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Sida Decentralised Evaluation

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Review of the Swedish support to the HIV/AIDS programmes in South Africa 2004-2013

Final Report

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The views and interpretations expressed in this report are the authors' and do not necessarily reflect those of the Swedish International Development Cooperation Agency, Sida.

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Abbreviations and Acronyms

ABC	Abstain, Be faithful, Condomise
AC	AIDS Consortium
ADRA	Adventist Development and Relief Agency
AFSA	AIDS Foundation of South Africa
AIDS	Acquired Immune Deficiency Syndrome
ALN	AIDS Legal Network
ALP	AIDS Law Project
ARASA	AIDS Rights Alliance of Southern Africa
ART	Anti-Retroviral Therapy
CADRE	Centre for AIDS Development Research and Evaluation
CBO	Community Based Organisation
CCM	Country Coordinating Mechanism
CD4	Cluster of Differentiation 4 – T-cells or white blood cells/part of the human immune system
CEO	Chief Executive Officer
CEP	Corridor Empowerment Project
CSO	Civil Society Organisation
DFID	Department for International Development, UK
EU	European Union
FBF	FieldBand Foundation
FPD	Foundation for Professional Development
GBV	Gender Based Violence
GPD	Global Policy for Development (Sweden)
HBC	Home Based Care
HCT	HIV Counselling and Testing
HEARD	Health Economics and HIV/AIDS Research Division, UKZN
HIV	Human Immunodeficiency Virus
KZN	KwaZulu Natal
LGBTI	Lesbian, Gay, Bi-sexual, Transgender and Inter-sex
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MIC	Middle Income Country
MMC/MMC	(voluntary) Medical Male Circumcision
MSM	Men who have sex with men
MTCT	Mother to Child Transmission
NAC	National AIDS Council

ABBREVIATIONS AND ACRONYMS

NACOSA	Networking HIV, AIDS Community of South Africa
NBCRFLI	National Bargaining Council for the Road Freight and Logistics Industries
NDoH	National Department of Health
NGO	Non-Governmental Organisation
NSP	National Strategic Plan
ODA	Overseas Development Aid
OMC	One Man Can Campaign
OVC	Orphans and Vulnerable Children
PDC	Partner Driven Cooperation
PEPFAR	President's Emergency Plan for Aids Relief
PHC	Primary Health Care
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
RFSU	Riksförbundet För Sexuell Upplysning (Swedish organisation for sexual enlightenment)
SA	South Africa
SABCOHA	South African Business Coalition on HIV and AIDS
SADC	Southern African Development Community
SANAC	South African National Aids Council
SANDF	South African National Defence Force (
SAPS	South African Police Service
SAT	Southern African AIDS Trust
SEK	Swedish Kroner
Sida	Swedish International Development Cooperation Agency
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STATS SA	Statistics South Africa
STI	Sexually Transmitted Infection
TAC	Treatment Action Campaign
TB	Tuberculosis
UN	United Nations
UNAIDs	United Nations AIDS
UNISA	University of South Africa
USAID	United States Agency for International Development
WAC	World Aids Campaign

Preface

This evaluation was commissioned in the beginning of 2013 by the Embassy of Sweden in South Africa through Sida's framework agreement for reviews and evaluations. Indevelop undertook the assignment between April – September 2013 with a team of four evaluators. The Project Manager at Indevelop for this study, Anna Liljelund Hedqvist, has been responsible for compliance with Indevelop's QA system throughout the process and quality assurance was performed by Ian Christoplos, Project Director for the Framework Agreement.

The independent evaluation team included the following members:

Annika Nilsson, Team Leader
Ingrid Obery, Deputy Team Leader and Evaluator
Tshidi Mohapeloa, Evaluator
Tracey Konstant, Evaluator

Acknowledgements

The evaluation team would like to thank the Swedish Embassy staff, and all of the Swedish-funded organisations who provided information, and much of their time, to ensure that we could build a comprehensive picture of ten years of Swedish support. We held useful discussions with other stakeholders in the Department of Health, among the donor community, as well as various community groups – many thanks to these individuals and groups for the warm welcomes and their open sharing of information and opinions. The support from the Indevelop head office team was also invaluable in ensuring precision and quality – we are indebted. The evaluation team would like to thank the Embassy of Sweden in Pretoria for providing this opportunity for exploration, joint learning and a great analysis process, where the four evaluators became a most cohesive team.

Executive Summary

Background

This evaluation documents the results of the 2004-2013 Swedish support to South African HIV/AIDS programmes and assesses the effectiveness of the methods and approaches used by Sweden and its partners. The evaluation also extracts lessons learnt and makes suggestions to optimise the reach and impact of interventions supported by Sweden after 2013. The evaluation has been carried out in the light of the phasing out of Swedish bilateral development support to South Africa from 2014 and the new forms of partner driven cooperation anticipated.

The conclusions are based on a desk study of annual reports and previous evaluations, an analysis of official statistics, interviews with previous and present Sida and Embassy staff, site visits and interviews with staff and beneficiaries of Swedish partners. In total, 115 persons were met and interviewed.

The review covers two strategy periods: 2004-2008 and 2009-2013. During the first period, Sweden was focused on influencing and supporting the South African government in developing a national policy response to the HIV/AIDS epidemic in order to reduce the number of new infections (prevention) and mitigate the impact of HIV/AIDS on individuals, families and communities (treatment, care and support). During the second strategy period, Sweden focused on strengthening national ownership of the HIV/AIDS responses, using the National Strategic Plans on HIV/AIDS as a point of departure. Swedish support was geared towards prevention, with a specific focus on underlying causes, such as a lack of gender equality and sexual and reproductive health rights. Sweden also supported South Africa's efforts to coordinate national, bilateral and multilateral initiatives. The South African programme was implemented in close cooperation with the Swedish regional HIV/AIDS team in Lusaka.

Findings

The evaluators found that Sweden contributed substantially to the positive policy changes that took place in South Africa, the development of the two National Strategic Plans, the subsequent campaigns for voluntary HIV testing, and the roll out of anti-retroviral therapy (ART). These responses have led to reduced mother-to-child transmission, reduced AIDS-related deaths and an improved quality of life for persons living with HIV/AIDS, who have now access to ART. Presently, 2 million people, out of 6 million infected with HIV, are receiving ART. In 2003, only 8 600 persons were on ART. New infections have slowly begun to decrease. Despite these positive developments, the challenges remain huge. The health system has difficulty delivering on the local level and social causes, which are drivers of the epidemic, remain an obstacle. Young women are most at risk; and prevalence in this group is still around 30%.

The Swedish support to community-based organisations (via AIDS Foundation South Africa) has directly impacted the lives of around 45 000 men and women every year in the Eastern and Northern Cape provinces. They have been empowered to address their situation and access government services. Thanks to Swedish support, the trucking industry has taken responsibility for its employees through mobile wellness centres, which have substantially reduced HIV prevalence and improved the general health of this key population.

Swedish support led to the development of innovative models for prevention, e.g. the combination of methods, involvement of men, addressing gender norms and gender based violence, etc. However, the models have not yet been sufficiently evaluated and shared; there is limited coordination among actors and there are no plans for how these models could be brought to scale. With few exceptions, community-based organisations have yet to engage with issues related to gender norms, gender-based violence and key populations (most infected and at risk groups).

Swedish partners in South Africa have played an important role in regional and global networks and processes. The cooperation between Sweden's South African and regional HIV/AIDS programmes has been very close. However, synergies have not been fully explored. The South African programme has also played an important role in the development of the Swedish global policy and programmes on HIV/AIDS.

Conclusions and way forward

Swedish support played a catalytic role in the policy changes and in developing the South African response to the HIV/AIDS epidemic in the period 2004-2013. There are still challenges, but improvements are notable. There is reduced stigma and people have started to look at HIV as a chronic illness. Many stakeholders have expanded their work beyond treatment and care services and have begun to address a range of underlying causes of the continued spread of HIV.

The success of Swedish support to the HIV/AIDS programmes in South Africa is attributed to:

- The coherent and proactive approach taken by the Embassy, which included the political dialogue with high level officials, the proactive role taken in donor coordination and hosting of the EU+ coordination group, the long-term, flexible core support to strategic partners, the arranging of strategic events and competent and well-connected Embassy staff.
- Risk taking and the forward-looking strategic selection of partners that could channel the voices of men, women and children who are affected, hold the government to account through legal procedures and challenge the underlying causes of high infection rates.

Based on its substantial experience in the fight against HIV/AIDS, South Africa has been able – and can continue – to play an important role in the region. Sweden should continue to partner with South Africa – on government, CSO and research levels – to strengthen regional efforts. To do so, key South African actors must be enabled to continue their important development and advocacy work, which is a basis for such a partnership and experience exchange.

In line with the findings in this evaluation, and the Swedish policy on HIV/AIDS, Sweden and South Africa could continue to build partnerships in the following areas, which are all important and relevant to the development of responses in the region:

- Holding governments to account. Keeping the pressure up, building a critical mass and enhancing national level initiatives.
- Empowering grassroots. Developing models for community-based responses and cooperation with, and monitoring of, local government. Sharing these models and facilitating processes towards bringing them to scale in various contexts.
- Innovation and research.

Sweden's partner, AFSA (AIDS Foundation of South Africa), has the potential to become a local hub, support Sweden's SRHR work as an intermediary in relation to South African actors and contribute to regional level experience exchange on CBO capacity development. The Swedish partners Sonke and FPD (Foundation for Professional Development) are already supported via both AFSA and the Sida Regional HIV & AIDS-Team.

The Bargaining Council is ready to take over full responsibility for their Trucking Wellness programme, managed by CEP, if given a phase-in period. The programme could eventually be fully sustained and serve as a model for other industries (e.g. mining). Success will also require better coordination with the SADC-supported trucking programme (North Star Alliance) to find synergies and avoid duplication. The potential of Zivikele in a regional context is doubtful and needs to be further analysed.

South African efforts could be supported through regional programmes, through carefully selected Partner Driven Cooperation initiatives (e.g. research and industry responses) and through the Special Appropriation for Democracy (e.g. watch dog organisations).

1 Context of the Programme

1.1 THE SOUTH AFRICAN CONTEXT

In the late 1990s to mid-2000s the South African health policy on HIV/AIDS was influenced by ‘denialists’.¹ Resources to the HIV/AIDS response were not forthcoming and there were attempts to silence the voice of civil society as it asserted the rights to HIV treatment, care and support. In 2003 ‘people aged 30-34 were dying in larger numbers than people in their 60s, infant deaths had increased substantially, and there was a ‘very dramatic increase’ in deaths among young women [in this age group] – numbers increased by 93% from 1997 to 2003.’² It was in this context the first Swedish strategy of support to HIV/AIDS programmes in South Africa was developed and implemented.

Although ART was approved by cabinet in 2003, roll-out was virtually stalled until 2007, and by 2006 the country was experiencing 1000 HIV-related deaths per day. The 2006-2007 breakthrough was a result of new leadership and a shift in HIV-related policy and attitudes. Notable among these developments were the National HIV Counselling and Testing (HCT) strategy which aimed to test 15 million people by 2011, and scaled up provision of ART in line with the 2007 National Strategic Plan (NSP) which focussed on treatment, care and support. As will be shown later in the report, Sweden played a catalytic role in this shift of policy. According to official reports³ the following impacts are seen as results of the policy shift (also refer to *Emerging impacts* in Chapter 3):

- Reduced levels of Mother to Child Transmission (MTCT)
- Increase in the number of people tested for HIV
- Increased coverage of ART (2 million out of 6 million infected), reducing AIDS related deaths and increasing quality of life for people living with HIV/AIDS
- Enhanced national political leadership around HIV/AIDS
- Roll-out of the Medical Male Circumcision (MMC) programme
- Strengthening of provider initiated counselling and testing

¹ TAC defines ‘denialism’ as the promotion of one or more of the following pseudo-scientific views: (1) HIV does not cause AIDS, (2) the risks of anti-retrovirals outweigh their benefits and (3) there is not a large AIDS epidemic in sub-Saharan Africa, <http://www.tac.org.za/content/debunking-aids-denialism>.

² Staff Reporter. ‘Achmat: HIV/AIDS is an emergency’ *Mail and Guardian* 21 June 2006

³ South Africa, *Global AIDS Response Progress Report 2012*

However, there are still major challenges such as:

- Slow progress in addressing the social drivers of HIV, particularly widespread poverty and food insecurity, unemployment, poor basic education, endemic gender-based violence, severe patriarchy and gender inequity, multiple concurrent partners particularly among mobile male populations. There are differences between provinces and pockets of good practice, but the overall statistics show that new infection rates are not decreasing much. 30% of pregnant women and 28% of young girls are still infected.
- Limited political will in many provinces, weaknesses in provincial governance and administration, and inefficient, under-resourced and systems-depleted health provision, particularly at local level.
- Limited availability and uptake of female condoms
- Mother to Child transmission has not (yet) been reduced to zero largely due to health-seeking behaviour by pregnant women, and poor public awareness of the importance of early presentation for antenatal care.
- Poor monitoring and evaluation of interventions and programmes.
- Poor multi-sectoral coordination and integrated household-level access.
- HIV and Tuberculosis (TB) co-infection is increasing. South Africa now ranks the third highest in the world in TB, with an incidence that has increased by 400% of the past 15 years⁴. Due to co-infection and poor treatment adherence (among other factors), South Africa has the fourth highest number of multi- and extensively-drug resistant TB (MDR- and XDR-TB) cases globally.⁵

As a consequence, in 2013, 450 000 people will still become newly infected by HIV, most of them young women; stigma is still a big obstacle to testing and treatment, prevention measures are still not effective enough, 180 000 people will die from HIV related illnesses – mostly TB and; most deaths in South Africa are still among people in the 25-44 age group. At the same time, conditions have been created and processes started that are very promising. In 2013, the policy environment actively facilitates prevention, treatment, care and support; the National Department of Health (NDoH) is addressing a wide range of health systems issues as well as HIV-specific issues such as the cost of ART. Much better data are being collected nationally which enables more targeted thinking around responses. The view that HIV is a chronic but treatable condition is slowly percolating through the population. A transformation towards a public health insurance system is launched, which aims at providing all South Africans with affordable, accessible, quality health care. Although it is facing huge challenges in its implementation, it is the first of its kind in Africa.

⁴ South Africa, *Global AIDS Response Progress Report 2012*.

⁵ Figures in this paragraph have been drawn from the SA Health Review 2010 and 2012. NDoH reports at least 14000 cases of MDR.

If successful in its endeavours, SA can play a role as a driving force in health system reform, HIV/AIDS and TB prevention and treatment and sexual and reproductive health (SRHR) issues in Sub-Saharan Africa.

1.2 THE SWEDISH POLICY CONTEXT

Human rights and gender equality have always been central to the Swedish international responses to HIV/AIDS as compared to a more bio-medical approach taken by many other agencies. In the first strategy period (2004-2008), Swedish global and regional HIV/AIDS responses were quite broad. The right to access to treatment and care was emphasised along with efforts to prevent further spreading. A plethora of initiatives and a wide range of approaches were supported. Mainstreaming in all development efforts was promoted.

In the second strategy period (2009-2013), the Swedish responses became more focussed, emphasising prevention and addressing underlying causes such as gender norms and lack of SRHR. The Swedish global policy 'the Right to a Future', adopted in 2008, states that Swedish support to HIV/AIDS should give priority to two areas: prevention and mitigation of long-term effects. Sweden should also use its resources to strengthen research on these subjects. The importance of support to youth and their ability to influence their situation is stressed. Other focus areas of Swedish policy are:

- Adaptation to local contexts and the specific needs of the target groups.
- Increased responsibility of men and boys for gender equality.
- More attention to higher-risk groups' ability to influence their own situation.
- Ensuring women's and men's, girls' and boys' access to SRHR.
- Access to relevant sexuality education for youth.
- Increased research on prevention of HIV as well as on the long-term effects of HIV/AIDS and how to mitigate these effects.
- Building up of national systems, including health and education systems.
- Promoting the integration of SRH services with HIV/AIDS prevention and treatment services.
- Developing and strengthening social security systems.

South Africa has been a major contributor to the regional and global Swedish responses on HIV/AIDS in terms of policy input, research, innovative work on gender/gender-based-violence (GBV), and civil society (CSO) advocacy. This has been possible thanks to the Swedish involvement in and support to South African actors. During the period of review, South Africa was formally classified as a middle income country (using BNI per capita as a measure). Many donors have therefore reduced or phased out their bilateral development assistance to South Africa. Ahead of the strategy period 2009-2013, the Swedish government decided to further develop the countries' bilateral ties with a shift towards Partner Driven Cooperation (PDC) as well as continued direct support to the HIV/AIDS programmes. As from 2014, Sweden is phasing out all bilateral development assistance to South Africa.

The Swedish regional strategy on HIV/AIDS does, however, provide a possible framework for continued cooperation with HIV/AIDS-related programmes in South Africa if they are seen as innovative models and a driving force for the region. There are also still opportunities for partner driven cooperation focussing on HIV/AIDS.

1.3 THE SWEDISH COUNTRY STRATEGIES ON HIV/AIDS

1.3.1 Strategy 2004-2008

The first Country strategy 2004-2008 aimed at supporting the South African government to create conditions to reduce the number of new infections (prevention) and mitigate the impact of HIV/AIDS on individuals, families and communities (treatment, care and support). Focus was on development of policies and structures that could respond effectively to the HIV/AIDS epidemic. Sweden worked through dialogue with government and co-donors, through mainstreaming HIV/AIDS in existing programmes, through strategic support to CSOs that could influence government and develop model services, through initiatives combating violence against women and children and through support and assistance to the Swedish-Norwegian Regional Team on HIV/AIDS.

The results of these efforts have been sought in the nature and quality of responses from government, private sector and CSOs during the period and in the possible contribution towards *reducing the sexual transmission of HIV and enabling people living with HIV/AIDS to lead healthy and productive lives.*

1.3.2 Strategy 2009-2013

The *second Country strategy 2009-2013* focussed on developing partner driven cooperation modalities, strengthening *national ownership* of the HIV/AIDS responses and on *donor coordination*. The Country strategy takes its starting point in the support for implementation of the HIV/AIDS/STI Strategic Plans for South Africa, 2007-2011 (NSP) and 2012-2016 (NSP). The aims of the strategy are to:

- a) Strengthen and broaden the national efforts *to prevent spreading of HIV/AIDS* with focus on gender equality, human rights and sexual and reproductive health and rights in particular and
- b) Support South Africa in its efforts *to coordinate national, bilateral and multilateral initiatives.*

In order to achieve this, the Embassy took the following steps:

- Continued dialogue with the national leaders and authorities. Continued engagement in donor coordination
- Strengthening selected, strategic CSOs in their work to prevent spreading, mitigating the effects of HIV/AIDS and monitoring government performance (via support to AFSA)
- Supporting prevention of HIV/AIDS in transport industry and improved health status and well-being of employees and their families (via Corridor Empowerment Project)
- Supporting capacity development of public servants to respond more effectively to victims of GBV, e.g. securing forensic evidence, counselling, treatment and care (via Zivikele)
- Finding ways to address HIV/AIDS responses within the PDC modality

2 Background to the Evaluation

2.1 WHY THE EVALUATION IS NEEDED

While some components of Swedish support to the South African HIV/AIDS response have been evaluated, there is not yet a summative review of the results achieved and lessons learnt. Swedish support has been provided in the form of political dialogue, donor coordination, regional level initiatives, policy development support, capacity development of national, province and district level government (duty bearers), capacity development of CSOs (rights holders) and private sector capacity development efforts. A broad programme/strategy level evaluation allows lessons and findings to go beyond the individual circumstances of specific initiatives and enables an evaluation of the cumulative effects of support to policy reforms and capacity development of various actors. It also allows conclusions to be drawn about the best strategy for future support and identifying potential risk factors. Alternative financing modalities and the balance between multi-lateral and bi-lateral approaches can be evaluated in light of the evolving new relationship between Sweden and South Africa and the Policy for Sweden's International HIV/AIDS efforts.

2.2 OBJECTIVES OF THE EVALUATION

The objectives of the evaluation are:

1. To establish whether the Swedish Country strategies (2004-2008 and 2009-2013) were correctly and effectively implemented, and whether the goals and objectives therein were achieved.
2. To document the emerging outcomes and preliminary impacts, both positive and negative, of the strategies to date.
3. To analyse and document the key factors which enhance or obstruct positive outcomes.
4. To analyse and report lessons learned from current and completed contributions.
5. To reassess current support to partners, and whether the areas of support are still appropriate and topical, directly addressing the development and programmatic gaps in the current response to the AIDS epidemic in South Africa.
6. To evaluate the collaboration between the Embassy in Pretoria, the Regional AIDS Team in Lusaka and Sida Stockholm (HQ).
7. To analyse the nature and results of engagement with key partners, in particular the NDOH, SANAC, multi- and bilateral development partners, Sida Stockholm and the Regional HIV/AIDS Team based in Lusaka.
8. To present a risk matrix that would enable an assessment of the key challenges that threaten the sustainability of the interventions and achievements supported by Sweden.

9. To suggest the way forward after 2013, the end of the South African Country Strategy, to optimise the reach and impact of the interventions supported by Sweden.

2.3 METHOD

In order to answer the evaluation questions, the evaluation team gathered information from existing reports and evaluations, and interviewed external observers who are active in the HIV/AIDS field, NGOs and CBOs directly and indirectly reached by Swedish support, and some of the funding recipient beneficiaries. The team also participated in the national HIV/AIDS conference in June 2013, where all major stakeholders presented research and reports on developments. The experience of the evaluators from previous evaluations in the HIV/AIDS sector in South Africa has also contributed to the contextual understanding and the judgement on relevance.

As this is a summative evaluation, the evaluators focussed on the biggest partners (in terms of budgets), the overall effects of the Swedish support and the effectiveness of the approaches taken in the two strategy periods.

2.3.1 Data collection

The major sources of information were:

- Study of Swedish partners' annual reports, Swedish policies and strategies, plans and reports, previous evaluations, other donor reports, SA statistics (household surveys, etc.), newspaper articles
- Interviews with key stakeholders, main partners and their beneficiaries (such as CBOs, authorities or individuals)
- Site visits/observations
- Interviews with present and previous Sida and Embassy staff
- Informal discussions and participation in the annual HIV/AIDS conference in Durban in June

At a joint analysis workshop in July, the four evaluators met to analyse information so far gathered and identify the gaps and need for additional field work. Follow up interviews were then carried out with beneficiaries/indirect partners as required.

2.3.2 Selection of respondents

Respondents were selected to represent key stakeholders in the health and HIV/AIDS field, external observers such as other donors, government representatives, Sida staff in Stockholm, Lusaka and Embassy staff in Pretoria and last but not least – all major partners (recipients of grants and technical support) in the period 2004-2013. The focus was on long-term partners who were supported during both strategy periods and partners receiving substantial funding amounts. A list of proposed respondents was sent to the Embassy for approval with the inception report.

The outcomes claimed by major partners in reports and interviews were also followed up through visits to CBOs and other implementation sites, random face-to-face interviews with individuals participating in the programme and telephone interviews

with selected participants of trainings (in cases of programmes finalised some years back). Participants were girls, boys, women and men in communities, public servants and parliamentarians. By exploring changes perceived by participants, the evaluators aimed to verify the outcomes claimed by Swedish partners and capture any unintended effects. In total, 115 persons were interviewed (refer to Annex 9.4).

2.3.3 Questions asked

The evaluation used an analytical model which explored the influence of the programme *upwards* (influencing duty bearers for policy change), *downwards* (empowering grassroots and making a difference in the lives of women and men in communities) and *across* (building relationships and capacities of other organisations and stakeholders). The evaluators focussed mainly on outcomes (and to some extent impact), relevance and lessons learnt and less on efficiency and sustainability. The method is described in more detail in the inception report. Primary questions around each direction of outcomes were:

1. What **difference** did the organisation's work make (outcomes upwards, across and downwards)?
2. In what **way** did the organisation exert change (process upwards, across and downwards)?
3. What were the prevailing **conditions**, and how did these conditions impact on the relevance and focus of the programme, and on results, both enabling and constraining outcomes?
4. What has the organisation **learned** for future programmes or interventions?
5. To what extent do we feel confident that the described change was a result of these activities, and what reasons do we have for believing this? (Measures and **validation**)
6. What is **special or different** about the approach? (Innovation)

Variations on these themes, as they have been seen across the whole programme, have been posed to external observers. Further secondary questions have also been directed to external observers:

1. To what extent was the national, regional and global sphere influenced (impact, depth & penetration)?
2. How did the participation in the joint funding platform contribute towards programmatic and policy standards across the South African context (value added, upward influence)?

The evaluation thus involved exploring the programme and partners in terms of the levels at which they work, the extent of their influence and impact at these levels, the extent to which their claims can be validated, and whether the intervention or approach supports or builds good practice. Interviews sought to probe:

- The quality of outputs as they affect direct beneficiaries, recipients or targeted authorities
- The outcomes these interventions achieved in terms of changed behaviours, practices, policies, relationships etc.

- The ripple effect or influence of these results may have had on the broader population of stakeholders and beneficiaries

2.3.4 Challenges and limitations

It was difficult to find respondents who were able to provide information on outcomes relating to the first strategy period (2004-2008), especially if they were not considered for Swedish funding in the second strategy period. Some partner organisations had totally restructured; and the present leaders had little knowledge of the background of Swedish support. Information regarding the first period is therefore mainly derived from written reports and comments from external observers and other key stakeholders. Also, the exceptional continuity of Embassy staff over the two periods has been helpful in recalling the history.

The Embassy provided documentation relating to its annual planning and reporting processes, which gave an initial overview. However, the evaluators were not able to get written documentation relating to the various partners from the Embassy. The evaluators therefore have relied on partners and other stakeholders to submit reports, evaluations and other information, which was time consuming and some gaps were inevitable.

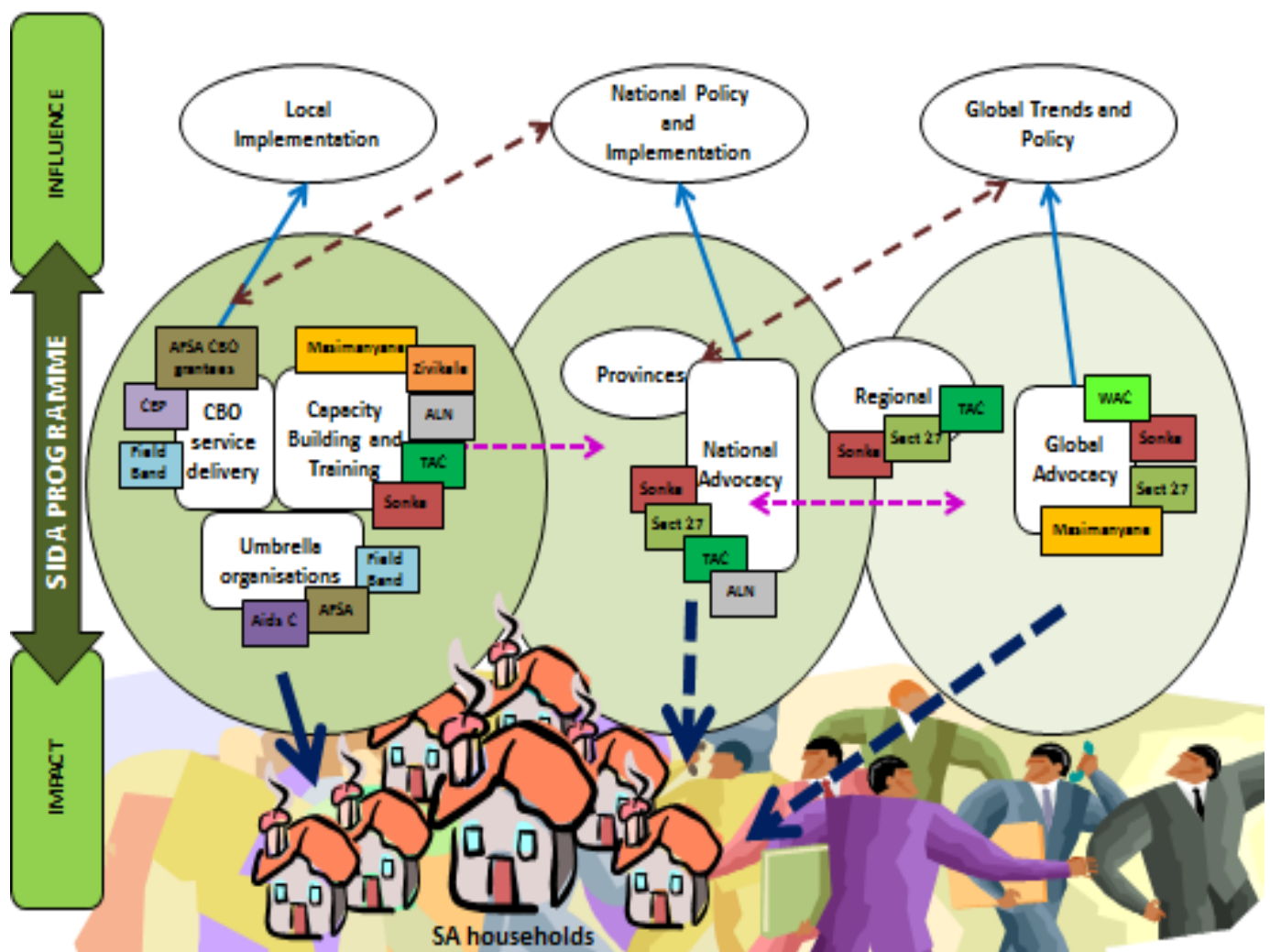
Swedish funding has been provided to a wide range of organisations and initiatives. It has not been possible, within the scope of this evaluation, to document and verify, in detail, the outcomes for each and every partner and project.

3 Outcomes of Swedish Support

3.1 ANALYTICAL FRAMEWORK

In reviewing the Swedish programme, the evaluators looked at the different categories of interventions and the level at which interventions took place. Ultimately, the evaluators were interested to see whether these interventions had, either singly or collectively, been able to:

- Improve capacities, methods and relationships that enhance the HIV/AIDS response and
- Influence upwards and potentially impact policy and implementation processes,
- Change the life circumstances of South Africans and South African households.



The programme categories depicted in the diagram above are as follows:

1. Those involved locally/directly in communities and therefore impacting households via service delivery, capacity building and awareness-raising. This category also included umbrella organisations that either coordinated activities or groups of smaller organisations undertaking these activities.
2. Those involved at a Provincial or National level, indirectly impacting households, and directly influencing policy, and possibly indirectly influencing global thinking.
3. Those involved at the level of global advocacy, influencing global thinking and indirectly through this impacting the local level.

Many organisations within the Swedish programme work at more than one level.

3.2 ORGANISATIONAL CAPACITY OUTCOMES

Based on proactive assessments and relationship building, Sweden identified a range of strategic change agents and supported the capacity development and operations of both national issue-based organisations (NGOs) and community-based organisations (CBOs). Initially there were also efforts to support capacity development in provincial government departments. The top 10 recipient partners were:

ORGANISATION	2004-13, Million SEK	ORGANISATION	2004-13, Million SEK
Corridor Empowerment Project (CEP)	44.7	Aids Law Project/Section27	15
Treatment Action Campaign (TAC)	43.1	Foundation for Professional Development (FPD) – now via PDC	9.5
Zivikele	32.9	AIDS Consortium	9.3
Aids Foundation South Africa (AFSA) core funding	28.2	South African National AIDS Council (SANAC)	9
Eastern and Northern Cape Provincial departments	20	AIDS Legal Network	8.7

In addition to its core funding AFSA also received Swedish funds for its CBO capacity building programme, in total SEK 18.6 million to 35 CBOs over the period. Since 2008, AFSA has acted as an intermediary grant maker and channelled almost all Swedish funding to civil society. Only two partners still receive direct funding from Sweden, namely Zivikele and CEP. All interviewed NGOs confirmed that the Swedish funding had played a vital role in the development and survival of their respective organisations. Through the combined programme and core funding from Sweden, the organisations were able to concentrate on their mission and achieve substantial results. Details of each partner's results are outlined in Annex 9.2.

Unlike Sweden, most donors are not willing to provide core funding, which means that NGOs are forced to be directed by funding availability rather than their vision for change. Watch-dog NGOs are affected more seriously than service-providing organisations. Largely thanks to Sweden's policy of supporting organisational

strategies and visions, Swedish-supported organisations were generally true to their purpose and mission, and were less donor-driven than is often observed in the NGO sector.

Although there was some initial discontent with losing the direct relationship with the Embassy, most of these NGOs are now happy with AFSA's sub-granting systems and governance mentorship. Although all continue to be dependent on external donor funding, many have improved governance and management systems, have developed strategic planning capacity, are able to use results-based management tools and have successfully applied for other donor funding, creating a more diverse funding base.

The supported organisations are still well-reputed key actors in their areas of work. AFSA is one of the three most respected CBO umbrellas/capacity builders in South Africa. ALP/Section27 is recognised as an influential force in rights activism, taking on high profile litigation cases and is a key advocacy resource for other organisations in South Africa and the region. CEP has managed to create a wellness programme, which is used and appreciated by both truck drivers and the industry. It has the potential to be sustained by the industry. TAC, which organises persons living with HIV from the grassroots level, still covers a large number of districts in South Africa, engages in awareness-raising advocacy for the human rights of their constituency and is recognised as a key player in setting the HIV advocacy agenda. TAC is described by respondents as being the most important voice of persons living with HIV and is a truly activist HIV/AIDS organisation. It now operates without Swedish funding. The noted challenges relate to:

- A few of the organisations experienced leadership and management difficulties, restructuring, senior staff turnover or other internal organisational experiences which were largely unrelated to Swedish funding. For some this affected their abilities to implement programmes and interrupted productivity. For others, changes impacted relationships with funding agencies and created resource challenges. In the case of community representatives, such as TAC, some of this challenge relates to the difficulty of finding a balance between grassroots voluntarism and authentic activism, and efficient and professional operations that meet funder expectations.
- Some NGOs are very dependent on certain individuals, which can be a threat to sustainability. Succession planning is a key concern.

In addition to the CSO support, Sweden has supported the provincial governments in Eastern, Northern and Western Cape to develop their capacity to respond to the HIV/AIDS challenges. The outcomes of this support on organisational capacity are bleak for the Eastern and Northern Cape. The Western Cape planning grant was only provided in 2013, and it is too early to expect outcomes. Sweden also supported the capacity development of the South African National Aids Council (SANAC). It has been established and kept alive thanks to the Swedish (and British) support (further described below). In total, Sweden contributed 9 million SEK to SANAC.

Below, the report outlines how the improved capacity of Swedish-supported national actors has led to outcomes in terms of e.g. policy change, changes in gender norms, improved prevention models and better services.

3.3 GLOBAL AND REGIONAL-LEVEL OUTCOMES

3.3.1 Global outcomes

A number of Swedish-funded South African organisations also have a global engagement, and have been part of the movement that has profoundly influenced global HIV approaches, agendas and priorities. The World Aids Campaign (WAC) was part of a broad international movement to pressure countries to meet their HIV response targets. Although WAC recently experienced internal challenges, the organisation contributed to highlighting the rights of key populations and women in the global agenda, including ground breaking discussions concerning sex workers, Men who have sex with men (MSM) and injecting drug users, years before the current prioritisation of these groups.

AIDS Legal Network (ALN) also provides regular input on rights, gender and HIV into the global debate, including representation on the Convention on the Status of Women. Engender Health, funded from 2005-2009, was part of the international process to establish the 'men-as-partners' network. This fitted well with Sweden's forward-looking strategy to focus on gender issues. Sonke Gender Justice, which has been funded since 2009, is also substantially contributing to gender awareness activities via ensuring the involvement of men and boys in gender issues and international networking and communication.

The litigation and advocacy work carried out by ALP/Section27 also had international influence. Mark Heywood (Director of ALP/Section 27, board member of TAC and ex co-chair of SANAC – all organisations largely funded by Sweden), has been visited for advice by constitutional judges from other countries. As a result, South African methods actively influenced campaigns in China, and had significant influence in guiding global priorities and the direction of the HIV response, and beyond.

Despite focussing most activities at a local level, Masimanyane (funded via AFSA) has also engaged with the Convention on the Status of Women in New York, Africa and the Middle East, and the UN organisation the Convention on the Elimination of Discrimination against Women (CEDAW) where they presented a position paper on the situation of women in South Africa.

3.3.2 Regional outcomes and synergies

Many of Sweden's South African partners are also active in regional African networks and programmes, such as AIDS Rights Alliance of Southern Africa (ARASA), FPD, MenEngage, MenCare where they have contributed substantially. In addition, many of the regional Swedish-supported HIV/AIDS initiatives have their base in South Africa, such as HEARD, Regional Psychosocial Support Initiative (REPSSI), UNAIDS, SAT, etc. The involvement and influence of South African actors in the region is significant and has been encouraged and facilitated by the Regional HIV/AIDS-Team in Lusaka according to a number of consulted regional organisations. Sweden is considered a key supporter of regional HIV/AIDS initiatives and the relationships built via the South African programme are viewed as important.

Cooperation between the Regional HIV/AIDS Team and the Embassy has been close. Despite this, synergies between the South African and regional programmes have not been fully explored. The research and development of combination prevention models, supported by the Regional HIV/AIDS-Team, have not yet influenced or connected with the local work carried out by the Swedish-supported CBOs in South Africa. Even when regional partners implement programmes in South Africa, they do so without linkages to partners supported by Embassy of Sweden. A lot of knowledge is being developed without being sufficiently shared and used. A particular case is support to programmes in the transport industry, where the South African partner (CEP) and the regionally supported organisation (North Star Alliance, funded through SADC) work in competition for funding rather than in cooperation, leading to lost synergies and potentially duplicate services in some areas and none in others.

Through its civil society grant system (CIVSAM), Sida has also supported HIV/AIDS programmes in South Africa via Swedish CSOs – with a budget of around 30 million SEK during the period. There have been limited efforts to share experiences and look for possible synergies between these initiatives and the Swedish South African portfolio.

3.4 NATIONAL LEVEL OUTCOMES AND IMPACT

3.4.1 National government response outcomes

The strategic, long-term support provided by Sweden to TAC, ALP/Section27, AIDS Consortium and SANAC provided these organisations with the capacity needed to influence national policy. Sweden supported partner organisations through core funding as well as covering programme delivery costs. This enabled responsiveness, latitude and autonomy to fund recipients to engage in general advocacy, lobbying, networking and coordinating activities that became central to influencing and directing policy, and maintaining the momentum pushing incremental changes to policy implementation.

The Embassy's HIV programme consciously partnered with CSOs and took a broad, human rights-based approach to the response to HIV/AIDS. The structures and approaches of partner organisations enabled them to reflect and amplify what people in communities wanted or were saying and effectively combined the following:

- empowerment of rights-holders (persons living with HIV, their families and communities) and organising bottom-up advocacy through TAC and the AIDS

Consortium,

- extensive public media engagement by TAC and ALP/Section27 and other high-profile activist organisations to raise awareness, create public pressure,
- legal challenges through ALP/Section27, which held (government) to account,
- promotion of active engagement of CSOs with SANAC, greatly increasing the vibrancy and relevance of SANAC as it has matured

This combination of forces⁶ ultimately served to ensure that South Africans – including pregnant women, infants and children, and people in prisons, among many others – gained access to treatment, care and support.

Almost without exception, all those interviewed in this evaluation named TAC and ALP/Section27 as the two organisations that had done the most to advance the HIV response, and in particular, had forced the government to honour its policies at a time when it was trying to avoid these obligations. TAC and ALP/Section27 achieved much more than just ensuring the roll-out of ART. They spearheaded the model of holding government to account using the law, which is an approach that has been adopted by civil society organisations both in South Africa and elsewhere.⁷

The support to SANAC at a critical time helped to keep the organisation afloat, and also strengthen CSO participation and multi-sectoral coordination. Between 2004 and 2005 Mark Heywood and Nono Similela⁸ were given a national mandate to negotiate SANAC's structures and functions. Prior to this, SANAC had not existed as a constituted AIDS Council; there was no civil society representation at all and no accountability for independent scientific input.

Sweden's support (together with DFID's) contributed substantially to SANAC's ability to develop two National Strategic Plans to guide the response – the 2007-11 NSP which outlined very specific targets for treatment, care and support, set goals for reducing incidence and prevalence and described explicit roles and functions for civil society; and the 2012-2016 NSP, which sought to build on the lessons of the previous five years, and broadened the scope of the response to address social drivers directly. The second NSP also identified the need to incorporate key populations, identified the gaps in prevention effectiveness, and was more realistic in its identification of goals, targets and the need to identify and secure funding sources to support programme

⁶ Sida grantees have been substantially present in SANAC, eg ALP's Mark Heywood as national co-chair beside the Deputy President; AIDS Consortium, AIDS Legal Network, Sonke and SABCOHA as coordinators of their respective sectors at various times; and AFSA as an active sector member..

⁷ The national NGO Equal Education – which works closely with Section27 – successfully employed this tactic in 2012 when the Limpopo Education Department failed to deliver school text books.

⁸ Mark Heywood was SANAC Deputy Chairperson and key Civil Society rep. Nono Similela later moved from the NDoH to take on the role of CEO within SANAC

implementation and monitoring and evaluation.⁹ These strategies ultimately contributed towards improving the quality of life for persons living with HIV. SANAC was also instrumental in supporting the NDoH to roll out its HCT campaign, which enabled millions of South Africans to know their status, and began to normalise testing and treatment. The HCT campaign also substantially reduced the stigma associated with HIV/Aids, which serves as a major barrier to treatment and prevention.

It can be concluded that national civil society advocacy prior to 2009 changed the direction of the South African response. The players contributing to that change would not have succeeded were it not for willing risk-takers, like Sweden, who provided flexible support to these activities. SANAC is now registered as a formal, independent body with a broader funding base, including government and the Global Fund for HIV, TB and Malaria. Although there are still capacity gaps and a need for increased independence from NDoH, SANAC has substantially increased its capacity and improved its systems. Importantly, SANAC's continued presence began to give life to the 'Three Ones' in South Africa: one coordinating mechanism, one strategic plan and one M&E system. SANAC CEO, Fareed Abdullah, commented that:

SANAC is finally on the way to becoming a functional NAC. It would not have survived without Sida and DFID funding. We are currently convening ministers of SA, Swaziland, and Lesotho on joint task team to combat TB.

Another national-level outcome to which Sweden contributed in some way, through funding of AFSA and the AIDS Consortium, was the pressure put on government to formalise the training and payment through stipends of Community Health Workers, and to recognise that staff at this level was critical to the successful re-engineering of the primary health care system. Through both organisations' efforts, and under the sector coordination role of the AIDS Consortium, the roles of CBOs and NGOs were explicitly outlined for a significant portion of the deliverables under NSP 2007-11.

3.4.2 Industry response outcomes

The Corridor Empowerment Project (CEP) has also provided national level outcomes. A draft HIV/AIDS policy for the road freight industry has been developed and a health insurance programme adopted by the industry, which covers the costs of treatment for employees. The project provides integrated wellness services on South Africa's main transport corridors and targets the key populations of truck drivers and sex workers. Therefore its coverage extends well beyond the 120,000 employees covered by the Bargaining Council. Importantly, the Bargaining Council views the

⁹ South Africa, *Global AIDS Response Progress Report 2012.*, p71

programme as integral to their overall industry wellness, and the Bargaining Council CEO commented that in 2005 the industry was in crisis with *‘38 deaths a week from HIV-related illness, and this is no longer the case’*.

In total, Sweden has contributed 44.8 Million SEK to the Trucking Wellness/CEP project during 2004-2013. Industry partners have begun to take over the direct funding of a few of the wellness centres and/or support wellness centres through support for drugs supply, but there has not been pressure for a complete takeover. The Bargaining Council believes Trucking Wellness must continue and are ready to take over full responsibility for the management of the project, but argue that they do need a *‘phase out plan so that we can manage the transition – possibly 3 years’*.

The Bargaining Council also believes that the industry would happily support the expansion of Trucking Wellness into the region, as many South African drivers frequent those routes. The industry is well aware that addressing the epidemic in one country is not a sufficient response. The full takeover of the project by the Bargaining Council could have been encouraged by the Embassy at an earlier stage to accommodate phase out.

3.4.3 Prevention model development outcomes

Many partners are engaged in developing and testing new prevention models. Some are focussing on addressing the structural or policy environments that affect GBV, gender norms and involvement of men (e.g. Sonke, ALP, Zivikele, Masimanyane). Advocacy organisations have engaged in campaigns for voluntary testing, prevention of mother-to-child transmission, voluntary medical male circumcision and condom use (e.g. TAC). AFSA’s technical support to CBOs helped to raise awareness and motivate behavioural change, and organisations assert that prevention messaging targeting boys, men and youth have strengthened sexual rights, greater safety, reduction of abuse and domestic violence. Dialogue around male circumcision have yielded positive outcomes, and have created a space for women’s participation in the sensitive area of male sexual health and engagement with traditional leaders.

Examples of indirect approaches to engage high-risk populations such as youth and address holistic well-being as a context for HIV vulnerability have been developed through initiatives such as Field Band Foundation. Swedish support also fostered knowledge generation around the epidemic and the response through SANAC, Race Relations, CADRE, the Foundation for Professional Development and others. Despite these pockets of good practice, there are still challenges. These include:

- Limited evaluation of methods and limited sharing of experiences.
- Bringing models to scale. There are no plans for how to bring successful models to scale and how to finance such scaling.
- The nuanced and indirect approach of effective prevention through broad personal development and general life skills requires a profound paradigm shift from commonly used, but ineffective, behaviour change messaging.

3.4.4 Emerging impacts

Sweden's support to the South African HIV/AIDS programme substantially influenced national policy and the response to the epidemic during the period from 2004-2013.

Through strategic financial support to key stakeholders, political dialogue and donor coordination, Sweden played a catalytic role leading up to the adoption of the national strategic plans (NSPs) and the subsequent roll out of ART to pregnant mothers and persons with severe immune system suppression. Although seven other bilateral donors contributed more money to the service delivery of the health system, Swedish funding of especially TAC and ALP at a crucial time (providing more than 50% of these organisations' budgets) combined with the active role played by the Embassy, were essential for the policy shift to happen.¹⁰

As a result of the policy shift, the face of the epidemic has slowly changed:

- Aids-related deaths¹¹ declined from 257 349 – which was 40.4% of all deaths – in 2002, to 178 373 in 2013 – or 31.9% of all deaths for the year. Research shows that deaths from HIV-related illnesses have definitely declined as a result of the ART roll-out. In 2003 only 8600 person were receiving ART as compared to 2 million in 2013, which represents 38% of all those infected. However, the overall trend of deaths by age still shows that the highest rates of death are in the 25-40 age-group, although to a far lesser extent than during the 2006 peak.
- Partly because of better survival rates, but also due to continued high rates of new infections, the number of South Africans living with HIV increased from around 4 million in 2002 to 5.26 million in 2013. This represented an increasing prevalence, for adults in the 15-29 age group, from 15.1% in 2002 to 15.9% in 2013. Over this period, prevalence in the population as a whole increased from 8.7% to 10%. The prevalence among women was significantly higher than for the general adult population – 15.9 in 2002 and 17.4% in 2013, and a range of studies show that young women have a higher prevalence within this female population.¹²
- HIV incidence (new infections) has decreased among the 15-49 age group – from 1.25% of the population in 2002 to 0.85% in 2013. In absolute numbers that means that 602 744 people were newly infected in 2002, new infections peaked in 2005/6 and by 2013 Stats SA estimates that around 450 000 people

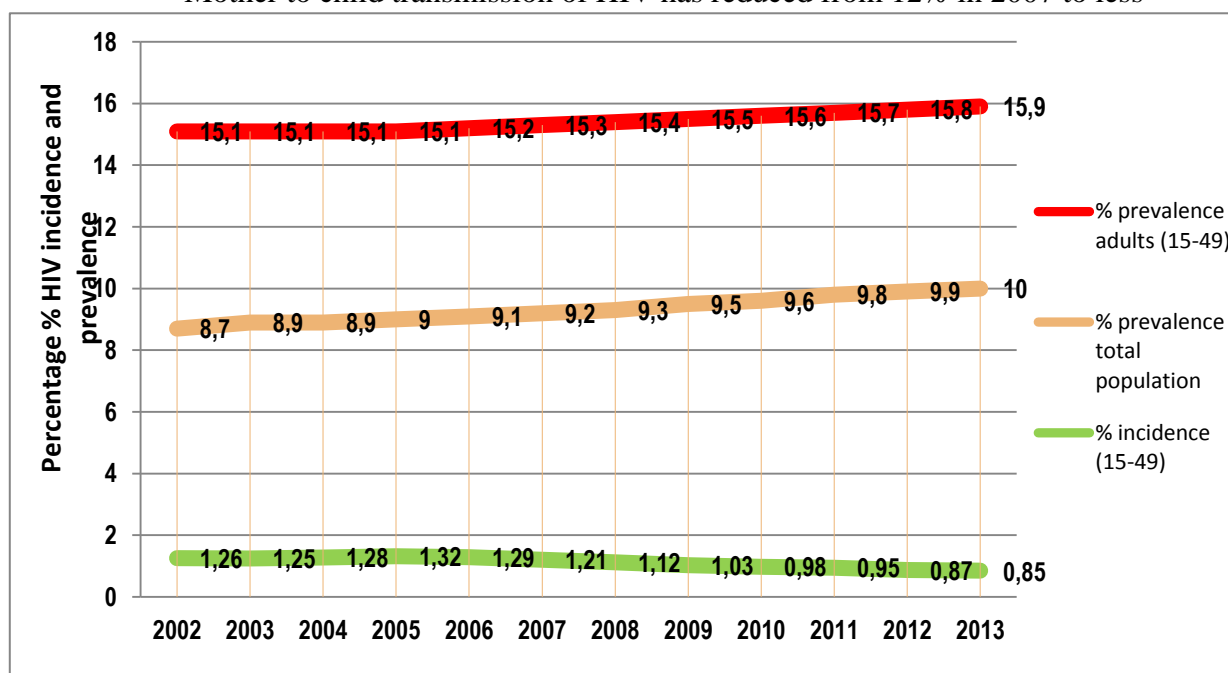
¹⁰ South Africa, *Global AIDS Response Progress Report 2012*. Donor/stakeholder interviews.

¹¹ Stats SA, April 2013 'PO309.3. Mortality and causes of death in South Africa, 2010: Findings from death notification'

¹² South Africa, *Global AIDS Response Progress Report 2012*.

will become infected. Over the decade 6.7 million people became infected with HIV. The majority are young women.

- Mother to child transmission of HIV has reduced from 12% in 2007 to less



than 5% by 2011. In 2010 PMTCT services were available at 95% of PHC facilities and MTCT at six weeks had been reduced to 3.5%.¹³

Statistics from a range of sources show different figures for incidence, prevalence, ART coverage, deaths and life expectancy over the 2004-2013 period, and the situation varies greatly between provinces, between men and women and between different socio-economic groups. The figures in the graph¹⁴ are averages. The most at risk are young girls in poor peri-urban and urban areas.

¹³ G Ngubane. June 2012. *Accelerating PMTCT outcomes: A case study from South Africa* HLSP Institute

¹⁴ Figures in the graph above are drawn from Stats SA. Mid-year population figures 2013, May 2013. Figures differ between the Stats SA's Mid-year population estimates 2011 and 2013, with incidence percentages being around .5% less in the 2013 table and incidence being generally between 1.5 and 2% lower on the 2013 table. Different prevalence figures have been cited in reports from TAC and others. The 2011 national census figures must have informed the 2013 Stats SA publication, and these are therefore taken as most up-to-date.

3.5 PROVINCIAL LEVEL OUTCOMES

Because the Embassy identified the need to work at all levels of the response, the initial strategy included support to the Eastern and Northern Cape provincial governments. Sweden already had a presence in those areas to support governance, as well as having concentrated its support to CBOs through AFSA to organisations in the Eastern and Northern Cape. In total, 20.3 million SEK were contributed to the provincial government HIV/AIDS responses.¹⁵

In the Eastern Cape, Swedish funds aimed to strengthen the Provincial Government's NGO funding unit, and the HIV cluster, so that they might provide better on-going support to the NGO sector. Funding was channelled via the National Treasury, then to NDoH and then to Provincial Health and was earmarked for capacity building in these two units, as well as funding and capacity building in identified CBOs supported through the NGO funding unit. Efforts at supporting provincial government were largely unsuccessful. The provincial structures proved too weak to support, coordinate and optimise the contributions of civil society. Coceka Nogaduka, previously member of the Technical Advisory Committee to Eastern Cape Aids Council (ECAC) said that:

... this funding provided salaries for provincial NGO coordinators. However they didn't have any other resources, so they couldn't really achieve proper coordination.

The Eastern Cape's provincial Health Department weaknesses are evident in the following table:

Capacity issue 2012 ¹⁶	%
Vacancy rate	46%
Hospitals without essential medical equipment	68%
Accessibility of health care facility (with telephone & by road)	16%
Health facilities with no electricity	42%
Doctor-patient ratio (Madwaleni Hospital)	1: 120 000

Similar efforts in the Northern Cape also had disappointing results. Beyond civil society coordination, provincial Departments of Health face a range of systems and capacity inadequacies, and have low absorptive capacity for support until basic functionality can be improved. Failures at the provincial level tend to cascade toward

¹⁵ The Eastern and Northern Cape got 10mil each and in 2013 the Western Cape got a planning grant of 284,000 under the Partner Driven Cooperation modality.

¹⁶ Bateman C. 2012 Will our public healthcare sector fail the NHI? *South African Medical Journal Review* 102 (11) p817, and 'Engaging with South Africa's National Strategic Plan'. *NSP Review*, Nov 2012-Feb 2013. p14-17

the district and local levels. For example, it is frustrating for organisations working to encourage adherence if ART and opportunistic infections' drugs are not available at clinics. This has been commonplace, as was shown in 2013 when TAC and local CBOs intervened to ensure ART supplies in the Eastern Cape.¹⁷

This seems to confirm the often repeated view from CBOs that, as a Manhlungulu care worker said '*.... we do not have defaulters [i.e. people who fail to take their medication regularly, risking that the virus becomes drug resistant]... defaulters occur due to government's incompetence.*

Sweden's partner AFSA has also attempted to engage with provincial structures in both the Eastern and Northern Cape to ensure alignment between provincial services and CBO activities, and also to ensure that officials in provincial structures can be made aware of conditions in communities or service delivery problems such as drug shortages. Memoranda of Understanding were signed, but AFSA reported that it is almost impossible for even provincial coordinators to ever meet with government officials and that this level is not accessible to local CBOs. Politics at provincial level excludes consultation, *so coherence cannot be achieved between provincial and grassroots levels.*

This evaluation could not identify any visible provincial level outcomes of the Swedish support. General adult population prevalence rates remained static in these two provinces,¹⁸ at around 16% in the Eastern Cape and 10% in the Northern Cape. Incidence rates at the provincial level were not found. The limited results and the difficulty in mainstreaming HIV/AIDS efforts in the general governance support to provinces led to the withdrawal of Swedish support at this level. While this was justified due to weak outcomes, the capacity and accountability gap in provinces remains a key obstacle to the delivery of adequate health services.

3.6 COMMUNITY LEVEL OUTCOMES

3.6.1 Organisational and socio-economic outcomes: CBOs

Swedish funding supported CBOs through three key modalities:

- Around 35 CBOs were supported by AFSA in the Eastern and Northern Cape in a capacity building programme that included core support at an average rate of SEK 200 000 per CBO per year. In total 18.6 million SEK was channelled to these CBOs during the period of review.

¹⁷ TAC. January 2013 'Emergency Intervention at Umthatha Depot: The Hidden Cost of Inaction'

¹⁸ HSRC, 2012 Household Survey key findings released at National AIDS conference 20 June 2013

- Several hundred CBOs were supported through the capacity building programme of the AIDS Consortium. This programme did not have the grant-making element provided through AFSA, but capacity building included training, mentorship, networking, access to information and representation.
- An average of almost 60 training events per year, many of which were directed at CBO members, were facilitated by AIDS Legal Network (ALN) on HIV, gender and human rights. These included most provinces, and were complemented by support in outreach, community dialogue and participation in community research.

Coceka Nogaduka, previously member of the Technical Advisory Committee to ECAC noted that:

The CBO work had a big impact on poor people at local level – you could see a difference in their level of organisation and motivation though the addition of a small office and a desk and chair. I liked that Sida was prepared to fund work at this very local level.

In addition to the desk review, the findings in this section are based on site visits to 12 AFSA-supported CBOs and telephone interviews with two ALN partners. The decade of Swedish funding and capacity development assistance to CBOs enabled many of these smaller organisations to develop strategies, improve management and financial management capacity, establish robust administrative systems and some data collection capabilities, build staff and structures, and establish a wide range of programmes that directly benefit vulnerable populations based on a careful situation analysis and dialogue in communities.

AFSA's model for long-term core funding at a low level proved to be a highly effective intervention at the local level. Many organisations have now been able to apply and receive programme funding from other sources, both in terms of government support and private funding. According to an external evaluation of the AFSA programme in 2010, substantial progress was made:

Improvement	% CBOs
increased donor base since AFSA intervention	78%
new and/or better functioning Boards	78%
new and/or improved operating systems, policies and procedures in place	100%
staff are demonstrably better skilled	100%
increased number and type of programmes offered to beneficiaries	67%

Both AFSA and AIDS Consortium gently but firmly insist that good systems and reporting did more than enable CBOs to meet donor reporting requirements – they enabled the organisations to work more efficiently and effectively. A valuable outcome of Sweden's support has been the development and documentation of capacity building models, which demonstrate the crucial combination of organised training with on-site coaching and mentoring.

An unintended, but substantial, impact of the Swedish support to CBOs is the empowerment of hundreds of women who work in the supported CBOs, gaining knowledge, community recognition, self-confidence and, at times, moving into

formal employment and economic independence. This is a generally unrecognised role of CBOs, and is largely excluded from donor or CBO strategies, but provides a substantial portion of CBO impact in communities.

3.6.2 Advocacy outcomes: CBOs

Most community-focussed organisations have no upward influence. Activism is often directly prevented by their partial dependence on the state for stipends, and the need to maintain good relationships with public sector actors for client referral. While many CBOs may fear exclusion from funding as a result of confronting government, some *are* able to confront services at a local level, such as the quality of clinic care, social worker availability, or staffing and resource and drug supplies in mobile clinics.

In an ideal world, CBOs would channel their complaints and suggestions upwards through Local and District AIDS Councils, or via engaged ward councillors or local government officials. It appears that these avenues are largely absent and they were certainly not evident in the communities where the sampled CBOs operate. This means that influence over policy or precedent-setting activism from local CBOs depends on the activism and representation of umbrella agencies. In this regard, agencies that are not primarily grant-makers are the most effective, as they focus on either research and global policy (ALN), or networking and activism (AIDS Consortium). With Swedish support, both of these organisations have been able to convert citizen voices and grassroots issues into advocacy, including providing community input into the powerful national activist organisations of TAC and Section27, as well as conducting direct campaigns and participating in global debate. AFSA's model, while exemplary in terms of capacity building, has not been as effective in strengthening CSOs in upward influencing or representing them in bringing sensitive cases to a higher level.

3.6.3 Community level outcomes: CBOs

Local CBOs offer direct home-based care and treatment support for chronic disease, prevention education, and some counselling on social concerns. Beyond these, the wide range of other issues that they confront are based on the strong network of referral relationships found in all organisations that were sampled. Mutual referral networks are the foundation of effective local support and include, among others, a social worker, health clinic, school, police and Departments of Home Affairs and of Agriculture. To varying extents the sampled organisations all actively pursue relationships and are creative about placing their clients in contact with the resources necessary to improve their situation. The CBOs function as a hub between government or larger NGOs, and citizens, facilitating women, men, girls and boys to address their situations and access services. Their effectiveness is greatly enhanced when they are supported with capacity development and networking. In combination, for example a rough estimate, based on AFSA annual report figures of beneficiaries reached by all CBOs supported, shows that AFSA-supported CBOs reached over 600,000 beneficiaries in the years covered by Swedish support, or 45 000 persons each year.

Examples of provided help ranged from documents, child welfare and health, identification documentation and support to OVC, adult illness, HIV and TB prevention and infection control education, youth engagement, education support, drug and alcohol support, issues of disability, identification of social crime including gender based violence, support for the elderly, basic food security, and all inter-related social, health and survival issues that affect households.

The evaluation found that CBOs are uniquely positioned to play an important role in facilitating poor households' to access services and address a range of issues. Through their multi-sectoral, household-centred, locally connected position, CBOs offer the optimal model for household-level responses, which integrate a full range of services based on need, rather than sector. This unique niche is difficult to replicate through other structures, including through a government department's outreach staff.

Government contribution of stipends for a specific range of services has been a successful and effective model. However, unless government finds a more uniform system to support these flexible, multi-purpose organisations, CBOs will continue to occur relatively randomly in communities, providing variable quality of service, and will invariably struggle to mobilise resources. In relation to the national response, Swedish-supported CBOs are few and have only reached a small percentage of the many communities in South Africa. Although these were carefully selected to represent the poorest areas, it is still a small share. Unless supported by district government structures and explicitly connected into government services, scalability is weak, and where they emerge volunteers will continue to provide crucial, but unpredictable services. Several efforts at mapping the CBO response have been undertaken, and CBO umbrellas are aware of the importance of this process.

3.6.4 Prevention outcomes: CBOs

Consistent with the national prevention strategy, and generally adopting the same Abstinence; Be Faithful; Condomise (ABC) model, CBOs have not had greater success in prevention than the broader response. New approaches and ways of addressing social drivers effectively are largely unknown to CBOs. This is an area where umbrella organisations can improve their support to CBOs, and where innovative models for effective prevention could be developed and communicated.

4 Analysis of Supported Areas

4.1 DEMANDING ACCOUNTABILITY

The Embassy has chosen to focus its support on capacitating CSOs to monitor and supplement government efforts, rather than supporting the government health system. South Africa has a substantial health budget and other donors are covering the shortfalls in costs of medication. This was therefore a rational and efficient approach.

Support to advocacy organisations was critical to holding government to account throughout the period covered by Swedish support, resulting in fundamental shifts in government policy as well as forcing government to hold to its promises outlined in policy. Core funding, which allowed organisations to optimally deploy staff, enabled citizen voices to be heard on the national, as well as the international, stage including an innovative combination of social mobilisation, media and litigation.

TAC's model for citizen voice is a valuable result in itself. It demonstrates the structures and flow that make this possible, as well as the fluidity and chaos that are inherent to genuine participation. It demonstrates both the challenges and possibilities for structured formal organisations to engage professionally with donors, while also achieving broad representation.

Presently, the health system's inefficiency is a major obstacle to implementing the NSP. Even national government acknowledges that there is a great need for continued monitoring and advocacy by civil society. Continued pressure on government to deliver, and to resolve provincial and district level bottlenecks, remains essential. CSOs have to rely on external funding for this important role. As a Department of Health official commented, *NGOs are our watchdogs! Civil society organisations need external money to ensure that they can continue to play this watchdog role.*

4.2 EMPOWERING GRASSROOTS

Between 2004 and 2013, through AFSA, Sweden supported over 30 CBOs to address HIV/AIDS-related challenges in their communities. These communities were deliberately selected to reach the least serviced and poorest households. Starting as centres for care and treatment, CBOs focussed on household needs, and grew to become hubs to support citizens to access government services including medical, social and educational. The most effective model for grassroots representation, however, is demonstrated by TAC: a combination of independence from government support, local level social mobilisation and structured insertion of grassroots' experience into a national advocacy agenda which has legal authority, have generated a highly effective national grassroots response.

There are challenges in the Swedish efforts to empower grassroots. While TAC has a great outreach in almost every district, Swedish-supported CBOs cover only a few communities out of many thousands. Synergies between the advocacy efforts of TAC with the more service-oriented focus of CBOs have not been well developed.

The NDoH has estimated that, in total, around 72 000 persons (mainly women who receive government stipends, are paid by the CBO, or who are unpaid volunteers) are presently engaged in CBO work on HIV/AIDS and poverty-related issues around the country. The coordination and coherence of services remain a challenge for government, however, and the NDoH wants to put in place a national cohort of community health workers. The Department believes these staff would eventually play the roles currently played by CBOs, thus freeing up departmental funds that are currently allocated to CBO support. The CSO sector, especially the umbrellas supporting CBO capacity development, has yet to engage with the government on these issues.

While the presence of a community health worker is likely to enable detailed analysis of health issues, this service is distinct from the multi-sectoral, integrated, holistic and needs-based function served by CBOs. Greater innovation and stronger collective advocacy among AFSA and AIDS Consortium, with the inclusion of NACOSA, is required for the uniqueness of this role to be articulated.

There is, as yet, no model described for scaled and consistent access to household-level support where CBOs are the first choice, but which provides for variation among municipalities depending on available organisational presence. Umbrella agencies have an opportunity to raise the seriousness and professionalism of a collective CBO sector by engaging meaningfully with this challenge.

4.3 FOCUS ON GENDER AND GBV

The Embassy's focus on gender was evident in almost all programmes. Sweden also funded specific programmes, which saw a benefit for the HIV response as residing in *first* dealing with gender norms and inequalities. It can be argued that Sweden's consistent focus on gender and GBV has contributed to the small gains made in getting these issues to become part of everyday thinking and on the agendas of many HIV/AIDS organisations. This mainstreaming outcome could also be seen, to different degrees, in the work of the national NGOs funded by Sweden. Participants in AIDS Legal Network's gender and human rights training sessions claim that the training has translated into active referral and a deeper understanding of rights in practice (60 sessions per year to groups of 25 participants from communities and civil society).

The Zivikele training of civil servants has raised awareness of the 450 participants on how to improve responses to GBV. However, this awareness has not translated into large-scale observable changes in practice by officials in communities, probably because the issue remains a low priority for the government departments involved. Sweden's support to Sonke Gender Justice was previously for core functions to support the development of gender awareness. Dean Peacock, co-founder and

Executive Director of Sonke Gender Justice Network, commented that *‘Sida is a very real champion of involving men and boys in gender issues’*. The recent PDC grant to Sonke and the Swedish organisation MfJ focussed on establishing fathers groups in communities through a range of partners, in an effort to get men involved in SRHR and to address gender and GBV issues. Two years of reports indicate slow progress. Perhaps both Sonke and Sweden believed that more was achievable within this short time frame, given the relative success of the Swedish fathers’ groups. The South African context has proved more resistant, both in terms of establishing partnerships with NDoH and the gradual development of enthusiasm among fathers to participate.

Sweden, through HIVOS, contributed to a Joint Gender Fund supported by a number of donors. This fund provided seed funding to small CBOs working around GBV issues. Recipients of these funds have reported that the Fund allowed them to initiate small but sustained processes in communities. Local CBOs began to respond to GBV issues, and started to provide support and facilitate responses by local police and health services. This became part of their daily practice. Once the practice was established, the funding was used in another community.

While CBOs work very effectively with women, as those most vulnerable to and affected by HIV, the evaluators found that CBOs generally attract few men directly into their activities. This means men remain more vulnerable to ignorance and to high risk attitudes and sexual choices. GBV issues are also more difficult for CBOs to tackle.

The greatest progress in working with men has been achieved through male-oriented organisations and programmes such as Sonke and CEP. Despite their efforts, however, high risk mobile men in the workplace continue to constitute one of the key drivers of the epidemic, engaging in underage sex in their transient workplaces. Relatively little workplace responsibility has been accepted for this concern, and substantial advocacy work into workplaces is clearly a priority for the men’s sector.

4.4 INCLUDING KEY POPULATIONS

Sweden has always included, and indeed insisted on, a focus on key populations and marginalised groups within the HIV response. As with gender, this foregrounding of key populations as requiring specific interventions at least raised these issues with organisations and communities that might otherwise have continued to ignore the presence of such groups within their targeted beneficiaries.

The evaluators found that, through rigorous door-to-door household support, persons with disabilities were often identified and effectively included by CBOs. Specific efforts include, as needed, transport and accompaniment to the clinic, requests for wheelchairs from government providers and comprehensive help with grant and document applications. However, persons with intellectual disabilities still seem to be invisible, despite their vulnerability to sexual exploitation.

The evaluators found that LGBTI persons and MSM, who do not self-identify as gay and may be in heterosexual relationships, are definitely part of the agenda of the larger Swedish-supported NGOs. Organisations like TAC and Section27 address

these groups specifically in campaigns. Zivikele addresses these issues as part of public sector training. In rural communities, key populations are generally not included in programmes, as here, men and young girls are more visibly at-risk groups. CBOs have not yet tried to access the often largely hidden groups of LGBTI or sex workers, or to map the extent to which these relationships take place in small communities. But dialogue and community discussion are raising awareness.

Swedish-supported programmes actively addressed mobile populations like truck drivers and, within this, sex-worker populations. These programmes tend to be based in urban areas or, like CEP, on major transport routes. No Northern Cape informants, for example, were aware of a commercial sex work industry in their area, and consider most transactional sex to be informal, even though several of these towns are on major routes for trucks serving the mines. The importance of building a network of support services through workplaces, both for contractors and truck drivers, and the development of formal sex work support structures, is highlighted by this challenge.

4.5 FOCUS ON PREVENTION

4.5.1 Finding models that work

The Embassy has been forward looking, working with NGOs that openly included high-risk populations in their focus, such as MSM and victims of GBV. When others hesitated, TAC, ALP/Section27, Sonke, ALN and Zivikele all challenged conventional thinking, and raised issues such as the consequences of specific behaviours, gender issues as well as human rights. Similarly, CEP, Field Band Foundation, Sonke, TAC and AIDS Consortium have worked on innovative prevention approaches and key populations, and have made significant progress in addressing this area of major national concern. Ordinarily it would be the role of the National AIDS Council to collate and disseminate good practice, but SANAC has not yet achieved the level of functionality, or the resources, to fill this role.

Although there has been an underlying focus on SRHR, gender norms and social drivers, each partner has developed its own understanding of the best way forward, and there is limited documentation or distillation of critical success factors or principles. Organisations generally lack incentives, resources or mechanisms to cooperate with others to share ideas, undertake joint advocacy for rights and bring models to scale. In community-level prevention work this is achieved, to some extent, by the larger umbrella-type coordinating organisations. In South Africa alone there is SAT, ALN, AFSA, AIDS Consortium, NACOSA and TAC, which all support community or household level prevention work.

4.5.2 Re-engineering the prevention approach

Despite pockets of innovative efforts, there is not yet a comprehensive answer to the prevention of new HIV infections. Risky behaviour is driven by a complex mix of gender norms, poverty, lack of opportunities and inaccessible SRHR services – especially for young girls. Another significant factor is the rate of TB co-infection which stands at around 65% of all PLHIV, according to the World Health

Organisation Global TB Report for 2012. Therefore, the key populations identified for the response include those most likely to be exposed to or transmit HIV and/or TB.¹⁹

Present prevention models have often been one-dimensional, involving awareness raising, condom distribution or cash contributions. All major players in the response recognise that combination prevention is more likely to begin to shift risk behaviours by addressing a range of drivers. Prevention interventions must provide real opportunities for empowerment, self-realisation, education and income, and ensure whole-person self-realisation. Where life skills and socio-economic solutions are fundamental to addressing key drivers, investment might take place through larger NGOs, such as Field Band Foundation, SABCOHA, Sonke and others who work with key populations, specifically around holistic prevention. Strategies should also involve government departments such as Department of Trade and Industry and Social Development finding creative solutions to national economic exclusion.

Because prevention strategies have not been sufficiently effective, SANAC, civil society and donors now have the responsibility to reinvent the basic principles of prevention, and to identify implementable strategies which, might improve upon the incidence results of the last 10 years.

If South Africa is to take serious responsibility for ensuring community level empowerment and support, and departments are to roll out or enable roll-out of this level of support, it will be necessary to understand the kinds of models that can be scaled up, what the surrounding criteria and context must be, and the costs that would have to be borne by government. Achieving this must start with a dialogue between donors and state institutions, as well as the umbrella organisations representing CBOs. The 2007 NSP listed specific roles for CBOs – what is missing is follow through of this into the new NSP, and a clear picture of who is best placed to deliver what and where. Yogan Pillay, Deputy Director General for Strategic Health Programmes, NDoH commented that:

...none of the donors do rigorous scientific research into which of their many many good projects are actually scalable and what this would cost – this is critical information for us – there might be two or three or even more models, but we need a thorough and scientific cataloguing to understand what they involve.

¹⁹ The NSP 2012-2016 identifies young women between 15 and 24, people living or working along national roads and highways, people living in informal settlements, migrant populations, young people not attending school, people with lowest socio-economic status, Uncircumcised men, people with disabilities, MSM (9.2% of all new infections are in this category), Sex workers and their clients (19.8% of all new infections), IDU and those who abuse alcohol, transgender persons and OVCs. For TB the additional key populations are workers in health care, mines, correctional services, and people living or working in poorly ventilated overcrowded environments.

5 Effectiveness, Relevance, Efficiency and Sustainability

5.1 EFFECTIVENESS

5.1.1 The first country strategy on HIV/AIDS 2004-2008

The evaluators conclude that the first HIV/AIDS strategy was very effectively implemented and the objectives were reached, despite a very complex context. The Embassy strategically supported efforts to:

- provide access to information and stigma reducing activities
- develop NSP 1, the first coherent SA strategy to respond to the epidemic, which provided the framework for provision of treatment, care and support
- develop NSP 2, which built on the learning of NSP 1 successes and failures and began to address both the drivers of the epidemic, but also the cost elements of treatment, care and support
- challenge the government's denialist approach, and advise, monitor and encourage the ART roll out and support activities as the situation required. This was achieved through legal challenges and through building effective civil society organisations working at community, local, and national levels
- ensure a comprehensive effort to prevent Mother to Child Transmission

These policy results created an environment that enabled contributions of other bigger donors to medication or service delivery. Sweden was only the 8th largest donor in the HIV/AIDS sector, but the provided support was catalytic. The major national policy shifts achieved over the last 10 years can be directly attributed to the Swedish support. Sweden provided substantial funding (often more than 50%) to virtually all of the most important and influential actors. Sweden also led donor coordination and engaged conclusively in dialogue with government (e.g. messages at World Aids Day). The results of this evaluation confirm that Sweden's role has been a major factor in the transformation of the HIV situation in South Africa at the national level.

The strategy was less effective in terms of influencing the provincial governments in the Eastern and Northern Capes to address HIV/AIDS. The results of the mainstreaming efforts at this level are very limited.

5.1.2 The second country strategy on HIV/AIDS 2009-2013

The first strategy was implemented in a context where the overarching and unifying aim was to galvanise a South African government response. The second strategy was set in a context where this overall aim had been achieved. This required a change in mind-set – government's positive intent now had to be assumed, but contingency measures were needed due to the risk that this intent might not materialise. Also, while it is relatively clear, in hindsight, that epidemic drivers within key populations (most infected and at risk groups) impact significantly on incidence, and that

combination prevention measures are needed, research was still emerging around these issues. Achieving a clear focus amid competing priorities was challenging. In view of this, Sweden positioned itself well in the new context.

The second strategy period was also influenced by the Swedish policy shift towards partner driven cooperation (PDC) and phase-out of the bilateral development assistance. PDC relies on the ability and willingness of Swedish and South African partners to identify areas of cooperation and here the Embassy is more limited in terms of direct and strategic engagement with development actors.

Prevention results

The evaluators conclude that the second HIV/AIDS strategy was quite effectively implemented in terms of continued support to existing projects; although the impact in terms of overall reduction of new infections is only slowly becoming visible. However, there is evidence of emerging outcomes of the Swedish support in terms of:

- Umbrella organisations, funded by Sweden, definitely had a role in enhancing CBO efficiency in targeted communities.
- Support to organisations such as TAC, AIDS Consortium and Sonke leveraged mechanisms for citizen representation, which ensured the linkage of the grassroots to the top i.e., local voices into the NSP.
- Development of ideas, models, institutions and styles within the response, has begun to address the drivers of the epidemic/infection. Sweden encouraged and supported innovative initiatives, which moved away from ABC (Abstain, Be faithful and use Condoms), and supported the view of prevention as requiring a complex and multi-layered human rights/gender equality approach. This reflected a maturing approach to addressing the epidemic.
- Support to CBOs providing HIV-related and general access to socio/economic services and opportunities may well ultimately contribute to prevention.

The human-rights-based approach and the focus on gender norms and civil society actors was forward looking and different to the primarily bio-medical approach taken by many other donors (which was necessary to cope with the very acute burden of disease). The approach was informed by the rationale that more holistic approaches to people's circumstances are needed to shift their approach/behaviour/practice.

Swedish partners managed to develop many interesting models which addressed prevention in a ways tailor-made to individuals' life circumstances. What the Embassy and its key partners *did not manage to do* was to optimise, build onto, or package innovative models in a way that would make them accessible and scalable. In the context of a relatively directionless and therefore stagnant prevention response, Sweden did not use its creative approaches to stimulate new approaches. In particular, consciously combined and crystallised good practice models, as well as research results into the visibility and credibility of models, could have/should have been part of upward influencing and advocacy feeding into the NSP prevention strategy.

Coordination results

Coordination support took two major forms under the Swedish programme. Firstly, Sweden took a leading role in donor coordination, convening meetings of Nordic, EU

and global donors operating in South Africa. Secondly, the Embassy supported the national HIV coordination functions of SANAC in a range of ways.

In terms of donor coordination, the evaluators conclude that Sweden contributed to South Africa's efforts to coordinate national, bilateral and multilateral initiatives at the national level. Sweden was instrumental in building donor dialogue and coordination during both strategy periods. All multi- and bi-lateral sources recognise this contribution at a time when other donors were more hesitant to put their heads above the parapet. The evaluators noted, however, that the EU undertakes limited responsibility as a coordinator, or as an agency, that strategically plans programmes that add value or create synergies with the initiatives of member states. It may be that Sweden could have used its coordinating presence to influence the EU more.

Sweden's interest in coordination at the national level had a clear impact, particularly through indirect support to SANAC in the form of enabling Mark Heywood as co-chair, and the funding of several sector coordinators. In addition, direct financial support was requested for a 6-month bridging period during SANAC's early management transition. This support ensured SANAC's continuity and enabled the Plenary and the different sectors to continue to function. This was achieved despite severe limitations during a challenging period and, frequently, a lack of drive from those leading the organisation. While Sweden's contribution to SANAC was effective and valued, this opportunity was perhaps not taken to logical conclusions in all aspects. For example, all donors held separate meetings with SANAC to determine support rather than coordinating their efforts. It was mentioned that donors '*could have pushed for independence from NDoH*', and could have pushed for more accountability against supplied funds. This concern is well founded in hindsight, but the evaluators recognise the delicate balance between the emerging autonomy and institutionalisation of SANAC at the time, against the opportunities for external influence, and acknowledge that the decisions taken during that period were justified.

5.1.3 Selection of main partners

The selection of AFSA as a grant maker and CSO capacity builder was effective. AFSA had an established history of packaging funding and capacity building for CBOs, and had little difficulty fulfilling this role. Only two other organisations in South Africa have a similar role and capacity. Tasked with grant management for NGOs, some far larger than AFSA itself, posed some initial challenges. Most grantees, however, seemed to appreciate AFSA's support and even well-established organisations appeared to have improved systems and processes.

Greater efficiency and leverage might have been achieved if the Embassy had escalated the expectations, opportunities and roles of partners in the second phase, and built more strongly on experience. This would need to be offset against Sweden's other key quality of low interference and support to responsive and autonomous organisations. Nevertheless, opportunities which might have been valuable in the second phase include stronger collaboration in model building, facilitation of collective advocacy and representation for community organisations, expanded and intensified roles for umbrella organisations, expanded roles and capacity options for CBOs to include key populations, gender equality or socio-economic development (as

examples), and distillation of lessons learned and greater dissemination of prevention achievement. These examples only serve to illustrate the potential value of a stronger collective strategic thinking process between phases, which is aimed at building on the achievements of the past more explicitly.

The continued cooperation with CEP was strategic and very effective in reaching large numbers of mobile men with general health services, HIV/AIDS services and prevention messages. Greater sustainability would have been achieved had the Embassy put more pressure on CEP to encourage the transport industry to take a greater proportion of responsibility for the management of programme, with the aim of full integration of the project in the Bargaining Council. Mutual benefit would have been achieved with closer cooperation between CEP and the regional North Star Alliance programme, in order to scale up their very similar offerings. CEP has the potential to serve as a model for other industries.

The continued support to Zivikele enhanced the knowledge of hundreds of public servants on how to deal with GBV and its consequences, but was not effective in translating this into changed practices by public servants in communities. The Embassy could have encouraged Zivikele to form closer alliances with other agencies targeting civil servants with similar messages, together combining training efforts with continuous mentorship and efforts to remove structural and systemic obstacles.

5.1.4 Enabling and obstructing factors

The evaluators conclude that a number of factors enabled and obstructed the Embassy's intentions:

Obstructing factors	Enabling factors
The denialism of the government pre-2007	National political will post 2008 and a very competent Minister of Health
Poor health system	Funding is available for the medical response (Global Fund, PEPFAR etc.)
The difficulty of engaging with government at provincial and district levels	Culture of community solidarity, proactive citizen responses, volunteerism and action
Corruption and nepotism which: <ul style="list-style-type: none"> • instils fear and prevents holding government to account (lapdogs not watchdogs) • leads to poor services and weak public sector systems Growing limitations on freedom of expression, as evidenced by the Protection of State Information Bill, opposed by many South Africans.	Effective constitution, court and justice system which can be used to hold government to account.
Insufficient activism at local and provincial levels, and largely disempowered and	A few very powerful national activists and organisations

Obstructing factors	Enabling factors
inarticulate civil society	
SANAC is still not effective in coordination, M&E, scaling of models and influencing government	External pressure from the UN on the Three 'Ones'
Narrow focus on HIV/AIDS by key actors, limited coordination with TB, SRHR, gender and human rights issues	The coherent, proactive, well informed approach taken by the Swedish ambassador, councillor, HIV advisor.

5.2 EFFICIENCY

5.2.1 Use of funding

Sweden has spent around 310 million SEK on HIV/AIDS programmes in South Africa during the period 2004-2013 (on average 31 million SEK per year) to mitigate and prevent further spreading of the HIV/AIDS epidemic. Funding was placed primarily in the civil society sector to monitor and supplement government efforts. The impacts and outcomes are documented above in Chapter 3.

Around 80 million SEK were provided to national NGOs, which were instrumental in influencing the policy shift. This amounts to approximately 285 SEK per extended life (reduced HIV/AIDS related mortality and morbidity), and a far lower per-person cost to the many children brought up by their own, healthy parents. Although Swedish funding was augmented by other donors paying for medicine and health system administration, Sweden's contribution was catalytic to the results.

Approximately 18.6 million SEK were channelled to AFSA's programme for CBOs in the Northern and Eastern Cape, mainly in the period 2008-12 – details are provided in a table of figures in Annex 9.2.6. These CBOs reached and assisted around 45 000 women, men and children per year during this time. A rough estimate indicates an average cost of around 100 SEK per beneficiary. Compared to the improvements in quality of life for the women, men and children assisted, this seems like a low cost.

A total of around 20.3 million SEK were given to provincial governments; and the efficiency of this funding was limited.

It is too early to say if the funding provided to prevention work and model development will efficiently translate into averted new infections in the future. It is clear, however, that Sweden could have encouraged/required partners to cooperate more in prevention model development, research of good practices and dissemination of the CSO prevention initiatives.

In general, however, based on the rough calculations made and feedback from respondents, the evaluators find that the funding was used efficiently.

5.2.2 Management of funding

The overall management of the funding, which was flexible, long-term and proactively targeted key actors with core funding, was deemed very efficient. However, funding flows in the past few years have hampered partners' ability to effectively implement programmes. Since disbursements required audited annual statements, funding dried up for up to four months at the beginning of every financial year, thus only permitting implementation in the second half of the year. Fund disbursement delay meant that some sub-grantees, at times, had to retrench staff in contravention of normal labour practice and to the great discomfort of these low-income employees. Once funds were disbursed, these organisations incurred costs of recruitment and training new staff. There was also direct impact for beneficiaries where organisations were forced to suspend cost-bearing activities. It appears that relatively low priority was given to the implications of this funding interruption, and limited effective mitigation was considered. New Swedish guidelines with stricter requirements on risks, audits and reporting seem to have contributed to this growing inefficiency.

In addition to the Embassy of Sweden in South Africa's programmes, other sources of Swedish global, regional and Swedish CSO funding have been received by HIV/AIDS programmes in South Africa (e.g. NACOSA, Sonke, religious groups, CBOs in Eastern Cape, etc.). Closer cooperation between these other Swedish actors and the Embassy could have increased efficiency.

5.3 RELEVANCE

Most Swedish-supported initiatives have been relevant to the context and to the emerging needs in the South African response. Close contact between the Embassy and activists and government, in combination with flexible but long-term core funding of key actors, has ensured that the contributions stay relevant.

Core funding to national advocacy/watch-dog organisations continues to be highly relevant to ensure that all voices are heard and responded to. The mentoring, capacity building and core support to CBOs is still very relevant, particularly in light of the holistic service that they provide at the community level. There are opportunities to achieve scale and consistency in the CBO sector's relationships with government in the future.

Innovative and effective combination and linked-up prevention programmes are more relevant than ever, particularly in light of recent disappointments in conventional prevention strategies. Refreshing alternatives to youth prevention are highly relevant, as HIV message fatigue exacerbates vulnerability in this group.

Sweden's focus on SRHR and gender norms was also well chosen in light of recent statistics showing that young girls are most at risk, and the identification of key populations, such as truck drivers, sex workers and others as incidence vectors, shows that continued highlighting of these groups has on-going importance.

The training programmes (for public servants or CBOs) were relevant, particularly in establishing a knowledge foundation around rights, legislation and GBV. These

programmes will become less effective if learning implementation does not take place in an enabling environment. While impact is more likely to be achieved in the supportive context of civil society, the public service requires deeper support than training in isolation.

The South Africa programme has also been very relevant to the Swedish regional and global strategies for HIV/AIDS. The South Africa strategy has closely followed the intentions in these strategies. South Africa has been a useful resource, both for the global and regional programmes and South African partners are in the forefront when it comes to focus areas such as prevention, gender equality, GBV and SRHR.

5.4 SUSTAINABILITY

5.4.1 Sustainability of the HIV/AIDS response²⁰

A number of development partners, including Sweden, are poised to end or substantially reduce their ODA assistance to South Africa's HIV response. This exit is due to a range of factors: the MDG target date is looming and many programmes were aligned with these targets; programmes have run for upwards of 10 years; and South Africa is now categorised by the World Bank as an upper middle-income country based on GDP. This trend occurs despite the particularly high Gini Index indicating severe poverty among the majority of South Africans, and poor systems for distribution of services and GDP. As a result, decisions to withdraw at this stage are likely to affect the sustainability of earlier investments.

The risk is that the gains achieved over the period of intensive ODA, and the capacity building and strengthening interventions, have not been sufficiently embedded to continue without support, or resolved the underlying social challenges that remain as the legacy of apartheid. To challenge the deficit of accountability and effectiveness at provincial and district levels, and to sustain momentum at the national level, there is a critical need for continued civil society monitoring and activism. Equally, while progress has been made, HIV has not been resolved, and death rates as high as 800 people per day remain a reality. Systems for preventing and addressing HIV are effectively still being practiced. Support to the national response, both in terms of sustained activism, and in the innovation of effective models must still come from external sources according to the SANAC CEO:

²⁰ There is an ongoing debate around classification of countries eligible for ODA. Many respondents in this evaluation commented on this as well as the impact of donor funding leaving South Africa. See Annexure 9.1.

HIV is a special problem in SA and global solidarity in fighting the disease means there needs to be continued support to the SA response. If we don't win in SA the world will not win on HIV. To pull funding now is short sighted.

5.4.2 CBO sustainability

Sustainability can be seen as the development of overarching integrated systems to manage social, environmental and wider economic impacts of an organisation's activities²¹. However, CBOs have mainly viewed sustainability from a funding perspective, and rely on local-level social responsibility, donor funding and government stipends. These sources of funding come with different pros and cons. While local investment builds referral networks and local credibility, donor funding confers a level of autonomy and an ability to hold government to account. Government funding reinforces CBOs' role as extension service providers.

More urgent than the survival of individual organisations, the role of the institutional fabric constituting the CBO sector is a critical concern for sustainability. In order to safeguard the sustainability for this types of organisation and the specific niche in which they work, there is a need to support initiatives aimed at resolving the issue of government funding of, and relationship with, CBOs. Coceka Nogaduka, previously member of the Technical Advisory Committee to ECAC commented:

Government struggles to fund CBOs effectively – they channel funding through procurement which makes it subject to procurement rules e.g. that same organisations cannot receive funding year on year – i.e. procurement forces a spread among service providers, also funding different CBOs doing the same things in different districts can be seen by audit as 'splitting a tender', so there was no cognisance taken of the specificity of local organisations.

The organisational mismatch between a groundswell of citizen concern and contribution, and government's need for consistent, replicable, and efficient systems makes government engagement with CBOs difficult. Recognising their unique fit to the role of community access and household care, perseverance in finding models that enable this fit is a development and HIV priority.

5.4.3 Regional sustainability

South Africa plays a key role in the regional HIV/AIDS responses, as a role model and driving force. Unless South African actors are kept strong, this resource will no longer be regionally available.

²¹ SIGMA (Sustainability Integrated Guidelines for Management) Guidelines available from www.projectsigma.com

6 How Sweden Achieved Results

6.1 A PROACTIVE TEAM WITH A VISION

As mentioned above, Sweden played a decisive role in the process leading up to the shift in policy, the rollout of ART and the development of the National Plan of Action in South Africa. A precondition for the success was the coherent and proactive approach taken by the Embassy, through the close cooperation between staff placed at the political, tactical and implementation levels, respectively. All of these individuals shared a clear vision, were actively engaged, and maintained and nurtured their relationships with stakeholders throughout the response landscape.

The rather confrontational approach (via the supported CSOs) could be taken because of Sweden's good reputation with the ANC, which made it possible to raise issues of concern with government officials who were responsible for the poor response to HIV/AIDS before 2007. The good will also helped Sweden to be accepted by the government as a donor coordinator.

Apart from the coherent and committed work by the Embassy, the following features of the Swedish approach were recognised as having been especially effective:

- The fact that Sweden had a **healthy appetite for risk**, in funding decisions and diplomacy. Sweden was willing to place funds in places, and approaches, it believed were important for the future, but which might not at the time have been recognised as catalytic issues: gender-based-violence, gender issues in general, issues related to men's participation in the response, and the relatively unsecured investment in the SANAC bridging period.
- The fact that Sweden was **not focussed on programmatic or Swedish branding**, but was content to support basic operational costs to ensure the development of effectively managed organisations who could take credit for their achievements.
- HIV/AIDS was always addressed from a **human rights perspective**, rather than from a medical/health perspective. Sweden emphasises that programmes to address HIV/AIDS are part of SRHR.
- Sweden **proactively** looked for the most strategic partners and did not wait for applications for funding. The Embassy never used calls for proposals.
- Sweden provided **flexible, long-term core support** to strategic partners.
- Sweden effectively combined diplomatic dialogue and development assistance.
- The Embassy invested time and resources to take the lead in **donor coordination** when it became clear that, even with a new approach, the Government of South Africa would not take on this role.

It was the view of most respondents, that over the decade of support, the modalities and structures of Swedish support were effective, and that good relationships were

built with partners at the Embassy of Sweden in Pretoria. The SABCOHA CEO said that *‘these relationships were built on personalities, and that was very valuable’*. Sweden was also not afraid of adjusting approaches that had proved ineffective. For example:

- The first strategy identified mainstreaming of HIV/AIDS in other programmes as a necessary output. However, over time, it became clear that mainstreaming was not sufficiently effective. In the second strategy period, focus shifted to targeted initiatives.
- The first strategy supported capacity development of both government and the CSO sector, with 50% of funding going to each sector. Two provinces, Northern and Eastern Cape, were identified as focus areas for Swedish support. However, the lack of political will and capacity of national and provincial authorities made it difficult to achieve the desired results, and provinces, in particular, were not able to effectively absorb funding. In the second strategy, funding was primarily restricted to the CSO sector. The classification of South Africa as a middle income country also contributed to this decision.

6.2 BUILDING RELATIONSHIPS

6.2.1 Relationships with South African stakeholders

The good relationship between Sweden and South Africa provided Sweden with a good platform for frank dialogue with the government during the first strategy period. The relationship has become a bit more distant over the period of review. While some donors decided to support the health system to implement the NSPs and address the obstacles and bottlenecks in the system, Sweden decided to continue focussing on civil society and holding the government to account. While this was probably a more efficient use of the Swedish funding, and government acknowledges the importance of a strong civil society, it was a disappointment to the South African government.

The Swedish decision to phase out the bilateral cooperation/support from 2014 is yet another disappointment. It is felt that Sweden is cutting funding too early, and thus leaving South Africa in a vulnerable situation where the health system is still weak and in the midst of a reform process, in which donor-dependent activism organisations are a critical force.

At the same time, it is appreciated that the Embassy kept a close relationship with SANAC throughout the two strategy periods. Together with DFID, Sweden took a great risk in funding and assisting SANAC at a time when it was rather dysfunctional and achieving little. Through persistent engagement (directly and via Swedish funded South African NGOs) and core operations financial support, Sweden and DFID were instrumental in keeping SANAC alive and ready for its important role.

Sweden’s relationships with CSO partners are generally very good. There is great appreciation of the flexible, long-term core support from Sweden and the professionalism of the HIV/AIDS advisor. The decision to outsource grant making to

AFSA in 2008 was at first met with reluctance by some partners, but after receiving some useful support in terms of developing systems and procedures, partners now largely value the new arrangement.

6.2.2 Donor Coordination

During the period of review, Sweden played a crucial role in donor coordination. The Embassy staff who were involved cooperated closely to take these proactive and sometimes informal steps to bring donors together and adopt a joint approach. Donor coordination was especially important in the wake of the poor response that was initially taken by the government. Also, because development aid is a small share of the South African budget, the incentive to invest in donor coordination may be small.

Other donors view Sweden as a key actor in the HIV/AIDS sector. The coordinating and advocacy role taken by Sweden was appreciated by all, to the extent that the EU+ group that was formed in 2004 was soon joined also by most UN-agencies, including UNAIDS and WHO, and USAID.

There is still a need for donor coordination, now led by the Germans, but the Government of South Africa and SANAC are increasingly taking on their responsibilities for this role.

6.2.3 Partner Driven Cooperation (PDC) – yet to be evaluated

Partner Driven Cooperation is a modality (or a co-financed partnership) that aims to stimulate and strengthen the emergence of self-supporting relationships of mutual interest between Swedish partners and partners in low- and medium-income countries. Shared ownership, mutual interest, joint responsibility and long-term sustainability are some of the principles for partner-driven cooperation. A PDC requires that a South African organisation partners with a Swedish organisation. The partnership is generally relatively short-term, and is structured around a particular project or outcome. Sida provides funding to support the arrangement, but both the Swedish and the South African partner have to commit their own funds to the project. This modality is therefore limited to organisations, institutions and businesses that can afford this, e.g. research institutions, commercial agencies and professional organisations. Current Swedish PDC partnerships in the area of HIV/AIDS are between SABCOHA and Gothenburg University, Sonke and Män för Jämställdhet (MfJ), FPD and the National Centre for Knowledge on Men's Violence against Women (NCK) at Uppsala University Hospital, and lastly, Shout-it-Now and Uppsala University. There are mixed experiences of these partnerships and their effectiveness. In the case of the Sonke-MfJ partnership, for example, reports show that the Swedish partner has mainly been capacitated.

Because of the need for financial contributions from the South African partners, respondents are of the view that the modality is not accessible to advocacy/watch dog organisations or CBOs that do not have such resources. Interviewed treasury representatives commented that:

South African organisations are not yet equal to Swedish ones, so we are not ready for this modality. It is only possible for rich organisations, which do not need the support as much.

Although the intention is for PDCs to contribute to poverty reduction and equitable and sustainable global development, the PDC modality has no intrinsic poverty or human rights focus. Such focus need to be ascertained by Sweden in its assessments of relevance and expected outcomes of the supported partnerships. While recognising its limitations, the PDC model may be a good vehicle for some forms of cooperation. For example, in programmes engaging the government, e.g. the private sector or research institutions, according to the Department of Health:

We need help to develop our own support into Africa – perhaps a trilateral cooperation agreement would be the best idea.

According to the Embassy, an evaluation of the PDC modality is underway, which can further elaborate on strengths and weaknesses.

6.3 A REGIONAL APPROACH

The South African programme has formed an important part of the Swedish regional HIV/AIDS programme coordinated from Lusaka. Although the budget has formally been under the Embassy of Sweden in Pretoria, initiatives have been discussed and decision memos have been prepared in Lusaka. For a long period of time, the HIV/AIDS advisor from South Africa was part of the regional project committee, contributing and sharing experiences of value to both the Regional HIV/AIDS Team and to Sida in Stockholm.

Many of the regional, and some of the global, partners have their base in South Africa. In view of this fact, placing the regional office in Lusaka may not be the most effective approach. Despite the close relationship, synergies could have been more developed. For example, in the case of Sonke, at least four different Swedish funding channels are used to support the work of the organisation. The South African partner to the Sida-funded International HIV/AIDS Alliance is NACOSA, an organisation which has not been utilised in the SA programme or experiences exchange (see more above on synergies).

In the Swedish 2008-2012 HIV/AIDS strategy for South Africa, it was even envisaged to formally move the responsibility for the South African HIV/AIDS programme and the HIV/AIDS advisor to the Regional HIV & AIDS-Team in Lusaka. This never materialised, due to formal requirements regarding staff management and control at the Embassies.

Taking a regional approach has offered an opportunity for practitioners to hear experiences and perspectives between countries. Very different contexts enable lateral thinking and an opening up, or challenging, of beliefs and assumptions. Regional approaches can be cheaper, and they do provide a voice across, and into, all countries, particularly where some messages may not be tenable, i.e. coming from national

organisations. A number of the consulted stakeholders had experience of successful examples of regional influencing:

- When National Aids Council leaders and technical advisors, each with direct access to their respective Ministries, participate in meetings arranged by regional bodies or organisations, they meet informally behind the scene to share information from global experience, provide high-level technical input across countries, and take this back home to their ministries. The informal part of meetings is often seen as more useful than the formal, which often involves long presentations.
- Regional work can harness very high-profile champions. For example, MMC was stalled in Mozambique because of disagreements between the Ministry and NAC, and the way forward was facilitated by ex-presidents. The programme is now rolling out. This level of leadership has access to current political leaders and can influence from ‘above’.
- Promoting issues that are sensitive at the national level, such as LGBTI rights and SRHR, particularly where key populations are criminalised.
- Cross-border issues and mobile populations: The SANAC CEO said: *We are taking the lead to initiate a regional approach to HIV – if we don’t deal with our cross border problems we will never sort within SA – our populations are very mobile across borders. Trucking and other mobile populations are critical areas of focus. Sida’s flexibility may be a benefit in this regard.*

While recognising the areas where regional approaches are helpful, all respondents agreed that change mainly depends on pressure from below, and achievements that ultimately reach to the local level. Ireland Aids HIV advisor, Tamara Mathebula said:

...only country-level organisations can change countries ... if you remove country support you will lose this very important bottom-up influence and the voice from that level. The move to become more regionally focussed should be slow and should allow countries to get to a sustainable levels, donors can then identify national programmes that are critical for influencing the region...because of SA’s strategic position it may be useful to have more regional programmes working out of SA and these should probably also have SA elements.

While national programming offers greater effectiveness, it is acknowledged that a regional approach may be inevitable due to financial restrictions. Regional work should, however, be seen as a supplement and not as an alternative to national investment. In addition to operating in the regional context, according to Save the Children’s regional team, regional level structures should continue to provide a conduit for funding to national level programming.

7 Lessons Learnt

7.1 UNIFIED APPROACH

This evaluation demonstrates that having a coherent and unified Swedish approach to the development goals, using both diplomatic and development assistance efforts to achieve change, is a key success factor. This requires focus on a few issues that are jointly promoted over a longer period of time. It also requires local staff with high-level competency. Long-term presence and good connections with partners and co-donors are essential and help maintain continuity.

7.2 HUMAN RIGHTS PLATFORM

This evaluation confirms that the consistent and strong Swedish focus on human rights and gender equality is contributing to credibility and results. Being perceived as a country with a strong human rights focus and limited interest in ‘branding’, Sweden is widely trusted by co-donors, fund recipients, as well as a wider range of other stakeholders. Sweden can use this position to influence processes and priorities in the donor community. The EU platform could, however, be used more systematically to create and facilitate synergies (rather than having EU as a separate donor with its own agenda). This would also be in line with the Aid Effectiveness Agenda, which requires donors to coordinate around partner applications and report on funding.

7.3 SWEDISH DEVELOPMENT PRACTICE

7.3.1 Flexibility, core funding and risk taking

This evaluation showed that high risk-taking and flexible, core funding of organisations that have visionary, professional and brave leadership have been key factors in the success of the programme. Partners have been proactively selected based on assessments of their organisations’ potential as change agents and the capacities of their leaders. This was possible in a context where the Embassy staff could inform decisions based on local knowledge and engagement, as well as Sweden’s relatively flexible grant-making parameters. The recent, stricter, regulations from the Swedish government no longer allow for such risk taking and flexibility. The ability for activist organisations to respond to situations as they arose, to persevere in campaigns that took several years to bear fruit, to accept set-backs without viewing them as organisational failures, were all directly made possible by Sweden refraining from demands for short-term results and prescriptive detailed indicators. In terms of achieving real change in complex social contexts, the Swedish

approach in South Africa over the last 10 years has been ideal, and current trends in opposition to this approach are likely to reduce impact and effectiveness in the future.

In light of these observations, Sweden needs to find a way to combine legitimate demands for control and effectiveness with the need to be flexible and take risks – especially if the aim is to empower women and men living in poverty, and hold governments accountable. Whether aimed at the unpredictable processes of advocacy organisations, the learning environment of prevention solutions or the loosely structured and unsophisticated management systems of local community organisations, effective development requires responsiveness and flexibility.

7.3.2 Balancing voluntarism/grassroots engagement and professionalism

This evaluation noted that, in organisations that are grassroots membership associations, board members are often elected because of their ability to communicate the advocacy message and represent the opinions of the constituency. Qualities in areas such as strategic planning, organisation and management, recruitment, fund raising etc. are sometimes seen as being less equally important when electing the board. This affects the effectiveness of systems and structures of these organisations. As donors prefer to fund organisations with well-developed and professional management systems and structures, they tend to partner with organisations that are run by a small group of professional individuals. This reduces the opportunity for democratically-structured grassroots organisations to get funding. These kinds of problems were encountered by some of the Swedish-supported NGOs, as well as some of the CBOs supported by AFSA.

The Swedish CSO Policy (Pluralism) promotes democracy, self-organisation and the empowerment of poor women and men to have a voice. In order for such grassroots/constituency based organisations to be eligible and able to effectively use funding, there is a need to support these organisations in the application phase and find support models that can balance the trade-off between voluntarism/grassroots engagement and professionalism.

7.4 CRITERIA FOR DETERMINING SUPPORT

Based on the findings in the evaluation, the criteria that have been used for decisions of phasing out of Swedish bilateral development assistance could be challenged. While the Gross National Income (GNI) per capita could be a relevant tool for determining if a government should receive financial development assistance from Sweden, other criteria would seem relevant when determining if support to CSO watch dogs and human rights defenders in a country should continue. This is also the rationale that is used by Sweden in Eastern Europe and in post-conflict countries. It should also be considered that most of the world's poor live in middle income countries, where disparities contribute to instability and where human rights violations are still grave. In the case of South Africa, its important role in the region also needs to be considered. While appreciating that Sweden needs to concentrate its

development assistance to make it effective, a strict application of GNI per capita as criteria for phase out seems inadequate.

7.5 TRAINING IS NOT ENOUGH

In line with Swedish policies, the support to South African HIV/AIDS programmes have attempted to support the capacity development of rights holders to claim those rights and of duty bearers to respond to these legitimate claims. As in many other programmes, formal training seminars are often used as a method to achieve changes in behaviours, policies and practices. This evaluation confirms findings in other evaluations that, unless training is accompanied by organisational development, institutional support and on-the-job follow up coaching/mentoring, it often does not have an effect beyond the individual experience or knowledge boost. There are many obstacles that prevent people from putting knowledge into practice, e.g. structural, financial and cultural.

When designing programmes that aim for social or behavioural change, all these contextual factors need to be considered. The evaluation only found anecdotal evidence in support of training-only interventions leading to desired changes. By contrast, learning is better in interventions where training is supported by mentorship, coaching and practical technical advice.

In the absence of longer-term tracking studies, or more focussed follow up by the institutions, it is not possible to determine whether support to training-only interventions has produced value for money.

7.6 SCALING UP

This evaluation confirms findings in many other evaluations that point to the difficulty of bringing pilot or model projects to scale. The piloting and model development of HIV/AIDS prevention initiatives in South Africa has resulted in islands of good practices. For such models to achieve a broader impact requires that the lessons learned are documented and shared in a manner that can influence current approaches on a broader scale (e.g. prevention of new infections among youth or household level integrated support). In addition, practical options that are adaptable to a variety of contexts need to be distilled and promoted to broader civil society, donor practice and government for widespread adoption. This expansion needs to be encouraged and facilitated by donors.

8 Conclusions and Way Forward

The recommendations in this chapter have been developed in light of the Swedish decision to phase out bilateral development assistance to South Africa in 2014.

8.1 ENSURING CONTINUED PARTNERSHIP

With Swedish support being catalytic to the changes, South Africa has been able to develop its response to the HIV/AIDS epidemic during the period 2004-2013. Health system reforms are on their way; private sector responsibility programmes are operating; CSO monitoring and advocacy initiatives demonstrate how government can be held to account; and new models for treatment, care and prevention are tested and documented. Although major challenges still remain, survival and incidence rates are improving. Based on its substantial experience, South Africa has been able – and can continue to – play an important role in the region. South Africa shares the human rights value-base with Sweden and is an ally in the fight for SRHR in the region. Sweden should continue to partner with South Africa – on government, CSO and research levels – to strengthen the regional efforts.

To do so, key South African actors must be enabled to continue their important development work in South Africa, which is a basis for partnership and experience exchange. Respondents repeatedly emphasised that regional programmes need to take their starting point in national/local processes, where policies, laws and systems can be influenced and developed. Regional programmes can enhance and facilitate developments (especially in controversial human rights areas), but do not drive them.

Recommendation 1: The South African HIV/AIDS and SRHR programme should continue to form an integral and important part of the Swedish regional programme after the phase out of the bilateral development assistance to South Africa.

Recommendation 2: Sweden could consider moving the Swedish regional hub for SRHR from Lusaka to South Africa, as many regional UN and CSO headquarters are situated there.

8.2 FOCUS AREAS

In line with the findings in this evaluation and the Swedish policy on HIV/AIDS, Sweden and South Africa could continue to build a partnership in the following areas, which are all important and relevant to the development of SRHR responses and fulfilment of the millennium goals in the region:

8.2.1 Holding governments to account

The South African experience of combining *watch-dog and advocacy work, litigation and rights holder organisation*, could serve as an inspiration for other countries. The scope can, however, be further broadened to include *media/ICT activists/watch-dog organisations* that can hold the government accountable to human rights and good governance principles, in general, and *advocacy/culture organisations*, which can challenge gender norms and give citizens a voice. Such initiatives could be supported via the Swedish Special Contribution for Democracy or via the new regional appropriation – depending on its focus. The biggest challenges that are still apparent in South Africa and the region are:

- Monitoring of government accountability at district and provincial levels.
- Linking legal and advocacy expertise with CBOs and citizens' concerns.

Recommendation 3: Sweden should continue to partner with South African watchdog and human rights defender organisations in regional and global development programmes, and use the appropriation Special Fund for Democracy to augment the regional appropriation.

8.2.2 Empowering grassroots

Experiences of health system reform and methods for *empowerment and capacity development of CBOs* are of great mutual interest among countries in the region. Many countries are struggling to find ways to link government services through CBOs in order to facilitate access to these services and support poor and marginalised groups to claim their sexual and reproductive health rights, challenge gender norms and prevent the further spread of HIV/AIDS. Sweden could focus more of its regional support through umbrella organisations or NGOs that are willing and able to:

- Be a driving force in advocating for the continued government recognition of, and support to, CBOs in their dual role as development partners and citizen representatives.
- Provide evidence of the impact, scale and gaps in the CBO sector and stronger communication of this evidence – in cooperation with researchers.
- Be a collective voice of member CBOs, including more structured direct participation by grassroots members in advocacy, evidence and model development.
- Document and share experiences and lessons of these local CBOs and find flexible strategies for enabling them to develop their role and relationships in the communities (including the difficult balance between government cooperation and accountability demands).
- Build on local driving forces and priorities, without compromising the focus on human rights, SRHR and gender equality.
- Enable effective local capacity and innovative models that can be taken to scale with increased consistency – in cooperation with researchers.

Recommendation 4: Sweden should continue to include South African actors in its regional efforts to develop effective community-based models for addressing SRHR and the causes and effects of HIV/AIDS.

Recommendation 5: Sweden should encourage and support its partners to document and share experiences on community-based approaches and enable processes that can bring effective models to scale.

8.2.3 Innovation and research

The South African *research capacity and its position on SRHR issues in general and LGBTI in particular*, could serve as a motor for these issues in the region. The South African contribution could focus on innovative community-based combination prevention models and on models targeting key populations, along with research that proves what is effective and what is scalable at a reasonable cost. The involvement of existing tertiary institutions and research institutes (e.g. HEARD) could enhance long-term sustainability.

Recommendation 6: Sweden should continue to include South African research institutions in its efforts to enhance research on effective approaches to SRHR and HIV/AIDS in the region. The research should be linked to the potential users of the research findings in government and in civil society.

Recommendation 7: Sweden should use the partner-driven cooperation modality to augment its regional appropriation in the financing of research programmes. Donor coordination is of key importance.

8.3 EXIT AND TRANSITION SUPPORT

8.3.1 AFSA

AFSA has proven effective and efficient, both in terms of grant making and in terms of capacity development of CBOs. AFSA's work could, however, improve in terms of advocacy support to CBOs and the facilitation of cooperation and coordination among civil society umbrella organisations.

AFSA has the potential to become a South African hub and intermediary for networking with, and support to, South African actors. The Swedish partners Sonke and FPD (Foundation for Professional Development) are already supported via both AFSA and the Sida Regional HIV & AIDS-Team.

AFSA and South African peer organisations (notably NACOSA and AIDS Consortium), potentially through a regional network, have the opportunity to develop and share effective models for community level engagement.

Recommendation 8: Sweden should include AFSA more closely in its regional networking on SRHR and especially use them as a resource on CBO capacity development and community-level engagement.

8.3.2 CEP and beyond a single industry

Support to Trucking Wellness and CEP has been very successful, both in terms of outreach to an at-risk group and in terms of sustainability. The time has now come for the industry to take full responsibility. They are willing to do this; but immediate resource constraints and garnering industry-wide support for this change would require a phase out – three years was suggested by the Bargaining Council. The Council would also welcome expanding services into the region, alongside MoUs, with other service providers such as North Star Alliance (already supported via the SADC Cross Border program) to avoid the duplication of services and to ensure compatible systems and cooperation in the cross-border and regional efforts. Direct support to CEP should be phased out in agreement with the Bargaining Council.

This project was focused on a single industry, which limited its scope to the trucking routes of Bargaining Council employers. Despite this, the service was extended to include sex workers operating on these routes, based on the understanding that these two high risk populations could not be dealt with separately or exclusively. This valuable and innovative approach would definitely be of value at every truck stop in the region. Northern Cape mining communities, with their high levels of migrant workers, large driver and expanding sex worker populations, immediately spring to mind. Sweden would be well placed to consciously package and communicate the lessons learned over 10 years in one industry to a range of other industries and sectors. The partner-driven cooperation modality could be useful in this area and Business Sweden's on-going work/network could be explored as a potential avenue.

Recommendation 9: Sweden should facilitate the full takeover of the CEP project by the Bargaining Council. When doing this, Sweden should insist on a MoU between CEP and other similar service providers, in particular the North Star Alliance, which is supported via the SADC Cross Border program.

Recommendation 10: Sweden should use the successful model developed by CEP to inspire other industries, especially those that are engaging migrant workers.

Recommendation 11: Sweden should use the partner driven cooperation modality to augment its regional appropriation in the financing of industry-related responses.

8.3.3 Zivikele

Although participants of Zivikele training appreciated the new knowledge gained and found it useful in their personal capacities, there is little evidence that this enhanced knowledge has changed public sector service delivery practices and responses to GBV in communities. There are great obstacles to multi-sectoral cooperation and district-level political will is not yet sufficient to press for change. The changed focus on parliamentarians has not yet led to improvements in this regard. It is unclear how Zivikele can contribute to the regional level experience exchange. Sweden could make a deeper study of the potential of the Zivikele programmes as a basis for a decision on the way forward.

Recommendation 12: Sweden should more closely evaluate if Zivikele has the potential to contribute to the regional programme.

8.4 BUILDING ON LESSONS LEARNT

When designing its future interventions in the region, Sweden should take the lessons learnt in South Africa into account:

- Taking a unified approach to the development agenda, combining diplomatic efforts and dialogue, development aid and strategic funding of key change agents.
- Continuing to build on a firm human rights agenda and refraining from ‘branding’. Using the EU more strategically to create synergies between donors in partner countries.
- Continuing to provide long-term, core funding to carefully selected change agents. There should be space for risk-taking and flexibility in the grant making. Results frameworks sometimes need to be very open in terms of activities and outputs, and focus on vision and outcome-level results.
- Finding ways to reach and support constituency-based grassroots organisations with weak systems, and possibly funding umbrellas that can assist CBOs with management and advocacy. Governance support could include developing minimum criteria for the capacities of CBO boards.
- Considering advancing funds or allowing partners to roll funds over from the previous year to maintain operations. Significant continuity gaps cause ultimate beneficiary disillusionment.
- Investing in training only when it is combined with a strong component of follow up, on-site coaching/mentoring and institutional support to ensure that knowledge is put into practice.
- Facilitating processes that can bring research findings and successful models to practical use on a wider scale.]

8.5 MITIGATING RISKS

The proposed way forward comes with a set of risks that must be taken into account. We have attempted to identify these risks and propose ways of mitigating them.

8.5.1 Internal risks (under Swedish programme control)

There are a few internal risks that threaten the effectiveness of the future interventions in South Africa:

Risk	Probability / Consequence	Mitigation
Phasing out of the bilateral development relationships with partners in South Africa could lead to a loss of contacts and competence essential for a successful regional programme.	This situation is likely, which would have relatively severe consequences.	Establish a closer relationship with a few selected organisations serving as focal points in South Africa. Consider moving the regional HIV/Aids office to South Africa.
The ‘regional approach’ could result in a too-thin or too-narrow	This situation is likely to arise and	Focus on ensuring national level capacities in a few countries, (including

Risk	Probability / Consequence	Mitigation
programme. There will be no critical mass for change on national levels.	this would have a moderate effect on national initiatives.	SA as it is a motor in the region). Choose partners strategically. Use the regional approach mainly to facilitate learning, sharing and influencing.

8.5.2 External risks (beyond programme control)

A number of external risks threaten the sustainability of the outcomes achieved through Swedish support to South Africa during 2004-2013. As the regional programme is based on the assumption of South Africa being a strong partner, these risks would influence the effectiveness of Sweden's future regional programme. The risks of South Africa becoming a weaker partner and a less attractive regional model are as follows:

Risk	Probability / Consequence	Mitigation
The health systems may fail to deliver at provincial and district levels. Although infrastructure and resources are available, these have not yet been used effectively. When the middle class is opting for private solutions, the pressure on the public system is reduced (vicious circle).	This scenario is quite possible, and would have severe effects, especially for young women living in poverty and for other key populations.	Find ways to continue supporting watch dog organisations that can help CBOs which give poor women and men a voice in districts and provinces, and assist these local groups with advocacy and litigation. Document and share experiences regionally. Investigate if it is possible to support the government to succeed in its efforts to implement the NHI – perhaps through partner driven cooperation.
SA advocacy/watchdog organisations could become weak due to a lack of funding (especially core funding) as donors withdraw from middle-income SA.	These organisations are already feeling the 'funding pinch'. Losing this voice would severely affect holding government to account.	Find ways, via the Sida Special Fund for Democracy, to continue providing core funding to organisations/human rights defenders that have the potential and capabilities to make a difference, influence government and assist local level organisations that are dependent on good relationships with people of power. Support a free and accountable press through coordination within the EU in dialogue on these issues.
TB/ART integrated treatment may not be well realised, leading to increased death rates.	This integration is increasingly happening. If hampered, mortality and disease burdens would increase.	Emphasise this risk in policy dialogue and require a coordinated response in all SRHR/HIV strategies and programmes.
There is a risk that a solution to prevention is not found and the burden of treatment increases.	Although the incidence is decreasing, the absolute numbers are	Continue to include South African organisations and researchers in the regional programme. Support

Risk	Probability / Consequence	Mitigation
The number of HIV infected persons in need of ART would then become too large for the system to manage.	still substantial, making treatment an expensive exercise.	innovative/holistic prevention models (based on human rights, gender equality and social justice), support research of effects and strategies for bringing to scale (together with other like-minded donors). Facilitate the regional sharing of experiences and cooperate with other key agents.
CBOs often depend too much on single individuals, meaning that they lose their strength and role if the individual leaves.	This is an on-going problem that will probably continue without directed interventions.	Support organisations to prepare for a leadership transition.

9 Annexes

9.1 TERMS OF REFERENCE

The review of Sweden's support to the South African HIV programme during 2004 – 2013

May-June 2013 (dates to be confirmed)

1. General information

Sweden has focussed its support to the South African HIV programme over the period from 2004 to 2013 on two areas; strategic capacity building to release implementation bottlenecks, and continued support to rights based organisations that can act as watch dogs, ensuring the rights of the infected and affected poor in South Africa.

The support aimed at contributing to the effectiveness of the South African response to the epidemic through the implementation of the South African National Strategic Plan 2007-2011 and 2011-2014. The Swedish response has also been based on the Right to a Future, the Policy for Sweden's International HIV and AIDS efforts. The policy aims to create a platform for Sweden's international action in the field of HIV/AIDS. The objective of the policy is reduced vulnerability to HIV and AIDS and increased opportunities for the best possible conditions of life for the groups primarily affected. The implementation of the policy will contribute to the objective of international development cooperation – to create opportunities that will enable poor people to improve their conditions of life. The mainstay of the Swedish response has been prevention, as this is the only long term intervention that will curb the epidemic.

During 2007 – 2010 Sweden played an important role in a critical time in South Africa's HIV/AIDS history. Sweden convened the EU+ working group on HIV&AIDS, a loose network that constitutes of inter alia the EU member states, the European Commission Delegation, Norway, Canada, the US government, JICA, members of the Joint UN Team on AIDS, and the Department of Health and National Treasury. The aim of the working group was to increase effectiveness and efficiency of donors' work with partners, both government and civil society in South Africa through sharing information and discussion. The working group fully supported government's leadership in coordinating the development partners as well as taking leadership of the country's development agenda. The frequency of the meetings was demand driven, and since December 2007 bi-monthly meetings were held. The changes in government effected the EU+ working group on HIV&AIDS to consider its role and place in the new framework and a newly constituted organisation should be constructed on the principles of the Paris Declaration of Aid Effectiveness, named the AIDS & Health Development Partners' Forum.

The support comprises of a couple of direct agreements with organisations ensuring that the Embassy is constantly updated on the dynamism of the current societal dialogue on HIV and AIDS in South Africa. The Embassy established an agreement with the AIDS Foundation of South Africa to act as an umbrella that facilitates assistance to a number of relatively small but key interventions in both civil society and government structures in order to support the implementation of the NSP.

Targeted interventions in the sphere of HIV and AIDS are continuing during the strategy period, until 2013. The goal of support in the area of HIV and AIDS is to strengthen and broaden national efforts to prevent the incidence and spread of HIV and AIDS. Effective prevention involve dialogue with national actors on the underlying causes of the epidemic, such as lack of gender equality as well as insufficient respect for human rights, including sexual and reproductive health and rights. Sweden also highlights the urgent need for national, long-term commitments as well as the importance of addressing the long-term impacts of the epidemic in a sustainable manner as part of the dialogue on political, economic and social development.

In response to economic and social development in South Africa, a new modality of cooperation – selective cooperation – has replaced traditional Swedish development assistance. Previous development cooperation strategies have been marked by a shift to alternative modes of cooperation based on partnership, shared values, mutual benefit, common interests, shared responsibility and cost sharing. The goal of this mode of cooperation with South Africa is to achieve objectives by stimulating and strengthening the emergence of self-supporting relations of mutual interest between Swedish and South African actors.

Sweden's bilateral aid to middle income countries will be phased out by the end of December 2013. The current country strategy for South Africa ends in December 2013 and the Embassy is now embarking on a review of the support Sweden provided the to the country's HIV/GBV programme.

1. Objective

The review of Sweden's support to the South African HIV programme during 2004-2013 has the following objectives:

- To analyse and report lessons learned from current and completed contributions.
- Establish whether the Country strategies (2004-2008 and 2009-2013) were correctly and effectively implemented, and whether the goals and objectives therein were achieved.
- Reassess current support to partners, and whether the areas of support are still appropriate and topical, directly addressing the development and programmatic gaps in the current response to the AIDS epidemic in South Africa.
- Suggestions on the way forward after 2013, the end of the South African Country Strategy, to optimise the reach and impact of Sida's interventions.

- To evaluate the collaboration between the Embassy in Pretoria, the Regional AIDS Team in Lusaka and Sida Stockholm (HQ).

2. Scope of Work

In addition to the above, the Review will identify the following:

- The preliminary impacts, both positive and negative, of the strategies to date.
- The nature and results of engagement with key partners, in particular the NDOH, SANAC, multi- and bilateral development partners, Sida Stockholm and the Regional HIV/AIDS Team based in Lusaka.
- A risk matrix that would enable an assessment of the key challenges that threaten the sustainability of Sida's interventions and achievements.

3. Methodology

Sida subscribe to the OECD/DAC criteria and standards of evaluation, used by development organisations around the world: effectiveness, impact, relevance, sustainability, and efficiency. According to these five evaluation criteria the basic questions evaluations are expected to answer are:

- Efficiency - The extent to which the costs of a development intervention can be justified by its results, taking alternatives into account.
- Effectiveness - The extent to which a development intervention has achieved its objectives, taking their relative importance into account.
- Impact - The totality of the effects of a development intervention, positive and negative, intended and unintended
- Relevance - The extent to which a development intervention conforms to the needs and priorities of target groups and the policies of recipient countries and donors
- Sustainability - The continuation or longevity of benefits from a development intervention after the cessation of development assistance

Sida will make available all information, reports, and documents that are available. The methodology of the review will be twofold, firstly a desk study of all relevant information; and secondly semi-structured interviews with key stakeholders will be conducted that will enable the consultant to identify lessons learned and give concrete recommendations for phasing out support:

- Desk research/study will be conducted to review Swedish project documentation, strategies and reports; other documents of interest such as reviews/evaluations by other development partners, conduct interviews/meetings with project stakeholders; and other relevant institutions.
- Concomitantly, the consultant will, in collaboration with the Embassy, identify a list of key partners and stakeholders to be interviewed. The consultant will therefore interview both projects/organisations and people.
- Some part of the work will be done in Sweden, some in South Africa.
- A questionnaire will be developed and administered to these stakeholders, and their views collated.

- The consultant will present key results, conclusions and recommendations on support to the HIV/GBV sector until 2013.
- The recommendations should be clear and practical, with a view to complement the phasing out strategy.
- An amended report will then be produced and shared with key partners.

4. Outputs

Draft Report

The appointed consultant will draw up a draft report that will be circulated to the Embassy for comment.

Presentation on draft findings

The appointed consultant will make a presentation on the draft report to the Embassy and will use the information provided in feedback to guide the final report's development.

Final Report

The Final Report should be of a publishable quality – the report body text should not exceed 50 pages, including an executive summary (not including annexes). The Final Report including recommendations should only be produced following feedback from key stake holders and the Embassy.

5. Proposed composition and time frame

Time frame

The review will take place during March – June 2013, the core weeks being:

Activity	Date
Procurement of consultant	To be confirmed
Inception plan development and orientation	
Core weeks of the review: Desk research and interviews with key stakeholders	
Draft report submission	
Presentation to the Embassy of draft report	
Final report	

The budget should contain a daily professional rate stipulating the number of days. Reimbursable should be budgeted for separately. The travel budget should make provision for costs for flights from Stockholm to South Africa, South Africa to Lusaka, Zambia, and the main centres in South Africa (Johannesburg, Durban, Cape Town, East London, Kimberley, East London, Pretoria and some rural areas). Other travel costs such as ground transportation should also be included.

The consultancy

The Team size and composition is recommended to be:

- At least 3 people.
- One international and two others.
- The international consultant should have a track record and knowledge of Sida's policies and methodologies of evaluation and monitoring.
- Advanced professional degree, in public health, development, policy, policy analysis or other relevant field.
- Extensive experience, at least 10 years, in the HIV and/or gender fields, with proven track record, preferably from South and southern Africa.
- Consultants should have experience and track record from working with development partners and civil society.
- Consultants should have an in-depth understanding of current South and southern African HIV and gender context and prevention programming, knowledge of local partners and organisations working in HIV and gender, and experience with community mobilisation and community engagement.
- The consultants should have in-depth knowledge of institutional analysis and strong communication knowledge.

Payment schedule

Payment will be made to the consultant in Sweden in SEK in the following manner, 40% up front and then 60% on delivery of the final report.

For more information contact:

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9.2 INCEPTION REPORT

1. Executive Summary

This inception report outlines the proposed method for the review and how we plan to answer the evaluation questions.

The evaluation will begin by first studying all available reports and previous evaluations of Swedish funded initiatives and of other donors funding similar programmes. We have already contacted Sida global and regional teams and SA partners to request such documentation.

The evaluation will continue through interviews to explore the views and experiences of external observers and recipients of Swedish support. The selection of respondents used criteria to ensure that the evaluation covered all key stakeholders and a representative selection of the most important partners. The following respondents will be interviewed: past and present Sida and Embassy staff (global, regional and Pretoria), other donors and multilaterals (8), government representatives (7), direct partners (10), indirect partners via AFSA (17), regional Sida partners (3-4) and Swedish CSOs (2-3). All interviews will be held face-to-face with respondents. Exceptions are the interview with the Lusaka regional team – which will be carried out via video-link – and the questions to Swedish CSO which will be carried out via e-mail/telephone.

The evaluators will make use of the up-coming South African HIV/AIDS conference in Durban (18-21 June) to arrange discussions with important stakeholders/partners and to listen to relevant presentations. The conference will provide possibilities for informal discussions and networking as well as formal semi-structured interviews. The Swedish Embassy HIV/AIDS advisor, Ria Schoeman, will also be attending and will be able to supplement information.

The results frameworks of the Swedish strategies and the supported programmes are rather broad and vague. With few exceptions, the objectives are not clearly measurable. Therefore we have selected an outcome mapping approach to the evaluation, where we ask questions about change and learning. We will ask questions about outcomes upwards (towards decision and policy makers), across (towards other organisations and agencies working in HIV/AIDS field) and downwards (towards beneficiaries/participants). External observations, official statistics, interviews and focussed group discussions with beneficiaries will be used to validate and comment on processes and results. The same semi-structured interview method will be used by all evaluators, who will divide up the interviews. Careful notes will be taken and a summary posted in the drop box folder for all evaluators to read. The information gathered through the desk reviews, interviews and group discussions will be analysed by the four evaluators at a joint workshop towards the end of July. Supplementary information will be solicited if necessary.

The major challenges will be the limited institutional memory in Sida and among partners and the difficulty to attribute results to the Swedish contribution. The fact

that we are four evaluators with different experiences will add value to the analysis but will also demand a consistent approach and careful note taking.

An first outline of the report will be submitted to the Swedish Embassy by 19 August and a draft report will be submitted by 30 August for validation and comments by the Embassy and key respondents. Based on these comments, a final report will be submitted to the Swedish Embassy/Sida by 16 September. It will be presented at a seminar on 25 September.

2. Assessment of scope of the evaluation

2.1 The Assignment

2.1.1 Why is the evaluation needed

While some of the components of Swedish support to South African efforts to address HIV/AIDS have been evaluated, there is not yet a summative review of the results achieved and lessons learnt. Swedish support has been provided in the form of political dialogue, donor coordination, regional level initiatives, policy development support, capacity development of national, province and district level government (duty bearers), capacity development of CSOs (rights holders) and private sector capacity development efforts. A broad programme/strategy level evaluation will allow lessons and findings to go beyond the individual circumstances of a specific initiative and enable an evaluation of the cumulative effects of support to policy reforms and capacity development of various actors. It will also allow conclusions to be drawn about the best strategy for the future support and identify potential risk factors. Alternative financing modalities and the balance between multi-lateral and bi-lateral approaches can be evaluated in light of the evolving new relationship between Sweden and South Africa and the Policy for Sweden's International HIV and AIDS efforts.

2.1.2 What will the results be used for

Based on the conclusions from the review, the Embassy/Sida will be able to document the results and extract lessons regarding the relevance, effectiveness and sustainability of its 9-year engagement in the HIV/AIDS sector in South Africa. We interpret sustainability as lasting effects of the capacity development provided and ability of organisations and authorities to sustain their operations with other funding sources. We would like to discuss with the Embassy how to address the question on efficiency to ensure a common understanding and realistic expectations. It should also be possible to identify the most strategic approaches and combinations of support modalities, as well as less successful approaches and risk factors. The lessons from this review will be used to inform future strategising of Swedish efforts to address sexual and reproductive health and rights in South Africa and the region.

2.1.3 The objectives of the review

The objectives of the review according to the ToR are:

1. To establish whether the Swedish Country strategies (2004-2008 and 2009-2013) were correctly and effectively implemented, and whether the goals and objectives therein were achieved.
2. To document the emerging outcomes and preliminary impacts, both positive and negative, of the strategies to date.
3. To analyse and document the key factors which enhance or obstruct positive outcomes.
4. To analyse and report lessons learned from current and completed contributions.
5. To reassess current support to partners, and whether the areas of support are still appropriate and topical, directly addressing the development and programmatic gaps in the current response to the AIDS epidemic in South Africa.
6. To evaluate the collaboration between the Embassy in Pretoria, the Regional AIDS Team in Lusaka and Sida Stockholm (HQ).
7. To analyse the nature and results of engagement with key partners, in particular the NDOH, SANAC, multi- and bilateral development partners, Sida Stockholm and the Regional HIV/AIDS Team based in Lusaka.
8. To present a risk matrix that would enable an assessment of the key challenges that threaten the sustainability of the interventions and achievements supported by Sweden.
9. To suggest the way forward after 2013, the end of the South African Country Strategy, to optimise the reach and impact of the interventions supported by Sweden.

2.2 The scope of the review

In order to answer these questions, the review will gather information from existing reports and evaluations, seek general impressions and views on the Swedish support as experienced by the SA government, other donors and major stakeholders in the HIV/AIDS sector as well as the specific experiences and results that are found in the Swedish supported initiatives. The findings will be analysed in relation to the evolving context. The experience of the evaluators from previous evaluations in the HIV/AIDS sector in South Africa will contribute to the contextual understanding and the judgement on relevance.

2.2.1 Covering the two strategies

The two Swedish HIV/AIDS strategies for SA are different in nature. *The first strategy 2004-2008* aimed at supporting the South African government to create conditions to reduce the number of new infections (prevention) and mitigate the impact of HIV/AIDS on individuals, families and communities (treatment, care and support).

Focus was on development of policies and structures that could respond effectively to the HIV/AIDS epidemic. Sweden worked through dialogue with government and co-donors, through mainstreaming HIV/AIDS in existing programmes, through strategic support to CSOs that could influence government and develop model services, through initiatives combating violence against women and children and through support and assistance to the Swedish-Norwegian Regional Team on HIV and AIDS. The results of these efforts will be sought in the nature and quality of responses from government, private sector and CSOs during the period and in the possible contribution towards *reducing the sexual transmission of HIV and enabling people*

living with HIV and AIDS to lead healthy and productive lives. The main challenges in evaluating the results of the Swedish support during 2004-2008 are a) the lack of institutional memory among key stakeholders, b) uncertainties in statistics and baselines and c) determination of the attribution of the Swedish support.

The *second strategy 2009-2013* focuses on strengthening the *national ownership* of the HIV/AIDS responses and on *donor coordination*. The Swedish strategy takes its starting point in the support for implementation of the HIV and AIDS/STI Strategic Plans for South Africa, 2007-2011 (NSP) and 2012-2016 (NSP). The aims of the Swedish strategy are a) to strengthen and broaden the national efforts *to prevent spreading* of HIV and AIDS with focus on gender equality, human rights and sexual and reproductive health and rights in particular and b) to support South Africa in its efforts to coordinate national, bilateral and multilateral initiatives.

Initiative 1: Programme for grants and technical assistance to civil society: Improved capacity for effective HIV / AIDS prevention (AFSA), with the following

1. to equip community based organisations (CBOs) and NGOs with the necessary resources and support for effective HIV prevention, mitigation of AIDS impacts, promotion of gender equality and the prevention of gender-based violence
2. to provide support to organisations that have a watchdog function for government work
3. to develop the skills of selected organisations to plan, implement, monitor and evaluate their work efficiently and to increase organisations' organisational capacity for (1) good governance and sustainability, and (2) to support the government's delivery of services.

Initiative 2: Multi-sectoral approaches for treatment of victims and survivors of gender-based violence (Zivikele), with the following objectives:

1. to influence decision makers to support the implementation of a training model for broad-based support to victims and survivors of gender-based violence
2. to provide training to meet the needs of victims and survivors of gender-based violence
3. to develop a standard and an accredited programme that supports a training model for broad support measures to victims and survivors of gender-based violence.

Initiative 3: Programme for the prevention of HIV / AIDS in the road transport industry in South Africa (CEP), with the following objectives:

1. to reduce vulnerability to HIV and AIDS in the road sector
2. to increase the coverage of voluntary counselling and testing and promote regular testing
3. to upgrade and implement a system for monitoring and evaluation of the AIDS programme

Initiative 4: Dialogue, networking and donor coordination in support of the NSP implementation, with the objective of strengthening the national ownership and donor coordination as well as the regional synergies.

The results of these efforts can be sought mainly in the improved capacity and competency of the government and CSO partners to work effectively to prevent

spreading of HIV/AIDS, in particular in the way they manage to address gender equality and sexual and reproductive health rights in their responses. The objectives under each initiative will be used as measurements of this increased capacity and competency. The main challenges in evaluating these results are a) finding ways to evaluate progress in relation to the various (sometimes vague) objectives and b) attribution of the Swedish support.

2.2.2 Covering the various approaches

Sweden has used different approaches to influence and support developments. We will map the results and the lessons from each of the approaches taken during the period of review, namely:

Dialogue: Results and lessons learnt from the Swedish dialogue with government, civil society and private sector. Results and lessons learnt from the Swedish engagement in donor coordination efforts. Respondents will be previous/present Sida/Embassy employees, SA government representatives, NDOH, SANAC and multi- and bilateral development partners. Proposed respondents Sida/ Embassy: Christina Rahmstedt, Dag Sundelin, Ria Shoeman, Regional team members in Lusaka. Proposed multilateral and bilateral respondents: UNAIDS, USAID, Nordic countries, EU.

Mainstreaming: “Mainstreaming” was used as a strategy before and during the first strategy period. The understanding of the “mainstreaming” concept has often not been clear and reporting on results related to HIV/AIDS initiatives in other sector programmes has been anecdotal. We will still attempt to draw lessons from these efforts by studying reports and by interviewing Sida/ Embassy staff and partners responsible for the mainstreaming efforts 2004-2008. A problem is that the institutional memory both at Sida/ Embassy and among partners appears to be limited.

Targeted initiatives: Targeted initiatives were introduced in the 2004-2008 strategy, when it was determined that mainstreaming and dialogue was not sufficient. The foci of these initiatives were mainly a) to strengthen advocacy and watchdog functions of CSOs, b) to highlight the necessity of addressing gender based violence, gender equality and SRHR to be able to prevent spreading, and c) to develop adequate, accessible, affordable support services for prevention, treatment and care. The Swedish supported initiatives will be analysed in relation to the objectives and context. How strategic were partners and initiatives selected for funding? What results can be demonstrated? How did these results contribute to the Swedish strategic objectives? In particular, were the objectives successfully achieved regarding gender equality and SRHR? What conclusions can be derived about relevance, effectiveness, sustainability and efficiency of the efforts? Annual reports and previous evaluations will be studied first, followed by interviews.

The following initiatives will be selected for deeper analysis and interviews of staff, beneficiaries and external observers: CEP focussing on truck drivers and sex workers, Sonke’s MenEngage, AFSA as a grant manager, SABCOHA for workplace and private sector focus, ALP/ Section 27 for its legal and human rights advocacy, TAC

for the health and social justice advocacy work, Zivikele for the training programme and SAT/ Save the Children with Bonela on their PDC programmes in Botswana for a regional influence. In addition, selected grantees of AFSA in Northern, Eastern and Western Cape will be interviewed (including the AIDS Law project, AIDS consortium and Masimanyane which used to get direct funding from Sweden).

Cooperation/synergies: Sida has aimed to develop a regional approach and a coherent HIV/AIDS programme for the region. The SA programme was intended to be an integral part that could benefit from and contribute to the regional programme. According to the 2009 evaluation this did not happen sufficiently. We will assess what has happened since then. The synergies with Sida Global and regional programmes will be explored and relationships analysed. The global and regional programmes have substantial budgets and many partners have programmes in SA. The sample of global and regional programmes that will be analysed for synergies may include; International HIV/AIDS Alliance, AIDS Alliance for Southern Africa, Sonke, HEARD, SafAIDS and REPSSI.

In addition, Swedish framework organisations have received more than 30 million SEK via Sida CIVSAM for HIV/AIDS-related work in SA during the period. They are independent and not technically part of the Swedish government HIV/AIDS portfolio, but are required to follow Swedish policies and overall goals for the Swedish development assistance. For this reason we propose to solicit their views on the Swedish dialogue/coordination efforts and on possible synergies with initiatives funded via the Embassy. The sample may include RFSU (4.6 MSEK), PMU (6.5 MSEK), Africa Groups (6.7 MSEK), Forum Syd (2.1 MSEK), SMR (4.5 MSEK), LO-TCO (2.8 MSEK), Save the Children (3.6 MSEK).

2.3 Understanding the theory of change

As a basis for designing the method for the evaluation we have tried to understand the theory of change applied by the Swedish programme. This is how we have tentatively interpreted the intentions:

2.3.1 Theory of change 2004-2008

Goal 1: Reduced new infections/spreading of HIV

In order to make that happen, it was assumed that there is a need for

- a national, coordinated response from the government and the donor community
- awareness among women and men on how to be protected
- access to appropriate testing and treatment services
- reduced GBV

Goal 2: Mitigate the impact of HIV/AIDS on individuals, families and communities

In order to do so, it was assumed that there is a need for

- an appropriate social, legal and policy environment
- prevention, care, voluntary counselling and testing and treatment of HIV/AIDS in the workplace

- community based organisations with capacity to supplement and monitor the government services

In order to achieve these goals, the Embassy took the following steps

1. Persistent dialogue meetings with national leaders (including the vice president) and authorities to encourage a national coordinated response to HIV/AIDS. Taking the lead to coordinate the donor community response to HIV/AIDS.
2. Mainstreaming HIV/AIDS in all supported programmes (education, governance, health, etc.)
3. Supporting selected strategic CSOs which could influence policy makers, raise awareness and develop services
4. Supporting community based organisations in two provinces to supplement and monitor government services (Eastern and Northern Cape)
5. Supporting programmes working to reduce violence against women and children
6. Coordinating with the regional programmes supported by Sida

2.3.2 Theory of change 2009-2013

Goal 1: To strengthen and broaden the national efforts **to prevent spreading** of HIV and AIDS

Goal 2: To support South Africa in its efforts to coordinate national, bilateral and multilateral initiatives.

In order to achieve these goals, it was assumed that there was a need for

- improved capacity of the responsible government agencies/bodies, measured by delivery of the outcomes specified in the NSP
- improved capacity of strategic CSOs, measured by a) increased coverage of VCT services and prevention awareness among transport industry workers b) increased visibility and influence of advocacy and watchdog organisations c) increased resources and quality of services offered by CBOs in supported provinces
- improved regional coordination and experience exchange, measured by intensity of synergy effects and joint learning
- increased focus on GBV and SRHR in the response to HIV/AIDS, measured by the existence and use of an accredited training model for broad-based support to victims and survivors of gender-based violence

In order to achieve this, the Embassy took the following steps

- continued dialogue with the national leaders and authorities. Continued engagement in donor coordination
- strengthening selected, strategic CSOs in their work to prevent spreading, mitigating the effects of HIV/AIDS and monitoring government performance (via AFSA)
- prevention of HIV/AIDS in transport industry and improved health status and well-being of employees and their families (Corridor project)
- strengthening national, provincial and district authorities' capacity to respond effectively to victims of GBV and HIV/AIDS e.g. securing forensic evidence, counselling, care (Zivikele),

The team looks forward to discussing these interpretations of the theory of change with the Embassy, as they will be the basis for the analysis.

3. Relevance and viability of evaluation questions

3.1 Evaluation questions

Evaluation questions	How to make assessment	Considerations
To establish whether the Swedish Country strategies (2004-2008 and 2009-2013) were correctly and effectively implemented, and whether the goals and objectives therein were achieved.	Embassy and partner reports, interviews with external observers and key partners	Lack of institutional memory, attribution, statistical inaccuracy, broad objectives
Document the emerging outcomes and preliminary impacts, both positive and negative, of the strategies to date.	Interviews with partners and boundary partners upwards, downwards and across	Making a representative and interesting sample in order to limit the number of respondents. The 4 evaluators will have to take a consistent approach in questioning and note taking.
Analyse and document the key factors which enhance or obstruct positive outcomes.	Interviews with partners and external observers. Joint analysis workshop	As above
Analyse and report lessons learned from current and completed contributions	Interviews with partners and external observers. Joint analysis workshop	Focus on the second strategy period due to limited institutional memory
Reassess current support to partners, and whether the areas of support are still appropriate and topical, directly addressing the development and programmatic gaps in the current response to the AIDS epidemic in South Africa.	The present programme will be assessed in relation to existing research on donor funding and gaps (e.g. Carter)	Studies are available; the HIV/AIDS conference will be an opportunity to find out about the latest developments
Evaluate the collaboration between the Embassy in Pretoria, the Regional AIDS Team in Lusaka and Sida	The evaluation from 2009 will form the basis for questions to the Lusaka team and	

Stockholm (HQ).	the SA staff; ideas on models for future cooperation will be explored	
Analyse the nature and results of engagement with key partners, in particular the NDOH, SANAC, multi- and bilateral development partners, Sida Stockholm and the Regional HIV/AIDS Team based in Lusaka	Interviews with key partners in the government and key external observers/co-donors	Focus on the second strategy period due to limited institutional memory
Present a risk matrix that would enable an assessment of the key challenges that threaten the sustainability of the interventions and achievements supported by Sweden.	Interviews with partners and external observers. Joint analysis workshop, drawing on overall lessons learnt during the evaluation and the contextual developments.	
Suggest the way forward after 2013, the end of the South African Country Strategy, to optimise the reach and impact of the interventions supported by Sweden.	All respondents will be encouraged to contribute their proposals for the future. These will be analysed against the possibilities within the frameworks of the Swedish SA strategy, Swedish regional strategy and Swedish supported multilateral efforts.	The letter of appropriation from the Ministry of Foreign Affairs to be issued during the period of the review (hopefully) will set the frame for the discussions. Within this frame, views from various stakeholders will be solicited and analysed

3.1.1 Questions about results

The theory of change applied by the Swedish programme and the expected impact and outcomes expressed in the results frameworks are very broad. We have still not seen the annual reports from the various partner programmes and therefore we cannot judge how much is documented on progress and results. We can only assume that some of the objectives will be hard to report on as they are not formulated in a way that makes it easy to determine progress or fulfilment. Some objectives are formulated as inputs (“to provide training”) or outputs (“an upgraded monitoring system for the project”) and the expected changes are not explicitly mentioned. We will therefore adopt an outcome mapping approach to be able to find and document

results. We will assess the findings in relation to the tentative theory of change developed as part of this inception report, not only in relation to the objectives found in the Swedish strategic frameworks. See more below under methodology.

3.1.2 Questions about relevance, effectiveness, efficiency and sustainability?

The issue of relevance will be discussed in relation to the national context, other donor priorities and existing gaps in the HIV/AIDS response. There are recent studies of donor funding and existing gaps, which will be useful to us. Effectiveness will be determined by analysing the outcomes of the work carried out by the Embassy staff and the supported partners (what difference have they made) and the opinions of external observers of the Swedish contribution to these changes. Did the organisation or dialogue effort make a difference? How important/substantial were these changes? Sustainability will be determined in relation to a) the sustainability of the outcomes e.g. policies, structures, behavioural changes, accessibility to treatment and care etc. and b) the sustainability of the supported organisations/agencies and their operations. Efficiency will be commented on in terms of the budgets used in relation to the outputs and outcomes demonstrated. Comparisons will be made with similar programmes (when possible) to establish if the outputs and outcomes came at an extremely low or high cost. The possibility of making a detailed judgement of cost effectiveness can be done only if partners have activity- or outcomes based accounting systems and if commensurable data exists. The internal efficiency i.e. the smooth cooperation between various Sida units and the Embassy will also be studied and commented on.

3.1.3 Questions about the two perspectives

We will include questions on accountability, openness and transparency, non-discrimination and participation in our dialogue with partners and external observers. We will look at the contributions towards gender equality and identify possible (unintentional or intentional) exclusion of vulnerable groups (poor, rural, persons with disabilities, MSM, migrant workers and refugees etc).

3.2 Recommendations regarding evaluation questions

One of the main challenges will be to determine the Swedish attribution to the results observed. Sweden is a donor among many others, some of them with more substantial budgets (UNAIDS, USAID, EU etc.). Although the present partners are funded rather heavily by Sweden (40-70%), local ownership and independence has always been promoted. The attribution of the Swedish support will be discussed with partners and external observers and commented on by the evaluators. Already during the Inception period, we have picked up information on the strategic importance the Swedish support in particular situations. Information like this will be further explored and validated throughout the evaluation process. However, we would like to recommend that the evaluation will focus on contribution rather than attribution of the Swedish support.

Another challenge is to find a way to evaluate the efficiency, particularly around projects jointly funded with other development cooperation partners. We hope to be

able to comment on the costs in relation to results achieved and in relation to comparable projects. However, the total budgets for various interventions may not be available and accounting systems may not apply an activity based budgeting. It will then be difficult to say something about cost efficiency. We will try to compare similar projects or similar activities to be able to make a judgement. Again, in order to be able to make such judgements we rely on the availability of commensurable data. We will do our best, but would like to caution that we may not be able to access cost efficiency systematically. It is often easier to comment on the cost effectiveness of an activity than the cost activity of a whole programme. At the same time, cost efficiency at the outcome level is more interesting. A workshop may be very expensive per participant (compared to similar workshops), but if it the outcome is a government decision on free medicine for all pregnant women, it might still be cost efficient.

Efficiency can also be an issue of internal organisation of Swedish development assistance. The collaboration mechanisms (or obstacles) between various Sida units working in the area of HIV/AIDS may be a key question in relation to efficiency. We will also look at this aspect if we manage to find informants with clear recall of events.

Due to the difficulties in establishing measurements related to effectiveness, we recommend that efficiency will be discussed and commented on rather than rigorously evaluated.

Finally, we would like to bring up the uncertainty about the future strategic frameworks for the Swedish support to South Africa and the regional HIV/AIDS team. We would need clarity about the intentions of MFA regarding the planned phasing out of the Swedish support to HIV and AIDS programmes in South Africa. Within what framework will we be able to propose a way forward? When is the MFA letter of appropriation due?

4. Proposed approach and methodology

4.1 Data collection and analysis

We will first study all available reports and previous evaluations of Swedish-funded initiatives and of other donors funding similar programmes. We have already contacted Sida global and regional teams and SA partners to request such documentation.

Then we will explore the views and experiences of external observers and recipients of Swedish support through interviews. A full list of proposed respondents is attached in annex 2. The team would like to have comments and approval of the selection (method of selection is described below) from the Embassy.

All interviews will be held face-to-face with respondents. Exceptions are the interview with the Lusaka regional team – which will be carried out via video-link – and the questions to Swedish CSO which will be communicated via e-mail/telephone.

The evaluators will make use of the up-coming South African HIV/AIDS conference in Durban (18-21 June) to arrange discussions with partners and to listen to relevant presentations. This will provide possibilities for informal discussions as well as formal structured interviews. The Swedish Embassy HIV/AIDS advisor, Ria Schoeman, will also be attending and will be able to supplement information.

The evaluators will use a similar semi-structured interview method and will divide up the interviews. Careful notes will be taken and a summary posted in the drop box folder for all to read. The information gathered through the desk reviews and interviews will be analysed by the four evaluators at joint workshop towards the end of July. Supplementary information will be solicited if necessary.

A draft report will be submitted to the Embassy in Pretoria and respondents by August 30 for validation and comments. Based on these comments, a final report will be submitted by 16 September, provided feedback is received by the September 9.

4.2 Selection of respondents

4.2.1 SA organisations

The main focus of the evaluation will be on South African organisations and government agencies that have been influenced or supported by the Swedish Embassy during the period of review. The Embassy has funded organisations directly, especially during the first strategy period, and indirectly via AFSA in the second period. In order to make a feasible selection of respondents we have used the following criteria to select a sample:

- The organisation must have received funding from Sida for both phase 1 & phase 2,
- If funding was not received in both phases, the total budget allocation must be 2 million SEK and above,
- Diversity of organisations across, local, national and regional partners. This will enhance the quality of data to provide information related to impacts at regional, national and local level,
- Diversity of organisations across focus areas, i.e. covering youth, women & gender issues, HIV/ AIDS and OVC community based organisations (CBO), legal entities and training CBOs.

Based on these criteria, the following partners have been selected based on their unique services and the innovative approaches that serve a specific niche. These are:

- CEP, focussing on truck drivers and sex workers
- Sonke's MenEngage
- AFSA as a grant manager
- SABCOHA for workplace and private sector focus
- ALP/ Section 27 for its legal and human rights advocacy
- TAC for the health and social justice advocacy work
- Zivikele for the training focus
- SAT/ Save the Children with Bonela on their PDC programmes in Botswana for a regional influence

- South African Football Players' Union because it was the first partner in the HIV/AIDS field and it received substantial support (if we can find someone to interview with sufficient institutional memory).

For some organisations regional and national work has been funded for diverse programmes. In order to effectively triangulate data, key informants will be sought in both the head offices and district offices of organisations such as CEP, Sonke and TAC.

In addition to these partners, selected grantees of AFSA in Gauteng, Northern, Eastern and Western Cape will be interviewed (including the AIDS Law project, AIDS consortium and Masimanyane which used to get direct funding from the Embassy during the first strategy period). Please refer to annex 2 for a full list. AFSA has been funded by the Embassy and has acted as a grant manager for the major portion of the partners since 2008. In total 27 organisation and their beneficiaries (individuals or organisations) will be studied.

4.2.2 External observers and cooperating partners

In order to develop a well-informed opinion of the effectiveness of Sida strategies and support we need to capture the experiences and opinions of external observers and co-workers in the struggle against HIV/AIDS. We have identified other donors, SA government agencies and Swedish CSOs as such key informants. These actors will be able to give their view on Sida's modalities and approaches, particularly if they were strategically placed in relation to contextual developments over time. They will also be able to compare the Sida approaches with their own (different/better/worse) and confirm if synergies were sought. This will help our final assessment of whether the Sida approach was efficient and effective.

It has been noted that Sweden has been working within EU platforms that include other multinational, bilateral and government agreements on HIV and AIDS. It is based on this that key ministries such as Treasury and NDoH have been included. SANAC will be explored to gain a perspective from the national strategic viewpoint, and the Eastern Cape provincial AIDS Council for information on provincial-level outcomes.

Multilateral agencies that are strategically placed i.e. UNAIDS and EU representatives will be interviewed for assessment of Sweden's role during the period of review. Another key informant selected due to its strategic position is the Clinton Foundation, where the research on where funding goes will be of particular interest.

With Sweden as part of donor cooperation it is essential to include some European partners as respondents. Norway and the Nordic+, Ireland, GIZ, Netherlands & DFID have been selected as key informants.

Swedish framework organisations have received more than 30 million SEK via Sida CIVSAM for HIV/AIDS-related work in SA during the period and will have an opinion on the Swedish dialogue/coordination efforts and on possible synergies with

initiatives funded via the Embassy. We propose soliciting views from two or three of the following organisations: RFSU (4.6 MSEK), PMU (6.5 MSEK), Africa Groups (6.7 MSEK), Forum Syd (2.1 MSEK), SMR (4.5 MSEK), LO-TCO (2.8 MSEK), Save the Children (3.6 MSEK). Information will be sought through e-mail/telephone questions.

4.2.3 Regional Synergies

The main focus of the evaluation will be recipients of Sida/Embassy funding and the results in terms of increased capacity of these organisations to deliver services or act as advocates for change. However, discussion and available documents indicate that Sweden has had substantial global and regional strategic outcomes in the area of HIV/AIDS. Sida has aimed to develop a regional approach and a coherent HIV/AIDS programme for the region. The SA programme was intended to be an integral part that could benefit from and contribute to the regional programme and many partners of the regional and global programmes have programmes in SA and/or operate from SA. According to the 2009 evaluation the integration between the regional and South African programmes did not happen as planned. We will try to establish what has happened since then. In addition, because Sida is looking towards more regional approaches in the future, it will be instructive to understand the contextual and management factors and challenges at the level of regional programmes and outcomes. This information will inform recommendations. Therefore the Sida global and regional teams will be included in response to these issues, along with the Embassy in Pretoria. We will attempt to reach persons responsible for previous periods, as some of the present staff have been around for a shorter period of time.

Also, organisations working in the region over a significant period will be aware of Sida programmes, foci and approaches, and will also be in a position to comment on whether the South African and the regional initiatives have sought or achieved synergies and joint learning. The evaluators will solicit opinions from organisations such as SADC, SAT, Sonke and Save the Children which receive Sida regional funding, and therefore are familiar with Sida approaches and goals.

4.3 Proposed analytical framework and approaches to interviews

Even though Sida goals and objectives are broad, the evaluators will be able to make qualified value statements about the results of Sweden's support. This should be possible after many years of Sida contributing to SA's struggle against HIV. The evaluation approach will focus on exploring the outcomes of the various interventions in terms of improved capacities of the supported organisations and authorities to strategise, promote, coordinate, implement and monitor interventions that contribute to prevention of new HIV infections and to provision of human rights based treatment and care services.

The evaluation will study how the Sida interventions interacted with contextual developments and seek to answer how the questions:

- Where did Sida start?

- How did things develop? and
- Where is the programme headed, and how does this relate to the quality of the results achieved/or not achieved so far?

The evaluation will also examine whether different tools and approaches applied in delivery of aid (e.g. dialogue, mainstreaming, targeted interventions and coordination) achieved the desired outcome or not.

Finally, the evaluation will seek opinions and evidence regarding the possible contributions of the Swedish support towards prevention of new HIV infections and towards improved treatment and care services (accessible, adequate, affordable, quality services – reaching the most marginalised and vulnerable groups). It will not be possible however, to determine what the situation might be in the absence of any Swedish support (counter-factual), as other factors or donors may well have become involved.

The evaluation will review Sida-supported programmes as much as possible against the national indicators in the South African National Strategic Plan on HIV and AIDS. However, to make a valid connection, it will be necessary to link what respondents say and what reports (figures) from the supported organisations say regarding these indicators. To do this, the evaluators will identify the main quantitative indicators that the interviews suggest have been influenced by Sida-funded programmes. Given the size of Sida's fund compared with the overall HIV budget we will only be able to draw conclusions in cases where the Sida contribution was central.

For example, if respondents believe that Sida funded programme contributed to getting people onto ART, then the relevant data on numbers of people on treatment can be discussed. If the evaluation research finds that prevention activities have been weak, then the modelled incident data will provide comparative insight. However, again, given the size of Sida's fund compared with the overall HIV budget it is only safe to talk about specific areas where the Sida contribution was central. Also, because of the range of organisations funded from a range of sources working in similar areas (particularly at district and community levels), it would not be possible to match outcomes to national or provincial indicators.

We would like to caution that we may only be able to infer from (perhaps anecdotal) evidence what Sida's contribution was to national or provincial developments. There may be some evidence of impact in districts, communities or workplaces, but it is not certain if we would be able to conclusively and reliably get statistics at these levels.

4.3.1 Interview questions and process

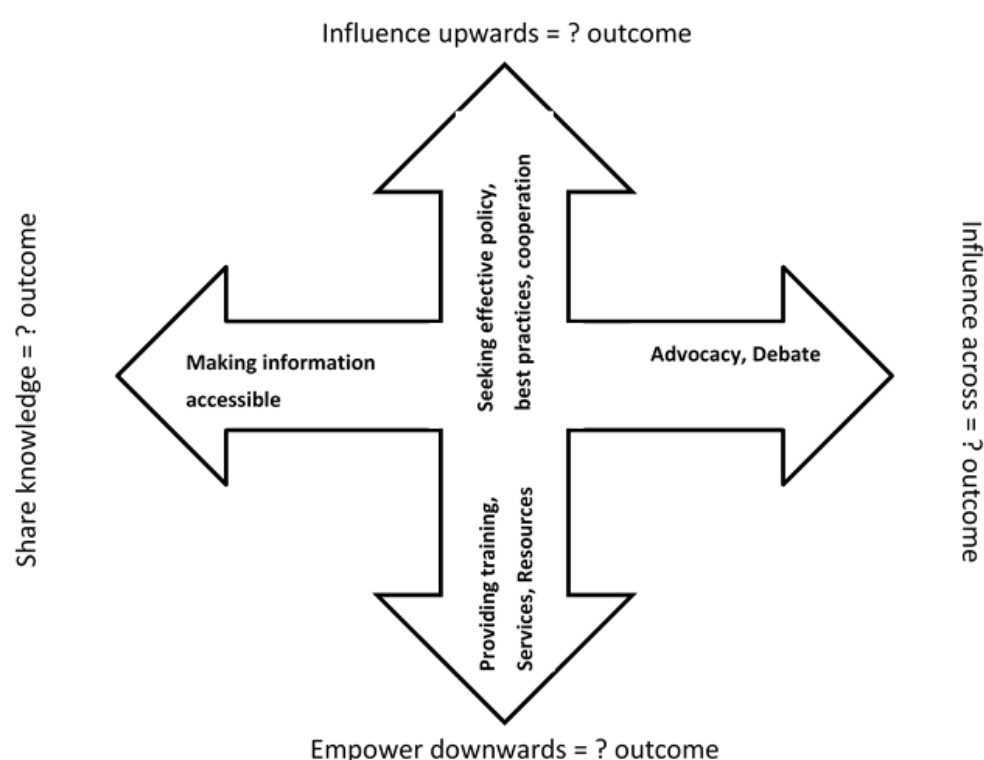
Looking at the evaluation questions and the objectives of the two Swedish strategies, we note that progress may be hard to measure. Many of the objectives are broad and/or vague. To capture results and lessons learnt we therefore propose to use an outcome mapping technique.

First we will explore partner activities over the period and identify the different **levels** at which the organisation operates

- Global
- Regional
- National
- Provincial/local

Depending on the areas of focus or the main objectives of the organisations involved, we will then explore influence and outcomes in three dimensions:

- **Upwards** into policy, and resourcing decision-making, particularly for advocacy organisations, (creating an enabling environment)
- **Across** to other institutions and peer organisations in SA and the region, through sharing knowledge and advocacy, particularly for networking aspects of programming (Building best practice/scalability)
- **Downwards** through building skills, organisational development, services, training, particularly for service delivery or capacity building partners



Primary questions pertain to each of these directions of outcomes:

1. What **difference** did the organisation's work make (outcomes upwards, across and downwards)?
2. In what **way** did the organisation exert change (process upwards, across and downwards)?

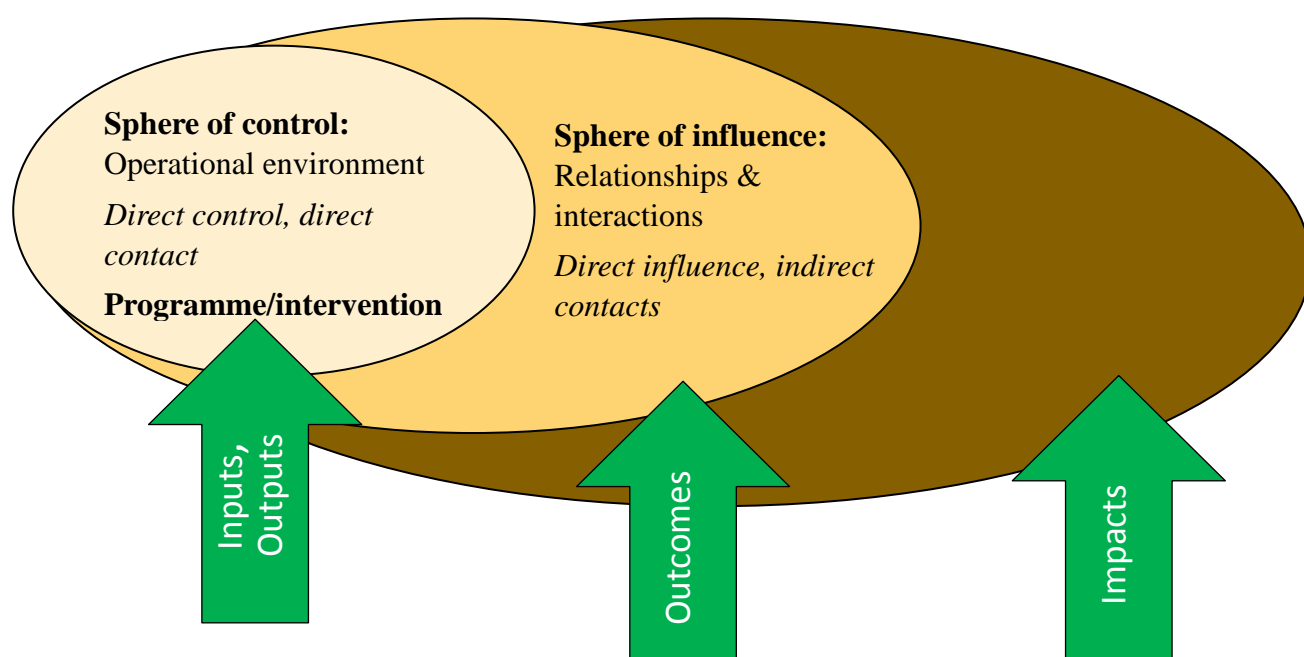
3. What were the prevailing **conditions**, and how did these conditions impact on the relevance and focus of the programme, and on results, both enabling and constraining outcomes?
4. What has the organisation **learned** for future programmes or interventions?
5. To what extent do we feel confident that the change described was a result of these activities, and what reasons do we have for believing this? (Measures and validation)
6. What is special or different about the approach? (Innovation)

Variations on these themes as they have been seen across the whole programme will be posed to external observers. Further secondary questions will also be directed to external observers:

1. To what extent was the national, regional and global sphere influenced (impact, depth & penetration)?
2. How did the participation in the joint funding platform contribute towards programmatic and policy standards across the South African context (value added, upward influence)?

The evaluation thus involves exploring the programme and partners in terms of the levels at which they work, the extent of their influence and impact at these levels, the extent to which their claims can be validated, and whether the intervention or approach supports or builds good practice. Interviews will seek to probe:

- the quality of outputs as they affect direct beneficiaries, recipients or targeted authorities
- the outcomes these interventions achieved in terms of changed behaviours, practices, policies, relationships etc.
- the ripple effect or influence of these results may have had on the broader population of stakeholders and beneficiaries.



The claims of possible ripple effects (impacts) for the targeted stakeholders/beneficiaries (i.e. organisations, authorities, individuals) will be verified by e.g. statistics available, stories told by selected beneficiaries and questions to targeted organisations.

For service providing organisations we will attempt to verify claims of impact by seeking experiences and opinions of beneficiaries and possible linkages to statistical trends (if available) regarding behaviours or health status. We will do this by means of case studies rather than surveys. We are of the opinion that a qualitative method, digging down to understand what the service has done at the level of individual lives will provide a better impact picture than a large survey. Also a survey will be impractical time-wise and far too expensive compared to the usefulness.

The information collection methodology would be via an informal outreach process, with visits and visuals of the setting and the men and women who are participating, with informal conversations about how they feel about the contributions of the CBO. Further probing discussions with the CBO informants who are more likely to take a view over the longer term will be organised. In addition, a few selected organisations, where Sida has invested a lot of time and funding, will be asked to organise focussed group discussions of 7-10 individuals who could contribute their experiences and add further depth to the analysis of results.

We will analyse existing quantitative data, where available, regarding beneficiary perspectives on services. Just like the interviews and group discussions, this data may not provide evidence specifically regarding Sida-supported programmes, but will inform the analysis in relation to beneficiaries' views about what constitutes quality programming.

For advocacy or training organisations, where beneficiaries are organisations or authorities, we will attempt to verify claims of impact by seeking experiences and opinions of the targeted stakeholders regarding to what extent the Sida initiative contributed to possible improvements in policies, practices, systems, behaviours, services etc. The information collection methodology will be interviews as we are seeking qualitative information rather than quantitative.

4.3.2 Analytical framework

Based on the information generated through the study of reports, evaluations and statistics along with the knowledge gained from discussions held with respondents, the team will use a series of analytical lenses to draw conclusions and recommendations. The focus of the analysis will be on the outcomes = sphere of influence (middle circle). We will also attempt to look at contributions towards impacts = "sphere of interest" when/if such data is available (often measured by proxy indicators) e.g.:

- the extent of influence on gender equality and reduced GBV
- the extent of reaching the most vulnerable groups (non-discrimination)
- the extent of influence on reducing new HIV infections

Following the analysis, the evaluators will seek to answer the evaluation questions and determine the following:

PROCESS

- How strategic were the choices of partners and dialogue measures?
- How well did the lead partners, or sub-partners function and relate to each other towards achievement of optimal results?
- How well did the programme relate to key stakeholders towards achievement of optimal results?
- What have the process and outcomes been in terms of platforms creating dialogue and exchange?
- What have the process and outcomes been in terms of support and synergies with the Sida regional and global HIV/AIDS teams? Swedish CSOs?

EFFECTIVENESS

- To what extent were Swedish Country strategies correctly and effectively implemented?
- To what extent did the Swedish measures and supported programmes reach the intended objectives (compared to theory of change and documented objectives)?

IMPACT

- What examples of outcomes and contributions towards impacts are observed?
- What was the extent of influence on government policy and practice, accountability and transparency?

EFFICIENCY

- Were any of the innovations or interventions particularly cost-efficient compared to the outcomes or other similar efforts?
- Are there interventions where the process was unnecessarily elaborate for the outcomes achieved?
- Has cooperation between Sida HQ and regional HIV/AIDS units and the Embassy been smooth and mutually reinforcing?

RELEVANCE

- Key illustrations of particularly relevant interventions
- Description of any interventions that were not relevant to the priorities or needs in their context, and the impact of this

LESSONS LEARNED

- Mistakes and successes: What are the key factors that enhance or obstruct positive outcomes?
- What kinds of good practice may be replicated by others/at scale: Lessons learned as can be applied beyond the context of the partner/s concerned?

SUSTAINABILITY

- What lasting outcomes in terms of behaviours, relationships, structures or policies can be seen?

- What is required to sustain effective activities, structures and organisations i.e. ways forward, and who might be appropriate partners in these ventures ‘beyond the Swedish support’?
- Areas of ongoing support: Is the nature of support still relevant? What are the ways forward for interventions after Swedish Support?

CROSS-CUTTING TECHNICAL THEMES/LESSONS

- The extent of and practical definition of mainstreaming achieved: How does the programme demonstrate the meaning, operationalisation and opportunities for mainstreaming?
- The extent of either innovation or scalability and building best practice
- What constitutes sustainability for particular forms of activity?
- The extent of understanding and applying a human rights based approach in programming. Including the most marginalised groups as active participants. Developing adequate, accessible, affordable, quality health services.

4.4 Limitations and challenges

The main challenges will be as follows:

1. To get sufficient information about results and the role of the Swedish interventions from the strategy period 2004-2008 will be a challenge. Institutional memory among donors as well as SA partners is limited and reporting is often activity oriented. The evaluation will try to find persons with an overview, but it is expected that the main focus of the evaluation will tend to be on results and lessons from the second strategy period.
2. The period under review has seen significant political changes as well as rather huge donor investments in the fight against HIV/AIDS. There are thousands of organisations and donors involved. Although Sweden has been an important player, it can be hard to determine attribution at an impact level. We will however attempt to map outcomes and discuss the possible contributions of the Swedish support towards important changes and improvements in policies, programmes and strategies.
3. The results frameworks of the Swedish strategies and the supported programmes are rather broad and vague. With some exception in the CEP program, many of the stated objectives are not quite measurable. Some of them are inputs or activities. Therefore we have selected an outcome mapping approach to the evaluation, where we ask questions about change and learning.
4. As we are four evaluators with different background we may look at things through different lenses. This adds value to our joint analysis, but also makes it important that we agree to use some standardised questions as a basis for our interviews. We also need to take careful notes for others to see and question.

Organisations to be included as respondents

Suggested sample of organisations		Location	Budget (SEK)		Sector/Focus/Shared interest
			Phase 1	Phase 2	
Partner government and donor organisations					
SIDA					
SIDA Stockholm		Stockhol m	n/a		SIDA global strategy, synergies
SIDA – Ria Schoeman		Gauteng	n/a		SIDA regional & national strategy
SIDA Regional team in Lusaka		Videoconf			SIDA regional strategy synergies and future
Nordic partners and CSOs					
Framework CSOs with HIV/AIDS programmes: Africa Groups, PMU, RFSU, SMR, LO-TCO, SC, FS		Sweden, e-mail	31 m		SA synergies and future
Norway and Nordic +		Gauteng	n/a		SIDA role in donor cooperation
Other European partners					
GIZ: Maren Lieberum, Bernd Appelt		Gauteng	n/a		SIDA role in donor cooperation and programme outcomes
Ireland: Tamara Mathebula		Gauteng	n/a		
Netherlands: Ronald Goldberg		Gauteng	n/a		
UK: Bob Fryatt		Gauteng	n/a		SANAC
EU/ EU+: Esther Bouma		Gauteng	n/a		SIDA role in donor cooperation
United Nations					
UNAIDS: Catherine Sozi, Miriam Chipimo		Gauteng	n/a		Programme outcomes
Other funding agencies					
Clinton Foundation: Celicia Serenata		Gauteng	n/a		Where Funding Goes’ research
Regional and Global Sida partners					
SAT, Sonke, HEARD , SafAIDS and REPSSI		Gauteng	n/a		Regional synergy, learnings, future
Treasury					
Robin Toli & Andile Kuzwayo		Gauteng	n/a		Development funding process outcomes
National Department of Health					
Yogan Pillay, Nelly Malafetse		Gauteng	n/a		Programme outcomes
SANAC					
Nono Similela: Office of Deputy President		Gauteng	SEK 12 million		SANAC / GOSA outcomes
Fareed Abdullah: SANAC CEO/ SADC liaison		Gauteng			
Paul Booth: informant re SANAC and ALP		Gauteng			
TA to SANAC Jacky Sallet		Gauteng			
EC Provincial AIDS Council: Bandiwe of ETU		Gauteng			EC programme experience
Directly funded NGOs and	Location		Budget (SEK)		

CBOs		Phase 1	Phase 2	Sector/ focus area/ shared interest
AFSA	National (Durban)	?	150m	CBO capacity building, grant-making
ALP and Sect 27 (At AC?)	National (GP)	2m	16m	Legal support, human rights advocacy
CEP	Regional (Gauteng)	6.4m	28m	Trucking and related key populations
SABCOHA	National (GP)	?	1.5m	PDC on workplace and private sector
SAT	Regional (GP)	?	45000	PDC HIV programme in Botswana
Save the Children and Bonela	Regional (Gauteng)	?	3m	PDC on Children Botswana
Sonke Gender	Regional (WC & GP)	?	15.8m	Men and LGBTI
TAC	National (WC + 5)	13m	18m	HIV/AIDS prevention, health advocacy
Zivikele	National (GP)	10m	6m	Training of Government in GBV
South African Football Players Union	?			To be determined

AFSA funded NGOs and CBOs	Location	Budget (SEK)		Sector/focus area
Eastern Cape		Phase 1	Phase 2	
Bonukhanyo Youth Organisation	Eastern Cape	1.4m		HIV/AIDS CBO
Gcinisizwe HIV/AIDS Project	Eastern Cape	2m		HIV/AIDS CBO
Masimanyane	Eastern Cape	7m	9.5m	Women
Siyakhana Support Group	Eastern Cape	2m		HIV/AIDS CBO
Mahlungulu Foundation: Community & Individual Development	Eastern Cape	2m		CBO
Gauteng				
AIDS Consortium	Gauteng	0	13m	HIV/AIDS CBO
Field Band Foundation	Gauteng (+prov)	7.8m		Youth Education
Tshwane Leadership Foundation	Gauteng	0	2m	HIV/AIDS CBO
Northern Cape				
Dingleton Community Health Workers Project (Kuruman)	Northern Cape	2m		HIV/AIDS CBO
Kgatelopele Social Development Forum (Kuruman) and/or	Northern Cape	0	1.4m	HIV/AIDS CBO
Ogone Home Based Care (Kuruman)	Northern Cape	0	1.4m	HIV/AIDS CBO
Masikhathalelane Multi Complex (Kimberley)	Northern Cape	0	1.3m	OVC
Tshepo Ya Sechaba (Kimberley)	Northern Cape	2m		Training
Richtersveldt Advice Office (Port Nolloth)	Northern Cape	0	1,4m	Legal
Steinkopf Advice Centre (Port Nolloth)	Northern Cape	0	1,4m	Legal
Western Cape				
AIDS Legal Network	Western Cape	0	7m	HIV/AIDS Legal
World AIDS Campaign	W. Cape (Global)	0	2.5m	Key pops

Timetable



Work plan RE93 HIV/Aids South Africa

	Total	AN	IO	TK	TM	TBD	April				May				June				July				August				Sept				Oct				
							14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42
Inception phase																																			
Start up meeting with Sida and the team (telephone)	2	1	1																																
Initial document review and scoping interviews and development of the study design (analytical framework, selection criteria for field visits, limitations in scope etc)	14	6	4	2	2																														
Submission of inception report	0																																		
Feedback from Embassy inception report	1,0	0,5	0,5																																
Finalisation of inception report	0,5	0,5																																	
Data collection (document review, data collection and key informant interviews)	0																																		
Interviews in Stockholm (Sida) and Lusaka	8	8																																	
Team meeting in South Africa		1	1	1	1,0																														
HIV/Aids conference in South Africa 18-21 June		2	2																																
Data collection in South Africa	68	5	13	20	20	10																													
Analysis, validation and report writing	0																																		
Team meeting		1	1	1	1																														
Synthesis and report writing	28	8	10	5	5																														
Submission of draft report	0																																		
Feedback on draft report	4	1	1	1	1																														
Finalisation of report	0																																		
Submission of final report	3	2	1																																
Presentation of final report	0																																		
Total days	129	36	35	30	30	10																													

Initials: AN= Annika Nilsson, IO= Ingrid Obery, TK=Tracey Konstant, TM=Tshidi Mohapeloi, TBD= Possible research support to be defined

Deliverables:

Inception report	27 May
Outline of Draft report	19 August
Draft report	30 August
Feed back from Embassy on draft report	9 September
Final report	16 September
Presentation of report at Aids conference	25 September

	Meeting/workshop
	Deliverable/report

9.3 ARGUMENTS FOR CONTINUED ODA TO SA

Although the World Bank utilises a set of 188 development indicators to categorise economies, its main criterion for classifying economies is gross national income (GNI) per capita (previously termed GNP or gross national product). The Bank defines South Africa as an upper middle income country with an average (in 2011) GNI of \$6,960. However, an analysis of a range of other indicators, in particular the Human Development Index (HDI), where South Africa sits at number 121 out of 185 and its rate of increase is very low (between 0.87 in 1980 down to 0.01 in 2010 and 0.11 in 2011), the Poverty Headcount Ratio, the Poverty Gap Index²² and the Gini coefficient (63 in 2010) (and the Multidimensional Poverty Index) together broadly indicate that 23% of the South African population²³ exist below the poverty line. The poverty gap can be used as a measure of the ‘minimum amount of resources necessary to eradicate poverty’. It can also be seen as a measure that calculates both the prevalence and the depth of poverty in a country.

An additional set of figures are even more compelling. While the number of people in South Africa living in poverty (on less than \$2/day) decreased by 82% between 1997 and 2011, the number of social grant beneficiaries increased by 520%, from 6% to 31% of the population, while unemployment increased by 103%. Put differently, in 2001, for every 3.3 people employed, one person received a social grant – in 2012 the ratio was 0.9-1 and grants will account for 60% of the 2013/14 government budget. Public health expenditure as a proportion of GDP increased from 3.4% in 2002 to 4.1% in 2011, and the actual proportion of GDP on health is now over 8% (public and private) making South Africa amongst the top five in the world! (USA is >14%)²⁴ – but our health outcomes will not nearly achieve even the MDG goals.

It might be argued then that the picture provided by these indicators is a more realistic reflection of the levels of on-going very real suffering hidden by GNI per capita figures. Thus a large proportion of the South African population continues to exist in conditions very similar to those of countries identified as having low human development, albeit alongside portions of the population that could be defined as experiencing high human development. And while South Africa may appear to have sufficient funds, these are increasingly drawn from a shrinking tax base which is required to deal with a deepening problem.

Many respondents in this evaluation also assert that South Africa lacks ability to manage its resources effectively. The SANAC CEO commented:

²² World Bank, *Choosing and Estimating Poverty Indicators*

²³ <http://www.indexmundi.com/facts/south-africa/poverty-headcount-ratio>

²⁴ South African Institute of Race Relations, June 2013 *Fast Facts No 6*

We have a health costing task team looking at the sources of funding the HIV response – we [South Africa] probably can't fund the whole HIV response domestically even though we are a MIC – this problem is too large. I estimate that we need between 12-15% of the response funding (which would include support to civil society organisations) to come from outside SA. We will get around 6% from the GF.

Respondents in this evaluation were unanimous that despite the relatively small amount of funding represented by ODA, these funds were vital to the response.

We are only half-way across the river of the response to HIV. Donors leaving will probably result in taking us back to where we were 10 years ago. Reduced funding will impact civil society HUGELY! All of the progress and gains made will be lost!

Also, if we look at CBO work – our rural realities are so very different to the standard view of what a 'middle-income' country looks like. So many communities have NO services provided by government. It is unlikely that government will be able to provide regular and reliable services or funding in the near future. The government actually relies on CBOs for extension services, but expects them to provide their own funding.

This view, expressed by the AFSA team, found echoes in the views expressed from other evaluation respondents within and outside of government. All of these people indicated, some with more emphasis than others, that government was not geared up to fund the range of CBOs currently working across communities, even while it might intend to eventually provide services. Dr Yogan Pillay, DDG at the NDoH said

*... if the donor is going to continue to support some organisations, it is important that **we have a dialogue to understand** what they are doing and how this fits in with our programmes – i.e. optimising donor and DOH resources together on a common agenda. The truth is that funding CBOs at community level for whatever reason, inevitably results in them delivering some sort of service, so we have to understand what this is.*

How to manage the transition away from donor funding? Some respondents were of the view that a *phased* transition was possible if sufficient information was collected. Dr Pillay argued that:

*It is very important that any project that ceases to exist must link the beneficiaries to **SOME** facility in their area, and provide us with evidence that the beneficiary does reach our facility. i.e. they must make the transition smooth and help us to make sure the service to the citizen is maintained.*

Tamara Mathebula, Irish Aid HIV/AIDS advisor believed that *the most important thing to do now is to document the need that exists in our sectors – all our partners and CBOs need to do this – governments can't see that far down.*

However, if the government can't see that far down, how will it manage services to that level? The overriding impression was that South Africa would experience a setback in the response if all the donors who are planning to, leave. There was also a common recognition that the greatest need remained at the lowest community level

...where government does not get to – government can do things in fixed settings like clinics and schools, but not in mobile or shifting or very remote settings. – Sida has facilitated this level of intervention for such a long time, should they really stop now?

The need for assistance in improving systems and management – possibly through TA support – is supported by TAC's assertion that [the recent inability of the Mthatha depot to provide ARTs consistently] *...indicates that the health crisis is overwhelmingly one of management constraints, rather than a shortage of funds.*²⁵

Nelly Malafetse, Director, Donor Coordination, NDoH indicated in this regard that

... TA is the main thing we need here. We will need it for a long time as new people come into our public service. However the track record of TA is not all that good. We would have to manage it very carefully to make sure that skills are REALLY being transferred.

All of those consulted in this evaluation agreed that the role of advocacy and civil society organisations holding government to account remained critical.

Donors MUST CONTINUE TO SUPPORT advocacy organisations.

This is definitely not the time to leave. Our key populations are still vulnerable and there is a thin line between providing focussed services and support and creating stigma – lots of work still to do in this area

²⁵ TAC. Emergency Intervention at Umthatha Depot: The Hidden Cost of Inaction, January 2013

9.4 SWEDISH PARTNERS CONSULTED

9.4.1 South African National Aids Council (SANAC)

Funding amount and time

SEK 9,000,000 over 2009-2010. SANAC was also supported indirectly as follows:

- Indirect funding through core funding which enabled the work of Jonathan Berger, Fatima Hassan, Mark Heywood and support staff in ALP/Section 27.
- Indirect support through core funding to the Treatment Action Campaign.
- Indirect support through core funding to the AIDS Consortium which was SANAC's NGO sector coordinator.
- Indirect support through core funding to Sonke Gender Justice which was SANAC's Men's Sector coordinator.

Purpose

The National AIDS Council's primary role is to coordinate a national response. It is responsible for consultative design of a multi-sectoral and comprehensive National Strategic Plan, coordination of the various sectors, both public and non-government, involved in implementation of the plan, and monitoring and evaluation of the national HIV response.

Established in 2002 and funded through an R30million Trust established by the Government, SANAC took a number of years to become functional. It met infrequently and by 2005 had failed to drive to implementation its 2003 'Operational Plan for Comprehensive HIV/AIDS Treatment, Care and Support'.²⁶

Sweden's investment supported South Africa's commitment of April 2004, where

*Donors, developing countries and UN agencies agreed to three core principles – known as the 'Three Ones' – to better coordinate the scale up of national AIDS responses. The 'Three Ones' principles are: one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad based multi-sector mandate; and one agreed country-level monitoring and evaluation system.*²⁷

Results

Sweden substantially contributed to progress made in setting up the Three Ones in SA. Celicia Serenata, previously Resource Tracking and Donor Coordination Manager in the SANAC Secretariat said that

²⁶ TAC worries about spending of AIDS budget, *Mail & Guardian*, 23/02/2005

²⁷ WHO, <http://www.who.int/3by5/newsitem9/en/>

.....without the Sida investments into advocacy and the SANAC structures over the previous five years, many gains would not have been made.

One Coordinating Mechanism. There were dramatic improvements in the credibility, structuring, functionality of SANAC over the programme period, with the organisation being described as ‘.....’ in 2003, while 2012 saw the organisation fully absorbing the Country Coordinating Mechanism (CCM) function, initiating a Stigma Index tracking process, and generally being visibly more proactive in initiatives within the general response.²⁸ Sweden’s contribution to this took the form of support to ALP, the AIDS Consortium and the Treatment Action Campaign.²⁹

One National Strategy. The NSP 2007-2011 was the first plan to coherently analyse the epidemic and to attempt to address its various components.³⁰ Although imperfect, it was a vast improvement on any past plans and included the first elements of integration between health, social development, education and justice, as well as the clearest yet division of roles between the public sector and civil society. Previously, the HIV response had been government-centred, and largely health led. Building on this foundation, the 2012-2017 NSP followed a similar consultative process, and began to institutionalise the planning and consultation processes. This strategy has a more achievable, simple and well-rationalised M&E framework.³¹

- TAC and ALP, both recipients of core funding from Sweden, contributed substantially to the contents of both of NSPs.
- Representation into the 2007-2011 NSP from the grassroots was facilitated through the AIDS Consortium as leader of the NGO sector, which improved the depth of input into the strategy.
- Similarly, Sonke – as leader of the Men’s Sector since 2011 – contributed to the quality of the 2012-2017 NSP.

TAC and Section27 jointly launched their NSP Review in 2011.

Although Sweden has not funded TAC since 2011, past support to TAC definitely contributed to the organisation’s capacity to provide this formal mechanism for continuous M&E and accountability.³²

²⁸ TAC worries about spending of AIDS budget, *Mail & Guardian*, 25 Feb 2005; Tensions between Manto and Zuma weaken Council, *Mail & Guardian*, 5 July 2002; South Africa, *Global AIDS Response Progress Report 2012*.

²⁹ Sanac adopts strategic plan to combat HIV/AIDS, *Mail & Guardian*, 27 Nov 2007; Achmat: HIV/AIDS is an emergency, *Mail & Guardian*, 21 Jun2006

³⁰ TAC press statement 2 May 2007 ‘National Strategic Plan on HIV and AIDS (2007-2011) a new opportunity for a fairer South Africa’

³¹ TAC/ALP, June2012. ‘The NSP needs a good M&E system. Will it get one?’, *NSP Review 2*

³² TAC/ALP, June2012. ‘The NSP needs a good M&E system. Will it get one?’, *NSP Review 2*

A Resource Mobilisation Committee (RMC) established to support SANAC in resource mobilisation, primarily acted as the lead for applications to the Global Fund for HIV, TB and Malaria. However, by November 2012, SANAC had made progress in addressing resource mobilisation, and also taken on the greater management responsibility of the Country Coordinating Mechanism, resulting in dramatic increases in Global Fund disbursements in South Africa – from USD20m to USD100m in 2012.³³

After the elation of its achievements during the structuring and drafting of the 2007 NSP, SANAC experienced a demoralising slump. SANAC remained an organisation without legal status, and the Development Bank (DBSA) was asked to host the organisation at this time. However, this arrangement proved untenable. Donors were approached to facilitate a bridging period for the Secretariat, enabling the organisation to continue with its mandate. Sweden funded eight salaries for the Secretariat, including the CEO, for six months. DFID provided funds to cover equipment and infrastructure, and UNAIDS offered TA.

At the end of this time, a new CEO of SANAC was recruited. Fareed Abdullah, implemented a controversial restructuring process that included the replacement of existing staff and an attempt to invigorate all systems. Nevertheless, the role of ‘keeping the seat warm’ is one that has enabled a fresh start with minimal reinvention. The outcome of SANAC’s survival is that Abdullah has an opportunity to overcome its many challenges and ensure that it fulfils its role effectively.

Substantially more M&E data is available for national monitoring than previously. In 2010, HIV statistics such as percentages of people who had tested and knew their status; who had had sexual intercourse before the age of 15; who had had sexual intercourse with more than one partner in the last 12 months could be reported, where data were not available for these basic statistics in 2006/2007.³⁴ Data is still unavailable on key populations, and the current NSP focuses on these groups.

Challenges and opportunities

The challenges SANAC faced over the past decade are outlined eloquently in the GARPR³⁵, and include in particular, the ambiguity of SANAC’s legal status; poor M&E and lack of human resources for M&E; limited cooperation and coordination between sectors; unreliable data; lack of a national prevention strategy; health system constraints; and limited programming for key populations.

³³ SANAC press release, SA now has a Global Fund CCM

³⁴ UNGASS 2008, South Africa, *Global AIDS Response Progress Report 2012*.

³⁵ South Africa, *Global AIDS Response Progress Report 2012*., p89

M&E of the NSP 2007-2011 was poor, lacking even a fair proportion of the basic national indicators requested by UNAIDS for global monitoring. Lack of data, poor district health information systems, non-integrated multi-sectoral data flow and poor M&E across all government functions would have posed an analytical challenge with insufficient reliable data on progress against the response, even if SANAC's M&E processes had been fully functional.³⁶

Until 2012 the Resource Mobilisation Committee was essentially a Global Fund Proposal writing structure. It did not perform in terms of mapping, coordinating and leading donor investment into all sectors and functions of the HIV response.

Housed in the Department of Health, the SANAC Secretariat has tended to be 'sucked into health'. Far from coordinating a multi-sectoral national response, the Secretariat accepted responsibilities such as arranging World AIDS Day or coordination of the DoH HCT campaign. Celia Serenata, previously of the SANAC secretariat, said

SANAC needs its own identity. It cannot sit in Health and be an effective NAC. The small advantage of saving rent and infrastructure can be relatively cheaply obtained elsewhere, and it is not worth the sacrifice.

SANAC's physical location in the DoH building may continue to prevent it from rising to its role as national multi-sectoral coordinating body. However, this remains to be seen under the leadership of Fareed Abdullah. The current location in Health has been a challenge, and constitutes an on-going risk.

Relevance and sustainability

SANAC has always been complex and highly politicised, but its existence is critical to ensuring that the response incorporates all sectors, and that the interests of all these sectors continue to be represented in national strategies and resource allocation. Sweden's support has contributed substantially to the continued existence and the continuously improving functionality of SANAC.

Via its funding to ALP in the early and mid-2000s, The Embassy contributed to negotiating SANAC's formation. Mark Heywood, employed by ALP, but as civil society co-chair of SANAC, and Nono Simelela, then Executive Director of the HIV/AIDS Unit in the DoH, were given a national mandate to negotiate the structures and functions of SANAC. Prior to this, SANAC had not functioned as an AIDS Council, there was no civil society representation, and there was no accountability for independent scientific input ... *we are now light years ahead.*

³⁶ TAC/ALP, June 2012. The NSP needs a good M&E system. Will it get one? *NSP Review 2*; South Africa, *Global AIDS Response Progress Report 2012*.

Without the bridging funds from Sweden and DFID, and UNAIDS TA, all provided directly into the SANAC Secretariat during 2008-2010, the investments into SANAC structures over the previous five years would have been lost. The new CEO, Fareed Abdullah, has the opportunity to implement SANAC's role effectively.

9.4.2 Treatment Action Campaign (TAC)

Funding amount and time

SEK 43,100,000 between 2005 and 2010.

- Within the core budget, salary to Zackie Achmat as an individual offered particular impact into the HIV activism sphere.
- Mark Heywood, also professionally funded by Sweden (through core funding to ALP), has served as an active and engaged Board member to TAC throughout the funding period, and continues to do so.

Purpose

By offering core funding, Sweden enabled TAC to operate and implement its activities at all levels, giving it the latitude to respond as appropriate to the evolving national HIV context, and to hold government continuously accountable to delivery of effective services.

TAC is unique in South African civil society, in its structure of community level branches and district governance structures, which feed into provincial programme coordination structures and their aligned governance arrangements, supported by a national secretariat and a national executive council. As an authentically citizen-driven organisation, the TAC model is a rare example of the power and the challenges of sincere constituency representation.

TAC's purpose, powerfully epitomised by founder Zackie Achmat in his personal stance against lack of treatment, is to ensure access to HIV treatment, care and support by all in South Africa. What began as a successful campaign against a denialist government has now evolved into a community level watchdog and awareness campaign to ensure both the availability of treatment, and its uptake. TAC seeks, primarily, to ensure that:

- Health and social service standards are upheld by branches which, through their activities, address both treatment and the social drivers of HIV, as well as gender-based violence.
- Community awareness of rights to treatment, care and support, and uptake of the full range of HIV-related services by citizens, including a focus on prevention support, VMMC, PMTCT and integrated HIV/TB care.
- Policy at all levels, from local to national, enabled delivery of effective services

It is frustrating for organisations working to encourage adherence if ART and opportunistic infections' drugs are not available at clinics. This has been commonplace, as was shown in 2013 when TAC and local CBOs intervened to ensure ART supplies in the Eastern Cape

The recent breakdown in the delivery of services by the Mthatha Depot is a single, particularly severe episode that caused an immediate crisis in service delivery. However, it is merely a symptom of the depot's longstanding inability to adequately serve its function. The problems at the depot go deeper than issues of labour disputes and flooding which precipitated the recent crisis. Inadequate human resource capacity, corruption, mismanagement and a lack of oversight by the National and Provincial Departments of Health (despite knowledge of the extent of the problems) left the Mthatha Depot vulnerable and the recent breakdown was predictable, as were the consequences.³⁷

With poor results in health systems and service delivery, TAC's local presence provides routine tracking of locally relevant issues, with an aggregated monitoring function of drug stockouts at its sample of clinics.

Results

End of denialism - TAC was one of the central figures in completely transforming society and was a key driver in the end of the denialist era. Swedish's support to TAC and ALP gave them latitude to do what they were called to do, and has had profound impact. A selection of joint legal challenges include:

- The **2002 PMTCT case**, which forced provision of Nevirapine to pregnant mothers.
- **2003-2004 Treatment in the public sector.** Promotion of access to treatment in the public sector in partnership with ALP, culminating in the approval of the ART roll-out in November 2003 by Cabinet³⁸.

For the first time ever, in 2003, people aged 30 to 34 were dying in larger numbers than people in their 60s.³⁹

- **Until 2006 Confronting AIDS denialism.** Implementation of this roll-out required sustained advocacy, partly against denialism that continues to actively obstruct the implementation of the roll-out until 2006.

He [Stephen Lewis, United Nations special envoy to Africa, International Aids Conference, Toronto, 2006] mentioned the arrests of Treatment Action Campaign (TAC) leader Zackie Achmat and 44 protesters who occupied provincial government offices in Cape Town earlier on Friday. They were calling for the arrest of Minister of Health Manto Tshabalala-Msimang after the death of a prisoner with Aids, which Lewis said should never have taken place.⁴⁰

³⁷ TAC. January 2013 'Emergency Intervention at Umthatha Depot: The Hidden Cost of Inaction'

³⁸ Slow road to drugs roll-out, *Mail & Guardian* 12 Jul 2003

³⁹ Achmat: HIV/Aids is an emergency, *Mail & Guardian*, 21 Jun 2006, *Mail & Guardian*.

⁴⁰ SA govt under fire at Aids conference, *Mail & Guardian*, 19 Aug 2006,

Twenty-three thousand babies die annually in the first month of their lives; Since Dr Manto Tshabalala-Msimang's appointment as national Minister of Health, more than one million South Africans have died of Aids-related conditions. This depicts an utter failure of her ability to fulfil her mandate and renders her unsuitable for the position of health minister, based entirely on utterly poor performance.⁴¹

The biggest problem we have in South Africa is that we have a president who doesn't believe that HIV causes Aids⁴²

The South African government on Friday announced a dramatic reversal of its approach to the country's HIV/Aids crisis, promising increased availability of drugs and endorsing the efforts of civic groups battling the disease.⁴³

- **2003 – date - Implementing the ART programme.** Thereafter, sustained activism was requested to induce political will, budgeting⁴⁴, basic and improved drug registration⁴⁵, facility accreditation and confrontation of drug pricing monopolies⁴⁶.

TAC's first report on the status of the ARV roll-out was released. It indicates that, after eight months, fewer than 10 000 people are receiving ARV medicines through public hospitals nationally [compared with a target of 53 000].⁴⁷

The Aids Law project has welcomed Minister of Health Manto Tshabalala-Msimang's response on Wednesday to an ultimatum from the Treatment Action Campaign. The minister ordered that there should be an urgent accreditation of facilities that meet the requirements to provide quality Aids care.⁴⁸

- **2009 Treatment in correctional services.** Access to ART by prisoners, and access to information on the state of health in prisons were confronted by TAC and AIDS Law Project.⁴⁹
- **2012 Treatment at clinics.** Although policy was approved for Primary Health Care facilities to be accredited to provide ART in 2010, the implementation of the policy was erratic. TAC held meetings with DoH, and lobbied through the District AIDS Councils in its model districts, to encourage the roll-out of

⁴¹ TAC starts support fund for Madlala-Routledge, *Mail & Guardian*, 27 Aug 2007.

⁴² ARV programme less than the sum of its (monetary) parts, *Mail & Guardian*, 15 Mar 2006

⁴³ SA government ends Aids denial, *Mail & Guardian*, 28 Oct 2006.

⁴⁴ TAC worries about spending of Aids budget, *Mail & Guardian*, 23 Feb 2005.

⁴⁵ MCC stalls new Aids drugs, *Mail & Guardian*, 02 Feb 2007.

⁴⁶ SA generic Aids drugs breakthrough, *Mail & Guardian*, 16 Oct 2003

⁴⁷ Slow road to drugs roll-out, *Mail & Guardian*, 12 Jul 2004

⁴⁸ Minister's Aids response welcomed, *Mail & Guardian* 24 Mar 2004

⁴⁹ Balfour ordered to furnish report to TAC, *Mail & Guardian*, 30 Jan 2009

agreed clinic accreditation. By 2012 all Gauteng districts, for example, had PHC facilities involved in the ART roll-out:

*We know we've made a difference to treatment accessibility, down referral systems and advocacy for more accreditation of sites, and treatment stock outs. Now treatment is available less than 5 km from people.... There are more accredited sites, more VMMC, HCT and PEP, and more community health workers [in the model districts]. Almost all professional nurses are initiating treatment and not waiting for doctors.*⁵⁰

- **Dealing with drug stock outs.** Educated ART patients are ideally positioned to monitor drug stock-outs, and branches have support through TAC to engage constructively with facility management. The national distribution of drug stock flow in all TAC-supported clinics is collated in the TAC central M&E system, which provides national level stock-out statistics. This enables TAC to raise stock-flow issues through the DoH hierarchy, and also provides the potential to escalate the issue into provincial and national level campaigns. TAC asserts that its activists have supported facilities in managing their drug supply chains for ART, and that where TAC has a presence, drug stocking is more consistent for ART than for many other drugs. In an Eastern Cape drug stock flow crisis, TAC provided interim staff and support to the OR Tambo District drug depot to ensure resumption of drug supply services.⁵¹
- **NHLS.** In a campaign around the National Health Laboratory Service (NHLS) service interruptions when Gauteng and KZN failed to pay their bills, a public activism effort contributed to resolution.⁵²
- **Monitoring the NSP.** By 2011 TAC held a key position, in partnership with Section 27, of monitoring the implementation of the National Strategic Plan. Current progress, challenges and the quality and impact of the response are published by TAC in the NSP Review.⁵³

Multiple on-going campaigns at all levels continue to be central to TAC's role. These pertain to around access to treatment, expanding to access to rights at community level in general, from local to national level, global commitment to sustaining support to the response⁵⁴. And at community level, TAC provides awareness-raising across all branches, and intensive treatment literacy training to PLHIV. The TAC tenet that a

⁵⁰ SA generic Aids drugs breakthrough, *Mail & Guardian*, 16 Oct 2003

⁵¹ Achmat: HIV/Aids is an emergency, *Mail & Guardian*, 21 Jun 2006, TAC worries about spending of Aids budget, *Mail & Guardian*, 23 Feb 2005 ; SA generic Aids drugs breakthrough, *Mail & Guardian*, 16 Oct 2003.

⁵² C Tomlinson, National Health Laboratory Service facing collapse – TAC. *Politicsweb*. 08/12/ 2011.

⁵³ <http://www.nspreview.org>

⁵⁴ Protesters ask US not to cut Aids funding, *Mail & Guardian*, 17 Jun 2010.

person on long-term treatment has the right and the ability to learn drug names including generics, drug combinations and dosages, specific side effects of each drug and their management. TAC education may give patients more sophisticated knowledge than the nurses who treat them. A ‘treatment expert’ model enabling far higher adherence rates and stronger engagement between patients and the health system.

I can even confront the doctors. I can tell the doctor that there is severe peripheral dystrophy and can you change from treatment A to B because it doesn't have that side effect. A lay person doesn't know what side effects are and think they are getting worse'. 'They give information on side effects and STIs, the reasons for bloods and clinic visits, reasons for second line regimens. They do a very good job.'⁵⁵

Treatment literacy and social mobilisation interventions are the daily work of TAC activists and trainers. TAC also seconded **Clinic-based Prevention Treatment Literacy Practitioners** into clinics in six model districts for part of the Swedish funding, as an experiment in strategy and design.

This was highly effective within the selected districts and clinics. Most patients would default if TAC was not there. Especially in the informal settlement where the community caregivers don't reach (Clinic nurse, Ekurhuleni).

In addition to providing treatment support, TACs was able to record patients' experiences such as harassment, changes in appointment dates after patients have arrived at the clinic, and excessive queue time were discussed with clinic management, with constructive input to solutions wherever possible.

The social mobilisation structures and engagement through branch membership, training and institutionalisation of meetings, planning and local activities has been another powerful sphere where TAC branches are active. Active branches provide a citizen force for surveillance, community support and awareness-raising which can be mobilised upwards for district, province or national campaigns where relevant.

Through the hierarchy TAC gathers information on the state of communities in access to HIV treatment, and to the wide range of services that enable HIV prevention, resilience to AIDS and address social drivers. Through a rather haphazard, but essentially effective process, issues in communities are communicated upwards. If unresolved or experienced at scale, issues achieve a critical mass at progressively higher levels of advocacy, and directly inform TAC's activism.

⁵⁵ SA generic Aids drugs breakthrough, *Mail & Guardian*, 16 Oct 2003

TAC's model for citizen voice is a valuable result in itself. It demonstrates the structures and flows that make this possible, as well as the fluidity and chaos that is inherent to genuine participation. It demonstrates both the challenges and possibilities for structured formal organisations to engage professionally with donors, while also achieving broad representation.

There are three key dimensions that make TAC a unique, effective but challenging organisation that is difficult to contain, drive and even predict.

- Firstly, TAC has been highly innovative in devising systems and structures for permitting genuine community participation and citizen voice. Its authentically representative governance structure provides representation from community members through to national and provincial governance structures.
- Secondly, alongside this model, TAC has a Secretariat, which has the role of interfacing with funders and providing an organisation that is governed in a responsive and representative manner, with a semblance of coherence, centralisation and professional management.
- Thirdly, in a further permutation, TAC's culture and leadership is rooted in activism, in all of its reactive, emotional and powerful energy.

Challenges and opportunities

Donors have found it difficult to effectively demand the level of organisational functionality that they seek in TAC. TAC's central management structures have struggled with their own coherence, internal communication, management, structure and effective donor management and communication. Various loyal donors recognise TAC's uniqueness, legitimacy, legacy and relevance. They have attempted to guide the Secretariat in terms of management processes and skills, but have not managed to produce the kind of simple, effective management structure that might benefit the organisation at the centre. TAC's head office has made progress, but remains an area where organisational development, strong management and coherent leadership are needed, while recognising the scale of challenge that this represents.

As the TAC and partners protest to the US government of 2010 clearly articulates, donor support has been key to the achievements of the HIV response in South Africa to date⁵⁶. The epidemic is far from resolved. HIV-related deaths remain high and new infections continue. The HIV response is a longer-term challenge, and 10 years of progress has not achieved a solution. For the donor community, including Sweden, to divert the attention it has invested to date from the South African HIV epidemic, the

⁵⁶ Protesters ask US not to cut Aids funding, *Mail & Guardian* 17 Jun 2010.

gains achieved could easily be lost. TAC, its partners, and this evaluation regard the current reduction in support to HIV globally, including in South Africa, to be a dangerous and short-sighted strategy. While emphasis, approaches and scope of work may evolve, particularly to include broad socio-economic solutions – the fact of HIV-related investment in the most appropriate form for the time should remain a top global priority.

Relevance and sustainability

TAC is, and has been since its formation in response to the South African government's slow response to the evidently growing HIV epidemic, one of the leading agencies in advocacy and policy influence in the country. Sweden has provided core funding to TAC since 2004 and has been a powerful ally in TAC's influence and impact.

During Sweden's funding period TAC restructured and shifted its strategy from being a broad-based community representative structure with actively supported branches across the country, to a focus on six model districts in the Health Priority Districts identified by the MoH. While the model districts approach demonstrated great potential for depth, lack of engagement diminished TAC's critical element of broad representation and universal access to a TAC voice, through branches across the country. Having been tested for a period, TAC has reverted to rebuilding branches, and a focus on a broader model. Both models were tested under Swedish core funding, and useful modalities for improving clinic performance and adherence to treatment were explored in the model district approach.

Despite challenges at head office TAC district offices, programmes, branches and members have a high level of intrinsic energy and passion, and TAC functions far better on the ground than might be assumed from the standard of engagement from the centre.

TAC recognises its over-riding strength, however, that of a structure that reaches into households and communities, and builds immediate representation at community level into clinics, police stations and local information campaigns. This groundswell of input from the grassroots, alongside a hierarchy that has the presence to confront intractable service delivery challenges at any level, remains its most powerful asset, and one that is not replicated to the same extent in any other South African organisation.

At a point in South Africa's history where citizen voice and engaged civil society are acknowledged to be weak, TAC's mobilisation and leadership provides an inspiration to many. During the height of confronting denialism, TAC branch participation grew in passion, and membership of TAC attracted and inspired many in a time of profound despair. Having laid a foundation and a culture of constructive but firm and well-articulated advocacy, TAC creates an example that is largely lost in protest action in other spaces. There is great potential to disseminate the principles explored by TAC into other sectors, such as governance, trade unions and local service watchdogs. For example, the current state of weak, incoherent, explosive but unsustainable, inarticulate and ineffective service delivery disputes could learn a great deal from TAC's approach, and if adopted by leadership in these spheres, could avert the violence that is inevitable without concerted activism.

TAC continues to offer a unique model and a critical source of accountability. With death from HIV at around 750 people per day, new infections seemingly uncurtailed and social drivers of the epidemic intensifying rather than abating,

TAC remains highly relevant. In the fragile progress made within a weak and inconsistent health system, its presence is a powerful stabiliser, providing useful motivation to government to continue to strive. TAC might benefit from simpler central management and an expanded decentralisation. From community to national levels, TAC remains an opportunity for impact by funding agencies with an appetite for true, and therefore untidy, democracy.

9.4.3 AIDS Law Project / Section27

Funding amount and time

SEK 14,950,000 between 2005 and 2013.

Purpose

ALP has provided legal support and litigation into activist campaigns for an equitable and effective HIV response. It has worked in close partnership with TAC throughout its engagement. It is through this close collaboration with TAC that ALP successfully litigated government through the Constitutional Court for ART availability and accessibility in the public health service in 2002 and recently with correctional services in 2012.⁵⁷ ALP provided the legal pressure and ultimately the force of the law and the constitution to compel government to meet its human rights obligations. ALP has been a respected voice and opinion-maker on a wide range of HIV and rights-related issues. One example is their engagement with the South African National Defence Force (SANDF) about HIV-related discrimination.⁵⁸

In 2010 ALP was incorporated into the newly formed Section27, with an expanded vision of influencing, developing and using the law to protect, promote and advance human rights, expanding from an HIV-focus to

all socio-economic conditions that undermine human dignity and development, prevent poor people from reaching their full potential and lead to the spread of

⁵⁷ A court case on the death of MM who should have been initiated on ARV treatment in November of 2003 some 32 months earlier. Published on <http://www.tac.org.za/community>

⁵⁸ ALP, representing the South African Security Forces Union (SASFU) and three individuals living with HIV, took the SANDF to court to challenge the blanket exclusion of individuals living with HIV. [Available from] <http://www.section27.org.za/2013/07/08/press-conference-and-founding-affidavit-new-court-challenge-to-ongoing-hiv-related-discrimination-in-the-sandf-9-july-2013/>

*diseases that have a disproportionate impact on vulnerable and marginalised people.*⁵⁹

The name Section27 derives from a key clause in the Constitution that states that everyone has the right to healthcare services, sufficient food and water, social security and emergency medical treatment.

*... Our intention is to take advantage of the Constitution to put new pressure on the government and the private health industry to move more quickly and effectively to provide proper healthcare.*⁶⁰

Sweden's core support has enabled both incarnations of the organisation to respond to the unfolding challenges to constitutional rights with latitude and autonomy, and has been a key partner in the successes that the organisations have achieved.

Results

Given a large degree of latitude to respond as required, ALP has profoundly contributed to a completely transformed society and was a key driver in the end of the denialist era. Sweden's support to APL gave it flexibility and encouragement to do what they were called to do with autonomy, and has had substantial impact.⁶¹

In a partnership of legal action by ALP and public action by TAC, ALP is a visible source of trusted advice and opinion in the press.⁶² A selection of opinion matters includes:

- children's rights to treatment without consenting adults;⁶³
- criminalisation of HIV transmission;⁶⁴
- the rate of treatment roll-out and analysis of constraints, including drug pricing, delays in drug registration, accreditation of facilities, political will;⁶⁵

A selection of litigation interventions includes:

- competition commission enforcement of licensing to produce affordable generic ART;⁶⁶

⁵⁹ <http://www.section27.org.za/about-us/>

⁶⁰ Mark Heywood, quoted in Farnaaz Parker, 7 May 2010. 'Aids Law Project discovers the power of a name', *Mail & Guardian*

⁶¹ SA government ends Aids denial, *Mail & Guardian*, 28 Oct 2006

⁶² Orphans, Aids drugs and the law, *Mail & Guardian* 24 Oct 2003

⁶³ Orphans, Aids drugs and the law, *Mail & Guardian* 24 Oct 2003

⁶⁴ Aids crime proposal under fire, *Mail & Guardian*, 27 Jan 2004

⁶⁵ Slow road to drugs roll-out, *Mail & Guardian*, 12 Jul 2004, Minister's AIDS response welcomed, *Mail & Guardian*, 24 Mar 2004, ARV programme less than the sum of its (monetary) parts, *Mail & Guardian*, 15 Mar 2006, MCC stalls new Aids drugs, *Mail & Guardian*, 02 Feb 2007, Bye-bye Balfour, *Mail & Guardian* 1 Feb 2009, Balfour ordered to furnish report to TAC, *Mail & Guardian*, 30 Jan 2009, Roll-out, what roll-out? *Mail & Guardian*, 18 Sep 2006

- employment discrimination, compulsory HIV testing and dismissal HIV-positive soldiers against the Defence Force;⁶⁷
- compensation for HIV-positive women whose privacy was compromised by the press.⁶⁸

The production of cheaper generic ART drugs was less the result of government intervention than the work of activists and lobby groups—like the Aids Law Project – which have fought for patent restrictions and pressured pharmaceutical companies to issue voluntary licenses to generic manufacturers.⁶⁹

There really has been a substantial reduction in price. It shows what can be done when you have government and civil society working towards the same goals.⁷⁰

ALP readily addressed broader human rights issues, such as conditions of refugees of xenophobia in 2008.⁷¹ This breadth became formalised in Section27's expanded role addressing HIV directly as one of four priority areas, while addressing human rights as a central social driver to the epidemic. Some examples include:

- Conditions experienced by learners in Limpopo schools⁷²
- Within the core funding to ALP, Mark Heywood was also able to take a leading role in the formation of a properly constituted SANAC.

Impact has extended beyond South African borders, with ALP/Section27 lawyers and spokespeople significantly influencing in guiding global priorities and directions with the HIV response. For example, Mark Heywood has been visited for advice by constitutional judges from other countries, and has actively engaged with human rights campaigns for China.

Challenges and opportunities

- Issues around linking effective programmatic interventions to ensure prevention are not only talk but a coherent strategy.

⁶⁶ SA generic Aids drugs breakthrough, *Mail & Guardian*, 16 Oct 2003

⁶⁷ AIDS activists challenge discrimination in the army, *Mail & Guardian*, 14 Oct 2003, Army faces law over HIV sacking, *Mail & Guardian*, 31 Aug 2004, Aids group to challenge army on HIV testing policies, *Mail & Guardian*, 14 May 2007, Union takes army to court over Aids policies, *Mail & Guardian*, 14 May 2008

⁶⁸ Battling the brutal stigma of HIV, *Mail & Guardian*, 25 Apr 2005

⁶⁹ Centre for the Aids Programme of Research in South Africa, UKZN – MG ...

⁷⁰ Govt awards antiretrovirals tender, *Mail & Guardian*, 27 Jun 2008

⁷¹ UN refugee agency to probe xenophobia response, *Mail & Guardian*, 14 Oct 2008

⁷² 'Section27 threatens more court action over Limpopo schools' *Mail & Guardian*, 15 Feb 2013

- Although the NSP shows that key populations are critical in reducing incidence, there are few focussed strategies that can ensure how this begins to work, particularly at schools/youth level.
- Investing in the social fabric via CSOs is a lengthy process that may not always have short-term impact, therefore results are not always clearly observed.
- Although legal frameworks (e.g. NSP) are available, implementation is still an ongoing challenge.

Relevance and sustainability

ALP has achieved more than just ensuring the roll-out of ART. The organisation spearheaded the model of holding government to account using the law. In a context where civil society has emerged from apartheid with a loss of leadership, direction and coherence,⁷³ the role models provided by organisations like ALP serve to raise the expectations of civil society for voice and impact. ALP's advocacy, press/media presence and legal cases have also informed the public and created a space for education and debate around the fundamental issues driving HIV.

Evidence based, successful litigation contributed to increasing the profile of ALP for PLHIV. The 2005 confidentiality case, for example, served to highlight the impact of stigma on people's lives and the dangers faced by people disclosing their HIV status.

*A positive diagnosis for a poor woman who cannot afford immediate medical care, or who cannot afford to lose her bread-winning partner after disclosure, makes her more prone to being traumatised, according to expert testimony in court on Thursday. Many people still live in an environment of fear and hopelessness that restricts their ability to be tested and disclose their status.*⁷⁴

ALP's advocacy also contributed in reducing stigmatisation around HIV. For instance ALP helped to form opinion around the suggestion that HIV transmission should be criminalised:

*The Aids Law Project has slammed suggestions that the transmission of HIV/Aids be made a crime, saying that such a move would create the dangerous impression that carriers of the virus are alone responsible for ensuring safe sex. Jonathan Berger, a lawyer with the Aids Law Project, said on Tuesday that such a provision would increase the stigma associated with the disease.*⁷⁵

⁷³ Dinokeng Scenarios

⁷⁴ Battling the brutal stigma of HIV, *Mail & Guardian*, 25 April 2005.

⁷⁵ Aids crime proposal under fire, *Mail & Guardian* 27 Jan 2004

Another example is the campaign for access to ART by children in child-headed households:

Liesl Gertholtz, a lawyer at the ALP, told the Mail & Guardian it is critical that mechanisms are put in place to ensure that children receive the full protection of the law, while also ensuring their health needs are met. 'Currently consent can only be given by a legal guardian or a parent, but there are many children who are living in child-headed households and have no legal guardian'.⁷⁶

ALP/Section27's work continues to be relevant, playing a critical role in representing the voice of civil society through the law in various sectors.

9.4.4 The AIDS Consortium (AC)

Funding amount and time

SEK 9,309,999 between 2008 and 2013

Purpose

The Aids Consortium (AC) is one of the oldest and largest NGO networks in South Africa. Formed in 1992, it currently has over 1000 registered affiliated organisations, more than half of which in Gauteng, with another substantial hub in Limpopo. The ACs programmes, based on an AIDS Charter facilitated by founder Justice Edwin Cameron, have included:

- Communication and media, including advocacy, citizen voice, representing members' voice in SANAC, support and participation in advocacy campaigns.
- Training (Organisational capacity building and technical training).
- Affiliate engagement and experience exchange (through networking, affiliate meetings or bua).
- Information and resources support to members (through a library, cyber café, and a distribution hub).

Through this combination, the AC is an example of performance in all three dimensions of the Swedish evaluation: upward influence through support to campaigns and engagement in advocacy; horizontal influence and coordination as a leader in the NGO sector and active engagement with SANAC; and downwards or grassroots development and empowerment through a range of capacity building opportunities to affiliated organisations.

Results

⁷⁶ Orphans, Aids drugs and the law, *Mail & Guardian* 24 Oct 2003

Justice Edwin Cameron, Patron and founder of the AIDS Consortium, provides an insight into the achievements of the AC, and its close advocacy partners, Section27, and TAC, as well as the many collaborating NGOs, including AFSA and Sonke Gender Justice. Justice Cameron says:

We were naïve 20 years ago, we did not know. Our Ugandan friends knew what lay ahead for us the grief and the suffering and the death and the physical and political struggle... What I want to take from the 20 years of the Consortium is the important lesson of what we can achieve through our efforts. When we started the Consortium at the end of 1991, there was no treatment for HIV, it was a death sentence..., stigma was almost unspeakable ... It silenced us, it closed our mouths and closed our hearts... we've come a long way through that grief and pain and titanic struggle, the struggle against the drug companies to reduce the cost of the drugs, the struggle against President Mbeki.

What do we have today? We have a Health Minister (with a supportive structure) who has energy and purpose, he has idealism and principles, and he knows what has to be done. We have in our country the biggest publicly provided ART programme anywhere in the world – let us congratulate ourselves! These things happened because of commitment, principles, determination, activism and courage.

If we are worried about social inequity, social injustice, poverty, let us see the struggle in this epidemic that 20 years ago threatened to overwhelm us, as an opportunity for social solidarity and for political turnaround and achievement. Let us see that as an example of what we can still do in the next 20 years!⁷⁷

Core support to the AIDS Consortium has enabled it to fulfil its mandate. The AIDS Consortium was particularly influential between 2005 and 2010, during which time the following major achievements were realised:

Upward influence

The AC actively supported TAC and ALP in confronting the denialist era as an active voice, and as a legitimate representative of CBOs in opposition to the state at the time. The AC provided a vocal and visible delegation to the Toronto international AIDS Conference at which the South African MoH's position became untenable. This was a major turning point linking with the other factors that resulted in the demise of this dispensation.⁷⁸

⁷⁷ Justice Edwin Cameron (Patron of AC and Constitutional Court Judge). AC Annual Report 2012

⁷⁸ AC Annual reports 2006 and 2007, Fran Blandy, 'SA govt under fire at Aids conference' *Mail & Guardian* 19 Aug 2006.

The AC was a key task team member in coordination of civil society influence during the formation of SANAC and design of the 2007 NSP, which

*...was seen as one of the key turning points of 2006, whereby government shifted its response to HIV/AIDS with new acknowledgements regarding the scale of the problem and new commitments to action.*⁷⁹

*The AC brings Civil Society Together! The AC was appointed as a key task team member of a Civil Society group responsible for planning and hosting a powerful congress of 350 delegates The AC, as the designated health representative of SANGOCO, together with the South African Council of Churches, COSATU (the country's largest trade union) and the Treatment Action Campaign (TAC) met weekly for six months to plan the congress. The Congress established six commissions: Prevention, Treatment, Care and Support, Women, Children and Partnerships, and Collaboration. These commissions developed action plans and resolutions that were then fed back to the South African National AIDS Council (SANAC) for the process of restructuring that body, as well as the National Strategic Plan (NSP) for 2007 – 2011.*⁸⁰

The AC was selected to represent the NGO sector in SANAC, and presented the role and niche of various NGO and CBO players into the NSP 2007-2011. This NSP offered a clear and defined position for civil society, and was far stronger in terms of civil society participation than the current NSP. The more active participation of civil society in the drafting of the previous NSP, which directly resulted in civil society's recognition, can also be partly attributed to the coordinating role taken by the AIDS Consortium.⁸¹

*The plan has identified 19 goals to reach the NSP's aims. ... Different interventions have been identified for each ... over 50 of those interventions have NGOs as lead agencies of implementation.*⁸²

AC was part of the working group leading the *One-in-Nine* campaign against gender based violence in 2006.⁸³ Additional examples of many campaigns include: donor policies on sexual and reproductive health;⁸⁴ grants and social service engagement with Department of Social Development;⁸⁵ the anti-stigma heroes campaign profiling

⁷⁹ Annual report 2006

⁸⁰ Annual report 2006

⁸¹ AC Annual reports 2007, 2008, 2009, 2010

⁸² AC Annual report 2007

⁸³ AC Annual report 2006

⁸⁴ It is women who will suffer, *Mail & Guardian* 6 Aug 2004, Protestors ask US not to cut Aids funding, *Mail & Guardian* 7 June 2010

⁸⁵ AC Annual report 2005

the journeys and inspiration of *Heroes, defined as prominent people or people who hold a prominent position in society, are openly living with HIV are willing to share their HIV journey*; campaign for girls' education ; campaign for funding flows to CBOs; Competitions Commission drug pricing campaign; and ongoing support and partnership with TAC and ALP.⁸⁶ The AIDS Consortium engaged government in advocating for efficient and timely payment of stipends to Community Health Workers, and to recognise that staff at this level was critical to the successful re-engineering of the primary health care system.

Citizen voice and capacity building

Through formal communication mechanisms and regular affiliate gathering, with an average attendance of around 130, the AC could authentically gather input from community members and actors on the realities of situations in communities:

*Monthly meetings for the affiliates were developed to be ... conducive to debate. This has enabled the AC to bring to the platform serious issues and challenges coming from the community ... and the identification of core advocacy issues in the local community at grassroots levels.*⁸⁷

Community organisations are often started by volunteers who are generally not formally trained in organisation management, and often have difficulty with basic literacy and numeracy. Staff members responsible for key functions often lacked essential skills and practical knowledge. These are effectively developed through combinations of training and mentorship.

*Before training we used email at an internet café. Our communication was weak. We had two computers, but they were out of date. We had no Human Resources structure: everyone in the organisation was involved in all projects. Everyone entered data into the database, so we had duplicate records; there was no checking of data quality and no record of how many clients we really had. We knew we had 800 children, the database counted 900.*⁸⁸

Capacity building took a number of forms over the period of Swedish funding, and was continuously adapted in response to evaluation, CBO feedback and action learning. One core model was provision of SETA-accredited trainers with community-based experience providing off-site training in modules on organisational management such as finance, strategic planning, resource mobilisation, project

⁸⁶ AC Annual reports 2007 and 2009, Cry for help for care-givers, *Mail & Guardian* 11 Aug 2009, TAC annual report 2003

⁸⁷ AC Annual report 2005

⁸⁸ AC Impact assessment 2007

management, human resources, governance, administration and information and communication technology, as well as technical HIV and AIDS training. Critically, all training was followed by a mentorship programme to ensure implementation and to receive feedback.

Training success was variable, with top performing CBOs able to absorb individual training and mentorship into enhanced organisational performance. Less inherently competent CBOs tended to rapidly lose the training content within individuals, although mentorship was valuable in mitigating this. Many CBOs, however, were more effective as a result of AC capacity building. Substantial improvements were recorded in strategy and planning; management and communication; organisational systems and structures; filing and administration; ICT skills; financial management; leadership and governance. Excerpts from the capacity building impact assessment evaluation of 2007 include:⁸⁹

We have job descriptions and policies. We pay our employees through the internet. We have Board members that are working. Through the training we have data collection that monitors what is being done by home-based carers. I am able to manage people and give them tasks. I have improved my monthly and quarterly reports.

Before, planning and implementation were my responsibility only, but now the whole staff takes responsibility.' (CBO Director on Leadership)

Through the training I learnt that I might have started this, and it might have been my idea, but it no longer belongs to me. It is owned by the community. We were trained to let go, and let the staff and the community also own the organisation.' (CBO Director on Leadership)

In setting up the new Board we focussed on getting skilled people with expertise that were needed in the programme - a doctor, ward councillors and business people ... We developed an understanding of rules and regulations, roles and expectations of the Board. (On governance)

In combination, the capacity building programme built organisational sustainability and stability. Of 12 organisations sampled in an impact assessment in 2008, nine reported an increase in funding. The AC confirmed that, after training, many participants expanded their funding base, or extended their relationship with DoH.

⁸⁹ AC Impact assessment 2007

Model building

The AC model, along with the variation demonstrated by other umbrella organisations such as AFSA and NACOSA, demonstrates set of modalities for coordinating, capacitating, mentorship and support to CBOs. It provides a model for the type of continuous support and mobilisation for organisation facilitating integrated household level access to rights, services and voice.

The AC, through a thorough and carefully interrogated action learning process, has arrived at a model specifically focussing on capacity building. Details such as participant selection criteria and induction processes, balance of practical and theoretical training, facilitation style, supporting materials and mentorship systems have all been tested and documented.

The AC continues to offer opportunities to share experiences and good practice with other umbrella organisations, to pilot the form of social franchising which enabled expansion of its model from Gauteng and Limpopo, to be a leader in models for capacity building and affiliate networking.

In recommendations around identifying and scaling the roles of CBOs, and the roles of umbrella structures or networks, the AC should certainly be a key participant.

Unintended effects: Empowerment of women

Part of the value of CBOs is as conduit for a flow of individual self-realisation and ... the role that CBOs play in creating pathways out of poverty.⁹⁰

CBOs successfully depend on volunteers, some on low stipends, but many unpaid. The incentive to work for CBOs lies in a hope for 'greener pastures'. In a context where effective secondary education is not guaranteed, and tertiary inconceivable, few of those who volunteer to work with CBOs realistically aspire to formal employment. Through their employment with a CBO, however, workplace experience, practical skills, confidence building and formal training all increase their opportunities. A great many volunteers in CBOs go on to find formal employment.⁹¹

Volunteer-based CBOs are a springboard into the formal economy – by volunteering and being trained they are able to access posts in local NGOs and public health facilities that both advance their own aspirations and lead to more competent local services. Community service as one pathway to skills and into the more formal economy can be seen as a positive impact.⁹²

⁹⁰ Konstant, T.L. (2010) Towards principles and practice of participatory development evaluation for community based organisations PhD Thesis, University of Pretoria, pg 273

⁹¹ AC Impact assessment 2007, Annual report 2008

⁹² AC Annual report 2009

*We welcome the fact that some of the trained carers are moving on. They found better jobs in our new clinic. Although we lost them, we welcome the move because it is going to help our community more.*⁹³

There is some irony that the legitimacy of CBOs is being threatened, partly because of the quality of trained personnel recently been absorbed into the health sector from their ranks, and are seen to have the role of replacing household level access.

Challenges and opportunities

The CBO environment is both inspired and burdened by a wide range of challenges and opportunities. These are discussed in a generalised section on CBOs and their umbrella support agencies.

AIDS Consortium organisational evolution

Related specifically to the AC, it is beyond the influence of Swedish funding that the AC no longer has the role and influence of five years ago. Following a change in leadership and management, the AC's funding sources, human resources, programmes and upward influence have contracted. Its relevance for affiliated organisations is also affected. Presently there are 400 affiliates and four staff left in the organisation. However, there is no effective M&E system that monitors relevance and effectiveness for the affiliates. The Swedish core funding has allowed the AC to stay alive, but the organisation is facing great challenges. It might have been beneficial, however, for stronger advice and influence from Sweden to have been expressed during the transition of Executive Directors of 2010/2011. Also, facilitation of networking between the major CBO umbrellas (AFSA, AC and NACOSA) might have helped in reformulating roles and methods.

What was clear within the organisation was that the focus for CBOs needed to broaden out from HIV/AIDS treatment and care, to social drivers and root causes, e.g. poverty, nutrition, income. While its programme of support to CBOs continues to be appropriate and strong potential remains for a revitalisation of the organisation with donor support, it no longer plays at the level or scale of its past.

Double edged sword of CBO growth and capacity

Large increases in funding or expansion of organisation size or function are often a mixed blessing for CBOs, and particularly those which then attract further donor support. Growth and formality present their own challenges, and rapid development is as threatening to an organisation as stagnation. One CBO increased from a single office to three branches in different areas, providing a far wider range of services.⁹⁴

⁹³ CBO leader, AC Impact assessment 2007

⁹⁴ AC Impact assessment 2007

The same staff with the same skills was managing a far more complex operation, with responsibility for more funding, from more sources, using new, formalised systems. Systems for financial accountability and control, reporting and supervision, site visits by management, all needed to be designed and rapidly established in order to ensure that this expansion was managed correctly.

As reliance on formal salaries and technology increases, vulnerability to unmet expectations, and also to a subsequent loss of funding and support, can and does cause well-established small organisations to collapse. *It is getting bigger quickly, beyond our powers.* Unlike the commercial model, larger is not necessarily better, and there are costs and benefits to multiple small relatively less formal organisations, and fewer structured organisations.

9.4.5 Trucking Wellness / Corridor Empowerment Project (CEP)

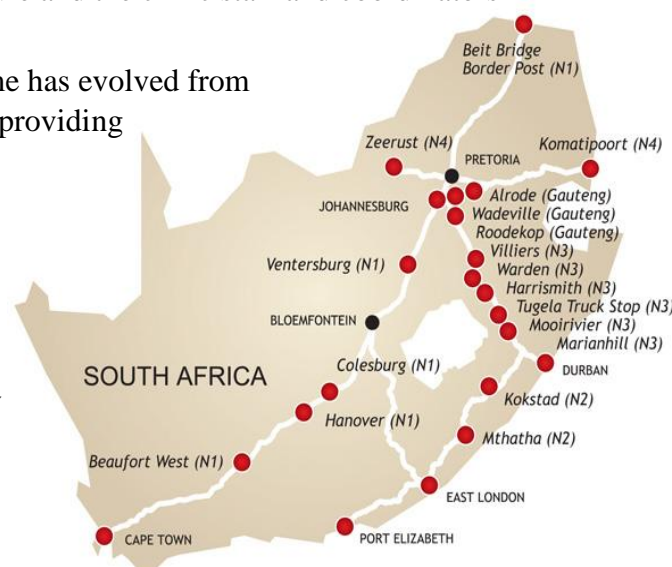
Funding amount and time

SEK 9,000,000 to the Trucking Wellness Project through the National Bargaining Council in 2006/7. SEK 35,677,580 directly to CEP between 2008 and 2013.

Purpose

CEP manages the Trucking Wellness project on behalf of the National Bargaining Council for the Road Freight and Logistics Industry (NBCRFLI), providing supervision, logistics, project management, and general coordination functions. The Council owns most of the project infrastructure and the clinic staff and coordinators are Council employees.

The industry's Trucking Wellness Programme has evolved from promoting HIV/AIDS and STI awareness to providing a holistic approach to health and wellness through a range of free primary health care services via five mobile and 22 fixed Wellness centres situated on all major trucking routes where Bargaining Council members trucks travel. These wellness centres are run in collaboration with industry partners (employers and trade unions), local government and relevant health departments and serve long-distance truck drivers, commercial sex workers and parts of local communities. The programme enjoys the support of the four industry unions, as well as the Road Freight Association (RFA). The Board comprises both unions and employers. The 22 National Roadside Wellness Centres are situated as shown on the map alongside.



Results

The National Bargaining Council CEO asserts that the Trucking Wellness project has made a huge impact.

Drivers with Code 14 [heavy-duty truck license] are scarce so we have to take care of them. The programme has had a huge impact on our industry – in 2005 we were seeing around 38 deaths a week from illness and that is no longer the case. General health has improved as well. The industry is also very aware that the service has to cover ‘ladies of the night’, as that is a reality of that life.

CEP/Trucking Wellness has addressed particularly high risk populations and on their sites have succeeded in normalising use of the clinics by these populations, which has in turn resulted in some reduction in stigma, and definitely a reduction in prevalence of both HIV and STIs. The programme has integrated the management of chronic health conditions with specific reference to high blood pressure and diabetes as this was identified as a pressing need among their beneficiaries. The latest addition to services will be to incorporate TB detection as part of infectious disease management.

A focus on both care and Peer Education also maintains awareness within these populations and encourages use of the services.

Good computer database monitoring of patients across the whole programme allows good patient tracking and improved quality of care. Quality of care is also ensured through good people management /performance monitoring of clinic staff.

Combination of mobile and fixed clinics has enabled both the mobile and office bound populations in this industry to access testing and care. Services do not only target trucking community but include surrounding communities, employees around the centres and sex workers. CEPs goal is to test every person in the industry sex/worker linked to the industry every three years.

The Corridor Empowerment Project has also provided national level outcomes. Their work covers the main transport corridors in the country and targets the key populations of truck drivers and sex workers. Inroads have been made to address general health, STIs and HIV & TB issues within the road freight industry. The organisation maintains pressure on the National Bargaining Council for the Road Freight and Logistics Industry (NBCRFLI) and its members to continue and extend support for the mobile clinic system.

Sweden provided a high proportion of CEP's core funding, which has enabled whole programme advancement, and in particular the visioning process of where the programme should focus, securing and maintaining industry employers' buy-in and support, and mobilising additional resources from various sources. Swedish funding also covered a range of general medications in a number of the roadside centres.

Sweden provided additional funding for the Walvis Bay corridor project which has now been taken over by Namibians. Sweden contributed directly to activities that resulted in a reduction of HIV and STI prevalence in the Trucking industry. From 2002 to end 2012, CEP/Trucking Wellness claims the following high level outcomes

- 219,360 patients visited their Wellness centres
- Over 67,000 STIs treated
- saw a reduction STIs in target populations from 44% in 2002 to 19% in 2011
- Initiated 1800 people on ART
- Monitoring CD4 counts for at least 2000 others not yet on ART
- HIV prevalence lowering in the industry – currently around 11%
- Distributed around 15million condoms over the period
- A draft policy doc for use by the industry (available on website)

Dialogue with SANAC about the high risk populations of truck drivers and sex workers

- Industry partners have taken over direct funding of a number of the wellness centres and/or support wellness centres through support for drugs supply
- Practical Approach to Lung Health and HIV/AIDS in South Africa (PALSA+) and TB/HIV integrated treatment initiated in CEP clinics in 2012/13.

Challenges and limitations

CEP has driven this roll out in South Africa. There is a relatively conflictual relationship with North Star Alliance which currently operates primarily in other African countries. It appears that this is due to a combination of personal differences

and funding histories. Both organisations are looking at the whole southern African territory. Unless productive dialogue and cooperation takes place, this will mean a risk of duplicated services, patients registered on both systems and hence a potential waste of resources, as well as an under-coverage of less densely trafficked areas.

At the mobile clinics, balancing wellness and expected deliverable outputs is an on-going challenge as employee performance is linked to outputs. The primary health care nurse from EC mobile clinic said that:

Although there is a good IT tracking and management system, when it fails or the system is down, it impacts directly on services. This system is not always well understood as at times incorrect information can be fed into it. Our finger-print system is a good system but if a new employee feeds the system incorrectly it hampers the follow up report at another centre.

Relevance and sustainability

While much of the Trucking Wellness infrastructure is owned by the Bargaining Council, the management of the project has been CEP's responsibility. Assets have not been maintained or upgraded as often as they ideally should have been.

In addition, a medical insurance financed through 1% from drivers' salaries and 1% from the employers covers referrals to private doctor to initiate ARTs and provision by postal/delivery service monthly ART supply as well as other general health services. The Wellness centres ensure initiation, and ongoing support. Some clinics are funded by truck stop or trucking companies or motor industry partners. Their funds cover general drugs and STI drugs, CD4kits and equipment.

Securing long-term funding for the coordinating management structure of CEP would be necessary, as this function is one which can often be 'hidden' from view when a physical service is provided as well. The role includes strategic visioning, stakeholder management, staff and system management and supervision, and resource mobilisation for services and equipment/drug stocks. According to Tertius Myburg, CEP's CEO, Swedish funding leaving will

take the heart out of the coordination and management of CEP. The Bargaining council is currently 'in a mess' and so is not focussing on this aspect at all, not enough units are fully sponsored, and there is clearly a job to do on an ongoing basis in terms of managing staff, engaging with industry and securing and maintaining buy-in to the project, fundraising, and strategic thinking for the Trucking wellness programme as a whole.

However, sustainability is a possibility if CEP can persuade companies in the industry to take on the full support of all aspects of the service provided as well as the central management and supervision function currently funded through Sweden. However, CEP core funding will still probably be a requirement for a number of years. The Bargaining Council CEO stated its ongoing commitment to Trucking Wellness:

We are responsible for the clinic staff who are providing the service, and we know that the industry needs this service. We cannot possibly lose all of the good

work done over the past 10 years. Also, many of the small trucking companies absolutely rely on the clinics to monitor their drivers' health.

The industry would be committed – but we do need a phase out plan so that we can manage the transition – possibly 3 years?

The Bargaining Council believes the industry would happily support expansion of Trucking Wellness into the region, as many South African drivers frequent those routes. The industry is also well aware that addressing the epidemic in one country is not a sufficient response.

9.4.6 AIDS Foundation of South Africa (AFSA)

Funding amount and time

SEK 28,180,356 between 2004/5 and 2013

These figures represent core operational and programme management costs (ie all costs that are not direct grants)

Purpose

AFSA was established in 1988 in Cape Town as a conduit for distributing money to HIV programmes. In 1993 the organisation consolidated its operations in Durban. The organisation aimed to provide funding for organisations working at community level. These organisations often had no funding history, and the grant making was therefore at risk, but this was mitigated through disbursement of grants on a monthly basis. AFSA provided the Treatment Action Campaign with its first ever grant in 1999. Sweden supported AFSA from 2004 and AFSA's approach to building from the ground up fitted well with the Swedish strategy. The CBO partners are small organisations located within target communities and who operate with an average annual budget of R500,000 or below. Over the last 20 years, AFSA has supported between 18 and 20 CBOs. According to their 2010/2011 annual report the organisation was managing 11 grants, supported and mentored 64 CBOs and 11 NGOs. The AFSA suite of offerings includes technical support, capacity building, developing financial systems, governance assistance, and raising funds.

Sweden's support has been in the form of core funding for the organisation and grant-making funds to support CBOs, and latterly also specific NGOs. AFSA has been fairly reliant on Swedish funding for its core operating costs. For example, in 2012, Swedish funds accounted for 42% of its R13m operating costs.

Results

AFSA believes that its coherent support model to CBOs has ensured sustainability for small organisations over an extended period, and that this contributed to Sweden's confidence that AFSA could manage NGO grants successfully. When Sweden contracted its South African programme in 2008/9, AFSA took over the grant administration to Sweden's major NGOs. AFSA also managed Sweden's grant to SANAC during the six months' bridging period over 2009/10.

AFSA⁹⁵ and its CBO partner organisations made considerable progress in extending the reach and uptake of HIV prevention interventions through behaviour change communication, education and life skills training, community dialogues on issues of gender, culture, patriarchy, sexual orientation and sexual behaviours, and promoting the uptake of biomedical prevention services such as HCT, PMTCT and MMC.

AFSA asserts that it was the first organisation to link capacity building to grant making. This involved enhancing skills related to the service the grantee organisation delivered, as well as organisational management skills. AFSA has provided a grant-making service to a partnership with AIDS Consortium and Choice in Limpopo, for example, where partners provide capacity-building and AFSA its specialist skills in grant oversight.⁹⁶

Annual core funding committed for several years enabled organisations to develop multi-year strategies, to build staff capacity and structures, to establish complementary programmes such as gardens and soup kitchens which require consistency. Long-term core funding at a low level is recognised as a critical intervention and a highly effective one. Many organisations now receive programme funding from other sources in excess of their core funding from Sweden, a situation which would have been difficult to achieve without reliable core funds. The AFSA team proudly explained that:

Some of them now get money from the Lottery, from the Department of Health and the Department of Social Development. And these departments also often ask our CBOs to provide statistics for government presentations.

All CBOs interviewed reported improvements in management capacity, financial systems, policies, administrative systems, M&E and to some extent governance relations. For example, AFSA staff report that CBOs in the Northern and Eastern Cape utilise AFSA's M&E reporting tools as part of management tracking system so *that they can manage their services better to get a picture of their clients and the household issues.*

⁹⁵ Sources include AFSA annual reports, interviews with AFSA management and delivery teams, interviews with AFSA grantees in the Northern and Eastern Cape, and NGO grantees.

⁹⁶ Aids Consortium Annual Reports 2010 & 2012

It appears that the factors enabling AFSA's success in capacity building are

- basic principles, not rigid systems – AFSA ensures that systems can be adapted to the organisational setting and does not prescribe the detail;
- coaching and mentoring has been consistent, enabling training to be implemented, and has strongly encouraged (perhaps enforced) application of these principles;
- maintaining a fine line between discipline and autonomy – there are certain basic expectations to demonstrate learning implementation, after training and compliance with reporting standards have been strongly enforced. *They are strict about this.*
- Capacity building accompanied by small grants – larger grants place excessive demands on organisations and are not necessarily helpful, but a total lack of finance gives little scope for activity, organisational development or systems.

AFSA has also maintained some focus on longer-term sustainability for the CBOs. Interest earned on income has been used to refurbish kitchen equipment for some CBOs who now provide catering services as part of income generation.

The technical skills development programmes have also meant that our people are more marketable into the department of Health and Social Development.

AFSA maintained reporting standards as a measure of each CBO's ongoing capacity. As a result, in 2012 AFSA stopped funding two CBOs when they proved unable to absorb and report on funding.

The services provided by AFSA-funded organisations have also evolved over time. Initially, and particularly during the palliative phase of the epidemic, most began as home-based care providers. However, most CBOs soon recognised that there were a host of related problems that needed addressing, ranging from homework support for children, vulnerable groups, food security, access to social grants, documentation, social protection, treatment adherence, access to education, and access to the full range of basic social rights. CBOs are positioned to enable access to these services, occasionally directly, but more often through a comprehensive set of referral relationships. AFSA remained responsive to this shift, recognising that poverty alleviation and addressing human rights issues ultimately also impacted on the community's and each household's ability to deal with the burden of HIV.

AFSA initiated setting up a national forum of community care workers to lobby government to ensure payment of stipends AFSA was a member of the founding 'task team' set up to lobby and influence the NDoH with respect to their policy and practice regarding the status/role, remuneration and training for Community Health Workers in the NDoH's strategy for the re-engineering of the primary health care system. AFSA also provided funding for background research & the hosting of a National Symposium bringing together people from NGOs, CBOs, provincial government departments, the NDoH and SANAC to discuss these issues and chart a way forward. A key intention was to contribute the voice of the CBOs to the national understanding of the important role and service these small organisations provide at community level. AFSA-supported CBOs have been able to engage and work across community needs:

- Alerting AFSA about interrupted government drug/other supplies (e.g. HBC kits).
- Through Early Childhood Development work identifying at-risk children and engaging the Department of Social Development to provide OVC support.
- Providing a physical space for departments to provide occasional services (e.g. Social Development, Home Affairs, Health)

From the level of AFSA head office, the organisation has been able to support these initiatives by, inter alia connecting CBOs with TAC, connecting the Community Care Worker network with the Sukuma Sakhe Campaign⁹⁷, and on occasion obtaining care kits via other means/ government departments to support CBO work. AFSA also works loosely with a wide range of organisations both within the HIV sector (such as Section27), but also more broadly across general human rights: for example work with Equal Education, a national NGO focussed on holding government to account in that sector; some work various children's rights organisations such as Child Welfare and Childline; and AFSA refers cases to the Commission for Gender Equality.

The table below gives some indication of the efficiencies achieved in the Swedish contribution to AFSA grant making. The table indicates the number of beneficiaries reached by CBO services and shows an approximate SEK cost per beneficiary to Eastern and Northern Cape CBOs.⁹⁸

	2006/7	2008/9	20010/11	20011/12
Total N° AFSA supported CBOs	50	74	64	77
Approx N° CBOs E & N Cape	23	23	25	23
Swedish contribution to grant funding (SEK)	328 602	12 566 517	17 273 330	12 071 708
Swedish contribution as % of total grants paid by AFSA (to CBOs and NGOs)	3%	45%	48%	44%
Swedish funding to NGOs approx 64% of AFSA NGO grant funding		5 734 400	10 240 000	7 616 000
Funding to CBOs averaged 44% of Swedish's total grant funds (SEK)	328 602	6 832 117	7 033 330	4 455 708
Beneficiaries reached by all CBOs ⁹⁹	54 000	163 045	174 534	200 470
Average N° beneficiaries per CBO	1 080	2 203	2 727	2 604
Average N° beneficiaries per E & N Cape CBO	24 840	50 676	68 177	59 881
Average SEK cost per beneficiary of E & N Cape CBOs	13.23	134.82	103.16	74.41

⁹⁷ Operation Sukuma Sakhe is KZN province's flagship programme in the war against poverty and supports the delivery of services through partnership with community, stakeholders and government.

⁹⁸ These figures are broad estimates based on information in the relevant AFSA Annual Reports. All Rand amounts in these reports were converted to SEK.

⁹⁹ All those supported through funds from AFSA

Challenges and opportunities

In recent years funding disbursement rules from Sweden have caused cash flow crunches in the first quarter of each year. Sweden's financial year ends in December and the programme audit takes three months. The first tranche of annual funds is therefore only available after audit approval (March/April). AFSA has been able to support CBOs out of its reserves with some bridging finance over this period, but this can hamstring operations. CBOs found that despite attempts at bridging, salaries were interrupted for up to four months, severely impacting on staff and volunteer livelihoods, and programme activities were suspended on occasion.

In an attempt to ensure HIV mainstreaming, effective communication and ongoing service delivery from provincial to community level, AFSA established Memoranda of Understandings with the Eastern and Northern Cape Provincial governments, provinces where AFSA supported a number of CBOs, but, the ongoing difficulty in meeting with provincial government officials has made these MOUs ineffective.

AFSA staff were clear about where and how CBOs could influence – at community level, and to a limited extent upwards into local government and very occasionally into the provincial level. However, the largely dysfunctional Provincial and District Aids Councils meant these could not provide a coordinating forum for the local CBOs, and even local municipal managers and Integrated Development Plans (IDP) managers were unresponsive. CBO influence was therefore limited to placing pressure on local service providers to meet community needs, such as ensuring that clinic management was aware of drug supply interruptions, or that the Department of Home Affairs remained up-to-date with documentation.

After several years of engagement it seems that the AFSA curriculum could be more progressive. There was some experience of the training becoming repetitive with only minor adjustments, and that evolving content and a smaller proportion of revision could allow for interest to be held in the long term. A review of the training curriculum taking long-term engagement into account might be useful.

While AFSA has been effective in its downward focussed model-building and support to CBOs, it has only offered this service to a small selection of partners. Considerable impact has been achieved in these areas. In order to have impact beyond this group of beneficiary organisations, and their clients, AFSA, and related umbrella organisations have an opportunity for clear upward communication and continued and intensified collaboration with peers. A similar comment was made in AFSA's 2010 organisational evaluation:

AFSA could work more effectively with its strategic partners to both ensure that they have access to learning acquired through the AFSA processes to support their lobbying and advocacy work as well as to complement the work that AFSA is doing in communities....[and] AFSA needs to build on and enhance its networking capacity at a national government level, in order to have a greater influence on policy and practice. It appears that certain board members could be more effectively utilised in this regard, and a more structured role for them should be considered.

It did not appear that this upward and consolidating work has received the focus it might have. This was a missed opportunity for AFSA to coordinate networks (amongst AFSA partners at CBO & NGO levels) and cascade capacity building to strengthening provincial structures and integrated interventions while giving a voice for CBOs.

Relevance and sustainability

Most organisations sampled were entirely positive about AFSA's role and felt that the capacity building, coaching and mentoring had been valuable. They felt that they had grown substantially in their relationship with AFSA, and some had gained confidence and capacity for resource mobilisation and internal management, ensuring their sustainability beyond the AFSA relationship. The training style was considered excellent by most, and coaching and direct support were even more valuable.

While AFSA offers highly relevant training in governance, financial management, Human Resources management, for example, many of the sampled organisations have organisational issues which are not addressed by training. There is some support through the coaching to address these issues, and the advice given has been useful. A more intensive organisational development stream of self-assessment and organisation-driven organisational growth might further enhance an already excellent capacity building programme. While the role of coach and mentor implies a level of strong oversight and permission to demand, there is a risk that this relationship is not mutually consented, and that the threat of dropping the grant is used to ensure compliance. Clearly stating the level of participation that is expected as a condition of funding is a wise decision, but there might be some scope for coaching contracts.

AFSA acting as grant maker for larger NGOs after 2009 also resulted in some positive gains for these organisations, although they required much less support than CBOs. Improvements were primarily in the areas of governance and internal financial controls. This positive result was confirmed by Sonke Gender Justice and Section27.

9.4.7 CBO grantees supported by AFSA

A total of SEK 57,434,614 in grant funding flowed through AFSA to 43 organisations between 2005 and 2013.

The analysis below is a discussion that combines the findings from all of the CBOs visited in this evaluation. A sample of CBOs funded over the decade from the Eastern Cape and Northern Cape were interviewed. Where an issue is organisation or province-specific, this is mentioned. Since only a small sample of CBOs was visited, observations cannot be extrapolated as true among CBOs in general, but this section does provide a picture of the extent and range of CBO activities, as well as the extent to which these organisations are embedded within their communities, and, as a result, their immediate and extensive impact on the lives of ordinary South Africans.

Results

Every community needs one

CBOs are the foot soldiers who know what occurs within their communities. They try to respond to community needs through door-to-door household needs and situational analysis, to identify and address a range of rights and access issues.

CBOs visited were seen to be effective in facilitating integrated, comprehensive access to services. They provided relatively few services directly, but acted as a critical interface between public services, rights and people in need. They achieve household-level impact through diverse interventions from community dialogues, engagement with schools and churches, to one-on-one conversations in the privacy of people's homes. The main areas addressed have been:

- Primary Health Education & HIV Prevention
- Home Based Care, Nursing & Counselling
- Support for Orphaned & Vulnerable Children
- Food security & income generation activities
- Social Security Grants
- TB DOTS (medicine for TB)
- Patients assisted to access ART.

These organisations approach the problems in each household from the perspective of need, rather than from a focus on a service or a sector. This holistic approach of integrated social needs-based referral sets local CBOs apart from any government agency and from larger NGOs. Whether the immediate limit to well-being in a household is documentation, food security, health issues, youth and education, abuse or social crime, including gender-based violence, drugs or alcohol abuse, the impact of HIV or TB, orphan or other forms of child vulnerability, the CBO is equipped to draw in the most immediately relevant support from the range of locally available services. Their proactive access to departments of home affairs, justice, agriculture and social security, local clinics, social workers, and police ensures that the various urgent and longer-term needs of households can be addressed. Partnership with government and complementary projects from any source are a key resource for these organisations.

CBOs sampled are reasonably certain that they have identified every needy household within their catchment. This approach ensures that those who may otherwise be excluded, particularly the disabled, youth, the elderly or abused women, as examples, are actively identified and comprehensively supported. CBOs are less likely to see households as cases that are opened and then closed, and are more likely to retain a monitoring presence after the initial household challenges are solved. Most CBOs keep a formal (some a more informal) register of households enabling follow-up and continuity of services.

Networks and referrals

All CBOs described how their key resource for ensuring benefits to their clients is a network of partnerships with complementary local CBO's, NGO's, projects, local councillors and government departments. Direct services might include lay counselling and advice, some food support, home-based care and treatment adherence

support, accompaniment for referral and some after-school care, all integrated with continuous social assessment and HIV/TB prevention messages.

Further impact is achieved through referral and referral follow-up. Mutual referral relationships include, but are not limited to, social work services, clinics, schools, Home Affairs for registration & death documents, police, tribal authorities and local council for housing related services and Department of Agriculture for gardening support services.

Relationships with umbrella agencies

CBOs reported how support from AFSA (or AIDS Consortium in Gauteng and Limpopo) greatly enhances their effectiveness. Umbrella agencies provide direction and context, technical skills and administrative systems or tools, facilitated planning, mentorship through organisational decisions. They also provide a local network of similar organisations, enabling shared experience and motivation. Finally, and crucially, umbrella agencies enable the voice of community organisations and their clients to be represented outside of communities, and input platforms of policy makers and service implementation monitors. Umbrella agencies are discussed in detail elsewhere in this report.

Upward influence: Advocacy

CBO influence was found to be most effective at a local level. Organisations are able to confront the quality of service at their clinic or the number of social workers serving their community, for example, and some have managed to achieve improvements in staffing, provision of mobile clinics to rural areas and drug supply.

Beyond their immediate network, the normal constructive channels for upward advocacy from the local level would be through Local and District AIDS Councils. These were inactive in all of the sampled communities in the Northern Cape, and not effective for the sampled areas of the Eastern Cape. Where AIDS Councils do convene, CBOs tend to feel intimidated in the formalised settings in which they generally function, and few have the presence or confidence to articulate their point clearly. And finally, in AIDS Councils or any other setting, CBOs value their referral relationships and stipends, and fear victimisation.

Prevention messaging – some successes

In the Eastern Cape CBOs sampled, HIV prevention intervention was the core service provided. Prevention campaigns include condom distribution, public awareness rallies, community dialogues and a range of youth sexual behaviour change interventions. CBO's have focussed their HIV prevention messaging on traditional Abstinence, Be faithful, Condomise (ABC) approaches amongst youth. In the Northern Cape sample, HIV prevention includes continuous mention of safe sex in campaign messages and outreach, and some condom distribution. However, intensive public awareness campaigns and aggressive marketing of safe behaviour are no longer a major programme focus.

The dialogues around MMC are yielding positive outcomes. Through a health lens, a safe space for sensitive dialogue is provided, while meeting community social concerns around boy-child deaths at traditional circumcision schools. Women use the

MMC discussion space to influence male sexual health, increase knowledge and communication on this highly sensitive topic and open dialogue with traditionalists.¹⁰⁰

Creative alternatives to prevention messaging, targeting boys, men and youth in particular have already been initiated by NGOs such as Masimanyane and Field Band (see attached annexes). These interventions focus on school-going youth targeting boys and girls on rights in terms of broad human rights, including sexual and reproductive rights.

Masculinity and gender are seen as core holistic issues that contribute towards prevention of not only HIV, but gender perceptions of self and others and gender-based violence. More holistic communication and life skills approaches have strengthened views and behaviours around sexual rights, safer place, reduction of abuse and violence.

Challenges and opportunities

A weakness in CBO effectiveness is the fact that their work tends to attract primarily women and school-age children, although across a wide selection of households. More girls than boys attend after school groups, youth with disciplinary or behavioural issues are less likely to be reached, and homes in which problems are hidden are more difficult to visit. Men are less interested in the strongly female-centred approaches of most CBOs. The effectiveness of ensuring access to services is also limited by the quality and availability of those services. Health facility problems, such as drug stock-outs, are a regular frustration. A lack of sufficient social workers to take action on cases of child protection is also a common challenge.

Most organisations accept that their members will find ‘greener pastures’, and see this as acceptable. CBOs were all able to cite examples of staff and volunteers who had gone on to find formal employment. Few, however, explicitly acknowledge their role in building the skills and creating opportunities for personal growth and development, particularly for women.¹⁰¹

CBOs described a lack of access to achieving meetings or contacts with local municipalities, district sector departments, or Integrated Development Plan consultation process. None of the organisations sampled saw this as an effective use of their energy. CBOs in this sample are therefore largely weak in representing their constituency into an advocacy space. They are very cautious of criticising beyond their local service providers. This caution is justified since active advocacy is seen as

¹⁰⁰ 30 died during one month, *EC News* July 8, 2013

¹⁰¹ Konstant, T.L. (2010) Towards principles and practice of participatory development evaluation for community based organisations PhD Thesis, University of Pretoria

‘biting the hand that feeds’ and stipends are indeed threatened by vocal objections. This is, for now, the reality of local (and indeed, provincial) politics. These legitimate challenges link to a separate (unfortunately) development sphere under the theme of Good Governance, which promotes support for citizen representation and transparent, accessible or effective local government.

As a result, there is no evidence of influence over policy or precedent-setting activism from local CBOs, nor does their current position in the fabric or approach suggest that they are likely to be able to influence policy from the ground in the future. The Dinokeng analysis tells us how South Africa’s current scenario includes a weakened, voiceless, ineffective civil society in terms of its role as representative of the citizens and a voice of the people. In the case of CBOs, this is certainly the case. Their role is essentially as extension workers or a sub-branch of government. Seen as the interface between services and society, and coming from and of society, these CBOs are not where real civil society takes place, and neither can they be. In the absence of mechanisms for CBO coordination, protection and representation, upward influence is not achieved.

Local CBOs acknowledged facing a huge challenge with regards tangible HIV prevention outcomes. Although different modalities have been applied these have failed to yield expected sexual risk behaviour results. CBOs in both provinces report that new infections and teenage pregnancy are common-place with more than 45 000 teenage pregnancies in any one year.¹⁰² Engagement may be stale, with familiar messages delivered in traditional ways to the same audiences no longer attracting interest.

Effective prevention is part of a far more complex, holistic and personal setting than simply ensuring safe sexual behaviour and provision of condoms. Family planning is balanced against opportunities for social grants within a poverty stricken community, and peer pressure, lifestyle, a hope that becoming dependent on an employed man might provide for family, as well as low self-esteem and low power in sexual interactions, are all contributing social factors in a reality for teenage girls. A steady increase in HIV¹⁰³ is being experienced, with little evidence of outcomes in prevention messaging. A lay counsellor/peer educator in the Eastern Cape said:

Distribution of condoms does not mean safe sex instead school children use condoms for socks and hair pony tail and female condom are scarce at clinic.

¹⁰² Teenage pregnancies/HIV prevention – doctors help fill official hiatus, 2012. *South African Medical Journal* 102(8)

¹⁰³ 2010 national trends highlighted 30.2% HIV prevalence with EC at 29% although NC was the lowest at 18.4% it had highest syphilis rate (DoH Antenatal HIV survey 2010)

Prevention efforts are undertaken in a context of severe poverty, patriarchy supported by social institutions, both cultural and religious, and violence against women. Young girls have little power in an environment where transactional sex, the sugar-daddy syndrome, forced marriage ‘ukuthwala’ (a cultural practice of forced marriages of young girls, usually to older men) are accepted.

CBOs also reported the impact of labour migration, particularly among men, due to the high rate of unemployment in the province¹⁰⁴. Absent fathers leave the task of role modelling with older, and often more traditional, men in a community. Migration also impacts on treatment continuity and adherence monitoring, and many ART clients are lost to follow-up.

Even more challenging, with much greater impact on HIV new infection rate, is a rapid expansion in new mining or construction ventures in several of the communities visited in the Northern Cape. Mining investments (and presumably also other industries) cause an influx of non-resident men in order to import skills where employability among local residents is inadequate.

These mobile men constitute a critical key population driving new infections. Contractors, sometimes in their hundreds for large investments, created a massive and sudden demand for recreational sex – a demand that is being met by school-age youth as young as 12. With sudden changes in migrant demographics, there is no acknowledged formal sex work presence, and children and youth are fulfilling this role in exchange for sugar-daddy type favours (luxuries, status, cash and technology). HIV incidence and teenage pregnancy, as well as alcohol abuse and loss of parental influence are serious social impacts of these towns.

Relevance and sustainability

There is no doubt that the CBOs visited in this evaluation play a critical and valued role in their communities, and it is not clear whether this fluid and evolutionary role could be replicated by any one or more government services. Research and advocacy are required to fully describe and acknowledge the role of CBOs in training and confidence building opportunities where under-education is a given. Umbrella agencies have a role in providing practical direction for leveraging this initiative by promoting CBOs as training and skills-development centres for the purposes of the broader development agenda.

To varying extents the organisations sampled all actively pursue relationships and are resourceful in placing their clients in contact with the resources they need to improve

¹⁰⁴ The Eastern Cape Province’s unemployment rate has always been above South Africa’s rate ranging from a minimum of 25.2 to a maximum of 28.4 %. - EC Economic Outlook 2010, p43, available from www.dedea.gov.za

their situation. For example, orchestrated visits by Departments of Agriculture and Home Affairs are actively organised by CBOs, contact with clinics, social workers and police is more effective with a trusting relationship between CBOs and these providers.

CBOs are highly effective as access extension workers because of their multi-sectoral perspective and network of relationships; an organisational structure which enables supervision, planning, debriefing and motivation; their integration into the community and the power of their local networks. These three qualities alone confer uniqueness, and provide an institutional layer that cannot be replicated by government.

9.4.8 Zivikele Training

Funding amount and time

SEK 32,880,000 between 2006 and 2013

Purpose

Zivikele Training was established in 2006 in response to the founders' increasing awareness of the poor response victims GBVs received from the structures, systems and personnel in the public service. The organisation set out to build the capacity of public servants and enable them to respond appropriately to victims and survivors of GBV. The hoped for result in working with care workers, police, and legal professionals was to enable women, men and children to access their constitutional rights through appropriate administrative and judicial action.

Zivikele works through partner trainers and training organisations. Individuals targeted for training include anyone who may be faced with GBV-related community challenges, including community members, CBOs, volunteers, community and traditional leaders, and individuals employed by SAPS and other government departments that deal with GBV. Zivikele offers GBV training through its providers in all nine provinces, and also engages with political leadership in government, traditional leaders and FBOs. A 2008 evaluation described Zivikele training as encouraging those employed in the different areas of government to connect and collaborate and to reduce information gaps on GBV, HIV /AIDS and victim support.

Results

Zivikele's approach is based on standards prescribed by the World Health Organisation, but is supplemented extensively, often through the expertise and experience of the trainers. Zivikele's training courses have recently been formally accredited which means participants must now demonstrate proof of competence and these results are registered with SAQA.

Originally, Zivikele worked primarily at community level. However, the organisation recently moved focus to include influencing parliamentary structures in an attempt to make this cohort of people become more representative and responsive to GBV issues in their constituencies. The organisation believes this approach merges top-down with bottom-up approaches, and encourages accountability. Eighteen months into their parliamentary project, Zivikele believes they are making progress:

We believe our dialogue processes resulted in the President mentioning GBV in his state of the nation address. Our parliamentary oversight and monitoring tool is also helping parliamentarians, and particularly the House of Traditional Leaders, to bring GBV issues onto their agendas.

Ms Virginia Carmelio-Benjamin volunteered for victim support centre when she participated in Zivikele's Humansdorp training. She is now Eastern Cape ANC whip. She described how the training helped her to discuss and deal with own experiences, and that now as a political leader she applies the skills gained in her work in the public office – she does this by creating space and environment to deal with critical and sensitive issues within her constituency.

Specific achievements noted by the coordinators of Zivikele include:

- Contributed to revisions to the Sexual Offences Act of 2007
- Produced a parliamentary oversight tool
- Accreditation of training materials
- Development of a web-based mapping tool which will eventually list all relevant local services that can support victims of GBV. 17 out of 57 identified districts have been mapped, and the aim is to eventually cover South Africa, Botswana, Swaziland and Lesotho.
- 26 victim support centres set up in police stations across the country – after police staff attended GBV training
- Work in multiple districts and across districts helping training delegates work out how they will cooperate
- Negotiated an agreement with Netcare (a large private service provider). Netcare now provides approved services to rape victims at all of their hospitals.
- Work with members of the House of Traditional Leaders: *They are now calling for the 'renaming' of headmen because a number of these people are now women!*
- Assistance to Mozambique colleagues to complete drafting of their Domestic Violence Act.

Feedback from a Warrant Officer in the KZN SAPS training division police showed that there was a better understanding of health processes as part of forensic and victim support:

Training broadened and shaped my linear thinking around forensic and management of GBV issues through the health perspective.

Other achievements noted include advocacy work with diverse stakeholders such as traditional leaders from Mojadji's Kloof, and people involved in KZN GBV networking structures. A 2010 Mid term review indicated that direct training reached 450 people in different events through a national network of service providers, trainers and subject experts. Police training participants apparently have increased awareness about the importance of correct forensic evidence gathering and the provision of comprehensive response, care and counselling to victims of HIV/AIDS

and GBV. Zivikele also reports facilitating inter-sectoral planning and the establishment of GBV forums in communities in the Eastern and Western Cape.¹⁰⁵

Challenges and opportunities

Although there were partnerships with other relevant stakeholders such as academic institutions (University South Africa, University of Pretoria and University of Durban Westville/ UKZN), the fact that the training materials were not accredited until recently with a Sector Education & Training Authority (SETA) has been an obstacle. However, accreditation was recently achieved, which opens the way for a more sustainable revenue model.

Advocacy is a major aim for Zivikele, but the effectiveness of advocacy interventions have not been verified.¹⁰⁶ Only one participant mentioned this training as adding value to her current job mapping hotspots and working with stakeholders in the establishment of a victim support centre.¹⁰⁷

Zivikele admits that it has not instituted monitoring and evaluation or tracking of impact.

We don't have M&E. We only know about impact if the communities tell us. But one Member of Parliament is doing things about GBV in his constituency. And in Beaufort West the local council has established a post to deal with gender issues, and it has a budget.

Relevance and sustainability

Over time Zivikele has moved from focussing mainly on empowering a broad range of public sector officials, to influencing key decision makers and thought leaders.

Some participants were interviewed. All had received training 5-6 years ago, but said that they still recalled and used the information, which does point to some impact.

One participant was a volunteer when she was trained, but now applies the skills gained in her current job in public office. In another case, a traditional leader¹⁰⁸ highlighted how he has helped community stakeholders to understand GBV, and he advises the traditional authority on GBV cases reported. Zivikele argues that working with constituency representatives in parliament has helped align GBV issues into Integrated Development Plans (IDP) at local Municipalities.

¹⁰⁵ The evaluators were not able to contact any of those involved in these forums, so cannot comment on impact.

¹⁰⁶ Mid Term Review Zivikele Training Programme. Dec 2010, p20

¹⁰⁷ Hankey, social service office manager, Department for Social Development

¹⁰⁸ Prince Mahlangu is the secretary general for Congress of Traditional Leaders of South Africa (Contralesa) for Mpumalanga House of Traditional Leaders

Sweden provided Zivikele with core funding. In order to move to a more sustainable financial model, Zivikele has begun to provide training on a fee-for service basis. The organisation recognises that extensive marketing is required, but they are confident that they have sufficient evidence of success, as well as credibility amongst relevant key stakeholders such as the KZN police commissioner and various parliamentarians.

However, while there are anecdotal accounts of impact at individual level, the evaluators were not able to find evidence of sustained impact as a result of the training courses within the practices of the various public service institutions supported. Also, the parliamentary monitoring tool may still need more time for its impact to be realised.

9.4.9 Sonke Gender Justice

Funding amount and time

SEK 5 600 000 between 2009 and 2013

Purpose

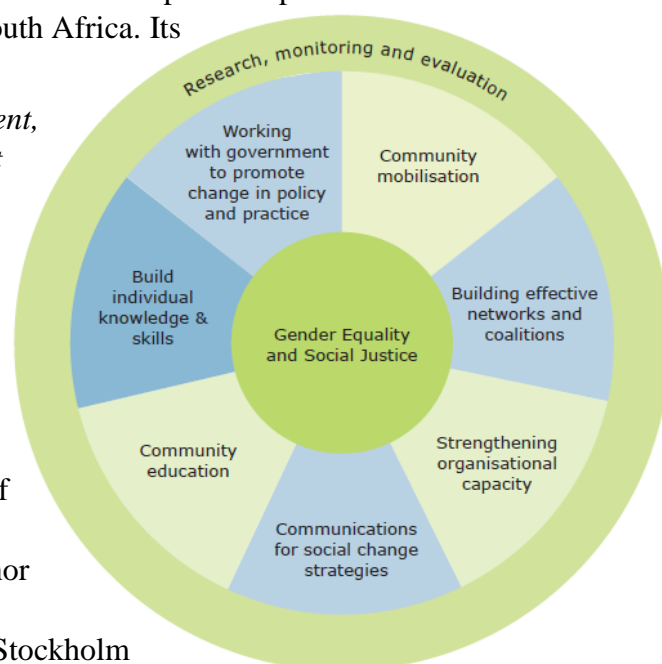
Sonke Gender Justice was established in August 2006 in response to pervasive and devastating male violence against women in South Africa. Its mission is to

Work across Africa to strengthen government, civil society and citizen capacity to support men and boys to take action to promote gender equality, prevent domestic and sexual violence, and reduce the spread and impact of HIV/AIDS.

Sonke has grown rapidly to provide a skilled and well thought-out response to the niche sector of working with men in issues of gender equity. With few equivalent NGOs, and none of its scale, geographic reach or calibre in South Africa, Sonke has attracted rapid growth in donor funding. Sweden funds Sonke through various channels, from the South African, Lusaka and Stockholm offices. Two Swedish grants were explored in this evaluation. First, Sweden provided SEK 3,5m in core funding to the organisation between 2009 and 2011. Second, SEK 3m was allocated to support a project known as MenCare, a Partner Driven Collaboration (PDC) between Sonke Gender Justice and a Swedish network organisation called Men for Gender Justice (MFJ).

Sonke leadership regard Sweden as a ‘visionary donor and a great partner’, because it remained committed to supporting the involvement of men and boys in gender issues and responses to HIV/AIDS. Sonke leads and participates in several influential global campaigns around male participation in gender equity.

Sonke’s engagement with its target audience is through a broad range of change strategies shown on the spectrum of change circle alongside.



Sida enabled us to work effectively as a global co-chair of MenEngage¹⁰⁹ Alliance. The Southern African chapter exists because of Sida... [this] work increased visibility and strengths of regional partners and country-level organisations.

Results

Sonke clearly filled a specific need within the CSO arena. By 2009, when the organisation was only two years old, it had grown to comprise a staff of 40 and by 2012, the organisation had 70 staff across three offices in Johannesburg, Cape Town and Bushbuckridge. Swedish funding contributed to core operations for three years, enabling some critical national advocacy and legal challenges, community level engagements and mobilisation. Sweden's contribution at first represented a significant portion and then far less of the total Sonke operating costs. However, the relationship with Sweden opened the door for Sonke to access significant funds (around SEK24m) from Sida's Regional and Global budgets. Between 2009 and 2011, Sonke reported, among many others, the following key results:

- Participation as experts in the development of the Operational plan for UNAIDS Action Framework: Addressing Women, Girls, Gender Equality and HIV.
- Production of digital stories produced by One Man Can participants from three rural areas, which encouraged open discussions about men disclosing HIV status and seeking support.
- In 2009, taking Julius Malema, President of the ANC Youth League, to the Equality Court over statements he made about the complainant in the Jacob Zuma rape case. In 2010 the court ruled in favour of Sonke. *This generated a sustained national conversation about the roles and responsibilities of men in positions of leadership and their willingness to act on their public commitments to advancing gender equality¹¹⁰.* And in 2011, challenging the appointment of Judge Mogoeng Mogoeng to the office of Chief Justice because of *his appalling track record on women's rights in general and the rights of rape survivors in particular. This advocacy generated very significant print, radio and television coverage of Sonke's efforts[to get men in positions of public leadership to demonstrate commitment to women's rights].¹¹¹*
- Taking on in 2010 the role of Global Co-Chair of the MenEngage Alliance, and participating in the UN Commission on the Status of Women's Beijing Plus 15 Review
- Maintaining a strong messaging presence at all 2010 Soccer World Cup fan parks, distributing condoms, performing ambush theatre and conducting

¹⁰⁹ Global alliance of 400 NGOs and UN agencies engaging men and boys on issues of gender equality.

¹¹⁰ Sonke Gender Justice Network Annual Report 2009/10

¹¹¹ Sonke Gender Justice Network Annual Report 2011/12

dialogues, as well as working with Grassroots Soccer and Matchboxology on the Red Card Campaign against sexual exploitation.

- Research into the impact of One Man Can activities, which showed ...*links between OMC and increased HIV testing, increased condom use, reduction in the number of partners and increase in intervention in situations of violence between men and women.*
- From April 2010 training radio presenters and flighting radio episodes of Sonke's Digital Stories, as well as weekly radio on-air discussions on topics such as HIV testing, peer pressure and stigma. A number of local municipalities showed strong support for the initiatives. Radio stations include both local community stations and two national stations.
- Launching of the Gugulethu Wellness Centres piloting approaches to increase men's use of HIV services including testing and treatment, in order to better take care of the own, partner's and family's health.
- Work with SANAC to ensure the 2012-15 NSP included clear language on gender equality and the need to engage men and boys.

In the MenCare project, Sonke has adopted the essential principles of MFJ's programme, of viewing fatherhood as a valuable entry point for the concrete and practical involvement of men in gender equity. Gender equitable fatherhood is rationalised to be *good for children, women and men since it improves maternal and child health, and prevents violence.* The MFJ model facilitates father groups for expectant and new fathers, which discuss pregnancy, birth and infancy, and parents' roles in this time. This concept requires considerable adaptation in an African context, where cultural norms, workplace policies and traditional roles are completely different from those of a northern European setting. Nevertheless the essential principle and sharing of ideas has been valuable, and the fathers' group project has been launched. Specific project objectives are outlined in the 2011/12 Annual Report:

Objective 1: To reduce reported levels of gender-based and household violence in four communities in Southern Africa by involving fathers from each community in expectant fathers' groups and the MenCare campaign.

Objective 2: To present a research based policy brief about gender equitable parenting policies to policy makers from South Africa, Botswana and Namibia.

Objective 3: To improve the effectiveness of gender equality programmes, especially those promoting involved fatherhood, implemented by four organisations in South Africa, Botswana and Namibia.

Under Sida's principles of Partner Driven Cooperation (PDC), the interventions also contribute to the development of both organisations, and the wider network with which the organisations work, especially member organisations of the MenEngage Alliance.

Objective 1: Fathers' groups

By the end of 2012 Sonke had developed a strong working relationship with collaboration partners, subcontracting the formation of fathers' groups to three organisations in South Africa, Botswana and Namibia, as well as directly facilitating experimental fathers' groups through its own programming. Partners were FAMSA

Western Cape in Cape Town, South Africa, Lifeline Childline in Windhoek, Namibia and Stepping Stones International in Gaborone, Botswana.

All partners then established relationships with local clinics in order to host fathers' groups through their antenatal functions. Partnership with a clinic involves sharing the model, concepts and demonstration with health professionals, in order to enhance sustainability.

Materials were developed, a poster series designed, 29 facilitators across all project sites were trained in 2012. The partners began to introduce fathers' groups and ideas of gender equitable parenting to potential group participants.

Four radio stations already working with Sonke have received new material and have begun to air shows supporting gender equitable parenting. In 2012 members of the MenCare team also contributed to, or were guests on, 17 radio shows related to gender equitable fatherhood.

All four project units launched fathers' groups, learned the key areas for adaptation in an African context and the particular needs of participants in their constituency communities. All four units successfully convened fathers' groups, some of which had achieved the goal of regular participation and meaningful shifts in participants' attitudes, assumptions and reported behaviour.

Through focus groups conducted with absent fathers, Sonke-MfJ learned that young, absent fathers are often intimidated by the idea that they have to become material providers and that this leads to them avoiding their parenting responsibilities. However, these fathers reported that it was a relief to learn that they can contribute in other ways than financially, and it was useful for Sonke and MfJ to discover that it is possible for fathers to make this change.

A key outcome has been a set of lessons learned, modalities and ideas to share with the MoH as a means of implementing its NSP imperative for greater involvement of men. Sonke has begun to engage with DoH for clinics to begin to take initiative in experimentation with fathers' groups and men's involvement in antenatal and post natal care.

Objective 2 – Policy influence

Sonke made one of the most complete and comprehensive submissions to the Department of Social Development White Paper on Families through formal public consultation processes. Significant sections of Sonke's submission were used in the drafting of the paper, such as the inclusion of a commitment by the Department of Social Development to explore the viability of paternity leave in South Africa. Sonke, and later MfJ, were also consequently invited to join the drafting task team on the implementation plan for the White Paper.

The White Paper sets greater involvement of fathers in child care and families as one of its key tenets. The MenCare programme, provides the practical tools, models and tested experience to provide to the public sector in order to achieve this objective. Interest has already been expressed by the Departments of Health and Social Development in adoption of the fathers' group concept.

The Director of maternal health and HIV prevention in the Western Cape Department of Health called the project a 'godsend' and supported presentations at the district level. She has allowed Sonke-MfJ to communicate her support to the districts with a bottom-up (from clinic level) and top-down (from provincial level) concurrent approach. She views the current MenCare programme as a trial and would be willing to recommend scaling up the project to a national level when she sees successful results.

The most important opportunity for sustainability and meaningful impact lies in the adoption of aspects of the model by the Ministries of Health in the three countries.

Objective 3: Complementarity with other Sonke programmes, and capacity building for all partner organisations

Sonke learned about MfJ materials and adapted the approach to be more process oriented for Southern Africa.

MenCare has been strongly mutually complementary with the already established Sonke One Man Can (OMC) Campaign, through sharing of material and perspectives for workshops intended to shift men's beliefs and practices associated with masculinity, fatherhood, and parenting. OMC engages with men in a range of settings, beyond the clinic-based fathers' groups.

Far from revealing a static notion of all men as distant, uncaring, or uninvolved parents, the literature in South Africa shows that masculinities are in flux, allowing for the positive roles that men play as fathers and caregivers. A particularly important aspect of South Africa's history of apartheid is fathers and grandfathers lacking much experience of active fatherhood, since many of them were themselves children in absent, abusive, or emotionally void households. Many participants described significant shifts in their own fatherhood beliefs and practices due to participation in OMC.

... In addition to describing improved communication and a better quality of relationships with children, men also recognised the positive role they can play in bringing up the next generation to be citizens who are healthy, and respectful of the equal rights of all, including women and girls.

MfJ and other partners began to learn from Sonke about how fathers' groups can be incorporated into broader campaigns, for example, through the MenCare introduction. Stepping Stones International in Botswana has participated in the MenEngage Africa regional network and now regularly participates in MenEngage activities.

To capitalise on the concern many men express for the well-being of their children, Promundo and Sonke recently launched the global MenCare campaign in collaboration with the MenEngage Alliance. This campaign encourages men to become more active in the lives of their children, and includes establishing respectful, egalitarian relationships with the mothers of their children.

The MenEngage Alliance adopted the MenCare Campaign developed by Promundo and Sonke and launched it in four MenEngage regions: Africa, North America, Latin America and South Asia

MFJ was also drawn into the Sonke global network, facilitating greater inclusion of Eastern European fathers' groups in the global men's issues discourse.

MfJ and Sonke began their partnership with two different organisational backgrounds. MfJ, being much smaller and with less funds and resources is more of a 'grassroots' organisation, whilst as a NGO working in the tighter confines of the South African system, Sonke operates in a much more systematised manner. MfJ has learned about Sonke's processes while Sonke learned from MfJ's guiding principles. MfJ learned about the South African context and cultural differences on fatherhood and Sonke about Swedish parental leave policies.

Sonke provided MFJ with organisational development input towards better structuring and coordination of its National Secretariat, and reports that organisational elements have been strengthened. MFJ capacity has also increased around systems and routines in sub-granting and tender processes, and monitoring, evaluation and planning for results.

Challenges and opportunities

Sonke faces many challenges, but primarily these relate to the size of the tasks they have set themselves. In the 2011/12 Annual Report, Dean Peacock, the ED, commented:

Despite our successes, our work remains as urgent as ever. While other forms of violent crimes decreased in South Africa in 2011, the SAPS reported that the number of rape cases reported to the police increased.....many police stations do not comply with the basics of the Sexual Offences Act.....gender inequalities continue to drive very high [HIV] infection rates.....men continue to access testing and treatment later than women and drop out of care with alarming frequency, a point which researched named a blind spot in the global AIDS response as a result of the lack of attention paid to it. In short, Sonke is faced with grave challenges which require us to take our work to scale in urgent and sustainable ways.

Relevance and sustainability

Sonke focuses extensive attention on maintaining its financial sustainability and in 2012 was supported by 46 donors. The organisation has increased its engagement with corporate social investors and grants from the private sector are increasing. Sonke has also begun to generate income to increase its reserves through consultancy services and training to national and international clients.

Sonke-MfJ explicitly focussed on sustainability from the start. They emphasised with partner organisations and beneficiaries that the programme would focus on the establishment of long-term, sustainable relationships, rather than reaching a high number of people in a short period. With principles, concepts and materials developed and shared, the intention was that each partner would integrate the fathers' group idea into its normal practice.

Through Sonke's direct fathers' group projects, however, it was found that routine programming and intensive and specific demands were not conducive to parallel or

integrated fathers' group work. Fathers' group facilitators need to commit to a regular time, and provide consistency and continuity. Without a dedicated funded post, this was found to be unrealistic.

The project was always acknowledged to be too short to move beyond exploring concepts and models, and did not expect either a fully-fledged, programme of functioning fathers' groups to be established within 2 years. These models have indeed been explored, and fathers in the pilot have experienced impact in their lives. Ideas have suffused partnering organisations, and have influenced their approaches across their broader work.

Sustainability and impact will depend on adoption of aspects of the programme by the Ministries of Health and/or Social Development in the three countries involved. Progress has been made in South Africa, and the programme is likely to influence the 'Greater Involvement of Fathers' agenda.

Establishment of fully functional, scalable and properly tested and branded fathers' groups would obviously take a far longer investment period, and is an appropriate and relevant opportunities for funding agencies.

9.4.10 Field Band Foundation

Funding amount and time

SEK 6,090,000 between 2008 and 2013

Purpose

Sweden supports the life Skills programme of the Field Band Foundation.

The programme is one component of an integrated, youth-centred experience in gaining musical and band skills, in a safe, tolerant, supportive and disciplined after school programme. Its aim is stated as: To create opportunities for the development of life skills in the youth through the medium of music and dance. At the centre of the life skills programme is comprehensive HIV/Aids education.

The specific objectives of the life skills programme include:

- To provide FBF members with Life Skills that enable them to make better lifestyle choices;
- To employ a range of behaviour-change interventions to restore their dignity and delay the start of sexual activity among young adults;
- To help the FBF members to prepare their future and develop the life skills they will need to be successful in their endeavours;
- To enable the FBF members to map-out their life-path, and achieve balance between personal life, career, and other areas;
- To provide support and care of FBF members that are in social distress; and
- To establish partnerships to strengthen and promote a caring and supporting environment for FBF members.

Once fully operational, the Field Band Life skills programme provided life skills education to around 1400 youth across the country each year.

Results

The FBF is one of the Swedish programme's most notable achievements. The prevention and behaviour change statistics for the FBF are unprecedented, and demonstrate remarkable impact. They identify a model, or a set of principles, which if understood and extrapolated to other situations, could provide the much needed ideas for the stalemate in the failed national prevention strategy.

This example of a very effective prevention strategy is the Field Band Foundation programme which has provided a meaningful alternative to hopelessness, a healthy focus for youth and opportunities for access to support and counselling from peers or adults over a long period of time. The central activity is playing music in bands with intense ability development, competition and fun. This demanding, absorbing and highly motivating programme then combines general life skills and knowledge inputs around the aims and hopes of youth, with the concept of safe sexual behaviour as only part of holistic personal development. The Field Band statistics speak for themselves:

- More than 4000 HIV tests have been conducted with Field Band members, revealing a total of 14 HIV positive youth (0,35%), compared with a national prevalence of 21.8% of 15-24 year olds in 2010.
- There are no known recorded school age pregnancies among band members: this compared with learner pregnancy rates of 62/1000 women country-wide in 2008. , and 34/1000 is the lowest rate provinces of Gauteng and Western Cape. Other statistics suggest that 15% of girls under 20 have been pregnant. Against the general population, one would expect 34 new mothers per year out of every 1000 girls who are band members. No recorded pregnancy is a remarkable feat.
- Only five out of the 36 young men and women over 22 years of age who are at the academy (FBF's tertiary tutor training school) or are tutors have had unplanned pregnancies.

FBF employs 184 young people in paid, professional employment as tutors. This group is drawn from band members who are among the least resourced, who cannot afford formal tertiary education. Five members of the national youth orchestra are members of the Field Band Foundation. There are numerous accounts of Field Band participation profoundly altering the course of a life:

- A youth who professed to being a thief, was promoted and transferred in the hierarchy and found the resolve to avoid damaging friends.
- A quote on listening to a professionally recorded piece: You hear that solo sax? Yes, incredible. Well she's the 5th born child of a sex worker.
- The FBF has recently formed two bands for children with disabilities.
- YouTube interviews on band members views:
http://www.youtube.com/watch?v=t2ZBNU8cw_Q
<http://www.youtube.com/watch?v=esv06NQVe14>

The achievement that has potential for greatest impact if effectively carried forward is the Field Band Foundation's model for effective whole person prevention education.

The model can be summarised as follows:

- Conventional prevention has been shown to be ineffective. Prevention communication has focussed on marketing a message, pointing out dangers, describing risky behaviour and telling youth what to do. This has not worked.
- To be effective, prevention must be tackled far more obliquely. FBF bases its programme on the assumption that behaviour is incentivised by whole person self-realisation:

Kids have to have a reason, then they can make a choice ... If you want to achieve your dreams, these are the things you can do and the way you can be.

- Youth in under-resourced settings have difficulty with hope, ambition, confidence and optimism.

Girls especially grow up with a sense of feeling pointless. They are brought up to get a man with money – a sugar daddy.

When we started, we said, 'Who has ever asked these kids who they are and what they really want in life?' ... So we start with their dreams – and then talk about the things that will help you achieve them – and reminding them that being ill or dropping out of school will not help you achieve your dreams.

Self-discipline comes from hope. So we tell them, if you want to do well in life and in the Band, you need to clean your teeth, wear neat clothes, practice your instrument, be on time for every practice and stay healthy. You are special.

Kids don't like being told what to do. They don't respect rules for their own sake. You have to show them the reason, and then they must make choices for themselves.

- The logic is that if you come to practice twice every week, you will play better, your band will do well and you could go on tour to the nationals, or to other performances. Indirectly, a person who cares for their art and their personal appearance, and has the confidence of a valued member of a band, is more likely to be able to negotiate sexual debut and safe sex.

Principles of success

The model centres on an extra-mural, collective, mutually dependent, artistic, physical, challenging and progressive, non-aggressive activity (although which of these is essential is difficult to say). Members depend on each other to attend and practice. Together they produce something inspiring, which they could not individually achieve. Dance, sport and extreme outdoor activity have the potential for similar outcomes, and there may be other examples of effective groups.

Ages are separated and intensive life skills workshops are provided one or twice a year for each age group. Life skills workshops begin with questions of personal identity and ambitions, and only incorporate the facts and warnings of safe behaviour around substances and sex later in the process. These are not laboured. Precedence is given to participants' personal visions and life plans.

Pride alongside tolerance: We talk about tolerance from the beginning, and regularly confront discrimination and stigma. There are openly gay tutors in several of the bands, providing role models, encouraging tolerance, confronting

discrimination and enabling youth to reflect on their own sexual orientation in a safe space. We create a space in which the question 'Who are you, and what do you really want?' does not have limits.

Each week there is a life skills discussion session of some sort, with potential to split boys and girls and age groups among the tutors. The coordinator and tutors have regular contact with each band member. If an issue arises that requires interventions with schools, social workers or health facilities, the coordinator refers, helps and accompanies the child as needed.

An information form is also completed for each band members that highlights vulnerability. The Foundation's Children in Distress programme deploys social work officers to the home of any member at with a more detailed profiling tool to identify situations of need. A particular home or school situation that needs to be addressed is followed through by this separate team.

The culture of the band is that considerable effort can be made to meet the individual needs of each member group. For example,

A band member came to me and said 'I am a robber'. We agreed that this would not help him to get where he wanted to get to in his life, instead he would get into trouble with the police. So we transferred him to another band in another town, gave him additional instruments to learn and had him performing on the DVD. He has become a highly talented musician. He was away from his bad friends, and too busy to be a criminal. We don't just get 'good kids' – a lot of these children are very naughty when they come here. I tell me friends to come to Field Band. It can change a person.

One of the secrets of the organisation's robustness is that top leadership is very engaged and accessible (*I have over 1000 friends on Facebook, all called Thabo, and they talk to me and raise problems directly with me.* (Director)). The decisions and plans of the organisation are transparent to all, and designed consultatively with band coordinators and tutors.

The duration of band members' time with the band is also a critical component of the model. Many join when they are 7/8 years of age, and stay as members into their 20s. The challenges, performances and the nature of continuous development that music offers all serve to keep them interested.

Challenges and opportunities

FBF has achieved an astonishing feat. It has taken an effective prevention method to scale, and demonstrated impact on behaviour and health and pregnancy outcomes. The Foundation has demonstrated how honest and authentic recognition and an opportunity for expression, commitment and growth in a person in his or her entirety is the secret behind effective prevention. It has not, however, crystallised the concept. The approach evolved naturally out of love and respect for youth and music, rather than from an attempt to prevent infections. As such, the components of the model are not clearly captured, and ideas for transferring the principles to a range of other forms of artistic expression have not been consolidated into a form that can be shared.

The FBF is an intensely emotional organisation, which lies to a large degree behind its success. Its model cannot necessarily be packaged and handed over to Departments of Education, or even to other NGOs, without losing the essential quality of spontaneity and integrity that makes it work. As with all best practice, there are questions around whether it can be replicated. Or is the combination of people, culture and context too subtle to reproduce?

These are challenges for any good practice model, and dilution is inevitable. The opportunity to attempt to capture the essential elements, and to explore learning exchange with other arts, sports and culture organisations is a key next step in effective HIV prevention, but more importantly, as a foundation stone for the uplift of society in general and an answer to the general malaise and hopelessness that drives an infection-prone society.

One challenge is that band members are attracted through general advertising at schools. There is no way to target and introduce youth in need. Closer relationships with police, social workers and CBOs working with household challenges for referral of youth with specific needs for a few of the places in each band, without dominating the natural band membership drive, might increase social impact.

Relevance and sustainability

Field Band has identified some key elements of an effective prevention strategy, which have not been documented or described in a format that focuses on prevention as an outcome. A good practice piece, supported by a DVD, would be appropriate. This should focus on principles that can be applied through other endeavours. Ideally similar examples of effective activities can be identified and compared.

The social welfare and life skills elements of the FBF's work require continued funding. This could be less than in the past, but the value of the FBF as a model and in its contribution to the HIV response should be a funding priority. The FBF considers R1million/year to be enough to continue to recruit professional adults and train them as Coordinators, with a role that includes life skills education, logistics for the band and social work follow-up as needed.

Prevention funding should focus on identifying and supporting models which are holistic, and which lead to greater skills, self-realisation and inspiration of individuals and communities. Having moved beyond the lessons learned about ABC, funding strategies should take forward the learning from organisations such as FBF.

9.4.11 Masimanyane Women's Support Centre

Funding amount and time

SEK 6,650,000 between 2009 and 2013

Purpose

Masimanyane works at eradicating gender based violence in order to achieve a healthy, safe, secure, equal, responsible and supportive society for all women and children. The organisation engages in the empowerment of women and girls through programmes for women and girls from marginalised communities who have experienced sexual violence. A broader focus that included paralegal services arose out of the work of counselling and support for victims and when it became evident that the criminal justice system provided very poor support for these people.

Activities include training, information sharing, developing leadership and building linkages with other women's groups as part of engaging communities to assess appropriate interventions. Building leadership capacity for women and girls contributes to ensuring accountability at community and local government levels. The organisation is always willing to try new and innovative approaches based on women's own experiences. Stories of women's experiences frame the content of the programmes, ensuring relevance. Masimanyane also address their programmes to both men and women, insisting on equality as a substantive and non-discriminatory aspect, instead of equity, which is government's focus.

Results

At the policy level Masimanyane lists the following results:

- Actively involved in contributing to the Shadow Report, which is a CSO parallel submission to the country progress report on gender equity for the UN.
- Participation in the Convention on the Status of Women in New York, Africa and Middle East and the Convention on the Elimination of Discrimination against Women (CEDAW).
- Policy influence through advocacy on the Sexual Offences Bill, the Children's Bill, and input into the NSP on strategies to address violence against women.
- Partnerships with local media have fed into influencing changes for women in the justice sphere, for example
 - Through inputs, improving the content of police training on GBV
 - Contributing to the move by the Justice Minister to separate maintenance issues from general court matters.

At the programmatic level, Masimanyane believes it has achieved considerable impact.

At individual level women have been empowered to make own choices, and are enabled to move from the position of victim to survivor. Personal case histories showed that different interventions empowered and acknowledged women's abilities to respond. Private legal services, mental health services, relaxation and massage therapy were therefore appropriate.

At community level, schools have become safer place with reduced abuse and violence as a result of SRHR, HIV, human rights and Violence Against Women training work with children. Masimanyane continues to be relevant through addressing core community issues such as ‘Ukuthwala’ which affects women and girls in the Eastern Cape. Ukuthwala is the practice of marrying young girls to older men either through parental consent or force, and some girls are as young as 12. This activity has helped to elevate the issue to both national and global levels, as the Police Ministry and the Ministry of Women Children and People with Disabilities have both taken a stand on the issue.

Community training and mentoring and coaching has strengthened behaviour change and community-based groups now participate in advocacy and apply learned skills to increase awareness within rural communities. For instance the current public educator for Masimanyane was once a teenage mother with poor self-esteem who was looked down on by the people in her village. She asserts that she was transformed through Masimanyane training, first as a volunteer and then moving on to becoming a full-time youth educator.

At provincial global level, Masimanyane contributes through ECAC to influence provincial disaster management policy using the various lenses of gender, child prostitution and women’s economic empowerment.

Challenges and opportunities

Religious and cultural institutions still act as barriers to Masimanyane’s entry into some communities. In some instances traditional leaders have forbidden Masimanyane entry to their communities, and have threatened the safety of staff and generated hostility from the community.

Existing institutions also tend to revert to intrinsic patriarchal approaches and diverse power or values. This reality makes it difficult for Masimanyane to work with some elements of SAPS and fundamentalist Christian organisations which through their practice increase vulnerability of women.

Relevance and sustainability

Masimanyane has realised that working with women only they had limited and that to achieve real impact it was necessary to work with men and boys at school as well in order to highlight women’s issues and increase knowledge for behaviour change while reducing the cycle of violence at private and public spaces. The organisation also stresses that working with communities requires investment in people using different approaches, platforms and networks to ensure the message is achieved. This is not a once-off process but requires time and effort to yield real results.

The organisation has actively aligned its strategic direction for relevance to priorities in GBV in the national space. Their training component moves beyond providing and communicating educational information and to include mentoring and coaching for women’s organisations to support activist and advocacy work in communities.

Masimanyane is not sustainable financially without external support, but its approach to training does enhance and ensure substantial and meaningful representation of rural women’s voices at national and global fora.

9.4.12 The AIDS Legal Network (ALN)

Funding amount and time

SEK 8,650,00 between 2004 and 2013

Purpose

Sweden has supported the AIDS Legal Network for 10 years, consistently providing core funding and supporting the broad aims of the organisations. The organisation as it has become provides services in the following core areas:

- **Networking and awareness-raising:** ALN is present in a vast number of networking forums (participation and/or presentation at 53 national, regional and global events in 2012). The organisation regularly publishes and presents particularly on issues of intersection between HIV, gender and human rights.
- **Research:** The ALN conducts ongoing formally designed community level research on rights and gender issues. This includes an intensive long-term presence in Atlantis (a disadvantaged community in the Western Cape) and regular research partnerships with community organisations across the country (e.g. the implications of HIV disclosure study with CBOs in several provinces).
- **Training and education:** By 2012 five substantial modules around HIV, rights and gender had been developed including training materials and facilitation processes. These are conducted with local organisations in resource-constrained communities, and supported by door-to-door outreach campaigns and community dialogue. An average of 58 courses of different lengths were provided per year in the last three years. A substantial proportion of Swedish funding has been invested in these training events. A legal advice desk also provides specific advice.
- **Lobbying and advocacy:** Integral to ALN's networking strategy, advocacy focuses on particular issues and relevant platforms.
- **Organisational capacity:** ALN has invested in organisational capacity, and in expansion of its network and resource mobilisation base.

Results

ALN is clearly a highly motivated, energetic and extremely productive organisation. It is unfortunate that its communication is generally not results or outcome oriented, but strongly focussed on activities and outputs, although these are all clearly valuable and we would anticipate positive outcomes. The upcoming evaluation, due for publication in October 2013, will review ALN's achievements of the last 10 years. In terms of building a national advocacy fabric and strong organisational platforms, Swedish funding has enabled the strengthening and establishment of the ALN:

10 years ago we were new and not yet established. The Sida funding has enabled ALN to build relationships with other funders. Now ALN is visible and known at regional, global and local levels.

Community saturation ALN takes a community-centred approach, intensively saturating an area through relationships with local partners, e.g. 53 events of different

kinds were held in Atlantis in 2011, and it was the site of a 5200 questionnaire research study on HIV testing experiences. Long term investment and sustained support are more likely to have impact than more dispersed activities.

Training is request-driven and ALN provides around 60 workshops/year. An indicator of the quality of training is that ALN is unable to keep up with demand.

Organisations are gathered for the training every year including community members, CBOs, NGOs, churches and Citizen Advice Offices. ALN trains an average of over 200 participants per year, in groups of 25-30 people. Around eight CBOs or NGOs from different towns participate regularly. Mostly there are different people in each group, but sometimes people attend more than one training. A further 300 are likely to be reached when they go on outreach or hold community dialogues. Their training is about gender-based violence, human rights, reproductive and sexual rights, and HIV and AIDS.¹¹²

ALN also comes and they have talk shows over the radio. People phone in with questions. They leave booklets and fliers after the training for us to use.

Training impact Training is highly participatory and enables participants to explore their own experiences and responses to the issues at hand. The discussion with facilitators is used to inform the advocacy content which feeds into the ALN research and advocacy agendas, and constitutes a direct form of citizen voice into the human rights discourse. In general, organisations whose caregivers and staff had received ALN training were very positive about the approach and the achieved learning. It was specifically mentioned that caregivers have been able to understand human rights issues better and that they act on this knowledge in their daily practice.

They have been very fruitful for the province – people didn't have much knowledge of HIV, and were clueless about human rights. There has been impact. There was a change of mindset and knowledge. Participants go out to spread the message, and they are well informed. Now caregivers have knowledge on human rights. When they see something is wrong, they intervene and report it immediately, and refer the person. ... They know if there is a violation of rights, so they know where to refer.

They have positive attitudes towards the organisations and participants. Caregivers never complain about their facilitation. With some other trainers, caregivers complain about the facilitators, like the way things are presented, the facilitator doesn't talk to people properly (respectfully), they have an attitude to

¹¹² ALN partners Compassionate Women (Northern Cape) and Lethabong Legal Advice Centre (North West Province) provided valuable feedback. A further two recommended partners could not be contacted, or felt that they had not received sufficient input from ALN to comment.

the learners that is not right (patronising and domineering). ALN is never like that. We always ask them to come back.

Now clients come to our office and we give advice and referrals, for example, we gave a talk in informal settlements on domestic violence – they didn't know they had rights – after that people started coming to the office for assistance more than before. The training definitely had an impact.

The culture of our organisation changed. We had felt stigma around HIV before. After the training, we felt so open. The fear was taken off by this training. People living with HIV approached us asking to form a support group – we gave them a space. Around 15 people attend every week. Also, as we met people in that group we identified skills and recruited people from that group to work in the organisation. They are now in our office. The training really opened our minds.

A few of the organisations included in the respondents list are other AFSA organisations. About eight organisations participate regularly.

We have been working with them for eight years and have a good connection. I can send through requests for workshops on new topics, and they come and do it.

They take you through their materials, and they can guide you take up any matter. There is a lot of interaction. Some people don't really understand English. They ensure that somebody is there to translate. The level of their training is good for everybody. ... People like the way it is explained to them.

Research ALN facilitated research and used their partner organisations to gather information. In one study AFSA partners in two Northern Cape towns administered questionnaires about experiences of HIV-related stigma and discrimination in their communities.

We were very happy with how they came and presented, and gave feedback to all the organisations who participated. It was. Questionnaires were filled out in the community. It was a very good study and the findings were interesting – especially about experiences of disclosure, and the consequences of not disclosing. Now the community is really thinking about these issues. Awareness was raised.

Advocacy and networking ALN's Director is currently the chairperson of the women's sector of SANAC, a position that both acknowledges the contribution of the organisation, and enables influence into national priorities, communication and coordination. Among its many networking and communication activities, ALN participates in the Commission on the Status of Women (CSW) as a key global platform.

Challenges and opportunities

From Sweden as sole funder 10 years ago, by 2012 ALN was supported by a total of seven funding agencies.

The training tends to be located around towns and larger urban centres, while many of those experiencing rights abuses, and those with least knowledge or rights, tend to live in more remote rural areas. While trained partners could escalate training to

remote areas they seldom have the resources to do so. Strategies for taking the knowledge beyond saturated centres, possibly through training and outreach funding combinations might resolve this challenge. Access to a toll free advice hub would be essential for newly trained outreach partners, since they are likely to be confronted with situations and issues that go beyond their level of training.

We prefer to have ALN here with us if we do community dialogues (although there are plans to conduct dialogues independently). ALN represent it nicely – they are more experienced.

A saturation centre in a remote, dispersed rural setting might be an appropriate learning and piloting option for ALN.

Relevance and sustainability

No other training orgs have visited here. Only ALN ... No-one else is doing it. People are hungry for the training. People are not aware.

ALN considers its success to be largely due to a highly participatory facilitation style, based on individual reflection and questions, and legal content that emerges from the particular challenges facing members of each group of participants. It also recommends that facilitation be conducted in women-only space as a key principle.

ALN warns of losing the progress made in working on gender, and losing sight of the central participation of women in addressing inequities and injustices that continue to face women in South Africa, in the focus on men as a key population in addressing these gender challenges.

9.4.13 South African Business Coalition on HIV/AIDS (SABCOHA)

Funding amount and time

SEK 1 500 000 for 2013

Purpose

SABCOHA has been a recipient of donor funding since 2003, but the current Partner Driven Cooperation grant is the first from Sweden. The organisation was established to support and encourage the development of a response to the epidemic in the workplace. Their focus has been on empowering workplaces to implement programmes, as well as to collect data from the private sector in order to feed into the country's M&E system and to show the extent to which the private sector is contributing to national targets.

Results

SABCOHA has worked with a range of Swedish-funded organisations over the years, most notably Trucking Wellness/CEP and SANAC. SABCOHA represented the private sector on the SANAC plenary for a number of years. The organisation has provided support to private sector wellness and HIV programmes, and has encouraged private sector enterprises to collect and contribute data to the project of monitoring the response – both in order to determine impact on themselves, but also to understand the situation within South Africa as a whole.

While the organisation has not received direct funding from Sweden, it has maintained a close working relationship with the Pretoria office.

We had many very fruitful discussions about funding and this was extremely useful in steering us towards good possibilities or away from unlikely ones.

In 2013 SABCOHA received a PDC grant from Sweden with the aim of building M&E capability around HIV/AIDS within the private sector. This grant involved establishing a relationship between SABCOHA, Gothenburg University in Sweden and Wits University in South Africa – masters' students get experience in M&E and HIV, and contribute research outcomes to the growing body of knowledge around good practice M&E. The programme aims to input into SABCOHA's Bizwell online technical M&E system. This system collects information from the private sector and is building a picture of the private sector from the perspective of general health and HIV. SABCOHA is of the view that Sweden supported M&E when this was not an activity generally supported by donors.

Sida identified this as a strategic area, and the support to SABCOHA and AIA in particular builds private sector reporting capabilities and therefore accountability.

SABCOHA believes Sweden has been a very responsive donor.

Sida has done good work...it has supported good organisations and made good choices in its partners. Sida has also seeded interesting development issues like GBV and M&E.

Challenges and opportunities

SABCOHA has had some engagement with the Swedish workplace organisation SHWAP, *although this was not as close and collaborative as we would have liked it to be. For example, our peer education programme could have benefitted their companies, but SHWAP appeared somewhat territorial.* This less than optimal relationship was not raised as an issue with the Embassy.

Relevance and sustainability

Both the private sector and SANAC desperately need good M&E in order to make better decisions and inform general policy and the broad response.

9.5 TABLE OF PARTNERS: TYPE AND FUNDING (SEK) 2004-2013

Some amounts in the table were originally in Rands. These have been reflected in SEK at the current exchange rate for consistency. There may therefore be slight discrepancies with original SEK amounts. However, the evaluators are confident that the overall picture is correct.

NAME OF ORGANISATION	2004/5	2006	2007	2008	2009	2010	2011	2012	2013	TOTAL
Annual total (SEK)	18 022 274	24 321 529	31 482 552	41 736 432	46 000 299	42 591 517	31 276 210	30 164 898	37 011 382	302 607 092
Non-Governmental Organisations (NGOs)										
AFSA core funding	913 935	1 017 251	1 844 600	2 409 952	5 660 284	2 811 089	3 517 033	6 036 374	3 969 838	28 180 356
AIDS Consortium	-	-	-	1 400 000	1 680 000	1 750 000	1 399 999	1 400 000	1 680 000	9 309 999
AIDS Legal Network	1 250 000	1 250 000	1 250 000	1 050 000	1 050 000	700 000	700 000	700 000	700 000	8 650 000
ALP/Section 27	1 250 000	2 500 000	-	1 050 000	1 050 000	1 750 000	1 750 000	2 450 000	3 150 000	14 950 000
CADRE	-	-	-	2 800 000	-	-	-	-	-	2 800 000
CEP/Trucking Wellness (& NBCRFLI grants 2004-7)	1 000 000	6 000 000	2 000 000	2 800 000	4 577 580	7 075 000	7 075 000	7 075 000	7 075 000	44 677 580
Engender Health	1 200 000	1 200 000	2 300 000		2 800 000					7 500 000
Field Band Foundation	-	-	-	700 000	840 000	1 190 000	1 050 000	1 050 000	1 260 000	6 090 000
Foundation for Professional Development						2 879 000	2 564 000	1 500 000	2 550 000	9 493 000
Health Systems Trust	-	-	-	-	315 000	-	-	-	-	315 000
HEARD (planning grant)									284 000	284 000
HIVOS - Joint Gender Fund	-	-	-	-	-	1 400 000	700 000	700 000	700 000	3 500 000
Masimanyane Women Support Centre	-	-	-	-	2 100 000	1 050 000	1 050 000	1 050 000	1 400 000	6 650 000
Provincial departments (Eastern & Northern Cape)			10 000 000	10 000 000						20 000 000
Rape Crisis	-	-	-	-	-	-	-	-	560 000	560 000
RADAR	2 000 000	2 000 000	2 000 000	148 000						6 148 000
SA Football Union	700 000	1 600 000	1 500 000	-	-	-	-	-	-	3 800 000
SABCOHA (PDC)									1 500 000	1 500 000
SA Institute of Race Relations					3 000 000				398 544	3 398 544
SANAC					4 500 000	4 500 000				9 000 000
Shout it Now (PDC)									1 500 000	1 500 000

NAME OF ORGANISATION	2004/5	2006	2007	2008	2009	2010	2011	2012	2013	TOTAL
TAC	8 700 000	4 200 000	5 800 000	12 400 000	6 000 000	6 000 000				43 100 000
Sonke Gender Justice Network	-	-	-	-	1 400 000	1 050 000	1 050 000	1 050 000	1 050 000	5 600 000
Tshwane Leadership Foundation	-	-	-	-	-	350 000	350 000	350 000	350 000	1 400 000
World AIDS Campaign	-	-	-	-	-	700 000	700 000	350 000	-	1 750 000
WCape Provincial Gov (planning grant) Lann Devt									284 000	284 000
Zivikele		2 960 000	2 960 000	2 960 000	6 000 000	6 000 000	6 000 000	3 000 000	3 000 000	32 880 000
Community Based Organisations (CBOs)										
Afrika Leadership Development Institution	-	-	-	-	1 400 000	-	-	-	-	1 400 000
Boikobo Community HBC Organisation	-	-	-	150 319	146 538	145 800	140 000	171 815	175 000	929 472
Bokamoso Home Based Care	42 338	-	-	-	-	-	-	-	-	42 339
Bonukhanyo Youth Organisation	70 000	118 527	157 342	185 500	154 000	140 000	140 000	-	-	965 370
Cebisanani Greenville HIV Support Group	70 000.00	51 660.00	-	-	-	-	-	-	-	121 660
Community & Youth Empowerment Centre	63 000	126 583	31 704	-	-	-	-	-	-	221 288
Community Media Trust	-	-	-	-	-	-	140 000	-	-	140 000
Dingleton Community Health Workers Project	68 600	111 475	136 990	186 340	175 000	140 000	140 000	178 990	197 193	1 334 588
Douglas AIDS Action Group	84 000	137 550	160 895	238 875	72 170	-	-	-	-	693 490
Durban Lesbian & Gay Community & Health Centre	-	-	-	114 451	210 000	210 000	-	-	-	534 451
Funda Nenja	-	-	-	-	-	-	-	-	91 154	91 154
Gcinisizwe HIV/AIDS Project	68 600	119 403	139 458	182 000	198 800	140 000	126 000	223 300	180 054	1 377 614
Ilungelo Home Based Training Development	68 600	111 318	151 113	201 185	151 900	147 000	126 000	171 990	231 872	1 360 977
Isibane Sezwe Community Based Organisation	63 000	106 287	138 538	222 527	161 000	147 700	150 500	197 614	212 325	1 399 490
Kgatelopele Social Development Forum	-	-	-	144 033	177 730	142 828	140 000	171 815	199 500	975 906
Laphumilanga Project	70 000	119 683	153 108	192 500	-	-	-	-	-	535 290
Mahlungulu Foundation Community Development	68 600	112 315	145 215	185 500	161 000	175 000	129 500	176 400	182 000	1 335 530
Masikhathalelane Multi Complex (Let Care)	-	-	-	125 958	163 520	135 674	140 000	174 300	194 807	934 259
Namaqualand Resource & Education Centre	-	-	-	153 230	154 882	145 758	-	-	-	453 870
Nceduluntu Home Based Care	63 000	112 455	150 640	237 955	201 565	140 000	140 000	184 590	280 646	1 510 851

NAME OF ORGANISATION	2004/5	2006	2007	2008	2009	2010	2011	2012	2013	TOTAL
Ogone Home Based Care	-	-	-	179 167	132 160	147 340	140 000	171 815	185 500	955 982
Out LGBT Well Being	-	-	-	-	-	280 000	-	-	-	280 000
PEN	-	-	-	-	-	-	-	-	700 000	700 000
Radio Riverside Upington Gemeenskape	-	-	-	163 912	161 000	-	-	-	-	324 912
Richtersveldt Advice Office	-	-	-	139 976	161 000	140 000	140 000	174 300	210 000	965 276
Siyakhana Support Group	68 600	122 815	155 435	189 000	230 300	140 000	154 000	184 800	175 176	1 420 126
Sizophila Community and Child Help Forum	-	-	-	-	-	146 300	129 500	227 990	232 400	736 190
Steinkopf Advice Centre	-	-	-	140 000	140 000	140 000	140 000	174 300	189 000	923 300
The Gugu Dlamini Foundation	-	-	-	-	-	-	140 000	140 000	249 200	529 200
The Khuphuka Project	-	-	-	-	-	-	140 000	177 800	249 200	567 000
The Thohoyandou Victim Empowerment Trust	-	-	-	-	-	-	-	-	700 000	700 000
Tshepo Ya Sechaba	63 000	124 806	153 392	208 667	175 000	147 000	140 000	171 815	189 000	1 372 679
Ubuntu Care & Development organisation	-	-	-	126 000	171 500	154 000	154 000	210 490	311 190	1 127 180
Unisa Tirisano Centre	-	-	-	-	-	-	315 000	-	-	315 000
Van Zylsrus Care & Support Group	77 000	119 403	154 123	183 387	170 870	142 030	115 178	-	-	961 990
Yizani Home Based Care	-	-	-	168 000	157 500	140 000	150 500	169 400	264 783	1 050 183

9.6 ORGANISATIONS/INDIVIDUALS CONSULTED

Person/group interviewed	Title	Organisation
Ria Schoeman	Senior HIV/AIDS Advisor,	Embassy of Sweden Pretoria
Marie Bergström	Counsellor , Head of Development Co-operation	Embassy of Sweden
Eva Charlotte Roos	Programme Coordinator HIV/AIDS	Sida, Stockholm
Pia Engstrand	Regional Advisor HIV/AIDS	Regional HIV & AIDS-Team
Christina de Carvalho	Regional Advisor HIV/AIDS	Regional HIV & AIDS-Team
Kristina Ramstedt	Former Head of Regional HIV/AIDS team in Lusaka	Former Sida, Regional HIV & AIDS-Team
Dag Sundelin	Former Head of Development Cooperation in SA, Former Head of Regional HIV/AIDS team	Sida, Stockholm
Malin Canslätt (e-mail)	International Programme Coordinator	PMU, Sweden
Izla Kaya (e-mail)	International Programme Coordinator	ADRA, Sweden
Jonas Tillberg (e-mail)	International Programme Coordinator	RFSU, Sweden
Celicia Serenata	Previously Resource Tracking & Donor Coordination Manager	SANAC
Fareed Abdullah	CEO	
Paul Booth	Research Assistant to SANAC Deputy Chair (2008/9) SANAC Policy and Research officer (2009/10)	
Coceka Nogaduka	Previously member of the Technical Advisory Committee	Eastern Cape Aids Council (ECAC)
Dean Peacock	Co-founder and Executive Director	Sonke Gender Justice Network
Wessel van den Berg	Programme Manager	
Yogan Pillay	Deputy Director General for Strategic Health Programmes	NDoH
Nelly Malefetse	Director, Donor Coordination	
Bernd Appelt	Multi-sector HIV and AIDS Prevention Programme	GIZ
Bob Fryatt	Senior Health Adviser	DFID/Ministry of Health South Africa
Dirk Mueller	Regional health / HIV adviser	DFID
Mokgadi Tena	Deputy Director International Development Cooperation	Department of Treasury, GOSA
Simon Ferreira	Deputy Director: International Development Cooperation	
Esther Bouma	Attaché - Health Sector Specialist	Delegation of the European Union to South Africa
Brad Mears	CEO	SABCOHA
Tamara Mathebula	HIV/AIDS advisor	Irish Aid
Mark Heywood	Executive Director	SECTION27
Debbie Mathew	Chief Executive Officer	AIDS Foundation of South Africa (AFSA)

Person/group interviewed	Title	Organisation
Nivanie Pillay	Finance & Administration Manager	
Lihle Dlamini	Programme Coordinator	
Jenny Palakdhari	Accountant	
Sibusiso Mkize	Grants Programme Manager	
McDonald Keetsemang	Programme Coordinator	
Andrew Miti	Research, Monitoring & Evaluation Specialist	
Phumelelo Ngcobo	Capacity Building Officer	
Lynette Marrian	COO	TAC
Fanayi Tshabalala	CFO	
Vanessa Franks	Organisational Secretary	
Vuyiseka Dubula	TAC General Secretary	
Johanna Kehler	Director	AIDS Legal Network
Catherine Sozi	South Africa country coordinator	UNAIDS, South Africa
Dr. Mugabe	Deputy Director Regional Office	UNAIDS
Jonathan Gunthorp	Executive Director	Southern African AIDS Trust
Flanny Chiganze	Chief Operations Officer	
Tertius Wessels	CEO	Corridor Empowerment Project (CEP)
Michelle Steyn	Marketing Director	
Themba Mtobeni	Coordinator	
Tertia Stroh	CEO	National Bargaining Council for the Road Freight and Logistics Industry (NBCRFLI)
Goai Gabaotsho	Finance Manager	
Fannida Rahman	Chief Funds Administrator	NBCRFLI mobile clinic Port Elizabeth N2
Zukisa Mciphela	Centre manager professional nurse - N2 PE clinic centre	
Sister E	Mobile Clinic Sister	Roodekop Mobile Clinic
Paul Matthew	Regional Director, Southern Africa	North Star Alliance
Luke Disney	Executive Director, Netherlands	
Gerard Payne	Advocacy Manager	AIDS Consortium
Prince Jan Mahlangu	Secretary General Mpumalanga: Congress of Traditional Leaders	Zivikele beneficiaries
Joelene Evans	Warrant Officer (KZN Police: Training officer)	
Yandisa Klass	Service Office Manager Dept of Social Development	
Virginia Camelio- Benjamin	Previously volunteer for Child Welfare currently Eastern Cape MP	
Rovaro Bayard	Project director	Zivikele
Rui Nunes	Project director	

Person/group interviewed	Title	Organisation
Valerie Kariem	Zivikele Project Coordinator EC	
Bukiwe Somazombe	Direct benefactor- victims of domestic violence	Masimanyane beneficiaries
Mrs Fotoyi		
Nokuzola Ntwanambi		
Thabisa Bobo- Nyathaza	Public educator	Masimanyane
Lundi Siwundla	M & E officer	
Christopher	Deputy director	
Focus group	Project coordinator/supervisor, Community Care Givers	Siyakhana support group
Sandile Mahlangu	Project Coordinator	The Mahlangu Foundation for Community Development
Mrs. Gawuza	Supervisor	
Wilna de Beer	Director	Tshwane Leadership Foundation
Ronald Goldberg	Coordinator Regional HIV/AIDS Programme Southern Africa	Embassy of the Kingdom of the Netherlands
Doreen Sanje	HIV and AIDS Unit coordination team	SADC Secretariat
Antonica Hembe		
Retha Cilliers	CEO	Field Band Foundation
Nana Pule	Lifeskills Programme Coordinator	
Field Band Finance Manager	Finance Manager	
FieldBand Alexandra	Alexandra Field Band Coordinator, Alexandra Field Band Tutor Observation of band practice including approximately 50 children	
Yumnah Hattas	Regional Programme Coordinator	Save the Children, Southern Africa Regional Office
Theophilous Chiviru	Child Rights Governance and PDC project coordinator	
Jeanette Mqomo	Director	Kgatelopele Social Development Forum, Danielskuil, Northern Cape CBO
Nomvula Peteni	Project Manager	
Focus group	Finance Manager and 3 staff members	
Focus group	Garden manager, 2 soup kitchen staff	
Focus group	Disabled beneficiary and PLHIV	Tshepo Ya Sechaba, Barkley West, Northern Cape CBO
Loraine Mondzinger	Focus group discussion with Director and 6 staff member	
Beneficiaries	Interviews in 2 households, both PLHIV, observation of garden projects.	Dingleton Community Health Workers Project, Dingleton, Northern Cape CBO
Kealeboga Seipotlane,	Director	
Focus Group	Focus group discussion 1 board member Finance Manager and 14 caregivers	Masikhathalelane Multi Complex, Petrusville, N Cape
Fuzile Tamane,1 staff	Director and Caregiver coordinator	

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Review of the Swedish support to the HIV/AIDS programmes in South Africa 2004-2013

This is an evaluation of Swedish support to South Africa's HIV/AIDS programme during the period 2004-2013. Bilateral development assistance to South Africa is ending, and from 2014 cooperation will focus on partner driven cooperation and joint regional efforts. The evaluation aims to document the results and lessons learnt during the 10 years of cooperation and to propose a way forward.

Findings indicate that Sweden played a decisive and catalytic role in South African policy changes and the subsequent adoption and implementation of National Plans of Action on HIV/AIDS, despite being a small donor (8th biggest). Swedish support has contributed to the rollout of VCT and access to ART for 2 million South Africans. Swedish support also enabled around 45 000 women and men to access health, social and economic services, helped develop models for holding governments to account, and enabled actors to develop innovative HIV prevention models and challenge gender norms.

The gains made, and the position of South Africa as a significant influence on SRHR in the region, are threatened by the closing down of bilateral support. To maintain the significant progress that has been made, Sweden needs to continue cooperating with South African actors within the new Swedish policy parameters.

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