

**An analysis of the sustainability of the United States  
Government (USG) aid-funded non-governmental  
organisations (NGOS) in the Namibian health sector**

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Research assignment presented in partial fulfilment  
of the requirements for the degree of  
Master of Philosophy in Development Finance  
at Stellenbosch University

The crest of Stellenbosch University is centered behind the text. It features a shield with various symbols, including a book and a scale, topped with a crown and a banner. The Latin motto 'Pictura rotundant cultus recti' is inscribed on a scroll at the bottom of the crest.

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H.N. Aipinge

December 2015

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## Acknowledgements

Firstly, I would like to thank the Almighty God for giving me the strength to keep on pushing until I eventually reached success!

Secondly, I would like to express my sincere gratitude to the following people for their continuous support during my M.Phil. in Development Finance studies and the related research assignment:

- To my greatest supervisor and advisor for the research assignment, Ms. Teresa Kaulihowa, your guidance and motivation helped me immensely. I am indebted to you for your continuous support in writing this research assignment. I sincerely thank you for having been there when I needed technical advice and direction.
- Professor Sylvanus Ikhida (USB), I would probably not have made it through this study journey without your constant words of encouragements, your support, inspiration and wisdom, and your passion for Development Finance. Thanks for your enormous contribution toward this success story in my life.
- Mr. Peter Opperman (USB), finding a suitable research topic can be very challenging, especially to newcomers in the world of research. Thank you for helping me to adjust and fine-tune my research topic, as well as for your valuable help and comments throughout my study.
- Wholehearted and special thanks to Mr. David Jarret. Thank you for your invaluable support and having been my tutor and mentor in the technical subjects of this programme.
- To all the individuals from the various NGOs who took part in the survey. Thanks for taking the time to complete the questionnaire and for participating in the interviews.
- To my beautiful daughter, Joanna, and her daddy, Emanuele Augello, thank you so much to both of you for your patience, support and encouragement during the course of my studies. I have taken so much of your precious time. I love you, and I will make it up to you!
- To my siblings and cousins, you have all contributed greatly towards my dream. Thanks for your support and for watching over Joanna while I was busy. My parents and my grandmother, you have been the best parents ever, thanks for the great upbringing. I wish grandfather was here to share this wonderful achievement with me. I dedicate this work to you!

- Finally, yet most importantly, to my employer, USAID/Namibia, my colleagues, friends, and fellow classmates, thanks for your contribution, encouragement and your prayers. You have been great and supportive throughout my studies. Remain blessed.

## **Abstract**

This study researched the sustainability of USG aid-funded local NGOs in the Namibian health sector. The first objective of the study was to analyse the continuity of NGO operations and the likely consequences of reduced PEPFAR funding on the key programmatic areas of NGOs such as the HIV/AIDS prevention, care and support services. The second objective was to investigate the other sources of funding that may be available to ensure sustainability of the NGOs.

The study largely employed a qualitative approach and a descriptive analysis technique was used. A comparative case study assessment of seven NGOs that had received USAID/PEPFAR funding at any point during the period 2007-2013 was provided. The NGOs included Catholic AIDS Action, Church Alliance for Orphans, Katutura Youth Enterprise Centre, Nawa Life Trust, Project HOPE, Society for Family Health and Lilfe/Line Child/Line.

The research findings were analysed and used to develop a set of conclusions and recommendations that could help to improve funding, ensure continuity of NGOs and sustain the health gains achieved over the years. The study found that on average PEPFAR constituted 80 per cent of the NGOs' revenue and that due to the reduction in funding as well as the shift in PEPFAR's focus to HIV treatment as prevention, the health gains achieved over the years could potentially be reversed if this behaviour did not change.

The research suggested, amongst others, that the long-term sustainability of the programmes and the continuity of NGOs is dependent upon support from local governments. Literature has shown that local governments elsewhere have acknowledged the role that NGOs play and, therefore, created systems to allocate funding to NGOs, which practices can be extended to the Namibian situation. The recommendations further encouraged NGOs to embark on self-financing strategies by appointing dedicated personnel with the capacity to focus on fundraising activities with a target of achieving 50 per cent of income self-generated.

### **Key words**

Non-governmental organisations, community-based organisations, faith-based organisations, civil society organisations, civic organisations, foreign aid, international aid, donor funding, official development assistance, organisational and financial sustainability

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## List of acronyms and abbreviations

ANC	Antenatal clinic
ATSE	Artisan training for self-employment
ART	Antiretroviral therapy
AU	African Union
BON	Bank of Namibia
CAA	Catholic Aids Action
CAF	Community action forums
CAFO	Church Alliance for Orphans
CBO	Community-based organisations
CCN	Council of Churches in Namibia
CHBC	Community home-based care
CHW	Community health workers
CO	Civic organisations
CSO	Civil society organisations
CRAIDS	Community response to HIV/AIDS
DAC	Development Assistance Committee
ECD	Early childhood development
EDT	Electronic dispensing tool
EU	European Union
FBOs	Faith-based organisations
FHI	Family Health International
GDP	Gross Domestic Product
GHI	Global Health Initiative
GRN	Government of the Republic of Namibia
HDI	Human Development Index
HCW	Health care workers
HDR	Human Development Report

HIV/AIDS	Human immunodeficiency virus/Acquired immune deficiency syndrome
HOPE	Health Opportunities for People Everywhere
HRH	Human Resources for Health
IPs	Implementing partners
KAYEC	Katutura Youth Enterprise Centre
KPs	Key populations
LL/LC	LifeLine/ChildLine
MAP	Multi-Country AIDS Programme in Africa
MAPP	Military Action Prevention Programme
MDGs	Millennium Development Goals
MoF	Ministry of Defence
MoHSS	Ministry of Health and Social Services
MTPIII	Medium-term Plan III
MSM	Men who have sex with men
NANGOF	Namibia Non-Governmental Organisations Forum Trust
NARP	Namibia Adherence and Retention Programme
NASA	National AIDS spending assessment
NDA	National Development Agency
NDF	Namibia Defence Force
NDP	National Development Plan
NDGOs	Non-governmental development organisations
NGO	Non-governmental organisation
NPC	National Planning Commission
NIP	Namibia Institute of Pathology
NLT	NawaLife Trust
NHA	National Health Account
NHIES	Namibia household income and expenditure surveys
NPI	New Partners Initiative

NSA	Namibia Statistics Agency
ODA	Official development assistance
OECD	Organisation for Economic Co-Operation and Development
OVC	Orphans and vulnerable children
PAN	Prevention Alliance Project
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary health care
PMTCT	Prevention of mother-to child transmission
PSEMAS	Public Service Employees Medical Aid Scheme
PSI	Population Services International
PV	Positive vibes
SACU	Southern African Customs Union
SADC	Southern African Development Community
SBCC	Social behaviour change communications
SFH	Society for Family Health
SHOPS	Strengthening health outcomes through the private sector
SSA	Sub-Saharan Africa
SW	Sex workers
TB	Tuberculosis
THE	Total health expenditure
TIP	Therapeutics information and pharmacovigilance
USG	United States Government
UN	United Nations
UNAM	University of Namibia
UNICEF	United Nations International Children's Emergency Fund
WASH	Water, sanitation and hygiene
YEI	Youth Employment Inventory

# CHAPTER 1

## INTRODUCTION

### 1.1 INTRODUCTION

Prior to independence, there were very few opportunities in Namibia for civic organisations (COs) to become involved. Various COs, including trade unions, churches, women's organisations, student movements and organisations for human rights, prevailed to mainly provide social protection and support in the country, whilst being highly critical of the colonial regime (National Planning Commission (NPC), 2005). The objectives of most civil society organisations (CSOs) were bound up in the aim of the liberation struggle (European Union (EU), 2008). Upon gaining independence in 1990, Namibia's democratically elected government acknowledged the importance of CSOs, including non-governmental organisations (NGOs), in the reconstruction and development of the country. Subsequently, Namibia saw a swift growth in the number and size of NGOs and other COs (NPC, 2005:2).

Generally, NGOs have commonly relied on funding from donor agencies, multilateral lenders, charitable institutions, as well as government ministries for conducting their operations and carrying out programme activities (Viravaidya, 2001). Although the civil society sector in Namibia emerged inexperienced and fragmented, the situation improved rapidly within the first few years after independence. Due to the democratic principles and practices that the government established, Namibia became a favourite of international donor agencies that were eager to extend support to the fast evolving civil society sector, which then assumed policy lead roles and became increasingly available for partnership in development (NPC, 2015), especially in the health sector.

Since independence in 1990, the Namibian health sector benefited from foreign aid to address various challenges such as the fight against HIV/Aids, tuberculosis and malaria. Although Namibia as a country is not an aid-dependent economy as official development assistance (ODA) inflows to Namibia were recorded at less than five per cent of GDP over the past years, the health sector, however, has over the years relied heavily on donor funding (Ellmers, 2010), which is mainly channelled through NGOs. According to the World Health Organisation (WHO) (2010:14), "Health is the highest priority area of support from donors, accounting for 79 per cent of all donor disbursement to Namibia". Donor agencies as well as numerous NGOs have worked together with the Namibian government to deliver HIV/Aids services, including prevention and treatment, across the country (Strengthening Health Outcomes through Private Sector (SHOPS), 2013).

According to Ellmers (2010), Namibia started receiving less and less ODA due to its status at the time as a lower-middle income country. Several bilateral donors such as the UK, Sweden, the Netherlands and Finland even closed their country offices and phased out their projects and programmes. The United States of America (USA) is one of the main Development Assistance

Committee (DAC) donors that is still active in the Namibian health sector, due to its enormous contributions of the US President's Emergency Plan for Aids Relief (PEPFAR) (WHO, 2010). A number of local NGOs that are involved in the delivery of the HIV/Aids treatment and prevention services and other health services have benefited greatly from PEPFAR funds. However, with the status shift to an upper middle-income country (NPC, 2012), a further sharp reduction in foreign aid for the country's developmental programmes, including health services, has been noted (SHOPS, 2013). Without proper planning, the reduction in ODA to the health sector can result in negative implications to both the sector itself and the continuity of NGOs.

The aim of this study, therefore, was to analyse the sustainability of the United States Government (USG) aid-funded NGOs in the Namibian health sector, with the intention to explore improved strategies to ensure continuity of NGOs and sustainability of the health gains achieved by the sector over the years.

## **1.2 STATEMENT OF RESEARCH PROBLEM**

As in other parts of the world, to date, civil society in Namibia is seen as a diverse sector with a wide range of individuals, communities and organisations that plays a crucial role in the development of Namibia's democracy (NANGOF, 2013). NGOs, community-based organisations (CBOs) and other COs in Namibia have performed remarkably in implementing development programmes and projects in different sectors at local, regional, national and international level (NPC, 2005). Under PEPFAR, the US government in collaboration with the Ministry of Health and Social Services (MoHSS) and through various non-governmental organisations (NGOs) have assisted in providing Namibia with a broad range of HIV/Aids prevention, care and support and treatment programmes that include support for Highly Active Antiretroviral Therapy (HAART) (USAID, 2013). SHOPS (2013) highlighted that Namibia's national HIV response was in scale-up mode between 2004 to 2009 due to an increase in donor funding that led to a slowdown in the spread of the HIV epidemic. Coverage on ART in Namibia was estimated at 87 per cent (CD4<350), while the coverage on prevention of Mother-to-Child Transmission (PMTCT) is estimated at over 90 per cent (MoHSS, 2012). It is worth noting that through PEPFAR and other external donors, Namibia has overcome some of the health system's constraints of financing and service delivery (SHOPS, 2012).

In spite of the progress made by both the government and the private sector, including civil society and the donor community, daunting challenges continue to persist in the Republic of Namibia, and the HIV/Aids pandemic has remained one of the most significant developmental challenges. The pandemic has been a major drain on the country's national and international resources for health. According to the 2012 Antenatal Clinic (ANC) survey, the HIV prevalence was estimated to have declined at 18.2 per cent from 22 per cent in 2002 (MoHSS, 2012). Another major contributor to



HIV-related mortality is tuberculosis (TB), with 556 cases estimated per 100,000 persons, of which 50 per cent is said to be co-infected with HIV (MOHSS, 2012). In 2008/09, the Government of the Republic of Namibia's (GRN) spending on the HIV/Aids response was around 27.5 per cent (Global Health Initiative (GHI), 2011) of the total national health spending. In addition, the investment of the US government in HIV/Aids prevention, care and treatment programmes makes up close to half of the total spending on HIV/Aids in Namibia. In other words, the Namibian government's spending on HIV/Aids constitutes 50 per cent, while USG/PEPFAR contributes 30 per cent, and the remaining 20 per cent comes from the Global fund (GHI, 2011), which also receives a significant contribution from the USG. SHOPS (2013), pointed out that Namibian government documents underlined the reliance of the country on external resources for the delivery of ART. SHOPS further stated that most NGOs and faith-based organisations (FBOs) that have invested in HIV/Aids prevention and treatment depend wholly on foreign aid.

Due to the re-classification of Namibia as an upper middle-income country with a per capita income in excess of \$5,200 (European Union (EU), 2015), external donor funding, including US government aid to Namibia is declining. For example, the budget for health care positions funded by the USG was reduced by five per cent (GHI, 2011) in 2011, and the reduction is expected to continue through to 2016 over the course of the Partnership Framework Implementation Plan (PFIP). The reduction will not only affect the HIV/Aids response programmes in the country, but will also have negative implications on the general sustainability of local NGOs in maintaining the health gains achieved over the past years, as well as employment created in executing the HIV/Aids treatment and care services. A reduction in external donor funding can have several implications for the Namibia developmental agenda. To ensure adequate adjusting mechanisms, a study that evaluates the sustainability of USG aid-funded NGO's in Namibia's health sector is, therefore, imperative.

### **1.3 RESEARCH QUESTIONS**

The research questions that underscore this study are:

1. Will reduced PEPFAR funding lead to: (i) Less focus on key programmatic areas of NGOs such as the HIV/Aids treatment and prevention services; (ii) retrenchment of personnel and capacities deteriorating; and (iii) NGOs leaving the health sector and opting for other areas of work where it is easier to obtain funding?
2. What alternative sources of funding might exist to address the financing gap, and what is the ratio of PEPFAR funding as compared to other donors?

### **1.4 RESEARCH OBJECTIVES**

The main objectives of this study are:

1. To investigate the likely consequences of reduced PEPFAR funding on: (i) The focus on key programmatic areas of NGOs such as the HIV/Aids treatment and prevention services; (ii) retrenchment of personnel and capacities deteriorating; and (iii) NGOs leaving the health sector and opting for other areas of work where it is easier to obtain funding.
2. To evaluate other sources of funding that may be available and examine the ratio of PEPFAR funding as compared to other donors.

### **1.5 CONCEPTUAL CLARIFICATION**

It is vital for this study that the term sustainability is well defined and understood upfront from the perspective of donor-funded NGOs. According to Aldaba, Antezana, Valderrama and Fowler (2000:676), the term organisational sustainability was defined by various studies as “the capacity of NGOs to consolidate and to increase their interaction with society to fulfil their mission”. Aldaba *et al.* (2000: 676) further stated that sustainability was an essential process that went beyond financial realm to consider a range of other factors that included, amongst others, resource mobilization. Consequently, Brundage (2011:2) defined NGO sustainability “as the ability of the organisation to continue doing its social mission into the future”. Pathfinder International (1994) expanded the definition to health care services and explained sustainability as a broader range of funding and increased ability to deliver crucial services to the targeted population. The author highlighted two types of sustainability: financial and organisational. The former refers to the organisation’s net income, liquidity and solvency, while the latter entails the organisation’s ability to manage sufficiently and secure its resources in order to enable it to carry out its mission effectively and consistently over time. In this paper, sustainability refers to the ability of the USG aid-funded NGOs in the Namibian health sector to: Maintain at a certain level their programme activities, maintain their priorities and objectives, continue to carry out their social mandates into the future, and retain staff of calibre.

### **1.6 SIGNIFICANCE/JUSTIFICATION OF THE STUDY**

The study was conducted at a crucial time when several donor agencies were either withdrawing or reducing their aid to Namibia due to the country’s reclassification as an upper middle-income country (UMIC). Namibia’s NGOs, including those providing critical HIV/Aids services are faced with a sharp decline in donor funding. The reduction may prompt NGOs to look for alternative source of funding to sustain the health gains achieved over the past years and to ensure continuity of NGO operations. It is also an important period as the GRN together with its development partners, including the USG, is embarking on significant reforms to ensure an effective transitioning approach that will increase government and civil society’s (including the for profit sector) capacity to coordinate, manage and finance the health sector (GHI, 2011). It is a period when PEPFAR Namibia is moving away from a regional targeted assistance to a site-based approach. PEPFAR’s

new focus is on treatment as prevention and the target is on seven out of 14 regions in the country with the highest HIV rates representing 80 per cent of people living with HIV in the entire country. Furthermore, the study is significant in that it will give an insight into already existing efforts by the GRN, donor agencies and NGOs in developing policies and strategies to maintain the health gains achieved over the past decade.

Botswana and South Africa have best practises that can be used experimentally in Namibia. In Botswana, a public-private partnership agreement exists between the government and a private medical aid scheme that saw a rise in the provision of ART in the private sector. In South Africa, the government reached contractual agreements with private health providers to deliver ART and HIV services (SHOPS, 2013). Most importantly, the study explored and will share the findings about the way in which USG/PEPFAR-funded NGOs plan to maintain their programmes. It further identifies the challenges and opportunities of ensuring continual delivery of essential health services such HIV/Aids and to retain staff, and also reflects on other alternative sources of funding that may be available.

The study also indicates the extent to which the Namibian economy is dependent on foreign aid for the provision of health services. Namibia can learn from other sub-Saharan African (SSA) countries such as Ghana that has cut donor funding in health significantly to 22 per cent as of 2013 from close to 60 per cent in the early 1990s (Ghana Global Health Initiative Strategy, 2012-2017). This leads to the belief that being heavily reliant on foreign aid is something that can be prevented or minimised. There has been very few publications on the sustainability of NGOs in Namibia, but outcomes on the way in which donor-funded NGOs plan to ensure continuity when foreign aid phases out seem to be sketchy and inconclusive. This study reached out to NGOs that are recipients of USG/PEPFAR funds and documented their concerns, plans and strategies on the way in which they intend to survive after PEPFAR. The MoHSS is committed to its mission of driving health services in the country and is working restlessly to attain the levels of health and of social well-being of all Namibian citizens that will allow them to contribute both socially and economically to the country's development goals (2008b).

Finally, yet importantly, from an academic research point of view, the study will serve a yardstick or reference to other researchers and policy makers and donors to compare their findings in future.

## **1.7 THE REPORT STRUCTURE**

The report comprises of six chapters:

- Chapter 1 – Introduction of the Study: In this chapter, the researcher gives the background of the topic; research problem, research questions and objectives; justification of the study and scope of the study. Furthermore, this chapter gives the structure of the rest of the research assignment.

- Chapter 2 – Background/Context of the study: In this chapter the background of Namibia, an overview of the Namibian health sector including the role of NGOs, sources of financing in the health sector and an overview of the selected NGOs are outlined.
- Chapter 3 – Literature review: The theoretical framework and empirical studies surrounding the sustainability of NGOs are discussed in this chapter to contrast and compare views of other authors in the area, as well as to identify methods of study used that may be relevant to this research.
- Chapter 4 – Research methodology: This chapter focuses on the research methods applied to the study and the reasons for choosing such methods.
- Chapter 5 – Interpretation of the results: This chapter provides answers to the research questions and interprets them in a language that readers are able to understand.
- Chapter 6 – Conclusion and recommendation: After having explored the international experience on the sustainability of NGOs and based on the research findings, this chapter makes recommendations that are suitable to the Namibian situation. The chapter concludes the paper.

## **1.8 SCOPE OF THE STUDY**

The study is limited to Namibian local NGOs, specifically in the health sector. Furthermore, the focus is on NGOs that have received USG PEPFAR funds sometime during the period 2007-2013 through the United States Agency for International Development (USAID). Although an international organisation, Project Hope is considered in this study under its local project known as Namibia Adherence and Retention Programme (NARP) that receives direct funding from USAID Namibia. Besides investment in the health sector, the US government's aid to Namibia has also supported other programmes such as democracy, human rights and governance, economic empowerment as well as disaster and climate change (USAID, 2013). Due to time constraints and the fact that the USAID's current focus is mainly on health, this study only focused on NGOs that played a role in the health sector in the fight against HIV/Aids, TB and other communicable diseases.

Although any other African country could easily have been chosen for this study, the researcher is a Namibian citizen and study was conducted in Namibia due to the researcher's knowledge of the economic set-up and context of the country. Moreover, Namibia was considered an ideal country for this study as it is reported to have the sixth-highest adult HIV prevalence rate in the world (SHOPS, 2013), and has been a recipient of foreign aid for the past 25 years since the country's independence in 1990. In addition, the country continues to experience a reduction in donor funding and various donors have already withdrawn their support. It is against this background that the researcher believes that the above justifies the scope of the study and expedites the accomplishment of the study timeously, appropriately and meticulously.

## **CHAPTER 2**

### **BACKGROUND/CONTEXT OF THE STUDY**

#### **2.1 INTRODUCTION**

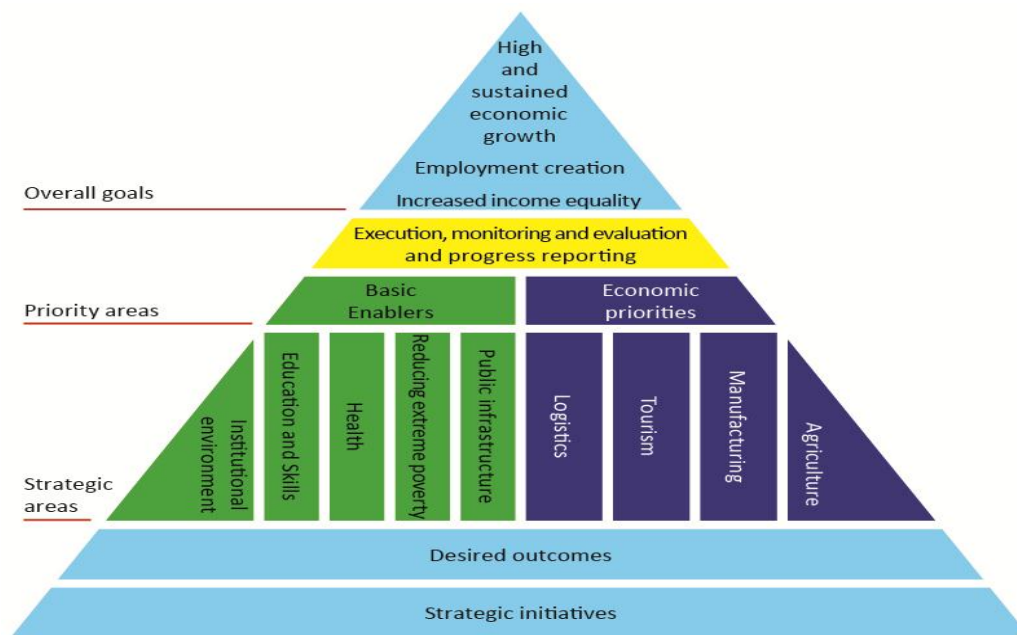
The study focuses on the sustainability of the USG aid-funded NGOs in the Namibian health sector involved in the provision of the HIV/Aids prevention, treatment and care. Hence, it is important to give: 1) A brief background of Namibia, including geographical location, history and economic development; 2) An overview of the health sector including the role of NGOs as well sources of financing for both the health sector as a whole and HIV/Aids response; 3) The history and overview of the USG/AIDS programmes in Namibia; and 4) A brief overview of the USAID/PEPFAR local funded NGOs considered for the case studies in this research.

#### **2.2 ABOUT NAMIBIA AND THE MACRO-ECONOMIC VIEW AND DEVELOPMENT**

Namibia is a vast country that covers an area of 824 000 square kilometres with a population of 2.2 million (Namibia Statistics Agency (NSA), 2012). The country is located in Southern Africa bordering Angola and Zambia to the north, Botswana to the east, South Africa to the south and east, while the western border is the Atlantic Ocean. Namibia is a dry country with generally low and highly variable annual rainfall that varies from less than 20mm along the coast to more than 600mm in the northeast (NPC, 2004), and the climate is mainly arid and semi-arid (WHO, 2010:3).

After almost a century of colonial rule by Germany and then South Africa, Namibia gained independence on 21 March 1990. Namibia has a multi-party system with general elections being held every five years, and is a member state of the United Nations (UN), the Commonwealth of Nations, the African Union (AU) and the Southern African Development Community (SADC) (MoHSS, 2014). Administratively, the country has 14 regions that are further subdivided into 121 constituencies. The Khomas region where Windhoek, the capital city of Namibia is located, has the largest number of the population, namely 342,141 inhabitants, according to the country's 2011 census. The smallest population of 71, 233 inhabitants is found in Omaheke region. At independence in 1990, Namibia inherited a dual economy from the South Africa's administration with formal and informal subsectors. The dualism in the economy of Namibia mainly features in the agriculture sector, but cuts across all sectors. The formal subsector is relatively small and modern comprising of reasonably high income. On the other hand, the informal subsector is largely based on traditional subsistence patterns of production (Bank of Namibia (BON), 2002). The inherited dualism in the economy is carried along four interrelated challenges of a high rate of poverty, low economic growth, inequitable distribution of wealth and income, and a high rate of unemployment (NPC, 2012a). To date, the economy of Namibia still relies heavily on natural resources from the primary industries, i.e. mining, agriculture and fisheries, which are extracted mainly for export

markets. Nevertheless, the primary sector, more especially agriculture, continues to be an important source of livelihood by supporting more than half of the population. Agriculture is known as one of the 'backbones' of the Namibian economy partly because many Namibians, whether rich, poor, black, white, urban or rural, still have a deep-seated attachment to the land and an ambition to farm (Sherbourne, 2009). In addition, agriculture is a priority sector under the fourth National Development Plan (NDP4), and continues to generate a substantial number of jobs. Furthermore, the Namibian economy remains integrated with the economy of South Africa, and in order to meet domestic demand for goods and services, the bulk of Namibia's imports originates there (NPC, 2012b). Upon gaining power in 1990, the Namibian democratically elected government has since been formulating policies geared toward addressing these challenges. The current fourth National Development Plan as per its structure shown in Figure 2.1 below, highlights the development objectives and priority programmes of the country to be implemented during the fiscal period 2012/13-2016/17 (NPC,2012a), all aimed at achieving the country's Vision 2030.



**Figure 2.1: Namibia fourth National Development Plan (NDP 4)**

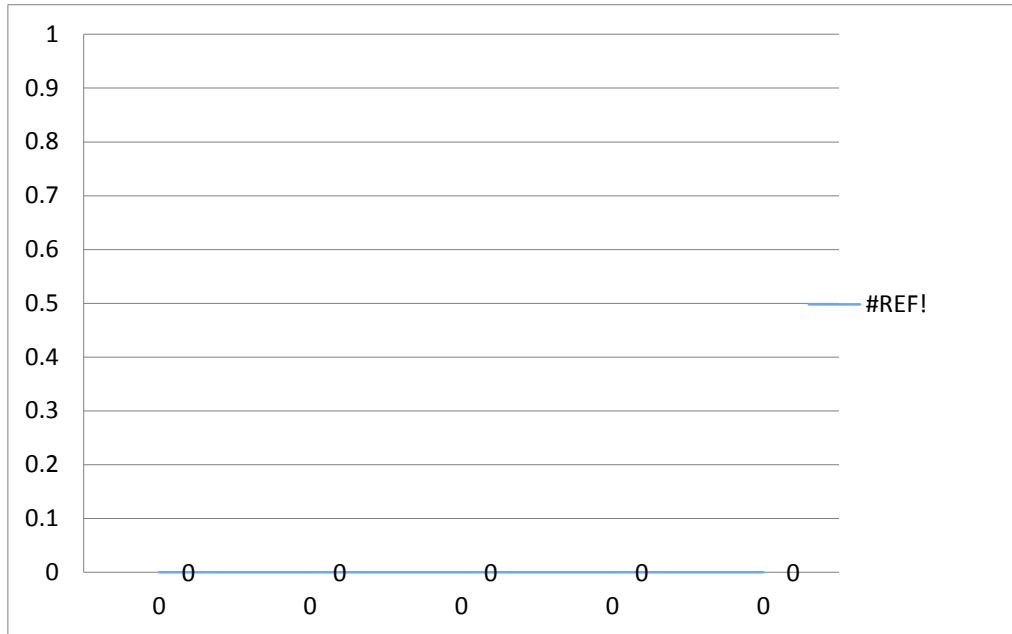
Source: NPC, 2012a.

Developed in 2004, Namibia's Vision for 2030 represents the government's long-term planning framework and is based on the notion of total balanced development. Vision 2030 envisions the country as "a prosperous and industrialised nation, developed by her human resources, enjoying peace, harmony and political stability" (NPC, 2004:38).

Namibia's economy is widely seen as well managed and the country has enjoyed peace, stability, and democracy since independence (World Bank, 2012). Namibia has been successful in creating critical institutional areas, which are relevant for sustained economic growth (BON, 2002). The

Namibian government has *inter alia* taken a conservative approach to fiscal policy that led to its debt receiving an investment-grade rating from Fitch and Moodys (NPC, 2012a and World Bank, 2012). Throughout the past decade, inflation has commonly stayed within the range of 3.0 to 7.0 per cent. Policies and regulations that have been formulated are generally favourable to private sector investment. From 1990, the Gross Domestic Product (GDP) has grown at an average annual rate of 4.2 per cent and later in 2000 moved to 5.7 per cent per year (World Bank, 2012). Figure 2.2 below gives a projection of the country's economic growth over the NDP4 period.

In 2009, the GDP increased at a higher rate than the population did, which resulted in Namibia being reclassified as an upper middle-income country with an estimated GDP per capita of US\$ 5,293 (NPC, 2012b). Although relatively high, Namibia's income status exhibits extreme inequalities in income distribution, quality of life and standard of living. Namibia is among the most unequal countries in the world with a Gini-Coefficient of 0.597. The Human Development Index (HDI) ranked Namibia as 128<sup>th</sup> out of 186 countries with an HDI of 0.608 ((NPC, 2012b). It was estimated that half of Namibia's population lives below the poverty line (WHO, 2010). Besides income inequality, other social economic challenges that still persists and continue to hinder the country's development include a high level of unemployment and HIV/Aids. According to NSA (2015), unemployment in Namibia currently stands at 28.1 per cent, but the rate of unemployment among youth aged 15 to 34 was recorded at 39.2 per cent. The goal of the Namibian government with regard to unemployment is to reduce the unemployment rate to below five per cent by the year 2030 (Vision 2030), and, therefore, the government is currently working tirelessly on developing different strategies to address unemployment as per the NDP4 manifesto. With regard to HIV/Aids, the rate of new infection cases was reported to have declined. However, the HIV/Aids death rate have increased lately resulting in a high number of orphans and vulnerable children (OVC) left in the hands of government for social grant support. Since independence, Namibia has received enormous support from international development partners in the fight against HIV/Aids and other challenges facing the country.



**Figure 2.2: Projected economic growth over the fourth NDP period**

Source: NPC, 2012a.

## 2.3 HEALTH SECTOR

### 2.3.1 Profile, overview and state of HIV/Aids in Namibia

At independence, Namibia's health system was very fragmented, "based on racial segregation and a concentration of infrastructure in urban areas such as Windhoek" (Brockmeyer, 2012: 1). Since gaining independence in 1990, several transformations have occurred. Amongst others, Namibia adopted primary health care (PHC) as an all-encompassing strategy to address the fragmented services inherited from the apartheid era. In March 2008, the MoHSS issued a national policy on community-based health care that followed a national assessment of community volunteers and community-based health care programmes as well as a national conference on volunteers held in December 2006 (MoHSS, 2008). Since independence, Namibia has developed 46 hospitals, 49 health centres and around 350 health clinics as well as other health care service locations across the 14 regions of the country (USAID, 2013). The country has further established 1 150 outreach points (Brockmeyer, 2012: 2). Government's funding for health has also increased since 2001 after the country signed the Abuja declaration, where it committed to allocate 15 per cent of the total national spending to health (USAID, 2013). Namibia has a good network of diagnostic laboratories that provides laboratory services to both the private and public health care facilities under the Namibia Institute of Pathology (NIP), and the country's private health sector has seen its share of growth (GHI, 2011). The main challenges in the health sector include HIV/Aids, tuberculosis and malaria as well as a high mother and child mortality rate (Brockmeyer, 2012). The first case of HIV was first reported in Namibia in 1986 (O'Hanlon, Feeley, De Beer, Sulzbach & Vincent, 2010).



Prevention and treatment for HIV/Aids has been the largest burden for the Namibian health care as HIV/Aids has been the leading cause of death since 1996 (Brockmeyer, 2012). Similarly, SHOPS (2013) stated that HIV/Aids remained a major source of illness and mortality in Namibia and was a major expense on the country's health resources. Although Namibia has made significant progress in the implementation of PHC, the provision of health services did not extend beyond the clinics, especially in sparsely populated areas (MoHSS, 2008c). Hence, the MoHSS in their review on national health and social services recommended that health services should be extended into communities in a structured way through the establishment of health extension services and the recruitment of paid community health workers. Subsequently, the MoHSS developed training packages to train health workers on the community home-based care (CHBC) approach. The trainees included facilitators and trainers of trainers intended to train community health workers (CHW). About 5-000 community-based health care providers were trained to provide community health services such as hygiene, home-based care and prevention and treatment of diarrhoea. A bigger part of community-based health care is to provide home-based care, which is an essential element of the continuum of care for persons living with HIV/Aids and other illnesses (MoHSS, 2008c).

### **2.3.2 Organisation of the health system and challenges**

The Namibian health system consists of two pillars, public and private (Brockmeyer, 2012). The structure of the Namibian public health sector consists of a three-tier hierarchy with central, regional and district levels. The central level has delegated authority to 13 regional directorates and 34 districts (WHO, 2010). Under the MoHSS the government of Namibia provides public services to approximately 85 per cent of the population, while the private sector deals with private health services provided through medical aid funds (Brockmeyer, 2012). The private sector charges exorbitant fees that the majority of the population cannot afford, hence more reliance on the public services that come with a reasonable flat fee of around N\$10.00 (depending on the level of the facility) per visit and free of charge for senior citizens. A national health insurance scheme does not exist in Namibia.

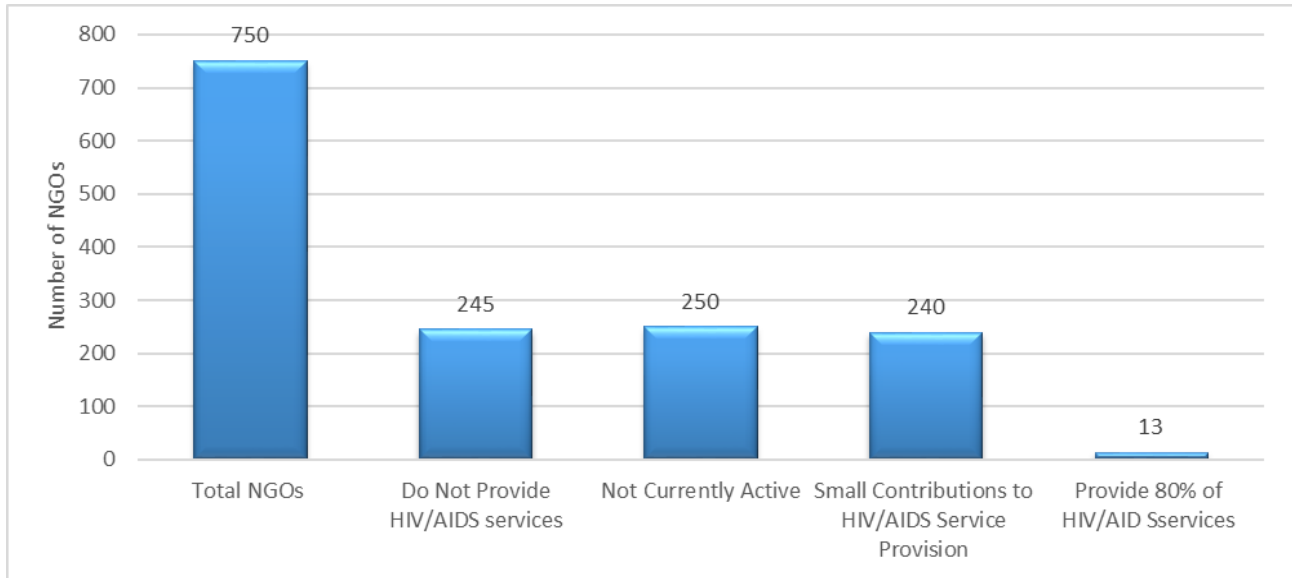
Although easily accessible and affordable, the public health service faces a number of challenges. Brockmeyer (2012) highlighted that the public health sector was faced with staff shortages. In 2003, it was reported that there was an average of 947 patients per registered nurse and more than 7 000 patients per registered doctor. Correspondingly, the United Nations Partnerships Framework (UNPAF) (2014) reported that in 2008, the public sector had a ratio of 2.0 health workers per 1 000 patients, a number that was very far below the WHO benchmark of 2.5. On the contrary, the private sector shows a ratio of 8.8 health workers per 1 000 patients. Brockmeyer (2012) further found that the number of deaths among mothers was high in public health facilities, reported to be at 80 in 2010 and 62 in 2011 respectively. UNPAF (2014) underlined poor

infrastructure, lack of health equipment and the vastness of the country to be the main predicaments that the public health sector faced in ensuring effective and efficient delivery of services around all corners of the country.

The Hospital and Health Facilities Act, No. 36 of 1994 regulates the private health sector. The facilities of the private health sector supplement the services of the public sector and both are permitted to provide health services to all patients. The number of private health facilities that were either registered with or licensed by the MoHSS in 2008 was 844, which included 75 primary care clinics, 13 hospitals, eight health centres and 75 pharmacies. Furthermore, 557 medical practitioners, which included psychologists, dentists and physiotherapists, existed in the private health sector (WHO, 2010:5). In total, ten different medical aid funds exist in Namibia. This includes the Public Service Employees Medical Aid Scheme (PSEMAS) managed by the Ministry of Finance (MoF). As compared to other countries in Africa, the Namibian private health sector is well organised and due to the colonial history, the health insurance industry is comparable to that of South Africa (Brockmeyer, 2012).

### **2.3.3 Role of NGOs in the health sector**

Other entities found in the health private sector are the not-for-profit organisations that include faith-based organisations (FBOs), NGOs and CBOs that are involved in the delivery of HIV/Aids prevention, care and treatment. A substantial number of NGOs and FBOs further provide support and care for OVC (O'Hanlon *et al.*, 2010). Similarly, the WHO (2010) indicated that churches and NGOs played an important role in promoting and protecting the social welfare and health of Namibian citizens, and a number of NGOs were involved in the delivery of community-based health care, mainly HIV/Aids programmes. MoHSS (2008c) stated that FBOs, NGOs and CBOs reached 39 330 of persons living with HIV/Aids. However, the country continue to face insufficient coverage of home-based care, as there was still 31 per cent of the 107 constituencies around the country not covered by NGO programmes. O'Hanlon *et al.* (2010) underscored financial sustainability as one of the biggest challenges that faced the non-profit sector, especially organisations that deliver the HIV/Aids programmes, as they relied heavily on external donor funds. According to SHOPS (2013), the number of NGOs in Namibia ranged from 700 to 800, and approximately two-thirds either provide or support HIV/Aids services. Figure 2.3 below compares the number of NGOs that are HIV focused to the total number of NGOs in Namibia.



**Figure 2.3: Active HIV/Aids-focused NGOs compared to all NGOs in Namibia**

Source: SHOPS, 2013:26.

SHOPS (2013:27) highlighted that only about 235 to 270 of the Namibian NGOs that were HIV/Aids focused were currently active, which were those that enjoyed regular donor funding and had ongoing projects. SHOPS (2013) further noted that within the HIV/Aids-focused NGOs, only 13 NGOs provided 80 per cent of HIV/Aids services and received over half of the HIV/Aids funding. The 13 NGOs are of a Namibian origin, although three have affiliation with international NGOs. Over half of the employees and volunteers involved in the delivery of HIV/Aids services in Namibia are linked to the 13 NGOs that together has an aggregate budget of around N\$198 million (US\$23 million), of which 52 per cent comes from USAID or other USG agencies. The funding for the remaining 48 per cent comes from a range of other international donors.

#### **2.3.4 Health financing**

Health continue to be a priority sector of the Namibian government, hence receiving a reasonably large chunk of public funds. MoHSS (2008a) in its report entitled Namibia National Health Accounts (NHA) cited that the sources of finance for the Namibian health sector were the government, companies, households and donors as illustrated in Table 2.1 below. This statement was supported by the WHO (2010), by stating that the source of funding for the public health services which catered for the majority of the people was predominantly government funds from taxation, while the private sector was funded largely through medical insurances schemes that comprised of employee and employer contributions. The WHO (2010) further indicated that health was a priority focus for donors, accounting for 79 per cent of donor funds in Namibia, mainly for the HIV/Aids programmes.

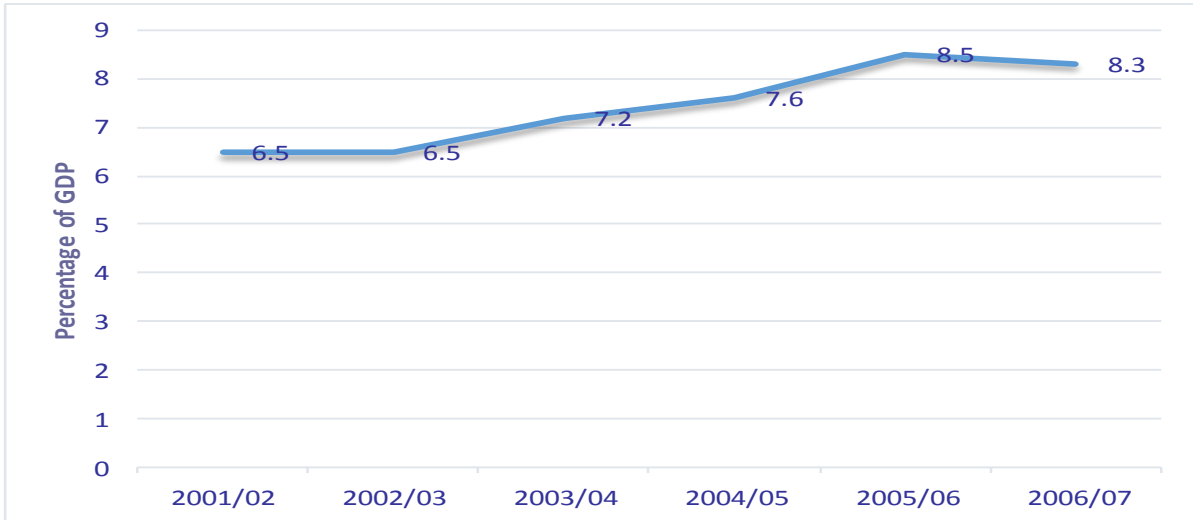
**Table 2.1: Health financing sources for the 2008/09 financial year**

<b>Sources</b>	<b>(%)</b>
Government funds	53.8
USG	13.5
Households	12.2
Employer funds	11.9
Global fund	5.4
United Nations (UN) agencies	2.1
Other bilateral donors	0.6
Other private funds	0.3
Other donors (foundations)	0.1

Source: (MoHSS, 2010)

#### **2.3.4.1 Total health expenditure (THE)**

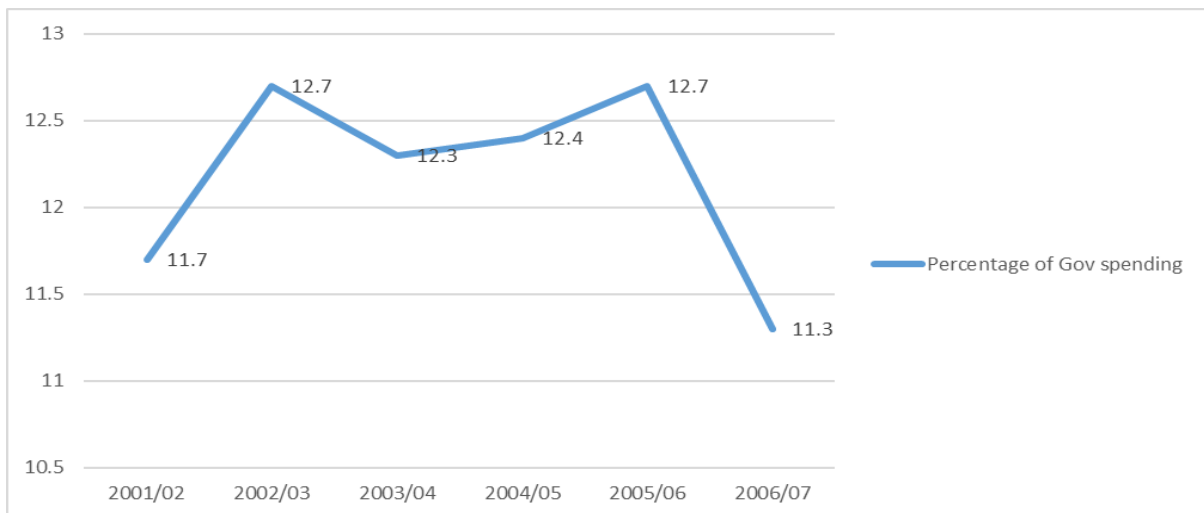
MoHSS (2008a:15) presented a total spending on health of N\$3,890 million for the 2006/07 financial year, which grew from N\$1,854 million expended in 2001/02. Figure 2.4 below gives a detailed overview of the total health expenditure for the period 2001/02-2006/07. The above table clearly indicates that government's spending on health is significant and for the 2008/2009 financial year, the government provided 53 per cent of the total health financing. Notwithstanding government efforts to ensure sufficient finance for health, almost half of the funds for health comes from other sources, including donor contribution of approximately 22 per cent with the USG contributing a substantial 13.5 per cent of the total financing for the 2008/2009 financial year.



**Figure 2.4: Total expenditure on health as a percentage of GDP, 2001/02 to 2006/07**

Source: MoHSS, 2008a: 17.

As a percentage of GDP, Namibia's health expenditure accounted for 6.5 per cent in 2001/02, which increased to 8.5 per cent by 2005/06, which declined slightly to 8.3 per cent by 2006/07 as indicated in Figure 2.5 below (MoHSS, 2008a:17). The government of Namibia signed the Abuja declaration where it committed to spend 15 per cent of the total public expenditure on health. Figure 2.5 below indicates that the average spending on health for the 2001/02 to 2006/07 financial years was 12.2 per cent, which is way below the 15 per cent threshold (MoHSS, 2008a:20).

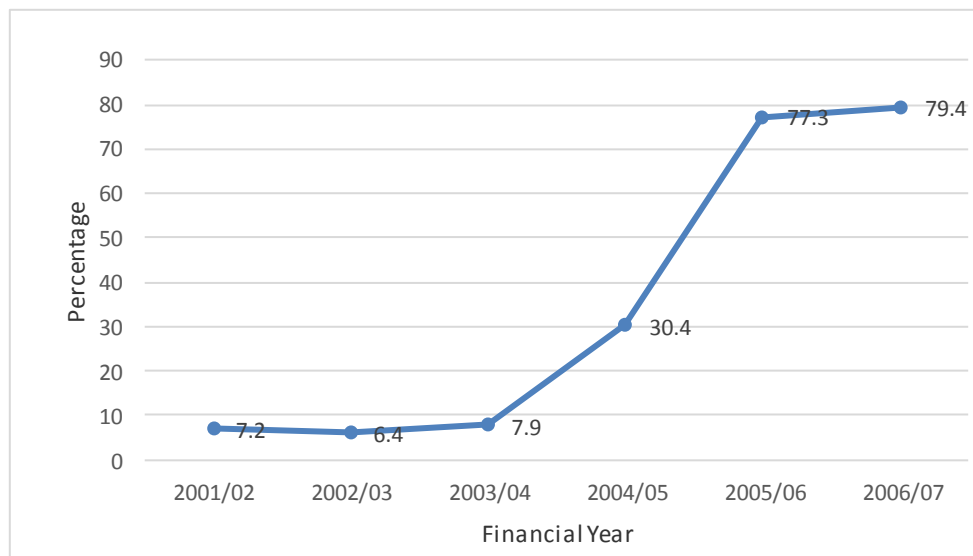


**Figure 2.5: Spending of government on health as a percentage of total government spending for the period 2001/02 to 2006/07**

Source: MoHSS, 2008a: 21.

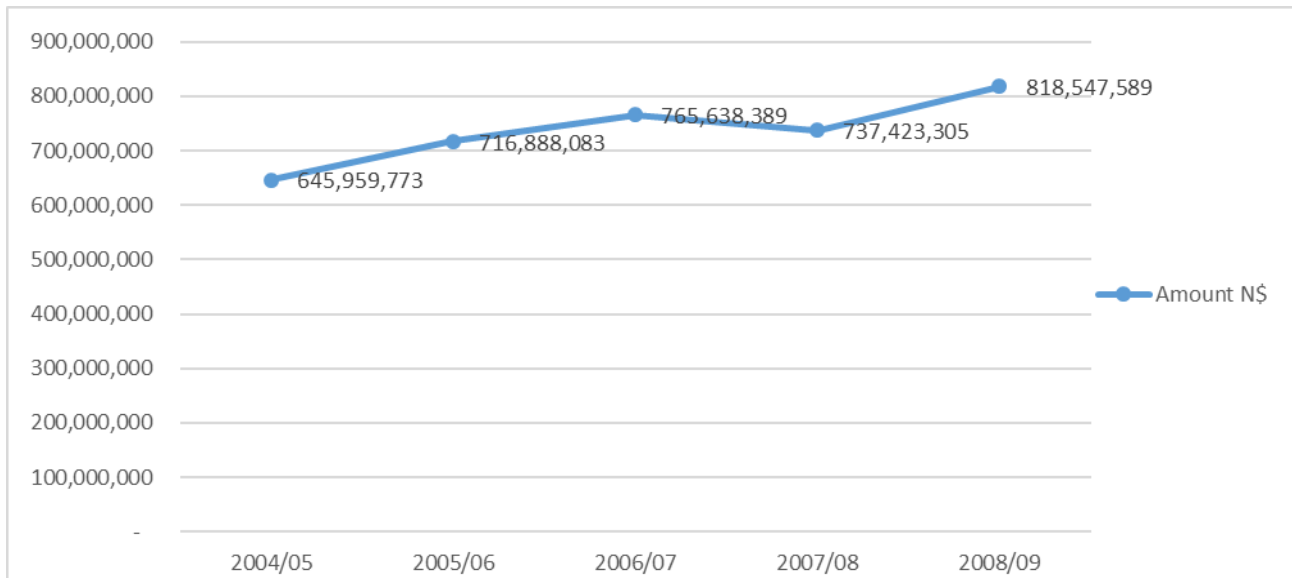
### 2.3.4.2 Donor spending on health

The attraction of international donors to Namibia immediately after independence can be seen in Figure 2.6, which illustrates an increase in donor funds from the year 2001/02 to year 2005/06. A sharp increase was noted in the year 2004/05 when the Global Fund and PEPFAR started to provide funds to the health sector that led to an overall increase in donor funding to the health sector (MoHSS, 2008a). However, it was noted by the NHA team during the period of their study that a number of donors were already scaling down. Ellmers (2010:11) confirmed this sentiment by stating that some bilateral donors such as Sweden, UK, Finland and Netherlands had closed their doors to Namibia or scaled down their programmes. Hence, to date the amount of donor funding to Namibia, including the allocation to the health sector, is much less than before. The recently released 2012/2013 national health account report highlighted that donors and NGOs together represented eight per cent of health financing, which shows a significant reduction from previous years (2008/2009) where they contributed 22 per cent of the THE, signifying the transitioning of donor funding from Namibia due to its status as an upper middle-income country (MoHSS, 2015).



**Figure 2.6: Donor spending on health as a percentage of total donor disbursements  
2001/02 to 2006/07**

Source: MoHSS, 2008a: 20.

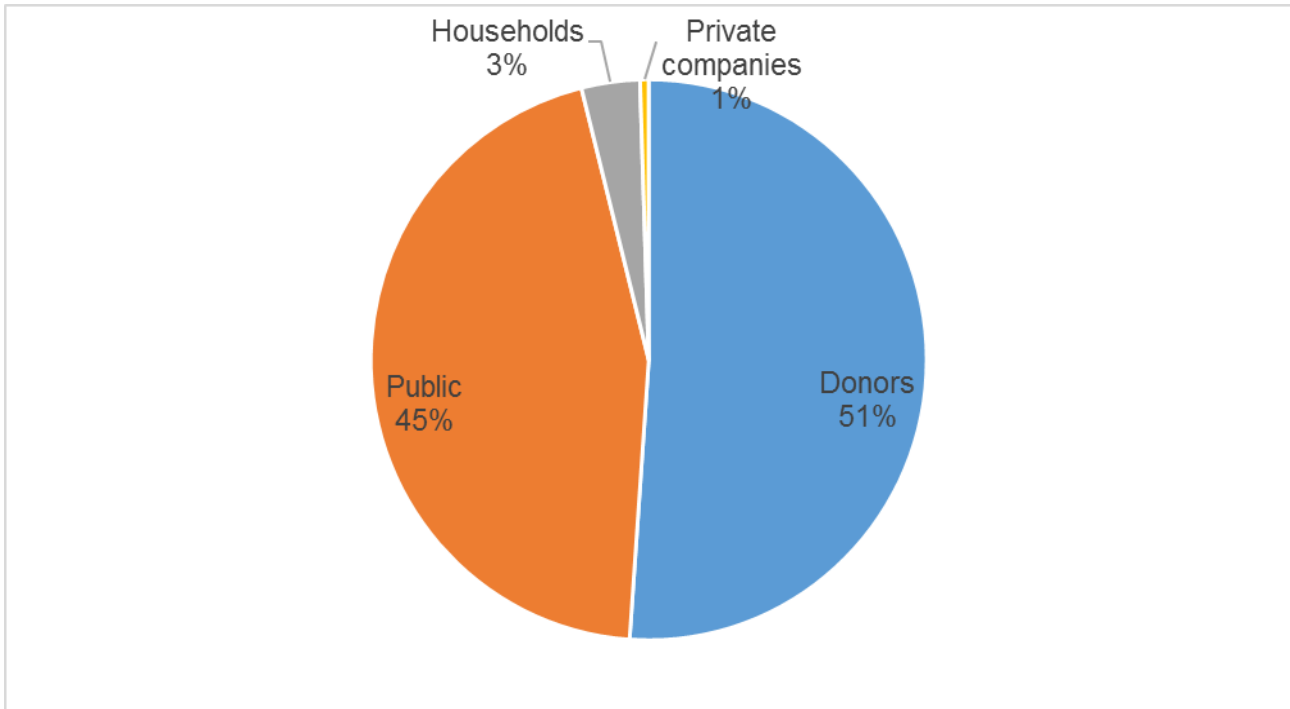


**Figure 2.7: Estimates for the national HIV/AIDS response for the years 2004/05 to 2008/09**

Source: MoHSS, 2010:47.

### 1.3.1 Source of finance for HIV/AIDS

In the fight against HIV/AIDS, an ample source of financing is required, as well as the government's involvement and that of all other sectors of the economy. The Namibian government, with the support of its development partners, including SADC, the US Government, Global Fund, European Commission, Department for International Development, Japan International Cooperation Assistance, German Technical Co-operation, the private sector, civil society organisations, line ministries and local authorities, play a role in the financing of HIV/AIDS programmes and the general campaign to fight and reduce the HIV/AIDS epidemic in Namibia. For the period 2004/05 to 2008/09, an amount of N\$3.684 billion (US\$406 million) was estimated by the Namibian government to be the figure that was required to fund the Medium-Term Plan III (MTP III). Figure 2.7 above shows year by year estimates for the country's HIV response for the period 2004/05 to 2008/09 (MoHSS, 2010). It is estimated that in the 2008/09 financial year, donors alone contributed 51.1 per cent, while the Namibian government's share was 45.0 per cent, while the remainder came from private companies and households. Figure 2.8 below gives a more precise picture of the HIV/AIDS financing sources for the year 2008/09.



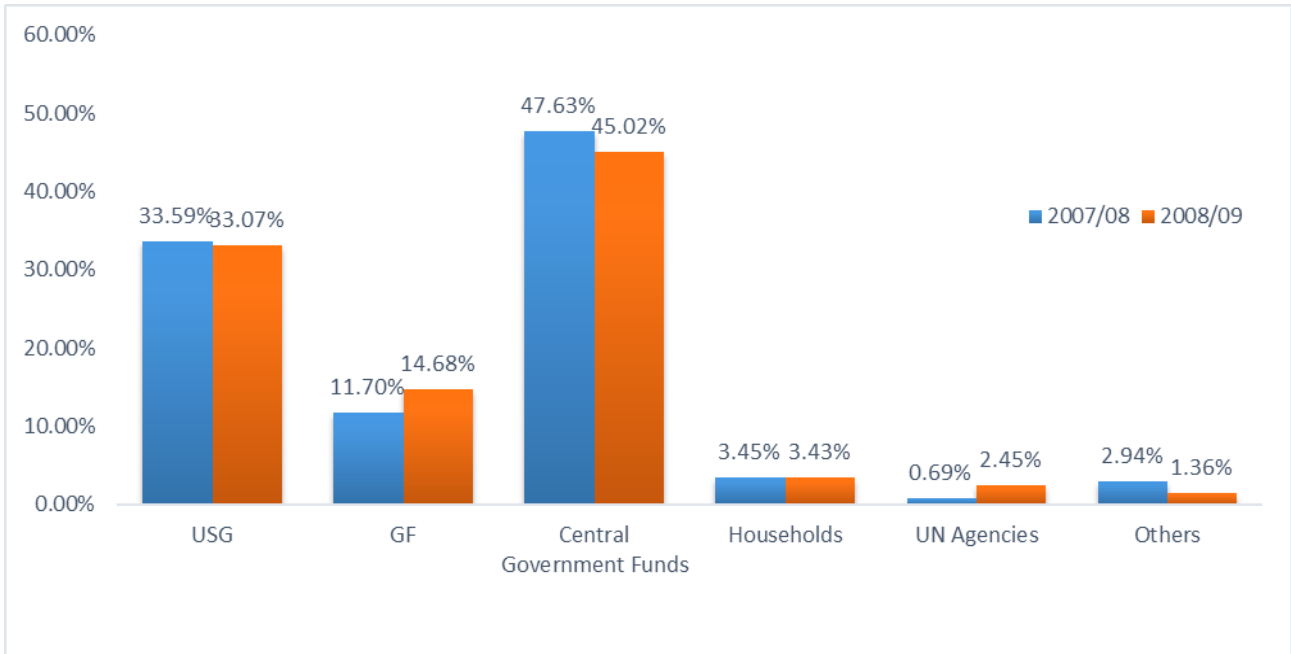
**Figure 2.8: Sources of finance for HIV/AIDS in Namibia for the 2008/09 financial year**

Source: MoHSS, 2010:51.

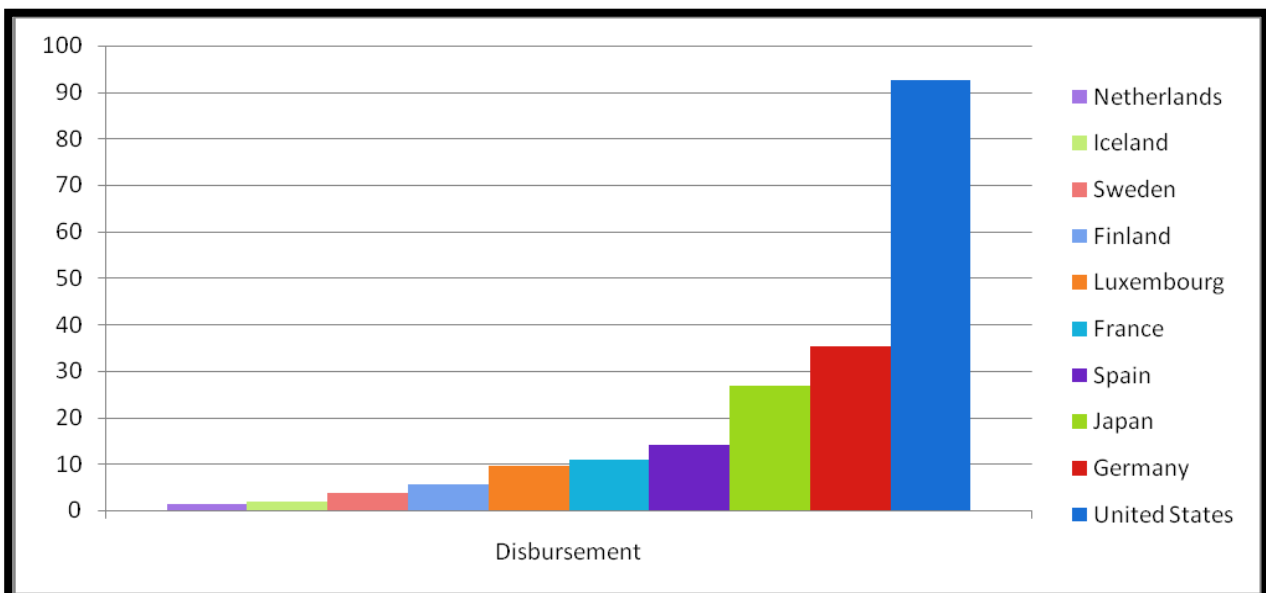
It is quite evident from Figure 2.8 that the country's HIV response continues to depend heavily on donor funding, and as indicated by MoHSS (2010:52), the US government through PEPFAR continues to be the largest donor for HIV/AIDS accounting for 33.59 per cent in the 2007/08 financial year and 33.07 per cent in the 2008/09 financial year, followed by the Global Fund with 11.70 per cent in the 2007/08 financial year and 14.68 per cent in the 2008/09 financial year respectively as reflected in Figure 2.9 below. A slight reduction of 0.52 per cent in USG resources is noticeable in 2008/09 as compared to 2007/08.

Besides the reduction in donor funding, Ellmers (2010) indicated that Namibia continued to be one of the countries in the world with the highest ODA per capita rates, and in 2007, the country received ODA amounting to US\$207.2 million, US\$144 million of which was from DAC donors. Apart from the various donors that closed down Ellmers (2010: 11) pointed out that 16 bilateral donors were still active in Namibia, but their donor support was scattered and fragmented over numerous small interventions. It is, however, worth noting that the USA, which is the largest DAC donor, targeted their funds mainly toward the combating of HIV/AIDS, and in 2009 approved PEPFAR funds to Namibia amounted to US\$107.1 million. Figure 2.10 below gives a snapshot of the top ten donors in Namibia during the period 2010-2011.





**Figure 2.9: Major financing sources for HIV/Aids for the years 2007/08 and 2008/09**  
 Source: MoHSS, 2010:52.



**Figure 2.10: Top 10 ODA donors to Namibia during the period 2010-2011**  
 Source: [www.oecd.org/dac/stats/idsonline](http://www.oecd.org/dac/stats/idsonline).

**2.4 HISTORY AND OVERVIEW OF THE USG HIV/AIDS PROGRAMMES IN NAMIBIA**

The USG started its HIV/Aids programme in Namibia in early 2001 with a number of prevention activities (mainly behavioural change, working with youth and work place programmes). Shortly thereafter, other programmes to support and care for orphans were added. In 2003, the US

government introduced programmes under President George W. Bush's initiative for Prevention of Mother to Child Transmission (PMTCT) of HIV, and again in 2004 after Namibia was selected as one of the 15 countries to benefit from PEPFAR (USAID, 2013). The support of the USG in Namibia's health sector is directed toward the national HIV/Aids response. The total funds received from the US government from 2004-2011 through PEPFAR totalled approximately US\$634 million, and since 2005, US\$8.9 million of child survival resources was received from the USG for TB activities. The USG's contribution toward HIV/Aids prevention, care and treatment makes up close to half of Namibia's total health expenditure on HIV/Aids (GHI, 2011). The Human Resources for Health (HRH) that included "training and direct salary support for clinical, non-clinical professional, administrative and support, and volunteer workers in support of HIV/Aids response – accounted for more than 30 per cent of the USG/PEPFAR budget for Namibia" (GHI, 2011:13). Five US agencies are involved in the implementation of PEPFAR in Namibia. These agencies are USAID, Control for Disease Centre (CDC), Department of Defence (DOD), Peace Corps and the State Department. Table 2.2 below gives an indication of the PEPFAR funding flow to Namibia since 2010.

**Table 2.2 US government assistance to Namibia (PEPFAR) 2010-2013**

	FY 2010	FY2011	FY2012	FY2013	FY2010-13
Prevention of Mother to child transmission	3,936,478.00	5,149,456.00	4,769,035.00	4,462,545.00	18,317,514.00
Abstinence and being faithful	7,989,917.00	3,620,421.00	845,000.00	-	12,455,338.00
Condom and other prevention	5,486,548.00	8,063,257.00	7,878,059.00	7,552,558.00	28,980,422.00
Blood Safety	1,000,000.00	857,458.00	660,220.00	330,110.00	2,847,788.00
Injection Safety	600,000.00	550,000.00	325,000.00	-	1,475,000.00
Intravenous Drug Users	-	-	-	-	-
Male Circumcision	1,887,798.00	4,345,666.00	5,679,832.00	-	11,913,296.00
Pediatric Treatment	3,143,196.00	3,273,038.00	2,581,876.00	2,070,204.00	11,068,314.00
Adult treatment	17,431,372.00	16,429,987.00	12,725,132.00	8,230,282.00	54,816,773.00
Turberculosis/HIV	3,087,488.00	3,408,282.00	3,943,349.00	4,673,542.00	15,112,661.00
Orphans and Vulnerable Children	8,121,902.00	7,499,600.00	6,905,774.00	4,819,162.00	27,346,438.00
Counseling and Testing	6,877,881.00	9,378,754.00	6,849,692.00	6,386,709.00	29,493,036.00
Pediatric Care and Support	2,658,958.00	3,344,275.00	2,352,346.00	1,459,580.00	9,815,159.00
Adult Care and Support	6,356,384.00	6,450,839.00	5,352,293.00	2,868,949.00	21,028,465.00
Anti-Retroviral Drugs	1,879,596.00	939,798.00	-	2,819,394.00	5,638,788.00
Lab Infrastructure	1,414,655.00	1,212,562.00	2,270,181.00	3,186,550.00	8,083,948.00
Strategic Information	3,520,720.00	5,961,718.00	6,798,847.00	8,276,029.00	24,557,314.00
Health Systems Strengthening	10,075,183.00	11,821,202.00	8,493,511.00	12,259,941.00	42,649,837.00
Management and Operations	16,841,105.00	8,002,869.00	11,879,034.00	13,423,839.00	50,146,847.00
<b>TOTAL</b>	<b>102,309,181.00</b>	<b>100,309,182.00</b>	<b>90,309,181.00</b>	<b>82,819,394.00</b>	<b>375,746,938.00</b>

Source: USAID, 2013.

The contribution of the USG to the Namibian health sector is enormous, and through PEPFAR resources, the USG's major achievements to date, according to USAID (2013), includes:

- Helped 380 000 Namibians to receive HIV counselling and testing;
- Supported over 72 000 Orphans and Vulnerable Children (OVC);
- Fostered the adoption of a national OVC five-year strategy and OVC policy;

- Developed a training programme to support and provide skills to 4000 caregivers that cater for special needs of OVC;
- Helped 113 000 Namibians to receive ART;
- Helped the male circumcision as a method of HIV prevention to get started;
- Encouraged over half a million Namibians to reach out for community outreach HIV/Aids prevention activities that promote consistent and correct use of condoms and related interventions;
- Assisted in strengthening the capacity of the Ministry of Information and Communication Technology and other institutions in the country to establish strategic plans for innovative HIV/Aids;
- Developed Community Action Forums (CAF), comprised of dedicated community volunteers who work proactively with community partners to coordinate activities, create synergies, and collaborate on larger events that include HIV testing days;
- Assisted the Namibian government to establish and implement guidelines and policies for safe injection and waste management practices;
- Trained and re-trained over 120 medical officers and pharmacists in drug-resistant TB management;
- Developed TB infection control guidelines for Namibia;
- Provided training to 34 laboratory managers to improve quality assurance systems for smear microscopy and improve TB lab management and surveillance systems;
- Developed the Electronic Dispensing Tool (EDT) that enables pharmacies to manage patients, plan follow-ups, monitor stock levels and quantify ARV needs, which is currently installed in 49 of the 66 facilities providing ART across Namibia and plays a major role in reducing the risk of drug-resistance;
- Assisted the MoHSS to reform the country's essential medicines selection process and bring in line with the WHO and international standards;
- Worked with the University of Namibia (UNAM) to develop the curriculum for a bachelors of Pharmacy;
- Helped to develop the Therapeutics Information and Pharmacovigilance (TIP) centre that monitors adverse drug reactions and provides access to drug information; and
- Successfully advocated for the transition of MoHSS and UNAM seconded staff.

The USG's achievements would not have been possible without the support of various implementing partners (IPs) that include local NGOs such as NawaLife (NL) Trust, Society for Family Health (SFH), LifeLine/ChildLine (LL/CL), Katutura Youth Enterprise Centre (KAYEC), Project HOPE, Church Alliance for Orphans (CAFO), and Catholic Aids Action (CAA). A brief overview of these NGOs follows in the following section. These NGOs receive PEPFAR resources mainly through USAID and they have been very critical in ensuring the successful implementation of the USG HIV/Aids prevention care and support programmes in Namibia. A sharp reduction in US government aid to the Namibian health sector can be observed over the years as set out in Table 2.2 above and it is expected to continue. Given the increased focus on sustainability and country ownership, the US government embarked on negotiations to transition to the Namibian government various programmes, including clinical and non-clinical positions funded by the USG and the Global Fund in order to ensure staff establishment (GHI, 2011). The transition can largely be associated with the overall reduction in donor funding to Namibia due to the country's status of an upper middle-income country. Between 2014 and 2015, PEPFAR used data analysis to pivot geographic focus and strengthen targeted efforts at regional and site levels to meet ART coverage targets, reduce HIV incidence and Aids related deaths. PEPFAR's new focus is on seven regions with the highest HIV burden and low ART coverage. The focus is also on eight urban hotspots outside the priority regions with large key populations or high volume of ART sites. Priority areas represent 80 per cent of persons living with HIV. With its new focus being on treatment as prevention, PEPFAR's goal is to work with the Namibian government, civil society and the private sector to expand ART coverage by focusing on high-yield sites and decentralising services and support the national goal of 80 per cent ART coverage among all persons living with HIV by 2017. PEPFAR plans to align HIV prevention, care and treatment interventions within priority regions for synergistic impact (PEPFAR, 2015).

**Table 2.3 USAID local partner organisations (NGOs)**

<b>Name of NGO</b>	<b>Period of agreement with USAID</b>	<b>Funding for the period in \$</b>
Catholic Aids Action (CAA)	10/07/2009-30/06/2013	3 663 112.00
Church Alliance for Orphans (CAFO)	30/12/2010-30/12/2013	2 701 638.00
Katutura Youth Enterprise Centre (KAYEC) Trust	20/04/2011-20/04/2014	3 680 000.00
NawaLife Trust (NLT)	31/10/2007-31/12/2016	3 750 000.00
Project HOPE	01/10/2010-30/09/2013	4 603 533.00
Society for Family Health (SFH)	01/01/2011-31/12/2014	5 403 638.00
LifeLine/ChildLine (LL/CL)	07/01/2011-30/06/2013	4 245 478.00

Source: USAID, 2013.

Table 2.3 above gives an indication of PEPFAR funds channelled to seven local NGOs through the USAID during the given periods for the implementation of various HIV/Aids programmes. The study focuses on these seven NGOs.

According to the SHOPS project (2013), NGOs in the delivery of HIV/Aids services faced a 33 per cent reduction in donor funding over the last few years, compelling NGOs to look for alternative financing to ensure continuation of their services.

## **2.5 OVERVIEW OF THE LOCAL NGOS SELECTED FOR THE CASE STUDIES**

### **2.5.1 Catholic Aids Action (CAA)**

CAA is a faith-based organisation that was established in 1998 through the Namibian Catholic Bishop's conference as the first Namibia's church-based response to country HIV/Aids crisis. CAA works closely with faith communities and local parishes. CAA's mission consists of four principal focuses, namely: home-based family care and counselling, care and support to orphans and vulnerable children, youth education and prevention, and voluntary HIV testing and counselling. CAA provides HIV/Aids services to all people regardless of race, religion, or background, but gives preference to very poorest that are affected by the pandemic (CAA, 2006). Catholic Aids Action also collaborates with the business sector, other faith-based organisations and NGOs, government ministries in the fight against HIV/Aids. CAA, therefore, builds on affiliated groups of Roman Catholic and other denominations, local communities and institutions to inspire and support HIV/Aids prevention, care and treatment programmes.

### **2.5.2 Church Alliance for Orphans (CAFO)**

CAFO is a Namibian faith-based organisation that was formed in 2002 as Southern Africa's first inter-religious coordinating body to respond to the increasing OVC population (Cronje, 2014). An initiative of the Council of Churches in Namibia (CCN), CAFO was created with the main aim of encouraging and empowering Namibian churches and other FBOs to provide spiritual, emotional, and/or material assistance to OVC. CAFO's membership totals 631 churches and other community organisations, and focuses on building the capacity of communities to deliver OVC services and interventions that are meaningful, holistic and effective (New Partners Initiative (NPI), 2012). Furthermore, CAFO advocates for the enforcement of applicable national and international policies and laws related to the rights and protection of children (Cronje, 2014). CAFO intends to boost synergy among faith-based organisations, churches, government and other stakeholders to provide optimal opportunities for OVC.

### **2.5.3 Katutura Youth Enterprises Centre (KAYEC)**

Katutura Youth Enterprise Centre is a non-member based NGO that was formed in 1994 as a joint initiative of the Anglican and Lutheran churches in Namibia. KAYEC was later registered as a trust

with the Namibian high court in 1999 (KAYEC, 2015). KAYEC's key activities include: 1) Vocational training with the aim of increasing self-employment to vulnerable out-of-school youth, OVC and OVC caretakers; 2) After-school centres to intensify resilience and school retention for 1 200 vulnerable youth in school; and 3) Networking and linkages with the private sector and other stakeholders to sustain support for youth development. KAYEC's Youth Development Programme consists of long-term after school courses for vulnerable youth aimed at keeping them in the school system. The programme equips youth with a range of effective skills that will help them survive the difficult years of adolescence and the negative influences of township life. Through the KAYEC's Artisan Training for Self-Employment (ATSE) programme, KAYEC increases opportunities for employment for young people who have left school and OVC caretakers (KAYEC, 2015). KAYEC's objective is to help young people develop the attitude, knowledge and skills that are required for productive work by providing non-formal vocational training skills for self-employment (Youth Employment Inventory (YEI), 2015).

#### **2.5.4 NawaLife Trust (NLT)**

The NawaLife Trust endeavours to improve public health by empowering community members through innovative health communication and behavioural change programming. Founded by the Johns Hopkins University Centre for Communications Programme that has operated in Namibia since 1998, NawaLife Trust became an independent entity in Namibia from 2006 (NawaLife Trust, 2015). NLT engages in strategic planning and implementation of media, community-level and interpersonal-level interventions. The organisation has specialised expertise to design and implement multi-level health communication that focuses on HIV/Aids, specifically stigma, sexual partner reduction, males seeking HIV testing, and family-unit and community recognition of alcohol abuse. It complements GRN routine communication on HIV prevention interventions. Since to 2007, NawaLife has been a key contributor in identifying appropriate messages as well as in designing the national HIV communication campaigns such as "Get tested and stand up against alcohol abuse" and others.

#### **2.5.5 Project HOPE**

Founded in 1958, Project HOPE is an international NGO dedicated to proving lasting solutions to health problems with the mission of helping people so that they can help themselves. Project HOPE was the "world's first peacetime hospital ship", and to date provides medical training and health education as well as conducts humanitarian assistance programmes in over 35 countries. Project HOPE opened its doors in Namibia in 2002, where it began strengthening health care services and providing health education while implementing HIV/Aids workplace education programmes. Project HOPE's programmes in Namibia have since grown to include TB treatment and education, strengthening the coping capacities of households and communities caring for OVC, working to prevent HIV/Aids among young women, and village health banks. In 2005, Project

HOPE introduced a programme to meet the increased economic needs of OVC by creating economic strengthening opportunities, micro-credit loans or savings groups together with health and parenting education. A targeted educational curriculum was developed for caregivers, which addressed essential OVC care and support. In 2008, Project HOPE Namibia expanded its programmes to specifically target OVC households headed by elderly women or older orphans themselves. In the same year, Project Hope further began to work on preventing the spread of HIV/Aids in selected regions in the country through the creation of economic opportunities and the health education of young women. A programme targeted at supporting community efforts in, amongst others, implementing a TB control strategy was also initiated in 2008 through the community-based approach (Project HOPE, 2015).

### **2.5.6 Society for Family Health (SFH)**

SFH is a registered trust that opened its doors in Namibia in 1997 as a Non-Governmental Organisation. The Society for Family Health is a member of the Population Services International (PSI) network. PSI recruited a Namibian Country Director as well as a more autonomous local board of directors to lead SFH. The health programmes carried out by SFH support the efforts of government to attain health for all and are aimed at improving the health and wellbeing of Namibia's most vulnerable population. The health programmes implemented by SFH are malaria control, maternal and child health, and HIV (PSI, 2015). With respect to the HIV programmes, SFH targets key populations (KPs) with the overall goal of creating an enabling environment to reduce the transmission of HIV within the KPs through comprehensive HIV prevention services and linkages to care and treatment for Men who have sex with Men (MSM), Sex workers (SW), and clients of sex workers. A second HIV-related programme carried out by SFH is the Military Action Prevention Programme (MAPP). The aim of the MAPP is to reduce the impact of HIV within the Namibian Defence Force (NDF) and to promote capacity development that will ensure long-term sustainability of the programme interventions in the NDF. Besides the health programmes, SFH also implements activities on water sanitation and hygiene under its project known as WASH (Water, Sanitation and Hygiene) (SFH, 2014).

### **2.5.7 LifeLine/ChildLine (LL/CL)**

Founded in 1980, LifeLine/ChildLine (LL/CL) is a leading child welfare civil society organisation in Namibia, affiliated with Lifeline Southern Africa and ChildHelpLine International. Its initial purpose was to provide counselling through telephone to people in crisis. Although counselling and counselling training continue to be its core business, to date, LL/CL's organisational purpose has expanded to promote emotional resilience in its broadest sense. LL/CL provides training and works closely with children and adults at community level to enable them to better address the challenges they face so that they can have better, healthier and safer lives. With the high prevalence of HIV and domestic violence as well as unusually high levels of child abuse in Namibia, LL/CL

programmes include HIV prevention, behaviour change to promote greater gender understanding and equity, and child protection. In order to achieve these goals and objectives, LL/CL works with the Namibian government, other civil society organisations and national and international development partners (EngenderHealth and LifeLine/ChildLine, 2011).

## **2.6 CONCLUSION**

In conclusion, Namibia inherited from the former South African administration a dual economy at independence in 1990. This dualism cuts across all sectors, but is mainly prevalent in the agricultural sector, which is known to be the backbone of the country's economy as it provides employment and food for the majority of the population. The dualism brought about numerous challenges. Besides high rates of poverty, income inequality, unemployment and low economic growth, Namibia's rate of HIV infections is still high compared to other African countries.

Namibia's economy relies on exports of natural resources as its primary industry. Notwithstanding its abundant natural resources, the country continues to depend heavily on foreign aid, especially for financing health expenditure. Donor funding makes up eight per cent of the country's THE, but half of the total spending on HIV/Aids comes from donors. The USG aid and the Global Fund make up close to half of the HIV/Aids spending.

Due to Namibia's income status as an upper middle-income country, there has been a sharp decline in donor funding. A number of NGOs that are involved in the delivery of HIV/Aids services and that have benefited from donor funds faces challenges in ensuring continuity of operations and programmes given the continuous decline in foreign aid. USG PEPFAR funded NGOs are no exception.



## **CHAPTER 3**

### **LITERATURE REVIEW**

#### **3.1 INTRODUCTION**

This chapter reviews the literature relating to the context of the study. The chapter consists of two parts, namely a theoretical and an empirical literature review. The theoretical literature discussed various theories pertaining not only to the general sustainability of NGOs that include financing, but also briefly looked at foreign aid and its effectiveness. Besides sustainability, it is important to look at the theories on aid effectiveness in general, because many countries, including Namibia, depend on foreign aid, the majority of which is channelled through the NGO sector, especially in fight against HIV/Aids. However, some authors claim that foreign aid may not necessary be the solution to the African problems, while others argue that aid effectiveness depends, amongst others, on stable policies, political stability, human capacity and putting management procedures in place. The second part of the chapter summarises the empirical literature reviewed on the sustainability of NGOs.

#### **3.2 THEORETICAL BACKGROUND**

For several years, the Gap Model promoted by Chenery and Strout (1966) has been used to project the macroeconomic impact of foreign aid. The model has two elements and is, therefore, also generally known as the Two-Gap Model. The first element is described as the relationship between investment and growth whereby the rate of growth is expected to be dependent on the rate of investment. The second element of the model is the relationship between savings, which is assumed to be a crucial factor for investment expansion and growth. This model is essential as it enables analysts to determine the rate of investment required to achieve level of economic growth needed. Savings or foreign exchange gaps can occur in an economy when the investment is below the required level. If a country cannot fill these gaps through domestic resources, then foreign aid inflows or foreign capital inflows would be required to fill the gaps, and thus it is assumed that foreign aid inflow should result in an upward shift in a country's economy (McMillan, 2011). However, various authors criticise the Two-Gap Model. Harms and Lutz (2004), amongst others, contended that not all aid was invested by the recipient country as by nature aid was interchangeable and thus could not be assumed to all go in investment. Harms and Lutz (2004) also acknowledges that the availability of aid can serve as incentive to corrupt administrations to intentionally lower their efforts to increase domestic investment so that they can continue to receive donor funding.

Besides the Two-Gap Model, Nelson (1956) used the Poverty Trap Model that assumes that growth is hindered by traps of poverty, which can be caused by various factors such as high population, weak savings and low production capacity. Notwithstanding the causes, poverty traps are known to compromise growth. Foreign aid is, therefore, seen as a temporary injection of capital to help the economy come out of the poverty trap and move toward growth (McMillan, 2011).

In Namibia and in many other developing countries, various sectors of the economy, including the health sector as well as NGOs that operate within the country, depend on foreign aid for their survival. In addition to the critics of the Two-Gap and Poverty Trap models, different scholars and academics have widely debated the effectiveness of foreign aid in general and others argued the sustainability of NGOs that rely on donor funding. Riddell, Robinson, Coninck, Muir and White (2014) questioned whether foreign aid worked in the article, "Does foreign aid really work"? Moyo (2009), in her book titled "DEAD AID", described aid in general as not being the solution to the African problem, but rather the disease for which it pretended to be the cure.

### **3.2.1 Foreign aid and its effectiveness**

According to Grant and Nijman (1998:3), foreign aid became an institutional part of international relations since the Second World War. In the late forties and at the start of the Marshal Plan, aid became a common foreign policy instrument of donors and served as a crucial source of income for many developing countries. By 1990, the amount of foreign aid to developing countries was estimated at US\$72 billion. During the post-war period foreign aid as a policy tool grew in the ways it was provided and the importance of many recipients and donors shifted.

After the end of the Cold War, new political challenges that included civil wars in parts of Africa and the former Soviet Union were experienced and put on the global agenda. Literature tells of exploitation, poverty, dictatorship and mismanagement that extended over a period of 30 years and resulted in major social divisions and weak governance, especially in Africa. Hence, humanitarian and development aid were employed to address these challenges under difficult conditions (Uvin, 1999). NGOs were part of the institutions that played a bigger role in humanitarian and development assistance since the end World War II on behalf of donor countries (Werker & Ahmed, 2008). OECD (2006) indicated that the amount of foreign aid given to NGOs to promote international development assistance rose from a negligible amount before 1980 to almost US\$2 billion in 2004. Riddell *et al.* (1995) reported that the estimated total resources channelled through NGOs for development projects rose to US\$6.3 billion in 1993 from US\$0.9 billion in 1995. The US government has been one of the biggest contributors to development assistance for decades. Werker and Ahmed (2008) confirmed this statement by underlining that as early as 1964 over six per cent of the USG's foreign aid budget was channelled through NGOs. The trend of foreign aid was constantly changing, according to Global Impact (2013: 4), and NGOs have found that there were new delivery mechanisms and that new players were becoming part of the aid system.

Moreover, in recent years, donor funding from the United States and European governments has declined because these countries have been compelled to reduce development aid budgets in order to address domestic economic turmoil.

Lately, there has been major concerns that yielded mixed views with regard to foreign aid effectiveness, especially in African developing countries (Adam & Gunning, 2002). In her study on the real-life relationship between donors and recipient, Hossain (2004: 2) used the concept of a gift. She stated that “aid is not paid for, it is ultimately a gift of the taxpaying public of the donor country, which is why it comes with their conditions for its use attached, but that does not mean donors are entirely disinterested; there are benefits for both sides”.

Even though analysis on foreign aid began in the 1970s, intense debates over aid effectiveness only started in the early 1990s. Theoretically, aid is intended to be a temporary measure complementing existing efforts and domestic resources in recipient nations. Unfortunately, to date, foreign aid turned out to be the opposite in many recipient countries, resulting in many economies being dependent on aid (Mallaye & Thierry, 2013: 6). Literature shows that many academics agree that ODA to Africa has been ineffective over the past decades and are of the opinion that it weakens development processes and economic progress in the recipient nations (Williamson, 2003; Mallaye & Thierry, 2013). According to Ezemenari, Kebede and Lahiri (2008) and Cruz and Mcpake (2010) there was strong evidence that too much aid created dependency in an economy and weakened the country’s accountability and legitimacy. Second, there was strong evidence that aid misuse occurred. Lastly, there were problematic governance issues when aid was allocated. Burnside and Dollar (2004) argued that aid could only be successful in environments with good policies, mainly good monetary, fiscal and trade policies. Deutscher and Fyson (2008) contended that aid effectiveness was compromised if there were too many donors with different policies and systems, and that countries should commit to strengthen their domestic systems and build local capacity. Alesina and Dollar (1998) claimed that bilateral aid might be effective at promoting strategic interests, but had little association with poverty, good policy and democracy.

There are, however, authors, who believe that developing countries still require aid to run various developmental projects. Nnadozie (2008: 182) argued that many African countries’ health care systems were in total disarray and due to a lack of resources they could not adequately deliver health services or cope with the effects of various diseases, resulting in the need for ODA. Mishra and Newhouse (2009) confirmed that in many countries, aid had brought positive changes in health sectors although not in economic growth. In recent years, studies on aid effectiveness have shifted in focus away from merely looking at the aggregate results of the overall project towards the long-term sustainability of resources within the receiving nations (Anyanwu & Erhijakpor, 2009). With regard to the effectiveness of aid, particularly for NGOs, Riddell *et al.* (2014) found that 75 per

cent of the NGOs studied met their immediate objectives and that impact had improved with aid, but sustaining the benefits remained a challenge, while aid failures continued to exist.

### **3.2.2 NGO financing**

By nature, NGO work such as helping the sick and needy, protecting the environment, preserving arts and culture is 'unprofitable'. Traditionally, the costs of NGO activities are covered through donations and grants provided through the goodwill and generosity of others (UNAIDS, 2001). According to Oxford Analytica (2005), NGOs raise billions of dollars each year from individuals, donors and charitable organisations in the private and public sectors. Viravaidya (2001) stated that non-governmental organisations commonly relied on donor agencies, multilateral lenders, charitable institutions, as well as on government ministries for conducting their operations and carrying out programme activities. Similarly, Scott and Hopkins (1999) stated that numerous NGO programmes were funded either by the World Bank or by multilateral and bilateral organisations.

Correspondingly, Glaser (2004) claimed that NGOs generally received support through the state, the public and the private sector on an international, national or local level. He further stated that within government, financial aid might be provided through international foreign sources or bilateral/multilateral grants or else through national or local governmental grants. On the other hand, the private sector may provide corporate grants or foundations grants.

### **3.2.3 Sustainability of NGOs**

The sustainability of foreign aid-funded NGOs can vary from one country to another, but it is a worldwide predicament, given the continuous reduction in aid flow globally. As certain countries receive status of aid 'graduate' due to certain factors such the reclassification of Namibia being an upper middle-income country, their civil societies will get to the point where they would seek for non-donor funding alternatives. In Namibia, 90 per cent of civil society organisations that have been involved in the provision of HIV/Aids services receive funding from either USG/PEPFAR or the Global Fund, and as the Namibian economy grows, donor funding reduces rapidly (SHOPS, 2013).

The UN secretary general, Ban Ki-moon, also expressed concern for the reduction in official development assistance (ODA) to developing countries, which has been reported to have dropped by four per cent in 2012 following a two per cent decline in 2011 (The Guardian, 2013). This reduction is assumed to continue and NGOs have to adapt accordingly (Viravaidya, 2001).

UNAIDS (2001) cautioned that today NGOs found themselves unable to meet the growing needs and rising costs as traditional funding sources were often insufficient. Moreover, uncertainty about these funds over time, as well as restrictions imposed on many grants and donations, make it difficult for NGOs to conduct long-term planning, improve their services or reach their full potential. It was further stated that often donor funding to NGOs are meant to only cover programme costs,

but not support services costs or other overheads costs. This creates a gap that should be self-financed by NGOs, which may often not be possible due to a lack of alternative resources. Even NGOs that may be fortunate enough to receive funding that covers both programme and operational costs may easily face uncertainty in future funding. This is in line with the sentiments of Murtaza and Austin (2011) who pointed out that the trend of increased funding by external donors to NGOs had declined, and a large number of conditions placed upon recipients by donors had limited the effectiveness of NGOs. They further indicated that the heavy reliance of NGOs on donor funding had made them more financially fragile as well as less accountable and representative of poor people. Correspondingly, Viravaidya (2001) underscored that in recent years, NGOs in many countries had been experiencing reductions in available donation from both foreign and local sources. Further research by Stuart (2003) also showed that the challenge in terms of financial sustainability of NGOs in developing countries was to establish domestic sources of funding or revenue to replace unreliable international donor funding. He contended that local governments had started to acknowledge and support the work of NGOs, "As NGOs expand their influence in their communities and countries, national governments are increasingly recognising the important role they play" (Stuart, 2003: 2).

USAID (2010) stressed that factors that influence the financial viability of an NGO depended, amongst others, on the extent to which volunteerism and philanthropy were being fostered locally, as well as the extent to which commercial revenue and government procurement opportunities were being established. Nevertheless, there are countries that have experimented with different ways to tap into domestic funds as a potential source.

In her paper entitled "Governance and financial sustainability of NGOs in South Africa", Hendrickse (2008) contended that a possible solution to guarantee NGO financial security would be to mobilise financial resources and in kind support from local entities such as private businesses, the media, private individuals and the general public. The author further argued that self-financing from own resources as an alternative appeared to be a much more attractive funding option to increase sustainability as compared to the more traditional fundraising approaches. She elaborated that when different funding approaches were combined, in the result was a much more sustainable funding prospect, and when financial sources were diversified, the NGOs' chances of achieving self-financial sustainability were greatly enhanced. Hence, NGOs require a diverse pool of financing sources and tools in order to limit the risk and sustain their work.

Similarly, earlier research by Aldaba *et al.* (2000), showed that regardless of the diversity of histories and contexts, the common and foremost concern of NGOs living beyond aid was self-sustainability, which could be achieved through various means. These include: 1) exploring domestic finance as an option by generation of income from third parties (requesting a fee for the services); self-generating income and concentrating on non-financial support; 2) exploring non-

material resources, which involves the provision of non-material input such as land and labour; 3) commercialisation of NGOs, which entails self-generating income through microfinance, business activities and sale of services such as the provision of technical assistance, training and consulting.

USAID (2010) explored beyond financial sustainability and highlighted that the legal and regulatory environment should support the needs of NGOs if they were to be sustainable. Hendrickse (2008) concurred by stating that the long-term sustainability of the no-profit sector was related to the country's legislative framework that governed the work of NGOs. In terms of organisational capacity, the author maintained that NGOs would be sustained if they were governed in a transparency manner, held publicly accountable, capably managed and portrayed essential organisational skills. With respect to advocacy, NGOs would be sustainable if the environment offered them ways to communicate their messages freely through media to the broader public, articulated their demands to government counterparts, and monitored actions of government to ensure accountability. The author also underlined that service provision should be ensured in an efficient and consistent manner that met the expectations, needs and priorities of their constituencies.

### **3.3 EMPIRICAL LITERATURE REVIEW**

Empirically, various studies complement the theoretical views of the subject at hand with supportive evidence focusing on both financial and organisational sustainability of foreign aid-funded NGOs. International examples of the ways in which governments can support NGOs financially are also highlighted.

#### **3.3.1 Studies on the sustainability of NGOs**

As strategies to strengthen NGOs capacity, maintain focus and priorities and ensure continuity of operations and programmes, a study by UNAIDS (2001) inter alia suggested establishing community clubs and associations to once-off charity events with donations and proceedings going to NGOs. In addition, private companies whose business mandate relate to the NGO's work could be approached to give in-kind donations such as equipment and supplies or cash. In the same vein NGOs in Indonesia were encouraged to self-finance and end the dependency on foreign aid by seeking funds from their government and private companies, local foundations, philanthropic institutions and individual sources (Jakarta Post, 2000). This can be extended to the Namibian situation where in order to maintain the health gains attained over the years and become self-sustaining, SHOPS (2013) suggested that Namibian NGOs should seek alternative source of funding domestically, and that Namibia's evolving for-profit private sector might be a potential source of such revenue. USAID (2010) in their 2009 sustainability index study for sub-Saharan Africa found that only a few NGOs in Africa were capable of generating significant income by pursuing economic activities, charging fees for services, collecting membership fees, and that

individual philanthropy tended to be weak. They did, however, acknowledge that CBOs and faith-based organisations tended to benefit from individual donations and remittances from abroad.

South Africa and Botswana are other neighbouring countries to Namibia facing PEPFAR transitions. In the 2011 fiscal year, South Africa received a total \$560 million of PEPFAR funding, but the amount was expected to scale down significantly over the following five years as the US government shifted the HIV/Aids financial and managerial responsibilities to the South African government (Brundage, 2011). To ensure sustainability of the health programmes and continuation of the USG/PEPFAR funded NGOs, a five-year PEPFAR partnership framework was developed in South Africa, in terms of which NGOs would be expected to partner directly with the South African government instead of the USG. Since they would function under the government's umbrella, the South African NGOs would be required to adapt to new changes such as new hiring practices and salary structures, as well as complex negotiation and planning processes both at local and regional level (Brundage, 2011). Hendrickse (2008) found that South African NGO sector revised funding strategies and commercialisation activities were noted in the form of consultations, contracts and the selling of the services and products. Furthermore, the author observed that the sector was compelled to establish an appropriate financial management system as well as to construct a well-executed fundraising strategy, comprising of elements such as diversification, sustainability, creativity and inclusiveness.

In Namibia, the USG/Namibian government HIV/Aids partnership framework laid out an effective transitioning approach that includes the provision of technical assistance to increase "government and civil society (including the for-profit sector) capacity to manage coordinate and finance the health sector". The provision of technical assistance by the USG will not only ensure the sustainability of the health gains achieved over the years, but will also build a workforce (both in NGOs and government ministries) that will ensure continuation of the health service delivery around the country (GHI, 2011: 5).

Prior research by UNAIDS (2001), however, cautioned that NGOs had different missions, skills, client bases and experience, and determined that becoming completely independent of donors might not be a realistic goal for some NGOs at this stage. However, increasing financial security is an essential component of planning for all NGO managers. A study by Walsh, Mulambia, Brugha and Hanefeld (2012) on the evaluation of the sustainability of HIV/Aids CBOs in Zambia, found that most CBOs would continue to require the support of donor funding if they were to carry on operating in the medium to the long term. A number of these CBOs relied heavily on donor funding from the World Bank Multi-Country Aids Programme in Africa (MAP) through a Community Response to HIV/Aids (CRAIDS) funding mechanism. The World Bank MAP funding to HIV/Aids, however, ended in August 2008 (Walsh *et al.*, 2012) leaving a financing gap among CBOs.

On the contrary, Viravaidya (2001) encouraged NGOs in Thailand to start establishing some degree of self-reliance if they were to create and achieve medium to long-term goals and targets. To this extent, NGOs in Thailand discovered innovative ideas of community development through income-generation for its own programmes and operations. Fowler (2000:652) in his work on non-governmental development organisations (NGDOs) beyond aid found that the primary risks of NGDOs beyond aid included a) “adopting the social entrepreneur framework as a basis of self-survival and b) not properly managing the interplay between potentially competing sets of values – social action set against the demands of market behaviour”. Further research by Malhotra (2000:665) highlighted that NGOs without aid would need to shift their focus from being mainly humanitarian relief and grantors of development finance, and redirect their limited resources and energies at advocacy, campaigning and other policy influential strategies targeted at ensuring that intergovernmental organisations and states attain their main responsibilities and commitments both nationally and internationally.

A study by Bidaurratzaga-Aurre and Colom-Jaen (2012) on HIV/Aids policies in Mozambique found that in order to build local capacity and ensure long-term sustainability beyond aid, the public health systems should be strengthened via training civil societies and local actors in the public sector to take a lead in the disbursement of current aid. Recent research by Moon, Burlison, Sidat, Pires and Solis (2010:11) on “lessons learned while implementing an HIV/Aids care and treatment programme in rural Mozambique”, concluded that “expanded health manpower and incentives for rural practice, strengthening of rural livelihoods, upgraded universal education, economic development, and expanded infrastructure and management for sustained chronic disease care programmes” is the solution to the sustainability of the health care programmes beyond aid.

With regard to the legal framework and regulatory environment, USAID (2010) revealed that legislative and regulatory framework in SSA countries made provision or created special advantages for the NGOs, such as significant tax exemptions for NGOs, tax deductions for businesses or individual contributions, open competition among NGOs to provide government funded services, etc. Hendrickse (2008) found that in South Africa, the Non-Profit Organisations (NPO) Act (Act 71 of 1997) gave a detailed framework for the establishment and operation of CSOs. Charities Aid Foundation Southern Africa (CAF) (2012) observed that an extensive process was carried out in South Africa to negotiate new policies and mechanisms of funding, including the creation of the National Development Agency (NDA), the lottery and tax exemption for NPOs.

### **3.3.2 Government/State funding**

A number of studies on international examples of financial support that governments can offer to NGOs is discussed below.



NGOs in the Czech Republic receive approximately 39 per cent of their funding from the government, while a quarter of organisations receive more than half of their funding from the resources of state. Kazakhstan took the first steps in drafting a law that would ensure an establishment of a legal channel for NGOs to participate in state tenders for social sector services (Stuart, 2003:5).

Layton (2003) claimed that NGOs in the USA received 31 per cent of their financing from government contracts. In 2004, however, it was reported that 37 per cent of more than 5 000 NGOs in the USA experienced a decrease in USG funding as compared to the year 2003.

Sorgenfrei (2004) found that in recent years, the French government had recognised the crucial role that NGOs play, which led to a restructuring of the funding system for NGOs, and the subsequent establishment of a system with the specific purpose of allotting funds to projects run by NGOs, “la Mission pour la Cooperation Non-gouvernementale (MCNG)”.

In Croatia, NGOs received support through the Government Office of Cooperation with NGOs for several years. In 2002, NGOs whose initiatives exceeded a one-year period received state funding for the first time. Likewise, in 2002, the Council of Ministers in Bosnia allocated US\$ 150 000 from the state budget to NGOs for the first time. Notwithstanding limitations in the plan to distribute the funds as well as the limited amount of money, NGOs regarded the state contribution as a vital sign that government acknowledged the crucial role that NGOs play in the country (Stuart, 2003).

In India, the NGO sector that is home to over a million of NGOs, largely depends on government and multilateral funding. “Indian NGOs suffer from a lack of awareness with respect to local resources mobilisation and there is a poor ethic of voluntarism”, said Misra (cited in Farouk 2002).

Donor funding for the South African NGO sector that boasts over 98 000 NGOs is channelled through the state, making public funds a major source of income for NGOs. Hence, international donors are more inclined to finance NGOs that support government programmes, creating a risk of compromising the credibility of the NGO sector (Farouk, 2002).

According to Stuart (2003), NGOs across Central and Eastern Europe received support from local-level government through grant competitions or tenders as well as in-kind support in the form of free or reduced cost office space.

### **3.4 CONCLUSION**

This chapter looked at the theoretical framework on foreign aid and sustainability of NGOs. The chapter further analysed different studies that empirically investigated the way in which NGOs can sustain their work. Some scholars argued that foreign aid might not necessarily be the solution to the various problems faced on the African continent. Moreover, NGOs that heavily rely on foreign aid/donor funding may not necessarily be sustainable, according to some authors, as not all NGOs

could survive beyond aid. However, studies carried out in various countries, including the Republic of South Africa, empirically found that NGOs could be sustained if, amongst others, they were governed by robust regulatory environments, could diversify funds, establish fundraising schemes, commercialise their products and services, and create effective and efficient financial management systems. NGOs in some countries receive financial support from their governments or compete for government tenders/contracts, are exempted from paying tax on their income as well as receive tax deductions for business or individual contributions. These are all examples that the NGO sector in Namibia can learn from, and hence this study intended to find what alternatives existed in Namibia, as very few studies conducted so far were conclusive.

## **CHAPTER 4**

### **RESEARCH METHODOLOGY**

#### **4.1 INTRODUCTION**

This chapter outlines the methodology and the research techniques applied in investigating the sustainability of the USG aid-funded NGOs. This chapter has four sections: the first explains the study design and population of the study; the second discusses the sampling techniques and size; the third gives a brief description of the sources of data and instruments used in gathering the data; while the last section summarises the different techniques used in analysing the data.

#### **4.2 STUDY DESIGN AND POPULATION**

This research adopted the methodologies used by Walsh *et al.* (2012) in their study on the evaluation of the sustainability of HIV/Aids CBOs in Zambia, and by Hendrickse (2008) in her study focusing on the governance and sustainability of NGOs in South Africa. Hence, this study largely employed a qualitative evaluation approach, which is deemed the most appropriate for an in-depth exploration of the results for both research questions 1 and 2. A qualitative approach aim to answer the what, how and why questions of the subject, instead of the how much and how many, which are addressed by a quantitative method (Patton & Cochran, 2002). Brynard and Hanekom (2006: 37) described qualitative methodology as a research methodology that produced descriptive data, which usually referred to participants' own spoken or written words pertaining to their experience or perception. Brynard and Hanekom (2006) further stated that generally no counts or numbers were assigned to such observations, and research methods used included case studies, in-depth interviewing of key informants, questionnaires, participant observation and review of personal documents that could include diaries, autobiographies and life histories.

Although a quantitative method was not considered to be the most suitable in this study, descriptive statistics were deemed appropriate in analysing the data. According to Schreiber (2013), descriptive statistics were important in both quantitative and qualitative analysis, as the reduction of large amount of data to an easily digestible summary was a crucial aspect in research. This study was carried out in form of a case study. A comparative case assessment of sampled NGOs was conducted. Brynard and Hanekom (2006) described the term case study as referring to a limited number of units of analysis such as institutions, groups and individuals that were being studied intensely. Hendrickse (2008:143) stated that as far as case studies were concerned, the aspects being studied deserved special mention: "Firstly, the case should be defined or demarcated. Secondly, whichever technique is used to collect data, the concern is not merely to describe what is being observed, but to search in an inductive fashion for recurring patterns and consistent regularities. Thirdly, triangulation is frequently used to discern patterns". Case studies

were based on a representative sample from the population of mainly USAID/Namibia funded partner organisations. Babbie (2013:135) defined a study population as the “aggregation of elements from which the sample is selected”. The targeted population consisted of seven NGOs which were: Catholic Aids Action; Church Alliance for Orphans; Katutura Youth Enterprise Centre; Nawalife Trust; Project hope; Society for family health and Lifeline/Childline. These NGOs have been benefiting from PEPFAR funding during the period studied (2007-2013) and are all involved in the delivery of the HIV/Aids related services.

### **4.3 SAMPLING TECHNIQUE AND SIZE**

A sample is defined by Mouton (1996:132) as elements, which are selected with the aim of finding out something about the overall population from which the elements were chosen. Since this study covered the entire population of seven NGOs, no sampling technique was needed. The sample was based on the researcher’s knowledge of the population and its elements as well as the purpose of the study (Babbie, 2013:135). In addition, the population size is relatively small and the researcher is familiar with all seven NGOs.

### **4.4 DATA COLLECTION AND INSTRUMENTS**

The study used both primary and secondary data. Primary data were collected by means of one-on-one interviews based on a questionnaire that was prepared in advance. According to Clarke (2005), primary data referred to first-hand information that was obtained through observation and investigation. In using a qualitative method, different types of interviews exist that range from semi-structured to less structured and very detailed. The interviews for this study were based on semi-structured questions to enable the researcher to capture all issues relating to the two main research questions.

A questionnaire was shared in advance with selected candidates (chief of parties and finance managers) who participated in the interview to provide answers based on their expertise and their technical areas. Brynard and Hanekom (2006:40) emphasised that interviews enabled the researcher to clarify his/her questions to the interviewees to ensure that they were clear on what was being asked, and also to allow the researcher to probe further following the respondent’s answer. The interviews for this study were conducted at the premises of the NGOs, which was necessary to ensure the interviewer’s direct participation and observation of the phenomenon being studied, as well as to guarantee that the data collected were descriptive, accurate, valid and relevant. Patton and Cochran (2002) stated that data collected through observation was useful in identifying and overcoming discrepancies between what people said and what they actually did, and it could assist in uncovering behaviour only known by the interviewees themselves. Although all seven NGOs in the population were involved in the delivery of HIV/Aids services, their sizes, mandates, missions as well as budgets were different and thus the researcher obtained different

views from the interviews. Valuable data were also obtained from the Technical and Programme Officers at USAID. The two key ethical issues, i.e. consent and confidentiality as highlighted in code of ethics for Stellenbosch University , were taken into account throughout the research assignment.

Besides the primary data collection approach, this study in part also relied on secondary information that included, amongst others, studies done in the area of NGO sustainability, national document policies and media reports.

#### **4.5 DATA ANALYSIS TECHNIQUES**

Different ways of analysing data after collection include thematic, descriptive or more in-depth methods (Patton & Cochran 2002:23). In order to answer the research questions and examine the effects of reduced donor funding on the continuity of the NGOs, the research employed a descriptive analysis technique as used by Hendrickse (2008) in the analysis of the governance and financial sustainability of NGOs in South Africa. Descriptive analysis intends to analyse the participants' own spoken or written words pertaining to their experience or perception of the phenomenon, taking into consideration that "All inquiry entails description, and all description entails interpretation" (Sandelowski, 2000:335). Hendrickse emphasised that qualitative descriptive studies gave a comprehensive summary of events in the everyday terms of those events. Therefore, in this study, simple descriptive statistics in the form of tables, graphs and/or pie charts were used to interpret the data from the various NGOs. With descriptive statistics, the researcher is simply describing what the data shows in terms of trends, patterns and perceptions, which is what this study tried to address (Trochim, 2002).

#### **4.5 CONCLUSION**

This chapter gave a brief summary of the methodology and the techniques applied in analysing the data on the sustainability of USG aid-funded NGOs in the Namibian health sector.

The next chapter presents and discusses the results and findings of the study

## **CHAPTER 5**

### **INTERPRETATION OF THE RESULTS AND FINDINGS: AN ASSESSMENT OF SELECTED NGO CASE STUDIES IN NAMIBIA**

#### **5.1 INTRODUCTION**

This chapter presents the research findings and provides answers to the research questions by interpreting them in a language that readers are able to understand. A descriptive analysis of multiple-case studies for all seven NGOs is given below.

#### **5.2 DESCRIPTIVE ANALYSIS**

The NGOs selected for this study were the Catholic Aids Action (CAA), Church Alliance for Orphans (CAFO), Katutura Youth Enterprise Centre (KAYEC) Trust, NawaLife Trust (NLT), Project HOPE, Society for Family Health (SFH) and LifeLine/ChildLine (LL/CL). This subsection analyses the results obtained through interviews and questions for all seven NGOs. The results for each NGO were analysed separately, first by looking at the operations and staffing of the organisations; the considering the funding arrangements for activities and sources of income, and, lastly, the organisational sustainability of the NGOs.

##### **5.2.1 Catholic Aids Action (CAA)**

###### ***5.2.1.1 Operations and staffing***

The national CAA office based in Windhoek provides supervision and support to 14 field offices situated in nine of Namibia's political regions. President Archbishop Laborious Nashenda leads the Board of Trustees, which governs CAA. Catholic Aids Action has more than 104 staff members who provide supervision, training and support to approximately 2 400 community volunteers who, in turn, provide home-based care to individuals living with HIV/Aids, as well as support to OVC in their home communities (CAA, 2006). Table 5.1 below presents the staffing pattern of CAA during the period under study. Voluntary counselling and testing provided by CAA reaches approximately 7 000 individuals each year. CAA provides home-based care to 7 500 individuals, while care, support and comprehensive prevention is provided to 12 000 orphans and vulnerable children (CAA, 2006).

**Table 5.1: CAA's staffing pattern for the period 2007-2013**

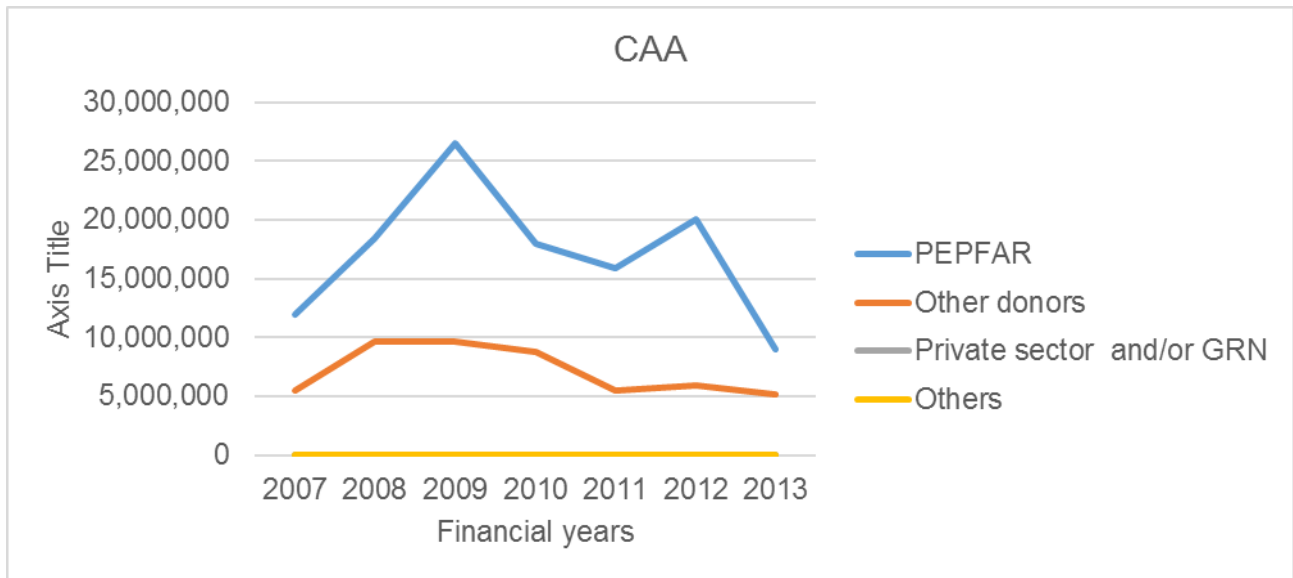
	<b># of PEPFAR funded positions</b>	<b>Positions funded with other fund sources</b>	<b>Total</b>
2007	0	0	0
2008	0	0	0
2009	0	0	0
2010	78	20	98
2011	82	9	91
2012	86	6	92
2013	49	14	63

As evident from the above table, the majority of CAA's positions are funded from PEPFAR and a significant decline in staffing is noted as years went by. The organisation has not experienced any capacity deterioration due to more focus on PEPFAR, as employees work as a team and are committed to the organisation as a whole. In 2013, however, the organisation retrenched all 63 employees due to there being no funding after the direct funding from USAID had ceased, and only backer-employed 41 employees after new funding was secured.

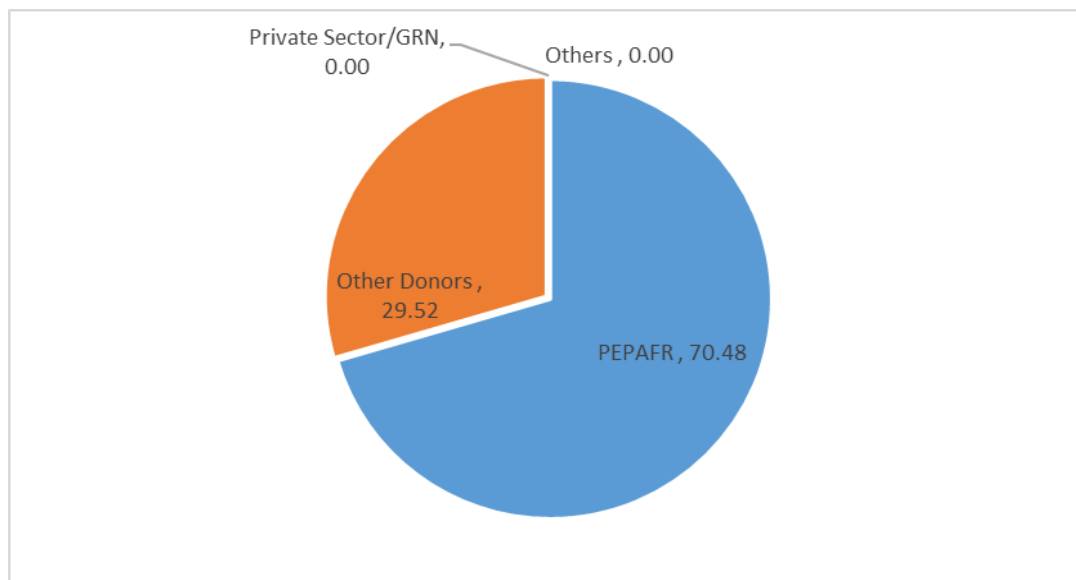
#### **5.2.1.2 Funding arrangements for activities and sources of income**

CAA has been a beneficiary of USG aid funds since 2003, when it started as a sub partner under Family Health International, Pact, and Intrahealth and thereafter graduated to being a prime recipient of USAID/PEPFAR funds.

Besides USG PEPFAR funds, CAA receives contributions from other donors, i.e. the Global Fund, European Union, Stephen Lewis Foundation, German philanthropists and from local donors. Figure 5.1 below analyses CAA's funding stream, while Figure 5.2 shows the ratio of PEPFAR funds as a percentage of total revenue during the 2007-2013 period. It is evident that CAA received the majority of its funds from PEPFAR, and in the year 2013, CAA has experienced a huge reduction in PEPFAR funding when direct funding from USAID stopped. Funds from other donors also declined significantly as can be seen from the graph. To date, CAA still receives PEPFAR funds as a subrecipient of other NGOs such as NawaLife, but that too is expected to end in the near future.



**Figure 5.1: CAA's funding stream and sources for the period 2007-2013**



**Figure 5.2: percentage of PEPFAR funds over total revenue for CAA for the period 2007-2013**

### **5.2.1.3 Organisational sustainability**

CAA does not receive any funds from the private sector or GRN, but the organisation intends to explore these options in the near future as strategies to ensure organisational sustainability. The decline in PEPFAR funding is experienced mainly as a shift in focus (more treatment as prevention than general prevention programmes). Secondly, with Namibia having made strides in development over the years, PEPFAR and other donor priorities have changed, thus the political regions of the country where CAA is implementing programmes may become non-priority areas.



CAA fears that the continuous decline in funding may lead to less focus on HIV prevention programmes (such as voluntary testing and counselling), and more focus on HIV/Aids treatment as prevention. Under this new focus of PEPFAR, there is a potential of reversal of the health gains obtained over the years, if behaviour change is less emphasised. Continuity of the CAA and other NGOs is also at risk as they rely heavily on donor funding.

## **5.2.2 Church Alliance for Orphans (CAFO)**

### **5.2.2.1 Operations and staffing**

Through its culture of volunteerism, national reach and expertise on psycho-social support, CAFO, is present in all regions of the country in 68 towns and villages to empower and support community projects through small grants. Table 5.2 below outlines the staffing pattern of CAFO for the period 2007-2013. CAFO's national office is situated in Windhoek, and the organisation managed to reach more than 8 000 OVC via the Regional Support Offices and their key volunteers (NPI, 2012).

**Table 5.2: CAFO Staffing for the period 2007-2013**

<b>Financial years</b>	<b># of PEPFAR funded positions</b>	<b>Positions funded with other sources</b>	<b>Total</b>
2007	Not available	Not available	
2008	Not available	Not available	
2009	Not available	Not available	
2010	20	3	23
2011	20	1	21
2012	19	0	19
2013	18	0	18

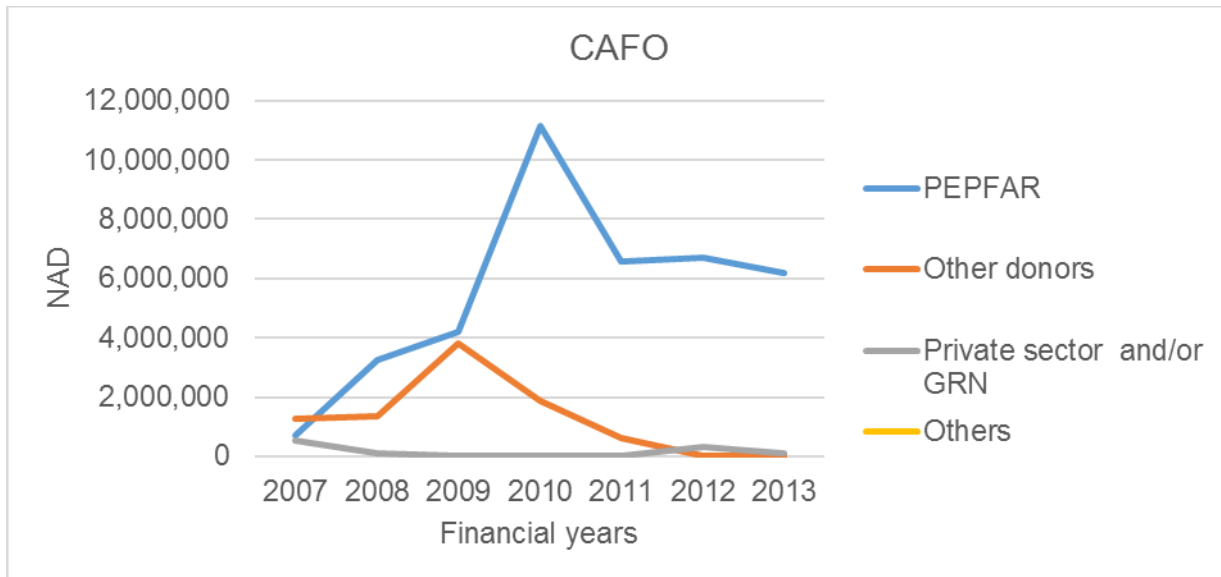
The above table indicates a decline in the workforce both for positions funded under PEPFAR and those funded from other sources. Due to the reduction in funding, CAFO had to restructure its activities in 2013. As employees got too comfortable with the availability of PEPFAR resources, the decline in overall donor funding compelled the organisation to phase out two positions considered being no longer essential in 2013.

### **5.2.2.2 Funding arrangements for activities and sources of income**

CAFO has received funding from USAID since 2004, initially as a subgrantee under Family Health International (FHI), and later directly from USAID/PEPFAR, intended to support OVC through: 1) Early Childhood Development (ECD) Centres targeting children aged 1-9 years; 2) Social Behaviour Change Communication (SBCC) for the age group 10-14; and 3) Advocate for the rights of children.

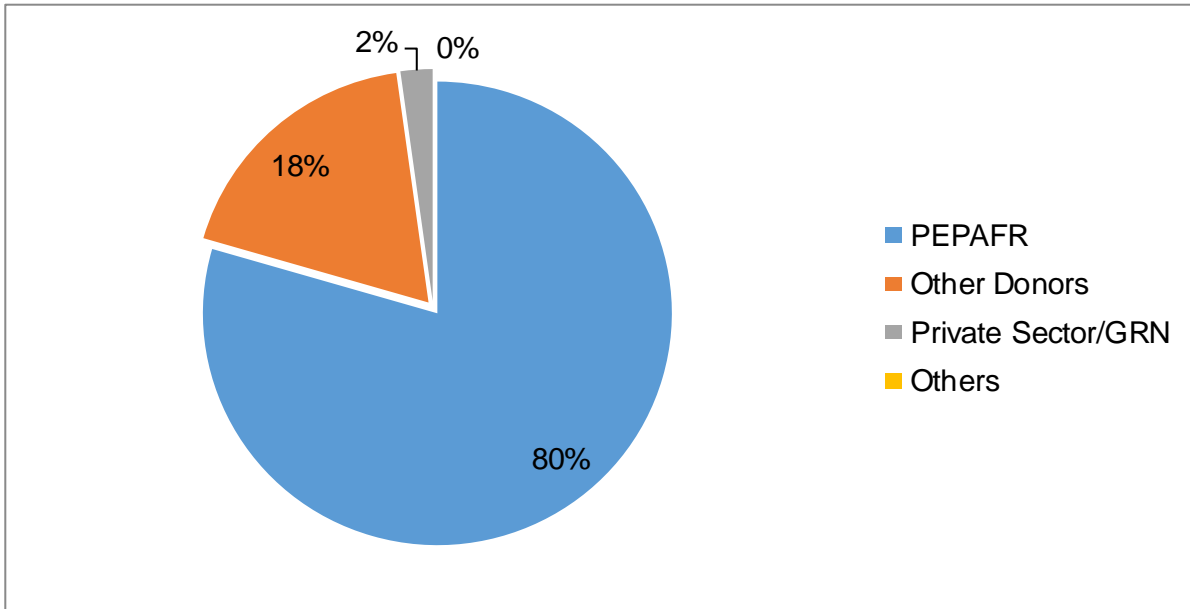
Besides USAID funds, CAFO received funds from other foreign donors that included the New Zealand Agency for Development, Stephan Lewes Foundation, Global Fund, UNICEF, FHI, PACT

and Elma Foundation. These funds were intended to mostly support CAFO committees in the regions that, in turn, supported smaller organisations to meet the needs of vulnerable children. Funds from Elma Foundation were received by CAFO in 2014 mainly for drought relief to provide OVC with food. Since 2013, CAFO also received funding from the Foundation of Luxembourg to support ECD centres. Figure 5.3 below gives a more clear indication of CAFO's revenue streams and sources during the period under study (2007-2013).



**Figure 5.3: Revenue stream and sources for CAFO during the period 2007-2013**

PEPFAR's contribution toward CAFO's revenue started low compared to other donors, but it continued to increase and reached a peak in 2010. However, shortly after, a reduction was experienced in both PEPFAR and other donor funding from 2011 onwards. Although CAFO received contributions from the private sector and/or government, contributing two per cent of the total revenue, these funds stopped from 2009-2011, then slightly picking up again in 2012 and 2013. Nevertheless, PEPFAR resources remained the main source of financing for CAFO's activities, making up 80 per cent of CAFO's total revenue as shown in Figure 5.4 below. Other donors contributed 18 per cent towards CAFO's income.



**Figure 5.4: Percentage of PEPFAR funds over total revenue for CAFO during the period 2007-2013**

### **5.2.2.3 Organisational sustainability**

Although the research focused on the 2007-2013 period, it was noted at the time of the study that USAID/PEPFAR funding to CAFO targeted for the early childhood development of OVC had ended in June 2015. According to The Namibian (2015), the closure of the programme came after it was realised that CAFO had reached the project goal with more than 30 000 OVC at the existing 3 000 ECD centres having benefited from the funds. Additionally, it was reported that the project goal of strengthening CAFO as an organisation, raise its public profile and diversify its funding had been achieved. The study, however, established that CAFO would like to continue with the programmes for the SBCC groups. Although CAFO managed to continue operating with other donor funding, the study determined that in order to ensure sustainability, CAFO was in the process of reviewing its core businesses so that it could focus more on issues of need and poverty reduction instead of HIV services. The study further found that CAFO had embarked on income generating projects with some of their ECD centres. Furthermore, there is a potential for the organisation to sell its expertise to the GRN and other stakeholders, but it would need an increase in staffing. Through its efforts to seek alternative financing to ensure continuity, the organisation was at risk of being distracted from its vision.

## **5.2.3 Katutura Youth Enterprise Centre (KAYEC)**

### **5.2.3.1 Operations and staffing pattern**

KAYEC's target area is countrywide, and it has one vocational training centre in the northern part of the country (Ondangwa area) and two in Windhoek. Its structure comprises of the Board of Trustees, Director and the management (KAYEC, 2015). Apart from the vocational training

centres, KAYEC has satellite offices in Rehoboth, Otjiwarongo, Rundu, Kalkrand and Outjo. KAYEC employs 50 staff on a full-time basis, as well as a number of non-paid community volunteers who assist with the activities. Table 5.3 below displays KAYEC's staffing pattern during the study period.

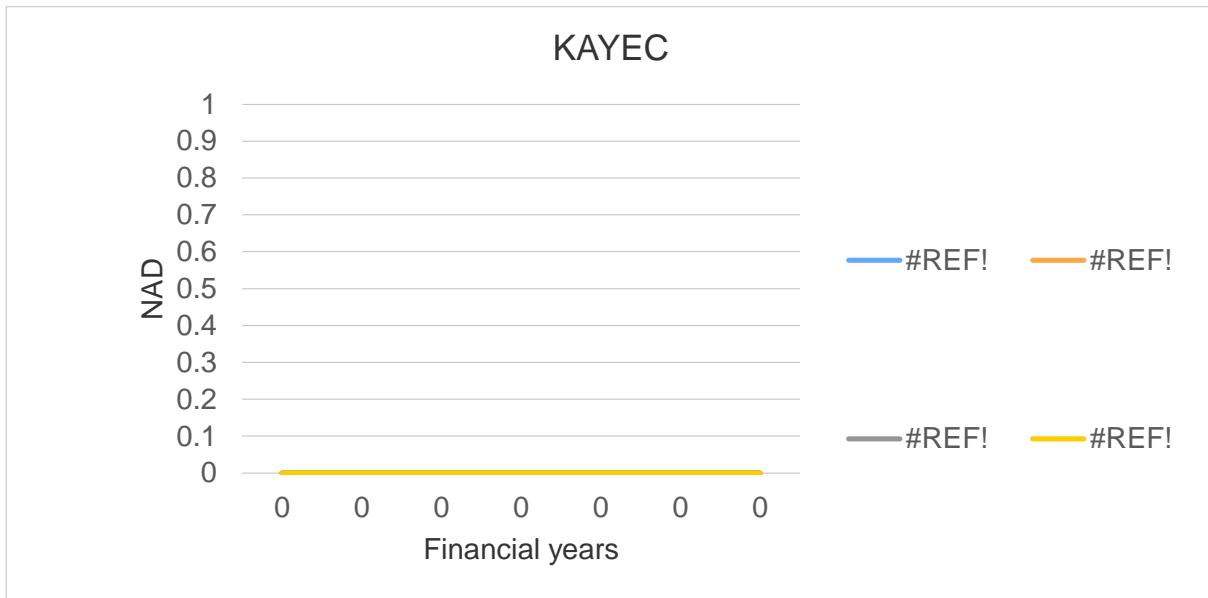
**Table 5.3 KAYEC's staffing pattern for the period 2007-2013**

	<b># of PEPFAR funded positions</b>	<b>Positions funded with other fund sources</b>	<b>Total</b>
2007	Not available	Not available	0
2008	Not available	Not available	0
2009	50	0	50
2010	50	0	50
2011	50	0	50
2012	50	10	60
2013	50	12	62

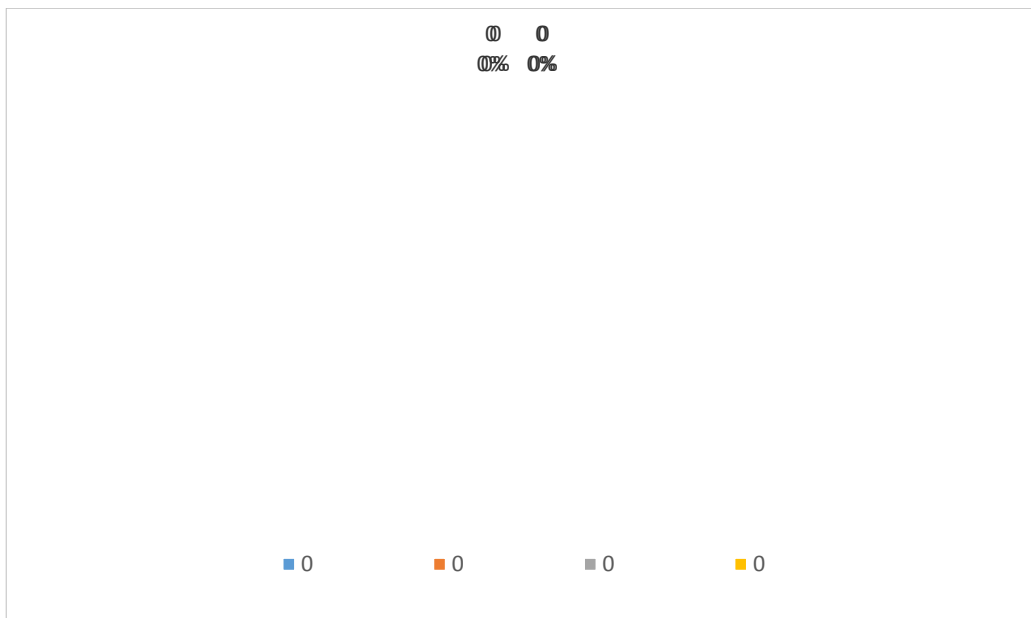
The picture shown in the above table indicates that the majority of KAYEC's staffing positions are funded with PEPFAR resources, and the pattern remained quite constant, with positions funded from other resources slightly increased in 2013. There were no retrenchments or staff lay-offs at KAYEC for the study period, and no capacity deterioration was noted due to an increased focus on PEPFAR activities. In order to ensure adequate provision of the services that include educational support and care to over 800 OVC, maintain school retention and increase school performance, it was imperative for KAYEC to maintain consistency in staffing.

### **5.2.3.2 Funding arrangement for activities and sources of income**

KAYEC has been a recipient of USAID PEPFAR funds since 2006, and through their agreement with USAID, KAYEC's goal is to increase the capacity of vulnerable youth to complete their education and enable out of school youth to gain marketable skills in applicable industry trades. Since 2011, KAYEC has trained 4 208 youth, and HIV prevention packages have been mainstreamed in all courses. KAYEC's after school centres have 1 239 active participants, 58 per cent of which are female (Prada, 2015). Figure 5.5 below gives an analysis of KAYEC's financing during the period 2007-2013. PEPFAR funds make up 89 per cent of KAYEC's total revenue as reflected in Figure 5.6 below. No reduction in funding was noted during the period of the study. the sharp increase in PEPFAR funding to KAYEC was to ensure the full implementation of the Self-development and Skills for Vulnerable Youth Programme during the agreement period 2011-2015.



**Figure 5.5: KAYEC's financing stream during the period 2007-2013**



**Figure 5.6: Percentage of PEPFAR contribution over total revenue for KAYEC during the period 2007-2013**

Apart from PEPFAR, KAYEC's vocational training activities also received four per cent funding from other donors, including the Evangelischer Entwicklungsdienst (EED), and seven per cent from the GRN.

### **5.2.3.3 Organisational sustainability**

Even though KAYEC did not experience any reduction in funding during the study period (2007-2013), it was noted at the time of the study that KAYEC's agreement with USAID would end in August 2015 and that due to the change in PEPFAR focus and prioritisation, the funding would stop. Reduced or no PEPFAR funding would have a negative impact on KAYEC's ability to deliver its key services to the communities. The in-school youth programme would be the most affected and the organisation's concern is that some of the in-school youth may start to drop out of school and that others might fail their examinations. This situation may hinder the academic progress of the youth.

Vocational training activities for out-of-school youth would be the least affected, as KAYEC has successfully transitioned such activities to the Namibian government for funding under the National Training Authority (NTA). Furthermore, KAYEC indicated at the time of the study that negotiations were underway with GRN to transition after-school centres. The organisation has also created a business wing to enable its mobilisation for the generation of self-financing funds. Notwithstanding the above arrangements, continuity of the organisation itself remains uncertain, as the Namibian government may not necessarily fund the operations and self-generated funds may be slow, which poses the risk of staff lay-offs. Moreover, KAYEC has tailor-made programmes to meet the needs of the targeted vulnerable groups of youth. The organisation's fear is that out-of-school youth may not be able to find subsidised, low-entry requirements vocational training that would meet their needs.

## **5.2.4 NawaLife Trust (NLT)**

### **5.2.4.1 Operations and staffing**

NawaLife has an office in Windhoek, but its communications campaigns, which is mainly through media, run nationally. The organisation started with 27 staff members as reflected in Table 5.4 below, and operates under a local Board of Directors, using community volunteers organised in groups called Community Action Forums (CAFs) to create a demand for HIV services. CAF uses community oriented and interpersonal communication approaches. The well-known NawaCinema is a platform where participatory discussions on issues relating to HIV/Aids, care and treatment take place in a comfortable and entertaining way.

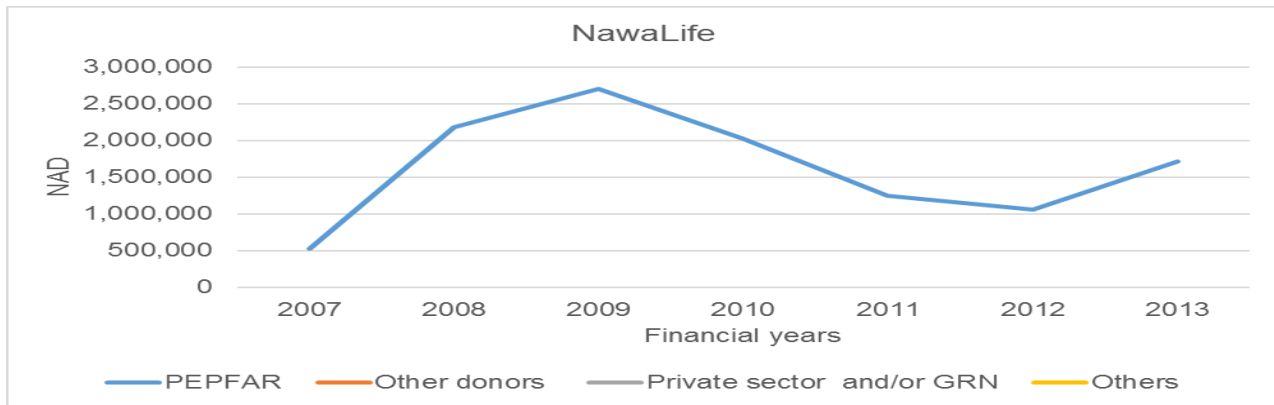
**Table 5.4: NawaLife's staffing pattern for the period 2007-2013**

	<b># of PEPFAR funded positions</b>	<b>Positions funded with other sources</b>	<b>Total</b>
2007	27	0	27
2008	27	0	27
2009	27	0	27
2010	27	0	27
2011	23	0	23
2012	10	0	10
2013	12	0	12

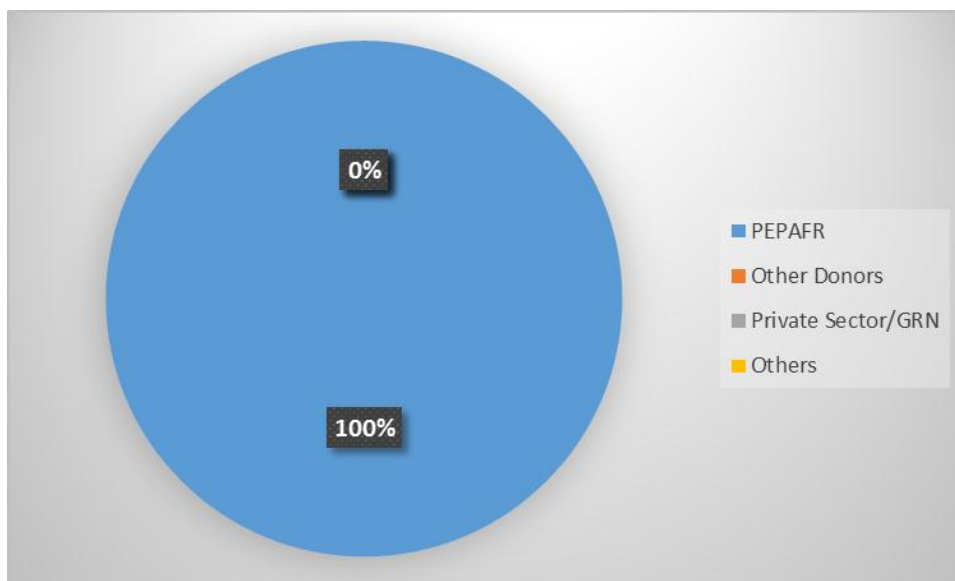
NawaLife fully funds its staffing positions with PEPFAR resources as indicated in Table 5.4 above. Since the organisation only deals with PEPFAR related activities, no issues of capacity deterioration occurred whereby PEPFAR funded employees became more focused on PEPFAR activities, with the result that they had difficulty in responding to other systems. However, due to a decrease in PEPFAR funding that started in 2010 as illustrated in Figure 5.7 below, the situation prompted NLT to reduce its work force in 2011 and temporarily close its operations.

#### **5.2.4.2 Funding arrangements for activities and source of financing**

Figure 5.7 below illustrates that PEPFAR resources make up 100 per cent of NawaLife's trust resources and USAID has been the only donor for NawaLife projects since its inception. In 2012, USAID approved funding for the Prevention Alliance Project (PAN), which is managed by NawaLife, as a prime recipient together with its sub-awardee partners of CAA, LL/CL, SFH, Pharmam Access (PA), and Positive Vibes (PV). PAN focuses on strengthening HIV prevention for the general population of Namibia through partnership, capitalisation of previous investments to increase scale and efficiency, and working toward greater quality and sustainability as well as integration with national responses. PAN's programme vision is to provide a unified voice to enhance resource mobilisation and sharing, programme harmonisation as a means to foster country ownership, sustainability and growing quality, local, cost effective and HIV prevention programming.



**Figure 5.7: Funding stream for NawaLife Trust during the period 2007-2013**



**Figure 5.8: Percentage of PEPFAR contributions over total revenue for NawaLife Trust during the period 2007-2013**

NawaLife experienced a significant reduction in PEPFAR funding in 2011 when its first direct award omf USAID ended. The revenue picked up again in 2012 when USAID approved funding for the PAN project. Figure 5.7 above clearly illustrates that funding received by NawaLife for the PAN project was not of the same size as the previous award.

#### **5.2.4.3 Organisational sustainability**

With PEPFAR being the only source of revenue for NawaLife, the organisation's continuity as well as the sustainability of its programmes are at great risk. The PAN project is expected to end in January 2016 and PEPFAR funding to the organisation will cease. This may lead to another phase of staff retrenchment and a subsequent closure of operations. NawaLife deals with the general population in communities, including those in very remote areas of the country. Hence, the



organisation has specialised intervention packages and expertise on reaching the targeted groups in such communities, but without funding, the organisation cannot fulfil its mandate and the sustainability of the health gains achieved over the years through its tailor-made programmes are at risk. Although commercialising the services could serve as an alternative source of financing, the majority of the targeted population are unemployed and have no income to pay for the services. Another alternative of financing that the organisation considered was to seek funding from the private sector; however, the nature of NawaLife's activities can hardly attract the for-profit sector as no return may be derived on their investments. The organisation is nevertheless thinking of considering other possible areas of business in other sectors of economy besides health.

## 5.2.5 Project HOPE

### 5.2.5.1 Operations, funding arrangements and sources of income

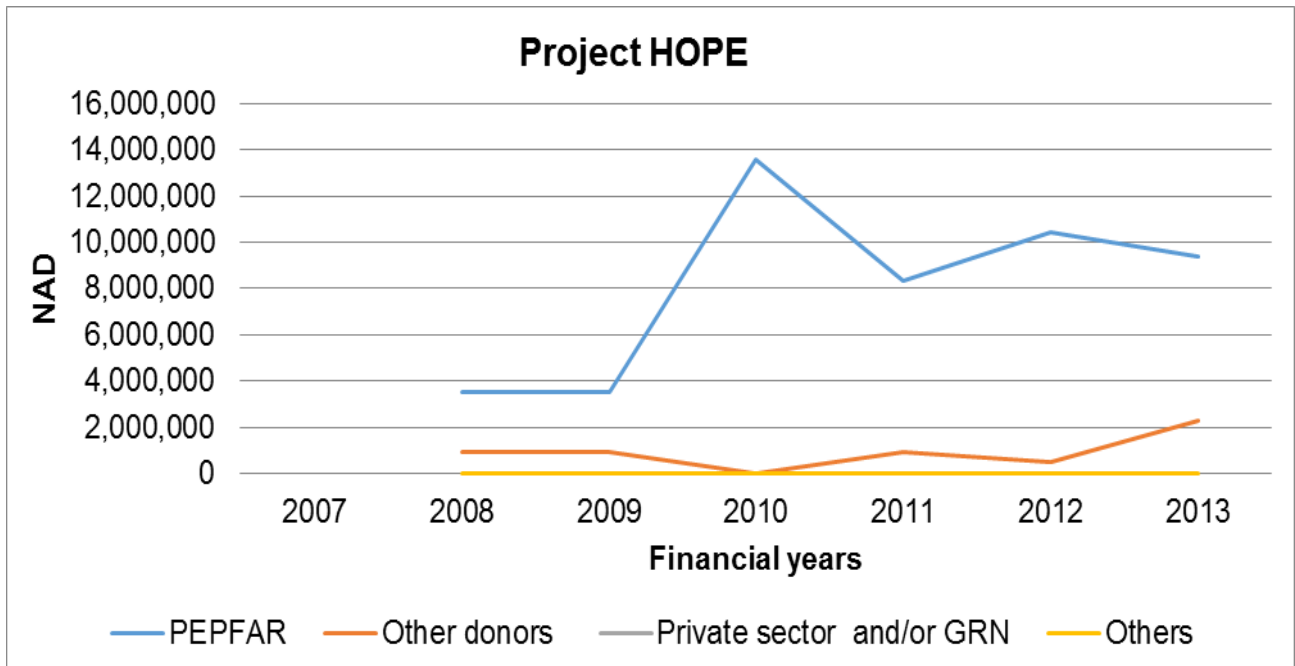
In 2013, Project HOPE Namibia signed an agreement with USAID to fund the Namibia Adherence and Retention Programme (NARP). The project has presence in priority regions of the country, namely Erongo, Hardap, Kavango East, Kavango West, Kunene, Ohangwena and Zambezi. Table 5.5 below reflects the staffing pattern of Project Hope. The purpose of the NARP project is to reduce the impact, transmission and spread of HIV/Aids through a comprehensive, integrated community-based response that provides a range of care and support interventions to vulnerable groups, including those that are hard to reach living with or affected by HIV. Previously, Project HOPE's activities only received funding from USAID; however, the NARP project is co-funded by the Global Fund. The latter is shown in Figure 5.9 below, while Figure 5.10 indicates the proportion of PEPFAR funds as a percentage of total revenue for Project HOPE.

**Table 5.5; Project HOPE'S staffing pattern for the period 2007-2013**

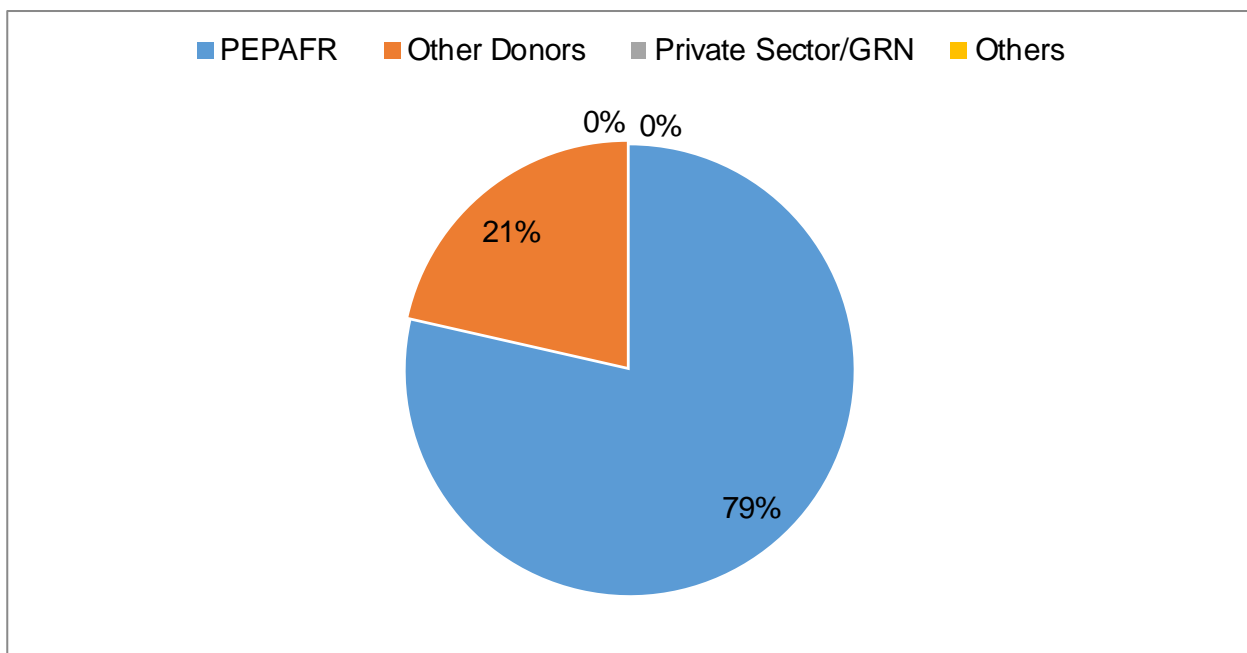
	<b># of PEPFAR funded positions</b>	<b>Positions funded with other sources</b>	<b>Total</b>
2007	Not applicable	Not applicable	
2008	60	63	123
2009	72	63	135
2010	101	0	101
2011	99	0	99
2012	37	63	100
2013	40	61	101

The above table shows that PEPFAR resources contributes the most to the staffing of Project HOPE. In 2010 and 2011, all positions were funded out of PEPFAR. A drastic reduction in the workforce was experienced in 2012 after approximately 30 employees were retrenched. This was associated with the reduction in funding that started in 2011 as can be seen in Figure 5.9. Notwithstanding the reduction in the workforce, the organisation did not experience any issues of

capacity deterioration. The organisation, however, indicated at the time of the study that seven more positions might be phased out by the 30 August 2015 when its OVC/TB programmes ends.



**Figure 5.9: Funding stream for Project HOPE for the period 2007-2013**



**Figure 5.10: Percentage of PEPFAR contribution over total revenue for Project HOPE during the period 2007-2013**

Although PEPFAR funds picked up slightly after funding for the NARP project was approved as shown in Figure 5.9 above, a slight decline was noted again shortly thereafter. Funding from other donors (mainly the Global Fund), which only represents 21 per cent of the total revenue, also reduced in 2012 and then increased slightly in 2013. Project HOPE receives no funding from the private sector or the GRN.

#### **5.2.5.2 Organisational sustainability**

With the continuous reduction in PEPFAR resources, Project HOPE Namibia fears that programmes that complements the efforts of the GRN to fight the HIV/Aids pandemic in the country may be negatively affected. Secondly, the continuity of the operations of the organisation in Namibia is uncertain with reduced or no PEPFAR funding. The organisation has started discussions with both the private and public sectors to seek alternative source of financing and avoid disruption in operation and programmes. However, there is no guarantee that funding will be obtained.

#### **5.2.6 Society for Family Health (SFH)**

##### **5.2.6.1 Operations and staffing**

The activities of the KPs programme target both male and female sex workers and their clients as well as MSM. Beneficiaries of the KPs programmes include individuals, groups of 25 persons or less, and larger groups of more than 25 participants. The aim of the strategies adopted by the KPs programme is to increase the motivation among the beneficiaries to adopt safer sexual practices and health seeking behaviours. The HIV prevention activities of the MAPP focus on developing the capacity of the NDF through the Ministry of Defence (MoD) in order to take full responsibility for implementing the MAPP. To achieve this goal, SFH has trained various personnel, including chaplains, unit coordinators, gender focal persons and peer educators. Together with the Ministry of Defence, SFH has developed steering committees at base levels to guide and monitor the implementation of the MAPP HIV activities. MAPP SFH implements its programmes in all 13 regions of the country and has regional offices in the Erongo, Kavango East, Khomas, Omusati, Ohangwena, Oshana, Otjozondjupa, Zambezi, and //Karas regions (SFH, 2014).

Table 5.6 below gives an overview of the staffing pattern of SFH during the period 2007-2013. The pattern shows that SFH does not solely depend on PEPFAR to fund its positions. A much more balanced picture can be seen as compared to other organisations. SFH did not retrench any staff during the study period, and no issues of capacity deterioration were noted in other areas due to more focus on PEPFAR, as staff members are committed to the entire organisation as a whole.

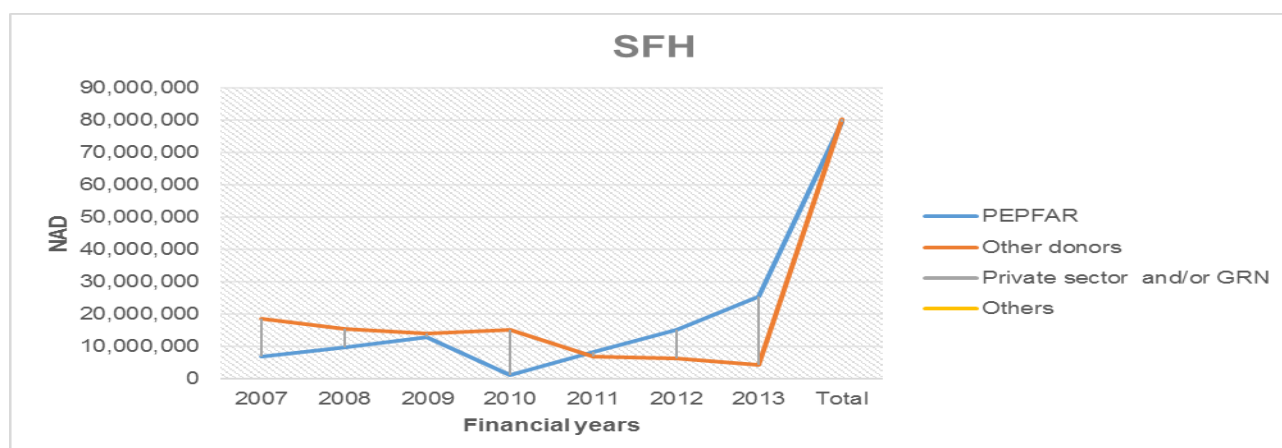
**Table 5.6: Staffing pattern for SFH for the period 2007-2013**

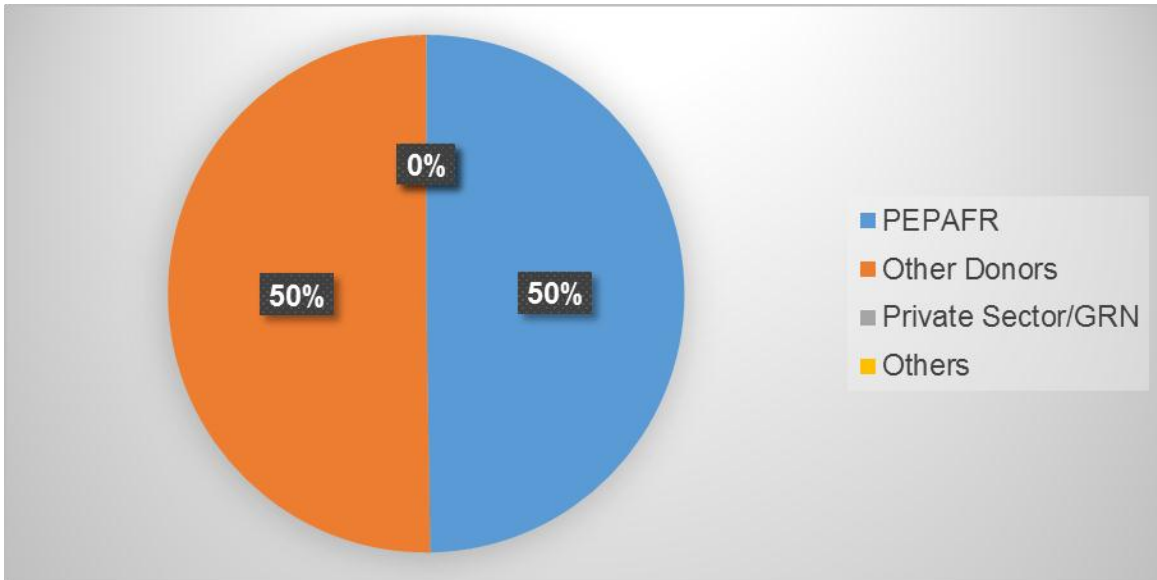
	# of PEPFAR funded positions	Positions funded with other fund sources	Total
2007	16	8	24
2008	14	14	28
2009	18	19	37
2010	7	27	34
2011	19	19	38
2012	25	11	36
2013	23	12	35

### 5.2.6.2 Funding arrangements for activities and source of financing

SFH became a direct recipient of PEPFAR funds from USAID since 2011. However, in previous years SFH received USAID/PEPFAR funding as a subrecipient of PSI and the International Centre for the Rights of Women. SFH's MAPP programme also received funding from the USG Department of State.

Included in the list of other donors that provide funding to SFH are the Global Fund and UNICEF. The Global Fund provides funding for HIV and malaria prevention among KPs, while UNICE and Synergos provide financing for the WASH project. The Millennium Challenge Account (MCA) Namibia also provided funding for the WASH project until the expiry of the agreement in September 2014. Figure 5.11 below demonstrates a balanced picture of donor resources at SFH, and Figure 5.12 below makes it evident that PEPFAR resources only contribute 50 per cent toward SFH's revenue, while other donors makes up the other 50 per cent. SFH does not receive any funding from the private sector and/or government and there are no any other resources at this stage.

**Figure 5.11: Funding stream and sources for SFH for the period 2007-2013**



**Figure 5.12: Percentage of PEPFAR contribution over total revenue for SFH during the period 2007-2013**

### **5.2.6.3 Organisational sustainability**

SFH has not yet faced any drastic reduction in PEPFAR funding during the study period. This is mainly because SFH's interventions are tailor made mainly for the KPS that may not necessarily be catered for under the MoHSS's funding. SFH, however, is concerned that with PEPFAR's change in focus and priority, a reduction in donor funding may be experienced in the near future, which will have a negative impact on the programmes for the KPs and continuity of the organisation at large. To ensure continuity, SFH has started to apply for government tenders as a form of fundraising and discussions is in progress with other donors such as UNICEF for future funding.

### **5.2.7 Lifeline/ChildLine**

#### **5.2.7.1 Operation and staffing arrangements**

LifeLine/ChildLine's head office is in Windhoek, but there are satellite offices in Ondangwa, Oshikango, Rehoboth and Rundu. In 2008/2009, LL/CL served 3 446 OVC in Khomas, Kavango, Oshana, Oshikoto, Ohangwena, Omusati and Hardap. The organisation has a strong and experienced Board of Directors and a staffing component that includes volunteers, a cohort of technical experts in the areas of child welfare and child development, and more than 200 active community-based councillors and facilitators (LL/CL, 2015). Table 5.7 below reflects the staffing pattern of LL/LC during the period 2007-2013. It is clear that only a very few positions are funded with other resources and that the majority of positions are PEPFAR funded. No major reduction in staffing occurred at LL/CL during the study period that could be associated with a reduction in funding. The organisation also did not note any capacity deterioration per se, but since most

employees are focused on PEPFAR related activities, there is no time left for them to focus on other activities such as fundraising mechanisms.

**Table 5.7: Staffing pattern of LL/LC during the period 2007-2013**

	<b># of PEPFAR funded positions</b>	<b>Positions funded with other sources</b>	<b>Total</b>
2007	37	9	
2008	52	10	<b>62</b>
2009	66	2	<b>68</b>
2010	75	1	<b>76</b>
2011	67	2	<b>69</b>
2012	68	3	<b>71</b>
2013	60	7	<b>67</b>

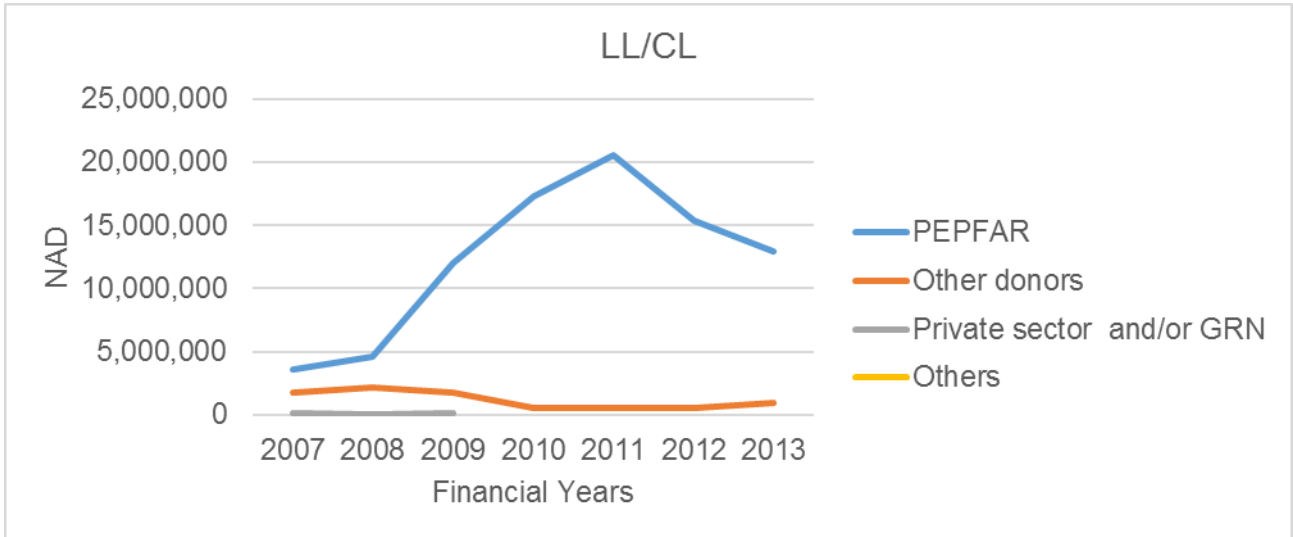
### **5.2.7.2 Funding arrangements for activities and source of financing**

For the period 2008-2013, LL/CL received USAID/PEPFAR funds as a subrecipient under Intrahealth to address: a) social and behaviour change for adults and children; b) counselling and counselling training that included children counselling and parenting training; and c) voluntary counselling and testing for HIV ChildLine Radio Uitani that received co-funding from UNICEF. The social behaviour change programme received co-funds from Brot für die Welt. LL/CL also received USAID funds under a subaward with PACT cofunded by UNICEF for the period 2009-2012, which was for the Child Protection Programme that included Child Helpline (116), referral, care planning, counselling victims and child protection committees in schools as well as parenting programmes. Further USAID funds to LL/CL were received through their subaward with Engender Health signed in 2011 to address a male engagement gender programme that encompassed advocacy, technical assistance and training.

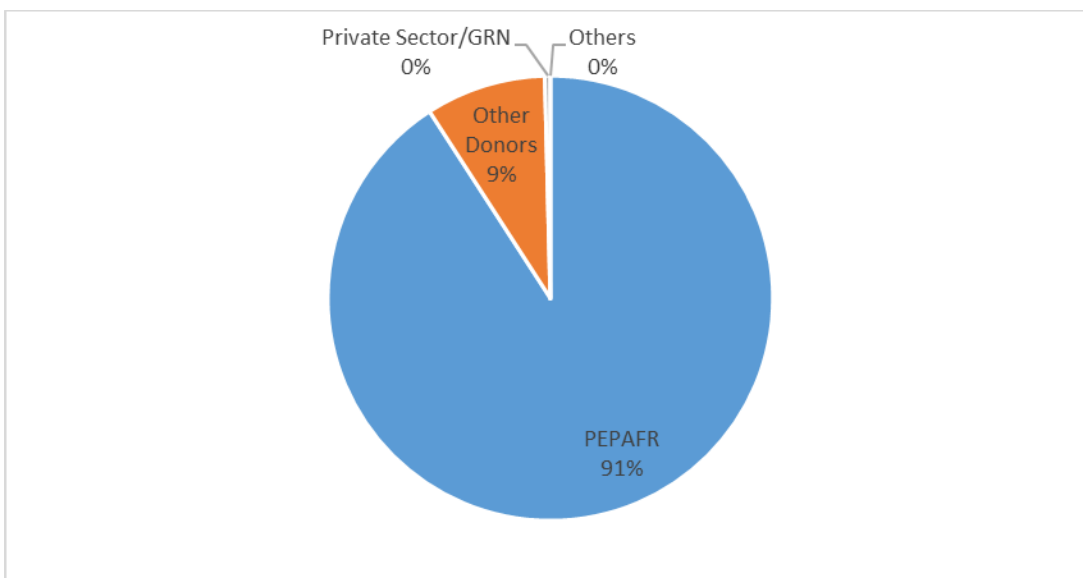
Currently, LifeLine/ChildLine receives direct funding from USAID for the Strengthening HIV/Aids Responses in Prevention and Protection (SHARP) award, which contributes much of the organisation's core funding. Under this award, LL/LC focuses on six key programme areas: 1) HIV/Aids testing and counselling; 2) Sexual prevention; 3) Family Strengthening and Child Protection (HKID); 4) Gender, which mainly looks at improving awareness of gender based violence (GBV), building capacity to respond to and prevent GBV, and increasing access to quality services for individuals affected by GBV; 5) Care and support; and 6) Organisational sustainability. Moreover, Lifeline/Childline with other CSOs receive USAID funds from NawaLife as a subrecipient under the PAN project, and from Project Hope as a subrecipient under the Namibia NARP project.

Figure 5.13 below explains the funding stream and sources of revenue for LL/CL during the period 2007-2013. Furthermore, Figure 5.14 describes the ratio of PEPFAR funds over LL/CL's total revenue for the period 2007-2013 as compared with other resources. It is apparent that even for

LL/CL, PEPFAR resources contributes the most towards its activities and operations. As of 2010, LL/CL saw a reduction in both PEPFAR and other donor funding, which continued over the years. In 2007 and 2009, LL/CL received a small amount of funding from the GRN and another small amount was received from the Social Security Commission in 2009. However, thereafter only donor funding served as source of revenue for LL/CL.



**Figure 5.13: Funding stream and sources for LL/CL for the period 2007-2013**



**Figure 5.14: Percentage of PEPFAR contribution over total revenue for LL/CL during the period 2007-2013**

#### **5.2.7.4 Organisational sustainability**

It is apparent that LL/CL relies heavily on PEPFAR funding for survival. Although no major reduction in staffing was experienced during the period of the study, the organisation indicated that in June 2015, it closed its office in the Rehoboth area and two staff members were retrenched.

Furthermore, both the SHARPP and PAN awards are expected to end in September 2015, and 50 staff members are facing retrenchment. Moreover, the entire programme ends in December 2015 and three or more positions may be phased out. Reduced or no PEPFAR funding would negatively affect all HIV prevention, care and support activities rendered by LL/CL unless funding is received from government or other sources.

LL/CL created a business wing to ensure sustainability. In addition, the organisation is trying to reduce its core costs and at the same time seek corporate funding and government funding by embarking on different models and mechanisms. A good example is the “lollipop” campaign sponsored by First National Bank of Namibia. These funding mechanisms have managed to build some reserves, but are not sufficient to ensure the continuity and sustainability of the organisation. With the majority of the staff members having been employed to focus on PEPFAR specific activities, the organisation did not have sufficient resources to invest in more fundraising activities.

### **5.3 CONCLUSION**

This chapter presented and interpreted the results of the research findings of the qualitative research carried out to meet the objectives of the research as outlined in Chapter 1 of this study. It provided a descriptive analysis of the sustainability of the USAID-funded NGOs that are involved in the delivery of the HIV/Aids programmes by positing the theoretical knowledge against empirical evidence.

The researcher reached the following conclusions:

1. With regard to the effect of reduced PEPFAR funding on key programmatic areas, all NGOs expressed similar concerns. Reduced PEPFAR funding, especially due to PEPFAR’s new shift in focus to treatment as prevention, posed a risk of potential reversal of health gains achieved over the years on HIV prevention, care and support programmes (such as testing and counselling) if behaviour did not change. A decline in PEPFAR funds would also have negative implications on NGO operations to deliver key services to the various communities they served. This was mainly due to the fact that most if not all NGOs had tailor-made programmes for specific populations of the communities such as the general populations, KPs and OVCs.
2. With respect to capacity deterioration and retrenchment of personnel, it was found that although most if not all NGOs did not experience any capacity deterioration in other areas of the organisation’s operations due to a stronger focus on PEPFAR activities, some NGOs expressed that PEPFAR activities required full attention from employees leaving no time for employees to focus on other activities such as fund mobilisation. Moreover, 57 per cent (four out of seven) NGOs surveyed laid off staff members at some point during the study period due to the reduction in PEPFAR resources. All NGOs feared that this might happen again in



the near future as PEPFAR funds were expected to cease due to PEPFAR's paradigm shift in focus and prioritisation.

3. In relation to NGOs opting for other lucrative areas of work where it is easier to obtain funding, the study found that the nature of the activities (HIV/Aids prevention, care and treatment) of the NGOs was so specific and specialised that it would make it difficult for NGOs to operate in other sectors. However, 28 per cent (two out of seven) NGOs indicated that they were reviewing their core business to focus on other issues such as poverty reduction and education where funding could be easily obtained rather focusing solely on HIV-related services.
4. With regard to other alternative source of financing that may exist and the ratio of PEPFAR as compared to other source of financing, the study empirically found that on average, PEPFAR resources made up 80 per cent of the total revenue of all seven NGOs surveyed. Only one NGO showed a balanced picture of PEPFAR funding as compared to other donor funding, while six NGOs received between nine per cent to 30 per cent of other donor funding, with the exception of one NGO that solely depended on PEPFAR resources. Three NGOs managed to obtain very negligible amounts of less than seven per cent from either the government or the private sector. The study found that all NGOs were either considering or were in negotiations with the GRN to seek alternative funding through different mechanisms, including outsourcing of services. The majority of the NGOs indicated that they had created business wings as a way of generating own funds, but with limited resources, so far only few reserves had been built such that they were not sufficient to ensure continuity of NGO operations.

## **CHAPTER 6**

### **SUMMARY, CONCLUSION AND RECOMMENDATIONS**

#### **6.1 INTRODUCTION**

The chapter presents a brief summary of the main findings and then concludes the study with recommendations. Section 6.2 gives a summary of the main findings. Section 6.3 outlines the implications of the study globally and in the Namibian context. Section 6.4 gives policy recommendations, while Section 6.5 highlights the limitation of the study. Lastly, Section 6.6 suggests directions for future research.

#### **6.2 SUMMARY OF MAIN FINDINGS**

Namibia's economy is widely seen as well managed and the country has enjoyed stability, peace and democracy since independence. Although the country's health sector was very much fragmented at independence, various transformations have occurred. Amongst others, the MoHSS issued a national policy on community-based health care. The country has also developed a number of hospitals, health clinics and other health care service locations across all 14 regions. The country has a good network of diagnostic laboratories that provide services to both the public and private health care facilities. The government's funding for health has also increased since 2001 after the country signed the Abuja declaration where it committed to spend 15 per cent of the total national spending to health. Despite the progress made, daunting challenges continues to persist in the Republic of Namibia, and the health sector is no exception.

The health sector is faced with staff shortages and the HIV/Aids pandemic has remained one of the most significant challenges, which has been a major drain on the country's national and international resources for health. In 2012, the HIV prevalence was estimated at 18.2 per cent from 22 per cent in 2002. In 2008/09, the HIV/Aids response consumed around 27.5 per cent of the total national health spending. However, Namibia's HIV/Aids response continues to rely heavily on international donor funding and in 2008/09, donors alone contributed 51.1 per cent toward the HIV/Aids financing, 33 per cent of which around was from the USG, mainly PEPFAR. USAID/PEPFAR funding are channelled through various NGOs, and the country's local NGOs that has benefited from PEPFAR funds continue to play a major role in the delivery of the HIV/Aids prevention, care and treatment services. Besides the 5 000 community health care providers trained by the MoHSS, a number of PEPFAR-funded NGOs are heavily involved in the delivery of community-based health care services through their tailor-made programmes.

With Namibia's current economic status of an upper middle-income country, donor funding to the country is declining, and donor priorities and focus have changed. PEPFAR Namibia's new focus is on HIV/Aids treatment as prevention and only certain regions of the country with the highest rates of HIV infections will be prioritised for funding. Priority areas represent 80 per cent of all persons living with HIV, and PEPFAR Namibia plans to work with GRN to support the national goal of 80 per cent ART coverage among all persons living with HIV. Given the decline in PEPFAR funding, the new shift in focus and prioritisation, the sustainability of USAID/PEPFAR-funded NGOs is at risk.

The study found that on average, PEPFAR funding makes up 80 per cent of the NGOs' revenue and without PEPFAR, there is a potential reversal of the health gains achieved over the years on HIV prevention, care and support programmes (such as testing and counselling), if behaviour does not change. A decline in PEPFAR funds will also have negative implications for NGOs' operations to deliver key services to the various communities that they serve. Various NGOs were compelled to retrench staff due to the reduction in funding and this may happen again in the near future. The study, however, also found that NGOs were either considering or were in negotiations with the GRN to seek alternative funding through different mechanisms, including outsourcing of services. The majority of the NGOs indicated that they had created business wings as a way of generating own funds, but with limited resources, so far the few reserves that have been built are not sufficient to ensure continuity of NGO operations

## **6.3 POLICY IMPLICATIONS**

### **6.3.1 Globally**

In many developing countries, various health sectors and the NGOs that operate within those countries depend on foreign aid for their survival. By 1990, the amount of foreign aid to developing countries was estimated at US\$72 billion. Globally, NGOs play a significant role in delivering the services. The sustainability of foreign aid-funded NGOs can vary from one country to another, but is a worldwide predicament, given the continuous reduction in aid flow globally. NGOs have commonly relied on funding from donor agencies, multilateral lenders, and charitable institutions for conducting their operations and carrying out programme activities. To date, the trend of foreign aid is constantly changing and NGOs have found that there are new delivery mechanisms and that new players are becoming part of the aid system. In recent years, donor funding from the United States and European governments has declined, because these countries have been compelled to reduce development aid budgets in order to address domestic economic turmoil. Hence, developing countries that relied heavily on donor funding, especially in financing health programmes, would need to seek for alternative source of financing to fill the financing gap and sustain the health gains achieved.

### 6.3.2 Namibia

As in other parts of the world, donor funding in Namibia is declining, and the reduction will have negative implications on the developmental agendas of both the Government and the NGOs. The long-term sustainability of the NGOs would mainly depend on GRN funding and the country would have to fund its own health programmes, including all HIV/Aids programmes, in order to sustain the health gains made since Namibia gained independence in 1990. Namibia can no longer rely on donor funding from other countries for the health of its citizens and development in the long term.

## 6.4 POLICY RECOMMENDATIONS

Below are recommendations that can be considered by NGOs, the government and donor agencies:

1. In order to ensure long-term sustainability of the health gains achieved over the years through donor funding, the GRN should consider increasing its spending for the HIV response, so that it can fill the financing gap created, to ensure the continuity of the HIV/Aids prevention, care and support programmes (such as testing and counselling). Besides the health extension workers trained by the government to deliver the community-based health care services, the GRN should recognise the role that NGOs have played over the years, and collaborate with them by tapping into their expertise, and specialised interventions. NGOs can thus sell their services to the government and work toward a common goal of ensuring continuous delivery of community-based health care services and the sustainability of the health gains achieved over the years. Alternatively, the GRN can consider creating a funding system for NGOs with the specific purpose of allotting funds for projects run by NGOs as done by the French government where the MCNG Cooperation was formed.
2. For the medium term, NGOs should consider realigning their work and expertise to be in line with the national goal of 80 per cent ART coverage among all persons living with HIV by 2017, which is the goal supported by PEPFAR and other donors to the health sector, so that the NGO business can remain relevant and possibly continue to attract remaining donor funding.
3. NGO operations can only continue if NGOs embark on self-financing strategies that can include a focus on income generating activities to pursue their own sources of financing. NGOs can achieve this goal by having dedicated personnel with the capacity to focus on fundraising activities targetting 50 per cent of self income generated. The mobilisation of financial resources can include in kind support from local entities such as private businesses, the media, private individuals and the general public. The cost of the positions focusing on fundraising activities should be factored proportionally within the budget of every project that the organisation is implementing. Donor agencies should assist in building the capacity of

NGOs through training on fundraising undertakings. NGOs require a diverse pool of financing sources and tools in order to limit the risk and sustain their work.

4. Last but not least, NGOs operating within the health sector should consider linking their core businesses to other sectors of the economy as well as to the United Nations Millennium Development Goals (MDGs) such as poverty reduction. Since the levels of poverty in Namibia continue to be daunting irrespective of the country's current economic status, donor agencies in the country may re-channel their reduced donor funding toward the eradication of poverty. Several donor agencies usually tend to link their financial assistance to policies and programmes designed to address the MDGs within the socio-economic context of the country.

## **6.5 LIMITATIONS OF THE STUDY**

The study focused on the period 2007-2013, since the seven NGOs surveyed received funding from USAID at some point during the aforesaid period. The study was limited to USAID/PEPFAR-funded NGOs operating within the health sector in order to allow for an in-depth exploration of the subject within the limited time at the researcher's disposal.

## **6.6 FUTURE RESEARCH**

A study should be conducted to explore fundraising/fund mobilisation practices relevant to the business of the NGOs operating within the Namibian health sector. The research should put forward the recommendations as to what fundraising practices are suitable for the NGOs that have been focusing on HIV/Aids prevention, care and support programmes, and what makes certain fund mobilisation undertakings more successful than others. Although there is enough literature on how to conduct fundraising activities, there is insufficient literature on successful NGO cases, especially in Namibia.

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## APPENDIX

### Semi-structured questionnaire

Dear Sir/Madam

I would like to thank you for honouring my request to participate in this research project. I am a final year student at the University of Stellenbosch Business School, pursuing an MPhil in Development Finance. I am conducting a survey to examine the sustainability of the United States Government aid funded NGOs in the Namibian Health Sector.

Your participation in the survey is voluntary and anonymous, hence no individuals name or contact details are required. However, your contribution will be highly appreciated, as it will be of high importance to the outcome of this study. Please base your responses on personal experiences and knowledge relating to this particular subject.

I would like to assure you that all information gathered would be treated with the highest degree of confidentiality as highlighted in the code of ethics for the University of Stellenbosch. Please also note that this is an independent study and has no link to my status as an employee of USAID.

If you have any questions relating to this study, please feel free to reach me at mobile number +264 81 25 24310 or my research project supervisor Ms. Kaulihowa Teresa at mobile number +264 81 443 7903.

Yours sincerely

Hilja Namene Aipinge

## Background

Due to the re-classification of Namibia as an upper middle- income country, external donor funding including United States Government (USG) aid in Namibia is declining. For example, the budget for health care positions funded by the USG was reduced by five per cent (GHI, 2011) in 2011 and the reduction is expected to continue through to 2016 over the course of the Partnership Framework Implementation Plan (PFIP). The reduction will not only affect the HIV/AIDS response programmes in the country, but will also have negative implications on the general sustainability of local NGOs in maintaining the health gains attained over the past years, as well as employment created in executing the HIV/AIDS care, prevention and treatment services.

The study thus aims to examine the effects of reduced donor funding on the sustainability/continuity of the USG PEPFAR funded NGOs in the Namibian health sector, and to explore alternative sources of funding opportunities.

## Questionnaire

Please indicate the name of your organisation and answer the below questions. You are welcome to use a separate sheet for the answers.

**Name of NGO**.....

1. Briefly describe the various PEPFAR funded HIV/AIDS activities your organisation is involved in?

.....  
 .....

2. Describe any other HIV/AIDS non-PEPFAR programmes that your organisation is working in.

.....  
 .....

3. To your knowledge, other than PEPFAR, what other source of funding is available at your organisation? Please give a brief description and use the below table to indicate the total income received under each category for each year.

.....  
 .....

	2007	2008	2009	2010	2011	2012	2013	Total
PEPFAR								
Other donors								
Private sector and/or GRN								
Others								
<b>Total</b>								

4. In your opinion, will reduced PEPFAR funding lead to less focus on your key programmatic areas such as the HIV/AIDS care, treatment and prevention services? If yes, what impact will this have on your future programme activities as well as to the health gains obtained over the years?.....

.....  
 .....

5. What other alternative sources of funding do you think might exist to address the financing gap, and what options exist for these NGOs to become self-sustainable?

.....  
 .....

Please use the table below to indicate the number of employees at your organisations working directly under PEPFAR and those that are funded from other sources besides PEPFAR during the period 2007-2013.

<b>Years</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>2012</b>	<b>2013</b>
# of PEPFAR funded staff							
Other Sources							
<b>Total</b>							

6. To your knowledge, has your organisation experienced capacity deterioration whereby PEPFAR funded employees become focused on PEPFAR systems that they have trouble anticipating or responding to other systems?

.....  
 .....

7. To your knowledge, has your organisation experienced any retrenchment of personnel due to the reduction in PEPFAR funding or do you foresee this happening in future? Please describe and give the number of employees affected.

.....  
 .....

What organisational changes have you had to make or intend to make in future (if any) due to the changing funding environment regarding PEPFAR? Changes such as: creating business development wing or considering leaving the health sector and opting for other areas of work where it is easier to obtain funding (including for profit sector), fundraising, etc.? Please describe.

.....  
 .....



.....  
Are there any other information relating to this study that you would like to share?

.....  
.....  
.....

Thanks a lot for your participation and contribution