



Praxis Paper No. 11

# Counting the Organisational Cost of HIV/AIDS to Civil Society Organisations

*Pilot Research Study, Malawi*

By Rick James with Brenda Katundu

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### Executive Summary

HIV/AIDS mainstreaming has traditionally been equated with adjusting programmes to be more relevant to beneficiaries affected by HIV/AIDS. Bitter experience is demonstrating, however, that civil society organisations (CSOs) are not immune to the impacts of AIDS within their own organisations. There is increasing evidence that CSOs in sub-Saharan Africa are being adversely affected by rising absenteeism and increased medical and staff welfare costs. It also appears that few CSOs are responding adequately to this threat. In the context of fragile infrastructure, inadequate healthcare provision and sickness benefits, high levels of poverty and low levels of skilled labour this is cause for concern.

The lack of proactive response is partly a result of CSOs (and their donors) simply not knowing the extent of the economic costs they are experiencing from working in a context of high HIV/AIDS. To address this knowledge gap and attempt to assess the economic costs of HIV/AIDS on the organisational capacities of selected CSOs, INTRAC, together with CABUNGO (Malawi), TRACE (Tanzania) and CDRN (Uganda) are undertaking an exploratory research study in these three countries. To test out the proposed methodology and to highlight initial findings, INTRAC and CABUNGO undertook a pilot research project working with four CSOs in Malawi in 2005.

The 16 respondents in the pilot study estimated, on the basis of recall interviews, that as a result of HIV/AIDS, their CSOs were experiencing:

- 12.5% average increase in staff costs
- 3.3% increase in overall budget costs
- 12.4% drop in CSO output
- 20% + overall perceived reduction in impact

It needs to be emphasised that these figures are tentative estimates, not definitive, verifiable facts and should therefore be treated with caution at this stage.

Despite this apparent *individual awareness* of the costs of HIV/AIDS to the organisation, this has not yet translated into a corresponding *organisational response*. Most of the CSOs surveyed are still doing very little to respond to the threat of HIV/AIDS to their own organisation, which is indicative of the fragility of the

organisation and management structures. Respondents believe the response has been limited because:

- CSO focus is on programmes and beneficiaries, not their own organisation
- HIV/AIDS is still a taboo subject, particularly when a sick staff member is present
- Some leaders are HIV+ themselves and do not push an organisational response
- CSOs had no real idea of the actual costs of HIV
- CSO management does not have the competence in HIV/AIDS
- CSOs do not have the financial and human resources, and may have precarious organisational and management structures
- Despair and a sense of hopelessness undermine motivation to respond

Respondents suggested that donors could support CSOs' organisational strategy to deal with HIV/AIDS by:

- Focusing more on CSO organisational capacity, not merely CSOs as vehicles for programme delivery
- Making partners more aware of the organisational threat of HIV/AIDS
- Developing clear and open guidelines for funding HIV-related costs of partners
- Ensuring adequate budgeting for HIV/AIDS-related costs by making this a condition for funding
- Supporting HIV/AIDS workplace trainings and consultancies
- Developing the supply and quality of local providers of such services
- Funding research, workshops, publications and dissemination of good practice on organisational responses to HIV/AIDS

Ultimately, CSO respondents admitted that while donor partners have a role to play, the real responsibility still lies with the organisations themselves.

If such initial estimates from the small pilot are characteristic of the impact on the sector as a whole, this would raise major strategic questions about the future of CSOs in sub-Saharan Africa. Moreover, Malawi is far from the worst affected country in the region — Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia and Zimbabwe all have much more severe rates of HIV infection. CSOs in this region are already fragile and often function with scarce financial and human resources; these limited resources will be further stretched by the economic costs of HIV/AIDS. Working in a context of high HIV prevalence will cost CSOs more money to achieve less output. Will CSOs be able to survive the loss of valuable staff, time and money? Will donors be prepared to pay these costs? What can CSOs themselves do to make themselves more resilient to the epidemic? How can donors support these processes?

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Finally I would like to thank the respondents in this research who gave of their time, their knowledge, their fears and their sadness in responding to the research. We hope this research proves of practical use to your organisations.

## List of Abbreviations

ART	anti-retroviral therapy
CSO	civil society organisation
FBO	faith-based organisation
ILO	International Labour Organization
INTRAC	International NGO Training and Research Centre
NGO	non-governmental organisation
UNDP	United Nations Development Programme
WHO	World Health Organisation

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# 1. Introduction

## 1.1 Background

HIV/AIDS has slashed the average life expectancy to less than 40 years of age in many sub-Saharan African countries (WHO 2005). More than three million people are dying each year from HIV-related illnesses. Predictions for the next decade are even worse. The impact on poor countries like Malawi is so devastating that HIV specialists warn that: 'Development becomes virtually impossible in the era of AIDS' (Barnett and Whiteside 2002). The Millennium Development Goals may remain a dream for many.

The international development community has responded with considerable effort and financial commitment. But while there has been laudable emphasis on mainstreaming HIV into external programme work with communities, less attention has been paid to the impact of HIV on the capacity of local organisations (James 2005; Holden 2003).

Any organisation working in a context of high HIV/AIDS prevalence will face increasing internal costs from higher medical and insurance expenditures and reduced productivity through the loss of valuable staff and management time for reasons of sickness, care and funerals. African civil society organisations (CSOs) are not immune from these impacts — indeed the age profile of their staff and the amount of travel required for work makes CSOs more susceptible to the impact of HIV. Despite the global emphasis on HIV/AIDS, these debilitating costs to organisations are still largely ignored, both by Northern donors as well as African CSOs themselves. We are in effect living in 'organisational denial' of HIV/AIDS. The extra financial costs of HIV/AIDS to organisations are rarely budgeted for and are usually silently absorbed into other budget lines. This makes CSOs in HIV/AIDS-affected contexts appear expensive and increasingly inefficient. In addition the likely loss of staff is rarely factored in to human resource planning strategies, making already fragile CSOs even more vulnerable. Most CSOs and some donors are hoping to continue business as usual, but if CSOs themselves are going to survive this pandemic they need to seriously adjust their organisational strategies, management systems and financial budgets. In an increasingly competitive aid system this is no small challenge.

There are a number of factors constraining the CSO response (see James 2005), but one of the most basic is that CSOs and their donors have no real idea about the extent of the economic or social cost of HIV/AIDS to their organisations. Nor do they know the amount they need to invest to implement an effective response. Limited record-keeping in many CSOs makes it very difficult to analyse trends in absenteeism, sickness, and increased medical costs. Fear of job loss means that colleagues cover up for absenteeism thereby camouflaging the actual costs. CSO leaders also fear that addressing HIV/AIDS will dramatically increase budgets as the organisation takes responsibility for paying for family access to anti-retroviral therapy (ART) for life. This lack of quantification means that both the extra costs of HIV/AIDS impact and the added costs of internal HIV/AIDS mainstreaming are very rarely factored into donor budgets. Consequently even planned actions, such as staff awareness workshops, are not implemented. As donors place increasing emphasis on CSOs meeting results-based targets, this may undermine CSOs' attempts to obtain funding in the future.

## 1.2 Pilot Research Project

To find out the extent of the costs of HIV/AIDS for CSOs, INTRAC initiated a two-phase research project. Pilot research was carried out in Malawi with CABUNGO in 2005 and is being extended to Uganda (with CDRN), Tanzania (with TRACE) and within Malawi in 2006. The overall aim of the research is:

*to assess the social and economic costs of HIV/AIDS infection to the organisational capacities of selected CSOs*

This research adds value to development programming work in sub-Saharan Africa by estimating the economic costs of HIV/AIDS to CSOs in the region. Currently we only know about the diversity of socio-economic costs to CSOs, but we do not know, other than anecdotally, what this actually costs CSOs in financial terms. We hope this research will stimulate CSOs to proactively address the impact of HIV/AIDS in their organisations and adjust their budgets accordingly. We also hope that it will catalyse donors to co-operate and encourage their partners to rise to this challenge. This research is a key part of a wider INTRAC Praxis initiative for developing international capacity to address the organisational impact of HIV/AIDS.

The main aims of the pilot study were to:

1. explore the hypotheses that:
  - HIV/AIDS may be incurring significant economic costs for CSOs
  - CSOs may be struggling to implement an effective response
2. raise overall issues about the social and economic costs of HIV/AIDS to CSOs
3. explore the relevance and reliability of the methodology to extend it to other countries of the region
4. raise donors' awareness of the pressures CSOs face in working in a context of high HIV prevalence.

Four CSOs in Blantyre, the largest city in Malawi, were selected for the pilot research to enable comparison based on the same location and HIV-prevalence. In Malawi, with a generalised HIV epidemic (ie, a high level of infection in the whole population), it is not possible to have a control group of unaffected CSOs as even the least infected rural areas have almost 10% rates of infection.

We interviewed 16 staff from four CSOs (including the Director, the Human Resources Manager, the Finance Manager and a programme staff person) to explore the extent of the organisational impact and the nature of the CSO response. Recall interviews were used as the prime data-gathering methodology. The numbers estimated do not therefore claim to be definitive and should be treated with care at this stage.

Forty-eight CSO leaders also filled in a 'Leadership Impact' questionnaire examining the personal cost of HIV/AIDS to leaders. This questionnaire enabled disaggregation of the results by gender to see how the costs of HIV/AIDS affected men and women differently. (For more information, see Methodology in Appendix 1).

### 1.3 This Paper

This paper is written for staff of development agencies working and supporting others to work in areas of high HIV/AIDS prevalence. We need to know how HIV affects organisations and what can be done to build organisational resilience to HIV if we are to work effectively in sub-Saharan Africa. We hope that in reading the paper and appreciating the extent of the impact you will be challenged to apply the strategic implications to your own organisation, whether as a donor, a capacity builder or as an implementing NGO.

Section 2 of this paper contains the bulk of the research findings. Section 2.2 highlights the quantitative findings about the impact of HIV/AIDS on pilot CSOs. The direct and indirect costs are analysed to calculate the overall extra financial expenditure incurred from working in a context of HIV/AIDS as well as the loss of staff time leading to reduced output and performance. Section 2.3 describes the variety of different impacts experienced by CSOs, largely in the respondents' own words. We highlight the different impacts of having staff both infected by HIV/AIDS themselves and affected by HIV/AIDS in their families and communities. Section 2.4 outlines the personal impact of HIV/AIDS in leaders' families, disaggregating this by gender to show how women leaders are disproportionately affected in Malawi.

Section 3 describes the limited ways in which pilot CSOs have so far responded to the threat of HIV/AIDS. The response has largely been confined to ad hoc staff awareness programmes and some work on HIV/AIDS policy development. The paper then analyses the factors constraining CSO responses. Section 4 goes on to make suggestions for the ways forward, outlining recommendations for both CSOs and donors. The conclusions make up Section 5.

This Praxis Paper has largely been taken from the research report of the same name. The research report of the pilot study as well as the Regional Research report from the three-country study is available from [rjames@intrac.org](mailto:rjames@intrac.org).

## 2. CSO Experience with HIV/AIDS in Malawi

This section highlights the impact of HIV/AIDS on the CSOs in the pilot research. It starts with an overview of HIV/AIDS in Malawi before presenting the bulk of the findings. Section 2.2 identifies the direct and indirect economic costs of HIV/AIDS to CSOs, quantifying the overall impact on budgets and outputs. It shows that working in a context of high HIV prevalence will cost CSOs significantly more money for significantly less output. Section 2.3 describes the variety of ways in which interviewees experienced the impact of HIV in their own organisations. Section 2.4 presents the findings from the Leadership Impact questionnaire revealing the considerable personal cost of HIV/AIDS to CSO leaders and how this impact is disproportionately experienced by women.

### 2.1 HIV/AIDS in Malawi

Malawi is the poorest country in the world which is, neither in the midst of, nor emerging from civil war. Sixty-five per cent of the population is living at or below the poverty line (all statistics from Government of Malawi 2002). It has one of the most unequal income distributions in the world where the poorest 20% consume only 6.3% of goods and services. Forty-nine per cent of Malawian children are thought to be stunted because of long-term malnourishment. Malawi has a low adult literacy rate, estimated at 58%, with gender disparities leading to adult female literacy of only 44%. Life expectancy has dropped to just 39 years, due in part to HIV/AIDS.

Malawi has a generalised heterosexual epidemic that is not stabilising (WHO 2005). The national rate of infection amongst people 15–49 years old is estimated at 14.2% but with greater levels of infection in urban areas. In Blantyre the rate is estimated at 27.6%. HIV/AIDS is now the leading cause of death in the most productive age group, resulting in 86,000 deaths annually. Although the total number of reported AIDS cases according to sex is about equal, the distribution by age group and sex is quite different. For women, cases are concentrated in the younger age groups: more than four times as many women between 15–19 years old have AIDS, whereas between 20–25 years old there are about 30% more women infected than men. The pattern then reverses and after 30 years old, more men than women have AIDS (See Table 1).

**Table 1: Age specific prevalence for aggregated urban sites**

Age group	Total sampled	HIV+	% HIV+
<15	2	1	50.0
15–19	481	78	16.2
20–24	1079	225	20.9
25–29	565	138	24.4
30–34	251	75	29.9
35–39	60	12	20.0
40+	11	3	27.3
<b>Total</b>	<b>2,460</b>	<b>535</b>	<b>21.7</b>

There was no significant difference in HIV prevalence among women whose partners were skilled, professionals or in business. However, prevalence in women whose partners are farmers or fishermen was significantly lower than those partnered to business, skilled and professional men as shown below:

**Table 2: HIV prevalence by partners' occupation**

Partner occupation	Total sampled	% HIV+
Unskilled	205	15.1
Skilled	950	20.2
Professional	930	25.2
Business	1900	24.1
Military/police	55	21.8
Security agent	315	20.6
Student	65	23.1
Farmer/fisherman	3446	16.0
None	109	19.3
<b>Total</b>	<b>7975</b>	

HIV/AIDS is still largely a taboo subject in Malawi with many people referring to it obliquely using phrases such as *'being sick for some time'*. When AIDS is spoken about, it is usually in the abstract. Although this is changing and people are becoming more open, it is still extremely rare in Malawi for HIV+ people to disclose their status, even if they know. This makes research into the economic costs of HIV/AIDS a matter of conjecture. Having said that, most people now have sufficient knowledge about the disease and its symptoms to make a reasonable judgement about whether or not someone has AIDS. This paper therefore uses the term HIV/AIDS as short-hand for 'suspected HIV/AIDS', while acknowledging that without testing this remains anecdotal.

## 2.2 The Quantified Impact of HIV/AIDS on CSOs

Respondents in the research suspected that they had experienced the following:

**Table 3: Suspected HIV deaths and sickness in organisations**

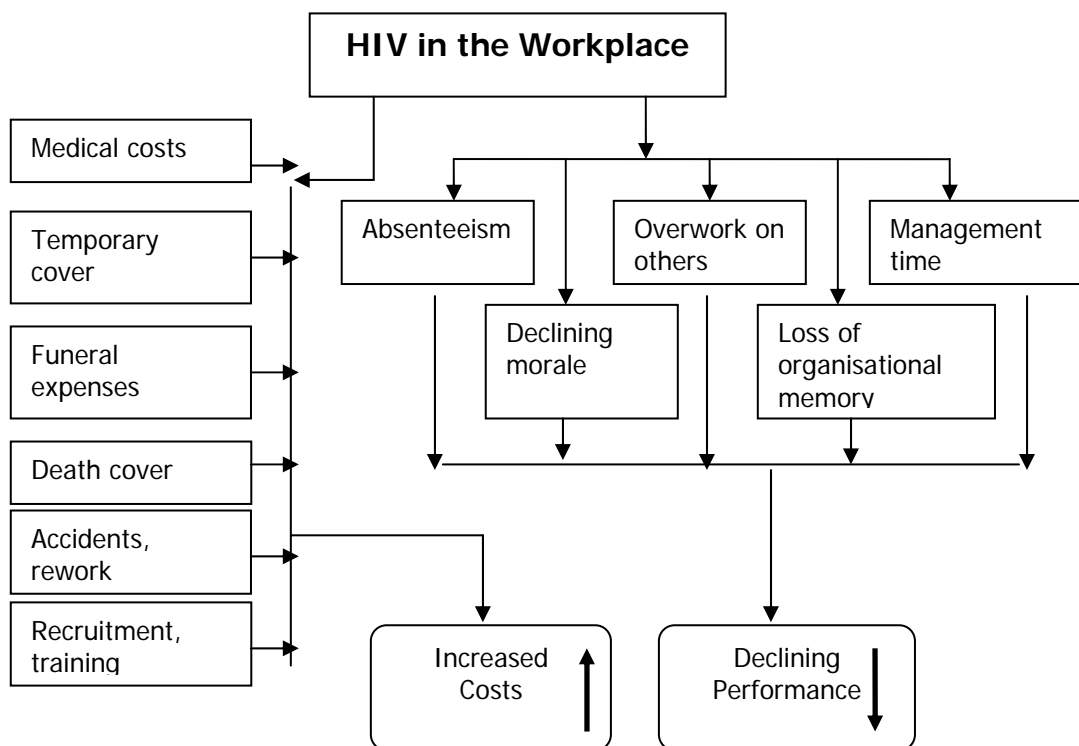
	CSO 1	CSO 2	CSO 3	CSO 4
Number of staff	61	104	37	28
Suspected AIDS-related staff deaths in 5 years	7	5	0	4
Suspected AIDS-related dependant deaths	4	?	6	4
Suspected sick HIV+ staff	5	1	6	2
Likely HIV+ (given HIV prevalence of 27% in Blantyre Ministry of Health 2003)	16	28	10	8

*NB These figures are anecdotal and impossible to verify without post-mortems, but there is no reason to suspect they are not accurate.*

Seventy-five per cent of the CSOs surveyed had lost four or more staff to suspected AIDS in the past five years. This amounts to between 5% and 15% of the current workforce. Only one (the youngest) had not lost a member of staff and even this CSO had seen six dependants (spouse or children of staff) die of suspected AIDS in the last five years.

Despite already experiencing deaths from AIDS, respondents were still under-estimating the number of their staff who might be HIV+ (when compared with the prevalence rate in Blantyre). They estimated that in all there were 14 staff with HIV in the four CSOs. If these CSOs are 'average' for Blantyre (with 27% prevalence), there would be 62 staff likely to be HIV+. Given the susceptibility of many CSO staff, given the need for them to travel away from home for work, it is likely that CSO staff prevalence is close to the city average, if not even above. People are under-estimating the number of their staff who are HIV+, probably because staff do not appear sick until they start displaying symptoms of AIDS (5–10 years after contracting the virus — 85% of people with HIV have not yet developed AIDS). CSOs are therefore able to remain in denial about HIV/AIDS in their organisation to some extent.

HIV/AIDS causes both direct and indirect costs to a CSO. There are costs associated both with an individual being sick and more general organisational costs illustrated diagrammatically:



## 2.2.1 The Direct Costs of HIV/AIDS to CSOs

The pilot research revealed that HIV/AIDS is having a very significant economic cost to CSOs consulted, as illustrated by Table 4 below. These figures were calculated from the estimations by interviewees of the actual costs to their CSO in the last year from having staff infected or affected by HIV (using the model illustrated above). Where the estimates could not be solely attributed to HIV (such as medical or funeral costs), 70% were assumed to be related to HIV/AIDS. It must be stressed that these are estimations, not definitive or 'scientific' answers. As such, the findings should be seen as tentative and treated with caution. But they do represent the best estimates of a cross-section of senior managers (including the Director and Finance Manager) in each CSO.

**Table 4: Economic costs to CSOs**

<b>Quantified Direct Costs<sup>1</sup></b>	<b>NGO 1</b>	<b>NGO 2</b>	<b>NGO 3</b>	<b>NGO 4</b>	<b>Average \$</b>
Productivity, accidents, replication of work	\$23000	\$1855		\$99	\$6239
Temp cover, outsourcing, overtime	\$9818	\$8909		\$654	\$4845
Death cover	\$9164	\$3436	\$6109	\$610	\$4830
Medical costs, insurance	\$1209	\$6364	\$4264	\$1604	\$3360
Funeral costs	\$636	\$1527	\$454	\$454	\$768
<b>Direct Total</b>	<b>\$43,827</b>	<b>\$22,091</b>	<b>\$10,827</b>	<b>\$3421</b>	<b>\$20042</b>
Direct costs per employee <sup>2</sup>	\$719	\$212	\$293	\$122	\$336
Direct costs as % salaries	20.1%	6.8%	7.4%	15.7%	12.5%
Direct costs as % turnover	5.4%	2.2%	2.0%	3.8%	3.3%

CSOs are spending significantly more on medical costs, insurance, pensions, re-work, accidents, funeral costs and overtime/temporary staff because of staff being infected with HIV/AIDS — an average of \$336 extra per person per year according to respondents' estimates. From the pilot four organisations, we see that this amounts to an increase in the staff bill of more than 12.5%, which corresponds to 3.3% of total turnover. CSO overhead costs are therefore considerably higher and only a proportion of these have been budgeted for.

## 2.2.2 The Indirect Costs of HIV/AIDS to CSOs

The increase in direct costs is only part of the equation, however. Working in a context of high HIV/AIDS prevalence led to considerable loss of staff time through staff being off sick; taking compassionate leave to look after sick relatives; being absent from work to attend funerals; and taking up valuable management time as a result. This had a direct impact on the performance of the CSOs. This is illustrated in Table 5.

<sup>1</sup> To estimate the impact of HIV/AIDS we make assumptions about the proportion of the medical costs, funerals and death cover that can be attributed to HIV/AIDS. The proxy indicator that 70% of in-patients in Malawi government hospitals are HIV+ (UNDP/MIM 2002) is used to extrapolate that 70% of the above costs are HIV related (see also ISSS 2003 and Garbus 2003). Evidence from the interviews of numbers of HIV-related funerals compared to non-HIV-related funerals suggests this is fairly accurate.

<sup>2</sup> Costs per employee, as percentage of labour costs and overall turnover taken from CSO reports.

**Table 5: Indirect cost in time to NGOs of HIV/AIDS**

Quantified Indirect Costs <sup>4</sup>	NGO 1	NGO 2	NGO 3	NGO 4	Average
Management time (regarding HIV-infected staff)	20 days	27 days	33 days	16 days	24 days
Absence for HIV-related funerals per person	8.4 days	10.5 days	4.2 days	8.4 days	7.8 days
Absence for HIV-related sickness per person	6.3 days	4.3 days	3.9 days	10.2 days	6.2 days
Management time (for affected staff)			11 days		2.75 days
Absence for sick family members per person			3 days	4 days	1.75 days
Percentage loss of staff/management time	10.2%	12.1%	13.1%	14.1%	12.4%
NGOs' own estimation of reduction in performance <sup>5</sup>	- 30%	- 15%	- 27%	- 9%	- 20.3%

The CSOs surveyed perceive that they lose on average 12.4% (28 days per year) of staff time because of HIV/AIDS. This figure is remarkably consistent between the four organisations. The most significant losses come from the time managers have to re-direct to tasks dealing with HIV-related issues (an estimated average of 7.5% of their time) and staff absences for funerals (estimated at 5% of staff time).

The estimated 12.4% loss of time leading to a decline in performance may even underestimate the true cost. This figure does not take into account any decline in performance that comes from the impact of the more indirect, organisational costs mentioned by respondents such as:

- stress and overwork for remaining members of staff;
- knock-on effects of other staff being unable to work themselves when a key staff member is absent (for example when a 'driller' is absent the whole water team cannot work)
- declining morale as a result of having sick colleagues and family members;
- worry and distraction at work from sick relatives;
- the loss of organisational memory when a staff member dies;
- undermining their vital relationship with beneficiaries, donors and clients (if CSOs perform poorly this may have an ongoing detrimental impact on their reputation and relationships).

Some of these unmeasurable costs were perceived to be the most significant to CSOs (see Table 6). For example, the impact of the decline in morale from HIV was perceived to be the second highest cost to CSOs and the resulting overwork on remaining staff was fourth highest. The overall impact on organisational performance

<sup>4</sup> Estimated by respondents during interviews.

<sup>5</sup> Estimated by respondents during interviews.

may be more than the 12.4% loss than we can count. It might even be closer to the 20% decline that respondents estimated themselves in the interviews. It is costing CSOs significantly more money for considerably less output. The strategic implications of such figures need very careful consideration and a proactive response. We now go on to consider these costs in more detail.

## 2.3 The Qualitative Impact of HIV/AIDS on Pilot CSOs

The impact that HIV/AIDS has on organisations has two related dimensions from:

- staff being *infected* with HIV themselves
- staff being *affected* by HIV in their extended families and communities

The impact of having both infected staff and affected staff were analysed and are dealt with in turn in the next two sections.

### 2.3.1 The Impact of Having HIV-Infected Staff

The most significant economic impact perceived from having HIV-infected staff is the cost of the sick leave as Table 6 illustrates. The next most serious impacts are felt in resulting overwork on remaining staff and the loss of productivity, rework and accidents.

**Table 6: Respondents' perceptions of costs of HIV/AIDS to CSOs**

Perceived impact	NGO 1	NGO 2	NGO 3	NGO 4	Average
Absenteeism – sickness or leave	5.25	5.5	6	4.4	5.3
Overwork on others	6.75	4.5	5	3.5	4.9
Productivity, accidents, replication of work	7.5	4	4.8	3.25	4.9
Morale	7	4.25	4.3	3.25	4.7
Medical costs, insurances	6.5	5.5	3.5	3.3	4.7
Management time	5.25	3.25	4	2.5	3.8
Recruitment	1.75	6	3	3.6	3.6
Funeral costs	4	3.6	2.5	3	3.3
Loss of organisational memory	5.75	5.3		2	3.3
Training costs	3	4	2.5	3	3.1
Temp staff costs/ Outsourcing/ Overtime	4.75	0.66	0	4.3	2.4
Death benefits/ Pension	2.75	1.5	0	5	2.3
Unpaid loans	0.75	0	0	0	0.2

Scale of severity ranked 0–10 with 0 being 'Not at all' and 10 being 'Very considerably'.

Interestingly when this is compared with the estimated average quantified costs of these different factors shown in Tables 2 and 3, it appears that the real financial costs of the loss of management time (ranked 6) and employing temporary cover (ranked 11) are being considerably underestimated.

A valuable dimension of the study was the ability to look in-depth at the CSO level, at the impact of HIV. Looking in detail at the specific costs of having infected staff we see that interviewees highlighted the impact of:

**Absenteeism – sick leave:** Respondents estimated that they were losing on average 3.2% of their staff time, seven days per person per year, through staff being off sick with HIV/AIDS-related illnesses. Productivity is exacerbated when sick staff report for work, but are unable to function properly: *'some are sleeping at work for the whole day*. The organisational impact of having sick staff was illustrated by one respondent who said: *'Sometimes a programme will come to a standstill because a person holding critical information reports ill for a whole month'*. Frequently staff take a few days off here and there, struggling into work, rather than risk losing their jobs. They would rather hide their sickness until they have no choice and are hospitalised. The extent of staff sickness, the lack of systems and the fear of legal problems, means that many CSOs: *'have not managed sick leave properly. We are not very strict.'*

**Overwork on others:** These absences and vacancies cause overwork for the remaining staff but generally colleagues cover up for each other at no obvious cost to the organisation. The cost, however, is merely transferred to remaining staff in the form of stress. As one respondent noted when a key staff member was recently sick for some time: *'I felt really overworked. I had to compromise on some of my own work priorities as a result.'*

**Productivity, accidents, replication of work:** The impact of having staff with AIDS affected the productivity of one of the CSOs, involved in drilling bore-holes, in an extreme way. When two key staff members were very sick earlier this year, there was *'sub-standard drilling and the contractor was unhappy so work had to be redone. This doubled the programme cost and delayed work.'* It cost the CSO a further \$8000 and may have irredeemably undermined their reputation with the client. Furthermore, the temporary staff who filled in were untrained, and badly damaged essential drilling equipment costing more than \$15,000 in repairs. The agriculture programme of this same CSO has also seen its productivity fall by at least 25% as there is no activity in one of the four impact areas due to long-term staff sickness.

Another CSO highlighted that because of the chief mechanic being off sick, they had to contract out his work to a garage costing them an estimated extra \$7500 this year and delaying work for long periods while the vehicle was out of service. Yet another CSO highlighted that having sick staff was leading to delayed reporting and strained relationships with donors. They commented: *'Having sick staff means the whole vehicle slows down and we are not performing well in some areas. Our reports are 3-4 months late as a result. It is affecting our output and hampers the quality of our work'*.

Clearly some types of staff are more vulnerable to HIV/AIDS than others, especially those whose work involves frequent travel away from home. The CSO with the water programme has lost six staff (out of a full team of 14) in the last three years alone, and two more are currently sick. This was thought to be because the nature of their work means: *'they are away from their spouses for six weeks, have generous allowances of MK 2800 (\$25) per day, see rural area girls... even though they know about HIV'*. This has a multiplied effect on productivity. Amongst the four pilot CSOs each one feared that one of their drivers was sick. This meant that programme staff were sometimes not able to go to the field as a result. Similarly the way the drilling team functions is that if one key staff member is absent, then sometimes none of the others can work.

**Morale:** Having a staff member suffering from AIDS has a very detrimental impact on staff morale. One programme manager related: *'My morale went to zero. When*

*everyone was sick I said "Let's do this. Let's do that" — nothing. I was very low'. Another said: 'I have never seen anything like him. Almost every year I have lost a brother or sister or cousin, but this was something else. No-one could go back and visit him a second time. It affects our emotions. We are demoralised and disoriented'. The declining morale affects motivation — as one person commented: 'It is so sad when you see colleagues dying. You start blaming the organisation'. Having sick colleagues also costs staff time. Respondents related: 'If we see a colleague showing HIV-related symptoms we talk and spend significant amounts of time sitting and discussing'. It is harder to accept when the staff member refuses to accept that they are seriously ill and refuses treatment. One respondent remembered: 'The staff met several times asking — what should we do? The man refuses to go for treatment despite the doctor's report. It touches us deeply.'*

**Medical costs, insurances:** The medical costs of each CSO in the pilot study were also increasing because of HIV/AIDS. Respondents noted: *'A lot more people going for medical treatment from the office than five years ago'. One director admitted 'I fear to quantify the cost. We have just had two people in the hospital for one month each'. This is worse with HIV/AIDS because the spouse and children are also often infected, so the medical costs to the CSO are multiplied. One of the CSOs interviewed had a policy that covered the cost of Anti-Retro Virals (ARVs) for staff and dependants, but found that: 'They have not come forward. They are probably accessing ARVs privately preferring to pay MK 2500 (\$20) monthly themselves than come into the open. We will only see it when they are hospitalised.'*

**Management time:** The actual estimates of management time lost dealing with HIV-related issues were far in excess of the perceived economic cost to the organisation. It is not clear which is more accurate, but respondents noted: *'It does eat my time. I am crying for that time. I have to constantly chase people. I have to do things for them. Should I really be draining my energy on this? I end up chasing and chasing'. Another highlighted that one programme manager 'has been called in the night to take people to hospital many times. He spends a lot of his time visiting, talking, and counselling both in hospital and at home'. Management has to look into the welfare of staff and 'death is no respecter of weekends'. As one respondent said: 'When there is a funeral management has to run up and down. It is an ongoing drain on management time: 'We have to sit as management most of the time to decide on what to do with this issue which cannot best be tackled using the current systems and resources'. In addition, management often has to cover when someone is sick. In two of the organisations, managers had to stand in for drivers who were off sick.*

**Recruitment:** The impact of the cost of having to recruit staff to replace the sick and dead also depended on the level of the post. Many of the deaths experienced by the CSOs so far were at a relatively unskilled level, which meant that it was not difficult or costly to replace. Others, however, noted that there was a very limited skilled resource pool, which meant that losing skilled staff was *'potentially a massive cost. There are no readily available skills for our work. We develop them all ourselves'*.

**Funeral costs:** All the organisations surveyed provided support for the funerals of staff and their dependants. This support covered the costs of coffin, food and transport of the body to the place of burial. The costs of this amounted to between \$400–\$1000 each time according to interviewees. One respondent from an organisation yet to experience a staff death noted: *'If what I see comes to reality, it (our budget) will all be blown. We will have to double our budget for this next year.'*

**Loss of organisational memory:** The extent of the cost due to the loss in organisational memory obviously depends on the level and experience of the person lost to the organisation. So far, many of the deceased staff in the CSOs interviewed were at a junior level and thus had little economic impact. In one CSO, however, *'One programme came to a complete halt due to passing away of the then programme head'*. This programme lost two of its four staff and has since been closed as the donor pulled out. In another organisation the loss of the two experienced staff from the water department (both had worked for 15–16 years) was very costly. As one respondent said: *'They drilled all over Malawi. That part of Balaka, we will need this equipment. It will take this time and cost this amount. That knowledge has now gone'*.

**Training costs:** Similarly the costs of training new staff depended on the level. For unskilled staff it was not a problem, but for skilled staff it proved very costly. Most of the training is done in-house with hidden costs in extra management time to induct, orient and train. As one respondent put it: *'I cost more when I am in the field training people on the job'*. Also the time lag between the post being vacant and filled up to the required standard is significant. In some cases this could take six months.

So far with both the recruitment and training, the CSOs in this pilot had not experienced any direct costs in the last year due to deaths from HIV/AIDS. By hiring less skilled staff, however, some had merely passed on these costs to extra costs from rework and accidents.

**Temp staff costs/Outsourcing/Overtime:** The economic impact of having to hire temporary staff, to pay overtime or even to out-source was not perceived as very significant, as illustrated by the low score above. While some organisations absorbed all these costs internally in overwork on others, in other organisations the actual costs were considerable, costing one CSO an extra \$1700 in over-time and extra allowances. These costs are particularly significant because they are rarely budgeted for. Another organisation had just had to employ a relief driver to cover for the sick one.

**Death cover or benefits/pension:** Death benefits were significant only in one of the CSOs interviewed, costing them approximately \$5000 for up to one year according to the respondents. The other organisations paid for death cover and pension schemes and in some cases life assurance. Death cover amounted to between 2.5%–6% of salary costs of the CSOs interviewed and covered most, if not all, staff. In a context of high HIV/AIDS, CSOs prefer to pay death cover, rather than be liable themselves for paying death benefits.

**Unpaid loans:** The problem of CSOs being left with unpaid staff loans proved unimportant in this study. Since HIV appeared, most CSOs in the survey had changed their systems and now no longer gave staff loans. Where they did exist they were for very small sums of money and were either recouped from death payments or taken as a bad debt.

### 2.3.2 The Impact of Having HIV-Affected Staff

CSOs are also considerably affected by staff having family members infected with HIV. Every respondent in the interviews had their own story to tell. The questions often elicited emotional responses such as: *'I have lost two sisters to AIDS. One was in hospital six times before she died. She left a one-year old child who died one month later (another set of expenses). I educated her 13 year old daughter, but she has taken to sleeping with men for money'*. Table 7 shows how respondents rated the

extent of the organisational cost of having staff who are affected by HIV among their family members.

**Table 7: Analysis of affected staff**

	NGO 1	NGO 2	NGO 3	NGO 4	Average
Absence for funerals	5.75	6.25	5.1	6	<b>5.8</b>
Morale	5	5	3.75	4.5	<b>4.6</b>
Psychological distress — productivity	6	4	3.75	4	<b>4.4</b>
Absence for sick family	4.5	4	2.9	4.25	<b>3.9</b>
Exhaustion from funerals	2.75	4.75	2.5	4	<b>3.5</b>
Management time	4	2.75	3.6	2.6	<b>3.2</b>

Scale of severity ranked 0–10 with 0 being 'Not at all' and 10 being 'Very considerably'.

**Absence for funerals:** On average respondents estimated that 5% of staff time (more than 11 days per person per year) is lost to funerals in Malawi at the moment. Given an average size of CSO of 57 staff in this pilot sample, this corresponds to each CSO losing more than 630 working days each year. This is currently the biggest single cost to an organisation. The findings from the leadership impact questionnaire corroborate this. The average time spent by the 48 respondents amounted to more than 14 days each per year — 6.5% of their time. Culturally in Malawi it is extremely important to attend funerals. Respondents noted that it was very difficult to refuse to go to a funeral: *'According to our culture you cannot abandon sick relative. You just cannot say no.'* As a result as another said: *'It is impossible to deny someone permission to attend a funeral — not just relatives, but friends. You cannot discipline absence if the word funeral is used.'*

In most organisations, time off for funerals, even if limited in the conditions of service, is not strictly enforced. Most local CSOs do not keep a register because they cannot refuse permission. *'People can telephone and say I cannot come in today as I have a funeral and it is not questioned.'* It is largely left up to the individual to decide responsibly which funerals they 'must' attend, but people fear social ostracism from their community if they refuse. There is a now popular saying in Malawi used to justify attendance at funerals, *'Kwanu anthu safu'* — *'Are you saying that people do not die where we come from?'* — meaning that if someone dies one has to attend the funeral.

**Morale:** Staff morale can suffer when a relative is sick. In one of the CSOs: *'A staff member's wife was chronically ill with TB. When he realised it was AIDS, he started drinking heavily and came to the office drunk so often that eventually he was sacked'* (a further cost not calculated by this research). Not surprisingly this affected the office atmosphere. Similarly one Director mentioned how when he said 'no' to staff requests for money advances (as cash flow would not permit): *'This made people upset. There are times I will be looked at as bad because there is so much demand for advances.'*

**Psychological distress — productivity:** Knowing you have sick relatives at home can affect your performance at work. As one respondent described: *'You cannot concentrate. You have to restart the same work over and over again.'* Another mentioned that having his sister sick with HIV-related TB in his house meant that he was preoccupied not only with the *'the fear of losing loved ones, but also the possibility of my children getting infected with TB.'* Another noted that staff: *'are really*

*stressed and stretched. I have staff in here in tears about nursing their sick brother at home. She would come to work and ask me — what do I do? My brother is dying.'*

**Absence for sick family:** Although non-working extended family members look after most sick relatives, at times, if it is a spouse or child that is sick, there is an impact on the organisation. In one case the economic cost was described as 'Quite great. They call people from the field to attend to a sick wife or child. I do not have spare staff. The teams remaining have to cope or activities completely stop'.

**Exhaustion from funerals:** While travelling to and sleeping over at funerals is exhausting, 'particularly for people used to the comforts of a mattress', the economic cost of this to CSOs was not deemed very significant.

**Management time:** Similarly for management time, while there was a cost attached to attending to staff concerns over sick relatives and the constant demand for advances on salaries, it was not perceived as particularly costly to CSOs.

**Cash flow problems:** One CSO interviewed highlighted a new organisational problem from HIV/AIDS, not noted in any literature to date — that of affecting the cash flow. They found that there were so many staff requests for advances for sickness and funerals that: *'management was forced to support these at the expense of programmes'*.

## 2.4 The Personal Impact on Leaders and Gender Dimensions

The Leadership Impact questionnaires filled in by 48 CSO leaders and senior staff revealed further important findings about how leaders and others are affected by HIV/AIDS.

### The Personal Impact on Leaders

- Respondents estimated that they are paying 47% of their disposable income for funerals, family medical bills and support for extra dependants. This obviously puts CSO leaders under considerable personal financial stress.
- Respondents are looking after an average of three extra dependants because of HIV/AIDS.
- Funerals mean more than 15 days off work per year (6.8% of time). This is worse than the figures from the interviews which estimated 11 days off work.
- HIV/AIDS is estimated to take up an average of 6.4% of management time (the organisational interviews averaged 7.5%).

The research highlighted that women are disproportionately affected by having HIV+ relatives, as has been found globally. In Malawian culture it is the female role to care for the sick and attend to the services required during a funeral. Working men are more expected to provide financial support, whereas working women have to give both time and money. The expected absences of women from work may inhibit their performance and, according to respondents, might lead to women missing out on training opportunities and even promotions. The disproportionate impact of HIV/AIDS on women was illustrated by the responses to the Leadership Impact questionnaires:

#### **Gender Dimensions to HIV Impact**

- Female respondents look after 66% more sick relatives than men and pay 100% more in medical costs of sick relatives
- Female respondents have taken on 39% more extra dependants than male respondents and whereas 75% of these females' dependants live with the family only 37% of the males' ones do.
- Female respondents go to slightly more funerals than men, but take 10% less time off work for this.
- Female respondents pay 23% more towards funeral costs than male respondents

### 3. CSO Response to HIV/AIDS in the Workplace

Individual respondents in the research were clearly aware of the costs of HIV/AIDS to their organisation, and yet this individual awareness had not yet translated into a corresponding organisational response. This section outlines the different ways in which CSOs have responded to the crisis, particularly in the area of staff awareness programmes. Overall, however, response has been limited and respondents' perceptions of why this should be are highlighted. In order to move forward, it is essential to know the factors that are holding organisations back and constraining change.

#### 3.1 How Aware Are CSOs of the Direct Costs of HIV?

The interviews revealed that individuals are clearly aware of the costs of HIV/AIDS to their organisations. Consequently some CSOs in the study were budgeting adequately for the medical and insurance costs. Most respondents, however, were under-estimating these costs or failing to take into account unforeseen costs such as accidents, rework and temporary cover. As a result, most organisations are failing to budget sufficiently for the direct costs of HIV/AIDS to their organisations, and consequently, when reporting, hiding these costs in other budget lines. Quite surprisingly, respondents were also able to estimate fairly accurately the percentage loss of output and performance from HIV/AIDS (see Tables 4 and 5).<sup>6</sup>

#### 3.2 Are CSOs Responding Appropriately Yet?

Despite respondents estimating a 20% drag on their performance due to HIV/AIDS, so far the CSOs in the study have reacted in a very limited way. Most are still doing very little to mitigate the impact. Only one out of the four CSOs interviewed had a working HIV/AIDS policy. Two others had drafts that had not been ratified. As one director admitted: *'It is regrettable that we are not doing anything. We cannot cheat ourselves that because we are a faith-based organisation we have no problems in this area'*. Another said the problem was that: *'We take it for granted that people know.'*

The activities that are being undertaken include:

- staff awareness programmes
- critical illness policy development
- cost avoidance responses
- budgeting

**Staff awareness programmes:** Staff awareness training was largely *ad hoc*. Respondents spoke of *'occasional briefings in which the Director says something'*. HIV/AIDS is sometimes brought up in staff meetings. Management staff in many of the organisations informally encourage staff to go for voluntary counselling and testing. In one CSO the more systematic staff awareness programme, which included half-day meetings every two months, halted nine months ago when the focal person left. Without perceived management support this awareness programme has since died away.

<sup>6</sup> Only one CSO's estimate of 9% was significantly under the calculation.

**Critical illness policy development:** Most of the staff awareness that has taken place has been part of an HIV/AIDS policy development process. Two of the organisations had been through fairly comprehensive policy development processes that involved having an external facilitator assisting staff to discuss the issue and come up with an agreed organisational response. Only one of these organisations felt that this policy was now being implemented. Yet even in this CSO, half of the interviewed respondents were not aware of the policy's existence or had not seen it. In the other organisation, the close link with the church had put a number of organisational change processes on hold, including the approval of the HIV/AIDS policy: 'The church has taken almost nine months of looking at the document and as of now it is not yet endorsed. The project has to align the document with the church doctrines thereby prolonging the process.' CSOs were not sure of the costs of developing the policy, though one estimated it had cost \$9000 (2.8% of the staff salary bill) so far in consultants' fees and workshop venues alone — not counting staff time.

In the other two CSOs — interestingly the two most affected by HIV/AIDS — one had not developed a policy at all and the other had merely taken a policy from another organisation, adapted it slightly and submitted it to the board for approval. Without any costings tied to the policy the board refused to ratify it as they were concerned about the increase in budget that implementation would entail. Weak internal governance structures may therefore also be inhibiting CSO response.

**Cost Avoidance Responses:** The only changes that CSOs had made to their systems were 'negative' responses to HIV, such as introducing term-specified contracts and abandoning the system for making loans available to staff. In this way CSOs are shifting the burden of HIV/AIDS away from the organisation and onto individuals. This is a frequent private sector response to avoid the costs of the disease (Bendell 2003).

**Budgeting:** Some of the CSOs were budgeting adequately for some of the direct staff welfare costs of HIV/AIDS, though these were based on precedent, rather than projections of likely rates of infection. Many of the non-welfare costs of HIV/AIDS were being ignored in budgeting. None of the CSOs in the study appeared to have already budgeted for implementing a workplace response to HIV/AIDS though if they did, one Director estimated this might cost an extra \$100 per staff per year (amounting to a further 2.5% increase in the staff salary bill). Another CSO had begun to draft a proposal to the National AIDS Commission for implementation of their HIV/AIDS policy, but the proposal was not accessible, finalised nor costed.

CSOs in the pilot survey had not made much effort to secure specific support for internal HIV/AIDS costs from their donors. Donors were generally perceived to be very resistant to the idea of accepting greater staff costs. They wanted as much of their money (if not all) to be spent on beneficiaries. Donors appeared to respondents as more interested in '*trimming CSO budgets*' than supporting extra HIV-related costs. Consequently CSOs believed that '*everything HIV-related had to be done within the 5–10% administration ceiling*' or by paying for it with their own income earned. These assumptions about donors had not really been tested by CSOs though one mentioned that one of their donors was increasingly interested and likely to respond positively.

### **3.3 Why Is There a Limited Response from CSOs?**

In answer to why there is limited response from CSOs in Malawi, respondents mentioned a number of different factors that are analysed in turn.

#### **3.3.1 Focus on Programmes and Beneficiaries, Not Their Own Organisation**

CSOs are set up to provide services to others and tend to see the problems as being 'out there' in the communities. As one respondent stated: *'We do not realise that HIV will negatively affect us. We think of it in terms of our programmes and beneficiaries — after all, the NGO sector is about service to others.'* This is exacerbated by CSOs who are involved in home-based care (HBC) programmes: *'We see so many deaths in our HBC programme that we externalise the problem.'* This perception of the problem being external and in communities is reinforced by donor-supported training workshops that perceive HIV/AIDS mainstreaming to be directed to programmes, not also the internal organisation. It is also exacerbated by CSO pride: *'We think we are better off than those we are teaching'* — there is still stigma about the problem being close to home.

#### **3.3.2 HIV/AIDS Is Still a Taboo Subject**

To some extent HIV/AIDS is still a taboo subject in Malawi as is the case in most other countries of the world. In Malawi it is not something that is openly discussed, because it either causes people trauma or embarrassment. With faith-based organisations in particular HIV is still thought of as *'resulting from "ungodly" behaviour so we do not want to talk about it.'* HIV is rarely openly discussed in the organisation *'just like in families'*, and people fear *'repercussions and discrimination if my friends know I am HIV+'. I will not get opportunities'*. Once a staff member starts displaying symptoms of HIV/AIDS it becomes even harder to discuss the matter openly in an organisation. Any discussion will be interpreted personally and will become extremely sensitive as highly emotional issues such as sexual behaviour and death necessarily arise.

#### **3.3.3 Clash of Values**

One of the problems of developing workplace policies is that it is a very sensitive and contentious issue raising staff emotions. There appears sometimes a difficult choice to be made between being seen as a 'caring' organisation and surviving financially. One Director related a recent management discussion: *'I said, "We would like to be nice, but we are not a charity. If we close then everyone will suffer". My staff said I was cruel.'*

#### **3.3.4 Some Leaders Are HIV+ Themselves**

All studies of effective HIV response point to the need for it to be strongly supported and even driven by the top leadership. A number of respondents pointed out that in Malawi some CSO leaders' lifestyles (not those in the pilot study) are perceived as *'reckless'* and therefore they believed a good proportion of CSO leaders are likely to be HIV+ themselves. As a result these leaders may not push their organisation to respond to HIV, *'because they fear if they do, they will be exposed themselves'*.

#### **3.3.5 CSOs Had no Real Idea of the Actual Costs of HIV**

Respondents also said that their lack of knowledge of the actual costs of HIV/AIDS had severely inhibited proactive responses. As one respondent lamented: *'We are only now*

*in the draft stages of the policy, but we have suffered for many years. We agree we have suffered but nobody has taken the time to say how much this has affected us. Because no economic value has been attached, it has been neglected.'* Another respondent pointed out that nobody has the time to calculate economic value. People are all too busy with more urgent programmatic work.

### **3.3.6 Lack of Financial Resources**

The lack of financial resources required to respond to HIV/AIDS was frequently mentioned as a major constraint on response. CSOs felt they had extremely limited finances of their own and as mentioned before, their donors are perceived as unwilling to support the internal costs of responding (further driving up overheads). They pointed to *'a donor limit on admin expenses/salaries. They are only interested in activities and numbers of beneficiaries.'* CSOs were not only unaware of the current costs that HIV poses for their organisations, but also what it would cost to respond. As one stated: *'We have a fear of the unknown — if we go this way shall we find the money to cover this? We do not want to promise the moon in developing a policy, which we cannot then deliver'*. Some CSOs think that by developing a policy that specifies upper limits on compassionate or sick leave, this will merely encourage staff to abuse the system.

### **3.3.7 Lack of In-House Competence**

Respondents also cited the lack of competence or confidence in the human resource departments to deal with HIV/AIDS. Two respondents commented to the effect that: *'Our focal person does not have the competence. They fear their lack of knowledge will be exposed'*.

### **3.3.8 Despair and a Sense of Hopelessness**

Finally, CSO response is constrained by a resignation and acceptance of HIV/AIDS. As one person said: *'We take it as a normal part of life. If someone is sick we just say "Ah this is normal "'*.

## 4. Ways Forward

This research revealed that the costs of HIV/AIDS to CSOs in Malawi are considerable, but CSO response to this threat has so far been very limited. This section analyses how these costs are predicted to change in the future — unfortunately they are likely to deteriorate. The section then highlights possible ways forward for CSOs, before identifying resulting policy implications for donors working in contexts of high HIV/AIDS prevalence.

### 4.1 The Future Projections of AIDS in Malawi

The International Labour Office (ILO) estimates that in the next five years a further 536,500 Malawians will die from AIDS-related sicknesses (2004). This is 8.33% of the current estimated working age population. From 2010–2015 there are a further 610700 predicted deaths (9.5% of the current working population). For CSOs in Malawi this means that it is likely that over the next ten years they will lose significantly more staff than they have to date, causing even greater costs than they are currently experiencing. As Table 8 shows, CSOs are under-estimating the projected impact on their organisations, because they are under-estimating the number of staff infected (HIV is non-symptomatic for the first 5–10 years). As one respondent said: *'we have never tried to use statistics to estimate the number of our staff who may be infected'*.

**Table 8: HIV/AIDS projections**

	FBO 1	FBO 2	FBO 3	NGO 1	Average
Number of staff	61	104	37	28	<b>57.5</b>
Interviewee-suspected HIV+ staff	5	1	6	2	<b>3.5</b>
Likely HIV+ (27% average)	16.5	28	10	8	<b>15.5</b>
Likely to develop AIDS each year (15%) <sup>7</sup>	2.5	4	1.5	1	<b>2.3</b>
ILO predicted deaths 2005–2010 (8.3%) <sup>8</sup>	5.1	8.7	3.1	2.3	<b>4.8</b>
ILO annual predicted deaths 2005–2015	<b>1.1</b>	<b>1.9</b>	<b>0.7</b>	<b>0.5</b>	<b>1.0</b>

Should these projections prove accurate, then one staff member from each CSO in this study will die every year from AIDS. More than two staff members in each organisation are likely to become very sick with AIDS every year. Such chronic illness of staff may be more costly to CSOs even than deaths. Hopefully, greater availability of ARVs will mitigate these costs to some extent, though WHO estimates that only 15% of Malawians who need ARVs are currently accessing them (2005). ARVs will not cure the problem, but will only slow down the impact. Given, however, that the ILO figures are based on national statistics, urban-based CSOs may be more affected than even these stark predictions.

<sup>7</sup> 15% is the average percentage of HIV+ people who develop AIDS each year (Holden 2003).

<sup>8</sup> ILO 2004 predicts that Malawi will lose 8.33% of its workforce between 2005 and 2010 from AIDS.

## 4.2 What Should Be Done by CSOs?

Most CSOs saw it as their own responsibility to respond to the threat of HIV/AIDS in their organisation. While outsiders may catalyse and encourage them to respond, ultimately respondents realised that they had to take action themselves if they were to build organisational resilience. There were a number of ways they felt that they should be doing more.

1. **Raising awareness amongst staff** — respondents felt there should be more training events and sensitisation workshops — *'making discussion of HIV a policy'*. They felt there should be deliberate programmes for staff, not just beneficiaries, with management alerting staff to the problem. Some respondents also felt that there should be training for staff in counselling, given the amount of time spent discussing such issues with staff who are looking after relatives or who are sick themselves.
2. **Implement HIV/AIDS policies already developed** — respondents wanted their organisations to be clearer about the benefits and organisational commitment if staff declare their status, and to give stronger assurances about confidentiality. Respondents were unsure about how much they could regulate the behaviour of staff outside of work. While recognising peoples' lives are private, they also recognised the public cost of their private behaviour. After all, the organisation is suffering *'because people are indisciplined outside work'*. There is also a need for CSOs to address uncontrolled time off for funerals, given the extent of the time costs involved. CSOs need to monitor and enforce the compassionate leave days stipulated in the Conditions of Service with extra time being taken out of annual leave, as many international NGOs do.
3. **Undertake long-term human resource response** — one respondent suggested the need to develop such a strategy. Yet if 12.4% of staff and management time is lost to HIV/AIDS, there is a need to increase staffing levels simply to maintain performance. There is clearly also a need to identify the critical posts in the CSOs — such as finance, director, programme manager and ensure that others are able to shadow these positions and take over if necessary. Certainly the research would point to the value of CSOs 'over'-employing drivers, as each organisation was finding its performance constrained by sick drivers.
4. **Cost and budget the HIV response** — Clearly to do these things requires the HIV/AIDS response to be costed and budgeted for. For example, as one respondent noted: *'Men should take their wives to the field, but this would bring extra costs'*. It would also need to be *'sold to our donors that people are also sick in the organisation'*. CSOs therefore need to budget for the extra costs from having HIV infected staff and families, but also for the costs of developing a workplace response and then also for the costs of implementing the workplace response. Implementation costs might include: having money to purchase ARVs should the government supply run out (as often happens); providing nutritional supplements to sick families; the costs of training; the time costs for peer educators and HIV/AIDS focal people; staff welfare costs and being able to hire temporary cover.
5. **Analyse financial costs of HIV/AIDS** — respondents highlighted the importance of making people aware of the economic and social costs. A

number mentioned the potential importance of this research. Once people know the actual costs, *'only then will they say this is worth addressing. Only when NGOs are aware of the cost to performance will they take action.'* After hearing preliminary feedback of these findings one Director said: *'We only take action when it affects our funding. Now I know the costs, I will talk to the departments, explain the effects and tell them that donor funds will go to the more efficient organisations.'*

The implications of rising overhead costs and declining performance are serious. If donor budgets are limited and even declining in some cases, having to spend more on CSO overheads may force donors to prioritise support for fewer partners. In an HIV/AIDS-affected environment there may be a process of 'natural selection' amongst CSOs with the 'survival of the fittest'. The 'fittest' CSOs may well be those who have adapted most readily to their new environment and developed most organisational resilience to HIV/AIDS.

### 4.3 What Should Be Done by Donors?

International NGOs and donors need to rise to the challenge to become more than 'concerned bystanders' (Kerkhoven and Löwik 2004). They need to actively seek to influence the context in which their partners are working. There are a number of potential strategic adjustments they may have to make to remain relevant and effective in an HIV/AIDS context.

1. Donors need to first decide whether or not to continue working in contexts of high HIV/AIDS prevalence. If donors do prioritise working in the poorest countries, these will include many of the countries in sub-Saharan Africa worst hit by HIV/AIDS. They will have to accept that in high HIV/AIDS contexts it will cost more money to achieve less results, if everything else remains equal. Partners will necessarily face higher direct costs (which may appear as overheads) and reduced outputs (due to the loss of staff and management time, morale and so on). Consequently donors have to adjust their plans, targets and budgets accordingly. To accept rising costs and declining performance in an increasingly competitive aid market will be a considerable strategic challenge.
2. To remain effective in a context of high HIV prevalence, donors will need to focus more on CSOs' organisational capacity, rather than simply on CSO programmes. If CSOs do not develop an organisational resilience then they will not meet programme deliveries and targets.
3. Donors will need to have clear and open guidelines for support to partners, including the amounts acceptable for implementing an HIV/AIDS workplace response (extra medical bills, funeral costs, temporary cover, rework...). Donors do have a clear and important role in funding CSO response to the issue. Respondents in the research felt that donors needed to shift their exclusive interest in beneficiaries and *'should help implementing organisations with sorting out their internal HIV/AIDS-related challenges'*. Respondents wanted donors to: *'Listen to us and understand the impact on us. Be ready to support these elements of sickness and funerals in budget lines'*. They should also fund staff awareness programmes and the costs of implementing well-developed HIV/AIDS policies. These extra costs mean more investment, perhaps in fewer

partners, and for longer time periods. Adjusting to working in an HIV-affected context requires donors to *'take a long-term perspective'* to partnerships.

4. Donors have the option of making the development of a budgeted internal response to the threat of HIV/AIDS a conditionality for funding of partners. A number of respondents in the research advocated for their donors to do just this, suggesting that: *'In order to get funding you must show how you are addressing HIV internally.'* After all as another respondent argued, *'they make rights-based approaches a conditionality, why not HIV/AIDS?'* Donors would need to look for clear evidence that a considered workplace response exists in the appraisal stage (looking for it in the budget and the proposed monitoring systems) as well as insisting that information about the ongoing workplace response is part of the regular donor reports.
5. Donors can also stimulate partners to respond by making partners more aware of the organisational costs of HIV/AIDS through dialogue, field visits, and dissemination of information.
6. Donors can directly assist this response by sponsoring projects that seek to enhance understanding around the multiple dimensions of HIV/AIDS through workshops for partners and workplace response consultancies.
7. At a wider level, donors may need to work together to develop the supply and quality of local providers of capacity building services in HIV/AIDS mainstreaming.
8. Donors need to fund research, workshops, publications and dissemination of good practice organisational responses to HIV/AIDS. CSO respondents in Malawi felt that they needed practical case studies of how others have responded and what they are doing. They felt that *'nobody has shared this with us yet'*.

Ultimately, CSO respondents admitted that while donor partners have a role to play, the real responsibility still lies with the organisations themselves. Donors can encourage, cajole, incentivise, threaten, but in the end respondents believe: *'It is our problem. We have to do it ourselves.'*

## 5. Conclusions

The initial findings emerging from the pilot study are tentative, due to the sample size and methodological limitations. But given that these are the best estimates by the best-placed respondents, they cause considerable concern:

- 12.5% average increase in staff costs
- 3.3% increase in overall budget costs
- 12.4% drop in CSO output
- 20% + respondent-estimated drop in impact

HIV/AIDS is clearly having a significant cost for the four CSOs who took part in this pilot study. The extent of the impact needs to be verified by more extensive coverage of CSOs in Malawi (which will occur in the next phase of the research). Although individuals in CSOs were aware of different costs, there was a very limited organisational response, in part at least because CSOs were simply not aware of the aggregated economic cost to the organisation.

The costs that were analysed in this research may even under-estimate the true impact of HIV/AIDS. The direct costs do not even take into account the additional costs of developing and implementing a workplace response (estimated by CARE in South Africa at a further 2% of staff budget [CARE 2006 forthcoming]). The indirect costs of HIV/AIDS, which inhibit CSO performance, were remarkably consistent between the CSOs, averaging 12.4% loss of staff time, but did not even include the costs of declining morale, overwork and stress, loss of organisational memory and relationships.

The limited response of CSOs (and their donors) to date makes the matter even more concerning. To have anything reducing development impact by perhaps more than 20% each year and to do be doing very little about it is a major failure of leadership. To argue that responding to HIV/AIDS is not urgent enough is simply no longer tenable. Waiting until the crisis comes when a valued staff member becomes sick, makes developing an organisational response even more difficult as any organisational policy discussions will be interpreted personally.

The projections for CSOs in Malawi are not good. The ILO estimates that more than 8% of Malawi's workforce will have died from AIDS in the next five years and 18% by 2015. For the size of CSOs in this study this would mean that two staff members will become sick with AIDS every year and one staff member is predicted to die of AIDS every year. The chronic illness of two staff members each year may prove more costly to the CSO than the death of one.

Yet Malawi — with 14.2% national HIV-prevalence — is far from being the worst infected country in the region. Botswana (37.3%), Lesotho (28.9%), Namibia (21.3%) South Africa (21.5%), Swaziland (38.8%), Zambia (16.5%) and Zimbabwe (24.6%) are much harder hit. The organisational impact on CSOs in these countries needs to be analysed urgently in order to catalyse proactive response.

CSOs in sub-Saharan Africa must build organisational resilience if they are to survive the loss of valuable staff, time and money that HIV/AIDS will cause. Leaders must take responsibility for leading their organisations in a very harsh and threatening

environment. Failure to address HIV/AIDS in the workplace is likely to lead to organisational failure in many CSOs. Responding to HIV/AIDS must include, but also go beyond, developing and implementing workplace policies. It will require changing the prevailing culture and ways of working in many CSOs. Being resilient to HIV/AIDS will require CSOs to have open and gender-sensitive decision-making processes, for example.

Donors also cannot remain comfortably on the sidelines as their partners struggle with the disease. Donors must get actively involved in assisting their partners to respond in a strategic and cost-effective way if they are to remain relevant in the region. Working in a context of high HIV/AIDS prevalence will cost partners more money to achieve less output. However unpalatable, this is an essential truth that donors must integrate into their plans and targets. It will require donors to invest, not just in capacity building, but even in simple capacity maintenance. Donors will also have to change their ways of working to move beyond the 'project' mentality to take the responsibilities that come with 'partnership' much more seriously.

This is the opportunity that HIV/AIDS presents. HIV/AIDS causes such organisational costs that the only way to build resilience is by implementing the good management practices and good donor practices we have voiced so easily in the past. For many CSOs, survival requires that development rhetoric finally becomes a reality.

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## Appendix 1: The Methodology Used

1. Research planning and design. We decided to use a semi-structured questionnaire to interview four members of staff from each organisation in order to get different perceptions of the organisational costs and verify and moderate findings. INTRAC's knowledge of the different organisational impacts of HIV/AIDS enabled us to isolate 13 potential costs of having HIV-infected staff and six potential costs of having staff affected by HIV in their families and communities.

Organisational Costs of HIV-Infected Staff	Organisational Costs of HIV-Affected Staff
Absenteeism — sick	Absence for funerals
Overwork on others	Morale
Productivity, accidents, rework	Psychological distress — productivity
Morale	Absence for sick family
Medical costs, insurances	Exhaustion from funerals
Management time	Management time
Recruitment	
Funeral costs	
Loss of organisational memory	
Training costs	
Temps / Outsourcing/ Overtime	
Death benefits/ Pension	
Unpaid loans	

The CSOs selected were all from Blantyre, the largest city in Malawi, to enable comparison based on the same location and HIV-prevalence. In Malawi, with a generalised HIV epidemic, it is not possible to have a control group of unaffected CSOs as even the least infected rural areas have almost 10% rates of infection. Furthermore, CSOs in these areas are highly informal with no paid staff, which would make comparison unfeasible.

2. Semi-structured interviews gathered the experiences and perceptions of four staff members (including the director/HR/finance/programme staff person) of four CSOs to find out the extent of the organisational impact and the nature of their response. Questions such as C4. below were asked.

**C.4 In the last 12 months, how significant has been the economic impact on your whole organisation of the following?:**

C.4.1 **Staff absence or sick leave** (whether agreed or not)

0	1	2	3	4	5	6	7	8	9	10
None		A little		Moderate amount			Quite a bit		Very severe	

C.4.1.1 Approximately how much time has been lost in the last year?

A scoring system was used so respondents could rank the different economic costs to their CSO. This was done on a scale of 0–10. Where possible and appropriate, follow-up questions were asked in order to quantify the financial or time costs. In this pilot research no economic value was ascribed to non-quantifiable costs such as increased stress and overwork, declining morale, worry and distraction at work, loss of organisational memory and the relationship with beneficiaries, donors, clients being undermined. These interviews were complemented by monthly forms to track absenteeism and leadership impact monitoring forms providing data that triangulated the interview responses.

3. Secondary data (such as HIV policies, terms and conditions of service) was reviewed where appropriate, to see how CSOs are responding to HIV/AIDS in the organisation.
4. An 'Absence Monitoring System' was set up to track the ongoing costs of HIV/AIDS. Key individuals in the administration of the same CSOs will monitor absenteeism for sickness and funerals on a daily basis for two months.
5. The personal cost of HIV on CSO leaders was examined through Leadership Impact questionnaires being filled in by 48 participants at CONGOMA Capacity Building seminars in Lilongwe and Mzuzu. This was more successful than attempts to get e-mail responses from Blantyre participants — only 2 out of 50 replied.
6. The interview data was analysed and written up in this document. A draft of this report was shared with HIV specialists for comment and suggestions.
7. The findings of the pilot have been disseminated:
  - a. Confidentially to each individual respondent CSOs (October 2005)
  - b. To Oxfam partners (October 2005)
  - c. To 150 Malawian CSOs through regional CONGOMA meetings (September and October 2005)
  - d. To the Blantyre Capacity Building Providers network (October 2005)
  - e. Regional meeting with CABUNGO, CDRN, TRACE to plan regional research (November 2005)

# Counting the Organisational Cost of HIV/AIDS to Civil Society Organisations

## *Pilot Research Study, Malawi*

By Rick James with Brenda Katundu

HIV/AIDS mainstreaming has traditionally been equated with adjusting programmes to be more relevant to beneficiaries affected by HIV/AIDS. Bitter experience is demonstrating, however, that civil society organisations (CSOs) are not immune to the impacts of AIDS within their own organisations. CSOs in sub-Saharan Africa are adversely affected by rising absenteeism and increased medical and staff welfare costs. Few local CSOs are responding adequately to this threat, partly because they simply do not know the extent of these costs.

This paper presents the tentative findings from pilot research carried out with four CSOs in Malawi. Initial estimates from respondents are that HIV/AIDS is causing:

- 12.5% average increase in staff costs
- 3.3% increase in overall budget costs
- 12.4% drop in CSO output

Despite this apparent *individual awareness* of the costs of HIV/AIDS to the organisation, this has not yet translated into a corresponding *organisational response*.

This paper suggests how CSOs in sub-Saharan Africa can build organisational resilience in order to survive the loss of valuable staff, time and money that HIV/AIDS will cause. It also concludes with practical recommendations for their donors in how they can move beyond being 'concerned bystanders'.

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# INTRAC

Postal address: PO Box 563, Oxford, OX2 6RZ

Registered and visiting address: Oxbridge Court, Old Fruiterers Yard, Osney Mead, Oxford OX2 0ES

Tel: +44 (0)1865 201851 Fax: +44 (0)1865 201852

Email: [info@intrac.org](mailto:info@intrac.org) Website: <http://www.intrac.org>

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