SADC HIV AND AIDS CAPACITY BUILDING STRATEGIC FRAMEWORK
2010-15

SADC Directorate of Social and Human Development and Special Programmes
(SHD&SP)
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### Abbreviations

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<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ACHAP</td>
<td>African Comprehensive HIV and AIDS Partnership</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Treatment</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>CCM</td>
<td>Country Coordinating Mechanism (for GFATM grants)</td>
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<td>CB</td>
<td>Capacity Building</td>
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<tr>
<td>CSOs</td>
<td>Civil Society Organisations</td>
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<tr>
<td>CHWs</td>
<td>Community Health Workers</td>
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<tr>
<td>FBOs</td>
<td>Faith Based Organisations</td>
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<tr>
<td>GFATM</td>
<td>Global Fund to Fight AIDS, Tuberculosis and Malaria</td>
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<td>HCT</td>
<td>HIV Counselling Testing</td>
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<tr>
<td>HIV</td>
<td>Human Immune Virus</td>
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<tr>
<td>HR</td>
<td>Human Resources</td>
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<tr>
<td>HRH</td>
<td>Human Resources for Health</td>
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<tr>
<td>ICPs</td>
<td>International Cooperating Partner</td>
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<tr>
<td>IDU</td>
<td>Intravenous Drug User</td>
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<tr>
<td>INGOs</td>
<td>International Non Governmental Organisations</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<tr>
<td>MCP</td>
<td>Multi Concurrent Partnerships</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<td>MS</td>
<td>Member States</td>
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<tr>
<td>NAA</td>
<td>National AIDS Authorities</td>
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<td>NAC</td>
<td>National AIDS Council</td>
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<tr>
<td>NGOs</td>
<td>Non Governmental Organisations</td>
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<tr>
<td>OVCY</td>
<td>Orphans and Vulnerable Children and Youth</td>
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<tr>
<td>PEPFAR</td>
<td>The US President’s Emergency Plan for AIDS Relief</td>
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<tr>
<td>PLHIV</td>
<td>People Living with HIV and AIDS</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of mother to child transmission</td>
</tr>
<tr>
<td>PPPs</td>
<td>Public Private Partnerships</td>
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<tr>
<td>QA</td>
<td>Quality Assurance</td>
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<tr>
<td>RISDP</td>
<td>Regional Indicative Strategic Development Plan [of SADC]</td>
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<tr>
<td>SADC</td>
<td>Southern African Development Community</td>
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<tr>
<td>DSHD&amp;SP</td>
<td>SADC Directorate of Social and Human Development and Special Programmes</td>
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<tr>
<td>STIs</td>
<td>Sexual Transmitted Infectious</td>
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<tr>
<td>TB</td>
<td>Tuberculosis</td>
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<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session on HIV and AIDS</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Aid</td>
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<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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EXECUTIVE SUMMARY

Capacity building (CB) is a process that enhances performance and contributes to sustainability in meeting long term goals. This Capacity Building Framework considers the capacity necessary within the SADC Region to reach the goals of the SADC HIV and AIDS Strategic Framework 2010-2015.

The Framework is expected to contribute to achievement of the Millennium Development Goals as the impact of the HIV and AIDS epidemic on specific Goals and general development within the SADC Region is profound. Health and social sectors are required to deliver services at unprecedented levels in the areas of prevention, treatment, care and support. This, coupled with the direct impact the HIV and AIDS epidemic has on sectors that are highly dependent on human resources such as health, makes capacity building a key intervention to bolster the efforts of the Region to meets it’s HIV and AIDS goals.

Capacity Needs and the Capacity Building Approach

The SADC HIV and AIDS Capacity Building Needs Assessment conducted across fourteen Member States (MS) indicated capacity needs in all of the focus areas of the SADC HIV and AIDS Strategic Framework 2010-2015. Five main cross-cutting themes were identified as the focus of the CB Framework through analysis and prioritisation of the needs, as well as assessment of which responses are most appropriate for regional-level action.

This Framework adopts a systems approach to understanding the capacity challenges underlying the existing response to the HIV and AIDS epidemic at both a SADC Regional and MS level. A systems approach recognizes that all areas of performance involve a complex and interdependent set of human and operational systems. Key role-players include organizations, institutions or individuals with specific responsibilities or authority. Success factors for CB tend to include: a) Sound analysis of which systems obstruct performance and the nature of capacity gaps, as well as key systems and key stakeholders in each performance area, which may be internal to the system or external influences; b) Use of strong, well facilitated processes that involve all key role players, build relationships and have flexibility to respond to evolving understanding of issues; and c) Targeting system components with the greatest potential for improving overall system performance, and which can have multiplier effects through a system.

The Framework adopts an asset based approach, which concentrates on building on existing capacity and successes to realise their full potential, rather than just gaps and problems that can become debilitating. Strategy also focuses on developing collective capability of organisations not just competencies of individuals, and on ensuring that a range of creative CB strategies can be applied in each outcome area. The range of challenges means that prioritisation is necessary in strategy and in operational plans.

Goal and outcomes of Regional HIV and AIDS capacity building

The SADC HIV and AIDS Capacity Building Strategic Framework (CB Framework) 2011-2015 has one goal and five key outcomes. The goal addresses the capacity
necessary to enhance the delivery of the outcomes of the SADC HIV and AIDS Strategic Framework 2010-2015. This ensures that the Capacity Building Strategic Framework is aligned with current regional HIV and AIDS priorities and plans. The outcomes that are to be achieved address the significant capacity challenges facing the implementation of the SADC HIV and AIDS Strategic Framework, and are considered to be strategic capacity building interventions that will unlock better performance. It is important to recognize that this CB Framework is not designed to comprehensively address all the capacity gaps facing the HIV and AIDS response. Rather, it focuses on those that can best and most feasibly be addressed through a regional strategy. Furthermore, some capacity challenges require relatively long term perspectives in order to ensure that the region and MS really achieve sustainable solutions.

The first four Outcomes focus on the following:

1. The importance of strengthening leadership across all sectors and levels for effective prevention, care, support, impact mitigation and resource mobilization.
2. Creating capacity for excellence in planning and management for the HIV and AIDS response in health and other relevant sectors, and in both senior and lower levels of management across MS.
3. Overcoming the present human resource crisis in the region by ensuring adequate planning, production, recruitment and retention of personnel in health and other sectors necessary to the HIV and AIDS response, including use of a sustainable, efficient mix of staff.
4. Continuing to promote policy development that is conducive to action and facilitates effective social protection, public private partnerships, development partner roles and evidence based policy making in the region.
5. Addressing the capacity and resources necessary both, at a SADC Regional level, and within MS to drive a programme of capacity building. This will ensure both sufficient technical knowledge of capacity building and establish the resources and effective processes necessary to support change.

The outcomes also emphasise coordinated action across sectors especially in the health and social sector, and incorporating the contribution of civil society and other partners in a systematic way. Another common theme is ensuring that leaders and programme managers act and make decisions based on the best available evidence.

The narrative in this document discusses the context and nature of each capacity need and the proposed outputs and activities to address the needs. The selection of outputs and activities represent processes that involve a wide range of capacity building activities. Knowledge management is prominent and many activities will set up and support mechanisms for ongoing sharing of plans, good practice and learning between MS, and development of a range of networks across the Region. Training features prominently, but not in isolation to other complementary developments such as the development of a Network of Excellence for Health Planning and Management which may evolve into a Regional Institute, as well as the provision of appropriate system
tools such as M&E data, HR planning and resource tracking to support planners and managers in fulfilling their role effectively.
1 Introduction to the SADC HIV and AIDS Capacity Building Strategic Framework

Economic and social development in the SADC region is being challenged by limitations and incremental weakening of institutional and human capacity in many Member States (MS). At the same time the HIV and AIDS epidemic has had major negative impacts on human, social and economic development, as well as ability to achieve Millennium Development Goals.

Service demands arising from the HIV and AIDS epidemic have worsened capacity inadequacies, resulting in unmet needs and poor service delivery not only in HIV and AIDS programmes but in broader health, education, social welfare, management and planning functions. Serious concerns exist not only about the availability of skilled personnel, but also about equitable distribution, quality and productivity of the workforce. Fiscal constraints, particularly in a challenging economic environment, make it even more difficult to address these capacity deficits.

Increasing demands on health and social welfare have arisen in response to commitments such as the Millennium Development Goals (MDGs), new targets for access to HIV and AIDS treatment, and definition of minimum packages of health interventions. Other challenges are raised by the need for integration in order to avoid inefficient vertical programme approaches to particular health problems.

In this context HIV and AIDS programme interventions have great potential to serve as a catalyst and means to access resources for initiatives that can also help to strengthen broader health and welfare services. So it is important to make the most of opportunities to strengthen those systems, and also ensure that HIV and AIDS programmes do not inadvertently harm capacity of other sectors.

The main focus of this Capacity Building (CB) Framework is to guide capacity building that can enhance the delivery of outcomes of the SADC HIV and AIDS Strategic Framework 2010-2015. In addition it is intended to:

- Provide a SADC Strategic Framework to support the response of MS to HIV and AIDS.
- Set out how regional action over the longer-term will contribute to a sustainable solution to key capacity challenges.
- Serve as a reference point for partners and MS in developing their own CB strategies and interventions

The CB Framework will guide development of shorter-term business and action plans which tackle more specific priority actions and areas. They will also define responsibilities of the SADC Secretariat and MS for specific actions.

Needs Assessment Findings

The Framework has been developed from findings of the SADC HIV and AIDS Capacity Building Needs Assessment. Key findings of the assessment are discussed in the key performance areas of this Framework and are summarised in Annex 1. The Framework is structured around prominent overall themes arising from the assessment
which can be addressed at regional level. The themes cut across health and other sectors, and also across the specific needs identified in prevention, treatment, care, and support, and impact mitigation. Themes included: the central challenge of human resources (HR) and skills shortages; the need to strengthen capacity for evidence-based policy, planning and management of systems, programmes and services; the need for policy making in underdeveloped areas of the response; and the importance of strong leadership across all components of the response and at all levels in society and government (see Annex 2).

The Assessment also highlighted that successful CB cannot just focus on skills development and training of larger numbers of human resources. Institutional strengthening is also required as systems, structures and organisational environments must also be addressed if performance really is to improve.

The Framework itself was developed in a process that consulted with MS technical representatives and National AIDS Authorities. In these consultations and the Needs Assessment itself MS indicated that a successful CB response must ensure appropriate roles of SADC and MS responses. Regional actions should mainly facilitate capacity building by MS, not replace MS action.

1.1 The basis for SADC HIV and AIDS Capacity Development roles

This CB Framework is intended to support the achievement of objectives and results of the SADC HIV and AIDS Strategic Framework 2010-2015 (Table 1). This builds on the Maseru Declaration on HIV and AIDS which called for urgent action to address capacity challenges through strengthening skills, policies and systems in collaboration with civil society, the private sector, labour and international partners.

The Framework will also contribute to achievement of the Millennium Development Goals (MDGs) (2000) which highlight that sufficient capacity for the AIDS response is critical to achieve several goals. In particular Goal 4 (reduce child mortality), Goal 5 (improve maternal health) and Goal 6 (combat HIV and AIDS, malaria and other diseases) will be supported. Building capacity to combat HIV and AIDS will also address a number of other MDGs indirectly, along with African Union commitments.

The SADC HIV and AIDS Strategic Framework includes several initiatives that focus on the development of skills, systems and structures. They include: leadership by regional Champions interacting with heads of state; more evidence-based, prioritised and results-oriented practices though improved quality of planning, programming and programme management; and streamlining of national AIDS structures and roles of key stakeholders. Other areas marked for CB are health and community systems, health HR, M&E, resource mobilisation, mainstreaming and stronger partnerships with civil society and the private sector. A prominent feature is facilitating technical responses and resource networks to generate and manage knowledge, and leverage scarce capacity. Other SADC Frameworks in specific priority areas of the AIDS
**Response** also promote CB and have been considered in this Framework.¹ They cover areas such as prevention, OVCY, research and M&E.

### Table 1: The SADC HIV and AIDS Strategic Framework 2010-2015

<table>
<thead>
<tr>
<th>Thematic area</th>
<th>Objectives</th>
<th>Outcome results</th>
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| Prevention and social mobilisation          | 1. All Member States deliver on their universal access to prevention targets by 2015 | 1.1 Strong and proactive political leadership and champions drive the HIV and AIDS response and social mobilisation around HIV prevention and other priorities from 2010.  
1.2 All MS have in place effective, evidence-based and coordinated responses to HIV prevention needs of men, women, youth, children and other populations at particular risk by 2015. |
| Improved Access to Care, Counselling, Treatment and Support | 2. All member states deliver on their Universal Access targets to achieve access to quality treatment for people living with and affected by, HIV and AIDS and TB/HIV co-infection by 2015 | 2.1 The SADC region is able to meet universal access to effective HIV, AIDS and TB treatment, care and support and MDG targets by 2015.  
2.2 MS health systems and services are scaled-up to address HIV, AIDS, TB/HIV co-infection and other health priorities by 2015  
2.3 Access to quality HIV and AIDS, TB and other essential drugs, medical supplies and technology is sustained from 2010 |
| Accelerating development and mitigating impact of HIV and AIDS | 3. Reduced impact of HIV and AIDS and TB/HIV co-infection on the socio-economic and psychological development of the region, member states, communities and individuals, with all orphans, vulnerable children and youth having access to external support by 2015 | 3.1 An enabling environment that supports infected and affected people, including children, and that protects them against HIV and AIDS stigma and discrimination in place by 2015  
3.2 HIV, AIDS and TB/HIV co-infection and gender issues are effectively integrated into initiatives under the Regional Integration Strategy by 2010  
3.3 A coordinated, multi-sectoral, sustainable response to strengthen community coping and social protection in order to address the needs of children, OVCY and caregivers in place by 2015 |
| Resource mobilisation                       | 4. Sufficient resources mobilised for a sustainable, scaled-up, multi-sectoral response to HIV and AIDS in the SADC region that channels resources efficiently to operational and community level. | 4.1 SADC and MS able to increase alignment and efficient use of financial and other resources from 2010  
4.2 All MS including hyper endemic middle income countries able to sustain financing for AIDS by 2015 |
| M&E and Institutional Strengthening         | 5. Enhanced institutional capacity in the region supports evidence-based programme design, implementation, monitoring, reporting and evaluation at regional and MS levels to ensure progress towards regional, continental and global commitments | 5.1 The region has in place effective systems for gender sensitive M&E, knowledge generation and management to inform the response  
5.2 SADC and MS demonstrate stronger, evidence-based HIV and AIDS planning and implementation from 2010 |

The SADC *Regional Indicative Strategic Development Plan 2000-2015* is the overall framework for regional integration and cooperation. This foresees CB through

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regional coordination in areas such as: policies in health, education and welfare; exchange programmes, centres of excellence for training, and sharing of specialist capacity; qualification and accreditation systems; and systems such as joint procurement of health goods. Regional action is proposed to address the brain drain, harmonise policy on HR movement in the region, and standardise human capital information systems. Cooperation among MS is envisaged to strengthen capacity to absorb funding and reform relationships with development partners. The SADC Protocol on Health and Health Policy Framework (1998) stresses that MS need to work together, harmonise policies and share information to achieve Health for All. The Human Resources for Health Strategic Plan (2008) also proposes regional promotion, coordination and support for individual and collective action by MS.

Improvement of capacity for the HIV and AIDS response also responds to continental and global frameworks in addition to the MDGs. They emphasise the importance of inter-sectoral capacity building and also of linking HIV and AIDS into broader health system capacity building. The Abuja Declaration (2001) undertook to mobilize all the human and financial resources needed for care, support and quality treatment of people with HIV, TB and related infections. Universal Access commitments also require sufficient capacity to achieve targets in prevention, care and impact mitigation.

1.2 The approach to development of the CB Strategic Framework

This Framework defines capacity building as improving performance and ability to achieve certain outcomes or results, such as better service delivery. 2,3 This definition fits with current good practice, and also links it to existing plans and commitments. It helps to avoid CB strategies that are too narrow (e.g. restricted mainly to training), or that are too broad and risk duplication and confusion where other plans and Regional commitments already seem to cover aspects of the CB agenda.

Some of the initiatives will however focus on establishing processes that enable MS to fully achieve their capacity targets after 2015, given the long term nature of capacity development and large backlogs.]

The CB Framework aims to achieve results at both the Regional and MS levels. Therefore it is envisaged that interventions will:

- Build capacity at regional level to support MS in some areas
- Facilitate CB at country level through Regional level interventions that support MS action.
- Include CB for the SADC Secretariat itself so that it has sufficient capacity and resources to perform its roles.

MS will play important roles in establishing sound processes, contributing learning and experience, and implementation to achieve desired outcomes. In some cases providers appointed by SADC Secretariat may be used to supplement its own capacity to implement the Framework.

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2 A recent review defined capacity development in the public sector in terms of, “enhancing the ability of the state to deliver on its mandate” (Kersher et al 2006).
The Framework recognises that CB initiatives which are relevant to its priority areas are already under way in MS and a number were identified as potential good practice examples in the Needs Assessment. Actions under the Framework will coordinate with these activities and are intended to build on them in order to consolidate their benefits for MS and the Region.

1.2.1 Conceptual foundations of the CB Framework

The approach to capacity building used in this Framework draws on the following foundations which are discussed further in Annexure 3.

1) A systems approach. The systems approach recognises that performance depends not only on operational systems such as referral or information systems. It also depends on a set of complex human systems which affect ability to achieve desired changes, as well as various sub-systems. This is particularly important when addressing a complex range of MS realities, priorities and stakeholders. CB that can lead to real change, will need to consider several key issues:
   - Analysis of which systems obstruct performance and the nature of capacity gaps in each performance area. These may be internal to the system or related to external influences on a system (e.g. government policies outside of health).
   - Emphasis on setting up sound, well facilitated processes. These need to identify and involve all key role players, build relationships and have flexibility to respond to evolving understanding of issues and priorities. These may be internal to the system or related to external influences on a system (e.g. government policies outside of health).
   - Targeting system components with the greatest potential for improving overall system performance, and which can have multiplier effects through a system.

2) An asset based approach. Successful CB needs to build on some form of capacity which can be worked to realise its full potential. There should, thus, be a focus on available capacity, what is working and the positive capabilities and energy of stakeholders. Heavy emphasis on the many gaps and problems can be demotivating and debilitating.

3) Development of individual competency and collective capability. Capacity building is often about building collective capability of organisations and systems to perform. Focus on just building the competency of individuals can have disappointing results. Attention also needs to be given to the networks and systems in their immediate and broader work environment, which may be the key determinants of their ability to perform and exercise their competency.

4) The need for a range of creative strategies for effective capacity building. Strategies to resolve major system weaknesses usually need to incorporate sufficient types of CB interventions which can reinforce one another and address a range of systems and stakeholders. These may, for example, include effective facilitation of processes; enhancing leadership; training; strengthening system tools; enhancing communication; building working relationships and networks; HR planning; and providing technical support.

5) Need for prioritization. The range of capacity challenges means that prioritisation is necessary both in strategy and in subsequent operational planning.

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4 A Results Orientated CB methodology was used for analysis in this framework. See ROACH, Annex 3.
2 Capacity Building Strategic Framework Principles, Goal and Outcomes

This section of the report gives the principles, goal and outcomes of the draft Capacity Building Framework. The outcomes are also described as “strategic performance areas” and these areas or outcomes are unpacked in Section 3 of the report into outputs and activities.

2.1 Principles informing the CB-Framework

The regional response analyses, as well as emerging issues and trends in the region have informed the development of the following guiding principles.

a) Comparative advantage. [Delete: Capacity building activities and programmes should reflect the comparative advantages of regional and MS organisations. In particular,] Regional action should support MS to achieve their goals and be in harmony with MS needs and priorities. Regional actions should not try to replace MS action. Areas in which regional actions tend to have a comparative advantage include:
   o Development of coordinated, harmonized policy and guidelines
   o Knowledge management, including generating and disseminating knowledge, and developing networks to facilitate learning across MS.
   o Capacity building in particular new areas of common interest.
   o Issues which inherently involve more than one MS such as approaches to mobile populations or coordinated behaviour change strategy.
   o Activities which generate regional “public goods” or cost-effective solutions which are difficult to produce optimally through uncoordinated action of individual MS such as specialized services or joint procurement.

b) Multi-sectorality and partnerships. Capacity building initiatives should ensure effective collaboration across government sectors, civil society, development partners and other sectors to use their comparative advantages to facilitate a stronger MS response. In particular the CB response for HIV and AIDS must coordinate with broader initiatives in the health, welfare/social development and education sectors, which face the largest demands for capacity to address the epidemic.

c) Integration with the Regional Indicative Strategic Development Plan (RISDP). Capacity building initiatives must coordinate with the priorities, challenges and opportunities arising from the RISDP which has a specific focus on capacity building and has a major influence on collaboration across MS.

d) Gender sensitivity. Gender sensitivity must be ensured in all HIV and AIDS capacity building policies and programmes.

e) Evidence based and contextual relevance. Capacity building should enable responses based on evidence of what works and on sound data to design more effective prevention, treatment and impact mitigation initiatives. Interventions should also fit the contexts of MS and communities.

f) Respect for human rights. Policies and programmes must promote, protect and respect human rights. [Delete: of people who are infected and affected by HIV and AIDS, as well as those of uninfected people.]

g) Participation. Meaningful participation is imperative for successful action.
This requires input of all MS, all relevant sectors and all segments of citizenry, including participation by people living with and affected by HIV and AIDS, and by marginalised groups.

h) Transparency and accountability. Transparency and accountability are imperative between MS, SADC, international partners and other partners as they tackle capacity issues in the AIDS response. This includes subjecting MS to peer pressure to hold each other accountable for their national responses and resource allocation to AIDS.

2.2 Goal SADC Capacity Building Strategy

The Capacity Building Framework aims to enhance the performance of the Region in achieving the vision, mission and main objectives of SADC’s HIV and AIDS Strategic Framework (2010-2015). The goal is:

Enhanced delivery of the outcomes of the SADC HIV and AIDS Strategic Framework 2010-2015 through CB interventions that unlock performance at regional and MS level

2.3 Outcomes for SADC the CB Framework Capacity Building Strategy

Five high level long term outcomes have been identified to contribute to achieving the goal of the CB framework. These outcomes address priority capacity building interventions in strategic performance areas. Although the CB Framework aims to assist the region and MS to meet specified results by years given above in the stated goal, some CB interventions may have longer term targets and time horizons to create sustainable and effective capacity beyond 2015.

The strategic capacity building intervention areas are described in Section 3. Medium or short term outputs and actions that lead to these outcomes are also described. The five outcomes of the CB framework are as follows.

Outcome 1: Well established and supported leadership for a coordinated, evidence-based HIV and AIDS response exists at regional level and at all levels within sectors in MS for effective prevention, care, support, impact mitigation and resource mobilisation by 2015.

Outcome 2: Capacity is in place by 2015 to produce required numbers of skilled planners and managers for excellence in Planning and Management of the HIV and AIDS response in health, welfare, education and other key partner sectors in the Region

Outcome 3: Planning, production, recruitment and retention systems are in place to ensure availability of the required human resources for health and other priority sectors for the HIV and AIDS response in the region by 2019.

Outcome 4: Policy and guidelines developed, implemented and monitored to support MS to enhance social protection, public private partnerships, development partner roles and evidence based policy making in the SADC region.
Outcome 5: Capacity Building work in priority areas of the HIV and AIDS and health system response is suitably informed, resourced and supported at regional and MS level.

Figure 1 illustrates how Outcome 5 will support the other outcomes, and that together they will facilitate both achievement of the objectives of the HIV and AIDS Strategy Framework and Member State capacity building initiatives.

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**3 Strategic Capacity Building Intervention Areas**

**3.1 Strategic Performance Area 1: Leadership**

**3.1.1 Summary of leadership capacity needs**

Strong and visible leadership in political, community and institutional settings has given momentum to improved planning, implementation, monitoring and resourcing of regional and national responses to HIV and AIDS. However, the scale and complexity of the response continues to create an ongoing need to reinforce leadership capacity at all levels and across sectors to achieve the objectives of the HIV and AIDS Strategic Frameworks. Key challenges have been noted in relation to leadership for prevention. Heavy demands on available leadership capacity are also
reported at various levels in treatment, care, support, impact mitigation, resource mobilisation, M&E and institutional strengthening of NAAs and other sectors.

The main areas in which the Needs Assessment identified opportunities to strengthen leadership capacity included:

- Support to reinforce *knowledge and skills* among leaders in various sectors and levels. This can for example help them to more easily engage and use emerging technical information. A particular challenge is that leadership often requires an integrated picture of the HIV and AIDS response across sectors and various program components in order to produce coordinated action by stakeholders.

- Promoting ways to address *structural challenges* to coordinated leadership. The allocation of responsibilities for the HIV and AIDS response falls across a complex range of structures such as NAAs, Ministries, partnership structures such as CCMs, and civil society. This makes strong and coordinated leadership more difficult as, at all levels, leaders within separate structures need to create incentives for stakeholders to work together constructively and efficiently. Also the location of leadership can be unclear within sectors, particularly those that have responsibility for mitigation.

3.1.2 *The Present Regional Response to strengthen leadership*

The Regional HIV and AIDS Strategic Framework and Business Plan include interventions associated with leadership particularly, but not only, in relation to prevention. Coordinated leadership across NAA of MS has emerged through interaction at regional level. Increasing leadership has been provided on HIV and AIDS issues at Ministerial level across MS, not only in health but also other sectors such as education. SADC Parliamentary Forum initiatives have also enhanced ability of political leaders to influence the HIV and AIDS response. The regional HIV and AIDS Champions is an important recent initiative.

In addition, a range of projects with development partners at MS level have included initiatives to cultivate leadership at national and local level, as well as among health sector managers.

The coverage and impact of these initiatives has not been systematically assessed. However, they clearly provide a foundation for ongoing strengthening of leadership across the region. The Capacity Building Needs Assessment highlighted opportunities to strengthen leadership to support the overall HIV and AIDS response, especially by expanding leadership development to adequately cover all levels sub-components of the response, and by reinforcing coordination between its components and structures.

3.1.3 *Framework to strengthen leadership capacity for the HIV and AIDS response*

| Outcome 1: Well established and supported leadership for a coordinated, evidence-based HIV and AIDS response exists at all levels within sectors in MS for effective prevention, care, support, impact mitigation and resource mobilisation by 2015. |
HIV and AIDS leadership includes leadership in planning and management in the health, welfare and other relevant sectors, and also political, civil society and community leadership to actively champion issues related to HIV and AIDS. This requires coordination with other leadership development initiatives in partner sectors in order to maximise synergy.

The strategies and activities outlined below propose that the focus of the capacity building intervention should be on highlighting leadership, mobilisation and coordination that are working well in MS, and providing the opportunity for others to learn through workshops, twinning of programmes and Ministries to share experience. Opportunities will also be developed to groom and mentor leaders despite some of the challenging structural arrangements facing leaders today. The strategies and activities acknowledge the structural challenges facing the location and recruitment of leadership in and across sectors and structures, and at national and lower levels. Changes to the structures found within MS may be desirable but changes to them are not assumed or a major focus of the framework.

A number of key systems across the region actively support and rely on strong leadership at various levels for prevention and other performance areas. These systems include senior political leadership, community and civil society leaders, Government and other Officials in lead institutions and Ministries involved with the HIV and AIDS response and leadership and training centres.

Key stakeholders involved with leadership are Ministers and Advisors; Parliamentarians; Youth and Women Leaders; Civil Society organizations; the private sector; Religious and Traditional leaders. Among government and other officials, important stakeholders to involve are: Senior and middle management in government sectors; NAA Officials; members of partnership fora and structures such as CCMs; and providers of management and leadership development programmes. Partnership fora at national and regional levels can also provide key support to initiatives.

The proposed programme will directly support senior leadership across MS combined with development of approaches, knowledge and tools which can then be rolled out by MS to develop leadership in all relevant levels and sectors within MS.

<table>
<thead>
<tr>
<th>Output</th>
<th>Activities</th>
</tr>
</thead>
</table>
| 1.1 Recognition and profiling of effective leadership and leadership development practice | • Review progress with Champions initiative and other leadership development in AIDS across the region by end of 2011.  
• Collect best practice leadership studies to profile leadership in action and guide new leaders from 2011  
• Events to enable leaders to meet and mentor new leadership from 2011  
• Awards to recognize excellence in leadership in key areas of the response in various sectors by 2012 |
| 1.2 Creation and support of leadership networks at regional level and then nurturing of network development in MS from 2011 | • Integrate or align plans and activities with prevention and other aspects of the HIV and AIDS Strategic Framework.  
• Consult with key leadership to establish effective models for networks and leadership development by end 2011.  
• Establish a database of AIDS leadership across sectors by |
### Output

<table>
<thead>
<tr>
<th>Activities</th>
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<tbody>
<tr>
<td>mid 2011.</td>
</tr>
<tr>
<td>• Facilitate recruitment of leaders into networks from 2011</td>
</tr>
<tr>
<td>• Develop and update quality leadership information packs, electronic communication and a regional workshop programme for leadership from mid 2011.</td>
</tr>
<tr>
<td>• Mentor and twin leaders across MS from 2011</td>
</tr>
<tr>
<td>• Develop processes to extend leadership networks to new and decentralised levels and sectors within SADC and MS beginning in 2012</td>
</tr>
<tr>
<td>• Ensure succession by new leaders at regional level and support succession in MS where appropriate from 2011</td>
</tr>
</tbody>
</table>

### 1.3 Leadership on HIV and AIDS and health integrated in planning and management curricula and modules by 2012

<table>
<thead>
<tr>
<th>Activities</th>
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<tbody>
<tr>
<td>• Align leadership plans and activities with planning and management CB (See Performance area 2 CB Framework)</td>
</tr>
<tr>
<td>• Identify, adapt or develop modules in HIV and AIDS leadership for planners and managers in health and related sectors by end 2011</td>
</tr>
<tr>
<td>• Pilot and facilitate roll out of training modules with leaders in MS including NAAs, MoHs, other Ministries, CCMs and civil society from early 2012.</td>
</tr>
<tr>
<td>• Incorporate modules into existing training programmes at public sector management training centres in the Region beginning in 2011.</td>
</tr>
</tbody>
</table>

### 3.2 Strategic Performance Area 2: Planning and Management

#### 3.2.1 Summary of the Planning and Management capacity needs assessment gap

Planning and management is a complex capacity challenge across the Region that spans all thematic areas of the HIV and AIDS Strategic Framework.

At MS level there are frequent concerns about capacity to develop evidence-based, prioritised strategic plans and proposals in an efficient and effective way. Furthermore, there are difficulties translating national level strategies into effective operational and decentralised planning, budgeting and management, which can really enhance implementation. There are specific limitations around capacity for programming and programme management to operationalise key interventions effectively. Also, ability to institutionalise performance-based planning and management is very limited. These factors make it difficult to ensure and demonstrate efficiency in response to resource constraints.

For managers and planners there is a particular need for mechanisms to support better co-ordination across programmes within the health sector and HIV and AIDS program components, as well as to involve sectors outside health in impact mitigation and other areas that require a more comprehensive approach. In addition to insufficient numbers of planners and managers in this area, there are also limited links between HIV and AIDS programme plans and core national planning and budgeting systems, as well as other national plans in areas such as poverty reduction. Planning and management limitations also make it more difficult to realise the full potential of civil society in contributing to sustainable responses.
The most pressing capacity gaps to target in this area relate to limitations in the following areas.

a) **Systems and system tools**

Gaps in systems and system tools to support the planning and management process are a capacity issue raised by stakeholders across MS. There are few generally accepted, quality tools and approaches that can enable planners and managers to do their work effectively and efficiently. Relevant systems include:

- Persisting limitations in systems to align donor funding proposals and systems with MS and Regional priorities and systems.
- Inadequate data and systems to support evidence based planning both for domestic and donor funded programmes. This includes lack of priority planning information on effectiveness and how efficiency can be enhanced to deal with resource constraints.
- Underdeveloped data, tools and approaches for HR planning and management
- Inadequate, uncoordinated M&E systems. This includes lack of alignment of donor and government M&E systems, and limited systems to produce qualitative information or facilitate use of M&E in management decision making.
- Limited systems and tools to support wider application of performance based management.
- Poor mechanisms to plan and then track resources and funding during programme implementation

b) **Knowledge and skills**

Even where tools and methodologies exist there is not a critical mass of knowledge and skills in key areas of planning and management for HIV and AIDS response in the Region. Skills and experience for HR planning and management is clearly a huge challenge which confronts MS. Some other gaps are specific to technical areas such as the design and evaluation of communication and prevention strategies. Other gaps are more generic and concerned with how do planners and managers apply new research and data to the planning process, and knowledge of good practice in planning. A particular shortage of programming and programme management skills is widely reported to limit ability to operationalise plans.

Planners and managers express the need for support with the preparation of proposals and plans for both domestic and donor purposes. Constraints arise from lack of skills and experience, although they are made worse by demands on existing capacity due to lack of alignment between government and HIV and AIDS program systems, including multiple donor systems. They also require support to develop the skills associated with lobbying, bargaining and negotiating in order to secure resources and support, facilitate prioritisation, and improve alignment of policies and systems.

Limitations of planning and management skills also reduce the ability to realise the full potential of civil society in contributing to sustainable responses.]

Planners and managers faced with huge capacity challenges also lack knowledge about capacity building itself. They therefore have difficulty in guiding and
supporting capacity building interventions at regional, national and lower levels. Even where resources are available to address capacity challenges they may thus not produce the results that they could.

c) Incentives and expectations

The HIV and AIDS response has been undermined by a culture within the development sector as a whole which does not create appropriate expectations and incentives to ensure good practice. The use of evidence-based and sustainable approaches to HIV and AIDS planning and programmes is not fully embedded within key stakeholders in the Region. This contributes to ongoing development of plans that fail to pay adequate attention to evidence, prioritisation and sustainability.

Likewise performance and results based management have not yet been integrated into the organizational culture and systems of many institutions in the health and development sector. Some potentially useful precedents have been introduced, for example by the Global Fund or public sector management reforms. However, linkages with key stakeholders such as Ministries of Finance and Public Service have not been well developed. Resulting complexities increase demands on managers and planners, while opportunities are lost to use HIV and AIDS programmes to develop good practice precedents for broader health and public services. Limited learning is available to MS about good practice in decentralised HIV and AIDS and health planning in order to overcome culture and system obstacles at that level.

3.2.2 The Regional response to planning and management challenges

Within the present HIV and AIDS Strategic Framework the need to strengthen planning and management is recognised in all the thematic areas. Particular attention is given to planning around HIV prevention strategy, programmes to address OVC and youth, scaling up to achieve national service delivery targets, and capacity building for SADC and MS on M&E and health information systems. In keeping with the CB Needs Assessment the framework emphasizes taking plans from paper into implementation, appropriate monitoring and the value of evidence-based approaches. There is also specific mention of the importance of involving planners from education and social welfare-related sectors in programming for OVCY. Lessons from previous SADC initiatives to build regional and MS capacity in mainstreaming, are also available to inform further action in this area.

A number of initiatives, many of them donor funded, have attempted to build capacity of planners and managers. Some examples of progress have emerged in creation of centres and networks of excellence to serve the region in relation to HIV and AIDS planning, including prevention planning.

The most common approach to challenges in HIV and AIDS planning and management are short-term interventions that match specific types of planners with training programmes that address particular needs such as programming for OVCY or for Global Fund applications. Some have been regional initiatives around specific tools and methodologies while others have sought longer term engagement and large scale CB with MS. Many have focused on training, although some have had broader approaches to skills development as well as tackling systems and other aspects of
capacity. Some countries and development partners have actively tried to manage negative implications of unharmonized programmes, such as efforts to avoid paying project salaries that attract planners and managers out of core public services.

Whilst these short-term interventions have value they often have limited impact in strengthening the overall capacity for planning and management. They tend to impart skills to a limited number of stakeholders who may have high attrition rates, and often have difficulty engaging with and changing broader organisational culture and systems that impede effective planning. There has been lack of systematic sharing of experience, best practice and lesson learning which creates tendencies to repeat mistakes in CB intervention design. Strategies are also often inadequately coordinated to amount to large scale, mutually reinforcing inputs.

Overall, the benefits of interventions to strengthen core, sustainable country institutions and capacity for planning and management do not seem to be maximised across MS. In addition, it is not clear that many providers of formal tertiary training and education have sufficient linkages to real-life and strategic priorities in planning and management. The ability of the region to provide intellectual leadership on planning and management of the response remains limited, and too dependent on external support and resources.

Several key systems need to be addressed in CB for management and planning. One is public sector planning and management systems that influence skills and system development frameworks, as well as organisational culture and incentives. The tertiary education system is required to support sustainable capacity building at scale for MS in the longer term and can also contribute to short term CB. Various development partner and other systems provide capacity building to meet shorter term needs. These should be engaged to ensure that their activities are coordinated to maximise benefit across and within MS. They should also feed into longer term institutional and system development for CB, rather than distract from them.

Key stakeholders to engage in CB strategy for management and planning include Public Sector management and planning bodies such as planning commissions, as well as senior managers in MoH, Welfare/social development, NAAs and partner sectors. Less senior managers in these sectors and at decentralised levels such as districts should also be engaged. Tertiary education stakeholders are key players and include Schools of Public Health, and institutions offering Public Administration, Public Sector Management, and Nursing Management. Providers of shorter term Capacity Building programmes who should be engaged include donor programme managers, and technical and Capacity Building staff who develop interventions.

3.2.3 Framework to address Planning and Management Capacity Building

Outcome 2: Capacity is in place by 2015 to produce required numbers of skilled planners and managers for excellence in Planning and Management of the HIV and AIDS response in health, welfare, education and other key partner sectors in the Region

The Capacity Building framework proposes a long-term strategy to develop planning and management capacity at scale in the region. Interventions are expected to
strengthen not only HIV and AIDS responses but also health and social protection planning and management.

An important first aspect of the Framework will be shorter term interventions to identify and roll out access to training modules that address priority needs and build towards a longer term, sustainable system.

In the long term a cadre of professionals qualified to plan and manage health and social services is required. A key aspect is to build a larger stratum of mid-level staff who are well orientated to be the next generation of planners and managers. Senior planners often have limited time to exercise new skills, or move to new jobs.

The second strategic output will establish a Network of Excellence for health and social sector planning and management that can over time progress to a Regional Institute for these sectors. The Network will be comprised of centres offering training in MS across the Region, and will focus on enhancing their ability to achieve excellence and greater coverage. The Institute and Network will provide recognized qualifications and institutional capacity, and systems such as knowledge management, to support continued capacity building.

The strategy’s third area of focus will be to facilitate improvements in key systems in areas such as M&E, HR systems, resource tracking and procurement and supply management. Processes will be identified and supported to ensure better availability and quality of information, and its more systematic use in planning and management. Weakness in these areas is multi-factorial, but there is a clear gap in the area of identifying and facilitating use of more effective tools and methodologies, in order to maximize opportunities for planners and managers to use more evidence informed and good practice approaches. Specific attention will be given to M&E of planning and management needs and CB under Output 4. Across all four outputs the regional programme will facilitate processes to enable MS to coordinate and streamline donor and country systems in priority areas.

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Activities</th>
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</table>
| 2.1Quality training modules about HIV and AIDS planning and management priorities are integrated into curricula at Public Sector and academic training institutions across the Region by 2012 | • Establish a Regional task team of academic, training, planning and management specialist practitioners to review needs and curricula by end 2010  
• Agree priority CB topics to be addressed in training by mid-2011 and regularly update them in consultation with AIDS programs e.g. HR planning and development, prevention planning, programming, procurement, MARPS.  
• Prioritise modules for HR planning, management and development in health and welfare to support Outcome 3 by end of 2011  
• Develop a regional database and network of quality providers of relevant planning and management CB by mid-2011.  
• Mobilise resources to develop and implement modules addressing priorities by mid-2011.  
• Review priority curricula in HIV and AIDS planning and management for a) health and b) other key sectors across the Region by end-2011  
• Integrate or align plans and activities with planning and |
<table>
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<tr>
<th>Outputs</th>
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| management initiatives in the health and other sectors.  
• Develop planning and management training modules, addressing all priority aspects of the HIV and AIDS response from prevention to mitigation at different qualification levels.  
• Make modules available through sufficient institutions from from mid-2012.  
• Develop approaches and methodologies for effective CB e.g. case studies; simulation exercises; coaching, mentoring and attachments, communities of practice.  
• Facilitate ongoing collaboration between network members and HIV and AIDS programmes.  
• Collaborate with leadership development module to ensure alignment and efficiency. |

2.2 A Network of Excellence for Health Planning and Management established by 2012 in collaboration with health and other service sectors to support HIV and AIDS planning and management excellence in the Region  
• Consult with training centres in the Region to establish a Network of Excellence and develop action plan and options for institutional model by mid-2011.  
• Integrate or align plans for a Health Planning and Management Network and Institute with planning and management initiatives in the health and partner sectors.  
• Facilitate coordinated support to strengthen the Network of existing planning and management institutions in the region from 2012.  
• Facilitate ongoing collaboration between network members and HIV and AIDS programmes. Create regular opportunities to share good practice and experience, and refine collaboration.  
• Consultation and workshop program for the Network and program managers to share learning and establish buy-in for Regional Institute for management CB.  
• Review career paths, qualifications and professional bodies for health sector planners and managers  
• Commence Registration of health planners and managers in the Region with the Network/Regional Institute from 2012.  
• Establish learning forums (eg. communities of practice) for registered planning & management practitioners in priority areas from 2012.  
• Establish “evidence for planning” project providing information to practitioners across the Region from 2012. |

2.3 Health and related sector managers apply good quality, up-to-date methodologies and tools for HIV and AIDS-related planning, M&E, HR, programme management, supply and procurement, and resource tracking in the planning and management process from 2011.  
• Prioritise tools and methodologies for HR planning in health and welfare to support Outcome 3  
• Consult with MS to confirm other priority areas for action by mid-2011.  
• Mobilise resources and support for training and CB initiatives around selected priority tools and approaches from 2011.  
• Review and refine tools available to HIV and AIDS planners and managers at different levels of the health system to support the HIV and AIDS response. Align donor and other tools with Regional and national priorities where required beginning 2011  
• Review tools available to support planners and managers in sectors outside health beginning 2011  
• Facilitate establishment of a peer review mechanism between MS to encourage learning across the Region in planning.
### Outputs

<table>
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<tr>
<th>Outputs</th>
<th>Activities</th>
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<tbody>
<tr>
<td>2.4. Output and outcomes of planning and management CB are effectively monitored, evaluated and researched</td>
<td>• Facilitate MS development of baseline assessments, targets and implementation of M&amp;E systems for planning and management CB at MS and from mid-2011</td>
</tr>
<tr>
<td></td>
<td>• Conduct annual reviews with key stakeholders to assess progress and refine strategic priorities beginning 2012</td>
</tr>
</tbody>
</table>

### 3.3 Strategic Performance Area 3: Human Resources for the HIV and AIDS response

#### 3.3.1 Summary of the Human Resources capacity needs

The crisis in human resources in the health and welfare sectors impacts significantly on the HIV and AIDS response especially in the area of access to care, counselling, treatment and support. Human resource challenges for HIV and AIDS are not confined to the health sector and extend to social workers, other care givers and sectors such as law enforcement and social development, that are important for mitigation strategies and to support health services. There is also recognition across MS that the formal public and private sectors cannot achieve coverage targets without substantial support from community and civil society resources.

The human resource gap is complex and respondents in the Needs Assessment raised many of the important challenges known to hamper human resource provision such as staff shortages, inequitable and inefficient distribution of staff, reliance on foreign doctors professionals and the brain drain from Ministries and services.

The review of HRH strategies indicates that a fundamental underlying challenge is inadequate institutional capacity and output from pre- and in-service training to meet short and long term needs of the region and most MS. It is essential that a more effective structural solution to this most pressing human resource challenges is found within the Region. Other structural challenges include traditional demarcation of roles, responsibilities, training and career paths that are geared to heavy reliance on high level professionals to perform various tasks.

However, weak operational systems also contribute to the HR capacity gap. Many of the Poor conditions of service for health professionals, identified as a key reason for problems of attracting and retaining key staff, are often due to inefficient HR planning, development and management systems at central and decentralised levels. Morale of staff is affected by shortcomings in other systems, such as procurement and supply of essential drugs and equipment, which undermines service quality. Lack of coordination across programmes, services and sectors, as well as weak general management also prevents efficient use of available capacity. There is also limited experience in health and welfare sectors of how best to operationalise task shifting and sharing approaches and developing systems for use of new cadres of staff that are cheaper and easier to train. A related challenge is limited development of sustainable systems for using community capacity for support and mitigation, including CHW systems and use of volunteers. In many MS the capacity of civil society organizations and NGOs is not systematically and well utilized in the response.
The human resource crisis is also experienced as a **skills gap**, both in technical areas and in areas such as basic problem solving and service management. In some MS there are too many staff who have inadequate training to contribute meaningfully to the response and roll out of HIV and AIDS services. In other sectors outside health, the training of new cadres of human resources for impact mitigation programmes is a challenge especially where interventions are to be taken to scale. Staff, such as social workers, educators and other staff in the education sector, community care givers and law enforcement personnel are the usual targets for training. The training and subsequent retention and updating of volunteers for prevention strategies is also identified as an important component of civil society participation in the HIV and AIDS response. PLHIV also remain marginalized or under-utilized in the response and could be targeted for skills development to play a number of roles.

**Annexure 2** summarises the common HR issues faced by components of the HIV and AIDS response as identified by informants in the Needs Assessment. There are overlaps with the capacity gap in planning and management: HR planning and management limitations are major contributors to HR shortages, as well as under-performance, inefficiency and difficulty in attracting HR. The **HR planning and management** capacity gap is addressed above (see Strategic Priority Area 2

### 3.3.2 Current Regional response to HR needs

Addressing the human resource crisis in the *health sector* is a core component of health systems’ strengthening initiatives and is also a core aspect of developing HR for HIV and AIDS responses. The existing SADC Human Resources for Health Strategic Plan 2007-2019 proposes the following objectives:

- Conduct a situational analysis on the magnitude of brain drain, prevailing conditions of service and working environment, implementing strategies and policies, and monitoring of the processes.
- Develop and implement policies and strategies to retain health personnel and improve their working conditions
- Facilitate the management of the impact of HIV and AIDS on HRH in the Region
- Develop a costed SADC Strategic Plan on Human Resource for Health
- Identify, establish and develop Regional centres of specialization on HRH
- Facilitate continuous training through exchange programmes and attachments
- Recommend a framework for health worker skills mix for the Region.

Of note, the Strategy seems to place relatively limited emphasis on greatly increasing production of health workers as stressed in the CB framework below.

Formal assessments of the extent of implementation of the strategy at regional and MS levels are not available, so information on progress is incomplete. HRH plans have been developed in several MS but vary in methodology and there has been no systematic attempt to coordinate plans, or to implement M&E to assess progress, successes, challenges and good practice. Quantification of needs is inconsistent and often needs to be updated to reflect changes in delivery models, staff mix and financial resource assumptions. Some MS have increased remuneration to try to retain workers, and have made attempts to control health worker migration in the region. However their impact and lessons learned are not well understood. Anecdotal evidence suggests that some measures may have led to unintended negative effects or sustainability challenges. For example, some MS attempts to limit regional migration...
may inadvertently have led to loss of skilled professionals to other areas of the world or under-utilisation of professionals who have migrated nevertheless in the region.

The SADC HIV and AIDS Strategic Framework recognises the challenge posed by HR deficits affecting not only health, but also in welfare/social development and other sectors. Many interventions in the Framework and its business plan propose development of coordinated, innovative policies, plans and monitoring mechanisms to address this. SADC initiatives such as the CSTL (Care and Support for Teaching and Learning) Programme organized by the SADC Education Secretariat can provide insights for other sectors around how to support mitigation on a large scale.

Key Systems to address in the response to the HR crisis include political leadership; HR systems and policies in ministries delivering social services as well as finance, planning and public service management; professional certification frameworks; tertiary and other training, academic and research centres; civil society and community involvement; and international partnerships.

The key stakeholders to engage in the CB process include political stakeholders such as Ministers and Advisers. Key officials to engage with include senior and middle management in Ministries that need to meet service demand such as Health, Welfare/social development and NAAs. Other key government sectors are those that determine ability to obtain and manage human resources such as finance, planning and public services management. Representatives of service providers such as professional bodies, unions, and capacity building and service CSOs will also need to be engaged. African institutions providing training for HR for health and other sectors, along with academics researching and working in the area of public sector human resources will also have key roles. Multi- and bi-lateral international development partners need to be engaged to provide expertise and other resources in a coordinated, targeted way and on a large scale.

### 3.3.3 Framework to address Human Resource Capacity Building

<table>
<thead>
<tr>
<th>Outcome 3: Planning, production, recruitment and retention systems are in place to ensure availability of the required human resources for health and other priority sectors for the HIV and AIDS response in the region by 2019.</th>
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</table>

Activities to achieve this outcome will focus on setting up and supporting mechanisms for ongoing sharing of plans, good practice and learning between MS, and facilitating development of effective and harmonised policies and plans by MS to achieve needs for HR capacity across the region.

The CB framework for HR capacity building sees as a primary priority the establishment of sustainable training capacity at sufficient scale by 2015 to meet the health HR needs of the region by 2019, in line with the SADC HRH Strategy. Close collaboration to complement broader health sector HRH initiatives will be imperative to avoid fragmentation or duplication of effort. Within this key output area, priority

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5 The SADC HIV and AIDS Strategic Framework and programme of action (2003-2007) also identified policy in the area of policy on HR in the health and other sectors as a priority.

6 This outcome is an amendment of that in the present SADC HRH Strategic Plan 2007-2019.
areas of activity include:

- Facilitating adequate *quantification and M&E* of needs and progress by MS and for the region, including aspects such as health worker migration.
- Facilitating *coordinated planning, sharing of information and learning* across MS.
- Facilitation of coordinated assessment, planning and strengthening of *institutional capacity* for training.
- Identifying and facilitating support for coordinated *lead wave initiatives* as well as *regional networks or centres of specialisation* in aspects of HR for HIV and AIDS services.
- Facilitation and support for MS in identifying and *mobilising support and resources* and other interventions.

A second output is increasing recruitment and training of *professionals in other sectors outside health* to meet HIV and AIDS related needs, particularly for mitigation. In this area activities are expected to be similar to those for HRH, including facilitation of: agreement on priority HR capacity needs by MS; quantification of needs at MS and regional level; and development by MS of sustainable institutional capacity and other mechanisms to ensure availability of required HR by 2019.

To address problems of retention and performance of professionals, a third key output is improved *health and welfare workers’ work environments*. Activities will include:

- Initial coordinated *review of MS plans, progress and learning* around strategies to retain health and welfare staff in the HIV and AIDS response and define priorities and plans in line with that combined information.
- Facilitating coordinated learning and sustainable systems development by MS for *task shifting and sharing*, including use of *new cadres* of health and welfare workers.
- Development of *coordinated policy to manage staff attrition* to address issues such as cross border migration and loss of key staff to donor programmes.
- Assisting MS to identify and act on *quick win and lead wave interventions* to relieve bottlenecks e.g. efficient recruitment and placement of priority health workers.
- Setting up mechanisms for *ongoing sharing of learning, progress and good practice*. Key topics are likely to include HR management, conditions of service, quality assurance and planning systems, and also effective local interventions to improve staff morale.
- Facilitating investigation of development of ways to *retain priority specialist expertise* in the region and maximise benefit across MS e.g. regional career paths.

The final focus area responds to the need for *systems for optimal use of community systems and capacity* for the HIV and AIDS response. Regional actions will include facilitating review of *systems and models for community health workers* inputs into prevention, treatment and mitigation aspects of the MS response. Activities will then support MS to refine or develop effective *systems for the sustainable use of community capacity*, including developing more sustainable donor or other systems for volunteer involvement. The regional programme is also expected to facilitate *ongoing learning and sharing of experience* in use of community workers and
systems. The Framework also proposes support for MS to develop more systematic use of PLHIV capacity for prevention and other interventions.

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Activities</th>
</tr>
</thead>
</table>
| 3.1 Training capacity is sufficient by 2015 to produce appropriately qualified health workers to meet the needs of the HIV and AIDS response by 2019 | • Set up and support mechanisms for ongoing sharing of plans, good practice and learning between MS to help to refine and accelerate HRH initiatives from 2011.  
• Support quantification of HR needs for the HIV and AIDS response and underlying health systems at MS and SADC levels by end of 2011  
• Facilitate review of MS and regional institutional capacity to meet HR needs for HIV and AIDS and HRH strategy, including review of possibilities for curriculum reform for more efficient, sustainable output at scale by the end of 2011  
• Integrate or align plans and activities where necessary to strengthen HRH initiatives in the SADC health sector by mid-2012  
• Support MS to develop plans to strengthen institutional capacity for key HR production at increased scale which are coordinated across the region where relevant by 2012.  
• Facilitate establishment of adequate M&E systems by MS to track HR needs and responses in a manner that also allows region level monitoring of the HR status and issues such as cross border migration by 2012  
• Identify and facilitate support of coordinated lead wave initiatives with MS to rapidly start scale-up by end of 2011  
• Advocacy and policy development to mobilise resources to build the production capacity to scale by 2015  
• Support establishment of networks or centres of Regional specialization in aspects of HRH for HIV and AIDS from 2011.  |
| 3.2 Recruitment and training systems for professionals in sectors outside health are established by 2015 to enable MS to meet their needs of HIV and AIDS mitigation strategies by 2019. | • Agree on priority areas for collaboration and action with MS, with particular emphasis on welfare/social development, education and other social and community development initiatives by end of 2011.  
• Support MS to adequately quantify HR and other resource needs for scaling up mitigation strategies by mid 2012.  
• Facilitate learning across MS through research and sharing learning, good practice, innovative approaches for sustainable service provision beginning 2011.  
• Facilitate development and implementation of coordinated plans to assist MS to scale up in priority areas of HR end of 2012.  |
| 3.3 Improved work environments for health and welfare/social development workers by end of 2015 | • Facilitate coordinated review of MS plans, progress and learning around retention of health and welfare staff, and define priorities and plans for further coordinated action by end 2011.  
• Develop standard guidelines for use by MS in HR development and management by end of 2012  
• Facilitate processes to assist MS to coordinate learning and develop sustainable systems for task shifting and sharing, including use of new cadres of health and welfare workers.  
• Consult MS and develop a coordinated policy across the region to manage attrition including cross border migration and loss of key staff to donor programmes by end of 2012.  |
From 2011, assist MS to identify and act on *quick win and lead wave interventions* to relieve bottlenecks and ensure consistency with longer term strategy e.g. efficient recruitment and placement for workers in priority roles.

Set up mechanisms for *ongoing sharing of learning, progress and good practice* in relation to strengthening HR planning and management, conditions of service, task shifting, quality assurance and planning systems, and effective local level interventions to improve staff morale beginning 2011.

Investigate ways to *retain priority specialist expertise* in SADC and maximise benefit across MS e.g. regional career paths beginning 2012.

**3.4 Systems developed for optimal use of community systems and capacity for the HIV and AIDS response**

- Facilitate *ongoing review and sharing of learning around systems and models* for CHW and other community worker inputs into prevention, treatment and mitigation aspects of the MS response to HIV and AIDS from mid 2011.

- Advocate and facilitate support for MS to *refine or develop effective systems* for the sustainable use of community capacity, including development of more sustainable donor and other systems for *volunteer involvement* beginning 2011.

- Assist MS processes to develop more *systematic use of PLHIV capacity* for prevention and other interventions beginning 2011.

**3.4 Strategic Performance Area 4: Policy**

### 3.4.1 Summary of priority Policy needs

Several priority areas for policy and guideline development to support capacity building were identified in the needs assessment. The social protection agenda, addressing issues such as cash transfers, social grants, women and child abuse and the protection of OVCY is clearly making a mark in the sectors concerned with mitigation strategies. The assessment highlighted that there is wide variation in approaches to social protection across the Region. Many initiatives in this area have not been run at scale and there are also issues about sustainability at the community level. Therefore this capacity gap is to a significant extent one of policy or policy guidelines. These can guide responses and mobilise resources, as well as harmonise approaches to the structures needed for social protection and roles of different stakeholders, especially civil society.

A second area highlighted in the needs assessment is lack of clarity on policy and guidelines around *Public Private Partnerships (PPPs)*. These can assist MS to optimise engagement of private and non-governmental sector human resource and institutional capacity to support the HIV and AIDS response. PPPs could for example involve partnerships with private practitioners, other clinical services, NGOs and insurers in the delivery of prevention and treatment, care and support services. PPPs can also help to support mitigation strategies. Among the many possibilities is coordination with large corporate organizations involved with social responsibility programmes such as large mining companies. Food production and distribution systems may also be able to support impact mitigation in vulnerable communities. Policy lessons need to be more widely understood about how to engage the civil society organizations to support efficient and sustainable services on a large scale.
The need to reinforce capacity among key policy makers to adopt evidence based approaches to policy making was also identified. Evidence based policy making is particularly relevant in the HIV and AIDS sector where evidence may evolve rapidly or issues may be contentious. Examples include changing understanding of the role of HCT, promotion of male circumcision, and use of needle exchanges in MS communities with IDU epidemics. Robust approaches to public policy making that consider technically sound policy options, costs and other evidence are essential, especially as resources for the HIV and AIDS response become more stretched.

An underlying gap is availability of information to support evidence based policy and planning. This is due to challenges in accessing available information, as well as limited capacity in the region to undertake priority research and surveillance.

A final priority highlighted in many areas of the response is the need for more effective policies towards development partner support. There is merit in coordinated approaches across MS to promote more efficient harmonisation and coordination of systems. This can for example reduce unnecessary demand on available capacity, avoid unintended negative short or long term consequences of donor action on overall system capacity, and harmonise support for capacity building.

### 3.4.2 The Regional response to priority policy issues

Development of policy and policy guidelines that ensure coordination across the Region is an important role for the SADC Secretariat, as indicated in the HIV and AIDS Strategic Framework. Current initiatives under the Framework and in other SADC programmes, especially around social protection and OVCY, create potential for overlap with focus areas identified in the capacity building needs assessment. Similarly, PPPs are considered under mainstreaming activities as well as the RISDP. Evidence based policy making and donor alignment and harmonisation are included in the HIV and AIDS Framework.

Nevertheless, it seems necessary to reinforce the importance of certain policy that affects capacity and to ensure that there is action in these areas, while ensuring coordination and responsiveness to developments under other frameworks. In addition, SADC experience indicates that while there has been considerable success in generating various policies and guidelines, improvements can be made in mechanisms to ensure that MS can implement them efficiently.

The key systems to engage in processes to address the above policy areas include political leadership; technical leadership in Government ministries; programme implementation by private, NGO and civil society sectors; corporate social responsibility programmes; and development partner systems.

The key stakeholders that therefore need to be engaged in the policy processes include government role players such as Ministers, advisers, policy makers and senior and middle management in MOHs, NAA and ministries such as welfare/social development, education and finance. Academic and other policy research groups can make key contributions, as can civil society and NGO representatives. From the private sector, bodies representing private health care providers will be critical role
players, along with business coalitions and corporate social responsibility structures and initiatives. Involving policy makers in SADC sectors such as mining and food security may also be important. Development partners, along with CCM members and others engaged with major donor programmes will also be key.

3.4.3 **Framework to address Policy in key areas related to Capacity Building**

**Outcome 4:** Policy and policy guidelines developed, implemented and monitored to support MS to enhance social protection, public private partnerships, development partner roles and evidence based policy making in the SADC region by end 2012.

Interventions under the framework will facilitate accelerated development of strong policy at regional and MS level to ensure effective capacity building through enhanced performance in the areas of social protection, PPPs, evidence based policy making and development partnerships. Actions will focus, firstly, on facilitating processes and providing support that are needed to analyse and generate policies, and secondly on enhancing ability of policy makers to drive implementation of policy at SADC and MS level. Follow-up actions will facilitate implementation and M&E of policies by MS. In addition, activities will strengthen availability of research and other information to inform evidence based policy making and planning.

<table>
<thead>
<tr>
<th>Outputs</th>
<th>Activities</th>
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</table>
| 4.1 Policy development fast tracked in priority areas by end 2011      | •Review the alignment of policy development activities across SADC DSHD&SP programmes and programmes by June 2011  
•Re-prioritise policy development where necessary to ensure that the priority CB-related areas are addressed quickly  
•Review processes at a MS level for acting on regional policy and guidelines with a view to strengthening practices by June 2012 |
| 4.2 Priority policy and policy guidelines developed in consultation with key stakeholders in the areas of social protection, PPPs, evidence based policy making and donor alignment | •Collaborate with initiatives to prioritise and develop capacity-related policy in relation to social protection and OVCY.  
•Establish processes by 2012 to facilitate learning and sharing of good practices across MS on policy development in relation to PPPs to meet priority capacity needs.  
•Prepare policy guidance materials, briefings and other mechanisms to enhance ability of politicians and policy makers to support up-to-date evidence based policy making in MS.  
•Establish processes by 2012 with Partnership Forum and other stakeholders to align partner interventions and systems in priority areas for CB.  
•Continually update policy needs and priorities related CB as they evolve, and provide responsive support where appropriate |
| 4.3 Enhanced availability of information to inform evidence based policy and planning | •Coordinate with research coordination systems and Agendas at SADC and MS level to define priority information and research needs by mid-2011.  
•Establish systems by 2012 to share information on priority policy issues across MS.  
•Establish mechanisms to build capacity for research and surveillance in priority policy areas by 2012. |
3.5 Strategic Performance Area 5: Capacity and resources to support more effective CB at regional and member State Levels

Previous sections in this framework have highlighted the scale, diversity and large resource requirements of meeting CB needs for the HIV and AIDS response in both the short and longer term. However they also indicated that effective CB is challenging, particularly when it involves complex systems and long term processes that are difficult to define in their entirety from the beginning. Optimal design and implementation of CB interventions will require considerable expertise and capacity to facilitate ongoing learning and flexible, effective responses to evolving needs and priorities within various areas of the CB Framework.

Emerging CB-related priorities in areas of the response not covered by this Framework may also need support at regional and MS level so they can identify and use best practice CB approaches wherever possible. Specific CB support may be required, for example, in current SADC interventions around mobile and migrant populations, pharmaceutical strategy, and prevention.

Previous experience of CB-related activities under the SADC HIV and AIDS Strategic Framework 2003-2007 covered mainstreaming, M&E and various issues addressed through policy and guideline development, networking and sharing of experience, expertise and good practice. Other CB related initiatives have included operationalising the Human Resources for Health strategy and the SADC Pharmaceutical Strategy. Together they have demonstrated the demands on process, technical and CB skills that are required for success, and the challenges to the Secretariat to operationalise them successfully.

Key Systems addressed in this area are leadership and management in the SADC programme, as well as specific performance areas and interventions; guidance and oversight by MS; coordination systems; resource mobilisation; and linkage of key initiatives in MS with the regional programme and providers of support.

Key stakeholders include: Secretariat and DSHD&SP leadership and managers; high level representatives and focal points in MS ministries, NAA and programmes; development partners, civil society and providers of expertise in CB and technical areas. Around specific CB performance areas and interventions, other important stakeholders will also need to be involved.

3.5.1 Framework to address Capacity and Resources to drive CB at regional and MS levels

This strategic performance area addresses capacity and systems in the following areas:

- Strong stewardship of process and technical aspects of CB initiatives in the regional workplan by SADC secretariat, stakeholder and technical groups, and strategic use of projects and external technical capacity where needed.
- Generating information on CB through M&E and research, linked mechanisms to disseminate learning as well as to build stakeholder relationships and input. Mechanisms may for example include commissioning or facilitating research in priority areas of common interest, electronic communications and CB
conferences, as well as support for development of M&E mechanisms that enhance learning from CB initiatives.

- Facilitating access to resources for strategic interventions, large or small, at regional or MS level, and facilitate efficient, collaborative use of resources to maximise benefits across MS.

**Outcome 5: Capacity Building work in priority areas of the HIV and AIDS and health system response is suitably informed, resourced and supported at regional and MS level.**

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<th>Outputs</th>
<th>Activities</th>
</tr>
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</table>
| 5.1 By mid-2011 systems and structures are in place to provide managerial, process and technical guidance, as well as M&E to CB processes | • Determine needs for capacity to facilitate & coordinate processes and provide CB technical expertise in line with CB workplans e.g. internal secretariat capacity, mentoring of program managers, networks or technical assistance by mid-2011.  
• Establish stakeholder Steering Committees and Technical Working Groups to oversee overall workplans and interventions in each strategic performance area by mid 2011.  
• Define discrete projects to undertake activities and achieve outputs in each performance area where necessary by April 2011 and then commission priority projects from mid 2011.  
• Develop an M&E framework to track program implementation and progress in CB MS and regional level by mid-2011.  
• Conduct annual reviews with key stakeholders to assess progress and refine strategic priorities begin from 2012. |

| 5.2 CB M&E, information sharing and stakeholder relationship building mechanisms in place by 2011 | • Facilitate MS development of baseline assessments and implementation of M&E systems for planning and management and human resources CB from mid-2011  
• Commission or facilitate research to elaborate understanding of CB challenges and interventions of common interest to MS in key Outcome areas, and disseminate learning from 2012.  
• Implement mechanisms for regular updating of key stakeholders in CB on progress, learning, good practice and results e.g. regional CB conferences; electronic discussion or news groups.  
• Support development of effective M&E for CB interventions |

| 5.3 Systems to facilitate access of regional and MS CB initiatives to funding and technical resources from 2011 | • Review available and potential sources of funding and sources of technical support for CB for HIV and AIDS and health sector by mid-2011  
• Advocate and support policy development to allocate resources to priority CB needs at regional and MS level from 2011  
• Create a mechanism from 2011 to link funding needs, funders and technical support providers in priority areas of the Framework, as well as promote projects that cover more than one MS where this can enhance learning and efficiency.  
• Consider mechanisms to support innovative and priority CB initiatives at MS level such as a Regional Challenge Fund. |

4 Implementation mechanisms
The CB Framework will be implemented through a series of workplans, which set out and operationalise more detailed objectives and activities for priority interventions.

Several structures and stakeholders will be key to implementation of the CB Framework. At the political level the Summit will provide overall high level policy guidance. This is expected to be particularly important because of the need to ensure inter-sectoral collaboration. Addressing HIV and AIDS capacity requirements, particularly around HR, will require active support from partner sectors such as education, welfare, health, finance and public service management, for example.

The Ministers in charge of Health and HIV and AIDS provide policy guidance and leadership for implementation. The SADC Secretariat will provide regular progress reports to the Ministers, and policies and programme plans will be submitted to them for decision-making and approval. The final policy approval will be through the Council of Ministers who will receive regular reports and recommendations through the Ministers in charge of HIV and AIDS. Where Ministers of other sectors meet in SADC fora, the DSHD and other Directorates will ensure that their agenda’s consider HIV and AIDS issues relevant to their sectors.

At the operational and technical level the SADC Secretariat, through the Directorate of Social and Human Development and Special Programmes (DHSD), will coordinate the implementation of the Framework and workplans. The HIV and AIDS programme in DSHD will lead implementation but will work closely with other components such as the Health, Education and OVCY programmes. The Secretariat will be responsible for planning and management of programmes, resource mobilisation, coordination and development of harmonised programmes and policies. Where necessary, the secretariat may develop specific projects to provide the capacity to take forward processes in key areas of the Framework. The Secretariat will also coordinate monitoring and evaluation to ensure that regional programmes deliver on objectives for the region, and for ensuring appropriate, efficient use of funding.

As indicated under Outcome 5, implementation of the Framework is also expected to require access of the Secretariat and its partners to specialist capacity building expertise to assist the Secretariat and MS to design and implement processes, and allow for ongoing monitoring, review and adaptation to refresh initiatives and ensure that they are responsive and innovative.

The Secretariat will work closely with the NAAs and their MS collaborating sectors, with tertiary training and academic centres, as well as with Regional and International partners. The NAAs will ensure that the regional initiatives are integrated into MS plans, monitor implementation of programs at national level and provide feedback to the SADC Secretariat. A key function will be to identify and share emerging successes, good practices and lessons learned.

The SADC Technical Advisory Committee on HIV and AIDS will provide technical guidance, direction and oversight to the CB programme’s plans and implementation, as well as provide a critical link to national programmes and partners. It is anticipated that the Committee will establish a Technical Working Group on Capacity Building to support planning and guide implementation. Other advisory Steering Groups and Technical Working Groups are expected to be required for particular complex and
long term processes such as development of HRH capacity and planning and management capacity.

The Partnership Forum will facilitate information sharing, consensus building and mutual support for all partners in the HIV and AIDS field at a regional level. The Forum has a role in coordination and mobilizing resources and technical support. Comparative advantages of individual institutions will be considered in assigning responsibilities. International Partners are expected to play a key role in providing resources and access to technical support for implementation of the Framework.

At MS level, NAAs will coordinate with key sectors and partners to conduct an HIV and AIDS capacity needs assessment and develop MS national capacity building strategic frameworks where required. Where assistance and learning could be obtained from the SADC Secretariat or through regional processes, the NAAs will engage with the Secretariat to facilitate the processes. NAAs and partner sectors will ensure participation of appropriate MS stakeholders in processes established under this Framework to ensure that they are responsive to MS needs as they develop.

Integration of regional initiatives into MS plans and activities, and the monitoring of implementation of programmess at national level will rest with NAAs in each MS. NAAs will also provide feedback to the SADC Secretariat on progress being made by MS regarding programme implementation emanating from regional initiatives. In addition NAAs will coordinate the identification and sharing emerging successes, good practices and lessons learned at MS level.

5 Monitoring and Evaluation mechanisms

An M&E plan will be developed for the CB Framework which should incorporate a means to measure enhanced performance and methodologies that track the value and impact of capacity building interventions.

As the CB framework aims to enhance the performance of the HIV and AIDS Strategic Framework where practical M&E will use a results-based methodology where the CB interventions are seen as a part of the broader development programme. However, where the M&E of the Capacity Building Framework interventions themselves is the immediate objective, other methodologies will be required. It should be expected that the M&E plan would have features that are unique to best practice in the area of capacity building.

In particular, M&E of capacity building interventions should place an emphasis on learning. This is because introducing change into some of the complex systems that are being addressed will result in the intervention itself being continuously influenced by them. It is therefore important to systematically build learning into the project cycle allowing flexibility. There is need for an action learning project cycle with willingness to continuously adapt the project design on the basis of experience in project implementation. Approaches to monitoring and evaluation that encourage learning and that are qualitative rather than quantitative will be important components
of the M&E plan. More discussion of approaches to learning orientated M&E and evaluation of capabilities resulting from interventions are described in Annexure 4.
ANNEX 1: Summary of Needs Assessment Findings

Consultation with stakeholders in MS and the document review identified a number of priority areas and issues in relation to capacity gaps, development needs and good practices in the region. The findings are set out below in line with the thematic activity areas of the SADC HIV and AIDS Strategic Framework 2010-2015.

1. Prevention and Social Mobilisation

Despite recognition of prevention as an important component of any HIV and AIDS strategy, progress in these areas has been challenged by several key capacity issues.

- Limited capacity at Community level.
  - Limited numbers of well trained Community Health workers and high turnover
  - High Turnover of Volunteer Based Programmes with limited sustainability
    - Inconsistent Systems (Stipends)
    - Problems with Specific systems (Selection, Training and Support)
  - Limitations of Civil Society organisations
    - Organisational Effectiveness and sustainability
    - Underdeveloped capacity for Advocacy, Lobbying, negotiation, Management, Proposal Writing and Resource Control. This has a negative effect on prevention and mobilisation.

- Planning and Management capacity.
  - Limited capacity to design programmes
    - Communication Strategies
    - Lack of Research Based Management
    - Initiatives show little understanding of time and types of intervention required to translate knowledge into behaviour, and how to measure impact
    - Particular challenges in relation to New Prevention initiatives
    - Communications around risks
  - Programme Managers have limited experience
    - How to operationalise prevention policies and strategies
  - Limited Expertise and systems for planners to access and apply new research and M&E information to inform design and implementation

- Health service provision and management for prevention.
  - Efforts to use health serves for prevention activities have limited success
  - Inequitable access to quality prevention services for all
    - Poor infrastructure, contributing to HRR and other capacity gaps
  - A Range of prevention efforts is limited

- Capacity to take male circumcision to scale

- Under-utilisation of civil society and NGO capacities
  - Public services limit innovation and flexibility in prevention & community mobilisation
  - Low involvement on PLHIV networks in planning and implementation

- Coordination and Leadership
  - Inconsistent leadership at all levels
    - Limited recruitment of leaders to champion HIV and AIDS issues
    - Limited understanding and expertise among leaders
  - Inadequate understanding between different sectors and actors at all levels
    - Hinders the impact of prevention programmes
Lack of coordination and sharing of capacity makes it difficult to tackle key drivers of the epidemic

- **Capacity for addressing specific challenges and initiatives**
  - Limited resources undermine ability to keep up with new priorities and how to address needs of vulnerable groups

2. **Improved Access to Care, Testing and Treatment:**

Limited capacity for treatment and care of people infected and affected during the next phase of ART roll-out is prominent, within a set of broader MS concerns about health care system weaknesses. Other more specific problems include inadequate capacity to cope with problems such as drug resistant TB, and the failure to integrate HIV and AIDS with other key programmes such as reproductive health.

- **Health System and Service planning and management capacity.**
  - Inefficient use of available resources
  - Problems in key areas of health systems
  - Undermines the success of Health Professional Training or retention schemes
    - Brain Drain from Ministries, Departments and Services
    - Inadequate M&E and Information Management Systems
    - Weak service frameworks and plans
    - Weak links in services, such as transport, laboratories, drug procurement and supply, and opportunistic infection treatment

- **Shortage of Health Human Resources**
  - In all Health HR areas
  - The extra need for capacity in HIV and AIDS programmes shifted clinical staff into new programme and management roles
  - Reliance on foreign doctors who have a high turnover rate
  - Inequitable and inefficient distribution of staff
  - Underlying problems across MS:
    - Inefficient HR Planning
      - Underproduction of new Professionals
      - Excess staff with inadequate training’
    - Limited output and quality of pre- and in-service training
    - Poor conditions of service for health Professionals
    - Weak HR Management

- **Underutilisation of available resources** at all levels.
  - Poorly deployed staff
  - Underdeveloped use of community and civil society capacity, and Public Private Partnerships (PPPs)

- **Capacity to serve mobile populations**
  - Systems remain underdeveloped

- **Quality assurance systems** and processes around treatment

3. **Accelerating Development and Mitigating Impact of HIV and AIDS**

Capacity to respond to the developmental impact of HIV and AIDS across many sectors was a concern of many, as was the potential of development itself to increase aspects of HIV and AIDS vulnerability.

- **Shortages of human resources with adequate training and skills to support the mitigation response**
Social Workers
- Short supply especially in Education sector
- Community Care workers to support OVC, other vulnerable people and community mobilisation on HIV and AIDS
- Suitable trained Law enforcement personnel to ensure non-discrimination and support for vulnerable people

**Limitations of planning and management.**
- Limited, localised coverage of mitigation strategies compared to large scale needs
- Insufficient numbers of planners and managers with skills in place to guide effective approaches to mitigation and mainstreaming
- Weak systems and skills in HR management and systems combined with other management problems
  - Centralised financial management and budgeting
- Management capacity of CSO’s remains limited

**Limitations in leadership and coordination of action**
- Many mitigation activities fall under relatively small and weak Ministries or require coordination across several ministries
  - Forceful leadership and coordination is difficult
- Inter-sectoral mainstreaming is often not well coordinated or prioritised
  - Links to poverty alleviation strategies and inter-sectoral collaboration too weak for successes
  - Linkages to programmes in related areas are underdeveloped
- Inadequate structures related to focal points and coordination are major impediments
  - Confusion about mandates and capacity of NACs

**Gaps in policy** undermine system and capacity building in key areas
- Social protection structures and frameworks that avoid creating dependency and promote sustainable, community-based responses
- Roles and support for community-based care givers and councillors
- Systemised roles and functions for civil society

### 4. Resource Mobilisation

Capacity challenges include gaps in relation to both resource mobilisation and ability to demonstrate efficient use of available resources. Particular gaps are felt to occur in:

**Planning and proposal development.**
- Limited skills, systems and processes to support use of evidence-based planning and strong proposal development.
  - Required for successful proposals to both donors and domestic funders
  - Limited capacity in areas such as lobbying, bargaining and negotiating

**Programme management capacity.**
- Limited ability to ensure that programmes are able absorb funding
- Concerns about whether there is efficient use of available resources.
- Underlying capacity weaknesses related to systems and organisational culture, not just lack of knowledge and skills.
  - Performance based management
  - Financial management and procurement (pharmaceuticals)

**Capacity to harmonise and align donor systems**
• To address country and regional priorities more effectively,
• To avoid duplication and other inefficiencies
• Capacity to ensure that donors support more sustainable types of interventions

Limited coordination and leadership in and across MS.
Use of private sector capacity.
• Policies, systems and capacity are not in place in many MS to allow for efficient use of PPP with non-government resources.

5. M&E and Institutional Development

In most MS, institutional strengthening and M&E are seen as priority areas where capacity and systems have to be strengthened and streamlined at national and decentralised levels. As indicated in previous sections, a number of capacity gaps in specific programme areas are evident. There are several prominent overall limitations.

• Human resources
  • Institutional function at central and decentralised levels are limited in number and in skills for programming and programme management
    ▪ Limited numbers of planners and management that have as strong understanding of M&E, skills in interpretation and use of data
    ▪ High turnover among skilled staff.
  • Effective planning capacity and systems are still limited
    ▪ Evidence based planning and policy making and strong planning methodologies are not well established
    ▪ Data and information are often not very accessible
• Management in certain priority areas is weak
  • Performance based management
  • Procurement and supply chain management.
• Stretched M&E capacity at national and lower levels.
  • Un-harmonised M&E systems of different donors and government which can duplicate effort and even be contradictory
  • Priority is often given to data for donor programmes rather than national plans
  • Many systems do not have capacity to incorporate a mix of both qualitative and quantitative approaches to inform managers
• Limited capacity to guide capacity building.
  • Many key MS players have no clear idea of what it takes to build capacity of institutions or individuals.
  • Efforts are often limited to training and sometimes changing work processes.
• Coordination, governance and leadership capacity for national responses
  • Despite improvements, there are frequent suggestions that national mechanisms should be overhauled
    ▪ Most NAC’s, MOHs and CCMs perform aspects of their roles with limited success due to: structural limitations; role confusion; political factors.
    ▪ Skills deficits
  • At decentralised levels functional capacity also remains a challenge.
• Institutional and M&E mechanisms for Civil Society participation.
  • Institutional mechanisms are lacking to capacitate effective participation of Civil Society in national and decentralised processes
  • CSO capacity deficits in areas such as M&E and management
ANNEX 2: Analysis of Needs Assessment findings – Major themes across SADC HIV and AIDS Strategic Framework Priority Areas 2010-2015

The following analysis grouped findings of the Needs Assessment reported in Annex 1 into thematic areas that could be addressed in a coordinated, strategic manner. Emphasis was placed on distinguishing challenges that informants felt could be addressed at regional or MS level.

<table>
<thead>
<tr>
<th>Thematic Area</th>
<th>Prevention and Social Mobilisation</th>
<th>Access to Care, Treatment, Support</th>
<th>Mitigating Impact of HIV and AIDS</th>
<th>Resource Mobilisation</th>
<th>M&amp;E and Institutional Strengthening</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Leadership</strong></td>
<td>Inconsistent leadership at all levels</td>
<td>Forceful leadership and coordination difficult across Ministries involved in Mitigation</td>
<td>Limited coordination and leadership in and across MS and Region</td>
<td>Leadership for coordination and governance at national level improved but can be strengthened incl. NACs, MoH &amp; CCMs.</td>
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<td></td>
<td>Poor recruitment of leaders</td>
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<td></td>
<td>Limited understanding and expertise among leaders</td>
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<tr>
<td></td>
<td>Poor understanding of issues and actors across sectors</td>
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<tr>
<td></td>
<td>Unable to tackle key drivers due to lack of coordination and sharing of capacity</td>
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<tr>
<td><strong>Planning and Management</strong></td>
<td>Limited capacity to design communication strategies and programmes</td>
<td>Inefficient use of available resources</td>
<td>How to scale up limited and localised mitigation strategies</td>
<td>Limited skills and systems to support use of evidence based planning &amp; proposal development for domestic and donor funding sources</td>
<td>Un-harmonised M&amp;E systems esp. between donors and govt. Priority given to donor systems not national plans</td>
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<td></td>
<td>Lack of results based management</td>
<td>Inadequate M&amp;E and Information Management Systems</td>
<td>Insufficient numbers of planners and managers for mitigation and mainstreaming</td>
<td>Limited capacity for lobbying, bargaining and negotiating in planning and proposal development</td>
<td>Poor mix of qualitative and quantitative methods in systems used to inform planners and managers</td>
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<td></td>
<td>Limited knowledge of how to change behaviour and how to measure impact</td>
<td>Weak service frameworks and plans</td>
<td>Intersectoral mainstreaming activities are poorly coordinated and prioritised</td>
<td>Need to harmonise and align donor system to address Regional and MS priorities</td>
<td>Evidence based planning and methodology is not well established</td>
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Areas amenable to Regional Level CD support
### Thematic Area

#### Prevention and Social Mobilisation

<table>
<thead>
<tr>
<th>Area</th>
<th>Access to Care, Treatment, Support</th>
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<th>Resource Mobilisation</th>
<th>M&amp;E and Institutional Strengthening</th>
</tr>
</thead>
<tbody>
<tr>
<td>New prevention initiatives are a challenge esp. communication around risks</td>
<td>Inefficient HR Planning</td>
<td>Poor link into poverty alleviation strategies</td>
<td>Limited capacity to ensure that donors support more sustainable types of interventions</td>
<td>Poor use of M&amp;E data for HR planning</td>
</tr>
<tr>
<td>Limited expertise and systems to apply new research and M&amp;E information to design and implementation</td>
<td>Weak HR management</td>
<td>Weak systems and skills in HR management</td>
<td>Limited ability to ensure programmes are able to absorb funding</td>
<td>Lack of knowledge on how to build capacity of institutions or individuals. Main experience is of training and changing work processes</td>
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<tr>
<td>How to operationalise prevention strategies</td>
<td>Centralised financial management and budgeting</td>
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<td></td>
<td>Weak HR management systems and skills</td>
<td>Poor programme management</td>
<td>Build Performance Based Management</td>
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<td></td>
<td></td>
<td>Lack of performance based management systems and organisational culture</td>
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#### Planning and Management (cont.)

<table>
<thead>
<tr>
<th>Area</th>
<th>Access to Care, Treatment, Support</th>
<th>Mitigating Impact of HIV and AIDS</th>
<th>Resource Mobilisation</th>
<th>M&amp;E and Institutional Strengthening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited capacity for lobbying, advocacy, negotiation, management, proposal writing and resource control</td>
<td>Shortage of HR in all areas</td>
<td>Shortages of HR with adequate training and skills to support mitigation esp. social workers in education, CCGs, law enforcement personnel</td>
<td></td>
<td>Lack of mechanisms to capacitate effective participation of civil society in national and decentralised processes</td>
</tr>
<tr>
<td>Under utilisation of CSO and NGO capacities</td>
<td>Inequitable and inefficient distribution of staff</td>
<td></td>
<td></td>
<td>High turnover among skilled staff</td>
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<tr>
<td>Low PLHIV involvement in planning and implementation</td>
<td>Reliance on foreign doctors</td>
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<td></td>
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<tr>
<td>High turnover of volunteers</td>
<td>Clinical staff moving to management roles</td>
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<tr>
<td>Poor selection, training and support of CHWs</td>
<td>Brain drain from Ministries and services</td>
<td></td>
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<tr>
<td>Inconsistent stipends</td>
<td>Underproduction of new professionals</td>
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<tr>
<td>Weak organisation and sustainability in CSOs</td>
<td>Excess staff with inadequate training</td>
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<tr>
<td>Limited number of adequately trained CHWs</td>
<td>Limited output of pre and in-service training</td>
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</tbody>
</table>
### Thematic Area

<table>
<thead>
<tr>
<th>Prevention and Social Mobilisation</th>
<th>Access to Care, Treatment, Support</th>
<th>Mitigating Impact of HIV and AIDS</th>
<th>Resource Mobilisation</th>
<th>M&amp;E and Institutional Strengthening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor infrastructure and HR challenges</td>
<td>Poor conditions of service for health professionals</td>
<td>Social protection frameworks to avoid dependency &amp; for sustainable community response</td>
<td>Lack of policy guidance on the efficient use of public private partnerships</td>
<td>Limited capacity and systems are for evidence based policy making</td>
</tr>
<tr>
<td>Policy</td>
<td>Underdeveloped use of community and civil society capacity and PPPs.</td>
<td>Defining the role of CCGs and counselors in social protection</td>
<td>Need to harmonise and align donor system to Regional and MS priorities</td>
<td>Un-harmonised M&amp;E systems. Priority given to donor systems.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Defining the role of civil society in social protection</td>
<td></td>
<td>Public private partnerships not working</td>
</tr>
</tbody>
</table>

### Areas amenable to action mainly at Member State Level

| Health and Related Systems Strengthening | Inequitable access to prevention services | QA around treatment | Mitigation strategies can be under small and/or weak Ministries | Weaknesses in systems related to the financial management and procurement of pharmaceuticals | NACs, MoHs and CCMs perform some roles with limited success due to role confusion, skills deficits, structure limitations, political factors. |
|-----------------------------------------|------------------------------------------|---------------------|---------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| Use of health service for prevention activities has limited success | Systems to serve mobile populations are underdeveloped | Coordination required across several Ministries | | | Support for Procurement and Supply Chain Management |
| Poor infrastructure and HR challenges | Weak links in services e.g transport, laboratories, drug procurement and supply and OI treatment | Inadequate structures of focal points and for coordination incl. confusion about roles and capacity of NACs | | | NAC, MoH and CCM coordination and governance improving, but can be strengthened. |
| Can't take male circumcision to scale | Underdeveloped linkage to programmes in related areas a | | | | Functional capacity at a decentralised level is a challenge |
| Limited resources for new priorities & vulnerable groups | Confusion about NAC role | | | | Poor capacity in CSOs in M&E and management |
| Public service limits innovation/ flexibility for prevention & community mobilisation | Poor management capacity in CSOs | | | | |
ANNEX 3: The conceptual foundation and process applied in development of the Capacity Building Framework

Several approaches to CB provide the theoretical foundation for developing this CB Framework and will underpin successful implementation.

1. Systems thinking

This Framework is informed by systems thinking. Many managers in the health sector and HIV and AIDS programs are familiar with aspects of organizational development and institution strengthening such as improved planning, organisational structures and performance management systems. But they are less familiar and confident with a systems development approach.

Within the health sector the word “system” is most commonly used to describe operational systems such as recruitment, referral or information systems, for example. However CB also addresses human systems, which are the way in which people relate, communicate and perform within an organisation or environment.

Systems thinking recognises that everyone is part of a number of complex human systems. If we understand how these systems shift and change, this can help us to understand individual, group and organizational behaviour. There is growing focus on systems thinking within public health and general development, as it presents a new understanding of the nature of development issues. Systems thinking helps us to understand processes of change, by identifying specific properties of systems that affect their ability to change, a critical factor in building their capacity.

Recent studies have identified that development often involves enhancing performance of “complex adaptive systems”. Complexity and an inevitable amount of uncertainty arise because many development programmes have objectives that are contested, confront uncertainty about how the objectives can best be tackled, or have a diverse and changing cast of stakeholders.

One such challenge in HIV and AIDS programmes, for example, is how to avoid working in “silos” and, instead, adopt approaches that are more holistic and build relationships and collaboration between diverse stakeholders. Many comments by respondents in the CB Needs Assessment point to the challenge of building relationships and coordination between sectors, such as the public and private sectors, civil society and health services, health and public service management authorities, or health and welfare/social development.

Systems thinking allows us to think about how human systems do work and behave rather than focusing on how we think they should work. Firstly, this helps us to acknowledge that in any system there are things that are unpredictable so CB processes must build in ability to adapt to new information or dynamics. Secondly, it

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7 Green, L.W. March 2006 “Public Health Asks of Systems Science: To Advance Our Evidence-Based Practice, Can You Help Us Get More Practice-Based Evidence?” American Journal of Public Health vol 96 no3 p406-409
9 Baser, H. and Morgan, P. April 2008 Capacity, Change and Performance Study Report. ecdpm
also recognises that change in system performance often depends on relationships between the component parts of the system, not only the functioning of individual components. So CB initiatives need to respond to, and influence, *relationships* between components.

This is a critical point for capacity building and this framework. Too often health and development sector energy and resources are spent on fixing component elements without tackling key relationships that fundamentally affect their ability to boost results of the program and the broader system itself. So for example, a national program may develop skills of planners to develop an HIV prevention strategy that is based on the latest evidence. But unless the focus of capacity building extends to realising the numerous players in the system\(^\text{10}\), and how to use or influence relationships between them (e.g. health workers and local FBOs), it is quite possible that prevention practice at community level may not change much.

In this Framework the “systems” within the Region that have a bearing on the present levels of performance have been specifically identified, along with the key role players who have to relate within them. It is these systems that form the foundation for the Capacity Building Framework.

It is important not to confuse the different concepts referred to as “*systems*”, “*systems development*” “*systems thinking*” with “*systems strengthening*”. Some of the key distinctions are summarised in Box 1.

**Box 1: “Systems” - Key concepts and definitions**

- **System**: *Operational systems* are processes or procedures that are set up to perform tasks e.g. provide management information; support financial management; *Human systems* are the relations between people that influence their performance in undertaking tasks (this can be both within the same organisation and between organisations)
- **Systems development**: Creation or strengthening of large or fairly localised systems to support more effective action to achieve objectives.
- **Systems Thinking**: Identifies the *complex human systems* and *complex adaptive systems* which influence performance of individuals, groups or organisations, and also what leads to change in these systems. It emphasises that system behaviour is often difficult to predict so CB should be flexible to adapt evolving understanding of issues and priorities.
- **Systems Strengthening**: Health Systems Strengthening\(^\text{11,12}\) (HSS) focuses on “building capacity in critical components” of health systems to achieve more equitable, sustained improvements across health services and outcomes”. Systems’ strengthening relies on best practice Capacity Building to strengthen specific components, but may put relatively little emphasis on relationships between components.

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\(^\text{10}\) e.g. Planners; district managers; clinic staff; NGOs; FBOs; donors providing influencing incentives for implementers; community health workers


\(^\text{12}\) The components identified by the World Health Organisation for systems strengthening are:

- **Policy**: defining sector strategies, clarifying roles and managing competing demands
- **Financing**: ensuring fair and sustainable financing
- **Human resources**: creating sufficient and productive workforce
- **Supply systems**: ensuring supply, maintenance, proper use of drugs and equipment
- **Service management**: improving organization, management and quality of services
- **Information and monitoring systems**: facility or population-based.
When systems are being targeted, there is potential for *multiplier effects* which mean that the effect of the different CB interventions is often more than the sum of the component parts. This can markedly improve ability to achieve change.

2. **Asset-based capacity building**

Most traditional capacity building frameworks address “capacity gaps” and shortfalls. However, successful CB strategy needs to build on some form of existing capacity, which can be worked with and enhanced. Therefore it is essential to identify what is working and not only the gaps. This asset-based approach to capacity building is informed by an organisational development approach called “Appreciative Inquiry.” This works with the positive interests, energy and capabilities of stakeholders to achieve more of what is working and use it as the launch pad from which to expand and achieve new things. The approach thus tends to be cautious not to over-focus on problems and challenges that drain stakeholders of energy for action and innovation.

Reported capacity and other positive developments that can support a process of change and CB have helped in the selection of performance areas, priorities and strategies in this framework. The approach therefore acknowledges and encourages existing capacity and what is working, and aims to realise their full potential.

**Box 2: Key concepts and definitions**

**Capacity Building:** Improving performance and ability to achieve desired outcomes or results.

**Appreciative approach:** Identifying what is working, not just gaps, and focusing on building on successes and existing capacity as the foundation for expansion and further Capacity Building.

3. **Individual competency and collective capability**

Capacity building can focus on two distinctive areas:
- development of individual competency
- building organisational, systems or collective capability.

Most health sector and program managers have some knowledge of the value of assessing and developing the competency of individuals. They can thus easily, but incorrectly, assume that CB is only about training to develop skills and knowledge.

Rather capacity building is more often about building the collective capacity of whole organisations, or whole systems of people and organisations, to perform better. The term *collective capability* is used to describe work focused on building organisational or systems capability.

Even when we are focusing on the capability of an individual to enhance performance, this often requires us to address aspects of their environment and its systems which can constrain or assist them. Aspects such as organisational *structures, processes, resources and management styles* affect how individuals are used to accomplish particular tasks and whether the environment is enabling and supportive of their ability to be productive. Beyond the individual’s immediate working environment, their performance is affected by the task network of other people and organisations involved in achieving the desired goal, as well as the institutional environment (e.g. general public sector HR policies) and the external environment.
Capacity building therefore requires working with an organization or institution and engaging in more holistic systems development.

4. Need for a range of creative strategies for effective CB

Capacity building requires an holistic understanding of the capacity challenges facing MS in their response to HIV and AIDS, and other health and welfare needs. A CB programme addressing a specific area of under-performance is also likely to use more than one strategy. This is because the capacity challenges facing the region are found within complex systems as described above, and are unlikely to be resolved by tackling only one aspect of weakness.

In developing strategy, it is important to understand all of the components of the system at regional, national and lower levels, who the key stakeholders and change agents are, as well as the strengths or difficulties of linkages and relationships between them. For example, a strategy relying on training to increase numbers of staff may be undermined by other components of the system that raise attrition of staff. These may include poor conditions of service, or weak leadership. Furthermore, inefficient processes and use of HR often constrain the capacity of institutions as much as lack of staff alone. Processes to build service capacity may also need to manage relationships with various professional groupings and stakeholders. Thus more than “technical” skills and solutions may be needed for success.

Interventions and tools used in CB to address such complexities are wide ranging, but some of the main ones are summarised in Box 3 below. A mix of these can be used to address the various performance issues within a certain system, and the mix may change as challenges evolve during the process of Capacity Building.

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**Box 3: Types of interventions used in capacity building**

**i) Effective facilitation of processes**

Capacity Building around complex issues and systems can only be undertaken with a sound process in place to support the required changes. Process-sensitive activities include: designing and implementing stakeholder advocacy and participation; analysing challenges; planning; problem solving; creating and implementing new structures; facilitating workshops; review of progress and refining strategy; and effective hand-over of tasks or leadership in implementation of change. This makes it vital that the individual(s) performing the Capacity Building process have facilitation skills.

**ii) Strengthening system tools and their use**

Systems tools include a range of instruments that help operational systems to perform more effectively. These include documents that describe the functioning of the system such as procedure and policy documents. An analysis of a system will indicate where there are weaknesses in existing tools that support the functioning of the system. Systems tools that may need to be strengthened can include codes of practice, monitoring and evaluation frameworks, reporting templates and mechanisms, and job descriptions, to mention but a few.

While improving some priority tools can lead to quick improvements, certain problems may ultimately require larger changes to a system, sub-systems and related tools. For example, improving HR planning may require development of staffing models and tools to project

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future needs. Stronger HR management may require quite big changes to strategic systems and tools in areas such as efficient recruitment, career pathing, payment and labour relations.

**iii) Strengthening relationships**

Improving performance of complex systems often requires *more effective working relationships* between system role players and components. One method of developing relationships is through a *focus on learning.* Techniques for creating *learning organisations* can be used to encourage people in a system to develop through asking questions and formulating new working practices and ideas from their own and others experience. Such learning is often horizontal, from colleague to colleague as opposed to top down from a manager to their staff.

Creating opportunities for *appreciative learning* is another way to build effective relationships, by encouraging stakeholders to identify and build on positive examples of collaboration and performance, and also to identify solutions rather than just problems.

**iv) Building Networks**

Networks, whether formal or informal, can be powerful strategies for use in Capacity Building. A network consists of individuals or organizations willing to collaborate to achieve common goals. A network allows for the rapid dissemination of information including lessons, innovations, tools, questions and ideas. It can give participants a strong sense of solidarity. Establishing *communities of practice* and *action-learning sets* are good examples of how people can start engaging and learning together to tackle challenges in particular focus areas on specific types. The development and use of networks tends to require expertise if they are to be effective and sustainable.

**v) Human resource planning and development**

At the level of whole sectors such as the health, creating a sustainable system with adequate scale may need macro level HR planning and development. This may require careful consideration of new ways of organising and staffing services and functions, including changing staffing norms and systematic task sharing or shifting, for the short or longer term. Training or other HR skills development methods complements this, on large scale or targeted at particular priorities needs.

At the level of individual organisations or institutions, HR planning may involve re-thinking roles and processes. Changes in post structures, job descriptions or conditions of employment may follow, along with new appointments, to assist both the organisation and employees to fulfil their required roles. Human resource and skills development can be addressed through e.g. training, mentoring and networking.

**vi) Strengthening communication and information flows**

Improved communication can enhance system performance in many ways. These include increasing awareness, knowledge or understanding; ensuring stakeholder commitment; and mobilising action. Systems thinking highlights the relationships between systems’ component parts, and how sharing of information by them is often critical. Some key questions to identify how to unblock the potential of systems include: Who has information? How is the information flowing between system components? What are the blockages and obstacles to information exchange, and what is facilitating it?

The type of need or action required will influence the choice of communication method. Often, CB involves commitment to face-face communication through interviews, meetings and workshops. In some cases, better use of communication such as emails, memoranda and electronic newsletters can be a relatively simple way to enhance organisational learning and performance.
### vii) Training

The development of training programmes is often an important part of the Capacity Building challenge. Training ranges from formal in- or pre-service training, to informal training around specific issues.

Often it is necessary to adapt the training for various types of staff and stakeholders within an organisation or system. This ensures the appropriateness of content to the training need, and the effectiveness of teaching methods. For some types of training, a key intervention may be to formalise and accredit it, to ensure buy-in from trainees and other stakeholders.

Training tends to have limited effectiveness on its own, and is more functional if part of a broader Capacity Building programme. Training programmes often have to consider the broader environment which will impact on the capacity of learners to use their new skills and knowledge. Follow-up support to learners to consolidate learning and correct, practical implementation is often essential. This can include mentoring programmes, effective supervision and quality assurance.

### viii) Leadership development

Leadership is a critical component of capacity. Understanding how leadership is exercised and where and how it needs to be strengthened is likely to be a component of the analysis of Capacity Building needs. Leadership development is supported by training, coaching, mentoring and shadowing. Leadership interventions can focus on the grooming individuals or on strengthening of the role of committees or groups to provide leadership on certain issues.

### ix) Technical input and expertise

Technical support can enhance capacity to perform certain functions, usually in specialized areas such as monitoring and evaluation, preparation of strategic, operational or HR plans, or aspects of financial costing and budgeting or resource tracking. Technical support should develop skills, systems and tools that allow an organisation to undertake the task itself. Optimal technical support provision requires not only technical expertise, but also interpersonal, process and Capacity Building skills to leave behind enhanced capacity.

### x) Investment in infrastructure and equipment

In some cases, Capacity Building in the health or other sector will involve investment in infrastructure and equipment. Sometimes investment in IT or communications infrastructure is the key to allowing information or other systems to perform adequately. In other instances lack of equipment and facilities is often a push factor contributing to poor retention of staff. Capacity Building programs need to ensure that technical or other considerations do not dominate the choice of investment, with too little consideration of the interface with human and other systems which will determine whether the investment will actually improve performance.

## 5. Choice of potential CB strategies

The choice of potential strategies for CB at a sector level arises through:
- Identification of an area of performance that can be enhanced through capacity building
Consideration of which systems are relevant to a specific area of performance and which stakeholders, institutions and organisations combine to make up a system. 

Analysis of the functioning of a specific system. This provides an understanding of the strategies necessary for Capacity Building.

Tools to support this kind of analysis include ROACH “results-oriented approach to Capacity Building and change”.

<table>
<thead>
<tr>
<th>Box 4: Results orientated Capacity Building and change (ROACH)</th>
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<tbody>
<tr>
<td>The six components of a ROACH assessment are:</td>
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<tr>
<td>• <strong>Structures:</strong> Institutional structures, structure between organizations/institutions, management, leadership and staffing of stakeholder organisations</td>
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<tr>
<td>• <strong>System tools:</strong> Equipment, procedures, guidelines, audit systems and legal instruments defining and describing the process of work.</td>
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<tr>
<td>• <strong>Skills and awareness:</strong> Knowledge, skills and competency gaps, existing needs assessment, training provision and opportunities, formats and approaches to training, institutional arrangements for training</td>
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<tr>
<td>• <strong>Inter-relations:</strong> Institutional relations between institutions/organisations, internal organisational issues that are about relationships between different structures, categories of staff and individuals.</td>
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<tr>
<td>• <strong>Incentives:</strong> Aspects affecting system performance, penalties, organisational culture, other government policies e.g. affirmative procurement and career paths etc</td>
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<tr>
<td>• <strong>Funding:</strong> Pricing and cost, budgeting, release of funds and the authority for financial decision making</td>
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This system identifies six components of any system that affect its capacity. Each component not only affects internal functioning of an organization but prompts examination of how internal areas of functioning may be impacted on, positively or negatively by a wider context.

**a. Key success factors**

In the context of this understanding of the systems approach to CB, several key success factors are likely to determine what can be achieved. These include:

a) **Tackling priority systems.** The key systems that determine performance in the most important areas of the AIDS response must be identified and prioritised. Certain systems will have greater opportunity to change and/or to change overall performance.

b) **Improving connections and inter-relationships.** People, groups, structures, ideas and system components inter-relate, and thus support or obstruct each other. This may have as much influence as the strength of any of those components. Helping to create or strengthen good connections between systems components therefore has great potential to improve performance.

c) **Targeting priority system components where necessary.** Individuals, organisations or sub-systems, within a “task network” that needs to achieve a certain outcome, may need strengthening in themselves. This should not

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14 Boesen, N. and Therkildsen, O. Feb 2005 A Results-Oriented Approach to Capacity Change Ministry of Foreign Affairs Danida www.evaluation.dk
d) Involving and affecting the key stakeholders. Certain organisations or even individuals will have a large influence on performance of a system and ability to change it. They need to be involved or addressed.

e) Recognising the institutional environment and external environment. Within the public sector, donors, civil society and the private sector, aspects of the institutional environment may need to be addressed as opportunities or constraints. Similarly external factors may have strong influences on what is viable. These include the political and economic environment.

f) Prioritising quick wins that support the momentum for Capacity Building. Actions that are “quick wins” may unlock potential for change and build enthusiasm for Capacity Building.

g) Effective process. Capacity Building involves complex systems. Building them is inherently a process, and it tends to take time for whole systems to function better. The priority factors affecting performance often cannot be immediately understood in their entirety and will often change over time. Thus, Capacity Building strategy and activities must be able to adapt to changing understanding of priorities, challenges and opportunities.

h) Sustained leadership and support is usually required to develop capacity and change performance of complex systems. Thus short term “quick fixes” without follow-up should be considered with caution.

A good and continually updated understanding of the opportunities and constraints in each of the above areas, and related prioritisation and processes, will allow systems’ capacity to be addressed most effectively.
ANNEX 4. Approaches to M&E of Capacity Building Interventions

1) Loops of learning

The concept of learning loops clarifies the kinds of learning that can occur during implementation of a project. The dynamics of learning are characterized into single-loop, double-loop and triple-loop learning. Complex issues such as those tackled in capacity building should use double or triple loop learning in order to: be effective in different contexts; make learning an integral activity; and achieve sustainable results.

**Loops of learning**

<table>
<thead>
<tr>
<th>Context</th>
<th>Assumptions</th>
<th>Actions</th>
<th>Results</th>
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**Single-loop learning** is characterized by following the rules or plan. *Are we doing things right?* In this form of learning primarily considers activities, making small changes based on what has or has not worked. It involves doing things better without necessarily challenging underlying assumptions. Improvements often take the form of addressing operational processes of programmes, or changing procedures and rules. For example, single loop learning would assess whether a program has achieved output targets and adapt planned processes to achieve more output.

**Double-loop learning** gives insights about why something worked. Through process analysis planners and managers change the way they make decisions and understand their assumptions. Double loop learning works with major changes like redesigning organizational (or programme) structure or function. *Are we doing the right things? Here’s why this works – insights and patterns.* For example, a program may consider whether to change aspects of a curriculum, or add follow-up distance learning to training courses to skills development more effective and relevant to participants.

**Triple-loop learning** involves principles. It goes beyond insight and patterns to context and creates a shift in understanding by leaders, planners and managers of their own context or point of view. This form of learning challenges them to understand how problems and solutions are related and how their previous actions may have

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created the conditions that led to current problems. The results of this learning include enhancing ways to understand and change their purpose, developing better understanding of how to respond to their environment and being more aware of why they have chosen to do the things they do. *How do we decide what is right? Here’s why we want to be doing this – principles.* This type of learning is critical for CB to succeed in a dynamic environment. For example, training providers may find that their focus on academic learning or training alone may not be achieving system performance improvements because there is need to change systems in participants’ work environment or help them to manage obstacles to implementing their skills.

2) **Evaluating CB programmes by identifying capabilities that have resulted**

An alternative approach to the standard evaluation criteria of relevance, effectiveness, efficiency, impact and sustainability is to assess what capabilities have resulted from capacity building programmes.  

Five core capabilities that have been identified as relevant to capacity building are the capability – to survive and act, to generate results, to relate, to adapt and self renew, and to achieve coherence. These capabilities are illustrated diagrammatically below with some of the key questions associated with understanding each capability. Developing indicators for these requires creative thinking and these are much more likely to be qualitative rather than quantitative.

**Figure : Five core capabilities and related questions**


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