

# The Response to HIV/AIDS in Malawi: A Civil Society Sector Study

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## Acronyms

Blantyre City Assembly	BCA
Canadian Physicians for Aid and Relief	CPAR
Capacity Development Consultants	CADECO
Civil Society Organization	CSO
Community AIDS Coordinating Committee	CACC
Community Based Organization	CBO
Council for Non-Governmental Organizations in Malawi	CONGOMA
District AIDS Coordinator	DAC
District AIDS Coordinating Committee	DACC
Faith Based Organization	FBO
HIV Testing and Counseling	HTC
International Nongovernmental Organization	INGO
Kinder Not Hilfe	KNH
Malawi Business Coalition Against HIV/AIDS	MBCA
Malawi Development Growth Strategy	MDGS
Malawi Network of AIDS Service Organizations	MANASO
Malawi Network of People Living With HIV/AIDS	MANET
Ministry of Health	MOH
National AIDS Commission	NAC
National Action Framework	NAF
National Association of People Living With HIV/AIDS in Malawi	NAPHAM
Nongovernmental Organization	NGO
Organizational Network Analysis	ONA
People Living With HIV/AIDS	PLWHA
Prevention of Mother-to-Child Transmission	PMTCT
Rapid Organizational Scan	ROS
Umbrella Organization	UO
United Democratic Front	UDF
World Health Organization	WHO

## Key Terms

### **Civil Society Organization**

A civil society organization is an organization that is indigenous to a particular context and is neither a for-profit institution, nor an institution of government. This report focuses on the following types of civil society organizations: Community Based Organizations, local Non-Governmental Organizations, and local Faith Based Organizations.

### **Organizational Capacity**

Organizational capacity refers to an organization's ability to achieve its mission effectively and sustain itself over the long term. Capacity building is the "process of developing and strengthening the skills, abilities, processes and resources that organizations...need to survive, adapt and thrive in the fast-changing world."<sup>1</sup>

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<sup>1</sup> Philbin, Ann (1996) *Capacity Building in Social Justice Organizations*. Ford Foundation

# 1. Executive Summary

The effects of the HIV/AIDS pandemic are endangering decades of economic and social progress in Malawi. The number of infected Malawians is rising, and will soon exceed one million. Likewise, over 500,000 children have been orphaned. Civil Society Organizations (CSOs) – including Non-Governmental Organizations (NGOs), Faith-Based Organizations (FBOs) and Community-Based Organizations (CBOs) – are playing an active and vital role in the response to the crisis by providing a range of HIV/AIDS services. However, CSOs themselves are not immune from the pandemic, and are in fact suffering great hardships as staff and volunteers, who are already overtaxed, become infected themselves.

In order to better understand the strengths and challenges of the segment of Malawi's civil society sector that is engaged in the fight against HIV/AIDS, Pact and our local partner CADECO conducted a USAID funded civil society sector study to support the work of Pact's Community REACH Program in Malawi. The study focused on the profile of the Malawian CSO community, CSO capacity levels, the coordination of the response to HIV/AIDS, and collaboration around service delivery and resource mobilization.

## **The Profile of CSOs Responding to HIV/AIDS**

The study found that the majority of organizations involved in the civil society response to HIV/AIDS in Malawi are small CBOs. Local NGOs make up a comparatively small percentage of the Malawian civil society response. Larger and more established organizations appear to be clustered around urban centers, and CSOs operating in the Southern and Central Regions tend to be more established, with larger staff and greater resources, than their Northern counterparts.

Many CSOs within Malawi have shifted from their original missions to focus on HIV/AIDS. In some cases this move is issue driven, in others it is resource driven. Stakeholders spoke of the prevalence of "briefcase CSOs", that exist to access funding rather than to benefit communities.

Malawian CSOs are currently very active in providing services related to the care and support of those infected and affected by HIV/AIDS, and the prevention of HIV/AIDS. They are much less active in the provision of more technical services related to testing and counseling and the medical treatment of HIV and other sexually transmitted infections. CSOs offering these more technical services tend to be clustered around urban centers. This may be because more established and/or agile CSOs are operating in these districts.

## **Capacities of CSOs Responding to HIV/AIDS**

Pact and CADECO's research showed that CSOs generally report high capacities in the core organizational areas of Mission and Strategy, Financial Management, Human Resources, Leadership and Governance, Accountability, and Service Delivery. The most complex core capacity issues reported by organizations are human resource challenges brought about by the HIV/AIDS pandemic.

Technical service capacities reported by CSOs are generally much lower than core organizational capacities. This is particularly true for the service areas of HIV Testing and Counseling (HTC), Advocacy and Capacity Building. Today, however, there are increasing demands upon Malawian CSOs to fill service gaps in these highly technical areas.

Both technical and core organizational capacities of CSOs in the Northern Region are lower than their counterparts in the Southern and Central Regions. Although CSOs face many capacity related challenges, stakeholders cited a number of positive trends within the current environment, including increased cooperation facilitated by District AIDS Coordinating Committees (DACCs) and the impact of debt relief.

### **Coordination of the Response to HIV/AIDS**

The National AIDS Commission of Malawi (NAC) is the primary national coordinating support body responding to HIV/AIDS. The NAC has developed an umbrella mechanism, contracting with five INGO partners to manage basket fund grants and provide CSOs with capacity building support,

An evaluation of the first phase of the umbrella mechanism, completed in the summer of 2006, saw a major realignment with two INGOs dropping out and the NAC taking a more direct role in the management of 10 districts through the Umbrella Project. The beginning of the second phase also marks a change in the umbrella mechanism's capacity building strategy, from a focus on the technical capacity of CSOs to a focus on the core organizational capacities of district assemblies and DACCs.

Key actors in the HIV/AIDS response have a mixed reaction to the changes that have taken place since the summer of 2006. The NAC is commended as being a confident and well organized organization. However, there is a degree of apprehension surrounding the new structure of the Umbrella Project, particularly regarding how progress in the 10 districts will be monitored and whether the goal of decentralizing power to the district level by 2009 is realistic.

At the community level, Community AIDS Coordinating Committees (CACCs) have great potential for mobilizing and coordinating CBOs. At present, however, because CBOs are funded at the district level they are disproportionately powerful, undermining the role of the CACCs.

Networking organizations, such as Malawi Network of AIDS Service Organizations (MANASO), Council for Non-Governmental Organizations in Malawi (CONGOMA), Malawi Network of People Living with HIV/AIDS (MANET) and National Association of People Living With HIV/AIDS in Malawi (NAPHAM), play a key role as connectors within civil society. While they still have capacity challenges and require further assistance to achieve maximum effectiveness, they should be considered important stakeholders in any civil society strengthening initiative.

Furthermore, discussions about donor-implementer relationships, conducted during the study, highlighted the importance of clear and effective communication, to increase the efficiency and impact of the national HIV/AIDS response.

### **Collaboration around the Response to HIV/AIDS**

Pact and CADECO applied an Organizational Network Analysis (ONA) to assist with visualizing and understanding patterns of collaboration and networking between CSOs and their partners in government, business and international actors.

The analysis found that there are dense linkages between many Malawian CSOs involved in HIV/AIDS service delivery, highlighting the existence of local social capital. There is,

however, potential for the further strengthening of these networks to allow for increased flows of resources and information. Network strengthening may be assisted by organizations such as MANASO, MANET and NAPHAM who currently play a key role as connectors within civil society.

The Umoyo Network has played an important role in developing Malawian CSOs and networking organizations. Many of the ex-Umoyo Network members have grown in stature and capacity over the course of the intervention – becoming leaders within civil society. With the Umoyo project closing out in the summer of 2007 there is some uncertainty over who will take over this important facilitator role.

A number of international NGOs play a role in HIV/AIDS service delivery networks. However, that role is generally a peripheral one with INGOs tending to work consistently with a small number of local partners around a wide range of service areas. Donor organizations also feature in networks because, despite their lack of direct interaction, they are viewed as collaborators by civil society stakeholders.

At the periphery of many of the networks there are interactions occurring at the district level, often involving DACCs, local hospitals and smaller CBOs. A district level application of the ONA tool may be powerful in highlighting those districts where collaboration is strong and whose example might benefit others.

### **Resource Mobilization by CSOs Involved in the Response to HIV/AIDS**

The study found that the single most important resource hub for Malawian CSOs is the NAC. The NAC primarily provides funding, but also plays an important role in distributing intellectual capital and providing mentoring to CSOs. Still, however, international actors as a group are the primary providers of financial resources, mentoring and intellectual capital to the majority of Malawi's civil society.

Many of the Malawian CSOs that have been most successful in leveraging resources and capacity building services are also those that are more active networkers. The Malawian networking organization MANASO also plays a role as a resource hub.

The majority of organizations providing capacity building services to Malawian CSOs are international actors. However, the five umbrella organizations are surprisingly underrepresented as service providers given their particular mandate in this area.

Capacity building service provision is equally split between core capacities and technical capacities. Core capacity service provision is heavily biased towards areas such as Financial Management and Mission and Strategy, where CSOs are already relatively strong. There is comparatively little service provision directed towards weaker areas such as Human Resources and Leadership and Governance. In terms of technical capacity services, the majority are focused towards Care and Support and Impact Mitigation. However, there are also relatively large service offerings in growth areas such as Treatment and Testing and Counseling.

### **Conclusions and Points for Reflection**

The report ends with a number of points for further reflection around the continued strengthening of the civil society response to HIV/AIDS:

- There is a significant capacity gap between CSOs in the Southern and Central Regions, and their counterparts in the Northern Region and future capacity building or networking interventions may seek to involve, or even give precedence, to organizations from these districts.
- There is a need to monitor progress towards the 2009 goal of decentralizing the umbrella mechanism to the district level, especially given fears that district capacity is low and that DACCs will not be able to undertake the broad range of responsibilities required following handover.
- With national attention moving from CSO capacity building to capacity building at the district level, additional attention from elsewhere will need to monitor progress and fill gaps in the provision of assistance to CSOs.
- There are a number of larger Malawian CSOs whose experience and capacity could and should be leveraged to the benefit of civil society. These organizations still have capacity challenges moving forward, but the value of having local actors at the vanguard of the response should not be ignored.
- The success of CSOs that participated in the Umoyo Network highlights the value of networking and capacity building interventions. With this intervention coming to an end, there is value to be gained from working to ensure the sustainability of this kind of activity, either through a locally owned network or through a similar external intervention.
- International NGOs would benefit from closer coordination. By working together to minimize duplication and leverage core competencies, these external actors can continue to have a strongly positive impact upon the HIV/AIDS response.
- Where Civil Society is asked to play new roles, special attention should be given to building relevant technical capacities. In particular, attempts to boost CSO involvement in HTC or Treatment activities should therefore be accompanied by complimentary technical capacity building.

## 2. Introduction

This study of civil society's response to HIV/AIDS in Malawi was supported by the USAID/Malawi through Pact's Community REACH Associate Award Program in Malawi. The purpose of this study was to gain an increased understanding of the present state of the Malawian civil society, and in particular, to:

- Generate a better understanding of the landscape and operating environment around HIV/AIDS in Malawi.
- Determine the capacity levels of civil society organizations operating HIV/AIDS programs across Malawi, and identify those with the potential to play lead roles.
- Review the current situation with regards to HIV/AIDS coordination, in terms of who the key actors are, what roles they play, and how effective they are.
- Map organizational actors and resources, as well as inter-organizational collaboration across the HIV/AIDS sector in Malawi.

This report synthesizes a large amount of primary and secondary data and concludes with a set of recommendations for further consideration.

### Malawi and HIV/AIDS

Located in Southern Africa and sandwiched between the two larger nations of Zambia and Mozambique, Malawi is a country of 13 million people. The country is split into three regions – Northern, Central and Southern – which in turn are partitioned into 27 districts, as shown in Figure 1.

Malawi is one of Sub-Saharan Africa's most densely populated countries. The capital city of Lilongwe, in Central Region, houses all of the major government institutions and has a population exceeding 400,000. However, Blantyre in Southern Region, the capital until 1971, remains Malawi's major commercial center and largest city, with a population of 500,000. Mzuzu, in Mzimba District, is the largest city in the Northern Region.

Malawi declared independence in 1964, but remained a one party state under President Dr. Hastings Kamuzu Banda until 1993 when the Malawi Congress Party was defeated by the United Democratic Front (UDF) in the country's first

**Figure 1: Map of Malawi**

*Central Region (Gold)*

1. Dedza
2. Dowa
3. Kasungu
4. Lilongwe
5. Mchinji
6. Nkhatakota
7. Ntcheu
8. Ntchisi
9. Salima

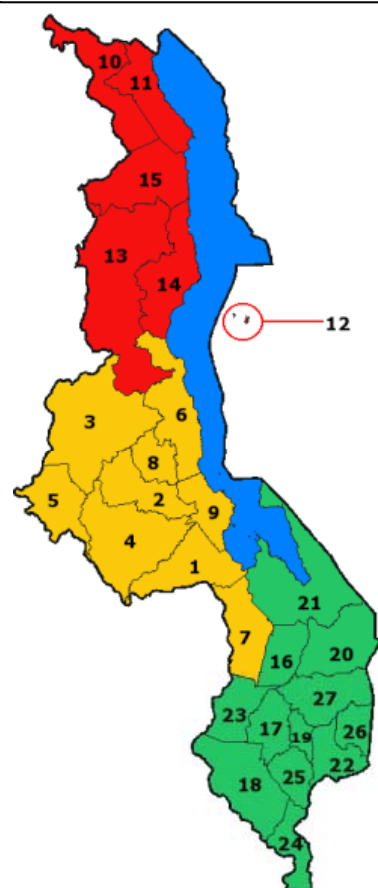
*Northern Region (Red)*

10. Chitipa
11. Karonga
12. Likoma
13. Mzimba
14. Nkhata Bay
15. Rumphu

*Southern Region (Green)*

16. Balaka
17. Blantyre
18. Chikwawa
19. Chiradzulu
20. Machinga
21. Mangochi
22. Mulanje
23. Mwanza
24. Nsanje
25. Thyolo
26. Phalombe
27. Zomba

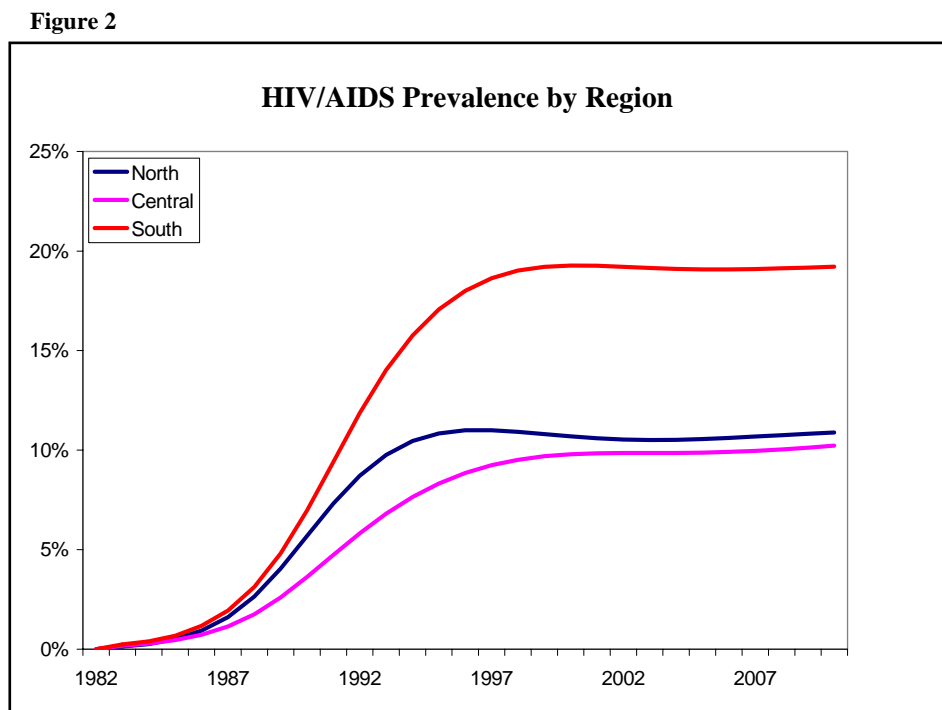
Map Source: Wikipedia,  
[www.wikipedia.com](http://www.wikipedia.com)



democratic multiparty elections. Today, the UDF remains in power under President Bingu wa Mutharika.

The effects of HIV/AIDS are endangering decades of economic and social progress in Malawi. The number of infected Malawians is rising, and will soon exceed one million. Likewise, over 500,000 children have been orphaned.<sup>2</sup> More than 80,000 Malawians die from the disease every year making it the leading cause of death amongst Malawian adults.<sup>3</sup>

Figure 2 shows how HIV/AIDS prevalence rates have changed over time in the three regions of Malawi<sup>4</sup>. Data prior to 1994 and following 2003 are estimates, but the graph clearly shows however, that prevalence rates in all three regions rose very quickly until the late 1990's before beginning to level off. Today, prevalence is clearly highest in the Southern Region, where at 20% it is about double the level in the Centre and North. Anecdotal evidence collected in interviews suggests that rates in the Northern Region are continuing to rise, a development that requires close monitoring.



In a country of just 13 million people, such devastating losses impact every level of society: from the family to the workplace, including schools, hospitals, businesses, and government. Civil Society Organizations – including nongovernmental organizations, faith-based organizations and community-based organizations – are playing an active and vital role in the response to the crisis, providing a range of HIV/AIDS services. However, CSOs themselves are not immune from the pandemic, and are in fact suffering great hardships as staff and volunteers who are already overtaxed, often filling double roles, themselves become infected.

<sup>2</sup> USAID Health Profile: Malawi. 2005. [http://www.synergyaids.com/Profiles\\_Web/Profiles\\_PDFs/MalawiProfile2005.pdf](http://www.synergyaids.com/Profiles_Web/Profiles_PDFs/MalawiProfile2005.pdf)

<sup>3</sup> Ibid.

<sup>4</sup> National AIDS Commission (2003) *Estimating National HIV Prevalence in Malawi from Sentinel Surveillance Data: Technical Report*. Lilongwe, Malawi

## Background on Malawi's Civil Society

Through nationwide outreach with District AIDS Commissioners (DACs), in all 27 of Malawi's districts, Pact and CADECO generated a directory of more than 500 organizations working to address the HIV/AIDS pandemic in Malawi<sup>5</sup>. This data is summarized in Table 1 on page 15. Three types of CSO were identified. These are:

### Malawian Civil Society Organizations:

- **CBOs** – Small and mostly informal organizations, reliant upon community volunteers and with limited capacity to undertake technical tasks<sup>6</sup>.
- **Upcoming NGOs** – Local Malawian organizations that are registered and active within the community, but still struggling for survival.
- **Established NGOs** - Local Malawian organizations that are registered and have operated actively for several years.

Over the years, Malawi's civil society has been influenced by numerous internal and external factors. Historically, NGOs struggled simply for their existence when, during the Banda regime, the NGO sector was limited primarily to church based and international organizations providing services to Mozambican refugees.<sup>7</sup> In recent years, however, the NGO sector has expanded – in both numbers and focus. Undoubtedly this is partially due to the growth of HIV/AIDS in Malawi and the urgent need for rapid and effective responses to the problem.

However, the expansion of the NGO sector should not be confused with dramatic changes in its maturity. Indeed, according to a 2006 study, “most local NGOs are still in the pioneer or dependent stage of development”<sup>8</sup>, needing to enhance their professionalism and adopt a greater strategic orientation. This perspective is also evident in the *PSO Evaluation of Malawian NGOs* which explores changes in Malawian NGOs over a ten-year period from 1995 to 2005.<sup>9</sup> While some clear improvements were found over that time period – with noted advancements in networking/advocacy, and the formalization of organizational systems and procedures, for example – the study also highlighted numerous areas where change is still needed. Some of these needs include: the greater effectiveness of boards of directors, less donor dependence, and an overall increase in absorptive capacity. (See Annex A for a table summarizing the study's findings).

Alongside the steadily growing Malawian NGO sector, there has been the emergence of a large number of community-based organizations whose focus has been on serving communities at the grassroots level. Funding entities such as the Global Fund are relying more and more on CBOs to deliver HIV/AIDS services, with the National AIDS Commission alone supporting 600 CBOs with financial resources (as of June 2006)<sup>10</sup>. According to a 2005 study on the Global Fund in Malawi, as of April 2005 approximately \$10 million of the \$36

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<sup>5</sup> Data was collected through outreach visits to each of the 27 District Aids Commissioners in Malawi and represents the most comprehensive mapping exercise of CSO activity completed in Malawi to date.

<sup>6</sup> In some cases, organizations registered as NGOs have been classified by Pact and CADECO as CBOs. This is because their characteristics more accurately reflect that of a CBO than that of an NGO.

<sup>7</sup> Malunga, C.. Improving Strategic Planning Among Local NGOs in Malawi, Doctoral Thesis, Department of Development Studies, University of South Africa. 2007

<sup>8</sup> Ibid.

<sup>9</sup> Source: Cooney, Janszen and Malunga, 2005: PSO Evaluation of Malawian NGOs, Ecorys, The Hague, Netherlands.

<sup>10</sup> NAC Overview of HIV and AIDS Response, June 2006.

million drawn down from the Global Fund grant agreement was disseminated to CBOs and various institutions to address HIV/AIDS challenges in Malawi.<sup>11</sup>

To better understand the assets and challenges of the segment of Malawi's civil society sector that is engaged in the fight against HIV/AIDS, Pact conducted a civil society sector study to support the work of its Community REACH Program in Malawi.

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<sup>11</sup> Mtonya, Brian, Victor Mwapasa, and John Kadzandira. October 2005. *System-Wide Effects of the Global Fund in Malawi: Baseline Study Report*. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.

### 3. Methodology

Pact's Capacity Building Services Group partnered with Capacity Development Consultants (CADECO) – a Malawian NGO – to conduct a four-month study of the HIV/AIDS civil society sector in Malawi, paying special attention to the profile of Malawian CSOs, CSO capacity levels, the coordination of the response to HIV/AIDS, and collaboration around service delivery and resource mobilization. The study included a combination of traditional research methods and highly innovative approaches to gathering and acting on research data. Key activities are described below:

#### A. DESK REVIEW

The study began with a **rapid desk review** to gather and examine key documents on the civil society sector and donor trends in Malawi. Pact and CADECO used the desk review findings to refine the research methodology, build on quality research already conducted, and focus on areas where the greatest information gaps exist.

#### B. NATIONWIDE OUTREACH

**Individual outreach sessions** were held with a cross-section of 42 CSOs operating countrywide across a range of program activities. Outreach sessions involved the collection of biographical data, and implementation of rapid organizational scans (ROS) designed to gather information on HIV/AIDS sector demographics, as well as issues of technical capacity and organizational priorities. A sample ROS survey is included in Annex B, and a list of organizations that participated in the ROS is included in Annex C.

In addition to individual outreach visits, half-day **group outreach sessions** were held simultaneously in Lilongwe, Blantyre and Mzuzu. At these sessions, Pact and CADECO team members explained Pact's role in Malawi and built excitement around the forthcoming Strategic Linkages Event. Group outreach also provided an opportunity to learn more about networking and capacity building challenges at the local level, fostering preliminary connections where they did not already exist.

#### C. STRATEGIC LINKAGES EVENT

A two day **Strategic Linkages Event** was held in Lilongwe on April 23-24, 2007, serving as a key data collection mechanism for gathering information on sector-wide collaboration. Over 45 civil society participants were joined by representatives from USAID, the NAC and several international NGOs. As part of the event, attendees participated in an Organizational Network Analysis survey (Annex D) that allowed us to map out and explore the complex web of relationships between civil society organizations, donors, and other key actors in the HIV/AIDS sector in Malawi. In addition to data collection, the event provided a springboard to highlight the value of collaboration and catalyze networking between key actors in the Malawian HIV/AIDS response. A list of organizational participants in the Strategic Linkage Event is included in Annex E.

## **D. KEY INFORMANT INTERVIEWS**

In order to supplement data collected through the outreach and strategic linkages events, key informant interviews were completed with the following participants considered to be key actors in the coordination of the civil society response to HIV/AIDS:

- Godfrey Chitsanthi – the Umbrella Project (National AIDS Commission)
- Ethel Kapyepye – World Vision, Malawi
- Carrie Osbourne and Lesley Holst – Save the Children, Malawi

These interviews focused primarily of issues of HIV/AIDS coordination, CSO capacities and opportunities for civil society moving forward.

## **4. Profiles of CSOs Working in the HIV/AIDS Sector in Malawi**

**CHAPTER HIGHLIGHTS - The following list highlights key findings related to profile and distribution of CSOs responding to the HIV/AIDS pandemic.**

- The majority of organizations involved in the civil society response to HIV/AIDS in Malawi are small Community Based Organizations, usually run by volunteers. Local NGOs make up a relatively small percentage of the Malawian civil society response to HIV/AIDS.
- Larger and more established CSOs appear to cluster their operations around urban centers, suggesting that rural communities may be underserved.
- CSOs operating in the Southern and Central Regions are more established, with larger staff and greater resources, than their Northern counterparts.
- Many CSOs within Malawi have shifted from their original missions to focus on HIV/AIDS. In some cases this move is issue driven, in others it is resource driven. Many stakeholders spoke of the existence of "briefcase CSOs" that exist to access funding rather than to benefit communities.
- Malawian CSOs are currently very active in providing services related to the care and support of those infected and affected by HIV/AIDS, and the prevention of HIV/AIDS. They are much less active in the provision of more technical services related to testing and counseling and the medical treatment of HIV and other sexually transmitted infections.
- CSOs are offering technical services related to treatment, testing and counseling, and impact mitigation, tend to be clustered around urban centers. This may be because more established and/or agile CSOs are operating in these districts.

### **Distribution of Organizations Responding to HIV/AIDS**

Figure 3, on the following page, shows the distribution of CSOs and other organizations engaged in the fight against HIV/AIDS in Malawi.

From this table, we can see that in all three regions, CBOs greatly outnumber all other organizational types. Conversely, local NGOs make up a relatively small percentage of the Malawian civil society response to HIV/AIDS. These more established organizations are clustered primarily in districts with large urban centers – Mzimba, Lilongwe and Blantyre – and are limited in number in the rural districts of Malawi. International NGOs are also more active in the urban districts, and have higher prevalence in the Southern and Central Regions, than in the Northern Region.

**Figure 3: Malawian CSO's and Other Organizations Engaged in the Fight Against HIV/AIDS<sup>12</sup>**

District	CBO	LNGO (Upcoming)	LNGO (Established)	INGO	Government	Total
Chitipa	8	0	1	0	1	10
Karonga	26	1	0	0	1	28
Mzimba	20	0	5	6	6	37
Nkhata Bay	22	3	3	1	1	30
Likoma	9	1	0	0	1	11
Rumphu	19	0	4	0	3	26
<b>Total Northern Region</b>	<b>104 (73%)</b>	<b>5 (4%)</b>	<b>13 (9%)</b>	<b>7 (5%)</b>	<b>13 (9%)</b>	<b>142</b>
Dedza	20	0	1	0	0	21
Dowa	12	0	1	0	1	14
Kasungu	20	1	1	2	2	26
Lilongwe	22	2	6	4	3	37
Mchinji	19	0	1	0	2	22
Nkhotakota	14	0	2	4	0	20
Ntcheu	14	0	1	5	1	21
Ntchisi	5	0	3	0	1	9
Salima	29	0	2	0	1	32
<b>Total Central Region</b>	<b>155 (77%)</b>	<b>3 (2%)</b>	<b>18 (9%)</b>	<b>15 (7%)</b>	<b>11 (5%)</b>	<b>202</b>
Balaka	1	0	3	1	1	6
Blantyre	28	0	13	6	3	50
Chikwawa	3	0	1	1	1	6
Chiradzulu	22	0	0	0	0	22
Mahinga	10	0	0	0	1	11
Mangochi	15	0	1	3	2	21
Mulanje	11	0	2	1	2	16
Mwanza	0	0	1	2	1	4
Nsanje	7	2	4	2	4	19
Pholmbe	24	0	1	0	1	26
Thyolo	10	0	0	0	0	10
Zomba	11	1	2	3	1	18
<b>Total Southern Region</b>	<b>142 (68%)</b>	<b>3 (2%)</b>	<b>28 (13%)</b>	<b>19 (9%)</b>	<b>17 (8%)</b>	<b>209</b>
<b>Overall Total</b>	<b>401</b>	<b>11</b>	<b>59</b>	<b>41</b>	<b>41</b>	<b>553</b>

Using this directory, we are able to map the prevalence of HIV/AIDS CSOs at the district level. Figure 4, on the following page, shows the number of CBOs, upcoming local NGOs and established local NGOs operating in the HIV/AIDS sector in the each of the 27 districts of Malawi. The following observations can be drawn from this information:

<sup>12</sup> Data was collected through outreach visits to each of the 27 District Aids Commissioners in Malawi and represents the most comprehensive mapping exercise of CSO activity completed in Malawi to date. The table uses the following typology for CSOs and non-CSOs:

**Malawian Civil Society Organizations:**

**CBOs** – Small and mostly informal organizations, reliant upon community volunteers; have limited capacity to undertake technical tasks

**Upcoming NGOs** – Local Malawian organizations that are registered and active within the community, but still struggling for survival

**Established NGOs** - Local Malawian organizations that are registered and have operated actively for several years

**Non-Civil Society Organizations:**

**International NGOs** – Organizations primarily headquartered in developed countries but operating locally and registered with the DAC

**Government Institutions** – Government agencies/ departments registered with DAC; provide HIV/AIDS services to local communities

- Each of the three districts with large urban centers – Lilongwe, Blantyre and Mzimba (Mzuzu) – has a relatively high concentration of CSOs. These three districts are among those with the highest concentration of CSOs.
- There appear to be larger numbers of CSOs operating in the Northern and Central Regions of Malawi, with fewer in the Southern Region, particularly in the districts of Balaka, Mzimba and Chikwawa where the DAC reported five or fewer CSOs actively participating in the HIV/AIDS response.

In reality, the patterns of CSO prevalence reported in Figure 4 may reflect more upon the varying registration policies and effectiveness of individual DACs, rather than of actual levels of CSO activity. This is an important area for additional follow-up.

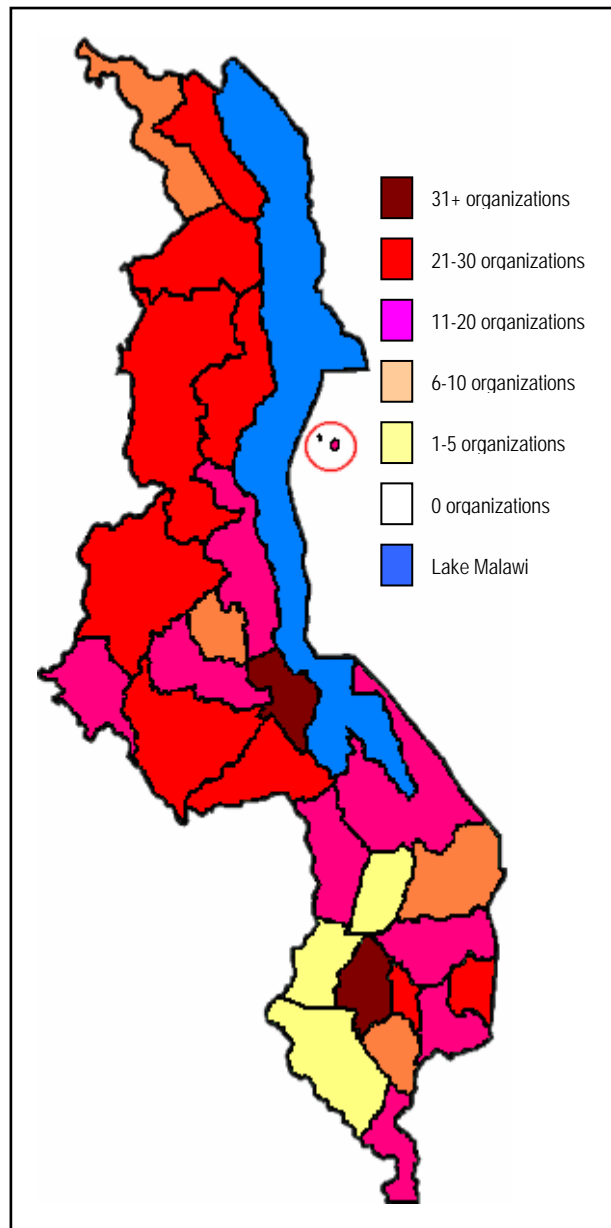
### CSO Biographical Data

In order to generate a greater understanding about the profile of CSOs involved in the response to HIV/AIDS in Malawi, biographical data was collected during outreach visits to 42 CSOs operating countrywide. Participant organizations were distributed across the three Regions – Northern (11), Central (15), and Southern (16) – and were chosen to participate based on their high level of activity, and potential as leaders of the civil society response to HIV/AIDS.

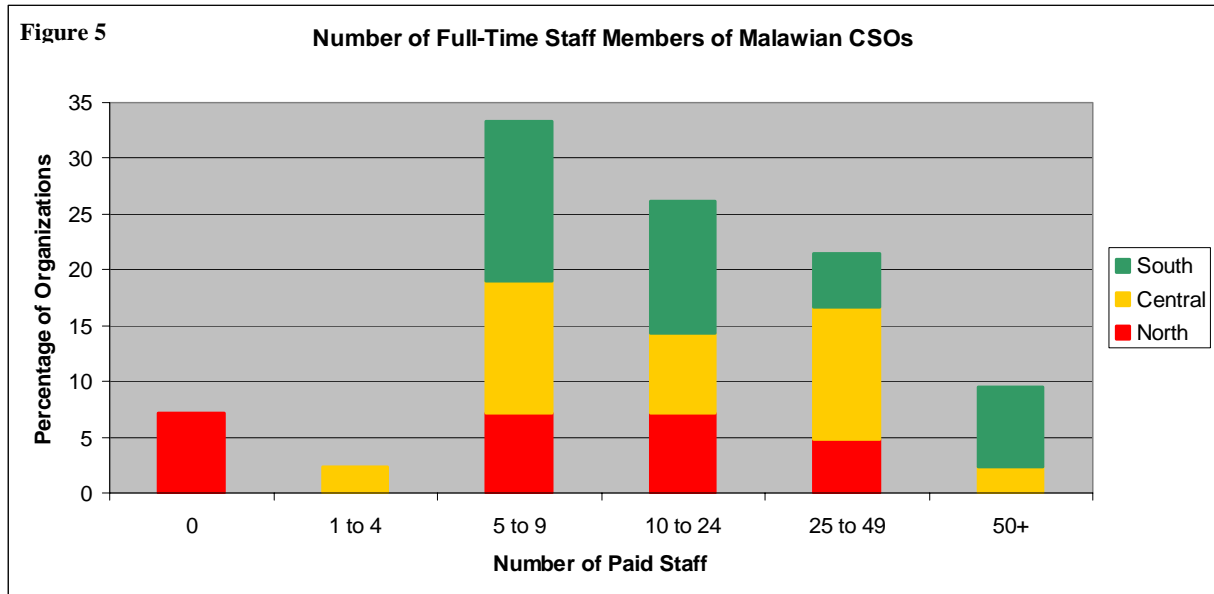
Figure 5 shows the number of paid staff working at participant CSOs. Among these lead organizations, there is striking variation in staff size. The modal group of CSOs has between 5 and 9 staff. However, over 50% of organizations have ten or more staff and nearly 10% have more than 50 staff. This is in great contrast to the 7% of organizations that are unable to employ any staff and rely solely on the contributions of volunteers.

There is a strong regional pattern of CSO size. The North is characterized by smaller organizations, all of the CSOs with no paid staff, and none of the organizations with 50+ paid staff are from this region. By contrast, the Central and Southern Regions are similar, dominated by mid-size CSOs with between 5 and 50 paid staff.

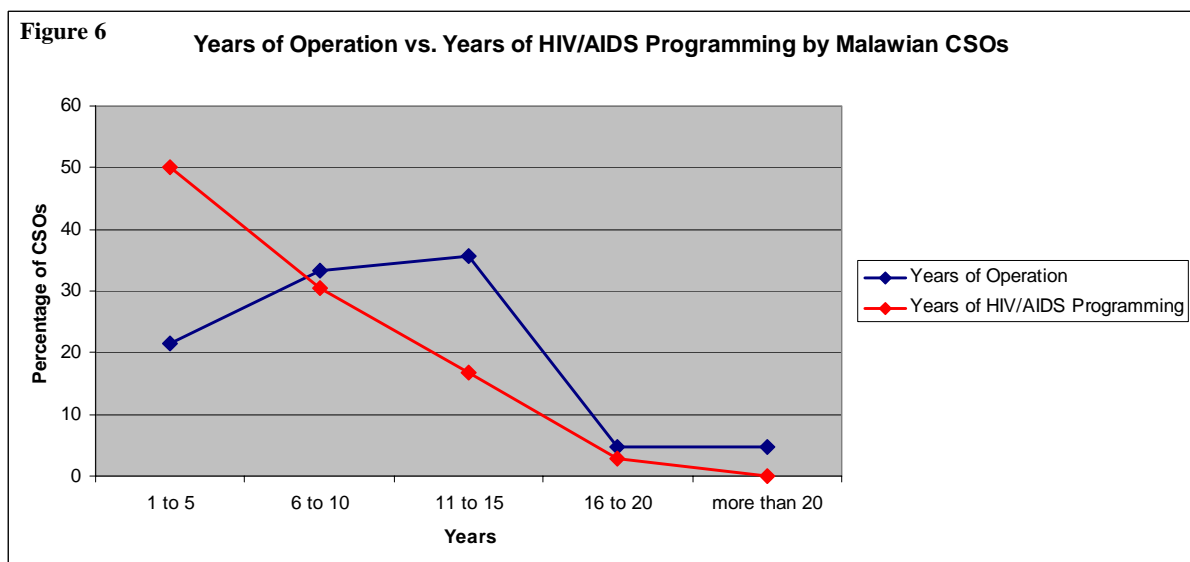
Figure 4



This pattern of larger, more established organizations in the Southern and Central Regions is supported by data related to resource mobilization. The median size of the largest grants awarded to participant CSOs from the Southern and Central Regions is \$110,714 and \$142,857 respectively. By contrast, the equivalent figure for CSOs operating in the Northern Region is \$35,714 – less than one-third of the amount for the other two regions.<sup>13</sup>



In addition to looking at the staff size and financial history of CSOs, the outreach visits also collected data around the longevity of organizations, and their history of HIV/AIDS programming. Figure 6 summarizes this data, comparing CSO years of operation with years of HIV/AIDS programming.



CSOs in the modal group of organizations are relatively well established, having been in operation for between eleven and fifteen years. There are a large number of newer

<sup>13</sup> The data for Figures 5 and 6 was collected from the 42 organizations that participated in the biographical section of ROS interviews.

organizations, however, and over 50% of participants began operations during the last decade. About 10% of organizations have existed for sixteen years or longer, and about half of these have been operating for over twenty years.

The pattern for years of HIV/AIDS programming is very different. Only around 20% of CSOs have been performing HIV/AIDS related services for longer than a decade, none for more than twenty years, and exactly 50% of those polled have been operating in the sector for five years or less.

This pattern is relatively common in international development. Where there is a large influx of external resources directed towards a particular sector or issue organizations will naturally seek to mobilize these resources. The results shown in Figure 6 indicate that even amongst these lead CSOs a large number shifted their focus to HIV/AIDS activities. What is not clear is whether this shift was primarily issue driven or resource driven. Certainly, conversations with stakeholders revealed an ongoing challenge related to “briefcase CSOs”, organizations that form primarily to pursue funding rather than to represent the interests of their broader community.

While the formation of new CSOs to address the growing threat of HIV/AIDS is both desirable and inevitable, a review of the literature highlights concerns that a number of recently emergent organizations may not be utilizing donor funds prudently.<sup>14</sup> Since the arrival of the Global Fund in 2002, these concerns have grown. A large shift in focus of both donors and development agencies to HIV/AIDS over the last few years has meant that fewer dollars are available for other development areas including general health, education, and economic opportunities.

### **Sectoral Focus of CSOs**

Through the National AIDS Framework, Malawian CSOs are engaged in a variety of HIV/AIDS activities. For the purposes of this study, Pact has disaggregated these into seven technical service areas:

1. **Care and Support** – improving the quality of life of those infected and affected by HIV/AIDS through increased access to improved and holistic health treatment for persons infected with HIV. This includes medical and non-medical support services delivered through home- and clinic-based care, as well as support for orphans and vulnerable children.
2. **Treatment** – the provision of medical treatment such as antiretroviral therapy, as well as diagnosis and treatment of sexually transmitted infections and opportunistic infections.
3. **Testing and Counseling** – strengthening and promoting access to ethically sound voluntary counseling and testing services in order to reduce the transmission of HIV and impact of HIV/AIDS.
4. **Prevention** – reducing the incidence of HIV and sexually transmitted infections

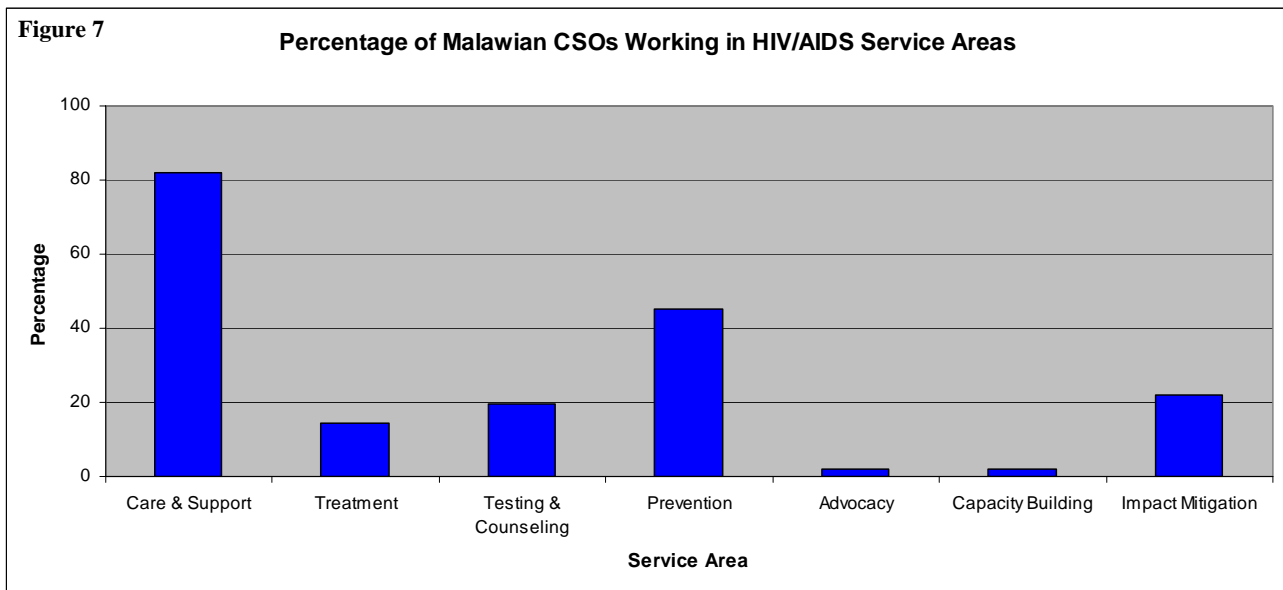
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<sup>14</sup> Mtonya, Brian et al. October 2005. *System-Wide Effects of the Global Fund in Malawi: Baseline Study Report*. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.

through behavior change interventions and knowledge sharing. Prevention activities include the promotion of abstinence and faithfulness, condom distribution, and the prevention of mother to child transmission.

5. **Advocacy** – use of collaboration and networking to influence decision-making related to HIV/AIDS policies, programs, and practices.
6. **Capacity Building** – strengthening the organizational and technical capacities of institutions to respond to the HIV/AIDS epidemic at all levels.
7. **Impact Mitigation** – developing appropriate strategies to minimize the impact of HIV/AIDS on the infected and affected, including support in implementing income generating activities and community gardens. Also includes activities aimed at reducing stigma, discrimination and denial for persons living with HIV/AIDS.

Figure 7 shows the percentage of Malawian CSOs, included in the directory, that identify themselves as operating within each of the seven HIV/AIDS technical service areas. CSOs were allowed to choose all of the service areas that they operate in, so the results for one service area are not contingent on the results of others. From the graph we can see that the most common service type are Care and Support services, performed by over 80% of CSOs. The majority of these services are related to the provision of home based care and support services to orphans and vulnerable children.



HIV/AIDS Prevention activities – including community awareness and condom distribution – are being undertaken by a little over 40% of organizations, while around 20% are engaged in the provision of Impact Mitigation and Testing and Counseling services. Smaller cadres of CSOs are involved in the more technical areas of HIV/AIDS Treatment (14%), Advocacy (2%), and Capacity Building service provision (2%).

These results reinforce findings from the Global Fund study which states that “most NGOs are involved largely in activities such as behavior change and care/support and short-term

impact mitigation, while with the exception of a few larger NGOs..., NGO involvement in treatment and HTC efforts are limited.”<sup>15</sup>

Discussions with stakeholders and key informants revealed two potential explanations for this pattern. Firstly, as noted earlier, the majority of Malawian CSOs are small CBOs, staffed primarily by community volunteers. These organizations are much better suited to performing labor intensive services related to Care and Support, Prevention and Impact Mitigation than more technical services related to Testing and Counseling, Treatment, Advocacy, and organizational Capacity Building. Secondly, historically, the Government of Malawi and international actors have played lead roles in the provision of the more complex technical services. Only relatively recently have CSOs been asked to fill gaps in the existing delivery of these services.

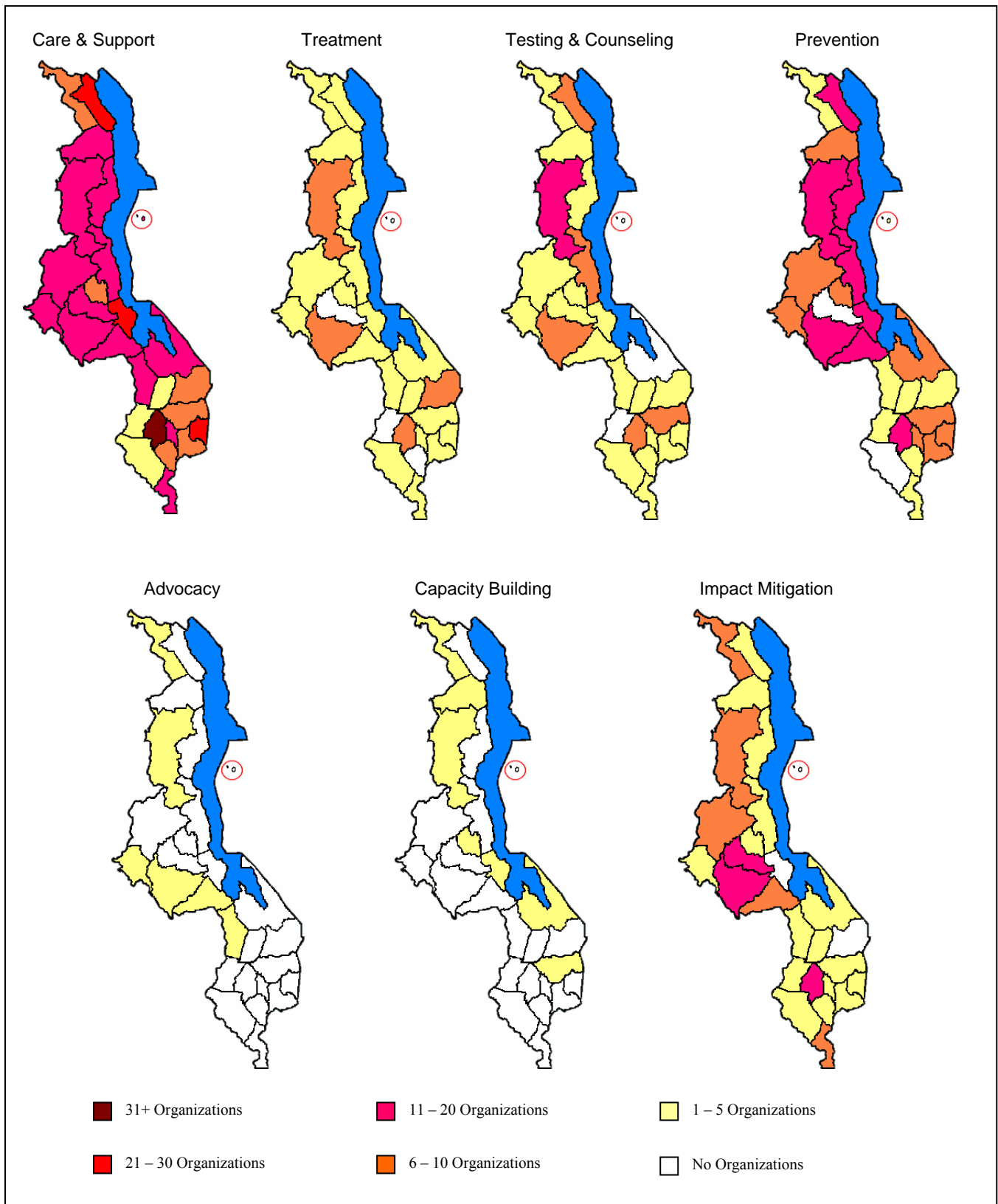
Sectoral activity can also be disaggregated into regional and district level patterns (Figure 8). The maps confirm the wide coverage of Care and Support, Prevention and Impact Mitigation and the particularly sparse coverage of Advocacy and Capacity Building services.

One of the more interesting features of these maps is that they show how some of the more technical services are clustered within the urban districts. Larger numbers of CSOs are performing technical Treatment, Testing and Counseling and Impact Mitigation services in the urban districts of Lilongwe, Blantyre and Mzimba than in the majority of other districts. This may be because larger, more established, NGOs are based in these cities. Alternatively, it may be because organizations operating in these districts are more agile at moving into new service areas than their rural counterparts.

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<sup>15</sup> Mtonya, Brian, Victor Mwapasa, and John Kadzandira. October 2005. *System-Wide Effects of the Global Fund in Malawi: Baseline Study Report*. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.

Figure 8



## 5. Capacity of Malawian CSOs Responding to HIV/AIDS

**CHAPTER HIGHLIGHTS - The following list highlights key findings related to the core organizational and technical capacities of Malawian CSOs involved in HIV/AIDS service provision.**

- CSOs generally report high capacities in the core capacity areas of Mission and Strategy, Financial Management, Human Resources, Leadership and Governance, Accountability, and Service Delivery.
- The greatest core capacity issues reported by CSOs are those related to human resources challenges brought about by the HIV/AIDS pandemic. Governance and volunteer mobilization challenges were also highlighted.
- The technical capacities reported by CSOs are generally much lower than core organizational capacities. This is particularly true for the service areas of Testing and Counseling, Advocacy and Capacity Building.
- Today, there are increasing demands upon Malawian CSOs to fill service gaps, particularly in the technical area of Testing & Counseling where civil society currently plays a key support role in several other Southern African countries.
- Both technical and core organizational capacities of CSOs in the Northern Region are lower than their counterparts in the Southern and Central Regions.
- Although there are many capacity related challenges facing CSOs, stakeholders were also able to cite a number of opportunities within the current environment, including cooperation facilitated by DACCs and the impact of debt relief.

### Previous Civil Society Capacity Assessments

A review of existing literature on the capacity of Malawian CSOs revealed limited quantitative information describing the degree to which civil society in general is delivering high quality, accessible services. Some reports, however, did provide insights into service quality for small subsets of CSOs and/or offered “big picture” themes.

For example, according to the mid-term evaluation report of Save the Children’s Capacity Building for Quality HIV/AIDS Services (Umoyo Network)<sup>16</sup>, “the Network, through a pragmatic, flexible, ‘hands on’ approach to training and mentoring, has succeeded in demonstrably increasing the professionalism and reach of key group of Malawian NGOs.” While this is a promising finding, it refers only to a small group of organizations and is not representative of Malawian CSOs in general. Nor does it supply data that defines what “demonstrably increasing the professionalism” actually means.

A second report, *System-Wide Effects of the Global Fund in Malawi: Baseline Study Report*, is less positive, noting that the civil society sector in Malawi, “is seriously underdeveloped – with limited infrastructure and inadequate ability to access necessary resources.”<sup>17</sup> Again, although this conclusion highlights a potential capacity pattern, it neither tells us about

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<sup>16</sup> Capps, Jean Meyer, Putnam, Jr., Eliot T., and von Briesen Lewis, Ann. *Mid-Term Evaluation Report: Save the Children’s Capacity Building for Quality HIV/AIDS Services (Umoyo Network)*. June 2005.

<sup>17</sup> Mtonya, Brian, et al. (2005) *System-Wide Effects of the Global Fund in Malawi: Baseline Study Report*. Bethesda, MD p38

particular strengths and weaknesses, nor offers any practical suggestions for building a stronger civil society.

### **The Rapid Organizational Scan (ROS)**

In order to obtain more comprehensive data on the capacities of Malawian CSOs, Pact and CADECO customized a Rapid Organizational Scan, which was used with the 42 CSOs participating in individual outreach visits. This capacity assessment tool (included in Annex B) is based upon the theoretical underpinnings of the Human Resources School of organizational development, shaped by Abraham Maslow and Frederick Herzberg.<sup>18</sup>

The tool was split into two complementary sections. The first section focused on core organizational capacities, issues of organizational management that apply broadly to any CSO regardless of their technical and sectoral focus. The second section focused on technical capacities, issues related to specific service delivery functions. Each of these sections was subdivided into a number of capacity areas. These capacity areas, defined below, represent functions that an organization must excel at in order to perform effectively. They were chosen based upon over a decade of Pact expertise working to assess CSO capacities worldwide.

#### **1. Core Capacities**

- **Mission and Strategy:** The extent to which an organization has a clearly defined mission, vision and strategy that informs its operations.
- **Financial Management:** The extent to which an organization has in place strong mechanisms for accounting, budgeting and financial reporting, and whether an organization is audited on a regular basis.
- **Human Resources:** The extent to which an organization is successful in recruiting, training, compensating and retaining staff, particularly given the challenges resulting from the HIV/AIDS pandemic.
- **Leadership and Governance:** The extent to which opportunities for strong leaders, and has an active board of directors that is representative of its constituency.
- **Accountability:** The extent to which an organization has strong monitoring and evaluation and reporting systems, and the extent to which it is accountable to donors and beneficiaries alike.
- **Service Delivery:** The extent to which an organization effectively and efficiently carries out its services through all phases of the project cycle.

#### **2. Technical Capacities**

- **Care and Support:** The extent to which an organization is effectively able to improve the quality of life of those infected and affected by HIV/AIDS through increased access to improved and holistic health treatment.
- **Treatment:** The extent to which an organization is effectively able to provide medical treatment such as antiretroviral therapy, as well as diagnose and treat sexually transmitted infections and opportunistic infections.
- **Testing and Counseling:** The extent to which an organization is effectively able to strengthen and promote access to ethically sound HTC services in order to reduce the transmission of HIV and impact of HIV/AIDS.

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<sup>18</sup> American psychologist Abraham Maslow is best known for his theory of human motivation, which led to a therapeutic technique known as self-actualization. Together Maslow and psychologist Frederick Herzberg developed several theories related to work factors and employee motivation.

- Prevention: The extent to which an organization is effectively able to reduce the incidence of HIV and sexually transmitted infections through behavior change interventions and knowledge sharing.
- Advocacy: The extent to which an organization is effectively able to use collaboration and networking to influence decision-making related to HIV/AIDS policies, programs, and practices.
- Capacity Building: The extent to which an organization is effectively able to strengthen the organizational and technical capacities of institutions to respond to the HIV/AIDS epidemic at all levels.
- Impact Mitigation: The extent to which an organization is effectively able to minimize the impact of HIV/AIDS on the infected and affected.

In order to ensure maximum accuracy, the ROS was conducted as a semi-structured interview, with clarification and supporting documentation requested where appropriate. The results, therefore, reflect a balance between the self-reporting of organizational participants, and the expert opinions of interviewers with decades of experience in organizational capacity building. Questions around the seven technical capacity areas were asked only when an organization reported offering services in that area.

Average capacity scores for each area were calculated using the results of the ROS, and are reported as an index score of between 0 and 1.<sup>19</sup> Figure 9 defines scores within a given range.

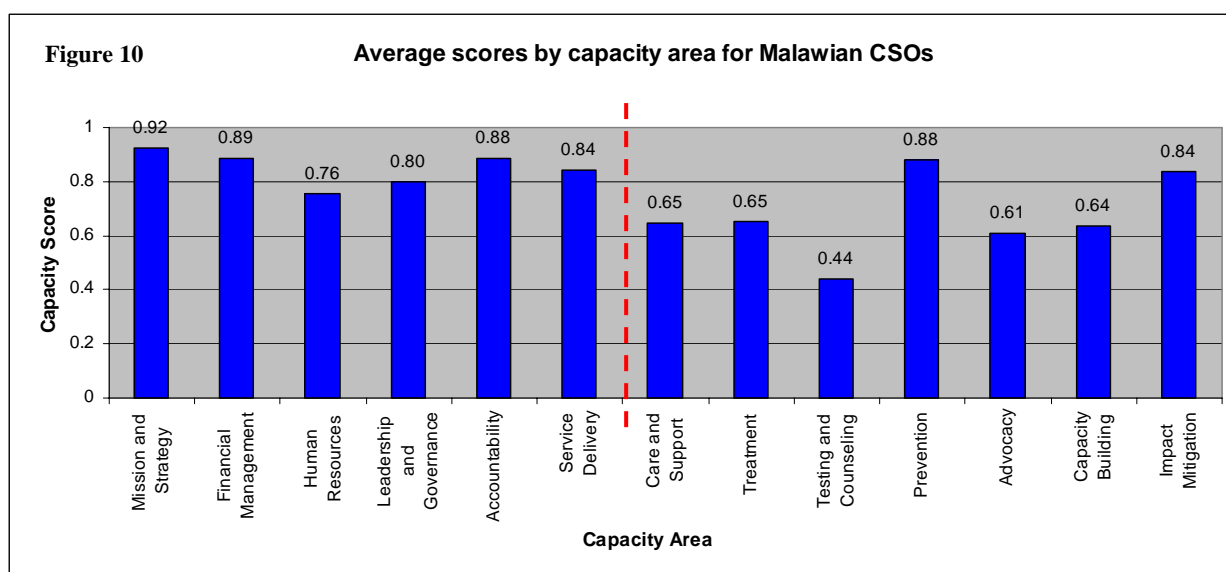
**Figure 9**

Capacity Score	Meaning <sup>20</sup>
0.95 - 1.00	CSO's reported capacities greatly exceed acceptable performance standards in this area
0.85 - 0.94	CSO's reported capacities exceed acceptable performance standards in this area
0.65 - 0.84	CSO's reported capacities meet acceptable performance standards in this area
0.35 - 0.64	CSO's capacities are below acceptable performance standards in this area
0.00 - 0.34	CSO reports little or no capacity in this area

Figure 10, on the following page, shows average scores for each capacity area across all of the CSOs participating in ROS interviews. In general, we can see that organizations report higher capacity in core capacity areas (the six bars to the left of the dotted line) and lower capacity in technical capacity areas (the seven bars to the right of the dotted line).

<sup>19</sup> Index score is calculated using the following formula: [Capacity Index Score = (Average ROS Score – 1) / 2]

<sup>20</sup> The techniques that form the theoretical basis of the ROS were developed by applied social scientists in the early 20<sup>th</sup> century. This early survey research was later refined by Rensis Likert, who between 1950 and 1970, refined the use of written survey questionnaires to collect information about an organization and its problems, and to stimulate joint planning. The vast majority of today's organizational assessment tools including the ROS are built on the foundation of Likert's pioneering survey testing.



### Core Capacity of CSOs

Although the highest capacity score was not achieved by any organization in any of the six core capacity areas, organizations do report above acceptable performance standards in three areas – Mission and Strategy, Financial Management and Accountability – and acceptable performance in the remaining three core areas – Service Delivery, Leadership and Governance. These results indicate that the majority of CSO participants understand what it takes to be a high-performing organization, and meet the majority of basic operating standards.

The following table, Figure 11, shows the highest scoring indicators for the six core capacity areas. Over half of these high performing indicators fall under the Mission Strategy capacity area. Most of these higher scoring indicators are basic yes/no issues, such as whether an organization has a mission statement, or is formally registered. Some of the other high scoring indicators – those related to accountability mechanisms and the relationship between an organization’s mission and its projects – are much more complex, however, and it would be interesting to see whether these scores would vary under a more comprehensive capacity assessment, such as Pact’s Organizational Capacity Assessment (OCA).

**Figure 11**

Rank	Indicator	Capacity Area	Capacity Score
1	The organization has a written mission statement	Mission & Strategy	0.96
2	The organization is formally registered	Mission & Strategy	0.95
3	The organization has mechanisms to ensure accountability to donors	Accountability	0.94
4=	Staff and volunteers are familiar with the mission of the organization	Mission & Strategy	0.93
4=	The day-to-day projects of the organization are directly related to its mission	Mission & Strategy	0.93
4=	The organization regularly prepares financial reports	Financial Management	0.93
4=	Staff members have written job descriptions	Human Resources	0.93

The second table (Figure 12) shows the core capacity indicators for which CSO participants recorded the lowest scores. Three of these five indicators are in the Human Resources capacity area. These results highlight several key challenges facing Malawian CSOs – many of which have been recognized in previous reports on the national HIV/AIDS response.

Figure 12

Rank	Indicator	Capacity Area	Capacity Score
1	The organization has successfully dealt with human resources challenges resulting directly from the HIV/AIDS pandemic	Human Resources	0.57
2=	Volunteers/members are adequately compensated for their efforts (cash/in-kind)	Human Resources	0.60
2=	The composition of the board of directors – in terms of PLWHA – is representative of the broader community	Leadership & Governance	0.60
4	Volunteers/staff receive regular refresher trainings to ensure they have the proper skills to complete their assigned duties	Human Resources	0.68
5	The organization maintains confidentiality for all clients	Service Delivery	0.78

These results confirm that most CSOs are struggling to deal with the human resource challenges brought about by HIV/AIDS, a result in line with the conclusions of several recent reports. According to a 2005 study by Rick James of INTRAC<sup>21</sup>, the impacts of HIV/AIDS on the human resources of Malawian CSOs can be felt at three levels:

- *Program performance* – program activities are superseded by funerals, former volunteers are focusing their attention on their own families, and previously successful models such as self-help groups are dismantled by reduced participation and instability.
- *External relationships* – donor priorities are shifting to HIV/AIDS and leaving a “vacuum” of services in non-HIV/AIDS sectors; and government entities are becoming more involved in the coordination of HIV/AIDS activities but often not performing this role effectively.
- *Internal organizational functioning* – generally small resource pools mean that the reduced productivity of CSO staff has a greater effect and that long-term medical coverage is lacking; the death of staff members contributes to a type of “organizational depression” and also to the loss of institutional memory; leaders are overextended, overburdened, and in the position of trying to maintain people-centered organizational values while also ensuring the sustainability of the organization.

This challenge is exacerbated by the "brain drain" of qualified health professionals working in the HIV/AIDS sector who are moving to take jobs in developed countries. Trained professionals are leaving faster than the government is able to replace them. Low salaries, poor working conditions, and a lack of drugs and medical supplies for medical workers are largely to blame. In addition, many health care workers in Malawi have become sick with HIV/AIDS or have died. This has left Malawi with only 156 public sector doctors, of whom 81 work in central hospitals—leaving some districts without a single doctor.<sup>22</sup> The Malawian Ministry of Health reports a vacancy ratio close to 100 percent for surgeons and various types of doctors. It also notes a severe shortage of nurses—with 64 percent of established posts

<sup>21</sup> James, Rick. *Building Organisational Resilience to HIV/AIDS*. March, 2005.

<sup>22</sup> Record, Richard & Mohiddin, Abdu. *An Economic Perspective on Malawi's Medical "Brain Drain."* Globalization and Health 2006, 2:12. December, 2006. <http://www.globalizationandhealth.com/content/2/1/12>

going unfilled. According to Atta Gbary, Africa adviser to the WHO on human resources and health, the severe shortage of health care workers in Malawi makes it impossible for CSOs to absorb funding at the rate provided, a comment reiterated in key informant interviews.<sup>23</sup>

A second issue area for CSOs highlighted by the ROS is the challenge of volunteer management. A 2006 USAID report analyzing community mobilization in Malawi supports this result. The study found that development actors provide varying levels of financial support to community volunteers during the initial stages of programmatic activities, but concluded that, “until all committee members and the community understand that they must tap internal resources, there is unlikely to be a genuine sense of ownership or responsibility” for projects.<sup>24</sup>

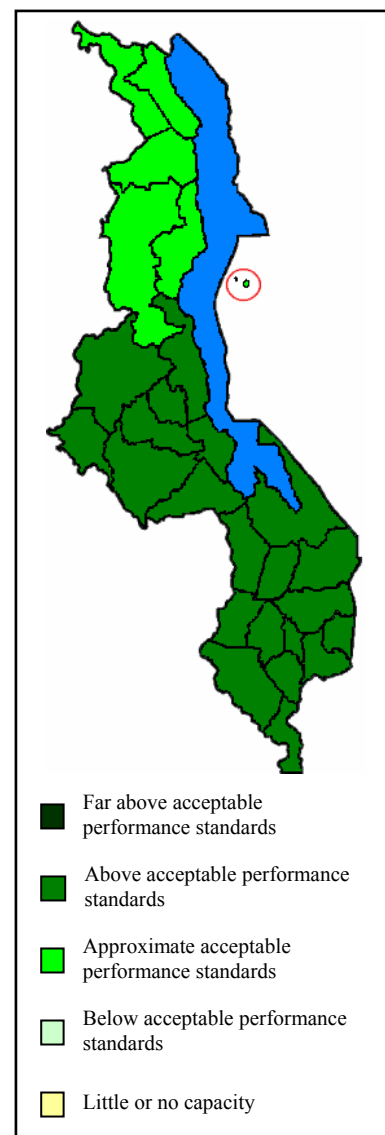
In addition to disaggregating the data by capacity area, we can also examine how CSO capacities vary by region<sup>25</sup>. Figure 13, shows the average scores across all six core capacity areas for CSOs operating in the three regions of Malawi – Northern, Central and Southern. From this map, we can see that in both Central and Southern Regions, the self-reported core capacities of CSOs are generally above acceptable performance standards. This is not the case in the Northern Region where reported core capacities are lower, approximating average performance standards.

The capacity gap between the Northern region and the remainder of the country was highlighted in key informant interviews. One interviewee noted that, “in general, there are more high capacity organizations in the south, followed by the center, followed by the north.” It was suggested that one reason for this may be because the Malawian Government was previously located in Blantyre in the South, before relocating to Lilongwe in the Central region in 1971, and that funding and services tend to cluster around where the Government is located. As a result, “the north tends to get left out. There are fewer NGOs in this region and now HIV/AIDS prevalence is increasing there.” This disparity between regions has been an issue for many years and is constantly cited in reports written by both local and external development actors.

Figure 14, on the following page, shows regional variation in capacity scores across all of the six core capacity areas. From these maps we can make the following observations:

- Self-reported capacity in the highest rated Mission and Strategy capacity area is above acceptable

Figure 13



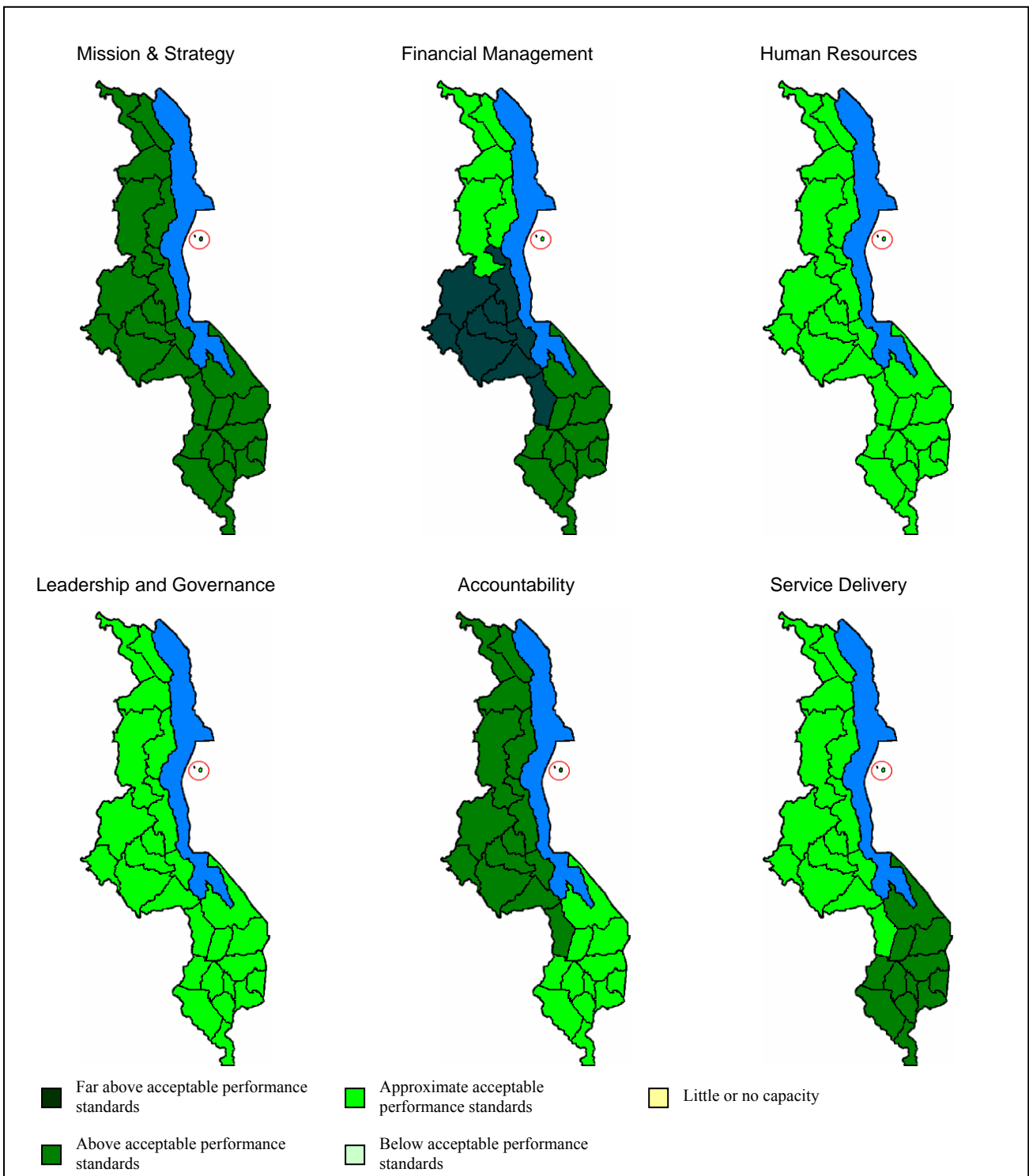
<sup>23</sup>Record et & Mohiddin. *An Economic Perspective on Malawi's Medical "Brain Drain."* Globalization and Health 2006, 2:12. December, 2006.

<sup>24</sup> Donahue, J., & Mwewa, L. (2006) Community Action and the Test of Time: Learning from Community Experiences and Perceptions

<sup>25</sup> Although the amount of data collected is sufficient for regional level analysis, in order to make meaningful observations at the district level, it would be necessary to perform significant additional data collection.

- performance standards in all three regions.
- Capacities reported in the lower rated Human Resources and Leadership and Governance capacity areas meet acceptable standards in all three regions – suggesting that these might be important areas of focus for a nationwide capacity building effort.
  - The data supports assertions about the low capacity of CSOs in the northern region. Only scores reported in the Accountability capacity area, go against this trend, and are lowest in the Southern Region.
  - None of the three regions reports “below acceptable performance” in any of the six core capacity areas. However, the high prevalence of average scores suggests that significant room for improvement exists.

Figure 14



## CSO Core Capacity Challenges and Opportunities

### Challenges

In addition to the quantitative data collected through the ROS interviews, qualitative data on CSO capacity challenges and opportunities was also collected from participants in regional outreach workshops. Without exception these focused on core capacity issues rather than challenges related to technical capacity.

The challenges cited by CSO participants greatly outnumbered opportunities, and are summarized by region and capacity area in the following table (Figure 15):

Figure 15

Capacity Area	Northern	Central	Southern
Mission and Strategy	<ul style="list-style-type: none"> <li>Inadequate and ineffective policies, systems and procedures to guide decision making in organizations</li> <li>Inadequate strategic thinking</li> <li>Poor planning</li> </ul>	<ul style="list-style-type: none"> <li>Lack of focus, often changing activities to get funding</li> <li>Implementation of strategic plans</li> </ul>	
Human Resources	<ul style="list-style-type: none"> <li>Inadequate technical capacity (skills and knowledge) on HIV/AIDS management</li> <li>Not valuing personal development among staff and volunteers</li> </ul>	<ul style="list-style-type: none"> <li>Inadequate skilled and competent personnel</li> <li>Inadequate human resources due to staff turnover and HIV</li> </ul>	<ul style="list-style-type: none"> <li>Inadequate skilled and competent personnel</li> </ul>
Leadership and Governance	<ul style="list-style-type: none"> <li>Poor leadership styles that tend to frustrate organizational and staff initiatives</li> </ul>	<ul style="list-style-type: none"> <li>Founder syndrome (The original leader dominates the organization) – producing internal challenges</li> </ul>	
Financial Management			<ul style="list-style-type: none"> <li>Inadequate capacity to handle large amounts of money</li> </ul>
Networking	<ul style="list-style-type: none"> <li>The North tends to be forgotten in national and other networking activities</li> </ul>	<ul style="list-style-type: none"> <li>Inadequate networking</li> <li>Lack of sharing culture amongst organizations</li> </ul>	
Information and Documentation	<ul style="list-style-type: none"> <li>Poor documentation and report writing skills</li> </ul>	<ul style="list-style-type: none"> <li>No documentation, consolidation of programs being implemented</li> </ul>	<ul style="list-style-type: none"> <li>Poor documentation, record keeping and dissemination capacities</li> </ul>
Culture			<ul style="list-style-type: none"> <li>Inability to effectively challenge deeply rooted cultural beliefs that promote the spread of HIV and AIDS</li> </ul>
Donor Issues		<ul style="list-style-type: none"> <li>Donor funding procedures that are complex and create delays</li> <li>Donor dependence for the CSOs</li> </ul>	
Monitoring and Evaluation		<ul style="list-style-type: none"> <li>Inadequate monitoring of services and programs</li> </ul>	

Many of the challenges raised by participants correlate closely to the capacity areas examined in ROS interviews. As was the case with the ROS results, Human Resources challenges were highlighted by participants in each of the three regions. In particular, a dearth of skilled and competent personnel, high staff turnover and a failure to value personal development were mentioned.

Leadership and Governance, another low scoring capacity area, was mentioned as a challenge by participants in both the Northern and Central Regions. Poor leadership styles and overzealous founders were noted as common challenges.

Somewhat surprisingly, and in contrast to the self-reported scores from the ROS, the Mission and Strategy capacity area was raised as a source of challenges for CSOs in both the Northern and Central region. Issues highlighted included ineffective systems for decision making, inadequate planning and strategic thinking, failure to implement strategic plans and donor driven decision-making.

Other capacity areas mentioned as challenges in one or more regions were those related to networking, report writing, handling large grants, deeply rooted cultural beliefs that hinder prevention strategies, donor funding procedures and monitoring and evaluation.

Challenges across the three regions are generally very similar. The only region-specific challenge was raised by participants in the Northern region who emphasized that they are often inadvertently excluded from national level networking initiatives – an observation that may be a partial explanation for the lower capacity in this region.

It is interesting to note that specific technical issues were not mentioned as capacity challenges by CSO participants. From this we might infer that challenges surrounding core capacity areas such as Human Resources, Leadership and Governance and Mission and Strategy are actually at the root of many of the service delivery challenges flagged by the ROS results. When deciding who to fund, donors may look first at technical capacity in HIV/AIDS, making CSOs eager to excel technically. Furthermore, the core capacity areas tend to be less understood and appreciated by CSOs and donors alike.

### **Opportunities**

Although limited in comparison to the broad range of capacity challenges, CSOs did report a number of opportunities related to capacity that exist at present in Malawi. These were as follows:

1. Forums such as DACCs provide space and time for CSOs to collaborate
2. CSO staff operate in good working conditions in comparison to government staff
3. Donor funding is highly accessible for HIV/AIDS activities
4. Most CSOs have developed strategic plans
5. Debt cancellation may eventually lead to government funded opportunities for CSOs
6. The Malawi Growth Development Strategy (MDGS), launched by the Government of Malawi in 2006 offers a strong guiding policy for CSO activities
7. CSOs are supported by good will from communities, as well as political will and commitment by government

### **Technical Capacity of CSOs**

The seven bars to the right of Figure 10 (page 25) show the average scores for Malawian CSOs in the seven technical capacity areas. We can see that, generally speaking, technical capacities of CSOs are much lower than core capacities.

There is only one technical capacity area – Prevention – in which average CSO capacities are above acceptable performance standards. Capacities in three of the remaining technical areas

– Impact Mitigation, Care and Support and Treatment – meet acceptable performance standards. However, technical capacities in Capacity Building, Advocacy and Testing and Counseling all fall below acceptable performance standards as reported by CSO participants.

An analysis of the indicator level data supports these conclusions. Of the five highest ranked indicators, shown in the table below (Figure 16), the top three relate to Prevention activities and the remaining two are related to Impact Mitigation. These results describe a cadre of CSOs that are particularly strong at delivering tailored messages around the prevention of HIV/AIDS and the reduction of HIV/AIDS related stigma and discrimination to targeted beneficiary populations.

**Figure 16**

<b>Rank</b>	<b>Indicator</b>	<b>Capacity Area</b>	<b>Capacity Score</b>
1	Prevention messages are provided in the local language of beneficiaries	Prevention	0.91
2	Prevention messages use the most up-to date and accurate information about HIV/AIDS	Prevention	0.90
3	Prevention messages are tailored to reach specific audiences	Prevention	0.87
4	The organization conducts education sessions to decrease stigma/discrimination in the community	Impact Mitigation	0.87
5	The organization works with health care providers to reduce discrimination	Impact Mitigation	0.86

Conversely, the six indicators with the lowest capacity scores (Figure 17) are all related to the technical areas of Treatment and Testing & Counseling. It is no surprise that these are service areas of low CSO capacity since they have traditionally been the domain of government actors. Today, however, there are increasing demands upon Malawian CSOs to fill service gaps, particularly in the technical area of Testing & Counseling where civil society currently plays a key support role in several other Southern African countries. This changing environment is evidenced by the highlighting of Testing & Counseling activities both as an underrepresented service area within the US Government’s Malawi portfolio, and as a priority activity on Pact’s 2007 Annual Program Statement.

**Figure 17**

<b>Rank</b>	<b>Indicator</b>	<b>Capacity Area</b>	<b>Capacity Score</b>
1	The organization uses safe needle protocols	Treatment	0.33
2	Counselors participate in regular training sessions	Testing & Counseling	0.44
3	Clients receive pre- and post-test counseling	Testing & Counseling	0.47
4	Counseled beneficiaries are always made aware of services available to them	Testing & Counseling	0.47
5=	Organization provides both medical and non-medical care and support services	Treatment	0.52
5=	The beneficiary’s right to privacy is always maintained	Testing & Counseling	0.52

As with core capacities, we can also look at variations in self-reported technical capacities across the three regions of Malawi. From Figure 18, we can immediately see that average technical capacities are lower across the entire country than core organizational capacities. Furthermore, the pattern of stronger organizations in the Southern and Central region, and weaker organizations in the North, is repeated in terms of technical capacity.

Organizations in the Southern and Central regions of Malawi meet acceptable performance standards in terms of their overall capacity. Their counterparts in Northern Malawi, however, report falling below acceptable performance standards. This indicates that while strengths exist in certain technical areas, Malawian CSOs face a number of serious challenges in providing high quality technical services.

Figure 19, on the following page, explores regional variation in greater depth, with individual maps for each of the seven service areas. From these maps, we can make the following observations:

- Capacities in Prevention, the strongest technical area, are above acceptable performance standards in all three regions. Impact Mitigation scores are similarly high, only falling to average in the Southern region.
- Scores in the technical area of Advocacy fall below acceptable performance standards nationwide.
- There are particularly large disparities in capacity scores between the Northern region and the remainder of the country in the Care and Support and Capacity Building technical areas.
- There is also significant regional variation in CSO capacities within the Testing and Counseling technical area. Capacities approximate acceptable performance standards in the South, are below acceptable standards in the North, and there is little or no capacity in the Central region.
- The prevalence of low CSO capacities across numerous technical areas suggests that there is a need to identify priority services to ensure focused capacity building efforts.

Figure 18

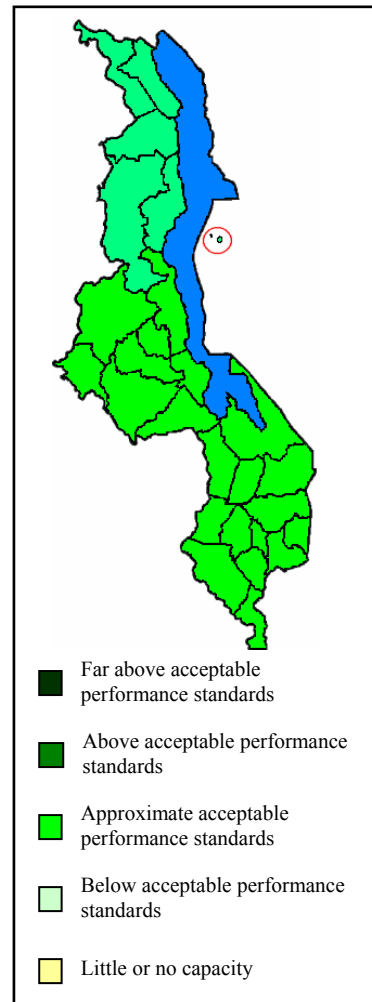
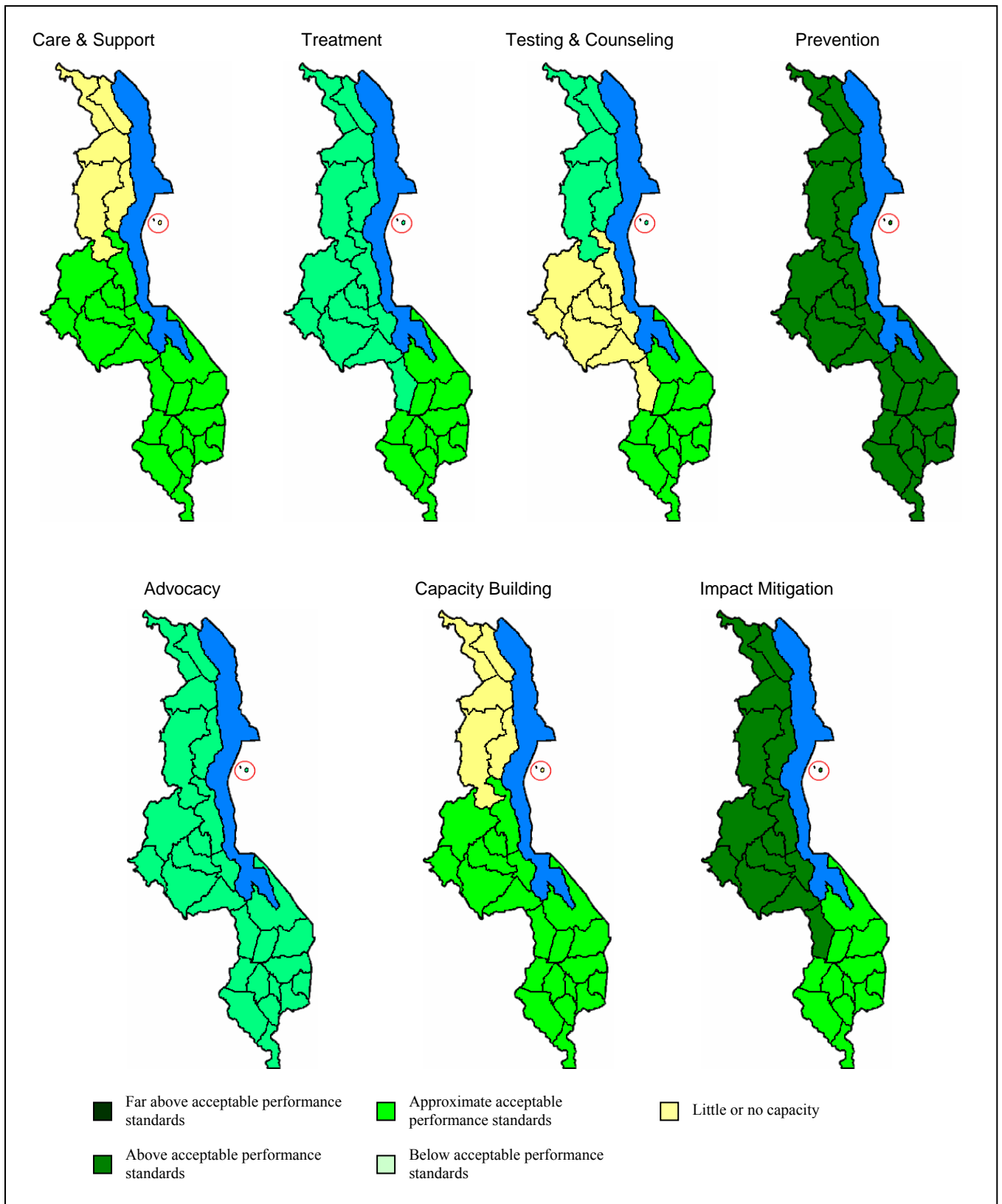


Figure 19



## **6. Coordinating Civil Society's Response to HIV/AIDS**

**CHAPTER HIGHLIGHTS - The following list highlights key findings related to the coordination of civil society's response to HIV/AIDS in Malawi.**

- The National AIDS Commission of Malawi is the primary national coordinating body for those organizations responding to HIV/AIDS. In order to provide grants management of basket funds and capacity building to CSOs, they developed the umbrella mechanism, contracting with five INGO partners.
- An evaluation of the first phase of the umbrella mechanism, completed in the summer of 2006, saw a major realignment with two INGOs dropping out and the NAC taking a more direct role in the management of 10 districts through the Umbrella Project.
- The second phase of the umbrella mechanism also heralds a change in capacity building strategy from a focus on the technical capacity of CSOs to a focus on the core organizational capacities of district assemblies and DACCs.
- Key actors in the HIV/AIDS response have a mixed reaction to the changes that have taken place since the summer of 2006. On a positive note, the NAC is commended as being a confident and well organized organization. However, there is a degree of apprehension surrounding the new structure of the Umbrella Project, particularly regarding how progress in the 10 districts will be monitored.
- The goal of the umbrella mechanism is to decentralize power to the district level in two years. However, there is widespread concern that capacities at the district level are insufficient for coping with this challenge.
- Certain districts have implemented initiatives to better serve civil society. In a successful example of this, the Blantyre City Assembly drew together civic groups and key stakeholders to pilot a collaborative effort to manage HIV/AIDS at the local level.
- At the community level, Community AIDS Coordinating Committees (CACCs) have great potential for mobilizing and coordinating CBOs. At present, however, because CBOs are funded at the district level they are disproportionately powerful, undermining the role played by CACCs.
- Networking organizations, such as MANASO, CONGOMA, MANET and NAPHAM, play a key role as connectors within civil society. As such they should be considered important stakeholders in any civil society strengthening initiative. However, they still have capacity challenges and require further assistance to achieve maximum effectiveness.
- In a discussion on donor-implementer relationships, stakeholders highlighted the importance of clear and effective communication, to increase the efficiency and impact of the national HIV/AIDS response.

### **National Level Coordination**

The National AIDS Commission of Malawi, established in 2001, is responsible for coordinating the national response to HIV/AIDS, mobilizing and disbursing resources from the Global Fund, and monitoring and evaluating progress of the national effort. The NAC is guided by the National Action Framework (NAF) – a 2005/09 strategic plan that guides program design and implementation at the national level.

The NAC works with public, private, and civil society sectors as the central coordinating body, and reports to the President and Cabinet through the Minister Responsible for HIV and AIDS. The Commission also works closely with the Malawi HIV & AIDS Partnership Forum, which provides technical advice; the Inter-Faith HIV/AIDS Association, which coordinates HIV/AIDS activities among FBOs; and the Business Coalition Against HIV/AIDS (MBCA), which coordinates the response in the private sector. Meanwhile, the Department of Human Resource Management and Development (DHRMD) coordinates the public sector response.

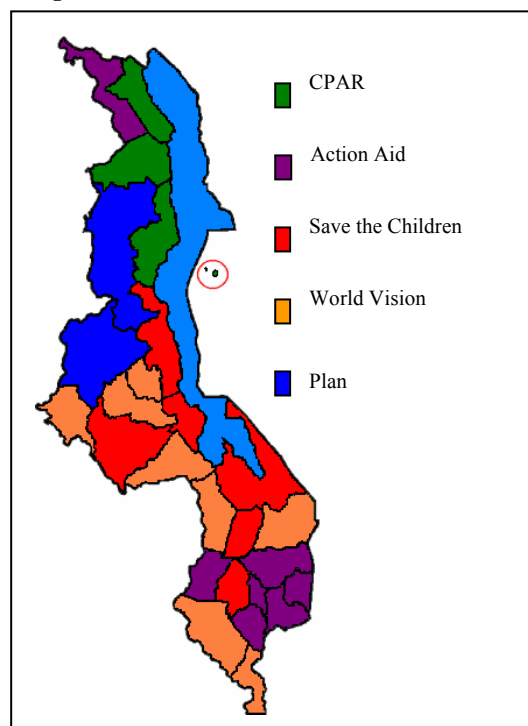
The funds managed by the NAC are a consolidation of resources provided by the World Bank, the governments of the United Kingdom, Norway and Canada and the government of Malawi, and represent the first-ever “basket fund” for HIV/AIDS in Africa. Because sub-granting capacity at both the national and district levels was severely limited, a single financial management agent was assigned to help manage grants in an accountable and transparent manner. Simultaneously, a search was initiated for umbrella organizations that would manage grants, build capacity, and monitor progress at decentralized levels – with the eventual aim of handing control over funding decisions to the district level.

Following a process through which proposals were solicited from experienced national and international NGOs, the NAC contracted with five organizations to manage the initial phase of funding, which ran from 2004-06. Despite the NAC's efforts to include larger national NGOs, the five successful umbrella organizations were all international NGOs, and included:

- Canadian Physicians for Aid and Relief (CPAR)
- Action Aid
- Save the Children (USA)
- PLAN International
- World Vision

The process by which the districts of Malawi were allocated to umbrella organizations resulted in the distribution shown in Figure 20. CPAR operated solely in the Northern districts of Likoma, Karonga, Rumphi and Nkhata Bay. Action Aid's districts were split between the two extremes of the country, the Southern districts of Mulanje, Thyolo, Phalombe, Mwanza, Chiradzulu and Zomba, and the northernmost district of Chitipa. Save the Children operated in the Central districts of Lilongwe, Nkhonkhotakota and Salima, and the Southern Districts of Balaka, Blantyre and Mangochi. World Vision also operated across the Central and Southern Regions in Dowa, Ntcheu, Machinga, Chikwawa, Nsanje, Mchinji, Ntchisi and Dedza. Finally, Plan International worked in the Northern District of Mzimba and neighboring Kasungu in the Central Region.

Figure 20



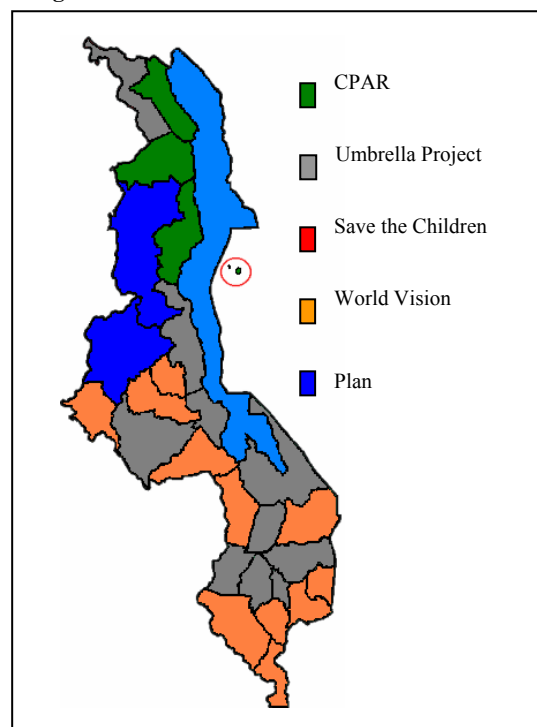
Between 2004 and 2006, the five UOs worked with District AIDS Coordinating Committees to submit proposals for local-level HIV/AIDS activities, based on district implementation plans. Once funding was received from the NAC, UOs worked with local CSOs in the preparation of district-level HIV/AIDS proposals for funded activities. UOs also provided capacity building services, training local CSOs in budgeting, finance, and project management. Moreover, they worked closely with DACCs to build capacities to carry out their roles ahead of the eventual handover of responsibility from the UOs to the district level.

An evaluation of the first phase of this strategy, carried out in July and August of 2006 found that although four of the UOs were broadly successful in their mandate (CPAR, Save the Children, Plan International and World Vision), Action Aid had performed comparatively poorly. As a result of this evaluation, Action Aid was removed as an umbrella organization, with World Vision and Save the Children earmarked to take over operations in these districts.

During the first phase of the project Save the Children had waived indirect costs in order to comply with NAC policy. However, with the additional burden of three extra districts, it was felt that the organization could no longer afford to waive these costs. When no compromise was reached, it was mutually agreed that Save the Children would pull out of the program, leaving 10 districts without an UO.

In order to administer these districts, the NAC set up a new quasi-independent umbrella unit within its own organizational structure. Initially, this unit was to be called the “NAC Umbrella Project”, however, the other UOs insisted that the new unit be as independent of the NAC as possible – for parity with INGO umbrellas. Hence, the new unit is now known as the “Umbrella Project” and the map of umbrella organization activity in Malawi has been revised to the distribution in Figure 21.

Figure 21



The nascent Umbrella Project is currently still in a building phase. Eventually, there will be a backstopping team of the project manager, an accountant, a monitoring and evaluation specialist, and a capacity building officer located in Lilongwe. The Project is also opening an office in Blantyre, since many of the districts they are responsible for are in the Southern Region of Malawi. In addition, district training teams will provide training in core capacities such as project management and financial management, and officers linked to the Umbrella Project will be based in individual DACC offices as coordinators and trainers.

In addition to the new distribution of umbrella organizations, the second phase of NAC funding, from 2006-2009, also brought a new capacity building strategy. First, there has been a change in the organizations targeted by capacity building efforts, from local CSOs to district assemblies. Second, there has been a change in the types of service provided, from technical training for HIV/AIDS service provision to development of core capacities in financial and grants management. These changes are intended to support the goal of devolving power to the district assemblies within two years. Key actors in the HIV/AIDS

response have mixed reactions to the changes that have taken place at the NAC since the summer of 2006.

On a positive note, the NAC is commended as being a confident and well organized organization. Interviewees noted that the NAC has been particularly strong at monitoring progress and results. The Commission also has a strong reputation for clamping down on corrupt practices. In February 2007, for example, the NAC suspended funding to 240 CBOs and 11 district authorities based on audit irregularities.

However, there is a degree of apprehension surrounding the new structure of the Umbrella Project. Firstly, the NAC's new role as implementer raises questions about who will monitor their activities and how they will monitor themselves. Secondly, capacity issues at the district level indicate that an early handover of responsibility to the DACCs is unlikely.

### **District and Community Level Coordination**

In 2005, as the original group of UOs were beginning their work, the government established a district-level system to coordinate and plan HIV/AIDS activities. Within each district, a District AIDS Coordinator heads this effort and works closely with the Ministry of Health (MOH) and the NAC to support the national HIV/AIDS response at the district level. The DAC also acts as secretary of the District AIDS Coordinating Committee. The DACC is made up of representatives from key ministries including Gender, Youth, Information, Health, and Education, as well as from NGOs and community based organizations.

The NAC's goal is to decentralize power to the district level. However, according to a 2005 Global Fund report, country-wide DACs and DACCs lack capacity in key technical areas and need more developed financial and logistical systems.<sup>26</sup> This sentiment was echoed by numerous stakeholders interviewed as part of this study who worry that district assemblies are not capable of taking on this responsibility at present.

Human resources are stretched thin at the local level and there are not enough administrative staff or trained trainers in most districts. This problem has been compounded by delayed local elections, which are likely to leave districts without local counselors through at least November 2007.

Certain districts have implemented initiatives to try to improve relationships with, and better serve, civil society. A case study of one of these district-level initiatives in Blantyre<sup>27</sup> states that historically there has been a deep level of mistrust between CSOs and the Blantyre City Assembly (BCA). In an effort to improve relations and better serve those affected by HIV/AIDS in Blantyre city, the BCA drew together civic groups and key stakeholders to pilot a collaborative effort to manage HIV/AIDS at the local level. The initiative has had some success including:

- BCA now works with 223 CBOs, NGOs, and FBOs on the HIV/AIDS program.

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<sup>26</sup> Mtonya, Brian, et al, (2005) System-Wide Effects of the Global Fund in Malawi: Baseline Study Report. Bethesda, MD p25.

<sup>27</sup> Bandawe, Lycester R., (2006) Managing HIV/AIDS at the Local Level in Africa, Project Outputs and Achievements, Malawi, Blantyre

- They have mapped all local CSOs according to their activity areas where related to HIV/AIDS and call on them to partner on BCA led initiatives when possible.
- Relations between the BCA and CSOs have improved.
- Increased community and PLWHA involvement has helped improve capacities at the Ward level, enabling community groups to develop project proposals and examine the cultural and socio-economic factors fuelling spread HIV and collectively come up with mitigation factors.
- District Implementation Plans on HIV/AIDS are now being prepared annually with contributions from all local civic groups and local communities and submitted to NAC for funding.

Additionally, according to the same study, the BCA has been able to help the National AIDS Commission and international donors distribute funds to local CBOs through the creation of the City Community HIV/AIDS Challenge Fund. This fund works to link NGOs, CBOs, FBOs and other community organizations to NAC for financial, technical, and capacity building support to help carry out HIV/AIDS activities at the local level. In one year, over US \$400,000 was disbursed to local Blantyre organizations through the Umoyo umbrella network (via Save the Children, US).

At the community level, Community AIDS Coordinating Committees are mandated to mobilize and coordinate CBOs. However, because CBOs are funded at the district level through the umbrella mechanism, they are disproportionately powerful. This undermines the CACC and has resulted in accountability issues. Key informants suggested that the CACC system has great potential arguing that with more recognition they could play a key role in monitoring CBO activity.

### **CSO Coordinating Bodies**

There are several CSOs that operate as networking groups for Malawian civil society.

**MANASO** – The Malawi Network of AIDS Service Organization was established in 1996. Its mandate is the coordination and capacity building of Malawian CSOs involved in the response to HIV/AIDS. MANASO’s mission is to contribute to the reduction of HIV, and alleviate suffering caused by the HIV/AIDS epidemic, through capacity building, coordination, mobilization and allocation of resources to AIDS service organizations in Malawi. MANASO has a membership of 450 AIDS service organizations including CBOs.

**CONGOMA** – The Council for Nongovernmental Organisations in Malawi (CONGOMA) is a membership umbrella body for NGOs in Malawi. It has a membership of 175 National, International and Emerging NGOs. It was established in 1992 as an offshoot of the council for Social Welfare Services in Malawi with the mission to enhance and maximize the potential and actual impacts that NGOs can and do have upon development in Malawi through mutual support between NGOs.

**NAPHAM** – The National Association of People Living with HIV/AIDS in Malawi started with four members in 1993. Membership has since increased to 200 covering 24 districts of Malawi. NAPHAM’s objective is to promote health through self-care and support for people

living with HIV/AIDS. They do this by organizing themselves into support groups for self-empowerment. Support groups provide care and support to members and work together to give voice to member's needs.

**MANET** – The Malawi Network of People Living with HIV/AIDS began in April 1997. Founded and run by PLWHA, MANET forms a network support groups for HIV positive persons and those affected by the pandemic. As a coordinating and facilitating body, MANET is built upon democratic values to ensure equitable and effective utilization of scarce resources for all member support groups and associations to maximize service delivery.

As we will see in the following chapter on CSO Collaboration, these networking organizations, and MANASO in particular, play a key role as connectors within civil society. As such they should be considered important stakeholders in any civil society strengthening initiative.

As members of the Umoyo Network, MANASO, MANET and NAPHAM thrived, increasing their annual funding and building their organizational capacities. However, as coordinating organizations, they still have some important areas for improvement. Increased funding has seen these organizations move away from facilitation and towards service implementation. Furthermore, despite the successes of the last few years, they have not increased staffing levels proportionately. As one interviewee concluded, these civil society networking organizations still “need to be empowered.”

## **Donor-Implementer Relationships**

The issue of the relationships between civil society implementers and donor agencies was discussed during an ‘open space’ forum where CSO representatives had the opportunity to pose questions directly to representatives of donor and coordinating institutions. Highlights from these discussions are included below:

### **Strengths of Current Relationships**

- Review meetings hosted by donors provide an excellent forum for information sharing around lesson learned and best practices.
- Capacity building services provided by donors have shown success. As a result, CSO participants are able to develop good proposals and are becoming more accountable to communities and donors.
- Stakeholders in the response to HIV/AIDS are united through national priority areas
- There are strong accountability mechanisms by which targets and timeframes are clarified and monitored.
- Donor initiated networks provide conducive environments for peer-to-peer collaboration.

### **Areas of Continuing Need**

- Civil society organizations do not currently have a strong unified voice to advocate for their own perspective.
- Monitoring efforts by donors and coordinators are sometimes misunderstood by CSOs and perceived as showing a lack of trust.

- Larger organizations are more successful at mobilizing resources. There are relatively fewer opportunities for small organizations.
- Occasionally paternalistic donor - recipient relationships place a strain on the formation of effective partnerships between coordinators and implementers.
- There is a lack of coordination between international NGOs, leading to the duplication of activities and inefficient use of resources.
- Short-term funding cycles, long proposal processes, and the exclusion of administrative costs from some grants all negatively impact organizational sustainability.

### **Lessons Learned**

- Effective communication and information sharing is essential for high quality program implementation.
- Good donor-implementer relationships are key to project success.
- Sharing concerns between organizations is vital for avoiding misunderstandings and improving partnerships.
- Partnerships based on common interest areas have proven to be effective.
- Capacity building of CSOs helps them to improve service delivery and to be more accountable to communities and donors.

## **7. Collaboration and Networking between CSOs Involved in the Response to HIV/AIDS in Malawi**

**CHAPTER HIGHLIGHTS - The following list highlights key findings related to collaboration and networking between civil society organizations and with organizations in other sectors involved with HIV/AIDS service provision.**

- An Organizational Network Analysis was implemented by Pact and CADECO to assist with visualizing and understanding patterns of collaboration and networking between CSOs and their partners in government, business and international actors.
- Malawian networking organizations play an essential role as connectors within civil society.
- Even though they do not usually interact directly with Malawian CSOs, donors are viewed as collaborators by civil society stakeholders.
- Several INGOs play a role in HIV/AIDS service delivery networks. However, that role is generally peripheral, with INGOs tending to work consistently with a small number of local partners around a wide range of service areas, rather than focusing on their own areas of core capacity and taking advantage of multiple entry points into networks.
- The Umoyo Network has played an important role in developing Malawian CSOs and networking organizations. Many ex-Umoyo Network members grew in stature and capacity over the course of the intervention – becoming leaders within civil society. With the Umoyo project closing out in the summer of 2007, there is some uncertainty over who will take over this important facilitator role.
- The dense linkages between Malawian organizations at the center of many of the networks highlight the existence of local social capital. However, potential exists for further network strengthening to allow for increased flows of resources and information.
- At the periphery of many of the network maps there are interactions occurring at the district level, often involving DACCs, local hospitals and smaller CBOs. A district-by-district application of the ONA tool may be extremely powerful in highlighting those districts where collaboration is strong and whose example might benefit others.

### **Organizational Network Analysis**

The desk review carried out by Pact and CADECO highlighted a need for further exploration of the breadth and quality of networks and alliances between CSOs, donors, and other key actors in the HIV/AIDS sector in Malawi. In order to foster greater understanding of existing patterns of collaboration, and simultaneously highlight the value of networking, an Organizational Network Analysis was implemented alongside group discussions at the Strategic Linkages Event in Lilongwe.

ONA is a particularly powerful tool for visualizing and understanding patterns of collaboration and networking between organizations. The survey applied at the Strategic Linkages Event is included in Annex D and included questions on collaboration around the seven HIV/AIDS service provision areas – Care & Support, Treatment, Testing and Counseling, Prevention, Advocacy, Capacity Building and Impact Mitigation, as well as a questions about the provision of capacity building services and the mobilization of resources.

Participants were asked to rate the intensity of each partnership on a scale of 1 (very weak) to 5 (very strong) using the typology in the following table (Figure 22):

**Figure 22**

<b>Level of Collaboration</b>	<b>Relationship Characteristics</b>
<b>5. Very Strong</b>	<ul style="list-style-type: none"> <li>- Members belong to one system</li> <li>- Frequent communication is characterized by mutual trust</li> <li>- Consensus is reached on all decisions</li> </ul>
<b>4. Strong</b>	<ul style="list-style-type: none"> <li>- Share ideas</li> <li>- Share resources</li> <li>- Frequent and prioritized communication</li> <li>- All members have a vote in decision making</li> </ul>
<b>3. Average</b>	<ul style="list-style-type: none"> <li>- Share information and some resources</li> <li>- Defined roles</li> <li>- Frequent communication</li> <li>- Some shared decision making</li> </ul>
<b>2. Weak</b>	<ul style="list-style-type: none"> <li>- Provide information to each other</li> <li>- Somewhat defined roles</li> <li>- Formal communication</li> <li>- All decisions are made independently</li> </ul>
<b>1. Very Weak</b>	<ul style="list-style-type: none"> <li>- Aware of organization</li> <li>- Loosely defined roles</li> <li>- Little communication</li> <li>- All decisions are made independently</li> </ul>

Survey results were input and processed through InFlow, an ONA software application. The network maps and performance metrics generated through this process were used as “talking documents” to support stakeholder conversations about existing patterns of collaboration and generate ideas for building stronger networks over time.

### **Collaboration around HIV/AIDS Service Provision**

The first network map, Figure 23, on the following page aggregates patterns of collaboration around all seven services areas to give an overview of networking for HIV/AIDS service provision in Malawi. The nodes of the network represent organizations, both those that completed the survey, and those listed as collaborators by those completing the survey. Organizations appearing towards the center of network are relatively better connected than those towards the periphery. The light grey links represent instances of collaboration. Arrows indicate the direction of flows of collaboration, from the organizations completing the survey to those listed as collaborators.

We can see that the center of this network is characterized by dense linkages between several highly active Malawian NGOs (red nodes) and FBOs (pink nodes). Three networking organizations (yellow nodes) – MANASO, MANET and NAPHAM – are also at the center of the network along with the green node representing the NAC. Surrounding the central cluster of organizations are a large number of international actors (blue nodes), suggesting that these organizations collaborate with selected partners, rather than the broader network, in HIV/AIDS service provision. Towards the edges of the network, several nodes representing district specific actors – DACCs, Health Centers and local Home Based Care organizations – indicate the presence of district level networks.



In addition to these initial observations from the network map, performance metrics enable us to explore patterns of collaboration in greater depth. Allowing us to make the following observations:

- The **group size** of this network is 96 and the **density** of linkages is 3%. Both of these metrics are particularly valuable when comparing similar networks – as we will demonstrate in the following comparisons (pgs. 45-49) of the networks of collaboration for the seven individual HIV/AIDS service areas.
- As a network grows in size, so the number of linkages required to maintain a similar density increases. Thus, we can consider the **relative network density**—the density of linkages within a network adjusted for group size according to the following equation [relative network density = (group size/100)\*density]. In this case, the relative network density is 2.88 (96/100\*3)—a score that is particularly useful when comparing this network with others generated through the analysis.
- Another important metric is **network reach**. Network reach describes the percentage of organizations within a network the average network participant can access within two steps – or in other word, the number of friends (one-step linkages) and friends of friends (two-step linkages) that the average organization has compared with the overall size of the network.<sup>28</sup> The service level collaboration network has a network reach of 10.2% - a relatively low score that a network strengthening intervention might seek to address.
- ONA performance metrics can also provide us with information about the position of individual nodes within the network. For example, we can identify the **most active networkers** – organizations completing the survey that reported the highest levels of collaboration around HIV/AIDS service provision. In this case, the five most active networkers are Word Alive, Malamulo, Tovwirane, MAICC, Matindi Youth.
- Moreover, we can identify the **most named collaborators** – organizations most frequently mentioned as collaborators by those completing the survey. In terms of HIV/AIDS service provision, the five most named collaborators are MANASO, MACRO, NAC, NAPHAM and MANET, a result very much in line with our initial observations from the network map.

By sharing the network map and metrics with Strategic Linkage Event participants, we were able to draw out the following conclusions about collaboration around HIV/AIDS service provision in Malawi:

1. Networking organizations such as MANASO, NAPHAM and MANET play an essential role as connectors within the network of service provision.
2. Many of the most active networkers and most common collaborators are members of the Umoyo Network organized by Save the Children.
3. CSOs view the NAC as an important collaborating partner, even though the NACs structure does not support direct interaction with service provider organizations.
4. Networking around service provision is occurring both on a national level and also within certain districts.

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<sup>28</sup> A maximum of two steps is used for defining network reach because information and resource transfer generally occurs freely between immediate partners and partners of partners. At the third degree of separation, however, information transfer becomes significantly more difficult.

## Networking Around Individual Service Areas

The following table, (Figure 24), summarizes performance metrics for the seven HIV/AIDS technical service area networks, as well as the overall service provision network discussed in the previous section. Observations on these networks follow, and accompanying network maps (Figures 25-31) are included at the end of this chapter on pages 52-58.

Figure 24

Network Name	Group Size	Network Density	Relative Network Density	Average Network Reach	Top 5 Most Active Networkers	Top 5 Most Named Collaborators
<b>0. Service Provision</b>	96	3	2.88	10.2%	1.Word Alive 2.Malamulo 3.Tovwirane 4=MAICC 4=Matindi Youth	1.MANASO 2=MACRO 2=NAC 4=NAPHAM 5=MANET
<b>1. Care &amp; Support</b>	77	3	2.31	6.5%	1.Malamulo 2.DAPP 3.Tovwirane 4=MAICC, SASO, Word Alive	1.NAC 2.MANASO 3=CHAM 3=NASO 3=USAID
<b>2. Treatment</b>	49	3	1.47	3.6%	1.MBCA 2.DAPP 3=Malumulo 3=SASO 5.MAICC	1.BLM 2.CHAM 3.MSF 4=Adventist Health Service, DAPP, NAC, Government Hospital, MACRO, MANET, MoH
<b>3. Testing &amp; Counseling</b>	58	4	2.32	9.7%	1=Tovwirane 1=Word Alive 3.MAICC 4=DAPP 4=NASO	1.MACRO 2.NAC 3=BLM 3=DAPP 3=NAPHAM
<b>4. Prevention</b>	66	3	1.98	7.2%	1.Tovwirane 2.MAICC 3= Malamulo 3=Matindi Youth 5.MHRRC	1.MANASO 2.NAPHAM 3.MANET 4=MACRO, NAC, NASO
<b>5. Advocacy</b>	51	3	1.53	5.2%	1.Malamulo 2.AYISE 3.MBCA 4=SWAA 4=Word Alive	1=MANASO 1=NAC 3=MANET 3=NAPHAM 5.MACRO
<b>6. Capacity Building</b>	62	3	1.86	5.0%	1.Malamulo 2.Word Alive 3.MHRRC 4.AYISE 5.SASO	1=MANASO 1=NAC 3=CHAM 3=MANET 5=MACRO,NAPHAM
<b>7. Impact Mitigation</b>	49	4	1.96	7.8%	1.Tovwirane 2.MAICC 3.NASO 4.Word Alive 5=MBCA, Malamulo	1=NAC 1=NAPHAM 3.MANET 4=DAPP, MACRO, MANASO, SASO

## 1. Care and Support

We can make the following observations about the network map (Figure 25, p52) and performance metrics for collaboration around Care and Support activities:

- The majority of organizations at the center of this network are Malawian NGOs, FBOs and networking organizations. International and government organizations are comparatively marginalized.
- The network is relatively dense and well-connected, however, there are two small groups that are isolated from the larger network.
- The group size of 77 and relative network density of 2.31 are the highest for any of the seven individual service area networks.
- The network reach score of 6.5%, however, is only 4<sup>th</sup> highest of the seven networks.

In discussion with the ONA participants, the following conclusions were reached about collaboration around Care and Support:

- Many of the more active NGOs and FBOs began as CBOs and are diversifying their activities, indicating that well-organized CBOs that leverage networks have the potential to grow over time.
- Former Umoyo Network partners have been actively collaborating with each other.
- The peripheral role played by international and government organizations indicates that Care and Support activities are a primary domain of local CSOs.
- The low network reach metric suggests that there may be value in performing interventions that strengthen this network.

## 2. Treatment

We can make the following observations about the network map (Figure 26, p53) and performance metrics for collaboration around Treatment activities:

- This network is much smaller and diffuse than many of the others – this is reflected by a low group size of 49 and relative network density of 1.49.
- A number of pockets of interaction exist that are completely unconnected to the core group. In addition one large subgroup is joined to the core group through only a single connecting node.
- The smaller size of this network appears to be the result of lower participation by Malawian organizations. Conversely, the relative importance of international actors is higher in this service area than others.
- The three most named collaborators, Banja la Mtsogolo, the Christian Health Association of Malawi and Medicins sans Frontiers, focus specifically on Treatment, and appear very rarely in other service areas.
- The network reach of 3.6% is the lowest for any of the seven service area networks, and is typical of this kind of poorly connected network.

The following conclusions about collaboration around the Treatment of HIV/AIDS were reached through dialogue with network analysis participants:

- City and district level hospitals appear on the periphery of the network. This indicates that while these institutions are not key players at the national level, they may play a significant role in more local networks.
- Many of the most active collaborators are former Umoyo Network members.
- Several of the most active networkers and most named collaborators specifically focus on the provision of treatment services – indicating that this is more of a niche activity involving fewer actors than other service types.

- The relatively high participation of international actors in this network suggests that treatment activities are driven primarily by these actors, rather than by local institutions.
- The diffuse nature of this network suggests that numerous opportunities exist for network strengthening interventions.

### **3. Testing and Counseling**

We can make the following observations about the network map (Figure 27, p54) and performance metrics for collaboration around Testing and Counseling:

- Although this is one of the smaller networks (group size 58), it is characterized by dense interaction and has the highest relative density (2.32) and network reach (9.2%) for any of the seven service area networks.
- The center of this network is dominated by local NGOs, with international, government and networking actors playing a more peripheral role.
- The most named collaborator is MACRO (Malawi Aids Counseling and Resource Organization), a Malawian NGO that has been at the forefront of civil society efforts in this service area for over a decade.

The following conclusions about collaboration around Testing and Counseling were reached through dialogue with the network analysis participants.

- MACRO, the largest provider of HTC services in the country, is at the centre of the network and should be considered as a key player in any efforts to strengthen the network of testing and counseling services offered by Malawian CSOs.
- Organizations such as USAID and the NAC are situated towards the center of the network because they currently provide large amounts of funding to HTC service providers.
- Former Umoyo Network members are near the centre because Umoyo Network facilitated a lot of networking activities and offered flexibility in the use of funds.
- Networking is more effective when organizations (CSOs) are geographically close to each other.

### **4. Prevention**

We can make the following observations about the network map (Figure 28, p55) and performance metrics for collaboration around Prevention activities:

- The prevention network is the second largest (group size 66) and has the third highest relative density (1.98) and network reach (7.2%) of the seven service area networks.
- Three of the networking organizations – MANASO, MANET and NAPHAM – play central roles within this network. A result reflected in the network metrics that highlight these organizations as the top three most named collaborators.
- The majority of the other organizations in the densely packed hub of this network are Malawian NGOs and FBOs
- International organizations are very much on the periphery of this network, with the notable exceptions of DAPP and World Vision who tend to operate like local NGOs in their interaction with Malawian communities.

The following conclusions about collaboration around the Prevention of HIV/AIDS were reached through dialogue with the network analysis participants.

- Donors are not as central to networking and collaboration in this service area, an indication that Prevention is one of the greater strengths of local organizations.

- The networking organizations are at the “hub” of the network. However, despite this important role, there has been a tendency for these organizations to drift from their primary role as facilitators towards having a greater role in implementation.
- Some international organizations – World Vision and DAPP – have also turned from facilitators into implementers.

## 5. Advocacy

We can make the following observations about the network map (Figure 29, p56) and performance metrics for collaboration around Advocacy activities:

- The advocacy network is one of the smaller (group size 51) and least dense (relative density 1.53) of the service area networks.
- The network is dominated by a small number of highly active members – Malamulo, MANASO, AYISE, NAC, MBCA, and MANET. However, relatively low levels of collaboration between the remainder of participants results in a low network reach (5.2%).
- At the center of this network are the three networking organizations – MANASO, MANET, NAPHAM – the NAC. Malawian NGOs and FBOs are relatively underrepresented and marginalized.
- There are five small pockets of interaction around advocacy that are completely disconnected from the main group.

The following conclusions about collaboration around HIV/AIDS Advocacy were reached through dialogue with the network analysis participants.

- The pattern of this network is similar, in many respects, to the one observed for Treatment activities. In particular, the under-representation of Malawian NGOs and FBOs at the center of the network indicates that Advocacy is not a traditional domain of these organizations.
- It is unsurprising to see the networking organizations at the center of this network. Actors such as these have the potential to bring together a diverse array of viewpoints into a powerful advocacy effort.

## 6. Capacity Building

We can make the following observations about the network map (Figure 30, p57) and performance metrics for collaboration around Capacity Building activities:

- The network includes a relatively large number of organizations (group size 62) but has one of the lowest densities (relative network density 1.86).
- The network map shows that there is no central hub around the delivery of HIV/AIDS Capacity Building services. Instead there are three smaller centers of interaction, one involving a large number of FBOs (towards the bottom of the network), a second involving primarily local NGOs (at the top of the network), and a final hub including many of the networking organizations and the NAC (on the left of the network). Many of the organizations in this final hub – MANASO, NAC, MACRO, NAPHAM and MANET – are among the most named collaborators, indicating that this group holds the other two hubs together.
- Two small pockets of interaction are completely isolated from the main group.
- International actors exist primarily on the periphery of this network.

The following conclusions about collaboration around Capacity Building for HIV/AIDS service delivery were reached through dialogue with the network analysis participants.

- Most of the Malawian CSOs that are more active in collaboration around capacity building are well-established. This is a common pattern for capacity building, where more established organizations reach a level where they become able to offer training to others.
- For the same reason, it is surprising that international organizations and government actors are so peripheral to this network given their strong experience, large resource base and capacity building mandate.
- It appears that local FBOs tend to collaborate with other local FBOs on capacity building service provision. The same is true for non-faith based local NGOs. This is a pattern unique to collaboration around capacity building service provision and may be the result of larger local FBOs acting as mentors and trainers to their smaller counterparts. This interesting observation is a potential area for further exploration.
- In this multi-hub network, networking organizations have a particularly important role to play as facilitators.

## **7. Impact Mitigation**

We can make the following observations about the network map (Figure 31, p58) and performance metrics for collaboration around Impact Mitigation activities:

- The organizations at the hub of this network are larger local NGOs – MAICC, MACRO and Tovwirane.
- The networking organizations are at the top of the most named collaborators list, but are less central to this network than several of the others.
- The group size of this network (49) is the smallest of any of the HIV/AIDS service provision networks.
- Despite the small size of this network, interaction is relatively dense, with a relative network density score of 1.96.
- International organizations are well represented in this network, but as peripheral nodes collaborating with only one or two local partners.

The following conclusions about collaboration around Impact Mitigation activities were reached through dialogue with the network analysis participants:

- Most of the CSOs at the centre of the network are Malawian organizations and have Impact Mitigation as a core function.
- The majority of the most active CSOs began as CBOs and have grown successfully over time. Furthermore, many of these organizations are ex-members of the Umoyo Network.
- The small group size of this network is surprising given the large number of organizations involved in impact mitigation activities (Figure 5, page 15). This suggests that civil society is not currently leveraging its collective knowledge around this important service area.

## **General Observations on Service Area Collaboration**

The results of the network analysis provides policy makers with a large amount of useful information regarding collaboration around HIV/AIDS service delivery in Malawi. Some of the highlights are as follows:

### **Networking organizations play an essential role as connectors within civil society**

In the majority of the service area networks, the same Malawian organizations reappear as the most named collaborators. These organizations are the networking organizations MANASO, MANET and NAPHAM, and the local NGO MACRO. Any intervention to strengthen local capacities and networks for HIV/AIDS service provision in Malawi would benefit from involving these organizations – bearing in mind their own capacity issues discussed in the chapter on HIV/AIDS coordination. The importance of these organizations is relatively lower in some of the more technical service areas, however. In particular, these organizations are less active in the area of HIV/AIDS treatment where Bangwe la Mtsogolo (BLM), Christian Health Association of Malawi (CHAM), and Medicins sans Frontiers (MSF) were named as key collaborators.

### **Donors are viewed as collaborators by CSOs**

Although they tend not to interact directly with CSOs, both the NAC and USAID were named as important collaborators by several CSOs participating in the analysis. In other words, many CSOs perceive the NAC and USAID to be in direct partnership or collaboration with their own organization. By contrast, USAID and the NAC view themselves as facilitators with little or no direct links to implementing CSOs operating in communities. This is important in that it highlights a disconnect between perceptions and reality. This kind of misconception of the role of donor organizations appears to be common, and is an issue that should be addressed.

### **International NGOs are not fully leveraging local CSO networks**

A number of international NGOs play a role in HIV/AIDS service delivery networks. However, that role is generally a peripheral one. International NGOs tend to work consistently with a small number of local partners around a wide range of service areas, rather than focusing on their own areas of core capacity and taking advantage of multiple entry points into networks. This may be the result of the insufficient coordination between INGO actors, discussed in the chapter on coordination.

### **The Umoyo Network has played an important role in developing Malawian CSOs and networking organizations**

Of all of the organizations participating in the network analysis, the most active networkers were members of the Umoyo Network facilitated by Save the Children. This suggests that the Umoyo Network was particularly successful at fostering collaboration, and that participants saw high value in these networking activities. Participants also noted that many of the ex-Umoyo Network members had grown in stature and capacity over the course of the intervention – becoming leaders within civil society. With the Umoyo project closing out in the summer of 2007, there is some uncertainty over who will take over this important facilitator role.

### **Local social capital exists within Malawian civil society – but opportunities remain for network strengthening**

The dense linkages between Malawian organizations at the center of many of the service delivery networks is very encouraging, highlighting the existence of local social capital, that policy makers and coordinators may wish to leverage. However, the low reach scores for many of the networks (all less than 10%) indicate that there is potential for further strengthening of these networks to allow for increased flows of resources and information.

**District Level Networks Exist**

We can see from the periphery of many of the network maps that there are interactions occurring at the district level, often involving DACCs, local hospitals and smaller CBOs. These networks were not addressed as part of this particular exercise. However, a district level application of this tool may be particularly powerful in highlighting those districts where collaboration is particularly strong and whose example might benefit others.



Figure 26 – Collaboration Around Treatment Service Provision

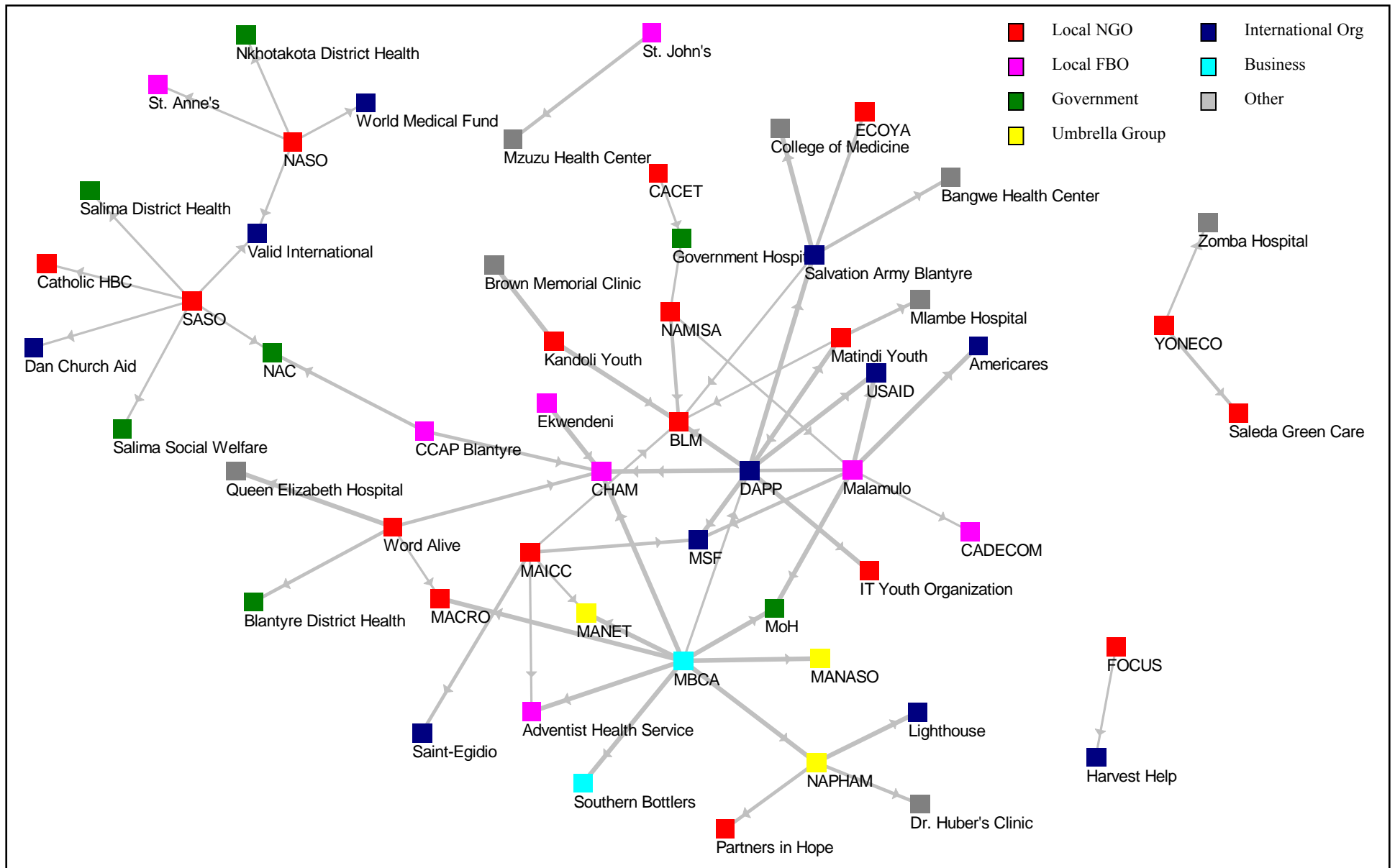


Figure 27 – Collaboration Around Testing and Counseling Service Provision

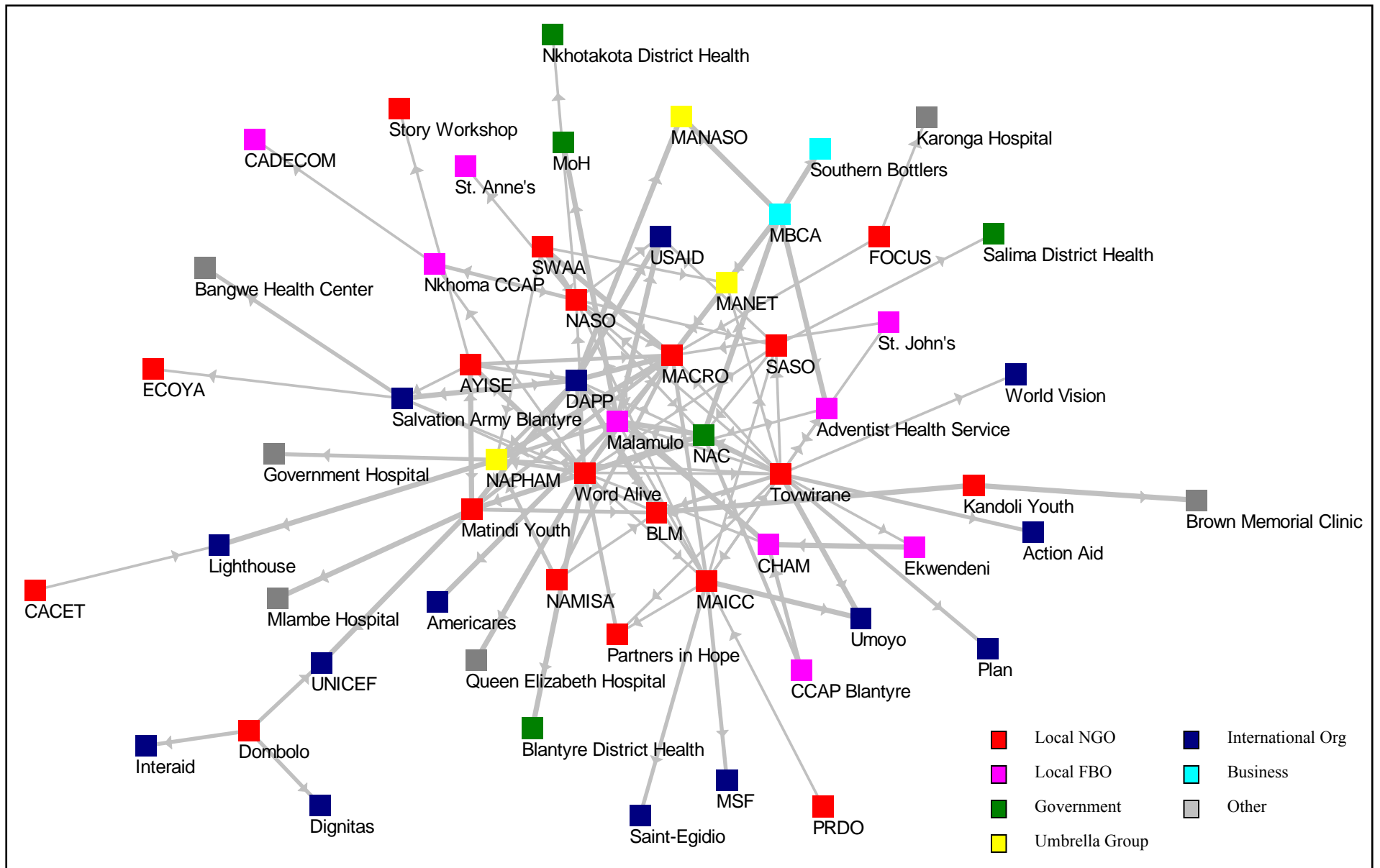


Figure 28 – Collaboration Around Prevention Service Provision

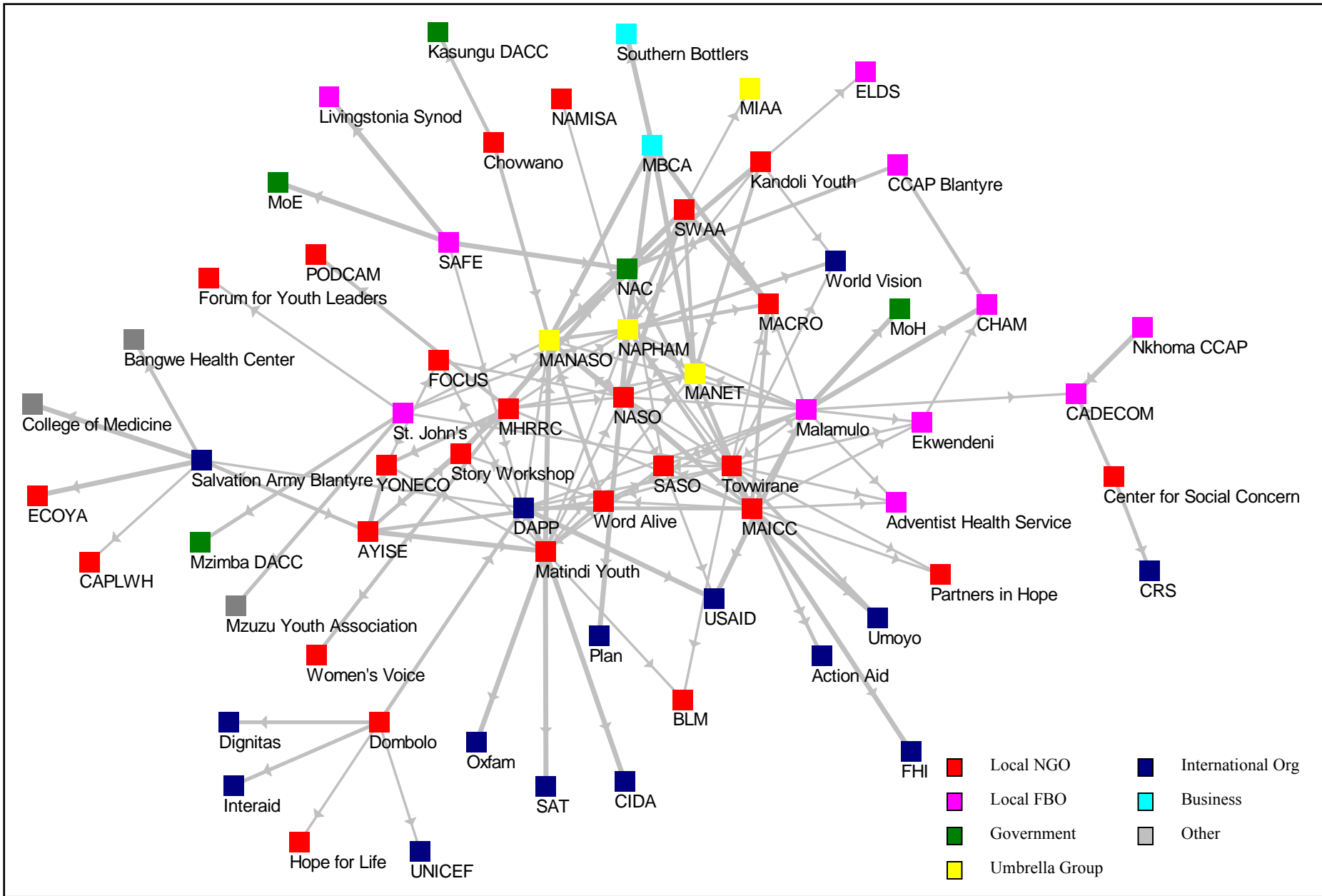
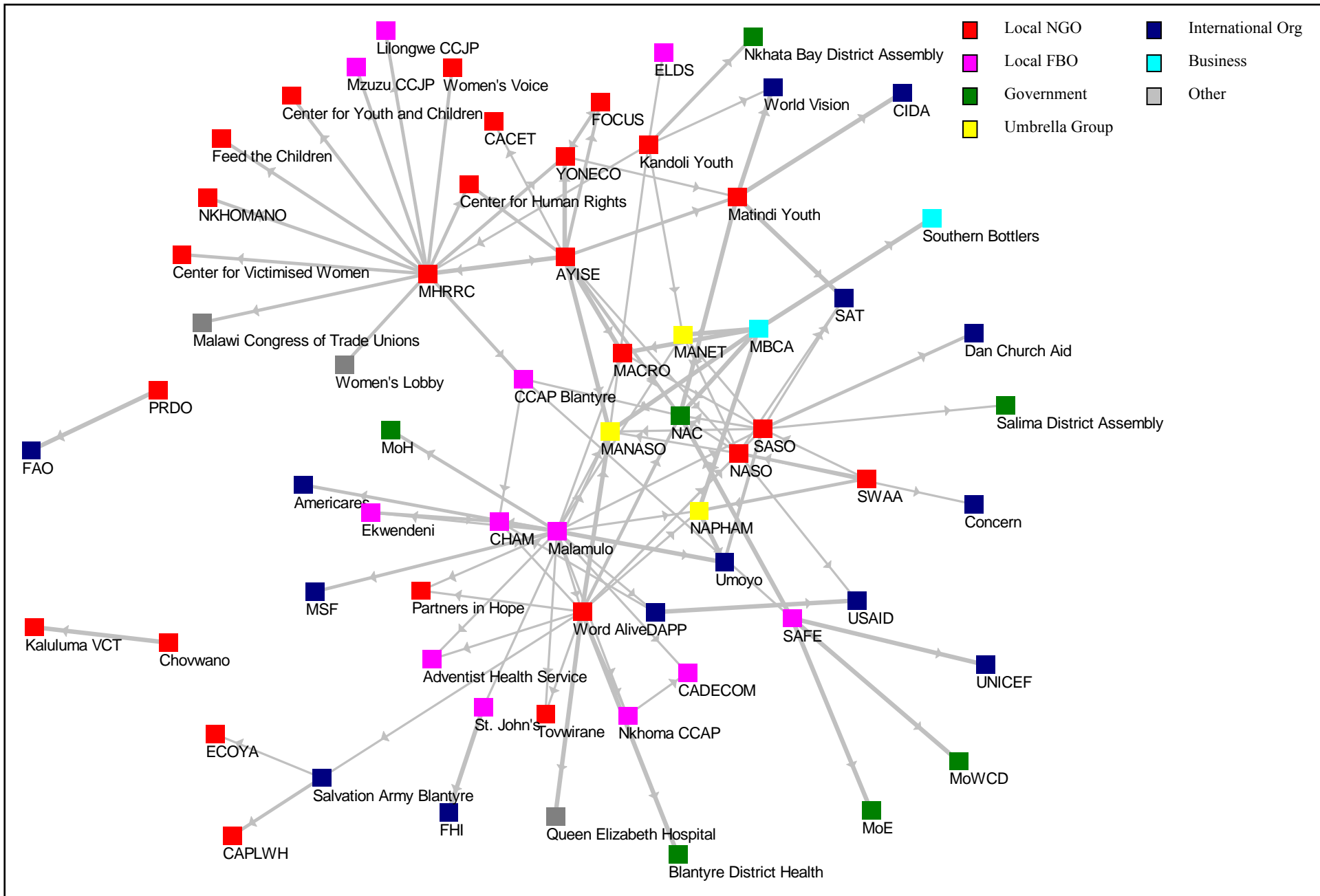
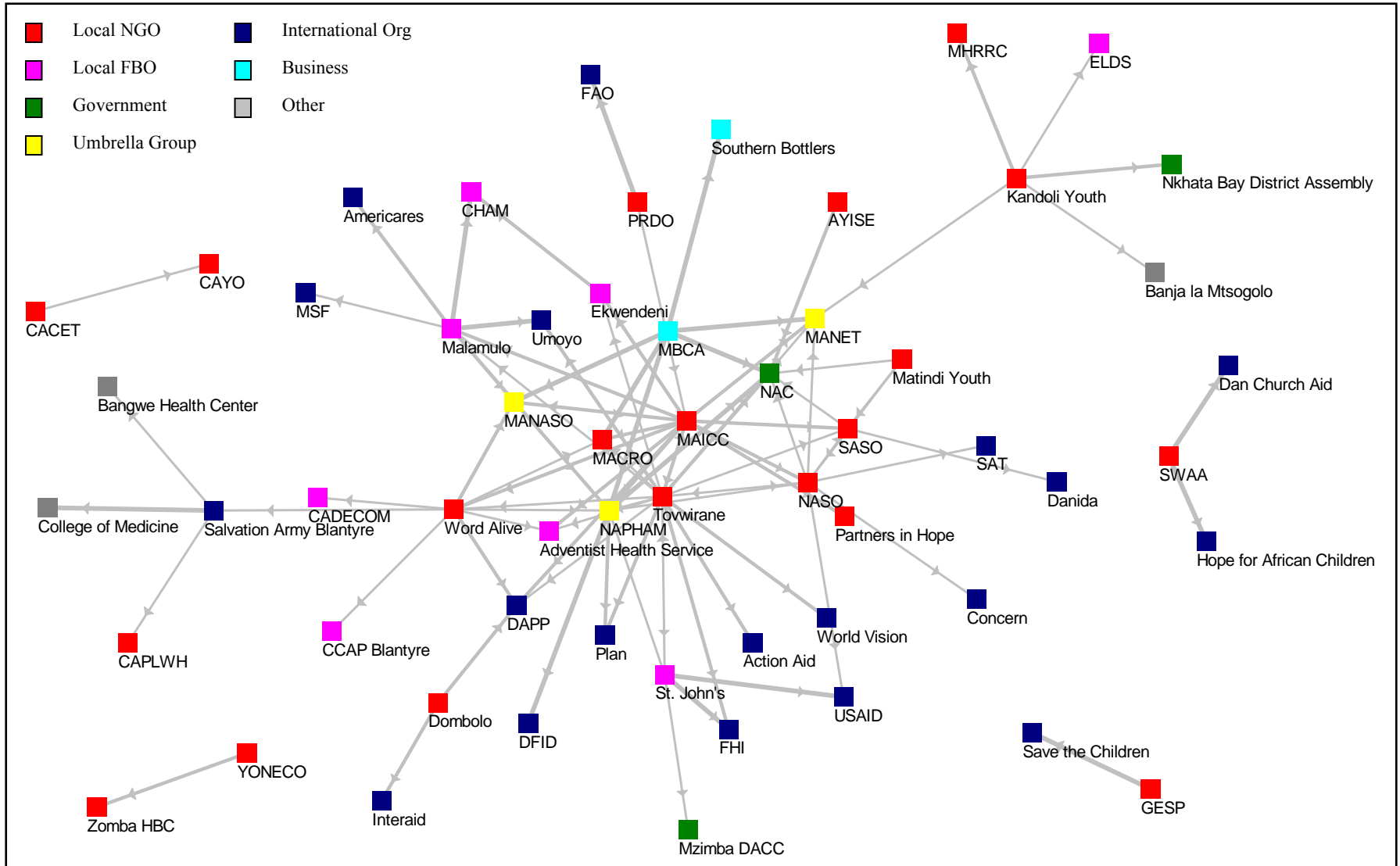




Figure 30 – Collaboration Around Capacity Building Service Provision



**Figure 31 – Collaboration Around Impact Mitigation Service Provision**



## **8. Civil Society's Access to Resources and Capacity Building Services**

### **CHAPTER HIGHLIGHTS – The following list highlights key findings related to Malawian civil society's access to resources and capacity building services**

- The single most important resource hub for Malawian CSOs is the NAC. The NAC primarily provides funding, but also plays an important role in distributing intellectual capital and providing mentoring to CSOs.
- Despite the key role played by the NAC, the majority of resources provided to Malawian civil society come from international actors. These actors also primarily provide financial resources, but also provide significant amount of mentoring and intellectual capital to CSOs.
- The Malawian networking organization MANASO also plays a role as a resource hub. Ideally, the role of larger more experienced local organizations such as this should be encouraged.
- Many of the Malawian CSOs that have been most successful in leveraging resources and capacity building services are also those that are more active networkers.
- The majority of organizations providing capacity building services to Malawian CSOs are international actors. However, the five umbrella organizations are surprisingly underrepresented as service providers given their particular mandate in this area.
- Capacity building service provision is equally split between core capacities and technical capacities.
- Core capacity service provision is heavily biased towards areas such as Financial Management and Mission and Strategy, where CSOs are already relatively strong. There is comparatively little service provision directed towards weaker areas such as Human Resources and Leadership and Governance.
- In terms of technical capacity services, the majority of services are focused towards Care and Support and Impact Mitigation, where there is a lot of CSO activity. However, there are also relatively large service offerings in growth areas related to Treatment and Testing and Counseling.

### **Resource Mobilization by Malawian Civil Society**

In addition to analyzing CSO collaboration around HIV/AIDS service provision, the ONA carried out at the Strategic Linkages Event in Lilongwe also studied patterns of resource mobilization among Malawian Civil Society organizations over the preceding twelve months.

The types of resources included in the analysis were, financial, in-kind, intellectual capital and mentoring from more experienced organizations. Participants were asked to make a note those organizations that provided them with the various resources within the period May 2006 – April 2007.

Figure 32, on the following page, shows the overall pattern of mobilization for all four resource types. The fact that this resource network is contiguous with a large group size of 104 indicates that there are several “resource hubs” currently accessed by groups of CSOs. Resource hubs are organizations that were noted by ONA participants as providers of resources. Using network performance metrics, we can identify these resource hubs – highlighted with red circles.

Of the ten resource hubs highlighted in Figure 32, the single most important is the NAC – a result that is not surprising given the central role played by the NAC in HIV/AIDS coordination and funding dispersal. Indeed, around 57% of the resources distributed by the NAC to Malawian CSOs during the last year were financial. The NAC also plays important roles as a distributor of intellectual capital (22%) and a mentor to Malawian CSOs (17%). CSOs also reported receiving a small level of in-kind contributions from the NAC, around 4% of the NACs total resource distribution.

Eight of the nine remaining resource hubs are international organizations – Umoyo, UNICEF, Southern African AIDS Trust (SAT), CordAid, Family Health International (FHI), Firelight, USAID and Kinder not Hilfe (KNH). The majority of the resources provided by these organizations are financial (52%). In fact, outside of the NAC, the great majority of financial resources directed toward the HIV/AIDS response come from international actors. As with the NAC, international organizations also play a role in mentoring (23%) and distributing intellectual capital to Malawian CSOs (18%). Similarly, CSO participants reported receiving some in-kind contributions (7%) such as medical supplies, food, and clothing from international organizations.

The only Malawian CSO featured in the top ten resource hubs is MANASO, a networking organization. Of the relatively small resource pool distributed by MANASO during the last year, 50% was intellectual capital, 25% financial and 25% in-kind.

The CSOs that have been most successful at mobilizing resources – PRDO, AYISE, NASO, FOCUS, NAPHAM, Tovwirane, Word Alive, CCAP Blantyre, DAPP, Kandoli Youth – correlate closely to the group of organizations that network the most actively around service provision. This suggests that a strong networking strategy can pay dividends to local CSOs in terms of mobilizing resources for improving or scaling-up programs.



## **Capacity Building Service Provision to Malawian CSOs**

Pact and CADECO also analyzed the network of capacity building service provision to Malawian CSOs. This is different from the network of collaboration around capacity building service delivery, analyzed in the previous chapter, in that it focuses specifically on the provision of organizational development and technical training to Malawian organizations, rather than services provided by local CSOs to beneficiary communities.

We can see from Figure 33, on the following page, that the majority of organizations providing capacity building services to Malawian CSOs are international actors. Three of the four most active providers – Umoyo, FHI, SAT – are international organizations, and numerous other international actors provide services to one or two local partners.

It is interesting to note that of the five Umbrella Organizations whose mandate includes building the capacity of civil society, only two – Save the Children (through the Umoyo Network) and Plan International – were reported as having provided services to more than one organization. This may be because these organizations are contracting with others to provide services, or because the majority of capacity building provided by UOs is directed at smaller CBOs that did not participate in this analysis. Either way, this would certainly be an interesting area for additional follow-up.

Government institutions also play some role in the provision of capacity building services to CSOs. Both the NAC and the Ministry of Health are amongst the more active providers at the national level, and the district assemblies in Salima and Nkhata Bay appear in the network as providers operating on a more local level.

Finally, there are a handful of Malawian CSOs involved in the provision of capacity building services. Some of these, such as CHAM and MACRO are larger NGOs that offer services within their areas of expertise to smaller organizations. Others such as CADECO and CABUNGO are capacity building specialists who usually operate in collaboration with international organizations.

Larger organizations appear to be more successful than their smaller counterparts in accessing capacity building services, and six of the ten most successful organizations were members of the Umoyo network. These results are in line with trends that Pact has experienced in several countries: when a local CSO is selected by one international actor as a participant in a capacity building intervention, they often enter a virtuous cycle, able to access additional resources and capacity building services.



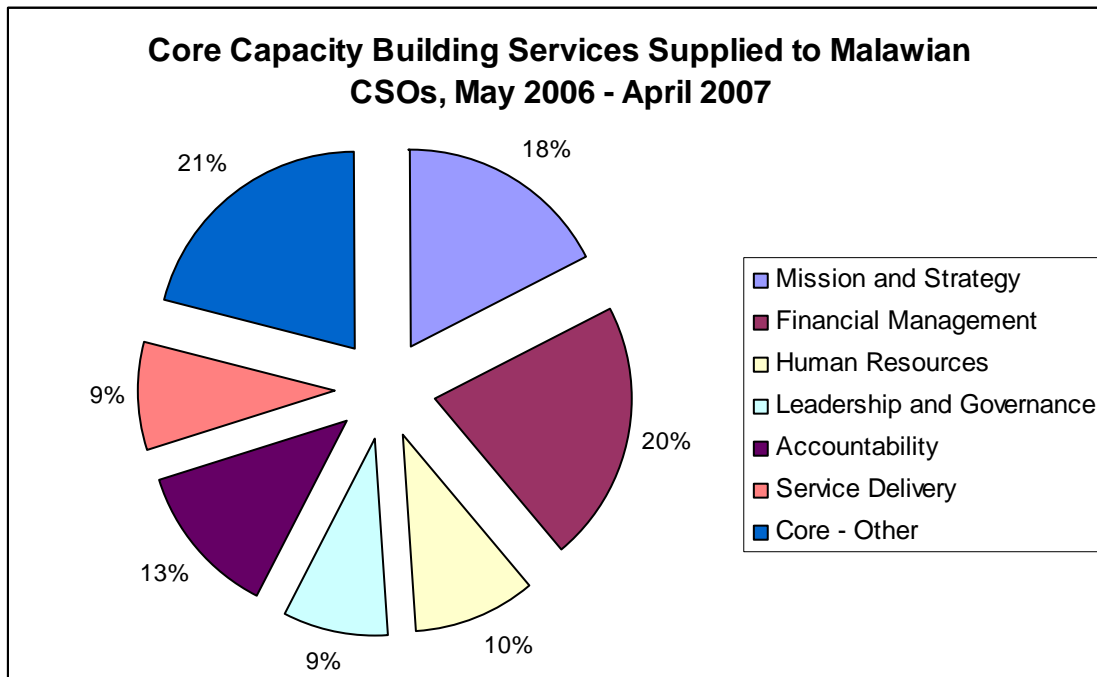
## Types of Capacity Building Services Supplied to Malawian CSOs

The 162 capacity building services the CSOs reported receiving over the past 12 months were split almost equally between technical capacity building (82 services) and core capacity building (80 services).

Of core capacity building services (Figure 34), the most strongly represented of the six areas from the Rapid Organizational Scan is Financial Management (20%). Services in this capacity area include training in accounting, budgeting and financial reporting, as well as the development of financial management policies for an organization. Mission and Strategy services (18%), primarily strategic planning consultancies and Accountability services (13%), mostly trainings in monitoring and evaluation, are also well represented.

The relatively large number of 'other' core capacity building services (21%) includes offerings in information technology, gender mainstreaming and resource mobilization.

Figure 34

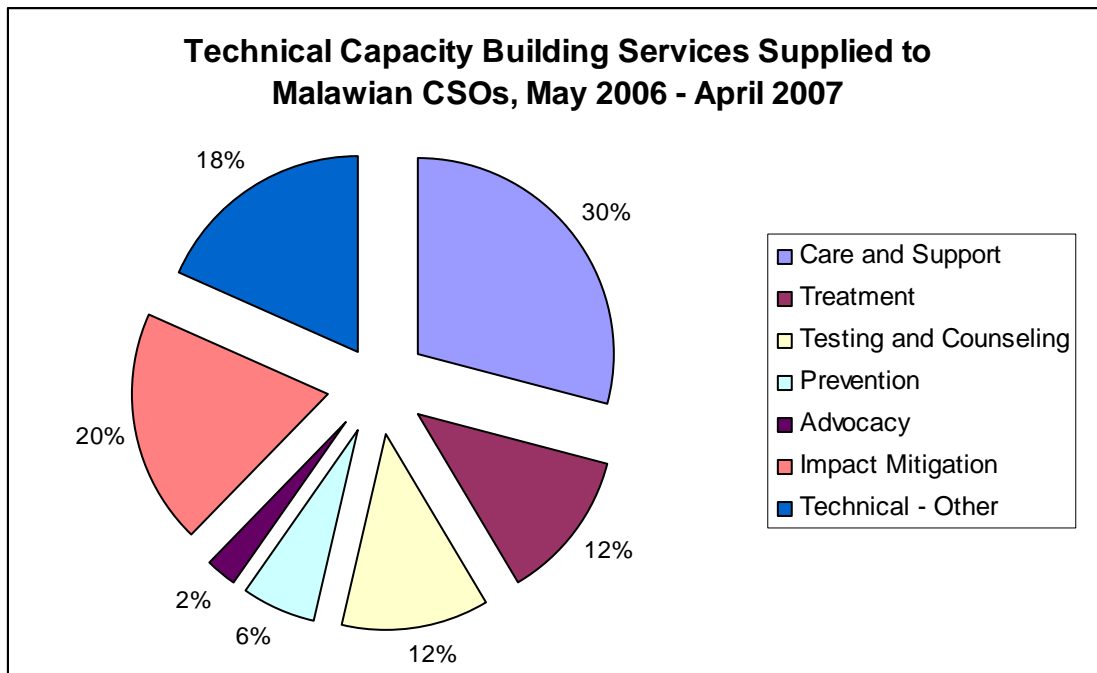


Less well represented are some of the areas identified previously as lower capacity areas – Human Resources (10%) and Leadership and Governance (9%). Human Resources services provided included the development of HIV/AIDS workplace policies and consultancies in volunteer mobilization and management, while Leadership and Governance services included board development and entrepreneurship training. Given the acute needs in these capacity areas we might have expected to see a greater volume of services directed to these challenges. However, recent research, conducted by Pact in Zambia and Ecuador, suggests that the provision of core-capacity building services to local CSO tends to be driven by the preferences of international actors rather than the needs of local actors.

The most frequently offered technical capacity building services, as can be seen from Figure 35, are those related to Care and Support (30%) and Impact Mitigation (20%). This is in line with the fact that these are the technical areas where CSOs are most active.

The next most frequent group of capacity building services supplied were in the technical areas of Treatment (12%) and Testing and Counseling (12%). As discussed previously, these are currently areas of growth for civil society in Malawi and focal technical areas for donors such as USAID and Pact.

Figure 35



Much smaller levels of capacity building service provision were directed towards Prevention (6%) and Advocacy (2%). This is not surprising in the case of Advocacy, where civil society plays such a minimal role. In the case of HIV/AIDS Prevention, however, it is more surprising, given the proliferation of new mechanisms for increasing awareness and need for up-to-date information.

## 9. Conclusions and Points for Reflection

The preceding chapters highlight a wide range of opportunities and issues that impact the response of civil society to HIV/AIDS in Malawi. Although many of these have been around for some time, the present situation offers a unique set of opportunities for empowering civil society in the fight against HIV/AIDS. To this end, the following conclusions provide a number of suggestions for further research and reflection around ideas that may help to improve the effectiveness of Malawian civil society over time:

- A. **There is a significant capacity gap between CSOs in the Southern and Central Regions, and their counterparts in the Northern Region.** The results of the ROS found that Northern CSO capacities in both core organizational areas and technical service areas lagged behind capacities in other regions. Furthermore, CSOs in the North indicated that they felt excluded from the majority of networking and capacity building interventions. Future capacity building or networking interventions may seek to involve, or even give precedence to organizations from these districts.
- B. **There is a need to monitor progress towards the 2009 goal of decentralizing the umbrella mechanism to the district level.** Despite significant changes to the umbrella mechanism following the 2006 evaluation, the timeline for decentralization to the district level remains in place. This is despite fears that district capacity is low and that DACCs will not be able to undertake the broad range of responsibilities required following the handover. It will be important to monitor progress toward this goal and maintain flexibility in international efforts to support this work. Some of the higher capacity local NGOs and providers of capacity building services may have an important role to play in this effort.
- C. **With national attention moving from CSO capacity building to capacity building at the district level, additional attention from elsewhere will need to be focused on building CSO capacities.** The strategy for the second phase of the umbrella mechanism involves Umbrella Organizations building the capacity of DACCs, and the DACCs in turn building the capacity of CSOs. However, there are some questions about the ability of district level staff to complete this task. As a result, it will be important to monitor progress and fill gaps in the provision of assistance to CSOs.
- D. **There are a number of larger Malawian CSOs whose experience and capacity could and should be leveraged to the benefit of civil society.** Several larger, high-capacity organizations such as MANASO, MACRO, MANET and NAPHAM already play lead roles as connectors and resource hubs in the civil society response to HIV/AIDS. They still have capacity challenges moving forward, but the value of having local actors at the vanguard of the response should not be ignored.
- E. **The success of CSOs that participated in the Umoyo Network highlights the value of networking and capacity building interventions.** There is broad agreement that the organizational participants in the Umoyo Network have benefited greatly from their participation in terms of organizational capacity, networking and resource mobilization. With this intervention coming to an end, there is potentially high value to be gained from working

to ensure the sustainability of this kind of activity, either through a locally owned network or through a similar external intervention. It is important, however, that new interventions should aim at building from where Umoyo left and not simply be seen as a continuation of what Umoyo was doing. There should be continued creativity and innovation in addressing capacity building and networking issues that go beyond the efforts of Umoyo.

- F. International NGOs would benefit from closer coordination.** From the network maps generated as part of the sector study, it appears that international actors tend to work in a relatively narrow way, with a select group of local partners. By working together to minimize duplication and leverage core competencies, these external actors can continue to have a strongly positive impact upon the HIV/AIDS response.
- G. Where Civil Society is asked to play new roles, special attention should be given to building relevant technical capacities.** Today, Malawian CSOs are being asked to fill gaps in service provision within more technically complex areas than they have traditionally operated. The result of this sector study has found, however, that CSO capacities are generally low in these areas. Any attempt to boost CSO involvement in HTC or Treatment activities should therefore be accompanied by complimentary technical capacity building.

## Annex A: Evolution of the Local NGO Sector in Malawi

The table below demonstrates some of the major shifts that have happened in the local NGO sector in Malawi from 1995 to 2005.

Source: Cooney, Janszen and Malunga, 2005: *PSO Evaluation of Malawian NGOs*, Ecorys, The Hague, Netherlands.

### Evolution in the Context of NGOs in Malawi 1995 and 2005

CHARACTERISTICS	1995	2005
Staff skills and competencies	<ul style="list-style-type: none"> <li>• Most of the organizations were originally managed by NGO founders</li> <li>• Most of the founders had did not have tertiary education</li> </ul>	<ul style="list-style-type: none"> <li>• In most of the reviewed organizations, the founders have moved on, replaced by staff with higher level education, up to and including PhD in one case</li> <li>• Donors have increased influence over NGO staff hiring practices, demanding increased qualifications of the staff of NGOs (e.g. accounting qualifications) in return for their financial support.</li> <li>• There has been a large investment in training for NGO staff by donors (e.g. financial management, project management, monitoring and evaluation (but not results-based management). However, staff have had some difficulties in translating training into practice due to work and training overload.</li> <li>• In general, there is a shortage of well qualified staff in the NGO sector, leading to some staff turnover and some staff "poaching" by international NGOs from local NGOs in return for higher salaries</li> </ul>
Organizational culture and values	<ul style="list-style-type: none"> <li>• Tended to be top down and set by founders</li> <li>• A culture of fear and insecurity dominated many NGOs</li> </ul>	<ul style="list-style-type: none"> <li>• Tends to be top down and set by donors.</li> <li>• Hierarchy</li> <li>• Lack of openness to say what they think and fear of authority or organizational leaders among staff</li> <li>• No culture of feedback as directors and staff are too busy to create time for reflection and learning</li> <li>• A culture of fear and insecurity continues to dominate many organizations</li> </ul>
Financial and Material Resources	<ul style="list-style-type: none"> <li>• Limited resources available from donors so NGOs are preoccupied with survival</li> </ul>	<ul style="list-style-type: none"> <li>• Increased resources available, and potential for more resources due to global crises such as HIV/AIDS and increased attention paid to human rights.</li> <li>• While potential for more resources exists, many NGO face absorptive capacity challenges.</li> </ul>
Board and governance	<ul style="list-style-type: none"> <li>• No clear demarcation between board and staff responsibilities, sometimes leading to perceived board interference by management. This has contributed to board-staff conflicts in some organizations.</li> <li>• Boards tended to be passive</li> </ul>	<ul style="list-style-type: none"> <li>• As a consequence of conflicts, most boards have gone through Board orientations regarding their role. However boards are not generally assuming their governance roles. Executive Directors continue to make all/most organizational decisions.</li> </ul>

CHARACTERISTICS	1995	2005
Policies, systems and procedures	<ul style="list-style-type: none"> <li>Organizations tended to be run like families, without formal procedures</li> </ul>	<ul style="list-style-type: none"> <li>Finance: Donor demands for accountability for their resources has led to increased formality of systems and procedures.</li> <li>Administrative: NGO growth has led to increased formality of systems and procedures.</li> <li>HR and conditions of service: NGO growth and professionalism has led to increased formality of systems and procedures (recruitment, selection). NGOs continue to face challenges with regard to staff induction, development, appraisal etc. However, a lack of certainty regarding long-term funding and gaps in funding hampers staff development and retention.</li> <li>Monitoring and evaluation: Mostly activity driven rather than results driven. Limited emphasis on results-based management. Evaluations tended to be commissioned externally rather than internally by NGOs in response to Board needs. Moreover, Monitoring and evaluation tend to be accountability rather than learning focused</li> </ul>
Organizational structure, roles and responsibilities	<ul style="list-style-type: none"> <li>Mostly informal with all staff reporting to the Executive Director</li> </ul>	<ul style="list-style-type: none"> <li>Executive Directors continue to play a decision making key role. There has been limited progress by Directors in devolving responsibilities to others. Management teams tend to exist in name, but not functionally.</li> <li>Many Executive Directors are over-committed and often absent from offices. This, combined with limited delegation of authority and lack of effective management teams, can reduce the organizations' effectiveness.</li> </ul>
Strategic Planning and Management	<ul style="list-style-type: none"> <li>Did not exist. Tended to focus on short term plans and on projects than on organizational and institutional development</li> </ul>	<ul style="list-style-type: none"> <li>Most organizations have strategic planning documents due to donor requirements and support, however organizations generally have not developed strategic management capacities</li> <li>NGOs still tend to be in relatively early stages of understanding of the development process and how it relates to the work of the organization. There is limited understanding regarding the need for NGOs to move from dependence, to independence, to inter-dependence through partnerships and networking.</li> </ul>
Organizational, mission and vision	<ul style="list-style-type: none"> <li>Tended to be general rather than focused</li> </ul>	<ul style="list-style-type: none"> <li>Organizations tend to be more focused. However, NGOs' missions and visions are still not the driving engine for the organizations.</li> </ul>
Networking	<ul style="list-style-type: none"> <li>Limited networking</li> </ul>	<ul style="list-style-type: none"> <li>A number of networks exist now, especially in Human Rights, HIV/AIDS areas, food security and education. Networking is still in early stages.</li> <li>The key challenge for NGOs is to function in collaborative synergistic ways among network members rather than bilaterally with the lead network agency.</li> </ul>
Programs	<ul style="list-style-type: none"> <li>Over-riding emphasis on service delivery aimed at helping others (communities or individuals)</li> <li>Limited evidence of advocacy by NGOs</li> </ul>	<ul style="list-style-type: none"> <li>NGOs are now more active in advocacy activities.</li> <li>Some NGOs are embracing capacity building approaches however, most NGOs still engaged in service delivery at community level.</li> <li>Limited emphasis on empowerment of communities, partnership with communities. However, some NGOs are asking themselves whether their roles should be implementing or facilitating communities and their members.</li> </ul>

CHARACTERISTICS	1995	2005
Financial and Organizational Sustainability	<ul style="list-style-type: none"> <li>• Not perceived as a critical issue or need</li> </ul>	<ul style="list-style-type: none"> <li>• Still continued dependence on a limited resource based (usually one donor). In the past, some donors (e.g. DFID and USAID) appear to have fostered this dependence by not permitting NGOs to explore alternative funding sources.</li> <li>• Limited alternative funding strategies are being explored and utilized by NGOs</li> </ul>

## Annex B: Rapid Organizational Scan (ROS) – For CSOs Operating in the HIV/AIDS Sector in Malawi

Outreach facilitators complete questions in interviews with CSO staff. Answers may be verified through interviews and supporting documentation where appropriate.

Biographical Data	
Organization Name	
Location (Town/City and District)	
Number of full time staff	
Number of volunteers	
Years in operation	
Years working in the HIV/AIDS sector	
Year and amount of largest grant received	
Activities conducted with largest grant received	
Average grant size	
Year and amount of first grant received for HIV/AIDS	
Activities conducted with first grant received for HIV/AIDS	
Service Areas – Check boxes next to service areas that your organization operates in	
Care and Support	
<ul style="list-style-type: none"> <li>• Orphans and Vulnerable Children</li> </ul>	
<ul style="list-style-type: none"> <li>• Home-based care</li> </ul>	
<ul style="list-style-type: none"> <li>• Clinic-based care</li> </ul>	
Treatment	
<ul style="list-style-type: none"> <li>• Anti-retrovirals</li> </ul>	
<ul style="list-style-type: none"> <li>• Sexually Transmitted Infection / Opportunistic Infection diagnosis and treatment</li> </ul>	
Testing and Counseling	
<ul style="list-style-type: none"> <li>• Pre-testing counseling</li> </ul>	
<ul style="list-style-type: none"> <li>• Post-test counseling</li> </ul>	
<ul style="list-style-type: none"> <li>• Referral for treatment</li> </ul>	
Prevention	
<ul style="list-style-type: none"> <li>• Abstinence</li> </ul>	
<ul style="list-style-type: none"> <li>• Be Faithful</li> </ul>	
<ul style="list-style-type: none"> <li>• Condoms</li> </ul>	

<ul style="list-style-type: none"> <li>• Prevention of Mother to Child Transmission</li> </ul>	
Advocacy	
<ul style="list-style-type: none"> <li>• Direct advocacy activities</li> </ul>	
<ul style="list-style-type: none"> <li>• Advocacy training</li> </ul>	
Capacity Building	
<ul style="list-style-type: none"> <li>• Organizational development</li> </ul>	
<ul style="list-style-type: none"> <li>• HIV/AIDS technical assistance/training</li> </ul>	
Impact Mitigation	
<ul style="list-style-type: none"> <li>• Stigma/discrimination reduction activities</li> </ul>	
<ul style="list-style-type: none"> <li>• Positive living training</li> </ul>	
<ul style="list-style-type: none"> <li>• Income Generating Activities</li> </ul>	

## Capacity Checklist

### Mission and Strategy

1. The organization is formally registered.      Agree     Somewhat Agree     Disagree
2. The organization has a written mission statement.      Agree     Somewhat Agree     Disagree
3. Staff and volunteers are familiar with the mission of the organization.      Agree     Somewhat Agree     Disagree
4. The day-to-day projects of the organization are directly related to its mission.      Agree     Somewhat Agree     Disagree
5. The organization has a strategic plan.      Agree     Somewhat Agree     Disagree

### Financial Management

6. The organization has an accounting system in place.      Agree     Somewhat Agree     Disagree
7. Books are closed at the end of each month.      Agree     Somewhat Agree     Disagree
8. The organization regularly prepares financial reports.      Agree     Somewhat Agree     Disagree
9. The organization performs regular internal financial audits.      Agree     Somewhat Agree     Disagree
10. The organization performs regular external financial audits.      Agree     Somewhat Agree     Disagree
11. The organization prepares an annual budget.      Agree     Somewhat Agree     Disagree

## Human Resources

12. Staff members have written job descriptions. Agree  Somewhat Agree  Disagree
13. The organization is successful in recruiting volunteers/members. Agree  Somewhat Agree  Disagree
14. The organization is successful in retaining volunteers/members. Agree  Somewhat Agree  Disagree
15. Volunteers/members are adequately compensated for their efforts. [cash/in-kind] Agree  Somewhat Agree  Disagree
16. Efforts are made to ensure that people living with HIV/AIDS are involved in *all aspects* of the organization. Agree  Somewhat Agree  Disagree
17. Volunteers/staff receive regular refresher trainings to ensure they have the proper skills to complete their assigned duties. Agree  Somewhat Agree  Disagree
18. The organization has successfully dealt with human resources challenges resulting directly from the HIV/AIDS pandemic. Agree  Somewhat Agree  Disagree

## Leadership and Governance

19. The organization has an active board of directors. Agree  Somewhat Agree  Disagree
20. The composition of the board of directors – in terms of PLWHA – is representative of the broader community. Agree  Somewhat Agree  Disagree
21. Organizational leaders model excellence in their actions. Agree  Somewhat Agree  Disagree
22. The organization's staff/volunteers are given opportunities to take on leadership roles within the organization. Agree  Somewhat Agree  Disagree

## Accountability

23. The organization has systems in place to routinely monitor and evaluate its activities. Agree  Somewhat Agree  Disagree
24. The organization openly reports on its activities and results. Agree  Somewhat Agree  Disagree
25. The organization has mechanisms to ensure accountability to beneficiaries. Agree  Somewhat Agree  Disagree
26. The organization has mechanisms to ensure accountability to donors. Agree  Somewhat Agree  Disagree

### Service Delivery

27. Before designing activities the organization conducts a thorough community needs assessment. Agree  Somewhat Agree  Disagree
28. All clients of the organization and the services they receive are properly registered. Agree  Somewhat Agree  Disagree
29. The organization maintains confidentiality for all clients. Agree  Somewhat Agree  Disagree
30. The organization maintains an effective referral system to link clients to the services they need. Agree  Somewhat Agree  Disagree
31. Clients' movement through the referral system is tracked on a regular basis by the organization. Agree  Somewhat Agree  Disagree
32. All services provided by the organization follow national guidelines and standards related to HIV/AIDS related care and services. Agree  Somewhat Agree  Disagree
33. The organization has written standard operating procedures for all of the services it provides. Agree  Somewhat Agree  Disagree
34. The organization has mechanisms in place for gathering feedback from beneficiaries on the quality of services. Agree  Somewhat Agree  Disagree

### Care and Support (complete if appropriate)

35. The organization is successfully able to mobilize community members to participate in care and support activities. Agree  Somewhat Agree  Disagree
36. The organization takes a holistic approach to home based care activities. Agree  Somewhat Agree  Disagree
37. The organization takes a long-term approach to dealing with orphans of the HIV/AIDS pandemic (including education, livelihoods etc.) Agree  Somewhat Agree  Disagree
38. Organization provides both medical and non-medical care and support services. Agree  Somewhat Agree  Disagree

### Treatment (complete if appropriate)

39. The organization has a regular and reliable source of medical supplies and drugs. Agree  Somewhat Agree  Disagree
40. The organization works in close collaboration with fully trained medical staff. Agree  Somewhat Agree  Disagree
41. Organization staff are properly trained in the administration of ARVs. Agree  Somewhat Agree  Disagree

**Testing and Counseling (complete if appropriate)**

42. The organization utilizes safe needle protocols. Agree  Somewhat Agree  Disagree
43. Counselors participate in regular training sessions. Agree  Somewhat Agree  Disagree
44. The beneficiary's right to privacy is always maintained. Agree  Somewhat Agree  Disagree
45. Counseled beneficiaries are always made aware of additional services available to them. Agree  Somewhat Agree  Disagree
46. Clients receive pre and post test counseling. Agree  Somewhat Agree  Disagree

**Prevention (complete if appropriate)**

47. The organization targets high-risk groups in its prevention activities. Agree  Somewhat Agree  Disagree
48. Prevention messages are provided in the local language of beneficiaries. Agree  Somewhat Agree  Disagree
49. Prevention messages use the most up-to-date and accurate information about HIV/AIDS. Agree  Somewhat Agree  Disagree
50. Prevention messages are tailored to reach specific audiences. Agree  Somewhat Agree  Disagree

**Advocacy (complete if appropriate)**

51. The organization has a well-defined advocacy plan. Agree  Somewhat Agree  Disagree
52. The organization has the necessary skills to conduct advocacy activities. Agree  Somewhat Agree  Disagree
53. The organization conducts advocacy training with community groups. Agree  Somewhat Agree  Disagree

**Capacity Building (complete if appropriate)**

54. The organization ensures that local actors have the necessary technical skills to carry out HIV/AIDS activities. Agree  Somewhat Agree  Disagree
55. The organization uses a variety of approaches to capacity building that go beyond traditional 'training' events. Agree  Somewhat Agree  Disagree
56. The organization builds capacity in core management areas (financial management, strategic planning, resource mobilization, etc.) with a view to fostering strong, sustainable local institutions. Agree  Somewhat Agree  Disagree

**Impact Mitigation (complete if appropriate)**

57. Internal stigma/discrimination is reduced through activities that build the self esteem of PLWHA. Agree  Somewhat Agree  Disagree
58. PLWHA play significant and visible roles within the organization. Agree  Somewhat Agree  Disagree
59. PLWHA are provided with a range of effective tools for positive living. Agree  Somewhat Agree  Disagree
60. The organization conducts education sessions to decrease stigma/discrimination in the community. Agree  Somewhat Agree  Disagree
61. Organization works with health care providers to reduce discrimination. Agree  Somewhat Agree  Disagree

## **Annex C: Organizations that Participated in the ROS**

1. Karonga Foundation (KAFA)
2. FOCUS
3. Livingstonia Synod AIDS Project
4. Ekwendeni CCAP Hospital
5. Tovwirane HIV/AIDS Organization
6. Rural Foundation For Afforestation
7. St Johns HIV/AIDS Support Organization
8. Mzuzu Youth Association
9. Forum For Youth Ladder
10. Kandoli Youth Organization
11. Yamikani Support Group
12. Nkota kota AIDS Support Organization
13. Salima AIDS Support Organization
14. Mponela AIDS Information & Counselling (MAICC)
15. Participatory Rural Development Organization
16. Malawi Interfaith AIDS Association (MIAA)
17. National Media Institute for Southern Africa
18. Circle For Integrated Community Dev. (CICOD)
19. Centre for AIDS Care & Training (CACET)
20. Christian Health Association of Malawi
21. Chovwano For Development
22. Nkhoma Relief & Development
23. Society for Women & Aid in Malawi
24. NAPHAM
25. Malawi Human Rights Resource Centre
26. World Relief
27. Association of Prog Women
28. Church & Society BT Synod
29. Development Aid from People to people
30. Matindi Youth Organization
31. The Salvation Army (Malawi Command)
32. Evangelist Trust For Church Development
33. Blantyre Syunod Dev. Commission
34. Sub-Saharan Africa Family Enrichment
35. Story Workshop Educational Trust
36. Hygiene Village Project
37. Gender Support Programme
38. AYISE
39. Malamulo Hospital
40. Youth Net and Counsellig
41. Dombolo-Freeworld
42. University of Malawi Students Union

## Annex D: Organizational Network Analysis Survey

### Question 1

Please place an X before the names of those organizations that your organization has collaborated with on *Care and Support* activities over the past year – since May 2006.

Add any additional organizations to the list that you have collaborated with on Care and Support activities. Note the type of organization

How would you describe your collaboration? (please enter the number that best reflects your level of collaboration)

Worked together?	Name of Organization	Organization Type	Collaboration Level

### Question 2

Please place an X before the names of those organizations that your organization has collaborated with on *Treatment* activities since May 2006.

Add any additional organizations to the list that you have collaborated with on Care and Support activities. Note the type of organization

How would you describe your collaboration? (please enter the number that best reflects your level of collaboration)

Worked together?	Name of Organization	Organization Type	Collaboration Level

### Question 3

Please place an X before the names of those organizations that your organization has collaborated with on *Testing and Counseling* activities since May 2006.

Add any additional organizations to the list that you have collaborated with on Care and Support activities. Note the type of organization

How would you describe your collaboration? (please enter the number that best reflects your level of collaboration)

Worked together?	Name of Organization	Organization Type	Collaboration Level

**Question 4**

Please place an X before the names of those organizations that your organization has collaborated with on *Prevention* activities since May 2006.

Add any additional organizations to the list that you have collaborated with on Care and Support activities. Note the type of organization

How would you describe your collaboration? (please enter the number that best reflects your level of collaboration)

<b>Worked together?</b>	<b>Name of Organization</b>	<b>Organization Type</b>	<b>Collaboration Level</b>

**Question 5**

Please place an X before the names of those organizations that your organization has collaborated with on *Advocacy* activities since 2006.

Add any additional organizations to the list that you have collaborated with on Care and Support activities. Note the type of organization

How would you describe your collaboration? (please enter the number that best reflects your level of collaboration)

<b>Worked together?</b>	<b>Name of Organization</b>	<b>Organization Type</b>	<b>Collaboration Level</b>

**Question 6**

Please place an X before the names of those organizations that your organization has collaborated with on *Capacity Building* activities since May 2006.

Add any additional organizations to the list that you have collaborated with on Care and Support activities. Note the type of organization.

How would you describe your collaboration? (please enter the number that best reflects your level of collaboration)

<b>Worked together?</b>	<b>Name of Organization</b>	<b>Organization Type</b>	<b>Collaboration Level</b>

**Question 7**

Please place an X before the names of those organizations that your organization has collaborated with on *Impact Mitigation* activities since May 2006.

Add any additional organizations to the list that you have collaborated with on Care and Support activities. Note the type of organization.

How would you describe your collaboration? (please enter the number that best reflects your level of collaboration)

Worked together?	Name of Organization	Organization Type	Collaboration Level

**Question 8**

Please name those organizations that have provided your organization with *resources* (financial donations, in-kind donations, intellectual capital) since May 2006. Include any associations or networks where you have membership or participate informally.

Enter the code(s) that best describe the kinds of resources provided by these organizations.

F = Financial Donations

K = In-Kind Donations

I = Intellectual Capital (Key Information, Methodologies, Tools etc.)

M = Mentoring (ad hoc assistance upon request)

O = Other (Please List)

How would you describe your collaboration? (please enter the number that best reflects your level of collaboration)

Name of organization	Org Type	Resource Type	Collaboration Level

**Question 9**

Please name those organizations or individual consultants who have provided your organization with *capacity building services* since May 2006.

What type of capacity building service was provided? Please describe in the space provided (for example, fundraising, technical support related to HIV/AIDS activities, financial management, strategic planning etc.)

How would you describe your collaboration? (please enter the number that best reflects your level of collaboration)

<b>Name of Provider</b>	<b>Description of Service</b>	<b>Collaboration Level</b>

## Annex E: List of Participant in Strategic Linkages Event

Name of participants	Organization
1. Peter Mangisa	AYISE
2. Kistone A G Mhango	Ekwendeni CCAP Hospital
3. Masozi Mkandawire	YONECO
4. Piet Mghogho	FOCUS
5. Dan Nthara	NASO
6. Jones Mwalwanda	Mathindi Youth Organization
7. Marvin Hanke	Story Workshop
8. Duthman Bisani	DAPP
9. Doreen Sapanga	DAPP
10. Bosco Sabulani	The Salvation Army
11. Maziko Matemba	Gender Support Programme
12. Roy Khoyongwa	Hygiene Village Project
13. Alick Kafunda	Word Alive- ICOCA Programme
14. Harrings JK Chirwa	Chovwano For Development
15. Hilda Petani	Malamulo Hospital
16. Yonaha Gondwe	Ekwendeni Hospital
17. Peterson Katumbi	Malamulo Hospital
18. Mary Phiri	SAFE
19. Frank Jumbe	Dombolo-Freeworld
20. Adamson Mkandawire	MHRRC
21. Francis Nyirenda	CACET
22. Billy Mayaya	Church & Society, CCAP Blantyre Synod
23. Rington Taibu	CCAP Blantyre Synod
24. Emily M Banda	Participatory Rural Dev. Organization
25. Kossam Munthali	FOCUS
26. Tifa Ngoma	NASO
27. Charles Mlogera	St Johns HIV/AIDS Support Organization
28. Albert C Moyo	Tovwirane
29. Sheeda Mwale	Kandoli
30. Maxwel Kadutsa	MAICC
31. Luke Edward	Tovwirane
32. Judith Chirwa	St. Johns HIV/AIDS Support Organization
33. Steve Mfuno	SASO
34. Gavelet Mzembe	SWAM
35. Christopher Boyer	CFSC
36. Nellie Mhanda	CCAP Nkhoma Synod
37. JJA Nkwazi	RUFA
38. John Soo Phiri	MHRRC
39. Keegan Banda	SASO
40. Cecilia Maganga	World Vision International
41. CSJ Mchenga	NAMISA
42. Wilfred Maluwa	SWAA

43. Richard Banda	APW
44. Blessings Chimphamba	National AIDS Commission
45. Andrew Chikopa	MBCA
46. David Nyirongo	NAPHAM
47. Humphrey Shumba	USAID-Malawi
48. Levison Longwe	World Relief - Malawi
49. Gibson Nkanaunena	World Relief - Malawi

## Annex F: List of Resources

1. Chitsanathi, Godfrey; Interview – the Umbrella Project (National AIDS Commission). Interview with Matthew Reeves; Blantyre, Malawi. April 18, 2007.
2. Kapyepye, Ethel – World Vision, Malawi. Interview with Matthew Reeves; Blantyre, Malawi. April 19, 2007.
3. *Local Government Responses to HIV/AIDS: A Handbook to support local government authorities in addressing HIV/AIDS at the municipal level.* World Bank: <http://www.worldbank.org/urban/hiv aids/handbook/handbook.pdf>. 2003
4. Malawi Sustainable Development Network Programme—list of Malawian NGOs, Feb. 2003. <http://www.sdn.org.mw/ngo/ngo-mw-list.html>
5. *MALAWI: Chiefs lead by example in response to HIV/AIDS.* IRIN PlusNews Network. 21 December, 2006. <http://www.plusnews.org/report.aspx?reportid=62875>
6. *Malawi's 'Brain Drain' Crisis; Physicians for Human Rights Ad, Letter Highlight African Crisis, Financial Times Examines.* 10 July, 2005. <http://www.medicalnewstoday.com/medicalnews.php?newsid=27192>
7. Malunga, C. 2007. Improving Strategic Planning Among Local NGOs in Malawi. Doctoral Thesis, Department of Development Studies, University of South Africa.
8. Mtonya, Brian, Victor Mwapasa, and John Kadzandira. System-Wide Effects of the Global Fund in Malawi: Baseline Study Report. Bethesda, MD: October 2005.
9. National Aids Commission (NAC): Public Sector HIV/AIDS Training and Induction Manual for Project Managers and Coordinators. August, 2005.
10. NAC Overview of HIV and AIDS Response, June 2006 {charles and chikku—need further citation)
11. Osbourne, Carrie and Holst, Lesley – Save the Children, Malawi. Interview with Matthew Reeves; Blantyre, Malawi. April 20, 2007.
12. Putnam Jr., Eliot.; Capps, Jean Meyer RN, MPH; Von Briesen Lewis, Ann. Mid-Term Evaluation Report: Save the Children's Capacity Building for Quality HIV/AIDS Services (Umoyo Network). June 2005.
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14. *Taking Stock: Health worker shortages and the response to AIDS.* World Health Organization. August 2006.
15. USAID Health Profile: Malawi. February, 2005. [http://www.synergyaids.com/Profiles\\_Web/Profiles\\_PDFs/MalawiProfile2005.pdf](http://www.synergyaids.com/Profiles_Web/Profiles_PDFs/MalawiProfile2005.pdf)
16. World Bank Website-- <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/EXTAFRHEANUTPOP/EXTAFRREGTOPHIVAIDS/0..contentMDK:20450345~pagePK:34004173~piPK:34003707~theSitePK:717148,00.html>