Programme performance in times of HIV/AIDS

Implications for Capacity Building

PSO capaciteitsopbouw in ontwikkelingslanden

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Acknowledgement

This thank you is different for me. Different because there are so many people to thank. And because I want to thank people for so much more than their contributions to this report.

Thank you Russell, for sharing what you know (a lot!) and for your never-ending commitment and enthusiasm. Roel, I hope you realise that your input was crucial. It is so nice and clarifying to philosophise with you. You made time when I asked you for it. I hope to be able to do something in return. Sibrenne, I will never forget how you coached me this last year. Thank you for being there when I needed it most, for showing me direction and staying there when I started to find it. Thank you Maaike, Pieter-Bas, Martsje, Hetty, Bram, Ineke and Nico for being around, listening, supporting and sharing experiences. Thanks to everyone in the Netherlands and Southern Africa who made time to talk to me. Many of you showed interest, asked questions and opened my eyes without even being aware of it. Last, but certainly not least, I thank you, Anouka. For your patience, your insight and for making highly complex matters suddenly seem simple. That is a quality I rarely find in people. Of course, I should not forget my fellow students. I can almost say that I will miss the long train trips because you guys (or in this case, girls) were there.

In an earlier travel report on my trip to South Africa and Namibia, I observed the personal commitment of people working on HIV/AIDS. Their personal commitment impressed –and still impresses– me. I then noticed that people sometimes get so involved, that it is difficult for them to take a step back and see the bigger picture.
Only a few weeks later, I found myself in exactly the same situation. I got lost in a maze of details on HIV/AIDS, organisations, people and concepts. I experienced at first hand how easy it is to get involved in, and confused about, HIV/AIDS.

Writing about and analysing capacity building with a focus on the practice of southern partner organisations, also confused me. At one point, I realised that the issues I observed in their organisations, are very much alike the issues my own organisation struggles with. Of course we do not operate in a local context so dramatically changed by HIV/AIDS. Our context is however changing rapidly in other ways, especially due to the changing relation between state, markets and civil society.

The similarity in our issues strengthens my personal vision on development. Northern development organisations do not develop southern partner organisations, we develop each others capacities, and the added value of development work is when we co-operate to face our similar issues.

Glossary of terms and abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ALU	AIDS Law Unit
CBO	Community Based Organisation
CSO	Civil Society Organisation
DGIS	Dutch Ministry of Foreign Affairs, Development Co-operation
GDF	Green Development Foundation
GRCF	Greater Rustenburg Community Foundation
FTTSA	Fair Trade in Tourism South Africa
HIVOS	The Humanist Institute for Co-operation with Developing Countries
HIV	Human Immunodeficiency Virus
HRD	Human Resources Development
ID	Institutional Development
LAC	Legal Assistance Centre
MEA	Micro Enterprise Alliance
M&E	Monitoring and Evaluation
NACOBTA	Namibian Community Based Tourism Association
NiZA	Netherlands institute for Southern Africa
NFPDN	National Federation of People with Disabilities in Namibia
NGO	Non-Governmental Organisation
PLWHA	People Living With HIV AIDS
PSO	PSO currently stands for: Capacity Building in Developing Countries
OD	Organisational Development
OVCs	Orphans and Vulnerable Children
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
VSO	Voluntary Services Overseas

Summary

In many countries in sub-Saharan Africa HIV/AIDS affects a major part of the adult population. Civil society organisations (CSOs) are affected through their staff and volunteers, beneficiary group and external relations. HIV/AIDS therefore has considerable implications for CSOs. Capacity building is a potentially promising approach to strengthening CSOs. But what happens when HIV/AIDS becomes a part of the reality of these organisations? PSO, the Dutch Association for Capacity Building in Developing Countries suggested to further explore the relation between HIV/AIDS and capacity building.

CSOs plan and organise their work in projects and programmes. The focus in this study is on the implications of HIV/AIDS for building capacity in these projects and programmes. This study combines theory and the practice of PSO member organisations (northern CSOs) and their partners (southern CSOs) to explore these implications. It is an attempt to link the work of practitioners to that of researchers, and to contribute to both. This study seeks to answer the central question:

What role can capacity building play in coping with the impact of HIV/AIDS on programme performance and what are the capacity building practices of PSO members and their southern partners?

Chapter 1The impact of HIV/AIDS
This study starts with an exploration of the impact of HIV/AIDS. Alan Fowler describes how different types of CSOs employ different forms of capital and therefore experience HIV/AIDS differently. Rick James suggests that to be effective, CSOs need to be strong in three related areas: their internal organisation, programme performance and external relationships. HIV/AIDS affects CSO capacity in those three areas. Amoaten pictures how the virus and illness changes the lives of households and communities and what this means for programme work in Malawi. She presents several lessons from her experiences in livelihood programmes.

The work of these researchers is brought together to present an overview of elements to consider in analysing the impact of HIV/AIDS on programme performance. Those elements are: changes in the profile of the target group, a worsening situation of the target group, an increasing demand of the target group, an increased workload, stigma, demoralisation, a loss in programme output and increasing programme costs.

Most of the elements of the theoretical overview recur in the practice of the partner organisations of PSO members. Partners especially make assumptions about the impact of HIV/AIDS on the ultimate beneficiaries of their work. The profile of the target group changes, their situation worsens and their demand increases. They find it harder to concretise how organisations in their network experience the consequences of HIV/AIDS, and have the least information about the impact in their own organisation. Stigma still seems to play a big role.

The perceptions of these partners reconfirm Fowler's typology and shed a new light on it. Fowler distinguishes between formal and informal organisations, and between organisations that citizens form to serve themselves or others. These different CSO types experience HIV/AIDS differently. The experiences of partners add to this that it makes a difference whether CSOs serve the ultimate target group directly or through intermediaries. Moreover, it makes a difference whether they interact with individuals, households, communities or organisational staff in their programme work.

Chapter 2 Responses to HIV/AIDS
This chapter focuses on CSO responses to the impact of HIV/AIDS. Sue Holden distinguishes five strategies for responding to HIV/AIDS: AIDS work, integrated AIDS work, mainstreaming HIV/AIDS externally, mainstreaming HIV/AIDS internally and complementary relationships. External mainstreaming is a very relevant strategy for responding to the impact of HIV/AIDS on programme performance. The concept of external mainstreaming is however disputed, and researchers and practitioners are still in the process of defining it further. Holden and Amoaten both discern four key steps in the external mainstreaming process.

As in Chapter 1, the theory posited in this chapter is framed to present an overview of elements to consider in analysing responses. This overview (see box 2 on page 12) follows the last two key steps in the process of external mainstreaming as defined by Amoaten: adapting ways of working and reviewing & revising programme interventions.

The theoretical overview of responses in this chapter does not seem to be particularly appropriate to frame the practice of partners. The partners do adapt their ways of working, but usually don't follow a holistic and articulated strategy to respond to HIV/AIDS in their non-HIV/AIDS programme work. Three organisations in this study set up a new programme for HIV/AIDS separate or on top of their non-HIV/AIDS programme work. This did not in all cases result in reducing the negative impact of HIV/AIDS on their non-HIV/AIDS programme work, and in some cases even diverted attention and budget away from non-HIV/AIDS activities.

The practice in this chapter adds to the theory that different types of organisations are likely to respond to HIV/AIDS in different types of ways. The responses described by Amoaten apply to the situation of partners that work directly with households and communities, but not to the situation of partners that work with intermediaries or member organisations.

Chapter 3 Capacity building in times of HIV/AIDS
This chapter explores the role and place of capacity building in the process of coping with the impact of HIV/AIDS on programme performance. The capacity building concept of PSO is relevant for the purpose of this study. For PSO, capacity building is not a one-off activity, but a wide range of interrelated activities covering a longer period of time. PSO operationalises capacity building by explaining it as investing in Human Resources Development, Organisational Development and/or Institutional Development.

James and Mulder perceive a need to develop staff and other organisational processes and systems in times of HIV/AIDS. James refers to five key areas in which organisational capacity building takes place: staff awareness programmes, organisational staff policies, long-term human resources implications, financial budgeting and monitoring, and wider OD interventions. Mulder takes it a step further by referring to the need for organisations to develop further in the programme and institutional area. He presents five capacity building needs in the context of HIV/AIDS: dealing with HIV & AIDS on their own workforce, ensuring that front- and back-office operations are synchronised and mutually supportive, positioning and innovating, developing, expanding, improving and/or adapting front-office services, and going to scale**.**

Fowler adds to this that the possibilities that CSOs have to build their capacity in responding to HIV/AIDS, depend on the type of CSO they are and the functions they perform. For formal CSO types (the CSOs in this study) Fowler suggests capacity building responses including: HIV/AIDS information dissemination to members, voluntary counselling and testing services for members, HIV/AIDS policy related analysis for advocacy and negotiation with state and market actors, a non-profit organisation (sub-)sector wide HIV/AIDS forum and development of common support services.

In this chapter, the various capacity building elements identified by James, Mulder and Fowler are drawn together in one overview (see box 3 on page 16). I have chosen to use the PSO subdivision of capacity building in HRD, OD and ID in this overview, to see how the PSO 'frame' applies to the practice of partners or PSO members.

The capacity building practices of partners are highly varied and at an early stage of development. Few of the elements in the theoretical overview on capacity building and HIV/AIDS recur in the practice of the partners in this study. In testing out the theory in this chapter in practice, I noticed how difficult it is to make a distinction between the *responses* of partners (described in chapter 2) and the *capacity building practices* of partners. In conversations with partners I came to realise that responses are the new or adjusted activities of partners in reaction to HIV/AIDS. Capacity is what partners need to design or change their activities.

To better understand the meaning of capacity building in coping with the impact of HIV/AIDS, it is interesting to return to Holden's definition of external mainstreaming. In Holden's theory on external mainstreaming, capacity building is regarded as a step that organisations take within their organisation, prior to revising their programme work and systems to HIV/AIDS. The practice in this chapter shows that capacity building can potentially be a continuous development process that transforms the capacities of organisations –preferably simultaneously within their organisation, programme work and external relations–to cope with the impact of HIV/AIDS on programme performance.

Chapter 4 The role of PSO members
This chapter concerns the role of donors and capacity builders (PSO members) in the process of coping with the impact of HIV/AIDS on programme performance. James poses challenges for capacity builders and for donors in this process. He puts an emphasis on developing the capacity of individual partners to make changes within their own organisation and within their programme work. Fowler proposes NGOs to consider five 'complementarities' and one 'bias' (towards women and girls) in dealing with capacity building in the era of HIV/AIDS. He presents capacity building for HIV/AIDS as a mutual effort of north and south, and especially stimulates organisations to match their capacity building process (both internally and in the programme area) to the efforts of others. The findings of James and Fowler are drawn together to provide an overview of possible aspects of the role of development NGOs in coping with the impact of HIV/AIDS (see box 4 on page 22).

Limited time and inappropriate circumstances are a restraint for some staff of PSO members in this study to put HIV/AIDS on the agenda in conversations with partners. Several dilemmas are mentioned in addressing HIV/AIDS. Some partners are interested in support from PSO members, while others do not see a role for them. The general expectation of partners is that PSO members are not interested in working on HIV/AIDS with them. Considering the expectations in theory on the role of NGOs in working on HIV/AIDS with partners, the role of PSO members in this study is in its infancy. Most PSO members in this study are, however, currently shaping or expanding their role in supporting partners to cope with the impact of HIV/AIDS.

Conclusions
This report concludes with the position that it might be too early to speak of 'capacity building practices to cope with the impact of HIV/AIDS on programme performance'. The concept and application of capacity building in times of HIV/AIDS is new to most PSO member organisations and southern partner organisations in this study. They have an idea of the impact of HIV/AIDS on their programmes, and (re)act in various ways. They do not, however, take strategic action to reduce the negative impact of HIV/AIDS on their non-HIV/AIDS programme work. Capacity building can potentially transform the way PSO members and their partners cope with the impact of HIV/AIDS on their programme performance. It requires that they invest in a continuous change process.

The effects of HIV/AIDS are initially felt at a personal level. It is people who become infected, get ill, and live the rest of their lives dependent on medicines, or die. It is through people that HIV/AIDS affects organisations. The theory in this report shows that HIV/AIDS undermines the capacity of civil society organisations in three ways, through three groups of people. Through their staff, through the beneficiaries of their programmes and through the people in organisations and institutions they relate to. The capacity of CSOs can be undermined, and built in these three ways. This study focuses on one way: programme performance. Practice shows that building capacity in the programme area is strongly connected to building capacity in external relationships and in the internal organisation. Responding and building capacity in the internal organisation often precedes and even replaces responding in the other areas. It is not surprising that personnel are the first priority of CSOs. A transformation of the current situation, however, demands equal attention for the other areas. Both PSO members and their partners are responsible for ensuring this attention.

Recommendations
The information in this study provides several opportunities for PSO members in the process of building capacity in the context of HIV/AIDS. A first step in the process can be to determine if and how HIV/AIDS can be addressed in the dialogue with partners that work in a context of HIV/AIDS. PSO members can support partners in determining what the impact of HIV/AIDS is on their work. PSO members can support partners in articulating and shaping their response to cope with the impact of HIV/AIDS. Finally, PSO members can support partners to articulate the capacity they use and need for their response, and support them in developing their capacities.

The findings in this report provide several opportunities for the PSO bureau. PSO bureau staff can consider if and how they want to give HIV/AIDS a place in their dialogue with PSO members and stimulate PSO members to do the same. The PSO bureau can play a role in bringing together members with a similar problem context with regards to HIV/AIDS. The PSO bureau can stimulate PSO members to work out case examples with partners regarding their capacity building approach in addressing HIV/AIDS. Finally, the PSO bureau can stimulate PSO members to (continue to) work on their own HIV/AIDS policy, and connect them to organisations that can assist them with this process.

Contents

Introduction

Context

Worldwide, 60 million people have been infected with HIV. 20 million of them have now died as a result of AIDS (UNAIDS, 2004: 6). HIV/AIDS has been reported from every inhabited continent and every country, but it has not affected all nations or people equally. HIV/AIDS has hit hardest in Africa south of the Sahara, where it is still gathering speed (Barnett & Whiteside, 2002: 9).

Civil society, the private sector and governments are struggling to respond (James, 2005: 6). In their response, civil society organisations (CSOs) increasingly use capacity building. The meaning of capacity building is contested. Capacity is one of those words that mean all things to all people, and non-profits have approached and interpreted capacity building in many different ways (Venture Philanthropy Partners, 2001). The basic principle behind capacity building is to build high-performing organisations, rather than just strong programmes. Programme performance is considered within the context of an organisation's capacity.

HIV/AIDS has implications for CSO capacity. In many countries in sub-Saharan Africa adult infection rates are between 20-40 per cent and this statistic applies as much to CSO staff and volunteers as it does to the beneficiary group (James, 2005: 6-7). This scale of infection has considerable implications for CSOs. It affects their own organisations due to sick leave, extra medical expenses and the loss of invaluable learning and experience. It affects their programmes due to changes in the profile and demand of beneficiaries, and reduced productivity and effectiveness within programmes. It affects their relations with others, due to a shift in priorities and scarce time and resources to invest in linking and networking. Ultimately, it affects their role in society. In times of HIV/AIDS, CSOs thus struggle to *build* –and not *lose*– capacity.

Relevance

Information about the relation between HIV/AIDS and capacity is scarce. Many researchers and practitioners stress the importance of finding practical ways forward in the current situation. So does PSO, the Dutch Association for Capacity Building in Developing Countries. HIV/AIDS was placed on the agenda of PSO in 2002, when PSO member organisations and PSO bureau staff suggested exploring the issue. The above mentioned burdens for CSOs were considered potentially relevant for the southern partner organisations of PSO members. Several PSO initiatives with regards to HIV/AIDS are now in process. The PSO Knowledge and Learning Centre enrolled an HIV/AIDS learning trajectory in close co-operation with PSO member organisations. The PSO International Human Resources department drafts an HIV/AIDS policy for field workers financed by PSO and for PSO bureau staff. Another initiative is this study on the capacity building practice of PSO member organisations and their southern (civil society) partner organisations.[1]

Some information on their capacity building practice is already available. Various Dutch and international organisations - i.e. WHO, KIT, Cordaid, Stop AIDS Now, Share-Net, Novib, INTRAC - have been exploring capacity building and HIV/AIDS in the Health sector. This study commissioned by PSO, focuses on the practice of capacity building in sectors other than the Health sector. The focus is on non-HIV/AIDS organisations that work in socio-economic sectors funded by PSO, namely Economic Development and Human Rights. A few Dutch and international researchers -i.e. Kerkhoven & Löwik (2004), James (2004 & 2005) and Fowler (2004) study capacity building regarding the internal functioning of CSOs in a context of HIV/AIDS. This study focuses on programme performance in a context of HIV/AIDS and the implications for capacity building.

Aim and research questions

The objective *in* this study is to establish an insight in the capacity building practices of PSO members and their southern partners to cope with the impact of HIV/AIDS on programme performance. The objective *of* this study is to provide insight into these practices to provide PSO members and their partners with an opportunity to reflect on these practices, and to identify options of the PSO bureau for supporting them.

This objective results in the following central question:
What role can capacity building play in coping with the impact of HIV/AIDS on programme performance and what are the capacity building practices of PSO members and their southern partners?

[1] In this document, Dutch PSO member organisations to the association PSO are regularly referred to as 'PSO members'. The southern partner organisations are referred to as 'partners'.

To answer the central question, the following sub-questions are formulated:

1. What is the *impact* of HIV/AIDS on programme performance and what impact do partners perceive?
2. What *responses* exist to cope with the impact on HIV/AIDS on programme performance and what responses do partners perceive?
3. What *capacity building practices* exist in this context and what are partners' capacity building practices?
4. What is the *role of PSO members*?
5. What options does the PSO bureau have to support PSO members and their partners in capacity building?

In answer to the above questions, chapters 1-4 include both theory and the practice of PSO members and/or their partners. When attempting to understand the process of capacity building in times of HIV/AIDS, theory and practice complement each other. Theory on capacity building and HIV/AIDS is relatively new and in constant development. Few written accounts are available of current practices. This study is an attempt to link the work of practitioners to that of researchers, and to contribute to both.

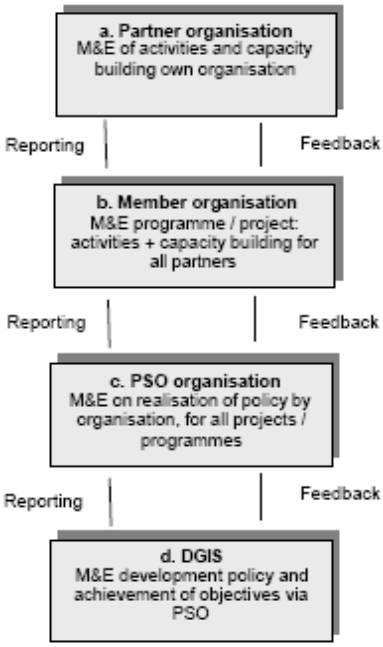
Methodology

The research in this study is of an exploratory nature. The main research methods used are an examination of (policy) documents, literature review and semi-structured interviews. The study is limited to research in Namibia and South Africa, both countries with a high HIV/AIDS prevalence rate (±20%). They face enormous challenges in responding to what WHO calls a now-mature and generalised HIV/AIDS epidemic (WHO, 2005). The experience in facing the epidemic in these countries is valuable in this research context.

Case selection

The relationship between the PSO organisation, PSO member organisations and partner organisations is visualised in a chain of relations (figure 1). The empirical research within this study consisted of two phases:
1. semi-structured interviews with PSO member organisations (level b)
2. semi-structured interviews with partner organisations (level a)

Figure 1 Chain of relations (PSO, 2003)



The PSO members researched in phase one are VSO, NiZA, HIVOS and GDF. This selection of PSO members is made on the basis of:

- the **countries** in which the partners of these members are located (countries in Africa with a medium to high HIV prevalence);
- the **sectors** in which they work (Human Rights & Economic Development);
- the **status** of their **HIV/AIDS policy** (two members in the selection have an HIV/AIDS policy, two do not have one).

In August 2005, respondents (of PSO member organisations) were asked to provide examples of successful encounters with partners. This method was used because of the limited available information on the nature and form of capacity building in times of HIV/AIDS. The questions about these encounters were adjusted throughout the interview period with PSO members.

The partners researched in phase two (see Annex 2 for a brief description of these partners) were proposed by PSO members on the basis of:

- the **country** in which they are located;
- their **focus** (not HIV/AIDS, but Human Rights or Economic Development);
- the **nature of their relation** with the PSO member (capacity building relation and contact for at least 1 year);
- their **sustainability and size** (> 5 years, > 5 staff members);
- the **availability** of the partner for an interview with the researcher.

In September 2005, respondents (of partner organisations) were asked about the changes they see as a consequence of HIV/AIDS and the changes in their work as a reaction to it. Their reaction was explored along the lines of selected capacity building dimensions. These dimensions are drawn from the PSO definition of capacity building (see Chapter 3). Depending on their value in the interviews, dimensions were added or remained unmentioned.

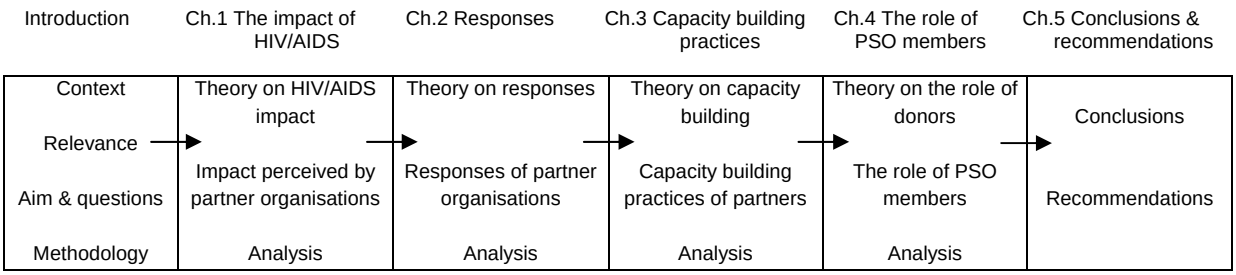
Methodological restraints

The research in this study is carried out in Namibia and South Africa. Information on their local context is included in Annex I. The context in these countries is very different to that of many African countries, and even more so with regard to other developing countries. Distinct features of these countries –including their history, the position of government and civil society, the HIV prevalence and the stage of the AIDS epidemic– affect the research outcomes. South Africa and Namibia especially distinguish themselves from other countries due to their history of Apartheid, high HIV/AIDS prevalence and mature stage in the AIDS epidemic. In both countries, government has become (very) active in coping with the impact of HIV/AIDS in the last decade and the role of civil society is strong and becoming stronger (WHO, 2005). It is therefore likely that HIV/AIDS-related capacity building practices in these countries are at a more advanced stage than in other countries.

In the selection of PSO members and partners in this study, it was important to include non-HIV/AIDS organisations with various approaches and with a willingness to co-operate. This pragmatic way of selecting organisations is necessary to obtain enough information about their practice, but can certainly affect research outcomes. One consequence is that some of the partners in the research are co-funded by PSO, and some not. Another consequence is that no 'informal' (community-based, social) partner organisations are included in the research selection. This was not a deliberate choice, but appeared as a bias in the selection of partners proposed (and possibly funded) by PSO members.

Structure of this report

The structure of this report follows the 5 sub-questions above. Chapter 1 answers question 1, chapter 2 answers question 2, and so further. Chapters 1-4 all start with a theoretical part based on literature and other resources, and continue with a practical part based on the interviews with PSO members and/or their partners.



Chapter 1 The impact of HIV/AIDS

Introduction

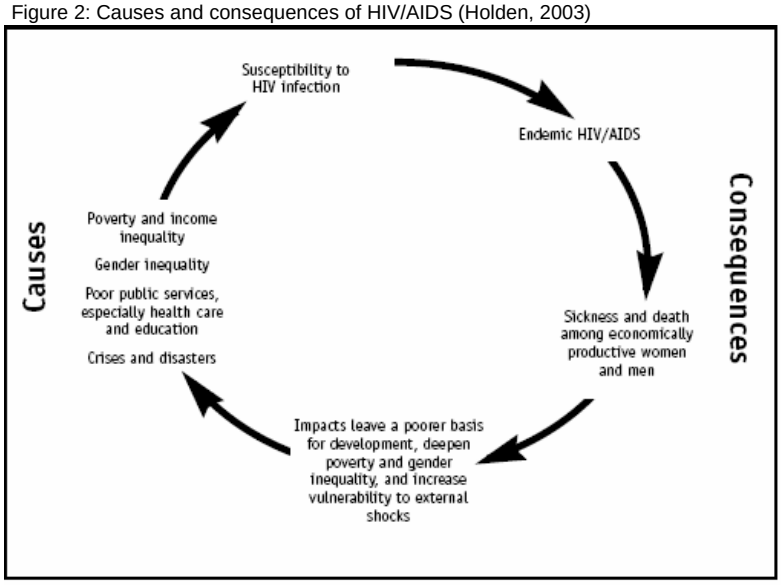
HIV/AIDS and development are strongly interrelated. Organisations in the domain of government, the market and civil society deal with the impact of HIV/AIDS. This chapter focuses on the impact of HIV/AIDS on the programme performance of CSOs. The chapter starts with an outline of theory on HIV/AIDS impact, and continues with how partner organisations perceive impact. Both parts (theory and the practice of partners) together offer information of details to be considered when analysing the impact of HIV/AIDS on programme performance.

1.1 The impact of HIV/AIDS on development

The likelihood of becoming infected with HIV, *susceptibility* to HIV, is generally greater for people that live in a development country. Their environment is shaped by conditions of underdevelopment: poverty, disempowerment, gender inequality, and poor public services. The likelihood of HIV & AIDS harming people, the *vulnerability* to HIV/AIDS, is also greater in these conditions (Holden, 2003: 5).

As the figure on the right shows, underdevelopment does not only increase (or cause) HIV/AIDS, it is also a consequence of HIV/AIDS (2003: 7). This places the people working on development (in government, corporations and civil society) in an important position to counter the disease, and turn the negative circle in figure 2 into a positive spiral.

Figure 2: Causes and consequences of HIV/AIDS (Holden, 2003)



Different levels of impact

The impact of HIV/AIDS is often communicated by means of figures aggregated by WHO and UNAIDS. They provide an estimate of the number of people living with HIV and the number of AIDS deaths. The figures are broken down into countries, groups, and knowledge and behaviour indicators. They are informative and useful for responses on global, regional and national levels. What the statistics cannot provide is an image of what happens to infected and ill people, their families, their work, and the systems in their society. That image is necessary as a starting point for developing methods to react to the disease.

In most development research, the impact of HIV/AIDS is described on a societal level (as in the above model) and on the level of communities, the household and the individual. For capacity builders, a plausible level as a starting point for (re)action is the **level of the organisation**. Researchers have recently started exploring the impact of HIV/AIDS on the organisational level. The core problem identified in an ILO study (2004) is the loss of skilled workers with job-specific competence and organisational experience. Because of the variation in characteristics of organisations, the impact of HIV/AIDS is different for every organisation. The focus in this study is on organisations that are part of civil society. Civil society as part of the three sector institutional model of state, market and civil society.

1.2 The impact of HIV/AIDS on civil society organisations

Civil society organisations (CSOs) come in many varieties. Alan Fowler (2004: 5) discerns the typology in figure 3, showing that citizens form associations to serve themselves or others. Citizens may choose to be recognised by society through some form of registration, or remain informal by not seeking legal status.

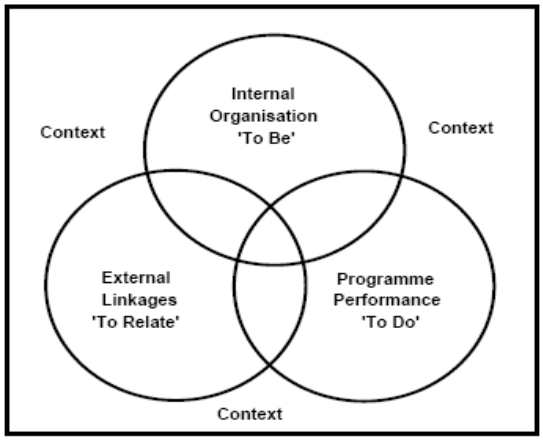
Figure 3: Typology of CSOs (Fowler, 2004)

Beneficiary Focus	Informal	Formal
Self, Mutual or Member Serving	Community-based organisations (CBOs), traditional/kinship sets and societies, clubs, groups, local (services) committees	Professional bodies, Unions, Cooperatives, faith-based organisations
Third-party serving	Social movements, Networks	(Development) NGOs, welfare institutions

Fowler (2004:8-11) describes that different types of CSOs employ different forms of capital and therefore experience HIV/AIDS differently. **Informal member-serving** CBOs experience decreasing household incomes and increasing (health care) costs in communities. In **informal third-party serving** CSOs, the impact is typically felt through the individuals who drive and lead these person-based initiatives. When they fall ill or die, much of the activity falls away. **Formal member-serving** CSOs struggle with increasing demands of members, decreasing resources, weakening of paid staff and pressure to lobby & advocate on HIV/AIDS. For the **formal, third party serving** CSOs, problems include increased costs due to HIV/AIDS infection, moral issues in establishing HIV/AIDS polices, absenteeism, demoralisation and 'organisational depression', distraction of staff, reduced programme effectiveness, self-absorption at the cost of collaborative initiatives and the pressure to 'do something developmentally' about HIV/AIDS.

James (2004: 12) presents the Three Circles Model to analyse the impact of HIV/AIDS on CSO capacity. This model posits that to be effective, CSOs need to be strong in three related areas: namely their internal organisation; their programme performance and their external relationships.

Figure 4 The Three Circles Model (James, 2004)



How does HIV/AIDS affect CSO capacity in these three areas? Impacts on the internal organisation are a lower staff productivity and morale, direct & indirect financial costs, recruitment costs, loss of organisational memory & learning, and leadership & management costs.
Impacts on external relationships are shifting donor funding priorities, a shift in the relationship with government and less willingness to invest time and resources in longer-term networks and collaborative relationships. This study focuses on the impact on programme performance, which is dealt with in the theory below.

1.3 The impact of HIV/AIDS on programme performance of civil society organisations

Ryan Manning's (2002: 25) efforts to quantify the impact of HIV on programme output resulted in a best-case scenario of NGOs in Natal, South Africa losing 1-2 per cent of output. James (2005: 13) suggests this to be a very conservative figure. He states that working in a context of high HIV/AIDS prevalence will undoubtedly undermine programme performance. HIV/AIDS will cause development productivity to fall (all else being equal) at a time when donors are demanding more visible, short-term results.

CSO programmes reliant on volunteers are finding that these volunteers are increasingly focusing their support on their own immediate families as there are more income and medical needs closer to home. Families of sick mothers are not eligible to take part in her programme activities for her. NGOs in Malawi report that their meetings with communities are now frequently being 'bounced' by funerals, with programmes therefore increasingly falling behind schedule and budget (James, 2005: 13)

Susan Amoaten (2004: 3) from Oxfam Malawi reports on the impact of HIV/AIDS on livelihood programmes in the Shire Highlands. The virus has changed many people's daily lives by increasing everyone's workload, reducing productivity and increasing household expenses. Whilst everyone is vulnerable, women and girls are particularly affected. This is because of limited access to information and services to protect themselves, low status in the community and lack of economic opportunities and the fact they are usually care givers in the community. Not only is the virus affecting individuals within households, but this has a direct impact on the community in general as people are less able to be involved in community meetings and development projects. Although people's knowledge about HIV/AIDS is quite high, stigma is a huge problem. Few people are comfortable to talk about their own households' illness or death related to HIV/AIDS.

Oxfam Malawi has learnt valuable lessons. Amoaten (2004:4) mentions:

- The importance to look at the increase in widow or child headed households and in chronically or acutely sick households. These households are either discouraged from or drop out of community activities and may not be visible using traditional targeting techniques.

- Some development approaches may unintentionally exclude HIV affected households because they presume people are mobile, not housebound.
- HIV/AIDS changes the way poverty and vulnerability is seen in the community: a family may at one time be seen as poor with workable livelihoods options but quickly slip into highly vulnerable status due to ill health or death in the family.
- Increasing levels of poverty make it difficult to select who to include and exclude with targeting strategies.
- Young people may become increasingly vulnerable and need special attention.
- Labour constraints become a reality for many families and make it difficult for families to participate in livelihood activities.

Although they have a different viewpoint on the impact of HIV/AIDS, the findings of Fowler, James and Amoaten show several points of agreement. All mention consequences for the target group and staff, and put an emphasis on emotional and more quantitative aspects. In the figure below, their findings have been drawn together to propose an overview of elements to consider in analysing the impact of HIV/AIDS on programme performance.

Box 1 The impact of HIV/AIDS on programme performance

1. **Changes in** (the profile of) **the target group**, sometimes leading to exclusion: more children, elderly, widows, sick people
2. **Worsening situation of the target group:** the poor become poorer, the vulnerable more vulnerable
3. **Increasing demand of the target group:** for health, community and CSO programme services
4. **Increased workload:** labour constraints for families in livelihood activities, less time for volunteer work, pressure for programme staff to work on HIV/AIDS activities instead of programme activities
5. **Stigma:** denial of infection or disease, sometimes resulting in discrimination
6. **Demoralisation:** depression, self-absorption at the cost of collaborative issues, distraction and absenteeism of both target group and programme staff
7. **Loss in programme output:** programmes run behind schedule and budget, reducing effectiveness and productivity within programmes, weakening of programme staff, weakening of target group and CBOs
8. **Increasing programme costs:** cost escalation for CBOs, because of increasing costs of target group

The next paragraph considers how partners of PSO members perceive the impact of HIV/AIDS. The above overview is used to interpret their practices.

1.4 How partners of PSO members perceive impact

The partner organisations in this study are located in South Africa and Namibia. Annex II gives an impression of the involved organisations. The partner organisations are categorised in Fowlers' typology matrix in figure 5.

Figure 5 The selection of partners in Fowlers' typology matrix

Beneficiary Focus	Informal	Formal
Self, Mutual or Member Serving	-	MEA, NFPDN, NACOBTA
Third-party serving	-	GRCF, FTTSA, LAC, Friendly Haven

As mentioned in the Introduction of this report, no informal partner organisations are included in the research. The two formal organisational types are. The impact perceived by formal partner organisations is described in the next two sub-paragraphs. The description in these sub-paragraphs is based on interviews in September 2005.

Impact perceived by formal self/mutual/member serving partner organisations

Micro Enterprise Alliance (MEA) is a micro credit membership organisation in Johannesburg. MEA's members are micro finance organisations and micro finance consultancy organisations. Although HIV/AIDS statistics are familiar to them, MEA staff members don't discuss HIV/AIDS impact in a personal way with contact persons from member organisations. This feels awkward, or inappropriate to them. Once or twice a year, MEA staff members visit the communities (co-operatives) that participate in micro credit schemes of their member organisations.

MEA staff members are not sure about the impact of HIV/AIDS on the co-operatives and do not discuss this with members. MEA staff can estimate the percentage of co-operative members that fall ill or die theoretically. The practice in co-operatives is however unclear. MEA is not sure what happens financially when a smaller number of co-operative members are responsible for the costs of ill members. The micro finance organisations rarely write off bad debt within their micro credit schemes and schemes rarely fall out.

In its work with community groups, the **National Federation of People with Disabilities in Namibia (NFPDN)** notices that many disabled people do not know what HIV/AIDS is, or what to do in case they are HIV+. The public idea is that disabled people don't have sex and if they do, that is a taboo. Because of this idea, disabled people rarely receive information about HIV/AIDS. Disabled women are victims of rape more often than able-bodied women. Because of the problems that exist when disabled women give birth to children, the Namibian government has set up a programme to sterilise (!) disabled women. Disabled people that have HIV/AIDS are often excluded, or doubly discriminated. Because of their disability, and their HIV/AIDS status.

NACOBTA is an organisation that supports communities to develop tourism enterprises in Namibia. Staff members from NACOBTA do not see consequences of HIV/AIDS for their member organisations, which are community tourism organisations and small to medium tourism enterprises. Some NACOBTA staff members have heard of people that died, or know them personally. They know little about the affect of HIV/AIDS on people, or organisations.

NACOBTA technical advisor:
'We were just not confronted with HIV/AIDS. I think we were lucky. Or maybe people are mysterious about it. You can never be sure if a person takes leave. Some people just go, and you don't know exactly why. That has even happened within our own office.'

Impact perceived by formal third-party serving partner organisations
The team of the **Greater Rustenburg Community Foundation (GRCF)** in South Africa have seen different consequences of HIV/AIDS in their region. Overall human degradation prevails in the mining areas of the Greater Rustenburg Area, where a growing number of funeral parlours open every year. When GRCF assessed some of the local communities in the region, they found an enormous increase in the number of orphans and vulnerable children (OVCs) in the villages. Between July 2004 and February 2005, an average community of about 4000 people faced a rise from 80 to 130 orphans.

Early learning centres and schools funded by GRCF don't just take care of the education of children anymore; they take care of children's development. The centres become the one moment that children come into contact with an adult. The demand for food, clothing, shelter and personal attention grows. Where teachers used to go home after work, they now take care of many children that need a place to sleep.

Impact is also clear in the *women's networks* funded by GRCF. Abuse has been a problem in the region for a longer period, as the tension in families is usually high when the man of the house has to go away for long periods to work at the mines. More abuse cases were reported in the last 5 years. Couples often fight over who was the cause of HIV-infection. If one or more family members become ill or even die, tension rapidly builds up.

Fair Trade Tourism in South Africa (FTTSA) says that when it comes to HIV/AIDS, most people in the tourism industry have their head in the sand. People know the statistics, but don't relate them to their own organisations. FTTSA sees two reasons. First, talking about HIV/AIDS in your organisation might scare your guests away. Second, most tourism business are rather small, and it might take some time before the impact of HIV/AIDS is visible. In some organisations certified by FTTSA, people are open to FTTSA staff about their HIV+ status. For many owners and managers of lodges, HIV/AIDS is still a problem 'at a distance'.

FTTSA development officer:
'I remember a man that was ill and could no longer do his work as a night guard. Other staff members covered for him, worked for him while he was asleep.'

The Legal Assistance Centre (LAC) based in Windhoek has been confronted with the impact of HIV/AIDS through litigation work. When the number of infections grew explosively from 1991, HR lawyers started to get more and more cases related to HIV/AIDS. Many of the cases concern HIV+ people dealing with stigma and discrimination in the workplace. Employers breach confidentiality rules and many people get fired because of their HIV+ status. This creates a climate of fear in organisations and households. People become afraid to be open about their HIV+ status and do not want to get tested voluntarily. Apart from dealing with the disease, women and children are confronted with additional problems when their husbands or fathers die, for example because they do not automatically inherit the property of their family members.

1.5 Analysis of impact perception

The findings in the work of Fowler, James and Amoaten clearly recur in the perception of partners. A 'worsening of the situation of the target group' and an 'increase in demand of the target group' are often mentioned by partners. Most partners make assumptions about the impact of HIV/AIDS on the ultimate target group of their programme work, even if they do not have a working relation with the beneficiaries in this group. The respondents in this study find it harder to concretise how organisations in their network (of members or intermediary organisations) feel the consequences of HIV/AIDS. The impact in the own organisation appears most unclear; none of the respondents could mention examples of PLWHA in their organisation.

This might be because personal conversations about HIV/AIDS, whether within the organisation or externally, are not commonplace. Stigma still seems to plays a big role: 'it doesn't happen to us'. People know about the statistics, but don't relate to them personally. Another reason might be that HIV/AIDS sneaks in; people fall ill and die very gradually. As FTTSA and GRCF point out, especially in small organisations it can take a while before HIV/AIDS visibly takes its toll.

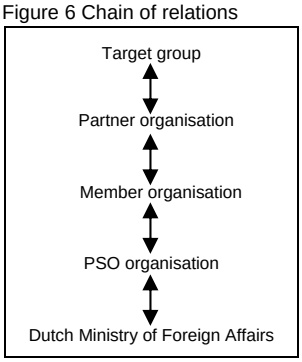
What stands out is that partners have a different view of the ultimate target group. LAC staff members interact personally with communities, and seem to have a good idea of the impact of HIV/AIDS on their legal clients. GRCF and NFPDN mention developments on a broader scale, as in 'the profile change of communities in Rustenburg', and 'the double discrimination of people with disabilities in Namibia'. The difference in perspective seems to originate in a different working relation. LAC works directly with the target group, whereas GRCF and NFPDN work through other organisations (intermediaries) to reach the target group. Their programme activities are operational on the level of the intermediaries and not on the level of the ultimate target group.

Going back to the theory, the practice of these partners reconfirms the typology of Fowler and sheds a new light on it. Fowler distinguishes between formal and informal organisations, and between organisations that citizens form to serve themselves or others. The experiences of partners add to this that it makes a difference whether organisations serve the ultimate target group directly or through intermediaries.

Chain of relations

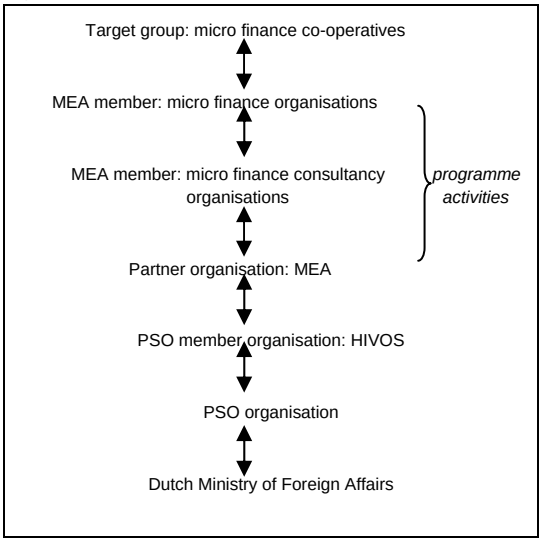
This point is important for PSO members and their partners, as it means that their perception of the impact of HIV/AIDS can be influenced by the 'chain of relations' they find themselves in. Figure 6 represents the 'chain of relations' PSO discerns.

Figure 6 Chain of relations



HIV/AIDS impacts all components of the chain in a different way. Generally, the impact of HIV/AIDS is larger and more direct for the target group and smaller and less direct upward in the chain. This is a general tendency. In practice, the chain is not as straight forward as in figure 6. Most partner organisations in this study do not have a direct relationship with the ultimate target group.

Figure 7 Chain of relations MEA



This can be explained using MEA as an example. In the case of MEA, a large number of intermediaries operate between MEA and the ultimate target group (see figure 7).

For MEA, this means that it is easier to perceive the impact of HIV/AIDS on its member organisations, than the impact on co-operatives. This does not seem to be a problem for its programme performance, as the MEA programme activities are operational on the level of MEA member organisations and not on the level of the co-operatives.

It cannot be underrated however that ultimately, MEA programmes (need to) realise something for the co-operatives. Moreover, the HIV/AIDS impact on the co-operatives interacts with the impact on MEA members.

In other words, if one group in the chain feels the impact of HIV/AIDS, it can impact other groups as well. If co-operatives cannot carry the financial burden when members in the co-operative become ill, the burden possibly passes on to the micro financier. Vice versa, if micro financiers officers cannot visit the co-operatives regularly due to illness and leave, this threatens the sustainability of the co-operatives. The impact of HIV/AIDS on both groups can be crucial for the programme work of MEA. The chain of relations influences the way partner organisations experience the impact of HIV/AIDS.

Impact level

Various levels of impact are mentioned In the theory at the beginning of this chapter. The level of the organisation is mentioned as the most important level for capacity builders. The practice of partners shows that other levels are just as important when exploring the impact of HIV/AIDS on programme performance. Figure 8 lists examples of those other levels.

Figure 8 Various impact levels in this study

groups in society:	people with disabilities (NFPDN)
organisational staff:	micro finance organisations (MEA)
community groups:	tourism lodges (NACOBTA)
households:	women, children & families (Friendly Haven)
individuals	legal cases (LAC)

What partners perceive of the impact of HIV/AIDS is influenced by the impact level on which they work. The Friendly Haven is concerned with the impact on households, as it interacts with women, children and their families. NACOBTA is concerned with organisations and communities. The impact level of programme work influences the way partner organisations experience the impact of HIV/AIDS.

Advertising poster in a bus stop in Namibia

Chapter 2 Responses to HIV/AIDS

Introduction

It is now time to look at possible responses for coping with the impact of HIV/AIDS. A range of responses exists. This chapter focuses on CSO responses to cope with the impact of HIV/AIDS on programme performance. It outlines theory on mainstreaming HIV/AIDS and relates it to the practice in partner organisations. The analysis of their practice provides core insights in responses to cope with the impact of HIV/AIDS.

2.1 Responses to cope with the impact of HIV/AIDS

Barnett & Whiteside (2002: 316) argue: '*There should be a continuum of policy and practice spanning prevention and impact mitigation. Care is an important component of both of these. Prevention responses have been inadequate and generally ineffective. In the poor world the spread of HIV continues, requiring planning for increased care needs and other aspects of impact mitigation. There are few signs that this is happening.'*

Responses and their target groups depend on the stage of the epidemic. Early response should focus on prevention. If prevention does not work we have to deal with impact. There is no prescription for dealing with impact. Few national or regional plans address this in a holistic manner and there exist a sparse range of responses. The range has recently grown, to include initiatives as National AIDS Co-ordinating Authorities. What responses exist to cope with the impact of HIV/AIDS on programme performance? Mainstreaming HIV/AIDS is a relatively new response strategy of organisations working on HIV/AIDS within a programme context.

2.2 Mainstreaming HIV/AIDS

The understanding of mainstreaming HIV/AIDS is evolving. Mainstreaming is not an intervention per se. It is a process and constitutes a range of practical strategies for enhancing responses and addressing HIV/AIDS impact (UNAIDS/GTZ, 2002: 3). Experience in mainstreaming HIV/AIDS is relatively limited. Many theorists and practitioners are in the process of further defining the concept. Sue Holden (2004: 34) defines five strategies for responding to HIV/AIDS, summarised in figure 9.

Figure 9 Five strategies for responding to HIV/AIDS

1. AIDS work: Work which is directly focused on preventing HIV/AIDS, or care, treatment, or support for those who are infected – *work which is distinct and implemented separately, from other development and humanitarian work.*
2. Integrated AIDS Work: AIDS work which is implemented along with, or as part of, development and humanitarian work. The focus is still on direct prevention, care, treatment, or support, but with the difference that the work is *conducted in conjunction with, and linked to, other projects, or within wider programmes.*
3. Mainstreaming HIV/AIDS externally: *Adapting development and humanitarian programme work in order to take into account susceptibility to HIV transmission and vulnerability to the impacts of AIDS.*
4. Mainstreaming HIV/AIDS internally: *Changing organisational policy and practice* in order to reduce the organisation's susceptibility to HIV infection and its vulnerability to the impacts of AIDS.
5. Complementary relationships: Organisations focusing on their strengths, while *linking actively with other organisations that can address other aspects of the HIV/AIDS pandemic.*

Some activities may be hard to categorise. There is a lot of difference between AIDS work –whether it is separate or integrated– and mainstreaming HIV/AIDS externally. For AIDS work, the starting point is the problem of AIDS, and AIDS projects are developed in response. For external mainstreaming, the starting point is organisations' existing development work, with processes modified to take account of HIV/AIDS.

Some practitioners do not find the distinction between internal and external mainstreaming desirable, because both are part of the same process. The Swiss Agency for Development and Co-operation designed an approach to combine mainstreaming HIV/AIDS in the internal and external sphere (SDC, 2004: 26). Belgium Development Co-operation refers to the internal domain as an entry and starting point for mainstreaming in the external domain (ITM, 2003: 72). For the purpose of this study, it is interesting to make the distinction between internal and external mainstreaming. External mainstreaming is a very relevant strategy for responding to the impact of HIV/AIDS on programme performance. The strategy is explored in the next paragraph.

2.3 External mainstreaming of HIV/AIDS

The concept of external mainstreaming HIV/AIDS is as disputed as mainstreaming HIV/AIDS. The meaning of the concept remains undefined in most contexts, and therefore leads to much confusion among practitioners. Holden (2004: 76) defines four main sequential steps for external mainstreaming in development work:

1. training & capacity building for staff about external mainstreaming
2. community research
3. designing development work which indirectly addresses susceptibility to HIV & vulnerability to AIDS
4. adapting systems

Training and capacity building helps personnel who are not AIDS workers to respond to the problem through their normal work and not through AIDS work. Within the **community research**, both the research methodology (i.e. peer groups) and research topics (i.e. the impact of AIDS and responses at household and community levels) are relevant. The findings of the community research feed into the process of **designing development work** which indirectly addresses HIV and AIDS. This process aims at minimising the negative effects and maximising the positive effects of development work and involving stakeholders via joint planning or consultation. **Systems are adapted** by including HIV/AIDS in employees' roles and responsibilities and including appropriate elements of HIV/AIDS in all aspects of the project cycle.

In her report on livelihood programmes in Malawi, Susan Amoaten (2004: 5) discerns four steps in the mainstreaming process. They resemble the steps of Holden:

1. develop the capacity of the partner organisation through mainstreaming HIV/AIDS internally
2. research in the programme area on the impact of HIV/AIDS
3. adapting ways of working
4. reviewing and revising programme interventions

Steps 3 and 4 cover the response within the programme. Amoaten illustrates these steps in her report, by describing them as part of an external mainstreaming process in one of the existing programmes:

Adapting ways of working

The overall support to local structures was reviewed. The programme embarked on a major capacity building initiative that included specific recommendations on how to better include affected families and support those infected or affected by HIV. The programme looked at developing new ways of working that can directly reach affected households such as home based care groups, faith based organisations and orphan support groups. Lessons learned include:

- Capacity building needs to include training and workshops on a regular basis to account for increased turnover of people;
- Prioritise training and capacity building on how to identify and respond to chronic illness and death but also to tackle the issue of stigma and discrimination;
- Tools used with the community need to include an HIV/AIDS perspective, including participatory tools;
- Encourage people affected by chronic illness and death to be represented and promote women into leadership positions and prioritise gender awareness.

Reviewing and revising programme interventions

The programme looked at how it needed to adapt its interventions to ensure they were relevant in light of labour shortages. Staff and extension workers went through Oxfam's objectives, activities and indicators, and were encouraged to make small, tangible modifications rather than drastic changes to build on the core competencies of existing staff. Testing of new and innovative ideas was encouraged, and much attention was paid to developing model farmers to spread innovation and learning amongst men, women and young people.

A number of new ideas have evolved, most have a labour saving element this being the biggest constraint to HIV affected households, but many have other benefits such as improving nutritional status of households (particularly relevant for the chronically sick, the elderly and the young). Some increase income security creating a living bank to rely on rather than forcing people into risky survival strategies such as migration or sex work. The most important lesson learned was that development agencies need to search for and develop new strategies which can provide some level of social welfare or safety nets within the framework of the existing design and structure of the programme.

These last two steps in the process of external mainstreaming –adapting ways of working and renewing & revising programme interventions– provide a useful starting point for analysing responses to the impact of HIV/AIDS. Responses as defined in this chapter and in this study are part of the process of external mainstreaming. It is easier to segment this process into smaller parts, as the concept of external mainstreaming is relatively abstract and often unknown or unclear to practitioners.

In the box below, the work of Holden and Amoaten has been brought together to propose an overview of elements to consider in analysing responses to the impact of HIV/AIDS on programme performance.

Box 2 Responses to the impact of HIV/AIDS on programme performance

Adapting ways of working:

1. **Training and capacity building** on how to identify and respond to chronic illness and death, but also to tackle the issue of stigma and discrimination
2. **Involvement of stakeholders**, including those affected by AIDS and women, via joint planning or consultation;
3. **Tools** used within the programme include an HIV/AIDS perspective
4. Special attention for **youth, elderly, women and People Living With HIV/AIDS** in programme activities

Reviewing and revising programme interventions:

5. Search for and development of **new strategies** which can provide some level of social welfare or safety nets within the existing design and structure of the programme;
6. Appropriate elements of HIV/AIDS in all aspects of the **programme cycle**, including the **formulation of programme** objectives, activities and indicators together with stakeholders in the programme;
7. HIV/AIDS in **employees' roles and responsibilities**;
8. Testing of **new and innovative ideas**, for example: labour saving elements, benefits improving nutritional status, benefits increasing income security;
9. **Monitoring** of implementation and modification as appropriate.

As in chapter 1, this overview provides a tool to move on from resources on responses to see what responses look like in practice. The next paragraph considers how partners of PSO members respond to HIV/AIDS.

2.4 How partners of PSO members respond to cope with HIV/AIDS impact on programme performance

In this paragraph, the response practice of partner organisations is described. Their responses are not described per organisation, as in Chapter 1, but per response step. This approach is chosen to focus on the responses of CSOs, and not on the individual organisations.

Adapting ways of working

Many of the partners in this study mention that a starting point for their response was to organise informal HIV/AIDS awareness trainings for member organisations and/or beneficiaries. That is, after they had organised HIV/AIDS sensitivity activities in their own organisation, such as putting condoms on the toilets, hanging up informational posters and discussing HIV/AIDS together. The partner organisations that did not organise HIV/AIDS activities in their own organisation did not organise activities for their beneficiaries either.

Programme Manager GRCF:
'You have to go and treat the reasons why people have unsafe sex. The biggest reasons why people have unsafe sex…prostitution, substance abuse…are not addressed in awareness trainings.'

Training courses often breaks new ground for other HIV/AIDS response activities. The HIV/AIDS officer –a VSO volunteer– of the National Federation of People with Disabilities in Namibia (NFPDN) used to be Fundraising officer. He got engaged in HIV/AIDS when VSO asked him to organise HIV/AIDS sensitivity activities. He then organised a conference on HIV/AIDS and Disability. The conference was a huge success, and NFPDN decided to set up an HIV/AIDS & Disability Programme. The Micro Enterprise Alliance (MEA) was encouraged by donors and its member organisations to 'do something' about HIV/AIDS. MEA set up an HIV/AIDS task group. The task group proposed to start an HIV/AIDS Programme for MEA members. In this programme, MEA guides and trains staff of member organisations in setting up their own workplace policies. The Legal Assistance Centre (LAC) established a separate unit (AIDS Law Unit) to better address the needs of legal clients. The unit not only supports its regular clients in HIV/AIDS related matters, but also actively informs communities, staff of large organisations and government officials of their rights related to HIV/AIDS.

Not all partners initiate separate HIV/AIDS programmes. The Greater Rustenburg Community Foundation (GRCF) decided not to train the non-profit organisations in its portfolio, but to build the capacity of the local AIDS council. GRCF funded and organised their strategic planning process and an exchange with local AIDS councils in Mozambique and Botswana.

The director of the Friendly Haven explains that, due to its limited size, the shelter has no policy or activities on paper with regards to HIV/AIDS. All women that start to live in the shelter are however informed about testing facilities and care for themselves and their babies in case of illness. One partner in this study, NACOBTA, does not respond to HIV/AIDS in any way. The Namibian umbrella organisation 'NACSO' organises HIV/AIDS awareness workshops for NACOBTA staff and for members of NACOBTA (community tourism organisations). According to the technical officer of NACOBTA, most staff within NACOBTA feel no ownership to do anything about HIV/AIDS in the work with its members, in part because this is 'what NACSO does'.

The HIV/AIDS co-ordinator of NFPDN naturally mentions disabled people as a priority target group for its activities. None of the other organisations mention prioritising certain groups of stakeholders in the planning and implementation of programme activities. However, due to changing demand, most partners increasingly work with youth, elderly, women and People Living with HIV/AIDS (PLWHA). GRCF for example provides a major part of its grants to early learning centres, projects for orphans and women networks.

Reviewing and revising programme interventions

LAC, NFPDN and MEA spent a considerable amount of time and resources on their response to HIV/AIDS. The AIDS Law Unit of LAC ensures a constant attention for HIV/AIDS and human rights within LAC. According to the director of LAC, staff of other programmes are also more sensitive to the problems that people face due to HIV/AIDS. Within the Land Development Unit for example, legislators support women in their struggle to inherit land or property after their husbands die.

LAC director:
'I am not satisfied yet. I would like to see a lot more attention for HIV/AIDS and Gender in all of our units. HIV/AIDS is such a complex human rights issue, that it is difficult to integrate it in the other programmes. It asks a whole different mindset, and it is a challenge to make HIV/AIDS a cross-cutting issue in our organisation instead of just another separate unit.'

NFPDN General Secretary:
'We are struggling. Our donor-base is decreasing and we plan to decentralise to the region in the next two years. Those issues ask my complete attention.'

Since the VSO volunteer was appointed HIV/AIDS officer for NFPDN, HIV/AIDS is discussed in every meeting. The two other staff members however have too much work on their hands to get strongly involved.

The MEA staff are in a similar position. The Membership Development Officer came to spend most of her time on the HIV/AIDS programme and most other membership development work came to a halt. The 3 other staff members of MEA need all their time to continue their own work.

Some partners chose to make adjustments in existing programmes. These adjustments are often small and practical. The Friendly Haven started growing a vegetable garden so that the shelter can provide women and children with nutritious food, and teach them how to grow and cook their own nutritious dinner. As mentioned earlier, FTTSA recently integrated HIV/AIDS in its certification process. In practice this means that tourism organisations that want to receive a fair trade certificate now have to look into the impact of HIV/AIDS on staff and visitors and possibly initiate a response. FTTSA dedicated a newsletter to HIV/AIDS to highlight the importance of HIV/AIDS and present the lodges with response options.

Abstract from FTTSA newsletter:
'A game lodge in Kwazulu-Natal has an exemplary HIV/AIDS staff programme. It features awareness workshops and one-on-one staff counselling. Staff have access to medical care, multi-vitamins and a high-nutrition diet. Partners of staff are permitted to live with them on site. This is not an industry norm.'

None of the partners administrates adjustments to HIV/AIDS in project and programme documentation. It is not common to make reference of HIV/AIDS in programme proposals and monitoring reports of (non-HIV/AIDS) work. Neither do they document new ways of working, as in the profile description of employees.

2.5 Analysis of responses

The theoretical overview of responses in this chapter does not seem to be particularly appropriate to frame the practice of partners. The partners in this study do adapt their ways of working, but usually don't follow a holistic and articulated strategy to respond to HIV/AIDS in non-HIV/AIDS programme work. The activities that partners do undertake in their non-HIV/AIDS programme work to respond to HIV/AIDS are small and practical.

Three organisations in this study set up a new programme for HIV/AIDS separate or on top of their 'regular' programme work. In the case of the LAC, the new HIV/AIDS unit has not only resulted in new programme work related to HIV/AIDS, but also in attention for HIV/AIDS in the non-HIV/AIDS programme work of other units. In the case of NFPDN and MEA however, the staff working on HIV/AIDS operate separate from other staff, and the HIV/AIDS programme draws away attention and budget from non-HIV/AIDS activities. NFPDN and MEA seem to risk diverting from their regular programme work to work on HIV/AIDS, instead of making adjustments to reduce the negative impact of HIV/AIDS on their regular programme work.

Some of the respondents are afraid that this will happen to their organisation if they get involved in responding to HIV/AIDS. 'We don't want to become just another HIV/AIDS organisation.' HIV/AIDS can however increase the demand for non-HIV/AIDS programme work in such a way, that organisations end up being something similar to an HIV/AIDS organisation. GRCF chose not to invest in the endless stream of HIV/AIDS organisations in Rustenburg, but does invest a great part of its funds in child and day care centres. Would these centres exist without HIV/AIDS?

A reason why the theoretical overview might not be applied easily to the practice of partners in this study is that Amoaten describes the responses of organisations working directly with households and communities. The partners in this study that work with intermediaries or member organisations respond in other ways (i.e. lobby and advocacy or exchange meetings on HIV/AIDS) than those organisations. This finding is in agreement with Fowlers' findings on CSO responses to HIV/AIDS. He promotes that different CSO types employ different response strategies (Fowler, 2004: 9)

In analysing the response of partners working with intermediaries or member organisations, it is difficult to discern whether they mainstream internally or externally. This can best be explained with the example of MEA. MEA guides its member organisations in drafting an HIV/AIDS workplace policy. For the members concerned, the activities are in the internal sphere. For MEA, the activities are in the external sphere. It is thus important to be clear about the focus level within the 'chain of relations' (see chapter 1) when talking of mainstreaming.

This study started from the premise that responses to cope with the impact of HIV/AIDS require certain capacities. In the key steps in external mainstreaming discerned by Holden and Amoaten, capacity building precedes the actual 'response'. The next chapter zooms in on capacity building in responding to the impact of HIV/AIDS. It further defines the 'place' of capacity building in the response process.

Chapter 3 Capacity building in times of HIV/AIDS

Introduction
This chapter explores the role and place of capacity building in the process of coping with the impact of HIV/AIDS on programme performance. It starts with an examination of the concept of capacity building and continues with capacity building practices and requirements of partner organisations of PSO members. The practice of partners is used to review current capacity building concepts including capacity building in times of HIV/AIDS.

3.1 Capacity building: the concept

The capacity building concept of PSO is relevant for the purpose of this study. For PSO (2003: 5), capacity building is not a one-off activity, but a wide range of interrelated activities covering a longer period of time. PSO discerns the following capacity building characteristics:

- **strengthening the functioning** of an organisation or developing new strategies/activities;
- taking account of **external influences** on the context in which (groups of) organisations operate;
- interventions not only concerning individuals, but **primarily organisations** as autonomous entities and the entire institutional community;
- a central role for **sustainability** and **ownership**;
- **investing in** one, or more of the following levels: human resources development **(HRD),** organisational development **(OD)** and institutional development **(ID)**.

The subdivision of capacity building in HRD, OD and ID is an operationalisation of capacity building. PSO refers to HRD as the improvement and maintenance of the quality of personnel resources within an organisation. This includes the way in which people develop and focus their knowledge, skills, attitudes and motivation within their daily routine – their work within the organisation. To PSO, OD means sustainably improving and strengthening the internal capacity of an organisation (or sections thereof), so that it is better able to achieve its objectives and fulfil its mission. This is not just about improving the quality of the staff, though this may be part of the strategy. ID is often defined as the general development and influencing of the broader context in which organisations operate. The focus of PSO in ID is the strengthening of ties between organisations and their interactions.

3.2 Capacity building in the context of HIV/AIDS

Few resources report on capacity building in the context of HIV/AIDS. This paragraph outlines what is written by Rick James, Alan Fowler and Arjen Mulder. James (2005: 22-27) notes that there is still ‘very little evidence in CSOs of organisations modifying the way in which they are behaving’. The focus of James is on responses in the area of the internal organisation. He refers to the following key areas in which organisational capacity building response to HIV/AIDS takes place:

- **staff awareness programmes:** a precondition for tackling problems in the workplace and in programmes. Programmes include themes as anti-retroviral treatment, living positively, use of condoms, counselling skills and personal responsibility;
- **organisational staff policies**: critical illness/health policies aim to cover human resources management, welfare and insurance policies and address the increased need for sick leave and recruitment.
- **long-term human resources implications:** a strategic plan of how programmes will be staffed to mitigate the impact of HIV/AIDS (by multi-recruitment, multi-training), not just today and next year, but five years on.
- **financial budgeting and monitoring:** register direct & indirect costs, by increasing, splitting and adding budget (lines).
- **wider OD interventions:** issues such as power and decision-making, gender and sexual harassment.

Arjen Mulder (2005: 5-10) describes how development organisations need 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. Based on lessons learnt from the VSO practice in Southern Africa, he presents five capacity building needs of VSO partners (both HIV/AIDS and non-HIV/AIDS organisations) in the context of HIV/AIDS:

- **dealing with HIV & AIDS on their own workforce**: by means of workplace programmes, training of additional staff, adjustments to medical care packages or the addressing of stigma and denial within and outside the organisation;

- ensuring that **front and back office operations are synchronised and mutually supportive**: growth in service delivery should be accompanied by the strengthening of finance and administration systems;
- **positioning and innovating**: including facing limitations, finding niches, focusing on certain aspects and deciding what can be done better by other organisations to keep in phase with the pandemic and to pro-actively position themselves;
- **developing, expanding, improving and/or adapting front-office services**: organisations need support in developing new or better services, and in developing models for 'multiplying' interventions;
- **going to scale**: both the quality of interventions and the *coverage* are important. The challenge to organisations is to find ways to replicate models of good practice at the lowest possible cost. 'Going to scale' needs to be backed up by systems, a clear vision and strategy and a system for learning.

James and Mulder both mention the need to develop staff and other organisational processes and systems. Mulder takes it a step further by referring to the need for organisations to develop further in the programme and institutional area, especially in how to deliver HIV/AIDS services. His main focus is on AIDS service organisations, but he mentions that the above needs are just as relevant for organisations working in different areas that are challenged to adapt their external service role to deal with the effects of HIV & AIDS.

Apart from this service delivery function, Fowler (2004, 12) identifies various other CSO functions: mutual social and economic support, local management, connecting and energising constituencies, advocacy and participation and political engagement. Depending on their function(s), they have various capacity building requirements. For formal CSO types (the CSOs in this study) Fowler suggests capacity building responses including: HIV/AIDS information dissemination to members, voluntary counselling and testing services for members, HIV/AIDS policy related analysis for advocacy and negotiation with state and market actors, a non-profit organisation (sub-)sector wide HIV/AIDS forum and development of common support services.

In box 3, the various possible elements identified by James, Mulder and Fowler have been drawn together in one overview. The PSO subdivision of capacity building in HRD, OD and ID has been chosen in this overview, with the objective to see how the PSO 'frame' applies to the practice of partners or PSO members. Their capacity building practices are the subject of the next paragraph.

Box 3 Capacity building in the context of HIV/AIDS

Human resources Development

1. **HIV & AIDS in the workplace**: staff awareness activities addressing stigma, training counselling skills & personal responsibility, adjustments to medical care packages, welfare & insurance policies, sick leave & recruitment policies;
2. **Long term HR strategy**: strategic plan of how programmes will be staffed;

Organisational Development

3. **Financial budgeting & monitoring**: finance and administration systems registering direct and indirect costs, by increasing, splitting and adding budget lines;
4. Developing **new or better programme interventions** and **models** for 'multiplying' interventions;
5. **Synchronising** growth in **programme with** the strengthening of finance and administration **systems**;
6. **Greater coverage** of programme interventions: find ways to **replicate good practices** at the lowest cost;
7. **Wider OD interventions**: gender awareness, staff empowerment, shift in organisational culture towards an open decision making process;

Institutional Development

8. Policy related analysis for **advocacy & negotiation** with state and market actors;
9. **Positioning & innovating**: deciding what can and cannot be done, or done better by others;
10. **HIV/AIDS forum** & development of **common support services**.

3.3 Capacity building in times of HIV/AIDS by partners of PSO members

In this paragraph, the capacity building practices of partner organisations of PSO members are described on the three levels HRD, ID and OD.

Human resources Development

The CEO of FTTSA speaks frankly about the problem she –and many other partners in this study– face when it comes to dealing with HIV/AIDS for her own staff. Although FTTSA has an internal HIV/AIDS policy, she would not know what to do if a staff member actually fell ill. Due to the HIV/AIDS policy, FTTSA has some medical inventory in-house, but that is not enough. FTTSA is unable to pay for hospital transportation or medicines. It is difficult enough to find donors that want to pay salaries, let alone medical expenses, or sick leave. FTTSA wants to account for these matters, but cannot afford to.

Anonymous:
'One of my colleagues recently lost a family member to HIV/AIDS. This person worked half days for a long period to take care of that family member. The emotional strain on my colleague and the rest of us was high.'

NFPDN and FTTSA mention that working on HIV/AIDS means that involved staff members need a basic understanding of HIV/AIDS, and communication skills. Staff members participated in awareness trainings, but those do not necessarily prepare them for facilitating group discussions or one-on-one dialogues on HIV/AIDS. Some organisations hired new staff for HIV/AIDS work. NFPDN appointed an HIV/AIDS co-ordinator and LAC started up an AIDS Law Unit employing lawyers, paralegals and administrative staff. NFPDN, FTTSA and LAC see a need for more staff to continue HIV/AIDS related programme activities in the future. FTTSA needs someone to implement an HIV/AIDS policy that would really work for the organisation. The director of LAC mentioned how he would like to hire a co-ordinator for cross-cutting issues (including HIV/AIDS and Gender).

Organisational Development

CEO GRCF:
'The challenge for us is that it asks more money and time. Once you have a sound response strategy thought through with an NPO, you have to give them a chance to work it out.'

GRCF receives a great many proposals from non-profit organisations (NPOs) that want to initiate HIV/AIDS awareness activities, treatment facilities, supply of food supplements and vitamins, home based care programmes and OVC centres. Most of these NPOs are initiatives of young and enthusiastic, but inexperienced people. GRCF can not possibly reward all proposals. GRCF sees a lot in fast-tracking and upscaling its current capacity building activities to help these NPOs to strategise, professionalise and to bring them together to help them co-operate instead of compete. Right now, GRCF does not have the staff, means or administrative back-up to realise this.

NFPDN has a similar problem. The HIV/AIDS co-ordinator sees a demand for information materials on HIV/AIDS for visually impaired and deaf people. He realises that it will take more staff and administrative back-up than the NFPDN currently has to publish these materials and get them into use in several regions in Namibia.

LAC saw a rising demand due to HIV/AIDS coming early on. When LAC started the AIDS Law Unit (ALU) in 1998, lawyers dealt with numerous cases reacting to stigma and discrimination in the workplace. Currently, the ALU team provides for the wants of People Living With HIV/AIDS (PLWHA) with litigation services as will-writing and legal assistance in cases regarding access to treatment, wilful infection and land inheritance. The ALU employs several skilled staff members and can fall back on the administrative and financial systems of LAC to act upon the demand. It took LAC much time and effort to build the unit as it is now. Some staff members did not agree with the decision to address HIV/AIDS in such a comprehensive way. Back in 1998, the idea that HIV/AIDS is a human rights issue was new. It took many internal discussions to get the staff on one line.

Apart from more staff, resources and administrative back-up, several partners in this study have either built or are in need of more research capacity to address the impact of HIV/AIDS. MEA researched the HIV/AIDS activities of its members before starting up its workplace policy programme. LAC researches emerging issues to address the needs of PLWHA, seeks international precedents of new cases and shares groundbreaking cases with other (international) human rights organisations. FTTSA would be interested in researching the needs and possibilities for tourist organisations regarding HIV/AIDS.

Institutional Development
LAC is not the only CSO in this study that connects to and relies on external relations to respond to HIV/AIDS. FTTSA asked help from its network of expertise (assessors, IUCN, expert panel, board, tourist organisations) to adjust its certification process to include HIV/AIDS indicators. The CEO of FTTSA is interested in networking with other (HIV/AIDS service) NGOs to share best practices. NFPDN created linkages with HIV/AIDS organisations to refer beneficiaries to them and for joint (advocacy) undertakings in the area of HIV/AIDS. MEA hired HIV/AIDS consultants to assist in its HIV/AIDS programme.

Another changing practice in the institutional area is that LAC started using more and alternative media and public fora (national television, newspapers) to present notable cases of PLWHA to break through the culture of stigma and discrimination in Namibia. Moreover, LAC adapted an advisory role (not only an advocacy role) in its relation with Namibian government and private corporations to advocate and negotiate for the rights of PLWHA.

3.4 Analysis of capacity building practices
The capacity building practices of partners are highly varied and at an early stage of development. Few of the elements in the theoretical overview on capacity building and HIV/AIDS recur in the practice of the partners in this study. In the area of human resources development, the partners mostly address HIV/AIDS in the workplace. Due to a lack of money, internal HIV/AIDS policies do not always result in practical measures. None of the partners in this study have formulated longer term HR strategies.

With regards to organisational development, most partners in this study have to overcome organisational obstacles to design and implement a response to HIV/AIDS in their own field of expertise, due to their size (5 or less staff members) and level of professionalism (lack of administrative systems, skilled staff). The OD elements mentioned in the theoretical overview in this chapter go a step to far for most partners in this study, as the idea that responding to HIV/AIDS requires an organisational change is new.

Capacity building in the institutional area is promising. Many of the partners in this study link in to other organisations to find information or partners in responding to HIV/AIDS. Partners only occasionally search for their competitive advantage or niche in reacting to HIV/AIDS, compared to that of other CSOs, state and market.

Capacity building in theory and practice
Going back to the theory at the beginning of this chapter, it is interesting to see what the practice of partners tells me about it. In putting the theory to the test of practice, I noticed how difficult it is to make a distinction between the *responses* of partners (described in chapter 2) and the *capacity building practices* of partners. The practice in this chapter made me realise that responses are the new or adjusted activities of partners in response to the impact of HIV/AIDS. Capacity is what partners need to adjust their activities.

To better understand the meaning of capacity building in coping with the impact of HIV/AIDS, it is interesting to return to Holden's definition of external mainstreaming. In her definition, Holden defines four steps: (1) training & capacity building for staff about external mainstreaming, (2) community research, (3) designing development work that addresses susceptibility to HIV & vulnerability to AIDS and (4) adapting systems.

In Holden's definition, capacity building is a step that organisations take within their organisation, prior to revising their programme work and systems to HIV/AIDS. Considering the theory and practice in this chapter, building capacity to cope with the impact of HIV/AIDS on programme work comprises more than a first step in external mainstreaming. Capacity building can potentially be a continuous development process that transforms the capacities of organisations –preferably simultaneously within their organisation, programme work and external relations–to cope with the impact of HIV/AIDS on programme performance. From such a point of view, capacity building can be the 'missing link' in turning external mainstreaming into a transformational process.

Chapter 4 The role of PSO members

Introduction
This chapter concerns the role of PSO members in the process of coping with the impact of HIV/AIDS on programme performance. The first three chapters dealt with the practice of partners in defining impact, responding and building capacity. The role that PSO members have in this process is considered in this chapter.

4.1 The role of donors in coping with the impact of HIV/AIDS
Few resources report on the role of donors in building capacity to cope with the impact of HIV/AIDS. James (2004: 27) describes some implications for donors. He poses challenges for capacity builders and challenges for donors. PSO members can be both. The challenges that James sees for both groups are paraphrased below.

Challenges for capacity building providers
Capacity building providers need to adapt the **content of capacity building**. They should systematically mainstream HIV/AIDS into all their capacity building work. This includes amongst others assisting clients to develop staff policies, adapt financial and monitoring systems, become a more learning organisation and reinforce leadership development. HIV/AIDS requires **adapting the process of capacity building**; taking a more organisational approach, rather than individually targeted training inputs. By means of **collaborative approaches**, CSOs should be encouraged to work together to address capacity building issues, by setting up economies of scale through joint programmes, peer-to-peer support and national working groups. Finally, capacity building providers will need to **evaluate and assess impact**, by taking declining capacity baseline into account in impact assessment of development work.

Challenges for donor organisations
Donors have a role in **raising partners' awareness of their needs**, by helping them become more aware of the pressing issue of HIV/AIDS. They may be in a position to **support capacity building interventions**, to mainstream HIV/AIDS externally into partners' programmes and internally into their organisations. This could be realised by contracting local partners to train partners, encouraging partners to develop policies, funding processes with outside facilitation, funding to develop a network of capacity building providers and encouraging the pooling of resources. Donors need to be willing to **provide extra funding support** to cope with the organisational impact; cover costs of increased staff benefits and strategic capacity maintenance costs including overstaffing, multi-skilling, increasing salaries and paying for sabbaticals. Working with partners in contexts of high HIV/AIDS prevalence requires **adjusting the overall partner strategy**. This means supporting organisations longer-term rather than projects short-term, accepting that it will cost more money to do less work and being aware of the passing on of conditionalities.

In thinking about how to respond to HIV/AIDS, for Fowler (2004: 16) the starting point is to look at strategies in a comprehensive way. He proposes NGOs to consider five 'complementarities' and one 'bias' (towards women and girls) in dealing with capacity building in the era of HIV/AIDS:

1. **Short-long term strategies**: NGO strategies can encompass both a long-term view in an incremental and responsible way alongside more immediate actions.
2. **Intermediary CSOs and Constituency-based CSOs:** protecting and rebuilding the capacity of third-party serving CSOs should be matched by similar efforts with grassroots and communities.
3. **Organisational and (sub)sector wide**: matching the effort put into capacity building of individual CSOs with attention to sector-wide initiatives, to cost-effectively reach a scale of capacity building services and to increase the visibility and weight of argument towards governments, donors and corporations.
4. **You and your partners:** the search for complementarity between northern NGOs and counterparts remains essential. HIV/AIDS may test the extent to which deep lying moral and ethical views coincide.
5. **Levels of engagement:** to work out where engagement with others (including government, corporations and back donors) can be the most productive.

James puts an emphasis on developing the capacity of individual partners to make changes within their own organisation and programme work. Fowler presents capacity building for HIV/AIDS as a mutual effort of north and south, and especially stimulates organisations to match their capacity building process to the efforts of others. In box 4 (on the next page) I bring the findings of James and Fowler together to provide an overview of possible aspects of the role of development NGOs in coping with the impact of HIV/AIDS.

Box 4 The role of development NGOs in coping with the impact of HIV/AIDS

1. **Adapt your own capacity building work** with partners to include HIV/AIDS;
2. **Evaluate and assess** impact of HIV/AIDS on the capacity of the partner;
3. **Raise partners awareness** of their needs with regards to HIV/AIDS;
4. Support capacity building interventions **to mainstream HIV/AIDS into partners' programmes;**
5. Provide **extra funding** support;
6. **Match** capacity building **efforts**:

- in the short term with long term views and actions;
- of intermediary CSOs and constituency based CSOs;
- of individual CSOs with (sub)sector wide initiatives;
- with other Northern CSOs, with partners overseas and with (inter)national governments, corporations and back donors.

The next paragraph considers the role of PSO members in coping with the impact of HIV/AIDS on programme performance. The above overview is used to interpret their practices.

4.2 The role of PSO members in coping with the impact of HIV/AIDS on programme performance
In this paragraph, the role of each PSO member is first described from their own perspective, then from the perspective of their partner(s). The descriptions are based on interviews held in August and September 2005 and may therefore be unrepresentative of the current situation.

Voluntary Services Overseas the Netherlands (VSO NL)
VSO NL recruits and selects volunteers, collects funds and provides programme support in development countries. Of the 6 VSO International development goals, VSO NL chose to focus on 3: HIV/AIDS, Disability and Participation & Governance. A VSO programme office is located in almost every country where VSO volunteers work. Staff members from VSO NL mostly contact partners through VSO Programme offices. VSO programme offices and partner organisations either have occasional contact (twice a year) for monitoring & evaluation purposes or regular contact (monthly) regarding various issues. Staff members of VSO NL usually have an impression of the programmes and activities of major partners and visit some of them on duty trips.

VSO NL is currently formulating an 'official' HIV/AIDS policy. VSO International performs and publishes on HIV/AIDS responses, including on mainstreaming HIV/AIDS. VSO runs a regional HIV/AIDS programme (RAISA) in Southern Africa since 2000, supporting and funding both HIV/AIDS and non-HIV/AIDS organisations. VSO NL has ample experience with HIV/AIDS in Southern Africa, and is now also implementing HIV/AIDS programmes in Asia. VSO Netherlands employs an HIV & AIDS officer, just as most programme offices engaged in RAISA.

According to the HIV & AIDS officer of VSO NL, VSO volunteers play an important role in responding to HIV/AIDS. In partner organisations, they organise posters and condoms on the toilet. In some cases, volunteers or VSO programme office staff step up the response and discuss HIV/AIDS with partners on an organisational level. The main objective of the partner –and how HIV/AIDS touches it– is central in those discussions.

VSO HIV/AIDS co-ordinator: 'Everything we find important in capacity building seems to get an extra weight in the context of HIV/AIDS.'

For the VSO HIV/AIDS officer, capacity building in the context of HIV/AIDS encompasses supporting partners in organising their operational processes, in networking and in co-ordinating with other organisations. VSO's support varies, as it depends on the need of the organisation. VSO NL has a minor role in this process. It is limited to one visit every two years for planning, monitoring and evaluating programmes of (groups of) partners. VSO NL draws lessons learned in these visits and communicates them to international VSO offices and Dutch development organisations. Local VSO programme offices are responsible for the capacity building support as described by the HIV/AIDS officer.

In the interview, the HIV/AIDS officer of VSO NL brought forward the following questions:

- What is an organisation capable of coping with HIV/AIDS like?
- How far should organisations go in adapting to HIV/AIDS? When should they to it themselves and when should they seek partners to take over?
- How do you get to know about the local context and problems of an organisation in the little time you have to organise a funding programme proposal?

- Do you stick to strict monitoring & evaluation norms in times of HIV/AIDS?

VSO partners NFPDN and Friendly Haven

NFPDN and the Friendly Haven relate directly with VSO Namibia, not VSO NL. Their relationship is long-standing and close. Most communications run through VSO volunteers (HIV/AIDS co-ordinator of NFPDN, daily manager of the Friendly Haven). They are in contact with VSO Namibia on a weekly to monthly basis. HIV/AIDS is a regular topic of conversation. VSO Namibia funds most of the overhead and programme costs of both organisations. VSO supports them in capacity building, of which the majority is carried out by VSO volunteers.
VSO Namibia trains VSO volunteers on HIV/AIDS and motivates them to address HIV/AIDS within 'their' partner organisation. The volunteer within NFPDN is setting up a regional HIV/AIDS & Disability programme. The volunteer within the Friendly Haven focuses on practical assistance to HIV+ women and children (nutritious food, offer of voluntary counselling & testing). In working on HIV/AIDS in programmes, what partners especially value is VSO connecting them with other (HIV/AIDS service) NGOs, governments and donors in the VSO network.

HIVOS

HIVOS provides financial and political support for local NGOs. HIVOS is also active in networking, lobbying and in exchanging knowledge and expertise. HIVOS' policy focuses on 2 central policy fields: civil society building and sustainable economic development. HIVOS headquarters are based in the Netherlands, with regional offices located in Zimbabwe, India, Indonesia and Costa Rica. These regional offices are responsible for identification as well as follow-up contacts with partner organisations in their region.

In 1992, HIVOS first elaborated a separate policy paper on HIV/AIDS. According to the current HIV/AIDS policy (2001-2005), HIVOS regards HIV/AIDS as a human rights and development issue, exceeding the scope of health care and requiring a cross-sectoral approach. HIVOS focuses on lobby by supporting partner organisations that lobby decision makers (government, donors and pharmaceutical industries). In addition, HIVOS itself is actively engaged in most Dutch and European HIV/AIDS networks. HIVOS works on organisation building and network development for PLWHA organisations and self-organisations of sexual minorities, sex workers, women and youth. HIVOS has had an HIV/AIDS sector team, including 1 programme manager and 6 programme officers based at all (head and regional) offices since a reorganisation in July 2005.

According to one of the HIV/AIDS officers of HIVOS some staff members discuss sensitive topics such as HIV/AIDS with partners; others prefer not to overask on these topics. It is therefore possible that not all programme staff members have insight into the impact of HIV/AIDS on non-HIV/AIDS partner organisations. HIVOS Harare promotes and funds the implementation of HIV/AIDS workplace policies and expects a spin-off effect that stimulates organisations to break the taboo at the workplace and stimulate staff to mainstreaming HIV/AIDS in their programmes. HIVOS organises workshops in Africa and the Netherlands connecting HIV/AIDS partners to partners in other sectors (micro finance, gender).

HIVOS HIV/AIDS officer:
'The sensitive character of HIV/AIDS is important in our contact with partners. Taboo and fear for discrimination play a big role and therefore it requires time and trust to address the topic on our visits to partners.'

In the interview, the HIV/AIDS officer brought forward the following questions:

- How can you discuss HIV/AIDS without disrupting the relationship with your partner? Partners feel very vulnerable discussing HIV/AIDS in relation to their own organisation. How do you build up enough trust?
- When you have limited time to talk to your partner (management, staff, board on issues like result assessment, gender), when are the circumstances (trust, quiet, confidential) suitable to bring up HIV/AIDS?
- If you bring up HIV/AIDS in the conversation with partners, how can you ensure 'ownership' instead of 'resistance' or 'donor-driven action' on the side of the partner?

HIVOS partners FTTSA, MEA and LAC

FTTSA, MEA and LAC normally meet HIVOS contact persons from the regional office in Harare 1-4 times a year and e-mail regularly. Due to unfortunate circumstances, LAC and HIVOS have not met in the last few years. Hivos stimulated LAC's involvement in a joint Hivos/Ibis community response to HIV/AIDS programme in the North of Namibia and they are now an active partner in this program. HIVOS is a small to medium donor for these organisations. HIVOS funds overhead costs and programme activities, including contributions for staff development, research and networking. HIVOS Harare communicates with MEA on a regular basis and in inter-donor workshops with the Ford Foundation and CIDA. In their contact with MEA, the three donors focus strongly on HIV/AIDS and Gender. MEA started up an HIV/AIDS workplace programme with its members on the initiative

and with funding of the three donors.. HIV/AIDS is not an issue in the communication with FTTSA. The CEO of FTTSA is interested in meeting other HIVOS partners in the region to exchange with them on topics as HIV/AIDS.

Netherlands Institute for Southern Africa (NiZA)

NiZA primarily collaborates with organisations in southern Africa in which Africans themselves have joined forces to promote the freedom of expression, free media, human rights, peace building and economic justice. Together with and on behalf of these organisations NiZA works towards strengthening their capacity and influencing the policy-making process in the South and the North. NiZA also promotes the involvement in southern Africa of the Dutch population. NiZA staff generally meet partners personally 3-4 times a year. The contact is rather close. NiZA staff try to build up a trust relationship with partners, to enable ongoing reflection with the partner. In many cases, NiZA works with clusters of partners.

NiZA is in the process of drafting an HIV/AIDS policy. NiZA has no experience of funding or supporting partner organisations regarding HIV/AIDS (and supports no HIV/AIDS organisations). In the progress of formulating a policy, NiZA is setting up a pilot in Zambia. NiZA strives to find a niche in its work on HIV/AIDS, for example by approaching HIV/AIDS from a political perspective, stigma, human rights and/or gender. NiZA's ambitions with regards to HIV/AIDS are likely to encompass (lobby) work in the South and in the North.

> NiZA contact person for HIV/AIDS:
> 'We are setting up a pilot in Zambia to shape our HIV/AIDS policy. Questions to be answered in this pilot are: what HIV/AIDS players are there in Zambia? What stakeholders? What is important for partners? What is the role of government? What is the Dutch embassy doing? And then: what should be our role and focus?'

The NiZA contact person for HIV/AIDS started organising HIV activities within NiZA in 2005. She is in the process of setting up a dialogue about HIV/AIDS with NiZA partners. According to the NiZA contact person, up until 2005, NiZA staff members did not easily discuss the impact of HIV/AIDS on programmes with partners. It seemed as if the issue of HIV/AIDS did not touch partners of NiZA. She noticed that most partners did not mention HIV/AIDS in conversations, or in strategic planning sessions.

In the interview, the programme officer responsible for HIV/AIDS brought forward the following questions:

- If I question partners on HIV/AIDS, what do I have to offer? Why would I start talking about HIV/AIDS if I have nothing to offer to that contact person?
- What role can I play when I first raise the matter of HIV/AIDS? On what occasion do I start about the topic?
- What is the difference between addressing HIV/AIDS with an urban and a city partner?
- Do I endanger a relationship if I start talking about HIV/AIDS? How do I build or maintain trust?
- Should I address HIV/AIDS? Are our partners interested in it?
- What can and can't the partner fund? What is our role in this?
- How can I balance my actions with those that I expect from my partner?

NiZA partner GRCF

GRCF and NiZA partner in the context of the NiZA programme Peace, Principles and Participation. NiZA and GRCF have regular phone and e-mail contact, and meet face-to-face twice a year. NiZA mainly funds capacity building support for organisational strengthening and lobby & advocacy. HIV/AIDS is no topic of discussion between NiZA and GRCF. GRCF thinks this is because the focus of the programme funded by NiZA is different.

Green Development Foundation (GDF)

GDF guides and facilitates the sustainable development of small producer organisations in rural areas of developing countries. GDF has identified several sectors, such as coffee and tourism, as viable and profitable products and services that can improve the living conditions of members of such organisations. In contact with partner organisations, GDF positions itself as supporter and adviser, more than as a donor. The market mechanism is central to the perspective of GDF. GDF supports partners in finding their way in this mechanism. GDF is highly engaged in the work of partners and visits them two to three times a year.

GDF has no HIV/AIDS policy and has no intentions to draft it. The director of GDF is interested in HIV/AIDS and finds it an interesting and important topic to discuss in further detail. Within the own work field (fair trade), the director feels no direct responsibility to work on HIV/AIDS.

When the director visits a country or region for his work, he usually has an idea of the HIV prevalence, and he observes HIV/AIDS-

> GDF director:
> 'When a father dies in Tanzania, his land is divided under his sons. As fathers and their sons die earlier, the ground is divided faster and in smaller pieces than before. Coffee producers eventually have too little land to make a living.'

related problems during his visits. He does not discuss HIV/AIDS in conversations with partners. He suspects that a contact person from a partner in Tanzania recently died of HIV/AIDS.
According to the director, a familiar response approach taken by coffee producers is to invest 5 % of turnover in a social fund, as a means of insurance. In many cases, too many farmers apply for relief from that fund. The director feels no direct responsibility for GDF to work on HIV/AIDS with partners. He mentions the certification process of Fair Trade International as a possible entry point for responding to HIV/AIDS in the programme area,

In the interview, the director brought forward the following questions:

- In areas with a high population of children and the elderly, who should we train in certification processes?
- Are we the right organisation to address HIV/AIDS, considering that we work from a different culture, perception and level of education?
- What could we do to work on HIV/AIDS without losing our main objectives?

GDF partners FTTSA and NACOBTA
FTTSA and NACOBTA relate to GDF in the context of the GDF Tourism Support Programme. Both organisations visited each other in an exchange facilitated within this program. Face-to-face contact with a tourism advisor hired by GDF is twice a year, calls and mails two-monthly. Communication between NACOBTA and the advisor recently increased because of a critical change process in the organisation. GDF funds some overhead costs (personnel) and capacity building costs including workshops, trainings and conferences. HIV/AIDS is no topic of discussion between GDF and the two partners.

4.3 Analysis of the role of PSO members
Limited time and/or unfavourable circumstances are a restraint for some PSO members to put HIV/AIDS on the agenda in the dialogue with partners. Several dilemmas are mentioned in addressing HIV/AIDS. Should we raise the subject, or is that their role? How about stigma and confidentiality? If you address it, what can you do for the partner?

Partners' perspectives show that some partners are interested in support from PSO members, while others do not see a role for them. Generally, there is interest in linking up with the (national and international) network of the PSO member and in money for staff policies and salaries related to HIV/AIDS. Many of the partners in this study do no expect PSO members and other donors to be interested in working on HIV/AIDS with them. Consequently, they don't ask PSO members for support, or consider the types of support they could ask for.

Given the expectations of James and Fowler for the role of NGOs in supporting non-HIV/AIDS partner organisations in responding to HIV/AIDS, the role of PSO members in this study is in its infancy. Most of the PSO members in this study are, however, currently shaping or expanding their role in supporting partners to cope with the impact of HIV/AIDS. The distinction James makes between capacity builders and donors is difficult to make in practice. PSO members position themselves differently on a continuum between these two 'ideal types'.

In chapter three, capacity was described as 'what partners need to adjust their activities in response to the impact of HIV/AIDS.' Following that description, capacity building in the context of HIV/AIDS requires PSO members to support partners in the process of (1) assessing the impact of HIV/AIDS, (2) adjusting their activities in response to it, and (3) finding out what they need to adjust their activities. The PSO members in this study work on HIV/AIDS with partners in various ways. HIVOS Harare is active in stimulating non-HIV/AIDS partners to do research and network regarding HIV/AIDS and to take measures in the workplace. At the time of this research, only VSO Namibia stimulates partners to articulate the capacity they need to adjust their activities in response to the impact of HIV/AIDS.

It is important to mention here that building capacity for coping with HIV/AIDS is a process, and that HIVOS and VSO started this process in the early and late nineties respectively. NiZA has only recently started working on HIV/AIDS. Moreover, the approach of HIVOS Harare and VSO Namibia can be very different of that of other local and regional offices of HIVOS and VSO. However, it is noticeable that the two PSO members in this research survey with a local or regional presence started working on HIV/AIDS with partner organisations at an earlier stage than the two PSO members that are located only in the Netherlands.

Chapter 5 Conclusions and recommendations

Introduction
This report aims to establish insight into the capacity building practices of PSO members and their southern partners to cope with the impact of HIV/AIDS on their programme performance. This chapter starts with the main findings of the first four chapters in this report and continues with more general conclusions. These are relevant for both PSO members and their partners, as they jointly implement programme work together. The conclusions are the basis for a number of recommendations, for both PSO members and the PSO bureau.

5.1 Conclusions

Main findings
The first chapter starts with an outline of theory – and continues with perceptions of partners – on the impact of HIV/AIDS. The theory results in an overview of elements to consider in analysing the impact of HIV/AIDS on programme performance (see box 1 on page 6).
All partners in this study perceive one or more of these elements. In particular, they make assumptions about the impact of HIV/AIDS on the ultimate target group. The profile of the target group changes, its situation worsens and its demand increases. The partners in this study find it harder to concretise how organisations in their network experience the consequences of HIV/AIDS, and have the least information about the impact in their own organisation. Stigma still seems to play a big role. In this chapter, partners' experience adds to the theory that CSO's experience HIV/AIDS differently, depending on whether they serve the ultimate target group directly or through intermediaries, and depending on whether they interact with individuals, households, communities or organisational staff in their programme work.

Chapter two reports on CSO responses that exist in theory to cope with the impact on HIV/AIDS on programme performance and on responses that partners perceive. The theory in this chapter outlines five major response strategies for responding to HIV/AIDS: AIDS work, integrated AIDS work, mainstreaming HIV/AIDS externally, mainstreaming HIV/AIDS internally, and complementary relationships. External mainstreaming is a very relevant strategy for responding to the impact of HIV/AIDS on programme performance. The theory in this chapter results in an overview of elements to consider when analysing responses (see box 2 on page 12).

This overview does not seem to be particularly appropriate to frame partners' practice. The partners in this study do adapt their ways of working in their response to HIV/AIDS, but usually don't follow a holistic and articulated strategy to respond to HIV/AIDS in their non-HIV/AIDS programme work. Three partner organisations in this study, set up a new programme for HIV/AIDS separate or on top of their non-HIV/AIDS programme work. This did not in all cases result in reducing the negative impact of HIV/AIDS on their non-HIV/AIDS programme work, and in some cases even diverted attention and budget away from non-HIV/AIDS activities. The experience of partners adds to the overview in this chapter that CSOs that work with intermediaries or member organisations respond to HIV/AIDS in other ways than organisations working directly with households and communities.

Chapter three explores the role and place of capacity building in the process of coping with the impact of HIV/AIDS on programme performance, in theory and in the practice of partners of PSO members. It presents a concept and operationalisation of capacity building, which results in an overview (based on the model of PSO) encompassing elements within the three subdivisions of capacity building (see box 3 on page 17).
The capacity building practices of partners are highly varied and in an early stage of development. Few of the elements in the theory on capacity building and HIV/AIDS recur in the practice of the partners in this study. In putting the theory in this chapter to the test of practice, I noticed how difficult it is to make a distinction between the *responses* of partners (described in chapter 2) and the *capacity building practices* of partners. In conversations with partners I came to realise that responses are the new or adjusted activities of partners in response to the impact of HIV/AIDS. Capacity is what partners need to design or change their activities.

In theory on external mainstreaming, capacity building is regarded as a step that organisations take within their organisation, prior to revising their programme work and systems to HIV/AIDS. The practice in this chapter shows that capacity building can potentially be a continuous development process that transforms the capacities of organisations –preferably simultaneously within their organisation, programme work and external relations–to cope with the impact of HIV/AIDS on programme performance.

In chapter four, attention is paid to the role of donors and capacity builders in coping with the impact of HIV/AIDS on programme performance. Limited time and/or unfavourable circumstances are a restraint for some PSO members to put HIV/AIDS on the agenda in conversations with partners. Several dilemmas are mentioned in addressing HIV/AIDS. Some partners are interested in support from PSO members, while others do not see a role for them. The general expectation of partners is that PSO members are not interested in working on HIV/AIDS with them. Considering the expectations in theory on the role of NGOs in working on HIV/AIDS with partners, the role of PSO members in this study is in its infancy. Most PSO members are however currently shaping or expanding their role in supporting partners to cope with the impact of HIV/AIDS. It is noticeable that the two PSO members in this research with a local or regional presence have started working on HIV/AIDS with partner organisations in an earlier stage than the two PSO members that are located only in the Netherlands.

In conclusion, it might be too early to speak of 'capacity building practices to cope with the impact of HIV/AIDS on programme performance'. The concept and application of capacity building in times of HIV/AIDS is new to most PSO member organisations and southern partners organisations in this study. They have an idea of the impact of HIV/AIDS on their programmes, and (re)act in various ways. They do not however take strategic action upon reducing the negative impact of HIV/AIDS on their non-HIV/AIDS programme work. Capacity building can potentially transform the way PSO members and their partners cope with the impact of HIV/AIDS on their programme performance. It requires that they together invest in a continuous change process.

Concluding remarks
The effects of HIV/AIDS are initially felt at a personal level. It is people who become infected, get ill, and live the rest of their lives dependent on medicines, or die. It is through people that HIV/AIDS affects organisations. The theory in this report shows that HIV/AIDS undermines the capacity of civil society organisations in three ways, through three groups of people. Through their staff, through the beneficiaries of their programmes and through the people in organisations and institutions they relate to. The capacity of CSOs can be undermined, and built in these three ways. This study focuses on one way: programme performance. Practice shows that building capacity in the programme area is strongly connected to building capacity in external relationships and in the internal organisation. Responding and building capacity in the internal organisation often precedes and even replaces responding in the other areas. It is not surprising that personnel are the first priority of CSOs. A transformation of the current situation, however, demands equal attention for the other areas. Both PSO members and their partners are responsible for ensuring this attention.

5.2 Recommendations

Recommendations for PSO members
The information in this study provides several opportunities for PSO members in the process of building capacity in the context of HIV/AIDS. A first step in the process can be to determine if and how HIV/AIDS can be addressed in the dialogue with partners that work in a context of HIV/AIDS. This proves to be challenging in case of limited time and/or unfavourable circumstances during contact moments with the partner.

PSO members can support partners in determining the impact of HIV/AIDS is on their work. In determining impact, it is important to take into account that different types of partners experience a different impact. It makes a difference whether partners work with final beneficiaries or not, and whether the partner works with households, communities and/or organisations.

PSO members can support partners in articulating and shaping their response to cope with the impact of HIV/AIDS. What has changed in the work of partners as a result of HIV/AIDS? Did partners adjust their current work to HIV/AIDS, or initiate new work? Is the response in line with the perceived impact? What response is in line with their organisational type?

Finally, PSO members can support partners to articulate the capacity they use and need for their response. What do they (need to) do to adjust/design their work to cope with the impact of HIV/AIDS? What can PSO members do to support them in developing their capacities? Depending on their organisational type and thus function, partners can have various capacity building requirements.

Recommendations for the PSO bureau

The findings in this report provide several opportunities for the PSO bureau. First of all, PSO bureau staff can consider if and how they want to give HIV/AIDS a place in their dialogue with PSO members and stimulate PSO members to do the same.

The PSO bureau can play a role in bringing together members with a similar HIV/AIDS problem context. As an example, the Green Development Foundation (GDF) and Fair Trade Assistance (FTA) potentially have the same problems and opportunities in their relationship to partners with regards to HIV/AIDS. The PSO bureau can connect PSO members in similar positions or PSO members that add value to each other because of their different positions. This might stimulate PSO members to connect their partners in a similar way.

The PSO bureau can stimulate PSO members to work out case examples with partners regarding their capacity building approach in addressing HIV/AIDS. PSO members can present these specific cases to other PSO members, with the objective of raising their awareness of possible approaches, and initiating a discussion on possible approaches. PSO has stimulated this kind of practice in a learning trajectory on HIV/AIDS, and can further stimulate PSO members in the (written and spoken) articulation of concrete case examples.

The PSO bureau is currently drafting an HIV/AIDS policy for field workers financed by PSO and for staff members of the PSO bureau. In this process, time and resources need to be reserved to enhance the understanding and skills of the PSO bureau staff with a basic level training or workshop on HIV/AIDS. This experience is likely to enable PSO bureau staff to address HIV/AIDS in the contact with PSO members and field workers. It is just as important that the PSO bureau stimulates PSO members to (continue to) work on their own HIV/AIDS policy. The PSO bureau can play a role in connecting PSO members to organisations that can assist PSO members in drafting a policy and training their staff members.

Recommendations for further research

Due to limited time and resources, this research has been restricted to a number of PSO members in the Netherlands and a number of partners in South Africa and Namibia. It would be interesting to include partners from other countries and continents in further research. Moreover, it would be interesting to include a broader variety of CSO types. Not only southern CSOs, but also northern CSOs.

It is noticeable that the two PSO members in this research with a local or regional presence have started working on HIV/AIDS with partner organisations in an earlier stage than the two PSO members that are located only in the Netherlands. From the limited number of cases in this study, it cannot be concluded that this presence leads to better results in coping with the impact of HIV/AIDS. Further research could possibly examine the influence of local and/or regional presence of northern CSOs in capacity building in the context of HIV/AIDS.

The focus in this study is on HIV/AIDS and programme performance. In other research, much attention is paid to HIV/AIDS and the internal organisation. The capacity of CSOs can be undermined and built in these two areas and in how CSOs relate externally. It is therefore interesting to further explore this last area in research on HIV/AIDS and capacity building.

The emphasis in this study is on the vulnerability to the impact of HIV/AIDS (the likelihood of HIV & AIDS harming people). The susceptibility to HIV/AIDS (the likelihood to become HIV infected) has not received much attention. Because of that, I want to emphasis here that prevention and doing no harm in the context of programmes of civil society organisations, are just as important as impact mitigation.

Resources

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Interviews

July and August 2005:

Arjen Mulder, Programme Officer HIV & AIDS VSO The Netherlands
Mariel van Kempen, Senior Programme Officer Human Rights & Peacebuilding NiZA
Rodney Nikkels, Director GDF
Miriam Elderhorst, Programme Officer HIV & AIDS HIVOS

September 2005:

Christine Delporte, CEO Greater Rustenburg Community Foundation (GRCF)
Corne Theunissen, Programme Manager Greater Rustenburg Community Foundation (GRCF)
Jennifer Seif, Executive Director Fair Trade in Tourism South Africa (FTTSA)
Tatia Curie, Development Officer Fair Trade in Tourism South Africa (FTTSA)
Takalani Tambani, Director Micro Enterprise Alliance (MEA)
Judy Blom, Programme Officer Business Development Micro Enterprise Alliance (MEA)
Armin Sethna, Country Director World Education, MEA member
Daan Gerretsen, Director VSO Namibia
Lisa Davidson, RAISA co-ordinator VSO Namibia
Mathieu Janssen, HIV/AIDS Officer National Federation of People with Disabilities in Namibia (NFPDN)
Mike Matheus, General Secretary National Federation of People with Disabilities in Namibia (NFPDN)
Marie-Louise Groen, Manager the Friendly Haven
Niseth van der Meulen, technical advisor NACOBTA
Olga Katjinougua, Director NACOBTA
Norman Tjombe, Director Legal Assistance Centre (LAC)
Delme Cupido, Co-ordinator AIDS Law Unit, Director Legal Assistance Centre (LAC)
Damoline Muruko, Project lawyer AIDS Law Unit, Director Legal Assistance Centre (LAC)

Annexes

Annex I Local context South Africa and Namibia
Annex II The partner organisations in this study in brief

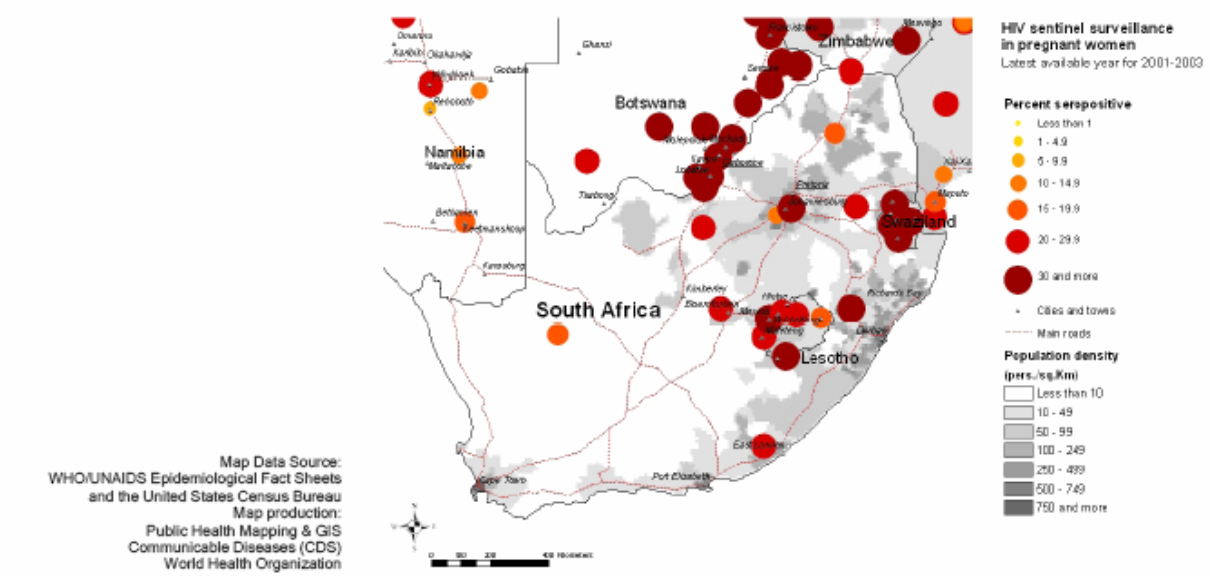
Annex I Local context South Africa and Namibia[2]

Civil society in South Africa

Although in South Africa the position of CSOs at the end of the 'Apartheid' regime was not significantly better than that of Malawi or Tanzania, since 1994 this sector has not only grown in number but also in professionalism. The relatively good educational infrastructure is one of the explanatory factors, as well as the support provided by the National Government. The state has had a direct role to play in creating and promoting a more enabling environment for the non-profit sector.

HIV/AIDS in South Africa

South Africa has more people living with HIV/AIDS than any other country worldwide and faces enormous challenges in scaling up its response to the now-mature and generalised HIV/AIDS epidemic. The national HIV infection rate among pregnant women in antenatal clinics has shown dramatic growth: from less than 1% in 1990 to 27.9% in 2003. The magnitude and growth of the prevalence rates of HIV infection differ by province. Since its inception, the HIV/AIDS epidemic has had a profound impact on life expectancy. Adult deaths in South Africa are estimated to have increased by more than 40% over the past six years. An estimated 370 000 adults and children died from AIDS during 2003. According to South Africa's Medical Research Council, HIV/AIDS has now become the single largest cause of death in South Africa and has caused a dramatic shift in the pattern of mortality from the old to the young, especially among young women.



Responding to HIV/AIDS in South Africa

The government has demonstrated a high degree of political commitment in tackling the HIV/AIDS epidemic and has committed significant financial and institutional resources to reforming the public health service to meet the challenges of HIV/AIDS. The health budget has increased over the last several years, and decentralisation to the district level has high institutional and donor support. The country has undergone a major transformation of the health care system, moving towards primary health care delivered through a district health system.

The South African National Department of Health manages and co-ordinates overall antiretroviral therapy service delivery. National as well as international NGOs are also highly engaged in activities related to antiretroviral therapy service delivery. The private sector is actively involved in antiretroviral therapy service delivery through workplace programmes. Capacity-building among people living with HIV/AIDS is supported primarily by national NGOs such as the National Association of People Living with HIV/AIDS and the Treatment Action Campaign. Information, education and communication activities are also supported by NGOs. The AIDS Foundation of South Africa supports local community-based HIV/AIDS interventions, as does the AIDS Consortium, which is a network of over 300 organisations and 200 individuals active in information, education and communication.

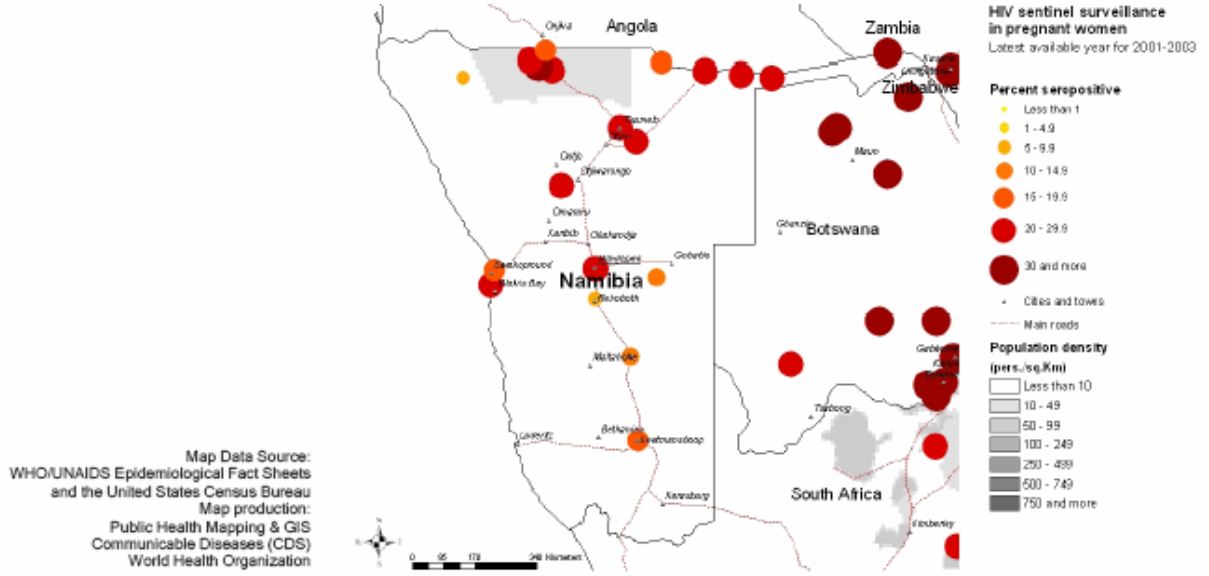
[2] The text in this Annex is drawn from the PSO evaluation 2005 and from the WHO "3 by 5"country profiles.

Civil society in Namibia

With the advent of independence and ascension to power of a democratically elected government, many civil society organisations have emerged. However, despite the number of civil society organisations and the advances they have made, many ordinary people still feel disengaged from the structures which are entrusted with addressing their lot. The state is generally supportive of civil society. In a speech in 2003, the then Prime Minister of Namibia Theo-Ben Gurirab already highlighted the importance of the partnership between civil society and government in promoting democracy and ensuring respect for human rights and the rule of law.

HIV/AIDS in Namibia

With an adult HIV/AIDS prevalence averaging 20% and close to 210,000 adults and children living with HIV/AIDS in 2004, Namibia is one of the five most severely affected countries in the world. The average HIV prevalence among women attending antenatal care services increased from 3% in 1991–1992 to 17% in 1996 and 22% in 2002. Between 2002 and 2004, the national HIV prevalence rate began to stabilise for the first time. The 2004 sentinel survey showed a prevalence rate of 20% among women attending antenatal care services, but the rates in various sentinel sites vary considerably. Infection rates are high in urban areas, including Windhoek and Walvis Bay.



Responding to HIV/AIDS in Namibia

Political commitment in Namibia to fight HIV/AIDS has been strong since independence in 1990. The national response is decentralised, and regional and local authorities are involved in the decision making structures. The National AIDS Committee (NAC) was created in 1990 to lead the national response to the epidemic, and the National AIDS Coordination Programme was created in 1999 to incorporate a multisectoral approach. With financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, the government plans to extend access to antiretroviral therapy, voluntary testing and counselling services, programmes for preventing mother-to-child transmission, workplace programmes, home- and community-based care programmes and social mobilisation and awareness campaigns.

Several NGOs are engaged in providing psychosocial and nutritional support to people receiving treatment. However, these services are not readily available around all the centres that currently offer antiretroviral therapy. The Ministry of Women's Affairs and Child Development co-ordinates community mobilisation activities to support orphans and vulnerable children, supported by UNICEF and NGOs such as Catholic AIDS Action. Members of the Partnership Forum on HIV/AIDS established the Small Grants Fund to be used by NGOs and CBOs currently supporting the national response to fight HIV/AIDS. These organisations are called to apply for funds through the development of high-quality projects. The Namibian Network of AIDS Service Organisations is currently in the process of being strengthened to fulfil a more comprehensive role as an umbrella organisation for NGOs. Similarly, Lironga Eparu (the main organisation of people living with HIV/AIDS) and other networks of people living with AIDS are involved in community mobilisation activities.

Annex II The partner organisations in this study in brief

PO	CSO type	Established in	Size & management	Client base	External relations	Donors	Core work
GRCF South Africa	formal, third-party, serving welfare institution	2000	5 full-time staff, supervised by board	200 non-profit organisations (NPOs)	CBOs, local and national government, community based foundations from various countries	several local and international **(PSO back donor)**	Mobilisation of resources, grant making ($45,000 per year), capacity building, stimulation of networking and mediation in conflicts
FTTSA South Africa	formal, third-party serving, NGO	2002, started as IUCN pilot	4 full/part-time paid staff, 2 volunteer staff	3 types of tourism organisations: commercial, privately owned & community based	corporate tourism sector	several international, some national (**PSO back donor)**	Certification of and collective marketing for responsible South African tourism organisations. Research, capacity building and development services for certified organisations.
MEA South Africa	formal, member serving, network	2000, started as club of micro-financiers	5 full-time paid staff members, supervised by board	micro finance institutions & business development service providers	African Microfinance Network, financial consultancy organisations, government bodies	Some international, decreasing donor base	Lobby and advocacy, stimulation of networking, information and knowledge exchange and capacity building
NFPDN Namibia	formal, member serving, professional body	1991, founded by 5 organisations for people with disabilities to act as an umbrella body	2 full-time paid staff members, 1 VSO volunteer (distant worker), Executive Committee	organisations for people with disabilities	NGOs, government bodies including the Ministry of Health and Social Services	Some international and local, decreasing donor base (**PSO back donor)**	Lobby and advocacy, stimulation of networking, information and knowledge exchange and capacity building
The Friendly Haven Namibia	formal, third-party serving, local (service) committee	1996, founded by a Christian group/welfare organisation	2 full-time paid staff (caretakers), 1 VSO volunteer (social worker), Management Committee	battered women and children	police, churches, Human Rights NGOs	small local and international donor base	Assisting battered women and children in becoming independent of abusive relationships from which they have fled.
NACOBTA Namibia	formal, member serving, NGO	1995, formed by a group of 16 communities	3 full-time staff members (down from 18 staff members in 2004), supervised by Management Committee	community tourism organisations (70%) and small to medium tourism enterprises (30%)	government bodies and NGOs regarding Natural Resource Management, private sector	various (inter) national, rapidly decreasing donor base (**PSO back donor)**	The organisation is in a process of change. It used to provide a vast range of different services including training, business advice, marketing, funding, product development, advocacy, mediating for joint ventures and networking.
LAC Namibia	formal, third-party serving, NGO	1988, founded just before Namibia became independent from South Africa	42 full-time staff members, supervised by a trust	communities, service & development organisations, government	international human rights networks, (inter)national NGOs, government, private sector	many (inter) national donors, highly varied donor base	Three broad areas: litigation and advice, education and training, research and advocacy. Six units: Human Rights & Constitutional Litigation, AIDS Law, Gender Research & Advocacy, Legal Education, Land, Environment & Development, Juvenile Justice.