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BOTTLENECKS AND BENEVOLENCE: HOW THE WORLD BANK IS HELPING COMMUNITIES TO ‘COPE’ WITH HIV/AIDS

SOPHIE HARMAN

This paper looks at how Goal 6 of the UN Millennium Development Goals impacts on the well-being of the people affected by HIV/AIDS. The paper looks at a specific aspect of this: how the aid emphasised by Goal 6 is channelled towards community groups responding to the HIV/AIDS crisis. It does so by exploring the institutional mechanisms used by one of the key international organisations involved in the realisation of the MDGs – the World Bank – and its Multi-Country HIV/AIDS Program (MAP) in Kenya, Tanzania, and Uganda. The paper explores the role of local government, rivalry between different forms of civil society organisations, the problems associated with effective delivery and community feedback, donor responses to these problems, and how these factors impact upon the immediate and long-term realisation of Goal 6, and the position of communities within it. Key to which are themes of government ownership, conditionality, and divisions between implementation and decision-making. The paper is based upon extensive qualitative research into the MAP in East Africa.

Key Words: HIV/AIDS, World Bank, Goal 6, Community

The effective realisation of the eight UN Millennium Development Goals (MDGs) rests on the ability to transfer rhetoric into practice and delivery. At the crux of this delivery is the need to involve multiple actors at every level of governance, state and society to reach people living in extreme conditions of poverty. This paper looks at how the MDGs affect the human and social well-being of vulnerable groups by examining how the aid emphasised by Goal 6 – to combat HIV/AIDS, malaria and other diseases - is channelled towards community groups responding to the HIV/AIDS crisis. Loose-knit community groups have played a vital role in the prevention, treatment and care of HIV/AIDS since the epidemic was first identified in sub-Saharan Africa in the early 1980s. The rural demographic of sub-Saharan Africa combined with the limited government resources in some countries has led to a front line of community health practitioners – predominantly female – who provide support systems and care for the sick, the dead, and their families. Through the prominence

of Goal 6 and the work of the Joint United Nations Programme on HIV/AIDS (UNAIDS) the role of communities has risen to prominence, with aid agencies prioritising ways that address their concerns and support their ability to 'cope' (UNAIDS, 2008; Global Fund, 2008). This paper considers the role of community groups by exploring the institutional mechanisms of community engagement used by one of the key international organisations involved in the realisation of the MDGs – the World Bank – and the Multi-Country HIV/AIDS Program (MAP).

Launched in 2000, the MAP was a US\$1billion commitment to scaling up prevention, treatment and care and helping countries in sub-Saharan Africa cope with HIV/AIDS. MAP funding was available to any country in sub-Saharan Africa that had a national strategic plan to fight HIV/AIDS, a national co-ordinating body, emphasised a multi-sectoral approach to HIV/AIDS, and committed to directing 40-60% of the MAP funds it received to civil society organisations (CSOs) (World Bank, 2007). CSOs in this instance predominantly meant small community groups or national non-governmental organisations (NGOs). This project was significant in that it was the first multilateral project of its kind to earmark such funds to community groups and that government ownership and accountability of the project was central to the conditional lending (World Bank, 2008). This paper examines the Bank's implementation of the MAP in Kenya, Tanzania and Uganda 2004-2006. The findings of the paper are drawn from research into the World Bank's HIV/AIDS policies in East Africa. The paper's conclusions are based on the findings of 163 semi-structured interviews with community groups, national and international non-governmental organisations, government agencies, and international organisations; 50 issued questionnaires; and participant observation of community meetings and partnership forums, conducted over the course of six months fieldwork in Kenya, Tanzania, Uganda, the UK, and the US.

This paper pursues its aim in the following manner. First, it situates the MAP and the role of the World Bank within the context of Goal 6. Second, it outlines the main mechanisms of community engagement utilised by the Bank. As such, it discusses the role of local government facilitators within such a relationship, the District AIDS Councils (the DACs) and their inter-relationships with the central government National AIDS Councils (the

NACs). Methods of interaction are analysed in line with the Bank's established structures of funding, dialogue, partnering and networks. Third, the paper discusses the problems inherent within processes of engagement, the application of ownership at local government level, and the prevailing views of the community groups and NGOs that participated in research. Fourth, the discussion qualifies such opinions within the interests of these groups, the contentions within their arguments, and the Bank-proposed solutions to problems with the MAP. The paper then draws together its main findings as to what the implementation of the MAP reveals about the effectiveness and issues involved with delivery of Goal 6, its ability to reach people affected by poverty, and the impact it has on well-being.

HIV/AIDS, the World Bank and Goal 6

Understandings of the World Bank's role in public health have shifted from the mapping of the relationship between the structural adjustment policies of the 1980s and early 1990s (Loewenson, 1995) to critically engage with how Bank policy and practice is influencing the global health agenda. The introduction of user fees and mechanisms of privatisation during the 1980s gave rise to the emergence of the Bank's 'top-down' style of health policy reform that favours a pluralistic style of implementation and delivery of healthcare services (Lee and Goodman, 2002; Owoh, 1996). According to Buse, the World Bank's role in healthcare has grown exponentially since 1969 as the World Health Organisation has become institutionally marred by negative publicity and a lack of organisational direction (Buse, 1994). What has occurred within this process has been the reduction of state financing and state provision for key aspects of the population and a rise in privatised service delivery as a perceivably more effective way of addressing health concerns (Gilson et al, 1994; Lorgen, 1998; Owoh, 1996). The use of multiple actors within healthcare provision has been acutely felt at the community grassroots where public policy initiatives seek to strengthen familial and community structures that care for the sick. The tendency towards community provision is not specific to public health, but has been a constant within development policy and planning over the last ten years. Specifically within the Bank's Comprehensive Development Framework (CDF), Poverty Reduction Strategy Papers (PRSPs), and model of community-driven development.

The practice of community delivery and how it is organised however rests on the state structures. It also necessitates a certain level of institutional infrastructure for delivery, feedback and monitoring. As this paper will show, in practice community engagement within healthcare provision, is bounded within service delivery and a lack of reciprocity in terms of decision-making and the input of local ideas. The need for state structures of funding and feedback, the Washington-based dynamic to decision-making and agenda setting, and the lack of community consultation all limit the responsiveness of people living with and affected by HIV/AIDS.

This becomes particularly significant to Goal 6. The UN's commitment to fight HIV/AIDS, Malaria and other diseases has thus far been addressed through financial means. A significant part of the US\$10billion that is channelled to the fight against HIV/AIDS is directed to community groups. The logic being that the epidemic targets and spreads through communities, provision is based at the community, so prevention, treatment and care interventions should target local activity. However, as the MAP indicates, processes of getting the money to the community, what happens when it is there, and the structures and directives initiated by the Bank to do so make this initiative problematic.

Methods of Community Engagement: '1000 Flowers Bloom'

The methods of community engagement used by the Bank through the MAP fit within a particular interpretation of community-driven development, rooted in the idea that communities are best placed to generate projects and ideas for policy as they can identify the main issues and means to address them. The inclusion of community groups within its HIV/AIDS policies reflects a wider trend in community inclusion in issues of public health that has long been recognised within health policy literature.ⁱ The MAP has no clear objectives or criteria which community groups must fulfil, other than an overall strategy to direct funds to a vast array of groups so as to cover all aspects of the response and encourage an upsurge in community participation. Key to this was the community's ability to hold their governments to account for how they addressed HIV/AIDS. Each of the three countries explored within this paper have a specific community project: the HIV/AIDS Community Initiative in Kenya; the Community Action Fund (CAF) in Tanzania; and the Community HIV/AIDS Initiative (CHAI) in Uganda (World Bank, 2000a; World Bank,

2000b; World Bank, 2000c; World Bank, 2000d; World Bank, 2000e; World Bank, 2003a; World Bank, 2003b; World Bank, 2003c; World Bank, 2003d). Each of these projects uses funding, dialogue, and networking as the main method of community-driven development. Key to these methods is the District AIDS Councils (DACs).

The District AIDS Councils (DACs)

Access, funding, and feedback from community groups to the Bank occur within a decentralised governance structure through the DACs. These agencies function as the intermediaries between the community and the centralised government NACs, and in some cases the Bank. As District representatives of the NACs, the DACs work in close association with their national counterparts. The DACs plan the District's response to HIV/AIDS in line with the national strategic plan, draw up and manage the District HIV/AIDS budget, facilitate community sensitisation and awareness-raising of the MAP, design and issue the call for proposals, disburse funds to the community, conduct monitoring and evaluation of funds, and feed information back to the NACs and the Bank. The DACs are responsible for the co-ordination of all CSOs active in one area; they should be aware of their coverage, activities and outcomes. The average DAC in Uganda is supposed to co-ordinate the 500 CSOs under the CHAI (Harman, 2005a). The number of DACs per country varies with size and the government, but the scope of CSOs they cover is approximately the same (National AIDS Control Council, 2005a).

Funding

Funding of community groups forms the basis of the MAP's engagement methods. Funding of approximately UK£2,500 is disbursed quarterly to community groups or CBOs by the Bank, through the DACs (National AIDS Control Council, 2005a; Harman, 2005b). Communities funded under the MAP do not have to follow particular activities or fulfil standard objectives. Initial community access, mobilisation, and calls for proposals are conducted through posters, meetings, notices in local markets, and targeting key people within communities as 'community mobilisers' (Harman, 2005c; Harman 2006a). Proposals from community groups are submitted and if viewed viable and workable, approved. Activities at the community level include the thematic areas of care and treatment, prevention and mitigation of new infections, improvement on quality of life for people

infected with HIV/AIDS, support and co-ordination, mitigation of socio-economic impact, and civil society and private sector engagement. The scope of the activities depends on the size and capacity of the group.

The majority of community groups interviewed had begun as issue-specific organisations, but responded to growing needs in the community by expanding and adapting their practices. Those organisations that had expanded their practices were able to attract wider funds, as donors perceived them to have a more holistic approach in responding to the epidemic, and it is more cost effective to fund one group that engages in multiple activities than various different organisations. Expansion of practices, however, requires greater funding in the first place. Thus organisations seek a range of funding in order to attract additional funding. The cyclical nature of this excludes smaller community groups that do not have the means to provide a small amount of seed money to expand their operations, or may have limited access to other, slightly larger organisations that may assist with this. This co-dependency between expansion and funding is felt acutely by many of the community groups interviewed, and is seen as one of the main limitations to their expansion and ability to delivery services to the community (Harman 2005c; Harman 2005d; Harman 2005e; Harman 2005f).

Interviews with community groups suggest that the majority of funding disbursed to the community is for training programmes. Training occurs from the top down. Community groups are trained in home based care, counselling, peer education, and basic methods of prevention of mother to child transmission by INGOs and NGOs. The community groups then utilise these skills to train and ‘sensitise’ other members of the community.ⁱⁱ The result is that most community activity focuses on training, whilst issues of delivery in health services, education, and psycho-social support remain unfulfilled.

Feedback and Dialogue

Dialogue is the second form engagement takes at the community level. The Bank engages in dialogue through the decentralised NAC/DAC system and community visits. There are three central forms of community feedback and dialogue. The first is through the submission of quarterly reports from MAP sponsored community groups to the DACs.

Second, quarterly meetings are held within the District in which recipients of MAP funds discuss their activities, the problems in implementation, and put questions to the DACs. Third, through joint planning meetings and operations. The groups partnered by the DACs are notably national or international NGO representatives such as TASO in Uganda and World Vision (Harman, 2005g), and the heads of particular community-based networks that prove their utility through longevity and direct links to the community. Bank representatives – nominally Task Team Leaders of the project (TTLs) - visit communities quarterly. Unstructured forms of dialogue occur through Bank TTL quarterly visits to different community groups, and ad hoc partnerships such as a representative issuing awards at a football tournament designed to educate young people about HIV/AIDS (Harman, 2005c). Of the community groups interviewed none had engaged in unstructured dialogue (dialogue that was not report-writing) with the Bank.

Networks

The final form engagement takes at the community level is networking. The utility of networks as a means of influencing decision-making has been recognised by some community groups (Harman, 2006a; Harman, 2006b). Groups at the community level stress their wider interactions through joint referrals, combining services, and mutual stakeholder meetings as a way of demonstrating their efficacy and thus securing greater funding from donors (Harman, 2005e; Harman, 2005h; Harman, 2006c; Harman, 2006d). Networks of people living with HIV/AIDS (PLWHAs) are on the increase, and are often linked with their national counterparts. However, the issues of distrust and issues of who or which organisation represents who are less clear at the community level where the greater concern is in regard to greater care and treatment of the sick (Harman, 2005i). Networks at this level are thus less to do with influence upon decision-making and more involved with efficiency in delivery of services.

Problems and Contradictions of World Bank-Community Engagement

Effective CSO engagement that facilitates community empowerment and widespread provision of services is a theme evident in discussions with World Bank or government representatives, but is less so in discussion with community groups. The majority of community groups interviewed remarked on the problems with funding, the lack of

feedback to and interest by donors, and the problems with the DACs and NACs. Each of these factors was seen as significant limitations to their ability to influence decision-making and formulate their overall mandate within Goal 6. This section addresses each of these problems in turn.

Funding and the DACs

Community opinion suggests the central obstacle to effective engagement has been the short-term nature of funding. Funding is too little, too late (Harman, 2005g; Harman, 2005h). Community groups sponsored under the MAP often end up with operational projects but no funds to continue to support them beyond their first year of operations. The mass sensitisation work conducted under the MAP has led to community awareness that the money is there, but the general perception is that the money has not reached the community (Harman, 2005j; Harman, 2006b; Harman 2006f). This issue presented the main concern of the community groups interviewed: where money from donors and the government goes.

Community groups offer two explanations as to why the money is not reaching them. The first is the presence of 'briefcase NGOs' that present high standard proposals, receive the money and then disappear (Harman, 2005k; Harman, 2005l; Harman, 2005m; Harman, 2006f; Harman, 2006h; Harman 2006i). The second explanation is failure of the DACs to be transparent and accountable to those organisations they engage with. Communities funded under the MAP are sometimes unclear about the disbursement process at the District level. They do not feel represented by the DACs and do not see a clear feedback structure from their report-writing, questionnaires or community visits (Harman, 2006j). Community groups see funding access and dialogue as dependent on knowing 'the tricks of getting the money' and having 'someone who will push for you' (Harman, 2005n). CSOs have to establish relationships at every level of decentralised government to achieve any outcome from their engagement (Harman, 2006k).

A contentious issue given the bureaucratic nature of the DACs that is felt by both select community groups and INGOs is the issue of allowances. Allowances exist to a degree in Kenya and Uganda, and are widespread in Tanzania. Allowances are payments supplementary to wages. There is no clear definition of what they are paid for, but at the

level of the DACs, they are claimed when DAC representatives attend meetings away from their headquarters, and/or go on community visits. Within the context of HIV/AIDS, allowance costs for the attendance at meetings and community visits are required by DAC officials at the approximate amount of UK£20 per day (Harman, 2006l). The majority of donors treat it as a grey area open to interpretation at the local level (Harman, 2006m). This is a barrier to effective community empowerment as the money paid to the DACs under allowances often comes directly from funds earmarked for community delivery, which in turn restricts the budget for community visits and direct engagement (Harman, 2006l).

Capacity and the DACs

Allowances are representative of the wider issue of limited institutional and financial capacity of the DACs. The emphasis upon rapid disbursement under the MAP led to the DACs being established with little understanding of the issues, mechanisms of governance, community engagement or training to address these gaps in knowledge. Management and disbursement of funds leaves minimal time and ability to co-ordinate activities within the District, the DACs central role (Harman, 2006n). The burden of managing multiple community groups and different donors on the DACs results in the slow disbursement of funds and a lack of absorptive capacity within the communities themselves (Harman, 2006o).

The relationship between problems in funding mechanisms and the DACs are underpinned by a contradiction between ownership and conditionality. DAC staff members in all the countries considered acknowledge the influence of the MAP and World Bank priorities, yet reiterate ownership of the project. However, the DACs did not exist prior to the MAP. District HIV/AIDS work plans are designed in partnership with the NACs under the guidelines of each specific national strategic plan (Harman, 2005o) that represent the key principles of the MAP in each of the three countries studied. The DACs resisted CSO involvement, but had to agree to a CSO component of the District HIV/AIDS work plan in order to receive any funds. MAP funds earmarked to 'familiarise' DAC staff with the concept, was in effect training to teach them the 'operationalisation of a multi-sectoral approach' (Harman, 2005g). As such, every level of DAC-CSO engagement is 'determined by the centre' (Harman, 2005g), leaving minimal space for community and government input into the direction and implementation of the project.

The Bank

Community viewpoints on the Bank itself are limited to non-existent (Harman, 2006b). Those aware of the Bank's involvement in HIV/AIDS have a pragmatic view that their intentions were good but 'their hands are tied due to the size of the project/policy and the 'through - through - through structures' (Harman, 2005n; Harman, 2006p). Community groups are more critical when discussing the MAP and its 'owners', the NACs, than the Bank. Many of the groups that took part in research do not feel the presence of the MAP at the community level and believe the majority of activity to be conducted by other donors (Harman, 2005n; Harman, 2005p; Harman, 2005q; Harman, 2005r; Harman, 2006q). Despite contributing to the capacity of smaller organisations, the community component of the MAP is viewed as unsustainable (Harman, 2005c; Harman, 2005i).

The problems and perceptions underpinning CSO engagement have negative ramifications for communities affected by HIV/AIDS. Blockages in funding channels caused by bureaucracy, limitations in institutional capacity and questions of ownership reduce the amount of money, education and support for people living with HIV/AIDS. In separating decision-making and implementation whilst maintaining government ownership of the project, communities are unable to address these issues. There is, however, a need to qualify such criticisms with a critical assessment of how these problems relate to the community groups themselves, compared to the experience with other donors, and reflect wider issues within development delivery.

Assessing the Problems and Perceptions of Community Groups

The problems with engagement identified by the community groups that participated in research need to be offset by a deeper assessment of the issues these problems pose and the Bank's response to them. Issues over funding, bureaucracy, and leverage are often based upon community group perception. This is evident in three ways. The first is in relation to the short-term nature and lack of evidence of funding. The US\$10billion annually directed to HIV/AIDS relief, and the existence of multiple CSO activity suggests there is an abundance of funding. Often those groups that flagged the issue of funding had received money from the MAP and were submitting proposals to other donors. One of the main interests of

community groups working in HIV/AIDS is to secure funds for their projects, and thus compete with other groups, and stress the need for more funding in line with their own interests. The issue of funding is pertinent for all community groups involved in research; however, problems associated with allocation and disbursement may be over-emphasised.

Issues of what activities are funded are also in part the responsibility of community groups. None of the MAP community initiatives stipulated the need to fund specific activities; thus if all the activities funded are for training purposes it is because of what community groups specified in their project proposals. The MAP was the first multilateral commitment to HIV/AIDS of its kind; thus in engendering mass community responses, a degree of training people with the means of educating, caring and addressing issues facing communities affected by HIV/AIDS is inevitable. A greater problem with funding is the absorptive capacity of community groups themselves. MAP representatives in Kenya and Tanzania stipulated that should the funds be disbursed effectively, further funding would be made available by the Bank (Harman, 2005s; Harman, 2005t; Harman, 2006m). Issues with disbursement are part the problem of DAC infrastructure, but also part community group infrastructure.

The second issue is that of bureaucracy and transparency. A degree of bureaucracy is inevitable within a project the size of the MAP and its use of state agencies and structures as the main channels for CSO engagement. Comparatively, the MAP has fared better in community opinion than other programmes of a similar scale such as the Global Fund (Harman, 2005n; Harman, 2006a; Harman, 2006j). A simple way of avoiding such bureaucracy would be to engage with fewer groups and focus on the national level alone, which would then undermine any form of community participation in the system. A further alternative would be to fund community groups directly with minimal state intervention. However, the Bank is mandated to work in partnership with states. To work independently of states would undermine any long-term commitment to building infrastructure and the means to address the epidemic independent of foreign aid. The level of intricate problems associated with the MAP shows the ability of community groups to hold government agencies to account, and push for increased transparency, indicating the emergence of an effective civil society and fulfilling one of the MAP's central objectives.

World Bank Responses to Community Criticism

The Bank is fully aware of community perceptions and issues over funding, feedback and the capacity of the DACs. The changes it has made to the implementation structures of the MAP suggest that it is responsive to community needs and flexible with regard to state interests. The Bank interprets community awareness and complaints about the lack of funding as a good sign that communities are beginning to take ownership of the response and thus will incentivise the government to take action (Harman, 2005s). TTL of the MAP in Uganda, Peter Okwero, emphasises that despite some of CSOs' misgivings concerning the community component of the MAP, the project has succeeded in motivating the community where other community focused projects have failed (Harman, 2005u).

The NACs and the Bank have responded to the problems of the DACs in two distinct ways. The first, in reference to the DACs in Kenya, was to dismantle the DACs and replace them with District Technical Committees, to all intents and purposes fulfilling the same role but with greater emphasis upon addressing the difficulties and technicalities of channelling money to the communities. These committees are then assisted by Provincial AIDS Control Councils that co-ordinate the response at the regional level and provide support to the new District Technical Committees and the National AIDS Control Council (NACC), Kenya. Training and consultation was conducted by UNAIDS and the NACC so that each agency was able to better understand their role. Dismantling of the original structures combined with the problem of corruption at the national level led to a severe delay in MAP funding disbursement in Kenya. The second approach was to maintain the DACs but introduce Regional Facilitating Agents (RFAs) in Tanzania, or AIDS Control Units in Kenya, that would operate as an extension of the NACs mandate thus increasing the working capacity of the MAP at the national and district level. The RFAs were most obvious and influential in Tanzania. The central role of RFAs was to build the capacity of the regional secretariat, the Local Government Authority (LGAs), the DACs and the community, and to oversee and co-ordinate the overall implementation of the MAP community component. RFAs built capacity by mapping the number of CSOs in the area, their activities, shortfalls and successes, demonstrating successful models for implementation and monitoring of projects

to both the DACs and the community, assisting the DACs with project appraisal and subsequently disbursing funds to communities.

The difficulties and complexities of community delivery are reflected in the role of the regional agents introduced within the MAP, whose ability to reach people affected by HIV/AIDS was limited by the following. First, an initial lack of institutional support from the DACs because of a discrepancy over their respective mandates which in turn led to further delay in reaching the community (Harman, 2006r; Harman, 2006s). Second, because the lack of funding and human resources with the DACs, the RFAs had to spend much of their time training DAC staff (Harman, 2006l). Third, delayed disbursement gave rise to the notion that the system of community delivery was not working, and frustrated community trust in the process. Compounding this distrust of the RFAs by both the DACs and the community was the fact that the idea for them did not stem from the community, but by the Bank

The introduction of RFAs reveals the following about community engagement under the MAP. First, the Bank does acknowledge problems with funding of community groups and the DACs, and offers pragmatic responses to such issues. Second, the inclusion of INGOs and the private sector represents a third tier of governance structures separating the Bank from the community. Despite being designed to increase CSO engagement under the MAP, in the interim RFAs are seen by communities to reduce it by adding additional bureaucracy, further delays to funds, and a further removing the Bank from any form of direct engagement. Similarly to the issues with DAC funding, these problems can, however, be attributed to wider community distrust of INGOs and initial problems with the RFAs to the wider benefit of long-term engagement practice. Third, the introduction of RFAs challenged the Bank's model of community-driven development. The Bank's approach to community driven-development is based upon funding and tokenistic dialogue only, with little direct feedback to policy and decision making, whereas direct partnership and influence in decision-making remains the realm of the Bank's natural partners, INGOs and the private sector.

Conclusion

This paper has explored one of the main contentions within Goal 6 of the MDGs: the desire to channel resources and engage the opinions of those affected by HIV/AIDS as a means of combating the epidemic, and the problems associated with doing so. The paper has explored this issue by considering the central mechanisms of engagement used within the World Bank's MAP project and the institutional problems associated with it. In so doing, the paper raises several concerns as to how the MDGs promote and achieve well-being for people affected by HIV/AIDS in East Africa. First, community participation in Goal 6 of the MDGs is characterised by service delivery only. Select community groups are receiving funds, but much of the money directed to them is lost in the process, and once the money arrives, it is often too little, too late. Second, communities do not drive the agenda of Goal 6 with their ideas. The emphasis placed on funding as a means of engagement had bred increased competition and mistrust between various types of CSOs that compete for funds to maintain their relevance and influence within decision-making. This limits the formation of networks and collaborative mechanisms that increase communities' capacity and leverage in making Goal 6 accountable and responsive to their needs.

Third, the role of local government agencies as implementers of Goal 6 is central to understanding the problems and limitations of delivering resources to the community. Community engagement does not occur between the local and global levels but is dependent on government agencies and their ability to internalise and promote the rhetoric of the MDGs. These government agencies are limited by a loose-mandate that has to manage the competing objectives of multiple donors instead of designing locally responsive policies independent of international priorities. In sum, the international cycle of minimal direct community engagement and institutional bottlenecks that has continued to limit poverty efforts continues within Goal 6: with community groups managing their situation, but in no way coping with it.

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ⁱ For further literature on the role of CSOs within HIV/AIDS see Poku, 2002; Sanders and Sambo, 1991; Seckinelgin, 2005; Whiteside, 2002: for the MAP see Doyle and Patel, 2008; Harman, 2007: for the emergence of CSOs in healthcare see Gilson et al, 1994; Lee and Goodman, 2002; Rifkin, 1986; Smith, 1989; Walt and Gilson, 1994

ⁱⁱ 'Sensitise' and 'sensitisation' were commonly used in discussions of CBO activity. These phrases refer to education on the causes of HIV/AIDS; the socio-economic implications; and more often, issues of stigma and denial affecting those stricken by AIDS or sometimes even those suspected of being HIV positive.