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## THE ROLE OF CIVIL SOCIETY ORGANIZATIONS IN HIV/AIDS CONTROL

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The concept of civil society, one of the most popular paradigms of the twentieth century, conveys different meanings to different people. To the poor in Nigeria, for example, civil society may represent the only access to the few services available. To others, though, it may represent the voice of Nigeria Labor Congress, which has become synonymous with fighting for pro-poor policies from the government.

In his book on civil society, Michael Edwards draws from earlier work by such civil society thinkers as Thomas Hobbes and Alexis de Tocqueville to present three theoretical frameworks for viewing civil society: as an association of people with similar goals; as a “good” society or utopia that defines development; or as a “public sphere” in which the right and appropriate interplay of all the actors in the tri-sector model leads to development action (1).

In this chapter we use the term “civil society organization,” or CSO, to refer to all associations and networks between the family and the state in which membership and activities are voluntary (2). This definition encompasses such organizations as local and international nongovernmental organizations, community-based organizations, faith-based organizations, community development associations, support groups for people living with HIV/AIDS (PLWHAs), professional associations, and trade unions.

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Other categories include such networks and coalitions as the Civil Society Consultative Group on HIV/AIDS in Nigeria, the Network of People Living with HIV/AIDS, the National Network on Reproductive Health, the Nigerian Network of Sex Work Projects, the National Union of Road Transport Workers, and the Christian Health Association of Nigeria. While these examples suggest the range of groups included in the term “civil society organization,” a great deal of ambiguity remains in the statutory and general understanding among practitioners in the field (3), especially in Nigeria.

In furtherance of humanity’s search for the right recipe for development, CSOs have taken center stage. The HIV epidemic is one area on which they have made their mark during the past two decades. This trend has translated to the now-recognized best practice of creating multisectoral and multidisciplinary partnerships at national and international levels to respond to an epidemic that may prove to be humanity’s biggest challenge ever.

### THE COMPARATIVE COMPETENCIES OF CSOS

HIV is intimately linked to sex and sexuality, areas that norms and taboos moderate in Nigeria. Community leadership and structures in turn tend to regulate these norms and taboos. While government policies may create environments that enable change, the reality is that the obstacles to such change lie outside the control of formal policies and processes and more within the domain of community’s socialization processes and upbringing—the informal policy arena (4). The unique strength of CSOs is their ability to provide platforms to challenge some of these informal policies, particularly if they are indigenous to that locality and well accepted in the communities. Their use of more participatory approaches and integration with communities place them at a vantage point to be able to tackle the social and cultural determinants driving the epidemic in a way that the public sector struggles to do.

One such area is outreach to female sex workers. The illegality of commercial sex work hampers government efforts to promote safer sex among this critical segment of society. As a result, CSOs must step in to fill this gap. CSOs are particularly adept at uniting the underprivileged and marginalized fringes of society, building their capacities, giving them “voices,” and promoting their social inclusion. The pioneering efforts of such organizations as The AIDS Support Organization (TASO) in Uganda are oft-cited examples of the contribution CSOs can make to HIV/AIDS prevention, care, and support. Uganda’s success in reducing its rate of HIV infection has been attributed to the highly politicized and energized civil society at the forefront of the country’s response (3).

### THE EVOLUTION OF NIGERIAN CSOS AND HIV-RELATED ACTIVITIES

Nigeria is blessed with a flourishing CSO sector, especially in traditional institutions, such as community development associations and women’s groups. From time immemorial these groups have served as a source of vital social capital across many Nigerian communities and in the Diasporas.

By contrast, more formal nongovernmental organizations (NGOs) are a recent phenomenon, with roots in the years of the country’s military dictatorship. NGOs were the main organizations with which Nigeria’s international development partners were willing to cooperate. Some of the earlier organizations were formed by civil servants who, privy to donor policies, were quick to set up shop. Donor requirements of formal registration disenfranchised most indigenous groups in favor of these newer creations, a trend that continues.

In the earlier phase of Nigeria’s response to the epidemic, before 1999, the predominant role of local CSOs was program implementation (3), with some limited attempt by a few international NGOs to mediate in the policy formulation process. The CSO response was fragmented, limited in scope (5), and even incoherent. Their funding was mainly limited to implementing interventions; few donors were willing to invest in strengthening local organization until the Department for International Development (DFID) funded its Capacity Building for Decentralized Development Project. Relationships among CSOs were marked by mistrust, competition, and limited collaboration.

Some NGOs did make their marks, however; examples include STOPAIDS, the Association for Reproductive and Family Health, Action Health Incorporated, the Society for Family Health, and Planned Parenthood Federation of Nigeria. After the advent of democracy in 1999 and the development of the HIV/AIDS Emergency Action Plan (HEAP) the following year, all stakeholders recognized the need for CSOs to broaden their roles beyond program implementation.

With DFID support, ActionAid International Nigeria and Family Health International facilitated a national forum of CSOs of all shades, which gave birth to the Civil Society Consultative Group on HIV/AIDS in Nigeria (CISCGHAN). Initially composed of 75 members, the coalition now has more than 350 members spread across the country (6). A facilitating committee of 16 members from all the geopolitical zones manages the coalition, whose initial operation was based on the concept of a “virtual secretariat.” This concept has since evolved with the establishment of a fully functional office and enhanced capacity to manage programs, including a grant from the Global Fund on AIDS, Tuberculosis and Malaria to strengthen the civil society response across the country.

The Network of People Living with HIV/AIDS (NEPWHAN) originated in 1998 under the auspices of PLWHA-friendly NGOs and some faith-based organizations. Its poor funding base precluded tangible activities or projects, however, until 2000, when the Federal Ministry of Health, working through its National AIDS and STD Control Program (NASCP) along with a number of NGOs and faith-based organizations, brought together PLWHAs from all over the country again in a bid to re-establish and invigorate the network. The meeting succeeded in reviving the network. The network opened a permanent office in 2003 and has managed to catalyze the emergence of PLWHA support groups across the country. It has also been able to engage the national response in a coordinated way despite limited funding.

## POLICY FORMULATION, IMPLEMENTATION, AND EVALUATION FOR CSOS

### Medium-Term Plans I and II

The involvement of CSOs with Nigeria's Medium-Term Plans (MTEPs) I and II was limited to the implementation of a few interventions. Donors funded most of these interventions, and CSOs tended to design such programs outside the parameters of the plans. The formal partnership that CSOs formed with the government were ad hoc; personal recognition was the key criterion for being able to take a seat at the table. Competition was intense among CSOs, and little collaboration was discernible. The CSOs also lacked a systematic framework for influencing the policy formulation processes. Each organization seemed more preoccupied with scrounging resources for their own initiatives than building a common voice on issues. Most donors supported the cost of the program interventions of such CSOs; little was spent in the institutional development of CSOs. The situational analysis that preceded the development of HEAP described the CSO contribution as receiving little government recognition (5).

### HIV/AIDS Emergency Action Plan

The emergence of CISCGHAN in 2000 provided the first opportunity for local CSOs to provide coherent input to Nigeria's HIV/AIDS policy formulation process. The inaugural meeting of CISCGHAN provided its members with a forum to articulate, based on their years of experience in program implementation at the community level, what they considered to be important for the CSO input in the national response. The result of this policy research and analysis session became known as "CISCGHAN core position statements." These 16 statements provided the framework in which CISCGHAN engaged other actors in shaping the HEAP document and the emerging institutional arrangements of the National Action Committee on AIDS (NACA). With its motto "the voice of CSOs working on HIV/AIDS in Nigeria" (7), CISCGHAN maintained four representatives in NACA before NACA became reconstituted in 2003. With the following words, CISCGHAN summarizes its bold mission: "CISCGHAN exists to coordinate, facilitate and advocate and to ensure the needs and issues of CSOs working on HIV/AIDS are addressed and to provide a coordinated and coherent input into the national response to the HIV/AIDS epidemic."

The "arena" in which CISCGHAN and other CSOs had to operate differed markedly as the government, through NACA, displayed a better understanding of the role of CSOs in policy development. They were thus able to maximize the input of CSOs into the process. The CSOs, for their part, soon realized that their understanding of policy formulation processes was limited. While they had gained a seat at the table, many still struggled to ensure a bidirectional flow of information between CISCGHAN and the wider CSO constituencies. Some CSO practitioners in Nigeria even believed that the government had more or less co-opted CISCGHAN, and the network would thus find it difficult to take any principled position if it disagreed with what NACA wanted.

International NGOs also were actively involved in developing HEAP. They provided a broad perspective by drawing on experiences with the best practices in parts of the world where programs were more

mature. Several were involved in building the capacity of local organizations to understand the policy process, especially policy research and analysis; drawing from their field experience and capacity for networking (as distinct from networks); and developing platforms to push their policy agendas. Others, however, maintained a narrower interest, as they were keen to gain mileage for their organizations, especially from the government. Collaboration among the international NGOs also was weak, as everyone had made it to the policy table yet few had any distinct positions to argue. The media, with the exception of specialized media NGOs, rarely were represented at the table, unlike other countries where the media are known to set the policy agenda; public interest news and coverage were limited at that time. A handful of media representatives, however, attended some of the sessions held during the development of HEAP.

### The World Bank Multi-Country AIDS Program

CISCGHAN also engaged in the consultation process of the World Bank Multi-Country AIDS Program (MAP) to ensure that the the program implementation manual for the World Bank HIV/AIDS Fund (HAF) reflected the needs of CSOs. The then moderator of CISCGHAN worked closely with the World Bank and NACA to determine how the HIV/AIDS Fund and the implementing organ for the project would operate, especially with regards to the revision of conditions that CSOs have to meet in order to access the HAF, such as the issue of counterpart funding and the years of existence. MAP has earmarked 33% of its funds for CSOs and community interventions.

### State Action Committees on AIDS and Local Action Committees on AIDS

While CISCGHAN as a vehicle clearly succeeded in formalizing CSO involvement in policy formulation, the situation differed at the state level, as CSOs could not organize. Participation in the emerging SACAs and LACAs became arbitrary, as the SACAs invited NGOs they were comfortable with to the table. Some states — such as Lagos, Plateau, and Akwa Ibom — had a fair amount of CSO representation. Yet most CSO members of SACAs rarely fed back to other CSOs, and they lacked a coordinated process for collating issues from their constituencies and feeding the information back to the SACAs. The limited capacity and weak funding base of most SACAs resulted in few activities in their states. Their inability to strengthen the capacity of their CSOs became one outcome of this coordination challenge.

### Contributions of Faith-Based Organizations

Although faith-based organizations wield considerable influence in defining "informal policies" — some of which hinder efforts to promote safer sex and positive living, their involvement in the formulation of the HEAP document was minimal. Since the development of HEAP, however, NACA has made a concerted effort to bring faith-based organizations on board in a structured way. This is important in view of the fact that the creation of an enabling environment is one key strategy articulated in HEAP (8).

## Network of People with HIV/AIDS in Nigeria

NEPWHAN was formed at a time when PLWHAs were not involved in NGO programs in accordance with the GIPA—or Greater Involvement of People Living with HIV/AIDS—principle. They were viewed as beneficiaries rather than major stakeholders and had input into neither the design nor the development of HIV/AIDS interventions. The network was created to address the absence of rights-focused approaches and abuses of PLWHAs' fundamental human rights. It serves as a coordinating body for PLWHA support groups across the country. Since its formation, NEPWHAN has demonstrated tremendous potential as an advocacy group and a logical entry point as gatekeepers for HIV/AIDS interventions. It has succeeded in creating a defined advocacy and consultative position in all relevant bodies in terms of facilitating activities such as access to care, research, and the creation of a legal and policy framework for HIV/AIDS.

NEPWHAN's major challenge may lie in its decentralization. Currently, its work is confined to the national level, leading to a disconnect with its state PLWHA groups.

## CSOS AND PROGRAM INTERVENTION IN NIGERIA

CSOs are now significant actors in HIV/AIDS program implementation in Nigeria. The programs range from prevention to care and support; the country has few impact-mitigation programs.

A review of the major programs shows that international NGOs working with and through local CSOs manage more than 70% of the program interventions (Table 13-1) (9). This scenario is not unexpected, as most donors, upon consideration of the history of corruption in the public service and the bureaucracy involved in getting anything done, would rather give resources to CSOs that can rapidly deploy them. The CSO sector also has contributed to providing the few data sources available, such as the National HIV/AIDS and Reproductive Health Survey and the Nigerian Demographic and Health Survey. This section presents some of the previous and ongoing interventions in which CSOs have been involved.

### Prevention

#### *High-Risk Groups*

Communities with high-risk behavior—characterized by large numbers of brothel-based sex workers and transactional sex—are common in Nigeria. Working with this group is challenging for two principal reasons: it must deal with the migratory nature of sex workers and long-distance drivers and the illegality of the sex trade means that society views working with sex workers as encouraging the trade. A number of development partners have commended the pioneering work of such organizations as Women's Health, Education and Development (WHED), which works with sex workers in the northern part of the country, and Nka Iban Uko and the Society for Women and AIDS in Africa, Nigeria (SWAAN), which work in the south.

These groups are still active in the sector, with such new entrants as ActionAid Nigeria and the Society for Family Health's Promoting Sexual and Reproductive Health for HIV/AIDS Reduction (PSRHH) project, which seeks to conduct sex worker interventions in more than a hundred communities across Nigeria. These communities deploy a mix of program interventions, such as peer facilitation,

Table 13-1. Major Programs and Implementing Agencies in Nigeria

Program	Description	Agencies	Total Amount
World Bank Multi-Country AIDS Program	Resources both public sector and CSO HIV/AIDS responses	Funded by the World Bank; implemented by the National Program Team (NPT)	US\$90.3 million for 2002-2006
Promoting Sexual and Reproductive Health and HIV/AIDS Reduction (PSRHH)	Major prevention program targeting MARPs and young people; provides research capacity for the national response	Funded by DFID and USAID; implemented by Population Services International, ActionAid, and the Society for Family Health	Approximately US\$90 million; included in DFID and USAID commitments listed below
Nigeria AIDS Response Fund	Funds CSOs response to HIV/AIDS, with a special focus on gender	Funded by CIDA; implemented by Pathfinder International	Can\$4.8 million for 2004-2008
POLICY Project	Public sector policies in reproductive health and HIV/AIDS in Nigeria	Funded by USAID and implemented by the Futures Group's POLICY Project	US\$6.155 million for 2000-2004
AIDS Prevention Initiative in Nigeria (APIN)	Provides serosurveillance for HIV and other STIs, scales up prevention interventions among high-risk groups, conducts research, builds laboratory capacities, funds CSO interventions, catalyzes government policy responses	Funded by the Bill & Melinda Gates Foundation and implemented by the Harvard School of Public Health	US\$25 million for 2001-2005
DFID Nigeria HIV/AIDS/reproductive health programs	DFID commitment to HIV/AIDS over seven years, less investment in wider health sector	Multiple implementing organization for programs such as PSRHH, Strengthening Nigeria Response, and Partnership for the Transformation of Health Systems (PATHS)	£81.5 million (US\$123 million) for 2001-2008
USAID program	request for proposals were due in the last quarter of 2003	Implementing partners were selected after a bid process	More than US\$82 million for 2004-2009 (US\$99 million in related sectors, reproductive health, maternal and child health, and enabling environment)
Global Fund for AIDS, Tuberculosis and Malaria	PMTCT program; promotion of CSO participation in the HIV/AIDS response; the national antiretroviral program	National Action Committee on AIDS/Yakubu Gowon Centre	US\$28 million for 2004-2005

**Abbreviations:** CIDA: Canadian International Development Agency; CSO: civil society organization; DFID: Department for International Development; MARPs: most at risk people; PMTCT: prevention of mother-to-child transmission of HIV; STIs: sexually transmitted infections; USAID: United States Agency for International Development

peer education, the provision of services, advocacy work targeted at reducing police harassment, and the promotion of condom use in brothels.

The PSRHH project has also introduced a water-based lubricant in addition to other existing products such as condoms. The water-based lubricant is intended to prevent the frequent condom breakage that sex workers report experiencing when using petroleum-based lubricants.

#### *Youth*

Young people are the primary target group in HIV prevention. CSOs continue to implement various programs targeted to this group, ranging from school-based programs to out-of-school programs. Examples

include the pioneering work of the Association for Reproductive and Family Health in its expanded life-skills program and the youth-friendly centers of Action Health Incorporated.

Other notable youth CSOs include the Adolescent Health and Information Project in Kano, the Girls Power Initiative in Calabar, Life Vanguarders in Osogbo, and the Halt AIDS Group in Jos. Ford Foundation West Africa has supported many of these organizations using the youth development approach to tackle youth sexuality problems, gender issues, and livelihood issues. These programs have demonstrated how better livelihood support reduces the vulnerability of young women to HIV infection. UNICEF Nigeria has also funded a large number of in-school peer education programs.

In addition, CSOs have been instrumental in developing sexuality curricula for schools and contributing to the adolescent sexuality policy of Nigeria.

### Care and Support

The involvement of CSOs in home-based care is relatively new (3), with a number of CSOs operating on a small scale scattered across the country. Some of the initial CSO experiences were in Benue State under a DFID-supported project on sexually transmitted infections. PLWHA support groups also have flourished in the past five years with the active support of NEPWHAN.

As the HIV epidemic in Nigeria matures, the need for care and support will grow. Newer programs focus on care and support and include CSOs as program managers and implementers. Some CSOs—such as Mothers Welfare Group in Kaduna, Living Hope Care in Ilesha, and the Family Health and Population Action Committee in Ibadan—have successfully pioneered home-based care of PLWHAs and even sparked many support groups.

CSO involvement in facility care has been limited mostly to work in mission hospitals and clinics providing care to PLWHAs. Some of these institutions have facilities for voluntary counseling and testing and, for those taking antiretrovirals, monitoring capabilities for CD4+ counts and other laboratory tests excluding viral load. Some of these hospitals provide prevention of mother-to-child transmission of HIV services. Several NGOs—such as the Centre for the Right to Health, Treatment Literacy Action, and AIDS Alliance in Nigeria—are involved in treatment literacy and access to antiretroviral treatment programs.

## RECENT ACHIEVEMENTS AND ONGOING CHALLENGES

Since 2000 Nigeria has seen a flurry of activities in the HIV/AIDS sector with an increased level of engagement by the international development actors. The new era builds on best practices from around the world and has adopted a multisectoral, multidisciplinary approach. CSOs have been key beneficiaries of this new approach as their roles within the national response to HIV/AIDS have broadened and become more resourceful. In some way international NGOs have responded to this challenge with increased capacity and a more collaborative approach to bidding, designing, implementing, and evaluating their programs. While the international NGO presence in Nigeria has grown tremendously since 2001 to take

advantage of the increased in-country funding opportunities, not much can be said for local CSOs capacity building; although there are more funders, CSOs still lack the technical and institutional capacity for an effective response. This is evidenced by the inability of local CSOs to take a significant leadership role in any of the bigger programs that donors have put up for bidding. This section of the chapter critically reviews some of the achievements, lessons, and challenges CSOs have faced since 2000.

### Recent Achievements

CSOs have already made a number of strides in Nigeria's HIV/AIDS control efforts. Among their achievements are:

- **A more coordinated approach.** The emergence of CISCGHAN, NEPWHAN, and the Nigeria AIDS Research Network has led to some coordination in terms of the civil society contribution to the national response. This achievement has made representation in NACA and the United Nations' Expanded Theme Group on HIV/AIDS easy and systematic. With more than 400 local CSOs involved in HIV/AIDS programs in Nigeria, the coordination of their input into any national process is important. Such coordination is not the norm at the state level, however; with the exception of five states, CSO input into the SACAs still tends to be sporadic and unsystematic.
- **An increased capacity.** The increased engagement of CSOs in HIV/AIDS interventions has resulted in an increased capacity for fundraising and program work. The CSO capacity for influencing policy and networking has also increased tremendously. The use of bidding options by donor for contracting their implementing partners has resulted in international NGOs scaling up their in-country capacity for program implementation. The process has relegated local CSOs to the background, however, as they have become subgrantees to the larger international NGOs. Most of the programs have provisions for strengthening the institutional capacity of local CSOs to enable them to participate more actively in future bid process as equals.
- **A greater involvement in policy development.** The civil society mapping by ActionAid in 2001 showed that most CSOs were seen only as program implementers. The emergence of CISCGHAN and the development of the HEAP strategy provided the basis for the formal involvement of CSOs in influencing policy in Nigeria. The success in getting the needs of CSOs reflected in HEAP is one such achievement. CSOs have since continued their involvement in policy influencing, including such processes as adolescent sexuality policies and the Nigeria Economic Empowerment and Development Strategy (NEEDS).
- **Better collaboration and networking.** The CSO communities have become more collaborative in seeking funding and implementing programs. Information flow has improved, with the Nigeria e-forum acting as a medium of information flow. Networking has also flourished as other networks at state and zonal levels are emerging. One example is the Northern Coalition of PLWHA Support Groups. Program coordination is still weak, however, as CSOs continue to duplicate efforts, tread paths that others have walked, and relearn lessons already mastered.

- **A greater role in program implementation and research.** Most program interventions in Nigeria are being managed by international NGOs working with local counterparts. Some of the larger programs — such as PSRHH and the AIDS Prevention Initiative in Nigeria — have a national focus. Other CSO-managed programs include the Canadian International Development Agency-funded Nigeria AIDS Responsive Fund project, with Pathfinder International, UNICEF programs, and the POLICY Project of the Futures Group. Most HIV/AIDS research is coordinated in partnership with government and other actors such as the Society for Family Health. The Global Fund grant to CISCGHAN is a clear testimony of the growing role of the coalition in program implementation in the country.
- **A broadened participation beyond NGOs.** The range of organizations involved in HIV/AIDS work has also broadened to include faith-based organizations, community groups, and specialized media groups. The faith-based response at the grassroots level, in fact, kick-started the national response. An example is the Catholic Diocese of Makurdi, which initiated the first home-based care program and information, education, and communication materials development. In 2004, members of the Islamic and Christian communities came together to form the Interfaith Coalition on HIV/AIDS. Private sector initiatives for HIV/AIDS prevention and control include HIV/AIDS hot-lines supported by Coca-Cola and Vmobile Nigeria. MTN also has a Partnership Against AIDS in Communities program in six states. Cadbury, Unilever, and Nigerian Brewery are examples of private sector organizations that have instituted HIV/AIDS workplace policies.
- **Stronger partnerships with government agencies and the private sector.** Partnerships have deepened between CSOs and government agencies and between CSOs and the private sector. The government and private sector now recognize the competence of CSOs and value their contribution to the national response. For their part, CSOs now recognize the role of government in policy design and evaluation. In 2003 alone, these enhanced collaborations led to the development of such subsidiary strategies as the behavior change communication strategy of Nigeria, the monitoring and evaluation framework, and the rural access strategy.

### Ongoing Challenges

#### *Tapping the Power of Indigenous CSOs*

CSOs that are indigenous to a community have been shown to better than nonindigenous organizations at driving HIV/AIDS program interventions that achieve a genuine impact on that community. This notion is stated clearly in the Panos Institute report *Missing the Message*: “What works is when the energy, anger and mobilization of civil society have been at the forefront of the response to HIV and AIDS” (9). This publication attributes the success of the Uganda civil society sector primarily to the fact that its response was internally driven rather than built on external resources. Community-based organizations in Uganda had to adapt their normal functioning to the reality of AIDS when little external money was available. They were thus already fully politicized on the issue. When external funds arrived, the organizations were able to build on this energy, and success was quick in coming.

In Nigeria, external money has driven most of the HIV/AIDS response. For CSOs, the focus has been on program and project implementation, and most local CSOs have lacked a deep understanding of sexual and reproductive health and HIV/AIDS issues beyond that implementation. *Missing the Message* recognizes this gap and emphasizes the need “within civil society, to increase emphasis on advocacy” (9). Programming must focus on bridging the skills gaps, dealing with the inappropriate motivations of some CSO actors, and deepening the understanding of networking and collaborative programming.

#### *The Need to Build Institutional Capacity*

While the CSO capacity for implementing programs is generally good, most of those skills lie within the narrow confines of prevention efforts that focus on sensitization and information, education, and communication (10). Few CSOs have the skills and capacity to run a care and support program; indeed, few PLWHA support groups can fully define the parameters of positive living. Fewer still are working on treatment literacy and wider health sector reform issues. The capacity for policy analysis and influencing needs significant strengthening.

International NGOs that focus on the capacity building of local CSOs tend to focus on building technical capacity rather than institutional capacity. The result is that the institutional capacity of decades-old organizations lags behind that of their programs. This weak capacity translates to an inability to engage fully in policy development and a dependence on the government for assistance in being involved in this process. CSOs’ scope of input is thus already limited because reliance on government support compromises their independence. Donors should be willing, therefore, to support the holistic development of local CSOs, including their institutional capacity.

#### *The Challenges Inherent in Networks*

The evolution of CISCGHAN and NEPWHAN as institutions highlights the challenge of running structures that promote networking as distinct from a network NGO. This distinction is important, as network NGOs tend to compete in the same market as their members, a trend that eventually leads to conflicts of interest.

At inception CISCGHAN viewed its role primarily as articulating the CSO position on HIV/AIDS issues and strengthening members’ capacity through training by other members. Several years down the line, however, the coalition has found itself pressured to broker funds for members. Other members have become disenchanted by what they perceive as the coalition’s failure to meet members’ expectations, which were primarily for CISCGHAN to raise funds for its members. The understanding of members, most of whom joined the organization after its inception, thus differs from the initial ideal that led to the birth of the coalition. The Global Fund project remains a key test of whether CISCGHAN will survive where others have failed in combining networking with being a network NGO.

#### *A Diversity of Motivations*

The motivations of CSOs are as varied as the kinds of organizations the sector represents. Coalitions and networks such as CISCGHAN seek to increase resources for their members’ interventions, broaden

the CSO participation in the national response, and ensure the judicious use of available resources. NEPWHAN and a host of support groups work to enhance the quality of life for PLWHAs, increase access to public-sector antiretroviral programs, and ensure greater involvement of PLWHAs. The overriding interest of faith-based organizations is to ensure the non-pollution of their doctrine. They seek to reduce the “Westernizing influence” of secular NGOs while remaining committed to service delivery; they are also concerned about reducing that Westernizing influence on their own doctrine. Other CSOs’ greatest concerns are securing funds for their programs and gaining recognition in their communities

In response to such varied motivations, NACA must create a functional coordination framework that attempts to balance the different interests within the sector, and the different organizations need to reflect always on their comparative competence and work toward synergizing their programs.

#### *The Need for Documentation*

A lack of documentation tends to be a weakness of CSOs in Nigeria; they rarely capture programming lessons, experiences, or successes. The project mentality of donors has contributed to this state of affairs as most CSOs’ only recourse to documentation is writing up the donor report. The lack of such vital program information leads to reinvented wheels and a waste of scarce resources. Skills for documentation are weak, and the lack of an effective monitoring system further limits projects, as there is no framework to capture change.

#### *The Difficulty of Resource Mobilization*

CSOs have found it increasingly difficult to secure funds for their activities because the dwindling resources cannot meet their growing needs. Several other factors are exacerbating the situation: a colossal increase in the number of CSOs, a lack of government investment in CSOs, and the changing political agendas of the donors from which the CSOs derive much of their funding. These agenda changes have resulted in the shifting of resources from one thematic area to another.

#### *Learning to Navigate Donor Politics*

Donors have diverse motives for working in any country, and those motives determine their actions in that particular country. Their motives may encompass different developmental ideals, for example, which they may not necessarily impose but they may propagate as much as possible while serving as a vehicle for driving political interest.

In addition, most donors have favored groups that are aligned with their political interests. These groups benefit from the funding for as long as they help achieve the donors’ goals. Thematic priorities and geographic considerations play important roles in donor politics as donors often dispense most of their resources on a particular thematic or geographic region for reasons best known to them; unfortunately, this tendency deprives other resource-poor areas of assistance.

Perhaps the most obvious example of donor politics is the issue of adopting donor-driven programs to ensure funding for CSOs. This scenario allows donors to determine which programs are conducted

with their resources with little or no consideration paid to the communities’ needs; such a practice creates a sustainability predicament.

## CONCLUSION

The role that CSOs have played in Nigeria’s national response to the HIV/AIDS epidemic has enlarged significantly since 2000, with better results and enhanced capacity. The multisectoral approach adopted by the Nigerian government in its HIV/AIDS program has improved the operating space for CSOs’ intervention in the sector. Limited capacities and a weak collaboration especially among local CSOs have reduced their ability, however, to fully occupy the space that has been made available to them.

Specific recommendations include:

- **Decentralize the responses and roles of CSOs.** Seen as implementers, CSOs have broadened their roles to include participation in policy formulation, monitoring and evaluation, advocacy, and influencing, especially in the context of the multisectoral approach at the national level. This has not been true at the state level, however. International development partners therefore need to intermediate in this process as the response continues to devolve to the state level. Financial support to enable active CSOs participation in the policy process should be provided. This is important so that CSOs participation can occur without being compromised by government funding. This recommendation is needed especially in the implementation of HEAP’s successor, the National HIV/AIDS Strategic Framework.
- **Broaden CSOs beyond NGOs.** The CSO sector continues to be largely limited to more formal NGOs. The untapped potential and the less formal community structure of community-based groups must be leveraged in the scaling up of the national response. Their deeper link with the poor will ensure that the voice of poor people has a directly influence on policy formulation process rather than the existing scenario, in which NGOs act as intermediaries to the people. Broadening CSOs beyond NGOs will require donors to rethink their funding criteria and their engagement in direct capacity building of this local structure but the benefit in the long run will exert an impact beyond the HIV/AIDS sector on wider governance issues in Nigeria.
- **Build the capacity of CSOs.** To be able to progress, CSOs need capacity building. They need skill development in such areas as program design beyond prevention, policy research and advocacy, and TRIPS issues and medicines. International development partners and NACA must prioritize the capacity building of CSOs in a structured way. SACAs, because of their proximity to CSOs in their states, are in a better position to build the capacity of CSOs but they need support from NACA. The larger programs should develop models that the smaller CSOs can adapt for effective nationwide scale-up.
- **Introduce participatory approaches.** A high level of skill in participatory — or “bottom-up” — approaches is one area that makes CSOs distinctive and enables them to work on complex cultural issues on a context-by-context basis. In Nigeria, though, most CSOs lack skills in participatory

program design and implementation. Most intervention continues to be didactic and does not reflect the principles of adult learning. The capacity of CSOs must be built for incorporating participatory approaches in their work and exploring options to domesticate participatory methodologies, just as Reflect and Stepping Stones—first developed in Uganda in 1995—incorporate participatory approaches to HIV, sexual health, and gender.

- **Support CSO networking and collaborations.** Collaborations can deepen the skills of CSOs while ensuring optimal program delivery. State and local governments need to support the networking of CSOs. Some donors have already set good examples by compelling CSOs to form consortia to bid for their funding (3); implementing international NGOs need to adopt this same strategy in funding local CSOs.

CSOs have a unique role to play in helping to stem the HIV epidemic in Nigeria and to provide care for those affected by AIDS. With the capacity-building support of governmental agencies and international donors, CSOs can play an even broader and more effective role.

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