



**Aid and HIV/AIDS Policies in Mozambique:  
Successes and Obstacles towards Country Ownership**

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This document represents part of the author's study programme while at the Institute of Social Studies. The views stated therein are those of the author and not necessarily those of the Institute.

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## List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Treatment
CBOs	Community Based Organizations
CIDA	Canadian International Development Agency
CNCS	<i>Conselho Nacional de Combate ao SIDA</i>
DAC	Development Assistance Committee
GARPR	Global AIDS Response Progress Reporting
GDP	Gross Domestic Product
GFTAM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
ICT	Information Communication Technology
IMF	International Monetary Fund
INSIDA	Population-Based Sero-Behavioral Survey <i>Inquérito Nacional de prevalência, riscos comportamentais e informação sobre HIV e SIDA</i>
MDGs	Millennium Development Goals
MISAU	<i>Ministerio de Saude/Ministry of Health</i>
MNHDR	Mozambique National Human Development Report
NGOs	Non-Government Organizations
NPCS	<i>Nucleo Provincial de Combate ao SIDA</i>
OD	Opportunistic Diseases
ODA	Official Development Assistance
OECD	Organization for Economic Cooperation and Development
PEPFAR	President's Emergency Plan for AIDS Relief
PAR	Participatory Action Research
PARPA	Action Plan for the Reduction of Absolute Poverty <i>Plano de Acção para a Redução da Pobreza Absoluta</i>
PBA	Program Based Approaches
PEN	National HIV and AIDS Strategic Plan <i>Plano Estratégico Nacional de Combate ao HIV e SIDA</i>
PLWHA	People Living With HIV/AIDS
POMD	District Multi-sectorial Operational Plan <i>Plano Operacional Multisectorial Distrial</i>
POMP	Provincial Multi-sectorial Operational Plan <i>Plano Operacional Multi sectorial Provincial</i>

SAPs	Structural Adjustment Programs
SSA	Sub-Saharan Africa
UN	United Nations
UNAIDS	The Joint United Nations Programme on AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNHDR	United Nations Human Development Report
UNICEF	The United Nations Children's Fund
UNDP	United Nations Development Programmes
WHO	World Health Organization

## ***Abstract***

This paper seeks to understand the relationship between aid and AIDS in Mozambique's aided response towards the HIV/AIDS struggle and in assessing to what extent aid impacts on the country's HIV/AIDS policies. Mozambique's HIV/AIDS policy document is its guiding document with guiding principles towards the country's fight of the disease yet it is met with many challenges. *First* it is barely implemented at country level, *second* there is little control of the actors by the coordinating body, *third* donors still prefer vertical funding although they support the general budget which when analysed decreases financial resources towards direct policy implementation and *fourth* the policy lacks a valuation making it hard to evaluate to which extent expenditures correspond to priorities in financial terms. 96% of aid to fight HIV/AIDS comes from external sources which questions the country's sustainability of the HIV/AIDS response. And with increased focus on "Ownership", Mozambique has few options but to scale up its aid and improve on aid effectiveness while bringing all its actors on board for an effective coordination and policy implementation.

## ***Relevance to Development Studies***

Aid in international relations is a heated debate for those giving (North) and for those receiving (South). Current shifts in aid flows and the disproportionate funding to HIV/AIDS than other health issues has gained coverage from those within development and global health arenas. It is on this basis that regional and country studies on aid be discussed as a way of finding a balance between the effective fight of HIV/AIDS and other health needs in aid dependent countries .

## **Keywords**

Aid, HIV/AIDS, Mozambique, Ownership, PEN III, Actors,



*Dedication*

To My Children Genesis and Reis

## *Acknowledgement*

I wish to express my utmost gratitude to my supervisor Prof. Kees Biekart for believing in me even when I didn't think I could make it. Your guidance gave me confidence when I had none. Thank you very much!

To my reader, Sylvia Bergh, Thank you for your comments and suggestions, they helped me get in line.

Dr. Narciso A. Mahumana, Thank you for getting me started!

To my family, I say 'Kanimambo'

# Chapter 1: Introduction

## 1.1 Introduction and Background

With renowned political will to lead the efforts in stopping HIV/AIDS, in the last 10 years, the Government of Mozambique has had a number of policies put in place for controlling the expansion of HIV/AIDS. This however does not mean that the country has been effective at reversing the results. Rather it has guided the country's focus in combatting the disease and as well as increase on aid. Current policies include; the National Strategic Plan to Combat HIV and AIDS (2000-2002, 2005-2009 and 2010-2014), commonly known as *Plano Estratégico Nacional* (PEN I,II,III), the Strategy for accelerated prevention of HIV and AIDS (2009-2010), the National Strategy for Responding to HIV and AIDS in the Civil Service (2009-2013) and the initiative by the President of the Republic on reflection for a multi-sectorial response to HIV and AIDS (see PEN III, INSIDA 2009). With increased numbers of infected people, the current AIDS policies have been reviewed in order to accommodate the changing epidemiology of HIV/AIDS based on experience and best practices.

Also with two laws on HIV/AIDS and Human rights, it might seem like Mozambique is equipped to fight the disease yet with so many policies all running back to back, and with evident lack of monitoring procedures, as expressed in UNGASS country reports, it is hard to authenticate if over the past 10 years there have been intense achievements against HIV/AIDS. This concern has been voiced in the country evaluation reports and also in the HIV/AIDS policy paper (GARPR-CNCS 2012:28). Thus the challenge henceforth questions the country's goal towards aid effectiveness in the implementation of the HIV/AIDS policies. Which then translates into following up on the five principles of the Paris declaration towards better aid management and better implementation.

However, different from past policies was the participation of the civil society organizations in consultations for the first time (Follér 2013:50). This initiative is seen as positive, although mere participation in such consultations is said not to be enough especially if the civil society actors are to gain skills

and be able to debate with donors on the same issues. Over the years critics have described Mozambique's civil society as weak, see (Sogge 1997, Hanlon 2004, Awortwi and Nuvunga 2007), yet in the aid effectiveness discourse, the ability of actors to manage, own, align and act is paramount.

The current HIV/AIDS policies emphasize ownership of the AIDS response as a way of achieving aid effectiveness, increased leadership and a coordinated response. In this case aid effectiveness translates into aid having impact in reducing poverty and inequality, increasing growth, building capacity and accelerating achievements towards the Millennium Development Goals (MDGs), (OECD). Thus the focus on reforming the way aid is delivered. For Mozambique reform has been set in its HIV/AIDS strategic plan known as PEN III, which is a guiding document meant to harmonize and coordinate all HIV/AIDS response interventions. With this, the government renews its commitment to promote an effective response to HIV/AIDS at all levels. But with 96% external aid to Mozambique's AIDS fight, sustainability and ownership of the response is put to question. And thus the need to analyse how the set targets in the AIDS policy can achieve a level of ownership and effective leadership amidst increased external assistance?

## **1.2 Mozambique's AIDS Specifics**

At 11.5% of HIV/AIDS prevalence rate, Mozambique does not rank amongst the top highly affected countries in sub-Saharan Africa, yet we cannot say the same for its neighbours, for instance; South Africa (17.8%), Swaziland (25.9%), Zambia (13.5%), and Zimbabwe (14.3%) Botswana (24%), Lesotho (23.6%) and Namibia (13.1%) (UNAIDS 2010). However Mozambique is among the world's top 5 with absolute numbers of people living with HIV (Bidaurratzaga-Aurre and Colom-Jaen 2012:235).

Generalization can be misleading on HIV/AIDS in Mozambique as indices differ largely nationally. The South region has the largest indices at 25% followed by the central and then the north region with the least at 9%, (see table 1). Contributing factors to increased indices within regions also vary largely to the country's international boundaries. For example; the southern

region is bordered with South Africa and Swaziland, the central region bordered with Zimbabwe, Malawi and part of Zambia while the North borders with Tanzania and part of Malawi<sup>1</sup>. Mozambique has 11 provinces: North, with provinces of Niassa, Cabo Delgado and Nampula; Central region with provinces of Zambezia, Tete, Manica and Sofala, the South region, has provinces Inhambane, Gaza, Maputo Province and Maputo City. “Each province is divided into districts, making a total of 128 districts and 43 municipalities” (INSIDA 2009:02)<sup>2</sup>.

**Table 1: Mozambique's Regional HIV/AIDS Prevalence rates in adults**

<b>HIV Prevalence rates in Adults (15-49)years</b>			
<b>Period</b>	<b>2004</b>	<b>2007</b>	<b>2009</b>
South	19%(14-21%)	21%(16-23%)	21%(17-25%)
Central	18%(17-20%)	18%(17-12%)	18%(14-21%)
North	8% (6-9%)	9% (7-10%)	9% (7-11%)
National	15%(13-15%)	16%(14-16%)	15%(14-17%)

**Source: UNGASS/CNCS, (2008-2010)**

Factors also vary greatly towards increased HIV rates in the regions. The province of Gaza in the south of Mozambique has the highest percentage of HIV infected adults, the fact that most of its population works in the mines in neighbouring South Africa. The impact of migration for work purposes on increased HIV infections can be noted in this region. Data on national and local epidemiological trends clearly shows variations in the magnitude of the disease displaying unique epidemiological characteristics over time (PEN III 2010-1024). Unlike other diseases HIV/AIDS affects the economically productive groups which puts into question the country’s economic growth and sustainability.

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<sup>1</sup> See chapter 3, sub section 3.3 for a detailed analysis of the regional trends on HIV/AIDS.

<sup>2</sup> See Map 1 on page 9

Statistical data shows that Mozambique has about 1.6 million people living with HIV/AIDS accounting for 15% of the Mozambican population of which 55% are women and 9.2% children under 15 years (PEN III, INSIDA 2009, UNAIDS fact sheet 2012). Further, it is estimated that every day about 440 Mozambicans get infected by HIV and AIDS (PEN III, INSIDA 2009). Thus HIV is one of the burdens to the human development of Mozambicans which calls for extreme ventures in its control. Not forgetting that HIV/AIDS has tremendously reduced the life expectancy years of Mozambicans.

However ventures have been seen in increased aid for health yet Mozambique's indices are still high contrary to its neighbours who receive less aid. Thus the need to critically analyse why Mozambique continues to have higher HIV indices amidst increased aid for its health policies. How does aid impact on the country's struggle against HIV/AIDS, and in achieving ownership and control of the response? These are some of the drivers that orient this research.

### **1.3 Research Objectives**

The main objective of this research is to understand how foreign aid has impacted on HIV/AIDS policies in Mozambique for the periods of 2005-2012. And assess how the country can achieve ownership of its response amidst policy implementation challenges.

Thus the research will try to answer the following **questions**:

1. What is the relationship between aid and AIDS in Mozambique's HIV/AIDS policies? What are the successes and obstacles in the implementation of the HIV/AIDS policies?
2. How does the increased AIDS budget translate into results for the country's HIV/AIDS policies?
3. How has Mozambique owned its HIV/AIDS policies in view of increased aid effectiveness?
4. How have the actors impacted on Mozambique's HIV/AIDS policies under the increased focus on aid effectiveness?

This research topic and specialization is motivated by my interest in Social Movements, Civil society and Non-Government Organizations having been involved with them for over 15 years both in Uganda and in Mozambique. Most processes regarding AIDS strategies I have taken part, thus the need to learn and relearn through this research process in order to be able to contribute to the on-going and future development dialogue on aid and HIV/AIDS in both countries.

## **1.4 Justification of the study**

Apparently Mozambique is not one of the countries in the sub-Saharan Africa region with overly high rates of HIV/AIDS, although its HIV/AIDS policies raise interesting questions. This is coupled with huge flows of aid to finance its HIV/AIDS situation which consequently brings forward issues of aid dependency, ownership and sustainability.

Mozambique has been implementing its AIDS policies since 2000 when the first HIV/AIDS strategic plan was approved. Thus progress recorded in the expansion of prevention, treatment and mitigation services is noticeable yet additional efforts are still needed to improve the impact of the national HIV/AIDS response. And as well as to ensure country ownership and effective leadership in leading the AIDS struggle (PEN III). As a nation, Mozambique has to contend with a larger young population 10-24 years (19.4 %) that is in need of social and basic services in order to prevent the negative influence on the future trends of human development (as noted in the Government's five year program 2005-2009). Mozambique has an impressive record of international, national and local organizations thus uncoordinated and unfocused AIDS actions makes it hard to know exactly what and how the country is progressing in stopping AIDS.

With increased focus on ownership and with increased aid towards the general budget support, the government has to show effective leadership of its own development yet this aid is said to be putting donors in the driver's seat (Jelovac and Vandeninden 2008:02). Contradictory to the Paris declaration on

aid effectiveness is the continuous vertical funding of some donors with aid not being aligned to the government's priorities. Therefore analysing the relationship between aid and AIDS and assessing how aid impacts on the existing policies will help inform strategies for future mechanisms on better aid management.

## 1.5 The Methodology

### *Methodological overview*

This research is based on the analysis of quantitative secondary data within a defined time frame of 2005-2012 on aid and AIDS in a period that has seen changes in the way aid is delivered and monitored. **Desk review** of relevant documents on the topic by different authors, donors, NGOs and government including policy documents are reviewed. Other methods for this study include;

*Literature review about the key debates on the relationship between aid and HIV/AIDS*, reviewing what has been said about foreign aid, HIV, and what has worked and the perspectives in which this has been derived. The literature review provides a framework in which I prepare the ground for a more analytical approach on how foreign aid impacts on existing policies, and how actors are involved including factors that impede the successful implementation of these strategies. This includes information about aid and HIV/AIDS between 2005-2012 from authors, websites such as the World Bank, Organization of Economic Development reports, aid statistics (OECD), UN agencies, the Paris declaration on aid effectiveness, government of Mozambique portal for policy documents and other reports, Civil Society NGOs and regional reports. Key words of the review include aid, HIV, AIDS, aid effectiveness, funding priorities; sub-Saharan Africa, Mozambique, National aid council, as well as key budget documents.

**Quantitative data** has been said to be very important for policy analysis (Wuyts and Mukherjee 2007). Here I will review and interview documents, journal articles, policy documents etc. These will help in getting and quantify-



ing numeric data on aid within the health sector. Data got from these materials feeds into the overall objective of the research on budget needs and funding needs to fight HIV/AIDS and whether these translate into results for an effective AIDS implementation. Statistical data taken from the OECD web page which has data on Official Development Assistance (ODA) from members of the Development Assistance Committee (DAC) and World Bank statistics is calculated to fit the purpose, it has been put either into graphs, made into percentages or calculated into ratios in order to understanding the level at which HIV/AIDS statistics are assessed. All calculations are done by the author. This set of data can be mainly found in chapter three in understanding the correlation between the budget and the HIV/AIDS needs.

*Interviews* were carried out on professionals who have experience in different development institutions within the non-profit sectors of Mozambique. Selection was based on local NGOs and the National AIDS council. These respondents provided qualitative information. Information here deals with responding to how the National HIV/AIDS strategic plan is being implemented and whether there is coordination and collaboration from the government under the National AIDS Council (NAC/CNCS) and with the civil society organizations. The table below shows the selection of institutions that supported this research. Complete lists and questions are included in appendix 2.

**Table 2: Interview Respondents**

<b>No</b>	<b>ORGANIZATIONS- Mozambique</b>	<b>TYPE</b>
1.	HIKONE –Moçambique	NGO
2.	Comunidade Moçambicana de Ajuda	NGO
3.	ISEDEL Moçambique /PROMETRA- Institute of Higher Education	Academic Institute
4.	Provincial AIDS Council/ Xai Xai – NPCS	NPCS –Government
5.	ACIDECO	Local CBO
6.	Xithlango	Local CBO

### ***Research procedure***

A literature review was carried out in order to define the scope of the research focusing on key debates on aid and HIV/AIDS and the existing policies to fight the disease within the global, regional and national stage. This review looked at the intents of aid and the successes of aid towards the AIDS policies. Understanding donor preference towards any given type of aid helped in informing the intents of aid under the different aid modalities widely used in the country. Here I briefly looked at project support and general budget support as aid supporting the HIV/AIDS and health policies in Mozambique. Challenges and successes were also reviewed. The data on key debates was analysed, treated and critiqued accordingly. An analysis on AIDS budgets was carried out. This analysis was to assess how aid has impacted on AIDS and AIDS policies under the ownership discourse and the increased focus on coordinated AIDS response. Regional trends on aid for HIV/AIDS was also analysed as a way of learning from within. Here I looked at some sub-Saharan African countries and how much aid they are receiving towards their aid budgets in comparison to Mozambique. Chapter four was answering research question four with focus on understanding how the current AIDS policy is being implemented. Here interview information was widely used to back up claims on the implementation and impact of the AIDS policy. Statistical data was got from OECD and World Bank online data sites. This data was analysed and turned into tables, graphs, calculated percentages and what each of these meant.

However, missing statistical data made it difficult to calculate and make conclusions. Also the fact that different donors have different data yet all operating in the same country made it difficult to analyse their information. Thus I focused more on reliable and mostly cited sites and government reports, UN reports and other reliable sources.

For the qualitative interviewing, a set of NGOs were selected on the basis of; i) their expertise on development aid in Mozambique; ii) expertise on HIV/AIDS; iii) their involvement with the national AIDS council, iv) the relevant experience in the development aid field and v) their involvement in the formulation process of the national AIDS policies and; vi) being beneficiaries

of vertical funding. Interviews were face to face with the respondents in Mozambique.

The research focused on Mozambique, which is bordered by highly endemic regions of sub-Saharan Africa (SSA). Mozambique's case with its high collaboration with donors; huge economic growth amidst increased rural poverty; high aid inflows; and development policies made it an interesting research and not forgetting its privileged location within the region.

### Risks

The author was involved in the provincial AIDS network working groups and platforms on seeing that the civil society worked together with the government (CNCS/NPCS) on HIV/AIDS in the country. The risk was to avoid being biased while analysing the national AIDS policies, thus I refrained from taking sides although my voice as a practitioner is involved.

**Map 1:** Geographical Location of Mozambique and its Southern Africa Neighbours



(Map analysed in section 1.2 above)

## **Chapter 2 : Key debates on the relationship between aid and AIDS and its impact on HIV/AIDS Policies**

### **Introduction**

This chapter provides a theoretical review of literature on the relationship between aid and AIDS and how aid has or is impacting on the HIV/AIDS policies for countries with high HIV prevalence and in particular Mozambique. It analyses this relationship by defining the key concepts while showing the different views and how they are influencing the international and regional perspectives on the topic. This chapter is in line with research question one

### **2.1 Defining AIDS**

The Human Immunodeficiency Virus (HIV) which causes AIDS, (Acquired Immunodeficiency Syndrome) was first clinically identified in 1981 (UNAIDS) and since then, it has spread around the world. In Mozambique the first case of AIDS was diagnosed in 1986. AIDS weakens the immune system in the body of the host making him susceptible to Opportunistic Diseases (OD) that ultimately leads to death. Over 3 decades since the ‘unexpected emergency’ (Singer 1998:33), HIV cure has not been found yet. The numbers of people living with HIV/AIDS have continuously spiralled to peaks especially in sub-Saharan Africa. This leaves the world perturbed since it affects the most productive members of the society. The 2000 UNAIDS report showed that 34.3million people were living with HIV, and 34 million in 2011. Sub-Saharan Africa (SSA) accounts for 69% of these figures and 85% of estimated AIDS deaths, making AIDS an exceptional disease within the region yet critics state that making HIV exceptional may have increased stigmatization (Smith et al 2011, England 2007).

## 2.2 Aid Defined

Because aid comes in so many different forms, this makes it extremely difficult to define. These forms have different effects and different time lags (Pronk 2004:04). Pronk (2004) believes that such difficulties can be ‘partially overcome’ by relating the specific form of aid to specific target variables (*ibid.*:04). OECD defines Official Development Assistance (ODA) by the Development Assistance Committee (DAC) as the sum of flows (grants and loans) to countries and territories provided (a) by official agencies and is administered with (b) the promotion of economic development and welfare of developing countries (c) and is concessional in character and conveys a grant element of at least 25 per cent of the total (OECD). OECD definition of aid rejects grants and loans for military purposes as ODA since these activities are a threat to the donors and the countries they support. Also donations, foreign direct investment and commercial loans are not counted as official aid. The definition above shows that foreign aid is not always a free resource transfer and often arrives with economic and political conditions (Finn 2009). The emphasis of this paper relates to ODA towards project aid and general budget support and how this aid impacts on AIDS policies in Mozambique.

## 2.3 Project aid versus General budget support

This sub section is targeted at understanding why donors prefer these kinds of aid modalities.

Project aid is not new in development especially since it has been overly used by funding agencies in the past. Project aid benefits a number of small projects and large public investments which typically focus on direct implementation by the donors, NGOs and the local communities. The criticism towards project aid is linked to donors taking on leadership and ownership of the development initiatives rather than giving the beneficiaries or aid recipients a chance to act (Buitenlandse Zaken Ontwikkelings samenwerking 2006). In the fight against HIV/AIDS, civil society actors have been increasingly sought as partners and “critical contributors” towards the effectiveness of project aid (Kelly 2010:1580). More criticism has been linked to lack of harmonization by the donors and the failure to align with the recipient governments’ procedures

(Glennie 2008:92) and a reduction in public investments (Mavrotas 2003:12, De Renzio 2008:627) and due to aid fragmentation, project aid was said to have insufficient accounts of the broader context in which poverty could be tackled, as there was inconsistency in aid and poor governance (Buitenlandse Zaken Ontwikkelings samenwerking 2006). Donors such as Global Fund to Fight Tuberculosis, AIDS and Malaria and the Presidents Emergency Plan for AIDS Relief have largely supported project aid because such aid is gets to the people who need it. Such projects are drawn by local implementers for local solutions thus the never ending support which is in clear contradiction to the principals of the Paris declaration on aid effectiveness (Bidaurratzaga-Aurre and Colom-Jaen 2012:226).

On the other hand, donors believe that general budget support can remedy aid effectiveness (De Renzio 2008). With a scenario were governments have to take active leadership, ownership, develop and prioritize their own development policies. Budget support means that with support of donors and participation by all relevant actors, aid can be administered by recipient governments (*ibid.*:629). Here donors support would be in terms of alignment with the recipient's policy and budgets yet this kind of aid modality has been also found lacking (Glennie 2008). However literature notes that "there is little evidence to suggest that the necessary change is under way" for donors to continuously and consistently align with budget support (Glennie 2008:92). Donor preferences towards these two modalities can only be analysed against the objectives and intents of giving. Even with increased budget support some donors still continue to provide aid through vertical funding for project support (Shiffman 2008:99) superseding the countries domestic budgets.

However Mozambique has continuously benefited from both aid modalities although the government is more in favour of taking control of the aid through budget support. Budget support improves greater predictability and increases effectiveness of state and public administration (De Renzio 2008). Although reduction in project aid means less vertical funding for civil society organizations as their actions need to be aligned with the government and sector wide approaches to avoid duplication of efforts. The hypothesis is that aid

can work if recipient countries have sound policies and good governance (Awortwi and Nuvunga 2007, Baulch 2006:933), this is also voiced by the World Bank. Testing this is by emphasizing the importance of country ownership for sustainable development. OECD and the Paris declaration is committed to this yet both modalities are still donor driven, see (Jelovac and Vandeninden 2008:02) thus the need to analyse why aid continues to be given amidst mixed reviews and contradictions.

## 2.4 Intents of aid

Aid is given for many purposes and intentions. Some say aid is given for economic purposes (Pronk 2001:199), or for social purposes (De Renzio 2006, Baulch 2006, Bjornskov 2013) others for reconstruction (Awortwi and Nuvunga 2007, Moyo 2009, Bjornskov 2013). In the cold war period, aid was to fulfil political rather than transformational aims which are said to have espoused the principles of capitalism (Picard et al. 2008:26), but for whatever the intention, aid has been said to have its own effects (Bjornskov 2013). Glennie (2008) notes that the literature on aid impacts is complex, as one author will be positive, and the other will be negative (*ibid.*:25).

Aid for reconstruction has been found effective especially in Mozambique, for the flooding of 2000. Here results were immediate which cannot be said about other types of aid (Bjornskov 2013). For that reason, aid in international relations was intended to be for a fairly shorter period, targeted towards reconstruction or a “medium term gap-filling”<sup>3</sup> mechanism in developing countries with the assumption that change could be achieved fairly quickly. Which meant that aid was meant to help poor countries move forward on their own way into the industrial technological age (...)to raise their level of economic development (Randel et al. 2002:26). But as it is, aid is continuously growing and following on from the Monterrey consensus, DAC countries in alignment with the Millennium Development Goals (MDGs) are committed to increasing

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<sup>3</sup> Chenery and Strout 1966 as quoted by Nuvunga and Awortwi 2007 stated that this aid was targeted towards the reconstruction, as in the case of Europe or as a medium-term gap filling mechanism in developing countries, supplementing domestic savings and foreign exchange earnings (p.34)

aid and making it effective as well. In Mozambique aid's intents are manifold. With increased HIV prevalence and high poverty index, aid can be given for many intents regardless of need.

## 2.5 Aid for HIV/AIDS

HIV/AIDS is a long-term problem which requires long term financing, thus countries in developing regions need to know how resources required for combatting HIV/AIDS will be met. While putting into considering the changing dynamics and scaling up of aid on a global scale (Hecht et al. 2010:1254). Hecht implores countries ravished by AIDS to think of increasing their domestic expenditures towards the disease in view of increased economic uncertainties (*ibid*).

Sub-Saharan Africa tops the list of highest ODA recipients. 2/3 of all ODA from DAC goes to this region (Organisation for Economic Co-operation and Development 2008). Also overall, about US\$1 trillion worth of aid in the last several decades is said to have been spent in Africa in form of development-related aid yet this same continent houses the poorest of the poor (Moyo 2009:xix). But this is just one side of the debate considering the fact that although issues regarding aid are relevant, they are also contentious and have to be discussed consciously (Bidaurratzaga-Aurre and Colom-Jaen 2012:226).

Health Aid to developing countries is supposed help meet the health related millenium development goals; (reduce child mortality Goal4, improve maternal health Goal 5, and combat HIV/AIDS, malaria and other diseases, Goal 6). The aid is provided by major Development Assistance Committee (DAC) which comprises of 28 developed countries in support for developing countries through general budget support and pooled funds among other mechanisms for programs (Organisation for Economic Co-operation and Development 2009, Bjornskov 2013, Buitenlandse Zaken Ontwikkelings samenwerking 2006). This as explained above is to promote country ownership and as well as increase leadership (Whitfield 2009:02). Yet as donor budgets get squeezed, scarce resources must be allocated where they are most needed especially if the MDGs are to be met (Glennie 2008:29); and second, if



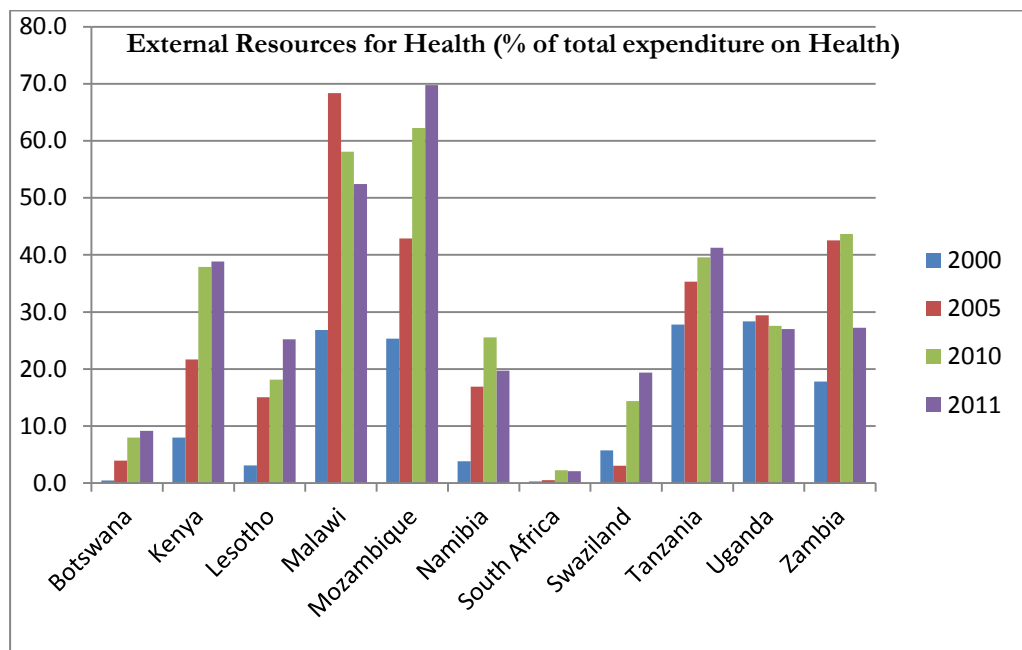
the eradication of absolute poverty is not the only purpose of aid (Pronk 2004:190).

Aid for HIV/AIDS has revolved and evolved since the early 1990s. The period 1990-1995 was characterised by high HIV infections reaching a peak in some countries, which led for increased aid and worldwide awareness towards prevention interventions, the period 1995-2000' emphasis for increased aid was focusing on mitigation efforts which included but not limited to supporting Antiretroviral Treatment (ART) and a focus on AIDS orphans. Thus most aid provided then went to reconstruction, integration and mitigation. From 2000 -2005 scaling up for aid effectiveness started as aid coordination was found absent. This led to the elaboration of the "Three Ones, One HIV/AIDS action framework that provides the basis for coordinating the work of all partners; One national HIV/AIDS coordinating authority with a broad-based multi- sectorial mandate; and One country-level monitoring and evaluation system", UNAIDS 2004 quoted by (Kelly 2010:1581). This vision was to increase the national HIV/AIDS response by harmonising the national strategic plan while aligning it with funding agencies to reinforce the framework of a single plan, authority and monitoring and evaluation. Not only was this effective on the "formulation of international funding mechanisms, it also increasingly rationalised as fulfilling components of national strategies and as accountable to national authorities"(Kelly 2010:1581). However, this period was also hit by the economic crisis.

From 2005 to date has been characterised by increased focus on aid effectiveness and reinforced by three high level forums, Paris declaration, Accra Agenda for Action and Busan partnership. Also worthwhile to note during this period is the heightened efforts towards result based monitoring and evaluation and increased domestic accountability (De Renzio 2006:628). Under general budget support, aid towards HIV/AIDS for Mozambique's health sector has been channelled to the Ministries of Health who are responsible in aligning it with the health policy priorities. Considering the huge amounts involved, alignment and harmonization are seen as good indicators (Bidaurratzaga-Aurre and Colom-Jaen 2012). These increases have surmounted to increased debates on aid in sub Saharan Africa with some saying that HIV funding is out of bal-

ance and with more billions committed to meet the health MDGs and other goals, HIV will claim half of all health aid (England 2007). Yet the other camp argues that resources are woefully short in almost every area of public health. Whereby aid should provide an opportunity and entry point for strengthening health and social service systems if it is used appropriately (de Lay et al. 2007).

**Figure 1: External Resources for Health for Selected sub-Saharan Africa (2000-2011)**



*Source:* Made by author based on World Bank dataset (2013) on selected countries.

External resources for Health within SSA have continuously increased over the years, occupying more than 50% of some of the countries health expenditure as shown above and largely explained in the chapter. Data above shows increases and changes in external dependence for health provision within years. For example Malawi shows higher dependency in 2005 and less dependence in 2011 contrary to Mozambique which received fewer resources in 2004 and a peak in 2011 to about 69.8%. Noteworthy is South Africa, which has high HIV rates and receives less external resources for its domestic health provision. However this aid should translate into tangible results for countries receiving a higher proportion of aid more than their percentage of GDP. Here

domestic health aid should show healthy diversions towards other health needs in coverage of external resources.

## **2.6 Success and Obstacles of aid towards HIV/AIDS policies**

Although there are competing theories on the effectiveness of aid, a vast body of literature shows how aid impacts on the fight against AIDS, poverty and inequality and how essential it is in promoting democracy and growth (see Hecht 2010, UNAIDS, Paris declaration, Moyo 2009).

In 2000, The UN's Millennium Goals Project estimated an increase of global ODA to at least US\$ 195 billion by 2015 (Bidaurratzaga-Aurre and Colom-Jaen 2012:31), this as we know was and is to be used on the on-going need to achieve the MDGs before deadline. Not only was this an advancement, more agencies and coordinating bodies were launched to ensure the effectiveness of this aid. UNAIDS, Global Fund, G19, the Health Partners+ (HP+), the President's Emergency Plan for AIDS Relief (PEPFAR), Global Fund to fight AIDS, Malaria and Tuberculosis (GFTAMT) and many others came into existence principally to coordinate the fight against HIV, malaria, Tuberculosis and other infectious diseases. They have a mandate to make sure that AIDS gets all the funding needed regardless of other health needs making aid disproportional (Shiffman 2008). Successful focus on AIDS by these agencies has been met with criticism (*ibid*, England 2007, Moyo 2009).

The successful engagement in AIDS activism from the top is important in fighting HIV/AIDS. Political support has not lacked in some sub-Saharan Africa Countries and especially in Mozambique's. In otherwise the creation of the AIDS commissions in developing countries meant the successful monitoring and coordination of the work of the NAC. In Mozambique NAC/CNCS is chaired by the prime minister and the vice president of the council is the minister of health. These participate and lead actively in government policies (INSIDA 2009). Thus the successful implementation of the AIDS policies and other HIV/AIDS multi-sectorial plans lie on the assumption that leadership is from the top. Aid effectiveness can be achieved although in Mozambique, the amount of aid involved does not equate to decreased indices as Subramanian *et*

*al* noted that generalised assumptions on aid effectiveness are unwarranted, well as policies relying on such should be re-examined (Rajan and Subramanian 2005:19). Also Nunnenkamp *et al.*(2011) argued that, HIV/AIDS variables had to show a decline if ODA was effective suggesting that donors also had to be aware if their ODA had effect in the recipient countries regardless of the motive of giving (Nunnenkamp and Öhler 2011:1706).

The obstacles of aid towards a successful AIDS fight in Mozambique have been linked to aid dependency, increased poverty levels and the failure for some governments ownership of their HIV/AIDS response (Moyo 2009:05, UNAIDS, Bidaurratzaga-Aurre and Colom-Jean 2010 ). Thus the analysis of successes in the fight against AIDS can be linked to obstacles from country to countries in understanding how these translate into better policy framing, increased coordination and increased learning from within.

## **2.7 Factor impeding the AIDS success**

There exist a number of factors impeding the success of the AIDS struggle under the AIDS debate in developing countries. The factors listed below are some of those that have been mentioned in Mozambique's progress reports, donor reports, national strategic plans and various articles on aid and AIDS;

### ***Weakness of the state***

The problem of weak states has been justified by Brautigam who stated that;

“States are weak for many reasons; many states in the developing world are relatively new, and skill levels are low. Economic crisis has challenged their claim to legitimacy. Governments in weak states remain weak because they are unable to resist the pressures from powerful vested interests to distribute funding resources in ways that dilute capacity and lower effectiveness” (Geddes 1994 as quoted by (Brautigam 2000:35)

This classification of weak states is rooted in post-colonial failures for countries to pull themselves out of the trance after over 40 years of independ-

ence. However, changes in the aid modalities have also contributed to the weakness of states and the inability to provide services from central government to local government. In 1997, Webb, stated that the spread of HIV/AIDS had been hindered in southern Africa because government intervention had very little impact on the course of the epidemic (Webb 1997:71). However Riddell (2007) found that the political and governance dimensions of the aid relationship were hindered by inability for governments to put aid to good use no matter the intent of donor giving. The reality is that for the poor countries with the greatest need for development aid, conditions for good use rarely apply. Mozambique has not lacked political will in its battle against AIDS yet it has weak institutions, capacities, and weak governance which constrain its ability to use large amounts of aid effectively (Riddell 2007:357). Government's willingness to strongly lead the HIV/AIDS fight coupled with support from the civil society remedies the case of weak states as the declaration by the United Nations General Assembly (UNGASS 2001) urges. HIV/AIDS is now a cross cutting issue requiring strong governments and a committed civil society.

### ***AID dependency***

In a situation where Mozambique receives over 96% external aid for its Health programme and more that 40% towards the state budget, this characterises it as aid dependent (Youde 2010:527). Aid dependency has been defined as a situation in which a country cannot perform many of the core functions of government, such as operations and maintenance, or the delivery of basic public services without foreign aid funding and expertise (Brautigam 2000:04), or (Edgren et al. 1996:24), a situation in which continued provision of aid appears to be making no significant contribution to achieving self-sustaining development. In general, Brautigam (2000) states that aid becomes institutionalised in the system of international relations as a way in which countries with higher and lower incomes interact. Or even the quality of governance in developing countries is also a result of how aid has impacted on them. Aid does not promote economic take-off because it undermines the necessary domestic institutions (Nuvuga and Awortwi 2007). For poor countries institutional constraints

define a set of payoffs to political and economic activities that do not encourage productive activity (Nuvuga and Awortwi 2007:37). The premise is that given the various interests of, we can now begin to see how aid dependence structures the incentives for action and affects institutional context within which decisions are made (Brautigan 2000:04). The intention of the “*aid institution paradox*” led by (Moss 2006:04), explains that “aid can undermine long-term institutional development, despite donors’ sincere intentions” explaining that inflows of external resources like aid can be a disincentive to institutional development, governance capacities and state transformation principally in SSA where political leaders have relied on a systematic ‘clientelism’ and the private appropriation of state resources for political ends” (*ibid*). Aid dependency has been associated with corruption as well. see, (Moyo 2009, Hanlon 2004). Following on from the aid effectiveness debate, governments are urged to “take the lead in coordinating aid at all levels in conjunction with other development resources in dialogue with donors and encouraging the participation of civil society and the private sector” (OECD 2005, Paris declaration).

### ***Communication***

Mozambique has been applauded in its efforts for improved communication strategies. Under the President call for a reflection on a multi-sectorial response to HIV and AIDS (see PEN III, INSIDA 2009), communication for prevention has greatly improved yet there remains a lot to be done to effectively reach all communities regardless of age with appropriate preventive communication (PEN III). Uganda was also applauded within sub-Saharan Africa for improving its communication strategies where as for the majority, this is still prevailing. Kesby (2000) stated that poor communication was still a major element of Africa’s HIV crisis, where people are still reluctant to talk about sex publicly or privately. This was when he was researching two Participatory Action Research (PAR) projects in Zimbabwe. In his work, Kesby emphasizes the importance of PAR in communication while dealing with sensitive issues of Sexual health (Kesby 2000). Virtually all people have some information regarding the epidemic, either through direct knowledge, education programmes or through interpersonal contacts (Webb 1997:163).

The importance of communication in the control of the epidemic cannot be underestimated. The 20<sup>th</sup> century was characterised by the “death of distance” whereby the UN Human development concept believes in the potential that Information Communication Technologies (ICTs) have to drive human development while helping to achieve the MDGs. Here large amounts of in-depth information is said to reach populations that are on the margins thus “offering extraordinary opportunities for social and economic mobility” (UNDP 2008:04). Even with improved communication strategies, communication for AIDS is still a major factor impeding the successful struggle against the disease.

Mozambique has learnt from experience. This has led to the “*Mozambicanization*” of AIDS messages targeting the young and the old, together (PEN III, GARPR-CNCS 2012). This trend reaches all populations with AIDS awareness messages. Yet with such communication strategies in place, Mozambique has more people living with HIV/AIDS than most countries in the region. And with low literacy levels, printed messages may not be so effective (CIA World fact book 2013). Communication is crucial in opening direct channels of interaction but it should not be limited to a time frame, it has to be ongoing with improved and targeted messages. The UNHDR (2012) stated that there has to be transparency and inclusive public administration for effective communication.

### ***Culture***

We cannot ignore the role culture plays in Mozambique’s struggle against HIV/AIDS. Unlike western countries, African beliefs are culturally rooted thus AIDS in Africa revolves around cultural transformations. To date, the Ministry of health and NAC/CNCS still recognise that most HIV and AIDS patients prefer traditional remedies to biomedicine (PENIII). In cultural transformations one identifies his/herself in relation to family, language, religion, and culture, whereas the latter is the issue of social morality, which ultimately is defined, at least in part, by national policy (Picard et al. 2008:08). Cultural relativity in the spread of HIV/AIDS must be considered when analysing responses to the epidemic, involving both the cultural context of HIV infection

and the manifestations of the different cultural constructions of the disease (Webb 1997). Bailey (2008) argues that culture is highly underestimated and the impact it has on HIV. In understanding the culture of AIDS, emphasis is put on the impact the disease has had at different levels whereas culture in AIDS examines how culture permeates the shared domains of human life to contextualise risk and risk behaviour (Bailey 2008:21). And as a way forward, the ministry of health and NAC are now working together with culture leaders in awareness raising and safe practices towards treating AIDS patients. This factor is crucial in understanding why alienation of cultural practices would not work for Mozambique considering the number of followers nationwide.



## **Chapter 3 : AIDS budget and Mozambique's AIDS control**

### **Introduction**

Chapter Three seeks to answer research question Two. The chapter focuses on Mozambique's aid programme for HIV/AIDS, in understanding how policies are being financed and or how they are impacted by aid. The premise is that if Mozambique receives lots of aid to particularly fight HIV/AIDS, why is it that its prevalence rates are still high. Also this chapter will look at the budget implications on available funds in understanding how AIDS funds are being spent and also look at how this affects the country's ownership of its HIV/AIDS response. Lessons from within the sub-Saharan Region will also be delved into on HIV/AIDS regional trends.

### **3.1 Aid Expenditure and AIDS Results**

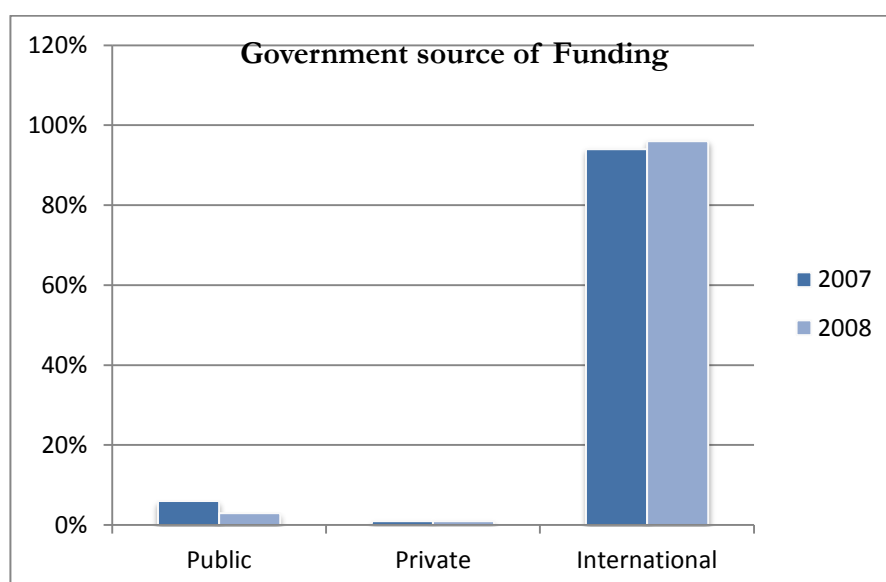
Analysing what has been spent on HIV/AIDS for a country like Mozambique is complex. Literature on the Mozambique's aid system dates back as early as the 1960's when the country still had the soviet union's support (Kayizzi-Mugerwa 2003:200). Currently with the new socioeconomic reforms there seems to be no near sight of an end to receiving aid. Thus in analysing aid expenditures it is important to know how aid has been effective and results should show this.

Since the country's struggle for independence and to its attainment in 1974, Mozambique has had a history where aid had to be an option for its reconstruction. The country has been managing huge inflows of aid from both multilateral and bilateral donors while implementing its structural adjustment programmes (Hanlon 1991:243). For HIV/AIDS, aid has been coming in through project aid and through general budget support to the health ministry budget. In 1984 when Mozambique joined the IMF and World Bank, the country agreed and opened its doors to the US organizations to work in and thus its continuous relations with all kinds of donors to date (Hanlon 2010). In 2004 Mozambique had pledges reaching US\$240 million of which US\$180 mil-

lion was in grants and US\$60 million in soft loans. This was said to be one of the largest joint programmes in Africa, both in terms of amounts and the number of partners involved (UNDP 2006:76). In 2006 Mozambique Ranked 6<sup>th</sup> on the list of the top 10 ODA recipients in Africa whereby in the same year ODA to the continent reached 43.4billions of which 39.9billion was for sub-Saharan Africa (Organisation for Economic Co-operation and Development 2008). By 2007, 19 members had signed an annual contract with the Mozambican government covering all policy areas with donor representatives at the heart of decision-making process within government (Hanlon2010:87). In 2010 Government expenditures were at US\$ 2.8 billion, which was equivalent to 27.9% of GNP. More than half of these expenditures were made through grants and loans (World Bank dataset for 2010 selection).

When Ireland, Sweden and European Union cut on their commitments towards program support, Mozambique saw a decrease in general budget support which affected most of the sectors (State Budget 2010:29), not forgetting that HIV/AIDS budget for Mozambique is funded mainly through international sources which undermines the sustainability of AIDS programmes.

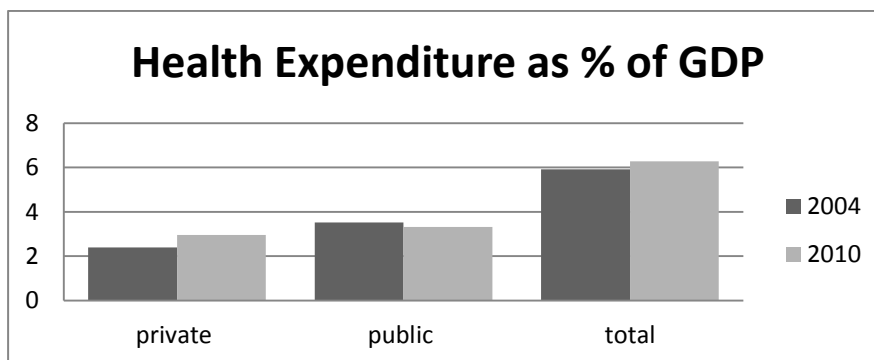
**Figure 2: Expenditure by source of funding- Health 2007/2008**



Source; 2012 Global AIDS Response Progress Report, UNGASS

Data above shows that international funds increased from 94% to 96%. Public funds went down from 6% to 3% in 2008 while private funding remained at 1%. In 2007, health expenditures reached US\$ 317 million, accounting for 11.6% of the total state budget. In per capita terms, health spending grew from US\$ 7.50 in 2000 to US\$ 18 in 2007 (Mozambique Health Sector Strategic plan September 2007). The Canadian International Development Agency's evaluation noted that in the same period, donors funded approximately 70% of the health sector expenditures of which 15% was through on-budget support and 55% through project funding (CIDA 2009), proving that donors still favoured vertical funding. This also shows that Mozambique is still behind in meeting the target of allocating at least 15 per cent of its annual budget to the improvement of the health sector, in accordance with the Abuja Declaration and Framework for Action (UN Resolution to stop HIV/AIDS)<sup>4</sup>.

**Figure 3: Mozambique's Health expenditure - 2004/2010**



*Source:* Made by author based on World Bank data (2012).

*Note:* figures are percentages of GDP for 2011

The table above shows minimal commitment from the government in increasing its domestic financing of the health sector with a margin of 0.3% between the private and public sector. With government priorities on education, health, water and sanitation more commitment should be shown quantitatively if the objective of improving on service provisions for Mozambicans is being met. Under the current PENIII the guiding principles involve reduction of risk

<sup>4</sup> At the 95<sup>th</sup> plenary meeting, the General Assembly adopted the political declaration on HIV and AIDS with a theme; Intensifying our efforts to eliminate HIV and AIDS urging developing countries to increase their domestic funding for HIV (2011).

and vulnerability, prevention, care and treatment, and mitigation of consequences. However in 2008, the focus was highly manifested towards HIV/AIDS related research as the table below show.

**Table 3: Mozambique's HIV/AIDS expenditure by areas 2007/2008 in US dollars**

<i>Category of Expenditure</i>	<i>2007</i>	<i>2008</i>	<i>2007/2008</i>	<i>2007/2008 %</i>
	<i>USD</i>			
<b>Prevention</b>	26,133,742	40,242,840	66,376,582	54%
<b>Care &amp; Treatment</b>	28,566,098	41,735,566	70,301,664	46%
<b>Orphan &amp; Vulnerable Children</b>	9,239,784	12,593,144	21,832,928	36%
<b>Program Management &amp; Administration</b>	32,822,701	36,085,951	68,908,652	10%
<b>Human Resources</b>	5,056,421	8,486,865	13,543,286	68%
<b>Social Protection &amp; Social Services (excluding OVC)</b>	928,090	1,899,639	2,827,729	105%
<b>Conducive Environment</b>	1,810,620	2,497,158	4,307,778	38%
<b>HIV and AIDS related research (excluding operational research)</b>	678,132	2,879,532	3,557,663	325%

Source: (GARPR-CNCS 2012, Global AIDS Response Progress Report)

From the table above, it is clear that funds between 2007 and 2008 went up almost 20% more towards the priority areas. Also estimates reveal that the expenditures on HIV and AIDS totalled US\$ 251 million over the 2007/2008 period. The 2007/2008 estimated expenditure is 23% higher than what was recorded in previous years (GARPR-CNCS 2012:12). With focus on prevention, in 2007/2008, 54% of the total expenditure was spent on prevention activities which targeted a reduction in the incidence of new HIV infections. With an estimation of 25% decrease in new HIV infections by 2014 awareness activities should achieve these estimations (PEN III). This is based on a 2.8% decrease from 11.5% in 2007, to 8.5 % in 2014 of HIV infection in pregnant women aged 15-24. Prevention strategies are key to ensuring increased economic growth for Mozambique since no sector has been left unaffected by AIDS. Other interventions are directed at reducing sexual transmissions, reduction of hospital based transmission, counselling and testing (PEN III).

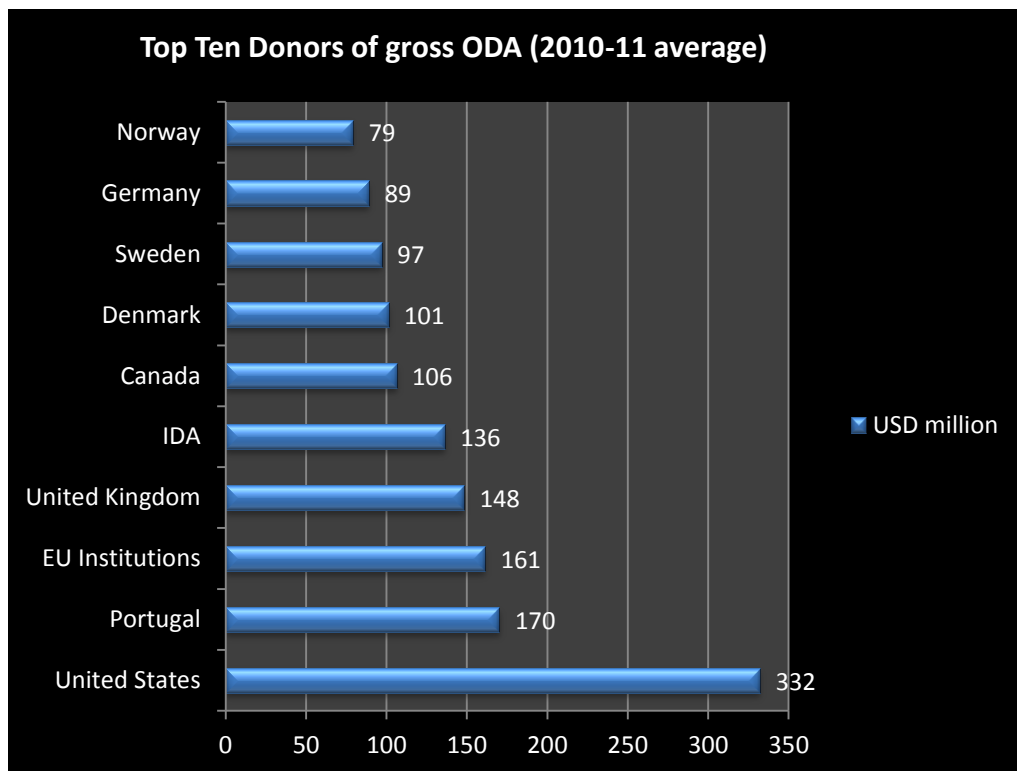
HIV/AIDS related research accounted for 325%, and social protection services at 105%. These expenditures represent increased prioritization in studying the key drivers towards increased HIV infections in the country and how these can be dealt with. Such changes are taken up within the third strategic plan (PENIII 2010-2014). The impact of AIDS on orphans and vulnerable children including the caregivers among other key populations calls for increased expenditures in the AIDS budget. This means that funds should be allocated in ensuring the social protection of orphans and vulnerable children. In summary, annual expenditure on HIV/AIDS in Mozambique shows an accelerated increase of 39% between 2007 and 2008 confirming the trend of high growth rates over the years (See Global AIDS Response Progress Reporting 2012).

The current HIV/AIDS strategic plan shows that actually the country can own its HIV response by learning from past experiences and focusing on key areas of the epidemic while applying local realities to the fight. While HIV infection rates in highly endemic regions has been said to be going down and in some, stable, (Bongaarts and Over 2010) argue that global health funding should be rebalanced between AIDS treatment, as also funding should not be static, but rather proportional to the marginal returns of reducing the disease. (England 2007) agrees saying that HIV funding is out of balance even for sub-Saharan Africa especially if the disease contributed only 17% of the burden in 2001. This assertion has been overly voiced in favour of other health needs and diseases. The ideology of ‘underfunding’ of other diseases can be found in the writings of (Bongaarts and Over 2010, England 2007, Feldbaum et al. 2006, Shiffman 2008). Here the emphasis is based on improving health systems rather than looking at the disease. GFTAM can be pin pointed out. The government of Mozambique benefits from GFATM. However, performance of GFTAM grants is measured and rated against the country-owned targets at each periodic disbursement of funds. For Mozambique, performance data shows that even with huge amounts in play, results are still inadequate although potential is demonstrated (Global Fund portfolio). Aid per se is “not necessarily problematic” as Brautigam writes, “yet high levels of aid, delivered over long periods of time, can create incentives that work against the im-

provement of government capacity and commitment” (Brautigan 2000:10). Mozambique’s commitment to stop AIDS should focus on evaluating the effectiveness of aid coming in through general budget support and other smaller projects which in turn will help in monitoring of priority areas against expenditures.

For increased and effective aid, the government of Mozambique under the leadership of the ministry of health and the NAC, in 2008 produced a commitment of intent for all development partners. This document was to reinforce existing mechanisms for harmonisation and alignment at the country level, thus its principles are targeted at bilateral and multilateral agencies, non-Government Organisations and civil society as a way of spearheading progress towards the health MDGs (IESE 2008).

**Figure 4: Top Ten Donors of Gross ODA to Mozambique**



Sources: Based on OECD - DAC, World Bank; [www.oecd.org/dac/stats](http://www.oecd.org/dac/stats)

Note: Figures are in constant 2009 USD million

The United States of America as shown in the figure above, provides more aid for Mozambique's development as well as being the number one bilateral donor to Africa (Organisation for Economic Co-operation and Development 2008:46). Thus the figures above confirm that Mozambique is highly supported by the G19, whereas critics have stated how this leaves the donors in charge (Follér 2013). Critics say that because countries depend more on foreign aid to provide their domestic health services, they tend to leave donors in the driver's seat, who suggest and take up the overall management of how aid should be allocated and used (Brautigam 2000, Bidaurratzaga-Aurre and Colom-Jean 2010, Hanlon 2010). This is described in the illustration box below, and how it affects strong Non-Government Organizations.

**Figure 5: A case of donor dependency**

***Fall from Grace: The case of The National Network of  
HIV/AIDS Services Organization (MONASO)***

MONASO was created in 1993 and officially registered as a non-profit organization in 1995 under Mozambican laws. At the peak of HIV, MONASO founders saw that such an organization would contribute to the decrease in the HIV indices, improve the quality of life for those infected, promote human rights and mitigate the negative effects that the disease brought up on people, families and communities. Thus MONASO's mission was to mobilise and train civil society organizations for an effective response in fighting HIV/AIDS and its effects at all levels. By the year 2010 MONASO had support for project aid from over 9 major donors with a budget of about 37 million US dollars. By the end of 2012, three quarters of these donors had pulled out and requested a refund of the remaining funds in view of misappropriation of funds, internal conflicts and mismanagement of project equipment among others (Valoi 2012).

With no sustainability plan, MONASO had to close over 9 of its 11 offices since it could not maintain them. The case of donor dependency and oversight is causing many good and active NGOs to shut down. Today MONASO is still functioning although meeting the designed objectives in its 5 year plan (2010-2014) needs a big push and effective reorganization with skilled and dedicated staff that can manage sustainable programs.

### **3.2 Prioritization of budget allocations**

Setting priorities in combatting AIDS is crucial for developing countries. This entails domination of the key strategies, knowledge of key HIV populations, up-down knowledge and vis-a-vis of actors and ownership of the AIDS response. When the 2005 Paris declaration came up, the objective was to help developing countries to effectively manage aid if they were to achieve development and change. Thus the priority areas to which support was to be offered had to come from within the countries policy plans and these were to be in alignment with donor support. Donor support meant that they had to respect partner country's leadership and help strengthen their capacity to exercise it (Paris Declaration 2005).

Before 2005 Paris declaration, Mozambique was already managing its AIDS strategies and poverty reduction policies effectively, making it one of the advanced countries in the aid effectiveness era (OECD 2010a). In prioritising ownership, Mozambique clearly achieves the Paris declaration target of having in place an operational development strategy. The objective of setting priorities in budget allocation is to ensure the predictability of aid towards the general budget support. This comes from knowing the epidemic, and how effective budget allocation can target these key areas of the epidemic. These strategies have to be aligned with the international and regional commitments on better aid management and ownership of the AIDS response. The budget needs with resource needed to fight AIDS have to be strategically coordinated if aid is to be used where it is mostly needed.

### **3.3 Regional Trends on Aid in Fighting HIV/AIDS**

It is now general knowledge that HIV/AIDS is severely affecting sub-Saharan Africa more than other areas with over 69% of the disease burden in the region. UNAIDS in 2008 estimated that over 25 million people had died of AIDS and with over 33 million people positive with HIV. Of this total sub-Saharan Africa still maintains the highest rate at 5%, followed by the Caribbean at 1.1%, Eastern Europe and central Asia at 0.8%. In 2011, UNAIDS fact sheet showed that there was an “estimated 1.8 million [1.6 million–2 million]



new HIV infections in sub-Saharan Africa compared to 2.4 million [2.2 million–2.5 million] new infections in 2001—a 25% decline. Between 2005 and 2011, the number of people dying from AIDS-related causes in sub-Saharan Africa declined by 32%, from 1.8 million [1.6 million–1.9 million] to 1.2 million [1.1 million–1.3 million]” (UNAIDS fact sheet 2012).

Mozambique’s geographical location situates it on the south east of Africa with a prevalence of “11.5%”, (INSIDA 2009), with whom it shares some of the highest prevalence rates. The region is marked off as endemic because it has prevalence over 10% within adults of 15-49 years. This prevalence rose greatly from the early 1980s and peaked off in the late 1990 to early 2000s, since then prevalence levels have either decreased or stabilised at high levels (MNHDR 2012). Meaning that even with less new infections within the SSA region, the absolute number of people living with HIV has increased from 20.3million in 2001 to 22.5million in 2009 (Smith et al. 2011). HIV/AIDS in sub-Saharan Africa is heterogeneous. Other factors contributing to the spread of HIV which as Smith (2011) explains, “stem from a context of poverty and inequality and a history of social upheaval” (*ibid.*:347). And although the disease has become a generalised epidemic, each of the countries involved has varied strategies in its fight.

The political- economic analysis of AIDS has seen advances since the early stages of HIV in the global sphere. In the third world, this analysis focused the attention on AIDS as a disease of development and underdevelopment (Singer 1998:20), whereas in the developed world, the political-economy analysis of AIDS is examined in terms of unequal class, gender, sexual orientation, and ethnic/racial social behaviour (*ibid.*:21). The “oppressed minority populations do not face AIDS as a single epidemic, but rather as part of a synergism of plagues” (Wallace as quoted by singer et al 1998:21). Thus AIDS in Africa is aggravated by the debt crisis, recession and the structural adjustment programs designed by the World Bank. “Economic stability has caused more workers to migrate in search for work disrupting family life(...) while economic instability has led to political instability creating further disruption and dislocation(...)the consequences of privatization of public services and part of the SAPs has considerably increased poverty and the hardships of the poor” (Singer et al

1998:173). Bailey (2008) states that HIV infection is primarily a behavioural affliction, whereby any attempt to prevent the infection is only possible by bringing about behaviour change. Since the dominant route of transmission is through risky sexual behaviour; then people have to realise this and change their behaviour (Bailey 2008:13).

The table below shows the decreases and increases in HIV prevalence for adults (15-49 years) as percentage of the total population in selected countries of sub-Saharan Africa between 1990 and 2011. In this table Mozambique Ranks in the 8<sup>th</sup> position after Zambia also proving that the country is not among the top five with high indices of HIV/AIDS adult population yet it receives high aid more than the top 7 countries.

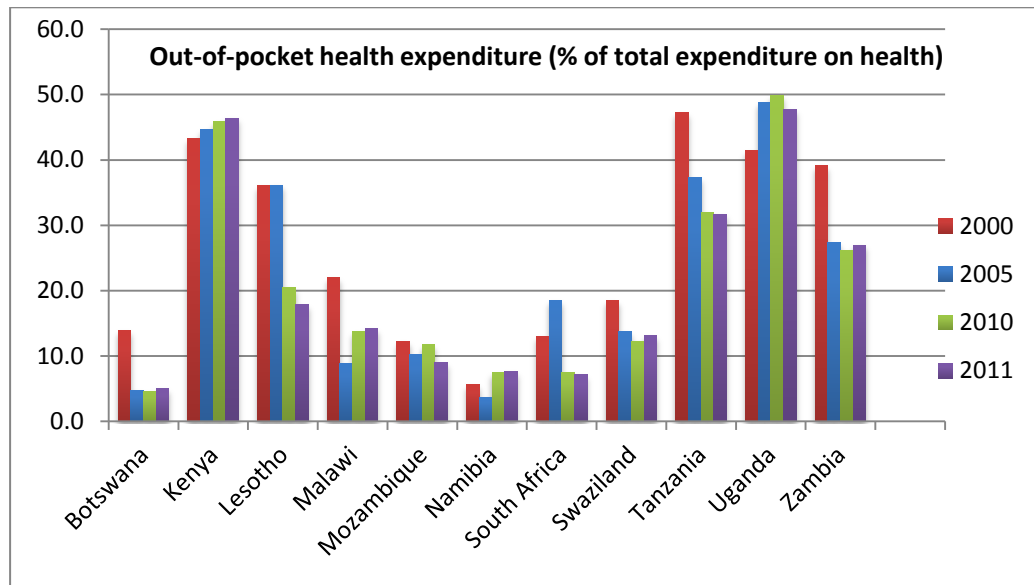
**Table 4: HIV/AIDS Prevalence rates in Sub-Saharan Africa**

Country	1990	1995	2000	2005	2011
	%				
Swaziland	2.3	10.6	22.3	25.6	26
Lesotho	0.8	14.3	24.5	23.6	23.3
Botswana	3.5	16.6	26	25.5	23
South Africa	0.7	6.1	16.1	18.1	17.3
Zimbabwe	10.1	25.1	24.8	18.4	14.9
Namibia	1.6	7.1	15.3	15.7	13.4
Zambia	12.7	15	14.4	13.9	12.5
Mozambique	1.2	4.1	8.6	11.3	11.3
Malawi	7.2	13.9	14.2	12.1	10
Uganda	10.2	9.3	7.3	6.4	7.2
Kenya	3.9	10.3	9	6.8	6.2
Tanzania	4.8	7.8	7.3	6.2	5.8

Source: Made by the author based on World Bank statistics (2013).

Noticeably in the above table is the upward trend that characterised AIDS in the mid-1990s to the mid-2000s. Although there have been modest declines for countries like Kenya, Mozambique and Uganda, the prevalence is stabilising at high figures.

**Figure 6: Government's Domestic Funding for Health (2000-2011)**



*Source:* Made by author based on World Bank dataset (2013) for selected countries in SSA.

The changes in the aid architecture and increases in aid for HIV/AIDS, shows modest increases for selected countries commitment to financing their epidemic. These include; Kenya and Uganda. Yet the table also shows decreases and below the 15% commitment to increase on domestic funding for health (see Mozambique, Namibia and Botswana). Can we assume that increased foreign aid reduces the role of countries in increasing their public revenues towards public health? How is this monitored under the five principles of the Paris declaration and 2001 Abuja declaration which clearly calls on countries to increase on their public health expenditure?

Facts show that AIDS is an expensive disease to treat, and low-income African countries face many resource constraints. This aggravates the efforts for on-going treatment, especially in ensuring that whoever needs treatment gets it (Smith et al. 2011). Further efforts to achieve such goals put constraints on other important development and health goals. UNAIDS stated that in 21 countries of sub-Saharan Africa, external funding sources accounted for more than 50% of HIV investments. However, some countries in the region are assuming a greater role in funding national responses to HIV. For example: “Botswana and South Africa cover more than 75% of their national HIV re-

sponses through domestic public sources; Namibia, Gabon and Mauritius fund more than half of their national HIV responses. Kenya doubled its domestic HIV spending from 2008 to 2010; Togo doubled its domestic HIV spending from 2007 to 2010; and Rwanda doubled its domestic spending from 2006 to 2009” (UNAIDS 2012). Some lessons that Mozambique can easily learn from these countries if found applicable.

**Table 5: Indicators of Health Expenditure on selected SSA countries in comparison to Mozambique**

Country	2010	2010
	<i>External resources for health (% of total expenditure on health)</i>	<i>Out-of-pocket health expenditure (% of total expenditure on health)</i>
Botswana	<b>8.0</b>	<b>4.5</b>
Kenya	<b>37.9</b>	<b>45.8</b>
Lesotho	<b>18.2</b>	<b>20.5</b>
Malawi	<b>58.1</b>	<b>13.7</b>
Mozambique	<b>62.2</b>	<b>11.8</b>
Namibia	<b>25.5</b>	<b>7.5</b>
South Africa	<b>2.2</b>	<b>7.4</b>
Swaziland	<b>14.4</b>	<b>12.2</b>
Tanzania	<b>39.6</b>	<b>31.9</b>
Uganda	<b>27.6</b>	<b>49.9</b>
Zambia	<b>43.7</b>	<b>26.1</b>

*Source:* Made by author based on World Bank dataset (2013)

The above table summarises the data in figures 1 and 6 in analysing how much external resources countries get in comparison to their domestic financing for health as a percentage of total expenditure on health.

### **3.4 Achieving accountability**

Accountability has been defined as answerable, chargeability, culpability, liability and responsibility whereas scholars and practitioners of development define it each differently (Dictionary). Accountability should be a means by which individuals take internal responsibility for shaping their missions and values(...) for assessing performance in relation to goals (Ebrahim 2003:815). Yet due to a shift in the aid modalities and general budget support, donors

have gained interest in supporting recipient-country parliaments. This is meant to strengthen domestic budget accountability, and increase the civil society role in lobbying for greater involvement of domestic institutions in development policy (De Renzio 2006:638). Accountability mechanisms recently focus more on upward and external accountability, giving significant power to donors who are neither the actors implementing the programs nor receiving resources (Ebrahim 2003).

Actors in Mozambique have been conscious about how to demand for accountability, especially for those in the NGO sector. The fact that state budgets are annually published for the public does not mean that these actors have the capability to analyse and demand clarification (Bidaurratzaga-Aurre and Colom-Jaen 2012). But with the government managing official aid through general budget support, it is of consensus by both parties on the policy expectations yet this is not sustainable. Because of the focus on accountability as stated in the Paris declaration, the government knows exactly how to respond to donor demands (De Renzio 2006:635). Timely responses mean that less time is wasted on answering to each and every donor yet also knowing how to respond to donors means that more data gets omitted in order to answer for what donors want. This is also voiced in the OECD reports on how the current trajectory of costs towards HIV programs is lacking sustainability, proper governance, and has poor financial accountability yet programmes should be able to deliver better value for money, which as a result is impeding progress (Organisation for Economic Co-operation and Development 2009). Mutual accountability is one of the five pillars of the Paris declaration on aid effectiveness calling on donors and partners to be accountable for development results. With increased aid, the commitment should be two sided. Governments being able to hold donors to account for meeting their commitments as well as donors holding developing countries to account for their performance (OECD Paris declaration). However this has been one sided (Bidaurratzaga-Aurre and Colom-Jaen 2012). Progress reports on aid effectiveness recognises that there is quite a wide range of existing and evolving mechanisms for mutual review at various levels which make contributions towards fulfilling this commitment.

## Chapter 4: Implementing Mozambique's HIV/AIDS Policies

Mozambique has over 740,000 orphans due to AIDS, aged 0-17 and 1.600,000 people living with HIV (UNAIDS 2012)

### Introduction

The analysis on implementing the AIDS strategies in Mozambique's fight against HIV/AIDS is very crucial in assessing the effectiveness of aid. The National Strategic HIV and AIDS Response plan also known as *Plano Estratégico Nacional de Combate ao HIV e SIDA* (PEN) is a guiding document for fighting HIV/AIDS in the country from 2010 -2014 making it the third after the first and second AIDS plans. This chapter thus aims at analysing how Mozambique has owned its AIDS response amidst increased focus on aid effectiveness. Thus the chapter will strategically respond to research question Three.

### 4.1 Mozambique's HIV/AIDS strategic Plan (2010-2014)

The 2010-2014 AIDS plan, also known as PEN III is Mozambique's third strategic plan after PEN1(2000-2004) and PEN II (2005-2009). This is supposed to be the countries guide towards combatting HIV/AIDS yet it laments lack of funding for its implementation.

In an interview with the CEO of HIKONE Moçambique; “she stated that the current PEN III was not being implemented as it should be due to; (i) lack of funds, (ii) and because the last PEN II was not implemented in totality iii) and because there is low involvement of the civil society in the planning process”. She lamented also that “this plan was elaborated mainly for the government sectors under the SWAPs since the NGOs and other private organizations are without financial resources to implement such projects and activities” (interviewed on 5<sup>th</sup> November 2013). The CEO of HIKONE

comments confirm what the Current PENIII states as challenges towards its implementation.

The current Strategic paper is targeting four results which have been tailored to meet the AIDS response in the country. These include; the reduction of risk and vulnerability, prevention, care and treatment, and mitigation of consequences (PEN III). As a reaffirmation of the guiding principles, this plan is rooted in achieving human rights for all. The focus on human rights is said to be fundamental in achieving PEN III results as this looks at respect of all human beings regardless of their sero status. This calls for free participation and involvement of all people yet a few of the key HIV populations like Drug users and men who have sex with men are not included herein (GARPR-CNCS 2012:17, PENIII). Consensus shows that these groups are not yet key populations to Mozambique's modes of HIV transmission and the fact that there is no segregated information and evidence to show the epidemic dynamics (*ibid*).

The lack of valuation makes PEN III hard to evaluate. Whereby the NGOs and donors that support PENIII operate from outside the country and are unwilling to disclose their HIV/AIDS related expenditure. This causes a challenge of analysing the impacts of aid on AIDS policy implementation (GARPR-CNCS 2012).

However a few NGOs implementing PEN III were named in an interview with the programmes coordinator at *Comunidade Moçambicano de Ajuda*, he stated that, *“in alignment with PEN III, activities in prevention were being carried out by Fórum Mulher under vertical funds from GFTAM, working on gender based violence. Family Health International under funds from USAID is working along the transport corridors sensitizing long distance truckers and other key populations along these routes. The Ministry of Health is also working with the male youth in promoting and providing male circumcision as a way of HIV prevention”* (interviewed on 5 November 2013).

Also, *the Youth Coordinator at the NPCS and Coordinator at ACIDECO a local CBO confirmed that they are receiving some funds from NPCS to implement youth friendly services”* (interviewed on 9 November 2013). *The Youth Coordinator added that there are funds indeed but what is lacking is the capacity of local CBOs to present fundable proposals and projects”*.

With scarce resources to the grassroots level, Policies have been proved to be hard in implementing. This has been widely mentioned on the part of the NGOs and CBOs who are aid dependent, and fail to implement their plans due to lack of funds and with less skills in fundraising. Mozambique boasts of so many NGOs that operate in and out of the country (Bidaurrat-zaga-Aurre and Colom-Jaen 2012), and these if effectively coordinated by the National AIDS council taking up effective leadership and control of PEN III would get raving reviews.

The *CEO-HIKONE-Moçambique* acknowledged that *the provincial AIDS councils had excess funds this year but because there was less propagation of information and lack of transparency from the projects evaluations committee, only a few NGOs benefitted*". Confirmation of this is can also be got from Follér who states that the few NGOs benefiting from donor funding are tangled up in massive power relations that controls and governs from a distance asserting that, NGOs find it really hard to stay on track with their planned activities, and end up doing what donors want for fear of losing the funds (Follér 2013:53).

*"The Programs coordinator at Comunidade Moçambicana de Ajuda also stated that although some activities were being carried out in relation to PEN III, many prevention activities since late last year were not being funded because donors now prefer improving and financing for ART treatment and better conditions for AIDS patients"*. This contradicts still the principles of aid effectiveness especially if aid is not aligned according to the country's priority. This comment means that many NGOs working in prevention are not supported due to donor preference and selection of initiatives. This selection has to be the role of CNCS in alignment with PEN III priority areas. This then poses a challenge.

PEN III implementation has improved drastically in its communication strategy. After years of combatting the disease, Mozambique is now coming from within and with experience. Investments in its key populations in AIDS have brought about changes in the way the awareness messages are relayed. Here messages like *"Andar fora é maningue arriscado"* -Having affairs is just too risky or *"Amores a mais é demais"* - Too many lovers is just too much have been used to strategically bring awareness to risky behaviours. Not forgetting that 97% of HIV infections are through heterosexual (INSIDA 2009, PEN



III). Efforts have been made to include culture and the role this plays in AIDS treatment and care. Thus the government and CNCS are integrating and addressing myths and taboos in the local HIV/AIDS strategies. Also the *Mozambicanization* of HIV messages blends well with the natives but this is said not to be enough (GARPR-CNCS 2012). Managing Mozambique's health system is said to be met with limitations on the state's capacity to manage an increasingly complex international aid framework, which comes from a tradition of fragmentation and lack of coordination, but at country level this is improving (Bidaurratzaga-Aurre and Colom-Jean 2012:234, GARPR-CNCS 2012 OECD-DAC 2008).

## **4.2 Implementing the Sector Wide Approach in Mozambique**

One of the donor mechanisms of issuing aid was the adaptation of the sector wide approaches (SWAPs), where donors changed the way they channelled aid for the designed policies in the hope that better accountability, coordination and monitoring could be achieved (Bidaurratzaga-Aurre and Colom-Jaen 2012:231, Follér 2013:52). Sector Wide Approach is often referred to as Programme-based approach (PBAs) This approach is favoured by donors as they align with the recipient government by supporting initiatives within sectors, say in education, health or in agriculture (OECD 2010a, De Renzio 2008). Initiatives are then supported and monitored against the proposed indicators ensuring that aid in any given sector is used effectively. Donor funding though is not limited to programme-based approaches as recipient government have civil society organization that also benefit from vertical funding not related to budget support initiatives (Bidaurratzaga-Aurre and Colom-Jean 2012). Mozambique has a common fund known as PROSAUDE that was created in 2003 (OECD 2010a). This is supported by 14 development partners of which 30% of external funds go to the health sector through the common fund. PEN III also focuses on public sectors for its implementation because they have funds ready under the budget support to implement the set priorities, yet for NGOs as noted in the interviews, only a few are managing to implement, see figure in (PENIII p.79). Therefore Mozambique faces the challenge of ensur-

ing that the policies are functional from paper to action and with all actors aboard (Follér 2013:52).

At present the government and the National Aids Council (NAC)-*Conselho Nacional de Combate ao HIV e SIDA* (CNCS) are working hand in hand to ensure that actors have orientation materials in operationalizing PEN III, and while also in 2011 provinces signed a Memorandum of Understanding (MoU) which guarantees the exchange of documents in the response to HIV. These include documents and plans such as Five Year Government Plan (2010-2014), PEN III (2010-2014), National Strategy for Responding to HIV and AIDS in the Civil Service (2009) and the Action Plan for orphans and vulnerable children. Also in the pipe line is the elaboration of sectorial operational plans, the District and Provincial Multi-sectorial Plans-*Planos Operacionais Multisectoriais de níveis Distrital (POMD) e Provincial (POMP)*. However, there seems to be a challenge of decentralizing these efforts. At the district level little is happening in operationalizing such commitments.

This was confirmed in an interview with the *Coordinator of Xitlhango a local CBO* who Stated that “*although PEN III is being somehow implemented, at the district level there is absolutely nothing, efforts stay at the provincial level without trickling down to our district. People living with HIV are here in the districts yet interventions never get here*” He also reaffirmed CEO-HIKONE’s Concern on how PEN III was elaborated without resources, “*There is apparent lack of financial resources although we know that there is a lot of money at the central level. This is not practical how is PEN III supposed to be implemented without actors? He asked*” (interviewed 9<sup>th</sup> November 2013).

In respect to such plans all actors within provinces play a role in holding the government accountable but also take part in the planning and implementation (PEN III) yet as stated by my interviewee “*When initiatives come to the district level, all they do is perform training workshops without further monitoring or coordination post training*” what are we supposed to do with such training, if initiatives that need funding are not supported? (Coordinator-Xitlhango). However, the coordinator at ACIDECO, interviewed on 9 November 2013, attested to receiving these trainings and some amount for follow up implementation.

### 4.3 Implications of aid on HIV/AIDS Policies

Foreign aid is the backbone to Mozambique's fight against HIV/AIDS. In 2008 of the US\$251 million, government contribution was only three per cent (UNAIDS 2013, UNDP 2008, GARPR-CNCS 2012). Previous chapters largely elaborated on this correlation. In general, Mozambique's HIV/AIDS fight has been characterised by aid dependency. The 2001 Abuja declaration and other policy makers have urged states to increase their domestic expenditures in fighting the disease to about 15% yet on-going trends show little to no increases from country to country since it has been noted that most developing countries lack the resources to finance their individual "country's longer-term development" (see Moyo 2009:66)<sup>5</sup>. This should not be an excuse since countries signatories to the declaration committed to achieving this call. In *The Political Economy of HIV/AIDS in Developing Countries*, Coriat emphasized the high costs involved in fighting HIV/AIDS (Coriat 2008). Country ownership is important if countries are to take effective leadership towards their own development as it has been overly voiced in the Paris declaration and Accra Agenda for Action. In an interview with the *CEO of ISEDEL and PROMETRA*, "He stated that instead of NGOs focusing of foreign aid to implement the AIDS policies, government should create mechanisms to support them locally, or the NGOs should look for sustainable ways which promote ownership. Philanthropy cannot be done based only on aid. Otherwise those NGOs without aid should close down and rethink their strategies (Interviewed 9 November 2013)<sup>6</sup>.

With no AIDS cure, controlling the spread and impacts of the disease has to be tailored to the individual country's strategy. The implications that foreign aid has on HIV/AIDS may need national commitment, ownership of the development agenda, and increased domestic resources not forgetting strengthened coordination. Thus strong policies, coupled with good governance make aid effective and countries with these qualities tend to make progress unassisted. This should be Mozambique's goal.

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<sup>5</sup> See table on page 35

<sup>6</sup> Field interviews with the selected respondents. Complete list is added in appendix 2

#### **4.4 Aid fragmentation and HIV/AIDS Strategic Plan**

OECD and Paris declaration note the effects of aid fragmentation on country's development towards aid effectiveness. Aid fragmentation has been noted from the aspect of donors who fund too many little projects with too little funds in too many countries. This congestion of funds and donors is said to impair aid effectiveness on the global, country and sector level (OECD-DAC 2008:12). This not only increases transaction costs and administrative burdens but also diverts country attention from implementing the defined objectives (*ibid*). Dataset from OECD/DAC 2007-2011 on aid allocation shows aid fragmentation for Mozambique at 33%, amongst 36 donors. This means that these donors have their own processes and priorities which are often overlapping with each other (OECD 2009). Implementing PEN III has been met with the challenge of coordination amidst scarce resources. Coordination between central, provincial and district levels, in the planning processes is still weak and slow yet there is urgent "need to secure an effective integration of HIV/AIDS-related activities, in institutional plans" (PEN III). The need for strengthening and interaction of local partners is also low yet these are known for adding value to the work carried out. With many donors operating and funding local partners, the NAC/CNCS is faced with the challenge of improving the architecture and operationalizing financial management as well as aid predictability (*ibid*). For organizations and partners supporting Home Based Care (HBC) and OVCs this has been noted as a major challenge since the government under the CNCS and Ministry of Health are faced with increased numbers of CBOs in HBC and a larger number of small back to back funds with no mechanism to measure the number of beneficiaries being supported without duplicating these (GARPR-CNCS 2012). Crucial is the alignment of partner's activities within the present AIDS policies.

# Chapter 5: Mozambique's Actors and Aid Effectiveness: The case of Ownership

## Introduction

This chapter looks at Mozambique's actors in HIV/AIDS and how they influence the country's HIV/AIDS policies and the need for increased ownership of the country's AIDS response. Crucial is the role these play in ensuring coordinated and aligned responses towards the health policies. It also briefly looks at the High Level Forums and how they have evolved while analysing the meaning of ownership. This chapter is in response to research question four

## 5.1 The Actors and Aid Effectiveness

### *NGOs as actors*

The role of NGOs as actors in social development has expanded over the past several decades as criticism has also mounted (DeJong 2003:160, Bebbington et al. 2008:04). Many have observed or clearly expressed a tendency for NGOs to become more accountable to their external funders than to their declared constituencies. Also they have been said to take on the label but tell little about their practical workings (Hilhorst 2003:09). Thus NGOs have been called upon to claim their place since they are known to link the grass-roots, emphasise on commitment and sustainability, and known for their cost effective strategies among others (Shivji 2006:13). NGOs need to recognise where power lies and how it is currently used in North –South funding chains. The funding patterns and practices change in line with political priorities, global strategies and current theories depending on how development can be best effected (Wallace 2006:31). Such changes may greatly impact on the fight against HIV/AIDS in developing countries.

Mozambique has over 4,853<sup>7</sup> organizations yet these are characterised and broken down in two; as those with experience and can attract lots of project aid (NGOs), and those Community Based Organizations (CBOs) that can achieve short term goals but have less capacity to run big projects and negotiate with funding agencies (Holmen 2010:213). With most aid going to general budget support, most NGOs and CBOs are being financed through vertical approaches and with no clear evidence of any government support. For example PEPFAR and GFTAM still provide a reasonable amount of aid for these organizations with the assumption that they NGOs/CBOs can easily reach the beneficiaries.

This was stated in the interview with the Programs Coordinator at Comunidade Moçambicana de Ajuda, “*stating that Health Alliance for Children’s Initiatives, FHI360-CAP, Family Health International and MONASO are implementing various components of PEN III using funds from Global Fund and USAID*”. Also the Coordinator at ACIDECO confirmed this, *saying that activities related to prevention and youth were being carried out under funds from FHI in alignment with PEN III and as well as funds from NPCCS* (Interviewed, 9 November 2013)

The implementation of PEN III clearly encourages civil society participation at all levels yet it cannot evaluate to what level these NGOs/CBOs are actually contributing to the defined actions. Thus the successful implementation of PENIII lies in the NGOs/CBOs ability to align and harmonize their activities. The past 25 years have seen millions of aid going towards NGO activities yet with the new funding modalities this has decreased tremendously. For increased aid effectiveness and mutual accountability, NGOs have to work together with their governments while aligning their activities within the set priorities. Yet this has been found deficient as mentioned by the Coordinator of Xithlango and the CEO-HIKONE -Moçambique when interviewed “*they narrated that, alignment is difficult at the moment because the current PENIII is focused more on sector wide implementation since these sectors have health budgets already drawn. This is different from CBOs and NGOs. These have no funds to implement*”, they concluded.

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<sup>7</sup> The last census by INE-*Instituto Nacional de Estatística* in 2007

### ***Donors as actors***

Bilateral and Multilateral donors strongly continue to influence health policies in Mozambique. As they are known the G19 take part in the planning and implementation processes of the health policy including HIV/AIDS. These partners have been and continue to be influential in the implementation of the PEN III however they have been critiqued for taking over the governance and implementation of aid in recipient countries, this has been boldly stated that “donors such as USAID remain reticent about shifting decision-making power to recipient governments or to sectorial coordinated groups of donors” (Bidaurratzaga-Aurre and Colom-Jaen 2012:234), the excuse given is still the same that leads to aid fragmentation as explained in section 4.4 above. The UNGASS report emphasizes the importance of donors towards financing PEN III. This report calls upon donors to support Mozambique’s efforts to stop and reverse HIV/AIDS (GARPR-CNCS 2012). Although some donors still prefer vertical approaches of funding, the Paris declaration encourages Program Based Approaches and the general budget support, which builds the government’s capacity in managing, owning and aligning within set priorities (Bidaurratzaga-Aurre and Colom-Jaen 2012:245). Thus following all the five principle on aid effectiveness, donors as actors are highly committed to harmonize and align aid delivery just as they promised.

### ***Silent actors***

These may seem to be silent actors but they are highly influential in the aid management within Mozambique. In-country they are unknown to the civil society and as such donors get more reference than them (OECD 2010a). In Mozambique overall coordination of aid and aid effectiveness issues lie with the Ministry of Planning and Development, in coordination with the Ministry of Finance and the Ministry of Foreign Affairs (...) however, in practice these three ministries work together on many aspects of aid effectiveness and Paris declaration implementation (*ibid.*:23). This lack of clarification and knowledge about these silent actors is said to have donors complaining on the division of labour within government, and aid effectiveness strategy. These actors are also the focal point for OECD-DAC activities (OECD 2010a).

The impact of NGOs, donors and silent partners on policy implementation and on the implementation of the Paris declaration is both stressful as well as an eye opener. *First* the actors mentioned in the chapter are partners in development although they have less coordination towards each other; *second* they aim at achieving aid effectiveness at all levels or we assume they do, and *lastly* their zeal in harmonizing may lead to improved pathways towards an inclusive aid architecture in the future.

### ***Aid Effectiveness***

Aid effectiveness gained its major support in 2002 after the Montreal conference on financing for development. Although talks on aid effectiveness were on going in the 1990s and how poverty would be stopped, donors needed to know that if aid increased, it had to be used effectively. This meant reducing the transaction costs as these were costly for the countries they wanted to support and which made aid less effective. So the Monterrey Consensus of 2002 set in motion a series of reference points for ensuring improved financing for development and aligning it with the achievement of the MDGs. Thus all actors and aid opened a new partnership and since then a series of other declaration have been signed under the international development cooperation umbrella. These include but not limited to the Doha declaration, Paris declaration, Accra agenda for Action and the Busan partnership for effective development cooperation (OECD 2010b).

These commitments call for a prioritization of actions that focus on increased and improved aid coordination. The 2008 Accra Agenda for Action reinforces the Paris declaration commitments. Eight years later data shows that countries are actually improving on their core commitments although there still remains “uneven progress” from the donors (Schulz 2008) as well as their competing objectives when allocating and delivering aid (Addison and Scott 2011). The 2011 Busan partnership for effective development cooperation also committed to “modernise, deepen and broaden the cooperation of actors and non-state actors in supporting a coordinated development agenda” (OECD Busan partnership 2011). Yet prior to this, the 2000 declaration on the Millennium Development goals (MDGs) also provided a set of objectives that



ensured that aid had to increase if the objectives were to be achieved. Addison and Scott (2011) find that the “initial increases in the amount of aid delivered did not lead to the anticipated development impacts”. Thus emphasis should not be put on how much aid is spent but on how it is delivered in order to successfully meet the target (Addison and Scott 2011:01). Mozambique’s PEN III is focused on having one HIV/AIDS action framework, one coordinating authority and one monitoring and evaluation system as mentioned in the UNAIDS document on the “Three Ones”. With this as an objective, NAC/CNCS is focused on owning the national AIDS response although tougher and stringier rules have to be set in managing an ever growing number of actors and each with their own donors and activities.

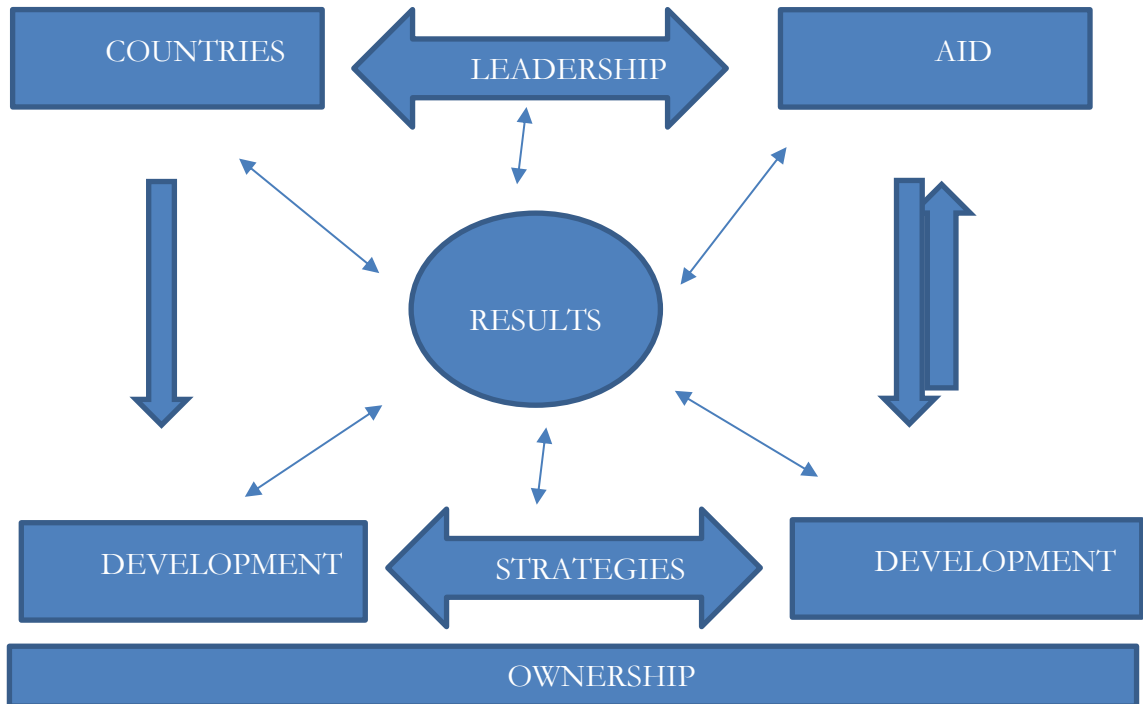
## **5.2 Decreasing the gap: The case of Ownership’**

### ***Ownership and the Paris Declaration on aid effectiveness***

The Paris declaration in 2005 set the pace for aid effectiveness which was then reinforced by the AAA of 2008. “In other words, the Paris Declaration is said to be representing the foundation stone of the new aid architecture, which is being built upon the ashes of previous development models and approaches to donor-recipient relations” (Schultz 2009:04). Country achievements are met with inefficiencies due to poor alignment with government principles while little attention is paid to building the systems that are needed to deliver better outcomes (OECD 2009). Ownership was criticised for focussing on “procedural standards for consultations and a common framework for formulating the National Development Strategies” (Schultz 2008:06). However many of the principles underpinning the Paris Declaration on Aid Effectiveness and Accra Agenda for Action have contributed to higher quality, more transparent and effective development co-operation (HLF4 Busan 2011:04). In Mozambique, aid effectiveness was already being implemented. The OECD aid effectiveness evaluation report notes that Mozambique was already way ahead before 2005. Also “some excellent work has been carried out by certain civil society institutions on analysing government policies and attempting to hold government to account, but this is still limited and reaches a fairly narrow au-

dience” Meaning that both civil society and parliament are very weak and do not fully represent the people of Mozambique (OECD 2010a).

**Figure 7: Focus on Ownership - Paris Declaration 2005**



Source: Made by the author based on the definition as stated in the Paris declaration

Ownership under the Paris declaration focuses on developing countries owning their development agenda with increased leadership for increased aid effectiveness yet the focus is more on what results development, leadership and strategies these can achieve. Since countries focus more on development, aid and development have to be reciprocal to achieve effectiveness towards better aid. Thus the graph shows a single arrow for countries focus on development and with two way arrows for aid and development. Also noticeably is the lack of defined roles of actors demonstrated in the ownership graph based on the Paris declarations definition. The declaration states that countries are to dialogue with donors and encourage participation of civil society and the private sector (OECD 2005 Paris Declaration). This makes the role of actors purely fictional. Contrary, the Accra Agenda for Action (AAA) places greater

emphasis on country ownership putting the task to citizens and their parliaments in shaping development policies. It acknowledges the experience of all actors as being valuable in building more effective and inclusive partnership while achieving development result (OECD Accra Agenda for Action 2008). Ownership of the AIDS response can be measured against achievements on individual country level.

## **Chapter 6: The relationship between aid and AIDS: A review of findings**

### **Introduction**

This chapter gives an analysis of findings and in answering the major research questions.

### ***On Aid in Mozambique***

The key debates on aid and HIV/AIDS have focused more on the changing aid architecture. There has been increased focus on aid effectiveness. This discourse has been largely favoured by donors as a way of improving aid delivery. The G19 members of Mozambique have largely supported the general budget support under the Sector Wide Approach giving government power to manage and lead its development agenda. However there are bottlenecks to government's leadership. These are linked to lack of capacity and time to respond to the ever increasing workload of donors. This as discussed in chapters has led to the changes in the way government responds to donor demands omitting and only responding to what is requested. The analysis also found that some donors were still in favour of project support. These donors include PEPFAR and GFTAM. However most of GFTAM funded projects are in alignment with the country's priorities.

Mozambique's HIV/AIDS battle has experienced massive support in financial terms and technical support, yet the current PEN III is faced with funding challenges. With over 96% aid for HIV/AIDS coming from international sources, Mozambique's openness to receiving has made it very dependent on aid. This dependency should translate into improved strategies to fight HIV/AIDS however this is not the case. The relationship I found between aid and AIDS shows a stagnation of efforts towards the effective implementation of the AIDS policy. The policy is well formulated yet the actors are not mapped. However, this does not slow the pace at which donors continue supporting Mozambique, rather it seems the intent of giving is to continue giving.

With this in mind and in understanding the intents to why aid is given, focus should be put on analysing how Mozambique can make aid work. This aid should be able to improve the country's health systems and most importantly fight AIDS to reduced indices. Aid for HIV/AIDS has been linked to achieving the health related MDGs. Mozambique is meeting halfway these goals with successes. Noticeable successes have been noted nationwide towards the reduction of mother to child transmission. Aid towards achieving this goal shows that the relationship between aid and AIDS when targeted can be effective yet many priority activities are not being supported due to lack of valuation measures. This lack stems from the missing of assessment tools at given periods. Donors need to support targeted and focused initiatives that have practical frameworks thus vertical transmission is one of those and that's why it is proving to be a success.

Unprecedented aid for Mozambique's AIDS budget should empower the country in searching and researching for effective measures in fighting HIV/AIDS. Mozambique can learn from other sub-Saharan African countries that have succeeded in reducing the incidence of HIV. These lessons can be then translated into local realities. Ownership of the AIDS response should empower all actors and as well as strengthen the country's role in fighting HIV/AIDS.

### ***On HIV/AIDS in Mozambique***

Mozambique remains highly devastated by AIDS. The amount of aid given to Mozambique to fight the disease has to be equivalent to the outputs, however even with stable rates at 11.5% the number of people living with AIDS is still high. These figures plus the new infections call for effective strategies that target key population, trade routes and commercial borders as these are at the thresholds of the epidemic. Women, children and youth have to be targeted as these are the majority in the country as stated in AIDS country reports. For Mozambique the HIV/AIDS policy has these ventures outlined yet the strategic implementation and effective targeting is largely missing. This comes from a tradition of uncoordinated activities and aid fragmentation.

Many NGOs are benefiting from vertical funds, with activities that are not in alignment with the guiding policy document. OECD acknowledges that this impairs aid effectiveness. With regional HIV variations, alignment within the HIV/AIDS policy should be easy as characteristics towards HIV propagation vary. These variations should be seen positively as targeting key populations becomes straight forward.

The positive results in Mozambique's AIDS battle backs up increased effectiveness post 2015 MDGs. Communication for behaviour change in HIV/AIDS is effective and very necessary as a strategy for HIV prevention. Theory dictates that apart from babies and children, all the others have in one way or the other information about HIV/AIDS. The factors impeding effective communication stem from a culture of information reject, neglect and disinterest. No more is AIDS a hidden disease. Investments on key HIV populations can be cost effective if fully targeted although Mozambique data base shows deficiencies in keeping up with its statistics on these populations. Lack of statistical data on key indicators impedes the full engagement of key populations in the designed awareness and control programmes.

Mozambique is said to be among the top 5 countries with the highest number of people living with AIDS. This alone brings forward the questions of sustainability of the AIDS response especially were the country's mode of infection is through sexual contact and with the earliest debut of sexual contact among teenagers and youth. Fighting HIV in this sense has to be a health priority if the country is to achieve its strong and broad-based economic growth. Aid evolutions have to be symmetrical to HIV evolutions. As aid modalities change, so should the mechanisms in fighting the disease. Also a high number of PLWHA means increased numbers of people in need of treatment. As an interview declared, that donors were now supporting more the provision of ART to PLWHA rather than to prevention measures. ART is very costly thus the country has to prevent stock outs. There should be guarantee of life saving drugs to all the people that need them at any given time.

### ***On Mozambique's HIV/AIDS policies***

Sound policies have been said to be good for improved, increased and better aid management. The joint venture in ensuring that PEN III trickles down to the grassroots is helping bridge the gap between the government and the beneficiaries although a lot remains to be done as the interviews illustrated. However this coordination obliges the grassroots to take responsibility and ownership instead of hampering implementation. The successful implementation of the PENIII requires operationalizing to make it functional rather than focusing on aid as the sole goal to its fulfilment. Through SWAPs, public institutions have benefitted from health funds under the budget support. Lack of skills in implementing PENIII in public sectors has been noted yet little is being done especially where these lack time and experience. HIV at the work place is one if not the only strategy that public sectors deploy which is also widely funded. This is not enough however PEN III acknowledges the effort. For improved policy implementation and traversing the negative impacts that aid has on PENIII, coordination should be key in ensuring non-duplication of efforts within donor preferred funding modalities. Mapping actors and beneficiaries is also crucial.

As a guiding document, Mozambique's PENIII outlines a set of objectives. These objectives should be a target for operationalization within the public sectors, civil society and private sector. However the impact that aid has on this plan shows that interventions are more centralized in actions and very decentralised on paper. The interviews carried out attested to this. Although the provincial directorates have funds for local CBOs to reinforce the Policy implementation, their capacity to fully engage is limited. Also due to a deficiency in communication for funding proposals, these CBOs loose out.

The fact that both government and local actors are aid dependent does not help matters. Most NGOs and CBOs are phasing out under the new aid architecture whereas government gains its strong hold on leadership. This strong hold should be seen positively however if there is no decentralization of actions, many beneficiaries are left out. Ownership of the AIDS response lies on commitment towards knowing the epidemic. Knowing the epidemic means focusing on key drivers of the epidemic.

### ***On Actors and Partnerships***

Never before has the emphasis on the role of actors been important in bringing about change. Development cannot be achieved alone. Government, citizens and donors are important in ensuring direct implementation of strategies. Although Mozambican civil society is considered weak, this should not stop the actors to participate actively in development. There have been successes in more than one area while implementing the signed declarations whether global or regional for Mozambique yet more effort is still needed in bringing all actors in the planning and implementation process. Actors impact greatly on the country's goal of achieving accountability. Aid for AIDS and other development agendas need to be accounted for in order to make aid better. Actors are meant to hold each other accountable yet this has been found largely missing in Mozambique due to the inability and the lack of capacity to hold the responsible parties accountable. A few big NGOs try to demand accountability but with little impact. Donors demand accountability for the aid given yet the government does not account for its population on how the given aid is implemented. State budgets can be found on line, however, mechanisms to access internet are inexistent. This means that Mozambique is behind in achieving an all-round accountability. Also the arena in which government responds to donor demands remains at the top and never trickles to the bottom.

The factors impeding the effectiveness of actors in implementing the national HIV/AIDS policies stem from aid and knowing that the country receives a lot of financial support. This knowledge impairs the ability to act, especially where aid is said to be reaching a little few. NGOs help in reaching the grassroots yet the relationship between the government and NGOs is just nurturing. Crucial is the re-examination of the aid architecture that can help in finding appropriate models towards funding the civil society actors as this can ensure that all actors are targeting the same goal when implementing the HIV/AIDS policies.



The on-going changes in aid modalities for Mozambique calls for a restructuring between all actors. Data analysed showed that aid to the general budget supported sector wide approaches which neglects the civil society. Thus in planning and budgeting processes, aid has to be allocated for civil society initiatives and measured against priority indicators. The country's full ownership of development lies in participation and full leadership in the way aid is used. To achieve success, Mozambican government and civil society with the support of donors must have the capacity needed to implement better aid. Here parliamentarians have to be trained in aid planning and budgeting and monitoring and evaluation if they are to meet the policy objectives (De Renzio 2008:637) also of importance is the interest to vest in these measures. There has to be a two way, bottom-up and vis-a-vis in accountability and measurement of development results. The relationship between aid and AIDS is not linear as many factors come to play in HIV prevention and where Mozambique can capitalise on these factors. Now what remains is the open knowledge of the role of the silent actors as a way of focussing claims and accountability to the right parties.

## Conclusion

Data analysed on the relationship between aid and AIDS has been critical of Mozambique and overly questioning the role of ownership of its AIDS response amidst increased external funding. This does not come as a surprise as many developing countries continually rely on external sources to finance their health budgets. Also taking from the factor of weak states, since independence, majority of these countries have had a series of civil wars and natural calamities making them susceptible to external funding. Thus with the burden of HIV, and increased poverty, and after 30 years governments are still overwhelmed.

Mozambique's HIV/AIDS policies are neat on paper, yet their implementation is still in question. Aid for implementing these policies, coupled with government's control of the response should translate into a more coordinated and effective response which promotes country ownership. However as more aid comes into play so do the actors. This in the end leads to uncoordinated responses. Actors have to be answerable for their actions and government should be answerable to the population. The public needs to know how best to demand for answers. However there is a wide gap between reality and what the actors can do. Aid should be able to create positive impacts towards the policies rather than create gaps between the actors. Finger pointing has been going on due to the knowledge that there is health aid inform of general budget support although it rarely gets to the beneficiaries. With strong leadership, most of the bottlenecks towards fighting HIV/AIDS can be overcome.

Policy documents should clearly state how sustainability of actions is to be achieved. However the document suggests that public sectors should plan and budget for AIDS activities within their operational plans. This requires guidance and alignment. Such programming can increase the predictability and security of funding towards HIV and AIDS response activities as stipulated in support documents (PEN III:70). However the challenge remains on how NGOs and CBOs are to contribute to the policy implementation if not fully supported by the government.

Mozambique has rather positive remarks for the implementation of the Paris declaration, yet data analysed shows that Mozambique's actors still have a

lot to do to ensure overall ownership of the HIV/AIDS response and of development policies. Donors supporting Mozambique have to strengthen the country's goal of achieving ownership of its development agenda rather than impose their own interests. Likewise parliamentarians have to be fully engaged in the planning and budgeting processes. This focus on parliamentarians is widely voiced in the Busan declaration rather than the Paris declaration.

Future research should focus more on analysing the impact of aid and AIDS on key populations. This can inform better policies targeted at making aid effective on these populations. There is already a vast body of literature on aid and growth which focuses on macro-micro economics, however aid and AIDS debate needs to be integrated into researched. HIV/AIDS in Mozambique is not highly researched as much as aid is. Here scholars and researchers should focus on how HIV/AIDS can be analysed and evaluated in Mozambique's highly aided HIV/AIDS response. Findings show that AIDS as a disease gets more reviews if it is analysed with aid rather than the impact of the disease on individuals.

Lastly, this research process has taught me a lot about Mozambique surpassing my professional years in the country. This means that my focus on Mozambique has opened new arenas to which I can openly relate on issues regarding HIV/AIDS and as well as issues on aid.

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## Appendix 1: Interview Questionnaire

1. How is the implementation of PEN III being carried out at national, provincial and district levels?
2. Do you think PEN III is in alignment with most of your and other NGOs and CBOs activities?
3. Who are the actors involved?
4. What are they doing concretely in regards to the AIDS policy
5. How is aid impacting on the implementation?
6. Do you think that aid is enough?
7. Do you know how it is distributed among the actors?
8. How is ownership envisaged within the national AIDS response?
9. How is your organization benefiting from implementing PEN III?

## Appendix 2: Interview Respondents

1. Olga Muthambe, CEO HIKONE – MOÇAMBIQUE, Maputo Province
2. Gabriel Marcos, Programs Coordinator, Comunidade Moçambicana de Ajuda (CMA), Maputo city
3. Narciso Antonio Mahumana, Director, Instituto Superior de Estudos de Desenvolvimento Local (ISEDEL) and PROMETRA Mocambique, Maputo Province
4. Benedito Magaia, Youth Coordinator, Nucleo Provincial de Combate ao HIV/SIDA, (NPCS) Xai Xai, Gaza Province
5. Antonio Bembele, Coordinator, ACIDECO, Manhica district
6. Abilio Mahumane, Coordinator, XITHLANGO, Manhica district