SITUATIONAL ANALYSIS AND NEEDS ASSESSMENT OF MANAGEMENT CAPACITY AMONG HOME AND COMMUNITY BASED CARE SERVICE PROVIDERS

HIV&AIDS Multi-Sectoral Support Programme

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Department:
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HOPE worldwide

National Office
Department of Social Development
Private Bag X91
Pretoria
0001
Tel: 012 312 7500
www.socdev.gov.za

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EXECUTIVE SUMMARY

This report presents and discusses the findings of the Home Community Based Care (HCBC) Organisational Capacity Research Project, which was conducted within the context of the HIV/AIDS Multi-sectoral Support Programme in South Africa between October 2005 and January 2006. The purpose of the research was to assess management capacity among HCBC organisations in South Africa and to make recommendations for the design and content of a proposed national HCBC institutional capacity-building programme.

The research took the form of a rapid, qualitative needs assessment that was conducted in three provinces through key respondent interviews with national, provincial and district-level government representatives; visits to 12 HCBC organisations; and a review of the work of mentoring groups and non-profit organisation (NPO) support structures. A desk review of literature, policies and legislation was also conducted.

The objectives of the study were to identify factors that influence the capacity of HCBC organisations; identify gaps in the management capacity of HCBC projects; identify minimum organisational capabilities required by a HCBC organisation; identify priorities for a HCBC management capacity-building programme; identify existing capacity building programmes and mentorship models that could be modified, replicated or scaled up; identify existing non-governmental (NGO) support structures that could be integrated into the programme and contribute towards overall sustainability of programme results; and to recommend effective and efficient approaches, methodologies and models for the management capacity building and mentorship of HCBC programmes.

HCBC organisations include NGOs, CBOs and FBOs that provide services at community level to people infected and affected by HIV and AIDS. The number of HCBC organisations in South Africa has grown rapidly as the HIV and AIDS epidemic has intensified. The Department of Health and Department of Social Development both provide funding to HCBC organisations to deliver services to people in remote and/or underserved areas. However many HCBC organisations have weak internal systems for managing and reporting on funding, and struggle to attract other sources of support for their work, making them heavily dependent upon government finances. It is widely agreed that HCBC organisations require training and capacity building in order to work more efficiently and effectively.

Key findings related to the current management capacity of HCBC organisations include the following:

- Most HCBC service providers do not have well-developed management systems in place and do not consider their vision, mission and goals in decision making, service delivery and other functions. Many CBOs developed a constitution for registration purposes only.
- Registering as an NPO and complying with the annual registration requirements is generally not difficult for larger NGOs, but it can be a major challenge for emerging CBOs. NPO registration is a pre-requisite for accessing government funding and CBOs often require intensive help from local DSD officials to become registered.
- Most CBOs are governed by a five-member Executive Committee, comprised of officeholders who are elected on an annual basis. The organisational structure is flat with little differentiation of roles and responsibilities between managerial and technical duties. In more mature HCBC organisations, staff have more specialised roles and functions, such as fundraising, bookkeeping, or project management/supervision.
- Strategic planning and project management skills were generally lacking, and community-level needs assessments are conducted largely informally. As a result few NGOs are

planning ahead more than a year in advance, while CBOs generally only plan on a micro (activity) level.

- Information management and financial systems are limited. Systems are often developed in response to donor requirements, but are not used to empower the organisation or to evaluate its work. Many records are kept by hand and extra copies are not retained in the organisation when they are submitted to funders or other agencies.

- Fundraising is a challenge for NGOs and particularly for CBOs, whose sustainability is threatened by limited fundraising skills and a non-diversified resource base. HCBC organisations have difficulty accessing non-project funding to cover general operating costs such as transportation, office space, utilities, and telephone calls. Few donors are willing to fund individual HCBC organisations because it is too labour intensive to administer small-scale funding.

- The basic working conditions in HCBC organisations are difficult and emotionally taxing. Support programmes for caregivers are not always well-developed. Volunteer caregivers often work full-time for a small stipend without the protection of labour legislation, while some volunteer caregivers do not receive a stipend or any remuneration. The payment of stipends can cause conflict within and between HCBC organisations.

- Skill levels and work experience among personnel in HCBC organisations is generally low and there is limited attention to career development or career pathing. Many existing training and capacity building schemes focus on training individuals and do not ensure that the skills are transferred to the organisation as a whole. This can lead to turnover among trained personnel who are able to find paid work in other organisations.

- Networking and external relations with other organisations working in the sector is limited. There are few if any examples of networks that draw together HCBC organisations. Links between HCBC organisations and local businesses are relatively uncommon.

- The relationship between emerging HCBC organisations and government officials at district level is complex. In many instances officials play a prominent role in the legal establishment of the organisation and then come to manage the organisation remotely.

Factors that influence the management capacity of HCBC organisations in South Africa include: the rapid and uncoordinated growth of the HCBC sector, which has accelerated due to the availability of government funding; the financial and statutory requirements with which some HCBC organisations struggle to comply; challenges in intergovernmental alignment around HCBC activity, including overlapping mandates between the Departments of Health and Social Development; the fragmented training and capacity building environment for HCBC organisations; an overall resource environment which is challenging for HCBC organisations to break in to; time and capacity constraints among front-line district-level government officials tasked with overseeing and supporting HCBC organisations; and the ‘crisis environment’ in which HCBC organisations work, particularly the direct and on-going contact with seriously ill patients and affected family members.

The research found a high degree of consensus among government officials and HCBC representatives about areas of need within a future capacity building programme. These areas include: general organisational management; project management and planning; financial management; fundraising; human resource management; monitoring and evaluation; and networking and external relations. Respondents from HCBC organisations tended to name specific areas of training related to the content of the services they provide or to broad principles of organisational functioning. The training areas cited by government respondents related mostly to compliance with reporting requirements.

DISCUSSION

Training and mentoring models already in use in South Africa provide examples of approaches that could be incorporated into a national capacity building programme. These include NGO/CBO partnerships ('twinning'), short and medium-term training and mentoring activities by service providers, sub-granting arrangements, and the establishment of NGO/CBO consortia that access funding collectively and transfer skills and experience to one another. Existing models also provide evidence of key principles that should underpin a scaled-up capacity building programme. These include: 'grading' organisations according to their baseline capacity and adjusting the content of training accordingly; establishing clear agreements between service providers and beneficiary organisations about the process and respective roles and responsibilities; providing training and training materials in local languages, not only English; and ensuring that training and mentoring does not capacitate only the top leadership of an organisation, but is internalised into organisational practice.

Minimum capacity requirements for HCBC organisations should be understood in relation to the changing needs and abilities of organisations as they progress through organisational 'life stages.' HCBC organisations can be expected to perform at different levels depending on their stage of evolution, and a capacity building programme should aim to elevate organisations to the highest level they are able to achieve.

CBOs can be understood as emerging organisations which need to meet certain basic technical requirements in order to be funded, but which also require high levels of monitoring and support in the use of those funds. NGOs are generally established organisations that have more evolved systems and are able to work in a stable way with minimal supervision. Some mature NGOs operate relatively autonomously and sustainably, in accordance with their own mission and vision. Forms of support could be tailored to these different levels, with higher levels of capacity making HCBC organisations eligible for greater amounts of funding.

Priority areas for a national capacity-building programme for HCBC organisations include: training to transfer essential management skills to HCBC organisations, ensuring that the support is tailored appropriately to the organisation's level of development; mentorship to provide guidance and support in the application of the management skills over time; and role clarification and mutually supportive coordination between HCBC organisations and district-level government officials. Findings from this research suggest that investing only in the skills of individual HCBC caregivers and officeholders will be insufficient to bring about sector-wide change. It will also be necessary to address some of the broader institutional and systemic issues which shape HCBC capacity.

Areas identified for further research or investigation include the link between management capacity in HCBC organisations and the quality of the services they provide; the implementation of the EPWP in the HCBC sector, including the experiences of both volunteers and the organisations that host them; and assessing the strengths and accomplishments of existing models for training, capacitating and supporting HCBC models in South Africa.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARV	Antiretrovirals
CANSA	Cancer Association of South Africa
CBO	Community Based Organisation
CDW	Community Development Worker
CSO	Civil Society Organisation
DFID	Department for International Development
DoE	Department of Education
DoH	Department of Health
DSD	Department of Social Development
DOT/S	Directly Observed Treatment/Shortcourse
EC	Eastern Cape
EPWP	Expanded Public Works Programme
FBO	Faith Based Organisation
FS	Free State
GP	Gauteng Province
HCBC	Home Community Based Care
HIV	Human Immunodeficiency Virus
ICHC	Integrated Community-based Home Care
IT	Information Technology
KZN	KwaZulu-Natal
M&E	Monitoring and Evaluation
MRN	Mentoring Resource Network
NGO	Non-Governmental Organisation
NPO	Non-Profit Organisation
NQF	National Qualification Framework
NW	Northwest Province
OVC	Orphans and Vulnerable Children
PFMA	Public Finance Management Act
PLWHA	Person Living With HIV/AIDS
PPP	Public Private Partnership
SANGOCO	South African NGO Coalition
SETA	Sectoral Education and Training Authority
TB	Tuberculosis
UNDP	United Nations Development Program
VCT	Voluntary Counselling and Testing
VSO	Voluntary Service Overseas

1 INTRODUCTION

This report presents and discusses the findings of the HCBC Organisational Capacity Research Project, conducted between October 2005 and January 2006 as part of the HIV/AIDS Multi-sectoral Support Programme.

The research was designed to assess management capacity among Home and Community Based Care organisations (HCBC organisations) in South Africa and to make recommendations for an institutional capacity-building programme. Research activities were qualitative in nature and included policy and literature reviews, interviews with key government representatives, HCBC organisational assessments, and interviews with mentoring groups and support structures for non-profit organisations (NPOs).

For the purpose of this research, the definition of HCBC developed by the Department of Health and Department of Social Development has been adopted:

> Home care is defined as the provision of comprehensive services, which include health and social services by formal and informal caregivers in the home in order to promote, restore and maintain a person's maximal level of comfort, function and health including care towards a dignified death.
>
> Home care services can be classified into preventive, promotive, therapeutic, rehabilitative, long-term maintenance and palliative care categories.
>
> Home/community based care and support is the care/services that the consumer can access nearest to home, which encourages participation by people, responds to the needs of people, encourages traditional community life and creates responsibilities.[1]

1.1 BACKGROUND

South Africa is one of the countries most severely affected by HIV and AIDS. Sero-prevalence surveys conducted by the Department of Health at public sector clinics in 2005 found that 30.2% of pregnant woman were HIV-positive (compared to 29.5% in 2004); extrapolating this to the general population using modelling techniques, it is estimated that 5.54 million South Africans are HIV-positive (Department of Health, 2006).

In addition to the impact of HIV on the health of individuals, it also affects the economic and social status of households by placing increased burdens upon families that can ill afford the financial costs of care or a loss of income. As a result, children may be forced to assume much higher responsibilities in the household and are often put at risk.

Rising HIV prevalence and associated mortality rates have increased the burden on the state's healthcare and social systems. Civil society has responded to the need for community-based care services through non-governmental organisations (NGOs), faith-based organisations (FBOs) and CBOs. These groups provide a range of services including care for bed-ridden and home-bound patients, assistance in accessing grants, childcare, food parcels and referrals to other services.

Whilst the number of HCBC organisations has grown rapidly in South African in recent years, the quality and coordination of the services available have not kept pace, and the need for institutional capacity building is evident. The low remuneration of participants in the sector has an influence on the retention of skills in the sector; newly emerging CBOs are often unstructured and inexperienced; monitoring and evaluation system are poorly developed where they do exist; and donor institutions and government departments struggle to receive adequate reports on services

[1] Department of Health, 2002. *Integrated Home/Community Based Care Model Options.*

rendered and the use of funds. Many HCBC organisations currently operating in South Africa are not registered as NPOs and do not have the capacity needed to register. As a result, they cannot access funding from government departments or other funders.

These and other concerns around the capacity of HCBC groups to meet the long-term need for community-based care has led to the intention to develop a three-year capacity-building programme for HCBC organisations. The government of the United Kingdom through DFID is funding a HCBC management capacity building programme in the DSD, as part of the multi-sectoral programme. It is envisaged that the programme will improve management performance and organisational sustainability of HCBC organisations.

1.2 RESEARCH OBJECTIVES

The objective of the research was to produce a rapid assessment of the current management capacity amongst HCBC organisations and the minimum level of management skills and capacities required to effectively render HCBC services.

The specific objectives of the study were to:

1. Identify factors that influence the capacity of HCBC
2. Identify gaps in the management capacity of HCBC projects
3. Identify minimum organisational capabilities required by a HCBC organisation
4. Identify priorities for a HCBC management capacity building programme
4. Identify existing capacity building programs and mentorship models and / or programs that could be modified or adopted where necessary
5. Identify existing NGO support structures that could be integrated into the programme and contribute towards overall sustainability of programme results
6. Recommend effective and efficient approaches, methodologies and models for the management capacity building and mentorship programme for HCBC organisations

2 RESEARCH METHODOLOGY

2.1 RESEARCH DESIGN

This study was designed to provide a rapid needs assessment and situational analysis of the management capacity of HCBC organisations in South Africa. While some research has previously been conducted into HCBC organisations in South Africa, these studies provided only limited insight into the management capacity of organisations in the sector.

The research was conducted in three provinces – North West, Free State and Eastern Cape – which were selected because they had been under-represented in previous research work.

Data was collected qualitatively, using the following methodologies:

- Interviews with key informants at national and provincial levels of the Departments of Health and Social Development;
- Focus group discussions with district-level officials of the Departments of Health and Social Development;
- Organisational visits, including interviews and focus group discussions with representatives of HCBC organisations;
- Interviews with representatives of mentoring and support NGOs.

HCBC organisations that were selected for visits fell into five categories, based on perceived level of performance: 1) organisations that are perceived to be efficiently and effectively managed; 2) organisations perceived to be established and average performing; 3) organisations that are emerging and performing on a low level; 4) organisations that are unregistered; and 5) organisations that have lost funding. The research was intended to identify factors that influence the management capacity of organisations operating at these different levels of performance.

Research tools, including interview guides and questionnaires, were designed to meet the specific research objectives. The tools and data collection techniques for use with the HCBC organisations were pilot-tested with two organisations in Gauteng Province and revised prior to their use in the other provinces.

2.2 DATA COLLECTION

Fieldwork was conducted over a three week period in November and December 2005.

2.2.1 Key Informant Interviews

Fourteen in-depth interviews were conducted with key informants at national and provincial level of the departments of Health and Social Development. Respondents included Chief Directors, Directors, Assistant Directors, Provincial Coordinators, District Facilitators, and Programme Managers responsible for HCBC, HIV/AIDS and TB, VCT, OVC, NGO/NPO funding, and care and support.

These interviews were intended to capture respondents' experiences and perspectives on HCBC management capacity; to determine the extent to which their division or department plays a role in developing the capacity of HCBC; to determine their skills, resources and gaps in delivering on their capacity development role; to determine how capacity development is mainstreamed into the policies, norms and standards for the delivery of HCBC services; and to determine their department’s vision of an optimal HCBC capacity development programme.

2.2.2 Focus Group Discussions

Three focus group discussions were conducted with district health and social development officials in the Xhariep and Fezile Dabi districts in the Free State and Bophirima district in the North West province. Focus groups involved between six and eight participants, drawn from among social workers, community development workers (CDWs) and HIV/AIDS coordinators. Each focus group lasted for about two hours and was facilitated by a pair of experienced interviewers.

The focus groups were designed to elicit information about the roles being played by the departments of Health and Social Development in aiding HCBC organisations to meet their objectives; to understand the skills, resources and gaps that may shape the ability of the participants to play the supporting role they are required to play; and to solicit perspectives from the participants on current government policies that may affect HCBC organisations' ability to meet their objectives.

2.2.3 Visits to HCBC Organisations

Visits were made to 12 HCBC organisations (see Table 1) operating at five different levels of performance. The organisations were identified by provincial DSD officials.

Each visit involved an interview with one or more key respondents in the organisation, as well as a group assessment exercise with the organisation's caregivers.

Specific objectives for this element of the research were to:

- assess the HCBC organisations in terms of key areas of management capacity;
- identify individual and systemic influences on the ability of organisations to deliver on their objectives;
- identify gaps in the management capacity and resource base (supplies, equipment, infrastructure) of organisations that hinder them from reaching their objectives;
- determine the resource networks, training, mentoring and support structures that organisations interact with, and the strengths and weaknesses of those interactions; and
- gather HCBC perspectives on the priorities for a management capacity building and support programme.

Table 1: HCBC groups visited in the research, by level of performance

	Pilot (Gauteng)	**Free State**	**North West**	**Eastern Cape**
Perceived to be efficiently and effectively managed		Lady Brand Hospice	Lifeline Klerksdorp	Ikhwezi Lomso Engcobo
Perceived to be established and average performing	Abangani Inkosini	Mokwallo HBC	Ikageleng Tshwaragang	Not Available
Emerging group that is perceived to be performing on a low level		Phakamani Volunteers Group	Thusanang HBC Kedinametse	Sakhuluntu Mthatha/OR Tambo
Unregistered groups	Vah, Tuma Art Project	Kopanang Youth Forum	Tiisetso Lokgabeng Care Group	Not Available
Deregistered groups or those that have lost funding		Lindikuhle Place of Safety	Sakhubuntu	Not Available

Eight areas of organisational capacity were identified for assessment: strategic and corporate governance; organisational structure and leadership; planning; administration and information systems; human resources; finances; service delivery; and external relations.

2.2.4 Reviews of Mentoring and Support Groups

Interviews were conducted with six organisations that mentor or provide other forms of support to NGOs and CBOs, and the work of other similar organisations was reviewed using publicly available information.

This component of the research was designed to identify existing capacity building programmes, mentorship models, and NGO support structures in South Africa; to identify lessons from their work; and to begin a database of organisations and networks involved in training, mentorship and support for CBOs and NGOs. The services and performance of the mentoring and support groups were not assessed in any way.

Interviews were conducted with two national-level groups – Starfish and the Mentoring Resource Network – and six provincial-level groups: Unsung Heroes (GP); Mohaladitwe Joint Venture, a training and mentoring consortium (FS); Seboka Training and Support Network (NW); and the Eastern Cape NGO Coalition (EC).

Other groups that were reviewed include the Children in Distress (CINDI) network (KZN), the Health Economics and HIV/AIDS Research Division (HEARD) of the University of KwaZulu-Natal, OLIVE, the Barnabas Trust (EC), Heartbeat, Southern African AIDS Trust (SAT), the International HIV/AIDS Alliance, the United Nations Development Programme (UNDP), Catholic Institute for International Relations, and South African NGO Coalition (SANGOCO).

2.3 METHODOLOGICAL LIMITATIONS

This study was designed as operational, rather than academic research and was intended to inform the development of a DSD-led capacity building programme for HCBC organisations. The research is relatively small scale in terms of the number of respondents and was conducted in only three provinces. However, the research questions are far-reaching and further investigations would almost certainly reveal additional findings. For these reasons, one should be cautious in generalising findings.

A short period of time was initially allocated for completion of the study and it was necessary to set boundaries appropriate to the time and resources available. Where specific additional research needs were identified, these have been included in the conclusions section.

A practical limitation to this study was the unavailability of certain respondents due to the fieldwork dates coinciding with other HCBC research projects, as well as the 16 Days of Activism campaign and World AIDS Day. A number of representatives from the Department of Health were unavailable for interviews.

It should be noted that all HCBC organisations visited were currently or previously funded by DSD. The potential bias introduced as a result of this was considered acceptable, given that such organisations represent the target participants for the proposed capacity building programme.

3 LITERATURE REVIEW

This section presents a brief review of key literature and policy frameworks that relate to issues of home-based care and capacity building of NGOs and CBOs, with particular reference to South Africa. Given the extensive literature that exists on these issues, this literature review cannot claim to be comprehensive, but rather to highlight major points of relevance in framing the research questions.

3.1 CIVIL SOCIETY, HIV/AIDS, AND CAPACITY BUILDING

3.1.1 Civil Society and HIV/AIDS Response

In most parts of the world, strategies developed in response to the HIV/AIDS epidemic have been led by and implemented through government institutions – particularly ministries of health. In recent years that the important role of civil society organisations – NGOs, CBOs, FBOs and informal associations of ordinary people – in responding to HIV/AIDS has begun to be acknowledged by national governments, funding institutions, and international agencies (Rau, 2006).

While national AIDS programmes took time to be established and to become operational in many countries, civil society organisations were quicker to respond to the effects of HIV/AIDS appearing in communities (Iliffe, 2006). In many places, local organisations of infected and/or affected individuals became involved in home-based care for the sick, support groups, counselling, door-to-door education campaigns, and care for children made vulnerable by AIDS before such initiatives became part of a national response framework. In some of the best-known examples of HIV prevalence reduction – for example, in Uganda and within the gay community in the United States –local-level community mobilisation is believed to have played an important role (Low-Beer & Stoneburner, 2003; Thornton, 2003).

As national programmes have been scaled up, civil society organisations continue to complement services provided by governments and, in many cases, to fill critical gaps (Rau, 2006; UNDP, 2003). They have also been a powerful force for advocacy and policy change, particularly in relation to expanding access to treatment (UNDP, 2003; WHO, 2004), and have been credited with advancing understandings of the link between AIDS, poverty and gender inequality (UNDP, 2003).

CSOs are seen as well-placed to reach communities of people that are marginalised, remote, or otherwise difficult to access. Because the organisations are often small in size, their operational costs are lower than those of more established institutions, and they are able to work in a flexible manner. Many CSOs are led by women. Community-level responses to HIV/AIDS are seen by the World Health Organisation as one of the clearest examples of community participation in health, a principle that has become increasingly recognised since the 1970s as a cornerstone of public health (WHO, 2004).

3.1.2 Absorptive capacity and scaling up

As the AIDS epidemic has intensified, there has been a push to scale up prevention, support and treatment programmes in many parts of the world. This has required a great expansion in the amount of resources being spent on HIV/AIDS interventions, from both domestic and international sources. Civil society organisations are now seen as important strategic and programmatic partners for donor institutions, national governments and development agencies and are receiving funding from external sources in ever greater amounts.

The increased demand for interventions and the greater availability of resources has produced a tension between the desire to ‘scale up’ programmes, on the one hand, and challenges of

'absorptive capacity,' on the other. Absorptive capacity refers to the ability of an institution or organisation to make use of a greater level of resources in a way that is effective and that brings about intended results (De Renzio, 2005). With the expansion of funds for HIV/AIDS, donor institutions have become concerned about the ability of government institutions (ministries, agencies, departments) and individual organisations, such as CSOs, to manage and spend growing amounts of resources, without waste or corruption, and in line with pre-agreed programme frameworks.

For CSOs, the challenge of taking activities 'to scale' should not be underestimated. 'Scaling up' generates tensions between reaching more people and maintaining the quality of services and accountability to funders and beneficiaries. Expanding the scale and scope of programmes requires that certain key organisational elements – such as administrative and financial systems and organisational governance arrangements – be firmly in place (Lee, 2001).

Donors employ a range of reporting and accountability mechanisms to monitor the use and impact of funds, but these procedures are often burdensome from the perspective of civil society organisations that have little or no experience managing external resources. Familiarity with concepts such as project management, proposal writing, financial management, and monitoring and evaluation can be limited among groups that evolved out of informal associations of volunteers. The notion of 'capacity building' has emerged, in part, as a way to strengthen the efficacy of institutions, including CSOs, in managing funding and in contributing to development outcomes.

3.1.3 Capacity and capacity building

3.1.3.1 Definitions of capacity and capacity building

Over the past decade, 'capacity' and 'capacity building' have become widely used concepts in relation to a range of developmental issues, including HIV/AIDS. There is much debate but no commonly agreed definition of capacity, making it an elastic concept that can mean many things to different people (Lusthaus et al, 1999; Morgan, 2006).

Various interpretations and applications of the concept focus on different units of analysis, from the knowledge and ability of individuals or organisations to act in a way that brings about certain kinds of results, through to ability of governments or societies as a whole to organise and manage their affairs successfully. Some examples of definitions of capacity include:

- 'The ability of an organisation to produce appropriate outputs' – (Boeson & Therkildsen, 2005)
- 'The ability of individuals, organisations and societies to perform functions, solve problems, and set and achieve goals' (UNDP, 2003, cited in Whyte, 2004)
- 'The ability of individuals, communities, institutions, organizations, and social and political systems to use the natural, financial, political, social and human resources that are available to them for the definition and pursuit of sustainable development' (UN, 2002, cited in Whyte, 2004)
- 'Capacity is that emergent combination of attributes that enables a human system to create developmental value.' (Morgan 2006)

According to Lusthaus et al (1999), in their review of uses of the concept of capacity, most definitions of capacity share the following elements: (1) capacity building is about strengthening or enhancing something that already exists, rather than building up brand new institutions; (2) capacity building is oriented on the longer term and seeks to contribute to sustainable social and economic development; and (3) capacity building responds to needs as identified by the people in question and helps them to attain their own developmental objectives.

3.1.3.2 Approaches to capacity building

Concepts of capacity and capacity building have become a central to the strategies of many agencies that provide funding and technical support for economic, social or institutional development, despite the fact that the concepts, language and frameworks for capacity building remain fragmented and unclear and the fact that there is little agreement about how best to undertake capacity building or how to measure its success (Lusthaus et al, 1999; Whyte, 2004; Boesen & Therkildsen, 2005; Morgan 2006).

The current emphasis on capacity and capacity building should be understood in the context of shifts in development thinking over time (see Table 2). For example, while early approaches to capacity building focused on building individual professional skills (eg. through training programmes and graduate-level education), over time capacity building has come to focus more on strengthening the performance of institutions and ensuring the 'sustainability' of these institutions (Whyte, 2004). This is in line with broader trends in donor funding which favour channelling funds through governments and government sectors and which emphasise good governance and institutional change.

Table 2: Evolution of donor approaches in capacity building for development

Evolution of donor approaches in capacity building for development[8]

Decade	Terminology	Capacity Building Approaches
1960s	Institution building	Provide public-sector institutions Design functioning organizations Focus on individual organizations Models transplanted from North Training in Northern universities
1960s–1970s	Institutional strengthening/development	Shift to strengthening rather than establishing Focus still on individual organizations Provide tools to improve performance Training in the North
1970s	Development management/administration	Reach neglected target groups Improve delivery systems and public programs to reach target groups
1970s–1980s	Human resource development	Development is about people Education, health, population key sectors to target People-centered development emerges as concept
1980s–1990s	New Institutionalism	Structural adjustment, policy reform, governance paradigm Capacity building broadened to sector level (government, private, NGOs) New focus on networks More attention to external environment and national economic behavior Shift from project to program focus Concern with sustainability of capacity-building efforts
1990s	Capacity development	Reassessment of technical cooperation Donor discussions on capacity building Coalescing of different ideas around capacity building Emergence of importance of local ownership Participatory approaches seen as key
2000s	Capacity development/ knowledge networks	Millennium Development Goals become key driver Increased participation in capacity building Spread of ICT-based knowledge networks Emphasis on ongoing learning and adaptation Systems approaches and emerging talk of complex systems Balancing results-based management and long-term sustainability More emphasis on needs assessment/analysis Increased donor coordination Concern with how to secure long-term donor investments

Source: Whyte (2004), adapted from Lusthaus et al (1999)

The earlier focus on individual-level capacity building has given way to 'systems approaches' aimed at multiple levels: individual, community, organisational, sector-wide, regional and national. Such approaches are based on the understanding that these different contexts are 'nested' and that for capacity building at one level to be effective it must take into account other elements of the larger system (Whyte, 2004). The effectiveness of such an approach, however, depends on correctly assessing which broader contextual and structural factors can be influenced and

shaped, and which are beyond influence. There are different views about the role that outside agents, such as donor agencies, can play in building capacity. Some argue that capacity development must be largely a 'domestic affair' if it is to be successful (Boesen & Therkildsen, 2005).

3.1.3.3 Organisational capacity building

These broader trends in thinking about capacity building have influenced the way capacity building has been approached at an organisational level. Issues of long-term organisational sustainability have become more important, as donors have learned from experience that many organisations struggle to survive once external support is withdrawn. As a result, areas of competency such as business plans, leadership and governance, and organisational ownership have become more important over time (Whyte, 2004).

In her review of donor approaches to capacity building, Whyte identifies some key shifts in the way organisational capacity building is currently approached:

- A shift away from developing individual 'professional skills' towards general 'institutional competence;'
- Closer links between training for individuals and strengthening their home institutions;
- A move towards interdisciplinary training, rather than narrow skill sets;
- Emphasis on leadership training;
- Emphasis on good governance and organisational administration (finances, administration, human resources);
- Strengthening inter-organisational networks;
- More attention to the gender and equity dimensions of training programmes.

Approaches to organisational capacity building generally emphasise the ability of an organisation to analyse its environment; to identify problems, needs, issues and opportunities; to formulate strategies to deal with these problems, issues and needs; to design a plan of action; to assemble and effectively mobilise resources to implement, monitor and evaluate the plan of action; and to solicit and utilise feedback to learn lessons on an on-going basis (ACBF, 2001).

Some of the most common formats for capacity building include the placement of long and short-term advisors and consultants (local and international); training programmes (both short and long-term, in-country and overseas); providing computers and software for training purposes; twinning arrangements between organisations; and research and policy workshops (Whyte, 2004).

At an organisational level there is sometimes a tendency to think of capacity constraints as only about a lack of resources – funds, transport, and skills – and to explain limitations in effectiveness by a lack of 'inputs' (Boesen & Therkildsen, 2005). However, according to Boesen & Therkildsen, such analyses need to be closely questioned, since it 'invites the conclusion that the solution to capacity development is to provide…more funds.' This is rarely the only problem – organisational effectiveness needs to be examined in the context of the appropriateness of the organisation's goals in relation to its available resources, inflexibility and rigidity in the way budgets are set up, and the effect that uncertainty over future funding may be having on the level of on-going work.

Morgan (n.d.), in one of his organisational case studies, concluded that the organisation had 'within itself' most of the potential solutions needed to improve its capability and performance, and that the key was determining how to unlock this knowledge and potential. He argues that capacity development strategies are not 'programmable,' since they depend upon experimentation and improvisation in a given context. There is a danger that organisations try to expand and change too quickly. Rather, what is required is to 'act with strategic intent over time.'

An important question, therefore, that needs to be answered at the beginning of any capacity building programme is 'building capacity for what?' Is it to improve the quality of service delivery, to ensure compliance with accountability requirements, or to build long-term organisational

sustainability? The approach to capacity building that is ultimately taken needs to be determined first and foremost by the expected outcome of such a programme. There are numerous methodologies available for assessing and optimising organisational capacity, many of which are linked to theories of organisational change and growth.[2]

3.2 HOME AND COMMUNITY-BASED CARE IN SOUTH AFRICA

South Africa is home to one of the world's most severe HIV/AIDS epidemics, with an estimated overall national HIV prevalence of 10.8% among the general population aged 2 and above (Shisana et al, 2005). Rising HIV prevalence and associated mortality rates have increased the burden on the state's healthcare and social systems. Civil society has responded to the need for community-based care services through NGOs, CBOs and FBOs. These groups provide a range of services including care for bed-ridden and home-bound patients, assistance in accessing grants, childcare, food parcels and referrals to other services. Such services have become known collectively as Home and Community-Based Care (HCBC).

Over time, as the policy framework for HIV and AIDS response has been strengthened and more resources have been made available for programmes and interventions, the work of HCBC organisations has been brought into the national response framework in a more systematic way, including the provision of funding to HCBC organisations and the development of guidelines to shape their work.

This section reviews key policies and guidelines that relate to the work of HCBC organisations in South Africa. It is followed by a section that summarises the findings of previous studies on HCBC organisations in the country.

3.2.1 Policy Review

3.2.1.1 HIV/AIDS/STD Strategic Plan for South Africa, 2000-2005

The HIV/AIDS and STD Strategic Plan is the overarching framework that guides all responses to HIV and AIDS in South Africa. The Plan's primary goals are to reduce the number of new HIV infections and to reduce the impact of HIV and AIDS upon individuals, families and communities. The Strategic Plan is multi-sectoral in orientation, foreseeing roles for government, civil society and the private sector within its broad parameters.

The Plan is structured into four key areas of intervention: prevention; treatment, care and support; research, monitoring and surveillance; and legal and human rights. One of the sub-goals under treatment, care and support is to provide adequate treatment, care and support services in communities, including implementing models of community/home-based care in all provinces and promoting the acceptability of such care. Among the strategies to be used are the development of implementation guidelines, the establishment of inter-sectoral teams at community level to develop HCBC activity, and use of the media to explore and promote the role of HCBC organisations. The lead agencies for these activities include the Department of Health, the Department of Welfare, NGOs and the media.

3.2.1.2 Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa, November 2003

The Operational Plan provides a detailed framework for the care and treatment of South Africans infected with HIV and AIDS, including the provision of anti-retroviral treatment.

[2] See, for example: CORE Initiative, 2005; UNDP, 2005; Simon & Donovan, 2001; Lusthaus et al, 2002.

The Plan recognises the role of HCBC organisations in providing services to people infected with HIV and AIDS. It identifies home-based care as a useful tool for assessing and supporting patient adherence to ARV and other therapies, including locating and reaching out to patients who miss scheduled appointments, and promoting continuity of care and adherence with ARV regimens.

The Plan also recognises the importance of community-linked prevention strategies carried out through organisations such as FBOs, workplace programmes, traditional health practitioners, and PLWHA and notes that such services can do a great deal to minimise fear and discrimination, providing and reinforcing accurate information to address stigma surrounding HIV infection.

The Plan acknowledges the contributions of both paid and volunteer caregivers, noting the risks of burnout from emotional and psychological stress and overwork. It advocates for the provision of time and structured programmes for debriefing and grief management for caregivers.

3.2.1.3 Guidelines for the Establishment of Home/Community-Based Care and Support Programmes, Department of Social Development.

These guidelines, developed by the Department of Social Development, are intended to assist individuals or groups wishing to establish HCBC projects. The document takes readers through a sequence of technical steps, such as performing community needs assessments, calling for volunteers, and establishing management committees.

The guidelines do not directly address any organisational capacity issues, but recognise the need for HCBC management committees to be trained on project management, fund-raising and resource mobilisation, financial management, networking and relationship building, accounting and reporting to donor agencies, governance, people management and drafting operational plans.

3.2.1.4 Non-Profit Organisations Act No. 71 of 1997

The Non-profit Organisations (NPO) Act was established to create an environment conducive for the functioning of NPOs. It establishes an administrative and regulatory framework for the operation of NPOs to conduct their affairs and encourages NPOs to maintain adequate standards of governance, transparency and accountability. The Chief Directorate for NPOs is tasked with carrying out the provisions of the Act, including determining and implementing programs to help NPOs register and helping NPOs maintain and improve their governance systems.

To be registered as an NPO, the Act requires a group to submit a properly completed application form and two copies of the group's constitution. To maintain its registration status an NPO must provide a narrative report of its activities; financial statements; and an accounting officer’s report certifying that the group’s financial statements are consistent with its accounting records and that it has complied with the Act and its own constitution.

NPO registration is a requirement for tax exemption and is often a requirement for receiving donor funding. Compliance with the NPO Act (eg. maintaining registration) requires annual narrative and financial reporting.

3.2.1.5 Public Finance Management Act No. 1 of 1999

The purpose of the PFMA is to regulate financial management in the national and provincial governments; to ensure that all revenue, expenditure, assets and liabilities of those governments are managed efficiently and effectively; and to outline the responsibilities of persons entrusted with financial management in those governments

Conditional grant funds for the HCBC programme flow to provinces via both the DoH and DSD, and each province is responsible to comply with the PMFA for funds distributed to services providers. By implication, CBOs and NGOs in receipt of public funds are also called upon to comply with the Act and Guidelines.

The proper implementation of the PMFA will increase the speed and efficiency with which funds are distributed to service providers in the provinces and improve the transparency and feedback systems of the budgeting process. However, some of the standards outlined in PFMA, and the financial management processes that are required to meet them, may not be readily understandable or achievable by emerging community organisations without substantial and on-going assistance.

3.2.1.6 Expanded Public Works Programme – The Social Sector Plan 2004/5 – 2008/9.

The Expanded Public Works Programme (EPWP), adopted by Cabinet in November 2003, is one part of an overall government strategy to reduce poverty by providing work experience and short-term employment to unemployed South Africans. The programme is focused on unemployed, under-skilled and under-qualified persons and aims to draw significant numbers of the unemployed into productive work. This will enable them to earn an income; provide unemployed people with education and skills; ensure those participants in the EPWP are able to translate the experience and either enabled to set up their own business/service or become employed; and to utilise public sector budgets to reduce and alleviate unemployment.

Opportunities for implementing the EPWP have been identified in the infrastructure, environmental, social and economic sectors. The social sector (DSD, DoH and DoE) plan has two initial focus areas: Early Childhood Development and HCBC. Both programmes have traditionally been under-serviced and have relied heavily on volunteers and NGO/CBO service providers. The EPWP has provided an opportunity to work with these volunteers and develop their skills base and capacity to deliver quality service in an area of great need.

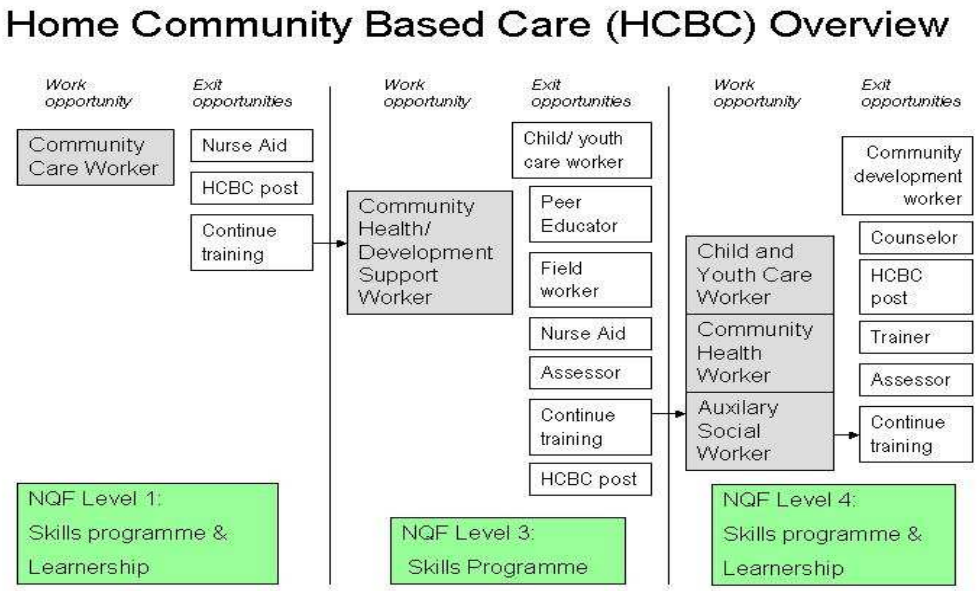
In relation to the HCBC component, the EPWP is targeting 122,240 work opportunities. This includes 19,988 work opportunities for existing volunteers who will now receive accredited training and an allowance and will work full time; 90,252 newly employed volunteers, rolling out a bridging programme to the Community Health Worker programme, working in partnership with Umsobomvu (National Youth Service) and creating 17,400 learnerships; and expanding HCBC to 300 new sites per annum, reaching 12,000 additional people with HCBC work opportunities. All the work opportunities are being provided in HCBC sites managed by NGOs, CBOs, FBOs or similar organisations. As such, the Departments are not providing the opportunities directly, but are facilitating them through their conditional grant funding programmes.

The special targeted beneficiaries of the HCBC programme are volunteers who are unemployed adult dependants of the terminally ill and people living with HIV/AIDS who are not in receipt of a state grant.

Figure 1 below provides a visual picture of the various work opportunities provided through EPWP. Beneficiaries can exit at the end of a 12 to 24-month workplace opportunity or can apply to continue training at the higher level. As only a limited proportion can be accommodated at the higher levels, the emphasis of the programme is on equipping people to find paid employment.

The plan standardises and caps the ‘allowance’ or stipend at R500 (or R1000 for more highly qualified individuals). While this stipend will represent welcome income for many new carers brought into the programme, it may also cause conflict: if one considers carers ‘employees’ who are effectively working full-time jobs, R500/month falls below the minimum wage, and some caregivers who are working *outside* the EPWP framework may receive different amounts. Further clarification is needed as to the extent to which the EPWP is exempted from much of the current labour legislation.

Figure 1: Overview of Home Community Based Care



3.2.2 Research on HCBC in South Africa

No large-scale studies on home/community-based care have been conducted in South Africa and no research has looked specifically at issues of organisational capacity among HCBC organisations. However some smaller-scale studies into various aspects of HCBC, and into community responses to HIV/AIDS more broadly, have produced findings of relevance to this research.

One of the earliest investigations into HCBC in South Africa was conducted by Russell and Schneider (2000), who reviewed 20 community projects in 1999 with the goal of identifying different models of community care, the challenges they were experiencing, and ways that the government could support their development. At that time, they found much evidence of attempts to provide care at community level, even though the coverage of services offered by HCBC organisations was still 'patchy.' Russell and Schneider identified five emerging models of care: (1) funding, technical assistance and support programmes; (2) advocacy and community mobilisation; (3) drop-in centres and support groups; (4) home visiting programmes; and (5) comprehensive home-based care. They also identified four different models for providing support to orphans.

Among the challenges they noted that face HCBC organisations were: managing a volunteer base, organisational structure, staff capacity, access to resources, forming partnerships and linkages, and a lack of standardisation in the quality of training and services. They concluded that there is a need for a large-scale technical assistance or capacity building programme, the development and dissemination of standards and guidelines for care, and the creation of an M&E system if community-based care is to become effective and sustainable.

An evaluation conducted by Fox et al (2002) for The POLICY Project examined the operations of seven hospices in South Africa that are implementing the Integrated Community-based Home Care (ICHC) model promoted by the Department of Health and the Hospice Association of South Africa. The report discusses the similarities and differences between the ICHC model and four other home-base care models. In relation to capacity issues, the report highlighted certain challenges in the implementation of ICHC, including the high demand for care services in many communities, the need for strong organisational management and infrastructure within hospices in

order to cope with changing needs, and the growing demands on management resources within hospices and similar institutions.

The Departments of Health and Social Development conducted a rapid appraisal of home/community-based care projects in South Africa in 2003. The study was designed to generate information about the location of existing HCBC and support programmes, the range of services being provided, the number of beneficiaries being reached, the level and types of human resources linked to programmes, partnerships, networking structures, funding sources, and level of expenditure being incurred. Close to 900 organisations were identified, with approximately half being NGOs and another third being CBOs. The greatest number of HCBC organisations was identified in the Eastern Cape and KwaZulu-Natal.

More than 30,000 personnel were affiliated to HCBC organisations, including more than 15,000 volunteers that were not receiving stipends and more than 4000 volunteers that were receiving stipends. Only a few organisations had the capacity to train other groups, and training was primarily focused on service delivery issues. For example, the study found that more than 29,000 personnel had been trained in HIV and AIDS and more than 17,000 in HCBC; however, only 2,983 were trained in project development and management. Organisations were in need of professional staff, management information systems, and basic office equipment. The study revealed that HCBC funding comes primarily from government, with comparatively little coming from NGOs, international organisations, and businesses.

The Community Agency for Social Enquiry (CASE) conducted a national evaluation of HCBC programmes for the Departments of Health and Social Development in 2004 (Mwite, Lopes & Dudeni). The assessment was designed to evaluate whether HCBC services were accessible to users, whether they adhere to common service standards, the range and quality of the services being provided, HCBC organisational capacity to deliver services, and the extent to which HCBC services are integrated with others in the community. The research involved a desk review, site visits to HCBC organisations, a survey of beneficiaries and caregivers, and interviews with provincial and national-level officials.

The evaluation found that the beneficiaries of HCBC services valued the care being provided to them by HCBC organisations, but that the impact of this care was limited by the lack of basic caregiving supplies and food parcels. Caregivers were found to be highly committed to their work, but only half of them reported receiving stipends and the amounts received varied widely. The relationship between the Departments of Health and Social Development was found to be constructive on the whole, but links between national and provincial government, on the one hand, and local government, on the other, needed to be further strengthened.

At an organisational level, the research found that 92% of the 120 organisations surveyed were registered as NPOs. Forty-eight per cent of the organisations had at least one full-time or part-time paid staff person. Sixty per cent of the organisations named lack of finances as their biggest problem, with 23% citing lack of transport and infrastructure. The most commonly noted internal organisational challenge was shortages of staff linked to absence of salaries. More than 85% of organisations surveyed provide basic training and support on home-based care, child and orphan care, training on first aid and counselling to their caregivers.

Naidu (2005) conducted an evaluation of the costs of HCBC programmes and the factors that promote and hamper HCBC activity. The study focused upon 13 HCBC programmes in the Nelson Mandela Metropol in the Eastern Cape, Ugu in KwaZulu-Natal and Sekhukhune in Limpopo. Data was collected via in-depth interviews with management and caregiver staff. Financial and economic costs were obtained from HCBC organisations to determine the total cost of services being rendered.

Although HCBC organisations' resources overall were limited, the research found that they manage their available funds well and spend their income on essential expenditures only. In many cases, organisations stretch their resources to cover a greater number of beneficiaries, which at

some point has negative consequences for the quality of services. Overall, the study found that the higher the cost of services, the better the content of the service.

The study concluded that the HCBC programmes examined were well-established with adequate infrastructure to deliver services in the community. HCBC staff are generally trained and are sensitive to the needs and values of the community they serve. However they need financial and material support from the government departments to deliver better quality services consistently

CADRE conducted an audit of local-level responses to HIV and AIDS in an urban, rural and small town setting in South Africa in 2003-2004, mapping the HIV and AIDS-related activities being carried out by NGOs, CBOs and FBOs (Birdsall & Kelly, 2005). Seventy per cent of the 88 organisations surveyed provided some form of care and support services, such as counselling, support groups, home-based care, and assistance to orphans and children. Civil society organisations were the primary providers of care and support services in all three sites. Most of the organisations relied heavily upon the contributions of volunteers, although only 10% of them paid stipends. Forty per cent of the organisations surveyed were receiving funding from government. Challenges around resources were commonly cited and there was a general lack of capacity for basic monitoring and evaluation.

The Horizons Programme undertook operational research on six home-based care programmes in four provinces of South Africa. The research analysed the cost of HCBC services being provided and assessed how best to use resources and how well the programmes meet the needs of their beneficiaries (Homan et al, 2005). The research included a review of financial records and service statistics, as well as interviews with programme staff.

Across the six cases, the scope and intensity of service provision varied in terms of number of clients and frequency of visits. Training and remuneration also vary, with the most common model being trained field staff (receiving a stipend or incentive) supplemented by a professional, salaried worker (nurse or social worker). Some of the main issues affecting caregivers include: lack of sufficient resources to meet the needs of sick patients; insufficient acknowledgement of their efforts and remuneration for their work; and concern that families of sick patients rely on them more than is practical or desirable. The study found that record keeping and data collection systems are not as developed in HCBC organisations as they could be, in part because of the lack of funding for institutional development and administrative systems. The researchers conclude that there is a need for longer-term funding arrangements for HCBC organisations which would allow them to plan better for the future. The economic and emotional support needs of caregivers also need to be addressed.

4 RESEARCH FINDINGS

This section presents key findings from the research and is structured into two main parts. The first part (section 4.1) focuses on findings related to management capacity within HCBC organisations. It begins by summarising the key expectations for HCBC management capacity that were expressed by officials from the Departments of Social Development and Health at national, provincial and district levels. It then presents findings on existing HCBC capacity across eight core competencies: governance, organisational management and leadership, human resources, financial management and resource issues, operational and strategic planning, service delivery, monitoring and evaluation, and networking. Finally, it reviews findings on the factors that influence HCBC management capacity, and summarises the areas of need in HCBC capacity building that were cited by respondents.

The second part (section 4.2) focuses on the findings from a review of mentoring and capacity building models for CBOs and NGOs in South Africa. It describes the range of models that currently exist and highlights key lessons that have been learned in their implementation to date.

4.1 HCBC MANAGEMENT CAPACITY

4.1.1 Expectations for HCBC management capacity

The provision of HCBC services by NGOs and CBOs is seen as a central component of the government's strategic and operational plans related to HIV and AIDS. There is a recognition that the scale of the required response is such that government needs to work in close partnership with civil society organisations to maximise the coverage of services available.

As recipients of government funding and implementing partners in the response to HIV and AIDS, HCBC organisations are expected to demonstrate certain key capacities in carrying out these roles. First, HCBC organisations are expected to comply with certain technical eligibility requirements (eg. registration, constitution); to manage their finances in an organised and accountable way; and to report regularly on their activities they conduct, including the numbers of people reached through various services. These can be understood as the minimum 'technical' capacities necessary for an organisation to be funded by government, and certain management structures and functions flow from these.

Second, at a more strategic level, there is an expectation that HCBC organisations be capable – or become capable, over time – of operating sustainably and relatively independently in providing care and support services to communities. It is envisioned that, with a certain degree of training, mentoring and support, HCBC organisations can evolve into established, self-governing institutions that are not solely dependent upon government funding and support, but which continue to work alongside government in providing care and support services. This suggests a more complex set of capacities that extends beyond mere technical fundability to include elements such as strategic planning, human resource management, resource mobilisation, monitoring and evaluation, and networking and external relations. These can be understood as the capacities required for quality service delivery and organisational sustainability.

Interviews with national, provincial and district-level officials highlighted expectations for HCBC capacity in relation to both of these realms. At a technical level, officials raised the following points:

- HCBC organisations are expected to manage their funding honestly and transparently, and to expend received funding on approved expenses only;
- HCBC organisations need to comply with the terms of the NPO act in order to be eligible for funding;

- HCBC organisations need to have the capacity to understand the terms and conditions of their funding agreements with government, and to fulfil these requirements; and
- HCBC organisations are expected to be capable of maintaining basic records about the services they render, so that they can provide statistics to government about the reach of their activities.

In relation to the strategic partnership role of HCBC organisations, the following points were raised:

- HCBC organisations need to be able to translate their implicit understandings of community needs into actual projects that can meet those needs;
- HCBC organisations need to be capable of diversifying their resource profile over time in order to become less dependent on government funding;
- HCBC organisations need to have the capacity to manage volunteers and remunerated staff, including identifying and recruiting personnel who are committed to their work and not simply motivated by a stipend;
- HCBC organisations need to be capable internally of sharing and internalising the training and capacity-building inputs they receive from other sources, rather than allowing it to vest with one or two senior individuals;
- HCBC organisations need to understand the value of monitoring and evaluation beyond basic reporting requirements and to develop systems that allow for information about their work to feed into larger data gathering efforts.

Against the backdrop of these expectations for HCBC organisations in HIV and AIDS response, the following section summarises the main findings about current HCBC capacity.

4.1.2 Overview of present HCBC management capacity

Findings related to HCBC management capacity are discussed in relation to eight broad areas, as follows:

- *Governance:* Issues related to the legal and statutory standing of the organisation (registration status, compliance with the NPO act, constitution, and organisational mission and goals);
- *Organisational management and leadership*: Structures and systems in place for leading and managing the organisation (board of directors, executive/management committee, roles of officeholders);
- *Human resources:* Systems/procedures for recruiting and managing volunteers/staff, policies and procedures governing personnel, remuneration, monitoring and evaluation of staff/volunteer performance, training and skills development;
- *Financial management and resource issues:* Issues related to financial accountability (bank account, bookkeeping, payment and procurement procedures, financial audits) and resource mobilisation (fundraising strategies, proposal development, diversification of funding);
- *Operational and strategic planning*: Approach to defining needs and operationalising programmes (situational analyses, community needs assessments, programme evaluations, level of participation and consultation);
- *Service delivery*: Programme implementation issues (identification of beneficiaries, quality of services, recordkeeping systems, case management, internal information sharing), support systems for caregivers, supplies and resources;

- *Monitoring and evaluation:* Systems for gathering and filing information about services rendered and impact, reporting and programme/project evaluation;
- *Networking:* Contact and collaboration with other organisations, including relationships with government, private sector and donors, involvement with local coordination bodies, and mentoring/capacity building arrangements.

In each of these eight areas, research findings are presented in an integrated way, drawing upon the observations of both government officials and HCBC representatives. In cases where clear distinctions can be made between the situations in different provinces, these are explicitly noted.

As indicated in the section on research design (see section 2.1), the HCBC organisations visited fell into three different categories of performance: efficiently and effectively managed, established and average performing, and emerging and performing at a low level. In the presentation of findings and discussion section, these categories are referred to as A, B and C respectively. HCBC organisations that are unregistered, or that have been de-registered or lost funding, are also referred to specifically where relevant.

4.1.2.1 Governance

Registration as a non-profit organisation (NPO) under the terms of the NPO Act of 1997 is one of the technical requirements for an organisation to receive funding from the Departments of Health and Social Development, as well as from most other funding institutions. NPO status also allows an organisation to qualify for tax exemption and bestows a degree of legitimacy upon an organisation by recognising it as a formalised entity. Once registered, organisations are required to meet annual compliance requirements (eg. financial and narrative reports) and can be deregistered if they do not do so.

Applications for NPO status are processed at national level, through the NPO Section of the National Department of Social Development. There is no cost to registration; organisations are required to submit two copies of their constitution along with a completed application form that indicates how compulsory requirements are addressed in the organisation's constitution. There are currently 35,000 registered NPOs in South Africa and new applications are received by the national office at the rate of about 500 per week. Approximately 40% of these are accepted and the remainder are returned to applicants with feedback about further information that is required. A staff of 12 people is responsible for overseeing NPO registration and compliance, and processing backlogs are reported.[3]

Interviews with HCBC organisations bore out observations made by an official in the NPO section, who noted that registration and compliance with the NPO Act is not difficult for most established NGOs, but can pose significant challenges for emerging organisations who are 'inhibited' by the process.

Among the 12 HCBC organisations researched, nine were registered, one had applied for registration and was awaiting notification, one was unregistered and one had been deregistered. The more mature organisations did not express any difficulty in regard to applying for or complying with the NPO Act. By contrast, district-level social workers had been instrumental in assisting two of the emerging ('C-type') organisations to become registered by walking them through the application process. At least two registered organisations had had their initial applications returned as incomplete, while the unregistered organisation had little knowledge about the application process or how to approach it.

Officials at the provincial and district level noted that young organisations are sometimes focused upon the process of getting registered in order to access funding (eight of the nine registered

[3] A focus group discussion with district-level DSD officials noted waiting periods of 1-2 years for NPO registration.

HCBC organisations cited access to funding as the main motivation for registering as NPOs), but do not fully understand the compliance implications of registration. While district-level officials are active in assisting organisations in their area to become registered, it was frequently noted that their workloads are so heavy that they cannot possibly support all emerging organisations with the support they may require to remain compliant.

Eleven of the twelve HCBC organisations had constitutions, but for the most part these did not seem to be living documents that have a real bearing on the way the organisations operate. Organisational constitutions are a requirement for NPO registration, and some of the emerging HCBC organisations had used template constitutions provided by district-level officials and completed them with the relevant information as part of the registration process. Constitutions seem to exist largely as formal documents that outline the organisation's mission and goals, membership, management structures, financial responsibilities, and the roles and accountabilities of office holders.

HCBC organisations are able to articulate what they do and the reasons why they exist as an organisation. Mission statements and objectives are captured in organisational constitutions, but the extent to which they are consciously drawn upon in operations and planning processes varies across HCBC organisations. Generally, the NGOs were more sophisticated in their understanding of their mission and goals, and were more inclined to evaluate their actions and impacts in relation to these and to think critically about the changing relevance of their missions and goals over time. Emerging organisations which are still building up experience in service delivery displayed less of a tendency to reflect upon their mission and goals and focused more upon their ongoing activities.

It was observed by DSD officials at a number of levels that most HCBC organisations know what the needs are in their communities, but do not necessarily know how to translate these needs into articulated objectives and implementable programmes. The same can be said for mission statements, which seem to exist largely as formalities on paper, rather than as a guiding vision to be drawn upon in refining and evolving an organisation's work. Mature organisations that have more experience and a greater degree of ownership of their activities may be better placed to use their mission statements strategically to shape their organisational development over time. Among the 12 HCBC organisations interviewed in this study, only one of the most established NGOs could be regarded as having the capacity to do this.

4.1.2.2 Organisational management and leadership

There are three different levels of leadership that can be considered in relation to organisational management: a *board of directors* or advisors, comprised of members of the community and key staff from the organisation who provide overall strategic direction and guidance; a *management or executive committee*, comprised of senior staff who oversee day to day operations;[4] and *programme or department managers*, who oversee the work of particular teams of staff within the organisation.

Most emerging organisations begin with an internal management or executive committee, often comprised of founding members, and may evolve, over time, to greater degrees of managerial complexity. External boards of directors can be instrumental in mobilising resources for the organisation, brokering partnerships with other institutions, and helping to raise the organisation's public profile.[5] As an organisation grows larger and its activities diversify, internal layers of management – in the form of programme or department heads – may become necessary to oversee staff working in various programme areas.

Of the 12 HCBC organisations interviewed, 11 had either an executive committee or management committee that oversees day to day operations; of these, two also had an external board of

[4] The terms management committee and executive committee (Exco) are used interchangeably.
[5] The involvement of 'external' people on a board of directors also reduces the likelihood of fraud.

directors. The twelfth organisation had only a board of directors. A small number had programme managers that oversee specialised teams of personnel.

The most common management model in relatively young HCBC organisations is an Executive Committee comprised of five to seven office holders (eg. chairperson, deputy chairperson, treasurer, secretary) who are chosen from among the HCBC members[6] and oversee the day to day functioning of the organisation. Exco positions are generally unpaid, although its members who are also caregivers may receive monthly stipends. The committee members are selected from among the member-caregivers, and members generally have no particular skills or training for their posts. The role of the chairperson is commonly understood as representing the group and as chairing the monthly meetings. The secretary takes minutes and the treasurer cashes cheques, collects receipts and in some cases tracks spending.

Although Exco office holders hold distinct portfolios, in many cases their roles are fairly undifferentiated – in other words a number of functions, such as fundraising, external representation and planning, remain collective rather than individual responsibilities. The membership of Excos rotates annually on an election basis. It should be noted that this is the standard organisational management 'formula' outlined in the sample organisational constitution adopted by many newly established HCBC organisations.

More established organisations have slightly more complex management structures. Some NGOs in the study had external boards of directors comprised of doctors, lawyers, nurses, community workers, or other professionals who volunteer as board members in an advisory capacity. In these organisations, the internal management was more 'permanent' than within CBOs and were often salaried staff, thereby differentiated from volunteers who receive a stipend or are not remunerated at all. In such cases, job descriptions were more differentiated and office holders had particular training or expertise related to their functions, such as bookkeeping, social work or management training. In the largest HCBC organisations, programme managers were responsible for a team of staff or volunteers who provide a particular service; these managers report upwards to the management/executive committee and ultimately to the board of directors.

In all organisations, except perhaps the very smallest where roles have not differentiated, there were tensions and challenges between those in management positions (including members of the board) and rank-and-file caregivers. Feedback from HCBC members regarding the contributions of their boards and/or Excos was mixed depending on the composition of its members, their perceived dedication, their motivations, and the extent to which they are seen to understand the community. While some saw their leadership structures as actively engaged and committed to building the organisation, others perceive a gap between the management and the volunteers or point to autocratic forms of decision making and leadership that leave the caregivers feeling alienated.

4.1.2.3 Human resources

HCBC organisations are staffed in a variety of ways, ranging from a mix of salaried and volunteer personnel through to fully volunteer-run organisations. It can be challenging to describe the human resource profile of HCBC organisations due to the many different staffing and remuneration arrangements which exist and the confusing and overlapping terminology applied to these arrangements. This includes 'volunteers' who receive monthly stipends for their work and volunteers who receive no stipends (and are thus volunteers in the truest sense of the word) and HCBC 'members' and 'staff' who could be in either management or non-management roles, remunerated or non-remunerated.

[6] Indiviudals affiliated to HCBC organisations are often referred to as 'members' of the HCBC organisation. In many cases they are also caregivers, although the two designations are not interchangeable as there are people involved with HCBC organisations that do not provide care services and may play other roles within the organisation.

While it is difficult to generalise about the human resource situation within HCBC organisations, it should be noted that only a minority of HCBC organisations employ staff on a formal, salaried basis.[7] In the 12 organisations considered in this study, there were approximately 8 full-time paid staff (the majority of whom were employed in the two 'type A' HCBC organisations) and more than 400 volunteers. The number of volunteers per HCBC ranged from a low of 10 to a high of 270.

A stipend was paid to volunteers in 10 of the organisations; the other two organisations were unfunded and therefore not in a position to pay stipends. Stipends were generally R500 per month. Apart from one organisation where a lunch allowance was paid, there were few or no tangible or material incentives for volunteers apart from the stipend.[8]

In interviews with both HCBC organisations and government officials, the practice of paying volunteers stipends was repeatedly and consistently identified as a highly fraught issue. Among the points raised were the fact that not all volunteer caregivers receive stipends, that the payment of stipends is sometimes delayed (prompting discontent and protest from caregivers), that stipends are not adequate compensation for the difficult and essential 'care work' being conducted by volunteers, and that the stipend is too often perceived as a salary even though, from the perspective of government, it is clearly and deliberately framed as a 'thank you.'

Among the 12 HCBC organisations, there were wide-ranging understandings of the concept of 'human resource systems' and 'human resources management.' Some of the newest organisations work in quite a mechanistic way, with a fixed number of caregivers affiliated to the project and little by way of procedures, policies and systems to bind those individuals to the larger organisation. For such HCBC organisations, the notion of a human resource system comprised of interrelated components was not readily grasped.

Among the more established organisations, elements of a human resource system become more apparent: in addition to more developed policies and procedures, this system might also include an awareness of the skills that are present and lacking among staff; understanding and articulating the types of qualities they are looking for in new volunteers; and the presence of a small number of staff with specialised qualifications in areas like bookkeeping and social work. As organisations grow larger, human resource systems appear grow apace – if only for administrative purposes. However the findings also suggest that even the 'type A' organisations face human relations challenges, particularly in terms of the professional development and empowerment of volunteer caregivers and internal communication between managers and other staff.

Relationships between HCBC organisations and their staff are not always formalised, and when they are formalised they take different forms. In five organisations there was some form of contract outlining the terms of the relationship between the HCBC organisation and the member; in three of these the contracts included job descriptions or key performance areas. In three other organisations volunteers operated on the basis of signed membership forms, pledge forms, or daily sign-in sheets. In organisations where volunteers are paid stipends, but there are no contracts, the relationship is governed by a 'gentlemen's agreement' that stipends will be paid in return for caregiving work.

HR-related policies and procedures seem to emerge as an organisation matures and evolves. The younger, less established organisations had few or no policies in place, while the most established among the sample had a complete set of policies and procedures ranging from codes of conduct and confidentiality agreements through to office policies related to fire hazards. Where policies do exist, the most common ones are codes of conduct and disciplinary procedures. Leave policies and HIV/AIDS policies were in place in only a small handful of organisations. Although the evidence was somewhat contradictory, there is reason to believe that most HCBC organisations

[7] Including, for example, contracts and benefits such as medical aid and provident funds.
[8] One organization provided food parcels to volunteers and issued a 'Home-Based Carer of the Month' certificate.

in this study were not well-informed about South African labour law, including the Basic Conditions of Employment Act.

The processes by which volunteers are recruited into HCBC organisations also differ from one organisation to another, ranging from a formal strategy for attracting applicants and reviewing their experience and qualifications, through to fairly ad-hoc word-of-mouth processes. In one of the most developed HCBC organisations, new caregivers are hired according to a standard procedure and serve out a probation period during which their performance is appraised and reviewed. However this degree of deliberateness was not widely in evidence; in most organisations there were informal processes in place for attracting new volunteers, such as announcing opportunities at local community meetings or putting the word out through personal networks.

Some government officials noted that HCBC organisations are challenged in recruiting volunteers who have 'the right motivations' for undertaking caregiving work – that there is a risk, particularly in impoverished areas with high levels of unemployment, that volunteers are motivated more by the prospect of a monthly stipend than by the content of the work, and that this can feed into both discontent with the 'stipend policy' and subsequently into a high turnover rate. Among HCBC organisations it is clear that this pattern does exist to an extent, but it should also not be overstated. Volunteer caregivers who find jobs elsewhere *are* likely to cease working as volunteers, but there are also organisations where a core group of caregivers carry on in their roles for relatively long periods of time and where high turnover does not appear to undermine the ability of the organisation to function.

Systems for monitoring and managing the performance of staff were more sophisticated among the larger HCBC organisations, where staff were affiliated to departments or teams that are headed by a dedicated manager who provides direct management and oversight. However in the bulk of HCBC organisations, the HR systems remain at a fairly basic level and have not yet evolved in the direction of a performance management system. For example, in most HCBC organisations, staff do not have differentiated roles or individual workplans and the work of the organisation is done more or less collectively. Tasks are not linked to certain standards or indicators and monitoring the quality of work is done through spot checks, if at all.

In terms of training and professional development, many but not all volunteer caregivers in the organisations surveyed had undergone basic training, with the '59 day' module the most commonly mentioned form of training.

4.1.2.4 Financial management

Basic financial management competencies are essential for any organisation that receives external funding. All of the funded HCBC organisations in the study had some form of financial system in place. These systems ranged from basic receipts-based systems to account for expended funds, through to electronic budget and accounting systems to manage multiple sources of funding, track and project expenditure, and generate financial reports. The degree of sophistication of the financial systems increased with the size and complexity of the organisation.

One of the notable differences between the HCBC organisations is the extent to which they need assistance to handle their financial affairs. While some organisations have evolved systems and basic expertise that allow them to manage their finances relatively independently, others receive significant support from the Department of Social Development. In several of the younger HCBC organisations, DSD officials appear to be quite 'hands on' in helping the HCBC organisations to develop budgets and review and track expenditure.

To the extent that it is possible to generalise, the newest HCBC organisations ('type C' organisations) tend to have basic financial systems that include minimum number of signatories for cheques; retaining and organising receipts related to expenditure; sign-off sheets for payment of stipends; monthly bank reconciliations; and annual audits. The treasurer of the organisation

would be nominally responsible for these functions – particularly gathering and organising receipts and sign-off sheets – and would be supported in this role by DSD officials as needed. For all of these organisations, DSD is the only source of external funding and the finances are therefore relatively straightforward to manage: the financial management requirements are clear and unambiguous and DSD officials provide close oversight.

When organisations receive more than one stream of funding, their systems and procedures become more complex. Budgeting and expenditure needs to be done individually per donor, and reporting requirements also differ. The paperwork linked to financial transactions becomes more extensive and data may be kept electronically, rather than on paper. As sources of funding become more numerous, HCBC organisations need to grapple with formulas for covering institutional and general operational costs that can not be linked to specific project budgets. In the two 'type A' organisations, trained bookkeepers handle the finances. In a number of cases, financial management was effectively 'outsourced' to a part-time bookkeeper or someone not directly involved with project implementation.

The main sources of funding for the HCBC organisations were the Department of Social Development (national and provincial) and Department of Health (national and provincial); local funders such as the AIDS Foundation of South Africa, the Development Bank of Southern Africa, Old Mutual, CANSA, and Labour Job Creation Trust; and international donors such as the Elton John AIDS Foundation, UNDP, Save the Children, Rotary Club and the US Embassy. Of the 12 HCBC organisations, six had government as their sole funder, four groups had more than one source of funding, and two groups had no funding at all. There were also examples of small-scale income generation activities among some of the HCBC organisations, such as soliciting donations from the community and selling sweets and baked goods at pension pay points to buy food parcels for patients.

Fundraising emerges as a clear weakness in many organisations, particularly in CBOs for whom government funding is the only support they have ever received. Very few groups had any kind of marketing or fundraising plan. The main limitations to their ability to fundraise were lack of awareness about potential sources of funding, little or no experience with proposal writing, and little familiarity with other approaches to resource mobilisation. In almost all the organisations the responsibility for fundraising was a collective one, spread across the organisation's management. In some of the more established organisations the director or members of the board of directors were actively involved in pursuing funding opportunities.

Government respondents were almost unanimous in their assessment of fundraising as a major point of weakness in HCBC management capacity. There was also recognition from government officials that a large proportion of emerging HCBC organisations are solely dependent upon government funding, as opposed to receiving support from a diversity of sources.

4.1.2.5 Operational and strategic planning

Operational and strategic planning exercises can be used by organisations to identify priorities, highlight important trends related to their work, and determine programmatic interventions. While strategic planning exercises orient on a longer-term perspective (at least a year in advance, but possibly longer), operational planning focuses upon shorter-term workplans. Both types of planning are commonly based upon some sort of situational analysis or assessment of the context in which the organisation works.

There is limited evidence of this type of planning among the HCBC organisations studied, although eight of the organisations reported having some type of strategic plan. The organisation with the most developed approach (a type 'A' organisation) has annual planning sessions at a departmental level that then feed into the organisation-wide plans that are developed by an internal committee. They use a variety of methods for understanding and assessing community needs, including links with the local clinics and homes for the elderly; participation in a local

service provider network; discussions with social workers, caregivers and home-based care clients; and notes taken during staff and management meetings.

Most organisations, however, do not have such formal and regular processes in place, and planning is more loosely informed by 'meetings with stakeholders' or 'door-to-door visits' in the community. Only three organisations mentioned conducting some type of situational analysis, and all of these were once-off efforts. Although there was little understanding of what a situational analysis entails in organisations that did not do structured situational analyses, most of the organisations knew and were able to articulate the needs of the people they serve. This was expressed in a variety of ways: 'we know what we are supposed to do,' we 'go with our own experience', or we use 'word of mouth' and feedback from patients. The issue, therefore, is less about the actual approach used – formal and structured, or informal and on-going – but rather how these understandings of the local context are ultimately factored into an organisation's focus and orientation.

One of the most commonly mentioned planning tools was the 'business plan' that is prepared as part of the process for receiving support from DSD. Particularly among the newer HCBC organisations, the business plan emerged as the primary planning and operational document. In some instances, staff from the Department of Social Development have been actively involved in preparing and shaping this plan.

In a number of instances, HCBC organisations noted that the management or 'top staff' were responsible for planning activities, with limited participation from other staff. This comment was heard from several HCBC organisations of different types and stages of development. By contrast, however, a small number of emerging organisations indicated that they essentially plan collectively – 'we just caucus among ourselves.'

Neither CBOs nor NGOs had goals that were outcomes-based, measurable or time-based. As is noted in section 4.1.2.1, mission statements were not used actively in defining organisations' plans and actions. In fact, the research uncovered instances where the services being offered by groups had changed in relation to their original mission and goals. The most common shifts involved adding services for children of patients, food security activities, facilitating access to grants, education and counselling. Few groups had consciously made the decision to change their mission or goals (and to update their constitutions accordingly); rather they were responding to changing situational needs or donor agendas.

4.1.2.6 Service delivery

The research was not specifically designed to assess capacity for service delivery. Nonetheless, it is possible to present some broad findings that relate to the conditions that exist within HCBC organisations that affect their service delivery role.

The visibility and accessibility of HCBC services in the community is important for the effectiveness of their service delivery function – for example, by allowing for 'drop ins' by people who might want to access their services. The HCBC organisations in the study operate out of widely varying physical spaces and with a range of equipment. The two most established organisations (type 'A') work from their own facilities with a full range of office equipment, storage space, and in one instance, vehicles. The type B organisations also operate from publicly accessible premises – one has a room at the local clinic and one has an office with a five-year lease – while at least three organisations have no office space.

Some HCBC organisations noted that they face operational challenges due to the lack of transportation and to insufficient or sporadic availability of key supplies, such as home-based care materials. Particularly in rural areas, lack of transportation – or funds to cover transport costs – limits the quality and scope of the services provided. This was corroborated in interviews with many officials from the departments of Social Development and Health, who noted an overall lack of resources among many HCBC organisations, extending from absent or insufficient

infrastructure through to a shortage of funds for basic running expenses, transportation, and caregiver stipends. The limited resource base is often mentioned hand-in-hand with weak fundraising skills – suggesting that a vicious circle is at play in many emerging organisations trying to establish themselves.

HCBC organisations use different systems for meeting internally about the services they provide. Three organisations report holding daily meetings with volunteers to review the status of patients and to address difficult cases; four organisations have such meetings weekly and two organisations – monthly. Only one organisation indicated that minutes of meetings were kept.

Support systems for caregivers also vary. Apart from one emerging organisation where there are no debriefing or counselling opportunities for caregivers, every other HCBC in this study had in place some form of support for caregivers. These included regular meetings, debriefing sessions, and informal counselling sessions.

4.1.2.7 Monitoring & reporting

Monitoring and evaluation (M&E) is an increasingly emphasised area of work for organisations in the field of HIV and AIDS. Donor institutions are keen to understand the impact of the funding they make available, as well as the number of people reached through interventions. The Departments of Health and Social Development are no exception in this regard, and expect that the organisations they fund be able to provide them with basic information about their activities and the numbers of people reached with services.

Monitoring and evaluation systems encompass a range of functions – from tracking and documenting work done (eg. recordkeeping systems), gathering information about the impact of that work (eg. feedback from clients), and specially designed evaluations that assess the extent to which planned objectives were met over the course of an intervention.

Findings about the capacity of HCBC organisations to monitor and document their work were mixed. On the one hand, there were DSD officials who expressed frustration that some HCBC organisations that are being funded by the department are not able to provide them with the type of data and statistics that they require for planning and evaluation purposes. On the other, at the level of the HCBC organisations themselves, there appear to be at least basic forms of recordkeeping in place. The issue appears to be in the alignment between these systems and the types of data requests that are made: in many cases HCBC organisations employ paper-based, manual recordkeeping systems that may not be well-suited for quickly generating data about project activities and numbers of people reached with services.

Systems for record keeping related to case management become more evolved as HCBC organisations grow and mature. In most emerging HCBC organisations, caregivers keep hand-written notes about their patient visits in small notebooks that form the basis for reports to DSD and other funders. It is not always clear what rules, if any, apply to the monitoring and use of these records, including how they are stored. In the established and mature organisations, case management systems are more formalised, involving patient intake and assessment forms, confidentiality agreements with caregivers, and records on children in the households they work with – all kept in locked cabinets.

In most of the HCBC organisations, reporting functions are the responsibility of the chairperson or director, although in the case of HCBC organisations that are running more than one project (using different streams of donor funding), reporting responsibilities are decentralised to the respective programme heads. However it should be stressed that this is the exception, rather than the norm, as few of the HCBC organisations in this study had evolved to this level of complexity.

There was no evidence emerging from this research that any of the HCBC organisations in the study had conducted formal evaluations of their programmes.

4.1.2.8 Networking and external relations

Links and partnerships with other organisations can be of great help to HCBC organisations at all stages of development. They can assist in accessing information and opportunities, transferring knowledge and skills, and engaging in advocacy work.

Eight of the 12 HCBC organisations in this study indicated that they had links with other organisations. Emerging organisations were the least networked, but the more established organisations reported links with a range of groups: local AIDS councils, home-based care networks, the Khomanani campaign, local health forums, hospices and other 'stakeholder' meetings. Links with government departments – not only Social Development and Health, but also Education and Agriculture – were cited. One of the respondent HCBC organisations (a hospice) has close links with the National Hospice Association.

One NGO had established a local networking forum that brought together local officials and other leaders, community members and other civil society organisations. The purpose of the forum was to avoid the duplication of services, to share lessons and to tackle common challenges together.

Another CBO had close ties with other CBOs working in the same district because of the leader's additional roles on municipal healthcare committee and her attendance at the DoH-led Local AIDS Council. A few of the other HCBC organisations participated in their local Community Childcare Forums or had links with local CBO/NGO networks, such as SANGOCO.

Organisations reported that they network with other groups through stakeholders and town meetings, by sharing clients, through referrals, and by attending government events and meetings. Links with local businesses appear to be quite underdeveloped.

4.1.3 Factors affecting HCBC capacity

Following on the presentation of key findings about existing HCBC management capacity, this section presents findings on factors which may influence this capacity. It draws upon interviews and group discussions conducted with government officials and HCBC representatives and highlights issues that respondents believe are shaping the capacities of HCBC organisations (both enabling and limiting them). These factors are presented thematically, moving from macro-level systemic factors down to more specific ones.

4.1.3.1 HIV and AIDS and the Home Community-Based Care Environment

Against the backdrop of a worsening HIV and AIDS epidemic in South Africa, there has been a rapid increase in the number of community-level organisations that conduct activities in response to HIV and AIDS. Some of these organisations have emerged in response to perceived needs, while in other cases their creation has been encouraged by government officials or other funding institutions seeking local-level partners to provide home and community-based care services. The HCBC sector has grown exponentially and its very growth creates challenges for capacity building, sustainability, and quality of service delivery.

Government officials often spoke of a 'mushrooming' of HCBC organisations that are not necessarily properly trained or equipped to provide services, to report on activities, and to account for financial support. Many newly emerging HCBC organisations are staffed by individuals who have limited work experience and qualifications. This puts strain upon the sector as a whole, as efforts to streamline, rationalise, and develop HCBC are sometimes eclipsed by the pace of growth and change. A large number of small organisations are emerging in an environment where resources to support their work are either insufficient or difficult to access; where training and capacitation is not always readily available; and where the policy framework, including unified norms and standards for HCBC organisations, is still evolving.

4.1.3.2 Policies affecting financial support to HCBC organisations

Government support for HCBC organizations is informed by a variety of overlapping policies, frameworks and guidelines that emanate from both the Department of Social Development and the Department of Health (see section 3.2.1 for more detail on the policy framework). This policy environment is still evolving and a number of officials noted the need for updated, integrated norms and standards to govern various aspects of home community based care.

Three particular areas related to government policy emerged in the research as directly affecting HCBC capacity.

Any HCBC receiving government funding is subject to the conditions of the *Public Finance Management Act* (PFMA), which ensures the efficient and effective management of government revenue and expenditure. Yet the findings from this research suggest that some of the standards outlined in PFMA, and the financial management processes that are required to meet them, are not readily understandable or achievable by emerging community organizations without substantial and on-going assistance. This can be seen in the significant number of HCBC organisations who receive regular 'hands-on' support from social workers or community development workers in developing budgets and tracking expenditure, as well as the involvement of DSD-appointed auditing firms. At the same time, more established organizations in the study had clearly grown to a stage where they were capable of not only meeting the basic requirements, but handling fairly complex and diversified streams of funding. Compliance with the PFMA is therefore more of a challenge for emerging organizations with little prior financial management experience and can be overcome through capacity-building over time.

NPO registration is a pre-requisite for accessing government funding and as such directly impacts upon the capacity of HCBC organisations to provide services. The study found that some HCBC organisations – generally, the more established ones – did not face any challenges in relation to registration and compliance. However other HCBC organisations in the study had either struggled to become registered, were not aware of how to register, or felt that they were not 'supported' adequately with compliance following registration. Government officials, including those from the NPO Section at the national DSD noted that compliance with the Act 'demands an organizational structure' and systems that CBOs often do not have. Concern was expressed that the terms of the Act were not well known or understood at community level, and that there may be a need to reform the registration procedures into a two-tiered system that is more appropriate for the differing capacities of CBOs and NGOs. Moreover, backlogs in the processing of registration applications were noted by several respondents and it was noted that devolving the responsibility for NPO registration to provincial level could assist with this.

The practice of paying *stipends to volunteer caregivers* is another factor that affects the capacity of HCBC organisations in both the short-term and long-term. One of the positive aspects of caregiver stipends is the simple fact that it has enabled a steady scale-up in the number of caregivers providing services (and therefore the number of people benefiting from services) and has contributed to a poverty reduction agenda by remunerating people who might otherwise have no steady source of income. Caregivers affiliated to HCBC organisations and receiving stipends may gain access to training or networks that will lead to greater opportunities, new skills and possibly additional qualifications. These aspects of the stipend policy could be said to enhance HCBC capacity.

However the flipside, which was frequently cited by all types of respondents, is that the payment of stipends can lead to conflict and increases the likelihood that caregivers will move on to other opportunities if such arise. The policy as it stands places many caregivers in a type of employment limbo – they work on a regular and almost full-time basis, but are not protected by any national policy or legislation that outlines their rights and options for recourse. This dynamic has negative effects upon the capacity of HCBC organisations of various types, by contributing to turnover and low morale among personnel.

4.1.3.3 Intergovernmental Alignment

The research highlighted the area of intergovernmental relations as one that has bearing on the context in which HCBC organisations operate and their capacity to deliver services. This is important, as HCBC is constituted as a shared programme between the Department of Social Development and Department of Health.

Apart from officials at national government level, all other government officials as well as HCBC organisations noted that the working *relationship between the Department of Social Development and Department of Health* needs to be strengthened at the local level. There were frequent references to competition, lack of coordination, and lack of alignment between the two departments. One respondent described the relationship in her area as 'hostile.' The issues raised by respondents primarily linked to an overlap in departmental mandates, where both DSD and DOH see themselves as responsible for providing care services in people's homes.

Both departments fund HCBC organisations that provide services in the community, yet it was reported that some clinics show preference to carers supported by DoH, giving them client referrals, supervision and preferential access to protective equipment. There were several references to the confusion that results when both the DSD and DOH fund the same organisation for similar services; in some groups carers who were performing identical roles were receiving different amounts in stipend (depending which department funded them and whether they were part of the EPWP). Another example given was a community where DOTS and home-based care activities are artificially separated because they are funded and overseen by different departments. This lack of alignment presents additional burden to civil society groups and may limit their capacity to deliver quality services.

Respondents from national government departments noted that there is a need for *stronger links between the three spheres of government* (national, provincial, local). It was also noted that local municipalities could and should be playing a much stronger role than they currently are in terms of interactions with local HCBC organisations. An official at national level noted that all three spheres of government need to understand and operate according to a common strategy.

The research also highlighted examples where policies advanced by one level of government lead to unintended effects in practice at another level. For example, district-level officials are responsible for recommending HCBC organisations for funding, but the decisions about which organisations to fund are taken at a provincial level. If the district recommendation not to fund a particular organisation is overridden, the front-line officials at district level then become responsible for monitoring and overseeing an organisation that is not ready to manage funding.

Similarly, in at least one province it was reported that district-level officials are responsible for submitting a set number of HCBC 'business plans' per district and that in some places it can be very difficult to identify organisations that qualify for funding. This has led to the deliberate 'creation' of new HCBC organisations in certain areas, under the close guidance of social workers or community development workers who provide template constitutions, assist with the formulation of mission statements, advise on NPO registration, assist with setting up Executive Committees, and bring the new organisation into a funding contract with the department. Some respondents expressed concern that this approach prevents or impedes the emergence of HCBC organisations that see themselves as independent entities, rather than as service deliverers for government.

4.1.3.4 Training and Capacity Building for HCBC organisations

The availability, accessibility and quality of training and other capacity building services are important factors shaping the management capacity of HCBC organisations.

The research findings suggest that training and capacity building is currently fragmented across a range of different types of models and providers, and that responsibility for HCBC capacity building vests in a number of places. For example, the NPO Section of the national DSD is

mandated with strengthening the capacity of NPOs through the NPO Act, but the unit itself acknowledges that it is under-resourced and not able to devote sufficient attention to this area.

In practice, responsibility for supporting HCBC organisations in particular falls to the provincial and district officials who 'do the best they can at any point in time,' according to a national-level official. Presently there are not any standardised processes in place and no specific person (i.e. post) at district level who is explicitly mandated to handle capacity building.

Having said this, the research revealed that most HCBC organisations have had at least some access to training opportunities. Eleven of the 12 organisations interviewed indicated that they had received some kind of training in the past. This included the 59-day HCBC training, various HIV-related trainings, first aid, counselling, DOTS, financial management, project management and stress management. Training courses ranged from one-day to several day in-house training programmes.

The research also revealed that there are a number of different training approaches in use in the some of the provinces studied. The Department of Health, for example, maintains a network of 'master trainers' that can be called upon to run capacity building sessions for HCBC organisations. In the Free State, where funding through the DoH is made available to consortia of NGOs and CBOs, training and capacity building components are built into this funding practice. The DSD in Free State divides the HCBC organisations it funds into type A and type B organisations, depending on their financial management capacity, and provides much greater support to type B organisations whose monthly financial reports are closely scrutinised before the next payment is issued. A Public Private Partnerships (PPP) unit provides direct support on basic bookkeeping, financial systems and financial compliance to funded organisations. Social workers and community development workers also assist CBOs with financial compliance and can make recommendations about organisations that are ready to absorb more funding.

Several points were made about the adequacy of existing training opportunities. First, it was commonly noted that those training opportunities that do exist are generally conducted in English, which greatly reduces the effectiveness of the training and limits the people who can be trained to those who have basic English proficiency. Second, some respondents noted that training is not appropriately 'targeted,' and that this results in organisations attending training sessions that are too advanced for their level of development, or where participants have not been screened correctly and inappropriate people are sent for the content being covered (eg. a HCBC treasurer being sent to project leadership training). Third, concern was expressed that it is difficult to ensure that the benefits of training are shared with whole organisations, rather than with specific trained individuals. Some respondents referred to the phenomenon of 'one man shows' – meaning organisations that are led and driven by one capacitated individual – and 'bi-polar NGOs' that have relatively skilled management personnel and unskilled caregivers.

All of these findings suggest that the training environment can be one of the strongest positive factors shaping HCBC organisations' effectiveness, but can also obstruct the development of management capacity if not designed and implemented carefully.

4.1.3.5 Resource Environment

The research identified the overall resource environment as a significant factor affecting HCBC capacity. It is important to stress, however, that the situation is much more complex than simply a lack of resources. Rather, it is the complex interplay of available resources, mechanisms for channelling/accessing resources, and the conditions attached to the use of resources that makes the overall environment a challenging one for many HCBC organisations.

Interviews with both government officials and HCBC organisations revealed general concern about insufficient resources for many HCBC organisations to operate effectively. Among the main points raised were the limited amounts of funding available to cover caregiver stipends, transport costs, basic supplies and other organisational running costs. Resource constraints also extend to

things like renting office space, paying for telephone usage/cellular airtime, office furniture and equipment, and stationery. It was often noted by HCBC organisations that the funds received from DSD, no matter how welcome, were insufficient for covering their expenses.

Equally significant, however, are the dynamics which help to create this situation, for it is important not to fall into the trap of simply blaming capacity constraints on a shortage of resources. First, there is a lack of information at community level about sources of funding besides government departments. Coupled with under-developed fundraising and proposal writing skills, this leads to a situation where emerging organisations have a very difficult time breaking into the funding environment and thereby run the risk of becoming dependent on government support. This is a particular challenge in rural or remote areas, and in places with limited media/electronic penetration, where access to information and networks is more constrained than in urban areas.

Second, as noted by one national-level official and echoed in other interviews, 'money goes to money:' there is a perception that the NGOs which are most successful in accessing donor funding are those that are already funded. Moreover, these tend to be 'not of this country' – in other words, projects or organisations linked to foreign institutions or foreign donors, rather than indigenous South African organisations. While this cannot be directly corroborated from this research, anecdotal evidence suggests that organisations that succeed in establishing links with foreign donors or institutions may have increased chances of seeing their work funded from other sources.

Third, restrictions and conditions attached to the use of donor funding – both governmental and private – present HCBC organisations with ongoing challenges around how to cover their general operating costs. Received funds are often earmarked for very specific purposes and deviations from approved expenditures can be cause for termination of funding. While these conditions are often imposed – particularly on young organisations – in order to ensure financial accountability and to build experience in managing finances, the rigidity of these funding arrangements is at the same time an obstacle to the natural and creative evolution of organisational functioning. They also impose additional administrative burdens on organisations as they grow and struggle to 'triangulate' multiple sources of project-specific funding to cover core institutional functions that are essential to the growth and sustainability of operations.

4.1.3.6 Capacity among District-level Officials

The research revealed that local-level figures such as social workers, community development workers, and district HIV/AIDS coordinators play a very direct and important role in relation to the functioning of HCBC organisations. According to interviews with HCBC organisations and the focus group discussions at district level, these individuals fulfil a wide range of functions, including helping new HCBC organisations to become registered, setting up management and financial systems, reviewing regular financial and narrative reports, and assisting with the development of new business plans. In the absence of a more integrated capacity building initiative, these individuals at the coal face are effectively providing individualised training and support. They are the front-line liaisons between HCBC organisations and government financing. Many HCBC organisations noted this close contact and support from governmental officials, and on the whole seemed to regard it positively.

However interviews with officials at district and provincial levels revealed a somewhat different picture, which suggests that this very intensive direct support at local level is not sustainable and perhaps not even that effective. Social workers and community development workers have a range of other responsibilities. They are overworked and overstretched and cannot invest the amount of time or effort required to individually mentor HCBC organisations in their areas. According to some respondents, these local level positions are not well remunerated and the individuals that are in these roles often become de-motivated by the sheer scope of the tasks they are meant to undertake. Turnover at this level is observed to be significant, meaning that

institutional and 'system' memory can be undermined as people move on to other jobs. There seems also to be an assumption that these individuals possess basic knowledge and experience in project management, financial management and M&E systems, when in fact they themselves often require training and support in these areas.

As one respondent noted, the hands-on role played by social workers and community development workers in helping to shepherd groups forward may 'get the job done,' but in the long run, it risks disempowering the HCBC organisations and is not a substitute for an integrated training and capacity building programme.

4.1.3.7 Other Factors

Other factors raised by respondents that impact HCBC capacity include:

- The absence of a strong history of civil society in some parts of the country
- Limited exposure to the development sector among HCBC leadership;
- The absence of HCBC umbrella bodies that could link individual organisations into information and skills-sharing networks;
- General weakness in conflict management skills within HCBC organisations which impacts negatively upon organisational functioning;
- Challenges with literacy, numeracy and computer skills among the management and staff of some HCBC organisations;
- The emotional and psychological stress of caregiving work in the context of an epidemic. Many caregivers and HCBC staff are themselves HIV-positive and are continuously confronted by the effects of a disease which afflicts them personally as well. The epidemic's effects upon the lives of individuals in HCBC organisations cannot be ignored and impact upon organisational capacities in the form of stress, bereavement, absenteeism, illness, and depression.

4.1.4 Areas of capacity building need

Overall there was very little difference in the areas of capacity building need for HCBC organisations cited by different types of respondents in the study. Specific areas of need identified by government officials and HCBC organisations are listed in Table 2 below, clustered into eight thematic areas.

Table 3: Areas of capacity building need

Government Officials	**HCBC organisations**
Organisational management	
Overall management processes Planning, including business plans	Planning organisational growth and development Organisational leadership Developing policies and constitutions Defining roles and structures within organisation Internal communication
Project management	
No specific elements mentioned	No specific elements mentioned
Financial management	

Bookkeeping	Bookkeeping Understanding budgets
Fundraising	
Proposal writing	Proposal writing Marketing
Human resource management	
Conflict resolution Support systems for staff	Conflict resolution Labour law Staff development Personnel management
Monitoring and evaluation	
Information management Report writing Conducting needs analyses	Report writing
Networking and external relations	
Building linkages with other institutions	Nothing mentioned
Specialised training	
Computer skills	ARVs Computer skills Legal issues related to social work with children Dispensing medications Counselling, including for trauma & bereavement

The areas cited the greatest number of times were project management and financial management, with human resource management, fundraising and other organisational management issues close behind.

HCBC organisations were much more specific than government officials in identifying areas of need. There were references to the need for computer and IT training, and for training and 'top-up' courses in specific areas of care, such as ARVs and counselling. They also noted specific issues within the broad areas of organisational and human resource management that they feel require attention within their organisations. Comments by government officials tended to be much more over-arching in nature and were largely related to compliance with funding and reporting requirements.

4.2 MODELS FOR HCBC MENTORING, SUPPORT AND CAPACITY BUILDING

This section presents findings from the review of mentoring and support organisations currently working in South Africa.

4.2.1 Mentoring, support and capacity building models

The mentoring and support organisations that were reviewed combine different capacity building elements in the services they provide. While some work only on capacity building for NGOs and CBOs, other provide additional services or implement programmes as well. Some work specifically with organisations focused on HIV and AIDS, while others capacitate various types of CBOs and NGOs. Of the organisations that were directly interviewed, four of them have started

the process of becoming accredited by SETA, and all but one were established in the past five years.

The models identified are described in the sections that follow, and are summarised in Table 4 below.

4.2.1.1 Twinning arrangements (NGO/CBO partnerships)

Twinning arrangements allow for the establishment of time-bound partnerships between a more established NGO and an emerging CBO, usually located in the same area. Over the course of the relationship, the NGO is expected to work with the CBO to transfer specific skills and capacities that they have succeeded in developing in their own work.

Sometimes twinning arrangements involve a financial sub-granting and accountability role as well. The NGO would either serve as a channel for funding to the CBO, or would be responsible for working with the CBO to manage a certain small amount of funding. In such instances, the NGO might be accountable to the original donor for the CBO's use of the funding.

NGO/CBO partnerships have been established on a small scale (9 partnerships) among the member organisations of the CINDI (Children in Distress) Network in Pietermaritzburg, through funding and support from Development Cooperation Ireland.

4.2.2.2 Consortia of NGOs/CBOs

A group of CBOs/NGOs with a similar purpose, working in the same district, form a consortium that is led by an executive committee made up of representatives of each member organisation. Each member organisation has its own work plan and activities, but these are linked together into an overall implementation plan. Funding is provided to the consortium as a whole, and the executive committee is responsible for allocating funds to members. Within consortia there is often a 'lead' organisation that is well-established and has a track record with previous funding.

One of the benefits of consortia is that they minimise the duplication of funding of similar services in one area. It is also a mechanism for sharing limited resources and for ensuring the efficient management of funding, by vesting the consortium executive with responsibility for the financial accounting. Consortia can also apply collectively for funding to various donors. Finally, the consortium model also allows for the transfer of skills and experience between NGOs and CBOs at the local level.

NGO/CBO consortia are common in the Free State, where it is the policy of the Department of Health only to fund NGOs through consortia.

4.2.2.3 Independent service providers

There are a sizable number of organisations and companies that provide capacity-building services to CBOs and NGOs. Some of these are focused only on CBOs/NGOs working on HIV and AIDS, while others are more generic in orientation. The types of services provided include trainings (either in-house or at a central location), sub-granting functions (providing 'seed' money to CBOs without financial management experience) and hands-on mentoring. Some organisations provide what is called 'aftercare' support, which involves periodic follow-up visits to CBOs/NGOs which have graduated on to other sources of support, but which still need assistance with functions such as M&E.

Some of these organisations are themselves NGOs, such as the Barnabas Trust. However there are also examples of for-profit companies that provide capacity building services for NGOs and CBOs (eg. PriceWaterhouseCoopers). There is also a network of mentoring organisations – the Mentoring Resource Network (MRN) – comprised of nine members, located around the country, who together support close to 70 different groups.

4.2.2.4 Sub-granting and grant-related support

Another approach identified is to build an element of capacity building into a funding relationship. Under this approach, the main focus of the support organisation (the funder) is its role as a

channel for small-grants to community organisations. But because it needs to ensure that the beneficiary organisations comply with accountability conditions for donors, it also provides support to the beneficiary organisations in the form of special trainings and project 'mentors.'

The Starfish Foundation is an example of this model. It works nationally in South Africa to fund community-level projects and provide organisational support to the funded organisations through a set of provincially based project officers. These project officers are seen as 'relationship builders' between the foundation and the funded organisations, assisting them with reports and offering help with various institutional challenges where possible.

4.2.2.5 Placement of a skilled person

A variation on the training and mentoring model is the placement of a skilled person – either local or foreign – in a CBO/NGO for a period of a year or longer to work alongside the organisation's staff and to transfer particular skills to the organisation. This approach has the benefit of allowing knowledge and skills to be built up and reinforced over a longer period of time, which may lead to better results than short-term trainings. Longer-term mentoring arrangements increase the likelihood that certain systemic changes in the organisation may result.

One of the best-known examples of this model in South Africa is Voluntary Service Overseas (VSO).

4.2.2.6 Network support

A final model of capacity building takes the form of resources made available to NGOs and CBOs through resource centres, umbrella bodies and other kinds of forums where organisations with similar interests and agendas are able to meet and share experiences. Examples in South Africa include the AIDS Consortium (a national umbrella body for CBOs working on HIV and AIDS), provincial and national NGO coalitions (such as SANGOCO), and local resource centres.

Table 4: Mentoring models and implementing organisations

Model	Elements	Examples
Twinning arrangements	Technical assistance Grant-making	CINDI Network, Pietermaritzburg Heartbeat's Tswelopele Mentorship Programme Seboka Training and Support Network
NGO Consortia	Partner mobilisation Technical assistance Grant-making Resource mobilisation Monitoring and evaluation	HCBC organisations in the Free State
Independent service providers	Technical assistance Grant-making	Barnabas Trust Unsung Heroes PriceWaterhouseCoopers
Sub-granting and grant-related support	Grant-making Technical assistance Monitoring and Evaluation	Starfish Barnabas Trust
Placement of a skilled person in an NGO/CBO	Technical assistance	Voluntary Service Organisation (VSO) Lily of the Valley Children's Village
Network support	Partner mobilisation Technical support	Networks and associations SANGOCO

4.2.3 Lessons learned

Mentoring and capacity building groups interviewed shared a number of lessons learned from their experiences working with NGOs and CBOs.

4.2.3.1 Agreeing the terms of the relationship

Both partners must be committed to the relationship. It is critical to have in place a negotiated and written agreement signed by both parties. The success of the mentorship relationship is determined to a great extent by the clarity and feasibility of the expectations outlined in that agreement.

The agreement should be based on a clear definition of what mentorship/capacity building means (and what it does not mean), the expected outcomes of the process, and the expected duration and intensity of the relationship. It should specify roles and responsibilities of both parties. The agreement should take into account expectations and fears of both partners. In all undertakings both partners need to be frank, honest and truthful to enable a balanced, credible relationship.

4.2.3.2 The capacity building process

The respondents reported that any capacity building process must begin with an assessment of the current status of the group being worked with and an articulation of the desired development outcomes. It is important that the relationship between the partners be developmental and empowering. The focus needs to be placed on developing the self-reliance of the mentored group, in line with their own perceived needs and those of the community.

It is important that any capacity building initiative be allowed adequate time to have an impact (most groups spoke of 2-3 years). It should include both training and mentoring components to ensure that skills transferred are implemented in practice. The approach needs to be flexible enough to accommodate leaders with a low initial skills base.

The respondents noted that mentoring is more effective if it is focused upon one or two key leaders. Trying to coach the whole organisation at once is unlikely to be successful.

Skills transfer and training should be organised into manageable segments to allow time for assimilation, implementation, evaluation and feedback. It is important for the mentor or trainer to have the opportunity to observe the participant implementing the skill in practice. The process should allow NGO/CBO learners to experience the need for a new skill and to become aware of inadequacy in the current way of operating.

There is a need to ensure that the learning events are relevant to the CBO's objectives and line of work. Respondents noted that participants consistently request simple and relevant training that is not overly-academic. Extensive reading material is not necessary. As far as possible, trainers and mentors should be from the local community, or at a minimum, must be able to understand the local context and culture. Presentations should be done in local languages; where possible, training materials should be translated as well.

4.2.3.3 The environment for mentoring and capacity building

The funding environment is an issue for mentoring and capacity building organisations. Respondents expressed that it is frustrating and ultimately unproductive to attempt to capacitate organisations that do not have any funding. There are advantages, therefore, to having the

capacity building group sub-grant a small amount of funds to the beneficiary organisation and to share responsibility for reporting on those funds. The disadvantage is that the receiving group may come to perceive the mentor as a funder, which can erode the honesty and transparency of the relationship and has the potential to lead to dependency. Organisations may also participate in the initiative in order to access funds, and not for the purpose of learning.

Respondents noted that there are many factors which shape the capacity and operational realities of NGOs and CBOs with whom they work. Many of these issues – payment of stipends, volunteer retention, motivations of caregivers, resource constraints – fall outside the scope of what a capacity building programme can address or control. Yet they remain influential and can impact upon the nature of the relationship between the capacity building organisation and the beneficiary organisation.

Successful mentoring and capacity building requires the mentors and trainers who are experienced and competent in both technical skills (service delivery, content issues) and management skills (organisational capacity). The organisations interviewed note that they experience challenges in identifying enough mentors who fit these criteria. Issues include the small number of skilled candidates willing to work for the salary offered; the very high ratio of mentors to organisations that is required by many models; and the large geographic areas that need to be covered by mentors.

5 DISCUSSION

5.1 FACTORS INFLUENCING THE CAPACITY OF HCBC ORGANISATIONS

The emergence of Home and Community Based Care organisations has been one of the most prominent manifestations of community-level response to the HIV epidemic in South Africa. However, like the epidemic itself, the phenomenon of HCBC organisations – including their capacity to perform effectively and efficiently in accordance with their guiding missions – cannot be understood apart from the broader socio-economic context in which they have evolved.

The HIV prevalence rate in South Africa is one of the highest in the world, and is impacting upon a young nation undergoing massive social and economic transformation. Levels of poverty and unemployment are high in many parts of the country, and social welfare and public health services are still being reformed so that they are accessible and appropriate to the country's developmental needs as a whole.

As the epidemic has progressed, groups of individuals providing care services have emerged in many parts of the country – often independently and sometimes quite informally – to address the impacts of HIV and AIDS that are visible in their communities. While some of these groups might have had access to external forms of support, such as donations or grants from donors, many of them were 'un-resourced' – operating on a purely volunteer basis.

In recent years, as the policy framework for HIV and AIDS response has been strengthened and more resources have been made available for programmes and interventions, the work of HCBC organisations has been brought into the national response framework in a more systematic manner, including the provision of funding to HCBC organisations and the development of various guidelines to shape their work. It has also extended, at least in some places, to encouraging the formation of HCBC organisations in areas where they had not previously emerged as a way of increasing the coverage of services available to people infected or affected by HIV and AIDS.

This has resulted in some newly formed organisations 'leapfrogging' a number of natural developmental stages in the normal evolution of an organisation. Community members who have come together voluntarily to look after sick neighbours and friends may have found themselves racing forward – with the encouragement of a local official and the prospect of receiving stipends – to become registered organisations with a constitution and outside funding, which, in turn, requires systems for recordkeeping, reporting and bookkeeping. The inherent risk of this approach is that the organisation skips the natural evolutionary life stages of developing an organisational identity, articulating a vision, mission and goals, deciding when (and why) to register formally, and evolving systems as they perceive the need for them.

These systemic changes in the context in which HCBC organisations operate are of critical importance in understanding issues of HCBC capacity. The past several years has witnessed a shift away from un-coordinated, un-resourced community-level activity towards a closer alignment between government frameworks and locally provided home and community-based care services. Organisations that previously worked with little or no external support are now in a position to receive regular financial support from government (and possibly other donors), but in return need to grapple with a range of accountability requirements. In effect, government is 'buying' services from these groups and there are certain expectations that flow from this arrangement in terms of the organisations' ability to report on services rendered and funds expended. Organisations that might have been founded on a 'do good' basis, with a primary focus on delivering certain services, are now needing to operate in a more formal manner, in accordance with organisational and management principles that are foreign to them.

Thus, the management capacity of HCBC organisations to deliver services effectively is shaped in large part by their historical evolution. The experience and capabilities of the founders and leaders

of these organisations are also important factors: some volunteer-driven HCBC organisations are led by individuals with minimal educational qualifications and limited literacy and numeracy abilities. In many areas with high levels of unemployment, volunteers affiliated to HCBC organisations may not have any prior work experience. While educational background, literacy and previous work experience are certainly not prerequisites to running an HCBC effectively, they do suggest some exposure to principles of organisational management and a stronger base from which to build capacities in areas such as financial management.

Against this backdrop of a limited skills and experience base, other factors then compound the challenges for HCBC organisations that are trying to evolve and become more sustainable in their operations:

- The payment of *stipends to caregivers* is a double-edged sword. While allowing for an expansion of service reach and contributing to poverty alleviation by providing a regular, if small, source of income to thousands of caregivers, stipends also seem to generate conflict and discontent within HCBC organisations. Provision of stipends has contributed to the expansion of home and community-based caregiving, but does not appear to have led to increased stability or professionalisation of the sector.

- The *resource environment* is challenging for HCBC organisations. Although the overall amount of funding available for HIV and AIDS programming has been steadily rising in South Africa in recent years, it is not necessarily available in a shape or form that can be accessed by HCBC organisations, particularly those that are emerging or have only basic systems in place. Many funding mechanisms are oriented on supporting programme implementation via larger-scale NGOs that have well-developed administrative and financial systems in place. Small grants to CBOs are too labour intensive for many donor institutions to administer, and as a result, CBOs have a limited number of funding avenues to pursue.

- *Overlapping mandates* between the Department of Social Development and Department of Health appear to complicate the operational environment for HCBC organisations on the ground. It is perceived by some that DoH-funded HCBC organisations have preferential access to referrals and support from clinics, that the duplication in funding by DoH and DSD creates confusion, and that cooperative relations between the two departments need to be strengthened at provincial levels in particular.

- Home and community-based caregiving is highly *stressful work*. Caregivers frequently encounter desperate situations in households and feel powerless to alleviate the suffering. Many caregivers are themselves HIV-positive, and are regularly working with patients suffering from advanced stages of a disease which will ultimately afflict them as well. The work is tiring and can be psychologically traumatic, in addition to carrying with it certain risks.[9] It is important not to discount the effect that this 'crisis environment' has upon the operations of HCBC organisations. The capacity of HCBC organisations to deliver services is affected by a whole range of intangibles: sickness and absenteeism among caregivers, depression, stress, death, and bereavement. While it is common for organisations to provide some form of counselling or debriefing to caregivers, it should be noted that the nature of caregiving work is such that it often leads to burnout. The management of HCBC organisations are thus faced with the on-going challenge of motivating, supporting and overseeing the work of its caregivers under very difficult circumstances.

[9] Caregivers face at least two layers of risk – first, the risk of HIV infection in the course of their caregiving work, and second, personal risk they face when traveling long distances alone between households, and entering households that they do not know.

5.2 ASSESSMENT OF THE MANAGEMENT CAPACITY OF HCBC ORGANISATIONS

HCBC organisations are delivering important services at community level, but their present capacity and future evolution are impeded by the environmental and systemic factors outlined in the previous section. For the sector to go to scale at the extent which is required, given the size of the HIV epidemic in South Africa, it is necessary to focus not only on capacitating individual caregivers (as is being done through training programmes such as the '59 days' module and now the Expanded Public Works Programme), but also to build stronger management skills at an institutional level.

The following sections discuss the key findings relating to existing management capacity of HCBC organisations in several core areas.

5.2.1 Governance, Organisational Structure and Leadership

The prevailing system of NPO registration appears to be largely unproblematic for established NGOs, but may represent a barrier to the formalisation of emerging groups. Of concern here are both the reported backlogs in processing applications and the requirements for registration and compliance, which are reportedly difficult for new CBOs to meet without 'coaching' or other forms of assistance. The NPO Section at the National Department of Social Development acknowledges that they have 'two tiers' of applicants, and that there might be a need to simplify the registration procedure for CBOs.

One of the results of the current NPO registration framework is the proliferation of new CBOs that are formed according to a standard template constitution and a standard management structure. The prevalence of the 'Exco model' of management seems to be driven by a lack of awareness of alternative management structures. While the Exco model is perhaps appropriate for young organisations, in that it is relatively straightforward and easy to implement, it seems to lead to a situation where management roles within HCBC organisations rotate amongst members on an annual basis and works against a process of specialisation of roles within the organisation. The tendency towards equality and collectivism amongst caregivers means that, in practice, there is little difference between the roles and actual work of Exco and non-Exco members.

The lack of distinct and permanent leadership is evident in the low organisational capacity of the groups. This is contrasted by the situation in NGOs, where over time a natural process of role differentiation has led to more stable management structures and to those in management roles developing specialised skills around particular functions (eg. fundraising, accounting, human resources, or project management). NGOs are also more likely to have structured departments, where dedicated staff manage the provision of specific services and build up expertise in those areas. Such models were not in evidence among CBOs. Where there were team leaders, their responsibility was coordination and monitoring, not leadership, coaching or discipline.

For emerging CBOs it is perhaps not feasible to require an external board of advisors in addition to an internal management committee or Exco. However the presence of a board is important for many reasons. It can assist in mobilising additional funds, it can help to raise the profile of the organisation through various networks, and can lend a degree of credibility to an organisation as it works to establish a positive track record. External boards of advisors are also very important in ensuring against fraud and mismanagement of funds, and the possibility of requiring a small board of community members – apart from the organisation's own management – could be considered. In practice, however, external boards are not common among newly emerging organisations, either because they are not required or because the organisation has not progressed to a level where the utility of an outside board is recognised. Among NGOs they are much more common and in some cases clearly contribute to the success and reputation of the organisation within the community.

A final issue of note pertains to organisational leadership and the phenomenon of the charismatic leader. It is not uncommon for civil society organisations of all types to have their roots in the efforts of a particular individual, or 'champion,' whose vision and drive attract the support and involvement of others. However, if the organisation is to become viable in the longer term, it is necessary for skills, experience and leadership to be shouldered by more than one individual. Many organisations are prone to collapse if the original champion ceases to be involved, or, as often happens, other members chafe under fixed leadership and split off to form a new entity.

5.2.2 Strategic and Operational Planning

Organisational growth and development often happens haphazardly during the early stages of an organisation's evolution. It is not uncommon for an organisation to emerge in response to a defined opportunity – for example, the availability of project funding to support a group of orphans – and then to branch out, over time, into other areas of work. Under this developmental path, there may be very little initial 'planning' within an organisation. As its activities become more complex, the organisation might branch into short-term operational planning (What activities will be conducted? How? Who will be responsible for implementing them?). Strategic planning generally only comes later, once an organisation is more established and sees the need to reflect on its work and to shape its future role more deliberately.

Most groups were proficient at micro- or activity-level planning, and were, for example, effectively managing feeding schemes for hundreds of children on a daily basis. However, with the exception of one NGO in this study, longer-term planning was generally done for the following year only and was motivated primarily by the funding cycle – the development of a business plan was required as part of the process of securing DSD support. Planning therefore took place mostly at an operational level and did not involve participatory reflection by staff/members about the approach being taken by the organisation to meet its mission and goals over the longer term. In the NGO that did undertake annual strategic planning, this was done in a decentralised way, relying upon department-level processes that fed into an organisation-wide review.

Strategic planning exercises are often linked to needs assessments among target/beneficiary groups or other methods for assessing the environment in which the organisation works. Most groups in this study felt that they were in touch with the needs of their clients and the broader community through their daily interactions and informal feedback from other stake-holders, such as the clinics and schools. Few of them relied upon or had ever used formal approaches to conducting situational or analyses.

The absence of longer-term strategic planning therefore does not appear to be related to an absence of information and understandings about the local environment. Rather, it seems to be a reflection of a weak sense of ownership and empowerment on the part of the organisations' leaders and members. Strategic planning may require knowledge of certain skills and approaches that are lacking among emerging organisations, but it may also be that longer-term planning feels relevant where organisations are more confident in their possibilities for growth and self-determination. This, in turn, could be shaped by factors such as the extent to which the organisation is networked with others, has access to information about opportunities, and knows where it can turn for specialised support.

5.2.3 Financial Management and Resource Mobilisation

The Public Management Finance Act is the overarching legal framework which shapes the financial accountability requirements of HCBC organisations receiving public funding. Although CBOs in particular were frequently criticised for a lack of financial capacity, the financial systems in place within the organisations studied appeared sufficient to meet donor requirements. However, the more pertinent issue is the extent of hands-on assistance that is required to keep these systems performing at the required level. Among CBOs with little prior experience, social workers and community development workers appear to play a major role in assisting with

financial reports, developing budgets and tracking expenditure. Financial audits are conducted annually in accordance with DSD requirements. None of the CBOs that visited had any recordkeeping systems over and above those required for compliance with government funding obligations.

Although basic bookkeeping and financial reporting on single streams of funding are routine technical skills that can be transferred through training and mentoring, the situation becomes much more complicated when organisations receive more than one source of funding. Funders rarely have uniform reporting systems and it becomes necessary to evolve systems for separately tracking and reporting on funding streams. Multiple bank accounts may be required. As an organisation's finances become more complex, it may need to begin negotiating overhead costs to cover institutional expenses such as rent, electricity, photocopies, and administrative staff, and many funders are hesitant to support this type of expenditure. At this stage, organisations require a different calibre of financial management – one that is capable of working across multiple budgets, projecting cash flow and expenditure, and generating more complex financial reports. Trained bookkeepers or financial managers are then required. There is clearly a need for a 'tiered' approach to capacity building in financial management, with the introductory level focusing on basic principles and procedures and higher level training for those organisations that have diversified their sources of support.

The study revealed a general lack of coordination among funders and weak alignment in funding strategies. Besides government, a limited number of funders seem prepared to take on small, single-community projects or emerging initiatives that may not have audited financial statements. Those HCBC organisations that have succeeded in accessing some funding noted that funders are much more willing to support direct project expenses for children, food parcels and even buildings, but will not cover salaries, administration or running costs.[10] Examples were cited of large donations being made with no allocation to cover the costs of distributing the goods to the beneficiaries. This may link to concern about financial accountability on the part of donors, who believe that it is more feasible to monitor and verify 'hard' project expenses than it is to ensure that general institutional support was used appropriately. It likely also relates to concern about the sustainability of supported projects.

HCBC organisations reported being put under pressure to become 'self-sustainable' in their operations. But in a sector where the core function is caring for patients and children – which in and of itself is not an income-generating activity – it is difficult to understand what can be meant by the notion of self-sustainability, apart from diversifying one's funding base to effectively spread financial support across a greater number of donors. The skills to develop sustainability strategies were generally not present among the organisations surveyed, the majority of which were much more focused on their day-to-day service delivery functions than on these longer-term visions.

5.2.4 Human Resources

Human resources are one of the greatest challenges within the HCBC sector, for reasons that are systemic and difficult to change. The emotional and psychological challenges of caregiving are unlikely to diminish; what can be addressed are the institutional conditions in which caregivers work and the training and support they receive in their roles. It is important to note that great attention is being paid to this issue from a variety of angles, including in the form of the Expanded Public Works Programme which will make training and career pathing opportunities available to thousands of caregivers in the coming years. The institutional environment for caregiving therefore remains in transition.

The study has highlighted some of the main tensions in the human resources context that link to the status of volunteer caregivers. Many caregivers and government officials asserted that

[10] This observation has emerged from other pieces of research on related issues and appears to have basis in fact.

volunteers are expected to behave as employees, but are not recognized as such. Volunteer carers often work without any kind of contract; they are affiliated to the organisation by verbal agreement, signing a code of conduct and for receipt of their stipend. Carers do not get paid leave or enjoy any labour protections (unless granted under organisational policy), despite the fact that they effectively work full-time jobs. The present situation, and the conflict it seems to generate at organisational level, throws into question the sustainability of the HCBC sector which depends very much upon the conscientious efforts of thousands of individual caregivers.

Overall, skilled human resources in the NPO sector are generally lower than in the corporate sector, which is driven by the differing motives, entry requirements and prospects for remuneration. Although civil society has motivated champions among its leadership, these individuals are seldom trained in management.

Among more established NGOs, skills tend to cluster among white managers, with little or no evidence of these being transferred to carers, who are often dedicated, but largely unskilled. Challenges in communication and mutual respect between management and caregivers were evident in the NGOs. Caregivers often have limited knowledge of and access to information about the functioning of their organisation, including how operations are structured, what the main challenges are, or what decisions are being made. Managers generally believed that they were pursuing an ‘open-door’ policy and struggled to come to terms with the ‘silence’ they would encounter in staff meetings, whilst carers felt that management was unapproachable.

Personnel within the HCBC sector operate under high stress conditions, including the imperative to constantly seek funding, low levels of remuneration, working with minimal resources, patient needs that go beyond existing levels of training and equipment/supplies, and low job security. These stress-inducing elements are compounded in cases where the support infrastructure for members (such as debriefing or counselling) is weak, and where the organisation has difficulty saying ‘no’ and limiting the scope of its work to available resources and personnel.

Some of the NGOs interviewed had evolved techniques for countering the effects of these difficult conditions, such as honouring a ‘Caregiver of the Month’ or providing extra food parcels for caregivers from time to time. There were few examples of this among CBOs.

However, despite the stress and challenging working conditions, volunteer turnover in the organisations studied was lower than might be anticipated. This may, however, be driven by a lack of other opportunities for low-skilled volunteers. In most cases when caregivers did leave an organisation, it was for more secure or paid work, or due to illness or death.

Whilst most organisations had systems of some sort in place to monitor the work of caregivers, very few had any kind of performance review system that would feed into a staff development process. Carers in both CBO and NGOs expressed that they saw no growth opportunities in their organisations. It will be important to track the success of EPWP in training caregivers to a qualification level that might be transferable to other types of job opportunities. This type of career pathing would clearly welcome by the majority of caregivers.

5.2.5 Service Delivery

Amongst the HCBC groups interviewed, a wide range of services were provided, including palliative care, care for orphans and vulnerable children, counselling, support groups, assistance in accessing grants, crèches, and distribution of food parcels. Clients were generally referred to the HCBC groups by the local clinic or social worker, but others were referred by community members or identified during door-to-door campaigns. Some groups had client assessment systems in place for palliative care patients, but this was less common among social cases, such as vulnerable children. One of the NGOs in the study, a hospice, utilised quite a well-developed system of client assessment and recordkeeping that they were trained in by the National Hospice Association.

Most carers had received some form of training related to the work they were performing, with the 59 Days training module the most commonly mentioned form of training. The fact that training had been so widely accessed by caregivers should be noted as a success. Caregivers did express a desire for more advanced training in areas such medical home-based care, ARVs, working with traumatised children, counselling, case assessments and networking.

Infrastructure and equipment are a significant limitation in the ability of some HCBC organisations – especially CBOs – to deliver services consistently and effectively. Many of the emerging organisations do not work from publicly accessible office space, which reduces their visibility, and do not have use of basic office equipment such as phones, faxes, computers or filing cabinets. This makes the task of complying with various donor reporting requirements that much more challenging, and also affects processes such as receiving and following up on referrals, storing and managing client records, and filing receipts and other financial information.

Transport issues place a huge burden on the carers who need to cover long distances through difficult terrain to reach their clients, often carrying food parcels and other equipment. Carers often hitch-hike or use their stipends to pay for taxis, and the overall impact is to limit the number of clients that can be served and the frequency of home visits. Transport is also an issue in helping clients to reach the clinics, and for vulnerable children to get to school or a day-care facility.

Another issue that affects service delivery is the inconsistent availability of equipment and protective gear for palliative care services. In instances of insufficient supplies, CBOs seemed to be particularly 'blocked,' in that they had no additional sources of funding or resources upon which to draw in order to close the gap even temporarily. This also feeds into a sense of dependence on government by perpetuating an attitude that government is the sole supporter of the organisation and the first and last port of call in the case of difficulty.

5.2.6 Information Systems and Monitoring & Evaluation

NGOs generally had good administrative systems in place, ranging from human resource files to financial records. Client records were generally up to date and were kept in lockable cabinets. CBOs' administrative systems were less comprehensive, focusing on client visits, referrals and monthly service reports. Carers use a combination of notebooks and client assessment/client visit forms provided by social workers or the clinic sister. In CBOs, recordkeeping systems were almost always paper-based due to a lack of computers, office space and, in some cases, electricity.[11] Often copies of reports that had been prepared were 'given away' to DSD or to the clinic sister without any copies being kept for the CBO's own records. Where records were kept, they were sometimes stored in a cabinet or cupboard at the office or shared space, but more often were in box or drawer at the chairperson's house.

The NGOs that had not fully automated their recordkeeping expressed a desire to transfer their paper-based systems to electronic ones, having recognised the various cost and time savings benefits in generating automatic reports. This seems to link to the reporting burden experienced in organisations with multiple funders, where the report formats are not standardised and require individual attention. NGOs noted frustration over the multiple reports and formats demanded from their donors and were not convinced that the reports and statistics they submitted were ever truly reviewed or used.

In most organisations, patient records and special cases were reviewed at team meetings and solutions would be discussed for difficult cases. However for the most part, HCBC organisations in this study did not track or evaluate their own records and statistics to identify trends or to inform programmatic planning.

[11] Where computers had been donated, they were often kept at the chairperson's house for safety reasons.

In terms of internal monitoring processes, HCBC organisations generally had systems in place to ensure that work was being done, but did not have a deliberate approach to measuring the quality or effectiveness of their services. Client and community participation, as formal concepts, were largely unfamiliar to the groups that were visited: stakeholders do not actively contribute to the design, delivery, and evaluation of the groups' activities. Thus, for both CBOs and NGOs, basic systems for monitoring the delivery of services were in place, yet evaluations of the quality of these services were not done and lessons learned were not documented.

This failure to engage in structured self-assessments seems to be influenced by two perceptions: first, that the organisation is operating in a quasi-permanent crisis mode, where processes like evaluations cannot be afforded; and second, that the organisation does not possess the necessary skills and techniques to evaluate and analyse its own work. This is a common view among civil society organisations, which have unfortunately come to believe that programme evaluations require sophisticated research techniques best provided by external consultants, rather than more accessible approaches that can be done by organisations with widely varying levels of experience.

5.2.7 Networking and External Relations

It is difficult to make a general statement about the external relations and networking capacity of HCBC organisations due to the wide and conflicting range of evidence presented within the research sample. The spectrum extended from one established NGO, which had established a local multi-sectoral forum for coordinating HIV and AIDS activities, through to some of the CBOs which were not aware of any other groups operating in their district and worked in complete isolation, apart from their contacts with government. The only consistent factor that emerged in interviews was the interaction between HCBC organisations and local government officials.

Although networks and partnerships can be incredibly valuable to organisations in solving practical challenges, learning new approaches to work, and becoming aware of funding opportunities, they are often not prioritised – either because the main focus is on day-to-day operational issues, or because it isn't clear how or with whom to make build networks. This is particularly true in remote areas where there is a very low density of local activity around HIV and AIDS.

Based on the interviews with HCBC organisations, there is a noticeable lack of interaction between HCBC organisations and the business sector. A number of government officials also noted that this is an area that needs to be strengthened.

5.3 MINIMUM CAPACITIES REQUIRED BY AN EFFECTIVE HCBC ORGANISATION

This research has highlighted the need for a differentiated understanding of management capacity amongst HCBC organisations. It has revealed that the historical evolution of organisations, combined with various environmental factors linked to policy, the resource environment, organisational leadership, and the nature of the work itself, combine to shape the capacities of organisations.

Rather than prescribing a set of minimum capacities that must be achieved by all HCBC organisations, a more pragmatic approach is to understand HCBC organisations as progressing through various 'life stages.' HCBC organisations can be expected to perform at different levels depending on their stage of evolution, and a capacity building programme would aim to elevate organisations to the highest level they are able to achieve. The forms of government (and other donor) support available to HCBC organisations could be tailored to these different levels, with higher levels of capacity among HCBC organisations making them eligible for greater amounts of funding.

Particular attention needs to be paid to the institutional differences between CBOs, which are young and emerging organisations with little experience and an undiversified funding base, and NGOs, which have progressed to a certain level of autonomy and stability. While these organisational types can be understood as existing along a single developmental continuum, the gap in capacity and functionality between a CBO and NGO is large enough that for many purposes they are better treated as separate institutional categories. A differentiated approach to support is required, including in respect to minimum requirements for fundability, funding levels, reporting requirements, allowable costs and the nature of the capacitation and support provided.

5.3.1 Minimum capacities for fundability

CBOs are emerging organisations that are either newly formed and or that have existed for some time, but lack an institutional track record in terms of their interactions with donors and their experience managing external sources of funding.

In order for government to support such HCBC organisations financially, it needs to be confident that basic capacities for fundability will be met. These include the following:

- NPO registration (to comply with PMFA)
- A constitution, setting out the organisational mission and basic accountabilities
- A functioning management structure, including office bearers and regular meetings
- A business or operational plan outlining planned activities
- A basic financial management system, including the ability to track expenses and report on them in accordance with an agreed budget and expenditure plan
- Ability to generate periodic reports on activities, in accordance with a prescribed format

Organisations in this category require regular and fairly close oversight to ensure that these basic requirements are met.

5.3.2 Minimum capacities for consistent service delivery

Established NGOs generally possess the basic capacities for fundability outlined above, but have also evolved systems and processes that enable them to deliver services in a stable and consistently satisfactory manner, with much less oversight than is required with CBOs. The additional minimum capacities required by this category of HCBC is as follows:

- A differentiated organisational structure, including an external board of advisors whose roles and functions are clearly defined;
- Stable organisational leadership, including management figures with relevant qualifications and/or prior experience
- Financial management systems suitable to handling more than one funding stream
- Some diversification in funding, including either core (institutional) support or a formula for covering operating costs
- Ability to develop proposals and access sources of funding proactively
- System for managing and projecting supply needs

- Funding for or access to transportation for programme implementation purposes
- Basic human resources system, including
    - Signed contracts/conditions of employment with all personnel
    - A training or skills development plan for staff/volunteers
    - Support systems for caregivers
    - Individual job descriptions and annual workplans
- Specialisation of roles or affiliation to programme teams
- Regular operational planning and period strategic planning sessions
- Information management system for recordkeeping and monitoring purposes
- Standard process for identifying and assessing clients
- Competency in basic techniques for assessing community needs
- Involvement in networks or partnerships with other organizations/institutions

5.3.3 Minimum capacities for sustainability

Mature NGOs are those that have evolved over time through the first two stages to achieve a degree of 'permanence' in their work and to operate independently, in full accordance with their own vision and objectives. Sustainable organizations essentially work for themselves and their beneficiaries alone, and are not unduly beholden to the agendas or priorities of the institutions that support them.

The key capacities of sustainable organizations include:

- Diversified sources of funding and a long-term funding strategy (eg. endowment, bequests, individual donor base)
- Access to institutional funding or core organizational support
- Strategic planning process enshrined in organisational culture
- Strong and independent board of directors
- Recruitment procedures for attracting and retaining staff and volunteers
- Performance management and skills development system for staff
- Ability to conduct situational analyses and needs assessments
- Ability to undertake monitoring and evaluation of programmes
- Active involvement in networks and/or advocacy activities

6 CONCLUSIONS

The small-scale and operational nature of the present research provides an insufficient evidence base from which to make specific recommendations about the shape and form of a future capacity building programme. However it is possible to conclude with some general reflections first, on the broad approach which might be taken into account in developing such a programme; and second, on issues which may merit further investigation.

6.1 TOWARDS AN EFFECTIVE CAPACITY BUILDING MODEL

Effective delivery of HCBC services requires that those institutions providing the services are well-managed. At present, HCBC organisations operate at community level and tend to be staffed by people close to the community being served. They are often overseen by district-level officials who may not have experience or training in organisational development issues.

To enable effective management of HCBC organisations, a capacity building and mentorship model is envisaged that rests on three pillars:

- Training to transfer essential management skills to HCBC organisations and, to a lesser extent, to district-level officials;
- Mentorship to provide guidance and support in the application of the management skills over time;
- Role clarification and mutually supportive coordination between HCBC organisations and district-level government officials.

It is evident from this research that investing only in the skills of individual HCBC caregivers and officeholders will be insufficient to bring about sector-wide change. It is also necessary to address some of the broader institutional and systemic issues which shape HCBC capacity.

Although South Africa currently lacks a standardised training and capacity-building programme for HCBC organisations, the small scale training models that do exist provide valuable insight into the priority areas that need to be addressed in any scaled-up initiative.

First, a national capacity-building initiative for HCBC organisations needs to take into account the different stages of development that exist among HCBC organisations. It is important to differentiate between NGOs, which tend to be older, to have in place some skilled staff and systems, and to have diversified their funding to enable them to pursue their organisational vision, rather than being solely dependent on the agendas of funders; and CBOs, which are younger and still establishing themselves as organisations. CBOs tend to operate on the basis of one funding stream – in this case, governmental – and have skills and systems in place that are adequate to deliver on their obligations related to their government funding, but little more. Any loss of government funding would lead to a dramatic scaling down of activity as there is limited capability to strategize and implement alternative fundraising strategies. Their level of organisational development is often too low to win the trust of non-government funders.

Second, training and mentoring approaches need to be developed that target organisations at various levels and offer content that is relevant to them through a format that is appropriate in its degree of technicality and sophistication. Mechanisms need to be put in place to assess the baseline capacity of an organisation in order to determine the appropriate level of entry into the programme. One of the factors that currently undermines the effectiveness of some training programmes is that participants/organisations are inadequately screened prior to the commencement of training and discover only during the programme itself that the material is too advanced or too basic to be of use to them.

Third, it is important that technical issues (the 'content' of HCBC work as it relates to service delivery around HIV and AIDS) and process issues (concepts of organisational development and growth) not be treated as two separate elements, but as interlinked ones. In a successful training and capacity building programme, the training curriculum and the trainers/mentors themselves need to address both technical and process-related issues. This, therefore, suggests the need for caution in appointing service providers who are proficient in only one, but not both realms. For example, a growing number of consulting firms offer training services on a fee for service basis, and may bring significant institutional expertise to issues of organisational development. Yet without an understanding of the principles of community development in general, and HIV and AIDS in particular, the services they offer are likely to be of limited value. It is important that capacity building programmes 'speak the language' of the organisations they seek to develop – in both a literal sense (use of local languages is highly encouraged) and a figurative one. Mentors and trainers need to be able to understand – ideally from personal experience – the conditions under which HCBC organisations are operating and the types of challenges they face.

Fourth, a broad-based capacity-building programme would ideally incorporate a range of different approaches, or modalities, each of which addresses a certain set of processes or issues, but which is reinforced over time by other approaches. For example, standard training modules of short to medium-term duration (eg. two-week courses) may be the most effective way of transferring a 'block' of concepts and basic knowledge to individual participants, but for this learning to take root it will likely be necessary to make individual site visits to organisations or to provide other forms of on-going advisory support. One-on-one mentoring approaches are often seen as effective in translating new knowledge into practice, but cannot be rushed and need to roll out steadily over a longer period of time. Established NGOs may be in a position to assist local CBOs with certain functions, but cannot be expected to fully capacitate them and need to be part of a broader approach which also offers more specialised training for their own needs. In other words, a capacity building programme should be multi-faceted in its elements, with each individual component designed to play a particular role alongside the others.

Fifth, the programme should emphasise quality of the training experience over quantity of individuals/organisations trained. Organisational development is complex and multi-layered, and is unlikely to occur if the approach taken is to train as many individuals as possible through boilerplate modules. Emphasis on quality of training will require setting minimum standards around the duration of the mentoring partnership; the type and level of participation (Who should attend? What levels of performance are they expected to attain?); the profiles and skill levels of trainers/mentors; the appropriate ratios of trainers to participants; and the expected outcomes of the process, including interim milestones and benchmarks.

Finally, participation in the capacity building programme should be not compulsory for HCBC organisations to obtain funding. Rather, funding should be made available to groups that can demonstrate their competency according to the established minimum capacities. This creates a dynamic where organisations recognize the need for these skills and choose proactively to develop them, rather than undergoing a training process for instrumental purposes only.

An effective capacity building programme should also ideally address the district-level officials that work closely with HCBC organisations, as well as the organisations themselves. At district level, the provincial DSD employs junior managers entrusted with HCBC monitoring and support. These officials need to become partners in the management capacity building programme and to develop a sounder grasp of management and organisational development issues. Elements of the capacity-building programme should be directed at these officials as participants.

6.2 AREAS FOR FURTHER INVESTIGATION

The present study investigated a large number of questions through a research design that was relatively limited in terms of sample size and geographical spread. Although it succeeded in identifying many key issues of relevance to a future capacity building programme, the research also threw up additional questions which could benefit from further attention or investigation.

First, the research did not attempt to evaluate the quality or reach services being provided by HCBC organisations or to link the quality of services to issues of HCBC management capacity. This would be an important area for further research. It would be of interest, for example, to understand the extent to which strong management capacity enhances the effectiveness of the services being rendered and indeed which aspects of management capacity appear to be important in this respect. An understanding of this link could help to shape the emphasis of future capacity building efforts.

Second, it will be important to conduct assessments of the Expanded Public Works Programme in relation to the HCBC sector as the initiative rolls out across the country. The successful implementation of the EPWP represents an enormous opportunity for and investment in the HCBC sector. It directly impacts the training and funding of HCBC carers, providing individuals with skills, economic support and enhanced opportunities for future employment. It advances the sector as a whole by formalising the HCBC-associated training and qualifications. However there are some inherent risks to the EPWP framework as well, and it will be important to understand the experiences of EPWP volunteers in HCBC organisations, as well as those of the HCBC organisations that host them.

Third, this research identified a number of models that are currently being used in South Africa to train, capacitate and support HCBC organisations in their operations. It would be of interest to undertake a more detailed assessment of these models to better understand their strengths, weaknesses and opportunities for being taken ‘to scale.’ What elements of these models have been particularly successful and why? Which could be replicated in other settings?

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Welfare Laws Amendment Act, No. 106 of 1997

ANNEXURES

Annexure 1 CBO/NGO Support and Service Providers

1. Partner Mobilisation	
Child in Distress CINDI – Networking for Children affected by AIDS	www.CINDI.org.za
Eastern Cape NGO Coalition	www.ecnoc.co.za
WC-NACOSA	www.wc-nacosa.co.za
Local AIDS councils	
Mentoring Resource Network (MRN) (Umbrella Body of Member Mentoring Groups)	www.mrn.com
HIVAN – Centre for HIV/AIDS Networking	www.hivan.org.za
South African National NGO Coalition (SANGOCO)	www.sangoco.org.za
Project Empower	www.projectempower.org.za
AIDS Consortium	www.aidsconsortium.org.za
AIDS Foundation of SA	www.aids.org.za
Human Health Development Trust (KwaZulu Natal)	
2. Technical Support	
HOPE *worldwide* SA	www.africa.hopeww.org
South African Training Schools without Walls	info@satregional.org
Heartbeat, Centre for Community Development	www.heartbeat.org.za
International HIV/AIDS Alliance	www.aidsalliance.org
OLIVE – Organisational development and training	www.oliveodt.co.za
Seboka (North West)	Mr Nombe 012-7032273 083-372-2485 083-2273449
Ragoga Support Group (North West)	Mr S Sehloho 018-4621810 082-4681721
NACOSA (Western cape)	www.wc-nacosa.co.za
Barnabas Trust (Eastern Cape)	www.barnabastrust.co.za
Unsung Heroes	www.Provision-International.org www.Unsung-Heroes.org
LAMP (Free State)	Boysie Motang PO Box 9569, Bloemfontein 9300 Tel: 051 430 3769
ANCRA (Northern Cape)	Marcia Manong 053-7120791/2/3 083-2851932
Thabiso (Northern Cape)	Mrs S Cronje 053-4975962
HEAPS (Mpumalanga)	Oupa Dlamini 017-6324171

CHOICE (Limpopo)	Fiona MacDonald PO Box 2181 Tzaneen 0850 Tel: 015 307 6329
3. Grant-making	
Starfish, Great Hearts Foundation	www.starfishcharity.org
National Development Agency	www.nda.org.za
The Funding Site	www.thefundingsite.co.za
4. Resource Mobilisation	
Starfish, Great Hearts Foundation	www.starfishcharity.org
HOPE *worldwide* SA	www.africa.hopeww.org
5. Documentation and Research	
Centre for AIDS Development, Research and Evaluation (CADRE)	www.cadre.org.za
Health Economics and HIV/AIDS Research Division (HEARD)	www.heard.org.za
Capacity.org (online resource)	www.capacity.org
Population Council	www.popcouncil.org
6. Policy and Advocacy	
International HIV/AIDS Alliance	www.aidsalliance.org
Treatment Action Campaign (TAC)	www.tac.org.za
Family Health International	www.fhi.org
7. Monitoring and Evaluation	
African Evaluation Association	www.afrea.org
Centre for Disease Control	www.cdc.gov