Praxis Paper No. 4

# Building Organisational Resilience to HIV/AIDS

*Implications for Capacity Building*

By Rick James

# Contents

# Acknowledgements

# Building Organisational Resilience to HIV/AIDS

## *Implications for Capacity Building*

By Rick James

## Executive Summary

HIV/AIDS is fast becoming the worst ever human disease disaster, with 3 million people dying each year. The economic and social costs are escalating, particularly in sub-Saharan Africa. In many places this is reversing progress towards the millennium development goals. For civil society organisations (CSOs), HIV/AIDS is leaving a significant proportion of their beneficiary groups sick, further impoverished and more vulnerable – thereby directly undermining programme impact. The pandemic is putting CSO relationships with donors and other CSOs under pressure, at a time when greater collaboration is essential. HIV/AIDS is also having an immense impact on the internal organisation of CSOs as staff themselves become both infected and affected. The loss of staff time through sickness, family care and funerals; depressed morale from the emotional grief; combined with rising costs for medical expenditure, recruitment and training leaves CSOs struggling with increasing overheads and declining output. In a very demanding, results-oriented donor environment this threatens the survival of many CSOs. There is therefore a desperate need to build not just individual, but organisational resilience to the disease.

Organisational resilience can be developed through a combination of interventions – the most common ones being staff awareness programmes and creating HIV/AIDS organisational policies. But CSOs need to go further and analyse the long-term human resource implications, ensuring that the costs of responding to the organisational impact are built into their financial budgeting, planning, monitoring and evaluation processes. Such responses are all too rare as many CSOs who do have HIV/AIDS policies do not have the resources to implement them. Yet HIV/AIDS is requiring CSOs to go even further and address wider organisation development (OD) issues such as the organisational culture, how decisions are made, organisational boundaries with employee 'private lives' and gender roles. Such broader issues have a profound influence as to whether an organisation becomes resilient to HIV/AIDS.

> HIV/AIDS is having an immense impact on the internal organisation of CSOs as staff themselves become both infected and affected.

Capacity building providers have a vital role in ensuring that organisational resilience to HIV/AIDS is brought onto the agenda of their clients. This is especially important because many CSOs may feel overwhelmed by the possible impacts of HIV/AIDS on their own organisation. Capacity builders need to be very aware of the issues and have the competencies to support clients in addressing HIV/AIDS mainstreaming in their external programmes and relationships as well as in their internal organisation. It will require HIV/AIDS specialists to develop OD skills as well as OD practitioners developing knowledge and skills in HIV/AIDS. HIV/AIDS will require capacity building practitioners to adapt both the content of their services and methods of delivery.

Some international NGOs and donors have been at the forefront in assisting partners to see and respond to the challenges of HIV, but many have lagged behind. To remain relevant and effective in sub-Saharan Africa today (and even more so tomorrow), all donors need to decide how they can help bring greater awareness of the issues to partners; how they can help partners access necessary capacity building support and what extra funding this will require. More strategically, donors will need to examine and adjust their overall relationships with partners so that these 'partnerships' assist CSOs to adapt to an HIV-infected world and not be shackled to outdated and inappropriate modes of relating.

Clearly there are no easy answers to building organisational resilience to HIV/AIDS, but the need to find practical ways forward is of the utmost urgency and importance. There is a need to develop understanding of the actual quantitative costs involved and the efficacy of different responses. INTRAC is therefore prioritising learning in this field as part of its Praxis programme. This overview paper is a first step. INTRAC will be supporting the discussion and documentation of emerging experiences about appropriate local and international responses. Please contact Rick James rjames@intrac.org for more information.

# Introduction

The intensity of human suffering brought about by HIV/AIDS is impossible to ignore, especially when those affected are close friends and colleagues. Even as I was writing this introduction I got a call from a Director of a local NGO. He said:

> One of my most experienced field-workers has just asked me to let her work mornings only. Having endured the trauma of watching her three young children die in the last four years, her husband is now critically sick in hospital and she needs to look after him. What should I do? Our terms and conditions limit is five days compassionate leave, but he will need her care for much longer than that. But if I give her more the organisation will suffer and it will set a precedent... ***How would you respond?***

Such stories are all too commonplace nowadays in sub-Saharan Africa. The leaders of many local CSOs in Africa face many dilemmas like these:

> The phone rings. It is your finance manager telling you that her husband is very sick again and she won't be able to come into work this week. It's a disaster! You have a major financial report to send to the donor. This report is already overdue and the donor is withholding the next instalment until this financial report is submitted. Added to this you have not had any monitoring information from the food security programme manager who has also been sick for some time. His recently recruited deputy is out in the field, covering for his absent manager and has not come up with any figures yet. ***What would you do?***

As the number of people infected with HIV rises above 40 million, civil society, the private sector and governments are struggling to respond. In sub-Saharan Africa, which has been most affected so far, human development indicators are declining. Indeed as HIV specialists Barnett and Whiteside (2002) warn:

**Development will become virtually impossible in an era of HIV/AIDS.**

So far the efforts of both international and local civil society organisations (CSOs)[1] have been largely focused on external HIV programming. Less attention, however, has been paid to the internal organisational impact on local CSOs – an impact that may undermine their ability to continue to function and survive. In many countries in sub-Saharan Africa adult infection rates are between 20–40 per cent and this statistic

---

[1] Civil society organisations include faith-based organisations, churches, trade unions, pressure groups, community groups, non-government organisations (NGOs), NGO networks and coalitions.

applies as much to a CSO's staff and volunteers as it does to the beneficiary group. This scale of infection has considerable organisational costs for CSOs in sick leave, extra medical expenses, and funeral expenses, let alone the loss of invaluable learning and experience. This places great emotional, financial and time burdens on financially fragile CSOs already operating with scarce resources.

The capacity building context in sub-Saharan Africa has been fundamentally changed by HIV/AIDS and is likely to deteriorate. The capacity baseline is crumbling very dramatically. Ryann Manning's research in South Africa warns: 'The difficulties inflicted by HIV on organisations are becoming increasingly apparent and will inevitably and inexorably rise over the next 10–15 years'. (2002: 6).

In such a context it may be more realistic to talk of *capacity maintenance* rather than capacity building (James and Mullins 2004). Certainly a core facet of CSO capacity building in sub-Saharan Africa has become building organisational resilience to HIV/AIDS. HIV is not simply a contextual variable to add to the lengthening list of issues for mainstreaming. Peter Piot, the Executive Director of UNAIDS challenges us:

> **We must rewrite the rules...not simply do more or do it better. I now believe we have to act differently as well. An exceptional threat demands exceptional actions. (2003)**

INTRAC's Praxis Programme is looking at the way approaches to organisational capacity building could recognise and respond to different cultures and contexts. In sub-Saharan Africa, HIV/AIDS is an extreme contextual shift that threatens the very existence of many CSOs. If capacity building is to be relevant in this context, it has to address the far-reaching organisational issues that HIV/AIDS raises. HIV defies being compartmentalised simply as a technical or human resource issue. It profoundly affects other aspects of an organisation including Praxis priority themes such as leadership, organisational learning, creativity and innovation, value-based capacity building and impact assessment. While sub-Saharan Africa is the current epicentre of the disease, other parts of the world are also increasingly affected. Working in a context of high HIV/AIDS prevalence may soon become a global challenge.

> If capacity building is to be relevant in this context, it has to address the far-reaching organisational issues that HIV/AIDS raises.

This Praxis paper focuses on what the shifting HIV/AIDS context means for capacity building in sub-Saharan Africa. It aims to see what can be learnt and applied to that context and also to raise questions for different contexts in Europe, Asia and Latin America. It aims to give civil society support providers an overview of the relationship between HIV/AIDS and capacity building. It is hoped that readers in

different contexts, even where HIV/AIDS prevalence is still limited, will learn about the need to adjust any capacity building to the specific context and prepare themselves to proactively respond to the threat of HIV/AIDS, should it become significant in their own country. The paper is based on practical capacity building experiences with CSOs in Malawi over the last eight years as well as a recent PSO-supported research consultancy that involved an international literature review, interviews and focus group discussions with other capacity building practitioners.

# 1 The Current and Projected Scale of HIV/AIDS

According to global AIDS expert Susan Hunter:

> **HIV/AIDS is fast becoming the worst human disease disaster the world has ever seen…Although still in its infancy, it is clear now that in the next 10–15 years AIDS will claim more lives than any other human epidemic ever recorded. The 28 million deaths from AIDS at the end of 2002 are only a paltry beginning. It is little wonder that HIV/AIDS is the first disease to be labelled a global security threat. (2003:7)**

Current estimates (UNAIDS, Holden 2003, Hunter 2003) are that:

- 3 million people die each year and 8200 are buried each day
- 42 million people are infected
- 15,000 new infections every day
- 90–100 million people will be infected by 2010 (double current rates)
- By 2010, the death toll will be higher than the two world wars combined

This situation is likely to deteriorate over the next 10–15 years as rising infection rates combine with the currently a-symptomatic becoming sick. Due to slow onset of symptoms it is likely that high rates of infection will continue. HIV affects all parts of the world, though with significant regional and global variations (see table overleaf). For instance there are already 4 million people infected in India and another 1 million in China, with generalised HIV epidemics in Cambodia, Myanmar and Thailand (Holden 2003:13). Eastern Europe and Central Asia suffer from the fastest growing HIV infection rates in the world (largely due to intravenous drug use) but many at-risk groups are 'hidden' and thus excluded from official statistics.

HIV spreads most quickly among the most sexually active, who are often the most economically productive. Therefore it has a deeper and more sustained impact on national development than other illnesses. There is a very significant gender

dimension to HIV/AIDS as women are harder hit by the virus[2] and have a greater social role in taking care of the sick[3] (see also Hunter 2003:32–4). The poorest and marginalised not only suffer from the disease itself, but also the effect on the economy, the lack of treatment and the overwhelming stress on social networks that are traditional coping mechanisms for many poor people[4]. The impact of the disease not only affects human capital but also the social capital of which CSOs are a part. *Ninety-five per cent of people living with HIV/AIDS and 98 per cent of all deaths are in developing countries.*

**HIV/AIDS Statistics by Region for end of 2002** (taken from Hunter 2003: 13)

| Region | Adult prevalence rate | Numbers HIV+ | % HIV+ women | Main mode of transmission |
|---|---|---|---|---|
| Sub-Saharan Africa | 8.8% | 29.4 million | 58% | Heterosexual |
| North Africa and Middle East | 0.3% | 550,000 | 55% | Heterosexual, IDU |
| South and South-East Asia | 0.6% | 6 million | 36% | Heterosexual, IDU |
| East Asia and Pacific | 0.1% | 1.2 million | 24% | IDU, MSM Heterosexual, |
| Latin America | 0.6% | 1.5 million | 30% | MSM, IDU, Heterosexual |
| Caribbean | 2.4% | 440,000 | 50% | Heterosexual, MSM |
| Eastern Europe and Central Asia | 0.6% | 1.2 million | 27% | IDU |
| Western Europe | 0.3% | 570,000 | 25% | MSM, IDU |
| North America | 0.6% | 980,000 | 20% | MSM, IDU Heterosexual |
| Australia and New Zealand | 0.1% | 15,000 | 7% | MSM |
| **Total** | **1.2%** | **42 million** | **50%** | |
| IDU – injecting drug use, | MSM –men who have sex with men | | | |

---

[2] Many women experience sexual and economic subordination in their personal relationships and at work, and so have less power to negotiate safe sex or refuse unsafe sex. See ILO Briefing Paper (2003).

[3] ILO 2003; Oxfam International 2004.

[4] Studies of the health sector in Malawi for example, illustrate the extent of the impact on organisations with 70 per cent of their outpatient capacity now taken up by HIV+ patients and more than 60 per cent posts vacant in some hospitals (*The Lancet* 2004).

In sub-Saharan Africa, home to 70 per cent of the people currently infected with the virus the development impact is predicted to be devastating:

- 20% predicted drop in sub-Saharan Africa's gross domestic product in less than ten years

- 26% predicted cut in the rural labour force in the ten hardest hit African countries

- 20% smaller labour force by 2010 in Africa and by 2020 in Asia

- Infected populations of five countries alone: Nigeria, Ethiopia, Russia, India and China are predicted to be above 75 million by 2010

    *(sources: ILO [www.ilo.org](http://www.ilo.org) July 2004; Hunter 2003)*

## 2    Organisational Impact of HIV/AIDS on CSOs

These startling statistics run the risk of remaining abstract numbers. We must now analyse what these statistics imply for CSOs in sub-Saharan Africa. A recent study by Oxfam International of nine NGOs in sub-Saharan Africa concluded: 'The impact of the HIV/AIDS pandemic on the majority of participating NGOs is extensive' (Oxfam International 2004:4). The following description of a small organisation with less than 10 staff, which I have worked with closely over the last eight years, illustrates some of the diverse and profound ways HIV/AIDS can affect CSOs:

---

*Personal Experiences: TUBA, a small umbrella NGO[5]*

When INTRAC first worked with TUBA in 1997, one of their main programme staff members was already very sick. John was the key PRA trainer who had built up extremely good relationships with the community. He was heading up one of TUBA's most successful programmes, but once he started to absent himself regularly from work the programme suffered. Although staff tried to stand in, they also had their own work to do and felt overworked with the extra burden. Key meetings were missed, the community became disaffected and eventually the programme had to be reluctantly closed. At the time, John's refusal to disclose his HIV status caused internal tensions as programme performance declined, and some staff felt that his denial was not consistent with the TUBA developmental values. When he died TUBA paid a significant part of the funeral expenses as well as paying death benefits.

A few years later another staff member, Simon, in charge of communications, also started displaying symptoms of AIDS. Again the output of the department slowed almost to a complete halt and someone

---

[5] Names changed for reasons of confidentiality.

else had to be transferred from administration to take over. She also required training in communications, as this was not her field. When Simon became sick his behaviour was very dysfunctional. He started to use the NGO's resources for his personal use and forged receipts and travel expenses. On the rare occasions he turned up to the office, he was angry and often shouted at his colleagues. The TUBA director tried to exercise understanding and compassion, but at the same time felt such behaviour was unacceptable. After a series of abortive attempts to resolve the situation, Simon was sacked some months later, having cost a considerable amount of management time and stress as well as misappropriated resources.

When the Director started getting sick only a few months later, morale in the organisation crashed even further. Reporting and proposal deadlines were missed and donor funding was suspended for a time. The Director eventually took the decision to get himself tested and when found HIV+ decided to take ART drugs. He decided to step down as Director and to work independently as a consultant, precipitating TUBA into another leadership crisis due to the recruitment time lag as well as the expense of advertising and interviews.

The impact has not only been felt within TUBA – it has also affected the sector. For much of the last few years TUBA has been unable to fulfil its co-ordinating role adequately. It has failed to bring member NGOs together on critical advocacy. TUBA's lack of leadership of the civil society coalition on Land Policy was one factor in the coalition's poor performance and eventually led to TUBA's removal from the role of secretariat.

One way INTRAC finds useful for analysing issues of CSO capacity is applying the Three Circles Model. This model posits that to be effective, CSOs need to be strong in three related areas: namely their internal organisation functioning; their programme performance and their external relationships.

Three Circles Model of organisational development:
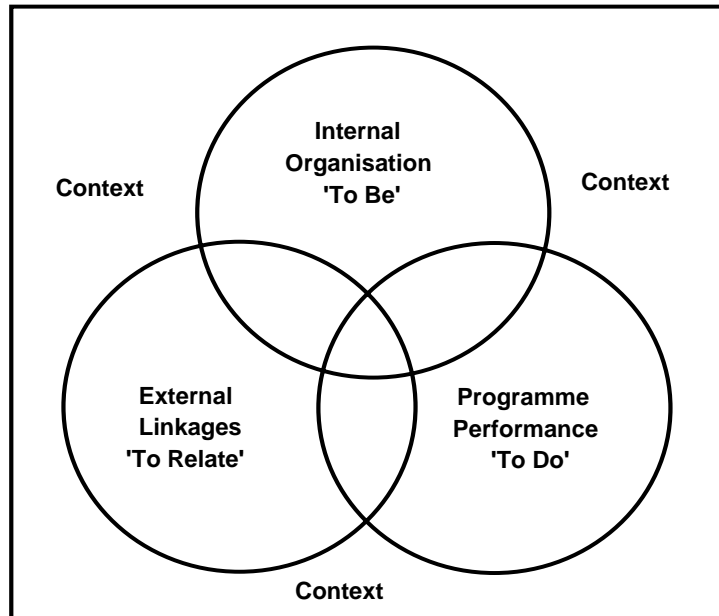
We will explore how HIV/AIDS affects CSO capacity in these three areas, initially outlining some of the programmatic impacts as well as the impact on external relationships. The main thrust of this Praxis paper focuses its attention on internal functioning and the implications for organisational capacity building.

## 2.1  Impacts on Programme Performance

With a high proportion of their beneficiaries now HIV+, CSOs in sub-Saharan Africa have found their programme work in communities considerably affected. NGOs in Malawi, for example, report that their meetings with communities are now frequently being 'bounced' by funerals, with programmes therefore increasingly falling behind schedule and budget. Others involved in micro-credit have found it increasingly difficult to get solidarity groups to function effectively in the context of high HIV prevalence (James 2004).

---

**Case Study: Micro-finance cuts out affected families**

One NGO in Mulanje, Malawi, has recently initiated a micro-finance scheme focusing on women. The system used is similar to that of the Grameen Bank: groups of women choose their own members, and then guarantee repayment for one another. Should any member default on repayment, the rest of the group is obliged to repay her loan. The NGO does not discriminate on the basis of HIV sero-status, and never requires an HIV test. In the context of HIV and AIDS in Mulanje, two issues have arisen:

- *Informal health checks:* Members have begun to evaluate the health of those who want to join their groups, and are refusing entry to anyone who 'doesn't look healthy'. Given the high rates of chronic illness and

---

death of young adults in Mulanje, the women feel it is important to look after their own interests, and not take on new members who could fall gravely ill or die, and thus leave the others to repay their debts.

- *Families of sick members often are not eligible:* The NGO focuses specifically on women, and does not provide loans to men, or to children under legal age. At times, when a member has fallen chronically ill or died, her husband or children have asked to take over her position in the loan scheme. However, neither situation is allowed. The family is thus ineligible for loans, exactly when they might be most in need of cash to carry on some productive activities.

HIV and AIDS are seriously challenging efforts to make micro-finance available to increasing numbers of poor people throughout Africa, forcing a rethink of programme methodologies.

*Source: Oxfam Malawi (2001)*

The Oxfam research also revealed how families affected by chronic illness drop out of community activities. These conspire to make the most marginalised groups increasingly invisible and isolated from developmental interventions. There are considerable challenges to programming strategy as the needs in the community escalate and the CSO capacity to respond diminishes. As Dan Mullins points out, 'there is an increasing tendency for 'old style' programmes to become less and less relevant to highly vulnerable members of the community' (personal communication October 2004).

> There are considerable challenges to programming strategy as the needs in the community escalate and the CSO capacity to respond diminishes.

Many CSO programmes that have relied on volunteers to provide extension or care services to communities are finding that increasingly these volunteers are focusing their support on their own immediate families as there are more income and medical needs closer to home. There is now a danger of over-estimating the feasibility of development approaches that rely on volunteerism, such as home-based care (Marais 2004). It is also apparent that HIV/AIDS may be draining the wider development sector of volunteers – those now taken up with home-based care activities have less time available for involvement and leadership of other community-based development initiatives.

Although it is very difficult as yet to quantify the impact of HIV on programme output, Ryann Manning's best-case scenario estimated that NGOs in Natal, South Africa might be losing 1–2 per cent of output (2002:25). Abundant anecdotal evidence, such as TUBA, suggests this to be a very conservative figure. 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.

## 2.2 Impacts on External Relationships

HIV does more than simply affect programmes and their beneficiaries – it also affects roles and relationships throughout the whole aid system. In terms of relationships with donors, CSOs are finding that funding priorities are dramatically shifting. Most donors (government or NGO) have made HIV/AIDS a funding priority for sub-Saharan Africa. With limited and in some cases declining aid budgets, this represents a redirection of funds from other areas. Livelihoods, environment, gender and even general health programmes are becoming harder to fund, yet the need for these is not decreasing. This shift in funding provides a significant strategic challenge for highly resource dependent CSOs and many have found that for their survival they need to undertake HIV/AIDS work (but often embark on inappropriate projects such as a regional gender lobby organisation starting and running a home care programme [Kerkhoven, personal communication October 2004]). Organisations can quickly become (over-) stretched as they move into new areas that may be outside their core purpose and require new skill-sets. Even within the HIV support, money is increasingly directed to voluntary counselling and testing (linked to anti-retroviral therapy and WHO '3 by 5' targets[6]) and away from the more traditional CSO activities of HIV awareness/education and home-based care.

> HIV affects roles and relationships throughout the whole aid system…and CSOs are finding that funding priorities are dramatically shifting.

In many countries CSOs are seeing their relationships with government shift. In theory CSOs are afforded an official role in Country Coordinating Mechanisms and The Global Fund's Partnership Forums. Yet as with many other initiatives for engaging with civil society, government practice is taking some time to catch up with its rhetoric (Fowler 2004).

HIV also has significant implications for how CSOs relate to each other. At the same time as CSOs need to work together as a sector in addressing the overwhelming threat of HIV, the very limited capacity at individual organisational level makes this more challenging. Concerns with immediate survival may make CSOs less willing to invest very scarce time and resources in longer-term networks and collaborative relationships. As the TUBA example illustrated, HIV/AIDS can undermine the working of civil society coalitions by reducing capacity at secretariat level.

---

[6] 3 million people on ARTs by 2005.

While the effect of collaboration between organisations is hard to value, there is a risk that relationships within the sector (through which social capital may develop) are likely to be reassessed in the same way that communities are re-evaluating their traditional support and coping networks. Certainly what is striking from the literature review is the limited attention paid to the impact of HIV on civil society roles and relationships and how the sector may need to reshape itself as a whole to meet this extreme systemic challenge.

## 2.3 Impacts on Organisations Internally

While all organisations suffer in an HIV/AIDS affected environment, CSOs are arguably less resilient than other kinds of public or private organisation. Research by Ebony Consulting International found a greater effect on organisations with 11–20 employees as opposed to larger organisations (cited in James and Mullins 2004). Many CSOs fall into this category. Additionally, CSOs have a smaller resource pool than public or private organisations, which means that the reduced productivity of individuals has a greater effect (Manning 2003). It also means that in many cases financial resources to cover the long-term medical aid for staff members or dependants living with HIV/AIDS or multiple replacement costs of staff are lacking (Oxfam International 2004:8). Finally, managing the human resource issues may be more difficult in a values-led organisation where personal and organisational boundaries are less clear.

HIV/AIDS has a big impact on many organisations as some staff are being infected with the virus while others are affected through their sick family members. In countries like Swaziland and Botswana, where adult urban infection rates are rapidly approaching 40 per cent, this would mean that a CSO employing 30 staff is likely to have at least 12 HIV+ staff. Using the average of 15 per cent of HIV+ people reaching symptomatic stage 4, this would mean that there would be always at least two staff sick with AIDS. As soon as they reach the symptomatic stage, there are considerable costs to the organisation. While the lack of adequate information systems in almost all CSOs precludes most meaningful attempts to quantify these costs, this does not make them any less real. In 1996 some private sector companies were already estimating that it was costing them 6 per cent of their profit (Holden 2003:96). Some organisations such as Oxfam and HEARD have developed models for approximate estimates of the cost of staff death and conclude that they exceed the cost of providing free ART to staff (even before the recent fall in price). An Oxfam International study found that even if they did not know precisely the extent: 'Most of the NGOs were reeling from the financial implications of the crisis' (Oxfam International 2004:4).

> With some urban infection rates approaching 40%…a CSO employing 30 staff…would be likely to have at least 2 staff sick with AIDS…with considerable costs to the organisation.

14

<u>Infected Staff</u>

The impacts of HIV/AIDS are felt at many different levels:

*Staff Productivity and Morale*

- Increasing sick leave and absenteeism – in Natal it is very conservatively estimated that an average CSO would already be losing 1 per cent of staff time to sick leave and absenteeism which would rise to 2.5 per cent by 2007 (Manning 2002).

- Even when the sick person was able to come to work, performance would often be poor.

- Extra work would be created for other staff, who will have to take on the sick person's workload in the short term at least, adding to their own stress levels, and reducing overall work quality.

- Declining team working as sick colleagues are isolated and stigmatised. One survey in Malawi revealed that around 50 per cent of people believe that an HIV+ co-worker should not be allowed to continue working (Mann 2002).

- The very real costs of grief and emotional problems should not be underestimated – it can be described as 'organisational depression'. Manning indeed found that 'the greatest impact was the emotional toll of these losses enacted upon co-workers and the organisation itself, damaging morale and hurting productivity' (2002:14).

- Staff morale can also be affected by a lack of clear policy guidelines on support for treatment and other costs. Morale may also be affected by financial pressures and may result in people 'moonlighting' from official CSO work for extra income – or worse, in professional misconduct. Colleagues may be further demoralised through the loss of a co-worker and will need to take time out from work to attend the funeral.

*Direct and Indirect Financial Costs*

- Increasing payouts for medical expenses and in the medium term increasing medical insurance premiums.

- Overtime, temporary cover or contractors wages to compensate for absenteeism (PraxisNote 11 on Mulanje Mission Hospital calculated that

casual wages had increased by 228 per cent between 2000 and 2003 and overtime wages by 385 per cent over the same period[7]).

- Potentially increased theft and fraud as HIV+ staff resort to illegal means to provide for their family's future as occurred in the TUBA case.

- Death benefit, life insurance and/or pension benefits are paid, which if not initially borne by the CSO will soon be passed on in higher premiums.

- The funeral expenses (usually borne by the employer in much of Africa).

- Staff loans are increasing and not being repaid.

*Recruitment Costs*

- The organisation has to pay the costs of recruitment.

- The position is vacant until the appointment is made and others have to cover gaps.

- Work taken on by colleagues may be poorly done, or simply left undone

- Induction and training costs are incurred.

- Salary is still paid to the new employee before being up-to-speed and performance is low.

- Other employees spend time inducting and training the new staff person.

*Loss of Organisational Memory and Learning*

- Unless there are rigorous mechanisms for organisational learning, when an organisation loses an employee their learning and knowledge may also be lost.

- There will also be systemic costs incurred by the loss of the key skills and experience of that employee, and the resulting decrease in quality of performance.

*Leadership and Management Costs*

- There is a loss of scarce management time – managers undoubtedly have to spend more of their limited time dealing with HIV-related issues. This causes considerable stress – in a survey of NGOs in South Africa, several senior managers stated they found it hard to cope with managing staff with long-term illness, compounded by lack of disclosure on HIV status (CDRA 2002).

---

[7] PraxisNote 11 is free to download from www.intrac.org.

- Leaders have to work extra hard to keep a depressed workforce motivated and performing and willing to take on extra work in the face of spiralling numbers of dependants and medical bills. Furthermore, it is more often the case that the manager, rather than the peers, provides the cover for sick staff.

- CSO managers are put into the impossible task of 'playing God' – deciding whether this person should be given organisational support to keep living or consigned to die (even if human resource policies exist, there is always some latitude of interpretation).

- These decisions cause a clash between personal/organisational values and good financial management. The CDRA study found that some managers openly went beyond the limits of organisational policy to provide much greater support than allowed, despite the fact that this set a precedent the organisation could not maintain (CDRA 2002).

---

**Personal Experiences: Loss of valued colleagues**

An innovative NGO capacity building programme in Malawi trained a team of organisation development (OD) practitioners to work with the local NGO sector. Alfred was one of the stars of this programme – an analytical, incisive, mature individual, committed, determined and ambitious to make a difference to his country. Alfred had a brilliant ability to synthesise his rural cultural roots with the more 'Western' urban-educated world. He brought a wide experience from the public sector, the NGO sector and the private sector and dreamt of establishing his own OD consultancy. Sadly this dream was brutally shattered when he fell ill and rapidly died of AIDS. In a country with precious few human resources dedicated to capacity building, Malawi lost one of potentially the most effective agents of change in the NGO sector. Obviously the loss to his wife and young family is even greater.

---

Affected staff

*Influences of the Commitment to Family, Community and Culture*

Yet even if no one in the organisation is *infected* with HIV almost everyone will be *affected* by the disease in ways that influence performance and costs. The Oxfam International report points out, 'NGO staff members are also members of communities themselves and cannot divorce themselves from the emotional, family, social, economic and spiritual impact of the HIV/AIDS epidemic where they work and live' (Oxfam International 2004:8). Even if staff themselves are not sick, they have to

cope with sick and dying relatives, friends and colleagues. By being part of an extended family culture, CSO staff:

- have to take time off work to care for sick relatives

- ask for more time off for funeral leave (PraxisNote 10 analysing the costs of HIV to CSO leadership mentioned one leader who said he had to take about six weeks off a year to attend crucial family funerals[8])

- spend weekends attending funerals, not relaxing from work

- may be distracted and demoralised at work by worries about sick relatives and increasing financial burdens

NGO staff also tend to be financially burdened. In places with high unemployment, they usually have above-average incomes. This encourages many members of the extended family to go to them for financial and material support for a range of things related to HIV and AIDS: requests for food, medical care, funerals, school fees, and support for orphans are common. It is normal to have several staff in a single organisation who are each caring for more than one orphaned nephew, niece, or other child. Two of the NGO Directors I work closely with in Malawi currently have 12 and 17 dependants each (one having recently gained another five dependants when his sister died of AIDS earlier this year).

---

**Personal Experiences: Providing support to family**

When my divorced sister told us she was HIV+ we put her on ARVs, costing MK 3000 per month. She was looking fine, but after some time said she was going to live with a man who was also HIV+ and they would look after each other. Before they showed signs of sickness things were OK, but when the man was hospitalised for two months and lost his job, things deteriorated. They asked us to assist them paying their rent, but we were already overstretched paying for the ARVs. We also knew they needed to be eating well for the ARVs to work. What can we do? I suggested she move back in with us and the man goes back to his family as we cannot have both of them, but he claims to have no relative…

It affects me at work. It takes up my time. I have to go and visit them and see their condition, but mostly the pressure is mental. I had to go into debt to pay for the ARVs, and if I stop giving ARVs she will die quickly.

---

CSO leaders are particularly affected as they are often culturally bound to respond to serious issues relating to their extended family. Women leaders additionally have all the cultural expectations of the woman as care giver, alongside the financial

---

[8] PraxisNote 10 is available to download for free from www.intrac.org.

obligations expected from those with salaries (James 2004). Given that the burden of caring usually falls more on women than men, there will be important gender implications, with female staff taking on additional burdens at home. This may lead to problems in the workplace, and discrimination against women in recruitment in the future. Women in senior roles may be able to use their greater financial resources to hire in others for day-to-day caring responsibilities, so the impact is maybe hardest on lower-level female employees.

The actual extent of the impact on CSOs, however, is not known. There have been very few attempts to quantify the impact due to inherent methodological difficulties. Some of the quoted statistics therefore may prove to exaggerate the impact (for example a World Bank Paper in 1998 estimated that Malawi would lose 40 per cent of its health workers between 1998 and 2005 – the reality may be closer to 15 per cent). In order for CSOs to develop an appropriate response, they need quantitative evidence to justify the investment of time and resources. They need this information to plan and budget accordingly – how much extra should CSOs add to their budget, for example, to implement an HIV/AIDS response? Without such information, CSOs will continue to be constrained in their response.

# 3    What Has Been Done? Capacity Building Responses

So far the organisational response of most CSOs in sub-Saharan Africa has been very

> The organisational response of most CSOs in sub-Saharan Africa has been very limited, despite them being most affected by HIV.

limited, despite them being most affected by HIV. Many CSOs have not even gone the first steps of developing an HIV/AIDS or critical illness policy. Even those CSOs that have, find implementing it even more challenging. There are a number of factors inhibiting a strategic response to HIV/AIDS. The slow on-set nature of the disease enables both individual and organisational denial, leading to an underestimation of the impact.

## 3.1  Understanding the Constraints

To effectively overcome the contextual challenges facing CSOs it is important to understand the factors (personal, organisational, and systemic) that have inhibited action to date:

*On a personal level:*

- Many CSOs are too busy to stop and think about strategic issues. The urgency of immediate questions of survival limits their strategic horizons.

- Many CSOs still lack understanding of HIV/AIDS and are too small to employ specialist staff, or have adequately staffed HR departments.

- Sexual behaviour is still a 'private' subject and developing a policy can be interpreted as making negative assumptions about the sexual behaviour of staff.

- The organisation is still seen as a safe place away from the trauma of extended family life and HIV is not always spoken about openly.

- Developing an HIV/AIDS policy is made much more sensitive and personal if a member of staff is already sick.

- Few CSOs make the direct link between HIV and organisational impact, unless they are directly asked about it (personal discussions with CDRN Uganda, and CDRA South Africa).

*On an organisational level:*

- The lack of quality information systems in most African CSOs makes it impossible to accurately measure the organisational impact (e.g. monitoring absenteeism or higher medical expenditure).

- Experience is showing that even the basic step of developing a participatory HIV/AIDS policy is very time-consuming and costly.

- The process of developing a policy may raise staff expectations before funding to implement the policy is secured.

- The costs of implementing an HIV/AIDS policy can be considerable.

*At a systemic level:*

- There is very little quantified information outlining the actual costs of HIV/AIDS to CSOs. This makes budgeting very difficult.

- Many CSOs believe that donors are unwilling to support the costs of implementing HIV/AIDS policies. NGOs interviewed by CDRA in South Africa stated that when they did ask, they were inevitably told that it was not possible (CDRA 2002).

- There are few comparative experiences of other CSOs to learn from, particularly in documented form, and a distinct lack of CSO-specific resources and guidance for organisations seeking to develop a response (Manning 2002).

- HIV/AIDS stigmatism among southern NGO partners and the need for Southern NGOs to appear competent to perform acts as a barrier to them openly reporting on HIV/AIDS related problems. These barriers prevent Southern NGOs from lobbying for international mainstreaming which has resulted in the international NGOs having to lobby themselves to develop HIV/AIDS sensitive policies towards their partners (PSO Interviews 2004).

## 3.2 Emerging Approaches and Practices

HIV/AIDS throws up a number of new and distinct organisational capacity building needs for CSOs but at the same time exacerbates existing needs. Such capacity building is necessary to preserve organisational capacity and build organisational resilience to HIV. In order to ensure the organisation survives and functions effectively, the managers and staff need to understand how the organisational workplace is affected. To date the organisational capacity building response to HIV/AIDS has taken place in four key areas, but it is becoming clear that a fifth area of wider OD interventions is also necessary:

1) staff awareness programmes

2) organisational staff policies

3) long-term human resource implications

4) financial budgeting and monitoring

5) wider OD interventions

### 3.2.1 Staff Awareness Programmes

A common and important first step is to launch staff awareness programmes. Personal understanding of the issue is a pre-condition for successful efforts to tackle AIDS-related problems in the workplace and in programmes. Staff awareness programmes aim at supporting staff to reduce their susceptibility to infection and cope better if they are infected. Ultimately staff need to take personal responsibility for HIV.

Personal understanding of the issue is a pre-condition for successful efforts to tackle AIDS-related problems in the workplace.

In many countries in Southern Africa, labour legislation obliges employers to provide employees with information on HIV/AIDS. Staff should be made aware of the legal rights attributed to staff by domestic labour law, training in writing wills and other inheritance matters. This training should be ongoing due both to the constant developments in dealing with HIV/AIDS and the staff turnover.

Staff education can address a broad range of themes, and some topics frequently discussed (James and Mullins 2004) include:

- basic information on HIV transmission, progression from HIV to AIDS

- introduction to organisational policy on HIV

- overview of common opportunistic illnesses, and basic treatment

- overview of anti-retroviral treatment

- living positively with HIV/AIDS

- discrimination and legal rights of people living with HIV

- how to draw up a will

- use of condoms

- counselling skills

- programme work on AIDS

- personal responsibility to make right choices

Staff awareness must also work to address the problem of stigmatism attached to co-workers who are HIV/AIDS positive (Oxfam International 2004; James and Mullins 2004). This stigmatism often marginalises co-workers and prevents teamwork as well as impeding the implementation of coping policies such as shifting an infected worker to lighter duties within the organisation. The Red Cross 'peer education' approach to awareness and training has worked as a means to overcome this barrier.

Staff awareness programmes may include appointing someone as an HIV/AIDS resource person to lead on in-house HIV education or provision of HIV-related services. The method of addressing this is key. New and additional responsibilities associated with HIV/AIDS demand that some previous responsibilities are removed, as experience has shown that merely adding on 'gender' or 'HIV/AIDS' as additional elements to an existing full-time job is likely to fail.

### 3.2.2 Organisational Staff Policies

A second element is to develop an HIV/AIDS or better a Critical Illness/Health policy[9]. These policies aim to cover human resource management, welfare and insurance policies and address the increased need for sick leave and recruitment (Rau 2002). Organisational responsibilities are outlined, but need to be developed in such a way that individual responsibility is not undermined. Organisations may have to limit the time that employees can use to attend funerals. Development of a staff

---

[9] HIV/AIDS should not be focused on exclusively. The same response should apply to all critical illnesses such as cancer or diabetes.

health policy should be guided by good practice, such as the SADC Code of Conduct on HIV/AIDS in Employment, and the ILO Code of HIV and Employment. Staff health policies must fit within the framework of national policy and regulation, with particular reference to labour law (James and Mullins 2004).

Organisational Staff Policies should be guided by good practice, fit within the framework of national policy and regulation and may need to expand to cover the costs of HIV/AIDS treatment.

Staff health policies may need to expand to cover the costs of HIV/AIDS treatment. The cost of anti-retroviral therapy (ART) has reduced significantly in the past few years, thus making organisational funding more feasible. Many larger CSOs and companies, including the Anglo-American Mining Corporation, Heineken, Oxfam GB, Save the Children, DFID, and UNICEF, find it affordable to pay for ART for infected staff (Macalister 2002; Oxfam International 2004; UK Consortium on HIV/AIDS 2003). The cost of providing ART is thought to be significantly offset by the organisational benefits in reduced absenteeism and reduced need for recruitment (provided assumptions about ART uptake are realised). One of the greatest demands of local organisations is the need for expanded medical coverage to pay for medication. The extent to which coverage for ART can be extended to employee family members must, however, be pragmatically evaluated according to the costs incurred.

There are plenty of manuals and websites to assist an organisation through the process of developing a workplace policy. Common guiding principles now exist. This information, however, is rarely tailored to NGO-specific practice (UK Consortium on AIDS in International Development 2003). There is also

A participatory policy development process is time-consuming and costly…and can often reveal deeper and wider organisational issues related to prevailing organisational culture, relationships and decision-making.

very little documented and accessible information about individual CSO experience of undertaking such processes (Kerkhoven and Löwik 2004:9). Even though materials may exist in some form, 'many CSOs are not familiar with them, do not know how to use them, and also such work is very resource intensive for fragile organisations' (Mullins personal communication 2004).

Experience is showing that a participatory policy development process is time-consuming and costly. It can often reveal deeper and wider organisational issues related to prevailing organisational culture, relationships and decision-making. As has been previously mentioned, implementing the policy may require considerable resources and could provoke a clash of values. Even in Europe the Sharenet found 'the start of a policy response on paper, but there is very seldom an operational plan to ensure implementation' (Kerkhoven and Löwik 2004: 35). For small NGOs the debate about the need for a formal organisational policy is ongoing. While it is acknowledged that the problem of HIV/AIDS is one that must be addressed

systematically, small CSOs often have very few organisational policies and do not want to over-commit themselves in an uncertain funding environment.

Some CSOs have also linked the development of an HIV/AIDS workplace policy with other organisational policies such as travel and relocation. This ensures that staff are not required to undertake significant travel away from home, or to live in a separate location from their spouse. There may also need to be alterations in travel policies, with staff no longer encouraged to stay in the cheapest 'rest houses' or with travel allowances paid directly into bank accounts.

### 3.2.3 Long-Term Human Resource Implications

> Organisations need to plan strategically how they will staff their programmes to mitigate the impact of HIV/AIDS, not just today and next year, but five years on.

A third area but less common organisational response is analysing and then planning for the long-term human resource implications of HIV. Organisations have to assume some people will fall ill even where there are good efforts to minimise new infection and illness through awareness-raising and support, guided by a good policy. Organisations need to plan strategically how they will staff their programmes to mitigate the impact of HIV/AIDS, not just today and next year, but five years on.

Private and public organisations have implemented long-term planning caused by increased illness and death. Some have used Barnett and Whiteside's Institutional Audit model (2002) to examine the vulnerability of critical posts, to estimate how likely the post-holders are to fall ill, and to identify how this would affect the ability of the organisation to function effectively.

Some NGOs, such as Novib, are beginning to develop longer-term HR strategies. They are contemplating supporting:

- Integration of HIV/AIDS labour rights into staff recruitment including the prohibition of pre-employment HIV testing to avoid unfair discrimination (Oxfam International 2004).

- Multi-recruitment or extra-staffing at certain levels to make sure the organisation can continue to operate when staff members fall ill.

- Multi-training staff in order that persons can have a wider variety of responsibilities and skills.

- Light duty for those that are ill so that they can continue to work, though this may be resisted to avoid stigmatism (Oxfam International 2004).

- Creating a second tier of leadership within the organisation if the leader falls ill, a strategy that will lessen the responsibilities and dependence of an organisation on a sole source of leadership and support.

- Creating a new staff support position such as a staff welfare counsellor.

But the reality that most CSOs face in sub-Saharan Africa is that they are struggling to secure support to cover existing posts, let alone have the luxury of budgeting for extra posts.

### 3.2.4 Financial Budgeting and Monitoring

The effects of HIV/AIDS and the policies to manage the impacts will inevitably raise the costs for NGOs without a corresponding increase in their ability to implement programming. It is important for organisations to understand and anticipate these costs to be able to proactively manage and budget for them. So far this is very rare.

Changes in budget formats and financial monitoring, in ways that register both the direct and indirect costs, would enable organisations both individually and collectively to use this data as a part of a broader debate with back-donors as well as helping organisations to manage these costs.

Some examples of budget changes include:

- *increase amounts in current budget lines*: Some important costs may already be known, but are under-budgeted. For example, there may be a budget allocation for medical care, but this may be insufficient.

- *split existing budget lines*: Some important costs may currently be lumped together in the budget and financial monitoring system, making it impossible to track them separately. It is common in some organisations to have a single budget item for 'staff costs,' which includes salaries, housing subsidies, medical cover, and so on.

- *new budget lines*: Some organisations have no budget at all for certain costs, even though they incur expenses. For example, funeral costs may be 'stolen' from other funds. This hides the real costs of illness and death, while taking money away from its intended use. New budget lines may be needed to cover expenses such as: temporary staff, medical costs, capacity building expenses, HIV/AIDS staff education; research on HIV/AIDS, as well as the development of HIV/AIDS programmes.

There are some innovative ways in which some international NGOs are attempting to cover the financial implications. CARE USA for example is globally setting aside the equivalent of 1.5 per cent of the national payroll, putting this into a global fund and

redistributing to regions with higher burdens of HIV and AIDS – this fund can be called on when staff benefits are exhausted (Mullins personal communication October 2004). ActionAid in the UK is considering adding a percentage levy to all funding proposals (Holden 2003:152).

### 3.2.5 Wider OD Interventions

There is still 'very little evidence in CSOs of organisations modifying the way in which they are behaving'. This presents challenges for both providers of capacity building support and donors.

It is clear that the capacity building implications of HIV/AIDS are by no means limited to a technical intervention at programme level or even to human resource policy or training events. To address capacity building in times of HIV/AIDS requires an organisation-wide response. HIV is inextricably linked to other organisation development issues such as power and decision-making, gender and sexual harassment, as well as private/organisational boundaries. Reducing the stigma of HIV/AIDS and making a CSO more resilient to HIV/AIDS may involve shifts in organisational culture towards more open decision-making processes. HIV/AIDS also pushes gender awareness and empowerment within organisations to the fore of capacity building needs. Appropriate capacity building responses may therefore need to be adapted to differing personal, organisational, cultural and sectoral contexts. As well as the four areas outlined earlier, a strategic organisational response to HIV/AIDS requires shifts in these broader OD issues. To date, however, Holden has found that there is still 'very little evidence in CSOs of organisations modifying the way in which they are behaving' (2003:152). This presents challenges for both providers of capacity building support and donors.

# 4    What Can Be Done? Implications for Future Practice

## 4.1    Challenges for Capacity Building Providers

Building organisational resilience to HIV/AIDS will require skilled organisations and individuals able to provide appropriate capacity building support to CSOs. The challenge is to bring an organisational perspective, an understanding of change as well as some knowledge of HIV/AIDS issues. According to Russell Kerkhoven (personal communication 2004) at present: 'There are only a limited number of capacity building providers who have both an understanding of HIV/AIDS and an understanding of organisational development and change'.

Organisational development (OD) providers in Southern Africa have been slow to respond to the challenge of HIV/AIDS. Dan Mullins of CARE asserts that: 'Many OD providers still have not started to address the impacts of ill health on their client agencies' staff or the viability of the clients themselves' (personal communication

October 2004). Some AIDS support organisations (such as CHAMP, Zimbabwe AIDS network) have begun to develop more organisational change perspective and competence to their work. ACET Uganda found that the organisational implications of working with an increasing number of rapidly growing HIV/AIDS organisations 'forced them to diversify their capacity-building services to offer OD services as well as technical input in HIV/AIDS programming work' (James 2002:60).

---

**Case Study: ACET UGANDA — Shifting from AIDS Programming to Organisation Development**

ACET Uganda has provided technical capacity building support to HIV/AIDS organisations for a number of years. ACET is a specialist in programming issues of HIV/AIDS care and education. They found, however, that this technical support to HIV/AIDS organisations was insufficient. Their clients were suffering from many organisational and management issues. They were not able to cope with the rapid organisational growth, or make effective strategic choices in planning ahead.

As a result, ACET developed a complementary organisation development programme for clients. As well as offering support in general project planning and evaluations, they are also increasingly involved in providing consultancy in organisational change.

---

The scale of the problem in regions such as sub-Saharan Africa means that concerted efforts are needed to identify and support intermediary technical service providers who can provide support to a larger number of smaller organisations.

*Adapting the Content of Capacity Building*

In terms of the *content* of capacity building, practitioners in sub-Saharan Africa must systematically mainstream HIV/AIDS into all their capacity building work. If they are to remain relevant in an HIV-infected context, they need to develop competencies to be able to assist their clients or at least signpost their clients to people who can help CSOs develop organisational resilience by addressing both HIV-specific and wider OD issues of:

- setting up a staff awareness programme for HIV/AIDS

- helping clients develop organisational staff policies, such as for critical illness

- addressing the long-term human resource implications

- adapting financial budgeting and monitoring through improved systems and skills

- helping clients anticipate the impact of HIV over the next 5–10 years and proactively precipitate a strategic response

- understanding the implications of HIV/AIDS for relationships, gender, teams and organisational culture and vice versa to be able to move clients forward

- being able to assist clients in becoming more of a learning organisation. The need to develop appropriate systems for ensuring organisational learning[10] is made even more necessary by the inexorable loss of key staff and their skills, knowledge and experience. Organisational learning can no longer be viewed as a luxury, but as a precondition for future organisational sustainability

- the need for leadership development[11] is reinforced by HIV/AIDS. The potential loss of key individuals makes second-line leadership development essential and the strain of managing an organisation in such a difficult context puts extreme demands and stresses on leaders. Leaders could benefit from training to help them anticipate such situations. Counselling could also be offered and the possibility to exchange experiences and ideas with other managers facing similar issues. Managers also have to counsel and support others and could therefore benefit from training in basic counselling skills

*Adapting the Process of Capacity Building*

Capacity building providers need to recognise that their traditional modes of delivery may no longer be appropriate. Some workshops may even be promoting the spread of the virus. As Hoover and McPherson (2000) rightly question: 'Under conditions where HIV prevalence is high and death from AIDS is rising, why should we expect conventional approaches to training, managing, organising and motivating workers to be valid? What does capacity-building mean where those whose capacities are being enhanced will become debilitated and die?' As for the capacity building *process*, working in an HIV-infected context requires taking more of an organisational approach, rather than individually targeted training inputs.

With the increasing risk involved in focusing resources on a few key people, many organisations are shifting their staff development programmes to broader, shorter course training. An OD approach to capacity building, which is a participative, organisation-wide approach to change, becomes more appropriate as the decision-making and learning is spread across a greater number of people. If some leave, the organisational capacity remains. This OD approach helps build up and spread the institutional memory and is also potentially an important morale-boosting intervention.

---

[10] See Praxis Paper 3, free to download from www.intrac.org.

[11] See Praxis Paper 6, free to download from www.intrac.org.

<div style="border: 1px solid black; padding: 1em;">

**Case Study: CABUNGO: Mainstreaming HIV/AIDS in OD Practice**

CABUNGO, an OD provider in Malawi, assists clients to:
1) Become aware of the impact of HIV/AIDS on their organisation
2) Assess the impact on their organisation
3) Manage and deal with the impact of HIV/AIDS by integrating HIV/AIDS issues in each of the following OD services:
  - organisation assessment (OA)
  - strategic thinking and review
  - vision, mission and strategy development
  - systems, procedures and policy review
  - board management and governance
  - operational planning, monitoring and evaluation
  - leadership development
  - human resource management and development
  - team and relationship building
  - understanding organisations and groups
  - conflict management
  - advocacy training
  - appreciative inquiry

</div>

*Collaborative Approaches*

The capacity building approach should also seek to encourage CSOs to work together to address these capacity building issues. According to Alan Fowler: 'The existing evidence suggests that individual organisations are putting little effort into finding mutually supportive solutions to shared problems' (2004:9). Not only are many of the issues very similar and there may be 'economies of scale' through joint programmes,

> Through CSO umbrella bodies or other mechanisms CSOs could usefully explore establishing national working groups to specifically focus on identifying areas where collaborative effort could help address shared organisational problems.

but this would enhance peer-to-peer support as well as CSO cooperation in other areas. As Fowler goes on to point out: 'The difficult climate for fundraising makes a stronger case for looking in this direction to both reduce costs and help change the rules of the game commonly employed by funders. In other words, common problems merit sector-wide solutions. For example, CSOs could collaborate to establish a joint non-profit insurance policy that can negotiate lower premiums because of economies of scale. A similar approach could be adopted for burial insurance and to cover other HIV/AIDS related costs' (ibid.). Through the aegis of CSO umbrella bodies or other mechanisms CSOs could usefully explore establishing national working groups (such as are more common in the private sector) to specifically focus on identifying areas where collaborative effort might help address shared organisational problems.

*Evaluating and Assessing Impact*

HIV also makes impact assessment of capacity building work even more difficult. We have noted that the capacity baseline in many organisations is crumbling in the face of the attrition from HIV/AIDS. In order to be able to monitor and evaluate their work more accurately, capacity building practitioners will need to find out how they can take this declining baseline into account. Otherwise it may appear that their capacity building interventions are not as effective as they really are.

## 4.2  Challenges for Donor Organisations

To be an effective, relevant and appropriate donor in the context of high HIV/AIDS prevalence has considerable implications. A strategic, considered organisational response to the issue is essential. To date, international NGOs have also been relatively slow to respond to the organisational impact of HIV/AIDS (with some notable exceptions such as Oxfam International and CARE). Donors perceive themselves as 'concerned bystanders, not really responsible, until it has affected the quality of their partners' work' (Kerkhoven and Löwik 2004:38).

> To date, international NGOs have also been relatively slow to respond to the organisational impact of HIV/AIDS and...have tended to limit the response to their human resource (HR) departments.

Those that have responded have tended to limit the response to their human resource (HR) departments. A recent survey of Dutch CSOs (Sharenet members) concluded that they 'have so far barely started to address the employment dimension of HIV/AIDS' (Kerkhoven and Löwik 2004:9) and that, 'too often the responsibility for an HIV/AIDS response is dumped on the HR departments that do not have the appropriate capacity or means' (ibid.). Most Dutch NGOs, for example, have focused on mainstreaming HIV/AIDS in programmes with a standard reference to HIV/AIDS impact on every project application[12]. Some are in the process of developing HIV/AIDS policies; are contributing to research; and have existing HR strategies that could provide additional funding for HIV/AIDS.

According to the 2004 Oxfam International study:

> **NGOs need far greater support from donors to address their internal organisational needs. The current situation for most NGOs involved in this assessment is unsustainable.**

---

[12] The following information is taken from interviews conducted with Dutch NGO staff for the PSO research consultancy in 2004.

The study found that 'managers were very concerned by the lack of recognition amongst donors of the financial impact on them of HIV/AIDS at a time when donors push for expanded HIV/AIDS programming' (2004:4). But international NGO donors will appreciate that responding to HIV/AIDS requires resources (which are scarce), overhead costs increase and organisational efficiency goes down. But while it may be costly, it is also essential. Donors (both NGOs and official agencies) look at a number of strategic interventions to remain relevant in this time of HIV/AIDS:

1) raising partners' awareness of needs

2) supporting capacity building interventions

3) providing extra funding support to mitigate the organisational impact

4) adjusting the overall partnership strategy

*Raising Partners' Awareness of Their Needs*

International NGOs have a role in stimulating demand from partners by helping them become more aware of the pressing issue of HIV/AIDS. This might be done by:

- actively putting HIV/AIDS onto the partnership agenda through dialogue and bringing the issue into personal discussions during field visits

- sharing information about other partners' processes and their experiences

- providing basic outlines of suggested outputs, processes and links to technical support

- informing partners about resource availability to support such processes

- actively encouraging local partners to ask funders to support HIV workplace interventions

- funding peer meetings of CSO partners, which may also encourage the essential sector-wide support for CSOs working together on these issues

- funding research into actual costs of HIV/AIDS to CSOs, something that is not affordable for CSOs on an individual basis

- ensuring consistency in supporting the costs of implementing policies once in place

*Supporting Capacity Building Interventions*

Donors may be in a position to fund interventions to mainstream HIV/AIDS externally into partners' programmes and internally into their organisations by:

- contracting local providers to train partners

- encouraging partners to develop policies

- funding processes with outside facilitation

- funding providers such as a CARE-initiative in sub-Saharan Africa to develop a network of capacity building providers in this field

- encouraging the pooling of resources e.g. partners' joint benefits packages and, where there is field presence, negotiating directly with medical insurance companies for better deals

*Providing extra funding support for partners to mitigate the organisational impact*

Ultimately it will cost money for partners to implement an organisational response to HIV/AIDS. The Oxfam International study showed that 'many NGOs will not be able to survive without substantial additional support. Skilled staff members are being lost and NGOs lack the resources to train new staff. Institutional memory is being lost. Something has got to give.' (2004:20). As Sue Holden points out, 'If donors are concerned that partners would preserve their effectiveness, they emphasise internal mainstreaming. In doing so they need to recognise and be willing to pay the internal costs which arise' (2003: 169). Some international NGOs, for example, are experimenting with one-off annual donations of between $3000–$5000 for partners working in contexts of high HIV/AIDS prevalence to give them some up-front resources and incentives to develop their organisational response. But such support cannot be seen as one-off donations to develop a critical illness policy for example. Ongoing support of extra 'overheads' will be necessary to implement that policy once it is developed.

> Donors have a major role in encouraging their partners to budget for these costs individually, but also may need to set aside a central fund from which any partner with unanticipated expenditure can draw.

Donors may have to cover the costs of increased staff benefits (including medicines), insurances, funeral costs, coffins, and transport. It may also involve them paying for the more strategic capacity maintenance costs of overstaffing, multi-skilling, increasing salaries and paying for sabbaticals. Donors have a major role in encouraging their partners to budget for these costs individually, but also may need to set aside a central fund from which any partner with unanticipated expenditure can draw. They will need to think through where they themselves will access the resources for such support by diverting existing money or by raising new money to cover this.

Working with partners in contexts of high HIV/AIDS prevalence requires longer-term organisational support rather than the short-term project support that still remains the norm. The need for organisational capacity building support to avoid an organisational crisis makes project funding even less relevant and appropriate. According to the Sharenet study, 'the predominant project funding mode and accountability to the ultimate donor (Dutch government) thwarted all efforts to articulate an organisational response to HIV' (Kerkhoven and Löwik 2004:35).

As HIV takes its toll on partners, donors will have to accept that performance and results may suffer and the results-based frameworks may look less positive than hoped. If all else remains equal, it will cost CSOs more money to do less work in a context of high HIV/AIDS prevalence. The extra pressures that working in such a context places on CSOs should make donors think about lifting some of their demands rather than constantly putting extra demands on already overstretched partners.

As always, donors need to be aware of the passing on of conditionalities. A simplistic funding condition such as requiring a partner to have an HIV/AIDS policy may simply prompt a cosmetic, template-type response. Such conditions need to be preceded by serious dialogue and understanding of the issue if they are to be effective. Otherwise they may also lead to CSOs thinking that once they have a written HIV/AIDS policy, their strategic response to HIV/AIDS is complete.

## Concluding Remarks

This is certainly not an ideal time for developing a strategic response to HIV/AIDS. Aid budgets are already overstretched and shrinking and practitioners are already struggling to respond to the multiple demands for capacity building. Developing the competencies to respond or providing the financial support to do so is a costly and long-term initiative. Neither is it likely to be popular – a project honestly entitled 'CSO capacity maintenance' is not very likely to be supported.

> It is an essential time to 'rewrite the rules'…HIV has changed the face of development in sub-Saharan Africa and consequently capacity building efforts must also change.

But although it is not an ideal time, it is an essential time to 'rewrite the rules'. HIV has changed the face of development in sub-Saharan Africa and consequently capacity building efforts in that region must change if they are to remain relevant to CSO needs. In other regions, such as India, China, Eastern Europe and Central Asia, HIV infection rates are growing dramatically which may also have implications for capacity building interventions.

In building organisational resilience, however, there is still so much we do not know:

- What is the extent of the impact of HIV/AIDS on CSOs in sub-Saharan Africa?
- How will greater accessibility to ARVs affect the costs to CSOs?
- What will be the impact in other regions, where the mode of HIV transmission is different and therefore the impact on CSO staff will be different?
- What capacity building interventions are really making a difference?
- Which interventions are cost-effective for the majority of CSOs who are small and informal?
- What different interventions by donors are proving effective?

In collaboration with other NGOs, such as PSO, CARE and Oxfam International, INTRAC is attempting to rise to this challenge and answer some of the questions through its Praxis Programme. The Praxis Programme is about increasing the effectiveness of organisational capacity building interventions in order to support CSOs to:

a) improve their existing capacities;
b) fulfil their missions and
c) continuously adapt to their changing contexts.

The very extreme contextual shift brought about by HIV/AIDS threatens the very existence of many CSOs and therefore we cannot talk about building capacity without rising to this challenge. If CSOs, and the organisations that support them, prevaricate, not only will the eventual costs rise, but also vital capacity will be further lost in the delay.

There is an urgent challenge for capacity building practitioners to take their own learning more seriously as they get more involved in HIV/AIDS work. Praxis believes that local practitioners in developing and transitional countries have a key part to play in generating new ideas and approaches. We all need to learn more about how CSOs are developing organisational resilience in practice, and appropriate roles for capacity building practitioners and donors. The Praxis Programme can therefore play a key role in nurturing, capturing and disseminating solutions with practitioners for practitioners. Based on the issues and challenges outlined in this Paper, Praxis will facilitate the interchange of experiences amongst capacity building practitioners engaged in this field and assist practitioners in sub-Saharan Africa and countries currently less affected by HIV/AIDS to develop a proactive capacity to respond.

If you would like to engage in this process or have any further questions, please visit the INTRAC website or contact us via e-mail or the address below. Please also circulate this Praxis Paper within your networks, and especially to those who do not have easy access to such information or the Internet.

Rick James rjames@intrac.org
Praxis Programme, INTRAC, PO Box 563, Oxford, OX2 6RZ  United Kingdom
Tel: +44 (0) 1865 201851  Fax: +44 (0) 1865 201852
www.intrac.org

# References

Barnett, T. and Whiteside A. (2002) *AIDS in the Twenty-First Century*, Basingstoke: Palgrave Macmillan.

CDRA (2002) *Positive Organisation: Living and Working with the Invisible Impact of HIV/AIDS,* Cape Town: CDRA.

Fowler, A. (2004) 'Civil Society Capacity Building and the HIV/AIDS Pandemic: Perspectives and Strategies for PSO Members'.

Holden, S. (2003), 'AIDS on the Agenda – Adapting Development and Humanitarian Programmes to Meet the Challenge of HIV/AIDS', Oxfam GB in association with ActionAid and Save the Children UK.

Hoover, D. and McPherson, M. (2000) 'Capacity-Building Programmes - Facing the Reality of HIV/AIDS, HIV/AIDS in the Commonwealth', presented at XIII International AIDS Conference, Durban.

Hunter, S. (2003), *Who Cares? AIDS in Africa*, New York: Palgrave Macmillan.

ILO (2000) 'Percentage of Workforce Lost to AIDS by 2005 and 2020 in Selected African Countries', POPILO Population and Labour Force Projection.

ILO (2001) 'Code of Practice on HIV/AIDS and the World of Work', Geneva: ILO, available at www.ilocarib.org.tt/infsources/general_reports/aids/cop_aids.pdf.

ILO Briefing Paper (2003) 'Women, HIV/AIDS and the world of work', Geneva: ILOAIDS, International Labour Organisation Programme on HIV/AIDS, available at www.ilo.org/aids.

James, R. (2002), *People and Change: Exploring Capacity Building in NGOs*, Oxford: INTRAC.

James, R. (2004), '"Dodging the Fists?" The Crushing Blows of HIV/AIDS on Leaders in Malawi', Oxford: INTRAC.

James, R. and Mullins, D. (2004) 'Supporting NGO partners affected by HIV/AIDS', *Development in Practice*, 14 (4).

Kerkhoven, R. and Löwik, M. (2004), 'Human Resource Management and HIV/AIDS', Study among ShareNet members, The Netherlands.

*The Lancet* (2004) 364 (9428) Jul 3–9.

Macalister, T. (2002) 'South African mining giant to give staff free Aids drugs,' *The Guardian*, 7 August.

Mann, G. (2002) *Business Counsellors' Workbook*, Blantyre: Kadale Consultants.

Manning, R. (2002), 'The Impact of HIV/AIDS on Civil Society: assessing and mitigating impacts: tools and models for NGOs and CBOs', Health and HIV/AIDS Research Division (HEARD), University of Natal.

Marais, H. (2004) 'The Quicksand of Quick Fixes: The vexing temptation to make HIV/AIDS manageable', Centre for Civil Society, University of Kwa-Zulu Natal (www.ukzn.ac.za/ccs).

Oxfam International (2004) 'Managing HIV/AIDS in the Workplace: Examples of Nine NGOs in South Africa, Zambia and Zimbabwe', Oxford: Oxfam.

Oxfam Malawi (2001) 'Programme review on HIV and AIDS in development', March.

Piot, P. (2003) 'AIDS: the need for an exceptional response to an unprecedented crisis', A Presidential Fellows Lecture, Washington, November 20.

Rau, B. (2002) *Workplace HIV/AIDS Programs: An Action Guide for Managers,* Arlington, VA: Family Health International.

Rode, H. (2005) 'Capacity Building at Mulanje Mission Hospital', PraxisNote 11, Oxford: INTRAC.

SADC (1997) 'Code on HIV/AIDS and Employment in Southern African Development Community (SADC)', available at www.safaids.org.za/polyempl.html.

Smillie, I. and Hailey, J. (2000) *Managing for Change, leadership, strategy and management in Asian NGOs,* London: Earthscan.

UK Consortium on AIDS and International Development (2003), 'Working Positively – A Guide for NGOs Managing HIV/AIDS in the workplace', December.

UNAIDS (2000) *Best Practice Collection Guidelines for Studies of Social and Economic Impact of HIV/AIDS*, Geneva: UNAIDS.

UNAIDS (2002) 'AIDS as a security issue', Fact Sheet, Geneva: UNAIDS, www.unaids.org.

UNAIDS website 2004.

UN Department of Economic and Social Affairs (UNDESA) (2003), *Reproductive Health Services in KwaZulu Province South Africa: A Situation Analysis Study Focusing on HIV/AIDS Services*, Washington DC: The Population Council/Horizons Program, July.

Whiteside, A. and Sunter, C. (2000) *AIDS: The Challenge for Africa*, Cape Town: Human and Rousseau.

World Bank (1988) *AIDS Assessment Study 10: Malawi*, Washington, DC: World Bank.

**Praxis Paper No. 4**

# Building Organisational Resilience to HIV/AIDS: Implications for Capacity Building

By Rick James

HIV/AIDS is fast becoming the worst ever human disease disaster. The economic and social costs are escalating, particularly in sub-Saharan Africa. For civil society organisations (CSOs), HIV/AIDS is leaving a significant proportion of their beneficiary groups sick, further impoverished and more vulnerable – thereby directly undermining programme impact. The pandemic is putting CSO relationships with donors and other CSOs under pressure. HIV/AIDS is also having an immense impact on the internal organisation of CSOs as staff themselves become both infected and affected. There is therefore a desperate need to build not just individual, but organisational resilience to the disease.

This paper highlights the vital role of capacity building providers in ensuring that organisational resilience to HIV/AIDS is brought onto the agenda of their clients. This is especially important because many CSOs may feel overwhelmed by the possible impacts of HIV/AIDS on their own organisation. Capacity builders need to be very aware of the issues and have the competencies to support clients in addressing HIV/AIDS mainstreaming in their external programmes and relationships as well as in their internal organisation. It will require HIV/AIDS specialists to develop OD skills as well as OD practitioners developing knowledge and skills in HIV/AIDS. HIV/AIDS will require capacity building practitioners to adapt both the content of their services and methods of delivery.

**INTRAC**
International NGO Training and Research Centre