Civil Society Capacity Building And the HIV/AIDS Pandemic:

A Development Capital Perspective and Strategies for NGOs[1]

Alan Fowler[2]

December 2004

[1] Paper originally prepared for a PSO Seminar, 19th November, the Hague.

[2] Alan Fowler is development analysts and adviser, an Honorary Professor at the Centre for Civil Society, University of KwaZulu-Natal and president of the International Society for Third Sector Research. With thanks for helpful comments from Roel Snelder of PSO and Sara Methven of Intrac. Responsibility for the paper rests solely with the author.

1. Introduction

It is not difficult to find quotations to support a view that HIV/AIDS represents a danger to the world as we know it. For example,

> "….HIV/AIDS is the first disease to be labelled a global security threat." (Hunter in Intrac 2004:1)

Depending where you live, HIV/AIDS is emerging or already exists as a human tragedy and economic problem that could become a catastrophe.[3] No society is immune from the presence of HIV/AIDS. Nevertheless, while HIV/AIDS infection has no boundaries of geography, culture, class or wealth, the negative prospects for development and developing countries are anticipated to be particularly severe.

> "The global HIV/AIDS pandemic, which now infects approximately 40 million people, is at pandemic status in sub-Saharan Africa and poses a serious threat in every other developing region." (UN-MP, 2004:63)

> "Development will become virtually impossible in an era of HIV/AIDS." (Barnett and Whiteside 2002, quoted in Intrac 2004:1)

The starting point of this paper is that the potential for HIV/AIDS to structurally undermine gains in human well being is very real. Improvements in life expectancy are being slowed or reversed. Reproductive age groups are shrinking, creating demographic distortions that increase burdens on the old, on the young and on public services. Growing claims and increasing dissatisfaction with failure of public services – themselves not immune from the pandemic - and shrinking voter roles are undermining democracy and stability. Countering this accumulating potential for disaster alongside so many other destabilising factors (Fowler, 2004) is vital for moral and practical reasons and civil society has a pivotal role to play.

The purpose of this paper is to provide a framework and approach that could be used to develop strategies and interventions that address capacity building features of civil society that result from the HIV/AIDS pandemic in a comprehensive way.

The analytic perspective starts, in Part 2., from the founding principles and driving assumptions of the aid system and its still guiding paradigm, namely that at its core aid for development it is about capital: transferring it, increasing it and making it more productive. Knowledge and skill building through technical assistance and volunteering are common examples of this paradigm in practice. Over forty years, the aid system has come to recognise the development significance of different types of capital. Understanding how HIV/AIDS is affecting each type of capital is the entry point for analysis. The subsequent issue is to determine where the development capabilities of civil society fit into this 'capital for growth' aid paradigm with its strong concentration on the Millennium Development Goals (MDGs). To help answer this question, Part 3 considers the major formations, functions and roles of civil society that require particular competencies.

These two sets of analysis are brought together in Part 4 to identify relationships between HIV/AIDS, development capital and civil society that call for attention and dedicated action. Part 5 reviews the international institutional landscape that is addressing HIV/AIDS while Part 6 provides observations and suggestions about priorities and policies that could inform strategic choices and practices.

[3] One reckoning is that HIV/AIDS is depressing GDP growth in Sub-Saharan Africa by 0.8 percent with the burden reaching 2.6 percent in countries with prevalence above 20 percent.

The purview is global. However, the concentration of HIV/AIDS in Africa and the significance of this region for many NGOs will slant attention towards this continent. While relying on relevant literature, much that follows is a personal view and interpretation.

2. Human Competencies and Development Capital

From inception, and still, 'capital' – its transfer, increase and productivity required for economic growth - has been the foundation of international development. However, over four development decades, the notion of what constitutes capital for development has expanded. Today, international development practice recognises the importance of seven types of capital. According to the UN Millennium Project, these are:

> *"Human capital*, including health, nutrition, education, and on-the-job skills, which together contribute to the productivity of an individual worker;
> *Business capital*, including factories, equipment, transport machinery, improved farm land, and the like, which constitute the capital base of private-sector production;
> *Infrastructure*, including roads, power grids, sea ports and airports, water pipes and waste treatment centers, which underpin the productivity of the private sector and contribute directly to human health and wellbeing;
> *Knowledge capital*, including the base of scientific knowledge and technological knowhow that underpins modern economic productivity;
> *Natural capital*, including the effective functioning of ecosystems, to ensure the high productivity of agriculture, public health and safety, and the stream of direct services in the form of renewable resources (fisheries, horticulture, fibers, and the like);
> *Social capital*, including the trust and understanding of the community, especially across ethnic, religious, and gender divisions, to enable a high-level of peaceful and efficient economic interactions;
> *Public institutional capital*, including the effective operation of public institutions based on the rule of law and the enforcement of commercial law."

Importantly, all of the forms of capital are required to support long-term economic growth. The processes of capital accumulation in an economy needs to ensure that all seven forms of capital are increasing in order for the economy to function well in the long run. Investments in these different types of capital come from household savings or from public investments drawn from government revenue, savings from abroad and other sources of income (foreign assistance, borrowing etc.)" (UN-MP, 2004:66)

Surprisingly, capital - as money, financial instruments, assets and investment - are not included in this list. Yet, improving a country's ability to attract both concessionary aid, for example from Challenge Funds, and commercial investment is precisely a goal of today's development approach. Finance will therefore be included in the analysis.

Further, the UN listing neglects the importance of political capital, understood as the level and quality of mandate enjoyed by the regime in power. Quality is formed by free and fair elections, transparent public decision-making, no corruption or political interference in judicial processes etc. All these features are part of the good governance agenda propagated by the aid system and increasingly a condition for accessing Challenge Funds.

Each type of capital is only developmental if people have the capabilities required for their use. A tractor is no good without a trained and responsible driver. Simple or sophisticated medical equipment is only developmental if the operator has the skills required for their use. A hoe or a plough require human agency to become active implements rather than passive assets. A social network is only developmental if the person has the inter-personal capabilities to draw on it. In other words, capital for development is intimately related to human competencies, not just as skills and knowledge, but also

as interests, relationships, values and motivations. As will be argued below, on an increasing scale, as an ultimately fatal disease, HIV/AIDS' draining away the human capacity to act is what gives its serious and multi-faceted anti-developmental impact.

The competencies required to make good the development potential of capital are spread across all institutions within a society. The exact divisions and locations of competencies and capacities vary between countries and their ideologies about ownership and divisions of labour. But, in today's neo-liberal economic and democratic development paradigm, there is a general pattern in terms of emphasis about what the picture s*hould* look like. If the common three sector institutional model of state (including political regime and public administration), market and civil society organisations are applied, distribution of competences that are believed to hold, create, sustain and increase capital most cost-effectively often looks as follows, where the number Xs indicates relative significance.

It is important to recognise that CSOs are not simply the adding up of all the citizens in a country. As individuals, citizens are to be found in state and market as well as CSOs. Their roles in these sectors still carry citizenship with them. The point is, that international aid is trying to configure societies in ways that allocate different types of capital to the most efficient users within different sectors of society.

The table is only illustrative as a way of stimulating thinking. It needs refinement in relation to specific countries and their policy frameworks. For example, privatisation and decentralisation are altering the degree to which (local) government, the market or civil society produce human capital by providing health and education services and how costs are shared. However, for our purposes the table allows a focus on the more critical areas of CSO capacities and what HIV/AIDS is doing to them. Important CSO capacities would be related to social and political capital and, for Africa, business capital because of the importance of small-scale production of agricultural (export) commodities.

Table 1. Development Capital and Distribution of Competencies

	State[4]	**Market**	**CSOs**
Human capital	XXX	X	XX
Business capital	XX	XXXX	**X(XX)**[5]
Infrastructure	XXXX	XX	X
Knowledge capital	XXXX	XXXX	XX[6]
Natural capital	XX	XX	X(X)
Social capital	XX	X	**XXXXX**
Public institutional capital	XXX	X	XXX
Political capital	XXXX	X	**XXXX**
Financial capital	XXX	XXXXX	XX

The question now is: what does civil society look like where these types of capacities are supposed to be found?

[4] The state includes all levels of government administration and delivery system.

[5] The issue of the distribution of capacities in relation to business and natural capital is tricky if – as in much of Africa - largely agrarian economies and subsistence agriculture are taken into account. This informal sector of users of natural resources and producers of primary commodities and are market-oriented but not part of normal business models.

[6] The score would be higher if Universities were included as CSOs. In this table they are allocated to the state and to the market.

3. Civil Society and Development Capital

There is no uncontested definition of civil society. For our purposes civil society will be understood as:

> a public domain of normative associational life created by citizens that is not part of a state or for-profit business.[7]

Configurations of civil society show significant diversity. Nevertheless, a simple typology allows a straightforward disaggregation that usually works in most settings for most CSOs. This typology recognises that citizens form associations to serve themselves or to serve others and that they may choose to be recognised by society through some form of registration, or remain informal by not seeking a legal status. For example, a study suggests that some fifty-two percent of CSOs in South Africa are informal. I'll argue later that in many settings, particularly in Africa, the capacity of informal CSOs is a significant feature of establishing and dealing with the HIV/AIDS landscape.

Obviously, there are cases where a member-serving CSO also serves a wider public good. For example, in Uganda as well as the population at large, TASO also serves its staff in terms of their HIV condition. The Ethiopian Economic Association serves the development of its members but, through advocacy and policy statements, the Association also tries to influence the public arena in ways that would affect everyone. This combination of advocacy beyond services for members is quite common. Similarly, faith based organisations (FBOs) serve their believers but can also provide support to people of other denominations. Social movements that mobilise membership behind a cause are also benefiting non-members who are in similar circumstances, for example, the landless or unemployed.

While recognising the existence of hybrids, the two features noted above allow disaggregation and illustration of CSO categories and types shown in Table. 2.

Table 2. Typology of CSOs

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

Generally speaking, formal CSOs have professionally trained employees, while informal associations do not operate with paid staff. To function, formal CSOs typically require money derived from other sources. Money is often not a necessity with informal CSOs and, where it is required, members are the source. The affects of HIV/AIDS make these differentiating factors significant for selecting capacity building interventions.

If this is a reasonable way of recognising the diversity of CSOs, the next question is what is it that they do in and for society? In other words, capacity building for what?

[7] The public sphere is understood as being outside of the family.

Civil society organisations provide three major functions. First, they offer mutually supportive social and economic relationships, acting as locations where people with shared affinities or needs come together. With overlays and multiple memberships, these roles help CSOs create a binding social fabric and assistance for economic advance, risk spreading and local 'management' of public goods and affairs. Second, they deliver social, economic and other public services that society values. This happens at a wide range of scales and levels of socio-political organisation.

Table 3. Functions performed by different types of CSOs

Beneficiary Focus	Informal	Formal
Self, Mutual or Member Serving	• Mutual social and economic support • Local management	• Protection and promotion of member interests • Member services • Advocacy • Participation and political engagement
Third-party serving	• Connecting and energising constituencies • Advocacy	• Public service delivery • Advocacy • Participation and political engagement

Third, CSOs provide mechanisms and vehicles that connect, aggregate and articulate citizen's diverse interests, enabling them to engage with each other as well as other actors, such as states, markets and political processes.[8] People's participation in development activities and in advocacy are typically mediated through CSOs. Crudely speaking, the dominant, but certainly not exclusive location of these functions in different types of CSOs is shown in Table 3. Each function calls for individual competencies and collective capacities. What is HIV/AIDS doing to both development capital and CSO capacities?

[8] The boundaries and interfaces between political systems and civil society are complicated and not well researched or understood.

4. HIV/AIDS, Development Capital and Civil Society

How is HIV/AIDS impacting on different forms of capital and CSO capacity in relation to the major areas of contribution identified in Part 3? Table 4 below provides a summary.

4.1 HIV/AIDS and Development Capital

Table 4, indicates the sort of influence HIV/AIDS is having on different types of development capital. Areas of CSO concentration (from Table 1.) are highlighted. As can be seen, all areas of development capital are feeling the impact of HIV/AIDS in a variety of ways. This is one reason why the anti-development effects of the pandemic are more far reaching than the greater numbers of deaths caused by other endemic diseases, such as malaria and tuberculosis.

Table 4. HIV/AIDS' Impact on Development Capital

Type of Capital	HIV/AIDS Impact
Human	Debilitates the human condition; alters demographic profile away from (re-) productive age group; reduces skill pool and person-power.
Business	**Decreases productive use of resources; reduces economic security.**
Infrastructure	Skews public infrastructure demands towards health and education services and increases their cost.
Knowledge	Erodes knowledge base at all levels and locations within society.
Natural	Can reduce natural resource demand and extraction.
Social	**Increase social stress and claims on family and community economics and coping systems; redistributes burdens towards children and the elderly.**
Public institutional	Weaken public delivery systems and government responsiveness across the board; foster stigmatisation and discrimination in public service access and challenges respect for human rights.
Political capital	**Reduce voter participation; feeds political dissatisfaction and instability.**
Monetary/ Financial	Reduction in domestic savings, economic returns and attractiveness for domestic and foreign investment.

Overall HIV/AIDS erodes most types of development capital and reduces the productive application of what remains. And, this is precisely why investment in HIV/AIDS prevention and cure generates far higher returns than investment in other areas that also have a negative influence on the human condition and the planet. A recent analytic exercise re-confirms the significant benefit of investing in reversing the HIV/AIDS pandemic.

> "The organising idea was that resources are scarce and difficult choices among good ideas therefore have to be made. How should a limited amount of new money for development initiatives, say an extra $50 billion, be spent? Would it be possible to reach agreement on what should be done first? ……. The top of this list was not the problem. Ranked first was a package of measures aimed at controlling HIV/AIDS. Next came a set of interventions aimed at fighting malnutrition."[9]

[9] The Economist, 15th April, 2004.

The pandemic also eats away at different types of capital in different ways at different rates, often with long 'rebuilding' time scales. For example, when retroviral and other treatments are not available, the transition from infection to morbidity to mortality may only be a few years. Yet, depending on mortality rates across total competencies, sustaining or rebuilding a societies aggregate level of knowledge, networks, skills, etc. may take decades. In other words, HIV/AIDS is both a "short-term emergency and a long term crisis" (Marais, 2004:3). Time related dimensions of HIV/AIDS have important consequences for strategies, remedies and counter-measures addressed later.

If the human and development case for fighting HIV/AIDS is clear-cut and cannot be ignored, where does civil society fit in?

4.2 HIV/AIDS and Civil Society Capacities for Development

Bringing together the preceding tables allows a focus on areas of CSO capacity that are likely to feel the impact of HIV/AIDS and analyse the ways that this might happen. It is beyond the purpose of this paper to analyse all possible combinations of CSO types and specific functions. Developing a HIV/AIDS capacity building strategy would need to do this, starting by filling in country-specific information in relation to Tables 1 to 3.

At a general level, available literature suggests the following areas of CSO capacity building, where hybrid organisations would face a larger and more complex combination of challenges.

Informal member-serving CSOs

Typically labelled as community based organisations (CBOs) in both rural and urban areas, though operating within all socio-economic classes, these institutions form the bedrock of social safety nets for the poor. They form an element of peoples' survival strategies and are typically part of the beneficiary constituency of formal third-party serving CSOs, like development NGOs.

Of the many roles CBOs perform, three are vital. But, in terms of community responses to HIV/AIDS, each are threatened. CBOs provide:

- A system for collaborating in economic production and distribution of assets that shares risk and help with survival.
- Non-material, emotional support to the bereaved.
- Material support mechanisms, particularly in allocating food and clothing, for child/orphan headed households and for the elderly who become carers of orphans.

A recent, ongoing study shows that CBO capacity in terms of mutual support relies on three principles: altruism, reciprocity and trust and cooperation for shared advance (Wilkinson-Maposa and Fowler, 2004). These principles are important because, for example, data from Tanzania (cited in Marais 2004:3) indicate that the where reciprocity fails and altruism is simply not an economic option, poorer household slip into deeper debt, with women disproportionately burdened.

A study by Desmond et al (2000) shows how HIV/AIDS is undermining the capability of CBOs to carry out the above tasks. This is occurring because the pandemic is decreasing household incomes, increasing costs (on health care), eroding the productive capacity provided by adults and changing expenditure patterns. Consequently, as Marais (2004) notes, there is a serious danger of over-estimating the extent to which "community or home-based care" offers a viable HIV/AIDS coping strategy.

A further problem for CBOs to respond to HIV/AIDS burdens is that the age group most likely to contract the disease are likely to be better educated and hence more able to provide leadership to manage local affairs, bring in information from outside, negotiate external support, etc.

The viability of CBO-related community-based care therefore rests on adequate short-term responses in terms of strengthening the economic foundations of communities themselves. Longer tern strategies must address the HIV/AIDS related loss of knowledge that is required for productivity but, as importantly, for life. Here recent study indicates that interventions will be more effective if they focus on life-skills development rather than formal education per se. Specifically, to invest in competencies allied to functional literacy for orphans and remedial literacy programmes for others (Economist, 28th August 2004). Evidence also suggests that there are greater returns for basic life-skill development for women than for men.

This perspective differs slightly for urban areas, where 'community' is much more fluid and resembles networks. Here community is less kin-based and is just as likely to rely on friendship and sharing similarly harsh circumstances and vulnerabilities that create stable and trusted bonding. Money, information and advice play a larger role in patterns of mutual support towards coping with HIV/AIDS.

Informal third-party serving CSOs

Informal organisations that serve others are not very common. Their principle contribution and required capacity is often two-fold. First is an ability to actively network with and inform constituencies about issues that are significant to them. Second is to link constituencies to each other, i.e., horizontal connectivity, in ways that that can project their interests or concerns into the public arena to benefit everyone with similar characteristics. The Network of Zambian People Living with AIDS is one example of this role as is the Landless People's Movement that agitates for land rights everywhere. The general point is that these types of CSO break down isolation, energise and stimulate engagement and build constituencies that politics and policy have to take into account. This capability is strongly dependent on:

- access to information;
- capacity to translate and articulate information towards constituencies, the general public and policy makers;
- capacity to network in ways that energise; and
- ability to engage in public policy arenas.

The impact of HIV/AIDS is typically felt through the individuals who typically drive and lead these types of person-based initiatives. In other words, capacity relates to the frailty of individual leaders who live – and die – for a cause.

A capacity building strategy, therefore, is to assist by providing platforms and forums where such voices and causes can be 'broadcast' to a wide audience.

Careful consideration should be given to the merits of otherwise of promoting formalisation of these entities. This move could be de-energising and create non-sustainable, aid dependent organisations that loose flexibility and a cutting edge.

Formal member-serving CSOs

Variations if CSOs to be found in this category are shown in Table 2. It is beyond the scope of this paper to deal with each type of CSOs within this category. However, it is possible to review common a common task of all such organisations, which is to serve members and their interests in line with the expectations associated with being a member. In this sense the benefits are private, not public.

What benefits and services mean in practice obviously differs, for example, between professional associations, trade unions and faith based organisations (FBOs). The former are predominantly urban and skill/knowledge oriented with wage-based membership. Faith-based organisations do not exhibit an urban bias to the same degree and membership is not tied to livelihood. In fact, in the case of FBOs, arguments are being made that credit them with features – such as extensive (rural) networks and infrastructures, high levels of people's trust and voluntary commitment and a natural involvement in issues of belief and family life with counselling and behavioural advice - that may be particularly relevant for helping people cope with HIV/AIDS (Liebowitz, 2002).

In terms of HIV/AIDS impact, the following are likely to arise:

- Increasing demands of members as legitimate claimants on CSO services that may run beyond what is normally expected.
- Decreasing resources due to shrinking membership and non-payment caused by members' increasing health care costs.
- Attrition of paid staff, precipitating organisational stress, demoralisation, cost escalation and reduced effectiveness.
- Pressure to lobby and advocate in behalf of members towards state and businesses in terms of HIV/AIDS effects such as medical insurance and benefits, burial support, pension payments for dependents.

A number of responses are possible to deal with the organisational capacity-eroding affects of HIV/AIDS on the one hand and increasing and expanding member demands on the other. In terms of organisational capacity, much in the INTRAC study is relevant to this type of CSO and is discussed in the next section.

In terms of capacity building towards members, HIV/AIDS would been to be factored into existing information and communication services. This requires at least access to relevant information and an in-house capacity to process this into member-outreach and communication. This would probably include advice on where to go for advice, counselling and other support. In addition, information gathered about HIV/AIDS would need to be analysed in relation to the particular features of the membership. For example, Transport Unions would be attentive to the distinct risk profile of their members. In South Africa, this has lead to condom distribution and HIV/AIDS awareness initiatives at places, like the town of Colesberg, where long-distance lorries are parked over night. This type of initiative requires an in-house capacity that tracks how HIV/AIDS is playing itself out within the membership allied to the connections required to evolve services and relationships accordingly. The general point is to ensure that member-oriented capabilities are not just protected, but enhanced to deal with their exposure to HIV/AIDS.

Formal, third-party serving CSOs

The INTRAC study pays detailed attention to how HIV/AIDS can impact on this type of CSO. Many of its findings are relevant to formal member-serving CSOs as well. This work will not be repeated, but briefly summarised. The purpose here is to complement this work with a view of ways in which a multi-organisational or a sector-oriented approach may be relevant.

The INTRAC study brings an organisation-centric view HIV/AIDS in relation to CSOs as intermediary organisations, typically referred to as NGOs. The findings suggest the following features:

- Increase costs due to HIV/AIDS infection and expressions
- Delayed response to HIV/AIDS as an organisational issue requiring action
- Moral issues in establishing HIV/AIDS polices
- Absenteeism, demoralisation and 'organisational depression'
- Distraction of staff due to HIV/AIDS in family and personal environment
- Reduced programme effectiveness due to staff attrition and HIV/AIDS impact on constituencies/CBOs.
- Self-absorption at the costs of collaborative initiatives.
- Pressure to 'do something developmentally' about HIV/AIDS even if this has only an indirect bearing on their work and expertise.

In terms of remedies, again the INTRAC study offers a number of ideas about good practices and learning. They include: staff awareness programmes; HR policies; long-term human resource planning; revising budgets and including HIV/AIDS related costs as elements in funding proposals; restructuring to give HIV/AIDS an acknowledged capacity and 'face' within the organisation, etc. These remedies point in the direction of an organisational development (OD) rather than piecemeal approach to the capacity challenges that HIV/AIDS brings. But this, in turn, means developing the capacities of OD service providers to fully understand the way that HIV/AIDS plays out organisationally as well as learning lessons to date in how responses need to be identified and implemented.

The impact of HIV/AIDS on individual organisations creates specific and common problems. Existing evidence suggests that individual organisations are putting little effort into finding mutually supportive solutions to shared problems. Yet, difficult climates for fundraising make 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 (sub-)sector wide solutions. For example, CSOs could collaborate to establishing a joint non-profit organisation 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. Obviously country conditions will determine the sense and potential or doing so. Organising accelerated, tailor-made training programmes to make good erosion of sectoral knowledge and skills is another cost-reducing option.

Through the aegis of CSO umbrella bodies, or other mechanisms, this type of CSO could usefully explore establishing a national forum to specifically focus on identifying areas where collaborative effort could help address shared organisational problems related to HIV/AIDS. Donor support for such an initiative could reap significant benefits in terms of reducing the costs of dealing with the pandemic.

The following table summarises the discussion and suggestions made so far.

Table 5. CSO Capacity Building Requirements and Possible Responses

CSO Type		CSO Functions	HIV/AIDS Related Capacity Building – Possible Responses
Informal	**Member-Serving**	• Mutual social and economic support • Local management	• Short-term economic investment at community level, e.g., micro-finance. • Productivity-enhancing (rural) technologies. • CBO self-development management initiatives and networking. • Long-term basic skill development and competencies around functional literacy, especially for (female) orphans and child-headed households.
	Third-Party Serving	• Connecting and energising constituencies • Advocacy	• Increase platforms, forums and channels for 'broadcast' and outreach. • Investment in HIV/AIDS information access and communication. • ART provision for key actors/energisers.
Formal	**Member-Serving**	• Mutual social and economic support • Local management • Service delivery • Advocacy • Participation and political engagement	• HIV/AIDS information dissemination to members. • Member referral, advice, behavioural counselling and support services. • Human resource HIV/AIDS policies and support protocols. • Internal HIV/AIDS compensatory organisational development programmes. • Short and medium term 'gap filling' secondments. • Long-term expanded training initiatives. • Member-focused HIV/AIDS policy-related analysis for advocacy and negotiation with state and market actors.
	Third-Party Serving	• Service delivery • Advocacy • Participation and political engagement	• Human resource HIV/AIDS policies and support protocols. • Internal compensatory organisational development programmes. • Internal HIV/AIDS compensatory organisational development programmes. • Short and medium term 'gap filling' secondments. • Accelerated and long-term training initiatives. • Beneficiary-focused HIV/AIDS policy-related advocacy with state and market. • Non-profit organisation (sub-)sector wide HIV/AIDS forum and development of common support services. • Advocacy on HIV/AIDS-related issues tailored to specific groups.

5. The International Institutional Framework for HIV/AIDS

The breadth and depth of HIV/AIDS as a human and development disease disaster makes clear that no single agency, institution or initiative can ever hope to deal with its consequences alone. While not exhaustive or detailed, this section offers pointers for PSO members in terms of the wider institutional framework that is addressing HIV/AIDS.

A number of specialised official institutions and/or programmes are dedicated to tackling the pandemic. Examples are:

- President Bush's Emergency Plan for AIDS Relief, managed by USAID (PEPFAR)
- Global Fund for AIDS, Tuberculosis and Malaria (GFATM)
- UNAIDS
- World Health Organisation's '3 by 5' Initiative,
- Millennium Development Goal Number 6, 'managed' by UNDP

Not all programmes are global in scope. Some, like the Bush Emergency Plan, are directed at specific countries, often in sub-Saharan Africa.

From the perspective of PSO members, two issues are important. First, is the relationship between programmes. Second, is the potential and value of engagement with them. Both factors will help determine possible points of entry and an assessment of the capacities required.

5.1 Donor Co-ordination, Coherence and Consistency

In terms of coherence of effort, to avoid fragmentation and duplication, UNAIDS is promoting The Three Ones Principles. That is:

- **One** HIV/AIDS Action Framework providing the basis for co-ordinating the work of all partners.
- **One** national AIDS Co-ordinating Authority, with a broad-based multi-sectoral mandate.
- **One** agreed country-level Monitoring and evaluation system.

There is some indication that UN-related programmes and some bilateral agencies will buy into this idea. However, given the way USAID programmes often work, there is a high likelihood that this will not be very closely tied to the UNAIDS approach. For example, the US delegation tried to block the Global Fund's third round allocation of finance to projects. Reasons suggested are the US penchant for the use of branded, rather than generic, drugs and abstinence as a preferred preventive strategy.[10]

However another potential overarching framework for HIV/AIDS programmes is the soon to be launched Millennium Development Plan with mobilisation around Goal 6. Here the proposal is to establish country-level MDG goal-oriented planning around Poverty Reduction Strategy (PRS) processes (UN-MP, 2004:217-225).

> "The MDG-based PRS needs to be developed through an *open consultative process* which involves all of the key stakeholders, domestic and foreign. Each country should convene an MDG Planning Group *chaired by the national government*, but also including bilateral and multilateral donors, UN specialized agencies, provincial and local authorities, and domestic civil society leaders, including women's organizations who are traditionally under represented. The

[10] Financial Times, 17 November, p. 9.

> MDG Planning Group can then organize a series of thematic working groups, each with broad participation, to develop the scale-up strategies within various thematic areas like health, rural infrastructure, agricultural productivity, and so on. Each of these thematic groups should include gender expertise." (UN-MP, 2004:220)

In this set up, HIV/AIDS would probably be the responsibility of a thematic (sub) working group where civil society presence and interests could be exerted.

It remains to be seen which framework for donor and country co-ordination will be adopted. Depending on UN decision-making next year parallel operation with different preferences in different countries is a possibility.

5.2 Civil Society Engagement

All official HIV/AIDS programmes have an acknowledged role for civil society organisations. They are specified any of three levels, international national and local which, in theory, should provide for both policy-level and operational engagement. For example, The Global Programme has instituted a biennial Partnership Forum operating internationally. This is complemented by Country Coordinating Mechanisms (CMS). The GP-PF has representatives from government, donors and project implementing entities, such as CSOs. However, complaint about neglect or inadequate CSO presence on CCMs suggests that theory and practice do not always match. Further, government acceptance of CSO involvement in policy is more difficult than accepting involvement in terms of contracting for service provisions, increasingly on a competitive basis.

Similarly, the quote above foresees a place for CSOs in MDG planning and implementation. Again, it remains to be seen what happens in practice. Previous PRSP processes give a very mixed picture in terms of meaningful CSO participation. In addition, despite the stress on CSO significance, the UN conference on MDGs+5 planned for next year intends to limit CSO presentations to one only.

5.3 Positioning CSO Efforts

Northern CSO and their partners in developing countries need to be clear about how to locate their efforts in relationship to others within civil society – to also avoid duplication and fragmentations - and towards other sectors and their HIV/AIDS programmes and initiatives. In considering options, a couple of factors can be taken into account.

First is the desired level(s) of engagement. Getting involved with international policy debate, national policy and planning and operational delivery call for different competencies and amounts of effort. The potential for influence will be an important assessment in terms of the cost-benefit of choices. However, with so many CSO specialising in HIV/AIDS, it may make more sense for CSOs concerned about the pandemic in relation to their areas of expertise to team up to gain leverage rather than invest in creating their own capabilities in-house.

The broader point is for CSOs, like PSO members, to determine the merits of establishing a thematic group around HIV/AIDS. The task for such a groups could be to:

- Investigate in detail official HIV/AIDS programmes and facilities for CSO engagement;
- Assess potentials for CSO to gain influence or leverage on policies and practices;
- Formulate proposals about where individual and collective energy can be directed in terms of promoting capacity building agendas.

Irrespective of how positioning in the international framework is contemplated, it is important to bear in mind that a major capacity limitation for CSO engagement can lie with the other parties – governments and donors. Put another way, CSOs need to assess the capacity of others to deal with them properly as they need to do in terms of their capabilities to exert influence.

6. Concluding Perspectives for NGOs – 5 complementarities and 1 bias

HIV/AIDS is a comprehensive assault on the many dimensions of capacity that contribute to human well being. Correspondingly, in thinking about how to respond a starting point would be to look at strategies in a comprehensive way. One approach would be to consider five types of complementarity in dealing with capacity building in the era of HIV/AIDS. This concluding section suggests five complementarities worth considering alongside one essential bias.

6.1 Complementarity 1: Short-long Term

In impacting on CSO capacity, HIV/AIDS has a Janus face. On the one hand is short-term stress on emotions, livelihoods and coping capacities that require urgent responses. But simultaneously, there are deep structural losses to society that call for a generational perspective and time scale for investment. Financial support available to many CSOs is such that long-term commitments are very difficult to make. But this does not preclude strategies that take a long-term view in an incremental and responsive way alongside more immediate actions. Linking short and long term in thinking and action would be worthwhile if the symptomatic is not to outweigh structural responses to building CSO capacity.

6.2 Complementarity 2: Intermediary CSOs and Constituency-based CSOs

A second complementarity that can be considered is between the capacity building requirements of third-party serving CSOs and the parallel but different capacity building needs of constituencies they work with. Predominantly but not of exclusively, this means grassroots organisations poor people. One reason for this complementarity is efficiency and effectiveness of aid use. Little will be gained in terms of sustainable development and poverty reduction if protecting and rebuilding the capacity of intermediary CSOs is not matched by similar efforts with communities. While a common feature of micro-development programming this linking could be reinforced and become business as usual.

6.3 Complementarity 3: Organisational and (sub)Sector Wide

Arguments have been made in favour of matching the effort put into capacity building of individual CSOs with attention to sector-wide initiatives. Reasons for doing so are both economic and ‘political’ in a non-party sense. The economic justification for sector investment is one of cost-effectively reaching a scale of capacity building services that reflect the size of common HIV/AIDS related problems CSOs face. The political feature is to increase the visibility and weight of argument towards actors like governments, donors and corporations in favour of direct or indirect support to CSO capacity building efforts.

6.4 Complementarity 4: You and your Partners

The search for complementarity between northern NGO’s / donors (such as PSO members) and counterparts overseas is not new and remains essential. However, what HIV/AIDS may test, is the extent to which deep lying moral and ethical views organisationally coincide. The INTRAC study suggests that HIV/AIDS invites debate with partners around culturally sensitive areas and notions of how responsibilities can or should be carried. In other words, are their limits to complementarity that have to be more consciously explored and (re)negotiated?

6.5 Complementarity 5: Levels of engagement

There is probably little or no justification for CSOs to go it alone in terms of HIV/AIDS. Consequently, it is important to work out where engagement with others can be the most productive. However, the complexity of HIV/AIDS' impact on development capital and CSO capacity suggests that engagement with others at different levels is called for and be made complementary.

6.6 The Bias: HIV/AIDS and Gender

> "We cannot have women carrying hospital beds on their heads. Women and girls in southern African are overwhelmed by the burden of looking after these people. These women and girls have no medical training.
>
> HIV/AIDS infects and affects women more than men. It is women who care for the sick and shoulder the burden. It is rare that you find a grandfather looking after the sick. If people get sick in the city they end up with grandmothers in the village, …
>
> The situation is further compounded by the fact that in southern Africa, women and girls are disproportionately affected by the pandemic. The World Health Organisation/UNAIDS World Epidemic Update shows that 56 percent of those infected in the region are women, and that young women and girls aged between 15-24 years are 2.5 times more likely to be infected than their male peers." (IPS, 2004).

The above quotes are the forefront of an ActionAid campaign in South Africa to coincide with National AIDS Day on 1st December, 2004. They indicate why HIV/AIDS strategies have to contain one bias, towards women and girls.

References

Desmond, C., Michael, K. and Gow, J., 2000, "The Hidden Battle: HIV/AIDS in the Family and Community", Health Economics and HIV/AIDS Research Division (HEARD), University of KwaZulu-Natal, Durban.

Economist, 2004, "The cost of AIDS: An imprecise catastrophe", May 2nd, p. 82.

Economist, 2004, "Counting heads: A breakthrough in measuring the knowledge economy", August 24, p. 66.

Edwards, M, 2004, *Civil Society*, Polity Press, London.

Fowler, A., 2005, "Aid Architecture Reflections on NGO Futures and the emergence of Counter Terrorism", Occasional Paper, No. 45, International NGO Training and Research Centre, Oxford, forthcoming.

Fowler, A, 2003, "Civil Society and International Development: Towards a Complex Systems Perspective and Practice", in Pratt, B. (ed.), *Changing Expectations?*, pp. 183-196, International NGO Training and Research Centre, Oxford.

Intrac, 2004, "Rewriting the Rules? Capacity Building in the Times of HIV/AIDS", International NGO Training and Research Centre, Oxford, mimeo.

IPS, 2004, "HIV/AIDS Burden on Women Grows", Other News, Independent Publishing Service, othernet@ips.org 12th November, 2004.Liebowitz, J., 2002, "The Impact of Faith-Based Organizations on AIDS Prevention in Africa, Health and HIV/AIDS Research Division (HEARD), University of KwaZulu-Natal, Durban.

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 KwaZulu-Natal, Durban.

Marais, H., 2004, "The quicksand of quick fixes: the vexing temptation to make AIDS Manageable", Centre for Civil Society, University of KwaZulu-Natal, (www.ukzn.ac.za/ccs> (in the Zone).

Nelufule, M. 2004, "AIDS and Democracy: What Do We Know*?* A Literature Review Update", Health Economics and HIV/AIDS Research Division (HEARD), University of KwaZulu-Natal, Durban.

NORAD, 2004, "Human Resources for Health and the AIDS crisis", Theme Group HIV-Health, Ministry of Foreign Affairs, Oslo, mimeo, October.

Swilling, M. and Russell, B., 2002, *The Size and Scope of the Non-profit Sector in South Africa*, Centre for Civil Society, University of Natal.

UN-MP, 2004, A Global Plan To Achieve The Millennium Development Goals, The UN Millennium Project, New York, September. www.unmillenniumproject.org

Wilkinson-Maposa, S. and Fowler, A., 2004, "Promoting Community Philanthropy by Understanding 'Philanthropy of Community' in four Southern African Countries", paper prepared for Community Foundations: Symposium on a Global Movement, Berlin, 2-5 December.

WVI, 2004, HIV/AIDS- where is hope?", Global Future, Second Quarter, World Vision International, Monrovia, CA.