THE ROLE OF COMMUNITY-BASED ORGANISATIONS IN RESPONSE TO HIV/AIDS IN BOTSWANA: THE CASE OF GABANE COMMUNITY HOME-BASED CARE ORGANISATION

by

FORTUNE MICHELO CHIBAMBA

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Declaration

I, Fortune Michelo Chibamba declare that " **The Role of Community-Based Organisations in Response to HIV/AIDS in Botswana: The Case of Gabane Community Home-Based Care**" is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

---------- Date----------

Fortune M. Chibamba

Supervisor:

---------- Date----------

Dr. Stephan P. Treurnicht

SUMMARY

This study examines the role of Community Based-Organisations (CBOs) in the response to HIV/AIDS as a development challenge drawing examples from the Gabane Community Home-Based Care CBO in Botswana. The study adopted qualitative methods of research and used group discussions, relative unstructured interviews, direct observation and literature review as methods of data collection. The study found out that HIV/AIDS is indeed a development problem and that it can be dealt with using some existing development approaches such as the sustainable livelihoods approaches. The study further identified specific roles that CBOs play in the response to HIV/AIDS. It also revealed the potential that CBOs have in achieving development. In addition, the study identified and outlined challenges that CBOs face in responding to HIV/AIDS. Key recommendations are that CBOs must integrate poverty reduction interventions in their activities. They must also form coalitions and strengthen their capacity to sustain their activities and manage partnerships.

Key Terms: HIV/AIDS; Community-Based Organisation; Community Home-based Care; Civil society; Development; Globalisation; Community regeneration; Capacity building; Community participation; Empowerment; Social capital; Social mobilisation; People centered development; Community participation.

DEDICATION

I dedicate this wok to my children, Musama and Chileleko Chibamba and to all the children of the world. Get the bits and pieces of life together. Where we did wrong, have courage and correct our mistakes and do the right things. Where we did well, be proud and excel so that you may create a better environment for the future generation for them to excel and perfect further for their succeeding generations.

Remember, do not only live to enjoy ours and your success but to make those who come after you enjoy even more. This is the only road to a better world. Be other-centered, live for a better future.

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I further extend my sincere appreciation to my wife Julian who had to push me at times to get down to complete this work despite the numerous family and work related callings and engagements. She always reminded me that our children need higher academic benchmarks in life and that my successful completion of my postgraduate studies would serve as a good example to them.

I am profoundly grateful to my daughters, Musama and Chileleko Chibamba for their understanding and patience during the long hours of writing this thesis. I surely sacrificed some family time to get this work done. It is my hope that they learnt something out of this whole episode.

Lastly, but certainly not the least I extend my gratitude to the Gabane Community Home-Based Care volunteers, some international volunteers and my professional colleagues in the HIV/AIDS sector for accepting to discuss and provide me with valuable information and guidance with regards to this study.

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Anti Retro-viral Treatment
ARV	Anti Retro- Viral
BOTUSA	Botswana-United States of America Partnership
CBO	Community Based-Organisation
CD	Community Development
CHBC	Community Home-Based Care
CSO	Civil Society Organisation
FAO	Food and Agriculture Organisation
FBO	Faith-Based Organisation
GCHBC	Gabane Community Home-Based Care
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IGA	Income Generating Activity
IK	Indigenous Knowledge
IMF	International Monetary Fund
MDG	Millennium Development Goal
MTPI	First Medium Term Plan
MTPII	Second Medium Term Plan
NACA	National AIDS Coordinating Agency
NGO	Non Governmental Organisation
NSF	National Strategic Framework
OVC	Orphans and Vulnerable Children
PAR	Participatory Action Research
PCD	People Centered Development
PLA	Participatory Learning and Action
PLWHA	People Living With HIV/AIDS
PRA	Participatory Rural Appraisal
PO	Participant Observation
RRA	Rapid Rural Appraisal
SLA	Sustainable Livelihoods Approach
SLF	Sustainable Livelihood Framework
STP	Short Term Plan
SNV	Netherlands Development Agency
TASO	The AIDS Support Organisation
UK	United Kingdom
UNAIDS	Joint United Nations Programme on AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
WUSC	World University Service of Canada
YONECO	Youth Net and Counseling

CHAPTER 1
INTRODUCTION

1.0 Introduction and background to the study

This thesis is based on the study that I conducted with the Gabane Community Home Based Care (GCHBC) community-based organisation (CBO). Gabane is a small village on the periphery of Gaborone, the capital of Botswana. It is one of the first villages to start a CBO to respond to the HIV/AIDS epidemic in Botswana.

By focusing on the role that the GCHBC CBO plays in the fight against HIV/AIDS in its community, I intend to demonstrate the potential that CBOs have, not only in responding to HIV/AIDS but also to poverty reduction and development endeavours in the long run. While this thesis focuses on GCHBC CBO it will also draw examples from other CBOs in Southern African countries to complement the results.The thesis will further analyse the challenges that CBOs encounter in their development efforts.

This thesis is influenced by my understanding that CBOs are important development actors in their own right and have huge potential in responding to HIV/AIDS. It will therefore provide details of how the GCHBC CBO has contributed towards the response to HIV/AIDS as a challenge in its community by participating in the national quest towards HIV/AIDS prevention, and the care and support of afflicted persons including orphans and vulnerable persons.

The thesis further acknowledges that among other variables, such as entrenched poverty and its contributory factors, HIV/AIDS has become a critical factor that complicates the development scenario, and will show how HIV/AIDS can reverse development gains (World Bank/IMF 2008).

The thesis will also demonstrate that through CBOs, people and communities can meaningfully get involved in responding to HIV/AIDS and other development issues other than merely relying on proclamations from governments and international agencies pledging their commitment to addressing their developmental needs (Hope 1984). CBOs have potential to leverage activities that can improve well-being of community members and guarantee that of future generations. The potential for CBOs and grassroots communities to organise themselves is addressed in the United Nations Development Programme Poverty Report (UNDP 2000:7). The report reveals that experience is beginning to confirm that once afforded the opportunity, communities can quickly build their own organisations and develop their own leaders to spearhead their own development.

In addition, this thesis reveals and discusses the notion that efforts to deal with HIV/AIDS at community level have yielded development perspectives and strategies such as community home-based care (CHBC) programmes, which can be used to foster development within the community (Russel and Schneider 2000). The development of CHBC programmes is a good initiative because HIV/AIDS is a complicated epidemic that has overwhelmed health care systems in high prevalence countries (UNAIDS 2007:12). For instance, Browning (2008) notes that HIV/AIDS patients have created a demand for health care that is beyond the capacity of health facilities, while at the same time leaving most hospital beds occupied by patients needing HIV/AIDS related care. This assertion is further supported by Stegling's (2001:243) observation that in 2000 in Botswana for example, "HIV/AIDS patients occupied more than half of the beds in main referral hospitals."

CHBC programmes have been established in most high prevalence communities as part of the community-based responses to the HIV epidemic particularly in the face of limited health care resources (McElrath 2002). CHBC programmes are an appropriate mode of health care service delivery system because much of the burden of HIV/AIDS in developing countries has fallen onto households and communities because health care facilities have been overwhelmed (Russel and Schneider 2000:1). Besides, the long term reality of the epidemic is such that most HIV/AIDS patients spend the bulk of their illnesses at home, and as such, they prefer to be cared for

within their home environment (Jackson and Kerkoven 1995; Kikule, 2003; Sepulveda 2003). Because community home-based care promotes community participation and involvement of family and community members, people living with HIV/AIDS can be cared for in the familiar environment of their homes by relatives at convenient times. This also affords caregivers time to attend to other household commitments while providing care to the ill relatives. The presence of relatives and community members during difficult times reduces stress and depression among patients (Foster 2002). On the other hand, CHBC provides an opportunity for health professionals to give health education to family members and relatives when visiting the sick in the community. It is for this reason that I assert that when effective coordination is in place with health facilities through an effective referral system, CHBC programmes complement formal health structures (Jackson 2002).

According to the World Heath Organisation (1993), Community home-based care is care provided to the terminally or chronically ill patients in their homes or their familiar communities. Care is primarily provided in the home by family members and community volunteers with support from social and health care professionals. Such care includes physical, psychosocial, palliative, spiritual care, and other services such as clinical monitoring and management of infections, counseling, food and nutritional supplemention (WHO 2002). The goal of CHBC is to "provide hope through high quality and appropriate care that helps ill people and families maintain their independence and achieve the best possible quality of life" (WHO 2002:6). As Russel and Schneider (2000) argue, community home-based care services make it easier for the hospital to discharge chronically ill patients knowing that they will have some access to support and care in the community. Uys and Cameron (2003) and Defilippi (2005) identify 3 types of CHBC as follows:

i) The integrated model that links all service providers with patients and family through a continuum of care.
ii) The single service model that includes only one service provider e.g. hospital, clinic, NGO or CBO that administers the services and
iii) The informal model that involves care of patients by family members with informal assistance from their own social network.

Stein (2002) and Chaava (2005) contend that the integrated model is more effective than the other two in terms of providing holistic care and support to patients and family and therefore more ideal for CBOs to pursue. I also support this notion.

It must be mentioned that while CHBC initially focused on providing holistic care to people living with HIV/AIDS, this steadily changed to integrate development programmes that aim at improving family and social values of people and improve their well being and the future of their children. According to Jackson et. al (1997), the services provided under most CHBC programmes have now expanded to deal with social economic issues that affect not only people living with HIV/AIDS but also their families and community members at large including orphans and the elderly. CHBC programmes have included activities aimed at strengthening the capacity of individuals and communities so that they may be able to deal with the impact of the epidemic and be in a position to support their needs. CHBC programmes have included life skills training activities for youth, training and facilitating improvement of income generating opportunities for widows, orphans, and other vulnerable persons to expand their opportunities for a sustained livelihood. The role that CHBC programmes play in mobilising communities for action against HIV/AIDS is an impetus for development from below.

1.1 Background to the problem

1.1.1 The Development disorder in Africa

Both as a student of development studies and as a development practitioner, I subscribe to the idea that development in poor countries, especially in Africa is skewed and spatially disproportionate living out some sections of society mostly the poor in rural areas. This is because conventional technocratic top-down forms of development have not worked to reduce inequalities and alleviate poverty (McGee 2002). This is mainly because the beneficiaries are alienated to the development process itself (Thomas and Allen 2000).

Hague (1999: 14) rightly observed that "many Asian, African, and Latin American countries, in spite of their decades of intensive development efforts still suffer from diverse forms of development crisis." Africa is experiencing a development crisis and the apparent political indifference, mismanagement of collapsing economies as well as entrenched poverty, hunger and HIV/AIDS deepen this disorder. While some Asian countries like China and India are reaching significant milestones in their development, little is happening in Africa, especially in sub-Saharan Africa.

Schuurman (2000) agrees with the development crisis and contends that this impasse was reached in the mid 1980s because of crisis at two levels: A crisis in the Third World in terms of increasing levels of poverty, exclusion, and inequality, and a crisis in development thinking, with the dominant theories and paradigms that had dominated our understanding and explanation of the world being challenged and subsequently losing their hegemony" (Kothari 2002: 3). Schuurman (2000:9), further contends that this crisis characterised by increasing gap between the poor and the rich countries, and the rich and the poor within the poor countries themselves also set in motion development pessimism. This inequality and the persistence of poverty despite the initial social and economic gains continue to be a problematic issue in development (Hanmer *et al*., 1997). The World Bank (2000:19) similarly observed that "despite gains in the second half of the 1990s, sub-Saharan Africa… enters the 21st century with many of the world's poorest countries. Average per capita income is lower than at the end of the 1960s. Incomes, assets, and access to essential services are unequally distributed. And the region contains a growing share of the world's absolute poor who have little power to influence the allocation of resources."

The development crisis manifests itself in various forms. The United Nations Development Programme identifies some manifestations of development disorder as, "lack of basic human capabilities, illiteracy, malnutrition, abbreviated life span, poor maternal health, illness from preventable diseases" (UNDP 2000: 20). To this list one can add low productivity, lack of collateral assets and low investment, all due to the effects of HIV/AIDS. In conformity with this argument, Adedeji (1989: 34) summarises the manifestations of Africa's development crisis as "deterioration in the main macroeconomic indicators, disintegration of productive mechanisms and infrastructure facilities, and accelerated decline in social welfare."

The above manifestations lead to a situation that severely degrades and undermines human life and compromises people's ingenuity to come up with processes that can otherwise enrich their lives. This is the reason that I support the contention that "the idea of development stands like a ruin in the intellectual landscape. Delusion and disappointment, failures and crime have been the steady companions of development and they tell a common story: [development] did not work" Sachs (1992: 1). Given this development crisis in Africa it is important to discuss some of the causes that have led to this crisis.

1.1.2 Factors leading to development disorder in Africa

There are different theories that have been developed to explain the current poverty and development disorder that many African countries are experiencing. These have given rise to various perspectives of analysing factors that contribute to the current development disorder in Africa.

Webster (1984) and Kothari and Minogue (2002) for instance, argue that it is literally not possible to analyse Africa's development disorder and its current economic, social and political situation without an understanding of the historical background and its relationship with the capitalist world. This perspective will be discussed further in chapter 2.

The development disorder in Africa can be traced back many centuries and includes the humiliating periods of slave trade and colonialism. Africa was divided for purely economic reasons by capitalist states through divide and rule methods that left uneven development in the scrambled territories (Shivji 2005). The colonial economies in the scrambled territories were deliberately broken up to facilitate exploitation of resources for the benefit of the metropolitan capitalist states (Kitching 1982). The industries that were set up and plantations developed were designed to extract resources to meet the needs of capitalist economies (Dos Santos 1968). This era saw unprecedented siphoning of resources from Africa and the destruction of social frameworks on which the sustainable livelihood of many African depended (Mkadawire and Soludo 1999:11).

Dual economies were left behind where satellite metropolis relations characterised the economies of the colonised states (Frank 1967). This relationship left an entrenched structural exploitative arrangement and social classes in the colonised territories (Baran 1957). The legacy of this period continued even after African states gained political independence and this complicated the development of the independent countries. It is my view, that though consideration for such historical events is important to understand factors that have affected the development of most less developed countries, it must not blind us to the realities of the period when this happened and also to the internal inefficiencies of less developed nations long after they celebrated their independence.

The African struggle for independence saw a growing passion among Africans to lead the development process of their own territories and this reality marked the beginning of the changing development discourse in Africa as colonial territories started fighting for their independence.

Even after political independence, it remains indisputable that colonial relations have influenced the postcolonial period, politically, economically, and culturally (Dhaouadi 1994). Political sovereignty and national independence has not ended all forms of colonialism because neocolonialism and the process of re-colonisation are sustaining economic, political and social control by the West over 'the rest' (Kothari 2002). It is evident even today that former colonies are still very much attached to their colonisers. Examples can be drawn from the relationship between Zambia and Britain, the Democratic Republic of Congo with France and Mozambique with Portugal. This is seen in areas such as education and even sport.

The development trajectories of the post-independence era also complicated the development reality of most new states. The newly independent states were faced with the challenge of responding to demands of national building and democratisation as well as economic development (Beetham 1994). This created a profound dilemma for the already economically and politically feeble states.

A further problem was that the underlying philosophies of the founding fathers at this time focused on responding to the tenets of the Cold War that had gained dominance during this time. Most African states aligned themselves with communism and this brought them into confrontation with capitalist states.

Nevertheless, after political independence some African economies demonstrated modest growth, but this was not easily sustained. Economic development of the post-independent states was not easy to sustain since the new states were already entangled in unfair trade relations with the colonial masters and their economies were already designed to produce for the capitalist world (Arega 1990). Despite this, there was overwhelming demand from the populace for expanded social services and an urgent need to deliver to them.

African leaders started seeking other development options, some of which tied them even more to the capitalist economies and their institutions. For example many approached the International Monetary Fund (IMF) and the World Bank for assistance in the form of loans. The loans became debt burdens that deepened the economic crisis of the African states. Repaying these debts become unsustainable, inflation soured and social services collapsed (Welch 2000). The way out of this was to implement the recommendations of the Bretton Woods Institutions on structural adjustment programmes (SAPs) to stabilise the suffering African economies. Structural adjustment programmes of the World Bank and IMF prioritised fiscal goals such as debt reduction over human welfare priorities such as poverty reduction and recently the AIDS epidemic (Cheru 2002; Poku 2001). In actual fact structural adjustment policies made debt repayment and economic restructuring priorities (Shah 2008). These prescriptions advised that subsidies should be reduced even in critical sectors such as agriculture, education and health, and this caused even more problems to the already troubled African economies (Mahjoub 1990). As a result, structural adjustments programmes have contributed to the greatest peacetime transfer of wealth from the periphery to the imperial center in history (Smith 1994). In agreement with the woes brought about by the structural adjustment programmes, Medact (1999) commented that the SAPs are hurting, not working. They are pushing poor people even deeper into poverty; SAPs may even be increasing vulnerability to HIV

infection, and reinforcing conditions where the scourge of HIV/AIDS can flourish (World Bank 1999).

The post-independence period witnessed the apogee of political and leadership misbehaviour. This led to deteriorating governance, compromised judicial systems and feeble legal frameworks, and a lack of calculated direction and well-informed policies (Robbins 1999). The situation in the Democratic Republic of Congo under the Mobuto regime and Zambia under Kenneth Kaunda present examples of countries that inherited sound economies that were later mismanaged due to poor governance.

The leaders "typically pursued policies that served the elite at the expense of the poor, neglecting the politically disconnected or those living in remote areas and reflected short-term expediency rather than long-term survival" (Clark 1990: 4). They carried on consumption tendencies and continued importing from their former colonial masters and this promoted further hemorrhaging of the post-colonial economies. There were also "psychological influences that colonialism engendered in the colonised populations: a sense of inferiority in themselves and their own people and a sense of confidence in European people and things" (Chandra 1992: 23).

Said (1989:207) notes that "to have been colonised was a fate with lasting, indeed grotesquely unfair results especially after national independence had been achieved. Poverty, dependency, underdevelopment, various pathologies of power and corruption, plus of course notable achievements, in war, literacy, economic development: this mix of characteristics designated the colonised people who had freed themselves on one level but who had remained victims of their past on another."

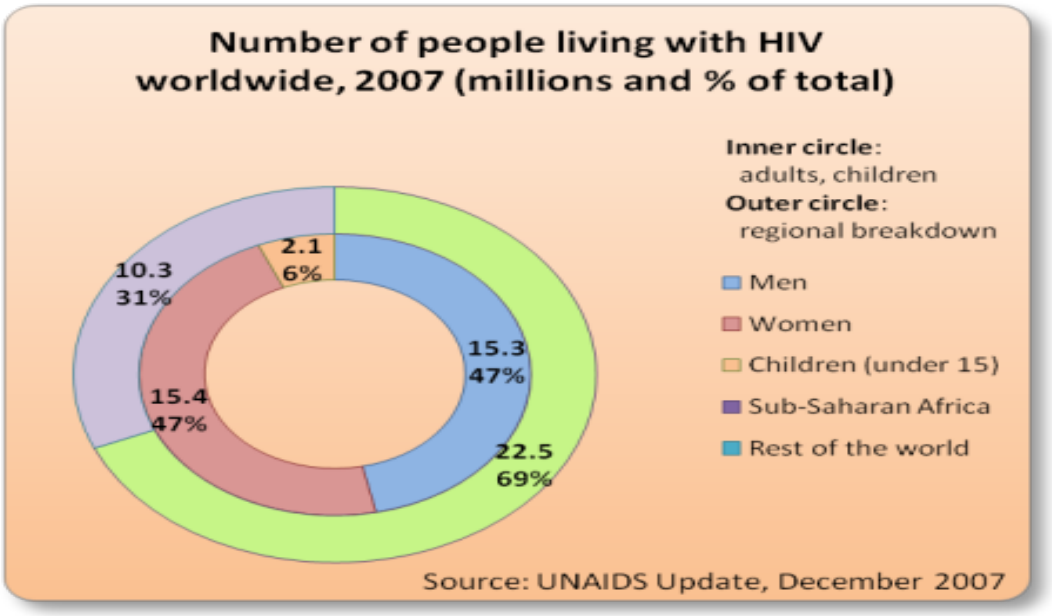
Lastly, coupled with the historic factors and the internal variables of corruption and mismanagement of resources, African countries especially sub-Saharan African countries were confronted with another factor, HIV/AIDS, which has had a crucial and fundamental effect on any development endeavour. As will be discussed later in this thesis, HIV/AIDS skewed the development horizon of most sub-Saharan African countries in the late 1980s and beyond.

1.2 The extent of the HIV/AIDS problem

According to WHO (1999), Acquired Immunodeficiency Syndrome (AIDS) is a fatal transmissible disease of the immune system caused by the human immunodeficiency virus (HIV). HIV slowly attacks and destroys the immune system, the body's defence against infection, leaving an individual vulnerable to a variety of other infections. AIDS is the final stage of HIV infection (Unnikrishna et al. 1993; Janeway Jr. and Travers 1997; Lindenbaum 1999; Barnett and Whiteside 2002; UNAIDS 2002). "When HIV is present in the human body, it inhibits the ability of the immune system to respond to what would, in normal circumstances, be manageable illness" (UNESCO 2007:74).

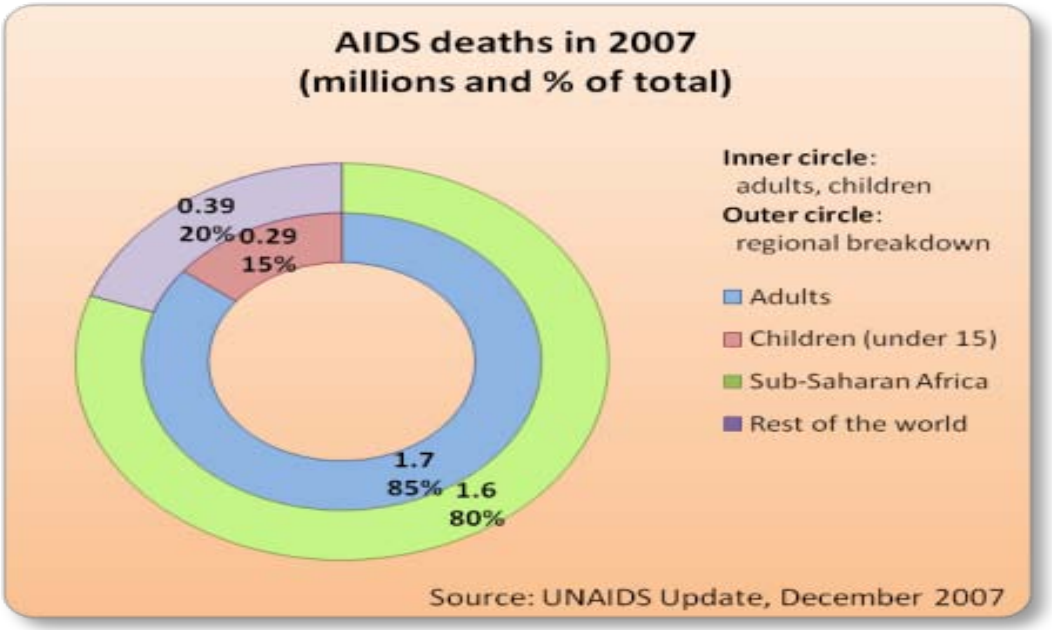
The HIV/ AIDS epidemic has expanded to all corners of the globe and no country and sector has been unaffected (Jackson and Lee (2002). For example, an estimated 22.5 million people were living with HIV by the end of 2007 with approximately 1.7 million additional people being affected with HIV during that year. In the same year AIDS claimed an estimated 1.6 million people in sub-Saharan Africa leaving more than 11 million children orphaned by AIDS (UNAIDS 2007). Figure 1 below shows the number of people living with HIV/AIDS in Sub-Saharan Africa and rest of the world in 2007. Figure 2 on the other hand shows AIDS deaths worldwide and in Sub-Saharan Africa ad rest of the world in 2007.

Figure 1: The number of people living with HIV/AIDS in Sub-Saharan Africa and rest of the world in 2007.



Sources: UNAID Update, December 2007.

Figure 2: AIDS deaths worldwide and in Sub-Saharan Africa ad rest of the world in 2007



Sources: UNAID Update, December 2007.

These two illustrations suggest to us that there are regional variations in the prevalence and effect of HIV/AIDS. According to McElrath (2002: ix), "the developing and most impoverished countries of the world have been most affected by the [HIV/AIDS] disease." Africa, particularly sub-Saharan Africa, is more affected than any other region of the world (ibid). This is the reason that it is referred to as the epicenter of the epidemic (Jackson and Lee 2002: Birdsall and Kelly 2007:15). According to USAID (2006) Southern Africa region has the highest HIV prevalence rates in the world, accounting for 32% of all HIV infections. Four Southern African countries, Botswana, Lesotho, Swaziland, and Zimbabwe have national adult HIV prevalence rates exceeding 20% (Ibid).

In Botswana for instance, in 2007, 23.9% of people aged between 0-49 years were infected with HIV, 300,000 had died and 95,000 children were orphaned due to AIDS by the end of that year (UNAIDS 2007). Epidemiological models conducted by the Botswana National AIDS Coordinating Agency (NACA) indicate that in 2007, Botswana had an incidence rate of 2.4% implying that there were approximately 18,000 new infections among the 15-49 age group (both males and females) each year. In real numbers this means that almost 50 people become infected with HIV/AIDS on a daily basis in Botswana (NACA 2008).

Considering that people are at the center of development, these statistics review that HIV/AIDS has now become the greatest challenge to the development question in Africa today, potentially rolling back decades of development and progress (Claude Nankam (2003). Former UN Secretary General Kofi Anan once said "more people have died of Aids in the past decades in Africa than in all the wars on the continent" (Brittain 2000).

1.3 The motivation for the study

Initially, this thesis was supposed to look at the 'Critical Role of CBOs in Sustainable Development'. I later changed it to the 'Role of CBOs in Response to HIV/AIDS in Botswana: The case of Gabane CHBC CBO'. There are a number of factors that influenced this change in topic. Over and above the desire to meet the requirement for the fulfillment of the Masters Degree in Development Studies, the selection of the topic was to a large extent influenced firstly, by my own experience working with civil society organisations particularly CBOs in dealing with HIV/AIDS as a development issue. Over the years I have noted the involvement of CBOs and the role that they play in responding to HIV/AIDS in various communities, yet their contribution is less reported and usually over-shadowed by large NGO's and government programmes that support CBOs to deliver services. Therefore, I wanted to study one CBO, the GCHBC, with the view of documenting the role that it has played in responding to HIV/AIDS and how its experience has influenced the response in Botswana.

Secondly, I wanted to step up my professional debates with colleagues through a study on the role that CBOs have in the fight against the HIV/AIDS as a development challenge in sub-Saharan countries. A number of my colleagues and indeed other scholars (Ogden et al. 2004) still argue that CBO are weak, they lack capacity and have an insignificant role to play in this global HIV problem. I have always differed with this view and therefore committed myself to find out more on this subject.

Despite the fact that CBOs are small and lack resources, their contribution in the fight against HIV/AIDS is important. For instance, Ninan and Delion (2007:213) noted that "community responses [through CBOs] are a critical component of scaling up responses to achieve the Millennium Development Goal of halting the spread of HIV/AIDS and providing universal access to prevention, treatment, care and support by 2015."

1.4 Assumptions of the study

Based on the fact that HIV/AIDS is a development concern that affects all sectors of human society, and the eminent need to involve local people to develop locally appropriate strategies to deal with the epidemic, I developed three assumptions to guide the objectives and methodology of the study including the articulation of results and recommendation. These assumptions are:

i) That though small and faced with limited resources, CBOs can make notable contributions to the fight against HIV/AIDS in high prevalence countries such as Botswana.

ii) That CBOs are appropriate entities at community level to confront community challenges such as HIV/AIDS and other development concerns. Once their capacities are enhanced they can facilitate community participation for development.

iii) That the response of CBOs to HIV/AIDS as a development challenge can generate development insights and lessons that can be replicated beyond HIV/AIDS itself and the boundaries of communities they serve.

1.5 Statement of the problem

Botswana's development has been highly affected by HIV/AIDS which is killing the most productive persons and has already claimed lots of resources earmarked for development towards its response (The Guardian 8th July 2002). The epidemic has overwhelmed the government's ability to respond prompting the leadership to call for all sectors and people to get together to fight this epidemic.

In response to government's call for a multi-sectoral[1] response, a lot of CBOs were established to complement the efforts of government in fighting the epidemic at community level. As a result CBOs achieved considerable results in addressing needs of their communities beyond responding to HIV/ADS. It is important therefore to recognise the important contribution that CBOs have made in responding to HIV/AIDS as a development challenge. To validate this assertion, examples from the GCHBC CBO will be presented in this thesis.

Given the foregoing, the main problem of this study is to determine the role of CBOs (drawing examples from the Gabane CHBC) in the fight against HIV/AIDS as development challenge with the view of highlighting the potential that these entities have towards contributing to development in general.

1.6 The objectives of the study

Given the above guiding assumption, the objectives of this dissertation are:

1) To analyse the effects of HIV/AIDS in order to determine whether it is a development challenge
2) To examine the challenges that CBOs encounter in response to HIV/AIDS as a development issue.
3) To propose recommendations that can make CBOs be more effective in responding community challenges.

[1] Multi-sectoral response here means a call for all sectors of society to get involved in the fight against HI/AIDS.

1.7 The significance of the study

The impact of HIV/AIDS on the national economy and development programmes of Botswana and other high prevalence countries is so great that it cannot be left to the state alone to take responsibility for combating it. This requires the development of innovative ways of developing partnerships between the state and civil society organisations, including local CBOs. This study will show that HIV/AIDS has stimulated people to work together for the greater good of their communities (Foster 2002).

Some development practitioners have critiqued CBOs as weak entities that have less to contribute to development because they lack the capacity to organise and manage themselves well (Taylor and Mackenzie 1992). Though this thesis acknowledges this challenge, it shows the immense potential that CBOs have in development discourse particularly when members are motivated to participate; when mutual partnerships have been developed and when the capacity of the members has been enhanced.

Significantly, this study will show how Gabane Community Home-Based Care CBO influenced local people's response to the epidemic and participation in the development of their community. The study will further show that lessons learnt from this CBO can influence policies and programmatic approaches of government and civil society organisations.

1.8 The relevance of the study

This thesis is important in a number of ways. Firstly, it will contribute to the existing body of knowledge in development theory and development practice on the role of CBOs in development. Previous development approaches placed more emphasis on centralised planning and economic growth as a trajectory to development. The uncovering of failures of such approaches has opened avenues for further information and strategies to deal with the current development disorder crippling Africa and to look for solutions within the local context. This thesis will assist to clear some uncertainties surrounding the role that local CBOs can play to stimulate development.

Secondly, this work will provoke development thinking towards appreciating people-centered development through the use of participatory techniques. Examples will illustrate the possibility and potential that CBOs have in steering people-centered development.

Thirdly, this thesis will demonstrate that a response towards a crisis can become an impetus to development in the long run by developing new, innovative strategies for dealing with the crisis.

Fourthly, the thesis will increase the understanding of the interrelationship between HIV/AIDS and poverty and the role that CBOs can play in development if they are supported and managed.

Finally, the thesis will demonstrate the importance of collaboration between government, private sector and civil society organisations including CBOs in tackling development challenges such as HIV/AIDS.

1.9 Summary of the methodology of the study

A detailed methodology of this study is presented in chapter 7. This section provides a summary of the factors that influenced the selection of the methodology; the selection of study respondents; methods of data collection and the method of verifying information.

1.9.1 Selection of the methodology

According to Leedey (1993:12), a research methodology is "…an operational framework within which the facts are placed so that their meaning may be seen more clearly". There are various methodologies that can be applied in different studies to generate desired meaning depending on the researcher's underlying assumptions.

The selection of the methodology of the study was largely influenced by my social science background and belief in qualitative research and my competencies in using qualitative methods in social research. I selected to use qualitative methods because of their interpretive and naturalistic approach to phenomena (Creswell 1998; Strauss and Corbin 1990; Glaser and Strauss 1967).

1.9.2 Selection of respondents

This study was conducted in Gabane village where the CBO is located 15 km south west of Botswana's capital city, Gaborone. Purposeful sampling was used to select people to participate in this study because of the need to obtain information about the CBO from people that have interacted with it (Du Plooy 2001;Lynn 2004:431) and also to obtain focused responses (Creswell 2002; Monomer 2005). Fisher (1935:206) notes that to get focused responses it is important to control the variety of population interest by using subjective judgment to select a sample. Another reason for selecting this type of sampling was proximity, accessibility and availability of the respondents to the researcher (Magemero 2005).

There were 93 respondents to this study and these were divided into five categories including;

i) 12 GCHBC volunteers including pre-school teachers.
ii) 15 professional international volunteers seconded to the CBO over time.
iii) 42 managers of selected NGOs working with the CBO and,
iv) 14 support group members of people living with HIV and AIDS.
v) 10 participants from the Kids club.

The selection of respondents to take part in the group discussions and unstructured interviews was done purposeful. As a result participation also depended to a large extent on who was available and willing to participate in the discussions among the categories stated above. Though this may have restricted the number of participants to the study it was a critical consideration on behalf of the GCHBC volunteers and beneficiaries of services to avoid taking a lot of time from their busy and sensitive

schedules. The GCHBC has 33 volunteers[2], 28 support group members and 185 orphans and vulnerable children.

1.9.3 Methods of data collection

1.9.3.1 Literature review

Literature review was the starting point of my study and I continued with it through out the study which helped me gain a good understanding of the subject I was studying. I extensively referred to exiting literature from various sources that included published books, journals, periodicals, articles (both published and unpublished), reports from international volunteers attached to the CBO, UN agencies, NGOs, and the CBO itself. This provided me with an understanding of the theoretical underpinnings, the extent of the problem and different view points from various proponents on the subject. Most importantly, the literature review assisted me to have a broader understanding of the role of CBOs in the fight against HIV/AIDS and the challenges they face, beyond my experience with the GCHBC CBO.

1.9.3.2 Focus group discussions

I also used group discussions as an interactive process (Kreuger 1988; Kreuger and Casey 2000) to obtain in-depth information on participant's perceptions regarding the GCHBC, the services it provides and the role it plays in the fight against HIV/AIDS in the Gabane community. I facilitated the group discussions process and took notes of the proceedings to inform the results presented and discussed in chapter 8.

[2] The number of registered volunteers is 33 but their participation varies greatly bring the size to 20 in some instances. This is the reason that only 12 were reached because their participation to CBO activities was consietent.

1.9.3.3 Relative unstructured interviews

I conducted free interviews with key informants that included the CBO's committee members, international volunteers, and mangers of NGOs. According to Mason (2002:62), unstructured interviews have four important common aspects; interaction or dialogue between interviewer and interviewee; informal conversational interviewing as opposed to rigid formal questions and answer sessions; topic by topic or theme by theme narrative approach; and it points out specific context within which knowledge is to be constructed or reconstructed.

1.9.3.4 Direct observation

Since I have been working with this CBO for over 9 years I have been making observations and taking notes of the activities and meetings with the CBO members to have an in-depth understanding of the CBO. The advantage of direct observation as Wilkinson (1995:213) contends is that there is "no time delay between the occurrence of the response in question and their recording by either the observer or some recording device." This allowed me to timely analyse my observation in relation to the issue I was studying.

1.9.3.5 Method of verifying information

Neuman (2000:279), Du Plooy (2001:145) and Breakwell (1995:233) contend that every interview, regardless of technique used runs the risk of interviewer bias and vague and leading questions. In order to minimise this occurrence, I used conversational techniques to facilitate an open flow and exchange of information, feelings and opinions among the respondents (Magomero 2005). I also crosschecked the information for accuracy to avoid biases. To determine this, I used the method of triangulation to check for the credibility, dependability and reliability of the information (Lincoln and Guba 1985; Stringer and Genat 2004).

1.10 Limitations of the study

One of the limitations of this study is that there is very limited written information available on the GCHBC. When available it is often in the form of short reports. As such most of the information on this CBO was generated through interviews with CBO volunteers and some CBO reports that are written by volunteers with difficulties of articulating them. To overcome this limitation I referred to literature published on similar CBOs. This also assisted to validate the information obtained from the CBO participants.

It was also difficulty to follow up discussions with some volunteers because they had left to seek gainful employment in urban areas. Some people living with HIV/AIDS had died over time. In this case I had to rely on the information that I obtained in participatory workshops that I conducted (in my line of duty) with various representatives of CBOs in Botswana though this tended to be more general to the situation of CBOs in Botswana than focused on the GCHBC CBO.

1.11 Organisation of the thesis: The summary of chapters

Chapter 1 introduces the topic of the thesis and provides a general context of the study. It also discusses the background to the study by analysing the development question in Africa focusing on factors that led to Africa's development disorder. The chapter also describes the extent and impact of HIV/AIDS as a development problem. It also highlights some factors that motivated me to select the topic and pursue the study. In addition, it brings out clear the assumptions of the study, the study objectives, the statement of the problem, as well as the significance and relevance of the study. It also summarises the methodology of the study and it outlines the organisation of the chapters.

Chapter 2 presents the theoretical framework of the study. It reviews the traditional development theories and debates their relevance to the fight aginist HIV/AIDS. The chapter reviews among others, the modernisation theories of development; dependency/underdevelopment theories of development, and alternative development perspectives.

Chapter 3 also forms part of the theoretical framework of the thesis and discusses contemporary development approaches and links them to the fight against HIV/AIDS. It focuses on sustainable development as the umbrella for new development thought. It further discusses the sustainable livelihoods approaches (SLA); indigenous knowledge and culture. It also examines the globalisation perspective on development and links this to the discussion on HIV/AIDS. Based on the review and analysis of the various theories and approaches, the chapter provides an operational definition of development used as reference in this study.

Chapter 4 zeroes in on the question of whether or not HIV/AIDS is a development challenge. The chapter starts with the debate on the origin of HIV/AIDS to demonstrated how complicated the phenomenon of HIV/AIDS is. It also advances the assumption that HIV/AIDS is indeed a development challenge and qualifies this with an analysis of the impact of HIV/AIDS on various sectors of society. The chapter pays particular attention to the link between HIV/AIDS and poverty. It also draws on the gender dynamics of the epidemic and how this affects development.

Chapter 5 discusses various approaches in responding to HIV/AIDS at the global, national and local levels. The chapter identifies CBOs as part of civil society responses to HIV/AIDS. It goes on to define civil society organisations and identifies various typologies of CSOs. It further discusses the role of civil society organisations particularly CBOs in response to HIV/AIDS since this is the focus of the study. In addition, the chapter reveals that communities have always attempted to organise themselves in the form of local organisations to participate in their development discourse. It also underpins the fact that CBOs have a place both in the theory and practice of development. Lastly, the chapter discusses the significance of CSOs in response to HIV/AIDS.

Chapter 6 provides an overview of the HIV/AIDS in Botswana including the prevalence, impact on national development, and factors that contribute to increased HIV infection. It also articulates how Botswana as a country responded to the HIV/AIDS epidemic leading to the call for a multisectoral response that motivated the establishment of CBOs to respond to the epidemic. The chapter further discusses the stages that CBOs go through when they form as action groups. It also presents a detailed description of the GCHBC as the unit of study and the framework within which it operates. It explains how the CBO has evolved to a point where it has an operational structure and has described its vision, mission, values, goals and objectives. It also discusses the programmes and activities of the CBO focusing on issues of community sensitisation and mobilisation; capacity building; HIV/AIDS prevention; care and support including home visits; the support group for people living with HIV/AIDS; the support it gives to orphans and its feeding programme; as well as its support to the kids' club and the pre-school for OVCs.

Chapter 7 looks at the methodology of the study in more detail. It also elaborates on the research design and the philosophical orientations that influenced the choice of the method and process of data collection and the mode of analysis. It further elaborates and debates the participatory methods used in the study. In addition it discusses issues related to the validity of the study as well as some pertinent ethical considerations.

Chapter 8 presents and discusses the findings of the study and focuses on the role that CBOs play in responding to HIV/AIDS and the challenges that CBOs face. It reveals the critical role that CBOs play in the response to HIV/AIDS despite confronting challenges. Examples are drawn from the GCHBC CBO.

Chapter 9 makes recommendations on how best CBOs can enhance their role in responding to HIV/AIDS and other development endeavours. Recommendations made are specific to CBOs, development partners and donors as well as to governments.

Chapter 10 makes conclusions of the study and emphasises that despite their small in nature, limited resources and skills, CBOs have a critical role to play in the fight against HIV/AIDS as a development issue particularly when their capacity is developed. The conclusion also highlights that CBOs play a good role in mobilising community members to participate in community activities.

1.12 Conclusion

This chapter presented the introduction to this thesis. It introduced the topic of study and how it was arrived at including some motivations that influenced the choice of the topic. The chapter further provided the background of the study and highlighted some of the issues it will focus on. In order to clear the way for the succeeding discussions on HIV/AIDS and development in this thesis, the chapter provided a background to the development disorder in Africa, mainly highlighting factors leading to the development disorder in Africa. The chapter acknowledges HIV/AIDS as one of the factors affecting developing in modern times. The chapter went on to discuss the extent of the HIV/AIDS problem, the statement of the problem, and articulated the objectives of the study. The significance of the study as well as the relevance of the study in the field of development studies was also highlighted. A summary of the methodology employed was discussed as well as the organisation of the overall thesis in terms of the summary of chapters. The chapter also acknowledged and presented the limitations of the study.

CHAPTER 2

A HISTORICAL REVIEW OF DEVELOPMENT THEORIES

2.0 Introduction

This chapter constructs the conceptual framework of the study. Its locus of attention is to review some historical theories and approaches of development and to see how these have influenced the understanding of development and propositions for the occurrence of development. The chapter will focus on theories such as modernisation theory, dependency/underdevelopment theory, alternative development theory and the post-development theory.

2.1 The historical perspective of development

When the term development was first introduced, it was considered an economic term and development was generally perceived to be synonymous with economic growth (Hawi 2005:2).Since then the debate on development has been alive with deferent perspectives dominating at different periods in time.

Kothari and Minogue (2002:7) assert that, "the history of development discourse over the past 50 years has been complex and the mainstream dominant and powerful development ideology has remained within the framework of neoclassical economics." The dominance of this particular development ideology and the exclusion of certain groups of people from the development process has generated debate on the subject (Brohman 1996).

Development perspectives have been changing over time because of the evolving debate surrounding development theory. The understanding of development itself has also changed over time although these have in one way or the other carried the legacies of old views (Taabazuing 2009). The evolving debate on development theory has also attracted new perspectives on the subject that have in turn motivated new considerations for development practice.

According to Preston (1996), development theory is a conglomeration of theories about how desirable change in society can best be achieved. Such theories draw on a variety of disciplines and approaches. The concept of development captured the imagination of social scientists following the Harry Truman's speech to congress in 1947. This was later known as the Truman doctrine that influenced the generation of various development theories as social scientists engaged in the search for the explanation of why some countries are poor while other are prospering. The Truman Doctrine represented the post World War II policy of the United States of America to protect European countries such as Greece and Turkey from the communist insurrection. This led to the U.S.A to sponsor programmes designed to rehabilitate the economies of these countries with the aim of creating stable conditions in which democratic institution could survive. The Truman Doctrine helped set the stage for the Marshall Plan, through which the United States of America assisted to rebuild Western Europe and counter communism.

The search for explanations on why development occurs or doesn't occur in certain circumstances led to the emergency of numerous development theories and approaches. Given this background, my discussion of development theories will have some historical reflections to account for the origins of the debate on development itself. However, because of the broad nature of the subject and for purposes of this thesis, I will limit myself to reviewing and analysing the structural and normative approaches (Sheth 1987) since I believe these have a bearing to the conclusions of this study. The theories that I will discuss include modernisation theory, dependency/underdevelopment theory, alternative development theory, and the post-development theory.

2.1.1 Modernisation theory of development

Modernisation theory refers to a group of theories which emerged after the Second World War (Khun 2005). These theories were influenced by the industrial revolution in Europe and North America as a result of the advancements of western countries in science and political organisation (Ha-Joon Chang 2003; Crafts (2003). Modernisation theory is an evolutionary theory that is used to summarise and explain modern transformations of social life. It focuses on internal factors such as poverty

and inadequate culture and perceives them as causes of lack of modernisation and therefore responsible for making poor countries remain undeveloped.

The emergency of modernisation theories aimed at providing explanations why poorer countries failed to evolve into modern societies. This was based on the assumption that for a country to develop, it must first modernise, implying that it has to undergo an evolutionary advance in science and technology which would in turn lead to an increased standard of living (Weber 1973).

According to Chilcote (1981) cited in Taabazuing (2009) modernisation theories can be classified under three themes; political development; development and nationalism, and modernisation itself. The proponents of the political development theme perceive democracy as a critical variable to development (O'Brain 1972), while the promoters of development and nationalism theme emphasise the importance of the process of socialisation that helps to develop a sense of nationalisation which consequently provides the thrust for development to occur. Modernisation theory emphasises on transforming values from traditional to modern ones. This theory remains the dominant theme among them all and will therefore be discussed in detail in this thesis.

To a large extent modernisation theorists dwell on the traditional and modern dichotomy in explaining development. For example, Leftwich (2000: 33) maintains that human societies evolve from rather simple traditional forms of life to much more complex ones of modernity. Traditionalism and the values embedded in it, e.g. values of extended family, ascription, particularism and collectivism are seen to block the process of modernisation and ultimately development (Okolie 2003). Therefore, for development to occur modernisation theorist see the need to replace traditional values with modern meritocratic values of achievement, universalism and individualism, and competition. In this case the role of the state is important in adapting new technologies and influencing the review of internal dynamics with particular focus on social and cultural structures and the adaptation of modern values that are synonymous with western civilisation (Weber 1973; Kambhampati 2004; Stewart 2005; Szirmai 2005).

Talcott Parsons (1961) is a key defender of modernity. He contributed to modernisation theory by complementing the traditional and modern dichotomy. He defined the qualities that distinguish 'modern' and 'traditional' societies through his functional sociology hypothesis (Mayhew 1984). Parsons's point of view is that education and technology play a key role in creating modern societies and the lack of it is characteristic of traditional societies. His theory prescribes advancement in technology and that this would spur growth and development in poor societies (Parsons 1961).

Khun (2005) associates modernisation theories to globalisation. For instance, he argues that the concept of globalisation has greatly been influenced by the emphasis on advancement of science and technology and the impact of economic growth of developed nations. He further argues that the new technologies and systems are leading to a more greatly homogenised world with cultural mores and ideas easily spreading throughout the world, leading to some sort of universal culture that serves as a baseline for all cultures. Nevertheless, this has its own difficulties. For instance, the benefits of new technologies and economic prosperity of developed countries have led to increased migrations from less developed countries of the south draining these countries of the much required human resources. On the other hand the desire of poor countries of the south to develop by adopting values and science and technology of developed countries has left them tied to international lending institutions such as the World Bank and IMF.

Other prominent scholars of modernisation theories such as Rostow, A.F.K Organski and Samuel Huntington perceived development as a linear process. For instance Rostow (1960:4-16) prescribed 5 stages of development through which every country evolves. These stages include:

1) The traditional society stage which is mostly characterised by low levels of technological knowledge and low per capita production. The economic activity of this stage is still subsistence and the output is often consumed by the producer rather than traded. The predominant industry is small scale agriculture highly dependant on labour intensive technologies.

2) The pre-conditions for “take-off” stage is the demonstration of the removal and replacement of the variables that inhibit growth, intrinsic in traditional societies with scientific advances in sectors such as manufacturing and agriculture. During this stage surplus for trading emerges and savings and investment are slowly growing due to the emergency of entrepreneurs (Rostow 1960).

3) The “take-off” stage represents the stage at which societies move towards self-sustained growth. According to Harrison (1998) this stage is characterised by rising net investment and savings that can be used for re-investment to garner industrialisation.

4) The drive to maturity stage represents the phase were growth is now diverse supported by technological innovations and the economic structure shows continuous changes as older industries stagnate and make way for new ventures.

5) The stage of high mass consumption is Rostow’s final stage of his evolutionary proposal. This stage features improved consumption patterns and an apparent shift towards services and durable consumer goods (Etzioni-Halevy 1981; Blomsstrom and Hettne 1984).

The implications of Rostow’s stages of economic growth is that for a country to develop certain conditions must exist within it that can promote accumulation of capital and technological advancements. This assumption of a general linear trajectory to development that all countries must follow is a very subjective point view. A detailed critic of modernisation theory is provided below.

Modernisation theory has been criticised as being heavily embedded in western industrialisation and economic growth as critical factors of development (Bergeron 2006). This is a top-down orientation that assumes that economic growth and technological advancement will trickle down and ignite social and economic progress among the poor. The assumption that the socio-economic and political frameworks that led to the countries of the west to develop can be applicable to less developed countries is simplistic and ignores the very socio-cultural fibre of these countries.

In my view, the assumption of universalism of socio-economic and political circumstances across the globe is a fallacy. Those conditions that existed a long time ago at the time of industrialisation and development of the western countries no longer exist in the less developed nations of the global south. This is why I contend that this theory is historical and as such extreme care must be taken if one has to apply it in modern day development analysis. The world has since changed, with a lot of interaction in many ways between the global north and the global south. This interaction has also filtered a lot of cultures and systems of the global north to the south. Take for example the education systems, the use of science and technology, the way people talk and dress in poor countries of the south, there is lots of resemblance with those of the rich countries of the north but the former are still poor. It can even be argued that this global interaction has even led to poor prioritisation of development objectives among the poor nations of the south as they race to catch up with the developed north.

The impact of economic growth and advancement in technology for instance, has not universally translated into development but rather increased exploitation and the gap between the rich and the poor including increased dependence of poor nations on the rich ones. One must be careful to link scientific inventions to development because some of the inventions have been detrimental to human kind, taking an example of the scientific milestones such as the invention of dynamite by Alfred Nobel and the invention of guns and bombs that have killed many people especially in the less developed countries (Khun 2005).

The aggressive desire and search for resources to create the base for economic growth has brought its own problems. For example, the influx of Chinese investors in African countries has not come without complaints of corruption and abuse of rights of workers. In other parts of Africa people have experienced wars because of the scramble for resources (such as the so called blood diamonds) for economic objectives of a few.

Economic growth can not completely eradicate poverty. Todaro and Smith (2006) support this view and observe that economic growth maybe a necessary ingredient to development, but it does not ascertain poverty reduction and social stability. For

example, Botswana is a country that has seen an increase in economic growth to a point of being reclassified as a middle income country while close to 40% of its citizens still live below the poverty line. It is also common knowledge that even in the backyard of the USA, from where most modernisation pundits originated from, there is plenty of unemployment, crime, inequality and poverty. In my view the over-emphasis of modernisation theory on economic growth further leads to economic selfishness which can also lead to corruption.

Modernisation theory has also received criticism because of it's over emphasis on the modern/traditional dichotomy and also the linear economic growth models to explain occurrence and non-occurrence of development. Its emphasis on values (traditional vs. modern) presents a biased perspective about the diversity and heterogeneity nature of societies. Modernisation theory is very biased towards western capitalism and deliberately ignores the global situation and external influences that could affect the occurrence of development in certain societies (Haines 2000; Szirmai 2005). It is also ethocratic because it devalues traditional values and social institutions such as extended family and yet such institutions could be pivotal in strengthening social capital and leverage resource that can be used for development purposes. It is important to also note that the pursuit of western modern values such as democracy has in some instances brought about tension in the world and even led to wars, e.g. the invasion of Iraq and Afghanistan and the recent civil war in Libya.

The proposition that development must follow a linear path is highly questionable because different cultures and value systems characteristic of different societies can influence the development path that may not even be linear (Smith 1973; Khun (2005). Rostow's model of stages of development assumes that a country must save and invest a certain amount of its money for it to develop. The problem with this thinking is that it does not consider the fact that though some countries may manage to save, they may be some internal factors that will affect investment; factors such as corruption, poor skilled labour force due to weak education systems. It also overlooks the influence of external factors to development such as imbalance of trade practices (Haines 2000: 38). There are also countries that do not have many natural resources to generate enough savings to invest, such as Somali and Rwanda. According to the Rostowian theory such countries have no chance for development. Experience has

also shown us that countries can make a false start and then slip back from the stage of high mass consumption to a nation in transition such as Russia. Yet some countries such as Singapore may even skip some stages. Things have changed so much so that there are now other factors at play in the explanation and analysis of development; factors such as globalisation and the consideration of environmental issues as will be discussed in chapter three.

Given the above critic of the modernisation theory and the Rostowian model, one must not be blinded to the legacies of the theory itself. Khun (2005) warns that this theory has a great deal of social, economic and political relevance and implications to our present world.

There are examples of application of the modernisation thinking in the analysis of the dynamics of HIV/AIDS and responses against it. For example, the prevailing traditional behaviour of people in high prevalence countries, the inadequacy to respond to information and lack of modern managerial technologies have been cited as some of the reasons for the little progress made in the fight against HIV/AIDS in these countries. Following this perspective, the so-called 'experts' from low prevalence western countries are brought to Africa as volunteers to teach the Africans how to manage HIV/AIDS; a problem the Africans have lots of experiential knowledge on as compared to the so called experts from low prevalent countries.

2.1.2 Dependency theory of underdevelopment

The dependency theory of underdevelopment gained ground around the 1960s when a number of Latin-American development economists and social scientists questioned the validity of earlier theories such as evolutionism and modernisation theory.

This theory was informed by Marxist social thought on capitalism and its exploitative tendencies focusing on the analysis of historical changes as a way of accounting for the inequalities in the world economy and the lack of development in the Third Word Countries (TWC) (Webster 1984). The shortcomings of modernisation theories and the criticisms wedged against them were significant to the emergency of the dependency theory of underdevelopment.

The debate on the problem of underdevelopment was deepened following the insights provided by the studies conducted by Economic Commission for Latin America (ECLA) after the economic failures of Latin America. The studies concluded that the regional differences in development between developed countries and less developed countries were a direct result of the economic activity in the richer countries leaving serious economic problems in the poorer countries (Blomstrom and Hettne 1984). Raul Prebisch the Director of the ECLA was instrumental in popularising this point of view.

Key to appreciating dependency theories is the understanding of dependency and underdevelopment as concepts. According to Sunkel (1969); Dos Santos (1971) and Aryes (1995), dependency means a situation in which the economy of certain countries is conditioned by the development and expansion of another economy to which the former is subjected. The relation of inter-dependence between two or more economies and between these and world trade, assumes the form of dependency when some countries (the dominant ones) can expand and can be self-sustaining, while other countries (the dependent ones) can do this only as a reflection of that expansion, which can have either a positive or a negative effect on their immediate development (Ferraro 1996). Dependency also implies a situation were major decisions which affect socioeconomic progress within less developed areas, for example, decisions about commodity price investment patterns are made by individuals and institutions outside those countries. Simply put dependency is a situation in which the economy of certain countries is conditioned by the development and expansion of another economy to which the former is subjected Aryes (1995).

On the other hand, underdevelopment is seen as a flip side of the coin of development. It refers to a process where by a country, characterised by subsistence agriculture and domestic production progressively becomes integrated as a dependent into the world market through patterns of trade and or investment (Kuhnen 1986; 1987). The production of that country thus becomes geared primarily to the demands of the world market; in particular the demands dictated by the industrialised nations, with a consequent lack of integration within the country between the various parts of its own domestic economy (Ayres 1995). This in fact means that underdevelopment is a condition of negative progression to development and not of being undeveloped.

Proponents of dependency/underdevelopment theories perceive the relationship between nations in terms of dominance and dependency, where the economies of developed nations condition economies of developing nations such that the growth of developed countries is seen to create deteriorating conditions in less developed countries thereby inhibiting growth (Roxborough 1979). This relationship is historically determined. According to Baran (1957) and Leys (2006), this historically determined unequal relationship played a crucial role in developing capitalism in the west while it prevented economic growth in the developing nations.

Most dependency theorists regard international capitalism as the driving force behind dependency relationships. For example, Andre Gunder Frank (1972:3), one of the earliest dependency theorists, is quite clear on this point, he states that; "...historical research demonstrates that contemporary underdevelopment is in large part the historical product of past and continuing economic and other relations between the satellite underdeveloped and the now developed metropolitan countries… these relations are an essential part of the capitalist system on a world scale as a whole". According to this point of view, international capitalist system enforced a rigid international division of labor such that poor dependent states were only able to supply cheap minerals, agricultural commodities, cheap labor and also serve as the repositories of surplus capital, obsolescent technologies, and manufactured goods (Madziakapita 2003). According to Burkey (1993), this division of labour was exploitative and oriented the economies of the dependent states towards the outside dominant countries. In addition, economic and political power remained imbalanced and this influenced unfair trade between the developed countries and the less develop countries (Leys 2006).

Prebisch's (1951a) explanation of the international capitalism is very straightforward; that poor countries exported primary commodities to the rich countries that then manufactured products out of those commodities and sold them back to the poorer countries, simply because the value added by manufacturing a usable product always cost more than the primary products used to create those products (Yergin and Stainislaw 2002). Therefore, poorer countries would never earn enough from their export earnings to pay for their imports. This leads to deepened exploitation and dependency.

Supporters of the dependency/underdevelopment theory further ague that capitalism penetrates the less developed countries and creates an exploitative local class of elites who aid the underdevelopment process of their countries (Frank 1972). A distinct characteristic of this local elite class is that its economic interests, ideology and culture are inclined towards the developed countries (Ferraro 1996). The economic position they occupy is an intermediary one and destructive to development in less developed countries in favour of economies of developed countries.

Webster (1984) summarised the tenets of dependency theories and indicates that the common ideas among the majority of the proponents of the dependency theory include the following:

- That underdevelopment is intimately connected with the expansion of the industrialised capitalist countries.
- That development and underdevelopment are different aspects of the same universal process.
- That underdevelopment can not be considered as an original condition in an evolutionary process.
- That dependency is not only an external phenomenon but is also manifested in different ways in the internal structures.
- That scarcity of capital for investment in the less developed countries led to the massive importation of required commodities, which further led to reliance on AID and loans.
- That the international division of labour subjected less developed countries to being exporters of raw materials, thus making their development foreign oriented.
- That the international trade operates against the less developed countries. The imperfect factor markets create conditions for exploitation of less developed countries (Roxborough 1979).

Dependency theories emphasise the importance of external forces on underdeveloped countries and pays less attention to the role of internal motivations within these countries. As a result dependency theorists propose that for less developed countries to develop, they must break ties with developed nations and pursue internal growth

and use their resources in a different manner than imposed by dominant states especially in the use of agriculture produce. They argue that most poor economies experience rather high rates of malnutrition even though they produce great amounts of food for export. They further argue that his can be averted by utilising agricultural land for domestic production which could consequently reduce the high rates of malnutrition prevelent in the less developed countries (Leys 2002).

In my view the outlook that the politico-economic advantage of technologically advanced countries is based on the disadvantages of less developed nations is simplistic, superficial and fatalistic. For instance, the prescription of strategies such as import substitution and de-linking from the west is not feasible because the world has become interdependent. De-linking from the western world either through internal policies or external policies such as sanctions and trade embargos creates deeper development challenges for the poor nations. Countries such as Tanzania and Zambia tried the import substitution approach but failed mainly due to the inherent management inefficiencies, small markets, and huge cost associated with acquiring factors of production such as technology from the developed countries. Contemporary examples on the effects of this approach can be drawn from the Zimbabwe experience.

The less developed countries of the south will for sure need technologies of the north to turn their resources into capital. They also need a broad market that includes trading with western nations to generate the capital needed for investment and development. The world has shrunk so much and has become interconnected more than ever before and what is needed in my view is not to de-link but to mange these relationships better through organised structures such as the Southern African Development Cooperation (SADC) and the African Union (AU).

Critics of dependency theory contend that the theory has actually not freed itself from the doctrines of modernisation theory and its parentage is not Marxist oriented because it still perceives development as economic growth, industrial growth and liberal democracy. Sheth (1987) argues that in fact dependency theorists do not question development per se but dependent development or underdevelopment. Dependent theorists put so much stress on the external obstacles to development that

the problem of how to initiate a development process once these obstacles are removed was neglected and thus failed to construct a theory of development of their own (Hettne 1996; Leys 2006).

Dependency theorists' proposals for options did not consider internal situations of the less developed countries in detail. For example, they proposed that the south must de-linking from north and that the state becomes central and introduce radical reforms such as import substation without consideration of the status of local markets factors of production. They failed also to make plausible recommendation for the involvement of the poor in their own development. In support of this view Leys (1977:99-107) asserts that dependency theory was no longer applicable, and that it somehow had to be transcended. He stated that it was repetitious and theoretically stagnant; it was incapable of providing a solution to problems.

O'Brein (1975) also questioned the use of the concept of dependency itself. He concluded that the way in which this has been used is rather too vague because it fails to explain in what sense the less developed countries are dependent on the metropolitan centers. An example in this regard was given on Canada that its economy was once profoundly dependent on foreign-owned subsidiaries but now it is a developed country.

Other critics of the dependency approach still believe that foreign capital investment can promote development. For instance Cordoso (1979) introduced the concept of dependent development as opposed to dependency. On the other hand Petras (1969) had earlier on acknowledged the fact that some sort of growth may occur but the extent to which this leads to autonomous industrial growth is not clear and thus questionable. What may be pertaining in this situation is that some developments may emerge, but these would just be for the sake of promoting advanced and excessive extract of surplus. This would not trickle down to the rest of the national economy.

Etzioni-Halevy (1981) also criticised the theory for been one-sided. She states that its main achievement is its convincing demonstration of the exploitative character of the capitalist world system and of western modernisation, but it vitiates a considerable part of that achievement by turning the concept of exploitation into its almost

exclusive analytical instrument. Bill Warren (1973) also presents a challenge to the dependency theories. He still perceives colonialism as a vehicle that improved the scope of capitalist development in some Third World Countries. He further argues that this led to development in Brazil, Argentina, and Mexico.

Notwithstanding the observed criticisms of dependency/underdevelopment theories, I contend that dependency tendencies can still be observed in the response to HIV/AIDS in most high prevalence countries. HIV/AIDS responses in these countries are highly dependant on external resources which come with prescriptions of how they must be utilised. This has left the response at both national and community levels heavily dependant on donors; a situation that inhibits local initiatives and utilisation of local knowledge. Besides, the high prevalent countries are highly researched providing information (which I interpret here as raw materials) to experts in developed countries to use and generate technologies and approaches (which I interpret as finished products) which they patent and bring back to the high prevalent countries (usually at a cost) to adopt and use. With this analogy I can say that the legacies of these historical theories on development are present in current development endeavours including responses to HIV/AIDS. It is for this reason that consideration should be made to blend alternative development theories in contemporary development discourse including in the fight against HIV/AIDS. I will discuss the alternative development theories in the next section.

2.1.3 Alternative development theories

A shift towards alternative development emerged from the call for 'another development' in the 1970's following the cloudy development horizon in developing countries and the contentions against classical economic approaches to development (Pieterse 1996). Since then mainstream development has gradually been moving away from the preoccupation with economic growth towards human development which is people-centered and geared towards the satisfaction of needs, endogenous and self-reliant and in harmony with the environment (Dag Hammarskjöld Foundation Repot 1975; Pieterse 1996).

Alternative development is perceived to promote people's collective initiatives and possess the potential of raising their standard of living (Rupasingha et. al 1999). Kothari and Minogue (2002:8) refer to these alternative development views as "popular development" that is people-centered, bottom-up and participatory.The apparent logic behind the emerging alternative view is that indigenous people must reclaim their confidence and rely on local ways of thinking and indigenous knowledge to determine their future (Gegeo 1998; Maiava 2001). After all, development is for the people that need it; besides they best know what they want.

It is not yet clear whether or not to classify alternative development as a development theory, a paradigm or merely a roving critic of mainstream development, or a development style by itself (Pieterse 1996). This is certainly not the focus of this thesis. However, I conform with the positions held by Burkey (1993) and Andreasson (2005) that alternative development falls within the normative approach to development which is opposed to the structuralist or positivist approaches manifested in modernisation and dependency theories. The locus of attention of the normative approach is on the content and not the form of development, i.e. how development should take place and not how it actually takes place (Taabazuing 2009).

Though the emergence of alternative development is commonly perceived to suggest a radical departure from mainstream development, my point of view is that it still comes under the genus of development. The difference, which is its strong point, is that it focuses more on involving people to meet their needs (Korten 1990: Max-Neef 1991; Rahman 1993; Carmen 1996). There is consensus among supporters of alternative development (Korten 1990; Pieterse 1998; Latouche 2004; Andreasson 2005) that it is concerned with redefining the goals of development and introducing alternative practices of development that which is participatory and people-centered. Contained within alternative development is the assumption that this approach will facilitate the reconsideration of societal value systems towards appreciation of cultural diversity, solidarity, equity, social justice, inclusiveness and environmental integrity where people can work together to fulfill their needs (Pieterse 2000; Haverkort 2002; Madziakapita 2003).

In current development practice, divergent approaches to development seem to be narrowing towards an acceptance that development is more successful if it focuses its benefits on the people and when people on the ground are part and parcel of the process. Though alternative development advocates for people and communities to design and pursue their own development and utilise as much as possible the locally resource available, there is an important realisation that in most instances, the people for whom development is intended for can not do it all by themselves because of limited resources. Therefore, there is need to create partnerships with other institutions to leverage resources. This convergence is mostly evident through the work of NGOs and CBO in communities and the apparent increase in the flow of development fund to support development that focuses on people at the community level (Pieterse 1996).

The recognition of alternative development and the importance it places on grassroots and local involvement in the development process and the need to involve community members in "all the stages of development from diagnosis to implementation to monitoring and evaluation in a participatory manner" (Khan and Humayun 2008:1) has attracted substantial support from development administrators and academicians alike (Ekins 1986:43; Khan and Humayun 2008). This has also opened debates about other approaches such as the development form below or people-centered approach which I will discuss further in the next section.

2.1.4 The development from below perspective

Though I agree that development from below and people-centered development are usually used interchangeably, I have carefully selected to use the term development from below for two reasons. Firstly, because I would like to emphasise the need for local people at community level to work in an organised fashioned through local institutions as pointed out by Pieterse (1996:3). Secondly, I do not want to fall into the trap of debating the idea that to use people-centered development is to suggest that development is only about humans as advanced by Norgaard (1994), Reason (1998), Breu and Peppard (2001) and Taabazuing (2009).

According to Healy (2003), development form below is contextual and participative and aims at achieving qualitative development in place of imbalanced and unsustainable growth. Some recent conceptualisations of development from below emphasise liberation and empowerment of people to make their own choices as important outcomes (Bradfield 2000:27).

Development from below is concerned more with qualitative aspects of life and the equitable distribution of income and it seeks to satisfy basic needs (Stöhr and Taylor 1981) to increase human welfare (Ekins 1986:8) and to foster diversity and complementarity by addressing the needs of the producers, the consumers and the local community (McRobie 1986:xii). McRobie (Ibid: xi) and Graham (1986:19) further contend that development from below is concerned with making people "more productive, creative and self-reliant and strengthening the support systems of family and community."

The underlying assumption behind development from below is that structural imbalances necessitate unequal access and distribution of resources needed for people to develop. These consequently confine people to poverty. Therefore if people are to realise development, there is need to build their capacity so that they can liberate themselves from poverty and enjoy economic justice. There is also need for social transformation to remove the existing structural impediments (Korten1990; Bergeron 2006; Taabazuing 2009).

According to Burkey (1993: 31), supported by Madziakapita (2003: 97) and Healey (2003), there are five basic principles of development from below. These were first outlined in a 1975 report of the Dag Hammarskjöld Foundation entitled *What Now: Another Development*. These principles conceive development from below as:

- "Need-oriented, responding to both material and non-material human needs.
- Endogenous, that is, derived from locally determined priorities.
- Self-reliant, with an emphasis on maximizing community strengths and resources.
- Ecologically sound, with attention to sustainable and equitable resource use.

- Based on structural transformations in social, economic and spatial relationships in order to foster the participative decision-making required to achieve the above four principles" (Ekins 1992:99-100).

Development from below promotes a profound shift in thinking from the service delivery system to one that relies on community resources and the vision, strengths and creativity of local people (The Hunger Project 1994). According to (Ekins 1986) development from below represents the philosophy and action of learning from below which advocates for the need to consult first with those who are last (Chambers 1986:319) in determining the development agenda (Healey 2003). Healey (Ibid) further contends that the learning from below perspective cautions that the 'first thinking' of most professionals is incongruent with and therefore of little value to those who are 'last'. It is imperative therefore that these emerging alternative models of development focus more on the contribution and benefits of those who are last; the vulnerable people in the community. This can be achieved by:

- Putting first what those who are last want and need.
- Understanding their situation, resources and problems.
- Combining these to determine program and research priorities (Chambers 1986: 319).

The development from below perspective places emphasis on the needs of human beings. The human dimension to development is a critical factor and must not be taken to be just another addition to the development discourse. In order to realise development from below importance must be placed on articulating the concept of human need. Max-Neef (1986:49) argues that human needs must be understood as "a system of interrelated needs 'of having' and 'of being', including permanence (or subsistence), protection, affection, understanding, participation, leisure, creation, identity (or meaning) and freedom." This argument is cognisant of the fact that the means by which people satisfy their needs change over time and through cultures. Since alternative development approaches seek to satisfy basic needs and to increase human welfare over time (Stöhr and Taylor 1981), human beings are important to development and so should approaches that place them at the center. In relation to this point of view, Mayfield (1997) explains that the human dimension to development is

an entirely new perspective, a revolutionary way to recast our conventional approach to development. This perspective recognises people's strength and creativity and that people themselves are key to their own development through their involvement in local organisations. With this transition in thinking, human civilisation including democracy may reach yet another milestone.

On the other hand, the development from below thesis has equally received some criticism. This perspective has been influenced by Pieterse (1998) who for example, sees the risk of these alternatives being absorbed into mainstream dominant classical economic ideologies. Pieterse (1998: 344) suggests that instead of these alternatives to development focusing on launching substitute practices and redefining the goals of development, they must place emphasis on questioning modalities of development and suggest improvements (Pieterse 1998:354).

My point of view regarding this debate is in agreement with Pieterse's position, and I contend that rather than call for alternatives as substitutes all together, development scientist must seek and utilise complementary approaches to development such that the very processes and procedures (development from below) that were designed to be alternatives should be perceived and applied to complement other ideologies and practices. This way the practice of development will have an array of perspectives and processes so that we can "overcome past shortcomings and meet changing perceptions or priorities…" Simon and Narman (1999: 271).

2.1.5 The Post-development perspective

Proponents of post-development theory question the concept of development itself because of the failures of development approaches to tackle inequality and poverty (Maiava 2001; Sidaway 2002). For example, they argue that development is a western generated phenomenon that is used to control the world (Morgan 2002; Eaterly 2006). As a way of challenging this notion, they propose a total rejection of external driven development interventions and allow local people to define and determine by themselves how they want to progress in life. This is one of the important assumptions underlying the post-development or otherwise known as anti-development perspective to development.

My support of development from below must not be mistaken to support post-development views, because these are two different perspectives. While I agree that over dependency on western perspectives to development can skew the much needed local development and that local people must drive their own development, I find it too radical to reject some other existing development initiatives wholesomely and to be anti-development. The global influence of western civilisation and perspectives on development cannot be ignored. This is seen not only in the way local people perceive development but also by the way development knowledge is gained, i.e. through western oriented institutions. My experience is that western values and way of life have deeply penetrated local communities of the south such that to suggest halting this influence and starting all over again would itself be rejected by the people that require development. My experience working on a CARE project to improve livelihoods of vulnerable poor women in Lusaka, Zambia confirmed my conjectures that poor people perceive western orientated way of life to be good life and associated with development. For instance when determining livelihood categories for measuring their own livelihoods trends the women indicted material items such as television sets, hi-fis, good clothes and cars on the highest level of their understanding of an improved livelihood. This stands to remind us that while it is important to work with people to redefine their perceptions regarding poverty and development to reflect their on realities with minimal external influence, the fact that the world has become more connected now than ever must not be ignored.

Therfore, I do agree with Zai (2004) and De Vries (2007) that despite proposing a people-led development, post-development theorists have not provided a convincing approach of dealing with inequality and poverty. In conformity with Leftwich (2000), De Vries (2007) and Taabazuing (2009) my point of view regarding the post-development thinking is that rather than reject the entire concept of development we must continue seeking in a broader sence, ways of making people's lives fulfilling. What is important is for people to first understand and strive to achieve what they perceive to be the important things in their life. Then through their local organisations they work together to achieve the kind of life they want. Again they must work as equal partners with other entities that would like to contribute towards their development endeavour. Hawi (2005) also supports the view that creating partnership

from the community level through to national level should be considered as an alternative approach for development particularly in Africa.

2.2 Conclusion

This chapter introduced the debate on development thinking starting with the review of historical perspective of development. It reviewed some traditional theories of development and how this influenced the definition of development itself. It is clear from this chapter that the debate on development and how this must be achieved has been going on for a long time generating various schools of thought. We have seen how the modernists see social transformation as key to achieving development, while the dependency pundits suggest a locally based development. What we have seen is that both orientations have not yielded development results but rather more counter reactions from other perspectives.

The chapter also highlighted the emergency of alternative development thinking which I believe to be appropriate, but again this must be flexible enough to accommodate views from other theories and approaches. The world is slowly becoming a global village and local development perspectives are being influenced by interactions with other cultures. It is therefore important to allow for cross-cultural learning. The availability of information in this age must be appreciated and used to learn from best practices.

This chapter has set the stage for the discussion on some contemporary perspectives of development. These are discussed in the next chapter.

CHAPTER 3

A REVIEW OF CONTEMPORARY DEVELOPMENT PERSPECTIVES AND THEIR RELEVANCE TO THE FIGHT AGAINST HIV/AIDS

3.0 Introduction

In this chapter I will review some of the contemporary perspectives on development approaches and link these to the fight against HIV/AIDS. Some of the perspectives I will interrogate include Sustainable Development (which has become the umbrella for contemporary development thinking); Sustainable Livelihood Approaches (SLA); Indigenous Knowledge; and Culture and Development. I will also discuss the Globalisation perspective to development and how this relates to HIV/AIDS and its responses.

3.1 Sustainable development: The new umbrella in development thought

Sustainable development has become a catch word among development practitioners. This is a result of the realisation that previous development undertakings have occurred to the detriment of the environment without regard for the future generations. This realisation called for futuristic thinking that requires rational use of environmental resources (Todaro and smith 2006). The 1987 Brundtland Commission report on global environment and development steered great interest on sustainable development among development scientists (Sneddon, Howarth and Norgaard 2006). Since then different scholars have defined sustainable development differently depending on the development school of thought they subscribe to.

For example, Pearce (1986) sees sustainable development as a rational trajectory where people pursue and satisfy their current needs with consideration of those of future generations. Others such as Barbier (1989: 185) cited in Taabazuing (2009) perceives sustainable development as a process of interaction based on a trade-off relationship between biological, economical and social systems.

The commonly cited definition of sustainable development is that which was articulated by the World Commission on Environment and Development (WCED) otherwise known as the Brundland Commission (Kates, Parris and Leiserowitz 2005). It states that sustainable development is "development that meets the needs of the present without compromising the ability of future generations to meet their own needs" (WCED 1987:43). This means that the environment and development are inseparable; the environment being where we live and development being what we do within the environment to better our lives.

This understanding of sustainable development places emphasis on how the current generation uses resources to meet its needs. I interpret this definition to mean that as rational beings we must be mindful that this world is not for us alone and that we are not the last ones to inhabit it. As such we must be considerate and think about the welfare of future generations and the environment they will inherit as we utilise it to meet our needs. In other words, we have to live our lives (using water, electricity, coal, oil, fossil fuel, carbon dioxide, greenhouse gases) in such a way that our children and our grandchildren and all the generations coming after them will also have the same chance of living a sustainable life (Kates et al 2005). This is what is referred to as intergenerational justice (Costanza 1991; Vercelli 1998).

3.1.1 The different perspectives of sustainable development

According to Carley and Christie (1992) and Bergh and Jeroen (1996) there are various theoretical perspectives used to characterise sustainable development. Carley and Christie (1992) identify five prominent strands that include the following; populist view, the political ecology view, the deep ecological view, the technocratic view, and the ecological feminist (ecofeminism) view. A brief description of each view is given below.

i) The populist view

This view recognises the importance of local knowledge systems and the need to mobilise local people and to motivate them to participate in their own developments (Sneddon et al. 2006). This view advocates for home grown culturally appropriate development approaches as opposed to adoption of western models.

ii) The technocratic view

This view is opposed to the populist orientation and closely related to the classic modernisation perspective. Treurnicht (2000) perceives this view as reductionist because it contains some exploitative aspect within it. For example, the technocratic perspective places emphasis on the use of technology to utilise the environment to maximise economic growth with little consideration of both short and long term effects.

iii) The deep ecological view

This perspective represents a social movement of groups that challenges the technocratic perspective of human centeredness approach. It is opposed to reductionism but rather recognises the importance of all life (both human and non-human life). It also propounds that human beings are part of the earth and as such they must not exploit it (Chatterjee and Finger 1994).

iv) The ecological feminist view

This perspective of sustainable development focuses on the unjust domination of nature by humans. It relates this injustice with the prevailing gender imbalances against women. Proponents of this view advocate for ecological integrity through social transformations where dominant value systems are replaced with those of equity and justice (Cuomo 1998). Supporter of this view see nature as a feminist issue and suggest that a good understanding of power relations i.e. the domination of women can help to understand how the domination of the environment leads to an environmental crisis.

v) The political ecology view,

This view of sustainable development recognises the influence of socio-economic and political factors on environmental issues (Robbins 2004). Political good will towards environmental issues is seen to be very important towards addressing the environmental crisis the world is facing. In my view this perspective provides a more comprehensive understanding of environmental issues. Political good will is a very important incentive to many development issues including that of HIV/AIDS. Political commitment can facilitate formulation of environmentally friendly policies that can assist ameliorate the current environmental crisis. Political commitment has already proved to be effective in fighting HIV/AIDS in Uganda and Botswana.

Building on the above perspectives promulgated by Carley and Christie, Bergh and Jeroen (1996:21-35) also came up with 12 different perspectives of sustainable development. These perspectives are an indication that sustainable development is not static. Its interpretation changes in accordance with the dynamics in social organisation and technological innovations (Brooks 1992; Froger and Zyla, 1998). Table 1 below presents a summary of theoretical perspectives used to characterise sustainable development according to Bergh and Jeroen.

Table 1: The theoretical perspectives of sustainable development

Theory	*Characterization of sustainable development*
Equilibrium-Neoclassical	Welfare non-decreasing (anthropocentric); sustainable growth based on technology and substitution; optimizing environmental externalities; maintaining the aggregate stock of natural and economic capital; individual objectives prevail over social goals; policy needed when individual objectives conflict; long-run policy based on market solutions.
Neo-Austrian-Temporal	Teleological sequence of conscious and goal-oriented adaptation; preventing irreversible patterns; maintaining organization level (negentropy) in economic system; optimizing dynamic processes of extraction, production, consumption, recycling and waste treatment.
Ecological-Evolutionary	Maintaining resilience of natural systems, allowing for fluctuation and cycles (regular destruction); learning from uncertainty in natural processes; no domination of food chains by humans; fostering genetic/biotic/ecosystem diversity; balanced nutrient flows in ecosystems.
Evolutionary-Technological	Maintaining co-evolutionary adaptive capacity in terms of knowledge and technology to react to uncertainties; fostering economic diversity of actors, sectors and technologies

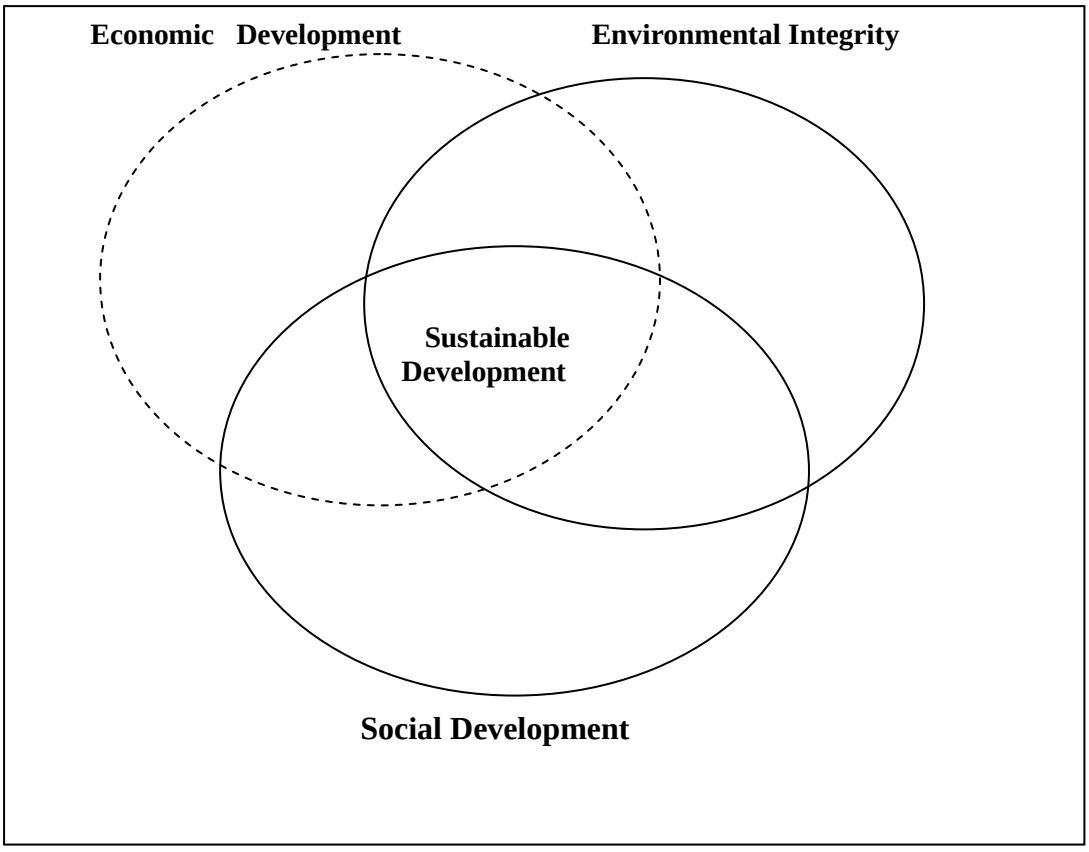
Physico-Economic	Restrictions on materials and energy flows in/out the economy; industrial metabolism based on materials – product chain policy: integrated waste treatment, abatement, recycling and product development.
Biophysical-Energy	A steady state with minimum materials and energy throughput; maintaining physical and biological stocks and biodiversity; transition to energy systems with minimum pollutive effects
Systems-Ecological	Controlling direct and indirect human effects on ecosystems; balance between material inputs and outputs to human systems; minimum stress factors on ecosystems, both local and global.
Ecological Engineering	Integration of human benefits and environmental quality and functions by manipulation of ecosystems; design and improvement of engineering solutions on the boundary of economics, technology and ecosystems; utilizing resilience, self-organization, self-regulation and functions of natural systems for human purposes.
Human Ecology	Remain within the carrying capacity (logistic growth); limited scale of economy and population; consumption oriented toward basic needs; occupy a modest place within the ecosystem food web and biosphere; always consider multiplier effects of human actions, in space and time.
Socio-Biological	Maintain cultural and social system of interactions with ecosystems; respect for nature integrated in culture; survival of group important.
Historical-Institutional	Equal attention to interests of nature, sectors and future generations; integrating institutional arrangements for economic and environmental policy; creating institutional long-run support for nature's interests; holistic instead of partial solutions, based on a hierarchy of values.
Ethical-Utopian	New individual value systems (respect for nature and future generations, basic needs fulfilment) and new social objectives (steady state); balance attention for efficiency, distribution and scale; strive for small scale activities and control of 'side effects' ('small is beautiful'); long-run policy based on changing values and encouraging citizen (altruistic) as opposed to individual (egoistic) behaviour

Source: Bergh and Jeroen (1996:21-35; Gallopin 2003:23).

These various perspectives of sustainable development demonstrate that the concept has garnered a lot of interest in the development discourse and people have used it for different purposes in both scientific and political realms (Drummond and Marsden 1999). As such the concept has remained laden with values of who ever is interpreting it and in some instances clouding it with ambiguity (Drummond and Marsden 1999).

Given all these perspectives of sustainable development, I posit that it is still important to use it as a development framework upon which most approaches can be referenced onto. I support the idea of co-existence with nature and to use it in a rational manner so us to ascertain availability of natural resources for future generations. When crafting development initiatives, it is critical to consider integrating economic, social, cultural, political, and ecological factors (UNCED 1992, Gallopín et al. 2001, Kates et al. 2001). Treurnicht (2004) illustrated this integration in terms of economic development, environmental integrity and social development as shown in figure 3 below:

Figure 3: The sustainable development model



Source: Adapted from Treurnicht 2004.

Figure 3 illustrates that sustainable development is a result of integration of various factors and that no one factor is dominant. The economic development circle is doted because as Treurnicht (2004) aptly contends, we are currently not living within the

limits of our fragile planet. Economic growth should therefore be adapted constantly to promote radical green sustainable development.

This model can be applicable in considering responses for HIV/AIDS. When dealing with HIV/AIDS as a development challenge, responses to the epidemic must take into consideration the interaction between economic, socio-cultural, and environmental factors. As much as it is important to consider various factors in responding to HIV/AIDS it should also be acknowledged that HIV/AIDS itself does affect sustainable development (UNAIDS 2000). This will be discussed in much detail in chapter 4.

3.2 The sustainable livelihood approach (SLA)

The idea of sustainable livelihoods was developed by Robert Chambers in the mid 1980's (Kollmar and Juli 2002; Haidar 2009:4). This was a result of the realisation of failures of conventional development concepts to yield desired development outcomes to improve people's lives (Thomson 2000). These failures were mainly due to the fact that previous livelihoods analysis were too narrow and focused only on certain aspects or manifestations of poverty such as low income and did not consider other vital aspects of poverty such as vulnerability and social exclusion (Krantz 2001:1).

The Brundtland Commission on Environment and Development was instrumental in advocating for the expansion of the application of the SLA as a broad goal for poverty eradication. This led to the apparent realisation that more attention must be paid to the various factors and processes that either constrain or enhance poor people's ability to make a living in an economically, ecologically, and socially sustainable manner (Neeley et al 2004). As a result the SLA became a popular concept for enhancing the efficiency of development cooperation. For example in 1997 the Department for International Development (DFID) integrated the sustainable livelihood approach in its development cooperation programme (Kollmair and Juli 2002). Organisations such as CARE, UNDP and OXFAM also adopted sustainable livelihood methodologies in the work (Krantz 2001; Haidar 2009).

3.2. 1 Defining livelihood

In order to fully appreciate the meaning of sustainable livelihood approach (SLA), it is important to understand the meaning of livelihood. Chambers and Conway (1992:9), provide a widely used definition of livelihood. They state that "a livelihood comprises the capabilities, assets (stores, resources, claims and access) and activities required for a means of living: a livelihood is sustainable when it can cope with and recover from stress and shocks, maintain or enhance its capabilities and assets, and provide sustainable livelihood opportunities for the next generation; and which contributes net benefits to other livelihoods at the local and global levels and in the short and long term."

Later on Scoones (1998) expanded the understanding of livelihood beyond the definition provided by Chambers and Conway and brought in the dimension of wise utilisation of natural resources. Krantz (2001:1) and Serrat (2008) cite Scoones definition which states that "a livelihood comprises the capabilities, assets (including both material and social resources) and activities required for a means of living. A livelihood is deemed sustainable when it can cope with and recover from stresses and shocks and maintain or enhance its capabilities, assets, and activities both now and in the future, while not undermining the natural resource base." Both definitions of livelihoods provided by Chambers and Conway and by Scoones place emphasis on livelihoods being sustainable. To me this brings in an interesting dynamic to understanding livelihoods because it calls for the need to go beyond the conventional definitions and approaches to poverty eradication (Krantz 2001:1). Emphasis on livelihoods being sustainable is critical because it influences people's perceptions of the available resources and how these can be used as well as the selection of strategies that should be used to achieve livelihood goals.

For a livelihood to be meaningful it has to be sustainable and for this to happen people have to gain access and utilise various types of resources (tangible and intangible ones) that can assist withstand stress and shocks (Solesbury 2003). Allen and Satteur (2002) provide a clearer view of sustainable livelihood and states that it is concerned with people's capacities to generate and maintain their means of living, enhance their well-being and that of future generations.

My perception of sustainable livelihood is influenced by Chambers and Conway and Scoones because I agree that a livelihood comprises capabilities and assets, and that a sustainable livelihood must be able to cope and deal with stress and shock. However, I emphasise that this must not only take into consideration, social, political or economic issues but also environmental ones such that the present generation must leave a better place for future generation to effectively function within.

3.2.2 Exploring the meaning of sustainable livelihood approach

The concept of sustainable livelihood has increasingly become critical to the debate on development (Scoones 1998) and the SLA is broadly used by development practitioners in different contexts (Krantz 2001). According to Krantz (2001:2) there are three assumptions about poverty that underpin the SLA. "Firstly is the realisation that while economic growth may be essential for poverty reduction, there is no automatic relationship between the two since it all depends on the capabilities of the poor to take advantage of expanding economic opportunities. Secondly is the realisation that poverty, as conceived by the poor themselves is not just a question of low income, but also includes other dimensions such as bad health, illiteracy, lack of social services, etc., as well as a state of vulnerability and feelings of powerlessness in general. Thirdly is the recognition that the poor themselves often know their situation and needs best and must therefore be involved in the design of policies and project intended to better their lot."

According to Haidar (2009:4), the sustainable livelihood approach is a way of thinking about the objectives, scope and priorities for development activities. It is based on evolving thinking about the way the poor and vulnerable people live their lives and the importance of policies and institutions (DFID 2002). The SLA places people at the center and uses participatory methods to identify challenges and opportunities faced by poor people as expressed by themselves. It provides a framework that helps to understand the complexities of poverty. It also suggests a set of principles that facilitates the identification of practical priorities for actions based on the views and interests of those who are concerned about the development challenge that needs to be addressed (Abu 2002). By so doing this approach empowers the poor and cultivates the inherent potential in them in terms of skills,

social networks, access to physical and financial resources and ability to interact and influence core institutions. As Clark and Carney (2008) contend, SLA makes the connection between people and the overall enabling environment that influences the outcomes of livelihood strategies.

3.2.3 The core principles of sustainable livelihood approach

The application of SLA to any development intervention must consider the core principles and framework of the approach as observed by various proponents of the approach (Chambers and Conway 1992; Krantz 2001; Carney 2001; Kollmair and Juli 2002; Haidar 2009). However, it is important to note that these principles and the framework do not in any way prescribe solutions or dictate methods that must be used in determining people's livelihoods; instead, they must be perceived to be flexible and adaptable to different conditions. The core principles of SLA include the following: people-centered; holistic; dynamic; building on strengths; macro-micro links; and sustainability. These will be elaborated below.

a) People-centered

The SLA puts people at the center of development and actively involves them in the analysis of their livelihoods and how these change over time. Focus on people is important because it assists understand the dynamics of poverty and livelihoods based on the views of those who experience it (DFID 2000b). This principle also entails that support that is received must be channeled to the people within their current livelihood strategies, social environments considering their ability to adapt and utilise the support. The focus on people further helps to understand the impact of various policy and institutional arrangements within which people must function to achieve sustainable livelihood outcomes (DFID 2002).

b) Holistic

This principle is based on the acknowledgment that people adopt many different strategies to secure their livelihoods and that many actors are involved in this

endeavour (Farrington et al 1999). It emphasises that SLA is neither sector specific no limited to a specific geographical location or only applicable to a certain social group (Norton and Foster 2001). This principle facilitates analysis of various influences on people and identifies factors that constrain or provide opportunities for sustainable livelihood outcomes that are people-centered. It further seeks to understand how these factors relate to each other and how they jointly impact on livelihoods (DFID 1999).

c) Dynamic

The SLA is dynamic because people's livelihoods, the contexts, the policies and institutions are ever changing too. The SLA therefore seeks to understand the dynamic nature of livelihoods and what influences them. It emphasises on learning from people's changes and helps mitigate negative impacts whilst supporting positive effects. Understanding the dynamism of livelihoods not only enriches the analysis of livelihoods but also creates possibilities of coming up with appropriate measures of boosting livelihood outcomes (Solesbury 2003).

d) Building on strengths

This principle is closely related to the first one (people-centeredness) because it emphasises on recognising and analysing people's strengths and potential first and then build on the strengths and opportunities rather than focusing on their problems (DFID 2000b). It also appreciates and supports existing livelihood strategies and assists people to identify and remove constraints to realising their potential and to be able to achieve their objectives.

e) Macro-micro links

Often development activity tends to focus at either the macro or the micro level (DFID 1999) and decisions made at these levels affect people's livelihoods. SLA therefore tries to bridge this gap and stresses the link between the macro and micro levels. It also examines the influence of policies and institutions on livelihood options and highlights the need for policies to be informed by insights from the local level and by the priorities of the poor.

f) Sustainability

The principle of sustainability is an important aspect of the SLA. It focuses on creating lasting poverty reduction efforts rather than short-lived ones. Sneddon (2000; Kollmair and Juli 2002:4) argue that livelihoods can be classified as sustainable when;

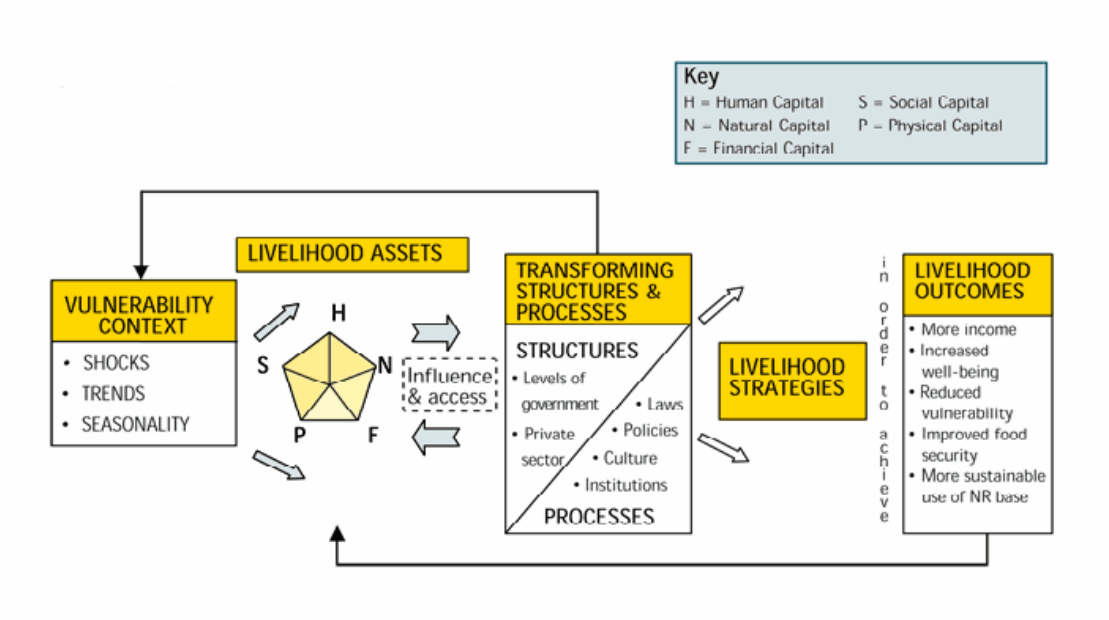
i) They are resilient in the face of external shocks and stresses.
ii) They do not dependent upon external support (or if they are, this support itself should be economically and institutionally sustainable).
iii) They maintain the long-term productivity of natural resources.
iv) They do not undermine the livelihoods of, or compromise the livelihood options open to others.

While I agree that livelihoods must strive towards sustainability, I also recognise that due to the many dimensions of sustainability (environmental, economic, social, and institutional sustainability) it is difficulty for livelihoods to qualify as sustainable across all these dimensions (DFID 1999). What is important is that a measure of sustainable livelihoods is set and the path towards its achievement is clearly defined.

3.2.4 The sustainable livelihood framework (SLF)

The SLF was developed to aid with the implementation of the SLA. It forms the core of the SLA and serves as an instrument for analysing people's livelihoods especially the poor (DFID 2000a). The framework guides to understand people's livelihoods and provides a checklist of livelihood components and how these are interrelated to either constrain or enhance people's livelihoods (Carney 1998; Kollmair and Juli 2002; Haidar 2009). The SLF is presented in schematic form showing main components of the SLA and how they are linked. Figure 4 below illustrates the SLF.

Figure 4 The Sustainable Livelihood Framework.



Source: DFID 2002:1; Haidar 2009:5)

The common livelihood components as illustrated in the SLF above include the vulnerability context, livelihood or capital asserts, transforming structures and process, livelihood strategies, and livelihood outcomes. The framework shows the vulnerability context within which people and stakeholders operate to gain access to assets that must be transformed to reach livelihood goals. These gain their meaning and value through the prevailing social institutional and organisational environment (the transforming structures and processes) which influences livelihood strategies that are open to people in pursuit of their self-defined beneficial livelihood outcomes (Kollmair and Juli 2002:5). The livelihoods components are further elaborated below.

3.2.4.1 The vulnerability context

People's lives are dynamic and from time to time move in and out of poverty due to changes and influences from the environment they live in (Elasha 2005). According to the SLF this environment is referred to as the vulnerability context. Generally, vulnerability is characterised as insecurity in the well-being of individuals, households, and communities in the face of changes in their external environment (Devereux 2001). The vulnerability context includes shocks e.g., conflict, illnesses, natural hazards such as floods, storms, droughts, earthquakes; seasonalities, e.g.,

prices, and employment opportunities; and critical trends, e.g., demographic, environmental, economic, governance, and technological trends.

It is important for people to understand their context of vulnerability and how these may affect their lives. It is worthwhile to note that not all trends and seasonality changes have negative influences on the lives. For example, some trends in new technologies or seasonality of prices could be used as opportunities to withstand and recover from stresses and shocks and secure livelihoods (Carney 2002).

3.2.4.2 The livelihood assets (or 'capital')

In this thesis, livelihood assets and capital are used interchangeably. These are an important component of the SLF because they form the strength upon which people construct their livelihoods and achieve their goals (Bebbington 1999). Bebbinton (Ibid) further stresses that in traditional economic systems, capital, or wealth, were commonly understood to comprise goods and services that can be assigned monetary value and tended to ignore non-monetary assets such as human health and well-being, social networks, clean air and water, and biological diversity. However, in order to achieve sustainability, the traditional definition of capital must be expanded to include natural and social, as well as economic resources.

Given the foregoing, livelihood assets are considered to be stocks of different types of capital that can be used directly or indirectly to generate livelihoods. They can give rise to a flow of output, possibly becoming depleted as a consequence, or may be accumulated as a surplus to be invested in future productive activities (Elasha, Elhassan, Ahmed and Zakieldin 2005). People require a range of assets to achieve their self-defined goals because no single capital endowment is sufficient to yield the desired outcomes on its own. The SLF is based around the analysis of five capital assets that include human, physical, financial, natural and social capital as discussed below.

a) Human capital

In development practice, human capital is important because development pursued must benefit people first. In the context of the SLF, human capital represents good health, nutrition, skills, knowledge, capacity to adapt and work which enables people to pursue different livelihood strategies and achieve their livelihood objectives (DFID 2000).

b) Social capital

Social capital also places emphasis on people and the way they interact with one another and with systems within their communities. It represents the social resources upon which people draw on to achieve their livelihood outcomes (Ashley 2000). These include networks and interactions that increase people's trust and ability to function in a more formalised manner with systems of rules, norms and sanctions within the framework of Indigenous Knowledge Systems (IKS) (World Bank 1997). Indigenous Knowledge Systems will be discussed later in this chapter.

c) Natural capital

Natural capital refers to natural resource stocks from which resource flows and services (such as land, water, trees and forest products, wildlife, air quality, erosion protection, etc.) that are useful for livelihoods are derived (Saab 2009). Within the SLF there is a particularly close relationship that exists between natural capital and the vulnerability context because most of the livelihoods shocks for instance are a result of natural processes that destroy natural capital (these may include fires, floods, earthquakes etc). Understanding the available natural resources and preserving them for careful current and future use is important in achieving sustainable livelihood outcomes.

d) Physical capital

Physical capital implies human-made resources that comprise some basic infrastructure and producer goods that make labour more productive to support

livelihoods such as infrastructure (transport, roads, vehicles, secure shelter and buildings, clean water supply and sanitation, energy, communications), tools and technology for production (Kollmair and Juli 2002:7). Physical capital can be natural capital that has been transformed by people to use in achieving desired livelihood goals.

e) Financial capital

This denotes resources of financial nature that people use to achieve their livelihood objectives (Serrat 2008). Two main sources of financial capital are available stock (cash or equivalent, savings, credit and debt [formal and informal]), and regular inflows of money (labour income, remittances, pensions etc). Financial capital can be converted into other types of capital that provide people with livelihood options and enable them to adopt different livelihood strategies and achieve livelihood strategies such as purchasing food or acquiring means of production (Cattermoul, Townsley, and Campbell . 2008). However, financial capital is least available among the poor.

3.2.4.3 The transforming structures and processes

Transforming structures and processes represent institutions, organisations, policies and legislation that determine access to assets and shape livelihoods (Shankland 2000; Keeley 2001; Kollmair and Juli 2002).

In this context structures are the public and private sector organisations that set and implement policy and legislation; deliver services; and purchase, trade, and perform all manner of other functions that affect livelihoods (Serrat 2008:3). Processes embrace the laws, regulations, policies, operational arrangements, agreements, societal norms and practices that in turn determine the way in which structures operate (Shankland 2000). Both structures and policies compliment each other to influence livelihoods. Structures provide a context within which processes can be created and made functional while processes themselves make structures more functional. Both structures and processes do influence people to make livelihood choices. It is important to recognise that while structures and processes are vital in

transforming assets and enhancing livelihoods, they can be restrictive if they are not representative and pro-poor (Ellis 2000).

3.2.4.4 The livelihood strategies

Livelihood strategies aim to achieve livelihood outcomes (Serrat 2008:3). They are a combination of activities that people choose to undertake in order to achieve their livelihood goals (Haidar 2009:6).They represent ways in which people transform and deploy their assets and capabilities to improve their livelihoods which include consumption, production, processing, exchange and income-generating activities (Solesbury 2003). The choice of adopting livelihood strategies to meet changing needs is critical because some of the strategies adopted may be detrimental to the environment (e.g. over-cutting trees for charcoal, over- poaching etc) or even cause rural collapse due to young people migrating from rural areas to urban areas. This may also mean girls and women engaging in risk behaviours such as exchanging sex for goods and finances to sustain their livelihoods. An application of the SLA in these circumstances offers the advantage to being sensitive to such issues (Kollmair and Juli 2002:9).

3.2.4.5 The livelihood outcomes

Livelihood outcomes represent achievements of livelihood strategies and these may include increased income, increased well-being, reduced vulnerability, improved food security and more sustainable use of natural resources (Carney 2002). The livelihood outcomes are usually a result of a combination of strategies people adopt at individual and community level and can show how people reacted to their context and utilised the various resources at their disposal. It is important to note that due the influence of structures and processes different people and communities will combine resources differently to arrive at their desired livelihood outcomes.

Though SLA and the SLF provide a good opportunity for analysing livelihoods and encourages participation among vulnerable people it does not provide universal solutions. Effective application of the SLA and the framework requires appropriate modification and adaptation to suit local circumstances and priorities.

3.2.5 Application of sustainable livelihood approach to HIV/AIDS responses

In attempting to contextualise the SLA in response to HIV/AIDS, one question that most development practitioners have to deal with is whether SLA and the SLF can actually be applied in the response to HIV/AIDS. This question arises because historically the SLA was widely used to analyse poverty in poor households and less if at all, in health related programmes. This was also influenced by the thinking that solutions to HIV/AIDS rested in medical sciences.

My view, which is based on my experience working in the HIV/AIDS sector for close to two decades is that the SLA can actually be applied in responding to HIV/AIDS especially in high prevalence, poor settings.

While discussing the SLA earlier in this section, we have seen that the approach provides an analytical structure for building an understanding of livelihoods. It can be used both as a tool (to organise and analyse data) and as a programme (to plan and define interventions) to address diverse issues that affect people's livelihoods, including HIV/AIDS thereby becoming a pathway to effective response to HIV/AIDS.

As will be discussed in detail later in chapter 4, it should be noted that HIV/AIDS affects people at various levels, the individual, and community, national and global levels and that its impact is mostly felt among the poor. The impact of HIV/AIDS on livelihoods is apparent and the thinking of applying various development approaches is becoming prominent in response to HIV/AIDS. White and Robinson (2000:5) support this perspective and state that the "epidemic has become a matter of concern beyond the fields of biomedicine and preventive and curative health and has become increasingly understood as a development issue", calling for development oriented responses.

Therefore, when considering the place of HIV/AIDS responses in the SLA and its framework, it is important to remember that those living with HIV and AIDS are still people trying to achieve livelihood goals including productive activities, investment strategies, reproductive choices, etc Seeley (2002). Besides, the purpose of

responding to HIV/AIDS is to assist those living with HIV/AIDS live better lives themselves and to achieve their goals and create sustainable livelihoods for their families.

The principles of SLA as outline earlier are relevant to the HIV/AIDS response. The fact that HIV/AIDS affects people implies that responses must adopt people-centered approaches that are responsive and promote participation of those affected. HIV/AIDS responses also call for a holistic approach that looks at people's lives in totality beyond the epidemic. Rather than view HIV/AIDS in isolation and focus on one sector, responses must adopt multi-layered approach across all sectors targeting HIV/AIDS as a development concern by addressing poverty, illiteracy and gender while promoting income generating activities among the afflicted people. The responses must aim to work at various levels, recognising macro-micro linkages and creating partnerships between public, private institutions and civil society organisations including grass-roots initiatives and CBO that are close to the people. Countries such as Uganda that have applied these principles, coupled with good political will have had good results in the fight against HIV/AIDS.

3.2.5.1 *Fitting HIV/AIDS analysis in the sustainable livelihood framework*

The impact of HIV/AIDS can be seen within the context of the SLF. Therefore efforts to address the impact of the epidemic must also occur within the SLF framework starting with awareness and analysis of the vulnerability context to transforming assets through available structures and processes that will enable adoption of appropriate strategies to achieve safer livelihoods , be it through better health care provision, supplies of condoms or through finding ways to address the fundamental cause of the spread of much of the epidemic: poverty and inequality (Seeley 2002:1). The HIV/AIDS epidemic itself is a shock (though not a sharp one when compared to droughts or floods). Long term illness in high prevalence countries is part of the vulnerability context and it exacerbates socio-economic vulnerabilities (Seeley and Pringle 2001). For instance, long term illness may affect people's access to work and means of production as well as financial assets. It can also complicate problems created by vulnerability to other shocks such as natural disasters, seasonality changes

and trends. In such circumstance people may adopt quick-fix livelihood strategies that throw them back into the vulnerability context.

Health and well-being are an integral part of human capital such that incapacity due to long term illness and death brings serious ramification at household, community and macro-level (Seeley and Pringle 2001). This also affects how both physical and natural resources are managed and used. These may be neglected and create bigger challenges needing more labour or capital intensive interventions. Financial resources are diverted to deal with shocks brought about by illness and social capital is diminished as family members and friends are lost, and social networks are weaken because of stigma attached to HIV/AIDS.

The transforming structures and process are important in the response to HIV/AIDS. Policy reforms and laws can be instituted to reduce stigma, promote inclusiveness in programming and decision making as well as provide better opportunities for the people to ensure that responses to HIV/AIDS are not confined to health strategies alone (Du Guerny 2002). Examples of good responses due to good policies initiated by governments in Botswana and Uganda have been mentioned earlier in this thesis.

As a tool that is used to improve understanding of livelihoods and how these fit together, the SLF can provide an opportunity to mitigate the impact of HIV/AIDS on people by looking at their circumstances broadly and also by looking at the connections between different livelihood assets and taking into account the fact that an intervention in one area will impact on other areas of people's lives.

Given all these interrelations of the dynamics of HIV/AIDS and how they affect livelihoods it is clear that with participation from the people concerned, the SLA and the SLF in particular can be applied to analyse the HIV/AIDS epidemic and come up with appropriate livelihood strategies that can generate sustainable outcomes.

While I appreciate the utilisation of SLA in development practice and recommend its application in responses to HIV/AIDS, I do recognise that the approach cannot address all aspects of the livelihoods of the poor. The intention must remain that of employing a participatory and holistic perspective in the analysis of livelihood

situations and to identify important issues so that an appropriate intervention could strategically be identified for adoption and subsequent utilisation at individual household, community and national levels.

3.3 Indigenous Knowledge, culture and development

Indigenous knowledge (IK) and culture are important aspest that must be considered in comtemporary development debate and analysis. In this section, I will discuss these and their relevance to development. Since HIV/AIDS is conceived to be a development issue in this thesis, I will also debate how these influence the dynamics of HIV/AIDS and its responses. I will start with IK and then proceed with culture.

3.3.1 Defining indigenous knowledge and its divergence with western knowledge

A number of terms are used interchangeably to refer to the concept of IK. These include Traditional Knowledge (TK), Indigenous Technical Knowledge (ITK), Local Knowledge (LK) and Indigenous Knowledge System (IKS). These will also be used interchangeably in this thesis.

Gorjestani (2000) emphasises that human beings gather knowledge basically for two purposes: survival and meaning. This is to say, human beings always strive to interpret and gather meaning of the environment they live in so that they figure out how they can live and survive within it. This process is as old as human history itself and this in my view is the process of creating knowledge.

I have taken interest in IK because it represents the true roots of humanism (Magga 2005) and it is often discussed in reference to people of societies that are seen to be less modernised and hence undeveloped according to proponents of modernisation theories. What is import to note is that long before the development of modern science, indigenous people had developed their ways of knowing how to survive and also of ideas about meanings, purposes and values (Altieri 1995).

In an attempt to define IK I have observed that most literature does not provide a single definition of the concept though the various definitions by different scholars overlap in many aspects (Warren 1991; Flavier 1995; Ellen and Harris 1996; Grenier 1998; Odora Hoppers 2000; Melchias, 2001; Eyong 2009; Mapara 2009). For instance, Warren and Mc Kiernan (1999:427) suggests that IK is knowledge that is unique to a given culture or society. IK contrasts with the international knowledge system generated by universities, research institutions and private firms. Flavier et al. (1995: 479) explains that IK is the information base for a society, which facilitates communication and decision-making. Indigenous information systems are dynamic and are continually influenced by internal creativity and experimentation as well as by contact with external systems (Flavier et al. 1995: 479).

A more general definition of IK provided by Grenier (1998) and cited by Odora Hoppers (2000:3) states that IK is the "sum total of the knowledge and skills which people in a particular geographic area possess and which enables them to get the most out of their environment." Most of this knowledge and these skills have been passed from earlier generations but individual men and women in each new generation adapt and add to this body of knowledge in a constant adjustment to changing circumstances and environmental conditions They in turn pass on this knowledge to the next generation in an effort to provide them with survival strategies (Kolawole 2001; Liebenstein 2001:2).

In this study, IK refers to "a set of interactions between the economic, ecological, political and social environments within a group or groups with a strong identity, drawing existence from local resources through patterned behaviours that are transmitted from generation to generations to cope with change. These patterns are sustained by micro level institutional arrangements vested with differentiated responsibilities that ensure the group's continuous survival" (Eyong 2009:122). IK is the basis for local decision-making in a given society and it manifests itself through different dimensions such as agriculture, health and medicine, education, food preparation, natural resource management security, botany, zoology, craft skills and linguistics as well as a host of other activities in rural communities (Mapara 2009:140). It is embedded in community practices, institutions, relationships and rituals. This definition encompasses all forms of knowledge (explicit or implicit) that

include technologies, know-how, skills, practices and beliefs used in the management of socioeconomic, spiritual and ecological facets of life that enable the community to achieve stable livelihoods in their environment (Melchias 2001).

There are some common aspects about how different scholars have defined IK. For example there is consensus that IK is a system of knowledge that has survived for a long time and has proved flexible enough to cope with change (Mapara 2009:140; Melchias 2001). Indigenous Knowledge has failed to die despite the western interference for years (Warren 1995). Another common perspective is that IK originates locally and naturally and that an indigenous (local) community accumulates it over generations of living in a particular environment (ILO 1989; Altieri 1995:114). According to Hammersmith (2007:2), IK is actually linked to the communities that produce them. Another general agreement is that IK is different from cosmopolitan western knowledge of scientific discoveries, economic preferences and philosophies (Kolawole 2001:1).

I will highlight below some traits of IK that distinguishes it from other form of knowledge. According to Ellen and Harris (1996:52), the distinguishing features are that IK is:

i) Local and is rooted in a particular community and it comprises a set of experiences generated by people living in those communities.
ii) Tacit and therefore not easily codifiable.
iii) Transmitted orally or through imitation and demonstration.
iv) Experiential rather than theoretical knowledge and purely based on people's daily experiences, trials and error (Melchias 2001).
v) Learned through repetition, which helps in the retention and reinforcement of IK.
vi) Constantly changing, being produced as well as reproduced, discovered, some aspects maintained others lost.

3.3.2 The significance of Indigenous Knowledge to development and responses to HIV/AIDS

Every society has a knowledge base and this guides its development process and ensures its survival (Eyong 2004:122). This knowledge base has existed as long as society itself and sets the basis for the creation of indigenous knowledge systems upon which other forms of knowledge is founded (Magga 2005:6).

Indigenous knowledge is part of the lives of the people particularly the rural poor; it is truly human-oriented in a broad sense and many communities and cultures are dependent on this kind of knowledge since it provides the basics for skills needed for essential survival (World Bank 1997). Azmat and Abdullahi (2008) supports this point of view and recognises that the basic component of any society's knowledge system is its indigenous knowledge which encompasses the skills, experiences and insights of people applied to maintain or improve their livelihood. Knowledge capital is an important resource to sustainable development because it adds value to people's lives and has relevance in itself and to the local community from which it is produced. It is in fact a key element of the social capital of the poor and it constitutes their main asset in their efforts to gain control of their own lives. As such a society's ability to build on its Indigenous Knowledge is as important as mobilising other forms of capital (World Bank 1997). The most important aspect of IK to development is that it takes into consideration the role and position of human beings in a wider context based on a deep understanding of the inter-relationships among the different elements of a habitat (Hoppers 2000; Eyong 2009:124). IK has so far proved to be important in areas that are critical to development such as food security, human and animal health, education, natural resource management, and other vital economic and social activities including fighting HIV/AIDS (Gorjetani 2000).

Both IK and HIV/AIDS have affected each other in some way. For example HIV/AIDS precipitated knowledge erosion and severely threatened the sustainability of IK due to deaths of young adults on whom the continuation of culture and local knowledge depends as this is passed on to them by aging adults. The migration of young adults in search of alternative livelihood strategies after the death of bread earners also comes at the expense of local knowledge because migrants often leave

their environments to adapt to new localities where they have to learn the new culture and knowledge systems. For example the vulnerable children on the streets (wrongly referred to as streets kids) have de-linked from their original environments and culture and adapted an environment were survival is the order of the day.

Indigenous knowledge through traditional medicines proved to be very useful in alleviating AIDS conditions especially at the time when there was no treatment for the disease. Traditional medicine is one area that IK flourished in African societies and was used prior to the on set of HIV/AIDS and long before contact with western knowledge and medicines (Alhassan 2006:530). Traditional medicine was developed through traditional health care systems known as native medicine or traditional medicine. This health delivery system was contextualised and allowed to flourish within the context of the African cultural heritage, and there were remarkable evidences that proved the efficacy and efficiency of this delivery system (Amzat and Abdullahi 2008). Passed on from one generation to the other orally and through experiential learning, it was widely accessible, accepted and affordable because it was delivered within the community care context.

However, the traditional health delivery system became affected by the advent and adoption of modern health care delivery system which was championed by the local elites. Modern health care systems questioned and debated the efficacy and efficiency of traditional medicines. This debate led to the emergency of two schools of thought referred to as the “pessimistic” and “optimistic” schools of thought. I will not go much into details about the arguments of the two schools of thought because this is outside the main focus of this thesis. Amzat and Abdullahi (2008) provide insightful reading on this debate.

Nevertheless, the advent of HIV/AIDS and the burden it carried necessitated the involvement of the extended family to provide care and support. Most people with HI/AIDS were cared for in villages by old people in their homes. These old people relied on indigenous knowledge to manage a condition they were not familiar with. They related the manifesting HIV conditions with illnesses they may had seen or heard about in the past. Traditional medicine was also administered to alleviate the suffering of patients. Even today a lot of infected people still rely on traditional

medicines in Africa. The UNAIDS (2004) reveals that of the 6.5 million people in developing countries who need AIDS drugs not up to a million receive them, leaving traditional medicines a viable option. This seriously calls for the need for the two health systems to compliment each other to maximise the efficiency and effectiveness of health care. Over-reliance on one leaves a lot of gaps and affects holistic provision of care. For example, it is a fact that the distribution of modern medical personnel is usually uneven in most high prevalence countries with majority being found in the urban centres and being mostly difficult for many affected people to access in rural areas. To corroborate this point of view WHO (2002) observed that in Uganda it is estimated that there is one traditional healer for every 200-400 people. This contrasts sharply with the availability of trained medical personnel for which the ratio is 1:20,000 or less. This scenario is common in most high prevalence countries.

3.3.3 Limitations of applications of IK in the development process

Indigenous knowledge is not yet fully utilised in the development process and most of IK practices are not well documented to be referenced upon for replication in other areas.The limitations of IK in the development process is very much a question of power relations between local cultures and foreign cultures with the latter being more sceptical and opposed against the former (Magga 2005).

Today, many indigenous knowledge systems are at risk of becoming extinct because of the intrusion of foreign technologies and rapidly changing natural environments and fast pacing economic, political and cultural changes on a global scale (Burgess 1999:8). The potential of local experiences and practices are often overlooked because of the perception that foreign technologies or development concepts that promise short-term gains or solutions to problems are better than local ones without considering issues of sustainability. For instance, the change from extended to nuclear families is weakening links with the grandparent generation that holds much knowledge and the new generation is alienated from IKS due to the huge power of modernity (Eyong 2009).

To make IK more appropriate to the development process there is need to appreciate and understand it the way it is. It is important in this case to increase learning about IK just as much as it is to learn what local communities know and have in order to understand the local conditions to enrich and improve the effectiveness of development processes. IK, like any other knowledge, needs to be constantly used, challenged, validated and adapted to the evolving local contexts.

Development agents such as CBOs, NGOs, governments, donors, local leaders and private sector initiatives do have an important part to play to maximise the relevance of IK in the development process. They need to recognise it, value it and appreciate it in their interaction with the local communities. They also need to facilitate the careful fusion of IK with foreign knowledge so that the local communities can benefit from positives of various knowledge forms. IK is one of the familiar assets that the poor control, therefore integrating it into the development process allows for mutual learning and adaptation which in turn contributes to the empowerment of local communities (Gorjestani. 2000). Development agents further need to facilitate sharing of IK within and across communities to enhance cross-cultural understanding and promote the cultural dimension to development. This can promote ownership and sustainability of the development process.

3.4 Culture and development

In this section I will present and examine the definition of culture as presented by various scholars with the aim of generating an operational definition of the concept that will create the basis for discussing its relation with development and the responses to HIV/AIDS as the focus of this study.

3.4.1 Defining culture and its role in development

Culture is an integral aspect of people's lives. Dabaghian (1970: 103) observes that "…the pride of any society lies in its culture since no society in the world could be considered great without reference to its tradition and culture."

As a concept, culture has different meanings and connotations to different people depending on the context it is being used (Mbakogu 2004; Schech and Haggis 2004). However, Oyeneye and Shoremi (1985: 3) cited in Mbakogu (2004) suggest that when defining culture, it is import to bear in mind that culture is;

- Commonly shared by members of a society.
- Not genetically transmitted.
- Historically derived and transmitted from one generation to another.
- Created through the process of adjustment to the social setting.
- Universal and can be found in every human society.
- Not static but dynamic.

Early scholars such as Kluckhohn (1949:12-13) defined culture as that spectrum encompassing the total way of life of a people; the social legacy the individual acquires from his group; a way of thinking; feeling and believing; a storehouse of pooled learning; a mechanism for the normative regulation of behaviour; and a set of techniques for adjusting both to the external environment and to other people.

Andah (1982:4-5) cited in Mbakogu (2004:37) presentes a more embracing definition and stated that culture embraces all the material and nonmaterial expressions of a people as well as the processes with which the expressions are communicated. It has to do with all the social, ethical, intellectual, scientific, artistic, and technological expressions and processes of a people usually ethically and or nationally or supra-nationally related, and usually living in a geographically contiguous area; what they pass on to their successors and how these are passed on. Ukeje (1992) supports this perspective of culture.

Bartle (2007) cited by Taabazuing (2009:91) offers a contemporary dimension to understanding culture and identifies six dimensions of culture that seem to summarise most definitions of the concept. These include the technological dimension; the economic dimension; the political dimension; the institutional dimension, and the values and belief that people have about the world around them.

My understanding of culture borrows much from the above features. I recognise that culture is a public system that defines a way of life of people in a particular society (Ukeje 1992:395; Shoremi 1999:94). It represents a totality of material, non-material and spiritual aspects of life that define people's behaviour manifested through arts, beliefs, institutions and all other products of human work and thought (Odora Hoppers 2000; Visvanathan 2001a; Geissler 2004; Njoh 2006;). This broad understanding suggests that culture is the framework that shapes man's life through learning from the experience of both the past and present. Without culture man is nothing.

3.4.2 Exploring the relationship between culture and development and its implications to the responses against HIV/AIDS

The relationship between culture and development is viewed differently by different scholars. Some see the relevance of culture to development (Mervyn 1994; Sen 2000; Kuran 2004; Cassar and Bezzina 2005; Punnett 2006) while others perceive culture as an impediment to development (Rostow 1960; Landers 2000; Sorenson 2003). The debate on the relevance of culture in development thinking became increasingly important in postcolonial era in the 1960s due to evident deficiencies of cultural diversity in the adopted development models (Mbakogu 2004:40). People in independent nations started challenging the notion that development is synonymous with modernisation and the adoption of westernisation values, and not necessarily on their own culture and traditions. This debate led to the establishment of a United Nations organ, the United Nations Educational Social and Cultural Organisation (UNESCO). In its declaration of 1966, UNESCO clearly stated that "each culture has a dignity and value which must be respected and preserved" and that "every people have the right and the duty to develop its culture" (UNESCO 1966:1). In order to drive the momentum towards meeting this ideal, UNESCO initiated the World Decade for Cultural Development between 1988 and 1997 that focussed on the following four objectives:

(i) Acknowledging the cultural dimension of development.
(ii) Affirming and enriching cultural identities.

(iii) Broadening participation in cultural life.

(iv) Promoting international cultural cooperation.

The quest to meet these objectives created the impetus and reaffirmed the need to recognise the importance of the connection between culture and development.

My point of view in this discourse is that culture and development are closely related (Jarchow, Friedemann and Geue 2010). To begin with, it should be realised that there is no society that exists in a vacuum, therefore, existing cultural patterns of people determine the dynamics of that society (Isamah 1996). Through out history people's culture has been closely linked to its development (Mervyn 1994:14). As such it is indistinct to think that any development initiative would be successful if it does not have roots in people's culture.

Development is about change, and change must come from the forces within the society even if this may be stimulated by external forces. Therefore, development initiatives and the processes thereof, must take into consideration socio-cultural issues of people that must benefit from its outcomes. It is imperative to note that no meaningful development can take place without people's willingness and acceptance to change because every culture has within itself mechanisms that can either accept and facilitate development or reject it. Culture is the basis of all social action and a significant factor in shaping behaviour and various aspects of life including economic and social life (Punnett 2006; Oniango 2007; Taabazuing 2009) and development in a broader sense. The role of indigenous knowledge and practices in this case is also critical.

The overriding objective of development is to contribute to poverty reduction. In this context poverty is not solely regarded as a lack of economic and social resources, but also as exclusion, a lack of rights, influence, status and dignity (Okolie 2003: 249). It is valuable, therefore that culture must be incorporated as a resource to be drawn upon and not seen as an obstacle. Consideration of socio-cultural factors in the development process encourages the involvement of local people and subsequent utilisation of their creative capacity and potentials towards sustainable development (Umeh and Andranovich 2005). For example, Japan's development is rooted in its

socio-cultural structures which guided its innovative characteristics that led to the transformation of its socio-economic and political landscape (Mervyn 1994).

My position on the relationship between culture and development is not void of the understanding of the conflicting view points on this subject. I do realise that there are various forces at play that affect the relationship between culture and development. For instance, globalisation posses a major challenge and places a lot of pressure on local cultures as dominant cultures of the west penetrate the hinterland of the globe through information and technology (DANIDA 2002).

There is an explicit link between culture and HIV/AIDS and the responses adapted to fighting the epidemic. In chapter 6, I will discuss how some cultural practices have exacerbated the spread of HIV infection in high prevalence countries. Though there is not much literature to show how HIV/AIDS has actually affected evolution of culture, I have observed during my course of work that HIV/AIDS has actually affected the way people behave especially when it comes to issues of sex and sexuality. For instance, the use of condoms is becoming a common behavioural practice among the youth and people who choose to have casual sexual relationships. To me there is a shift in the way people live now and how they did before HIV/AIDS became an issue of concern. Partly, this is due to the abundant knowledge on HIV/AIDS necessitated by free flow of information as a result of globalisation. Globalisation has become an important factor in understand HIV/AIDS and its responses in recent times. This perspective will be discussed further in the next section.

3.5 The globalisation perspective to development and its role in the fight against HIV/AIDS

The Globalisation perspective is an important phenomenon to consider in development debate more so that it affects all facets of human life, including health and well-being. The link between globalisation and HIV/AIDS is inevitable especially when considering the fact that the infection has spread worldwide.

It is important therefore to note that although the causes and consequences of HIV/AIDS are multidimensional, AIDS presents itself in the context of health, particularly in the disease form. Bearing this in mind, I agree with Caroline Thomas's (1989) assertion that disease is a transnational phenomenon which pays no heed to territorial state boundaries. Barnet and Whiteside (2000) also point to the fact that health and wellbeing are international concerns and global goods. I support Ronald Labonte's (1997) contention that most of what creates 'health' lies beyond organised health care sectors. Poverty, income inequalities, social inequalities, environmental pollutants/degradations, violence and other complex social phenomena are far more important health determinants than access to health care services. It is in this broad context that I perceive health, particularly HIV/AIDS to belong to and as such can be seen in the spectrum of globalisation. Conceptualising HIV/AIDS within the context of globalisation assists to analyse the responses from a larger picture perspective and determine what sort of development approaches can be applied to mount effective responses.

3.5.1 Defining globalisation

Globalisation has become a buzz word in contemporary analysis of the development discourse. There is of course vast literature available on the subject (Giddens 1994; Forecast 1996; Gill 1998; Haines 2000; Barnett and Whiteside 2002; Stiglitz 2003; Kambhampati 2004; Baghwati 2004) and this has also increased the risk of it being used loosely.

Though globalisation is commonly understood to be a recent phenomenon in development literature, Barnett and Whiteside (2002) argue that in fact it is not. They place the concept in the 16th and late 19th centuries that were characterised by innovative developments in communication, transportation and production systems. However, they are quick to acknowledge that the present era has distinctive features characterised by shrinking space, shrinking time and disappearing borders. These have linked people's lives more deeply, more intensely, more immediately than ever before (UNDP 1999).

Different scholars explain globalisation differently. For instance, Giddens (1994) comments that globalisation is short-hand [term] for a whole series of influences that are altering not just events on the large scale but the very tissue of our everyday lives. Gill (1998) argues that globalisation is just another term used to describe the further stage of capitalism. Others such as Paul Kennedy (1996:28) argue that globalisation in fact means "the inter-connectedness of capital, production, ideas and cultures at an increasing pace." This entails that individual life and global features such as increasing economic, political, social and cultural interdependence diffuse across state boundaries (Castells 1996; Laison and Skidmore 1997). Joseph Stiglitz (2003) corroborates this idea and affirms that globalisation is in fact about the removal of barriers to free trade and the closer integration of national economies. It affects human health, livelihood and wellbeing aspects as much as it does political, cultural and social life aspects of people across the globe.

This interpretation of globalisation (which I subscribe to) conforms to the definition presented by Haines (2000:54) and reiterated by Taabazuing (2009) that globalisation is both a concept and a process, which carries a variety of meanings and ideological interpretations. The face of globalisation is seen as a concept through the penetration of systems of production and movement of capital, goods and people deep into the corners of the globe. As a process it manifests itself through the transformations of social relations, ideas, concepts and values necessitated by improved communication systems which make the world seem like one village (Held, McGrew, Goldblatt and Perraton 1999; Haines 2000; Kambhampati 2004).

The effect of globalisation in developing countries has been a subject of debate. It is perceived to diminish differences and enhancing development opportunities on one hand and being a threat to development in the developing nations on the other hand (IMF 2001:1). Regardless of which position one takes, globalisation has become a factor in development analysis; it is a phenomenon that is here to stay (Chan and Scarritt 2002:51). The two different perspectives on globalisation will be discussed in detail below.

On the one hand there are scholars who argue that globalisation brings opportunities for economic growth and development to developing countries (Baghwati 2004:28). The argument that proponents of this view advance is that globalisation facilitates a free flow of goods and services including labour across the world because of the reduction of trade barriers (Richardson 2000: 42; Dierks 2001: 63; Gangopadhyay and Chatterji 2005: 28). The assumption behind this thinking is that increased trade will generate enough capital for development. Related to the issue of an open flow of goods and services is that this promotes positive competition among nations which leads to increased innovations and careful planning (Corsi 2009: 9). Globalisation is also seen as a facilitator of knowledge and skills transfer from developed nations to less developed ones. It is this knowledge and skills that can be used to garner development (OECD 2000: 61). This perspective has its own consequences as will be discussed later.

Supporters of globalisation further argue that globalisation increases capital flows and financing from rich countries to poor nations throw loans and grants that can be used to capitalise development projects and create employment in less developed countries (Aurifeille 2006:254; Welfens 1999:158). This in itself enhances the filtering of money in form of wages to the household level thereby empowering the people.

On the other hand there are some scholars who argue that globalisation has in fact skewed the development process and increased levels of poverty in developing countries (Whiteford and Wright-St Clair 2004:353). Proponents of this view argue that the world is still not equal and that developed countries have an edge over the less developed nations in terms of trade, education, science and technology enabling them to benefit more from globalisation (IMF 2000; Bhagwati 2004: 4). This makes the

developed nations to assume a superior position relative to the less developed nations and gain influence over policies across the spectrum of development (Richardson 2002).

Due to the nature of globalisation and in its bid to open up social, economic and political boundaries currently in place, various functions in different countries have been affected (Bhagwati 2004: 4; Zedillo 2007:11). For example the reduction in trade barriers has led to the infiltration of inferior quality goods from developed to the less developed nations which are normally retailed at low prices compared to locally produced goods and services. This does not only increase dependency on foreign goods but also affects the markets of locally produced goods which is a disincentive to investment and can accelerate unemployment (Robert and Lajtha 2002).

Globalisation has also facilitated increased migration of labour force from less developed nations to developed ones in search of better wages (IMF 2000; Stiglitz 2003). This deprives the poor nations of the much needed skilled human power to drive development objectives.

A notable effect of globalisation on less developed countries is culture erosion (Whiteford and Wright-St Clair 2004:350). This has been necessitated by increased interaction of people. It has come with vices such as increase in the level of crime, immorality among other evils. There is a considerable erosion of cultural identities and boundaries between nations. Nowadays it is common for both young people and adults mimicking western accents and adopting and promoting foreign culture at the expense of their own. This level of culture suicide has an effect on local development and leads to deepened dependency.

The analysis of the effects of globalisation can also be applied to the HIV/AIDS situation at two levels. Firstly, that globalisation acts as a midwife to the spread of the epidemic. Modern technology and swift modes of travel has made it quick and easy for HIV to cross borders as evidenced by its unprecedented pervasive spreading to the remote corners of the world. Secondly, that globalisation itself has played a part in influencing the world to see the need to cooperate towards global action against the pandemic. Both these perspectives will be discussed further in the next section.

3.5.2 Globalisation as a conduit for the rapid spread of HIV/AIDS

The economic policies advanced by supporters of globalisation and economic theorists aimed at promoting faster development have had an impact on the spread of HIV/AIDS more so that they influence urbanisation and global migration patterns (Poku and Graham 2000). Population shifts due to the quest for economic benefits have bread conditions of social dislocation and poverty coupled with limited access to health due to the illegal nature that people are pushing these activities (Went 2000). The promotion of international trade has also seen the increase in the transformation of sex as an international commodity (Gui 2000). These activities increase people's vulnerability (especially women) and the diffusion of HIV and its rapid spread into almost every corner of the world. Asthana (1995), for instance presented the view that the overemphasis on economic development has led to the impositions of structural adjustments by the World Bank and the IMF which have in fact increased the vulnerability of many people to infection and limited the resources available for public health.

On the other hand the international diffusion of cultural has brought about the dominance of western culture over traditional cultures of poor nations. The implication of these changes is that certain ideas and beliefs about behaviour and identity are widely dispersed, such that new ways of behaviours have been adopted which often conflict with traditional values. This in itself increases people's vulnerability as they are left in the confusion of which culture they must embrace.

The diffusion of international culture in some instances has created political dilemmas towards responses to HIV/AIDS yet political will is essential to facilitate creation of an environment within which interventions can be mounted. Political will is critical to making decision about distribution of resources and funds; elimination of barriers (usually religious or cultural in origin) to addressing the problem and removing stigma associated with HIV/AIDS (Barnett 2002). On the contrary, in the name of protecting national identity and culture, politicians differ in their willingness to admit the seriousness of the epidemic and to encourage effective measures to address it. In such situations global inequalities and international interferences are often given as excuses to support their failures. Political denial promotes stigma which leads to

resistance to promotion of condom use and regularisation of activities of gays and prostitutes. For instance, in the mid 1990s in South Africa, when former president Thabo Mbeki questioned the relationship between HIV and AIDS, a lot of people missed an opportunity to access life saving medications.

Because of imbalances in power and resources required to mount effective global response to HIV/AIDS local politicians may reject international assistance even when it is well meaning for mere fear that their political power may be compromised at the hands of international organisations (Giddens 1994; Bancroft 2001). This is still happening in Zimbabwe today where President Mugabe is accusing some HIV/AIDS NGO to be interfering with national politics.

3.5.3 Globalisation as a facilitator of the global response to HIV/AIDS

Ironically HIV/AIDS has linked the least developed and the most developed regions of the world (Kahn 1995). The spread of the virus has made a mockery of national borders and sovereignty despite some countries attempting to close borders by imposing entry restrictions for HIV-positive persons into their countries. In conformity with this assertion, Richard Parker (1994) stated that "the rapid spread of the AIDS pandemic has profoundly changed the ways in which we live and understand the world. Never has a common, global problem so clearly drawn attention to the important differences that shape the experience of diverse cultures and societies."

While HIV/AIDS highlights the global nature of human health and welfare, globalisation has given rise to a trend towards finding common solutions to the problem. Globalisation has offered an opportunity for concerted global response and action against the epidemic by creating a unique meld of resources, political power and technical capacity of wealth countries with the needs and capacities of poor nations with high HIV prevalence (Merson 2006). The development of international responses to HIV/AIDS has formed part of the globalisation of human welfare (Hopkins and Wallerstein 1996) giving rise to new forms of global co-operation. For example numerous international funds have been set up and bilateral agreements signed to avail funds and share ideas on how best to tackle HIV/AIDS. According to

the Commission on HIV/AIDS and Governance in Africa (CHGA 2004:7), in 2003 alone, international organisations, foundations, nongovernmental organisations, and governments spent an estimated $4.7 billion to address the AIDS epidemic in low- and middle-income countries. This represents a nine-fold increase from 1996 to 2003 (CHGA 2004:7). The global response to HIV/AIDS will be discussed further in chapter 5.

I would like to bring down my argument regarding HIV/AIDS and globalisation to the point that these two are closely linked. For example, the very features of globalisation; economic development, population movement, the diffusion of culture and the breakdown of traditional ways of life facilitate the spread of HIV/AIDS. While I appreciate the international concern and funds that have been mobilised and channelled to poor high prevalence countries, these have come with prescribed strategies and approaches which have even made the response to be more complicated leaving local communities dependent on donor support.

3.6 Towards an operational definition of development

Traversing through the review of various development theories and approaches; from the debate on the historical perspectives of development to the review of contemporary development perspectives, I do agree with Robert Chambers "that the language of development rhetoric and writing changes fast. The reality of development practice lags behind the language. In other cases words persist and prevail, whatever happens to the field of reality…?" (Chambers 2000:35). The concept of development has been defined and used for many decades, sometimes in modified form, yet the central focus remains on how people must live and achieve the kind of life they must enjoy.

We have seen that the origin of the concept of development is in classical economics and as such its definition has been evolving mostly in economic terms (Todaro 2000:84). From the economic perspective, development is measured using growth in income levels such as the gross national product (GNP). According to Lipsky et. al. (1973:48) this is merely "a crude index of economic development" and must not

totally be relied upon because despite the importance of GNP to economic growth, this view does not elaborate the conditions under which development does or does not occur. Neither does it account for how the generated wealth is distributed (Ekins 1986: 8). As a result, “there is no compelling evidence that development however defined is taking place” (Adedeji 1989: 33; Calderisi 2007), especially in the developing countries.

In conformity with this assertion, abundant evidence is present in the development literature of the failures of conventional development efforts and centralised prescriptions of development strategies (Hope 1984; Magomero 2005). Centralised and paternalistic approaches based on conventional economics have failed to provide appropriate strategies and a framework to bridge the disparities that exit between developing countries and developed ones. It is clear, for example, that social, economic and spatial disparities are overwhelming and there are lots of examples of un-balanced distribution of national wealth in developing countries living the majority of the citizens very poor. For more examples see World Bank 2001; Khor 1997; Maser 1997. It is for this reason that the definition of development is becoming more encompassing of the human demission as discussed in chapter 2 under alternative development theories, particularly the bottom-up approach.

3.6.1 The meaning of development

Though development is generally considered a broad concept and its definition altered over the past decades with changing economic, political and social trends, I still find some old explanations striking and I have adopted some for purposes of advancing my conceptualisation of the concept. For example, I still support the notion advanced by Seers (1972) that development is a multi-dimensional process and has both qualitative and qualitative aspects. Rather than placing emphasis on economic growth, social and humanitarian aspects have become central in defining development (Potter and Salau 1990). These authors further contend that the significance of quality life, including liberty and basic human rights are the criterion of development. Following this reasoning development must be understood to be about things that make human life satisfying and fulfilling. Otherwise, the essence of development itself maybe questioned.

This thesis asserts that development is about strengthening communities and focuses on "people becoming empowered to bring about positive changes in their lives; about personal growth together with public action; about both the process and the outcome of poverty, oppression and discrimination; and about the realisation of human potential through social and economic justice… it is about the process of transforming lives and transforming societies" (Eade and Williams 1995: 9). From a development from below perspective, Korten (1990: 67) adds on and interprets development as "a process by which the members of a society increase their personal and institutional capacities to mobilise and manage resources to produce sustainable and justly distributed improvements in their quality of life consistent with their own aspirations." These explanations about development sound a fundamental inclination to the link between participation, enhanced abilities (capacity building) and empowerment, a perspective that I totally agree with. To add on to this view, I posit that all these endeavours towards development must be done in a rational manner with full consideration of the impact on environment and to future generations. This is in congruity with my understanding of sustainable development as discussed earlier in this chapter.

However, for all this type of development to be achieved, realisation must be applied and recognition made that societies do have inherent weaknesses that must be dealt with. In this case there is need to develop partnerships that can assist develop the capacity of local people to deal with the inherent challenges without compromising their own initiative and perceived development trajectory.

In the long run, real development should establish processes of "grassroots empowerment for the excluded to influence the way society is being run by becoming organisationally visible and by speaking up communally for their own rights and the rights of all the poor and excluded" (O'Gorman 1995: 211). In short, development is a process that focuses and aims to reduce vulnerabilities and scale up human capabilities and skills as well as improving people's lives. This must be a result of planned activities through participation of local people to generate solutions to common problems towards the well-being (economic, social, environmental and cultural) of the community (Frank and Smith 1999: 1). Participation, capacity building and empowerment are important variables contained within my operational definition of development; as such I will elaborate them in much detail below.

3.6.2 Participation

The Oxford English Dictionary (2000) literally defines participation as the action of taking part or becoming involved in an activity. However, the understanding of participation has evolved and is now understood not only as a development concept but as a paradigm (Tri 1986:36-37). The origins of participation as a paradigm has been largely attributed to the shortcomings of top-down development theory and practice that failed to understand the needs of the people for whom development was intended (Escobar, 1985; Rahnema and Bawtree 1997). From a development perspective, participation is conceptualised in different ways. For instance, it is perceived to be both a means (towards empowerment and development) as well as an end (full involvement of the people and control of their development process; the initiatives and the decisions and resources that affect them) (World Bank 1996; FAO 1989b). This view is supported by Cohen and Uphoff (1977) and Cernea (1991).

Pearse and Stiefel (1984) in Oakley and Mardsen (1984:36) also state that "participation is considered to be an active process, meaning that the person or group in question takes initiatives and asserts his/her or its autonomy to do so. They further contend that participation involves organised efforts to increase control over resources and regulate institutions in given social situations, on the part of the groups and movements of those hitherto excluded from such control."

In understanding participation as a development process, Deshler and Sock in Michener (1998), emphasise the importance of distinguishing between genuine participation and pseudo-participation. Pretty et al. in Gaventa, (1998) discusses this further and highlights seven levels of participation, ranging from passive participation, in which communities are simply told what is going to happen, but have little say in the process, to self-mobilisation, where individuals take action independently of external institutions. Arnstein (1969:216-224) promulgates a typology of eight levels of participation that include manipulation, therapy, informing, consultation, placation, partnership, delegated power and lastly citizen control.

Given the various view points and understanding of participation, it is critical to take into consideration the level of involvement of local population and at times stakeholders in determining endeavours aimed at changing their lives (Jennings 2000). Care must be taken to avoid manipulation of people by outsiders in the pretext of facilitating participation and development (***which I call facipulation***).As a social process, participation must seek to involve everyone concerned through all the stages of development (Tri 1986:34). This brings me to the importance of community involvement, otherwise referred to as community participation as will be discussed below.

3.6.3 Community participation

Community participation is an active process where intended beneficiaries influence programme outcomes and gain personal growth (Oakley 1989). It is "key to building an empowered community… and critical to community success" (Reid 2000: 1). It is the process by which individuals and families assume responsibility for their own health and welfare and those of the community and develop capacity to contribute to theirs and the community's development. They come to know their own situation better and are motivated to solve their common problems. This enables them to become agents of their own development instead of passive beneficiaries of development aid (Olico-Okui 2002).

While I consider participation to be an important aspect towards reaching desired development outcomes, I am also aware that it can be manipulated to drive other objectives. Scholars such as Cooke and Kalahari (2001); Kapok (2002); and Golooba-Mutebi (2004) are critical about participation. While it is true that participation may be laden with some hidden interests among its promoters and that it calls for a lot of sacrifice in terms of people's time, which in itself could lead to participation fatigue (Taabazuing 2009), it still remains a viable endeavour towards development that can be sustained over time. In my view these negative aspects of participation must not dissuade people to get involved to achieve their desired development objectives. The question remains, how else can people acquire their truly desired livelihood outcomes if they are not involved? These challenges of participation in my view are expected

dynamics when dealing with the heterogeneity nature of people that development practitioners must learn to deal with.

3.6.4 Capacity building

Capacity building is another important variable in understanding development. However, it may mean different things to different people and organisations. According to Skinner (1997:2), capacity building is "a systematic approach to assisting community organisations to play a major part in the regeneration of their neighborhoods…" It is therefore about strengthening the ability of community organisations and groups to build their structures, systems, people and skills so that they are better able to define and achieve their objectives and engage in consultation and planning, manage community projects and take part in partnerships and community enterprises. It includes aspects of training, organisational and personal development, and resource building organised in a planned and self-conscious manner, reflecting the principles of empowerment and equality" (Skinner 1997: 2).

Capacity building must involve the augmentation of core skills and capabilities to drive the development process (Leach et al 1997). It must stimulate a process of assisting an individual or group identify and address issues and gain the insights, knowledge and experience needed to solve problems and implement change.

Capacity building should be manifested in people's enhanced ability to transform and use resources, skills and social relations to improve their lives and those of future generations. It can be facilitated in various ways including providing technical support such as training, coaching and mentoring. The need for capacity building highlights the necessity to build partnerships with entities that can assist develop skills without hijacking the locally defined development path.

3.6.5 Empowerment

Empowerment is a concept that is used in many disciplines to explain in one word the enhanced ability of people to confidently and rationally take charge of their own affairs. However, empowerment is not an easy term to define. As Zimmerman (1984) states, asserting a single definition of empowerment may make attempts to achieve it formulaic or prescription-like, contradicting the very concept of empowerment.

Empowerment as a concept is shared by many disciplines such as community development, psychology, education, economics, and studies of social movements and organisations among others. Therefore its definition varies among these perspectives (Page and Czuba 1999). Rappoport (1984) notes that it is difficult to define empowerment because it takes on different forms in different people and contexts. Rather it is easy to define empowerment by its absence. However, regardless of this difficulty to define empowerment as a concept, it is important to attempt to reach a common understanding of the concept in a practical way.

Elliot (1994: 188) for example defines empowerment as "a desired process whereby particularly impoverished and marginalised groups become the agents of their own development." Skinner (1997: 39) defines empowerment as a process whereby underprivileged and marginalised individuals and groups gain confidence and capabilities and begin to be involved in decisions and endeavours that affect their lives. In his definition he perceives empowerment in three ways:

- As an enabling process whereby people and groups gain direct control of their resources, activities and circumstances.
- As a process that leads to a strong sense of personal worthiness and effectiveness, removes feelings of powerlessness but builds on elements that promote confidence and self-esteem.
- As a process whereby people gain confidence to analyse and understand their vulnerabilities and the causes of their deprivation and discrimination and are able to maximise their capabilities.

My understanding of empowerment therefore is that it is a multi-dimensional social process that helps people gain control over their own lives (Page and Czuba 1999). It is a process that fosters power (the capacity to implement) in people for use in their own lives, their communities and their society, by acting on issues that they consider important. Empowerment is multi-dimensional because it occurs within various dimensions (sociological, psychological, economic, and so on). It is a social process, because it occurs within a context of a relationship with people. It is a process because it develops with time (Kindervatter 1979). Given this understanding, it is imperative to note the significance of capacity enhancement and also participation and how these are closely been linked to empowerment as both means and an end towards people driven development.

In my effort to elaborate development as a concept via the historical reference and review of various theories of development, we have seen that earlier theories of development, particularly the structuralistic perspectives neglected the human dimension to development assuming that would be taken after automatically through growth. Modern considerations of development must not leave chance for such speculations.

My position on the debate on development theories and approaches is that there is need to complement various approaches to development, arguing for or against one theory is assuming a simplistic position. Development is a very complex phenomenon laden with economic, social, cultural, political and environmental variables that need to be taken into consideration for any approach to work. To me a mix of approaches is important for purposes of learning and borrowing those aspects that can be used. For instance funds, skills and at times simple technologies may be needed to motivate the development energies of communities because the lack of these may even be a very big hindrance to development itself.

However, above this I place my conviction towards the understanding that development must be participatory and driven by local people (Long 1992); it must be empowering and must create opportunities for capacity enhancement so that it evolves over time to suit different time periods. It must be about broadening people's choices to enable them have a valuable life and acquire and utilise knowledge to access and

transform resources towards their desired end (UNDP 1994:2; UNDP 2001). Whatever is borrowed or received from outside must be considered only as incremental to the process of development. It is important that all this is happening not in a haphazard fashion but rather in an organised manner; a framework of which community-based organisations can provide.

3.7 Conclusion

This chapter has provided a review of some contemporary perspectives in development thinking. It examined the meaning of sustainable development and discussed its various perspectives as it is steadily becoming the locus of the current development discourse. In addition, the chapter reviewed the sustainable livelihood approaches and discussed how these may be applicable in the analysis of HIV/AIDS and in coming up with appropriate intervention strategies. The relevance of indigenous knowledge and culture to development was also conversed. The chapter also discussed globalisation as a factor in development thinking and how this is linked with HIV/AIDS. Lastly, the chapter provided an operational definition of development as will be referred to through out this thesis.

Chapter 4

TOWARDS COMPREHENDING HIV/AIDS AS A DEVELOPMENT CHALLENGE

4.0 Introduction

With regards to this thesis, one question to ask is 'what has HIV/AIDS got to do with development?' Apparently, it has in many aspects as will be discussed later in this chapter. Central to comprehending HIV/AIDS as a development concern is the understanding of ways it is transmitted; how it leads to vulnerability, poverty, gender and income disparities, factors that influence risk behaviours, the impact of long illness, reduced productive and death of productive people and the expenses required to challenge its toll from household level to national economies.

4.1 Conceptualising HIV/AIDS and the debate about its origin

To begin with I would like to clarify that though HIV and AIDS are closely related they are actually different. HIV is a lentivirus that belongs to a larger group of viruses referred to as retroviruses that take a long time to produce any adverse effects in the body (Cohen 2000:3). Once in the human body HIV attacks the immune system. On the other hand, AIDS is a result of this massive attack of HIV on the immune system rendering the body defenseless against infections and diseases (Grmek 1990; Farmer 1992).

The origin of HIV/AIDS still remains a puzzle to the scientific world (Webb 1997). The history of HIV/AIDS provides one of the most complex and enlightening global public health issues in modern times. Since its emergence in the 1980's HIV/AIDS has had enormous influence on the lives of people, health systems and financial flows globally (Jackson 2002).

Different theories have been developed in an attempt to explain the origins of HIV/AIDS. These have just managed to generate further debate on the issue. Some of the common theories propagated to explain the origin of HIV/AIDS include the following:

1) The Hunter Theory: Apparently this seems to be the most commonly accepted theory of the origin of HIV/AIDS. This theory assumes that HIV descended from a Simian Immunodeficiency Viruses (SIV), a virus found in chimpanzees (Ward 1999). Proponents of this theory argue that the SIV was transferred from chimpanzees to humans as a result of hunting and eating infected chimpanzee meet. During this process the infected chimpanzee blood got into humans through cuts and the SIV mutated to adapt within the human host and became HIV (Moore 2004).

2) The Oral Polio Vaccine Theory: This theory contends that HIV was transmitted through various medical experiments especially through the polio vaccines. Supporters of this perspective argue that an oral polio vaccine called Chat which was cultivated on kidney cells taken from the chimpanzees infected with SIV was given to millions of people in the Belgian Congo, Rwanda and Burundi in the late 1950s (Moore 2004). The virus spread to a large number of people because African healthcare professionals were using one single syringe to inject multiple patients without any sterilisation in between. This theory has been refuted, with critics pointing out that at the time of the mass polio vaccinations, HIV was already in human beings; besides the Macaque monkey kidney cells used at the time can not be infected with SIV or HIV.

3) The Conspiracy Theory: This theory asserts that HIV was manufactured as part of a biological warfare programme in the USA designed to wipe out large numbers of black and homosexual people (Farmer 1992). This perspective too was widely disproved.

The main reason I have selected to highlight some theories of the origin of HIV in this thesis is to show how complicated this phenomenon of HIV/AIDS is. However, my point of view is that, most of these so called theories of the origin of HIV are just blame games that have at times sparked conflict among people. As a development practitioner I will limit my focus to the effects of HIV/AIDS on development and how best we can generate appropriate responses.

4.2 Qualifying HIV/AIDS as a development challenge

Although development has various meanings and takes on many different forms depending on who is defining it, there seems to be a convergence, as discussed before, towards a general understanding that it must take into consideration economic social and environmental factors (UNESCO 2000: Kothari and Minogue 2002). With consideration of social, economic and environmental implications of the HIV/AIDS epidemic, it is clear that HIV/AIDS has become a critical dimension when discussing development.

Before HIV/AIDS became widespread, some African countries did make impressive achievements in human development. Botswana is one such example (Kgathi 2006:38). However, these achievements have been undermined by HIV/AIDS which has decreased economic growth in countries that were recording positive gain while it has worsened the economic situations in countries that already had fragile economies primarily due to loss of young productive people to HIV/ AIDS (UNAIDS 2000). Households have fallen into deeper poverty, economies have stumbled and the impact of the epidemic is felt across society (UNAIDS 2002).

Jackson and Lee (2002:201) state that in Sub-Saharan Africa, HIV/AIDS affects development because it "unfolded at a very difficult historic period when most heavily affected countries had to deal with and implement the IMF and World Bank approved structural adjustment programs which have often been detrimental to health, education and welfare services as well as formal employment." During this very period, many countries were confronted with public corruption and inappropriate government expenditures; political upheavals and change; the legacies of colonialism; civil wars and other forms of conflict; population, movement; and environmental

difficulties, including severe drought and floods (Ibid 207). These factors have made it more difficulty for countries to mount adequate responses to the epidemic, while at the same time they have tended to exacerbate HIV infection, increased morbidity and death. HIV/AIDS has certainly complicated the development challenge that most highly infected countries have to deal with.

Loewenson & Whiteside (2001:14) observe that "countries ravaged by the HIV/AIDS epidemic are facing a double jeopardy. On the one hand, their capacity for planning and implementing development strategies is greatly compromised by the loss of human capital and diversion of scarce resources due to HIV/AIDS. On the other hand, strong national capacity is becoming even more crucial as countries face the formidable challenge posed by the epidemic." To move towards understand whether or not HIV/AIDS is a development issue I will examine its impact in the following section.

4.3 The impact of HIV/AIDS

"Throughout history, few crises have presented such a threat to human health and social and economic progress as does the HIV/AIDS epidemic" **FAO 2001:1**

HIV/AIDS is the leading cause of death in Africa and the continent's greatest challenge to making progress in economic and social development. Callisto Madavo the former Vice President of the World Bank, Africa Region, corroborated this assertion and once said, "HIV is now the single greatest threat to the future economic development in Africa…AIDS kills adults in the prime of their working and parenting lives, it decimates the workforce, fractures and impoverishes families, leaving millions of orphans and shreds the fabric of communities" (Machipsa 1999).

The HIV/AIDS pandemic is unique in that it affects all sectors, makes all groups potentially vulnerable and reaches from villages to national capitals (Merson 2006).
It has a significant impact on society on almost every aspect of life, whether from a short or a long-term perspective (Mead 2004). In most countries that have a high prevalence of HIV/AIDS, the demographic aspects, households, health sector, educational sector, and economy in general have been severely affected (Haacker

2004). The epidemic in these countries continues to affect and exacerbate chronic poverty that already exists, thereby reducing the ability of people and communities to respond to it and deal with other development challenges.

Though the long term impact of HIV/AIDS (sickness, death, and orphaning) on social and economic functioning and development is difficulty to determine with accuracy, the impact of HIV/AIDS on national economies cannot be underestimated (Birdsall and Kelly 2007:15). The impact is not only cross-sectoral, it is systemic and transforms the landscape upon which development must take place. The scale and velocity of the epidemic and its wide-ranging, catastrophic effects has affected the socioeconomic development of many societies and has undermined the sustainability of livelihoods particularly in rural areas.

HIV/AIDS depletes society's resources and capacities as well as distorting national development plans and expenditures (Topouzis 1998). According to Claude Nankam (2003), HIV/AIDS complicates the lives of those who survive it.

For example, the epidemic increases demand for social and welfare services but its broader effect erodes the capacity of governments to provide these essential services (Stephenson 2000). Provision of social services to people living with HIV/AIDS is always done at the compromise of expenditure in potentially generative sectors of a country (BIDPA 2000).

HIV/AIDS exerts pressure on the health sectors of high prevalence countries because of increased demand for health care among those infected, especially as the infection matures (Browning 2008:8). This further puts strain on the capacity of health institutions to cope with increases in the number of admissions in hospitals that already have limited bed capacity (UNAIDS 2006). The influx of in-patients too has a direct impact on the quality of care provided, primarily because of the shortage of beds, shortage of staff and to some extent the illness and death of health workers themselves. For example between 1990 and 2005, Botswana lost 17 per cent of its healthcare professionals to AIDS (Ibid.). The effects are worse in the context where health professionals are already scarce. The increased decimation of the workforce

brings further costs in training new staff to replace those who have died or unable to work.

On the other hand, HIV/AIDS weakens economic activity by reducing productivity, increasing costs, diverting resources and depleting skills. It hits productivity through absenteeism, organisational disruption and the loss of skills and organisational memory (Stokes 2003). It increases pressure on managerial, professional and technical expertise thereby reducing capacity to deliver (UNAIDS 2002). While it "reduces the opportunities for development, HIV/AIDS compromises the rights of those who have the virus because of stigma and discrimination associated with it" (Collins and Rau 2000: 57). This has made the interrelationship between the AIDS epidemic and human development issues increasingly evident over time (Malungo 2000; UNAIDS 2006).

Through long term illness and death of parents and guardians, HIV/AIDS erodes the social fabric of communities. This impairs social cohesion in terms of the role modeling of norms of trust and good citizenship in the community and affects the transfer of local knowledge and skills between generations (Haddad and Gillespie 2001). According to Ayieko (1998), this results in future generations to lose the informal experience of knowledge exchange that prepares them to sustain their livelihoods.

The death of parents and young adults increases the number of orphans and vulnerable children. According to UNICEF (2002), approximately 42 million children drop out of school each year due to AIDS, with girls forming a disproportional share of these children. The effect of HIV/AIDS on children, particularly orphans, leads to children dropping out of school and losing their childhood altogether as they assume the roles of ill or dead adults; roles of providing care, fending for food and other necessities. Often children orphaned to HIV/AIDS risk poor socialisation poverty and lack of education, as well as sexual and physical abuse (Jackson and Lee 2002: 210). Girl children, who are more likely to be withdrawn from education when household resources are squeezed grow at risk of HIV themselves (Lee et al. 1999). These children become a link in creating and perpetuating inter-generational poverty and creating another generation of poor vulnerable families (Steinberg et al. 2002).

4.4 The relationship between HIV/AIDS, poverty, and development

This section will discuss the relationship that exists between HIV/AIDS and poverty and poverty and HIV/AIDS elaborating how each one of them feeds into the occurrence or exacerbation of the other. It is important to elaborate this because the bi-directional relationship between HIV/AIDS and poverty has a huge impact on development because it affects the well-being of people and functioning of society (Barnett and Whiteside 2002).

4.4.1 HIV/AIDS and poverty

The HIV/AIDS epidemic is very stressful in many aspects of life. The experience of long term illness and death from HIV/AIDS pushes non-poor households into poverty and the already poor into deeper poverty and vulnerability (UNAIDS 2002). Death from AIDS has greater impact on livelihoods than deaths from other causes because it usually occurs earlier in people's lives and after a long period of illness and is often associated with death of a bread winner leaving families vulnerable to its consequences (Nankam 2003).

HIV/AIDS impoverishes people in a way that intensifies the epidemic itself (Collins et.al 2000). When the most productive members of a family die, coping mechanisms of the remaining family members are limited as they become powerless and vulnerable. In some instances families dissolve while the extended families become over-burdened with an increased number of dependants and responsibilities.

Responses to HIV/AIDS at household level often influence a shift in expenditure from necessities such as food, school fees and income-generating prerequisites including agriculture inputs to costs associated with long-term illness and death such as medical and funeral-related expenses. For example, in a Uganda study 65% of AIDS affected households were obliged to sell property to pay for care (FAO 2001). Also Steinberg, Johnson, Schierhout and Ndegwa (2002) found out that in South Africa households

that were already poor and coping with members sick with HIV or AIDS were reducing spending on necessities even further.

Collins and Rau (2000:39) also observed that "where the income earner dies, the afflicted households have typically responded by selling their stores of value and assets to buy drugs and meet expenses related to long term illness." The consequences of such a shift in domestic expenditure and reduced production are grave particularly were there is already a general decline in household production and food insecurity for other non-HIV/AIDS-related reasons (UNAIDS 2004). For instance, it was reported by UNAIDS (2006) that in Malawi, where food shortage is already endemic HIV/AIDS has diminished household agriculture output thereby affecting the agricultural output and general nutrition of the citizens. With poor nutrition people are weak and labour productivity is further lowered, making household members more susceptible to poor health including HIV/AIDS itself.

In addition, stigma associated with HIV/AIDS limits the opportunities of infected persons to seek and access services and support. This often leads to isolation and discrimination of infected people, such that even traditional forms of social support for the poor and the sick become inoperable leaving them trapped in a poverty circle. Once people become trapped in the poverty circle, poverty itself creates the biological conditions for greater susceptibility to infectious diseases; it also limits the options for treating the disease (Stillwaggon 2001).

Although HIV/AIDS has both rural and urban dimensions its impact on rural people tends to be greater. Not only do rural families lose remittances from relatives working in towns, mines and farms (Jackson and Lee 2002:209), they are also overburdened with caring for sick relatives. Most often when people are sick for a long time they migrate back to rural areas, increasing the already heavy burden of the poor rural citizens making them more vulnerable and poorer. Besides, the poor are already on the margins of survival and unable to deal with the consequences of long-term illness and the costs associated with it. Diversion of labour to incorporate caring roles also compromises household productivity, which in turn affects household food security.

4.4.2 Poverty and HIV/AIDS

Poverty is at the crux of HIV/AIDS vulnerability and impact. It is a key factor in HIV transmission. In fact it creates an environment of increased risk to the infection and it aggravates factors that predispose people to the infection (Poku 2002a). It also accelerates the onset of the AIDS disease and increases the impact of the epidemic (Cohen 2002). Though anyone can be affected by HIV, it is often the poorest who are the most vulnerable to HIV/AIDS and on whom the consequences are most severe, thereby driving them deeper into the circle of poverty as meager family resources are committed to responding to the effects of HIV/AIDS (Jackson and Lee 2002).

Although there are various factors that influence the spread of HIV, for a long time now, AIDS has largely been understood to be a disease of poverty, hitting hardest where people are marginalised and suffering economic hardship (Medact 1999). In conformity with this assertion, Desmond Cohen (2002:7) states that "the HIV/AIDS epidemic has its origins in African poverty and unless and until poverty is reduced there will be little progress either with reducing transmission of the virus or an enhanced capacity to cope with its socio-economic consequences." Poverty has contributed to the general lack of resources in most high prevalence countries and this has undermined and broken down health care systems leaving health care infrastructure eroded and unable to cope with the impact of HIV/AIDS and other diseases (Colgan 2002).

There are a number of theories that can be used to explain the relationship between poverty and HIV/AIDS. For instance, social epidemiology is one such theory (Krieger 2001). However, for purposes of this study, the 'drive' theory is adopted. The premise of the drive theory arises from the idea that drives are the motivating force behind human behaviour. The drive theory dates back to 1930 during the apex of behaviourism and points out that there are certain necessities of life without which human beings cannot survive and that the drive to obtain these necessities is part and parcel of human life. In such incidences when a need arises, e.g. basic survival needs like hunger and thirst, it leads people to act in ways that are aimed at satisfying these needs (Jordaan & Jordaan 1989). Given this theoretical underpinning, I contend that when people become deprived of the necessities of life, e.g. food and shelter due to

poverty they are likely to respond in ways regardless of the risk, to obtain these necessities to survive.

Stillwaggon (2001) argues that poverty increases the vulnerability of people to the spread of diseases and to other health problems. This is true because the relationship between poverty and ill-health is well established and is evident from the mounting literature on the subject (Barnett & Whiteside 2002; Booysen 2004; Wojcicki 2005). The deepening poverty across the continent has not only decreased health status of the people by declining the living conditions and reducing access to basic services, it has also created fertile ground for the spread of infectious diseases including HIV/AIDS (Colgan 2002). Take for example the existence of undiagnosed and untreated sexually transmitted diseases among many of the poor. For instance, WHO (2004) indicated that in 2003 the African continent had the highest incidence of curable STDs at 284 cases per 1,000 people aged 15–49 years, compared to the second highest of 160 cases per 1,000 people in South and South-East Asia during the same period. A study conducted by Mutangadura (2000) established that the presence of an untreated STD can enhance both the acquisition and transmission of HIV by a factor of up to ten. What it requires to cure most STDs are antibiotics, yet, in the developing world, even when the poor have access to health care, the clinics may have no antibiotics to treat the bacterial STDs that act as cofactors for the transmission of HIV (World-Bank 2000c).

Poverty is associated with weak endowments such as human and financial resources. It is also associated with low levels of literacy and education as well as limited knowledge and information regarding the risk of infection; low marketable skills; generally poor health; low labour productivity and low income (Alban 2001; Whiteside & Sunter 2001; Barnett & Whiteside 2002; Booysen 2002; 2004; Wojcicki 205). In most cases the poor are vulnerable and have fewer income opportunities. They have limited options to cope with their poverty, which makes them adopt short-term risky mechanisms to survive, such as survival sex. Girls and women opt to exchange sex for money, food and goods because poverty diminishes their perceived value of avoiding HIV infection, as they have seen and undergone a lot of suffering already and they believe they will die soon in any case (Jackson 1992). For instance, Booysen (2004), in his study on ‘Poverty, Knowledge of HIV/AIDS and Risky Sexual

Behaviour', found that the likelihood of engaging in risky sexual behaviour was higher among women from poorer households relative to those from more affluent ones.

Nattrass (2004) also illustrated how destitution as a result of a combination of HIV/AIDS, high poverty and unemployment rates can lead people to behave in ways that they would not adopt in more favourable conditions. Nattrass (2004) further concluded that the high unemployment rates and poverty experienced in South Africa contributes to the high HIV infection levels experienced in that country.

Exclusion too, is fundamental to the condition of poverty. The poor are marginalised and socially excluded and this reduces their chance of reaching services and programmes. Low socio-economic status robs the poor of the knowledge necessary for the prevention of infection from HIV/AIDS and also increases susceptibility to infection by making the poor more likely to practice unsafe sexual behaviour. For instance, HIV/AIDS and other health-related messages are designed and disseminated in languages that the poor do not understand. Even when programmes such as Information, Education and Communication (IEC) do reach the poor, the messages themselves are irrelevant, given the reality of these people's lives (UNDP 2002). Although they may understand what they are being urged to do, they rarely have the incentive or the resources to adopt the recommended behaviours and actions; besides, the policies and programmes that recommend deferral of gratification do not matter to them at all. A link between lower socioeconomic status or education levels and higher rates of HIV infection has also been established and documented in Ethiopia, Nigeria, and Tanzania (Roseberry and Paul 1998).

Antiretroviral treatment programmes have been implemented without considering that food is an important factor. Even if poor people can access antiretroviral programmes, the treatment is not effective because patients do not have the prerequisite food requirements to complement the treatment. Besides, these antiretroviral services are located far from the reach of the poor, making these programmes ineffective.

The nature of poverty leads to outcomes which expose the poor to a higher probability of contracting HIV. Poverty, especially rural poverty, is characterised by the absence of access to sustainable livelihoods which leads to rural collapse and increased population mobility particularly from rural to urban areas (Whiteside and Sunter 2000). Mostly it is the young and energetic people who move into urban areas in search of income opportunities. These young people become isolated from traditional cultural and social networks and the new conditions make them vulnerable to risky behaviours. This contributes to the conditions in which HIV transmission occurs (Nattrass 2004).

The reality of the inter relationship between poverty and HIV/AIDS and their combined consequences is that they remain stubbornly persistent and will require sustained effort through collaborative action (Philbin and Mikush 1999).

The above discussion must not influence one to be limited only to the relation between poverty and HIV/AIDS and HIV/AIDS with poverty, but also to the fact that development itself is often a major determinant of the spread of HIV. In many countries the "spread of HIV/AIDS is documented along transport and trade routes, in ports and cities and in boarder towns and rural growth points" (Jackson 2000:28). Another aspect that HIV transmission is increased by development is the relative income that mostly men are exposed to (Bataringaya 2000). Take for example the consequences of migration from less developed to more developed regions and the vulnerabilities this brings. Consider also the risks and vulnerabilities brought about by some development projects that require workers to move away from their families for long periods. These factors increase chances of causal relationships which can facilitate the spread of HIV infections.

4.4.3 HIV/AIDS and gender

I have selected to discuss the relation between HIV/AIDS and gender because of the importance of gender in the development agenda. HIV/AIDS has gender implications and influences gender inequalities which in turn affect development. Therefore, gender is an important factor to consider in response to HIV/AIDS because of the prevailing gender imbalances and inequalities that put women at higher risk of

HIV/AIDS infection, which further complicates their participation in development endeavours.

Women comprise an increasing proportion of people living with HIV/AIDS worldwide. According to the 2008 WHO and UNAIDS global estimates, women comprise 50% of people living with HIV. In Sub-Saharan Africa, women constitute 60% of people living with HIV. Sub-Saharan Africa is the only region globally, where more women than men are infected with the virus.

The gender dimensions relevant to HIV/AIDS penetrate a whole range of aspects of society, including the economic, legal, cultural, religious, political and sexual status of women (UNIFEM 2004). Riding on the back of existing gender inequalities, HIV/AIDS aggravates the situation of women, translating existing differences into harsher conditions and into higher HIV prevalence for women (Tadria 2004).

Women are biologically, socio-economically, and socio-culturally more at risk of HIV infection than men (Gupta 2000; Topouzis 2000). Biologically, the risk of women becoming infected with HIV during unprotected vaginal intercourse is between two and four times higher for women than for men because the viral concentration in semen is higher than that in vaginal fluids, and women have a larger mucous surface, which is exposed to the virus for longer durations (World Bank 1997). In addition women get infected at a younger age than men.

There are some cultural practices that make women and girls vulnerable to HIV/AIDS. These sexual practices, for instance genital cutting, dry sex, ritual cleansing and widow inheritance increase women's vulnerability to HIV infection. For example in southern Zambia, some parts of Zimbabwe, Malawi and Botswana there are norms that allow men to have more sexual partners than women and encourage older men to have sexual relations with much younger women, who often have limited access to resources. Such practices make men exercise power over women, sometimes using violence. In these circumstances they are likely to have unprotected sex and spread HIV (UNAIDS 2004). Jackson (2000) and the International Fund for Agriculture Development (IFAD) (2000:7) outlines some of the risk sexual practices as follows:

- Men's preference for unprotected sex and deny women (unmarried as well as married) the power to decide on sexual practice.
- Ritual cleansing (where the surviving spouse is 'cleansed' and freed of the dead person's spirit through sexual intercourse with a family member of the deceased).
- Widow inheritance (a practice which traditionally was a social safety net for women, that allows a brother or close male relative to inherit the widow); and
- Heirship for chieftaincy (where a woman from each family in the community has sexual intercourse with the chief thus giving all families the opportunity to produce his heir).

There is also a culture of silence and passivity regarding sex among women and this makes it difficult for them to negotiate safer sex or even to access treatment services in fear of stigmatisation. There is also an austere norm regarding virginity among adolescent girls, which restricts them from seeking information about sex, further increasing their risk of infection from sexually transmitted diseases (IFAD 2000b).

The dynamics of gender and HIV/AIDS create multiple mechanisms that exacerbate the vulnerability of women both to contracting the virus, coping with the disease and caring for others infected and affected by the pandemic (UNAIDS 2002). Many of these links do not only manifest themselves as mechanisms of vulnerability, but also become factors that fuel the spread of the epidemic (Barnet and Blaikie 1992). Inequalities of economic nature such as lack of employment opportunities and poor access to education, health services and information, make women more vulnerable to HIV infection and the impact of AIDS than men. On the other hand HIV/AIDS exacerbates the social, economic and cultural inequalities that define women's status in society (World Bank 1999).

HIV/AIDS has a disproportionate impact on the lives of women survivors in relation to men survivors. Upon the death of their spouse, women often lose their house, land, livestock, and other resources. In Zambia, for example, IFAD (2000b) found out that not only does the death of a spouse reduce household productivity and livelihood

options, it is also exacerbated by the impact associated with the practice of property grabbing by the deceased's relatives.

In addition, it is often not easy for women to access HIV/AIDS programmes, services and education because these programmes do not address the underlying gender inequalities, so the barriers to accessing them remain. The programmes and strategies assume an idealised world, where everyone is equal and free to make empowered choices such as abstaining from sex, staying faithful to one's partner or always using condoms. In practice this doesn't happen because of the social, economic and cultural factors at play. UNAIDS (2008) observed that most national HIV/AIDS programmes fail to address underlying gender inequalities of budget restriction to support women-focused HIV/AIDS programmes.

The gender dimensions that HIV/AIDS presents as discussed above have a very strong bearing to development because it increases the vulnerability of women and hinders their effective participation to the development process. Until these factors are eliminated, efforts to contain and reverse the HIV/AIDS epidemic and engage women in meaningful development will remain patchy.

Given all these considerations coupled with social, economic, cultural and at times political influences on the spread of HIV/AIDS; and the manner in which HIV impinges on economic growth, both slowing it and distorting the allocation of resources because of the demands it places on health care systems (Labonte 1997), and the political realities involved, I am confident to argue that HIV/AIDS is indeed a development problem.

4.5 Conclusion

Chapter four presented the debate on whether HIV/AIDS is really a development challenge. To determine this, the chapter focussed on the impact of HIV/AIDS on people and society. It also closely looked at the relationship between HIV/AIDS and poverty and some gender dynamics that surround the epidemic since these are also critical aspects of development. These discussions led to the conclusion that indeed HIV/AIDS is a development challenge. One important thing that this chapter reviewed is that HIV/AIDS is a very completed issue that affects all aspects of life. It origin is still a mystery until today.

Chapter 5

CONSIDERATIONS FOR EFFECTIVE RESPONSES TO HIV/AIDS: AN ANALYSIS OF THE GLOBAL, NATIONAL AND CIVIL SOCIETY RESPONSES TO HIV/AIDS

***The challenges posed by HIV/AIDS in the modern world encompass a potent mix of sex and death, science and politics and deep-rooted divisions and inequalities between North and South, as well as between rich and poor, men and women, black and white, homosexuals and heterosexuals*. The Commission on HIV/AIDS and Governance in Africa (CHGA) (2004:1)**

5.0 Introduction

This chapter examines various approaches to responses to HIV/AIDS starting from the global to the local levels through civil society organisations and CBOs in particular. As mentioned in preceding chapters HIV/AIDS has spread to all corners of the globe, as such efforts to deal with the epidemic must be addressed at global, national and local levels. In this chapter I will discuss how the responses to the epidemic have evolved from the global to the local levels. This chapter will discuss CBOs in the context of civil society organisations and link them to the responses to HIV/AIDS with specific focus on highlighting their significance in the general fight against the epidemic.

5.1 The global response to HIV/AIDS

The World Health Organisation (WHO) took leadership and orchestrated the initial global response to the HIV/AIDS epidemic. At this time HIV/AIDS was generally perceived to be a health problem. In 1987, WHO established the Global Programme on AIDS (GPA). This programme operated towards "raising awareness about HIV/AIDS; formulated evidence-based policies; provided technical and financial support to countries; initiated relevant social, behavioral, and biomedical research; promoted participation by nongovernmental organisations; and championed the rights of those living with HIV" (Merson 2006: 2). According to Altman (1999: 265), the Global Program on AIDS had three clear achievements that included:

i) The establishment of an international discourse around HIV/AIDS that stressed the language of empowerment and participation.

ii) Technical support for a number of developing countries in a range of policy and programme areas.

iii) Mobilisation of donor countries to support a multilateral response to the epidemic.

Despite these achievements, the leadership of WHO in the global response was increasingly being questioned by UN organisations and donor governments during the 1990s. The growing rivalries among UN organisations and the increasing preference of wealthy countries for bilateral aid programmes towards action against HIV/AIDS led to the failure of the GPA (Merson 2006:2). In 1996, the Joint United Nations Programme on HIV/AIDS (UNAIDS) was established to provide leadership, coordination, technical support and monitoring responsibilities to the global responses. Up to date UNAIDS is working towards making the international system work more effectively by pushing, cajoling, and advising governments around their response to HIV/AIDS (UNAIDS 2003). It also advocates for a multifaceted response to the epidemic.

Initially, UNAIDS started coordinating activities of seven international agencies involved in AIDS work including the World Health Organisation; the United Nations Development Programme; the United Nations Children's Fund; the United Nations Population Fund; United Nations Education, Scientific and Cultural Organisation; the World Bank, and the United Nations International Drug Control Programme. These organisations mustered political will from both rich low prevalent countries and poor high prevalent countries; increased funding; intensified and increased reach of prevention programmes; and increased availability of drug therapies.

The advocacy efforts of the UNAIDS paid some dividends when more international and development partners became involved in responses to HIV/AIDS. For instance, in 1998, the World Bank increased its commitment and lending from $500 million to $2.7 billion in 2006 much of it for sub-Saharan Africa (Merson 2006). In 2003, the U.S. government announced the President’s Emergency Plan for AIDS Relief (PEPFAR) pledging $15 billion over a period of five years towards prevention,

treatment and care focusing in 15 countries with high HIV prevalence. The Global fund to fight AIDS, Tuberculosis and Malaria also became another important mechanism in the global response to HIV/AIDS. The aims of the Global Fund is to "attract, manage and disburse additional resources through a new public-private partnership that will make a sustainable and significant contribution to the reduction of infections, illnesses and deaths, thereby mitigating the impact caused by HIV/AIDS, tuberculosis and Malaria in countries in need and contributing to poverty reduction as part of Millennium Development goals" (Global Fund Website: www.theglobalfund.org).

Despite the influence of international organisations and funds organised towards the response, the question remains, have these succeeded?

The elation that these global initiatives bring, particularly the funds disbursed to poor high prevalence countries, have a strong potential of camouflaging real social, economic and political inequalities that are the result of the globalising process itself. Take for example the prescription of top-down prevention programmes; the issue of patent drugs and technology used; the recommendations of culture shift as a way of preventing further spread; the engagement of qualified experts from the south by international organisations and UN agencies at their headquarters away from where the real need dearly exists. These to me are manifestations of legacies of neo-liberal approaches indicative of modernisation theory practices.

It can not be ignored that the global response to HIV/AIDS does define relations between wealthy nations and the poor high prevalence nations (Fortin 1998). This has integrated poor communities in imbalanced relations leaving them dependent on external resources such that even local initiatives depend on donor resources to succeed. The fact remains clear here that just like the failed promises of globalisation to reduce poverty (Todaro and Smith 2006), the global responses to HIV/AIDS has had little impact on communities and people that really need the help. While the blame is poised on the so called poor absorptive capacity of governments and communities in poor high prevalent countries for the lack of impact, I contend that some prescription of interventions have been confusing and inconsistent. Take for example the issues with breast feeding. During the early days of the campaign for the

prevention of mother-to-child transmission (PMTCT), infected mothers were told not to breast feed, just to pronounce later that breast feeding is safe after all. Consider how many babies may have been subjected to malnutrition during the 'no feeding period' where families could not afford supplement baby feeding.

The other thing that the global influence has brought to the response to HIV/AIDS is the pressure on recipient governments for fiscal prudence and to restructure health systems that are buckling under the pressure of the increasing disease burden at the expense of motivating and supporting local initiatives from affected local communities. To me this is another form of structural adjustment disguised in the response to HIV/AIDS. Atman (1999: 575) rightly argues that the global response to HIV/AIDS is largely at a rhetorical level than real and well meaning.

5.2 The national responses to HIV/AIDS

In most high prevalence countries, the evolution of the national responses[3] to HIV/AIDS has been similar because of the influence of the global response. Most national response to HIV/AIDS started between 1982 and 1986 and this was largely confined to the health sector. As such, HIV/AIDS was handled like any other epidemic. National AIDS Control Programmes (NACP) were established to spearheaded response particularly the formulation of national HIV/AIDS policies (UNAIDS 1999). In Africa, Uganda pioneered this phase largely due the severe impact it experienced. Following the creation of NACPs and policy development phase, most high prevalence countries established national strategies based on research and surveillance, prevention, care and support, and impact mitigation (Webb 1999). To date most countries still base their responses on these three broad approaches (Takpo 2000:12) as discussed below.

1) Research and surveillance: This focused on widening the knowledge and understanding of the epidemic through sentinel survey to obtain behaviour data and through epidemiological, biomedical and social research to compliment planning and

[3] National responses here are interpreted as interventions spearheaded by governments as opposed to civil society organisations.

implementation of the response (UNAIDS 2002). This also necessitated mass screening of all blood and blood products to avoid new infections via contamination.

2) Prevention, Care and support: This focused on optimising on approaches that would reduce further spread of the infection such as increased information, education and communication (IEC) interventions, voluntary counselling and testing screening and treatment of sexually transmitted diseases targeted to the high risk groups and the public in general. Prevention also targeted the prevention of mother-to-child transmissions (PMTCT). Care and support aimed at providing respite services to people infected with HIV and provide them and their families with support to enable them cope with the complications of HIV/AIDS (UNAIDS 1999).

3) Impact mitigation: This was a strategy of ameliorating the impact of the epidemic by providing services that would improve the quality of life of afflicted persons and families (United Nations High Commission on Human Rights 2001).

Despite government responses starting in the late 1980's, HIV continued to spread and even reached epidemic proportions. In my view most governments in high prevalence countries delayed to mount concerted efforts towards the prevention of further spread of HIV infection mostly because of denial. HIV/AIDS was de-prioritised both in the mind and the pockets of key decision makers (Webb 1999:70). This contributed to worsening the situation. On the other hand the complex nature of the HIV/AIDS problem overwhelmed the governments' ability to effectively respond. The governments were acting within the context of scarce resources and some what weak leadership. As Webb (1999:71) indicated the epidemic required an institutional response beyond the means and resources of most national governments. As such the interventions that were mounted were merely inadequate in many respects and had therefore little impact on the course of the epidemic.

In the late 1990s most high prevalence countries realised that HIV/AIDS was not merely a health problem that could be addresses through orthodox health approaches but that it was a much more complicated phenomenon that touched on various aspects of life. As a result the response took a twist and saw the call for a multifaceted approach that would include all sectors to complement the government responses.

During this phase civil society organisations (CSOs) became even more vivid in the response assuming leadership in provision of integrated services and engaging governments to demonstrate political will and grant the response full support. CSOs expanded the response to include promotion of income generating activities, small scale credit facilities, and vocational skills training, orphan care, and advocating for ethics and rights of infected persons as well as reducing stigma associated with the epidemic and provision of ARV (WHO 2002). The coming on board of civil society organisations changed the landscape of the HIV/AIDS response in high prevalence countries.

5.3 The civil society responses to HIV/AIDS

The civil society response to HIV/AIDS was mainly influenced by the failures of the national responses to curb the spread of the epidemic. Governments in high prevalence countries did show that they were stretched thin and could not just handle a problem that had become multifaceted. HIV/AIDS had just become beyond the ability of these governments that had to grapple with many other development issues. The appearance of civil society organisation suffused the HIVAIDS response to cover the concerns of people on the ground.

Before I interrogate the civil society response to HIV/AIDS, I will look at the debate on civil society from a historical perspective and then go on to define the concept as is applied in this thesis. Since my development philosophy is much inclined to bottom-up, I will discuss also how the civil society responses, particularly at the level of CBOs is associated with this approach.

5.3.1 The debate about civil society: A historical perspective

Civil society has become a critical political, social and analytical construct in an attempt to have greater understanding of the importance of independent, self-regulating citizen associations, citizen participation and empowerment as a way of achieving a people driven development (Salamon 1994: Howell and Pearce 2001). According to Edwards (2004) civil society has become a big idea on everyone's lips

and this has equally attracted a lot of debate about its meaning. Birdsall and Kelly (2007: 37) argue that civil society is an old concept that has experienced a major renaissance over the past decades. Civil society is inherent in the ability of communities to act together to achieve a common purpose. This ability has existed for centuries although in some instances it is triggered in a very short time by some urgent problem (UNAIDS 1997:3; Edwards 2004). Mabaso (2008:13) supports this view and further argues that in fact the history of civil society organisations can be traced back to the earliest civilisations.

Communities have always had a good level of humanitarian concern for others and community members endorsed communal mechanisms to ensure that the vulnerable received support in times of need (Trickett 2005). For instance, early Egyptian civilisation developed some solid moral code regarding social justice that encouraged people to help others in relation to their needs. Even the Pharaohs contributed by giving shelter, bread and clothing to the poor almost 5000 years ago (Hudson 1999).

Local people, whether individually or through groups and associations, have engaged in a variety of activities to address their problems and tried to improve their communities. Traditionally, African families turned towards extended family, friends and neighbours for support and assistance when resources of individual households become exhausted. This is because people and communities have had the potential to be creative and they have always organised themselves to deal with societal challenges and to take care of collective and individual needs (Foster 2001). This enables them to survive even though they are poor and face critical circumstances such as HIV/AIDS (Taylor 1992: 223).

However, the interest in the growth of civil society organisations appears to coincide with the rise of neo-liberal economic policies in Africa, which were mainly influenced by the international financial institutions from the 1980s (Van de Walle 2003: 4; Powell and Geoghegan 2004: 17). These policies involved the reduction in the role of the state in providing social services to enable the African states repay international debt (Danaher1994). This brought about an increase in the expectation of the role that the private sector and civil society organisations would play in the development discourse to fulfill the roles given up by the troubled African states. Civil society

organisations were seen as the means through which democratisation could be achieved as institutions through which locally driven development could be achieved (Van de Walle 2003: 5).

5.3.2 Defining civil society

Because of some fundamental ways in which people perceive and assign meaning to various phenomena, different scholars view and define civil society and its role in development differently depending on the school of thought one subscribe to. It is not easy though to arrive at consensus with regards to defining civil society (McCarthy 2000). For instance, some scholars claim that civil society is a specific product of the nation state and capitalism while others see it as a universal expression of the collective life of individuals, at work in all countries and stages of development but expressed in different ways according to history and context (Edwards 2004).

Edwards (2005:59) further argues that the concept of civil society "seems so unsure of itself that its definitions are akin to nailing jelly to the wall." He draws lots of questions to demonstrate the complexity surrounding the meaning and essence of civil society. He questions whether "Civil society is a bulwark against the state, an indispensable support, or dependent on government intervention for its very existence. Is it the key to individual freedom through the guaranteed experience of pluralism or a threat to democracy through special interest politics? Is it a noun, a part of society, an adjective - a kind of society, an arena for societal deliberation, or a mixture of all three?" In the end Edwards remains unsure weather these questions really matter, or only do to academicians.

Barber (1995:1) offers a philosophical definition of civil society and says, it is "a societal dwelling place that is neither a capitol building nor a shopping mall. It shares with the private sector the gift of liberty; it is voluntary and is constituted by freely associated individuals and groups. But unlike the private sector it aims at common ground and consensual, integrative, and collaborative action. Civil society is thus public without being coercive, voluntary without being private." Alan Fowler (2004), supports this view and states that civil society is a public domain of normative

associational life created by citizens that is not part of a state or for-profit business. (Grant 2000:15) perceives civil society as "the well-spring of social capital - the ability of people to work together for common purposes; which in turn, is integral to good governance."

Regardless of how civil society is defined and the various typologies that exist Fowler 2004:6), identifies three major functions of civil society organisations. These include;

i) Provision of mutually supportive social and economic relationships, acting as locations where people with shared affinities or needs come together. CSOs also create a binding social fabric and assistance for economic advance, risk spreading and local 'management' of public goods and affairs.

ii) Delivery of social, economic and other public services that society values.

iii) Provision of mechanisms and vehicles that connect, aggregate and articulate citizen's diverse interests, enabling them to engage with each other as well as other actors, such as states, markets and political processes.

My view regarding the complexity surrounding the meaning of civil society is congruent with Edward's (2004) that, it is imperative to move towards clarifying the concept in a simple and practical manner to avoid falling in the trap of using it as a political slogan or a shelter for dogma and ideology.

Therefore, the application of the meaning of civil society in this argument regarding its role in response to HIV/AIDS as a development problem is borrowed from the developmental view that civil society is a third sector (apart from the government and or commercial sectors) Robinson and White (1997).

One argument for this position is that both the business and the government sectors cannot solve all the problems that originate in society. In other words civil society provides a balance to the otherwise-overburdened state and business sectors. Given the failings of paternalistic approaches and centralised planning especially in developing countries (Scott 1995), civil society serves as a framework for both resisting injustice and providing alternative solutions to social, economic political and

now the HIV/AIDS problems (Edwards 2005). Besides, it can be argued that civil society as a third sector is better positioned to work with people in an inclusive, flexible and participatory manner within the community (Tripp 2003). It plays an important role in reaching the poorest and neediest of society more easily than it would be the case with the bureaucratic state (Robinson and White 2001). Uphoff (1993: 619) supports this view and states that civil society organisations are "more in touch with the needs of ordinary people, have knowledge of local conditions and are more responsive to local needs than the state." Other scholars for instances argue that since civil society organisations focus on people and encourage participation, they "empower local people to express themselves on their needs; explore possible alternatives for satisfying their needs; choose the most appropriate course of action; mobilise local resources to implement the chosen course of action; and evaluate the contribution of that action to their livelihoods" (Blunt and Warren 1996: xii; Koehn and Ojo 1997). The realisation that both business and government sectors can not provide solutions to the development questions brings in the need for the involvement of the third sector (the involvement of civil society organisations) into the equation. This thinking creates the basis of this thesis; to look at CBOs (as civil society organisations) and examine the role that they play in development.

For purposes of aligning the definition of civil society to this thesis, the concept will refer to non-state organisations or networks of organisations that directly serve community members. With particular reference to the HIV/AIDS sector in Southern Africa , there are various categories of civil society organisations that are commonly referred to, and these include; community based organisations (working in one community or area), Non-governmental organisations (working in more than one community but not in any other country, International NGOs (with branches and programmes in more than one country), Faith-based organisations [FBOs] (associated with church or has faith-based orientation), umbrella organisations (which have functions of coordinating or funding a cluster of organisations) and AIDS service organisations (that are primarily focused on providing HIV/AIDS services) (Waddell and Brown 2002; UNAIDS 2005; Birdsall and Kelly 2007:43; Gaist 2010).

Non-governmental organisations appear to overshadow other civil society organisations because of their size in structure, focus and resource base. Since my thesis is specifically looking at CBOs and the role they play in responding to HIV/AIDS as a development challenge, I will examine the relationship between the NGOs and the CBOs. This will also justify my focus on CBOs and not so much on NGOs.

5.3.2.1 Non-governmental organisations versus community-based organisations

As stated earlier, both non governmental organisations and CBOs alongside other non state organisations form part of the diversity of civil society. Both NGOs and CBOs are instrumental in igniting the power of the community. They play a key role in developing inclusive approaches and bring community members to focus on issues that affect them and to help raise community awareness and to leverage existing resources (Mc Carthy 2000). Gaist (2010) also recognises the important role played by civil society organisations. He observes that at a time of unprecedented challenges such as economic crises, social inequalities, environmental stressors, emerging health threats, civil society organisations are driving change, often being the first to call attention to the issues and increasingly forging significant and sustainable solutions.

The main difference between NGO and CBOs is that NGOs tend to be more sophisticated than CBOs. They are legally established and have professionally trained employees with formalised structures and procedures. Participation in NGOs is through formal membership though volunteers are not kept away. The objectives and activities are designed for public benefit.They function at local, regional, national or international levels and are usually operated not for profit (Mc Carthy 2000).

Community-based organisations on the other hand are organisations that are formed and developed within a community usually in response to the felt needs of the people; they may be development oriented or exist for social cohesion purposes (Eade 1997). They are often referred to as grassroots organisation. CBOs are distinct in nature and purpose from non-governmental organisations (World Bank 1995). They mainly operate at a local level usually in a specified community which may be a village or

location in an urban setting. The objectives and activities are mostly based on common needs and shared benefits. Governance, decision making, management and planning procedures are informal and made by members. They may not be legally registered (though most CBOs are now striving to formalise structures and procedures to be seen to comply with donors requirements) and membership is open and often voluntary, comprising of a group of individuals who have joined together to further their interests (Malena 1995; Eade (1997: 6). The membership cuts across gender, age, marital status, level of formal education, occupation and levels of income in society. Thus, CBOs bring together people of all walks of life (Mc Carthy 2000).

My experience working with NGOs and CBOs in Southern Africa for more than nineteen years now is that CBOs are closer to the people that need development than NGOs. The relation between these two civil society entities is also interesting. NGOs usually assume a more superior role than CBOs often providing the later with resources and using them to realise development objectives. They also attempt to change the way CBOs function so as to conform to modern ways of management. In the end NGOs become too cozy to meet the real needs of the people on the ground (World Bank 1999). NGOs at times do manipulate objectives of local CBOs towards fulfilling their own end. For example, Oyugi (2004) observed that during the Moi era in Kenya some CBOs were manipulated from being autonomous self-reliant development organisations for mobilising local resources to initiate durable local development to mobilising political support for politicians. The relationship between NGOs and CBOs has never been equal.

Nevertheless, I perceive CBOs to form the bedrock of social safety nets for the poor. They form an element of peoples' survival strategies and are typically part of the constituency that form the third sector. They operate on very basic yet important principles of cooperation, trust and reciprocity (Wilkinson-Maposa and Fowler 2004; Marais 2004:3).

CBOs occupy diverse roles and pursue a variety of activities in society ranging from education and health care to advocating for marginalised groups and policy-oriented movement. With regards to the response to HIV/AIDS, CBOs have been outstanding in creating systems for support to help with survival through livelihood support mechanisms such as gardening and promoting small income generating activities (Trickett 2005). They have provided emotional support to the afflicted families; they have set up systems for providing material support, particularly in allocating food and clothing for vulnerable children and orphans and for the elderly who become carers of orphans (Foster 2004). Generally, CBOs have been credited with their ability to successfully engage communities in activities which have contributed in tangible ways of improving their living conditions (Grant 2000:18).They have also advocated for abolition of risky traditional practices. For instance, in Monze district in the Southern province of Zambia, local CBOs were instrumental in working with the local chiefs to abolish risky sexual behaviours such as ritual cleansing which had been practiced for many years[4]. If the success of community participation can be measured by the capacity of citizens to engage in dialogue that results in joint action to resolve their concerns and sustain their development as Grant (2000) argues, then this Monze case is surely one of the examples of people participating through CBOs to reach a desired end.

In conformity with Grant (2000:18), my experience working with CBOs in the HIV/AIDS sector and beyond has made me realise that CBOs have important features that place them in a better position than NGOs to facilitate development. For instance:

- They have direct relationship to the poor.
- They identify with concerns of the communities they serve.
- They respond to local issues.
- They stimulate participation and articulate local views.
- They are cost effective and operate simply.
- They are driven by volunteers.

[4] This information is based on my own experience when I was the district Coordinator for the Monze district HIV/AIDS prevention and care project in the early 1990's. I was involved in dialogues that happened between the local CBOs and the traditional leaders. The outcome of this process was that all the six traditional chiefs including the paramount chief agreed to abolish the practice of sex ritual cleansing in the district. Measures were put in place to deal with people who did not comply.

- They are flexible enough to respond to a variety of emerging community situations (UNAIDS 1999a: 45).

It is for these reasons that this thesis focuses more on CBOs than NGOs though it recognises that both fall within the genus of civil society. Detailed examples of the role of CBOs particularly in response to HIV/AIDS will be discussed in chapter 8.

Even when I prefer CBO to NGOs as champions of the bottom-up development approach, I do acknowledge, however, that they have shortcoming and challenges (that include inadequacy of resources and restricted focus). My point of view however is that these must be eliminated. I also do agree that NGOs can play an important part in their relationship with CBOs if they enter into participative and open partnerships (and not manipulative ones). They can do well in building the capacity of CBOs to overcome their shortcomings and promote their knowledge and processes to leverage resources. However, certain basic issues must be sorted out for this to occur. For example, issues of unequal relationships, openness to processes and maters to do with resources and also competing timeframes must be addressed.

5.4 The significance of CSOs in response to HIV/AIDS as a development challenge

In this section I will discuss the importance of civil society organisations, particularly CBOs in response to HIV/AIDS epidemic as a development challenge.

Earlier in this chapter, I discussed how HIV/AIDS is the greatest threat to human well-being, public health and development in modern times. Its emergence in the mid 1980s complicated the development discourse especially among sub-Saharan countries. People were not only threatened by poverty but also by HIV/AIDS, which has killed resourceful members of society and left many families vulnerable. It is for such reasons that the UNAIDS (2002a: 44) describes HIV/AIDS as “one of the most devastating epidemics in human history, one that threatens development in major regions of the world”. This being the case the response to this challenge requires action from government, civil society organisations including CBOs. In support of a multi action response to the epidemic, the former United Nations Secretary General,

Koffi Annan recognised HIV/AIDS as a major crisis for the African continent and "that governments and communities have got to do something to end the conspiracy of silence and the shame over this issue" (Brittain 2000:5).

The significance of the involvement of CSO, particularly CBOs, in response to HIV/AIDS must be understood within the historical context that the involvement of community members in community challenges is an old practice. As McGee (2002:92) asserts, "people have always been agents of their own development, sometimes working alone, sometimes through collective endeavours." It is important therefore even in modern times to recognise and utilise grassroots organisations to maximise local knowledge and facilitate the involvement of people (including the socially and economically marginalised) to participate in decision making over their lives (Guijt and Shah 1998:1). HIV/AIDS has made the need for organised action become a matter of fact and this has led to the proliferation of CBOs and support groups in most high prevalence communities.

The response to HIV/AIDS in high prevalence countries by civil society organisations particularly emerged somewhat slowly. This reflected both a lack of resources and experience and a widespread reluctance to recognise publicly or acknowledge the threat it posed (Haslegrave 1988). However, as the epidemic progressed, CSOs were among the first to respond to the HIV/AIDS challenge. They have played a key role since the early 1990s in the fight against the epidemic. For example, they have advocated and encouraged people living with HIV/AIDS (PLWHA) to form their own organisations through which to address their concerns. They have worked with communities that emerged with shared concerns to prevent the spread of the virus and to care for those affected by HIV /AIDS as well as to advocate for health and human rights (UNAIDS 1997:3). Since then, CBOs, faith-based organisation and support groups of PLWHA (as part of civil society) have been in the vanguard of providing various services towards HIV/AIDS programmes. They are now recognised as the most effective immediate and direct intervention strategies for fighting HIV/AIDS by promoting access to health care services including counselling, psychosocial, material and spiritual support for persons living with HIV/AIDS (Morna (1991). They have also consistently drawn attention to the need to link prevention, provision of treatment, care and support to those affected including dealing with the effects of increased morbidity and mortality as well as the growing number of orphans and

vulnerable children, with broader issues of poverty, gender equality, governance and human rights (Foster 2005). They have constituted themselves as community safety nets to try and cushion the impact of HIV/AIDS.

In sub-Saharan Africa a range of interventions from communities emerged and they have played a crucial role in mitigating the HIV/AIDS epidemic (Hsu et al. 2002). For instance, a World Bank study in the Kagera region of Tanzania reported that 90 per cent of the assistance to families that lost breadwinners through AIDS came from family and community groups (UNAIDS 1999b: 29). Such community level commitment has made the response of CBOs to HIV/AIDS reputationally strong in high prevalence countries such as Botswana, Malawi, Tanzania, Uganda, Zambia, and Zimbabwe, providing good examples of the role of CSOs in response to HIV/AIDS (Russel and Schneider 2000:6). Some CBOs in these countries have even evolved into strong NGOs like TASO in Uganda, and the Family AIDS Trust (FACT) in Zimbabwe and the Family Health Trust (FHT) in Zambia.

Civil society organisations have exerted their position as the first line of defence in fighting the epidemic (UNDP 2002). CBOs in particular are adept at uniting the underprivileged and marginalised fringes of society, building their capacities, giving them 'voices,' and promoting their social inclusion. (Action Aid Nigeria, 2003:26). For instance, the illegality of commercial sex work hampers government efforts to promote safer sex to prevent spread HIV infection among this critical segment of society. This is because by nature HIV is intimately linked to sex and sexuality, areas that are usually dominated by norms and taboos that most governments in high prevalence countries will not work on. Therefore, the unique strength and ability of CBOs provides a platform for addressing issues of cultural taboos because obstacles to addressing these issues lie outside the control of formal policies and processes and more within the domain of community socialisation processes and upbringing, otherwise in the informal policy arena (Idogho, Kinyanjui and Ogundipe, 2004). The work of CSOs outside of the formal policies in reaching marginalised and often criminalised vulnerable populations such as drug users, sex workers and migrant communities that are usually reluctant to deal with government officials has been well accepted in communities (Mercer et al. 1991; NORAD 1991). These local organisations act as catalysts for social change by empowering people who face various forms of socially sanctioned violations. Their use of participatory approaches

and integration with the community places them at a vantage point to be able to tackle the social and cultural determinants thereby driving the epidemic in a way that the public sector struggles to do. In Botswana for example, CSOs have championed the call to respond to HIV/AIDS as a national development issue and influenced government to demonstrate political will and provide the necessary resources needed. Today Botswana stands out and provides an example of a well coordinated and supported response to HIV/AIDS in Africa (UNAIDS 2002).

In Nigeria, CSO have proved to be important actors in HIV/AIDS programme implementation by managing more that 70% of the country's programme implementation (Ogbogu and Idogho 2003). They are also playing a significant role in contributing to data on the epidemic and have contributed towards a more coordinated approach to the response, through increased collaboration and networking among themselves and with government.

In South Africa a campaign launched by several national and international CSOs led to 39 multinational pharmaceutical companies dropping their case against the Government of South Africa in April 2001, allowing the country to import anti-retroviral drugs (CPT 2001). In Thailand too, CSOs have been a driving force behind the effort to increase access to treatment (Ford et.al. 2009).With their emphasis on empowerment and awareness-raising, civil society organisations have brought in a rights-based approach to the HIV/AIDS response focused on reducing vulnerabilities by addressing root causes such as social exclusion, economic deprivation and discrimination.

Mabaso (2008: 24) agues that local CSOs have also pioneered a bottom up approach of delivering HIV/AIDS services. For example they have championed the idea of the greater involvement of people living with HIV/AIDS (GIPA). They started community home based care programmes, as a medium for providing care and support to orphans. They have played an important part in educating and sensitising people about HIV/AIDS, based on their situation (De Jong 2003). This has influenced a growing acknowledgement among development scientists that CBOs are critical players in fighting HIV/AIDS (UN-OSAA 2003). For example Kevin De Cock, former Director of the Department of HIV/AIDS for the World Health Organisation,

stated that “since they provide a substantial portion of care in developing countries, often reaching vulnerable populations living under adverse conditions, CBOs must be recognised as essential contributors towards universal access efforts and to the general fight against HIV/AIDS” (WHO 2001:2). Above all, they have provided a cost effective response to HIV/AIDS because they cost less to manage, are based on local needs and available resources and the mutual understanding of community members working as volunteers (UNAIDS 1999a: 45).

Overall, the role of CSOs particularly CBOs in the response to HIV/AIDS has been significant in creating awareness about the epidemic; mobilising community members; advocating for prevention, treatment care and support services; building community capacities to the response; and promoting volunteerism (Russel and Schneider (2000:1). They have also mobilised impressive efforts for education and training and other supportive services (Haslegrave 1988; and Mercer et al. 1991).

Given the manner in which CSOs have complemented the response to HIV/AIDS, it should be noted that despite the overwhelming negative impact that HIV/AIDS has had on communities, its episode has had a somewhat positive influence on social cohesion as communities have recognised the importance of working together and organise initiatives to address this challenge. In support of this view, Baylies (2002b) argues that vulnerabilities brought about by HIV/AIDS has provided a possibility that can foster a collective response among community members, which, in turn, can foster personal empowerment and social change in the community. The positive cohesion of civil society organisations has even played a critical role in shaping international policy towards the response to HIV/AIDS particularly with regards to access to treatment and advancement of human rights.

Despite the evidence that exist to speak for the role of CSOs in response to HIV/AIDS as a development challenge, there is still debate regarding their effectiveness in delivering services. On one hand CSO are perceived to be more efficient and effective than the state sector, for instance, in delivering services to needy people at the community level (Green and Matthias 1997:54). This notion is the central justification for increasing the call to involve CBOs in providing service to prevent HIV infection and mitigate its impact. There is substantial literature from which to draw lessons on

the operational experiences of CSOs in delivering HIV/AIDS service in developing countries (Mabaso 2008; Biekart 1998: Fowler 1999; Clayton et al. 2000).

On the other hand, Clayton, Oakley and Taylor (2000:8) cite Robinson and White's (1997) argument against the effectiveness of CSO and highlight their shortcomings. They contend that though CSO, especially CBOs may aim to deliver services to poor people the scale of their operations and coverage is limited and consequently many people do not benefit from them. They further posit that smaller CSOs such as local CBOs are notoriously weak on co-ordination; there is duplication on each others work; they compete and concentrate on their efforts in the same geographical areas.

Given this debate, my position is that even with the weakness inherent among CSOs especially smaller ones like CBOs and Faith-based organisations, they are still useful in stimulating development and also promoting bottom up, people focused approaches. With regards to HIV/AIDS, CSOs have provided leadership in the response to HIV/AIDS locally and globally (Panos 2003).

It is also important to note that CSOs have not only been critical in providing services, implementing programmes but have also been critical instigators in influencing opinion leaders and policy-makers as well as politicising HIV/AIDS to attract political commitment. As a result of civil society advocacy, many governments have changed their attitudes towards HIV/AIDS. In fact, a major characteristic of countries where efforts against HIV/AIDS have been successful is a vibrant civil society. An example of this can be drawn from Botswana and Uganda's experience in their response to HIV/AIDS. Seeley and Pringle (2001: 8) corroborate this idea and emphasise that "What has worked in arresting the HIV/AIDS epidemic and mitigating its impact have been local responses, not global initiatives or grand strategies. What needs to be done is to support such local responses and to share the learning across sectors, regions and organisations."

5.5 Establishing the link between CSOs and the development from below paradigm

The widespread pressure for popular participation and a declining faith in the capacities of governments to solve the interrelated problems of social welfare, development and the environment has lead to the upsurge of organised community action through local volunteering (Salamon 1997; Sethna 2003). Being locally-based organisations, CSOs represent the voluntary sector where members are held together by common beliefs and shared values, rather than by political imperatives (government) or economic incentives (the commercial sector) (Brown and Korten 1989). The importance of dealing with community challenges at the local level is supported by Maser (1997: 96) when he affirms that "it is… imperative that we address the fundamental causes of our problems at their roots – our thinking and behaviour at the level of the local community or we will always be dealing with symptoms and Band-Aid solutions that compound the problem by denying the cure."

The role of CSOs in the response to HIV/AIDS has become more critical since the inclusion of the human dimension to the definition and understanding of development. Green (2002: 58), states that "the human face of development was formally recognised in the new set of development indicators first released by the UNDP in 1990." The human dimension of understanding development became prominent because of the need to focus more on the human development indicators that provide qualitative proxies for human wellbeing, as well as a range of more instrumental proxies for participation in the development process than only focusing on economic indicators (i.e. gross national product and national debt) (Ibid Green 2002). The Human Development Report (UNDP 1994:2) also emphasised the need for human centeredness in measuring development and identified healthy life, knowledge acquisition and accessibility to resources as important elements in achieving development without which other opportunities may be inaccessible (Magomero 2005). These can not be achieved through government interventions alone but with complement from organised action from the communities through CSOs.

Given the tenets of alternative development theories as discussed earlier, particularly the emphasis on mobilising local people and stimulating their creativity, I perceive CSOs particularly CBOs to be suitable context for advancing the development from below paradigm because they empower local communities and people to act on their development needs. Again, this position is influenced by my understanding and belief in people's inherent dignity and their right to self-reliance because the true goal of sustainable development is progress for all humanity (Suk-Young 1999). To achieve this, people through local organisations must be regarded as partners in the process of development and their capacities (individual, organisational and systems) enhanced to create cadres of indigenous animators, catalysts, facilitators, and leaders to stimulate the process of development over a long time (Lucius Botes and Dingie Van Rensburg 2000). CSOs present this opportunity; the opportunity for bottom-up participation, which according to Goulet (1989: 167) "is a key to development from within, a result of deliberate initiative taken by members of a community in need."

CSOs complement the fundamental understanding; that development is a process that is internal to its beneficiaries and that the community and people are the best initial resource to implement development (UNDP 2000: 73). In order for CSOs especially CBOs to foster people driven development, it is critical that people, especially those experiencing poverty, organise themselves, because "organising is the guiding force that creates development opportunities" Medoff and Sklar (1994: 261). The duo further state that "when communities are not organised first, development is less likely to occur" (Ibid: 276).The need to get organised and confront the development concerns of people on the ground has an enormous potential to bring about meaningful change that has a lasting impact on local communities. When people get interested in an endeavour and decide to participate because they perceive some gain, they are likely to work very hard to succeed and sustain the change. They will "initiate an empowerment cycle, a counterweight to the poverty cycle, in which a community's success engenders more positive feelings, solidarity, and momentum for another successful cycle" (Lamboray and Skevinton 2001:516). This in itself is an incentive for the people to take stewardship and ownership of their development processes and the outcomes which are essential to sustainability (Nayyar et al. 2006). As a result the norms and values of self-reliance are cultivated within communities,

thereby increasing the chances of these norms and values becoming the basis of a new culture that is likely to be passed on to future generations as a way of life.

Because of their focus on the grassroots populations and pursuit to include and reach marginalised and vulnerable groups, CSOs as a third sector promote the tenets of development from below approach.

5.6 Conclusion

This chapter discussed various responses to the epidemic starting from the global to national and local levels. It is clear that rich countries of the west have shaped the response to the epidemic. In most cases the strategies for dealing with HIV/AIDS have remained external to the communities most affected by the epidemic.

The chapter further discussed the involvement of civil society organisation in the fight against HIV/AIDS. The significance of CSOs particularly the role played CBOs in response to the epidemic was examined. A link between the bottom-up approaches to development and the work of CBOs towards the response to HIV/AIDS was discussed. Fundamentally, the chapter did establish that as a development challenge HIV/AIDS can be dealt with through the application of participatory bottom-up approaches that must focus on empowering people through building their capacity. The chapter also highlighted the need for CBOs to work with other stakeholders through effective partnerships that are open and balanced. This is important not only for complementing ideas but also for leveraging recourses and building on lessons learned and results and experiences gained.

Through this chapter I have highlighted the perspective that civil society organisations can influence the community's success in the development process because they act as catalysts of social change and empower people who face various forms of socially sanctioned violations (Schumaker 1996). For this reason, CBOs can be used as channels to route development information and other resources required for improving living conditions in communities. Their self-initiative, knowledge of the community

and acceptance by the community and relative cost-effectiveness render them suitable owners, advocates and participants in community development programmes.

CHAPTER 6

BOTSWANA'S RESPONSE TO HIV/AIDS AND THE EMERGENCY OF CBOS RESPONSES

6.0 Introduction

This chapter will discuss three main issues. Firstly, it will present the HIV/AIDS situation of Botswana and elaborate how this has affected national development. The factors that led to the spread of the infection and the response that the country has mounted will also be discussed. This will assist to understand the background of the involvement of CSOs, particularly CBOs in the response to HIV/AIDS in Botswana.

Secondly, this chapter will discuss the process of formation of CBOs as action groups. It is mostly assumed that CBOs form spontaneously because people want to act to pursue a common interest. This may be true but the dynamics of this process can be associated with a systematic process constituting various distinct phases. This is important to understand so that those interested in meaningfully working with CBOs may understand the specific phases of development that the CBOs experience and the likely challenges they encounter at each stage. This will assist development parishioners to appropriately align and deliver their support to CBOs in accordance with the phase of development of the CBO. This will also avoid overwhelming the CBOs with support that may actually be beyond their comprehension because of the phase they may be at. It is common for instance, for stakeholders to load a CBO with complicated issues of governance, strategic planning and reporting when in fact the CBO must be dealing with issues of understanding the critical issues of its existence and how it must move forward to sustain its aspirations.

Thirdly, this chapter will discuss the GCHBC organisation, elaborating how it was formed, how it is organised and what it does. This will assist to contextualise the results of this study since most of the examples are drawn from the experiences of this CBO.

6.1 The HIV/AIDS situation in Botswana

6.1.1 An overview of Botswana's development

Despite the hazy development record of most African states, especially among the sub-Saharan African countries, there have been isolated cases of social, political and economic achievements. For instance, Botswana is considered an economic success story because of the discovery of diamonds in the 1968 Patterson (2009). Some economic analysts though argue that this should be attributed to God's grace rather than well-planned and articulated programmes. However, the fact that these gains have been maintained is a result of the country's effort and prudent economic management of the national resources. Nevertheless, Botswana's economic success story has been seriously affected by the HIV/AIDS epidemic, as will be demonstrated later in this discussion.

Botswana is a landlocked country in Southern Africa. It shares international boarders with Namibia to the northwest, South Africa to the south, Zimbabwe to the east and Zambia to the north. It is formerly a British protectorate, which gained political independence in 1966. The country has a population of 1.7 million people (Central Statistics Office 2001).

Unlike other former British colonies or protectorates, Botswana's economic future at independence was desolate until the discovery of diamond reserves in 1968, which transformed the country's economic growth (Acemoglu et al 2002). Diamonds now constitute about 80 per cent of the country's export earnings. Tourism and beef exports also contribute to earnings of foreign income. In addition to diamonds, copper-nickel matte, coal, gold, cobalt, salt and soda are mined in comparatively smaller quantities mainly for in-country consumption (Hope 1996).

Botswana has been stable politically since independence and has fostered a steady socio-economic and physical infrastructure development. The country now boasts of a very good network of roads, which facilitates the movement of goods, services and people across the country. The conversion of the mining driven growth into social investment has meant that Botswana is seen as an African success story and a lesson for other developing countries (Acemoglu et al. 2003).

6.1.2 The impact of HIV/AIDS on Botswana's development

Despite its economic growth, Botswana faces two key development challenges: the decline in diamond mining, and HIV/AIDS since 1985. This thesis will focus on the problem of HIV/AIDS.

The prevalence of HIV in Botswana remains among the highest in the world. According to the UNAIDS (2007) report, it is estimated that 17.3 per cent of the population is infected with HIV. The biggest concern is that the epidemic mainly affects 15–49 age group, who are the most sexually, reproductive and economically active age group. As a result life expectancy has dropped from 65 years in 1990–1995 to less than 40 years in 2000–2005 (Avert 2007).

Before the onset of HIV in the mid-1980s, human capability indicators on health and education showed very impressive figures in Botswana, but HIV/AIDS has emerged as a serious challenge to the socio-economic growth of this country. For example in 1990 Botswana ranked 110 on the human development index and by 2003 it had dropped to 131 because of the impact of the HIV/AIDS epidemic (Kgathi et al. 2006). During the phase of heightened HIV infection and the increased number of deaths from AIDS, Botswana suffered a dramatic slowdown in economic growth. For example, between 1960 and 1990 Botswana's gross development product (GDP) grew at an average of 11.4 per cent per year but this dropped down to five per cent per year during the 1990s and a low of 3.7 per cent annually since then (World Bank 2005).

HIV/AIDS also increased the death rate of the productive citizens and reduced the national life expectancy at birth from 65 years in 1990–1995 to less than 40 years in 2000–2005 (UNAIDS/WHO 2006). The fiscal burden that HIV/AIDS creates undermines economic diversification and is a strain on the national economy because the response to the epidemic claims a lot of money that would otherwise have been allocated to other poverty reduction and development programmes. The focus on HIV/AIDS treatment means that expenditure on other non-health sectors is compromised. Although provision of treatment is good for growth and poverty reduction, it has its own consequences. For instance, it worsens inequality because it primarily benefits the urban households as the prevalence rate is higher in urban areas and most treatment facilities are situated in urban centers (Ravallion and Chen 2003). This inequality deepens spatial differentials and widens the gap between the rich and the poor especially with regards to access to health services.

Botswana has an HIV/AIDS National Strategic Framework (NSF) (2003) that stipulates the overall national response to the fight against the epidemic. It aims to improve substantially the treatment available to people living with HIV/AIDS, especially by increasing access to highly active antiretroviral treatment with the hope that by 2009 all those living with HIV/AIDS return to productive life. To implement all these programmes and achieve the stipulated results it calls for a huge investment of resources. Table 2 below shows the projected programme cost of the HIV/AIDS National Strategic Framework for Botswana.

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Table 2: Projected programme cost of the HIV/AIDS National Strategic Framework for Botswana (in millions of pula)

Item	*Year*						
	2002/3	*2003/4*	*2004/5*	*2005/6*	*2006/7*	*2007/8*	*Average*
Prevention of HIV infection	185.8	241.0	264.5	234.3	164.3	156.7	207.8
Provision of care and support	408.9	641.6	781.0	1,117.1	1,577.4	2,229.9	1,126.0
Antiretroviral therapy (ART) drugs	38.6	139.2	251.0	374.0	504.0	642.0	324.8
Other costs	354.3	299.4	455.5	617.6	868.3	1419.4	669.1
Total programme cost	949.0	1,182.0	1,501.0	1,969.0	2,610.0	3,806.0	2,002.8
Percentage of GDP	2.78	3.16	4.04	4.84	5.92	8.00	4.99

Source: NACA (2003:95); Masha (2004:292)

The projected cost of implementing the NSF is approximately 12 billion pula (about US$2.4 billion) over the programme years (2003–2009). This translates into an average of 5 per cent of GDP devoted solely to HIV-related spending each year (NACA 2003). This demonstrates how much is spent responding to HIV/AIDS from the national budget**.**

6.1.3 Factors leading to HIV/AIDS in Botswana

Before analysing the factors responsible for exacerbating HIV infection in Botswana, it must be understood that, among the various means of HIV transmission, the heterosexual mode is predominant in Botswana. This should not suggest ruling out other modes of transmission such as among men who have sex with men, although this is a scantly researched topic in Botswana.

Several factors have contributed to the spread of HIV/AIDS in Botswana. According to the Botswana National Strategic Framework for HIV/AIDS (NSF) (2003:16) factors that contribute to the spread of the HIV/AIDS infection have been grouped under four broad categories as socio-economic, demographic mobility, stigma and discrimination associated with HIV/AIDS, and cultural and gender inequalities. Other

factors include high rates of sexually transmitted infections, sexual behaviour patterns, poverty and rapid urbanisation, which leads to the breakdown of traditional mechanisms of controlling social and sexual behaviour (UNDP 2001). Some of the factors contributing to spread of HIV/AIDS are discussed below.

6.1.3.1 Socio-economic factors

Despite carrying a good socio-economic story, Botswana still has pockets of severe poverty. According the UNDP (2008) 47 percent of the population in Botswana live below the poverty line of a dollar per day and most of these are female-headed households.

The huge income disparities present in Botswana contribute to an increased risk of HIV infection because those in high income brackets exploit those in low income brackets when negotiating for sex (Kgathi et al. 2006). Income disparity has encouraged commercialisation of sex particularly intergenerational sex (older men buying sex from young girls) because older men use money to entice young girls with gifts in exchange for casual sex. This is commonly referred to as the three Cs: car, cell phone and cash.

6.1.3.2 High mobility among citizens

There is a good network of roads in Botswana and the Batswana[5] are a highly mobile people (NACA 2003). Traditionally, Batswana have three homes: a town house, a cattle post home, and another home in the lands (fields) in the village. This influences people to travel often between the urban and rural areas. People normally move between these settlements unaccompanied by their spouses, which increases the potential for casual sex. In addition, married couples are usually separated in the line of duty through transfers and often live in different distant places (NACA 2001). This too increases the temptations to have casual sex. In addition, Botswana is a "transport hub for Zimbabwe, South Africa, Namibia, and Zambia all of which share the high prevalence rates that characterise the pandemic in Southern Africa (NSF 2003:17).

[5] The citizens of Botswana are called Batswana regardless of their tribe.

This highway connection to neigbouring countries particularly by trucks also places Botswana at high risk of transactional sex and HIV infection.

6.1.3.3 Stigma and discrimination associated with HIV/AIDS

AIDS-related stigma refers to the prejudice and discrimination directed at people living with HIV/AIDS (PLWHA) and the groups and communities that they are associated with (Botswana Ministry of Health AIDS/STD Unit 2003). This often results in people living with HIV/AIDS (PLWHA) being rejected from their community, shunned and treated negatively, discriminated against and even denied opportunities or even being physically abused because of their HIV status (Dodds 2004). Stigma and discrimination occurs at all levels of a person's daily life, for example, when they wish to travel, use healthcare facilities or get a new job (UNAIDS 2002).

Despite a seemingly increasing acknowledgement and acceptance that HIV/AIDS exists within communities, the level of social and institutional stigma and discrimination still exist mainly because of fear and ignorance about HIV/AIDS (Shreedhar and Colaco 1996). As a result there are still a lot of people in Botswana who are ignorant about their status, because they fear the consequences of an HIV positive test. According to Avert (2010:1) some factors that contribute to HIV/AIDS-related stigma and discrimination include the following:

- HIV/AIDS is perceived to be a life-threatening disease.
- HIV infection is associated with behaviours (such as homosexuality, drug addiction, prostitution or promiscuity) that are already stigmatised in many societies.
- There is a lot of inaccurate information about how HIV is transmitted.
- HIV infection is often thought to be the result of personal irresponsibility.
- Religious or moral beliefs lead some people to believe that being infected with HIV is the result of moral fault (such as promiscuity or 'deviant sex') that deserves to be punished.

In recognition of stigma and discrimination as factors effecting national responses to HIV/AIDS, the UN Secretary-General Ban Ki Moon (2008) said:

"Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world."

HIV/AIDS-related stigma and discrimination builds upon and reinforces existing prejudices. They play into and strengthen existing social inequalities, especially those of gender, sexuality and race. They also play a key role in producing and reproducing relations of power and control that cause some groups to be devalued and others to feel that they are superior. Ultimately, stigma creates and is reinforced by social inequality which in turn affects responses to HIV/AIDS (Crane and Carswell 1990). As Parker (2002) stated, stigma and discrimination directed at PLWHA not only makes it more difficult for people trying to come to terms with and manage their illness on a personal level, but it also interferes with attempts to fight the AIDS epidemic as a whole. McMillin (1995) further observed that not only does stigma interfere with interventions and treatment; it also turns diagnosis into accusations.

In Botswana there are still some significant barriers and social stigmas associated with HIV/AIDS despite programmes being implemented. Because of fear of rejection people living with HIV/AIDS are reluctant to seek or access services instead opting to live in isolation without support (Russel and Schneider 2000:2). Fear of stigma and discrimination leads to late testing and reluctance to access treatment and other services that can reduce chances of causing new infections or re-infection and prolonging life. This implies that infected people continue to have a "normal" life and continue infecting and re-infecting themselves and others (AIDS/STD Unit 2004).

6.1.3.4 Traditional and cultural factors

Culturally, Botswana is a country that is layered with complexities and conundrums. Given the lifestyle of its citizens, Botswana is a society that is modernising at a very fast rate where one can see the interface of modernity and tradition. This is leading to a clash between traditional values and modern life styles. Consequently there are some uncertainties among young people leading to changing life dynamics (Garner 2009).

While modernising at a fast rate, Batswana still engage in some traditional practices that increase the risk of HIV infection. For instance, it is culturally and socially acceptable for men to have multiple partners and extra marital sex (Aliro, Ocheng and Fiedler 1999). Because of traditionally prescribed preferences for dry sex especially by men and boys, safe sex is rarely practiced increasing the risk of HIV infection. Substance and alcohol abuse particularly among youth of both sexes also contributes to high risk of HIV infection.

Despite high levels of HIV/AIDS in Botswana and deaths that result from it, HIV/AIDS still remains a difficult issue to discuss at family and community levels including in churches. This difficulty is associated with the taboo that goes with sex and death (Jackson and Lee 2002).

Ntseane (2004:3) in her study on 'Cultural dimensions of sexuality: Empowerment challenge for HIV/AIDS prevention in Botswana' identified a number of cultural practices among different tribes of Batswana that increase risk of HIV infection. The common ones include;

1) Mantsala: This is a practice where blood or ethnic cousins have recreational sex. This is common among the youth and perceived as a practice for an active future sex life. This encourages youth to have multiple partners and put them at risk of infection.

2) Nkazana: This is a heterosexual behavior practiced by the Kalanga ethnic group in the northern part of Botswana. Nkazana (literally translated as "small house") is a cultural practice where a husband is given authority to have a sexual relationship with a younger female sibling of the wife (Ntseane 2004:4).

3) Seantlo: This is a form of wife or husband inheritance. This involves a widow or widower marrying a sibling of the deceased husband or wife. This practice is common among the Barolong.

4) Xakanaxaamaa: This is common among the Basarwa (commonly known as the san or Bushmen). Xakanaxaamaa is a sexual practice of multiple partners, which serves an important social function. It involves a woman having sex with any man as long as the man leaves a spear at the door to alert other men of his presence. Due to the traditional nomadic culture of the Basarwa, it is believed that every woman needs protection from the hostile environment, especially in relation to wild animals. The male who provides this service in return has access to sexual favors.

These cultural practices, as long as they encourage practice of sex with multiple partners increases the risk of spread of HIV infection. The strong beliefs in these practices also limit prevention opportunities and jeopardise programmes designed reduce spread of HIV infection.

6.1.3.5 Existing gender inequalities

Gender inequality is a social phenomenon that places women to relatively low social status as compared to men. This puts women and girls at an accelerated risk of exposure to HIV infection (Ntseane et al 2005). Apparently gender inequality is rampant in high HIV/AIDS prevalent communities.

Botswana is relatively progressive in terms of women's empowerment. Women are playing an increasingly important role in higher-level positions within government. As of 2004, women held 11% of positions within parliament, 25% in cabinet, 19.6% of Councillors and 20% of House of Chiefs (SADC 2004). Women are increasingly

becoming empowered in Botswana on a political level, with increasing decision-making power and control; however there is still significant progress to be made.

Despite the fact that women are relatively empowered at a political level, the issue at domestic level is far different. Women still suffer marginalisation in Botswana, maintaining a subordinate status physically, economically and socially. This disempowerment is often manifested in unequal employment opportunities, unequal access to wealth, and unfair division of labour in the household and overall unequal power relations. Women also suffer the highest rate of HIV/AIDS in comparison to men. For example, according to the 2002 Botswana Second Generation HIV/AIDS Surveillance Technical Report, 64% of adult HIV infections in Botswana are of women.

Gender related factors that make women vulnerable to HIV infection include;

1) Cultural of silence around issues of sex and sexuality: Women and girls in Botswana have less power to decide on safe sex because of some cultural perceptions and prescriptions regarding the sexual behaviour of women. They are still culturally mute and not free to openly discuss issues related to sex with male counterparts. For instance, women are culturally not expected to negotiate and suggest where, when and how to have sex. Husbands are deemed to have complete conjugal rights on their on terms (Jackson and Lee 2002) making sex within marriage very risky among women. This has implication on women's health with particular regard to reproductive health and sexually transmitted infections such as HIV/AIDS (Mogwe 1988).

2) Exploitative transactional and intergenerational sex: Because women jobs are generally less paying than men's, their level of economic vulnerable is increased and their power to select appropriate options is compromised. Adoption of sex as a coping mechanism for survival becomes apparent. Young females become more vulnerable at the hands of older men who have access to income and finances. Poverty and unemployment among women have been cited by various researchers as contributory factors to increased HIV/AIDS infection among women and girls (Gil 1970; Mogwe 1988; WAD 1999; WLSA 1988).

3) Gender-based violence within relationships: According to Ntseane (2005:189), gender-based violence is “any act that results in or is likely to result in physical, sexual or psychological harm or suffering to women including threats such as coercion or arbitrary deprivation of liberty whether occurring in public or private life”. This includes rape and incest by family members, female genital mutilation, female killings and infanticide and emotional abuse such as coercion and abusive language (Republic of Botswana/UNDP 1998:4).

Because women have less power and authority they are subjected to abuse and forced sex in a society with very few established social institutions to deal with related distress. Passion killings are very common in Botswana. This often involves a male lover killing his female lover on suspicions of cheating. This subjects women to be submissive to men for fear of being hurt or even killed.

The use of alcohol in Botswana has become a preferred way of recreation especially among the young. This selected way of life contributes to gender-based violence and other risky behaviours associated with increased risk of HIV infection. The relationship between alcohol, gender-based violence and HIV/AIDS has been established in various studies (Clement 1999; Hamilton & Collins 1981; Kalichman 1999; LaBrie & Earleywine 2000; Martin et al 2004; Letsholo 2002; Parker 1993; Taylor Dlamini, Kagoro, Jinabhai & de Vries 2003; The Voice 2003; WAD 1999).

The gender issues discussed above as prevalent in Botswana and other high incidence countries position gender as a critical factor in the spread of the HIV/AIDS and its effect on development.

6.2 Botswana' systematic response to HIV/AIDS

As in many other countries where the effects of HIV/AIDS were beginning to take a devastating toll in the late 80s, Botswana was also grappling to accept the reality that HIV/AIDS was a problem among its people. During this time blame for the infection and its prevalence was thrown onto foreigners (homosexual westerners and promiscuous African immigrants) and socially stigmatised local groups such as commercial sex workers and their clients. Other people blamed were those who did not adhere to local traditions and practices such as a widow having sexual intercourse within a year of the death of the spouse or a man who has sex with a woman who has had an abortion and not "properly cleansed". Initial government denial also worked to delay the introduction of effective interventions and in some countries this denial may have contributed to the worsening of the epidemic (Ainsworth and Teokul 2000).

As HIV/AIDS spread exponentially in Botswana, the government mounted a systematic response to fight HIV/AIDS by developing several strategies. The systematic response to HIV/AIDS in Botswana can be divided into three distinct phases (Government of Botswana and UNDP 2000:41) as follows:

6.2.1 Phase 1(1987-1989)

This marked an early stage of reacting systematically to the epidemic. This phase mainly focused on reducing the risk of HIV transmission through blood transfusion by screening all blood and blood products before transfusion. A government programme was established to ensure the safety of blood and blood products as well as the availability of disposable needles in all health facilities throughout the country. During this period an interim short term plan of action was developed. This paid particular attention to clinical and health-sector-related concerns such as training health workers in securing safe blood supply, the clinical management of HIV/AIDS and sero-surveillance.

6.2.2 Phase II (1989-1997)

The second phase took place when the first Medium Term Plan (MTPI) was drafted. MTPI expanded the efforts of the preceding phase by introducing information, education and communication programmes at national level. In 1993 the national policy on AIDS for Botswana was adopted.

6.2.3 *Phase III (1997–2002)*

This phase expanded the focus of the national response further to include prevention, comprehensive care and the provision of antiretroviral treatment. All this was articulated in the second Medium Term Plan (MTPII) developed during this phase. MTPII outlined a national multi-sectoral response to the epidemic calling for all sectors to get involved in the fight against HIV/AIDS and reducing its impact at all levels of society. In order to coordinate these efforts the National AIDS Coordinating Agency (NACA) was established in 2000.

During the third phase there was a call for political commitment and leadership to the HIV/AIDS response. The then president of the country stood up to this challenge and declared HIV/AIDS a national crisis. Festus Mogae, President of the Republic of Botswana, said publicly, “We are threatened with extinction. People are dying in chillingly high numbers. It is a crisis of the first magnitude” (Avert 1999).

Following this declaration government provided leadership and created an enabling environment within which the public and private sector, civil society (NGOs, CBOs, FBOs and support groups) and international development partners, could execute their mandates towards the national goal of preventing further spread and reducing the impact of the epidemic. Currently most government ministries have mainstreamed HIV/AIDS as part of their core business and have recruited focal persons to coordinate HIV/AIDS activities. Civil society organisations stepped up their activities and a lot of CBOs were established to respond to the epidemic. The GCHBC was one such CBO.

Before describing the GCHBC CBO and elaborating how it started, I will provide a general insight as to how CBOs as action groups form. This is very important because development practitioners must understand the stage at which a CBO is at in its formation and function to be able to direct the appropriate support.

6.3 The formation of CBOs as action groups

In this section I will discuss the formation of CBOs. Given that CBO start as small groups of individuals, I will consider and discuss selected theories and models of group development including factors that influence people to join groups, as well as the processes and phases that groups go through to develop and reach a point where they are ready to act and function.

Like any other group, CBOs do not just form from nowhere; they get established for a purpose (Philbin and Mikush 1999). It takes an impetus and a process as well as time for CBOs to form and develop to a point where they can be effective and where all members feel connected. Though purposes may differ, the common reason for forming CBOs remains similar; to deal with an undesirable situation and achieve a preferred one and this could mean attempting to reverse conditions of misery, and social, economic and political exclusion. At the time that CBOs form their biggest asset is their unity of purpose and vision.

It must be understood from the on set that, the tendency of people to come together and form groups is inherent in the structure of society (Colemen 1990). The question of how groups form, take shape and evolve over time and engage in collective action has become of great interest to social scientists since the 1970's (Olson 1971) especially in social psychology (Levine and Moreland 1991; Moreland & Levine 1992; 1996; Moreland 1987).

For purpose of this study, Forsyth's (2006) definition of a group is adopted; that a group connotes some people (minimum of five) who come together on a free and voluntary basis and with a spirit of co-operation expressed by mutual love and

assistance, sister/brotherhood, justice and honesty; to work together for mutual benefit.

McGrath, Arrow, and Berdahl (2000) define small group formation as the emergence of a functionally interconnected whole from a set of elements. As has been indicated earlier, McGrath et.al (Ibid) also acknowledge that groups may form for many different reasons, but the pressure or force that initiates them can be divided into several different kinds. He further identifies four different general forms of groups as i) concocted groups; ii) founded groups; iii) emergent groups and iv) circumstantial groups (McGrath et al. 2000).

Concocted groups are groups that are deliberately planned and created. These form to complete a specific task. A founded group is formed when several individuals link up with other people who agree on a common purpose. An emergent group is a group that emerges spontaneously out of already existent relationships. Friendships are often formed in this way. Circumstantial groups arise out of unexpected environmental situations (McGrath et al. 2000).

Most of CBOs experience these different pressures when they are forming. This certainly was the case when the Gabane Community Home-Based Care CBO formed. The CBO was formed as a result of some changes (circumstantial) in the community resulting from long term illness and death. A group of concerned individuals known to each other (emergent) influenced other community members (founded) to deliberately come together (concocted) to form the GCHBC CBO to deal with the common challenge of HIV and AIDS in their community.

To clearly understand why people identify themselves with a group and decide to belong to it, one needs to examine some existing perspectives on group identity. Bouas and Arrow (1996:155) suggests three general categories: (1) those that emphasise interdependence, common fate, and collective interests (a behavioral or experiential component); (2) those that emphasise cohesiveness and the development of interpersonal bonds among group members (an affective component); and (3) those that emphasise awareness of the group and identification of oneself as a group member (a cognitive component).

When analysing groups and why they form, it is important to note that while groups emerge for different reasons, so do reason why people join them. Generally, people are more inclined to join groups with people who share their own values and opinions. The goals of a group for instance can also influence why people decide to join it and participate in its endeavours. Others may join a group for personal reasons e.g. to be its leader and fulfill personal need for power and status or they may along with other members join and participate out of an interest in a project the group will undertake, or a benefit that being in the group can provide (e.g. emotional, social, economic, or political) (Moreland & Levine; 1996; Ibid McGrath et al.). Bartle (2007:1) asserts to the view that there are various factors that encourage group formation and he summaries them as follows:

- Physical proximity: People who live in the same village are likely to form a group than people who live in different villages.
- Physical attraction: Individuals who attract to each other physically might form a group, e.g. young and energetic boys and girls.
- Rewards: satisfaction of economic and social needs; and
- Social support: perhaps provided by members of a group in times of crisis.

Regardless of the factors that have influenced the group to form, the most important thing is for the group to hold together for the purpose for which it was formed because "the degree of success and failure of the group is critical because in turn it affects outsiders' willingness to join the group or the incumbent member's desire to remain in the group" Ahn et al (2005:2).

6.3.1 Theories and models of group development

A number of theoretical models have been developed to explain how groups develop and change over time. Some models view group change as regular movement through a series of 'stages' while others view them as 'phases, that groups may or may not go through and which might occur at different points of a group's history (Gersick 1988).

George Smith (2001) argues that group development theories are based on one's perceptions regarding group dynamics i.e. whether group change occurs in a linear

fashion, through cycles of activities, or through processes that combine both paths of change, or which are completely non-phasic. The general consensus which I agree with is that groups do go through several predictable stages before useful work can be done (McGrath and Tschan 2004).

According to Van de Ven & Poole 1996; Smith, 2001, some of the most common models of group development includes the following:

i) Kurt Lewin's (1947) Individual Change Process consisting of three-stage process unfreezing, change, and freezing.
ii) Bruce Tuckman's (1977): Forming, Storming, Norming, Performing and Adjourning Stages.
iii) Tubbs' Systems Model.
iv) Marshall Scott Poole's multiple-sequences model.
v) McGrath's (1991) Time, Interaction, and Performance (TIP) Theory.
vi) Gersick's (1988, 1989, 1991) Punctuated Equilibrium Model.
vii) Wheelan’s (1990;1994) Integrated Model of Group Development; and
viii) Morgan, Salas and Glickman (1994).

For purposes of this study I have borrowed much form Bruce Tuckman’s Model and Morgan, Salas & Glickman’s Team Evolution and Maturation (TEAM) model which combines other theories and add onto Tuckman’s model. Caveat must be observed that the stages that are discussed here are mere guidelines because the process of group formation can be influenced by the cultural context within which it takes place.

6.3.1.1 Tuckman’s model

Bruce Tuckman (1965) identified five stages that characterise the development of groups a follows:

6.3.1.1.1 The Forming Stage

The forming stage marks the initial stage of formation of groups. This stage is very dynamic because it is the phase when people perceive a conflict in their community.

This defines what is and what ought to be and acts as an impetus for action. This stage occurs when people begin to experience a turbulence that threatens their community order, either socially, economically, environmentally or because of a large-scale epidemic such as HIV/AIDS. This phase is characterised by contemplation as people reflect on the conflict, realise and acknowledge their situation, and decide what they should do (Tuckman 1965).

My interpretation of what is happening during this phase is that people realise and rediscover themselves and recognise the potential that they and the community possess. At this point collective action is stimulated in the face of a community-wide threat before that threat begins to undermine the ability and incentive for people to act collectively. For instance, people will talk and start to share their experiences of the turbulence. This kind of dialogue and sharing grows to a point where people come together in a group and begin to develop a relationship with one another based on a common experience, and trust starts to develop. Group members begin to anticipate perceived future benefits of the group cohesion and they start to establish a pattern of behaviour leading to action to deal with the conflict or challenge.

6.3.1.1.2 The storming stage

The storming stage is the second stage of the formation of groups. During this stage, people have built up energy from the previous phase and are ready, charged up to take action and willing to take risks (Tubbs 1995). This phase is characterised by taking in many ideas from members. There may be some interpersonal conflicts and differences of opinion that arise about the group and its purpose during this phase. Succeeding in understanding and agreeing on what the group intends to do at this point is critical, because it is at this stage that members need to be motivated by the prospect of good results (Op cit Ahn et al 2005). If the group is unable to state its purposes and goals clearly, or if it cannot agree on shared goals, the group may collapse at this point. It is important therefore to work through the conflict at this time and to establish clear goals. Members must discuss and reach an agreement so that everyone feels relevant and committed to the purpose of the group. At this stage the group can even talk about the ideas openly and can contact community leaders for assistance knowing that they are clear about their intention and what they want to achieve in the group.

6.3.1.1.3 The norming stage

The norming stage is the third phase of group formation. At this point members are committed to the group and ready to resolve any conflicts among them. The group begins to be organised and is now able to establish patterns of how to get its work done. Expectations of one another are clearly articulated and accepted by members. Formal and informal procedures are established in delegating tasks and the process by which the group functions (Tuckman et al. 1977). Members of the group come to understand how the group will operate. During this stage members establish the norms and values of working together and are committed to face the community challenge. This is important because for any change to take place a certain way of thinking and behaviour needs to exist among the group's members. This thinking should be followed by creating some values and beliefs that propagate assertiveness and willingness to take action and learn from it. It is very important that the group achieves the intangibles (group norms, values and so on) and uses these to achieve tangible results (group activities). In support of this Rahman (1991: 14) observed that people should develop their own endogenous consciousness-raising and knowledge generation in order for them and their succeeding generations to bring about meaningful change.

6.3.1.1.4 The performing stage

Performing is the fourth stage of the formation of groups. During this stage issues related to roles, expectations and norms are no longer of major importance. This is the phase for action and the group is now focused on its task, working intentionally and effectively to accomplish its goals (Tuckman 2001). At this point it is important for the group to develop partnerships and consolidate relationships with other entities (within or outside its community) that can assist it achieve its purpose. The group members learn new skills to enable them to carry out their roles. Just as in other stages in the formation of groups, this phase is not static, it is dynamic. New members join the group while other members may leave. It is important for the groups to go through the preceding stages of forming, storming and norming as the group grows and gets organised so the old and new members learn about one another and recommit to the group's purpose (Forsyth 1990).

6.3.1.1.5 The adjourning stage

Tuckman added a 5th stage to his earlier four stages, the 'adjourning stage'. This stage involves dissolution of the group; that is letting go of the group structure and moving on (Tuckman and Jensen 1977). It entails the termination of roles, the completion of tasks and reduction of dependency (Forsyth 1990: 77).

6.3.1.2 The Team Evolution and Maturation (TEAM) model

The TEAM model was propounded by Morgan, Salas & Glickman. The model is a combination of multiple theories and the development models including that of Tuckman and Gersick (Morgan, Salas and Glickman (1994). The TEAM model perceives groups as teams. It describes a series of nine developmental stages through which newly formed task-oriented teams are hypothesised to evolve.

According to the TEAM model, the phases of development are conceived to be relatively informal, indistinct, and overlapping. The group's progression through the stages depend on factors such as the characteristics of the group and team members, their past histories and experience, the nature of their tasks, and the environmental demands and constraints (McGrath 1991).

Morgan et al (1994) postulates that the TEAM model has a total of nine stages, seven central ones supplemented by two additional ones. The seven central stages begin with the formation of the team during its first meeting (forming) and moves through the members' initial and sometimes unstable, exploration of the situation (storming), initial efforts toward accommodation and the formation and acceptance of roles (norming), performance leading towards occasional inefficient patterns of performance (performing-I), re-evaluation and transition (reforming), refocusing of efforts to produce effective performance (performing-II), and completion of team assignments (conforming) (Morgan et al 1994).

The core stages of the model are preceded by a pre-forming stage that recognises the forces from the environment (environmental demands and constraints) that call for, and contribute to the establishment of the team; that is, forces external to the team (before it comes into existence) that cause the team to be formed. The last stage indicates that after the team has served its purpose, it will eventually be disbanded or de-formed. Here individuals exit from the group (separately or simultaneously) and the team loses its identity and ceases to exist (Morgan et al. 1994). This stage is similar to Tuckman's additional last stage of adjourning.

My experience working with the CBOs and support groups motivates my argument against the last stage of group separation or adjournment. Rather, I contend that after reaching the confirming stage, instead of adjourning, groups maintain cohesion. McGrath (1984) and McGrath and Tschan (2004) also raised questions about the variations of the phases particularly the stage where the group disbands. While I agree that groups and CBOs do reach the adjourning stage, I posit that those that have recorded good success and processes of working are more likely to expand their mandate. At this point the group develops confidence and is ready to take on more and even much more complicated challenges beyond its original mandate than disband. This also greatly depends on the leadership of the groups and how well the group has achieved its purpose. I refer to this stage as the sustaining phase. This is the stage when the CBO has matured and is ready to diversify the efforts of the group. During this phase the CBO is interdependent and forms partnerships with other organisations to leverage resources and develop the capacity and enhance skills of the group members.

The various stages of group formation discussed above provide a theoretical understanding of the processes of group formation. This will help to understand and contextualise the formation of the GCHBC CBO to respond to HIV/AIDS in its community. The succeeding section will describe details of the GCHBC CBO, how it started, how it is organised and the work that it does.

6.4. Overview of the Gabane Community Home-Based Care CBO

This section will present a description of the Gabane village and the GCHBC CBO since it is the case under study. The description is mostly based on my discussion with the GCHBC CBO participants since there is very little written information about the CBO. The discussion will highlight when the CBO started, why it started and how it started, and describe the programmes and activities it implements in response to HIV/AIDS as a development challenge.

As discussed at the beginning of the previous chapter, Botswana is one of the countries with a high prevalence rate of HIV/AIDS in the world and its effects are threatening the country's development efforts. For instance, the country's health system became over-stretched. The need to seek other care options such as the shift from over-reliance on hospital care to community home-based care (CHBC) became imminent (Stegling 2001). Botswana's reaction to the HIV/AIDS epidemic has been systematic and evolved considerably (World Bank 2001). The country demonstrated good political will and adopted a multi-sectoral response to HIV/AIDS that motivated government institutions and civil society organisations including CBOs and faith-based organisations to take action.

The formation of CBOs in response to HIV/AIDS through the CHBC programmes in Botswana was supported by the then Minister of Health, Joy Phumaphi who said: "Community home-based care is taking us back to the root of human coexistence. It reminds us that we all have the responsibility to one another. If we hold hands through this tragedy... we will be able to retain our humanity and will come out of this epidemic as a stronger community" (WHO 1999:8).

Most support groups and CBOs providing HIV/AIDS services started by providing home-based care to patients in their communities. This is particularly the case in rural settings where due to the extended family system "people live in closely organised groups, and willingly accept communal obligations for mutual support… the sick, aged and children are all cared for by the extended family" (Shawk (1972: 4–5). However, extended families and communities have been overwhelmed by HIV/AIDS.

The health care system too has not been spared (WHO 2000). Nevertheless, as the epidemic matured most care and support groups developed into CBOs and their activities evolved as they responded to the changing needs of families and communities (Horman et al. 2005).

6.4.1 Overview of Gabane village

Gabane is a small peri-urban village located in the south western region of Botswana and is only 15km away form Gaborone, the capital city of Botswana. The village covers an area of 2038 square meters. In 2001 the village had an estimated population of 10,399 people (Central Statistics Office 2002). The local people belong to the Balete tribe and are headed by a headman who is assisted by village elders in running the affairs of the village. Like all traditional chiefs in Botswana, the Balete chief reports to the house of chiefs which is the legislative branch that forms part of government (Republic of Botswana 2008). The residents of Gabane village have easy access to the capital city with some people having full time employment in Gaborone.

6.4.2 The formation of the GCHBC CBO

"When women move forward, the world moves with them." (CEDPA 2006:1)

The GCHBC CBO was founded in 1997 and is one of the oldest CBOs responding to HIV/AIDS in Botswana. It started when a group of local women from a local church started a funeral support group after noticing an increase in the number of funerals in the community. They realised that there were lots of residents who were terminally ill with HIV/AIDS and that the number of orphans was increasing. The women brought this challenge to the attention of church elders to try and find a way of dealing with the problem that was emerging in the community.

The Ministers Fraternal, a collaboration of local churches in the Gabane community, stepped up to provide leadership to deal with the HIV/AIDS problem. The church leaders brought the issue to the attention of the local traditional leaders to invite local residents to discuss this emerging community problem and find a way of dealing with it. The traditional leaders and church leaders through the Ministers Fraternal appointed two representatives from each church in the community to mobilise community members to participate in assisting chronically ill patients and to sensitise local people about the HIV/AIDS challenge. Community members agreed to volunteer their time to assist taking care of patients and vulnerable patients in the village. Originally, the GCHBC focused on providing home care to the chronically and terminally ill patients but has now expanded its activities and provides support to a broad range of population groups that have been affected by HIV and AIDS including orphans and vulnerable children and the elderly. The GCHBC is still operating with its pioneers as central figures and drivers of the organisation (Glasl 1994).

Some people argue that the GCHBC must be categorised as a Faith-Based Organisation (FBO) since it was initiated through the local churches. I still maintain that it is a CBO because its work transcends religious boundaries and it is a registered CBO with the registrar of companies and societies. Since its establishment the GCHBC CBO has provided care to hundreds of patients within its community, making it one of the most accomplished CBOs providing services in response to the epidemic in Botswana. The CBO is now structured and provides a systematic framework for community development. It uses the community home-based care approach to provide HIV/AIDS services and in addressing other community development concerns. It has also mentored other communities and motivated government to support community-based organisations as actors in local development.

The GCHBC CBO is run by 33 volunteers and operates from two donated caravans. The CBO was allocated a 10,000-square-metre piece of land by the local authorities to enable it to establish its community offices. The CBO plans to construct a multi-purpose community centre for people living with HIV/AIDS and orphans and vulnerable children (OVCs). Its aim is to develop a centre of excellence for

community care approaches and incorporate information technology and other technical subjects and services that youth and community members can access. The CBO also plans to introduce vocational training programmes for the out of school youth.

6.4.3 Organisational structure of GCHBC CBO

Besides being managed by a team of motivated local volunteers the CBO has a board of directors from members of the community. The board members are members of the community including some local elders. The board of directors provides strategic direction, motivation and support to the organisation. They resolve some of the organisational difficulties and conflicts that arise among volunteer members.

The organisation has a committee that consists of a chairperson, a vice-chairperson, a secretary, a vice-secretary, a treasurer and three regular members. The committee members are responsible for the day to day management of the CBO and they are elected to the committee every year.

6.4.4 The GCHBC's philosophy

The CBO seeks to revitalise and renew family and community relationships, commitment and participation towards community sustainability by working with the community to reverse the impact of HIV/AIDS. The CBO members believe that rather than re-inventing the wheel, it should reinforce the community structures and mechanisms that already exist within the community and encourage community participation to save and sustain their community from the impact of HIV/AIDS.

The GCHBC CBO gained experience in responding to community challenges by interacting with other CBOs and NGOs. The CBO has developed a vision, mission and organisational values to guide its existence and operations. These are elaborated below.

The Vision

In conformity with the NSF the GCHBC vision is to have an HIV/AIDS-free community and nation in the long run.

The Mission

The mission of the GCHBC CBO is to provide quality care and support to the sick and OVCs while empowering people to live positively with HIV/AIDS.

The Values

The CBO's values include trustworthiness, compassion, transparency, team spirit and community involvement.

6.4.5 Goals and objectives of the GCHBC CBO

6.4.5.1 The Goal of the GCHBC CBO

The goal of the GCHBC CBO is to prevent further spread of the HIV/AIDS, reduce the impact of the epidemic on individuals, families and community and improve the lives of those affected by providing holistic care and support to them and other vulnerable members of the community such as orphans and the elderly in order for them to continue living productive lives in the community (Barker 2008)[6].

6.4.5.2 The objectives of the GCHBC CBO

The objectives of the GCHBC CBO are as follows:

- To prevent the spread of HIV by sensitising and educating people, mobilising them for action and promoting non-risky behaviour.
- To provide holistic care for people with HIV/AIDS and their loved ones.
- To reduce stigma and discrimination associated with HIV/AIDS.
- To create a positive and nurturing environment for OVCs to learn and grow.

[6] Taryn Barker was a World University Services of Canada Volunteer attached to the GCHBC CBO in 2008 to build the capacity of the CBO members in resources mobilisation and strategic planning

- To strengthen the ability of families and communities to care for orphans and vulnerable persons.

6.4.6 The programmes managed by the GCHBC CBO

The GCHBC CBO focuses on thematic areas that conform to the National Strategic Framework (NSF 2003-2009) including:

- Community sensitisation and mobilisation.
- Capacity building.
- Prevention of HIV/AIDS.
- Care and support (with advocacy for treatment and a human rights approach to HIV/AIDS as a crosscutting issue).

The CBO implements activities including community sensitisation and mobilisation, capacity building for volunteers, HIV/AIDS prevention, care and support to people affected with HIV/AIDS including orphans and vulnerable children. The details about these services and what the CBO has done in these areas will be discussed in chapter 8.

6.4.7 Challenges faced by the GCHBC CBO

The challenges include but not limited to issues regarding coordination and management; volunteer's commitment to the CBO; the growing demand of the CBO's services by the community; and inadequate skills and resources. These will be discussed in detail in chapter 8 as part of the results of the study.

6.5 Conclusion

This chapter has described Botswana's response to the HIV/AIDS and the government's commitment to motivate CSOs to participate in the response. It has also looked at the process that groups go through to form. An example of how the GCHBC CBO started has also been elaborated as an example. It has also highlighted how the CBO has evolved to a point where it has an operational structure and has described its vision, mission, values, goals and objectives. It has highlighted the programmes and activities of the CBO and its volunteers, focusing on issues of community sensitisation and mobilisation, capacity building, HIV/AIDS prevention, care and support.

CHAPTER 7

THE METHODOLOGY OF THE STUDY

7.0 Introduction

This chapter describes the methodology of the study. It discusses the research process and elaborates the underlying research philosophy; the research approaches; the research strategies; the time horizon and data collection methods and analysis. In order to complete the design of this methodology I extensively read and referred to work from other qualitative research to ensure that my approach conforms to what other social researchers have done or believe is a good qualitative methodology. The findings resulting from this methodology draws attention to the role of CBOs in responding to HIV/AIDS as a development challenge by looking at the perspectives of social actors, in this case, the CBO participants,[7] local volunteers as well as international volunteers who work with GCHBC CBO as well as fellow managers of NGOs.

7.1 Rationale of the study

Most literature that describes activities of CBOs arrives at negative conclusions about the impact of CBOs in development because they are small in nature, have internal weakness and the fact that their impact is negligent. For example, some scholars in development studies (Weisbrod 1997; Opare 2007) doubt the ability of CBOs to undertake successful self-help initiatives and contribute to development. They argue that CBOs are grotesquely under-funded organisations working in disinvested communities requiring massive capital infusion yet with little potential for impact (Ibid). Other development scientists doubt the impact of CBOs since they represent a bottom-up or development from below approach based on their perception that "there is inadequate specification and theoretical underpinnings of development from below" (Taylor and Mackenzie 1992: 234).

[7] CBO participants is used here to refer to people that are receiving services from the GCHB. Such people include OVCs, patients and people living with HIV/AIDS and community members

This study intends to highlight the real potential that CBOs have towards contributing to the fight against HIV/AIDS as a development challenge at community level and its influence at the national level. With systematic and well-targeted support from stakeholders including government, CBOs has huge potential for contributing to development.

7.2 The research design

In general terms research is defined as an activity that contributes to the understanding of a phenomenon (Lakatos 1978; Kuhn 1996). A research design therefore is a plan for collecting and using data so that desired information can be obtained with sufficient precision. “It is essentially a plan or strategy aimed at enabling answers to be obtained to research questions” (Burns 2000: 145). In other words a research design provides the glue that holds the research project together and is used to structure the research, to show how all the major parts of the research project work together to try to address the central research questions (Trochaic 2006). There are two distinct types of research designs; quantitative and qualitative. The choice of the design depends on the philosophical orientation of the researcher and the desired outcome, whether quantitative or qualitative information (Leedy 1993:13).

Because this study is of social nature and the emphasis of the results is qualitative than quantitative, qualitative research methods were deemed appropriate. A case study approach was adopted and data collected using a combination of informal interviews, group discussion and direct observations “to fill in a ‘jigsaw’ of differing accounts of the reality” (Mayoux 2005:5) of the GCHBC CBO.

7.2.1 Quantitative research methods

According to Mayoux (2005) and Straub, Gefen and Boudreau (2004), quantitative research methods were originally developed in the natural sciences to study natural phenomena. The main purpose of quantitative research is to explain the cause of changes in societal happenings. It carries a strong belief that there is a single reality separated from individual or societal beliefs. Quantitative research is deeply rooted in

numbers and statistics and often yields empirical data (Neuman 2000; Mason 2002). Quantitative research easily translates data into quantifiable charts and graphs. It generates data that can be projected to a larger population.

7.2.2 Qualitative research methods

On the other hand qualitative research methods were developed in the social sciences to study social and cultural phenomena (Mayoux 2005). Examples of qualitative methods of research include action research, case study research, and ethnography. Participatory research methods such as participatory rural appraisal (PRA) and participatory learning and action (PLA) have been included as methods in qualitative research (Mukherjee 1993; Mouton 1996).

According to Creswell (1998: 15) qualitative research is "an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports detailed views of informants and conducts the study in natural settings." Qualitative research is multi-method in focus and involves an interpretive, naturalistic approach to its subject matter. The researcher attempts to make sense or interpret phenomena in terms of the meanings people bring to them. Data comes in the form of words, images, impressions, gesture or tones which represent real events or reality as it is seen symbolically or sociologically (Denzin and Lincoln 1984). Qualitative research uses data collection methods such as relative unstructured interviews, documents, participant observation, the researcher's impressions and reactions, personal experience, introspection, life stories and visual texts to describe, understand and explain social phenomena.

Given that qualitative research looks beyond the numbers and places emphasis on understanding feelings, impressions and viewpoints of the social actors, qualitative case study approach with reference to some principles of grounded theory and some participatory techniques was employed in this study in order to understand the role that the Gabane Community Home-Based Care organisation plays in the development of its community and in its response to HIV/AIDS.

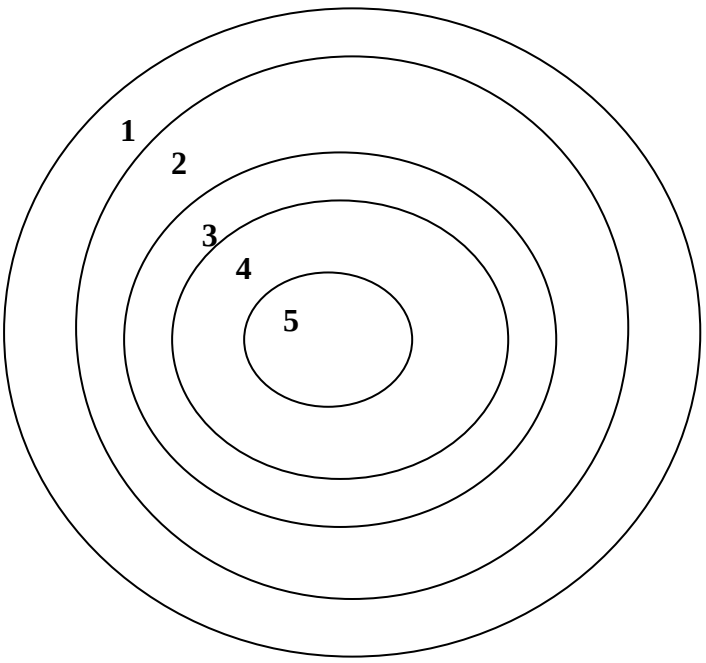
7.3 The underlying assumptions of the study

All research whether quantitative or qualitative is based on some underlying epistemologies and assumptions about what constitutes good research and the appropriate methods to be used (Hirschheim 1992). These assumptions influence the process of the research and considerations that the researcher has to make when planning the research. These considerations form what Saunders, Lewis and Thornhill (2003: 83–84) call the research process onion. The research process onion was employed in this study to decide on:

- The underlying philosophy of the study.
- The research approaches.
- The research strategies.
- The time horizons.
- The data collection methods.

The research process onion is illustrated in figure 5 below.

Figure 5: The research process onion



Source: Saunders, Lewis and Thornhill (2003).

7.3.1 The research philosophy

Philosophers have been debating the issue of philosophical perspectives in research for many years. There are various philosophical orientations to research that influence the researcher's selection of research methods. Guba and Lincoln (1994) suggest four underlying paradigms of research, which include positivism, post-positivism, critical theory and constructivism or interpretive research. These will be discusses below.

7.3.1.1 Positivist research

Positivism is mainly associated with quantitative research. It holds the view that science is largely a mechanical affair (Healy and Perry 2000). It emphasises empiricism, the idea that observation and measurement are the core of the scientific endeavour. It further emphasises that the goal of knowledge is simply to describe the phenomena that we experience such that the purpose of science is simply to stick to what can be observed and measured. Positivism also assumes that reality is objectively given and can be described by measurable properties, which are independent of the observer (researcher) and his or her instruments (Orlikowski and Baroudi 1991: 5). Because positivism is inherently quantitative in nature, I did not apply its tenets to this study.

4.3.1.2 Post-positivist research

As a modification of positivism, post-positivism is a common consideration in qualitative research. Post-positivism gained prominence after the Second World War. It assumes that human beings cannot perfectly understand reality, whereas with rigorous data collection and analysis, researchers can approach the truth. This approach emphasises that the researcher assumes a learning role as opposed to a testing one.

Post-positivism postulates that the researcher can never achieve objectivity perfectly, but can approach it. It assumes that all observations are theory-laden and that scientists are inherently biased because of their cultural experiences and world views. Because of the belief that all measurement is fallible, post-positivism emphasises the importance of triangulation as a way of achieving objectivity across multiple perspectives since objectivity is inherently a social phenomenon. It recognises that the best way to improve objectivity is to conduct multiple measures and observations with credible social actors that may genuinely criticise each other's work. This cross-checking of information then leads to the natural selection theory of knowledge, which holds that ideas have 'survival value' and that knowledge evolves through a process of variation, selection and retention (Myers 1997).

With specific reference to this study, as researcher I took a post-positivistic view mainly because this study is qualitative in nature and the participants are human beings who may have varying views about a situation. I triangulated the information I got from the participants with my own views based on my observation of the dynamics of the GCHBC. I conducted discussions with various people who are outside the GCHBC but have a working partnership with the CBO. Such people included representatives from prominent partners of the GCHBC and also the international volunteers[8] who are often placed to build capacity of the GCHBC and its members. I also referred to appropriate literature on the subject to cross-check my conclusions.

7.3.1.3 Critical research

Critical research assumes that social reality is historically constituted and that it is produced and reproduced by people (Hirschheim and Klein 1994). Critical research relates well with post-positivism because of its focus on social phenomena. Social critique (commonly referred to as critical realism) is perceived as the main purpose of critical research whereby the restrictive and alienating conditions of the status quo are

[8] International volunteers are normally experts in a particular discipline. The volunteers are placed with partner organisations to build capacity in specific areas. My organisation the World University Service of Canada has a volunteer programme that places volunteers in government and civil society organisations. WUSC has a functional partnership with the GCHBC CBO and it periodically places volunteers to build capacity in various area such as resource mobilsation, advocacy etc.

brought to light (Myers 1997). Like post-positivists, critical realists recognise that all observation is fallible and has errors and that all theory is revisable. Critical realists believe that science steadfastly aims to get reality right, even though we can never achieve that goal. They are critical of the ability of humans to know reality with certainty. Critical realism as expounded by critical realists assumes that there is a reality independent of our thinking about things that science can study.

7.3.1.4 Constructivist and interpretive research

Interpretivism and constructivism are related approaches to research that are characteristic of particular philosophical world views. Schwandt (1994) describes these terms as sensitising concepts that steer researchers towards a particular outlook. Proponents of these persuasions share the goal of understanding the complex world of lived experience from the point of view of those who live it.

For example, interpretive research attempts to understand phenomena through the meaning that people assign to them. The proponents of this body of knowledge assume that access to reality can only be attained through social constructions such as language, consciousness and shared meaning.

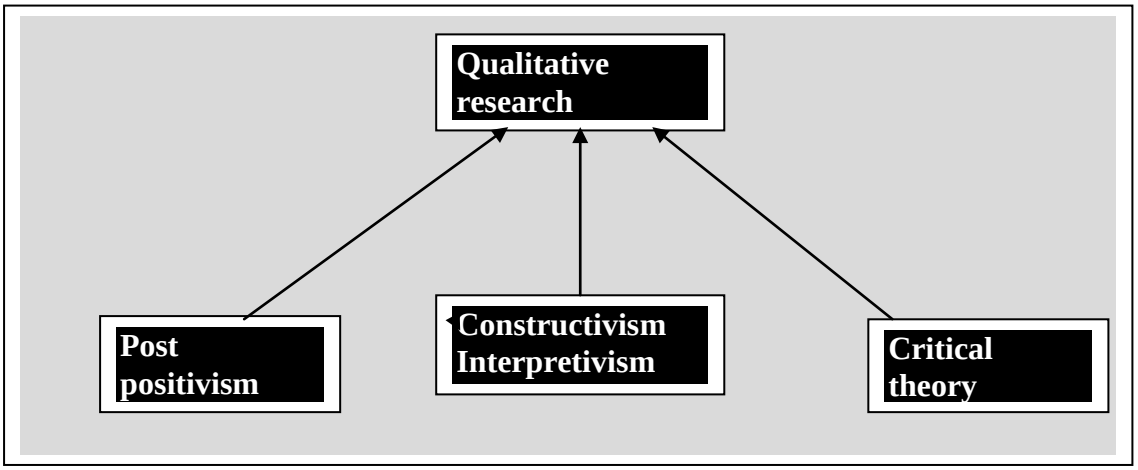
On the other hand constructivism views knowledge as the outcome of experience mediated by one's own prior knowledge and the experience of others. Like interpretivism, constructivism relates to post-positivism because of the emphasis placed on social actors in the generation of knowledge. Constructivists believe that humans construct their view of the world based on their perceptions of it. According to the constructivist, new understandings are constructed based on knowledge gained from observing previous perceptions and lived experiences. In conformity with critical realism constructivists avow that perception and observation are imperfect, therefore triangulation is imperative in constructing knowledge.

With regards to the study, interpretivism and constructivism principles played a significant part in designing the study process and application of methods, approaches and strategies as well as reaching conclusions. As a social scientist I believe that humans construct meaning from current and prior knowledge structures to

understanding a given social context better. Therefore, I maintain that the conclusions reached to constitute the results of this study are based on very careful construction and consideration of the views of the social actors, the interpretation of their reality and the way they presented it to me during our interaction through open interviews and discussions. I then triangulated these with my own observations,[9] with the literature that I interacted with during the process and with the views of key informants from the CBO and other partner organisations.

Given the explanations of the research philosophy above, the selection of qualitative research methods for this dissertation was guided by post-positivism, interpretive research or constructionism and critical realism. Figure 6 illustrates underlying epistemologies leading to this study.

Figure 6: The underlying epistemologies of the study



Source: This illustration has been adopted from Saunders, Lewis and Thornhill (2003)

7.4 The research approaches

The research approaches here treat deductive and inductive processes as two broad methods of reasoning. This study adopted the inductive reasoning approach to generate a position about the role that CBOs play in sustainable development based

[9] Given the constructivist assumptions I subscribe to, I am aware that my own prior experience and knowledge about the way CBOs function may influence my perceptions, I therefore remained "self-aware", candid and observed very carefully issues and events as they unfolded.

on data gathered from the GCHBC CBO, its participants, its partners and literature available.

7.4.1 Deductive reasoning

Deductive reasoning is closely associated with quantitative and positivist research. It works from the general to more specific and this is why it is at times referred to as a 'top-down' approach. For example deductive reasoning starts with a theory on a topic of interest and this is narrowed down to a hypothesis, then to observations and collection of data to test the hypothesis to confirm or reject the original theory.

7.4.2 Inductive reasoning

Inductive reasoning is more common with qualitative research. The inductive approach is a systematic procedure for analysing qualitative data where the analysis is guided by specific objectives. Contrary to deductive reasoning, inductive reasoning moves from specific observations to broader generalisations and theories. It is more open-ended and is also referred to us a 'bottom-up' approach.

According to Thomas (2003), an inductive approach is used:

- To condense extensive and varied raw text data into a brief summary format.
- To establish clear links between the research objectives and the summary findings derived from the raw data.
- To develop a model or theory about the underlying structure of experiences or processes which are evident in the raw data.

Inductive reasoning was applied in this study. To begin with my observations of the work of the GCHBC led to my interest to study its activities broadly and understand the potential that this single CBO has in contributing towards the fight against HIV/AIDS and the general development of its community. It is therefore my hope that this thesis will influence some perspectives among development scientists about the

role of CBOs in sustainable development and what should be done to enable CBOs to participate effectively in the development discourse.

7.5 The research strategies

The research strategy is the approach adopted to address the stated research questions and objectives (Saunders et al 2003). The strategy may be positivist in nature and use experiments or surveys, or may be phenomenological and use case studies, action research, grounded theory and ethnography. This study used the case study method because the unit of study was one CBO, the GCHBC. The study referred to principles of ground theory and participatory methods because of their relation with inductive reasoning approaches.

7.5.1 Grounded theory

Grounded theory is a research method that seeks to develop theory that is grounded in data that is gathered and analysed systematically. According to Martin and Turner (1986:141), grounded theory is "an inductive, theory discovery methodology that allows the researcher to develop a theoretical account of the general features of a topic while simultaneously grounding the account in empirical observations or data." Grounded theory emphasises theoretical development and suggests a continuous interplay between data collection and analysis.

7.5.2 The case study

Given the nature of the study, case study approach was preferred. This method was found relevant because it is an empirical enquiry that investigates a contemporary phenomenon within its real-life context when the boundaries between phenomenon and context are not clearly evident and in which multiple sources of evidence are used (Yin, 1989:23).

Researchers have used the case study research method for many years across a variety of disciplines. As a distinct approach to research, the use of the case study originated only in the early 20th century and was further developed by the sociologists Barney Glaser and Anselm Strauss.

Social scientists in particular, have made wide use of this qualitative research method to examine contemporary real-life situations and provide the basis for the application of ideas and extension of methods. Case study research excels at bringing us to an understanding of a complex issue or object and can extend experience or add strength to what is already known through previous research.

According to Yin (2000) the term case study has multiple meanings. It can be used to describe a unit of analysis (for example, a case study of a particular organisation) or to describe a research method. The discussion here concerns the use of the case study as a research method.

A case study is a form of qualitative descriptive research that looks intensely at an individual, group or pool, drawing conclusions based on the analysis of the accounts of the subjects (participants) and variables relevant to the subject under study (Polit and Hungler 1983). A case study is normally conducted within its real-life context (Yin 1984: 23).

This case study was conducted in situ,[10] within the community in which GCHBC CBO operates. A holistic description of GCHBC was made in chapter 7 and this was important because, according to Stainback and Stainback (1988), a holistic description of events, procedures and philosophies occurring in natural settings is often needed to make accurate situational decisions. Descriptive elements were factored in order to have a technical account, which Blockier (2000) calls an 'adductive approach', to interpret and describe the dynamics of the GCHBC in order to gain a total or complete picture and understanding of its role in responding to HIV/AIDS as a development challenge. The GCHBC CBO was purposefully selected because I assumed it has the ability to generate a lot of insights on the role of CBOs in response to HIV/AIDS because it has been functional for more than 10 years now. This means that while

[10] As a researcher I have worked with the Gabane Community Home Based Care organisation for nine years now and have a thorough understanding of how it has evolved since its formation.

holding together it has experienced the challenges, acted on them and continued to function to meet its objectives.

7.5.3 Participatory research methods

The use of participatory methods has increasingly become common in a variety of fields beyond livelihood analysis. Participatory methods have gained prominence among development practitioners because of the need to involve the beneficiaries of development in the development process itself (Krishnawamy 2004). Participatory methods and participatory development has been popularised by Gordon Conway and Robert Chambers (1992) and also David Korten (1996) among others.

There are various participatory research methods that are used in enhancing development work. The common ones include Participatory Action Research (PAR), Participant Observer (PO) and Rapid Rural Appraisal (RRA) and Participatory Learning and Action (PLA) as a recent addition (Jules Pretty (1995). I will only further elaborate PRA because its principles were substantially relied upon in this study.

While proponents of PRA emphasise that it is a form of qualitative research used to gain an in-depth understanding of a community or situation (Chambers 1992: Norton et.al 2001:6), I believe that it is more than merely a research methodology used for data collection but a critical process in the development process. Its leading proponent, Robert Chambers, claims that it represents not just a set of research techniques, but rather a whole new paradigm of development. Chambers (1997:188) further argues that PRA offers "…a new high ground, a paradigm of people as people…good PRA goes further, in empowering lowers. Its principles, precepts and practices resonate with parallel evolutions in the natural sciences, chaos and complexity theory, the social sciences and postmodernism and business management…." This is the reason that it has become the preferred approach for participatory development by many NGOs and development agencies working at grassroots level such as The World Bank, UNDP, ILO,. World Bank, Action Aid, Aga Khan Foundation, Ford Foundation, GTZ, SIDA, UNICEF, UNDP, UNCHS and Habitat among others.

Participatory rural appraisal (PRA) has been defined as a family of participatory approaches and methods which emphasise local knowledge and enable local people to do their own appraisal, analysis and planning (Chambers 1994). It is also referred to as a collective learning process with partners and communities using a series of flexible and participatory techniques to analyse situations and problems and to plan activities in a systematic and intensive manner (Botswana Orientation Center 1994). PRA uses group animation and exercises to facilitate information sharing, analysis and action (World Bank 1995:175) to enable and facilitate planning processes of appropriate interventions between the development practitioners, government officials and the local people (Brown 1985; World Bank 1998).

Some of the tools used in this approach are local graphic representations created by the community that legitimise local knowledge and promote empowerment. These include transect walks ('show me walk'), historical timelines, maps, seasonal calendars, venn diagrams, matrices, wealth and well being ranking and semi or un-structured interviews, observations and exploration of secondary data. Each of these tools is useful in eliciting different local information and leads on to the next planning rung.

PRA is guided by some tenets, and these include teamwork; participation; flexibility; optimal ignorance; triangulation; reversal learning; personal responsibility; self critical awareness; offsetting biases; and looking for learning from exception (Chambers 1997).

7.5.3.1 The debate on use of PRA as a research method

Because of its ability to include marginalised groups and empower them to analyse their situation and to plan and act, PRA has gained a preference amongst qualitative researchers. As a social scientist I have valued the use of these methods because the process is liberating, empowering and educative, and yields collegial relationship that brings local communities into the policy debate and validating their knowledge (Nabasa et al.1995). It is a fun process that transforms the researchers into learners and listeners, respecting local intellectual and analytical capabilities. The extensive and creative use of local materials and representations encourages visual sharing and avoids imposing external representational conventions. PRA is an appropriate method

because it enhances sensitivity to the local culture through attention to process and it also includes marginal and vulnerable groups, women, children, aged, and destitute in it processes.

On the other hand there are critics of PRA who claim, for instance that it can degenerate into a process of co-option of local communities into an external agenda, tightly controlled by the centre or an exploitative series of empty rituals imposing fresh burdens on the community's time and energy and serving primarily to legitimise the credentials of the implementing agency as grassroots oriented (Christoplos 1995; Mosse 1993). Chambers (1994c) warns of the danger of 'naïve populism' in which participation is regarded as good regardless of who participates or who gains. Some scholars (Moore et al. 1998; Brown 1990) argue that the transactional environments in which participatory methods are often employed also make for difficulties. For instance, there is a risk of information generated through participatory methods being distorted or manipulated when the same organisations or persons providing services in the same community are involved in the process. The community members may feel obliged to be good or may be good for fear of losing the services. In such circumstances, the assumption that the methods can reveal the 'true' values and interests of the community can be doubted (Moore et al. 1998; Clark 1982; Richards et al. 1999).

Nelson and Wright (1995) and Sellamna (1999) separately argue that there are methodological concerns over the potential reductionism which derives from PRA's preference for the visual over the verbal. The concern is mainly that the emphasis of visual over verbal probing simplifies the information gathered.

In selecting the participatory methods and tools for this study, I was very aware to the dangers and shortcomings of participatory methods. Bearing in mind that the purpose of the study was purely academic rather than to engage participants to formulate solutions to the problem; and in conforming with the reality that HIV/AIDS is still a very sensitive and stigmatised phenomenon and that great care must be taken to respect the confidentiality of people afflicted with AIDS when working with then, there was a limit to which I could apply the PRA tools techniques in this study. This

study predominantly used existing secondary information, relative unstructured interviews, group discussions and observations and memoing for collecting data.

The lesson learnt in considering PRA as an option in qualitative research is that its purpose, that of empowering community members to analyse, plan and act must remain paramount as opposed to extraction of information for purposes external to the source community. I contend therefore that the use of PRA in academic undertakings has to be critically examined especially when the output of the PRA exercises is taken away from the source community for publication in journal and books without any benefit to the participants. I lot of scholars have fallen into this trap.

7.6 Selection of respondents

As discussed in chapter one, purposeful sampling was used to select the respondents of this study. This sampling method was chosen in order to include respondents that would provide a very focused and experience based information on the CBO (Lynn 2004). This sampling method was appropriate to ascertain accessibility and availability of the respondents given that most of them are volunteers and would not always be available at the GCHBC center where the discussions were taking place. There were 93 principal respondents that participated in this study apart from the numerous informal dialogues that I had with colleagues working in the HIV/AIDS sector. Respondents that participated in the study included the GCHBC volunteers (12); international volunteers (15); managers and coordinators of NGOs and CBOs (42); support group members (14); and kid's club members (10).The selection of participants for this study from among the CBO participants was carefully made considering that at the time of the study there were only 33 CBO volunteers whose involvement in CBO activities varied. The 12 that were select had been with the CBO for a long time and were consistent in their participation. The same applies with the selection of the support group members.

7.7 Data collection methods

Though several methods of collecting data were used in this study, primarily, participatory methods were applied. I collected data through facilitating group discussions, moderating relative unstructured interviews, making direct observations and recording deliberations and events right there and then as they unfolded. I collected data from CBO volunteers, support group members, Kids' Club coordinators, pre-school teachers, international volunteers attached to the CBO and from partners that work with the CBOs. I had discussions in workshops with managers of non-governmental umbrella organisations to get their views on the role of CBOs in development. I reviewed the reports of the GCHBC and relevant literature on the subject.

Firstly, I conducted a review and analysis of existing literature on CBOs and this included reading the reports of the Gabane Community Home-Based Care CBO. The review of literature helped me understand in broad terms what CBOs are, how they form, what makes them form and how they function. I also learnt about some success stories and the challenges they face in their daily functions. This made me aware of the potential that these entities possess in contributing to development despite the challenges they face. The reports (oral and written) from the GCHBC demonstrated the achievements of the CBO to date.

Secondly, I conducted relative unstructured interviews with some key informants who included CBO committee members and 15 international volunteers who work with CBOs involved in HIV/AIDS sector. Relative unstructured interviews with committee members were appropriate for enlisting their perspective as they provided contextual information by describing their experiences and interactions within the CBO (Marshall and Rossman 1999). Interviews with international volunteers provided an unbiased perspective of how the CBO functions, its challenges, weaknesses, strengths, achievements and potential for contributing to the development of the local community.

Thirdly, I conducted group discussions with the local volunteers who work with the CBO. Twelve volunteers participated in two separate group discussions to discuss their experiences and perspectives on the CBOs. I also conducted group discussion with fourteen (14) support group members and ten (10) kid's club members. The focus group discussions were intended to explore ideas and opinions from the volunteers and beneficiaries of the CBO service. Focus group discussions provided further insight into the volunteers' perspectives of the role of the CBO in their community. This helped me understand why people decide to volunteer their time, effort and skills in the activities of local CBOs. I also gathered information on the work and challenges of CBOs in two participatory workshops I held with leaders of CBO and NGOs involved in the response to HIV/AIDS in Botswana. A total of 42 people were involved in these workshops. I organised the workshop in such a way that participants worked in smaller groups to discuss the role of CBOs (based on their experience in the field), the challenges that CBOs face and what must be done to enhance the participation of CBOs in the response to HIV/AIDS as a development challenge.

Lastly, I used memos to record on paper the experiences that I encountered while working with the CBO and its volunteers. I took extensive notes of the work of other CBOs whose members I interacted with during project visits and in workshops. This assisted me to address wider and more detailed issues of the dynamics of other CBOs. Memoing was important in this study because, as Brower, Abolafia and Carr (2000: 365) state, "qualitative researchers assume the presence of multiple realities, constructed by various participants as they engage their own local, everyday experiences". Memoing therefore assist to record an accurate account of events when they happen. This also helps to avoid misrepresentation and misinterpretation of events.

In order for me to have an accurate account of the CBO and its activities, I ensured that I listened very carefully during my discussions with CBO participants and understood the main issues arising from the dialogue. I also tried as much as possible to remain candid and tried to achieve balance between my perceptions and those of the participants and other partners, and took careful notes of the divergences and convergences of the information.

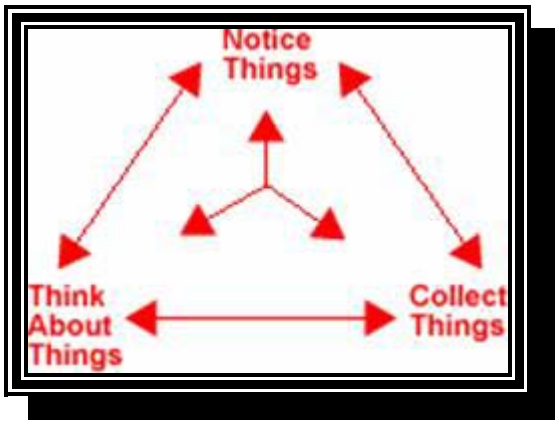
7.8 Data analysis

In constructing the method of analysing data, I extensively relied on literature from Coffey, Holbrook and Atkinson (1996); Gibbs, (2002) Seidel, and Kelle, (1995); Seidel, (1998); and Lewins et al (2005). As indicated earlier under research approaches, I used inductive reasoning as the mode of analysis to enable me understand the potential that CBOs have in contributing towards sustainable development. The information collected in this study was in non-numeric form. It consisted of summaries of literature and documents reviewed (reports, meeting minutes and so on), interview notes and my written notes from the field based on my observations and experience through "participatory intermingling" with CBO participants. In conformity with Brower Abolafia and Carr (2000), I derived conclusions from the multiple realities of the participants, my own experience and the literature available on the subject.

As is commonly recognised among social scientists, data analysis in qualitative research is fundamentally an iterative set of processes. However, Jorgensen (1989: 107) states that "analysis is breaking up, separating, or disassembling of research materials into pieces, parts, elements, or units. With facts broken down into manageable pieces, the researcher sorts and sifts them, searching for types, classes, sequences, processes, patterns or wholes. The aim of this process is to assemble or reconstruct the data in a meaningful or comprehensive fashion." To comply with this principle, I established 10 themes (see chapter 8) to enable me categorise the information in a meaningful manner. Lewin et al (2005) proposes that in qualitative data analysis, information can be combed into categories that comprise, themes, topics, ideas, concepts, terms, phrases and key words.

To come up with findings for the study leading to this dissertation, I used Seidel's (1998) model of data analysis in qualitative research. This data analysis process model includes three iterative phases vis-à-vis noticing, collecting, and thinking about interesting things. These phases are interlinked and cyclical as Figure 7 illustrates.

Figure 7: The data analysis process



Source: The Data Analysis Process (Seidel 1998)

The application of the noticing phase started during my interaction with various CBOs in Southern Africa, particularly in Botswana with the GCHBC during my course of professional duty. I noticed that many CBOs were set up, responding to poverty and development issues especially with regard to the HIV/AIDS epidemic. I particularly noticed how the GCHBC was dealing with its local community challenge of long-term illness, death and the issue of vulnerable persons including orphans and the elderly. As I noticed their response, I started thinking about the potential of such collective action to sustainable community development. As I experienced and noticed more I developed further interest and thought more deeply about the role that this CBO's actions can contribute towards broader community development using HIV/AIDS as the impetus. This prompted me to start collecting information on development issues and CBOs and I started talking notes on the activities of the GCHBC. Noticing things was the beginning of my analysis of the role of the GCHBC CBO in sustainable community development.

As I collected more information by reviewing development documents and thinking and reflecting on the notes I was taking during my interaction with people involved with the GCHBC, I perceived a pattern of action form. It began with people acknowledging a common community challenge, which led to people sharing a common interest to act (action), to participation, to mobilising resources, to networking, to seeking capacity enhancement, to advocacy, and to developing programmes that seek to address local community challenges over and above the initially perceived difficulty.

As I was engaging in noticing and collecting phases I was also employing within each phase the thinking about things phase progressively and paying attention to recursive[11] issues needing further information and analysis. While going through the thinking about things phase I was critically analysing the contents of the issues I was noticing and collecting and triangulating them with further reading, or discussions with committee members, volunteers and even fellow managers of NGOs. As a result of analysing the contents during the thinking about things phase I identified a progressive pattern that a community follows to organise itself and respond to a community challenge (acknowledging a common community challenge, developing common interest to participate and act, action, mobilising resources, networking, capacity building, developing and refining programmes for further action). During this phase I also analysed the strengths the GCBHC CBO possesses, the challenges it encounters and potential that it has in stimulating development within its community. I was analysing all this with reference to other CBOs that I have interacted with in workshops or in my capacity as technical advisor and learning from fellow managers of NGOs who have valuable experience working with CBOs.

As is often the case with qualitative research my data seemed to be "confusing" notes, but in conformity with Charmaz (1983) I started creating order by pulling together and categorising series of events and activities, statements and observations that I identified in the data. This gave me a pattern of results in terms of how the GHCBC has contributed to the response of HIV/AIDS and development of its community by promoting health (among patients), promoting education for the young OVCs, increasing participation of community members, mobilising resources, developing partnerships and networking with various stakeholders.

Finally, I organised all the information I collected in what (Lindblom and Cohen 1979; Fischer 1995) refer to as 'usable knowledge' in the form of results consisting of 10 themes that other development scientists can refer to, question or acknowledge.

[11] According to Seidel (1998) the process is recursive because one part can call you back to a previous part.

7.9 Triangulation and ensuring validity

When I selected to use a qualitative research method for this study, I was aware that at times this research method is criticised for being subjective and lacking objectivity (Oka and Shaw 2000). To ensure that the information I gathered was accurate and that this study is credible and valid I used a variety of data sources and collection methods as a way of triangulating the data to achieve an accurate account of my investigation (Gable 1994; Kaplan and Duchon 1998; Lee 1991; Mingers 2001; Ragin 1987). Furthermore, I applied the notion of trustworthiness as developed by Lincoln and Guba (1985: 290) who propose that the notion of trustworthiness has four elements: credibility, transferability, dependability and conformability (Isaac and Micheal 1995, citing Lincoln and Guba 1985).

To ensure that my study was valid and conformed with some elements of the notion of trustworthiness:

- I provided a 'thick description' of the HIV/AIDS and development reality in Africa and the GCHBC CBO in particular. According to Geertz (1973), to have a 'thick description' one must describe the context of the study substantially so that other users of the research can determine whether the findings apply to the context described.
- I compared my observations and findings with available literature on the subject. I discussed the observations and findings with committee members of the CBO as a way of crosschecking the information I was gathering, thereby ascertaining conformability.
- I invested enough time in understanding how the CBO works and gaining the trust of CBO participants. In other words I had what Lincoln and Guba (1985: 301) refer to as "prolonged engagement" with the CBO. This made me not to be the stranger with big eyes who does not see (Calderisi 2007: 3).
- I also employed "peer debriefing" (Erlandson et al. 1993: 140). This enabled me to collaborate, share and expose my thoughts, observations and progressive findings with my fellow mangers of NGOs who have experience and an interest in the subject to review and make comments. According to Stainback

and Stainback (1988), the purpose of corroboration is to ensure that the research findings accurately reflect people's perceptions, whatever they may be and to help researchers increase their understanding of the probability that their findings will be seen as credible or worthy of consideration by others. This allowed me to triangulate the information I gathered and bring experiences of others regarding the similarities, differences and realities of my peers into my analysis.

- As for the question of transferability, I leave this to those who will seek to apply the findings of this study and thesis to other CBOs.

7.10 Time horizons

The horizon refers to the period within which data is collected, whether data is gathered just once (cross-sectional) or over a long time (longitudinal) (Burns, 2000). As a researcher I have been interacting with this CBO since it started in 1997 participating in its activities and meeting over the years. For the purposes of this study I particularly used information I obtained by attending meetings and group discussions, relative unstructured interviews, literature reviews between December 2007 and April 2010.

7.11 Consideration of ethical issues

Since the researcher is the primary research instrument in qualitative research, the research process can become very personal so it is important to consider ethical issues. To ensure that this study is ethical, I made a declaration of my study intentions and its objectives. I explained the purpose of the study and that my role was that of student in development studies. I sought permission from the GCHBC CBO members to allow me to conduct the study with their CBO and asked for the consent of CBO committee members and local volunteers to have interviews and focus group discussions with them. I asked international volunteers and my peer managers if I could involve them in free peer discussions, and told them that the exercise was for the purpose of completing my thesis for the fulfillment of a master's degree in development studies.

Since I was dealing with HIV/AIDS, which in most cases is a sensitive issue particularly among the support group members living with the virus, I sought their informed consent and assured them of confidentiality of sensitive issues that they discussed with me. I made sure that I negotiated and repeated this assurance at different points in the research because, according to Louis (1996: 58), "informed consent is not some thing that can be handled once and for all at the beginning of a study".

I also prepared for the emotional safety of the participants in case they had an emotional crisis by informing them that I am a trained counsellor in HIV/AIDS issues.

In order to deal with ambivalence on my part and to attempt to meet the participants' reciprocal expectations I used my professional discretion as HIV/AIDS Sector Specialist for the World University Service of Canada (WUSC) and attached some WUSC international volunteers to the GCHBC CBO to build its capacity to mobilise resources and to enable the CBO deliver services to participants and community members effectively. I borrowed and applied the notion of reciprocity from Glesne (1999: 126).

7.12 Writing the thesis

I stated writing the dissertation at the time that I decided to examine the role of the GCHBC in response to HIV/AIDS as a development challenge. I intensified my writing by developing specific chapters once I realised that I had reached a saturation point of information such that the responses I was getting and observations I was noticing were repeating themselves. At this point I realised I had enough information to analyse, arrange and present as results.

7.13 Limitation of the study

Though there is substantial literature on CBOs in general there is very little written information on the GCHBC CBO; when available it was often limited to reports written by volunteers. Because the CBO depends on volunteers it was not easy to follow up some issues because some volunteers leave the community either to seek paid employment or to visit relatives. Because I work for an international organisation some partners of the GCHBC were not very cooperative during discussions, because they thought that my organisation was competing with theirs and would outshine their contribution to the CBO.

As researcher, I was at times not available at the time that I planned to meet the CBO members because my regional responsibilities require me to travel often at short notice on regional missions. Having worked with the CBO for a long time, even longer than some volunteers, my extensive knowledge of the CBO threatened to bias information about the CBO given by some new volunteers. However I tried to manage this by applying the process of ensuring validity and maintaining ethical considerations discussed earlier.

7.14 Conclusion

This chapter has discussed the methodology of this study. It has stated the rationale for selecting this dissertation topic. It has elaborated on the research design and the philosophical orientations that influenced the choice of the methods and process of data collected and the mode of analysis. It has also debated the application of participatory methods such as PRA in research. Issues related to the validity of the study as well as some pertinent ethical considerations were also highlighted.

CHAPTER 8

PRESENTATION AND DISCUSSION OF FINDINGS ON THE ROLE OF CBOS IN RESPONDING TO HIV/AIDS: EXAMPLES FROM GCHBC CBO

"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has" Margaret Mead (cited by Robert Cassidy 1982:152; Raph Keyes 2006:xvi).

8.0 Introduction

This chapter presents the results of the study with specific reference to the role of the GCHBC CBO in its response to HIV/AIDS as a development challenge. The results presented are based on the analysis of secondary information including a review of literature, field observations, discussions with GCHBC CBO participants (local volunteers, people living with HIV/AIDS, pre-school teachers and kid's club members), international volunteers attached to the CBO as well as with managers and staff of organisation working in the HIV/AIDS sector in Botswana.

The GCHBC CBO has gone through dramatic changes over the last decade from being a support group of church women to a CBOs contributing to the national response of HIV/AIDS. The results presented here provide an insight to the role that the GCHBC has provided in response to HIV/AIDS in its community and paves way to the understanding of the potential that CBOs have in responding to community challenges.

The results focus on 10 themes that emerged clearly from the data (Charmaz 1983). These themes are:

- The continued existence of the CBO for more that a decade.
- The role of sensitising the community on HIV/AIDS.
- The role of mobilising community residents to participate in anti HIV/AIDS activities.

- The role of stimulating community participation.
- The role of mobilising local and external resources as well as creating strategic partnerships.
- The role of mitigating the consequences of HIV/AIDS through prevention, care and support to afflicted people and their families.
- The role of building capacity of the community to deal with the epidemic.
- The role of promoting volunteers and enhancing social capital.
- Creating the potential for community regeneration, and
- The challenges faced by the CBO.

8.1 The establishment and continued existence of the CBO

The way that a CBO starts has a bearing on the ownership and support it receives from the local people and therefore its success and possible sustainability. CBOs that start from within the community, based on the people's felt needs (organic CBOs), last longer and have long-lasting results than those that are kick-started by outsiders (inorganic CBOs) with resources and planning from outside (Foster 2001). The formation of the GCHBC CBO can be described as organic.

Starting a community effort is generally much easier than sustaining it (UNAIDS 1997). Therefore, the successful formation and continued existence of the GCHBC CBO since 1997 is one of its major successes so far. This is noteworthy because not many CBOs exist and continue functioning and providing community-based services to the community for such a long time because of the many challenges they confront. The GCHBC CBO still remains focused and committed to its mandate and has even developed a concise five-year plan around which it will organise its activities.

Although every community has its own divisions and schisms, a shared sense of belonging has been demonstrated by the GCHBC volunteers and the general community members towards the CBO's activities. There is a high degree of cooperation within the community starting with the local chief, including all the local institutions such as churches, schools, the health center and local businesses. This is

evident through their voluntary involvement and contributions to the CBO which is an indication that they understand and support the vision and purpose of the CBO.

As already stated in preceding chapters, when HIV/AIDS was declared a national crisis in Botswana a lot of CBOs were formed (Browning 2008). Most of them fell through because they were jump-started by organisations outside their community. These CBOs were more responsive to the demands of the outside founders than developing people-centered structures of participation and service delivery. For example, at almost the same time that the GCHBC CBO was established, another CBO known as Bobirwa Community-Home Based Care was started with the help of the Netherlands Development Organisation (SNV) in the north east part of Botswana. The Bobirwa CHBC CBO was well supported with funds and even technical support from outside such that at one point it was recognised as the model for CBO's response to HIV/AIDS in Botswana. However, when SNV stopped supporting the CBO, its activities drastically scaled down to a point of collapse while the GCHBC continued growing steadily with support from the local people.

8.2 Sensitising the community about HIV/AIDS

Like any other community, the Gabane community is not a single entity but a collective of people with different interests, ideas and values. In order to garner common action within diversity, there is need to create awareness and sensitise people about a phenomenon to be acted upon whether or not it constitutes common need. Community sensitisation therefore is an important undertaking in the process of development regardless of the focus of the development outcomes (social, economic, political or environmental). It promotes understanding of community problems and informs residents of options available for action (Birdsall and Kelly 2007). While community sensitisation must take place early in the programmes, it must be an ongoing two-way process between the programme and the community (UNAIDS 1997). It must also be reinforced through constant dialogue in which community residents periodically voice their views and suggest alternative courses of action. Community sensitisation encourages communication among residents, which leads to

collective problem identification, decision making and community-based implementation of solutions to development issues.

Since its establishment the GCHBC CBO has played an important role in sensitising community members on issues of HIV/AIDS as well as the purpose and activities of the CBO. Community sensitisation is done through provision of HIV/AIDS information during kgotla (public) meetings, parents' teachers association and other school meetings, church gatherings, funeral gatherings, and through outreach activities when visiting sick patients. The CBO further raises people's awareness about HIV/AIDS by providing information in an interactive way using the local language. The CBO volunteers use the local health workers to reinforce the messages during health talks. This has created considerable interest in the CBO and generated further community dialogue and discussions about the HIV/AIDS problem and also attracted interest from different stakeholders. The volunteers have maintained regular contact with the community, receiving feedback which is further used to understand the community perspectives of HIV/AIDS including their fears and concerns. Without good community sensitisation the CBO would not have mobilised the community to respond to the HIV/AIDS problem so effectively; perhaps the CBO itself would not have been established.

8.3 Mobilising the community to participate in HIV/AIDS Activities

Following sensitisation and creating awareness about HIV and its consequences, the GCHBC CBO played a critical role in identifying community volunteers to help increase the momentum of community sensitisation and community mobilisation to participate in HIV/AIDS activities. Community mobilisation was also conducted through various community meetings as discussed above.

Community mobilisation is a dynamic process which involves all relevant segments of community in dialogue and encourages local individuals, groups or organisations to participate in identifying needs, planning, carrying out and evaluating activities to improve their lives through coordinated action (Levene and Maclean 2005). It is

significant to guaranteeing sustainability and success of community-based responses to HIV (Russell and Schneider 2000:10). It brings local leaders to the table together with community members (youth, parents and culturally diverse groups) to maximise their resources in response to needs identified by the community. In addition, local institutions such as schools, health institutions and other organisations also support the community efforts by implementing programmes and activities that will have the desired community development outcomes.

In the fight against HIV/AIDS, where communities are on the front lines, and community involvement often decides the battle, community mobilisation helps to maximise existing community 'safety nets'", both the formal and informal mechanisms and coping strategies that mitigate against the effects of poverty and other risks on vulnerable households during times of severe stress (Foster 2005). The experience with the GCHBC CBO confirmed this assertion. Dialogue with fellow managers of NGOs supporting CBOs also confirmed that indeed communities do matter in steering development and that community mobilisation is a grounded approach to deliver development outcomes (Sherman 1997) because it harnesses the energy and passion of every person to create a community which proudly supports each and every member towards a common goal.

The GCHBC CBO mobilised its community and obtained support from community members. It established collaborative links with existing institutions such as the local clinic so as to integrate HIV/AIDS issues in their service and to provide technical guidance to the CBO. The CBO volunteers became leaders in the community and demonstrated that their CBO was appropriate and best ready to support the most vulnerable and marginalised members of the community in a holistic and sustainable manner. They helped the CBO to leverage resources for the efficient delivery of services and to promote the well-being of community members. This was in conformity with the UNAIDS (1997) philosophy that in order to fight the HIV/AIDS epidemic effectively communities across the continuum need to be engaged, organised and motivated to work together and use their resources wisely to meet the challenge. The Executive Director of UNAIDS, Peter Piot, also expressed in his preface to *The Global Framework on HIV/AIDS* the need for mobilisation. He commented that "the only way the epidemic can be reversed is through total social

mobilisation… leadership from above needs to meet the creativity, energy and leadership from below, joining together in a coordinated programme of sustained social action" (UNAIDS 2001b: iv).

In conformity with Donahue and Williamson (1999), the experience with the GCHBC CBO demonstrated that mobilised communities are not only the vanguard of the impacts of HIV/AIDS, but are the frontline for making effective responses. The greatest resources that CBOs have to confront HIV/AIDS are the people themselves especially those who are willing and motivated to take action and care for others who are ill and affected by HIV/AIDS.

In agreement with the UNAIDS (1997:2) understanding of a 'mobilised community', it can be stated that the GCHBC CBO succeeded in mobilising the community because the community members became aware of HIV/AIDS and their individual and collective vulnerability to it in a detailed and realistic manner; they were motivated to take action to reduce this vulnerability by participating in the activities of the CBO; they owned the CBO and sought partnerships with different stakeholders within and outside of their community. The sensitisation and mobilisation processes sow the seed for community participation because as Golooba-Mutebi (2005:955) argues, "participation will not just happen, simply because opportunities for it have been created." Community members must therefore be sensitised and mobilised to create social relations and buy-in the idea and need to commit themselves to an endeavor.

8.4 Promoting community participation

Reid (2000:3) describes participation as "the heart that pumps the community's life blood (its citizens) into the community's business." Reid (Ibid: 3) further comments "that community participation is one of the key ingredients of an empowered community." In response to HIV/AIDS, community participation is not merely a requirement, it is a condition for success because studies have shown that communities that engage their citizens and partners deeply in the work of community

endeavours raise more resources, achieve more results and develop in a more holistic and ultimately more beneficial way.

By sensitising and mobilisating the community, the GCHBC CBO played an essential role in creating a good context for the participation of community members in fighting HIV/AIDS. For instance, other than only drawing interest from community residents wanting to volunteer, the local school takes in orphans and the district authority administers the food basket and destitute rations through the CBO. Currently community members voluntarily participate in identifying patients, orphans and vulnerable person and help them access services at the local health facility and the social welfare office. The key community leaders also participate in making decisions about what development activities and actions the CBO must pursue.

The promotion of community participation as an outcome of community mobilisation is an important result here for several reasons. Firstly, participation is a critical precondition for the success of any community-based organisation and an indispensable factor of all forms of development from within (Dongier et al. 2003). It promotes a spirit of togetherness among members and this in itself creates a cadre of local animators and development forerunners where people become both beneficiaries and controllers of the development process (Narayan et al. 2000).

Secondly, participation helps overcome the indifference, pessimism and passivity of local people (Conyers 1981). It also empowers local people and maximises resources and compensates for severe resource limitation in poor communities (Diamond 1994). For instance, the GCHBC volunteers brought their own tools to work with their hands to clear land for the CBO gardens to grow vegetables to assist HIV/AIDS patients and orphans and vulnerable people in the community. In other words the CBO promoted a strong sense of belonging and ownership of the CBO activities among the community members. This enabled it to obtain, through mutual help, the resources that would otherwise not have been available to the CBO.

Thirdly, participation encourages people to interact in an informal fashion where there is free and open communication and dialogue, making exchange of ideas and learning exciting and effective. As Twelvetrees says, “participation in CBOs increases confidence, efficacy, power, and identification with the community, leadership development, and problem solving capacity” (1989: 132).

Fourthly, participation and interpersonal interactions among CBO members and with other partners unfolds a variety of learning opportunities that in many ways enhances civic knowledge in the long run (Michener 1998).When people work together there is an increase in understanding of the local dynamics that helps to consolidate indigenous knowledge and to develop activities that suit the local circumstances (Malan 2000). The sovereignty of local people is consolidated and this creates an environment where they can more effectively identify their needs and make decisions to address them (Jennings 2000). Besides, local participation is said to fill the critical gap left by state-run programmes, with long lasting results (Dongier et al.: 2003). Successful community participation that actively involves community members creates a multiplier effect that empowers the very community members (Pettit 2000).

As mentioned by all the GCHBC volunteers, participation has been the cornerstone of the CBO. It is the means towards shaping the confidence of the residents to mount a sound response to HIV/AIDS in the community. Participation increased self determination of the people and strengthened their wisdom of the CBO, ultimately empowering them to the course. As a result, even the people living with HIV/AIDS came out to raise their voices calling for services and action at a time that HIV/AIDS was stigmatised. In this case participation and engagement of local people in community matters saw the beginning of the process of awakening to the challenge of HIV/AIDS in the community (Jennings 2000:4).

On the other hand there is emerging criticism of participation as a means to local development (Golooba-Mutebi 2004; 2005). For example some scholars argue that participation is problematic and hard to sustain because it requires ordinary people to give their time and limited resources (Putzel, 2003). Nevertheless, given the contribution of the local residents of Gabane towards the activities of the GCHBC CBO activities in mitigating the complications of HIV/AIDS, I still contend that

participation is key to development and specifically so to the fight against HIV/AIDS. In actual fact the current influx of social movements and civil society organisation including NGOs and community based organisations (CBOs), is a manifestation of organised community participation (Botes and Van Rensburg 2000).

8.5 Mobilising resources and creating strategic partnerships

"Communities are not closed, self- sustaining systems" UNAIDS (1997:6). No matter how well organised or motivated a community may be, its ability to meet all of its needs is limited. It is important therefore that communities that seek to undertake community development endeavours acknowledge these limitations and plan and decide how to overcome them (Tumwine 1989). This will entail mobilising resource from within and outside of the community and also developing partnerships with organisations that can share resources including skills and experience. My experience working with CBOs for many years has taught me that developing partnerships brings together diversity of experience, skills and perspective and new ways of thinking that catalyses innovation within a CBO.

The GCHBC tries to overcome the challenge of inadequate resources by mobilising more human (volunteers), technical and financial resources to support its outreach activities for the benefit of those at risk of HIV infection; those already infected and are sick; the orphans and vulnerable children and elders in the community. Though the CBO still has challenges of resources, its resource mobilisation efforts have brought the CBO in contact with various stakeholders willing to support it. The CBO has developed partnerships and garnered support from stakeholders including those from outside of the boundaries of Gabane community. The determination of its pioneers has proved to be critical and this has helped create an opportunity for leveraging of locally available resources with contributions from local people and those outside the community such as the government, local and international NGOs. The contributions from local residents come in the form of labour, money, food, clothing and providing other things that vulnerable people need for their daily living. For example a local shop owner offers groceries and food that are distributed among patients and other poor and vulnerable families. Another local company, Pelegano

Village Industries, has offered to provide meals for the pre-school children and a stipend for the pre-school.

The willingness of stakeholders to work with the CBO is a result of the evidence of its work. As Daemen and Schaap (2000) state, where there is evidence of success it is easy to create strategic partnerships to leverage resources. Funding organisations tend to support and assist local efforts that present motivation and evidence of the potential to strengthen and advance the community needs (Schumaker 1996).

The GCHBC CBO has developed good collaborative partnerships with UNICEF, the Government of Botswana through the Ministry of Health (MoH) and Ministry of Local Government (MoLG), Barclays Bank of Botswana, World University Service of Canada (WUSC), Masiela Trust Fund, Gleeds UK and the Botswana–USA (BOTUSA) partnership project, and many more. For instance, UNICEF has assisted the CBO for the last three years to strengthen community understanding of childhood illnesses and demonstrating simple ways of minimising the impact. The day care centre staff and pre-school teachers were also trained by UNICEF in identifying children in need of help and given the knowledge to assist them.

The CBO has been able to generate resources through donations. For example, it received a donation of Pula 63,359 (US$9,000) from Gleeds UK an international construction and management company. A Local trust, the Masiela Trust Fund has contributed a further Pula 100,000 (US$17,000) towards the construction of the two classrooms and a kitchen with catering equipment. Employees of Barclays Bank of Botswana visit the CBO centre once every quarter to spend a day with the children. The employees have also contracted play equipment and donated educational toys. Barclays Bank has given a financial contribution of Pula 100,000 (US$17,000) towards the construction of two classrooms and a kitchen.

The wives of diplomats in Botswana assisted the CBO to constructed three low-cost houses to poor residents who are keeping orphans. The African Women’s League visits the CBO once a month on Saturday, spending time and sharing a meal with the children, volunteers and support group members. This helps to motivate people living with HIV/AIDS and OVCs. The League has provided various items such as clothing

to the children and needy families. The Marang Child Care Network Trust is providing useful support in strengthening advocacy for OVCs, assisting GCHBC to better understand the national legal framework for providing care and support to these children.

Baylor's Clinical Center of Excellency is networking with the CBO to pilot its outreach programme for children living with HIV and AIDS, mobilising the community; screening children of HIV positive parents; registering those needing treatment; and providing the treatment within the community.

The World University Service of Canada (WUSC) provides technical support placing international volunteers to build the CBOs capacity to manage its activities better. The WUSC international volunteers have trained CBO members in areas such as project planning and management, simple proposal writing and reporting results. The CBO has now developed its five-year plan with the assistance from WUSC volunteers. The CBO has attracted several people from civil society and the corporate world to talk about management issues.

The partnerships and resource mobilisation efforts of the CBO were once reported by Arnold Letsholo, correspondent of a local newspaper the Mmegi Newspaper at various occasions as the quotes in the box below illustrate:

"An international construction and management company has donated P63,359 to the Gabane Community Home-Based Care (CHBC) centre. The donation by Gleeds was handed over by British peer Lord Nigel Jones accompanied by his wife Katy and daughter Amy. The money will be used to help complete classrooms currently under construction at the CHBC plot." Mmegi Newspaper, 27 September 2007, Vol. 24, No. 147

"Gabane Community Home-Based Care last weekend became one of the beneficiaries of Barclay's global activity dubbed 'Make a Difference Day'. More than 30 employees of the bank gathered at the plot to paint the class room block, which the bank has played an important role in its construction from its inception. The employees helped de-bush the plot's garden's surroundings and prepare seed beds for growing vegetables in the future." Mmegi Newspaper, 7 November 2007, Vol. 24, No. 168

"I am delighted that Gleeds have made this very kind donation which will make such a difference to the lives of young people in Gabane. I shall keep Gleeds informed of the progress", Jones said. His wife added that the parliamentary spouses in the April trip were impressed by the care delivered by inspirational

leaders at Gabane, including Benjamin Motlhalamme, Boitumelo Leburu and the team of volunteers. "It is important that those affected by HIV/AIDS should receive not only proper food and medication but also the chance to learn and change their lives for the better" she said (Ibid).

8.6 Mitigating the consequences of HIV/AIDS

Mitigation provides poverty reduction that not only alleviates the hardships of those directly impacted by HIV/AIDS, but reinforces the community's resilience to better resist and respond to the epidemic (UN-OSAA 2003:37). In order to reinforce the communities' resilience to better resist and respond to the epidemic and other development challenges, the GCHBC CBO has played a fundamental role in providing services that deal with various community challenges including fighting HIV/AIDS. The CBO has been responsive to emerging community problems and has been flexible in responding to these issues in a concerted manner to ensure the community survives the complications of HIV/AIDS. The CBO provides preventive services; information on HIV/AIDS and other services such as health and nutritional care, material support including shelter for poor (usually, child headed or elderly headed) families; education for the orphans and vulnerable children as well as young people; and counselling and support for the families and people living with HIV/AIDS. The specific role and achievements that the CBO made in each of these will be discussed in much detail in the section that follows.

8.6.1 Providing prevention services

Prevention is fundamental and it remains the single most important approach to sustainable control of the HIV epidemic (Voetberg 2008). This is the reason that it is commonly appreciated as 'half the solution to the problem' among HIV/AIDS activists. Comprehensive HIV prevention requires a combination of programmatic and policy actions that promote safer behaviour to reduce vulnerability to transmission, promote social norms that favour risk reduction and address drivers of the epidemic (Ngwira et al. 2001).

Prevention, nonetheless, is not very easy to achieve let alone measure because the risk behaviours are enmeshed in complex webs of economic, legal, political, cultural and psychosocial determinants (Brown, et al 2005b). Besides, the major means of transmission especially in Africa is through sexual intercourse, which is usually a nocturnal activity. Effective prevention measures require comprehensive and well-coordinated efforts from the community to national level institutions in partnership with other stakeholders (Lule et al 2007). This is the reason why it is important to involve all sectors of society in championing the cause for HIV prevention. The role of CBOs in this case can not be discounted.

Even with the availability of antiretroviral therapy, prevention still remains a priority because of the cost related to the therapy that complicates the care systems. The Global HIV Prevention Working Group (2003: 22) observed that "unless the anticipated growth in new infections is prevented, the burden on treatment and care systems in low and middle income countries will be unsustainable over the long run, even with dramatically greater global assistance for the purchase and delivery of drugs. To preserve the hope of effective long-term treatment for the 40 million people currently living with HIV/AIDS, prevention efforts must be redoubled."

CBOs play an important role in creating an enabling environment that fosters the behavioural change needed to confront HIV/AIDS and cope with the illness, death and dependency that AIDS causes (Gorgens-Albino et al. 2007). Other than sensitising and mobilising communities for action against HIV/AIDS they also facilitate and manage information and education campaigns to change behaviour; they distribute condoms; they work with vulnerable groups; and they advocate for accessibility to services. Ninam and Delion (2007) observe that individuals cannot change their behaviour in a vacuum, but are heavily influenced by their social networks and group norms. Individual attitudes, knowledge and behaviour change takes place within a community context that can support, facilitate or frustrate such behaviour change efforts (Carter et al, 2007; Gregson et al, 2002, Parker et al, 2007). This argument can be linked to the earlier discussion on culture and how it shapes societal norms and behaviours. In most cases CBOs that are established to respond to HIV/AIDS are built on values of compassion and these positive values influence the action of the CBO members and the people they reach out to with their services.

Therefore, CBOs have a huge potential in influencing the attitudes and behaviour of their community members by building on relationships of trust and respect. This attribute makes CBOs valuable assets in the fight against HIV/AIDS. Most important, CBOs have roots and are closely linked to the cultural and social environment of the people and have effective channels of communication that can be used to reach isolated areas (UNAIDS 2007). This makes them well positioned to address cultural and traditional issues including stigma and discrimination associated with HIV/AIDS that exacerbate HIV infection.

In order to meet its objective of preventing the further spread of HIV infection among community residents, the GCHBC provides HIV/AIDS information to the general public and teaches people about the HIV/AIDS facts, aiming to change their behaviour by continuously reinforcing the basic facts[12] and debunking the myths among different target groups. This is important because knowledge, though not sufficient, is necessary to get people to change their behaviour willingly. The CBO also works with young people and involves those living with HIV/AIDS in disseminating the information. Its work with the support group of people living with HIV/AIDS (this will be discussed later), has helped to reduce stigma and discrimination in the homes and community. The CBO continues to address social and cultural factors such as sexual norms and beliefs by carefully explaining the roles that these play in both prevention and increasing the spread of the infection.

The CBO connects the people who require treatment with the local health workers and the health facility. For instance, the CBO collaborates with the Ministry of Health and other civil society organisations that produce materials on HIV/AIDS. It acquires such materials and uses them to support risk reduction in the community by continuously providing information and prevention materials (condoms) as well referring and facilitating people's access to various services such as voluntary counselling and testing and antiretroviral treatment. This link is very important. For instance, the evaluation of The AIDS Service Organisation (TASO) programme in Uganda revealed that provision and accessibility of counselling support facilitated family and community acceptance of PLWHA and has a positive influence on

[12] Some of the HIV/AIDS basics discussed include the common and effective methods of transmitting the HIV virus and ways by which one can not be infected with the virus.

behaviour change including usage of preventive measures such as condoms (Kaleeba, et al. 1997). Given its experience, the GCHBC CBO has realised the need to balance the scaling up of prevention and treatment to capitalise the synergies between the two.

8.6.2 Providing care and support services

Equipped with knowledge and information about its community, the GCHBC CBO volunteers provide care and support to patients and families affected by HIV/AIDS. Knowledge and sound information about the community enables the volunteers to identify individuals and families who are directly affected by the epidemic, including the vulnerable ones that need assistance; those who have died; those who have been taken in by relatives; those living alone; and those who are hungry (Child Protection Society 1999). The volunteers have identified a number of patients on home care. Though this number varies, currently there are 56 patients needing care and support in their homes. The volunteers provide a range of services including social, medical, psychological, spiritual and emotional support to people living with HIV/AIDS and their family members to enable them cope with the difficulties and stress related to long term illness. For instance, the volunteers visit patients twice a week to assist them with domestic chores such as collecting water, providing and preparing food (especially vegetables from the community garden) and maintaining good sanitation. Volunteers further equip caregivers with skills and knowledge about community home- based care. This is done so that community and home-based care does not only make the care individualistic and person centered but is beneficial to the family as it allows members to be involved in the care process (Osborne 1996: Chaava 2005). In addition to training and assisting in care, volunteers help patients and incapable families to do minor renovations on their houses such as fixing broken doors and windows as well as mending leaking roof.

Through community-based services, the CBO has saved the patients from unnecessary and prolonged admission to health care facilities. It has helped to avoid unnecessary referrals to and from higher level institutions because care services are taken to the patient. For instance, in 2007 volunteers made nearly 2,000 home visits to 56 patients. In the same year 22 bed-ridden patients graduated from needing home-

based care; they got back to good health, and are now able to perform their duties in the community.

The CBO also provides food and other basic requirements to people living with HIV/AIDS. This kind of care and support is an important aspect of managing HIV/AIDS and particularly essential if HIV/AIDS-affected households are to live with dignity and security (Mohammad et al 2005). The provision of community-based care and support services promote awareness and acceptance of HIV/AIDS as a community problem and feeds into prevention efforts (Russel and Schneider 2000). Studies have shown that when care and support are provided people are more inclined to reveal their HIV status, understand the need for prevention, and be motivated to protect others as opposed to when no services are provided and they feel abandoned by the health care system (MacNeil and Anderson 1998).

In collaboration with local clinic staff, the volunteers supervise and monitor the patients' treatment, ensuring that patients adhere to the treatment plan. When necessary, the CBO volunteers arrange transport for very ill or poor patients to the local clinic for treatment and for special medical attention including the administration of antiretroviral drugs. The clinic in turn refers patients in need of home-based support to the CBO. The volunteers provide monthly reports to the clinic and the community social worker for professional follow up. Because of the care provided by these volunteers, many patients have recovered and become active members of their society.

Indirectly, the role that the GCHBC CBO plays in bringing care and support into the community contributes to the overall reduction of the national cost towards caring for people with HIV/AIDS. This is in line with the application of the care economy concept.

The concept of the care economy has emerged recently in the economic literature. It encompasses many of the aspects of community and home-based care but focuses especially on the economic costs and benefits of care, the division of labour involved in various types of care, and the contribution of care to economic growth and development. An example of the care economy is the unpaid provisioning (non-

market work) that is carried out in households and communities, primarily by women (Elson 2002). It must be noted that bringing care to the community and home of people has a direct cost reduction in expenses that would otherwise have been incurred for long hospitalisation on part of the government and for frequent transportation to health facilities and costs related to lodging on the part of the care givers at the level of the household. The care givers also appreciate some time that would have been lost in accessing and queuing for services. Russel and Schneider (2000:1) also acknowledge that community based care and support programmes are often viewed as a cost effective way of addressing the impact of HIV/AIDS and a cheap alternative to hospital care.

To give an insight into the number of people reached by the CBO in recent years,[13] table 3 below illustrates the type of service that the CBO provided to needy community members between 2005 and 2007.

Table 3: Services provided by the CBO between 2005 and 2007[14]

Service provided	Year		
	2005	**2006**	**2007**
Outreach services	2,407	1,800	2,000
Psychosocial support	1,424	537	432
Counselling and referral for testing	2,128	349	576
Palliation and antiretroviral treatment	3,784	4,071	3,013
Transport to hospital for patients	548	69	108

Source: Records of the GHCB CBO

[13] I have interacted with the CBO for a long time now and it is my opinion that the figures projected here have been under-reported because volunteers sometimes forget to record their activities. This is a typical challenge for CBOs.

[14] I have not interpreted these fugures in the form of percentage to the general public because some clients have been countered more than once. I am also mindful that the CBO has challenges in keeping its records. These fugures are just as they were presented by the CBO.

To illustrate the importance of the services rendered by the CBO, one of the GCHBC volunteers recalls:

"I was looking after one person at the blink of death. The person was living alone and would have easily perished and died. I took him under my total care, and now, five years later, he is in charge of his life and is a happy person." Volunteer, January 2008.

8.6.3 Providing care and support to orphans and vulnerable children

Orphans and vulnerable children (OVCs) face a variety of problems, from the lack of parental love and care, to lack of financial resources, to unfair treatment within the community (Mason et al 2003). The GCHBC CBO plays a key role in identifying OVCs made vulnerable by HIV/AIDS. It deals with this situation by firstly sensitising and mobilising the community about the problem and secondly by providing psychosocial support to the children, feeding them, teaching them in pre-school and providing school pre-requisites to those attending junior school. Currently there are 185 OVCs between the ages 3 and 18 under the care of the CBO.

The CBO manages a pre-school for children, mostly OVCs aged between 3 and 6. Currently there are 28 children attending pre-school at the GCHBC center. The children are taught English and arithmetic and important values that relate to their community. The pre-school teachers monitor the children in their homes and supervise guardians to ensure that the children are taken to a clinic regularly as some of them are HIV positive. In 2007 the GCHBC CBO finished constructing two classrooms with support from Barclays Bank, Masiela Trust Fund and Gleeds UK. The classrooms have electricity, running water, a small kitchen, tables, chairs and a limited collection of school supplies and toys. The GCHBC CBO provides transport to take children to and from the pre-school each day with a vehicle purchased from the global fund. The pre-school has made a lot of difference to the children because it gives them a chance to interact with other children and to develop a sense of belonging. This is very pleasing not only to the children but to the CBO volunteers and community members in general. One volunteer shared this experience that;

"When one of our pre-school children enrolled, she had never left the side of her bedridden mother. At first she was terrified of other children, but today she is always playing happily in the middle of the park." Volunteer, January, 2008.

The CBO also manages a children's feeding programme for OVCs from poor families. The children receive at least two nutritious meals a day. The feeding programme is a result of the partnership between the employees of Barclays Bank and the GCHBC. Through this programme OVCs are provided with a nurturing environment conducive for their physical, cognitive and behavioural development at the GCHBC centre. In 2007 the CBO provided more 13,000 meals to 30 children. The CBO is only supporting 30 such children out of 64 eligible ones because of inadequate resources. The 30 children receiving support are selected from orphans staying with their poor old grandmothers and those whose parents are critically ill. The feeding programme has proved to be a success and children are motivated to stay at the CBO centre and attend pre-school. Other than feeding, the children are provided with some basic education and lots of play and interaction with their peers before they go home every afternoon. Some of them have even enrolled for standard 1 at the local school. For example, in 2008 out of 22 children, 8 successfully enrolled in standard 1 and still receive support from GCHBC volunteers.

8.6.4 Supporting the Kids' Club

As a way of supporting children in the community, the GCHBC CBO runs a kids club. The club was established in collaboration with the American Embassy and Marang Child Care Network to assist children aged between 7 and 18 years become responsible citizens by providing them with guidance and life skills

The kids club has 155 members who meet once a week (on Saturday) to participate in a number of activities designed to help them identify and develop their individual skills and talents. The club's activities include traditional dancing, singing, leatherworking, sports and various life skills. The club runs work camps periodically where the young people learn interpersonal skills like trust and teamwork. During their meetings members discuss HIV/AIDS issues and support each other to maintain good behaviour to avoid HIV/AIDS and become good citizens. The club has helped make young people in the Gabane community aware about the HIV/AIDS challenge.

In order to support all these initiatives the CBO manages income generating activities such as sewing and knitting, gardening and selling vegetables. It also relies on donations from government, well wishers within the community and partners from outside. In appreciation of the clubs activities, one of the members said:

"The kids' club has helped us build our self-esteem and confidence. We feel like we are part of a community and we can talk to each other more easily. It helped us learn what good behaviour is and now we try to behave as a model for the younger children." Kids' club member, January, 2008.

The role that the CBO takes in nurturing the vulnerable children is an important undertaking because not only does the CBO keep the children out of the streets and provide them with food and welfare but also facilitate their education and upbringing so that they can grow into responsible adults. This in the long run has positive developmental effects.

8.6.5 Supporting the support group of PLWHA

The principle of encouraging greater and meaningful involvement of people living with HIV has become central to many HIV/AIDS interventions throughout the world (UNAIDS 1997). Almost everywhere in the world, particularly in areas with high HIV prevalence, people living with HIV/AIDS have established networks, advocacy and support groups within which they work and speak out for their rights and receive the support they need (Kalibala 1999). Through these support groups they have been involved in a wide variety of activities at various levels of the AIDS response, from sharing their personal stories, advocacy for treatment, to treatment literacy initiatives. People living with HIV/AIDS often understand each other's situation better than anyone else and are well placed to educate, counsel and advise one another (Center for Development and Population Activities[CEDPA] 2003).

One of the innovative interventions of the GCHBC CBO is the mobilisation of people living with HIV/AIDS who have formed a support group. During the early years of HIV/AIDS in Botswana, the stigma associated with the disease was a serious problem and people suffered and died in silence. The need to break this stigma became urgent and CBO volunteers started sensitising community members and counselling individuals who were HIV positive to disclose their status and speak out for the silent

infected persons. Through the support of CBO volunteers, one courageous woman publicly disclosed her status in 2001. She became the pioneer and encouraged other infected persons to disclose their status to give HIV a human face so that community members can understand that HIV is indeed present in their community. With the support from the GCHBC volunteers, these infected people formed a support group called the Loving Care Support Group. The support group provides a friendly environment for its members to come together and share their experiences and provide peer counselling and support to one another. The support group now consists of 28 members who have recovered from HIV/AIDS related illnesses after treatment. The members have become active participants in the community and they assist GCHBC volunteers with their outreach activities. The group meets every week. The purpose of this group is:

- To promote and enhance prevention, care, support and treatment among infected persons and community members at large.
- To motivate and encourage people living with HIV/AIDS to live positively.
- To encourage other PLHWAs to try to reduce the stigma and discrimination associated with HIV/AIDS.

The support group members have given a human face to the epidemic in their community. Their involvement as outreach workers has proved to be a successful participatory strategy to "ensure that messages are appropriately communicated and the needs of the target group are better understood" (UNAIDS 1999a: 61).

The support group is also instrumental in helping newly diagnosed HIV positive patients deal with their condition and register for antiretroviral treatment. The support group members visit homes to give emotional support to patients, encourage testing among those who have not yet been tested and conduct awareness campaigns in the community to discuss HIV/AIDS related issues. The Loving Care Support Group has significantly contributed to the prevention, care and support activities of the GCHBC and helped to reduce the stigma associated with HIV/AIDS within the Gabane community.

In appreciation of the support the PLWHA are receiving from the support group and the CBO, one support group members said the following:

"I was a very sick person and all alone. I didn't believe I could meet people like me but then I was welcomed by the support group… they helped me accept myself and my status and I managed to survive."

The fact that the support group members who once were very sick and at the point of death in some instances are still alive and now making a valuable contribution to the general health of their community, able to care for their families and see their children grow, is a positive outcome from a development perspective.

With the help of the GCHBC CBO volunteers, the support group members have demonstrated self-esteem and assertiveness even during workshops and partnership meetings. They have become very important resource persons in the community and some of them have become role models for their proactive positive living and planning for the future of their families. Their involvement has proved essential to many components of the HIV/AIDS response in the Gabane community especially in the areas of HIV/AIDS awareness, prevention, impact alleviation, advocacy, and community care and support. For instance the outreach and awareness services of the support group have increased the demand for voluntary counselling and testing, as well as acceptance of those who are HIV positive by themselves, family members and the community thereby contributing to reducing the isolation of infected people.

The support group members are also involved in planning for HIV/AIDS at various levels (community, district and even nationally) adding value and meaning to the process of policy and programme development of HIV/AIDS services. The UNAIDS (1997:3) also acknowledges the role of people living with HIV/AIDS in stimulating community action for awareness, prevention, policy and legal changes, impact alleviation, advocacy, and family or community care and support in the global response to AIDS.

Working with PLWHA has been a very good advocacy strategy of the CBO because it has drawn people's attention and stimulated debate about how best PLWHA can be assisted. This debate has expanded beyond the boundaries of the Gabane community to national level where policy makers now call for national action of engaging PLWHA in planning for HIV/AIDS services across the continuum of care.

8.7 Building capacity of the community to deal with HIV/AIDS

"Reinforcing the capacity of communities to provide support, protection and care is the foundation of a response that will match the scale and long-term impact of the HIV/AIDS crisis." UNICEF (2004:18)

Capacity building has become a buzzword for most development initiatives and programmes because it is fundamental to individual and community empowerment (De Vita and Fleming 2001:1). According to (Eade and Williams 1997) capacity building is commonly interpreted to mean training and introducing new skills. However, interaction with the GCHBC CBO has revealed that capacity building involves more than just that. It is fundamentally a process of learning by doing which stimulates people's abilities and commitment to adapt to change and to learn to take control and ownership of the resources and process to improve the overall quality of life (Bromiley 2008). In support of this thought, Jupp (2000) observes that though training is useful for capacity building, it is not sufficient in its own right. Capacity building therefore requires building relationships among people and organisations to enable individuals take an active role to tackle new challenges in their communities and contribute to the overall well-being of their communities. It is an important element in local development (Rubin 1986).

Notwithstanding what has been said about capacity building throughout this thesis, it is important to realise that it does not happen in a vacuum but that people are at the heart of it and that they are a resource (human capital) themselves. Talking about building community capacities must not be interpreted to mean that communities have no capacity at all; what is often needed is to bring people together in an organised way and develop their inherent potential to identify their needs and to act appropriately (De Vita and Fleming 2001). CBOs are in a better position to facilitate this and

empower people to deal with passivity and transform their communities into organised, self-determined and self-reliant ones that can reduce their various vulnerabilities (Hsu et al. 2002).

In any development endeavour capacity building is important for a number of reasons. Firstly, there is strength in numbers because it involves more than one person. Secondly, it makes community members become more conscious and understand better the context within which they live. It also gives communities a greater stake and promotes local ownership of development endeavours. Their attitudes, confidence and skills sharpen and they learn when and how to act. This avoids taking premature actions that are not well calculated and often lead to wasting resources and ultimately failure (Light 1998). Thirdly, the level of confidence of community members to undertake non-orthodox and complex tasks is enhanced when community members are equipped with useful skills and are well informed about what resources and threats exist within their community (Nye et. al 1996). As a result they are able to plan better. This assists them to commit their energies and resources to the right purpose at the right time. As a result the community members steadily increase their level of control of resources towards their development discourse. This way they are likely to succeed in their undertaking. Success in this case is critical because, as Clark (1990: 90) observes, “minor successes can instill great confidence in the poor, confidence which if skillfully channeled quickly leads to ambitions of tackling much bigger problems through their new-found weapon of collective action.”

In Malawi For instance, a CBO known as Youth Net and Counselling (YONECO) was initially established to provide counselling and skills training for AIDS-afflicted young people. After a series of capacity building workshops of its volunteers, the CBO expanded its service to address the growing needs of street children, providing them with shelter and food, as well as activities such as sports; tasks they initially felt uncomfortable undertaking.

Building the capacity of community members is important because people do not need handouts, rather they need a ‘hand up’ so that they can organise themselves and be able to solve their own problems and become both beneficiaries and controllers of the development process (De Vita and Fleming 2001). Benjamin Mukapa, former

president of Tanzania, once said in Stockholm that "our people must be encouraged and facilitated to be owners of their development; not just beneficiaries but doers of development" (World Bank 1999:7).

Capacity building develops community members' leadership skills and ability to make good decisions and take responsibility to motivate and empower others to take action for a common good. It builds their confidence to work with local leaders and engage government and other civil society organisations to participate and make a contribution towards the CBO's course. Examples can be drawn from The AIDS Support Organisation (TASO) in Uganda, Ha Ramapepe in Lesotho, Boane in Mozambique and the Chipego Women's CBO in southern Zambia (US Department of State 2002; Birdsall and Kelly 2007). Examples such as these have led social analysts and development practitioners to acknowledge that CBOs are "critical to community development for linking national and international institutions with people in their local communities by serving representational functions, facilitating communication and providing mechanisms for seeking accommodation on central vs. local interests" (Batei-Doku 1998: 303).

As indicated earlier, GCHBC is totally managed by community volunteers whose level of literacy and knowledge about health and other development issues varies greatly. Capacity building is a critical aspect of the work of the CBO, which attempts to enhance the understanding, skills and operational knowledge of the volunteers so that they can perform their functions better. In order to sustain itself and the services it provides, the CBO requires its organisational, networking, resource mobilisation, programmatic and to some extent its political capacities developed. Political capacity is required so that the volunteers may be able to influence the recognition and support from local politicians.

The CBO volunteers receive various trainings from different organisations on various issues related to HIV/AIDS and development. For example, they are trained to have a general understanding of HIV/AIDS, how it is spread and methods of preventing infection. They also receive training in counselling, case-finding (identifying patients), record-keeping, coordinating activities and mobilising basic resources. In

turn, the volunteers conduct community level training to family care givers and patients, and people living with HIV/AIDS.

Because the GCHBC CBO operates in a resource challenged context primarily due to the burden and strain of HIV/AIDS itself (Baylies 2002; Whiteside 2002), assistance from partners is important. It must be noted, however, that while outside assistance is important to build the capacity of CBOs and that CBOs must seek it, capacity building must be seen only as an addition to the existing ideas, knowledge and skills that people and the community already have (Dave and Bromiley (2008). This must be done in a manner that involves local people so they can take advantage of the unveiling opportunities to catalyse the process of their development. This must be facilitated in a way that should neither overwhelm indigenous thinking nor corrupt and change the objectives of local people. Partners such as the World University Service of Canada (WUSC) and other civil society organisations provide support to the CBO to facilitate several workshops to enhance the capacity of volunteers and other CBO participants thereby empowering them to respond to HIV/AIDS and its complications.

For example between 2005 and 2007, the GCHBC CBO (with support from partners) facilitated skills training sessions in the community to approximately 791 people (of whom 466 were women) in various aspects of HIV/AIDS. Some of the areas that were covered during these skills training sessions included basic facts on HIV/AIDS and counselling, community transformation, community mobilisation, leadership, conflict resolution, entrepreneurship skills, basic financial management, sexual harassment, treatment literacy, and legal and ethical considerations of HIV/AIDS including communication skills. Community residents who received skills training include selected community members, community leaders, CBO members, church leaders and support group members (see Appendix 2 for detailed training schedules).

The skills training sessions built strong leadership skills among CBO volunteers. The trainings also motivated them to communicate and translate complicated terminologies related to sex and sexuality appropriately when disseminating HIV/AIDS information. This was clearly observed during public meeting.

Most of the volunteers that received the various capacity building sessions particularly the women, reported maintaining a good balance between personal and CBO activities. For example, most of the volunteers reported starting and managing their own income-generating activities such as backyard tuck shops and gardens to supplement their household income, a manifestation of the increased ability to use the skills they had acquired in a much broader manner. The female volunteers also tended to be more assertive than before and were able to make contributions during community meetings that are dominated by men. Generally, the CBO volunteers articulated better the activities of the CBO and the processes they undertake as a result of capacity building. They gained confidence to interface with government, local authorities and donors to discuss their requirements and lobby for the resources they needed. There was also strengthened interaction and social cohesion among volunteers and the recipients of CBO services. This result is particularly important because according to John Field (2003:2), "interaction enables people to build communities, to commit themselves to each other, and to knit the social fabric." As a result of enhanced social interactions and social networking, there is increased understanding of community issues, a sense of belonging, relationships of trust and tolerance and a growth in enthusiasm to act and resolve problems (Gaffeo 2003).

Another example of the outcomes of community capacity building is the involvement of locally HIV positive people in providing information on the infection. Through capacity building, CBO volunteers built on common experiences of people infected and affected with HIV/AIDS and made them community foot soldiers (sensitisation agents) to sensitise other community members about the epidemic. This is one activity people living with HIV/AIDS would not undertake due to lack of confidence and fear of stigma associated with HIV/AIDS. Capacity building in this case catalysed the shift of PLWHA from orthodox service recipients to participants in their own development This result conforms with the nearly universal consensus among development scientists that empowerment of people is a vital ingredient to development because it enables them to initiate and take control of their own development process (Dave and Bromiley 2008). When people are empowered, some passive and submissive attitudes begin to give way to self-respect and self-esteem and people are able to decide on their own what they want to do and how they want it done based on their acquired knowledge, experience and interests(Dean 1999). If people are not empowered, they

are likely not to identify opportunities and even miss out on the growth that a community or nation may achieve. For instance, while the government of Botswana has exhibited exemplary political will and has committed some resources to deal with the HIV/AIDS problem, there is still a striking dichotomy in terms of the response made to HIV/AIDS and other community-oriented programmes between the Gabane community, which has an active CBO, and other neigbouring villages, which do not have functional CBOs. The Gabane community has responded better than those villages that do not have CBOs. Because the GCHBC CBO is proactive and has some influence, it has managed to access government resources to enable it to organise activities and provide services to members of its community.

Capacity building has given volunteers the confidence to carry on with their work and is one of the major reasons why the GCHBC has continued to exist for such a long time when some CBOs that were started at the same time have fallen apart. The CBO has started training and mentoring other CBOs from across the country on CHBC. The CBO has actually become a conduit for trainings provided by government and other stakeholder.

Notwithstanding the capacity building milestones attained by the CBO, there still is more work required to spread the benefits of capacity building across the community to free them from vulnerability. As Clark (1990: 4) mentions, “building capacities of communities must not simply enable people to survive poverty but to be freed from it.” These initiatives must not be a substituted for government efforts; rather, they should complement government efforts and help to ensure sustainability of development programmes.

8.8 Promoting volunteerism and enhancing social capital

Like most CBOs, the GCHBC CBO membership is on voluntary basis. The very existence of the CBOs is testimony that it has provided a good environment for local participation and has succeeded in mobilising local volunteers. The CBO has encouraged community members to be pro-active and get involved in community activities in an organised rather than spontaneous and uncoordinated manner. Through

the CBO, volunteers have worked together as a group that reinforces social norms and commitment to community development. The interaction of volunteers with other community members has also strengthened social capital within the Gabane community. Consolidation of social capital is important in any community as some scholars have shown (Brett, 2003; Fukuyama, 1995; Harriss and de Renzio, 1997; Putnam, 1993; Putzel, 1997), that the capacity for co-operation in any community depends on a certain level of social capital being available within it (Golloba-Mutebi 2005: 955).

Social capital has become an important concept in debating and understanding the modern world (Bourdieu et.al 2008:1). It now features in much scholarly discourse across a variety of disciplines. According to Stephen Baron et.al (2008:57) "social capitals flows from the endowment of mutually respecting and trusting relationships which enable a group to pursue its shared goals more effectively than would otherwise be possible."

According to Robert Putnam (2000: 289), social capital "greases the wheels that allow communities to advance smoothly. Where people are trusting and trustworthy, and where they are subject to repeated interactions with fellow citizens, everyday business and social transactions are less costly." Francis (2002) in Kothari and Minogue (2002), further states that social capital has some of the characteristics of a public good; it produces benefits to society as a whole that cannot be captured by those who create it. Quinn (2008:6) observes that "social capital is something thought of as the metaphorical glue that holds groups and societies together and enables them to get things done."

Some scholars (De Haan 1998; Francis 2002; David 2008:78) argue that HIV/AIDS reduces social capital because of the stigma and discrimination associated with the disease, the burden it poses on social networks and the insecurity it brings and socially excluding those affected. However, given that CBOs have been credited with mobilising people living with HIV/AIDS and reducing stigma, and encouraging community members to provide care and support for afflicted persons, it can logically be argued that effective CBOs do foster social capital, which is important for community development (Adler and Kwon 2002).

8.9 Creating the potential for community regeneration

The purpose of community regeneration is to assist communities that have suffered economic, social or environmental decline to function again (Alston 2004; Page 2006). Community regeneration is important because it assists the community members to have a good understanding of the local community and helps create positive attitudes, optimism and a vision of self-reliance that stimulates commitment to change for a better sustainable community. Regeneration of communities is particularly important because as Power (2007: 22) says "communities help to shape people's lives, they form a base for wider activities, providing many of the social services that link individuals with each other, giving rise to a sense of community; they also provide a context within which different social groups develop contact with each other", this gives rise to the emergency of social capital.

The GCHBC CBO has demonstrated that there is a huge potential for the regeneration of its community despite suffering the impact of HIV/AIDS. It has used the response to HIV/AIDS as an impetus to community development by creating an empowered community where members participate in community development programmes. It has helped connect the vulnerable and socially excluded to health institutions. It has provided the possibility of an education to disadvantaged children through the development of skills, knowledge and positive attitudes at the pre-school, in the kids' club and through community-based learning. In appreciation of the completion of a classroom for the pre-school, one of the pre-school teachers spoke to the local newspaper and said:

"The classroom block would be fully utilised, both by the pre-scholars and the kids' club. It would enable the centre to double its intake from the current 32 children to 60 children. Older children will use the building for revision and learn and use information technology. The intention is for the centre to enable Gabane orphans to catch up with the rest of the society and realise their full potential." Sila Press Agency, Mmegi Newspaper, 27 September 2007, Vol. 24, No. 147.

Such developments as the construction of classroom blocks go beyond the need to meet the immediate educational needs of OVCs. They prepare a generation through the transfer of information, knowledge and skills for future family, community and national responsibilities.

As earlier demonstrated by various examples in preceding chapters, the GCHBC CBO has increased opportunities in the community through its capacity building processes, promoted the use of local resources and consolidated social capital within the community and ownership of outcomes of the CBO activities. In a way this is the CBO's contribution toward the regeneration of the Gabane community.

8.10 Challenges that CBOs faces in responding to HIV/AIDS as a development challenge: Examples from the GCHBC CBO

Starting a CBO is generally much easier than sustaining it (Shreedhar and Colaco 1996). This explains why many CBOs have been established and many have withered, lost energy and disappeared (UNAIDS 1997:3). Like other development actors, CBOs face challenges and these may stem internally from within the CBO itself such as weak leadership skills and inadequate resources, while others maybe a result of relationships with local or external organisations or from political-economic forces (Kasfir 1998; Mohan & Stokke 2000; Orvis 2001). The following are some of the challenges that CBOs face with specific examples are drawn from the GCHBC CBO.

8.10.1 The vulnerability of CBOs to HIV/AIDS

The HIV/AIDS epidemic directly impacts on the CBOs because the volunteers come from an environment of increased prevalence and they are vulnerable as individuals (Manning 2002). CBO volunteers may contract HIV due to the very nature of their work and this tends to affect the morale of other CBO members because it is hard to maintain motivation among volunteers when their colleagues who are infected with the virus eventually succumb to it (UNAIDS 1997:4). This also influences high turnover among volunteers of CBOs. The case for the GCHBC was not any different given that some of the CBO volunteers are people living with HIV/AIDS and would need care and support themselves. This experience especially before the coming of ARV treatment affected the morale of many volunteers. In a way HIV/AIDS itself carries a risk of undermining the capability of the CBO (Desmond, Michael and Gow (2000).

8.10.2 Cultural perceptions and entrenched traditional beliefs

Despite the fact that HIV/AIDS has been around for more than two decades now, there are still myths and misunderstandings about it that are rooted in cultural, traditional and religious beliefs and these may hinder collective action and reciprocity (UNAIDS 1997:4). HIV/AIDS remains a largely misunderstood phenomenon among people especially in Africa. This not only exacerbates suspicion, mistrust, fear and stigmatisation, but also complicates community initiatives that are meant to address the epidemic (UN-OSAA 2003).

The fight against AIDS in Africa is fraught with cultural prejudices and theories especially regarding causes of HIV and its possible treatment (Gausset 2001). Such misunderstandings make it more difficult to take collective action. Prevalent external and indigenous explanations about HIV/AIDS often contradict and compete with each other. For example, western theories are often based on prejudices about sexuality in Africa, placing the blame for the exponential spread of the epidemic on excessive promiscuity among African people[15] (Hunt 1996; Gausset 2001). On the other hand the local people blame infiltrating western customs and urban life for the spread of HIV/AIDS (Gausset 2001). They see it as a disease resulting from a breakdown of traditions and moral codes. This then becomes "a fight between cultures, one culture trying to impose its own conditions on the others" (Gausett 2001: 512). This is basically because "social constructions of causation inform notions of what should constitute appropriate responses and 'who' should take primary responsibility for mitigation" (Baylies 2002: 619).

These conflicting perceptions are counterproductive and may dissuade community members from taking action against AIDS. In the initial phase of the establishment of the GCHBC CBO cultural and traditional issues did influenced the level of participation in CBO activities among community members. However, this has been overcome by intensive and continuous sensitisation and mobilisation efforts of the volunteers.

[15] The perceived solution to this challenge often remains fixated on behavioral change, overlooking other critical factors, such as poverty.

8.10.3 Inadequate resources to support activities

While it is widely believed that CBOs are built on local resources and knowledge, these organisations usually start small and normally face the challenge of resources especially in their initial stages. This makes it challenging for them to function and expand their services particularly when measured against the challenges and critical issues that they have to address. This makes them explore external avenues for resources, which in itself may bring problems of dependency if not well managed.

Generally, CBOs do not have enough resources to meet their growing needs because they find it difficult to mobilise resources due to limited skills in resource mobilisation and development. This is also a result of lack of government investment in CBOs and also changing political agendas of the donors from which the CBOs derive much of their funding. These agenda changes have resulted in the shifting of resources from one thematic area to another. For instance, currently donors are keen to fund projects to do with good governance, human rights and environmental sustainability than HIV/AIDS as was the case a decade ago.

The GCHBC CBO has experienced lack of resources to expand its services. Though it has received some donations form partners, such as a vehicle to carry patients to the clinic and bringing in pre-school children, funds are needed to maintain the vehicle. In addition, the cost of feeding the children and buying equipment for the pre-school is very high. The GCHBC CBO coordinator Boitumelo Leburu described the resources challenge in the local media and said:

"The running costs of this HBC are high. We have nursery, pre-school children and orphans to educate. As you can see, there are still more developments to do here. Some of these children will after completing Junior Community School (JC) have nothing to do. We have the mandate to seek ways of molding them into better future citizens. Training is needed." Boitumelo Leburu, Mmegi Newspaper, 7 November 2008, Vol. 24, No. 168.

The CBO has attempted to deal with inadequate resource by developing partnerships with other stakeholders.

8.10.4 Lack of technology, coordination and management skills

As indicated earlier, the GCHBC depends on volunteers. Most of them, like in most other CBOs have limited formal education with a paucity of skills in management as well as in information technology (Treuhaft et al., 2007). This makes it very difficult for them to understand and interpret key national policies and strategies on HIV/AIDS and OVCs and to interpret information on funding options, which is normally written in English. Because of their limited literacy skills, the volunteers are not able to develop funding proposals to the standards demanded by some donors. They also have limited skills in documenting their activities and reporting to the standards expected by partners and donors (UNAIDS 1997:5). This means that the CBO rarely captures programming lessons, experiences, or successes. The lack of such vital programme information leads to re-inventing the wheel and a waste of scarce resources. In addition, the weak skills in documentation and the lack of an effective monitoring system further limits progression of the activities as there is no framework to capture change.

In most cases when the CBO has to deal with information in English they have to rely on translation and interpretation by members who have proficient knowledge of English. This slows down the speed at which they can respond to such information and sometimes it is misinterpreted altogether. This has led to the CBO to miss out on various calls for funding and potential partnerships. In addition, there is very limited written information on the CBO because there are no structured monitoring activities of the performance of the CBO. Again, this is because of the poor literacy skills of most members and the lack of technology to manage information. Absence and lack of ability to use technology such as computers and internet makes CBO member to function in an environment of hesitancy, wariness and isolation from what others are doing (UN-OSAA 2003).

8.10.5 Dealing with increasing demand for expansion of CBO activities

There is a tendency among CBOs to expand prematurely and to scale-up services based on their initial success. They sometimes increase their responsibilities and geographical coverage in an attempt to increase their impact, but unless they have the resources and skills to do this, the CBOs become overwhelmed and members' morale drops (Edwards and Hulme 1992). Some CBOs prematurely scale-up because of pressure from their outside supporters. This is one common reason why CBOs fail; they attempt too much and end up sacrificing quality for quantity. As the scope of the CBOs grows, the demands on the volunteers' time also increases. This becomes a challenge particularly when the volunteers do not have any income to support their families with. In the case of the GCHBC, some volunteers work at the CBO centre almost on daily basis to deal with the demands of the CBO's services. This has led to the loss of some volunteers through volunteering fatigue and burn-out. As a result there tends to be some disruption of the services provided and effective coordination of the CBO's activities.

The effect of HIV/AIDS on the Gabane community has been felt by community members. The expectations of the Gabane residents for the CBO are huge and usually overwhelm its capacity due to insufficient resources. The scope of the CBO has expanded to try and meet this demand resulting in an increase in volunteer's time. Besides, some of the interventions require a certain level of skill competency to undertake, for example HIV voluntary counselling and testing that requires specialised training at a certain level of which the volunteers do not have.

8.10.6 Managing the founder member syndrome

In most cases the formation of a CBO is spearheaded by either one person or a small group of people. As the CBO grows, more people join in and the demand for service increases. The pioneers usually want to continue leading the CBO activities but do not necessarily have the skills to do so. Ideally the pioneers have to learn the skills (which in most cases they are not able to) or hire qualified people, or step aside for more qualified leaders to manage the CBO. Unfortunately, the pioneers are not always willing to pass on responsibilities to newer and more able members (UNAIDS 1997:

5). This is what is called the founder syndrome. Another problem is that pioneers want to be rewarded more than other members simply because they spearheaded the formation of the CBO. Though this is not outstanding with the GCHBC CBO, discussions with some long term volunteers reviewed that they felt they deserve allowances and that they must have fulltime paying positions in the CBO. This has the potential of creating conflict within the CBO and could lead to collapse of the CBO if not well managed.

8.10.7 Over-reliance on funding from donors and outside partners

As has been elaborated earlier, CBOs have limited resources. They therefore have to develop partnerships with other organisations that can provide resources. While external funding and support is essential among CBOs, dependency on donor funding creates a substantial risk to the identity, autonomy and mission of CBOs (Sabatini 2002). The donors and outside partners do not just give resources; they also want to control the activities of the CBO to make sure that they are aligned with their interests. The erosion of CBO autonomy could entail the CBO being expected to adopt the donor's criteria for implementing and monitoring programmes, including using a logical framework and articulating results in complicated formats using western languages (UN/OSCAL 2003: 46) which the CBO members are not familiar with. If this happens CBOs become more attuned and accountable to donors' needs than to the people they are meant to represent and serve (Hulme and Edwards 1997). "When the donor/CBO relationship is too close for comfort the latter risks losing the local innovative attributes that make it an attractive alternative to mainstream development" (Hulme and Edwards 1997:276; UN-OSAL 2003: 46).

It was observed that as the results of the GCHBC became apparent and known to various stakeholders, the CBOs became vulnerable to manipulation by donors and government who wanted it to scale up its services even before it acquired capacity for that. When this happens, it is usually done on the pretext and promise of continued support to the CBO. Because of the experience that the GCHBC CBO has generated over time working with governments and other partners, the CBO seems to have been able to work around this issue without much effect on it operations.

8.10.8 Meeting the expectation for rewards by volunteers

As with most CBOs, the GCHBC volunteers are local residents with no formal employment and they must balance the time they spend volunteering with the time they need to spend on domestic chores to fend for themselves and their families. The question of maintaining their motivation levels can not be taken for granted particularly when the CBO offers no guarantee for rewards. During group discussions with CBO volunteers it was reviewed that after contributing to the CBO some volunteers expect some rewards from resources provided by donors (tokenism). When this is not forthcoming some feel frustrated and leave. Volunteers also drop out due to pressures to contribute to household and livelihood chores, which sometimes require them to engage in paid labour in order to support their families (UNAIDS 1997). In this case the very fervent intrinsic motivation of the volunteers may result in individual agendas that if not well managed become detrimental to the CBO itself (Sieber 2000). The experience with the GCHBC CBO was that volunteers come and go but there are always some, usually, pioneers who remain to maintaining the purpose and existence of the CBO.

8.10.9 Managing the emotional and physical stress of volunteers

Due to the very nature of the work that volunteers do, they experience stress, especially when they are continuously taking care of long-term and terminally ill patients. The volunteers feel helpless when the anticipated assistance from the nurses and social workers is not forthcoming to the patients. This forces volunteers to provide assistance such as food from their own resources, when they are able to. Such experiences are stressful on the volunteers and if not managed well leads to burn out and withdrawal of their services.

I have discussed above some of the challenges that CBOs face in their work to fight HIV/AIDS in their communities. I will now discuss below the extent to which the research question has been addressed by this study.

8.11 Discussing the extent to which the research question has been addressed

As indicated in chapter one, the main problem of this study was to determine the role of CBOs (drawing examples from the Gabane CHBC) in the fight against HIV/AIDS as a development challenge with the view of highlighting the potential that these entities have towards contributing to development in general.

This was against the understanding that CBO are small, have limited resources and skills and quite often operate in an informal and less structured way. It is therefore easy to ignore the role as well as the potential that these entities have in the general development discourse.

To begin with, this study has elaborated and ascertained the link between HIV/AIDS and development. For a long time now HIV/AIDS has been thought be a health problem whose solution rests in the health sector. In arguing the relationship between HIV/AIDS and poverty, poverty and HIV/AIDS as well as the gender dimensions it creates, it has been clarified that HIV/AIDS is a development problem that needs multi sectoral interventions. Its impact is felt at household level, community level as well at national level. Examples from Botswana have been given to illustrate the impact of HIV/AIDS to national development. Details of the HIV/AIDS situation in Botswana and the national response have been discussed paving way to the justification of the involvement of CBOs in the response. In addition, the study discussed the formation of groups and linked it with the formation of the GCHBC CBO. The study has also re-enforced the position that CBOs are made up of people, who have identified a need or issue in their community and organise themselves to address it.

The study further demonstrated that responses to HIV/AIDS can be explained within the context of existing development theories and strategies. For instances the work of CSOs, particularly CBOs at the grassroots level involving community members fit well with the paradigm of development from below because of their potential in stimulating community participation. The study further established that people-

centered approaches that CBOs undertake can actually influence development policy at macro levels. For example the involvement of people living with HIV/AIDS through support groups has led to shift in policy decisions regarding treatment, discrimination and rights of vulnerable and marginalised groups.

The study has also revealed the dynamic relationships that exist between CBOs and other stakeholders such as international NGOs and donors. It has discussed the pitfalls that CBO risk if they over-depend on outside influence. For example, the power imbalances between CBOs and other stakeholders are huge. The informality of CBOs and their lack of formal education puts them at risk of being sidelined to the bottom of partnerships and may easily be excluded and overlooked in decision-making processes. On the other hand large NGO receive a huge share of the resources while CBOs only access a negligible portion and struggle to survive yet they are the ones who do so much of the actual work at the grassroots level on a voluntary basis. However, this is not to say they do not need to develop partnerships and collaboration, they need them as long as they do not high-jack the purpose of the CBO.

The study has further revealed that CBOs do fill up the service gaps left by governments; they are often playing roles that government is not taking sufficient responsibility for, for instance home-based care for people living with AIDS and care for orphans and vulnerable groups. This makes CBOs important entities and must therefore be seen to be at the center of the development process and not at the margins. Schirin Yachkaschi (2006) acknowledges the work of CBOs and observes that they are relevant for the survival and development of communities, as they often pick up local problems and develop ways of addressing them. As opposed to the view that development services are mainly provided by formal and professionally run NGOs, a study by Swilling and Russell (2002) revealed that 53% of all civil society organisations in South Africa are CBOs or voluntary associations established by people from the poor communities to meet their own needs from within.

In demonstrating the role that CBOs play in response to HIV/AIDS as a development challenge, the study has highlighted that CBOs have strengths and assets, which need to be acknowledged and promoted. These strengths need to be appreciated in order to build other levels of capacity that the CBOs may wish to develop. Therefore, instead

of focusing mostly on weaknesses, deficiencies and gaps of CBOs, development practitioners and stakeholders must look out for the available strengths and priorities of CBOs and align these with the available resources.

The study has also discussed the potential that CBOs have in regenerating their communities embattled with HIV/AIDS and poverty by harnessing social capital. In addition, the study has discussed and provided example of how CBOs have responded to the HIV/AIDS challenge ascertaining their critical role in the development discourse. CBOs have for example played an important role in:

- Sensitising the communities about HIV/AIDS.
- Mobilising the communities for action.
- Developing partnerships and mobilising resources to facilitated implementation of programmes.
- Scaling up prevention activities.
- Providing care and support to affected families, orphans and vulnerable persons.
- Facilitating the great involvement PLWHA in policy dialogue.
- Advocating for treatment and dealing away with discriminatory practices against PLWHA.

The study went further and discussed the challenges that CBO face in their endeavours. It also highlighted how HIV/AIDS is undermining the capability of CBOs to carry out their responsibilities. This threat is paramount because the pandemic is decreasing household incomes, increasing costs (on health care), eroding the productive capacity provided by adults and changing expenditure patterns (Desmond et al 2000).

The study also highlighted that most CBOs members lack formal skills like financial management, writing skills etc leaving CBOs grossly deficient in terms of capacity. This further limits the extent to which they can bring in resources, particularly finances to deliver their services.

Despite these challenges, this study concludes that CBOs have a critical role and huge potential in not only responding to HIV/AIDS but to the general development

discourse especially among the marginalised and vulnerable populations especially when their capacity is enhanced.

8.12 Conclusion

This chapter has presented the results of the study. Here we have seen the various roles that CBOs play in fighting HIV/AIDS. Examples have been drawn from the work of the GCHBC. From the results it is clear that despite being small, informal and resource constraint, CBOs are essential partners in the response against HIV/AIDS, in most cases providing services were government has failed. The activities of CBOs are significant and actually present good practices for government and other development partners to follow. The chapter also highlighted some challenges that CBOs confront when fighting against HIV/AIDS. These must be overcome by building capacity of CBOs and developing partnerships with relevant stake holders

CHAPTER 9

RECOMMENDATIONS: TOWARDS ENHANCING THE ROLE OF CBOS IN RESPONDING TO HIV/AIDS

9.0 Introduction

The importance of CBOs in response to HIV/AIDS is widely recognised and has become a part of the development policy in many countries (Birdsall and Kelly 2007). Despite this, the actual integration of these organisations in development practice has often been ineffective. This is because firstly, the real commitment of governments and government agencies to seriously recognise the support of local organisations has been very limited. Secondly, the sociological understanding of the basis for effective organisations is relatively weak within government agencies (Fisher 2002).

This chapter offers some recommendations for consideration to optimise the contribution of CBOs not only in response to HIV/AIDS but to general development. These recommendations must be considered with each CBO as a different entity since CBO may not present the same challenges at the same time.

9.1 Integrating HIV/AIDS into development work

To begin with I recommend that HIV/AIDS must be fully integrated in development interventions especially among the high prevalence countries. As Haddad & Gillespie (2001: 497) aptly advise, "development practitioners should not be blind to the threat of HIV/AIDS, but neither should they be blinded by it." HIV/AIDS still remains one of the most significant development challenges today (International HIV/AIDS Alliance 2000). Over the past two decades a lot of development insights have been generated as a result of the experience of HIV/AIDS particularly in Southern Africa. However there is still a great deal to learn about how to slow the spread of HIV/AIDS and deal with its consequences. One lesson that remains clear is that though the structure of the HIV/AIDS response has evolved over the past two decades this still remains hierarchical with health professionals claiming that they are best positioned to lead the response despite the fact that its causes and consequences are more socially

inclined. This approach has been influenced by western models that were initially used to address gay men and injecting drug users (De Kock, Mbori-Ngacha and Marum 2002). The western models placed a lot of emphasis on the human rights approach and confidentiality such that HIV/AIDS was not treated as a public urgent concern. To put it simply, HIV/AIDS was perceived as a medical problem requiring a medically oriented solution rather than a problem that was influenced by socio-economic factors as well. According to Illiffe (2006) this may have contributed to the earlier failures of curtailing the epidemic. The AIDS epidemic is not simply about public health, and if the responses to HIV/AIDS must be effective, a broader approach to prevention, treatment, care and support as well as mitigation must be adopted. Now that HIV/AIDS is understood as a development challenge, it is important that development practitioners draw lessons from different approaches attempted over time and consolidate them into existing opportunities for addressing HIV/AIDS as a development problem and not as an isolated sectoral issue. For example, HIV/AIDS issues must be included in core areas of development policy, such as food security and public education, and involve government ministries and other stakeholders in these sectors (UN-OSAA 2003). This calls for the incorporation of other disciplines particularly those in social sciences to try and shape a holistic yet multi faced approach to the response against HIV/AIDS. To contain the epidemic at community level, assistance to CBOs must not be based solely on the presence of HIV/AIDS, but equally on poverty indicators that reflect future vulnerability to the epidemic.

On the other hand, countries that are highly affected by the epidemic, the Southern African countries must take leadership in this initiative.One way of doing this is to garner political support so that leaders can advocate for this integrated approach and influence the integration of HIV/AIDS in the general development framework and increase funding for HIV/AIDS activities. An example can be drawn from the Botswana experience. Botswana's response to HIV/AIDS has been seen as a best practice for Africa (UNAIDS 2007) because HIV/AIDS was declared a national crisis and government called for all sectors to participate in the fight. Government also facilitated the establishment and expansion of civil society organisations especially CBOs that are in the forefront of the fight; it also facilitated the enhancement of capacity and sharing of information and experience among players in development sector (NACA 2003). In Uganda president Museveni's leadership and political will is

also attributed to the drop in the HIV/AIDS prevalence rates in a country that once had the highest prevalence in the world.

9.2 Incorporating poverty reduction strategies in HIV/AIDS activities

Despite the fact that AIDS epidemic in Sub-Saharan Africa has clearly demonstrated that it is a systematic problem that is closely linked with poverty, research on HIV/AIDS especially in Sub-Saharan Africa suggests that mitigation is not receiving the support and attention it deserves (UNAIDS 1999a: 47).

Scholars have debated the relationship between HIV/AIDS and development and concluded that the epidemic has an association with development outcomes (Arbache 2008). It is important therefore, now that we have a good understanding of the epidemic to include dimensions of poverty mitigation to shape the responses to HIV/AIDS. This thesis has argued that poverty is both a causative factor as well as an outcome of HIV/AIDS. It makes people vulnerable to HIV infection because they have to adopt risky coping mechanisms to survive. For example, women can be pushed into survival or commercial sex; young people may select to migrate away from their homes and their social support networks to seek employment in urban areas. This makes them vulnerable to new ways of living which even increases their risk of contracting HIV infection. Given the forgoing, it is important to address the co-factors of vulnerability to HIV infection particularly the issue of poverty and livelihood insecurity. This can be done by exploring income generating opportunities and promoting and undertaking income generating activities (IGAs) and some empowerment programmes such as functional literacy, food security and nutrition programmes and by addressing gender inequalities. All these must be implemented at the community level with local residents.

9.2.1 Promoting income generating activities

Although income generating projects have inherent risks of economies of scale and overhead costs (UNAIDS 1999a: 41), income-generating activities at local level will increase the income-earning opportunities of the poor especially persons living with HIV so that they can support their families and strengthen socio-economic safety nets. The types of the IGAs undertaken must be carefully selected and determined based on what is viable in a given community. Collaboration with "microfinance institutions to respond to the changing needs of vulnerable people is crucial to HIV/AIDS mitigation efforts" (Haddad & Gillespie 2001: 490). For example, in Nigeria the Country Women's Association of Nigeria (COWAN), has successfully used micro financing to empower communities in addressing AIDS (UN/OSCAL 2003:40).

9.2.2 Promoting functional literacy activities

Functional literacy activities will increase the literacy levels of community people especially women. This is a good way of empowering women and reducing their vulnerability and poverty through information and skills building. Functional literacy does not only enable people to read and write and gain new knowledge, it also motivates them to appreciate diverse ways of generating income, understand better issues of care and nutrition and also helps create networks with others. Improved literacy fosters self esteem and self confidence and motivates behaviour change that reduces risk of HIV infection.

9.2.3 Improving food security and nutrition

Food security and nutrition programmes will reduce malnutrition which is an aspect of poverty that significantly contributes to people's vulnerability to HIV/AIDS infection and its impact. Food insecurity for example, is a key factor in the vicious poverty cycle that exacerbates the Sub-Saharan Africa's AIDS epidemic. Low nutritional status is critically linked to susceptibility to HIV and opportunist infections that are associated with AIDS (World Bank 2008). What this means is that inadequate nutrition will quicken the progression of illness in people living with the virus. Therefore improving nutrition and dietary intake of vulnerable people is a sound

prevention and care strategy. This can be done by promoting nutritional gardens and nutrition education. These have been found to be effective in increasing household food security. For instance in 2007, in Malawi, as part of my responsibilities at the World University service of Canada (WUSC), I placed two volunteers at Kaggwa CBO to build capacity of the CBOs members to provide nutritious foods to patients and orphans. The volunteers assisted the group to start community gardens and taught them various ways of identifying and preparing food that is good for the human body. Currently the CBO has expanded the community garden and volunteers are harvesting from it to supplement the food requirements of their clients. Most of the volunteers have also started their own family gardens as a result.

9.2.4 Addressing gender inequalities

Addressing the gender inequalities in communities is another strategy of incorporating HIV/AIDS in development activities (Esu-Wiliams 2000). The gender inequalities resulting from the epidemic have been extensively discussed earlier in this thesis. There is now the urgency of addressing these issues and empower women to have more control over their sex and sexuality issues. This will mean advocating for gender fairness, lobbying government as well as policy and law makers to adjust laws and influence policies that protect and encourage women to participate fairly in activities that affecte their lives (Voetberg 2008).

9.3 Increasing CBOs' understanding of HIV/AIDS as a development concern

It is important to acknowledge and accept that the HIV/AIDS epidemic will be with us for a long time and must therefore be demystified. Society at large must accept the responsibility for the epidemic, which requires that people understand its urgency and the consequences of inaction (Kelly (2000a). Since CBOs are the pioneers of local-level responses to HIV/AIDS and have become the mainstay to the response (Birdsall and Kelly 2007:1) they have an important role to play in championing innovative responses to HIV/AIDS at community level to prevent further spread of HIV; improve care and support to people and families affected; as well mobilising communities

around the rights of people living with HIV/AIDS. However, for this to happen CBOs need to have a good understanding of the dynamics of HIV/AIDS and how this affects community's development agendas (UNAIDS 2003). This can be achieved by providing CBOs with adequate and up to date information (UNAIDS 2007).

Because CBOs have insight and access to communities and have the potential to catalyse action among residents as well as generate community interest to demand for services, they are likely to identify and appropriately address the mitigation factors of HIV/AIDS. CBOs must also influence residents to be receptive to issues of HIV testing and treatment as prevention strategies. HIV/AIDS awareness education and consciousness-raising demystifies the virus and breaks down associated stigma, discrimination, and other cultural barriers to effective action. This fosters an atmosphere in which community members feel more able to speak out and mobilised towards issues regarding HIV/AIDS. "In AIDS competent communities, it is predicted that quality of life will start to improve from the point in time that the community acknowledges the problem collectively and begins to take action" (Lamboray & Skevinton 2001: 617).

9.4 Scaling-up CBO services

Most good local-level responses to HIV/AIDS have remained local and small-scale and the many lessons learned have not been translated into bigger projects or wider coverage (UNAIDS 2001: 2).This has been one of the common criticisms of CBOs, that they have a limited coverage and normally not going beyond the boundaries of their communities. CBOs must be supported by other partners to utilise their experience and lessons learnt to scale-up and expand their coverage and improve targeting of recipients of their service to optimise on limited resources. They must also establish functional referral systems. The World Bank (2003) asserts that the challenge now is to move from successful small-scale projects that reach relatively few individuals to effective strategies that really make an impact on the pandemic. This implies that CBOs must scale up their activities. To do this they must build their capacity and move away from being short term project implementers to creating long

term visions for sustainable development. According to International HIV/AIDS Alliance 2003:31) scaling-up effective action involves key considerations such as:

- Focus i.e. ensuring that their programmes work most closely with individuals and groups that have the most significant effect on epidemic dynamics.

- Coverage i.e. ensuring that as many key people and groups as possible are reached.

- Quality i.e. ensuring that programmes and interventions are appropriate to the local context and target group and are of a consistently high standard.

- Sustainability i.e. ensuring that the organisation, its programme and its effects last over time.

While the CBOs scale up, they must remain focused to visible and achievable objectives. This will "keep people's interest, spark more participation, and show people that their collective action can actually lead to success" (UNAIDS 1997:6).

Despite some reported progress made in responding to HIV/AIDS epidemic in Sub-Saharan Africa (Stover et al 2007), I still contend that as they scale up, CBOs must place prevention activities at the center because this turns out to be cheaper in the long run as it keeps more people out of the need for contingent programmes and services such as CHBC and ARV treatment.

In Southern African countries, notably, Botswana, Malawi, Zimbabwe and Zambia, the initial response to the epidemic focused more on providing care and support to affected people than prevention because of the large numbers of people falling ill and dying. This delay in putting up preventive programmes and interventions is one of the reasons that this region still maintains with high prevalence rates (Johnson et al 2006). CBOs in this region must therefore scale up the dissemination of information through information, education and communication (IEC) strategies and increase advocacy for counselling and testing to motivate behaviour change. In agreement with Voetberg (2008) I contend that behaviour change is an important step in the pathway of breaking the silence, creating awareness and knowledge and changing attitudes.

9.5 Building strategic partnerships with key stakeholders

While building partnerships has been the clarion call for effective HIV/AIDS responses, there have been examples of dysfunctional collaborations between civil society organisations and government because governments are always suspicious of CSO and fear that CSO will challenge their power and raise issues of governance (DeJong 2001). Despite the differences and potentially antagonistic relationships, the success of CBOs in addressing HIV/AIDS largely relies upon support from and co-operation with the government (Bebbington and Riddell 1995; Johnson 2001; Nel 2001; UN/OSCAL 2002). Given the magnitude of the HIV epidemic, no single actor can effectively address its cross-sectoral effects. Strategic partnerships are required with governments and various development partners as well as among CBOs themselves. They must work together and bridge their differences and recognise the fact that different actors have different experiences and skills to contribute towards the fight. For instance, while governments may be uncomfortable working with socially excluded groups such as commercial sex workers or men who have sex with men, CBOs do not have limitations working with these groups. While there are some political challenges for CBOs in their relationship with governments, HIV/AIDS presents new possibilities for negotiation and collaboration. Also important to note is that by their very nature, CBOs are highly localised and lack political-economic leverage, while the state is the final arbiter and determinant of the wider political-economic climate in which communities and respective CBOs operate (Edwards and Hulme 1992; Farrington and Bebbington 1993; Chaplowe & Madden 1996). A mutually supportive partnership in development could benefit both CBOs and governments. In addition to financial support, governments can provide technical assistance and research in the fight against AIDS that is typically beyond the reach of communities and their respective CBOs due to their limited budgets and lack of access to scientific and technical information.

Partnerships can be enhanced through dialogue by all the involved parties and this can defuse tensions, reduce many of the political obstacles for CBOs and inform national policy-makers of existing social structures to better design policies for local realities. Some mechanisms for dialogue, such as policy consultations, conferences, mutual

evaluations and forums should be created, preferably at the country level (UN-OSAA 2003). The partnering entities can also involve each other in planning processes, training and evaluation processes. For example, CBOs must be included in the design, implementation and review of national AIDS programme plans. This will further strengthen the operationalisation of multisectoral responses to HIV/AIDS.

In order for these partnerships to flourish, CBOs must be seen to be at the center of the development process and not the margins. The roles of all the parties involved must be clearly spelt out. For example, government can create a conducive environment for CBOs to function and help address development priorities and reduce the burden of the state (UNAIDS 1997:3). The government can also create a specific support mechanism for supporting CBOs and protect them from being dominated and run by external organisations. Governments can also increase funding to CBOs (Over 2004).

On the other hand, donors and lager NGOs can play an essential role in channelling resources, funds, providing technical support, assisting with capacity development and providing mediation and facilitation between competing interests (Fisher 2002:9).

Given that CBOs are small and can easily be eclipsed by larger partners, donors, governments and external organisations must not impose their organisational norms, values and management systems, on CBOs but acknowledge and utilise pre-existing practices whenever possible (Brown and Korten 1989; Crane and Carswell 1990; Jonsson and Soderholm 1994; UN-OSAA 2003).

Due to the dynamic and prolonged nature of the HIV/AIDS epidemic, it is important that CBOs remain focused, flexible, "continually in a learning mode, identifying problems and weaknesses, experimenting, evaluating, and modifying" (Uphoff et al. 1998: 208). While CBOs must work with external organisations, with help from government, they must avoid, the bureaucratic procedures often dictated by the external organisation that place emphasis on utilisation of predetermined time-bound project cycles and quantitative short-term targets, rather than qualitative long-term investments (Manning 2002). Caution must be taken to ensure that the external organisations do not impose their cultural paradigm on locals, which could "alienate

the local populations whose cooperation is crucial if we are to prevent the further spread of AIDS" (Gausset 2001: 517).

The donors must also be very realistic with their demands for calls for proposals and reporting of results because most CBOs are managed by local volunteers who have limited literacy skills. Donors must be flexible with their funding and be able to provide smaller grants in support of local initiatives and to allow for spending across mission objectives, administration and other requirements of CBOs such as capacity in information technology. Donors must also take responsibility to coordinate their efforts and learn local conditions so that they can provide appropriate and adequate support. They must not confuse fledgling CBOs with international buzz worlds and development nomenclature but listen to local people on the ground. CBOs should be funded based on their strengths regarding their role in prevention, care and support and advocacy for rights of marginalised groups (Shreedhar and Colaco 1996).

One of the more notable examples of CBO-government partnership has been The AIDS Support Organisation (TASO), which started out as a small CBO in 1987; one year after President Museveni began the county's AIDS campaign. TASO initially advocated for care and support for AIDS patients, as well as people and families living with HIV, and with government cooperation, it rapidly grew, culminating in 1992 when one of its founders was appointed to the national AIDS Control committee. Today, TASO is one of the largest AIDS service organisations in Africa, providing HIV prevention education, counseling and support activities, basic medical care for opportunistic infections and sexually transmitted infections, and skills training for income generating activities" (UN-OSAA 2003:41). As a result of this, Uganda has become the first African country to have "subdued a major HIV/AIDS epidemic" (UN-OSAA 2003: 42).

The various challenges that CBOs encounter have been discussed earlier acknowledging the limits to what they can do on their own in the fight against AIDS because of the multi-sectoral nature of the epidemic, its debilitating magnitude and duration and strained community resources. Therefore partnerships are necessary risks that CBOs must carefully negotiate to accomplish their mission. To fulfill this, CBOs must cultivate skills to negotiate externally with other organisations, various levels of

government, private companies, banks, donor agencies and other relevant institutions (Cornwall et al. 2000:7).

Partnerships must be well nurtured by all parties involved and pursued to enable rather than disable relationships because when abused, partnerships can be used as a facade to disguise underlying political-economic agendas of more powerful partners (Farrington and Bebbington (1993).

9.6 Forming CBO coalitions

Coalitions among CBOs are increasingly viewed as vehicles that are critical to CBOs' ability to effectively play their role in HIV/AIDS response. This is based on the realisation that the co-operation of multiple stakeholders is necessary to transform social problems in development. Coalitions and networks are also seen as important in helping CBOs to learn from each other and scale-up the impact of service delivery. They also seek to increase resources for their members and broaden their participation in the national response. Coalitions will also deepen the skills of CBOs while ensuring optimal programme delivery. To get this working well, the state, local governments and stakeholders need to support these coalitions and networks. Some donors have already set good examples by compelling CBOs to form consortia to bid for their funding.

While CBOs must create partnerships with government and other organisations, individually they are still weak and in a disempowered position in relation to donor and governments. It is also very important for them in this case to establish coalitions (networks and alliances) with other CBOs outside of their geographical communities. Coalitions will help CBOs to support and strengthen each other as well as expand their learning and sharing experiences. This will make their work more visible and be recognised by governments and other entities. CBO coalitions will not only increase access and sharing of information, experiences and resources but also create a strong foundation for creating a strong sector to advocate for development (Birdsall 2007:205). For example, if CBOs have to play a significant and effective role in advocacy, they must work together and speak in a unified voice, rather than with lone,

isolated and divided voices. CBO coalitions are able to bring together a wide range of expertise and experience, enabling them to combine competence and resources in innovative ways. Chaplowe & Madden (1996) support this point of view and mentions that coalitions assist organisations and communities to better share and conserve limited resources which can avoid duplication. They also allow for development partners to identify common interests from which to build a unified agenda and solidarity (Lamboray & Skevington 2001). For example in Botswana, the Botswana Network of AIDS Service organisation (BONASO), the umbrella organisation of all CSO responding to HIV/AIDS in Botswana facilitated the creation of district coalitions to improve the coordination of work of CBOs in Botswana. Since the creation of these district coalitions, BONASO has reported improved coordination among CBOs; increased communication and sharing of results and experiences[16]; increased learning and motivation; reduced competition; and improved performance among CBO members.

9.7 Learning to navigate donor politics

In seeking increased resources through funding from donors, CBOs must learn to navigate the politics of donors and even development partners. Donors have diverse motives for working in any country and with certain organisations. Their motives may encompass different developmental ideals which they may not necessarily impose but propagate as much as possible while serving as a vehicle for driving political interest.

Most donors have favoured groups that are aligned with their political interests. These groups benefit from the funding for as long as they help achieve the donors' goals. Thematic priorities and geographic considerations play important roles in donor politics as donors often dispense most of their resources on a particular thematic or geographic region for reasons best known to them. Unfortunately, this tendency deprives other resource-poor areas of assistance (Action Aid Nigeria 2003). An example of donor politics is when donors determine the programmes that the recipient CBO will undertake and receive funding for without consideration of the

[16] Dialogue among coalition members improves knowledge sharing, which broadens dissemination of successful strategies, as well as lessons from problems, creating a multiplier effect that improves outreach and impact at the community level.

communities' needs. These factors if not well manage can hijack the original ideas and purpose of the CBOs to that of meeting donor demands and priorities.

9.8 Strengthening CBO capacities

CBOs especially in Sub-Saharan African are limited in their capacity and resources, largely due to material poverty and the magnitude and duration of the AIDS epidemic. The pandemic is placing an enormous strain on the traditional coping mechanisms of the extended family and community, steadily eroding capacity not only to care for people afflicted with HIV/AIDS, but the very survival of households and communities. As Haddad and Gillespie (2001: 508) warn, "capacity as a constraint to effective interventions is often overlooked with disastrous consequences, and the fact that HIV/AIDS directly undermines this capacity makes it even more important to assess what remains."

Local CBOs should be assisted in strengthening their own capacity and in undertaking activities to strengthen the capacities of other collaborating organisations including the communities they serve. Since the epidemic systematically destroys human capital and undermines organisational structures, there is need for strengthening capacity and for maintaining it (Hudock 1999; Uphoff et. al. 1998). Research shows that community-based initiatives that have worked with external support to build their capacity have been very responsive to the needs of those affected by AIDS (UNAIDS 1999a: 45).

CBOs do have a strong advantage as channels of development that benefits the people on the ground. However for them to be effective in their cause they must have strategic direction, technical HIV-related skills, knowledge and attitudes and good organisational structures and procedures. Most CBOs have the ability to manage small prevention efforts that focus on sensitisation and information, education and communication as well as running care and support program (Odutolu et. al 2003).On the other hand very few have the skills and capacity to engage in treatment literacy and wider health sector reform issues which are emerging as priorities in the HIV/AIDS sector. Their capacity for policy analysis and institutional strengthening

needs significant reinforcement. This can be done by focusing on building the institutional capacity of CBOs rather than only the technical capacity (Panos 2003). Most international NGOs that conduct capacity building of local CBOs tend to focus on building technical capacity rather than institutional capacity. This results in the institutional capacity of CBOs lagging behind that of their programmes (Odutolu et. al 2003). This further translates to an inability to engage fully in policy development. Partners (government and Donors) should therefore support the holistic development of local CBOs, including their institutional capacity.

Instead of focusing more on deficiencies and the problems of CBOs, there must be a shift to try and understand how best these organisations can be capacitated and brought into mainstream development. This can be done by appreciating the strengths and potential that CBOs have and assist them to develop sound institutional base (agreed vision, rules, and practices) and institutional systems. CBO members, volunteers and staff must also be trained in organisational development issues such as leadership, management, governance and constituency building so that they may be able to manage the CBOs little by little until they create a solid base for future self sufficiency (UNAIDS 2001). CBOs must also be encouraged to adopt a developmental approach where they work on what is relevant to them and what they are ready for.

Strengthened capacity of CBOs to function effectively is one way of promoting good governance, and once this has been done at a large scale it can promote the appreciation of democratic practices i.e. giving people a say in planning and managing projects, transparence and accountability (Hudock 1999). CBOs must also have the capacity to monitor and evaluate their work focusing on both qualitative and quantitative aspects.

Once the capacity of CBOs is enhanced they stand a good chance to leverage their experience in scaling up of the national response. In addition, their deeper link with the poor will ensure that the voice of poor people has a directly influence on policy formulation processes.

9.9 Utilising local knowledge and skills

"Pre-existing resources in a community such as skills, knowledge and practices are valuable tools in the fight against AIDS. Community initiatives that build upon traditional systems are more efficient as they typically require less training and input from external sources; more relevant as they are readily understood and accepted by community members; and more sustainable as people are quicker to identify with, adopt, and take ownership of such initiatives" (UN-OSAA 2003:51). Responses to community challenges must start with what is available in the community. CBOs must therefore promote the use of local knowledge and skills in dealing with local challenges. They must promote community participation so that local residents can take part in the identification of community challenges and allow them to set their own priorities and design locally appropriate solutions. As (Jennings 2000: 6) aptly states, "participation must be a precondition for all activities and not merely a footnote or addition to conventionalism development tool Kit." Community support is essential in a community based organisation, which emphasises the interactivity and participation of its community members to develop solutions to their own issues (Blau and Tekin 2001).

One way that CBO can maximise on local knowledge is to work with local leaders. The participation of influential and well-known persons in the community facilitates transfer of local information and knowledge. CBOs must create the space to work with community leaders and communicate results, processes and challenges. This helps to create a culture of trust and sharing. A culture of trust and sharing is central to creating good leadership that is open to new ideas, responsive to the changing needs of the people.

Another way of utilising local knowledge and skill is to promote the use of participatory methodologies. Participatory approaches build on the importance of local knowledge and participation of local communities in analysing and appraising their situations, planning and acting (Chambers, (1994). Again this calls for capacity building from stakeholders. Once community members are competent to use participatory methods they will use group animation and exercises to facilitate

information sharing, analysis and action among stakeholders. They can also assess current impact, anticipate future impact and identify potential interventions.

9.10 Motivating volunteers

Most CBOs are managed by volunteers and they have limited time to contribute to the activities of the CBO given that they have to attend to their domestic and personal chores. As has been discussed earlier in the thesis, combating HIV/AIDS is emotionally demanding (ACTIONAID 1997; Brodhead and O'Malley 1989; Brown and Korten 1989). There is therefore need to maintain a balance among volunteer responsibilities in order to maintain continuity of CBO activities , while at the same time preventing attrition, which apparently is common. Keeping the CBO volunteers and staff motivated is important to maintain the momentum of a CBOs' activities. It is important in this case to regularly replenish volunteers' energy, skills and also resources to keep them doing the job. Mechanisms of avoiding and dealing with burn out must be well thought out and applied. To do this there must be good leadership that must be ready to re-engineer some roles of volunteers and even leaders when need arises (UNAIDS 1997:7). Non-financial support, such as skill- building for CBO volunteers is important. Regular communication of results and advice from experienced members of the CBO can also be helpful in maintaining momentum of the CBO.

9.11 Recommendation for further research

There is need for further research to understand the role that CBOs can play in mainstream development and not necessarily focusing one development issue such as HIV/AIDS. More studies of best practices of CBOs need to be conducted (De Vita and Fleming 2001). There is also further need to explore how best lessons learnt at community level can be used at national level to inform development policy. Further research is also needed to determine to what extent local communities have been influenced by external factors to an extent that they perceive foreign interventions as best for them.

9.12 Conclusion

This chapter has highlighted some recommendations that must be considered to optimise the contribution of CBOs in response to HIV/AIDS and other development challenges. These recommendations are certainly not exhaustive and their application may vary from one CBO to another depending on the focus and complexity of the undertaking and the experience of each CBO. It is important for example to build the capacity of CBOs to mobilise resources and mange their activities in order to scale up and reach more population. We have also seen the importance of CBOs to form coalitions among themselves and to develop appropriate partnerships with stakeholders without compromising their purpose. The chapter has also highlighted the importance of motivating volunteers to keep them active in the CBO.

CHAPTER 10
CONCLUSIONS

10.0 Introduction

This chapter provides a summary and conclusions of the study. The conclusions are based on the objectives outlined in Chapter one and these include the following:

- To analyse the effects of HIV/AIDS in order to determine whether it is a development challenge.
- To examine the challenges that CBOs encounter in response to HIV/AIDS as a development issue.
- To propose recommendations that can make CBOs be more effective in responding community challenges.

This thesis is organised in 10 chapters linked together to provide an articulation towards the discussion on the '**Role of CBOs in responding to HIVAIDS in Botswana: the case of the Gabane Community home based care organisation'**. The major conclusion of the study is that CBOs do have an important role to play in the response to HIV/AIDS as a development challenge; they have a huge potential in contributing to the general development of their communities if capacitated, well managed and supported with the requisite resources. The thesis has re-invigorated the philosophy that "big outcomes may be born of small inputs and that more heads are better than one" (Jennings 2000:1).

10.1 Summary of key findings

The findings of this study are linked to the objectives and discussed below.

10.1.1 Objective no. 1: To analyse the effects of HIV/AIDS in order to determine whether it is a development challenge

In order to address this objective the thesis discussed the position of HIV/AIDS within the development discourse. To have a deeper understanding of development itself and to construct an operational definition of development to align to this thesis, various theories of development were reviewed and analysed. The development from below perspective was adopted as the appropriate approach to increase people's participation in responding to HIV/AIDS and other development challenges.

HIV/AIDS was then analysed to determine whether or not it is actually a development challenge. This analysis was made against the background that HIV/AIDS has been for some time perceived to be a health problem requiring a medical driven approach. Literature reviewed, complemented by my own experience on the issues points to an understanding that given the factors that facilitate the spread of the HIV infection and the consequences it brings, despite the fact that the immediate modes of transmission lay in the bio-medical realm, HIV/AIDS is a development problem. A broad consideration of understanding health also conforms to this fact (Labonte 1997). To validate this thinking an analysis of the relation between poverty and HIV/AIDS and its inherent gender dynamics was made. Poverty and gender were deliberately selected as factors of the analysis because they are common and important variables to consider when analysing the phenomenon of development. Examples of how poverty creates conditions for the spread of HIV infection, and how HIV/AIDS exacerbates poverty conditions were given. Further to this the impact of HIV was also analysed. This left an enhanced appreciation that the impact of HIV/AIDS is by far developmental by nature with a myriad of social, economic, political, cultural and environmental implications. The analysis of the causative factors and its impact, amplified by the fact that HIV/AIDS affects human wellbeing led to the conclusion that indeed it is a development issue (not merely a health one) that needs a comprehensive development approach to address it.

This conclusion then led to the consideration of how best HIV/AIDS can be addressed. The review of development theories offered a good theoretical framework to answer this question. Further to this, various approaches that have been mounted so far were analysed focusing on the global response, the national or governmental response and the civil society based responses. The response by civil society organisations was perceived to create a strong link with the development from below perspective because of CSOs ability to mobilise people and involve them in understanding the HIV/AIDS problem and crafting people focused solutions. Given that civil society is a general term that represents a diversity of organisations including NGO, CBOs, FBO, local support groups and so on, analysis of which organisation within the civil society genre is most suitable to offer a response that is in line with the development framework selected was discussed. NGO and CBOs were compared and a conclusion reached that both types of organisations play an important role and often do provide services that the state is not able to, but that CBOs provide a much more conducive context for a bottom-up, people focused response. CBOs are formed and driven by local people and located deep in the community; they are flexible and function on simplicity, as a result they motivate participation from members of the community mostly on voluntary basis. CBOs confront health, social and economic challenges that threaten their communities as a result of HIV/AIDS. A summary of roles that CBOs play in responding to HIV/AIDS was given, and these include the following:

- Mobilising community members to act together and consolidating social capital.
- Disseminating information for prevention of spread of HIV infection.
- Provision of care and support to affected persons.
- Mitigating the effects of HIV/AIDS, by promoting livelihood improvement options such as income generating activities as well advocating for the rights of afflicted persons and to reduce the stigma associated with the disease (Sethna 2003).
- Promoting partnerships for building the capacity of members and to facilitate mobilisation of resources.

10.1.2 Objective no. 2: To examine the challenges that CBOs encounter in response to HIV/AIDS as a development issue.

The other objective of the thesis was to identify challenges that CBOs face in responding to HIV/AIDS. Through out the thesis an acknowledgement is made that despite CBOs being appropriate and well positioned to offer a people focussed response, they face challenges some of them grave enough to send them in oblivion. The position of the thesis is that these challenges must be eliminated and CBOs capacitated in order to provide appropriate and sustainable solutions not only to HIV/AIDS but also to other development challenges. The common challenges that CBOs encounter in their response to HIV/AIDS include:

- Limited resources which can lead to limiting the scope of operation and dependency on outside resources.
- Lack of technical and managerial skills which can lead to poor coordination of CBO activities.
- Poor documentation of results because of limited literacy skills.
- Managing dynamics of volunteers' such as expectation of reward and burnout due to over work.
- Navigating entrenched cultural and traditional beliefs.

10.1.3 Objective no. 3: To propose recommendations that can make CBOs be more effective in responding community challenges.

Given the acknowledgement of HIV as development issue and the recognition of the role of CBOs and the challenges they face in responding to HIV/AIDS as a development problem, it is appropriate that these organisations are strengthened. The following are some of the recommendations to consider in order to make CBOs more effective in their response to HIV/AIDS:

- Incorporating HIV/AIDS into development work and utlilise poverty reduction strategies

- Building the capacity of CBOs to enhance their understanding of HIV/AIDS as a development challenge and for them to develop partnerships and be able to mobilise resources and scale up- their services.
- Forming CBOs coalitions so that they can strengthen their voice when dealing with government and other donors. This will also help to navigate donor and partner influence and condition.
- Encourage CBOs to capture and utilise local knowledge through the application of participatory methodologies such in their work.

10.3 The general conclusion

This thesis has established that HIV/AIDS is a development challenge that needs to be addressed using appropriate development approaches. It has brought to light the fact that HIV/AIDS respects no territorial borders or specific sector. However there are spatial disparities in terms of prevalence of HIV/AIDS with Africa and sub-Saharan African in particular being worst affected region of the world.

The thesis has also demonstrated that poverty drives HIVAIDS and HIVAIDS drives poverty implying that poverty eradication efforts must be intensified to avert a deepened development crisis. Because of the heterogeneity nature of the pandemic effective responses must be diverse and can only be achieved through combined efforts at local, regional and global levels (UN-OSAA 2003: Cock et al. 2002: 57). This means that efforts to fight the HIV/AIDS cannot be left to be handled by one sector alone. Partnership between the state, private sector and the civil society is invaluable. This will enhance better coordination, planning and implementation as well as mobilisation of resources from a broad base towards managing and sustaining HIV/AIDS interventions (Brown, Anyvalikli and Mohammed (2004:37-38). Political commitment and support from the highest level of leadership is imperative to forge a strong and sustained action HIV/AIDS and its impact.

The thesis has also brought about the realisation that though HIV/AIDS has negative development impact, efforts to deal with it have in a way contributed to the growth of CSO particularly CBO responses. These have reconstituted themselves as important development partners and that they have an important role to play in creating HIV/AIDS competent communities that spearhead the response through prevention, care and support, mitigating the impact, advocating for human rights and reducing stigma associated with HIV/AIDS (Jackson and Lee 2002: 216; Thornton 2003; Low –Beer and Stoneburner 2004a; 2004b; Panos Institute 2003; Rau 2006;). CBOs have demonstrated potential far greater than being mere service providers but also leaders in community-based responses to HIV/AIDS (UN/OSCAL 2002: 13). They can even be entry points for bigger development programmes (UNAIDS 2006a). Given that CBOs function in a manner that promotes development from below by motivating inclusiveness and promoting participation in local development endeavours it is very important that their work is recognised in mainstream development and their capacity developed and resources availed in order to maximise their complementary role to that of government and other partners.

Lastly, for those communities that want to start and manage successful CBOs to respond to HIV/AIDS or any perceived development challenge, they must ensure that:

- There is an accumulation of good knowledge and understanding of common local needs that need to act on.
- They build good communication channels and facilitate people's debate and dialogue about their perceived concerns on local issues that affect
- They build people's awareness through sensitisation regarding the issue to be acted on.
- They mobilise people to participate in community action and demonstrate that the benefits of participating outweigh the costs of not doing so.
- They set reasonable goals and objectives and applying participatory methods and processes.
- They create local ownership.
- They foster strong and good leadership and lobby the creation of a conducive political environment.

- They forge alliances and developing partnerships within and outside the community and mobilise resources.
- They build local capacity and develop knowledge and skills to carry out their activities.

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APPENDIX 1: DISCUSSION GUIDES

Discussion Guide for GCHBC CBO Volunteers

1. Personal introductions
2. Introducing the purpose of the discussion
3. How long have you been a volunteer with the GCHBC CBO?
4. What motivated you to be a volunteer with this CBO?
5 Please explain the reasons that have kept you involved in the CBOs activities?
6. Please explain when and how this CBO started?
7. What was the main reason that led to the formation of this CBO?
8. How are the day to day affairs of the CBO managed?
9 What services does the CBO provide?
10. Where does the CBO get its support to provide these services? (Explain if support comes from within the community of outside)
11. Who in this community are these services provided to?
12. What would you say are the major accomplishments of this CBO so far?
13. The CBO has been in existence for a long time now (since 1997). What do you think are the reasons that have kept it going for this long?
14. Reflecting on your experience with the CBO, what would you say are the challenges that the CBOs face?
15. How does the CBO try to deal with these challenges?
16. What are the challenges that you as volunteers experience?
17. How do you deal with these challenges?
18. What benefits has the CBO brought to the Gabane community?
19. What benefits has the CBO brought to you personally?
20. From your experience and the feedback you get from community member, how do people feel about the existence of the CBO and the services it provides?

Discussion Guide for Support Group Members

1. Personal introductions
2. Introducing the purpose of the discussion
3. When did this support group start?
4. How did this support group start?
5. When did you join this support group?
6. What made you join this support group?
7. How often do you meet?
8. What services does this support group provide?
9. What would you say are some of the benefits of belonging to this support group?
10. What challenges does the support group face?
11. What challenges do you as support group members?
12. How do you attempt to resolve these challenges?
13. What would you say is the role of the GCHBC CBO in this support group?
14. What would you say are the benefits of this support group to the community of Gabane if any?
15. Would you encourage the formation of such a support group in other villages? If yes, please explain why.

Discussion Guide for Kids Club members

1. Personal introductions
2. Introducing the purpose of the meeting
3. When did you join this Kids Club?
4. What made you join this club?
5. How do you fell about coming to this club every week?
6. What would you say are the benefits of belonging to this club?
7. What would you say members of this club get what others kids may not?
8. Would you encourage other kids to join this Club?
9. What reasons do other kids in the village give for not joining this club?
10. What challenges do you experience in this club?
11. How do you address these challenges?
12. What benefits do you see this club bringing to the village?

Discussion Guide for mangers of civil society organisations (CSOs) and some international volunteers

1. Introducing the purpose of the discussion

2. How long have you been working with civil society organisations?

3. What do you see to be the role of CSO in the responses to HIV/AIDS?

4. What do you perceive to be the major difference between NGO and CBOs?

5. Do you see differences in the role that NGOs and CBOs play in response to HIV/AIDS? Please explain.

6. From your experience what would you say is the major role of CBOs in the fight against HIV/AIDS?

7. From your experience what would you say are the strengths of CBOs?

8. From your experience what would you say are the weaknesses of CBOs?

9. From your experience what would you say are the challenges that CBOs face when responding to HIV/AIDS?

10. How do you think these challenges can be overcome?

11. What role do you perceive CBO to play in the mainstream development beyond HIV/AIDS services? Please explain.

12. What do you think should be done to maximise the role of CBOs in development?

13. What do you think should be done to create more awareness of activities of CBOs in development?

14. What recommendations would you provide to sustain the work of CBOs?

Appendix 2 List of capacity building activities conducted between 2005and 2007

Name of workshop	*Date(s) of Workshop*	*Target group*	*Attendance*		
			Male	Female	Total
Stigma and Discrimination Workshop	1 March 2005	Community leaders	13	18	31
Capacity Building Workshop	16–17 March 2005	Volunteers	18	33	51
Advocacy Workshop	14 April 2005	Village elders	25	35	60
C-IMCI Training Workshop	24–26 May 2005	Community members	19	11	30
C-IMCI Training Workshop	21–23 June 2005	Volunteers	41	9	50
Workshop on Basic Facts on HIV/AIDS	28–30 June 2005	Community members	44	6	50
Transformation Workshop for People Living with HIV/AIDS	15–19 August 2005	Support group	6	36	42
Community Mobilisation on Prevention, Care, Support and Treatment for HIV/AIDS patients Psychosocial Support and Care for Orphans and Vulnerable Children	15–19 August 2005	Community members	5	25	30
	24–25 August 2005		10	20	30
HIV Intervention Workshop	27 October 2005	China state employees	80	10	90
Training Workshop for Untrained Volunteers (GAMATHAKU)	February 2006	Volunteers in the Kweneng East Region	3	147	150
The Roles of Legal Service Providers in the Community (Marang Child Care)	February 2006	Gabane CHBC OVCs	15	37	52
Stigma and	March 2007	Church	29	6	35

Discrimination Workshop		leaders and community leaders			
Sexual Harassment and HIV/AIDS	March 2007	Gabane Primary School pupils	17	73	90
Total			325	466	791

Appendix 3 Future Plans of the GCHBC CBO (2013 Strategy)

The CBO has a five-year plan (2008–2013). This plan was developed with the help of one of the WUSC international volunteers attached to the CBO. The objectives of the five-year plan are:

- To improve GCHBC's capacity to fulfill the needs of its programmes
- To expand the reach and increase the effectiveness of the patient care programme
- To expand the reach and increase the effectiveness of the patient care programme.
- To expand the peer support given to people living with HIV/AIDS in Gabane
- To be running a fully qualified pre-school for 60 children by 2012
- To develop a structured kids' club programme by 2012
- To cover one-third of its operating expenses through income generation by 2012.

The Strategy

GCHBC is pursuing a three-phased strategy for development over the next five years, focusing first on stabilising the internal needs of the organisation, then improving the quality of services offered, and finally expanding its services.

Phase 1: Stabilisation (2008–2009)

The first phase will strengthen the foundation of GCHBC by focusing on resource mobilisation for currently operating activities. GCHBC has expanded at a rate that has stretched its capacity to provide its services. The first phase will include the financing and hiring of a centre coordinator, the licensing of the pre-school, and the financing of the salaries for the full-time volunteers: the pre-school teachers and the cooks. During this time, GCHBC will also seek in-kind donations of the resources needed for the preschool and the kids' club. GCHBC will also kick start its first income generation project.

Phase 2: Improve Quality of Service (2010–2011)

The second phase will focus on improving the services already offered by GCHBC. This will include the hiring of a social worker or counsellor who will provide psychosocial support to orphans and vulnerable children, the support group and patients as well as a family welfare educator to guide and supervise volunteers in their home visits to patients. GCHBC will increase the frequency of patient visits during this time and increase community outreach.

Phase 3: Expand Services (2012)

In the third phase, GCHBC will secure the financing for building a multi-purpose centre that will be able to house a daycare for patients, an after-school programme for the kids' club, two pre-school classes and the space to run workshops and outreach programmes.

The three-phase strategy will be applied to seven specific programmes of GCHBC, each related to one of the strategic objectives for the next five years. The success of each programme will be evaluated quarterly and annually against the indicators mentioned and the results communicated to partners and other stakeholders.

Physical and Human Infrastructure Improvement Programmes

Objective 1: **To improve GCHBC's capacity to fulfill the needs of its programmes**

Project Summary: In phase 1, GCHBC will seek resources necessary to hire a full-time coordinator who will manage the various programmes, mobilise resources and partnerships, and be responsible for monitoring and evaluating the centre's activities. GCHBC will also seek resources to pay full-time volunteers especially the two pre-school teachers and the cooks. GCHBC will install an alarm system, a sewerage line, and clean up the grounds to ensure safety of the children.

In Phase 2, GCHBC will hire a counsellor and a family welfare educator to increase the amount of psychosocial support for the various programmes. It will seek funding to pay volunteers a monthly stipend. It will build a kitchen facility and install computers in the schoolhouse.

In phase 3, GCHBC will begin to construct a multi-purpose centre, which will include a large hall, office space, a patient rest area and rooms for the support group and the kids' club. GCHBC will obtain another van so that it can transport patients to the centre.

Support Group Programme

Objective 2: **To expand the peer support given to people living with HIV/AIDS in Gabane.**

Project Summary: During Phase 2, GCHBC will develop a more structured peer counselling system with several members of the support group being trained in-depth in peer counselling for people living with HIV/AIDS. These peer counsellors will in turn train other members of the support group on how to discuss HIV/AIDS related issues with their families, friends and the community. The support group will seek a micro-finance arrangement for its members to be able to develop small income-generation projects.

Patient Care Programme

Objective 3: **To expand the reach and increase the effectiveness of the patient care programme.**

Project Summary*:* As the volunteers cannot make a large time contribution without incentives, the first phase of the improvement programme will be to secure a small stipend for each volunteer. GCHBC will implement a volunteer-scheduling system and require each volunteer to track the time they spend with patients. When the multi-purpose centre has been built, a day care for patients will allow GCHBC to better monitor its patients' medication and nutritional intake.

Preschool programme

Objectives 4: **To run a fully qualified pre-school for 60 children by 2012.**

Project Summary: GCHBC will first license the pre-school with the department of social services. It will have its two teachers certified for teaching pre-school children and will develop a curriculum for the children's education. GCHBC will increase the nutritional balance of the two meals provided to children.

Kids' Club Programme

Objective 5: **To develop a structured kids' club programme by 2012.**

Project summary: In the short term, GCHBC will seek donations of items for the children's activities, so they can practise their artistic and athletic skills. GCHBC will expand the role of the kids' club leadership to develop a structured activity plan for the children's weekly meetings. In the long term, the kids' club will develop a small after-school programme where children will have access to books and tutoring support.

Outreach Programme

Objective 6: To educate and train the community about HIV/AIDS-related issues

Project summary: GCHBC will train various groups of people on HIV/AIDS issues including:

- Pastors, on how to communicate about HIV/AIDS matters and on the pastoral counselling of people living with HIV/AIDS
- The support group, on how to counsel their peers
- The community, about orphan issues and patient care
- Patients, on proper health practices.

GCHBC will establish a schedule of training and will seek help from various organisations in Botswana for the preparation and facilitation of the workshops.

Income Generating Programme

Objective 7 **To cover one-third of operating expenses through income generation by 2013**

Project Summary: GCHBC will seek the support of the Ministry of Education as well as microfinance organisations to receive the training and obtain the loan to begin the small business. GCHBC is currently exploring the potential of several different opportunities and will seek technical assistance in choosing the best option for the organisation.