A critical analysis of NGOs in addressing HIV and AIDS in the context of gendered inequality: The case of Makhanda, Eastern Cape, South Africa

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Abstract

South Africa has the highest number of people living with HIV and AIDS in the world. The HIV pandemic has, and continues to have, negative implications for communities and individuals, especially women, in South Africa and beyond. HIV and AIDS has left women disproportionately more infected and affected than men because of social, cultural and economic factors, leading to the feminisation of HIV. South African NGOs have tried to fill in the gap and to respond to the HIV pandemic, either independently or in partnership with government departments. In this context, the purpose of this thesis is to provide a critical analysis of NGO programmes in Makhanda (in the Eastern Cape Province) to ascertain whether NGOs address the feminisation of HIV and, if so, how. In doing so, the study utilises qualitative analysis with the use of interviews, a focus group discussion and primary documents as research methods. The study concludes that local government in Makhanda has failed to address women's vulnerabilities to HIV and that it does not provide a sufficiently enabling environment for NGOs in this regard. In addition, inadequate funding from donors, alongside issues of accountability and the failure to engage in HIV programmes from a perspective founded in feminism, were factors found to contribute to NGOs not fully considering women's vulnerabilities to HIV. Resultantly, NGOs in Makhanda rarely, at least intentionally, address the feminisation of HIV.

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I am truly blessed to have had such an amazing support system!

Dedication

This thesis is dedicated with loving memory to my late sister

Forget Mavhika

Acronyms

AIDS- Acquired immunodeficiency syndrome

ART- Anti retroviral therapy

CADRE- Centre for Aids Development, Research and Evaluation

CSO- Civil Society Organisation

DoH- Department of Health

DREAMS- Determined, Resilient, Empowered, AIDS-free, mentored, and Safe women

DSD- Department of Social Development

FPD- Foundation for Professional Development

GBV- Gender based violence

HCT- HIV Counselling and Testing

HIV - Human immunodeficiency virus

IEC- Information Education and Communication

NACOSA- National Aids Convention of South Africa

NGO- Nongovernmental Organisation

NSP- National Strategic Plan

OVC-Orphans and Vulnerable Children

PEPFAR- U.S. President's Emergency Plan for AIDS Relief

PLWHA- People Living With HIV and Aids

PMTCT- Prevention of mother-to-child transmission

SRHR- Sexual and reproductive health and rights

USAID- United States Agency for International Development

VAWG- Violence against women and girls

Contents

Chapter 1: Introduction and Methodology

1.1 Introduction

This thesis examines the role played by Non-Governmental Organisations (NGOs) in addressing HIV and AIDS in South Africa with specific reference to gender-based inequalities, and with a particular focus on NGOs in Makhanda. For the purposes of this research, NGOs are defined broadly as organisations not driven by profit and which seek to fill gaps in ineffective national government policy and programmatic responses to social problems, including to the HIV pandemic (Rau, 2006:286). The terms NGOs, civil society organisations (CSOs), not-for-profit (or non-profit) organisations are used interchangeably in the thesis. This opening chapter sets out the research problem and thesis objective, as well as the research methods used in addressing the thesis objective.

1.2 Research Problem

HIV and AIDS has led to disastrous effects in sub-Saharan Africa including depletion of the labour force and the proliferation of orphaned children (Nweze *et al*., 2007:251; Lau & Muula, 2004:402). Further, HIV and AIDS is gendered but not "everywhere in the same way" (Bujra, 2000: 7), and South Africa provides a particularly interesting context for a study of gender and HIV and AIDS because of the ways in which gendered inequalities have contributed to a high HIV prevalence rate of 18.9 per cent among the general population (Mannell, 2016: 316). South Africa in fact has the highest number of HIV-infected people in the world, with 7.7 million people living with HIV in 2018 (Avert, 2019: para 1). Young women are particularly at risk of infection. The HIV prevalence among young women is almost four times greater than that of young men (SANAC, 2017). Hence, a correlation between patterns of HIV heterosexual transmission and gendered inequalities has been established such that HIV has a female face (White & Morton, 2005: 187). The feminisation of HIV exists more broadly in sub-Saharan Africa where an estimated 56 per cent of people living with HIV are women (UNAIDS, 2018: 5). Therefore, from transmission to impact, women bear the brunt of the pandemic and South Africa is no exception.

Gender-Based Violence (GBV), differentiation in terms of resource control and the overall socio-cultural milieu, all of which reflect and endorse the dominance of men over women in social relationships, are some of the key known factors which have led women in particular to be infected (become HIV positive) and affected (for instance, providing care for

orphaned children) by the pandemic in South Africa (Jackson, 2012). I illustrate these three factors in turn.

First of all, GBV puts women at risk of HIV infection through coercive sexual acts, and the trauma associated with violent experiences can impact negatively on later sexual behaviour (Amdie, 2005: 7; Ritzer, 2010: 474). In this regard, South Africa has one of the highest rates of violent sexual crimes in the world (Ghanotakis, 2009; Nagtegaal, 2018). Secondly, for women, the pandemic is exacerbated by gender-based socio-economic inequalities (Rau, 2006: 287). At household level, men are typically the main income-earners and decision-makers leaving women often unable to negotiate for safer sex and the use of available HIV preventative measures (Bujra, 2000: 8). This highlights the relationship between power and women's risk of HIV infection from male partners, including outside marriage (Rosenthal & Levy, 2010: 22). Thirdly, culture in South Africa makes it acceptable (sometimes not explicitly) for men to have multiple sexual partners, with the practice of lobola further limiting married women's decision making powers (Sovran, 2013: 34; Campbell & Nairb, 2014; Chiweshe, 2016).

The pandemic has had clear negative implications for the lives and livelihood capacities of many women, both infected and affected. Socio-cultural obligations, for instance, mean that women have to provide care for the HIV infected and, in doing so, they lose out on livelihood opportunities (Kang'ethe, 2015: 212). As well, HIV-positive women who become widowed are sometimes deprived of their rights over land (or other assets) and have limited access to key resources, which leaves them vulnerable to poverty. In some cases, and because of their economic situation, single women may turn to transactional sex as a way of earning an income, thereby leading to HIV risk-taking practices (Chikono, 2014: 39). More broadly, women infected with HIV face diverse challenges, including social discrimination, abuse, harassment and blame.

Like elsewhere, the South African state has responded to the pandemic, including around HIV prevention and the management of its effects (Wouters *et al*., 2009). It has, however, failed to address vigorously the social, economic and power relations between women and men. Simultaneously, NGOs (including in South Africa) play a crucial role in responding to the pandemic and confronting – at times – gender inequality as a key social driver of HIV-related vulnerabilities for women (Mannell, 2016: 315). The Treatment Action Campaign (TAC) has been one of the most influential NGOs, promoting access to HIV treatment and care (SANAC, 2017). The roles which NGOs in South Africa play stretch from prevention to support and care of people living with HIV (Benotsch *et al*., 2004:321). At the same time, NGO initiatives have given women "greater voice and visibility as organisers and

advocates around HIV" (Rau, 2006: 288). Indeed, NGOs seem to implement many of the more innovative and effective initiatives to address HIV (Rau, 2006: 288; Blas *et al*., 2008:1687). Regrettably, in the case of HIV in South Africa, research on NGOs has often tended (at least initially) to assess their local work "in isolation from wider factors, such as the existence or absence of supportive national policies to prevent HIV and to assist affected individuals and households" (Rau, 2006: 288).

In Makhanda, NGOs which work on HIV and related issues include Families South Africa, Black Sash, Grahamstown Hospice and the Raphael Centre. Makhanda, with a high rate of unemployment, has been described as one of the ten Eastern Cape HIV and AIDS "hotspots" (Jones, 2011:68; *News24*, 2001). The Raphael Centre is one of the better known NGOs in Makhanda and was established in 1999 to provide support services to people living with HIV; and the Centre's mandate has now broadened to incorporate general health and wellness services. Alongside other NGOs, the Centre also provides HIV Counselling and Testing (HCT) and follow up services to high risk groups (including young women).

Overall, the prevailing literature points to the "deepening strains the epidemic places on households and communities" (Rau, 2006: 287), so that the role of NGOs in addressing HIV and related gender issues in particular becomes crucial. Nevertheless, NGOs have limitations and their approaches are subject to criticism in relation to donor dependence and the absence of deep participatory methodologies when working with local communities (Bebbington *et al*., 2008: 4; Jamil & Muriisa, 2004: 25; Islam, 2017: 764). The shallowness of NGO downward accountability (to community members) is seen as a major shortcoming (Lewis & Opuku-Mensah, 2006: 668). The constraining linkages between NGOs and donors often does not provide for significant NGO leeway in deciding which programmatic and "policy approach should be followed" (Seckinelgin, 2005: 359).

In the end, the most NGO effective responses to HIV seem to be long-term, cross-sectoral and locally-driven. These are precisely the NGO strategies which donors find most difficult to support (Panos, 2003: 4). In the case of South Africa, most NGO funds for addressing the pandemic come from the South African government (supported financially though by donors and their HIV programmatic agendas) (Avert, 2019). Due to government funding limitations, though, some NGOs do depend directly on external donor funds. With such funding, many South African NGOs have focused on the linkages between gendered inequality and HIV (Ghanatokis *et al*., 2009: 357). But there are factors which enable and inhibit these efforts. For example, NGOs might not achieve their goals because of certain "local

dynamics and global pressures" which include lack of national political commitment to address HIV and shifting global development frameworks (Islam, 2017: 766).

1.3 Thesis Objectives

The main objective of the thesis is to critically analyse the role played by NGOs in Makhanda in addressing HIV in the context of gendered inequality. The subsidiary objectives include:

- To identify and understand the organisational programmes and practices of HIV NGOs in Makhanda in relation to HIV prevention and care;
- To examine the ways in which HIV NGOs consider the relevance of gendered inequalities in their HIV programmes and practices;
- To determine ways in which donor funding influences HIV NGOs' programming with reference to the feminisation of HIV; and
- To assess the attitude and practice of the South African government as an HIV NGO donor, partner and a policy maker in addressing HIV, particularly HIV vulnerabilities faced by women in Makhanda.

1.4 Methodology

The thesis examines the perspectives and practices (of NGOs) and is framed within a qualitative-based interpretive methodology. Qualitative research involves an investigation and interpretation of the meaning that people attach to events, in order to produce an understanding of social phenomena in the form of descriptive data (Taylor *et al*., 2016:7-8). This research entailed a qualitative case design, focusing on three NGOs operational in Makhanda (the Raphael Centre, Grahamstown Hospice and the Jabez Centre) as examples of a broader set of social phenomena, namely, NGOs, HIV and gender inequality (Hagan, 2006: 240). This is no claim made to the effect that the case study provides findings which are representative of NGOs, HIV and women more broadly in South Africa, though the findings about Makhanda will likely resonate with other sites in the country.

While the research refers to the role of government departments in Makhanda, this is done so as to show the significance of NGO work in the light of any weaknesses displayed by government. This also facilitates an appraisal of NGOs' gender and HIV work from the perspective of government, to indicate how the work of NGO has been affected, either positively or negatively, by working with government. The researcher interacted with the Settlers Day Municipal Clinic, the Department of Health in the Sarah Baartman District (under

which Makhanda falls) and the Eastern Cape Provincial Department of Social Development, all of which are involved in HIV and AIDS work. The Municipal Local AIDS Council was quick to refer the researcher to the Department of Health since according to the Makana Municipality HIV and AIDS coordinator, they did not do much apart from dealing with workplace issues.

Data collection took place between August and October 2019. Tendai Wapinduka, as a former student of my supervisor (Professor Helliker), in her then capacity as a Senior Social Worker and Project Coordinator at Child Welfare Grahamstown, referred the researcher to Raphael Centre as an NGO that used to work with Child Welfare on HIV issues. The researcher then approached Raphael Centre and interacted with the Manager, also requesting names of other NGOs working on HIV issues, with the Centre referring the researcher to the Jabez Centre and Families South Africa (FAMSA). Raphael Centre also stressed the importance of interviewing the manager for Community Development and Research at the Department of Social Development (DSD) and workers at the Department of Health (DoH). The respondent at DSD subsequently referred the researcher to Grahamstown Hospice and the Local AIDS Council. Local AIDS Council referred the researcher back to the DoH, mentioning that DoH also worked with local clinics. In this context, the research used the nonprobability snowball sampling technique (Babbie, 2013:129-130). This made it easier to locate HIV NGOs and ensured that crucial NGOs and government departments were not left out in the study, thereby enhancing the validity of the research findings.

To address the thesis objectives, the research entailed the use of primary documents, interviews and focus group discussions. Document analysis "involves the analysis of any type of document in order to obtain facts" (Wagner *et al*., 2012: 141). The documents used and scrutinised included those provided by NGOs and government departments as well as others publicly available on their websites. NGOs especially Raphael Centre have produced a significant array of documents about their HIV work, many of which are publicly available, and these documents were studied. In fact, the documents from the NGOs and government proved invaluable for purposes of understanding the role of NGOs in Makhanda. However, one of the NGOs was not forthcoming in providing access to documents which are otherwise not publically available. In this context, it is important to note that publicly-available documents are crafted with an audience in mind, and they provide interpretations which might be contrary to actual practices. Hence, they are an inadequate stand-alone research method.

Therefore, to complement the use of documents, the researcher made use of other primary evidence, specifically interviews and a focus group discussion. The interview and

focus group schedules were semi-structured to allow for flexibility in engaging with the question of HIV, women and gendered inequality. In this regard, it was important to allow participants to articulate and reflect freely on their own understandings and perspectives about the NGOs and government HIV programmes (Parker, 2008: 911). The interviews and focus group discussions were conducted in English and were not tape-recorded (as the researcher took notes).

In this respect, in-depth interviews are an important avenue in qualitative research for probing the social phenomenon under investigation and they provide in-depth information consistent with an interpretive sociology. During such interviews, research participants are not treated as "passive vessels of answers for experiential questions put to them by interviewers" (Teddlie & Tashakkori, 2009: 239). Rather, participants actively engage in narrating and interpreting their experiences and practices (Gubrium & Holstein, 2002: 13; Warren, 2002: 83). At the same time, the process of conducting the interviews and subsequent data analysis sometimes can be time-consuming. One-on-one interviews were arranged with a total of seven participants (three from NGOs and four from the government departments, using the snowball sampling technique). One NGO interview turned into a focus group discussion consisting of three NGO staff, so that nine people in total participated in the study. All interviews were recorded and then transcribed.

As one of NGO the respondents, the Administrator for 21 years at Grahamstown Hospice was interviewed and brought forward important facts about funding issues since, besides knowing the day-to-day work of the NGO, she is also highly involved with the finances. Also interviewed was the Manager at Raphael Centre, who previously volunteered at the Centre (when she was a student in Anthropology at Rhodes University) and who has now been employed at the Centre for ten years. Another interview was arranged with the community care worker for 15 years, now HIV-tester, at Jabez Centre, though this turned into a focus group discussion. Further, despite having approached Child Welfare and Families South Africa (FAMSA), both organisations were adamant in saying that they do not have any HIV related programmes, with both referring the researcher back to the Raphael and Jabez centres. In addition, four officials in government departments (two from the Department of Health, one from the Department of Social Development and one from the Settlers Day Clinic) that work on HIV issues were interviewed and these interviews were of considerable importance in appraising the local NGOs' work. At the DoH, one interview was undertaken with the Programme Manager for HIV (in this position since 2007) who has worked for the department since 1980; the other interview was with the Coordinator for the HIV prevention programme,

who has been working in that capacity from 2015 (although she has worked for the department since 2002, where she started as a junior, professional nurse and was promoted to a Safety Manager in 2008 until 2014. At the DSD, the researcher interviewed the Manager for Community Development and Research who has worked within the department for the past 33 years. At Settlers Clinic, the nurse – who prefers to be referred to as the HIV focal person – was interviewed. The interview schedules for NGOs and government departments appear in Appendix B and Appendix D respectively.

An interview at Jabez Centre ended up, unintentionally, being a focus group discussion of three people (I improvised the interview schedule to suit the discussion – see Appendix C). The participants were a community based care worker for 15 years turned HIV tester since last year, a home based care worker and tester, and the HIV programmes team leader). However, focus groups are useful in exploring perspectives, allowing the researcher to study how participants react to each other and bounce off ideas. At times, though, group discussions may be dominated by one or two participants (Teddlie & Tashakkori, 2009: 239). In this case, one participant was more vocal than the other, without though drowning out the thoughts of the other two participants. Importantly, out of the nine participants (from all interviews and focus group discussion), just one was male.

Finally, after the researcher transcribed the interviews and focus group, and familiarised herself with the documents, qualitative thematic data analysis was undertaken in categorising and identifying themes from the data which related back to the subsidiary objectives of the thesis. This was done through drawing meaning from the data through the identification and populating of key thematic categories. This involved using the constant comparative method which compares each piece of data with previously coded data (David & Sutton, 2004:191; Wagner, 2012:231).

Nonetheless, this study has limitations that could have possibility affected the quality of the research. Firstly, in order to obtain a more nuanced and fuller picture of NGOs and their HIV work in Makhanda, the study would have been enhanced by talking to beneficiaries of the NGO programmes. Regrettably, because of ethical challenges, this was not possible. As well, the study was undertaken under a very limited time frame and with no budget; and this meant that data had to be collected within a minimal space of time, at no cost. In addition, the interviews and focus group were undertaken in English which might have been a limiting factor for some respondents to fully express themselves (the researcher is from Zimbabwe, and is not fluent in the local isiXhosa language). However, one of the study's strengths is the fact that the

researcher was able to access relevant government departments, and to consider their perspectives of local NGO work around HIV and gender inequality.

The research received ethical clearance from the Rhodes University Human Ethics Sub-Committee (RUESC-HE) and conformed to the ethical standards set by the University. Consent forms (see Appendix A), which briefly explained the purpose of the research, were provided to each and every research participant to sign after a verbal explanation. The interviews and focus group were conducted at convenient places for the participants which was their area of work. The researcher ensured the non-disclosure of the respondents' identity in the drafting of the findings by using pseudonyms.

1.5 Significance of the Study

There is significant literature on HIV in South Africa. However, there is not much written about HIV in Makhanda in particular, including in relation to NGOs and gender inequalities. Hence, though a case study, this research seeks to aid to the body of knowledge by contributing to our understanding of NGOs, HIV and gender inequality with specific reference to Makhanda. In this context, only limited literature focuses on the role of NGOs globally in addressing gender inequality as a determinant of HIV (Muriisa, 2010; Hope, 2007). Further, the literature on South Africa and beyond does not examine in sufficient detail the gender-related activities which NGOs undertake for instance in enabling HIV prevention for women (Mannell, 2016: 315). This provides a strong justification for examining NGOs in Makhanda with reference to HIV and women.

1.6 Thesis Outline

The following chapter (chapter two) is the contextual chapter for the case study of Makhanda. It provides an account of HIV trends at national level in South Africa, the feminisation of HIV in the country, and the efforts by government and NGOs, alongside donors, to address the pandemic, including in relation to women and gender. The chapter also outlines the theoretical framing for the thesis, based on feminist thinking. Chapter three is the case study chapter about HIV, women and NGOs in Makhanda, and raises many of the same themes discussed in chapter two. The manner in which specific NGOs in Makhanda seek to address HIV, with specific reference to women, is brought to the fore, including in relation to local government and national and international funders. The last chapter (chapter four) demonstrates how the

empirical evidence in chapter 3 speaks to the main and subsidiary objectives of the thesis, in the context as well of the theoretical framing for the thesis.

Chapter 2: HIV, Women and NGOs in South Africa

2.1 Introduction

HIV and AIDS has had, and continues to have, multi-faceted negative effects on development in South Africa (and beyond) through its socio-political, economic and psychological impacts on the population. Stopping its spread and responding appropriately and effectively to its effects is essential, universally, to ensure the realisation of the 90-90-90 HIV targets by 2020 and the 2030 Agenda for Sustainable Development. As Nelson Mandela put it with specific reference to South Africa, "AIDS is no longer just a disease, it is a human rights issue" (quoted in Tutu, 2012:137). In this regard, women make up 51% of South Africa's population, and are more vulnerable than men to HIV. Hence, there is great urgency in tackling factors that leave women in particular vulnerable to HIV.

The devastating implications of HIV and AIDS for South Africa cannot be underestimated and neither can the gender dynamics of HIV which have brought extreme suffering for women. The country has the largest Anti-Retroviral Therapy (ART) treatment programme globally, and this is undoubtedly helping to address the impacts of HIV by improving the health of those infected. This is the case for women in particular, as they are more prone than men to HIV infection. In Africa more broadly as well, where heterosexual transmission accounts for the highest percentage of HIV infections, women outnumber men amongst the HIV-infected (Schoepf, 1997:310). Further, in terms of the broader implications of HIV infections for society, women are likewise more affected than men, including in terms of caring for the HIV infected. This speaks to the feminisation of HIV (Tallis, 2012). The South African government, despite its efforts in mitigating the pervasiveness and implications of the HIV pandemic, has failed to adequately address the centrality of gender and power relations in responding to the pandemic, with NGOs coming in to fill the gaps, at least trying to do so.

This chapter examines HIV in South Africa, with a focus on gender, and discusses government and particularly NGO responses to the HIV pandemic in the country, at times drawing on broader (non-South African) literature. Sections 2.2 detail the trends, prevalence and implications of HIV in the country. Sections 2.3 and 2.4 have a more gender focus, considering the ways in which women suffer disproportionally from the pandemic and the reasons for this. After this, section 2.5 discusses the role of the South African government in responding to the pandemic and then, in section 2.6, there is an extended discussion of HIV and NGOs including their role in addressing the gendered character of HIV. In the penultimate

section (section 2.7), there is a theoretical overview of feminist thinking about women and gender in society, and how different feminist theories relate to questions around HIV, women and gender.

2.2 HIV and AIDS in South Africa

In 1982, the first case of AIDS was documented and, at that time, it seemed to be occurring amongst gay men; though, around 1985, it became clear that all people could be infected. As HIVSA (a South African NGO) notes, the rapid increase in South Africa's HIV prevalence happened between 1993 and 2000, and this is when the country had political controversies on the causes and treatment of HIV, leading to HIV issues taking a back seat (Denberger, 2014).

The human-immunodeficiency virus (HIV) that causes AIDS, is now known to be transmitted through sex (homosexual and heterosexual), blood, and/or mother to child during pregnancy, delivery and lactation (Cohen *et al*., 2008). However, HIV in South Africa is primarily transmitted through heterosexual sex, followed by mother-to-child transmission (MTCT) (United States Agency for International Development, 2011:1). With the main mode of transmission in South Africa being heterosexual sex, issues of gender-based power and more broadly gender inequality come into play. In this light, the thesis seeks to explore the role that NGOs play in responding to gender inequality as a determinant of HIV for women.

2.2.1 HIV Trends and Prevalence

Despite a recent fall in new infections, South Africa still has the highest number of HIV-infected people in the world, with 7.7 million people living with HIV in 2018 (Subedar *et al.*, 2018; Avert, 2019: para. 1). The 2015 statistics of people infected by HIV in South Africa indicate that around 6.7 million were adults (15 years+), and 240,000 were children (14 years and under) (UNAIDS, 2015). In 2017, amongst sexually-active South Africans, the prevalence was highest in KwaZulu-Natal province (27%) followed by the Free State (25.5%), with the Eastern Cape taking the third highest spot (25.2%) (Kanabus, 2018: para 5).

Alarmingly, the HIV prevalence rate among young women is nearly four times greater than that of young men, indicating how young women are particularly at risk of infection (SANAC, 2017). Clearly, young women are disproportionally affected by HIV with young women aged 15-24 years accounting for 37% of new infections (Subedar *et al.*, 2018: 1). The current National Strategic Plan (NSP 2017-22) on AIDS calls for an urgent focus on adolescent girls and young women, indicating that South Africa has recognised the problem of

feminisation of HIV and AIDS – in particular, the even higher rate of HIV amongst Black African women has been brought to the fore (Subedar *et al*., 2018; Kanabus, 2018: para. 3). More so, HIV prevalence is especially high in marginalised communities, suggesting how social factors like poverty determine HIV risk and vulnerability in communities (Peacock & Levack, 2004: 179).

2.2.2 Implications of HIV and AIDS on South Africa

In South Africa, the pandemic has brought with it devastating impacts at both micro and macro levels, affecting individuals, households and communities. From lowering life expectancy to the proliferation of orphans and putting pressure on resources for addressing its effects, the HIV pandemic is now a significant human and social challenge. Also, HIV related deaths and challenges have major implications for human rights (such as rights to equality and access to healthcare) that are enshrined in the constitution (Heywood, 2009:14-15; Avert, 2015). The UNAIDS (cited in Avert, 2019) concludes that South Africa has the highest rates of HIV related illnesses and deaths, with 71,000 South Africans having died from AIDS-related illnesses in 2018. More so, research done by Hosegood *et al*. (2004) for the early to mid-2000s reveals that almost 48% of adult deaths in South Africa were due to AIDS. However, there has been an increased commitment to fighting HIV, leading to AIDS mortality rates declining from 45.9% of all deaths in 2007 to 31.1% in 2014 (Statistics SA, 2014).

In addition, HIV has affected households and livelihoods in ways which even lead to girl children having to take care of the sick and finding a source of income for their families. Children are being orphaned on a widespread basis, with 2.1 million children (0-17 years) orphaned due to one or more parents dying from the pandemic (UNAIDS, 2015). The Eastern Cape Province is believed to have the second highest number of orphans in South Africa (26%). Several studies (Breckenridge *et al.*, 2019; Cluver *et al*., 2012; Kirkpatrick *et al*., 2012) have indicated that children who are orphaned due to AIDS face greater psychological, emotional, and behavioural problems than non-AIDS orphaned children. Child headed families also face many challenges including a lack of access to decent education, abuse and more broadly poverty.

As alluded to earlier, women in South Africa are infected and affected more than men, and thus they experience a more significant burden in terms of the implications of HIV. People often need to provide home based care for sick relatives, and this work is usually placed on women because they are considered as domestic care-givers. At an individual level, as well,

HIV-infected women who become widowed have to deal with a myriad of issues ranging from emotional and social to financial matters (Tallis, 2012:22). More generally, because of feelings of fear and hopelessness, and the social discrimination, abuse, harassment, blame and financial burden the pandemic brings with it, infected women face a great deal of challenges. Further, the HIV effects for women are intensified by the high rates of violence against women in South Africa.

2.3 HIV & AIDS: Who Bears the Brunt?

Gender refers to socially and culturally constructed roles, attributes and responsibilities associated with an individual on the basis of being either male or female (World Health Organisation, 2011; Ferrante, 2003:342; Taylor *et al*., 2000:274). Gender inequality thus refers to people not being afforded equal opportunities on the basis of their sex. In this regard, there are inequalities that have exacerbated women's vulnerability to HIV in South Africa and elsewhere. South Africa is part of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) signed in 1993, and its full realisation ensures that women are protected from inequality, poverty and violence that highly expose them to HIV infection and increases its impact on their lives (Clayton *et al*., 2014:18). Despite the existence of progressive legislation in South Africa, and with gender equality entrenched in the constitution, South African women still face gender inequality and violations in their homes, institutions and society as a whole and this leaves them vulnerable to HIV (Marx *et al*., 2018:8; Tallis, 2000:59).

2.3.1 Vulnerability of Women

Vulnerability refers to the "range of factors that reduce a person's ability to avoid risk" (Perry & Moore, 2010: 21). Research has exposed how HIV affects women disproportionately, with NGO initiatives seeking to give "women greater voice and visibility as organisers and advocates around HIV" (Rau, 2006:288). However, Tallis (2012:22) argues that the general HIV and AIDS response, by both governments and NGOs, "has done little to reduce women's experiences of the pandemic and this visibility of women in discourse, policy and practice has not fundamentally changed the underlying assumptions that blame women [for contracting HIV]". Thus, women, and particularly black African women, remain vulnerable and subject to many HIV risks in South Africa.

A range of social, economic and cultural factors have fuelled the feminisation of HIV in South Africa. These include feminisation of poverty, cultural and gender norms that tolerate men's risky behaviours (which also leave women with no power to negotiate safer sexual practices), gender based violence, challenges in relation to access to health care for HIV infected people, and women's role in caregiving – all of which affects women's economic participation and pursuit of livelihoods (Dageid *et al*., 2012; Hawkes & Buse, 2013; Pettifor *et al*., 2012; UNAIDS, 2012). Overall, then, HIV for women is amplified by poverty, inequality, and social injustice, meaning that the social, cultural, economic environment shapes conditions of vulnerability (Heywood, 2000). Besides women broadly, there are other groups in South Africa which are more vulnerable to the pandemic than others, and these groups include sex workers (mainly women) and people who use drugs. However, in general, women (and young women in particular) bear the brunt of the pandemic. Undeniably, the pandemic affects women's lives both in terms of rates of infection and the burden of care and support they carry for those with AIDS-related illnesses.

2.4 Social Factors for Feminisation of HIV and AIDS in South Africa

The vulnerability of women across South Africa is facilitated by a range of factors; as indicated, not only at individual level but also at community level (Phaswana-Mafuya *et al*., 2010: 25). Thus, as in most sub-Saharan African countries as well, women's vulnerability is exacerbated by the social context which breeds a cocktail of problems for women, such as: women inadequately accessing sexual and reproductive health information and services, low personal agency, lack of access to quality education, and the experience of various forms of gender-based violence (GBV) (UNAIDS, 2015). A study by De Wet (2016) for the 2009 to 2011 period concluded that South African males have lower secondary education rates than females, yet females have a higher prevalence of HIV. Therefore, there are a number of factors and different dynamics contributing to high rates of HIV among women. Below, I explore these issues under broad topics, namely, poverty and inequality, gender based violence, customary law and the patriarchal system.

2.4.1 Poverty and Inequality

In sub-Saharan Africa, women do not only experience feminisation of HIV but also the feminisation of poverty, which further deepens the risk for young women to the pandemic (Kang'ethe, 2015: 213). Most women living with HIV are poor and HIV makes them poorer

(Tallis, 2000: 60). Young women, especially heads of households, are more likely to be poor and at the same time infected by HIV (Shisana *et al*., 2010:39-40). In some cases, and because of their economic situation and abject poverty, single women may turn to transactional or commercial sex as a way of earning an income/survival, thereby leading to HIV risk (Chikono, 2014: 39); and female sex workers, as indicated, are one of the most vulnerable groups in South Africa. Thus, poverty forces women into high risk sexual activity as a coping strategy, making it crucial for women to be economically dependent on themselves or self-reliant (since it seems most women are economically dependent on men) (DeSouza, 2009: 697). According to Shisana *et al*. (2010: 40), poor women are more likely than richer women to have engaged in risky sexual practices with a recent sexual partner.

Tallis (2000: 59) argues that men are expected to perform sexually, in some cases with different women, and that this leaves them at great risk of infection. In a study by Poulin *et al.* (2016), in Malawi, mature wealthier men are in fact viewed to be at great risk of being infected and to die of HIV because they are more likely to have casual sexual encounters, thus increasing their chances of becoming HIV positive. In fact, the evidence presented indicates that HIV incidence, amongst men, is particularly high for middle-aged men in their early 30s. But HIV campaigns, especially in Malawi, have focused on poor women, only involving men in order to make them better (safe-sex) partners for their women. Bor *et al*. (2015) make a similar point, indicating the implications of this for HIV infection amongst promiscuous men. Though this may be true, the prevailing HIV literature has consistently indicated and argued that poor young women in most parts of sub-Saharan Africa (including South Africa) are the most severely impacted, in terms of HIV risk, because of power dynamics in heterosexual relationships.

Feminisation of HIV is clearly exacerbated by class inequalities (Rau, 2006: 288). Muula (2008) argues that, as a consequence of apartheid and racial discrimination, most South African black African women might not have attained or might not attain tertiary education, which affects their earning potential. In a country with high rates of poverty and unemployment, women are sometimes left to rely on men in a very vulnerable condition. In this respect, black African women constitute the highest percentage (20.6% in 2017) of the HIV infected in South Africa (Kanabus, 2018).

2.4.2 Customary Law and Patriarchal System

In the context of HIV, women face cultural pressures that undermine their autonomy and make them vulnerable to HIV (Clayton *et al.*, 2014; 13). These pressures include particular ways of

handling relationships and marriages that certain cultures endorse. As Bujra (2000: 9) notes, "trying to bring about change in gender relations constitutes a cultural offensive" because, in many societies, men are used to being at the forefront in terms of decision-making powers. In an African context, men have – or are given – control over sex, leaving women passive and not in a position to make decisions for themselves. These differences in power between men and women in heterosexual relationships leave women at great risk (Dunkle *et al*., 2004).

This form of gender inequality impacts on women's agency in sexual and reproductive health decisions (Marx *et al*., 2018:2; Perry & Moore, 2010: 24). Sexual norms and traditional gender roles render young women powerless and unable to negotiate safe sexual practices, and this in part can explain the underutilisation of the female condom (United States Agency for International Development, 2011:1-2). Thus, if dominant forms of masculinities are not challenged and ways are not put in place to empower women, gender inequality along cultural lines will continue to negatively impact women in the face of HIV (Bujra, 2000: 8).

In Zimbabwe, for example (but also relevant to South Africa), sex is for men to enjoy and for women to pursue sexual pleasures for men, while disregarding their own preferences around sexual practices (Bujra, 2000: 11; Campbell *et al*., 2006). Therefore, in most instances, cultural and gender norms leave women submitting to men's choices (Perry & Moore, 2010; 24). Within marriage, women are taught to please their husbands sexually, sometimes with little knowledge or awareness of how this might impact their health. At times, women might constrict their vaginas by using different herbs for the pleasure of their partner (Fourie, 2006: 44; Schoepf, 1997:315). This, however, increases the roughness of the sex which can lead to tearing and bleeding of vaginal tissues ultimately increasing their risk and susceptibility to HIV infection.

Furthermore, the practice of *lobola* limits married women's decision-making powers (Sovran, 2013: 34; Campbell & Nairb, 2014). Increasingly, *lobola* commercialises and commodifies women and leaves married women's sexual rights in the hands of men. In this respect, Chiweshe (2015: para 6) views the practice of *lobola* as a transfer of sexual rights and "an instrument of patriarchy that perpetuates the subordination of women" (see also Njovana & Watts, 1996: 48). Historically, *lobola* was a way of bringing two families together, and men did not have to pay huge amounts to cement and consolidate the union. However, families are now demanding exorbitant amounts for their daughters, and the idea that a man pays literally for a wife leaves him often treating his partner with utmost disrespect, and expecting her to do whatever he says. It then seems near impossible for a married woman to refuse her husband's sexual preferences if large amounts of *lobola* were paid. To add to this, parents expect their

daughter to stay and obey her husband even in cases of her rights being violated. Further, women are taught to tolerate and forgive when a man is unfaithful. This attitude is fortified by some religious groups who encourage endurance within marriage, leaving women suffering in silence and putting them at risk of HIV infection (Njovana & Watts, 1996: 47).

Moreover, in many instances, African customary law encroaches on women's economic security. Society's dependence on women and girls as caregivers within the household makes it impossible or very difficult for females to pursue their chosen career paths. In many countries, wives take care of their HIV positive husbands if they fall ill. In a sense, then, women often remain suppressed and thus economically insecure. Men, in this way, can be said to be benefiting from women's unpaid work (domestic chores) in caring for the sick, with men ignoring the negative effects of this on women. Also, some widows of AIDS casualties become victims to cases of 'property-grabbing' (Fourie, 2006: 44) after the death of the husband and they are often left to start a new life and look desperately for a means of earning a sustainable income. Therefore, some customs leave women vulnerable to the pandemic (in terms of infection) while also having to shoulder the burden of taking care of those infected.

2.4.3 Gender Based Violence (GBV)

Gender based violence (GBV) is rife in South Africa and partly explains women's greater vulnerability to HIV (Kalichman & Simbayi, 2004; Andersson *et al*., 2008). It is also a manifestation of the overall system of patriarchy. GBV refers to a range of harmful behaviours against women and girls which can also put them at risk of HIV infection. These include rape, domestic violence and psychological violence, which can later lead to trauma and negative impacts on later sexual behaviour for women (Staden & Badenhorst, 2009:22, Amdie, 2005: 7; Ritzer, 2010: 474). Socio-cultural norms can mean that, in some societies, "boys and men are expected by their peers to display dominant, sometimes violent behaviour towards women and girls" (Clayton *et al*., 2014:13). A study by Dunkle *et al*. (2003), which focused on women accessing voluntary counselling and testing (VCT) for HIV services in Soweto, found that HIV positive women were significantly more likely (than women who were negative) to have experienced violence in an intimate relationship. This shows how women are violated every day in South Africa and these violations may place them at higher risk of HIV exposure and reduce their ability to prevent HIV infection (Clayton *et al*., 2014: 44).

South Africa has one of the highest rates of violent sexual crimes in the world, with former state president Jacob Zuma at one point being accused of raping an AIDS activist (Ghanotakis, 2009; Nagtegaal, 2018; Peacock & Levack, 2004: 174, Hunter, 2010: 1). Despite violence against women and girls (VAWG) being rife in South Africa, there is significant under-reporting of cases. However, because of its violent nature, rape in most cases is unsafe and the risk of HIV infection is high. This may be minimised by taking the post-exposure prophylaxis (PrEP) drug, which may not be readily available or in limited access, especially in remote rural parts of the country (Muula, 2008). An abused woman may be unable to get tested and seek services after experiencing GBV, depending on different factors (Adams *et al*., 2011: 1018-1020). At the same time, the health system is often poorly equipped to provide services to survivors of GBV (Aschman *et al*., 2012). As a result, women in South Africa who are survivors of GBV often do not receive the necessary medical treatment and psychological support, further putting them at risk of HIV infection (Seedat *et al*., 2009).

All the factors discussed above, from economic insecurity to patriarchal arrangements, mean that men tend to be in positons of power vis-à-vis women, such that women continue to be on the losing end, both infected and affected by HIV at levels far more than men.

2.5 South African Government HIV and AIDS Response

In the light of the sheer challenges associated with the high prevalence of HIV and AIDS in the country, the South African government was faced initially with significant criticism regarding its commitment to adequately responding to the HIV pandemic. Government's restriction of ARV'S under former state president Thabo Mbeki (from 1999 to 2008) led to the death of around 330 000 people, and 35 000 babies were born HIV positive due to non-timeous implementation of an ARV programme (Leclerc-Madlala *et al*., 2009:3). In 2006, South Africa's then deputy health minister (Nozizwe Madlala-Routledge) spoke out strongly against this, claiming that this involved "denial at the very highest [government] level" over the country's AIDS crisis (South African History Online, 2017). Nevertheless, the South African government's Cabinet in 2002 announced the go-ahead for an ART roll-out plan. Overall, though, intransigence at the highest level meant that the government initially frustrated rather than facilitated the HIV fight in the country. More recently, there have been more genuine and far-reaching efforts at tackling the pandemic.

The Government in South Africa has three levels or tiers, which are national, provincial and local government (Swartz & Roux, 2004: 100). In HIV programming, national government

sets policies and gathers resources which are used to fund the nine provinces, and thus it "sets broad policy frameworks and define norms and standards for service provision" (Schneider & Stein, 2001: 724). Many of the government's responses to HIV were created from 2000, after the transition from apartheid. However, many of the earlier interventions lacked political commitment (Schneider & Stein, 2001: 727). In 2000, the National Department of Health (DoH) outlined a five-year plan (National Strategy Plan - NSP) to combat AIDS, HIV and sexually transmitted infections (STIs) with the South African National AIDS Council (SANAC) set up to oversee policy and strategic developments. In the end, the government responded with a multi-sectoral response, including a "national strategic framework involving 16 key sectors and a wide range of partners and a 15 percent allocation of all government expenditures to HIV programs" (United States Agency for International Development, 2011:2). The South African government's response to HIV has yielded noteworthy results in recent years, with over 13 million South Africans tested in a 2012 campaign and over 2 million people on ART (Makusha *et al*., 2015). In fact, South Africa now has the largest HIV treatment programme in the world. Currently, the national HIV efforts falls under the NSP for 2017-2022.

In this context, it is thus important to understand the government's efforts, roles and responsibilities pertaining to the pandemic in order to ascertain the character and significance of NGO (with or without government support) – and with particular reference to the feminisation of HIV. In the end, national government policies on HIV may enable or frustrate the work of NGOs (Manell, 2016: 315; Rau, 2006: 288).

2.5.1 Prevention, Care and Treatment

The government response to HIV heavily relies on provincial public health systems for prevention, care and treatment services like condom distribution, HIV Counselling and Testing (HCT), ART and preventing mother to child transmission (PMTCT) (Kelly *et al*., 2010:12). HIV treatment is now widely available and accessible and, while accessibility issues (including cost of travel to clinics) and stigmatisation hamper attempts to get all HIV positive people onto treatment, the treatment has had a positive effect on HIV positive people who are now hopeful of a longer life (Wet, 2016: 171; Nachega *et al*., 2004; Phakathi *et al*., 2011). Despite South Africa having the largest national HIV and AIDS programme in the world, and funding more than 75 percent of its own national response, the HIV prevalence rate amongst women is still high (U.S. President's Emergency Plan for AIDS Relief-PEPFAR, 2019).

At the same time, the (the United States-driven) President's Emergency Plan for AIDS Relief (PEPFAR) has been a key part in supporting the national HIV response in South Africa. It has provided over 3.7 million South Africans with ART and has invested more than 5.6 billion US dollars into South Africa's HIV (and tuberculous – TB) response, thereby helping to support the expansion of prevention, treatment and care services (Kavanagh & Dubula-Majola, 2019). Additionally, there are other donors including the United Kingdom's Department for International Development (DfID) which have funded the Department of Social Development in supporting community and home based care (Kelly *et al*., 2010:15). Through this international financial support, government has been able to fund non-state actors at local levels through provincial Departments of Social Development and Departments of Health (which usually supports work around HCT and home based care). Without external funding, government's own commitment and funding would not enable the country to reach the 90-90-90 targets by 2020 (namely, that 90% of people living with HIV will know their status, 90% will be receiving ART, and 90% will achieve viral suppression) (Kavanagh & Dubula-Majola, 2019).

A further problem within government responses has been, at times, the existence of power struggles and disunity between various tiers of government (national, provincial and local structures), and this has done more harm than good for the HIV response (Swartz & Roux, 2004:101; Kelly, 2003; Medical Research Council, 2000). This has led to services being replicated and other HIV areas not receiving services at all (Swartz & Roux, 2004: 101). Coupled with this, the top down approach that the government mostly uses does not make it easy for communities and even local governments to jointly come up with strategies that work for the particularities of each community. In addition, a study by Swartz and Roux (2004) of local government HIV projects in South Africa found out that local level governments face challenges such as transportation, funding and trained personnel. This is coupled with their lack of capacity, and in some cases commitment, to fully incorporate HIV and AIDS issues and programmes into their local Integrated Development Plans (which is a requirement).

Additionally, focusing on HCT alone is not enough to improve HIV prevention and health outcomes. Thus, the government's National Strategy Plan for 2017-2022 suggests "holistic approaches to intervene in new infection cycles through curbing gender-based violence and strengthening the social (keeping girls at school, prevention of teenage pregnancies) and economic position of young girls and women" (Raphael Centre, 2019:1). In this regard, most local governments' responses to HIV are gender neutral if not gender blind as they do not take into account the vulnerabilities of women, at least in any significant manner.

2.5.2 Government Tackling of the Gendering of AIDS

The South African Constitution postulates that everyone has the right to have access to health care services, including reproductive health care (SA Constitution, Section 27). However, in South Africa, "with poverty, inequality, and unmet needs, the state faces legitimate budgetary constraints that may limit rights" (Heywood, 2009: 23), or the government's capacity to ensure health care for all. This is particularly important in the case of women and HIV. Gender equality is also enshrined in the constitution, and ensuring HIV prevention, treatment and care for women is indispensable in enhancing gender equality. However, numerous challenges have inhibited government's efforts in effectively fighting gender inequality as a determinant of HIV infection. These include a lack of strategic allocation of appropriate funds and the absence of will and commitment on the part of government officials – leading to limited effects on the gendered dimensions of HIV. Overall, at least in the early years of the government's response, government personnel (from central to local government) lacked understanding and skills on integrating gender into policies or programmes as well as in addressing gender inequality. In this regard, sometimes the "programme personnel have not dealt with gender issues at a personal level and thus, may be resistant to change at a programmatic level" (Tallis, 2000: 58). Therefore, most government HIV prevention programmes tended to overlook or inadequately deal with gender issues.

As an illustration, 'Men in Partnership against AIDS' was a project that was introduced by a provincial government health department in collaboration with civil society groups. It was soon abandoned, though, and the civil society groups were never informed about this – leading Kelly *et al*. (2010:43) to argue that the government does not take such work seriously. More so, until recently, there was no specific mention made in government calls for proposals (and in the application form) about women or gender, when government was seeking to fund NGOs working on AIDS issues (Tallis, 2014:69). Yet, programmes meant to tackle HIV cannot be effective without a gendered component, including focusing on increasing the agency of women and providing them with greater access to opportunities and voice (Campbell & Nairb, 2013: 1219).

However, the 'She Conquers' campaign is one of the efforts by government to increase young women's agency in dealing with HIV. In 2015, there was a collaborative response (state and non-state actors) to the high rates of HIV and its key drivers among adolescent girls and young women, leading the government to launch, in June 2016, the 'She Conquers' campaign. It sought to reduce HIV infections, improve overall health outcomes, and expand opportunities for young women through collectively tackling the social and structural determinants of HIV

(Subedar *et al.*, 2018). It also included programmes on sexual and reproductive health, HIV testing, GBV and employment (Subedar *et al*., 2018). National, provincial, and district levels of government and stakeholders from civil society groups, the private sector and academic institutions have all participated in the campaign. Such efforts need to be continuously supported, though many of the responses by government still fail to meaningfully address the social, economic and power relations between women and men.

Government funding and resources for programmes need to consider and address the factors that leave women vulnerable to HIV (including GBV, poverty and inequality). Because of this, international donors have sought to shore up government's response to the feminisation of HIV. For example, PEPFAR has made South Africa a priority for the DREAMS programme and has injected millions worth of (US dollar) funding for prevention programmes for adolescent girls and young women (Fourie, 2006: 3; Kavanagh & Dubula-Majola, 2019:3). This is not without problems, though, as not many government programmes have sought to shift gender norms, beliefs and practices which are important determinants of women's HIV vulnerability (Mokganyetji *et al*., 2015; Baral *et al*., 2013: Latkin & Knowlton, 2005). Change will be possible only by considering this (patriarchy-based) socio-cultural context and by enabling stakeholders (such as NGOs) that may be in a better position to influence and sustain change in such contexts (Seckinelgin, 2005: 365).

2.6 NGO Responses to HIV and AIDS

Broadly speaking, NGOs often fill in the gaps of governments' failure to provide adequate services and they have had a significant impact on the lives of many people especially the marginalised (Choudry & Kapoor 2013: 3). As Austin and Mbewu (2009:150) put it, NGOs "can model ways to integrate social and economic development, serving as tools for building effective social policy". There are many HIV NGOs in South Africa, with some focused on supporting women's agency in health issues and others not explicitly women-oriented but having programmes meant to empower women around HIV (Marx *et al*., 2018:2). All NGOs in South Africa are governed by the Non-Profit Organisations Act (NPO Act), which was adopted in 1997.

The funding streams for HIV NGOs in South Africa include: PEPFAR (the largest HIV donor in South Africa with most of its funds distributed through the government), Australian Aid, Canadian International Development Agency (CIDA), Department for International Development (DfID), German Society for International Cooperation (GIZ), Global Fund to

Fight AIDS, TB and Malaria (GFATM), Open Society Foundation, and the Law and Health Initiative Programme (Gideon & Porter, 2016:789). Some of the notable NGOs that work to curb HIV and related issues include Treatment Action Campaign (TAC), Sonke Gender Justice, Lovelife, Rape Crisis, and Families and Marriage Society of South Africa (FAMSA). In this context, it is necessary to explore the role of NGOs (as part of civil society), including analysing their influence and highlighting specifically their role in promoting gender equality to address HIV.

2.6.1 Genesis of NGO Response to HIV in South Africa

NGOs' work in South Africa date back to the apartheid era where there were many advocacy NGOs involved in the fight against, and dismantling of, the apartheid system, leading to the transition to democracy in the early 1990s. Many of these organisations were sponsored by international organisations. Post-apartheid, and in the HIV and AIDS context, NGOs are known to have pushed the state under Thabo Mbeki to ensure the availability of treatment for the HIV infected (Marx *et al*., 2018:1).

Certainly, TAC is one of the internationally known organisations in South Africa to have taken on the HIV and AIDS fight, and quite vigorously. This NGO, formed in 1998, has been at the forefront of demanding treatment, care and education for all – using a human rights discourse and approach. It undertook many successful campaigns in seeking proper health treatment and care for HIV infected people and, in doing so, took advantage of constitutional and legal provisions (Heywood, 2009: 15). This also involved pursuing HIV Treatment Literacy for the public, including AIDS knowledge passed on to Treatment Literacy Practitioners.

However, the early 2000s also ushered in many other NGOs that aimed to address HIV. Like TAC, these NGOs came forward to advocate for people living with HIV, particularly given the lack of the South African government's enabling response to ensure the rolling out of HIV treatment and services. As a consequence, as with TAC, "the struggle [for these NGOs] has been framed in large part as a discourse on rights, through which activists have used the Constitutional Court to challenge the legitimacy of the national government's actions" (Mindry, 2008:82-83).

In the 1990s, NGOs globally were the donors "favoured child, actors of largely untapped potential" (Lewis & Opuku-Mensah, 2006:666). Thus, NGOs were seen, initially, as having comparative advantages over governments in terms of their participatory

methodologies, involving bottom-up approaches, flexibility and innovation. However, a large body of literature has now sought to undermine any romanticised notion of NGOs – they are seen as having their own set of limitations, sometimes transmitted to them through funding constraints and conditions attached to financial aid (from donors) but also because of the political environment in which they operate (with hostility at times from the state) (Bebbington *et al*., 2008:4). Nevertheless, NGOs have seemingly initiated some of the most effective and innovative strategies of dealing with the pandemic in South Africa, including in relation to women and gender.

2.6.2 NGO Strategies in Addressing Gender Inequality and HIV in South Africa

This section discusses some of the work of HIV NGOs in general and the work targeted specifically at addressing gender inequality. It is undeniable that NGOs have been very influential in developing strategies to limit the spread of HIV and to help people affected by the virus through training and education, prevention of HIV infection, and treatment. This includes counselling (one-on-one and in support groups), care and support programmes including social services (financial, legal and material support); medical and nursing care (home-based and palliative care), policy and advocacy initiatives, and research (NGO Pulse, 2006: para 4-5; Russel & Schneider, 2000:1). NGOs have provided specific HIV health services both with and without the partnership of government health departments and facilities.

Training and education as a prevention strategy has seen some NGOs using workshops in communities to train people on the pandemic. Also as part of raising awareness about HIV, other NGOs engage in HIV campaigns, usually around health calendar days like World AIDS Day, sometimes using media platforms in educating people. Media and edutainment programmes (for instance, Soul City and Soul Buddyz by the NGO Soul City Institute) have been used to this end.

Moreover, NGOs have offered mobile HCT programmes with the ability to reach marginalised areas, with many of them providing home-based services for the HIV infected and their families (Jamil & Muriisa, 2004; White & Morton, 2005). An example is the provision of ART by *Medicins sans Frontiers* before it was available in government health facilities. This NGO later handed over their treatment programme to the Western Cape Department of Health (Marx *et al*., 2018:3). NGOs have also provided care programmes for AIDS orphans. Located in the Eastern Cape, Isipho Charity Trust helps to care for 300 orphans infected and affected by HIV through providing pre-school classes, an after-care programme and a feeding scheme,

as well as the provision of material for schooling and psycho-social support (Amakhala, 2016). Thus, NGOs are known for providing home and community based care to community members living with HIV (Amakhala, 2016). NGOs like Lovelife and Rape Crisis in Cape Town offer prevention and care programmes, with their joint National Adolescent Friendly Clinic programme supporting and counselling victims of sexual violence and GBV (Marx *et al*., 2018:3). Additionally, prevention and care programmes have included the distribution of condoms.

Kelly *et al*. (2010:21) also note that most activities are based on "simple awareness-building and have not targeted those most vulnerable to HIV", thus making them inadequate in addressing key populations – including women. Because of this, some NGOs in South Africa have recently started prioritising gender inequality as a factor that leads to HIV risk and vulnerability. While some NGOs are women-focused, others have included both sexes in tackling unequal gender relations (Manell, 2016: 315). Therefore, there have been steps towards addressing gender issues. This has included: NGOs training educators about gender equality in the context of HIV; advocating for inclusion of programmes to support gender equality and reduce GBV in government's national strategy plans; capacity-building and training of women; raising awareness amongst religious and traditional leaders as well as community members at large about the links between sexual practices and HIV transmission to women; and facilitating the economic empowerment of women.

However, there has been a realisation by NGOs that, to improve HIV-prevention, there is a need for more holistic approaches. This includes considering the material conditions which might lead to HIV risks for women. In this light, not only have NGOs focused on behavioural change, as they also implement programmes which seek to economically empower women – giving them, in this way, power and a voice in families and communities. Income generating activities (including gardening, farming, crafts and savings schemes) for women have been initiated to avoid dependence on men. According to Pronyk *et al*. (2006) income generating activities supported by loans improve the livelihoods and quality of life of those already infected by HIV in South Africa.

Notably, other South African NGOs (as TAC did) have played an advocacy and watchdog role and have taken the government to court using the constitution and the law to help in ensuring the efficient delivery of health services to the general populace and specifically women. For example, the South African Sexual and Reproductive Justice Coalition advocates for reproductive justice through challenging gendered power relations. As Manell (2016:319) concluded from her research on South Africa, advocacy activities carried out in the country

include “discussions with potential funders about the need to address gender inequalities, conducting gender-related analyses of HIV policy as an advocacy tool, and holding meetings with government employees and other organisations to discuss gender issues in the context of HIV prevention”.

Several researches (Abramsky *et al*., 2014; IDS *et al*., 2015; Wagman *et al*., 2015) have shown that community mobilisation has the potential to change gender norms, reduce GBV and help in addressing HIV. Mobilisation has been done in many forms including through sports and general training and education workshops in communities. Some NGOs, like the Sonke Gender Justice Network, have tried to mobilise and engage men in changing gender norms and harmful gender practices that increase HIV related vulnerabilities amongst women. A study (Mokganyetji *et al*., 2015) was undertaken on their ‘One Man Campaign’ in rural South Africa that engaged men (18–35years) so as to increase their support for women’s rights and decrease men’s unsafe sexual practices, especially those that increase women’s risk of HIV. This research indicated how men’s attitudes concerning gender and masculinities were being changed.

Attempts by NGOs to focus on transforming men’s attitudes and behaviours to reduce GBV and HIV prevalence also include EngenderHealth, which has worked in South Africa since 1995. The organisation seeks more broadly to improve reproductive health services, including screening for STIs and HIV. But, in an effort to address GBV, which is a key factor in putting women at risk of HIV infection, EngenderHealth launched the ‘Men as Partners’ (MAP) programme in South Africa in 1996. The programne includes workshops, peer-education initiatives, and the use of media in challenging men’s behaviour (Engender Health, 2019; para 2-3). NGOs have been training men in home-based care skills (although men involved sometimes withdraw from these programmes) and recruiting men to women’s rights campaigns, including practical steps to transform unequal gender norms (Manell, 2016:319). The focus on young men in particular, in these campaigns, is important. This is because literature (MacPhail *et al*., 2007; Pettifor *et al*., 2005; Stern *et al*., 2015) has shown that young adults are more open to changing their perspectives around gender norms and their sexual attitudes and behaviours as they transition to adulthood.

Attempting to address gender inequalities in South Africa through improving men’s knowledge about the “social factors that make women particularly vulnerable to HIV” is thus crucial, and it entails “conducting training to impart information, facilitating group sessions to build skills, and developing educational videos” (Manell, 2016:318). This is exemplified in the widely known HIV-prevention training programme known as ‘Stepping Stones’. It seeks to

improve sexual health through building stronger, more gender-equitable relationships and better communication between heterosexual partners (USAID, 2019: para 1). It utilises "participatory learning techniques to develop communication skills between partners, self-awareness and knowledge about sexual health, and the consequences of sexual risk-taking" (USAID, 2019: para 1).

2.6.3 Effectiveness of HIV NGOs in South Africa

Clearly, NGOs are implementing important work in South Africa around HIV generally, and women, gender and HIV specifically. With the shortcomings of the government in addressing gender inequality and HIV, it is indisputable that NGOs have played not just a watchdog role but have crafted important initiatives in addressing gender inequalities as a social determinant of HIV (Blas *et al*., 2008:315). Besides their seemingly increasing focus on women and HIV (through mobilisation and advocacy), there are NGO successes in meaningfully engaging men and boys to deal with masculinities in addressing the gendering of AIDS (Mokganyetji, 2015). Though many of the South African HIV NGOs play an increasingly important role, there are factors that frustrate their efforts, leading to failure of some of their projects and initiatives. Hence, NGOs experience both strengths and weaknesses in their HIV work.

Broadly, NGOs are considered to be in a stronger position to respond to challenges more readily, partly because their programmes are more flexible and less bureaucratic (Davids, 2005:67-74). Unlike in the case of government services, NGO decision making processes tend to be less convoluted and more responsive to emerging development issues. They are also often located close to their areas of operation and are sometimes more able (than government) to understand the influences at a local level (Dejong, 2003:7). Kelly *et al*. (2010:33) for example note that men tend to avoid government clinics and the public eye and might find it easier to utilise NGOs for HIV services, allowing NGOs more easily to provide HIV services at a local level. However, in a study by Kareithi and Flisher (2009:23-24) in Cape Town, it was found that the preferred location for NGO offices was far away from areas of high HIV prevalence rates (in working-class communities), thus affecting detrimentally their localised character and responsiveness. The local rootedness of NGOs, vis-à-vis local government, thus may be open to questioning.

At the same time, many of the non-governmental HIV initiatives are not even explicit in addressing gender. As well, some HIV NGOs merely address gender because it is imposed upon them by donors (as a condition for funding), leading some NGOs to include gender issues

in donor proposals with no understanding, capacity or plan to address those issues in practice (Marx *et al*., 2018:3). In this regard, the claim that NGOs have more flexibility, and are less cumbersome organisationally, in pursuing programmes is somewhat problematic. This relates to their upward accountability to donors – either to international funders or government itself. To illustrate this, in a paper on donor influence in South Africa, Smith (2001:12) argues that, from 1994, donors "have contributed significantly to making SA NGO's more aware of the importance of issues such as gender and HIV in their work, and have provided capacity building and other resources to increase the ability of NGOs to deal with such issues". However, even when an HIV NGO is committed vigorously to undoing the feminisation of HIV, NGO dependence on outside funding is still an ongoing challenge, as the donor-NGO relationship involves power differentials. This is despite the official development discourse about donors and NGOs being partners in development (Fowler, 2001).

Hence, the strengths of NGOs have corresponding weaknesses which may lead to them not achieving their goals. Donor agenda setting, decision making and resource allocation, in the context of often shifting global development agendas and frameworks, cause sustainability problems for HIV NGOs; as does the lack of national political commitments on the part of governments to gender and HIV (Werker & Ahmed, 2008; Islam, 2017: 766). In the case of South Africa, most NGO funding for addressing the pandemic comes from the South African government – which funds 75 to 80 percent of the AIDS response (supported financially by donors and their HIV programmatic agendas) (Avert, 2019; UNAIDS, 2019). Though the South African government funds many HIV NGOs activities, the availability of government funds to deal with gender and HIV is inconsistent, unreliable and unpredictable. Due to government funding limitations, some NGOs do depend directly on external donor funds which often have conditions attached to them.

This illustrates how NGOs are not independent and are shaped by the funding environment, such that the sustainability of their programmes is always uncertain (Kelly *et al*., 2010:10). NGOs operate within a shifting funding environment that impacts negatively on their work, on a long-term basis, to reduce the vulnerabilities of women to HIV. Further, in such a context, the relationship between the funder and the funded is characterised by uneven power which can influence the agenda of the funded and how they operate and function (Tallis, 2014:67). Also linked to funding, some of the processes to apply for donor money are gruelling, and NGOs might not have the time and capacity to effect the changes needed to ensure their work gets funded.

A similar situation emerges when it comes to the arduous and time-consuming mechanisms required for reporting to donors on funds used. Hence, "reporting guidelines place a heavy burden of expectations on NGOs" (Choudry & Kapoor, 2013: 17). Donors have their timelines and they expect their reports (including annual, financial, quarterly, performance assessments and audits) to come through as agreed upon. Because of this, decisions about NGO operations involve a top-down approach which goes contrary to empowering local communities (Ebrahim, 2003:121; Knight, 2013:48). These reporting, monitoring and evaluation systems are put in place so the NGOs can follow what the donors consider as good practices (Ropper & Pettit, 2003:12). But, it takes time for a NGO to create ties and trust with communities and build a mutually beneficial relationship in order to achieve set goals; and the fickleness of donors regarding funding can undermine this inclusive process.

In the end, effective responses to HIV seem to be long-term and locally/community-driven, though donors put NGOs in a position to scramble for measurable outcomes within donors' timelines (Kelly *et al*., 2010:9; Amaya *et al*., 2014; Power *et al*., 2003:25). In this way, long term, community driven responses are precisely the NGO strategies which donors find most difficult to support, leading to donor agendas and the programmes implemented by the NGOs on the ground possibly conflicting with community needs (Panos, 2003: 4). This illustrates the quandary of upward accountability (to the donors) and downward accountability (to the beneficiaries) which is seen as a major shortcoming in ensuring that goals are met and meaningful and long term impact is achieved (Lewis & Opuku-Mensah, 2006: 668). For NGOs, accountability is not "straightforward", especially in cases where the NGO has to be accountable to multiple stakeholders leading to a conflict of interest (Ropper & Pettit, 2003:11-12). NGOs seem, at times, to more often serve the interests of the donors rather than the community. It is in exceptional cases that NGOs remain more accountable to the local people (Choudry & Kapoor, 2013: 8; Ropper & Pettit, 2003:18). However, Bawole and Langnel (2016:924) argue that the absence of downward accountability might be because beneficiaries do not have adequate skill sets for project planning and management, so that this can lead to failure unless beneficiaries are trained and skilled.

Overall, NGOs are caught in between conflicting and contradictory expectations from the donors and the communities, with NGOs being particularly accountable to the former, for reasons which include ensuring the survival of their organisations through continuous cascading of funds (Power *et al.*, 2003: 23; Helliker, 2007:123). Due to this, Choudry and Kapoor (2013: 5) argue that any "analysis of NGOs should examine ways in which the funding climate and other material support can orient organisations to prioritise institutional survival

and maintenance at the expense of mobilisation and account for how NGO … action may be shaped by material incentives". NGOs almost always seem to consider the survival of their organisations to be based on the relationships with donors (Choudry & Kapoor, 2013: 6; Bebbington *et al*., 2008:18; Rojas, 2007).

In this light, NGOs as organisations are embedded in competitive donor environments and this can lead to territorialism and an unwillingness to network with like-minded NGOs (Choudry & Kapoor, 2013). Besides this external conflict, NGOs are also characterised by "internal politics, conflict and power differentials" (Ropper & Pettit, 2003:4), particularly larger NGOs which are arranged quite hierarchically, or where severe funding pressures and strains exist.

Though NGOs might have their own agendas, they are forced generally to operate within the parameters set by donors, and there is not enough room to manoeuvre when it comes to making decisions. Thus NGOs face constraints transmitted to them through funding decisions and conditions linked to funding (Bebbington *et al*., 2008: 4). This donor dependence, coupled with problems of pursuing deep forms of community participation in HIV programming, thus often leads to minimal downward accountability (to communities) on the part of NGOs – thus undercutting the possibility of constructing sustainable projects. Sustainability entails continuation of a programme and "maintain[ing] community capacity in bringing benefits and outcomes through a program from which the funder has withdrawn from" (Humpries *et al*., 2011:86). Many programmes have failed when external funding was withdrawn.

Sustainability could be ensured through enhancing community ownership of projects. Ideally, this would entail intended beneficiaries being part of the initiation, planning, implementation and evaluation of projects (Burger, 2014), so that beneficiaries (such as the HIV infected and affected) see themselves as much more than just recipients of projects but leading actors in them (Choudry & Kapoor, 2013). Under these conditions, a community can see the relevance of pushing forward with the objectives of the project long after funding is withdrawn (Seckinelgin, 2005: 363; Copestake, 2013). Otherwise, NGOs are often questioned in their ability to implement long term sustainable projects, such that their work may become "palliative rather than transformative" (Banks *et al*., 2015: 708).

NGOs should be in a position to meaningfully engage communities in collecting and building their thoughts and voice, with a focus on the particularities and peculiarities of any specific community. However, funders seem to favour projects that have the potential to be duplicated across many communities (Gideon & Porter, 2016:786). A 'one size fits all'

approach favoured in terms of some donor frameworks may be deeply problematic in the case of NGO work around HIV. In fact, it may work to deepen gender inequalities since "relationships that play important roles in people's health, including such contexts as families and communities, are not easily standardized, and therefore they are often ignored or made irrelevant to study designs" (Adams, 2013: 85) – yet, context is critical in understanding gendered vulnerabilities to health inequalities.

The importance of local context arises in the case of messaging materials used by NGOs in South Africa. It is not uncommon to find NGOs using materials (such as pamphlets and t-shirts) in their community mobilisation activities. The message packaging, however, almost always seems to be "adopted internationally, lacking local adaptation which might be hoped for in community based responses" (Kelly *et al*., 2010:32). In this process, local particularities are not captured (Seckinelgin, 2005:357). Local contexts are mostly not taken into account when international and external donors fund local projects with their programmes; with their expectations and conditions already drafted and crafted. When donors fund NGOs, they already have their ideas on what works; though such ideals might not work, since they are prone to disregarding local contexts (MacDonald, 1994: 75). Jackson (1997) also questions the idea of having 'outsiders' such as development agencies expressing women's gender interests.

HIV NGOs in South Africa also face criticisms in relation to the effectiveness and adequacy of some of the programmes that they pursue. Most NGOs implement behaviour-change initiatives through workshops, in changing gender norms and practices that leave women vulnerable to HIV. Peacock and Levack (2004: 180) note that "much contemporary research suggests that positive change promoted by an intervention such as a workshop is likely to be eroded once individuals return to their families, communities and day to day lives". Donors are aware of this (Rau, 2006:292). However, the 'One Man Campaign', which also heavily rested or relied on behaviour change strategies (such as gender, HIV and alcohol workshops, community outreach, theatre and discussions) seems to tell a different story of behaviour change strategies in South Africa. Mokganyetji *et al*. (2015:10) hence note that the 'One Man Campaign' effectively mobilised men and women in 11 intervention communities to address harmful gender norms and HIV risks, with some of the men who were trained actually changing their behaviours significantly and seeing themselves as local role models for boys.

Clearly, the prevailing literature on NGOs (including HIV NGOs in South Africa) does not portray a romanticised image of NGOs. Nevertheless, it is clear that NGOs play a

meaningful role in HIV programmes (including in relation to women and gender), often in conjunction with government funding and assistance.

2.7 'A Marriage of Convenience': Government and NGO Partnership

The government of South Africa (alongside a number of ministries and departments at different levels of the state) has sought, in conjunction with a diverse range of NGOs, to address and overcome the challenges of the HIV pandemic, including in relation to HIV and gender. This broad collaborative effort is not surprising, given that tackling the pandemic effectively requires an all-embracing, inclusive and multi-sectoral approach which crafts innovative and effective interventions (Humpries *et al*., 2011:86; Austin & Mbewu, 2009:149; Mahlangu *et al*., 2019: 1). After all, HIV and AIDS are not mere medical issues, but have wide-ranging and far-reaching conditions, causes and consequences which require the expertise, enthusiasm and experiences of multiple agencies, communities and individuals. It is certainly not practical or wise for government or any NGO, or any other stakeholder, to think that they can alone, and in isolation, address the implications of HIV. Even though the South African NSP for 2017-2022 acknowledges the importance of government partnering with non-state actors, this is not an easy process – as planning of government strategies is often done without fully consulting NGOs and communities more generally (Heywood, 2004).

In South Africa, there are instances of collaboration between government and civil society groups around HIV, as Kelly *et al*. (2010:13) note, and as noted earlier. However, evidence suggests that such arrangements need to be widened, consolidated and strengthened (Theron, 2008:162). At the same time, this should not be at the expense of an independent watchdog role by NGOs of government's HIV strategies and programmes, the significance of which is clearly shown in the case of TAC (Heywood, 2004). While constructive criticism and healthy conflict should not be avoided, it is necessary to move beyond perpetual conflict towards a mutually beneficial partnership which allows for innovation and greater responsiveness through effectively fighting the deep effects of HIV in South Africa (Mahlangu *et al*., 2019:1). A notable effort by the South African government has been the establishment of the national, multi-sectorial coordinating structure, the SANAC, to drive programme implementation.

The 'She Conquers' campaign' (as previously discussed) illustrates how multi-sectoral responses, involving government and NGOs, are likely to yield positive results. As well, 'Men as Partners' (MAP) also serves as an example of state-society collaboration. As an

"intervention designed to engage men in reducing GBV and to promote men's constructive role in sexual and reproductive health, including HIV", MAP was "carried out through a partnership of civil society organizations collaborating with governmental and academic institutions" (Peacock & Levack, 2004: 173).

When a government is progressive (including around human rights) and NGOs are well-funded and committed, there is significant potential for collaborative relationships between the government and civil society (Jamil & Muriisa, 2004). However, this can only happen if and when both actors do not see themselves in competition with each other, including fears by governments that NGOs can erode their political power (Theron, 2008:162). While conflict and power dynamics are almost endemic to relationships between government and NGOs, the building of trust over time will consolidate levels of trust in pursuing successful multi-sectoral responses (Mahlangu *et al*., 2019:1-2).

Further, insofar as collaboration is limited or weak, the blame cannot be placed solely at the feet of government. The NGO community is regularly engaged in the duplication of efforts and it lacks a unified approach and collective planning, despite the existence of NGO networks including in relation to HIV. NGOs rarely speak with one voice, and thus a disjointed message is heard by government. There is need for NGOs to speak with a clearer voice, as this will facilitate relationships with government in terms of meaningful partnerships (Kelly *et al*., 2010:48). Government and NGOs in South Africa, ultimately, should complement and support each other in tackling AIDS in general and the gendering of AIDS in particular.

2.8 Linking HIV and Women to Theory: A Feminist Interpretation

In seeking to assess the significance of the work of NGOs focusing on HIV and women, it is crucial to draw upon feminist theory in order to have an analytical basis for assessment. Various forms of feminism advocate for political, social and economic equality between men and women, though feminist theories differ in their understanding of gender inequality and oppression. Nevertheless, feminism broadly examines the ways in which men, since time immemorial, have been privileged while women have been placed in subordinate positions in society. A feminist approach to HIV must consider the unequal power relationships between men and women (in economic, cultural, social and political spaces) and how this has heightened risks for women and led to the feminisation of HIV, including in South Africa (Tallis, 2014: 83).

A feminist approach can lead to more effective tackling of HIV and AIDS since it brings analytical light to the forms of inequality that leave women, as the majority infected and affected by HIV, vulnerable to HIV. There are different feminist approaches to gender inequality, including Liberal, Radical, Marxist, Socialist and African feminism. A discussion of the basic tenets of these various strands of feminism, and how they relate to HIV and women, follows.

Liberal feminism advocates for equal political, economic and educational opportunities, for men and women, to achieve gender equality; and it asserts that female oppression is rooted in legal and institutional discrimination. The main tenets of this branch of feminism are equality, individualism and choice, for women and men; and the removal of legal and institutional barriers hindering women's advancement therefore becomes crucial. Liberal feminism seeks to fight for equality mainly in the public sphere (including the economy) through changing laws and institutional policies (MHRD, 2017b). Increasingly, at least amongst more progressive liberal feminists, there is an attempt to explain how private or domestic life can affect public forms of inequality (Lewis, 2019: para 3). The traditional nuclear family structure, in this regard, is seen as discriminatory towards women and the marriage institution (as currently arranged) reinforces gender norms and stereotypes.

Bringing about social change through the gendered reconfiguration of legislation and other forms of state regulation (including of employment) is of some significance in overcoming women's vulnerabilities to HIV. But, the lived realities of women are not given detailed consideration in liberal feminism – including class distinctions between women (with liberal feminism often seen as a middle-class feminism) and the range of sexual discourses and practices which create HIV risks for women (Lewis, 2019: para 15). In the end, its main focus is on the public sphere and the restructuring of this through formal processes.

Radical feminism views the oppression of women by men through the prism and system of patriarchy, as the most fundamental form of human oppression in human societies. In her book *Feminisms, HIV and AIDS: Subverting Power, Reducing Vulnerability,* Tallis (2012) links the vulnerability of women to HIV to patriarchy, but also points out that women can develop the power to create another reality. Radical feminists seek to uproot patriarchal power structures and they are also widely known for their 'personal is political' mantra which encapsulates how larger structural contexts influence the personal experiences of women (MHRD, 2017a). Overall, the focus is on the connections between sex and power (i.e. men controlling women), and masculinity and femininity as social constructs (Tong, 2014: 51-52), with the domestic sphere seen as the key place in which women's subordination is produced

and reproduced. This means that sexual relationships are characterised by the sexual objectification of women which in many instances leads to sexual violence and GBV (Bue, 2014:37; Tong 2014:65), as "both a manifestation of gender inequality and a weapon to entrench hegemonic masculinity" (Tallis, 2014:147). In this way, rape is an instrument of power used by men.

This argument by radical feminists about the sexual practices of women being controlled by men is clearly of great significance to South Africa, given the high rates of GBV in the country and how this exposes women to the HIV virus. Despite this, its overemphasises gender at the expense of class (and race) and thus underplays the ways in which patriarchy is structured and experienced differentially by women, as well as the ways in which the ensuing risks and vulnerabilities arise from women's different class locations. Gender inequality in South Africa, for instance, also stems from the fact that many women are financially and economically dependent upon men (Morgan, 2019: para 16).

In criticising liberal and radical feminism, *Marxist feminism* focuses on class inequality (within capitalism) and how this inequality generates other forms of inequality, including gender inequalities (Sheivari, 2014). They examine critically the division of labour within the capitalist economy (as part of the public sphere), so as to show that women are integrated into the economy in a subordinate manner. But they also consider the division of labour within the domestic sphere, with women in large part confined to this sphere and engaged in unpaid domestic and reproductive labour, which ultimately subsidises the wages of male workers (labouring in the sphere of production) for the benefit of capitalist profit. This insight is of some significance, as it highlights the economic vulnerability of women vis-à-vis men – this certainly resonates with the economic vulnerability which women experience as a risk factor in becoming HIV infected. But it involves a reductionist argument, as women's subordination and vulnerability is reduced in almost unmediated form to economic subordination. This undercuts the importance of social and cultural aspects that are also crucial in order to understand the feminisation of HIV, about which radical feminism is more sensitive.

Socialist feminism seeks to offer a synthesis of radical feminism and Marxist feminist, by claiming that gender (patriarchy) and class (capitalism) are co-determining forms of inequality and domination which are mutually constitutive of each other (Tong, 2008:96). Hence, like Marxist feminists, social feminists highlight the economic subordination of women to men (Lorber, 1997: 15). At the same time, they are sensitive to the concerns of radical feminism, including that men yield power over women in deeply personal forms (including sexual practices) within the sphere of social reproduction and in ways which are not explainable

merely in terms of an economic rationale. Because of this, the vulnerabilities of women are seen as located in both the spheres of (social) reproduction and (economic) production (Pasque & Wimmer, 2011:18). This stance is of great significance in seeking to understand the female face of HIV in South Africa, and the extent to which HIV-focused NGOs are able effectively to challenge women's vulnerabilities with regard to HIV as both HIV infected and HIV affected.

Like class, the feminisms discussed integrate the racialised dimension of gender into their analyses to vary extents and in different ways. In this light, *African feminism* offers a more focused investigation of the status of race and gender, and their relationship. In particular, in seeking to offer an African perspective on gender, African feminism argues that the experiences and realities of African women in an African context cannot be equated to 'women' in the Western context – since the political, social, economic and cultural structures and practices in Africa differ significantly from elsewhere (Wang'ondu, 2019: para 1). African feminism has various strands, including Motherism, Femalism, Nego-feminism and African Womanism. Despite their differences, African feminisms address cultural arrangements and dynamics which pertain to the complex and differential experiences faced by women on the African continent. Linked to a theme so central to radical feminism (the domestic sphere), this emphasis on the part of African feminism includes understanding the peculiar forms and characteristics of families and households in Africa, and not simply condemning these families on the basis of an imposed human rights discourse. The cultural arrangements navigated by women in Africa include cultural norms like *lobola*, the nurturing of women to pursue the sexual pleasures of men and tolerance for multiple sexual partners for men. In the book, *African Feminism: The Politics of Survival in Sub-Saharan Africa*, Mikell (1997) speaks about the feminisation of HIV with specific reference to black African women, and also brings to the fore the necessity of involving African men in the gender equality struggle (Hunt *et al.* 1997; Tallis, 2012).

Overall, the gendering of HIV, and the significance of the work of NGOs around HIV, can be most fully understood through the important thoughts of socialist and African feminist thinking. Combined, these theories show how women in most cases are economically dependent on men, how their sexual rights are in the hands of men, and how culture, race and class has influenced the feminisation of AIDS. These points relate back to the factors outlined earlier which condition if not cause the extreme vulnerabilities of women in South Africa, and particularly black African women, to the HIV pandemic. As well, and like other feminist thinking, socialist and African feminism do not seek to examine the female face of HIV in

terms of women, but not in terms of gender and the structured relations of domination between men and women.

2.9 Conclusion

It is clear that gender inequality (founded in patriarchal arrangements) exists in many forms in South Africa and it leads to the feminisation of HIV in terms of women's greater susceptibility to being both HIV infected and affected. The government, though initially problematic, and NGOs have tried to fight the HIV pandemic for years now, either independently or in partnership, with both successes and failures. This chapter has revealed that, despite the government's efforts to tackle the pandemic, it has not sufficiently addressed the gendering of AIDS which seems to be a, if not the, major issue surrounding HIV and AIDS. At the same time, NGOs have sought to fill in the gaps by strengthening the national response to the pandemic while also recognising in some ways the relevance of gender inequalities to HIV. Again, like government, NGOs have attained successes but they are not beyond criticism. One particular concern in this regard is the prevalence of upward accountability to funders and how this may minimise the embeddedness of NGOs in local communities. In this context, the next chapter focuses on the case study of Makhanda.

Chapter 3: HIV and NGOs in Makhanda

3.1 Introduction

Makhanda, located in the Eastern Cape Province, and with a population of around 67,264 people according to the 2011 census records, "offers an opportunity to explore the dynamics of the HIV/AIDS epidemic within a context in which unemployment, poverty, and HIV/AIDS intersect in critical ways" (Jones, 2011:68). Makhanda falls under the Makana Local Municipality and has the largest concentration of people in the Sarah Baartman District Municipality. Located in Makhanda is the widely known Rhodes University which brings together thousands of academics and students from across South Africa and indeed the world (Planga, 2017: 42). Makhanda was founded in 1812 and was formally known as Grahamstown and is the hub of the Makana Municipality (Eastern Cape Socio Economic Consultative Council (ECSEC), 2017:2). Seventy-eight per cent of its population is Black African, 12% is Coloured, and 10% is White (Kelly *et al.*, 2006:8). In 2016, 10,800 people in the Makana Local Municipality were said to be HIV infected, reflecting "an increase at an average annual rate of 3.29% since 2006, and in 2016 [this figure] represented 12.41% of the local municipality's total population" (ECSEC, 2017: 20).

This chapter starts off (in section 3.2) by considering the local context of Makhanda, including the ways in which women in particular may be subject to HIV vulnerabilities and risks. In section 3.3, I examine the ways in which government at local level in Makhanda has tried to tackle the challenges of HIV, and section 3.4 then turns to the local work and programmes of NGOs. Because of the significant relationship which NGOs have, or do not have, with other 'stakeholders' in the fight against HIV in Makhanda, sections 3.5, 3.6 and 3.7 examine the relationships between NGOs on the one hand, and government, funders and local communities on the other hand, respectively. Though questions about women and HIV in Makhanda are discussed by the end of section 3.7, section 3.8 entails a more focused discussion on government, HIV and women in Makhanda, and section 3.9 does the same with regard to NGOs. In this light, in terms of the fight against the pandemic and its effects on women in Makhanda, NGOs' relationship with government is particularly crucial in terms of the day-to-day work and programmes of NGOs.

3.2 HIV and Women in Makhanda

The Makana Local Municipality, in 2016, consisted of a female population of 51.84% which almost corresponds with the national average of 51.07% (ECSEC, 2017:13). As elsewhere, different forms of gender inequality exist in Makhanda, and this inequality has repercussions in the HIV context whereby women are infected and affected more than men by the pandemic. Gender inequalities have implications when it comes to HIV prevention, treatment and care for women. As Tallis (2000:58-59) notes with specific reference to prevention, "gender inequality is perhaps the main problem area impeding HIV/AIDS prevention". In this section, I consider the different faces of gender inequality in Makhanda and how this impacts on women in relation to HIV. Poverty and socio-cultural practices put women in Makhanda at great risk of being infected and affected by HIV.

3.2.1 Poverty and Unemployment

According to Statistics South Africa (cited in Raphael Centre, 2019a:1), for 2017, 72,8 % of the population in the Eastern Cape lives below the poverty datum line, which was R 1,138 per person per month in 2017. In Makhanda alone, 63.4% of potential workers (i.e. those seeking employment) are not working, and there are growing levels of poverty as 45% of the people have no viable source of income; and a further 10.5% earn less than R801 a month (Statistics SA, 2011; Makana Municipality, 2019:75). Unemployment in Makana rose from 8,270 people in 2006 to 9,100 people in 2016 with the total number of unemployed people within Makana constituting 24.83% of the total number of unemployed people in Sarah Baartman (ECSEC, 2017: 46). Makana local municipality, in comparison to other districts in the Sarah Baartman District, has the highest official unemployment rate which is 25.5% (ECSEC, 2017:47).

With the high levels of poverty and unemployment, Makhanda has been described as one of the ten Eastern Cape HIV and AIDS "hotspots" (Jones, 2011:68; News24, 2001). ECNGOC (2013) describes unemployment, inequality and poverty as the "triple challenge" in Makhanda (Raphael Centre, 2019c:1). The vast majority of residents in Makhanda are unemployed and rely on welfare grants and casual work. African women in particular are excluded from the formal economy, with significant reliance on their part on child support grants.

An important repercussion of the dire economic situation in Makhanda is the large number of young people who are 'loitering' on the streets, with some female youth engaging in 'survival sex' because there is insufficient money at home to care for their needs. Female

teenagers are, in particular, involving themselves in inter-generational relationships (with older men) as a source of income and material gain in response to the economic situation, with has led to early pregnancies and contracting of STIs (Raphael Centre, 2019b). At the same time, many teenage girls are being 'sold' for sex by their families. Because of economic desperation, some parents at times encourage this type of engagement with older males, as the income generated can be channeled into meeting household expenses. Young women's vulnerability to HIV infection is compounded by the age gap between her and her older partner. Hence, in a study undertaken by Jewkes *et al*. (2006) in the Eastern Cape, it was shown that HIV infection is associated with having a partner three or more years older (amongst 1,295 sexually active female volunteers aged 15-26 from 70 rural villages).

An official from the Department of Social Development (DSD) (Olivia, Interview, 19/09/2019) highlighted this problem. She indicated that DSD undertook a study around 2015-2016 about why there is a high teenage pregnancy rate within the Eastern Cape. It found out that, along with Amathole district, Sarah Baartman district (in which Makhanda is located) has the youngest age at which young girls engage in sex for the first time. They start sex when they are 13 to 14 years' old compared to other districts where the respective age is 15 and 16. In part, the first and later sexual experiences involved seeking to obtain goods or money in exchange for sex, with the support of parents:

> *If you speak to why this is happening, the story was narrated by this young girl how her mom sells her for a loaf of bread because there is no food at home, so it's economic. But also she doesn't know where to go because there is no one else to support them so it's horrific the stories that you hear.* (Olivia, DSD, Interview, 19/09/2019)

Economic challenges at home also lead to stress and distress within the family, sometimes ending up in cycles of substance abuse and compromised mental health and depression. Further, as Ava from the Raphael Centre (Interview, 18/09/2019) brought to the fore, when the social situation at home is economically unstable and uncertain, there is a likelihood of gender-based (domestic) violence (or GBV) that can lead young girls to pursue some kind of stability by dating older men, with this relationship somehow substituting for the absence of love in the home and the quest for belonging. Clearly, at least in an indirect manner, economic challenges translate into social and health problems (including HIV), for women of all ages.

3.2.2 Socio-Cultural Institutions

Besides economic conditions (i.e. poverty and unemployment), socio-cultural institutional arrangements exacerbate the situation for women when it comes to HIV. HIV infections amongst women reflect the all-encompassing power relationship between men and women. In many cases, women do not feel empowered sufficiently to insist on condom use, to such an extent that sometimes they do not even dare to use the female condom for fear of domestic violence. In South Africa, gendered power inequality in intimate relationships places women at risk of violence, abuse and an increased susceptibility to HIV infection (Jewkes & Morrell, 2010). It thus leads to women being very submissive when it comes to establishing and enforcing rules around sexual engagement. In fact, entrenched gender norms "condone men's dominance over women in sexual relationships and contribute to men being less likely to use condoms, more likely to force sex on their partners, and more likely to have multiple partners" (Jewkes & Abrahams, 2002; Dunkle *et al*., 2004 cited by Manell, 2016:318). Women, in turn, become less able to negotiate safer condomised sex (Thege, 2009). Emma from Grahamstown Hospice suggested people in Makhanda were not using condoms widely. She said:

> *We definitely have noticed the trend that more women are infected and I think the use of condoms is not a regular occurrence*. (Emma, Hospice, Interview, 20/09/2019)

Heightening this HIV challenge for women is the reality that generally African societies tolerate multiple sexual partners for men, while expecting women to be faithful. Certainly, this seems to be the situation in South Africa and Makhanda in particular (Bujra, 2000: 10). As Aphiwe from the Department of Health (DoH) highlighted:

> *It's kind of allowed for men to have several partners and they take it as a culture.* (Aphiwe, DoH, Interview, 25/09/2019)

This puts all the other partners (all women) at risk of HIV infection. In this context, a study involving academic and support staff at eight tertiary institutions in the Eastern Cape found out that a high number of males were sexually active with more than one partner in the past 12 months (Phaswana-Mafuya & Peltzer, 2006) This is a precarious situation for women, especially considering a main concern that was echoed – by all interviewees – that men do not want to be tested for HIV. Buhle from the Settlers Clinic in Makhanda feels that statistics indicating that more women than men are infected exist because women are the ones willing to be tested:

> *I don't think women are infected more but women are the ones that are testing, they often come to test. If a woman is negative the man will say 'I'm also negative'. There are few*

men coming voluntarily to test; they … come when they are sick. (Buhle, Settlers Clinic, Interview, 01/10/2019)

Men's reluctance to take control of their own health alongside their authority in sexual relations is reinforced by women's unwillingness or fear to use the female condom. When partners agree to use a condom, it is usually the male condom and this has exposed women in Makhanda to infection. Men should be knowledgeable about the importance of condom use, HIV testing and treatment, to reduce women's risk of acquiring the virus from their male partners (Mokganyetji *et al*., 2015: 14).

A further issue is that of peer pressure placed on young girls to become sexually active when they are actually (in a bodily sense) not ready for it. As an example, as noted by Olivia from DSD (Interview, 19/09/2019), there was an incident recorded in Hankey (a small rural community in Sarah Baartman district) where girls were making videos (on their cell phones) of themselves having sex. In doing so, they were allowing themselves in effect to be date raped and even gang raped just to feature in a video that circulates on social media.

Another central point that was also brought out from interviewees from both government and NGOs, as indicated by Olivia from DSD (Interview, 19/09/2019) and Ava from the Raphael Centre (Interview, 18/09/2019), is the issue of Lesbian, Gay, Bisexual, Transgender, Queer and Intersex (LGBTQI) people in Makhanda. Of particular significance is the issue of 'corrective' rape that happens particularly in Joza (a location in Makhanda) and how this affects them. Families and communities often assume that, if 'corrective' rape happens, the man or woman will realise that they are 'straight'. Typically, in Makhanda, there is no acceptance and support for LGBTQI youth from their parents and it is very difficult for them to remain in the formal school system, leading to dropping-out of school. Despite attempts to hold inter-generational dialogues around this issue (by the DSD), Olivia from DSD reports that parents do not show up for these sessions although young LGBTQI people do avail themselves of this opportunity with an interest in talking to their often intolerant parents. Like young women more broadly in Makhanda, young women within the LGBTQI 'community' (including transgender women) are vulnerable to HIV infection – not only because of 'corrective' rape, but also because they are out of school and out of work, leaving them vulnerable to preying and abusive men.

3.3 HIV and Government in Makhanda

Understanding government's efforts around HIV at the national and provincial level leads to a fuller understanding of the role and activities of government at local municipal level in relation to HIV. This also facilitates a fuller understanding of the HIV work of NGOs locally and how they may or may interact with municipal and other tiers of government (such as provincial government departments) operating at the local level. Broadly speaking, local government is "a sphere of government located within communities and well placed to appropriately respond to local needs, interests and expectations of the communities" (Koma, 2010:113). Hence, municipal governments in particular are expected to engage more fully with the needs of communities, including in Makhanda.

In relation to government work on HIV and AIDS, this is usually funded through the main provincial government departments of Social Development, Health and Education. Nationally and locally, through funding from the national DoH, the government funds NGOs to provide particular services for HIV infected and affected people, including HIV treatment and home-based care. In Makhanda, the government also offers health services and facilities such as Settler's Hospital which is the main health care facility at municipal level (Makhanda Municipality, 2019:144).

Settler's Hospital was selected as a rollout site for ARV therapy when it was launched in May 2004 in Makhanda (then Grahamstown) (Mahasele & Srinivas, 2008; Jameson, 2007:850). Settlers Hospital provides HIV and AIDS related services such as PMTCT, prophylaxis for rape victims and palliative care for terminally ill HIV patients, as well as providing care for patients with other chronic diseases. By March 2010, Settlers Hospital had enrolled a total of 1,908 patients on ARVs since accreditation. This included 108 children under the age of 15, 1,090 female adults and 614 male adults, as well other patients who were deceased, who had defaulted on treatment or were lost during follow ups, or who had transferred out of the area (Mahasele, 2011:50). This indicates that females constituted a higher percentage of the total of the HIV infected.

Joza and Raglan Road clinics, and Fort England Psychiatry Hospital, also started initiating ART in 2010 (Mahasele, 2011:18). These primary health care facilities submit data on their HIV and AIDS activities to the District Health Office. Makana municipality also has a Local Aids Council which is supposed to shoulder some of the HIV work (Rhodes University, 2016). The government departments and institutions that are working to address HIV, and that agreed to take part in this research, are Settlers Day Clinic, the DoH and Eastern Cape Department of Social Development (DSD).

In terms of HCT, the government is focusing on the 90-90-90 strategy in which at least 90% of the South African population knows their status and are on treatment. In this regard, it can be noted that a new drug is becoming available in December, to be taken as one pill per day rather than the current three pills which are taken. In the meantime, the DoH in Makhanda is implementing the 'Universal Testing and Treat' programme, in which all persons testing HIV positive are immediately offered ARV treatment, irrespective of their CD4 count and viral load. Prior to this, there was a delay in treatment, with some persons prevented from accessing treatment based on their CD4 count and viral load. However, Buhle from Settlers Day Clinic believes that the government's Test and Treat programme is the cause of defaulters of treatment:

> *The government's Test and Treat, I think it's the cause of many defaulters because you are not even ready to start treatment; you are being diagnosed and being given treatment* [immediately]. *It was better in the olden days whereby there were readiness; programmes now, you are just being tested and treated, so I don't think that is enough and it's causing high volume of defaulters of which that leads to resistance.* (Buhle, Settlers Day Clinic, Interview, 01/10/2019)

According to Clara from DoH (Interview, 23/09/2019), for Makhanda alone, there are between 5,000 and 6,000 defaulters, or at least possible defaulters, dating back to the start of the ARV programme. She still needs to trace these people, with an unspecified number likely having died or migrated out of Makhanda. Because of educational institutions like Rhodes University, the Department of Health also notes that Makhanda has a significant number of visitors (including non-South Africans), who are also able to access HIV treatment locally. Many of the so-called defaulters may include students on treatment who have subsequently left the university. All HIV-positive people on treatment are expected to inform the Department before they depart Makhanda, as they are then given a transfer letter which allows access to treatment anywhere else in the country.

The government is currently seeking to strengthen the information system because of the large number of missing clients. There is already in place a district health information system (the Tier.net system), which means that individuals that go onto HIV and TB treatment are captured in a system. But, presently, unless the client informs the Department about his or her new place of residence, it is not able to trace the exact location of a client once s/he has moved. Thus, the department is trying to put in place the Health Patient Registration System (HPRS), which would be linked to identification numbers – so, wherever the person moves and seeks ARVs (at a particular health facility elsewhere), the identification number would be

entered to ensure that the patient's health profile is available to the facility. This new programme is still in the 'infant' phase.

Amongst government departments, the Department of Health occasionally refers clients to other departments like the Department of Social Development and Social Welfare for support, where clients need financial assistance or other forms of assistance not offered by the DoH. At the same time, government departments' relationship with Makana Municipality is an uneasy one, which contributes to undercutting a coordinated and cohesive government response to the pandemic locally. There used to be small projects on offer by the Municipality for HIV-positive people (for example, picking up waste) but these are no longer in existence. More importantly, the Municipality often fails to attend HIV meetings or to show up for HIV activities, even when invited by the DoH. As Aphiwe from the DoH said:

> *There is a gap my dear, a big one particularly us and the local Municipality because we are supposed to have that link in terms of empowering our people.* (Interview, 25/09/2019)

Facilitated by funding provided by the national government through the treasury and international funders like PEPFAR, local government activities around HIV have included education campaigns and training workshops, which has involved collaboration with NGOs on issues such as home based care and HIV counselling and testing (HCT). The municipality in Makhanda, through the DoH, organises campaigns in the community and with Rhodes University in line with the health calendar (such as World AIDS Day on December 1st). For instance, Settlers Clinic marks and celebrates World AIDS Day, whereby every client who comes to the clinic gets tested for HIV.

These initiatives also include undertaking the First Things First campaign during which students and staff at Rhodes are educated on HIV. This is run by the Rhodes University Health Care Centre on an annual basis. It is an innovative HIV counselling and education campaign which receives support from government through the DoH. It aims to help students to be responsible by getting tested for HIV and by empowering themselves in knowing their status (Rhodes University, 2019). More so, there is the *Tuma Mina* Campaign whereby the DoH goes into the community, including churches, to address HIV issues and local NGOs take part as well. Clara from the Department of Health (Interview, 23/09/2019) said they invite the NGOs because the Department considers them as key stakeholders. The government health promotion team from the Health Department also utilises Radio Grahamstown in educating people and are planning in future to utilise the Rhodes University radio station.

The local municipality, as indicated, undertakes educational activities, but it has challenges in terms of capacity in the area of Information Education and Communication (IEC). Clara from the DoH (Interview, 23/09/2019) hence noted that information pamphlets on HIV are normally standardised and the ones available are produced nationally. She estimates that 80% of the pamphlets are in English, yet the vast majority of Makhanda residents speak isiXhosa. There is remarkable lack of locally made pamphlets, since the DoH has and only relies on the general pamphlets produced at a national level, while NGOs like Soul City Institute (which runs HIV awareness initiatives through television, radio, print and social mobilisation programmes in communities) writes and provides pamphlets for other South African provinces without supporting the Eastern Cape. Responding to the question on the availability of pamphlets, Clara had this to say, in response to a question about the availability of pamphlets:

> *Not specifically on HIV in Makhanda because there is no one that is writing anything about it. The pamphlets are normally standardised so its national pamphlets if we have them* (Clara, DoH, Interview, 23/09/2019)

Therefore, the HIV pamphlets that are presently available are usually very old, not updated and in a language most of the population might not fully comprehend.

In addition, the DoH distributes condoms, involving dual protection in terms of male condoms and female condoms. Again Clara from DoH highlights that the actual utilisation of the condoms is hard to monitor and people are reluctant to access female condoms in the first place. As she notes:

> *The demand for those condoms is very minimal because we can see our stock is not really moving… especially female condoms. Male condoms, yes you do get it that they will take them to their partners, for those who have got open communication with their partners; but the others depend on their partners to take the decision* (Clara, DoH, Interview, 23/09/2019)

In their work with existing NGOs, the Department of Health says that it tries to capacitate NGOs to make their HIV work effective. The department provides NGOs with the testing kits for free and, in return, NGOs send their HIV statistics to Settlers Day Hospital. NGOs are also involved, as indicated, in the training sessions of the DoH, and the department shows up if an invite is extended from the NGOs for the government to participate in their activities. In this context, Ava from Raphael Centre expressed some level of both enthusiasm and doubts over what the government has been doing around HIV, but she thinks that, overall, the government has done phenomenal work in addressing HIV in South Africa:

> *That's a tricky one. I know that the government has done tremendous work in the field of HIV and AIDS. I mean we have got the biggest and most complex HIV programme in the entire world and I think it's an amazing improvement.* (Ava, Raphael Centre, Interview, 18/09/2019)

Eugine and Memory from Jabez Centre (Focus Group Discussion, 26/09/2019) also spoke about the incredible work being undertaken by government.

However, Ava (from Raphael Centre) also feels that the government could and should do more since their reach seems very limited; for example, in rural areas, despite the capacity to deliver child support and other grant money monthly, health services are not widely and properly available. Certainly, the area covered by Makana municipality is vast and the various agencies involved in HIV work often struggle to ensure HIV services are universally provided. Both the DSD and DoH, as government departments, have major challenges pertaining to transport, with places far away from Makhanda often beyond their reach. Emma from Grahamstown Hospice shared stronger sentiments about the failures of government and the need for improvement, also in relation to deep rural spaces:

> *I think that the government's education and awareness programmes have failed over the last sort of 20-25 years. I don't think that it has changed the lives of populations particularly in the more rural areas.* (Interview, 20/09/2019)

As part of their efforts to fight the HIV pandemic, the government is concerned about the traditional initiation ceremonies of men. Makhanda is predominantly Xhosa and traditional initiation forms part of the local culture. This is a process whereby young men go to the bush every year for circumcision and to be taught responsibility and how to behave as men. There are forums in the local Makana municipality to deal with the issue of the traditional initiation of men so as to ensure that the traditional surgeons and nurses involved in circumcision are registered and that the prospects of HIV infection are reduced.

Overall, this section has detailed some of the key HIV work that government is pursuing at a local level in Makhanda and it reveals how the government view NGOs as agencies in addressing HIV and the forms of collaboration between government and NGOs. The following section focuses more specifically on the HIV activities and services of NGOs in Makhanda.

3.4 HIV and NGOs in Makhanda – Filling in the Gaps

Currently, Makhanda does not have a significant variety of NGOs that operate in the field of HIV. A google search on NGOs that are working on HIV and AIDS issues in Makhanda shows

a list of around eight organisations, some of which have ceased to exist and some of which are no longer actively running HIV programmes, like Families South Africa (FAMSA). The research unearthed that the most common HIV activities which are undertaken by NGOs in Makhanda include HCT, home based care, educational activities and condom distribution. In addition, one NGO focuses on Asset Based Community Driven Development (ABCD) with a HIV dimension. The three NGOs incorporated into this study are Raphael Centre, Jabez Centre and Grahamstown Hospice.

Firstly, the Raphael Centre is an NGO that was established in 1999, to initially provide support services to people living with HIV. It has recently began incorporated all sectors of the community in its programmes and activities. Its core programmes are Health Testing Services Programme and the Asset-based Community-driven Development (ABCD), though it does have other activities that include HIV awareness and education. The organisation executes its work through the help of local and international funders including the Emthonjeni Trust, Ikhala Trust, Club Peloton, National Lottery Commission and the DG Murray Trust. As one of its key achievements, it was nominated the 'Best Grantee of 2018' by Ikhala Trust (14 November 2018) (Raphael Centre, 2019e:1-4). Currently, it is under massive financial constraints.

The Grahamstown Hospice is also an HIV NGO that has been operational for the past 22 years, with the main aim of providing care for adults and children with illnesses that include HIV and AIDS. The organisation operates not only in Makhanda but in areas such as Bathurst, Kleinemonde, Port Alfred, Kenton-on-Sea and Alexandria in the Eastern Cape. Its mission is "to provide optimal, compassionate, holistic, home based support to all Hospice patients and their families." (Grahamstown and Sunshine Coast Hospice, 2019:1). The organisation is also funded locally and internationally through the Department of Health (DoH), Foundation for Professional Development (FPD), United States Agency for International Development (USAID) through the University Research Council (URC), National Lotteries Commission and Haven Hospice in Florida (Grahamstown and Sunshine Coast Hospice, 2019:2).

Like the Hospice, the Jabez Centre offers home based care services and is located in Extension 9, Makhanda. It has other HIV programmes and activities that include partnering with all the clinics in Makhanda whereby its caregivers educate the patients about HIV and the other chronic diseases, while also running support groups, dialogues and other awareness and prevention activities. The NGO administers its work through the help of both local and international funders including Department of Health (DoH), Foundation for Professional Development (FPD), and United States Agency for International Development (USAID).

3.4.1 HIV Counselling and Testing (HCT)

Some NGOs are predominantly involved with testing and counselling, based on the strategic policy of Testing and Treating. All the NGOs reached had HCT as part of their core business. In this regard, NGOs work hand in hand with the government's Department of Health in that – as indicated – they surrender their HIV statistics to Settlers Hospital; they also help government in seeking to trace defaulters. Settler's Clinic retrieves files every day, and it contacts (by telephone) every patient who was supposed to come for an appointment but did not do so. If not reachable, the Clinic requests the assistance of Jabez and Hospice. Thus, these NGOs not only trace defaulters, but also help in establishing (and ensuring ongoing) contact between government health agencies and HIV-positive people who should be on treatment.

The local NGOs now also have a recent strategy that, if the clinic tests a female for HIV, the clinic refers her to the NGOs so that she can tell them about her partner. If the partner is not tested, they then try to arrange for the (male) partner to be tested. This strategy has only been in existence for a few month's now, with the assistance of Settlers Clinic.

3.4.2 Care and Support – Home Based Care and HIV Support Groups

There are two existing NGOs that the research studied that work on home based care. The first one was Grahamstown Hospice, whose core business is home based care, including providing free and compassionate care to patients with life threatening illnesses such as cancer, Motor Neuron Disease and Multiple Sclerosis (Hospice Annual Report, 2019). Increasingly, many patients have HIV (or HIV and TB) and Hospice is caring for such patients as well. Testing for HIV, and HIV prevention, is only a minor focus for the Grahamstown Hospice. Secondly, Jabez is a home based care centre based in Extension 9 and working amongst most poor communities in Makhanda (like Joza and Vukani) and also providing home based HCT and a support group for HIV positive people. This home-based care work of NGOs is seen as of great significance by the Department of Health, as it takes some of the burden off government clinics. Thus Clara from the Department of Health speaks of the importance of community-based support systems, claiming that:

> *I think what's also lacking at home it's the support system*. (Interview, 23/09/2019)

3.4.3 Education and Awareness

Raphael Centre, besides providing newsletters, uses newspapers by publishing regularly in the local *Grocott's Mail* newspaper as well as monthly hour-long broadcasts on Radio

Grahamstown (Raphael Centre, 2016:7). The telling of personal stories is very important for Raphael Centre when it comes to the use of media. However, their newsletters have not been translated into Xhosa. Their hope is that, in the future, they can have a couple of inspiring stories about the lives of HIV infected and affected people. Their aim is to be able to leave these stories at the clinics so that people, after reading them, can be educated about HIV and encouraged even in the face of HIV. More so, Jabez has been conducting awareness and ongoing education about HIV in the community and in the clinics coupled with health talks in person or via radio dialogues.

3.4.4 Prevention: Condom Distribution

All the participating NGOs are involved in condom distribution as a way of prevention of the spread of the pandemic. Ayanda from Jabez Centre (Focus Group Discussion, 26/09/2019) stressed that the Centre does not just distribute condoms but demonstrates how to correctly use the condoms. However, Memory, also from Jabez Centre, noted that the young boys are the main recipients of condoms since some women are afraid of the female condoms:

> *They say it's too big; even if you show them how to use it, they will say the male one is the better one.* (Focus Group Discussion, 26/09/2019)

This reiterates the point that, in Makhanda, the trend is for the female condoms to be under-utilised because people prefer the male condoms. However, in as much as it is important to provide condoms, this is not enough as "issues of power and inequality within the domestic context cannot be resolved with a condom" (Bujra, 2000: 20). In other words, prevention is merely one dimension of addressing the HIV pandemic, in particular the feminine face of HIV.

3.4.5 Asset Based Community Driven Development (ABCD)

The NGOs under study all in some way engaged in activities ranging from prevention to treatment and care. But the Raphael Centre's involvement in ABCD sets it apart. Raphael Centre is the only organisation that took into account the importance of having a sustainable income in addressing HIV. Some of the other organisations that aim to improve food and livelihood security to address HIV include the Umthathi Project, though I did not have an opportunity to talk to any one person in this initiative; and none of the other organisations talked about this NGO, leaving one to wonder if it still does exist (Rhodes University, 2016: para 1).

According to Jones (2011), most of the people living with HIV and AIDS (PLWHA) in Makhanda rely on social assistance grants. The HIV infected who are very ill are eligible to receive a Disability Grant but they are continuously tested every six months to ascertain whether their health has improved; if so, they lose their Disability Grant (Govender *et al*., 2015:2). This has led to some patients not taking their treatment, in order to maintain a low CD4 count so they are continuously considered for a disability grant (Jones, 2011). However, Clara from DoH alluded to the fact that, if a person is HIV positive and extremely sick, s/he can receive a disability grant whatever their CD4 count or viral load:

> *What they do is they look at you as a person in totality – if you are functional, if you are able to work irrespective of your CD4 count or your viral load. You must be there on your death bed, bed ridden and then they will assess and say maybe for the next few months* [you will receive the grant] *just to get you on your feet.* (Interview, 23/09/2019)

In the light of this, NGOs that work to economically empower people potentially play an invaluable role in helping address the pandemic in South Africa. In Makhanda, though, there seems to be a shortage of such initiatives except for Raphael Centre and its ABCD programme. According to Ava (from Raphael Centre):

> *ABCD is citizen driven, basically a strength based approach to growth, to progress. It basically looks at the strengths of an individual or a community and links this strength with opportunities that are out there.* (Ava, Raphael Centre, Interview, 18/09/2019)

Since the start of this programme, there have been a number of testimonials or personal stories about ABCD. One is about a single mother who has a talent for sewing and, with support from Raphael Centre, she has improved her household income and economic status (as a single mother) by way of a small sewing business in Extension 10.

Overall, ABCD provides training and helps to recognise and uncover the strengths of HIV infected people, brainstorming opportunities with them, and providing some basic project development skills which include formulating a vision, setting long term and short term goals, and instructing them about simple forms of budgeting. Through the ABCD, Raphael Centre has been working with youth, even in high schools with the permission of Principals, and has been receiving feedback indicating that people feel more self-confident and see positive prospects for their lives in the near future. After this training, they are expected to focus in particular on mobilising available resources to kick-start a small business enterprise.

Therefore, the work of NGOs in Makhanda is reasonably comprehensive. In the next section, I consider the interface between government and NGOs more fully, in relation to HIV.

3.5 HIV-NGOs and Government in Makhanda

Chapter 2 of the Non-Profit Organisations Act of 1997 discusses issues relating to the government's need to create an enabling environment for NGOs in which to operate. Clause 3 of chapter 2 notes that "within the limits prescribed by law, every organ of state must determine and co-ordinate the implementation of its policies and measures in a manner designed to promote, support and enhance the capacity of nonprofit organisations to perform their functions" (Non-Profit Organisations Act, 1997:25). Though this is commendable, the evidence from Makhanda, with specific reference to HIV (and HIV and gender in particular), demonstrates serious shortcomings in this regard in terms of what happens on the ground.

South African government departments, including the Department of Health and Department of Social Development in particular, are expected to use (and do use) NGOs as service delivery partners for certain activities relating to HIV and AIDS (Kelly *et al*., 2006:32). The government recognises that, alone, it is unable to effectively overcome the wide-ranging implications of HIV on South Africa and its population; thus, partnering with NGOs is seen as crucial. This is evident in cases where government invites NGOs to participate in government-initiated activities especially around health calendar days; and where it facilitates NGO work around the provision of HIV services to the community. In turn, when HIV NGOs pursue their own activities, they invite government to participate where and when appropriate.

In engaging with NGOs, Clara from DoH (Interview, 23/09/2019) says the department (with health specialists) does not want to monopolise skill-sets, so it tries to capacitate NGOs by involving their members in appropriate health-related training. The department also seeks to lay down guidelines in terms of HIV interventions so that these interventions (whether by government of NGOs) are standardised. According to Clara (Interview, 23/09/2019), government does not want NGOs to do "*their own thing*" in relation to the implementation of HIV programmes, either in their campaigns or services. In particular, it would be regrettable if NGOs acted in a manner which goes contrary to government's approaches around HIV. In this respect, government has its own reporting methodologies and indicators pertaining to the character of the HIV pandemic and the effectiveness of HIV programmes; and, ideally, NGOs should recognise this so that their evidence (gained form their practices) can feed into government's national HIV strategy and programme.

At first glance, it seems the government and NGOs in Makhanda are in a healthy relationship. Ayanda (Interview, 26/09/2019) from Jabez Centre felt that their relationship was a "*nice*" one. But problems do exist. Certainly, this is the perspective of HIV NGOs in Makhanda. In the case of Ava (Raphael Centre), government does not even recognise let alone

appreciate the significant work undertaken by NGOs including in seeking to empower communities. She thus argued:

> *An enabling environment starts also with acknowledging the work of NGOs and I have the feeling the government takes a lot of things for granted.* (Interview, 18/09/2019)

Memory and Ayanda from Jabez Centre concur with this, in indicating that NGO work is not taken seriously by government. Despite their strenuous efforts in addressing HIV in Makhanda, the government fails to acknowledge this with appropriate and sufficient funding:

> *They expect more from us but they don't give us enough funds. For instance, the money they give us for the OVCs* [Orphans and Vulnerable Children] *from Social Development* [is insufficient] *and then HIV also we are doing all* [this] – *bathing the patient at homes, and then taking their treatments from the clinic to homes.* (Focus Group Discussion, 26/09/2019)

Whether it is absence of funding, failure to acknowledge the work of NGOs, or even ignorance about the actual work that NGOs are undertaking, the perspective from NGOs in Makhanda is that the government is failing the non-profit sector. In the end, NGOs have the sense that government treats them as junior rather than equal partners in the quest to address the HIV pandemic.

Ava (Raphael Centre) noted that, in the past, they had worked with Makhanda Municipality in campaigns and that the NGOs would be involved in government HIV testing campaigns but that really has turned very quiet. Further, a recent meeting (in early 2019) was held to look into improving the communication between NGOs and the Department of Health, as the communication is irregular and haphazard. This was in large part an information-exchange meeting but Ava doubts if such a one-off meeting would in any strengthen communication channels over the long haul. She spoke to these problems:

> *In the past, the NGOs would often be involved in the testing campaigns you know but I haven't heard of anything like this in a very long time … It almost fell a little bit to sleep and here in Grahamstown, we have also worked in the past with Makana Municipality also in campaigns, yah but that really has turned very quiet*. (Ava, Raphael Centre, Interview, 18/09/2019)

3.6 Funding and HIV-NGOs in Makhanda

HIV-NGOs are either funded by the government (through the national fiscus or government's use of international donor funding) or directly by international donor and foundations. NGOs

in Makhanda partner with different government departments for specific projects (for example the Department of Health for tracing defaulters, and Department of Social Development for home based care) and funding is forthcoming on this basis. They also receive funding from the Foundation for Professional Development (FPD) for HCT, and the Networking HIV, AIDS Community of South Africa (NACOSA) for care and support, as well as other funding partners. This is because core funding from the government's national fiscus, which is available and provided annually, is never constant and is never guaranteed. Generally, HIV-NGOs in Makhanda experience great uncertainty around funding streams and, hence, organisational unsustainability is a constant pressure point.

This is clear in the case of Raphael Centre. In this regard, Ava highlighted that the Centre was simply unable to carry out any HIV interventions or services at the moment. Indeed, Ava is the only employee still remaining at the Centre, as all others have been retrenched. Thus, the issue of NGO sustainability comes clearly into focus. Gibbs *et al*. (2014: 114) reveal that HIV and AIDS projects and programmes often collapse "when outside funding, [and] supervision and support are withdrawn [by donors]", indicating how HIV-NGO work, as with all NGO work, is wholly dependent upon outside funding. This is the case whether the funds are coming from the South African government or aid agencies, including from funding NGOs such as the Ikhala Trust. Thus, the very existence of HIV-NGOs is always at risk.

Olivia at the Department of Social Development noted that there is in fact increasingly less funding from government for HIV work by NGOs. This is happening to such an extent that, in the year 2018, many of the well-established NGOs like Child Welfare and FAMSA had to retrench staff. They had to withdraw and use their savings to pay retrenchment packages and are now undertaking fewer services with less resources, such that their staff profiles may show evidence of lack of certain skills-sets. When contacted for interviews, both Child Welfare and FAMSA said that they no longer have any HIV programmes. Currently, the government departments only fund two NGOs in Makhanda which are Grahamstown Hospice and Jabez Centre. Ayanda from Jabez Centre said:

> *Even now we have got two funders. The organisation is funded by two separate funders, Social Development and then the FPD* [Foundation for Professional Development] *one. FPD funding is the one that we are using for the* [HIV] *testing but now it's going to stop in September this month, end of this month.* (Focus Group Discussion, 26/09/19)

The fact that these two NGOs still receive funding is of course advantageous to them. But the relationship between government and these NGOs does not appear to be based on equal partnership principles. Government tends to wield power over the NGOs, such that it imposes

terms and conditions for purposes of dispersing funding. It sets down the type of HIV programmes to be pursued by NGOs and, at times, how these programmes should be implemented. More generally, because of donor conditionalities, programme expectations are inflexible, such that NGOs are not always afforded the opportunity to be creative and innovative in their practices (Ropper & Pettit, 2003:18-20). In this light, despite having received government funding from the Department of Social Development in 2017, Raphael Centre decided to stop applying for and accepting annual government funding. Ava explained that government funding did not seem worth the effort, as it was an annual battle to be ensured of this funding. Further, NGOs often have to wait "*forever*" for the funding to be transferred to organisational accounts. NGOs almost become the mere executor of government programmes (as arms of the government) and therefore lose their character, identity and integrity. As well, in the words of Ava:

We actually also lost our voice. (Interview, 18/09/2019)

This becomes deeply problematic for HIV-NGOs, particularly if they wish to act as HIV advocates and push forward the HIV agenda in the public sphere.

Raphael Centre does continue to work with government on a more ad hoc basis, with funding involved. This includes collaboration through (government-NGO) project partnerships as well as applying for government tenders for contracted work. Olivia from the Department of Social Development applauds the Raphael Centre for adopting its stance:

> *I think this is where Raphael Centre made the brave step to say, 'thank you we don't want government money because this is not how we want to operate'. They are struggling because of that but the fact is that what we are saying to NGOs is 'be careful of whom you partner is as you need to have a fit'. Who your funder is must be somebody that has the same understanding, the same purpose…Money is power; if I'm the giver, I demand which doesn't make an equal partnership and an equal partnership is to realise that 'yes, I have the money but you have the skills, the knowledge; you have the people that you need to take care of so we need to add value to assets that is not monetary'* (Interview, 19/09/2019).

While the stance of Raphael Centre is remarkable in that it involves a challenge to upward accountability to donors (in this case, government), the subsequent consequences were quite devastating for the NGO.

Because of problems with government funding, HIV-NGOs have sought to rely more heavily on other funding sources and streams. In this context, there has been significant international funding of NGOs in the post-1994 period for work on HIV and AIDS, thereby

providing practitioners working on gender with a potential source of funding (Manell, 2010:319). But, in recent years, the international funding basket has lowered, including for even gender-based interventions. From Manell's (2016) research, funding for projects in South Africa is dropping apparently because of its status as a "middle-income country" under the classifications established by the World Bank. Thus, since 1994, funding for South African NGOs has continuously dropped leading to some NGOs struggling to continue their work due to financial constraints and, in some areas, this has led to competition over government's inadequate funding (Marx *et al.*, 2018:3; Budlender & Mbere, 2000:5).

This has had ramifications in Makhanda. The studied NGOs in Makhanda have been struggling financially, to the extent of not being able to pay their staff and stopping the rendering of certain HIV services. As Eugene and Memory from Jabez Centre noted:

> *People were supposed to get paid yesterday* [but] *they didn't get paid. It hurts us! It's the second month now* [without pay], *but they* [staff] *are* [still] *working.* (Focus Group Discussion, 26/09/2019)

Additionally, in an interview with Buhle from Settlers Day Clinic (01/10/2019), she revealed that funding for NGOs remains very difficult. She highlighted that Grahamstown Hospice had to stop their services at the clinic at the end of September because of funding constraints. The workers from Hospice would continuously visit the clinic, through their HCT programme partnership, but they stopped going at end of September indicating that their contract had not been renewed. This seems like Foundation for Professional Development (FPD) funding, because Jabez Centre also said that their FPD funding would end in September. Also for Jabez Centre, their Orphans and Vulnerable Children (OVC) funding from the DSD ends in March 2020.

Funding constraints hence affect NGO work in the HIV field and this leaves NGOs, even those committed to addressing HIV vulnerabilities for women, with no budget for the work. They may end up rather pursuing the thematic areas that the government funds, though even this is a problem. In this regard, Ava and the team from the Raphael Centre had planned an event for women, which was unsuccessful due to funding:

> *For Women's Day, unfortunately this year, we didn't have the funds. But we actually wanted to do a flash mob with a little podium where we have 4 speakers at the podium; women, actually, who share stories of how they overcame very critical moments. I think they are too little stories told by women who actually managed to get out of abusive relationships and they are women that were infected by HIV and but today are employed, they are married, they have a child.* (Interview, 18/09/2019)

In a study commissioned by the Open Society Initiative for Southern Africa (OSISA) examining the funding trends to civil society through resource flows to NGOs and community-based organisations for HIV and AIDS in southern Africa, Birdsall and Kelly (2007) found out that funding to is mainly in favor of service delivery, with only one per cent of funding awarded for advocacy or rights-based campaigns. Clearly, this indicates the small funding resources for the type of activities needed to tackle women's oppression and the disproportionate burden of HIV for marginalised women. What is clear, as well, is that the situation has not improved since then, at least for NGOs in Makhanda.

3.7 NGOs, HIV and Downward Accountability

Academic literature has exposed how involvement of the recipient communities is essential in the development work by NGOs (including HIV). Effective programmes are those that are crafted in consultation with the community in question and take into account the importance of having the local people participate and voice out their concerns in what they consider important. Thus, the communities must be consulted and engaged as 'agents of social change' to ensure downward accountability (Mantzaris & Ncobo, 2007:24).

In this regard, the HIV NGOs in Makhanda indicate that they involve the community in coming up with their ideas but in actual case this is in exceptional cases. Emma (Interview, 20/09/2019) from Grahamstown Hospice was upfront in saying that the NGO usually decides on which projects they want to pursue, and they then pitch this to funders. In doing so, they try to ensure that they obtain funds for their own priorities, rather than to simply take whatever funding is on offer. At the same time, engagement with the community with regard to Hospice programmes is minimal, in part because of the costs involved in seeking to consult widely with community members. In this sense, in its relationship to the community, the Hospice tends to be self-referential by not including, in any vigorous manner, the voice of the people they claim to represent.

Ava (of Raphael Centre) said they did not consult the communities even at the proposal stage. Instead they have strategic planning meetings, once a year, normally starting with a reflection on the past year and so this is how they decide on which activities to fundraise for during that current year. However, to improve downward accountability, they are in the process of developing questionnaires to get feedback from their beneficiaries which they will use then to decide, as an organisation in their strategic planning meetings, which programmes to

execute. Ava thinks that their future plan of using questionnaires will ensure that the beneficiaries contribute in deciding their programming:

> *So ideally the people we work with will have a big contribution in this* [deciding on programming]. (Ava, Raphael Centre, Interview, 18/09/2019)

So until that is done, the Centre is the one deciding and planning on which programmes to execute.

Ayanda from Jabez Centre (Interview, 26/09/2019) said that, since their organisation has offices in the community where they work, they know the issues facing the community through community dialogues and their door-to-door activities. The challenges around HIV which are highlighted by community members are then discussed between management and care workers in Jabez, upon which strategies and programmes can be based.

Admittedly, because this research on Makhanda did not entail interviewing beneficiaries, it is not possible to come to any definitive conclusions about the form and extent of downward accountability amongst the three NGOs. Indeed, it may vary between the NGOs. It is also the case that, because NGOs are expected to align themselves with the strategic and programmatic expectations of government, their capacity to engage with communities in bringing about innovative projects around women and HIV is foreclosed from the very beginning. A further point relates to the actual need for NGOs to engage in in-depth participatory methodologies in relation to communities, given that the HIV pandemic seems to be taking the form of a humanitarian crisis in South Africa which, more than anything else, needs urgent interventions by NGOs and government. Nevertheless, the pandemic has long-term development impacts and it is deeply animated by entrenched gender-based inequalities – for this reason alone, it is crucial to craft responses in line with needs identified by local communities and to adapt existing approaches to the particular context, thus establishing relevant responses (White & Morton, 2005: 198).

3.8 Government, Women and HIV in Makhanda

Often times, even when projects are initiated on the basis of gender equity principles, they do not fully empower women and adequately shift the power relations between men and women (Tallis, 2000:58). While there is a "growing acknowledgment of the interface between HIV and AIDS and gender inequality amongst those working in the field, much still needs to done to translate this into effective action" (Tallis, 2012:66). This section seeks to examine whether

the existing HIV activities by government in Makhanda take into account HIV vulnerabilities for women, if at all. After this, NGOs will receive more sustained focus.

A primary concern from Ava (from Raphael Centre) is that, despite attempts by government to tackle the feminisation of HIV at national level, at local government level it lacks ethical and strong leadership and perseverance, including strategic coordination and communication with NGOs – for Ava, the government/NGO interface is crucial for effective work around women and HIV. Even from the local government's side, when asked what the government does in addressing gender inequality as a determinant of HIV vulnerabilities for women, Aphiwe from DoH had to say:

> *It's not being addressed, let me not lie. It's just done partially, as I said, when we are doing those campaigns. It's not being specifically addressed, it is not.* (Aphiwe, DoH, Interview, 25/09/2019)

Additionally, my analysis of the Integrated Development Plan (IDP) of Makana Municipality (under which Makhanda falls), alongside indicators of what has been done to address women's challenges, indicates a lack of commitment in this area. The Municipal Systems Act (No. 32) of 2000 requires that local municipalities prepare IDPs that serve as tools for the facilitation and management of development within the areas of jurisdiction (Makana Municipality IDP, 2017-2022: 14). Makana's current IDP does not, however, fully mention HIV issues and the plans put in place to tackle the problems associated with HIV. The lack of a strategy for municipal-level HIV and AIDS responses seems like a recurring problem, and having the official IDP being insufficient in its HIV and AIDS components is worrisome.

However, Olivia from the Department of Social Development (Interview, 19/09/2019) notes that there are various women-centric programmes undertaken by government, including the victim empowerment programme that deals with the victims of gender based violence. Additionally, there are HIV and AIDS programmes (as noted earlier) which focus on people (including women) who are infected and affected by HIV and AIDS. Olivia also noted the ongoing emergence of a woman development policy and programme in South Africa that focuses specifically on women's empowerment and gender equality – this in the process of being finalised, at a national and provincial level, and it is meant to mainstream women's issues (including around HIV) across all government programmes. At the same time, Olivia admitted the existence of significant difficulties and challenges in seeking to bring this about. Lastly, as Olivia noted, DSD seeks to mobilise and bring together women to talk about issues and problems which they are facing. In the case of the Sarah Baartman district (in 2018) at least,

this also involved women within the LGBTQI community who self-identify as women, although this was not exclusively for HIV purposes and included a broad range of issues.

The DSD, as well, has a women empowerment programme where they specifically train women on life skills, and business and technical skills, to help them to become economically independent by, for instance, establishing cooperatives. At times, the department also funds the cooperatives to ensure some level of viability from the beginning. This initiative, as Olivia says, is taking place on a very small scale in Makhanda. In this light, DSD claims that it is currently working to establish women's forums at local level, where women can talk about their issues (including HIV and women). This would include the involvement of NGOs, as NGOs are rendering many services and because joint action by government and NGOs on the HIV front is crucial. Again, though, this process is taking place at a very slow pace (Olivia, DSD, Interview, 19/09/2019).

Despite these programmes, either in place or in the pipe-line, it was noticeable that the NGO interviewees almost had to scratch their heads (literally) to think about and identify the programmes that government had in place locally in Makhanda, in relation to gender inequality and HIV – this, of course, is very telling. It seems that, apart from the activities in which they partner with government, as well as campaigns such as First Things First, there may be only limited knowledge amongst NGOs on the details of what government has done and is doing with regard to the feminisation of HIV in Makhanda. This might reflect merely ignorance on the part of NGOs or a minimal effort on the part of government when it comes to women and HIV. Whatever might be the case, it is now important to examine NGOs specifically, to consider their attempts to overcome the challenges that women in Makhanda face in the light of the HIV pandemic.

3.9 Women and HIV-NGOs in Makhanda

From the work described earlier about NGO activities around HIV in general, it is clear that NGOs are engaging in significant efforts in the HIV field, with some of them (like Jabez Centre) directly emerged in the communities they serve. However, of great concern is that, in Makhanda, and despite the consensus that women are infected and affected more often than men by HIV, there are no existing NGOs that are deliberately, specifically and intentionally working on addressing gender inequality as a determinant for HIV vulnerabilities for women in Makhanda. Most NGOs, often with government funding, focus on home based care and HIV counselling and testing, alongside more limited work around prevention (in the form of

dialogues and condom distribution). The two NGOs, the Jabez Centre and Grahamstown Hospice, studied which are currently being funded by the government have HCT and home based care programmes in common. This is important, but the government needs to extend its funding scope if HIV, including around women in particular, is to be adequately addressed in Makhanda. Failure to do so means that there are factors and challenges preventing a more comprehensive response in countering HIV in Makhanda (Muula, 2008:423).

Overall, the three NGOs participating in this study are quite upfront in saying that they are not properly and sufficiently working against gender inequality in HIV, and that there is still a long way to go in this respect. However, even without an intentional and directed focus on women and HIV, these NGOs (like government itself) implement HIV programmes which in some way recognise (at least implicitly) the feminisation of HIV. These include home based care programmes which assist women who are affected by HIV. Cultural norms leave women and girls as the primary caregivers in Makhanda communities and homes, therefore they are required to take care of family and community members who fall ill from HIV. From this angle, NGOs like Grahamstown Hospice and Jabez Centre are doing important work by ensuring that women are not under unbearable pressure and facing the care of the HIV infected alone.

Furthermore, Ava (Raphael Centre) says that women, because they are more likely to be HIV infected and affected, are invariably given more attention in its programmes and thus are the main beneficiaries of their work; for instance, in one HIV programme, there are only 5 or 6 men but 25 women. Again, this is in large part because women are considered as domestic caregivers – in other words, when engaging with households, Raphael Centre depicts women as the key point of engagement. The higher concentration of women in its programmes may also reflect the fact that women are more prone than men to be economically inactive or unemployed (and thus at home when Raphael Centre makes visits). Such programmes did not originally intend to work with women specifically. Though this type of intervention implies reinforcing the patriarchal-based division of labour (as women are associated with the domestic sphere), and perhaps it reproduces the vulnerabilities of women as well, this does not deny the value of this NGO work. Ava put the matter this way:

> *There is still a huge gap here in Grahamstown. An organisation that would really just focus on that* [women and HIV] [would be important], *and I really hope that in the future, maybe, if it's not us but maybe someone else actually works a little bit more on this.* (Ava, Raphael Centre, Interview, 18/09/2019)

Despite FAMSA Grahamstown claiming that it no longer runs HIV programmes, Ava (Raphael Centre) was of the understanding that it still offers trauma counselling in relation to

gender-based violence in the domestic sphere. It is regrettable, however, that there no longer appears to be a local NGO which specialises in gender-based violence and HIV, as this violence is a key social condition contributing to women being both HIV infected and affected.

In the case of ABCD, the emphasis is on the public sphere and incorporating women more fully into productive activities in the economy. The nurturing of skills and talents of women, and facilitating their pursuance of informal economic activities, would provide a basis for women becoming more independent financially vis-à-vis men and husbands. However, it is deeply worrisome to note that the NGO associated with the programme (Raphael Centre) is on the verge of collapse because of lack of funding, as discussed below.

NGOs in Makhanda have done important work around HIV, but there is no explicit and clearly-formulated gender-based perspective and strategy. Insofar as women are 'targeted', this at times seems to arise only because they happen to have a higher rate of HIV infection than men. The particular ways in which HIV impacts on the lives of women, such as their burden of caring for the HIV infected, is addressed by for instance enhancing women's capacity to provide home-based care, but this does not entail a critique of the domestic division of labour. The ABCD initiative, though also focusing on women, is based on a gender-neutral perspective about economic self-reliance and the significance of integrating women (as unemployed people, rather than as women) more fully into productive economic activity. Without wanting to appear totally unsympathetic to these interventions, HIV-NGOs in Makhanda have not fully reflected upon and examined the multi-faceted vulnerabilities which women experience daily, at least from a gendered viewpoint.

At the same time, all NGO interviewees agreed and accepted that women are infected and affected more than men by HIV at a national and local level. Failing to act out this recognition may be a reflection of many challenges faced by these NGOs – including lack of organisational capacity (including operational and analytical capacity) and as well insufficient donor funding or the character of donor funding priorities). Challenges related to funding can be said to have led to a relative absence of NGOs working on HIV in Makhanda. Kelly *et al*. (2006: 12-13) indicated that through an audit conducted by Centre for Aids Development, Research and Evaluation (CADRE) in 2003/4, 30 civil society organisations were involved with AIDS response activities in the now Makhanda. However, l could not identify more than 8 HIV NGOs through snowball sampling, indicating how there was a decline of NGOs working on HIV. As well, the sheer scale of the HIV pandemic in Makhanda is overwhelming, such that HIV-NGOs (as well as government) are only able to skim the surface when it comes to tackling the pandemic.

One of the key problems in local NGOs around HIV in Makhanda is the absence of a gendered perspective, in the sense of highlighting not just HIV and women, but HIV and gender more broadly, thereby recognising head-on the prevalence of gender-based inequalities and the role that men play in making women vulnerable. Ayanda from Jabez Centre and Ava from the Raphael Centre, respectively, seem to see this approach as an important way forward:

> *I think this* [addressing women's vulnerabilities] *would require an NGO for men that can tackle issues of dominance and masculinities. This way men can talk men things and discuss issues of men's behavior because men are so stubborn, they don't want to listen to females. They prefer men to men dialogues and initiatives.* (Focus Group Discussion, 26/09/2019)
>
> *I honestly wish we could move in the future a little bit more towards also doing gender work and a little more about SRHR* [Sexual and Reproductive Health and Rights]. (Interview, 18/09/2019)

Broadly, there is a consensus amongst NGOs that insufficient attention is being paid to the feminisation of HIV in Makhanda, and there are thoughts about the need to adopt a more gendered perspective. However, to ensure that this takes place will require a much more vigorous presence of well-funded HIV-NGOs in Makhanda, with heightened organisational capacity and with meaningful embeddedness in local communities.

3.10 Conclusion

This chapter examined the role that NGOs are playing in Makhanda in addressing HIV, including the extent to which their programmes consider HIV related vulnerabilities for women. Of importance was detailing the activities of government at local level in Makhanda, and how NGOs and government at times enter into partnerships to address the pandemic and its effects on women. Overall, though, there seems to be an absence on the part of NGOs of any well-established and deep-rooted intentional to counter the feminisation of HIV, including the patriarchal basis for women's vulnerabilities. In an effort to explain this, at least in part, the chapter focused in particular on the challenges faced by NGOs with regard to upward accountability to donors, and how the organisational sustainability of NGOs depends quite fundamentally on donors, whether private donors or government. This predicament became evident in the case of NGOs in Makhanda, with Raphael Centre for instance on the verge of closing.

Chapter 4: Conclusion

4.1 Introduction

This study sought to critically analyse the role played by NGOs in addressing HIV in the context of gendered inequality, with specific reference to Makhanda in the Eastern Cape Province of South Africa. Chapter two revealed how NGOs in South Africa, as part of the worldwide development system, engage in work around the HIV pandemic. They do so in a manner which seeks to complement the work of the South African government, while simultaneously being heavily reliant on funding from donors (which includes government). While there is significant literature on the work of HIV NGOs in South Africa, this study sought to contribute to the literature which focuses specifically on addressing HIV in the context of the feminisation of HIV and the manner in which gender inequalities lead to greater risks and vulnerabilities for women in terms of being HIV infected and affected. Chapter two also discussed feminist theories, which highlight the character and depth of gendered inequalities. This is important as it facilitates an examination of the ways in which, and the extent to which, HIV NGOs manage to undercut the existence of gendered inequalities. No literature on HIV and women exists in the case of Makhanda, and hence the significance and relevance of this particular study. Evidently, with the growing acknowledgement of the feminisation of HIV in South Africa, it has become of utmost importance to appraise the work of HIV NGOs in this light, and this is most aptly done by studies focusing at local level.

Broadly, then, this study explored and examined the various forms of gendered inequalities that leave women vulnerable to HIV, and then demonstrated the work of HIV NGOs, showing how the NGO-donor and NGO-government (at all levels) relationships have influenced the work of NGOs in addressing gendered inequalities in the HIV context. In the end, despite their seemingly best efforts, Makhanda HIV NGOs are marked by a number of limitations and challenges that have led to them, in most instances, implementing gender blind programmes even with the full knowledge that women are disproportionately affected by HIV. Therefore, in the following sections, and drawing upon the case study (chapter three), I reconsider the main and subsidiary objectives of the study to show how the case study addressed these objectives. The chapter also hints on areas that might need intensive research in the future.

4.2 Addressing the Subsidiary Objectives

To remind the reader, the subsidiary objectives of the thesis are as follows:

- To identify and understand the organisational programmes and practices of HIV NGOs in Makhanda in relation to HIV prevention and care;
- To examine the ways in which HIV NGOs consider the relevance of gendered inequalities in their HIV programmes and practices;
- To determine ways in which donor funding influences HIV NGOs' programming with reference to the feminisation of HIV; and
- To assess the attitude and practice of the South African government as an HIV NGO donor, partner and a policy maker in addressing HIV, particularly HIV vulnerabilities faced by women in Makhanda.

In addressing the first subsidiary objective, chapter three examined in detail the programmes and activities which NGOs pursue in responding to HIV in Makhanda. Some NGOs, which were known to work in the HIV field in Makhanda in the past, are no longer actively working on HIV issues, and there is evidence of decline in the intensity of HIV work on the part of others. Despite this, the HIV NGOs currently operational in Makhanda implement a number of programmes. These include prevention programmes, such as condom distribution and HIV counselling and testing, education and awareness programmes (with the use of community dialogues, newsletters and health talks on radio), which all NGOs studied implement. For HIV care and support, Makhanda HIV NGOs employ the use of home based care (with Hospice and Jabez Centre being active on this) as well as HIV support groups. Raphael Centre, which is on the verge of collapse, had an Asset Based Community Driven Development (ABCD) programme which sought to financially uplift the HIV infected and affected.

With reference to the second subsidiary objective, the study interrogated the programmes implemented by the NGOs, to determine whether they consider the need to tackle gender inequalities as a way of addressing HIV vulnerabilities for women in Makhanda. Doing so would be crucial, as chapter three showed that women in Makhanda (as elsewhere in South Africa) experience inequality along economic, social and cultural lines. Overall, women in Makhanda are facing deep levels of poverty and unemployment, and the socio-cultural environment continues to infringe on their rights vis-à-vis men. Despite alluding to the fact that females are HIV infected and affected more than men by HIV, and even noting some of the factors that leave women vulnerable to the HIV pandemic, all NGOs were explicit in indicating

that they do not address gender inequality in their HIV work. By analysing the NGO programmes, the study concluded that there is no clear intention and deep commitment on the part of Makhanda HIV NHOs in terms of confronting the social, economic and cultural inequalities that leave women vulnerable to HIV. Though addressing gender inequality is not intentional, home based care does tend to highlight how women are affected by HIV in local communities, but only because – culturally – they are considered as key caregivers. More so, ABCD by Raphael Centre tackles the economic positioning of people (including women) though, because of funding, the Centre is not actively engaged in this.

In pursuing the third subsidiary objective, it is clear that NGOs are highly dependent upon funding from donors (local and international), and that funding for their work is becoming increasingly scarce, leading to competition between NGOs for donor funding. As an illustration, because of funding constraints, Raphael Centre is currently not operating, the Jabez Centre is having trouble paying its employees on time, and Child Welfare and FAMSA no longer have any HIV programmes and have retrenched some employees. In addition, there has been a continuous and sharp decline in the number of NGOs working on HIV issues in Makhanda and, as of 2019, there is barely a handful of HIV NGOs operating. This has affected the number of initiatives that HIV NGOs (as a sector) can possibly address, including gender inequality initiatives if they were so inclined to pursue these.

Moreover, funding is characterised by issues of power and the setting of conditions by donors, which does not allow NGOs flexibility and creativity in executing their work. As a result, the NGOs are not fully involving communities in coming up with solutions to fight HIV; instead, they tend to follow the donors' priority areas of funding. Nevertheless, it is quite likely that the most innovative solutions to the HIV pandemic could arise from the HIV infected and affected, as they understand their situation and what exacerbates the pandemic in their context. The study shows that this has left Makhanda NGOs being upwardly rather than downwardly accountable, for reasons that include ensuring survival of their organisations through continuous funding. Thus, despite being at the coalface of the HIV pandemic, NGOs are left with minimal power and voice in relation to the content of their work.

In terms of the fourth and last subsidiary objective, the government plays a central role as a policy maker, a donor and a partner in the HIV response. Findings reveal that the government implements activities independently of NGOs (such as education and awareness campaigns) and in partnership with NGOs through activities such as HCT (providing NGOs with testing kits, setting guidance rules and tracing of defaulted clients) and home based care. However, there is often a gap or disjuncture between the government and NGOs in tackling

HIV in Makhanda, with neither fully knowing nor even appreciating the work of the other. This means, for instance, that the government is not in a strong position to fully capacitate HIV NGOs in the Makhanda context, even if willing to do so. Significant levels of funding for HIV NGOs come directly from government. For example, the Department of Health funds Grahamstown Hospice and the Jabez Centre through the home based care programme. However, issues of inconsistent and unreliable government funding affect NGOs detrimentally, leading to considerable frustration on their part. Also, despite the NSP 2017-2022 calling for a focus on adolescent girls and young women (as they are the most infected and affected), this initiative and the many HIV initiatives of government at local level in Makhanda do not appear to be based on a deep sensitivity and understanding of the feminisation of HIV – as, I argued, is also the case with the HIV NGOs in Makhanda.

Therefore, the thesis managed to address the four subsidiary objectives by showing what NGOs are doing in terms of HIV prevention and care, interrogating how their programmes may or may not tackle women's vulnerabilities, examining how donor funding has affected their work and, lastly, showing how their relationship with the government has influenced their HIV work. In doing so, the main objective of the thesis has been indirectly addressed.

4.3 Addressing the Main Objective

The main objective of the thesis is to critically analyse the role played by NGOs in Makhanda in addressing HIV in the context of gendered inequality.

It is certainly the case that the HIV NGOs in Makhanda do not consistently, if at all, understand their work from a clearly-articulated feminist perspective; as I discuss below. At the same time, it should not be concluded that a failure by NGOs to address HIV in Makhanda in the context of gendered inequality can be fully explained in terms of the absence of a feminist approach to their work. Even if a fully-formed feminist perspective informed the work of the HIV NGOs in Makhanda, this would not imply that this perspective would be embedded in their organisational programmes.

In this regard, the study unearthed certain challenges faced by HIV NGOs in Makhanda with regard to tackling the HIV crisis broadly. These broad challenges include the sheer intensity of the pandemic's existence and implications. It appears that the NGOs are so overwhelmed by the multifaceted and widespread implications of the pandemic, that seeking to focus more specifically on HIV, women and gender might be an unnecessary or unwanted burden. The HIV NGOs are simply over-stretched in terms of organisational capacity. Further,

their relationships with both government and donors do not provide even the necessary enabling conditions to address the HIV pandemic in general, let alone a concentrated focus on the feminisation of HIV. Hence, the failure to address the feminisation of HIV by the HIV NGOs is irreducible to the absence of a feminist perspective, which is an important finding of this study.

Nevertheless, it remains the case that a feminist perspective is not ingrained in the worldview of the HIV NGOs in Makhanda. This is important, because the study shows that a variety of socio-economic and cultural factors leave women in Makhanda vulnerable to the pandemic with men being in positions of dominance and power. Feminism explains gendered inequality (or patriarchy) as a phenomenon of women being controlled and subjugated by men in various structures of society (Koester, 2015; Allen, 2016), both in the public and private spheres.

Women (especially black African women) in South Africa face poverty, in an environment where there are high unemployment rates, and in a situation in which men are still seen as dominant within the public sphere, including in the economy: a point raised in various ways by socialist and African feminisms. Even when incorporated into the public sphere, this happens in a subordinate manner for women. Further, the idea that women in large part should be confined to the domestic sphere (as a point emphasised by radical feminism) prevails in South Africa. This relative powerless of women, and the gendered inequalities it generates, leads to women being infected and affected by HIV on a more pronounced basis than men. It is important to highlight that this gender-based differentiation has both economic and cultural dimensions. Further, the issue should not be framed in terms of women and HIV, but in terms of gender and HIV, so as to emphasis the character of patriarchy as a relational concept.

Through an examination of NGO activities in Makhanda, in isolation or in partnership with government departments, the study has shown how the currently-operating NGOs in Makhanda are not deliberately considering women's vulnerabilities in tackling HIV and AIDS. In fact, the work of NGOs may simply reinforce these vulnerabilities. For instance, focusing on women when it comes to home-based care reproduces the gendered division of labour, as it equates women with care work as if there is an almost natural connection drawn between women and the domestic sphere. Further, when it comes to the public sphere (and specifically the economic sphere), the only noticeable initiative was the ABCD programme of Raphael Centre. This programme tends to integrate women into the economy without any recognition of the ways in which the labour market in South Africa is deeply segmented, including along gender lines. For this reason, it slots women into lower segments of the economy (including

the informal economy). Its capacity to empower women vis-à-vis husbands and senior males at household level, by enhancing their control over resources and perhaps therefore their bargaining power, remains unclear.

4.4 Areas for Further Research

Despite the critical examination of the HIV NGOs in Makhanda, in particular from a feminist perspective, this does not deny the important work that these NGOs undertake given the sheer level of the HIV pandemic in Makhanda. Nevertheless, it is crucial that further work, focusing on HIV NGOs in relation to gender inequality, be forthcoming because of the widespread recognition of the feminisation of HIV. In particular, it would be useful to consider more fully (than this thesis) the relationship between HIV NGOs and the people and community with whom they work, so as to offer a fuller account of the organisational activities of these NGOs. Further, this study also noted that the LGBTQI community in Makhanda face challenges in the HIV context. They are at risk of infection because of the alleged rape cases that are said to be happening in Joza. Further research, focusing specifically on LGBTQI, is needed to determine the HIV vulnerabilities they face and how best they can be helped by NGOs.

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Appendix A – Consent Form

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Name of Researcher: Moreblessing Mavhika

I am a Master of Development Studies student at Rhodes University undertaking an academic research on –the role of Non-governmental organisations in addressing HIV and AIDS in the context of gendered inequality in Makhanda. I kindly request for your participation in the interviews. It will take no longer than 45 minutes of your time. I would, thus like to kindly ask you to spare your time with me and respond to my questions as honestly as you can. I have confidence that this research will contribute to the useful information that will assist organisations who might be interested in this area of concern.

The information you contribute is completely confidential and it will be treated with anonymity and your name will not be mentioned in the findings. Participation is voluntary and in case of you choosing not to take part in the study you will not be affected in any way. Also, in case that you agree to participate and if you feel like you want to withdraw, you are free to do so and you are not subjected to any form of penalty and will not be victimized in any way.

Declaration

I confirm that the purpose of the research and the nature of my participation has been explained to me verbally and in writing.

I voluntarily agree to be interviewed for the research on the role of non-governmental organisations in addressing HIV/AIDS in the context of gendered inequality.

I understand that I can withdraw from this research at any given time should I not want to continue and that this decision will not in any way affect me negatively.

I know that this is a research project whose purpose is not necessarily to benefit me personally.

I have understood that my answers will be treated with confidentiality.

…….

Participant's Signature Date……

I hereby agree to the tape recording of my participation in the interviews

……

Participant's Signature Date…….

Appendix B - NGO Interview Schedule

-Greetings and introduction.

-Researcher explains about confidentiality and anonymity.

-Use for academic purpose only.

-Ask for permission to switch on audio recorder.

Interview questions for NGO Staff

1. How long have you been with the NGO?

2. I have noticed that from some of NGO reports available like the Raphael Centre notes that HIV infection rate is high amongst women. What are some of the reasons you are aware of which leave women infected and affected more than men in South Africa and Makhanda in particular?

3. One scholar, V.Tallis considers gender inequality as perhaps the main problem area impeding HIV and AIDS prevention. Do you or your NGO share the same view and why?

4. What are the existing strategies, both government and non-governmental, to address women vulnerability to HIV in Makhanda that you know of?

5. What is your opinion about the effectiveness of government intervention and strategies to reduce women's vulnerability to HIV and AIDS?

6. Are there activities and projects that you have partnered with governmental departments or institutions that you can tell me of? What is your opinion on the government-NGO partnerships? (Probe: Do you think the South African government has created an enabling environment for HIV NGOs to operate?)

7. The Khanya Report by Raphael Centre notes that focusing on HIV testing and counselling alone does little to improve HIV-prevention and health outcomes. Please can you tell me,in detail, of programmes or activities that have been used by your NGO to address HIV in Makhanda?

8. Do you consider gender a cross cutting issue in your HIV programming or are there any specific activities that you use to address gender inequality as a means of addressing HIV related vulnerabilities for women that you can tell me about?

9. Are there any requirements for one to be eligible to the programs/activities?

10. Are there any challenges, other than funding, that you face in implementing your work as an HIV and AIDS NGO? If yes, can you please share?

11. It seems you get most of your funds locally with instances of international funding. Would you say funding is your biggest challenge in tackling women's vulnerability to HIV and all your work in general?

12. When your donors give you funds, do they already have their own expectations and ideas on how you are supposed to use that money? How do you manoeuvre around their expectations and your beneficiaries expectations in the implementation of your work?

13. Do you have any last comment, contribution or question?

Appendix C – Focus Group Schedule for Jabez Centre

Greetings and introduction.

-Researcher explains about confidentiality and anonymity.

-Use for academic purpose only.

-Ask for permission to switch on audio recorder.

Focus Group Questions

1. How long have you been with the Centre and which position do you occupy?

2**.** I have noticed that from some of NGO reports note that HIV infection rate is high amongst women? Why do you think women are the most infected and also affected by HIV and AIDS than men?

3. V. Tallis notes that gender inequality is the main problem when it comes to addressing HIV. Do you personally, or the Centre share that view?(Probe: Why do you think males don't want to be tested?)

4. What are the existing strategies to address women vulnerability to HIV and AIDS in South Africa, Grahamstown in particular that you know about?

5. As a Centre are there any activities that you have partnered with any government departments?

6. What is your opinion of the government-NGO partnership in Makhanda?

7. Which communities do you work in? (Probe: Would say you are in a better position to serve the community because you are actually in the community?)

8. Do you think the SA government has created an enabling environment for NGOs to operate?

9. You said you do HTC. I read that HIV Testing and Counselling does little to address HIV? Is there anything else that you do besides what you have already talked about?

10. Do you consider gender a cross cutting issue in your HIV programming or are there any specific activities that you use to address gender inequality as a means of addressing HIV related vulnerabilities for women that you can tell me about?

11. Would you say there are any requirements for one to take part in your activities?

12. Do you do Home based care?

13. What do you think about the government intervention and strategies to reduce women's vulnerability to HIV and AIDS in Makhanda?

14. Are there any challenges that you face in implementing your work as an HIV/AIDS NGO? If yes, can you please share?

15. Do you also face any funding challenges? (Probe: Are your financial issues dealt with here or at some office somewhere else?)

16. Have you ever applied for government funding? (Probe: Would you say your partnership with the government is unequal?)

17. Have you ever tried international funding?

18. When you do your programs do you ever consult the community?

19. I asked you about the existing strategies the government is implementing and you don't know?

20. In Makhanda there is a high rate of unemployement? And if you say the government is doing well, when addressing HIV requires a holistic approach, and there are no jobs here, what do you mean?

21. What recommendations would you give in order to fight HIV efficiently in Makhanda?

22. What king of programs should be initiated to address women's vulnerability?

Appendix D - Interview schedule for Government Departments

-Greetings and introduction.

-Researcher explains about confidentiality and anonymity.

-Use for academic purpose only.

-Ask for permission to switch on audio recorder.

Interview questions

1. How long have you been with the Department/Clinic and which position do you occupy?

2. From much of the Government communication on HIV and the National Strategic Plan 2017-2022, it is noted that HIV infection rate is high amongst women? Why do you think women are the most infected and also affected by HIV and AIDS than men in Makhanda?

3. What are the existing government strategies and programmes to address HIV and AIDS in South Africa, Makhanda in particular that you know about?

4. V Tallis, who considers gender inequality as perhaps the major challenge in fighting HIV/AIDS. Do you personally, or the Department/Clinic share that view and why?

5. What activities do you use as a government department/clinic to address gender inequality as a means of addressing HIV related vulnerabilities for women? (Probe: Do you consider gender a cross cutting issue in your HIV programming or are there any specific activities that you use to address gender inequality as a means of addressing HIV related vulnerabilities for women that you can tell me about?)

6. Are there any requirements for one to be eligible to the programs/activities?

7. How do you decide on the HIV programmes to implement? It seems PEPFAR has put in a lot of funds for the HIV and AIDS fight in South Africa, would you say decisions on programmes you implement are already made by such donors when you get your budget for the year?

8. Besides PEPFAR, are you aware of any other donors who fund your work? Other than donors, how do you get other funds? Does the government set aside funds for HIV programmes in every Province or sub-district?

9. What do you think about the effectiveness of the government intervention and strategies to reduce women's vulnerability to HIV and AIDS? (Probe:What would you consider some of the successes thus far in your work?)

10. What do you think of the role of NGOs in addressing HIV and HIV related vulnerabilities for women in Makhanda? (Probe: Do you think the South African government has created an enabling environment for HIV NGOs to operate?)

11. Are there activities and projects that you have partnered with NGOs in Makhanda that you can tell me of? What is your opinion on the government-NGO partnerships when it comes to addressing HIV?

12. It seems South African government tries to fund most of its HIV programmes through departments and NGOs but these funds are not enough that is why some NGOs apply for international funding. Would you consider funding a challenge in implementing HIV programs that seek to address the vulnerability of women?

13. What are other challenges that you face in implementing your work as a Government Department?

14. Do you have any last comment, contribution or question?