Capacity Building in an AIDS-Affected Health Care Institution:

Mulanje Mission Hospital, Malawi

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Introduction

It is increasingly clear that capacity building for those civil society organisations (CSOs) working in contexts of high HIV/AIDS prevalence presents specific challenges and costs. However, there have been few documented experiences which explore these challenges and costs and suggest ways to address them appropriately.

This Praxis Note is an attempt to fill that gap. It will initially provide an overview of the impacts of HIV/AIDS on the Malawi health care system and on the organisational capacity of Mulanje Mission Hospital (MMH). It will then describe the experiences and lessons learnt from the first four years of capacity building at MMH, a CSO in rural Malawi owned by the Church of Central Africa Presbyteria Blantyre Synod.

This capacity building programme was designed to address capacity deficits and erosion caused by HIV/AIDS attrition. As the programme was implemented, it evolved in response to an environment of HIV/AIDS prevalence. Less emphasis was placed on external training courses and increasing attention given to short-course inputs and distance learning. The initial focus on technical training was broadened to take more of an organisation-wide approach including management, structure and systems development.

Impacts of HIV/AIDS on Health Care in Malawi

HIV/AIDS has a profound impact on the functioning of individuals, organisations and whole societies. In Malawi, adult prevalence rates of HIV/AIDS were estimated at 14.2% in 2003, with urban rates up to 23% and rural incidence at 12.4% (UNAIDS 2004). Life expectancy has dropped to below 39 years mainly due to HIV/AIDS.

HIV/AIDS has radically altered health care in Malawi. Providing health care has become more complicated and expensive because of: simultaneous opportunistic infection; longer periods of admission; more complex, expensive and less successful treatments; slower recovery; and more drug requirements. This creates a context where 70% of out-patient capacity is taken up by HIV/AIDS patients (UNDP/MIM 2002).

This is exacerbated by a context where:

- There are only 1.6 medical officers per 100,000 population, versus 4.1 in Tanzania and 28.7 in Botswana. Nurses in Malawi are 28.6 per 100,000 compared to 85.2 in Tanzania and 241 in Botswana (Martin-Staple 2004)

- Staff shortages in the health sector are extremely high: 68% of the positions for medical officers are vacant, 44% for nurses, and 50% for lab technicians (Martin-Staple 2004).

- The World Bank estimated in 1998 that 40% of the health care professionals in Malawi would have passed away by 2005 (James 2002).

As a result, health is becoming an expensive commodity at a time when resources for health are declining in real terms (UNDP/MIM 2002). This especially affects the poor, who are the least able to afford private health care.

Organisational Impacts of HIV/AIDS at Mulanje Mission Hospital

Mulanje Mission Hospital (MMH) is a 192-bed hospital, established around 1890. It is a non-profit organisation, which receives funds from government (38% – mostly for salaries), its membership with the Christian Health Association of Malawi, patient fees (14%) and donations (48%) (MMH 2004). Its primary health services cover a catchment area of 71 villages (67,000 people). In 2004, MMH had 289 employees, of which four were expatriates, and saw over 60,000 patients over the year.

Mulanje is one of the more HIV/AIDS-affected districts of Malawi. While the national averages for infection rates amongst women visiting antenatal clinics is 19.8% (MSF 2004), at MMH, 35% of the antenatal women that were screened were HIV positive. Of the total hospital admissions in 2004, 80% were HIV/AIDS-related. As more people were affected by HIV/AIDS, health care in Mulanje district saw an enormous increase in demand. At the same time the hospital staff were themselves affected by HIV/AIDS (MMH 2001). Despite the higher levels of awareness among health professionals and the religious conviction of MMH staff, there is no evidence that they are less prone to HIV infection; it has even been argued that the higher levels of affluence and mobility of educated professionals places them at a greater than average risk from HIV/AIDS (Potts 2003).

The organisational impacts of these two factors led to increased absenteeism, exhaustion, emotional strain, mobility and compromised productivity.

Absenteeism

HIV/AIDS-related diseases have had a double impact on absenteeism rates. Staff are becoming ill themselves but also almost every health worker in Malawi has family members suffering from HIV/AIDS. They therefore have to travel sometimes long distances to their home villages to look after sick relatives and attend funerals that can last up to three days. The increasing numbers of landless widows and orphans have put an extra burden on those in the extended families with a job, such as hospital staff. This has been severely disruptive to all departments of MMH, especially administration, has increased overtime costs and has placed more pressure on the remaining colleagues.

Exhaustion

Working in a context of a high prevalence of HIV/AIDS has considerably reduced opportunities for the physical and mental rest staff need to remain healthy and work effectively. At weekends and on leave days MMH staff are taking care of sick relatives, attending funerals and doing the work their relatives can no longer do (e.g. working in the fields, taking care of the children). In the

long term this may have serious consequences for both employees and employers. One staff member described the situation as follows:

> *'I am the only one with a job in our family. When a relative dies, everyone expects me to pay for a coffin and for transport to go back to our home village where our relative will be buried. I had to go back to my village (four hours drive away) for family funerals three times in the last six months. Being away for two to three days at a time means I have to spend my holidays on these visits, because our hospital allows only ten compassionate days a year. If we need money, the MMH doctors let us work in other hospitals where there are not enough clinicians during holidays. I go to a very remote area where the calls are relatively quiet, so at least I manage to rest a bit. Those hospitals pay us on top of what we get in MMH, so we earn double the normal salary that month.'*

Emotional Strain

In a context of high HIV/AIDS prevalence, health professionals can easily get frustrated and demoralised in their work. Some of their patients may improve temporarily, but usually relapse, suffer enormously, and eventually die. Health workers have to cope with the reality that they can no longer fulfil their vocation and training by *curing* patients. More often than before, and at younger age, relatives, neighbours, patients and colleagues are dying, placing an overwhelming emotional burden on many people, including health workers.

Mobility

HIV/AIDS is contributing to much greater mobility of health sector staff. This is partly due to their increased market value which has resulted from a lower availability of trained staff and a higher demand by both hospitals and health-focused NGOs. The transition to democracy in the 1990s in Malawi also facilitated increased career mobility, especially among young professionals. Of the 500 nurses trained in 2003, only 70 ended up working in the Malawian public health sector. It is known that around 150 nurses emigrate overseas annually, mainly to the United Kingdom (Martin-Staple 2004). With this new freedom professionals are increasingly critical of conditions of service and are willing to make quick and radical changes in employment. It is therefore becoming necessary for employers to offer more attractive packages of incentives to attract competent staff.

Compromised Productivity

In conclusion the combined effect of these factors is likely to significantly compromise the productivity of health workers, although this has proven difficult to measure. This inevitably results in increased costs for the employer and reduced organisational capacity.

Capacity Building in Mulanje Mission Hospital

During the last six years there has been a number of phases in the programme of capacity building at the Mulanje Mission Hospital.

1999–2001: Human Resource Planning

The strategic and operational planning carried out in 1999 assisted MMH to anticipate the challenges it was facing from the HIV/AIDS pandemic and other trends. In 2001, the first Human Resources Management and Development Plan (HRM&D) was launched, supported by the Dutch Inter Church Organisation for Development Cooperation (ICCO). This plan focused mainly on recruitment and training to cope with high attrition rates (MMH 2001). It attempted to counter the drain of staff by making it attractive for high-potential personnel to stay in rural hospitals, and to regard the challenging work of a rural training hospital as a secure stepping-stone in their personal development.

2001–2: Training Programme

In 2001–2002 a training programme was developed and implemented to address gaps in staff capacity at MMH. Clinicians, nurses and other staff participated in various workshops, courses and exchanges. For example:

- 5 junior nurses took the three-year course to become state registered nurses
- 1 accounts assistant followed the two-year programme to become an assistant accountant
- 2 laboratory attendants went for the three-year course to become laboratory technicians
- 1 radiography attendant entered a six-month exchange programme

Staff members who entered training programmes signed a contract stipulating that they would continue their work at MMH for a number of years after completion of their training to pay back the fees. Should the employee leave prior to the end of the contract, a balance will remain, which is legally seen as an outstanding loan for which the employee or his/her new employer is then liable.

2001–4: Staff Recruitment and Retainment

In 2001–4 MMH recruited 64 new staff members, making a total of 289. Several newly graduated nurses from MMH College of Nursing were recruited, but MMH was often unable to retain them for more than one year. In 2003 more training initiatives were introduced, which successfully reduced the number of resignations.

As well as training, MMH invested in a number of improvements of working and living conditions in order to attract and retain staff. Many houses were renovated, four new ones constructed and a new nursing hostel was built to accommodate extra staff and students. The laboratory was rebuilt with better training facilities and more modern technology and a new maintenance workshop was built. Technical infrastructure was also improved, with the installation of telephone extensions, separate electricity meters, and e-mail. Financial incentives, such as school fee support and salary top-ups, were introduced to facilitate recruitment of staff.

The table below illustrates turnover rates for staff in MMH in the years 2001–2004. By 2004, the number of people that left MMH during the year decreased to less than 45% of the number that left in 2001 (MMH 2001; MMH 2004).

	2001	2002	2003	2004
Death	*5*	*2*	*4*	*1*
Resignation	*14*	*20*	*5*	*9*
Dismissal	*2*	*2*	*3*	*1*
End of contract	*4*	*3*	-	-
Suspension	*2*	*1*	-	-
Total Loss	27	28	12	11
Recruitment	50	32	36	24
Balance	+23	+4	+24	+13

2003–4: Evolving to an Organisation-Wide Capacity Building Programme

In 2003-4 the impacts of the first phase of capacity building began to become evident (MMH 2004) and MMH made some important adjustments to the capacity building programme. A hospital-wide approach was adopted, acknowledging the importance of all departments, and including training for administrators, secretaries, accounts assistants, various computer courses, HIV/AIDS and ARV counselling, and in-service workshops on HIV/AIDS awareness and policies for all staff members.

In 2003–2004 MMH staff participated in the following training programmes:

- 43 staff members went for short courses (two to six weeks) covering a variety of topics including accountancy, computer training and ARV therapy
- 1 clinical officer started a distance learning programme in palliative care
- The hospital administrator went to the UK for an MSc in health management

- 3 nurses went for a one-year upgrading course in midwifery

In 2003–4, investments in improved working and living conditions continued with new buildings erected and old ones refurbished. The ARV clinic was renovated and an HIV/AIDS centre was added to the laboratory. To guarantee a reliable power supply, a new generator set was purchased.

Capacity Building at MMH: The Benefits

Some important indicators of progress have emerged from the MMH capacity building programme.

Increased Staff Satisfaction and Motivation

In the first two years, 11 high-potential and strategically important staff members left to attend training for two to three years and many new employees in various sectors were recruited. The hospital experienced a number of positive effects from this huge investment in human capital. The arrival of newly recruited staff, in particular the nursing and clinical department, provided much-needed relief, allowing some staff to take their first holiday in two years. Many others could attend national workshops on various topics, bringing them in touch with their peers and enhancing their professional expertise. As one staff member said:

> *'I like to go to workshops because the allowances are usually good, as is the food and accommodation. We learn a lot sometimes, although many things never get implemented. You also get to meet up with colleagues and friends and share stories and experience…when we come back to work, we disseminate what was learnt during the workshop.'*

Capacity building in MMH also offered opportunities for career advancement and professional development. Even those who did not attend training courses learnt new skills through their colleagues and were inspired to work on their own personal and professional growth. Staff have been showing a more participative and self-sustaining attitude. Some examples of these are indicated in the following table:

Example	2003	2004
'Open' job applications per year	6	36
Attendance of workshops	30%	90%
Complimentary letters to management	0	7
Proposals to improve working conditions (staff initiative), per month	1	4

Stronger loyalty towards MMH, both voluntary and as a result of the binding clause in contracts, was found in an external assessment of staff attitudes by a group of consultants (Cabungo 2004).

Increased Expertise of Trained Staff

Once the period of training was over, employees returned satisfied and refreshed, with new knowledge and competencies. Improved skills and knowledge have helped staff to perform their duties more effectively. Administrative training has also helped to lighten workloads. For example the new meeting schedules and management meetings have enabled staff to interact more frequently with their colleagues.

Reduced Job Vacancy Levels

A major boost for MMH's image as a training hospital was felt in the number of professionals from all over Malawi and beyond who spontaneously applied for jobs at the hospital. This resulted in a decline in vacancies from 45 vacancies in 2002 to only 10 by 2004 (MMH 2001; MMH 2004). Vacancies are also being filled more quickly than previously.

Innovation

One important advantage of extra staff was the opportunity that this created for new developments and differentiation within the clinical field, mainly relating to HIV/AIDS. The expansion of clinical capacity allowed a Medical Officer to set up an ARV clinic and train all staff in its prescription and

management. This gave hope to many frustrated and desperate patients, nurses, and clinicians. The ARV clinic attracted national and some international attention, generating increased and more sustainable donor aid, networks, and publicity. One staff member commented:

> *'Some months after we opened our ARV clinic, we noticed that we spent a lot of time on HIV-positive patients, counselling and testing, which is great. But we never thought of including our own staff in the programme as well. We work with HIV/AIDS and our clients every day, but never focused on educating our employees! We immediately included everyone working in MMH in an in-service workshop, where current knowledge levels were tested and improved. There were many questions about various HIV/AIDS related issues.'*

Less Organisational Vulnerability

One of the lessons learnt in the past few years was the significance of the organisation's vulnerability when heads of departments fell ill or went for training. MMH accordingly appointed deputies for all key positions in MMH.

Capacity Building in MMH: The Costs

While there are evident benefits from the Capacity Building Programme at MMH there have also been some costly, and sometimes unexpected side-effects.

The extra capacity created ongoing increases in operational costs that were not immediately apparent. The accounts department could not cope with the expansion of the hospital and greater workload. Because of this, it was not until December 2003 that MMH realised that its expenditure had vastly exceeded the budget. This coincided with a decline in donor funds and almost caused the hospital to become bankrupt. While higher wage bills had been anticipated as a result of extra recruitment, the hidden costs of capacity building were less predictable.

The table below shows an overall increase in costs related to capacity building.

Expenses	Expenditure (US$)			
	2000	2001	2002	2003
Salaries/wages	54,236	51,649	57,676	100,396
Transport	5,761	12,414	19,010	18,877
Casual wages	1,984	1,568	3,562	4,539
Staff loans and advances	1,236	1,300	4,100	5,834
Staff welfare/life insurance	2,544	1,762	2,205	3,860
Duty allowance/ overtime	8,935	7,885	29,791	34,390
Drugs and dressing	5,775	29,940	59,306	44,029
Total	**80,471**	**106,518**	**175,650**	**211,925**

Further analysis revealed that the successful capacity building programme had created many hidden or latent costs, described below.

Disruption Caused by Staff Training

Staff training programmes created hidden costs caused by the, albeit temporary, loss of staff and the difficulties of covering their absences quickly and effectively. Replacing staff members who went for training was planned for, but proved to be more difficult than expected, as good health professionals were scarce, and some newly contracted employees were unreliable. This meant that some posts could not be filled at all and some training programmes were postponed until a replacement could be found.

In other departments, where trainees were already accepted or tuition fees had to be paid well in advance, it left those remaining with a huge workload. In one case, two Laboratory Attendants went for training, another colleague went on maternity leave, and the expatriate volunteer left unexpectedly. This left the laboratory with only one staff member who was able to take calls, putting him on constant call for about 12 months without a break!

When existing staff members are away, temporary replacements can only partially fill the void. Since procedures in the hospital were not always clearly documented, institutional memory was also lost when experienced employees left for an extended period of training. A management team member noted:

> *'The management team saw six different acting nursing officers (matrons) come and go between 2003 and 2004. National policies and departmental improvements were sometimes difficult to implement because the acting colleagues sometimes left MMH without notice or handover. At one point, the nurses claimed that one of the matrons had made a promise to raise duty allowances, but left without informing management. The nurses threatened to strike and stop filling gaps for sick colleagues if the succeeding matron would not implement the promise that was never documented. A decent handover procedure and clear conditions of service could have prevented this difficult situation.'*

Extra Staff Costs

When a staff member leaves for training, their family will stay behind and a salary will continue to be paid. At the same time MMH needs to find a temporary replacement for the position. This person also has to be paid. MMH often budgeted for double salaries and allowances to cover training absences, but donors rarely accepted these extra costs.

The temporary replacement of employees has also had an impact on the provision of institutional accommodation. Because of HIV/AIDS, employees need more room to house their ever-extending families, especially orphaned relatives. A few years ago staff were more willing to share houses, whereas today, in a rural hospital like MMH, a strategically important position is only filled when a house is offered.

In many cases, the trainees left their family occupying a hospital house and therefore the replacement recruited often could not be offered an institutional house in time. It was found that even if an employee under training vacates a house, which is taken by a replacement, a similar shortage exists when the trainee returns to the hospital, finding the house occupied. Sending a staff member for training often meant building another staff house, which might cost four to five times as much as the training fee.

Incentives

To attract and retain staff, incentives have been introduced. Although some indirect incentives could be funded by donors or government, financial ones could not and have been exhausting MMH's budget.

Higher Cost of Quality Provision

Capacity building also meant an improvement in the quality of health services offered. This improvement and differentiation of clinical care is positive but comes at a higher price. However, poverty means that patient fees can only be increased to a limited degree.

Staff Dissatisfaction

After training, employees appeared more demanding and critical. They were trained in an urban and sophisticated environment, and therefore returning to MMH sometimes caused them to feel dissatisfied. Due to the lack of communication between hospitals and to staff shortages, some hospitals responded to staff complaints and threats to strike by topping up salaries. In 2004, MMH suggested to their employees that they should take a nation-wide approach by forming a trade union for health workers and jointly addressing their concerns to the Ministry of Health, which is responsible for health sector terms and conditions. In the meantime, all staff members were given a reasonable temporary salary increase.

Systems Overload

The financial administration was designed for a 150-bed hospital with around 150 staff members. Expansion in the last few years, together with the introduction of VAT and a new salary structure rendered this system

outdated. MMH therefore had to replace the existing system with a computerised one and train staff accordingly. Recruitment systems were also overloaded by dealing with the increased volume of applicants as a result of the improved reputation of MMH.

Extra HIV/AIDS Related Costs

There are also additional capacity building costs added resulting from operating in an HIV/AIDS affected context such as:

- **Welfare expenses:** Historically, the hospital has contributed to funeral and coffin expenses for staff members and their immediate family members. Nowadays, the typical number of dependant relatives is growing and funerals have become a regular burden, for the employee as well as the employer. The Ministry of Health estimate the cost of a funeral for a junior or middle level staff is $660 (UNDP 2002:81). In addition, increased absenteeism affects the hospital's budget negatively.

- **Overtime:** The workload in hospitals has increased as staff are absent more frequently due to HIV/AIDS-related problems. The remaining staff therefore often have to work overtime. This leads to substantially higher costs for the hospital.

- **Staff loans/advances:** Staff at MMH can apply for both loans and advances from their employer. With an increasing number of (sick) relatives in their care and more funerals to attend, the need for loans and advances increases, and this money cannot be paid back to MMH when staff members themselves get sick and eventually pass away.

Towards an Organisational Approach to Capacity Building

The initial capacity building programme was very successful in improving the quantity and quality of human capital in MMH, though this had imposed its own financial burdens. However, neither the hospital's revenue, nor its administrative capacity were able to keep pace with the rapid developments. To redress this problem, a number of organisational innovations have recently been initiated:

- **Improve management skills:** interventions in various departments were implemented, such as strategic planning sessions, short courses and hiring of expert coaches. Improved communication facilities, a comprehensive meeting schedule for all departments and various committees were established to decentralise decision-making and promote participation.

- **Upgrade management systems:** Consultants were hired to revise and upgrade the existing systems.

- **Develop HR capacity:** an external, part-time Human Resource Advisor was recruited to guide and develop the HR department for two years.

- **Implement holistic OD process:** external organisational development (OD) practitioners were hired to assess and intervene within the whole organisation. This process is ongoing and involves many staff members from different departments.

- **Revise terms and conditions:** the hospital administrator was promoted to a Synod Health Coordinator and will revise conditions of service, procedures concerning sick/compassionate leave, appraisals and allowances. In addition, he will design a more structural and institutional approach in collaboration with CHAM and the Ministry of Health.

- **Encourage distance learning:** new trainees are now sponsored to take on distance learning courses as much as possible. This is expected to prevent

both the expense and the distorting and disrupting effects on the working and domestic situation of a trainee undertaking courses far from home.

- **Educate donors:** MMH tried to educate donors on HIV/AIDS-related complications in capacity building activities through presentations, donor conferences and donor visits. Some donor programmes were revised and more understanding donors were linked with traditional ones to advocate more flexibility in donor management.

Implications for Future Capacity Building Practice

MMH ventured into a major capacity building programme without much experience and as a result almost went bankrupt, despite achieving many of the capacity building aims. There is much to be learnt from this salutary experience about the complexities of undertaking capacity building in the context of HIV/AIDS, especially given the dearth of comparable documentation.

Revise Training Programmes

In the context of HIV, short course training and distance learning programmes are much more appropriate than longer-term training overseas. There is, however, a need to maintain adequate quality standards. One staff member relates a recent success:

> *'A clinical officer at MMH took the initiative to look into palliative care and the way this service was offered at MMH. He felt there was room for improvement and, together with his employer, looked into possibilities for further training. A donor was found who was willing to pay for a distance learning training programme, which requires the clinical officer to travel abroad within Africa three times in one year – the rest is self-study with the assistance of a local mentor. The set-up is a success: the clinical officer remains at his position in the hospital, therefore does not affect his colleagues workload. He also remains at home with his wife and family.'*

Take an Organisational Approach to Capacity Building

Capacity building activities need to address the organisation as a whole, and to encompass relationships with other key stakeholders. The MMH experience reveals some key themes that capacity building needs to address:

- **Structures and systems:** these need adapting to the context of HIV. It may lead to the creation of new departments and new positions. Human resource systems need to ensure policies are in place to cover critical illnesses such as HIV/AIDS and for occupational health and safety. There may also be a need to adjust travel policies and terms and conditions of employment.

- **Human resource strategies:** these need to be developed in line with financial budgets, analysing critical posts and identifying 'non-replacement responses' such as 'multi-tasking' where possible.

- **Culture, values and relationships:** the consequences of HIV/AIDS cause a clash between the organisational/ institutional expectations of employers and the cultural expectations of participation in funerals and caring. When staff themselves are ill, their motivation as well as that of others around them is undermined. This causes management to work under added pressure to keep morale and performance high.

Implications for Donors

Successful capacity building necessitates professional and sustainable donor management to compensate for rises in costs. If this is not acknowledged, capacity

building programmes will soon result in a higher dependence, and may even weaken the organisation. Donors should be aware of and prepared to face these consequences. If none of the parties involved are willing to do so, it might be wiser not to initiate capacity building programmes. As well as taking on board the implications for capacity building from the previous section, donors need to:

Be flexible with funding and prepared to maintain funding beyond the initial capacity building inputs despite perceived risks: even when increased operational costs from capacity building were budgeted for by MMH, donors often refused to accept paying for staff to cover absences. In one case a donor withdrew promised capacity building funds for training when the nurse in question asked to be allowed to take her children with her to the UK (having experienced domestic problems during a training course she attended some years ago in Kenya). The donor was afraid she might not return to MMH, despite her tight family ties and lucrative job opportunities in Malawi and 'wanted only to invest in people that are guaranteed to last'. In an HIV/AIDS setting there are no guarantees: not for donors or employers, and certainly not for employees. HIV/AIDS makes training a more risky but still necessary intervention.

Support capacity building in the long term: capacity building in the context of HIV/AIDS is not a one-off event. The rate of attrition means that capacity is continually being eroded and just to maintain capacity will require significant and on-going investment.

Support increased operational costs: it is short-sighted and perhaps even negligent for donors to support capacity building in isolation without accepting any responsibility for also supporting the resulting increased operational costs. If donors are unable to support operational expenditure then they need to collaborate with other donors who are able to do so.

Accept declining productivity: donors may have to accept the unpalatable truth that for partners working in a context of high HIV/AIDS prevalence it will cost more to do the same amount of development work. The more adverse the context, the more costly it will be to achieve impact.

Conclusions

This paper has highlighted the potentials and the pitfalls of capacity building in the context of an organisation working in an area of very high HIV/AIDS prevalence. It has offered some suggestions as to how capacity building should be modified in such as situation.

The MMH case study starkly illustrates the importance of budgeting and securing support, not only for the capacity building inputs, but also for the resultant ongoing associated increases in operational costs.

Capacity building in an area of HIV/AIDS prevalence therefore requires careful planning, budgeting and implementation in order to overcome its potentially damaging side-effects. Donors also need to respond to capacity building in an HIV-affected context in an enlightened, flexible and long-term way, rather than expecting one-off capacity building inputs to bring the desired results.

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