Capacity Building IN TIMES OF HIV & AIDS

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Capacity Building in Times of HIV & AIDS

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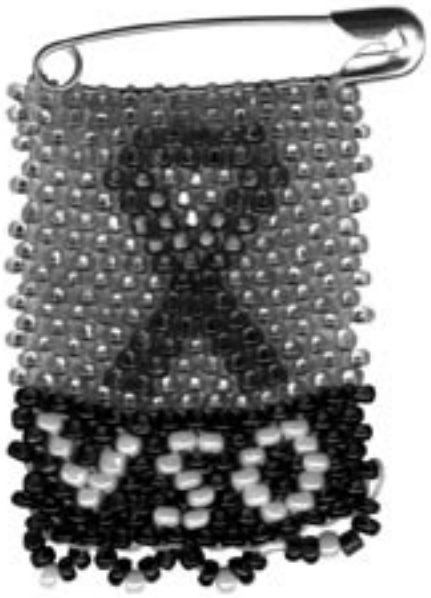

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Acronyms

ASO
AIDS service organisation

CAA
Catholic AIDS Action; large faith-based NGO in Namibia

CBO
community-based organisation

DFID
Department for International Development (UK)

DPMCAS
Provincial Directorate of Women and Coordination of Social Action in Mozambique

ETC
Crystal, public health consultancy group, working in the field of health programme management, health sector reforms, training and applied research. It is a business unit within ETC International, a not-for-profit but market-oriented organisation based in Leusden, the Netherlands

FACT Mutare
Family AIDS Caring Trust, NGO in Mutare, Zimbabwe

IT
information technology

KCTT
Kara Counselling and Training Trust, NGO in Zambia

LoveLife
collective label for a series of high-profile HIV & AIDS prevention initiatives in South Africa. Implementation is by existing organisations one of which is PPASA, a VSO partner organisation

M&E
monitoring and evaluation

MANASO
Malawi Network of AIDS Service Organisations

MONASO
Mozambique Network of AIDS Service Organisations

NGO
non-governmental organisation

PLWHA
people living with HIV & AIDS

PPASA
Planned Parenthood Association of South Africa

PSO
Dutch organisation that enables capacity building in developing countries (formerly Personnel Service Overseas)

RACOC
Regional AIDS Coordinating Committee in regions of Namibia

RAISA
Regional HIV & AIDS Initiative of Southern Africa

SRH
sexual and reproductive health

STI
sexually transmitted infection

UNAIDS
the joint United Nations programme on HIV & AIDS

UNITAR
United Nations Institute for Training and Research

VCT
voluntary counselling and testing

VDW
VSO development worker

VSO
Voluntary Service Overseas

Glossary of Key Terms

Back office
Functions of an organisation that are related to running the internal organisation (systems and processes like management, administration, finances). These functions enable the functioning of the organisation's front office

Capacity building
Capacity building is a process, a means to an end, leading to a 'capable organisation'. What constitutes capacity building and a 'capable organisation' must be defined in any given context

Capacity-building interventions with a multiplier dimension/effect
Capacity-building interventions that are designed to strengthen expansion and replication of good practice

Front office
Functions of an organisation that are directly related to the provision of services to clients

Mainstreaming
VSO-RAISA defines mainstreaming as 'the concept of addressing HIV & AIDS both internally and externally in all sectors, at all levels, particularly where the pandemic might not ordinarily be addressed'

Preface

In the mid-1990s, while working on HIV & AIDS with a regional NGO based in Zimbabwe, an inquisitive VSO development worker, Tim Lee, engaged me in thoughtful conversation around a possible regional VSO initiative on HIV & AIDS. We shared the concern about the nature and impact of the spread of HIV & AIDS in southern Africa. At that time, it was obvious that not enough was being done and many people and organisations underestimated what was happening. It was a great pleasure to meet an informed and critical mind, who was commissioned by VSO to undertake a feasibility study to find out how VSO could become involved with HIV & AIDS at a scale that was far beyond the single placement of one person, the scale of VSO's involvement with HIV & AIDS at that moment. The detailed suggestions articulated by Tim Lee resulted in the Regional AIDS Initiative of Southern Africa (RAISA), launched in 2000 by VSO. Three years later VSO first engaged the services of a colleague, Joanne Harnmeijer, to undertake an external review of capacity-building efforts in RAISA and later my services were contracted to undertake a mid-term review, an opportunity not to be missed.

Earlier prescriptive approaches to HIV & AIDS are beginning to be replaced by more appropriate responses that link HIV & AIDS to responsible employership, refocus services, reassess the client/customer base and address the gender dimensions of the HIV epidemic wholeheartedly.

One of the main dilemmas encountered over the years as a development professional and working on civil society organisations appears to be:

In impacting on Civil Society Organisations capacity, HIV/AIDS has a Janus face. On the one hand is short-term stress on emotions, livelihoods and coping capacities that require urgent responses. But simultaneously, there are deep structural losses to society that call for a generational perspective and time scale for investment.
(Fowler 2004, page 12)

Such quotes as this one could be interpreted as if interventions to curb the spread of HIV, cope with AIDS and respond to the impact are fruitless as they are isolated drops in a sea of problems and misery. This would be a negative and even disrespectful stance. Civil society organisations are engaging with HIV & AIDS much more forthrightly than during the 1990s. Still, it would be foolish to deny that recent research conducted by various researchers in Malawi, Zimbabwe, South Africa, the United Kingdom and the Netherlands shows that NGOs and other civil society organisations continue to struggle to adapt to the impact of HIV & AIDS on the internal organisation and the changes to their operating environment.

Working with organisations that operate in a high HIV prevalence environment on a day-to-day basis will reveal how organisational life is struggling to include the many realities of HIV & AIDS. Earlier prescriptive approaches to HIV & AIDS are beginning to be replaced by more appropriate responses that link HIV & AIDS to responsible employership, refocus services, reassess the client/customer base and address the gender dimensions of the HIV epidemic wholeheartedly. Over

the years it has become obvious that some organisations are being overwhelmed; others, however, have worked out an adequate response and continue to explore further actions. A sustained response to the HIV epidemic and its input will require us to re-examine earlier positions and 'rules' on the assessment of sustainability, the role of technical assistance and partnership. In the longer term the service-oriented model and extreme donor dependency will probably need to be examined if NGOs and other civil society organisations are to maintain their role as social innovators. Examination of and reflection on progress will need to be linked to transparency and accountability in creative ways. VSO's engagement with HIV & AIDS occurred at the same time that the organisation sought to make the transformation from being a volunteer sending agency to becoming a development agency.

VSO responded to the challenge of HIV & AIDS by developing a regional programme in Southern Africa. This programme had to operate in different settings and worked with a wide range of different organisations; in most countries this included working with the movement of people living with HIV & AIDS, thus applying the principle of the 'greater involvement of people living with AIDS' or GIPA. So far too few development organisations have dared to follow that example. The RAISA programme has demonstrated that it is possible to develop partnerships, identify placements and other capacity-building interventions, and combine them in such a manner that contributes significantly and in different ways to the capacity to deal with HIV & AIDS.

By assessing the dilemmas faced, by reflecting on our experience, we can begin to conceptualise new or further ways forward. This demands that we take a step back and make our tacit experiences explicit which, in turn, requires that we document our achievements in an honest manner and that we recognise that working on HIV & AIDS is possible if we adopt a learning approach. Such an approach can be compared with travelling and visiting a strange community, village or country. We need to learn as we are walking around, we need to look for clues and identify how people behave, respond and are organised. It is this open mind of the traveller, who is grateful for brief encounters and unasked-for assistance, combined with the ability to accept that we make mistakes that would serve us well in dealing with HIV & AIDS. It is in this spirit that I suggest that the reader approaches this VSO-RAISA publication.

Following the reviews mentioned VSO has taken the time to reflect and develop a new conceptual framework for further programme development; thus VSO has managed to build on their earlier experience. It is expected that this framework, developed in action, will ensure that VSO is able to move beyond the realms of the first RAISA programme into a second-generation programme that includes dimensions of assisting their partners to scale up and out. Given the need for civil society organisations, including capacity-building organisations, to learn how to respond to HIV & AIDS, one can only hope that other parties will benefit from this exercise in reflection and transparency.

It is worth reading this brave effort with care and thought; I hope that it will inspire you and your organisation to identify its own strategy of engaging with HIV & AIDS. I wish you the courage and dedication shown by many of the VSO development workers consulted for this publication.

Russell Kerkhoven
Head Knowledge and Learning Centre
PSO – Capacity building in developing countries.

Executive summary

EXECUTIVE SUMMARY

HIV & AIDS does not mean development business as usual. The HIV & AIDS pandemic leads to specific challenges for development agencies and for their partner organisations. In high-prevalence countries, civil society organisations and governmental institutions are all affected by HIV & AIDS and need to address the ever-changing challenges around the pandemic. This forces development organisations to analyse how the demands and effects of the HIV & AIDS pandemic determine the needs of their partner organisations and what implications this has for their capacity-building interventions. They are challenged to look at capacity building 'through an HIV & AIDS lens'.

This publication is based on external evaluations of capacity-building interventions within the Regional AIDS Initiative of Southern Africa (RAISA), a programme of the international development agency Voluntary Service Overseas (VSO). The RAISA programme is a clear statement of intent to start on a learning curve of responding to the spread and impact of HIV & AIDS and to tackle the development management challenges that HIV & AIDS presents to development practitioners, development organisations and technical assistance agencies in particular. The programme supports both organisations that have HIV & AIDS as their main focus (e.g. AIDS service organisations or ASOs) and organisations working in different areas that are challenged to adapt their external service role to deal with the effects of HIV & AIDS.

Defining general challenges of organisations working in an HIV & AIDS environment

Eight case studies are presented, giving examples of the work of some RAISA partners, their capacity-building needs, the support provided by VSO-RAISA and the lessons learnt.

Based on these lessons learnt, general organisational and institutional challenges faced by partners are identified, with regard to their back-office work, their front-office work, and going to scale:

1 Dealing with the impact of HIV & AIDS on their own workforce

HIV & AIDS is affecting not only beneficiaries of partner organisations, but also their own staff. A lot of partner organisations face growing direct organisational costs for sick and compassionate leave, medical expenses, funeral expenses and management time. At the same time, work performance is inhibited by emotional stress, stigma and sickness; and knowledge, learning and experience are lost when staff members stop working or pass away. These challenges are driving organisations to strengthen such responses as HIV & AIDS workplace programmes, the training of additional staff, adjustments to medical care packages or the addressing of stigma and denial within their own institutional set-up and in its core businesses. At the same time, the nature of and opportunity for capacity building comes into question.

The functioning of the back office is not only challenged directly by an impact on the workforce. HIV & AIDS is also changing the *scale and way of working* of these partner organisations, requiring organisational change and development of the back office.

2 Ensuring that front- and back-office operations are synchronised and mutually supportive

Many rapidly expanding HIV & AIDS organisations struggle to keep their houses in order and ensure that front- and back-office operations are synchronised and mutually supportive. As a result of the growing need for their services, many HIV & AIDS organisations experienced rapid growth in terms of their service delivery, number of staff and the funds that need to be managed. These organisations need to strengthen their finance and administration systems to keep up with the workload and the size of the organisation. The expansion of services is not sustainable if there is not a strong supporting back office.

3 Positioning and innovating

The constant pressure to deliver and expand services also brings challenges with regard to the strategic positioning of HIV & AIDS organisations. These organisations are confronted with needs and expectations beyond their capacity and capability; they are occupied with 'doing' and they struggle to find time and capacity for strategic planning, monitoring and evaluation, reflection and learning and for acting on these. Yet the capacity to position oneself strategically and to keep innovating are crucial elements if an organisation is to be strong and able to respond effectively to the pandemic. Organisations need to strengthen their capacity to face their limitations, to find their niche, to focus on certain aspects, to decide what can be done better by other organisations, to keep in phase with the pandemic and to proactively position themselves. They must develop good systems for reflection, learning, and planning to support these strategic decisions.

4 Developing, expanding, improving and/or adapting front-office services

HIV & AIDS organisations face challenges in improving, expanding and adapting their front-office services to changing and growing needs as a result of the pandemic and this is closely linked to the above-mentioned 'positioning and innovating' and 'going to scale' capacities of the back office. HIV & AIDS organisations need technical support in developing new or better services, and in developing models that have a built-in multiplier mechanism.

5 Going to scale

The impact of organisations on the pandemic depends both on the quality of interventions (and their effectiveness) and on their coverage. The challenge to organisations is to find ways to replicate models of good practice at the lowest possible cost. This can include expanding their operations, developing new models of good practice and creating multiplier mechanisms; these include sharing models of good practice (which are then adopted by other NGOs and/or by government), horizontal learning, twinning, introducing cascade models, setting up networks and influencing changes in the policies and actions of governments and donors. For 'going to scale' to be effective, it needs to be backed up by a lot of organisational and institutional capacities mentioned under points 2 and 3 above: for example a solid administrative and management system, a clear vision on the role of the organisation and the way going to scale fits in that strategy and a system for learning.

The five general needs areas described above are relevant for both HIV & AIDS organisations and organisations that don't have HIV & AIDS as their main focus. The latter group faces similar challenges. They need to deal with the impact of HIV & AIDS on their own workforce as well. They also face challenges with regard to positioning and innovation, as they have to find ways to deal with and adjust to the pandemic in a way that is congruent with their core business. As a result of their changed role, they may face sustainability challenges as their services expand and their organisation grows, and the need for back-office–front-office synchronisation increases. Also, the need to find ways to adjust their services to the pandemic may require technical support for the front office.

Redefining capacity-building roles

Drawing on the case studies and the main findings with regard to general needs of partner organisations, it becomes clear that HIV & AIDS forces VSO and other development organisations to redefine their capacity-building roles.

Outward support roles, such as *professional and technical assistance* to services of partner organisations, often involve introducing additional methods that further expand the services that respond to the partners' growing needs or adapting services to the HIV & AIDS reality. Organisations are supported to start up HIV & AIDS-related services that were not there before or apply new mechanisms. This support to partners' front-office work is provided through facilitating the sharing of experiences and good practices between organisations, or through placements of external advisors. It is in such placements that HIV & AIDS advisors coming from other high-prevalence countries have an invaluable advantage. Development organisations need to be aware that the nature of the pandemic makes the outward support roles

of development workers hard, as in these roles they have to deal with stigma and the acute difficulties brought about by the disease. There is a need to arrange for HIV & AIDS-relevant counselling and support.

As well as front office support, more inward *management assistance* must be provided to support partner organisations to keep their internal systems in order and ensure that front- and back-office operations are synchronised and mutually supportive. This management assistance is crucial for the sustainability and effectiveness of developing and fast-growing HIV & AIDS organisations, especially in areas such as strengthening and reshaping internal systems for financial administration, human resource management, resource mobilisation and information management. For bigger, national-level partner organisations this may also include supporting the decentralisation of their work through increasing numbers of satellite offices. This back-office support is often provided by training and advisors.

The next level of institutional challenge is supporting *organisational development* in partner organisations. There is a clear need to support positioning, strategy development, planning, monitoring and evaluation, and reflection processes, especially in times of HIV & AIDS when organisations are challenged to identify their niche and strategic focus, knowing when to stop expansion or learn and identify good practices. A hallmark of strong organisations is that they realise when to opt for consolidation rather than further expansion.

Support to *relational development* between HIV & AIDS organisations is extremely important. Networks and partnerships need to be strengthened to improve coordination and create multiplier mechanisms such as sharing models of good practice, cascade models, and spin-offs to policy level. This includes support for preparing models of good practice that can be replicated by other users (based on or as a follow-up to models of good practice resulting from the support roles mentioned above).

For an effective response to HIV & AIDS, *national frameworks* also need to be *strengthened or adapted*. For example, changes in legislation might be needed to enable NGOs to replicate good practice.

It needs to be stressed that a lot of these capacity-building roles are happening at the same time, or in progression, depending on the needs or partner organisations and their organisational development (maturity). In programme design, organisational capacity building strategies should be developed that take into account the specific needs of the partner organisation, the stage of organisational maturity of an organisation, the specific capacity-building roles required from the development agency, the 'progression' from one support role to another, and the multiplier dimension.

All capacity-building roles should be strengthening mechanisms for expansion, replication and sharing of good practices to keep up with the growing needs of the pandemic.

A special form of capacity building in times of HIV & AIDS (that can involve all types of capacity-building roles described above) is building capacity for *integrating and mainstreaming HIV & AIDS*. Every organisation in every sector in a high-prevalence country is affected by HIV & AIDS. However, this does not mean that all these organisations have recognised how HIV & AIDS affects their own workforce and core business. Often a readiness to address the issues is lacking. Development agencies such as VSO can play a role in building capacity for mainstreaming in their partner organisations by supporting the identification of the right entry point. HIV & AIDS needs to be mainstreamed in organisational strategy, planning and everyday activities with target groups, including workplace policies. In virtually all sectors there are entry points for meaningful HIV & AIDS-related work that stands a chance of being sustained. Generally, the closer the opportunity is to the core of the partner organisation's mission and work, and to the interest of its senior staff, the greater is the likelihood of its being successful.

Judgement on the effectiveness of these capacity-building roles must take the degree of difficulty into consideration. The effectiveness of relatively straightforward inward roles (e.g. setting up a database for orphan registration) cannot be judged the same way as complex outward roles (e.g. setting up a relevant large-scale community-based service for orphans). Where judgement can be unambiguous is in the multiplier dimension of capacity-building roles. This is a dimension of 'capacity' (capacity as in 'scale') which is inherent to a pandemic, but which is not usually acknowledged. All capacity-building roles should be strengthening mechanisms for expansion, replication and sharing of good practices to keep up with the growing needs of the pandemic.

Redefining impact

The reality of the pandemic in high-prevalence countries requires a new take on concepts and assumptions which are rarely questioned, or that most people take for granted. Impact normally has the connotation of 'improvement'. However, in the current crisis impact at the individual level can be as unassuming, but significant, as 'dying with dignity', as opposed to dying in solitude on a bare concrete floor.[1] Based on the field visits and her experience, Harnmeijer suggested that the most appropriate dimension of impact would be 'replication of models of good practice, at the least possible cost' (2003, p.27). This cannot fail to benefit the target group, including women and people living with HIV & AIDS, since lack of any HIV & AIDS appropriate services is the rule rather than exception. The point is: everybody is affected, and systems such as the health system and the education system need all-out transformation, not just a partial solution or a solution for a fragment of the population. Real impact that is measurable in terms of decreasing HIV & AIDS infection rates depends both on the quality of interventions (and their effectiveness) and on coverage. Therefore it was recommended to aim for capacity-building support that incorporates the strengthening of multiplier dimensions. Development organisations such as VSO need to support their partner organisations working in an HIV & AIDS environment in such a way that effective and qualitative interventions are scaled up. Only then can these partnerships result in real impact.

Redefining organisational capacity

Harnmeijer also suggests that organisational effectiveness is a reliable indicator of impact. In normal times (read 'stable conditions') characteristics such as transparency, accountability, and the drafting of policies and procedures are indicative of a strong organisation. Harnmeijer is making the point that in the trying times of the HIV & AIDS pandemic organisations dealing with the growing demand for HIV & AIDS services become 'strong' of necessity. Organisations that have managed to respond effectively to the pandemic have a proven track record of fast growth and adaptive responses; they have learnt by doing, analysed and reflected on their implementation experience; they have been able to stick to their core values and they knew when to stop the expansion of their work and coordinate and network with others. They acquired the characteristics of transparency, accountability, and so on, as they moved along. It is inconceivable that these organisations would have been able to deliver without the conventional qualities of capacity. In other words, their capacity is prompted and shaped by the opportunities and difficulties the pandemic poses. And, similarly, as their capacity improves they are increasingly able to respond. The ability of organisations to be proactive and responsive to the pandemic is thus a superior measure of an organisation's capacity. Organisations that are corrupt or manage to thrive on the crest of donor money for a while will not be able to respond *effectively* to the pandemic at the same time.

There is an argument that capacity itself can be self-demonstrating because of HIV & AIDS. This would mean that by monitoring and evaluating organisational development in the five main needs areas described above, proxy indicators could be given of the organisational capacity to respond effectively to the HIV & AIDS pandemic. These findings need to be further analysed.

Organisations that have managed to respond effectively to the pandemic have a proven track record of fast growth and adaptive responses; they have learnt by doing, analysed and reflected on their implementation experience; they have been able to stick to their core values and they knew when to stop the expansion of their work and coordinate and network with others.

[1] Kara Counselling and Training Trust (Zambia), *Strategic Plan 2003–2005*, page 29, on indicators for Jon Hospice. Some telling examples: 'peer support among children with terminal illnesses'; 'number of patients accepting their illness and dying peacefully'. See Case Study 3.7 for further information on KCTT.

VSO-RAISA

The external reviews have showed that in the RAISA programme there are numerous examples of VSO supporting partner organisations in one (or more) of the five general needs areas listed above. The new insights into general partner-needs areas as presented in this publication will contribute to further focus in partner assessments and the design of more appropriate capacity-building interventions.

The reviews also recognised that VSO-RAISA is undertaking the five capacity-building roles (plus mainstreaming) described above. Through these roles (and sequential placements) VSO-RAISA plays a significant role in strengthening back-office and front-office operations in partner organisations. Both Harnmeijer and Kerkhoven mentioned the increased confidence and capacity of RAISA partners to discuss their internal dynamics and the clear focus that some of the organisations had adopted due to the partnership with VSO-RAISA. Harnmeijer noted the increased capacity of RAISA partners to articulate their own position and more realistic ambitions in the response to HIV & AIDS. The impact of capacity building in the sense of an improved organisational response to HIV & AIDS is obvious from the remarkable confidence and openness with which organisations are able to discuss their internal change process, the way they articulated their focus on HIV & AIDS and the importance they attached to improved internal systems development. Following Harnmeijer's argument about self-demonstrating organisational capacity, this is an important achievement.

The consultants indicated that RAISA has created some multiplier effects by facilitating horizontal learning and the exchange of experiences between partner organisations (through facilitating exchanges, study tours, conferences, workshops etc.), but the challenge is to incorporate a multiplier dimension in the design of all capacity-building interventions.

Recommendations for capacity-building providers

In times of HIV & AIDS, development organisations like VSO need to design appropriate responses to the identified general needs for capacity building in the front and back offices of partner organisations. These capacity-building roles need to incorporate a multiplier dimension and need to recognise the implications of redefined concepts such as impact and organisational capacity **(see Table 1 on page 10)**.

The challenge for VSO and other development organisations is to develop appropriate capacity-building roles for partner organisations in HIV & AIDS environments, identify opportunities for multiplier dimensions and monitor the development of organisational capacity as well as the organisation's impact on the pandemic in terms of replication of models of good practice at the least possible cost. This implies that they need to strategise the sequence of capacity-building roles in order to be able to build on achievements. For example, the 'positioning and innovation' capacity is a logical follow-up of mutually supportive front-office and back-office operations, but also shapes the multiplier potential and outward role of the organisation ('going to scale'). This will not always be a straightforward process. Support needs to be designed in a way that allows some kind of 'flow' to respond to situations as they occur, and which cannot always be predicted. Donors may find all this fluidity hard to accept because it is by nature undefined. Yet sticking to the reverse makes for stagnation, which is in no one's interest.

This publication has showed that capacity building in times of HIV & AIDS is a far from conventional endeavour, which extends beyond what used to be seen as capacity building. The HIV & AIDS pandemic leads to specific challenges for partner organisations related to expanding services and organisations, adapting their core business to HIV & AIDS, developing systems for learning and sharing of good practice, and creating multiplier effects to counter the pandemic. Development organisations like VSO need to support this organisational change and development in partner organisations; they need to reconsider concepts like impact and organisational capacity and they need to change their capacity-building interventions and monitoring and evaluation practices accordingly.

Table 1: Capacity-building roles of development organisations such as VSO

Roles	Dimension of capacity building	Strengthening/addressing	Incorporating a multiplier dimension
Professional and technical assistance	Building individual capacities (human resource development)	Addressing front-office challenges: Strengthening service delivery *skills*, to expand, improve, adapt or develop services	Capacity building in this need area should involve the developing service models that have a built-in multiplier mechanism. The interventions need to be designed not only to serve unusual and rapidly increasing needs such as orphan care, but also to do this in a way that is replicable. Usually there are forms of peer review and peer learning built in the more successful formulae
	Building organisational capacity (organisational development)	Strengthening service delivery *systems*, to expand, improve, adapt or develop services	
Strengthening management systems	Building organisational capacity (organisational development)	Addressing back-office challenges: Ensuring that front-office and back-office operations (such as management, administration and finance systems) are synchronised and mutually supportive	The case studies showed that multiplier effects were achieved by providing this type of assistance to umbrella organisations. In this case an outward multiplier role may be added by offering similar services to member organisations of the umbrella organisation
		Strengthening the capacity to deal with the impact of HIV & AIDS on the own organisation	
Strengthening mission, goals and strategies	Building organisational capacity (organisational development)	Addressing back-office challenges: Strengthening the capacity of positioning and innovation	Although essentially serving the organisation itself, the outcome of strengthening positioning could be a more outward-looking organisation, with multiplier potential
Relational development	Institutional development	Addressing challenges related to going to scale: Strengthening sectoral and intersectoral networks and partnerships	Relational development has an inherent multiplier dimension: a focus on expansion and replication to be achieved through organisational means such as networks or cascades or the application of horizontal learning methods such as sharing, developing best practice, twinning and forms of mentoring. This will be based on (or a follow-up of) models of good practice as a result of the roles described above
Strengthening national frameworks	Institutional development	Addressing challenges related to going to scale: Strengthening national policies and supportive legal frameworks	This again links the roles described above, for example through a partner organisation's role in national theme groups, providing on-the-ground experience of newly developed best practice There is strong need for the adaptation of policies and legal frameworks which would enable the multiplication of good practice

Chapter 1

CHAPTER 1

Introduction

VDWs working hand-in-hand with their colleagues

VSO is an international development organisation that primarily works through development workers. VSO works in 38 developing countries towards a set of development goals identified in country strategic plans, linking the priorities of VSO's partner organisations, international development targets and VSO's distinctive competence. HIV & AIDS is one of the six corporate goals. VSO aims to combat stigma, support prevention and increase the availability of treatment, care and support for those infected and affected by the HIV & AIDS pandemic.

In 2000 VSO started its four-year Regional HIV & AIDS Initiative of Southern Africa (RAISA) in six southern African countries (namely Malawi, Mozambique, Namibia, South Africa, Zambia, and Zimbabwe). The purpose of the RAISA programme is to strengthen the capacity of civil society and government to develop and implement multi-sectoral responses to HIV & AIDS challenges in prevention, care, access to treatment and voluntary counselling and testing (VCT). Special attention is given to the reduction of stigma, gender issues, people living with HIV & AIDS (PLWHA) and orphans and vulnerable children. The main sponsors of the first phase of the initiative, which ended in 2004 and had a budget of £2.8 million, were the UK Department for International Development (DFID), The Big Lottery Fund and PSO.

In 2003 two external reviews were undertaken for RAISA, one initiated by VSO and one by two of the main donors of RAISA – DFID and PSO. Joanne Harnmeijer (ETC Crystal) reviewed and formally documented experiences, results and the effectiveness of capacity building placements in a selected group of RAISA partners (Harnmeijer 2003). Russell Kerkhoven (ETC Crystal) and Phineas Murapa (PricewaterhouseCoopers) reviewed the overall achievements of the programme and the ways in which it has been able to contribute to capacity building in times of HIV & AIDS. The learning from both reviews was used to develop a second phase for the RAISA programme, starting in April 2005.

This publication presents the main lessons and best practices identified in the afore-mentioned reviews and makes the experiences of VSO-RAISA more widely available to an internal and external audience. This paper integrates the learning from both of the complementary external reviews and pulls out key issues and lessons for VSO-RAISA staff, partners and other organisations working in HIV & AIDS. Through this publication VSO aims to highlight the processes whereby capacity building has taken place, to identify helping and hindering factors and so to outline the strengths and weaknesses of this approach, and to propose actions to strengthen capacity-building interventions in times of HIV & AIDS.

The publication will discuss how HIV & AIDS tests the capacity of partners, what their capacity-building needs are in various stages of organisational development, how VSO has supported them and, finally, what general lessons can be learnt for organisations involved in capacity-building programmes in the context of an HIV & AIDS pandemic. With this publication VSO aims to develop its understanding and skills to respond, in order to be better equipped to support partner organisations in responding to the HIV & AIDS crisis. At the same time VSO aims to make a theoretical contribution to the debate around capacity building in times of HIV & AIDS, and to provide some tools for other development organisations working in this field.

VSO aims to combat stigma, support prevention and increase the availability of treatment, care and support for those infected and affected by the HIV & AIDS pandemic.

Chapter 2

Capacity Building in Times of HIV & AIDS – the Conceptual Framework

2.1 HIV & AIDS

Southern Africa has the regrettable position of being the region most affected by HIV & AIDS in the world. HIV prevalence rates continue to rise in most countries. South Africa currently has the highest number of HIV-positive people in the world.

Primary school in Soweto, South Africa painted with HIV & AIDS slogans

Zimbabwe continues to have high HIV prevalence rates; an astonishing 30% of the adult population is estimated to be HIV positive. There are some anecdotal or incidental reports of HIV infection rates levelling off, but overall the current HIV infection rates indicate that southern Africa continues to carry the burden of high numbers of people living with AIDS and care needs will be increasing in five to ten years' time. A fully fledged AIDS pandemic is maturing in many African countries, as much greater numbers of people – who acquired HIV over the past several years – fall ill. In the absence of massively expanded prevention, treatment and care efforts, the AIDS death toll on the continent is expected to continue rising before peaking around the end of this decade. This means that the worst of the pandemic's impact on those societies will be felt in the course of the next decade and beyond.

It seems increasingly likely that southern Africa will face reversals of important development achievements in the areas of health, education and social services. This impact is increasingly becoming visible at community and household levels in the most affected urban and rural areas. Lasting changes in household and community characteristics will lead to the emergence of increasing vulnerability, and the breakdown of coping capacities. According to Russell Kerkhoven, the impact of the increase in orphans, which in many situations has begun to exceed the mythical 'African extended family', will lead to age groups that have limited socialisation and poor parenting skills and that lack essential stability. It will clearly have major long-term effects on operations, planning and future developments. This negative cascade of small and large shocks will increase the distinction between those households that are able to cope and respond and those that survive or simply end up without essentials such as access to productive resources, shelter and food. Even though the impact of the HIV & AIDS response remains unclear the need for sustained action that gives people some control over their lives and is centred on mobilisation is obvious.

The state of the response coordinated by the national authorities obviously varies from country to country. In southern Africa the governmental response depends on the effective coverage of the health and outreach services for prevention, care and support. Although HIV & AIDS is termed a developmental or multi-sectoral problem, the health sector is generally expected to be the primary service-delivery actor. The education sector is often the second leading governmental actor in delivering the national HIV & AIDS response. Sadly, these ministries appear to be the most depleted by the spread of HIV & AIDS, as these essential development services are heavily affected by staff attrition rates. The achievement of development goals set in the past (i.e. the Millennium

Development Goals) that depend on the sustained delivery of basic services will become problematic and often impossible to realise.

The long-term consequences of HIV & AIDS are becoming apparent.[2] In the immediate future, large capacity problems will be observed in important developmental sectors such as health care, education, agricultural production systems and governance. The health care sector is particularly badly affected with capacities already being overwhelmed by the increase in patients. At the same time the need for extended and more complex interventions (e.g. in treatment and counselling) is increasing. Staff attrition, burn-out as a result of staff's growing workload and staff attending an increasing amount of funerals will add to the capacity problems. The daily functioning of organisations will be affected and as a result so will be the quality of their services.

It can be expected that development organisations like VSO will operate in an AIDS environment for well over a decade. Understanding and following the dynamics of HIV & AIDS in southern Africa and translating this into coordinated development action is required in order to use resources effectively and to respond to the needs and demands of the people. Responding to this changing environment – characterised by an ongoing deterioration of human development indicators and in many countries a heavily affected civil society – will require an ongoing commitment. As the pandemic and its outcome continue to surprise, working in this setting will require a smart combination of focus and learning at all levels involved. One important area of learning is capacity building in times of HIV & AIDS.

2.2 Capacity building

The term 'capacity building' is usually applied to interventions that aim to strengthen the ability of an organisation to improve its performance; for example, services to target groups. The focus is on improving the capacity of the organisations, not just the capacity of the individuals who work within them. Considerable confusion arises when 'capacity building' is used as a generic term without some qualification as to the *type* of capacity which is being built. Defining what is meant by 'capacity building' should help to identify more clearly the particular purpose of any capacity-building intervention and provide a framework within which to develop partnerships.

VSO in general, and RAISA specifically, is focusing on capacity building. Within RAISA, VSO is building the capacity of HIV & AIDS organisations by strengthening service delivery systems, management systems, strategies, networks and supporting the development of national policy.

Within RAISA, VSO has various ways to support capacity building in partner organisations: through placements of development workers (recruited in Canada, Kenya, the Netherlands, the Philippines, the United Kingdom, India and Uganda), small grants and facilitating (horizontal) learning and networking between partner organisations in exchanges, workshops and conferences. Capacity-building needs of HIV & AIDS organisations are identified through participatory assessments. Areas in which support is needed vary per organisation, but capacity building is focused on the front offices (provision of services to target groups) as well as the back offices (internal systems and management structures) of partner organisations.

In addition to supporting HIV & AIDS organisations, RAISA also works with organisations in different sectors that are challenged to adapt their work to respond to the realities of HIV & AIDS. Internal organisational responses to HIV & AIDS are necessary within all sectors (HIV included). VSO works with partners to realise these multi-sectoral responses through an integration and mainstreaming framework.

Part of VSO's work falls outside the capacity-building remit, as it concerns operational service delivery. Although service delivery often involves some building of the capabilities of individual beneficiaries, the main focus of such interventions will be to improve service quality and availability for the more disadvantaged. The VSO-RAISA work that concerns operational service delivery will not be discussed in this paper. Although it is realised that VSO development workers provide much-wanted care and mitigation services, these fall outside the scope of this paper on capacity building. The paper will focus on building the individual capacities of staff (strengthening their individual skills), building organisational capacity (strengthening service delivery systems, management systems or strategies) and institutional development (strengthening networks, policy and legal frameworks).

[2] See recent data on the UNDP (Human Development Index): http://hdr.undp.org or http://www.undp.org/hiv/.

Table 2: Classification of VSO interventions[3]

SERVICE DELIVERY improving service quality and/or availability	Beneficiaries **BUILDING INDIVIDUAL CAPABILITIES** Staff	**building individual capabilities**
PROFESSIONAL AND TECHNICAL ASSISTANCE strengthening service delivery skills strengthening service delivery systems		
MANAGEMENT ASSISTANCE strengthening management systems	**BUILDING ORGANISATIONAL CAPACITY**	**capacity building**
ORGANISATIONAL DEVELOPMENT strengthening mission, goals and strategies		
RELATIONAL DEVELOPMENT strengthening sectoral and intersectoral networks and partnerships	**INSTITUTIONAL DEVELOPMENT**	
STRENGTHENING NATIONAL FRAMEWORKS strengthening national policy and supportive legal frameworks		

2.3 Capacity building in times of HIV & AIDS

Capacity building is a process, a means to an end, leading to a 'capable organisation'. What constitutes capacity building and a 'capable organisation' must be defined in any given context, as this will vary with the stage of organisational development, external context, culture, country, etc.

Therefore, the context of the HIV & AIDS pandemic forces VSO and other development organisations to analyse how the demands and effects of the HIV & AIDS pandemic determine the needs of their partner organisations (both organisations focusing specifically on HIV & AIDS and organisations working in other areas) and what implications this has for capacity-building interventions. This publication will take VSO's classification of interventions as a starting point and will discuss how HIV & AIDS challenges VSO to redefine capacity building.

[3] Source: Burnett, N., *Guidelines for Skill Share and Capacity Building* (VSO, September 1999), page 8.

Chapter 3

RAISA Case Studies

During the two external reviews by Joanne Harnmeijer and Russell Kerkhoven of ETC Crystal, staff and beneficiaries of 18 partner organisations in which VSO-RAISA supported capacity building have been interviewed (see Table 3).

Table 3: RAISA partner organisations included in reviews

Country	RAISA partner organisations included in reviews
Namibia	Catholic AIDS Action Regional AIDS Coordinating Committee in Gobabis, Omaheke Region Tate Kalungu Mweneka Omukithi wo 'AIDS' Moshilongo Shetu (Oshiwambo for 'Almighty Father Protect Our Nation Against the Disease AIDS' or TKMOAMS) Lifeline/Childline National Federation of People with Disabilities Khomas Women in Development Lironga Eparu
Malawi	Malawi Network of AIDS Service Organisations National Association for People Living with HIV & AIDS in Malawi (NAPHAM) Tovwirane Centre (Mzimba) Population Services International Kasungu Department for Social Welfare and Orphans (UNICEF-supported programme of the Ministry of Gender) Kasungu Teacher Training College Mzuzu Central Hospital
Mozambique	Provincial Directorate of Women and Coordination of Social Action Mozambique Network of AIDS Service Organisations
Zambia	Prison Fellowship Kara Counselling and Training Trust
South Africa	Planned Parenthood Association of South Africa Joint Education Project in Pholokwane (or Pietersburg)

In this chapter, a number of case studies are presented; the challenges the organisations are facing, the way VSO has contributed to capacity building and the lessons learnt will be examined.

3.1 Catholic AIDS Action (Namibia)

Catholic AIDS Action (CAA) is a church-based non-governmental organisation (NGO) working throughout Namibia. The organisation was founded in 1998. Its mission is 'to challenge the AIDS pandemic in Namibia with the courage to fight and the strength to care'. It builds on Roman Catholic affiliated groups and institutions throughout the country to inspire and support programmes of HIV & AIDS prevention, home-based care, spirituality, support of orphans and advocacy. Using this existing network CAA has been uniquely positioned to work at grassroots level, particularly in the area of care and support. The main services that CAA provides are training in home-based care and support of orphans and vulnerable children, self-help groups and empowerment projects, the training of peer educators (using methodologies such as 'My Future My Choice'[4] and 'Stepping Stones'[5]) and the production and distribution of HIV & AIDS information (in six local languages).

Identified challenges that CAA is facing

The development of CAA shows a rapid growth in response to demand. In the four years of its existence CAA has developed from an organisation with two staff members to one with 63 staff and 1800 active volunteers, in 118 volunteer groups in nine regions, caring for over 2500 people living with HIV & AIDS and servicing 15,000 registered orphans and vulnerable children. This quick growth has led to challenges with regard to the internal management of the organisation (e.g. financial systems and decentralisation). CAA is also facing its limitations. The ability to respond is not infinite and hard decisions have to be made: consolidating its home-based family care programme or expanding into new areas where support is also needed. 'We are overwhelmed, day after day, with new and deserving demands for help. We must reorganise our tasks, but on some tasks you simply cannot cut back'.[6]

[4] http://www.edsnet.na/Resources/AIDS/MFMC.htm.
[5] http://www.steppingstonesfeedback.org/.
[6] Maria Breeuwsma, VSO development worker, quoted on page 16 of Joanne Harnmeijer's report.

CAA is recognising that its demanding operation is claiming unusual sacrifices from its personnel. The pressures and difficulties staff and local volunteers are facing are ingredients for burn-out. CAA, alone, cannot address the needs of the many thousands of people infected and affected by HIV & AIDS. It should look for strategic partnerships and work proactively to ensure that other providers, particularly government, take on their share of the responsibility. The challenge for CAA is to position themselves, focus and decide what can be done better by other organisations. Their role now is a combination of implementation and advisory work.

Without changes in legislation there is only so much that NGOs can do. CAA has proposed a practical solution to the problems of clinical social workers that have to respond to the huge number of families willing to adopt orphans. Access to a monthly allowance for these families depends on the 'case probation' (an assessment of the adoption case) by clinical social workers and a confirmation in court. Currently the backlog of cases is such that it takes several years for cases to be assessed and for families to get their money. CAA has proposed to have community members trained and officially approved as 'case assistants'. However, with the recent shift of responsibility for orphans from one ministry to another this idea had to be put on hold yet again.

VSO-RAISA support

VSO has been involved with CAA since 2000. Three VSO development workers (VDWs) have been placed in the organisation, working in very different positions. Over the years VSO-RAISA also provided two small grants and enabled CAA to participate in five learning and networking exchanges.

The support of the VSO financial management advisor based in the Windhoek head office was a combination of a relatively straightforward inward role and strategy development, the next level of institutional challenge. He has been instrumental in the development of effective financial systems in CAA and the successful CAA bid for funding from the Global Fund.[7]

The VSO clinical social worker in Bernhard Nordkamp Centre in Katutura (on the outskirts of Windhoek) had more of an outward role in strengthening CAA's services in the community-based HIV & AIDS drop-in centre with outreach for home-based care, a soup kitchen for orphans and clients, counselling services and many more activities. She has supported the development of a stronger referral system from the state hospitals and CAA.

A VSO programme associate in the regional CAA office in Keetmanshoop supported the decentralisation process in CAA. Within one year she has significantly strengthened the organisational capacity of that office and the individual capacity of the staff members. She also coordinated the opening of a VCT centre in Keetmanshoop and recruited a new regional manager who is now taking on most of the work that the VDW was doing. The VDW is now providing additional support to CAA at central level.

CAA indicated that they were pleased with the level of skills provided by the VSO development workers. 'In terms of partner assessments and matching needs with skills VSO does it better and more comprehensively than any organisation I know. We need the person from VSO because we cannot get such a person locally to fit our priorities'.[8]

Lessons learnt

Through its programmatic approach, VSO-RAISA has been able to support CAA in the multiple-level challenges of this growing organisation: the need for support for internal management at headquarters, support in its decentralisation process, support in improving its services, support in challenging legislation and support in developing strategic relations and partnerships for cooperation. Through the different kinds of placements (both inward and outward roles) and other interventions, VSO has been instrumental in targeting these areas.

[7] The Global Fund (http://www.theglobalfund.org/en/) attracts, manages and disburses resources to fight AIDS, tuberculosis and malaria.
[8] Lucy Steinitz, CAA Namibia, quoted on page 11 of Joanne Harnmeijer's report.

3.2 Regional AIDS Coordinating Committees *(Namibia)*

In 2000, Namibian regional AIDS action plans were developed by external consultants in all 13 regions of the country. Consequently, new institutional (governmental) arrangements were established in all regions: the Regional AIDS Coordination Committees (RACOC). Implementation of the plans, and functioning of the committees, has hinged on the employment of a new cadre of government staff, the regional HIV & AIDS coordinators, under the Ministry of Local Government.

Identified challenges that RACOC is facing

RACOC is a new governmental arrangement focusing on expansion and replication through networking and enabling peer support. This service typically faces a situation of vast needs, a wide choice of things to do and few human and financial resources. Linking up with existing efforts thus is pivotal to its success.

VSO-RAISA support

Since 2001, VSO has assisted in the implementation of regional action plans through RACOC. Two VDWs have been placed in different regions (Gobabis and Keetmanshoop), RACOC staff and members have participated in RAISA workshops and conferences and via RACOC small grants from RAISA have been dispersed to members of the committees. Both VDWs ended their placements in RACOC, but the partnership with RACOC will continue and VSO is going to provide further support to RACOC in Kunene (March 2005).

Through VSO's facilitation the Regional AIDS Coordination Committees met more regularly, based on clear agendas, and District AIDS Committees have become more active and have been supported with finance and training. RAISA's small grants have remarkably boosted applicants' confidence to an extent that three groups have since successfully applied for UNAIDS-governed grants. VSO has also supported the development of linkages with the churches and other key RAISA partners in Namibia (e.g. CAA), but also with the agriculture sector that became more interested after the VSO HIV & AIDS trainer took them through thematic sessions, such as HIV & AIDS in the workplace. They have, for example, expressed a need for staff to get counselling skills.

Lessons learnt

VSO-RAISA recognises the importance of regional government institutions for coordination, working and cross-learning. RAISA has contributed to better-functioning coordination committees and has seen that support to these new arrangements has sustained the work of RAISA partners working at local level. With the support of VSO-RAISA, RACOC has developed its capacity to strengthen linkages between its members. This has been enforced by the RAISA small grants provided to RACOC members that have proven to be catalysts for further funding to these organisations. These integrated multi-level partnerships are considered to be essential components of VSO's programmatic approach.

3.3 Planned Parenthood Association of South Africa *(South Africa)*

Since the 1930s, Planned Parenthood Association of South Africa (PPASA) has been the country's leader in reproductive health issues and the organisation has seen many changes in the course of its lifetime. The HIV & AIDS pandemic has prompted PPASA to increase its emphasis on adolescents and start new programmes for high-risk groups. Another innovative programme is 'Men as Partners', addressing sexual and reproductive health issues. The overall aims of the programme are to reduce the incidence of domestic violence, sexual violence and HIV transmission; to promote gender equality at all levels in society; to increase knowledge of sexual and reproductive health (SRH) especially amongst men; to increase men's involvement in home-based care for family and community members with HIV & AIDS and to increase men's participation in activities aimed to prevent gender-based violence and HIV & AIDS.

PPASA's Adolescent Reproductive Health Services (ARHS) is now operating under the loveLife initiative, which gives them a high profile. The service is adolescent-specific and geared to reach out by using media such as radio and Internet and by franchising to multiply the services. The youth centres (called Y-centres), for example, provide a number of services ranging from clinical services, to 'chill rooms', to positive-sexuality workshops, to sports and recreation (such as dancing and basketball, on the premises), to computer training (CyberY's), to Million Voices (peer education) and radio stations (Y-stations), with recording facilities on the premises.

Identified challenges that PPASA is facing

PPASA is facing challenges both in the back office (related to its rapid growth in response to demand) as well as in adapting its services to the HIV & AIDS pandemic. PPASA needed support in financial management at both headquarter and provincial levels and in providing new types of service, for example adding youth-oriented HIV & AIDS prevention to its conventional core task. These new services are challenging conventions and routine. It is difficult to get official acceptance (accreditation) of the unconventional new type of computer-skills training – chosen for its multiplier potential – as this requires the adaptation of standing rules.

The Ministry of Health in Limpopo Province, South Africa, entered into a partnership with the PPASA to implement its prevention of mother-to-child transmission (PMTCT) programme. PMTCT is in many ways a complex issue. One of the things that make it difficult is that expectant mothers come very late for antenatal checks and testing. At the time of delivery there is little or no time for testing and for discussing the implications. A conclusion recently drawn by PPASA is that it will be necessary to do door-to-door visits in order to encourage women to come in time for antenatal checks and testing. Therefore an initiative of community-based reproductive health services is now being drafted.[9]

[9] Source: Ria Moleva, PPASA, Acting Provincial Director and Provincial Programme Manager in Limpopo Province, South Africa, referred to on page 25 of Joanne Harnmeijer's report.

This is but one example of the specific and labour-intensive demands the pandemic poses for services – demands that can only be met in partnerships with the non-governmental sector.

VSO-RAISA support

Through the RAISA programme, VSO supported PPASA through three development workers placed at different levels within the organisation (at headquarter and provincial levels). One VSO financial advisor recently completed his contract as a financial advisor in the Johannesburg headquarters. Another part-time VSO financial advisor has been placed in the Pietersburg Provincial Office. She provides hands-on training in financial management. Both are clear inward roles: 'There was no financial manager in PPASA before and the Provincial Director and office staff were coping as best as they could with the financial data. Since coming in, I have trained all PPASA staff on the new financial policies and procedures, provided accurate reporting and financial management, improved the management and operations of PPASA in the Limpopo Province, prepared proposals and helped out wherever necessary. I am now training the financial manager for his role (a one-year training schedule), assisting in decision-making and providing support to the Acting Provincial Director. I am going to be training PPASA staff in areas they identify they require training in and that I am capable of training.'[10]

A VSO computer-training coordinator is providing support at headquarters level. She designed and initiated computer-skills training for adolescents in the Y-centres. Some 6000 pupils have been trained through a cascade system of training for trainers, who in turn train trainers, etc. Every two months a new batch of students graduates. The VSO training coordinator had an outward role in adapting PPASA services to the HIV & AIDS reality, supporting the design of a training system with an inbuilt multiplier dimension and making it work. 'Reflecting the fast-moving and funky nature of the loveLife initiative, the Y-centre computer-training programme experienced an identity change and at the end of 2001 was reborn as the CyberY's programme. As with all programmes learners participate in the Sexuality and Life Skills workshops first.'[11] 'We realised we could not do all that without compromising what we are doing already. We thus had to start provincial-level training teams. This, not incidentally, also gives job opportunities to outstanding students trained in the Y-centres.'[12]

Lessons learnt

This case study provides a good example of support that is focused on creating new models of good practice and spinning them off for multiplication. The information technology (IT) training in South Africa's loveLive Y-centres is a combination of a service (computer-skills training) and a communication function (creating websites and connecting the Y-centres with HIV & AIDS-relevant themes). This special form of service (IT) is by nature expansive. It shows that impact that is measurable in terms of decreasing HIV & AIDS infection rates depends both on the quality of interventions (and their effectiveness) and on coverage. This is in fact what initiatives such as loveLife in South Africa are aiming for. 'The motto is: If it works, expand!'

'The motto is: If it works, expand!'

[10] Source: Ada Yee, financial advisor in PPASA Pietersburg, South Africa, quoted on page 12 of Joanne Harnmeijer's report.
[11] From the PPASA 2001 *Annual Report*, quoted on page 13 of Joanne Harnmeijer's report.
[12] Alison-Jane Edge, VSO computer-training coordinator at PPASA, in the PPASA 2001 *Annual Report* , quoted on page 13 of Joanne Harnmeijer's report.

3.4 Provincial Directorate for Women and Coordination of Social Action (Mozambique)

DPMCAS in Sofala (Mozambique) is part of the Ministry for Women and Coordination of Social Action (Welfare) and in the process of setting up a large-scale community-based service for orphans. Through its care interventions for orphans and vulnerable children, DPMCAS aims to make the burden for communities more bearable.

Identified challenges that DPMCAS is facing

This governmental institution was facing both front-office and back-office challenges. DPMCAS was requesting advice and support in adapting its services and role to the HIV & AIDS reality: planning HIV & AIDS services in advocacy, public education and counselling; training trainers in HIV & AIDS prevention and basic home care for AIDS patients; producing materials for HIV & AIDS awareness; and developing and implementing programmes on the effect of HIV & AIDS on the community.

But DPMCAS also needed back-office support in managing the increasing work with regard to HIV & AIDS: developing the capacity of DPMCAS staff in project designing, planning and managing an HIV & AIDS programme; financing; implementation; gathering and processing HIV & AIDS-related information and reporting on HIV & AIDS.

VSO-RAISA support

DPMCAS was supported by a VSO HIV & AIDS advisor from Uganda. In his home country he had done seven years of programme development, with a focus on community level planning. He had solid management and fundraising experience and a degree in statistics and economics.

The VSO advisor has proceeded from fundraising for community-level surveys in five (out of 13) districts in the province, to the actual design and implementation of the surveys, through community-based volunteers who first needed to be trained. Now the surveys are done, he and his colleagues 'can speak with confidence' on the numbers of orphans and vulnerable children in each district. In the surveys the sensitivity of mentioning AIDS as a cause of death was circumvented by using *'doença prolongada'* (lengthy disease) as an implicit reference. The VSO advisor has subsequently helped to draft a standard district action plan for each of the province's districts, again based on community action. His ministry is squarely behind the plans. There is in fact already interest in the data, and in the way the surveys were executed, at higher levels and also among agencies such as UNICEF. The model is for local NGOs to take up implementation of the plans, with guidance and quality control by the ministry. A next step is to support the directors in accessing funding for these plans.

Lessons learnt

In the case of DPMCAS a VSO HIV & AIDS advisor has played a catalytic role in designing a model for public–private partnership in a deserving area – orphan care. He followed a strategic sequence of steps that suited the circumstances: choosing data collection as the starting point, *and* staying close to the ministry's core mission (orphans and vulnerable children; the elderly), *and* adhering to the ministry's preferred way of working, which is community based and bottom-up. All this is novel terrain in Mozambique, and clearly someone with vision was needed to pull this off and translate the elements of VSO's needs assessment and job description into a coherent plan. In the case at hand it was the prior experience of the HIV & AIDS advisor in designing and implementing HIV & AIDS-relevant community-level programmes in his home country Uganda that did the trick.

Through its care interventions for orphans and vulnerable children, DPMCAS aims to make the burden for communities more bearable.

3.5 Mozambique Network of AIDS Service Organisations *(Mozambique)*

MONASO is the umbrella organisation for AIDS service organisations (ASOs) in Mozambique. It has its headquarters in the capital Maputo, but also has offices in Manica, Sofala, Tete, Nampula, Zambezia, Niassa and Maputo Province. Harnmeijer's review focused on the MONASO offices in Manica Province, primarily on the office in Chimoio. The office has limited human resources (three staff only) and a wide choice of relevant things to do. The office is working along the lines of agreed plans of headquarters in far-off Maputo.

In the interview with the MONASO Chimoio coordinator a list of three current professional interests emerged:

1. A project that is under negotiation with World Food Programme (WFP) and the Food and Agriculture Organisation (FAO), on food security in times of HIV & AIDS, focusing on nutritious and yet low-labour crops such as soy. MONASO members and MONASO itself would be involved.
2. Higher priority to the member organisations run by people living with HIV & AIDS (PLWHA organisations), encourage and support twinning options between 'strong NGOs' (such as the Red Cross) and PLWHA organisations, building on partners' strengths and working on a topic of common interest.
3. Strengthening cross-border cooperation, such as exchange of staff and experience, with FACT Mutare in Zimbabwe,[13] the nearest strong partner. Areas of cooperation between MONASO and FACT Mutare (with potential to also include a nearby partner in Malawi) are: VCT; advocacy, gender and human rights; community, orphan and home-based care; HIV prevention; integrated community-based HIV & AIDS programmes; care and support of people living with HIV & AIDS; capacity-building initiatives; regional linkages; co-funding by donors.[14]

Identified challenges that MONASO is facing

The MONASO offices in Manica Province are facing challenges in the support and networking role toward its members: there are vast needs, a wide choice of things to do, but very limited human resources. The main challenge is building the capacity of MONASO's member organisations. The province's 30 or so registered members have little in common, and could be supported best through individual tailor-made assistance. Most small community-based organisations (CBOs) need basic assistance in getting started and running their organisations. 'They have nice programmes, but implementing them is a problem.'[15] In a meeting of MONASO members it was clear that members operate on their own, and that funding – for which they compete – is their main concern. Most members appear to move from one project to the next, without having a core identity.

VSO-RAISA support

VSO has supported the outward role of MONASO Chimoio in supporting the institution and its member organisations. A Kenyan VSO advisor (with an accountancy background) provided assistance in, for example, bookkeeping, bank reconciliation, basic computer skills, reporting and proposal writing.

Another VSO advisor supported the MONASO office in Beira. She is also from Uganda, has an organisational development background and has in her home country worked for The AIDS Support Organisation (TASO) in Uganda, an NGO with a very solid reputation. Her specialty is counselling, and more specifically counselling of traumatised children. Based in MONASO's Beira office, she travels the country to train MONASO members – NGOs and CBOs of all sizes. According to her superiors her background and expertise is 'unique for Mozambique', and she is regarded as a real asset.[16]

The challenges are to focus on coordination, not competing with its own members, and to facilitate replication through networking and enabling peer support.

Lessons learnt

Networks of ASOs such as MONASO clearly have a specific learning curve in which they find that 'coordination' is different from 'doing'. The challenges are to focus on coordination, not competing with its own members, and to facilitate replication through networking and enabling peer support. MONASO has built some experience in what is conveniently called 'horizontal learning' between like-minded partners. Hierarchy is not an issue and informality is key in these horizontal learning partnerships. MONASO in Chimoio and FACT Mutare in Zimbabwe organised face-to-face work visits for peer education at the instigation of peers themselves. Physical proximity is of course not enough: what sustains the link between FACT Mutare and MONASO is the fact that the two have truly shared interests, and that FACT especially has a lot to offer, and is willing to do so, for its Mozambican partner.

An HIV & AIDS ribbon painted on a tree in Mozambique

[13] FACT Mutare (Zimbabwe) is another well-known NGO, with sizeable experience in working with orphans and vulnerable children, and models of community care. See, for example, FACT Mutare (2002) *Expanding Community-based Support for Orphans and Vulnerable Children*, report published with the HIV & AIDS International Alliance; also Geoff Foster, *Zimbabwe Orphans through Extended-hands*, reporting on a workshop for 30 church-based initiatives established during 1993–2001, in Zimbabwe. In localresponse@unaids.org, February 2002.

[14] Listed by Henry Singili, VSO advisor in MONASO Chimoio, on page 48 of Joanne Harnmeijer's report.

[15] Source: Henry Singili, VSO advisor in MONASO Chimoio, on page 12 of Joanne Harnmeijer's report..

[16] Sources: interviews with Dr Emilia Adriano, MONASO Maputo, and Florinda das Victorias, MONASO Chimoio, Mozambique, on page 20 of Joanne Harnmeijer's report.

3.6 Prison Fellowship *(Zambia)*

Prison Fellowship Zambia (PFZ) is a Christian organisation, which targets men and women, including juveniles, in prison. Volunteers have always been the mainstay of PFZ. At some point they numbered over 800, all Zambians. Traditionally these volunteers have offered care and support to prisoners, which would suggest that in the time of the HIV & AIDS pandemic (HIV prevalence in prisons where surveys were done was some 60%) they are a suitable vehicle for prevention, care and mitigation. However, the evidence is that it took a new initiative – a health department within PFZ – to attract the sort of volunteers who would be taking on this caring role. The current situation is that within PFZ there are two groups of volunteers, with the care volunteers still exclusively focusing on religious messages, and the health volunteers busy with the hands-on work. No 'care' is actually provided to prisoners dying of HIV & AIDS, but a home-based care (i.e. prison-based care) group is in the making, facilitated by the health volunteers.

Identified challenges that PFZ is facing

Conceived in 1995, the PFZ's health department started business in Ndola in 1998. The health department's aim is to alleviate the health problems that prisoners country-wide are facing. Under the inspired leadership of Dr Maurice Shakwamba the health department has had to tread carefully in its dealings with prisoners and prison authorities, particularly on sensitive issues such as violence, sex, condoms, rape, anal sex, sexually transmitted infections (STIs) and HIV & AIDS in particular. 'An irony of Prison Fellowship is that its mission is one of love and care, but that its key actors – the care groups all over the country – have yet to come to terms with the care required by prisoners as a result of the HIV & AIDS pandemic.'[17] The health department has had to start from scratch, building up a group of strong and motivated national volunteers. The group of seven Ndola-based health volunteers (six men and one woman) are now planning and coordinating their own health projects, and several volunteers are taking relevant courses, encouraged by their colleagues.

[17] Source: interview with Dr Maurice Shakwamba, Prison Fellowship, Ndola (line manager of VDW Carl Edmunds) on page 8 of Joanne Harnmeijer's report.

VSO-RAISA support

PFZ was supported through two VDWs, a health development worker and an office management advisor. VSO also facilitated linkages with other NGOs in Zambia.

A health development worker has been instrumental in supporting the Ndola-based health volunteers and getting them to bond into a team. In the absence of payment, and in demanding working conditions, this is no easy feat. Progress in PFZ's new health department has been remarkable. The health department has managed to gain the trust of prison authorities, but inherent obstacles to dealing with prisoners' health in the times of HIV & AIDS remain and the victories are small: national volunteers can come in to give health talks and bars of soap, which is much appreciated; but they cannot discuss condoms, let alone distribute them.

The VSO office management advisor had a more inward role, supporting the strengthening of administration and accountancy within PFZ. She also pursued her interest in gender matters and, in addition, has also supported the designing and drafting of a project proposal on an innovative exchange of opinions on sensitive issues between (600) female and (13,000) male prisoners in 80 prisons in the country. The project is now in the pilot stage and already yields interesting results.

The linkages most commonly seen are between partner organisations that benefit from different, but complementary strengths of VDWs. An example is the exchange of expertise between PFZ and Copperbelt Health Education Project (CHEP) in Zambia where one VDW gave his IT experience and the other his group-building experience, to the mutual benefit of their partner organisations.

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Lessons learnt

It is clear that VSO-RAISA supported PFZ in a difficult process of setting up a relevant new type of HIV & AIDS service for prisoners. This new approach that is trying to adapt PFZ's support to prisoners to the HIV & AIDS pandemic is challenging conventions and routines, not only in the prison environments PFZ is working in but also in their own organisation. VSO-RAISA has been instrumental in facilitating this organisational change. A PFZ staff member indicated that it was the health department that made the organisation change. By consistently supporting the national volunteers, training them and getting results, they sent a message to staff in other departments that volunteers are the backbone of this organisation. The change in the level of confidence in these volunteers was considered remarkable.

A natural progression from the placements in PFZ would be to turn to the prison service itself, dealing with officers' training. This is a sensitive area which would require more than the usual preparation from VSO. The demand for this type of assistance was expressed in interviews with senior staff, both from PFZ and from the prison service itself.

3.7 Kara Counselling and Training Trust

(Zambia)

KCTT is Lusaka's leading organisation in providing a broad set of services in HIV & AIDS prevention, care and mitigation. Established in 1989, KCTT, a pioneer NGO in HIV & AIDS work in Zambia has grown from humble beginnings to become the most versatile provider of HIV & AIDS services in Zambia. Its range of services includes HIV counselling and testing centres (plus a resource centre), hospice and palliative care services, a project for orphaned teenage girls, skills training for people living with HIV & AIDS, community outreach programmes, home-based care training and the hiring out of conference, lodging and hostel facilities.

Its pioneering work has made it a high profile organisation with an excellent reputation. Apart from its services in Lusaka, KCTT also works in Choma and Kabwe. Plans for further expansion of the programmes have been incorporated into the planning for the next five years and will see KCTT opening centres in Solwezi, Lundazi and Mongu. What makes KCTT special is the way it has created a network of mostly new services, dealing integrally with the HIV & AIDS-relevant situations persons can find themselves in.

Being one of the leading NGOs working in the area of HIV & AIDS work, KCTT collaborates with government agencies and NGOs at both local and international levels in their common plight of addressing the pandemic. It enjoys high regard from many stakeholders at individual and institutional levels and is well respected by its supporters. Currently there are three core donors who provide the main support to KCTT and a host of others who support specific programmes and activities executed by KCTT. The core donors are NORAD (Norwegian Agency for Development Cooperation) for most Lusaka programmes, LED (Liechtenstein Development Agency) for the Choma programme and Danchurch Aid for the Umoyo Project.

KCTT's own income-generating activity is counselling, in which it is the country's acknowledged key resource: staff from all over the country, and from government, NGOs and the private sector alike, come to be trained at KCTT. The organisation has challenged conventions by developing certified courses in counselling and gained recognition as Zambia's key training institute for this support. Courses include training for trainers and counselling the counsellors. A key feature is participation of openly HIV-positive trainers. All institutions of KCTT are thus linked and refer to each other creating a veritable network in itself. Living positively is ingrained in the network and its components.

Established in 1989, KCTT, a pioneer NGO in HIV & AIDS work in Zambia has grown from humble beginnings to become the most versatile provider of HIV & AIDS services in Zambia.

Mulima Kasote, a skills-training coordinator, has been with KCTT since 1993, three years after it started as a small effort focusing on peer support. He relates the learning curve in his work at Hope House with HIV-positive groups: counselling initially was done by external volunteers amongst who was the founder of Kara, Father Kelly. It soon became clear that participants faced similar problems: they all had too little to eat at home. The focus thus shifted to income generation – tailoring, candle-making and the like. However, the single-mindedness needed for income generation did not sit well with the main purpose of 'giving AIDS a face, and a place in people's lives'. Also, as was to be expected, some participants got clinical symptoms of AIDS. The focus shifted back to counselling, especially to advice on healthy living, natural remedies and nutritious local food.

In 1995/6 the Network of People Living with HIV & AIDS in Zambia was created with support from KCTT staff and course participants. In 1999 it was clear that staying at Hope House had for many become a way of life. Hope House was temporarily closed and the process of support and counselling remodelled into distinct courses of four months' duration. Nowadays activities such as candle-making and cloth-printing are still there, but are used as catalysts to enable people to feel at ease and bond as a group, rather than to make money. Participants get business training and after their course has ended they are supported as a group by external consultants. More and more people decide to live openly positive and, for example, take up positions as counsellors and trainers. From Mulima's story it is clear that the learning continues. KCTT continues adapting their services to HIV & AIDS pandemic.

KCTT is one of the very few partner organisations to have successfully included attention for stigma and denial in their outward servicing role. This is mostly because this NGO has created a set of options for dealing with the HIV & AIDS-relevant situations persons can find themselves in. The organisation practises what it preaches.

Courses include training for trainers and counselling the counsellors. A key feature is participation of openly HIV-positive trainers.

Identified challenges that KCTT is facing

KCTT has had challenges of coping with demand for its services as the organisation has undergone an accelerated expansion process within 13 years of inception. Together with KCTT, VSO has identified the following challenges: communication (across the different levels of the organisation); lack of clear organisational structure and weak general administration; donor dependency for its operations; lack of internal monitoring routines and capacity; high staff turnover particularly at programme level owing to relatively poor conditions of service and limited capacity to network with other organisations (partly due to lack of access to in-country training).

VSO-RAISA support

Since 2000 KCTT has received capacity-building support from VSO-RAISA including four VDWs who have been placed in the organisation, starting with two VDWs at the Thorn Park training and counselling resource centre. Supported by these VDWs, KCTT has managed to upgrade the quality of all counselling courses (these have evolved from basic counselling courses to specialised counselling courses such as child counselling). The organisation has managed to increase its courses from three initially and has maintained a standard minimum of 22 counselling courses per year. The organisation is leading efforts by institutions working in HIV & AIDS counselling in Zambia to develop a standardised training system among counselling training bodies. KCTT has helped build the capacity of cooperating organisations in counselling and has developed an effective referral system. KCTT has improved its conference and guesthouse facilities at the Thorn Park training and counselling resource centre and these facilities can now generate funds for the organisation through hosting workshops and providing accommodation.

These two placements at Thorn Park were followed with another placement at the headquarters. An M&E (monitoring and evaluation) advisor from the Philippines supported the development of KCTT's M&E systems and capacity. Management practice has changed and where resources and time were not allocated to M&E in the past, there is now great appreciation of M&E by management and staff. Initially the aim of KCTT was to set up a monitoring evaluation and research unit to provide monitoring, evaluation and research services to KCTT and its various programmes. However, recognising the needs for similar services by other organisations working in the field of HIV & AIDS in Zambia and in the sub-region, a double-pronged aim has been developed, to include the 'selling' of these services. KCTT has also developed a research unit within the organisation to undertake research on counselling, testing and care in HIV & AIDS in Zambia.

Another VDW from the Netherlands has worked for the last seven months in Jon Hospice (a KCTT institution), mostly in a care-giving capacity as a palliative care nurse. With her support, KCTT has enhanced the quality of life of more than 750 patients and 100 children living with HIV & AIDS who are under its care at the Jon Hospice annually, and KCTT is working to foster the development of hospices as complementary services to regular medical systems in Zambia.

Lessons learnt

VSO-RAISA's involvement with KCTT started with providing support to its front-office work (training and counselling services) and graduated to an advisory role with regard to its back-office systems (M&E). In both areas multiplier effects have been created: counselling training provided to other organisations, standardised training system among counselling training bodies, referral systems and provision of M&E services to other organisations outside KCTT. The operational service delivery at the Jon Hospice shows that as the result of a growing demand for HIV & AIDS services; and at the same time the human resource pool for provision of such services is declining rapidly due to attrition and burn-out in the health sector, direct service delivery needed to be reconsidered as part of the front-office support in the context of HIV & AIDS.

KCTT is one of the very few partner organisations to have successfully included attention for stigma and denial in their outward servicing role.

3.8 Malawi Network of AIDS Service Organisations (Malawi)

MANASO, like other ASO umbrella organisations in southern Africa, has experienced rapid growth. The number of organisations served by MANASO has rapidly increased: from 30 members in 1996, to 189 members in 1999, to over 300 organisations in 2002.

Identified challenges that MANASO is facing

Continued expansion presents the risk of a steady reduction in quality and effectiveness of performance. MANASO is unable to meet training demand of its member CBOs and lacks skills in specialised areas which members seek help in, such as home-based care and SRH. To help solve the above issues, one suggestion has been for MANASO to make more use of the particular skills and experience of other players, especially its members. MANASO acknowledges that it does not, and should not, support all sorts of specialised training itself, particularly where it lacks the expertise. Like MONASO, MANASO is moving from 'doing' towards a greater degree of 'coordination'. MANASO seems to be very clear on this and now successfully engages its members to supply services to each other, each on their own strength and specific expertise.

Another challenge for MANASO is to get their own internal systems in order, and those of its member organisations. This is crucial to ensure that front- and back-office operations are synchronised and mutually supportive. ASOs are often in a situation where they cannot afford skilled financial staff. Yet when they have such staff this dramatically improves their financial situation as improved finance systems translate in increased trust of funding agencies.

Like MONASO, MANASO is moving from 'doing' towards a greater degree of 'coordination'. MANASO seems to be very clear on this and now successfully engages its members to supply services to each other, each on their own strength and specific expertise.

VSO-RAISA support

VSO supported MANASO through a VSO management advisor, who finished his placement in August 2002. His role was to support the MANASO headquarters office in Blantyre in financial administration, fundraising, strategic planning and getting the board of directors re-energised. He had effectively achieved all four objectives. It proved that for this type of assistance a one-off placement was sufficient. Building on the achievements at headquarters level, VSO has now placed another management advisor in the regional MANASO office in Mzuzu.

Lessons learnt

The role the VSO management advisor in MANASO has been similar to the role of the financial management advisor in CAA. Similar jobs are done by VDWs at regional or provincial levels, for example in MONASO's office in Chimoio, Mozambique, and in PPASA's provincial office in Pietersburg, South Africa. The examples show that VSO placements can successfully support partner organisations through combining a relatively straightforward inward role with a more challenging positioning role, and a focusing on expansion/replication through networking (enabling peer support).

Chapter 4

Learning

4.1 Partner organisations and their main challenges in times of HIV & AIDS

The case studies in Chapter 3 demonstrate that RAISA works with a number of organisations that do not have HIV & AIDS as their main focus, for example PFZ in Zambia. These organisations are challenged to adapt their external service role to deal with the effects of HIV & AIDS. Good examples of organisations that need to adapt their core business are organisations focusing on services in health, education and social development; orphan care; gender issues and services for prisoners, people with a disability or youth. These services are provided both by government as well as by NGOs and CBOs. These organisations that do not have HIV & AIDS as their main focus encounter challenges related to finding ways to deal with and adjust to the pandemic in a way that is congruent with their core business. Challenges are faced when they need to add a service they did not have before, or when they need to change an existing service. For governments to adapt their services is quite a milestone.

RAISA also supports a number of organisations that have HIV & AIDS responses as their main task or mission, such as CAA in Namibia and MANASO in Malawi. These organisations specifically focus on HIV & AIDS interventions like prevention, care and support, advocacy, orphans, or reducing stigma. Good examples are ASOs, networks and umbrella organisations of ASOs, organisations of PLWHA and government HIV & AIDS initiatives such as institutional mechanisms for coordination. All these organisations or institutional arrangements are specifically created to deal with HIV & AIDS.

Partner organisations that have HIV & AIDS as their main focus often face challenges related to finding their niche. The ability to respond is not infinite and eventually organisations face their limitations. Partner organisations providing HIV & AIDS-relevant services may deal with different aspects of prevention, mitigation and care, but invariably are confronted with needs and expectations beyond their capacity and capability. All organisations dealing with HIV & AIDS-relevant services are in new territory and thus need to find out what works and what does not. Organisations are challenged to learn by trial and error and find ways to create multiplier mechanisms such as sharing models of good practice, cascade models, networks and spin-offs to policy level.

There is a continuous dilemma for organisations between doing very well and delivering within the confine of project models, and responding to mounting requests for similar activities beyond those boundaries. This quality versus quantity dilemma is especially difficult for organisations with a national mandate, but it also applies to organisations that deliver innovative and much-wanted services, unusual combinations of services or hard-to-access services such as antiretroviral treatment. Because this is a pandemic with unusual and growing needs requiring unusual solutions, staff members often feel overloaded and are working beyond their sustainable limits. The risk of burn-out is a real one for all those working directly with HIV & AIDS. A lot of the HIV & AIDS organisations that experienced a rapid expansion of their services and a rapid growth of their organisation also struggle to adjust their internal systems to keep up with the workload of the organisation. In some cases this seriously challenges the sustainability of these organisations. It is important that these rapidly expanding organisations keep their house in order and ensure that front- and back-office operations are synchronised and mutually supportive.

All organisations dealing with HIV & AIDS-relevant services are in new territory and thus need to find out what works and what does not.

A hallmark of strong organisations is that they realise when to opt for consolidation rather than further expansion. Strong NGOs such as CAA and KCTT eventually put their energy in getting others to work, rather than doing all the work themselves. As recommended by CAA's reviewers, 'CAA should work proactively to ensure that other providers, particularly government, take on their share of the responsibility.'[18] It is difficult to adhere to these decisions because they have an opportunity cost, there is no guarantee of success, the demands are ever-increasing and perhaps most of these organisations were created to fill gaps – they thus come in from a service-delivery angle.

There is a predictable sequence of events for strong organisations: at some point they call for a halt, have a review or a strategic planning exercise and emerge with new innovative plans to proactively position themselves. This usually consist of increased networking and sharing with other organisations, optimising and 'selling' of models of good practice and rethinking their own role versus that of regular (government) services.

There is a clear role for VSO and other development organisations to support partner organisations in their process of reflection, strategic planning and networking, and make organisations increasingly ready to prepare models of good practice that can be replicated by other users.

The HIV & AIDS pandemic is challenging old conventions and routines. Systems that used to work satisfactorily when numbers were small now have to be adjusted. HIV & AIDS has brought with it a demand for new skills (which has translated into new types of courses and qualifications), new models of good practice and new multiplier modalities. NGOs play an important role in responding to this demand, as they are seeking and implementing new modalities in dealing with the HIV & AIDS pandemic. This often involves breaking with established patterns and dealing with sensitive issues. This is especially hard for government systems, with ingrained routines, sealed by legislation. A good example is getting officials to agree to new counselling training courses or new modalities in which these courses are given and to approve accreditation.

A hallmark of strong organisations is that they realise when to opt for consolidation rather than further expansion.

Essentially all organisations working in high-prevalence countries are also affected by HIV & AIDS themselves and need to deal with the impact of HIV & AIDS on their own workforces. For example, they need to consider HIV & AIDS workplace programmes, training additional staff and adjusting their medical care packages; they may be challenged to deal effectively with stigma and denial within their own institutional set-up and in its core businesses. Remarkably, but not unexpectedly, even the most capable and forward-thinking organisations have not necessarily succeeded, or attempted, to deal with HIV & AIDS at the level of their own offices. Staff falling ill keep quiet or hide their condition; colleagues likewise respect this unspoken rule and avoid the topic. This of course is a problem for organisations that claim to fight stigma and denial.

There are specific challenges around building the capacity of PLWHA organisations. These organisations have specific strengths and qualities, such as openly living a positive life, that are invaluable for meaningful work in HIV & AIDS prevention, care and mitigation. The potential of utilising the specific qualities of such PLWHA organisations is definitely under-utilised. The challenge, however, is to also acknowledge the inherent limitations and specific requirements of such PLWHA organisations and safeguard them from having to perform against the norms of healthy people.

When assessing partner needs, their different stages of organisational maturity need to be recognised. This has implications for the instruments that are used to explore partner organisations' needs. If help is usually needed in a predictable order of priority, it follows that persons with insight in such patterns should take part in such partner assessments. Likewise meetings, however participatory, may achieve little if participants lack such insights. Meetings in which needs are assessed should be adapted to the stage partner organisations are in and respect the existing insights. During these participatory partner assessments, gender analyses are also essential. In a high-prevalence region like southern Africa, HIV & AIDS cannot be addressed without also addressing gender.

[18] Namibia Resource Consultants, *Catholic AIDS Action: Organisational Review and Foundation for a Strategic Plan; Final Report* (September 2002) quoted by Harnmeijer.

4.2 Capacity-building roles of VSO and other development agencies

VSO is an international development organisation involved in capacity building of partner organisation, mainly through placements of VSO development workers. Since RAISA's inception 164 development workers have been placed with 127 different partners in southern Africa. The external reviews focused specifically on the roles of these development workers in response to the specific capacity-building needs of partners in times of HIV & AIDS.

Below, the same classification of VSO interventions as presented in Table 2 will be used again to identify the VSO capacity-building roles in the specific HIV & AIDS context:

Outward (or front-office) capacity-building roles focusing on *professional and technical assistance* in strengthening (parts of) services, expanding the range of services (diversification); increasing the coverage of the organisation (expansion) or by introducing additional methods that aim or contribute to expansion or diversification. This support relates to adapting services to the HIV & AIDS reality, starting up HIV & AIDS-related services that were not there before, or applying new mechanisms. Outward roles are often less predefined (the nature of the job typically changes over time), diverse, complex, longer term and generally part of a team effort. VDWs are asked to advise on and support in the development of services that often have no precedent; no one knows what to expect or what works best. A lot thus depends on their own initiative and background, and their aptitude to encourage and support others. It is in such placements that VSO learnt that their development workers coming from other high-prevalence countries like Uganda have an invaluable advantage and inherent credibility because of their relevant personal experience. Some of the case studies showed that support in these outward roles has been evaluated positively by partner organisations, but the effectiveness is more difficult to ascertain than inward roles.

Harnmeijer considers these outward roles to be more challenging than more inward roles (see below). The nature of the pandemic makes these roles harder, as development workers have to deal with stigma and the acute difficulties brought about by the disease. Some of them may need specific moral assistance to be able to face their work and maintain their own balance in life. Several VSO programme offices have arranged for HIV & AIDS-relevant counselling and support to be available for VDWs. Also peer support is arranged among the development workers themselves. Harnmeijer suggests that moral support ought to be part of a standard support package provided to VDWs. In addition it could be a service that is offered to staff of the partner organisation, or a service that is negotiated with the partner for its entire staff, including the VDW.

Inward (or back-office) capacity-building roles focusing on *management assistance*, for example strengthening and reshaping internal systems for (financial) administration, human resource management (e.g. workplace policies), resource mobilisation and information management. For bigger, national-level partner organisations this may also include supporting the decentralisation of their work through increasing numbers of satellite offices. Development workers in these positions can be distant from HIV & AIDS thematic issues, and yet sit at the heart of the organisation. These inward roles are often clearly defined jobs whose effectiveness can easily be ascertained. The emotional charge of partner organisations' missions does not necessarily translate in support roles of a highly emotional nature. Yet development workers with expertise in management assistance are found to be drawn to these placements precisely because of the nature of the organisation's mission.

Positioning roles focusing on *organisation development*; for example, strategy development, setting up monitoring and self-evaluation systems based on strategy and mission and strengthening executive boards and utilising that strength to benefit the organisation. Positioning roles can be additional to inward roles and can thus be perceived as a sign of success: once the administration and finance are in order there is an atmosphere of achievement and readiness to turn to the next level of institutional challenge.

Institutional roles focusing on *relational development*; for example, building networks and partnerships or regional government institutions for coordination (see the RACOC case study in section 3.2). This will be based on (or will be a follow-up of) models of good practice as a result of the roles above (or service delivery roles – see below).

Policy roles focusing on *strengthening or adapting national frameworks*; for example, legal frameworks. Often practical solutions are needed to enable multiplication of good practice. Without changes in legislation there is only so much NGOs can do, as the case study of CAA showed.

> It needs to be stressed that a lot of these capacity-building roles are happening at the same time, or in progression, depending on the needs or partner organisations and their organisational development (maturity). All roles identified above can be played both in organisations that have HIV & AIDS responses as their main task, as well as in organisations that do not have HIV & AIDS as their main focus but that are challenged to adapt their external service role to deal with the effects of HIV & AIDS.

Mainstreaming roles are a special form of capacity building in times of HIV & AIDS (that can involve professional and technical assistance, management assistance, organisational development, relational development, and strengthening or adapting national frameworks) building capacity for *integrating and mainstreaming HIV & AIDS*. Every organisation in every sector in a high prevalence country is affected by HIV & AIDS. However, this does not mean that all these organisations have recognised how HIV & AIDS affects their own workforce and core business. Often a readiness to address the issues is lacking. Development agencies such as VSO can play a role in building capacity for mainstreaming in their partner organisations by supporting the identification of the right entry point. HIV & AIDS needs to be mainstreamed in organisational strategy, planning and everyday activities with target groups, including workplace policies. According to Harnmeijer, in virtually all sectors there are entry points for meaningful HIV & AIDS-related work that stands a chance of being sustained. Generally, the closer the opportunity is to the core of the partner organisation's mission and work and to the interest of its senior staff, the greater is the likelihood it will be successful. With regard to building capacity for mainstreaming HIV & AIDS in other sectors, Harnmeijer concluded that during the design phase of sectoral programmes, development agencies such as VSO should actively look for entry points for mainstreaming HIV & AIDS in the work of their partner organisations. This way 'mainstreaming' at the level of individual partners fits a bigger picture. This has considerable implications for the way partner organisations and placements are selected, and possibly for whole sectors. It essentially means that development agencies need actively to scout for opportunities where they can effectively support work in a specific sector and address HIV & AIDS in it. In other words: development agencies such as VSO need to mainstream their sectoral programmes.

Although this paper focuses on capacity building, it is important to mention that as the result of a growing demand for HIV & AIDS services and at the same time a growing capacity problem due to attrition and burn-out, *direct service delivery* might need to be reconsidered as part of the front office support in the context of HIV & AIDS. Prevention, and even more so care and mitigation, are by nature labour intensive. The HIV & AIDS pandemic poses specific problems that make services more labour intensive and demanding. In the face of growing demand regular service providers such as doctors and nurses are likely to be drawn into full-time service provision, in keeping with their professional background. Harnmeijer stressed that putting development workers in these positions and expecting them to do more sustainable (capacity building) work is unrealistic, and a recipe for frustrations.

The case studies showed that VSO is in the position to play all of the six roles listed above. This is done through placements of development workers as well as through other RAISA tools such as workshops, conferences, training, exchanges, study tours and small grants.

VSO-RAISA regional conference on orphans and vulnerable children

With regard to the placements, Harnmeijer concluded that the strength of VSO rests in its ability to match the demand of partner organisations and the supply of skills provided by VDWs. This in the case of this pandemic is a tall order. The placement of VDWs was appreciated positively by nearly all partner organisations interviewed during the external reviews. This includes those placements that focused on internal systems development and strategic positioning.

VSO was considered specifically suited in several ways:

The VSO modality of having several new arrivals of development workers each year is suited to being adaptive and to responding to demand.

The diversity of VDWs in terms of personalities, age, gender, ethnicity and country of origin, on top of the diversity in skills and experience, matches the diversity of needs of ASOs, as well as organisations that wish to adapt their services to the new reality. The VDWs were qualified as mature, hardworking and yet easy-going with a talent for seeing opportunities and the patience to guide weak organisations (some of them mere community-based initiatives), plus a sound basis of expertise in administration and management.

VSO is able to recruit development workers from Uganda and Kenya who are willing to work on VSO terms and conditions. VDWs from other high-prevalence African countries have an invaluable advantage, and inherent credibility, because of their relevant personal backgrounds and experience.

VSO is able to provide flexible support, as VSO not only provides partner organisations with development workers with qualifications that match their needs; it also has options of sending several development workers with different backgrounds and skills who can concurrently and often in synergy address different domains (and so have inward, positioning, outward and multiplication roles). Case studies in this paper have shown the relevance of this option. In addition there is the option of doing the above in sequence – the 'progression' discussed above as particularly relevant in the times of this pandemic. Many examples were seen of networked opportunities, within partner organisations, but also from one partner to the next one. This could become more of a strategy, aiming for potential and desirable scenarios of cooperation; for example, a progression from an outward role of adapting a service, to one of multiplication through another service. VSO has recognised these opportunities for synergy and a multiplier dimension in its corporate strategic plan: 'Placements may be geographically clustered or linked in other ways to increase their impact and to provide opportunities for networking between partner organisations.'[19] As partner requests become more specific, and VSO's own programmatic plans and capacity-building plans for partners require specific support at a particular time, the recruiting and matching of development workers will become more challenging.

VSO's way of working offers a suitable combination of firmness (in partner assessment and in agreement on job details) and flexibility (in leaving room for adaptation of the job, at some point into the contract). Job descriptions and placement objectives are thus allowed to improve over time, as they ought to, within set boundaries. Not all contracts will work out as intended, and this applies to HIV & AIDS-related placements as well. VDWs can make a balance and decide to leave early. These 'early returns' do occur. The point is that leaving is an option. Those who stay implicitly indicate that for them the balance is positive. This is an important feature for healthy relationships with partner organisations.

The VSO programme has a natural advantage in that it is 'sympathetic' in its profile and approaches. The fact that VDWs have modest allowances, and yet come with considerable skills, is a recipe for acceptance by colleagues, and distinguishes VDWs from well-paid expatriate staff in conventional projects.[20] VDWs themselves are attracted by the combination of challenging jobs and the worthwhile missions of the partner organisations offering these jobs. The level of motivation of VDWs in HIV & AIDS placements is high despite their modest allowance, as it gives them tremendous exposure and work experience, and at the same time they are able to contribute to the mitigation of HIV & AIDS.

[19] VSO (2002), *Focus for Change*, VSO's strategic plan, page 8: Focusing our work: being more programmatic.
[20] The contentious issue of salaries and perks (central to the technical assistance debate) is rarely openly discussed, but according to Harnmeijer it has a significant bearing on working relationships and, ultimately, on effectiveness.

4.3 The multiplier dimension of capacity building

Judgement on the effectiveness of these capacity-building roles must take the degree of difficulty into consideration. The effectiveness of relatively straightforward inward roles (e.g. setting up a database for orphan registration) cannot be judged the same way as complex outward roles (e.g. setting up a relevant large-scale community-based service for orphans).

Where judgement can be unambiguous is in the multiplier dimension of capacity-building roles. This is a dimension of 'capacity' (capacity as in 'scale') which is inherent to a pandemic, but which is not usually acknowledged. All capacity-building roles should be strengthening mechanisms for expansion, replication and the sharing of good practices to keep up with the growing needs of the pandemic. Multiplier effects may be achieved through organisational means, such as networks or cascades, or the application of horizontal learning methods such as sharing, developing best practice, twinning and forms or mentoring. Usually there are forms of peer review and peer learning built in the more successful formulae. The multiplier dimension would be an appropriate measure in the times of a pandemic (as it is so characteristic of the pandemic's needs), provided of course the service that is being expanded is of proven relevance and effectiveness.

As well as placements, VSO-RAISA provides additional tools to support capacity building and facilitate horizontal learning and the exchange of experiences between partner organisations and VDWs. The reviews recognised that these additional tools supplied by VSO-RAISA play a role in creating multiplier effects through the facilitation of exchanges, study tours, conferences, workshops, training and small grants.

There is a great need for sharing and learning to prevent organisations and people from constantly reinventing the wheel. Even the best examples of good practice are rarely shared, for the simple reason that those who develop good practices tend to be very busy people. Given the day-to-day workload and coping strategies, priority is not given to writing reports, let alone to creating websites or keeping up e-networks. For the same reason regional linkages have not been easily forthcoming in RAISA. NGOs are very busy coping with whatever they are doing, and spending time on networking, especially across borders, often seems to be a luxury they cannot afford. However, some NGOs are gradually coming to the conclusion now that networking with what used to be seen as 'competitors' is a necessity, for the greater good.[21] It is a challenge for development agencies like VSO to facilitate linkages between partners that really facilitate peer-to-peer learning and exchange of practical experiences. Exchange through large-scale conferences can be daunting, and lessons in such conferences are often distant from home realities. In the opinion of Kerkhoven, there is more potential in face-to-face work visits between like-minded partners. This is thus a form of peer education at the instigation of peers themselves. It is especially useful between new initiatives that are in a steep learning curve, and thus have a lot to share with similar initiatives.

Sustainability of course is a difficult issue at the time of such a pandemic: trained human resources are rapidly eroded. For care and mitigation, recourse is sought in alternative pools of human resources and more often than not this shifts the burden to the level of communities. The argument can thus be made that new models of good practice are necessary to make the burden for communities more bearable. The dimension of sustainability that VSO and other development agencies can realistically adopt would have to focus on supporting the development and replication of models of good practice. These models should directly alleviate the burden for communities and distribute it better. They should be such that linkages with local service institutions such as health and social services are made and utilised. They should build on existing (gender equitable) community initiatives, which are widespread and yet under-valued. For sustainability's sake and for the sake of replication recurrent cost should be as low as is possible.

The reviews indicated that VSO's support often had a multiplier dimension, as VSO was committed to expanding and linking with others: VDWs and programme offices played a role in this through respectively supporting learning and expansion, and developing linkages or sequential placements.

This multiplier dimension is often inherent in the more challenging capacity-building roles and for most VDWs the multiplier dimension is what makes their jobs extra interesting. For example, for Alison-Jane Edge, supporting PPASA in Johannesburg in coordination of their computer training, 'My position now is very different from the position I was in when I came, 17 months ago. It is much more strategic. I am working on curriculum development for higher-level courses, and looking into partnerships with the corporate sector, to explore career paths for trainees.'

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[21] See, for example, KCTT (Zambia) *Strategic Plan 2003–2005*.

Some other examples of VSO's capacity-building roles with multiplier dimensions:

★Network organisations that, with the initial assistance of a VDW, service the needs of a number of weaker organisations and enable peer support between them; for example, by becoming a contract holder for a group of weaker agencies, thus allowing non-registered members to implement activities and access funds.

★VSO's initiative to arrange for skill training in proposal writing has been developed with a clear focus on expansion: partners taking responsibility for their resource mobilisation for improvement and expansion of their services.

★VSO's support to a special form of service that is by nature expansive: communication and IT; for example, the support to the production of video productions (for national broadcasting), or the creation of websites in so far as this has an HIV & AIDS-relevant purpose such as advocacy or information campaigns.

★In CAA (Namibia) and MANASO (Malawi) the external reviews saw some strong examples of multiplier dimensions in management and positioning roles. The assistance consisted of tasks ranging from drawing up contracts to doing budgets to writing proposals (and teaching others how to do so), to knowing about ways to register new NGOs. The outward multiplier role was added by offering similar services to institutional arrangements that these organisations were part of. For example, VSO's financial management support in CAA was extended to the platform of NGOs that successfully applied for Global Fund money. By providing organisational development support in MANASO, VSO strived to contribute to a more outward, sharing profile for the organisation.

★Multiplier roles in services may concern a whole sector or a large ramified organisation such as a ministry or a large company. The innovation then usually starts with a pilot project to establish a new form of good practice, to be followed by large-scale introduction. This demands strategising a sequence of events, and networking from one achievement to the next. An example is that of a UNICEF-supported programme in the Ministry of Gender in Malawi, where three VDWs are working in different districts on a model for community-run child care. A similar example is that of DPMCAS in Sofala, Mozambique.

Examples 1 and 2 below give a good indication of how RAISA conferences and exchanges created some clear multiplier effects.

Example 1

In RAISA, yearly regional conferences are organised around themes identified in the Southern African region. RAISA has had positive experiences with these regional conferences that have motivated partner organisations to take these themes forward at the national and local levels. For example, as a result of the 'Men and HIV & AIDS' *regional conference* held in February 2003, Padare (Men's Forum on Gender), a key RAISA partner in Zimbabwe who attended the conference, officially launched their HIV & AIDS advocacy project in June 2003. Under the auspices of the Future Zimbabwe AIDS Policy Advocacy Project, Padare seeks to increase male participation and involvement in the fight against the HIV & AIDS pandemic through confronting patriarchy and deconstructing male power in sex. The project aims to initiate change in both men's sexual behaviour and legislation that will lead to men playing a significant role in the fight against HIV & AIDS.

RAISA supported Padare and other RAISA Zimbabwean partners that attended the regional conference to plan and facilitate a *national conference* (September 2003) exploring the various ways in which men could be actively involved in the fight against HIV & AIDS. Fifty-three participants attended the conference, where they discussed many issues including how to break cultural barriers and involve men, the role of the media, issues of male-on-male sexuality and the current and long-term impact of the prevalence of HIV & AIDS among men in the workplace. The aim was to bring together NGOs, the government and the private sector to share good practice and lessons in tackling these issues. It was agreed that there should be a well-designed advocacy and lobby campaign to Parliament to focus on the role of men in the HIV & AIDS pandemic. The workshop was regarded as significant around placing the issue of gender in HIV & AIDS on the agenda in Zimbabwe. In his keynote address, the Chairman of the Parliamentary Health Portfolio in the Parliament of Zimbabwe stated that he was going to spearhead the debate, that he would lobby other parliamentarians, and that the Committee on Health and Child Welfare had prioritised male concerns in its work plan during this session.

Following the workshop Padare decided to initiate a home-based care organisation for men (in an overcrowded suburb on the outskirts of Harare): Tiri Tose. The principal aim of the organisation was to send a message to all that caring for the sick is not and should not be regarded as a female role, especially given the scale of the pandemic. It also aimed to provide essential HIV & AIDS education to men, because the common trend in Zimbabwe has been to aim AIDS-related workshops and training at women, leaving men ill-informed and therefore vulnerable. RAISA provided a *small grant* to Tiri Tose to facilitate the training of a group of 20 men in home-based care skills as well the as purchase of basic materials for effective infection control. Every week they hold HIV & AIDS education sessions for the group, where they are learning all about related issues such as STI treatment, positive living, stigma and discrimination, antiretrovirals etc. The work being done by Tiri Tose has attracted many stakeholders, most of whom want to learn about what motivated the men to take part in the project, and it is hoped that their credibility will be sufficient for them to access more funding to implement a fully-fledged HIV & AIDS prevention and care project. It is still unusual to see male volunteers in home-based care in Zimbabwe, and even more unusual for them to go on home visits. It is hoped that this will prompt other men to revisit their own attitude towards the care and support of PLWHA. This is not only an important breakthrough in the issue of gender and HIV & AIDS, but also a good example of the dissemination of learning from a regional level to a national level, and finally impacting on a local level.

Example 2

In May 2003, RAISA and the Ugandan Network of AIDS Service Organisations (UNASO) facilitated a study tour for RAISA partner organisations, focusing on community responses to orphans and vulnerable children. It aimed to give participating organisations from all six RAISA countries as well as those within Uganda the chance to create stronger networks and share learning and good practice. The selected Ugandan organisations (members of UNASO) provided participants with plenty of examples to discuss and compare.

Three main areas emerged as most striking:

1 the level of coordination between ASOs working in Uganda
2 the multi-sectoral nature of the responses, and
3 the empowering use of memory work.[22]

Dorotea Balane, Head of Reecontro (a Mozambican CBO supporting orphans and vulnerable children) was one of the participants in the UNASO study tour in Uganda. It is remarkable to see how Reecontro have benefited from the exposure and peer-to-peer learning during the study tour and taken this forward. Back in Mozambique, Reecontro shared its learning within a forum of the Children's Network, MONASO, the Christian Council and Men Against AIDS, particularly around how government and civil society were working together in Uganda. A challenge was put out to those in Mozambique to initiate a similar type of linkage. This in turn has really helped to raise the profile of Reecontro with the National AIDS Council who helped them write a funding proposal, resulting in a grant of $200,000 to be shared with a PLWHA organisation. Reecontro also replicated the memory work and appears to be one of the first (if not the first) organisations within Mozambique to be undertaking memory work. Currently, Reecontro is working with the Ministry of Justice to ensure that the memory books have the same legal standing as a will. Reecontro also started to organise youth debates and income generation initiatives based on examples seen whilst in Uganda.

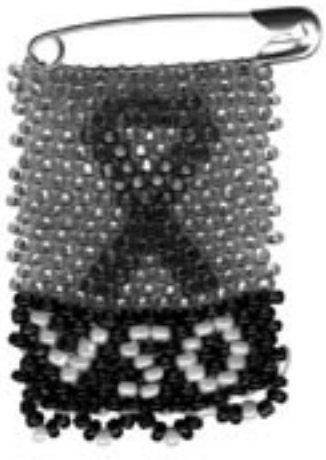
Multiplier roles in strategy and policy development have so far been relatively under-exploited by VSO. VSO recognises that such roles would fit with VSO's new strategic plan, since they fit a longer term and progressive relationship with key partner organisations.[23] Ideally the multiplier role is fed by on-the-ground experience of newly developed best practice. Often, however, the chance for a multiplier role is barred, waiting for a change in legislation. VSO programme offices need to be well connected, to be informed on opportunities for placements that could contribute to strengthening national policy and supportive legal frameworks.

[22] 'Memory work' refers to a wide range of psychosocial interventions which seem well suited to addressing the needs of children and adults made vulnerable by a range of structural problems and in particular by HIV & AIDS. For more information please refer to http://web.uct.ac.za/depts/cgc/Jonathan/index.htm.
[23] VSO (2002), *Focus for Change*, VSO's strategic plan.

Chapter 5

CHAPTER 5

Conclusions and Recommendations



The central issue of this paper is that the context of the HIV & AIDS pandemic urges VSO and other development organisations to redefine 'capacity building', as HIV & AIDS influences the nature of capacity building. The traditional modes of capacity building may no longer be appropriate and conventional approaches to training, managing, organising and motivating need to be revised. This paper analysed how the demands and effects of the HIV & AIDS pandemic determine the needs of VSO's partner organisations, and what implications this has for capacity-building interventions and the impact that those interventions are trying to generate.

5.1 Organisational challenges

Redefining capacity building in times of HIV & AIDS needs to start with an identification of the organisational and institutional challenges of partner organisations and their related capacity-building needs. The reviews showed that partner organisations are facing challenges specifically related to the HIV & AIDS pandemic that can be differentiated as back-office challenges, front-office challenges, and challenges related to going to scale.

A billboard in Namibia

✓ Building the capacity of partners' back offices

As a result of the HIV & AIDS pandemic, three general needs areas have been identified that are related to the functioning of the back-office of partner organisations:

① **Dealing with the impact of HIV & AIDS on their own workforces**

The fact that HIV & AIDS is affecting not only beneficiaries of partner organisations but also their own staff is not always getting the required attention. A lot of partner organisations (which already operate with scarce resources) face growing direct organisational costs for sick and compassionate leave, medical expenses, funeral expenses and management time. At the same time work performance is inhibited by emotional stress, stigma and sickness, and knowledge, learning and experience are lost when staff members stop working or pass away.

All organisations working in these circumstances need to find a way to respond to these challenges. For example, they need to consider HIV & AIDS workplace programmes, training additional staff and adjusting their medical care packages; they may be challenged to deal effectively with stigma and denial within their own institutional set-up and in its core businesses. Partner organisations can be supported in strengthening the functioning of their back office in these areas, but development organisations need to consider as well that, in such an adverse context, the nature of and opportunity for capacity building comes into question.

The functioning of the back office is not only challenged directly by an impact on the workforce. HIV & AIDS is also changing the *scale and way of working* of these partner organisations, requiring organisational change and development of the back office.

② **Ensuring that front- and back-office operations are synchronised and mutually supportive**

Many organisations that focus on HIV & AIDS are facing organisational sustainability challenges (over and above the sustainability issues related to the impact of HIV & AIDS on their workforce). These often rapidly expanding HIV & AIDS organisations struggle to keep their houses in order and ensure that front- and back-office operations are synchronised and mutually supportive. As a result of the growing need for their services, many HIV & AIDS organisations experienced rapid growth in terms of their service delivery, the number of staff working in the organisation and the funds that need to be managed. These organisations need to strengthen their finance and administration systems to keep up with the workload and the size of the organisation. The expansion of services is not sustainable if there is not a strong supporting back office.

③ **Positioning and innovating**

The constant pressure to deliver and expand services also brings challenges with regard to the strategic positioning of HIV & AIDS organisations. These organisations are confronted with needs and expectations beyond their capacity and capability; they are occupied with 'doing' and they struggle to find time and capacity for strategic planning, M&E, reflection and learning, and for acting on these. Yet the capacity to position oneself strategically and to keep innovating are crucial elements if an organisation is to be strong and able to respond effectively to the pandemic.

Partner organisations need to strengthen their capacity to face their limitations, to find their niche, to focus on certain aspects, to decide what can be done better by other organisations, to keep in phase with the pandemic and to position themselves proactively. They need to develop good systems for reflection, learning and planning to support these strategic decisions.

The hallmark of a strong organisation is that it realises when to opt for consolidation rather than further expansion. Strong NGOs such as CAA and KCTT eventually put energy in getting others to work, rather than doing all the work themselves. As recommended by CAA's reviewers, 'CAA should work proactively to ensure that other providers, particularly government, take on their share of the responsibility.' It is difficult to adhere to these decisions because they have an opportunity cost, there is no guarantee of success, the demands are ever-increasing and, perhaps most of all, these organisations were created to fill gaps – they thus come in from a service-delivery angle.

This paper analysed how the demands and effects of the HIV & AIDS pandemic determine the needs of VSO's partner organisations, and what implications this has for capacity-building interventions and the impact that those interventions are trying to generate.

✓ Building the capacity of partners' front office

④ The **three needs areas discussed above** were related to the functioning of the back office of HIV & AIDS organisations. However, the reviews also identified a general need for building the capacity of the front-office work of HIV & AIDS organisations.

HIV & AIDS organisations face challenges in improving, expanding and adapting their front-office services to changing and growing needs as a result of the pandemic and this is closely linked to the above-mentioned 'positioning and innovating' and 'going to scale' capacities of the back-office. HIV & AIDS organisations need technical support in developing new or better services and in developing models that have a built-in multiplier mechanism.

✓ Building partners' capacity for going to scale

⑤ According to Harnmeijer 'real impact that is measurable in terms of decreasing HIV & AIDS infection rates depends both on the quality of interventions (and their effectiveness) and on coverage' (2003, p.27). Growing consideration is being paid as to how to scale up effective NGO and CBO responses for a greater impact in preventing the transmission of HIV and mitigating its effects. The challenge to organisations is to find ways to replicate models of good practice at the lowest pos-

sible cost. This can include expanding their operations, developing new models of good practice and creating multiplier mechanisms such as sharing models of good practice (which are then adopted by other NGOs and/or by government), horizontal learning, twinning, introducing cascade models, setting up networks and influencing changes in the policies and actions of governments and donors.

For 'going to scale' to be effective, it needs to be backed up by a lot of organisational and institutional capacities mentioned under points 2 and 3 above: for example, a solid administrative and management system, a clear vision on the role of the organisation and the way going to scale fits in that strategy, and a system for learning.

✓ Challenges of organisations that don't have HIV & AIDS as their main focus

The five general needs areas described above were related to HIV & AIDS organisations. However, organisations that don't have a main focus on HIV & AIDS face similar back-office and front-office challenges. They as well need to deal with the impact of HIV & AIDS on their own workforce. They also face challenges with regard to positioning and innovation, as they have to find ways to deal with and adjust to the pandemic in a way that is congruent with their core business. As a result of their changed role, they may face sustainability challenges as their services expand and their organisation grows, and the need for back-office–front-office synchronisation increases. Also, the need to find ways to adjust their services to the pandemic may require technical support for the front office.

5.2 Redefining impact and capacity

✓ Redefining impact

The reality of the pandemic in high-prevalence countries requires a new take on concepts and assumptions which are rarely questioned, or that most people take for granted. Impact normally has the connotation of 'improvement'. However, in the current crisis impact at the individual level can be as unassuming, but significant, as 'dying with dignity', as opposed to dying in solitude on a bare concrete floor.[24] Similarly the call for baseline studies must be reconsidered: the pandemic is not in a steady state and interventions do relatively well if they slow down the pace of what ultimately is a rapid decline in all major health and well-being indexes. Slowing down the pace of deterioration is not an undertaking that funding agencies eagerly sign up for, nor is such impact measurable as one will never know what would have happened without interventions. Impact thus needs to be seen in a different light because of the HIV & AIDS pandemic.

Based on the field visits and her experience, Harnmeijer suggested that the most appropriate dimension of impact would be 'replication of models of good practice, at the least possible cost'. This cannot fail to benefit the target group, including women and people living with HIV & AIDS, since lack of any HIV & AIDS appropriate services is the rule rather than exception. The point is: everybody is affected, and systems such as the health system and the education system need all-out transformation, not just a partial solution or a solution for a fragment of the population. Real impact that is measurable in terms of decreasing HIV & AIDS infection rates depends both on the quality of interventions (and their effectiveness) and on coverage.

Therefore it was recommended to aim for capacity-building support that incorporates the strengthening of multiplier dimensions. Development organisations such as VSO need to support their partner organisations working in an HIV & AIDS environment in such a way that effective and qualitative interventions are scaled up. Only then can these partnerships result in real impact.

✓ Redefining organisational capacity

Many organisations working in the HIV & AIDS field struggle with the identification of impact. Harnmeijer suggests that organisational effectiveness is a reliable indicator of impact. In normal times (read 'stable conditions') characteristics such as transparency, accountability and the drafting of policies and procedures are indicative of a strong organisation. Harnmeijer is making the point that in the trying times of the HIV & AIDS pandemic organisations dealing with the growing demand for HIV & AIDS services become 'strong' of necessity. Organisations that have managed to respond

[24] KCTT (Zambia), *Strategic Plan 2003–2005*, page 29, on indicators for Jon Hospice. Some telling examples: 'peer support among children with terminal illnesses'; 'number of patients accepting their illness and dying peacefully'.

effectively to the pandemic have a proven track record of fast growth and adaptive responses; they have learnt by doing, analysed and reflected on their implementation experience; they have been able to stick to their core values and knew when to stop the expansion of their work and coordinate and network with others. They acquired the characteristics of transparency, accountability, and so on, as they moved along. It is inconceivable that these organisations could have been able to deliver without the conventional qualities of capacity. In other words, their capacity is prompted and shaped by the opportunities and difficulties the pandemic poses. And, similarly, as their capacity improves they are increasingly able to respond. The ability of organisations to be proactive and responsive to the pandemic is thus a superior measure of an organisation's capacity. Organisations that are corrupt or manage to thrive on the crest of donor money for a while will not be able to respond *effectively* to the pandemic at the same time.

There is an argument that capacity itself can be self-demonstrating because of HIV & AIDS. This would mean that by monitoring and evaluating organisational development in the five main needs areas described in above, proxy indicators could be given of the organisational capacity to respond effectively to the HIV & AIDS pandemic. These findings need to be further analysed.

5.3 VSO-RAISA

The external reviews have showed that in the RAISA programme there are numerous examples of VSO supporting partner organisations in one (or more) of the five general needs areas listed above. The new insights into general partner needs-areas as presented in this publication will contribute to further focus in partner assessments and the design of more appropriate capacity-building interventions.

The reviews also recognised that VSO-RAISA is undertaking the five capacity-building roles (plus mainstreaming) described above. Through these roles (and sequential placements) VSO-RAISA plays a significant role in strengthening back-office and front-office operations in partner organisations. Both Harnmeijer and Kerkhoven mentioned the increased confidence and capacity of RAISA partners to discuss their internal dynamics and the clear focus that some of the organisations had adopted due to the partnership with VSO-RAISA. Harnmeijer noted the increased capacity of RAISA partners to articulate their own position and more realistic ambitions in the response to HIV & AIDS. The impact of capacity building in the sense of an improved organisational response to HIV & AIDS is obvious from the remarkable confidence and openness with which organisations are able to discuss their internal change process, the way they articulated their focus on HIV & AIDS and the importance they attached to improved internal systems development. Following Harnmeijer's argument about self-demonstrating organisational capacity, this is an important achievement.

The consultants indicated that RAISA has created some multiplier effects by facilitating horizontal learning and the exchange of experiences between partner organisations (through facilitating exchanges, study tours, conferences, workshops, etc.), but the challenge is to incorporate a multiplier dimension in the design of all capacity-building interventions.

5.4 Implications for capacity-building providers

In times of HIV & AIDS, development organisations such as VSO need to design appropriate responses to the identified general needs for capacity building the in front and back offices of partner organisations. These capacity-building roles need to incorporate a multiplier dimension, and need to recognise the implications of redefined concepts as impact and organisational capacity.

Table 4 shows that the classification of VSO interventions in Table 2 can be used to address the challenges resulting from the HIV & AIDS pandemic. The table also implies that development organisations need to strategise the sequence of capacity-building roles, to be able to build on achievements. For example, the 'positioning and innovation' capacity is a logical follow-up of mutually supportive front-office and back-office operations, but also shapes the multiplier potential and outward role of the organisation ('going to scale'). This will not always be a straightforward process. Support needs to be designed in a way that allows some kind of 'flow' to respond to situations as they occur, and which cannot always be predicted. Donors may find all this fluidity hard to accept because it is by nature undefined. Yet sticking to the reverse makes for stagnation, which is in no one's interest.

Table 4: Capacity-building roles, addressing the general needs, with possible multiplier dimensions

Roles	Dimension of capacity building	Strengthening/ addressing	Incorporating a multiplier dimension
Professional and technical assistance	Building individual capacities (human resource development)	Addressing front-office challenges: Strengthening service delivery *skills*, to expand, improve, adapt or develop services	Capacity building in this need area should involve the developing service models that have a build in multiplier mechanism. The interventions need to be designed not only to serve unusual and rapidly increasing needs such as orphan care, but also to do this in a way that is replicable. Usually there are forms of peer review and peer learning built in the more successful formulae
	Building organisational capacity (organisational development)	Strengthening service delivery *systems*, to expand, improve, adapt or develop services	
Strengthening management systems	Building organisational capacity (organisational development)	Addressing back-office challenges: Ensuring that front-office and back-office operations (such as management, administration and finance systems) are synchronised and mutually supportive	The case studies showed that multiplier effects were achieved by providing this type of assistance to umbrella organisations. In this case an outward multiplier role may be added by offering similar services to member organisations of the umbrella organisation
		Strengthening the capacity to deal with the impact of HIV & AIDS on the own organisation	
Strengthening mission, goals and strategies	Building organisational capacity (organisational development)	Addressing back-office challenges: Strengthening the capacity of positioning and innovation	Although essentially serving the organisation itself, the outcome of strengthening positioning could be a more outward-looking organisation, with multiplier potential
Relational development	Institutional development	Addressing challenges related to going to scale: Strengthening sectoral and intersectoral networks and partnerships	Relational development has an inherent multiplier dimension: a focus on expansion and replication to be achieved through organisational means such as networks or cascades or the application of horizontal learning methods such as sharing, developing best practice, twinning and forms of mentoring. This will be based on (or a follow-up of) models of good practice as a result of the roles described above
Strengthening national frameworks	Institutional development	Addressing challenges related to going to scale: Strengthening national policies and supportive legal frameworks	This again links the roles described above, for example through a partner organisation's role in national theme groups, providing on-the-ground experience of newly developed best practice There is strong need for the adaptation of policies and legal frameworks which would enable multiplication of good practice

The challenge for VSO and other development organisations is to develop appropriate capacity-building roles for partner organisations in HIV & AIDS environments, identify opportunities for multiplier dimensions, and monitor both the development of organisational capacity as well as impact in terms of replication of models of good practice at the least possible cost. In RAISA, VSO will further develop its experience in capacity building in times of HIV & AIDS, build on the learning from both reviews, and take forward the conclusions and recommendations of this publication. One crucial element will be the development of an appropriate set of M&E indicators. VSO will build on the self-evaluation framework proposed by Harnmeijer and the AIDS Competence Programme (ACP), the self-assessment scheme developed by UNAIDS and UNITAR. These can be used for both accountability and learning purposes.

This publication has showed that capacity building in times of HIV & AIDS is a far from conventional endeavour, which extends beyond what used to be seen as capacity building. The HIV & AIDS pandemic leads to specific challenges for partner organisations related to expanding services and organisations, adapting their core business to HIV & AIDS, developing systems for learning and sharing of good practice, and creating multiplier effects to counter the pandemic. Development organisations like VSO need to support this organisational change and development in partner organisations; they need to reconsider concepts like impact and organisational capacity, and they need to change their capacity-building interventions and monitoring and evaluation practices accordingly.

Annex 1

ANNEX 1

Simplified Indicators for M&E of Capacity Building in Times of HIV & AIDS

Harnmeijer proposed a set of indicators for both monitoring as well as self-evaluation. The dimensions listed are closely related to the general needs areas identified in section 5.1 of this paper.

Table 5: Monitoring and self-evaluation questions for VSO partner organisations

Dimensions	Organisation that has HIV & AIDS as its main focus	Other organisations
Capability*	1 Has the partner organisation found its own niche in dealing with the pandemic?	1 Has the partner organisation found ways to deal with/adjust to the pandemic?
Sustainability; chances of success	2 Has the partner organisation been able to adjust its finance and administration systems to keep up with the workload?	2 Has the partner organisation done the above in a way that is congruent with its core business?
Stigma and denial	3 Does the partner organisation within its own institutional set-up and/or in its core business effectively deal with stigma and denial?	
Capacity*	4 Has the partner organisation found ways to create multiplier mechanisms? (Such as: sharing models of good practice, horizontal learning, twinning, cascade models, networks, spin-offs to policy level.)	
Innovation/ positioning	5 Is there evidence that the partner organisation keeps in phase with the pandemic and proactively positions itself? (For example through strategic planning, monitoring, internal evaluation and acting on these.)	

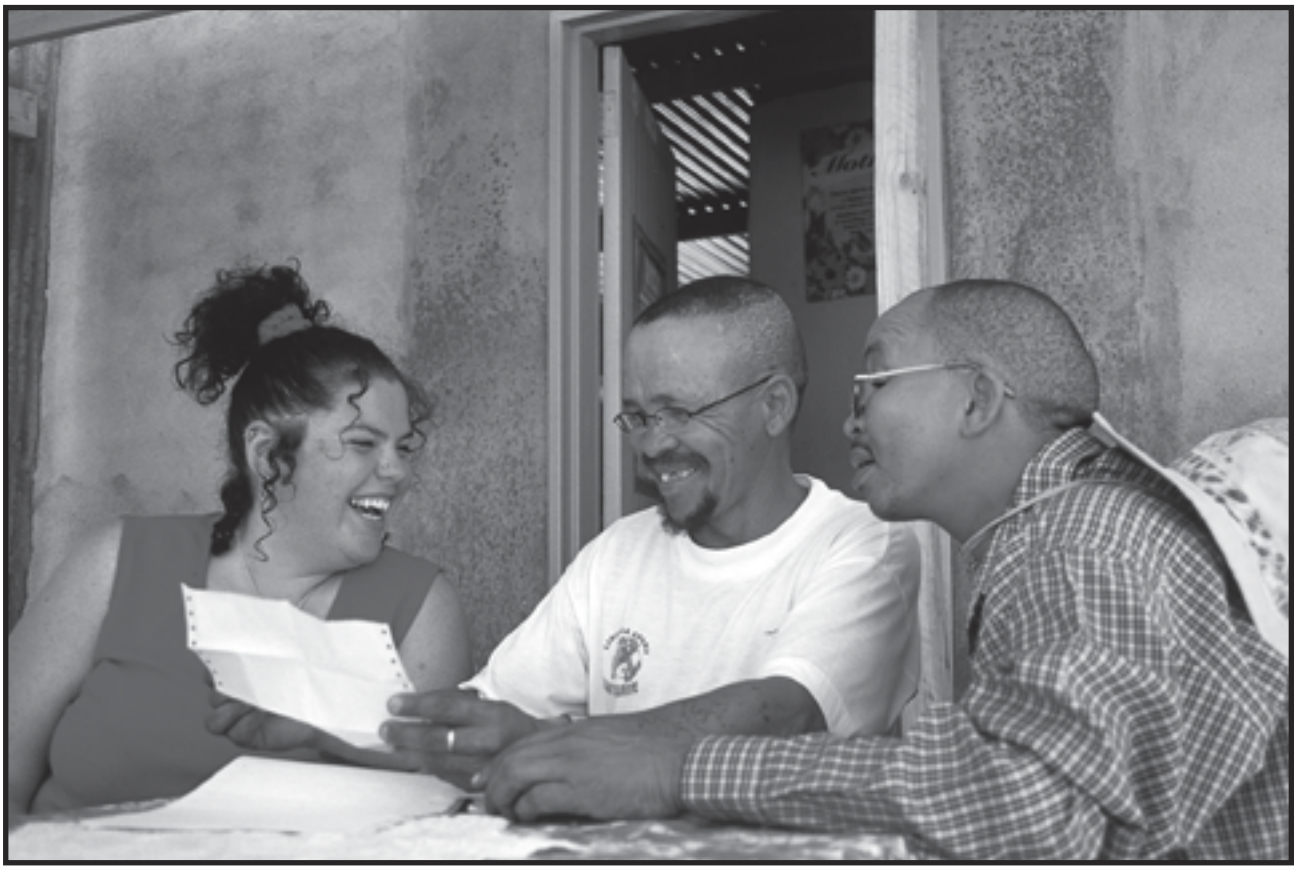
* *'Capacity' is used here in its original meaning of 'going to scale', while 'capability' indicates aptitude.*

Answers to the monitoring and self-evaluation questions listed above can be tracked qualitatively and quantitatively. The indicators can be monitored through discussions with staff of partner organisations during individual participatory partnership reviews. Some of the dimensions (e.g. stigma) could also be analysed in a more collective way through annual partner review meetings, to identify what is working and/or how to overcome barriers and/or share good practice. A scoring system could allow for comparison over time. Alternatively, linear or graph scales could be used.

Table 6: Scoring system for quantitative monitoring of simplified indicators

0	2	4	6	8	10
No/none	Is open to the idea, but has not taken action	In a limited way/is trying to	Yes, to some extent	Yes, in many ways	Yes, is a shining example

VSO and other development agencies working mainly through development workers can pose additional questions to reflect on the role of the development worker and utilisation of his or her skills. To what extent the development worker has been instrumental in supporting the partner organisation in reaching the identified results can be evaluated in terms of all five dimensions listed above. Given the difficulty of demonstrating effectiveness, utilisation – both of what the VDW has to offer and of the service the partner is able to offer (through the development worker or because of the development worker) – would be a good proxy measure of success for VSO to adopt. It may also be feasible for partners and development workers working in these organisations to self-assess trends over time, using the numerical scores.



A VSO development worker and her colleagues

Further Reading

- Sue Holden, *AIDS on the Agenda: Adapting Development and Humanitarian Programmes to Meet the Challenge of HIV*, www.oxfam.org.uk/what_we_do/issues/hivaids/aidsagenda.htm#pdfs

- Joanne Harnmeijer, *Building Capacity in the Times of HIV & AIDS. A Review Based on Case Studies in VSO's RAISA Programme in Southern Africa* (ETC Crystal, February 2003)

- PSO Knowledge Centre, Learning Trajectory HIV/AIDS, www.pso.nl/knowledgecenter/dossier.asp?dossier=10

- Russell Kerkhoven and Phineas Murapa, *VSO Regional AIDS Initiative Southern Africa, a DFID/PSO Review* (ETC Crystal, May 2003)

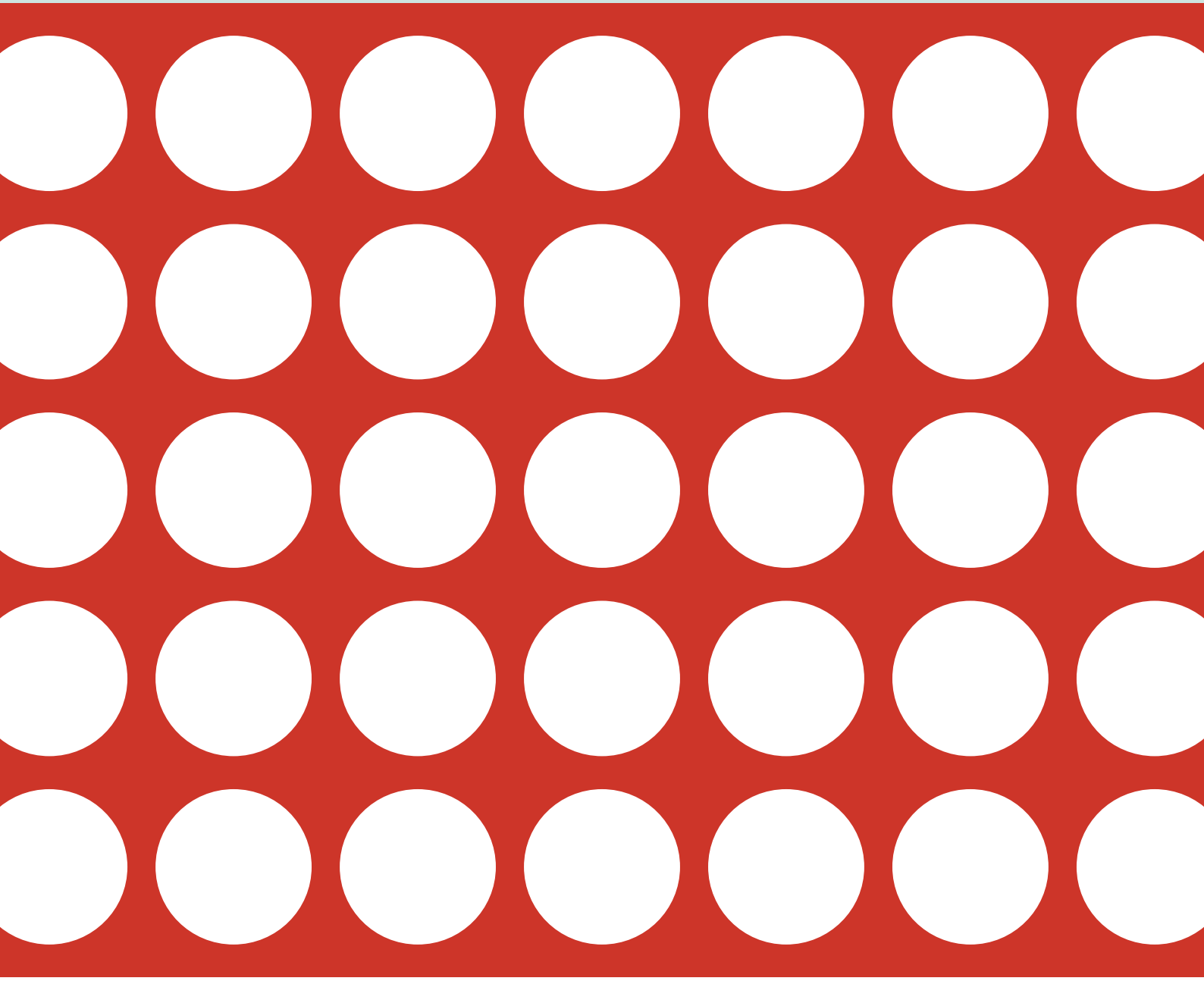
- UNAIDS / UNITAR, *AIDS Competence Programme (ACP)*, www.unitar.org/acp

The beaded Zulu dolls on the front cover are crafted and marketed by women who are members of Siyakhula Arts and Craft Project, an Africa Centre Community Development Office (ACCDO) project in Mtubatuba, Kwa-Zulu Natal, South Africa. Through these ACCDOs, the Africa Centre for Health and Population Studies (one of VSO's partner organisations in South Africa) supports community initiatives like this craft business, in addition to their core research work. Siyakhula means WE ARE GROWING.

The big doll adorns traditional Zulu attire and beads, and the red hat symbolises that she is a married woman. The small dolls have been termed "adopt an orphan dolls". The big doll connotes a grandmother who is taking care of her grandchildren, the orphans. By "adopting an orphan" the buyer is indirectly supporting families who have been affected by HIV & AIDS. Call ACCDO on +27 35 550-7500 or go to www.africacentre.org.za

Capacity Building in Times of HIV & AIDS

Capacity building in times of HIV & AIDS is a far from conventional endeavour, which extends beyond what used to be seen as capacity building. The HIV & AIDS pandemic leads to specific challenges for partner organisations related to expanding services and organisations, adapting their core business to HIV & AIDS, developing systems for learning and sharing of good practice, and creating multiplier effects to counter the pandemic.



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