SUPPORTING LOCAL GOVERNMENT RESPONSES TO HIV/AIDS: POSITIONS, PRIORITIES, POSSIBILITIES

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ACRONYMS

CBO - Community based organisation
CSO - Civil society organisation
DOH – Department of health
DOTS - Directly Observed Treatment Short-Course
GFATM - Global Fund to Fight AIDS, Tuberculosis and Malaria
IDP -Integrated Development Plan
IEC – Information, education and communication
IGR – Inter-governmental relations
KPI - Key performance indicator
LG – Local government
LGA - Local government association
M&E – Monitoring and evaluation
PMTCT - Prevention of mother-to-child transmission
NGO - Non-governmental organisation
PHC – Primary health care
PWHA: Persons living with HIV/AIDS
R&D – Research and development
STI - Sexually transmitted infection
TA - Technical assistance
TB -Tuberculosis
VCT - Voluntary Counselling and HIV Testing

FOREWORD

This report was commissioned by the Transport and Urban Division of The World Bank and the intended users are those involved in funding, supporting, managing and implementing programmes designed to enhance local government responses to HIV/AIDS. The purpose of the report is to review local government responses to HIV/AIDS, to understand the priority challenges and development needs associated with responses and to identify promising possibilities for improvement.

A companion document to this report, 'Local government responses to HIV/AIDS: A handbook' is designed to translate the key issues raised in this review into a set of useful practical guidelines.

The report and companion toolkit are based on a study of efforts to develop HIV/AIDS responses at local level, and specifically efforts which have engaged with or been developed through local government structures. This involved an extensive review of the literature in this field and a process of fieldwork. The fieldwork was conducted in Namibia, South Africa, Senegal, Zambia and Uganda and involved interviewing a range of people involved at various levels of local government response to HIVAIDS. An attempt was made to view local government responses to HIV/AIDS from a number of perspectives including the perspectives of: departments of local government; inter-governmental support structures; local government associations; national AIDS councils; municipal mayors, councillors and managers; civil society organisations and networks; international aid organisations and multi-country HIV/AIDS programmes; and a number of acknowledged experts in this field.

A specific attempt was made to understand the forms of local government in different countries and to understand the impact that these have on the effective and sustainable functioning of programmes at local level. Understanding the challenges of decentralisation of national HIV/AIDS prevention and control programmes led to the need to understand the challenges of decentralisation more generally. Development of co-ordinated and ultimately integrated programmes at local level faces a range of challenges and these must be understood and addressed in developing local government responses to HIV/AIDS.

Within sub-Saharan Africa there is little uniformity between countries in the structures of local government, the levels of HIV prevalence, the resources available to societies for HIV/AIDS response, and the types of response that are necessary and possible at different levels of local government. Further, local government entities range from highly professionalised management structures of sprawling metropoles to committees in isolated rural communities, and at different levels and in different spheres of local government there are different needs and capacities, making a generic prototype for local government response unviable. However, it is hoped that by addressing issues and challenges faced in decentralising HIV/AIDS responses to LG level, rather than proposing solutions, the document has some general relevance. It is further hoped that although the fieldwork for this report was conducted in sub-Saharan Africa, and much of the literature accessed and reviewed relates to this context, the key issues addressed may be relevant to discussions about local government responses in other contexts.

EXECUTIVE SUMMARY

The document is a review of HIV/AIDS needs, challenges and responses of local government authorities (LGAs) to HIV/AIDS. It is a companion document to 'Local government responses to HIV/AIDS: A handbook'[1] which has a more explicitly practical orientation than this review.

The sequence of the review

- HIV/AIDS is viewed as a problem that is closely tied to the movement of people and urbanisation. In this context it is seen as an urban development concern which is of direct relevance to local government.
- The major issues which face local governments in responding to HIV/AIDS are sketched out, with special emphasis on the challenges of decentralisation, integrated response planning and relationships between local government and non-governmental social formations.
- Responses and models for HIV/AIDS response at local government level are presented.
- The information and research needs relating to improving local government responses to HIV/AIDS are discussed.

The need for LG responses to HIV/AIDS

- HIV/AIDS is spreading most rapidly and pervasively in urban informal areas. The movement of people from rural to urban areas and the establishment of new communities with poor infrastructure and low levels of social cohesion, has proved to be a hotbed for the spread of HV/AIDS in urban areas.
- The multi-faceted impact of HIV/AIDS on society at all levels requires that LG cannot avoid becoming involved in HIV/AIDS responses, even when it is not directly responsible for providing health services.
- HIV/AIDS impacts on LG functioning itself and an internal focus on HIV/AIDS prevention and care is an important part of any LGA response.
- Reasons why it is strongly advisable to support LG responses to HIV/AIDS include: the need for greater co-ordination and integration of local HIV/AIDS responses; the need to implement national AIDS plans at a local level requires a governmental framework for operations; HIV/AIDS is not simply a health issue and requires a multi-sectoral approach to addressing problems at local level.

The challenges of dealing with HIV/AIDS through LG

- Although the emphasis on local responses to HIV/AIDS has been a strong focus in the fight against HIV/AIDS world-wide, there has been relatively little work done on understanding challenges to LG in dealing with HIV/AIDS.
- There has been little done to understand the meaning of the growing trend of decentralisation for HIV/AIDS programmes. Whereas there has been much attention focused on supporting decentralisation of LG, this work has not generally extended into understanding and tackling the difficulties decentralised LGs have in responding to HIV/AIDS.
- There is a need to find ways of decentralising national HIV/AIDS programmes, to overcome the problem of under-spending and poor development of local level programmes, and to counter over-emphasis on broad national campaigns with questionable value at local level. The unsystematic development of local programmes and the poor participation of LGAs relative to local NGOs, points to the need to urgently develop LG responses to HIV/AIDS.
- There are many structural challenges facing local governments generally and these affect HIV/AIDS response. These include: lack of clarity about the powers and functions of different tiers and spheres of government; poor integration of vertically decentralised departments (particularly health departments) at the local level; lack of coincidence of boundaries between LG and departmental administration areas; poorly articulated frameworks for fiscal decentralisation and unfunded mandates for LG to respond to HIV/AIDS; lack of discretionary budgets for LG to support start-up projects and to support programme development activities; problems in efficient management of inter-governmental transfers; lack of support for inter-governmental relations and co-ordinating structures; split functions of government; poor capacity of local

[1] The World Bank 2003, http://www.worldbank.org/urban/hivaids/localgovernments.htm

government officials and councillors for managing the affairs of LG beyond delivering of basic services, and specifically for planning and managing the new demands on LG as a consequence of HIV/AIDS; and lack of models for leading local government responses to HIV/AIDS.

- There are many obstacles to the effective functioning of LG and these need to be overcome before LG can be an effective conduit and facilitator of HIV/AIDS response. Many of these problems are structural and cannot easily be overcome, and add urgency to the need for decentralisation support and reform.
- Often national mandates to LG are not well spelled out and they do not assign the responsibility for co-ordination and integration. They tend to only assign service delivery activities such as VCT, PMTCT, nutrition and HBC to specific governmental agencies . The responsibility for co-ordination and integration of HIV/AIDS responses resources at community level is a largely unfunded responsibility in most systems of local response, although it is an intensive and time consuming activity involving planning and detailed monitoring. In the absence of other agencies for co-ordinating local responses the responsibility falls to LG, as an unfunded mandate. The mandate fits in well with other LG development management mandates such as leadership of local economic development, management of community affairs and local integrated planning. HIV/AIDS has major impacts at local level and is therefore a threat to the delivery of these basic functions of LG and it becomes a LG imperative to mobilise, co-ordinate and integrate proliferating local responses.
- Meeting the challenge of turning rapid 'organic' growth into a systematic and efficient system of responses is an important and overlooked activity and this is an impediment to delivery of accessible, integrated and comprehensive services.

Local government solutions

- There are numerous cases of promising LG responses to HIV/AIDS, but there is no collection of best practices around LG responses to HIV/AIDS. Although the differences between LG systems are sufficiently different to mean that solutions in one system might not provide a benchmark for other systems, there are many promising leads which need to be more widely recognised and studied.
- Areas in which there has been encouraging development include: integrated municipal level response planning; development of functional integration at points of service delivery; development of district level HIV/AIDS co-ordination systems which attempt to link LGAs and NGOs into a coherent system of response; development of ward-level co-ordination and funding forums that link communities and LG; synergistic partnerships between municipalities and CBOs; and leadership and management development and support programmes.
- The systemic decentralisation problems associated with HIV/AIDS programmes at LG level are far from being resolved and addressed. In particular financial decentralisation frameworks are generally not adequate for supporting local government responses and the conditionalities of vertically decentralised budgets are a significant impediment to the development of LGA integrated responses.
- There is a strong need to develop local responses to HIV/AIDS through national and systemic support, as well as through development of operational models at LG level.
- Attempts to mainstream HIV/AIDS responses into LG often encounter problems of inter-governmental relations and are faced with the challenge of overcoming split functions of government (different government agencies contributing separately towards a particular governmental function) which leads to delivery failures. Partnerships between departments and across the tiers and spheres of government are critical to development of sustainbale local responses, but local government systems in many countries are at a rudimentary stage of development and often such supports are far from eing achieved meaning poor prospects for development of LG support for HIV/AIDS response at the local level. There has also been little development of benchmarks for municipal inrastructure and there is much work yet to be done at this level.

Monitoring, evaluation and research

- Some of the key elements of a monitoring and evaluation framework approach which is tailored to understanding local government responses to HIV/AIDS are identified. Stress is laid on factors which are particular to the challenges facing local government authorities, as opposed to local responses more generally.
- A set of research priorities to support LG responses is identified.

1. THE NEED FOR LG RESPONSES TO HIV/AIDS

Political commitment and leadership are widely regarded as cornerstones of success in tackling HIV/AIDS. Leadership plays an important role in mobilising country and international resources and when HIV/AIDS is regarded as a priority at the highest level as in the case of Uganda, the society orients to meeting the many challenges of HIV/AIDS response[2]. However, whilst central political leadership is arguably a necessary condition of change it is certainly not a sufficient condition.

For successful responses to HIV/AIDS the path-breaking of leaders needs to be followed by concerted and systematic efforts on the part of all elements of government and civil society to initiate, coordinate and support the development of response frameworks and associated activities. At this level, irrespective of the motivations of leaders, the problems of governance which are faced by many of the countries most affected by HIV/AIDS hamper the effectiveness of responses.

The governance of HIV/AIDS response is a topic which has received surprisingly little attention. As is the case in relation to international development aid generally, there is much concern about the capacities of recipients to use funds efficiently and effectively. In this context international organisations which provide support for developing responses to HIV/AIDS at country level, have insisted on certain basic requirements as prerequisites for receiving support. For example, World Bank requires that before receiving funds, a country engaging in its Multi-country AIDS Plan for Africa (MAP) must, amongst other things, establish a National AIDS Council and formally adopt a National AIDS Plan.

But it is not only at the central level that there is need for a strategic response framework. Attention is increasingly turning to the local government context, noting that, certain national level imperatives apart,[3] the delivery level of HIV/AIDS programmes is inevitably local. The capacity for national HIV/AIDS programmes to absorb funds, depends on spending at local level. Accordingly, attention is increasingly being focused on local responses and to the decentralisation of national AIDS control and prevention plans. Emphasis is turning to the role of local government authorities (LGAs), but often in the countries concerned, local government (LG) is not well established or systematised, making funding support at sub-national level problematic. It is much more difficult for funders to engage with government at local level, as sub-national systems of governance are often poorly organised, supported and administered, and the kinds of problems experienced by LGAs are often deeply entrenched in social and political structures which are not well regulated or are regulated in ways which are rigid and inflexible.

The annual amount of money spent on developing HIV/AIDS responses in Africa has dropped since the early 1990s. This is not because there is less need, or because the high costs of setting up basic infrastructures for HIV/AIDS response have been met. Rather it is because of cautiousness of the part of donor and aid organisations, about whether funds are being used to good effect, given the problems of governance within developing countries where HIV/AIDS is most rife. Arguably the bigger part of this problem is the inability to plan and regulate spending at local level. It is well known, for instance, that countries most in need for development of more effective HIV/AIDS responses often underspend their own national and provincial AIDS budgets.[4]

In the context of needing to develop local responses there has been much effort on the part of donor agencies and international health development agencies to develop locally relevant systems of HIV/AIDS response. In many cases world-class facilities and services have been developed in otherwise under-resourced environments, often as models and in the hope of creating centres of excellence which can seed further developments. It is often the case that these initiatives are developed as 'local' responses rather than 'local government' responses. They may dwarf corresponding local government responses in terms of scale and efficiency and in many respects are established in parallel to local government. This is not inherently problematic and it certainly is not a new phenomenon. In some countries such as Uganda and Zambia church-based health facilities are the bigger part of local health services in many districts. But ultimately, given that HIV/AIDS is a long-term problem which requires strong inter-sectoral collaboration and sustainability, development of local government systems for responding is a more appealing prospect.

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[2] Putzel 2003

[3] For example, securing safe blood supply and development of national AIDS plans.

[4] Notwithstanding the problem of provincial directors hastily commissioning ill-considered expenditure at the end of a financial year to avoid criticism for underspending.

It is important to note that external funding for HIV/AIDS is much greater than internal contributions to HIV/AIDS response in most countries in the developing world. One of the biggest challenges in this context has been to find ways of embedding support and funding in local systems of response rather than at a national level. However, it is the rule rather than the exception to find that managers of internationally funded programmes, often partnered with local civil society organisations (CSOs) know precious little about the management and administration of the country's local government systems. The same can often be said about the managers of large CSOs within countries. However, it seems that if country response systems are to be developed this cannot occur in a sustainable way through increasing proliferation in both number and size of CSOs. In Uganda, local organisations that deal specifically or in part with HIV or AIDS grew exponentially during the 1990s and up to the present. This pattern is mirrored all over the developing world. The organic growth of civil society responses, if it is to cohere into an integrated system of prevention, support, care and treatment needs ultimately to be connected to the functions of government and broadly work in partnership with government; although the existence of a healthy independent civil society lobby which is free to criticise government responses is no doubt an important element in mobilising AIDS responses, as is evident in the impact of advocacy groups such as South Africa's Treatment Action Campaign.

Existing health and welfare systems are enormously under-resourced relative to the scale of the HIV/AIDS problem in many developing countries. Whereas some successes have been claimed in stemming the rapid spread of HIV, there are few if any countries in the developing world that have developed anything near adequate countrywide responses to AIDS. For example, prevention of mother to child transmission and provision of social support and treatment to AIDS sufferers and their dependents are nowhere adequately developed. Even a relatively simple and inexpensive service such as voluntary counselling and HIV testing (VCT), widely regarded as one of the cornerstones of HIV/AIDS response, is available to only an estimated 1% of the sub-Saharan population. Further, in many African countries and underdeveloped countries in other parts of the world there is no welfare system to speak of and the delivery of health services is hampered by lack of skilled personnel, poor health infrastructure, poor information and communication infrastructure, poor transport infrastructure and lack of the basic elements of good health like adequate food supplies and clean water.

HIV/AIDS has highlighted the problems of underdevelopment, and many of the needs which have come to the fore in the face of the HIV/AIDS epidemic are the same needs which can be identified as the most pressing social development needs which one finds in contexts of underdevelopment. Because of the immediacy and undeniable need to respond urgently to the human catastrophe of HIV/AIDS, the international community is trying to strike a balance between the long term development needs of the world's poorest and most troubled regions and also do what can be done in the short term to contain the spread of HIV and deal with the attendant suffering and humanitarian crisis. Anyone who has visited AIDS hotspots in the developing world will know that these needs, both reactive and development oriented, are far from being met.

This review is oriented to understanding the role of local government, as a bridge between the resources of the state and local communities. In understanding the role of local government in responding to HIV/AIDS it is important to appreciate the close connection between patterns of human settlement and HIV/AIDS.

1.1 HIV/AIDS and the movement of people

Within countries there are often enormous disparities between regions and localities in terms of HIV prevalence. Unfortunately not a lot is known about HIV/AIDS at local level and the sampling methodologies used to develop national statistics frequently don't allow disaggregation[5] to anything finer than provincial or regional levels. Particular town or districts usually have to extrapolate their HIV prevalence rates from national statistics, and such research efforts are often plagued by untested assumptions. Further, it is costly to conduct such modelling studies and even more costly to conduct HIV seroprevalence surveys, which means that frequently areas under jurisdiction of LGAs will not know how they differ from other local communities.

A further problem with our understanding of HIV prevalence is that it is usually based on antenatal surveys[6]. Antenatal clinics are generally regarded as the most suitable sites for systematic screening of HIV prevalence.

[5] Disaggregation is a term used to describe the process of breaking down epidemiological data so that it applies to smaller population units of interest. For example, national prevalence statistics may be disaggregated to obtain data for population groups categorised according to socio-economic or education levels.

[6] Antenatal data is usually systematically connected in a sample of clinics using pregnant mothers reporting for antenatal care.

Whereas this makes for convenient comparison of levels of infection across the years it does not provide much of an understanding of the distribution of HIV across the population or the patterns of spread. This requires an understanding of human sexual association, and an appreciation of the movement of people.

It is well established that the movement of people and populations plays an important role in the HIV/AIDS epidemic. There are a number of forms of movement of people which need to be considered:

- Migration – People who take up residence or who remain for an extended stay in a foreign country or who move to new areas of their own countries.
- Migrant labour – People who live and work away from home for extended periods.
- Mobile workers – People whose work requires them to travel, including students.
- Displacement – People who are forced to move, on either a temporary or permanent basis because of threat, famine, work seeking or asylum seeking.

There is relatively little ongoing monitoring of the movement of people and its effects on the distribution of HIV infection. For instance neither Uganda nor Thailand has data on HIV amongst refugee populations.[7] Much of what we know in this area is a result of isolated studies and there is very little data available for most countries with refugee populations.

1.1.1 Migration

It is estimated[8] that 150 million migrants (people who take up residence or who remain for an extended stay in a foreign country) currently live outside their country of citizenship. In addition there has been a marked trend of movement from rural to urban areas and this is probably the largest single category of modern migration.[9] Such movement typically follows perceptions of perceived prosperity and opportunity in countries of destination, although in reality the living conditions (urban informal settlements) of many migrants in cities may be considerably lower in terms of living standards than where people come from, and opportunities may be based more on hope than reality. Migrant labour or economic migration is probably the largest single category of modern migration.[10]

It is important to understand the impact of migration on both source and receiving locations. Some countries tend to be sources of migrant people and others tend to be recipients or destinations for migrants. The Phillipines, for instance, is a source of migrants with about 8% of its citizens working overseas. South Africa is a destination for migrants. Estimates[11] of labour migration to South Africa in the 1990's suggest that between 7% and 20% of those residing within the country are workers from other countries or legal and illegal opportunity seekers who do not have formal work.

The heightened vulnerability of migrants is well documented.[12] The most most widely documented risk situation in situations of migrancy, and especially migrant labour is the case of men separated from their regular sexual partners through migrancy, using commercial sex services. Another well documented area of risk is the risk faced by female work seekers and women in transit,[13] who may arrive at their destinations without accommodation, food or employment, and who may have to seek temporary sex partners to survive or complete their journeys, and who may become involved in commercial sex work.

In such instances the partners who remain behind, usually in rural areas, become vulnerable to infection when their migrant partners return for brief visits. It is not uncommon for migrants to maintain two homes and many in rural areas subsist on monies sent to them by family members who are able to find work in cities. The risks of

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[7] UNAIDS 2002
[8] UNAIDS 2002
[9] UNAIDS 2002
[10] UNAIDS 2002
[11] The lower estimates are from "Labour Migration to South Africa in the 1990's" of the SAMAT Policy Paper Series and the higher estimates, said by the Labour Market Commission to be too high, are from The South African Policy Service.
[12] UNAIDS 2002
[13] Protecting vulnerable populations on the move, including adolescent girls and young women, is now a focus of a regional initiative in Latin America and the Caribbean. UNAIDS 1002, p36.

infection in such instances are particularly difficult to manage as use of condoms in marital relationships implies acknowledgement of infidelity.

In addition to work in cities migrant labourers may be attached to seasonal and temporary industries – for example, harvesting on commercial farms, road and dam building and the fishing industry. There has been relatively little documentation or mapping of patterns of seasonal migration, but it is recognised that this is an important vector of HIV transmission.

It is important in assessing HIV infection risk to understand the relative advantages of addressing the risks of HIV infection in both sending and receiving contexts. Although migrant communities may be better addressed where they are assembled in their destinations at workplaces and in informal settlements, as opposed to the scattered rural areas that they originate from, prevention programmes for migrants tend to be neglected at points of destination. A notable exception is the efforts of well-established mining industries in Botswana and South Africa which rely on migrant labour. UNAIDS[14] recommends preparatory intervention with people destined for migrancy, before they are exposed to situations of risk and a number of inter-country HIV prevention programmes exist which are located along migration routes.[15]

1.1.2 Transport routes

There is much evidence to link transport routes to the spread of HIV. In Mwanza, Tanzania, the prevalence of HIV was twice as high in communities living along the roadsides in comparison to those living in villages distant from the main road[16]. A study conducted in the remote mountains of Lesotho in 1995, found that all cases of HIV infection occurred amongst those subjects living along the main road and no cases were detected amongst the subjects living away from the main road.[17] Recent evidence from northern KwaZulu-Natal in South Africa has shown a strong correlation between the mean distance of a homestead from a primary or secondary road and HIV prevalence, with much higher prevalence in homesteads near roads.[18] A prevalence of 56% HIV prevalence was found among South African truck drivers at five South African truck stops – well above the national adult prevalence rate.[19]

The primary vector behind these findings is the association of transport routes with commercial sex workers and there is much evidence to suggest that settlements along truck routes, often referred to as 'hotspots' become seedbeds for more gradual epidemics which spread through regular patterns of sexual mixing.

1.1.3 Displacement

Displacement refers to the enforced movement of people away from home communities to new environments which they occupy temporarily, sometimes leading to permanent settlement.

The United Nations High Commission for Refugees[20] spearheads efforts to provide reproductive health care for refugees and the United Nations Population Fund[21] has also been active in this area, particularly in addressing the health needs of adolescents. Displaced people typically have little right of access to the facilities and services in their receiving environments. These need to be supplied or links to existing resources need to be built and when entire communities are displaced to a particular location as is often the case with outbreaks of war or natural disasters this is achieved through emergency relief efforts which are targeted at temporary settlements of displaced people. Such communities of displaced people may offer a risk of spreading HIV infection from their own high levels of infection to the lower levels of infection of receiving environment or the heightened risk may work in the other direction. The greatest risk is for those refugees not in refugee settlements, who are moving *from* somewhere

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[14] UNAIDS 2002
[15] Example's are USAIDs 'AIDS prevention on the major migratory routes of West Africa', UNAIDS Inter-Country Team for West and Central Africa, Mexico's National Institute of Public Health's 'HIV and Migration Project in Centra America and Mexico', and the Association of Southeast Asian Nations (ASEAN) to tackle HIV among mobile populations.
[16] Grosskurth 1995
[17] Colvin 2000
[18] Tanser 2000
[19] UNAIDS 2000
[20] http://www.unhcr.ch
[21] http://www.unfpa.org

without a clear sense of destination. They typically join the burgeoning ranks of informal urban settlers looking for opportunities for work or self-employment in urban environments.

It is estimated that about one-in-ten of the world's migrants are refugees and asylum seekers. Some 40 million people world-wide are estimated to have been driven from their homes by natural disasters such as earthquakes, drought or floods, or else by war and civil strife, persecution or genocide and who are living as refugees in foreign lands or as displaced persons within their own countries.[22] Such displacement is not always temporary and may lead to permanent settlement.

Another category of involuntarily displaced people is people who are trafficked – mostly for prostitution or forced labour – which is estimated to be between 1-2 million people annually.[23] Such people are usually denied their rights and held in situations of captivity. This captivity is often reinforced by addiction. Because trafficking is illegal there is relatively little known about its extent and about vulnerability to infection in such circumstances.

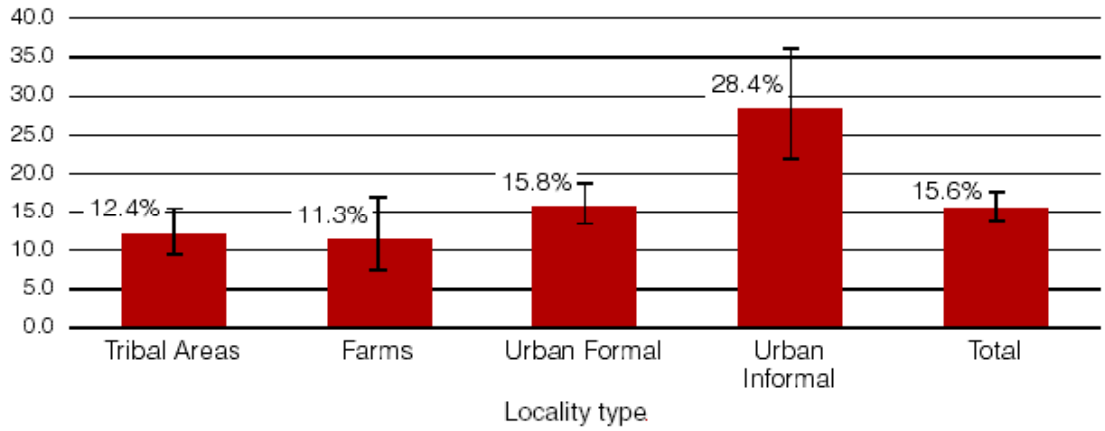
1.2 Villagisation and urbanisation

- In 2001, 34% of sub-Saharan Africa's population of 611 million lived in urban areas.[24]
- Up to two-thirds of African urban dwellers live in informal settlements with inadequate transport, water, sanitation, electricity and health services.[25]
- The capacity of urban areas to generate employment and provide social services is failing to keep pace with the rapidly growing urban population.

Comparisons of urban and non-urban antenatal HIV prevalence data presented in the UNAIDS global AIDS report[26] in countries with the highest prevalence rates, notably those in sub-Saharan Africa, shows that for the majority of countries where there are known prevalence differences[27] between rural and urban areas, there is a strong trend towards higher urban prevalence.[28] Research from a recently released population-based survey conducted in South Africa[29] shows a similar trend, with rural areas having significantly lower prevalence rates.

There is little data which reflects the impact of type of urbanisation. Unfortunately, because most HIV prevalence data is not population based, we are not able to make comparisons across housing type or settlement type. A notable exception is recent South African research[30] which shows that urban informal settlements have the highest prevalence rates amongst four settlement types.[31] Urban informal settlements are the makeshift housing settlements that can be found burgeoning on the outskirts of virtually every African city and in many other cities in the developing world.

[22] UNAIDS 2002
[23] UNAIDS 2002
[24] Urban Management Programme Team, UN-Habitat 2002
[25] Urban Management Programme Team, UN-Habitat 2002
[26] UNAIDS 2002 p192
[27] There is either unavailable rural-urban comparative data from countries in most other regions or the general population prevalence rates are relatively low making rural-urban comparisons less stark, although in most of such cases the tendency is towards higher prevalence in urban areas.
[28] The countries with the most notable differences are Botswana, Congo, Ethiopia, Lesotho, Mozambique, Namibia, Rwanda, Uganda and Zambia. The only strong exceptions are Liberia and the Democratic Republic of Congo.
[29] NMF/HSRC 2002
[30] NMF/HSRC 2002. This research is a population-based household survey representative at the level of province, population group and gender.
[31] Urban formal, urban informal, rural formal (including commercial farms) and tribal areas (deep rural).



HIV prevalence among persons aged 15-49 years by locality type, South Africa 2002[32]

The above table depicts nationally representative statistics and shows marked elevation of HIV prevalence in urban informal settlements. Furthermore people in urban informal settlements showed the highest levels of self-reported sexually transmitted infections (6.5%) compared to urban formal (2.3%), tribal (2%) and farms (2.6%).

The trend to higher prevalence in urban areas is reflected in findings from other countries. Researchers investigating factors accounting for differences in HIV seroprevalence in the rural Rakai district in south western Uganda suggest that the spread of HIV infection flowed from main road trading centres, through intermediate trading villages, to rural agricultural villages[33]. Whilst the weighted seroprevalence of HIV for the district was 12.6%, seroprevalence was highest in main road trading centres (men 26%, women 47%), intermediate in rural trading villages on secondary roads (men 22%, women 29%), and lowest in rural agricultural villages (men 8%, women 9%). A similar urban/rural distribution was found in Tanzania where 2.5% of the adult population in rural villages, 7.3% in roadside settlements and 11.8% in town were infected[34]. Other studies have confirmed these findings.

On the one hand there is higher prevalence in urban areas compared to rural areas and within urban settlements there is higher prevalence amongst informal settlements. Urban living clearly represents heightened susceptibility to HIV infection risk, especially in newly established communities largely comprised of displaced and recently migrated people.

Newly urbanised informal settlements usually have fewer basic services such as sanitation, piped water, electricity, refuse management and poorer access to education, welfare and health services. Often this does not correct in time, as there are frequently disputes about land ownership and rights where informal settlements develop, and this prevents municipalities from planning and delivering services to such communities. One element of heightened susceptibility in such contexts relates to generally lower standards of health which are a result of poor services. This is exacerbated by high population density which makes people particularly vulnerable to infectious diseases. In such circumstances not only are there significant health risks[35] but preventive, promotive and curative services in relation to HIV/AIDS are also not likely to be readily available. Access to treatment for sexually transmitted infections (STIs),[36] access to HIV prevention media and health education, access to condoms, VCT (voluntary counselling and testing), access to antiretroviral therapy and other treatment for opportunistic infections are usually significantly less than in well established communities. An exception is temporary communities of refugees where basic services are provided on a temporary basis, or in special project areas.

But poor infrastructure is typically also a problem the case in rural communities and in many instances services are even less available without there being higher HIV prevalence, leading to the conclusion that the absence of prevention efforts or services is not a strong explanatory variable in explaining prevalence.

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[32] NMF/HSRC 2002
[33] Wawer et al. 1991
[34] Barongo et al. 1992
[35] Unfortunately these are often only recognised when there are outbreaks of cholera, typhoid and many other diseases which take hold in such circumstances.
[36] An untreated sexually transmitted infection greatly increases vulnerability to HIV infection.

To understand high prevalence in informal urban areas it is necessary to examine the social conditions in situations of rapid urbanisation. Unfortunately this is a largely under-theorised and under-researched area and second generation[37] HIV/AIDS surveillance has typically not studied community level interactions, except in an anecdotal way. Most of the research on social aspects of HIV/AIDS has been conducted using the individual as the unit of analysis, with a focus on behavioural indicators and the consequence is that we have only rudimentary understanding of the relation between the state of communities and HIV prevalence. Although a largely unresearched area there is reason to believe that the forms of social organisation in informal urban areas and urban areas generally, are likely to heighten the susceptibility of members of such communities to sexually transmitted infections.

1.3 Social capital: A useful concept for understanding responses to HIV/AIDS

A recent UNAIDS publication on the global epidemic[38] includes a section on 'What drives HIV/AIDS in Africa?' There is no mention of the complex social factors and the state of society and communities that dispose sub-Saharan Africa to such high levels of infection, other than a mention of socio-cultural systems that limit women's control over their sexual lives. At least in relation to the epidemic in Latin America and the Caribbean there is some acknowledgement that: "Among the factors helping drive the spread of HIV is the combination of unequal socio-economic development and high population mobility…The epidemic is worsening and is concentrated chiefly among socially marginalized populations."[39]

Unfortunately the fact that there are behavioural solutions to HIV infection risk has tended to lead to the assumption that behaviour is the problem in the first place[40]. This is linked to the tendency to overlook socio-economic circumstances found in informal urban settlements, which predispose people to heightened susceptibility to HIV infection. Amongst these are:

- Such communities often represent new social formations with little shared history and few previous ties. The lack of a sense of community may be exacerbated by diverse languages, nationalities and cultural backgrounds. This means that traditional forms of social identification and interaction are not sufficient to create a community. In such contexts the deepest sense of shared social life is that which binds people struggling to overcome their marginalisation from access to resources and opportunities, and their struggle to survive. This struggle may predispose them to resorting to crime and unhealthy ways of dealing with intolerable living circumstances, such as abuse of alcohol and drugs.
- These new environments are poor in: the supports offered by extended families; the lack of child care facilities for working parents; fewer opportunities for sharing the burden of child care with grandparents or extended families; use of customary ways of coping with crises, traditional community support systems, religious network supports and traditional belief systems; enculturation rituals, rites of passage and many of the other social practices and conventions which amount to systems for coping and ordered social living.
- There are many ways in which such circumstances may lead to heightened susceptibility to HIV/AIDS. Amongst these are: 'disassortive' sexual mixing patterns[41] which are more likely in crowded circumstances where people more commonly encounter partners outside of their usual networks of associations and relationships; breakdown of norms and expectations relating to sexual debut and initiation; higher exposure to predatory sexual approaches for which young people may be unprepared; and breakdown of marriage relations and family coherence. For example, people living in urban informal settlements in South Africa have more sex partners and higher levels of sexual experience amongst young people than those living in other settlement types.[42]
- High density living in 'neighbourhoods of strangers' makes for increased vulnerability to rape in informal settlements.
- The vulnerability of women to 'sex for financial gain' relationships in circumstances where there are no other means of emergency financial support.

[37] First generation surveillance refers to the measurement of prevalence of HIV, whereas second generation surveillance attempts to understand the contexts in which HIV is transmitted.
[38] UNAIDS 2002
[39] UNAIDS 2002 p36
[40] Katz 2002
[41] Anderson & May 1992
[42] NMF/HSRC 2002

- Lack of recreational facilities and living space not articulated to create safe environments for age-group specific social mixing.
- High levels of neighbourhood alcohol and drug use.

All of these factors appear to have a foundation in poor social cohesion and social organisation. But surprisingly this lens has not been much brought to bear in understanding heightened susceptibility to HIV infection.

The term 'social capital'[43] is increasingly being used to understand the ways in which susceptibility to HIV/AIDS reflects a breakdown or poor development of coherent and cohesive social fabric which fundamentally orders the relationships within communities and determines the relationships of communities to the broader environment. The concept reflects both the internal social order of communities and the ability of communities to respond to or engage with organs of the broader society.

Social capital and the allied concept of social cohesion are important in understanding the relationship between the socio-economic functioning of communities, and response to HIV/AIDS. However, whilst there is a burgeoning literature on social capital and its effects on health status of communities, there has been relatively little systematic investigation of the relationship between social capital/cohesion and the impact of HIV on communities, including the response of communities to HIV/AIDS.

At a macro-level the framework for developing social capital is no different from the framework for developing societies. Essential elements are democratic governance, accountability, economic development, development of social infrastructure, education, health services, human rights and international co-operation. But none of these necessarily, in the medium term at least, translate into development of social capital in communities. This is where the need to develop local government comes to the fore. Social organisation at district, town and community levels is the concern of local government.

What forms and activities of LG are necessary to develop social capital in such a way as to deal with the underlying causes of high susceptibility to HIV/AIDS? This key question takes us to the role of LG in coordinating the link between communities in need of HIV/AIDS response systems and the means which governments and NGOs have at their disposal to provide the same.

But HIV/AIDS points to the need for immediate, emergency-type intervention and relief[44], which is in many ways is methodologically different from long-term developmental approaches. Immediate intervention, however, needs to be developed in such a way as to be aligned the longer term developmental approach to intervention. This challenge is central to the concerns of this document.

1.4 Implications for local government

> "For too long HIV/AIDS has been seen as a health issue rather than recognised for its wider reaching development implications."[45]

- The implications of HIV/AIDS for local government are severe. The following are some of the recognised reasons why local government needs to be directly involved in developing HIV/AIDS responses.
- It is often said that the greatest burden of HIV/AIDS is on the family and at household level[46]. Certainly the primary economic impacts of HIV/AIDS are felt at a household level. The impacts resulting from a loss of income include increasing expenditure on health care, burials and diminished resources available for food, education, clothing and basic needs for the remaining household members. This affects local economies and local governments are directly affected by this both at the revenue level and at the level of needing to increase support and services to ailing communities.
- Whatever the burden of HIV/AIDS may be to countries as a whole, the burden is felt most immediately at local level and communities look to the closest level of government for assistance, namely local government. When governments look to improve services to such communities they look to local government to facilitate this and they pass the mandate for the same to LG agencies. The burden of doing something about HIV/AIDS in such communities becomes the political responsibility of local government.

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[43] For a recent critical review of the concept see Hawe & Shiells 2001.
[44] Putzel 2003
[45] DDP/GTZ date, p.27)
[46] Booysen et al. 2002

- The need to prioritise HIV/AIDS response through local government initiatives cannot be avoided. The well-being of communities is undermined by HIV/AIDS to such an extent that it impacts on all areas of service provision and development planning at LG level.
- LG is well placed as the hub of government service delivery and as the link between communities and government resources, to co-ordinate the honing of government service delivery to optimally serve HIV/AIDS response needs.
- LG is well placed to facilitate integration of services provided by non-governmental organisations and government at local level.
- It has been suggested that HIV/AIDS takes root most easily in communities of relocated people and especially in informal urban settlements that are internally less cohesive. Further it has been suggested that there is a distinct link between urbanisation and HIV/AIDS. This fact warrants a special focus on understanding the urban environment and HIV/AIDS.
- HIV/AIDS draws attention to urban development needs and especially to the needs of informal urban settlements and communities of relocated and displaced people. LG is best positioned to understand and address these needs in an integrated way.
- Local government is at risk due to HIV/AIDS because of the demand for new and increased services. Local government is faced with the burden of caring for large numbers of chronically ill people and unprecendented numbers of orphans who have few means of economic and social support.
- HIV/AIDS impacts on local government functioning itself. Local government is at risk due to: the direct impacts of HIV/AIDS on its LG employees; the increased demands for services; the burden and cost of HIV/AIDS planning processes; and the compromised ability of local communities to pay for services and local taxes.

2. A REVIEW OF THE CHALLENGES FACING LG IN RESPONDING TO HIV/AIDS

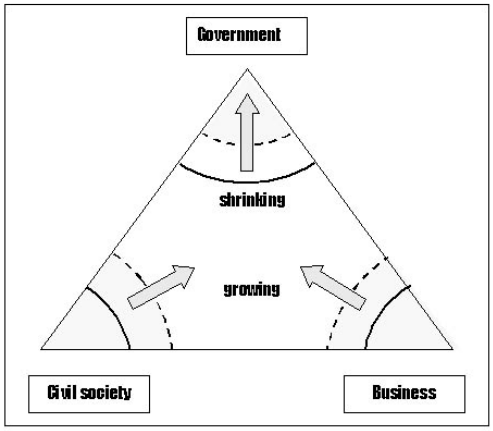
The premise that locally crafted responses to HIV/AIDS are important has been well established in the literature as has recognition of the need for participatory methods of programme development and management. But most of this work does not identify the specific issues facing LGAs endeavouring to support local responses, which is the particular concern of this review.

There has been remarkably little written on the subject of local government and HIV/AIDS. The varieties of local government and the differing structures of society tend to work against a simple, generic best practice approach to local government involvement in HIV/AIDS programmes. Perhaps the best approach to developing a generic understanding of issues facing LGAs, is to focus on decentralisation, and how the parts of decentralised systems relate to each other, and periphery and centre relate to each other. This raises the central issues of co-ordination and integration within decentralised systems which will be primary concepts in this analysis and are also central themes in the companion handbook.

> A 1994 survey of developing and transitional nations showed that out of 75 economies with populations greater than five million, all but 12 claimed to have embarked on some type of transfer of power to local governments. [47]

To set the context for understanding the emergence of local government as an increasingly prominent sphere of government, it helps to appreciate that certainly in the Commonwealth Group of countries, and possibly more generally, the role of governments as the primary agent of governance appears to be shrinking. The following diagram[48] illustrates:

The changing shape of governance



It shows that relative[49] to the inputs of civil society and business or private sector interests the input of government into the provision of public goods is shrinking. There is increasing recognition by governments that the traditional functions of governance, including health, welfare, economic development, education and infrastructure, cannot be adequately provided for by governments. The roles of civil society and business have grown accordingly. This is perhaps nowhere more evident than at the local level of government, and the shrinkage of governments and the growth of local government models seem to coincide and in many respects support each other. The changing shape of governance places increasing emphasis on interaction between the three sectors of government, civil society and business.

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[47] Dillinger 1994 in Aikin et al 2001

[48] Adapted from Commonwealth Foundation 1999

[49] Whereas government spending on public goods may be growing in absolute terms in keeping with growing economies and populations, civil society and business are increasing their contributions relative to government.

Public goods are those services and resources associated with the public sector such as provision of basic health care, basic education, personal security for citizens, social welfare, financial provision for old age elderly and sickness and unemployment benefits. There are increasingly business agencies which are providing these as services, albeit to wealthier and employed members of societies. Equally international civil society agencies (including NGOs and multilateral donor agencies) are increasing providers of humanitarian aid, poverty relief and interventions for health development.

At local government level the picture needs to be more clearly articulated. In a context of increasing decentralisation[50] the influence of local government is growing relative to the influence of provincial and national government. Yet within local government, in South Africa and Uganda at least, there is growing evidence of public goals being served by extra-municipal service providers, either directly or through forms of technical assistance. The trend is probably less evident in Francophone countries of sub-Saharan Africa.[51] Later in this report the funding of civil society organisations (CSOs) through government funding channels is discussed, showing how civil society and business resources can serve the goals of LG and how city municipalities are increasingly facilitating partnerships for harnessing these resources.

Although there has been only a little work done on quantifying the relative contributions of government, civil society and business to mitigating the impacts of HIV and AIDS, evidence points to the fact that the larger part of response is donor funded. In 1996, for instance, the government of Senegal contributed less than 8% to HIV/AIDS funding, and Uganda less than 7%.[52] These are widely heralded as the most successful country level programmes for containing the epidemic and yet they are overwhelmingly externally funded. The situation in South Africa is possibly different as the South African government has a much greater revenue resources than do many other developing countries and South Africa has not relied as heavily on donor funding and development aid, compared to own contributions. Nonetheless, there has been an exponential growth in civil society and business involvement in HIV and AIDS interventions[53], and government budget allocations have probably not grown to the same extent.

The growth of non-governmental HIV and AIDS service provider organisations registered in Uganda has grown by more than 500% between 1990 and 2003.[54] This is probably the case in South Africa[55], although there has been little research on civil society responses to HIV/AIDS. A visit to any small town in South Africa, however, will show without need for statistics that there has been a growth in community based organisations and civil society interest in assisting with HIV/AIDS responses. Also the commitments of large business interests to HIV/AIDS responses has grown to scale with mining houses, the parastatal sector, the automotive assembly industry and the financial services sector leading the way.

What does this mean for local government? It means that local government responses to HIV and AIDS are made in a context of an expanding range of responses by business and civil society interests which are not regulated or co-ordinated at local level. It means that in terms of provision of new services, LG is probably not well positioned to match the upscaling of other local resources. It means that LG has allies in the struggle to mitigate the impacts of HIV/AIDS. In this context the role of LG is to co-ordinate the contributions of the range of stakeholders such that the net effect is an expression of national policy that fill the gaps and develops the reach of existing efforts.

In summary it may be said that public goals (delivery of basic services) may be achieved, and increasingly are by *non-public* means. There are both opportunities and risks associated with this. The opportunities involve increased human and capital resources flowing into the pool of resources available locally for HIV/AIDS response. The risks are an unregulated, unsystematic and poorly integrated set of responses. To capitalise on the opportunities and diminish risks local governments are increasingly developing strategies for actively managing these resources through development of partnerships between LG and civil society and business. This is appropriate as in most systems of LG it is a mandated function of LG to co-ordinate local planning and development. It does, however,

[50] Commonwealth Foundation. 1999.
[51] Personal communication with Professor Babacar Kante, University of San Louis, Senegal
[52] UNAIDS 1990
[53] This is speculation as there have been no comprehensive attempts to quantify business of civil society contributions in South Africa
[54] Thornton 2003
[55] DSD 2002 suggests that the ASA NGO sector has burgeoned in the last few years.

require resources and it is important to understand what kind of inputs are necessary to ensure that organic development of local responses develop into a system of response rather than a range of individual responses.

> "Governance is broadly defined as the system of values, policies and institutions by which a society organizes collective decision-making and action related to political, economic and socio-cultural and environmental affairs through the interaction of the state, civil society and the private sector. Governance comprises the complex mechanisms, processes and institutions through which citizens and groups articulate their interests, mediate their differences and exercise their legal rights and obligations." (UNDP: Overview of decentralization: p.3)

The emergence of local government as an increasingly important form of government world-wide in both the developed and developing worlds, involves the increasing decentralisation of public functions, stimulating citizen participation and enhancing government accountability and transparency. A case in point is Latin America where a recent movement towards democracy has been accompanied by a trend towards decentralisation of national governance, strengthening of local government, and greater emphasis on participatory forms of democracy:[56]

- It might be said that global tensions apart, the developing world is in the throes of a movement towards political democratisation and enhanced government accountability. This includes the growing independence of legislative branches, increasing mobilization of civil society organisations, growing demands for openness in government, and forms of representative if not participatory democracy.
- Accompanying this has been a marked shift to decentralisation of previously highly centralized governments and increasingly passing on of governance functions to LG, often accompanied by attempts to develop and strengthen LG.
- "From Bolivia, where a new popular participation law is designed to encourage the movement of the poor into the nation's political mainstream through the development and strengthening of local institutions, to the Peoples Republic of China, where the granting of substantial degrees of municipal autonomy to selected local governments has produced, for example, in Shanghai, a major economic boom that includes the largest amount of new construction activity in a single urban area in human history, one witnesses the stirring of new leadership and creativity at the local level."[57]
- Whereas post-conflict countries may need a central government power to unify divisions, emerging democracies find that the deconcentration of power and government functions away from the centre strengthens a society's ability to accommodate political differences.
- In many emerging countries there is a strong movement for greater participation of citizens and private sector organisations in governance. Whilst not outside of the realm of politics local government provides an opportunity to engage the power of the state around community needs and aspirations.
- Increasingly throughout the world, local government is playing an important enabling role in the development of civil society. Far from being in competition with civil society local government is encouraging partnerships with civil society and recognising the role that civil society has to play in social and economic development. Municipal regulations and national statutes are increasingly supportive of close alliances between local government and civil society organisations (CSOs).

International donor and development organisations including United Nations agencies, the World Bank and regional organisations are increasingly paying attention to the need to support decentralisation. In many countries there are national support programmes for decentralisation, and constitutional reform and legislative changes have been undertaken or are underway in support of decentralisation.

Turning now to the role of LG in local HIV/AIDS response in many countries in the developing world the larger part of the sum total of HIV/AIDS response programmes are programmes not funded or run through government, but through non-governmental programmes. But counter to this situation and in the hope of building more sustainable programmes donor organisations are increasingly seeking to support governments in their attempts to devolve HIV/AIDS programmes to LG. However, there are significant risks associated with working through LGAs, which are often not geared and do not have the capacity for the task of leading and coordinating HIV/AIDS responses.

[56] Many of the points in this section are derived from United Nations Global Forum 1996
[57] United Nations Global Forum 1996 p.18

Decentralisation programmes and frameworks for local government in the developing world are largely 'in the making'. There is much uncertainty in most developing countries about the powers and functions of local government and how these should be devolved through the tiers and spheres of government. Local government often consists of a patchwork of governmental institutions at various stages of developing towards sometimes poorly defined endpoint, and the relationships between levels of government are often not fully worked out. In this context one of the most glaring problems is the mismatch between mandates and budgets where local governments are expected to provide services for which there is no fiscal provision and little opportunity for raising local revenues.

In such situations it is not surprising that managers of large HIV/AIDS and allied programmes are often quite unaware of how LG functions, and they engage with government programmes mainly at the service level. There are increasing attempts to coordinate donor efforts and to integrate programmes with government strategies and programmes, but local government is often seen as an accessory in such attempts rather than a central cog in the machine. Such programmes often provide services on behalf of local government, absolving them of their constitutional responsibilities, and they are often not hatched out of, or integral to, LG HIV/AIDS response planning.

There appears to be an emerging realisation that the challenges facing local government have much to do with the reasons why national AIDS programmes are not rolling-out as hoped at the local level, and why provinces and regions are not spending their budgets for HIV/AIDS response. There is clearly need for supporting the development of decentralisation programmes and there is currently increasing emphasis on this focus in international aid provision to the developing world. Many of the issues that are faced in developing LGA responses to HIV/AIDS also need to be resolved from the centre, at the level of decentralisation legislation and reform. However, HIV/AIDS response cannot wait for such legislation and reform and the challenge is to find ways to address some of the problems that exist at a local level, or within the decentralised system of governance. But patchwork solutions run the risk of being part of the problem. It is already a problem facing departments of local government that the web of patchwork solutions that define the relationships between government institutions run counter to the plans of reformers. At the same time reformers are faced with the paradox that the relationships between local government departments, NGOs and international donors within the systems they plan to reform, sometimes lead to remarkably effective HIV/AIDS response systems, and creation of new regulations sometimes threatens to disrupt effective practical arrangements that have evolved over time, but which are not 'proper' in the sense of being aligned with government decentralisation frameworks and planning.

The table below provides definitions of some of the key local government issues that are central to understanding the problems of HIV/AIDS response and that will be used in the following analysis.

Term	Definition
Fiscal decentralisation	Rationalisation of the systems of fiscal disbursement in keeping with the mandates to local government structures.
Functional integration	Integration at the points of delivery of the health services, to ensure a continuum of engagement with systems of service delivery, recognising that integration must primarily be oriented around utility. It also involves development of referral networks and consistency of norms and standards of practice across functionally related services.
Horizontal decentralisation	Decentralisation of decision making powers and functions from the centre to mandated committees and structures within LG.
Integrated services	A general term to refer to services which require inputs from different departments and partners of LG, but which are a unitary and seamless service from the perspective of service users (e.g. health and welfare services).
Integrated development planning	Development of a single development plan for a LGA which incorporates inputs from all sectors of that government at that level. It also refers to integration of development plans from lower level tiers of government into the development plans of higher levels (e.g. municipal plans into district plans).
Inter-governmental relations	Relations, communications and operational co-operation agreements between different domains of government at the same level of decentralisation and also across the tiers of government (e.g. provincial-district).

Inter-governmental structures	Structures within government which are designed to support inter-governmental relations and coordinated functioning between systems which are other.
Mainstreaming HIV/AIDS	Embedding HIV/AIDS response in development programmes rather than making it a special issue to be separately dealt with.
Multi-sectoral programmes	Programmes which are designed to include the efforts of different government departments and usually funded jointly by departments.
Split functions of government	Functions of government, which are performed in parts at different levels of decentralisation (e.g. salaries for VCT staff paid at one level, and laboratory costs at another level).
Unfunded mandate	A requirement imposed by legislation on regional or local governments with no matching funding (e.g. provision of internal workplace HIV/AIDS programmes but without provision for the costs involved).
Vertical decentralisation	Decentralisation that occurs within sectors and departments, disconnected or not integrated with decentralisation structures and frameworks in other sectors and departments.

2.1 IMPLEMENTING NATIONAL AIDS STRATEGY AT LG LEVEL[58]

Local government refers to constitutionally established governmental structures that are in differing degrees and forms, governing at the level of formal government closest to communities. LG is specifically distinguished from civil society forms of social regulation, including non-statutory forms of community or traditional leadership. Very often the challenges of developing 'local responses to HIV/AIDS', an area where there has been relatively much work done, is assumed to include local government responses. But local government faces specific and unique challenges in addition to the challenges it faces in working at a local level.

In many countries (e.g. Angola, DRC, Sierra Leone) the formal structures of government are only weakly established and are in many cases contested. In such cases there is often no government to speak of at local level and certainly no set of constitutional arrangements determining the powers and functions of local authorities. Even when these are legislatively established local government may amount to not much more than basic maintenance of infrastructure such as roads and hospitals, but even then the powers of local government may be severely limited by lack of funds, poor governmental infrastructure, conflict, corruption or well-meaning ineptness.

These extremes aside, in many areas the stronger force in local social organisation is not the government, but various forms of civil society organisation (CSO). By this is meant organisations that in different ways are part of the social fabric and organisation of societies. These may include traditional authorities (clan structures, chieftainships, kingships), burial societies, agricultural co-operatives, religious institutions and so on, which exercise some form of authority and organisation on the functioning of communities. These are often well-accepted authorities but not government structures, although they may perform the same functions that government structures in other contexts are expected to fulfil. They may order and regulate the functioning of communities and perform services (e.g. enforcement of law, collection of payments and taxes for social organisation, provide health services, regulate access to communal resources).

The structure of decentralised government varies across countries. Three main levels are distinguished. National government refers to the central administrative and legislative authorities. Provincial or regional government refers to the second tier (in more decentralised systems referred to as a sphere rather than a tier) which would usually include administrative and/or legislative functions. Some countries such as Uganda do not include this second tier[59] and are decentralised from national level to districts. The third tier is usually some version of the concept of districts. In many contexts districts are the lowest formal local government institutions, but in some

[58] A very important resource in this area is the work of Hollister (n.d.) titled 'Decentralisation in national AIDS control and prevention programs'.

[59] Although regions may continue to play an administrative coordinating function this is usually conceived as a relationship of convenience often carried over from previous administrations and often with uncertainty about their role and continuation.

contexts, for example Uganda, there is a range of smaller structures which fall under the rubric of local government, including municipalities, sub-counties and parishes. In other countries rural communities, villages and various forms of civil society authority are drawn into formal local government forums, but are not part of the formal structure of local government. A special case is usually made of large cities or metropoles which in many local government systems are regarded as the equivalent of districts.

Local governments also differ in degree of decentralisation.

2.1.1 The varieties of decentralisation

Decentralisation can take a number of forms.

Forms of decentralisation

There are four commonly recognised forms of decentralisation possible within a unitary state. Often these are mixed, and point to a process of evolution from centralised to decentralised governmental organisation, in most cases starting with deconcentration.

Deconcentration is the transfer of functions and resources to local level units of the same administrative system while power remains at the centre.

Devolution is the transfer by legal or constitutional provision of functions, resources and power to the community level.

Delegation means that the Government temporarily assigns specific functions to an institution such as a health or education board.

Privatisation involves transfer or surrender of responsibilities of state enterprises to private entitities.

What can be done to support LG responses to HIV/AIDS is greatly determined by the framework for decentralisation that exists within countries. Frequently the problems besetting decentralisation of HIV/AIDS response are the problems inherent in legislation which lays the foundations for decentralisation. These need to be identified and addressed in the long term. For example, Uganda has a well developed local government dispensation enshrined in the constitution and supportive legislation. However, there are clearly problems in the system of financial decentralisation and a process is underway to overhaul this legislation in keeping with the challenges that have emerged in the running of local government.

In many instances the constitutional and legislative foundations of local government are still in the making. Because local government involves reorganising communities and the way they are governed into more structured frameworks, and fitting functions of government into geographical boundaries,[60] the process is complex and fraught with challenges. It is often explicitly said in LG development strategy documents that LG development should include a high degree of flexibility. Local arrangements need to be tailor-made to suit local circumstances, rather than prescribed, and there needs to be, and often is, recognition that well-functioning local government systems in years to come will benefit from early tolerance of a 'learning by doing' approach.

The downside of this is that in most LG systems in the developing world, whereas the arrangements between various spheres and tiers of government, and their relationships with CSOs may 'work', when local variants are the rule rather than the exception it makes support and funding on a systemic basis difficult. So there is a major challenge to developing local government systems in a more rational and systematic way, but without losing the organic functionality and responsivity of local government responses. The challenge of developing sensitivity to context in an ordered way which fits within a constitutionally defined framework for LG is important. Meeting both of these challenges allows for both contextual sensitivity and a knowable structure through which to engage, fund and support LG in responding to HIV/AIDS.

2.1.2 Powers and functions of local government

The powers and functions for each level of government are often outlined in the country's constitution. If not, it is often the case that separate legislation has been promulgated to define them. However, in many cases, the

[60] See McCoy et al 'Fitting functionality into boundaries'

functions of the different levels of government are not defined or are poorly defined. Further, the responsibilities for each level of government for the performance of a function is often not clearly understood by practitioners.

Before advising or supporting a municipality in developing services or forming service delivery partnership agreements, it is essential to know what powers and functions the municipality is responsible for. This requires answering the following questions:

- Where are the powers and functions for local government outlined?
- What are the powers and functions for local government?
- Are the functions adequately defined?
- Are there norms and standards for the performance of functions?

One of the most common areas of confusion concerns what basket of services should be provided at each level of decentralisation. Some of the issues that governments struggle with in making decisions in this area are:

- What basket of services will be provided at each level?
- How will these services be funded? By local government from their own revenues? Through provinces? By financial transfer from the national treasury? Which services will be regarded as functions of different levels of government?
- Answers to these questions are often not obtained by consulting legislation or practice guidelines. These do not always exist, and when they do, ongoing reform often ensures a degree of uncertainty, as do accepted lags between legislative decentralisation reform and practice. Such anomalies and uncertainty become especially problematic in planning new services and integrating services. This means that planning HIV/AIDS responses may face challenges which are not otherwise prioritised for resolution.

2.2 INTEGRATION

2.2.1 Vertical decentralisation

It is not uncommon to find that different sectors of government are not decentralised at the same pace, to the same extent, or through the same tiers and structures of government. For instance, it is not uncommon, and Senegal is a case in point, to find health departments following different patterns of decentralisation to the rest of LG, even to the extent of having separate demarcation boundaries. This leads to the need to create inter-governmental structures to support co-operation of government agencies at the different levels and spheres of government. Procedures for inter-departmental co-operation in relation to specific functions (e.g. HIV prevention) are often made on an *ad hoc* basis in contexts of vertical decentralisation.

The lack of overlap between the administrative localities of the different functions of government poses a challenge to the development of local government HIV/AIDS programmes, especially given the need for multi-sectoral responses and integration. As it is sometimes put, there is a need to fit functionality to boundaries. Health departments are often an exceptional case in respect of demarcation. In Senegal, for instance, the geographical regions through which the health department is decentralised differ from the local government decentralisation regions. In such instances special attention needs to be paid to developing the relationship between health departments and local government. Resetting of demarcation boundaries is a costly and complicated process for health departments and *ad hoc* arrangements are often set in place to accommodate the working together of health departments and various local authorities. Decentralised government is usually a process 'in the making' and decentralising systems usually show the remnants of past governmental dispensations, including persistence of old demarcation boundaries and related structures alongside new ones. South Africa is a case in point, with 'old' health districts continuing to exist a few years into the designation of new local governmental demarcation boundaries. Whilst such problems may adequately accommodate existing arrangements they may pose a problem in the planning of new, co-ordinated or integrated responses.

Within government departments there are often programmes which are vertically decentralised in the sense of being managed by central units rather than through the tiers of decentralisation followed by other programmes within the department. National TB programmes sometimes operate like this, as do programmes for integrated management of childhood illnesses, integrated nutrition programmes, and provincial or district directorates of HIV/AIDS. Ironically, programmes which have cross-cutting links and which are intended to integrate functions within departments are sometimes themselves not well integrated into the decentralisation framework.

These are important problems that are inevitably faced in developing integrated HIV/AIDS programmes. Frequently appropriate structures and communications frameworks are not in place and these need to be developed in the form of inter-governmental or inter-departmental support programmes. Some examples of these will be discussed in Section 3.

The structure of health services - which range from teaching hospitals and research facilities to local clinics and health promotion programmes - tends to be more intricate and complex than is the case with many other government departments. It is often the case that health ministries retain control over certain parts of a health system, notably hospitals, irrespective of where they are situated, but primary health services may be coordinated and managed at district level and environmental health at municipal level. This appears to be the prevailing trend.[61]

This means that within the geographical boundaries of a municipality one may find officials representing both district and municipal levels of local government. Further, because particular functions (see split functions below) may be functions at both levels of governance (e.g. HIV prevention) projects and programmes which develop in these areas may be confusingly cross-located at different levels of local government. Local government councillors are themselves often confused by the complexities of governance of health systems at different levels.[62] This makes integrated planning and effective inter-governmental relations all the more challenging.

2.2.2 Split functions of government

Split functions of government refer to different levels of government performing different aspects of an overall function. In health departments different levels of government may be responsible for the planning, management, maintenance and financing of different types of service in relation to the needs of people living with HIVAIDS. For example, payment for laboratory costs of HIV testing may be the function of district or provincial departments, whereas staff and facility support for VCT may be the function of a municipality. In other words, one service is organised concurrently at different levels of government, giving rise to co-ordination and alignment problems. Breakdowns and resource constraints in any part of such systems, can be an obstacle to service delivery.

Confusion may occur as to which aspect of a function is to be performed by which level of government. This may give rise to problems including: indecision and lack of action concerning critical elements of services for which no level of government takes responsibility; conflicts about areas of responsibility; overlap in planning and service provision between levels of government;[63] uncertainty leading to unwillingness to take decisions or commit to programmes of action; poor phasing of rollout of services;[64] poor planning with scale of services determined at one level not matching realistic or required scale at another level; temporary or makeshift arrangements[65]; mandates which are unfounded;[66] poor coordination of activities; and difficulties and obstacles in preparing partnership agreements when a service is split across different levels.

Inadequate funding for the provision of a function at one of the levels of government may result in only portions of the service being provided and in some cases result in the entire function failing.[67] It is important that there be clear articulation of the different parts of a function: for example, voluntary counselling and testing which requires staff, facilities, training, laboratory procedures, social work support, follow-up, research, health promotion, education and social marketing. The funding of these elements needs to be closely co-ordinated as it often

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[61] An interesting case is South Africa where recent decisions have rescinded earlier plans to decentralise primary health care services to municipal level.

[62] Kelly (2002) found in an evaluation of local government leaders training programme that local leaders were usually unclear about how services were organised across different levels of LG.

[63] For example, similar programmes being planned at district and local level.

[64] For instance a building may be supplied by a provincial department without appropriate and timeous arrangements for salaries of staff to work in the facility being budgeted and paid at district level.

[65] For instance secondments and temporary appointments which create uncertainty and job insecurity.

[66] This is a very common problem in decentralising systems, where mandates are attached to functions of local government but where the LG authority does not have the necessary funding or revenue base to deliver into the mandate.

[67] A good example is VCT. Where the budget for laboratory costs at one level is exhausted, the entire function comes to a standstill. This situation is not uncommon in many South African municipalities.

happens that breakdown at one level disrupts a chain of activities which are required for the service to be provided.

Often the more resourced level of government takes on the provision of those aspects of the service for which they are not legally responsible. This may lead to:

- Distraction from the provision of their own core function.
- Stretching the capacity of the responsible department financially and in terms of human resources.

2.2.3 Integrated planning

The need for integration of planning efforts is particularly important in developing HIV/AIDS response for the following reasons:

- The need to mitigate the impact of HIV/AIDS involves almost all sectors of government. A multi-sectoral approach is required in respect of most elements of HIV/AIDS response. Sometimes departments which have had little previous reason to co-operate may need to work together. For instance, agriculture, education and welfare may need to co-operate closely in providing food security for rural people affected by HIV/AIDS.
- Binding the split functions within government sectors for HIV/AIDS response requires agencies of government to work together at different levels, which has otherwise not had to happen.
- There is a need to create a sense of continuity of service delivery to ensure efficient use of resources and maximum uptake of resources on the part of users.
- Integrated planning is more costly, needs support and needs to be budgeted for. Support needs to include development of guidelines and frameworks for local government planning as well as for resolving the difficulties and confusions around integrated functioning in decentralisation programmes.
- Support for integrated planning needs to happen at all levels, from national government to local level programme development.

2.2.4 Inter-governmental relations and support

Inter-governmental relations refers to the communication and planning frameworks which exist for co-operation of departments and spheres of government, and across levels of government, in joint planning. In the field of HIV/AIDS intervention and mitigation there is a widely recognised need for diverse sectors to work together, but there may little history of their working together.

Inter-departmental support structures are one way in which ministries have attempted to build bridges with other departments. It is necessary to have specific agencies promoting such support as the demands of service delivery usually eclipse the need for collaboration between departments in planning services, with the consequence that inter-departmental, and ultimately integrative work is overlooked. It should not be assumed that the small scale of local government departments allows for easier relations between departments, as the practicalities of service delivery are the abiding concern and integration may be given scant attention.

Existing pressures on local government to deliver basic services creates a sense of reluctance to develop new programmes. Responsibility for developing HIV/AIDS programmes is often shunted to health desks and departments, and the well recognised need for a multi-sectoral approach to HIV/AIDS is more often than not overlooked. This is especially the case in LG systems where decentralisation has taken place vertically, with few linkages between departments at higher levels. It is not uncommon to find interministerial committees at parliamentary level but nowhere else, meaning that whereas there is encouragement for operational integration, the actual systems of service delivery are not interconnected at lower levels.

2.3 CO-ORDINATION

In many areas in the developing world and certainly in Africa, where HIV/AIDS is having particularly devastating impacts, the larger part of the response framework is in fact not governmental but is conducted by various types of CSOs including churches, international aid organisations and community support organisations[68]. This is not only

[68] Putzel 2003

the case in societies where there is poor governmental infrastructure, and may be the case in relatively highly resourced societies, such as South Africa.

In some versions of local government, as will presently be seen, decentralised government fades into local committees and structures, so that both governmental and civil interests are incorporated under the concept of local government. However, the politics of central government particularly in democratic systems usually means that people are strongly aware of the distinction between governmental and civil spheres.

It has become increasingly important in the local government context to understand the relationship between civil society and government. The growth in number and influence of civil society organisations in many developing countries has outpaced the growth in size and influence of government, which in many cases is actually shrinking.[69] This growth in CSOs is strongly apparent in the HIV/AIDS field, and in most sub-Saharan countries it has certainly outstripped the growth in size and spending of government efforts. However, many CSO efforts are conducted in close association or partnership with government, and there is increasing interest in the notion of partnership and how governments can interact efficiently and effectively with CSOs.

Many of the larger partnerships between government and CSOs are established at national or provincial level and support government HIV/AIDS programmes. There has been relatively little corresponding support for the development of LG HIV/AIDS programmes, amongst other possible reasons is that the scale of these is often not sufficiently large to attract the interest and support of large donor and aid organisations. Support to local government by these organisations for LG has largely concerned developing LG itself; e.g. capacity building of managers, overcoming decentralisation problems and supporting democratisation. There has been relatively little direct interest in local government HIV/AIDS responses specifically. District level HIV/AIDS programmes are a possible exception, but they are often not conducted at a national scale and many such programmes are in the pilot or early stages of development. There has also been some notable development supporting city-level responses to HIV/AIDS.[70] Municipal and small-town level LG HIV/AIDS responses are arguably the most neglected area of support for LG responses to HIV/AIDS.

While the relationship between civil society and local government is very clearly a reinforcing and mutually beneficial one to both parties, there are also some complexities and ambiguities, indeed even paradoxes, in such relationships. In particular, the relationship between local governments and civil society organisations (CSOs) can be problematic. In many countries, some of the strongest CSOs were originally initiated by the international donor community as vehicles to facilitate going around government for the provision of various kinds of technical and material assistance. This has meant that, in some instances, significant rivalry for international donor resources has developed between the institutions of government and non-governmental organisations. Nevertheless, whatever the potential pitfalls might be, there is no question that the emergence of local government as a governance force is occurring hand in hand with the emergence of CSOs in many countries. Clearly, working both separately and together, strong local government and vibrant CSOs are among the key builders of an effective civil society. The challenge is to support their co-ordinated functioning.

2.3.1 Decentralisation and the non-government sector

Major non-governmental HIV/AIDS programmes may have very little to do with LGAs especially when the main services they provide are not services specifically mandated to be provided at the most local level of formal LG. For example, it is often the case when health departments are vertically decentralised that CSOs interact with district health departments, or equivalent, but might have little to do with municipal health services. Also, CSO services may be set up independently of local services and have only occasional communication with government services.

The need for such CSOs to understand decentralisation frameworks and to engage with the system at all levels is increasingly being recognised. There is a need for co-ordination and alignment of strategies and programme implementation at local level, not only to avoid duplication, but to avoid conflicts of interests, link services, create referral networks and orchestrate the functioning of different services so that these are experienced at the user end as a continuous and integrated service. If co-ordinated HIV/AIDS responses are to be achieved, and this is important considering the extent of service provision on the part of CSOs, a relevant challenge is to construct ways of co-ordinating and ultimately integrating CSO and LGA responses.

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[69] Shaw 2000

[70] Notable here is the work of AMICAALL.

2.3.2 Partnerships

The term 'partnership' has been used to describe many forms of interaction between public and community-based, non-profit sectors in the area of policy formulation and implementation[71]. Partnerships may include bilateral or multi-party arrangements between such diverse groupings as government departments, volunteer agencies, national NGOs, local common interest groups and individuals. These may be pragmatic relationship involving no more intensive communication than fortnightly talks on the telephone[72], or 'elaborate' and 'extensive' arrangements linking government and the non-profit sector.[73]

The model of partnership between CSOs and LGAs has taken many forms. In developing countries and certainly in sub-Saharan Africa it is relatively new and not widely applied, although in more developed countries, and perhaps particularly in the United Kingdom, there is a well-established history of partnerships and research and literature to support this. In many underdeveloped countries, there can be found numerous relatively small scale co-operation and funding agreements which link CSOs and government.

A number of alternative methods of service delivery[74] are available within the local government framework, one of which is partnerships with CSOs.

One of the most widely spoken about advantages of partnerships for health is in that it allows greater co-ordination of resources, thereby avoiding duplication and developing better economies of scale. In relation to the burgeoning of numerous small and often struggling HIV/AIDs organisations, for example, it has been said that "Small local NGOs/CBOs are providing a range of services in specific locations individually, which if coordinated together and with government services, could provide a comprehensive integrated HIV/AIDS programme, including community participation and multi-sector collaboration."[75]

Some of the more common areas of partnership are: technical assistance programmes; service partnership agreements; monitoring and evaluation services; and programme management services.

Problems with partnerships

Whereas partnerships between CSOs and LGAs promises to deliver many advantages, the research and literature warns of a few possible problem areas. Amongst these are:

- CSO activities are often conducted by committed staff and volunteers, but they often lack the resources to run existing programmes effectively, and to improve capacity and security[76]. They often operate at a local level and do not have the administrative or management skills and experience to be accountable to government, and certainly not the experience of working within government frameworks.
- Maintenance of partnerships between sometimes large and usually bureaucratic LG services and small CSO service providers (which may be highly focused, efficient and cost effective in the way that they deal with meagre resources), is likely to be fraught with challenges from both sides. For example, health workers in the formal health sector are accustomed to working within particular protocols of practice and there may be clashes between these 'communities of practice'. This may take place at any of a number of possible levels including: working conditions, salaries, work culture, motivation, reporting structures, referral practices, record keeping, attitudes to clients, expectations of clients, ethics and professional procedures.
- Related to the above, there is in many context a prevailing negative attitude towards co-operation with government on the part of CSOs. Government services are often perceived to be inefficient in terms of service delivery and administration, poorly geared for responding to development challenges, slow to adapt to new and unique circumstances and less than sensitive to staff needs.
- Many projects involving partnerships report professional rivalries and jealousies between health workers and even competition for patients, which may show in unco-operativeness and unwillingness to share and learn from each other. Mistrust about the skills of trained volunteers is frequently reported in community health

[71] For useful conceptual reviews see: Mellor, 1985; Kramer and Grossman, 1987; Salomen, 1987; Billis, 1993
[72] Mellor, 1985
[73] Salomen, 1987
[74] These include corporatisation, public-public partnerships (between municipalities), contracting out, leases and concessions and transfer of ownership.
[75] Gordon & Ndondo, 2002, p.7
[76] Gordon & Ndondo, 2001

worker programmes. Professionals are prone to jealously guard their hard-earned qualifications and partnership programmes are prone, in some contexts at least, to face difficulties around issues to do with professional competencies, standards and licenses[77].

- It has been reported that "There are a lot of concerns about contracting with government and fears of privatisation of health services."[78] This necessitates 'bridging' the two sectors and building capacity in both to work as partners. "There can be no valid 'partnership' without respect, mutual capacity-building and some equality in decision-making."[79]
- CSOs are usually based in towns and in some countries this means that benefits flowing from partnership are not likely to reach rural environments. In other countries, of which Uganda is a notable example, it is often said that towns are overlooked in favour of rural areas where planners perceive the strongest areas of need to be. As a consequence it is said that urban environments are neglected.
- Partnerships may be easier to invoke than manage, develop and sustain. Management of partnerships requires specific mechanisms which need to be developed anew in different circumstances. Experience in the NHS system in the UK has shown[80] that the 'hype' of partnerships, which sees partnerships as unquestionably advisable, often overlooks the significant development challenges that are faced.
- Partnerships which strongly rely on the services of volunteers are not necessarily sustainable in the long-term or up-scalable unless the specific motivations of volunteers[81] are taken into account and met. These vary considerably and whereas altruistic attitudes and civic responsibility may partly account for volunteer motivation, amongst other possible reasons people may volunteer are: to obtain experience and training; in the hope of future salaried employment; and because they are unemployed and have time on their hands. In such contexts the ongoing commitment of volunteers to remain volunteers is by no means secured.
- In the process of implementation, decentralisation and partnerships programmes tend to be shaped by local baseline conditions (for example, local political conditions) which were not evident prior to implementation.[82] For this reason thorough appraisal of possible risk factors is necessary in forming partners.

The above points should signal that partnership programmes between LGAs and CSOs are likely to pose difficulties which need to be specifically identified and tackled if they are not to gnaw away at the quality and effectiveness of services. Each of the above problem areas could easily go undetected and unaddressed if not purposefully identified.

Elements of successful partnerships

Some of the findings of research and reviews relating to successful partnerships are:

- A review of partnerships for health[83] concludes that: partnerships operate most effectively when built on explicit and structured planning, nurturing and maintenance; partnership building is a skilled process that requires a significant investment of time and resources; partnerships are more likely to succeed in circumstances where an open and honest discussion of the potential difficulties involved in collaborating is possible; partnerships function best in circumstances where the partners offer contributions to an agreed common goal; partnerships are maintained most effectively in circumstances where change has been brought about in an incremental and co-operative fashion.
- Partnerships are not in all circumstances the preferred way of delivering health or social development services. It should be clear why a partnership approach is the best response to the perceived need or problem.[84]

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[77] Tovey & Adams, 2001
[78] Gordon & Ndondo, p.6
[79] Gordon & Ndondo, p.6
[80] HEBS, 2000
[81] The work of Senekal *et al* (2001) provides important insights into the motivations of volunteer DOTS supporters in a rural area of South Africa.
[82] Atkinson *et al*, 2000
[83] HEBS, 2000
[84] HEBS, 2000

- A review of partnerships[85] suggests that the shape of partnerships should be crafted according to specific needs and circumstances rather than based on a prototype of a partnership ideal. This means that whilst models are useful, successful large-scale partnership strategies will need to have strong capacities for developing partnerships-to-fit, rather than work through applying formulae or prototypes. However, both elements are clearly necessary to accommodate the dual and somewhat contradictory needs of specificity (developed to fit particular circumstances) and efficiency (based on a prototype or particular formula).
- Partnerships will vary in their rationale, scope, scale, lifespan and formality[86] and the partnership 'type' chosen needs to be "appropriate to the circumstances within which a partnership exists and the associated expectation".[87]
- In a review of large scale contracting of NGOs for HIV/AIDS response in Brazil and Gautemala[88] it was found that a combination of 'assistance' and 'expectations' of accountability in financial monitoring worked most successfully in improving CSO performance. Qualities of successful administration include a single administrative unit and consistent systems and procedures. An analysis of the relative merits of 'contracting' and 'grants' suggests that contracting may be a more favourable approach as it places the onus on CSOs to deliver, focuses on measurable outputs, creates a greater accountability for how funds are spent and opens the way for legal remedies. Unanswered questions include whether CSOs are cheaper and in what situations, how to operationalise performance contracting and whether CSOs and government have the capacity for this.
- Service agreement contracts at PHC level do not have a strong history of success in many cases and this is certainly the case in South Africa.[89] Principles and processes need to be carefully spelled out. Recommendations[90] for contracts between provincial and local governments point to the need for PHC contracting to be based on: sound policy frameworks and strategic planning; trust and a shared vision between the contracting parties; flexible contract specifications which stress constructive M&E procedures; and the need to start slowly and build capacity. These principles would as well apply to LG and CSO contract agreements.
- In a preparatory study for a large scale partnership programme at district level it is suggested that "It seems more helpful to find ways of supporting a group of smaller CSOs in a catchment area, perhaps coordinated and supported by a larger, more established CSO, than selecting one or two CSOs with a higher level of organisational performance based on conventional measures."[91] This suggests that the highest gearing for change may come about through working with small or forming CSOs which may have an insignificant funding base, if any funding at all. It would be easy to overlook such organisations in conducting an audit of existing CSO initiatives, as they might not even be integrated into CSO networks or be recognised by other organisations in the area. Selection of partners is a topic around which there is much current interest, particularly concerning assessment of the readiness of CSOs for partnership.
- The greater the level of local community involvement in setting agendas for action, the larger the impact. Volunteer activities, peer programmes, civic activities and involvement of local committees have been shown to increase the benefits which flow from alliances and partnerships for health promotion.[92]

2.4 THE CHALLENGE OF MOBILISATION

2.4.1 Service prioritisation

In the large and sprawling cities across the developing world, the gap between what is needed to meet the requirements of basic services and the capacity to deliver these services on the part of municipalities and town councils is massive. In probably the majority of urban informal settlements there is no piped water into homes, no electricity, unsatisfactory refuse removal and sewerage management, and only the most basic health and social

[85] HEBS, 2000
[86] HEBS, 2000
[87] HEBS, 2000, p. 4.
[88] Connor & Barnett, 2001
[89] McCoy *et al*, 2000
[90] McCoy *et al*, 2000. This publication also contains a useful annotated bibliography of key readings on contracting for health care.
[91] Gordon & Ndondo, 2001, p.7
[92] Gillies, 1998

services. In this context HIV/AIDS is often not seen as a priority by LGAs hard-pressed to provide basic services and to develop infrastructure for the same.

There are a number of other reasons why it readily happens that as pressing a problem as HIV/AIDS might not be regarded as a priority: HIV/AIDS stigmatisation means that AIDS-related illness is generally suffered in silence and it is often not perceived by communities as a priority issue, even in areas where AIDS prevalence is particularly high; people who are most affected often do not have the opportunity, skills or resources to enter the public domain as activists, especially they are coping with illness in their homes; HIV does not show its consequences for many years; organisations representing such people frequently do not have active and strong local chapters and their membership is often depleted by ill-health and death; health services are usually highly under-resourced and understaffed and where provision of basic health services is not established HIV/AIDS is regarded as being on a par with other serious medical conditions; and perceptions that too much attention is paid to AIDS at the expense of other medical and developmental problems.

Health and social services for those living in informal and recently established settlements – with the exception of those communities in acute crisis that receive specific attention from international agencies – are often non-existent. The concerns of local authorities often leans more towards moving such communities so that urban development can occur in an orderly way, and provision of services tends to be seen to condone and even encourage unplanned urban settlement. Health, education and welfare services may even be systematically denied.

For many municipalities there is little to no money available for development of new services. At the time of visiting a municipality in Zambia officials pointed out that they had not been paid for the past six months. There was a revenue crisis in that provinces had removed a number of sources of LG revenue and the funds of the municipality were simply exhausted. In the context payment of workers was a more immediate problem than the apparently postponable problem of HIV/AIDS. In Jinja in Uganda 33% of the town's budget is spent on waste management. The proliferation of markets and informal trading has given rise to a great need for management of vegetable waste in particular. It is a health risk, and harbours mosquitoes which cause malaria, a major health problem in the area. Managing solid waste in this area is clearly a more immediate service delivery issue than is HIV/AIDS, especially given the presence of a number of active HIV/AIDS CSOs in the area, which creates the impression amongst municipal officials that HIV/AIDS response needs are being attended to.

Prioritisation of HIV/AIDS at local government level is a major and unresolved problem. Later it will be suggested that mainstreaming HIV/AIDS into the activities of departments may be a solution to this problem, and one that makes sense also because HIV/AIDS is not simply a health problem.

2.4.3 Service delivery

It is well established that HIV/AIDS will mean an increasing need for clinic services, expenditure on new services to care for people who are infected and affected by HIV/AIDS, and increased expenditure on planning and developing integrated response systems. There is also mounting evidence that the financial burden on communities will negatively affect people's abilities to pay for basic services. At the same time HIV/AIDS has a direct impact on the capacity of LG to provide services; e.g. through poor productivity, absenteeism, illness and death amongst LG employees. In addition the financial implications in terms of viability of pension funds, health schemes and the costs of recruiting and retraining staff may amount to unbearable strains on LG resources.

Local government effectiveness is being severely compromised by HIV/AIDS, at a time when it should be rallying to the challenges of responding to HIV/AIDS.

It is increasingly accepted in the business environment that investing in preventing HIV/AIDS and managing its impacts makes good financial sense from a service delivery perspective. Similarly investment in safeguarding the functioning of LGAs by provision of 'internal' HIV/AIDS workplace policies and programmes makes good sense. This is arguably the first challenge of LGAs. This secured they are in a position to tackle the greater challenges of responding to mitigating the effects of HIV/AIDS in the communities they serve.

2.5 FINANCING LOCAL GOVERNMENT RESPONSES

One of the most pervasive problems of local governments in contexts of decentralisation is the problem of unfunded mandates. An unfunded mandate involves the assignment of a function of government to an agency of government without funding for this particular function.

In such contexts most budgetary provision is in the form of conditional grants[93] and there is often little leeway for discretionary spending to meet emergent needs of municipalities responding to HIV/AIDS. It is often incumbent on the local authority to raise the necessary funds through external funding or through taxes. When the authority to raise funds and enter into partnerships to fulfil such mandates is afforded in LG systems, the capacity to do this is often inadequate.

Funding flows are necessary to ensure continuous operations. There are frequently major problems in this area and funding flows between tiers of government are notoriously problematic.[94] Payment systems within government (inter-governmental transfers) are usually highly bureaucratic and when procedures are not followed exactly the chain of actions cannot simply be reversed at the point of discovery of a problem. In this case the procedure may need to be rerun leading to long delays which often compound the problems which need to be resolved.

The effectiveness of local government agencies in developing and managing decentralised systems of HIV/AIDS response poses a number of other financial management challenges, probably most problematic of which is procurement. In many local government systems there is little experience in procuring the services of external providers. Many larger municipalities are experimenting with outsourcing of key municipal services but this is often a subject of debate and conflict. In South Africa, for instance, privatisation of service provision is usually strongly contested by trade unions. Larger cities, for example Kampala, are experimenting with outsourcing of important services such as waste removal, but capacity for management of municipal service providers needs to be developed. Capacity and procedures for management of outsourced municipal services is poor in many contexts.

Development of systems for managing community based service providers, for example home-based care providers, requires co-operation of finance and service departments, which in turn requires political leadership. Without strong political will to develop partnerships with community based organisations, the resources that communities have to offer remain underutilised and undeveloped. A report by the South African Cities Network[95] highlights what can be achieved when municipalities utilise latent community resources, but also shows that this involves a degree of risk and requires initial investment and effort.

[93] A conditional grant allocates spending to particular areas of functioning. This means that LGAs are not able to determine priorities or to use discretion as to how the money is spent.
[94] Whilst conducting field research for this review it was found that municipal workers in a Zambian copperbelt town had not been paid salaries for six months because of bureaucratic logjams and conflict about fiscal decentralisation.
[95] Kelly 2003

3. LOCAL GOVERNMENT RESPONSES: A REVIEW OF RESPONSES AND MODELS

The following review outlines important elements of LG HIV/AIDS response and presents illustrative examples of key issues, processes and innovations.

3.1 ROLLING-OUT NATIONAL AIDS STRATEGY AT LG LEVEL

In 1994 the Ministry of Health in Brazil embarked on a programme to decentralise the HIV/AIDS and STI programmes to health districts. An external evaluation conducted three years later found the following[96]:

- Decentralisation requires national level support
- Efficiency of the model depends on contracts between government at different levels
- Political goodwill enjoyed by the health ministry was important
- The strategy must be effectively monitored
- There are risks in financial transfers to the periphery but the benefits of funds being available at the periphery are greater and likely to be sustainable
- The development of management capacity in areas like planning, monitoring and assessment is critical to success.

Decentralisation programmes require concerted support. Amongst the above issues, the one most frequently raised as an obstacle to decentralised HIV/AIDS programes is the management of financial transfers. Often ministries and provinces are not able to spend the money they are allocated to deal with HIV/AIDS (this is strongly the case in South Africa, for instance). This is in part because of the difficulties involved in allocating money to programmes where it can be spent in ways which are accountable to national strategy, and where the management of programmes and resources for them is subject to appropriate controls. Because of the weakness of local governments many large donor and aid organisations have provided funds at national level, often to national AIDS programmes. Alternatively they have funded multi-site projects at district or local level through partner organisations, but they have generally not funded municipalities directly. Municipalities have consequently tended not to have funds to develop partnerships with and support development of community based HIV/AIDS initiatives.

In contexts where there exist capacity development or programme support organisations specifically oriented to working with HIV/AIDS organisations, provinces or districts are able to enlist their support in managing the development of such organisations to receive and manage municipal funds and to prepare them for partnership with LGAs. In the Western Cape Province of South Africa, for example, a province-wide capacity development organisation specifically geared to support HIV/AIDS CSOs has greatly assisted in building bridges between province and community level service providers. The Umsunduzi Municipality, also in South Africa, has had to promote the formation of such an 'intermediary' organisation which can serve this purpose. There seems to be an emerging realisation of the value in doing this and in many countries there are initiatives underway to support the development of community organisations to the point of being able to receive funds and manage projects.

Unfortunately national AIDS programmes are themselves often not well integrated with LG decentralisation programmes and ambitious plans to decentralise national AIDS programmes in some countries seem quite out of touch with the real difficulties of working in existing local government systems. It is a major outstanding challenge in many countries to develop frameworks for implementing national and provincial HIV/AIDS programmes at local level, and the location of the infrastructure for roll-out of national strategy is often a problem. If afforded broad political influence, for example by being located in the office of a head or deputy head of state, there appears to be a stronger base for developing mainstreaming approaches and for creating inter-sectoral initiatives. But frequently such national plans are associated with health departments and carry little inter-sectoral influence.

[96] Ministry of Health 2000

3.2 LEADERSHIP AND MOBILISATION

3.2.1 Mobilizing leadership

The work of AMICAALL (Alliance of Mayors Initiative for Coordinated AIDS Action at the Local Level) focuses on developing a cadre of African leaders who inspire and lead local government responses to HIV/AIDS. It is arguably the most significant multi-country programme oriented to development of leadership for HIV/AIDS response.

AMICAALL directly appeals to LG leaders with the questions: What can you do to be useful in the struggle against HIV/AIDS? What is the role of the municipal leader in this struggle?

Political leaders at local government have a high turnover. For example, in the 2002 elections in Uganda there was over 70% turnover of local government leadership. This points unequivocally to the need to institutionalise leadership by establishment of structures and processes in LG institutions. Towards this end AMICAALL promotes the involvement of local government as a whole in understanding local needs and co-ordinating responses of different parties active in HIV/AIDS at local level.

AMICAALL generally works towards embedding AIDS response in municipal functioning rather than establishing separate structures. This sometimes requires placing co-ordinators within municipalities as a first step in establishing a multi-sectoral approach. It has been AMICAALL's experience that HIV/AIDS response requires capacity building, as it has been found that the experience of LG leaders at either management or political level does not prepare them for the challenges of responding to HIV/AIDS.

Engagement with municipalities follows a sequenced process beginning with a sensitisation workshop where municipal leaders are introduced to ideas about what they might do as municipal leaders. This is followed by launching of municipal initiatives which is accompanied by a programme development process and resource mobilisation. Then attempts are made to find ways of strengthening the municipal framework for multi-sectoral response. This is done with special sensitivity to the need to avoid imposing additional burdens on already burdened structures.

The programme has been launched in nine African countries to date. It relies on mayors as key link points to municipalities. This has proved to be valuable from the mobilisation point of view, but the greater challenge is institutionalising responses. AMICAALL leadership is concerned to involve town clerks and government officials in the process of mobilising leadership as well as political heads of LG. Not only do they not have as high turnover as political heads but they often understand the challenges of working in LG more than do the political heads.

3.2.2 Capacity building

The South African 'Local government leadership in the partnership against AIDS' programme is an innovative and well developed programme aimed at developing leadership of councillors and LG officials for leading responses to HIV/AIDS. A useful toolkit[97] has been developed as part of this programme which prepares local government leaders to adopt proactive roles within their municipalities.

An evaluation of this programme[98] showed that as important as it is to train leadership, systems of local governance need to be developed in order to optimise and support initiatives. Capacity needs to be developed in the system as a whole, as training of local government leaders does not necessarily lead to required changes and mobilisation. This programme requires support at the provincial level, for instance through monitoring the formation of local HIV/AIDS councils which are either non-existent, inactive or ineffective.

Another training programme conducted by the Department of Social Development[99] in South Africa focuses on local government planners and promotes AIDS responsive HIV/AIDS planning at provincial, district and local level.

It has been the experience of those involved in these two programmes, and who have at times worked closely together, that capacity-building for municipal officials and managers on the one hand, and councillors or political heads on the other, has different requirements. The functions of councillors and municipal officials are distinct.

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[97] Smart 2002
[98] Kelly 2002, available at www.cadre.org.za
[99] http://population.pwv.gov.za.

They do, however, have to co-operate closely together and understand the scope of each other's roles and functions.

3.3 ASSESSMENT FOR HIV/AIDS RESPONSE

3.3.1 Taking stock of impact

In some larger cities there have been expensive exercises in taking stock of the impact of HIV/AIDS on the area of jurisdiction of the LGA and on the LGA itself. Whilst a comprehensive impact assessment may be a useful tool for mobilising responses, the amounts of money and time involved call into question the value of such research. External researchers are often used for such risk assessments and often the product, whilst technically of a high quality, does not meet the programme development needs of the LGA. In a number of cases it has been said of the researchers that they do not understand how local government works and that they do not understand the challenges of HIV/AIDS response.

There are two areas to consider in taking stock of the impact of HIV/AIDS at LG level: the impact of HIV/AIDS on areas governed by local authorities; and the impact of HIV/AIDS on the functioning of municipalities. These are related in that the impact of HIV/AIDS in areas governed by municipalities places increased and new demands on municipal services, requires additional planning and reorientation of services, increases inter-governmental work and increases workloads. But HIV/AIDS also affects the functioning of municipalities directly through illness, absenteeism, boarding and death of skilled workers.

Assessing impact on LG areas

There are a number of methodologies available for rapid assessment of impact of HIV/AIDS in industries and workplaces. Most of these involve use of computer modelling based on existing data sets. These methods may not factor in specific areas of risk faced by an area (e.g. seasonal cropping). There are also tools[100] under development for mapping high transmission areas within towns, but these are not widely used and have yet to be formally written up for dissemination, having been piloted in a number of municipalities in South Africa.

Many cities have embarked on processes to assess the impact of HIV/AIDS[101], and usually it has been necessary to model the impact using existing data sets, mostly based on antenatal clinic HIV prevalence studies which often have an untested relation to actual prevalence figures. For example it is well known that relative levels of infection differ markedly between men and women but the measure of this difference differs across the age range and in turn this differs across areas. In many areas surveillance data is not available and estimates can at best be rough extrapolations from clinic statistics or based on what is known about similar sized towns in the region.

In some countries, and South Africa is notable in this respect, there is an emerging group of consultants and businesses responding to the need for services relating to HIV/AIDS planning and development. Services typically offered include impact and risk assessment, HIV prevalence assessment, tailored education campaigns, training, organisational development, education programmes, media production and social marketing. The quality of such services is variable and although amongst such providers there are some of the most reputable experts in this field, there are clearly many opportunists who use questionable standard instruments for producing formularised results and recommendations.

The questionable value of impact studies

In the case of large towns, specific impact studies are often warranted. However, they are typically time consuming and costly. In LGAs there are frequently debates about the costs of the extensive research processes involved in such analyses and in such contexts it is common to hear that the money used in costly research efforts would be better spent on responding to HIV/AIDS. Whether or not this is the case depends to a large extent on the usefulness of the research. Research which addresses broad research questions is probably not all that useful at this stage. The larger part of the findings of many such studies reach conclusions which could safely have been reached on the basis of qualitative data and gathering together of what is known by health and other community development workers.

[100] Available at http://www.equity.co.za

[101] Notably, 5 towns in Namibia have commissioned specific studies to assess the impact of HIV/AIDS on their towns.

Overly ambitious impact studies frequently do not provide the kind of information that is useful for project planners. Frequently small-scale projects are accompanied by over-engineered and overly-detailed research reports and only a fraction of the information made available is ever put to practical use.

There is strong reason to believe that "the need for research" has, in some municipalities at least, been used as an excuse for inaction, and it needs to be asked whether what needs to be done demands fine-tuned research studies, or whether it can be embarked on the basis of understanding what constitutes general good practice. Research conducted for the South African Cities Network[102] on information and research needs of municipalities suggests that the main use of research studies is in securing political commitment rather than in developing a sound basis for planning.

Impact on the civil service

As employers[103] LGAs have to deal with, amongst others, the following costs of HIV/AIDS: direct costs associated with recruitment, training and provision of HIV/AIDS programmes; indirect costs such as absenteeism, morbidity and use of management resources; and systemic costs such as a lack of workplace cohesion and reduction in workforce performance and motivation.[104] [105] Further the impacts of HIV/AIDS on local communities are likely to affect the need for services, and the ability of community members to pay for services[106], which places an additional burden on the LGA in terms of its planning and service delivery mandates.

There are a number of guidelines and briefs for assessing the impact of HIV/AIDS on municipalities.[107] A toolkit has been produced for ministry employees that helps them identify, plan for and mitigate the impact of HIV/AIDS on their ministries or departments. The toolkit warns that "the ability of some ministries to fulfil their functions will be severely impacted."[108]

As important as this issue is, as with the impact on local communities, what it useful is not the fine details of impact, but the implications for response planning. Were the scale of need not so overwhelming it may be important to have a fine tuned impact assessment in order to know what scale of response is necessary. But in almost every case the need so far outstrips responses that it is questionable whether LGAs need to do much more by way of impact assessment than to understand the areas where impact is likely to be felt and to use this for mobilising and planning. Where specialist input is necessary for quantifying impact, for instance concerning the impact of HIV/AIDS on pension funds or the security of health insurance schemes, or on the demand for housing, more specialised input may be necessary, especially in large LGAs. In this case such input might be separately and specifically commissioned. Fortunately there is an emerging group of specialists in such areas that use projection methods based on available data, and to create scenarios that assist in planning. Such relatively inexpensve exercises may be preferable to more time-consuming and comprehensive methods involving, for example, measurement of prevalence amongst municipal employees or communities. Some of South Africa's most successful city responses to HIV/AIDS have opted to follow this route and tis has led to development of comprehensive responses. Some smaller municipalities have undertaken more expensive exercises that have not been as oriented to planning and consequently have not been used to such good effect.

Finally, there may be more value in applying well known principles of good planning and intervention practice, than in planning responses from scratch through empirical research.

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[102] Kelly 2003

[103] In many towns and cities in the developing world the municipality is the largest employer and it is not uncommon to find cities with workforces of 20 000 or more employees.

[104] Whiteside A., and Sunter C., 2000. AIDS: The Challenge for South Africa, Human and Rousseau and Tafelberg, Cape Town.

[105] DDP & GTZ.p.5

[106] Although Booysen et al. point out, in the context of a South African city where the economic impact of HIV/AIDS on the municipality was researched, that the most affected sector of the community is also the sector that contributes least to municipal revenues.

[107] These and other guidelines or tools referred to in this review are referenced in the companion handbook.

[108] Abt Associates 2000

3.3.2 Taking stock of response

It is important to understand the response of the society for a number of reasons:

The understanding of impact

Much of the work of HIV/AIDS researchers in the social sciences over the past 15 years has been directed at understanding the impact and associated costs to the society of the HIV/AIDS epidemic. Impacts are usually compared to a 'no-AIDS' scenario and the difference is understood to be the impact of the epidemic. This kind of analysis has typically failed to take into account the responses of the society to the epidemic.

Understanding of responses needs to be factored into understanding of impact: The impact of the epidemic is mitigated by a range of responses designed to prevent infections and to mitigate impact at individual, familial, community, infrastructural and societal levels. Until we factor in the scope and extent of response we are not in a position to accurately predict the impact of the epidemic. It has been suggested[109] that investment in HIV/AIDS programmes, apart from its humanitarian value, is good business practice, and the costs of prevention and care programmes are recovered through reducing costs incurred in mitigating impacts of AIDS on business. Following this argument AIDS ultimately costs the LGA less when resources are committed to responding to it. This means that when we estimate the impact of AIDS on the economy, or on a municipality, we must factor in an understanding of how interventions are likely to impact positively on these costs, and what impacts are likely to be yielded by what interventions. Cape Town Metropole in South Africa has modelled the costs of the epidemic and on the basis of this been able to make a convincing argument for provision of antiretroviral therapy (ARV) to municipal employees, that has successfully led to the implementation of an ARV programme. It is anticipated that the impact of AIDS on municipal functioning will be significantly reduced by this intervention.

AIDS responses involves opportunities as well as costs: HIV/AIDS is clearly capable of having a devastating impact on societies in almost all areas of social development. AIDS is usually described as a crisis or a threat, even a catastrophe. In this context it seems important to move beyond the focus on estimating the potential impacts of AIDS, in ever more specific areas, such as the impacts on democracy, crime and international relations; and to focus on how to integrate HIV/AIDS response and positive social development planning. There is growing evidence of transition to democracy in Africa and the developing world and ambitious plans are afoot for the rejuvenation of African economies, for instance. For momentum to build in these areas it is going to be necessary for social development and HIV/AIDS response agendas to coincide. To do this, much more understanding is necessary about the opportunities and possibilities for more effective AIDS responses which are commensurate with the broader aims of social development, economic upliftment, security and democracy. HIV/AIDS responses are likely to have generalised effects, beyond the immediate field of AIDS impact. Amongst these there are some outcomes of AIDS response that are likely to have positive ramifications for the society, including: a sense of urgency and fast-tracking of development of health and social services and infrastructure; development of better integrated public service infrastructure and more responsive governmental institutions; better links between civil society, business and government; funding for health systems and infrastructure; improvement in efficacy of inter-departmental functioning at local and provincial government levels; growth of community-based organisations and possibly the creation of higher degrees of social capital. A focus on the links between ill-health and poverty and the prevention focus on healthier lifestyles and positive social values are also are possible positive by-products of social development programmes aimed at reducing susceptibility to HIV/AIDS.

Building an information base for co-ordination and integration

The organic and piecemeal way in which HIV/AIDS responses have developed locally in most contexts means that the response 'system', if it may be called that, in any area is likely to be made up of an assortment of services from different government authorities and CSOs, not necessarily comprehensive, often barely co-ordinated and usually not well integrated.

In some countries, Zambia and Uganda being notable examples, significant health facilities and programmes which provide essential HIV/AIDS services (e.g. VCT and AIDS care) are managed independently of the formal health services, by CSOs including international health and social development agencies and church groups. The

[109] Rosen et al. 20001

growth of CSOs in most countries affected by HIV/AIDS has been exponential.[110] Private services (including, for example, mining and other labour intensive industries that may contribute to HIV/AIDS prevention, support and care responses at a local level) and public-private partnerships may also contribute to stock of services available locally. It is often difficult to know, even for those involved in managing district and local health systems, how such services interrelate and 'who is doing what, where?'. The most important assessment studies in developing LG responses in such contexts are ones which are oriented towards understanding the resources available for local response, and which might be integrated into manageable and rational systems of response.

Taking stock of responses can take place at different levels. In some of South Africa's larger cities, ward level[111] HIV/AIDS forums comprised of all local organisations working in the field effectively take stock of what areas of response are being covered by who and what areas remain unserviced. They are assisted and funded to a limited extent by provincial and municipal staff and resources, and connected to a ward committee headed by a councillor that is intended to represent community development and support needs. Other municipalities have engaged in more formal, researched based approaches. The problem with the latter approach is that audits of resources become rapidly redundant in a fast-developing and changing environment.

Alongside the need to take stock of response resources and co-ordinate them, is the need to monitor the development of resources. Umsunduzi Municipality in South Africa has developed a computer-based data-base of AIDS referral resources that is connected to a helpline. This may be called toll-free and appropriate resources in an area provided to the caller, be it a member of the public or a service provider. This system needs to be regularly updated to accommodate developments and changes and systems have been devised for doing this. In other municipalities resource handbooks tend to rapidly become updated.

Whatever systems are used to take stock of resources it seems that this activity is foundational to development of local AIDS response systems. It is an activity that LGAs can relatively easily co-ordinate, and that is not a strongly technical or expensive process to engage in.

3.4 INTERNAL RESPONSES

Municipal HIV/AIDS are usually conceived as having an internal and an external focus. The external focus relates to the mandates of LAs to provide services and leadership for local development, whereas the internal framework regards the municipal workforce as the site of response.

Although there are few, if any, municipalities that have fully implemented comprehensive internal responses, the following are some of the elements that feature in implementation plans and to a lesser extent in practice: development of a workplace policy in close collaboration with trade unions and management, that commits the LGA to a programme of action and clarifies employee rights and protections; anti-stigmatisation programmes; peer-education programmes; systematic and ongoing education programmes designed to reach all sectors of the workforce; condom distribution programmes; counselling; VCT; prophylactic treatment for occupational exposure to HIV; integrated treatment of TB, STI and HIV/AIDS; support groups for HIV positive people; and antiretroviral therapy.

The responsibility for planning and managing internal programmes often rests in human resources or occupational safety departments of municipalities, but it is also sometimes located in health departments, HIV/AIDS units or in inter-sectoral programmes in municipal manager or mayoral offices. It is also sometimes the case that departments conduct their own programmes and there is little central co-ordination and integration of efforts. The key issue in deciding where to locate such programmes seems to be how best to secure support for an ongoing programme that will inevitably involve some commitment of time and resources by departmental officials. Obtaining political support and a dedicated budget for an internal programme – as opposed to using departmental budgets – appears to be an important element in developing sustained responses and commitment of heads of departments. This would suggest location in a special programmes unit under central leadership. However, it seems that well-functioning programmes may be located in departments. An example is Cape Town Municipality in South Africa, where a strong and comprehensive workplace programme is located in a human resources and occupational safety department. In this case a high degree of professional expertise and personal commitment on the part of key municipal officials seems to have secured the necessary commitment of others in the municipality. A concerted promotion and ongoing campaign amongst city departments has also greatly assisted in the acceptance and roll-out of the programme.

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[110] Putzel 2003 describes this effect in Uganda.

[111] A ward in such contexts comprises a densely populated area of between 30 000 – 50 000 people.

There is much to be learned from the experiences of municipalities in launching and managing internal programmes, and although various guidelines exist,[112] there would be good value attained by a compendium of best practices in the area of internal municipal HIV/AIDS responses.

3.5 MULTI-SECTORAL RESPONSE PLANNING

Mainstreaming[113]

A "Mainstreaming HIV/AIDS Training Manual"[114] has recently been produced for the purpose of assisting NGOs funded by OXFAM OZ to incorporate HIV/AIDS issues into all their activities. The manual was developed from a desktop review which had as its aim to: "…review and analyse gender and AIDS mainstreaming programmes in an attempt to develop an effective model for HIV/AIDS mainstreaming."[115]

Mainstreaming HIV/AIDS into all the affairs of the LGA is a frequently mentioned strategy for intervention. However, when questioned about what this means LG leaders are often at a loss to explain what mainstreaming implies.

Mainstreaming is usually taken to mean multi-sectoralism (many sectors active in developing HIV/AIDS responses), and does not necessarily involve inter-sectoralism (integrated responses in the sense of working together). In the World Bank handbook for supporting local government responses to HIV/AIDS it is suggested that whereas there are important and focused contributions that can be made by departments, these ultimately need to be integrated into a cohesive, integrated framework where inter-sectoral collaboration is the emphasis. In the following section the challenges of integration are dealt with.

Concerning multi-sectoral responses the experiences of many LGAs shows that there is a need for greater guidance as to how departments might meaningfully engage and departments are in need of hearing from each other about what they are doing.

It is often said that if multi-sectoralism is to be taken seriously by municipal officials, it needs to be made a key performance area of municipal managers. For this there needs to be formalisation of expectations and clarification of the extent and nature of commitment that is required. Without this involvement of LG departments will be limited to supporting or contributing to interventions with relatively limited scope such as community health calendar events, or facilitating the working of the workplace programme in their departments.

Unfortunately there is no set of guidelines or supportive literature on mainstreaming within local government departments. Yet in visiting municipalities it is evident that there are many creative innovations that need to be documented and shared. Some of these are highlighted in a document supporting the South African Cities Network[116]HIV/AIDS mainstreaming project. Examples include a water and electricity department that assists in identification of families in financial crisis due to AIDS illness and death, a finance department that assists in developing financial management skills in community HIV/AIDS support organisations and a planning department that assists in developing proposals for community organisations.

3.6 INTEGRATED RESPONSE PLANNING

3.6.1 Integrated development planning

> "Unless HIV/AIDS is going to be dealt with as part of integrated municipal development planning, it will not be adequately addressed in an integrated manner by municipalities"[117].

In this section focus is on a model of LG integrated development planning applied in South Africa. This has been instituted through legislation.

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[112] See companion handbook for resources in this area.
[113] Cohen D., Mainstreaming the Policy and Programming Response to the HIV Epidemic, HIV and Development Programme, UNDP Policy paper No.33.
http://www.undp.org.hiv/publications/issues/english/issue33e.htm
[114] CABANGO/OXFAM OZ
[115] CABANGO 1999 Mainstreaming HIV/AIDS: A DeskTop Review for OXFAM.
[116] Kelly 2003
[117] DDP & GTZ … study by …?(p.1)

Legislation for integrated development planning

(South African model)

"Integrated development planning will become the defining feature for development programmes in the new municipalities." [118]

In terms of the Municipal Systems Act (sec 23), "Each municipal council must within the first 12 months of its elected term adopt a single, inclusive plan for the development of the municipality which: links, integrates and co-ordinates plans, schemes and proposals for the development of the municipality; aligns the resources and capacity of the municipality for the implementation of the plan; forms the policy framework and general basis on which annual budgets must be based; complies with the provisions of this Chapter (of the Bill); and is compatible with national and provincial development planning requirements binding on the municipality in terms of legislation." [119]

Legislative support for integrated development[120]

"A Municipality must give effect to its Integrated Development Plan and conduct its affairs in a manner which is consistent with its Integrated Development Plan."

"Each Municipal Council must… Adopt a single inclusive and strategic plan for the development of the municipality which … aligns the resources and capacity of the municipality with the implementation of the plan."

"Municipal services must… be provided in a manner that is conducive to the prudent, economic, efficient and effective use of available resources."

"The crucial question is: in which way HIV/AIDS should become part of the IDP process. To answer this question, we need prior knowledge of:

- ways and means in which HIV/AIDS is dealt with by local government at present (ongoing or envisaged initiatives)
- ongoing or envisaged national-level initiatives of other actors (Dept of Health, South African Local Government Association (SALGA), donor agencies) to enhance the involvement of local government in the fight against HIV/AIDS
- the perception of municipal leaders and local level resource persons of ways and means to deal with the issue
- the impact of HIV/AIDS-related planning on other spheres of government on a local level."[121]

Integrated development planning (IDP) is an ambitious approach to local government development which requires local municipalities and districts in South Africa to draw up and submit for approval plans for their future development. Their performance as LGAs, is assessed on the basis of the extent to which they realise their plans and meet associated targets.

It has been important in developing this approach to provide support for the same. "An integrated multi-sectoral response to HIV/AIDS is needed at all levels of government in partnership with civil society. National level leadership, and guidance through appropriate policy is needed, to inform responses at other spheres and levels. The Department of Provincial and Local Government has a responsibility to provide guidance to local authorities

[118] Ngidi S No provinces - no great loss, says Sutcliffe Dr M Sutcliffe Independent on Saturday 13.10 2000
[119] Municipal Systems Act 2000
[120] The following are extracts from the South African Local Government Municipal Systems Act 2000
[121] DDP/GTZ (p.1)

in the local authorities' role as both a service provider to the broader community, and as employers."[122] The guidance provided has taken many forms including:

- A nationwide roll-out of IDP-training for municipal managers, councillors, sector specialists and professional planners;
- The development and dissemination of a user-friendly IDP Guide Packs.
- The setting up of Planning and Implementation Management Support (PIMS) centres at district level and a web-site[123] to support the same.

Although the South African Department of Provincial and local Government's Integrated Development Planning guidelines[124] highlight the importance of HIV/AIDS and development planning and recommend that HIV/AIDS be considered as a key issue in IDP, reviews of local authority responses to HIV/AIDS[125] reveal many problem areas, including:

- Many IDPs are devoid of any real reflection on the specific challenges facing the LGA in responding to HIV/AIDS, and show little real evidence of being based on an understanding of local contexts or HIV/AIDS resources.
- Participants in the IDP process often do not include organisations with an active involvement and concern with HIV/AIDS in their consultative processes.
- The lack of available data on HIV prevalence in the area, and lack of expertise in modelling impacts of the epidemic prevent planners in departments other than health and social development from including HIV/AIDS within their plans.
- The need for the IDP to focus on tangible results (targets) for the delivery of hard services, against which their performance can be assessed, often leads them to overlook planning and development indicators and processes.
- Alignment of IDPs between neighbouring municipalities is often not considered or satisfactory.
- Alignment with national and provincial departments is often not satisfactory.
- Many HIV/AIDS plans lack substance and are based on general principles only, with no situation analysis, and is poorly informed about best practices or new ideas and policies in the field.
- HIV/AIDS is not yet incorporated into some provincial departmental policies and strategies or national policies - e.g. housing, provincial growth and development strategies – meaning there is little guidance in such areas.
- Priority is given to the ongoing delivery of services and local authority maintenance activities rather than 'softer' and cross-cutting areas of local development such as support for local HIV/AIDS planning and forums.

The following are some of the unrealised needs associated with integrated development planning[126]:

- Local authorities need support in preparing IDPs that integrate HIV/AIDS mitigation into municipal planning. The support required needs to include access to information such as HIV/AIDS prevalence rates, provision of demographic support, guidance as to areas of impact, guidelines outlining possible strategies and best practice case studies.
- Key performance indicators for executive mayors and top officials are needed as a way of ensuring adequate attention is given to HIV/AIDS as a key issue.
- At a local level, political support, inter-sectoral action and partnerships are needed, which should be informed and supported by guidelines generated at higher levels of government.
- Careful consideration of a range of strategies are needed to ascertain the most cost-effective/appropriate response at a local level. There is need for guidance in this.
- A municipal level HIV/AIDS advocate/director of community development or some similar designation is needed to ensure that HIV/AIDS issues are addressed through strategies, resourced, planned for and implemented on the ground.
- The above ideas need to be underpinned by political commitment by leadership at a local level and require training of officials and councillors.

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[122] DDP/GTZ. n.d. (p.5)
[123] http://www.pimss.gov.za
[124] DPLG 2001. http://www.dplg.gov.za/documents/publications/idp/guide0.pdf
[125] Ambert 2004
[126] Ambert 2004

It can be seen from the above that integrated development planning is a comprehensive and ambitious approach that requires requires a highly developed system of local government policy and legislation as a foundation. It also requires substantial support with a specific HIV/AIDS focus if it is to live up to expectations in regard to HIV/AIDS.

3.6.2 Local integration

An alternative and more intensive approach to development of integrated HIV/AIDS responses has been developed in Uganda.

District level integration: The AIDS/HIV Integrated Model (AIM) District Programme

This recently established Ugandan district level programme aims to establish effective and replicable models of service integration in districts that successfully contribute to the decrease in HIV incidence, and improvement in provision and quality of comprehensive care and support services.

It works in partnership with government, NGOs, CBOs, FBOs (faith-based organisations) and the private sector to assure that more people access and utilise appropriate, affordable and quality integrated services.

It has a mandate from the Uganda AIDS Commission (UAC), the Ministry of Health and other ministries and agencies. At a national level it supports activities such as HIV/AIDS policy and guideline development, recognising that successful local programmes needs to be supported at the highest levels. However, the primary focus is district HIV/AIDS Commissions and their partners.

AIM is not an implementing body but supports and strengthens district level service implementation through technical assistance and financial support. Districts plan and implement their own HIV/AIDS programmes with support from AIM. AIM has defined ten core services that constitute a comprehensive package for a model district HIV/AIDS programme. AIM attempts to support the integration of resources into a comprehensive network of inter-relating organisations. A primary mechanism of integration is improvement of the client referral mechanism.

The idea of functional integration supported by the programme has shifted from provision of one-stop service centres (multi-centres), to development of existing elements of services into a well-functioning system based on linkages between providers and users of services and between providers.

The first step of the AIM process is strengthening of the co-ordination capacity of District Aids Task Forces which have been made mandatory by the Ugandan AIDS Commission. This process includes clarifying roles and responsibilities, leadership development and management training, including financial management.

A second step in the process is assessment. Each district is assessed through a 3-day assessment procedure. Results are taken back to districts for confirmation. Part of this process is focused on identifying service providers and referral systems.

A third step involves improvement of the quality of systems and expansion of services. This begins with development of a district strategic plan, a work plan and development of proposals for NGOs to gain necessary support.

The programme is closely tied to the District AIDS Commissions (DAC) and an AIM staff member is located in the DAC offices. The entire process is supported by development of guidelines in close co-operation with the UAC.

Location of the programme at district level means that municipalities and other lower level organisations tend to be neglected in the process. The programme works at the highest level of local government (district: there are no provinces in Uganda) and decentralisation at sub-county level is not well provided for, including areas where there are health sub-districts, and where services could be better co-ordinated. It is one of the greatest challenges in working in LG to reach into all parts of the decentralised system.

A second problem, pending the financial decentralisation reform is that the autonomy of LGs in terms of deciding how to use services/resources is restricted by conditional grants through which most of district services are prescribed via sectoral ministries. Priorities/issues to be addressed are more or less determined at ministry level through the conditional budget allocation.

This is an ambitious programme which aims to tackle the critical issue of integration and comprehensive service

provision. Whereas it has all of the elements of a successful programme at district level, it is still subject to the problems of the larger system and it well illustrates that work within the local government system cannot be done only at local level. It involves tackling the entire system, above and below.

3.6.3 Inter-departmental support for integration

Inter-governmental relations (IGR) refers to communication and planning frameworks for co-operation of departments in joint planning. In the field of HIV/AIDS intervention and mitigation there is a widely recognised need for diverse sectors to work together, but often little recognition of the challenges of inter-sectoral work, particularly when there is little precedence of working together.

Inter-departmental committees are one way of building IGR. It is necessary to have specific agencies promoting development of inter-departmental communication as the demands of departmental service delivery within departments usually eclipse the need for collaboration between departments in planning services. It should not be assumed that the smaller scale of local government departments allows for easier relations between departments, as the practicalities of service delivery are the abiding concern whatever the size of the LGA.

Existing pressures on local government to deliver basic services creates a sense of reluctance to develop new programmes. Responsibility for developing HIV/AIDS programmes is often shunted to health departments and the well-recognised need for an inter-sectoral approach to HIV/AIDS is overlooked. It is not uncommon to find inter-ministerial committees at parliamentary level but nowhere else.

The World Bank MAP programme has strongly emphasised the need for coordination of efforts at every level of decentralisation. The Uganda programme for instance is aimed at national, district and local level coordination. However, in this process the municipal level tends to get bypassed. Whereas municipalities may participate in district level coordination programmes and may be funded for local level programmes there appears to be relatively little recognition of the need to develop integrated plans within municipalities.

In South Africa, municipalities and districts are being encouraged to form AIDS coordinating committees, but support for this is largely lacking. Such committees need to be guided in their activities and this needs to be stronger support for the concept of permanent inter-departmental structures. Generally it seems to be believed that inter-departmental collaboration is desirable, but it is usually not emphasised. At provincial level there are various inter-departmental support groups, and importantly in each province of South Africa there is a Government AIDS Action Plan (GAAP) desk, a Partnership Support Programme and an Inter-departmental Support Programme. A National Partnership Committee is spearheaded by the Uganda AIDS Commission and many countries have similar programmes. The problem is that these structures often busy themselves with provincial or national integration and their efforts only filter down erratically. Inter-governmental support needs to be supported at all levels of decentralisation and is especially important in systems where there has been a strong history of vertical decentralisation.

A notable and innovative HIV/AIDS inter-governmental unit at provincial level in South Africa, is located in the provincial premier's office of Gauteng province, as opposed to within the health department where there is a separate Directorate of HIV/AIDS and STIs. This unit has been remarkably successful in supporting local level projects, working in conjunction with municipalities, and funding local organisations working in concert with ward-level municipal structures. Most striking about this work is the provincial initiation of HIV/AIDS responses at local level. Such provincial level input has greatly assisted municipalities in initiating local level support, and LGAs then increasingly take responsibility for supporting such initiatives and forming municipal level partnerships. Where there is limited local capacity to initiate programmes, good IGR across levels of government can effectively use the expertise of higher tiers of government to assist lower tiers of government to establish programmes that can then be managed at local level.

Local government associations

In many countries there exist local government associations which look to the developmental needs of the local government system. In some countries such as South Africa these have both national and provincial chapters. In other countries, for example Uganda, there is a rural and an urban local government association. It makes sense to involve these institutions in the process of training for effective local governance and to support such organisations to develop. It is often said by people in local government that ministries do not understand local government. In decentralising local government systems there may be reluctance for district or municipal functions to be overseen and catered for at regional or provincial level. Therefore, it makes sense that local

government associations which are committed to the support of local government be supported as future training and support organisations.

In South Africa the South African Local Government Association (SALGA) has been involved in a training programme for local government leaders to develop skills for advocacy and development of HIV/AIDS programmes at local level.[127] This is a good instance of a partnership (anchored by a Department of Health Inter-departmental Support Committee, the Department of Provincial and Local Government and the Department of Social Development). In this instance SALGA recruited master trainers who have expertise in local government capacity building and they were exposed to an intensive training so that they would be equipped to train councillors and local government officials. The SALGA offices at provincial level organised the recruitment of trainees and provincial workshops which were conducted by the Master Trainers. Whilst the programme was not without difficulties it effectively established a role for SALGA in training in this area. SALGA would probably not have had the capacity to develop the programme itself but was a good base for the training aspect of this programme. This seems like a viable model except that in many countries local government associations are not as well established.

Decentralisation and local government support

The Decentralisation and Local Governance Support project is a key component of USAID/Senegal's development assistance program. It is aimed at improving the performance of local elected officials and other actors for more effective, democratic, and transparent management of services and resources. Its ambition is to contribute to the emergence of viable local government, with more dynamic institutions and more effective citizen participation in the management and supervision of local affairs. The project targets three levels of local government: the *communautés rurales*, the municipalities, and regions. It is designed to provide assistance not only to governmental institutions, but to grassroots community organisations as well, to assist them in relating to local government. The project is implemented by the Associates in Rural Development (ARD).

Expected results of the project are:

increased capacity of local institutions;

increased access to financial resources;

increased participation of local populations in the management and supervision of local affairs;

more effective implementation of decentralisation policies and regulations.

This is typical of many programmes for local government support. They provide a good context and programme structure for integration of HIV/AIDS issues and useful links might be made with LGAs that have already been through processes of this type.

3.6.4 Functional integration[128]

Functional integration involves integration at points of delivery of services. It is primarily oriented around utility for the service user. It usually involves alignment of services and development of referral networks, as well as sharing of resources such as office space. Consistency of norms and standards of practice across functionally related services is usually a concern of well-developed functional integration systems.

The efficiency and utilisation of services is greatly enhanced when there is operational continuity between the different facets of service systems. When users of services are referred to services such that they are expected in the receiving service, the procedures involved for gaining access to services are familiar to them, and the advice offered to them is consistent, their motivation to use those services and their compliance with the requirements of those services is generally much better.

It is widely promoted in the HIV/AIDS field that a continuum of care and a continuum of prevention and care be aspired to.

***Continuum of care**:* This refers to establishment of an experience of continuity for users of care services across the different locations where care is provided. This would mean that services ranging from social grants to

[127] Kelly & Smart 2002
[128] Toomey n.d.; The Equity Project n.d.

medical treatment to psychosocial support are knitted into an integrated framework for improvement of access to care. This may be as simple as rearranging HIV/AIDS clinic times to coincide with social work support or arranging office space for social support services in health clinics. It may involve more complex and systemic changes relating to referral procedures. It could also require development of services across departments that are unfamiliar with each other's ways of working (e.g. social welfare grants and medical officers) and possibly across tiers of government. Such arrangements would require budgetary planning and achievement of a continuum of care is an ideal which is not easily achieved in the context of services that are slow to change and amongst employees who hold on tightly to familiar procedures or who are not motivated for change and the work it brings.

***Continuum of prevention and care**:* Whilst it is obvious in one sense, it is often overlooked that HIV is transmitted by people who are already HIV positive. They are seldom targeted in HIV prevention programmes which are mainly aimed at those not already infected. Prevention efforts can be greatly enhanced through bringing those who are already infected into the system of HIV/AIDS care. Within the system of support and care they can able to be drawn in as allies in the fight against the spread of infection. This involves establishment of prevention programmes through accelerated care programmes. VCT programmes, PWLHA support programmes and PMTCT programmes are examples where prevention and care can developed alongside each other.

The challenges of establishing such continua involves synchronisation of service delivery and this is especially challenging when multiple points of delivery are involved.

Examples of functional integration:

- Formation of inter-organisational committees (e.g. home-basd care; orphans and vulnerable children) concerned with particular areas of service around which there can be functional integration, rationalisation of responses and focusing of efforts.
- Point of delivery integration through sharing of clinic resources and multi-service centres.
- Networks of organisations which align themselves around developing standard protocols of service delivery and shared information systems.
- Development of co-ordinated referral networks which allow multiple points of access.
- Problems experienced in functional integration often involve the reluctance of civil servants to change their practices and share their facilities, and the risks of partnerships discussed previously. However, the rewards of functional integration appear to far outstrip the possible risks in terms of costs or operational inefficiencies. Functional integration requires guidelines, monitoring and administrative support, but none of this is so technical that it can't be achieved by service staff.
- This is a form of integration which should be highlighted to a much greater extent.

3.7 CO-ORDINATING LOCAL RESPONSES

> "The realms of state and civil society are interconnected, fluid, and reflective".[129]

One of the most important roles which LGAs can play is to co-ordinate or support co-ordination of local HIV/AIDS response resources. This area of intervention is extensively dealt with in the World Bank handbook for supporting LG responses to HIV/AIDS. Beyond convening a local co-operative process this resource book presents tools for the relatively complex task of gathering data about local HIV/AIDS response resources and analysing it. The task of understanding and synchronising local AIDS response resources is critically important especially in contexts where CSOs provide the greater part of HIV/AIDS services, meaning that there is no natural central hub of co-ordination within the government services.

In the city of Ndola in Zambia the Catholic Diocese of Zambia runs a large-scale, comprehensive HIV/AIDS programme, which has trained and deployed over 600 volunteers in a home-based care programme, runs a professionally led staff which is highly motivated, and is arguably at the cutting edge of community HIV/AIDS responses. The local government responses are paltry in comparison. Further, there are a number of international organisations working in this area. As these systems of response have grown the various stakeholders have had to interact with each other on an *ad hoc* basis, but until recently there has been no city-wide planning process and

[129] Harbeson p108

there has been an unmet need to take stock of what is available, what is being done, what are the gaps, and how further development and integration might proceed.

One city which has done this with a high degree of purpose is Umsunduzi Municipality in South Africa where the LGA, business, community based organisationa and faith-based organisations maintain close links and appear to be strongly aware of each other's activities. They are assisted in this through a regularly updated data-base of organisations, a strong network of organisations aligned with the needs of children in distress, use of the local press to ensure publicity of HIV/AIDS activities and developments, and a LGA that is committed to the idea of partnerships, and particularly to development of and support for community response initiatives and multi-partner projects. The operational co-ordination that is necessary in multi-partner projects appears to make additional co-ordination, in the form of general co-ordinating forums less important.

3.8 PARTNERSHIPS AGAINST HIV/AIDS

A win-win partnership

In South Africa, Hospice[130] branches staff and operate inpatient units in some provincial hospital facilities, respite units[131] in rural hospitals and in at least one province, Hospice home-based carers are paid a stipend by the Department of Social Development and rents are paid by the Department of Health. In exchange, Hospice provides training and care services in response to AIDS, which would otherwise fall to the direct responsibility of the public health sector. Such arrangements are congruent with a broad legislative framework which endorses partnerships. However, the newness of the concept of partnerships means that the operational procedures for the same are being developed in the process and the procedures for this are mostly established at the level of memoranda of understanding. In fact in the entire developing world there are probably few countries where no examples can be found of partnerships for service provision between government and CSOs. Much donor funding is couched in terms of 'partnerships', but the parameters of such partnerships and the background legislative framework through which such partnerships are held in place are often based on makeshift arrangements which suit the relatively limited scale of involvement at programme and project level.

Partnerships may be in place without there necessarily having developed a framework for establishing partnerships on a large scale and acceptance of this and readiness to work within a framework of trust is important.

Whereas at national and provincial government level partnerships would usually be with well established organisations with demonstrable competence at the level of financial management, established organisational infrastructure, skilled and experienced staff and so on, LG authorities may well need to partner with smaller and less established organisations but which are important in responding to HIV/AIDS; for example, organisations representing people with HIV/AIDS, small church based home-care groups and organisations representing traditional leadership. Such organisations may well be adequately functioning organisations within the context of their present functioning, but their readiness to enter into legally binding contracts with LG may be questionable. Similarly LGAs may not have the capacity to contract partners or to monitor and manage partnership agreements.

One solution to this which appears to work is the establishment of memoranda of understanding rather than binding legal agreements. This of course implies that the partnership does not involve binding service agreements, but only an agreement to work closely together, either generally or in specific areas.

Memoranda of understanding

'Partnerships' is a loose concept for establishing working associations, that might be based on no more sound a footing than an intention co-operate. One vehicle for establishing a partnership of thisnature is a memorandum of understanding, sometimes used as a first step towards what might later become a more binding agreement, for example, a service provision agreement.

[130] Hospice Association of South Africa is the largest and most well established organisation in South Africa concerned with care for the chronically ill and dying.

[131] A respite unit offers care to sick patient on a temporary basis in an inpatient facility, in the hope that this will temporarily relieve the family from the burden of care and allow both patient and family to stabilise and recover.

A memorandum of understanding between a Ugandan NGO concerned with providing VCT services and a local municipality sets out a frameworks for working together in providing VCT services and training in a district capital. In terms of the memorandum the NGO is to provide: training and support to staff in three municipal clinics where VCT will be provided by government services; and laboratory testing services. The LG body is to provide: consumables involved in testing procedures; close co-operation in referring to and from PHC clinics. They also agreed to work together in other areas of mutual interest.

As it happens the LGA has mostly (although not completely) failed to meet its commitments to provide the consumables, but the NGO has had a tolerant attitude towards this failure. In other respects the agreement seems to have worked well.

In spite of this apparent failure to meet some expectations, the LGA and the NGO feel that the partnership has been more or less successful. A stronger and more legally binding agreement would have been inappropriate and may have eroded the spirit of necessary co-operation, which has survived, as has the hope on both sides that the LGA might ultimately meet all of its commitments.

The truth is that many partnership agreements are like this and when there are risks of non-delivery, memoranda of understanding seem to be a more promising framework of agreement than are legally binding contracts.

Partnerships with community-based organisations are found in many municipalities and also between provinces and CSOs. These take various forms, including for example: the provision of municipal buildings in which NGOs are housed; support for NGOs in writing proposals and raising funds (partnerships between CSOs and LGAs are attractive to funders of CSOs as this heightens the accountability of CSOs); administrative support, training, and secondment of municipal staff to community projects. In such cases the LGA deploys its resources in exchange for community-based, and community supported service provision. Investment in development and support of community organisations is often seen as part of a long term solution aimed at empowering communities to deal with HIV/AIDS and using latent human resources within communities to provide services. Many community-based organisations survive by virtue of the community-mindedness of citizens and the enormous resources that can be mobilised in this way are seen by LGAs in monetary terms as good value for money, and also as a way of investing in social capital. Concerning the latter such programmes allow skills transfer, as community members are trained in financial and management skills, and acquire HIV/AIDS related skills that builds up the community stock of knowledge for coping with epidemic.

3.8.1 Developing capacity for managing partnerships

LGAs are often poorly equipped for initiating and managing partnerships. The value of partnerships with CSOs is sufficiently compelling for the Ugandan AIDS Commission to have established a unit especially for the promotion of partnerships. In most other countries, although the concept of partnerships is broadly endorsed, there is little institutional support backing it. The following questions might be applied to assess the preparedness for LGA partnerships for HIV/AIDS response:

- Is there a policy addressing partnerships between LGAs and CSO service providers?
- If not, is there a general policy document addressing public private partnerships in the country?
- Are partnerships with CSOs addressed in the policy document?
- Is there a policy or a strategy document on CSOs generally?
- If yes, is there sufficient detail to act as a guideline for preparing LG/CSO partnership agreements?
- Is it necessary to draft policy for supporting partnership agreements?
- What is the current use of CSOs by LG?
- What additional roles can such organisations play in the rendering of HIV/AIDS response services?
- Are there sufficient resources and supports provided to LG unit for preparing and monitoring CSO partnership agreements?

3.8.2 Assessing capacity of NGOs to enter into partnerships

An area of programme development that is receiving increasing attention is the assessment of the readiness of civil society organisations to enter into partnerships at local government level. Until now there has been relatively little work on understanding readiness of CSOs to enter into partnerships with LG. A notable exception is a study aimed at developing a tool to assess the readiness of civil society organisations to enter into partnership with

municipal health departments[132] in South Africa. Practical experience is being gained in this in South African cities where municipalities and provinces are committed to the challenge of directly funding local community-based organisations to receive funds, manage the delivery of outputs and account for their performance.

In Senegal under the World Bank MAP programme, NGOs have been classified according to experience and capacity and this classification is intended to act as a guide to eligibility for different levels of financing. But the evaluation and classification of the capacities of NGOs to enter into partnerships or receive funding may be a costly and time-consuming process. The inherent risks in contracting an organisation are not always self-evident and a fairly thoroughgoing process is necessary if this is to be adequately evaluated. Within World Bank Projects various schema have been developed to classify organisations according to their capacity to receive, manage and use funds accountably. Criteria of eligibility are set out in the MAP operational manual which considers such factors as the legal status, previous experience, financial management capacity and experience. A country based fiduciary agent assists in the process of screening organisations for eligibility.

There seems to be no easy way passed the significant risks associated with LGAs contracting small agencies to perform particular functions. The problem is that LGAs might not necessarily be in a good position to assess CSO capacities and to manage the tensions which may develop around certain organisations meeting eligibility criteria and not others. It is also a significant burden for LG to act as a procurement agency and this is an area where there is a strong need for capacity development. It has already been mentioned above that in some cases province-wide CSOs that specialise in CBO support and capacity building are useful partners to LGAs. Such capacity building CSOs in some contexts have been of invaluable help in assessing capacity of CBOs to enter into partnership agreements and in training them to the point where they are able to receive support and provide specific outputs in a systematic way that can be monitored and for which they can be held accountable.

3.8.3 Technical support/assistance programmes

Many externally funded LG HIV/AIDS programmes receive funding only for technical support in developing or improving programmes, and they are expected to bear the operational costs of the programme. Funders are generally not willing to fund basic service delivery costs, at least at the level of basic services provided by LG.

There can be no doubt that most local government programmes are severely lacking in expertise in areas relating to development and effective management of HIV/AIDS programmes. Some common areas of technical support for LG HIV/AIDS programmes are: financial management; programme management; human resources; health information systems and management; programme research, monitoring and evaluation; and specific assistance in areas of public health such as drug supply and management, sexual and reproductive health and syndromic management of tuberculosis and sexually transmitted infections.

From the perspective of the recipients of technical assistance a number of problems may arise. These include:

- Perceptions that technical assistance is offered by foreign consultants at high cost and could as well be offered by local experts (for instance local research consultants) and that there is sometimes a patronising approach on the part of foreign technical assistants.
- Perceptions that foreign institutions do not always understand local conditions and attempt to introduce strategies and models which they have developed elsewhere but which are practically problematic in the context.
- Technical assistance training programmes are often not locally accredited and professional recognition, credit or promotion might not flow from extended periods of training, whereas it may flow from country professional training programmes.
- Monitoring and mentoring of trainees in project work or practical application is often neglected, especially if technical experts are not based in the country.
- Technical assistance is of little value unless accompanied by roll-out support and training. For instance, technical training in management of district health information systems requires not only training of health information officials but also support for developing data collection standards at clinic level. Transfer of necessary skills to administration officials is also an important but often overlooked area of skills development.

[132] Gordon & Ndondo, 2001

- Concern that operational systems set up in technical assistance programmes cannot be absorbed in the long term by LG systems, or they may be inconsistent with other systems.
- A more general concern about technical support programmes is that technical assistants might temporarily provide the capacity to service and trouble-shoot programmes, but once the assistant leaves, the re-emerging capacity gap might leave the institution worse off than it was before the programme.

Given these reservations that appear to be features of LG in many different countries, considerable caution needs to be exercised in providing TA. To avoid these problems the TA component of a proposed programme should have two parts. The first would comprise of technical assistants who act as 'peers' and mentors. They would enter the programme on a long-term basis and ultimately would become the repository of the skills and expertise. Importantly they would have the capacity to self-seed these skills into the programme environment. The second tier of technical assistance would then be the provision of hard-skills specialist technical assistants who would be contracted by the programme to provide short and medium term skills training and enhancement. In local government where there is often high turnover of councillors, the importance of embedding technical assistance in posts and portfolios of officials cannot be underestimated. In Uganda in the last LG elections there was a 70% turnover of councillors and whilst they were not necessarily lost to the broad political and governmental system, this represented a significant drainage on the skills base of councillors, and new councillors needed to be inducted and trained. The importance of having a repository of skills and training departments or units to serve local government needs cannot be overestimated.

In technical assistance programmes attention should also be given to partner organisations and it is often the case that partners both within government and service providers at community level are not equipped to fulfil their roles in operationalising the technical assistance programme. For instance management of a VCT clinic operated by a municipality needs to be supported by technical assistance at higher levels of government where clinic consumables are supplied and at the lower level where technical training in monitoring, record keeping and counselling may need to be imparted to clinic staff and community health workers. But partners may also be outside of government altogether, in which case there is a need to extend technical assistance into the programme as a whole including all partners.

A comprehensive approach to technical assistance

DISC (Decentralisation et Initiatives De Sante Communautaire) is a small and highly geared organisation based in Dakar, Senegal which has as its mission the development of the capacity of district local government for responding to health needs. The core team consists of five highly skilled professionals. They have developed a process which they take district health teams through in a structured way. The outcome is a district management team which is geared to function as an accountable legal entity, which understands its powers and functions, and which has the capacity to form partnerships and raise funds.

The essential elements of the process are:

Use of technical agencies of international health organisations to provide focused technical support.

Works horizontally through a consultative process to connect with and develop support for community initiatives for better health services, bringing community members and LGA representatives together in a mentored planning process.

Eight candidates from a district are trained in health planning. Four are from the health sector and four are from the community. The training involves two domains: health and decentralisation; and community interaction/facilitation methods. They then lead the community planning process.

The 5 day community level planning process links locally elected bodies, government administration officials and health technicians (medical personnel).

Through the planning process the community develops a project scope, priorities, a budget and an annual work plan. It then enters into a matching funds arrangement with funders.

Notable about this process is that in a fairly short space of time the community is able to generate a workable plan. The programme makes optimal use of technical assistance which is available on tap, but whilst the entire process is closely mentored by experts, in a real sense it is conducted by communities and LG leaders themselves.

3.8.4 Networks

In many developing countries in the absence of strong local government responses to HIV/AIDS and in a context of burgeoning civil society responses, a measure of integration of HIV/AIDS response has been achieved by bringing together 'common interest' service, support and advocacy organisations into larger entities. Zambia, for instance, is notable for the presence of a number of large and influential networks of organisations. These are typically networks of CSOs with cognate concerns such as care of orphans and vulnerable families, or care for PWHAs.

There are a number of clear advantages to the formation of networks of CSOs:

- Networks assist in the consolidation of CSOs into clusters according to function and this helps to clarify confusion about who is doing what.
- Networks assist in the integration of planning processes for service delivery.
- Networks avoid problems of duplication and promote collaborative relationships between institutions and programmes.
- Networks facilitate focus in service provision and rationalisation of the combined services of a range of organisations into an effective HIV/AIDS response framework.
- Networks have larger advocacy muscle and political influence than individual organisations.
- Networks can unite common interest groups across regions and are not necessarily geographically confined, allowing for national strategic planning.
- Networks facilitate coordination of donor foci and allow a more strategic approach to development aid.
- Networks facilitate sharing of experiences and learning.
- Networks facilitate information dissemination and technology transfer.
- Existence of a network allows emerging and often local organisations rapidly to find support and recognition, and to be mentored by larger and more established organisations.
- Networks facilitate sharing of expertise, training and capacity building resources and processes.
- The scale of networks allows mobilisation of larger resources and investments and up-scaling of programmes.
- The existence of networks allows promotes co-financing of agencies involved in different functions within the same area of service provision leading to better integration of services.

There are also disadvantages to networks:

- Networks can be costly to establish, maintain and strengthen.
- There has been little evaluation of networks, and in some instances the perceptions of people involved suggest that they may cost more (usually human effort) than they are worth.
- Many networks are launched with great enthusiasm but member organisations often do not realise that resources and effort needs to be put into the network on the part of the organisation if benefits are to accrue from being part of the network and also to sustain the network.
- Networks may begin to operate independently of local government and to an extent where there are differences of approach between local government[133] and a large network of organisations this may lead tension between CSOs and government.
- Networks often do not involve active local government participation.

Elements of successful networks include:

- Clear advantages accruing from membership of a network.
- Regular production of communication resources and updating of websites.

[133] Which is often confined by national frameworks and policies.

- Representation of the network in consultations with government and HIV/AIDS strategic planning forums and conferences.
- Involvement of a range of partners which bring different areas of expertise to bear including academic and research institutions, labour and trade unions, media institutions, professional associations, as well as grassroots and community based organisations.
- Active use of the media and a communication strategy.
- Involvement of local government agencies in the network.

3.9 PUBLIC PARTICIPATION

> "Community mobilization is the core strategy on which success against HIV has been built. Fostering such mobilization requires eliminating stigma, developing partnerships between social and government actors, and systematically involving communities and individuals infected and affected by HIV/AIDS."[134]

3.9.1 The rationale for participation

The concept of participation is a cornerstone of the vision of PHC and is enshrined in its founding document.[135] Yet its meaning and significance is by no means certain. Participation of the public, health service users, HIV positive people and others directly affected by HIV/AIDS and CSOs has been widely promoted as an essential ingredient of effective approaches to community participation.

It is important to distinguish between two different forms of representation: voice and formal representation. One's interests may be given voice and one may be free to advocate for one's interests without necessarily being formally represented. The World Bank handbook for support LG HIV/AIDS responses provides some ideas about how to support community involvement and the converse, which is to develop LG accountability to the communities it represents.

It is often suggested that community ownership of projects is a desirable objective and that participation should work towards this end. This idea is also often connected to the ideal of sustainability. However, in reality there are few examples of this and ownership of projects should be defined as a sense on the part of the community that the project is shaped by the community and that there are opportunities to participate in the process of shaping it. In reality projects are usually run by professionals with experience in project management and the many skills which are required to receive and manage funds, hire staff, allocate resources and redirect the programme. The community may be represented at this level, but representation inevitably involves the possibility of unaccountability, and some level of distance from 'the community'. The ideal of democratic local government is that LG is by its nature representational, but in practice the matching of LG actions and community needs is a complex matter, especially since communities are not usually of one voice.

The converse of public participation is LG accountability. In democratic local government LG would ideally be committed to the ideal of participation. However, even when this is established problems are inevitable. There is an inherent tension between the two arms of local government, represented by politicians (councillors) and officials (administrators). Very often the nuts and bolts of programme implementation are left to officials and managers, who are supposedly accountable to political figures in local government. But, there are obstacles to such accountability, notably that the technical details of, for example, the resource requirements for a municipal VCT centre, are beyond the area of competence of elected officials. Managers with technical expertise are frequently required to develop plans and elected representatives are not necessarily in a position to review the satisfactoriness of such decisions against whatever mandates they may represent as elected officials. Furthermore, elected officials have a high rate of turnover. So in reality it is administrators and managers who ensure the continuity of programmes.

To ensure accountability of LG programmes to communities, it has become standard practice to develop ways of more direct participation of public representatives in local programmes. Usual ways of achieving this are through hospital boards,[136] clinic committees and on district and municipal planning and coordinating committees.

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[134] UNAIDS 2002 p.16
[135] The Alma Ata Declaration 1976
[136] Bennet et al. n.d.

LG officials are not necessarily well equipped to assess and know public opinion. There is a great range of programmes designed for capacity building amongst local government officials, but few which take into account the specific role of elected councillors or officials in participatory efforts at local level.

There has been little work done on evaluating participatory processes although there have been some efforts to develop a sense of what issues are important to take note of.[137] Evidence suggests that if participation of communities is satisfactory it is likely to make programme development processes more rather than less difficult and cumbersome, but also more sensitive to needs and better supported.

3.9.2 GIPA

The principle of greater involvement of people affected by HIV/AIDS (GIPA) in developing responses to the epidemic was endorsed by 42 National Governments at the 1994 Paris AIDS Summit. It has since become one of the guiding ideals in developing HIV/AIDS intervention programmes.

There are a number of international movements dedicated to promoting access to treatment, international associations for people living with HIV/AIDS, as well as numerous regional and country-based organisations. Many countries have national associations for people living with HIV/AIDS. However, some such organisations are beset by difficulties and they do not necessarily play a prominent role in guiding national policies, strategies and priorities.

The role of people living with HIV/AIDS in education campaigns has been widely endorsed by UNAIDS and most other international HIV/AIDS programme support organisaitons. It is widely claimed that the involvement of PWHAs in such campaigns increases impact.

The following of some of the ***advantages*** commonly claimed to accrue from including PWHAs in intervention programmes:

- PWHAs best understand the context of AIDS care and understand what it means to live with HIV/AIDS.
- It is motivating and empowering for PWHAs to become involved in intervention programmes and social action around tackling HIV/AIDS.
- It promotes de-stigmatisation to have PWHAs directly involved in running programmes and consultation.
- PWHAs provide living proof that HIV/AIDS is not a death sentence and may provide an example of 'positive living' meaning living positively with HIV/AIDS.
- There is much evidence to suggest that PWHAs can be powerful and committed educators and that people tend to be more positively affected by education conducted by them.
- The personal involvement of PWHAs often means that they are committed to and passionate about working in the field.
- PWHAs remind others of the human dimensions of the epidemic and their presence in meetings serves to mitigate the subtle forms of prejudice which may otherwise operate in programme development and planning. Their presence in project teams is also motivating.
- The presence of PWHAs creates the credibility and trust in the organisation in the eyes of the community of people affected by HIV/AIDS.

The following are some of the ***challenges and pitfalls*** associated with involvement of PWHAs in intervention programmes:

- Personal understanding of what it means to live with HIV/AIDS does not necessarily translate into understanding of solutions at a structural or strategic level.
- PWHAs are not necessarily equipped educationally or in terms of previous experience to the demands of organisational culture or programme development and implementation. It is important to involve people at a level and in activities where they can meaningfully contribute.
- People with AIDS tend to have high levels of absenteeism due to illness.[138]

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[137] Kelly & van Vlaenderen 1996;

[138] One of the more significant problems associated with an education project which employes PWHAs is the high

- Where there is no national association of PWHAs and no strong advocacy movement PWHAs do not necessarily represent a common interest and are not necessarily united in a common strategic vision. Because someone is living with HIV/AIDS does not mean that he/she represents the interests of others who are, and this assumption can easily be made.
- It can be self-defeating and dis-empowering for people to be involved in activities where they are not equipped to make a meaningful contribution.

There are different levels and types of involvement

- GIPA may take place at a number of different levels: service delivery, advocacy, training, managing, strategising, being consulted, and benefiting. These might be listed on a continuum from active to passive involvement.
- Most commonly GIPA involves representing the voice of PWHAs at all of these levels. It is generally regarded as good practice to involve people at all levels. At a practical level of local response this translates into including PWHAs in committees, consultative forums and advisory groups. It is preferable that representatives be drawn from credible organisations representing PWHAs in the interest of consolidating and coordinating AIDS response.
- At LG level there is a need to create recognition of the importance of involvement of PWHAs and to create opportunities for active participation.

levels of absenteeism due to illness.

4. MONITORING, EVALUATION AND RESEARCH

The role of LGAs in responding to HIV/AIDS has been described above as important, but as facing considerable development challenges. Some examples have been sketched of innovations and directions which appear promising, but there remains much to be done by way of model development, benchmarking and consolidation of directions for LGAs in stimulating, managing and co-ordinating local responses to HIV/AIDS. Monitoring, evaluation and research will play an important role towards this end.

4.1 M&E of LG response to HIV/AIDS

In searching for resources whilst conducting the review, no set of M&E indicators for local government responses to HIV/AIDS was located. Many of the available standard frameworks for monitoring and evaluation of HIV/AIDS responses cover some of the key areas such as participation, GIPA, behavioural responses, and the many areas of practice that are the focus of integrated planning. These are useful resources, but the priority in developing M&E frameworks for the different spheres and tiers of LG need to focus specifically on the challenges facing LG, rather than generally on issues concerned with local response. The issues which need to be looked have been described in this review, and a basic protocol for measuring LGA responses to HIV/AIDS is presented in the World Bank handbook. Also presented in the toolkit is a tool for identifying the powers, functions and capacity of LG for responding to HIV/AIDS, including challenges. These tools could be used in any LG context to develop indicators for measuring progress. Similarly the tool for assessing local responses to HIV/AIDS and the processes associated with local co-operation and integration, is useful for identifying issues which will be central to response and hence to monitoring and evaluation.

Some of the most important general elements of local HIV/AIDS response to consider in developing M&E frameworks are:

- Commitment of leadership to HIV/AIDS response.
- Evidence that the local context has been understood in developing response frameworks.
- The existence of LGA internal programmes.
- The integration of departmental HIV-AIDS response systems through a LGA co-ordinating group.
- The existence of local level (LGA-CSO-CBO) HIV-AIDS response co-ordinating committees.
- Existence of inter-governmental support programmes oriented to improving HIV/AIDS response at different tiers of government.
- Evidence that systemic decentralisation problems are being identified and addressed at a national level with specific reference to HIV/AIDS response including focus on: fiscal decentralisation; split functions of government; and vertical decentralisation.
- Evidence of existence of programmes for functional integration of services in key areas of service especially: VCT, PMTCT, TB, STI, OVC, treatment, home-based care, de-stigmatisation and social support.
- Given the lack of local M&E skills it is important in developing country LG programmes to include assistance for M&E through a national support unit, but there is little evidence of such support units being available for assisting LG programmes.

4.2 Research needs

Tools for assessing the impact of HIV/AIDS on local communities and on LGA functioning, and a tool for taking stock of local responses to HIV/AIDS are presented in the World Bank handbook. For each of these, more sophisticated and comprehensive protocols are possible, and large municipalities and cities or districts may need to employ research consultants in such areas. Unfortunately there is a dearth of researchers knowledgeable about both LG and HIV/AIDS. For this reason and to ensure that baseline and other research is closely tied to programme development processes, it is often advisable to do as much research as possible at programme level, even if this means down-sizing the scale of research and the sophistication of methods. As far as possible research should be built into programme budgets to ensure that it is focused and programme-development oriented.

An example of simple and inexpensive local research is the following suggestion for researching functional integration (continua of care and prevention-care). Remarkably revealing research can be conducted using a few

case studies reporting on the experiences of individuals or families entering and moving through and between HIV/AIDS response systems. By doing this it is possible to identify problems associated with functional integration, showing problems of access to services and the functioning of referral networks, different standards and qualities of service, and gaps and strengths in service delivery.

In addition to the need for M&E support as suggested above, country level programmes for developing LGA responses to HIV/AIDS need to include a research support component. As far as possible this should work through mentoring and support for programme development research rather than through centrally conducted programme research.

As well as ongoing programme monitoring and review there are a number of areas of research worth pursuing at a general level; i.e. not necessarily tied to specific programmes. These are:

- Research on partnerships[139]: There is need for research towards developing frameworks for assessing the capacity of CSOs to enter into partnerships and capacity of LG systems to develop and accommodate partnerships. There has been little work done on this and further understanding of these issues for different types of partners and programmes, is important in developing LGA responses to HIV/AIDS.
- Benchmarking: This refers to the use of performance standards and best practices as references against which to measure and improve performance. There is a strong need for development of best practices relating to LG responses to HIV/AIDS at different levels. Best practices related to integrated planning, functional integration, inter-governmental support for HIV/AIDS programming, budgetary support for local government responses, innovations and reform in financing LG responses, and leadership development for HIV/AIDS response are some of the areas in which best practice studies would be valuable. Whether or not performance standards could be developed which are relevant across the different local government contexts is a moot point, but certainly within countries these would be valuable.
- Cost-effectiveness research: There is need for research into the economics of scale in decentralising HIV/AIDS programmes. There is also need to research the cost-effectiveness of functional integration frameworks. It is particularly important to know whether it is more cost-effective to add new services onto existing services and facilities (e.g. add PMTC to existing VCT programmes), or to develop the scale of services independently. Comparison of marginal and incremental costs is important in this regard.
- Another area of research might follow the approach of 'decision space analysis'[140] to investigate the functioning of local government systems in a decentralised framework. Such research might be tied to a programme for monitoring of LG decentralisation processes and their relation to HIV/AIDS response, including the role of inter-governmental structures at different levels.
- An associated area of research where there has been troublingly little work is research into decentralisation of national AIDS programmes and difficulties associated therewith. An important emphasis here should be on the consequence of local level priority setting for national AIDS strategy and *vice versa.*

[139] One suggestion for researching and evaluating partnerships involves three contrasting, though related, components: the preparatory work of assessing potential; the process of joint working and monitoring thereof; and an assessment of the extent to which objectives have been reached.
[140] Bossert et al 2000

6. BIBLIOGRAPHY

This bibliography includes cited and uncited references of relevance to this review.

Abt Associates. 2000. *AIDS Toolkits: HIV/AIDS and Ministry Employees.* HEARD, University of Natal, Durban.

ADF. 2000. Theme 3 ADF document: scaling up the response to HIV/AIDS. African Development Forum. Available at www.uneca.org/adf2000/theme3.htm. [Accessed 10 January, 2003.]

Africa Region, The World Bank. Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis. The World Bank.

Ainsworth M. & Teokul W. Realistic priorities for AIDS. Breaking the silence: Setting realistic priorities for AIDS control in developing countries. Development Research Group, The World Bank, Washington D.C.

Aitken I. 1998. *Decentralization and reproductive health: opportunities and challenges.* Harvard School of Public Health, Cambridge MA.

Akeroyd A. 1997. Sociocultural aspects of AIDS in Africa: occupational and gender issues. In: Bond, G.C., Kreniske, J., Susser, I. & Vincent, J. eds *AIDS in Africa and the Caribbean*. Boulder, USA & Oxford, UK, Westview Press.

Alban A. 1999. AIDS and development: socio-economic perspectives. In: *AIDS & development: prospects and constraints*. Report from April 1999 Copenhagen seminar. Copenhagen, Denmark, The Danish Society of Tropical Medicine, Danida & The ENRECA Health Network.

Ambert, C. 2004. *Integrated development planning in a context of HIV and AIDS - municipal planning perspectives and responses*. Development Works/IFAS. Johannesburg 2003.

Annan K.2000. Address to the United Nations Security Council by UN Secretary-General, 10 January 2000, New York.

Ashton P and Ramasar V. 2001. Water and HIV/AIDS: Some strategic considerations in southern Africa. In: Turton A & Henwood R. (eds) *Hydropolitics in the Developing World: A Southern African Perspective.* African Water Issues Unit and International Water Management Institute Pretoria pp.22 (In press)

Asia-Pacific HIV Impact Assessment Tool (2/20/2001)
http://aidssouthasia.undp.org.in/hivimpact/hiv_impactool.htm

Atkinson S, Medeiros R, Oliveira P & de Almeida R.. 2000. Going down to the local: incorporating social organisation and political culture into assessments of decentralised health care. *Social Science and Medicine, 51*(4), pp.619-636.

Atkinson S. 1997. From vision to reality: implementing health reforms in Lusaka, Zambia. *Journal of International Development* 9(4), pp. 631–639.

Barnett C, Conner C & Putney P. 2001. *Contracting NGOs to combat HIV/AIDS*. Abt Associates, Bethesda MD.

Barnett T. & Blaikie P. 1992. *AIDS in Africa: its present and future impact*. London, UK, Belhaven Press.

Barongo L, Borgdorff M, Mosha F, Nicoll A, Grosskurth H, Senkoro K, Newell J, Changalucha J, Klokke A & Killewo J. 1992. The epidemiology of HIV-1 infection in urban areas, roadside settlements and rural villages in Mwanza Region, Tanzania. AIDS, 6 (12),1521-1528,

Barron P & Asia B. 2001. Chapter 2. *The district health system. South African Health Review – 2001*. Health Systems Trust, Durban.

Barron P & Sankar U. 2000. Chapter 10: Developments towards a district health system. South African Health Review – 2000. Health Systems Trust, Durban.

Barron P. 2000. Who's the boss – Local government health services. Unpublished document available at http://www.hst.org.za/ [accessed June 2002]

Bataringaya, J. Integrating HIV/AIDS into the work of development organizations: the experience of ActionAid. *Sexual Health Exchange, Summer 2000 v2000 i3 p4*

Bennett J & Rohde J. 1999. *Mapping for primary health care: district maps, clinic catchment areas and community mapping in the Eastern Cape Province.* Equity Project, Bisho.

Bennett S, Miller Franco L, Kanfer R & Stubblebine P. 2000. *The development of tools to measure the determinants and consequences of health worker motivation in developing countries.* Partnerships for Health Reform Project, Abt Associates, Bethesda MD.

Bennett S. 2000. *Analyzing the process of health financing reform in South Africa and Zambia: Zambia Country Report.* Abt Associates, Maryland.

Bennett, J., Msauli, L., Manjiya, F. 2001. *Guidelines to strengthen community involvement in District Hospitals and to make hospitals more District friendly.* Equity Project, Bisho.

Bennett, J., Thetard, R., Msauli, D. & Rohde,J. n.d.(a) *Strengthening community participation in health: Ideas from the Eastern Cape*. Equity Project, Bisho. The Equity Project/USAID. Pretoria, South Africa. Available at www.equity.co.za

Bennett J., Thétard R., Rohde J., Pama Y, Ncanywa B, Manjiya F, Arosi N, Msauli D. n.d.(b) *Strengthening community participation in health promotion and primary health care clinics*. The Equity Project/USAID. Pretoria, South Africa. Available at www.equity.co.za

Berman P. 1995. Health sector reform: making health development sustainable. *Health Policy* 32(1–3), pp.13–28.

BESG. (Built Environment Support Group). 2003. The Msunduzi HIV/AIDS strategy: A partnership response at local government level. Pietermaritzburg, South Africa.

Bijlmakers L & Harnmeijer J.-W. 1995.. In: Chabot, J., Harnmeijer, J.-W. & Streefland, P.H. (eds): *African primary health care in times of economic turbulence*, 119–148. Amsterdam, The Netherlands, Royal Tropical Institute.

Billis D. 1993. *Organising public and voluntary agencies*. Routledge, London.

Boerma T & Urassa M. 1997. Situation analysis for a district HIV/AIDS programme. In: Ng'weshemi, J., Boerma, T., Bennett, J. & Schapink, D. eds *HIV prevention and AIDS care in Africa. A district level approach*. Amsterdam, The Netherlands, Royal Tropical Institute.

Booysen, F., Burger, P, Pelser, A. & Pretorius, A. (2002). The impact of the HIV/AIDS epidemic on the revenue of Mangaung Local Municipality. Centre for Health Systems Research & Development, University of the Free State, Bloemfontein, SA.

Bossert T, Beauvais J. & Bowser D. 2000. *Decentralization of health systems: preliminary review of four country case studies.* Abt Associates, Bethesda MD.

Bossert T, Chitah M, Simonet M, Mwansa L, Daura M, Mabandhala M, Bowser D, Sevilla J, Beauvais J, Silondwa G & Simatele M. 2000. *Decentralization of the health system in Zambia.* Abt Associates, Bethesda MD.

Bossert T. 1998. Analyzing the decentralization of health systems in developing countries: decision space, innovation and performance. *Social Science & Medicine* 47(10), pp. 1513–1527.

Braa J & Hedberg C. 2000 *Developing district-based health care information systems: the South African experience*. UWC/UCT, Cape Town.

Brinkerhoff D. & Leighton C. 2002. Insights for implementers: decentralization and health system reform. *PHRplus* no. 1, September 2002, pp. 1–12. Maryland, USA, Partners for Health Reform*plus* Resource Center.

Brown L. 1996. The potential impact of AIDS on population and economic growth rates. *Food, Agriculture, and the Environment Discussion Paper* 15. Washington D.C., International Food Policy Research Institute.

Buch E. n.d.(a)*The development of health service performance indicators for regional managers in Johannesburg*. Unpublished paper available at http://www.hst.org.za

Buch E. n.d.(b) *A proposal on the health component of performance management agreements for regional managers in the Johannesburg Metropolitan Council*. Unpublished paper available at http://www.hst.org.za

Buch E. n.d.(c) *The health component of performance management agreements for regionalmanagers in the Johannesburg Metroploitan Council*. Unpublished paper available at http://www.hst.org.za

Building Partnerships: Sustaining and expanding community action on HIV/AIDS. International HIV/AIDS Alliance.

Buthelezi G, Barron P, Makhanya N. & Edwards-Miller J. 1997. *Measuring the move towards equity.* HST, Durban.

Buvé A., Foster S, Mbwili C., Mungo E., Tollanare N. & Zeka M. 1994. Mortality among female nurses in the face of the AIDS epidemic: a pilot study in Zambia. *AIDS* 8(3), p. 396.

CADRE (2000) The Economic Impact of HIV/AIDS on South Africa and its Implications for Governance: A literature Review, Prepared on behalf of USAID through the Joint Centre for Political and Economic Studies, Pretoria, South Africa

Cassels A. 1995. Health sector reform: key issues in less developed countries. *Forum on Health Sector Reform, Discussion Paper* 1. Geneva, Switzerland, Division of Strengthening Health Services, World Health Organization

Center for Disease Control (CDC) (1999) *Intervention Checklist: A tool for Assessment of local HIV/AIDS interventions*, HIV/AIDS Prevention Research Synthesis project

City-level responses to HIV/AIDS: South African Cities Network. April 2002.

Clay R & Lee S. 2000. Building partnerships: sustaining and expanding community action on HIV/AIDS. *Pathways to Partnerships toolkit.* International HIV/AIDS Alliance, London.

Cohen D. 1997. *Evaluating HIV and AIDS: Why capacity development is central to assessing performance.* UNDP, New York.

Cohen, B. & Trussell, J. (eds). Preventing and Mitigating AIDS in sub-Saharan Africa: Research and Data Priorities for the Social and Behavioral Sciences. National Academy Press. Washington DC, 1996.

Colvin M. & Mullick S. 1997. *Draft outline of a National STD/HIV/AIDS surveillance strategy*. MRC, Durban.

Colvin, M. 2000. 'Sexually transmitted infections in Southern Africa: A public health crisis'. *South African Journal of Science*,. 96 (6): 335-339.

Commonwealth Foundation. 1999. *Citizens and governance: Civil Society in the new millennium*. Commonwealth Foundation/CIVICUS. Available at www.commonwealthfoundation.com

Conceptual Framework, Outputs of a Policy Research Workshop, Indian Institute of Health Management Research, Jaipur India.

Conner C & Barnett C. 2001. *Contracting NGOs for HIV/AIDS*. Presentation from PHR End of Project Conference, International Trade Centre, Washington D.C.

Constitution of the Republic of South Africa 1996 (Act 108 of 1996), Constitutional Court, Johannesburg.

Cupido, J. 2002. Assessment tool for NGO's: Proposed flow of EU funding for PHC Partnership Project. Provincial Government Western Cape Department of Health.

Day C & Gray A. 2001. Health and related indicators. In *South African Health Review 2001*,pp.283-340. HST, Durban.

Decentralization and Local Governance Project. Quarterly Progress Report March-June 2000. Prepared by ARD with USAID/Senegal, July 2000.

Department of Constitutional Development. 1999. Local Government for the 21st Century: Local Government Information Series. Modules: Local Government for the 21st Century; Demarcation; Elections; Participation & Accountability; Building Capacity; Metropolitan Government; District Government; Establishing New Municipalities; Types of Municipalities. Department of Constitutional Development, Pretoria.

Department of Health, 1999. The Electricity Supply Commission of South Africa (ESKOM): HIV/AIDS Best Practice Series. HIV/AIDS and STD Directorate, Department of Health, Pretoria.

Department of Health. 1997. *White paper for the transformation of the health system in South Africa*. Department of Health, Pretoria.

Department of Health. 1999. .*Health sector strategic framework 1999-2004*. Department of Health, Pretoria.

Department of Health. 1999. *The primary health care package for South Africa: a set of norms and standards.* Department of Health, Pretoria.

Department of Health. 2001. *Developing and Implementing an HIV/AIDS plan at District level.* Department of Health, Pretoria.

Department of Provincial and Local Government. 1997. *Green paper on local government.* Ministry for provincial affairs and constitutional development, Pretoria.

Department of Provincial and Local Government. 1998. *White paper on local government.* Ministry for provincial affairs and constitutional development, Pretoria.

Department of Provincial and Local Government. 2001. *Introduction to performance management for local government in South Africa.* Department of Provincial and Local Government, Pretoria.

Department of Provincial and Local Government. 2001. *Performance management: a guide for municipalities.* Department of Provincial and Local Government, Pretoria.

DPLG- Department of Provincial and Local Government. 2001. *Integrated planning guidelines – 2001.* DPLG/GTZ. Available at www.dplg.gov.za/documents/publications/idp/guide0.pdf

Designing and Implementing Health Financing Reform. Executive Summary Series, Partnerships for Health Reform.

DFID/UNFPA. 2001. Developing a tool to assess the readiness of civil society organizations to enter into partnership with Municipal Health Departments. Reproductive Health Alliance.

Dixon S, McDonald S. & Roberts J. 2001. HIV/AIDS and development in Africa. *Journal of International Development* 13(4), pp. 381–389.

Douglas R. 1998. A framework for healthy alliances. In A. Scriven (Ed.), *Alliances in health promotion: Theory and practice*. MacMillan, London.

Dramé M. 2000. GTZ/RAPA's multi-sectoral approach in West Africa in *Sexual Health Exchange* 2000/3 p9-10.

Durban Unicity Committee. 2000. *The changing role of local government as a service provider*. Unpublished paper available at http://www.hst.org.za.

EgeröB, Hammerskjöld M. & Munck L. (2000. *AIDS: the challenge of this century. Prevention, care and impact mitigation*. Stockholm, Sweden, Swedish International Development Corporation Agency (Sida).

Emthanjeni Integrated Development Plan. 2002. IDP Concept Plan. Emthanjeni Municipality, De Aar, South Africa.

Figueroa M, Kincaid D, Rani M. & Lewis G. 2001. *Framework and indicators for measuring social change process and outcomes*. JHU/CCP, Baltimore.

Figueroa M, Kincaid D, Rani M. & Lewis G. 2002. *Communicating for Social Change: An Integrated Model for Measuring the Process and its Outcomes.* The Communication for Social Change Working Paper Series: No. 1. The Rockefeller Foundation, New York.

Gauteng Government Inter-Departmental AIDS Unit: Literature Review of Behavioural Surveys. Final Report submitted 29 August 2001.

Gilbert, C., Rossouw, A.M.M., Weir, S., Venter, D.J.L. & Davids, A.S. A Pilot Study of A Rapid Assessment Method to Identify Areas for HIV/AIDS Prevention in Port Elizabeth. HTA Report: Gqebera (Walmer Township). Paper presented at the "Confronting Health Issues Through Interdisciplinary Research" Conference, East London. August 2001. Health and Development Research Institute, Faculty of health sciences, University of Port Elizabeth.

Gillies P. 1998. Effectiveness of alliances and partnerships for health promotion. *Health Promotion International, 13*(2), pp. 99-120.

Gilson L, Balfour V & Goosen V. 1997. *Towards well-functioning health districts in South Africa – A vision and indicators for assessing progress*. Centre for Health Policy Technical Report No TK27. University of Witwatersrand, Johannesburg.

Gilson L, Kalyalya D., Kuchler F., LakeS, Oranga H. & Ouendo M. 2001. Strategies for promoting equity: experience with community financing in three African countries. *Health Policy* 58(1), pp. 37–67.

Gilson L. 1995. Management and health care reform in sub-Saharan Africa. *Social Science & Medicine* 40(5), pp. 695–710.

Gilson L. 1997. *Implementing and evaluating health reform processes: lessons from the literature.* Abt Associates, Bethesda MD.

Goodland R and Mercier J (1999) The Evolution of Environmental Assessment in the World Bank: from "Approval" to Results, World Bank, Environmental Management Series.

Goodstadt M. & Kahan B. 2002. *Best practices in health promotion: a resource book*. Centre for Health Promotion, University of Toronto, Toronto.

Gordon G & Ndondo T. 2001. *Developing a tool to assess the readiness of civil society organisations to enter into partnership with municipal health departments*. Reproductive Health Alliance/ DFID/ UNFPA, Pretoria.

Govender V, McIntyre D, Grimwood A & Maartens G. 2000. *The costs and perceived quality of care for people living with HIV/AIDS in the Western Cape Province in South Africa.* Abt Associates, Bethesda MD.

Groelsema, R., Muncy, D. & Ott, D. 2000. Synthesis of Democracy and Governance Cross Sectoral Case Studies.

Grosskurth H, Mosha F, Todd J, et al. 1995. 'Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: randomised controlled trial'. *Lancet*, 346: 530-536.

Guinness, L. & Kumanarayake, L. 2002. The potential Costs and Benefits of Responding to the Mobility Aspect of the HIV Epidemic in South East Asia; A Conceptual Framework. UNDP South East Asia HIV and Development Programme.

Hanson, S. 2000. Health sector reform and STD/AIDS control in resource poor settings – the case of Tanzania. *The International Journal of Health Planning and Management* 15(4), pp. 341–320.

Harvey R. 2000. *National health accounts and health sector finance reform model: framework, model specification and calibration exercises*. Abt Associates, Bethesda MD.

Hawe, P. & Shiell, A. Social Capital and Health Promotion: a Review. *SocialScience & Medicine 51 (2000) 871-885.*

Health Education Board for Scotland. *Partnerships for health: a review. HEBS Working Paper Number 3.* HEBS research documents.

Health Systems Trust and Department of Health. 1996. *Health care in kwaZulu Natal: Implications for planning*. Health Systems Trust, Durban.

HEARD/KZN DOH. 1999. HIV/AIDS Toolkit for Local Government.

Heavens J. 1999. *Casemix: The missing link in South African healthcare management*. MRC, Tygerberg.

HEBS. 2001a. *Partnerships for health: a review.* HEBS working paper no. 3. Health Education Board for Scotland, Edinburgh.

HEBS. 2001b. *The health promoting health service: a framework for good practice*. Health Education Board for Scotland, Edinburgh.

Hingora, A. 2000. Statements by Dr. A Hingora, Ministry of Health. In: Lindboe, R. Tanzania's grand-scale AIDS-plan seen as useless. Available at www.ms.dk/Kampagner/aids/tanzania.htm. [Accessed 11 January, 2003.]

HIV/AIDS and Urban Poverty in South Africa. South African Cities network, August 2002.

HIV/AIDS Toolkit for Local Government. Health Economics & HIV/AIDS Research Division, University of Natal. KwaZulu-Natal Department of Health. October 1999.

Hollister, R.M. 1998. *Decentralization in national AIDS control and prevention programs*. North Carolina, USA, Research Triangle Institute.

Hollister, R.M. Decentralization in National AIDS Control and prevention Programs. Research Triangle Institute, Centre for International Development.

Howard-Grabman, L. & Snetro, G. How to mobilize communities for health and social change. Save the Children Federation.

HST. 2000. *Equity gauge: an approach to monitoring equity in health and health care in developing countries.* Health Systems Trust, Durban.

HST. 2001. *Investigating the roles and functions of Clinic Supervisors in Three districts in the Eastern Cape Province. A Research Report commissioned and published by the Health Systems Trust, July 2001.*

Hunt, C.W. 1996. Social vs biological: theories on the transmission of AIDS in Africa. *Social Science & Medicine* 42(9), pp. 1283–1296.

Initiative for Sub-District Support. 1999. *Local Government Transformation: A guide for Health Workers.* Health Systems Trust, Durban.

Institute of Municipal Financial Officers. 2001. Integrated development planning. *IMFO Journal,2* (3).

Jackson H, Kerkhoven R, Lindsey D, Mutangadura G. & Nhara F. HIV/AIDS in Southern Africa: the threat to development. SAfAIDS.

Jeppsson, A. 2001. Financial priorities under decentralization in Uganda. *Health Policy and Planning* 16(2), pp. 187–192.

Johnson K, Braden C, & Cairns L. 2000. Transmission of Mycobacterium Tuberculosis from medical waste In: *Journal of the American Medical Association*, vol. 284, no. 13 p1683.

Joint Action Between Local Government and Civil Society: Views and Reactions from an Online Discussion. ECDPM, July 2000.

Jordan-Harder B, Koshuma C, Pervilhac C & Vogel U. Hope for Tanzania: Lessons Learned from a Decade of Comprehensive AIDS Control in Mbeya Region. Ministry of Health, Tanzania & Deutsche Gesellschaft fur Technische Zusammenarbeit (GTZ) GmbH, October 2000.

Kaddar M, Makinen M & Khan M. 2000. *Financing assessment tool for immunization services: guidelines for performing a country assessment.* Abt Associates, Bethesda MD.

Kaddar M, Makinen M & Khan M. 2000. *Financing Assessment Tool for Immunization Services: Guidelines for Performing a Country Assessment.* Abt Associates, Maryland.

Kalipeni, E. 2000. Health and disease in southern Africa: a comparative and vulnerability perspective. *Social Science & Medicine* 50(7–8), pp. 965–983.

Katz, A.. 2002. AIDS, individual behaviour and the unexplained remaining variation. *African Journal of AIDS Research*, 1(2), 125-143.

Kelly J *et al*., 2000. Bridging the gap between the science and service of HIV prevention: transferring effective research-based HIV prevention interventions to community AIDS service providers. *American Journal of Public Health* 90(7):1082-1089.

Kelly K & Van Vlaenderen H. 1995. Evaluating participation processes in community development. *Evaluation and Programme Planning*, *18(4)*, 371-383.

Kelly, K. & Collins, T. Monitoring and Evaluation of the European Union (EU) 'Partnerships for Health' programme, South Africa: Outline and framework for baseline studies and monitoring and evaluation.

Kelly, M., Gordon, P., Parker, T. 2002. Alliance of Mayors Initiative for Community Action on AIDS at the Local Level. Mission report prepared for UN-AMICAALL Partnership Programme.

Kinghorn A, Schierhout G, Johnson S, Njobe T & Steinberg M. 2001. *HIV/AIDS sectoral impact assessments in South Africa.* Abt Associates, Bethesda MD.

Knowles J, Leighton C & Stinson W. 1997 *Measuring results of health sector reform for system performance: A handbook of indicators*. Abt Associates, Maryland.

Kramer R & Grossman B. 1987. 'Contracting for social services: Process management and resource dependencies', *Social Service Review*, 61, March.

Kutzin, J. 1995. Experience with organizational and financing reform of the health sector. *Current Concerns SHS Paper* 8. Geneva, Switzerland, Division of Strengthening of Health Services, World Health Organization.

Kweneng East Comprehensive District Plan on HIV/AIDS, Phase I: Situational Analysis and Response Analysis. May 1999.

Laga M, De Cock K, Kaleeba N, Mboup S, Tarantola D. HIV/AIDS in Africa: the second decade and beyond. *AIDS* 1997; 11 (suppl B): S1-S3.

Lake S, Daura M, Mabandhla M, Masiye F, Mulenga S, Antezana I, Mwikisa C, Leonard A & Muia E. 1998. *Community-based AIDS prevention and care in Africa: Building on local initiatives.* Population Council, New York.

Lake S, Daura M, Mabandhla M, Masiye F, Mulenga S, Antezana I, Mwikisa C & Bennett S. 2000. *Analyzing the process of health financing reform in South Africa and Zambia: Zambia country report.* Abt Associates, Bethesda MD.

Leonard A. & Muia E. 1998 *Community-based AIDS prevention and care in Africa: Building on local initiatives.* Population Council, New York.

Local Government Municipal Structures Act. 1998. *Republic of South Africa Government Gazette, 402*(19614), pp. 1-104.

Local Government Municipal Systems Act. 2000. *Republic of South Africa Government Gazette, 425*(21776), pp. 1-120.

London L. 1996. AIDS programmes at the workplace: A scoresheet for assessing the quality of services. *Occupational Medicine* 46(3):216-220.

loveLife (2001) Impending Catastrophe Revisited: An update on the HIV/AIDS epidemic in South Africa, Henry J Kaiser Foundation, Parklands South Africa

Luhamba, D., Schapink, D. & Msuya, W. 1997. Community level interventions. In: Ng'weshemi, J., Boerma, T., Bennett, J. & Schapink, D. eds *HIV prevention and AIDS care in Africa. A district level approach*. Amsterdam, The Netherlands, Royal Tropical Institute.

Macintyre, S. (1999) *The social patterning of health: bringing the social context back in.* Plenary address to the 1999 BSA Medical Sociology Annual Conference. http://medsocbsa.swan.ac.uk/MSN/msn001F/msn001plen.htm

Macintyre, S., Maciver, S., & Sooman, A. (1993). Area, class and health; should we be focusing on places or people? *Journal of Social Policy*, 22, 213-234.

Magwaza S, Cooper D & Hoffman M. 2002. *The delivery of integrated reproductive health services at district levels*. HST, Durban.

Magwaza S. 2002. *The delivery of integrated reproductive health services at district levels*. Unpublished document available at http://www.hst.org.za/ [accessed June 2002]

Mahlalela X, Rohde J & Bennett J. 1998. *The status of primary health care services in the Eastern Cape Province.* MSH, Bisho.

Major civic associations in Uganda, their composition, functions and geographical distribution within municipalities. (Summary prepared by Development Research & Training)

Management Sciences for Health. 2000. *Indicators of health status & health services in the Eastern Cape Province & South Africa.* Eastern Cape Department of Health, Bisho.

Mbananga N & Sekokotla D. 2002. *The utilisation of health management information in Mpumalanga Province*. Unpublished document available at http://www.hst.org.za/research

Mbatsha, S. & McIntyre, D. 2001. Financing Local Government Health Services. Health Economics Unit, Department of Public Health and Primary Health Care, University of Cape Town. http://www.hst.org.za/sahr/2001/chapter3.htm

Mbere, N. 2002. Local governance and HIV/AIDS. *Fifth Africa Governance Forum (AGF V), 23–25 May 2002 - "Local Governance for Poverty Reduction in Africa". Issue Paper No. 4.* Maputo, Mozambique.

Mbere, N. 2002. Local Governance and HIV/AIDS. Issue paper 4: Fifth Africa Governance Forum –Local Governance for Poverty Reduction in Africa. Maputo, May 2002.

Mbugua, J.K., Bloom, G.H. & Segall, M. 1995. Impact of user charges on vulnerable groups: the case of Kibwezi in rural Kenya. *Social Science & Medicine* 41(6), pp. 829–835.

McCoy D, Buch E & Palmer N. 2000. *Protecting efficient, comprehensive and integrated primary health care: Principals and guidelines for inter-government contracts/service agreements*. Health Systems Trust, Durban.

McCoy D, Engelbrecht B. 1999. *Establishing the district health system*.. South African Health Review -1999. Health Systems Trust, Durban.

McGarry B, Molefakgotla A, Ovens W & Sudworth E. 2001. *Public-private partnerships for the delivery of primary health care, including HIV/AIDS.* European Commission, Brussels.

McIntryre D. n.d. *Briefing note on local government health service financing and expenditure and moving towards monitoring equity in local governmenthealth services*. Unpublished document available at http://www.hst.org.za/local/docs/briefing.htm [accessed June 2002]

McPake, B. & Machray, C. 1997. International comparisons of health sector reform: towards a comparative framework for developing countries. *Journal of International Development* 9(4), pp. 621–629.

McPake, B., Asiimwe, D., Mwesigye, F., Ofumbi, M., Ortenblad, L., Streefland, P. & Turinde, A. 1999. Informal economic activities of public health workers in Uganda: implications for quality and accessibility of care. *Social Science & Medicine* 49(7), pp. 849–865.

Mechanic, D. (1993). Social research in health and the American sociopolitical context: the

Meer. S. & Rodwell, B. n.d. From Crisis to Development. Transitional National Development Trust.

Mellor H. 1985. *The role of voluntary organisations in social welfare*. Croom Helm.

Mills, A., Vaughan, J.P., Smith, D.L. & Tabibzadeh, I. 1990. *Health system decentralization. Concepts, issues and country experience*. Geneva, Switzerland, World Health Organization.

Ministry of Health, Secretary for Health Policies, National Co-ordination for STD and AIDS Brazil. 2000. The Brazilian response to HIV/AIDS: Best practices. Brazilia DF.

Mkuye, M., Schapink, D., Hamelmann, C. & Masesa, E. 1997. Training health workers. In: Ng'weshemi, J., Boerma, T., Bennett, J. & Schapink, D. eds *HIV prevention and AIDS care in Africa. A district level approach*. Amsterdam, The Netherlands, Royal Tropical Institute.

Møgedal, S., Steen, S.H. & Mpelumbe, G. 1995. Health sector reform and organizational issues at the local level: lessons from selected African countries. *Journal of International Development* 7(3), pp. 349–367.

MOH 2000. *National health strategic plan, 2001–2005*. Lusaka, Zambia, Ministry of Health.

Moloi G. 2000. *Municipal PPPs in South Africa: lessons and experience*. Available at www.miiu.org.za [accessed June 2002]

Moodley J, Orner P & Hoffman M. 2001. *Defining a set of reproductive health indicators*. South African Health Review - 2001. Health Systems Trust, Durban.

Morgan, L.M. 2001. Community participation in health: perpetual allure, persistent challenge. *Health Policy and Planning* 16(3), pp. 221–230.

Morgan, R. (2000). Pathfinder's Community-Based Projects Address Barriers to Reproductive Health Services. *Pathpapers Volume 1, Number 1, Spring 2000.*

MSH/USAID. 2000. *indicators of health Status & Health Services in the Eastern Cape Province & South Africa. Eastern Cape Department of Health.*

Municipal Infrastructure Investment Unit. 2001. *Municipal public-private partnerships. What are the real issues*? Available at www.miiu.org.za [accessed June 2002]

Municipal Strategy on HIV/AIDS: Innovation from Msunduzi Municipality, KwaZulu-Natal.

NACP & MOHCW. 1998. *HIV/AIDS in Zimbabwe: background, projections, impact and interventions*. Harare, Zimbabwe, National AIDS Coordination Programme & Ministry of Health and Child Welfare.

Ng'weshemi J, Boerma T, Bennett J and Schapink D (eds) (1998) *HIV prevention and AIDS care in Africa: A district level approach*, Royal Tropical Institute, The Netherlands

Ng'weshemi, J. & Bennett, J. 1997. Development of a comprehensive district HIV prevention and AIDS care programme. In: Ng'weshemi, J., Boerma, T., Bennett, J. & Schapink, D. eds *HIV prevention and AIDS care in Africa. A district level approach*. Amsterdam, The Netherlands, Royal Tropical Institute.

Nicholson J. 2001. *Bringing health closer to people: Local government and the district health system*. Health Systems Trust, Durban.

NMF/HSRC. 2002. The Nelson Mandela and HSRC Study of HIV/AIDS – South African National HIV Prevalence, Behavioural Risks and Mass Media Household Survey. South Africa, Cape Town, Human Sciences Research Council. Available at http://www.cadre.org.za

Ntuli A, Khosa S & McCoy D. 1999. *The equity gauge*. HST, Durban.

Oppong, J.R. 1998. A vulnerability interpretation of the geography of HIV/AIDS in Ghana, 1986–1995. *Professional Geographer* 50(4), pp. 437–448.

Organised Local Government Act. 1997. *Republic of South Africa Government Gazette, 389*(18421), pp.1-6.

Parnell B. 1997. *Evaluating HIV and development: Guidelines and suggestions.* UNDP, New York.

Partnerships for Health Reform. n.d. *PHR policy primer: Health worker motivation and health sector reform.* Abt Associates, Bethesda MD.

Partnerships for Health Reform. n.d. *PHR policy primer: working with private providers to improve the delivery of priority services.* Abt Associates, Bethesda MD.

Pedler M. 2001. *Issues in health development. Networked organisations-an overview*. NHS Health Development Agency, United Kingdom.

Performance Management: Local Government for the 21st Century. Local Government Information Series. Department of Constitutional Development.

Pillay Y & Marawa, N . 2000. *A Synopsis of Health Policies & Legislation: 1994 - 2000*. Department of Health, Pretoria.

Pillay Y, Bennett J, Serenata C & Asia B. 2001. *Developing and implementing an HIV/AIDS plan at district level.* Equity Project, Bisho.

Pillay Y, Mximba M & Barron P. 1998. *The District Manager's Handbook*. Department of Health, Pretoria.

Pillay Y. (ed) 1999. *The integration of health services.* Update Issue No. 45, August 1999. http://www.hst.org.za/update/45/editorial.htm

Pillay Y. 1999. *Health planning for district management teams*. Department of Health, Pretoria.

Pillay Y. Devolution of health services to municipalities: Issues, strategies and processes. Unpublished document available at http://www.hst.org.za.

Pillay Y. n.d. *Devolution of services to municipalities – Constitutional options*. Unpublished document available at http://www.hst.org.za.

Planact. 2002. Local Government & HIV/AIDS. The Planact Enhancement Programme for Ward Committees, Councillors & Officials: Module 7. Planact, Braamfontein.

Putzel J. 2003. *Institutionalising an emergency response: HIV/AIDS and governance in Uganda and Senegal.* Department for International Development, May 2003.

Rau, B. 2002. Workplace HIV/AIDS Programs: An Action Guide for Managers. FHI/USAID.

Responding to HIV/AIDS in the developing world. The GTZ contribution: 15 years of experience an overview-. Deutsche Gesellschaft fur Technische Zusammenarbeit (GTZ) GmbH. Eschborn, Germany, June 2001.

Richey, L. 2001. Does economic policy conflict with population policy? A case study of reproductive health in Tanzania. *CDR Working Paper* 01.7. Copenhagen, Denmark, Centre for Development Research.

Roche C. 1999. *Impact assessment for development agencies: Learning to value change.* Oxfam Publications, Oxford.

Rosen S, Vincent J, Simon J, Singh G & Thea D. 2000. *A model for assessing the costs of workforce HIV/AIDS.* Harvard Institute for International Development, Marvard University, MA, USA.

Russel M & Schneider H. 2000. *A rapid appraisal of community-based HIV/AIDS care and support programs in South Africa*. Centre for Health Policy, University of Witwatersrand, Johannesburg.

Salomen L. 1987. `Of market failure, voluntary failure, and third-party government: Towards a theory of government-nonprofit relations in the modern welfare state'. *Journal of Voluntary Action Research*, 16: 1&2.

Save the Children. No Quick Fix: A sustained response to HIV/AIDS and children. Briefing report.

Schierhout G. 1999. *The integration of primary health care services: A systematic literature review*. Unpublished document available at http://www.hst.org.za/research/phcinteg.htm.

Schierhout, G. & Fonn, S. 1999. *The integration of primary health care services: a systematic literature review.* Durban, South Africa, Health Systems Trust.

Schneider, H. & Stein, J. 2001. Implementing AIDS policy in post-apartheid South Africa. *Social Science & Medicine* 52(5), pp. 723–731.

Schuping S & McCoy D. 2000. *Fitting functionality into boundaries: Analysing the heatlh service rendering features of the new local government district councils. A case study of the Southern Free State Health complex*. Health Systems Trust, Durban.

Scott, G. 2000. Political will, political economy & the AIDS industry in Zambia. *Review of African Political Economy* 28(86), pp. 577–582.

Scribner S. 2001. *Improving surveillance and action systems: building support for implementation*. Presentation from PHR End of Project Conference, International Trade Centre, Washington D.C.

Senegal: Progress in the Fight Against HIV/AIDS through Partnership. November 2001.

Senekal I, Schoeman J & Njotina T. 2001. *Phase 2 report: An exploration of community DOTS models in the Eastern Cape Province*. Department of Health (EC) and the EQUITY Project, Bisho.

Sepehri, A. & Chernomas, R. 2001. Are user charges efficiency- and equity-enhancing? A critical review of economic literature with particular reference to experience from developing countries. *Journal of International Development* 13(2), pp. 183–209.

Setswe, G., & Mokwena K. Evaluation Report of the Interfund HIV/AIDS Development Project.

Sharp B, Martin C, Nawn J, Curtis B, Boulle A & Le Sueur D. 1998. *A collation of the current health boundary and facility data for South Africa.* Department of Health, Pretoria.

Shaw, R.P. & Ainsworth, M. eds (1995. Financing health services through user fees and insurance. Case studies from sub-Saharan Africa. *World Bank Discussion Papers, Africa Technical Department Series* 294. Washington D.C., The World Bank.

Smart R. 2000. 'AIDS Brief for sectoral planners and managers: Civil service.' HEARD, University of Natal, Durban

Smart R, Dennill K, Pleaner M. 2001. *Planning in the new millenium - A primary HIV/AIDS capacity development course for government planners*. Department of Social Development, South Africa.

Söderlund N & Peprah E. 1998 *An essential hospital package for South Africa: Selection criteria, costs and affordability.* Abt Associates, Bethesda MD.

Standing, H. 1997. Gender and equity in health sector reform programmes: a review. *Health Policy and Planning* 12(1), pp. 1–18.

Telyukov A, Stuer F & Krasovec K. 2000. *Design and application of a costing framework to improve the planning and management of HIV/AIDS programs.* Abt Associates, Bethesda MD.

Tennyson R. 1998. Ch 7. Tools for Measuring Impact. In *Managing Partnerships: Tools for Mobilising Public Sector, Business and Civil Society as Partners in Development*. The Prince of Wales Business Leaders Forum, London.

The Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa: Summary Reports. Xth International Conference on HIV/AIDS and STDs in Africa.

The Equity Project. 2001. Annual Report: Voices of change and progress. DOH, USAID & MSH.

The Equity Project. N.d. *Primary Health Care Services level of delivery a checklist for achieving an integrated service*. The Equity Project/USAID. Pretoria, South Africa. Available at www.equity.co.za

Thomas L. 2000. *HIV and integrated development planning: a review of current responses with a view to informing national guidelines.* MRC, Johannesburg.

Thomas, L. et. al. 2001. Impact of HIV/AIDS on Local Government with specific consideration of INCA's sphere of business. Draft, July 2001.

Thornton, R 2003. *The Uganda HIV/AIDS Success Story Examined: The role of Civil Society and Linkage to Social and Economic Development*. AIDSMark/USAID.

Tools to support participatory decision making, *Urban Governance Toolkit Series*, UN Habitat 2001. www.unhabitat.org

Toomey, L. n.d. Functional Integration of Primary Health Care within the District Health System. The Equity Project/USAID. Pretoria, South Africa. Available at www.equity.co.za

Topouzis D and de Guerny J (1999*) Sustainable Agriculture/Rural Development and Vulnerability to the AIDS Epidemic,* FAO and UNAIDS Joint Publication, UNAIDS Best Practice Collection

Tovey, P. & Adams, J. 2001. Primary care as intersecting social worlds. *Social Science and Medicine 52(2001) 695-706*

Tsui A, Wasserheit J & Haaga J (eds). 1997. *Reproductive health in developing countries. Expanding dimensions, building solutions.* Washington D. C.: National Academy Press.

Turshen, M. 1999. *Privatizing health services in Africa*. New Brunswick, New Jersey, USA & London, UK, Rutgers University Press.

Uganda'. *British Medical Journal*, 303 (6813): 1303-1306.
UNAIDS 2000. *Report on the global HIV/AIDS epidemic, June 2000*. Geneva, Switzerland, Joint United Nations Programme on HIV/AIDS.

UNAIDS Evaluation Unit. *Guidelines for using the IPAA Monitoring Framework: Indicators for measuring the National response to HIV/AIDS*. November 2001.

UNAIDS. 1997. *The Business Response to HIV/AIDS: Innovation and Partnership,* The Joint United Nations Programme on HIV/AIDS and The Prince of Wales Business Leaders Forum, Geneva and London

UNAIDS. 1998. *HIV/AIDS and the workplace: forging innovative business responses*, Joint United Nations Programme on HIV/AIDS Technical update

UNAIDS. 1999. Acting early to prevent AIDS: the case of Senegal. UNAIDS Best Practice Collection. UNAIDS, Geneva.

UNAIDS. 2000. *AIDS epidemic update: December 2000* Joint United Nations Programme on HIV/AIDS and World Health Organisation publication

UNAIDS. 2000. *Guidelines for second generation HIV surveillance*. UNAIDS/ WHO, Geneva.

UNAIDS. 2001. *AIDS Epidemic Update December 2001*. Joint United Nations Programme on HIV/AIDS and World Health Organisation publication

UNAIDS. 2001. *AIDS epidemic: update, December 2001*. Geneva, Switzerland, Joint United Nations Programme on HIV/AIDS / World Health Organization.

UNAIDS/UNFPA. Report on the Planning Meeting on Strategic Options for HIV/AIDS Advocacy in Africa.

UNAIDS/WHO. 2000. Guidelines for Second Generation HIV Surveillance. World Health Organisation and Joint United Nations Programme on HIV/AIDS.

UNDP. 2001. 'HIV/AIDS – A governance challenge." UNDP, Bureau for Development Policy, Special Initiative on HIV/AIDS, http://www.undp.org/hiv/index.html (03/02)

UNDP. 2002. Introducing Governance into HIV/AIDS Programmes. HIV and Development Programme.

UNDP. 2002. Towards Borderless Strategies Against HIV/AIDS. South East Asia HIV and Development Programme, May 2002.

UNDP/UN-HABITAT/ Urban Management Programme Regional Office for Africa. 2002. HIV/AIDS and Local Governance in Sub Saharan Africa. Occasional Paper 1, June 2002.

UNFPA. 1999. *The UNFPA private-sector initiative: Exploring ways to facilitate cooperation between governments and commercial sectors to expand access to reproductive health commodities.* UNFPA, New York.

UNICEF 1998. *Implementing health sector reforms in Africa: a review of eight country experiences*. New York, UNICEF, Division of Evaluation, Policy and Planning.

UNICITY Committee. 2000. The Changing Role of Local Government as a Service Provider. Compiled as part of the process to prepare for the Durban Metropolitan Unicity.

United Nations Global Forum. 1996. *Local governance: Report of the United Nations Global Forum on Innovative Policies and Practices in Local Governance*. Gothenburg, Sweden, 23-27 September 1996 UNITED NATIONS ST/TCD/SER.E/46 DDSMS and UNDP

USAID. 2000. *Handbook of indicators for HIV/AIDS/STI programs.* USAID, Washington D.C.

Van Praag, E., Schweyen, V. & Ng'weshemi, J. (1997. Care and counselling. In: Ng'weshemi, J., Boerma, T., Bennett, J. & Schapink, D. eds *HIV prevention and AIDS care in Africa. A district level approach*. Amsterdam, The Netherlands, Royal Tropical Institute.

Viljoen R, Heunis C, Janse van Rensburg E, van Rensburg D, Engelbrecht A, Fourie A, Steyn F & Matebese Z. 2000. *National primary health care facilities survey.* CHSR&D/HST, Durban.

Wallace J & Telchin D. 2002. Destination: West Africa. Resources for U.S. –Africa Private Sector Success. The Corporate Council on Africa.

Walraven, G. & Ng'weshemi, J. (1997. Integration and sustainability. In: Ng'weshemi, J., Boerma, T., Bennett, J. & Schapink, D. eds *HIV prevention and AIDS care in Africa. A district level approach*. Amsterdam, The Netherlands, Royal Tropical Institute.

Walt, G. (1994. *Health policy: an introduction to process and power*. London & New Jersey, Zed Books / Johannesburg, South Africa, Witwatersrand University Press.
Webb, D. (1997. *HIV and AIDS in Africa*. London, Chicago & Illinois: Pluto Press / Cape Town, David Philip / Pietermaritzburg, South Africa, University of Natal Press.

Wawer M. et al. 1991. 'Dynamics of spread of HIV. Infection in a rural district of

Whiteside, A. (ed.) 1998. *Implications of AIDS for demography and policy on Southern Africa*. Pietermaritzburg, South Africa, University of Natal.

WHO. 2000. *Protocol for the evaluation of HIV/AIDS Care and Support.* Initiative on HIV/AIDS and Sexually Transmitted Infections (HIS). The World Health Organisation.

Williamson F & Stoops N. 2001. *Chapter 6: Using information for health*. South African Health Review - 2001. HST, Durban.

Wilson R, Rohde J, Puchert R & Hedbuerg C. 2001. *South Africa's district health information system: case study Eastern Cape Province.* Equity Project, MSH, Bisho.

Wolfensohn J. 2000. "War on AIDS" Address by World Bank President before the UN Security Council, 10 January 2000, New York

World Bank. 1987. *Financing health services in developing countries: an agenda for reform*. Washington D.C., The World Bank.

World Bank .1997. *Environmental Assessment Sourcebook Update: Health Aspects of Environmental Assessment*

World Bank. 2000a. Decentralization & health care. Health: issues in program design. Available at www.ciesin.org/decentralization. [Accessed 10 June, 2003.]

World Bank .2000b. *Intensifying Action Against HIV/AIDS in Africa: Responding to a Development Crisis*, African Region,. World Bank, Washington. http://www.worldbank.org/html/extdr/pb/pbaidsactivities.htm

World Bank. 2001. *Cost of scaling HIV program activities to a national level in sub-Saharan Africa: methods and estimates*. London, UK, AIDS Campaign Team for Africa (ACTafrica) and The World Bank.

World Bank. 2003. *Local government responses to HIV/AIDS: A handbook*. http://www.worldbank.org/urban/hivaids/localgovernments.htm

Wouters A & DeRoeck D. 1998. *A short list of topics for prioritising and defining future work related to health sector non-governmental organisations*. Abt Associates, Bethesda MD.

Zewdie D. 2000. *The World Bank Perspective on HIV/AIDS*, Presentation at the XIII International AIDS Conference, Durban, July 11 2000.