EVALUATION OF NON-PROFIT ORGANISATIONS IN THE FREE STATE PROVINCE IN THE FIELD OF HIV/AIDS

STUDY UNDERTAKEN FOR THE FREE STATE YOUTH COMMISSION

BY THE

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EXECUTIVE SUMMARY

This report forms part of a five-year plan designed by the Centre for Development Support (CDS) of the University of the Free State on behalf of the Free State Youth Commission (FSYC). As part of a cluster of research projects on governmental youth programmes and actions, the project aims to inform government departments on how best to integrate youth related issues into their structures and programmes.

In terms of Section 27 of the Constitution (1996) access to welfare services is an inalienable right that every community is entitled to, except for certain types of services and during circumstances where government does not have adequate resources to provide the required services. This places a huge responsibility on government to find mechanisms and ways that would enable citizens to access services. The magnitude and complexity of government services alone, compels government departments to find and form partners with other service providers in order to complement government efforts. Therefore, the involvement of non-profit organisations (NPOs) in the provision of certain government services is crucial. In many cases NPOs are better placed to reach out to *communities*, which may not be easily accessible to government structures.

The overall aim of this study was to evaluate the role of non-profit organisations in the Free State in the field of HIV/AIDS, with specific emphasis on the youth as beneficiaries. The report outlines the circumstances and conditions in which NPOs in the Free State Province operate and interact with two government departments, namely Department of Social Development (DoSD) and Department of Health (DoH). The report is divided into nine sections.

The report begins by setting the broad framework for the study, including its objectives and purposes, which are an evaluation of non-profit organisations roles in the Free State Province. The research approach and methodology used for the study are then discussed, and the methodological difficulties encountered in the course of the study are outlined.

It then moves to a literature review that sets the context for the study. This begins with the modern impact of the epidemic across continents and regions and then focuses on Sub-Saharan Africa. The section concludes by defining and outlining the involvement and role of the NPOs in the fight against the HIV/AIDS epidemic.

The section on the structure and role of government departments involved with NPOs in the fight against HIV/AIDS presents an overview of the sub-directorates responsible for NPO coordination, funding and monitoring of organisations. The Free State province is divided into five District Municipalities. Accordingly, the delivery of services from government departments, including DoH and DoSD are cascaded in terms of this municipal demarcation.

The most important component of the report is the section detailing all nine case studies sampled for the study. The case studies outline the services provided by these organisations, and their human and financial capacity. Seven of the case study organisations are in the Mangaung (Bloemfontein) municipal jurisdiction and two in the Kopanong local municipality jurisdiction (Southern Free State).

The last sections of the report present the research findings drawn from the case studies. These findings present the challenges faced by many NPOs in their quest for extending services to communities often marginalised by lack of government delivery. Research findings indicate that Home Based Care (HBC) is the main service provided by organisations sampled. HBC is a form of community care, which encourages participation by people who are able to respond to the needs of their communities. HBC is viewed as an integral part of community based care where the consumer can access services nearest to home in a level of comfort and quality health care. However, service provision in this sector is constrained by a number of challenges, key of which is the lack of adequate funding and capacity constraints. Well-established organisations seem to have more sustainable programmes and relatively better access to funding opportunities.

Based on the research findings, a number of recommendations are made. Government departments are encouraged to embark on concerted campaigns to empower all stakeholders. Programmes targeting special groups need to be formulated in a language specific to the targeted groups. In addition, there should be clear policy guidelines on the future and long-term career prospects for home-based carers as an emerging sector of the labour market. The labour sector can lobby with government for the career pathing or creating learnerships for the carers who are a mostly unemployed young people from disadvantaged backgrounds.

Finally, a conclusion presenting an overall assessment of the study is made. In the conclusion, the study reveals that NGOs/CBOs are playing an important role in extending services to communities where government does not reach such people due to lack of capacity.

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GLOSSARY OF TERMS

ABC	Abstinence, Be faithful or Condomise
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-Retroviral
ART	Anti-Retroviral Therapy
ATICC	AIDS Training, Information and Counselling Centre
CBO	Community-Based organisation
CDS	Centre for Development Support
CSO	Civil Society Organisation
DosD	Department of Social Development
DoH	Department of Health
FBOs	Faith-Based Organisation
FSYC	Free State Youth Commission
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
IEC	Information, Education and Communication
KMD	Kerklike Maatskaplike Diens
MOU	Memorandum of Understanding
MUCPP	Mangaung University Community Partnership Programme
MTEF	Medium Term Expenditure Framework
MTY	Mangaung Tshwaraganang Youth
MRC	Medical Research Council
NAPWA	National Association of People Living with AIDS
NASREC	National Sports Recreation and Exhibition Centre
NGO	Non-Governmental Organisation
NPO	Non-Profit Organisation
UNAIDS	Joint United Nations Programme for HIV/AIDS
PBO	Public Benefit Organisation
PLWHA	People living with HIV/AIDS
PPASA	Planned Parenthood Association of South Africa
TB	Tuberculosis
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infections
VCCT	Voluntary, Confidential, Counselling and Testing
WHO	World Health Organisation

1. INTRODUCTION

Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) represents one of the greatest challenges facing South Africa today. It is estimated that at least five million people in the country are infected with the virus. Some statistics have put the number of people infected as high as 7 million people. Although, statistics differ and in some cases are controversial about the extent of the epidemic in the country, all indicators show that the HIV/AIDS infection rate is increasing and Sub-Saharan Africa is at the centre of the epidemic. While statistics differ about the extent of the problem, it is clear that everyone in the country remains affected. The impact of the epidemic is not only limited to those who are infected but affects everyone in the country.

Already the epidemic has had a devastating demographic impact in South Africa. The social and economic impact of the HIV/AIDS pandemic in South Africa on various fronts cannot be underestimated, which is one reason why the epidemic is a policy problem. The loss of such a high number of people has a debilitating impact on the economy of the country, let alone government resources and service delivery capacity. Nowhere in the world is the impact of HIV/AIDS starting to be felt like in South Africa, where the epidemic is beginning to exert a direct influence on every sector of society and the economy.

The Global Health Sector Strategy for HIV/AIDS (2003-2007) states that by the end of 2002 estimates of HIV/AIDS infected people worldwide stood at 42 million people. Sub-Saharan Africa has the most number of people infected, estimated at over 28 million. This has reduced the life expectancy of many Africans. More alarming is the number of HIV infections affecting the youth. A number of recent reports paint a gloomy picture for the youth of sub-Saharan Africa if proper precautions are not taken. In response to the impact of the epidemic a number of civic organisations are playing a crucial role, especially in rural areas where government services do not always reach communities. However, the effectiveness (or lack thereof) of these organisations is impeded by lack of adequate funding. It is of utmost importance that both the government and civil society are equal partners in the fight against HIV/AIDS.

This report evaluates the role of non-profit organisations in the Free State Province. The non-governmental sector in this report refers to non-governmental organisations, community-based organisations and faith-based organisations. While debates about the correct terminology for organisations of this type are noted, NPO in the report refers to all non-governmental organisations (NGOs), community-based organisations (CBOs) and faith based-organisations (FBOs).

2. PURPOSE AND OBJECTIVES OF THE STUDY

The major purpose of South African Health Research, as reflected in the Health Research Policy of South Africa, 2001, is to provide an enabling framework for the conduct of research that improves human health and well being in South Africa. According to the Health Research Policy document it is envisaged as an integral part of long-term health development to improving the health and quality of life of all South Africans and reducing inequalities within the system[1]. The Health Sector Strategic Framework (1999-2004) asserts the need for an effective and efficient health information system is vital for planning and managing health service delivery. Whilst some progress has been

[1] See Health Sector Strategic Framework, 1999-2004. Department of Health.

made in the last five years, progress must be accelerated during the next five years. It is imperative that health districts, municipalities, provinces, the private sector and the national department work together to build such an information system. In addition, various other government departments such as Home Affairs, Public Services and Administration and State Expenditure impact on the health system and we must ensure that the systems of these departments are integrated with that of the health system.[2]

Against this backdrop the overall aim of the study is to evaluate the role of the non-profit organisations in the field of HIV/AIDS in the Free State Province. Some of the gaps for research identified in the Free State Youth Environmental Scan are the question of reproductive health, including unwanted pregnancies and subsequent decisions to have a pregnancy terminated. Further implications include the spread of STIs and HIV/AIDS amongst the youth. Over the past few years there have been some concerted campaigns aimed at government for its perceived or real failure to come up with a comprehensive programme to effectively curb the scourge of HIV/AIDS. Now that government has outlined a comprehensive strategy for rolling out Anti-Retrovirals (ARVs), the focus has changed to other key sectors such as service provision for people in need, in particular Home-Based Care (HBC).

3. RESEARCH APPROACH AND METHODOLOGY

The research undertaken for this report was done by three agencies, namely the Human Sciences Research Council (Bloemfontein office), the Centre for Development Support (University of the Free State), and the Free State Youth Commission. The research method consisted of two components. Firstly, information was gathered through face-to-face focus group interviews with key stakeholders (see Appendix) from government and NPOs. For the primary interviews, only structured interviews were employed. In addition, on-site interviews with NPOs employees, caregivers and patients were conducted. Secondly, a literature overview and documentary study was undertaken. Secondary research also included a desk-top review of government policy documents and previous research on HIV/AIDS internationally and locally.

For the purposes of sampling, the team used a list of government-funded organisations provided by the Free State Provincial Department of Health (DoH) and Department of Social Development (DoSD). From these lists, organisations were contacted telephonically to determine if they have indeed received funding from government departments and their field of operation. From this procedure, a shortlist of 10 organisations was derived. These were then divided into three groups roughly representing the larger, medium-size and small organisations. Two structured questionnaires were used. One was developed for government officials and the other for NPOs. In the case of NPOs an additional structured questionnaire was developed for beneficiaries. Several problems were encountered in the course of the research. The most important include:

- One CBO withdrew its participation in the study after it became clear to the research team that it misrepresented its role and functions. In addition, the CBO demanded some form of compensation for taking part in the study.

[2] See Health Sector Strategic Framework, 1999-2004. Department of Health.

- The lists of government-funded organisations provided by government departments were not up-to-date and required further investigation. In some cases, organisations listed on the lists had not been funded in the current financial year or had never been funded by either government department.

- Identified stakeholders were not always cooperative and in many instances failed to provide the necessary documentation such as financial records and statements. Some of the claims made by both government and non-governmental officials could not be verified. As such, the factual basis for the study might be compromised.

- Different types and levels of NPOs officials' and staff presented themselves for the interviews with the result that the knowledge base of those officials differed. In the case of CBOs information provided was often contradictory and insufficient, with the result that extensive telephonic follow-ups had to be made. These follow-ups were not always successful, since many key stakeholders are extremely busy.

- Although permission for the study was sought and granted by heads of departments, some officials responsible for implementation of government policy were not cooperative and did not arrive for arranged interviews.

- Many HBC patients were not aware of the service standard that they are entitled and could not provide valuable insight about the quality (or lack thereof) of health care provided by HBC organisations. As a result it was difficult and sometimes impossible to evaluate the quality of services provided by organisations.

4. LITERATURE REVIEW

This section outlines the global overview of HIV/AIDS – with particular emphasis on the impact of the epidemic in sub-Saharan Africa. In South Africa the spotlight is on the impact of HIV/AIDS on the Youth where a number of surveys that assessed the sexual behaviour of teenagers are discussed. While surveys and statistics are unlikely to provide the full and accurate picture of the extent of the HIV/AIDS epidemic, they do however provide useful estimates. In addition, both surveys and statistics can be helpful in tracking the progress of the epidemic in a specific group of people or community. In the section, the history, involvement and role of the non-profit-sector in the field of HIV/AIDS in South Africa is discussed.

4.1 Defining HIV/AIDS

The first diagnosed cases of AIDS were made in the United States of America (USA) among homosexual men. In many parts of the world the mode of HIV transmission is largely unprotected vaginal or anal intercourse and possibly oral sexual contact under certain conditions. However, patterns in the mode of transmission tend to differ from one country to the next. For example, in certain parts of Europe such as Italy, Spain and Georgia intravenous drug (drug injection and sharing needles) use, fuels the epidemic. Another less prevalent mode of transmission is blood transfusion from HIV infected donors. Although all blood donated is screened for HIV, there are a number of cases where contaminated blood was used for transfusion. Also, many children acquire the virus through mother-to-child transmission, either through pregnancy, childbirth or

breastfeeding. The risk of becoming infected with HIV during unprotected vaginal intercourse is two to four times higher for women than it is for men.[3]

4.1.1 Global overview of HIV/AIDS

In 2003 the total toll of people who had died worldwide as a direct result of HIV/AIDS was estimated at around 22 million. In the same year the global number of AIDS deaths was an estimated 3 million, with a further 5 million new HIV infections - bringing to 40 million the estimated number of women, men and children living with the virus worldwide.[4]

The estimates for Eastern Europe and Central Asia indicate that in 2003, the total known cases of people infected with HIV was at 1.5 million with about 30 000 people having died of AIDS in the previous year. The spread of the epidemic in this region is associated with risky behaviour especially amongst young males and this includes mainly injecting drug use and unsafe sex.[5] According to Peter Piot (Executive Director of UNAIDS the United Nations Aids group) HIV/AIDS is spreading faster in Eastern Europe and Central Asia than anywhere else in the world, with a *50*-fold increase in new cases during the past 10 years. Piot points out that there has been slow and steady increase in new infections in every country in Eastern Europe and Central Asia. Piot is of the opinion that due to the focus in Africa over the last few years, this has resulted in Eastern Europe "slipping through the cracks". In both Eastern Europe and Central Asia it is estimated that 80% of those infected with HIV are aged 30 or below – a result largely of widespread sharing of needles by intravenous drug users. Although the numbers may not be as big as in some parts of the world, the scale and speed of the growth in these regions clearly makes this a crisis and if the problem is not taken seriously the situation will get out of control.[6]

In Russia and the Ukraine the infection rate is estimated at around one percent of the population. In the UK, newly diagnosed cases of the HIV increased by 20% between 2002 and 2003. Almost a third of the 49,500 people currently living with HIV in the UK are still unaware they are infected. This increase has been seen amongst women, heterosexual men and gay men. Sweden, with a population of 9 million people has an estimated 3200 people living with HIV/AIDS. While this number might be small the Swedish Red Cross warns that more young people do not seem to realise how serious this illness is. As a result there has been a sharp increase in the number of sexually transmitted diseases.[7]

In India, government statistics estimate that up to 4 million adults have HIV/AIDS. According to the Indian government study, about 100 000 infants are born with HIV out of 27 million pregnancies in the country each year. But government does not include these children or older ones who may have contracted the disease in brothels or through drug use to the official totals. In fact, children are rarely tested in India. Therefore, the figure could be much higher. This view is supported by a United States government report in 2002 that predicted that the number of Indians (in India) with AIDS,

[3] Van Dyk, A. 2001. HIV/AIDS Care and Counseling: A multidisciplinary approach: Second Edition. Pearson Education South Africa. Cape Town. P4-29.
[4] See The PANOS institute. 2003. Missing the message? 20 years of learning from HIV/AIDS. P5 and AIDS Epidemic
[5] UNAIDS. 2003. AIDS Epidemic update, December 2003
[6] http://www.iol.co.za/html/news/aids/index.php?caption. 23 February 2004.
[7] http://www.iol.co.za/html/news/aids/index.php?caption. 16 February 2004.

including children and adults, could jump to 25 million people by 2010 – a projection which the Indian government rejects.[8]

Estimates from the UNAIDS and WHO indicate that approximately 790 000- 1.2 million adults and children in North America were living with HIV/AIDS by the end of 2003. Statistics in the USA where the black (African-American) population make up only 12% of the entire US population indicate that black women are more at risk of contracting HIV than other racial groups. The US government studies found that in 2001 about 67% (an increase of 9% in the last four years) of black women living with HIV had contacted the virus through heterosexual sex and were 23% more likely to be infected with the AIDS virus than white women. Also, black women accounted for 71.8% of new HIV cases in 29 states. According to Cynthia Davis, an Assistant Professor at Charles R. Drew University, most women don't even know they're at risk and find out only when their spouse dies or when they deliver a sick baby. The situation is also compounded by an apparent scarcity of potential black male partners, particularly among the middle classes. This often contributes to black men having a higher turnover of relationships. Also, a Los Angeles survey in the same year found that 20% of HIV-positive black men have had sex with women in the past six months compared with 9% of HIV positive white men and 4% of infected Latino men. Beverly Guy-Sheftall, a Professor of women's studies at Spelman College in Atlanta argues that the disparities in HIV/AIDS are dramatic, but reflect other racial disparities in health that are most likely related to poverty and access to affordable health care.[9] In Los Angeles, the second biggest city in the US, health officials posted the first increase in diagnosed AIDS cases in more than a decade. According to the Los Angeles County Department Health Services a 0.05% rise in AIDS patients was registered in 2002[10].

China has estimated that 800 000 people are infected with HIV/AIDS. Health experts warn that the number could rise to 10 million people if the government fails to take the epidemic more seriously.[11]

In Asia and the Pacific the UNAIDS/WHO statistics revealed that over 1 million people were infected, and that the total number of people living with HIV/AIDS was at 7.4 million in the year 2003, with a further 500 000 people having died of AIDS. Available evidence suggests the intravenous drug use is on the rise as well as low levels of condom use among sex workers.

In Latin America nearly two million people are infected. Latin America and the Caribbean is the region that has the highest number of deaths associated with HIV/AIDS after Sub-Saharan Africa and Asia. In this region, more than 2 million people are now living with HIV and at least 100 000 people have died of AIDS in the year 2003. The modes of transmission in this region coexist, but the ones that can be ranked as the most prevalent are early sexual debut, unprotected sex with multiple partners and the use of drug injecting equipment.[12]

4.1.2 Sub Saharan overview of HIV/AIDS

Sub-Saharan Africa is the worst affected region with the highest number of people living with HIV. Statistics indicate that between 25 and 28 million people could be living with the virus. Last year

[8] http://www.iol.co.za/html/news/aids/index.php?caption. 01 December 2003.
[9] Mail&Guardian, April 8-12 2004. Aids: Black women in the US at higher risk.
[10] http://www.iol.co.za/html/news/aids/index.php?caption. 18 February 2004.
[11] http://www.iol.co.za/html/news/aids/index.php?caption. 16 February 2004.
[12] UNAIDS. 2003. AIDS Epidemic update, December 2003

(2003) estimates indicate that as many as 3 million new infections could have occurred in the region. The worst affected countries are South Africa, Botswana, Lesotho, Zimbabwe and Swaziland.[13] South Africa has the highest number of people living with the virus; estimated at around 4,7 million people. The HIV/AIDS epidemic continues to be a burden in the region and is now the leading cause of death in many Sub-Saharan Africa countries. Young people aged 15 to 24 years are at the epicentre of the epidemic. Therefore, HIV surveillance in this population group is crucial. It is expected that the total number of people infected with HIV will plateau in about 2005, as the number of new infections has slowed down and the people who are infected are dying. The MRC states that the deaths from AIDS has been increasing from the late 1990s, and without interventions such as implementation of (Anti-retroviral therapy) ART to reduce mortality, are expected to peak in 2010 at about 800 000 deaths.[14]

In South Africa the first two cases of AIDS were identified among homosexual white men in 1982. For the first eight years, the epidemic was primarily located among white homosexual men, but over time, the number of cases rose and the disease began to spread among other groups. Since then the homosexual epidemic has been completely overshadowed by the heterosexual epidemic.[15]

In 1990 South Africa had an HIV prevalence of less than 1 percent among antenatal clinic attendees, a proportion now at levels of over 25 percent. Antenatal surveys have largely been used by the WHO to estimate HIV prevalence and in tracking the progression of the HIV/AIDS epidemic in the country. More than twenty years into the epidemic, South Africa is now the country with the highest number of HIV-infected people in the world.[16] The antenatal survey of 2002 indicates that 26.5% of pregnant women were HIV positive. In 2002 KwaZulu-Natal recorded the highest HIV prevalence rate among antenatal clinic attendees at 36.5%. Gauteng also recorded a significantly high rate at 31.6%, followed by Free State (28.8%), Mpumalanga (28.6%), North West (26.2%) and the Eastern Cape (23.6). The other three provinces recorded a prevalence rate of less than 20%, Limpopo (15.6%), Northern Cape (15.1%) and the Western Cape (12.4%).[17]

4.1.2.1 Impact of HIV/AIDS on the youth in South Africa

Africa has the world's youngest population and estimates indicate that Sub-Saharan Africa is home to 70% of young people living with HIV/AIDS and 90% of AIDS orphans in the world. Literature studies indicate vulnerability to HIV/AIDS is compounded by gender and age, making young people, particularly young women more likely to contract the virus than others. The age distribution of HIV infection in Africa is skewed towards younger females, with infection rates among teenage girls five times higher than teenage boys in some countries.[18]

The Reproductive Health Research Unit of the University of the Witwatersrand study conducted a study in 2003 on HIV and sexual behaviour among young South Africans, with specific reference to the 15-24 year olds. This reflected high levels of sexual activism amongst the youth, especially amongst males. The survey found that among 15-24 year old South Africans the HIV prevalence

[13] Weekly epidemiological record, 5 December 2003, 78th year. No 40, 2003, 78, 417-424. http://www.who.int.wer
[14] http://www.mrc.ac.za/bod/faqaids.htm
[15] History and origin of HIV. Retrieved June 14, 2004, from the AidsInsite. http//www.aidsinsite.co.za
[16] History and origin of HIV. Retrieved June 14, 2004, from the AidsInsite. http//www.aidsinsite.co.za. P2.
[17] Antenatal survey, 2002. Department of Health.
[18] Multisectoral responses to HIV/AIDS: A compendium of promising practices from Africa. USAID-PVO steering committee on Multisectoral approaches to HIV/AIDS, April 2003. P33.

was 10.2%, with the incidence among women being higher (15.5%) than in men (4.8%). Among the 10% of South African youth who are HIV positive, 77% are women. The highest HIV prevalence was found in KwaZulu-Natal Province (14.1%) and the lowest in Limpopo Province (4.8%). In terms of geographic area, youth living in urban informal areas had the highest HIV prevalence (17.4%). More alarming is that 15% of young people who are often at greatest risk are not being reached by any HIV programmes. These include teenagers living on farms.[19]

On average, 67% of young people aged 15-24 years are reported to having had sexual intercourse. What is also significant about the findings is the fact that 6% of the interviewed youth reported having been forced to have sexual intercourse, that is 10% of females and 2% among males. Among the sexually experienced youth, 52% reported using a condom at last sexual encounter. Overall, among youth who reported having had sex in the past 12 months, females were significantly less likely than males to report always using a condom with their most recent partners (28% vs 39% respectively). Eighty seven percent of all youth sampled indicated that they were able to access condoms when they needed them. This clearly demonstrates that access to condoms does not guarantee condom use.[20]

The 2002 Human Sciences Research Council/Nelson Mandela study in collaboration with the Medical Research Council and Centre for Aids Development, Research and Evaluation (CADRE) sampled more than 9000 South Africans in 2002 from all walks of life. Eleven percent of respondents were HIV positive and 15.2 % were between 15-49 years old. The results of the study indicated that 36% of the youth stated that they were at no risk of HIV infection compared to 14% who stated that they were at high risk. Among all youth, 60% indicated that they would like to be tested for HIV. Significantly, more females than males reported having been tested for HIV (25% vs 15%). From the findings of the study, the vast majority of young people agreed that safer sex is a shared responsibility between partners and that it is not acceptable to force someone to have sex. In addition, they also agreed that having many partners is not acceptable and it also not desirable to engage in transactional sex.[21]

Another study worth noting is the 1st South African National Youth Risk Behaviour Survey in 2002, which comprised of learners in Grade 8, 9 10 and 11 in public schools across all nine provinces. The survey looked at amongst other things, the percentage of learners who ever had sex; the age of initiation of sex; the number of sexual partners learner have had; use of alcohol or drugs before sex and the methods of contraception mostly used by learners.[22] The study showed that heightened sexual awareness is part of adolescence development, but it is often characterised by experimentation which has the potential of placing adolescents at risk of unprotected sexual activity, unplanned pregnancy and sexually transmitted infections including HIV. In addition, the study shows that gender was found to be a predictor of condom use, with more males than females reporting having used condoms.[23].[24]

A study undertaken by University of Cape Town (UCT) academics, Fiona Ross and Susan Levine found that most students at tertiary institutions continue to have unprotected sex despite being aware

[19] HIV and sexual behaviour among young South Africans, 2004.
[20] HIV and sexual behaviour among young South Africans, 2004.
[21] HSRC/Nelson Mandela study. 2002.
[22] Umthente Uhlaba Usamila The 1st South African National Youth Risk Behaviour Survey in 2002. Chapter 6, P53.
[23] Umthente Uhlaba Usamila The 1st South African National Youth Risk Behaviour Survey in 2002. Chapter 6, P51
[24] Umthente Uhlaba Usamila The 1st South African National Youth Risk Behaviour Survey in 2002. Chapter 6, P53.

of HIV/AIDS and its dangers.[25] The UCT study, based on interviews with 480 students between the ages of 19 and 30 found many students had unprotected sex despite being aware of HIV/AIDS transmission. The survey revealed that students imagine that they are immune to HIV infection and continue to practise unsafe sex.[26] Reasons given to the researchers for this behaviour included: having gone too far without thinking, did not have condoms handy, being drunk, being in a long-term relationship and assuming it would be alright, among others. Furthermore, students also complained about HIV information fatigue. More positively, condom use was cited as socially acceptable.[27] This point validates the findings of the 1st South African National Youth Risk Behaviour Survey in 2002, which also found condom use to be socially acceptable. While many young people are aware of the importance of using condoms, studies indicate that condoms whilst being socially acceptable, might not be necessary popular in usage.

4.2 Defining non-profit organisations

The term non-profit organisation (NPO) embraces a variety of organisations and forms. It is made up of a number of organisations ranging from small and informal to big and organised organisations. The Non-Profit Act (1997) defines the term "non-profit" organisation as a collective of people who come together for a common purpose and agree to formalise a programme to fulfil this purpose. They conduct their activities towards this purpose and should there be excess income after expenditure (profit) this excess is made available to the benefit of the purpose. Non-profit organisations are known by other generic titles such as non-governmental organisation (NGO), community based organisation (CBO) civil society organisation (CSO), public benefit organisation (PBO), trust of foundation, charity and religious body or institution (also referred to as Faith Based Organisations - FBOs).[28]

An investigation into the creation of an enabling environment of non-profit organisations began in 1996 and culminated with the promulgation of the Non-Profit Organisations Act in 1997.[29] The Act came into operation on 1 September 1998 as a result of a lengthy process of policy and legislative reform negotiated between the state and NPOs. Primarily, the Act intends to establish a regulatory framework within which NPOs can conduct their affairs, while encouraging the maintenance of adequate standards of transparency, good governance and public accountability.[30]

4.2.1 Involvement and role of the non-profit organisations in the field of HIV/AIDS

The involvement of the non-governmental sector in South Africa began in 1985 when the apartheid government repatriated Malawian mine workers who were suspected of being infected with HIV. Thereafter, debates around the AIDS policy were started. In 1991 the Congress of South African Trade Unions (COSATU) held a conference at NASREC to deliberate deeper on the AIDS issue. It was then that the Congress' first principled approach to HIV and AIDS was adopted.[31] Although the apartheid government had an HIV/AIDS policy, this policy lacked leadership, initiative and credibility.[32] The challenge of HIV/AIDS facing South Africa became a struggle fought by labour

[25] http://www.iol.co.za/html/news/aids/index.php?caption 11 January 2004.
[26] ibid.
[27] ibid.
[28] The Non-Profit Act (Act 71 of 1997).
[29] http://www.socdev.gov.za/About%20us/chron.htm
[30] http://www.socdev.gov.za/About%20us/chron.htm
[31] Edwin Cameron, The principles of our progress in AIDS Bulletin, May/June 1997 vol 6.
[32] ibid.

unions, civil society movements, NGOs and CBOs. However, the task of these organisations was made even more difficult in an era where there was no coherent national AIDS plan and government funding.

Since the late 1990s with the scourge of HIV/AIDS, the number of NGOs/CBOs have grown at a phenomenal rate with many of them operating informally. What has become clear over the last few years is that government cannot deliver to all communities. Non-profit organisations have an important role to play especially at grass roots level. However, they face numerous problems, the key of which is the lack of adequate funding. It would seem no NGO/CBO can claim to have adequate resources. In fact, the numerous challenges faced by NGOs/CBOs are too big for the resources at the disposal of these organisations. Lack of government capacity in key departments such as DoSD and DoH has underlined the importance of NGOs/CBOs in serving the marginalised communities especially in rural communities. Voluntary community and non-governmental responses to HIV/AIDS are diverse, ranging from self-help groups that respond to a particular need within their locality (community). The magnitude of the need for HIV/AIDS related services alone compels all government departments, including the DoH and DoSD, to find and form partners with other service providers in order to complement government efforts.

The emergence of NPOs working with people living with HIV/AIDS signified an attempt to eradicate the failings of the government department's ability to address the HIV/AIDS epidemic. The inadequacy of the apartheid government to respond to the epidemic spelled out serious implications for the future of the country. The non-profit organisations focused mainly on the marginalised and disadvantaged groups in South African society by developing programmes that address the particular needs of their target groups and drawing the links between ill health and discriminatory legislation. In this way, the NPO sector began to address some of the pertinent issues associated with the epidemic in the context of the Third world.[33] The struggle was multifaceted in nature; there was the struggle of educating people about HIV/AIDS, prevention of the spread of HIV, combating ignorance, eradicating stigma and discrimination. The environment in which the struggle was conducted was often unsupportive and hostile, at the same time the HIV/AIDS epidemic was progressing from dream and nightmare to being a "plague", that is a felt reality.

The National AIDS Congress of South Africa (NACOSA) is an initiative that was created in 1992 to bring government and the private sector to formulate a national AIDS Plan. The national AIDS plan bears the mark of the work, energy and vision of the NPOs sector. The national AIDS plan was fully launched in 1994, but the implementation thereof by government is still making slow paced progress.[34] In this regard some NPOs struggled to integrate HIV/AIDS programmes into their development programmes.

4.2.2 Emergence of dominant non-profit organisations

Outside the government sector, a number of comprehensive networks of civil society role players have dominated the contemporary HIV/AIDS politics in South Africa. Although there are countless organisations that have received national exposure and some degree of success in the HIV/AIDS arena, none have been more successful in pushing their agenda nationally and internationally than

[33] Nikki Schaay, The history and development of NGO-based HIV/AIDS work in South Africa, in AIDS Bulletin, May/June 1997 vol 6
[34] Barry Smith, AIDS hits everyone: HIV/AIDS and the NGOs in AIDS Bulletin, May/June 1997 vol 6

the Treatment Action Campaign (TAC). Since its inception in 1998, the TAC has demonstrated the resilience that was characteristic of many pre-apartheid struggle movements.

The TAC was established on 10 December 1998, International Human Rights Day and since then it has specifically targeted a number of pharmaceutical companies about their monopoly and high pricing policy on HIV drugs. The TAC's main objective has been to campaign for greater access to treatment for all South Africans, by raising public awareness and understanding about issues surrounding the availability, affordability and use of HIV treatments. The Constitutional battle about the improved access to HIV drugs with the South African Health Department ranks as one of the most celebrated achievements of the organisation. The Constitutional Court in July 2002 ruled in favour of TAC- that the government devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their newborn children to have access to health services to combat mother-to-child transmission of HIV. Subsequently, in November 2002 the South African Government announced plans to implement the operational ARV treatment plan.[35]

Other organisations (although not an exhaustive list) that have also played prominent roles in bringing HIV/AIDS issues to the forefront on the national agenda include the AIDS Consortium and the National Association of People living with AIDS (NAPWA). The AIDS Consortium is a network of over 1000 member organisations, mainly CBOs focusing on HIV/AIDS related issues. The key objectives of the AIDS Consortium include amongst others, the need to build the capacity of member organisations with respect to information and to promote practical community-based HIV/AIDS response initiatives in conjunction with local communities, collaborative institutions, and local businesses.[36] The National Association of People Living was established in 1994 when a group of concerned people living with HIV/AIDS met in 1994 and decided to form a national organisation that co-ordinates the needs and resources of all people living with HIV/AIDS. NAPWA's membership is open to people infected and affected by HIV/AIDS and its major purpose is to organise, mobilise and empower people living with HIV/AIDS, and to represent their interests by providing care and support. NAPWA has a number of provincial offices and regional branches throughout the country[37] (NAPWA Free State is included as a case study in this report).

4.2.3 The challenges facing non-profit organisation in the field of HIV/AIDS

Over the last few years many NPOs have increasingly came under the media spotlight with media reports highlighting widespread incompetence, chronic mismanagement and corruption in some NPOs. These are problems faced by NPOs across different sectors of service delivery. However, it would be expected that those in the field of HIV/AIDS will always attract special attention because HIV/AIDS has become one of the dominant socio-economic issues in South Africa.

Results from a study commissioned by SAIH/INTERFUND in 1995, which was set out to investigate the capacity and feasibility of AIDS integration in the NPOs project revealed that the sector had a limited response to AIDS and there had been little consideration to how AIDS would impact on the organisation or target communities.[38] In addition, some communities in which NPOs

[35] http://www.tac.org.za/
[36] http://www.aidsconsortium.org.za/
[37] http://www.napwa.org.za/content/documents.html
[38] Nikki Schaay, The history and development of NGO-based HIV/AIDS work in South Africa, in AIDS Bulletin, May/June 1997 vol 6.

were operating, AIDS was not necessarily perceived to be a priority, thus AIDS integration would imply imposing AIDS issues onto the community and that would in turn deem contrary to how NGOs tended to operate. The state awareness of AIDS was superficial and insufficient to integrate AIDS into organisational debates and activities. Most organisations were facing funding crises due to changing political paradigms and priorities, with many NPOs thus under constant threat of closure, with some becoming reluctant to take up new issues.[39]

More recently, the AIDS Consortium has come under increasingly pressure to address its administration after it was realised that the Consortium was facing a financial crisis. At the beginning of 2004 there were media reports that the Consortium administration was under investigation for mismanagement. A financial audit was commissioned and the Director who was on sick leave at the time was suspended so as to allow for an uninterrupted flow of the audit process.[40] The resolutions adopted following the audit report includes, seeking legal advice on how best to instigate disciplinary action against the Director and Finance Manager of the organisation, to make recommendations on future issues of governance, under legal advice, and in compliance with the governing documents of the organisations[41].

Over the last few years, the relationship among many NPOs in the HIV/AIDS terrain has undergone very significant changes, and not for the better as many media reports would attest to. In March 2004, NAPWA was accused of verbally and physically attacking a member of the TAC in a monthly meeting of the AIDS consortium. It is alleged that some NAPWA members led a racist attack on a white member of the AIDS Consortium, who was told that "we are sick of white people sitting at the front of the meeting; it causes us pain." to the applause from NAPWA leaders. At the end of the meeting the national organiser of NAPWA, confronted a white TAC member and shouted in front of other people "we are sick of you fucking white racists taking advantage of black people and people with HIV/AIDS".[42] This infighting amongst prominent HIV/AIDS organisations may not necessarily benefit the broader struggle against HIV/AIDS. For Zackie Achmat, Chairperson of the TAC, HIV/AIDS affects everyone in the country irrespective of race and gender.[43]

5. GOVERNMENT DEPARTMENTS

This section presents a brief overview of the two government departments, namely Department of Social Development (DoSD) and Department of Health (DoH). The focus is on the sub-directorates responsible for coordination, funding and monitoring of non-profit organisations. The 2000 local government demarcation process resulted in the entire Free State being divided into five District Municipalities. All government departments (including the DoH and DoSD) have also divided their regional offices accordingly in pursuit of provision for improved and more efficient service delivery.

[39] Nikki Schaay, The history and development of NGO-based HIV/AIDS work in South Africa, in AIDS Bulletin, May/June 1997 vol 6.
[40] The AIDS Consortium Newsletter Special audit edition, March 2004
[41] ibid
[42] Mark Heywood. 2004. TAC & AIDS Consortium condemn the threats by NAPWA against AIDS activist. Available: www.equality.org.za/news/2004/04/02tacondems.php
[43] Zackie Achmat. 2004. The Treatment Action Campaign, HIV/AIDS and the government. Transformation Journal, Volume 54.

5.1 Department of Social Development[44]

The main priority of the department is to render service to the poor, while ensuring the development, care and protection of vulnerable groups in the society. This is achieved through programmes that focus on the alleviation of poverty and addressing the needs of special groups such as children, youth, older persons, persons with disabilities, women, victims of abuse and violence, persons affected by substance and persons affected and infected by HIV/AIDS.

A Strategic Plan for HIV/AIDS, and the National Integrated Strategy guide the provision of services for Youth and Children affected and infected with HIV/AIDS within the department. Both these documents place a priority on children infected and affected with HIV/AIDS, on women infected and affected with HIV and AIDS, on youth, especially out of school, on rural and vulnerable communities, on communities in routes of truckers where there's commercial sex workers, and on communities with high migratory patterns.

The Unit responsible for the coordination, funding and monitoring of NPOs was established in 2000. The unit divides NPOs into two categories, Annexure A and Annexure B organisations. Well-developed, established and better-resourced organisations are classified as Annexure A. All under-developed organisations with small budgets and little capacity are classified as Annexure B. The latter category is mainly made up of CBOs and over the last couple of years the focus of the Unit has been on the development of these organisations. Many Annexure B organisations lack sound managerial and financial skills.

5.1.1 Conditions and procedure for funding non-profit organisation

Before funding can be allocated to organisations there are set conditions that need to be met. Only organisations that are registered in terms of the Non-profit Organisations Act of 1997 are eligible for funding and may apply. In addition, organisations or consortiums (clusters of organisations) have to apply on the prescribed service plan format for a specific financial year that is available at one of the five district offices of the department. It is expected that all organisations should adequately reflect the demography of the target groups for the service in the Free State Province. Services should target at least 80% of the previously disadvantaged communities as a target group. It is important that all services rendered by organisations enhance and promote the policies of the department and safeguard the constitutional rights of beneficiaries.

A service plan in the prescribed format must be submitted before or on the deadline at the district office of the DoSD. The business plans of the organisation are received by deputy-district managers who then make recommendations and pass the plans to the Acting Executive Manager. Thereafter the department at district and provincial level will assess the submitted service plan. The approval of the service plan for funding is subject to the extent and level to which the organisation is able to

[44] See Free State Department of Social Development 2004/05, specifications for the implementation of programmes and the provision of services for HIV/AIDS in the Free State.
Free State Department of Social Development, position paper on services for 2004/2005.
Free State Province Department of Social Development. Policy on Financial Awards to the Non-Profit Organanisations in the Social Development Sector: Draft report.

deliver the services required. The services should be delivered in an effective and efficient manner that is in line with the service specifications and the availability of government funds. The key criteria in determining funding are:
- geographic re-distribution of services,
- addressing the urban/rural divide, and
- ensuring that services are extended to historically disadvantaged communities.

Once an application has been approved the department will enter into a formal contractual agreement with the successful organisation or consortium.

5.1.2 Funding guidelines to non-profit organisations

The department has a strict policy that stipulates that no funding is allocated without training being provided. This is a three week long training progrmme provided by the department and it covers all the basics regarding administration and management of an organisation. Since the mandatory implementation of this policy, less cases of mismanagement by organisations have been reported. The budget of a successful organisation is broken down into 12 months and allocated accordingly. The organisations are not allowed to have savings accounts; only cheque accounts are to be used. Auxiliary workers closely monitor all organisations through monthly financial statements. In cases of financial mismanagement and where fraud is suspected or alleged, the responsible official may recommend the suspension of payments in consultation with the sub-directorate and the district officer, pending an investigation. The NPO concerned shall be informed in writing of suspension of funds until further notice. The department shall inform the service provider regarding procedures to be followed with regard to departmental interventions including financial inspections or any other mechanisms deemed necessary by the department.

The financial monitoring focuses on whether the service provider utilises the allocated financial award in accordance with the agreement with the department. The service provider is expected to submit monthly financial statements to the department indicating all the expenses and income before the 15th of each previous month. The service provider is also expected to submit annually, before 31 august a copy of its audited financial statements of certified financial statements to the department. The department provides training in financial management to all new service providers in terms of the requirements by the department and general financial accounting mechanisms.

The department expects a detailed quarterly or bi-annual progress report from the service provider that receives a financial award. The manager of the Directorate: Developmental Social Services prescribes the format of the progress report. The department provides the service provider with the format of the progress report as well as the due dates of the reports at the start of the funding cycle. Then the comments and inputs on the progress reports are communicated to the service provider within six weeks after receipt of the report.

The department carries monthly monitoring to funded NPOs. The onsite monitoring entails the assessment of the service provided and the status of the organisation's finances. A 14-day notice is given prior to onsite monitoring. Depending on the nature and complexity of the onsite monitoring, the district officer or both the district officer and relevant sub-directorate of the provincial office carry out the task. Objectives for monitoring include assessing the quality of services rendered by NPOs for which funding has been allocated. Monitoring is also for ensuring that the target groups served are receiving effective and efficient services.

5.2 Department of Health[45]

The vision of the DoH is the provision of a comprehensive health care service to the Free State community. The priorities of the department are determined in line with the Medium Term Expenditure Framework (MTEF) of 2004 to 2007. The MTEF is based on the strategic direction provided by the National Department of Health Strategic Plan for 2003/2004 to 2005/2006 as well as the Free State Development Plan for 2002 to 2005.

The Department of Health (DoH) has a provincial unit responsible for funding, monitoring and support of all NPOs in the five district of the Free State Province. The unit offers funding to organisations that are rendering HIV/AIDS work that cannot be covered by the formal institutions of the DoH. However, due to the limited budget of the department, funding is only allocated to small-scale NPOs, while the National DoH funds large-scale organisations. In the Free State Province District Managers and Community Liaison Officers are responsible for monitoring of all NPOs.

Since the beginning of 2002 no individual NPOs have been funded. Funding is only made available to consortiums. The unit encourages consortiums to have a minimum of 5 member organisations affiliated to the consortium. The Unit prefers consortium funding to individual organisation funding as this reduces duplication of services and keeps in check community organisations that have no experience or track record. The money granted to the consortium is paid out as a lump sum by the department. Although, the money granted is shared amongst member organisations to the consortium, funding granted does not necessarily mean it is to be shared equally amongst the member consortiums.

5.2.1 Criteria for funding and capacity building

For a consortium to be considered for funding, its programmes must be in line with the focus areas of the department, e.g. in Information, Education and Communication (IEC) campaigns. Assessment of qualifications for funding is based on looking at the submitted business plan of the organisation. It is required of the organisation to submit a budget breakdown of their proposed programmes. Approval of proposals for funding does not guarantee the exact amount requested being granted by the department. The unit has the overall deciding power on which consortium is to receive funding and funds allocated are to be shared by organisations in the consortium.

The Unit has been involved in a two-year capacity building project with a Price Waterhouse Coopers led consortium to undertake a far-reaching capacity building initiative targeting NPOs in the province. The objective of the project was to improve and empower NPOs with better understanding of financial management, project management, human resources and general management skills over a two-year period. The first year involved training in the principles outlined above. After the first year training, NPOs had to be mentored through regular 2-day visits each in groups of not more than five. The Price Waterhouse Coopers consortium developed a Best Practice Guide that that covered project management, management skills, human resources management and financial management with the idea being to assist NPOs with the day-to-day running of their organisations. Although the project was aimed at capacitating 75 NPOs in the fist year, only 68

[45] See Free State Department of Health Strategic Plan 2004/2005 to 2006/2007.

managed to attend the training. It was subsequently decided that special attention would be provided to organisations that failed to attend the five-days training session.

This project is aimed at building the capacity of the organisations, and to enhance the relationship between the organisations and the DoH. Issues such as drafting the constitution are also tackled in this project. To date (June 2004) the department has offered a two-year training programme to 175 organisations in the province training through this Price Waterhouse Coopers led consortium. Feedback from organisations regarding this training has been very positive. The unit also engages in referring organisations to other relevant government departments according to the proposal of the organisation. The organisation must submit quarterly reports written in the format provided by the department.

The department has capacity constraints but the main challenges are to empower communities at local level and to monitor the services of organisations in those communities. There is a perception that capacity in these organisations can never be enough, considering the high turnover of cases and the high number of new people joining organisations. In most cases well-established NGOs do not only depend on government funding and according to the DoH, these big organizations are expected to mentor small organisations. Hence the department is fostering partnerships between well-established organisations and small organisations.

6. CASE STUDIES

This section details nine case studies that preceded the drafting of this document. All case studies outline the objectives, finances and the capacity of these organisations.

6.1 Free State Christian Church Leaders Forum

Free State Christian Church Leaders is a faith-based organisation that was established in 2001 following a request by the former Premier, Ms Winkie Direko to Christian organisations in the Free State. The Premier requested Christian organisations to assist in restoring the moral values of the nation. The forum is a joint HIV/AIDS venture between a number of Christian organisations in the province, representing the Dutch Reformed, Pentecostal, Charismatic, African Independent and Roman Catholic Churches. The mission of the Joint Venture is to attain an integrated response to the HIV/AIDS epidemic and to build a caring and responsible community through moral renewal actions based on Biblical principles.

As a Christian forum, the organisation contributes towards restoring family values, assisting with youth and leadership development programmes, showing compassion through outreach, and building centres for those infected and affected with HIV/AIDS. In addition, the forum assists with identifying people who qualify for social grants but do not know how to access these grants. It also serves on the Provincial Aids Council and Moral Regeneration Movement. The forum operates from a modest building with 16 offices that have been donated by a local businessperson. The forum has 4 offices across the province, at Bloemfontein, Botshabelo, Welkom and Thaba-Nchu. There are plans to expand to QwaQwa, Kroonstad, Bethlehem and Harrismith in the next few years.

Objectives of the forum

The objectives of the forum are to provide a platform for mutual interaction, sharing of perspectives and resources between the Free State Government and the Christian community in order to develop a coordinated and united action against HIV/AIDS and poverty. The forum is continually developing sustainable processes for effective service delivery to fight and cope with HIV/AIDS and poverty. The forum is also mobilising resources from both the government and non-governmental sectors to provide for the basic needs of the poor and those affected and infected by HIV/AIDS. In addition, the forum provides support and advice to local communities on how to increase their respective capacities to fight and cope with HIV/AIDS. The primary message is abstinence and faithfulness to one partner.

Financing the forum

In the 2003/2004 financial year, all four offices in the Free State received a total of R376 000. R96 000 was received from the provincial DoSD, R100 000 from the national DoSD, R80 000 from the provincial DoH and R100 000 from various churches. The forum is aware that funding from government departments is not enough and has approached several private companies and international donors in the United States of America for donations, since the project budget is over R1 million. Although funding is a challenge, a wide range of expertise and equipment is available within the forum. As a result, the forum can easily respond to opportunities for more funding.

Capacity within the forum

The forum has six full-time salaried staff members, including the project manager, four area facilitators, and a financial administrator. All these six individuals have attended the compulsory course jointly offered by the DoH and PriceWaterhouseCoopers in 2003. The course focused on Human Resources Management, Project Management and Administration. Since then, ongoing capacity building courses have been arranged to ensure that core staff is developing their human potential according to the growth of the organisation. However, more training is needed in the financial and information technology departments.

In all four regions there are 125 active volunteers who are providing Home-Based Care (HBC) to 458 patients. The forum provides HIV/AIDS, HBC, counselling and administration training to the volunteers who are provided with a T-shirt and a nametag for identification on successful completion of the course. In addition it provides drug and alcohol abuse courses to the volunteers; in 2004 nine out of 18 volunteers passed the course and were issued with certificates on the excursion day. To date 196 volunteers for HIV/AIDS, 235 for HBC, 66 for counselling and 16 for administration have been trained. All volunteers receive a monthly stipend of R200. The forum attends as many national conferences on HIV/AIDS as possible to learn more about the disease and enlighten the volunteers about the new developments on the disease.

Training and support from the government departments

No training has been received from government departments; a facilitator within the organisation trains all volunteers and caregivers. The facilitator attends as many HIV/AIDS conferences and workshops as possible, to learn more about development in the HIV/AIDS field. The drugs and alcohol abuse course offered by the forum to its volunteers is accredited by the DoH and the DoSD.

Monitoring of funds and accountability

Ongoing evaluation and monitoring to improve effectiveness and service delivery is ranked as one of the main priorities. The following system is in place to ensure effective financial accountability to donors and other key stakeholders. The financial administrator is responsible for the finances of the organisation. In addition independent accountants are appointed to audit the books of the forum. The financial year of the organisation terminates on the 31st of March every year, the books are handed over to the auditing firm, and then the audited financial report is submitted to the DoH. The forum holds an excursion day on an annual basis for all the AIDS desk offices to report on their progress. All the volunteers, facilitators from different offices and the two governmental departments' officials are invited to the function.

Care and support for the family

The forum visits and gives hope to the affected families by preaching the Word of God, and has a prayer network for family members of all those infected and affected by the HIV/AIDS epidemic. In addition, the forum offers free counselling to the families of infected patients. Two Pastors facilitate these prayer networks on behalf of the forum. The families are provided with information on how to care for AIDS patient. Diapers are also provided to bedridden patients who cannot control their bowel system. The forum would like for their carers to visit the patients on a daily basis, but the carers live far from the patients' homes and cannot afford the daily transport fee as the stipends they receive from the forum is not enough.

Programmes focusing on youth

The Department of Education (DoE) has a programme on abstinence called No Apology, based on Biblical principles, where children in school are taught about abstinence and run in collaboration with the DoE. In addition, the forum offers youth development awareness courses, youth camps and workshops.

Programmes focusing on boosting the immune system

There is a food parcel distribution project for people infected with HIV/AIDS. 160 families receive food parcels on a monthly basis, including the nutrition supplement e-pap, aimed at boosting the immune system. The forum also encourages its patients to use African solutions that are believed to have properties for strengthening the immune system.

General knowledge about HIV/AIDS

The organisation attends as many national conferences on HIV/AIDS as possible to learn more about the disease and enlighten the volunteers about the latest developments on the disease. The organisation also attends every workshop that the DoH and DoSD conducts on HIV/AIDS.

Links with the formal health care

It works hand - in- hand with the National Hospital in Bloemfontein, a public district hospital. They also enlist the services of one of the doctors in the hospital who is part of the forum. The doctor refers all hospital patients who have no support system and requires HBC to the forum. The organisation has partnership with Red Cross and World Vision with whom information is shared.

Achievements of the organisation

The forum organisation is financially sustainable and can survive without funding from the two governmental departments. The forum uses a biblical, holistic and integrated approach to empower infected and affected communities by linking the disease with prayer. Its focus groups are children, youth, aged and affected families. The organisation offers patients' food parcels, painkillers, care, support and counselling to needy households and terminally ill patients. In addition, plans are underway to establish food garden units on individual sites and communal gardens to improve and prolong quality of life to those infected and affected.

People (volunteers/members) living with HIV/AIDS

It has one carer who is openly living with HIV. The organisation has been very supportive and offers a monthly stipend, food parcels, counselling and information about living positively with HIV/AIDS.

Reasons for HIV/AIDS infection in the community

They believe that the lack of moral principle in society is part of the reason for the high rate of HIV/AIDS in the community; and that most people in the community are unfaithful to their partners. Poverty is also a contributing factor to the scourge, since people sell their bodies for money so that they can eat or buy something to eat. The forum believes it is important to educate the youth about abstinence and married couples to be faithful to their partners and strongly recommends that the youth should be taught to control their sexual urges.

Services the organisation offered to patients

The forum assists patients to apply for disability grants and child support grant from the government; it assists with documentation needed when applying for governmental grants. It has been instrumental in persuading the Department of Home Affairs to operate on Saturdays and is negotiating with the Red Cross to sponsor them with mattresses and blankets, which they intend to give to patients during this winter. They would like to accommodate patients who are bed ridden and those who are chased away by their family members and those who the hospitals cannot accommodate in the caravan.

6.2 Kerklike Maatskaplike Diens

The Kerklike Maatskaplike Diens (KMD) is a faith based social service organisation of the Dutch Reformed Church. For years the Dutch Reformed Church has been involved in doing charity work for the poor in the community, in 1903 the wife of a minister, Mrs Charlotte Theron came up with a concept of opening a children's home for orphans and neglected children in Bethlehem called the Charlotte Theron children's home. The first body to take care of social service work was formed in 1953 and the name was changed to Kerklike Maatskaplike Diens (KMD) in 1988. At present there

are 12 KMD offices in the Free State. The provincial office is in Bloemfontein. Other offices are in Reddersburg, Botshabelo, Senekal, Reitz, Viljoenskroon, Virginia, Heilbron, Fauresmith, Welkom, Kroonstad, Odendaalsrus KMD is a fully registered social services providing organisation. The goal and programmes of KMD Free State has expanded to include:

- Prevention programmes pertaining to: HIV/AIDS, Sexual abuse and Alcohol and Drugs
- Life Skills programme
- Poverty alleviation programmes
- Sanctuary for street children and life skills for them
- Programmes with respect to crèches- their inception and development
- Programmes with respect to persons suffering from AIDS

Services provided by the organisation

An estimated 6500 people in the Free State annually receive assistance in the form of food, clothing and blankets from KMD. Also, 567 children per year receive statutory intervention and about 117 of abused children receive protection. In 2003 the organisation handled 88 cases of rape/molestation across the Province. Shelter is also offered to 165 children in Bloemfontein centre. The organisation estimates that 20 000 children per year are reached in the whole of Free State in terms of spreading information about HIV/AIDS and child molestation messages reach about 30 000 people in terms of community work and development. Currently there are about 150 cases per social worker.

KMD offers home-based care via auxiliary social workers as well as volunteers. For boosting the immune system food supplements are offered to patients, this includes a supplement similar to e-pap, as well as giving health talks to patients. Furthermore, patients are encouraged to plant vegetable gardens in their back yards. Most of KMD's HIV prevention programmes are targeted at the youth and children. The HIV programmes for children are carried out mainly in crèches and primary schools. These programmes mainly use puppet shows to teach children about HIV and abuse. Through the puppet shows children are informed about the facts about HIV and how they can protect themselves, and who to talk to should they require more information.

For young people the message is carried mainly through drama performances highlighting the facts about HIV/AIDS. The prevention message is mainly abstinence and being faithful to one partner. However, the organisation is aware that not all young people need the message of abstinence. Therefore, information about condom use is also provided. KMD wants to promote a high moral standard in society by making people aware of the many different alternatives that are available to them instead of choosing self-destructive behaviour like engaging in alcohol and risky sexual behaviour as ways and means of getting by in life.

Finances of the organisation

Each of the 12 offices applies for funding individually from the DoSD because most of them are in different districts. The main sources of income for all the services are from the DoH and the Dutch Reformed Church congregation. KMD receives a small but substantial amount of funding from private donors in addition to the two main sources of funding. Each of the 12 offices drafts its own business plan based on the needs of the communities that they serve. For the 2002/04 financial year, the Bloemfontein office had an income of R1 million. R743 695 was received from the DoSD and R256 000 from donations. The rest of the money was sourced through fundraising campaigns.

A significant amount of the organisations expenditure goes towards recurrent costs (R842 276 on salaries and wages to social workers and office personnel). KMD acknowledges that it cannot rely on funding from DoSD alone, thus it has made applications of funding to the National Lotto organisation, and have taken Eskom Bloemfontein on board as a donor for the street children programme.

Capacity within the organisation

KMD employs 30 qualified Social Workers, 13 Auxiliary workers and 337 volunteer workers. In the Bloemfontein office there are 7 Social Workers and 1 Auxiliary worker. KMD receives training from the department of Social development in counselling, and training on the implementation of new laws, procedures and bills such as the Child Care Act. The training offered by the department has proved to be useful since KMD uses the training material for their auxiliary social workers as well.

Support from government departments

Each of the offices writes a progress report to the DoSD on a quarterly basis. KMD personnel attending the training always write evaluation reports and highlight areas where the department can improve. In general KMD is satisfied with the support received from the DoSD. KMD has however managed to retain most of its social workers and this is attributed to the kind of support and passion amongst personnel.

Monitoring of funds and services and accountability

KMD personnel operate on the supervisor system where each social worker, auxiliary worker and volunteer worker reports to a supervisor. Each office writes progress reports to the provincial office in Bloemfontein on a quarterly basis - sometimes done bi-annually due to heavy workloads.

General knowledge about HIV/AIDS

Through working with qualified social workers KMD has access to the latest developments in HIV/AIDS through academic journals and publication, but also through courses provided by the DoSD.

Links with formal health care system

They have a good working relationship with clinics in the KMD designated areas of operation, since in almost all those clinics there is a KMD service point for ease of access for people needing social work services. This has made social work access to the health sector easier for KMD patients.

Networking and partnerships

The Bloemfontein office has good networking relations with other CBOs such as Heidedal Youth Centre and Afro DIY Home Based Care. KMD also works with HIV/AIDS orphans shelters such as Lebone and Oreratile Atra Care Centre. These networks involve giving management support and mentoring to these organisations. For instance, KMD Bloemfontein helps Heidedal Youth Centre with their drafting of their constitution and the administration of an organisation.

Achievements of the organisation

They regard as one of their achievements the fact that it manages to handle a load of casework despite the shortage of staff. Rendering services in rural areas where the organisation is often the only one doing so viewed as more rewarding because personnel can see the difference it makes. Since in rural areas there is a strong sense of community, it is easier for people to know about services rendered by the KMD, and many refer others to KMD service points.

People (volunteers/members) living openly with HIV/AIDS

The organisation has no member living openly with HIV/AIDS. However, the organisation believes that it can offer the necessary support should one of its employees come out with his/her HIV positive status.

Reasons for HIV/AIDS infection in the community

KMD is well accepted in the communities that it serves. In the designated areas in which the KMD Bloemfontein office operates there is acceptance from the communities, and requests from Bainsvlei for KMD to extend its services. Staff shortages do not allow for this request at present. The organisation believes that the HIV infections are mostly prevalent amongst the youth. The main reason for the high rate of infection is attributed to individual sexual behaviour. For example, young people are seemingly engaging in risky sexual behaviour without putting too much thought to the consequences. The organisation believes that the only way to curb the rate of infection amongst the youth is if people can start living responsible lifestyle and making the right choices such as focusing more on education and other life skills programmes to ensure a brighter future rather than one sexual issues.

6.3 Leadership Achievement Management Project (LAMP)

The Leadership Achievement Management Project (LAMP) is a non-governmental organisation that offers capacity building to other NGOs and CBOs, especially those in the townships and rural areas. LAMP also offers capacity training on a consultancy and tender basis to some government departments. In addition, the organisation offers courses on Early Childhood Development (ECD) to institutions of elementary education.

LAMP categorises its programmes into two; the first programme focuses on Youth Development, which entails providing capacity skills pertaining to the running, and sustainability of an organisation. The focus here is on youth organisations that work with HIV/AIDS related issues in their communities. The second programme is on ECD whereby training is given to educators in learning institutions for children below the age of primary school level. This training pertains to implementation of best practice model for running a business in relation to the service provided. LAMP was registered as a non-profit organisation (NPO) in 2001 but has been in service long before that.

Objectives of the organisation

The goal of the organisation is to develop youth organisations in rural areas. Development in this regard refers to the creation of jobs and raising awareness of sexual issues including HIV/AIDS, among the youth. They offer programmes and training on encouraging youth creativity, project management, on the basics of a business, HIV/AIDS and on abuse. Other HIV programmes rendered by the organisation are; Training on basic facts of HIV/AIDS, Master trainer, which is a training course were people are trained to be trainers on HIV/AIDS issues such as home-based care, counselling and support on HIV/AIDS. Another training course is HIV/AIDS in the workplace, whereby guidelines are given to companies on how to formulate their HIV/AIDS policies. Most of the programmes offered are tailored according to the needs assessment done by the organisation in the communities. The role of the organisation in the ECD programme involves giving training to educators on project management and how to sustain their crèches. There is also training on fundraising and how to market the organisation. The organisation has a programme called food banking whereby proposals are sent to a private organisation for funding. As a result of this programme, Spoornet offers regular donations of e-pap, which are in turn donated to other needy organisations in the township, especially those on the training database.

Finances of the organisation

The main source of funding for the organisation's programmes is from the Free State Provincial DoH and DoSD. In addition, it often gets contracted to offer capacity building training by other institutions such as the Organisation for Albinism in South Africa. In the 2003/2004 financial year LAMP received R1 million from the two departments for training on ECD and capacity building to youth organisations. Given its important role in the province, they believe that funding from government departments is not enough as this hampers their aim to provide training to organisations throughout the province.

Currently, the organisation is confined to offer training to organisations in three of the five districts, namely Xhariep, Lejweleputswa, and Thabo Mofutsanyane. Since they are aware that funding from government in not enough, it embarks on fundraising campaigns as well as tendering their services to other organisations. They indicated that since the core business of LAMP is training and the main expenses are training related and it would be difficult to survive without funding since the funds from other income generating ventures are not enough. The organisation provides business plans based on guidelines and objective set by government departments, which are integrated with inputs from LAMP staff members as well as feedback from needs assessments in communities.

Capacity within the organisation

LAMP has a total of 11 employees, 10 of which are young people. The financial manager has received training from the DoH on how to manage the organisation's books and report back to the department. In addition to this training, the financial manager is studying financial management at tertiary level. An internal auditor and auditors from government departments audit the organisation's books.

Support from government departments

There is a good working relationship with the two government departments. LAMP sends monthly progress reports to DoH and DoSD, and so far there has not been any complaints from the two departments and more organisations are being referred to LAMP by these government departments for training. This, the organisation believes is an indication of the confidence that both departments have in LAMP.

General knowledge about HIV/AIDS

Through the relationship with the DoH, LAMP gets HIV/AIDS related information regarding the developments in the HIV/AIDS. The organisation also attends HIV/AIDS conferences to keep abreast of all the latest developments. This is in addition to reading accredited HIV/AIDS related publications.

Achievements of the organisation

Through their HIV/AIDS related work about 250 people were reached and over 35 organisations have been trained and mentored. Offering training to the National Organisation of Albinism is one of the achievements of LAMP. Getting rejection of proposals by the department is perceived to be the biggest challenge for LAMP because all proposals are drafted based on the identified needs during service delivery sessions of LAMP with communities. Rejections of proposals by government departments imply that the services provided by LAMP do not efficiently meet the requirements of the communities. However, according to their assessment of LAMP in the communities- there is still more that needs to be done and this depends on the funding available. There is great support from the communities in which LAMP is offering training to and the youth in the community are co-operative towards the programmes offered.

6.4 Mangaung Tshwaraganang Youth against HIV/AIDS

Mangaung Tshwaraganang Youth (MTY) against HIV/AIDS was established by Mr Teboho Finger, after testing HIV positive in 2001. The organisation is based in Batho location (just outside Bloemfontein), which is characterised by a high degree of unemployment and low economic development. The organisation sadly lost its founder through the illness. They do not have any staff or volunteer members who live openly with the disease (some have tested two or three years ago while others are unaware of their status). They have lost many of their patients since its inception, with the emotional toll these deaths have on staff members and the organisation itself, which damages morale and hurts productivity. The caregivers, after loosing patients, show signs of burnout and are usually stressed and fail to visit other patients. The worst thing reported is that the staff members and volunteers do not get any kind of counselling. Counselling is important since they get attached to the patients and when the patient dies they get traumatised.

Objectives and targets of the organisation

The objectives of the organisation include creating awareness in schools, providing door-to-door information in the community, proving HBC care and support to people living with HIV/AIDS, providing life-skills education to schools, building sound relationships between the organisation and various churches on HIV/AIDS related matters. Furthermore, the organisation creates support groups for people living with HIV/AIDS.

Financing the organisation

The organisation received R154 000 for the financial year 2002/2003 from the DoSD. It has ten permanent staff members and each caregiver receives a stipend of R500 a month. They approached several private companies for funding with no luck. At the moment the organisation is operating without any funding, and has recently applied for funding for the 2004/5 financial year. It falls within a consortium called Alliance Against HIV/AIDS - funded by the DoH to the tune of R80 000. The consortium has a number of programmes such as a puppet show where they promote HIV/AIDS education to crèches, condom distribution where they promote awareness and teach the youth and the general public how to use condoms and they also promote the prevention of HIV/AIDS in schools. They do not benefit financially from the consortium. The organisation is not happy to be funded as a consortium because they feel that some individuals benefit more than their organisation, preferring to be funded individually.

The main expenses are monthly rental of their office, telephone, transport and stipends, with the first amounting to R500, which they pay out of their own pockets. Each member donates R25 from their monthly stipend to pay for rent and the telephone bill. The rent has not been paid in the last couple of months.

Capacity within the organisation

They operate from an office in the Mangaung Resource Centre with all staff members based in the main office doing field- work (HBC) and coordinating educational and youth awareness programmes. In addition, the organisation usually has six freelance volunteers of which only three are paid according to the work they performed. These freelance volunteers are usually called in by the Department of Education to train, and the department pays the organisation for the work the volunteers performed for them. Rates are usually R250 to the organisation then the organisation pays the volunteers R100. Most of the staff have matriculated, but have no jobs and instead help the organisation with its awareness campaign and home based care. The area of concern that needs to be addressed is HIV/AIDS counselling to the patients. At the moment the only support that they are offering to people living with HIV/AIDS is moral support and they would like to have HIV/AIDS counselling training. They would like to offer counselling as one of their programmes.

The executive committee members draft all business plans for the organisation and they are confident that all their business and service plans meet the standard determined by the government departments, (they would not have received funding from the DoSD for the previous financial year). However, the organisation acknowledges that this is an area of concern that would require attention in the immediate future.

MTY has enough capacity for now as they do not have enough resources, but their employees need managerial skills. They would like to be trained in the following fields: financial management, project management, and HIV/AIDS counselling skills by the government departments and have approached a private company for project management training (but were told a fee was required). They try to attend as many workshops and conferences as possible so that they can gain some experiences, and received 59 days training from the DoSD in HBC. The Department of Health provided the department with one day's financial management training; this was felt inadequate since they are battling to manage their finances. They have an unqualified treasurer struggling with their finances and do not have the budget to hire an independent firm.

Support from the government departments

MTY appreciates the support they are getting from the government departments, but view the funding as not enough. While they view the departments as doing the best they can, the level of support is not enough, but at least their doors are always open to MTY.

Monitoring of funds and accountability

The organisation does not have monitoring systems in place. The department of social development audits its books once a year only because it is funded by the organisation.

Care and support by the family

The only support they provide to the patients and their family is moral support and they would like to help with counselling the family and patients, but do not have any training in that department. They would also like to form support groups for patients and the affected families.

General knowledge about HIV/AIDS

There is limited information on HIV/AIDS in MTY. It is not fully aware of all HIV/AIDS developments and does have formal access to information about the disease. There is poor coordination with both the governmental departments and they rely for information from the media.

Links with formal health care

They have a formal link with Batho clinic and Tshepong crisis centre. The beneficiaries are referred to the organisation by the Batho clinic, Tshepong crisis centre, neighbours and relatives of the patients. MTY does not only target people living with HIV/AIDS, they take care of sick people who cannot take care of themselves and those who suffer from cancer.

Networking

One affiliation is to a consortium funded by the DoH, called Alliance Against HIV/AIDS, yet they are unhappy re funding through a consortium since they believe that certain individuals gain from the consortium more than the organisations. MTY also has a formal network with the Bloemfontein Hospice; they refer some of their bedridden patients to the Hospice.

Achievements of the organisation

They adopted Marang Primary School to help learners to apply for social grants from the government. Because of the work they are doing with Marang they managed to get an interview in March 2004 from the Nelson Mandela fund through the help of the Department of Education. They are on the database of the Department of Education due to their engagements in Marang Primary School, and for promoting HIV/AIDS education in schools, and are fully supported by the community and the police. They would like to form partnerships with the local police. When they undertake door-to –door campaigns the community are always open to them. The community goes to the organisation when they need information on HIV/AIDS.

People (volunteers/members) openly living with HIV/AIDS

They do not have members living openly with the disease. The only person who was openly living with HIV/AIDS was the founder and members do not know their status.

Reasons of HIV/AIDS in the community

MTY thinks that poverty and alcohol abuse plays a major role in the spread of HIV/AIDS. They believe that the general public and the youth need to change their social behaviour and churches should preach HIV/AIDS education to their congregation. Parents need to start discussing sexual education with their children as charity begins at home. According to the organisation the schools and parents should have a relationship where children can be comfortable to talk about sex at school (with teachers) and at home a (with parents).

An area of concern that needs to be addressed is HIV/AIDS counselling. At the moment the only support that they are offering to people living with HIV/AIDS is moral support, and they would like to have HIV/AIDS counselling training and to offer counselling as one of their programmes.

6.5 Rephidisitswe Community-Based Organisation

This group was established in January 1999 and registered as a CBO in 2001. They operate from Botshabelo Township. Since its inception Rephidisitswe has been actively involved in all HIV/AIDS awareness campaigns in Botshabelo and surrounding rural areas, as well as in networking with other CBOs at district and provincial level. It is a member of the Botshabelo HIV/AIDS consortium, which is made up of 16 HIV/AIDS CBOs all based in Botshabelo.

Services provided by the organisation

The main developmental goal is capacity building for other CBOs. One of the main emphases in all capacity building programmes is the promotion of gender equality in the fight against HIV/AIDS. Other services include health talks and peer education, condom distribution and demonstration, capacity-building workshops for other community based organisations, project and financial management for sustainable development, HBC, pre and post HIV counselling and HIV/AIDS awareness campaigns.

Financing the organisation

In 2003 both the DoSD and DoH funded the organisation, with an allocation of R600 coming via the consortium. The consortium was allocated R50 000 by DoH. Clearly insufficient, it did not cover all their operational costs. However, it is contracted on a regular basis by the DoH to render a number of services on its behalf. The amount of funding from DoSD that is used for payment of caregivers was not disclosed, however the organisation believes it is not enough to cover all their expenses. The DoSD also donated a public phone container as part of a job creation project. Which has been used as a public phone business, which includes condom distribution and HIV/AIDS awareness programmes.

Due to this inadequate public funding, Rephiditsitswe approached a number of private companies and parastatals. In 2001 they were allocated R40 000 by the Development Bank of South Africa, which was used to establish an Internet café in Botshabelo Township. The success of the Internet and public phone businesses' generates a regular income that is used to supplement government funding. They are also sponsored by a local pharmacy and supermarket with free food when it hosts awareness campaigns in the local community. In 2003 Mangaung municipality funded the organisation with R10 000, which has been used to expand the telephone and Internet businesses.

Capacity within the organisation

Eleven full-time staff members are responsible for the day-to-day management of the telephone and Internet business. Thirty caregivers between the ages 18 and 35 are responsible for HBC and have to divide funding allocated equally. This often results in caregivers being allocated a stipend of R500 that is less than the standard rate for all caregivers, resulting in a number leaving the organisation. The need in the community is much greater than the capacity of the organisation and they would like to have more caregivers, and because they lose caregivers and staff because of financial constraints.

Support from governmental departments

All caregivers were provided with 59 days home-based care training by DoSD. Although the organisation believes it needs more support from government departments it realises that they are understaffed and cannot respond to all the needs of different organisations. However, they believe efforts should be made to improve their communication with all NPOs. Also, monitoring of services could help improve the effectiveness of these organisations. The negative thing stated is that the officials they work with are not professional and are sometimes not well informed about HIV/AIDS, especially those from the DoSD. On a number of occasions government officials criticised the proposals and service plans of the organisation without offering advice on how they can be improved.

Monitoring of funds and accountability

The management meets on a monthly basis to review the activities and programmes rendered. They also meet to evaluate progress and backlogs of the organisation on a quarterly basis. Where possible and if complaints have been raised, management visit patients to evaluate the services offered by caregivers. To maintain quality control they have forms that patients sign after the visits of caregivers.

Care and support by the family

They offer counselling to affected families and are planning to have support groups for affected and infected families in the community.

General knowledge about HIV/AIDS

They believe they are well informed about HIV/AIDS. The Internet café has been used to download the latest information and developments in the field, where they also access government departments' websites for the latest information.

Links with formal health care system and the community

The organisation works closely with the Hospice, Botshabelo Clinic and Hospital. The hospital and clinic refer patients who require HBC to the organisation. In addition, the organisation provides pre-post test HIV counselling on behalf of the clinic. Community members also contact the organisation when they have questions about HIV/AIDS.

Networking

Through its affiliation with Botshabelo HIV/AIDS consortium, the CBO has established a number of valuable links with other CBOs. This affords the organisation the opportunity to share and learn. Furthermore, there are links with development organisations to explore different measures that can be used to make the organisation more financially viable.

Achievements of the organisation

The establishment of an Internet café and public phone businesses' are listed as their main achievement. Also, over the last few years the number of youth who seek information and condoms from the organisation has been steadily improving. Sometimes they cannot keep up with the demand for condoms from the youth. They believe that their HIV/AIDS campaign has assisted in fighting the stigma and discrimination associated with HIV/AIDS. Pre and post HIV/AIDS counselling at Botshabelo clinic also affords them the opportunity to make a significant contribution to community development.

People (volunteers/members living with HIV/AIDS)

They have 6 staff members who are openly living with HIV. This has contributed in demonstrating to the community that one can still live a positive and normal life even when infected with HIV.

Reasons for HIV/AIDS infection in the community

Rhepidisitswe believe that poverty, ignorance and unemployment are the main contributing factors to the scourge of HIV/AIDS in the community. Lack of recreation facilities in Botshabelo Township is also cited as a contributing factor in young people experimenting with sex.

6.6 Lerato Care Group

Lerato Care Group is a community-based organisation offering services in the areas of Rocklands, Phelindaba, Bloemanda and Sejake. The organisation was established in 2001 as a response to the call by the State President that people should volunteer their services in the communities that they live in. Their main focus is to address the deficiency of health care services in the fight against HIV/AIDS and other related diseases such as STI's and TB. The services offered by the organisation are not only confined to HIV positive people, because they do not want to single out people based

on their HIV status. Lerato operates from the homes of the chairperson and co-ordinator in Rocklands Township and links with patients through referrals from people in the community.

Lerato Care Group is a member organisation affiliated to the Ngenani Emxholweni consortium. The consortium has 6 member organisations and was established in 2002 following encouragement by the DoH. The consortium was officially launched on 05 March 2004. The consortium committee has 12 members, two people from each organisation. Two people from Lerato occupy the roles of consortium chairperson and consortium fundraiser.

Service provided by the organisation

The main service provided is HBC. This is provided to patients on a daily basis, with volunteer carers coming in at the Chairperson's house to sign in a logbook before going to see patients. All carers keep fieldwork notes on the progress of their patients. Once every week the co-ordinator goes into the field with the carers to get feedback on the services provided from patients and their families. The nature of the HBC is that carers would come in the patients' home in the morning for about 20 minutes to check if the patient has been washed and fed and thereafter supervise with the administering of medication to patients.

Lerato has since expanded their HBC services to include paid HBC for patients who need 24-hour attention or whole day care. This move came about as a result of being approached by attorneys of patients who were already in the care of Lerato. The attorneys offered that if the organisation put their clients/patients on 24-hour care, they would pay an amount, which the organisation was reluctant to disclose. On average the organisation takes care of 64 patients at a time with the ratio of carer to patients is 1:3. However there are other carers who feel emotionally strong to care for more than 3 patients. Another service that the organisation has been doing is to help families that are struggling with funeral arrangements. This is done by approaching the local business community for donations of food as well as arranging with local ward councillors to authorise donation lists. They always strive to ensure that all deceased get a dignified funeral.

Lerato work closely with teachers in schools as the first points of identifying pupils who qualify to receive government grants, but are not getting them. Currently the organisation is working with three schools in the area of Rocklands, namely Kgabane School, Karabelo School, and Mothusi School. The organisation works with these three schools because they are the ones closest to the base from which the organisation operates. Other services include HIV/AIDS awareness campaigns in schools.

To help in boosting the immune system of patients, the organisation relies on supplements such as e-pap from the MUCPP clinic. For people whose immune system is compromised by lack of nutrition, they organise food parcels from the DoSD for these patients, especially those whose grant applications are still pending. Furthermore patients and their families are encouraged to plant vegetable gardens.

Finances of the organisation

The organisation does not receive any funding from government departments or the private sector. The only money available was a grant of R40, 000 over 2003/2004 from the DoH to Ngenani Emxholweni consortium, which was mainly used for marketing the consortium, as well as Information and Education Communication (IEC) and creating awareness in the community. The organisation does not have a draft annual budget because they don't have a fixed income to budget from. The paid home-based care is the only income-generating project, together with other small-scale fundraising initiatives. The organisation survives by using money from the members' own pockets to cover some of the organisation's expenses; this is sometimes a problem since most members of the organisation are unemployed.

Several private sector companies have been approached with proposals for funding, but so far no funds have been secured. Some of the reasons given by the companies were that they did not offer funding for the programmes that the organisations were offering, others said the organisation should apply in the following year. The organisation also approached the DoH and DoSD. The response has been that the funds for this year had already been exhausted. However the members were quick to point out that they can't complain much about the DoH because at least the department granted some albeit small funding via the consortium. They expressed some problems with the DoSD because there was a tendency for the department to invite organisations to submit proposals, yet no funding is ever granted - with reasons given that the due date for application for funding had gone by, or that funds had been exhausted.

Although Lerato acknowledges that survival of the organisation without funding is very difficult, they maintain that they can continue to survive as they are presently operating. It is perceived that nowadays, most funders prefer to grant funding to consortiums instead of individual organisation, and for them, it would be wise to seek such funding, even though the implications would be such that small amounts would be available. For now, Lerato is content with funding through the consortium because their needs are being included in the business plan, and there is sharing of information and networking via the consortium.

Capacity within the organisation

The organisation has 17 non-stipendiary volunteer members, 13 of which are young people, with 8 people serving in the executive committee. They have received donations, in the form of training, from the Department of Labour and St. John's Ambulance. The latter offered 5 days training in basic home-based care, followed by 2 weeks practical training at the military hospital. Department of Labour training was also on home-based care, and included project management, bookkeeping and financial control. The members also received counselling training, but it was not from an accredited body.

When the Lerato was originally established, many people joined the organisation with the hope that there would be financial gain. On realising that this is a voluntary organisation, many people left, which constituted a loss of skill on the part of the organisation. Members acknowledge that there are always ongoing discoveries in the research on HIV/AIDS, and they feel they need to keep abreast of latest findings. This should include getting information in the form of books and pamphlets from the DoE, and being invited to seminars and conferences where issues on HIV/AIDS are going to be deliberated. One of the skills required is counselling services for members. Currently members give counselling to their patients and they also give counselling to one another, yet this is not expert

counselling, mainly offering empathetic support to patients and to fellow members when the need arises.

They have a financial manager, and the executive committee does the auditing of their books, since they can't afford an external auditor. The chairperson together with the co-ordinator drafts the business plan, which is then presented to the executive committee for approval. This is based on the objectives set by the organisation in pursuit of meeting community needs.

The biggest challenge is access to adequate finances, as well as access to material for administering home-based care (dressing gauzes and gloves). Initially these were provided by the MUCPP clinic, but were insufficient since the clinic had to reserve these materials for their own HB carers. The members of Lerato often decide to be resourceful and use plastic bags for handling HIV infected patients. In the case of gauzes, the members use tissue papers to wipe wounds. Recently the DoH donated a box of dressing kits. However, there is no surety that this kind of donation is going to be sustained. The donation came about as a result of the organisation writing a letter of complaint to the former Premier, Ms Winkie Direko on highlighting the plight of the organisation in ensuring hygienic apparatus for handling patients in particular HIV positive patients.

Support of government departments

Lerato appreciates the fact that the DoH granted funding to the consortium especially given the fact that it was the first time that the consortium was invited to submit a proposal. However the organisation is not happy as to the amount granted considering that it was restricted to certain activities and also that there are 6 organisations in the consortium.

The organisation seemed to be having negative sentiments toward the Department of Social Development. Firstly, they were dissatisfied that the department kept on inviting them to submit a proposal, yet no funding is ever granted. Furthermore, they maintain the Department of Social Development offers support to other organisations that are offering the same services as Lerato, such as stipends and regular visits by department officials. From the consortium, only two organisations get that kind of support, and the members of Lerato expressed that this kind of treatment by government officials can create tension and competition amongst organisations affiliated to the same consortium.

Since the establishment of Lerato, they have been submitting reports on their home-based care services to the DoSD, but since 2003 they have stopped due to lack of support from the department. The organisation expects the DoSD to give support in terms of stipends for carers doing home-based care as well as providing food parcels to be distributed to the needy and poor. In general Lerato members feel that government departments have not done enough to offer support to capacitate their organisation.

Monitoring of funds and services and accountability

The organisation monitors the funds allocated to the consortium through their members who serve on the consortium committee. The treasurer reports on a monthly basis, and for any spending by the consortium there are requisition forms that have to be completed before the money can be issued. The consortium has to write quarterly reports on the financial activities of the consortium and present them to the affiliated member organisations.

Care and support to the family

Family support is one of the services offered, especially to families of patients who do not have enough knowledge about HIV/AIDS and the care of the infected. The organisations give health talks to these families, to ensure infection control and hygienic conditions are maintained for the family's sake and the sake of the patient

Programmes provided by the organisation

There is a Life Skills programme in schools. However due to the attitude of some young people toward the organisation, it is difficult to assess if the message reaches out effectively. Young people seem to be having a negative attitude toward the services provided. There is a perception that young people would never care for sick people, especially those infected with HIV.

General knowledge about HIV/AIDS

Lerato acknowledges that there are always developments in the field of HIV/AIDS, and would want to expand their horizons regarding knowledge. Currently Lerato has been getting information through their working relations with organisations such as the Planned Parenthood Association of South Africa (PPASA) and Befrienders (organisation offering grief and moral support to HIV infected and affected people).

Links with formal health care system

The organisation has formal links with the MUCPP Clinic in Mangaung, and is also well known in other clinics in the Rocklands area, because they get referrals from those clinics, and they collect medication for some of their TB patients.

Networking

The organisation has been able to form partnership networks with other NGOs that have proved to be successful; this includes LAMP, Befrienders, and PPASA. From LAMP they get a lot of information in terms of published journals, and training on how to write their own organisational publications. From Befrienders they get invited to motivational seminars on how to give empathetic support to people infected and affected by HIV. From PPASA they get condoms and information pamphlets and posters.

Achievements of the organisation

Registering as an NPO is one of the celebrated achievements of Lerato, as well as registering with Thembalizwe trauma counselling. This is an achievement because members of the organisation can now get counselling training from accredited organisations. In addition patients who require expert-counselling services can be referred. Having established networks with other established organisation such as LAMP, PPASA and Befrienders is also regarded as an achievement for the organisation because this helps in capacitating the organisation as well as ensuring its sustainability. Lerato's services are well accepted in the community, with the exception of some young people who seem to have a negative attitude toward the services provided. However, some families who have

not accepted the HIV positive status of their family members tend to associate patients in the care of Lerato with AIDS. This highlights that there is still a lot of stigma around the acceptance of HIV in the community, and this is a misconception that Lerato wants to do away with.

Reasons for HIV/AIDS infection in the community

The perception of the Lerato members is that it is largely young people who are infected with HIV. The reason associated with this perceived high rate of infection is believed to be ignorance amongst the youth, and that young people seem to be ignoring the consequences of their reckless behaviour purposely. Members of Lerato expressed the view that the youth have enough information about HIV/AIDS, and that condoms are distributed everywhere, yet many young people still engage in unprotected sex, while many have multiple partners. The one thing that members of Lerato feel need to be done is to keep the youth busy in sports and recreation activities.

6.7 National Association of People living with AIDS

The National Association of People Living with AIDS (NAPWA) is a non-governmental organisation that deals with HIV/ AIDS related social issues pertaining to both infected and affected citizens. NAPWA was established at national level in 1994 and the main focus of the organisation falls broadly under advocacy, which involves human rights issues, labour issues, care and support as well as dealing with stigma attached to HIV and AIDS in society. NAPWA Free State office was established in 1998. The organisation operates from the old Mangaung municipality building in Batho location, and carries out most of its work through volunteers who are members/beneficiaries of NAPWA.

There are 12 branches in the province at Bultfontein, Winburg, Virginia, Henneman, Zamdela, Botshabelo, Thaba-Nchu, Mangaung, Welkom, Zastron, Ondendaalsrus and Ventersburg. NAPWA sees HIV/Aids as a socio-economic issue more than a health issue. It has lobbied for grants for people who are HIV positive, especially those from a poor financial background. Assessment for qualifying for a grant involves NAPWA members doing a physical inspection and then a recommendation letter written to the DoSD. People who qualify include those who are HIV positive and unemployed from poor backgrounds.

Services provided by the organisation

NAPWA's Free State programmes are in line with national programmes, which include community mobilisation aimed at encouraging more people to disclose their HIV status. Performance indicators include the number of branches launched and support groups formed.

In terms of advocacy, most of the programmes are overlapping. When doing destigmatisation, there are instances were advocacy issues are dealt with, for instance financial exclusions, in relation to financial institutions such as banks and insurance companies. Destigmatisation is done through members of NAPWA who are open about their status. This puts a human face to the epidemic, which involves mobilising communities to acknowledge the existence of the epidemic by showing people who are openly living with the HIV.

NAPWA is of the opinion that visibility throughout the year such as at Easter (and not only in December and on AIDS day) is important in the fight against HIV/AIDS. They are in a process of

introducing a Gender programme, whereby people will be made aware of situations that women are made to be vulnerable to infections. NAPWA also take special notice of men as having a role in spreading the virus with the focus here on attitude and behaviour change.

Care and support for both infected and affected beneficiaries is provided in addition to Life Skills Education and Counselling. The opinion of the Free State office is that NAPWA members should not be doing home-based care, since many other organisations are doing home-based care. Furthermore, for an HIV positive person to care for a terminally ill patient might result in the carer reflecting deeper on their HIV status and start thinking of the time when they get to that stage. Members of NAPWA Free State are always discouraged to do home-based care because it is perceived that it is going to be traumatic for them, over involved emotionally and that in turn this will be detrimental to their already compromised health. At the time of the interview preparations were being made for the NAPWA national congress, and there were speculations that a different decision regarding this matter might be taken at the congress.

Finances of the organisation

At national level, the DoH funds NAPWA, and the funds are redirected by NAPWA's national office to all provincial offices. In the province, NAPWA receives funding from the DoSD. This came about as a result of the expansion of the services rendered by NAPWA to the communities. NAPWA is seen to be serving a role of linking beneficiaries to service providers. The service providers were mainly those organisations that received funding from DoSD. DoSD contacted NAPWA offices to monitor the funded organisations whether services are being delivered where they are due. With regard to the service for the department of Social Development there has not been implementation as per the agreement with NAPWA, because there was mismanagement of funds on the part of board members of NAPWA. The members of the board have since been expelled and there are plans to recover lost funds.

The programme for which funding is received from Free State DoSD has not yet started due to technical problems experienced by NAPWA. They are not content with the funding coming to the province, and take initiatives to fundraise by means of events such as beauty pageants. Main expenses include capacity building in the provincial office as well as in branches. NAPWA received R 234 000 from the DoSD, R106 702 from the Aids Foundation, and it has been communicated verbally that the provincial office has been allocated ± R422, 000 by NAPWA national from the funding received from the National DoH.

Capacity within the organisation

They have 3 fulltime staff members including an administrator, co-ordinator and a community outreach person. There is one fulltime stipendiary volunteer who comes in the office everyday. With 12 branches in the Free State, most of NAPWA members are young people. Bultfontein has 50 members, Winburg 26, Virginia 28, Henneman 36, Zamdela 29, Botshabelo 49, Thaba-Nchu 39, Mangaung 52, Welkom 71, Zastron 35, Ondendaalsrus 26, and Ventersburg 40 members. NAPWA has no financial manager; the coordinator and the administrator are responsible for internal auditing of books.

Support from government departments

NAPWAS believes that government departments are not fully supportive of the organisation. The general perception is that government officials, even at local level, are not as supportive as they are expected to be. NAPWA Free State is accountable to NAPWA national office and the national office accounts to the National Department of Health. However from this year 2004, NAPWA Free State will submit reports to the Free State DoH.

Monitoring of funds and services and accountability

Monitoring is done in terms of attendance registers, progress reports on the activities done, and evaluation reports. In the case of those doing awareness campaigns in schools, the school principal needs to sign on a report, and in clinics those doing counselling need to write reports indicating how many people have been counselled and how many have tested positive or negative. Furthermore, branches are expected to write monthly reports to the provincial office, and that is often a problem since some branches do not have the resources, such as faxes or computers. However that problem is going to be addressed soon because many branches are going to get offices from their local municipalities. They are sceptical of this move by local municipalities, because this might be a move to lobby for votes for the coming 2004 general elections.

Care and support to the family

The main service provided is counselling to both infected and affected people, with plans at present to form support groups for patients and families affected by HIV/AIDS. This is seen as a strategy that would decrease the stigma and help families to deal better with the status of their family members.

Programmes provided by the organisation

NAPWA acknowledges that HIV prevalence is high among the youth; hence most of the awareness campaigns are directed mainly at the youth in schools and tertiary institutions. NAPWA has included as part of their coming events, programmes to raise awareness and increase the sense of responsibility among males in the fight against AIDS. They intend to bring issues of same-sex couples in their awareness campaigns as well as support programmes since there are little or no programmes in the Free State that are targeted towards gays and lesbians. It is difficult to quantify the number of people reached during awareness campaigns; the only fool proof way of checking numbers reached is their database of branches in the province.

General Knowledge about HIV/AIDS

All the people interviewed at NAPWA Free State were HIV positive and seemed to have a sizeable knowledge about HIV/AIDS issues, being expressive and eloquent in their views. NAPWA members are always reading relevant material on HIV/AIDS. These include conference publications, medical journals and academic books. Through the network with the DoH they are in a better position to get relevant published material on the developments of HIV/AIDS.

Links with formal health care system

From 2001 until 2003, NAPWA had lay-counsellors in various clinics in Bloemfontein. However, early this year (2004) the lay counsellors had to be laid off because the funds, which had been paying their stipends, have been exhausted. Thus many of the links with formal health care systems have been terminated; there are however some counsellors who still offer their services voluntarily at clinics such as National Hospital and Mangaung University of the Free State Community Partnership Project (MUCPP) clinic. Currently NAPWA is making plans to get stipends for their counsellors from the Department of Health.

Networking

Since mid 2004, NAPWA has been part of a consortium together with Hospice, AIDS Training, Information and Counselling Centre (ATICC) and MUCPP, as well as the QwaQwa HIV/AIDS consortium. This is an independent consortium, which is more like a business venture and that is going to help with raising funds. They are also part of two other consortiums, which are under the Department of Education. In Bloemfontein, NAPWA has a relationship with Mangaung Caregiver's Association, Ngenani Emxholweni Consortium, and Lesedi la Sechaba. There is linking of services, in terms of programmes that these other organisations have that NAPWA does not offer. In addition, some organisations refer people to NAPWA for counselling.

Achievements of the organisation

NAPWA is 10 years old and maintain that they have achieved a lot in terms of helping HIV positive people, and that they continue to keep doing so. They continue to destigmatise HIV/AIDS, and believe the rate of stigma and discriminations against HIV positive people has reduced. Though a Memorandum of Understanding has been signed with the Department of Social development, there is underlying dissatisfaction on the part of NAPWA. It was expressed that dealing with government departments is difficult because they set the terms of agreement, in what is viewed as an unequal partnership. They maintain that some of the consortiums funded by the department have nepotistic undertones in their establishments, and suggest that Department of Social Development grants funding to organisations registered as PLWHA (People Living with AIDS), which end up not delivering effectively to the community.

People (volunteers/members) living openly with HIV/AIDS

Almost all NAPWA members are openly living with HIV/AIDS. The support provided by the organisation is credited as one of the key reason why members have been encouraged to come out and declare their HIV positive status.

6.8 Aganang HIV/AIDS prevention and Home Based Care

Aganang HIV/AIDS prevention and Home Based Care was established in January 2000 at Jagersfontein by a group of local volunteers. It was officially registered as an NPO on 19 November 2002. One of the main considerations in the establishment of Aganang was the realisation that the local community had many people who were ill and frail and there were no organisations that could provide HBC to those people. Although HBC is mainly provided to HIV/AIDS infected patients, the organisation does not confine its services to HIV/AIDS patients only. Over the last few years they have broadened their goals to include orphaned and vulnerable children and other people who need

help are also helped by the organisation. In addition, Aganang also helps by ensuring that needy people are aware of food parcels offered by various government departments and making sure that children and people who are impoverished are made aware of government grants. The organisation operates from a house in Itumeleng Township in Jagersfontein.

Aganang is a member of the Lekomo consortium. Lekomo HIV/AIDS Consortium is an umbrella body of clusters of NGOs and other community structures that render service to HIV/AIDS infected and affected people in the 17 towns of the district of Xhariep. The consortium is an initiative by the DoSD and the DoH to ensure that all towns are represented and guard against duplication of services. The consortium has four focus areas namely: home based care, information, education and communication (IEC) on HIV/AIDS, distribution of food parcels, and foster care identification. Each cluster is supposed to render service in all four areas of focus. The four clusters have one specific area of focus, which is delivered across the seventeen towns. To date, only the Department of Social Development funds the consortium.

Services rendered by the organisation

They strive to provide care for the ill, aged, and orphaned and vulnerable children, as well as facilitate education and training opportunities for life skills education. Aganang aims to promote the rights of people living and affected with HIV/AIDS through life skill education, emotional and social care of the patients. The biggest challenge is providing services to farm dwellers as most farms are far apart. Carers have to hire a taxi to take them to these farms and this is quite expensive, with the only alternative being hiking. This is in itself a problem since there are not too many cars that go to the farms. The organisation offers special courses to the local community and engages in community awareness projects on STI's and HIV/AIDS. In addition, Aganang helps in poverty alleviation projects.

They maintain that there is a direct link between poverty and HIV/AIDS in Jagersfontein. In order to address the high infection rate in the community, there needs to be measures that can be introduced to address poverty. Thus informing the community about various grants available and the need to get birth certificates for children whose parents are unemployed is crucial. There are no programmes specifically targeting same sex couples, since they have not considered this as part of their programme

Finances of the organisation

Since establishment in 2000, they have only received funding of R91 800 for the 2002/2003 financial year from the DoSD, after submitting a business proposal of R157 140. In the interim they relied on fundraising initiatives, donations and the goodwill of volunteers. However, these initiatives were not sustainable as the community of Jagersfontein is impoverished and mostly unemployed. It only became eligible for government funding after registering as an NPO in 2002.

In an effort to help to ease the financial burden of transportation to outlying farms the organisation has approached Spoornet, DoL and the local mining company, De Beers for assistance. They have also approached the local business community, including supermarket owners, taverns and bottle storeowners. However, the organisation has not had any successful responses.

Sometimes people who are in dire need of financial assistance and food, approach the organisation for help and this creates added pressure on the organisation's financial position. While people are made aware of available government assistance, sometimes it takes longer for government to respond and the organisation feels compelled to act in the meantime. On a number of occasions, volunteers help the community with money from their own pocket. They were happy with the initial funding from DoSD but soon realised that it was not enough to meet all their financial requirements. Consequently, the DoH was approached for funding to supplement the initial funding received from DoSD, but nothing has come through.

The DoSD stipulates that R150 should be spent on stationary (files, pens and writing material) every month, but the organisation feels that their stationary requirements far exceed R150 per month. Initially, all home-based carers used to get surgical gloves from the DoSD but the supply has since been terminated. As a result, the organisation has to purchase their own supply of surgical gloves, which is difficult since there are not enough funds. Carers have resorted to the use of plastic shopping bags as a substitute. The beneficiaries complain about the use of plastics since it is not hygienic and scratches them. DoSD has been made aware of the situation, yet nothing has been done.

Main expenses of the organisation

The main expenses are for payment of R500 per month stipends for each of the 14 volunteers members. Operational expenses, including telephones and electricity are covered. The organisation acknowledges that surviving without government funding will be difficult.

Capacity within the organisation

There are a total of 14 volunteers, six of whom are under the age group of 30. Ideally the organisation would prefer to have 18 caregivers because over the past couple of years, the need for the services offered by the organisation has increased. All home-based carers have received the 59-day home-based care training offered by DoSD. This department had arranged a First-Aid training for the organisation with the local ambulance service in Jagersfontein There is no administrator and financial manager, but they would like to receive training on such key aspects. When required to submit a service or business plan, they rely on the help of a teacher at a local school. The organisation would like to offer counselling to their patients and to improve the standard of their services by providing Hospice services. However, the fact that the organisation does not receive feedback from the department makes it difficult to determine if their service plans are acceptable.

According to the Memorandum of Understanding (MOU) between DoSD and Aganang the ratio of carer to patients is supposed to be 1:3. However, the needs in the community are much greater and often result in some caregivers attending to more than three patients.

Support from the governmental departments

They complain that no reasons are given if funds are not allocated. They would like to see that they could ensure that where people lack food they are helped. The organisation is very happy about the relations with the Dept. of Social Development, especially about the local social worker.

Monitoring of funds and accountability

Apart from the monthly financial reports submitted to the DoSD, there are no mechanisms to ensure there is no mismanagement of funds. Aganang signed a memorandum of agreement with the DoSD that clearly outlines what the organisation is expected to do. A social worker from the local DoSD office also helps the organisation to keep to the stipulated guidelines.

Care and support for the family

Aganang gives information on how to handle and live with an HIV/AIDS infected person to the family, and the nutritional value of eating a balanced diet is also explained. Emotional support is also offered to the families of people who have disclosed their HIV positive status. Part of the challenge is to ensure that people living with HIV/AIDS inform their families about the disease so as to ensure that everyone in the family takes proper precautions. They respect the wishes of all those who do not want to disclose their HIV positive status. People are encouraged to accept HIV/AIDS as another illness and being infected with the virus is nothing to be ashamed of.

General knowledge about HIV/AIDS

They believe Aganang has enough information on how to take the necessary precautions, and not to contract HIV/AIDS when providing services to patients. However, they do note that they fail to keep abreast of all the latest developments in the HIV/AIDS field.

Links with formal health care and networks

Relationships exist with the local Jagersfontein clinic, whereby they can arrange for immediate attention to patients needing emergency care. Even the health professionals working at the clinic refer some patients to the organisation for HBC services. Since the organisation is the only one of its nature in the Jagersfontein area, there are no formal networks with other organisations.

Achievements of the organisation

There is a close and good working relationship between Aganang and the local office of DoSD in Jagersfontein. Aganang has taken the role of linking and informing community members of the relevant services provided by DoSD. The organisation is proud to have been able to provide quality HBC to many patients since its inception. Through Aganang HIV/AIDS awareness campaigns, the level of HIV/AIDS knowledge in the community has improved.

Reasons for HIV/AIDS infection in the community

Child grants have been attributed to the rise in teenage pregnancies and the increase of HIV infection amongst the youth. Alcohol and drug abuse, especially dagga, seems to be major factors in the behaviour patterns of sexually active people. Aganang advocates the integration of condoms as part of people's sexual activities. Some people tend to associate HIV/AIDS with Aganang caregivers, especially young people. However, this is a misconception since Aganang does not only provide care to HIV/AIDS patients.

The organisation believes that educating people about the epidemic will help in the acceptance of people living with HIV/AIDS. It emphasises that its not only people with loose moral values who contract the disease. They note that, for instance children and women being raped and open wounds are avenues for transmission. There are no counsellors, and caregivers do not get counselling when their patients die. Stigma and confidentiality are still problems, however every one of their HIV/AIDS infected patients is encouraged to inform at least one family member.

The caregivers find that disclosing of HIV status is generally low in the community. However, more encouraging is that there are young people who have tested HIV positive and have disclosed their status. This is seen as an indication to the community that one can still live a productive. The adults population of Jagersfontein seem to be discreet about their HIV /AIDS status.

Volunteers/member openly living with HIV/AIDS

There is one member who is living openly with HIV/AIDS, and others are not aware of their status. It would seem they are afraid of knowing their status. They have seen how people who have tested HIV/AIDS react and are treated by the community. While members are encouraged, only one has gone for the test.

Stigma and confidentiality

Within the community stigma and discrimination is a problem; this is largely due to ignorance and the fear of death that prevails in the community. There is still a prevailing conception to associate HIV/AIDS with promiscuity.

6.9 Sakhisizwe HIV/AIDS organisation

Sakhisizwe HIV/AIDS organisation was established in 1998 after a group of local women in Koffiefontein realised the need to provide HBC and general information about HIV/AIDS to the local community. The ladies identified that there were a lot of people who did not know much about HIV/AIDS, some of which were at risk of contracting sexually transmitted infections as a result of many sexual partners and not using condoms. The organisation provides services in Ditlakeng township and surrounding farms, and operates from a rented backroom in the township. The organisation registered as an NPO in 2002.

Services rendered by the organisation

They offer Home-Based Care (HBC) as their core service, and their primary objectives are to ensure that basic needs of the children and families affected and infected by HIV/AIDS are met by providing food, shelter, education, alternative care, counselling and support. Sakhisizwe strives to promote acceptance of HIV/AIDS illnesses and for infected people to disclose in a non-discriminatory environment. The youngest patient under the care of the organisation is a 13-year-old girl who was infected after being raped by a neighbour.

The secondary objectives include improving HIV/AIDS awareness in the communities; encouraging healthy lifestyles and to ensuring self-sustenance of the infected and affected through vegetable gardens. In addition, the organisation encourages people to take part in Voluntary Confidential,

Counselling and Testing (VCCT), Community Home-Based Care (CHBC) and general health care. The need to use of condoms and to know one's HIV status is the main message of the organisation. Members of the organisation help with arrangement for identity documents (ID) and birth certificates for people who qualify for government grants.

Sakhisizwe sometimes embarks on door-to-door campaigns informing people about the different grants and assistance available from government departments including DoSD. Throwing street bashes where they give away condoms and pamphlets encourages youth involvement. There are no specific programmes for gays and lesbians; all the programmes are open to everyone in the community.

Finances of the organisation

Since its inception in 1998 it has been surviving mainly on donations and contributions from volunteers. They have also embarked on fund raising initiatives, including approaching a number of prominent local business people, who all rejected requests. The fact that they deal with HIV/AIDS related issues is held to make it difficult to access funding from the local business community. The business sector in Koffiefontein perceives HIV/AIDS as something that only affects certain racial groups and people on a certain socio-economic level. In 2002 they submitted a proposal for funding to the DoSD and an amount of R92 000 was granted for the 2003/2004 financial year.

The main expenses are monthly stipends of R500 for eight members, transport for visiting surrounding farm areas, and awareness campaigns.

Capacity and training

Initially there were eight members, with one subsequently withdrawing. The organisation also received five days financial management training from De Beers (the local mine). They maintain it was much better than the one offered by DoSD. All the members drafted the organisation's business plan and DoSD professionally drafted it. They are happy with the quality of their business plan. The organisation received 59 days HBC training from the DoSD, including three days foster care training and one day training in financial management. They think that the HBC training was excellent and the one-day training was not enough and would like the government departments to provide them with counselling courses.

Monitoring of funds and services and accountability

Sakhisizwe keeps a file for every patient and all the carers and patient (or patient's family) have to sign the form as proof that the patient was visited. They do not have a system in place for monitoring of funds because DoSD approves all expenditure incurred.

Care and support to the family

The only support they provide to the families affected is disseminating HIV/AIDS information. Members emphasise that HIV/AIDS is not something to be ashamed of and HIV/AIDS infected people are encouraged to come out about their status. There are however, people who still insist on keeping their HIV positive status a secret.

General knowledge about HIV/AIDS

Knowledge of HIV/AIDS is recognised as being limited to HBC principles, yet they are regularly invited to the DoSD workshops that are often a valuable source of information on HIV/AIDS and the latest developments.

Achievements of the organisation

They believe they have been instrumental in reducing the level of discrimination toward people living with HIV/AID. Discrimination is no longer such a persistent problem. However, young people seem to be still at the receiving end and are being stigmatised. This has led to a number of people being afraid to disclose their HIV status.

People (volunteers/members) living openly with HIV/AIDS

One member is openly living with HIV/AIDS. Other members do not know their HIV status.

Reasons for HIV/AIDS infection in the community

Poverty is viewed as the main contributing factor to the spread of HIV/AIDS in the community. Sexual exploitation of young people and minors is said to be rampant, thus increasing the number of vulnerable children and young people at risk. Some of the contributing factors were said to be rape, and parents who encourage child prostitution with mine workers. This means that any man who has money can have any girl he desires. Also, the number of child headed households has increased over the last few years, thus leaving many girls vulnerable. In some cases, social workers take too long to respond to some of the problems identified, thus further putting the children at risk. The service offered by DoSD is said to be inconsistent.

6.10 Interfacing of services

An overwhelming number of beneficiaries did not have responses for the questions posed by the researchers. The main aim of interviewing beneficiaries was to assess the quality of care they receive from NPOs and how it makes a difference to their lives.

In five of the case studies sampled, three patients from each case study were interviewed. In all the interviews the recurrent themes were satisfaction with the services provided by caregivers. In all cases the patients were unemployed and from poor backgrounds, and had a strong association with the caregiver rather than the organisation. The problem of lack of government delivery was apparent in the Southern Free State, where most interviewees indicated the frustration of applying for social grants from government departments. According to the beneficiaries the visitation of the carers is consistent and makes a meaningful difference in their lives. Many patients expressed their gratitude for the support they receive from organisations. When probed further none of the respondents could give meaningful responses. The organisation assists with washing and making sure that patients take their medication. However, all of them did not link the services they received from their carers with for example - Lerato Care Group as an organisation. When asked if they know about the government's plan to distribute ARV's, all of them seemed to support the move, but none of them knew what ARV's are and what the whole roll-out plan was all about. They appreciate moral support and the advice they receive from the organisation.

7. RESEARCH FINDINGS

Having examined the detailed case-studies, attention now turns to an integration of the key findings from the cases, with a view towards the identification of common themes – both positive and negative. It should be noted that this study does not represent a comprehensive evaluation of NPOs the Free State province, rather a small number of organisations in the field of HIV/AIDS in the province.

Objectives of non-profit organisations

The objectives of all the organisations are well articulated in their constitution and service plans. However, in the case of CBOs, it is clear that these objectives are not developed in line with their financial capability. Furthermore, it is difficult to differentiate between the actual services being provided by CBOs and the service that the organisations would like to provide. All CBOs, when probed, admitted that it would be difficult if not impossible to deliver services outlined in their constitution and service plans.

Funding

The recurrent theme throughout all the case studies has been the apparent lack of adequate resources, in particular funding. All organisations, including those that are relatively better financed, identified lack of adequate finances as one of the greatest stumbling blocks for the provision of services. In the case of CBOs the lack of finances was closely linked with lack of capacity. Often organisations with limited capacity would request large amounts of funding from government departments on the assumption that at least a fifth of the funding requested would be granted. This is more apparent in the case of CBOs.

FBOs and NGOs are relatively well funded and have the advantage of consulting private accounting firms for the auditing of financial statements. This can be attributed to the long-standing history and credibility of these organisations. A number of CBOs have approached the private sector for funding but many of these organisations have not received a positive response. While NGOs and FBOs knew well in advance if they would be funded in the next financial year, CBOs had no idea if funding for the following year would be granted. It was not uncommon to hear some organisations alleging sweetheart insider deals with government departments. Although, impressionistic evidence suggests that such deals are only confined to a small number of organisations; it places a huge burden on the already limited government resources and affects those (legitimate) organisations that would have benefited from such funding.

Sustainability of organisations

The success of community care is dependant on the investment of resources, skills, time and energy by government, private institutions, and communities. It is clear that without government funding most organisations would struggle to provide services, let alone pay for recurrent expenditure. This will be more apparent in NGOs than CBOs and FBOs since they have professional staff members who have to be paid regularly. There is a noticeable disparity of basic administration tools such as computers, fax machines and cable line telephones. Both NGOs and FBOs run their operations more

professionally than CBOs. It is relatively easy for large organisations to call on the requisite expert necessary for writing acceptable business proposals and service plans. The business and service plans of CBOs is at times contradictory and improbable. There exists a climate of uncertainty over funding with most organisations under constant threat of closure. However, there is a desire to assist in most problems facing the community. Hence many organisations are constantly taking up new challenges and issues that often impact negatively on the organisations' finances.

Service provision by non-profit organisations

Despite the lack of adequate resources, the quality of services, including HBC provided by all organisations is appreciated and the standard acceptable to most patients. Although CBOs lack the management and leadership capacity to run their organisations with the same professional principles displayed by NGOs and FBOs, their commitment, passion and dedication to the provision of services to beneficiaries far surpasses those of NGOs. In the case of CBOs there is passion and commitment displayed that cannot be identified in well-established organisations. CBOs do not keep office hours and can be called when required by patients. Many CBOs carers reside in the same localities as their patients and the relationship extends beyond that of a patient and carer, and an emotional bond is created. As a result, CBOs can forge strong working links with the local community. In relation to FBOs and NGOs, CBOs are better placed to provide services or respond to patients than NGOs and FBOs. However, the most worrying aspect of the research was the fact that many carers in CBOs do not receive counselling.

Relationship with government departments

There is poor communication and coordination between government departments and NPOs - all of which translate into less than optimal services. Based on the information gathered from the organisations interviewed, the relationship between government and NPOs seems to be multi-faceted, complex and sometimes problematic. The relationship between government department and the non-governmental sector is not complementary; the relationship seems to be skewed in favour of NGOs and FBOs. This is surprising, given that both government departments are aware that the scale and magnitude of the HIV/AIDS epidemic is much bigger and more complex than the capacity of government.

The level of cooperation between the NPOs and provincial officials is often determined by individual personalities, quality of leadership and knowledge of government departments. For NGOs and FBOs it is relatively easy to get information from government officials. In some cases, key government officials and politicians are invited as guest speakers to NGO and FBO annual functions. These put both FBOs and NGOs in a better position to gain valuable insights that helps in their application for funding. In fact, one large organisation claimed to have been allocated funds without signing a memorandum of agreement with the relevant government department. NPO in the Free State province lacks an established forum to champion their cause. Lack of funding has made most fragmented and only look the benefits that they can derive form these associations. As such there is the danger of cooptation or domination by government departments. Although consortiums have been established, this has been largely used for funding opportunities and has not really benefited some organisations.

Integration of services

Many organisations acknowledged that the impact of HIV/AIDS is much greater in areas were poverty, social and gender inequality exists. As result they provide a variety of services. However, the degree to which these services are integrated places a great deal of pressure on organisations. This is sometimes not by choice, for an organisation to respond to the needs of its beneficiaries it has to address other aspects of the HIV/AIDS epidemic. This means helping destitute communities with applications for social grants, identity documents and access to food parcels. This is more apparent with NPOs working in informal settlements.

Caregivers and advocacy

Caregivers are at the frontline of dealing with the HIV/AIDS epidemic yet they are not adequately informed with issues regarding developments of HIV/AIDS especially policy guidelines. The study revealed that an overwhelming majority of caregivers do not know their HIV/AIDS status. Lack of surgical gloves results in caregivers using plastic shopping bags to wash and care for their patients. Some patients have little or no idea what standard of service they are entitled to and in many cases patients are passive recipients of services. As a result, some caregivers purport to know what is best for their patients without consultation, which is often at times misleading and misinformed. This lack of professionalism is more apparent in CBOs. NGOs and FBOs have well trained officials who seem very knowledgeable.

Perceptions by government departments

A common theme in the interviews with government officials was the desire to promote the capacity of community-based organizations. In practice, this has often been more difficult than anticipated. For example, government departments would train a number of volunteers and those individuals would be lost to such organizations somewhere down the line. The government officials interviewed regarded their Units to be lacking the sophistication and technical skills to assist the non-governmental sector. Many organisations resented the "big brother" attitude often displayed by the two government departments.

Challenges facing government departments

Both government departments are striving to engage the NPOs in constructive partnerships. They are, however, sometimes frustrated by NPOs not delivering with poor performance, poor financial control and accountability, and poor uptake of capacity-building opportunities.

Two key challenges facing both the departments can be highlighted. Firstly, the introduction of the Public Finance Management Act of 1999 (PFMA, 1999) changed the way in which government resources, including funds, are utilised and accounted for by the departments. This Act is one of the most important pieces of legislation as it promotes the objective of good financial management in order to maximise delivery through the efficient and effective use of limited resources. The PFMA also requires accountability and sound management of the revenue, expenditure, assets and liabilities within government departments. Government departments are expected to draft strategic plans against which the allocation and utilisation of resources should be measured. Therefore,

services that are not aligned to the strategic priorities of government department as outlined in their respective strategic plan will not be supported with funding from the two government departments.

Secondly, good intergovernmental relations between the two departments at lower and middle management level is lacking. Officials responsible for coordination, funding and monitoring of NPOs in the two government departments are aware of double funding (an organisation funded by both departments for the same programme), but currently have no mechanisms to address this. In this regard, it is important to note that transfer payments to non-governmental service providers remain an obligation of both government departments in so far as the services to be delivered are rendered.

Monitoring and evaluation

The monitoring of services and accountability is weak to the point of being non-existent. Government departments only monitor and demand accountability for funds allocated to organisations. No monitoring of services provided by organisations has been undertaken and government officials leave it entirely up to organisations to monitor and evaluate the services provided by home-care givers. Although monthly and some times quarterly reports are submitted to government departments, these are not sufficient to give a detailed outlook on how services are provided. There seems to be a difference between the two departments in their monitoring policies. DoSD monitors more closely than DoH.

Stipends for caregivers

Government departments recommend a stipend of R500 for all caregivers, however the greater need for HBC in the community and lack of adequate funding compels many organisations to rely on many caregivers who cannot always be paid the recommended stipend. As a result, some caregivers receive less than the recommended stipend. These disparities are amidst a high turnover of HBC casers for many organisations.

Reason for HIV/AIDS in the community

The unemployment rate in South Africa disproportionally affects women than men. Women lacking income-earning opportunities use their bodies as a means of security. This leads to women having to exchange sex for food security, favours and cash. In some families young females are encouraged to actually go out and exchange sex for food. From the interviewees the main reason for the high rate of infection is attributed to individual sexual behaviour; young people are seemingly engaging in risky sexual behaviour without putting too much thought to the consequences. Most indicated that the only way to curb the rate of infection amongst the youth is abstinence, which is the only foolproof way to reduce the rate of infection. Also, the youth should be encouraged to lead responsible lifestyle and making the right choices.

Advocacy for non-profit organisation and HIV/AIDS infected people

The relation between different NPOs in the Free State is fragmented and lacks effective coordination. As result, advocating for their needs in particular funding is normally undertaken on an individual basis rather than as a collective. Only one organisation listed advocacy for patients as a

priority. Empowerment of Home-Based carers and patients should also be on the policy agenda, both at national and provincial level.

8. RECOMMENDATIONS

Programmes targeting the youth

Most organisations have programmes and campaigns focusing on HIV/AIDS education. While these programmes are commendable, only a few organisations have programmes specifically targeting the youth. The literature review reveals that the youth are at risk and special programmes need to be developed to specifically address the youth. In addition, none of these programmes specifically target same sex couples. A number of studies indicate that the most prevalent transmission of HIV/AIDS is sexual activity. These include both heterosexual and homosexual intercourse. It is important to include programmes that specifically target these groups in a language that is easily understood by the targeted groups.

Importance of Home-Based Care

From the South African National guideline on HBC, by DoH - HBC is viewed as an integral part of community-based care where the consumer can access services nearest to home in a level of comfort and quality health care to ensure a dignified death. HBC is a form of community care, which encourages participation by people who are able to respond to the needs of their communities. The success of community care is dependant on the investment of resources, skills, time and energy by government, private institutions, and communities. However, there seems to be lack of empowerment of patient and caregiver regarding care and resources. Government departments have to embark on concerted campaigns to empower all stakeholders. All indications project that the full impact of HIV/AIDS epidemic to peak at between 2008 and 2012. The brunt of which will be felt mostly in the formal health sector, which already is over-burdened and stretched to capacity. This is the time when the full importance of HBC will be appreciated, hence capacitating organisation supplementing government services, especially in the area of HBC is very crucial at this point.

Career pathing and learnerships for Home-Based carers

It is unrealistic for government departments to expect home-based carers to volunteer indefinitely for a monthly stipend of R500. There needs to be clear policy guidelines on the future and long-term career prospects for home-based carers as an emerging sector of the labour market. A grading system based on commitment, service and professionalism should be developed to encourage sustainability of organisations. This should be in addition to learnership programmes designed to map out market related career paths and opportunities for carers.

Create an enabling environment

The contribution of the non-governmental sector in the fight against HIV/AIDS is presently poorly quantified and under utilised, hence the other three pillars namely, government, business sector and the labour sector need to enhance the non-governmental sector. Already the two governments, Departments of Health and Social Development have made strides in acknowledging the role of the non-governmental sector. However, in the case of CBOs there is still more that needs to be done.

The environment in which these organisations operate is ridden with poverty, lack of skills and resources. From the business sector funding can be channeled to these organisations to supplement government funding. The labour sector can lobby with government for the career pathing or creating learnerships for the carers who are a mostly unemployed young people from disadvantaged backgrounds.

Improve institutional capacity

Government departments should focus more on improving the institutional capacity of organisations rather than focusing more on the improvement of individual capacity. While individual capacity is important and can go a long way in improving the standard and quality of services rendered by organisations. The problem is that when individuals leave the organisation, they often leave a skill vacuum that cannot be easily addressed.. Therefore, by improving and encouraging institutional capacity, this will enable NPOs to easily address and replace skills gaps within their organisations.

Counselling for carers

The need to provide support, especially counselling for caregivers is important to the caregivers' psychological well-being. Having seen first hand the devastating impact of HIV/AIDS not only of their patients on the patients families as well, many caregivers have made a conscious decision not to get tested and know their HIV/AIDS status.

Sex education and gender sensitivity

Sex education and gender sensitivity is crucial to the success of HIV/AIDS awareness campaign. This requires an organisation to develop programmes that can effectively target the intended group in a language specific to that group. Issues of gender sensitivity, culture and tradition are more prevasive in rural areas, where there is still a divide between males and females in addressing sex and sexuality. Women should be empowered to negotiate sex with their partners and men need to be educated and encouraged to respect women rights and be more responsible when it comes to safe sex, including condom use.

Consortiums

Government departments, in particular the DoH prefers consortium funding to individual organisation funding. Government departments are of the opinion that if they fund consortiums they will be more accountable. This form of networking and team-based approach can be impeding to the effectiveness of organisations, especially regarding allocation of funding as well as decision making. The needs of organisations differ and it would turn out that some organisations thrive at the expense of others. In funding consortiums there are often "winners and losers". This top down approach for funding invalidates the efforts involved in the formation of an organisation, which is often reactive to the needs of the community being served. The two government departments need to engage in environmental scans and needs assessments on the ground before applying clear criteria for granting funds and advocating for consortiums to be formed.

Monitoring and evaluation

After granting funding, government departments need to carry out onsite performance evaluation of the services provided by the funded NPOs. This is to ensure that the beneficiaries link the services with the government's overall plan of accelerated service delivery. Visits by government departments can furthermore increase the morale of carers and organisations to which they belong. This should also extend to providing the necessary equipment for organisations to effectively administer services.

Interdepartmental collaborations

There is a need for clear communication links between government departments; these relations should also extend to the business sector to ensure an integrated multi-sectoral approach to the fight against HIV/AIDS. This approach should not only view HIV/AIDS as medical issue, the economical and social aspects of HIV/AIDS need to be taken into account as well.

Forums for non-profit organisations and advocacy

Both government and large organisations should initiate forums where all government funded NPOs can share ideas and foster collaboration between organisations. In particular, small and relatively new organisations that are in most cases under-funded should be encouraged to link up and network with well-established organisations. This will ensure that small organisations pick up valuable skills necessary for the efficient and effective management of their operations. These forums can also serve as vehicles for advocacy purposes in relation to empowerment of carers and patients. Advocacy should be on the policy agenda, both at national and provincial level whereby CBOs can lobby government on HIV/AIDS related issues particular to their areas of operation.

9. CONCLUSION

There is no denying that non-profit organisations (NPOs) in South Africa play an important role in service provision, especially in areas where government is less visible. However, the environment and conditions under which they operate are fraught with challenges, the keys of which are the lack of adequate revenue and capacity constraints. These challenges are further compounded by lack of meaningful support from the relevant government departments, especially for CBOs. In addition, legitimate organisations have to compete with the emergence of many other organisations in "fashionable" areas like HIV/AIDS, not so much to answer a need, but rather for people who have no track record or knowledge in the area to access the funds that are perceived to be readily and easily available. The funding congruence between urban and rural organisations is also cause for concern. A number of studies and reports indicate that rural areas throughout the country have become the epicentre of poverty, yet more NPO funding tends to be allocated towards urban organisations.

Given the pivotal role that NPOs play in terms of service delivery and lobbying, one would expect the relationship between government departments and this important sector of society to be complementary. Most disappointingly this is not the case. It would seem these organisations are not treated as equal participants in the fight against HIV/AIDS. This is surprising, given that government departments are aware that the scale and magnitude of the HIV/AIDS epidemic is much

bigger and more complex than the capacity of government structures. The challenge of fighting HIV/AIDS does not lie solely with government. In many cases NPOs are better placed to reach out to communities, which may not be easily accessible to government structures. Access extends also to disadvantaged communities, which are the ones particularly vulnerable to HIV infections. It is in government's interest to support and improve capacity of NPOs. Both the non-profit sector and government have distinctive advantages that is combined can ensure more meaningful cooperation. Home caregivers are good in identifying potential orphans and informing the relevant government departments. Therefore government should strengthen the viability of the non-profit sector. However, it should be mentioned that sometimes the capacity building efforts provided by government to NPOs are undermined by the lack of professionalism and commitment in some NPOs. Furthermore, some organisations have failed to fulfil their mandate.

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ANNEXURE

Individuals interviewed:

Name	Organisation
Ms Ntsiki Jolinganc	FSDoH
Ms Shelly Hugo	FSDoH
Ms Rachel Sempe	FSDoSD
Ms Dithuso Monare	FSDoSD
Mr W Ntshona	FSDoSD
Pastor Bingo Rammile	Free State Christian Church Leaders Forum
Ms Liz Monamodi	Free State Christian Church Leaders Forum
Ms Susan Louw	Kerklike Maatskaplike Diens
Ms H Tshabalala	Kerklike Maatskaplike Diens
Ms Mabaso	Kerklike Maatskaplike Diens
Mr Msibi	Kerklike Maatskaplike Diens
Ms Puseletso Mokgothu	Leadership Achievement Management Project (LAMP)
Ms Wandi Majola	Leadership Achievement Management Project (LAMP)
Andries Stock	Rephidisitswe Community-Based Organisation
Boitumelo Thamae	Rephidisitswe Community-Based Organisation
Khotso Mmutlanyane	Rephidisitswe Community-Based Organisation
Tumelo Motingoe	Lerato Care Group
Galinyana Finger	Lerato Care Group
Nomvula Gaza	Lerato Care Group
Zithobile Maduna	Lerato Care Group
Patrick Rametse	Lerato Care Group
Zandiseile Luphahla	Mangaung Tshwaraganang Youth against HIV/AIDS
Nkagisang Molehe	Mangaung Tshwaraganang Youth against HIV/AIDS
Gloria Mojatau	Mangaung Tshwaraganang Youth against HIV/AIDS
Maria Molelekoa	Mangaung Tshwaraganang Youth against HIV/AIDS
Stephen Majalle	Aganang HIV/AIDS prevention and Home Based Care
Mma Anna Lechoko	Aganang HIV/AIDS prevention and Home Based Care
Mr Joseph Machachamese	Aganang HIV/AIDS prevention and Home Based Care
Ms Aleta Hartebees	Aganang HIV/AIDS prevention and Home Based Care
Ms Elisa Mokhathi	Aganang HIV/AIDS prevention and Home Based Care
Ms Sana Machachamese	Aganang HIV/AIDS prevention and Home Based Care
Ms Maria Lecoko	Aganang HIV/AIDS prevention and Home Based Care
Ms Rebecca Molefe	Aganang HIV/AIDS prevention and Home Based Care
Ms Sambu Edwards	Aganang HIV/AIDS prevention and Home Based Care
Ms Itumeleng Mahloko	Aganang HIV/AIDS prevention and Home Based Care

Ms Aleta Gaba	Aganang HIV/AIDS prevention and Home Based Care
Ms Mieta Mnqelani	Aganang HIV/AIDS prevention and Home Based Care
Ms Evelyn April	Aganang HIV/AIDS prevention and Home Based Care
Ms Anna Thipe	Aganang HIV/AIDS prevention and Home Based Care
Thandiwe Lobelo	NAPWA (Free State, Bloemfontein Branch)
Motlalepule Maine	NAPWA (Free State, Bloemfontein Branch)
Nthabiseng Matlokotsi-Taba	NAPWA (Free State, Bloemfontein Branch)
Molahlehi Taba	NAPWA (Free State, Bloemfontein Branch)
Ms Mirriam Modukanele	Sakhisizwe HIV/AIDS organisation
Ms Eni Dipholo	Sakhisizwe HIV/AIDS organisation
Ms Sherryn Ramosie	Sakhisizwe HIV/AIDS organisation
Ms Patoicar Ngobese	Sakhisizwe HIV/AIDS organisation
Md Dorh Mayekison	Sakhisizwe HIV/AIDS organisation
Mr Abertiur Petersen	Sakhisizwe HIV/AIDS organisation
Mr Maria Mjiba	Sakhisizwe HIV/AIDS organisation
Ms Tina Mokgoetsi	Sakhisizwe HIV/AIDS organisation