HDT experience in policy Advocacy in Tanzania

..... The hard stuff to talk!....

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LIST OF ACRONYMS.

AJAAT	Association of Journalist Against Aids.
ANNECA	African Network for the care of Children Affected by AIDS
CCT	Christian Council of Tanzania
CHAWATA	Chama cha Walemavu Tanzania
CSO	Civil Society Organization
CEPA	Campaign to end paediatric Aids.
CMAC	Council multisectoral Aids Committee.
FBO	Faith Based Organization
GAA	Global Aids Allowance.
GFATM	Global Fund to Fight AIDS, TB and Maralia
HDT	Human Development Trust
HIV	Human immunodeficiency Virus
ICASO	International Council of AIDS Services Organization
IMF	International Monetary Fund
JAST	Joint Assistance Stratergy for Tanzania.
LGA	Local Government Authority
MDA	Ministry Department and Agency.
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania(National Strategy for Economic growth and Poerty Reduction)
MoU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
NMSF	National multisectoral strategic framework.
PER	Public Expenditure Review
PRGF	Poverty Reduction Growth Facility
PRSP	Poverty Reduction Strategy Paper
REF	Result education fund.
TAF	Tanzania AIDS Forum
TACAIDS	Tanzania Commission for AIDS
TNCM	Tanzania National Coordinating Mechanism
TAPAC	Tanzania Parliamentarians Aids Coalition.
TGNP	Tanzania Gender Network Programme
UNAIDS	United Nation Programs on AIDS
UNDP	United Nation Development Programme

1.0. Introduction

The Human Development Trust (HDT) is a not for profit, non-government organization (NGO) operating at both grassroots and national level. HDT is registered under society ordinance 1954 (Rule 5) with registration number So. NO 12060 of February 2004. It was founded six years ago with the intention to partner with communities to develop interventions that improve health of poor families in Tanzania including taking care of Most Vulnerable Groups. The head office is located in Dar es Salaam and HDT has 2 field offices; one in Mbeya (Rungwe), which was opened in January 2007 and another in Kagera (Ngara), which opened in March 2007. HDT has presence in three regions now, which are Dar es Salaam, Kagera and Mbeya. In partnership with VSO, HDT also works in Mtwara region under Capacity building program. HDT is one of the organizations that is continually learning, driving to succeed and in doing so, helping to better serve its target beneficiaries – people living with HIV& AIDS and the community.

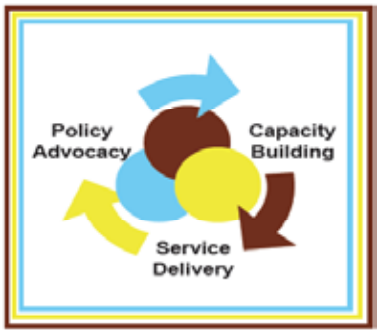
1.1. Vision and mission

HDT's vision is for a society where health is a community priority, where rights of children, women and old people are respected in all undertakings. [Health is defined as a state of well being and not merely the absence of disease or infirmity.]

The mission is to pioneer and develop new standards of substantive equality for men, children, youth and older people throughout Tanzania through working with communities and their organizations.

1.2. Areas of work

All the projects that are implemented by HDT are in line with the 3 strategic pillars: Capacity Development, Policy Advocacy and Service Delivery. Although service delivery is the core business appreciated by many actors, the other two areas of work are essential and reinforce each other. Details of achievements for capacity building and service derivery can be found in respective documentation such as changing methods for care to MVC, moving ahead together and annual reports, all available in the website at www.hdt.or.tz. In this document, experience and achievements under policy advocacy are highlighted.



1.3. What is advocacy?

There are many ways in which different people and organizations define advocacy, some of which are listed below:

- "A systematic succession of actions designed to persuade those in power to bring a change to a specifield issue of public concern" (Peter Bujari: CSO advocacy skills building workshop; Manzini Swaziland May 2005)
- 'Efforts and actions which successfully influence decision makers to act on interest to stakeholders by effecting meaningful and acceptable policy change'. Zanzibar ZAPHA^{+}
- "Advocacy is a process to bring about change in the policies, laws and practices of influencial individuals, groups and institutions". International HIV/AIDS Alliance, Zimbabwe
- "Advocacy is an ongoing process aiming at change of attitudes, actions, policies and laws by influencing people and organizations with power, systems and structures at different levels for the betterment of people affected by the issue". International HIV/AIDS Alliance, India.

1.4. Why engaging in policy advocacy?

Constitutionally, each citizen has a right to express her/his opinion; and since civil societies are by and large owned and or representing certain sections of communities, they can present the real issues from community members. CSOs occupy the third sphere of society, it's the responsibility of CSOs to ensure their own accountability as they provide services and accountability of other actors. The Joint assistance strategy for Tanzania of 2006 articulate that among the roles of CSOs as to mobilize communities in development issues, participate in planning, budget process, implementation and dissemination of relevant information to the public. By so doing they facilitate mutual accountability of government and development partners and they are accountable themselves for their actions and public resource utilization. The intention to engage in policy work is embedded in constitutions and the joint assistance strategy for Tanzania. HDT thus feels that engaging in policy advocacy is fulfilling one of our responsibilities as a member of Civil Society Organizations.

Publication of HIV Budget Analysis 2008/9

1.5. What are strategic focus under advocacy?

There are two overarching strategic objectives and therefore areas of work under policy advocacy namely:
1. HDT and other actors engaging in **policy advocacy related to HIV, health and poverty reduction (formulation, implementation and review)** as a strategy to improve ownership, seeking accountability and ensuring health in the community.
2. **Improve coordination of CSOs** (working in HIV, health, gender and poverty reduction) to effectively engage in the policy and budget processes through Tanzania AIDS Forum (TAF).

Under the above objectives, the following overarching results are expected.

- Increased availability and access to HIV related services for mothers, youth and children
- Improved linkage between macro and micro economic policies to facilitate poverty reduction
- Increased social accountability in public fund spending at community and national level
- Framework for capacity building of local organizations adopted and implemented

2.0. What HDT has done and learnt in policy advocacy work?

The scope of advocacy has ranged from local, national and international. The work has by and large been on policy issues related to HIV/AIDS, health and poverty reduction. The following has been done and accomplished:

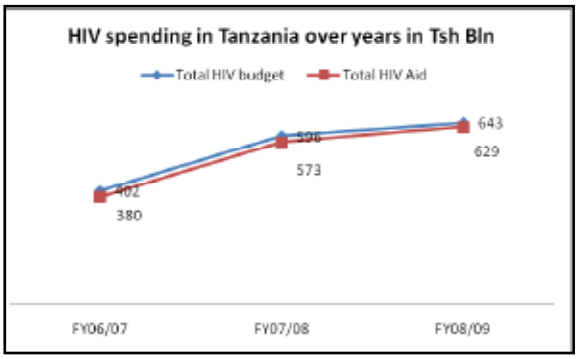
2.1. Engagement in budget process

HDT engaging members of parliament in advocacy

HDT has been working with other organizations in public expenditure review and at a later stage as leading organization in budget analysis. In 2006/7 and 2007/8 with limited information, HDT made an analysis of the HIV/AIDS budget. The findings indicated that the government allocated 2.67% and 2.19% of its available money to spend on HIV and AIDS for year 2005/6 and 2006/7 respectively. The mentioned allocation did not reflect that the

government was seriously implementing its own policies and not taking the HIV/AIDS issue as a National Disaster. Where as it is important to acknowledge non cash contribution of government in this scheme, it stands to reason that allocation needs to increase.

HDT together with other NGOs took the initiative of engaging Members of Parliament with the findings and it was really appreciated. From the presentation, recommendations were made that there is a need to track resources pledged by donors to avoid "*phantom aid*". The parliamentarians also recognized the need of organizing meetings bringing together TACAIDS, donors and CSOs to discuss how best to prioritize national interest. As a way of instituting good governance at the local level it was also acknowledged that the provided information helped them to influence the budget and follow up in their constituencies. The same exercise was done for the year 2007/2008 and it was discovered that only 5% of the total budget publically available (Tsh 328Bln) of HIV/AIDS budget was allocated to LGAs and regions as small as it was. This funding was necessary as large amounts of funds for HIV was being spent nationally. Among the ministries, the Ministry of Health had the largest share of the budget due to care and treatment, but this remains unclassified as the details of the breakdown are unknown. HIV funding seems to have increased to a maximum of Tsh 643bln and then levelling off.



Graph of HIV spending over years

HDT has also been a secretary of the Finance and Audit Technical Working Group. This group is the former Public Expenditure Review Committee which advocated for the funding to Local Government.

Achievement to date:

Engagement in both public expenditure review and budget analysis have been useful and regarded as a success because of the following:

- This time there is a formula based allocation for HIV and AIDS to districts and MDA,


HDT holding press conference on accesibility of HIV related services

contrary to how the case was where there was no uniformity. This now allows all MDA and LGA to plan and budget for HIV interventions in their MTEF under objective A.

- The relationship with Members of Parliament have improved. In addition there is a standing committee responsible for HIV and AIDS. This creates an opportunity for engagement and issues being officially discussed under the committee in the parliament.
- Members of Parliament have been proactively contributing to the budget debate and calling for more professional and judicial use of HIV funds.
- Members of Parliament agreed and made a call to news papers to follow up the funds allocated to their constituency.

Challenges:

The above achievement notwithstanding, there remains challenges to be addressed.

- The budget allocated to LGA and regions are still small compared to the needs on the ground thus this needs more advocacy to increase the size of the NMSF grant. The size of funding notwithstanding, tracking of the use of this money to ensure that its used judiciary remains imperative.
- Timing to meet the Members of Parliament as appropriate so that they are able to effectively participate in preparation of budgets and contribute during the budget sessions remains a challenge. Timely access of information to undertake analysis has not been easy and this causes delay in engaging the MPs or engaging them with inadequate information. Admittedly, the information flow from TACAIDS has improved in the last four years, but that of the Ministry of Health and Social Welfare has remained closed.
- Meeting the policy makers (Members of the Parliament) is often expensive in addition to limited time available hence information has to be compressed leaving some not being understood.

2.2. Collective actions to address structural policies; A case of IMF

HDT in 2008/9 worked in partnership with Result Education Fund and Ifakara Health institute on a study on the Impact of the IMF policies on TB and HIV/AIDS. Extended version of macro-micro economic analysis was also done and engagement with the public and Members of Parliament made. The study found that IMF policies are restrictive and had increased both morbidity and

mortality in poor countries. Findings from other Eastern Europe and Asia also indicated that IMF lead policies have impacted on public health spending and have lead to increased morbidity and mortality due to a number of diseases and medical conditions. The analysis showed that the restrictive conditions resulted into[1] :

- 29 sub-Saharan African countries experienced some increases in foreign aid from 1999-2005. A substantial portion of the increased aid was in the form of debt relief. From 1980 to 2005 there were dramatic reductions in fiscal deficits and in inflation rates.
- On average, 37% of all additional aid was indirectly diverted to increase foreign currency reserves; another 37% was diverted to reduce domestic debt; only 27% was actually spent in the respective countries.

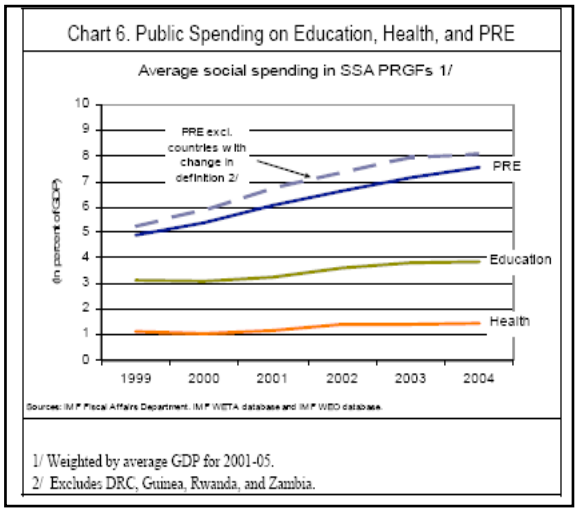


Chart of public spending on education

- Good performers (low inflation, high reserves) spent 49%, weak performers only 17% of aid. IMF Poverty Reduction Growth Facility (PRGF) have historically limited domestic financing of aid shortfalls and required full saving of windfalls; IMF discounts future aid flows, which reduces the amount of aid actually spent in the country.
- IMF signaling effect directed Tanzania to shrink its budget deficit from 3.7% of GNP in 2008/9 to 3.1% in 2009/10. After the financial crisis, IMF directed Tanzania to meet decrease in revenue with expenditure restrains. This happened when development countries were given stimulus packages exemplifying the double standard nature of practice.
- The overly restrictive IMF lead policies impact on the *"fiscal space";* How much the government has to spend. This means that the small budget has to be shared among the ministries, but more could have been allocated if the fiscal policies were flexible.

[1] Prof. Brook K. Baker of Global Health project, presentation during 2008 International AIDS conference

Dr. Bujari on congregational briefing

This last experience needs to be read and interpreted with care. Before the government is given too much flexibility, the strict dealing with grand corruption and misuse of funds by government such as "Ufisadi" needs to be given the attention it deserves. It therefore stands to reason that efficient public spending needs to be practiced before the use of expansionary policies otherwise significant amounts of money will be lost by benefiting few.

2.3. Ensuring youth participation in policy process and governance issues (Youth Policy Project)

Through the support from the Foundation for Civil Society, HDT promoted youth participation in policy in four district of Kagera and Mbeya region (Rungwe, Kyela, Ngara and Biharamulo).

Training of youth on youth policy and good governance

Young people engaging in dialogue

HDT provided education to youth on youth policy and good governance. This has included training on life skills and reproductive health in order for youth to be able to make the right choices. A total of 100 youths were trained and youth groups have been established in Biharamulo, Ngara, Rungwe and Kyela districs. Dialogue platforms have been formed and this included some officials from the district council and wards like the Community Development Officer and youth themselves. As a result of training and formation of the dialogue platform youth are demanding their rights of participation in various activities including decision making. This trend is however seen as chaos to some leaders at local level, who have no experience in involving youth in decision making.

Achievements:

- Mechanism and structures through which youth can be reached have been developed. In addition to that leaders recognized that youth policy was not completely pro youth and that implementation of the same was challenging.
- Through youth organizations, they have demanded inclusion in decision making and demanded accountability from their executive officers.
- The mixtures of out of school and those in school enabled youth to appreciate the needs of each group and chart out the mutual shared needs.

Challenges:

- The project was being done using a short and interrupted funding thus continuity was not smooth and posed continuation challenge after expiry of grant.
- Some local leaders were of the opinion that youth were being too demanding and that they had no right of demanding inclusion in decision making process. Since youth groups did not have a source of income, this remained a challenge intensified by the fact that the donor's condition limit income generating activities.

2.4. Ensuring strong voices from non state actors to engage with state actors (Tanzania AIDS Forum)

Why establishing the AIDS forum?

There were no mechanisms through which CSOs would speak with one voice, learn and share information on programming and give position to the Government in policy related issues as per section 1.3 above and per JAST.

CSOs inputing into policy process on HIV

HDT together with ACORD, BAKWATA, CCT, TNW+, CHAWATA, TGNP, Care International, Concern Worldwide, with the support

from TACAIDS, initiated the formation of the Tanzania AIDS Forum (TAF). The forum is a member-led network of NGOs, FBOs, and International Organizations aiming at strengthening the voice of non state actors and to improve programming on HIV & AIDS. To date this forum consists of 63 members who have signed the MoU. With its strong capacity of lobbying and advocacy in policy, HDT served as a secretariat of TAF and coordinates all TAF activities. HDT supported TAF to re-establish itself to have independent secretariat and a fully fledged office. To date, in addition to HDT being one of the donors to TAF, TAF has some other donors and the capacity to facilitate networking has greatly improved. TAF, from inception, was chaired by the director of HDT (Dr. Peter Bujari) for the period of four years and election for new chair was done in May 2010.

Achievements:

- The forum has contributed to the revision of the current National Multisectoral Strategic Framework for 2008 to 2012, the HIV and AIDS Prevention and Control Act, the development of the HIV policy, participating in the Technical Working Groups and strengthening CSO representative engagement with development partners and government.
- TAF has now received funding from ICASO/ITPC to support the mechanism at which TNCM members can fully engage in the TNCM and decision making. This project aims to improve the quality of engagement of CSO representatives and ensure accountability of CSOs to their constituencies. TAF is also working with its members to improve the delivery of services to prevent HIV infection from mother to child through the Campaign to End Paediatric AIDS (CEPA) which is funded by Global AIDS Alliance with national lead partner being HDT.
- TAF is now an independent recognized network of CSOs working in health, HIV and gender and seeks to position itself in contributing to the national response.

Challenge:

- The establishment of TAF for CSOs to self regulate was not embraced by some actors especially those who operate optimally in chaos for personal interest. As such, there were attempts to interfere with the freedom of the forum, which the leadership and the members resisted and it has generated a lot of momentum and trust to the forum as HDT leaves the steering of the network.

2.5. Strategic engagement in PRSP and National Multisectoral Strategic Framework

HDT has been working with the NGO policy forum through the PER working group. The organization contributed to the voice of the CSOs during the review of the Poverty and Reduction strategy I through a series of workshops. The aim was to make sure that HIV/AIDS is mainstreamed into all clusters in the PRSII popularly known as MKUKUTA for poverty reduction.

CSO engaging in MKUKUTA

Apart from that, HDT and PER conducted an evaluation of Council Multisectoral AIDS Committee to 26 CMACs in May 2006. The findings highlighted some issues on cold relationships between state and non state actors, infrequent meetings and unproper representation among others.In addition lack of funds for CMAC and difficulties in conducting meetings, lack of support from the district councils (from the chairperson and director as well). Advocacy for this was done to ensure that the councils received HIV allocation and as stated in area 2.1 on budget analysis, about 14 billion is allocated to all LGA for their planned HIV activities through objective A.

MKUKUTA 1 was implemented and underwent a review in 2009/10, where HDT also participated in the review of the implementation and development of the second generation.

Achievements:

- HIV/AIDS is mainstreamed into cluster one and two of the MKUKUTA. Cluster one address the economic growth while two focuses on social well being.
- The consultation by government is more inclusive of CSOs in this light and the Performance Assessment Framework indicators for MKUKUTA includes HIV indicators.

HDT engaging rural communities

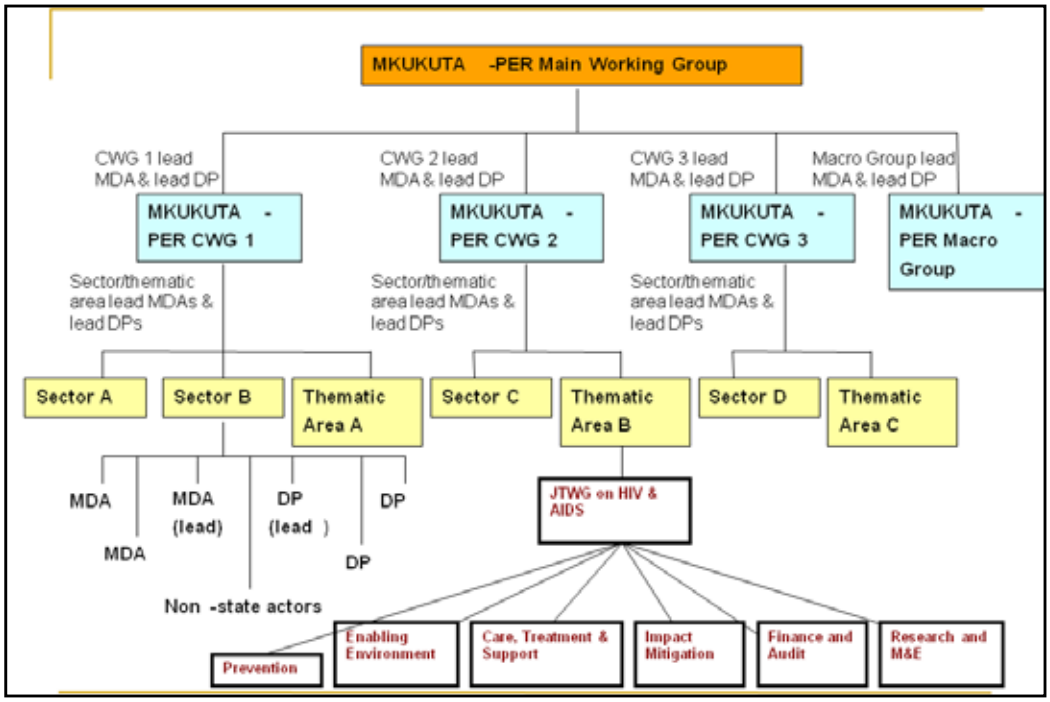
- Engagement with selected members of parliament, eg (Tanzania Parliamentarians AIDS coalition (TAPAC) on AIDS mainstreaming, through which a standing committee on HIV and AIDS for the parliament has been created.

Challenges:

- HIV/AIDS is still perceived as a social well being issue and not as development or governance issue with this concern HIV/AIDS was not mainstreamed into Cluster three of the MKUKUTA which focuses on governance and accountability.
- Inequality in the distribution of the resources; no increase in funding to community based responses at the district level .

2.6. Strategic engagement in the new national dialogue structure.

Through the joint efforts of the Government of the United Republic of Tanzania and Development Partners (DPs), a review of dialogue structures was carried out. In response to review findings and recommendations, the government and DPs agreed to develop a new dialogue structure to ensure a more organized, well coordinated and cost effective structure at all levels. This has necessitated the Government, DPs and non-state partners in HIV and AIDS to review their consultative and dialogue processes with the aim to align them to the agreed JAST dialogue structure.



MKUKUTA dialogue structure

In the overall dialogue structure HIV and AIDS has been identified as one of the thematic area under Cluster Working Group 2 (CWG2) with members from the Government Development Partners, CSOs and other non-state actors; to address and effectively respond to HIV and AIDs issues. Six technical working groups (TWG) were formed which respond to the joint technical committee. HDT is active in three TWG i.e The Finance and Audit Working Group where we are secretary to the committee and the enabling Environment and Impact Mitigation Working Group. The participation of HDT in these working groups reflects our program areas and thus positions HDT to input into the process and decisions based on our field experience.

With leadership of TACAIDS, HIV joint reviews are undertaken every two years whereby milestones are set. The Finance and Audit Group worked to establish a mechanism for local financing of AIDS and to this light an AIDS trust fund has been established.

2.7. Strategic engagement in the AIDS BILL

Civil Society Organizations play a pivotal role in the national response to HIV/AIDS and are the centre for multisectorality. During the development of the AIDS bill, a certificate of urgency was issued by the government and as such very little consultation to CSOs was done. To this effect CSOs through the TAF and the support from HDT, Concern Worldwide and Oxfam, coordinated the input from over seventy CSOs into the AIDS Bill which was passed. Noting that across the country many CSOs were not involved or consulted the meeting took an initiative of making participants aware of the Bill and provided some comments for improvement to increase its efficiency and applicability. Some of the inputs provided to the meeting include;

Building capacity for advocacy

1. The lack of multisectorality of the Bill as it mainly emphasizes on the health sector response.
2. The criminalization of HIV and few mechanisms and provisions embedded into the Bill to protect women infected but fear to disclose because they will be kicked out of the home.
3. Limited role of CSOs in many of the aspects such as the Research committee which seems only to include the government.

4. Limited accountability by government and a mechanism to hold accountable government officials who misuse HIV funds; provisions are only for CSOs.

2.8. Engaging in the Campaign to End Paediatric AIDS in Tanzania (CEPA).

HDT launches CEPA in Tanzania

"The Government is committed to increase coverage of service for PMTCT and to that effect it has committed in its strategic plan for health and PMTCT to increase the coverage to 80% by 2012." Said Hon. Dr. Lucy Nkya Deputy Minister for Community Development, Gender and Children during launching of the CEPA in Tanzania on April 29th 2010 in Dar ES Salaam. The minister was echoing the sentiments by minister for health *"There is no more 'excuse' for newborn babies to contract HIV from their mothers during pregnancy, birth or breastfeeding…"* Professor David Mwakyusa, Minister of Health and Social Welfare, Sept 2009, when inaugurating a CTC clinic at Arusha.

Planning together for CEPA

In Tanzania, there were 114,800 pregnant mothers who were HIV infected in 2008. In the same year, Tanzania estimated a total number of 217,704 new infections, 43,300 of them (20%) being due to mother to child transmission. This translates to 118 babies infected by their mother each day[2]. In Tanzania 6 in 10 HIV positive women access PMTCT+ services. Out of the all babies infected annually, 34,450 (75%) will die before their fifth birth day if interventions are not universally accessible. The remaining 10,450 babies will need lifelong treatment and the cost of maintaining life health expectancy will be high to family and nation.

[2] Tanzania HIV/AIDS prevention strategy 2009-2012 Draft

Looking at the statistics which created the rationale for the campaign, renowned paediatrician and CEPA matron Prof. Esther Mwaikambo said: "*The efforts to reach the target were far ahead*".

CEPA Tanzania team is made of Human Development Trust as national lead, Paediatric Association of Tanzania, ANNECCA, Association of Journalist Against AIDS and Tanzania AIDS Forum. The Tanzania AIDS forum which is a sub recipient of HDT in this program is engaging over 46 NGOs from different parts of the country to discuss and share the roles to galvanise the campaign. For more information see www.globalaidsalliance.org/index.php/1032.

Dr. Bujari speaking during CEPA launch in Johannesburg

CEPA aims to achieve the following among others; adoption and provision of PMTCT services under one roof, use of expert patients to reduce the work load, revision and implementation of treatment guidelines to include nutrition, to galvanize the process of early infant diagnosis and appropriate treatment.

Achievement to date:

In just ten months of its implementation in Tanzaia, CEPA has achieved the followings:

1. Brought together different professional background into the campain, NGOs, journalists, doctors, members of parliament and other high profile individuals.
2. Influenced the reallocation of 2 million dollars from GFATM for the Ministry of Health to be used for PMTCT services.
3. Influenced the GFATM round ten to focus among others on PMTCT.

3.0 Lessons Learnt

Lesson #1: Advocacy is often not perceived by CSO as their primary role

Most of local CSOs believe that their primary responsibilities are to provide services to communities and that advocacy is not their role. The main reason is that advocacy involves dialogue with decision makers who may be knowledgeable than many of local CSOs. International CSOs have less mandate to undertake advocacy as such advocacy remains weakly addressed. More often local CSOs do not include advocacy in their plan and hence they do not have budget and they often call advocacy**.....** ***hard stuff to talk*****.....** The understanding of advocacy is also limited particularly as mixed with activism. As such, HDT has embarked into capacity building for advocacy and will be conducting trainings to community based organization on policy analysis and advocacy. HDT will be working with other local organizations through coaching and mentoring to support them not only on advocacy skills but also on inclusion of advocacy in their mission, plan and budget.

Lesson #2: Stakeholder meaningful participation is essential in the development issues for collective voice

Stakeholder participation is vital for any development agenda. Programs and plans must be implemented focusing on the public interest. The only way policy agenda can address the local issues is involving those who live the problems. They know where the shoe ties... Within this framework, we have in the last five years seen an improvement in the involvement of civil society organizations though sometime is remains rubber stamping. We have to seek meaningful involvement from setting the agenda in advance and not at later stage. We have leant that working with the government requires some patience and institutional commitments. The bureaucratic nature of the government may demoralise the activeness of the CSOs, and this can be addressed by forging a strong network that gives a unified voice.

Dissemination and access to information remains to be the most critical issue for effective advocacy. As HDT moves into evidence based planning and advocacy, field based information and analysed information will be vital. These will not only require resource investment, but also government improved transparency and sharing of information classified as public.

Lesson #3: Inadequate and weak funding mechanism for local CSOs limits their participation in developmental issues.

HDT as a local organization enjoys the warmth of international organizations of working together and often being sub granted. However, the competition among other factors between local organizations and international organizations makes it hard for local organizations to excel. Mechanisms available for funding are competitive and in event no mechanisms have been put in place to build the local capacity; reaching hard to reach areas where local community based organizations operate remains weak.

The new partnership framework by PEPFAR with new Obama administration has improved local ownership and government oversight. Their priority to fund local CSOs has been hampered by international organizations re-registering as local organizations to continue enjoying the funding from PEPFAR which in HIV and AIDS account to about 84% of total HIV funding to Tanzania in 2009/2010. This practice is happening when the government hasn't realised because of weak mechanisms and Civil Society Organizations have not done enough home work to explore alternatives to this and the fate of local CSOs and community based organizations. HDT will be working with other organizations and AIDS forum to explore how this can be addressed.

Lesson #4: CSO self regulation will allow coordinated and authentic contribution of CSO to the national development agenda.

For Civil Society Organizations to meaningful contribute to the national development, room has to be given for self regulation. Often CSOs work independently and they are regulated by government, which don't know the nature and operations of CSOs. For meaningful operation, CSOs self regulation and code of conduct need to be allowed and practiced. This way, CSO will be accountable to their own resources as well as be able to hold government and development partners accountable. Attempt of government to control CSO further increases mistrust between the two parties and leads to some CSOs that are pro government and others that are not. Eventually the whole CSO sector becomes meaningless.