

Treatment Action Campaign (TAC) Evaluation

29 June 2005



“Our lives matter, the 5 million people in South Africa with HIV matter and the millions of people throughout the world already infected with HIV, their lives matter.”

Zackie Achmat, TAC chairperson, in a speech to the 14th International AIDS Conference, Barcelona 2002

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Executive Summary

The Treatment Action Campaign was established on Human Rights Day in 1998 as a response to the increasing numbers of South Africans who were dying of AIDS because they were not able to afford life-saving medication. The primary purpose of the organisation was, and has remained, to lobby for and facilitate access to affordable treatment for people living with HIV/AIDS in South Africa. This is achieved through the following means:

- a) advocacy and lobbying government and other institutions to accelerate a rollout of treatment
- b) raising awareness around treatment issues
- c) placing a limited number of AIDS patients directly on treatment
- d) playing an important role in the global lobby to accelerate treatment to people living with HIV/AIDS.

TAC has provincial and district offices in six of South Africa's nine provinces, with plans to expand to the three remaining provinces in the next few years. TAC also has a very large grassroots membership base of some 10 181 registered members, although significantly more than this number attend TAC marches and demonstrations.

TAC is regarded by many as a shining example of an organisation upholding the socio-economic rights of South Africans, and also as the most effective AIDS service organisation in the country. It has been widely praised for its excellent strategic skills, unique advocacy strategy and its creative use of litigation. Some of the direct achievements include: TAC's role in the South African government's decision to roll out antiretroviral therapy through the public health care system, compelling government to provide treatment to HIV-positive women during childbirth to decrease the transmission of HIV from mother to child, and increasing the levels of public literacy around the complexities of treatment. Some of the indirect achievements include the destigmatisation of HIV through the examples of positive living of many of its members, the building of the knowledge base of its members and the empowerment of members. Critics noted the need for focus and an over-reliance on litigation as the core strategic weaknesses.

Programmatically TAC's work is responsive to the needs of its members. Treatment Literacy is hailed as a well run, timely programme aimed at creating the enabling environment for the rollout of an ARV programme in South Africa. Its key challenge is how to balance the need to compensate members for their work and at the same time retain the spirit of volunteerism. The Treatment Project provided a life-line to members in need of treatment. With the rollout of the government's ARV programme there is a need for the Treatment Project to review its strategy and to exit members onto state programmes wherever possible. The organising department has been at the fore-front of the mass mobilisation. The work needs to become more systematic with a greater emphasis on decentralisation and empowerment of members. The research and communication programme has played a key role profiling TAC nationally and internationally. Internal materials while excellent in content are poor in terms of design and popular appeal. Finally the international department has correctly focused on Africa. This programme needs to be better integrated with the rest of the programmes.

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TAC has secured a diversified funding base. It has good relationships with its core funders, especially at the leadership level but needs to improve communication and participation in funders' events.

TAC has formed vital and strategic partnerships locally with important organisations such as COSATU. Internationally, TAC plays an important role in a looser network of partner organisations all aimed at increasing access to affordable treatment. There is however room to improve partnerships with health professionals and to involve other partners in a more systematic fashion in TAC strategy and review processes. TAC's relationship with the national Department of Health, while initially co-operative, has become more acrimonious over time, largely due to a worsening relationship with the Minister. This being said, there are several fruitful and beneficial relationships with other government structures, in some cases at a provincial level and frequently at a local level. It is important that TAC continues to work towards strengthening these constructive partnerships where they exist, while maintaining its lobbying role.

Another important achievement of TAC has been its ability to adapt to the changing public health landscape. This has meant that the organisation has grown as a response to the public health crisis. Decision-making has always been democratic and inclusive. In this stage of reflection, TAC may want to rethink the structure of its executive, some of its offices.

As with any pioneering organisation in the process of formalising itself, the systems in the organisation leave room for some improvement. While the financial system is effective and relationships with donors are generally good, there are a number of areas in which communication could be improved. Internal communication remains a challenge, as do more systematic feedback to donors, and monitoring and evaluation of performance and administration. The planning of events and activities also needs to become more systematic and less ad hoc.

TAC has, in general, a highly motivated and extremely energetic staff complement with an impressive work ethic. There appears, though, to be a large disparity in the workloads of various staff members, with some being underutilised, while others are overworked and prone to fatigue and burnout. Recruitment is not always systematic, and this has resulted in some inappropriate appointments.

The relationship between staff and volunteers is also one that needs to be carefully managed. Volunteers form the backbone of the organisation and perform several important functions. As a result, tensions sometimes occur between staff members, paid volunteers and unpaid volunteers. The payment of volunteers for work done is a highly sensitive issue which needs to be carefully managed by the organisation. There is also a cadre of highly motivated and skilled foreign volunteers who work for TAC on specific projects. These volunteers are a valuable source of labour and are not being utilised to their full potential at present.

While gender sensitivity is improving and a cadre of female leaders is emerging, significant challenges remain, both at the managerial and grassroots levels. At present, the organisation has no comprehensive gender programme in place, aimed at tackling some of the existing imbalances. While programmes exist around the role of Youth and People with AIDS (PWAs) both need to be strengthened.

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In conclusion, TAC is an extremely relevant and effective organisation, operating at moderate efficiency with some room for improvement. TAC's programmes have excellent sustainability and has been effective in its capacity building initiatives but has some unsustainable human resource practices and weak financial sustainability outside of its current donor strategy.

Recommendations

Short term

Strategy

- Slow down the pace of growth of the organisation.
- Deprioritise the national focus, allow for local and provincially based campaigns and cultivate a working relationship with provincial, district and local government.

Programmes

General

- Decentralise the management of all national programmes to existing provincial structures.

Treatment Project

- Formulate clear exit strategies, e.g. an exit strategy for TP recipients to local ARV sites where they exist.
- Reorganise donor administration of TP. The current reorganisation to provide for direct mails to donors needs to be implemented as soon as possible, providing systematic reports and periodic communication with donors on the progress of the TP.

Treatment Literacy Project

- Enhance networks with other organisations producing treatment-related materials, e.g. Soul City.
- Develop a clear framework for payment of bursaries linked to an exit strategy, along the lines of the EPWP.

Organising

- Shift from the current ad hoc campaign-driven approach to a programmatic approach which includes clear targeted outputs, skills to be developed and interventions to achieve these.

Policy, research and communication

- Redesign the website and all media outputs to make them more attractive, user-friendly and accessible.

Funding

- Ensure that management prioritises donor relations and improves donor communication.

Relationships

- Reprioritise partnerships and engage and consult partners around both the TAC and partners' own strategies and programmes to facilitate collaboration and co-operation.

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Structure

- Restructure the NEC, allowing it to provide the requisite oversight. This requires changing all organisational representatives to mandated appointments and barring staff from holding positions on NEC other than the general secretary post.
- Restructure the Secretariat to comprise the NEC management team, namely the chair, deputy chair and treasurer and the employed management of the organisation.

Systems

General

- Set aside the time required to develop robust systems, for example, databases of media contacts, members database, lists of suppliers, procurement guidelines, travel regulations, recommended rates for various budget items, etc. This is something that professional volunteers could be assigned to develop. However, work done will need regular management input if it is to contribute to robust and useful systems.

Administration

- TAC needs to take the time to develop appropriate systems, train staff in the systems and manage the ongoing use of the systems introduced.
- Urgently recruit an experienced administrative manager and give this person management authority to train and manage the existing core of administrative staff.
- Send materials directly to districts and ensure that each district develops a distribution policy that covers every branch in its area.

Human resource systems

- Fast-track the development of a comprehensive performance management system, including the training of managers in the implementation of the system.
- Develop a staff induction programme and the national implementation of the new system around exit interviews for staff departing.
- Advertise all posts, develop a competency framework for interviewing new staff and introduce performance-based contracts.

Policy, research and communication

- Provide at least two days' notice for any meeting, preferably more, along with details on what the meeting is about and why members are required to attend. In addition, develop a system of communication trees for volunteer communication.
- Prioritise the regular management meetings of staff already initiated by the new national manager, as well as a collective calendar/ diary for each office.

Staffing

- Define the role of both staff and volunteers, including the inter-relationship between the two, to address the current tensions and the "staff creep" into areas traditionally serviced by volunteers. Train all staff in volunteer management.
- Reassess the volumes of work and levels of responsibility assigned to each staff member and ensure a more equitable distribution of both. This requires developing a culture of trust and delegation.

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- Avoid hasty recruitment decisions and, where no suitable candidate applies for a post, re-advertise and put in place an interim solution, even if this involves the cost of employing short-term skilled consultants to plug the holes.
- Precede every permanent appointment by a probation period and performance appraisal. Any concerns that arise in this period need to be confronted head-on to avoid longer term problems and costly terminations.
- Prioritise staff development, given the predominance of staff with relatively low levels of formal training and experience, both in the budget and in staff management.
- Develop a more professional demeanour and attitude amongst staff.

Volunteers

- Assign the responsibility of managing volunteers to specified staff, especially the pool of international and professional volunteers.
- Review the system of stipends, bursaries and payment of volunteers and ensure that it is based on transparent and consistent criteria and is neither exclusive nor static.

Culture

- Take explicit steps to transform the current culture, including providing trauma counselling where needed, enforcing the "time in lieu of overtime" policy and the introduction of sabbaticals. The current work ethic demands 110% of staff. This is not sustainable and has resulted in burnout of core members and volunteers within the team.

Medium term

Strategy

- Develop a partnership with a public health organisation or recruit medical and other public health expertise into the organisation's own ranks.

Programmes

Treatment Project

- Reconstitute the TP as a component of a broader advocacy programme through developing the required experience and systems in partnership with public sector doctors committed to getting a site registered. Targets should be linked to the number of sites the organisations would like to see created, rather than the number of people on treatment.

Treatment Literacy Project

- Mainstream the TLP in the organisation.
- Get training accredited.

Organising department

- Develop a clear induction programme and an ongoing structured leadership school programme that taps the best skills and expertise in the organisation and aims to build real capacity around a set of identified competencies.

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International

- Redefine the strategy of the programme in a way that harnesses partners' capacity and links to other programmes in TAC. Communicate this to partners and potential partners.

Funding

- Provide opportunities for programme exposure to donors (and media). For example, invite donors to attend a treatment literacy training session.

Relationships

- Actively engage social actors such as teachers and workers, beyond partnerships with the leadership in these organisations. This could include focused campaigns, treatment literacy and partnership programmes.
- Expand the network amongst health professionals.

Structure

- Develop structural models that facilitate ongoing learning and mentoring of staff, as most staff are inexperienced. The current system of mentoring has been well received but is ad hoc and limited. Ongoing regular mentoring needs to be sourced either through the relocation of senior staff to offices or through the recruitment or contracting of mentors.

Systems

Human resource systems

- Develop an internal system of peer learning linked to new staff shadowing experienced staff, or exchange visits where staff are exposed to different situations that could facilitate their learning (both inside the organisation and in partner organisations).

Planning, monitoring and evaluation

- Improve planning systems to provide for advance planning, review of outputs agreed during planning and future planning based on the lessons of prior experience. We recommend that the organisation anticipates that an agreed percentage of its time will be caught up with reactive campaigns that emerge after planning meetings have taken place, for example, the Rath saga, and that management monitors these interruptions to ensure they do not derail the rest of the work.
- Give the same attention to reflecting on the internal functioning and infrastructural needs of the organisation as the organisation currently gives to political reflection.
- Develop a culture of feedback where management is open to input from staff, volunteers and external stakeholders, and appropriate mechanisms to facilitate the feedback, for example, annual partner reflection and planning sessions, a column in the newsletter and regular management meetings with staff.

Volunteers

- Induct every volunteer wanting to play a role in the office or providing a special service into the organisation and require them to complete a reasonable training period before being deployed.
- Develop volunteer career paths with real options for sustainable learning or employment.

Culture

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- Educate staff and volunteers around gender, and mainstream gender into every programme within the organisation. This should include partnerships with other organisations tackling the issue.
- Place increased emphasis on the leadership role of PWA volunteers.
- Develop a culture of open debate on diverse political perspectives and approaches to issues.

Long term

Programmes

Organising

- Develop a clear strategy around prevention, and prioritise the focus on youth.

Policy, research and communication

- Develop marketing materials targeting professionals and middle class volunteers.

Funding

- Shift the financial base to bring in more corporate and local donations.

Structure

- Reconceptualise the role and location of district offices. Districts are the face of implementation and require highly skilled staff, able to work without supervision. Current office arrangements do not use resources optimally and options such as sharing office space with a partner organisation should be explored.
- Employ a bottom-up approach starting at branch level with increased decentralisation of staff, leaders and budgets. Consciously redeploy people back to branches.
- Explore a geographic national management structure, as opposed to a programmatic approach, to facilitate integration between the programmes.

Volunteers

- Develop opportunities for middle-class working members, such as a “buddy” system for people on ART, or a roster for giving talks at Rotary, churches, etc.

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Glossary

AIDS	Acquired Immune Deficiency Syndrome
ALP	AIDS Law Project
ART	Antiretroviral therapy
ARV	Antiretroviral
CSO	Civil society organisation
DO	District Organiser
DoH	Department of Health
EPWP	Expanded Public Works Programme
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immune-deficiency Virus
KZN	KwaZulu–Natal
MSF	Médecins Sans Frontières
MTCT	Mother to Child Transmission
NEC	National Executive Committee
NGO	Non-governmental organisation
OI	Opportunistic Infections
PEC	Provincial Executive Committee
PMTCT	Prevention of Mother to Child Transmission
PWA	People with AIDS
SETA	Sector Education and Training Authority
TAC	Treatment Action Campaign
THO	Traditional Healers' Organisation
TL	Treatment Literacy
TLP	Treatment Literacy Practitioner
TLT	Treatment Literacy Trainer
TP	Treatment Project
VCT	Voluntary Counselling and Testing
ZCC	Zion Christian Church

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1 Introduction

In general, people interviewed for this evaluation were very positive about the Treatment Action Campaign (TAC) and its work. When asked to give TAC a score out of ten, most participants scored TAC's strategic skills, impact and work at eight or above, with an average score of eight. This reflects the positive assessment of TAC's strategies and campaigns. Scores for the internal operations were less favourable, at an average of five. This is not atypical of a civil society organisation (CSO) that has grown and is in the process of changing from a pioneering organisation to a more mature organisation, as detailed later in the report. It does, however, reflect a need to review the internal functioning of the organisation. The evaluation report is therefore focused to a significant extent on internal issues. However, the structure of the organisation and its systems are interlinked with the organisation's strategy and direction, and these issues cannot be separated from the key strategic choices facing the organisation.

1.1 Scope of the evaluation

In the original Terms of Reference (see Annexure 1 for the full terms of reference) two key components to the evaluation were outlined, namely that it should:

- assess TAC impact, focused on what the organisation has and has not achieved, its political impact, its current status in South African civil society, its potential and the opportunities for replication of aspects of TAC's strategy both in and outside South Africa (40% of effort).
- assess TAC internal effectiveness, focused on successes and failures – a review of TAC's operational systems including its structure, financial systems, fundraising mechanisms, communications, research, human resources, projects, information technology infrastructure, and functioning of national provincial and district offices (60% of effort).

Report contents

- Introduction
- Context
- Project profile
- Evaluation findings
 - Achievements and challenges
 - Organisational strategy
 - Programmes
 - Funding
 - Relationships
 - Structure
 - Systems
 - Human capital
 - Organisational culture
- Conclusions
- Recommendations
- Annexures

The evaluators structured the report based on the above guidelines.

1.2 Methodology and evaluation profile

The objective of the evaluation – both reflective and forward-looking – determined the methodology. This can be characterised by two key approaches – participatory reflection and learning. The evaluation team took as its starting

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point the evaluative work undertaken by TAC itself, as reflected in various papers and National Executive Committee (NEC) minutes. This was further unpacked over a period of three months during which the evaluation team:

- Met with TAC members to discuss different experiences and perceptions (at least 119 TAC members from six provinces were interviewed)
- Met with TAC staff to discuss their reflections on the organisation (approximately 85% of all TAC staff members were interviewed)
- Held discussions with the Secretariat and management to discuss the interim reflections and findings and further develop these
- Met with and conducted telephonic and electronic interviews with local and international partners to explore the impact of TAC, its approach to partnerships and the lessons from other situations
- Interviewed external stakeholders from national, provincial and local government, other non-governmental organisations (NGOs), and actors and experts in the HIV/AIDS field
- Interviewed donors
- Reviewed general information about the organisation, project documentation and previous evaluations of the organisation.

In addition to the interviews conducted (a full list of which is attached as Annexure 2), requests for interviews were made to the Minister of Health and district offices of the Department of Health in the Eastern Cape. Unfortunately, despite a number of follow-ups, these meetings were never secured.

Discussions were carried out through an open and learning-oriented dialogue which focused on unpacking TAC members' own reflections as a basis for a joint exploration of the challenges, lessons and way forward. Consequently the evaluation is not an end in itself, but rather a step in the ongoing restructuring and reflection process. It is a key input on the future direction of TAC and the process of continuous change and improvement.

2 Context

Overview of HIV/AIDS in South Africa

Sub-Saharan Africa is home to a total of less than 10% of the global population of more than six billion people. Yet this relatively sparsely populated portion of the globe is home to more than 70% of all cases of HIV/AIDS. According to the national HIV and syphilis sero-prevalence survey of 2003, it was estimated by the National Department of Health that there were approximately 5.3 million South Africans living with HIV/AIDS. This figure equates to more people living with HIV/AIDS than can be found in North and Latin America, the Caribbean, Western and Central Europe, as well as Oceania, combined.

As far back as 2001, a report released by the Medical Research Council of South Africa (MRC) indicated that AIDS was the leading cause of mortality in South

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Africa, with approximately 200 000 people having died of AIDS in 2001 alone. The MRC has also forecasted that the number of AIDS-related deaths can be expected to grow within the next 10 years to more than double the number of deaths due to all other causes, resulting in 5-7 million cumulative AIDS deaths in South Africa. Figure 1, which is a graph illustrating the sharp rise of HIV prevalence rates of pregnant women over the past 13 years, is unsettling because it shows where the virus is hardest hitting: among the young and economically active members of society. According to the report, AIDS accounted for 30% of all deaths during that period nationwide.

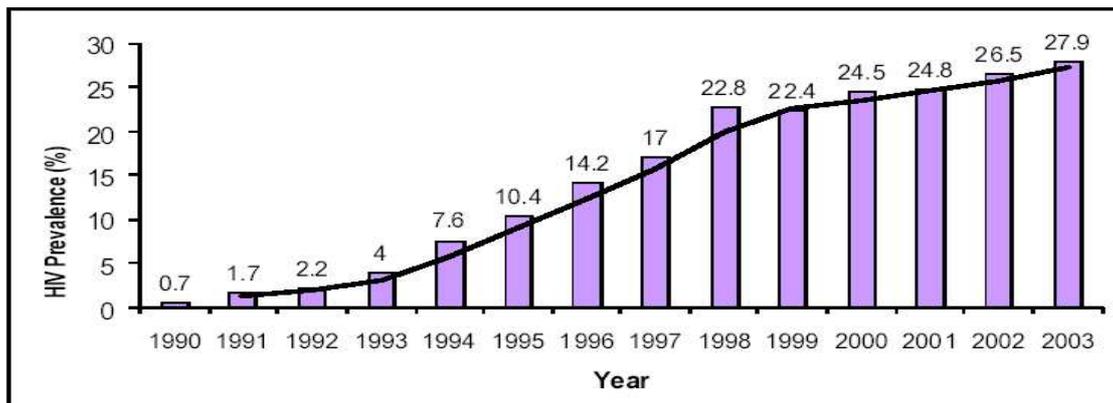


Figure 1: Prevalence of HIV among antenatal care attendees in South Africa. 1990- 2003

HIV/AIDS and poverty

The poor are hardest hit by HIV/AIDS. HIV/AIDS leads to a loss of household income due to illness, death of a household member and time spent on caring. In situations of minimal income these additional costs cannot be carried, resulting in increasing poverty and deteriorating food security. Often it is women who bear the primary brunt of the increased responsibilities. They are the ones expected to care for ill household members and for orphaned children, in addition to other domestic and economic responsibilities (SIDA, 2001).

Community responses

Problems are further exacerbated by stigmatisation, fear of violence and other social realities such as exclusion. The tragic case of Gugu Dlamini, an HIV-positive (HIV+) activist in South Africa who was stoned to death for publicly acknowledging her status, demonstrated the validity of these fears.

Government response

The South African government's response to the HIV/AIDS pandemic has been the subject of animated debate between those who believe the response has been the best possible under the circumstances and those who believe that it has been completely inadequate, given the extent of the crisis in South Africa. What is clear, though, is that not enough was done in the early 1990s, as the country stood on the abyss of an exploding HIV epidemic.

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While other countries such as Brazil began offering large scale public health treatment programmes in the late 1990s, the South African Cabinet only announced a national treatment plan in 2003, after years of advocacy by TAC and its partners, litigation and an ever-increasing mortality rate. The delay in rolling out treatment through the public health care system happened despite the government's success in staving off a legal challenge by the Pharmaceutical Manufacturers' Association. The legal action was brought against the passing of the Medicines Act, which contains a provision allowing for compulsory licensing, an important tool for decreasing the price of essential medicines.

3 Project profile

On 10 December 1998, a new chapter in AIDS politics in South Africa was opened. A group of about 15 people protested on the steps of St George's Cathedral in Cape Town to demand medical treatment for people living with HIV/AIDS. By the end of the day, over 1 000 people had signed up and the Treatment Action Campaign, or TAC as it is better known, was born. The organisation is registered as a Section 21 Company (or not for profit organisation) in terms of South African company law.

Through mobilisation, legal action, extraordinary personal sacrifices and visionary leadership, TAC has helped to galvanise a global movement to provide hope and gain access to treatment for those with HIV/AIDS.

These efforts have led to a number of major achievements: dramatic reductions in the price of antiretroviral (ARV) and other essential drugs; a contribution to the overhaul of global trading rules to give precedence to the protection of public health; a mother-to-child plan and a treatment plan in South Africa; and the public profiling of HIV/AIDS. TAC's efforts have also brought a unique ethos of activism and confidence to the international community.

The many awards and accolades given to TAC and its chair, Zackie Achmat, bear testimony to the organisation's national and international recognition and the efficacy of its work. These include a nomination for the Nobel Peace Prize (2004), the Silver Rose Award for Social Justice (2003), the Nelson Mandela Health and Human Rights Award (2003), the Jonathan Mann Award for Global Health and Human Rights (2003), the Desmond Tutu Leadership Award (2002), the Katlego Award for Excellence in Advocacy (third place) (1999). In addition, the support of high profile leaders like former President Nelson Mandela has been used effectively by TAC for advocacy purposes.

Objectives

In its constitution, the objectives of the organisation are described as follows:

- Campaign for equitable access to affordable treatment for all people with HIV/AIDS

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- Campaign for and support the prevention and elimination of all new HIV infections
- Promote and sponsor legislation to ensure equal access to social services for and equal treatment of all people with HIV/AIDS
- Challenge by means of litigation, lobbying, advocacy and all forms of legitimate social mobilisation, any barrier or obstacle, including unfair discrimination, that limits access to treatment for HIV/AIDS in the private and public sectors
- Educate, promote and develop an understanding and commitment within all communities of developments in HIV/AIDS treatment
- Campaign for access to affordable and quality health care for all people in South Africa
- Train and develop a representative and effective leadership of people living with HIV/AIDS on the basis of equality and non-discrimination irrespective of race, gender, sexual orientation, disability, religion, sex, socio-economic status, nationality, marital status or any other grounds
- Campaign for an effective regional and global network comprised of organisations with similar aims and objectives.

TAC demographics

TAC has thousands of volunteers, many of whom are living with HIV/AIDS. It is co-ordinated by a national office, has six provincial offices and six district offices by the end of May 2005. The bulk of TAC resources are concentrated in the largest urban centres, namely, Cape Town, Johannesburg and Durban, with the largest rural programme situated in the Eastern Cape.

The organisation has grown very rapidly. In its first two years of operation, 1999 and 2000, TAC developed its profile. The first campaign – mother-to-child transmission prevention – mobilised around 1 000 members by the end of 2001. 2002 and 2003 saw several more campaigns, the expansion of the membership to around 7 000 and the opening of 4 provincial offices, leading up to the announcement in August 2003 by the South African government of its intention to roll out ARVs. TAC continued to focus on its advocacy campaigns in 2004, with a parallel focus on the expansion of its service delivery, in particular its treatment literacy programme. The organisation has continued to expand, with three of the district offices established during the three month period of this evaluation in early 2005.

TAC resources

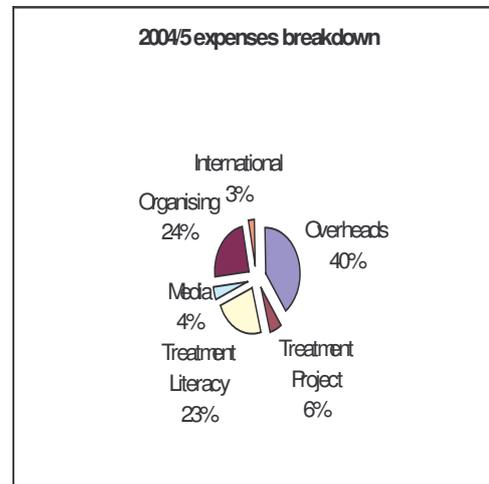
TAC has been successful at raising funds to pay for the work. In its six and a half years of operation, the budget has increased to a staggering R38 million for the coming year.

On average, TAC's budget has doubled annually since its inception. TAC's 2004/5 annual budget was R18.7 million. The budget is not a completely accurate reflection of the resources, as it does not include the costs of litigation funded through AIDS Law Project (ALP) and the Legal Resources Centre.

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Outside core operating costs, the treatment literacy and organising programmes are the largest programmes, as reflected in the pie chart below.

Income/ Expenditure
1999/00: R202,719/ R215,981
2000/01: R1,844,302/ R1,351,434
2001/02: R6,427,763/ R3,734,709
2002/03: R9,397,846/ R10,814,913
2003/04: R14,429,363/ R13,567,776



At the end of April 2005, TAC employed 56 full time staff, 16 in the national office and 40 distributed between the six provincial offices. Of these, 87.5% are African, 43% are male and 57% female, with 23% of all staff members living openly with HIV. Most staff members are young, with an average age of 28, and relatively inexperienced.

Treatment Literacy Programme

Building on the lessons learnt from a small scale pilot project it started together with MSF in Khayelitsha called Project Ulwazi, TAC began expanding aspects of this work, with emphasis on building the knowledge base of HIV positive advocates and their communities. So began the focus on treatment literacy. In 2002, TAC formalized its treatment literacy programme and employed a coordinator. The work is based on an understanding that awareness, human resources and systems need to be built at community level to create a demand for treatment, to avoid a lack of take-up once sites are established, and to limit adherence problems. This is achieved through providing education to people living with HIV/AIDS, healthcare workers and the broader community on HIV/AIDS treatment. When Cabinet announced the National HIV/AIDS Comprehensive Plan for HIV/AIDS management, care and treatment, TAC decided to expand its treatment literacy work and in 2004 a structured programme to train cadres as Treatment Literacy Practitioners and Treatment Literacy Trainers was rolled out. The training is provided by TL Practitioners (TLPs) who receive a foundational course and continual refresher and upgrading courses. TLPs are supported by TL Trainers (TLTs) who take the programme beyond TAC to partner organisations and provide supervision to TLPs. Topics covered in the training include, but are not limited to, prevention of HIV, general health and HIV, epidemiology of HIV, the science of HIV and treatment, opportunistic infections, mother-to-child transmission (MTCT) and its prevention, antiretroviral therapy, post-exposure prophylaxis, safer sex, nutrition, social and

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other impacts of HIV and health promotion in communities. (TAC annual report, 2004) The programme is operational in all 6 provinces. To date, 28 TLTs and 120 TLPs have been trained. Of these, 105 receive bursaries of R1 100 (TLP) and all 28 receive bursaries of R1 400 (TLT). Recipients of bursaries are expected to organise learning at an allocated site, run courses, and support their branches.

Part of the work of the Treatment Literacy programme has been the development of popular education and training materials. The programme has worked with Community Health Media Trust (CHMT) to produce the well known series is called *Beat-it*. To date, the programme has developed a series of 7 posters on Opportunistic Infections, a poster on ARVs, a new series of 8 posters on ARVs is being printed and an activist handbook called ARVs in our lives is in the final stages of completion.

The programme works with international partners such as I-base, Gay Men's Health Crisis and organizations in the Pan African Treatment Access Movement (PATAM) to strengthen Treatment Literacy. A Regional Treatment Literacy Training co-ordinator has been employed to support TL in the SADC region and beyond.

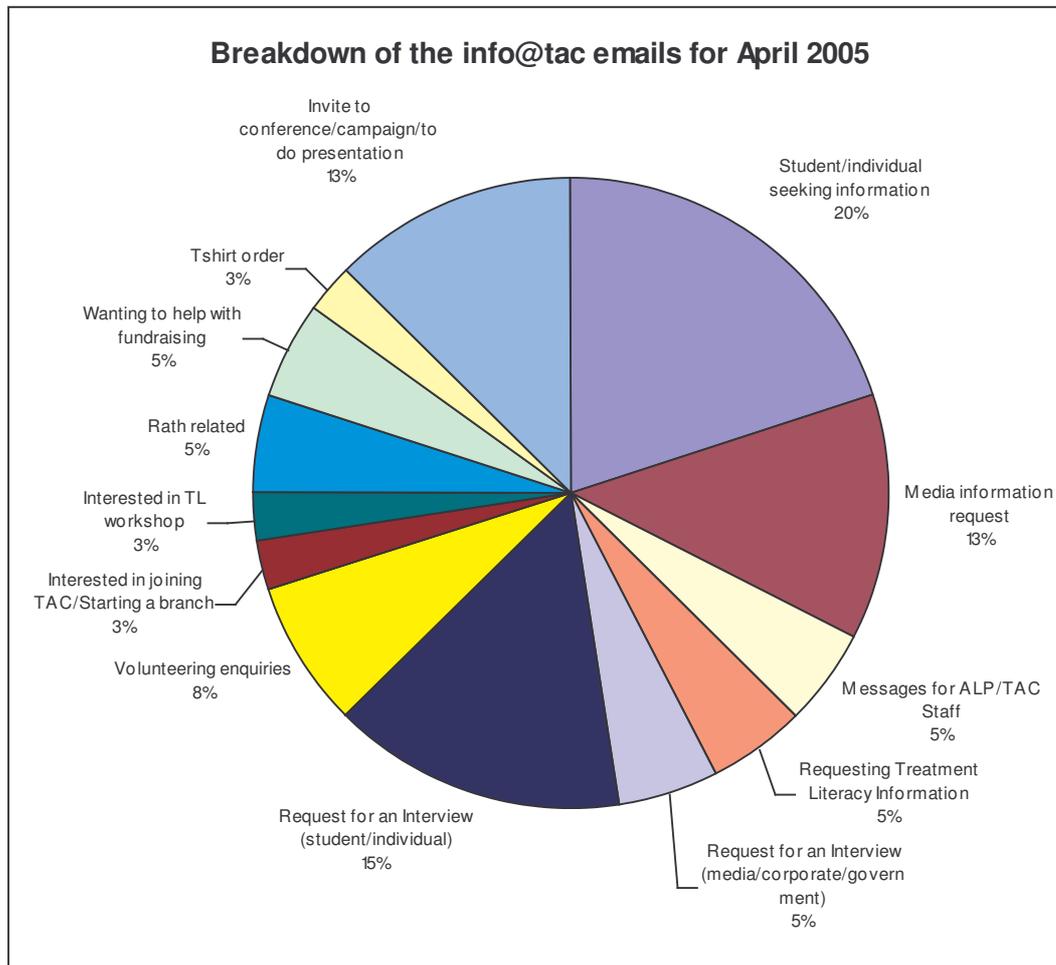
Treatment Project

The Treatment Project was initiated in May 2003 as an emergency intervention to provide TAC leaders and activists with access to affordable treatment in the absence of a government roll-out of ARVs. The programme supports CD4 count testing, ARVs and drugs to treat opportunistic infections (OIs). By providing this support, the programme promotes both voluntary counselling and testing as well as disclosure of one's status. It operates in the Western Cape, Eastern Cape, Gauteng and KwaZulu-Natal (KZN) provinces. It has over 100 people on treatment, 60 of whom are TAC members. Through the TP, TAC has distributed over 85 000 capsules of Fluconazole, undertaken 3 454 CD4 cell count tests and provided a range of other drugs and support to HIV positive people, hospitals and clinics linked to the programme. TP spends between R 7 900 and R 8 200 per year per patient on comprehensive treatment. Five percent of TP recipients are now in the position where they are able to buy their own drugs from the TP at cost price.

Research, policy and communication

TAC's research, policy and communications department works closely with the Community Health Media Trust. TAC produces an electronic newsletter and keeps its website updated. On average, the website receives between 90 000 and 155 000 hits per month, and between 5 000 and 6 000 unique visits per month. Around 50 e-mail queries are received from people accessing the website each month. The diagram below provides an overview of the type of e-mail queries received.

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Organising

The organising department is responsible for setting up and servicing branches and running TAC's campaigns. TAC has approximately 10 000 volunteers and about 220 branches. The branches are distributed throughout the six provinces in which TAC functions. (Western Cape province has the most branches with 57, while Limpopo has the fewest with 15.) Each branch must have a minimum of 10 members, a chairperson, secretary and treasurer. Volunteers are tasked with attending branch meetings, organising events, participating in campaigns and mobilising others in their community. Branches differ considerably in capacity and programmes. There are essentially three kinds of branches:

- a) Those linked to an AIDS clinic with work centred around the clinic
- b) Those in communities where either there is no clinic or no relationship with the clinic (these branches focus more on awareness raising and support)
- c) Those comprising a coalition of other organisations.

Within the organising department, there are People with AIDS (PWA) and youth sectors. The PWA sector targets PWAs and aims to secure treatment, resolve

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the special needs of PWAs and address social grants and other issues faced by PWAs. The youth sector targets young people through youth clubs and schools, and focuses on education, disclosure, prevention and awareness of rights. Each youth organiser (a volunteer) is responsible for organising the sector in their area and adopting a youth club and school.

Since its inception, TAC's key campaigns have been:

- Prevention of mother-to-child transmission (PMTCT)
- Campaign against patent abuse and profiteering
- Advocacy for improved access to medicines, including campaigns against the Pharmaceutical Manufacturer's Association
- NEDLAC treatment and prevention plan
- Competition commission complaint.

International

The International Desk at TAC was created in January 2002, with the objective of building global alliances with individuals and organisations who share lessons and engage in joint actions to increase access to antiretroviral therapy, to hold international multilateral institutions accountable and to create a more conducive international environment (TAC annual report, 2004).

Partnerships

TAC is aligned with the Congress of South African Trade Unions (COSATU), the largest labour union federation in South Africa. It has a very close partnership with the AIDS Law Project, which drives a lot of the legal work for TAC. In addition, TAC works closely with the AIDS consortium, the Children's Rights Centre, several religious groups and Médecins Sans Frontières (MSF). Finally, TAC has thrown its weight behind a series of broader campaigns with relevance for its work, for example, the Basic Income Grant Coalition Campaign, Zimbabwe Solidarity Actions and the jubilee campaign.

4 Evaluation findings

4.1 Achievements and challenges

In summary, the key achievements and challenges of TAC noted by interviewees are the following:

4.1.1 Achievements

The TAC has:

- Provided a lifeline to thousands of PWAs and affected people
- Destigmatised HIV/AIDS and sexual preference choices – in the words of an interviewee,

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“Before TAC existed, having HIV/AIDS was tantamount to a death sentence for most South Africans with the disease”

- Won the right to health care for PWAs, with victories in the mother-to-child-transmission prevention and ARV rollout
- Redefined the traditional relationship between medical practitioners and patients to one of partnership
- Provided a model for defending socio-economic rights and monitoring government accountability
- Developed a cadre of people schooled in rights-based advocacy
- Built capacity around treatment issues on a regional and continental basis
- Adapted as an organisation with the times – even in the course of this evaluation, there have been some valuable changes, e.g. improvement of the internal communications system and the training of media volunteers
- Created a cadre of leaders and post-1994 activists. TAC has also created the real possibility for black women leaders to emerge. However this possibility is yet to be fully realised.

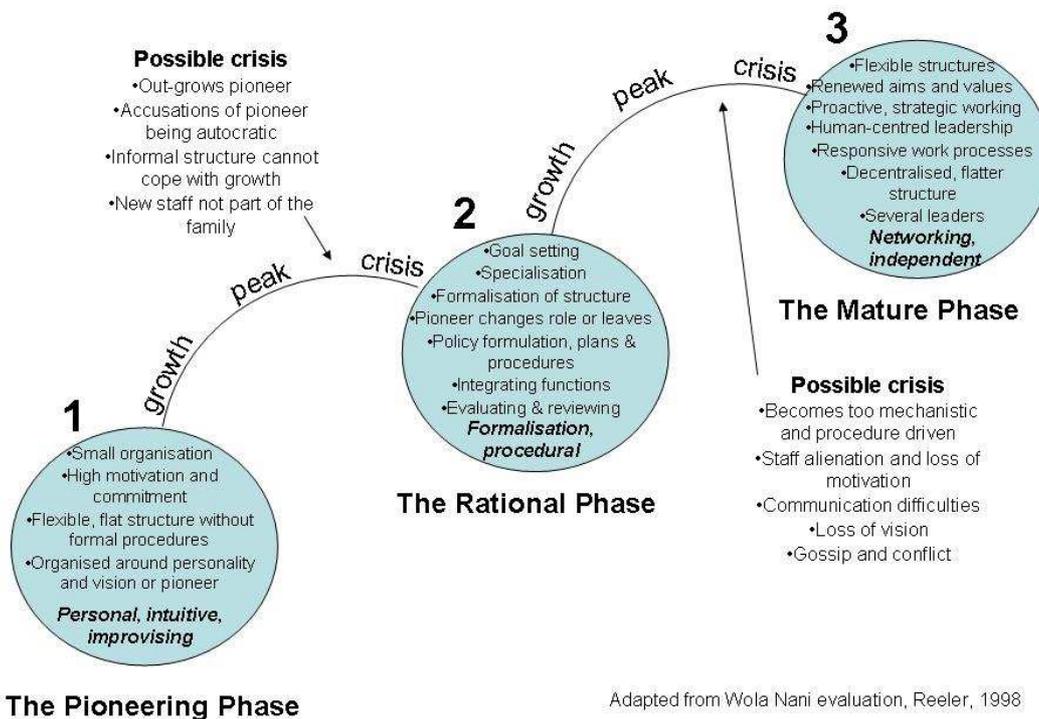
4.1.2 Challenges

- TAC has grown too quickly. One person interviewed said that she was *“scared of the growth”*. The pace of the organisation’s growth has impacted on systems and management capacity, both of which inhibit effectiveness.
- The focus of the organisation has proven to be a significant challenge. TAC is a victim of its own success, in that it has been so successful in its access to treatment campaign that members now expect the organisation to start addressing the broader socio-economic needs of its members. This has resulted in an over-confidence at times and a tendency to act as a *“monopoly”*.
- The organisation must sustain the growing need for more human resources in the organisation.
- Funding levels from the current pool of donors must be sustained.
- TAC does not spend enough energy on developing partnerships or reaching rural areas.
- TAC has been credited by almost all interviewees as being astute politically, but some believe that the organisation could do more when it comes to advocating or facilitating practical solutions to problems faced by the health system. It was felt by some interviewees, for example, that campaigns around pharmacy management, shortages in drugs distribution, district health budget structures, and allocations and capacity of health workers would be valuable.
- There have been allegations that the management have often made promises, to other staff, volunteers and branches, that could not be kept. The result has been an undermining of the organisation’s credibility.
- TAC has not made sufficient inroads into middle class constituencies across the race spectrum.

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Typically as an organisation grows so its structure and process change to meet the needs of the organisation. The diagram below provides a conceptual overview of the phases of development of a typical organisation. Obviously in reality the process of change is not as linear and the lines between the phases are blurred. However the diagram does provide a useful framework for understanding many of the challenges facing TAC. Viewed in this context they are typical of a pioneering organisation in the process of formalising.

Phases of organisational development



4.2 Organisational strategy

4.2.1 Strategy, vision, mission and motivation

Why do people join TAC?

People join TAC for a variety of reasons – Some because they are HIV positive, others because they are friends with or related to someone who is infected.

“I joined TAC because my friend died.”

Some people join because they are socially aware and identify with people living with HIV/AIDS and / or because they have a commitment to social change.

“I got involved because TAC provides an information base that enriches life and relationships and makes practical links between individuals and what is happening in society.”

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Regardless of what the motivating factor for joining might be, all TAC members have a common wish, which is to accelerate access to treatment for people living with HIV/AIDS.

Strategic focus

“We are spreading ourselves too thinly to be effective.”

Given the diversity of reasons why people get involved in TAC, it is not surprising that the biggest strategic challenge facing TAC is the question of how broad or narrow its focus should be. HIV/AIDS is a political issue in South Africa, both because of the way the government has chosen to engage with the issue and because of the profile of the majority of people infected. As one of the leaders of TAC explained:

“The fight for access to treatment raises a multitude of issues linked to politics, economics and health.”

It is the inter-related nature of issues around HIV/AIDS that has kept the issue of focus on TAC’s agenda.

There seems to be agreement that the primary purpose of TAC is a campaign for treatment, prevention of new infections and to create an HIV-positive leadership. Linked to this primary role is a secondary purpose, namely, to play a role in transforming the public health care system to provide a higher quality and a more comprehensive level of health care. A third and more implicit purpose, certainly for the leadership, is to make a contribution to developing a culture of human rights and democracy in South Africa.

How the two main roles relate to each other is at the heart of the debate around focus. In other words, the primary question is whether TAC is a focused issue-based campaign or whether it is a broad-based human rights movement. The box below provides an overview of the strengths and weaknesses of each.

Human rights focus

- Allows for holistic approach and sustainable long term solution for PWAs, given that treatment is but one (albeit the most important) of several required conditions for PWAs to lead healthy lives
- Provides endless opportunities for partnerships
- Stretches the organisation’s capacity
- Dilutes the clarity and power of the message
- Requires a more politicised support base, which may in turn, decrease the membership base
- Limits the quality and depth of the commentary and interventions, as the scope is so wide that it is not possible to be the expert in every area.

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Access to treatment focus

- Single issue campaign enables a broader support base
- Enables more targeted campaigns and delivery
- Enables the organisation to develop a real base of expertise in the area and become experts in the advocated field
- Prevents stretching the organisation too thinly, which in turn facilitates the achievement of results
- Does not allow for holistic approach to addressing HIV/AIDS – which cannot be separated from the other complex socio-economic issues impacting on the lives of poor people, especially those who are HIV-positive.

The debate in approach is evident in TAC's communications and its recent perceived broadening of its mandate by commenting on broader social and political issues, e.g. the lack of democracy in Zimbabwe, debt relief for developing countries, and the war in Iraq.

In the interviews, many people were not convinced that this is the best path for the organisation to follow. Instead they advocated the forming of strategic partnerships through which the broader socio-economic issues could be tackled, allowing TAC to remain focused.

Broadening of partnerships was not limited to addressing broader needs. Within the arena of treatment access some felt TAC had underestimated the popular support base of the Zion Christian Church (ZCC) and traditional healers' lobby against antiretroviral therapy (ART), and had not made enough of an effort to forge relationships with these groups.

Also in respect of strategy, some felt the confrontational manner in which certain debates and campaigns have been conducted has contributed to the polarisation of those for and against ART, with insufficient focus on the common ground. Some felt TAC should claim more of the middle ground and should be talking about the challenges associated with taking ARVs, in the course of its ARV campaign. There are also some feelings that issues of side-effects and resistance might not be getting the prominence they deserve. By talking about the difficulties around treatment, one might be able to decrease the polarisation around the debate.

Also linked to focus is the question of whether TAC should be purely an advocacy organisation or an advocacy and service delivery organisation, and whether the two can be successfully combined in one organisation. Despite the very real challenges of balancing the two (at times contradictory) roles, there seems to be agreement that since 2004, TAC can no longer be described solely as an advocacy organisation, but rather as an advocacy and service delivery organisation. Service delivery is a large component of both the treatment literacy and treatment project activities.

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Advocacy strategies

Leaving the debates on focus aside for a moment, one thing almost everyone interviewed agreed on was that strategy was one of TAC's strongest aspects. The combination of different kinds of advocacy strategies such as litigation, mass action civil disobedience, and the use of the media, was seen as a model for other CSOs. In particular, interviewees highlighted the groundbreaking litigation combined with mobilisation.

TAC has been extremely strategic in using litigation to hold government accountable to its socio-economic obligations. The most successful case, according to most interviewees, was the "nevirapine" case or the "mother to child case" (Minister of Health vs. TAC and others, 2002 (10 BCLR 1033) CC) in which TAC obtained a forceful constitutional court ruling compelling the Minister of Health to proceed with implementing a countrywide mother to child prevention programme "without delay." Another extremely successful example of litigation was the complaint to the competition commission which resulted in the reduction of royalty fees paid by generic companies to brand name pharmaceutical companies from as high as 40% to 5% for antiretrovirals.

The most successful examples of litigation appear always to have been accompanied by a robust and well orchestrated public campaign which, in essence, created the demand for the litigation to occur. TAC have also been praised for their generation of "a good paper trail", by affording government numerous documented opportunities to avoid litigation, and also for their excellent use of highly regarded experts (medical doctors, scientists, health economists, competition economists, amongst others) in increasing the likelihood of a successful outcome.

On the other hand, the least successful examples of litigation occurred where the public groundswell discussed above did not occur and where TAC's own members believed that they were not familiar with the facts of the case. The "Annexure A" case, focused on securing a copy of government's implementation plan, and has been often cited as an example of this. In addition, some members believed that TAC had become too reliant on litigation, and suggested that the organisation needed to pursue other strategies and not always resort to legal action. Overall, however, there is little doubt that litigation and advocacy have been extremely well used in tandem.

It is a well understood institutional lesson in TAC that achieving a court victory or policy gain is not enough, and that stopping at the signature on the dotted line is a strategic mistake. (TAC TLP overview, 2004) For true results to be achieved for its members, paper victories must be translated into practice through mobilisation. This requires a well co-ordinated strategy integrating all the resources and components of the organisation through campaigns that target service delivery and monitoring of the implementation of policy victories.

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TAC and health care workers

TAC's approach to health care workers and health service capacity has been both a strength and a weakness of the organisation. On the one hand, the organisation must be congratulated for taking the conscious decision not to attack health care practitioners. This has enabled relationships to develop at a local level in several instances, although much remains to be done to strengthen these. On the other hand, the organisation has not focused enough on the health care system and has missed opportunities to build a partnership with health care workers around some of the very real implementation challenges. Some felt the organisation was not innovative enough around implementation issues and was consequently:

“too reliant on litigation because it lacked the in-depth technical knowledge and skills”.

Future

On the question of TAC's continuation, only one interviewee felt that TAC's work had been achieved and that it was time for the organisation to close its doors. The rest either felt that TAC was needed until government had taken over treatment programmes in full, or felt that there will always be a need for education and monitoring of government, and that there was no end to TAC's role.

In future, TAC is encouraged to develop a relationship with a team of medical and related professionals who can provide the medical research and support, in the same way that ALP has provided invaluable legal support. The absence of this medical knowledge has diluted some campaigns and means that TAC is not "on the ball" around issues such as the capacity of health workers. Other consequences are that TAC does not have the same level of expertise or analysis on health economic, scientific and medical issues as it does on legal issues. The close working relationship between the ALP and TAC has been highly beneficial to TAC and where applicable, both MSF and TAC have benefited from a close working relationship – in Lusikisiki as well as in Khayelitsha. The fostering of partnerships with organisations with medical expertise would allow TAC to adopt a more holistic approach to its work.

4.3 Programmes

This section deals with each of the national programmes located within TAC. Historically, the programmes have operated in silos and have not co-operated in a way which creates maximum synergy. The shortcomings of this approach were recognised and the national manager and secretariat are currently co-ordinating plans to establish the post of general secretary to provide for programmatic co-ordination.

4.3.1 Treatment Literacy Programme

“The TLP has enabled me to engage with doctors and make active choices about my treatment regime.” TAC volunteer and TLP

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The introduction of the Treatment Literacy (TL) programme is an example of TAC's excellent strategic skills and foresighted. Once a Treatment Plan was announced by Cabinet in 2004, the biggest challenge facing the HIV/AIDS sector was building the demand for ARVs, spreading treatment knowledge to reduce adherence problems, and empowering patients who could work as partners with health care professionals. These are the aims of the TL programme.

Valued materials and practitioners

Through the programme, hundreds of HIV-positive people, health care professionals and community members have been trained, with far reaching impacts on adherence levels of people taking ARVs. In the words of one medical professional: "We have 98% adherence, thanks to the work of TAC".

"I was bowled over by how much the public knew about HIV/AIDS and treatment options. I had to find this material so I went to TAC..... The material is simple and clear..... I cut off the TAC logos and use it in my hospital." Nursing sister

Nurses and doctors interviewed at sites where TAC has full time TL Practitioners working all commented on the value added by TLPs to treatment programmes. One of the doctors interviewed explains:

"We have our own counsellors but I prefer to use the TAC TLPs, as are they are better informed and better workers."

In some instances, the TAC TLPs and TLTs fill a gap and provide a much needed service. In other instances, however, they duplicate the work of government health care workers. This is not a sustainable long term approach. Sadly, not all the responses to the programme have been positive. "A frequent problem encountered by TAC trainers wanting to provide peer education to patients in waiting rooms is that medical staff often feel threatened by the knowledge of TAC trainers and view them as 'trouble makers'." (Le Page, 2005, p. 13).

Patient attitudes

A negative perception of the effect of the TL programme on patient attitudes is exacerbated by the attitude of a minority of TAC members. In the words of one doctor:

"TAC members are the worst patients to treat. They want to fast track the process. They think they know everything. It is similar to the problem we experience with our own doctors and nurses, who also make bad patients."

On more than one occasion, the evaluators heard complaints that some TAC staff and volunteers can be very arrogant and rude to health care workers. This creates an unnecessary divide.

"Nurses do also know some things and need to be engaged. TAC should not force things when it is not necessary,"

said one health care worker who is largely supportive of TAC.

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It must be said that these are exceptions in an otherwise well managed programme. A very high percentage of the TL Co-ordinators, TLTs and TLPs commented on the excellent support they had received from their treatment literacy co-ordinator and from management. Most accounts of work indicated a dedicated team, meeting targeted outputs.

Relationship to branches

In many areas, treatment literacy has infused new life into branches and provided a much needed focus for branch members trying to redefine TAC's role in the landscape after Cabinet's announcement of a Treatment Plan. But there is some confusion over the role of TLPs within the organisation, in part because of the way the programme is organised, with its staff reporting directly to the national office rather than working through the local channels. It is felt that the TL programme is not sufficiently integrated into the organising department's work, resulting in tensions between TLP and the organisers on the one hand as well as between TLPs and various Provincial Executive Committee (PEC) and district executive members, because of a lack of clarity over their respective roles. The response of a member to the problem was:

"TLP reports need to go to branches as well as to the offices, so we can see what is being done and integrate it into our programme."

A number of other shortcomings were highlighted in an effort to improve an already strong programme further. These cover exit strategies, recruitment, gender balance and the lack of accreditation of the training offered to TLPs and TLTs.

Exit strategies

There is an absence of clear exit strategies for TLPs and TLTs. While the TL Programme Plan targets discussions with provincial and local government to ensure the sustainability of the programme, in practice the evaluators found no evidence of any agreements or of plans to channel TLPs or TLTs into new posts for counsellors and trainers being created at ARV sites. Given the debates around the payment of the bursary (see payment of volunteers under section 4.8.8), exit opportunities need to be prioritised.

Gender

Yet another concern was the predominance of women in the programme. On the one hand, the programme has provided a base for women to play a more active role and emerge as leaders, but on the other hand, the service was increasingly been seen as "*women's work*" or "*the nursing school of TAC*". The need to bring together the treatment literacy and organising departments into a more co-ordinated and gender integrated strategy was noted here.

Recruitment

Recruitment emerged as an issue in three respects. Firstly, in some areas concerns about the transparency of the process were raised. Secondly, the programme has creamed off the best leaders, depleting capacity at provincial, district and branch level. Thirdly, smaller provinces do not always feel they are

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being treated equally. For example, Treatment Literacy Trainers in Mpumalanga and Limpopo provinces were not provided with the opportunity to run training sessions on their own. As a result, people in Gauteng province were suggesting that these provinces' trainers were less competent, despite having completed and passed the same training programme. As one volunteer commented:

“There is a feeling that the criteria are not consistently applied”.

Accreditation

The TL Programme Plan indicated that all training products would be accredited with the Health and Welfare Sector Education Training Authority. However, this has not materialised, much to the disappointment of TAC volunteers, most of whom called for the training to be registered as a qualification. Interviews with the materials developer suggested that the issue of registering the course was still on the agenda, but that other avenues were being explored because of the complex prerequisites for SETA registration.

Partnerships

In respect of partnerships, as with the rest of TAC's work, partners have played an invaluable role assisting TAC develop the training materials. Most of this work is kept in the background. It is felt that TAC should publicise its team of technical professionals, where such professionals do not object to being mentioned publicly. This might assist in increasing the number of health care practitioners working with TAC and might also increase the levels of credibility associated with what is high quality TL material. In addition, drawing on the lessons of its partners internationally, TAC needs to broaden its group of peer reviewers from the local health profession, drawing on both doctors and key opinion leaders, and use this pool to review and endorse its materials. This will both diffuse the resistance to TAC materials at some hospitals and clinics and help to add legitimacy to TAC's service delivery programmes.

Furthermore, there is a need to prioritise the planned partnerships with other training initiatives outside of Beat-it, namely Mindset and Khomanani, which have not been developed, as well as improving links with Soul City.

Finally, with the robust treatment knowledge gained through treatment literacy, TAC should examine getting more involved with health care practitioners in the design of medical trials to influence the way in which they are designed and conducted. They also need to be doing more technical research by using the treatment literacy experience and knowledge to get onto medical trial and research committees, forge partnerships with universities and work with medical research groups. This will help to build bridges with health sector professionals and to ensure that medical and scientific trials have taken into account the concerns of PWAs.

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4.3.2 Treatment Project

“I would not be sitting here talking to you if it was not for the TAC Treatment Project. It has been invaluable in saving the lives of several of our members, including my own life.” TAC volunteer and treatment project recipient of ARVs

The Treatment Project (TP) was introduced at a time when many of TAC's leaders were dying, providing a lifeline to those with CD4 cell counts below 200. As the opening quote reflects, the programme has saved a number of lives.

In addition to servicing its members and programme participants, the TP has also played an important role as backstop to the public sector, and has provided state hospitals with drugs in instances where tenders have not been awarded or there are shortages in supply. This support, though it has been vital, is not sustainable and should not be encouraged.

Volunteer commitment

A strength of the TP is that it has operated largely on volunteer commitment, with just four paid provincial staff and a national co-ordinator. The TP has also served as a catalyst to encourage voluntary counselling and testing (VCT) and to improve treatment literacy in areas where it has been implemented.

Management systems

Weaknesses in the programme include the spread of the programme to more provinces without an exit strategy, a lack of formalised contracts with recipients, and problems with donor management, as detailed below.

Some interviewees felt that by spreading the clients of the TP too thinly across regions, TAC was not able to build the requisite capacity in the clinics, or the treatment systems needed to play an effective role as a pilot or site of best practice. In the words of a health professional:

“If a doctor is dealing with one patient s/he does not need a system, but if they are dealing with 10 then they need to begin to think about systems.”

A second concern is the lack of enforcement of the Memorandum of Understanding signed between patients and TAC TP. It is accepted that there is a general understanding entered into between the TP and its clients, but is unclear as to the exact extent of TAC's obligation to TP clients. This is a highly perilous situation for the organisation to be in. Treatment is a lifelong commitment and the legal obligations of TAC need to be very clearly defined in any undertaking to provide treatment to an individual.

A significant shortcoming of the TP has been the absence of an exit strategy. Firstly, where government sites have recently been established, the TP should be moving recipients onto programmes at these sites as soon as possible, as has occurred in Gauteng. One recipient's explanation of why he has not moved to the local government programme was disturbing:

“The queues at the government site are too long, and it would waste a lot of my time.”

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Donor management

The last area of weakness was the management of the TP donor base. An interested member of another organisation described how she had spent three months trying to find out how she could become a donor. She had not had any calls returned, had been sent from person to person and was still waiting. Those who do find their way onto the donors list have not been getting reports or feedback. Another donor said she stopped donating one day and never received a query to find out why. Plans are being developed to address this through a newsletter, annual reports to donors and consolidating the donor base into TAC's other donor management systems.

Looking to the future, since the adoption of the National Treatment Plan by government, the role of the TP needs to be reviewed. There are a few options mentioned for the future. These are to terminate the programme, to focus on numbers and increase beneficiaries, or to focus on target locations and set up a lobbying and best practice pilot matched with an advocacy programme to secure an ARV site from government. It is the evaluation team's view that priority should be given to establishing a clear exit strategy where applicable, so that treatment sites parallel with government sites do not occur.

4.3.3 Organising

"They don't come until we call them." A volunteer commenting on the provincial organising department and staff

Through its organising department and campaigns, TAC gives ordinary people, especially the poor and marginalised, a sense of their power and an experience of active citizenship. This department is one of TAC's greatest strengths and, as mentioned earlier, the key factor that differentiates it from most traditional NGOs. However, it is also one of TAC's weaknesses. Branches and their membership have varying capacity and have been identified as the biggest priority in this next phase of TAC's future plans, which entail advocating for improved service delivery.

Branch management

In general the organisation has grown too rapidly, with branches mushrooming all over the country without the parallel development of capacity to support them. There is a need for a branch induction programme covering the background and history of TAC, its vision and programmes, the local health care system, government's programme, and basic meeting skills, concluding with a strategic planning session mapping out the first three month programme. Every quarter this should be reviewed and renewed.

Regardless of the number of branches, the way that TAC works at the local level will need to change. The organisation needs to *"become more branch-centred"*, explained one member. The need for a change in planning processes was a frequent plea from members:

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“Branches need to be more centrally involved in planning. And we need to plan in advance and not leave everything to the last minute”.

District Organiser

The role of the District Organiser (DO) is to make sure that branches function, initiate new branches, support the rollout of campaigns and monitor sites. They should spend around 80% of their time in the field and visit each branch at least quarterly. Yet a combination of the ever growing number of branches, the lack of focus of staff employed in these posts, and a lack of understanding of their role within the organisation, has meant that few of the organisers actually achieve this. The approach of one of the more experienced organisers was sadly not the one applied in most areas:

“I have said no new branches until the current one functions. I would rather we have 10 functioning branches to have 30 branches with only 3 of these functioning.”

Education

“I thought I knew so much, but I have learnt so much at TAC. Every day I learn something new.”

There is no doubt that TAC members continually learn new things in the organisation. However, political education outside of treatment literacy has been haphazard and ad hoc. One encouraging initiative to address the need for more systematic education of members is the leadership schools initiative. Two types of leadership school exist – a nationally driven programme aimed at boosting the skills of members and leaders in targeted areas, and provincially driven workshops targeting districts. The one leadership workshop attended by the evaluation team demonstrated the usefulness of the meeting for members in terms of team building and enhancing knowledge. It was, however, evident that there is no clearly thought out systematic programme targeting an agreed range of competencies such as organising skills, chairing, minute taking, letter writing, political dialogue skills, the conducting of negotiations, understanding how your district or local municipality works and HIV/AIDS related skills.

Another initiative introduced in the Western Cape is the study group initiative, meant to help encourage reading amongst members. This might be a useful model for other provinces but is premised on having at least one person to lead each group.

Youth

In many areas TAC membership is dominated by young people under the age of 35 years. It is therefore not surprising that a youth programme has been established under the organising department. This programme has begun to engage with the challenges of prevention and has developed a series of innovative techniques to engage youth such as youth camps. This is a nascent programme and several interviewees noted that this was an area for expansion in the future. In particular, many people felt that TAC needed to expand its programmes around prevention. This will require increased resource commitments (financial and human) to the youth programme.

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Gender

Finally, there is a lack of gender consciousness in the programme. In one province a female volunteer on the organising team explained how she was “often excluded from trips to save money”, because her presence would mean an extra room in the overnight accommodation. This was despite the fact that many of the members in the area were women and that she felt she was able to bring different competencies to the team. This reflects a lack of understanding of gender politics and dynamics within the organising team, and within the administrative and provincial management structures who control budgets and allocate volunteers to assignments. There is also a lack of priority given to gender issues – seen in the failure to spend the 2004/5 women’s health programme budget, because of the demands of other work.

4.3.4 Policy, research and communication

This programme has five components, namely, the *Equal Treatment* newsletter, research, public information, public relations and information technology.

Research

In the area of research, TAC has relied on its partners in the Aids Law Project and on collaboration with universities and other NGOs. The appointment of a national programme director is likely to result in the expansion of this programme. Particular areas of neglect which needs to be prioritised in the future include documenting lessons outside of the legal lessons and victories, as well as research and information dissemination on the different drug regimes. There are new drugs being introduced currently with less toxicity. TAC needs to understand the implications of this and develop a position on the new additions, and be seen to be lobbying government accordingly.

Public information

In general, TAC’s public information is rich in content and poor in appearance. Interviewees commented on the user-unfriendliness of the website, the lack of attractiveness of posters and pamphlets and the general lack of awareness in TAC of media design issues.

“TAC materials are generally ugly and they just don’t seem to understand how important this is”

noted a frustrated volunteer.

One exception to this is the “HIV Positive” T-shirt, which is regarded by all members and partners as a highly effective medium to break the ice around HIV issues and tackle stigma and discrimination. There has also been an excellent translation of technical, scientific and medical information into comprehensive and useful information for public consumption.

Public relations

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TAC has developed an excellent national press strategy and profile. At no additional cost, the organisation has been able to secure regular space and retain its profile. This has not been transposed as yet to the provincial and local levels. The recent training of local media scouts has already begun to address this, with a growing number of articles having been placed since the programme started in March 2005. In addition, TAC's PR strategy has not really been developed, with the organisation relying almost exclusively on the media for its marketing.

Information Technology

TAC has developed a sophisticated information technology (IT) system. However, not everyone is able to access this or maximise its effectiveness. In addition, much of the IT is not user-friendly, especially its website, as mentioned above.

Finally, the workload in this programme is too much for the current staff capacity and will lead to burnout of staff, a backlog of tasks or in all likelihood, both. It is recommended that outsourcing of tasks be explored and utilised whenever practically and financially possible.

4.3.5 International

“TAC relies on international solidarity as a key support to its work but does not give enough back.”

TAC has developed a good international profile and set of partners. The extent of the international activities and collaborations has been impressive, given that the programme was co-ordinated by one person. TAC has brought a unique ethos to the international AIDS community and a clear understanding of *“We shall overcome”*. This has enabled the organisation to take up innovative campaigns and win battles that most would never have dreamed possible. A strength within these partnerships is that TAC has continued to set its own agenda and has not been diverted onto the agendas of others.

Three weaknesses of the programme are that it has not been adequately integrated into the rest of the work of TAC, that opportunities for solidarity have not always been acted on, and that it has not been focused enough. As one interviewee commented:

“There is a need for TAC to focus its international activities. The focus should not necessarily be a geographical one, but rather an ‘issues-based focus’, with a greater reliance on international partners working on issues that TAC feels are of interest, but chooses not to focus on because of a lack of time or capacity.”

Within its international programme, the biggest focus has been on building a Pan-African network of AIDS treatment activists. “Passing on experience in coalition building is a key goal, since TAC believes that, in many African countries, treatment activity is restricted to people living with HIV/AIDS, and that this isolates it and renders it ineffective.” (Friedman, 2004, p. 21)

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4.4 Funding

TAC is one of the most highly funded CSOs in South Africa. In the context of declining development aid to South Africa, it is both the relevance of the work of TAC and the credibility of its leaders that has produced this somewhat anomalous situation.

TAC is highly regarded by all its donors both for its work and for the commitment and calibre of its team. Notwithstanding the excellent personal relationships between some of the TAC leadership and donors which have opened many doors, institutional relationships are not always nurtured appropriately. As one donor commented:

“TAC treats us with carelessness.”

While the other donors interviewed spoke highly of the organisation, they too provided examples of experiences that substantiated the above statement. For example, a donor who hosts an annual HIV/AIDS roundtable for its partners was very disappointed by TAC non-attendance at the event, despite the fact that TAC was their largest grant recipient. Another donor to one of TAC's programmes stated that they had never met the programme co-ordinator. Finally, a donor noted that the failure of the national manager to attend the donor forum was unfortunate.

There is a need to continue professionalising TAC's operation with donors, particularly through programme-specific communication outside of regular meetings or campaigns, reporting and providing donors with opportunities to observe the “unglamorous” ongoing work of TAC. There is also a need for improved teamwork in the compilation of donor reports, which require the input of each staff member. To make these reports easier to compile and to obtain the necessary content, it is suggested that staff and volunteers avail themselves for interviews with the report compilers when requested rather than referring report compilers to already written reports and to the website.

While TAC is correct in ensuring that it, and not its donors, sets the agenda, donors need to be accorded respect, and a commitment needs to be made by management to facilitate positive and mutually beneficial relationships and ongoing proactive communication.

Communication and interaction between TAC and its donors have improved significantly with the hiring of a staff member and a consultant to manage the relationships between the organisation and its growing portfolio of donors. All donors warmly welcomed the improvements.

TAC, by its own acknowledgement, is too reliant on a small pool of international donors, and needs to diversify its funding base to local corporate and individual donations. Failure to do so in the context of a reduction of overseas development aid to South Africa could result in reduced funding. It could also result in a

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reversal in the current relations, making TAC so dependent on donors that it is no longer able to set the agenda.

4.5 Relationships

TAC pursues partnerships at many different levels. Relationships at the local level are usually focused on other CSOs and health workers, at the district and provincial level on CSOs, health workers, unions, business, government and political leaders, and at national level on strategic organisational partnerships locally and globally, spanning the public, private and civil society sectors.

In fact, TAC would not exist without partners. As Friedman comments: "TAC leadership approaches issues in a way that can best be described as 'thinking alliances'. Indispensable to planning of any campaign is considering where support can be sought from significant constituencies, including unlikely ones." (Friedman, 2004, p. 20) Yet, in addition to seeking support, there are many lessons to be learnt from these partners. This is because of the range of partners and the close working relationships with many of them as part of the 'thinking alliances'. In the words of one partner commenting on TAC's relationship with their organisation:

"At times it feels like you are dealing with an adolescent child. When they need you they come but they are constantly marking their turf."

The next section provides an overview of TAC's approach to partnerships and then comments in some detail on the key constituencies and the partnerships under each.

4.5.1 Health professionals

While TAC has developed relationships with a few individuals in the health sector over time, it has not developed a significant base in the health care sector to date. Given the shift in strategy from the provision of ARVs to the implementation of the national Treatment Plan, the relationship between TAC and health professionals is one crucial area for expansion. There were several ideas of how this could be pursued.

Firstly, TAC needs to publicise its existing partnerships more and use recognised medical experts to review and endorse its materials.

Secondly, a programme targeted at local health professionals, especially clinic nurses, needs to be developed both to raise awareness and to bring them on board as fully functioning partners. There is clearly a need, as expressed by a nursing sister who commented that, despite her having approached TAC for materials and having participated in a TL workshop, she did not receive any regular communication from TAC.

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“As professionals we would appreciate regular health news updates from TAC. This would need to be more than just an e-mail newsletter as many of the clinics and sisters do not have e-mail access.”

Others commented that they are not clear on TAC's role and activities and therefore don't refer people to TAC.

In addition to local relationship building, TAC's continued and intensified involvement in articulating the improvements required in the health system to ensure effective rollout of ARVs could be used to forge many alliances and partnerships.

4.5.2 Government

“TAC's mode of engagement with government, in which co-operation and conflict are intertwined, is not simply born of convenience. It does also recognise that while the power of democratic governments could be used against the grassroots, they are elected by the majority of voters and so cannot be dismissed as 'enemies of the people.' TAC's approach does recognise that alliances with democratic government are possible and that co-operation and confrontation can be complementary strategies” (Friedman, 2004, p. 15).

This is an excellent summary of the seemingly contradictory, yet highly successful initial advocacy strategy of TAC towards a heterogeneous state. Despite the active resistance to the organisation by the Minister of Health and the top government leadership's HIV and AIDS denialism, TAC has congratulated government on its ART rollout plan and offered to co-operate on facilitating it. TAC has developed good relationships with officials in the Department of Health (DoH) nationally, and at provincial level in Gauteng and the Western Cape province, as well as at numerous clinics across the country.

Increasingly, as TAC shifts focus from a campaign-centred organisation to one that also engages in service delivery, so this approach needs to be expanded into differing strategies for the different levels of government. At national level the focus remains that of ensuring that the Treatment Plan remains on the agenda and that it is meaningfully implemented. At local level, however, the emphasis needs to be on building close relationships based on practice and effective reach to those in need.

Yet these differing approaches do impact on each other. Some members have called for an active attempt to thaw the frosty relations that exist between the top structure of the DoH and TAC. A volunteer comments:

“One of the worst things about TAC is the relationship with national government because it affects us here. There is such a need at clinics, yet if we say we are from TAC we are not allowed in. Sometimes I lie and say I am from a community support group just to get into the hospital.” Another member added: *“TAC is too focused on the Minister. It distracts us from the real work. I think it is time to ignore her.”* And a member of government noted that: *“TAC is at times too aggressive where it is not necessary. For*

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example, there were no gains to Zackie's public fight with the Minister at the Health Systems Trust conference. TAC's aggressiveness just alienated people."

These are certainly valid comments deserving of reflection, despite the strong belief by leaders and staff that TAC has correctly handled its relationship with the Minister and the top structure of the DoH. Given the Minister of Health's intransigence on HIV matters in general and TAC in particular, evidenced by her recent public support of the Matthias Rath Foundation, the evaluators recognise that it would be inappropriate to attempt to foster a completely co-operative relationship at a senior national level, and unlikely that such an attempt would succeed. Less focus on the personal antagonism between TAC leaders and the Minister, however, would certainly address the concerns of members and supporters in government. It would also create a more conducive environment for engagement of local government health officials and work with the Health Portfolio Committee.

A gap in TAC's current relationship with government lies at the provincial and local levels - in relationships with parliamentary and municipal portfolio committees. Another possible option for TAC is to open and pursue a dialogue with other structures in national government such as the Department of Education. On a local level, Kwagga branch activities provide an encouraging indicator of the possibilities of improving the dialogue between TAC and local government.

Kwagga branch in Mpumalanga has forged a partnership with the local authority in terms of which they are provided free office space in recognition of the value of having an organisation actively raising awareness around HIV/AIDS in the area.

4.5.3 Other CSOs

TAC has developed a range of institutional partnerships with faith-based organisations, other NGOs and trade unions. Several partners are represented on the NEC, and those that are not, are invited to observe meetings. All CSOs interviewed, regardless of their assessment of TAC's approach to partnerships, agreed that TAC was playing a significant role and that society would be a lot poorer without it.

Two partnerships that merit specific comment are those with Médecins Sans Frontières (MSF) and the Congress of South African Trade Unions (Cosatu).

The partnership with MSF has been vital to TAC's strength and to a large number of the successes of both organisations. In some instances, MSF provided a direct service to TAC members, and direct support to TAC management, as well as training to staff. One volunteer commented that:

"If it was not for MSF I would not be here".

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TAC and MSF

In the words of MSF doctor, Dr Herman Reuter: *“We would not be here if it was not for TAC’s mobilising and campaigning demanding a pilot site. Also we have 91 – 95% adherence on our ARV programme thanks to TAC.”* and of Dr Hussein at the government ARV site: *“Registration of this site would not have been possible without the support of MSF.”*

Clearly the medical support came from MSF. However, as he detailed the counselling, treatment, awareness and destigmatisation support, it was hard to distinguish what role MSF had played and what role TAC had played. One suspects that the point is rather that as health professionals, the hospital feels more comfortable with a relationship with MSF rather than with TAC.

For TAC, the partnership has enabled them to access information about the Department of Health, who to date refuses to meet TAC, continually using administrative processes to delay a meeting. The partnership has also enabled TAC to demonstrate to members and their families the very tangible benefits of treatment, encouraging a remarkable level of testing and disclosure.

A combination of all of the above has seen spin-off benefits around the de-stigmatisation of HIV/AIDS, increased empowerment of women in the community, the emergence of a gay and lesbian community living openly and the placement of Lusikiski on the health service map in South Africa.

The partnership between TAC and MSF in Lusikisiki has been invaluable to TAC and offers a useful model for the future. Achievements include the securing of the MSF ARV rollout site, expansion to government rollout sites, a decentralised model of treatment service rooted in clinics as opposed to hospitals, a CD4 cell count machine, improvements in the payment of disability grants, and the donation of the Anglo-Gold clinic to the Department of Health as the new village clinic site.

However, it is the interdependence of the two organisations that offers the most lessons.

TAC’s relationship with COSATU has been very important to both institutions and is a good example of how partners with at times fairly divergent views can continue to find areas of common concern. For example, although COSATU distanced itself from the Civil Disobedience Campaign of TAC, it remained highly supportive on a number of other issues (Heywood, 2004, p. 14). Despite the warm relationship that exists between the two institutions at a leadership level, TAC needs to spend more energy on increasing the treatment literacy of COSATU workers. TAC has had a limited impact on the internal operations of COSATU or the organisation’s attitude to HIV/AIDS. The COSATU member interviewed recommended joint campaigns around testing, STDs and prevention.

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Yet, despite the excellent relationships with CSOs described above, there are some areas of concern. The identification and building of relationships with potentially valuable organisations and individuals across regions is not systematic. There is a need to map the stakeholders in each province, to identify new potential partners and to expand the network to CSOs addressing the myriad of social issues related to HIV, for example, those related to social grants and alcoholism. In this way, TAC would be able to refer members to other organisations rather than assume the burden for every issue itself.

Also, as with donor relationships, there are often dissatisfactions expressed at the quality of relationships established with partners.

“TAC does not take the trouble to find out exactly what we are about. They tend to believe in what they do. Obviously they have a programme that works. But we missed opportunities and only started working together when we offered to treat their volunteers.”

were the words of a partner actively involved in providing treatment to large numbers of volunteers. Some partners interviewed felt that they have at times been unfairly criticised by TAC, without the necessary research and homework to back up the allegations having been done. Other partners felt that TAC did not consult them to develop certain responses, despite the fact that these partners were more technically qualified on the issues. These partners complained about the low level of priority that is accorded to the partnership by TAC, which for them is manifested in the number of meetings cancelled without notice and the lack of agendas, minutes and circulated documentation at meetings.

Partners felt there was room to grow existing relationships by involving partners in reflection and review activities more regularly and systematically, and by building the capacity of certain partners where possible and appropriate, thereby allowing other organisations to share the burden of, for example, treatment literacy.

It is also noteworthy that there has not been an adequate attempt to pursue a relationship with any women's organisation. Such a relationship would make sense, given the high levels of sexual violence in the country and the clear link between sexual violence and HIV infection.

4.5.4 International partners

TAC is well regarded by its international partners, particularly those on the continent. It was through the TAC Treatment Congress meeting held in late June 2002 that the Pan African Treatment Access Movement (PATAM) was established. TAC has facilitated the co-ordination of PATAM through its international co-ordinator, resulting in a rich and ever growing sharing of treatment-related issues across an e-mail list serve. This is proving to be valuable to other access-to-treatment organisations in building their capacity. PATAM is also probably the best way that TAC can assist in fostering the growth

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of treatment access movements across the continent, given its limited human capital.

TAC also has a good collection of global partners. For the most part, it is highly regarded as having done excellent work in South Africa and is seen as a very credible partner on international initiatives on treatment access.

However, there are concerns that TAC is not always inclusive in its consultations with partners. While some partners have generally consulted TAC in taking action in their countries that might impact on TAC in some way, the feeling was expressed that this action is not reciprocated. Other partners accused TAC of being territorial at times, and exclusionary in their planning and execution of campaigns and collaborations. Other sentiments expressed were that TAC should be more forthright in identifying campaigns in which it would like to be involved with international partners. One international partner remarked:

“I do not know what they are or are not interested in, therefore I am not sure whether I should be consulting them in certain activities that my organisation is planning. If only I knew which activities they were interested in, that would help me co-ordinate my relationship with them”.

As with all other partners, the relationship with international partners needs to be handled with the requisite professional respect and the acceptance that some partners of TAC might also have things to offer TAC. As a partner explains

“We are also experts in our own right and might also have some things that they [TAC] can learn from us too!”

4.6 Structure

TAC has a complex structure that is not immediately clear to members, as reflected in this quote from an interviewee:

“Initially it was hard to understand how TAC operated and where staff fitted in. The overlap between staff and leaders was initially very challenging.”

This section unpacks how decision-making processes and structures work, and examines the branch and membership structure as well as the office structure.

4.6.1 Decision-making processes

TAC's structures are bottom-up and are designed to ensure participation in decision-making. Branches are represented on provincial executives, and at least one person from each province sits on the national executive, the highest decision-making structure. Minutes of national executive meetings reflect intense discussion on all the key campaigns. In addition, at the secretariat level, leaders interviewed noted that the checks and balances of colleagues limited strategic mistakes. As one member explained:

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“Different people balance each other out. Some are very emotional, others more rational, some are radical and others adopt a more measured approach.”

Within the core team, there is a real sense of camaraderie between members. The dialogue is often volatile in reaching decisions. Once a decision has been made, differences are put aside and the organisation presents a unified face.

However, not everyone agreed that decision-making structures were open and democratic and that upward communication was effective. Some spoke of the tension between democratic decision-making and control, and the need for more decentralisation in decision-making. A few went as far as calling the NEC a “*rubber stamping process*”. When asked who owns TAC, most replied that the members do, but some had a different idea and believed that TAC was owned by the national office, the secretariat or its founders.

Given the often confrontational relationship with government and the politicisation of TAC work, some level of centralised control has been necessary to avoid an escalation in conflict. The flip side of this is that the National Executive has not grown as fast as some would have liked, and has been slow to build the required leadership capacity. In particular, several people noted that although the majority of members were women, the public face of TAC remained male-dominated.

With the changing political context and the need for a more decentralised structure focused on local level delivery, there is recognition of the need to decentralise much of the decision-making to provincial and district levels, as conditions will differ from area to area. Decentralisation will also accommodate the different capacities and strengths at local level.

4.6.2 National and provincial executives

TAC executive structures have provided a vehicle for mobilising individual and organisational support, and through this, building a culture of participation and democracy. However, concerns were raised around the role and composition of the executives and the secretariat structure. This is compounded by the overlap of personnel on the different structures.

The role of the executive needs to be focused on strategy and oversight. This includes an active role in partnership development. The national or provincial staff should ideally report to the executives as staff would report to a Board in a Section 21 Company. This line of accountability needs to be clarified within the entire organisation.

Membership of the various executives was also raised as a concern. It would appear that some of the members are neither active on the ground, nor are they mandated representatives from an organisation, thereby raising concerns about the capacity in which people serve on TAC. Several members explained the advantages of allowing non-members to play a leadership role. This affords an opportunity for bringing in skills, forging partnership programmes and broadening

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the base of TAC support. However, several interviewees commented that such representatives need to be mandated by their organisation to participate in TAC. Branch representatives need to remain active in their branches to retain their executive position. There was no consensus amongst interviewees as to whether TAC branch members should be elected through their branches or directly at the congresses. The advantage of the former is that they can be held accountable at a local level, the disadvantage is that talent could be lost to the region.

Finally, there seems to be some confusion around the role of the Secretariat. This is compounded by the overlap of personnel on the different structures. As the structure currently stands, it confuses management and leadership roles and it is not clear who is responsible for implementation and who for oversight.

4.6.3 Branches and membership

“If there are no branches then there would be no TAC. Therefore the organisation must do more fieldwork.”

Of the approximately 350 branches in existence, officials estimated that 220 were active. Active branches interviewed were inspirational. They spend hours, at great personal sacrifice, raising awareness, countering stigma, providing treatment literacy, facilitating CD4 cell count tests, monitoring government delivery and advocating for changes where necessary. One branch took their mandate even further and have begun generating income for its members and for future branch activities.

TAC Masikhule branch a catalyst for other activities

Masikhule branch is an inspiring example of how taking the initiative can make a difference to the operation of a branch. Most TAC branches are financially constrained, in that they are only able to obtain a few hundred rand a month for their activities (which typically comprise awareness raising campaigns, information sessions for the community, door to door campaigns or condom distribution). This branch has commenced with its own income generation initiative to raise funds for branch activities. All branch members who were in the financial position to do so, contributed R10, which was used to buy beads and strings, from which beadwork is being made and sold for branch activities.

“We want to do more and we know that the office is not able to give us all the money we need, that is why we started this beadwork project” explained a member of the group.

Branch members also stated their desire to obtain more technical skills from CBOs in their vicinity (in sewing and needlework for instance) so that their income generation project can grow. With their infectious enthusiasm and their desire to generate income to increase their activities, there is every reason to believe that they will succeed.

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Despite this being an inspirational example of what can be achieved with initiative, if branches become involved in fundraising, it is important to ensure that this is done with transparency and that systems of accountability are implemented to prevent fraud. However, most felt TAC had not maximised the power of its branches outside of seeing them as a base for mobilising people in support of mass actions. As the focus shifts to monitoring the government's ARV rollout, branches are likely to become the centres of TAC activity. This means that the most skilled and dedicated staff and members need to be working at branch level. The current trend of upward mobility of good volunteers needs to be stemmed. The evaluators encountered some examples of the collapse or significant weakening of a branch because leadership was either redeployed at provincial level or employed by partner organisations (e.g. MSF). An interviewee, noting this, pleaded for

“a conscious decision to redeploy strong members back to the branches”.

Similarly, several interviewees at the local level called for more resources to be channelled to branches and for greater equity in resources. Many branches were frustrated by the lack of resources to fund planned activities. There is also a perception that some branches are given preferential treatment.

Finally, there was a plea from provinces that branches need to work via the provinces and not the national office. Members spoke of how some branches bypassed the provincial office and went straight to the national office, who then responded – causing problems with lines of communication, accountability and management.

4.6.4 Offices

At a around the location of offices are based on demand and capacity and are a coincidence of history. While there is agreement that *“one size does not fit all”* and that provincial programmes need to be rooted in the local context, the inconsistencies between offices are not always because of different needs but are rather a product of resource allocation.

Without exception TAC has historically favoured urban locations above a rural presence. This was understandable when the organisation was focused on advocacy, but as the mandate has broadened to include service delivery around HIV/AIDS, a rural presence has become more important, as demonstrated by the recent mushrooming of district offices. Despite the recognition of the need for an increased rural presence, Limpopo and Mpumalanga provinces complained that they were deprioritised and left out of some activities and the chairperson's travel schedule.

At district level, more thought needs to be given to the role and function of the offices. The current arrangement of exclusive TAC offices does not make the best possible use of resources, and it would seem that there are untapped

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opportunities for partnership arrangements such as those that existed in the early days of both the Pietermaritzburg and Lusikisiki offices.

Within the national office, the questions centred around the structure of the team. Some felt TAC should explore the possibility of shifting more to geographic co-ordination rather than programme management. This would give co-ordinators a wider grasp of what was happening at the local level and might make more logistical sense, while ensuring that branches are not bombarded with information and contradicting requests.

4.7 Systems

With the exception of the financial system, all the systems within the organisation require improvement. This is the result of a combination of factors – the phase of development TAC finds itself in, its young inexperienced staff and its extraordinary pace of expansion. This section consolidates the findings under the following systems – financial, human resource, communication, administration and finally planning, monitoring and evaluation.

4.7.1 Financial

TAC has always kept a tight reign on the finances. Since its launch 4 members have been dismissed for fraud-related activities. Each case reported is investigated and, where necessary, prompt action is taken. As a staff member explained:

“TAC has zero tolerance of crime but at the same time fair procedures, and staff are given a chance to speak about the situation before any action is taken”.

The financial system is one which has been uniquely constructed to fit the organisation. It is designed to minimise the opportunities for corruption in a context of enormous poverty and inequality. Provinces put together a monthly budget and work plan. Once approved by the relevant people in the national office, the funds are transferred to an external fund administrator. No staff in TAC have signing powers. The fund administrators then release cheques based on budget and cheque requisitions linked to the approved budgets. At the end of each month the slips are reconciled and a list of outstanding vouchers is prepared. The system works in almost all the provinces (with some concerns expressed in Limpopo), although staff noted it was cumbersome and often resulted in delays.

A much bigger concern was the portion of the budget that is spent in the regions and the process of budget approval. Firstly, branches felt that they did not always receive a clear indication from the national office as to what was or was not funded. They also requested a move to longer term budget periods, such as a move away from monthly to quarterly budgets. This would avoid the current situation of repeated disorganisation or curtailment of activities at the last minute

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due to a lack of funds. Secondly, administrative staff complained that they are responsible for managing the budgets but have not usually been included in the decision-making structures, and were not always able to manage within the approved budgets. The recent road-show by the financial team to each of the provincial offices and the consultations with administrative staff have been a proactive response to addressing these concerns.

4.7.2 Human resources

Many of the issues under human resource systems are dealt with in the next section on human capital. The most important system considerations are the need to document all processes in writing, such as probation reviews and exit interviews, and to ensure transparency around the policies in respect of recruitment and performance management.

In addition, systems to support staff entry and exit are critical to a comprehensive co-ordinated induction programme and the reinforcement of the recently introduced probation and exit interviews.

Finally, the implementation of proper performance management systems was a consistent plea from interviewees. In some instances, the system is non-existent. In others, a system has been developed but is not being implemented. For example, TLPs are required to keep journals for the purpose of generating information that can be used to measure the success of programmes and for other purposes. However, with a lack of management feedback on an individualised basis, the system has all but collapsed and is now merely regarded as an administrative requirement rather than a management tool. The information, if properly and consistently collected, could prove to be extremely useful for monitoring and evaluation of the TL programme and for helping TAC conduct its advocacy campaigns.

4.7.3 Communication

“TAC assumes we (volunteers) are always free and at their beck and call. They inform us at the last minute of meetings and actions. And often the information is not complete, such as explaining why we must be at a meeting, such as this meeting with you.”

TAC spends a significant portion of its budget on electronic and telephonic communications. Despite this investment, communication emerged as the most consistent problem throughout every level within the organisation and between TAC and its partners. Poor communication is in part a consequence of a high turnover of leaders and staff at provincial level where institutional capacity is not retained, and in part about poor systems and practices.

Internal communication between offices and members and between the national office and the provinces was highlighted as a problem area. Complaints included that there was insufficient communication, that some of the communication

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occurred at the last minute, that incomplete communication sometimes resulted in confusion, and that e-mail was relied upon too much. Some examples follow.

Poor communication around meetings was pervasive. Most meetings are set up at the last minute and participants are not always clear on why the meeting has been called. This was corroborated during the evaluation, when several people did not know why they were meeting with the evaluators and in some instances had only been informed on the day of the meeting, despite plans having been communicated to offices weeks in advance of the meeting.

With a few exceptions, staff members noted that staff do not respond to “please call me” smses, thereby forcing members to use their own money to call the office.

Many of the staff rely on e-mails as the primary form of communication, even when people are sitting in the same office. However, not everyone checks their e-mail regularly, and some volunteers have limited access to e-mail and are therefore excluded. A volunteer explained:

“Any urgent matters should be communicated via the telephone not via e-mails as often it is only the office that gets e-mails regularly and we are left out.”

With the plans to expand the organisation further, the need to improve communication cannot be overstated.

4.7.4 Administration

TAC would benefit enormously from an efficient administrative system and administrative staff complement. In the course of the evaluation there were countless examples of project staff getting involved in logistics organisation, and then not being able to meet their own commitments. The organisation lacks many systems (office diaries, phone message systems and record-keeping) and those that do exist are not operating properly (for example, in/out boards, filing, membership cards and databases that have not been updated.) For most staff, this was raised as one of the biggest challenges facing the organisation.

These problems are compounded by the fact that many of the administrative personnel do not have any formal administrative training, do not always work as a team and can be territorial about their work.

4.7.5 Planning, monitoring and evaluation

“ People in this organisation need to listen to each other more and to be more sensitive to processes and not just output-focused.”

While TAC is excellent at planning its broad strategic approach and interventions, more detailed planning around tactics is weak. Often, plans are last minute and

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continually changing. In addition, several branches complained about the domination of the national office in planning processes. As an irate member explained:

“National office comes and says ‘No, do this now’. But we have our own plans and want to stick to our programmes. We do not want last minute demands from national.”

Using the evaluation process as a benchmark, it can be said that TAC is very receptive to evaluative comments if the organisation can provide the time to engage with the process. At the end of every meeting, participants are asked to evaluate the process. Too often, however, these are not used to inform the next process. In addition, in most instances, there is no system for providing feedback on the quality of work or workshops. Managers seem to be reliant on branch and staff reports. There is a need for more direct supervision, with managers and organisers observing the work of others within their area of supervision. An example of this is the new system being introduced in KZN TLP, where the co-ordinator plans to spend a week per month with each TLT and TLP team, using the opportunity to evaluate the work of the team, provide *in situ* training and ensure co-ordination.

4.8 Human Capital: Leadership

There were very different responses to TAC’s successes and failures in respect of efforts of the organisation to develop leaders. Some noted that one of TAC’s biggest achievements was that it had developed a cadre of post democracy civil society leaders, manifested in many of the secretariat and NEC members. Others were less positive and raised concerns about the continued domination of the organisation’s founding members and concerns around the failure to develop the next tier of leaders. In addition, several interviewees note that not enough attention had been paid to developing a cadre of PWA leaders.

When asked, leaders noted that TAC cannot overcome the race, gender and class inequalities in society. For example, TAC might include a range of people in a press conference as part of its efforts to change the face of the organisation, yet the media are insistent that they want to interview Zackie Achmat. The camaraderie within TAC is such that other leaders are able to joke about the situation and are committed to acting in the interests of TAC, namely, to get the message out, regardless of who the spokesperson is.

The evaluators’ findings were that the organisation has become a home for new civil society activists and that a cadre of impressive new leaders was slowly being developed. However, the organisation has not paid enough attention to empowering the new emerging leaders and there are still numerous examples of the founding core’s continued centrality to the organisation. Having said this, a real strength of the organisation is its flexibility with respect to the roles and responsibilities given to people. These are often fluid and allow for shared responsibility and opportunities. Sadly, most of these opportunities continue to be identified by the central founding core members.

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4.9 Human Capital: Staff

In general, TAC has an exceptionally dedicated team of staff. People are driven by passion for their work and camaraderie above all else. At the centre is the national team, all of whom carry a disproportionate load, work long hours (often too long) at great personal sacrifice, and rely on personal relations and a shared vision rather than systems to manage much of the work. In many of the provinces the same level of commitment and dedication was witnessed. The burden on the more resourced staff members is exacerbated by the employment of many under-skilled but committed people. As one member explained:

“We recruit people who are committed and think we can develop them without the necessary commitment to training and management support. This impacts on our workload and performance.”

Clearly staff development must become a priority. In a few instances staff did not seem to be carrying a fair share of the load, which indicates a need for better performance management systems. Finally, the work pace, especially at national level, cannot be sustained and staff are burning out.

This section comments on the human resource policies, practices and experiences of staff.

4.9.1 Staff recruitment

Finding the right staff makes the difference between success and failure of an office and cannot be over-emphasised. Yet, too often, the pressures of deadlines have resulted in compromised appointments. Evaluators were told on more than one occasion how

“we could not find the right person so we appointed x and will see how it works out during the probation period.”

This is not an ideal way to recruit, but if the organisation were vigilant during the probation period, this could be excused. However, in TAC's case, probation has generally been a paper process and several staff members who, managers openly agree, did not perform in their probation periods were appointed as permanent staff members and continue to perform below standard. A plea from a volunteer in KZN *“Don't rush appointments”* is echoed by the evaluators. This includes allowing an adequate period of time for recruitment, unlike the short period of time allocated in the case of a critical post being filled during the evaluation.

At the same time, there needs to be a clear commitment to fill vacant posts, even where it may not seem urgent, before a crisis arises. A few provincial and district staff reported that posts lay vacant for months in the various provinces once an incumbent left.

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The actual recruitment process also came under criticism. TAC advertises most posts either internally or externally, depending on the seniority of the position. However, from time to time the leadership decides to re-assign staff or promote an existing staff member or volunteer. In many of these instances the appointments were not preceded by an advert, resulting in concerns around equity, access and transparency.

Staff employed are often set up to fail. The organisation does not have a sufficiently comprehensive induction programme that brings new employees "up to speed" and instead seems to drop people in the deep end. New employees spend a short period of time in the national office, most of which is spent fighting to secure a slot in colleagues' diaries and watching a few mandatory videos.

4.9.2 Staff job descriptions

Five main issues emerged under the category of job descriptions: these are the need for consistency, clarity on reporting lines, co-ordination, performance based job requirements and working conditions.

First of all, it was found that there was a disparity between many people performing the same job who either did not seem to be doing the same work or did not understand the work in the same way. This disparity in job descriptions was most pronounced amongst organisers and administrative staff. In the case of administrative staff there is some confusion among administrators about whether their roles are purely administrative or not. Several of the administrators in the provinces indicated a desire to move into projects, and a few had managed to realign their work to allow for this, but this then left gaps in the administration. This is a traditional area of tension within NGOs.

Secondly, the structure of reporting lines has not been optimal to date, with some provincial programme staff reporting directly to the national office, thereby causing management confusion, tensions and at times, chaos. A repeated example cited to the evaluators was that of the provincial treatment literacy co-ordinators who reported directly to national office and were therefore not accountable to the provincial co-ordinator.

"How does someone in national know which our priority areas are and how to best allocate practitioners in a way that enhances the local programme?"

questioned one co-ordinator.

Thirdly, there is a lack of co-ordination between different departments, who operate in silos, creating all the traditional problems of duplication, contradictions and inefficient use of resources. This lack, as well as poor co-ordination between staff and leadership, emerged as critical issues for TAC. For example, the TL project and the organising department programmes have operated in parallel, rather than in a co-ordinated fashion, and the job descriptions of provincial co-ordinators overlap with the mandate of the Provincial Executive Committee

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(PEC) chair. In most regions it was not clear to staff members who is responsible for what.

There are also very varied demands on staff – a few people seemed only to be required to do work that amounted to a half time post while others are working to meet the demands of two posts. For example, one project co-ordinator interviewed could only report on activities that accounted for less than half the working month, while some national staff reported working an average of an 11 hour day, seven days a week. This again points to the need for a performance management system, which several staff and volunteers suggested was needed.

Finally, bearing in mind the modest salary scales, a number of staff commented that they would like to see more generous working conditions such as sabbaticals, study leave and better training opportunities.

4.9.3 Staff development

Staff development is one of the weakest areas in TAC. In general, the pace of the organisation works against the implementation of any real programme to empower and develop people employed. Those who develop do so because of their own determination rather than because of any efforts on the part of the organisation. Yet, given TAC's relatively young and inexperienced team, it is also one of the areas of greatest need. A manager commented that TAC cannot continue to be serious about building capacity of staff in provinces, if such small amounts are allocated to capacity building programmes, e.g. only R 40 000 is set aside for staff courses every year. Staff development could focus on a number of general areas such as working with volunteers and public speaking, as well as others tied to specific job competencies such as computer and secretarial courses.

TAC has begun to use mentoring very successfully with the appointment of mentors to each provincial office and a mentor for the Development Officer. Both these positions seem to be successfully building capacity. Provinces all spoke of the value added by experienced leaders mentoring them. The model of a consultant supporting and mentoring staff, as in the case of the development officer, is a useful model and means to build capacity, meet the equity targets of the organisation and ensure that a quality service is provided.

Some interviewees suggested that this idea should be expanded to include the deployment of external mentors, as staff are generally too busy to devote enough attention to mentoring. In the same way as mentoring has been used, peer review could offer some benefits to the team through, for example, one organiser working with another colleague in a province for a period. This system has been used very effectively in local government in South Africa.

Finally, staff noted that there is a bias in assumptions about the nature of HIV work, which exaggerates its bio-medical character, and underplays the importance of the psychological aspects of HIV. Staff members are continually

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confronted with loss, and a few noted the need for a system of debriefing or counselling to help them deal with the traumas of the working environment.

4.9.4 Staff management

Three key management issues emerged: consistency of conditions, better management of staff and regular management meetings.

TAC's salary policy is commendable in two respects. Firstly, the organisation has refused to bow to pressure to escalate salary levels along with the majority of the NGO sector, standing by its commitment to minimising the divide between staff and volunteers. Secondly, TAC publishes its salary bands on its website, in line with its commitment to transparency. Despite these commendable efforts, discrepancies, for example, in salary levels between staff doing similar jobs or between project staff and administration staff, have resulted in some resentment and unhappiness, thereby impacting on the morale of the team.

The need for better management was a consistent cry amongst staff. This ranged from the need for more time from managers with those they supervise to the need to change the way in which staff are managed.

“We would like to see clearer performance management standards with targets for each staff member, clear reporting systems and a performance management system.”

When staff are not performing, the standard response seems to be to employ another person to do the work, as has been proposed with the introduction of provincial managers, rather than dealing with the performance problem at hand.

In addition, staff commented on the fact that managers are often too busy to provide feedback on work. This results in staff and volunteers not feeling appreciated, a collapse in systems and demotivation of staff. For example, TLPs mostly completed detailed journals of their work in the early days. However, a lack of individualised feedback has downgraded these to mandatory forms that need to be completed. A second example was given when a staff member explained how s/he had circulated a proposal three weeks before a meeting, received no feedback and then in the meeting was soundly criticised. The appointment of a new manager has gone some way to addressing these concerns. Regular weekly meetings with national programme and provincial staff have been introduced, allowing for co-ordination, feedback and performance monitoring.

Thirdly, more regular meetings are needed in the organisation. Again, the new manager has made significant progress here with the introduction of co-ordinators' meetings, regular staff meetings and administrative team meetings in the national office. This now needs to permeate other tiers of the organisation. In addition, and as far as possible, meetings need to be scheduled in advance.

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4.10 Human capital: Volunteers

TAC has three categories of volunteers. In the first instance there are the TAC members, the backbone of the organisation. Secondly, there are those members who volunteer their services to work in a district, provincial or national office – referred to as local volunteers in this section. Finally, there are a handful of dedicated professional volunteers, largely foreigners, who work at the TAC national office and will hopefully in the future work at the provincial offices. This section of the report unpacks the policy, procedures and practices in relation to TAC volunteer membership.

4.10.1 Volunteer recruitment

TAC's volunteer base is both its biggest strength and its greatest weakness. It provides commitment and energy, but also, because it is largely made up of poor and HIV-positive people, it is not always able to sustain the momentum required. Through its branches TAC has an active recruitment strategy and programme. TAC has 10 181 members registered on the database. In a recent round of constitutional voting, 3 084 of these voted, indicating the possible number of active volunteers. Most public actions like marches attract a lot more people, with estimates between 15 000 and 18 000, indicating a base of around three times the membership, made up of people who are sympathetic to and willing to be active supporters of TAC, albeit not through attending branch meetings. Regardless of the membership number used, TAC is one of the larger social activist membership organisations in South Africa.

Currently, however, TAC has no recruitment strategy targeting more affluent members of society. As a result, most of the members are either unemployed or under-employed people living in situations of poverty. Activities are generally held in the day and notification is provided at the last minute, making it almost impossible for working people to be active members. Several leaders raised this as a gap and a priority for TAC in the future.

Within the membership there was no evidence of a policy around local volunteer work. Generally volunteers are self-selected. They are not required to undergo any induction training and in general are used to plug holes and service emergency needs.

Within the professional volunteer cadre, TAC again does not have an active recruitment strategy and has worked on the basis of supply rather than demand. Consequently the organisation has not attracted any national professional volunteers, many of whom might also be happy to offer their services if the opportunity presented itself. Every year TAC receives dozens of applications from foreign nationals offering their services to TAC and currently works with 7 foreign volunteers per annum. TAC does not pay for any of the costs of these volunteers.

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4.10.2 Role and management of volunteers

TAC would not exist in its current form without its volunteers. Members, whether they be infected, affected or concerned social activists, are what differentiate TAC from so many other NGOs and provide the base for TAC campaigns, legitimacy and power. Once volunteer members have been recruited they are expected to participate in TAC activities through their branches and participating organisations.

In its staff and volunteer policy TAC states that "volunteers should be encouraged to come to the TAC offices, but will not be remunerated unless they are doing clearly allocated tasks". It also states that TAC will assist with skills development and training of volunteers in a strategic and organised manner, not on an ad hoc basis. Volunteer skills development is the responsibility of the provincial co-ordinator (TAC policy, 2004).

Yet in the visits around the country we generally found the policy was not being applied. The use of volunteers varied considerably from office to office. In some instances, volunteers remained the backbone of the office, while in most cases volunteers felt they were being increasingly replaced by staff. If these positions have been agreed to, volunteers are paid a small transport allowance and get a meal of bread, cheese and spreads while working in the office. Many of the local volunteers interviewed did not have clearly defined roles and did not have opportunities for progression or exit. Volunteers are often excluded from staff meetings and are not regularly briefed about events, compromising their usefulness. In addition, volunteers in offices across the country, with the exception of Cape Town, complained about not being sufficiently welcome in the office. Tensions between paid staff and volunteers existed. In many instances it was clear that staff had no idea of how to work with, appreciate or maximise volunteer input and therefore regarded them as an encumbrance rather than a resource.

Despite these problems, many of the volunteers could not speak highly enough of their time with TAC. It provided them with a reason to live, a community of colleagues, a sense of purpose and a meal each day. As one volunteer described:

"I live with my gran. She gets very upset when I stay at home and don't go to work at TAC. She knows it makes me excited to wake up for work and happy. If I stay home for a few days I get depressed and she says – Why don't you go and see if there is work at TAC tomorrow? When I go I always feel better."

The role of professional volunteers is often a bit more defined, but many of the problems are the same. There is no clear programme of how to use volunteers and maximise the inputs possible. While some of this has been addressed by allocating one of the international volunteers to co-ordinating all volunteer input, a co-ordinated system is not possible without real input, commitment and time from staff. Staff are often too busy to spend time with volunteers to equip them to help.

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This, combined with the absence of a clear system of decision-making, makes it difficult to move from ideas and research into implementation.

The new system being proposed, of allocating volunteers to a staff member, will alleviate the problem in some cases and exacerbate them in others, as volunteers will be almost exclusively reliant on their staff member to guide their work. In addition, the imminent departure of the current co-ordinator is of concern, as she has been playing an invaluable role that the organisation has come to rely on.

Finally, relations between the international volunteers and local staff and volunteers have had their ups and downs. Internationals often felt there was a perception (generally false) that they were wealthy and therefore could be expected to provide – loans, food or transport. This points to the need to train all staff in the handling of volunteers, be they local or international, as the organisation's effectiveness would be seriously undermined without this cadre of dedicated individuals.

4.10.3 Development / training of volunteers

TAC's biggest volunteer training programme is its treatment literacy programme, the success of which has been detailed earlier in this report. A new programme targeting media training is modelled on the treatment literacy success and looks set to produce the same positive impact. However, neither of these programmes provide broad training on how to be an active citizen. Here TAC has initiated its leadership schools. As discussed under the organising department's programme review, this intervention has had limited success. In the main, TAC relies on leaders trained in other organisations to play key roles in its ranks at the local level.

We found no evidence of a systematic programme to develop volunteers – be they members, people who volunteer to do work in the various offices or professionals. There was also no career path planning for volunteers who do work in the offices.

4.10.4 Payment of volunteers

Initially no volunteers were paid, but they did receive a transport allowance of around R10 per day and the office provided a lunch of bread to all those who were working in it daily. More recently the treatment literacy programme started to pay a bursary to volunteers linked to an expectation of certain deliverables that are reported on monthly. This model is being mirrored by the media programme. The introduction of pay has resulted in tensions between paid volunteers and unpaid volunteers.

In some areas there has also been the inevitable decline in volunteer energy of those who are not receiving anything. People feel they should not be doing so much work if some people who work as hard are being paid. This points to a

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danger not uncommon in the non-profit and community sector of disincentivising volunteerism, with potentially negative impacts on the life and work of TAC.

TAC needs to guard against this proactively by designing clear entry and exit criteria, caps on the period a person can benefit from a payment, and clear systems for rotating the opportunities to people with similar capabilities. The model used by the Expanded Public Works Programme (EPWP) is one possible role model for TAC. In theory this programme limits participation to one person per household, to a maximum of 24 months in any five year cycle per person, and prioritises the selection of people who have already been volunteers. In this way it hopes to build on the culture of volunteerism and rotate the opportunities. Finally, there also needs to be vigilance against favouritism and patronage by staff or leaders.

4.11 Organisational culture

TAC's biggest strength is its volunteers and staff, who are committed to equality, human rights, poverty eradication and democracy. This permeates almost every aspect of the organisation including the way it defines its strategy, the way it does its work, and the salaries it pays its staff. In part because of this commitment and dedication to secure a better life for people living with HIV/AIDS, the work is always urgent and never-ending.

The dominant work culture is reactive and crisis-driven, as the organisation lurches from one travesty against its members and HIV+ people in general to the next. For example, several plans were put on hold when Dr Rath entered the South African scene and launched his vitamin campaign, to enable TAC to arrange counter meetings, demonstrations and advertisements. While this campaign was important, the South African landscape to date suggests that there will always be a crisis to respond to, and at some point the organisation needs to decide how much of its programme it is willing to destabilise to respond to these crises.

4.11.1 Values

TAC is a "political", value-based organisation, committed to honesty, equality and human rights for all. It is an attractive home for people who share these values.

Given the response of the South African government to HIV/AIDS, the bulk of TAC's work has been in opposition and therefore it has become politicised. Most TAC members thrive on the political atmosphere. As an official commented:

"There is nothing like a crisis with the Minister or Rath to get TAC galvanised and taking action."

At the heart of the organisation is a strong sense of morality. This has enabled TAC to mobilise a broad cross-section of people in support of its fight, including the previous President Nelson Mandela. As Friedman explains: "The TAC approach assumes, therefore, that it is possible for a small movement with

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limited organisational power to compensate by appealing to a sense of compassion and fairness across many of the social barriers which are often assumed to impede a common morality” (Friedman, 2004, p. 17).

These values and moral base are not limited to TAC’s external operations. They are also woven into every aspect of the organisation. There is a demonstrated commitment to honesty, treating all members equally regardless of their race, class, status or sexual preference. One example of this is the issue of race, which tends to impact on the culture of almost every organisation in South Africa. Race emerged in only one set of interviews, in the Western Cape. For the rest, the issue was not raised either directly or indirectly. Another is a comment from an official of the Department of Health who noted that “*honest leadership*” has helped to ensure that even in a crisis situation it is possible to bridge the divide and maintain communication.

A big issue relates to the organisation’s language policy and practices. Staff are not always sensitive enough to language differences within the membership. Meetings are often only held in one language, consequently excluding some of the members or potential members. The most dramatic example of this was a treatment practitioner who spoke in her interview about training provided in a language she did not speak. She left the training workshop feeling very insecure about the content she had been given, and asked a peer to retrain her. Most of the written material is in English, which creates a barrier for many members.

Finally, while on the one hand TAC is very tolerant and non-discriminatory, there is a level of over-confidence, often perceived as arrogance, and resultant intolerance of those who disagree politically. As one member explained:

“The fact that we have won so many struggles makes us think we are always right.”

“In TAC you are either for us or against us”

was another member’s view.

4.11.2 Work ethic

TAC is extremely demanding of its staff and volunteers. This brings out the best in people, as reflected in the highly committed staff as compared with many other NGOs, but it also excludes people who for personal reasons either are not able to or choose not to make the organisation their entire life.

It has also created a frenetic culture that often does not pay enough attention to the needs of individual staff or members. As a treatment literacy worker explained:

“I was shocked that one of our treatment literacy trainers had a CD4 count of 10 and no-one had picked it up or stopped to ask.”

The frenzied pressure also makes the work difficult, as a staff member reported:

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“Everyone is so busy it is almost impossible to get them to sit down and provide inputs, making the work impossible”.

Another dominating characteristic of the work ethic at TAC is a perception of a lack of professionalism. This took many different forms, for example:

- TAC does not have a reputation for time-keeping and punctuality, and several members spoke of their frustration at being kept waiting. As one member interviewed explains:

“The least enjoyable thing about TAC is waiting for provincial staff to pitch up for meetings. The worst was waiting for four hours.”

- Several volunteers and donors commented on broken promises and commitments, for example, staff failing to arrive for meetings and often only communicating that they will not be attending minutes before the event, leaving a vacuum.
- Staff and leaders commented about the lack of boundaries between the personal and professional amongst the leadership. While this might have been appropriate when TAC was a small organisation, akin to a family, it is certainly no longer appropriate as the organisation has expanded.

The evaluators experienced some of these problems first hand, for example, phone calls were not returned (in the case of Cape Town this resulted in the cancellation of the evaluators’ programme after six weeks and nine telephone calls). Also, despite having confirmed times for interviews, on more than one occasion the evaluators were kept waiting while staff took time out for a coffee or lunch break.

4.11.3 Gender relations

Gender emerged as a key issue for TAC. Before commenting on some of the issues, it is important to note that TAC did not invent the gender prejudices which permeate our society and inhibit women from playing a more active role. However, given TAC’s commitment to equality and its constitutional provisions which state that “consideration must given to gender representation and the need to promote a leadership of people living openly with HIV/AIDS”, some comment is appropriate.

On the positive side, TAC has changed the gender landscape in communities, shown, for example, in the well known story that since TAC’s arrival in Lusikisiki, women have started wearing trousers, women speak at meetings at which chiefs preside, and gay and lesbian people have started living more openly. In urban areas, women interviewees spoke of developing a confidence to speak in public:

“I never thought I could stand up and talk in front of people and now I do it almost every day thanks to TAC”.

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Despite significant progress around gender and some representation of women at national and even provincial leadership levels, TAC still has some way to go before it becomes a truly non-discriminatory organisation and a vehicle for gender equality (Friedman, 2004). As is the case in society, in many instances women are still underestimated in the organisation. Most of the branch chairs remain men and the evaluators encountered a lack of gender consciousness on several occasions. For example, one organiser explained that women don't like to lead, therefore they were not suited to being branch chairs; while nationally the treatment literacy programme, with its majority of female employees, is fondly referred to as the "*nursing school of TAC*", with men dominating the organising department.

The organisation needs a comprehensive gender policy that guides every aspect of its work. As a staff member explained:

"There is a denial of the fact that women are not visible and that until this is recognised there will be no way forward".

Another member suggested that partnerships with other organisations working on gender issues need to be prioritised, and the lessons and programmes from these organisations brought back into TAC.

4.11.4 People with AIDS

As with gender, TAC still has a way to go before it can call itself a truly PWA-led and driven organisation. Members are unequivocal in their praise for TAC's work on destigmatising HIV/AIDS and helping to create an enabling environment for PWAs. There is also recognition of the work undertaken to set up a PWA sector within TAC and to ensure that this is resourced and active. Across the board, however, interviewees called for increased visibility and representation of PWAs on TAC staff, in leadership structures and among its volunteers receiving bursaries. Just 11 of TAC staff are living openly with HIV/AIDS. This number does not reflect the composition of TAC membership nor of commitment to developing a PWA leadership.

"TAC employs people who don't know their status. Why?"

was the question from one of the PWA volunteers who had found the courage to disclose since joining TAC. Other members pointed out that one of the strengths of TAC was the fact that it was a home for both the infected and affected, and that any over-emphasis on status would detract from this. Regardless of the approach, TAC needs to be more proactive in the development of its PWA sector.

Finally, there did not seem to be a consistent approach to or policy for dealing with people who are regularly incapacitated due to illness in respect of their work within the team.

"TAC is very lenient on PWAs working in the organisation,"
commented a PWA staff member.

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4.11.5 Youth

Given that such a large percentage of TAC members are youth, the percentage of its financial, human and material resources devoted to youth programmes and issues of importance to the youth, is small. TAC has not paid sufficient attention to youth priority areas such as prevention, either through its own programmes or through strategic partnerships with other organisations. Youth programmes are quite poorly resourced. It is also widely acknowledged that a meaningful youth intervention will play a vital role in halting the spread of the disease and for that reason, it is important for TAC to seriously consider scaling up its resources in this area.

4.11.6 Learning and change

TAC's approach to learning and change is contradictory. On the one hand the organisation was commended by interviewees for encouraging members to read and expand their horizons. As a volunteer explained:

“In TAC you are in a university. You learn and grow with knowledge”.

This culture of learning is best captured in the work around public education and treatment literacy. In addition, TAC has developed an excellent tradition of reviewing the political context and of rooting its campaigns in an analysis of the context.

Despite the success around individual learning, some still felt that TAC members and staff did not read enough, inhibiting the opportunities to play a more active leadership role.

TAC was seen as an organisation that had not been able to transform itself into a learning organisation. The pace of the work is so fast that the organisation seldom stops for long enough to really celebrate its successes or reflect on the learning from each campaign. This is evidenced in the lack of systems and systematic branch level programmes in the organisation.

In addition to this, several members spoke about their fear of commenting or criticising.

“I am scared of commenting publicly because of fear of being criticised by national office. Therefore I only speak when I have prior approval.”

Interviewees added that at times TAC is intolerant of different views and finds it hard not to perceive these as an attack on the organisation. As a member of a partner organisation explained:

“TAC tries to make people think like it”.

5 Conclusion

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5.1 Relevance

Without exception, interviewees agreed that TAC was a highly relevant organisation. HIV/AIDS is clearly one of the most critical challenges facing South African society today. TAC's relevance is not limited to the HIV/AIDS field only. Civil society organisations and donors look to TAC as a role model for defending socio-economic rights and for advocating for constitutional rights in South Africa. Internationally TAC is hailed as one of the most successful advocacy campaigns, providing excellent case studies of how to combine mobilisation, litigation and mass action.

5.2 Effectiveness

While TAC has not succeeded in changing the attitude of the Minister of Health and a few other senior members of government in respect of HIV/AIDS, it has been very effective as an advocate for HIV-positive people.

The court victories and their subsequent impact on the lives of HIV-positive people provide the first example of TAC's effectiveness as an organisation. Thanks to TAC's work, South Africans have access to prevention of mother-to-child transmission treatment, cheaper drugs and a state-funded ARV rollout programme.

A second demonstration of TAC's effectiveness is the positive impact of the organisation on the lives of its membership, as the following series of quotes demonstrate:

"I am living because of TAC"

"TAC wants me to know my status and talk publicly about my status"

"TAC gives hope on how to live positively"

"TAC puts self-esteem back into people"

"In TAC you are in a university. You learn and grow with knowledge".

TAC has been one of the most effective civil society organisations in recent times. It has mobilised thousands in support of its demands. For every signed up member, TAC has another three active supporters in partner organisations or communities. These supporters are regularly called upon to participate in mass action. Collectively, the membership and active supporters are equivalent to around 10% of those needing ARV treatment in South Africa.. Obviously this is too simplistic as many TAC members are not HIV+ and/or do not need treatment.

5.3 Efficiency

TAC is very efficient, if one regards the TAC annual budget as a cost per HIV+ head in South Africa. Taking the 2005 year end budget as the standard, TAC spends R3.52 per HIV+ person per year. The economic benefit of the victories won far outweighs this cost. Even if one took the TAC costs as a cost per

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member, the economic benefits of the victories far exceed the cost of R1 837 per member per year.

Administratively TAC is less efficient, with an average of 40% of the budget allocated to operating overheads and 60% to programme-based activities.

5.4 Sustainability

There are three aspects to sustainability: financial, human and impact sustainability.

Financially, TAC is not sustainable outside of donor funding. The organisation is reliant on a small pool of longstanding donors for the bulk of its funds. There is organisation-wide recognition that TAC needs to diversify and expand its donor base. The efforts to tap personal donations through the Treatment Project is commendable and offers opportunities for expansion.

TAC has been invaluable in building the skills and capacity of thousands of volunteers and creating a cadre of post-1994 activists experienced in using the rights enshrined in the Constitution. A major weakness of TAC is the demands it places on its core staff, most of whom work in excess of a 12 hour day, 6 days a week. This is not sustainable.

Finally, the treatment victories won have been secured through courts and mass action and resulted in new policies and the introduction of national programmes. These are unlikely to be undermined in the short-to-medium term, regardless of whether TAC continues or not.

6 Recommendations

Given the large number of recommendations made, these have been divided into short (i.e. immediate), medium (i.e. within a year) and long term recommendations. The recommendations have also been clustered under the various section headings used in the findings, each of which is repeated under the short, medium and long term.

6.1 Short term

6.2 Strategy

- Slow down the pace of growth of the organisation.
- Deprioritise the national focus, allow for local and provincially based campaigns and cultivate a working relationship with provincial, district and local government.

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6.3 Programmes

General

- Decentralise the management of all national programmes to existing provincial structures.

Treatment Project

- Formulate clear exit strategies, e.g. an exit strategy for TP recipients to local ARV sites where they exist.
- Reorganise donor administration of TP. The current reorganisation to provide for direct mails to donors needs to be implemented as soon as possible, providing systematic reports and periodic communication with donors on the progress of the TP.

Treatment Literacy Project

- Enhance networks with other organisations producing treatment-related materials, e.g. Soul City.
- Develop a clear framework for payment of bursaries linked to an exit strategy, along the lines of the EPWP.

Organising

- Shift from the current ad hoc campaign-driven approach to a programmatic approach which includes clear targeted outputs, skills to be developed and interventions to achieve these.

Policy, research and communication

- Redesign the website and all media outputs to make them more attractive, user-friendly and accessible.

6.4 Funding

- Ensure that management prioritises donor relations and improves donor communication.

6.5 Relationships

- Reprioritise partnerships and engage and consult partners around both the TAC and partners' own strategies and programmes to facilitate collaboration and co-operation.

6.6 Structure

- Restructure the NEC, allowing it to provide the requisite oversight. This requires changing all organisational representatives to mandated appointments and barring staff from holding positions on NEC other than the general secretary post.

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- Restructure the Secretariat to comprise the NEC management team, namely the chair, deputy chair and treasurer and the employed management of the organisation.

6.7 Systems

General

- Set aside the time required to develop robust systems, for example, databases of media contacts, members database, lists of suppliers, procurement guidelines, travel regulations, recommended rates for various budget items, etc. This is something that professional volunteers could be assigned to develop. However, work done will need regular management input if it is to contribute to robust and useful systems.

Administration

- TAC needs to take the time to develop appropriate systems, train staff in the systems and manage the ongoing use of the systems introduced.
- Urgently recruit an experienced administrative manager and give this person management authority to train and manage the existing core of administrative staff.
- Send materials directly to districts and ensure that each district develops a distribution policy that covers every branch in its area.

Human resource systems

- Fast-track the development of a comprehensive performance management system, including the training of managers in the implementation of the system.
- Develop a staff induction programme and the national implementation of the new system around exit interviews for staff departing.
- Advertise all posts, develop a competency framework for interviewing new staff and introduce performance-based contracts.

Policy, research and communication

- Provide at least two days' notice for any meeting, preferably more, along with details on what the meeting is about and why members are required to attend. In addition, develop a system of communication trees for volunteer communication.
- Prioritise the regular management meetings of staff already initiated by the new national manager, as well as a collective calendar/ diary for each office.

6.8 Staffing

- Define the role of both staff and volunteers, including the inter-relationship between the two, to address the current tensions and the "staff creep" into areas traditionally serviced by volunteers. Train all staff in volunteer management.

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- Reassess the volumes of work and levels of responsibility assigned to each staff member and ensure a more equitable distribution of both. This requires developing a culture of trust and delegation.
- Avoid hasty recruitment decisions and, where no suitable candidate applies for a post, re-advertise and put in place an interim solution, even if this involves the cost of employing short-term skilled consultants to plug the holes.
- Precede every permanent appointment by a probation period and performance appraisal. Any concerns that arise in this period need to be confronted head-on to avoid longer term problems and costly terminations.
- Prioritise staff development, given the predominance of staff with relatively low levels of formal training and experience, both in the budget and in staff management.
- Develop a more professional demeanour and attitude amongst staff.

6.9 Volunteers

- Assign the responsibility of managing volunteers to specified staff, especially the pool of international and professional volunteers.
- Review the system of stipends, bursaries and payment of volunteers and ensure that it is based on transparent and consistent criteria and is neither exclusive nor static.

6.10 Culture

- Take explicit steps to transform the current culture, including providing trauma counselling where needed, enforcing the "time in lieu of overtime" policy and the introduction of sabbaticals. The current work ethic demands 110% of staff. This is not sustainable and has resulted in burnout of core members and volunteers within the team.

6.11 Medium term

6.12 Strategy

- Develop a partnership with a public health organisation or recruit medical and other public health expertise into the organisation's own ranks.

6.13 Programmes

Treatment Project

- Reconstitute the TP as a component of a broader advocacy programme through developing the required experience and systems in partnership with public sector doctors committed to getting a site registered. Targets should be linked to the number of sites the organisations would like to see created, rather than the number of people on treatment.

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Treatment Literacy Project

- Mainstream the TLP in the organisation.
- Get training accredited.

Organising department

- Develop a clear induction programme and an ongoing structured leadership school programme that taps the best skills and expertise in the organisation and aims to build real capacity around a set of identified competencies.

International

- Redefine the strategy of the programme in a way that harnesses partners' capacity and links to other programmes in TAC. Communicate this to partners and potential partners.

6.14 Funding

- Provide opportunities for programme exposure to donors (and media). For example, invite donors to attend a treatment literacy training session.

6.15 Relationships

- Actively engage social actors such as teachers and workers, beyond partnerships with the leadership in these organisations. This could include focused campaigns, treatment literacy and partnership programmes.
- Expand the network amongst health professionals.

6.16 Structure

- Develop structural models that facilitate ongoing learning and mentoring of staff, as most staff are inexperienced. The current system of mentoring has been well received but is ad hoc and limited. Ongoing regular mentoring needs to be sourced either through the relocation of senior staff to offices or through the recruitment or contracting of mentors.

6.17 Systems

Human resource systems

- Develop an internal system of peer learning linked to new staff shadowing experienced staff, or exchange visits where staff are exposed to different situations that could facilitate their learning (both inside the organisation and in partner organisations).

Planning, monitoring and evaluation

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- Improve planning systems to provide for advance planning, review of outputs agreed during planning and future planning based on the lessons of prior experience. We recommend that the organisation anticipates that an agreed percentage of its time will be caught up with reactive campaigns that emerge after planning meetings have taken place, for example, the Rath saga, and that management monitors these interruptions to ensure they do not derail the rest of the work.
- Give the same attention to reflecting on the internal functioning and infrastructural needs of the organisation as the organisation currently gives to political reflection.
- Develop a culture of feedback where management is open to input from staff, volunteers and external stakeholders, and appropriate mechanisms to facilitate the feedback, for example, annual partner reflection and planning sessions, a column in the newsletter and regular management meetings with staff.

6.18 Volunteers

- Induct every volunteer wanting to play a role in the office or providing a special service into the organisation and require them to complete a reasonable training period before being deployed.
- Develop volunteer career paths with real options for sustainable learning or employment.

6.19 Culture

- Educate staff and volunteers around gender, and mainstream gender into every programme within the organisation. This should include partnerships with other organisations tackling the issue.
- Place increased emphasis on the leadership role of PWA volunteers.
- Develop a culture of open debate on diverse political perspectives and approaches to issues.

6.20 Long term

6.21 Programmes

Organising

- Develop a clear strategy around prevention, and prioritise the focus on youth.

Policy, research and communication

- Develop marketing materials targeting professionals and middle class volunteers.

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6.22 Funding

- Shift the financial base to bring in more corporate and local donations.

6.23 Structure

- Reconceptualise the role and location of district offices. Districts are the face of implementation and require highly skilled staff, able to work without supervision. Current office arrangements do not use resources optimally and options such as sharing office space with a partner organisation should be explored.
- Employ a bottom-up approach starting at branch level with increased decentralisation of staff, leaders and budgets. Consciously redeploy people back to branches.
- Explore a geographic national management structure, as opposed to a programmatic approach, to facilitate integration between the programmes.

6.24 Volunteers

- Develop opportunities for middle-class working members, such as a “buddy” system for people on ART, or a roster for giving talks at Rotary, churches, etc.

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7 References

7.1 Cases

Pharmaceutical Manufacturers' Association of South Africa and Others v. The President of the Republic of South Africa, the Hon. Mr NR Mandela and Others, Case No 4183/98, High Court of South Africa (Transvaal Provincial Division)

Minister of Health v. Treatment Action Campaign and Others, 2002 (10) BCLR 1033 (CC)

7.2 Articles

Friedman and Mottiar, "A Rewarding Engagement?: The Treatment Action Campaign and the Politics of HIV/AIDS", 2004

Heywood, "How South Africa's HIV/AIDS National Treatment Plan was Won: Sustaining a Civil Society Campaign for Socio-Economic Rights", 2004

Heywood, "Shaping, Making and Breaking the Law: How South Africa's HIV/AIDS National Treatment Plan was Won" (Draft) November 2004

Le Page, "Truth and Treatment – The TAC's HIV/AIDS Literacy Programme in 2004", March 2005

Swedish International Development Cooperation Agency (SIDA), "Report on the Pre Award Survey of the TAC", April 2004

SIDA Report, "AIDS: The Challenge of this Century – Prevention, Care and Impact Mitigation", 2001

Reeler, "Wola Nani organisation evaluation", 1998

7.3 TAC

TAC website, policies and various internal reports provided by staff.

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8 Annexure 1: Terms of Reference

Why Conduct an Evaluation of the TAC?

There are two primary reasons for conducting an evaluation of the TAC:

- The TAC will benefit from an evaluation by learning more about the weaknesses and strengths of the organisation, thereby allowing it to take action to remedy weaknesses and consolidate strengths.
- Other organisations, in South Africa and across sub-Saharan Africa, might benefit from an evaluation by using the lessons learnt, both good and bad, to improve their organisations.

Furthermore, any organisation spending large donor funds has a duty to the public to conduct an evaluation occasionally to determine if the organisation is of benefit to society and how it can be improved.

What Should the Evaluation Examine?

The evaluation should examine and make findings on the strategy and impact of the organisation and on its internal effectiveness and efficiency.

Impact (40% of effort)

- what TAC has achieved and not achieved during its existence
- political impact of TAC
- the TAC's current status in South African civil society and its potential to continue operating successfully, meet its objectives and grow
- reproducibility of aspects of TAC both in and outside of South Africa.

Internal effectiveness (60% of effort)

- the factors that have been important in TAC's successes and failures
- the TAC's operational systems including its structure, financial systems, fundraising mechanisms, communications, research, human resources, projects, IT infrastructure, and functioning of national provincial and district offices.

Who Should Conduct the Evaluation?

A team consisting of two evaluators has been established. They are independent of the TAC. They are:

- Jacqui Boule, who has experience in management and organisational development, particularly in the NGO sector
- Tenu Avafia, who is a regional legal expert.

Atlantic Philanthropies, as one of the funders of the evaluation and one of the TAC's longest-standing partners, is welcome and encouraged to observe the evaluation, as well as to discuss the evaluation with the evaluators. However, to maintain independence, it is better that Atlantic Philanthropies does not participate in the writing of the evaluation, though the organisation should be able to make recommendations on the final draft.

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What Should the Evaluation Produce?

The output of the evaluation should be a publicly available report that is written in a clear style, such that other civil society organisations both in and outside of South Africa can understand and engage with it. The NEC should have an opportunity to review the final draft of the report. If disputes over the final text arise between the evaluators and the TAC NEC, these should be noted in the final document.

The precise layout of the final report must be determined by the evaluators¹. Here is a guideline: The executive summary should describe the purpose of the evaluation, key findings and recommendations. This should be followed by a brief history of the TAC, its major accomplishments and setbacks. Then there should be chapters describing structure and strategies, past, present and future. This should be followed by chapters examining offices, branches, finances, funding and operations.

It is not necessary for the evaluation team to redo research that has been done. An audit of TAC's financial structures has already been done by an independent auditing firm. Certainly the final evaluation should include a detailed evaluation of TAC's financial structures, but it should not redo the entire financial evaluation. Instead the financial team should examine the financial evaluation and then determine if it wishes to investigate any areas of financial control further. Nevertheless, the financial controls evaluation must be included for completeness.

Each of the above chapters after the executive summary should contain findings and recommendations. A concluding chapter examining the lessons learnt and the future of TAC should also be produced.

The entire report should be brief, perhaps 50 to 60 pages at most. It should be to the point, i.e. devoid of the rambling waffle that is characteristic of much that is published in the NGO sector.

How Should the Evaluation be Conducted?

The evaluation should be conducted over two months (February and March 2005) followed by a one month write-up period (April). The evaluation team should start off at the national office by interviewing key national staff and NEC members. Based on these discussions, a final evaluation plan should be formulated and submitted to the NEC for approval. The evaluation team should then proceed to each office, examining systems and interviewing key personnel, including key volunteers and provincial and district executive members. The evaluators should also visit two functional branches in each province, selected by the provincial office. Branch members should be interviewed.

¹The report should be produced using 12 point Arial on A4 paper to conform with the layout standards of TAC documentation.

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After all the information is collected, the evaluators should meet to discuss each of the areas being evaluated. Following this, the findings and recommendations should be written up and the final draft sent to the TAC NEC for review. The final evaluation will be made available on the TAC's website. It will be a freely distributable public domain document.

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9 Annexure 2: List of people interviewed

Organisation	Name	Position
TAC consultant	Ms Ashleigh De Villiers	Fund-raising
TAC consultant	Mr Gareth Rositer	TLP
TAC	Ms Nwabisa George	Administrator, Eastern Cape
TAC	Ms Rirhandzu Mathebula	Assistant to financial manager
TAC	Ms Fanayi Tshabalala	Assistant to financial manager
TAC	Ms Veronica Shumane	Assistant to national manager
TAC	Mr Zackie Achmat	Chairperson
TAC	Ms Bongikile Bhengu	Development officer
TAC	Ms Nombulelo Rangana	District Organiser
TAC	Mr Richard Shandu	District organiser, Pmb
TAC	Mr Mziwethu Faku	District organiser, Queenstown
TAC	Ms Dawn Wilson	Financial manager
TAC	Mr Ralph Berold	HR manager
TAC	Mr Njogu Morgan	International co-ordinator
TAC	Mr Cedric Nukeri	Materials and administrative assistant, Gauteng
TAC	Ms Faniswa Filani	Membership capturer
TAC	Ms Susan Fraser	National administrator
TAC	Ms Rukia Cornelius	National manager
TAC	Mr Xolani Tsalong	National organiser
TAC	Mr Nathan Geffen	National policy, research and media co-ordinator
TAC	Mr Arthur Jokweni	National youth co-ordinator
TAC	Ms Siphon Mthathi	NEC & out-going Treatment Literacy Coordinator
TAC	Ms Nonkosi Khumalo	NEC & Treatment Project co-ordinator
TAC	Ms Ncumisa Nongogo	NEC member and volunteer, Eastern Cape
TAC	Ms Buyi Ndlovu	NEC sector representative
TAC	Mr Gordon Mthembu	NEC, Gauteng rep
TAC	Mr Nkosinathi Mthethwa	NEC, KZN rep
TAC	Mr Isaac Skosana	NEC, Sector representative
TAC	Ms Portia Ngcaba	Organiser, Eastern Cape
TAC	Ms Tebogo Makhalemele	PEC and TLP, Limpopo
TAC	Mr Selby Mabele	PEC and Volunteer
TAC	Mr Desmond Dlamani	PEC and Volunteer, KZN
TAC	Mr Zakhele Xaba	PEC and Volunteer, KZN
TAC	Mr Gosime Chabi	PEC chair and volunteer
TAC	Ms Promise Makhanya	PEC member, TP organizer
TAC	Mr Lawrence Mbhalati	PEC Secretary, Limpopo
TAC	Mr Eddy Marilele	PEC, Acting chair, Limpopo

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Organisation	Name	Position
TAC	Ms Bridget	Provincial administrator
TAC	Ms Primrose Mathabatha	Provincial administrator, Limpopo
TAC	Ms Nondumiso Mvunjelwa	Provincial administrator, WC
TAC	Ms Laurain Sane Seme	Provincial administrator, KZN
TAC	Mr Luyanda Ngonyama	Provincial Co-ordinator, Gauteng
TAC	Mr Pholokgolo Ramothwala	Provincial co-ordinator, Limpopo
TAC	Mr Msanyana Skhosana	Provincial co-ordinator, MP
TAC	Ms Thembeka Majali	Provincial co-ordinator, WC
TAC	Mr Xolani Kunene	Provincial Organiser, Gauteng
TAC	Mr Thabo Cele	Provincial organiser, KZN
TAC	Mr Oupa Fazi	Provincial organiser, Limpopo
TAC	Mr Mandla Majola	Provincial organiser, WC
TAC	Mr Mark Heywood	Treasurer
TAC	Ms Nombasa Gxuluwe	Treatment Literacy co-ordinator Eastern Cape
TAC	Ms Nomfundo Eland	Treatment Literacy Administrator
TAC	Ms Johana Ncala	Treatment Literacy co-ordinator, Gauteng
TAC	Ms Bongwiwe Mkhutyukelwa	Treatment Literacy co-ordinator, KZN
TAC	Ms Vuyiseka Dubula	Treatment Literacy co-ordinator, WC
TAC	Lulamile Timbiliti	Treatment Project co-ordinator, Eastern Cape
TAC	Mr Zolani Mete	Treatment Project co-ordinator, Gauteng
TAC	Ms Sindi Blose	Treatment Project Co-ordinator, KZN
TAC	Ms Ntombifuthi Rapia	Volunteer
TAC	Ms Millicent Ndabeni	Volunteer
TAC	Ms Mamela Xhego	Volunteer & District Working Committee
TAC	Ms Emelda Ngxiya	Volunteer & TLP, Eastern cape
TAC	Ms Tandhi Mzukwa	Volunteer & TLP, Gauteng
TAC	Ms Akona Msaluba	Volunteer & TLP, Lusikisiki
TAC	Ms Sibongile Mashele	Volunteer and media
TAC	Ms Lungile Malembe	Volunteer and TLP, KZN
TAC	Ms Dudu Dlamini	Volunteer and TLT, KZN
TAC	Ms Hlengiwe Lwandle	Volunteer and TLT, KZN
TAC	Ms Lihle Dlamini	Volunteer and TLT, KZN
TAC	Ms Noloyiso Ntamehlo	Volunteer and TLT, Lusikisiki
TAC	Mr Xola Resha	Volunteer, DWC member, Queenstown
TAC	M Maria Mdakana	Volunteer, Eastern Cape
TAC	Mr Njongo Mgayi	Volunteer, Eastern Cape
TAC	Ms Nomsa Ngqalakwezi	Volunteer, Edongwe branch

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Organisation	Name	Position
TAC	Mr Xolani Mabuza	Volunteer, Gauteng
TAC	Mr Gerrie Mnguni	Volunteer, Gauteng
TAC	Mr Ronny Rampai	Volunteer, Gauteng
TAC	Mr Itumeleng Mokyethi	Volunteer, Gauteng
TAC	Ms Maria Masilela	Volunteer, Kwagga branch
TAC	Ms Ntombi Ntuli	Volunteer, Kwagga branch
TAC	Ms Jane Kabini	Volunteer, Kwagga branch
TAC	Mr Charles Jabu Makhubo	Volunteer, Kwagga branch
TAC	Mr Shaka Twala	Volunteer, Kwagga branch
TAC	Ms Emmah Mthlmunye	Volunteer, Kwagga branch
TAC	Ms Pinky Mokoena	Volunteer, Kwagga branch
TAC	Ms Ntombi Mbuthu	Volunteer, KZN
TAC	Ms Cindy Ngidi	Volunteer, KZN
TAC	Ms Nkhenseni Mvasa	Volunteer, Limpopo
TAC	Bonnie Witbooi	Volunteer, Machibini branch
TAC	Ms Monalisa Ngqisha	Volunteer, Masikhule branch
TAC	Nosiphiwo Class	Volunteer, Masikhule branch
TAC	Noluthando Mzoloshe	Volunteer, Masikhule branch
TAC	Ms Ruth Mlahlwa	Volunteer, Masikhule branch
TAC	Sicionyela Xoile	Volunteer, Masikhule branch
TAC	Mr Bandile Longman	Volunteer, Masikhule branch
TAC	Zanenhosi Mpufu	Volunteer, Masikhule branch
TAC	Vuyokozi Mbekwa	Volunteer, Masikhule branch
TAC	Asanda Mnwana	Volunteer, Masikhule branch
TAC	Me Ronald Sibuyi	Volunteer, Matsulu branch
TAC	Ms Santy Mnisi	Volunteer, Matsulu branch
TAC	Ms Nombuso Msithini	Volunteer, Matsulu branch
TAC	Mr Samson Shongwe	Volunteer, Matsulu branch
TAC	Mr Sydney Masinga	Volunteer, Matsulu branch
TAC	Ms Zodwa Zwane	Volunteer, Matsulu branch
TAC	Ms Fortune Mashaba	Volunteer, Matsulu branch
TAC	Mr Colina Malaza	Volunteer, Matsulu branch
TAC	Ms Linda Mavuso	Volunteer, Matsulu branch
TAC	Ms Magugu Sambo	Volunteer, Matsulu branch
TAC	Mrs Beauty Dube	Volunteer, no longer active
TAC	Ms Lorna Philanders	Volunteer, WC
TAC	Mr John Vollenhoven	Volunteer, WC
TAC	Ms Vuyisa	Volunteer, WC
TAC	Mteto	Volunteer, WC
TAC	Mr Mike	Volunteer, WC
TAC	Nombasa	Volunteer, WC
TAC	Ms Nomafu Booi	Volunteer, WC
TAC	Mr Welcome Makele	Volunteer, WC
TAC	Mr Vuyani Macotha	Volunteer, WC
TAC	Mr Isaac Mangwana	Volunteer, WC
TAC	Ms Ncedisa Lande	Volunteer, WC

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Organisation	Name	Position
TAC	Sedibeng Branch members	Volunteers
SACP	Sharon Ekambar	Ex-staff member
PATAM/ SAfAIDS	Ms Tendyai Kureya	Advocacy advisor
PATAM	Mr Delme Cupido	Co-ordinator, Aids Law Unit, Legal Assistance Centre, Namibia
ODAC	Alison Tilley	Chief Operations Officers
OD consultant	Mr Frank Meintjies	Consultant
OD consultant	Ms Davine Thaw	Consultant
MSF & TAC	Dr Herman Reuter	Doctor
MSF	Dr Wilbert Bannenberg	Consultant to MSF
MSF	Ms Sthembiso Mabaso	Counsellor co-ordinator
MSF	Dr Martha Darder	MSF Khayelitsha
Media	Ms Tamar Khan	Business Day
Media	Ms Kerry Cullinan	e-health news
Lusikisiki Child Resource Centre	Mr Sina Swana	Field worker
Love Life	Mr David Harrison	Director
Legal Profession	Mr Geoff Budlender	Advocate/Acting judge
Legal Profession	Justice Edwin Cameron	Judge, Supreme Court of Appeal
Jubilee 2000	Mr Tandeka Saleni	Provincial officer
I-Base	Ms Polly Sampson	International partner
Health practitioner	Sr Enoch	Addington Hospital
Health practitioner	Sr Mlamlala	Duncan Village day Hospital
Health practitioner	Dr Liz Thomson	Edendaaal hospital
Health practitioner	Sr Baloyi	Elim Hospital
Health practitioner	Sr Baninzi	Ilinge Clinic
Health practitioner	Sr Zethu Gumede	Ishowe Clinic
Health practitioner	Sr Jane Mdlovu	Katelong Clinic
Health practitioner	Dr Hussein	St Elizabeth Hospital ARV site
Health practitioner	Sr Bandezi	Village Clinic, Lusikisiki
Gay Men's Health Crisis	Gregg Gonslaves	Treatment and Prevention Advocacy Director
Funder: SIDA	Ms Ria Schoeman	AIDS programme manager
Funder: Bort feur die welt	Ms Astrid Berner Rodoreda	HIV/AIDS coordinator Africa
Funder: Belgium Embassy	Mr Jean-Jacques Waelput	Development consultant
Funder: Atlantic Philanthropies	Mr Zola Madikizela	Programme Executive
DOH	Dr Fareed Abdullah	Head of Department, Western Cape
DOH	Dr Liz Floyd	Head of Gauteng AIDS Directorate
DOH	Ms Precious Matsoso	Registrar of medicines (former)

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Organisation	Name	Position
Parliament	Mr James Ngculu	Chair of Health Portfolio Committee
COSATU	Ms Jacqueline Mpolokeng	HIV/AIDS co-ordinator
Consumer Project for Technology	Mr James Love	Director
Brotherhood of Blessed Gerard	Mrs Clare Kalkwarf	Vice-President
BIG	Pumi Yeni	National Organiser
Aids Law Project	Mr Jonathan Berger	Head: Law and Treatment Access Unit
Aids Law Project	Ms Marlise Richter	Researcher
AIDS Consortium	Ms Maxine McCalla-Kay	Acting Director
AIDS Consortium	Ms Phindi Malaza	Database officer
AIDS Consortium	Ms Susie Clarke	Information and Resource Centre manager
AIDS Consortium	Mr Rajesh Latchman	Training manager