PART IV

CASE STUDIES


ONDE ESTÁ A MULHER?
Foi traída pela SIDA.
FDC

The method for conducting the case studies is described in Part I Section 3.2.2.

It became apparent in writing up these case studies that each site tells a different story and highlights different issues. Accordingly, a uniform structure was not adopted for recounting all cases. The level and type of detail available about the community also differed greatly, and it was not possible to provide standard background information across all sites.

In compiling each of these studies we begin with a description of the place and the unique challenges facing each community in responding to AIDS. But beyond that we follow the lead of what appeared to us as most compelling and interesting about each community's responses to AIDS, with a view to appreciating and critiquing, as the case may be, existing attempts to build support for community-based efforts.

Having already developed a picture of each country from other components of the research process, there were inevitably preconceptions about what we would find. But we tried to set these aside in collecting narratives about community efforts to respond to AIDS in conversation with a large number of individuals and organisations, many of them well below the radar screen of 'national AIDS response.' What we found was in some senses refreshing, but also disturbing. It unravelled some of the official and usual accounts that we had heard at country level, and added a number of new perspectives to the picture.

Perhaps most notably, the case studies show that the interface of funders and CSOs has in some respects become a relationship conducted 'above the grassroots.' Our concern here is to consider the nature of the connection of community need and external assistance and to understand the emergence and role of CSOs in this context.

Through the case studies, the CSOs which we had previously encountered came to appear as an intermediary stratum representing communities in the activity of engaging with formal processes of seeking and receiving support. It became apparent to us in conducting these case studies that the reality of emerging attempts to tackle AIDS at community level also tells another story that never made it to our CSO survey and donor interview data collection efforts. To a large extent these stories are sobering accounts of the failure of authorities and funders literally to get to where they want to be – assisting struggling communities to cope with a scale of AIDS-related problems which is clearly much greater than existing resources are able address. But at another level they show the promise in supporting the attempts of community members to rally local resources and to provide assistance where there is often little or none from outside.

1. Ha Ramapepe, Lesotho

The case study was developed by Dr Mpolai Moteetee

'To a large extent these stories are sobering accounts of the failure of authorities and funders literally to get to where they want to be.'

1.1 Description of the site

The village of Ha Ramapepe is located in the lowlands, close to the foothills of the Maluti Mountains, about 20 km from Hlotse, the district centre of Leribe District. The village is situated 10 km along an all-

weather gravel road that splits off the main tarmac road from Hlotse in the direction of Pitseng/Katse. There is daily bus service from the village to Hlotse.

Winter in the foothills of the Maluti Mountains

Ha Ramapepe is one of three sub-villages that fall under the same chief. One of the other villages – Thaba Phatšoa – is home to an Outward Bound training centre that can host up to 50 people. Recent population statistics are not available for the village, but the 1986 Census placed the population of Ha Ramapepe at approximately 1,800 people.[288]

The village is comprised of separate homesteads, which are generally thatched rondavels or cinderblock buildings with corrugated roofs, surrounded by a fenced-in yard. The village is linked to a rural water supply system (a network of taps on the street). The toilets are primarily pit latrines.

The area is rich agriculturally, and farming and livestock are the main sources of livelihood. Most of the men who are formally employed are mineworkers, although retrenchments are now common. Economic opportunities for young people are limited. Fewer and fewer young men are finding employment in the South African mines.

While there are some local residents who pursue education up to tertiary level, most are reported to attend school up to secondary school level (Form C/3). Two primary schools (one government and one Anglican) and one secondary school are located within the village, as well as three primary health care facilities (one is a government clinic and the other two are run privately by nurses). Referrals are made to Motebang District Hospital in Hlotse. There are no other public facilities in the village.

1.2 AIDS in Ha Ramapepe

The national adult HIV prevalence rate in Lesotho, according to the 2004 Demographic and Health Survey, is 24%.[289] Women overall have a higher prevalence rate than men (26% vs. 19%).

At 30%, adult HIV prevalence rates are higher in Leribe District than in any other district in Lesotho. Women in Leribe District have a

[288] Sen, S. (1990).

[289] Ministry of Health and Social Welfare (2005).

prevalence rate of 31%; prevalence among men is 28%. Prevalence rates among youth, while lower than adults, are also highest in Leribe District. Nationally, prevalence is also highest among people living in the lowlands (25% overall; 28% among women, 20% among men), where Ha Ramapepe is located. However, people living in rural areas have a lower HIV prevalence than those living in cities (22% vs. 29%).

HIV prevalence figures are not available at sub-district level in Lesotho and there is no way to know the HIV prevalence among residents of Ha Ramapepe. However, its location in the lowlands of Leribe District suggests that the HIV prevalence rate in the village could well be between 20 and 30%.

According to the area chief, who records deaths in his territory, there were 56 deaths in the village between July 2005 and June 2006. Twenty of these were believed to be AIDS-related.

Factors which may contribute to HIV prevalence in Ramapepe, according to community residents, include: the frequent use of alcohol in the village, particularly among youth (places where alcohol is sold are reported to be the main places of entertainment for young people); the fact that many men from the village had worked in the mines in South Africa; and the large number of widowed and/or separated women who became migrant workers within Lesotho.

1.3 Responses to AIDS in Ha Ramapepe

At the centre of responses to AIDS in Ramapepe is the work of the local branch of the Society for Women Against AIDS in Africa Lesotho (SWAALES, or simply SWAA). A local youth group, a support group linked to the office of the First Lady, and community health workers (CHWs) affiliated to the local clinic are also present in the village, although in most cases their activities appear to link closely with those of SWAA.

All respondents identified activities by SWAA as the key activities occurring within the village. The two main pillars of their work are home-based care and support for orphans and children.

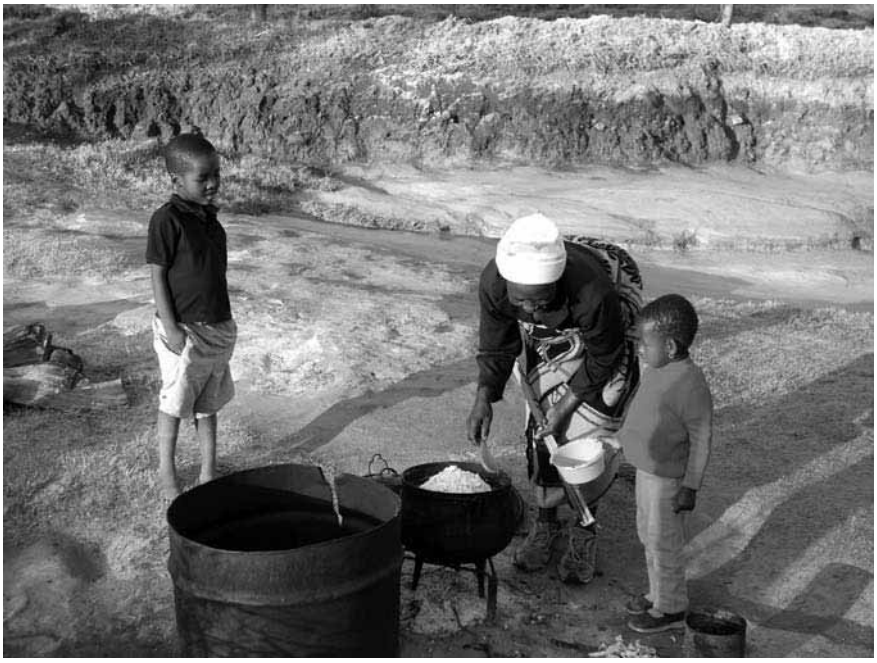
Home-based care activities include house-to-house visits where SWAA members support both the patients and family members/carers where these are present. They care for patients holistically, from bathing and cleaning patients to doing laundry, providing food, cooking for the patient and feeding them, providing basic medicines and drugs (pain killers, oral gels, disinfectants), and dressing sores. They also counsel HIV-positive individuals and members of the household.

Work with orphans emerged from the home-based care activities which heightened the women's awareness of the plight of children whose parents or caregivers had died. The women cook meals for children on a daily basis at the home of one of their members. When donations of second-hand clothing are received, they distribute these among needy children in the village.

According to the area chief, who records deaths in his territory, there were 56 deaths in the village between July 2005 and June 2006. Twenty of these were believed to be AIDS-related.

SWAA also engages in local awareness campaigns, including candle light ceremonies in remembrance of people who have died of AIDS and promotion of HIV testing. It has worked with the Lesotho Association of

Non-Formal Education (LANFE) to providing literacy classes in nearby villages.



Local women provide afternoon meals to orphaned and other vulnerable children in the village

With the support of SWAA, including mobilising limited resources to get them started, a local youth group has become involved in gardening and crop production as a form of income generating activity. Given the high unemployment rate in the area, this is seen as a strategy for keeping young people busy and productive. Some members of the group have been trained in peer education and HIV/AIDS education activities have been integrated into the group's work. The District AIDS Coordinator in Hlotse, through her familiarity with the SWAA group, has provided the youth group with seeds, fertilizer and tools for their gardening project.[290]

The local health centre offers HIV Testing and Counselling (HTC), among other health services, and has cooperated with SWAA to promote community-based HTC in Ramapepe. Community Health Workers affiliated to the health centre are equipped with home-based care kits, gloves, basic medicines and condoms for distribution. They also receive training from the nurses at the centre.

The Office of the First Lady of Lesotho supports community-level support groups linked to the wives of Members of Parliament in constituencies across the country. A support group linked to the wife of the local MP was set up in Ramapepe well after SWAA was already established in the community and was 'launched' at a ceremony attended by the First Lady. Its members were drawn from other women in the community who had not joined SWAA. However the group appears not to have taken root. Although it has distributed some second-hand clothes, it is not seen to be involved in home-based care, which is the typical focus area of support groups in Lesotho.

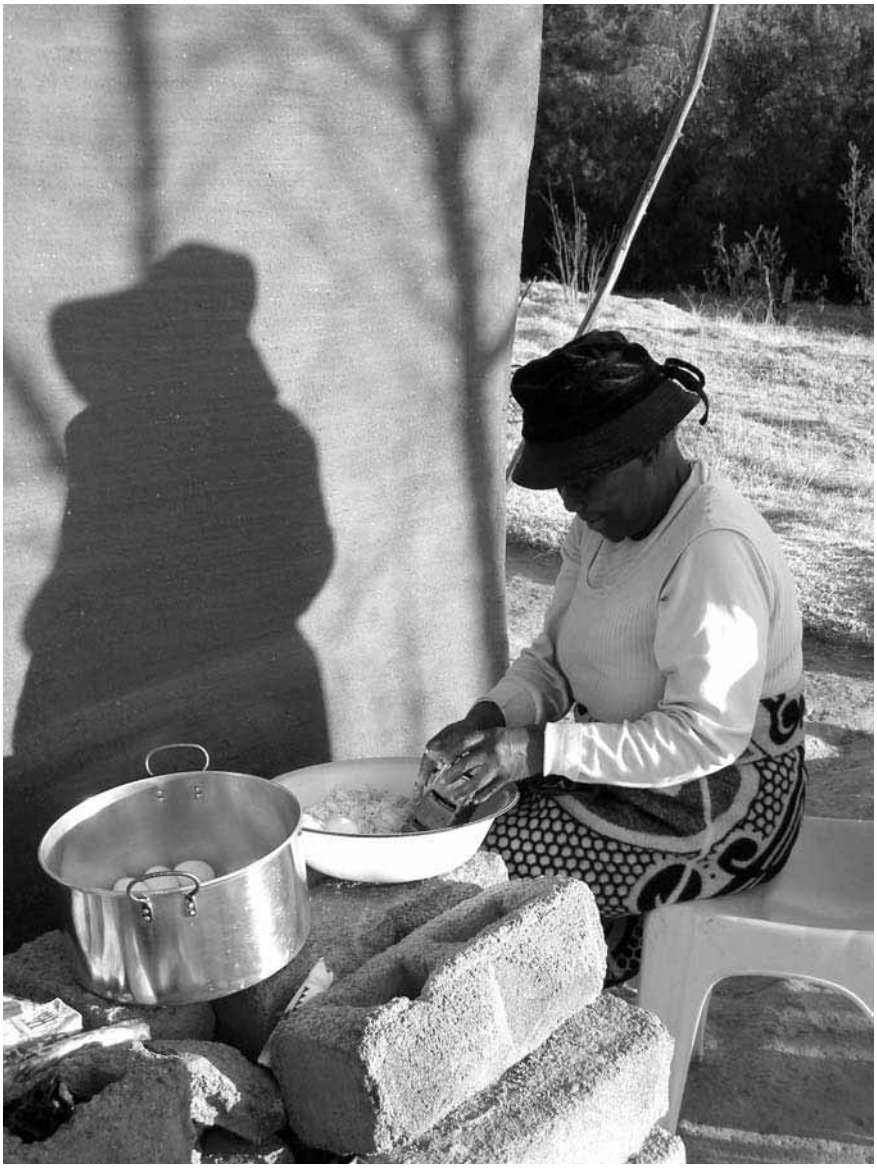
1.4 The evolution of SWAALES in Ramapepe

SWAA started its operations in the area in February 1997. The chair of the organisation took part in training conducted for members of the Anglican

[290] Support for these supplies comes from Global Fund financing provided to each DATF in the country.

Church Mothers' Union in Maseru by someone who also happened to be the chair of SWAA and a medical doctor. The woman from Ha Ramapepe realised that AIDS was accounting for the high mortality and morbidity in the villages and that there was a contribution that could be made at the local level. Upon her return to the village, she spoke with other concerned women who then organised themselves into a local chapter.

SWAA Ramapepe approached the Ministry of Health and Social Welfare and the district hospital and requested to be trained in the care of chronically ill patients, including those with hypertension and diabetes, with the intention to care for and emotionally support the affected and infected. While their concern was for patients with AIDS, they decided to include other diseases because of the stigma associated with AIDS. The hospital provided them with training and they began to provide home-based care services.



Meals are prepared and served outside the home of one of the support group members

As they continued, the women of SWAA realised that there was an emerging problem of orphans in the village, linked to the many AIDS-related deaths. They decided to expand their work to support these orphans with whatever resources they had or could mobilise and focused especially on feeding them.

From the beginning, the basic model of SWAA in Ramapepe has been that of a volunteer-driven and supported organisation. SWAA members donated from their own households what essential goods they were able to – e.g. food, soap, supplies – and would pay out of pocket to help patients get to the hospital. They would also help families pay for burial costs. Many of them grew vegetables in their own plots and contributed these to the collective 'food kitchen' that was run out of the home of one of the women. The group never wrote a proposal for support to any external organisation.

The project gradually became known outside the village and SWAA Ramapepe began to network with other groups and institutions. Through these links it began to receive external resources and training. The Leribe District AIDS Coordinator in Hlotse heard about their activities and invited the leaders to attend the District AIDS Task Force meeting at which they shared information on their activities.[291] Through this link, they began to receive more HBC supplies and medicines/kits from LAPCA channelled through the DAC.

Through the Anglican Church, overseas visitors once came to the area and put on a play as part of a community development programme. Following this, they invited some of the local orphans to Maseru for another phase of their work. At the end of the visit, the children, accompanied by two adults from SWAA, were taken shopping and bought items that were identified by the adults to be priority needs.

Through the national SWAA office in Maseru, SWAA Ramapepe began receiving regular deliveries of food supplies to use in preparing daily meals for the local orphans.[292] This support began *after* the women had already set up a feeding scheme using their own supplies and resources.

More recently, SWAA Ramapepe has taken steps to get involved with a project based out of Hlotse and linked to the Ministry of Forestry which provides fruit tree seedlings and training to orphans on how to care for the trees. The project is intended both to generate income and to engage the children in a productive role in the community. SWAA Ramapepe has already undergone the necessary training and discussions to join the project, but a delay in allocation of land has stalled this project for the time being.

As the organisation grew, it received training from LANFE in basic project development, project management, record keeping and financial accountability. CARE Lesotho has also provided it with 'capacity-building training.' SWAA Ramapepe has also received donations from both private individuals and Lesotho Planned Parenthood Association.

The group in Ramapepe has become something of a local example in the district and a number of similar support groups have sprung up in seven nearby villages. The District AIDS Coordinator in Hlotse pointed to the group as an example of a well-established, well-trained local organisation that is starting to play a leadership role in relation to other emerging groups in the area. For example, SWAA Ramapepe represents support groups from its area at the DATF meetings and reports back to them on key decisions and issues.

[291] The DATF is a multisectoral committee that meets monthly for the purposes of sharing information and ensuring coordination of activities within the district. All types of CSOs active in HIV/AIDS are expected to participate in this committee.

[292] The funding for this support appears to originate with a US Government-funded agency, although the women in the village know only that it is 'the Americans' who are behind the food donations. A group of Americans visited Ha Ramapepe to assess the work of the group before committing to the support.

1.5 Issues around funding and resources

Over its nearly 10 year history, SWAA Ramapepe has gradually become known in its own district and beyond and has built up a variety of institutional linkages which have attracted new resources. Some of the inputs of training and resources described above have contributed to this growth and allowed the group to work at a greater scale.

However this expanded resource base has not been unproblematic. Members of the group have been thankful for the offers of support and the donations made to the group, but also expressed a certain frustration that they do not have more control over these resources and that there isn't more consultation *in advance* about what resources are most needed or how often certain types of supplies need to be replenished.

One example given pertained to the overseas visitors who took some orphans from Ramapepe to Maseru for a few days and then wanted to buy them some things to take back to their village. The overseas visitors wanted to buy the children toys and blankets, and it took the intervention of the SWAA chaperones to convince the hosts that what the children really needed most were shoes. Although a small example, it characterises the type of well-intentioned charity that a CBO like SWAA Ramapepe often finds itself receiving.

Women are at the heart of community-level support groups across Lesotho

Members of the group are thankful for offers of support and donations made to the group, but would prefer more control over the resources and more consultation in advance about what resources are most needed.

A more important example, however, relates to the donations of food received from the national office for orphan support. Although the women in Ramapepe have been told that they have been allocated funding for feeding orphans, they are not clear about how much funding has been allocated in their name, nor the duration of this funding. The organisation does not see any of the funding: supplies are procured centrally and delivered to them. The amount of food as estimated by the central office does not always match the amounts required, based on their own experience. Often the supplies that are provided run out before the end of the month and the difference has to be made up out of their own pockets or with supplies from their own households. However,

they believe that it is important to provide the meals consistently so as not to lose contact with the orphans who have come to depend on the food and for this reason they bridge the gap in supplies themselves.The organisation has received training from LANFE in project management and financial management and would prefer to receive and manage the funding directly, as it would give them greater control over purchases. However under the funding scheme, they appear to have been designated as a recipient of support through funding received and managed at a central level.

Another sign of this is the fact that, as a condition of receiving the food supplies, SWAA Ramapepe was required to designate two individuals to act as coordinators of the project. They did this, although the request itself suggested logic that was antithetical to the collective way in which the group had been working to date. At the meeting where this requirement was discussed, it was not necessary to nominate or designate anyone among them, as two people volunteered to act in that capacity, seeing it as a reflection of the volunteer ethos which pervades the organisation.

SWAA's members report that they work without any stipends or remuneration. There is a wish that some type of support could be available for them, particularly given how much and how often they have donated supplies from their own households for the benefit of others. The carers for the orphans are mostly elderly women and expressed a wish that the SWAA members/volunteers could receive a regular incentive given their devotion to a good cause.

'They help us a lot by feeding these children. We do not have any vegetables and the vegetables the children are consuming are from their gardens.'

- A grandmother in the village, speaking about the SWAA women

1.6 Achievements and challenges

The most visible and most valued AIDS response activity in the community is the home-based care, provision of medicines, and feeding of children conducted by SWAA. The members were applauded for their empathy and assistance to people in need.

'Without their support the children would go to bed hungry, because I am old and can no longer be as economically active as I used to be.'

- Carer/grandmother of 5 orphans

The support group's latest project: children from the village will be trained to care for fruit tree seedlings

There appears to be genuine support within the community for SWAA's work – a fact which may in part be attributed to their practice of informing the Chief and the local councillor of the activities they conduct and the forms of support being received from outside parties.

Interviews with community members suggest that the community as a whole is increasingly 'paying attention' to AIDS issues. In addition to the outreach work being conducted by SWAA, this may be linked to the HTC activities being conducted by the community health workers at the home of the SWAA president and the discussions about AIDS being initiated by the youth group.

SWAA continues to deepen and diversify the type of work it conducts. The fruit tree project, in conjunction with the Ministry of Forestry, will add a new dimension to their activities if the issue around the land allocation can be resolved. Everyone interviewed in the research agreed that there is a problem around the land allocation, but there were differing opinions about whether the Chief or the local councillor was ultimately responsible. The recent changes in local government in Lesotho, linked to the process of decentralisation, may have contributed to the confusion over jurisdiction for local land issues.

Apart from this issue, the organisation's other main desire at the moment is to move into some type of office space so that the members can separate their organisational affairs from their own households. Until now, SWAA Ramapepe essentially operates out of the homes and yards of its core members.

The organisation thus far has grown on the basis of local connections and word-of-mouth. The group has never applied for funding and does not necessarily know where or how to begin with this process. Although the organisation does not presently have a bank account, they know how to open one should it be required by a potential funder.

2. Bangwe Township, Blantyre, Malawi

The case study was developed by Alister Munthali

2.1 Description of the site

Blantyre is the most populous city in Malawi and occupies a geographical area of about 23,000 hectares. It was founded in 1800 by Scottish missionaries and over the next 100 years grew to a city of 6,000 people. With colonialisation and the subsequent introduction of a hut tax by the colonial administrators in the surrounding agricultural districts of Thyolo, Chiradzulu and Mulanje, people migrated in massive numbers to the City of Blantyre where they could work for wages. In addition to people from these surrounding districts, there was also a significant movement of people from Mozambique which contributed to population growth in the city.[293] In the 1998 census, the population of the City of Blantyre was estimated at 500,000, up from 197,000 in 1977. The population of Blantyre more than doubled over the intervening 20 years and is projected to double again by the year 2020.[294]

According to the Integrated Household Survey, the proportion of people living below the poverty line is much higher than in Lilongwe, the capital

[293] Chikhwenda, E. (n.d.).

[294] National Statistical Office (2003).

city of Malawi.[295] Within the City of Blantyre, it is estimated that 70% of the population of Bangwe Township, the focus of the case study, lives below the poverty line.

Along the main street of Bangwe Township

2.2 Responses to AIDS in Bangwe Township

Fourteen NGOs and CBOs were identified in Bangwe Township and the following were visited: Active Youth Initiative for Social Enhancement (AYISE), Umunthu Foundation, Samaritan Trust, Tithandizane CBO, Caring for Persons with Disabilities (CAPDI), the Salvation Army and Bangwe HIV/AIDS Self-Help Initiative (BAHASI). The majority were initiated by members of the community in the early 2000s. They generally operate within the confines of Bangwe Township although some, such as Samaritan Trust, are linked to larger organisations and operate in a wider catchment area that extends beyond Bangwe Township.

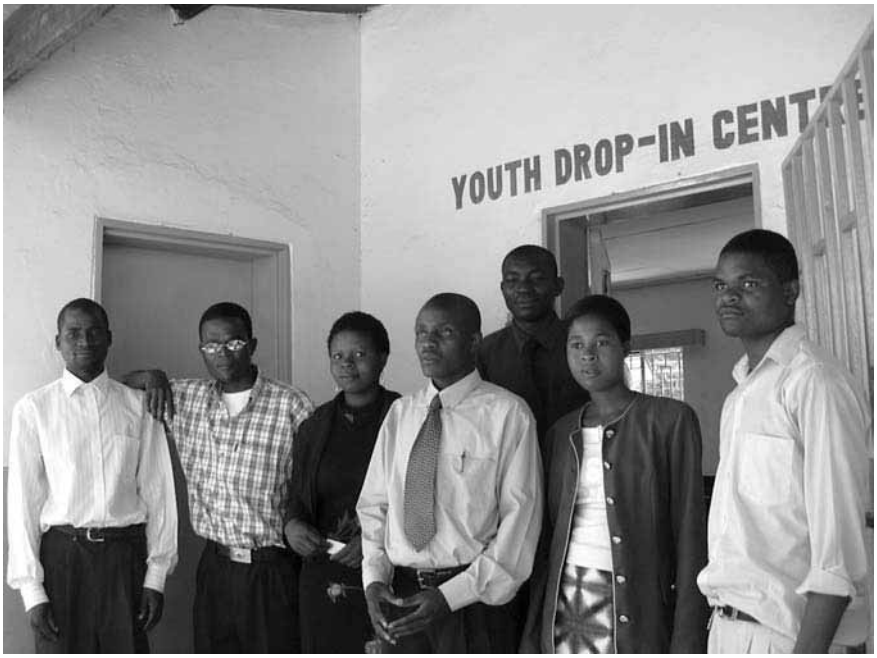
Some of these organisations are registered with the Office of the Registrar General and the District Social Welfare Office – a requirement of certain funding agencies and membership organisations such as CONGOMA (Congress of NGOs of Malawi). A few of the well-established organisations, such as the Samaritan Trust, Umunthu Foundation and CAPDI, have boards of trustees in addition to an executive management committee.

The most well-established organisations operate from their own offices, and others rent premises. However, the majority of organisations operate from premises donated by 'well wishers,' such as churches. There is much 'under the radar' and in-kind support for these organisations, apart from the official funding that some of them receive. Staff are comprised mostly of volunteers from the community working alongside a few formally employed staff members. Only AYISE and the Samaritan Trust have had expatriate volunteers work with them. During the interviews, it was found that most of the CBOs in Bangwe Township operate on a voluntary basis with limited or no external financial assistance.

The organisations target diverse groups of people, including street children, orphans, people with disabilities, chronically ill patients,

[295] National Statistical Office (2003).

people living with AIDS, widows, young men and women, the elderly and other vulnerable groups in the community. The AIDS activities that are being implemented by these organisations at community level include the provision of HIV testing and counselling services, orphan care, distribution of information, education and communication using drama and sport to reach people, providing community home-based care and promoting behaviour change for prevention. Some organisations make referrals to health centres for sexually transmitted infections and other reproductive health issues. The organisations involved with home-based care for the chronically ill also provide food, soap, assistance with laundry and household cleaning, and prayer and spiritual support.



Youth taking a lead in AIDS responses and at the same time seizing opportunities for career development

Given the poor socio-economic conditions in this township it is not surprising that many of the activities are aimed at mitigating the impacts of AIDS rather than on AIDS-specific services related to prevention, support and treatment. For example, the Samaritan Trust works to reintegrate street children with their families and to get children back to school. It provides material support, such as food, clothing, blankets and soap, to the street children and their families. CAPDI is broadly oriented on disability issues and works to create awareness about disability and human rights. BAHASI is involved in crop and vegetable farming; at the time of the research, they had 700 heads of cabbages in the garden and had harvested 15 bags of maize in the previous growing season.

Given the poor socio-economic conditions in this township it is not surprising that many of the activities are aimed at mitigating the impacts of AIDS rather than on AIDS-specific services related to prevention, support and treatment.

Growth of CBOs

While some of the larger organisations, such as Samaritan Trust and Umunthu Foundation, have relatively well-established and stable operations, it was clear that the smaller organisations are still quite fluid in terms of the types of activities they conduct. There were accounts of organisations scaling up particular areas of work, while others were cutting back on activity. This can be attributed to a range of influences, not least of which is the resource environment – i.e. the funds available for particular kinds of activities, which has a strong moulding influence on what organisations undertake.

It is important to take stock of how these community-based organisations evolve. There are certainly some major differences between them. The Salvation Army is a national organisation and was initiated at a national level, although its programme was adapted to local community needs and staffed by community members. But as an institution it was conceived elsewhere and its organisational culture did not have to evolve in the community – it only needed to be adapted to it. CAPDI, by contrast, started out much like a club or informal association within the community. Its members would meet at various venues within the community and not necessarily on a regular basis. Over time, it has grown into a more formalised CBO and now has its own office space. It has made efforts to establish working relationships with other organisations and the church, which has helped it gain recognition and assistance from partners. BAHASI shows a different model of growth. It has changed its area of focus over time. Beginning with the needs of orphans, the organisation has since come to incorporate widows into its programmes. Its evolution has partly been a result of funding opportunities, but importantly it has been driven by its encounters with needs in the community. Another organisation, Tithandizane CBO, grew through focusing on orphans and child-headed households and then contracted its operations within Bangwe, as it scaled up its operations in other areas. AYISE grew from being a modest organisation on the basis of efforts by largely one person, into being an organisation employing several dozen people. Whilst still limited to operations in the area, it is now at the point of considering whether it should also operate as a conduit for donor funds.

Each of these initiatives has gone through a different growth trajectory. Important issues have faced organisations as they have become increasingly more established, started paying salaries, expanded their range of services and opened other branches. Some organisations have sought outside assistance in managing decision making in these areas and others have coped on their own. Such processes have contributed to the establishment of these organisations as independent entities which, whilst based in a community and related to it, have increasingly developed their own organisational cultures as they have grown.

2.3 Major challenges faced by the CBOs and NGOs in Bangwe

The major challenge faced by CBOs and NGOs in Bangwe Township is the general lack of material and financial resources to meet the needs of the communities that they are serving.

In many instances, members and volunteers use their personal resources in order to cover the operating costs of the organisation. This limits the scale and scope of what they are able to accomplish and prevents expansion into other districts and areas. A number of CBOs, for example, are involved in home-based care. One of their major concerns is the fact that many of their clients are malnourished and require more nutritious food. However the CBOs are not in a position to meet this need and they can see how the absence of food is undermining their patients' overall well-being. Many of these organisations have also been forced to limit the number of clients they support because they visit people on foot due to a lack of transportation.

The lack of financial resources has prevented some CBOs from renting offices, which has made it difficult for the CBOs to build up their

operations and to provide a space for members of the community to visit. One CBO has been granted the use of a local church, however when the church requires the use of the space they have no office. This CBO mentioned that some of its members are from other denominations – a fact which is problematic for some members of the church and has led to tensions.

Mapping and locating community services within the bigger picture of AIDS responses in Malawi

In the case of the better-established NGOs, small salaries are provided through the budgets of the projects they are implementing. However, in most of the organisations, members work on a voluntary basis and only occasionally receive small allowances.

Some of the younger organisations require access to training linked to the services they provide. Some CBOs are involved in support for orphans and the provision of home-based care, for example, yet have not ever received any specialised training in these areas.

2.4 Funding and support for AIDS activities

Access to funding varied amongst organisations. On one end of the spectrum is the Samaritan Trust, whose Bangwe Township office is not involved in fundraising as this is done in another office. However most organisations visited are located at the other end of the continuum – they are involved in on-going efforts to secure funding for their work and have found this to be a difficult and frustrating experience. Some organisations in this community have written and submitted proposals for funding through the National AIDS Commission and international funding agencies. While these have been successful in a few instances, the majority of organisations have not succeeded in accessing support through these channels. What emerged from the research was that a very few organisations, mainly the Samaritan Trust, AYISE and Tithandizane CBO, had relatively well-established sources of funding, while the rest of the organisations operate with little or no assistance.

There were a number of problems that were mentioned by organisations in accessing funding. Among the younger organisations, the main problems included a general lack of information about how funding for AIDS activities can be accessed, a lack of knowledge of the umbrella

organisations through which they can apply for funding, and a general lack of capacity and experience in proposal writing. It was noted that it is too expensive to hire consultants to assist with proposal writing, even though this option is known to exist. Among the more established organisations, such as Umunthu Foundation, there was greater familiarity with the procedures for applying for funding, but frustration with the bureaucracy involved in accessing funds. Even if projects are approved for funding, it sometimes takes a long time before the funds are actually disbursed. Other concerns include the fact that some funding agencies do not accept proposals directly, but require that they are submitted through an intermediary (e.g. requests for support from UNICEF must be submitted through the District Social Welfare Office). These procedures and requirements are not always well understood.

Registration appears to be a barrier to access to funding in some cases. Many agencies require proof of registration with either the Ministry of Women and Child Development or the Registrar General. One organisation felt that it had missed out on a number of possible funding opportunities due to delays in the registration process. It took nearly two years for them to be registered.

There were no funding agencies that were viewed as 'easy' to work with. Rather, the overall impression is that funding organisations are 'mean' and overly strict about details. The CSOs expressed the view that there is a *de facto* bias against small organisations who struggle to access small amounts of funding and to build a track record. They perceive a tendency for already funded organisations to continue to receive funding.

Major sources of funding

Even those CSOs that are relatively well-supported in Bangwe Township are accessing support from many sources that fall outside the main international funding flows. The Samaritan Trust has a relationship with some organisations and individuals in the Netherlands who send funds; locally they get assistance from private companies such Illovo Sugar, Rab Processors, Bakhresa Grain Milling and Unilever South East Africa. Tithandizane CBO is funded by the Projects Office of the Synod of Blantyre and once in a while visiting church members from overseas also provide donations.

Most CBOs, however, are still struggling to be recognised and are operating on the basis of personal contributions, income generating activities, and ad hoc donations of clothes and medical supplies.

2.5 Sustaining AIDS activities

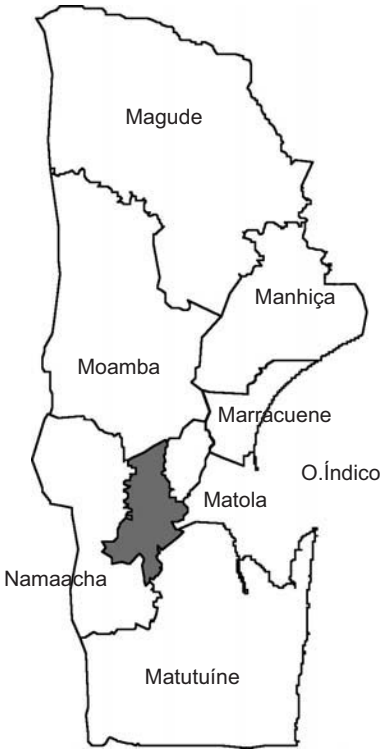
CSOs in Bangwe Township expressed the view that there is a bias against small organisations who struggle to access small amounts of funding and to build a track record. They perceive a tendency for already funded organisations to continue to receive funding.

Larger CSOs face greater pressure in sustaining their activities. The Samaritan Trust, for example, noted that it is unlikely that they could sustain their activities without outside support. This reflects the greater professionalisation of this CSO, which has grown to a scale where it has come to depend on a particular level of resourcing and would be institutionally vulnerable to cutbacks. Smaller CSOs were more likely to feel that they could sustain their AIDS activities irrespective of funding flows. At Tithandizane CBO, for example, there was a belief that the home-based care work could be sustained as it was already heavily reliant upon locally available resources, including herbs and

pain relievers from local sources and the contributions of neighbours and other community members. This was similar to what was reported at BAHASI, where it was expressed that home-based care and food gardening could continue without external funding.

The following is a summary of the needs expressed and suggestions made by the CSOs in Bangwe Township relating to how the funding environment could be improved:

- There is need to build CSO capacity to write proposals and to better promote available sources of funding. Financial management is an area of weakness among CSOs.
- Funding agencies should make their budget ceilings known to prospective beneficiary organisation so that they tailor their proposals accordingly.
- Funders should visit CSOs to hear some of the problems that they are facing in accessing funding. CSOs expressed that donors' reliance on umbrella organisations means that they are failing to fund organisations that could make impact on the ground.
- When funding is awarded, it is important that it is disbursed promptly so that activities can be implemented within the agreed period.



3. Boane, Mozambique

The case study was developed by Dirce Costa

3.1 Description of the site

The district of Boane is one of eight districts in Maputo Province. It is located approximately 30 km from the city of Maputo, and has a population of 81,000 inhabitants.[296]

According to 2005 estimates, 42% of the population of Boane is under the age of 15, 53% are women, and 68% live in urban areas. Illiteracy among women stands at 57%, compared to 35% among men. Overall school attendance in the district is 47%, although a significantly higher proportion of boys than girls attend school. It is not uncommon for marriages to occur among children as young as 12 years old.

In the early 1990s Boane benefited from an investment of US$1.3 billion for an aluminum smelter, Mozal I. The area is the country's top-ranking producer of aluminum and maintains a strong position in the international market. The construction of Mozal II was completed in 2003, resulting in a doubling of production. In recent years, Boane has shown clear signs of economic growth linked to the aluminum industry.

The Maputo–South Africa highway that runs through Boane is an important infrastructural feature that has also contributed to the development of the region and presents another important source of local income.

Agriculture is the basis of the local economy. The main crops are vegetables, maize, cassava, beans, banana and citrus; cattle breeding and poultry farming are also important. The NGO Médicos sem Fronteiras

[296] Metier – Consultoria & Desenvolvimento Lda. (2005).

(Doctors without Borders) estimates that 5% of the district's population is in a vulnerable situation regarding food security.

At the district level the state is represented by the Administrator, who is the head of the district. The government is organised into district directorates, each of which oversees a specific sector. The directorates dealing with AIDS-related issues are the Health and Women and Social Affairs Directorates and the District Aids Council (DAC). The main roles of these organisations are the coordination and control of the operations of all public bodies dealing with health, social affairs and AIDS.

A town located on the highway to South Africa, near a major factory

3.2 AIDS in Boane

Mozambique is not only one of the poorest countries in the world, but also one of the countries heaviest hit by the HIV epidemic. The national prevalence rate has risen from 3.3% in 1992 to an estimated 14.9% in 2004, placing Mozambique among the ten most-affected countries in the world.

There are an estimated 1.6 million people in Mozambique who were HIV-positive in 2005-2006,[297] 58% of which are women. Widespread gender inequities in the country contribute to this pattern of HIV infection. The HIV pandemic has and will continue to have a significant impact on Mozambique's key human development indicators, such as health status and life expectancy, as well as on the social and economic outlook.[298]

In 2002 the estimated HIV prevalence for adults (aged 15-49) in Maputo Province where Boane is situated was 17.4%. This represents the third highest prevalence rate in the country after Sofala (26.5%) and Manica (19%), both in the central part of the country.[299] The high mobility of people and goods along Beira Corridor is believed to be the main contributing factor spreading the epidemic in these other two regions. Maputo Province is relatively urbanised and its high prevalence typifies the elevated prevalence found in urban areas across the region.

There is no official information about the trends of the HIV epidemic in Boane district. However, data from HIV antenatal surveys by the Ministry of Health can be used to obtain estimates of the epidemic in

[297] MISAU/INE (2004).
[298] UNDP (2004).
[299] MOH/NIE (2004).

the area. In Maputo Province where Boane District is located, there are two sentinel sites, in Manhiça and Namaacha districts. The table below presents the respective prevalence rates for the period 2000-2002:

Sentinel Post	HIV Prevalence (%)		
	2000	2001	2002
Health Centre Manhiça	15.7	15.0	14.7
Health Centre Namaacha		16.7	21.0

Namaacha is the district neighbouring Boane and has similar epidemiological vectors to Boane. Records from an extensive international NGO-led voluntary programme in Boane show growing numbers of people testing and rising prevalence in this voluntary sample.[300] The table below presents annual data from VCT in the district.

Year	Tested	HIV Positive (%)
2002	1120	16
2003	1415	19
2004	2506	24
2005	3218	27
2006*	557	30

Source: ADPP monthly bulletin for 2002-2005; District Health Directorate for 2006.
**data for July, August and September*

3.3 Responses to AIDS in Boane

While the emphasis of early responses to AIDS was strongly on prevention, the focus in the last few years has shifted to include care and treatment. In early 2002, the Ministry of Health adopted a policy to prevent mother-to-child transmission and treat opportunistic infections through the public health system.

District Directorate of Health (DHD)

The District Directorate of Health (DHD) is responsible for health in Boane district. It establishes the public health strategy for the district, as well as the specific programmes for primary health care. This level of care in the district is provided by five public health centres, each with a maternity ward, and two public and four private health centres without maternity wards.

The Ministry of Health began financing HIV tests, CD4 counts and ARV treatment in July 2006.[301] In October 2006, the DHD began providing anti-retroviral treatment to 35 people and a target was set of bringing 50 new patients on to treatment each month.[302]

Apart from these services a PMTCT programme financed by the Elisabeth Glaser Pediatric AIDS Foundation is in place in the public health units. Analysis of CD4 counts is undertaken at Hospital José Macamo, a secondary health facility, located in the city of Maputo.

District AIDS Commission (DAC)

Another public institution with direct responsibility for AIDS response at district level is the District Aids Commission (DAC), the equivalent body of the NAC at local level. The executive secretary of the DAC is the

[300] Voluntary testing data does not necessarily reflect population trends, although in this instance given the general population outreach of the programme, and the numbers of people tested, it is probably broadly indicative of growing prevalence over the period; or at least lack of containment.

[301] The ADPP programme in place since 2002 was interrupted in December 2005. A big effort on the part of the DHD to get funds from different donors allowed the testing programme to start again in July 2006 with Mozal´s support. However the testing used to be done at six posts and now is done at one health centre and three posts.

[302] According to the medical doctor in charge of ARV treatment at the MoH there is a limited quantity of ARVs available to be used through the Mozambican National Health Service. The provision of ART demands an organisational set-up and trained technical staff to provide the treatment. Experience has also shown that, due to stigma, patients do not enter ARV treatment despite its availability. In this context a quota was established in order to monitor its use. Changes in the quota will be introduced according to patient behaviour and improvements in the organisational set-up.

District Health Director. According to her, the DAC this year received instructions from the provincial AIDS coordinating authority to present proposals to implement AIDS activities for health personnel and to develop district AIDS programmes.The DHD has no funds available from the NAC for specific AIDS programmes and there is no district or provincial strategy in place.

District Directorate of Women and Social Affairs

The official role of the district Directorate of Women and Social Affairs is to support orphans and other vulnerable children and people with HIV. However, in practice, its role appears to be extremely limited. One of its main areas of activity is to assist people in need to obtain milk from the National Institute of Social Affairs.

Significant non-governmental groups involved in AIDS response

During the period 2001-2005, responses to AIDS were largely undertaken by local and informal organisations. Their role was particularly important because of the weak state response. There are a significant number of NGOs, CBOs and FBOs working in Boane to respond to the growing AIDS problem in the area. According to a list of projects provided by the District AIDS Commission there are 12 organisations operating in Boane. Data from other sources, however, refer to more than 24 organisations operating in the district, showing that there is a stratum of organisations that operates independently of official channels and coordinating mechanisms.

Information gathered in meetings and interviews with different actors operating in Boane led to the conclusion that many of the recognised organisations do not actually implement specific programmes and there were many claims and much suspicion that some of them mismanage funds or at least do not use them for their intended purpose. There is in general in Mozambique a high level of suspicion around management of funds, both in government and civil society.

The most significant non-governmental groups acting in the community are:

- *Centro de Esperança de Beleluane:* Main activities include education and information activities through debates and film screenings, voluntary testing (approximately 75 people per month) and orphan support.
- *Pfukhani:* Main activities include education and information activities in the areas of prevention, advocacy, discrimination and stigma, impact mitigation and partnership with other organisations working on AIDS response.
- *Casa do Gaiato:* Main activities include education and information activities through debates, theatre, plays, and sport activities; training of activists, counsellors, and trainers; support to people with HIV and home-based care; nutrition and school material support. They focus in particular on young people (both in and out of school), orphans and other vulnerable children, and community members.
- *Kuphedza Association:* Main activities include distributing goods to orphans and people with HIV; home-based care; and transporting patients to health units for anti-retroviral treatment.

According to a list of projects from the District AIDS Commission, there are 12 organisations operating in Boane. Data from other sources, however, refer to more than 24 organisations in the district, showing that there is a stratum of organisations operating independently of official channels and coordinating mechanisms.

- *Kindlimuka:* Main activities include distributing goods to orphans and people with HIV; home-based care; and transporting patients to health units for anti-retroviral treatment.
- *Kulima:* implementation of an AIDS project to support people with HIV; information and education sessions on the disease; credit support for income generation activities; community education; and organisation of monthly workshops at community level to discuss different topics such as education, health, justice, security and AIDS.
- *Tembeka* is a faith-based organisation comprised of parish priests from 20 churches in Boane. Its main activities include spiritual and material support to 60 people with HIV and 400 orphans. Material support includes school material for children and food baskets provided every three months. A maximum of 20 orphaned children from each church are aided by the organisation.

The activities undertaken by local organisations[303] are centred on prevention through sensitisation campaigns where different topics related to AIDS are addressed, including sexually transmitted infections, voluntary testing, home-based care, and orphans and vulnerable children. Organisations employ various methods to get the message across including presentations, theatre plays and sports activities. Training of activists is another area of activity.

Some organisations, such as Kindlimuka and Kuphedza, focus their activities on supporting orphans and vulnerable children and people living with AIDS through provision of food, cleaning materials, school materials and second-hand clothing.

There is no notable coordination between the activities of the various organisations in the district. This may be part of the reason why there are so many small organisations 'doing everything' and little evidence of either scale or specialisation amongst these organisations. There is also little evidence of linkages to government programmes, although these are themselves so limited as to offer little tangible benefit. It must be concluded that development of AIDS response CSOs in this area of Mozambique is still largely unsystematised, unsupported and limited in scale and civil society is barely supported by official government institutions and initiatives.

3.4 CSO experiences in accessing funding

The main sources of funding for AIDS activities in Boane District are Mozal (private sector factory), NPCS (the provincial AIDS coordination structure), Spanish Cooperation, ActionAid and Geração Biz (a government project to support youth health and education programmes). But these represent only limited funding sources and CSOs are largely at sea in terms of knowing how to and being able to access funds.

The relations with NPCS are reported to be very difficult due to the complexity of the forms which must be submitted for funding. A number of the organisations in the district say that they do not have the human resources to satisfactorily complete funding forms or proposals. CSOs also see the NPCS as bureaucratic and slow-moving and they say that it takes an excessive amount of time for them to review project proposals. For example, Casa do Gaiato, an organisation dealing with orphans and

[303] The information presented here was obtained in a meeting organised by DAC on September 22, 2006 and through interviews with four local organisations: activists of Joaquim Chissano Secondary School, Pfukani, Casa do Gaiato, and Kindlimuka.

other vulnerable children, had a project approved by NPCS in 2005, but nothing had been disbursed by the latter part of 2006. This created significant problems as they had planned based on the project approval and urgently had to secure bridging funds.

No gloves: using plastic bags for home-based care

In this context, very few organisations have had access to AIDS funds. The volume of AIDS funding in Boane is irregular and small and this means that programme scale is also small. Some organisations have managed to access funds to implement activities, but few organisations have secure funding and amidst accusations and suspicions of mismanaging funding the entire funding environment is problematic. The result is that organisations tend not to have grown to the point of providing consistent services and there has been growth of many small initiatives which have little hope of making a significant difference apart from in their immediate surroundings.

Even in areas where support is relatively easy to provide, such as providing supplies for home-based care, there seems to be an absence of systematic support. Home carers at Kindlimuka use plastic bags for gloves when they care for bed-ridden patients and contributions from CSOs members, many of whom have very few resources, are an important element of support for the organisation in its efforts to support orphans and people with HIV. This organisation also has been promised support for renovating a building for its use from a local industry, but this kind of support is not systematic or at scale.

Views on NPCS/NAC from the CSO Survey

"NPCS is very bureaucratic. They take too long to analyse the reports and there are too many interruptions in the process."

"The NAC is very bureaucratic. They take too long to provide the funds for project implementation; the funds are reimbursed just for short-term projects; they do not pay incentives to the project staff; they take too long to disburse the funds."

"NPCS was the most difficult funding agency to work with because it

is very hard to get funds from them. In this context there is no way to implement projects."

"The NAC is very bureaucratic. There are no clear instructions for project presentation and they often change the procedures along the implementation of projects. The approval of a proposal can take one year."

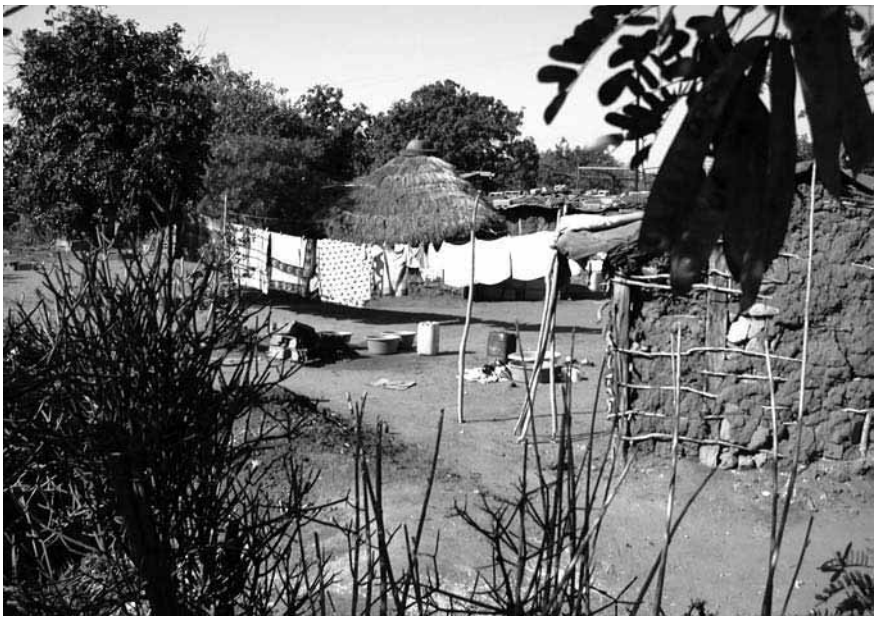
"NPCS - they are very bureaucratic because their decisions and policies are established at the central level and are not operationalised at local level."

"The NAC takes too long to approve the first project. Clarifications about access to funds are never correctly made and when the organisation gets the answers the project has to be reviewed because all the quotations are outdated."

The case of Kindlimuka Boane

Kindlimuka Association was the first organisation of people living with HIV/AIDS in Mozambique. It began its activities in 1996 and was legally established in 1998. Its main objective is to give moral and material support to people with HIV, people with HIV-related illnesses, orphans and relatives through the establishment of networks of social solidarity. The most important activities of Kindlimuka are counselling, advocacy, prevention, and sustainability of projects to help people with HIV and their relatives to deal with the disease in their daily life.

Kindlimuka has its national headquarters in Maputo. Since October 2002 a branch of Kindlimuka has also been operating in Boane District. Kindlimuka is one of the most active organisations in the district undertaking through the hard work of its members a considerable support to people with HIV and orphans in the district.



A support organisation in the midst of the community

It is comprised of 49 members. The organisation has an executive board comprised of the representative, executive secretary, the accountant, activists, the head of the sewing activities, trainees, the coordinator of orphan support, the counsellors, and the guard. Eighteen members are part of the working staff. All are volunteers who work without payment.

Kindlimuka Boane is a member of the District Aids Commission and of the Consultative Council of Boane's District. Since October 2006, it has been the president of NGOs and of the Associations Forum Against HIV/AIDS in the district.

With the support of the chief of the neighbourhood, Kindlimuka develops awareness sessions that are used to invite people to be tested for HIV. The Kindlimuka activists take those who test positive to a health unit for them to start treatment or receive appropriate care.

Through the work undertaken by the activists and counsellors, the organisation provides moral and material support to 444 orphans, 85 people with HIV and 188 affected women. The activists help the patients through home-based care: cleaning the houses, washing the patients and taking them to the hospital (although only cases where the patients have money to pay it); the counselors give them advice on how to inform the family of their status and how to deal with the disease. They support orphans with school materials and food.

Membership in a support organisation offers opportunities to help and to survive

Kindlimuka receives funding and material support from Kindlimuka headquarters, UNICEF and Southern African AIDS Trust. These funds consist of subsidies to pay the activists and counselors, school materials for orphans and food baskets. When the organisation has no funds available, the members of Kindlimuka (who are poor people without regular income) pay for urgent expenditures such as the transport of patients to hospital or needed materials for home-based care.

Kindlimuka also implements income generation projects in agricultural production, sewing and dress making, and in the production of mosquito nets as a means of sustaining its members.

A *machamba* (smallholding used for food production and traditionally managed by families) managed by the Kindlimuka headquarters and located at Boane is worked by the members of Kindlimuka Boane. Last year, however, there was no production due to lack of funds.

Kindlimuka is an exemplar of an organisation which has the leadership, community commitment and organisational culture to make a significant contribution, but this opportunity is largely lost due to the absence of a system for making funding available such that the organisation can undertake proper planning.

A project to open a new *machamba* was submitted to ActionAid and was expected to start in late 2006. One part of this *machamba* is to be used for food production to improve members' nutrition. This project will also provide funding for the medical assistance of 50 members and of 100 orphaned children of both members and non-members.

A dress making project is also in place; skilled members train other members in the basics of the work. Funding for the project came from NPCS. However the organisation currently has four sewing machines that are broken and there is little likelihood that they will be repaired due to lack of funds. Nonetheless, despite the fact that the trainees can not apply their knowledge, they consider the training very important.

Mozal supported the Kindlimuka project for mosquito net production by giving them an additional four sewing machines and materials for the training of its members. The training is already concluded, Mozal bought the product, and Kindkimuka is now using the income to continue the production.

On April 7, 2005, Kindlimuka was visited by Joana Mangueira, the Executive Secretary of the NAC, who promised to provide funds for home-based care. By early 2007 nothing had been forthcoming.

According to the representative of the Boane branch of Kindlimuka, the organisation's needs are a vehicle to transport patients to hospital and materials for home-based care, such as gloves, soap and kits.

Kindlimuka is an exemplar of an organisation which has the leadership, community commitment and organisational culture to be a significant support in an area where this is hugely needed. But the opportunity is largely lost due to the failure of any viable system for making funding available such that proper planning can be done by the organisation. It exemplifies a true community organisation capable of making a significant and probably cost-effective contribution, but the experience of which flies in the face of prevailing rhetoric around national support for CSOs. The opportunity remains mostly unrealised.

4. Epako, Namibia

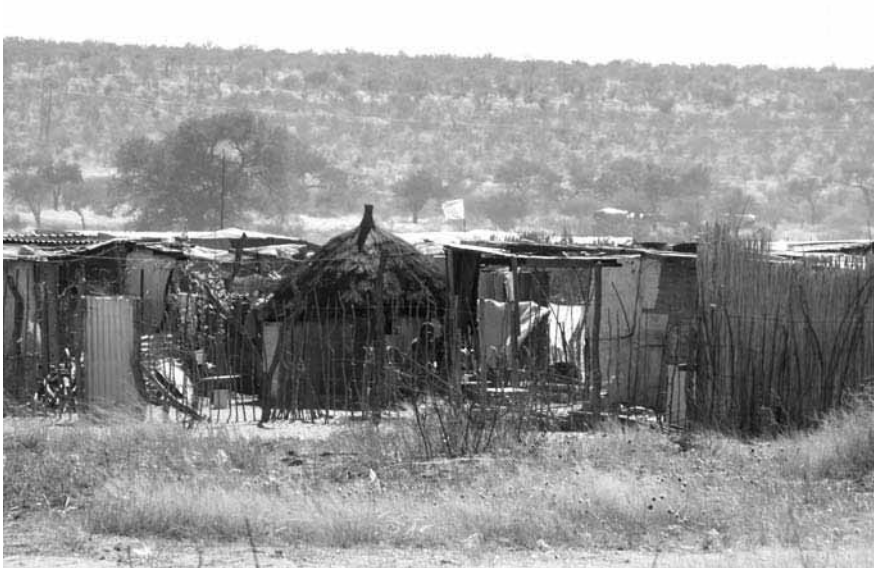
The case study was developed by Andrew Harris

4.1 Description of the site

Epako is a peri-urban mixed location on the outskirts of Gobabis, the market town and administrative centre of Omaheke Region in eastern Namibia. The population of Gobabis, including Epako, is approximately 15,000 people.

As a former township from the apartheid era, Epako is the residential centre for many of the poorer residents of Gobabis. Communities of all the main Omaheke groups are resident there – Hereros, Nama/Damara, San, Owambo, Tswana and Xhosa. The San, in particular, may be considered as a vulnerable group, being economically marginalised and educationally disadvantaged.

The ex-township status is reflected in the concentration of poor people in Epako. A recent series of village-level participatory poverty assessments in Omaheke identified Epako as one of the areas which should be included in a representative sample of poverty in Omaheke.



Informal housing in Epako

Gobabis is located 200 km from Windhoek on the Trans Kalahari Highway towards Botswana. It is thus the first (or last) stopping point in Namibia for traffic on the highway to Botswana, other than the border post. The highway brings its own risks: Epako is a place where truck drivers stay, and although prostitution is illegal and not talked about openly, it is known to exist along the highway. An army camp is located about 4 km away. Alcohol abuse is seen as a major factor in the spread of HIV, and the regional governor speaks about how the region is becoming more integrated due to greater levels of mobility.

Epako itself is a very mixed area that is described as dynamic and without a strong sense of community. Gobabis and Epako are growing as people move from the rural areas looking for work, even though there are no ready sources of employment. There is a transient element to Epako's population, with a number of people moving into and out of the informal settlements at the edge of the community. Epako is a place where many people live as their main residence, as well as a place in which people from other parts of the region stay when they come to Gobabis as the market town.

Omaheke Region

The Omaheke region is in the east of Namibia and covers an area of 84,612 sq. km. In 1991, the population of Omaheke was estimated at 52,000 (0.61 person/sq. km); by 2005, it is estimated that this has grown to 75,102 (1.13 person/sq. km) – still below half the average population density for Namibia as a whole (2.44 person/sq. km.). Centres (other than Gobabis itself) are small and the population is widely dispersed. Eighty percent of the population lives in the rural areas.

A general picture of Omaheke, as painted by the UNDP 2000 Human Development Index, is as follows:[304]

[304] Source: 1996 ICS and UN Population Division (life expectancy); 1993/94 NHIES (income); 1996 ICS (literacy enrolment); NHDR 1999 (UNDP); national accounts 1993-1999. The HDI is a comparative measurement of quality of life in countries around the world, taking into account levels of life expectancy, literacy, education and standards of living.

	Life expectancy	% Adult literacy	% School enrolment	Income N$	HDI 2000	HDI 1999	HDI 1998
Omaheke Region	44.3	67	74	3 944	0.607	0.644	0.706
Namibia (Overall)	43.1	81	84	3 608	0.648	0.683	0.770

In relation to poverty, the 1998 UNDP figures show:

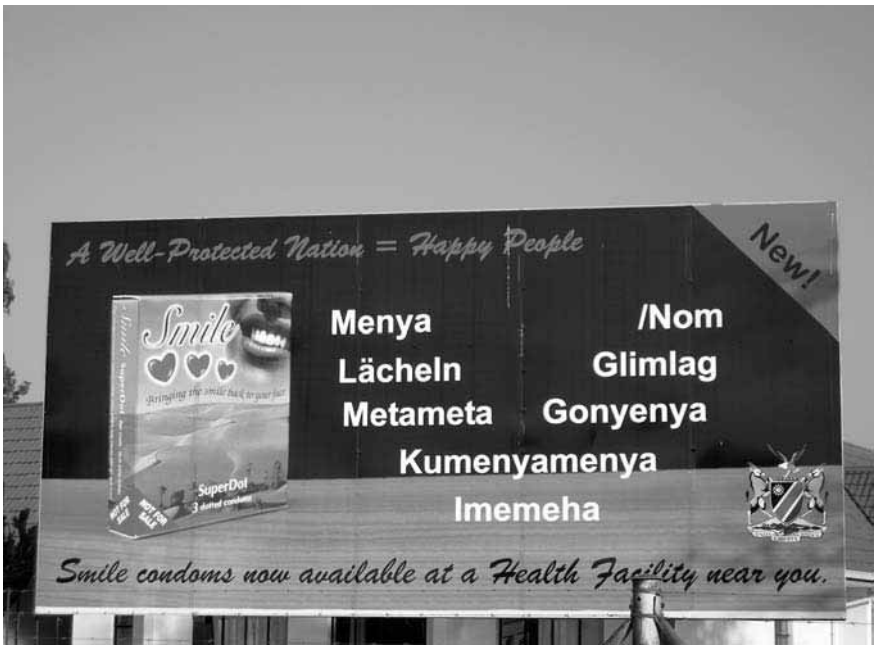
%	Non-survival 40 years	Illiteracy	Underweight children	No water supply	No health service	Poor living standard	Poor house-holds
Omaheke Region	21.1	36	9	6	89	35	25
Namibia (Overall)	18.0	19	15	23	45	28	9

At 25%, the proportion of poor households in Omaheke is by far the highest for all regions of Namibia. This is not inconsistent with the average income figures for the region in the first table – these income figures are inflated by the relatively high incomes of farmers in the region's commercial farming areas.

By language group, inadequate human development and poverty is heavily focused on the San community, whose human development index is only 0.28. Significant numbers of San live in the Omaheke region.

4.2 AIDS in Epako

Omaheke has a low HIV prevalence rate compared to other parts of Namibia. It is estimated that the HIV prevalence rate in 2004 was 13.8%, amounting to approximately 5,500 HIV-positive people in the region. This represents only 3% of the overall HIV-positive population in Namibia.



HIV prevention is one of top priorities in Omaheke Region, which has relatively low HIV prevalence levels

Given the relatively low prevalence rate, it follows that in Omaheke most attention is being paid to preventing new infections. However concern

was expressed during the case study research that the relatively low seroprevalence figures may actually mask the fact that HIV incidence is rising. A fair amount of skepticism was expressed about the accuracy of the prevalence rates in the region. Treatment and care services are on the increase in Omaheke and there is an emerging tension around the balance between prevention activities and those aimed at care and support.

The recent Participatory Poverty Assessment (PPA)[305] carried out by the National Planning Commission in 2006, which included Epako as one of the six reference sites, produced a number of findings relating to AIDS, as seen by the community.

The pandemic always ranked lowest among identified community problems, with a wide range of misconceptions and misplaced beliefs about AIDS. Of particular concern was a strongly held view that only prostitutes and women who live 'loose lives' would be infected by the virus. The PPA showed that poverty and hunger may indeed force a number of women to render sexual services in return for food, commodities or money. The gender circumstances that women face, with more limited control over and access to productive resources, coupled with cultural practices that put women at risk of losing a large share of their assets to a husband's relatives if he dies, mean that women are more vulnerable to being forced to opt for risky survival strategies and more vulnerable to exposure to HIV infection. On top of this, women described how men in the region were still stubborn when it came to regular condom use.

4.3 Responses to AIDS in Epako

Research in Epako revealed a remarkable density of organisations and structures working on AIDS activities in the community. These fell into two main categories – governmental (the Ministry of Health and related institutions, the municipality, and the Regional AIDS Coordinating Committee (RACOC)) and civil society, including NGOs, CBOs and churches.

Respondents uniformly held the view that local businesses have not taken on a role in AIDS response in the community. This was consistently understood as a continuing reflection of patterns established during the pre-independence period. There is no 'culture of donations' among the predominantly white owners of businesses in the area, and the same was said of white church congregations.

4.3.1 Government activity

Department of Health

Until recently the district hospital in Gobabis has been the focal point for AIDS services in the region, although increasingly functions are being devolved to clinics as health workers are trained in procedures and protocols.

Most health workers in the region have been trained in HIV counselling and testing and there is a counselor based in every clinic in the region. Rapid HIV testing has been introduced at the hospital in Gobabis, the Epako clinic and one other clinic. By the end of 2006, it was expected that approximately half the clinics in Omaheke would be equipped to

Research in Epako revealed a remarkable density of organisations and structures working on AIDS in the community, including from government and civil society. To date, local businesses have not taken on a role in AIDS response in the community.

[305] National Planning Commission (2006).

do rapid tests. Once this is in place, it will be possible for PMTCT to be provided at clinic level. Up until this point, blood had to be drawn in clinics and sent to Gobabis for testing. This was an undesirable situation, because of the challenges and time involved in transporting samples to Gobabis and sending back results. Post-exposure prophylaxis is available at all clinics in the region.

The Epako Clinic is located near the entrance to the community, just off the main road to Gobabis

At present, ARVs are provided at Gobabis Hospital, but doctors and nurses are being trained to administer ARVs so that this can be rolled out more broadly. All patients who test positive are registered at the clinics for screening to enter the ARV programme. In order to qualify they must have a designated treatment supporter. The majority of people receiving ARVs from the hospital live in Epako. One of the major challenges that has been experienced thus far is that people who are in the ARV programme move away and there is no systematic way for them to be reached for on-going support. There are clusters of ARV patients in the vicinity of other clinics; every Tuesday doctors from Gobabis travel to other clinics to reach these patients, but given the distances, this means that clinics are visited only once every one or two months. Transportation is a major problem. A doctor at the Gobabis Hospital noted that the condition of the roads means that vehicles are often 'grounded' after two or three months.

The Ministry of Health and Social Services in Omaheke works in close partnership with the Omaheke Health Education Project (OHEP) on TB and HIV services (see below). OHEP works in all the clinics in the region with the exception of one remote location. Otherwise there is not significant collaboration or interface between the formal health system and civil society organisations. A doctor at the Gobabis Hospital noted that there have been efforts to engage with civil society through community meetings and also through contacts with the Regional AIDS Coordinator, but other than with OHEP, these relationships have not solidified. He said that they do not have a good sense of which CSOs in the area work on AIDS and what types of roles they play.

RACOC

The Regional Aids Coordinator (RAC) is responsible for coordination of AIDS activities through a multisectoral Regional AIDS Coordinating Committee (RACOC). Constituency and District AIDS Coordinating Committees are expected to coordinate at a more local level, although the RAC reported these are less well established. The overwhelmingly rural nature of the region means that constituency (or village) committees are more likely to be effective than district-level bodies which would span large territories.

The main role of the RACOC is stimulating and coordinating AIDS response activities in the region, although it is also involved, to some extent, in implementing activities. Main areas of focus include awareness campaigns and combating stigma, home-based care and family counselling, support to orphans and getting children into school, condom distribution, and promoting the ARV programme in the region. The RAC felt that it has been drawn into implementation because there are not sufficient strong organisations in the region to drive the work forward in some of these areas.

The RAC works closely with CSOs in the region; one function is providing assistance in developing proposals, endorsing proposals, and assisting groups that have accessed funds to manage them properly. Although the RACOC is shifting gradually towards more of a direct funding role and will be issuing small grants through its own budget, until now most funding for CSOs in the area has come from the Small Grants Fund (SGF) administered by UNAIDS. The RACOC endorses all proposals to the SGF that emanate from the region and has had a reasonably good success rate. Another source of funds, particularly in 2002-03 when there was a development worker working in RACOC, was Voluntary Services Overseas (VSO) grants. However the VSO money has still not been completely used because of capacity issues. The RACOC also offers capacity-building and skills training programmes, but these are limited because of the shortage of resources.

The RACOC holds quarterly meetings which are reportedly well attended by a variety of groups. The Regional AIDS Coordinator describes CSOs as the 'backbone' of participation in the meetings. Overall, groups within the region as well as external entities believe that the Omaheke RACOC is largely successful in its coordination role. Local organisations noted that 'it listens to our problems and will try to assist the organisations. It helps in revealing the gaps.'

Gobabis Municipality

Since March 2006 the Gobabis Municipality has employed an HIV/AIDS Coordinator whose position is funded by a Dutch NGO. The focus of the coordinator's work is principally on outreach with municipal employees, but is also oriented towards community needs. Her position is guided by a municipality HIV/AIDS committee and her workplan is aligned with priorities in the national strategic plan. The Municipality is a member of RACOC.

The Regional AIDS Coordinator describes civil society organisations as the 'backbone' of participation in the quarterly meetings of the Regional AIDS Coordinating Committee in Omaheke.

The key work areas of the HIV/AIDS coordinator are: education and awareness, including weekly health sessions with municipal employees; distribution of condoms to all municipal offices and training in proper

use; organising municipal-wide events, such as 'Gobabis Cares' day; promoting and making visible messages about AIDS, including on municipal stationery; promoting community engagement; and consolidating information about AIDS resources in the municipality through a directory of service providers.

The Municipality has funds to support income generating activities in the town and is able to distribute funds for projects that it believes could be self-sustaining. Other projects that are being considered are an orphanage trust, a multi-purpose centre, home-based care activities for employees and supporting people with HIV (including financial support). At the time of the research, the process of advertising this funding and making decisions about allocations was at an early stage.

The municipality's HIV/AIDS coordinator was familiar with the major civil society initiatives in the community and had already developed links with at least one of them as a back-up source of condoms at times when her supplies ran low. However there was little evidence that her workplan included any structured collaboration with CSOs in the community. If anything, the community outreach work that she undertook on behalf of the municipality, such as visiting shebeens to distribute condoms and teach people how to use them, duplicated other existing work and might well have been better undertaken in partnership with a local CSO, rather than drawing upon her limited time and resources.

4.3.2 Civil society activity

A total of 41 CSOs are listed on the NANASO database as operating in Omaheke region. Twenty of the organisations are classed as NGOs, 13 as CBOs and 7 as FBOs. Four of these are branches of larger organisations and, of the remainder, 17 are based outside the region – all in Windhoek. Thus 20 (50%) of the organisations are locally based in Omaheke.

A number of these CSOs are either based in Gobabis and work in Epako, or are from Epako itself.

CSOs with international links

Organisations that are internationally based and have invested heavily in the area include the Omaheke Health Education Project (OHEP) which was launched as a project of Oxfam Canada; Health Unlimited, a UK-based development organisation with a focus on marginalised groups in remote areas; and ACORD. In two of these three cases, the initiating organisations have formed, or are forming, independent, locally based agencies to continue the work that they have initiated.

OHEP has developed a model response to community health needs, with a particular focus on TB.[306] This response is based on a close working relationship with the Ministry of Health through the hospital and clinics which refer people to OHEP. A nursing-based assessment is then undertaken and the referred person is taken into a community-based support programme. This includes field promoters, clinic health committees, village health committees (reporting to the clinic committees), and local support groups. The local support groups comprise the individuals who are identified to support people in the programme – typically a family member who is identified and then

[306] OHEP has since been re-launched as Community Health Care Services Namibia.

trained to play an effective support role to the person receiving home-based care. At the time of the case study research, OHEP was undertaking a community survey in Epako to make contact with every person in the community who was known to have TB or to have developed AIDS. They were a visible and organised presence on the streets of the community.

Health Unlimited also has a strong programme of community health support which is not specialised on AIDS, although the epidemic is central to the work it is doing. It works closely with the Ministry of Health to provide primary health care in hard to reach areas, including by training community members to provide particular types of services. The organisation has worked extensively in Omaheke Region because of the significant San and Danara population living there. It reports that the shift of funds towards tackling AIDS has led to it becoming much more difficult to raise funds for general community health programmes. This in turn has led to recent cutbacks in its community health programmes in Epako.

Both Health Unlimited and Total Child/ACORD have done significant work on health promotion in schools, focusing on teenage pregnancy and vulnerable children. Both have adopted a holistic approach to issues affecting children in an attempt to prevent drop-outs; for example, Total Child links work in schools to visits to families. They see that many of the factors leading to school drop-out rates emanate from conditions in the home and the community.

The governor and Regional AIDS Coordinator both noted that Johns Hopkins University is expanding its activities in Namibia into Omaheke region and will be forming community action groups, particularly in the informal areas of Epako. This is a research-based programme that is directed towards developing local evidence-based AIDS strategies. However, the researchers did not come across any evidence of this programme during the case study research.

National CSOs

A number of Namibian NGOs that work nationally or in more than one region are reported to have activities in Omaheke. However the experience on the ground seems to be that nationally based NGOs are not particularly known in the community, apart from those that have regional offices in Omaheke.

Catholic Aids Action (CAA) and the Evangelical Lutheran Church AIDS Programme (ELCAP) are the most prominent examples of national NGOs. CAA runs soup kitchens for 300 orphans and other vulnerable children two times per week and oversees eight groups of home-based carers from its church offices in Epako. It trains youth peer educators and also oversees a group of volunteers who support children in an after-school programme. ELCAP's office is in Gobabis town and was not visited as part of the case study. ELCAP also provides home-based care services in the area.

There are strong relationships between the regional government and both CAA and ELCAP; the regional governor acknowledged that 'government can't do everything' and that there is a need to rely upon organisations that are closer to the people. They also find the churches to be disciplined

and organised in the way they work, and regard them as a 'good platform' for disseminating messages.

The Omaheke branch of Lironga Eparu, the national network for people with HIV, is based in a small office at the municipal office in Epako and receives extensive support from OHEP. The branch works with little or no support from the national office, which appears to be related to its failure to liquidate a grant that had been issued two years earlier. It was explained that the grant could not be closed out, because the person in Lironga Eparu Omaheke who had been responsible for the grant had died and the other members were not able to provide the national office with sufficient records or supporting documentation for the grant to be closed out. OHEP supplies Lironga Eparu with food parcels for its members and has also set up a poultry project in Epako to supply eggs along with the food parcels.

Although Lironga Eparu is the national network for people with HIV and ostensibly has an active presence in every region of the country, the network as a whole remains quite weak and its branches are under-resourced and under-capacitated. The assistance that Oxfam/OHEP provides to Lironga Eparu in Omaheke is the primary source of support for the network locally, and the fact that the assistance is largely oriented on provided food for Lironga Eparu members also reflects the desperate situation in which many HIV-positive people in Epako find themselves.

Local CSOs

A local project to support children, Save the Children was initially set up by residents of Epako, but has since attracted sporadic assistance from international volunteers and benefactors

The Regional Aids Coordinator explained that the largest number of groups in the region are CBOs, FBOs, farming organisations and youth groups that emerge from the community itself. During the research in Epako, a number of small-scale, volunteer-run CBOs working on AIDS were identified.

- During the time of the case study research, a group of young British volunteers affiliated to Raleigh International were

constructing a playground in Epako in partnership with Light for the Children, a local CBO led by the pastor a nearby church. Light for the Children works with 150 children in Epako.

- A volunteer-run theatre group, which has been in existence for eight years and has received training from the National Theatre of Namibia, puts on plays for the community on a variety of social and development issues, including gender, AIDS, environmental issues and discrimination.
- The theatre group is based out of a small child care centre – 'Save the Children' – that provides orphaned and other vulnerable children who are approaching school-going age with supplementary support to 'bridge' them into school. The children also receive a meal every mid-day.

4.4 Sources of funding for CSOs in Epako

The main sources of funding for CSOs in Epako differ markedly by type of organisation.

Some of the more prominent organisations active in Epako are there as a result of action by international development organisations. These had secured and sustained their presence through access to international grant sources. Health Unlimited and OHEP are both perceived by other civil society organisations as being very successful, but part of their success is attributed to the fact that they have regular and significant levels of outside funding. This allows them to have broad community outreach; they have the physical means to get into the community (eg. vehicles); and they provide community workers who are well trained. They also have skilled managers, some of whom are expatriates, to oversee programme implementation. Moreover, the regular external funding means that staff have fewer fundraising responsibilities than do the leaders of other CSOs. This undoubtedly allows them to focus more attention on the content of the work they are conducting.

Local branches of national NGOs tend to receive significant core support from their national headquarters, and then supplement that support through local resource mobilisation. The larger research findings show that these agencies are often effective in securing a significant proportion of funds from international sources on a bilateral basis. For example, both CAA and ELCAP receive significant amounts of PEPFAR and Global Fund funding through their central headquarters which allows them to carry out programmes across the country. Other national NGOs such as YWCA Namibia, which carries out projects in schools in Omaheke, also source their support centrally through a national office, largely from international sources.

While support from a central office allows some stability, it does not mean that the local branches are without resource pressures. Catholic AIDS Action in Epako runs a soup kitchen twice a week, but has no financial resources to support this activity. They cover the costs in a variety of ways – for example, by cutting into their home-based care budget and, more recently, by convincing a local Pentecostal church to take on responsibility for the soup kitchen one week per month. A Peace Corps volunteer based at CAA has worked with its local volunteers to solicit donations from businesses in Gobabis – they are asking for pledges

of N$1/week – yet despite visiting local businesses in person, this approach has secured only a handful of responses.

The Small Grants Fund, administered by UNAIDS, is the most important source of open, competitive funding for local CBOs and NGOs. Since the start of the scheme in 2003, a total of N$958,462 (approximately US$150,000) has been allocated to 14 Omaheke organisations. The largest grant made was N$69,000 (approximately US$11,000) and the smallest was N$11,000 (approximately US$1700).SGF applications are submitted through the RACOC, which endorses them and passes them on to the secretariat in Windhoek. The SGF awards funds for one-year projects, so even this scheme has its limitations as it can be difficult for recipient organisations to sustain themselves after only one year of support.

Evergreen Theatre Company

The Evergreen Theatre Company, based in Epako, was established in 1998 and has been trained by the National Theatre of Namibia as a community theatre group. It develops and puts on plays on issues such as gender, discrimination, AIDS and the environment in school halls and community centres.

The group works on a voluntary basis. It has never received any funding; its members contribute what they can to prepare and stage the plays. Applications it has submitted for funding have been turned down. It asks for contributions from people who attend its plays and once received a donation from a Dutch woman who visited the project.

Two of the original members are still with the group, but over the years many members have come and gone. According to the director, people come to the group because they see an opportunity, but then leave in search of paid employment.

According to the director, the position of the National Theatre is that the regional theatre groups need to become 'self-reliant.' It remains in contact with the groups, but does not provide them with any resources.

Apart from the SGF, there were few other sources of financial support that had been accessed by CBOs and NGOs in Epako. Most of the other CBOs received limited in-kind assistance through linkages they had established with national and international sources: for example, the National Theatre Company of Namibia (training and workshops), and links with international volunteers and individuals overseas who make once-off donations to support project costs. The case study research found that this can place CBOs in vulnerable positions – not just in terms of sustainability, but also in terms of the ownership of their activities. One CBO related an instance when an individual from Gobabis reportedly secured a donation from a donor overseas in the name of the project in Epako, but did not transfer the funds to the project as claimed, essentially embezzling the resources. At a later stage, a foreign woman became heavily involved with the same project and, in the eyes of the original founders, began to steer the project in her own way on the basis of the argument that she had succeeded in securing funds from abroad to finance the project's work. A conflict emerged between the original founders from the community and the foreign woman over the direction of the project that remained unresolved at the time of the case study research.

The Small Grants Fund, administered by UNAIDS, is the most important source of open, competitive funding for local CBOs and NGOs in the area. Apart from this fund, there were few other sources of financial support that had been accessed by local organisations in Epako.

Although some of the organisations that were active in Epako had strong working links with government, there was no evidence of funds being

made available to civil society from government directly. Indeed, direct funding from government for mitigation of AIDS was seen to have declined, with the tightening up of the application of the disability grants and the discontinuance of drought relief programmes. The municipality, similarly, was not seen as a source of funds, although the municipality was seeking to develop a funding source for income generating projects.

Note has already been made of the perceived lack of support from local businesses and individuals, said to be the result of strong inclinations (or dis-inclinations) left over from pre-independence days. It was noted that local churches were beginning to awaken to the idea of support for local projects, but this remains at the level of sporadic, once-off events. As the RAC put it, the idea is 'still getting into their minds.'

4.5 The funding environment for CSOs

Every respondent in the case study research held strong opinions about the funding situation for AIDS in Epako. The most commonly expressed views were that there is insufficient funding available for CSOs in the area and that the funding that is available is directed at the wrong priorities.

Many respondents felt that donors and NGOs direct their attention to other parts of the country where HIV prevalence rates are higher. The Regional AIDS Coordinator noted that donors are 'being directed by government to other areas' and that low prevalence in Omaheke meant that 'the money doesn't come here.' This was indirectly corroborated by the UNAIDS Country Coordinator who noted that there has been a tendency for donors in Namibia to 'go North' where the highest prevalence and deepest levels of deprivation are.

While national NGOs and international organisations receive significant funding from their headquarters, there are few funding options available to local organisations and CBOs apart from the Small Grants Fund. This has a direct effect on their ability to sustain regular activities. Many of the CBOs interviewed carry out activities sporadically, if and when they have access to resources. There is very limited assistance available for core costs such as transportation. As one larger NGO representative commented, CBOs – particularly those in outlying areas – use donkey-drawn carts to do the 'running around' work that is required to organise and conduct activities.

The general consensus was that the Small Grants Fund and the limited support available through the RACOC were helpful, but extremely limited. This results in a situation where 'there are only three or four big NGOs which are doing the work' in the area, even though there are many entities in the community itself that wish to be involved.

Organisations were aware that Namibia has received large disbursements from the Global Fund, but the perception in Epako is that Global Fund support mostly reaches towns and larger NGOs. As the Principal Recipient, the Ministry of Health and Social Services allocates funds to civil society organisations, but 'civil society is big' and there are many organisations that need support. None of the organisations in Epako had any direct experience with Global Fund financing.

A different challenge was expressed by one of the large development NGOs working in Omaheke. This organisation focuses on extending

'The funders will give money for activities, but not the organisational modalities and the logistics. The resources are in the wrong form. There need to be resources to enable an organisation to survive, otherwise there will simply be a process of organisations starting and collapsing.'

- Respondent from a large NGO working in Omaheke

'When you write a proposal that includes all these things [food and poverty], it is too wide for a donor. My conscience does not allow me to just write a proposal on home-based care. [Why can't we write proposals] through HIV/AIDS funds that are about poverty alleviation? We need to tackle the bottom that bubbles underneath the formal programmes of home-based care or whatever.'

- NGO working on health promotion in Omaheke

primary health care services in underserved communities, and has lost funding in recent years due to the narrow targeting of funds for AIDS only. The NGO previously ran a large-scale community-based health promotion programme in Epako, but this programme was eventually terminated because they could not attract continued funding for a generic health care programme that was not specifically targeted at AIDS. This was a source of great frustration for the head of the organisation, who felt that the earmarking of funding was counterproductive, as AIDS is inextricably linked with patterns of health-seeking behaviour and other underlying issues within communities.

Capacity issues

A number of issues related to capacity were cited as factors that hamper that ability of local CSOs to access funds. It was noted that local organisations do not have much experience with recordkeeping, monitoring and evaluation, proposal writing, and tracking expenses. Low levels of literacy among CSO personnel are also an issue.

The Regional AIDS Coordinator commented that CSOs are eager to work, but sometimes can 'lose focus' during the dry spells when resources are not available. He observed that 'they have the capacity to deliver a message,' but that this doesn't mean they can do the 'process stuff.' Tasks that shouldn't be complicated – like putting together a workshop programme or making arrangements to hold an event – are in fact very challenging and organisations need outside support to learn to administer certain kinds of activities.

Comparing local CSOs to those based in Windhoek, he observed that there is a greater 'professionalism' in evidence among CSOs in the capital, which have learned to package and sell their activities in a more sophisticated way. He used an example related to funding proposals – the 'Windhoek NGOs' use research and attach supporting materials to their proposals to bolster their applications. CSOs in Omaheke, he said, 'don't know what else to attach to proposals.' They lack confidence around how to do certain basic things.

AIDS and poverty

'Poverty in Omaheke is the basis for all the problems we see.' This comment by one respondent was echoed by many others. Hunger and poverty are major underlying factors exacerbating the situation with AIDS in Epako, and poverty is at the centre of people's thinking. On the surface Omaheke may appear wealthier than it is because it is rich in cattle and commercial farms. However, this obscures deep poverty. A doctor at Gobabis Hospital noted that the ARV programme is compromised due to the fact that patients on ARVs do not have enough food to eat. He commented that 'the ones who own cattle aren't the ones who are sick.'

'The biggest problem is when our members die. Not all can afford to buy coffins.'

- Representative of Lironga Eparu

Local response mechanisms to deal with poverty have in the past been to access the drought relief programmes; however, this support is not currently available. Another mechanism was to register for disability grants. However, a circular from the MOHSS in 2005 reminded officials that the disability grants could only be given to those who were able to prove to a medical practitioner that they were unfit, wholly or partially for work. This immediately led to the withdrawal of a number of

previously given grants and, as the ARV programme takes effect, the ability to gain the relevant certification becomes progressively more difficult.

The increased international focus on AIDS was seen by some to be diverting attention and resources away from a broader developmental agenda, which would include a more balanced approach to community health programmes and social and economic welfare in the region.

Beyond the recently launched Participatory Rural Poverty Alleviation Programme, which has yet to translate into tangible programmes on the ground, there seemed to be little resolution available to the problems raised. Through Lironga Eparu Oxfam delivers maize meal to people on ARVs, but the broader government mechanisms that were previously available had been withdrawn. Moreover, in the search for adequate responses to the problems being faced, local organisations were facing the same dilemmas that have faced other rural development agencies in Omaheke in the past, namely that sustainable income generation projects or food programmes are not, in the end, sustainable in and of themselves because of the arid nature of the environment and because of competition from South African producers. The comparative advantage of Omaheke lies in cattle, not in small scale poultry (or similar) projects. This is not to say that the projects are not worthwhile in a larger social sense (when the value of local engagement of individuals and communities is factored into the cost benefit analysis). But such a message is not, typically, acceptable to donors who emphasise sustainability and cost effectiveness.

4.6 Implications

Concrete block houses in the formal area of Epako. Few streets in the community are paved

Overall, there was a strong awareness of AIDS on the ground in Epako. While stigma is still strong and much more needs to be done in relation to awareness and prevention, there is also recognition of the impact of AIDS in the community that was not there before. Despite this, AIDS does not feature much in the list of poor people's perceptions of the important issues facing them; here poverty issues, particularly food, dominate.

The focus of the discussions in and around AIDS organisations centred on the lack of resources to do as much as the organisations felt was needed. There was a perception that resources were going to other parts

of the country because the problems in Omaheke were not seen to be as pressing. CSOs argued that there should be as many resources going to Omaheke 'because we need to prevent the problem.' The fact that the region has a relatively low prevalence rate was not seen as a good reason for not funding the region.

There was very little perception of the larger flows of funding coming into Namibia. These are translating into Omaheke through, for example, the roll out of ARVs throughout the region. The ability of some of the larger NGOs to come and work in the region is also reflective of the increasing flow of funds, and the Small Grants Fund itself is supported by donations from several bilateral European donors who are part of the general resource scale-up.

But the underlying sense is that flows are not coming into the region in ways that the community response to AIDS can utilise. There has been a significant growth of local organisations, sometimes in response to education and training programmes and sometimes as a response to a growing awareness of the problems presented by AIDS on the ground. However these organisations are not succeeding in locking into the larger funding flows.

Some of the reasons for this relate to capacity. Community-based and smaller organisations are not geared up to the funding obligations required by the larger donor. While there was a great deal of discussion of the need to rectify this, through capacity-building and infrastructure support, the underlying question of whether smaller organisations should have to build themselves in this way was not sufficiently addressed. Nor is there clarity about whose responsibility it is, ultimately, to undertake this capacitation. There is an alternative response which suggests that the smaller and community-based organisation should be capacitated to do what it can do best on the ground, with funding structures that recognise this.

This need to think hard about funding systems was highlighted by the case of the local Lironga Eparu branch, which was working with little or no funding for itself as it had failed to liquidate a grant given to it two years before. Although the branch was being helped by other organisations with 'in kind' support, there seemed to be no constructive way forward to resolve the initial failure and to find mechanisms by which funding could be resumed, and in a way that might prevent a repeat of the original failure.

There was, in the light of all of the need to support local organisations, widespread endorsement of the Small Grants fund administered by UNAIDS. This mechanism was seen to work and a good proportion of smaller, local organisations had benefited from it. As may be seen from the larger study of which this case study is a part, the key problems faced by this popular mechanism were the small number of donor sources who were using the mechanism and the lack of transferability, with stronger recipients of Small Grants funding failing to move on to larger-scale funding sources.

Alongside the challenges of securing adequate funding, the challenges of coordination featured prominently in the discussions. Some of the mechanisms, such as those managed through OHEP, were seen as exemplary. More generally, despite a high opinion of the RACOC and

the RAC, much more was felt to be needed in relation to coordination. Interestingly, the churches were said to be taking this seriously, at least in Epako. But the Constituency AIDS Committees, which are seen in MTP III as the sub-regional mechanism for coordination, were still to prove their worth.

The importance of coordination in funding was highlighted by the Regional Governor, who argued that where funds went through the regional coordination mechanism, funding and funding flows worked well. But where the funding is coming from elsewhere it does not work as well.

On coordination, the RAC indicated that there is competition between civil society groups in the region: 'We have not learned that we are working for one people. Collaboration is poor.' The result is a lot of gaps. It was felt that civil society organisations will work together when necessary or when coordinated by an outside agency, but there have been problems of coordination in home-based care, with volunteers and clients moving from organisation to organisation according to the terms of resources offered to the volunteers. This has been a particular problem in Epako and Gobabis. In the rural areas, the work is more easily linked and coordinated around the clinics and local support groups.

Respondents note that Epako is a difficult community in which to mobilise people: meetings are called and people don't attend. Willingness to participate in community events is limited and turnout depends on whether the event is seen as 'attractive.' The head of one CBO noted that the atmosphere in Epako is very difficult in terms of working for change: people are 'passive' and 'no one is complaining;' donor organisations and resources are concentrated in Windhoek, which is far away; there are tensions in the area between some of the major ethnic groups, which plays out politically and may effect the way available resources are allocated; and low levels of education and employment lead to a sense of stagnation.

The local Lironga Eparu branch was working with little or no funding as it had failed to liquidate a grant given to it two years before. Although the branch was being helped by other organisations, there seemed to be no constructive way forward to resolve the initial failure and to find mechanisms by which funding could be resumed in a way that might prevent a repeat of the same situation.

5. Motshane, Swaziland

The case study was developed by Alfred Mndzebele

5.1 Description of the site

Swaziland has the highest HIV prevalence rate in the world. HIV prevalence among pregnant women in all age groups stood at 43% in 2004, but among pregnant women age 25-29, as many as 56% were HIV-positive in 2004.[307] The impact of the epidemic is being felt in many forms. For example, it is estimated that there are currently 150,000-180,000 orphans and other vulnerable children in Swaziland as a result of AIDS. Children are taking on greater domestic, agricultural and income generating responsibilities; are dropping out of school temporarily or permanently; go hungry or without meals for days; and are at risk of abuse, sexual violence and losing family assets.

Positioned along the highway from the Oshoek (Ngwenya) border gate with South Africa, Motshane community is located 15 km northwest of Mbabane, the capital of Swaziland. Given its proximity to Mbabane and the Ngwenya border post, Motshane receives a high volume of traffic. Its

[307] UNAIDS (2005).

highway is flooded by trucks, tourist buses and motor vehicles that enter and leave the country for South Africa on a daily basis.

A rural landscape may veil widespread and severe AIDS impacts

In 1999 a large-scale construction process was initiated to expand the road from Ngwenya to Mbabane into a highway. Motshane was seen as a suitable place to house the contractors' offices and also provided residential quarters for the employees, some of whom came from South Africa. The ongoing construction of the highway has added to the volume of people living in and around the community, especially Motshane centre, where a temporary compound that houses migrant workers has been set up. This highway also links to the northern part of Swaziland through another road which connects to South Africa on the north, at Matsamo border gate.

Motshane is a rural area under the control of a chief who is assisted by his council in governing the people. In 1997 the population of Motshane was 1,353 people. Motshane's location makes it an affordable residential place for people employed in Mbabane and Ngwenya industrial area.

The highway and the new Ngwenya industrial area, which is about 7km away, render Motshane vulnerable to HIV as it is regularly crossed by people in transit and provides a home to workers who have money in a community where there is widespread poverty. Like other parts of the country, Motshane has many unemployed residents and faces a severe AIDS problem.

5.2 AIDS in Motshane

The problem of AIDS has grown in Motshane like any other part of Swaziland. One community member lamented that there is an increasing number of funerals and these are largely for young people. The elderly are left to care for children as the parents pass on. In the primary school, it was reported that some of the children are HIV-positive, and deaths among pupils have been experienced in the past. A school teacher estimated that at least six children at that time were showing signs and symptoms of opportunistic infections associated with AIDS. Parents of some of the children were also sickly or had died. The Rural Health Motivator (RHM) and community carers both observed that there are a growing number of homes in Motshane that are headed by grandparents or children as the parents have died.

5.3 Responses to AIDS in Motshane

Women play the central role in organising community responses in Motshane

Communities and families – including children – are attempting to take care of affected children in many parts of the world where the epidemic has matured. This is also the case in Motshane community. A number of community structures and initiatives were identified in Motshane including:

- *Hope House* is a facility that provides a home for orphans and other vulnerable children. A new, expanded centre is currently being built.
- *Feeding kitchens*: There are about seven points in the area where children can access food.
- *Caregivers* include women who have volunteered to cook meals for the children.
- *Youth groups*: There are two youth groups in the area.
- *Rural Health Motivators*: These are community volunteers who play a major role in promoting health and other social programmes in the community.
- A *primary and a secondary school* that enroll children from Motshane, Ekupheleni and other adjacent areas.
- *Community fields*: These are community fields that are planted by

community members with maize and beans to support affected children in Motshane.

- *The community clinic.*

The clinic

Many people are infected and affected by the HIV epidemic in Motshane, according to the nurse at the Motshane Clinic. The clinic is one of the main institutions in Motshane that is involved with AIDS. It collaborates with Population Services International (PSI) in its New Start Programme, which provides counselling and testing every Wednesday at the clinic. Individuals testing positive who may need ARVs are referred to Mbabane Government Hospital, which is about 15 km from Motshane. On Mondays and Fridays, the clinic provides prevention of mother to child transmission services. Due to logistical constraints, including transport, clinic personnel seldom visit clients at their homes. Those patients who are sick and require specialised care are linked with Hospice at Home, a civil society organisation that provides services in Motshane to about 10 patients once a week. The rural health motivator who participated in the case study noted that it is not uncommon to see patients being transported to the clinic in wheelbarrows in cases of emergency, as the clinic nurses are not able to check patients who are sick at home.

The clinic has collaborated with the Ngwenya branch of Swaziland Positive Living (SWAPOL) to form a support group for people living with HIV. The support group has close to 20 members. Since its formation the support group has had two planning sessions, but does not yet have a formal programme. The support group's priority needs are to know more about AIDS issues related to treatment and to learn how to care for those already suffering from AIDS.

School fee support for children

The illness and deaths of parents has had major consequences for the lives of children in Motshane. Over 100 children who attend the Motshane Primary School have been identified as vulnerable and required support with school fees during 2006. The children were identified through an assessment done in collaboration with Rural Health Motivators among needy households in the community. The Rural Health Motivators and a community team used specific criteria to classify the children into distinct groups of vulnerability and non-vulnerabilty. The Government of Swaziland could only support 30 of the eligible children with a bursary for school fees - 70% less than in 2005. This decline in government support for school fees is caused by the increasing number of children that have been classified as orphaned or vulnerable countrywide.

The table below summarises the number of children who received support from the government for school fees in Motshane from the years 2003 to 2006.

Year	Number of children supported
2003	32
2004	85
2005	111
2006	30

In addition to government, other independent institutions and individuals have been providing support for children's school fees. In 2006, according to the Motshane Primary School, the following institutions and individuals provided support for 48 children. This included Hawane Lighthouse (14 children), Motshane Hope House (11), Mr J. Borrell (6), Father J. Dobson (16), and Compassion in Abundance (1).

In 2005, the primary school introduced a feeding scheme in view of the number of children that came to school with empty stomachs. The food is provided on a daily basis to all children, five days a week, when the school is open. The government through the National Emergency Council on HIV/AIDS (NERCHA) provides maize and beans. Parents also contribute towards this feeding scheme by paying a flat fee for each child at the beginning of the academic year.

Community kitchens

Hunger and malnutrition must be dealt with at a community level

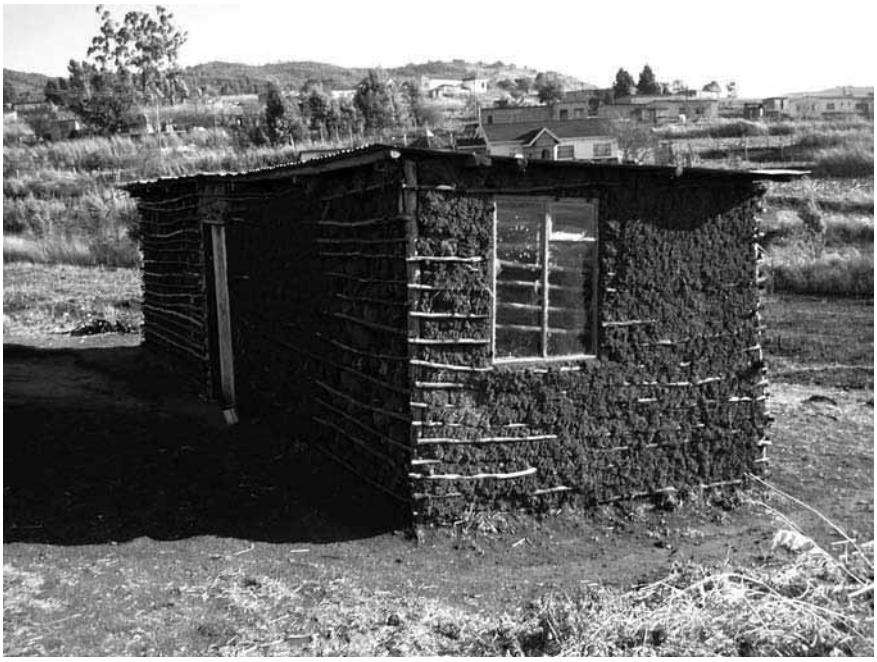
Seven community kitchens currently exist in Motshane community. These kitchens were started as a result of a directive by the Motshane leadership to address the problem of children who did not have food. A number of women, known as caregivers, were selected to do the work at a community meeting. They started the community kitchens by cooking their own food for the children; later three bags of mealie meal, oil, soya, peas and beans were received from UNICEF by each of the kitchens. The kitchens are now also supported by the harvest of mealie meal and beans from the community fields.[308] The community fields receive maize and bean seeds from NERCHA each season.

The Esibovini Kitchen has also been assisted by a couple from the United States who have donated 10 kilos of rice, 10 kilos of beans, bread and 5 litres of cooking oil on a weekly basis. This support came about after the couple visited the Motshane Hope House and were exposed to the work of the kitchen.

The caregivers report that there have been occasions when supplies run out and they have to contribute their own food to cook for the children.

[308] Community fields are fields located in each chiefdom in the country and which are used by the communities to plant crops that are distributed to vulnerable children in the area. All chiefdoms with fields receive seeds from NERCHA each planting season. This initiative is a nationwide response to address the food situation faced by orphans and other vulnerable children.

'*Lomtfwalo sewaba kitsi banakekeli*' ['It is now our burden to see to it that the children are fed']. Cooking and feeding utensils are also provided by the caregivers as no support has been received thus far to purchase such utensils from any organisation or from the community leadership. The commitment by the women of Motshane and their selfless attitude towards the challenge of children in the community reflects how the burden of AIDS is being shouldered largely by women. The caregivers were all volunteering their services without any allowance. For the caregivers the children's need for food is the most important motivating factor: 'If we were not to cook, the situation for the kids will be worse,' said one of the caregivers.



A community-built kitchen to cook and distribute food

At the time of the research, only one kitchen had been constructed, with stick and mud. In the other six places volunteers cooked from their homes and then brought the food to meeting sites. The most pressing issue for these kitchens is to have physical structures in place. Two male community members were donating their labour by cutting logs to be used to build a kitchen structure.

The kitchens play a very important role within the community, but they are not well linked with other services and structures. Caregivers report that there are sick children who come to the kitchens, but they aren't able to help them directly. The lack of linkages between the kitchen and the clinic leads to missed opportunities.

Although the kitchens play a very important role within the community, they are not particularly well linked with other services and structures. Caregivers report that there are sick children who come to the kitchens, but because they don't have any medical supplies (or the required training), they are unable to help them directly. The lack of linkages between the kitchen and the clinic leads to missed opportunities to assist children in need. When the initiative for the community kitchens was started, there reportedly was collaboration with the RHMs, however this stopped over time – reportedly as a result of lack of coordination and undefined responsibilities between the two groups. According to the recollection of the caregivers it was sometime in 2004 when the collaboration between the two groups stopped.

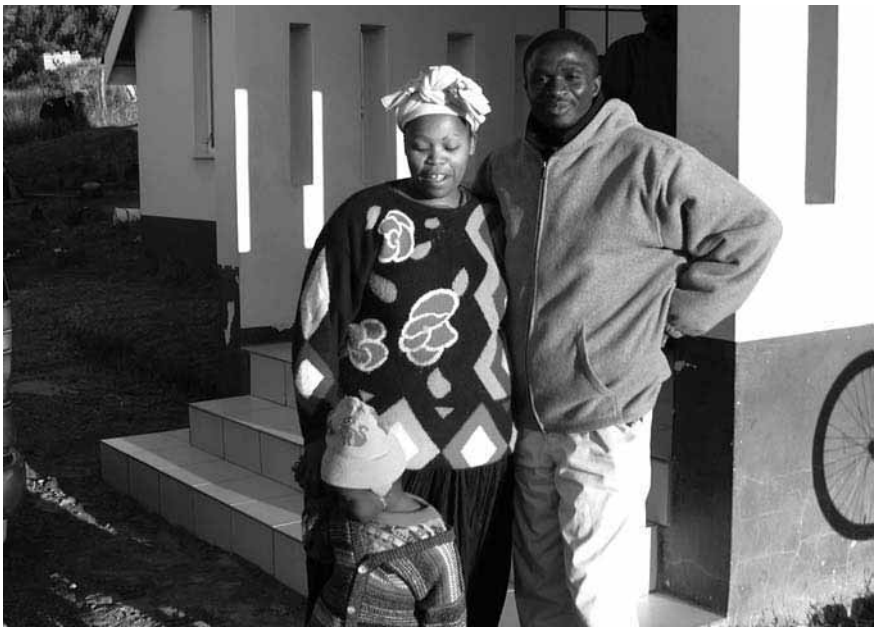
On occasion, the caregivers meet with their counterparts from other kitchens, particularly during workshops hosted by UNICEF. Apart from this, there is no apparent coordination of the community feeding kitchens. UNICEF officers conduct supervisory visits to the kitchen sites

in order to check and weigh children on a regular basis. There does not appear to be any specific focus on children who are HIV-positive, as the programme is broad in orientation.

Motshane Hope House

Motshane Hope House is a Christian faith-based organisation that supports 21 orphans and other vulnerable children in Motshane. The Hope House project initially partnered with Hawane Light House in providing a home for children in Motshane. However, as the initiative grew, more and more children came on board and independent funding was secured. The programme has evolved into a free-standing organisation.

The Hope House is run by directors who are not from Motshane Community, and is sponsored by patrons in the United States and the United Kingdom. It supports orphans and other vulnerable children by providing residential support, clothing, toiletries and food. It provides support for school fees, books and uniforms for children that are not resident in the home. There are four caregivers who work with the children residing at the centre. These children are referred by residents of Motshane, the government Social Welfare Department, the police, and Save the Children.



A Christian couple from Zambia dedicated to the well-being of orphans in Swaziland

'We came from Zambia to this country with 3 children and we were most welcomed and we have lived here as residents, it is our country. We are giving back what the country gave us.'

- Mrs. Borella, whose family provides school fees for children in 4 nearby primary schools

According to the pastor who is the director of the Hope House, all the financial support for running their programme comes from friends in the USA and the UK. In 2002, NERCHA provided support for setting up a chicken project. Local shops like the Spar and Woolworth provide food parcels and church members also give food and money. The organisation sent a number of proposals to local donors and funding institutions in the past, but has not received any support and the pastor has stopped submitting proposals for local funding. He noted great frustration in trying to follow the specified procedures, the long waiting time for the responses, and the fact that negative responses were never accompanied by explanations. 'If we had a steady income, we would be doing much more. Currently we are moving at a snail's pace as funding is unpredictable,' he noted.

The chief of Motshane donated land to be used to build the centre, as well as land to plant maize for the children residing in the centre. The community members help in ploughing and weeding the fields. The pastor attributed the village leadership's commitment to supporting the Hope House programme to its understanding of the vision of the Hope House.

Motshane Alliance Initiative on HIV/AIDS – A youth initiative

The response to the HIV epidemic in Motshane has not been restricted to the adult population. In 2001, a youth group called Motshane Alliance Initiative on HIV/AIDS was formed. This was the second youth group to emerge in Motshane to address the epidemic. To date the initiative has about 34 active members. Its focus is on educating the youth about sexually transmitted diseases and visiting the sick at their homes. The activities of the group include distribution of condoms, visiting schools for educational purposes and visiting children once a week at the community kitchens. The group members meet twice per month. Support for activities of the youth group has largely been from donations by the founding member who is an adult resident of Motshane.

The members of the youth group volunteer their services and need support for an office and salaries for two staff members who can provide counselling and coordinate the group's activities on a daily basis.

The group has received small donations from individuals, as well as from the United States Embassy, in the past. Swaziland Positive Living has provided training to some of the group's members on home-based care, counselling, ARVs and good nutrition. The youth group is also collaborating with the Motshane Support Group in some of its activities, including home visits.

According to the group leaders, NERCHA does not support activities that already exist and the group is facing a big challenge in funding its activities. The youth group wished that the local leadership would increase its commitment to AIDS responses by analysing what is happening in Motshane as a result of the HIV epidemic and supporting the different initiatives that are emerging. They noted that:

- Most of the youth are not involved in any income generating projects, nor are they employed;
- The Mbabane-Ngwenya highway does not allow for pass-bys by tourists who might be in a position to support a livelihood initiative in Motshane; and
- There is a growing problem with the use of intoxicating substances, particularly alcohol, as a pastime among the residents of Motshane.

5.4 Funding dynamics

The different initiatives that have emerged in Motshane appear to be benefiting from resources either originating from within the local community itself or from outside the country. Little support appears to be coming from funding institutions in Swaziland, apart from support to farming, supplies for meals and a limited number of scholarships to cover school fees.

The causes for the current resource deficiencies in supporting the AIDS responses in Motshane could be summarised as follows:

- Insufficient information of the scale of need in the absence of a coordinating mechanism for the AIDS problem within the Motshane Community;
- Insufficient expertise and information on the part of community groups in terms of accessing resources controlled by in-country institutions;
- Lack of expertise in advocacy, resource mobilisation and partnership building;
- There are few non-governmental organisations involved in social and development work in Motshane, despite it being a rural area and not too far away from Mbabane; and
- The challenging history of Motshane CBOs not receiving funding in the past from the country's funding institutions has made them hesitant to request funding for future projects and activities.

There is a sense among the residents of Motshane that the traditional authority could be overseeing a better response towards the epidemic and general development of the area. Also, the lack of involvement of men in the community response to the epidemic is viewed as a drawback, shifting more responsibility to women who find themselves overburdened with the responsibility of caring for the orphans and vulnerable children with little support from their male counterparts.

Whilst the responses to the AIDS epidemic are coming from different role players in the Motshane community, there is lack of coordination of these responses. The different role players ranging from the school, the clinic, volunteers, community kitchens, youth groups and the Hope House are convinced that if there could be better coordination of responses, initiatives would be more effective and more resources could be mobilised.

The responses that have emerged in Motshane community are very important and crucial to the beneficiaries, but lack synergy, collaboration, coordination and systematic monitoring, which might also be the reason why the resources that have been attracted from funding institutions in the country have been limited.

6. Linda Compound, Lusaka, Zambia

The case study was developed by Chandiwira Nyirenda

6.1 Description of the site

Linda Compound is a peri-urban settlement located approximately 10 km south of Lusaka. The compound has a population of approximately 20,000 inhabitants and borders on the relatively affluent Buckley Estates, which is a farming block made up of small holding farming units. The compound's proximity to this farming block makes it a strategic source of farm labour. Apart from being a source of labour, the compound has no other economic activities of significance as the majority of its inhabitants are engaged in work as casual labourers.

Having originally come into existence as an illegal settlement, the compound has received minimal attention from government in terms of social services and other programmes. Although the compound is now officially recognised as a peri-urban settlement, it lags far behind other similar settlements in Lusaka in terms of access to support from the state.

6.2 Impacts of AIDS in Linda Compound

Like most high density peri-urban areas in Zambia, Linda Compound has been seriously affected by AIDS. Data from the 2004 Sentinel Survey found an overall national HIV prevalence rate of 18.7%, but a mean prevalence rate in urban areas of 25%. The absence of a comprehensive AIDS awareness and education programme, as well as widespread alcohol abuse in the compound, has contributed to the high HIV infection rate.

In recent years there has been an escalation in AIDS-related deaths among adults and adolescents in the compound. One consequence of this is a deepening of household poverty due to a reduction in income earning capacity. Another immediate consequence has been the increase in the number of widows, widowers and orphans. In Linda Compound it is not uncommon for children who have lost both parents to simply shift next door because they have nowhere to go.

The high prevalence of HIV in Zambia and general poor performance of the economy has had severe repercussions for children's welfare. The loss of parents and guardians through AIDS-related deaths has placed a heavy burden on households that have taken on the responsibility of meeting the needs of these children. It is estimated that more than 1.1 million of the 5.1 million children under 18 in Zambia are orphans. This number is so overwhelming that it is now being considered a national disaster.

Given its origins as an illegal settlement, Linda Compound has not been well-reached by government services that might support orphans and other vulnerable children. While there is a national child policy that provides for a safety net for orphans and other vulnerable children,[309] there is little evidence to show that Linda Compound is benefiting from the provisions of this policy. Government supported programmes for children are not visible in the area, and there are no donor-supported NGO activities responding to the plight of vulnerable groups.

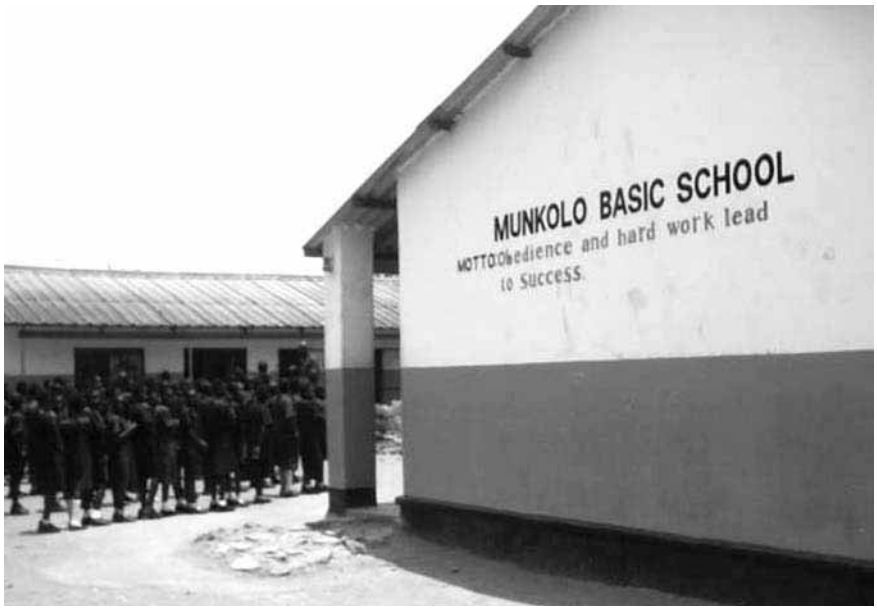
6.3 Identification of the problem

While there are government schools in the neighbouring areas of Chilanga and Lilayi, most children from Linda attend school at Munkolo Basic School, in Buckley, which enrols about 1,800 pupils in grades one to nine. The administration of the school observed that a growing number of children were missing classes for prolonged periods of time, or were dropping out altogether. Prompted by the increasing rate of absenteeism among her pupils, a teacher at the school decided to investigate the whereabouts of the missing pupils.

In the neighbouring Buckley Township, a local resident who is a development worker had also observed over a period of time that a number of children from Linda Compound were spending time playing near his home during times that they were supposed to be in school.

[309] The safety net programme includes a bursary for orphans and other vulnerable children through the Ministry of Education and provision of a food security pack to households looking after children.

After speaking with several of them, he learned that they were orphans who had dropped out of school following the deaths of their parents or guardians. His investigation traced these children to very poor households run by widows or old women with no means of providing any form of livelihood to the children, let alone meeting their education needs.



Growing absenteeism among pupils at the local school prompted community action

He visited Munkolo School to learn more about the magnitude of the problem. There he met the teacher, who shared with him her findings on the plight of these children. Their subsequent joint visits to the homes from which the children came revealed a willingness among their guardians to engage in community activities that would help them alleviate their problems, most important of which was that of sending the children back to school.

The teacher and the local activist encouraged the guardians, who were primarily women, to meet and talk together. During one of their meetings, the guardians agreed to negotiate with the school administration to re-admit the children to school and to allow them to attend classes without wearing uniforms.

With the intervention of the teacher and the activist, the school administration responded favourably to the request and offered to provide the children with basic school requisites, such as books. The readmission of the children into school was on the understanding that the guardians would mobilise themselves to secure financial resources to buy uniforms for the children and pay for the requisites that had been provided by the school.

During this initial phase, 30 households with orphans and other vulnerable children were identified. In each of these households one child was selected for support with enrolment, giving preference to those children who had dropped out. While the guardians recognised the magnitude of the challenge of sending the children back into school, they also acknowledged that with virtually no resources at their disposal they could only assist a limited number of children at the beginning. For this reason, they unanimously agreed on supporting one child per household in order to attain a reasonable spread of households being reached.

'I stopped school when I was in grade three following the death of both my parents. I stayed at home for two years until I was followed by my teacher who eventually helped me to get back into school. During the two years that I was at home I was doing nothing and never imagined that I would get back into school. I even forgot how to read and write. Now that I am back in school and doing grade 8, I can be certain that my future is secured.'

- Pupil, 15 years old

6.4 The emergence of a community project

The Chipego Women's Project was born out of the need to reintegrate orphans of Linda Compound into school. In Tonga, which is one of the languages spoken in the southern province of Zambia, *chipego* means gift. The name of the organisation symbolises the motivation of its founding members to give the gift of education to the children of Linda Compound.

The project began with 25 members who contributed 20,000 kwacha (approximately US$5) apiece to start up income generating activities. The original members included teachers from Munkolo School, widows, other guardians of orphans and vulnerable children, and some interested residents of both Buckley Township and Linda Compound. Members of the group identified specific skills among them which had a potential to generate income for the project. This guided the choice of initial activities they undertook: making peanut butter, which they sold to a local supermarket, and producing tie-dyed material for dresses.

With income from the two activities, the members were able to put some children back into school and over time they have increased the number of children they have supported from 30 to 70. Some of the children who were brought back into school became reference cases and were a source of encouragement for other children to seek help from the project.

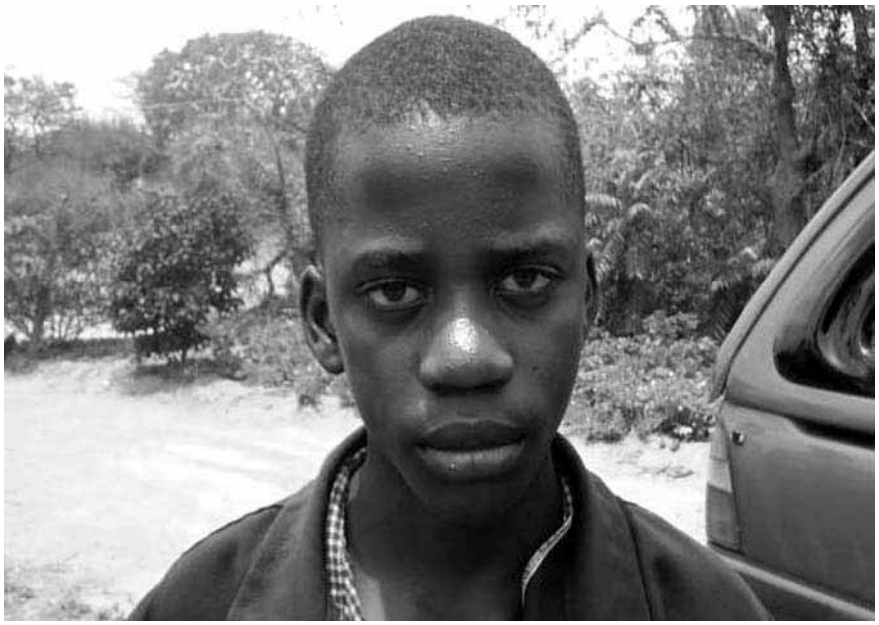
In the early stages of the project, some members of the community had misgivings about the work the women were doing. At that time, rumours circulated in Lusaka about 'satanic' organisations that would target destitute children and lure them away from their guardians by providing them with things that their guardians couldn't afford. Over time, however, the work being carried out by the project came to speak for itself and its reputation within the community was consolidated.

In 2002, the project was registered as a CBO to fulfil the requirements of the Registrar of Societies, which stipulates that any organisation that engages in community work must be registered as a legal entity. This legal status facilitated the project's links with other women's organisations and its membership with the Women Entrepreneurs Association, which supports its members through training and product promotion. Through this connection the project has recently enjoyed the benefits of exhibiting its products at trade shows.

In 2003 the Chipego Women's Project was introduced, through the local activist, to Communities without Borders (CWB), a US-based consortium of local churches in the Boston area that provides small-scale support to a handful of community development projects overseas. CWB provided the project an initial grant of US$3,000 to purchase school books and uniforms, and later loaned the project money to increase its production of tie-dyed material. Communities without Borders also helps the group sell its material in the United States. With the income from these sales, the project repaid its loan to CWB and reinvested in more production of the tie-dyed material.

The relationship between the Chipego Women's Project and CWB is largely informal, and the main thrust of CWB's efforts is to assist the women to access the American market for their tie-dyed material. The material and the proceeds are sent back and forth between the US and

Zambia via visitors and individual travellers. The income from the sale of the material is transferred to the local CWB contact person, who in turn transfers the money to the Chipego Women's Project account.



One of the children being supported by the Chipego Women's Project

Through a participatory process, the women decide on how the money will be split. Part of the money is kept aside for the school feeding programme (see below), while the other part is given to the women who reinvest it in the income-generating projects and use a portion to meet their own domestic needs. This arrangement for sharing the money ensures that there is an incentive for the women to continue supporting the project.

The Chipego Women's Project began by focusing on providing school uniforms and books for children who had returned to school. Yet the women came to realise that most of these children were poorly nourished or not fed at all and as a result, their performance in school was badly affected. Given that almost all the children that had been put back in school came from impoverished households, providing them with school uniforms and books meant that only half of their problems were solved. Nutrition was equally important for their active participation in school activities.

In 2004 the Chipego Women's Project started a school feeding programme for children under its care, supported by income generated through the IGAs. To support this programme, the school administration allocated a piece of land where vegetables started to be grown. However, the lack of adequate water at the school posed a major obstacle to the success of the initiative. With this problem of erratic water supply, the production of vegetables was seriously hampered.

The local activist who was involved with the project from the beginning approached UNICEF to find out if it could offer any support to the feeding scheme. UNICEF responded with the offer to sink a borehole for the school to improve water supply at the institution. Once this happened, the feeding programme was scaled up from two lunchtime meals per week per child to five meals. Although most schools in Zambia

'I am not a widow, but I made myself available because I noticed that the Chipego Women's Project had a noble cause which needed to be supported.'

- Volunteer/Vice Chairperson

receive support for meals through the World Food Programme, the feeding programme at Munkolo School does not receive external support. The meals are all provided through the efforts of the women who grow and prepare the food.

6.5 Structure of the project

The Executive Team of the Chipego Women's Project comprises seven people: the Chairperson, Vice Chairperson, Secretary, Vice Secretary, Treasurer, Vice Treasurer and the Coordinator. The team meets regularly – at least weekly – to discuss and make decisions on issues affecting the children under their organisation's care and to discuss reports on the performance of the children in school. The team also makes follow-up visits to households where the children live as part of the continuous assessment of the living conditions of the children.

Overall, the project is anchored in the premise that the community has to take responsibility for addressing the challenges of children in Linda Compound. The members have maintained a participatory approach to decision-making; planning for activities and the allocation of resources are handled with the involvement of all members. The local activist who was instrumental in the formation of the project remains involved, but mostly acts in an advisory capacity.

From the start, the project saw itself as a community-based organisation that would focus on generating its own income rather than surviving on 'handouts' from donor organisations. Members of the group have maintained this position over the years. They feel that externally driven support for children is often not sustainable, as exemplified by numerous cases of NGOs that have collapsed following the withdrawal of donor support. Within Buckley Township, for example, an orphanage that provided support to children there recently closed down following the decision by its main donor to withdraw support to it after three years.

This incident has been repeatedly referred to by the Chipego Women's Project members as an example of the institution they don't want to be. The members strongly hold on to the philosophy of self-reliance and are committed to supporting their services through earned income. The vision of being a self-sustaining CBO has been the major binding factor among the members of Chipego Women's Project and for this reason they pay great attention to managing the income generating projects well, rather than focusing on devising strategies for sourcing funding from donors. In order to improve their skills in managing the project, the members have undergone basic training in business management and budgeting.

6.6 Challenges and setbacks

Initially, the project attracted a lot of volunteers, but over time some members have left the project, resulting in a drop in membership from 25 to 15. The remaining members attribute this decline in membership to disillusionment among some of the members who felt they were not personally benefiting from their contributions to the project and were unhappy carrying on as volunteers. One member of the project expressed that volunteerism is difficult because the Chipego members themselves have personal problems that make them vulnerable to poverty and illness. Some of them struggle to carry on with Chipego activities in the

face of other pressing problems. It should be noted, however, that the members who have left the organisation all joined the project after its formation and that the core founding team is still in place.

Another setback occurred in 2004, when a woman from the US collected tie-dyed material from the project with the promise that she would help them broaden their market base for their product in the US. They never heard from the woman again. At the stage at which this occurred, it was a major loss of income for the project. The women struggled for some time to re-establish the project's income base from the sales of the tie-dyed materials.

The project has discovered that the extent of deprivation that exists in the community is so great that it sometimes undermines the contributions they are making. As part of its support to the project, UNICEF donated blankets to be distributed to children who did not have bedding at home. The project disseminated the blankets, however during follow-up visits it came to light that in many households the blankets had been sold for money or traded for food.

During a visit to the project by a representative of CWB in 2005, it was observed that only 2 out of the 60 children being assisted by the Chipego Women's Project were wearing uniforms, despite the fact that CWB's support was aimed at ensuring that the children had uniforms for school. It is not certain whether the donated uniforms are also being sold, however it is likely that many children may have worn out their uniforms because they don't have alternative clothing to wear when they are at home. Members of the project note that children are often seen wearing their uniforms even on Saturdays and Sundays.

Members of the Executive Committee of the project feel that the level of poverty in households which they support directly undermines their efforts to put the children back into school. While they understand that many of those households cannot afford to provide the children with alternative clothing, they also feel that children's readmission into school should be protected by ensuring that they always have decent uniform to wear in school.

With meagre resources the Chipego Women's project is making significant strides in meeting the basic education and nutrition needs of the children under its care. Yet its members struggle with the realisation that there are many children who need help that they are not able to reach. The overwhelming problem in Linda Compound prompted one of its members to start teaching children at her house, as a way to go beyond the work that the project was doing:

> *'I am also a widow who has been having problems sending my children to school and feeding them. I joined the Chipego Women's Project so that I could contribute to addressing the problem of orphans in our midst. I realised that networking with other widows and guardians of orphans to be the most effective way of helping our children to attend school and have something to eat. I also noticed that even children who have both parents alive were not able to attend school due to poverty in their households. Because of this, I even tried to start teaching children at my house as a way of supplementing the efforts we are making in the project. I had 65 children who were learning at my house, but I had to abandon this because I could not find dedicated volunteers to help me. Abandoning these children was a very painful thing to me because it was like killing their future altogether.'*

From the start, the Chipego Women's project has seen itself as a community-based organisation focused on generating its own income rather than surviving on 'handouts' from donor organisations. Members of the group feel that externally driven support for children is often not sustainable, as seen in cases where NGOs have collapsed following the withdrawal of donor support.

In the end, she abandoned this initiative because it became clear that her energies were better invested in the collective work of the group, rather than trying to initiate a complex activity on her own with limited support.

6.7 Plans for the future

Within Linda Compound and in the neighbouring Buckley Township, the Chipego Women's Project has won the respect of many who recognise the good work it is doing in sending disadvantaged children to school and providing nutrition support through the school feeding programme.

With contributions from well-wishers, the project has embarked on the construction of a feeding centre on the school premises. This centre, once completed, will provide an all-weather shelter where meals can be served. At the moment, the children are fed in the open space surrounding the teacher's house. During the rainy season, these arrangements are particularly unsuitable and feeding the children outside becomes problematic.

The problem of orphans and other vulnerable children in Linda Compound remains an enormous one. While the Chipego Women's Project is a useful intervention by the community to alleviate the problem, the members acknowledge that this initiative is only addressing a small fraction of the problem. For this reason the women in the project are seeking ways in which they can scale up their support to children. One of the approaches being considered is to co-opt community members who have different skills that can be exploited to start other IGAs, for example, dress making using their tie-dyed materials. However, they are aware that this activity will require them to invest in sewing machines, for which they do not presently have resources. Moreover, they are also aware that they cannot necessarily count on large-scale volunteerism, as community members want to engage in activities that will give them a source of livelihood.

7. Perspectives from the ground

Having looked through the lenses of a number of community AIDS initiatives and sought to explore the relatedness of CSOs to communities, we are in a better position to articulate some aspects of the role of CSOs as 'intermediaries'[310] between communities and external support.

There has been relatively little study of forms of social support and crisis response at community level that pre-date external assistance efforts and how these relate to official and organised sources of support. The term 'philanthropy of the poor'[311] has been coined as part of an appreciative enquiry into how communities help themselves. A key question raised by the case study research is the extent to which organised forms of support in response to AIDS relate to or grow out of indigenous forms of support.

In addressing this question it must be noted that community life, at least in some of the communities studied, is so lacking in resources that there is no real 'bedrock' on which to build. Political leadership and whatever traditional forms of leadership exist seem to be uneasy bedfellows, perhaps with the exception of Swaziland, and communities tend to have little united vision or coherence. In some sites, migration, urbanisation and other forms of social displacement have contributed to fragmented

[310] Naute, W. (2004).

[311] Wilkinson-Maposa, S., et al. (n.d.).

communities. The wisdom of elders does not seem to be drawn on or believed in in any meaningful ways. Local knowledge is largely about bare survival in environments which are either inadequate for meeting the basic resource needs of growing populations, or where infrastructure prevents optimal use of these environments for creating sustainable communities.

Having said this, there are clearly some forms of community support that are integral to community life and upon which individuals and families within these communities have traditionally relied in times of need. These have been significant resources for AIDS responses, prior to and parallel to any forms of support reliant on external assistance. Notable among these are various church structures and women's groups. Support within extended families is also evident, and has saved numerous children from abandonment. There is also a rallying spirit within some of the communities based on ideas of community connectedness and responsibility which creates a moral and ethical prerogative to support each other to do something about those in dire need, even when one's own circumstances are not good. This seems to apply particularly to children.

It is interesting to note that some of these forms of support, and perhaps even the most foundational, are difficult to 'capitalise' on. They cannot be funded. One cannot fund community spirit, the care of a grandmother, the commitment of a church to uplifting people or commitment to providing company to a bed-ridden neighbour. But what of supporting such phenomena, or making it easier for them to happen?

Here we find that the external modes of contact and support have had to work through official structures, and because these are limited, there have been attempts to reach communities through those points of access that have been easier to mobilize. On the difficulties of working through official structures, it is quite apparent that local government and traditional leadership structures have sometimes been an impediment to be 'worked through' rather than a ready vehicle for supporting community structures. Newly created local structures such as DACCs in Malawi (and equivalent examples in other countries) have often not been up to the task of really connecting with communities. But even traditional structures, such as are evident in Swaziland and Lesotho, have not been able to step to the fore in making links between community response mechanisms and external assistance. They seem to have functioned best when they step out of the way and 'allow' things to happen, or act within their own realms of authority by providing access to communal land, for example.

In such contexts the primary response has been the invention and introduction of modes of assistance that can be parachuted into communities by service providers which can provide baskets of particular services: e.g. counselling and testing; food parcels; particular health services; assistance with clothes and school fees. Because decentralised government is not well developed in any of the countries, CSOs have been promoted and used to fulfill these functions.

This has not been achieved without sensitivity to community needs, especially in consideration of 'how' services are delivered. But making contact with communities and building support at scale has introduced dynamics that are additions or 'constructions' in the community context.

There are clearly forms of community support that are integral to community life and upon which individuals and families have traditionally relied in times of need. However some of these forms of support are difficult to 'capitalise' on. They cannot be funded. One cannot fund community spirit, the care of a grandmother, the commitment of a church to uplifting people.

Perhaps the most notable example has been the involvement of young people in CSOs responding to AIDS. This has been promoted as a way of reaching young people, given that many new infections occur in young people. Some of the CSOs we encountered were formed by young people. But young people have career and other personal development interests that have been an important element of their engagement in forming and developing CSOs. Their interests in forming and managing CSOs are different to those, for example, involving a church serving its congregation.

These agencies of AIDS response are shaped by the opportunities offered by AIDS funding as much as they are compelled by needs to respond to AIDS. They stand between communities and funders. They are mostly new social institutions and perhaps even a new stratum of social organisation that is being increasingly strongly supported from outside.

It seems essential to appreciate this, to begin to differentiate this world of CSOs into its parts and types and to differentiate the backing and aspirations which underlie their development. There has been insufficient understanding of this world. It is hard to imagine that large-scale support programmes that are underway – albeit in different forms – can grow and be sustained without much more nuanced understanding, and indeed scholarship, that throws light on the structures and processes that underlie and drive the evolution of these CSOs. They cannot be adequately supported without being better understood.