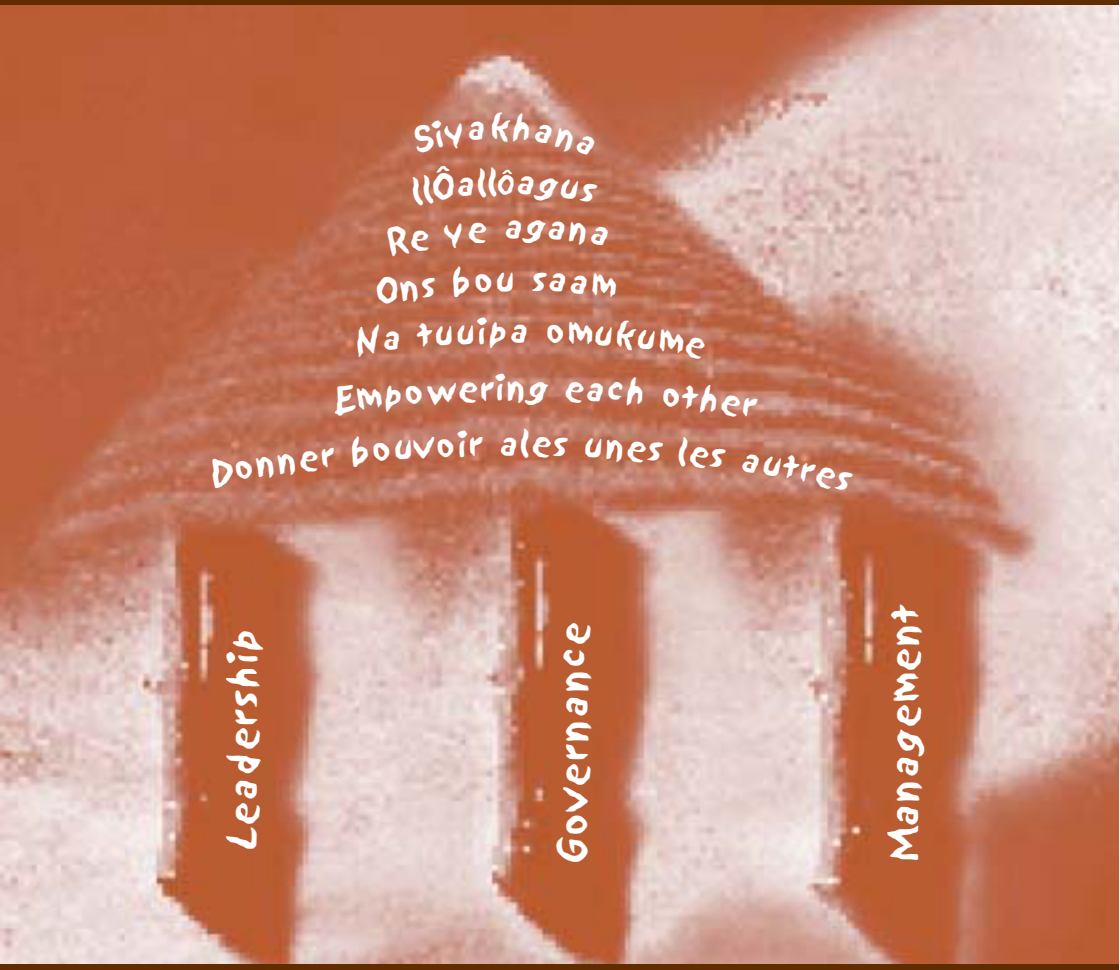
Secure The future™ Grantees Conference: Capacity Building for Effective and Sustainable Programming in HIV/AIDS



Conference Report November **2002**

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Capacity building towards effective and sustainable HIV/AIDS programming

By Phangisile Mtshali
Director: BMSF; Secure the Future COEF

The theme for the 2002 Grantees conference was "Capacity building towards effective and sustainable HIV/AIDS programming". This is in line with Secure the Future's objective to help facilitate the development of innovative, cost-effective and replicable HIV/AIDS care, support and capacity-building interventions by sub-Saharan service providers.

This theme was chosen because of the need to strengthen management, governance and leadership skills to improve on programme planning, management and delivery and measurement.

The topic provided opportunities for building skills and targeting discussion on capacity needs within Secure the Future's focus areas. Participants also shared experience from Swaziland, Botswana and Namibia, where in-country capacity-building grants provided valuable lessons and challenges

Who was there?

Represented at the conference were:

- Secure the Future grant recipients
- SACBC/CMMB grant recipients
- Secure the Future TAC members
- Funders - Gold Fields, Anglo Gold,
- Development agencies - NDA
- Government representatives
- UNAIDS
- Network of AIDS Service Organisations
- Organisations of people living with HIV/AIDS
- Representatives of traditional healer organisations
- Members of the press from the five countries

This was not to be a talkshop hence inclusions of four hour skills building sessions on the following:

1: Project and finance management
Robert Mbugua, PWC & Nkululeko Somhlahlo, NDA
This dealt with managing projects and finance to successfully execute projects by CBOs and NGOs. The session also equipped delegates with skills in proper project costings and procurement procedures.

2: Monitoring, evaluation and research in HIV/AIDS community-based programmes
Julian Moodley, Manto Management
Monitoring and Evaluation is critical where there is a demand for perfomance and transparency in the use of funding programmes. Planning was emphasised.

3: The science of HIV/AIDS and community-based treatment/Understanding the science of HIV treatment
Dr William Wester and Dr Mark Ottenweller
This session looked at the facts and myths of HIV/AIDS and the suggested treatment solutions available to PLWHAS. Lessons were drawn from Hope Worldwide case study based at Chris Hani/Baragwanath Hospital and Botswana's MASA ARV Programme.

4: Organisational development and communication
Sifiso Hadebe, Buhlebuyeza and Viccy Baker, STWS
The session exposed delegates to organisational development concepts, the importance of corporate governance as well as perfomance management systems. It also looked at communication and documentation to build relationships between the organisation and its important stakeholders.

There were also enlightening poster presentations by SOHACA, INTERFUND, Stellenbosch AIDS Action, SOWETO Hospice, Save The Children and SRHI.

Thanks to all who took time to be there to share their experiences. Thank you to BMS Company senior executives, BMS Foundation president and Ministries of Health from the five partner countries for their guidance and support. To my colleagues – Beryl Canham, Archie Smuts, Fatima Rahiman, Lesego Ramatsui, Sebastian Wanless, Colleen Richards and Mike Ramafoko – your hard work made this conference a success. We also thank our service providers MQQR, STWS, Media House Consultancy and The Travel Link. To CMMB and SACBC, thank you for being an active partner. Thanks to Dr Simphiwe Mngadi for preparing our presenters, facilitators and chairpeople.

Integrating HIV/AIDS in Development Planning

This gathering comes after an important announcement from Statistics South Africa which reported that HIV/AIDS is the main cause of death among females between the ages of 15 and 39. This can be easily extrapolated to the entire SADC region.

Both Stats SA and the Medical Research Council agreed that the number of HIV deaths is increasing. The five leading causes of death among South Africans are unnatural, ill-defined causes, TB, HIV and influenza or pneumonia. Famine and hunger have exacerbated this situation. The report also highlights that a massive social policy response is needed to integrate HIV/AIDS in development planning.

There are three critical elements that delegates should leave with or have at the end of this event. These elements are:

- highlight key issues around HIV/AIDS to be considered for integration in development planning
- conference to note points to be discussed and debated for consensus and how to take these forward
- the outcome to become a social contract between all the partners to address needs out there in a complementary way and not work in silos

We need to merge different perspectives and not only agree on best practice models but also manage auxiliary factors such as the politics around the issue. We have to agree on better methods, share experiences throughout the region and integrate initiatives to deliver more effectively and more efficiently.

However, while doing so, we should be mindful of the realities of ordinary people out there who are less interested in our different approaches and strategies but need help, support and delivery now. This puts a lot of emphasis on action and integrated response to HIV/AIDS as opposed to singular efforts and fragmented interventions. We need to transcend the debate a bit further than a clinical/treatment approach to wider socio-economic realities of HIV/AIDS in society.

There should be efforts to place HIV/AIDS at the centre of the regional and national planning, policy development and budgets. It requires mobilisation of a broad range of social forces to take advantage of resources to optimize the fight against the spread of this disease. Government has increased spending on HIV/AIDS by R3.3 billion over the next three years. This signifies political will and the conditions for this funding is to promote a holistic approach to bring the pandemic under control.

The concept of integration is complex and needs to be clearly defined at all levels. Integration does not only imply the rationalisation of multi-service providers but also integrating vertical programmes into comprehensive health care that do not reduce intervention to HIV/AIDS to the exclusion of other diseases.

Despite a comprehensive national HIV/AIDS/STD Strategic Plan for South Africa, HIV prevalence has continued to increase. This indicates inadequate implementation and conceptual confusion about different levels of entry in execution of the Strategic Plan.

The Human Rights approach was explicitly endorsed as a guiding principle, the life skills education programme has been rolled out and targets are met to a certain extent. Condom availability has improved but their use is less ideal. The importance of the STIs as a key HIV prevention strategy has not been fully grasped while the success of implementing VCT has varied greatly.

South Africa has created one of the most progressive and far-sighted policy and legislative environment including identification of very important pilot sites for further study. The laws and policies have not been adequately implemented and not impacted significantly on the ground.

Factors responsible for this include: poverty and under-development, restructuring in the public sector to decentralise health to district level, high staff turnover, lack of effective leadership and failure to mainstream HIV activities at all levels of society.

But the problem of leadership has been partially counter-balanced by the re-emergence of a vibrant health activism and social action to combat the pandemic by civil society movement.

The critical link and practical implementation of this integration has to take place at the grassroots, in communities where people living with HIV/AIDS are found. It will be meaningless if we put emphasis on home based care while affected people are isolated and frowned upon or they have no decent home to go to. Similarly, effects of treatment will be more visible if administered in tandem with a good nutritional programme.

The voluntary counseling and testing will materialise under conditions of respect and observance of Human Rights.

Strengthened extended families will give concrete meaning to care and support for children orphaned by AIDS – or any other illness for that matter.

The challenges posed by the HIV/AIDS pandemic are developmental – both in nature and in character. A comprehensive social security plan will have to guide this process to provide transition from recipients of grants or dependency syndrome, to a more developmental perspective that mainstreams all these elements.

In a number of ways, we have found grant-making organisations not talking to each other about the programmes they support. There is too much fragmentation and duplication. Programmes are left unsupervised and we are very weak on monitoring and evaluation.

The legislative and regulatory framework has presented us with even greater challenge in the restructuring of health delivery services to local government. This conference has to take a view to support local government processes in the administration of the health services through the process of the integrated development planning.

The integration of HIV/AIDS in the development planning requires a different set of interventions by all stakeholders. Targeted funding by any grant making organisation or institutions should ensure that areas that are supported get complementary support from others as well.

The SA Government has set macro health environment and it is up to all the stakeholders to find a niche at the district level. Conference will have to answer to how priorities identified with the Millennium Declaration, WSSD, Nepad and IDP get necessary support to deliver on those projects.

The trajectory requires extraordinary measures to create an environment that will integrate infrastructure development, linking it to addressing hygiene, sanitation and water and to support food security in the struggle to eradicate poverty.

The nodal points identified by the ISRDP and URP in the South African context should provide a learning experience in preparation for national rollout beyond poverty pockets as outlined in both plans.

It is only through a culture of human rights that you will create an opportunity which makes people go for voluntary testing and counseling without fear of discrimination and stigmatization.

For those who are already ill, we need to ensure that they have shelter to receive care, love and support in a home-based environment.

Chairperson: KT Masetlhe

HIV/AIDS – a dynamic enemy that calls for a state of war strategies and programmes.

Presenter By Dan Odallo, Program Development Adviser, UNAIDS Inter-country Team for Eastern and Southern Africa.

In 1983 the virus that caused AIDS was discovered by scientists in France and the routes of transmission were confirmed. The virus eventually became known as the human immunodeficiency virus (HIV). In the twenty odd years that HIV has been with us, it has moved from an infection of the privileged and sexual misfits in the West to a major catastrophe in Africa.

Over two-thirds of all the people living with HIV in the world (nearly 29 million) live in sub-Saharan Africa, accounting for 83% of the world's AIDS deaths. An even higher proportion of the children living with HIV in the world are in Africa, an estimated 87%.

There are a number of reasons for this, principal of which is the fact that approaches to tackle HIV/AIDS have tended to be routine and not based at all on the realities on the ground. To turn the pandemic around there must be a huge quantum leap in approaches and the design of programs.

First it must be recognized that HIV/AIDS is at the early stages of development and therefore only long-term vision will provide lasting solutions. Second is to ensure full community participation focusing on youth. Third, the fight to remove stigma and discrimination and ensuring access to comprehensive care and treatment for people affected and living with AIDS. Fourth is the recognition that there is an inextricable link between poverty, political disorder and strife, gender violence and HIV. So what impetus is necessary? These can be summarized as follows: equity-at all levels of the response, increased funding (and resource mobilization) that will facilitate going to scale, greater cross-border collaboration, human rights, generating accountability and transparency and intensification of biomedical research.

"From Pilot to Scale – The Bambisanani Model"

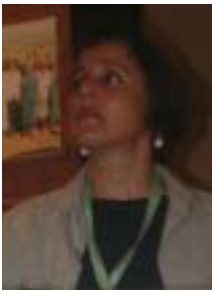
Presenter: Irna Senekal UPE/Health System's Trust, South Africa

Bambisanani is an initiative offering support to families and communities affected by HIV/AIDS in the Umzimkulu, Bizana and Lusikisiki sub-districts of the Alfred Nzo and OR Tambo Municipalities in the Eastern Cape Province. Senekal, Radebe and Mini found in a study commissioned by the EQUITY Project into the role of traditional leaders in the Bambisanani initiative that the process of establishing a working project is a mutual creation by Bambisanani and its community partners.

Roles played by project partners change as the pilot moves through its own life cycle from concept development, creating implementation mechanisms, to the stage where monitoring and evaluation become the defining focus.

The roles played by the project partners have three related sets of outcomes: increased will; improved match between project goals and actual needs; increased capacity to deliver to evolving needs. Roles provide ways in which the key activities within each set of outcomes that brings the project to life, is actualised. Bambisanani has not consciously articulated the roles played by project partners. Roles that fit the context and take the project forward have emerged through tactical responsiveness to the environment and the way staff continued to use their evolving learning.

As Bambisanani moves into the next phase of its development, describing roles played by all project partners for each element of the project, and ensuring that new staff assimilate these roles, will assist the process of scaling up.



Monitoring and Evaluation as a tool in the fight against HIV/AIDS

Presenter: *Juliann Moodley, Manto Management, South Africa*

Evaluating HIV/AIDS prevention and care programmes is a never-ending challenge, but recognising its importance in improving current interventions may help to enhance the success of future initiatives.

The monitoring and evaluation of HIV/AIDS prevention and care programmes is best captured by a description provided by Michael Quinn Patton: "The term monitoring and evaluation is broadly used to include any effort to increase human effectiveness through systematic data-based inquiry. When one examines and judges accomplishments and effectiveness, one is engaged in evaluations. When this examination of effectiveness is conducted systematically over a period of time, one is engaged in monitoring. The purpose of both as a tool is to inform action, enhance decision-making and apply knowledge to solve human and societal problems"

Until the mid-1990s, most monitoring and evaluation has been done in a relatively piecemeal fashion. A surveillance system for HIV is often in place but not functioning well, a few behavioural studies may have been done here and there, though not necessarily using the same sampling methodologies or indicators. Very few countries or projects are able to track changes in behaviour, and they may never be able to attribute such changes to interventions. Research studies may have contributed extra information in some areas, but the results are often not used for programmes and policy making. Extensive evaluation of a donor-sponsored project may have been carried out in an important area of programming, without the results ever being shared with others in the field. Rapid Plasma Reagin (RPR) for sero-syphilis testing may happen at local antenatal clinics (ANC) for diagnostic purposes without the results ever being passed on to the district or central level for use in monitoring. In short, the utility of much of the HIV-related measurement in a country may be lost because there is no coherent monitoring and evaluation system.

A coherent system has several advantages. It contributes to more efficient use of data and resources by ensuring, for example, that indicators and sampling methodologies are comparable over time and by reducing duplication of effort. Where resources are scarce, this is an important asset. Data generated by a comprehensive M&E system ought to serve the needs of many constituents, including programme managers, researchers or donors, eliminating the need for each to repeat baseline surveys or evaluation studies when they might easily use existing data. Good co-ordination should lead to better use of resources.

From the point of view of this paper a coherent M&E system helps ensure that donor-funded M&E efforts best contribute to national needs, rather than simply serving the reporting needs of agencies or legislatures overseas. A further advantage of co-ordination in monitoring and evaluation is that it encourages communication between different groups involved in the response to HIV. Shared planning, execution, analysis or dissemination of data collection can reduce overlap in programming and increase co-operation between different groups, many of whom may work more efficiently together than in isolation.

The ultimate use of data and indicators for programme planning and evaluation is crucial in any M&E system. Data that cannot or will not be used should not be collected. Countries have different M&E needs, dictated in part by the state of the HIV epidemic in that country, in part by the efforts being made by the HIV/AIDS programme and in part by the resources available. Hence monitoring and evaluation is an important tool in the fight against HIV/AIDS.

Capacity building within a learning organisation context

Presenter: *Saika Batouta Bagayoko, Groupe Pivot Sante Population, Mali*

Groupe Pivot is a unique model of a health sector NGO network in Africa. It was started 10 years ago by five NGOs in Mali. Today it has more than 100 in its fold. It objectives are to define the role of NGOs in the health sector, professionalise them and reinforce their role.

It also focuses on improving the relationship between the health department and the NGOs, maintaining a database of these organisations and providing them with technical support.

Groupe Pivot has trained over 600 people in advisory, project planning, development, management and planning, follow up and project evaluation. In the fight against HIV/Aids is concerned, this network of NGOs has put in place a number of programmes to fight the combined effect of STD/HIV/AIDS. This has been made possible through funding from USAID. These programme cover five regions in Mali including the Bamako district. Activities include partnerships between churches and NGOs.

The second programme targets prevention among the youth. It provides information about HIV/AIDS focussing on education, relaying information to communities such that they themselves start prevention centres. It also encourages parents and teachers to play a leading role in the prevention of HIV/AIDS. Their programmes also deal with STD and sexual behaviour for the youth in the high-risk area of Mali.

The third programme aims to reduce transmission of STD/HIV among the high-risk group. This programme involves 29 NGOs and focuses on road transporters, street vendors and single women.

This model of co-operation and support shows that:

- A strong partnership between civil society, government is possible.
- NGOs can work together
- Co-ordination of this sector is possible
- A co-ordinating role does preclude programme intervention
- The NGO sector should build programme management capacity

When PLWHAs take charge of their lives – the Buddy Programme

Presenter: *Emma Mwesa, Coping Centre for People Living with HIV/AIDS*

The COCEPWA buddy programme is a social support system for People Living with HIV/AIDS by PLWHAs resulting from a needs assessment conducted in 2000 to find out directly from HIV+ people in Botswana about Aids stigma and document how people were coping with their HIV diagnosis and find out what support services were offered and to identify the needs of the HIV+ community.

Buddies are COCEPWA members who go through interview and training processes and are then matched with other people living with HIV to whom they provide support and information. They provide one-on-one care, support and companionship to members who are:

- Newly diagnosed with HIV and/or are members of COCEPWA
- Pregnant women who are planning treatment

The programme is modeled on the Buddy Programme that was developed in the US to support people living with HIV/Aids but has been adapted for use in Botswana.

Buddies help in a lot of ways including:

- Helping them cope with a new diagnosis
- Support them during treatment
- Encourage them to get services
- Play and laugh together
- Offer comfort
- Phone them
- Encourage them to learn more about HIV and treatments
- Share information about transmission and re-infection
- Teach safer sex practices
- Encourage them to seek medical care when needed
- Encourage adherence to medication
- Be trusted with sensitive information and feelings
- Acknowledge that living with HIV can sometimes be very hard
- Encourage them to show their feelings
- Talk and listen

Buddies have responsibilities to:

- Follow all Buddy programme and COCEPWA guidelines
- Commit to at least six months in the programme
- Report to the Project Coordinator where they are members
- Regularly attend and participate in Buddy Group meetings
- Hand in reports at the end of each month, and
- Undergo ongoing training and workshops as needed

Buddies spend at least three hours a week with their clients. Buddies are not allowed to talk about their relationship with their clients or their client's behaviour with anyone outside of the programme. They sign a legal contract prohibiting them from doing so. However Buddies are not alone in doing this work and are supported by COCEPWA staff who also monitor the programme.

Client Issues that need to be reported are:

- Physical abuse
- Vulnerable children
- Suicidal thoughts and actions
- Excessive alcohol and drug abuse.

Building counseling capacity:

Presenter: *One Tabengwa, Botswana Christian AIDS Intervention Programme*

In 1996, the then President of Botswana, Quiett Masire publicly appealed to churches in Botswana to help in the national fight against HIV/AIDS. Christian communities responded by organizing themselves, hence BOCAIP. It is a network of grass-roots community initiatives, churches and para-church organizations with a Christian mandate that collaborates with government and civil society in the fight against HIV/AIDS. The BOCAIP intervention model is unique in that it is holistic and integrated counselling, community based and owned with collaborative and networking relationship with other stakeholders in the community. This model has been found to be cost effective because of broad volunteer base from the Christian community.

BOCAIP's experiences in mobilizing the Christian community to fill in the missing link proved invaluable. Counselling in response to the HIV/AIDS epidemic has been an available intervention for over a decade. Much of the counselling was first and foremost an elitist type, provided by the Social worker's and Heath providers'. Because of the nature of their work, they have limited time and resources to commit to one client.

The identified gaps influenced the model of intervention. The Christian community felt the need to design a sustainable Christian Intervention to contributing to the National AIDS Control Programme goal off prevention and transmission and the mitigation on individual, societal through counselling strategy. The strategy involved community mobilization and community outreaches to conduct workshops for all stakeholders.

The strength of counselling within BOCAIP is rooted in the training that counsellors and facilitators receive. Training is conducted as the initial activity to insure that project implementation is by qualified and well informed service providers.

The five components of a support structure for a person living with HIV/AIDS

Presenter: *Thanduxolo Doro, National Association of People Living with HIV/AIDS*

The five components of a support structure needed for person to live openly and positively with HIV/AIDS are:

Counseling

This should be encountered some time before diagnosis alongside diagnosis and continuously.

Support group

This is essential for an HIV positive person to understand the development process to gaining closure or reaching acceptance levels as is popularly known. It is only in a local support group that one can learn this. It has to be practical. Theory is unavailable, unfortunately.

Treatment (Medical)

HIV is all about the immune system and the mind. Opportunistic infections will come and go as the immune system becomes weak and strong. The immune system becomes weak when the CD4 is allowed to drop below unacceptable levels. If treated on time, all opportunistic infections go away. Access to treatment is a right.

Security (Job/Steady income/family/friends)

A job is needed for the basic needs to survive. More so with people living with HIV as the need for nutritious foods increases. NAPWA calls for a social grant for all unemployed HIV positive persons. Relying on family for provision of the basic needs to survive does drive the epidemic underground as women fear losing marriages, children fear losing shelter and others fear losing out on love. Discriminatory policies at all levels contribute vastly to a silent epidemic.

Positive outlook

HIV??? It is all in the mind. Our bodies act out what our minds harbor. Put differently: You mentally create happiness and wellness, you become happy and well. You mentally create illness or misery, you become ill and /or miserable. “Cowards die many times before their deaths, the villain never tastes of death but once.” I will live on. One can have all the above four components, without positive living they just will not work. Without positive attitude one will find faults with each of the above components..

From CBO to NGO – A Journey of Mentorship

Chairperson: Khanyisile Mmema

Value of volunteerism and networking in strengthening HIV/AIDS civil society response

Presenter: *Jeffrey Makgolo, Botswana Network of AIDS Service Organisations*

Voluntary service, in its many forms, has always been part of human interaction. Since the beginning of civilization, one of the most basic human values has been people helping people and, in the process, helping themselves. Most cultures have a name to describe it. From *shramadana* in South Asia, *harambee* in East Africa, *minga* in Latin America and *al taawun wal tawasu*l in many Arab States,

Volunteering means different things in different cultural settings but what is commonly agreed, however, is that the contribution of volunteerism is vast, both in terms of economic growth and of social capital. The value of volunteerism has manifested itself in the rapid growth of civil society organizations and volunteers sending agencies (VSAs) all over the world.

While volunteerism is not new, what is new, and has received great impetus by the global community is an acceptance of "…the need to approach voluntary activities strategically as a means of enhancing resources, addressing global issues (HIV/AIDS) and improving the quality of life for everyone"

The advent of HIV/AIDS and other development challenges has made the spirit of volunteerism more relevant than ever before. The majority of non-governmental organizations and community-based organizations particularly the ones offering home based care, palliative care, orphan care and community mobilization and education rely heavily on the use of both unskilled and skilled volunteers to effectively deliver their services.

Regrettably, the good spirit of volunteering seems to be declining mainly due to the changing economic forces. Volunteer based organizations are currently facing challenges of volunteer recruitment and retention. In light of theses challenges the need to move beyond traditional rules and assumptions on volunteer management cannot be overemphasized.

‘Retaining your volunteers is the key to success. There is no point in being good at recruitment if you cannot keep volunteers coming back. Recruitment is a solution to the problem of not having enough volunteers; retention is a way to avoid the problem altogether.’ (Steve McCurley and Rick Lynch, Volunteer Management: 2000)

Based on the experiences and trends of volunteerism in Botswana, regionally as well as globally, there are critical issues concerning volunteer recruitment and retention. The important role played by networking and partnerships principally with international volunteer sending organizations cannot be overemphasized.

Volunteerism is the key to effective and sustainable HIV/AIDS programming. McCurley’s Law of Volunteer Retention says:

"The longer a volunteer is around the more likely they are to notice when the elements of good volunteer management are not in place. The honeymoon is over.

Professionalising the CBO sector

Presenter: *Lauren Jankelwitz, Community AIDS Response*

The process of professionalising our new, growing organization was one that began when we were still a vision on paper attempting to gain enough attention to gain funding.

Community AIDS Response (CARE) was launched in November 2000. It was spearheaded by a group of volunteers in the HIV/AIDS field, two of whom were social workers. The value of professional skills in establishing a new organization, in sustaining it and helping it develop, and in carrying out our aims has been paramount.

Project managing and putting the vision of the organisation from paper to practice proved to be a real challenge. This involved hiring staff and structuring the organization. A group of professional nurses and social workers were hired in order to ensure a professional, quality service was offered. The collective background of social work with a community minded code of ethics and a broad knowledge base encompassing counseling, training, community development and organizational development, meant we were focused and added value to CARE.

Having a professional team as the foundation of the organization has also assisted us in growing and reaching larger numbers of people. The importance of armies of volunteers offering counseling, education and care cannot be understated if we are to deal with this epidemic, but without being underpinned by a professional team and approach we would only be able to offer well-intentioned but ineffective services. The processes of counseling and care-giving are sophisticated ones that must be undertaken in an ethical, professional manner in order to be helpful.

The team of professionals was required to recruit, screen and train community volunteers. They also continue to take responsibility for on-the-job training, supervision, in-service training and support for the volunteers. In the process, they have tried to professionalise the whole HIV/AIDS field by creating a career path structure for volunteers.

People start as pure volunteers, then receive a stipend which covers out-of-pocket costs, then become field workers (required to have both caregiving and counseling skills) and earn an honorarium. Finally, team leaders are full time lay helpers who coordinate a team of volunteers and field workers under them and one team leader has been promoted to another salaried position in the organization.

While CBOs are made up of community-minded, dedicated volunteers, the sad reality is that sometimes they do not have the skills necessary to follow through on great project ideas. This is because they do not have the knowledge necessary to acquire funding, do not have the skills necessary to manage that funding and/or do not have the professional skills to train and supervise their teams of workers. Having all these skills means that a CBO can become a credible organization within a short period of time.

Why are professionals used?

- It is crucial for Home Based Care practitioners to be professionals who can assess patients and assign care programmes. They also impart skills through their supervision so that the army of willing volunteers continue to learn and grow and service remains accountable.
- Counselling: must be trained and supervised by professionals as quite a sophisticated skill that needs to be mastered and ineffective counseling can be damaging to client.

That is our model, a professional staff team recruiting, screening, training, supervising and sustaining volunteers and creating a professional career path along which they can travel.

A professional team helps the organisation – especially a community based organisation.

BMSF legacy programme

Presenters: *Lucy Edward/ Alta Le Roux, NGO Institute Pilot Programme*

Since June 2002 a core group of people representing five different SADC countries, together with BMSF COEF have been holding consultative meetings to discuss the establishment of a NGO Management Institute.

The aim of the programme is to build management and leadership capacity among HIV/AIDS NGOs/CBOs in the five SADC countries where the Secure The Future™ programme is operative namely, Swaziland, Botswana, Lesotho, South Africa and Namibia.

Background

NGOs in the SADC region have long bemoaned the lack of capacity. Studies carried out within NGOs and CBOs all point to the need to develop management, leadership and programme implementation capacity within NGOs and CBOs. A sad result of the capacity deficits in some of our countries has been the withdrawal of resources for HIV/AIDS programmes due to mismanagement and inefficiencies. The lack of capacity does not only manifest itself at local level, national institutions are also plagued by it. The fact is that lack of leadership, bad management and ineffective programme delivery has a negative impact on the quality and effectiveness of services we deliver.

Pilot Programme

Key Issues

In run-up to the development of the pilot programme a number of key issues were discussed.

- There should be a balance between training, monitoring and evaluation
- Training should lead to hands on practical application
- Mentoring should support the training programme
- Programme delivery to should be flexible to allow for open learning
- Training should not focus on physical structure, could also be virtual institute, should rather focus on content

- Capacity building should take into account career - pathing to facilitate retention of trained personnel
- Strive towards accreditation of programmes as a means of quality assurance

Content

Despite differences in individual country programmes there are some common areas of knowledge and skills that the pilot programmes will focus on across countries, irrespective of modes of delivery or national peculiarities namely:

- Leadership Development
- Management Training: Human Resource Management, Financial Management, Project Management
- Reporting: Financial and Narrative
- Resource Mobilisation
- Governance Training
- Organisational Development
- Networking
- Lobbying and Advocacy
- Field programme implementation

Pilot Programme Implementation

In-Country Management and Co-ordination

Individual country programmes will be implemented by a number of different organisations that offer different types of expertise. In most cases these organisations have come together to form a Consortium that will co-operate to implement different aspects of the pilot in different countries.

Regional Co-ordination

In addition to the in-country management and co-ordination there will be regional co-ordination to hold together pilot programme implementation across the region. The co-ordination will take the form of two regional meetings over the one year pilot phase. The meetings will consist of:

•Mid Term Assembly

Aims

To assess progress

To critically l review of outcomes

To redirect the pilot phase – if necessary

• End Term Assembly

Aims

To critically review of outcomes

To review evaluation report and recommendations

To finalise documentation of lessons learnt

To finalise the five-year legacy programme

Monitoring and Evaluation

The focus of the monitoring and evaluation function will be to:

- Plan, design and implement monitoring and evaluation system
- Train country based core staff in the utilization of the system.

Chairperson: Mandla Mazibuko

SRHI - mid-term evaluation lessons

Presenter: *Mrs Elizabeth Mndzebele, Swaziland Rural Health Initiative, MOHSW*

The Swaziland Rural Health Initiative conducted a mid-term qualitative process evaluation to assess how the program has been implemented, its strengths and weaknesses and to review progress toward achieving its goals.

The study was commissioned to improve, modify and inform the expansion of the program. The framework for evaluation covered: Context, Structure, Function and Integrity.

Methodology

The design was a qualitative, cross-sectional descriptive design to carry out interviews with individuals and focus groups with all the levels of SRHI participants. A research team of 20 (13 from Swaziland representing the Ministry of Health & Social Welfare and Uniswa faculty and 7 students from the U.S.) was put together.

A selection of challenges & difficulties

- There are an increasing number of AIDS orphans – a problem as there's no breadwinner in the home, they lack food and children are dropping out of school to be caregivers or to take care of other siblings.
- Families in CHBC are not well-integrated into existing health programs. Referrals from hospitals are not routinely carried out, with community leaders now being made aware when a family in their community is caring for a sick family member.
- Family care-giving was stressful on the family both physically and psychologically.
- Lack of transport hindered visitation and supervision.
- Lack of money or a source of income to provide all that is needed for survival, including food (we are starving)
- Family members are forced to give up their jobs in order to provide home based care

The RHM lack many essential supplies to protect them and their patients from infection, such as gloves in addition to other material resources

The RHMs face unrealistic expectations from families and community members.

Recommendations

- The lack of necessary human and material resources need to be addressed. Separate funding streams should be developed so that supplies and training workshops are provided.
- Increasing the coordination between personnel, organisations and donors will bring about more appropriate and effective implementation a referral system that focuses on continuity of care.
- The CHBC programme staff and activities need to be regularly monitored and evaluated, particularly in regards to supervision of RHMs in the field
- There is a strong need to clarify roles and responsibilities of people and organisations implementing CHBC
- VCT sites should be made available at the tinkhundla or local clinic level to increase access to information and help to facilitate more informed and appropriate care delivered at the local level.
- Public awareness campaigns about the CHB programme, HIV/AIDS and other relevant topics will help to decrease stigma, increase access to information, and help to provide a sense of community ownership and responsibility toward home based care.
- The University of Swaziland should become increasingly involved in community health and development efforts.
- Local strategies at the chiefdom and / or *tinkhundla* level need to be developed in order for the CHBC programme to be sustainable, appropriate and accessible

Conclusion

Capacity building programme should be planned with service provision as a component – so that the effect of the training can be easily measured.

Secondly programmes or projects with too many partners and up having problems because no one takes the accountability. The use of existing structures e.g. primary health care has facilitated the delivery.

CHAL-lessons learnt from the mid-evaluation

Presenter: *Mrs Mantahli Mahase,Christian Health Association of Lesotho*

The Christian Health Association of Lesotho's Home-Based Care Project received funding for three years to support women and children affected and infected by HIV/AIDS, as well as create self-sufficiency through income generating activities (IGAs).

It is being implemented in three Health Service Areas (HSAs) in Lesotho with 10 participating villages in each. The components of the program include:

- education of professionals on effective home based care and improved counseling;
- education of the public on HIV/AIDS and acceptance of HBC in the villages;
- empowerment of women and children affected and infected by HIV/AIDS with emphasis on home based care and self-sufficiency, and
- improvement of the care and support for AIDS orphans.

The mid-term evaluation found that CHAL has developed a programme that reaches a large number of people in remote areas using existing structures, ensuring sustainability. Achievements in community mobilization and the training of community members will have longstanding benefits to the communities and individuals gaining skills. Importantly, improved agricultural methods have been initiated since the introduction of IGAs in the villages.

The evaluation pointed to the following areas for ongoing improvement:

- uniformity and quality of training and IEC materials;
- increased effort in obtaining understanding and buy-in from communities;
- properly supervised, supported, and monitored home based care in all project sites;
- the identification of short and long term strategies for serving orphans in project sites;
- and the implementation of a thorough monitoring system for all aspects of the programme.

CHAL's experience provides a number of important lessons for similar home based care projects. These include working in partnership with communities should be conceived as an ongoing process that needs constant monitoring; supervision needs to be given careful consideration, especially with many remote project sites; volunteer work is difficult to sustain in communities engulfed by poverty; and well planned income generating activities chosen locally can empower people economically.

Creating learning organisations

Presenter: *Lindi Illonze, Cactus Consult*

It is an conscious decision by management to create learning organisations, which provides personnel the opportunity and environment to learn from their past experiences through the action – reflection techniques.

Management supports a process, which gives opportunity to staff to learn from negative and positive experiences by assessing their work using the learning cycle of action reflection. The five questions that are used in the reflection process are:

- What went well and why?
- What did not go well and why?
- What did we learn from this?
- What will we do different next time?
- Where will we need more help?

The Learning cycle needs to be institutionalised as a regular event. It can be done on weekly, monthly or quarterly basis depending on how often an organisation can do this analysis and planning. The requirement is that each activity should have a plan with clear targets and objectives and strategies.

Planning

Most organisations only plan when they put together a proposal for funding. A proposal is fund-raising tool and not an operational plan. An operational plan is based on the proposal, but take into consideration the amount that was raised and the organisational capacity. This plan will then be used during the reflection process asking the five reflection questions.

Is this realistic to apply in an NGO? The argument is that NGO managers have no time. They have no management team and in most cases the NGO director is the financial manager, the human resource manager, the Public Relations Officer and the administrative manager. It is therefore more important to analyse the management style of NGO managers.

There must be a balance. Each of these functions is important and will impact on implementation capacity.

Management should create an organisational culture of nurturing and supporting their staff members to efficiently implement their programs, learn from their experiences and continuously improve on their implementation and skills. Only through investing time in internalising the action reflection techniques we can develop sustainable learning organisations that will be able to beat the deficit in capacity.

To summarise the challenges for NGO managers:

- Invest more time in building the internal capacity of your organisation;
- Create space for personnel to develop their own personal growth plan within their job description.
- Provide nurturing support to your employees;
- Create synergy between employees personal goals and organisational goals;
- Link your human resource plan to your operational plan.
- Do continouos planning and reflection within your organisation.
- Be realistic in your operational plans by taking into account your capacity and the time and resources needed to build that capacity.
- Building sustainability does not only refer to financial capacity but also to the skilled personnel to implement effectively in order to attract financial resources.

Developing countries do not have a pool of highly skilled personnel from which government, NGOs and private sector can draw. NGOs have to invest consciously in their team by in-service learning opportunities.

Community as partners and facilitators of own development

Chairperson: *Charlotte Ntsoku, Rhema Christian Services Foundation*

Rhema Service Foundation started rendering social services in Zandspruit in 1998 with full participation and involvement by the community. Further, the community made available and office to RSF. As social services grew, a need for the provision of health services was identified and a team was established to provide primary health care and integrated home based care services

Listed below are the principles of community participation and ownership which the organisation has applied successfully in its work.

Human orientation

- Addressing identified needs
- Recognising potential to fulfill needs
- Enhancing dignity
- Human orientation

Principle of participation

- Ensuring sustainability
- Sharing information

Principle of learning

- Bottom-up learning
- Confidence building
- Mobilizing social energy

Principles of empowerment

- Informed Decision Making
- Supporting guidance

Principle of ownership

- Establishing ownership

Principle of release

Transforming the community to be self-reliant

Where we began

We first undertook a research to identify the needs of the community. Once that was established, we made contacts and started creating networks. This was critical as lesson