Regional HIV/AIDS Work: An Added Value?

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Regional level responses to HIV/AIDS have become increasingly in vogue. Beyond the symbolism and established truisms associated with regional integration, however, much less is known about the specific substance of regional responses to HIV/AIDS. This article poses the question: what is the contribution of working at a regional level to the responses to HIV/AIDS? Further, can specific outcomes and any added regional value be identified? This article draws on evidence from an extensive, recent evaluation of a regional initiative. After a brief overview of conceptualizing 'regionality,' a typology of regional organizations working on HIV/AIDS is offered and regional level outcomes are then evaluated to identify characteristics of 'added value.' The article finds that regional agenda has been very relevant in tackling aspects of the epidemic not being met at the national level alone. Several examples of 'added value' at the regional scale are identified, as well as challenges to working regionally.

INTRODUCTION

In the last decade, a global architecture of health governance has emerged, albeit one characterised more accurately as 'work in progress.'[1] This 'architecture' has been shaped especially by HIV/AIDS funding, with new vertical programs involving different types of actors, such as bilateral and multilateral donors, philanthropic foundations, international NGOs, and local NGOs, AIDS activists, as well as community-based organizations and faith-based organizations.[2] Since around 2000, global focus has turned to regarding the epidemic as a problem requiring political commitment from both donors and countries with generalized epidemics. Funding was scaled up substantially from several multilateral and bilateral donors, with global mobilization to combat HIV/AIDS initiating a dramatic increase in funding commitments—a twenty-eight fold increase in just under ten years, according to UNAIDS.[3] The performance at the global level, however, only begins to make sense when placed in the context of other levels or 'scales' and in looking at how these are interrelated.

At the national level, for example, countries were required to set up national coordinating commissions and launch national strategies and monitoring and evaluation (M&E) systems to be eligible for funding from the first large-scale HIV/AIDS program, the World Bank Multisectoral AIDS Programme (MAP). Despite huge achievements in delivering anti-retroviral treatment ('ARVs') to more than 5 million people worldwide through global programs, there have been and still are grand challenges in implementation of programs at national and local levels in several countries.[4] In addition to the plethora of global (multilateral and bilateral) programmes to strengthen national level systems and responses, it became increasingly recognised by some stakeholders that an important contribution could also be made by using an additional scale, namely, the regional scale and establishing a *regional approach* to the epidemic.

In this article we explore what a regional approach, specifically in the SADC (South African Development Community) region, has implied in practice. We do this by studying the regional work on HIV/AIDS facilitated by the Swedish-Norwegian HIV/AIDS Team for Africa and the work by selected organizations this Team has supported in the SADC region in the period 2000-2009.[5] The main focus is therefore on the 'regional level' and these organizations themselves, although some discussion of the team itself as a regional player is also necessary. Evidence is selected from an evaluation of this regional initiative, especially drawing on the material concerning the regional economic community (REC) SADC, as well as the work by two regional NGOs.[6] As the work of these organizations is in progress, the assessment of their work varies with regard to how far they have come in developing their regional work. In addition, we provide a brief overview to show the contested notions of 'regionality' and what some of the pros and cons are of a regional approach to HIV/AIDS. The article then provides a typology of organizations working 'regionally.' Evidence for the 'added value' of working at the regional scale is thereafter summarized. The conclusion returns to some of the major issues in furthering effectiveness in regional level responses to HIV/AIDS.

DATA AND METHODS

The methodology used to arrive at these findings in the article can be seen in detail in the broader evaluation but includes over 61 interviews with key stakeholders, group work with beneficiaries and, in particular, workshops in three countries (Tanzania, Zambia, and South Africa) with mainly recipients but also non-recipients acting as 'controls.' This, along with document analysis, were used to map out the program logic of the intervention and identify outcomes, challenges, and 'added value.'[7]

The team supported 37 organizations at the time of the evaluation and we thus had to select some of these organizations for further analysis. For this article, two specific types of regional actors are selected for a closer study: the Regional Economic Commissions and regional NGOs. Among the Regional Economic Commissions, at the time of preparing the article, it was only the Southern African Development Community that launched activities for HIV/AIDS and it is the key regional entity that works on HIV/AIDS in the Southern African region.

Among the organizations, five were selected (SADC, REPSSI, SAT, ARASA, UNAIDS-RSTSA). One criterion for selecting these organizations was that they represented a good thematic spread across the team's thematic areas. A second criterion was that they represent the different modes of working regionally (see the typology in a later section). A third criterion was that these organizations exemplify how the team works at the different levels (i.e. from the global to the local level) as they are present at various levels (e.g. UNAIDS at the global and regional level, while SAT at the very local level). Among the regional NGOs, the ones sampled from the larger study are the Southern African AIDS Trust (SAT) and the AIDS and Rights Alliance for Southern Africa (ARASA). These organizations are selected because their experiences are somewhat illustrative of broader opportunities and challenges in working at the regional scale. All mentioned receive funding from the Swedish/Norwegian Regional Team for AIDS, but also get funding from a number of other bilateral and multilateral donors and are thus considered to represent important regional NGOs in HIV/AIDS work.

In addition, the selection had to fit with the country selection (Tanzania and Zambia). Limitations of this selection include the fact that sampling, by implication, raises issues concerning how representative the sample can be—in this case five

organizations out of 37. As the team itself did not give input into the selection of the organizations until the field work had already commenced, it was not always possible for the evaluation team to identify partner organizations for all of the Team's thematic areas in the two countries studied. Thus, while it can by no means be said to be exhaustive of the Team's wide geographic and thematic reach, based upon the criteria above, the sample of organizations is considered a reasonable representation of organizations working on these issues at a regional level.

WHY A REGIONAL APPROACH?

Our overarching entry point into discussions of 'regionality' is to regard it as a socially constructed phenomenon. In other words, the regional scale, like other scales such as the 'local,' 'national,' and 'global,' is not a naturally or inevitably occurring arena. Rather, the regional scale, like the 'global' one, is being actively constructed by a range of actors and processes, for different purposes and with different implications for distribution of resources.[8] With this entry point, we may explore why a regional approach to HIV/AIDS was pursued. The rationale for a regional approach to HIV/AIDS must lie in assumptions about inherent negative externalities to HIV/AIDS at the regional level, externalities that are better handled at this level than at any other level. An important negative externality that justifies a regional approach to HIV/AIDS is the regional concentration of HIV/AIDS in the Sub-Saharan Africa region. Countries in Sub-Saharan Africa are home to 67 percent of people living with HIV/AIDS (PLWAs) and record 75 percent of all deaths related to AIDS globally. The Southern African region, as the epicentre of the epidemic with 35 percent of all PLWAs and 38 percent of all AIDS-related deaths has a disproportionate burden.[9]

The Swedish policy framework that underpins the donor initiative discussed in this article, the Regional HIV/AIDS Team for Africa, makes an overall assumption that some externalities are shared by all countries in a region, but are not well handled by every country and also transcend the country level. Three concepts of essentiality, subsidiarity, and economies of scale are subscribed to in the Swedish regional policy framework and make up the rationale for a regional approach underpinning the Regional Team's work.

Essentiality concerns those aspects that can only be adequately met beyond the level of the nation state. HIV/AIDS may be seen as such an essential aspect, a negative externality that knows no territorial boundaries and easily spread across borders with migration and commerce. Hence, HIV/AIDS has to be managed beyond the nation states, at the regional and global levels. The negative externalities of HIV/AIDS involve issues such as mobile populations, economies of scale in terms of drug supply and transport across borders, and tackling the high prevalence rates in border areas. These are all important issues touching on prevention and impact mitigation in particular. SADC has pursued work in these areas.

Subsidiarity is the principle that if issues can be resolved at a lower level then this method should always take precedent. This principle may be used as an argument for why a regional approach is needed in addition to the global approach that has come forward since around 2000 with the global health/HIV/AIDS programs.

Economies of scale denote the aggregate benefits of being in a bigger unit. One such area identified relevant for 'added value' of regional co-operation concerns "…cooperation to develop methods and exchange experience for efforts to combat HIV/AIDS."[10] However, as acknowledged by the Swedish policy framework, the

added value of a regional approach only materializes "if coordination and exchange of experience take place at the regional level between the actors involved."[11] Here, regional cooperation affords added value for cooperation partners, compared with the situation of measures being taken in isolation at a national level. A regional added value that has been the foundation for SADC,[12] the Regional Economic Community covered in this article, is economic integration. A regional added value in this understanding is thus that further economic development may secure better living conditions for people in the countries cooperating. The idea of a *regional public good* that accrues to a larger collective unit is an important driver, therefore, for regional co-operation: "A regional public good is any good, commodity, service, system of rules, or policy regime that is public in nature and that generates shared benefits for the participating countries and whose production is the result of collective action by the participating countries."[13]

Furthermore an important consideration is that regional goods reside therefore not only in 'goods' physical in nature but also in policies and standards that can provide leverage for improvements in certain areas. Again, bearing in mind the overriding economic logic used to underpin arguments for regional integration, some observers claim regional integration in Africa has *over-emphasised* trade and investment as the engine of integration, while neglecting the need to create regional public goods, goods (such as infrastructure, water resources, electricity, health) that would be more relevant for the continent's poor.[14] It is thus interesting to note that the regional work by the Team and by the organizations that it funds has not focussed upon the economic elements, nor do the organizations emphasise economic aspects as the added value of working regionally. For instance, anti-retroviral treatment is highly relevant in terms of regional added value. With regards to treatment, however, SADC has been more concerned with other elements than treatment in their work for a regional approach. Why is that? An explanation may be that the global scale takes care of treatment—as most funding for treatment comes from global HIV/AIDS programmes[15] (UNAIDS, 2010). Indeed, one of the donors interviewed raised the question of whether in their HIV/AIDS work, SADC had the right priorities as they did not focus on economic aspects, such as for instance regional cooperation on procurement, pricing, and potential cooperation for production of generic anti-retroviral treatment.

Rather than focusing on the economic aspects and benefits of working regionally, the organizations see the added regional value in terms of 'giving visibility to unpopular issues,' enabling 'harmonization of strategies,' such as the 'standardization of interventions that work' across organizations.[16] For instance, Michaela Clayton from ARASA has argued that there was a need for a regional network like ARASA that focused on HIV/AIDS and human rights that could address issues regionally that were deemed too controversial at the national level. Several other informants also stressed the added value of working regionally in terms of organizations being able to address controversial issues that were not easily addressed at the national level.

REGIONALITY: BY WHOM? REGIONAL PROGRAMMES, INTER-GOVERNMENTAL ORGANIZATIONS AND CIVIL SOCIETY

Since 2000, the Swedish-Norwegian HIV/AIDS Team for Africa ('the Team' has provided funding and technical support, regarding its main role as building platforms for dialogue, enhancing regional cooperation, and especially, building the capacity of regional organizations to tackle the HIV/AIDS epidemic.[17] Methods

therefore include the use of dialogue-based work. The Team also subscribes to the Paris Declaration as a tool for working at the regional level, for example, working with the RECs and some regional organizations through Joint Financial Agreements (JFAs)[18] with other donors. This approach is guided by some overall principles, such as South to South learning initiatives, regional democratic ownership, and transparent and mutual responsibilities and coordination, both between regional programs and international collaborating partners.[19] The Team sits within key fora such as the UNAIDS convened International Cooperating Partners forum and the non-formalised HIV prevention group; also in a technical committee within SADC. The Team also finances key regional fora, such as the International Conference on AIDS and STIs in Africa (ICASA), the SADC Partnership Forum, and Regional Network of African AIDS Non-governmental organizations (RAANGO). Many of its partners are active in these networks (see later). A range of regional organizations are therefore supported which sharpens the issue of 'who' works regionally.

The organizations selected for discussion in the article were sampled from the larger evaluation. As an important first step in unpacking the practice of working regionally requiring an initial elementary 'typology' provided, which includes additional organizations for illustration, as follows:

Table 1: Typology of Regional Organizations

Regional Economic Commission (REC) (SADC)
Regional non-governmental organizations with offices in all countries they work in, having common systems, such as M & E, communications, materials (e.g. SAT)
Regional non-governmental organizations with sub-regional offices, i.e. not physically in all the countries they work in. (e.g. REPSSI)
Non-governmental organizations that are more typically multi-country, e.g. they are based in one country and operate in other countries without standardizing practices or approaches across countries or having strong linkages between the countries these organizations operate in. (e.g. Olive Leaf)
Regional network non-governmental organizations with formal membership. (e.g. ARASA)
Regional non-governmental networks, with informal membership – the network does not implement projects but has a specific lobbying and strategic focus. (e.g. RAANGO)
Research institutions which collaborate regionally and may also use the regional level as an entry point for national level political leadership; (e.g. HEARD (university-based) and IDASA (NGO-based))

UN Organizations, such as UNODC, UNAIDS, and also similar, like ILO, and IOM, with country offices but within regional structures, regional HQs typically based in South Africa or Kenya.

The table serves as a reminder that when it comes to working regionally, it is important to discern between different actors who may have different organizational structures and, of course, approaches to the 'regional scale.' Whether an organization's particular mode of working regionally has any bearing upon the ability to attain outcomes is an important consideration. The following section introduces and discusses the HIV/AIDS work of the RECs and the regional NGOs and evaluates the outcomes of their work.

SADC

The Southern Africa Development Community has 15 member states.[20] It was first established in 1980 but reformed in 1992 when it changed its name to SADC. As the Southern Africa region, as mentioned earlier, is the worst affected region in the world with regards to HIV/AIDS, it was considered increasingly imperative that SADC as a regional development community needed to be involved in fighting HIV/AIDS. Although SADC is an intergovernmental organization primarily oriented towards improving regional economic cooperation, HIV/AIDS was regarded as a common problem for all SADC states and thus, important to act upon. In order to work on HIV/AIDS, SADC established a separate HIV/AIDS unit in 2003. The Team started funding this unit in 2005. Since 2006, this funding has been channelled funding through a joint donor agreement. The Swedish/Norwegian Team is the lead donor and contributed 9.5 million Swedish kroner in 2009. The pooled donor funding is thus an example of donor alignment in practice and is cited approvingly by the SADC secretariat as it eases SADC's administrative burden in terms of reporting, negotiations over contracts, and other administrative issues.[21]

SADC's work on HIV/AIDS has mainly been confined to three areas: engaging member states to commit to HIV/AIDS by holding regional meetings, developing regional templates for surveillance, laws, and other measures to harmonize HIV/AIDS policies across the SADC region, as well as regular interaction with regional NGOs. Regarding the first element, a first achievement was in 2003 when SADC's member states adopted the Maseru Declaration on HIV/AIDS in 2003, in which they committed to prioritise the following issues with regards to HIV/AIDS:

> i. Prevention and Social Mobilization, ii. Improving Care, Access to Counselling and Testing Services, Treatment and Support, iii. Accelerating Development and Mitigating the Impact of HIV and AIDS, iv. Intensifying Resource Mobilisation, v. Strengthening Institutional, Monitoring and Evaluation Mechanisms.'[22]

In 2006, SADC organized a second high-level political meeting called the SADC Expert Think Tank in Maseru. The participants in this meeting identified the drivers of the epidemic in high-prevalence countries and produced a document to ensure political commitment by member states. This work was then taken forward and included in SADC's strategic plan for 2008–2010.[23] The strategy was intended to compliment the work of the Member States in order to achieve the shared goal of Universal Access to Prevention by 2010.[24] The Maseru Declaration and the Business Plan of 2005 builds upon the national and global structures of HIV/AIDS architecture already established, such as the Three Ones principles.

The second area of work for the HIV/AIDS Unit has been developing and harmonizing policies and protocols within the region and mainstreaming HIV/AIDS throughout the SADC organization. A key outcome of SADC's work has been the establishment of a surveillance system across all countries. A survey relating to this was undertaken in all SADC countries for the first time in 2008. In addition, SADC has worked towards developing a Model Law on HIV. Another advantage of regional approaches is the harmonization of strategies. The SADC Best Practices Criteria on HIV and AIDS that define the key characteristics of a 'good' intervention is an example of harmonization. Before the SADC Criteria were developed, different countries claimed that their interventions were 'best practices'; the criteria thus allow for minimum standards to be set vis-à-vis HIV and AIDS interventions.

Furthermore, SADC is regarded as an important partner for the National AIDS Commissions. One reason for this is that SADC arranges a meeting for all NACs in the region twice a year, where they agree on a number of documents, including HIV surveillance reporting formats. The other linkage that SADC has facilitated is the surveillance system it has made member states put up. As stated, the first time SADC obtained a regional surveillance overview was in 2008 and 14 countries used the SADC reporting format. The overview is facilitated through the SADC Technical committee interface with national ministries, and has been regarded as an important mechanism to get the heads of states to see the nature of the problems concerning the epidemic.[25]

A third area of work for SADC includes its formalized regular interaction with regional NGOs through the Partnership Forum. This forum developed a regional Global Fund application on cross-border work and received funding from the Global Fund with SADC as the principal recipient.[26] The project started in February 2011 and is called the HIV Cross Border Initiative. It works to harmonize the policies and health systems of mobile populations across member states, ensure improved coordination, monitoring and evaluation of initiatives, and to develop agreements for cooperation among health facilities that are close to the borders and may thus be used by cross-border populations.[27]

Moreover, the forum has created synergies on specific activities among organizations. One example of such synergy is that one regional NGO, REPSSI, and SADC have funded a position in the SADC HIV/AIDS Unit together "to ensure incorporation of children and young people."[28] The SADC Partnership Forum is the main forum for interaction between SADC and regional organizations. Several of the regional organizations that the Team funds participate in this forum, including Southern African AIDS Trust (SAT), Regional Psychosocial Support initiative (REPSSI), AIDS and Rights Alliance for Southern Africa (ARASA), and the Regional Network of African AIDS non-governmental organizations (RAANGO).

The RAANGO forum provides synergies among a substantial number of the recipients of Team funding. Moreover, there are synergies related to specific activities. Regional organizations are using SADC plans. VSO is rolling out SADC's plan for orphans and vulnerable children, and wishes to pursue this regional approach in its work. Regional organizations influencing SADC's plans and frameworks, for instance REPSSI, persuaded SADC to include orphans and vulnerable children in the plan and the position mentioned. REPSSI is also in discussions with United Nations Office on Drugs and Crime (UNODC) regarding children in prisons. Moreover, civil society organizations working closely with SADC have commented that regional organizations have a positive role to play to give attention to new issues "because national governments are often reluctant to embrace new ideas."[29]

On a general level, the attention that SADC has given to HIV/AIDS has led to accepted wisdom that certain things must be addressed as a region. A positive outcome of the work of the HIV/AIDS unit has been the peer pressure that has been exercised on national governments in relation to SADC as they have met other governments and reported. For instance, "Members of Parliament and other political leaders in different countries were pressured into participating in [one particular NGO initiated] activities because the latter had already secured buy-in from SADC."[30] However, at the same time, as one workshop participant and recipient of funding from the team in Tanzania stated that 'it is easier to work at the regional level. It is not easy to plan something at the regional level to make it fit at the local level'. The REPPSI representative in Tanzania stated for instance that "it takes a lot of time to work regionally, setting up offices in other countries, with different bureaucratic procedures." Also, another problem at the national level is the limited political commitment of politicians. As one informant said "the politicians have the political will, but when you come to the budget - the will is not there."

CHALLENGES FOR SADC

The key mandate of SADC is to facilitate economic integration and decrease trade barriers among member states. With this mandate, one question is why SADC should be expected to work on HIV/AIDS at all given its mandate and primary focus is on economic integration. Given this focus, there is a need to discuss whether the potential that lies in an established economic community, with reference to economies of scale, engaging in drug procurement negotiations, condom purchasing, for example, would enable SADC to focus on concrete steps for the mainstreaming of HIV/AIDS throughout SADC. The HIV/AIDS Unit has not given much attention to such trade-related issues, and it may thus be questioned whether it has the most relevant focus in its activities. Such issues were however listed among the arguments for why SADC should be supported by the team before entering into the JFTCA.

Another question, for instance, is the added value of regional versus global standards and systems. This is a valid question given that SADC has established a surveillance system at country level which thus exists in addition to the UN initiated systems of surveillance and national systems that may or may not already exist. Another surveillance system that requires data collection and reporting may just add an additional administrative burden to already overburdened national ministries and agencies.

An additional challenge concerns sustainability within SADC with regards to having a separate HIV/AIDS Unit, in which all but two of the positions are funded by the donors. Given the prevailing economic downturn in Western countries and donors increasingly reducing their HIV/AIDS budgets, the question of sustainability is a challenge to the unit. Moreover, internally in SADC, there seems to be a problem of imbalance between the strong HIV/AIDS unit and other areas of SADC's Directorate of Social and Human Development where the unit is placed, because other parts of the directorate have not received this level of technical and financial support.[31] The HIV/AIDS Unit in SADC moved from a position directly under the Chief Director's Office in the Department for Strategic Planning, Gender and Policy Harmonization to, at least visually, a less prominent position within the Directorate for Social and Human Development and Special Programmes. A third problem which is a common one for regional communities is that there is always a question of national implementation of regional commitments. There is an implementation gap at the national level, with SADC agreements not being taken forward by member

states. The limited number of states adopting the Model law on HIV/AIDS is a case in point. SADC also has no enforcement mechanisms at the national level to ensure implementation by member states.

A further issue for SADC is that there is no clear strategy for dissemination and use of the various guidelines and frameworks.[32] Harmonization of treatment, testing, and PMTCT protocols should be linked back to national standards. Again, there is a gap in communication and commitment between the regional and national levels, for example, between the NACs and respective Ministry of Health, and regarding drug procurement, Ministries of Finance and Trade. In other words, the 'buy-in' of other departments is required. National level challenges therefore remain which the regional level is not able to get involved in. In sum, there are several elements that the regional level is incapable of acting upon, but which need to be resolved at the national level.

REGIONAL NGOS

Southern African AIDS Trust (SAT)

SAT started as a program funded by Canada to provide capacity building to organizations. It has been receiving support from the Team since 2005. In 2003 SAT became an autonomous entity, and hence a regional NGO. SAT has country offices in Botswana, Tanzania, Malawi, Mozambique, Zambia, and Zimbabwe. SAT's work focuses on building the competence of communities and local organizations to respond to the epidemic and supported over 125 partner organizations in 2009 (which increased to 130 in 2011). The total number of SAT beneficiaries receiving prevention, counselling, and home-based care has doubled in the period 2005-2008, to 1.1 million. The support from the Team stood at approximately 4-5 million USD per year from 2009 to 2011.

A regional 'added value' that concerns both SAT and ARASA and that was addressed by several organizations interviewed was that they provided access for community-based organizations to donor funding. SAT's regional level intervention has undoubtedly given local organizations greater access to resources from other donors. The authors own field visits confirmed that SAT has a very relevant role in capacitating CBOs on the frontline of the epidemic. In an era previously characterized by huge increases in funding for HIV/AIDS initiatives, building the capacity of recipient organizations is critical for attempts to absorb funding in an effective manner. Good levels of knowledge and resources that SAT's capacity building has leveraged into communities was evident. Community level impact, for example, as observed by the authors, showed well-resourced and knowledgeable organizations, increased uptake in ARV medication and decreased stigma. In follow-up group work with members of local organizations receiving support via an SAT supported organization, representatives cited a range of benefits and improvements. Training provided information on nutrition, ARV management, materials, and general openness about the disease. Many beneficiaries interviewed had also acted as role models through testimonies and peer education. Support had also kick-started income generation, with, for example, goats' milk considered very important substitute to breast feeding for HIV+ mothers regarding PMTCT. Moreover, the regional organizations acted as mentors for the organizations and thus made 'a positive difference to the supported CBOs[33] and identified 'significant development results.'[34]

Regional Networks

The AIDS and Rights Alliance for Southern Africa (ARASA) is a regional partnership of non-governmental organizations established in 2002 and working to promote a human rights approach to HIV/AIDS and TB in Southern Africa through advocacy and lobbying (both regionally and internationally), capacity building and training, and producing materials. It has approximately 39 network partners in 15 SADC countries. Notable achievements of ARASA's work lie in generating a critical mass and momentum to regional lobbying around rights and HIV/AIDS in the region. Some of this includes lobbying over concerns about testing, disclosure and criminalization provisions contained in the West Africa Model HIV Law and deemed to be inappropriate. ARASA also worked with the SADC Parliamentary Forum (SADC PF) to provide technical input on the development of the SADC Model HIV Law and to facilitate civil society input on the draft model law. ARASA was central to a joint civil society statement on the criminalization of HIV transmission and which also fed into SADC PF lobbying in a number of countries with MPs in order to reverse moves towards more punitive approaches.

In addition, there are achievements in training, including the Regional Capacity Building for Access to HIV/AIDS Prevention and Treatment and Advocacy Programme in Botswana, Swaziland, and Lesotho. The Zambian AIDS Law Research and Advocacy Network (ZARAN), for example, described a situation in Zambia were previously 'nothing was happening on HIV and rights.' ARASA's support had added to their efforts to raise the profile in this thematic area. One example given was the benefit of attending a three-day meeting in Johannesburg on criminalization, and then being able to train others back in Zambia on these issues.

The partnership had, overall, been very useful and created a space to learn from others. Another example cited was a joint press release in Zambia on the harmful effects of the criminalization of HIV, and another on fake cures for AIDS. Both instances gave greater credibility than would have been the case alone. There was also a TV debate on criminalization. On this basis, ARASA involvement created some space on the issue, which enabled a national organization, ZARAN, for example, to write to ask the Attorney General to allow for debate and discussion before Parliament introduces criminalization. Other organizations also highlight the aggregate results of 'scaling up' voices and action and the benefits of training and building knowledge on rights and the epidemic, sometimes culminating in joint civil society statements. According to the Director of ARASA, the intention is for stronger network partners to assist less strong organizations.

Challenges Highlighted for Regional NGOs

Problem areas exist, which organizations such as SAT acknowledge. Some of these clearly relate to the organizational challenges of working regionally depicted in the typology provided earlier. For example, whilst SAT has 25 advocacy networks "staff constraints do not allow extensive SAT staff participation at national levels."[35] This is an important omission and tends to explain how SAT is relatively invisible in at least two of the countries visited (Tanzania and Zambia). Before creating an integrated regional management structure, the friction of distance from regional HQ also created unevenness in regional country office's performance.

However, harmonization across countries has been achieved by SAT country offices. SAT also refers to key regional documents and processes. SAT was key in

establishing RAANGO and also, like REPSSI, has good exposure in international and regional fora. Whilst appearing to be growing in use, it is still less evident, for example, the extent to which regional policy instruments and guidelines (such as Maseru Think Tank) are actually embodied in directing SAT's program. A case in point is the emphasis in the work of a number of country partners on treatment rather than goal of prevention. The Director was aware of this situation and identified that SAT and other organizations need to be better in discussing sexuality and prevention at the local level. More specifically for SAT, the issue of 'graduation' of partners—when they no longer require financial and capacity building support from SAT—appears to be a particular challenge. Granted that the issue is not clear cut, and that both SAT and the Team are aware of it, nonetheless the need for adequate discussion with partners and clear exit strategies is apparent. There are other challenging areas such as SAT's objective to integrate human rights and gender approaches into their overall direction. The field visits showed a rather limited imprint of gender and human rights considerations at the local level. This finding highlights one of the challenges that several regional organizations identified at a larger scale—addressing controversial issues at the national level. While an added value is that the regional scale facilitates 'common' regional activities, it also brings into question what the role of regional organizations and activities implies at the national level. The workshop participants identified that there are challenges in knowing how far their works should be assessed—only at the regional level or, additionally, at the national level.

Finally, the issue of income generation was raised by SAT partner beneficiaries as an increasingly significant part of their work, yet SAT did not appear to support this in their programming. Income generation and the small stipend for the local organization facilitators were considered very important in motivating them. A basic participatory exercise revealed progress since the intervention in terms of lessening stigma but also that stigma still persisted, showing a renewed need to work with churches and local health workers. While this is unlikely, of course, to be due to regional programming alone, perhaps the regional modus operandi further exacerbates the distance that already exists from HQ to the field.

For some network partners there is a challenge in dealing with unequal relationships in the network and also sensitive handling of issues. Another challenge concerns duplication of studies and material that ARASA and other HIV and human rights organizations have produced. Better regional networking is improving the problem of duplication. Seeking accreditation for ARASA training is also an ongoing challenge. The evaluators found that ARASA is proving effective in meeting its goals but that this is not necessarily readily translated into results-based indicators. The ARASA network is extremely active and engaged in the regional and international context. The Team was one of the first donors to contribute to the early growth of ARASA. We found that as one of a few regional HIV/AIDS and rights organizations, ARASA is extremely relevant to regional and global endeavours to achieve a rights-based focus onto the epidemic. It is particularly salient to note that in an era when many of the NGOs are acting primarily as service providers, organizations like ARASA are trying to lift other organizations to the level of providing more critical engagement. The regional level enables this.

Summing up, we turn to the more general findings from the discussion among several NGOs receiving support from the Team in a workshop the authors held in Pretoria during the evaluation. The benefits and challenges to working regionally were identified among the participants in this workshop. A major challenge that the NGOs acknowledged was the lack of a clear definition of what regionality is. One

benefit of working regionally is that 'it gives visibility to unpopular issues, another is the 'harmonization of strategies', a third is 'mentoring,' i.e. that organizations in other countries facilitate transfer of knowledge and capacity to other, less-capacitated organizations. A fourth benefit identified was 'access to resources,' as ARASA described. They stated that the small community-based organizations that form part of ARASA believed it to be easier to raise funds through ARASA than on their own.

Challenges for the Team

In terms of the Team itself, and aggregating regional interventions, one particular challenge has been at what level outcomes and added value can be said to accrue to working regionally. It was perhaps revealing that the donor entity was on occasions unable to identify what had happened to specific regional platforms because these areas had not been followed-up. When national-regional linkages are evident, these are either lost or, at least, not always easily visible in the Team's work.[36] While democratic governance and rights-based approaches, themes mentioned in the Team's approach, for example, are highly relevant at the regional level, both conceptually and operationally also clearly depend upon national political actors/duty bearers for implementation. These findings speak to a more general issue which concerns the scope and nature of nation-states. Although they have undergone substantial redefinition, states remain key actors in molding regional and global political and economic maps.[37] How to strategize around the problems with regional-national linkages is raised more generally in regional cooperation.[38]

IDENTIFYING REGIONAL 'ADDED VALUE'

Can specific instances of 'added value,' then, be distilled from these interventions? And how significant are these regional efforts in terms of other approaches at the global and national levels?

Through this support from the Team certain policy 'milestones' have been achieved. These include the Expert Think Tank on Prevention (May 2006) which for example highlighted the role of Multiple Concurrent Partners in the epidemic, but also resulted in member state commitments. The Team itself has contributed to building the capacity of the HIV and AIDS Unit at the SADC. There have also been numerous examples of standard-setting through regional guidelines and protocols. A model law on HIV and AIDS, as mentioned, has been developed through the SADC Parliamentary Forum, along with SADC Best Practices Criteria on HIV and AIDS, both of which help establish the characteristics of 'good' interventions. The Team was influential, alongside other donors, in creating the 'Framework for regional support to HIV and AIDS in Southern Africa,' which sets out a common vision of harmonization by ICPs to strengthen support to Southern African regional institutions.[39] The Team's approach is highly relevant to building regional capacity. In their outcome assessment, Devfin suggests that it appears "well harmonized with the overall regional strategy" with respect to adherence to the regional development cooperation strategy.[40] The Team is also regarded by several respondents as highly relevant and a critical ally in regional HIV/AIDS work, and as a significant regional player. The Team itself has added value in several areas in terms of building regional networks that exchange information, set agendas, and build competence related to sensitive issues and rightly claim building regional platforms as a considerable achievement. Capacitating regional organizations, driving processes in specific

instances (SADC, for example) and in initiating support to other organizations (e.g. ARASA) have also been significant achievements and the Team's specific approach has also been said to contribute to regional ownership. One National AIDS Council (NAC), for example, lauded the Team's flexible approach, i.e. its tendency not to impose programs on recipients, which, it was claimed, gives the Team programs a distinctive character and credibility.

The evaluation methodology supplements the methods mentioned earlier. For example, the country workshops, particularly the one in South Africa with several senior level staff of regional organization HQs and Embassies including SADC, were especially informative in looking for 'added value.'[41] An overall summary of these findings are made more tangible by the authors grouping them under the following two key areas:

Capacity Building

Information sharing—according to beneficiary organizations, more valuable lessons and practices were shared between recipients than would otherwise have been the case had they been locked into a specific national or even local level of work.

Access to resources—smaller community-based organizations have used partnerships with regional organizations in order to leverage financial resources that would not have been possible otherwise. The ARASA, for example, shared how many of its affiliates are finding it much easier to raise funds through the ARASA network than on their own.

There was added value found in *harmonizing approaches*—regional model laws, protocols, guidelines, and common standards were all regarded as important in standardizing responses to HIV/AIDS. Harmonization allows for inter-country comparisons and tracking of impact at a regional level as well, identifying genuine 'best practices.' For example, surveillance methods, which through SADC had for the first time enabled a common approach across a majority of the countries in the region, gave results that could be compared and contrasted.

Technical expertise—Technical expertise transfer is cited as very important due to the uneven capacity of different organizations. In this respect, training people from several countries at the same time was also deemed a more efficient method then holding several in-country workshops.

Networking—the benefits of belonging to a network as opposed to working alone were highlighted, e.g. for increasing the visibility of an organization.

There was also a range of *less tangible* 'added value.' One organization mentioned, for example, that through regional cooperation, laboratory equipment that was not available in Zambia was made available in South Africa for that organization to use.

Much of this reflects the *'economies of scale'* mentioned—not only with respect to training more people, but also information materials concerning treatment or prevention could be mass-produced regionally.

More specifically, '*essential*' regional issues were required such as cross-border migration, whether for refugee populations, or as transport corridors; or, an issue that will become increasingly significant, the free movement of member state citizens across national borders and commensurate access to health care.

In addition, there was a further set of findings related to 'political influence' of regionality.

Political Influence

Lobbying—as mentioned, for example, in the added value of having a network organization, ARASA, involved in its lobbying activities, which lent others greater credibility and visibility. This added political capital in some instances. Moreover, access to treatment and other *regional goods* were cited as things that were better coordinated and lobbied for at the regional level.

Political momentum—such as through the Maseru Declaration on Prevention, the Expert Think Tank meeting, again added political force aggregated at a regional level, where national responses had waned. The *peer pressure* on countries and competition generated at a regional level was deemed by several to be conducive to encouraging national leadership where previously little pressure was being exerted.

Sensitive issues—a number of issues were also highlighted that had been deemed too sensitive to approach at the country level. Men who have sex with men, HIV prevention in prisons, sex work—all were issues that struggled to be placed on national agendas. Regional awareness and regional approaches to these issues proved able to enter into the national context and policy debate in a number of countries.

From the above, the benefits of regionality are identified. These benefits reflect valuable dimensions of the regional approach, in what can be identified as the *aggregated added value* of working at this level. This aggregated added value brings us to the final question, that is, how significant are these regional efforts in terms of other approaches at the global and national levels? The number of global health/HIV/AIDS programs and their funding has increased rapidly over the last decade, transferred mainly to the national and local levels in countries. As the funding is channelled directly to the national and local level with attention being given to these levels, there is a need for a regional approach and funding to HIV/AIDS work at this level. Moreover, while regional cooperation in general has seen few successes in Africa, the cross-border project funded by the Global Fund may be the start of an improved linkage across the SADC region as well, as an example of linkages across global-regional and national levels. The main challenge of all development initiatives in African countries, however, remains in this project as well: implementation at the country level.

CONCLUSION

The article has highlighted how 'regionality' has added vitality to responses to HIV and AIDS in a number of key areas. Capacity has been strengthened in a number of regional organizations and in building various regional 'platforms.' These outcomes are even more significant when placed in a context previously characterized as having weak regional responses to HIV/AIDS and with states in particular reluctant to grapple with some of the issues considered more controversial in the region. Increasingly, nation-state members of the regional blocks, and several donors, also see the regional level as highly relevant for tackling HIV/AIDS. Regional organizations can provide a '*helicopter view,*' as one described it, in which local level organizations can be scaled up to national, regional and even international levels by

providing knowledge, resources, training, and political support: the 'added value' identified earlier.

Actors also hold different interpretations of regionality. Some responses of recipients raised the issue of whether harmonization in effect serves to erode national level distinctions and gives a too simplistic 'one size fits all' (such as the Model Law on HIV/AIDS) approach. Others felt that the HIV/AIDS agenda had shifted too far from the economic role and function of RECs. Ultimately, a particular challenge is whether regional mechanisms are actually implemented and impact is felt at country level, which raises important questions concerning at what level results are achieved. What happens to all the guidelines, protocols, laws, and so on that have been developed at a regional level is often not systematically followed-up. Many of the regional-national bottlenecks identified could be much better analyzed. When the main approach, building regional platforms, is placed in the context of these different levels of outcomes, it is apparent that it soon becomes an end rather than a means of achieving the overall goal. This is not a problem in the specific intervention mentioned alone but rather reflects the challenges in regional cooperation more generally. Ambitious regional plans, whether for monetary union, or disease control, may yet founder on the rocks of national implementation. Certainly the relatively short time frame of the regional interventions mentioned in the article concerning HIV/AIDS must surely engender a caution about the prospects for regionalism. That said, the fact is that our findings illustrate that many organizations are to some extent increasingly making use of the new standards and capacities that have been developed at the regional level to inform their work at the national and local levels. Organizations reviewed have either been strengthened through support or contribute themselves to capacity building of other organizations. In terms of sustainability, encouraging signs are that some organizations demonstrate increasing government involvement, even in mainstreaming some of their programs. SADC also plans to increase its member states' financial contributions. Several organizations now have basket funding from several donors which lessens dependence upon individual donors. Local level organizations have also been able to use support in order to leverage other sources of funding.

Better articulation and strategizing of regionality, to include regional-national-local bottlenecks is hampered, however, by overall regional goals and objectives that can appear more like activities. These risk leading to underdeveloped detail in outcomes, and especially, explanations of what causal mechanisms lead to prevention and mitigation of the epidemic. The roles and functions of states certainly undergo redefinition within complex global and regional constellations of the still emerging health governance 'architecture'. But such sweeping sentiments should not preclude focus on the more mundane and essential fact that states shape regional interventions as much as they are shaped by them. Responses to HIV/AIDS now have another considerable tool at their disposal. However, any intervention addressing regionality must also use a more strategic approach premised upon scales as interrelated and which requires 'jumping' from the regional scale to local, national (and sometimes global) ones when appropriate.

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[1] David Fidler, "Architecture amidst Anarchy: Global Health's Quest for Governance," *Global Health Goverance*, 1, 1: (2007).
[2] *Making Sense of Global Health Governance - A policy perspective*, eds. Kent Buse, Wolfgang Hein, and Nick Drager, (Basingstoke: Palgrave Macmillan, 2009).
[3] UNAIDS, "2008 Report on the Global AIDS Epidemic," (Geneva: UNAIDS, 2008).
[4] See Peris Jones, *AIDS Treatment and Human Rights in Context,* (Basingstoke: Palgrave Macmillan, 2009).
[5] The material used in the article draws from Peris Jones, Siri B. Hellevik, Aadne Aasland, and Berit Aasen. *Evaluation of the Swedish-Norwegian Regional HIV/AIDS Team for Africa- final report*, (Sida: Stockholm, 2009).
[6] Ibid.
[7] Ibid.
[8] There has been an extensive debate within geographic theory, for example. The implication has been that understanding the relationship between social and spatial processes is that they are mutually reinforcing. Geographic scale matters and that, in recognizing this; a more plural, relational meaning of scale is required, whereby, for example, the regional scale should not be seen in isolation from either the local, national or global scales. For a geographic overview see Neil Brenner, "The limits to scale? Methodological reflections on scalar structuration," *Progress in Human Geography,* 15 (2001): 525-48.
[9] UNAIDS, "2008 Report on the Global AIDS Epidemic" .
[10] Swedish Ministry of Foreign Affairs (SMFA), "Regional Strategy: Sub-Saharan Africa 2002-2006," http://www.sweden.gov.se/content/1/c6/03/97/83/5038c3b1.pdf, (2002): 11.
[11] Ibid, 9.
[12] "SADC's Vision is that of a common future, a future within a regional community that will ensure economic well-being, improvement of the standards of living and quality of life, freedom and social justice and peace and security for the people of Southern Africa. This shared vision is anchored on the common values and principles and the historical and cultural affinities that exist between the people of Southern Africa. The SADC Mission is to promote sustainable and equitable economic growth and socio-economic development through efficient productive systems, deeper co-operation and integration, good governance, and durable peace and security, so that the region emerges as a competitive and effective player in international relations and the world economy," "Introducing SADC." 2010a. Available at: http://www.sadc.int/index/browse/page/715.
[13] Jeggan C. Senghor, et al. "Going public: How Africa's integration can work for the poor," Africa Research Institute (2009): 67.
[14] Ibid.
[15] The national spending assessment presented in UNAIDS 2010 demonstrates that anti-retroviral treatment in African countries are largely financed by global health/HIV/AIDS programmes.
[16] Jones, "Evaluation of the Swedish-Norwegian Regional HIV/AIDS Team."(annex 9).
[17] The Team is a joint initiative of both the governments of Sweden and Norway, who have collaborated since 2001, with Norway contributing approximately one sixth of funding.
[18] Joint Financial Agreements are agreements intended to harmonise donor support mechanisms, producing greater coherence and more simplified reporting systems for the recipient.
[19] TEAM, "Annual Report," (Lusaka: The Team, 2008). A recent concept note on thematic focus does begin to define and set out its regional objectives (February, 2009). The most recent TEAM document that discusses regionality is the 'Regional analysis of HIV and AIDS in sub-Saharan Africa' (TEAM, June, 2009), which provides an overview, albeit, descriptive, of regional impacts and responses to HIV/AIDS.
[20] The member states are: Angola, Botswana, The Democratic Republic of Congo, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, United Republic of Tanzania, Zambia, and Zimbabwe.
[21] Jones, et al. "Evaluation of the Swedish-Norwegian Regional HIV/AIDS Team."

[22] SADC, "The Maseru Declaration on the Combating of HIV and AIDS in the SADC region," (Gaborone, SADC, 2003).
[23] Team "Annual Report 2008."
[24] Ibid, 10.
[25] Jones, "Evaluation of the Swedish-Norwegian Regional HIV/AIDS Team."
[26] See http://portfolio.theglobalfund.org/en/Contacts/PrincipalRecipients/MAS for information about this grant.
[27] See The Global Fund, 2011 Round 9, SADC application.
[28] Team, "Annual Report 2008," 7.
[29] Jones, "Evaluation of the Swedish-Norwegian Regional HIV/AIDS Team," 143.
[30] Ibid.
[31] S.R Chipamunga, "Final Evaluation of the JFTCA 2-year Short Term Support and its financing arrangements. SADC HIV/AIDS Unit. Draft Evaluation Report" (Gaborone: SADC, March 2009).
[32] Ibid, 20.
[33] Ron Titus and Unity Charo, *Southern Africa AIDS Trust Project Evaluation* (Stockholm: Sida, 2008): 33.
[34] Ibid, 4.
[35] SAT, Annual Report (2008).
[36] For example, the National Aids Council in Zambia cited the important role facilitated by SADC in generating peer pressure between member state NACs. Good programmes in member states create competition and also a desire to improve less well performing programmes. These are important dimensions that are not being tracked or even adequately reported by the TEAM.
[37] Dicken, *Global Shift*, op. cit, pp. 112.
[38] Devfin, *Outcome Assessment of Regional Development Cooperation in Sub-Saharan Africa 2002–2008*, (Stockholm: Devfin, 2009).
[39] Undated pamphlet publication, by UNAIDS, with Sida and several other donors, including NMFA.
[40] Devfin, *Outcome Assessment*.
[41] See Jones, "Evaluation of the Swedish-Norwegian Regional HIV/AIDS Team for Africa."