and AIDS.	Prevention focussed activities targeted at girls and women including economic and legal support activities	○ International NGOs (VSO, Help-Age, etc.) ○ Inter-governmental Organisations (IGOs) (SADC) ○ UN agencies (e.g. ILO)Specialised services organisations (e.g. REPSSI)	**7** (25%)
2. Increased respect for and enjoyment of the human rights of LGBTI people	Legal and social reform to create a conducive operational environment for HIV programming including and especially for Key Populations	○ Human Rights organisations at the regional and international level included ○ UN specialised agency for HIV and Law in the UNDP	**5** (18%)

Source: Compiled from Sida, 2014.Regional HIV & AIDS Team – Contribution Overview.Available on http://www.sida.se/globalassets/global/about-sida/sa-arbetar-vi/halsa/regionalt-hiv-aids-contribution-overview--final, Accessed on March 14, 2016.

Team members are organised under three strategic regional objectives (presented in Table 5.4) that focus on the broad areas of HIV: infection reduction, impact mitigation, health, social and economic challenges. The largest group of partners (57%) was constituted around Objective 1. Objective 2 had the second largest group at 25% of the total partners, while the rest (N=5) were mobilised around Objective 3 - focused on human rights issues (see Table 5.4). The objectives were linked to the Millennium Development Goals (MDGs), particularly: Goal 6 – focussed on HIV and other diseases; Goal 3 – Gender, child mortality; Goals 4 and

1: Reduction of poverty (UNDP, 2000). This demonstrates how the Sida regional response was also integrated into the broader UN global development agenda.

Table 5.5: Objective 1- Partners Recruited and Activities

Objective 1	Partner organisation	Activities focus
Decreased number of HIV infections	1. Africa Capacity Alliance (ACA) (formerly RATN):	"Developing Capacity of HIV and AIDS programmes in Eastern and Southern - strategic plan
	2.Health Economics and HIV/AIDS Research Division (HEARD):	"Knowledge and Evidence for Impact: Integrating HIV Response with Human Development, Phase ll
	3.International Organization for Migration (IOM):	"Partnership on Health and Mobility in East and Southern Africa 2 (PHAMESA)"
	4.The Industrial and Metal Workers' Union of Sweden (IF Metall) & International Council of Swedish Industry (NIR)	"Swedish Workplace HIV & AIDS Programme (SWHAP), Phase III"
	5.Population Council	"Expanding the Evidence Base and Networks for Sexual Violence Response and Management in East and Southern Africa, Phase III"
	6.Population Services International (PSI):	"Expanding and Improving Social Marketing in Southern Africa, Phase III"
	7.Southern Africa HIV & AIDS Information Dissemination Services (SAfAIDS):	"Sustainable Communities of Real Excellence – (SCORE) on SRH, HIV and GBV in Southern Africa"
	8.Southern African AIDS Trust (SAT):	" Strategy for Community Systems for HIV and Sexual and Reproductive Health & Rights"
	9.Save the Children:	"Improving Children's access to comprehensive Sexuality Information and Education in sub-Saharan Africa"
	10.Sonke Gender Justice/MenEngage Africa:	"Increasing the Scale and Impact of Work with Men and Boys for Gender Equality across Sub-Saharan Africa through MenEngage Network"
	11.Soul City Institute:	"To intensify its regional intervention in order to accelerate HIV prevention & address SRHR priorities"
	12.UNAIDS:	"Expanded Accelerated AIDS Response towards HLM Targets and Elimination Commitments in ESA Region"
	13.UNESCO:	"Strengthening Sexual and Reproductive Health and HIV prevention amongst children and young people through promoting comprehensive sexuality education in Eastern and Southern Africa"
	14.UNODC:	"HIV & AIDS Prevention, Treatment, care & Support in Prison Settings in 7 Countries in sub-Saharan Africa"
	15.UNICEF:	"Advancing Elimination of Mother To Child Transmission (EMTCT): Optimizing access to simplified HIV treatment to reduce new HIV infections among children in 4 countries"
	16.AIDS Foundation South Africa (AFSA):	"Making sexual and reproductive health rights real in South Africa "

Source: Compiled from Sida, 2014. Regional HIV &AIDS Team – Contribution Overview. Available at http://www.sida.se/globalassets/global/about-sida/sa-arbetar-vi/halsa/regionalt-hiv-aids-contribution-overview--final. Accessed on March 14, 2016.

These goals have been incorporated into the current UNDP (2015) Sustainable Development Goals especially Goals 1 to 5. The strategic objectives targeted the most-at-risk groups such as women, girls, lesbians, gays, transgender and intersex (LGBTI). In that regard, emphasis is placed on addressing legal issues related to access to health services, social and economic rights, and the protection of human dignity among the LGBTI community.

The LGBTI, women and girls are vulnerable groups in most parts of the region as in most cases definitive legal frameworks that adequately protect their rights are lacking, and in a context where cultural practices that exacerbate their vulnerability are widespread (even in South Africa where laws exist that recognise their rights). Sida mobilised resources to support the roll out of the response by various implementing partners identified and recruited against each objective (Tables 5.4, 5.5 and 5.6). This way, each of the objectives became a fundable programmatic area (a funding stream) for which resources were mobilised for channelling to projects under each objective.

In the team, there is careful targeting of requisite skills, for example, around Objective 1. five UN agencies and eleven civil society organisation of diverse backgrounds and competencies are mobilised to roll out programme activities that contributed to 'decreased HIV infection in the region.' The targeted skills are in the areas of prevention, and this included addressing all aspects (social, biomedical and economic) relevant for the management of the epidemic.

Table 5.6: Objective 2 - Partners Mobilised and Activities

Objective 2	Partner orgs	Activities focus
Improved living conditions for women and girls affected by HIV and AIDS	**Clinton Health Access Initiative (CHAI):**	"Towards Sustainable Health Financing II
	East African Community (EAC):	"Realigned EAC HIV & AIDS Multisectoral Strategic Plan"
	HelpAge International & Africa Regional Development Centre (HAI-ARDC):	"Strengthening Social protection to prevent and mitigate the impact of HIV/AIDS and poverty in Sub-Saharan Africa"
	International Labour Organization (ILO):	"Economic Empowerment & HIV Vulnerability Reduction Along Transport Corridors in Southern Africa"
	Regional Psycho Social Support Initiative (REPSSI):	"Strategic Implementation Plan"
	Southern African Development Community (SADC):	"SADC HIV & AIDS Business Plan"
	Voluntary Services Overseas (VSO):	"Gender Empowerment and Development to Enhance Rights (G.E.N.D.E.R)"

Source: Compiled from Sida, 2014.Regional HIV &AIDS Team – Contribution Overview. Available on http://www.sida.se/globalassets/global/about-sida/sa-arbetar-vi/halsa/regionalt-hiv-aids-contribution-overview--final.Accessed on March 14, 2016.

Similarly, under Objective 2 (Table 5.6), seven agents including two regional governmental organisations (the East African Community (EAC) and the Southern African Development Community (SADC)), four international NGOs, one UN agency and one regional NGO were mobilised on the basis of the relevance of their skills to deliver on the improved conditions for women and girls affected by HIV.

As questions around gender is a regional matter in the southern and east African communities, the involvement of EAC and SADC is deemed strategic as they would motivate for policy and cultural changes among member countries, and the focus is largely on macro level aspects of the epidemic that have to do with the policy environment. Strategic Objective 3 (Table 5.7) focuses on key populations and hence targets and mobilises organisations that centre on human rights so as to contribute to the component to the HIV response (to 'increase the respect and enjoyment of human rights by lesbians, gays, bi-sexual, trans-gender and the intersex (LGBTI').

The Sida-led regional HIV programme demonstrates that development agents become embedded in pre-planned HIV response processes based on donor objectives. Sida's Regional Team for HIV and AIDS was mobilised around each of Sida's three objectives to operationalise various aspects of each of the objectives.

Table 5.7: Objective 3 - Partners Mobilised and Activities

Objective 3	Partner orgs	Activities focus
Increased respect for and enjoyment of the human rights of LGBTI people	AIDS & Rights Alliance for Southern Africa (ARASA):	"Support to AIDS & Rights Alliance (ARASA) Strategic Plan"
	Human Rights development Initiative (HRDI):	"Regional Human Rights Law Clinics: Increasing Access to Justice for Vulnerable Groups in Africa"
	International Gay and Lesbian Human Rights Commission (IGLHRC):	"Responding to the Human Rights and Health Crisis Among African LGBTI"
	International HIV/AIDS Alliance (IHAA):	"Support to the Africa Regional Programme 3(ARP phase II)"
	UNDP – HIV and The Law:	"Strengthening Regional and National Legislative Environments to Support the Enjoyment of Human Rights of LGBTI People and Women and Girls affected by HIV and AIDS in Sub-Saharan Africa"

Source: Compiled from Sida, 2014.Regional HIV &AIDS Team – Contribution Overview. Available at http://www.sida.se/globalassets/global/about-sida/sa-arbetar-vi/halsa/regionalt-hiv-aids-contribution-overview--final . Accessed on March 14, 2016.

These objectives and the partnership constituted an institutionalised and donor driven HIV response in the southern African region. Participants in the programme were

compartmentalised and directed in their work to the extent that they contributed to Sida's objectives. I submit that whatever the justification that may exist, development programmes (including HIV responses) are directed ventures, steered by the organising hand of the donor as development agents (state and non-state, local and regional NGOs) are attracted to resources mobilised and streamed along the donors' strategic objectives.

Key informant interviews (KIIs, 2015-2016) with sample RNGOs in this thesis corroborated this observation when they confirmed that NGOs scan the donor community to identify sources of funding and funded areas, and adjust their strategies and programmes accordingly to access financing for their organisations and programmes (as discussed in chapters eight and nine). They noted that although this usually happened among those RNGOs that struggle to raise funding even for their organisational sustainability, every NGO needs to be found relevant by the donor in its programmes and identify its niche. In this sense, the search for relevance in a pre-structured environment, and faced with intra-RNGO deficiencies (lack of resources), occasioned sector-specific NGO gravitation towards donor control and succumbing to their priorities in defined response areas such as HIV. This leads to questions around the notion of donor fund-streaming and how donor-funding mechanisms reinforce funders' influences in programme design and activities of implementing organisations.

5.2.4 The Concept of Fund-streaming and Programme Influence

The concept of funding-stream has not been discussed so far, yet it featured quite prominently in interviews with RNGOs. Funding-stream refers to a source of finance but one that is channelled for a specific development project (all KII, 2016). I would like to begin by exploring this concept from its verb form in the present continuous tense to highlight the considered and purposive arrangement of funding for development. The word 'stream' in the verb form means 'move in large numbers – flow freely and abundantly' (English WordNet, 2001). A motion always has a source centre, a trigger, is directional, and has an impact point or destination.

Applied to funding, this means that donors initiate and channel development assistance to a beneficiary, as suggested by the river metaphor. Viewed in this manner, funding streams are channels of funds created and directed towards specific development areas. This means that development funding does not just occur but is created and targeted for a purpose. In this case, accessing such funds also becomes controlled, to the extent that access to funds is allowed by the donor to the targeted areas through selected development actors. In

other words, donor funding is *streamed* and can also be described as *directed* and *dedicated* resources. It is meant for a particular programming thematic areas and specific geographical area, and at a certain level (community, country, region etc.), for the assistance of specific beneficiaries.

External agents (donors) designate funding, programme location and beneficiaries on the basis of given developmental goals and objectives (as illustrated above) that respond to existing human challenges; but, as we have seen, this is all conceptualised by the external agents and then transmitted to local actors in such a way as to influence the response to challenges. In this sense, *fund streaming* is a useful tool for drawing attention to specific issues, and directing effort towards those areas needing development work. Once resources are availed in a specific area of work, development actors redirect their attention to close in on availed resources. Hence, they become part of a new network or revive existing connections to access the funding and participate in the development process. In this light, it is useful to outline some of the funding mechanisms in the HIV response in southern Africa to illustrate how funding is streamed in different forms and arrangements.

5.2.5 Donor-NGO Funding Mechanisms

Donor funding mechanisms are driven by their strategic objectives to the extent that funding is channelled through these objectives as fundable programmatic areas. Such funding is provided either bilaterally or under some form of joint financing arrangement (JFA). In some literature, it is referred to as basket funding (Sordabum, 2016:85). Each of these funding arrangements are analysed in this section to highlight their advantages and challenges especially for beneficiary RNGOs.

Much funding for civil society (including RNGOs) is availed under a bilateral arrangement. This is a funding arrangement where donor support is provided through a consensual settlement between the donor and the NGO intermediary partner (Nilsson, 2013; Giffen and Judge, 2010:5). Under this funding arrangement, an implementing partner follows the funding requirements of a single donor and accounts to that donor for programmatic delivery and impact of its investment. Like all funds, however, bilateral funding is premised on the relevance of the recipient NGO and its programmes/projects to the donor's own strategic objectives.

Following the recognition of NGOs as key mainstream development players from the late 1970s, there emerged a multiplicity of donors providing funding to the latter (Hilton, 2012). Many NGOs embraced this funding from multiple sources to enhance their financial

bases to ensure organisational and programme sustainability. The multiple donors acted individually without coordination among them, even as they funded the same NGO. This was just multiple funding as the donors were not bound by a Memorandum of Understandng (MoU) or coordinated in any way as they had separate bilateral agreements with the NGO (Giffen and Judge, 2010:6). This funding arrangement persists to date albeit at a smaller scale as donors currently prefer coordination to reduce duplication and also to facilitate the measurement and attribution of aid impact (RNGO KIIs 2016 – 2017).

5.2.6 Joint Funding Arrangements

The quest for more coordinated funding arrangements for sustainable development financing was preferred by donors after the Paris Donor conference, pushing most donors into joint financial arrangements (JFAs). A joint funding arrangement (JFA) is a mechanism of funding that involves a number of donors putting resources into a common pool from which they fund their implementing partner/s. Under this arrangement, the donors usually sign an MoU that governs them in providing the funds (RNGO KII, 2015-2016). JFAs provide both programme and core funding, thus enhancing organisational and programme sustainability. According to all KIIs with RNGO informants (RNGO KIIs 2016 – 2017), a JFA ensures pooled and coordinated multiple fund sources and larger amounts for the recipient organisation. This provides some measure of financial stability for the recipient organisation as the donors are less likely to abandon the arrangement haphazardly and without considering the plight of the recipient NGO.

This is illustrated in the case of SAT when the donors acted in unison to assist the organisation to correct its institutional weaknesses and refocus its programmes between 2011 and 2013 (Mushonga, 2014). As a result, SAT was able to retain its funding and to refocus its generalised institutional capacity building programme into a more project-based intervention in the donors' new focus area of HIV and sexual reproductive health and rights (SRHR).

While multi-donor funding ensures availability of different funding streams and levels (core programme or project), the diversity brings with it an increased management burden as each donor would require the maintenance of a separate account, accounting procedures, audit requirements and reporting for its funds (RNGO KIIs 2015 – 2016). Also it means dealing with different values and expectations from the different donors. In addition, RNGOs become embedded in a multiplicity of social network arrangements under diverse influences. The Regional Psychosocial Initiative (REPSSI) stated that this always presented

a great challenge, in trying to manage different accounts as well as relations with multiple donors (REPSSI KII, 13-06-2016).

These funding arrangements demonstrate that the beneficiary RNGO becomes intertwined in the value systems of the donor to the extent that such funding is released to operationalise the donor's own strategic objectives; as there is no donor that invests in projects that contradict its values and/or strategic objectives. As funding is released in such a manner, NGOs that need funding are therefore conditioned to tailor their work and value systems to fit into those of the financier. In this sense as well, though, there emerges a new culture of cooperation and collaboration in contexts where funding is accessed through multi-donor financing.

However, each funding arrangement has its own challenges; for example, even though SAT had not experienced any financial problems under its bilateral funding arrangement with CIDA, provided as core funding, it could only cover a limited geographical area. Thus, in 2002, SAT had to abandon its ambition to expand its capacity development programme to all SADC countries due to limited budgetary provisions (SAT, 2006:12). Under the JFA, however, SAT faced new challenges that forced the organisation to abandon its primary strategic focus on institutional capacity building for emergent and nascent CBOs in order to enhance community HIV and AIDS competency in southern Africa (Mushonga, 2014: 230-240). CIDA had funded the strategy bilaterally since 1990. It had to agree to review its strategy and turn to focus on community systems strengthening and sexual reproductive health and rights (SRHR) starting in 2012 as a condition for restoration of funding suspended (following the identification of institutional and programmatic weaknesses by its new JFA partners based on a forensic audit of the organisation). These examples illustrate the increasing complexity of RNGO life and work in the context of different financing mechanisms. Further, as discussed in the next section, there are different types of funding offered under these financing arrangements, and this demonstrates how they further limit the flexibility of RNGOs.

5.2.7 Types of Funding

There are a three types of funding that implementing partners can access from their funding partners. These include core, programme and project funding (Sorderbaum and Brolin, 2016:49). These types of funding can be provided on a bilateral or joint funding arrangement basis. I briefly discuss these types of funding to illustrate how they are designed and influence the way RNGOs operate.

5.2.7.1 Core funding

Core funding is like a general purpose fund that can be directed to any needed area of the organisation. Most donors have stopped providing core funding, preferring programme or project financing which ensures results in the specific area of funding. However, NGOs have greater preference for core funding as it affords them flexibility in budgeting and fund utilisation (RNGO KIIs, 2015 -2016). Nilsson et al. (2013:21-22) note that the OECD/DAC guidelines on funding mechanisms define core support as "general budget to the overall strategic plan and operations of a CSO, including administrative costs." Some more flexible and generous donors may include an element of core funding in programme support funding to cover programme administrative costs (DHAT, KII, 2016). According to the OECD/DAC funding guidelines, core funding is identifiable by characteristics outlined in Box 5.1.

Box 5.1: Characteristics of Core-Funding

- An un-earmarked grant to the organisation against its strategy and overall work plan.
- Individual donor funding goes to the main organisational account and is not separated from money received from other sources.
- Auditing, procurement and reporting are using the organisations systems and procedures, not the donors.

Source: Compiled from Nilsson et al. (2013:22).

Core funding is more flexible and amenable to reallocation to emerging, needed and priority areas as it is un-earmarked, supports the entire organisational strategy or work plan, is not managed in a separate account from other funds, and does not have separate accounting requirements (all KII, 2016). It is subject to general organisational auditing and procurement procedures and not those of each specific donor. This is not the case with programme funding which is dedicated to a specific programmatic area.

5.2.7.2 Programme Support

Programme support is another mechanism that donors use to fund their partner implementing organisations. From a Sida perspective, programme support is understood "as long-term support or partnership arrangements where partners cooperate on a multitude of issues to achieve results on an outcome level" (Nilsson, 2013:21). The major objective of programme support is to realise change in the focus area. It has broader objectives that can be realised over a longer period of time and supporting objectives which may constitute project areas to feed into the programme (see Table 5.8 for an example of programme support).

Programme support may include at least 10% of the total programme funding as core funding or service charges since there is usually no direct institutional funding for the entire organisation in programme support. In this regard, programme funding is less flexible than core funding and does not constitute a major component of organisational financial sustainability.

Table 5.8: Example of Programme Support

Regional Psycho Social Support Initiative (REPSSI) "Strategic Implementation Plan 2011-2015"			
PLUS ID: 21500180	Archive Ref. No.: UF2011/25265		Team PO: Francis Mangani
Agreement No. A2150109	Activity Period: March 2011- December 2015	Contribution (SEK) 79M	Contact: Noreen Huni, Ex. Director E-mail: Noreen@repssi.org
Support initiated: 2002	Total volume of support since start (SEK): 121.5M		
Short programme description	Aims to mitigate the psychosocial impact of HIV & AIDS, poverty & conflict among children & youth. Champions the cause of Psychosocial Care to OVCs in the ESA region. The focus is community & family centred support. REPSSI works closely, through technical partnership/advisory roles, with UN agencies, SADC, EAC at the regional level and with CSOs and governments at country level.		
Development Objective(s)	Increased capacity for impact mitigation. Promote enabling environments for communities & families in ESA to nurture psychosocial wellbeing of children and youth.		
Program/Project objective(s)	• Develop, accredit and share innovative, user friendly, evidence-based and culturally appropriate resources in the application of psychosocial support for children & youth. • Advocate for the integration of PSS into policies and programmes that affect children and youth, nationally, regionally and globally. • Provide technical assistance to national programmes in the 13 countries to mainstream PSS and enhance family and community competences to nurture, protect and empower children and youth. • To enhance REPSSI's Organisational effectiveness (e.g. generate % of operational costs through social enterprise measures).		
Main Results Since Initiation of Support	• **Research, development and refinement of resources**: REPSSI has developed resources for PSS in protection. New resources include a 6-module teachers' diploma that is being implemented in Zambia, guidelines for country domestication for the SADC minimum package of services and tools for community conversations on Children with Disabilities and Experiential Learning. • **Advocacy**: A number of advocacy events were held in conjunction with REPSSI@10 celebrations in REPSSI countries and the 2012 IAS in Washington. Partnerships with SADC and the EAC have been strengthened; REPSSI is involved and following the progress of the development of SADC's 'Youth Development & Empowerment Plan'. • **Technical support – National-level mainstreaming of PSS**: REPSSI is now directly working with a government body in each of the 13 countries; e.g. Ministries of social service (12 countries), education (2 countries), and health (2 countries). • **Improved organisational development**: Over the last year, an Organisational Development (OD) consultant has worked with them to review the organisational design in light of their strategic direction and regional growth. • REPSSI has been providing managerial oversight - under a nesting arrangement – for the Regional Inter-Agency Task team on Children and AIDS (RIATT) jointly funded by the UNICEF and the Regional HIV & AIDS Team. The 2013 external mid-term review noted that the RIATT network had been important in bringing together actors across sectors working on children and HIV, in the world's most HIV-affected region, and used its regional platform to keep children's care and support needs on the agenda. • Overall, 11 million children have, since 2002, accessed psychosocial support through various interventions provided by REPSSI's implementing partners.		
Beneficiaries/Stakeholders	Vulnerable children, care givers, community workers, families		
Region/Countries of implementation	Angola, Botswana, Mozambique, Zimbabwe, Tanzania, Kenya, Uganda, Malawi, Namibia, Zambia, Swaziland, Lesotho, South Africa.		
Co-funding Partners	Suisse Development Cooperation (SDC), Novartis Foundation. No JFA – but joint donor meetings and reporting.		
Link to Sweden Regional Strategy	Improved living conditions for women and girls affected by HIV and AIDS		
Website	www.repssi.org www.riatt-esa.org		
Key words	children, OVC, psychosocial support, care-givers, families		

Source: Adopted from Sida, 2014.Regional HIV &AIDS Team – Contribution Overview. Available on http://www.sida.se/globalassets/global/about-sida/sa-arbetar-vi/halsa/regionalt-hiv-aids-contribution-overview--final, Accessed on March 14, 2016.

RNGO key informant interviews (SAT, SAfAIDS, DHAT, REPSSI, ARASA, NAPSAR+) confirmed this as the major type of funding available and popular with donors, as it ensures

that funding is spent only on those areas for which they are intended – thus reducing abuse of funds on matters unessential to the specific programme. For RNGOs, however, this is a challenge because programmes cannot run smoothly if the institution is not financially stable because it means that only those funded activities may continue. Programme funding is similar to project funding discussed in the next subsection.

5.2.7.3 Project Support

Project support is one mechanism utilised by donors to fund their CSO partners at regional and country levels. Sida defines project support as "support to specific time bound initiatives to deliver specific outputs" (Nilsson et al., 2013:21). It was a short-term support facility that cannot be extended to other operations of the recipient organisation. I contrast ARASA and SAfAIDS to illustrate this point. For both organisations, the life span of their projects was four years as illustrated in Tables 5.9 and 5.10.

Table 5.9: ARASA Sida Project Funding: 2013-2017

AIDS & Rights Alliance for Southern Africa (ARASA) "Support to AIDS & Rights Alliance (ARASA) Strategic Plan 2013-2017 "			
PLUS ID: 51000143	**Archive Ref. No.:** UF 2013/49546		**Team PO:** Grace Chibowa
Agreement No. A5100262	**Activity period:** November 2013 – December 2017	**Contribution (SEK)** 49M	**Contact:** Michaela Clayton **E-mail:** Michaela@arasa.org.na
Support started: 2004	**Total volume of support since start (SEK):** 86.3M		
Short programme description	The project creates awareness through training, advocacy and lobbying governments on the need to domesticate international human rights conventions and to make adequate investments in the health and rights of communities. The activities will be implemented in the Southern Africa Development Community (SADC) region with ARASA's 73 partner organisations. Through this intervention, ARASA seeks to ensure the human rights of people living with HIV or TB through making the response more human rights based and hence more effective.		
Development Objective	To promote human rights based approach and gendered response to HIV in Southern Africa through capacity building and advocacy.		
Project objectives	• Increased documentation of human rights violations against LGBT persons as a means of influencing policy makers. • A more active public debate around legislation which criminalises same sex relations. • Increased participation by LGBT persons in policy processes in national, regional and global forums		
Main Results Since Initiation of Support	No results as of yet. Results from previous agreement periods include: • ARASA has made contributions to awareness of the importance of human rights and HIV/AIDS/TB and has mobilised civil society in Southern Africa around this and equipped them with advocacy and lobbying skills. They have reached about 70 organisations from 16 countries in SADC and the Indian Ocean area. • ARASA has monitored discriminatory legislation, policy and practices and has supported the development and strengthening of an enabling environment to tackle these issues by producing a regular report on HIV and Human Rights in SADC since 2006. • ARASA has conducted awareness and sensitisation campaigns for communities and governments on the rights of Gay, Lesbian, bisexual and Transgender populations.		
Beneficiaries/Stakeholders	CSOs engaged in building capacity in human rights, law and HIV & AIDS.		
Region/Countries of implementation	The Southern Africa Development Community (SADC) region.		
Co-Funding Partners	Ford Foundation, John M Lloyd Foundation, Robert Carr Foundation, Levi Strauss Foundation, RNE-HIVOS		
Link to Sweden Regional Strategy	Contribute to the long term objective of attaining increased respect for and enjoyment of the human rights of LGBT persons.		
Website	www.arasa.info		
Key words	HIV, AIDS, Human Rights		

Source: Adopted from Sida, 2014.Regional HIV &AIDS Team – Contribution Overview. Available on http://www.sida.se/globalassets/global/about-sida/sa-arbetar-vi/halsa/regionalt-hiv-aids-contribution-overview--final. Accessed on March 14, 2016.

Project support is far more restricted, and directed by a few specific, measurable, attainable, realistic and time-bound *(s.m.a.r.t*) objectives. In the case of ARASA, there were three objectives (Table 5.9)

Sida provided project support to some of its partner RNGOs and I examine the case of ARASA presented in Table 5.9. The project funding was provided for the period 2013-2017 to support ARASA's human rights training, and lobbying and advocacy work in southern Africa; and to promote a human rights-based approach to HIV and AIDS, but specifically focussed on three objectives (as specified in Table 5.9). The results under these objective were clear outputs stating the number of activities conducted and organisations and countries covered as part of the contribution towards the goal of a human rights-based approach. However, like in other forms of funding, the recipient organisation was entrenched in relations with many other development agents and its work remains directed by the objective under which funding is provided.

Table 5.10: SAfAIDS Project Funding 2014-2018

Southern Africa HIV & AIDS Information Dissemination Services (SAfAIDS) "Sustainable Communities of Real Excellence – (SCORE) on SRH, HIV and GBV in Sothern Africa 2014-2018."			
PLUS ID: 51040058	Archive Ref. No.: UF2014/21484		Team PO: Eva Atterlöv Frisell
Agreement No. A5100296	Activity period: 2014 - 2018	Contribution (SEK) 40M	Contact: Lois B Chingandu E-mail: lois@safaids.net
Support started: 1998	Total volume of support since start (SEK): 97M		
Short programme description	Southern Africa HIV & AIDS Information Dissemination Service (SAfAIDS) is a regional NGO established in 1994. SAfAIDS' mission is to promote effective and ethical development responses to the epidemic and its impact through HIV & AIDS knowledge management, capacity building, advocacy, policy analysis and research.		
Development Objective	Enhance health communication		
Project objective	To contribute to a sustained 50% reduction in new infections and improved positive sexual and reproductive health (SRH) outcomes for communities in southern Africa by 2018		
Main Results Since Initiation of Support	New agreement, no results reported yet		
Beneficiaries/Stakeholders	NGOs, FBOs, ASOs, CBOs, media, academic, research institutions as well as individuals and communities.		
Region/Countries of implementation	Zambia, Zimbabwe, Malawi, Lesotho, Swaziland and South Africa.		
Co-Funding Partners			
Link to Sweden Regional Strategy	The contribution is in line with the Strategy, especially to the first objective "Reduced number of new HIV infections".		
Website	www.safaids.net		
Key words	Capacity building, information repackaging and dissemination, HIV prevention		

Source: Adopted from Sida, 2014.Regional HIV &AIDS Team – Contribution Overview. Available on http://www.sida.se/globalassets/global/about-sida/sa-arbetar-vi/halsa/regionalt-hiv-aids-contribution-overview--final . Accessed on March 14 2016.

The SAfAIDS project funding spanned over four years from 2014-2018 (Table 5.10). It was based on a single objective that includes a 50% reduction in HIV infection and a 50% improvement in positive SRH conditions within the same target time. The project targeted several categories of CSOs, academic and research institutions, individuals and communities, and extended over six SADC countries. The project fund was based on a bilateral funding model between Sida and SAfAIDS.

The two project funds compare and contrast. Like ARASA, SAfAIDS' implementation period was also four years. This confirms that project funds are short-term. In both cases, the objectives were *s.m.a.r.t.* Unlike the ARASA project that has three objectives, SAfAIDS' funding focuses on a single but double barrelled objective; 50% reduction of HIV infection and improvement in SRH by 2018. Beneficiary identification and geographical coverage are common features of all funding arrangements, as well as relating to the Swedish Regional Strategy.

These two case examples have highlighted the fact that the embeddedness of RNGOs into donor networks through funding provisions depends on the type of funding. It also shows the extent to which joint project funding buries RNGOs deep into various forms of social relations with donors, countries where their programmes are located, and the specified local programme beneficiaries (as indicated for instance in Table 5.10). In other words, at the implementation level, RNGO are entrenched in various circles of partnerships.

5.2.8 General Donor/RNGO Partnership Initiation and Contracting Processes

The relationship between a donor and an RNGO began in one of two man ways. It was either initiated by the donor or the NGO. Either way, it is a calculated process that included strategising and marketing to attract the relevant partner. The RNGOs analysed in this thesis either responded to donors' calls for funding proposals or submitted issue/project-based funding proposals to a selected donor/s motivating for the financing.

Donors usually have funding streamed against their own specific strategic objective(s) for which they need implementing partners/organisations. Implementing organisations (as defined earlier in chapter 1) are the means through which donors roll out their strategic development objectives. The process of recruiting and enlisting implementing organisations involves a call for proposals to identify potential implementing organisations (RNGO KIIs, 2015 -2016). In response to a call for proposals, potential implementing organisations submit proposals that demonstrate their organisational capacity and hence suitability as implementers

of the proposed projects or programmes. This was usually a competitive tender process where the donor recruited those most suited for the task.

From an Irish Aid perspective (Williams, 2013:7, 23), which is also involved in HIV work in the region, and as the KIIs confirmed, the process also involved the assessment of compatibility between the donor and the implementing organisation in terms of vision, mission, goals and values in relation to the area/s of proposed work, to reduce conflicts and disagreement in the partnership process. Table 5.11 lists the various assessment areas that collectively determine the suitability of an organisation as an implementing partner.

Table 5.11: General Selection Criteria

Capacity area	Elements
Governance	➢ Organisational strategy: Vision, mission, goals, values and principles ➢ Composition and Role of the Board ➢ Separation of powers between board and management
Management	➢ Organisational strategic plan ➢ Management systems: accounting, procurement, human resource, fundraising,
Operational	➢ Operational plans ➢ Implementation plans ➢ Budgets ➢ Monitoring and evaluation ➢ Reporting and information management
Track record	➢ Experience in similar work and managing donor funding; including list of current and/or past funders

Source: Williams (2013); ECOSOC (2006); Nilsson (2013).

These assessment areas were judged against the requirements of the donor and especially its own development values and strategic objectives (Nilsson, 2013). Although the partner organisation needed to have some capacity, it was not a major determining factor as this could usually be enhanced as part of partner support to deliver the programme and account for the funding.

'Head-hunting' was an alternative method of recruitment of potential implementers. Donors utilised 'head-hunting' where there was apparent compatibility between donor development objective/s and values, and those of the potential implementing organisation. It occurred in instances where the potential implementing organisation was apparently the most suited organisation to implement the specific donor programme or project. In this thesis, an illustrative example would be the recruitment of key populations' organisations to participate in the KP REACH programme in southern and eastern Africa discussed later in this chapter.

According to the HIVOS key informant interview (KII, 02-08- 2016.), the recruitment of organisations of key populations (lesbians, gays, bisexuals, trans-gender and intersex

(LGBTI), drug users and sex workers) involved utilising their peers and network members to approach and motivate them to submit an expression of interest to participate in the implementation of the regional KP REACH programme in Southern and Eastern Africa. The organisations were approached because they were the only ones that focussed on the usually contentious issues (e.g. sex work, drug use and LGBTI) and, as well, the most strategically positioned among them were selected to lead the process. In this case, the key considerations were the type and focus of the organisations, rather than just their organisational capacity and ability to deliver the programmes.

In cases where institutional capacity deficiencies existed, potential partner organisations underwent capacity enhancement as a condition to receive donor funding. Between 2014 and 2015, NAPSAR+ underwent institutional capacity strengthening under the Management Science for Health (MSH) which was contracted to prepare the organisation to receive USAID funding (NAPSAR+ KII, 2015) to implement programmes for its member PLHIV network organisations in SADC. This programme was part of the USAID's support towards networks of people living with HIV in southern Africa. This is illuminative of the seriousness of the selection process because when, at the end of capacity development, assessment results were negative, the donor did not release any funding to NAPSAR+, (NAPSAR+ KII 05-11-2015).

Another route that led to partnership between a donor and RNGOs involved the latter submitting fund-raising proposals for either core funding to support the operations of the organisation, programme or project, or the entire organisational strategy. In this case, the RNGO had to initially have mapped for donors that provided funding of the type for which it wished to apply. Further, the applicant had to motivate and convince the potential donor why it would be worthwhile to fund the organisation. Once a donor expressed interest, the same due diligence process was initiated and carried through including, where necessary, site-visits to verify details of the motivation submitted. Again, depending on the conclusions of the assessments, relevant capacity strengthening was recommended and this included funding for requested strategic positions such as finance, monitoring and evaluation, communication and advocacy as the KP REACH programme illustrates later.

RNGOs' key informant interviews (KIIs, 2015 - 2016), as noted, indicated that core funding was the most favourable form of organisational financing for RNGOS as it was considered flexible and could be utilised for current and any emerging and priority organisational matters. RNGOs lamented the fact that since the global economic crisis (2008-10) very few donors provide core funding, preferring programme or project funding which is

directly linked to programme delivery and thus yields greater value for money than core funding which could be spent more on administrative components than programming (SAT and DHAT KIIs).

Overall, though, following the requisite assessments by the donor and approval of funding, the formalisation of the relationship between a donor and an implementing organisation was concluded by contractual arrangements. The contract was based on clearly defined terms of reference that constituted the agreement; and it clearly stated the rights and obligations of each party to the contract in relation to the specific deliverables in given time-frames. Although Table 5.12 is not a sample contract, it provides a summary of the key elements of a donor-implementing organisation relationship as would be incorporated into a contract.

Table 5.12: Example of Some Key Elements Considered in a Contractual Agreement

Regional Psycho Social Support Initiative (REPSSI) "Strategic Implementation Plan 2011-2015"			
PLUS ID: 21500180	Archive Ref. No.: UF2011/25265		Team PO: Francis Mangani
Agreement No. A2150109	Activity Period: March 2011- December 2015	Contribution (SEK) 79M	Contact: Noreen Huni, Ex. Director E-mail: Noreen@repssi.org
Support initiated: 2002	Total volume of support since start (SEK): 121.5M		
Short programme description	Aims to mitigate the psychosocial impact of HIV & AIDS, poverty & conflict among children & youth. Champions the cause of Psychosocial Care to OVCs in the ESA region. The focus is community & family centred support. REPSSI works closely, through technical partnership/advisory roles, with UN agencies, SADC, EAC at the regional level and with CSOs and governments at country level.		
Development Objective(s)	Increased capacity for impact mitigation. Promote enabling environments for communities & families in ESA to nurture psychosocial wellbeing of children and youth.		
Program/Project objective(s)	• Develop, accredit and share innovative, user friendly, evidence-based and culturally appropriate resources in the application of psychosocial support for children & youth. • Advocate for the integration of PSS into policies and programmes that affect children and youth, nationally, regionally and globally. • Provide technical assistance to national programmes in the 13 countries to mainstream PSS and enhance family and community competences to nurture, protect and empower children and youth. • To enhance REPSSI's Organisational effectiveness (e.g. generate % of operational costs through social enterprise measures).		
Main Results Since Initiation of Support	• **Research, development and refinement of resources**: REPSSI has developed resources for PSS in protection. New resources include a 6-module teachers' diploma that is being implemented in Zambia, guidelines for country domestication for the SADC minimum package of services and tools for community conversations on Children with Disabilities and Experiential Learning. • **Advocacy**: A number of advocacy events were held in conjunction with REPSSI@10 celebrations in REPSSI countries and the 2012 IAS in Washington. Partnerships with SADC and the EAC have been strengthened; REPSSI is involved and following the progress of the development of SADC's 'Youth Development & Empowerment Plan'. • **Technical support – National-level mainstreaming of PSS**: REPSSI is now directly working with a government body in each of the 13 countries; e.g. Ministries of social service (12 countries), education (2 countries), and health (2 countries). • **Improved organisational development**: Over the last year, an Organisational Development (OD) consultant has worked with them to review the organisational design in light of their strategic direction and regional growth. • REPSSI has been providing managerial oversight - under a nesting arrangement – for the Regional Inter-Agency Task team on Children and AIDS (RIATT) jointly funded by the UNICEF and the Regional HIV & AIDS Team. The 2013 external mid-term review noted that the RIATT network had been important in bringing together actors across sectors working on children and HIV, in the world's most HIV-affected region, and used its regional platform to keep children's care and support needs on the agenda. • Overall, 11 million children have, since 2002, accessed psychosocial support through various interventions provided by REPSSI's implementing partners.		
Beneficiaries/Stakeholders	Vulnerable children, care givers, community workers, families		
Region/Countries of implementation	Angola, Botswana, Mozambique, Zimbabwe, Tanzania, Kenya, Uganda, Malawi, Namibia, Zambia, Swaziland, Lesotho, South Africa.		
Co-funding Partners	Suisse Development Cooperation (SDC), Novartis Foundation. No JFA – but joint donor meetings and reporting.		
Link to Sweden Regional Strategy	Improved living conditions for women and girls affected by HIV and AIDS		
Website	www.repssi.org www.riatt-esa.org		
Key words	children, OVC, psychosocial support, care-givers, families		

Source: Adopted from Sida, 2014.Regional HIV &AIDS Team – Contribution Overview. Available at http://www.sida.se/globalassets/global/about-sida/sa-arbetar-vi/halsa/regionalt-hiv-aids-contribution-overview--final, Accessed on March 14, 2016.

This table highlights the key elements that formed the content of the contract between REPSSI and Sida: a statement on the high contracting parties, project/programme duration and a brief description highlighting its main and specific project objectives, target issues, intervention beneficiaries and programme geographical coverage. Additional elements demonstrate how the programme linked to the donor's development objective (to the Sweden Regional Strategy), including the specific type of financial arrangement under which funding is released as well as the fund size and duration. This reveals how specific and formalised funding relations are crafted between donors and their beneficiaries. It also gives an idea of the extent to which RNGOs' programming is beng predetermined and controlled by elements of contractual arrangements tailored to meet the development objectives of the donor, even as the RNGOs sought to meet their own organisational and development objectives.

In addition, the programme details as outlined in Table 5.15 illustrate how, in the process, the programme content created a chain of relationships, from the donors to the RNGO (REPSSI, the pririncipal fund recipient), national authorities (Angola, Botswana, Kenya, Lesotho, Malawi, Namibia, Swaziland, South Africa, Tanzania, Uganda, Zambia and Zimbabwe), to partner NGOs and beneficiary communities. In this case, a single partnership arrangement did not only link up several development agents and their programme beneficiaries but extended into and across diferrent levels (international, regional, country and community).

On the one hand, REPSSI linked the donors to the country level NGO and their community beneficiaries, and carried the burden to account for the use of programme funding to communities. On the other, the organisation linked communities and NGOs up to the donors and demanded accountability from partner NGOs for the money spent on community programmes, and a record of impact in the form of a report to the donors. In this case, REPSSI played an intermediary role to both the donors and the country level players (KII, 03-08-2016). REPSSI's continued receipt of funding was dependent on its satisfactory programme delivery toward Sida's objectives and accounting as agreed in each contract. The sub-recipient NGOs had a similar relationship with REPSSI.

The following section examines a Global Fund resourced regional programme (the Representation, Evidence and Advocacy for Change in Health (KP REACH) implemented through the Humanistic Institute for Development Cooperation (HIVOS) in Southern Africa, to further illustrate the extent of direct involvement of the donor in determining programme content and direction.

5.2.9 The Case of HIVOS

The Humanistic Institute for Development Cooperation (HIVOS) is a Dutch development agent that has several regional offices throughout the world. Its core funding is from the Dutch society but it also mobilises resources and implements programmes funded by other donors. It is the regional intermediary for the Global Fund, particularly for eastern and southern Africa 'key populations' (defined as sex workers, men who have sex with men, transgender, women who have sex with women and gender non-conforming people). This for example involved the Representation, Evidence and Advocacy for Change in Health (KP REACH) Consortium programme (2016 – 2018), where its role was to recruit, contract and disburse funds (a total of US$ 11 million allocated specifically for the programme) and manage implementers, while reporting progress to the funder.

The HIVOS-led KP REACH programme (2016 – 2018) is illustrative of directed and dedicated funding as described previously. The programme focuses on community systems strengthening to achieve KP REACH's goal of reducing HIV infection and HIV-related deaths among key populations in southern Africa (KII 01-08- 2016; KII, 02-08- 2016). To achieve this, it was intended to improve access by key populations to HIV prevention, testing and treatment services so as 'to bend the HIV curve' by addressing gaps in the HIV response for key populations in the selected countries. Directed towards key populations, the programme targets Botswana, Lesotho, Malawi, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. These countries currently account for 81% of people living with HIV in sub-Saharan Africa (HIVOS, 2016 – http://www.hivos.org/vacancies/4). The programme was not only a response to high HIV prevalence but higher rates of infection among key populations.

With directed and dedicated funding, the donor (Global Fund for TB and Malaria) and the principal receipient of the fund (HIVOS) in a designated region possess and exercise selection and allocative powers. HIVOS, as the Global Fund principal recipient (PR) of the funds, was to be responsible for recruiting and choosing receipients and allocating funding in specific areas relevant to facilitate the programme roll out. This included among other things resourcing baseline studies on communication and attitudes, and recruitment of staff to fill several positions within the HIVOS regional office and affiliate organisations in each targeted-programme host country so as to maximise contributions to the programme (as illustrated in Table 5.13).

Table 5.13: Funding Allocation Under the KP REACH Programme

Beneficiary organisation	Funder	Funded position	Country	Activity	Activity focus
African Men for Sexual Health and Rights (AMSHeR)	HIVOS/ Global Fund	HIV and Health Advocacy Manager	South Africa (Johannesburg)	Regional Advocacy work	Southern Africa
		Communication and Advocacy Manager	South Africa (Johannesburg)	Regional work	Southern Africa
		Finance and compliance Officer	South Africa	-	Southern Africa
SAfAIDS	HIVOS	Regional programme officer	Zimbabwe (Harare)	Regional work	Southern Africa
Gender DynamiX	HIVOS	KP REACH Finance and Administrative Officer	South Africa (Cape Town)	-	Southern Africa
	HIVOS	KP REACH Monitoring and Evaluation officer	South Africa (Cape Town)	-	Southern Africa
Coalition of African Lesbians (CAL)	HIVOS	KP REACH Programme Officer	South Africa (Johannesburg)		
		KP REACH Monitoring and Evaluation Officer	South Africa (Johannesburg)	-	Southern Africa
African Sex Workers Alliance (ASWA)	HIVOS	KP REACH Monitoring and Evaluation Officer	Kenya (Nairobi)	-	Southern Africa*
		KP REACH Programme Officer	South Africa (Johannesburg)	-	Southern Africa
M&C Saatchi	HIVOS	Consultant	South Africa (Cape Town)	Baseline to measure communication capacities of KP networks	Southern Africa
		KP REACH Accounts Director	South Africa (Cape Town)	Regional work	Southern Africa
Positive Vibes Trust: KP REACH REACT	HIVOS (GFATM)	Programme Coordinator	South Africa	KP REACH-regional work	Southern Africa
		Monitoring and Evaluation officer	South Africa, Namibia	KP REACH – regional work	Southern Africa
		Key Correspondents Programmed Coordinator	South Africa	KP REACH – regional work	Southern Africa
		KP REACH Finance and Administrative Officer	South Africa	KP REACH – regional work	Southern Africa
		KP REACH Capacity Strengthening Programme Coordinator	South Africa	KP REACH – regional work	Southern Africa

Source: Compiled from HIVOS 2016: http://www.hivos.org//vacancies/4?page=1 (accessed 10 March 2016).

In all, seven affiliate/partner organisations were selected to work on this programme and funding in each case was directed towards specific matters. Each of the seven partner organisations in the programme received funding for staffing in specific skills areas and, in all, eighteen positions were funded.

Table 5.14: Resource Distribution Under REACH Programme

Affiliate	Country	Regular Posts	Consultants	Total
AMSHeR	South Africa	3	0	3
ASWA	South Africa	2	0	2
CAL	South Africa	2	0	2
Gender DynamiX	South Africa	2	0	2
M&C Saatchi	South Africa	2	1	3
Positive Vibes Trust	South Africa	5	0	5
	Namibia	1	0	1
SAfAIDS	Zimbabwe	1	0	1
Totals		**18**	**1**	**19**

Source: Compiled from HIVOS, 2016 – http://www.hivos.org/vacancies/4 (accessed 10 March 2016).

In addition to these, the HIVOS Regional Office, which supports this regional team of implementers, funded and hired for the positions of consultants and commissioned the execution of regional baseline studies to establish the point of entry for the programme; this further illustrates how development assistance is dedicated and directed. In this way, an NGO once recruited performs within the expectations of the programme as conceived by the funder.

Interviews with the Executive Director (ED) of HIVOS (KII 01-08- 2016; KII, 02-08-2016) revealed that the current KP REACH programme was driven by both the Global Fund and HIVOS, with key populations organisations (KPOs) recruited to implement the project within the parameters drawn by the Global Fund. In this regard, as in the case of the UNAIDS and other main HIV players, we witness the same type of tockenistic engagement and not necessarily a cross-fertilisation of local inputs and global ideas in the KP REACH intervention.

Further, this case example demonstrates that donor financing usually comes as a package: the money and technical support. All the funded positions were intended to enhance institutional capacities of recipient partner organisations to ensure the programme's smooth implementation and accountability to the donors. Donor support seemed to increase and expand NGOs' skills levels and diversity including refinement of operating procedures. While capacities are enhanced as part of programme planning, programme designs are based

on baseline studies that do not only inform the programme planning and implementation but set benchmarks against which programme implementation is measured.

Table 5.15 demonstrates Global Fund investment in baseline work in the KP REACH programme to provide a scientific basis on which to premise the project, design the intervention, develop monitoring tools and ultimately lead to the measurement of its results. Necessary staff (e.g. consultants) are recruited to provide technical assistance to relevant implementing NGOs. This demonstrates the apparent adoption and implementation of rational and scientific principles and procedure as encouraged by modernisation as discussed earlier in the thesis.

Table 5.15: KP REACH Programme Regional Office Resourcing

Beneficiary Organisation	Funder	Position funded	Location	Activity	Region
HIVOS	Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM)	Consultant	Zimbabwe	KP REACH Formative research to understand regional attitudes, beliefs and perceptions to inform communication	Southern Africa
		Consultant	Zimbabwe	Baseline study of the KP REACH Programme	Southern Africa
		Consultant	Zimbabwe	Design and printing services	Southern Africa?
		Consultant	Zimbabwe	KP REACH advocacy action plan	Southern Africa
HIVOS Southern Africa Hub	Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM	Consultant	Southern Africa regional hub	Pastel customisation for the Key Populations Regional Programme in Southern Africa	Southern Africa
		Regional Advocacy Officer	Southern Africa regional hub	Regional work on Sustainable Diets for All	Southern Africa
		Consultant	Southern Africa	Key populations regional programme in Southern Africa	Southern Africa

Source: Compiled from HIVOS 2016: http://www.hivos.org/vacancies/4?page=1 (accessed 10 March 2016).

In addition, these processes demonstrate the extent of embeddedness of NGOs in donors' own programme plans and work culture and hence their susceptibility to donor influence. The last section utilises the Sida example to further illustrate how sub-granting is a mechanism for extending donors' embedding influence, and its impact on beneficiary NGOs.

5.2.10 Extending Donor Influence Through Sub-Granting

The forgoing examples demonstrated the strategic influence of donors on the HIV response in southern Africa and highlight how this is achieved through fund-streaming along specific

donor strategic objectives. At the regional level, most RNGOs mobilise funding to cover their institutional and programming costs. Programme expenses may include funds for sub-granting to other CSOs at the regional and/or country levels. Sub-granting extends donor-directed responses further down to the country and community levels.

Sub-granting is executed under the same conditions as those applied by the donor to PRs to the extent that they intend to achieve the same objectives. In this case, the recipient becomes an intermediary between the donor and the beneficiary organisation or community. An intermediary organisation is any organisation, consortium of CSOs, agency or company "that receives and passes on funds for the implementation of development cooperation or humanitarian assistance", together with local cooperating partners in the target southern countries, and such an organisation "can be an active partner in development or an administrative conduit" (Nilsson, 2013:21). Nilsson describes an active partner as "an organisation that engages in an exchange of ideas, mutual capacity development and joint advocacy" while an administrative conduit "limits the relationship to planning and monitoring of the funding arrangement." In this case, the funding arrangement creates a tiered structure with different levels of fund allocation and responsibilities for programme delivery as well as donor influence.

A common example among the sample RNGOs was the technical support category whose major role was capacity enhancement of other CSOs especially at the lower country level. I draw on the example of the Southern African AIDS Trust (SAT) to illustrate this arrangement. As a technical support regional NGO, SAT received funding from Sida for community-systems strengthening for sexual reproductive health and rights (SRHR). Such funding was intended to provide programmatic capacity strengthening related to community systems for SRHR and, within that, it included sub-granting to support community organisations to roll out their SRHR responses at the community level. SAT was the recipient of bilateral funds from Sida through a contractual arrangement that set the rights and obligations for each part to the arrangement, to 'strengthen community systems for HIV/AIDS prevention and improve sexual and reproductive health and rights' for women and girls.

5.3 Conclusion

This chapter examined the role of donors in the HIV response and in the architecture of HIV governance in southern Africa. It highlighted the centrality of donors as development architects and financiers, but largely from the global North. For instance, the Global Fund as

a joint financial mechanism for HIV, tuberculosis and malaria is dominated by major northern funders. Organisations located in the global South, including RNGOs, tend to serve as implementers of the strategic development objectives of northern funders. In addition, the chapter showed how, through fund-streaming, donors direct the activities of southern RNGOs, demonstrating how the funding mechanisms and types of funding stucture the programmatic interventions around HIV, including by RNGOs. As a general tendency, RNGOs operate in hierarchically arranged social networks which restrict their operations within the confines of the HIV responses as designed in the global North. Against this background, the next four chapters analyse how these matters influence the structures, roles and programmes of selected RNGOs in southern Africa. The following analyses are intended to further shape and enhance our understanding of RNGOs and *being regional*.

CHAPTER SIX: SPECIALISED FUNCTION MEMBER-SERVING NON-GOVERNMENTAL ORGANISATIONS

6.1 Introduction

This chapter presents the first sub-set of one of two main typologies of regional non-governmental organisations (RNGOs) I discuss in the thesis, the member-serving and other-serving RNGOs. It constitutes the first set of illustrative examples of RNGO typologies and regional programming, highlighting such aspects as defining elements of being regional, the resultant embeddedness of RNGOs and its implication for programme structuring and accountability to partners, stakeholders and beneficiaries. Further, it is a first attempt to demonstrate the diversity among RNGOs in terms of type, operation and coverage, thus further providing clarity on how operating regionally is constituted and linked to other levels of operations. In this chapter I discuss two different case examples (ARASA and RAANGO) to demonstrate their individual uniqueness and contribution towards understanding RNGOs, regional programming and being regional.

6.2 ARASA Case Example

The AIDS and Rights Alliance for Southern Africa (ARASA) is a regional NGO established in 2002, and operated as a regional partnership of NGOs constituted in the form of a trust. Under ARASA, the partner non-governmental organisations (NGOs) worked together to promote a human rights approach to HIV/AIDS and TB in southern Africa through capacity building and advocacy (ARASA, 2013a:3). Table 6.1 presents ARASA's purpose and vision statements for its work in southern Africa.

Table 6.1: ARASA's Vision

Purpose	Vision
➢ *To promote the rule of law and respect for human rights to safeguard the health status of all, especially of people living with HIV and TB and key populations at higher risk of HIV and TB, including LGBTI, sex workers, people who use drugs and prisoners.*	✓ *A southern and east Africa in which all are able to access and enjoy their fundamental human rights to health.*

Source: ARASA (2013:6) Strategic Plan, 2013 -2017; http://www.arasa.org/about/.

ARASA identified its geographical operational area as primarily southern Africa. It also specifies its niche in the HIV response as the promotion of the human rights of people living with HIV and AIDS (PLHIV) along with the socio-economic dimensions to the pandemic. At the same time, the organisation identified the challenge it addresses as the denial of such

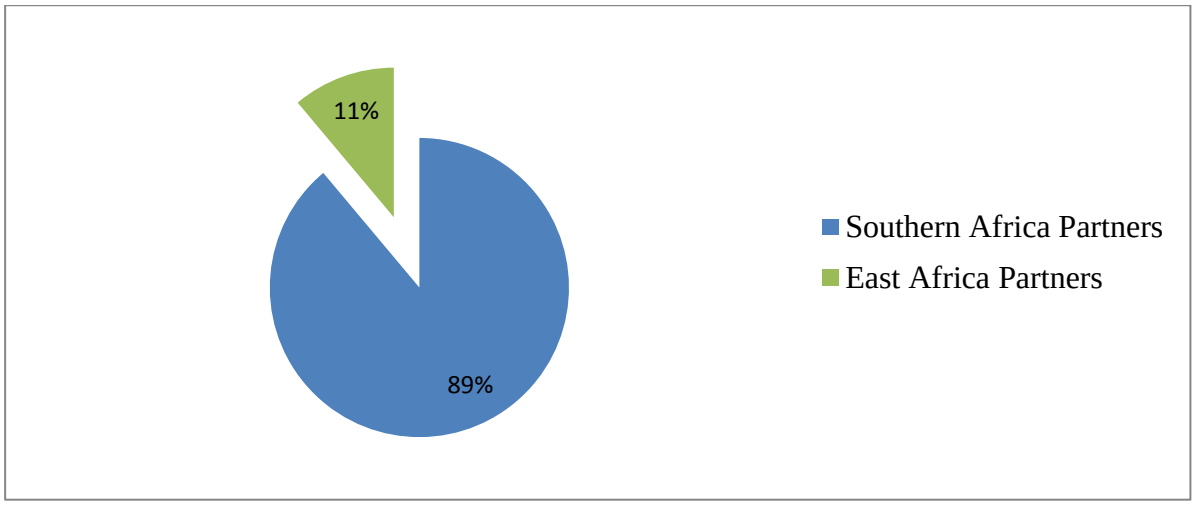
rights and the subsequent driving impact on the HIV epidemic, thus justifying the relevance of their response and their very existence as an organisation.

Similarly, ARASA identified their strategic modalities as advocacy and capacity strengthening, positioning the organisation in regional and country level operations as both advocacy and capacity strengthening can be delivered at these levels by targeting relevant stakeholders and authorities in contributing to the fulfillment of its vision. However, advocacy can extend to any other level including the international. In this sense, ARASA presented itself as an organisation that can extend its work to any level and address any human rights issues which fit into its strategic mission and vision. In the HIV and TB response, there are a wide range of rights issues specific to certain population segments (gays, lesbians, sex workers and so forth – the group known overall as key populations; along with prisoners, drug users, children and young people) as well as access-related rights such as those specific to health service provision and medication.

6.2.1 Geographical Coverage and Being Regional

ARASA works in the southern and east African regions covering eighteen countries with 89% of the countries located in southern Africa and the remainder of 11% in eastern Africa (Figure 6.1). ARASA defines a region as "a geographical area consisting of countries sharing a common border in a sub-region of the continent".

Figure 6.1: ARASA Partners Proportional Distribution



Source: http://www.arasa.org/about/; ARASA, (2015: 20-22).

The countries share a common border and are also characterised by common political, economic, cultural, historical and geographical elements that make it quite necessary and

justify working at the regional level – because "there are common political, cultural, economic and social challenges that we face as countries that share common borders" (ARASA KII, 05-10-2016). ARASA emphasised territoriality, geographical contiguity and commonality of externalities in its definition of a region.

The organisation defined itself as a regional NGO because it operated in the entire southern African region with an extension into East Africa and, in doing so, its work was driven by a single and centrally defined common strategy for both regions. The strategy addressed a common issue of human rights that concerned the the eastern and southern Africa regions (ARASA KII 05-10-2016). In this regard, ARASA defined *being regional* as "configuring yourselves as an organisation to operate in a manner that makes it possible to address common challenges in a fashion beneficial to all in the region" (ARASA KII, 05-10-2016). Such an organisational and programmatic configuration included mobilising and engaging different partner organisations that share the same values and principles in addressing HIV-related human rights. Because of this, it is necessary to present ARASA's partners and discuss the significance that the organisation attaches to partnership as both an organisational form and operational modality.

6.2.2 Partners

ARASA based its work on the concept of partnership, which the organisation understood to mean "a relationship of mutual trust and cooperation to achieve specific strategic goals" (ARASA, KII 05-10-2016). The organisation elaborated that "the relationship can be contractually-based or governed by a memorandum of understanding (MoU)". In this regard, a critical aspect of ARASA's work was partnership development, which primarily involved the recruitment of civil society organisations (CSOs) that were more or less established and working in the HIV and TB response or health sector generally. ARASA identified the specific categories of these organisations as "networks of people living with HIV (PLHIV), legal aid organisations, women's organisations, youth organisations and other AIDS service organisations" (ARASA, KII 05-10-2016). Partnership with these organisations was contractual and intended for the implementation of specific programmes. The contracts could be renewed depending on need, the performance of the partner organisation and the availability of resources. In other words, the partnerships were couched in the same manner as those between donors and their partner CSOs as discussed in chapter five.

Although registered as a trust (an organisation configured and operated for the benefit of others), ARASA defined itself and operated as a partnership as opposed to a membership

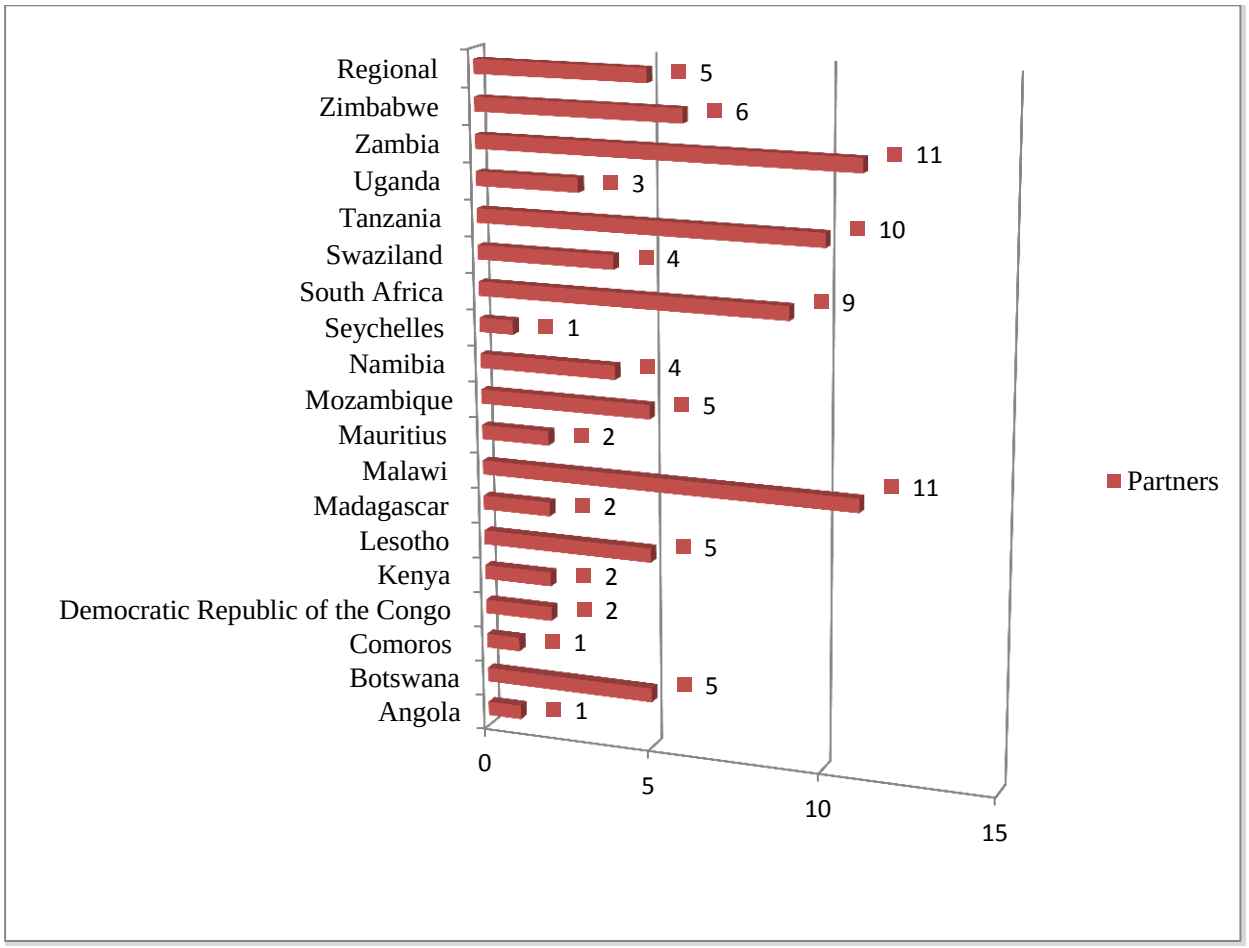
organisation. Civil society organisations (CSOs) that joined the partnership had to apply to become partners. As part of that process, they had to sign a declaration of principles that affirmed their commitment to the values to which ARASA's founding members aspired (KII, 05-10-2016; ARASA, 2013a:25). As partners, ARASA's members had a right to vote and to be voted onto the organisation's board, participate in developing the strategic plan, and determine the priority programmatic issues for the organisation (over and above receiving institutional support to enhance their operations) (KII, 05-10-2016). ARASA's objective was to develop and sustain a region-wide human rights movement and to promote collaboration and coordination within southern Africa to effectively mainstream a human rights-based approach to HIV and TB programming in the region.

Its partners were "a diverse mix of more and less well-established organisations including networks of people living with HIV (PLHIV), legal services organisations, women's organisations, lesbian, gay, bisexual, transgender and intersex (LGBTI) organisations, youth organisations and other AIDS service organisations" (ARASA, 2011:4). According to ARASA's Deputy Executive Director (DED), the organisation's partnerships were based on solidarity and shared responsibility for advancing social justice in the region, specifically targeted at the realisation of the right to health. Within southern Africa, ARASA prided itself as the only alliance of organisations that was addressing human rights in the responses to HIV and TB in southern Africa (KII, 05-10-2016).

Figure 6.2 presents the current ARASA country and regional level members. ARASA members spread over eastern and southern Africa (ESA) highlighting that the majority (95%) of the partner organisations were country level civil society organisations (CSOs), and only 5% were regional bodies. The concentration of ARASA partners at the country level illustrates that the bulk of ARASA's work was located at this level where it provided technical support for its members to enable them to mainstream human rights in their programmes, and to advocate for the protection of the rights of PLHIV in the HIV and TB responses.

ARASA further forged partnerships with other players in the HIV, TB and malaria responses to create a critical mass for change or for the generation of common understandings necessary for such change to occur. Some of these relations were governed by MoUs as they were less formal and non-contractual but still critical in the operation of the organisation. ARASA had such relations with other RNGOs, SADC, EAC, UNAIDS and national governments, ministries and departments, selected on the basis of the centrality of their role in the organisation's areas of programming.

Figure 6.2: ARASA Regional and Country Level Partners



Source: Compiled from http://www.arasa.org/about/; ARASA (2015: 20-22).

Another set of partnerships arose when ARASA sought and secured donors to fund its programmes or was recruited and funded by donors to deliver specific programmes. In other words, ARASA was contracted on specified terms to either deliver or facilitate the delivery of a specific programme. Partnerships with donors could be renewed subject to ARASA's performance in the delivery of the funded programme (ARASA, KII 05-10-2016). Critical to note is the fact that this set of partnerships was strategic because they were sought and secured to resource the organisation and thus ensure both organisational functioning and programme delivery.

6.2.3 Governance and Management

ARASA was constituted as a membership organisation although the organisation preferred to call itself a partnership. As such, its governance structures incorporated member representation on the organisation's Board of Trustees. ARASA's Board comprised of eight trustees elected from its partner organisations to provide strategic direction and exercise

oversight on the secretariat. It consisted of representatives of its five founding partner organisations (Box 6.1), two other elected members and ARASA's Executive Director who sat on the Board as an ex-officio member (KII, 05-10-2016).

Each elected members served a two-year rotational term and all trustees occupied their positions as representatives of their respective organisations, and of the rest of the membership. All founding trustees, except for SAfAIDS, were organisations already in the legal field, constituting a pool of relevant skills to driving a rights-based response. The board exercised an oversight role over the organisation's management. It did so through a committee system, and had a designated committee on programme advisory work which assisted the secretariat to design programmes that respond to issues raised by its trustees representing their various constituencies.

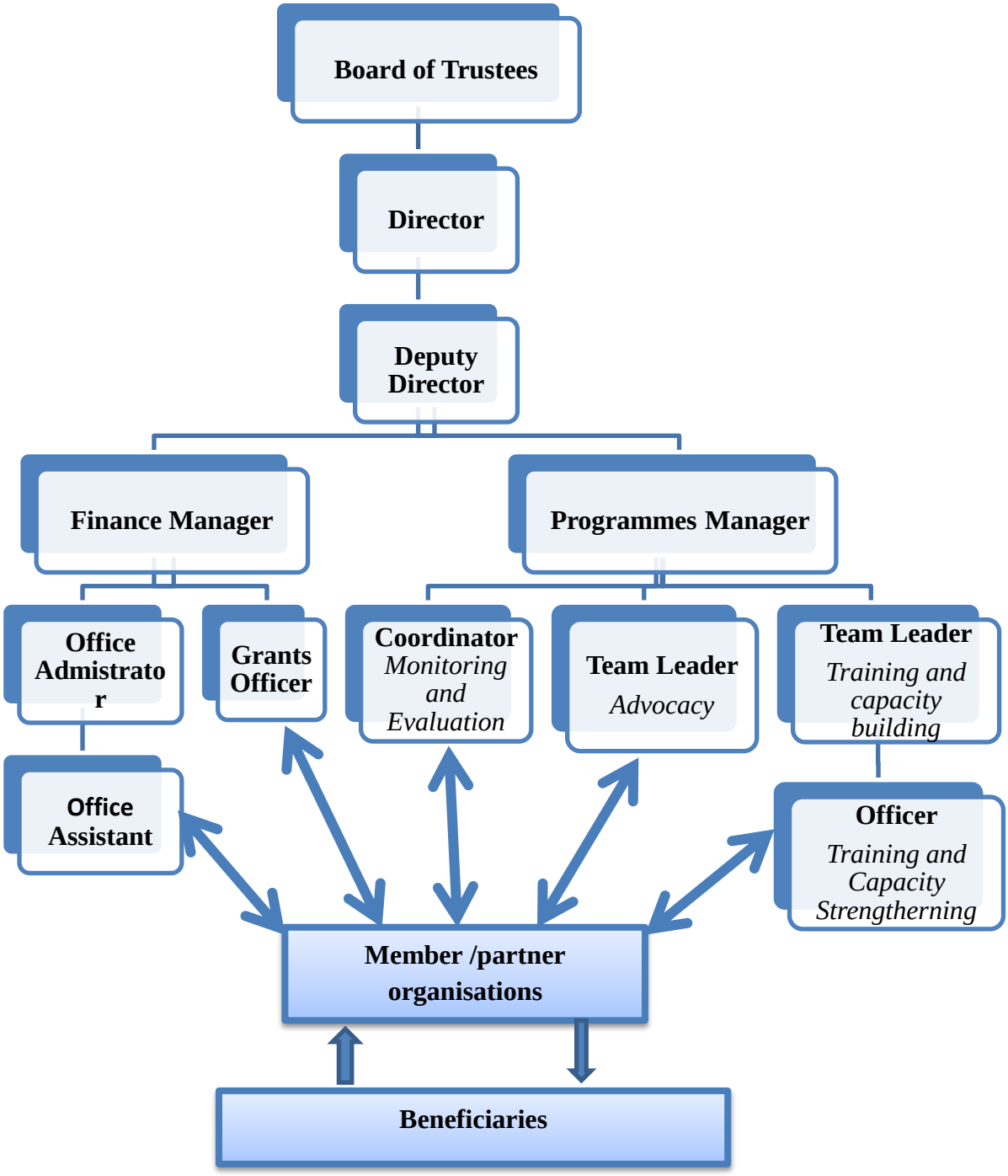
Box 6.1: ARASA Board of Trustees

- ✓ Zambia AIDS Law Research and Advocacy Network (ZARAN), (Chair);
- ✓ Legal Assistance Centre (LAC), (Namibia);
- ✓ Section27 (Incorporating AIDS Law Project), (South Africa);
- ✓ Southern Africa Information Dissemination Service (SAfAIDS), (Regional);
- ✓ Botswana Network on Ethics, Law and HIV/AIDS (BONELA); and
- ✓ Director of ARASA as an ex-officio member

Source: ARASA (2011:8).

Figure 6.3 presents ARASA's operational structure. The ARASA website (http://www.arasa.org/about/ ARASA - accessed in 08-2016) stated that the "partnership is supported by staff and consultants working out of Johannesburg and Cape Town, South Africa, as well as the head office in Windhoek, Namibia." In other words, the organisation had a lean secretariat that was complemented by out sourcing of specific tasks. According to its 2011 *Annual Report*, ARASA's secretariat comprised eleven members of staff and two consultants.

Figure 6.3: ARASA Organogram



Source: Compiled from http://www.arasa.org/about/; ARASA, (2011:8); (ARASA, KII 05-10-2016).

The secretariat was organised into two functional departments, of programmes and administration. Below the secretariat was a pool of beneficiary partners who, as we have noted earlier, were located at the country level where the organisation delivered its programmes through its partner organisations. ARASA's secretariat supported these

organisations to mainstream the human rights-based approach in their work as well as advocate and lobby for its adoption at the country level by various other stakeholders in the health sector. Their work also included leading litigation cases in the ARASA litigation programme (discussed later) as well as mentoring fellow members that needed support on human rights work.

6.2.4 Programmes and Operational Modalities

As earlier noted, ARASA strategically positioned itself to tackle issues of human rights violations in the health sector, especially the HIV, TB and malaria responses under two outcome areas presented in Box 6.2.

Box 6.2: ARASA Strategic Outcome Areas

- Strengthened civil society capacity for effective human rights and HIV/AIDS and TB advocacy in the Southern Africa Development Community (SADC).
- Increased mobilisation of civil society advocacy on human rights issues in the context of HIV/AIDS and tuberculosis in SADC.

Source: ARASA (2013a).

The organisation's programme activities are organised and rolled out to contribute to these two outcome areas, which did not only constitute the mission of the organisation but contributed to the realisation of its vision. The specific activities are organised around training and related technical and material support that helped strengthen partner civil society organisations to implement advocacy and lobbying programmes for positive transformation that could create a conducive environment for the roll out of an effective human rights approach to health. Such an orientation "takes a public health approach and emphasises the right to health and related services regardless of class, social category, colour, race, profession, sexual orientation, or immigration status" (ARASA, KII, 05-10-2016). ARASA added that "more importantly such an approach does not apply the penal code which usually creates barriers to access to health services by some population segments (e.g. sex workers, drug users etc.) and hence minimises the realisation of good health among them". As key aspects of its programmes, its activity areas are discussed in this light.

As noted earlier ARASA's partner portfolio consisted of a mix of more or less established organisations, and not all had a legal background; but the majority are involved in one or more areas of the HIV, TB and malaria responses. Inevitably, these organisations needed organisational capacity support to enable them to handle human rights-related matters

within the specific areas of their health responses. ARASA's technical support programme comprised targeted training to equip members with requisite skills and sub-granting to support the cascading of the training of trainers (ToTs) programme and other aspects of the programme (ARASA, 2013).

In this regard, ARASA's training and institutional strengthening programmes built the capacity of its civil society partners "for effective HIV, TB, sexual and reproductive health and human rights advocacy in southern and east Africa" (ARASA, 2013a:14). As part of this process, ARASA provided ToTs' courses to initiate a cascading of training activities through partner organisations down to community level (ARASA, 2014:3). The courses covered a wide variety of topics related to advocacy and rights, including country-level awareness training. In addition, the programme targeted the communities in which these organisations operated to promote a human rights-based culture and response to TB, HIV and AIDS at the community level in the countries served by its partner organisations. The bulk of the community level training and capacity strengthening was delivered through ARASA's partners operating at the national and community levels as presented in Figure 6.2.

We have already noted earlier that ARASA's implementation included both country and regional NGOs. These organisations all required different types and level of capacity strengthening. Therefore, ARASA's training and capacity strengthening programmes targeted all its partners to facilitate human rights training at both regional and national levels, and to strengthen skills and develop training materials related to HIV, TB and human rights programming, depending on the partners' needs.

ARASA's partner technical support included sub-granting to support partners' programmes, offering seven small grants of US$10 000.00 initially that had since been raised to eight valued at US$20 000.00 each (ARASA, 2013b:1, 17). Offered on a competitive basis, the small grants were intended to afford "an opportunity for participants of ARASA's regional training of trainer (ToT) programme to replicate their learning through the implementation of HIV, TB and human rights-related training and advocacy activities in their own countries" (ARASA, 2013b:2, 16). This was one illustrative example of how regional NGOs were involved in sub-granting and took responsibility to monitor the management of the funding for intended results for which they would also account to their donors.

Beyond capacity building, a key outcome area for ARASA relates to advocacy and lobbying. In a key informant interview, ARASA's DED (ARASA, KII 05-10-2016) stated that "ARASA's advocacy and lobbying work dealt with contentious issues. Human rights issues are always and need to be navigated carefully not only through the book (laws) but by

way of social and political engagement to achieve the desired results." ARASA engaged stakeholders at both the regional and country levels in this regard.

At the regional level, ARASA was actively involved in regional structures and processes as part of its regional advocacy and lobbying work in the area of human rights. According to its *Annual Report* (2013:18), ARASA was "represented on the UNAIDS Human Rights Reference Group which our Director co-chairs, the Global Fund Human Rights Reference Group, the WHO Civil Society Reference Group, the SADC HIV Technical Advisory Committee and the NGO Delegation of the UNAIDS Programme Coordinating Board (in 2010 and 2011). In addition it participated on several other boards and technical/ advisory committees at the regional and international levels." In a key informant interview (KII, 05-06-2016), the DED indicated that ARASA continued to participate in these regional and international spaces to create a critical mass to advocate and lobby for a human rights approach to HIV and TB programming in the region and globally through policy influence.

At the country level, ARASA strengthened and supported partner organisations' abilities to promote a human rights-based response to tuberculosis (TB) and HIV through technical assistance to them and the communities that they serve. It trained partner organisations and their communities to monitor and analyse the efforts of national governments to protect, respect and uphold human rights in the context of national responses to AIDS and TB. The organisation also taught its partners how to engage in effective advocacy initiatives on rights issues identified as relevant at their levels of operation at the community and national levels. In other words, country level advocacy was primarily targeted at eliminating practices that undermined human rights in the health and related sectors. These efforts were supported by strategic litigations where the organisation took on specific cases of human rights violation.

ARASA supported its advocacy work through getting involved directly in litigation of cases of human rights violation in the region offering pro-bono legal services. Working with South African Litigation Centre (SALC), ARASA reported the successful use of strategic litigation, "particularly where it was accompanied by advocacy on the ground including with law and policy-makers and service providers." Some of the successful litigations reported are listed in Table 6.2. These cases illustrate the manner in which ARASA engaged at the country level and how the partnerships worked to achieve practical results at that level for the greater good in the region; as the cases set a precedent on how justice could be achieved in the HIV response.

Table 6.2: Litigation Case Examples

Country	Case	Result
Botswana	Policy change: *Rights to ART for non-citizen, prisoners*	Successful
Namibia	Women: *Coerced sterilisation of women living with HIV*	Successful
Swaziland	Maseko and Makhubu: *defend rights versus state persecution*	Successful
Zambia	Policy change: right to food for prisoners living with HIV;	Successful
Zimbabwe	Mildred Mapingure: failure of the State to take steps to prevent pregnancy after rape	Successful

Source: Compiled from ARASA (2014a:6).

However, it also illustrates how the organisation was embedded at both the country and regional levels through the structuring of its programmes in addition to partnerships as earlier discussed; to this I now turn.

6.2.5 Embeddedness

ARASA partnerships entrenched the organisation into different forms of networks and numerous influences. Strategically, like all organisations in the HIV response, ARASA's work was premised on relevant UN declarations and statutes that provided a basis for its work in responding to the human rights situation in the region. It also rode on the fact that countries in southern and eastern Africa have committed themselves to advancing a human rights based response to HIV, yet continue to operate outside these commitments. Among others, the commitments included those in the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) Declaration on HIV/AIDS, the Abuja Declaration and the Maseru Declaration, (ARASA, 2013a:3) including those discussed earlier. In this sense, ARASA was embedded in the UN architecture of HIV governance and, as a result, it was to engage in the UNAIDS PCB structures, the Global Fund Human Rights Reference Group, and the WHO Civil Society Reference Group; and, at the regional level, it worked with SADC and other regional organisations and belonged to such forums as RAANGO. In these spaces, ARASA sought to influence policy and ensure the mainstreaming of a human rights approach to HIV and TB programming, not only in the region but globally as well.

A variety of donors funded ARASA constituting another set of social relations that influenced the organisation's work. Country level linkages were achieved through its member partners spread over southern and eastern Africa working directly with the national and community levels. Consequently, ARASA was embedded in a web of social relations in which it sought to influence the architecture of the regional HIV response; and was also influenced to adjust its work to be congruent with local influences (through partners),

regional bodies (through SADC and regional donor programmes) and global demands (through the donors and the UN structures). Towards each of these sets of partners, ARASA carried varying burdens of accounting, depending on the nature of its relationships.

6.2.6 Accountability

Social relations are characterised by both expectation and the burden of accountability as noted in chapter 3. ARASA utilised its strategic position as a human rights activist organisation to solicit and enlist UN, donor and SADC support to champion the roll out of a human rights-based response to HIV and TB. At the UN and SADC levels, it bore a key burden of providing expert input into the policy processes of the structures and to shape the architecture of the global and regional response through its participation in various regional and global platforms. These inputs were structured in accordance with ARASA's position within these structural arrangements.

In addition, ARASA was contractually bound to provide its donors with all relevant reports (vertical, administrative and fiscal accountability) stipulated in the funding arrangements. According to the DED (KII, 05-06-2016), these reports were compulsory and determined the continued funding of ARASA and its programmes, and hence the sustainability of the organisation. Therefore, there was great pressure on the organisation to ensure that all requisite reports were delivered on deadline and to the expectations of the donor. Donors' accounting expectations exerted pressure on both the organisational board and management to ensure the professional and efficient management of the organisation and of the funded programmes, in order to achieve the requisite results to give a return on the donor investments. In this regard, ARASA's Board diligently exercised its oversight role with reference to management to ensure the efficient and timeous implementation of programmes and the production of relevant deliverables and reporting (administrative and fiscal accountability). In this case, the ARASA's secretariat received the double burden to account to its board and donors, while at the same time delivering programmes to its partners.

According to the DED (KII, 05-06-2016), "the partners exerted the greatest pressure as the secretariat is in a daily interaction with them in programme implementation and additionally in the various meetings including the Annual Partner Meetings where programmes are reviewed, even though this did not directly determine the continued funding for the organisation." Overall, because ARASA was deeply intertwinned in both vertical and lateral social relations from which it drew different inputs, it had to account for its actions so as to maintain its relevance, credibility and hence sustainability as a development agent.

6.3 RAANGO Case Example

The Regional Network of African AIDS Non-governmental Organisations (RAANGO) is a case example of regional platforms of RNGOs in SADC and I discuss below its structuring and work. RAANGO is a member-serving RNGO uniquely designed, not to deal with country or community issues at the levels at which they occur, but to provide an opportunity for those working on the pandemic to engage in higher level discussions of the issues and sharing experiences and coordinating efforts towards better programming to resolve crucial matters. The analysis of RAANGO is informed by archival material provided by the Southern African AIDS Trust (SAT) which played an instrumental role in its formation in 2008. It also includes key informant interviews with the SAT Chief Operations Officer who was the Deputy Executive Director of SAT at the time of RAANGO's formation, and played an active role in that process, and the Deputy Executive Director of SAfAIDS who are the current host of the forum and are responsible for running its affairs.

RAANGO is a regional platform of what used to be the key civil society HIV players, all of whom now focus on SRHR and other health issues as well (SAT, 2016:32). The current host organisation of the forum (SAfAIDS) adds that the organisation was comprised of like-minded RNGOs that focused broadly on sexual reproductive health and rights (SRHR) and HIV issues in the SADC region (KII, 05-08-2016). Its work is set out briefly in its vision and mission as presented below. It should be noted from the outset, however, that it is not a particularly vibrant RNGO currently.

6.3.1 Mission and Vision

Initiated in 2007 under the leadership of the Southern African AIDS Trust (SAT), RAANGO was established to be a regional forum for Directors of regional NGOs working in the HIV and AIDS response in the southern African region, as part of an attempt to achieve HIV and AIDS response programmes based on coordination, harmonisation and promoting synergy (Jones et al., 2010:26; KII, 05-08-2016). In addition, and as a result, the organisation was intended to facilitate members' knowledge and appreciation of each other's work for complementing and for synergy building to avoid "stepping on each other's toes" (KII, 05-08-2016).

According to SAfAIDS' DED in a key informant interview (KII, 05-08-2016) "members of the organisation work in a complementary and collaborative manner because most of its members share the same funding partners, belong to the same alliances and

networks." However, at the time of this research (2015-2017), the organisation was not fully constituted and it was guided by only a mission statement as presented in Box 6.3.

Box 6.3: Mission Statement

To create smooth synergy, promote peer to peer sharing, learning and support among its members and create a strong advocacy group of champions who actively engage other regional development partners on matters of critical importance to the regions in the HIV and AIDS response including sexual reproductive health and rights (SRHR), TB and Malaria.

Source: SAfAIDS DED (KII, 05-08-2016).

The central focus of the mission was the creation of an environment for collaboration among regional NGOs working in the HIV and AIDS response, SRHR, TB and malaria in order to build a strong group that could lead advocacy in matters of critical importance in the regional HIV response.

6.3.2 Members and Partners

At the time of data collection, RAANGO's members were voluntary affiliate RNGOs that shared a common focus on RAANGO's mission, and were interested in contributing to it. RAANGO membership was undifferentiated, as all members had equal organisational entitlements, and membership was voluntary and free. According to Storey's (2014:1) RAANGO Organisation Assessment Report, the organisation was a regional consortium, consisting of twenty Directors representing twenty member organisations from the eastern and southern African regions interested in influencing regional advocacy in the HIV response.

Storey's (2014:19) consultancy report on the organisation proposes the disaggregation of the organisation's membership – in the future – into two categories: full members and affiliate members. The report prescribes a thorough selection criteria for would-be members through an application and assessment process (reviewed, discussed and approved) by a special sitting of all members of the organisation. Membership was proposed to be maintained at a nominal fee to be determined by the assembly of the full membership. In addition, all members were to be required to commit fully to the values and objectives of the RAANGO consortium at all times as a condition of membership. While membership remained voluntary in the proposed structure, two membership categories (as indicated) were proposed: full members and associate (or affiliate) members. RAANGO's full members would be those regional NGOs that would have paid their full membership fees and had

committed to all conditions of membership. Full members would enjoy all the benefits of the consortium including but not limited to those presented in Table 6.3.

Table 6.3: RAANGO Membership Types and Benefits

Membership type	Membership Defining Characteristics	Benefits
Associate Members	a. Share the vision of RAANGO b. Not necessarily regional African NGOs (e.g. regional development partners, private sector organizations, and international development agencies)	✓ Participating in RAANGO forums and documentation, lessons sharing forums, and ✓ Mobilizing for RAANGO advocacy agendas only
Full Members	a. Ratified and adopted RAANGO values and principles b. Subscription paying c. Selected regional African NGOs	✓ Participating in the RAANGO forums, lessons sharing, mobilizing; training activities ✓ Representation in governance committees; ✓ Access to RAANGO's funding resources. ✓ Participation in interest groups, and ✓ Task force and committee work.

Source: Compiled from Storey, (2014:19-20) OD Consultancy Report; Proposed RAANGO Governance Structure.

On the other hand, the consultancy report proposes that associate membership be opened to organisations that shared RAANGO's vision but were not necessarily regional African NGOs. These organisations were either regional development partners (donors, SADC, EACs, UN agencies, AU), private sector organisations, or international development agencies. Unlike their counterparts, associate members benefits were limited to participating in RAANGO's forums, lessons-sharing forums, and mobilising for the organisation's advocacy agenda.

The proposed associate members were RAANGO's partners; organisations that supported RAANGO's vision and work. Some were in a working relationship with the organisation: UNAIDS ESA-RSTA supported RAANGO, members of the the Swedish-Norwegian Regional HIV/AIDS Team (the TEAM) had contributed to the formation of RAANGO and remained a close ally to the organisation (Jones, et al., 2010:17, 26), and the SADC always involved RANGO in their regional meetings to incorporate their contributions at a regional level. A more formal RAANGO, as proposed in the consultancy report, seemed more likely to attract greater support and closer working relations and partnerships.

6.3.3 Geographical Coverage and Being Regional

Operationally, RAANGO defined a *region* as southern Africa, the area from which it drew its members, and where it sought to influence HIV policies and practices in the HIV responses. For RAANGO, *being regional* meant "operating within this specific geographical location (southern Africa) that comprises a collection of states, and working at the supra-national level, endeavouring to influence regional level policies and practices within the HIV and AIDS response, to enhance harmonisation and coordination of regional HIV NGO work" (KII, 05-10-2016). RAANGO operated within the SADC region, to the extent that it sought to influence the regional HIV and AIDS response in that region. Its indirect coverage was defined by the location of its members, namely, regional organisations within and operating in the SADC region. RAANGO was an intermediary organisation that did not directly interact with country or community level programming. The influence of its work was only indirectly cascaded by its members, but much depended on the willingness and ability of the organisational proxies to import RAANGO inputs into their organisational programmes and management processes, thus providing an opportunity for permeation to grassroots levels.

The organisation did not have a mandate to run programmes but had ad hoc coordinative and advocacy activities that were contingent upon the emergence of regional opportunities for policy influence through various regional fora, but especially SADC, UNAIDS and donor coordinating forums. In other words, RAANGO work primarily focused on impromptu and instantiated activities. In addition, it ran forum discussions that did not only support its ad hoc advocacy activities but equipped its members with solutions to challenges they faced in their organisations (the members' advisory and support roles). This was combined with information sharing for all relevant areas, viz., advocacy, funding, management and governance (KII 05-10-2016).

Thematically, the organisation dealt with a wide range of advocacy issues that included human rights, gender rights, women and sex workers' rights, young people, sexual reproductive health and rights (SRHR), LGBTI, drug users, and the ratification and domestication of relevant legal frameworks to facilitate the creation of a favourable environment for the realisation of health and social rights. By virtue of this strategic focus, RAANGO was predisposed to work in partnership with a huge variety of agents dealing with these matters at the regional level. The next subsection examines RAANGO's organisational configuration (governance and management) before discussing its specific programmatic work.

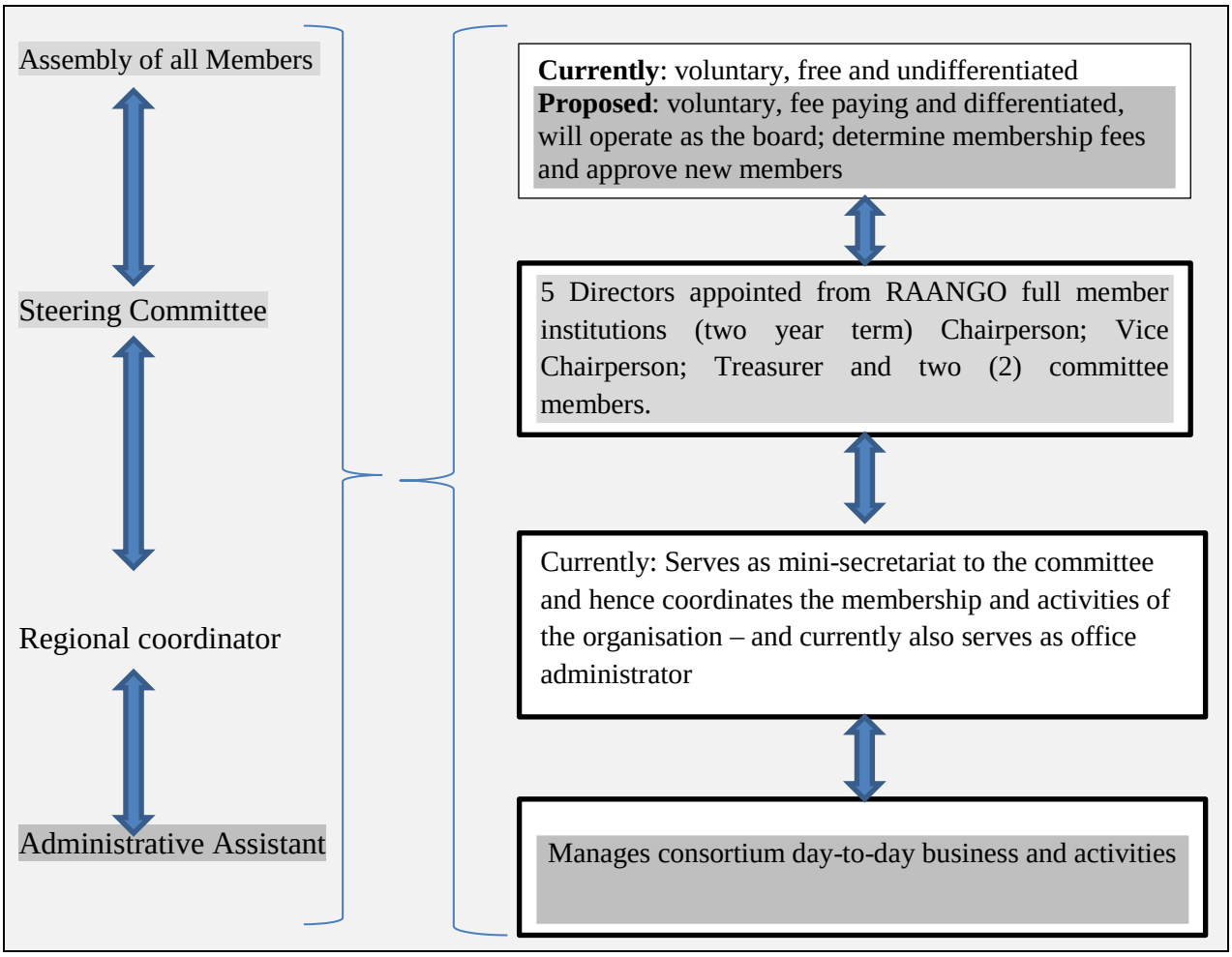
6.3.4 Governance and Management

Even though RAANGO was formed in 2007 and became operational in 2008, the organisation remained unregistered and without a formal organisational structure at the time of this research. It operated on the understanding and commitment of its member regional organisations, as an informal platform to support its member activities. For this and other reasons, in a review of the organisation, Storey (2014:1) describes RAANGO as "an informal platform for Executive Directors of Regional African NGOs from Eastern and Southern Africa to consult and share lessons on the implementation, management, and stakeholder engagement for effective HIV response in both regions." This made RAANGO a special RNGO typology of member-serving NGOs. Unlike other RNGOs discussed in this thesis, RAANGO was a Directors' organisation – some kind of a 'Directors' Golf Club', representing the apex of the skills driving the HIV response among civil society organisations in the two regions. It also represented a unique form of institutionalisation demonstrating that, in some cases, commitment rather than elaborate rule systems drive some organisations. This is reflected in its organisational structure.

From its inception, RAANGO had not had a fully and properly structured secretariat to run its business due to lake of funding. The one-person secretariat had also been shifting from one host RNGO to another as RAANGO continued to exist informally and without its own premises to house its business. Initially, the Southern African AIDS Trust (SAT) hosted the organisation (2010 to 2015), providing office space and facilities with support from UNAIDS and Voluntary Services Overseas (VSO). After support from UNAIDS and VSO halted around 2013, the organisation remained SAT's responsibility to coordinate and run its business until the hosting was relocated to the Southern Africa HIV/AIDS Information Dissemination Service (SAfAIDS) in 2015, (where the organisation currently hosts and runs RAANGO's secretariat business). The organisational assessment by Storey (2014) proposed and recommended an organisational transformation to establish a more formally constituted entity to improve RAANGO's efficiency in discharging its mission. It also proposed revisiting the mission statement once an organisational vision was framed.

Figure 6.4 presents RAANGO's structure incorporating existing arrangements and proposals of the Storey (2014) assessment marked in grey. The proposed reforms exhibited an intention to make the RAANGO function better but keeping it lean becasuse of the financial difficulty the organisation had been facing and continued to face. The proposed introduction of a steering committee was intended to facilitate both the strategic direction and management of the affairs of the organisation.

Figure 6.4: Structure Including Proposals



Source: Compiled from Storey (2014:19) - OD Consultant Report; (KII, 05-08-2016).

The steering committee was meant to be the key driver of the regional work of the organisation with the Coordinator and Administrative Assistant only serving as facilitators or support staff to the committee (keeping and managing its diary and taking charge of logistical support services for the committee). As the organisation was proposed to continue as a membership-based organisation, participation in the two-year rotational membership of the steering committee (which also operates as the board) was determined by the composition of membership. Only fully paid members could be appointed to the board to constitute the steering committee. In a Key Informant Interview (KII, 05-08-2016), the SAfAIDS DED indicated that members were endeavouring to secure funding so that there could be at least one person to run the business of the organisation.

In another Key Informant Interview (KII, 05-10-2016) ARASA's DED also acknowledged the importance of the organisation as a relevant mechanism for regional peer CSO support, coordination and mobilisation around critical issues in the HIV response. She

however bemoaned the fact that funding for a secretariat for the organisation was difficult to secure as donors did not consider RAANGO as a priority in the context of pressing programming issues in the region; such as treatment, prevention, interventions for key populations, and human rights and gender issues directly linked to the management of the HIV epidemic. Efforts to transform the organisation into a fully constituted regional organisation were clear in efforts to raise funding for staffing, as well as in the ongoing proposed process of strategy development and other work that sought to further clarify the niche of the organisation. This entailed conceptualising and establishing a suitable structure and relevant modalities to support its mission (KII 05-10-2016). In other words, it can be concluded that, although the organisation was formed and began to operate in 2008, it had stagnated in its formalisation and structural development and hence remained a rather inefficient and informal platform whose business was rotationally manned and ad hoc.

This illustrates the significance of operational contexts as noted in chapter two, and the influential nature of donors in the operations of RNGOs as highlighted in chapter five. More importantly, it shows the significance of the restraints that obtains from network systems in RNGOs exist and operate. When objectives of different (and significant) network systems to which RNGOs belong do not coincide, a limiting operational environment may result for certain RNGOs. Because of this, there must be inter-network system congruency for RNGOs and organisations generally to operate successfully. For RAANGO, donors did not perceive the relevance of the organisation and hence it was not a donor priority. RAANGO remained a weak organisation (because of lack of donor buy-in), but potentially a vibrant regional development agent (in part, because its members and regional bodies like SADC perceived it as so). In its current state, the organisation could not adequately establish and effectively sustain its positions in the network of HIV/AIDS and development relations at the regional level especially without sufficient personnel.

6.3.5 RAANGO's Work

RAANGO did run programmes as did other RNGOs discussed in this thesis. It was not designed to offer such programmatic work but to create "a platform for discussions and ad hoc advocacy actions for improved coordination and understanding among regional NGO Directors and their organisations, including engaging other regional development players such as SADC, EAC, as well as development partners supporting regional programmes in Eastern and Southern Africa, working in the HIV response" (Storey, 2014:19). In other words, RAANGO has focussed its activities towards both its members (to generate a common

understanding and strategy on HIV work) and other development players in the regions (as a mouth-piece of its membership), seeking to develop common advocacy agendas – by influencing regional policies and practices, as well as by sharing resources and best practice ideas regarding the implementation of regional HIV interventions.

RAANGO activities by target group are presented in Table 6.4. According to Storey (2014:1), the first manifestation of RAANGO collaborative efforts at the regional level was an agreement by its members to provide leadership for the civil society forum at the SADC level and in the cascading down of the High Level Meeting and the African Union (AU) Roadmap targets.

Table 6.4: Activities by Target Group

Target	Activities	Purpose
Members	✓ Information sharing and learning – including best practices ✓ Peer to peer advice and support (wide range of issues) ✓ Creation of common understanding, values and principles	✓ Capacity strengthening ✓ Information and education ✓ Influence
Other regional player	✓ Advocacy and lobbying ✓ Campaigns ✓ Information sharing for education	✓ Influence ✓ Information and education

Source: Compiled from Storey, (2014:1); Key Informant Interviews (KII, 05-08-2016; KII, 03-8-2016).

Secondly, RAANGO championed the 50-by-15 agenda involving parliamentarians from the SADC regions. This was a campaign for reducing HIV infection by 50% by the year 2015, a target developed under the MDGs. Thirdly, the organisation had from time to time provided a common voice during the civil society regional consultative processes in HIV and AIDS in such forums as UNAIDS PCB regional meetings, and had been the leader in advocating for a deeper understanding and appreciation of the role and value added of regional programming in relation to the HIV response (in the manner conceptualised by SAT and other RNGOs with the support of donors from 2004 as discussed in chapter four. Based on Storey (2014) and information supplied by in the Key Informant Interviews, RAANGO's expectation was that, in working collaboratively, African NGOs would be able to develop common advocacy agendas.

This illustrates that RAANGO was configured to add value to region-wide HIV responses through policy influence as well as coordination and technical support of its member RNGOs that supported and in some cases rolled out HIV interventions at the country level. In other words, its work illustrates an application of the various principles that define regional work and working regionally as earlier discussed in chapter four. Particularly evident is the coordination and advocacy aspects among its members and policy influences among regional RNGOs. But, as shown below, RAANGO executed its work in the context of many challenges, particularly limited resources and weak formal organisational institutionalisation.

6.3.6 Operational Modalities

As a forum, RAANGO had very simple working modalities which included meetings and mail exchanges among its members and between the coordinator and the rest of the members. The organisation also utilised similar communication techniques between the RAANGO coordinator and partners and stakeholders. In addition, RAANGO sought and participated in strategic regional meetings with SADC, the AU, UN sectorial agencies – particularly the UNAIDS, donors and other RNGOs. At these fora, RAANGO presented a common position of its member RNGOs on the relevant matters in discussion.

It also mounted campaigns like the '50 by 2015' which was intended to popularise agreed targets on HIV prevention and treatment. RAANGO also took up the cudgels to popularise working at the regional level through engaging members on the subject, including explaning what 'being regional' entailed in meetings with its members. In these processes, RAANGO depended on informal partnerships – informal to the extent that there were no contractual obligations informing the processes. This conditioned the type of partnerships which it forged.

6.3.7 Partners and Partnerships

RAANGO understood partners as "organisations that agreed to work with them and could add value to their work by contributing something: resources, funding, social and moral support etc." (KII, 05-08-2016). For RAANGO, therefore, partnerships were relationships of value to the extent that they contributed to the realisation of RAANGO's mission. These relationships could be formal or informal but they were founded on common values, principles, interests and ideas. The emphasis was less on the regulative aspects of institutionalisation than the normative and cultural cognitive elements as earlier discussed in chapter two. Hence, there

was less emphasis on contract-based partnerships (especially with its members) but rather a general understanding and willingness to cooperate on commonly defined issues.

According to a key informant interview (KII, 05-08-2016) with SAfAIDS' Deputy Executive Director (DED), RAANGO was "not that kind of network that depends on formalised relations, but general understanding among its members. There is no formal relationship with any of the regional bodies (SADC, UN agencies, particularly the UNAIDS, EAC, AU etc.) but it advocates on matters raised and discussed with relevant bodies." As a result, RAANGO did not have any formalised relationship with any of the regional bodies, even though the organisation sometimes dispatched a representative from among its members to attend and observe at regional meetings; and, at times, it gave a position statement on certain matters at some of their meetings. In some cases, the organisation was invited to do so by especially the SADC and UNAIDS PCB.

In this way, the organisation's partnerships were less for implementation purposes and more about general policy influence and technical support among its partner RNGOs. Viewed differently, these were consultative engagements which obliged neither RAANGO nor its partners to abide by the outcomes of the interactive processes. Against this backdrop, it is interesting to view some of the organisation's achievements to illustrate how this seemingly loosely integrated system of social relations worked.

6.3.8 Accomplishments

Although RAANGO was institutionally informal, in its eight years of service the organisation had made a footprint in the southern Africa region. Not only had the organisation been able to mobilise more than twenty RNGOs, but it had played a coordinative and policy influence role for HIV and AIDS issues at the regional level. In almost 86% (N=7 of 8) of RNGO key informant interviews, RAANGO was mentioned as 'an important regional forum' that played a 'central role in providing support and coordinating regional representation of RNGOs in critical spaces such as SADC, UNAIDS and the African Union to influence policy.'

Since its inception in 2008, RAANGO members had found numerous ways to leverage their collaborative advantage to champion many initiatives and realise achievements, some of which are presented in Box 6.4. The activities performed and achieved were characteristically regional and involved engaging regional bodies and structures for policy influence and popularisation of certain approaches.

Box 6.4: Achievements

1. Representation in SADC TWGs
2. Facilitated the SADC HIV forum for civil society
3. Organized the 50 by 15 campaign among its members and regionally
4. Supported the operationalization of the HLM targets for civil society
5. Supported the operationalization of the AU road map for civil society
6. Fostered the regionality agenda (SIDA discussions led by SAT the then host to RAANGO)
7. Mobilizing support for a common voice on respect for rights Key Populations (ARASA)

Source: Storey (2014:20) OD Consultant Report; KII, 05-08-2016; KII, 03-8-2016).

However, in a sense, the activities reflect the limitations of the organisation as they were not properly documented and presented with time bound results of each engagement. SAfAIDS' DED (KII, 05-08-2016) explained that, because of limited organisational capacity, RAANGO activities had not been sufficiently documented to allow proper analysis of the organisation's work.

RAANGO's work reveals the networks in which the organisation was involved, and to which it belonged in the roll-out of its activities. These included networks of peer RNGOs (both members and non-members), other regional organisations, donors and the UN structures. As discussed in chapter two, network relations enmesh organisations and as such have a facilitative and limiting effect on development agents. The form and extent of RAANGO's embeddedness invariably impacted on the operations of the organisation.

6.3.9 Embeddedness

Regardless of its structural weaknesses, RAANGO was connected to various development players at the regional level. The organisation formed and belonged to a network of RNGOs motivated by a common vision as earlier discussed. The spread of the RNGOs in the region reveals the extent to which it was exposed to a variety of experiences from diverse parts of the region. Such interlinkages were set to expand with the inclusion of associate members which would increase connections with other regional players as discussed in the proposed organisational strengthening programme.

RAANGO was also linked to regional governmental organisations like SADC and the African Union, bodies that it sought to influence as part of its policy influence drive. The organisation also connected with UN agencies particularly the UNAIDS generally and its PCB particularly as it pushed for a more inclusive HIV governance structure at the regional level – including compaigning for the mainstreaming of some sectoral issues such as

disability, sex work, LGBTI among others (Storey, 2014:20; KII, 05-08-2016; KII, 03-8-2016). It was also linked to donors: Sida, through participation in the latter's regionality agenda which it supported, and Voluntary Service Overseas (VSO) which co-funded the organisation with UNAIDS.

The organisation's embeddedness did enable it access a variety of regional players to influence the regional response but, as earlier observed, such work was constrained by its organisational capacity to plan and deliver programmes at this level. Its informal nature militated against its ability to attract network resources such as donor funding. In this sense, access to network resources do seem to also depend on the credibility of potential beneficiaries and, in the case of RAANGO, its organisational configuration and the congruency it had with donor priorities proved key determinants, regardless of the organisation's great potential to contribute to HIV governance in the region. Nonetheless, where does this leave us in terms of accountability? It is important to reflect upon this matter in terms of RAANGO's organisational configuration and operational modalities.

6.3.10 Accountability

RAANGO perceived accountability as "a process of taking responsibility and answering for the reason/s for which the organisation was established" as well as 'for any assistance that it receives in the process of delivering its mandate" (KII, 05-08-2016). In other words, the organisation recognised accountability as a mixure of fiscal, vertical and administrative accountability as discussed in chapter three. The organisation took responsibility to deliver tasks agreed upon by the organisational members as discussed earlier, as well as to represent views of its members on regional forums. In addition, where it sought to influence others, it "took responsibility to present empirical data on all matters raised, and to make honest proposals for desirable change that could benefit the regional response such as popularising regionality and regional integration in SADC" (KII, 05-08-2016). In the same vein, RAANGO was supposed to provide intelligence on donors available in the region and funding opportunities, and to share programmatic lessons obtaining from working models in the response to the pandemic (and the challenges in less successful cases), as compiled from its members' experiences.

However, the organisation did not bear the burden to account to any regulatory authority, as it was not formally registered in any country. Since it also did not work directly with country level communities, it could only account to its affiliate member organisations for the delivery of services to members on matters noted above. Its lack of direct donor

financial support meant that it had no funds to account for to donors, as this work was done on its behalf by its host organisation through the latter's own budget management systems. In other words, the organisation had no experience in accounting in this regard, except during the period it received funding from Sida and UNAIDS through SAT. Even then, SAT managed the accounts since there was only one coordinator. According to SAT Operations Manager (KII, 03-08-2016), in the absence of a well-established secretariat, the host organisation was responsible for managing the affairs of the forum and accounted to members on its plans of action; and activities and plans remained problematic, including in providing timely intelligence on the regional situation regarding donors and working models. The RAANGO Coordinator position had been vacant since 2013 and remained vacant at the time of this research.

6.4 Conclusion

This chapter has considered the first two examples of four RNGOs within the member-serving typology, ARASA and RAANGO, demonstrating what working regionally was and meant for these RNGOs. It highlighted the structure and operational implications of working regionally for these RNGOs, institutionally and operationally. Clear contrasts were observable in levels of institutionalisation and its impact on the operations and effectiveness of the organisations. ARASA, as a more fully formalised institutionalised RNGO organised its work more efficiently and attracted greater resources for wider geographical and programmatic coverages. On the other hand, RAANGO, as an informal network, depended upon the pro-bono contributions of its members and, again as an informal network, could not attract as much resources and partnerships beyond its members. This though did not completely limit the role of the organisation in the region.

The chapter also demonstrates that, like RAANGO, ARASA worked at the country level and hence its regional spread was owed to its members located and serving in the various countries in the eastern and southern African regions. Its direct contact and support were focused on its members which the organisation pursued by way of delivering programmes on HIV, TB and human rights. The main difference in this regard related to RAANGO's functioning and engagement through organisational proxies (notably Executive Directors) vis-à-vis ARASA's mobilisation and engagement of a variety of partners (technical and implementing partners, plus donors) which gave ARASA the necessary support to roll out its work, and also entrenched the organisation in multiple relations thereby embedding it more firmly into regional and country networks.

While this complex network of relations availed resources to the organisation, it increased the organisation's burden to account in various ways to its partners and beneficiaries, including managing the accountability of its implementing partners. Therefore, funding contracts with donors and technical supporting partners did not only entrench the organisation under greater formalised influences of the HIV governance structure but in accountability mechanisms as well. RAANGO on the other hand operated within national and regional relational contexts without any legal obligation to account as it functioned on a voluntary basis. Thus the chapter presents an interesting subset to compare and contrast with other RNGOs in the same typology as well as contrasting with those in the other-serving cateogry in chapters eight and nine.

CHAPTER SEVEN: NETWORK-BASED MEMBER-SERVING NON-GOVERNMENTAL ORGANISATIONS

7.1 Introduction

The previous chapter has illustrated how specialised function RNGOs, within the member-serving group, compare and contrast in the manner of their constitution, operation, connectedness and accountability in operating as regional NGOs. This chapter explores another sub-set of member serving RNGOs but one that is network-based. This sub-category comprises two different RNGOs, the Disability HIV and AIDS Trust (DHAT) and the Network of African People Living with HIV, Southern Africa (NAPSAR+). In addition to being established by and for its members, these organisations were umbrella bodies, each representative of a specific constituency: DHAT for people with disabilities, and NAPSAR+ for people living with HIV (PLHIV). Both organisations operated in southern Africa thus constituting an interesting basis to compare and contrast in terms of their formulation, operations, embeddedness and accountability to their constituencies, vis-à-vis their supporting partners.

7.2 DHAT Case Example

The Disability, HIV and AIDS Trust (DHAT) is a regional non-profit civil society organisation formed by people living with disabilities (PWD) in Botswana in 2005, and became operational in 2006 before relocating its regional office to Harare, Zimbabwe in 2010 where DHAT was registered as a trust. DHAT is another member-serving RNGO located and working in the Southern African Development Community (SADC) region. In a key informant interview (KII, 22-06-2016), DHAT's Executive Director (ED) stated that the relocation to Zimbabwe was prompted by the fact that "Botswana was less friendly to donors, and Zimbabwe offered a better operating environment." In Zimbabwe, DHAT could "tap into the good health practices that the government of Zimbabwe was implementing, utilise the government of Zimbabwe's capacity building programmes for disabled people's organisations (DPOs) delivered through the National AIDS Council (NAC), and its collaboration."

7.2.1 Mission and Vision

DHAT was established to represent and promote the rights of persons with disabilities having cervical cancer, TB, infected and affected by HIV and AIDS, and to build the organisational

capacities of disabled people's organisations (DPOs) in the SADC region. In other words, DHAT is an organisation established by and for people with disabilities (PWDs) to achieve inclusion and their full participation in the response to disability rights, cervical cancer, tuberculosis, sexual reproductive health rights (SRHR), HIV and AIDS. DHAT's work was also to ensure sensitivity to and inclusion of the real issues of concern among PWDs in all its activities and responses (KII, 22-06-2016).

Table 7.1 presents DHAT's mission and vision as articulated in its strategic plan. DHAT's mission and vision cover a wide range of intervention areas in the architecture of the HIV response in relation to disability. Such a broad framing of the mission and vision seems strategic as it fits the organisation into all the other areas in the HIV response even as it carves out its own niche around issues of disability.

Table 7.1: DHAT's Mission and Vision

Mission	Vision
To promote and facilitate comprehensive rights-based HIV and AIDS interventions responding to the needs of persons with disabilities in Southern Africa, through appropriate support to Disabled Peoples' Organisations, Governments and other stakeholders.	A society free from HIV and AIDS, guaranteeing full inclusion of people with disabilities

Source: KII (22-06-2016); www.dhatregional.org/index.php/aboutus accessed 18/08/2016.

This positioned the organisation's mandate around promoting the mainstreaming of issues of disability into TB, cervical cancer, SRHR, HIV and AIDS responses in order to reduce vulnerability, improve access to health services, and facilitate empowerment among people with disabilities in southern Africa. DHAT's operational area links it to the organisation's framing of regional programming and being regional in pursuit of its mission and vision.

7.2.2 Geographical Coverage and Being Regional

DHAT operated in nine southern African countries, namely, Angola, Botswana, Malawi, Mozambique, Namibia, Lesotho, Swaziland, Zambia and Zimbabwe. The organisation was registered officially and had Country Offices (CO) and operated in these nine countries, with Zimbabwe also doubling as its Regional Office (RO). While the RO provided the strategic direction, regional representation, and financial, technical and administrative support to the COs, the COs were extended operational arms of the organisation working directly with National Federations of disabled people's organisations (DPOs), beneficiaries and stakeholders at country level (KII, 22-06-2016). The RO, with the support of its established COs, worked with National Federations of DPOs to provide therefore the relevant support at

the country level. Although DHAT was yet to work with all national federations of people living with disabilities in SADC, the organisation was strategically positioned to achieve this by engaging and working with the SADC NGO Forum, and engaging national governments through SADC's technical committee on HIV.

For DHAT, it was not the number of countries that characterised an organisation as a regional development agent (being regional), but three aspects were crucial. First of all, there was the need for representation of a constituency (in its case disabled persons) at regional level fora such as SADC Forums, the East Africa Development Community, regional UN meetings and the Africa Union. Secondly, working regionally meant creating linkages from the community, district, provincial, national to the regional level and, in this regard, to intensify the responses in the interest of persons with disabilities. In framing *being regional*, DHAT's ED (KII, 22-06-2016) indicated that "we bring issues from the grassroots to the regional level and feed back down to grassroots level issues from the regional level, adding value either way." As third aspect, he added that "such issues should have a regional scope and relevance; affecting the region and hence advantageous to be addressed through a unified regional strategy capable of feeding into and drawing from national level programming."

According to the ED (KII 22-06-2016), DHAT worked with members of the disability community at all national levels due to the infancy and hence limited nature of current work on matters of disability at all levels. Its work encompassed service delivery at these levels, organisational capacity enhancement for DPOs and their networks, and advocacy for the mainstreaming of disability in both health and social services. However, DHAT did not regard such work as multi-country because, unlike in the latter as discussed in chapter 4, all its work was driven by a single regional strategy, targeted and unified to contributing towards a single regional vision as stated in Table 7.1. For them, in a multi-country setting there would be no need for a single regional strategy and the programmatic issues would not need to be the same nor contribute towards the same vision in each country. In effect, the conceptualisation and configuration of the organisation's work predisposed it to engage a large variety of organisations of persons with disability at different levels as briefly discussed in the next subsection.

7.2.3 DHAT Members

As earlier noted, DHAT is an RNGO established by persons with disabilities to address their concerns and advance their rights and access to social and health services. According to DHAT's ED (KII, 22-06-2016), DHAT was not designed as a membership organisation, but

as a technical support and representative body for people living with disabilities. However, organisations, associations and federations of organisations of people with disabilities voluntarily and freely affiliate to DHAT in a hierarchical manner as illustrated below in Figure 7.1. Federations were "national umbrella organisations formed by DPOs to represent their concerns as informed by their lower level affiliates" (KII, 22-06-2016).

In this arrangement, DHAT served as the uppermost and supra-national umbrella body located at the regional level, working through National Federations to reach DPOs that serviced people with disabilities at the community level through various associations. In this case, DHAT was directly linked to National Federations, and some DPOs depending on the national circumstances. In doing so, it represented the community of persons with disabilities down to lower community levels. DPOs were associations of persons with disabilities, such as associations of the deaf, associations of the physically disabled, associations of women with disabilities.

DPOs worked independently at the grassroots level in communities, and fed their issues into the National Federations, and through them to DHAT. Put differently, associations were affiliated to federations and federations to DHAT in a hierarchical formation. Through their membership, DPOs and National Federations received DHAT support (for example, organisational capacity strengthening, mentorship, and grants) and representation at the regional level in regional spaces such as SADC, AU, UNAIDS and other international fora. In this light, I now outline DHAT affiliates, partners and partnerships to map out the networks that the organisation created and to which it belonged, including their justification in relation to its regional work.

7.2.4 Partners and Partnerships

DHAT worked through partners and partnerships as understood in chapter one. DHAT understood partnership as "a relationship of mutual benefit governed by a contract or a memorandum of understanding (MoU) both of which are also grounded in mutual understanding, common values and specified areas of operation and purpose." (KII, 22-06-2016). In this sense, DHAT defined a partner as "an organisation that shares common characteristics with us and is in some working relationship of mutual benefit with us".

Programmatically, National Federations and DPOs were DHAT's first category of partners that benefited from DHAT support to implement intervention programmes in various communities of people with disabilities. This type of partnership was based, firstly, on shared externalities regarding disability: the violation of rights of persons with disabilities in

southern Africa, problems with access to social and health services, and the desire for representation and advocacy for disability rights. Secondly, the partnerships were based on mutual benefit between DHAT and its members; while DHAT gained its legitimacy as a constituency based RNGO and among DPOs as a leader in championing disabled people's cause, the affiliates received technical, financial and moral support from DHAT, and representation at the regional level.

The second set of DHAT partners comprised of various other development agents that included regional governmental organisations (SADC, AU), UN agencies, and other RNGOs (RAANGO, SAfAIDS, REPSSI, SAT, etc.). DHAT also affiliated to international organisations that represented disability issues globally and worked directly with the United Nations General Assembly (UNGASS) and/or the UN Economic and Social Commission (ECOSOC) (KII, 22-06-2016). Partnerships with these development agents were largely based on MoUs intended for mutual cooperation and support, except where programming and technical support were involved, which then dictated contractual arrangements of the nature discussed earlier.

At the national level, DHAT collaborated with national authorities at various levels (government ministries, National AIDS Councils (NACs), provincial and local government authorities, including traditional and religious leaders) (KII, 22-06-2016). Partnerships at this level varied in their intention, but involved some form of collaboration such as contractual technical support for the benefit of DHAT or the partner. As such, the nature of the relevant terms of the partnership were crafted in each instance.

In addition to these technical partners and peers, DHAT's work was supported by donors who included sub-granting RNGOs such as SAT, that also provided the organisation with technical assistance in the HIV response generally (but also for RNGOs working on issues of disability). Partnerships with donors were typically contractual as they involved the provision of resources and technical support for both organisational capacity strengthening and programme delivery on matters of disability, either directly to DHAT or through contracted technical support organisations such as SAT. In this sense, and as is becoming clear with each case example, partner mobilisation and partnership development are key institutional and operational activities in the life of an RNGO – and this requires relevant institutional configuration, governance and management, that can enhance organisational processes for the accomplishment of set missions and goals. Governance and management hence are crucial in facilitating the possibility of operating regionally in the context of a particular mission and vision.

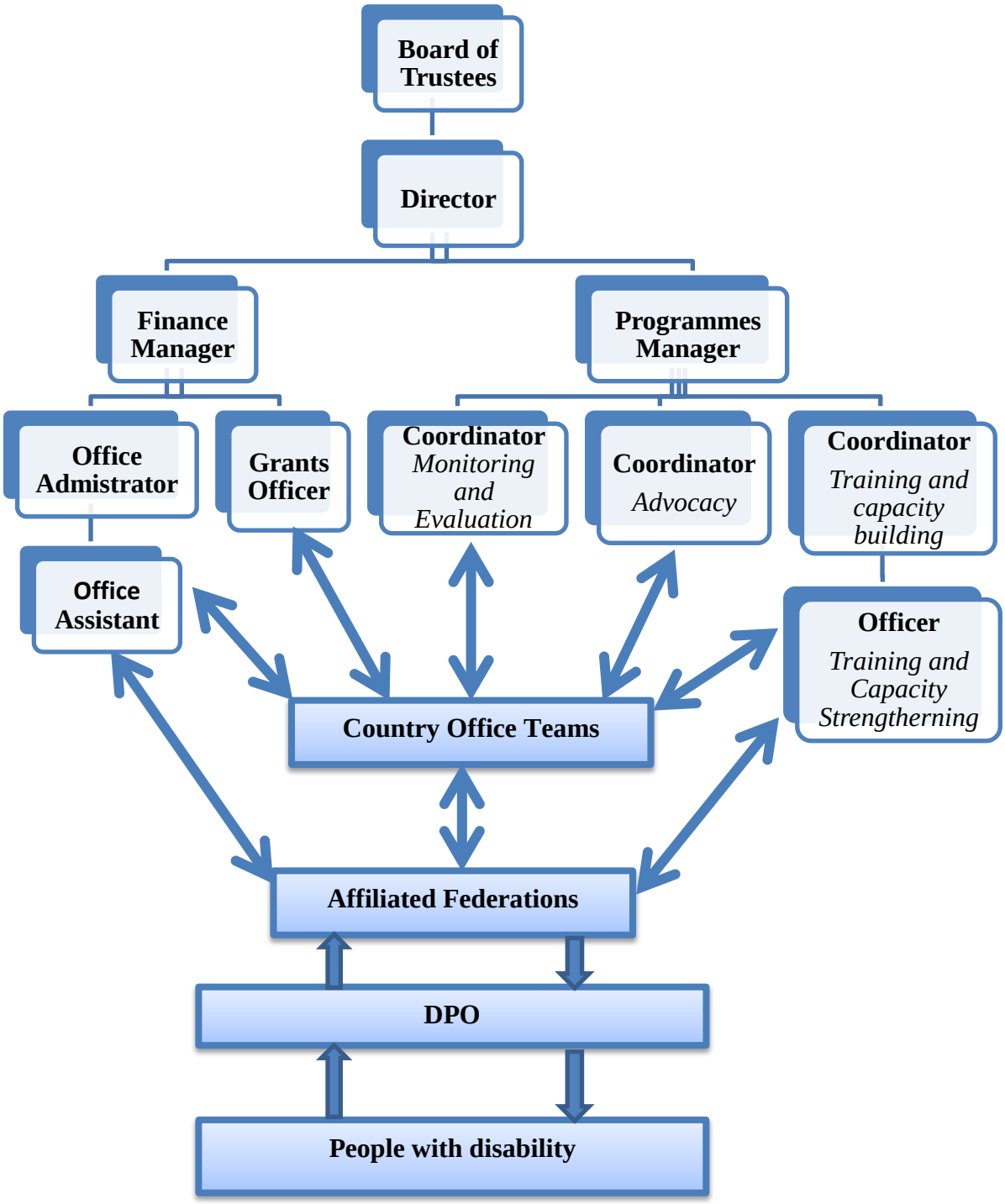
7.2.5 Governance and Management

DHAT's governance structure reflects its membership character and regional positioning, given its attempt to reach out regionally (with registration at country levels) and desire for expert and professional governance. The organisation was governed by a Board of Trustees that initially comprised representatives of National Federations of DPO but later transformed to include various experts in the areas of health, disability, finance and human resources. This was in compliance with the professionalisation of NGO governance consistent with good corporate governance (King III, 2009). The 2009 King III Report on good corporate governance has been adopted by many donors in southern Africa as a benchmark for assessing governance in their NGO beneficiaries. The document was adopted because it promotes the professionalisation of organisational governance and management. The DHAT Board provided oversight and strategic direction to a secretariat headed by an Executive Director (ED) who, as in other RNGOs, was an ex-officio member of the Board.

At the regional level, the ED presided over two main teams: Finance and Programmes each headed by a Manager under whom were relevant function-related officers. These officers included Administration and Grants positions in the case of Finance, and three coordinators (Advocacy, Monitoring and Evaluation and Training and Capacity Building) supported by an officer in the case of Programmes. Each Country Manager presided over two officers (Finance and Programmes) supported by an officer. Overall, the ED presided over and directed both the Regional Office Team (ROT) and the Country Office Teams (COTs) through Country Office Managers (COMs).

While the ROT provided financial and technical support to the COTs, as well as driving the regional advocacy agenda (in regional spaces such as the AU, SADC, UNAIDS PCB, RAANGO and RIAT), the COTs directly supported National Federations, DPOs and national level stakeholders (government departments, service providers - especially in the health sector, other civil society organisations, country level donors, and traditional and religious leaders) in an attempt to build national level programmes and facilitate their implementation (KII, 22-06-2016). In this way, DHAT formally configured and entrenched itself at both the national and regional levels to facilitate its reach and access to resources at both levels to promote its programmes and their accompanying modalities.

Figure 7.1: DHAT Organisational Structure



Source: DHAT (KII, 22-06-2016).

7.2.6 Programming

In relation to its programmes, DHAT's work was guided by a regional strategic plan (2016 to 2021) that operationalises its vision, mission and strategic goals. Because of this, the organisation was structured to operate at both the country and regional levels. DHAT's mandate included mobilising DPOs and their Federation to promote solidarity among people

living with disabilities (PWD), information management, training, research, advocacy and networking. Each of the programme activities involved partner mobilisation which DHAT understood to be "a process of identifying and targeting recruitment on potential contributors to its programmes in the region" (KII, 22-06-2016).

The organisation targeted various categories of players: the community of people with disabilities and their organisations, peer RNGOs, donors and technical support organisations, national and regional governmental organisations and relevant UN agencies. The mobilisation of any partner was determined by the nature of the programme to be implemented, otherwise the greatest focus was on the community of people with disabilities and especially their organisations. Within countries, and across the region, this is a process that was still under way as only four countries were mobilised and already engaged in programming through DHAT COTs (in other words, functioning COTs had only been established in four countries).

7.2.6.1 Advocacy

DHAT's advocacy work was targeted at three main levels: national, regional and internationally. DHAT aimed at policy influencing among international and regional leaders who in turn could influence national governments. At the national level, DHAT worked to influence policy and practices regarding the rights of people with disabilities and their access to medical and other services. Thus, at the national level, DHAT advocated for the integration of issues of persons with disability into various national level decision-making structures, including the government structures, parliamentarians, NGO structures, and local and traditional leadership structures.

In this process, DHAT also sought to mainstream disability in planning and implementation of all social services. For example, in Zimbabwe, DHAT worked closely with the Ministries of Health (MoH) and Social Welfare, which it used as 'key entry points' into government processes as they were already aware of the health and socio-economic conditions of people with disability. In this regard, DHAT focussed on government budgeting and the provision of services for people with disabilities, and the creation of national structures/platforms for people with disabilities to participate and present their issues.

DHAT held government structures to account for the provision of services to people with disability as provided for in the UN Convention on the Rights of People with Disabilities, which all governments in SADC have signed. DHAT advocated, lobbied and educated them on matters of disabilities to facilitate their mainstreaming within government structures, policies and programmes. DHAT also provided and explained information about

the rights of people with disabilities among its members through the Federations and DPOs and all the way down to the associations and the communities of people with disabilities to raise awareness and create demand for rights and services among people with disabilities, including those with HIV.

At the regional and international levels, DHAT's advocacy involved escalating national level issues of disability to bodies like SADC, UNAIDS, donors, other RNGOs and regional bodies to influence regional frameworks that informed intervention on matters of disability as earlier noted. DHAT sought not only to mainstream disability issues into the architecture of the regional HIV and AIDS responses, but for the inclusion of persons with disability into the implementing structures of the HIV response. This is because, while SADC had policy statements on disability, there is no significant implementation taking place: "We want to see people with disabilities in these organisations representing themselves, implementing these issues," asserted DHAT's Executive Director (KII, 22-06-2016).

Some of the work that DHAT had done with UNAIDS included providing guidance on the mainstreaming of disability matters in the regional HIV response. DHAT relentlessly made representation to the UNAIDS resulting in the inclusion of matters of disability in the UNAIDS 2016 Political Declaration on HIV and AIDS (KII, 22-06-2016). In this process, DHAT collaborated with its RAANGO partners to lobby the UNAIDS to mainstream disability in the regional HIV response. It also influenced its regional peer RNGOs to mainstream matters of disability in their own work throughout the region. The organisation reciprocated this support by incorporating its peers' issues into its own programmes. Beyond the common factor of HIV, DHAT incorporated matters of human and gender rights (collaboration with ARASA), psycho-social support (co-operating with REPSSI), and young people and key populations (all RAANGO members). In a Regional Key Populations Workshop of RNGOs in the SADC HIV response this writer facilitated in 2014, the RNGOs agreed to work collaboratively as HIV affected all categories of people in the region. DHAT attended this workshop, and argued for and won the inclusion of people with disabilities in the definition of key populations.

The RNGO also lobbied SADC and advocated for the regional body to develop a regional policy on mainstreaming disability matters within the region to operationalise the provisions of its 2000 Health Sector Policy. As part of this process, DHAT provided SADC with information on disability and disability programmes in the region, highlighting existing gaps in the response and proposing improvements. DHAT, which already sat on the SADC Civil Society Forum, was engaging SADC and had applied to sit on the SADC Technical

Committee on HIV and AIDS from which it hoped to influence the supra-national body to develop a regional policy on people with disabilities that incorporated the provisions of the UN declaration on the rights of people with disabilities (KII, 22-06-2016).

To this extent, DHAT was already collaborating with REPSSI (which was already a member of the Committee, but occupying the Psycho-Social Desk), and had produced a draft policy document for SADC to consider. DHAT and REPSSI were both members of RAANGO and the Regional Inter-Agency Task Team on HIV and AIDS, and they always exchanged notes on various matters of the HIV response. Further, DHAT extended similar efforts applying to sit on the AU civil society committee from which it intended to extend its influence on the continental body in advancing the issues of persons with disabilities. The AU had approved the application, but DHAT were yet to receive their invitation to sit on that committee. In this RNGO, we therefore see an organisation extending its influence through forging strategic connections with key development agents in SADC and on the continent.

7.2.6.2 Capacity Building

Most of DHAT's member Federations, DPOs and associations of people with disabilities lacked capacity to carry out their work. It was therefore one of DHAT's key roles to provide technical support to these social formations to enable them to deliver on their mandates and to manage donor funding. As part of this process, the DHAT deployed its Programme Coordinators to work in collaboration with NACs to build the capacity of the National Federations to implement advocacy programmes (KII, 22-06-2016).

DHAT capacity building included providing beneficiaries with current information and knowledge on rights of people with disabilities with regard to key advocacy issues including compiling and contributing policy-related inputs to national policy and disability law reviews. In addition, with the funding and technical support from SAT, DHAT offered training to enhance the Federations' capacities to engage with the different national structures, such as Members of Parliament (MPs), elected local councilors and chiefs. DHAT also provided skills training to equip their partners' staff with management skills to enable both Federations and DPOs to run their programmes and account for donor funds and to fundraise for their work.

7.2.7 Organisational Embeddedness

The structure of DHAT's work predisposed the organisation to forge numerous network relations with different development agents at different levels: country, regional and global.

We already noted some of these relations earlier in the analysis of the organisation's geographical coverage, partners and partnerships. These network relations integrate DHAT into different types of environments, such as the donor world, the UN system, the SADC regional governance structures, the African Union, other RNGOs, national authorities, and organisations and communities of people with disabilities. It is important to further explore some of these social relations and their content to illustrate the rationality that inspired them and level of embeddedness, and hence the extent of external influence on DHAT work and DHAT's influence on others in its network.

DHAT's strategy was a product of various influences, internal and external, demonstrating how the organisation operated subject to its operational contexts. These contextual influences were inevitable as they determined the relevance and opportunities of the organisations. The key voices in the strategy included those of the national federations of organisations of people with disabilities who represent their members and therefore raised issues that constituted DHAT's mandate. Every year, according to DHAT's ED (KII, 23-06-2016), input from DHAT member structures filter through its programmatic reports and also provide a basis for engagement in dealing with the concerns of PWDs (as programming feedback). DHAT incorporated these inputs into its annual programme review and revision processes, and fed them into the review of the organisation's strategy.

In addition, representations from national governments, traditional and religious leaders were also incorporated. For DHAT, national governments inputs are significant in two ways, as governments either had or did not yet have the requisite disability frameworks. Where frameworks existed, DHAT's work focused on monitoring and reviewing its implementation. Where disability frameworks did not exist, DHAT work focused on engaging the relevant structures for necessary reforms. The corollary of this is that DHAT operated within the existing frameworks – it had to comply while seeking to influence them.

The donors had contractual relations with DHAT to deliver on their own HIV programme objectives. When SAT, its sub-granter, shifted its strategic focus from 2013 to include sexual reproductive health and rights (SRHR), DHAT also had to include SRHR in its work to meet SAT's criteria for partner prioritisation following its fall out with donors at that time (Mushonga, 2014). Also, main donors such as Swedish International Development Cooperation Agency (Sida), Global Fund, IrishAID including UNAIDS, had turned their focus on and made funding available for, not only SRHR, but for youth, women, girls and key populations as well (sex workers, drug users, lesbians, gays, bisexuals, trans-gender and the intersex persons). This also influenced DHAT's priority programming in pursuit of funding.

In this case, we see the influence of donors and technical support-providers on DHAT work. Through their directed funding, they influenced DHAT to frame its programmes to incorporate funded areas such as HIV and SRHR, TB, cancer and malaria responses because that was where the available donor funding existed. Health, as we noted, is but one aspect of DHAT's concerns regarding disability but it had to use this as an entry point because it was funded.

7.2.8 Accountability Matters

DHAT viewed accountability as a two way process. For DHAT its operations' social relations created both social expectations and responsibilities (KII, 22-06-2016). These expectations were established through affiliations, MoUs and contracts that set out the nature and content of the relationship. Below I present a selection of some of the relations, mechanisms and processes of accountability.

Once affiliated, Federations, DPOs and persons with disability expected DHAT to deliver the services (capacity enhancement, resources, and representation in higher-level fora) that it promised in each case. In turn, DHAT expected support and cooperation from these social collectives and structures in the delivery of the programmes at every level throughout the country, and to provide evidence of changes occurring in programme implementation to further inform the response. In this case, there was reciprocity and an attempt to maintain a supportive environment for both the work of the organisation and the implementation of responses that enhanced the living standards and health of people with disabilities. This reciprocal accountability was maintained through regular programmatic processes such as participatory programme planning, implementation, monitoring, evaluation and reporting, and the provision of the requisite programme resources. More significantly, these processes were sustained through mutual support, collaboration, common respect and understanding.

Local government authorities expected and received feedback from DHAT on its work among people with disabilities, as well as advice on how to structure service delivery and policies so that they could respond better to the plight of people with disabilities. DHAT supplied such information in the form of programmatic reports to relevant authorities at least once a year in compliance with their registration and conditions of operations, as well as other relevant updates that could benefit national decision-making structures. Collaborating ministries like Health and Social Welfare received updates as regularly as they asked, as this was of mutual benefit to programming for people with disabilities.

In addition, it was mandatory for DHAT to submit to governments an annual, semi-annual, quarterly, mid-term or end of programme report in the four countries where it was registered, i.e, Zimbabwe, Zambia, Malawi and Botswana. Where DHAT worked in partnership with a government department such or NACs, field reports were shared as per the programme's terms to enhance partnership and cooperation. Where cost and personnel were shared, relevant accounting was carried out in compliance with the terms of the partnership. The DHAT's ED stated that governments expected DHAT to provide inputs and it did so through contributions to policy and legal reform, and by popularising the UN convention on the rights of people with disabilities to all structures down to the village level. In this regard, government expected DHAT to build the capacity of people with disabilities, so that they are able to understand the convention on disability and to play an advisory role on matters of national budgeting and programming for people with disabilities (KII, 22-06-2016).

At the regional level, DHAT advocacy and lobbying targeted SADC pressuring the latter to fulfil the provisions of various regional and international frameworks on disability. Simultaneously, the supra-national body expected DHAT to provide reports of its work annually during the Annual SADC Partnership Forum (which happens after the heads of state have met). DHAT provided such reports both bilaterally and through the regional NGO forum RAANGO, in a consolidated report on the work of RNGOs in the HIV response in SADC. For its part, SADC also shared its reports and documents including involving RNGOs in the development of its policy documents and regional strategy.

This writer was privileged to attend one such meeting in November 2015 which was for the review of the SADC Strategic Plan in line with the new UNDP (2015) Sustainable Development Goals (SDGs). At this meeting, DHAT shared its strategic plan, which it tailored to contribute to meet some of SADC's strategic objectives. In this context, DHAT's ED (KII, 22-06-2016) summarised accountability as follows: "We make sure that everything goes according to the SADC strategic plan; and, at the national level, our strategies are aligned to the host country national strategy and programming. As a result, there are certain deliverables that government may require from us which we must provide. There are also certain deliverables we may need from government, such that it is a two way process."

For DHAT, contractual relations such as those with donors had clearly laid out accountability mechanisms, and obligations and expectations, as was the case with other RNGOs. For the funding they provided, donors needed programmatic and financial reports on how their funds are utilised. In this case, DHAT received funding and in return accounted for the use of the money especially in terms of a demonstration of impact. To achieve this, it was

expected to have and utilise a M&E system to collect monitoring data for requisite reporting and to constitute as an input into programme evaluation so as to highlight programme impact and change as set down in programme objectives. As the DHAT ED (KII, 22-06-2016) put it, donors "always put pressure on us to account for the resources that they invest in our programmes. We have to provide evidence on how their resources have been used, and changed lives at the grassroots among beneficiaries. In some cases, we have allowed them to visit our programme sites so that they can see for themselves the work we are doing. Reports alone tend not to be enough in certain circles."

7.3 NAPSAR+ Case Example

The Network of African People Living with HIV, Southern Africa Region (NAPSAR+) is registered as a trust in South Africa, as a Section 21 non-profit organisation established in June 2007 (NAPSAR+, 2007:1; 2012a:1). Nine of ten national networks of people living with HIV (PLHIV) in the southern Africa region established NAPSAR+ to represent the interests of the national networks of PLHIV in the southern Africa region, including coordinating and building their capacity (NAPSAR+ 2012c:1;). NAPSAR+ is a "regional membership-based organisation formed of, by and for the national networks of people living with HIV (PLHIV) within the SADC region" (NAPSAR+, 2015:22). It is an intermediary organisation affiliated to the Global Network of People Living with HIV and AIDS (GNP+) an apex and global level representative outfit for the PLHIV community.

7.3.1 Mission and Vision

NAPSAR+'s vision is: "Best quality of life for people living with HIV achieved through the mobilisation, coordination, and advocacy for a comprehensive health package for people living with HIV in the SADC region," (Table 7.2).

Table 7.2: NAPSAR+ Mission and Vision

Mission	Vision
To coordinate and advocate for a comprehensive health package for people living with HIV in the SADC region	Best quality of life for people living with HIV

Source: NAPSAR+ (2015:22) Strategic Plan 2015 – 2020.

This vision includes ensuring that PLHIV have rights-based and universal access to prevention, treatment and care for HIV, and are able to use these services and systems to enjoy health and a quality of life free of discrimination and stigma (NAPSAR+ ED KII, 05-

11-2015). NAPSAR+'s work focussed at both the regional and national levels where NAPSAR+ worked to ensure the following:

- The regional secretariat has the advocacy capacity and profile to lobby SADC, SADC Parliamentary Forum, member States and key regional stakeholders to honour protocols, commitments and agreements,
- National PLHIV networks and their members have their organisational governance, management, programming and service delivery capacities improved and,
- The capacity of networks and local CBOs to advocate for improved SRH responses and services is progressively built (NAPSAR+ ED KII, 05-11-2015, NAPSAR+, 2015:32-40).

In essence, the work of NAPSAR+ was intended to benefit the PLHIV community through advocacy for the rights of the PLHIV and technical support for its member national networks of PLHIV. I explore NAPSAR+'s membership below to illustrate this link.

7.3.2 NAPSAR+ Membership

NAPSAR+ was constituted by ten member national networks from southern Africa as illustrated in Table 7.3. Each national PLHIV network represented networks and coordinated its member HIV and AIDS organisations from all levels within a country; from PLHIV support groups through CBOs and FBOs to NGOs operating and working on HIV and AIDS at the national level.

Table 7.3: Member Networks by Country

Country	National network
Angola	
Botswana	BONEPWA+: (Botswana Network of People Living with HIV/AIDS)
Lesotho	LENEPWA+: (Lesotho Network of people living with HIV and AIDS)
Malawi	MANET+: (Malawi Network of People Living with HIV and AIDS)
Mozambique	RENSIDA: (Rede nacional de associacoes de vivendo com HIV/SIDA em Mocambique)
Namibia	-
South Africa	NAPWA: (South Africa National Association of People Living with HIV and AIDS)
Swaziland	SWANNEPHA: (Swaziland National Network of People Living with HIV and AIDS)
Zambia	ZNP+: (Zambia Network of People Living with HIV)
Zimbabwe	ZNNP+: (Zimbabwe National Network of People living with HIV and AIDS)

Source: NAPSAR+ (2012a:2); KII, 05-11-2015.

This created a hierarchy of representation and a support chain from the community level through national networks to NAPSAR+, with NAPSAR+ completing the global connection through to the GNP+. This provided a support structure for all PLHIV to ensure their issues and concerns in the HIV responses were adequately factored into decision making structures that governed the HIV response.

7.3.3 Partners

In addition to members, NAPSAR+ worked with partners, less so as implementing agencies of its programmes, but as peers, collaborators and supporters (see Table 7.4). The organisation had the strength of eighteen partners which included a large variety of regional NGOs, UN agencies, and regional branches of international NGOs (NAPSAR+ 2012c:13). These partners were still working with the organisation in 2015 (KII, 05-11-2015).

Table 7.4: NAPSAR+ Partners as at 2013

Partner category	Number and names	%
Regional NGOs	1. Southern African AIDS Trust (SAT)	32
	2. Disability HIV and AIDS Trust (DHAT)	
	3. Regional African AIDS NGOs (RAANGO)	
	4. Regional Psycho-social Initiative (REPSSI)	
	5. AMSHER	
	6. Regional AIDS Training Network (RATN/ACA)	
	7. SAfAIDS	
UN agencies and governmental organisations	1. Joint UN Programme on HIV and AIDS (UNAIDS)	18
	2. United Nations Development Programme (UNDP)	
	3. National governments	
	4. Southern African Development community (SADC)	
International NGOs including some of their regional branches	1. Voluntary Services Overseas VSO-RAISA	22
	2. The International AIDS Alliance	
	3. Help Age International	
	4. INERELA	
	5. Global Network of People Living with HIV/AIDs (GNP+)	
Technical support	1. Management Science for Health (MSH)	14
	2. United State Agency for international Development (USAID)	
	3. Skill Share International	
Donors	1. Big Lottery Fund	14
	2. Swedish Agency for International Development (Sida)	
	3. Robert CARR Foundation	
Totals	22	100

Source: NAPSAR+ (2012c:13) Annual Report, 2011-2012; NAPSAR+, (2012d:2).

The largest number of NAPSAR+'s partners (54%) were civil society organisations, which included regional and international bodies. Some were peers while others were technical and moral supporters in the fight for the rights of PLHIV such as RAANGO and its

members not included here (see RAANGO case example). Nineteen per cent (18%) were UN and governmental organisations and 14% were technical support groups. Some of the organisations could contribute to NAPSAR+ financially but, at the time of the research (2015-2017), they were not in such a relationship with the organisation. For example, Skill Share had funded a NAPSAR+ project on livelihoods and USAID was running an organisational capacity assessment and enhancement programme of NAPSAR+ in 2015 to prepare the organisation to become a recipient of USAID funding (KII, 05-11-2015). NAPSAR+ only had two donors supporting its work.

7.3.4 Geographical Coverage and Being Regional

NAPSAR+ operated in southern African covering Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe (NAPSAR+, 2007:1, 3), and could expand into other countries to adequately cover the entire region as well as establish country offices in other locations to support its work (NAPSAR+ 2007, Constitution, Article, 3.14). As an apex organisation, and unlike DHAT, NAPSAR+ did not have direct country and community level reach except through national networks when its support was solicited by a national network.

The organisation defined a region in political and geographical terms as that area occupied by the countries it covered, but also as the area politically defined as southern Africa which covered the countries listed in its constitution (NAPSAR+ KII, 05-11-2015). For NAPSAR+, *being regional* meant "to amplify the voices from below at a higher level and taking down to the national level issues that benefit the national level – also taking issues that are common and affect a number of countries and engaging them for the common benefit of the people and countries of the region" (NAPSAR+ KII, 05-11-2015).

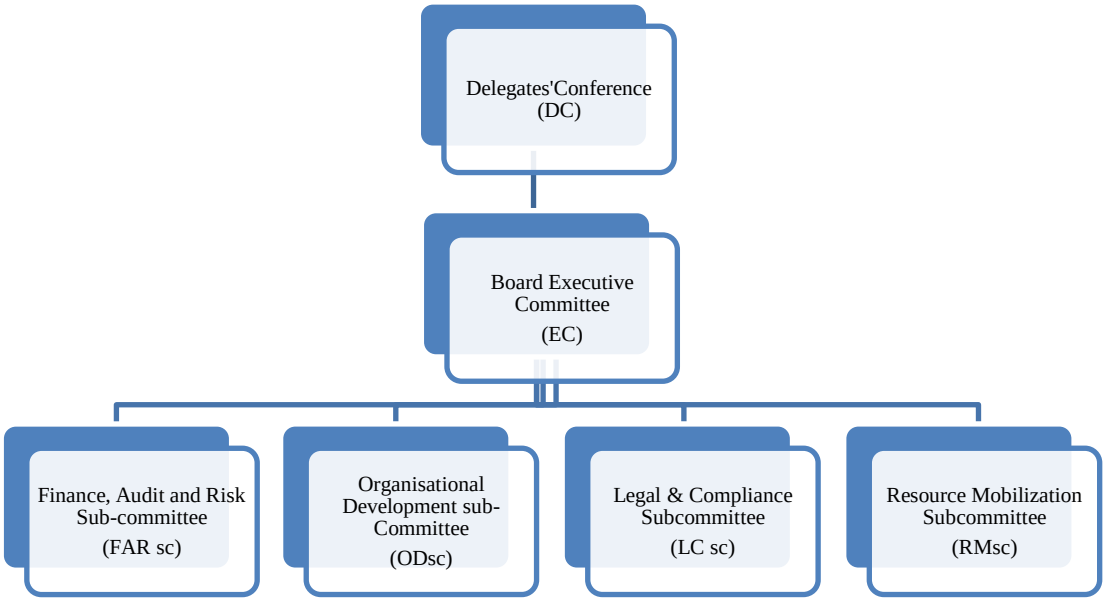
In other words, key in its perception and execution of regional work was a focus on addressing issues of regional significance to countries of the region (common externalities) as well as facilitating the flow of information and resources between the lower country and upper regional and global levels. NAPSAR+ viewed its role as complementary to other regional efforts and supportive of efforts at the national level, and supported the application of the principle of subsidiarity as espoused in the SADC (2010) HIV and AIDS Business Plan for 2010 to 2015 (NAPSAR+2015:23). In this context, I examine NAPSAR+'s organisational configuration to highlight how this reflected its perception of regional work and mandate as a regional player in the HIV response.

7.3.5 Governance and Management

Although it was a members-based organisation like DHAT, NAPSAR+'s governance and management structure illustrated its direct link with the PLHIV community, but through member national networks. Its supreme governing body was the Delegates Conference (DC), comprised of all member network representatives that were affiliated to NAPSAR+. DHAT governance did not include a provision for members' direct participation in governance matters.

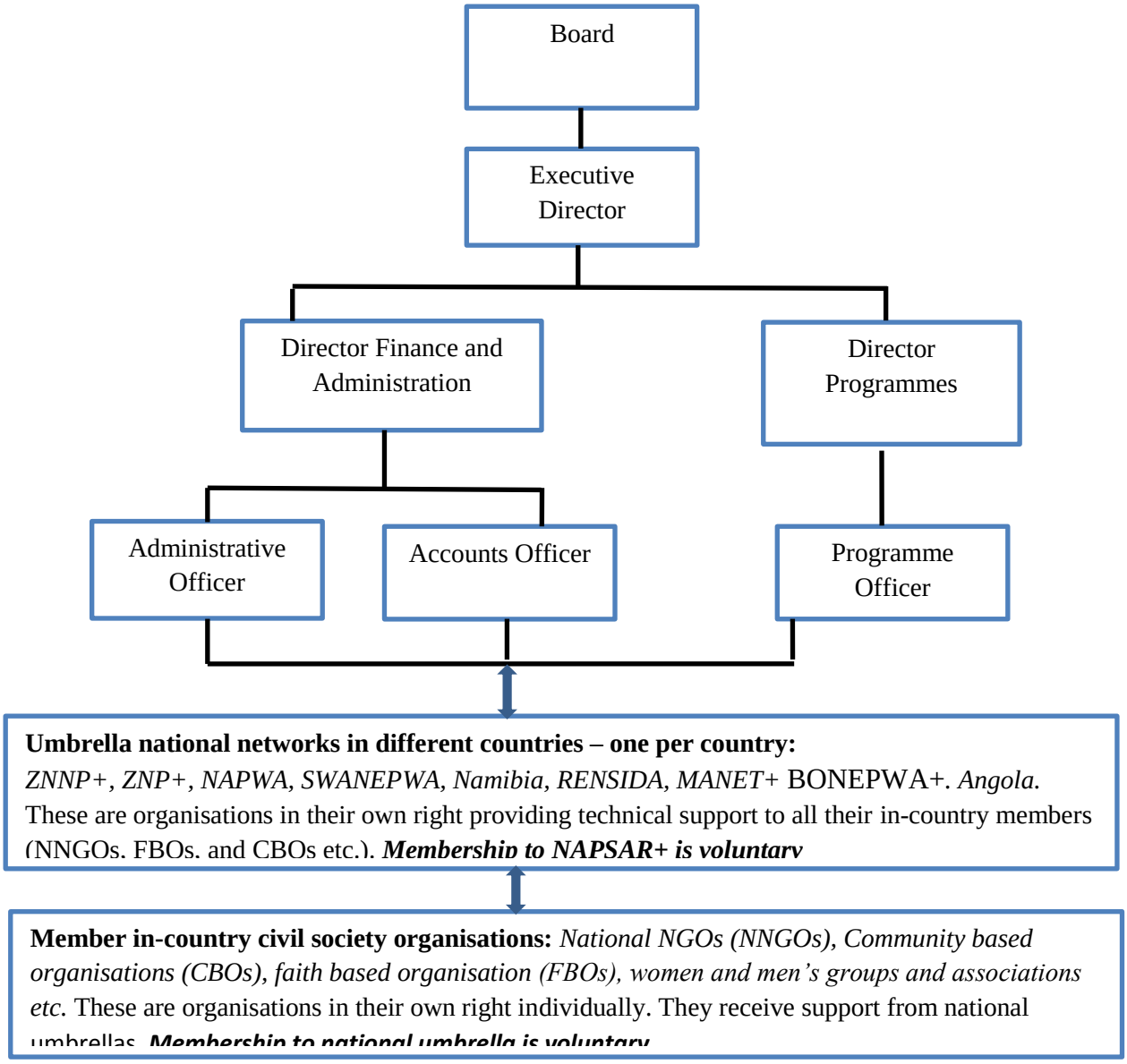
NAPSAR+'s DC supervised a Board of Directors comprised of eleven elected members, one from each of the ten countries plus the Regional Executive Director (who, like in other cases, also sat on the Board as an ex officio member). The NAPSAR+ Board was led by an Executive Chairperson through an Executive Committee (EC) comprising the chairperson, the treasurer and the secretary whose roles were to give effect to the decisions of the board, to take operational decisions to the Secretariat and then report to the board at its next sitting. The EC was supported by four function specific sub-committees: Finance, Audit and Risk (FAR), Organisational Development (OD), Legal and Compliance (LC), and Resource Mobilisation (RM). Through these sub-committees, the EC worked with the Secretariat supporting the latter in its functions, and providing strategic and operational support (NAPSAR+ 2007:2; 2015:5). Figure 7.2 gives an illustration of the NAPSAR+ Board.

Figure 7.2: NAPSAR+ Board



Source: Adopted from NAPSAR+ (2015:5) 2015-2020 Strategic Plan.

Figure 7.3: NAPSAR+ Secretariat



Source: NAPSAR+ (2015:5, 7) Strategic Plan 2015 – 2020; NAPSAR+ ED KII, 05-11-2015.

Led by an Executive Director, a team of five persons constituted NAPSAR+'s Johannesburg-based secretariat, providing the member networks with necessary support and executing PLHIV representation at the regional level, while also advancing their right to health and related services in the HIV, TB and malaria interventions in the region. It was a very lean secretariat that often relied on the services of consultants to roll out its programmes (KII, 05-11-2015), and was very directly linked to member networks as Figure 7.3 illustrates.

Although its member-networks were autonomous organisations, they collectively owned NAPSAR+, and directly gave the orgnisation its strategic direction. This did not only

happen through the DC and Board, but through inputs from individual networks in the form of consultative meetings and programmatic reports submitted by each country network (ED KII, 05-11-2015). This writer had the privilege to attend and, at times, facilitated some of these meetings, and directly observed these processes as a consultant for the organisation's Strategic Plan between 2014 and 2015.

7.3.6 Operational Modalities and Programmes

Like other RNGOs discussed earlier, NAPSAR+ employed a number of modalities to deliver on its mandate. These included first and foremost a process of partner mobilisation which ensured that the organisation had the necessary financial and social support it needed to roll out its programmes. Secondly, the organisation rolled out institutional support to ensure that its member networks had the relevant capacity to perform their roles as national coordinating bodies of PLHIV organisation. This involved NAPSAR+ conducting Technical Support Visits to assess the capacity needed amongst the organisations and respond to their challenges.

Responses to members' institutional challenges included organising member exchange and mentoring visits, as well as skills training, information sharing and educational workshops. NAPSAR+ also rolled out advocacy work as part of its representation of the PLHIV community and the promotion of their rights and interests in the HIV and AIDS response. These activities were supported through a sub-granting process that fed directly into each event. Some of these modalities are discussed below to further illuminate how they were conducted and benefited NAPSAR+'s members.

7.3.6.1 Partnerships

NAPSAR+ viewed partnerships in terms of collaborative and joint working among PLHIV organisations at all levels within the PLHIV community on one hand and, on the other, as relations between the PLHIV and other players in the HIV response (national governments, regional bodies like SADC, donors, the UN agencies and other civil society organisations – international, regional and country-based) (NAPSAR+, 2012a:1-2; KII, 05-11-2015). For NAPSAR+, developing cooperative and collaborative relations would generate common understandings of the key issues affecting PLHIV, and hence create an understanding of the matters that need mainstreaming into the HIV response to ensure that the PLHIV community has access to human rights-based HIV prevention, treatment, care and support including for sexual reproductive health (SRH), tuberculosis (TB) and malaria (KII, 05-11-2015).

NAPSAR+ worked closely with its RAANGO colleagues advocating for improved and rights-based health services for people living with HIV and AIDS. This included even organisations of vulnerable groups such as sex workers (e.g. ASWA), of lesbians and gays (e.g. the Gays and Lesbian Association of Zimbabwe (GALZ)), bisexuals, transgender and intersex (LGBTI) community members (e.g. AMSHER), people with disabilities (e.g. Disability HIV and AIDS Trust (DHAT)), and children and young people [e.g. through the Regional Psycho-social Support Initiative (REPSSI)]. Collectively and with the support of the International HIV Alliance and GNP+, NAPSAR+ organised a one week regional key populations workshop in Johannesburg, South Africa in 2014, at which participants worked out a common definition and understanding of the key populations group for southern Africa. Based on a communiqué developed at this workshop, they also developed and shared a regional key populations advocacy agenda based on the GNP+ global advocacy agenda for incorporation into their strategic plans going forward into the period beyond 2015 (KII, 05-11-2015; NAPSAR+, 2014:5).

In the area of PLHIV rights, NAPSAR+ worked closely with the AIDS Rights Alliance of Southern Africa (ARASA) to audit the ratification and domestication of international frameworks that provided for the rights of PLHIV. It also advised the SADC on the key areas of concern regarding PLHIV rights to access health services especially treatment and access by HIV positive members of the LGBTI community, including sex workers and people with disabilities (NAPSAR+ 2012a; KII 05-11-2015).

7.3.6.2 Institutional Strengthening

NAPSAR+'s institutional support services to its member network organisations comprised a number of modalities, notably technical support visits, exchange visits and grant-making. Each of these modalities were executed to support networks to function and deliver their programmes more efficiently. I discuss each of these modalities to illustrate how NAPSAR+ as a membership based organisation reached its constituency in operating as a regional organisation.

First of all, in the case of techical support visits, NAPSAR+ worked closely with national networks to support their organisational capacities in all areas, such as governance, management and programming matters. Technical Support Visits were meant to "keep track of issues confronting PLHIV and their organisations throughout the region and also broker working relations between member country networks and key stakeholders" (NAPSAR+,

2012:3). This work was supported by Sida through the Southern African AIDS Trust (SAT) as the intermediary and grant manager.

In the area of governance, NAPSAR+ helped networks establish relevant organisational structures especially the establishment of functional organisational boards that could support the secretariats and work with a clear separation of powers to promote transparency and accountability. While NAPSAR+ management and selected NAPSAR+ board members could provide such support where required, a consultant was utilised to support the team where necessary (KII, 05-11-2015). NAPSAR+ received such support from Management Science for Health (MSH) between 2014 and 2015, the period when it was preparing to meet the USAID requirements as a grant recipient.

In programming, NAPSAR+ provided advocacy support through identifying, prioritising and popularising policy issues for advocacy at the national level with which its member networks could work. This support was intended to enable member networks to work more efficiently but also to raise – with national authorities – identified policy issues through sharing NAPSAR+'s research findings to support national advocacy work (NAPSAR+2012c:5; KII, 05-11-2015). Most of the capacity issues were identified during these visits and resultant technical support was agreed on and planned as necessary. NAPSAR+ also took this as an opportunity to share relevant regional issues within the NAPSAR+ network as a whole and seek mechanisms for dealing with identified challenges, including mobilising support to present a unified position on any matter of significance for the PLHIV community in the region.

Secondly, exchange visits and mentoring were crucial for the RNGO. As part of institutional capacity strengthening. NAPSAR+ facilitated exchange visits among its members to promote learning and exchange of ideas and experiences. This was intended to promote inter-organisational learning and networking among its network members and learn from the greater regional experience. The organisations involved were chosen on the basis of mutually expressed interest in the process and perceived mutual benefit, since there was supposed to be something to learn from each other to enhance the capacity each of the organisation. I draw from one experience of this process to illustrate how it was carried out.

In 2010, the organisation had successfully facilitated one such visit between the Malawi Network of People Living with HIV/AIDS (MANET) and the Zimbabwe National Network of People Living with HIV/AIDS (ZNNP+) (KII, 05-11-2015). This exchange was intended to promote the "exchange of ideas and promote regional interaction between the two networks" (NAPSAR+, 2012b:1). MANET had an excellent model of governance which it

could share with ZNNP+. On the other hand, ZNNP+ had professionalised its serve delivery model, which was an experience from which MANET could also learn. Each organisation sent a delegation of its members that worked directly in the area of learning. In this case, MANET sent its ED and selected members of their Board to meet and exchange ideas with their counterparts in ZNNP+. ZNNP+ sent its programmes personnel to meet their counterparts in MANET. According to the NAPSAR+ ED, these visits were followed by participatory and joint development of action plans and monitoring procedures to monitor programme roll out (KII, 05-11-2015). In each instance, NAPSAR+ facilitated and monitored the process, and sponsored the meeting and the delegations.

The lessons drawn from exchange visits were not limited to knowledge, skills and information sharing and joint problem solving, but also promoted networking and continued exchange among participants. These exchanges also extended to other areas as well including increased sharing of organisational information for planning and programming, including joint working (NAPSAR+, 2012b:2).

Thirdly, training workshops were of some significance. Member network skills-based needs identified in Technical Support Visits for member country networks were usually addressed through training workshops if the challenge affected a large group of member networks, or simply exchange visits or mentoring if this involved one or two organisations. Skills workshops were organised on a regional basis (KII, 05-11-2016). They were either organised and facilitated by NAPSAR+ personnel or could be organised by NAPSAR+ and facilitated by a specialist consultant or indeed a NAPSAR+ member network competent in the area of skills deficiency. For example, NAPSAR+ organised and delivered a finance management workshop for Finance Managers and Programme Managers for five of its member country networks in its 2011-2012 financial year, to address issues of fraud detection and prevention, travel and communication policies in relation to allowable and excluded costs and conditions, HIV work place policy and asset disposal policy and procedures (NAPSAR+, 2012:3).

Fourthly, NAPSAR+'s grant-making process was directly linked to the organisation's technical support to its member national networks. It was a mechanism for enabling network members to execute key organisational activities, for which they neither had funding nor skills, yet were critical for their organisations. Some of the member activities and processes included regional exchange visits, programmes, annual board meetings, strategic reviews, work plan development processes and similar member network processes (KII, 05-11-2016). The grants were sized around the particular activity and were by no means standardised;

however, the most expensive activities were hardly larger than US$10 000 each. In addition, and as part of this support, NAPSAR+ always provided technical backing for these processes, either through its staff or paid consultant hired by the member network to support the process. Below I present one illustrative example of how NAPSAR+ rolled out its sub-granting.

NAPSAR+ supported the South Africa National Network of People Living with HIV/AIDs (NAPWA) in 2015 to carry out two main activities, that of strategic planning and organisational capacity strengthening. For that activity, NAPSAR+ had also planned to hire a consultant to facilitate the process but was itself in a financial crunch. In addition, NAPSAR+, at the request of NAPWA and in collaboration with NAPWA, initiated an organisational and programmatic capacity strengthening process to enhance the latter's overall management, its coordination with provincial, district and community branches, and its capacity to effectively deliver its programmes. All the preliminary work was funded by NAPSAR+ including a baseline on community mobilisation in KwaZulu/Natal in 2015.

Unfortunately, the programme could not be completed as NAPSAR+'s funding, received through the Global Network of People Living with HIV/AIDS (GNP+), was suspended on the basis of GNP+'s allegations of misuse of the funds by NAPSAR+. But, a forensic audit of the organisation did not bring out any information contrary to NAPSAR+'s own stated position regarding the use of a US$40 000.00 'unassigned' grant which it assumed was a make-up for a shortfall in the previous year (NAPSAR+ Board Chair, 01-2016). The matter thus became a conflict over authorisation rather than one of corruption, but the damaging impact of the impasse resulted in the suspension of operations and closure of offices by the organisation at the end of 2015, as the organisation was bankrupt and could not mobilise funding since donors shunned it.

This unfortunate development had been preceded by another conflict over the resignation of the Executive Director within the same period. At the conclusion of this research, there were efforts by the national networks to revive the organisation as its board had failed to account to the Delegates' Conference on all these developments, with the Delegates' Conference being the highest governing body of the organisation.

7.3.6.3 Representation and Advocacy

NAPSAR+ described itself as the only authentic regional PLHIV regional organisation that had a constituency that spanned from the community to the regional level and was directly linked to the global structure that represented people living with HIV, that is, the GNP+ (KII, 05-11-2015). It described its role in this regard as that of representing people living with HIV

at the regional level as linked with the global structure through GNP+, and lobbying and advocating for the consideration and inclusion of the issues/concerns of the PLHIV community as raised from country level and channelled to NAPSAR+ through its member national networks (NAPSAR+, 2011:6). I discuss these matters in more detail highlighting some the key structures that were engaged and the work that NAPSAR+ did.

According to the NAPSAR+ 2011-2012 Annual Report, the organisation worked closely with parliamentarians from the ten countries of its member networks through the SADC Parliamentary Forum. NAPSAR+ had sat on the HIV Technical Team of the forum to advise on the policy concerns of the PLHIV community as well as contribute to the Vision 2030 Economic Blue Print. In this forum, NAPSAR+ was able to raise issues brought through by member networks as well as provide a regional view of these concerns for consideration by the SADC PF (NAPSAR+, 2012c:2; KII, 05-11-2015).

NAPSAR+ supported its work through empirical evidence generated through its targeted regional researches and reviews which included the following: NAPSAR+ Review, 2012, which focussed on health providers' attitudes towards PLHIV and a situational analysis of people with disabilities and the aged in Botswana, Lesotho, Mozambique, South Africa and Swaziland; ratification and implementation of human rights treaties and declarations relating to stigma and discrimination; a review of understanding of Positive Prevention as well as positive prevention strategies and programmes in Botswana, Lesotho, Mozambique, South Africa and Swaziland; and a review of National Labour Legislation against the SADC Model Law provisions on HIV and AIDS and the rights to work (Article 23) in Botswana, Lesotho, Mozambique, South Africa and Swaziland (NAPSAR+2012c:3; NAPSAR+, 2012d:1-2).

7.3.7 Organisational Embeddedness

NAPSAR+ as a member-based network organisation was, firstly, entrenched in the life and workings of its member networks including their own members and the entire PLHIV community whose voice, interests and rights the organisation promoted at the regional level, and supported at the lower national level through the member networks. In other words, the organisation drew its mandate and owed its existence to the PLHIV community which founded the organisation through national networks. The continued control and exercise of power by the PLHIV community was perpetuated through the Delegates Conference which was constituted by all networks and formed the basis of the legitimacy, mandate and relevance of the organisation. Outside this frame of reference, the organisation had neither

legitimacy nor relevance to the PLHIV community, and hence could not be an authentic voice of the PLHIV within the region.

Secondly, in the process of exercising its mandate, NAPSAR+ forged and sustained different types of relations with various categories of development organisations: UN agencies (UNAIDS, UNDP), regional governmental organisations (SADC, EAC), donors (Sida, the Big Lottery, SkillShare International, Robert CARR Foundation), national governments and regional NGOs (mostly the RAANGO group of which it was a member). Through these network connections, NAPSAR+ received different forms of support for its work and also assisted other development players and their processes. While the organisation received donor financial support for its work, it had too fit into the donors' own development programmes and contribute to their objectives to qualify and receive the funding. In this case, network relations were determined and sustained by practical mutual relevance towards each other.

As part of a regional response to the HIV epidemic, NAPSAR+ needed and supported other bodies in order to develop a critical mass that was needed to drive the interventions. In this regard, cooperating with other RNGOs, especially in RAANGO, enhanced the organisation's ability to achieve its own mission and contribute to the response more generally. Engaging centres of power in the region (regional governmental bodies, national governments, the UN agencies) contributed to the creation of an enabling environment within which it could drive its mission. In other words, NAPSAR+'s national, regional and international level engagements were strategic to its work as well as the entire response. But, this also meant that the organisation was integrated into the global system of HIV governance as shaped by intervening regional and national inputs and processes. This created a major challenge for accountability for the organisation.

7.3.8 Accountability

The extent of NAPSAR+'s embeddedness had implications for the dynamics of the organisation's burden to be accountable. As a member-based organisation, the first level of accountability was its membership by which and for which it was formed. Hence, it had to deliver and account for the delivery on its mandate to its structures: the NAPSAR+ Board, and the Delegates Conference which was constituted by all member networks; and in that process, it accounted through the member networks to the PLHIV community in the region – as those affiliated to their national networks. The demands of member networks (and hence those of the PLHIV community) and the need to be accountable were always mitigated by

NAPSAR+'s relations with key organisations in the HIV response to HIV in the region, to the extent that these organisations influenced and structured how NAPSAR+ executed its work.

For example, as noted in other case studies in this thesis, its HIV response was framed in the context of the global, regional and national architecture and this architecture's response at the different spatial levels. This implied that, while accounting to its member networks, NAPSAR+ needed to do so in the context of broader expectations arising from this architecture; and, at times, it gave greater attention to these expectations than to its member networks. Typically, NAPSAR+'s programmatic framing, implementation, monitoring and evaluation were framed based on the guidelines of their donors and the UN, towards which the organisation also had an obligation to contribute towards the global changes in the response to the epidemic (KII, 05-11-2012).

Donors needed all of the requisite reports (as stipulated in funding contracts) on both financial and programmatic processes of all funded projects, regardless of the expectations at the NAPSAR+ member level. Like all RNGOs, the organisation found itself under pressure to pay greater attention to these demands than those of its members. This is illustrated clearly in the organisation's management of its dispute with the Global Network of People Living with HIV/AIDS (GNP+). Even though the organisation would have preferred to focus more on its members, the Board Chair and the Executive had to prioritise working on matters with the GNP+ even while members also needed their usual services. This was because it was funding from donors that determined programme delivery to member networks.

7.4 Conclusion

This chapter has highlighted the character of constituency- and member-serving RNGOs, showing their structural similarities rooted in their mandate to serve constituency members through arrangements that extend from the regional to community levels. The main difference between DHAT and NAPSAR+ in this regard was that the latter restricted itself to serving its constituency through national networks while DHAT extended its services further to lower structures at the country level. The organisation justified such an extension on the basis of lack of local structures of people with disabilities at this level. Both organisations viewed regional work as based on common and significant externalities that affected the region, and viewed intervention in this regard as – strategically – region-wide even though DHAT operations extended to lower levels.

The chapter also highlights why and how it was necessary for the organisations to mobilise partners and establish partnerships – in both cases, starting with organising its

constituency members to develop a regional movement to demand various rights provisioned in international and country level statutes related to HIV and disabilities. In this process, the significance of donor funding and technical support cannot be underestimated as each organisation needed resources to support its work, including partner technical support, representation and advocacy. Connecting at the regional and national levels and internationally meant that the organisations became embedded in international, regional and national processes directly or indirectly, subjecting themselves to governance influences at these levels. As such, these organisations found themselves needing to account to various nodes in their global network of development partners, illustrating that being regional is an intermediary positioning of significance to the international and country levels.

While this chapter concludes the first category of RNGOs (the members-serving), the next chapter presents the first subset of another category of RNGOs, namely, the other-serving RNGO group. This provides another opportunity to compare and contrast different categories of RNGOs as well as to highlight intra-category differences to construct a deeper understanding of RNGOs, and their role and significance in the practice of *being regional*.

CHAPTER EIGHT: OTHER SERVING GENERALISED TECHNICAL SUPPORT REGIONAL NON-GOVERNMENTAL ORGANISATIONS

8.1 Introduction

This chapter presents yet another typology of regional non-governmental oganisations (RNGOs), the other-serving RNGOs involved in generalised technical support. These are RNGOs whose major role was to provide a wide range of generalised technical support services primarily to other civil society organisations in the HIV and AIDS response. The services included organisational development and institutional capacity strengthening – including governance, programme support, grant-making, and individual skills training. The configuration of their work was different from member-serving technical support RNGOs in terms of the target beneficiaries. It was also different from those providing specialised services such as psycho-social support and information and advocacy. I present two case examples of generalised technical support RNGOs in this chapter; Africa Capacity Alliance (ACA) and the Southern African AIDS Trust (SAT), to demonstrate how they were configured and provided services in contrast with other typologies.

8.2 ACA/RATN Case Example

The Africa Capacity Alliance (ACA) is an RNGO that was established by the Universities of Nairobi and Manitoba in 1997 as the Regional AIDS Training Network (RATN) with funding from the Canadian International Development Agency (CIDA). RATN was founded after SAT, another child of CIDA, was launched seven years earlier as a CIDA project to provide institutional capacity strengthening for civil society organisations to enhance community HIV and AIDS competence in southern Africa (CPHA, 2008:7, S42; Mushonga, 2014). RATN was established to provide skills to lower level medical and support personnel to strengthen community level responses to HIV, and its vision involved strengthening health services delivery systems for maximising effective HIV responses around which was constructed its initial mandate.

8.2.1 Mission and Vision

RATN's initial mandate was to address the lack of HIV and AIDS-specific training for healthcare workers in resource-limited settings, and to do this through institutional partnerships in contributing to a favourable environment that could support healthy lives in Africa and globally (ACA, 2014:iii, 3). Although the organisation's mandate has remained

unchanged, its vision and mission have been tweaked. Much of RATN's work from inception until sixteen years later, centred on mobilising training institutions and local and international NGOs in east and southern Africa to deliver courses to African public healthcare workers and community volunteers in order to enhance their capacities to deliver effectively in the context of HIV. Table 8.1 presents ACA's current mission and vision.

Table 8.1: ACA's Mission and Vision

Mission	Vision
➢ Through partnership, provide sustainable capacity solutions to improve lives in Africa	✓ Healthy Lives, Better Africa. Better World

Source: ACA (2014: viii) Strategic Plan 2014 - 2019 Source: ACA Strategic Plan.

While the organisation was initially established to respond to HIV, its work has expanded to include technical support beyond HIV to include significant infectious diseases (such as co-infection in HIV, tuberculosis and malaria), non-communicable diseases (e.g., cancer, diabetes and heart disease), and issues of health equity and rights such as access to maternal and child care and gender equity (ACA, 2014:iii). It also expanded its training to include technical and institutional capacity building, advocacy, research, knowledge and information sharing to meet the challenges presented by the HIV epidemic and other health threats (ACA, 2014:3).

8.2.2 Institutional and Strategic Transformation

Contextual factors that included health threats and the demand for the organisation's services at both individual and institutional levels compelled the organisation to continue to broaden its scope of work and strategically reposition itself for a more significant role that could cover the entire African continent but still in pursuit of the grand vision of 'changing lives through better health'. RATN transformed into ACA to reflect this larger mandate and reconfigured its organisational mission as a result.

With a membership of thirty-nine (39) Member Institutions in twelve (12) countries within sub-Saharan Africa, ACA officially launched its five-year Strategic Plan (2014 – 2019) in March of 2014, which focused on health systems strengthening, community systems enhancement and capacity development for public-private partnerships in health, all underpinned by efforts at collaboration (http://africacapacityalliance.org/about-us/, accessed on 20-08-2016). This move saw the organisation's operations and reach expand in east and southern Africa.

8.2.3 Geographical Coverage and Being Regional

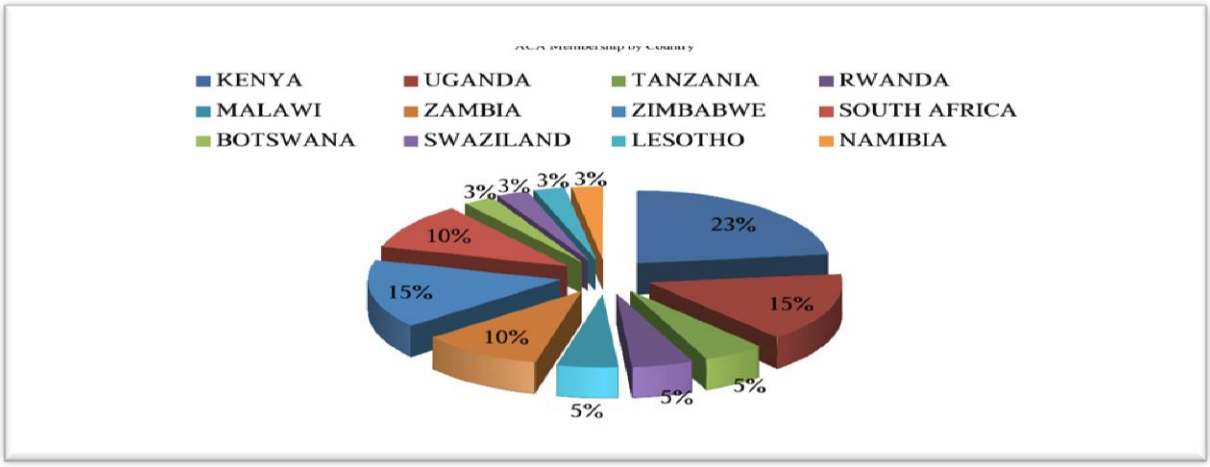
At the time of the research, ACA worked in twelve countries of east and southern Africa: namely Uganda, Rwanda, Tanzania, Kenya (where its secretariat is based), Malawi, Zambia, Zimbabwe, Botswana, Namibia, South Africa, Swaziland and Lesotho (ACA, (2014:3.) Although on its website (www.africacapacityalliance.org/what-we-do/ accessed 05-4-2017) the organisation claims to work throughout Africa, its actual documented spread only included three countries in east Africa (Kenya, Rwanda and Uganda) and nine in southern Africa.

If the East Africa Community (EAC) and the Southern African Development Community (SADC) are considered separately, ACA's reach was inter-regional. However, when the two regional economic communities (RECs) are combined as part of the sub-Saharan African region, or as the east and southern Africa region, ACA's programme reach was intra-regional from that perspective, just as it was from its regional strategic view and programme model. Like the other RNGOs, ACA's work was driven by a single and centrally controlled Strategic Plan that delineated its programmatic mandate. This, like in the other RNGOs, seemed to be a key defining element of regional programming. An examination of the spread of the organisation's partners gives further illustration of this.

8.2.4 Members and their Spread

ACA member institutions (MIs) were located in twelve countries of eastern and southern Africa (Figure 8.1).

Figure 8.1: ACA Membership by Country176

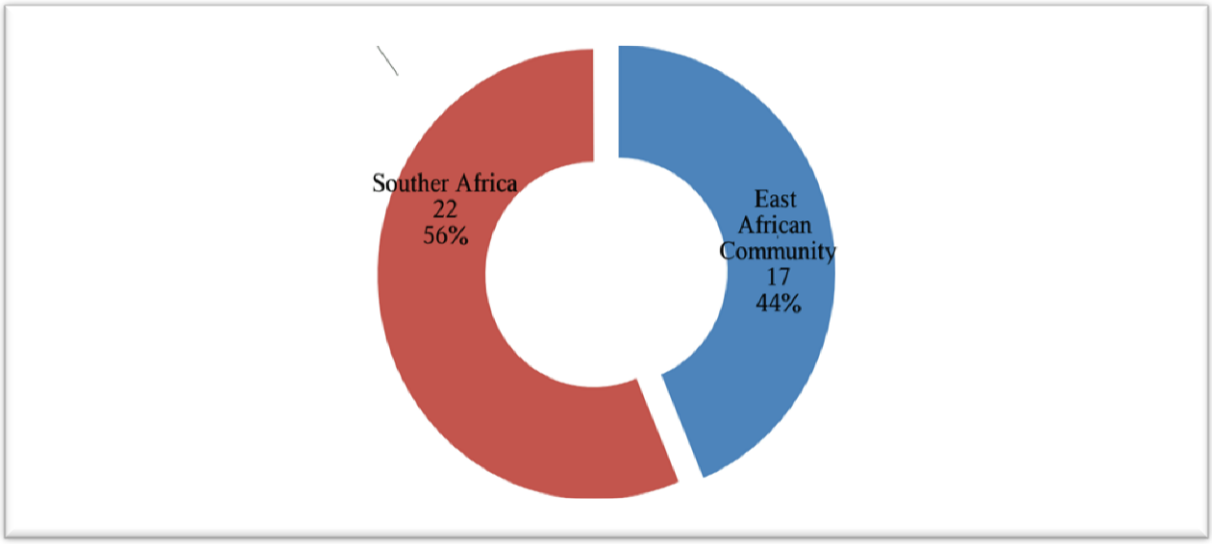


Source: Compiled from ACA 2014-2019 Strategic plan (2014:32-33); http://africacapacityalliance.org/partners/#.V7eEr_l961s accessed on 20-08-2016.

They included international NGOs (INGOs), national and local NGOs, management institutions, teaching hospitals and universities. ACA members were fee-paying institutions that had been assessed and approved by the organisation's Board, ratified by its General Council and had paid their full membership fees. These organisations did not only have voting powers and rights to stand for office, but were authorised to deliver services within the countries of their location and within the confines of ACA's regional strategy under an approved ACA curriculum. Also, they were training institutions and similar organisations that had been assessed and certified by ACA as capable of delivering its training courses, and could deliver on the organisation's mandate in sub-Saharan Africa.

Although ACA operated only in three countries in the east African region (Kenya, Uganda and Rwanda), it had the highest concentration of partners per country in this region accounting for 44% of the total members (N=39) compared to 56% spread over 9 countries in southern Africa (Figure 8.2).

Figure 8.2: Membership by Region



Source: Compiled from ACA 2014-2019 Strategic Plan (2014:32-33); http://africacapacityalliance.org/partners/#.V7eEr_l961s accessed on 20-08-2016.

This may be the result of the organisation having its roots in that region as well as the concentration of the epidemic in those countries when the organisation was established. The spread and concentration in southern Africa may be the result of both demand per country and a recognition of the need for such an organisation in some of these countries in the region. It

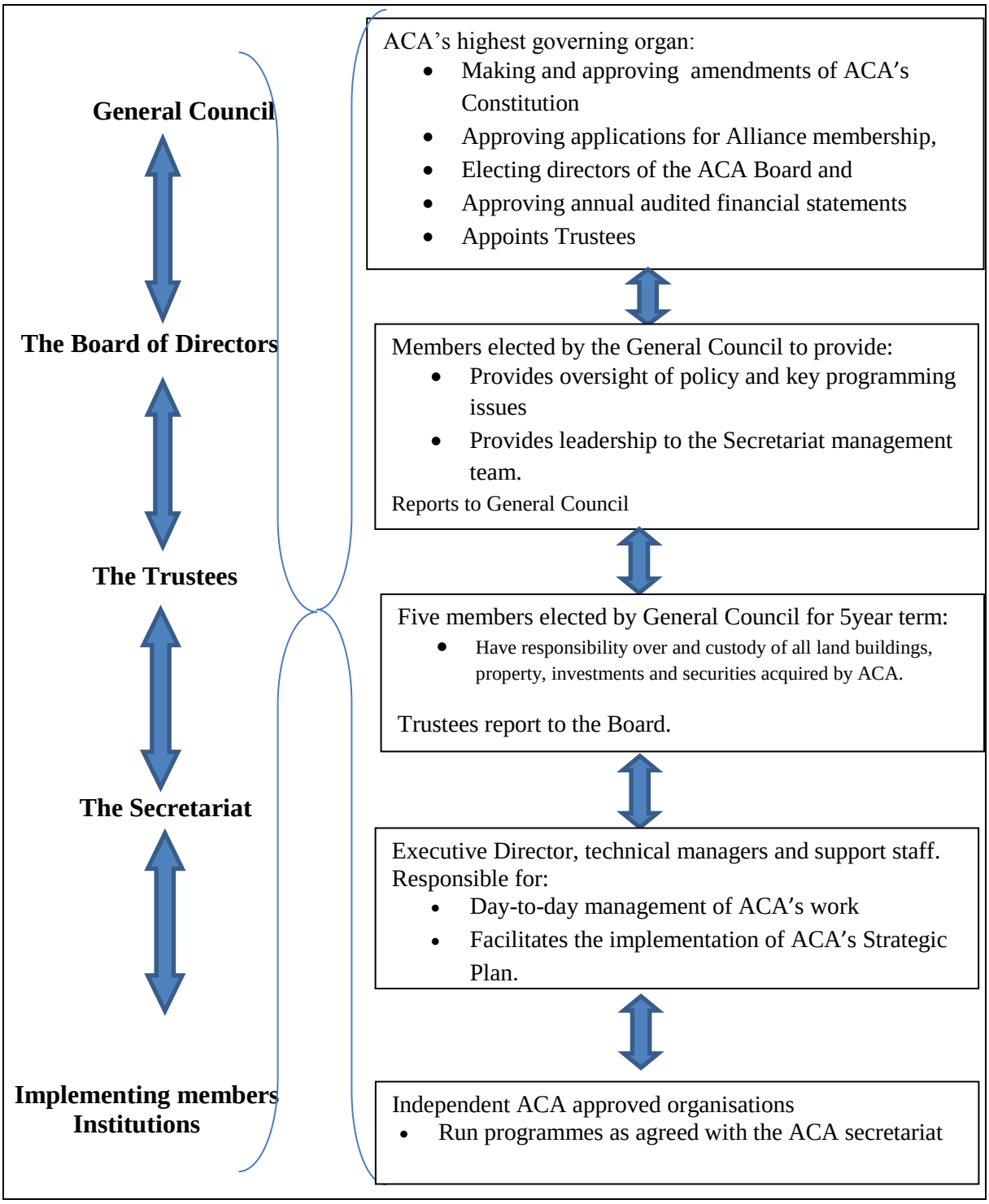
is important to examine the governance and management of the organisation in relation to the geographical spread and distribution of its members in pursuit of regional work.

8.2.5 Governance and Management

Although ACA's reach was spread over nine countries, the organisation did not have country offices since it operated through member institutions (MIs). As such, ACA tailored its governance and management structures to coordinate the work of its MIs, and protect organisational property and member interests, while ensuring the delivery of relevant quality health systems and capacity strengthening services at the institutional and individual levels. The supreme governing body of the organisation was the General Council which was comprised of all members of the organisation. There was a clear separation of powers and responsibilities from one governance organ to another that generated mutual support and accountability to guard the interest of the members and the organisation's ability to deliver on its mandate, as Figure 8.3 illustrates.

The creation of Trustee positions was a particularly interesting aspect which ensured that organisational property was not abused by either the Board of Directors or the Secretariat, but accounted for directly to the General Council. It mandated the Secretariat to implement the organisational strategy under the guidance of the Board of Directors whose efforts were also similarly directed towards facilitating the work of the Secretariat. In this light, I briefly discuss the ACA Secretariat as the implementing arm of the organisation to illustrate how it was structured to coordinate its MIs through which it implemented its programmes.

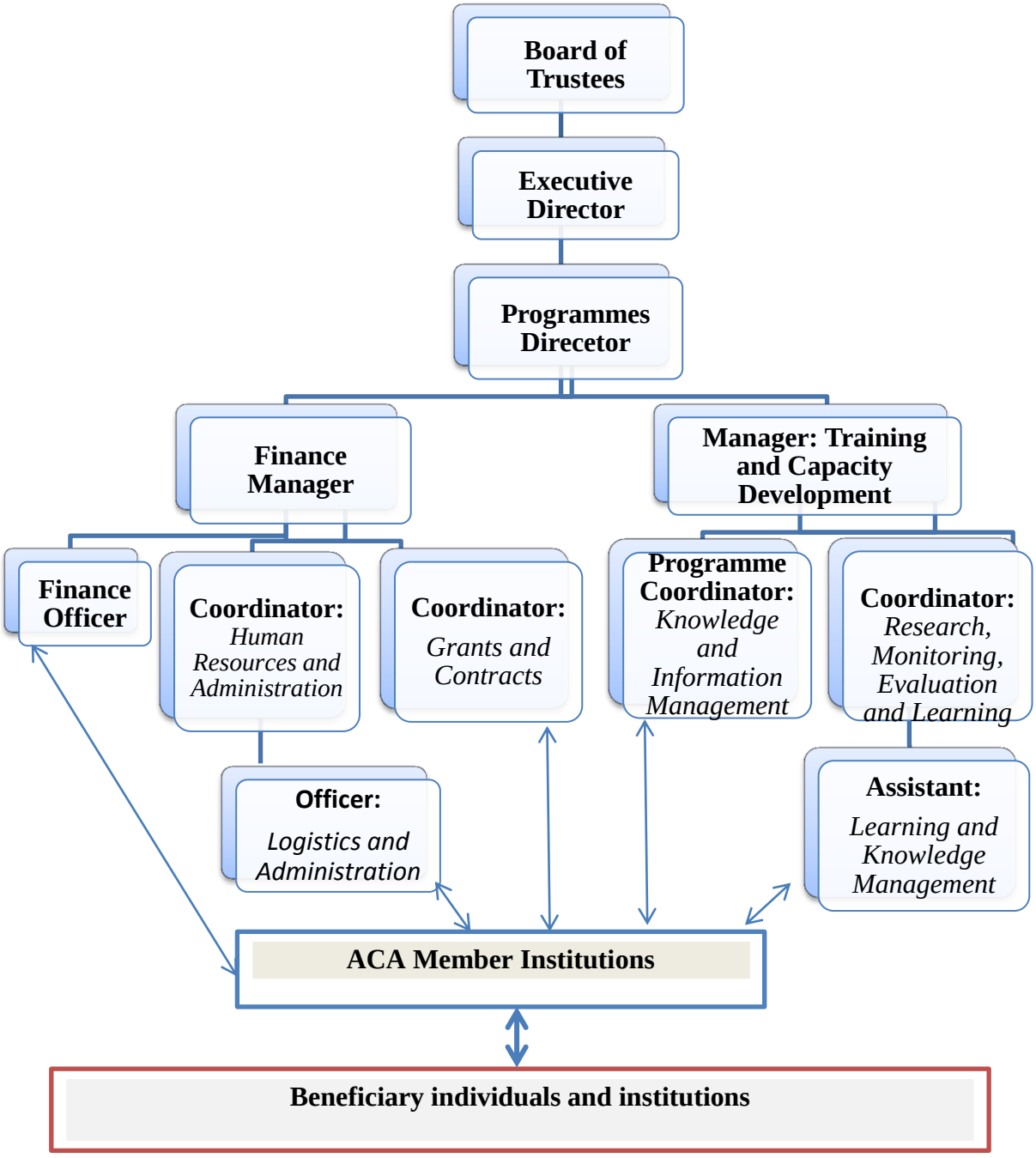
Figure 8.3: The ACA Structure



Source: Annex1- ACA structure and governance - ACA (2014:20-21), 2014-2019 Strategic Plan.

As illustrated in Figure 8.4, ACA's Secretariat was headed by an Executive Director who presided over a manpower strength of ten, including a Programmes Director and two Managers, one for Training and Capacity Development and another for Finance.

Figure 8.4: ACA Secretariat



Source: Compiled from www.africacapacityalliance.org/about-us/secretariat/ accessed 05-04-2017.

The Finance Manager headed four staff members responsible for human resources, finances, contracts and logistical administration. The Manager for Training and Capacity Development headed the operational team that delivered on ACA's programmatic mandate, and this included a Research, Monitoring, Evaluating and Learning Coordinator, and a Programme Coordinator for Knowledge and Information Management supported by an assistant.

According to ACA on its website (www.africacapacityalliance.org/about-us/secretariat/ accessed 05-04-2017), the Secretariat was configured to enable it to implement the organisation's policies, plans, strategies and budgets, as approved by the Board of Directors. Over all, ACA's structure exhibited a corporate formulation of the organisation consistent with donor needs for good corporate governance. This included the existence of a clear organisational structure that ensured the separation of powers, checks and balances, integrated functions and improved internal and external accountability. This leads to a discussion of how ACA was organised and performed its work.

8.2.6 Operational Modalities and Partnerships

To operationalise its mission (Table 8.1), ACA pursued a set of four strategic objectives (Box 8.1) which identify the specific focus areas of the organisation's work. In pursuit of these objectives, the organisation stated that it would "build the capacity of individuals and organizations to improve health outcomes," including information sharing and advocacy (www.africacapacityalliance.org/what-we-do/ accessed 05-4-2017).

Box 8.1: Strategic Objectives 2014 – 2019

- Strengthened health systems through improved leadership and governance, increased capacity of healthcare workers and robust information systems for evidence-based decision making;
- Strengthened community systems through improved leadership and governance, increased capacity for advocacy and networking and increased application of results-based management approaches;
- Strengthened public-private engagement in the health sector through increased capacity to develop and manage public private partnerships and proliferation of tools and best practices.
- Strengthened network through increased collaboration, combined application of technical expertise and expansion and diversification of network membership.

Source: ACA Strategic Plan (2014: iii – iv).

Such work required the organisation to work closely with health service providers. As such, partnerships with these stakeholders was inevitable as a key enabling modality for service delivery and as facilitating the roll out of the organisation's programmes.

Although all case examples discussed so far utilised partnerships as a facilitative modality, there are variations in its meaning and application. ACA conceptualised and operated partnerships like ARASA, emphasising them not only as a mobilisation strategy for collaborative work, but as a fee-based alliance for the implementation of its programmes.

Even though ARASA referred to itself as a partnership and ACA was seen as an alliance, both organisational partnerships were membership-based.

Partnership in this sense involved endorsing and abiding by sets of agreed governing principles, values, membership rules and a common vision, and not solely a contractual arrangement as in other cases. Under this arrangement, contracts were additional and task-based for those partners assigned to deliver on specific projects. In other words, the ACA network of partners (international NGOs, national and local NGOs, management institutions and university departments that delivered the courses) comprised a unified set of agents linked and cooperating to deliver standardised professional HIV training courses under a single strategic framework, regardless of their own existence as independent organisations. These partnerships thus involved relationships with implementing partners.

The other set of partnerships, based on contracts, involved relationships forged with donors and technical support partners. These were project-based partnerships which could be sustained even beyond the project life-span (see Table 8.2). ACA described partners in this category as 'cooperating partners' based on contracts (ACA, 2014). Through both its implementing and cooperating partnerships, ACA (like other RNGOs) was able to mobilise the requisite resources (human and financial) and technical support it needed to roll out and sustain its work. This also involved pursuing and fitting into donor funded projects that could contribute to its work. The following discussion focuses on the rolling out of ACA's work, which also raises issues around what constitutes regional work and being regional.

8.2.7 Programmatic Work

ACA's programming was predominantly targeted on individual and institutional capacity strengthening, delivered through a number of modalities. Individual knowledge and skills enhancement were delivered through skills training courses and various mechanisms of information sharing between ACA and its beneficiaries as well as among the beneficiaries. Institutional support was delivered through organisational-systems strengthening that was geared towards the delivery of ACA programmes such as training and institutional support in various countries. Detailing the modalities of the programmes highlights the organisation's achievements as well as the partnerships that were developed in the process.

8.2.7.1 Capacity Enhancement

The ACA's capacity development work was organised in project form, following funding streams availed to the organisation by its donors. The projects targeted various sectors and

organisations in the east and southern African regions. ACA capacity enhancement comprised five different projects that focused on various beneficiaries: local and regional NGOs in under-serviced areas, staff of Ministries of Health, the private sector and sector leaders as illustrated in Table 8.2.

Table 8.2: Capacity Development Projects

Programme	Target	Goal/objective	Funding partner	Coverage
Capacity Development Services for Regional and Local NGOs in East Africa	Regional and l Local NGOs	To create strong institutional systems that are adaptive to changing environments beyond the scope of any one particular intervention stems of	USAID supported program that started in Dec 2014 partnership with Deloitte, ACLAIM Africa and ACA member institutions.	Kenya.
Capacity Building for ISPs (CB4ISP)	Inadequately Served Populations (ISPs)	To improve the quality, effectiveness, relevance and equity of AIDS responses	Robert Carr Civil Society Networks Fund	(Kenya, Uganda and Tanzania)
Network for Africa (N4A)	Ministries of health staff and private sector leaders	To promote a greater understanding among public sector staff of the private health sector's contribution, and of its potential role in meeting public health objectives throughout the continent.		Online community of 24 African countries
GIZ BACKUP Initiative	Five MARPs-focused CSOs	To strengthen the institutional capacities of five MARPs-focused CSOs in results-based management	GIZ BACKUP Initiative	Kenyan
Capacity Summit	-	-	-	-
Center for Health Market Innovations (CHMI)	Regional and local NGO	To promote programmes, policies and practices that make quality health care delivered by private organizations affordable and accessible to the world's poor.	Managed by Results for Development (R4D)	East and Southern Africa region

Source: http://africacapacityalliance.org/aca-projects/ accessed 05-04-2017.

Each project was funded by a different donor and had a specific focus. Although there were projects specific for east Africa (GIZ BACKUP Initiative and Capacity Development Services for Regional and Local NGOs in East Africa), most were intended for both east and southern Africa (N4A), including the Capacity Summit project which was directly linked to

both capacity development and advocacy for capacity development as discussed later. The projects were rolled out with support from different donors and technical partners, such as USAID, Robbert CARR, Deloitte, and ACLAIM Africa among others. These projects illustrate the diversity of the focus of the capacity building programme, demonstrating how the organisation provided a full package of capacity enhancement in partnership with regional and international cooperating and implementing partners. An examination of individual skills training gives further illumination of ACA's work.

8.2.7.2 Individual Skills Training

Individual courses were intended for and delivered to African healthcare workers in private and public health institutions and communities, to support the HIV response in the east and southern African region. They were targeted and organised on a regional scale rather than on a country basis. They were delivered under the administrative coordination of ACA through its member institutions initially in seven countries, but eventually expanded to cover 24 countries in the region. Table 8.3 illustrates the delivery of the courses by modality and beneficiary.

Table 8.3: Training Courses and Reach

Modality	**No. of Beneficiaries**	**%**
Health care worker training courses	7334	50
Regular collaborative courses	*4700*	*32*
The INSTANT initiative	*2634*	*18*
Total reach	*14668*	*100*

Source: ACA 2014-2019 Strategic plan (2014:32-33).

These achievements were realised through the delivery of a total of 576 professional courses throughout the east and southern Africa region. According to the ACA Annual Report (2014), 43% of the courses were accredited by various recognised accreditation bodies that included universities and hospitals. An ACA alumni appraisal of the courses demonstrated their high quality, popularity, relevance and professional and individual benefit from the courses, as Table 8.4 illustrates.

Table 8.4: Course Evaluative Comments

Characteristics	Percentage (%)
Course accreditation	43
Relevance score to alumni work	92
Personally and professionally beneficial score	95
Application of skills at work places	91

Source: ACA 2014-2019 Strategic plan (2014:32-33).

The course beneficiaries were trained to enhance their on-the-job service delivery, thus improving health-services reach and quality especially for people infected and affected by HIV and AIDS in the region.

8.2.7.3 Advocacy

In addition to institutional and individual support, ACA rolled out an advocacy programme geared towards popularising individual and institutional capacity enhancement in the HIV response. In a joint presentation to a RAANGO meeting, Mwesingwa and Storey (2008:8) stated ACA's intention as "being the champion of capacity building – understanding the issues – and knowing the platforms to speak from." They described ACA's audience as civil society organisations, governments, regional bodies, the UN structures (especially UNAIDS /UNDP), their development partners as well as ACA's member institutions.

The programme was executed through a Capacity Building Partners Forum which was an annual ACA-led event that attracted a minimum of 300 participants yearly. The participants were "a consortium of organizations from multiple sectors committed to working together to advocate for inclusion of capacity development in national health policies and budgets" (http://africacapacityalliance.org/capacity-summit/ accessed 05-04-2017). The role of the consortium included popularising targeted capacity building in the areas of operation of ACA members, including "identifying and implementing capacity building initiatives in a focused and measurable way with the ultimate goal of improving national level policies and increasing the quality and access of services in communities" (http://africacapacityalliance.org/capacity-summit/ accessed 05-04-2017)

There was a direct link between advocacy and the organisation's overall programme roll out in this initiative. Advocacy was intended to promote the organisation's work, and ACA positioned itself to influence and take technical leadership of institutional and individual capacity strengthening in the HIV response. In addition, the organisation also sought mechanisms to harmonise regional collective efforts towards capacity building to fight HIV (Mwesingwa and Storey, 2008:12). Such efforts were targeted towards ISA, ICASA,

UNAIDS, SADC, EAC, and National AIDS Councils (NACs) in these regions, as well as HIV health service providers, extending the organisation's reach and embeddedness as discussed below.

8.2.8 Embeddedness

ACA was dynamically connected to webs of work relations, notably at the country level through national level institutions and authorities that provided general frameworks for responses in health and HIV generally as illustrated by its list of partners and partnership arrangements. Further, it was also connected to country level organisations through its institutional and individual capacity enhancement programmes as illustrated in the foregoing section. At the regional level, the organisation was connected through especially its annual Capacity Summit programme and its regional implementing partner organisations in east and southern Africa as discussed in earlier sections.

Similarly, the organisation was enmeshed in affective relations with its peer regional HIV players outside the circles of its implementing partners. These provided moral support and exchanged files with the organisation on the progress and challenges faced in the response. Like other RNGOs, the organisation was entrenched in transactional relations with its donors who provided vital resources requisite for financing ACA programmes while the organisation also delivered on the donors' own development objectives as earlier discussed.

In positioning itself as a key capacity development agency, naturally ACA predisposed itself to coupling with regional and international authorities that provide frameworks for health responses particularly HIV (such as UNAIDS, SADC, EAC, WHO) as these organisations are themselves components of the global health governance architecture. Such relations were regulative (providing frameworks) as well as facilitative (technical, financial and affective support). In other words, ACA's life and role were carved out in the context of a wide variety of social relations where it bore the burden of varying degrees of accountability to its stakeholders.

8.2.9 Accountability

Like other RNGOs, ACA had legal obligations to comply with registration requirements in Kenya where it was formally registered. This included fulfilling all financial prudence requirements and licencing conditions as laid down in the local statutes. This included submitting relevant reports annually to registering authority and government departments. In addition to these requirements, the organisation also had to account to its General Council

(Members) through the Trustees and the Board of Directors who exercised oversight and facilitative functions over the secretariat (Figure 8.3). Externally, the organisation had to account to its implementing partners for delivery on agreed programme implementation packages and, on its part, it expected the partners to uphold their part of the bargain. In a similar fashion, the organisation accounted to its funding partners on programme delivery and impact and utilisation of received financial support as it was expected to do so as stipulated in contracts. Donor reporting requirements were contractually bound as they were specified in the individual support contracts the organisation had with each donor.

The organisation owed it to its beneficiaries to deliver quality programmes that were beneficial to their work. It took an initiative to monitor key aspects of its programmes and it also ensured that it communicated about feedback on delivered courses, as illustrated in Tables 8.3 and 8.4. However, the organisation could not be accountable for the effective application of the capacities in various instances as this was in the hands of the beneficiaries. It can thus be stated that, as with other RNGOs, the demand for accountability was higher where transactional relations were involved than in contexts of affective relations.

8.3 SAT Case Example

SAT is an acronym that stands for Southern African AIDS Trust. At its inception in Zimbabwe, in 1990, SAT was known as the Southern Africa AIDS Training Programme (SAAT Programme), established by the Canadian International Development Agency (CIDA) as a project implemented by the Canadian Public Health Association (CPHA) (SAT, 2004a:ii; Mushonga, 2014). CIDA's aim was to found a regional organisation that would "enhance the capacity of nascent community based organisations (CBOs) in southern Africa to design and deliver effective HIV prevention and AIDS care, support and treatment activities" (CPHA, 2008:7, S42). The CPHA transformed SAAT into an autonomous regional Africa NGO to broaden its funding opportunities and concretise its organisational impacts in the region, thereby augmenting it into an organisation of repute in the rolling out a locally engineered HIV response and expanding into communities in the region (CPHA, 2008).

The organisation grew into a strong regional capacity building NGO which, between 1993 and 1999, operated in ten countries in southern Africa. From 2003 to 2010, SAT continued to assist CBOs to roll out sustainable and appropriate HIV responses in fewer (six) countries with a greater concentration of partner organisations (an average of 25 per country) supported by SAT Country Offices under the overall strategic coordination and technical support of the Regional Office. SAT's goal was to enhance community HIV and AIDS

competence through institutional and programmatic support of CSOs working in communities in southern Africa. SAT executed its mandate as a regional venture under a single strategy with the modalities of yielding economies of scale, lesson learning and sharing, and coordination and collaboration. But the organisation had since transformed its vision and mission at the time of this research, as noted below.

8.3.1 Mission and Vision

SAT transformed its initial vision and mission in 2012 when it abandoned its main focus on enhancing community HIV and AIDS competence. Between 2011 and 2012, internal institutional and programmatic challenges led its joint financing arrangement (JFA) donors to recommend the transformation of the organisation, among other things, from capacity building for community HIV and AIDS competence to a new strategic focus on community systems strengthening for the delivery of sexual reproductive health and rights (SRHR) through established partner CBOs, FBOs and other NGOs (Mushonga, 2014). SAT's current mission and vision are presented in Table 8.5.

Table 8.5: SAT Mission and Vision

Mission	Vision
➢ *Supporting communities to develop resilient community systems for equitable and inclusive health through engaging with the SRHR and systems for health*	✓ *SAT envisages a world in which resilient communities in Eastern and Southern Africa enjoy good health and wellbeing free of stigma and discrimination*

Source: SAT (2016:13).

SAT thus redirected its focus on broader community systems strengthening for health with an emphasis on sexual reproductive health and rights (SRHR). The organisation also extended its coverage to include eastern Africa.

8.3.2 Geographical Coverage and Being Regional

SAT operated in six SADC countries (Botswana, Malawi, Tanzania, Zambia, Zimbabwe and Swaziland) with an extension into Kenya planned under the new Strategic Plan for 2016-2021, which was meant to broaden the organisation's geographical reach into east Africa (SAT, 2016:6,11). Before 2012, the organisation had run programmes in over ten countries in southern Africa including Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe. Almost half of these countries

were no longer programmatically active when SAT became a trust in 2003 and they had hardly developed into fully-fledged SAT Country Offices.

Regardless of SAT's failure to establish Country Offices in some countries, it appointed point persons who mobilised potential partners which later 'graduated' as recognised partners upon completion of their capacity development processes. SAT abandoned this approach as it was considered more cost efficient and effective to operate in the five fully established country programmes: Malawi, Mozambique, Tanzania, Zambia and Zimbabwe. As this research concluded in 2017, SAT had a presence in six countries but was operating in only five of them; Botswana, Malawi, Tanzania, Zambia and Zimbabwe, as South Africa served only as a Regional Office (KII, 03-08-2016). The organisation had closed its Mozambique Office in the middle of 2012 (Mushonga, 2014).

SAT defined a geographical region as a territorial location characterised by a collection of countries united under a supranational body. As such, SAT viewed SADC/southern Africa and the east African countries as separate regions to the extent that they fall under independent regional authorities, and are located in different geographical spaces. However, operationally and as occasioned by the inter-regional characteristics of the HIV epidemic and its key drivers, SAT also regarded the two regions as a single region to the extent that east and southern Africa have been combined now into one region in the regional UN and donor responses.

SAT has had more than 27 years of operating as RNGO, being one of the leaders in initiating the debate on working regionally and *being regional*. It viewed regional civil society as NGOs that engaged in collaborative programming to address challenges that could not be effectively addressed at the lower national level because of their sensitive nature. The organisation had also adopted Godsater's (2013) characterisation of regional civil society presented in Box 8.2.

Box 8.2: SAT Defining Characteristics of Regional Civil Society

- That it creates regional organisational forms
- That it frames issues regionally
- That it engages with formal regional governance
- That it uses regional donor funds
- That it (attempts to) construct regional identities

Source: SAT (2016:29) SP 2016-2021 - adopted from Godsater (2013).

Key in this characterisation is the emphasis on the regional orientation of any organisational form, and the particular framing of programmatic issues, engagements and interactions which collectively give RNGOs their character and identity.

Against this background, according to the Chief Operation Officer (then the longest serving member of the organisation), SAT defined *being regional* as "operating in more than two countries, addressing issues of a regional nature and relevance," and that "as a regional organisation you cannot work on a problem that appears to be localised yet is affecting or likely to affect more countries than just one and likely to spread into other areas of the region" (KII, 03-08-2016). She added that the requisite intervention must be of such a "nature that it will allow economies of scale, and likely to produce multiple results and benefits that you would be able to share for the benefit of the entire region or most of the region." In other words, regional programming must allow for lessons and information sharing, which is only logical if the matter is of regional relevance, and in the same vein, it must promote regional coordination and collaboration – which is only possible where the challenge is of common interest and significance to the region.

In its Strategic Plan, SAT elaborately offers the justification for regional programming as the only process and platform through which 'controversial issues and rights' can be addressed by civil society, such as health rights for lesbians, gays, bisexual, transgender and the intersex (LGBTI), women's rights and gender equity, sexual reproductive health and rights (SRHR), comprehensive sexuality education of adolescents, and health rights for people who (SAT, 2016: 28). SAT argued that: "Despite global peer pressure, evidence and UN agendas, there remains across much of Africa, an extremely conservative backlash on social issues. The so-called Africa bloc or sections of the Africa bloc have led the global response to delete sexual rights from SRHR, to resist comprehensive sexuality education as un-African, to continue to or begin to criminalize LGBTI citizens" (SAT, 2016: 28).

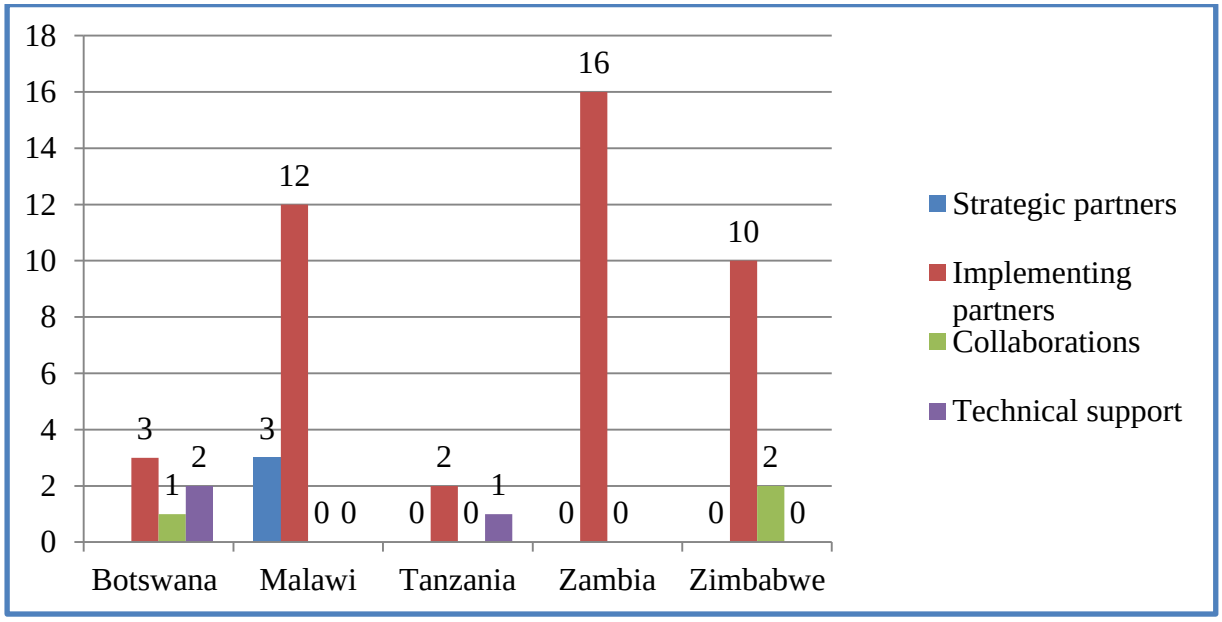
Most HIV NGOs struggle to address these issues especially at the country level because of diverse and especially negative perceptions, cultural and legal contexts not favourable to interventions for these groups. For SAT, with the exception of gender equity, "it has only really been the HIV response and the peer pressure generated by the response that have allowed for much activity at all" (SAT, 2016) in the SADC and EAC regions. SAT stated that interventions in these sensitive areas have been possible only through peer pressure utilising scientific evidence to support advocacy along with personal contacts and leadership at global, regional and country levels (SAT, 2016). For SAT, RNGOs have a niche in these

sensitive areas which must be addressed collaboratively. Thus SAT engages in partnerships to resolve such key regional issues.

8.3.3 Partners and their Distribution

SAT engaged and established relations with a variety of organisations at both the regional and country levels where it operated. SAT mobilised two types of partners: implementing and strategic. Its implementing partners were a selection of CBOs and NGOs that had capacity and competence to work with communities in addressing SRHR issues of women, girls and adolescents, and key populations (KII, 03-08-2016). For many years before the transformation in 2012, the organisation mobilised and maintained an average of twenty five implementing partners each year in each of the countries where it worked. These numbers have dropped as Figure 8.5 illustrates, but it introduced a tactical mix of implementing, strategic, collaborating and technical support partners amongst its fifty collaborators spread across five countries.

Figure 8.5: SAT Mix of Country Level Partners as of 2016



Source:http://webcache.googleusercontent.com/search?q=cache:http://www.atregional.org/where-we-work/&num=1&strip=1&vwsrc=0 accessed 05-04-2017.

The largest concentration of the partners were in Zambia (37%), Malawi (28%) and Zimbabwe (23%). The least concentrations were in Botswana (7%) and Tanzania (5%). The organisation only had three technical support partners in Botswana and Tanzania, three strategic partners located in Malawi and three collaborators in Botswana and Zimbabwe. At

the regional level, the organisations engaged with other RNGOs through RAANGO, the UNAIDS, SADC and donors that funded its regional work. In this way, SAT set itself to roll out its work, governed and managed by a regional organisational structure.

8.3.4 Governance and Management

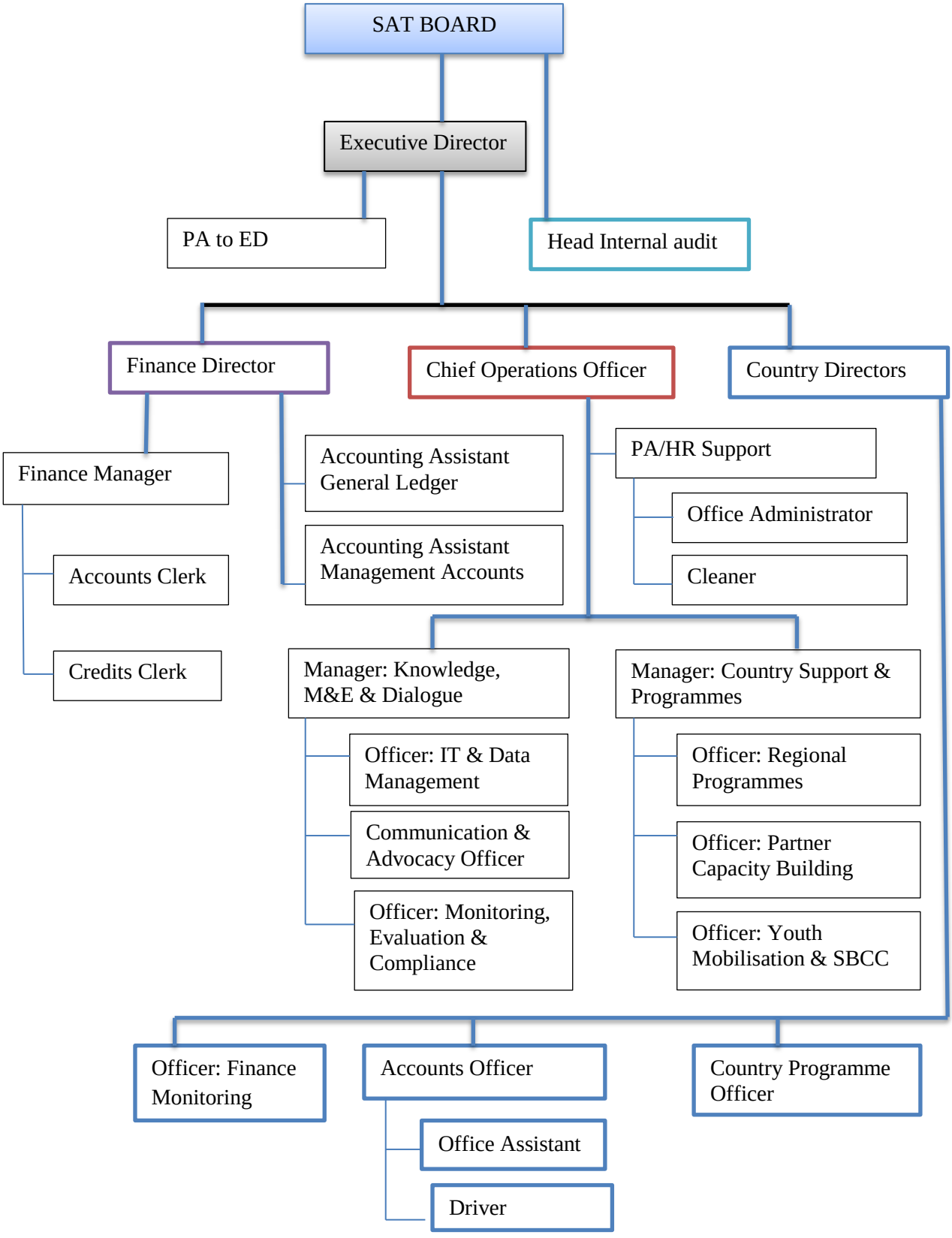
Subsequent to a 2011 – 2012 forensic audit, SAT underwent strategic and institutional transformation that resulted in the organisation adopting a more corporate type governance and management style informed by the King III (2009) Report (Mushonga, 2014) (see Figure 8.6). The King III Report (see chapter five) provides principles for good corporate governance under South African Law. A major feature of SAT reforms was not only the establishment of a meritocratic Board but the creation of the Board's Finance, Audit and Risk Committee (FARCO) that oversaw financial management and reporting which was one of the donors' concerns.

SAT was always organised into country and regional operational tiers such that, at the country level, SAT established Country Advisory Committees (CAC) made up of technical experts in each of its countries to provide advice to the Country Programme Director and to SAT Senior Management on country programmatic matters (SAT, 2016:38). Each CAC was supported by a finance sub-committee that met a minimum of four times a year to ensure financial compliance and fidelity. In addition to their routine oversight activities, the Board and the CACs met twice a year. The FARCO and the Country Finance Sub-committees met quarterly demonstrating the seriousness SAT placed on financial management.

SAT was organised into two teams comprised of a regional strategic, technical, coordinating and oversight team headed by an Executive Director who was supported by a contingent of Country Office personnel through their Country Directors, the Finance Director and the Chief Operations Officer who constituted the SAT Senior Management Team. The team provided representation, strategic direction, technical support and resources for country level work. In other words, like DHAT, SAT's RO also raised funding for operations at the country level, including driving the regional agenda for SRHR at regional and international fora.

Besides the regional team, there were Country Office teams each headed by a Country Director (CD) supported by Country Programme Officers (CPOs), a Country Finance and Administration Manager and a support team. The SAT COs were the engine that drove the RNGO's community systems strengthening work for SRHR and HIV under a single regional strategy.

Figure 8.6: **Organisational Structure**



Source: KII, 03-08-2016.

The CDs managed the implementation of all country level SAT activities, maintained links and coordinated with the SAT RO as well as with national stakeholders such as National AIDS Councils (NACs), government ministries, other NGOs and representatives of donors at that level.

The CD integrated SAT's work into the national response and expanded its influence in-country (KII, 03-08-2016). While the CD functions were largely administrative, programmatic work was rolled out by the CPO and the financial management and monitoring officers who collectively and directly implemented the country-level partnership processes with partners within chosen programme contexts. Their work was supported by the Accounting Officer for all field work activities (KII, 03-08-2016). It is important to discuss SAT's work to demonstrate how it linked to the organisational structure and geographical spread and its relationship with the partnerships the organisation forged at both the regional and country levels.

8.3.5 Programmes and Modalities

SAT's work, as noted, was to enhance community resilience for inclusive and equitable health with a specific focus of SRHR. SAT's programmes were constructed around what it called the "big five": keeping girls in safe schools, early and forced child marriages, gender-based violence, comprehensive sexuality knowledge and access to sexual reproductive health service, (http://www.satregional.org/our-strategy/ accessed 05-04-2017). The accompanying modalities were intended to raise the necessary awareness among women, men, girls, boys and authorities, and for directly resolving some of the challenges at the community level. Table 8.6 provides a list of SAT's programmes, target groups and modalities.

SAT's SRHR programme was intended to improve the health and wellbeing of girls and keep them in school. It involved sex and sexuality education and raising awareness that girls and adolescents did not need to miss school because of a natural process such as mensuration, as well as ensuring the provision of sanitary pads to prevent girls from missing school during their menstrual cycle. The programme had both community dimensions and policy implications that required engagement at higher national and regional levels as this challenge was established to be common in both eastern and southern Africa (ESA).

SAT also rolled out a Gender Equality Programme (GEP) which was a modification of its former Gender Mainstreaming Programme. The programme was intended to re-enforce the SRHR programme with a particular focus on women and girls. Additional elements were women and girls' empowerment through community engagement to promote their rights, the

provision of paralegal support to improve women's chances at socio-economic justice in the context of domestic violence, and challenging cultural frameworks and practices that favoured male domination in ESA. SAT's work in this regard was also intended to directly contribute to the realisation of the UNDP's (2015) Sustainable Development Goal number 5: *Achieve gender equity and empower women and girls.*

Table 8.6: Programmes, Target Groups and Modalities

Programme	Target group/s	Modalities
1. Sexual Reproductive Health and Rights	➢ Girls, ➢ Adolescents, and ➢ young women	✓ Provision of sanitary pads, ✓ Mobile base awareness ✓ Advocacy
2. Gender equality	➢ Women and ➢ Girls	✓ Mobile base awareness ✓ Advocacy ✓ Community dialogues
3. Civil Participation and Democracy	➢ Women and ➢ Girls	✓ Community dialogues ✓ Women and men ✓ Advocacy
4. Data for Systems for Health	➢ All partners ➢ All beneficiaries	✓ Regional Health Data xChange
5. Gender Transformative	➢ Women, ➢ Men and ➢ Leadership structure	✓ Community engagement/dialogues ✓ Mobile base awareness ✓ Advocacy
6. Capacity Strengthening	➢ All implementing partners	✓ Technical support (Skills training) ✓ Financial support

Source: Compiled from http://www.satregional.org/our-strategy/ accessed 05-04-2017.

As such, the programme encompassed aspects that required community level engagement, and included legal engagement in cases of violations, especially in domestic violence. In that regard, SAT worked closely with for instance the Botswana Police Service, in addition to engaging relevant government departments as well as the National AIDS Councils to integrate mechanisms for reducing grievous bodily violence (GBV) in the HIV response. At the regional level, SAT engaged in policy influence for gender norms transformation in ESA through participation in RAANGO and SADC along with engaging with the UNAIDS.

In its Gender Transformative Programme, SAT targeted both men and women, and boys and girls, in local communities to initiate and sustain dialogue for the transformation of gender norms and practices that perpetuated inequalities among men and women, and boys and girls, which was resulting in male dominance and the subjection of women and girls to violence and suppression – thereby restricting their choices in relation to sex and marriages

for example. The programme was implemented in all SAT country programmes as gender related challenges were common throughout the region. It targeted and engaged fathers, male community members, traditional and religious leaders and local government managers to provide them with information to raise awareness and campaign for improved understanding of SRHR and, in particular, of the needs of girls, adolescents and young women in SRHR. As in the Gender Equality Programme, SAT also engaged regional structures, working with SADC and EAC to promote gender transformative programming in SRHR in support of strengthening both gender equality and health outcomes.

The Data for Health Systems for Health (DHSH) and the Civil Participation and Democracy (CPD) Programmes were intended to support interventions in SRHR and gender mainstreaming and transformation. While the DHSH programme provided the requisite empirical data for social engagement and advocacy at different levels, the CPD programme created safe spaces in which women could raise their issues by offering opportunities for women and girls to engage in matters that concerned their lives, especially in relation to health, in community, national and regional leadership structures. With regard to the provision of data for health systems, at the regional level SAT hosted 'an open source Health Data XChange' where its partners posted data relevant to health at district, national, and regional levels. Such data could be accessed and utilised by participants in the HIV response.

Essentially therefore, SAT worked in SRHR, gender mainstreaming, and women and girls empowerment at both the country and regional levels. Country (community) level work sought the transformation of policy and practice through local engagement, but region-wide work supported transformative efforts through regional stakeholders engagement. SAT provided technical and financial support (capacity strengthening) to its partners working in these areas to ensure effective programme roll out.

SAT's Partner Capacity Strengthening Programme was directly linked to all the other programmes. The organisation provided technical support to all partners to ensure successful roll out of their programmes. According to the Chief Operations Officer, "capacity strengthening is implied throughout our work, but we have shifted from providing purely institutional capacity strengthening of emerging CBOs to focus on programmatic capacities of our implementing partners" (KII, 03-08-2016).

The programme had two main components, of technical and financial support. Technical support involved SAT providing skills-training in advocacy and community engagement, programme design and implementation and information sharing among other dimensions. Financial support to implementing partners was provided in the form of a sub-

grant to enable partners to execute their programmes, and by offering material support to beneficiaries such as tampons for girls in the SRHR programme. In other words, SAT sub-granting was a programme investment and not intended as institutional support because, as the organisation states in its Strategic Plan - 2016-2021, "at CBO/NGO level SAT continues to seek partnerships with organizations that have their own momentum outside of SAT partnerships and/or grants." (SAT, 2016:40). The pursuance of these different programmes required SAT to engage in a range of partnerships.

8.3.6 Partnerships

Like most RNGOs discussed in this thesis, SAT forged relations with both implementing and strategic partners as discussed already in relation to its programmatic work. For SAT, implementing partners were organisations such as CBOs and NGOs and other community level actors capable of delivering change at community and district level (SAT, 2016:33-34; SAT, 2004:7). Strategic partners included a wide variety of development agents involved in the HIV response at the international and regional levels. Table 8.7 presents a complete composition of SAT's partners as at April 2017. I discuss each of these partnerships and how they were crafted.

SAT's partnership processes were characteristically consistent throughout the organisation's history. It involved catalysing potential partner CBOs and NGOs into developing an interest in the partnership, as well as developing mutual knowledge between SAT and the potential partners (SAT, 2005). The only variation was SAT's choice of the potential implementing partners, which initially involved emerging and nascent organisations from under-serviced areas to established organisations that can deliver programmes in the area of potential partnership at the community and district levels (KII, 03-08-2016). For SAT, the partnership processes involved recruitment, contracting, partner support and monitoring and evaluation of progress towards meeting contractual obligations.

According to the SAT (2016 – 2021) Strategic Plan, "community and district based partners provide local knowledge, entry into broader communities and offer valuable community credibility. They were able to mobilize in targeted community members for action and are close enough to service delivery to be able to engage on issues of reach and quality." In this case SAT forged symbiotic relations with its implementing partners. However, SAT sought to ensure effective reach of target populations and areas, and coordination of its implementing partners through clustering partners into strategic cells. This involved grouping partners in either provincial or district areas in programme countries where there were larger

numbers of partners for mutual support and programmatic impact. SAT's strategic partners included international and regional NGOs, regional or global networking organisations, governments, academic and research institutions, and donors.

Table 8.7: Sets of SAT Partners by Level and Typology

Level	Partner	Partner typology	
		Strategic	**Implementing**
Continental	The African Union	➢ INGOs ➢ RNGOs ➢ Regional networks ➢ Global networks ➢ National governments ➢ Academic and research institutions ➢ Donors	✓ CBOs ✓ NGOs and ✓ Other community level groupings
Regional:	SADC, EAC, UN Agencies and Other Civil Societies (RNGOs – all RAANGO members +)		
Country:	Ministries, AIDS Councils, NGOs & Academia		
Local:	District Leaders and Managers, CBOs, Religious and Local Leaders, Community Health Leaders		

Source: Compiled from http://www.satregional.org/our-partners/ accessed 05-04-2017; SAT, (2016:2, 31-32).

SAT developed the partnerships for mutual benefit, focusing on scaling-up community responses on SRHR, as well as research, advocacy, policy and resource mobilisation (SAT, 2016:33-34). Also, SAT shifted its strategy to focus on closer partnerships with governments for ensuring "comprehensive systems for health as this required civil society to work more closely with governments to improve access to and functioning of health delivery" (SAT, 2016:40).

The organisation thus worked with the Ministry of Health and Child Care and the National AIDS Council (NAC) in Zimbabwe, and the Police Services Department in Botswana to roll out its prevention of grievous body violence (GBV) project. It also sought and established partnerships with technical partners such as private media companies. In Tanzania, SAT was working with Tanzania Media Association (TAMWA) to "pilot a mobile phone app for young people to rate their experiences at health facilities." In Botswana, it was utilising the technical support of Dure Technologies and Development Advance Institute

(DAI) to develop the GBV and Youth mobiles Apps respectively to support its SRHR programme with young people(http://webcache.googleusercontent.com/search?q=cache:http://www.satregional.org/where-we-work/&num=1&strip=1&vwsrc=0 accessed 05-04-2017).

SAT's work was supported by a Sida led basket funding arrangement with project-based funding in some of the Country Programmes, and with technical support from UN agencies such as UNAIDS and peer support from RAANGO members (KII, 03-08-2016). In this way the organisation was exposed to an extensive network of other development actors embedding itself into a web of hierarchical and lateral development relations.

8.3.7 Embeddedness

The bifocal nature of SAT's programming, and the numeracy and diversity of its partners and stakeholders embedded the organisation at both the regional and country levels. Its resources mobilisation from international donors and entrenchment in the global architecture of the HIV response and donor funding mechanisms further illustrates how deeply the organisation was entrenched in country, regional and global level structures and processes in the HIV response.

Like other RNGOs, SAT's registration (in five countries and a regional office) and operations at the national level entrenched it in national HIV and related frameworks which it had to consider in contributing to the national response and in its policy influence work at the regional level. Its partnerships with national level CSOs (implementing partners) connected the organisation to a wide variety of experiences at the community level as well as the operations of different CSOs. Such embeddedness provided diverse ideas (from state and non-state bodies, religious and traditional) which it had to reconcile with its own strategic and operational requirements as a regional NGO.

Similarly, SAT had to consider and operate in the context of the global architecture of the HIV and AIDS response conforming to the guidelines of the UN in relation to HIV, SRHR, women, youth and key populations, and in relation to donor priorities as mitigated by regional influences in the context of the epidemic in east and southern Africa where it operated. The significance of this context is evident in its bemoaning of the non-responsive character of some of the countries in the region to the issues of SRHR and key populations, as earlier discussed. In this context, the organisation (like others working in these sensitive areas) found itself in a precarious situation regarding accountability especially in relation to programming on the rights of sex workers and the LGBTI.

8.3.8 Accountability

As earlier noted, much of SAT's work involved demanding other stakeholders to account for their responsibilities as public social agents to deliver or take responsibility for poor or enhanced performance, including its own efforts to contribute to better service delivery for various population segments. For that reason, it is important to discuss how the organisation in turn accounted to its partners, for the support it received to perform its functions, and to its beneficiaries for its role in their lives.

SAT was obliged to account internally to its Board including its country level extensions, externally to its implementing and strategic partners, and to the communities it served. Internal accountability involved performing and meeting all the managerial and operational obligations as set by the organisation's mandate. As in any formally constituted organisation, the secretariat accounted to the Board on the implementation of the organisational strategy including the mobilisation of relevant partners and funding, and the management of these in contributing to the organisation's mandate (KII, 03-8-2016).

According to the Chief Operations Officer, for SAT, "accountability to communities is limited to the extent that there is funding to deliver the programmes that we have in place," and she acknowledged that: 'It's a fair assessment to say that where funding 'dries up' there is really nothing that NGOs can do except to close shop leaving the communities without options" (KII, 03-08-2016). More specifically, accountability to beneficiaries was externally constrained and limited to informing its implementing partners and, through them (or local Board Members), its beneficiaries about the challenges in the funding environment, and of the programmes that may or may not continue. At a higher level, SAT embraced as its responsibility the importance of advocating for more funding for areas that were critical and important to local populations so that relevant projects were not terminated, thereby jeopardising the welfare of beneficiaries and eroding the benefits communities had accrued in the HIV response.

Partnership agreements, in the form of contracts or memorandums of understanding, placed an obligation on the organisation to account to its partners. With donors, while they delivered the resources and other support to SAT as stipulated in the contract, SAT was required to account for the utilisation of the resources, demonstrating expenditure against work plans, activities and budgets, including emerging results among beneficiaries. According to the Chief Operations Officer, donors exerted the most pressure to account, apart from the organisation's board which required and approved all reports and programmes of the organisation (KII, 03-08-2016).

As SAT was formally registered in specific countries (both regional and country offices), it was expected to "comply with the country laws at the very minimum, and also provide evidence of delivery on our mandate" (KII, 03-08-2016). The organisation was obliged to submit relevant reports not only to the registering government department in each instance, but also to ministries and other departments the organisation engaged and worked with as part of information sharing and learning. Similarly, the organisation shared programme reports with its peers and non-contracted partners (UNAIDS, SADC, AU and RAANGO for example) as part of public relations. It also expected these organisations to similarly share, as part of building a common front and strong response to the epidemic in the region.

8.4 Conclusion

This chapter has examined the other-serving and predominantly capacity strengthening category of RNGOs, focussing on ACA and SAT. Both organisations had the same roots in the CIDA's international development programmes, and were each established as capacity development agents (SAT with community HIV and AIDS competence, and ACA as a regional AIDS training network for individual HIV skills development in underserviced areas). While ACA expanded its programme portfolio, SAT narrowed its own to predominantly SRHR, women and girls in the HIV response, and incorporating key populations, groups that were subsumed in the organisation's earlier programmatic formula. The analysis focused on their mandates and how these shaped their institutionalisation, programmes and operations as regional NGOs; this demonstrated that, despite their seemingly similar background and focus on capacity development to support the HIV and AIDS response, the organisations were radically different structurally.

ACA was conceptualised and operated as a network and membership organisation governed by a General Council of fee paying members, Board of Directors and Trustees in descending order, and was located and operated from a single location. SAT on the other hand was a corporate type technical support organisation governed by a meritocratic Board of Directors and it recruited implementing partners to roll out its programmes at the community level through its Country Offices. These basic structural and operational differences account for the manner in which the organisations viewed regional work, rolled out their programmes and connected with their different partners, as well as for the varying nature and extent of embeddedness and accountability as discussed.

CHAPTER NINE: OTHER-SERVING SPECIALISED TECHNICAL SUPPORT SERVICES REGIONAL NON-GOVERNMENTAL ORGANISATIONS

9.1 Introduction

The other-serving specialised technical support services RNGOs constituted another category by virtue of the fact that they provide technical support services in a specialised area. Two of the RNGOs discussed in this thesis fall in this category: REPSSI and SAfAIDS. REPSSI provided technical support in the area of psycho-social support (PSS) while SAfAIDS provided information services, documentation and advocacy. I discuss these case examples to illustrate how they compared and contrasted, and as variants of *being regional*.

9.2 REPSSI Case Example

The Regional Psychosocial Initiative (REPSSI) is an RNGO working to lessen the devastating social and emotional (psychosocial) impacts of poverty, conflict, and HIV and AIDS among children and youth across eastern and southern Africa. It was founded in 2002 out of the realisation that, while all other aspects of the HIV response where being rolled out, not only were HIV interventions for children delayed, but children bore the greatest economic, social, psychological and emotional burdens of the impact of the epidemic. They lost parents, had to nurse dying parents and relatives, care for each other in the worst case scenario, and at times were adopted by abusive families, dropped out of school and lost livelihoods, all resulting in traumatic experiences (KII, 13-06-2016).

9.2.1 Mission and Vision

Against this background, REPSSI was formed to "rapidly reach out and support people who were supporting children to also look into social and emotional issues" (KII, 16-06-2016). Its set mission and vision are presented in Table 9.1.

Table 9.1: **REPSSI Mission and Vision**

Mission	Vision
➢ To 'provide technical leadership in psychosocial support for children and youth'.	✓ To promote an enabling environment for communities and families to nurture, protect and empower children and youth to enhance their psychosocial wellbeing'

Source: (www.repssi.org/about-us/, accessed 19 - 08- 2016; REPSSI, (2014:2).

REPSSI's mission and vision identify its niche role (psychosocial support and technical support), the target beneficiary population segments (children and youth), and the desired

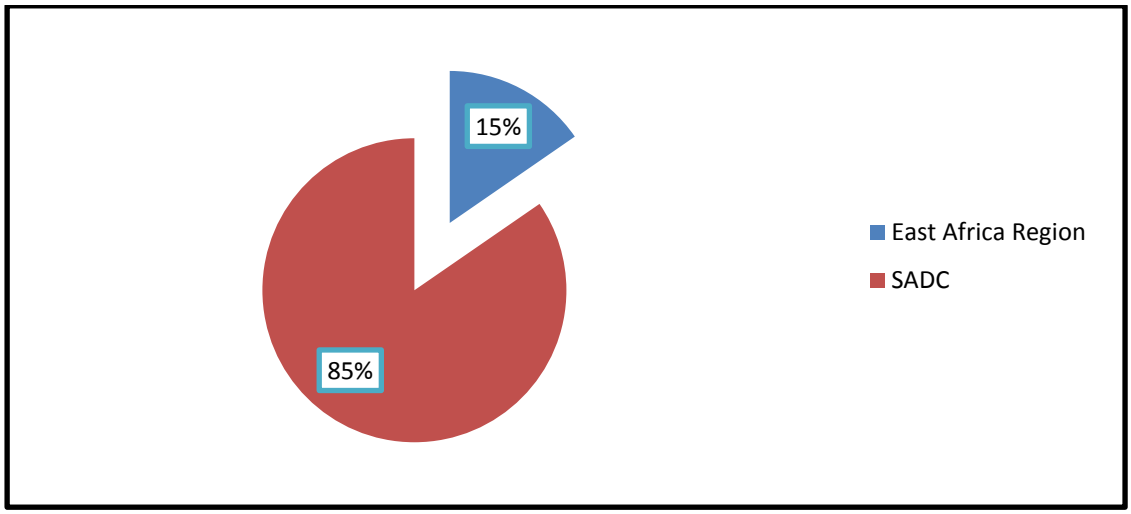
change (the existence of an enabling environment for communities and families to nurture, protect and empower children and youth to enhance their psychosocial wellbeing).

The organisation located the bulk of its work at the country level (community and family) where the changes envisaged needed to occur. The creation of an enabling environment brought another dimension that extends REPSSI's work to levels higher than the community level. Families and communities operate in a socio-economic context that includes institutional, structural and economic aspects that draw in different players and authorities who determine the effective delivery of services at the local level.

9.2.2 Geographical Coverage and Being Regional

REPSSI operated in 13 countries of eastern and southern Africa with the widest coverage in southern Africa (85%) and the rest in East Africa (Figure 9.1). The concentration of the countries served in SADC demonstrates the origins of the organisation in Harare and its spread into other parts of the region, as well as into East Africa. These countries include the twelve that had the highest HIV prevalence rates in the world as well as Angola.

Figure 9.1: Operational Coverage by Region



Source: Compiled from (www.repssi,org/about-us/ accessed 20 - 09- 2016.

All of the 13 countries (Angola, Botswana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Swaziland, South Africa, Uganda, Zambia and Zimbabwe) were part of the 35 that were included in the UNAIDS FAST TRACK response under the SDGs and defined as having the worst prevalence of HIV globally (UNAIDS, 2015).

The organisation was registered and operated in twelve countries where it ran Country Offices (COs) under the direct supervision of the Regional Office (RO). REPSSI work at the

regional level involved reaching international and regional players working on policy matters on psycho-social support for children and youth. But, within each country, the organisation's reach extended to national, provincial, district and community levels working directly or through its partners to connect to stakeholders and beneficiaries. The organisation defined its operational region as eastern and southern Africa but recognised the existence of political and economic regional blocs such as SADC. In the HIV response more broadly, there has been a tendency to combine eastern and southern Africa into a single region. REPSSI stated that this recognition was tailored to meet the similar trends in the HIV prevalence across eastern and southern Africa (KII, 13-06-2016). The UNAIDS and even donors also tend to combine the two regions into one single region even though there are programmes that remain specific to either eastern or southern Africa.

For REPSSI, *being regional* meant "configuring your organisation to adopt a common strategy and approach to address common challenges that occur in the region of your operation" (KII, 13-06-2016). Operating regionally would be justified by the existence of common externalities, issues that affect more than two countries, whose resolution or lack of it would bear consequences for the entire region. In addition, for REPSSI, such an approach would be characterised by harmonised approaches, quicker adoption and/or adaptation of new ideas, and drawing from economies of scale and peer influence to facilitate the roll out of the regional operations. It also provided an opportunity to engage with regional bodies such as SADC and EAC on matters that would be difficult to resolve at the national level (and hence required regional interventions), such as the development of a minimum package of psycho-social interventions for children and youth for the region (REPSSI, 2015:11). On the basis of the principles of supremacy and subsidiarity, regional governmental organisations should operate directly only at the regional level, dealing with regional level matters. National level matters are the preserve of national level players, both state and non-state. For REPSSI, these would be the defining elements of a regional programme and operating regionally.

However, REPSSI contended that "there is very little that happens only at the regional level; it only becomes real when it occurs at the country or even district and community level where it is implemented" (KII, 13-06-2016). All efforts, international, regional and country, are usually "directed at and contribute to a localised problem area and, with psycho-social support, it is the needs of child or youth in a particular family", it was added. In this sense, regional efforts are only facilitative of country level intervention, and the only difference with multi-country intervention is that regional work is driven by a single strategy and approach which may be adapted to contextual demands, but addressing a region-wide issue. A multi-

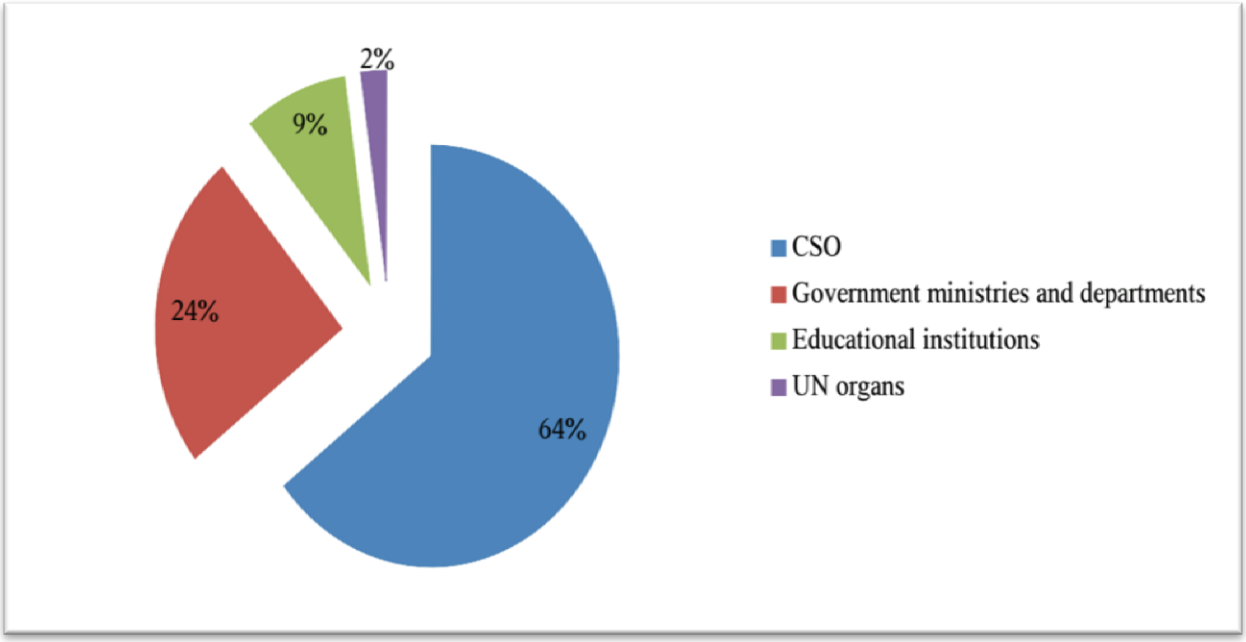
country approach does not need to follow these criteria but different issues can be tackled in diverse individual interventions in many countries. In this context, I explore REPSSI's partners to illustrate their composition, type, character and role in the organisation's work.

9.2.3 Partners

REPSSI considered its partners as programmatic assets in its work to the extent that they contributed to the realisation of its mission. The organisation divided its partners into three categories: international cooperating (donors), strategic (technical support and collaboration) and implementing partners (REPSSI, 2013:45; 2014:40; KII, 13-06-2016).

Implementing partners were central to programme roll out while strategic partners provided technical support and resources for the response. REPSSI implementing partners were mainly concentrated in the southern Africa region (80% of the partners, N=89), where it covered most countries. The East African region is still new ground with only 15% of the countries and 20% of the partners. The bulk of these partners were civil society organisations (CSOs) at 64% of the total, mainly implementing partners at the country level and a few RNGOs. The second largest category of partners was the government ministries and departments (24%) and educational institutions (9%), while UN agencies constituted only 2% of the partners, (Figure 9.2).

Figure 9.2: **Composition of Partners by Category**



Source: Compiled from REPSSI 2015 Annual Report.

In addition to its implementing partners, REPSSI worked with donors who support its work; as well, it benefited from technical support provided by UN agencies such as UNICEF, UNESCO and UNAIDS among others. In its 2015 Annual Report, the organisation reported having received financial support from twenty one funders, including from main donors such as the Swedish International Development Cooperation Agency (Sida) and NORAD, corporations (such as First National Bank Namibia and British Petroleum Angola), UN agencies such as UNICEF, and country-based donors such as USAID South Africa (REPSSI, 2015:30).

In addition to this large set of cooperating partners, REPSSI also forged relations with both regional and national governmental bodies and structures for policy influence purposes as well as programming. The organisation, as well, had links and works with a variety of other civil society organisations at the regional and country levels. Later in the chapter, I discuss the partnerships and the partnership mechanisms to illustrate how REPSSI worked with each one of these categories of development players.

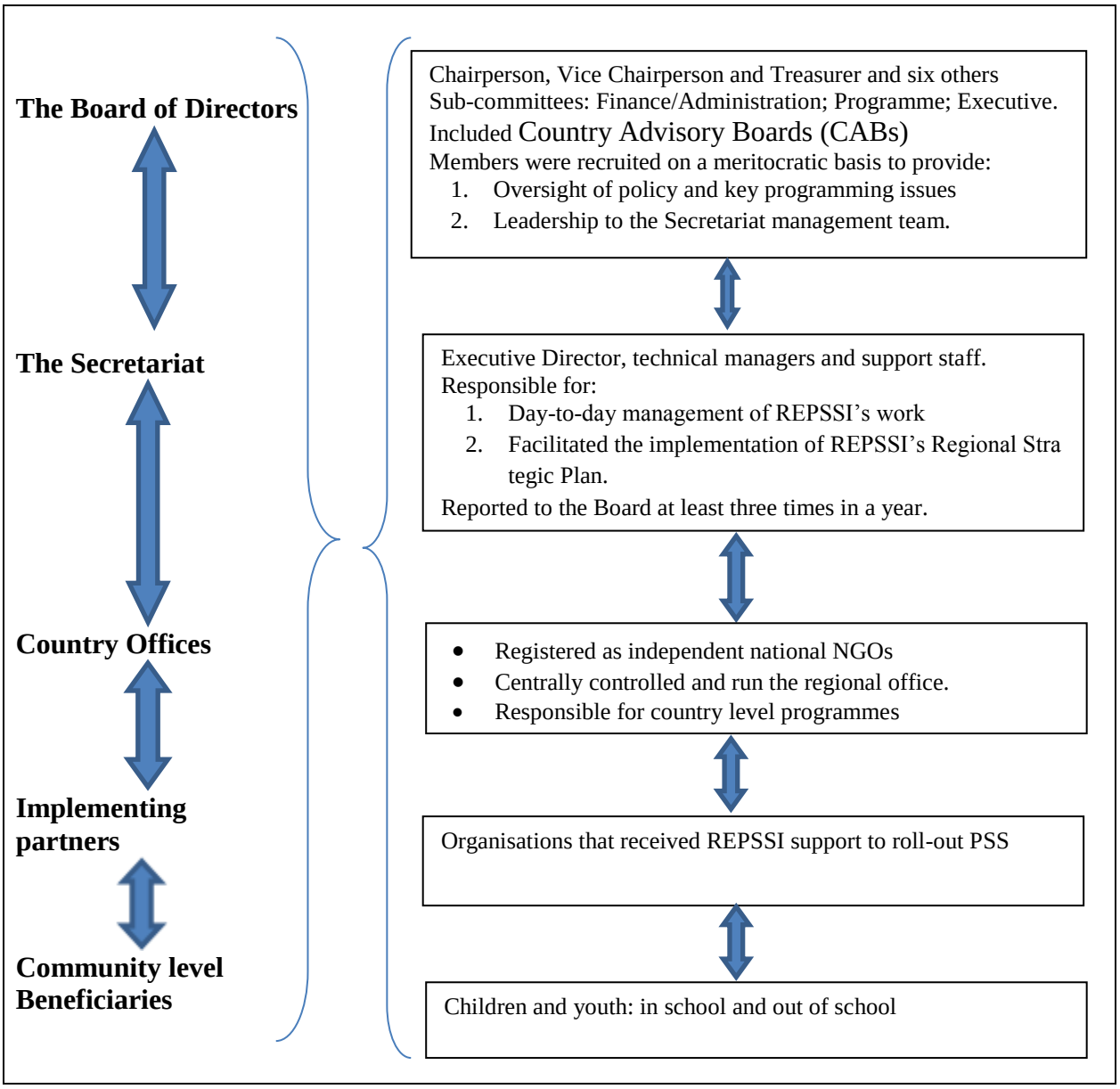
9.2.4 Organisational Governance and Management

REPSSI was organised into a Regional Office (RO) - the Secretariat - that operated through and with twelve registered Country Offices (COs). While the RO was the central administrative arm of the organisation, the COs were its extensions established for expansion and better reach at the country level. Through its COs, not only could REPSSI operate in closer proximity with country stakeholders and beneficiaries, but the organisation could tap into local resources from national governments and those availed by donors to country level operators for local issues (KII 13-06-2016).

Although in this context the COs had potential to grow into strong and autonomous national entities, as they were registered as independent corporate bodies in the respective countries, they were administratively and operationally subordinate to the RO. The RO not only provided strategic direction but provided technical and financial support. To this extent, therefore, the COs were local nodes and hubs that connected REPSSI at the country level and coordinated inputs that informed the regional operations.

By virtue of its structuring (country and regional), REPSSI was governed by a Regional Board (RB) of eleven elected members (a Chairperson, Deputy, Treasurer and eight others), supported by Country Advisory Boards (CABs) in the countries where it was registered (REPSSI, 2014:13) (see Figure 9.3).

Figure 9.3: REPSSI Structure



Source: Compiled from www.repssi.org accessed 20 - 09- 2016; KII 13-06-2016.

The RB, though elected, was an expert team to strategically guide the organisation in its work as well as provide oversight of the secretariat. The CABs were unique governance structures which gave country representation and voice in REPSSI work. REPSSI had six CABs in ten of its registered countries, namely, Botswana, Lesotho, Malawi, Tanzania, Zambia and Zimbabwe. These were locally constituted with REPSSI assistance to improve in-country governance and ensure that national PSS issues were fed into the REPSSI regional strategy and advocacy work.

REPSSI's work was driven by a secretariat that was supported by country offices. The Secretariat accounted to the RB for the running of the organisation and through the COs to

the CABs, a mechanism through which it did not only ensure delivery of relevant programmes to its beneficiaries, but in a sense account to them as well. CABs advised on local national issues and therefore contextualised REPSSI programmes, thus making them more relevant and enhancing the organisation's legitimacy in the local response.

Headed by a Chief Executive Officer, who presided over the regional team and worked with Country Directors, who in their turn were in charge at the COs, the REPSSI executive team (the ED, DED and programme directors) was structured in a manner intended to deliver on the organisation's mandate at all levels. On this basis, it is possible to consider how the organisation operated and highlight its work at different levels, and the partnerships it forged for this purpose.

9.2.5 Operational Modalities and Programmes

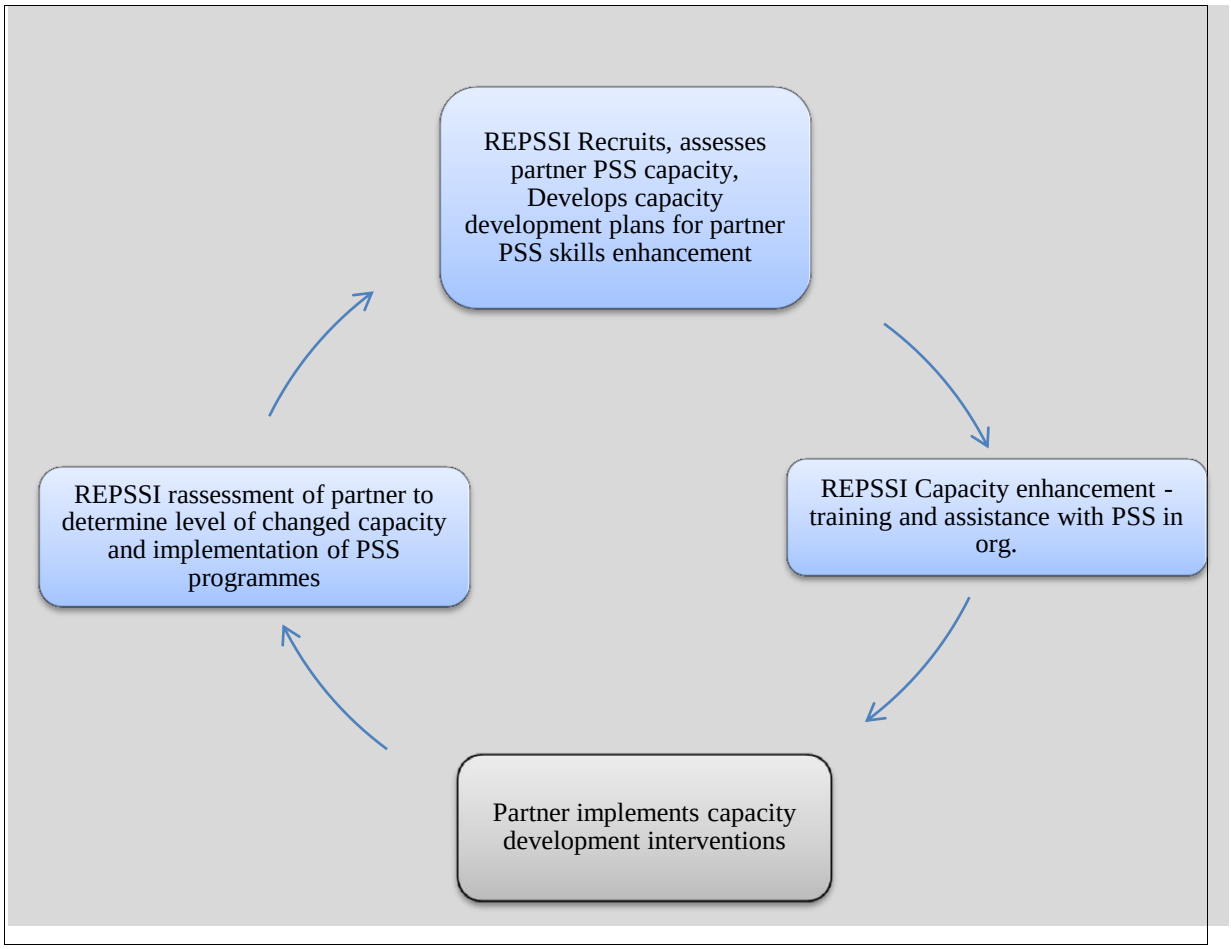
REPSSI's operational modalities were dependent on the organisation's ability to mobilise relevant implementing partners and to raise requisite support for its work. As such, the organisation rolled out a partnership development process which subsumed capacity development processes. Once this was achieved, training, material support and advocacy work were pursued. I discuss each of these modalities, it should be noted that this is only a small illustrative fraction of what the organisation does.

9.2.5.1 Partnerships

As noted earlier in this chapter, partners were vital to REPSSI programming. For REPSSI, partners were organisations that shared or were prepared to share the same vision regarding PSS for children and youth, and contributed in their various ways to this cause (KII 25-06-2016). The organisation defined a partnership process as a mechanism of mobilising and recruiting these social entities and providing them with the necessary capacity to mainstream and roll out PSS in their work (as illustrated in Figure 9.4). Social agents engaged in this manner constituted REPSSI's implementing partners.

Most of the CSOs that worked with REPSSI were engaged as implementing partners. For its implementing partners, REPSSI's partnership process was structured as a project cycle-based model of organisational capacity development. It was a systematic technical support model that was specific and focussed on building skills to deliver PSS for children and youth services. This model was adapted to the different needs of partners depending on their level (community, institutions, CSO, local government, national government etc.) and applied for different purposes (implementation of PSS, advocacy for PSS etc.).

Figure 9.4: **Elements of Partnership Development**



Source: Compiled from www.repssi.org, accessed 20 - 09- 2016.

In other words, REPSSI was modelled around technical support services provision to different social agents (within and outside the HIV and AIDS response) who were offering services for children and youth largely. However, REPSSI partnerships were formed at two levels, the country and regional levels. I discuss these in the next subsection to offer some comparison between the two levels.

At the national level, REPSSI developed partnerships with various national stakeholder structures for policy and plan influences. It established relations with national governments who were involved with the organisation as both consumers of its services and collaborators in creating a suitable national environment for the mainstreaming and roll out of PSS. In selected countries, REPSSI also collaborated with educational institutions to enhance its training services for PSS. About 9% of the partners were educational institutions offering such services over and above efforts made in schools through government ministries of education.

Another category of REPSSI partners comprised its funders; donor organisations that provided resources to support the organisation and its programmes. REPSSI considered donors strategic partners as they determined its organisational survival and programme sustainability (KII25-06-2016). The number of donors varied each year as this depended on existing projects and the number of donors supporting each project at a particular time. As noted earlier, the organisation had worked with twenty one donors throughout the region. Included in the category of strategic partners were also the UN agencies that provided technical support to the organisation on matters of children – UNICEF, UNESCO, UNAIDS – and the regional governmental organisations SADC, EAC and AU.

In the case of regional partnerships, these were formed around REPSSI's regional advocacy agenda targeted at creating awareness about the need to mainstream PSS in HIV programming, and creating a friendly environment for the roll out of PSS for children and youth. These partnerships were constructed with regional bodies such as AU, SADC and EAC and targeted to facilitate regional policy influence among their members-states. REPSSI had partnered with SADC in the implementation of the latter's strategic orphans, vulnerable children and youth (OVCY) plan, and became involved in the SADC standards for integrating SRH/HIV and AIDS, the development of the Draft Declaration on Youth Development (and the Draft SADC Youth empowerment and participation strategy and business plan 2015 - 2020). Further, REPSSI was accorded the status of technical advisory partner to the SADC Parliamentary Forum (REPSSI, 2014:21, 22).

REPSSI also forged relations with the UNAIDS and Save the Children International to influence the content of the HIV responses by ensuring the incorporation of PSS. In this work, REPSSI collaborated with its peers in RAANGO but especially the Regional Interagency Task Team for Eastern and Southern Africa (RIATT-ESA) which it chaired. It influenced the UN HIV governance structures to consider and incorporate all relevant issues (including PSS related) emerging from the grassroots into the regional HIV response (REPSSI, 2014:22; KII, 13-06-2016). In this way, REPSSI regional partnerships with peer RNGOs especially those in RAANGO were intended for mutual support in advocacy for policy influence as also discussed in chapter eight.

9.2.5.2 Capacity Building and Sub-granting

While capacity building was subsumed in the partner recruitment process, it continued for any area of ongoing need amongst REPSSI's partners, including skills training for organisational personnel, information sharing through tailored regional workshops, and

information, education and communication (IEC) materials. Where trainer-skills training was offered, it was accompanied by a small grant to support the cascading of the programme to lower levels or other organisations. Grants were also offered to directly support children and youth served by REPSSI partners. In cases where there were no intermediaries involved, REPSSI delivered the services directly to communities in collaboration with community structures and families.

Central to REPSSI's work was the provision of psycho-social support (PSS) training for organisations implementing programmes for children and young people, and for peer educators and motivators in PSS to enhance their ability to deliver PSS to children. Table 9.2 shows the course coverage by country throughout the eastern and southern African (ESA) region, including REPSSI's list of training activities as reported in their 2015 Annual Report.

Table 9.2: **Courses and Coverage by Country**

Course	A	B	K	L	Ml	Mz	N	SA	Sw	T	Ug	Za	Zi
Child care community focal persons													X
PSS facilitators													
Counselling and guidance teacher		x											
Government staff general PSS course													X
Early childhood development				X									
Government education officials			x										X
Awareness workshops	x						X			x			
Community engagement													
Teacher PSS training		x		X			X	x	X				
Child and adult PSS counsellors			x										
Sexuality education facilitators							X						X
Training on PSS tools	x	x				x							
Service provider on PSS	x	x				x							X
Peer educators and motivators													X

Source: REPSSI (2015:18-20).

Key:

A:	Angola.	**B:**	Botswana.	**K:**	Kenya.	**L:**	Lesotho.
Ml:	Malawi.	**Mz**:	Mozambique.	**N:**	Namibia.	**SA:**	South Africa.
Sw:	Swaziland.	**T:**	Tanzania.	**Ug:**	Uganda.	**Za:**	Zambia.
Zi:	Zimbabwe.						

1. Others

It demonstrates the technical support character of the organisation and its very direct involvement at the local (country and community) level. These activities incorporate national

and local government authorities as well as community leaders and the police to promote the mainstreaming of PSS in various ways and forums (REPSSI, 2015:18-20). REPSSI had a wide range of materials to support its delivery of PSS training.

Table 9.3 lists some of these key materials which included tools and processes in PSS interventions. REPSSI's tools and processes were utilised to train beneficiaries on achieving PSS for children and youth as well as to mainstream PSS in the programmes of service providers for children and youth.

Table 9.3: **PSS Tools and Processes**

Psychosocial tools	Psychosocial process
1. Memory work, 2. Child participation, 3. Community debates, 4. Advocacy 5. Peer-to-peer support and, 6. Community clubs	1. Tree of Life, 2. Hero Book, 3. Body mapping, 4. Journey of Life

Source: Compiled from www.repssi.org, accessed 20 - 09- 2016.

The materials were presented as "generic tools which could either be adopted or adapted to achieve the same strategic objectives set for the entire region – they were designed and developed as regional equipment" (KII, 13-06 2016).

9.2.5.3 Advocacy

REPSSI advocacy work was targeted at national and regional levels and, within that focus, directed at regional bodies, national governments and civil society organisations (REPSSI, 2015:11). The intention was to influence policies and plans to incorporate PSS for children and youth. But it also included at times international advocacy.

Overall, REPSSI work at the international level was less intense and largely characterised attending international conferences such as ICASA, AIDS Impact, and Child Sensitive Social Policies 2nd International Conference where the organisation presented papers highlighting the significance of mainstreaming PSS and related matters (REPSSI, 2015:16). However, the organisation was engaging vigorously with regional bodies through participation on key regional structureS. Within the SADC Secretariat, the organisation had seconded an officer to provide guidance on the mainstreaming of PSS matters in key regional HIV prevention, treatment and care strategies in 2015 following the successful lead in the development of the SADC Minimum Package for Service for OVCY and Regional PSS Framework in 2011 (REPSSI, 2015:11).

Within the Regional Inter-Agency Task Team for Eastern and Southern Africa (RIATT-ESA) REPSSI had not only taken on the Chairmanship and Secretariat of this key organisation but, through that, integrated PSS into the RIATT-ESA strategy. As a result of these efforts, in 2015, REPSSI reported that ten countries in the region were developing national PSS guidelines, demonstrating the extent of regional influence of the organisation and how operating regionally works.

In addition, REPSSI organised and hosted and/or co-hosted regional PSS forums on PSS for children and youth. Such forums drew large numbers of participants from different backgrounds, including UN agencies, donors, governments, academics, regional NGOs and other forms of CSOs. A 2015 forum co-hosted by REPSSI and nine regional and international organisations, UNICEF and several donors, attracted the participation of 28 countries, and 213 female and 186 male participants representing youth, children, governments, CSOs and academic institutions (REPSSI, 2015:12).

The organisation's direct interface with children and youth at the regional level was achieved through Regional Children and Youth Meetings where a preconference facility was availed for children to raise their concerns such as child-marriage, child labour, HIV, violence and rape. These meetings were usually held following in-country pre-conference consultations that feed into the meetings. In this way, the organisation facilitated its influence on PSS at the regional level.

In relation to national level advocacy, REPSSI sought membership and engaged national authorities and stakeholders in national coordinating bodies to influence national policies and plans. In Kenya, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania and Uganda, the organisation reported participation in national structures and influenced the integration of PSS matters in policies, strategies and guidelines on children and youth (REPSSI, 2015). In addition, REPSSI organised and facilitated in-country psycho-social support (PSS) forums for different target groups – teachers, psychologists, police, journalists, social workers, magistrates, CSOs, Village Chiefs and elected councillors – to raise awareness on matters of PSS that arise in their areas of work and how to resolve them and mainstream PSS. In addition to these efforts, REPSSI also participated in events that promoted the rights of children and youth especially the Day of the African Child and the end of child marriages campaigns (REPSSI, 2015:14; KII, 13-06-2016).

The organisation thus exhibited a strong presence at both the national and regional levels demonstrating how it practiced as a regional organisation, creating a link between the regional and national, and adding value to work at both levels through cross feeding between

the two levels. To this extent, one question that arises is the level of entrenchment or embeddedness of REPSSI in various networks resulting from its work.

9.2.6 Embeddedness

REPSSI's structure of work, as discussed, connected the organisation to a variety of development players in the HIV response at the national, regional and international levels. These links were different in nature, and the content of the relationships was also variable, as well as having different implications for the organisation's survival, sustainability of its work, and its focus and character.

At the time of this research in 2016, REPSSI had just completed revising its Strategic Plan, and had produced a new one (2016 – 2021). Recalling this and her past experiences with the process in the organisation, the Regional Advisor: Resource Mobilisation (KII 13-06-2016) mentioned two main sources of unavoidable influences on the strategy as outlined in Table 9.4, which interacted to generate and determine the organisation's priorities.

Table 9.4: Influences on REPSSI Strategy

Sources of influence	Parent agent	Specific influences
A. External	1. The UN	✓ Sustainable Development Goals (SDGs) – (UN General Assembly – UNDP) ✓ UNAIDS process towards ending AIDS (90 90 90) – the Fast track programme
	2. Donors	✓ Multilateral and bilateral donor priorities – where money is provided
	3. SADC	✓ Strategy, declaration, etc.
	4. Regional context	✓ Nature of epidemic and demand for PSS ✓ Other RNGOs – inputs
	5. Country context	✓ Issues emerging from our experience ✓ Partner/beneficiary needs ✓ National strategies ✓ National HIV and social context ✓ Services ✓ Role of other CSOs
B. Internal	1. Organisational context	✓ Organisational strategy ✓ Vision, mission (constitution) ✓ Resources: human, financial and material ✓ Infrastructural

Source: Compiled from KII, 13-06-2016.

The organisation was obliged to consider and incorporate aspects of the global (UN, donor), regional (SADC, EAC) and country (national government) frameworks for development, including in the specific areas of its programmatic focus in the context of its

own internal organisational environment. At the same time, she noted a second influence, indicating that "we are guided by and pursue an African perspective which encourages child support within a family context rather than institutionalisation, and our vision is for every child to receive PSS because they need it - it dominates the way we operate." For REPSSI, the cultural context influences the organisation to treat the 'group' as the 'best resource' for the success and sustainability of its work.

Regardless, however, the latter influence often had to be negotiated and reconciled with the global framework for HIV and children's rights as handed down from the UN and the donor priorities and agendas for development and development support as illustrated in chapter five. In addition, the organisation also had to take into consideration varying national legal frameworks that related to programming for children vis-à-vis parental rights over their children's socialisation and control (KII, 13-06-2016)**.**

This context directly connected the organisation to different national authorities at different levels (health, education, security and social welfare), families, community, and traditional and religious leaders, all of whom are stakeholders in the socialisation and welfare of children in the countries where it operated. In addition, through its partners, the organisation had to interface with other civil society organisations operating in all these sectors and at the regional, country and community levels; by extension, this involved interfacing with those in the circles of its partners and beneficiaries. The extent of REPSSI embeddeness pronounced the organisation's burden to account as discussed in the next subsection.

9.2.7 Accountability

REPSSI accounted to various stakeholders for various reasons. I highlight a few critical areas that justified a higher level of need to account. Like any secretariat, firstly, REPSSI had to account to its Board of Directors who were the 'owners' of the organisation including to sub-components of the board. In this regard, the secretariat had to account for all aspects relating to organisational functioning to allow the Board to exercise its oversight authority efficiently. Secondly, as any donor funded organisation, REPSSI accounted to its donors for the money it received as this was contractual and hence obligatory. Accounting to donors involved submitting all requisite reports showing progress and impact against work plans and expenditure against budgets as specified in each contract.

According to the Regional Advisor: Resource Mobilisation, even though the board required virtually all information, the greatest pressure to account was exerted by donors as

this had direct implications for organisational survival (KII, 13-06-2016). Even though REPSSI is a regional organisation, it experienced the least pressure to account from SADC, except where there was a collaborative agreement or contract (such as when it collaborated with SADC to develop the regional minimum standards for PSS). With national regulatory authorities, except where there is collaboration, usually the submission of an annual report or as may be required, was sufficient as long as such a report contributed to the national strategy.

In its accountability architecture, REPSSI did not have clearly stated mechanisms for accounting to its beneficiaries except through programme delivery to meet their needs. Like other RNGOs, the organisation's ability to deliver these programmes was dependent on the availability of donor funding and therefore, where funds ran out, there was nothing more that could be done except to leave the beneficiaries at whatever stage they were in the programme. Because of this risk, REPSSI indicated that it always encouraged interventions that involved families and communities and it tried to empower them to continue PSS work beyond REPSSI projects and support (KII, 13-06-2016). Against this illustrative first case example in this sub-category of RNGOs, I proceed to examine the second case.

9.3 SAfAIDS Case Example

The Southern African AIDS Information Dissemination Network (SAfAIDS) is one of the other-serving regional non-governmental organisations (RNGOs) which belonged in a sub-category of its own. The organisation was an HIV information and advocacy services body focusing primarily on the production of information, education and communication (IEC) materials to support the work of other organisation in the HIV response at the country and regional levels. Formed in 1994, SAfAIDS is a regional non-profit non-governmental organisation (RNGO) based in Harare, Zimbabwe. While SAfAIDS rolled out its programmes in SADC, it was ambitiously set up to cover the entire African continent; thus, giving a sense of a RNGO potentially positioned either to grow into a continental body or one whose work would discharge ripples that would blanket Africa to usher in the bright future that it envisioned. In doing this, it hoped to contribute to the global elimination of socio-economic injustices and ill-health particularly in the areas of sexual and reproductive health, HIV and TB.

9.3.1 Vision and Mission

The organisation set out its primary mandate as "sexual reproductive health and rights (SRHR) and HIV" (KII, 05-08-2016). In its mission statement, the organisation identifies its niche as "promoting effective and ethical development responses" with the primary modalities being advocacy, communication and social mobilisation. Alongside SRHR and HIV, the organisation also targets related challenges such as prevention of HIV transmision from mother to child (PMTCT) and TB to contribute to their vision as illustrated in Table 9.5.

Table 9.5: SAfAIDS Vision and Mission

Mission	Vision
➢ To be a centre of excellence that promotes effective and ethical development responses to Sexual Reproductive Health and Rights, HIV (including PMTCT) and TB through advocacy, communication and social mobilisation.	✓ To ensure that all people in Africa realize their sexual and reproductive health and rights (SRHR) and are free from the burden of HIV, TB and other related developmental health issues.

Source: SAfAIDS website: www.safaids.net accessed 17 – 08-2016.

The organisation had three main programmatic focus areas: policy, service provision and community and household reach as shown in Table 9.6.

Table 9.6: Level at Which SAfAIDS Operated

Focus	Activities	Level of operation
Policy advocacy	➢ Lobby and advocate to influence policy platforms either with governments or with SADC secretariat, or other regional entities	✓ Regional
Service provision	➢ Support implementing partners at country level, regional level	✓ Regional and country/ community
Community reach	➢ Reach community at household level to mobilise for behaviour change	✓ Community /household

Source: KII, 05-08-2016.

According to the deputy executive director (DED), the organisation also worked in areas of gender, human rights and other development issues because SAfAIDS' work was aligned to the UNDP (2015) Sustainable Development Goals especially Nos.1 - 5 that related to ending poverty, food security, equitable education health and employment (KII, 05-08-2016). This included pursuing programmes to respond to the needs of adolescents, women,

young people, men and key populations around reproductive health, HIV and TB. As the DED (KII, 05-08-2016) put it, the organisation's work "cuts across gender and human rights and other development issues because we have aligned to the SDGs as well; so, in certain cases when working with young women and youth, we integrate and liaise with partners around livelihoods as well." To understand this more fully, it is necessary to examine the organisation's regional coverage and how it defined working regionally. Such an analysis also includes consideration of the distribution and variety of partners that the organisation mobilised.

9.3.2 Geographical Coverage

SAfAIDS operated in nine SADC countries: Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe. With a Regional Office (RO) in Harare, Zimbabwe, the organisation had Country Offices (COs) in South Africa, Swaziland and Zambia; and Focal Points in Lesotho and Malawi, which operated as emerging COs. SAfAIDS implemented programmes in six countries with a focus on matters of both country and regional level significance. In addition, In Mozambique, Namibia and Tanzania, the organisation operated through selected partner organisations through whom it reached relevant beneficiaries.

The organisation understood a region to mean "a group of countries with a common agenda or a common trend or pattern; whether they be development patterns or disease patterns etc." (KII05-08-2016). It also recognised a region as being that territorial space under the control of a regional authority which presided over a number of countries that have joined together for mutual benefit – such benefit being economic, social, political or military. In other words, the key defining characteristic of a region for SAfAIDS was the existence of common externalities that cause national territories to be defined as a common collective. SAfAIDS' definition of a region fitted closely with how eastern and southern Africa have been combined and defined as a single region because of the common nature and characteristics of the HIV epidemic and its key drivers.

Against this backdrop, SAfAIDS understood *being regional* to mean "undertaking programming which addresses regional issues – these are issues that are common to those countries in an area defined by common characteristics" (KII, 05-08-2016). The DED gave the example of working regionally as when an organisation worked with SADC on the development of a package of minimum standards to be adopted by all SADC Member States. She regarded this as being regional because such "standards would be applied to harmonise

practices across all the countries in the region". This implies that one defining element of being regional would be the delivery of a unified programme that addresses a common issue or matters of significance and interest to all members of the region.

For SAfAIDS, this contrasted with multi-country operations which "involve programming in a number of countries regardless of whether or not they belong to one geographical/economic/political bloc like SADC" (KII, 05-08-2016). For the organisation, in a multi-country intervention to reduce gender-based violence in schools for example, it might apply a generic model; but in a specific country (e.g. Swaziland), the model may be adapted to the country's needs obtaining from the different dynamics around gender-based violence in each case. Viewed in this way, according to DED (KII05-08-2016), "SAfAIDS does both regional and multi-country interventions", and the differentiating factor in this regard is the adaption of variants of a single model rather than its adoption. However, against this backdrop, it is interesting to discuss how the organisation configured itself to be able to operate both at regional and country levels. This requires engaging with the issue of partners.

9.3.3 Partners

SAfAIDS worked with and through a mix of partners from both the country and regional levels. Its partners were divided into four main categories outlined in Table 9.7. The partner categories were translated into partnership levels: strategic, ally, peer and implementing and/or beneficiary.

Table 9.7: SAfAIDS Partner and Peers

Strategic partners		**Allies**	**Peers**	**Implementing partners and Beneficiaries**
Donors	**Technical supporters**			
➢ **HIVOS** ➢ **SIDA** ➢ **GFAMT** ➢ **USAID** ➢ **Save the children**	➢ UN agencies	➢ Government ministries ➢ SADC ➢ Traditional structure ➢ Stop AIDS Now	➢ RAANGO members ➢ SAT ➢ REPSSI ➢ ARASA ➢ NAPSAR+ ➢ DHAT	➢ CBOs ➢ NGOs ➢ Communities ➢ Health service providers ➢ UN Agencies ➢ ASOs

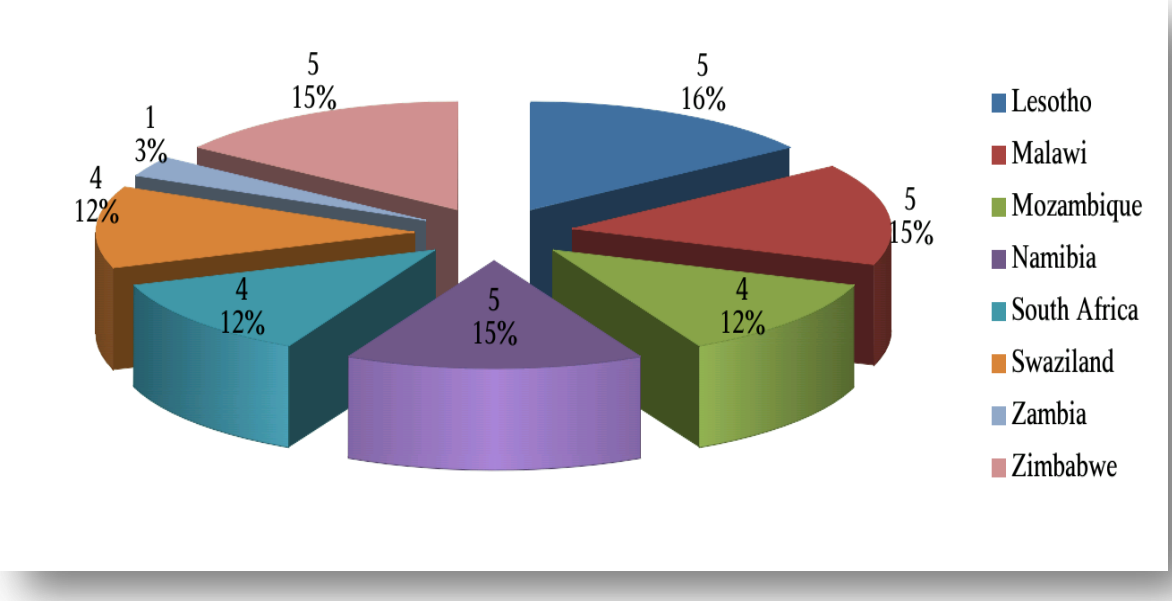
Source: SAfAIDS Website: www.safaids.net; SAfAIDS DED **(**KII, 05-08-2016).

Its strategic partners were the resource providers (bilateral and multilateral donors) and technical support providers such as UN Agencies (e.g. UNAIDS, UNESCO, UNICEF, UN Women) and international development agencies such as HIVOS and Save the Children,

who have expertise in specific areas of programming. Some of SAfAIDS' technical partners provided funding through their specific technical support programmes; for example, HIVOS provided expertise in dealing with issues of key populations and sub-granted to the organisation to facilitate its work (HIVOS, KII,02-08- 2016). Similarly, some donors directly provided technical support alongside their funding or subcontract a technical support provider to assist the funded organisation. In this way, what is strategic depends on what it contributes to the survival and function of the beneficiary organisation.

SAfAIDS' implementing partners were regional and country level civil society organisations that were rolling out programmes in the organisation's focus areas. They constituted the largest set of partners spread throughout the countries where it operated. Figure 9.5 illustrates the distribution of SAfAIDS' thirty-eight implementing partners. The partners were least concentrated in Zambia at 3%, with the rest almost evenly distributed amongst the rest of the countries. These organisation delivered programmes in different intervention areas that included women, gender, voluntary testing and counselling, youth, key populations and rights. This was a diverse mix that allowed the organisation to have a programmatic coverage that could contribute to its mandate.

Figure 9.5: Distribution of Implementing Partners



Source: compiled from www.safaids.net/programme_view/2877 accessed 17 August 2016; KII, 05-08-2016.

SAfAIDS was an active member and the current host of the RAANGO. As earlier discussed, the latter provided a mechanism for peers to share and learn from each other, as well as to collectively undertake advocacy in regional forums such as SADC and AU, albeit on an ad hoc basis. SAfAIDS peers were regional NGOs active in the HIV response with whom the organisation could sustain relational rather than transactional relations (Majchrzak et al., 2015:1346). Majchrzak et al. (2015) define transactional relations as formal and contract based relations, and relational as informal connections that are non-contractual. These relations were sustained for mutual moral support and hence create the necessary critical mass needed for advocacy at the regional level.

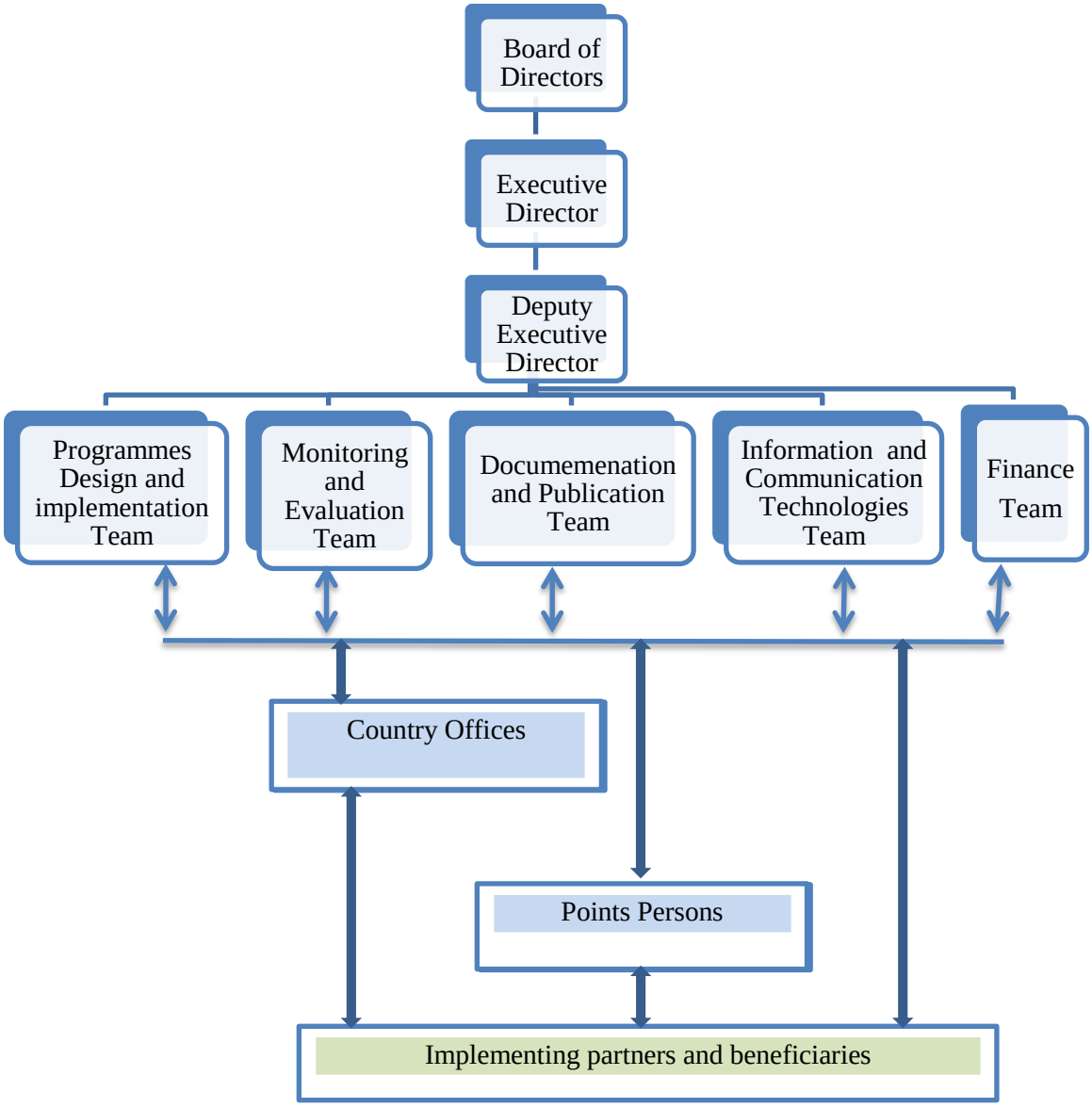
In addition to implementing partners and peers, the organisation also had a group of partners who served as its supporters – the allies. These gave the necessary backing to the organisation's work. This included all its peers but in addition there were also diverse development agencies that backed the organisation in its work as Table 9.7 illustrates. This array of connections required the organisation to be structured in a manner that could manage the spread, diversity and focus of its partners to its advantage and channel efforts towards its mission. Thus, as discussed below, SAfAIDS' organisational structure was important in relation to its internal institutional needs as well as delivery on its mandate.

9.3.4 Governance and Management

SAfAIDS had a standard governance structure comprised of a Board, Management and Staff (secretariat), but this was uniquely connected to communities through Country Offices (COs) and Point Persons. The secretariat was positioned to reach the upper regional level, while also coordinating the work at the lower country level under the oversight of the SAfAIDS Board of Directors. The Board was comprised of experts of different backgrounds hired for their relevance in directing the organisation in various aspects of its operations. Its constitution was much the same as SAT and REPSSI's by virtue of the fact that, like these two RNGOs, SAfAIDS had operations and was legally registered at the country level. This compelled the organisation to establish local Boards of Directors that provided oversight of the COs and contributed to the contextualisation of the organisation's work in-country.

SAfAIDS' Regional Office was headed by an Executive Director assisted by a Deputy Executive Director and other senior staff constituting the management. The rest of the staff were organised into functional teams that were designed to deliver on its mandate of research and documentation, information sharing, learning, capacity development and advocacy (as shown in Figure 9.6).

Figure 9.6: SAfAIDS Organogram



Source: KII, 05-08-2016.

SAfAIDS' programmatic work was delegated to interdependent and mutually supporting teams contributing different components to programme execution: finance, programme design and implementation, monitoring and evaluation, documentation and publication, and information communication technology (ICT).

In their different combinations of collective efforts, these offices reached out to strategic and implementing partners, and targeted programme beneficiaries at the national, regional and international levels. Critical to note is the three ways in which connections existed between the organisation and its beneficiaries. The organisation either reached

directly to beneficiaries from the regional office, or worked through its country offices or Points Persons. This demonstrates that the organisation at times sought out and worked directly with beneficiaries regardless of the existence of a possible intermediary. Thus, direct reach and indirect contact (through intermediary) were mechanisms employed to ensure engagement with communities.

9.3.5 Partnerships

The organisation forged partnerships at different levels and these were linked to the implementation of its programmes. Each category of partners served a purpose in the organisation's life and work. While strategic partners provided the necessary financial and technical assistance and also doubled as allies, implementing partners were mobilised to roll out SAfAIDS' programmes in the areas of their competence and potential. SAfAIDS' peers were other regional organisations that were involved in the HIV, SRHR, TB and malaria responses. SAfAIDS would share information with its peer organisations about the epidemics and indicate practical interventions which showed success; in that process, moral support was also provided to drive the regional response (KII, 05-8-2016). SAfAIDS' allies were organisations that could morally vouch for the organisation's interventions at both regional and country levels. These organisations were either strategic partners or peers. It is therefore important to examine how these partnerships were established and how they worked for SAfAIDS. In the end, the organisation aimed at "building strategic partnerships, and creating platforms for dialogues where the voices of individuals, communities and organisations could be heard" (www.safaids.net).

SAfAIDS' relations with its partners were governed by two main mechanisms, that is, formal and informal. Formal (and hence transactional) relations were either contractual or based on a memorandum of understanding (MoU). Contractual relations were established between SAfAIDS and some of its strategic partners but all of its implementing partners. Only those strategic partners that provided resources and or technical support entered into a contractual arrangement with the organisation. MoUs were the basis of relations between the organisation and its allies and some of its peers, especially where programmatic collaboration was involved as in the case of the organisation receiving funding as part of a consortium.

The relations developed around specific programmatic objectives commonly shared by the organisation and its partner. SAfAIDS mobilised donors to provide resources for its programmes. The organisation's programmes had to be in those areas the donor supported under the latter's own development strategic objectives, and for which it also needed

implementers. Technical support based partnerships, also involving contractual arrangements, were directly related to institutional capacity strengthening and/or programme delivery. Further, SAfAIDS also recruited implementing partners in the same manner (KII, 05-08-2016). The relationship was transactional in the sense that while one delivered services the other provided funding. As such, the obligations, rights and expectations of each party to the relationship were clearly articulated including the manner of accounting to each other.

The informal partnerships were relational and did not involve signing agreements. They were based largely on mutual understanding, common interests, shared values and perceptions, mutual respect and collegiality (KII, 05-08-2016). SAfAIDS shared relational partnerships with most of its peers in the regional platform, RAANGO, where members informally exchanged ideas on the regional HIV response (KII, 05-06-2016). In other words, while relations were legalistic between the organisation and its strategic and implementing partners, more informal and associational relations existed between the organisation and its peers and allies, carrying a more moralistic obligation to account than in the former. Relations were strengthened by shared and sometimes common purpose (providing a response) and/or concerns (HIV, SRHR, TB and malaria) which generated the need for mutual moral support.

All in all, therefore, partnerships were a mechanism for SAfAIDS to mobilise institutions and individuals that could contribute to its work in the region: financially, technically, morally and in rolling out SAfAIDS' programmes throughout the region, at both the regional and country levels. These partnerships related thus to the implementation of SAfAIDS' programmes as discussed below.

9.3.6 Programmes and Operational Modalities

SAfAIDS offered a wide range of programmes intended for policy influence, behavioural change, and institutional and systems strengthening targeted at different levels as part of technical support. Table 9.8 gives a list of the organisation's thematic focuses, programmatic modalities and target groups in the delivery of its policies, service provision and community and household reach and mobilisation. Together, this was intended to break socio-cultural barriers, bring about behavioural change, enhance demands for rights and facilitate access to various services in the response to SRHR, HIV, TB and malaria. In its work the organisation focused on four main thematic areas with gender, HIV and Human Rights factored as cross-cutting themes.

Table 9.8: **Thematic Focus, Modalities and Coverage**

Cross-cutting themes	Standing themes	Programmes/Modalities	Target group
A. HIV **B. Human rights** **C. Gender**	1. Sexual and reproductive health 2. Cultural and harmful practices reforms 3. Legal and Policy reforms 4. Systems strengthening 5. Tuberculosis 6. Malaria	I. Lobbying and advocacy II. Documentation, information sharing III. Training and skills learning IV. Communication, social mobilisation and linking V. Community dialogues VI. Organisational capacity development	✓ Regional bodies e.g. SADC, AU, Donor, UN agencies etc. ✓ Health services providers ✓ Government at different levels ✓ ASOs ✓ Young people ✓ Women ✓ Girls ✓ Key People ✓ Men ✓ Traditional and religious leaders ✓ Small and emerging CSOs

Source: Compiled from SAfAIDS Website: www.safaids.net/programme_view/2877 accessed 17 August 2016; SAfAIDS DED (KII, 05-08-2016).

The bulk of SAfAIDS' work was focused on the thematic areas presented in Box 9.1 and was targeted at three main groups: people infected and affected by HIV and AIDS, those most at risk of contracting the virus, and service providers or those in positions of influence that determine the spread, control and mitigation of the impact of the epidemic.

Box 9.1: **SAfAIDS Priority Areas**

i. HIV and TB prevention, care and treatment
ii. Integration of HIV and sexual and reproductive health services
iii. Addressing the links between HIV, culture and GBV
iv. Addressing the rights of marginalised communities (LGBTI and people living with HIV (PLHIV) and sex workers to access health services.

Source: SAfAIDS DED **(**KII, 05-08-2016).

Considered in the Sida HIV response in eastern and southern Africa, the organisation was contributing to Sida's objective as well as the Global Fund Key Population programme in the context of the UNDP (2015) Sustainable Development Goals, as earlier discussed. I examine the roll out of the organisation's work starting with its advocacy work and demonstrate how it spanned from regional through national to community levels linking the

organisation to different players at each level and spreading its influence in interactions with other development agents.

9.3.6.1 Advocacy, Communication & Social Mobilisation (ACSM) Programme

Advocacy was one of the main defining elements of SAfAIDS as a regional organisation, and it was pursued in a very penetrative manner especially at the country level. The organisation designed its programme as an advocacy, communication and social mobilisation (ACSM) agenda in collaboration with its implementing partners, and directed at the regional and community and family levels addressing policy and practice issues surrounding gender, HIV, SRH, TB and malaria service delivery (KII, 05-08-2016).

The ACSM programme was aimed at behaviour change in relation to negative practices that promoted HIV transmission, stigma and discrimination against people living with HIV (PLHIV), men who have sex with men (MSM), orphans and vulnerable children (OVC) and sex workers, the LGBTI community and gender-based violence (GBV) at the community and family levels. This work involved the utilisation of various tools and strategies "to support community-based organisations and community-based volunteers (CBVs) to initiate community-led mobilisation and advocacy programmes; community cultural dialogues, policy dialogues, structured e-discussions and policy briefs to further policy advocacy and resolve inhibiters of individual rights to health services of vulnerable populations" (KII, 05-08-2016; www.safaids.net/programme_view/2877, 17 -8-2016). It also included the participation of CBVs and the engagement of existing community structures and opinion leaders to promote community empowerment and enhance a sense of ownership and accountability.

SAfAIDS also utilised social mass media and a wide range of IEC materials, along with community outreach to influence behaviour change. In this work, SAfAIDS drew upon social behaviour change communication (SBCC) techniques which involved conducting baseline researches to determine the key issues, and collectively proposing and determining appropriate messages for change as well as appropriate mediums/channels of communication such as the combination of mass media, social media print, radio and television, SMS (short message service) and web-based media communication and targeting.

At the regional level, advocacy involved collaboration in forums such as RAANGO to create common understandings among members and define common regional positions on its priority areas (Box 9.1), as well as support others in their own endeavours in engaging with SADC, the UNAIDS PCB (and other UN agencies), the AU, donors and other regional

players critical in the framing of the regional policies relating to SRHR, HIV, TB and malaria responses.

9.3.6.2 Technical Support

SAfAIDS provided technical support to its partners in a number of areas including organisational development (OD), capacity strengthening and programme support in various areas. OD was offerred to smaller marginalised organisations "to support them to prevent shutdown, to help them manage their resources transparently and be able to deliver on their programmatic mandate" (KII, 05-08-2016). Capacity strengthening, mentoring and programme support were also offered to those of its implementing partners which were already established but needed support in selected area such as skills in advocacy, community mobilisation, documentation and the production of information, education and communication (IEC) materials, as well as individual leadership skills.

As part of technical support, the organisation therefore developed and distributed information and education (IEC) materials to support capacity strengthening for policy advocacy and social behaviour change communication. All IEC materials were targeted and developed in response to specific community issues identified through community mapping and baseline studies (KII, 05-08-2016). The RNGO also offered training in social behaviour change communication (SBCC) and the production of IEC materials. In this way, the organisation did not only work directly with communities or community-based organisations to effect behavioural change to support the HIV response, but reached wider audiences at various levels: community, national, regional and international.

At the individual level, the organisation offered skills development in leadership among young people, for whom it had established a leadership academy on SRHR and HIV and SBCC. Similar training was offered to political, traditional and religious leaders as potentials champions of the SRHR response (KII, 05-08-2016). Much of this work occurred at the country level and sometimes directly in communities where SAfAIDS collaborated with its partner organisations, including FBOs, CBOs, and networks of PLHIV, to build the capacity of local leadership, communities and activists in interventions that influenced both practice and policy (http//:www.safaids.net, 17-8-2016).

9.3.6.3 Sub-granting

SAfAIDS sub-granting was an important aspect directly linked to programme delivery. The organisation sub-granted to its implementing partners to enable them to roll out programmes

for which SAfAIDS sub-contracted them to implement. According to the DED (KII, 05-08-2016), varying amounts were provided depending on the size and nature of the project for which the partner was supported. There was a "direct link between technical support, sub-granting and project roll out, and hence sub-grants were tied to specific programmatic results areas" (KII, 05-08-2016). Therefore every SAfAIDS implementing partner received financial support that was tied to a project, and for which each accouted to SAfAIDS.

9.3.6.4 Knowledge Management and Documentation of Good Practices

As an information and communication specialist organisation, SAfAIDS was involved in research, documentation nd communication of best practices in the HIV and TB responses. The organisation was recognised and endorsed by the SADC Secretariat since 2007 as the experts in the documentation of best practices and policy analysis. In this work, the organisation has worked with the SADC, UN agencies and a wide range of other partners, some of whom have utilised its services (KII, 05-08-2016). The documentation and communication of best practices and gaps in the HIV, SRHR and TB policies and responses contributed to regional advocacy as these provided evidence of the approaches that worked which could be rolled out at different population scales in the region.

On its website (www.safaids.net/programme_view/2877, accessed 17-8-2016), SAfAIDS stated that the organisation **"**produces and packages a range of information resource tools and materials and communications targeting organisations to strengthen their capacity to communicate HIV and SRHR information." In doing so, this included supporting operational research and documenting evidence in support of policy advocacy and practices among its implementing partners. In this regard, SAfAIDS also had to maintain resource centres (physical and web-based), and manage a series of e-fora and websites to strengthen knowledge exchange and evidence collection in support of good practices. Through its knowledge management tools, the organisation influenced and strengthened a variety of programme implementers and managers who utilised evidence and best practices in designing their own HIV and SRHR programmes within the region, at the country and regional levels.

9.3.7 Embeddedness

Like REPSSI and DHAT, SAfAIDS' entrenchment resulted from the extent of its direct reach at the country level which extended to communities and families. In this way, the organisation developed very direct relations with communities like community-based organisations over and above playing a facilitative role at the country level. Its involvement

with communities led them to engage with local government, traditional and religious authorities. This provided the organisation opportunities to engage national authorities on first hand experiences which was impossible for those operating through intermediaries. Also it meant that the organisation conformed with local NGO regulations as national level NGOs do, as well as complying with national frameworks and delivering on national strategies.

However, the SAfAIDS applied the principle of essentiality and regarded its country level operations as ground clearing for the establishment of national structures to enhance its work through lesson learning and sharing amongst all its partners in the region. Further, the RNGO enmeshed itself in relations with the UN system, the donors and their funding frameworks, the SADC, AU and peer RNGOs, all of which constituted an influential context in the operations of the organisation as was the case with other RNGOs.

9.3.8 Accountability

Although SAfAIDS operated further down at the community level, this did not impose any variation to its accountability. Accountability remained a mechanism for ensuring that donors remained satisfied with the manner in which their funds were utilised and that funded programmes contributed to their objectives. In this sense, accountability remained restricted to the production of financial and programmatic reports to donors, its Board and other relevant authorities as was legally required or morally and politically correct.

Like in all cases of RNGOs, there was no evidence of accountability towards beneficiaries beyond programme planning and service delivery. The DED stated that there were no mechanisms to account to beneficiaries beyond programme delivery as planned because "civil society organisations do not have control over the sustainability of programmes: when donors pull out, CSOs 'leave communities hanging high and dry'" (KII, 05-08-2016). This is a consistent message in all case examples which demonstrates how vulnerable CSOs and their beneficiaries could be as a result of dependence on foreign funding.

9.4 Conclusion

This chapter presented specialised technical support case examples, namely, REPSSI and SAfAIDS. These organisations fall into the second sub-category of the other serving RNGOs. In other words, these RNGOs' work was intended to serve other organisations rather than their members, and they provided specialised services. REPSSI provided psycho-social

support (PSS) services and SAfAIDS provided information and advocacy support services as primary mandates.

The RNGOs displayed a number of similarities and slight variations. Both organisations had regional and national focuses and delivered programmes to community beneficiaries directly or through intermediary partner NGOs. But, as with all the other RNGOs, such work was performed under a single harmonised and centrally controlled regional strategy. For them, like in other cases, this was one of the main defining elements of operating regionally and *being regional*.

Both REPSSI and SAfAIDS justified country level work as necessary to establish viable local structures and to create a critical mass that can drive the national agenda in their specific areas of work, and feed into the regional level. For REPSSI, the dividing line between regional and country work was blurred. In this sense, RNGOs can plan regionally but the actual work, such as delivering PSS, occurred at the national level in communities. Similarly for SAfAIDS, direct community engagement, especially the door-to-door campaigns for community mobilisation, had a greater local orientation than regional character. The only way both organisations turned local activities into relevant regional level work was through learning for sharing with the wider regional community. For them, conceptually, their local programmes were designed to respond to region-wide challenges. Thus, both organisations rolled out coordinated local level activities as part of the regional response, and draw from them regional advocacy issues.

Both RNGOs defined a region as economic communities such as SADC and EAC, and on the basis of a common externality like HIV. Both RNGOs viewed eastern and southern Africa as a region defined by the common characteristic of the HIV epidemic. Further, they also viewed *being regional* as inclusive of country level operations to the extent that such operations were geared towards resolving a regional concern. These views accounted for the reach of the organisations and the nature of their operation leading to complex networks of social relations that spanned from the community and country up to the regional and international levels. Local level operations submerged them in country level accountability, more so with national authorities than with their community beneficiaries. However, with both implementing and strategic partners, the accountability mechanisms were similar to other cases.

Against a background of all these empirical illustrative examples (chapters 6 to 9), and the general theoretical frameworks that guide this analysis, the next and final chapter provides a synthesis of the entire thesis forcussing particularly on framing RNGOs, their

structuring, character of agency, and the definition of being regional and its practice. The analysis attempts to provide an initial effort towards developing a theory of RNGOs and being regional.

CHAPTER TEN: UNDERSTANDING REGIONAL NON-GOVERNMENTAL ORGANISATIONS, EMBEDDEDNESS, ACCOUNTABILITY AND BEING REGIONAL

10.1 Introduction

This thesis has offered an empirically based conceptualisation of regional non-governmental organisations (RNGOs) and *being regional* based on practical and theoretical perspectives. This has been achieved through a combination of social analytical tools within social systems, institutional and network theoretical frameworks. The key arguments consistently advanced are that RNGOs can be best understood as institutionalised social systems that exist in webs of social networks, as nodes coupled to other network components. These network components are also institutionalised and create a facilitative as well as constraining force on the behaviour of RNGOs relative to the entire network system, but also in relation to specific institutionalised centres of influence constituting the network system such as donors. This chapter synthesises the key supporting evidence establishing a case for theorising RNGOs and *being regional*. It however acknowledges that this field is still new to sociological analysis and requires further research before a more dependable theory of RNGOs and *being regional* can be tendered. In other words, this work is presented as an initial but relevant academic input towards that process, as there is need for additional independent academic investigation of RNGOs in other development fields.

10.2 Conceptualisation of RNGOs

RNGOs emerged in SADC as a result of a number of factors that included the need for representation at the supranational level for policy influence, coordination, maximising on economies of scale, the regional character of the HIV epidemic in southern Africa, and its key drivers that were region-wide common negative externalities. As a social phenomenon, RNGOs are a recent development emerging in the HIV field only in the early 1990s, a period in the HIV response when there was an acknowledgement of the HIV pandemic as a devastating epidemic needing multi-frontal interventions. As a result and as noted in the case examples, the first RNGOs were established at the beginning of the 1990s with others emerging later (see Table 10.1).

Their emergence occurred at a point in the development of the HIV response when there was a huge demand for representation and voice at the regional level, but also the need

for technical support services for lower (national and community) level civil society organisations.

Table 10.1: RNGO Establishment and Focus Areas

RNGO	Establishment	Area of focus
ACA/RATN	1992	Capacity strengthening of health personnel in under-served areas in the response to HIV and AIDS – expanded to include all areas of health and other forms of institutional support
ARASA	2002	Advocacy for and mainstreaming human rights into the HIV and TB responses
DHAT	2006	Representation and mainstreaming needs of people with disabilities into the HIV and AIDS responses at regional and country levels
NAPSAR+	2007	Representation and Mainstreaming needs of people living with HIV and AIDS into the regional HIV responses
RAANGO	2009	Platform for HIV RNGOs for affect
REPSSI	2003	Mainstreaming psycho-social support for children and youth into the HIV response
SAfAIDS	1993	HIV, TB, Malaria, gender, youth and SRHR information dissemination and advocacy
SAT	1990	Institutional capacity strengthening – initially community HIV competence – now emphasis on SRHR – women, girls and youth

Source: KII Data, Own compilation.

The quest for such representation was occasioned by HIV-related stigma, gender-based inequalities and discrimination that required legal and policy interventions to address these socio-cultural challenges; further, by international standards, these issues involved the violation of human rights of people living with HIV (PLHIV) in relation to access to health services, social and economic opportunities.

The emergence of RNGOs was incubated by liberalism that privileged the role of civil society over state bodies, especially in supporting community-level development programme delivery. Thus RNGOs were born in the comfort of lucrative financial support especially in the 1990s and the early 2000s, either established by bilateral donors (such as SAT, REPSSI, and ACA/RATN) or with the backing of donors (NAPSAR+, DHAT, ARASA, and RAANGO) as earlier noted. This thesis makes a case for conceptualising RNGOs as social systems, institutions and social networks (see chapter two), and attempts to demonstrate how this is linked to the regionalisation process (chapter four) including the practices and utility of RNGOs (Chapters five to nine). Key analytical points, based on the empirical evidence from the case examples, are presented in this section.

10.2.1 RNGOs as Social Systems

In all case examples, RNGOs emerged as social systems. An intra-organisational analysis of each RNGO revealed that they each comprised of people occupying hierarchical structures and functional positions: board members and, within that, members of different committees; and a secretariat within which there are various organisational staff and functional groupings, including management and programmes personnel. In addition, these structures were governed by a system of formal and informal rules that related to organisational membership, roles and relations, all oriented towards the vision, mission and goal of the organisation. Externally, they exist as components of a broader social system inclusive of the UN health system, donor funding structures, regulating authorities, other regional and international bodies, and the communities they support.

By their very character, RNGOs are open social systems to the extent that they interacted with their external environments from which they drew inputs (human resources, funding, and other forms of support), and to which they delivered services, products and influenced the entire HIV response. They interacted with regulating authorities – nationally, regionally and globally; sources of their organisational inputs – donors and communities in particular; 'markets' for their goods and services – other civil society organisations that utilised their services; and with ideas and frameworks that shaped their roles and how they expressed their agency in development. Within larger systems (communities, countries, regions such as SADC, and globally), RNGOs express their agency to effect developmental change, positively (when they facilitate the ratification and domestication of human rights laws to protect the public) or negatively (when they leave communities without funding in the middle of a project for lack of funding).

10.2.2 RNGOs as Institutional Forms and Network Nodes

All the RNGOs in this analysis, except RAANGO whose establishment was yet to be completed, were formally constituted entities that had a vision, mission, goal/s and the means to achieve the goal/s rooted in the organisations' rule systems relating to membership, structural positioning, functions and resources – material, human and financial. These elements endowed RNGOs with social agency in the HIV response, enabling them to connect with either lower or higher level institutional arrangements – the national and global governance of the HIV response.

As we noted, global HIV governance structures include major sub-institutional categories: the non-state and not-for-profit distribution, the non-state for-profit (including

donors) and the state structures that span from the national governments, to regional governmental bodies and the UN system of development. In other words, much as RNGOs were constituted under their own rule systems that facilitated and constrained intra- and inter-institutional behaviour from their point of view, they were likewise constituted as components of larger institutional arrangements and performed functions that were relevant to their own organisational demands, other sub-institutions and the wider institutionalised HIV response.

All RNGOs existed in a complex hierarchical system of social networks of development agents in the areas of their work or fields, as well as networking with the communities where they drew inputs and delivered services. As components of institutionalised systems of networks, they were linked to regulating authorities at different levels: global, regional and country. The character of the interfacing with these authorities varied with the nature of RNGOs' activities as the case examples illustrate.

Global level involvement was limited for most RNGOs except for those that had working relations with UN special commissions (REPSSI, ARASA and DHAT). Such RNGOs, in return, brought back to their constituencies and partners at the regional and country levels international frameworks and updates on HIV responses in their specific areas of work. All RNGOs were involved in international civil society conferencing and consultations at foras such as the International Conference on HIV for Civil Society Organisation (ICASO) and, at the regional level, they all participated in the UNAIDS regional and PCB meetings on a consultative basis.

Although RNGOs were regional level players, there were neither regional controlling authorities nor registration requirements at that level. Relations with regional governmental bodies such as SADC were based on MoUs related to service on special panels and committees of the body. SADC exercised its influence on RNGOs through its regional frameworks applicable to the areas of their operations. Organisational registration and hence control occurred where the RNGO had offices – the country level. Although this is an interesting theme to explore and thereby establish what benefits and disadvantages it could yield to RNGOs, SADC and other players, it was not explored further in this analysis.

RNGOs could freely and voluntarily affiliate to SADC through the SADC Forum and the SADC specialised committees. In fact, each of the RNGOs had a relationship with SADC (in one form or the other) and were influenced by the regional body's HIV and other frameworks that shape the HIV response in the region. RNGOs' interests in SADC were based on the assumption that SADC had the moral clout to influence regional policies and practices, as it was the only body that could mobilise and influence national governments and

generate consensus on the fomulation of regional policies on a variety of development matters including HIV and AIDS.

RNGOs also nurtured relations among themselves. In this study, RAANGO membership was a common denominator for the RNGOs and a platform for presenting a common and co-ordinated voice to regional bodies such as SADC, the UNAIDS regional team, and various regional donor consortiums in relation to key issues, funding and the nature of the HIV response. In other words, while individual RNGOs had bilateral relations with these regional bodies, RAANGO consolidated its member-RNGOs inputs to influence regional HIV policy and procedures related to specific areas of intervention: prevention, key populations, women, youth and sexual reproductive health and right (SRHR) for example.

At the lower national level, the level and nature of RNGO involvement with regulating authorities depended on whether or not an RNGO had country and/or community level programmatic activities, which extended the national level interface to community levels. At this level, links with the authorities occurred in planning and programme delivery, organisational registration, and applicable reporting and accounting procedures. There was thus more significant interfacing between national authorities and RNGOs that had country and community level activities (e.g. REPSSI, DHAT, SAfAIDS, SAT), than there was between national authorities and RNGOs that did not deal directly with country level work (e.g. ARASA, NAPSAR+, ACA/RATN, RAANGO). Interactions between national governments and these RNGOs was limited to fulfilling statutory obligations related to registration, reporting as well as compliance with fiduciary related matters applicable in each case.

At the country level, RNGOs inevitably interfaced with their beneficiaries to whom they connected through programmatic contracts. In the case of NAPSAR+ and to some extent DHAT, it was constitutionally mandatory to interact and account through relevant organisational structures such as the national networks, the Delegates Conference (in the case of NAPSAR+) and the Board of Directors. In addition, all RNGOs that had country level operations inevitably linked with peers (in the same field) at national level and sought their cooperation as well as supported them to strengthen the HIV response at that level.

10.2.3 RNGO Internal Organisational Structuring and Institutionalisation

Characteristically, all sampled RNGOs were formally constituted with formal hierarchical layers of relevant and targeted units/departments (e.g. programmes, monitoring and evaluation, management and finance, communication and advocacy) and, within them,

positions tied to organisational functionality (such as department head/manager, and programme coordinator/officer). Combined, these were designed to contribute to fulfilling the vision, mission and goals of the organisations. These structures were coordinated by goal orientation – with unit-specific goals set to direct unit contributions toward the RNGOs' main goals, which in turn supported their organisational mission and ultimately the realisation of their vision.

Around this was constructed rule systems that included individual employment contracts for its members. These defined conditions of employment – skills level; personal attributes such as honesty and team-player; level and duration of employment; and general conduct). As well, they outlined job descriptions and performance frameworks or standards – defining job specific expectations and performance levels as well as relational matters regarding other employees, power, authority and reporting structures). Like in all formally constituted organisations, rule systems of RNGOs analysed in this thesis were all constructed around organisational mandates, visions, missions and programme modalities regardless of individual RNGO structure, size and level of regional coverage and involvement. However, each RNGO presented typological characteristics that allow a categorisation as discussed below.

10.3 Typological Presentation of RNGOs

NGO role-analysis as noted earlier located the studied RNGOs into two main categories, viz., *member-serving* and *other-serving*. Within each category is located two sub-categories, that is, *advocacy* and *service delivery* depending on the nature and selected organisational niche. Though RNGOs typify this pattern, the presentations in chapters six to nine show the need for further classification. The case examples illustrate that the two roles co-existed as major and minor depending on the priorities of the organisation; but neither is usually totally absent. This thesis in fact demonstrates that RNGOs usually perform them concurrently but at different levels. I present key observations regarding the main categories (member-serving and other-serving) as well as the advocacy and service delivery sub-groups in each category.

10.3.1 Member-serving RNGOs

Member-serving RNGOs were those organisations formed by a certain social group or community to service their needs: women, youth, men, sex worker, gay or lesbian organisations formed by them to address matters of concern among themselves. In this thesis, four member-serving RNGOs are analysed: RAANGO (directors of regional NGOs), DHAT

(people with disabilities), ARASA (organisations involved in human rights programming for the HIV response), and NAPSAR+ (people living with HIV and AIDS).

Characteristically these were membership organisations mostly based on free affiliation. ARASA was formed to serve affiliate NGOs at both regional and national levels. Each ARASA affiliate became a member entitled to all privileges including actively determining ARASA's programmes and policies. However, these organisations did not necessarily need to be law firms or legally inclined organisations, but HIV NGOs that required legal knowledge relevant in their area of work. These could be women, youth or LGBTI organisations interested in knowing and tackling legal challenges that impact on their areas of work and therefore they need to mainstream rights issues to facilitate the effective delivery of their programmes.

DHAT was formed to represent and advocate for the rights and privileges of people with disabilities in socio-economic spheres of life. but particularly in the response to HIV and AIDS at the national and regional levels. Its members were national federations of disabled people's organisations (DPOs) and, through the DPOs, community groups of people with disabilities, thereby creating a hierarchical network of representation at the top of which sat DHAT as a regional voice of people with disabilities. DHAT members, through the national networks' representation on the DHAT Board, determined the strategy, policy direction and programmatic focus of the organisation. Like ARASA, membership was by affiliation, but only of organisations and networks of people living with disabilities. In other words, as an RNGO, DHAT was a disability people's organisation, formed by, for and serving the interests of people with disabilities as a primary mandate.

NAPSAR+ was formed and governed by its members' national network organisations through a Delegates Conference and Board of Directors that oversaw the work of its Secretariat in implementing programmes to support its members. Like DHAT, its membership comprised national networks of people living with HIV (PLHIV) that, ideally, should include all national level PLHIV organisations within any particular country in SADC, and at different levels (provincial, district down to community level). However, such a unified representation was yet to be achieved as not all national level PLHIV organisations were affiliated to the national networks. Like DHAT, NAPSAR+ was created for and to serve the interests of a specific constituency.

RAANGO was a markedly different organisation, constituted as a forum for Executive Directors of RNGOs participating in the southern African HIV and AIDS response. Its membership comprised organisational proxies – Executive Directors (EDs) of RNGOs or

whoever it was that occupied the highest office in management. It appeared more like a *Directors' Golf Club*, intended to provide support to peer RNGOs' Directors in dealing with issues that were critical to their organisations' roles in the HIV and AIDS response (addressing governance matters, sharing notes on working modalities in particular programmatic areas, fund raising strategies and donor and programmatic intelligence, and so forth). In other words, RAANGO was a platform established for and to service the interests of affiliated EDs as proxies of their respective RNGOs, thus fitting into the member-serving category.

Unlike DHAT, NAPSAR+ and ARASA, RAANGO was far less formal and structurally hierarchical, as it only had one layer of members – the EDs, who had equal rights in determining the vision, mission, goal and activities of the organisation. In addition, the organisation did not run programmes, but organised activities around specific issues. As a result, its institutionalisation was much different from the rest of its peer RNGOs. The secretariat did not have programmatic activities but a coordinating mandate, and served as an executive secretary to the Executive Board of the organisation.

Characteristically, all member-serving RNGOs had a membership to serve and to which they accounted. They worked with these members through their structures from the community to the national level. Through the same structures, they also received their mandate and accounted to their membership, and their membership to them (programme delivery and reporting). They all represented and mediated on behalf of their membership externally to influence other bodies in seeking to maximise benefits to their membership. Representation was accompanied by advocacy to popularise certain approaches and seek changes in practices that militated against the effective roll out of HIV responses.

There were two member-serving advocacy RNGOs; NAPSAR and DHAT. These RNGOs advanced and protected the interests, rights and aspirations of their members with regard to representation on decision-making structures and access to health and particularly HIV services. They advocated for the mainstreaming of members' issues, addressing matters of stigma and discrimination related to the conditions of their members. Such advocacy focussed on legal and policy changes to positively influence institutional and community practices in relation to health and social rights of PLHIV and PWD respectively. In other words, it was targeted advocacy work and specific for facilitating the delivery of service to members.

All RNGOs that were membership-based organisations delivered services to their member NGOs to support their work in HIV service delivery. These thus included ARASA,

DHAT, NAPSAR+ and RAANGO. The services rendered involved organisational and technical programmatic work and capacity strengthening including sub-granting. Their primary mandate was to serve their members' needs even as they could provide similar services to non-member organisations and communities in the HIV response. In this sense, serving other organisations was a subsidiary operation to serving members. Services provided included expert support in such areas as human rights training (ARASA), mainstreaming HIV (NAPSAR+), integrating issues of disability in HIV (DHAT) and regional coordination of HIV programming (RAANGO).

10.3.2 Other-serving NGOs

The other-serving category (ACA, REPSSI, SAfAIDS, SAT) was comprised of RNGOs established to provide services to anyone who needed their assistance in the HIV and AIDS response. They were not defined by the same representational modalities that characterised member-serving RNGOs, even though they supported the rights of PLHIV and popularised certain programmatic approaches in relation to PLHIV. As they were not member-serving, they were structured and operated like business entities, focusing on general service delivery. Their relations with beneficiaries were transactional and were either direct or through intermediary partner local NGOs. Structurally they did not include a membership-type element, and the Board of Directors was skills-based and was meant to support the management and programme portfolios for effective service delivery. The roles of these RNGOs were limited to delivery of relevant services to clients, individuals, groups or organisations, in the private or public sector; for instance, involved in the delivery of services to children and youth in the case of REPSSI, and HIV information services and advocacy in the case of SAfAIDS.

Programmatically, the RNGOs were structured to deliver programmes at different levels (community and national), and advocacy and skills training at regional level. In other words, their operational structures pervaded both the country and regional levels but were in each case driven by a single strategy to underpin the regional character. Institutionally, a regular formal organisational structure characterised all the RNGOs, in each case tailored to deliver services at different levels (programmatically) and the relevant support elements, including the monitoring and evaluation of its work. Within this category, accountability was directed externally to clients, regulating authorities and donors. Internal accountability was between the organisational board and its management.

In the case specifically of other-serving advocacy RNGOs, their campaigns supported the work of other organisations and the HIV response generally, and was not specific to a constituency such as people with disabilities. They contributed to the creation of a favourable environment for the implementation of the HIV response and improvement of the lives of people infected and affected by HIV in the region generally, but not from the perspective of any specific social group.

Some of their work involved information dissemination including the development and distribution of information, education and communication (IEC) materials on various HIV related issues, and the provision of technical support to other NGOs in these areas (which was SAfAIDS' programmatic focus). Others promoted the adoption of specific approaches to HIV programming such as psychosocial support (REPSSI), and various HIV related issues including sexual reproductive health and rights (such at SAT). These RNGOs performed advocacy so as to build the momendum around specific regional issues in the response and not primarily to serve a group of members. However, as earlier noted, organisations like ARASA, although they primarily served their member NGOs, their technical services were extended to other organisations since human rights was a key area in the HIV response.

With specific reference to other-serving service delivery RNGOs and their programmatic focus, they provided goods (IEC materials, food packs, educational support materials, sanitary items) and services (such as technical support – programmatic and organisational capacity strengthening in various areas such as programme design, monitoring and evaluation, a wide range of employee skills, and organisational development including governance matters). These services were offered as support to the work of other NGOs in the HIV response to enable them to operate efficiently and deliver their programmes.

SAfAIDS produced and provided IEC support services and products to both regional and country level players in the HIV and AIDS response, extending directly to communities through community dialogue platforms. REPSSI provided its services similarly, mobilising resources (money for food packs and educational support), developing and distributing psychosocial support (PSS) products such as tools for mainstreaming and delivering PSS services, and offering training in PSS to facilitate the process of mainstreaming PSS. SAT's work included partner programatic capacity enhancement, and sub-granting to strengthen services delivery in various areas at the community level especially in the provision of SRHR services and products for women and girls in the region.

10.4 RNGO Agency

This thesis confirms the significance of context to RNGO agency, and as a directed process. All case examples locate RNGO agency in two main role categories (*member-serving* and *other-serving*) and, within these, either primarily advocating for or providing goods and services, or performing both but at different levels of intensity. First of all, all RNGOs each had a niche in the HIV response (representation, advocacy, capacity development and grant-making) and they all served a purpose which other development agents recognised. In other words, their agency was legitimate to that extent. Secondly, the RNGOs also played their roles to some level of satisfaction for other agents and the beneficiaries of their programmes, to the extent that the others in the HIV response (for example, donors and regulating authorities at all levels) were prepared to support them and approved of their services, and beneficiaries continued to utilise their services. In this sense, the network systems survived because of some measure of symbiosis among the development agents.

Thirdly, RNGOs delivered their services at different levels and, in that regard, assumed a multi-character agency as illustrated in the various typologies earlier discussed. In these contexts, we have also seen those that sought to influence other agents and the entire HIV governance structure and those that provided goods and services – meeting the immediate needs of their community clients. We have also observed how advocacy inclined RNGO agency tends to lean towards supra-national spaces (the regional and the global) and transnational activity (RAANGO, DHAT, NAPSAR+, etc.), while goods and service delivery tended to restrict RNGO agency to country, community, organisational (SAT, ACA/RATN, ARASA, SAfAIDS etc.) and at times individual levels in the case of REPSSI's PSS services and products.

In this regard, although lower (national) level CSOs delivered advocacy, this could only occur at the national level, leaving regional advocacy as one key defining element of RNGOs' regionality – driving policy influence at the regional and global levels. RNGOs' advocacy at the lower levels was intended to facilitate advocacy skills development for beneficiary clientele, as part of coordinated region-wide advocacy skills development programmes. All RNGOs, except RAANGO, offered such training to national level beneficiaries but tailored the training to specific focus areas (ARASA: human rights advocacy; SAT: women, youth and SRHR advocacy; NAPSAR+: positive health, dignity and prevention among others; and REPSSI: popularising PSS).

All RNGO agency was consequent upon basic organisational credentials, as earlier noted, that facilitated participation in the HIV response. They had to be all appropriately

constituted as organisations, and most importantly have clearly articulated visions, missions and goal statements accompanied by relevant institutionalised organisational structures and resources to deliver their mandate. They also had to establish and sustain relations with other development agents in the HIV response. In this regard, RNGO agency was a systematic process that was guided by rationality and reflexivity rooted in the architecture of the entire HIV response. As such, there was deliberate incorporation of monitoring and evaluation mechanisms with regard to both programmatic and institutional processes, and trends noted in the external environment which then fed back into organisational planning and repositioning.

For example, all RNGOs had revised and incorporated into their new strategic plans, the new Sustainable Development Goals (SDG) and particularly the UNAIDS (2015) 90, 90, 90 treatment target to end AIDS by 2030. They also demonstrated how they linked and drew strategic inputs from beneficiaries, partners, national frameworks and regional priorities and followed UN guidelines on the HIV response. In this sense, RNGOs' agency was an active process of seeking, providing and repositioning to sustain relevance, positions and relations, confirming Seckinelg's (2005:357) view that "NGOs and community organizations are brought in (the HIV response) to localize global policies as free agents, although they will frequently represent the global frameworks." This is further reflected in their intermediary positioning.

10.5 RNGOs' Intermediary Positioning

Within the architecture of the HIV response, RNGOs occupied an intermediary position playing a facilitative role of top down and bottom up development communication, information management, fund-raising and resource distribution while also trying to influence these processes. Information management and communication involved the propagation of development ideas, agendas, frameworks and technologies from the global North. It is because of this that NGOs generally and RNGOs specifically are often seen as mere instruments of global capitalism and international donors. However, RNGOs also contribute to the regional and global arenas by providing inputs from lower country and community levels, resulting in the cross-fertilisation of local and global ideas in the HIV response, though this was not an act of balanced reciprocity.

As conduits of technical, financial and material support from the global North to the global South, RNGOs solicited and received development assistance from the predominantly northern donor community, bilateral and/or multilateral. Such funding was channelled along donor development objectives' funding-streams, which facilitated the achievement of donors'

development objectives in the global South. Limited local funding gravitated southern RNGOs towards northern donor funding, thereby facilitating the donor programmes' reach to southern communities. In this regard, RNGOs promoted the implementation of targeted donor development programmes, utilising their knowledge of the local context which donors usually lacked (Eade, 2000). They also facilitated the legitimation and hence acceptability of donor interventions in the HIV response in the global South, even in programming in contentious areas such as key populations about whom southern Africa governments had reservations in providing services. In this sense, RNGOs played facilitative roles as partners in development, though subordinate to their northern 'partners'.

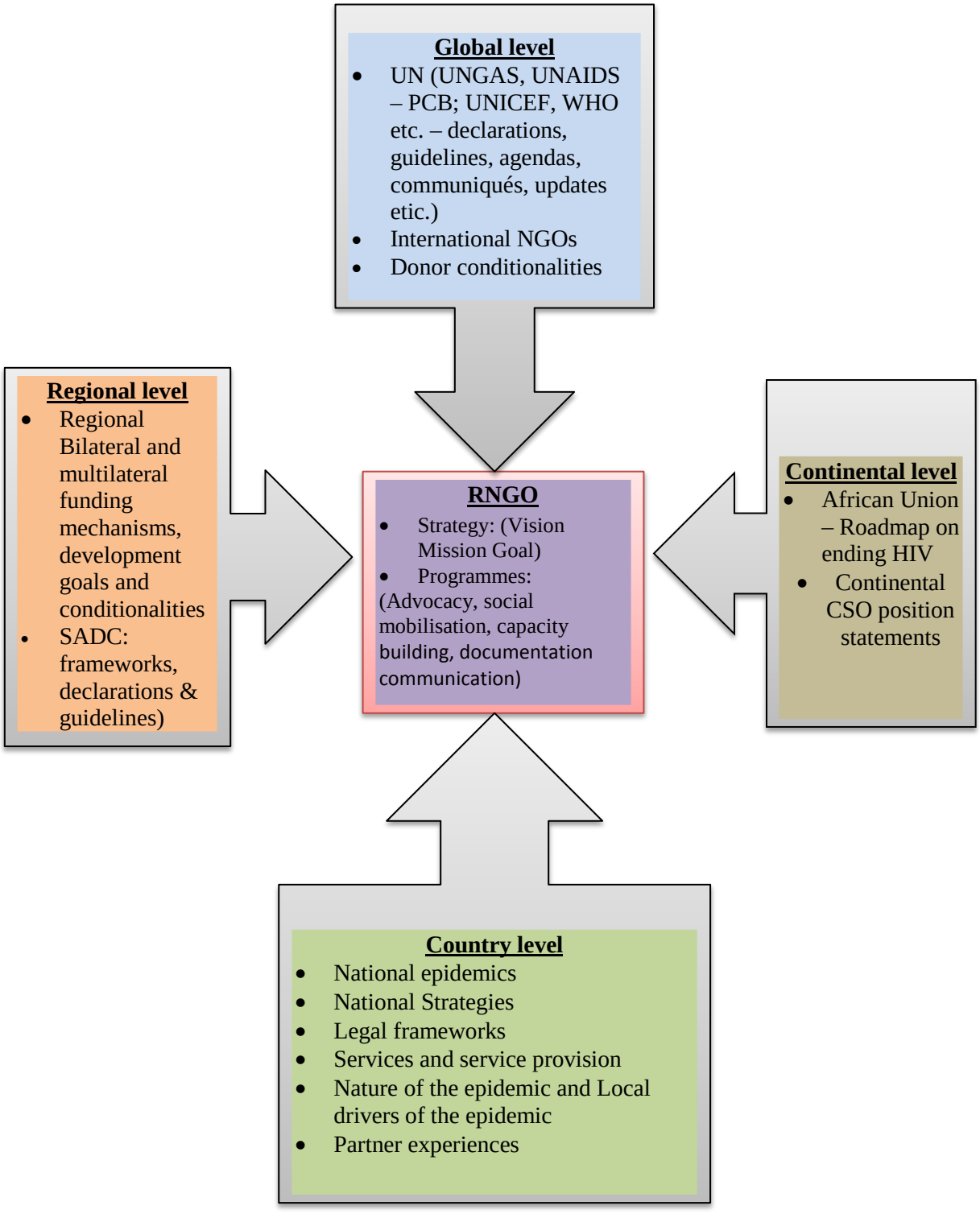
10.6 RNGOs and Partnerships

The term partnership reverberated in all cases of RNGO work, describing a relationship built on mutual understanding, trust and intended for mutual benefit. In all cases, partnership was practiced as an intentional and purposive affiliation initiated to drive specific organisational objectives of the parties involved. As a result, it tended to be a transactional relationship (Majchrzak et al., 2015:1346) that involved exchanging financial and material resources for service delivery and mutual support. The content of the exchange defined the value of the relationship. In all cases, it was a mechanism for reaching organisational goals – a modality in its own right, on which organisational life and programming depended, and facilitating target reach in the HIV programming. In the process, RNGOs became embedded in numerous layered, hierarchical and lateral relations that exerted varying degrees of demands for accountability, all shaping the manner in which they operated and their value to HIV interventions.

10.7 RNGO Embeddedness

This thesis has illustrated that RNGOs existed and worked within contexts of institutionalised networks of social relations located at different social levels and spaces, whereby they existed in symbiotic relationships with other social agents and were programmatically connected to UN agencies, their donors and beneficiaries. As such, contextual elements (UN development agendas, declarations, guidelines, HIV policy influences, institutionalised – bilateral/multilateral – donor development assistance regimes, dynamics of the epidemic, community experiencies and so forth) exerted varying levels of influence on how RNGOs were constituted, structured and operated. Figure 10.1 gives an illustration of the generalised main connections and influences on RNGOs showing the source and content of influence.

Figure 10.1: Key Influences on RNGO Strategy and Programming



Source: Constructed from Key informant interview data sets: (SAfAIDS KII, 05-08-2016); SAT, KII, 08-2016; DHAT KII, 07-2016; NAPSAR+ KII, 12-2015; ARASA KII 08-2016; REPSSI KII, 06-2016; RAANGO KII, 07-2016).

While individual RNGOs were entrenched in social relations with specific institutions in each category, they were further embedded into these networks through exchange processes which ultimately influenced the configuration of their work. Global influence on RNGOs was comprised of a variety of elements, including UN frameworks, and multi-lateral and bilateral donor funding regimes in the HIV response as determined by foreign policies of the donor countries. The specialised technical support UN agencies (in the case of health and HIV – WHO and UNAIDS primarily) also shaped the role of RNGOs in the HIV response.

As the resource providers, donors (mostly of northern origin) exerted great influence on the programmatic targeting and configuration of RNGO work in relation to community challenges. In addition, of course, donors influenced the funding strategies of RNGOs, as the latter needed to align to donor conditions in order to access the funds streamed along specific donor development objects. In this way, the donors determined the issues (regional and national) which RNGOs could address and influenced the selection and calibre of implementing agencies in the response.

Against this background, continental and regional frameworks and HIV governance structures were also influenced to reflect the global UN and donor led responses. This is because, like RNGOs, continental and regional governmental organisations were also recipients of northern donor funding, and were obliged to operate in the context of donors' objectives and the UN-led global HIV response framework. Consequently, continental frameworks were largely extensions of external strategies even though localised to specific continental contexts. In this way, they served to reinforce external responses and operationalised global agendas of key players thus essentially reinforcing the influence of northern inputs into RNGO programming. RNGOs' embeddedness in these intricate development networks and influences had implications on the direction and content of RNGOs' accountability in the HIV response.

10.8 RNGO Accountability

As earlier noted, issues of accountability arose in contexts of social relations. This thesis demonstrates that RNGOs' embeddedness resulted from development partnerships. Partnerships lead to the creation of obligations and expectations, which together create a burden to account. As outlined in chapter two, as social actors, development agents invest in social relations and expect a return (Lin, 1999). As illustrated in earlier chapters, including the four case example chapters, donors invest in NGOs' work and expect them to deliver development programmes. Development programme delivery was a way to account for the

investment; however, more evidence was expected in the form of activity reports, demonstration of expected changes and meticulous financial accounting against work plans. Accountability was thus a way of demonstrating that a development partner had help up its part of the bargain and had taken responsibility to fulfil expectations. As development agents exist in social relations, accountability was thus a mechanism of also taking responsibility for one's actions.

But it seemed that significant accountability occurred more among development partners than between them and their beneficiaries. Beneficiaries could not really determine what to receive, how to receive it and when to receive it, and they had did have any control over programme sustainability. The delivery of development assistance was externally determined and it could be suspended even where beneficiaries felt the need for continuation as the SAT case example illustrates (Mushonga, 2014), and as confirmed by KIIs in this thesis. In this sense, accountability operated in predetermined frameworks which did not necessarily and equally cover all areas and social partners to the extent that it was defined within contractual parameters that were not always all inclusive. This was particularly the case in the relationship between RNGOs and their beneficiaries, and between donors and RNGOs, highlighting again the hierarchical character of the development system in relation to the HIV response.

10.9 RNGOs' Added Value

The significance and contribution of RNGOs to the global and national responses was raised in the initial *being regional* meetings (SAT, 2002) and later in donor evaluative reports (Anamela

et al., 2010). The question has been that, if national level players (government, NACs, national networks, NGOs and so forth) directly address the HIV epidemic in communities, in what way are RNGOs necessary? This thesis demonstrates that RNGOs were valuable in the HIV response to the extent that they: linked the national and the global; co-ordinated responses to regional challenges in the epidemic such as addressing 'touchy' issues including availing health services to sex workers and LGBTI on an equal basis; and addressing common socio-cultural practices that promoted the spread of the epidemic, for example multiple and concurrent sex partners and gender inequality. Also, RNGOs channelled what obtained at the country level through to the global level, and what obtained globally was utilised by RNGOs for the benefit of the national response. In other words, RNGOs were intermediaries for a two-way process of engagement and communication between the global

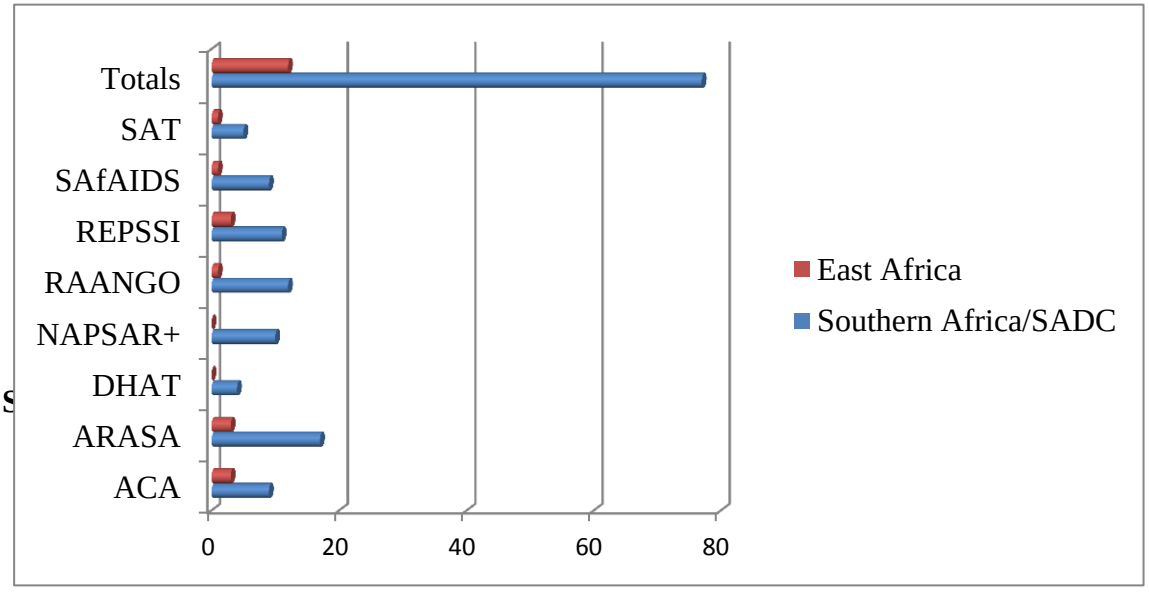
and the national levels – some kind of catalytic convertor that facilitates the exchange of information, technologies and goods, as well as a programme implementer for donors in the response.

The national level (through RNGOs) informed the global level about the nature and character of the epidemic to facilitate the development of appropriate evidence-informed technologies, commodities and programmes requisite for the response. RNGOs were strategically positioned to collect and collate all this input from the national to the global through programmatic reports and researches. They were similarly positioned to acquire and distribute global technical information, financial resources and goods to the national level, directly and indirectly. The following section synthesises the character and extent of RNGO geographical and thematic coverage in their work.

10.10 Geographical and Thematic Coverage

All RNGOs in this thesis focussed their operations on southern Africa, some specified SADC (DHAT and NAPSAR+), a few others extended over to east Africa (SAT, REPSSI, ARASA, SAT), with the more ambitious (ACA/RATN) extending from a regional focus in targeting the entire African continent (Figure 10.2). Regardless of where the work was located, RNGO programmes were characteristically defined as regional by the extent of the geographical coverage and in relation to specific regional externalities.

Figure 10.2: RNGO Geographical Programmatic Coverage



In each of these regions and individual countries, RNGOs sought to address specific HIV-related region-wide externalities. These included issues of human rights in relation to gender, key populations, access to health services and stigma and discrimination, and all in the context of similar and intolerant regional cultural practices and legal frameworks that condoned gender-based violence and the unequal treatment of key populations in accessing health services. As such, RNGO programming was not only geographical but also thematically defined by the regional nature of the challenges. It is in this context that the concept *being regional* was crafted. In this context, the following section offers RNGOs' definitions of being regional and seeks to identify and clarify the key tenets of the concept.

10.11 Being Regional

This thesis demonstrates that the concept *being regional* is difficult to capture in a single word as it denotes a variety of programmatic practices undertaken by RNGOs and accompanying organisational arrangements. In other words, it is the manner in which RNGOs configure themselves and their programmatic operations that constituted *being region* as a development practice. However, the practices varied from one RNGO to another, and each RNGO defined the concept uniquely as Table 10.2 illustrates.

Distinct elements relate to configuring an NGO for operating in more than one country (in a region), and addressing common regional issues under the direction of a common strategy and approach. This entailed representing sub-national and national constituencies at the regional level, advocating for the mainstreaming of their issues in the HIV response, and consequently influencing both regional and country level policies and practices on HIV through bottom-up and top-down exchange processes of information and resources, while also promoting harmonisation and coordination among participants in the response. In this way, RNGOs present being regional as a process of adding value to the response at the regional and country levels. A further analysis of their programme activities reveals more characteristics that further enhance the understanding of *being regional* as discussed below.

- **As distinct from multi-country operation**

RNGO work was characteristically performed in more than one country, across countries, under a single strategy, and involved addressing common regional challenges. The programmes were organised to draw upon and share experiences and lessons among participating countries, and to strengthen the HIV response in the entire region.

Table 10.2: RNGOs' Definitions of Being Regional

RNGO	**Definition of** being regional
ACA/RATN	Not available.
ARASA	'Configuring yourselves as an organisation to operate in a manner that makes it possible to address common challenges in a manner beneficial to all in the region,' (ARASA KII, 05-10-2016).
DHAT	'Bringing issues from the grassroots level to the regional level and back down to grassroots level issues from the region, adding value either way, but matters should have a regional scope, affecting the region and hence better addressed through a unified regional strategy capable of feeding into national level programming,' (KII, 22-06-2016)
NAPSAR+	'To amplify the voices from below at a higher level and taking down to the national level issues that benefit the national level – also taking issues that are common and affect a number of countries and engaging them for the common benefit of the people and countries of the region,' (NAPSAR+ KII, 05-11-2015).
RAANGO	'Operating within this specific geographical location (region) that comprises a collection of states, and working at the supra-national level, endeavouring to influence regional level policies and practices within the HIV and AIDS response to enhance harmonisation and coordination of regional HIV NGO work,' (KII, 05-10-2016).
REPSSI	'Configuring your organisation to adopt a common strategy and approach to address common challenges that occur in the region of your operation,' (KII, 13-06-2016)
SAfAIDS	'Undertaking programming which addresses regional issues – these are issues that are common to those countries in an area defined by common characteristics,' (KII, 05-08-2016).
SAT	'Operating in more than two countries, addressing issues of a regional nature and relevance,' (KII, 03-08-2016).

Source: Interview data.

Hence, the experiences and lessons learnt from country programming were consolidated as input into strengthening the entire regional response through sharing among countries and hence regionally. This was distinguished from multi-country operations that RNGOs define as characteristically individual and separate programmes or projects run by a single agent in several countries as earlier discussed. Multi-country operations were neither unified by a single strategy nor contributed to a unified regional operation that addressed a common region-wide externality, but usually localised challenges. In some cases, RNGO work stradded over two regions thus becoming trans-regional.

- **As trans-regional work**

Four RNGOs (ACA, REPSSI, SAfAIDS, ARASA) worked in both east and southern Africa. Among them, SAfAIDS and REPSSI believed that their work could be defined as both intra- and trans-regional to the extent that east and southern Africa were separate regions; though

they could also be viewed as one region as from the perspective of the Sida-led JFA donors. In this case, RNGO work was trans-regional, straddling two regions but still driven by a single strategy. In this sense, what was trans-regional was RNGOs' operational reach rather than a mark of strategic difference. From this perspective, *being regional* defined work that occurred above the national level including across regions.

- **As a mechanism for regional level representation and advocacy**

RNGOs' work involved significant regional level representation and advocacy. All RNGOs were involved in some form of regional representation and advocacy; either they embraced championing the rights of PLHIV generally or endeavoured to promote and support specific social groups (women, girls, sex workers, PWD and LGBTI) affected by the epidemic. In this process, RNGOs escalated matters affecting these social groups (stigma and discrimination, access to health and other services, and social justice generally) at the national level to regional and at times international levels for consideration and mainstreaming into policy frameworks and the HIV governance processes generally; and thus to ensure that the HIV response was informed by the real issues that affected communities ravaged by the epidemic.

All member-serving RNGOs (especially NAPSAR+ and DHAT) had represention as a primary component of their mandate, making the voices of PLHIV and PWD heard at regional fora such as SADC, and continentally at the AU. They were likewise seeking to extend their influences to the global level through participation at the UNAIDS PCB meeting and other such fora. ARASA, SAfAIDS, REPSSI, RAANGO and SAT did the same, although not as constituency ambassadors. Their work, though, reinforced the demands of PLHIV communities for human rights-based HIV programming, thus facilitating the elimination of hindrances to effective HIV service delivery especially to key populations (PWD, LGBTI, women and girls).

- **As a technical support operation**

The deficiency of country-level NGO capacity in various areas is noted as a key motivation for the emergence of RNGOs. Country level NGOs often lacked organisational and technical capacities to effectively roll out some aspects of their HIV responses such as PSS, advocacy and human rights-based responses, such that these became niche areas for RNGOs such as REPSSI and ARASA. In addition, as many local NGOs were nascent and organisationally weak, it became the role of RNGOs such as SAT to provide institutional capacity strengthening for community HIV and AIDS competence, which was later refocussed on capacity strengthening for SRHR programming. SAfAIDS took the lead in providing IEC

materials and training to support advocacy work, and RAANGO assumed the coordinative role among the RNGOs in enhancing certain dimensions of economies of scale.

- **As implementing agencies**

Individually and collectively, RNGOs' services supported the local response at the country level and paved the way for the smooth operation of donors, the UN and similar agencies in the response. The UN and donors' focus on interaction with specific population segments at the regional and country levels was implemented and achieved through RNGOs; for example: PWD through DHAT; PLHIV though NAPSAR+; PSS through REPSSI; human rights through ARASA; capacity strengthening through ACA and SAT; and information, education and communication materials for advocacy through SAfAIDS.

- **As community services provider**

With some RNGOs, the implementing role extended to the community level, reaching groups and individuals. Although neither donors nor RNGOs strictly considered country level work as regional programming, some of the RNGOs discussed in this thesis provided community-level services. These were in circumstances where there was need to work directly with local level implementers, mentors and at times beneficiaries in the direct delivery of services. SAfAIDS, REPSSI, ACA and SAT directly or through community groups and structures provided services to communities and individuals, bringing into question the exact content of regional work in the context of the principles of supremacy and subsidiarity. However, these RNGOs argued that their country level activities still constituted regional programming as these activities were intended to initiate national level work that could contribute to the region-wide response. More specifically, such work was deemed necessary to the extent that it was part of community and national mentorship that initiated a coordinated region-wide intervention permissable under the principle of essentiality.

- **As a globalised regionalisation process**

RNGOs found themselves in an unenviable and contradictory position where they had to promote regional integration but, by virtue of their location in the global capitalist economy (especially their heavy dependence on donor funding from the global North), were simultaneously compelled or obliged to pursue funded agendas that were at times inconsistent with regional or national perceptions of areas where they work. Specific contentious issues arose from HIV programming for sex workers, prisoners and LGBTI, which remain contentious in the context of ongoing contested legal and cultural practices in southern

Africa. In this sense, *being regional* was an act of balancing between pushing international programmes and agendas on the one hand, and ensuring – on the other hand – that intra-regional concerns were considered and understood in context, and thereby informed the entire HIV response.

Through RNGOs, the gaps (in HIV information, knowledge, technologies, products and facilities) between the national and the global levels was increasingly becoming narrower as RNGOs provided the necessary links and coordination of information and resource flows. In doing so, RNGOs supported and operated within UN (UNAIDS, WHO) frameworks that provided technical support at the national level in the global HIV response.

RNGOs' regional efforts also facilitated intra-regional coordination of the HIV response creating common understandings, ownership of the response, and solidarity and cooperation among inter- and intra-regional players. In this way, they promoted regional integration and cooperation. However, such regional integration and cooperation, to the extent that it is informed by external frameworks and funded on the basis of donors' own development objectives, is in effect a globalised regional integration in terms of its character and content. In this sense, *being regional* seems to denote a form of 'double' agency in the HIV response beneficial to global and country level processes.

- **As organisational configuration**

In addition to operational components, *being regional* involved organisational and structural configurations, ones which were suitable for delivering a contextualised regional response through the incorporation of relevant governance and administrative components. Whether member- or other-serving, RNGO governance structures required representation of key stakeholders – representatives of specific key groups to contextualise the work of the RNGOs, and diverse technical experts relevant to the mandate of each RNGO. For nearly all of the RNGOs, this involved designing formalised structures that comprised a regional coordinating and administrative entity (the secretariat) responsible for and capable of developing a regional strategy and programmes, mobilising both implementing and strategic partners, fund-raising, deploying regional programmes, providing technical support, monitoring and evaluation of the regional programmes and accounting to stakeholders. Country offices comprised strategic extensions of the RNGOs to facilitate better reach and support implementing partners – communities where this was necessary. This configuration characterised *being regional* and gave effect to the performance of defined regional activities. To this extent, *being regional* can be understood as both a state of existence and practice.

10.12 Conclusion

This chapter has drawn together the main elements of the thesis to answer the key questions regarding the emergence, form, operations and role of RNGOs. A link between regionalisation and RNGOs has been established in the context of transnational operations of both state and non-state actors with a centralised hub in the UN global governance structure as supported by the global North donor community. Such a system has been presented as the major embedding context of RNGOs, and being influential in conditioning the roles and functions of RNGOs as development agents in the global South. The chapter has also provided an empirically-based conceptualisation of the concept *being regional* as a multi-faceted organisational trait and process of RNGO configuration and programming, as informed by both hierarchical and lateral social relations, and by the dynamics of the power relations between the global North and South (which formS the context of RNGO operations). The value of RNGOs and hence *being regional* has been demonstrated to lie in the intermediary positioning and role of RNGOs as facilitators of both country and global level HIV programming among various development agents (the UN system, the donor community, regional governmental organisations, national governments and other country-level stakeholders in the HIV response).

In the end, this thesis has not sought to offer a fully-formed theoretical understanding of RNGOs and of *being regional*. Rather, given the still early stage in the analysis of RNGOs, it has provided a tentative attempt at theorising about RNGOs and *being regional*. Hopefully, it has given signficant analytical direction for future research and study of RNGOs, whether in relation to HIV and AIDS or other development issues. Although ubiquitous literature exists on NGOs, work on RNGOs and *being regional* remains relatively limited as the concepts are new and need further analyses including beyond the field of HIV.

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APPENDICES

Appendix 1 List of Key Informants and Interview Dates

ARASA:		Deputy Director,	KII, 05-10-2016
DHAT:		Executive Director,	KII, 23-06-2016
NAPSAR+:		Executive Director,	KII, 05-11-2015
RAANGO		SAfAIDS DED	KII, 05-08-2016
REPSSI:		Financial Advisor	KII, 13-06-2016
SAfAIDS:		Deputy Director,	KII, 05-08-2016
SAT:		Chief Operations Officer,	KII, 03-08-2016
UNAIDS		Advisor: Community Mobilisation	KII, 28-10-2015
HIVOS:	i.	Executive Director	KII,02-08- 2016
HIVOS	ii	Key Populations PO	KII 01-08- 2016

Appendix 2. Schedules of Questions for Key Informant Interviews

2.1 RNGO interview questions

A. About respondent

1. Please explain who you are (designation) and
2. What you do in (oranisational name)

B. About (oranisational name)

1. Basic information

Could you please explain:

i. What (oranisational name) is
ii. What you do
iii. Where your work happens

2. Organisational embeddedness and programming

Could you please explain:

i. How your work is organised

a. Structure?
b. Who you work with
c. How you work with them

ii. Who and what informs your programmes

a. Strategy (who contributes and whose voice is most dominant and why)
b. Programme content (who contributes and whose voice is most dominant and why)

3. Accountability

Could you please explain:

a. To whom you account for your work
b. What do you account for
c. How you account for your work (list of those you account to and what you do to account).
d. Which stakeholders demand the most of your work on accountability (rank and explain?)

C. Regional level work

1. Understanding the region and regional work (being regional)

From (oranisational name) perspective and from your experience working at the regional level with organisations in the HIV response:

i. What is your definition of a region?
ii. What does working at the regional level involve (what you do)?

iii. What do you think regional work should involve (what you expect)?

iv. Are there any rules/guidelines that help you define what constitute regional work as opposed to work at other levels?

v. What separates regional work from work at other levels?

vi. How do you compare and contrast regional against multi-country work?

vii. What are the similarities and/or differences between regional and multi-country programming?

2. (oranisational name) **and other regional and international players**

i. How does (oranisational name) relate with SADC?

ii How does (oranisational name) link and work with other regional NGOs?

iii How does (oranisational name) link with global civil society structure? - Specify the structures.

iv. What is (oranisational name)'s input in that process (Specify by structure and input)?

3. Any reference documents

I would appreciate the supply of any documents and/or reference to any accessible documentation that would help augment your input.

Thank you.

2.2 UNAIDS Interview Questions

1. What is UNAIDS?

2. How does the organisation operate?

3. How does it work with NGOs at the regional level?

4. How do you describe regional work?

5. Why is it important to work regionally?

6. **Reference/ documents**

I would appreciate the supply of any documents and/or reference to any accessible documentation that would help augment your input.

Thank you.

2.3 HIVOS Interview 1 Questions:

A. About respondent

1. Please explain who you are (designation) and

2. What you do in HIVOS (role)

B. About HIVOS

1. Basic information

Could you please explain:

i. What HIVOS is

ii. What you do

iii. Where your work happens

2. Embeddedness and programming

Could you please explain:

i. How your work is organised

a. Structure?
b. Who you work with
c. How you work with them

ii. Who and what informs your programmes

a. Strategy (who contributes and whose voice is most dominant and why)
b. Programme content (who contributes and whose voice is most dominant and why)

3. Accountability

Could you please explain:

a. To whom you account for your work
b. What do you account for
c. How you account for your work (list of those you account to and what you do to account).
d. Which stakeholders demand the most of your work on accountability (rank and explain?)

4. documents

I would appreciate the supply of any documents and/or reference to any accessible documentation that would help augment your input.

HIVOS interview 2: Questions - Regional work level

1. Understanding the region and regional work (being regional)

From HIVOS's perspective and from your experience working at the regional level with organisations in the HIV response:

a. What is your definition of a region?
b. What does working at the regional level involve (what you do)?
c. What do you think regional work should involve (what you expect)?
d. Are there any rules/guidelines that help you define what constitutes regional work as opposed to work at other levels?
e. What separates regional work from work at other levels?
f. How do you compare and contrast regional against multi-country work?
g. What are the similarities and/or differences between regional and multi-country programming?

2. HIVOS and other regional and international players

i. How does HIVOS relate with SADC?
ii How does HIVOS link and work with other regional NGOs?
iii How does HIVOS link with global civil society structure? - Specify the structures.
iv. What is HIVOS' input in that process (Specify by structure and input)?

3. Any reference/ documents

I would appreciate the supply of any documents and/or reference to any accessible documentation that would help augment your input.

Thank you.

Appendix 3. Concent Form

Dear ……..

Thank you very much for agreeing to assist with answering some questions for school project. As I explained, I am reading for a PhD student with Rhodes University. I am now conducting field work to collect data for the thesis. I attach herewith a supporting letter from my supervisor Prof. Kirk Helliker of the Department of Sociology at Rhodes University.

May you please sign and send back to me the consent form below, as it will be needed as proof of fieldwork and in compliance with research ethics.

Explanatory note

Thank you for accepting to assist me and answer the accompanying interview questions below. The questions are intended to facilitate the collection of information for a PhD thesis. I will treat your contribution with due confidentially and use it only in a manner consistent with academic requirements and for purposes of this thesis. Participation in this data gathering process is voluntary and consenting respondents are requested to sign the informed agreement below as an indication that they agree to answer the accompanying questions and for their input to be used for academic purposes.

Agreement to offer interview/answer questions

I ..... having read and understood the explanatory note voluntarily offer informed consent to participate and offer answer to the interview questions below. I am aware and agree that the answers I give will be used for purposes of the study as explained. I further agree to assist in case of any follow up needed in this regard.

Organisation:.....
Position:……
Signed: .....
Date:.....
Place:.....

Sincerely

Allan Mushonga

Appendix 4 Supervisor Supporting Letter

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November 25, 2015

To Whom It May Concern

Re: Mr Allan Mushonga

This letter confirms that Mr Allan Mushonga is a PhD student in the Department of Sociology at Rhodes University. I am his supervisor.

His PhD thesis focuses on regional non-governmental organisations and their work around HIV and AIDS in southern Africa. He is currently undertaking his research for the thesis.

Your assistance in this research would be deeply appreciated.

Sincerely

Professor Kirk Helliker
Head of Department