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Circus monkeys or change agents? Civil society advocacy for HIV/AIDS in adverse policy environments

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ABSTRACT

This paper explores the factors enabling and undermining civil society efforts to advocate for policy reforms relating to HIV/AIDS and illicit drugs in three countries in Eastern Europe and Central Asia: Georgia, Kyrgyzstan and Ukraine. It examines how political contexts and civil society actors' strengths and weaknesses inhibit or enable advocacy for policy change – issues that are not well understood in relation to specific policy areas such as HIV/AIDS, or particular regions of the world where national policies are believed to be major drivers of the HIV/AIDS epidemic. The study is based on in-depth interviews with representatives of civil society organizations (CSOs) ($n = 49$) and national level informants including government and development partners ($n = 22$). Our policy analysis identified a culture of fear derived from concerns for personal safety but also risk of losing donor largesse. Relations between CSOs and government were often acrimonious rather than synergistic, and while we found some evidence of CSO collective action, competition for external funding – in particular for HIV/AIDS grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria was often divisive. Development partners and government tend to construct CSOs as service providers rather than advocates. While some advocacy was tolerated by governments, CSO participation in the policy process was, ultimately, perceived to be tokenistic. This was because there are financial interests in maintaining prohibitionist legislation: efforts to change punitive laws directed at the behaviors of minority groups such as injecting drug users have had limited impact.

Introduction

The criminalization of injecting drug use is a major structural driver of the HIV/AIDS epidemic in Eastern Europe and Central Asia. It stimulates risky practices and can lead to human rights abuses and poor access to HIV/AIDS services (Gilson, Sen, Mohammed, & Mujinja, 1994; Latypov, 2009; Open Society Institute, 2007, 2009; Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005; Sanang et al 2010; Sex Workers' Rights Advocacy Network (SWAN), 2009; Wolfe & Malinowska-Sempruch, 2004). Civil Society Organizations' (CSOs) capacity to advocate on behalf of vulnerable groups has been explored previously (Biradavolu, Burris, George, Jena, & Blankenship, 2009; Doyle & Patel, 2008; Price, 2003). However, few studies have concentrated on specific policy issues such as HIV/AIDS (Halmshaw & Hawkins, 2004), or have considered the capacity of CSOs to advocate on behalf of vulnerable groups including injecting drug users (IDUs) in specific policy contexts such as Eastern Europe and Central Asia where the rights of IDUs and their access to services is weak (Malinowska-Sempruch, Bonnell, & Hoover, 2006; Open Society Institute 2009; Public Monitoring Mechanism 2011). With international attention now directed toward the links between prohibitionist drugs laws and HIV/AIDS (Vienna Declaration 2010), this paper provides a timely analysis of the factors enabling and undermining CSO efforts to advocate for policy reforms in three countries affected by these issues: Georgia, Kyrgyzstan and Ukraine.

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The term 'civil society organization' refers to '*the multitude of associations around which society voluntarily organizes itself and which represent a wide range of interests and ties*' (OECD, 2007). It is therefore an umbrella term that can include community-based organizations, nongovernment organizations, faith-based organizations, charities and voluntary organizations (DFID, 2010). CSOs perform various functions including service delivery, monitoring government behavior, and advocacy on behalf of particular communities including marginalized groups (Doyle & Patel, 2008; Howell & Pearce, 2001; Ibrahim & Hulme, 2010; Rau, 2006). Some studies have explored the extent to which CSO advocacy shapes health policies and have suggested that the capacity of civil society is an important influence including leadership, networking, credibility, information and resources, as is government corruption and lack of openness to CSO engagement (Nathan, Rotem, & Ritchie, 2002; Pollard & Court, 2005; and Court, Mendizabal, Osborne, & Young, 2006). However these studies are neither issue-specific nor geographically focused, nor do they explore the effects of international funding on which CSOs are increasingly dependent.

In this paper, we fill this gap in the literature by reporting qualitative findings from a three country study conducted in 2010. We explore the extent to which CSOs in Georgia, Kyrgyzstan and Ukraine are active in advocacy around policies that criminalize injecting drug use especially with regard to HIV/AIDS. CSOs have had a major role in implementing HIV/AIDS programs in these countries financed by international donors including the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), USAID, the World Bank, Open Society Institute and DFID. The Global Fund is the major external financer of HIV/AIDS programs in the three countries with totals as follows: Georgia Round Two (2003) $12M, Round Six (2007) $6M, Round Ten $4.4M (unsigned); Kyrgyzstan Round Two (2003) $17M (completed), Round Seven (2008) $11.8M, Round Ten (2011) $11.2M (unsigned); Ukraine Round One (2004) $23M, Round Six (2007) $132M, Round Ten (2011) $95.8M (unsigned). HIV/AIDS, illicit drug use, and sex work, bound up as they are in moral values and political and financial interests, remain highly emotive issues. The governments of our focus countries have repressive and entrenched stances on illicit drugs in common with other countries from the region including mandatory long term incarceration and coercive detoxification for drug users carrying minute quantities of banned substances (Latypov, 2009; Malinowska-Sempruch et al., 2006; Open Society Institute, 2009; Mounier, McKee, Atun, & Coker, 2006).

We draw on health policy analysis theory to understand how CSO advocacy influences policy making in FSU countries. In this respect we draw on a tradition within health policy analysis that focuses on the importance of policy actors, context, content and process. Walt and Gilson (1994) were among the first to recognize the central importance of *actors* in health policy, a point applied by Shiffman and Smith (2007) to understand why some global health issues are prioritized while others are rejected. Given the politically sensitive nature of HIV/AIDS and drug policy and the political-historical backdrop of the FSU countries under discussion, we hypothesized that *policy context* would have substantial implications for the influence of CSOs on the *policy process* (how policies are made) and the *policy content*. Further, Nathan et al. (2002), Pollard and Court (2005) and Court et al. (2006) highlight how (lack of) capacity of civil society actors undermines their advocacy. This led us to focus on exploring: how the *policy context* supports or undermines CSO advocacy efforts to change HIV/AIDS and drugs policies in Georgia, Kyrgyzstan and Ukraine; and how the *strengths and weaknesses of civil society actors* inhibit or enable advocacy for policy.

Methods

The paper draws on data from in-depth semi-structured interviews conducted in Georgia, Kyrgyzstan and Ukraine between February and August 2010 with representatives from a sample of CSOs based on a number of selection criteria: a) CSOs receiving Global Fund HIV/AIDS grants; b) working in the field of harm reduction for IDUs; c) operating in the capital cities – Tbilisi, Bishkek and Kyiv; and d) CSOs agreeing to participate in the study. Based on these criteria our sample was: Georgia $n = 14$, Kyrgyzstan $n = 16$ and Ukraine $n = 19$. All the sampled CSOs worked in the field of harm reduction for IDUs, and some sampled also provided a range of other HIV/AIDS interventions to different target groups (Table 1). CSO interviewees were managers/directors and all were paid employees of these organizations. Some were also people living with HIV/AIDS (PLWHA) and/or former IDUs or commercial sex workers (CSWs). In-depth semi-structured interviews were also conducted with national level informants sampled purposively including representatives of relevant government agencies (Georgia $n = 3$, Kyrgyzstan $n = 6$ and Ukraine $n = 2$) and development partners including donors and UN agencies (Georgia $n = 4$, Kyrgyzstan $n = 3$ and Ukraine $n = 4$).

Semi-structured interviews were administered by national researchers in Ukrainian or Russian in Ukraine, Russian in Kyrgyzstan, and Georgian in Georgia. Topic guides, designed jointly by the authors, were piloted in Tbilisi in January 2010 by researchers from Georgia, Kyrgyzstan, Ukraine and UK. All fieldwork was conducted by professional national researchers trained in qualitative data collection and familiar with the sensitive nature of the topic. They were employed by research organizations that were independent of the individuals and organizations they engaged with. Interviewers explained the focus of the study as the basis of informed consent before commencing interviews. Interviews were carried out in private spaces to maintain anonymity and confidentiality.

Informed by the health policy analysis approach described above (drawing on Shiffman & Smith, 2007 and Walt & Gilson, 1994) and by Court et al. (2006), Nathan et al. (2002) and Pollard

Table 1
CSOs sample description.

	Focus	Target groups
Georgia	• Harm reduction including needle/syringe exchange and addiction therapy • Education/awareness building • Condom distribution • Prevention of mother to child transmission • Voluntary counseling and testing	• IDUs • PLWHA • Women • Pregnant women • Men having sex with men (MSM) • CSWs • Young people
Kyrgyzstan	• Harm reduction including needle/syringe exchange and addiction therapy • Education/awareness building • Condom distribution • Rehabilitation of former prisoners • Detoxification • Care/support • Legal support	• IDUs • PLWHA • CSWs • Prisoners/former prisoners • Women IDUs
Ukraine	• Harm reduction including needle/syringe exchange and addiction therapy • Education/awareness building • Condom distribution • Voluntary counseling and testing • Care/support • STI testing	• IDUs • PLWHA • MSM • CSWs • Children • Prisoners • General public

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and Court (2005), interview tools were designed to explore *a priori* themes associated with the actors, context, and process of IDU policy. CSO representatives were asked to comment on the advocacy activities they had engaged in, factors enabling or undermining these activities, changing relations with government and with other CSOs, and the effects of Global Fund HIV/AIDS grants on advocacy. National informants were asked to comment on similar themes from the perspective of their organization. Interviews allowed respondents' own frame of experience and meaning to emerge, and were conducted until saturation of new themes was achieved. All interviews were recorded and transcribed, and translated by professional translators.

The lead analysts undertook a systematic thematic analysis of the qualitative data. We adopted a framework approach described by Pope and Mays (2006) whereby *a priori* and emerging themes were synthesized by tabulating them in a common analytic framework to enable direct comparison across the three countries. An investigator triangulation approach was adopted (see for example Seale, 2004): multiple researchers contributed to analyzing the findings and reaching conclusions thereby strengthening our confidence in the messages presented in this paper. In cases of differing interpretations of the investigators, data were re-examined before reaching a shared agreement on interpretation; in some cases where this was not possible we did not report these themes. The analysis involved a multiple-stage process: 1) transcripts were systematically coded by the lead analyst and major common themes identified based on a common analytic framework; 2) major themes were jointly agreed by country investigators and the lead analyst; 3) cross-country findings were summarized by the lead analyst by tabulating them in the common analytic framework and cross-checked and agreed by the country investigators; 4) the paper was drafted by the lead analyst and reviewed by country teams to confirm the accurate and coherent presentation of findings.

Our study has a number of limitations. Acknowledging the recent political and economic upheaval experienced, it is difficult to generalize our findings beyond the three focus countries. Further, sampling was restricted to the capital cities – thereby creating a selection bias. In Georgia this was not problematic since we interviewed representatives from *all* CSOs receiving Global Fund HIV/AIDS grants. In Kyrgyzstan our sample represented a relatively high proportion of all CSO Global Fund grantees at the time of the survey (16/44), although less so in Ukraine (19/135). In Kyrgyzstan and Ukraine our study excluded experiences of CSO advocacy beyond the capitals, although some CSOs working in different regions of their countries commented on regional variations. The majority of interviewees worked for CSOs. It was particularly difficult to interview many national government officials (although those we did interview were key government stakeholders in the field) due to their lack of availability, and in a few cases their lack of willingness to participate. Further, it was beyond the scope of our study to interview any local government officials. We found substantial consistency between most interviewees' accounts, including between civil society and government interviewees; we have drawn out the most important, commonly agreed themes. We have indicated where we found differences in accounts between CSO, government and development partner interviewees.

Ethical approval for the three country study complying with the Helsinki Declaration was granted by the London School of Hygiene and Tropical Medicine (reference 5078) and by the Medical Ethics Committee in Kyrgyzstan. Ethical approval was not sought in Georgia and Ukraine. The government of Georgia only requires ethical approval for studies involving biological samples/patients and no ethical approval is required in Ukraine.

Results

There have been energetic advocacy efforts by CSOs to influence government HIV/AIDS-related policies and their implementation in Georgia, Kyrgyzstan and Ukraine. Examples of the approaches adopted and issues advocated for at national and local levels, together with cases where CSO advocacy had led to self-reported changes are presented in Box 1. However, in relation to the criminalization of drug use, we found that across the three countries most CSO advocacy had either been unsuccessful or only partially successful, or that advocacy had not resulted in legislative reform. As one interviewee concluded: '*When it comes to any real, hot or sensitive issues I cannot recall that NGOs made any real breakthrough or influence on decisions*' (Georgian CSO). We start by exploring different dimensions to policy context that have undermined CSO advocacy. We then examine how strengths and weaknesses of civil society actors influence advocacy efforts.

Policy context

Weak governance: 'they are just sleeping in their chairs'

Government and CSO interviewees in Ukraine, Kyrgyzstan and Georgia widely reported that lack of transparency in policy making was an engrained feature of government institutions, including parliament and ministries. CSO interviewees perceived that the mentality of government officials was a problem: they feared 'rocking the boat' because this might reveal corruption within government: '*Because an official is afraid…that one day someone would get to know what he is doing and…that his wrong activities might become public*' (Ukrainian CSO). Further, public sector inertia was seen as rooted in financial self-interest, which had become institutionalized: '*Nobody is interested in doing anything, because his salary won't be increased due to his efforts, and he wouldn't get any kickbacks for that…we deal with officials who are difficult to move, who do not care about anything: they are just sleeping in their chairs*' (Ukrainian CSO).

In Georgia a lack of direction from the highest level limited the momentum of the parliamentary process, making government unresponsive to CSO calls for policy change: '*…perhaps the parliament is waiting for some directives from the President…I think that the lack of political will of the supreme authorities impedes progress*' (Georgian CSO). Interviewees in the three countries also described the slow and bureaucratic policy process and a tendency for government policies not to be implemented, particularly outside the capital cities. For example: '*…on one hand you can get the document signed…but implementation, which is generally still the government's responsibility, will either be lagging behind…or the funding won't be sufficient…*' (Ukrainian CSO).

Furthermore, low salaries among government workers, including health workers, fostered resentment toward CSOs receiving resources. A Kyrgyz CSO interviewee explained that CSOs were commonly seen by government officials as 'eating Global Fund grants' without doing much, while a Ukrainian government official said: '*[government] see CSOs as spongers, because it is CSOs who receive Global Fund money, not them.*'

Political change and instability: 'we learned to live with permanent changes'

Revolutions and frequent elections create political instability that impedes efforts by CSOs to influence government. All three countries experienced revolutions in recent years: the Rose Revolution (2003) in Georgia, Orange revolution (2004/5) in Ukraine and Tulip Revolution (2005) in Kyrgyzstan. Political instability

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remained a feature at the end of the decade, most recently in Kyrgyzstan when President Bakiyev was overthrown in 2010.

Frequent changes in governments have meant rapid turnaround of senior ministers – including ministers of health – which made it difficult for CSOs to engage government and sustain relationships. A Georgian CSO interviewee said: '*…probably in a more stable environment…CSOs would have…more room to do advocacy*'. A Ukrainian CSO interviewee explained political instability made long-term advocacy impossible: '*We should remember that we had eighteen ministers of health. We live in a unique country where everything can be changed in a year…we learned to live with permanent changes…which…undermines our advocacy efforts*'. Frequent swings in political support for changes in HIV/AIDS and drug laws tended to reflect the personal views of political leaders and senior ministers. '*…it depends on the Minister of Health…if a person is willing in principle it is possible to change everything…*' (Kyrgyz CSO).

Instability was not limited to national government. At the local level, particularly with enforcement agencies, low retention levels hampered advocacy: '*…seven chiefs of city district departments were changed recently. The work that I have been doing for a long time-…becomes useless and I need to start over again*' (Ukrainian CSO). The attitudes of local police chiefs, city officials and healthcare providers varied substantially, which had a bearing on the effectiveness of local level advocacy efforts: '*It really depends on the police chief. When the police chief changes everyone expects some changes…*'. (Georgian CSO).

Economic and political interests: 'drug users for our police, they are a huge resource'

Financial interests in maintaining prohibitionist drug laws were reported as undermining attempts to change drug legislation. Shifting ministry jurisdictions on drug-related issues from the Ministry of Health to the Ministry of Interior in Georgia and Kyrgyzstan led to increasingly punitive drug policies. The problem was widely reported in Ukraine where drugs have remained the remit of the Ministry of Interior which is seen as having strong political and economic interests in prohibition. Such interests were also reflected on the ground among local police commanders and officers on the street where extracting bribes and achieving crime detection targets incentivized a heavy-handed approach to IDUs. Several interviewees described this problem, for example: '*There is still very serious resistance…because drug users for our police, they are a huge resource: resource of money, resource of statistics, resource of manipulating and getting information, and they think that if they lost this resource it will be a very serious loss*' (Ukrainian CSO).Indeed, state law enforcement in controlling drug trade and extorting money from vulnerable populations in the region is reported as widespread (Kupatadze, 2008; Lewis, 2010; SWAN 2009; Sarang, Rhodes, Sheon, & Page, 2010).

In Georgia legislative changes in 2006, including increased fines for drug possession or a positive drug test, proved controversial: for possession a user could go to prison for a minimum of six years: '*…it is getting harder and harder because of this policy implementation…*' (Georgian CSO). Many functions were stripped from the Ministry of Health, including responsibility for drugs resulting in a twelve-fold increase in the numbers of people being tested for drugs by the police. Under the auspices of the Ministry of Interior there were also substantial increases in the amount of revenue raised from drug fines, and increases in the number of people imprisoned for drug-related crimes.

Prohibitionist Russian drug policies were believed to influence whether the three focus countries relaxed their drug laws. Interviewees suggested that Russian science, which opposes harm reduction including OST, influenced government officials and healthcare providers in Kyrgyzstan and Ukraine. A Kyrgyz CSO interviewee explained that Russian scientific articles had been used as evidence to maintain existing laws: '*They found a number of Russian experts on the internet who expressed the case negatively…therefore we faced delay*'. A Ukrainian CSO interviewee said: '*…there is still very serious resistance from some politicians, some professionals and especially from legal enforcement bodies like the Ministry of Interior, like the Security Service…they are very oriented to Russia…*'.

Interviewees widely reported that while Ministries of Health had started to adopt new ideas, such as OST, Ministries of Interior maintained their prohibitionist stance, and equated drug treatment with punishment counter to current global thinking on harm reduction. A Ukrainian CSO explained: '*The Ministry of Interior is, for us, a painful issue…they think…drug users should be treated in an old-fashioned way*'. Furthermore, HIV/AIDS, injection drug use and sex work, which have a long history of stigmatization, enabled governments to justify prohibitionist laws with tough penalties, and gave police an environment whereby extrajudicial practices were common and sometimes even encouraged: '*Unfortunately the general population are not very sympathetic to drug users, to gays, homosexual prostitutes, and this is why the police in fact have democratic support*' (Ukrainian CSO). Indeed, intensified surveillance of people accessing HIV/AIDS prevention services by the Ukrainian Ministry of Interior was reported by the International HIV/AIDS Alliance (2011).

Government marginalization of civil society: 'nongovernmental organizations aren't partners, they're like helpers…'

CSO interviewees suggested that weak governments in nascent democracies had sought to limit the power and influence of CSOs, while often paying lip service to CSO participation in decision-making. A Georgian CSO interviewee explained: '*We are welcomed, listened, sometimes heard. Nice smiles…they are very often very eager to emphasize that they work with…civil society and they try to find common ground and consensus - which looks like a diplomatic trick…*'. There was a strong sense from CSO interviewees that while advocacy was tolerated by government, CSO participation in the policy process was, ultimately, tokenistic: '*…although we have [jumped] and screamed…it still fails. We are tired of being circus monkeys in press-conferences and round tables, after which some resolutions appear that do not solve anything*' (Ukrainian CSO).

In the last ten years, different government administrations in Kyrgyzstan and Ukraine had taken varying standpoints. Some political leaders had been supportive of CSOs contributing to political decision-making, others were hostile – fearing the potential challenge to government power CSOs represented. A Kyrgyz government official noted: '*Maybe due to the fact that our democracy has not been strongly developed yet we are not allowed to listen to the opinion of the nongovernmental sector…*'. Kyrgyz government officials noted a tightening in recent regulation of CSOs in Kyrgyzstan, while a Kyrgyz CSO representative described the Bakiyev government (2005-10) as very cautious about increasing the capacity and influence of CSOs: '*…it was stricter, pressure was evident…I started thinking that if that power keeps reigning for another four to five years the NGO sector will be terminated…*'.

Under such conditions of hostility it is unsurprising that CSOs were disinclined to publicly criticize government for fear of damaging relations. A Kyrgyz CSO respondent admitted: '*I am not very willing to dig into advocacy. Because at any moment the guys from the Financial Police, Chamber of Accounts may visit us and drive*

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us into a corner'. Some interviewees also suggested fear of personal safety as a disincentive to criticize government, as the following Ukrainian CSO respondent noted: '*…of course it is a safety issue…I started the advocacy on the international stage because I felt safe there. Though I worried a lot when…I landed back home thinking what the results would be like*'.

Several CSO interviewees believed the governments of Georgia, Kyrgyzstan and Ukraine were seeking to construct CSOs as service providers rather than decision makers: '*For them, nongovernmental organizations aren't partners, they're like helpers…*' (Ukrainian CSO). It was also reported that government had on occasion exploited weaknesses within civil society to justify a limited CSO role in decision making as a Kyrgyz government official noted: '*NGOs make problems…they request much…they cannot come to a consensus…that makes for not a very good image*'.

Interviewees in the three countries explained that one reason why CSOs had not been effective at influencing government policy was that there were no effective mechanisms to enable this. Indeed, the government-dominated national coordination mechanisms for HIV/AIDS and other infectious diseases were widely reported as offering only tokenistic participation from CSOs. In Ukraine, the main obstacle was perceived as an institutionalized culture which excluded most CSOs from decision making: '*…we should clearly understand some cultural aspects of our politicians: most of problems and questions are settled in with a glass of vodka…*' (Ukrainian CSO).

Strengths and weaknesses of civil society actors

'The most important features are: skill, knowledge, experience'

CSOs with educated, trained staff were stronger in advocacy, and trained lawyers were seen as particularly valuable asset: '*…previously we just lobbied and shouted…now we start understanding legislation more*' (Kyrgyz CSO). Knowledge considered valuable included an understanding of legal issues relating to HIV/AIDS and drug policy, and of political processes and the motivations of government actors, and knowledge about HIV/AIDS issues and vulnerable groups' experiences. A Georgian CSO worker summed up: '*…the most important features are: skill, knowledge, experience…*'.

Interviewees suggested that the International HIV/AIDS Alliance and the Network of People Living with HIV/AIDS, the two Global Fund HIV/AIDS grant Principal Recipients in Ukraine, had grown in power and influence over national policies such as the introduction on Methadone OST. In contrast, smaller CSOs in all three countries with limited resources, fewer skills and less knowledge and experience continued to have limited influence, although some interviewees reported that they were starting to gain knowledge and advocacy experience : '*…in 2005 not many actors actually knew what advocacy is. Now there are many organizations that learned themselves, and now teach others*' (Ukrainian CSO).

Legitimacy: 'knowing people, presenting their views'

Several CSO interviewees explained that technical skills were less important than legitimacy derived from being seen to represent the views, needs and interests of target groups and protecting their rights. They emphasized the importance of motivation and commitment among CSO advocates drawing on personal experience; indeed several CSO interviewees were also PLWHA, and/or former IDUs or CSWs. Legitimacy also came from being seen to have a principled stance, following one's beliefs and adopting an open and honest public position. This strengthened the authority with which they were able to speak to government officials: '*…if the organization has no authority in the community…there would be no sense*' (Ukrainian CSO). Similarly, a Georgian development partner explained: '*Any NGO needs to have its policy [based on] relationships with the public. They should know people and build good relationships with them…Knowing people, presenting their views…*'.

CSOs that represented multiple target groups were described as having greater legitimacy than those representing a narrow group. However, interviewees explained that a substantial challenge was the diversity of voices and positions among CSOs, which sometimes raised the question about whose 'voice' or position was being represented. While having strong principles was recognized as strength, often ideological divisions between CSOs – particularly on the issue of drug reform – also weakened efforts to achieve a common advocacy position.

Access to evidence: 'the community has no evidence…'

Access to strong, convincing evidence strengthened the case being advocated for, thereby helping to persuade decision makers. Many CSOs carried out data collection activities to strengthen their advocacy work including surveys of target groups' and service providers' perspectives. One such evaluation in Abkhazia, Georgia helped strengthen CSO advocacy to change legislation and professional behavior toward IDUs. Some CSOs also drew on international evidence and best practices. Nevertheless many interviewees pointed to problems stemming from lack of evidence, or having equivocal evidence: '*…the problem is that the community has no evidence…we are good in practice…but we have to convey this to people who make decisions…*' (Ukrainian CSO).

Resources and financing: 'advocacy is a costly pleasure'

For many interviewees access to financial resources strengthened CSO advocacy significantly. Advocacy was not seen as an appropriate activity for volunteers and required dedicated, salaried staff. The CSO Global Fund HIV/AIDS grant Principal Recipients in Ukraine had substantial control over resources that interviewees described as enabling them to influence government policy including the introduction of methadone OST programs. However Global Fund HIV/AIDS programs in the three countries have allocated limited resources for advocacy among CSO sub-grantees and most interviewees reported that advocacy required substantial time and resources which they were lacking.

CSOs in the three countries are financially dependent on Global Fund HIV/AIDS grants. They feared that if they challenged the Principal Recipients they might forgo further funding. In Georgia and Kyrgyzstan CSOs receiving Global Fund grants were cautious about challenging the government since the Ministry of Health/subordinated agency acted as Principal Recipient: the *Republican AIDS Centre* (transferred to UNDP from July 2011) and the *Georgia Health and Social Projects Implementation Center* respectively. A development partner in Kyrgyzstan explained: '*…I have to note that nongovernmental organizations which received grants could not openly criticize [The Global Fund Principal Recipient's] policy and their activity*'. Conversely, having multiple donors, more common among larger, more established CSOs, meant a CSO was more independent enabling them to more freely advocate in line with their principles, goals and beliefs. A Georgian CSO interviewee said: '*…when an organization has an opportunity to cooperate with several donors it is less dependent on donor policy and is more flexible*'.

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Connections: 'much depends on personal relations with the administration'

Several interviewees described connections with government decision makers as strengthening advocacy: '*…it pretty much depends on personal relations with the administration…*' (development partner, Ukraine). Joint working, including contributing to government HIV/AIDS programs, demonstrated to government officials the value and competence of CSOs: '*The people worked together, shared views and came up with a joint document. This was a good example of how NGO initiatives may be accepted by government officials*' (Georgian development partner).

Interviewees reported that relationships were improving between many CSOs and government since the former had become more professional and better able to communicate with government officials, who increasingly recognized CSO strengths: '*Now we have real examples when officials said "no, it's better if this or that document is prepared by NGOs because we… have no access to vulnerable groups and we don't know the real needs of vulnerable groups"*' (Ukrainian development partner). The strength of relations should not be exaggerated, however, and some CSOs had stronger links with government officials than others.

Collective action: 'many voices - that's the power'

Interviewees widely accepted that collective action among CSOs strengthened advocacy, while CSOs working individually had limited impact on government policy, particularly at national level: '*…one organization is only one vote. Many voices - that's the power*' (Ukrainian CSO). In all three countries some CSOs were affiliated with networks or coalitions that were reported as strengthening advocacy attempts, particularly when common interests and goals were agreed. A Georgian CSO interviewee said: *'It is easier to influence political decisions when the organization operates in a network'*. Some CSOs indicated they were members of international networks or were closely connected to international CSOs from which they derived resources and power, strengthening their voice within their country. Further, knowledge exchange among CSOs strengthened advocacy; in some cases it motivated them to reinvigorate their advocacy efforts: '*…when we meet with others, new ideas come, in my opinion, strengthening is realized when we speak…it gives a positive stimulus to keep on working*' (Kyrgyz CSO).

It was common for Ukrainian CSOs to operate through networks/coalitions. While these were reported as being more effective than individual CSOs at advocating change in some instances, there were a number of problems. Most networks/coalitions embraced a narrow focus or worked with a specific group, resulting in a proliferation of uncoordinated networks/coalitions. While some networks/coalitions had worked together to advocate for change, this was quite rare and rivalry between and indeed within networks/coalitions was common.

Moreover, despite attempts to foster collaboration, civil society was a fragmented sector. Competition for scarce resources was a driving issue, and frequently acrimonious. There were reported examples of heated, public, exchanges, often in the presence of government officials, which reaffirmed their caution about working with civil society. '*Cooperation is very weak and there are a lot incomprehensible conflicts…*' (Ukrainian CSO). A Kyrgyz development partner commented that a cause for conflict related to rivalry, or 'star fever', among well known CSO leaders, while a Kyrgyz CSO interviewee said: *'There is unhealthy competition among NGOs: even some hatred, scandals'*. Global Fund HIV/AIDS grants were reported as exaggerating competition in Ukraine, Kyrgyzstan and Georgia as a Kyrgyz development partner explained: '*…the Global Fund helped to increase number of NGOs, but on the other hand, competition for funds has increased*'. Another obstacle was lack of ideological consensus. A Ukrainian development partner: '*…there are a lot of conflicting messages because civil society is quite diverse*'. In Georgia a group of CSOs had promoted the decriminalization of drug use, while others had adopted a more moderate stance that was closer to existing government policies.

Leadership and communication – 'advocacy must have her face'

Charisma, good public speaking skills, professionalism, energy and motivation were all cited as key to CSO advocacy. Leadership was essential: '*The head of the organization should have the ability to change the situation in favor of the organization*' (Georgian CSO). Having the ability to construct effective arguments was a key skill, for example by offering workable solutions to problems, or appealing to audience self-interests such as missed opportunities for taxing criminalized activities: '*Someone very clever calculated that average income of sex workers in Ukraine is about $70,000 per year, and how much money [in taxes] the state loses…*' (Ukrainian CSO).

Awareness of appropriate ways to communicate and convince decision makers was vital to effective advocacy such as modulating language to the audience. Communicating with law enforcement officials required particular sensitivity: '*…everything has to be presented to policemen in the police language*' (Kyrgyz government). Presenting the appropriate image was also important: '*It is not possible to allow a sex workers' representative in thigh length boots to come to the [Coordination Council]…*' (Ukrainian CSO).

While CSOs sometimes adopted confrontational approaches to advocacy, they also aimed at consensus building, believing that adopting a position not too radically opposed to government enhanced their influence. The language of advocacy was one of 'dialogue', 'balance', 'moderation' that was justified by an appeal to 'reality': '*We have a moderate position which is more realistic considering current Georgian realities: legalization of drug use is unrealistic*' (Georgian CSO). Some CSOs believed government officials perceived them as oppositional, confrontational or destructive but they had aimed to change these perceptions.

Discussion

Policy context

Our study highlights the importance of policy context as a factor that can enable or limit CSO advocacy. Others have commented on this relationship; Court et al. (2006) are positive about the possibility of successful advocacy in difficult political contexts, whilst acknowledging the challenges CSOs face; they identify a number of barriers to effective CSO policy engagement such as government corruption and lack of openness to CSO engagement – both issues that came out strongly in our analysis. Previous studies have identified financial incentives for maintaining a prohibitionist stance toward drug use leading to police extortion and intimidation of IDUs and CSWs (for example, Kupatadze, 2008; Lewis, 2010; Sarang et al., 2010; SWAN 2009). Our study confirms these findings and suggests this is a major factor undermining CSO attempts to change policy on drug use. An issue missing from previous studies that we draw out through our interviews, is a sense of fear permeating advocacy around IDUs and HV/AIDS: fear for the personal safety of advocates and fear of losing future largesse by openly criticizing government, and government officials who themselves fear 'rocking the boat' by supporting CSO advocacy. We

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also found political instability to be a major impediment to CSOs maintaining positive relationships with government actors – particularly in Kyrgyzstan and Ukraine. Indeed many of our interviewees accepted this was a part of life that was unlikely to change in the foreseeable future.

Studies of CSOs in the health sector inevitably focus on 'state-society synergy', a process where state and civil society work in partnership to achieve health outcomes that neither could achieve alone (Loewenson, 2003; Oxhorn, 2005). Our study, in contrast, provides few examples of synergy between the state and CSOs. With the responsibility for addressing illegal drug use firmly in the hands of the Ministry of the Interior – typically a much less sympathetic arm of government than the Ministry of Health and one with an interest in the revenue generated by drug fines – CSO-government relations have remained strained. Synergies are unlikely to develop if, as we report, CSO advocacy is tolerated by government but not genuinely embraced as a beneficial contribution to governance. Under these conditions, relations between CSOs and government actors are at best described as tokenistic, where CSOs are, as described by a respondent, circus monkeys to a ringmaster.

Looking at the institutions of state and their importance for CSO advocacy Loewenson (2003) argues that successful CSO policy engagement requires a layer of sympathetic bureaucracy to smooth the way. However, our study found that various layers of government were in a permanent state of flux, making it difficult for CSOs to form stable relationships with decision makers. Furthermore, the bureaucratic process was slow and frequently dampened any momentum that CSOs were able to generate. The legal system, too, proved to be a double-edged sword: on the one hand, it is the source (if not the cause) of the criminalization of IDU behavior; on the other, it is the advocate's tool in the sense that knowledge of legal rights was often cited as a route to stronger and more effective advocacy.

Strength of civil society actors

With the exception of a few high-profile CSOs, the vast majority of CSOs in the field of HIV/AIDS in our focus countries are relatively small-scale organizations that struggle to negotiate a temporary truce with local officials to enable them to deliver services to vulnerable groups. In common with previous studies, notably Court et al. (2006), Nathan et al. (2002) and Pollard and Court (2005), we found that the capacity of CSOs undermined their ability to influence government policy: key issues were limited resources, evidence, knowledge, skills and leadership.

Previous studies documented CSOs forming coalitions with other CSOs as one way of strengthening advocacy (Court et al., 2006; Loewenson, 2003; Nathan et al., 2002). However studies do not explore the effects of donor funding on CSO advocacy – which is a gap in the literature our study has aimed to fill. While we found evidence of coalition building among CSOs, we also found that competition for funding from donors including the Global Fund created tensions that impeded such efforts. Our study suggests that access to donor financial assistance strengthened advocacy through enabling CSOs to employ advocacy officers or legally trained staff, in some cases it also subdued their ability to challenge government policies especially in Kyrgyzstan and Georgia where government agencies acted as Global Fund HIV/AIDS grant Principal Recipients at the time of the study. At the same time, being beholden to donors/donor implementers and international agencies, and adopting professional presentational styles was also perceived to weaken CSO ties with the vulnerable communities they claimed to serve, an issue raised by previous studies (for example, Rau, 2006). Paradoxically this undermined their legitimacy – itself seen as a key capacity. Our study suggests that while external dependence on funding can impact negatively on a CSO's legitimacy, multiple rather than single-donor dependence might at least afford some protection from criticism about co-option.

Finally, though difficult to quantify, our study draws attention to a shift in CSO functioning away from advocacy and toward service provision. Governments appear to perceive CSOs, particularly smaller CSOs, as service providers ('helpers' as a Ukrainian interviewee described their relationship with government). On the other hand, donor funding is also primarily directed toward service provisions, with limited financing targeted directly at advocacy strengthening. It may be that the shift toward service provision is a consequence of increased donor funding, and CSOs are simply adapting to take advantage of a new opportunity. Either way – government perceptions of CSOs as 'helpers' and donors' committing limited funding to advocacy activities – there are few incentives for CSOs to concentrate on advocacy.

Conclusion

Our study provides a sober reflection on the realities of CSO advocacy. We found few examples of CSO/state synergy. Some CSO advocacy was tolerated by government, but we conclude that CSO participation in the policy process, especially in relation to drugs policies, was, at worst acrimonious, at best tokenistic. While we started our analysis with examples of successful advocacy, it was apparent that CSO advocacy efforts in the region were challenged at almost every turn, not least because of evident financial interests in maintaining repressive IDU legislation. Furthermore, while we found some evidence of CSO collective action, competition for external funding – including from the Global Fund - was often divisive.

Stability in the focus countries remains fragile, with democracy still finding its feet. We found a hostile political and economic climate that limited advocacy flourishing. In contrast to other studies of CSO advocacy that found *"more and more examples of CSOs engaging in informed advocacy"* (Court et al., 2006:14), we found a culture of fear derived from concerns for personal safety but also risk of losing donor largesse that inhibited effective policy engagement. We found that the majority of CSOs were under-resourced, had limited advocacy capacity, and thus struggled to advocate effectively. Under these conditions, it is no surprise to find a shift towards the relative comfort of service provision. This construction of CSO functioning could have profound implications for national governance, and warrants further study.

Our study draws needed attention to the reality that advocacy can be a risky and costly activity, but is also under-emphasized by the international community. While it is tempting for major funders such as the Global Fund to focus on service delivery, there is a demonstrable need to advocate for legal reform in relation to IDU rights. Supporting advocacy is an investment to secure better rights for minority groups, but also a route to more effective HIV/AIDS programs. National policies very often weaken the effectiveness of donor-funded HIV/AIDS control programs, a point made vividly by a Georgian CSO interviewee: *'When such legislation is in force the activities of the Global Fund are in vain'*. The publication in 2010 of the Global Fund's framework for *Community Systems Strengthening* (CSS) (Global Fund 2010) is a promising step towards addressing the need to strengthen communities to engage in policy making. It will be important to track the effects of this important development on Global Fund country programs.

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Box 1. CSO advocacy in Georgia, Kyrgyzstan and Ukraine

Common advocacy approaches

- Direct street actions
- Mass media including press conferences, TV/film, radio, newspapers and photography exhibitions
- Media training/sensitization
- Letter writing and petitions
- Presentations at conferences and events
- Lobbying and face-to-face negotiation with government officials
- Membership of national coordination mechanisms and/or similar bodies
- Collaborating with government through membership of working groups
- Monitoring budget expenditure of government agencies

Common issues advocated on

- Reduced price antiretroviral drug procurement by government
- IDUs and CSWs rights including entitlements to HIV/AIDS and other health services and exposing discrimination towards these groups
- Introduction of new commodities/approaches such as Methadone opioid substitution therapy (OST), needle/syringe exchange, pre- and post-counseling and express testing
- Decriminalization of injecting drug use and/or reductions in penalties
- Adoption of new regulations/protocols for prevention, testing and treatment
- Advocacy with local law enforcement/health officials to accept harm reduction services and for changes in militia training curricula.
- Advocating with local government for the allocation of additional resources

Examples of successful advocacy

- Ukrainian CSOs successfully advocated for: the national HIV program to incorporate OST and needle/syringe exchange; for a reduction in the price of antiretroviral drugs procured by government
- Kyrgyz CSO advocacy precipitated the integration of CSO HIV services within government primary health care and the inclusion of social aspects of HIV in medical school curricula; changes in the law on quantities of illicit drugs a person can legally carry; and to changes in militia training curricula
- Georgian CSO advocacy led to changes in drug testing protocols in line with the EU Convention on Human Rights

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