

**UNIVERSITY OF THE WESTERN CAPE**

**Factors that Impact on the Capacity of District AIDS Task Forces to Coordinate Sustainable Decentralized HIV/AIDS Services in Zambia: The Case of Lusaka DATF.**

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**A thesis submitted in partial fulfillment of the requirement for the degree Master of Public Health, in the School of Public Health, within the Faculty of Community and Health Sciences, at the University of the Western Cape.**

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**Keywords:**

**HIV/AIDS, District AIDS Task Force, Organizational Capacity Assessment, Stakeholders Forum, Systems Strengthening, Decentralization Strategy, Coordination, functions, DATF Mandates, Decentralised Structures.**

**December 2013**

## **DEDICATION**

To my best friend and wife Brenda

To our wonderful children Sonnja, Gabriella and Daniella



## **ABSTRACT**

### **Introduction**

According to (UNAIDS/WHO, 2011a) globally, 34.0 million [31.4 million–35.9 million] people were living with HIV at the end of 2011 out of which 80% live in Sub Saharan Africa. In absolute terms, the burden of HIV increased by 354% between 1990 and 2006 (Ortblad et al, 2010). The prevalence of HIV in Zambia stands at 14.3% in the age group 15 to 49 years. Having realized that HIV/AIDS is no longer a health issue alone Zambia embarked on the multisectoral response initiative which allows many stakeholders to play their role. In order to coordinate this multiplicity of stakeholders the government of Zambia created the National HIV/AIDS/STI/TB Council (NAC) with the core mandate to coordinate the national HIV/AIDS response agenda. In turn, the NAC created the Provincial (PATF) and District AIDS Task Forces (DATF) as decentralized structures through which to coordinate the response at provincial and district levels respectively. However, DAFT is not coordinating the response to HIV/AIDS epidemic effectively but the reason for the ineffective coordination has not yet been described.

### **Aim**

The aim of the study is to explore factors which impact on the capacity of Lusaka DATF to coordinate an effective and sustainable local HIV/AIDS response.

### **Methods**

A descriptive qualitative research was undertaken using purposive sampling methods. Data collection methods included a Document Review, Key Informant Interviews using semi structured interview guides, Focus Group Discussions and Field Notes.

### **Results**

The study has found that the following factors promote effective coordination of DATF stakeholders and their activities at local level: recognition of the DATF by stakeholders as a formal structure which is enshrined within the institutional framework of the government; joint planning and resource mobilisation for activities by stakeholders particularly around national commemoration days such as World AIDS Day and the National VCT day and holding of stakeholder forum meetings to share experiences and lessons learnt.

The study has also established that the following factors are responsible for preventing the DATF from coordinating effectively include: DATF does not exist as a legal entity enshrined in any Act of Parliament No. 10 of 2002 which created the NAC; there are multiple reporting channels for local stakeholders instead of having only one reporting framework through the DFATF; inadequate stakeholder forums; lack of memoranda of understanding between the DATF and stakeholders; weak technical capacity of the DACA due to factors such as lack of a training programme; inadequate joint planning and resource mobilisation plans and efforts; poor understanding and different interpretations of the of the concept of coordination by different stakeholders; weak feedback mechanisms from the DATF secretariat to stakeholders; and multiplicity of DATF guidelines by different partners which have at times contradicted each other. Poor political, civic and technical leadership engagement has been identified as key inhibiting factors.



## DECLARATION

I declare that *Factors that impact on the capacity of District AIDS Task Forces (DATFs) to coordinate decentralized HIV/AIDS services in Zambia: The Case of Lusaka DATF* is my own work, that it has not been submitted for any degree or examination in any other university and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Signed.....

Date.....



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May all praise honor, glory and power be to the Lord God Almighty who willed it that at a given point in time this momentous occasion would come to pass.

I am highly beholden to the Support to the HIV/AIDS Response in Zambia (SHARe) Project, for blessing me with the unforgettable and life-changing experience which saw me traverse the expanse of Zambia in all the then 72 districts building the capacity of District AIDS Task Forces from which experience the dream of conducting this research was conceived.

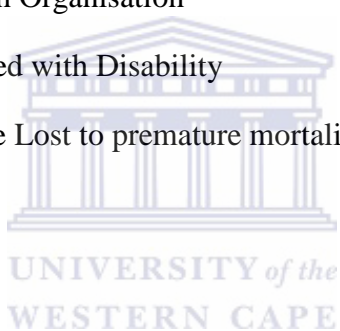
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## ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AMMICCALL	Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
ARV	Anti Retro Viral
CACC	City AIDS Coordinating Committee
CBNRM	Community Based Natural Resources Management
CHAZ	Churches Health Association of Zambia
COMESA	Common Market for East and Southern Africa
DACA	District AIDS Coordination Advisor
DALYs	Disability Acquired Life Years
DATF	District AIDS Task Force
DDCC	District Development Coordination Committee
DHMT	District Health management team
DM&EPCs	Disaster Management and Epidemic Preparedness Committees
DM&EPCs	Disaster Management and Epidemic Preparedness Committees
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People living with HIV/AIDS
GRZ	Government of the Republic of Zambia
HIV	Human Immunodeficiency Virus
HMIS	Health management Information System
NAC	National HIV/AIDS/STI/TB Council
NACA	National AIDS Coordinating Agency
NZP+	Network of Zambian People Living with HIV
PDCC	Provincial AIDS Coordination Advisor

PEPFAR	President's Emergency Plan For AIDS Relief
PLHIV	People Living with HIV/AIDS
SHARe	Support to the HIV/AIDS Response in Zambia
SOPH	School of Public Health at the University of the Western Cape
UNAIDS	United Nations Agency on HIV and AIDS
UNDP	United Nations Development Plan
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
YLDs	YEARS Lived with Disability
YLL	Years of Life Lost to premature mortality





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## **CHAPTER ONE: INTRODUCTION**

### **1.1 INTRODUCTION**

According (UNAIDS/WHO, 2011a) globally, 34.0 million [31.4 million–35.9 million] people were living with HIV at the end of 2011. It was also estimated that 0.8% of adults aged 15-49 years worldwide are living with HIV (UNAIDS/WHO, 2011). It must be noted, however, that the burden of the epidemic varies considerably between countries and regions. It also must be pointed out that Sub-Saharan Africa is the epicenter of the epidemic accounting for nearly 80% of all People Living with HIV (PLHIV) worldwide. The majority of these people fall in the age group of 15-49 year, with nearly 50% occurring among 15-24 year olds (UNAIDS/WHO, 2011).

In Zambia, the first case of HIV was diagnosed in 1984 at a time when not much was known about it (National HIV/AIDS/STI/TB Council [NAC], 2010a). By 2007, the HIV prevalence had plateaued at a very high rate of 14.3 % in people aged 15 to 49 (Central Statistical Office, 2007). It must be noted the incidence of new HIV infections has drastically reduced from 1.6% to 0.8% and that this is in part as a result of the PEPFAR supported robust antiretroviral treatment programme (NAC, 2013). According to the Prevention Convention reports of the National HIV/AIDS/STI/TB Council, there are now six key drivers responsible for fuelling the HIV/AIDS epidemic in Zambia (NAC, 2009a; NAC, 2011). These drivers include multiple and concurrent sexual partners, low and inconsistent condom use, low levels of male circumcision, sex workers and men who have sex with men, mother to child transmission and mobility and labour migration (NAC, 2009b). Other additional drivers include stigma associated with HIV/AIDS, gender inequalities (Government Republic of Zambia-Gender in Development Division, 2009), low levels of educational attainment (UNDP, 2011), rural-urban dichotomy in access to services, inadequate focus on vulnerable populations, and HIV prevalence in Zambian prisons, people with disabilities and hard to reach and underserved populations.

In their quest to halt and reverse the impact of the HIV/AIDS epidemic, many countries embarked on responses which were health-oriented and they were few or no signs of succeeding (Barnett & Whiteside, 2006). In order to meaningfully address HIV/AIDS issues it became necessary to look beyond the health sector by involving other sectors and to appreciate that coordination had to happen outside the health sector (Putzel, 2004a). This marked the birth of

stand-alone National AIDS Commissions outside the health sector mandated to coordinate and facilitate HIV/AIDS responses across sectors including in Thailand, Uganda, Senegal and other countries (Putzel, 2004b).

Zambia adopted a multisectoral approach aimed at managing an expanded and strengthened sustainable national HIV/AIDS response (Ministry of Health [MOH], 2009). In a multisectoral approach, there are many different sectors of society that work together to address a common challenge (Toro et. al, 2006). According to the Ministry of Health by December 2011, close to 400, 000 people had been started on life saving antiretroviral (ARV) drugs (MOH, 2011). This success story happened over a number of years and is a result of a series of collaborative activities between and among multiple stakeholders including the government, donor agencies and the civil society.

The National AIDS Surveillance Committee (NASC) and National AIDS Prevention and Control Programme (NAPCP) were established in 1989 to coordinate HIV/AIDS-related activities (NAC, 2005). The National HIV/AIDS/STD/TB Council (NAC) became operational in 2002 when Parliament passed the National AIDS Bill that made the NAC a legally-established body and it became the single, high-level institution responsible for coordinating the actions of all segments of government and society in the fight against HIV/AIDS (Government of the Republic of Zambia, 2002). With the creation of NAC came the formation of District AIDS Task Forces (DATFs) and Provincial AIDS Task Forces (PATFs) as decentralised structures of NAC. Lusaka DATF is the biggest DATF in Zambia. Due to its multisectoral nature, the DATF does not sit in under the Ministry of Health but it is sits in the office of the District Commissioner as one of the subcommittees of the District Development Coordination Committee (DDCC). Every year, subcommittees submit their annual reports highlighting not only their key achievements but also their coordination capacity and challenges. It must be emphasized that while NAC is a government created and government recognised structure created through an Act of Parliament, DATFs and PATFs were placed under government structures for administrative convenience only. Their formal positioning in the government establishment remains undefined.

In line with the Sixth National Development Plan (SNDP) and the Decentralisation Implementation Plan, decentralization through devolution is the strategy through which the

government, under the leadership of the Ministry of Local Government intends to improve service delivery (Ministry of Local Government and Housing, 2013). It is also thought that in order for coordination of HIV/AIDS services to improve there is greater need to devolve structures, functions and responsibilities to the local level in a manner that creates accountability for coordination among local stakeholders (UNAIDS-Zambia, 2009).

The Government of Zambia with development partners and civil society have, over the years, supported community responses to HIV/AIDS in various ways, including development of systems and structures that have resulted into improved responses to HIV/AIDS at local level in some areas (Ministry of Health, 2012). Major funders of HIV/AIDS services include the President's Emergency Plan For AIDS Relief (PEPFAR) through the United States Agency for International Development (USAID) one of the largest bilateral support agencies in the fight against the HIV/AIDS pandemic in Zambia, which also sub grants to such projects as Support to the HIV/AIDS Response in Zambia (SHARe), Zambian led Prevention and Counseling and testing (ZPCT), Zambia Information Systems Strengthening Project (ZISSP), Communication Science for Health (CSH) etc., as well as direct support to institutions. Other donor agencies include the United Nations family, Irish Aid, International Department for International Development (DFID), Danish International Development AIDS (DANIDA). The Global Fund on TB, AIDS and malaria is a big funder working through principle recipients including the Ministry of Health, Ministry of Finance and the Churches Health Association (CHAZ)

Evidence of effective coordination at district level include the formation of district health forums, joint planning by stakeholders and creation of linkages connected to service delivery within the continuum of health care (SHARe, 2010). Improved learning and sharing between stakeholders, documentation of good HIV/AIDS practices to promote wider learning between and among stakeholders such as the case is with the Kitwe District AIDS Task Force who developed a data base of all key stakeholders and created linkages between and those stakeholders does contribute to improved coordination (SHARe, 2011a). The manifestation of strong coordination can be seen through active involvement of various categories of stakeholders including increased leadership involvement, and greater involvement of PLHIVs. A case in point is that three local authorities namely Isoka, Chinsali and Mbala out of 72 which are increasingly

allocating portion of their budget for HIV/AIDS coordination work through the DATF (SHARE, 2012).

Successes made in the area of coordination include establishment of coordination structures and some level of partnerships in almost all districts in Zambia through District AIDS Task Forces and initiation of Annual District AIDS Forums in selected districts (NAC, 2010b). According to NAC (2010b), eight districts managed to host successful quarterly stakeholders' coordination forum meetings in 2010.

The District AIDS Task Force (DATF) is a coordinating committee of HIV/AIDS service providers and other district stakeholders. According to the NAC Guidelines on the functions of District AIDS Task Forces, a good DATF shows the following features:

- a. Bringing together stakeholders to develop strategy and coordinate implementation of projects.
- b. Assisting projects from civil society to get access to resources and to other government services and funding mechanisms.
- c. Ensure that the impact and consequences of AIDS are taken into account in the long term planning around the municipal Integrated Development Plan (IDP).
- d. Identify Community Popular Opinion Leaders (C-POL) and use them as role models for the community and provide moral leadership on dealing with AIDS and people who are affected by AIDS (NAC, 2008:4)

Anecdotal evidence coming from the DATF/PATF coordination office at NAC seems to suggest that a good DATF exhibits the following features:

- a. The DATF must have a sector-wide stakeholders forum that does not need to meet frequently but on a quarterly basis to share experiences and lessons learnt in the implementation of HIV/AIDS programmes by stakeholders;
- b. A smaller coordinating committee (Executive Committee) should be set up to manage the day to day coordination;
- c. Presence of task teams or technical working groups around specific areas of work;



- d. The DATF should try to bring together every organisation and service that can help in any way.
- e. The DATF should play a facilitating role and not try to take over the good work that others are already doing.

In some way, some DATFs help the Planning Units of the Local Authorities/Municipality to ensure that planning for mainstreaming of HIV/AIDS in the core mandates of stakeholders is well balanced. Some DATFs have developed Standard M&E AIDS Data Collection Tools developed for capturing data from all local actors.

## **1.2 PROBLEM STATEMENT**

According to Part II of the National HIV/AIDS/STI/TB Act number 10 of 2002, the NAC was formed to coordinate the multi-sectoral national response for the prevention and combating of the spread of HIV, AIDS, STI and TB in order to reduce the personal, social and economic impacts of HIV, AIDS, STI and TB in Zambia. Having realized that it was not possible for NAC to perform this mandate singularly from the national level, NAC decided to decentralize its functions to the provincial and district (Mwansa, 2011). Unfortunately, the Act that created NAC did not provide for its decentralization within that Act (SHARE, 2010). It was therefore logical for NAC to utilize the Cabinet Circular to declare the creation of DATFs. .

One of the key motivations for the creation of DATFs was the desire to improve the collective overall management of HIV/AIDS services and resources at district level (SHARE, 2011a). To achieve this objective, the United Nations Development Programme (UNDP) employed National United Nations Volunteers to manage each DATF office, supported them with a monthly grant, stationery, computers and even a vehicle each (SHARE, 2004). UNDP employed full time employees for each DATF because there was need to have a dedicated employee to manage the multiple stakeholders at district level. It must, however, be appreciated that this type of employment, outside the establishment of government institutional framework is a problem because it did not guarantee continuity and sustainability in the event UNDP discontinued providing that support. DATFs together with NAC only managed to coordinate the collection of information from 25% of all potential stakeholders principally because they never got to operationalize their mandate (NAC, 2010b). In 2009, a Sector Institution Assessment was



conducted which was aimed at assessing the functional capacity of NAC and its decentralized structures concluded that the DATFs functional capacity was very weak as evidenced by duplication of efforts, competition by service providers, lack of uniformity in the provision of services and lack of strategic information in DATF offices (UNAIDS-Zambia, 2009).

The perception of ward councilors in Lusaka when they participated in an assessment of the capacity of local authorities to absorb DACAs was that the Lusaka District HIV/AIDS response remains poorly coordinated in all sectors and sub-sectors (AMICAALL, 2009a). In the newly launched district coordination toolkit, it has been observed that in spite of the large number of service providers, there are still areas which remain either underserved or not served at all while there are some areas where there is duplication of efforts (NAC, 2012). According to the Lusaka Office of the President (2009), a critical analysis of the electronic mapping and reporting mechanism reveals that the numbers of HIV/AIDS service providers who report their work through the DATF remain small in comparison to the expected total number of service providers in Lusaka. For some years now, the DDCC, AMICAALL reports and other local stakeholders' reports have consistently been highlighting poor coordination of Lusaka DATF. However, there has been no investigation on the factors contributing to this poor coordination. There have been no studies conducted on Lusaka DATF which have been specifically conducted to establish the factors affecting coordination of HIV services. Therefore, this study seeks to identify and describe the factors that contribute to coordination among Lusaka DATF stakeholders specifically eliciting factors that hinder coordination and those that stimulate effective coordination to inform recommendations for corrective measures.

## **CHAPTER TWO: LITERATURE REVIEW**

### **2.1 INTRODUCTION**

Chapter one provided an orientation to the study by discussing the background information and the statement of the problem. This chapter reviews the relevant literature starting with an overview of HIV/AIDS continuing with multisectoral approaches to HIV/AIDS and finally coordination, defining and describing the types and challenges

### **2.2 OVERVIEW OF HIV/AIDS**

#### **2.2.1 Global HIV/AIDS Situation**

The World AIDS Day report for 2011 reported that the global incidence of HIV infection has stabilized and began to decline in many countries which had consistently been reporting generalized epidemics (UNAIDS, 2011). The report further stated that up to 6.65 million people were getting treatment at the end of 2010. The impact of antiretroviral drugs has now led to the use of treatment as prevention and that the use of microbicides has brought hope particularly for the women of Sub-Saharan Africa (UNAIDS, 2011).

In the midst of these great strides, the global number of people infected with HIV remains high at 34 million (WHO/UNAIDS, 2011), there are still regions where new infections are increasing and more people are dying of AIDS. These regions include Eastern Europe and Central Asia (UNAIDS, 2011). Surveillance data has now confirmed that globally there are some key populations who are disproportionately affected including sex workers, men who have sex with men, transgender people, people who inject drugs, prisoners and migrants in both concentrated and generalized epidemics (Vatican Radio, 2013). These marginalized groups are left out of National AIDS plans fundamentally because of legal, policy and other structural barriers which are beyond the scope of AIDS commissions. It must be stated that more than 50% of eligible people for treatment do not have access to antiretroviral therapy (WHO/UNAIDS, 2013).

Ortblad et al (2010) used the metrics and data produced by the Global Burden of Diseases, Injuries, and Risk Factors Study 2010 (GBD 2010) to assess whether HIV/AIDS remains a dominant cause of health loss and where disease burden is still increasing. They concluded that in the last 30 years, HIV/AIDS has emerged as one of the major global health challenges (Ortblad et al, 2010). The distribution of HIV/AIDS burden is not equal across demographics as

well as regions although it is known that in 2010, HIV/AIDS was the leading cause of Disability Acquired Life Years (DALYs) for both males and females aged 30 to 44 (Ortblad et al, 2010).

While HIV/AIDS is a global epidemic, a majority of the disease burden is concentrated in a handful of countries with particularly large epidemics. HIV/AIDS is ranked within the top five causes of burden in 26 countries (WHO, 2013). In absolute terms, the burden of HIV increased by 354% between 1990 and 2006 (Ortblad et al, 2010).

### **2.2.2 Sub-Saharan Africa HIV/AIDS Situation**

More than two-thirds (70 percent) of all people living with HIV, 25 million, live in sub-Saharan Africa. It must be stressed that 88 percent of the world's HIV-positive children live in Sub-Saharan Africa. It is estimated that 1.6 million people in the region became newly infected. It is also estimated that 1.2 million adults and children died of AIDS a figure which accounted for 75 percent of all the world's AIDS deaths in 2012.

According to the Global Burden of Disease for 2011, malaria and HIV/AIDS were the leading causes of premature death and disability in 2010 for Sub-Saharan Africa (World Bank, 2011). It must be highlighted, at the same time that in some countries, there has been significant progress in recent years. Rwanda recorded a 56% decrease in the rate of healthy years of life lost from malaria, while Botswana cut the rate of premature death and disability from HIV/AIDS by 66% and Zambia reduced the incidence rate from 1.6% to 0.8% between 2007 and 2012 (UNAIDS, 2012)

### **2.2.3 HIV/AIDS Situation in Zambia**

In Zambia it is estimated that 14.3 % of people aged between 15 and 49 are infected (CSO, 2007). According to NAC (2013), there are more females than males [16.2% female as compared to 10% in the same age group] who are infected with HIV. The good news is that as it has already been reported, Zambia is among the Sub-Saharan countries where new HIV infections have reduced drastically (UNAIDS 2012). It is also encouraging to learn that 90 percent of HIV positive women have access to PMTCT services (Ministry of Health, 2013). Up to 60 % of all people eligible for antiretroviral treatment (ART) are already on treatment accounting for 486,000 (MOH, 2012). What is disturbing nonetheless is the fact that infections in the age group 18 to 29 are increasing and more so among young women (MOH, 2012).

In 2001 HIV/AIDS was declared both as a disaster and as a developmental issue in Zambia by the President Levy Patrick Mwanawasa (Mwansa, 2011). For this reason, HIV/AIDS has been a critical component of the Fifth national development Plan 2006 to 2010 and the Sixth national Development Plan (SNDP) 2011 -2016 (NAC, 2013). One question which was asked during the planning phase of the SNDP IN 2010 was the following: “How do we, as a nation address the high prevalence of HIV?” (Ministry of Finance Zambia, 2010:42). In response to this question a task team of eight experts from the fields of social work, planning, medicine, public health, education, youth development and gender was constituted and asked to brainstorm on that question. The result of that brainstorming session was a presentation of causes and effects of the high levels of HIV/AIDS in Zambia in form of the Problem Tree Analysis (PTA) which is shown in Annex 3.

Problem tree analysis helps to find solutions by mapping out the anatomy of cause and effect around an issue in a similar way to a Mind map, but with more structure (Shaping Policy for Development, 2009). The PTA on HIV/AIDS developed in 2010 helped to breakdown the complexity of the HIV/AIDS scenario into manageable and definable chunks (Ministry of Finance in Zambia, 2012). The PTA helps in the classification of causes of the high HIV prevalence in Zambia into immediate causes (biomedical), intermediate causes (behavioural) and root causes (structural) (SHARe, 2012). Further, the PTA establishes the case for a multisectoral response in that the different causal factors are best addressed by different stakeholders who use their comparative advantages and their defined roles in the national development agenda (Mbilima, 2012).

### **2.3 MULTISECTORAL APPROACH TO HIV/AIDS**

A compendium of promising practices from Africa by the united States Agency for International Development-Private Voluntary Organizations (USAID-PVO) steering committee on multisectoral approaches to HIV/AIDS in 2003 revealed that HIV/AIDS was considered to be mainly a health issue, and that this was why programmes for addressing the epidemic were based on health and medical science (USAID, 2003). It was not surprising, therefore, that medical organizations were at the forefront of these efforts. However, the impact of HIV/AIDS on development institutions and their programmes in Africa has forced both the health and the non-

health development agencies to approach the problem from a different angle. The HIV epidemic is now considered to be an important cross-sectoral development issue, which has far-reaching implications for policy and programming for both government and international development agencies (USAID, 2003). It is now generally agreed that the complex nature of the global HIV/AIDS pandemic demands for a multisectoral approach (UNAIDS, 2005; World Bank, 2005). This approach has various names such as the partnership approach (Berkowitz, 2004), multidisciplinary health care team or multidisciplinary team (Chafe, 2006; Mitchell, 2004) and community-based effort (Casey et al, 2004). Regardless of the term, this approach addresses specific health and other care problems through collaboration within a multisectoral framework. In March 2009 the Common Market for Southern Africa (COMESA) Secretariat, endorsed an activity to develop a COMESA Multi-sectoral Programme on HIV and AIDS which complements the efforts of the African Union which had enacted the Africa Health Strategy 2007-2015, aimed at strengthening the health systems in Africa using the multisectoral strategy (COMESA, 2012).

According to the Commonwealth Secretariat Think Tank Meeting held in London in July 2001 defined a multisectoral response to HIV/AIDS as follows:

*"A multi-sectoral response means involving all sectors of society - governments, business, civil society organisations, communities and people living with HIV/AIDS, at all levels in addressing the causes and impact of the HIV/AIDS epidemic. Such a response requires action to engender political will, leadership and coordination, to develop and sustain new partnerships and ways of working, and to strengthen the capacity of all sectors to make an effective contribution."* (Commonwealth Secretariat, 2003: 2).

The main strength of a multi-sectoral approach is that it creates a mechanism for information sharing and coordination, supporting the inclusion of all major stakeholders in society, regardless of their sector or work and their organisational affiliation (Commonwealth Secretariat, 2003: 2).

According to Gillespie (2006) multisectoral approaches to HIV/AIDS are those seeking to reduce HIV prevalence, provide care and treatment to persons living with HIV/AIDS (PLHIV), and mitigate the impacts of the epidemic on affected populations by employing an appropriate mix of health and non-health based interventions and involving a broad array of stakeholders in their

design and implementation. Further it involves all sectors of society, governments, business, civil society organizations, communities, PLHIV at all levels in addressing the causes and impact of HIV/AIDS (Lule et al, 2007).

There are many examples which can be used to show the non-health impacts of HIV/AIDS. One such example is the agriculture sector in Kenya where research has shown that although HIV/AIDS prevalence in Kenya had shown a downward trend, it continued to impact negatively on agricultural production and food security in rural areas (Ndirangu et al, 2004). Poverty seems to reinforce the spread of HIV/AIDS and that once AIDS strikes it becomes a driver of poverty (Lule et al, 2007). A further complication is that valuable knowledge and experience, such as knowledge of agricultural practices, can also be lost, which can limit the livelihood strategies available to surviving household members (Harvey, 2004; Baylies, 2002 and Whiteside, 2002).

In Botswana, it has been acknowledged that the HIV/AIDS fight is a joint undertaking addressed by a multi-sectoral response with many partners involved in the response by the National AIDS Coordinating Agency (NACA) (NACA, 2008). In an attempt to facilitate communication and information flow between stakeholders and the general public at local, national and international level thereby building towards improved coordination, the National AIDS Coordinating Agency of Botswana (NACA) has created a National HIV and AIDS Directory which clearly stipulates the name of the organisation, geographical coverage, nature of services offered and other collaborating partners (NACA, 2008).

Stakeholder involvement is an important aspect of multisectoralism. *“The term stakeholder involvement is a warmly persuasive one that is seldom used unfavourably”* (Nelson & Wright in M Gomezulu, 2001: 68). However, the term can sometimes be used negatively. Non-abusive and meaningful stakeholder involvement takes place when the stakeholders are empowered to make decisions that influence organisational practices, policies and directions. To empower stakeholders, the leaders of organisations should be genuinely committed to sharing power with and training stakeholders because effective involvement requires certain skills, understanding and knowledge and when such prerequisites are met meaningfully, stakeholder involvement can be realised as has been the case with some initiatives concerning HIV and AIDS (Wood in M Gomezulu, 2001). Multisectoral response involves partnership formation in which a lot of power dynamics get played to the complexity of partnerships. According to Sandosham and



Winder (2008), when an entity enters a partnership there is an inevitable reduction in its individual power, visibility, authority and autonomy which situation is not easy for many to adapt to. This is the more reason why a clear articulation of the stake of each partner in the partnership is vital (Sandosham & Winder, 2008). In Malawi, the NAC collaborates with domestic and international partners through the Malawi Partnership Forum (MPF), an activity which is part of a broader reform programme aimed at improving coordination (UNDP, 2012). Evidence shows that such reforms have helped to create an enabling environment for cooperation and strategic analysis while minimizing the complexities associated with coordinating a comprehensive nationally-owned response (UNDP, 2013).

There are activities outside the HIV/AIDS sector from which lessons on effective coordination can be drawn in Zambia. One of them is the Ministry of Health which, working with the Ministry of Local Government and the office of the Vice President responsible for disasters, constitute Disaster Management and Epidemic Preparedness Committees (DM&EPCs) in all districts in Zambia. The purpose of the DM&EPCs is to prevent disease outbreaks including cholera and typhoid (Office of the President, 2012). It has been postulated that one of the key factors that makes DM&EPCs successful at executing their mandate is that they have a standing order to meet key stakeholders every month with a clear agenda and they host a stakeholders' forum for the general membership every quarter (Office of the President, 2012). The other example is the Community Based Natural Resources Management (CBNRM). CBNRM are structures created through a government and community partnership to safeguard wild animals in game management areas against poachers and to prevent animal-human conflict in the same areas in Zambia. They are believed to be working well because there is close collaboration between and among the community, game rangers, local police officers, and traditional leaders through clear memoranda of understanding with clearly stipulated expectations, duties and accountabilities of each partner (Ministry of Tourism, Environment and Natural Resources, 2008).

## **2.4 DEFINING COORDINATION**

It has long been observed that fragmentation of human service delivery systems including adult and children's behavioral health (U.S. Department of Health and Human Services, 2003a), early childhood care and education (U.S. Department of Health and Human Services, 2003b), general

and specialty health like HIV/AIDS care and treatment (IOM, 2005), has always presented a major service delivery coordination challenge. Additionally, it has equally been observed that as different functions of human services become fragmented into distinct service categories, clients fall through the cracks of the system because the connections between services are either absent or problematic, or needed services are missing all together (Cho & Gillespie, 2006). This is where coordination becomes important.

The concept of coordination has been studied by a variety of disciplines including sociology, public administration, economics, computer science, and organizational behavior (Crown & Malone, 1993). Historically, coordination has been discussed in the organizational behavior literature as a joint process of taking action whereby organizations adjust in response to one another to accomplish shared tasks or goals. The construct of service delivery coordination and HIV/AIDS services coordination falls within this scope, and may be defined as a process of managing interdependencies; where agencies engage in a process of exchanging needed resources, and adjust in response to one another to accomplish shared tasks or goals (Crown & Malone, 1993). At the heart of coordination is a relationship between organizations, and theories of inter-organizational relationships, specifically resource dependence and transaction cost economics have provided the underlying framework for studying coordination (Malone, 1993). In order to appreciate the concept of coordination, from a coordination theory perspective, it is necessary to highlight it in terms of resource dependence (Crowston et al, 2006). As providers exchange needed resources (such as information, funding, or client referrals), they become increasingly interdependent over time which requires them to manage their linkages through coordination mechanisms (Cho & Gillespie, 2006).

## **2.4.1 Forms of coordination**

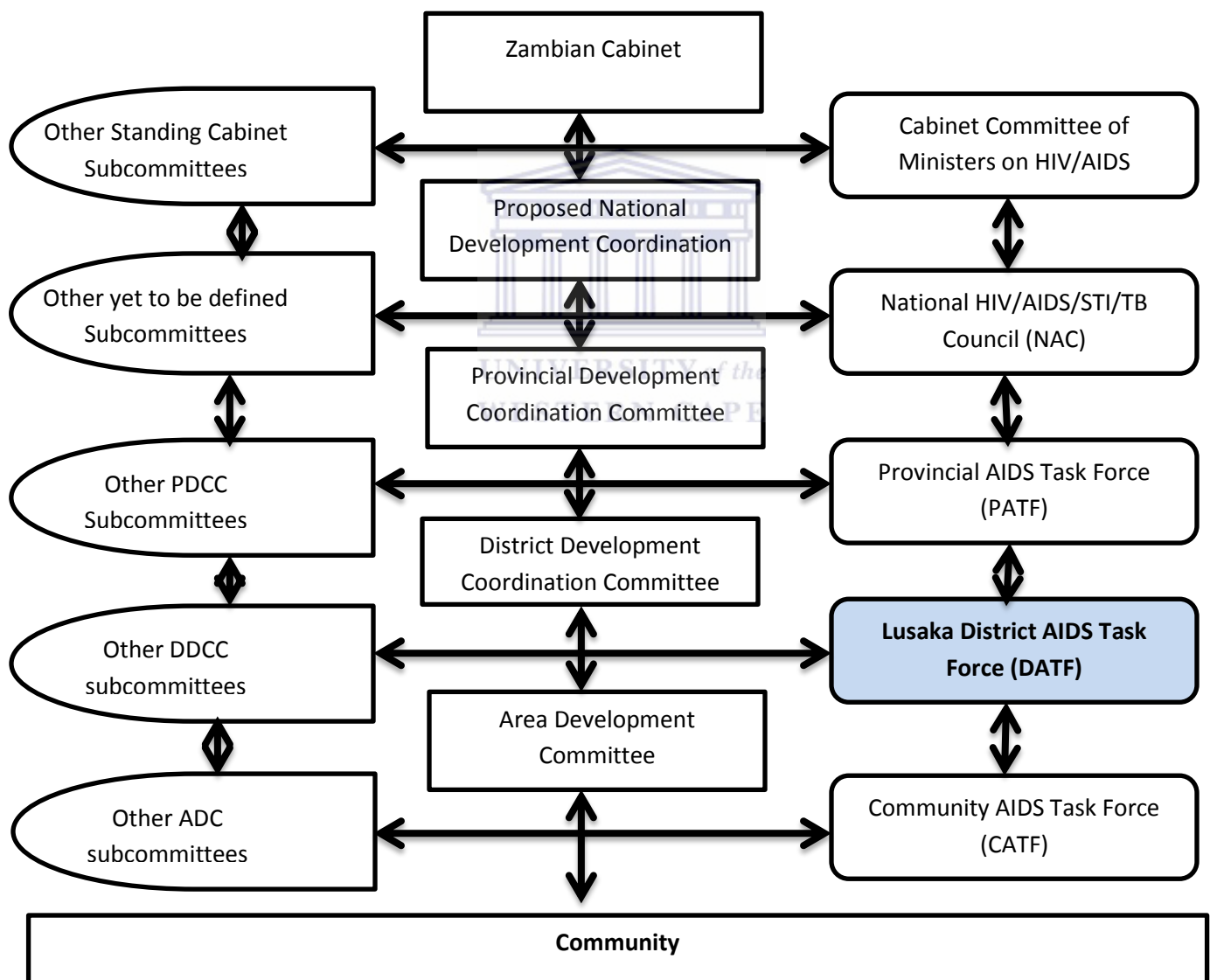
### ***2.4.1.1 Vertical/Horizontal and Internal/External dimensional coordination***

Christensen and Laegreid (2008) identified four distinguished forms of coordination along the vertical/horizontal and internal/external dimensions. The first form is known as horizontal internal coordination and represents the coordination between different ministries (and agencies) or policy sectors (Christensen and Laegreid, 2008) and local district stakeholders relate to each other in this manner. The second type is known as vertical internal coordination which is found between parent ministry and subordinate agencies and bodies in the same sector (Christensen and



Laegreid (2008). The relationship between the NAC at national level and DATFs at district level relate in this manner. A third form is vertical external coordination which is coordination between the government and (a) upwards to international organizations or, (b) downwards to local government. The fourth type of coordination is known as horizontal external coordination which implies coordination between national government and civil society organizations or private sector interest organizations (Christensen & Laegreid, 2008).

**Fig 1: An Illustration of Coordination Arrangements for District AIDS Task Forces and Related Structures**



#### **2.4.1.2 The three ones**

According to Kohlmorgen (2007), UNAIDS was designed to coordinate UN agencies. In spite of this creation, its co-originaors and sponsors continued to conduct their own policies and programs and they continued to do so with duplication and rivalry. In response to this fragmentation and lack of coordination horizontally as well as vertically, UNAIDS in 2003 tried to enhance harmonization of service delivery through “the three ones’ initiative, emphasizing the necessity of one coordinating framework for all partners, one national coordinating authority, and one monitoring and evaluation system (Kohlmorgen, 2007). ‘The three ones’ principle then adopted by the special session of the United Nations General Assembly in 2003 in order to ensure that all actors from the United Nations member states committed themselves to one national coordinating authority, one strategic framework and one monitoring and evaluation framework (Whiteside, 2006; World Bank, 2007). Although the Paris Declaration in 2005 was much broader than the UN three ones principle, it reinforced the former in many ways. The Paris Declaration which was done in Paris in 2005, where over 100 developed and developing countries agreed to change the way they do business based on five principles. Recipients of aid are expected to forge their own national development strategies (ownership); donors to support these strategies (alignment) and work to streamline their efforts in-country (harmonisation); development policies to be directed to achieving clear goals and for progress towards these goals to be monitored (results); and donors and recipients alike to be jointly responsible for achieving these goals (mutual accountability) (Foresti et al, 2006).

#### **2.4.1.3 Decentralization of HIV/AIDS Services**

According to the Working paper prepared in connection with the Joint UNDP-Government of Germany which sampled definitions of decentralization in 1999, the term decentralization was defined as follows:

*“ . . . Decentralization refers to the restructuring or reorganization of authority so that there is a system of co-responsibility between institutions of governance at the central, regional and local levels according to the principle of subsidiarity, thus increasing the overall quality and effectiveness of the system of governance, while increasing the authority and capacities of sub-national levels”.* (UNDP-Government of Germany, 2000: 2).

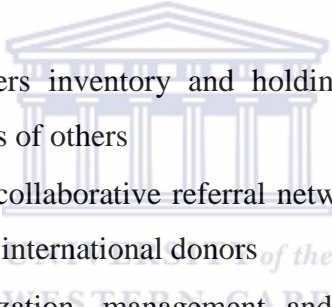
Decentralization has also been defined as *“the transfer of powers from central government to lower levels in a political-administrative and territorial hierarchy”* (Manor, 2011).

When it comes to health sector decentralization, it involves a shifting of power from central to peripheral levels (Mills, 1994). A point to bear in mind is that when decentralization takes place roles and responsibilities of each level of the system have to be re-aligned (Schneider et al, 2006).

In writing about the successes of decentralization, some authors have been less positive claiming that decentralization has remained more of a theoretical concept than a practiced reality. Nineteen country case studies addressing the relationship between decentralization and poverty was undertaken and the conclusion was that in an environment where the central state is not fulfilling its basic functions, decentralization could be counterproductive (Jutting et al, 2004). Additionally they concluded that in countries that are fulfilling their functions, decentralization could be a powerful tool for poverty reduction, improving representation of the poor and better targeting of service delivery (Jutting et al, 2004). In a study to examine how workforce knowledge and organisational factors of stakeholders affected the implementation of health sector administration decentralization in Ghana, it was learnt that factors that are militate against effective decentralization included inadequate funds, lack of qualified personnel, inadequate logistics and equipment, poor interpersonal relationships, lack of transparency and a good operational system, lack of incentives to motivate the staff, political interference, poor infrastructure and high rate of illiteracy (Kojo et al, 2013). In an inquiry, in Mali, to determine whether or not decentralization served everyone, it was concluded that the structure of decentralization which is the local government remains largely responsive to the central government or to the local elite group rather than being accountable to the local people (Nijenhuis, 2003).

Both Uganda and Senegal were successful in terms of coordinated decentralised multisectoral HIV/AIDS response (Sittitrai, 1999). In the case of both Uganda and Senegal the following successful features were recognised: strong political leadership from the president and other government leaders; political stability, a coordinated and agreed nationally owned strategy involving non-State actors over time and distribution and disposition of political power in society to a strategy which is in turn context specific. (Putzel, 2004b)

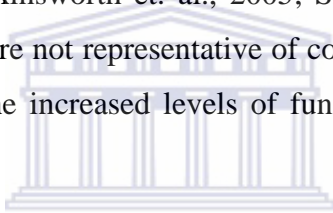
The open Society for Southern Africa (OSISA) commissioned a research study to assess the role of councilors in service delivery at local government level in South Africa in which some of the findings included poor channels of communication from the municipal administration, non-functional ward committees, the lack of a meaningful mechanism for councilors to influence decision-making and the dysfunctionality of Ward Committees in many municipalities (Paradza et al, 2010). In Malawi, baseline results about the work of the local authorities in coordinating HIV/AIDS services showed poor coordination due to low level of confidence in Blantyre City Assembly by the city stakeholders; lack of or delays in mobilizing resources to manage the coordination mandate; and frequent changes in membership representation which broke the chain of continuity (Mushamba et al, 2003). After observing the city for years an evaluation was conducted which revealed an achievement of satisfactory levels of coordination at decentralised structure and the observable outcome results were summarized by Mushamba et al (2003) as follows:

- 
- Maintenance of Stakeholders inventory and holding of stakeholder forums to learn lessons from the experiences of others
  - Formation of linkages and collaborative referral networks including very strong support from local stakeholders and international donors
  - Improved resource mobilization, management and accountability including that of acquiring antiretroviral drugs and sub granting of sourced funds to small community based organizations coordinated through the Blantyre Local Authority
  - Strong relationship between the Blantyre Civic Authority and the Malawi Local Government Association
  - Strong presence and utilization of a resource center with a technical support agency
  - A strong local strategy to mainstream HIV/AIDS into plans, budgets and programmes of government, private sector and civil society stakeholders with clearly defined indicators
  - A strong strategy on documentation and communication of best practices
  - Regular updating of evidence in the status of the HIV/AIDS response including mapping of stakeholder coverage, which yields into the wider result of documentation and communication
  - Formation of a multisectoral City AIDS Coordinating Committee (CACC) to assist the City Assembly coordinates all activities on HIV/AIDS at Assembly level

- Objective involvement of grassroots through organized groupings including People Living with HIV/AIDS
- District Implementation Plans on HIV/AIDS are now being prepared annually with contributions from all local civic groups and local communities and submitted to NAC for funding

In Malawi, formal appointment of full time HIV/AIDS coordinators or Focal Point Persons who receive specialized capacity building support in effective coordination. These coordinators from local stakeholders are the ones that constitute the CACC. (Mushamba et al, 2003).

However, following an evaluation of aid granted services delivery targeted towards improving the effectiveness of HIV/AIDS Assistance it was argued that the few commissioned studies have tended to focus on the coordination of multilateral donors rather the actual decentralised structures as the focus of study (Ainsworth et. al., 2005; Shakow, 2006). It has further been argued that studies before 2003 were not representative of coordination as it is understood today as they were undertaken before the increased levels of funding started flowing into countries (Putzel, 2004a).



Studies conducted to examine balancing rural poverty reduction and citizen participation and the contradictory nature of Uganda's decentralization strategy to this cause cited low technical and administrative capacity of local government and poor accountability as reasons that contribute to failure in decentralization (James et al, 2002; Jutting et al, 2004). Similar studies also argued that weak capacity is either a reason why decentralization has failed to increase the responsiveness of local government, or as a justification for the perpetuation of central control (Ahmad et al, 2005; Watson, 2002). In responding to the reasons why decentralization as a form of coordination has not yielded the intended results, a study to consider democratic decentralization of natural resources versus institutional choice and discretionary power transfers in Sub-Saharan Africa was conducted from which it has been argued that decentralization has not, in many cases, been implemented to full capacity (Ribot et al, 2004). It has also been argued that additionally decentralization has been undermined by other centrally led processes (Land and Hauck, 2003). Much earlier in the years, Mercado et al (1996) claimed that by retaining too much authority the central level can undermine the attainment of decentralization reform objectives. Within a decentralized system the central level should retain functions related to setting national

frameworks but give up responsibility for translating these policies into service delivery. However, if too much authority is transferred to the periphery, national goals of equity and coherence may be undermined (Collins and Green, 1994).

In addition other problems of coordinating through decentralization arise from poorly defined roles and responsibilities of stakeholders, coordination mechanisms remained incomplete, characterised by poor communication, poor consultation, proliferation of non-functional structures (Blaauw et al, 2004). Thomason et al (1991) had made a similar observation more than ten years earlier when they asserted that a common problem of decentralization reform was that the roles of the different levels may not have been clearly or appropriately redefined.

#### ***2.4.1.4 Country Coordinating Mechanisms of the Global Fund to fight AIDS, Tuberculosis and Malaria***

The creation of what would become The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) was announced in a G8 communiqué a month after the June 2001 United Nations (UN) General Assembly Special Session (UNGASS) on HIV/AIDS committed to working with the private sector, Non-governmental Organisations (NGOs) and communities on a coordinated response to the HIV/AIDS pandemic (UNAIDS, 2011). GFATM takes an unusually hands-off approach compared to most donors, leaving much of the responsibility for program design and implementation to country representatives and local groups. It has no staff resident in any recipient country because organizations and governments interested in receiving GFATM funding submit a proposal outlining their intended program, with the proposal in most cases crafted by a local Country Coordinating Mechanism (CCM). The CCM is a partnership of governments, NGOs, faith-based groups, civil society representatives, researchers, and affected people (Redelet, 2004). Its response signaled not only a new approach to international health financing but also a departure from traditional multilateralism and the once unassailable authority of nation states (Bartsch, 2007). Some scholars, however, have said that the CCM amount more to joint planning of procurement and harmonization of reviews and not to institutional coordination under the umbrella of the NAC (Dickinson et. al., 2008; Shakow, 2006). Additionally it has been argued that these funding mechanisms are only a subset of the overall national coordination through NAC (Dickinson et. al, 2008). The GFATM together with

its local CCM partner have been criticized for not assisting in building capacity and coordination among potential grantees as the case should have been (Shakow, 2006).

Several studies have reported systemic weaknesses in Country Coordinating Mechanisms governance, such as suboptimal communication between its members, and a lack of trust between government and non-government sectors (Stillman and Bennett 2005; Kelly et al. 2006; Wilkinson et al. 2006). Often CCMs were too large, bureaucratic and hierarchical, which detracted from efficient functioning (Doupe 2004; Grace 2004). Concerns emerged in 2004 about the degree of participation and the capacity of Mozambique's CCM to adapt to its new role in overseeing Principal Recipient activities, in that the two principal recipients of funding were bodies represented by the Chair and Vice-Chair of the CCM (Starling et al, 2005). Similar concerns were also reported in Uganda with regard to the CCM Chair influencing the selection of its own constituency as the principal recipient of funds (Donoghue et al, 2005).

A global evaluation of the Global Fund to fight AIDS, Tuberculosis, and Malaria showed that collective efforts have resulted in increases in service availability, better coverage, and reduction of disease burden (Redelet, 2004). However, in the countries studied, their grant oversight, monitoring, and technical assistance mobilization roles remain unclear and substantially unexecuted thereby diluting coordination efforts (Global Task Team, 2009).

#### ***2.4.1.5 National AIDS Commissions as Legal Entities for HIV/AIDS services coordination***

At national level, NAC was embraced as the leading coordinating unit by both African governments, multilateral and bilateral partners with the acceptance of 'the three ones' in 2003 (Sidibe et. al, 2006). NACs have been established, in most cases under the Prime Minister's Office (Futures group, 2005; UNAIDS 2006a). In 2008 a study was commissioned by UNAIDS to assess the application of 'the three ones' Principle in selected African countries. The report concluded that most countries in the Southern part of Africa have implemented 'the three ones' (Dickinson et. al., 2008). This report, like many others, however, contains very little analysis of the functions and coordination capacity of NACs and services being offered.

There are two probable reasons that gave rise to the National AIDS Commissions; the first reason can be found in the technical brief by the HLSP institute (2006) on the Roles and Responsibilities of National AIDS Commissions: debates and issues, which proposes that



National AIDS Commissions were created to delink or move out the duty of HIV/AIDS coordination from the medically dominated Ministry of Health to institutional structures that allowed other non-health institutions to participate in prevention activities through their own mandates. The second reason was that following the launch of the World Bank Multi-country AIDS Programme for the Africa region (MAP) in 2000 to deliver resources rapidly to countries there was a condition given that in order to access these resources, there was need for each targeted country to develop a high level multi-sectoral coordinating body, such as a national HIV/AIDS council or equivalent (Dickinson, 2008).

National AIDS Commissions (NACs) derive their authority from their legal framework (Studies have shown that clear institutional arrangements and legal status are important for NACs and their decentralised structures such as DATFs to effectively deliver their mandates, including coordination and resource mobilisation. Legal status makes the NAC legitimate and gives NAC power to function well (Dickinson, 2008). Confusion over legal status can undermine the authority and legitimacy of the NAC (Dickinson, 2008). In Uganda, the Decentralization Policy provides a legal framework for managing HIV/AIDS in Local Governments (Ministry of Local Government- Uganda, 2010). This policy mandates Local Governments to directly manage and monitor delivery of services, including those for HIV/AIDS within their areas of jurisdiction (Ministry of Local Government- Uganda, 2010).

Unless coordination structures have authority and are seen to be under country ownership, any decisions they make may be ignored potentially leading to poor alignment of Global Health Initiatives and donor programmes with government priorities (Murzalieva et al, 2009). In Peru and China the studies showed that NACs were able to make decisions and to allocate resources to HIV/AIDS programmes (Murzalieva et al, 2009; Brugha, 2004). By comparison national and particularly subnational structures in Zambia, Mozambique, Ukraine and Kyrgyzstan have had limited authority to make decisions or allocate resources to HIV/AIDS programmes (Semigina et al, 2008; Zhang et al, 2009 and Ndubani et al, 2009). According to Ndubani et al (2009), an important reason for this was that major donors for HIV/AIDS programmes continued to set priorities outside national and subnational structures; and their participation in such structures was seen as a formality. Donor interests continued to undermine country ownership and make coordinating multiple aid programmes difficult for countries (Gostin and Mok, 2009). The



Kyrgyz, Ukrainian and Zambian studies reported that donors including Global health Initiatives (GHIs) did not fully engage in coordination structures so as to maintain institutional visibility and attribute impacts to the activities they had financed (Zhang et al, 2009; Ndubani et al, 2009). This was reflected in donors' unwillingness to relinquish control of funds to national or subnational coordination structures and to share information with other partners (Mundy et al, 2007).

## **2.5 CHALLENGES IN COORDINATION**

This subsection highlights the common challenges which coordinating structures experience.

### **2.5.1 Redundancy**

In describing diverging views on coordination among global actors on how to fight HIV/AIDS, Peters (1998) found that when two or more organizations perform the same task it leads to redundancy and weakness in coordination. One of the challenges to horizontal coordination is the focus on results obtained by one specific program, rather than country-level results (PEPFAR/WB/GFATM, 2006). The 2007 evaluation focus on assessing the specific results deriving from the PEPFAR funding were described as creating disincentives for international coordination among donors and harmonization at the country and local level (Sepulveda et al, 2007). The evaluation further recognized that at local level the emphasis on specific results sometimes has meant that donors have tended to duplicate similar activities in similar areas which practice has led to redundancy (Sepulveda et al, 2007). The second element that hinders coordination is the diverging views among the three global actors .i.e. PEPFAR, Global Fund and the World Bank, on how to fight HIV/AIDS thereby hindering a suitable response adapted to local realities in the countries they operate and the coordination with the government (Sepulveda et al, 2007).

### **2.5.2 Lacunae**

At a first glance, there does not seem to be a problem of lacunae within HIV/AIDS, because there is at least one organization that is supposed to be in charge of horizontal coordination in most African countries, the National AIDS Coordinating Authority or councils (World Bank, 2005). According to Christensen and Laegreid (2008), a coordination lacuna is said to be present when there is a part of the response which is not being covered or is not known to exist through

legitimate channels of coordination. Let us take the example Kitwe DATF where, according to the e-mapping exercise of NAC in Zambia, there are some geographical areas reporting no coverage when in fact it is not the case, simply because the implementers involved have not been reporting their implementation activities through legitimate channels created by NAC (National HIV/AIDS/STI/TB Council, 2013).

### **2.5.3 Definition and execution of coordination mandate**

Although NACs and their decentralised structures are mandated to provide coordination, they have challenges and according to a UNAIDS report (2006), the NACs in reality lack the mandate to coordinate AIDS responses across many sectors, and do not have multisectoral boards that meet regularly. The mandate given to NACs as a national coordinating authority is not easy to claim, among powerful sector ministries and global actors. It must be pointed out that according to literature, some NACs have tended to drift away from ‘coordination and facilitation’ to ‘command and control’ and implementation bureaucracies, while at the same time building their own capacity rather than contract out fund management (World Bank, 2007). According to the World Bank, *“This may represent the single greatest danger for the national multi-sectoral HIV/AIDS program to implement rapid and sustainable action”* (World Bank, 2004: 23).

The Futures Group (2005: 2) in making submissions as to what has contributed to the failure of some NACs to perform on their mandate, state that *“NACs have a difficult job, due to the fact that the framework for coordination is in several cases poorly defined, and the staff of the NACs may thus be unclear about what the goals of their commission are”*.

The Zambian chapter of the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALLb) working with the Local Government Association of Zambia (LGAZ) during the latter’s annual general meeting in 2009 unanimously made a resolution to allocate 5% of all revenue collected in municipal councils as contribution towards the mandate of DATFs building the capacity of local stakeholders such as Faith Based Organisations (FBOs), small Non-Governmental Organisations (NGOs) and even government departments in selected areas of the HIV/AIDS response (AMICAALL, 2009b).

#### **2.5.4 Capacity of Substructures of National AIDS Commissions**

According to UNAIDS (2005), human resource capacity constraints, including for coordination of AIDS activities at sub-national levels, have been cited as a challenge to the effectiveness of NACs. It has been pointed out that low salaries in the public sector, inadequate staffing levels and lack of staff with the right mix of skills and experience particularly at subnational levels has remarkably contributed to poor performance on their coordination mandate (UNAIDS, 2005). In a study conducted to consider new developments to strengthen sexual and reproductive health and HIV linkages and a consideration of factors that continue to impede progress in selected countries, it was demonstrated how the provision of integrated services places considerable demands on health workers even when they may not have received appropriate training and technical guidance (Dickinson et al, 2009). The same study also demonstrated that health workers sometimes lack the confidence, skills, training and incentives required to take on new tasks resulting from the addition of HIV or sexual and reproductive health activities (Dickinson et al, 2009). Spicer et al (2010) undertook a study in seven selected countries, including Zambia, to assess national and subnational coordination of HIV/AIDS services by specifically enquiring into whether or not global health initiatives were closing the gap between intent and practice. One of the key findings was that there was overwhelming evidence of limited information flows within and between coordination structures which undermined meaningful exchange between members (Spicer, 2010). For Zambia, the major finding was that there had been considerable improvements in transparency between sub national actors. PEPFAR and NGOs funded by the initiative were unwilling to share information with District AIDS Task Forces, which undermined their authority (Spicer, 2010).

In 2009, NAC commissioned the Sector Institution Assessment (SIA) to assess the functions of NAC at its decentralized structures. The conclusion was that while the core mandate of any given DATF is that of coordination to be achieved through joint planning, joint monitoring and evaluation, advocacy and lobbying, collaboration and capacity building, the structure of the DATFs in their present form was making it difficult for them to perform this function (NAC, 2009b).

### **2.5.5 Interest variance between actors**

Each organization has a rationale for its action and is linked to a specific clientele. According to Peters (1998: 303), “*The clientele may in some cases be the same while it may in other cases at least be perceived to be different from the view of the organization itself*”. The problem of parallel institutions or duplication is addressed in the Paris Declaration on Aid Effectiveness and Donor Harmonization (OED, 2005) and was one of the reasons for the establishment of the Global Task Team on how to improve coordination (Global Task Team, 2005). The co-existence of the Global Fund Country Coordinating Mechanism (CCM) in addition to the NAC, while it has worked well in some countries, is mentioned as an example of duplicative efforts in the report, because it is noted as a problem in several countries (Global Task Team, 2005). The partnership forum has been pointed as a good example of collaborative effort between and among partners in countries like Malawi and Tanzania (UNDP, 2013).

The difference in interests between the global actors engaged in the NACs and the national government authorities also being represented in the NACs does contribute to poor coordination. Ollila (2005) argues that global health policy has become increasingly fragmented and verticalized and that at times, global health funding priorities differ from local needs. Goran & Mmuya (2008) observed that when it comes to agenda setting and policy formulation power is centralized i.e. the donors are the agenda-setters; and power is dispersed but ineffective when it comes to policy implementation.

Research has shown that while the World Bank supported move to strengthen national HIV/AIDS responses by strengthening the NACs, this very move has resulted in the marginalization of Ministries of Health in some countries (Putzel 2004a). Specifically, it has been argued that the processes managed to obscure the need to significantly reinforce the capacity of health sectors to be able to respond to the crisis, it tended to underestimate the role of the state and the philosophy of the leading political party and the reality of tensions which existed between democratic, decentralised and rights based agendas on the one hand, and the imperatives of confronting a public health emergency on the other (Putzel, 2004a).

Global Health Initiatives have had unintended consequences which include distortion of recipient countries’ national policies, notably through distracting governments from coordinated efforts to

strengthen health systems and re-verticalization of planning, management and monitoring and evaluation systems. The Country Coordination Mechanism (CCM); and coordination has continued to be a contentious issue for national planners (Wilkinson et al, 2006). The result has been duplication in planning for HIV/AIDS control, between CCMs and national AIDS councils. In Uganda, this led to competition between the MoH and the Uganda AIDS Commission for control and funds (Donoghue et al, 2005). In Malawi, it was reported that there were parallel planning structures for the NAC Integrated National Work Plan and the SWAP Programme of Work, which Global Fund support had aggravated (Mtonya and Chizimbi, 2006). The McKinsey study (2005) found that in Tanzania and the Democratic Republic of Congo there were at least four committees overseeing HIV/AIDS control, with little communication between them about their activities. In Angola there were too many coordinating bodies that did not meet the country's needs (McKinsey, 2005).

Spicer et al (2010) undertook a study in seven selected countries, including Zambia, to assess national and subnational HIV/AIDS coordination by specifically enquiring into whether or not global health initiatives were closing the gap between intent and practice. One of the key findings was that there was overwhelming evidence of limited information flows within and between coordination structures was a key finding in most of the countries, which undermined meaningful exchange between members (Spicer, 2010). For Zambia, the major finding was that there had been considerable improvements in transparency between subnational actors in Zambia, PEPFAR and NGOs funded by the initiative were unwilling to share information with District AIDS Task Forces, which undermined their authority (Spicer, 2010).

There are, however, positive signs of overcoming the problems of diverging interests which could be termed as cooperation instead of signs of horizontal coordination. In Tanzania, in the case of ARV treatment, where PEPFAR, the Global Fund and the Tanzanian government have engaged in cooperation in which PEPFAR provides funds for first-line antiretroviral therapy (ART) and the government, funded by Global Fund, provides second-line ART (Global Task Team, 2005). However national and local authorities in Tanzania lack the capacity to coordinate the country's HIV/AIDS response partly because it is not a political priority of the government, and partly because global programmes fund most of the country's HIV/AIDS effort directly (Hellevik, 2012).

In Ukraine, several formal and informal coordination structures have been set up to improve cooperation between government and nongovernmental stakeholders involved in HIV/AIDS programmes (Global Health Initiatives, 2009). Although the Global Fund programme has added significant impetus to this process, coordination structures at national and sub-national levels have made limited impact on improved coordination, especially at the sub-national level where decision-making authority is particularly limited (Global Health Initiatives, 2009). Key factors impeding the effective functioning of coordination structures include frequent changes in membership, limited effective communication between partners and a history of poor coordination between different government departments (Global Health Initiative, 2009).

In Malawi Matshalaga & Simwaka (2007) conducted an evaluation of the Malawi National AIDS Council and its decentralization structures at district level, and they were able to demonstrate that although there was poor coordination and poorly skilled personnel coordinating HIV/AIDS services in 2003 and beyond, there was new evidence of good coordination of multi-sectoral stakeholders through the District AIDS Coordinating Committees (DACCs). The assessment reported that NAC had very skilled personnel in key positions who were executing their tasks effectively (Matshalaga & Simwaka, 2007).

In attempting to ensure that there is some level of commitment and accountability among DATF stakeholder, NAC in Zambia is encouraging that DATFs and stakeholders sign memoranda of understanding (NAC, 2012). The use of memoranda of understanding aimed at streamlining how multiple services delivery partners can be coordinated in a municipality was highlighted in an assessment conducted in Toronto (Association of Municipalities in Ontario, 2007). Additionally developing and managing Service Level Agreements (SLA) and Memorandum of Understandings is recognised as a strong coordination and hence the inclusion of activities in the strategic plan for the government of Queensland (Queen's Land Government, 2010).

The District AIDS Task Forces (DATF) and Community AIDS Task Forces (CATF) had some success towards improving district level coordination in Zambia (Chibwe, 2006). However, the absence of a legal mandate for all service providers to register with DATFs proved a major impediment to coordination (Ndubani, 2009). In many cases PEPFAR recipient organisations were unwilling to share information with DATFs (Chibwe, 2006).

During a Rapid Assessment of Sexual and Reproductive Health in Zambia it was established that there was inadequate coordination between Health and HIV units at the national level (Ministry of Health, 2011). It was further observed that donors were interested in very specific interests in HIV and not in coordination; and there was failure to utilize Global fund opportunities to integrate HIV into other more strongly coordinated health interventions (Sundewall et al, 2009).





## **CHAPTER THREE: RESEARCH DESIGN AND METHODOLOGY**

### **3.1 INTRODUCTION**

This chapter outlines the aim and objectives of the research study. The chapter further describes the research setting, study population and sampling method. The chapter concludes with rigor, ethical considerations and limitations of the study.

### **3.2 AIM AND OBJECTIVES**

#### **3.2.1 AIM**

The aim of the study was to explore factors which impact on the capacity of Lusaka DATF to coordinate an effective local HIV/AIDS response to strengthen the capacity of the DATF to manage a well-coordinated local HIV/AIDS response.

#### **3.2.2 OBJECTIVES**

This research was directed by the following key objectives:

1. To explore and describe internal and external factors which promote the capacity of the DATF to coordinate the local response more effectively
2. To explore and describe internal and external factors which inhibit effective coordination of local HIV/AIDS services through Lusaka DATF
3. To explore and describe existing and future opportunities which could be used to strengthen coordination of the local response
4. To make recommendations to the DATF based on the findings from the study

### **3.3 STUDY DESIGN**

The study was qualitative in nature and the study design was a descriptive case study. Creswell (1998) defines a case study as ‘an explanation or in depth analysis of a “bounded” system of a single or multiple case(s) over a period of time. In order to take care of the advice that when dealing with a case study the researcher must be familiar with the case’ (Babbie, 2001). The case study in this research is the Lusaka DATF and represents a single unit of study.

A case study approach was adopted to look at factors that facilitate coordination of HIV/AIDS services in Lusaka district through the DATF was deemed more appropriate because it facilitates understanding of social phenomena in natural surroundings and emphasizes the meanings of



experiences and views of the respondents (Mays & Pope, 1995). This approach allowed a flexible investigation of the various issues which allowed the researcher to gain insight into the diversity of the experiences, viewpoints expressed by stakeholders in Lusaka who subscribe to the DATF (Kitzinger, 1994).

### **3.4 DESCRIPTION OF THE RESEARCH SETTING**

Zambia is a landlocked Sub-Saharan African country covering a total surface area of 752,614 square kilometers with a population of 13.8 million people, a population density of 12.1 people per square kilometer and an annual population growth rate of 2.9% (Central Statistical Office, 2010). The country is divided into ten administrative provinces which are further subdivided into 74 districts. Lusaka is the national capital and seat of government (CSO, 2007). According to the most recent census of 2010, Lusaka has an estimated population of 3million people. The majority of the people in Lusaka live in overcrowded shanty compounds with poor social services (CSO, 2011).

Lusaka has a very high HIV prevalence standing at 16 % in the age group 15 to 49 years old (NAC, 2012). Lusaka District AIDS Task Force (DATF) is the formal coordination body for HIV/AIDS related prevention, treatment, care and support services in Lusaka (NAC, 2005). It is a decentralised structure for the National HIV/AIDS/TB/STI Council and a sub-committee of the Lusaka District Development Coordination Committee (DDCC) and its secretariat is housed in the office of the District commissioner for Lusaka. In terms of composition, the DATF is divided into zones which correspond to political constituency geographical areas. Each zone is represented in the DATF executive committee by the zonal representative. Furthermore, the DATF is also sub-divided into the three major sectors namely public, private and civil society. Each of these sectors has a self-coordinating forum whose leadership is represented in the DATF executive committee.

The general membership of the DATF, which is constituted by representatives of organisations and institutions drawn from the private sector, civil society and the public sector as well as zones meets every quarter in what is termed the stakeholders' forum while the DATF executive committee meets monthly. While the executive discusses administrative issues, the DATF forum meets to share experiences and lessons learnt by different stakeholders in the fight against HIV/AIDS with a view to replicating what works.

As a sub-committee of the DDCC, the DATF prepares a report every quarter which is then submitted to the DDCC through the District Commissioner. The District Commissioner has powers to dissolve and reconstitute the DATF.

### **3.5 STUDY POPULATION**

The study population for this study was drawn from the DATF membership. The DATF membership consisted of stakeholders from the public sector, private sector and civil society organisations. The public sector comprised representatives from the 24 line ministries which at the time of writing this report had been reduced to 21 ministries following the change of government from the Movement for Multiparty Democracy (MMD) to the Patriotic Front (PF) led government. These represented government departments which had district level presence. The private sector was further subdivided into two categories namely the formal and informal private sector. Formal referred to big established private companies while informal referred to small businesses being run by one or two people. The informal sub-sector was represented by the Zambia Association of Small to Medium Business Associations (ZACSMBA) which is their coordinating body. The civil society sector was drawn from the Zambian Network of People Living with HIV (NZP+): a non-governmental national coordinating body of PLHIV groupings, Faith Based Organisations (FBOs), Traditional Leaders Association, the Forum for youth Organisations, District Orphans and Vulnerable Committee and many others. In total there were 180 civil society representatives mostly from community based organisations, 21 private sector representatives and 24 line ministries. Others included the Director of Programmes at NAC, the Association of Mayors and Civic Leaders against HIV/AIDS (AMICCALL), ward councilors and Members of Parliament from Lusaka.

### **3.6 SAMPLING METHOD**

Sampling in qualitative studies ought to aim at identifying participants who will provide a full and sophisticated understanding of all aspects of the phenomenon (Liamputtong & Ezzy 2005:45). It is also suggested that the study participants should be people who are easy to talk to and who can easily understand the information under investigation (Bernard, 2002:193). For this reason purposive sampling was used in two phases to select participants who were DATF stakeholders. This category of people is assumed to possess enough information about the DATF which is the subject of enquiry.

### **Selection of Participants for Focus Group Discussions (FGDs)**

A total 36 participants took part in five FGDs. These were selected using non probability purposive sampling methods that followed a two phased step by step process of which is illustrated is described below.

#### **Phase One**

**Step One:** All the stakeholders on the DATF register were listed and confirmed to be existing members by the affirmation of the District AIDS Coordination Advisor (DACA). Even at this very early stage, the sector to which stakeholders belonged was identified. This was to become important in stage four during sector allocation.

**Step Two:** All DATF stakeholders identified in step one were scored against a criteria of their importance to DATF work. The following questions were used to analyze stakeholders:

- a. What is the stake of the stakeholder in DATF coordinated work? This question helped to establish that a given stakeholder valued the concept of coordination through the DATF and that they were willing to invest time and effort in it.
- b. What do they need from the DATF to guarantee their continued engagement? This question allowed the stakeholder to state their expectation from the DATF in respect of their engagement and it further ensured that that expectation was within the formal mandate of the DATF and therefore, relevant to the subject of enquiry.

What value do they offer to the DATF? This question was self-reflection on the part of the stakeholder on how they thought their perceived, planned or actual engagement with the DATF was going to add value to the coordination of district HIV/AIDS services.

**Step Three:** Determination of commitment levels. This exercise was done by studying different DATF registers for DATF coordinated activities which were attended by the stakeholder. Three categories were identified in combination of steps two and three. These categories included Very committed, average in commitment and those with poor commitment.

**Step Four:** participating stakeholders were assigned to their appropriate sector i.e. public, private or civil society.

The number of participants for each FGD was targeted at eight since the literature advises that FGDs generally work best with 8-12 participants, and generally range from one to two hours in length. For this reason, eight participants were selected from each sector.

These criteria of mixing members with varying characteristics allowed for maximum variation. The maximum variation sampling strategy turns that apparent weakness into strength (Patton, 1990; Lincoln & Guba, 1985). Each participants had to belong to a sector which was either public, private (formal or informal), or the civil society. Members who came from the DATF executive committee were verified as being representatives of the Zonal Committees or were elected through the stakeholders' forum.

## **Phase Two**

**Step five:** With the help of the DATF executive committee members it was possible to brainstorm through some names of political and civic leaders from within the constituencies of Lusaka district. These were Members of Parliament and ward councilors who, according to DATF members, were either sympathetic to DATF activities or were very supportive of DATF activities at community level. Six leaders were identified and they formed their own heterogeneous FGD team which brought the total number of FGDs to four.

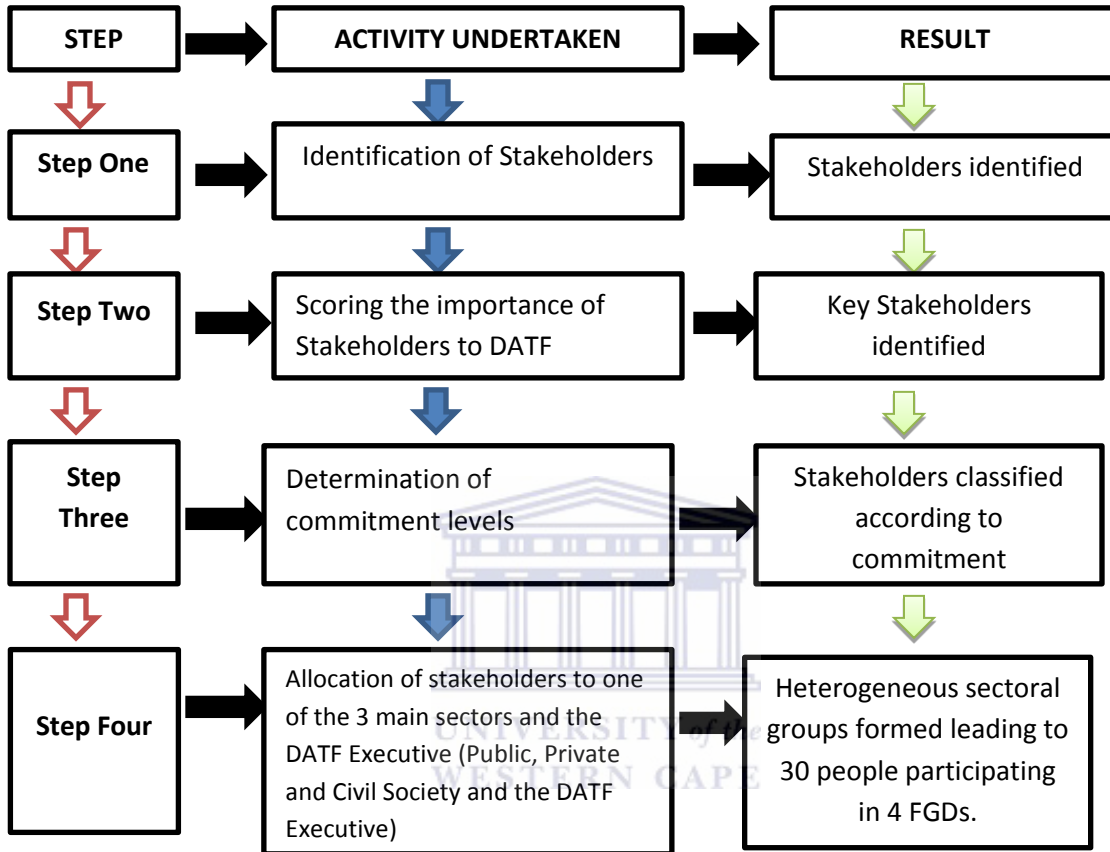
**Step six:** Additional participants were selected based on their potential contribution to the study.

## **Selection of Key Informants**

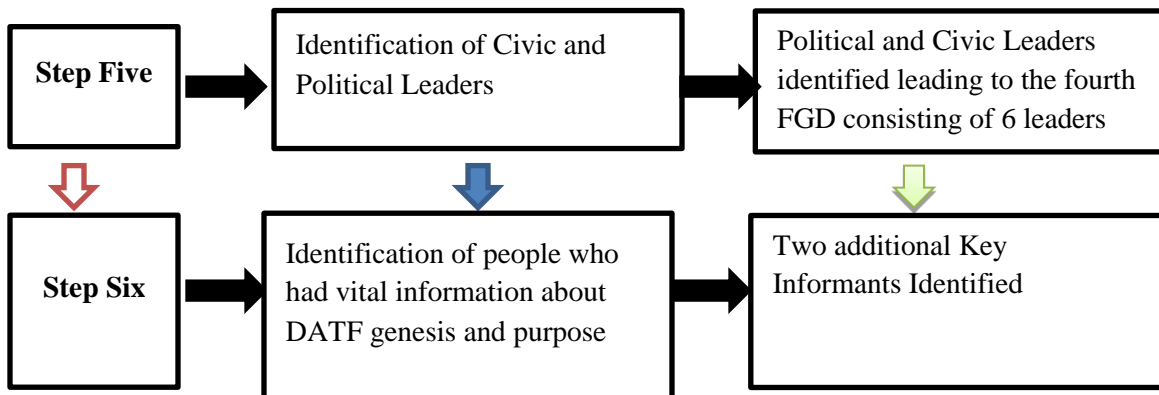
Key Informants were selected at the end of steps four and six. At the end of step 4 when the three sector FGDs were formed, the researcher, with the help of the DACA and other participants, and using his prior knowledge about the DATF selected five Key Informants who were picked because of the vast knowledge they had about the DATF. At the end of step 6 an additional two key informants were picked which brought the total number of Key Informants to seven.

**Figure 2: Flow Chart of Participant Selection for Focus Group Discussions**

**Phase One:**



**Phase 2:**



### 3.7 DATA COLLECTION METHODS

In this research different methods of data collection were used. These included desk review, semi-structured interviews with key informants and focus group discussions (FGDs) and field notes.

#### 3.7.1 Desk Review

A list of key policy documents and reports were compiled, collected and reviewed. The purpose for this review was to clarify on DATF mandates, identify pertinent issues and challenges. The key documents reviewed included the National HIV/AIDS/STI/TB policy (2005), National HIV/AIDS/STI/TB Strategic Frameworks (2006-2010 and 2011-2015), Zambia Demographic and Health Survey (2007 and 2010), National HIV/AIDS/STI/TB Council Annual Reports, Lusaka DATF Annual Reports, Lusaka District Development Coordination Committee Reports, Journals, a Thesis on Livingstone DATF, reports from the United Nations Family, World Bank and other global structures..



#### 3.7.2 Focus Group Discussion

The table below illustrates the 5 different Focus Group Discussions involving 36 participants which were conducted highlighting the sector and its composition. FGDs took place at different prearranged venues for each sector including the DATF office, Zambia National Farmers Union office and the office for the Member of Parliament of Lusaka Central Constituency.

**Table 1: Focus Group Discussion Sectors and Composition**

<b>Sector</b>	<b>Composition</b>
Public sector	Workplace HIV/AIDS workplace programmes Focal Point Persons from the public sector are expected to mainstream HIV/AIDS activities into sector plans, budgets and programmes with support from the DATF. They are expected to report HIV/AIDS activities back to the DATF.
Private sector	Focal Point Persons are expected to mainstream HIV/AIDS into the core business of the private sector, with support from DATF. They are expected to report progress to the DATF.

Civil Society	They are key stakeholders who work with DATF and are expected to perform the key HIV/AIDS related advocacy e.g. when there is a shortage of ARVs in government hospitals and clinics.
DATF Executive Committee	They form the management team of the DATF, provide oversight and possess strategic information about DATF functions.
Civic Leaders and Politicians	They provide overall political leadership and direction including that of HIV/AIDS agenda for Lusaka. They play a critical role in DATF sustainability.

All FGDs were recorded in English after permission was granted by the participants to be recorded.

**3.7.3 Key Information Interviews:** The researcher conducted interviews with six key informants using semi structured interview guides. These interviews took place in the office of each participant covering an average time of forty minutes to one hour.

In both the FGDs and KIIs the researcher personally made appointments through the DATF by visiting the identified stakeholders and explaining to them the aims and objectives of the study. All interviews were conducted and recorded in English and therefore, there was no need of having an interpreter.

**3.7.4 Observation and Field Notes:** I used field notes and pictures, which I took during DATF meetings and other activities as an additional source of information, which provided running descriptions of settings, including selected DATF meetings, people and immediate activities such as planning activities. In the acknowledgment of writing very extensive field notes during an observation, Lofland and Lofland (1984) recommend jotting down notes that will serve as a memory aid when full field notes are constructed.

### **3.8 DATA ANALYSIS**

Content analysis was used in this research. The analysis followed a standard procedure for conducting such qualitative analysis (Coffey & Atkinson, 1996), consisting of two key stages before moving on to synthesizing the data with wider theory and literature.



Under the subsection of data collection, it has already been documented that the interviews were recorded. That recording was then transcribed by listening to it and then manually typing the entire interview verbatim. This is the same script which was now subjected to analysis. The initial step was to read through the script over and over again in order to examine closely, compare for in text relations, similarities and dissimilarities. Parts of the script which had similarities were given same colour codes so that they would be identified for further analysis which gave rise to the identification of concepts. Concepts maybe described as abstract representations of events, practices, actions or interactions and they allow researchers to group similar information to better understand the data as advised (Straus & Corbin, 1990).

The next step was to define the categories by analyzing the codes to find the similarities amongst the concepts and group them into categories based on their common properties. Because of the nature of the study I used manual open coding which, instead of continuing with the word for word analysis, I found it more convenient to consider a broader scale and code against a sentence and sometimes a short paragraph. The advantage of open coding is that it allowed the researcher to build a descriptive, multi-dimensional preliminary framework for later analysis. Additionally, it must be appreciated that because it is built directly from the raw data, it process itself ensures the validity of the work (Larossa, 2005).

The process of open coding led to units of data organized according to category, thus creating a mass of data segments and annotations (McLeod, 2001). It is acknowledged that the categories identified did not stem only from the data but were influenced by the literature and background reading, the researchers' experience and values, and the professional culture and local practices of participants (Ryan & Bernard, 2000).

In summary, from the transcribed FGDs and individual interview transcripts, the researcher listed all emerging patterns expressed by participants during the entire process of data collection. Data that related to these classified patterns was then identified and placed under those corresponding patterns. A further step involving combining and recategorising related patterns into sub-themes was taken. Together, the combination of categories into themes and subthemes was able to translate into a comprehensive picture of the participants' collective experiences, perceptions and opinions.



Therefore, the write up of the thesis consists of summaries, interpretations and textual excerpts which represent the common themes (Stevenson, 2004).

### **3.9 RESEARCH RIGOR**

In qualitative inquiry ensuring trustworthiness is vital to support the argument that the findings are worth paying attention to (Lincoln & Guba, 1985). Guba borrows from positivist investigators and proposes four criteria which include the following properties: credibility, transferability, dependability, and confirmability that he believes should be considered by qualitative researchers in pursuit of a trustworthy study (Shenton, 2004).

**3.9.1 CREDIBILITY:** In order to ensure that credibility was achieved, three techniques were used namely methods triangulation, peer debriefer and member checking.

**3.9.1.1 Methods Triangulation or Crystallization:** Credibility of data was enhanced by using different data collection methods, (methods triangulation), including key informant interviews, focus group discussions, observations, field notes and document review (Patton, 1990). Credibility depends less on sample size than on the richness of the information gathered and on the analytical abilities of the researcher (Patton, 1990; Creswell, 1998).

**3.9.1.2 Peer Debiefer:** I enlisted the help of a competent Peer Debiefer (Lincoln & Guba, 1985) Dr. Peter Chungulo became my Peer Debiefer for this project. He holds an MPH from University of Pretoria and an MD from the University of Zambia and is an active Public Health Practitioner and teacher. Dr. Chungulo was responsible for meeting with me as I refined my procedure via pilot studies, after I collected the data, and periodically during the process of data analysis. During our meetings, he received regular progress reports of the project, and posed questions regarding the research question, methodology, ethics, trustworthiness, and other research issues. He made pointed observations, and suggestions, and posed “Devil’s Advocate” questions throughout the process. His role was generally consistent with that defined in the literature (Lincoln & Guba, 1985). This qualitative inquiry has been updated to take into account Dr. Chungulo’s comments as a Peer Debiefer. Each significant interaction from our meetings and the subsequent changes I made appear in my field journal.

**3.9.1.3 Member Checking:** This is when researcher submits materials relevant to an investigation for checking by the people who were the source of those materials (Lincoln and

Guba, 1985). Member checking is synonymous for respondent validation; it refers to relaying research material to respondents to for verification. Although member checking can also be done during the interviews it can also be done at the end of the research (Mays & Pope, 1995). All the 10 participants surveyed for member checking rated the findings of the data analysis as a “moderately” to “strongly” credible interpretation of the reality they experienced with the DATF.

**3.9.2 TRANSFERABILITY:** In this study, the researcher has attempted to provide sufficient thick description of the DATF phenomenon under investigation to allow readers to have a proper understanding of it, thereby enabling them to compare the instances of the phenomenon described in the research report with those that they have seen emerge in their situations (Shenton, 2004).

**3.9.3 DEPENDABILITY AND CONFIRMABILITY:** Every effort has been applied to ensure that the processes within the study are reported in detail, thereby enabling a future researcher to repeat the work, if not necessarily to gain the same results (Shenton, 2004).

### **3.10 ETHICAL CONSIDERATION**

Permission for ethical approval was requested and granted from the University of the Western Cape Research and the Zambia Research and Ethics Committee. Permission to enter the DATF was obtained from the National HIV/AIDS/TB/STI Council. Written informed consent was sought through providing the participants with a Participant Information Sheet explaining the purpose of the study, confidentiality, their right to refuse participation, that their participation is voluntary and where and how the researcher can be contacted. The participants were informed that the research is for the purpose of the MPH studies and that they had the right to refuse participation and the right to withdraw at time during the research study and clearly state that it will not result in penalty or any loss of benefits. Each participant to the research study was given an explanation on the process of data collection and the different data collection methods used. All questions which they asked were addressed and clarifications made, after which they were asked to sign the Informed Consent Form. The transcripts and its analyses will be kept in safe place at the University of the Western Cape, School of Public Health. An additional measure to ensure the confidentiality of the data and documents collected restricted to only the researcher and supervisors. The potential risk which participants faced admitting to failure or non-performance on the part of the participants would expose weaknesses because the researcher was

a known change agent with the DATF for many years. This was addressed by reassuring participants that they would never be victimized nor will their DATF receive less technical support going forward.

### **3.11 DISSEMINATION OF RESULTS**


The findings and recommendations from the study will be presented to the Ministry of Health, the National HIV/AIDS/STI/TB Council, Lusaka DATF and the Lusaka District Development Coordination Committee for possible implementation with an emphasis on data quality and information highlighting the importance of use of information for decision-making and planning. The final report will also be submitted to the University of the Western Cape as part of the repository into the university's existing body of knowledge.



## **CHAPTER FOUR: RESULTS AND DISCUSSIONS**

### **4.1 INTRODUCTION**

Effective functioning of coordination mechanisms for service delivery include the following features: Inclusive stakeholder representation; Strong civil society engagement; Appropriate level of membership; Strong and effective leadership; authority and strong ownership; Alignment with other coordination structures; clear functions and mandates; Clarity over structure, clear operating procedures and terms of reference; sufficient secretariat capacity; and effective communication between members (Biesma et al, 2009). Some of these will contribute to some of the themes which the researcher has used to present and discuss the results. Literature is still very limited regarding how the global health/HIV/AIDS programmes influence HIV/AIDS coordination at national and local government levels (Spicer et al, 2010). Biesma et al (2009), Harman (2007; 2009a; 2009b) and Putzel (2004b) have provided empirical analyses that identify national level coordination challenges in African countries, but did not address the efforts at national–local government coordination or coordination at the local government level. Based on this theoretical framework, the results and discussion chapter is presented using the following themes:

- 
- a. DAFT Origin, Authority and Ownership
  - b. Stakeholder Engagement in DAFT
  - c. Perceptions on DAFT Effectiveness
  - d. DAFT Functions and Mandates
  - e. DAFT Structure and Guidelines
  - f. Leadership Engagement
  - g. Capacity building for coordination
  - h. Stakeholder perceptions and proposed changes to DATF

### **4.2 DATF ORIGIN, AUTHORITY AND OWNERSHIP**

In order to discuss the authority and ownership of the DATF, it is inevitable to discuss its origin. Additionally, it is imperative that the starting point be grounded in DATF institutional

framework. According to the European Parliament (2012), institutional framework is generally understood to mean the systems of formal laws, regulations, and procedures, and informal conventions, customs and norms that broaden, mould and restrain socio-economic activity and behaviour. In the context of multisectoral HIV/AIDS response, therefore, institutional framework provides for a structural and regulatory environment for the prevention, treatment, care and support and impact mitigation of HIV/AIDS in Zambia (NAC, 2011).

The Director of Programmes at NAC, highlighting the origin and ownership of the District AIDS Task Forces and its impact on stakeholder perceptions had this to say:

*“In 1995, the Zambian government released Cabinet Circular No.1 which created the Provincial and District Development Coordinating Committees which were to coordinate overall provincial and district development programmes respectively. The National HIV/AIDS/TB/STI Council was created through Act of Parliament No. 10 in 2002, as a grant aided Agency for the Ministry of Health, to manage a well-coordinated national HIV/AIDS response. When NAC decided to decentralise its functions to provincial and district levels it had no structures of its own through which to do so. Taking advantage of a clause within Cabinet Circular No. 1 of 1995 which allowed both the PDCC and DDCC to form other sub-committees; the NAC working with Cabinet office with financial support from UNDP facilitated the formation of PATFs in all provinces and DATFs in all districts.”* Key Informant 4

From the submission above it is clear that NAC did not have a well thought out and systematically tabulated decentralization strategy for the DATFs because they were not included as part of the legal instruments that created NAC. This perceived decentralization is more of deconcentration rather than devolution. Deconcentration aims at transferring responsibilities to field and subordinate units of government, while field units basically remain under the hierarchical authority of central state authorities and have no distinct legal existence from the central state. In contrast to this, devolution refers to a transfer of competencies from the central state to distinct legal entities (Jutting et al, 2004). In Uganda, the situation is different because the Decentralization Policy provides a legal framework for managing HIV/AIDS in Local Governments (Ministry of Local Government- Uganda, 2010). The policy mandates Local

Governments to directly manage and monitor delivery of services, including those for HIV/AIDS within their areas of jurisdiction (Ministry of Local Government- Uganda, 2010).

Participants discussed the genesis of the DATF postulating that there could be a role conflict between the Ministry of Health and the office of the District Commissioner because DATF is a structure of NAC which is a Ministry of Health structure but institutionally it is placed under the District Development Coordination committee is subordinate to the District Commissioner.

*“Both the origin and the mandate of the DATF are not without controversy. The origin of NAC the mother of DATF is different from the origin of the DATF the child. NAC is from MOH while DATF is from DDCC. These institutions were created for different purposes.”* Key Informant 7

A representative from AMICAALL felt that the Zambian government had prepared adequately for an effective decentralised HIV/AIDS response through the DATFs when he said :

*“No sooner had the NAC been formed than United National Development Plan (UNDP) came in with funding for the multisectoral response for HIV/AIDS. Compared to Uganda and Thailand which were well prepared, our DATFs were created without much thought about decentralization particularly because the DATF was intended to be implemented using the strategy of decentralization. Both Thailand and Uganda had very strong decentralization policies and implementation plans as well as legislation which we did not have”.* Key Informant 3

The concern of participants may be addressed by reflecting on the work of Dickinson et al (2008), who postulated that the positioning of coordination structures within the wider public administration system has important implications for levels of country ownership and the authority a structure can exercise. An important reason for institutionally positioning NACs under the Presidential Office in some African countries has been to give the structures political legitimacy and demonstrate political commitment (Dickinson et al, 2008). Additionally it has also been established that the initiation of a coordination system is a daunting task that requires a clear understanding and grounding on the part of the initiators of coordination around a clearly defined area of intervention (New Zealand Ministry of Social Development, 2007).

### 4.3 STAKEHOLDER ENGAGEMENT IN DATF

One of the duties of the DATF is to provide technical support to the Zambian Network of People Living with HIV (NZP+), a movement of people who have openly declared their HIV status (NZP+, 2012). This duty and expectation is in line with one key mandate of the DATF which is to coordinate HIV/AIDS related capacity building among district stakeholders (AMICAALL, 2009). It was against this background that stakeholders were asked to describe how well coordinated and beneficial the DATF support had been towards their needs.

Most participants expressed dissatisfaction with the level of support they were receiving from the DATF. They expressed that they were not fully involved in the day to day DATF coordinated work save for the yearly events when their presence became necessary. A representative of PLHIV stated that:

*“In speaking for PLHIV, I can only say there has been very little meaningful involvement in serious DATF events. We are only remembered when they want one of us to openly give a testimony during big days such as World AIDS Day. For your own information none of the DATF Chairpersons since 2002 have come from our movement”*

Key Informant 1.

A representative of the civil society reported that the DATF had failed to involve them as they were left out of the resource mobilisation web.

*“They raised our expectations when they said that they will be able to direct us to potential funders. This has not worked very well”.* FGD3.

However, there were some stakeholders who acknowledged that the DATF had tried to capture district stakeholders by using the district stakeholders’ inventory as a pillar of coordination. The DACA had this to say:

*“Well we have managed to develop a stakeholders’ inventory. This is more like a register of all institutions doing HIV/AIDS work in Lusaka. The dream is to have all district players affiliate themselves to DATF. In this way we shall probably manage to capture everybody and know what they are doing.”* Key Informant 2



The observation above is in agreement with the thinking of the crafters of the National HIV and AIDS Directory in Botswana who observed that the fight against HIV and AIDS in Botswana is a joint undertaking addressed by a multi-sectoral response with many partners involved in the response (NACA, 2008). In an attempt to facilitate communication and information flow between stakeholders and the general public at local, national and international level, National AIDS Coordinating Agency of Botswana (NACA) has created a National HIV and AIDS Directory (NACA, 2008).

The civil society, nonetheless, expected the DATF to do more by documenting a similar inventory for the civil society and a civil society coordination forum which will in turn send representation to the DATF.

*“..... the DATF has not helped the civil society to form a civil society forum at district level with members who are clearly documented in some form of a directory or inventory” FGD 3*

The sentiments above may connote that there is inadequate engagement of the civil society by the DATF due to a clearly defined formal forum. This appears to be paradoxical because the civil society has played a leading role in the fight against HIV/AIDS in Zambia (SHARE, 2010). Research has shown that civil society can augment HIV services provided by the state (Zuniga, 2006). It can further be argued that civil society organizations have played a significant role in the direct provision of HIV-related services due to their presence in or connections with affected communities, especially marginalized groups (Zuniga, 2006; Berkman, 2006).

Some participants said that while they appreciated the DATF, it held very few coordination forum meetings through which stakeholder involvement and engagement could have been exercised more. For example a representative from the Office of the District Commissioner made the following observation:

*“I have been a member of this Lusaka DATF for the past six years now which makes me probably the longest serving member. As far as I can remember, we have only had two stakeholders meetings. As a result we don't know what others are doing”.*

Key Informant 7



We can learn lessons on the importance of a stakeholders' forum the Ministry of Health in the manner it prevents disease outbreak. The Ministry of Health constitutes, working with the Ministry of Local Government and the office of the Vice President responsible for disasters, constitute Disaster Management and Epidemic Preparedness Committees (DM&EPCs) in all districts in Zambia aimed at preventing disease outbreaks including cholera and typhoid. The critical success factor in all DM&EPCs is that they have a standing order to meet key stakeholders every month with a clear agenda and they host a stakeholders' forum for the general membership every quarter (Office of the President, 2012).

It was suggested that engagement and involvement should have started with signing of memoranda of understanding between the DATF and respective stakeholders. During FGDs, a member of the DATF Executive Committee reported that:

*"....at no time do I remember us sitting down as DATF signing memoranda of understanding with stakeholders. It will be interesting to learn from you how this works at DATF level."* FGD 4

The importance of a memorandum of understand illustrated by learning from the municipal fiscal and service delivery review in Toronto where stakeholders agreed that a memorandum of understanding, apart from stating the responsibilities of the signing parties also makes it possible for these parties to develop a sense of responsibility which in turn gives meaning to meaningful involvement (Association of Municipalities in Ontario, 2007). In 2010, similarly, the office of the chief health officer in Queensland while developing the strategy to improve service delivery recognized the need to strengthen services coordination; and one way of doing this was through the signing of agreements and memoranda of understanding (Queen's Land Government, 2010).

#### **4.4 CAPACITY OF SECRETARIAT TO PERFORM**

##### **4.4.1 Technical limitations of the DACA**

DATF stakeholders understand the importance of having a DATF secretariat which is managed by people with requisite knowledge and skills commensurate with the task of managing the mandate of coordination. It was against this background that participants had a discussion. The DACA is the fulcrum of the DATF, being the only full time employee of the DATF, while the rest of the members are volunteers. This is the reason why participants opened their discussion

by examining the technical capacity of the DACA relative to the DATF mandate. Civic leaders were very emphatic in making their point:

*“About skills, the starting point is the lack of a training programme for the DACAs to manage and coordinate the district HIV/AIDS response. So we end up with officers who depend on their common sense rather than learned skills and formally acquired knowledge. The second problem is the people at NAC secretariat also have no idea how this thing should be managed”.* FGD 5

The statement above was reaffirmed by the Director of Programmes who confirmed that to date there is no specific formal training directed towards DACAs which would, otherwise make them qualify to function as such. The view above was corroborated by a participant who had acted as a DACA who stated that:

*“There isn’t much practical guidance on how most of the roles and responsibilities are to be implemented. Further, most of the work I do is a product of commonsense. In the past two years I have not received much technical support from NAC. In other words there are times when I feel I am not very well prepared to coordinate the work.”* Key informant 4

Human resource capacity constraints, including for coordination of AIDS activities at sub-national levels, have been cited as a challenge to the effectiveness of NACs (UNAIDS, 2005). However, the story was different in Malawi where Matshalaga & Simwaka (2007), in their evaluation of the Malawi national AIDS Council and its decentralization structures at district level found that there is evidence of good coordination of multi-sectoral stakeholders through the District AIDS Coordinating Committees (DACCs), which are also multisectoral. The assessment reported that NAC had very skilled personnel in key positions (Matshalaga & Simwaka, 2007)

Some participants expressed surprise at the lack of an organized curriculum specifically developed to build the technical capacity of DACAs.

*“I will start with reflecting on the position of DACA. It is surprising how that such an important job upon which the overall district coordination of HIV/AIDS activities hinges doesn’t appear to receive much attention in terms of human capacity development. How*

*else can we explain the fact that this cadre of workers does not undergo any specialized management training?” Key informant 1*

The findings (above) corroborate well with the findings of another study which was conducted in selected countries to consider new developments to strengthen sexual and reproductive health and HIV linkages and a consideration of factors that continue to impede progress, which demonstrated that the provision of integrated services places considerable demands on health workers but few receive appropriate training and technical guidance (Dickinson et al, 2009). The study also demonstrated that health workers may lack the confidence, skills, training and incentives required to take on new tasks resulting from the addition of HIV or sexual and reproductive health activities (Dickinson et al, 2009). Some participants such as civic leaders were y shocked to learn that there was neither a specific course nor a deliberate well thought out programme which was specifically designed to train or orient DACAs to carry out their duties.

*“I am in a state of shock and disbelief to have learnt that there is no special training requirement which one has to undergo before they could be appointed to serve as a DACA. I am also told that even after appointment there is no serious orientation which people go through.” FGD 5*

In supporting community work, Pathfinder, a leading global reproductive health organisation, encourages community responsibility by building a cadre of community resource people who are provided with advanced training and support in semi-professional capacities and skills in community mobilisation and programmes coordination as well as resource mobilisation and coordination (Thurman et al, 2007).

#### **4.4.2 Strategic and operational planning for coordination**

District AIDS Task Forces are expected to develop district HIV/AIDS strategic and operational plans in line with the core mandates of the DATF (NAC, 2011). The NAC guidelines explain that joint planning ensures promotes effective and efficient coordination of activities. Against this background, district stakeholders expect that their DATF will facilitate both strategic and operational joint planning. The Lusaka DATF had developed its operational plan though it did not have the strategic plan. Participants highlighted the importance of collective planning if activities are to be well coordinated. Important as this activity may be, some participants from

the civil society group were not aware that there was a plan in existence to coordinate some targeted joint activities.

*“While a few of other DATFs such as our neighbouring Chongwe district DATF just 30 km east of Lusaka have gone ahead and developed that plan, we have not done so. Without that plan it has been difficult for us and others to hold the DATF accountable in the mandate of resource mobilisation”.* FGD 3

Spicer et al (2010) undertook a study in seven selected countries, including Zambia, to assess national and subnational HIV/AIDS coordination by specifically enquiring into whether or not global health initiatives were closing the gap between intent and practice. One of the key findings was that there was overwhelming evidence of limited information flows within and between coordination structures was a key finding in most of the countries, which undermined meaningful exchange between members (Spicer, 2010).

Some participants acknowledged having seen or having heard about the existence of the plan. Among those who acknowledged the existence of the DATF plan, there were some who strongly felt that developing a plan is one thing and getting stakeholders together for to execute the contents of the plan was another. The representative from the office of the District Commissioner argued that what was more important was to move together as a cohesive, united force.

*“What is important for DATF is not how excellent the planning documents come out, but the degree of cohesion, the unity of purpose and togetherness with which members emerge from the exercise”.* Key Informant 7

Meaningful stakeholder involvement takes place when the stakeholders are empowered to make decisions that influence organisational practices, policies and directions (Wood in Mgomezulu, 2001: 80). To empower stakeholders, the leaders of organisations should be genuinely committed to sharing power with and training stakeholders because effective involvement requires certain skills, understanding and knowledge (Wood in Mgomezulu, 2001: 80).

The plan developed by DATF is expected to be a joint district plan. Once developed, the district HIV/AIDS strategic plan is expected to form part of the broader district development plan. This was not the case as was reported by a political leader:

*“In 2006 the DATF had prepared what was termed the District HIV/AIDS/STI/TB Strategic Plan for 2006 to 2010. It was presented before the full council and I was in that meeting. The controversy started with the title of the document which included STI/TB and there was nothing about these conditions in the document. The second complication was the conflicting objectives and targets with the District Health Management Team (DHMT) plan. Lastly it was not aligned to our district development plan”.*

Key Informant 6

Planning for HIV/AIDS services in the district is not well coordinated and not mainstreamed or integrated into the planning cycle of the district. This state of affairs is in agreement with Kintu (2010) when he reported that planning for HIV/AIDS in district and local municipalities lacked substance, reflected in poorly integrated municipal sector plans, less articulation of HIV/AIDS plans in terms of deliverables or planned targets, and weak inter-sectoral coordination/integration for HIV/AIDS, as well as a marked preponderance of health based responses.

#### **4.4.3 Coordination of Resource Mobilisation Planning and Management**

Participants highlighted the fact that lack of a joint resource mobilisation plan has impacted negatively on their service delivery capacity. One of the civic leaders discussed the importance of a joint resource mobilisation plan.

*“Let me also add that the absence of a joint resource mobilisation plan coordinated through the DATF has meant that each implementer has to fend for themselves. The results have been a mixture of good and bad. .... there is very little accountability, too much duplication and double counting of beneficiaries while others receive no help at all.”* FGD 5

Research has shown that resources are critical if a coordinated initiative is to be sustainable and provide value for money (Mattessich, 2001). The main resource requirements are a dedicated budget, a working space that can sustain progress without overwhelming the group and, most importantly, sufficient time to establish working relationships, achieve outcomes and nurture the required behaviours (Mattessich, 2001). A participant representing the Association of Mayors observed that financial resources when used well by a coordination structure can facilitate the process of bringing stakeholders together.

*“Resources particularly financial resources if handled properly have the capacity to bring different stakeholders together. The catchword is accountability which builds trust and commitment”* Key Informant 3

Asked as to whether the DATF has enough financial and non-financial resources which would promote the process of coming together, planning together and sequencing activities beyond the usual national commemoration days the DACA had this to say in an iterative enquiry:

*“The DATF does not have adequate resources to make it a fully-fledged coordinating body as expected.”* Key Informant 2

Through research, it has been a long established fact that having money as a coordinating body can contribute significantly to an initiative’s capacity and can be the stimulus that brings parties to the table provided the sequencing of events that contribute to the building of trust are identified and consensus over an agenda is built (Hughes et al, 2007).

#### **4.4.4 Coordination at its peak**

Coordination is like a sine wave that has got peaks and deeps. It was encouraging therefore, to have learnt that even with the many challenges the DATF is facing, there are moments when coordination is optimal depending in the issues in need of coordination. This observation was supported during the private sector discussion when a participant said:

*“The Lusaka DATF is strongest around the periods when we commemorate national events. Specifically these are the national VCT day on 30th June and the World AIDS Day on 1st December each year. On these days the DATF manages to assemble a large number of district partners together”.* FGD 2

The World AIDS Day and the National VCT days can be likened to new initiatives different from the usual day to day programmes in the district. It is important that all stakeholders who are party to a new joint initiative understand the roles and responsibilities of those involved, and such understanding is thought to lead to better outcomes (Brown et al, 2003). Some of the responsibilities include the management of budgets, administrative support and the coordination of material resources (Brown et al, 2003). This is exactly what a participant is reporting when DACA reported the following:



*“During the World AIDS day and the National VCT day we try to come together. Both financial and non-financial resources which are donated through the DATF from different partners are documented in the resource book. A report is now always written soon after the event to show how resources were used.”* Key Informant 2

The statement of DATF working together during important international days was echoed as during the public sector discussion as follows:

*“I think that it will be unfair to conclude that we have not been working together. In this regard I will differ in opinion from my colleague in that I feel that we have been working together as local stakeholders in many different ways. For example we have some existing linkages between ourselves which we use to collaborate with each other. As the department of community development, we have worked very well with the department of health in linking home based care clients”.* FGD 1

Underscoring the importance of working together through collaborative efforts among stakeholders working in Federally Funded HIV/ AIDS Programs in the United States of America, the Centre for Diseases Control (CDC) , highlighted collaboration and coordination as essential components of any effective multi-agency community case management system. They further stated that the absence of collaboration and coordination among case managers can undermine the efficiency of case management in HIV health-care systems (CDC, 2008).

#### **4.5 PERCEPTIONS ON DAFT EFFECTIVENESS**

This subsection reports on how participants perceived the effectiveness of the DATF to be like.

##### **4.5.1 Perception on coordination**

Different participants presented different interpretations of what they understood to be the meaning of coordination through the DATF. From the office of the DACA the following was given as the understanding of coordination:

*“When we speak of coordination we are talking of firstly knowing all the stakeholders involved in HIV/AIDS service delivery. Secondly it involves knowing what these stakeholders are doing and where they are doing it. Coordination involves knowing the people who are benefiting from legally conducted services within our district and this is to be done through the DATF.”* Key informant 2

From the NZP+ representative it was the following:

*“Coordination is not a simple concept. We have different interpretations. The DACA seems to have his own way of understanding it and so does the District Commissioner. We also have our own understanding. For the DACA it might mean stakeholders reporting through her office. For the District Commissioner it means having all stakeholders declaring their resource baskets.”* Key Informant 1

Civic leaders also added their understanding to the concept of coordination.

*“Coordination also means that key players in the district know about each other, their activities, comparative advantage and funding levels.”* FGD 5

When multiple actors pursue goals together, they have to do things to organize themselves that a single actor pursuing the same goals would not have to do (Herman & Luc, 2004). Coordination can also be described as when a set of two or more actors perform tasks in order to achieve shared goals (Baligh, 1986).

Participants were asked to estimate the numbers of stakeholders in the district who they thought were being coordinated through the DATF and to what extent they thought the DATF knew the resource basket and quality of service being offered by these stakeholders. The DATF executive representatives could not answer accurately.

*“Obviously we will not be able to know the extent of the HIV/AIDS response. What we know is only that which is reported through us. The rest is not known, the quality is unknown, the cost is not known and the challenges are not known. One reason could be that some stakeholders have different priorities, so they don't report”.* FGD 4

The submission by the participants seem to be in agreement with the observations made by Ndubani et al (2009), that an important reason for this was that major donors for HIV/AIDS programmes continued to set priorities outside national and subnational structures; and their participation in such structures was seen as a formality.

#### **4.5.2 Perceptions DATF Performance**

In line with stakeholder involvement, it is equally important to ensure that stakeholders have confidence about the effectiveness of the DATF to perform on its mandate to coordinate district



activities by providing timely feedback to stakeholders. The opinion of the AMICAALL representative was as follows:

*“Currently there isn’t much to be talked about. I am aware that there is a NARF which is filled in by organisations and institutions. They hand it in to the DACA. I have received numerous comments that it is one-way-traffic in the sense that there is hardly any feedback given by the DATF to those who hand in the NARF”.* Key Informant 3

This finding was supported by participants from the DATF executive when they suggested that there were other attitudes and practices by the DATF which did not motivate them:

*“The other reasons are connected to what we have already alluded to earlier such as lack of a joint plan, poor agenda for meetings, failure to manage skilled stakeholder”.*  
FGD 4

The findings above may be compared with the findings of the German Technical Cooperation (GTZ) during its assessment of Lusaka City Council in readiness for funding towards Integrated Development Planning (IDP) in 2010. The findings were that the local authority had a central plan but did not have a joint plan for the townships and that it did not meet the target of achieving all quarterly meetings (GTZ, 2010). Additionally it was also reported that Local Authorities were not ready for accelerated decentralization because most of them lacked skilled manpower and they had also failed to identify local expertise (GTZ, 2010)

Some participants were able to recognise that coordination was, in part, a product of both the DATF and its stakeholders. They postulated that attitudes, practices and behaviours were not limited to the DATF alone; the civil society also identified some weaknesses among themselves as stakeholder when they (participants) reported that:

*“We are the stakeholders and we can only reflect on our attitude towards the DATF. There are those who are very committed and there are those who are not. Those of us who are committed are motivated by the desire to learn from the experiences of others who share their experiences through the DATF. Those who are not committed may be motivated by a lack of understanding of the principle of multisectoral response.”* FGD 3

There were participants who submitted that performance of the DATF had been negatively affected as a result of introducing money in form of allowances in exchange for most activities which had initially been performed on voluntary basis. The public sector group pin pointed that the introduction of money in what used to be voluntary activities had impaired the behaviour of stakeholders towards DATF coordinated activities:

*“Local stakeholders have been monetized too much. When we used to have a bit of money as DATF since we were sub granting together with CRAIDS we had some respect and recognition from stakeholders. May be because they knew at that time that we had the keys to their funding. Now that we have nothing we are not respected and we are not all that recognised.”* FGD 1

#### **4.7 DATF Structure and Guidelines Functions and Mandates**

A number of stakeholders reflecting on the clarity of functions and mandate of the DATF did so from the perspective of DATF legal mandate. The executive submitted that lack of the efficaciousness of DATF Legal Mandate is a source of coordination problems.

*“Confusion starts from the creation of DATF itself. NAC has failed to identify the existence of DATF in its own Act of Parliament. It is silent. If DATF is so important for coordination, as we have been made to believe it is, then why has NAC failed to include the DATF in the NAC Act for the past 10 years?”* FGD-4

This was re-enforced by the DACA.

*“The main weakness is that the DATF was never enshrined in any legal document from the outset and it has remained as an appendage of the DDCC and a pipe dream of UNDP which no longer funds it.”* Key Informant 2

The Support to the HIV/AIDS (SHARe) Organisational Capacity Assessment Report for 2009 noted that a key element of the proposed amendment to the NAC Act and the eventual development of the Statutory Instrument subsidiary to the parent Act No. 10 of 2002 must be the legalization of the DATF so that its functions are both formal and legal. This way, the DATF will have a more visible coordination role. According to the Uganda AIDS Commission (2012), Uganda’s response to HIV/AIDS has been guided by many policies and frameworks, among

them, the Decentralized Policy, in recognition of the effects and impact of HIV/AIDS at community level

The findings indicated that the DATF structure in its original form, contributes to poor coordination and that there is a discrepancy between what the guidelines provided for and what is practically obtaining in the ground. From experience the DATF executive committee submitted that:

*“While the NAC guideline talks about 15 DATF members, in reality we have a multi-layered DATF which accommodates more members”*. FGD 4

Provisions on the structure and guidelines for DATF composition limit its capacity by initially limiting membership which tends to exclude some key stakeholders. This point was further elaborated during the interview with the representative of the District Commissioner when it was found that though DATF mandates were not used very much when developing the guidelines.

*“....the DATF structure leaves much to be desired in the sense that DATF mandates have not been used to create a structure.”* Key Informant 7

The 2009 National HIV/AIDS/STI/TB Sector Institution Assessment (SIA) report explains that the core mandate of any given DATF is that of coordination. The report further states that coordination is achieved through the following strategies: Joint planning, joint monitoring and evaluation, advocacy and lobbying, collaboration and capacity building. To be able to make these strategies functional, the structure of the DATFs must change from an implementer based structure into one that responds to the DATF mandate of coordination (NAC, 2009). This was clearly not the case for this research study

In the eyes of the DATF executive, there was demonstrated discrepancy between what the guidelines provided for and what was being practiced and how that caused coordination challenges

*“We as DATF have decided to divide Lusaka into zones following political constituency boundaries. Each zone has got its own Zonal AIDS Task Force (ZATF). It is a decentralised form of a DATF. ZATFs are members of the DATF. Unfortunately NAC does not agree with this type of thinking and that is where the problem lies”* FGD 4

On further probing on how this structure's variance with the NAC proposed structure contributed to poor coordination the private sector team had this to say:

*“Because we are operating at zone level where we have so many players, the National AIDS Reporting Forms which the DACA distributes are very few. There are also a lot of activities which are not covered by using this form and therefore all those guys whose work cannot be captured get demoralized and stop attending our ZATF meetings even though they continue serving the community. These are the guys who sometimes even contribute to double counting” FGD 2*

Though participants acknowledged the existence of guidelines they remained unconvinced about the effectiveness and utilization of the guidelines for coordination. For example the DACA had this to say:

*“We have been given some guidelines by NAC which cover some aspects of how the DATF should be organized and there is also a list of roles and responsibilities in bullet form. However, these are either outdated or are completely out of context. How can you have guidelines that speak about having a maximum of 15 DATF members when there are more than a thousand key stakeholders in Lusaka alone? Furthermore, these same guidelines do not explain how the very roles and responsibilities are to be made operational” Key Informant 2*

This was supported by a participant in the DATF executive committee.

*“I have read through the guidelines and there is no mention of what stakeholders will do. Furthermore, the guidelines do not have any sanctions of institutions that will decide not to abide by them. May be this could be one reason why stakeholders remain unpredictable” FGD 4*

The available guidelines on DATF were collected and summarized and compared according to name and stated purpose. The analysis on the guidelines found that there were six DATF guidelines all developed within a span of nine years by different stakeholders and all of them claiming to be working with NAC. Four guidelines have addressed DATF composition and membership differently. The UNDP supported guideline stipulates that there shall be fifteen

DATF members only drawn from the listed stakeholders (NAC/UNDP Zambia, 2002). This is in contrast with what the SHARe supported guide stipulates when it states that there need not be a uniform structure and composition of DATFs because district contexts differ in terms of population, number of stakeholders and both HIV incidence and prevalence (SHARe, 2011). All the guidelines mention something on roles and responsibilities except they do so at different depths. The NAC developed guideline produces a list of roles including resource mobilization, monitoring and evaluation, support, policy interpretation, collaboration and planning (NAC, 2004). The SHARe supported coordination manual goes into details to elaborate on the mandate and provides verifiable performance standards for each mandate. On resource mobilization it clearly stipulates that this involves people, financial and non-financial resources which may be required to perform different DATF tasks at different times of the year (SHARe, 2011). It further goes on to suggest how a DATF can develop a priority based resource mobilization plan.



**Table 1: List of DAFT guidelines and their purpose**

Name of Guidelines	Purpose of guidelines	Source	Analysis
Guidelines for District AIDS Task Forces in Zambia (2002)	Provide guidance on DATF composition, roles and responsibilities	<ul style="list-style-type: none"> <li>• UNDP-Zambia</li> </ul>	<ul style="list-style-type: none"> <li>• Limited understanding and scoping of the DATF membership and mandate</li> <li>• No consultation during development</li> <li>• Document unknown to most DATF members</li> </ul>
DATF and PATF Guidelines (2004)	Guidance on definition, composition, functions and structure of DATFs and PATFs	<ul style="list-style-type: none"> <li>• NAC</li> </ul>	<ul style="list-style-type: none"> <li>• Contents remained the same as the UNDP-Zambia developed guidelines except for the cover and source</li> <li>• Failed to include lessons learnt which could have informed the</li> </ul>

			guidelines
Coordination handbook for DATFs (2005)	Guidance on DATF composition, its functions, reporting mechanisms and role of DACAs	<ul style="list-style-type: none"> <li>• NAC</li> </ul>	<ul style="list-style-type: none"> <li>• Contradicts earlier guidelines on functions as it borders on DATF implementing selected activities rather than restrict itself to coordination</li> <li>• Limited availability</li> </ul>
Revised handbook for DATFs and PATFs (2006)	Guidance on DATF composition, its functions, reporting mechanisms and role of DACAs. It introduced technical Working Groups which were never made operational at DATF level	<ul style="list-style-type: none"> <li>• NAC and DFID</li> </ul>	<ul style="list-style-type: none"> <li>• Developed by NAC with little input from key stakeholders</li> <li>• No dissemination done</li> <li>• Limited availability</li> </ul>
Coordination manual for DATFs and PATFs in Zambia (2009)	Guides the relationship between DAFs and the civil society at district level in Zambia.	<ul style="list-style-type: none"> <li>• Support to HIV/AIDS Response in Zambia (STARZ) project</li> </ul>	<ul style="list-style-type: none"> <li>• Donor driven and no consensus</li> <li>• Limited circulation</li> <li>• Not evidence based</li> </ul>
DATF/PATF coordination manual (2011)	Defines DAF performance standards and provides for a certification process	<ul style="list-style-type: none"> <li>• Support to the HIV/AIDS Response in Zambia (SHARE) project</li> </ul>	<ul style="list-style-type: none"> <li>• Donor driven rather than NAC initiated</li> <li>• Limited circulation to DACAs instead of all DATF members</li> </ul>

The analysis of the guidelines found that there are too many guidelines which are developed independently of each other. As it is the NAC's responsibility to coordinate it should also be theirs to coordinate the development of the guidelines. The implementation of the different but similar guidelines is having a negative impact at DATF level Lusaka where in that some of the guidelines do actually conflict each other.

## 4.8 Leadership

Leadership is essential if the HIV/AIDS response is to be effective at district level. Accordingly NAC, District Commissioners, Members of Parliament and Ward Councilors are supposed to provide leadership to the DATF.

### 4.8.1 National HIV/AIDS/STI/TB Council

The Organisation Capacity Assessment conducted by SHARE in 2009 had a component of stakeholder perceptions about the effectiveness of NAC. Pertinent to the topic of discussion is what stakeholders said about NAC and its capacity to support DATFs. The civil society overall perception was that NAC possessed neither the technical nor the financial capacity to support the DATFs (SHARE, 2009). The public sector perception was that most specialists at NAC lacked the required technical competencies to provide the much needed technical leadership (SHARE, 2009). The private sector overall perception was that the image of NAC needed rebranding and so did the DATFs if it had to convince the private sector to invest in coordination work particularly when NAC itself has invested very little in building competencies in DACAs at that level (SHARE, 2009).

### 4.8.2 District Commissioner

The District Commissioner is the overall supervisor of the DATF because they supervise the DDCC to which the DATF is a sub-committee. The District Commissioner is expected to offer optimal leadership to the DATF.

Some participants felt that the District Commissioner did not possess qualities that motivated unity of purpose in district HIV/AIDS interventions. The political leader was very particular about the role of the District Commissioner in DATF.

*“The District Commissioner does not consider HIV/AIDS coordination to be one of his priority areas beyond rhetoric. He is not a proactive leader who provides opportunities for coordination but a reactive critic of the DATF and he is supposed to be the DATF patron.”* Key Informant 6

Studies have shown that in organisations where coordination of activities has succeeded, the senior leaders have invested significant time and energy modeling and supporting this way of working (Graton & Erickson, 2007). Particular behaviours required of leaders include: seeking



out opportunities to work with others; incentivizing and recognizing staff involved in coordinated work; ensuring that resources and time are available for the team; and managing external and political pressures so that coordination can occur (Parker, 1994).

The lack of deliberate orientation could be responsible for why the commissioner did not apply themselves to the demands of DATF coordination work (SHARE, 2009). The NZP+ representative said:

*“With all due respect to the District Commissioner, in the absence of HIV/AIDS leadership related training and exposure, it is very difficult for her to offer quality leadership because HIV/AIDS is complex.”* Key Informant 1

Another view shared was that political expediency contributed to weakening the District Commissioner’s commitment to offering the much needed leadership to DATF coordination (AMICAALL, 2011). This point was discussed in the public sector discussion where a participant reported the following:

*“As you might know the District Commissioner is the overall responsible officer of the DDCC and all its sub-committees. He was appointed by the president and his number one duty is to please his appointing authority first before remembering the people he is supposed to serve. This creates a very big weakness.”* FGD 1

In reflecting about the district leadership’s role and support towards the DATF coordination mandate, participants acknowledged that there is a district leadership. However, civic leaders expressed dissatisfaction with the working relationship between the District Commissioner’s office and the Town Clerk’s office in comparison to another district which they had visited during an exchange visit.

*“In Kitwe I saw what I haven’t seen or heard about here in Lusaka. Down there, the Local Authority has offered the Council Chamber for important DATF meetings. HIV/AIDS is always on the agenda of the full council meeting and the District Development Coordination Committee quarterly meetings. In Kitwe, unlike here, the District Commissioner and the Town Clerk work well together to support the DATF work.”* FGD 5



The observation of how strong the leadership in Kitwe was, in comparison to Lusaka DATF can be confirmed by Campbell (2010) who suggested that political will and leadership are increasingly considered key contextual influences on the outcomes of HIV/AIDS programmes in sub-Saharan Africa. The advocacy work which the Lusaka DATF wishes to learn from the Kitwe DATF can also resonate well with the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL) in Namibia when they pointed out the fact that mayors and Councilors have the potential to be important advocates in the fight against HIV/AIDS (Mattessich et al, 2001).

#### **4.8.3 Ward Councilors and Members of Parliament**

It is a fact that leadership invested by key members of coordination bodies and commitment of high-level government leaders are important factors in controlling HIV/AIDS epidemics in countries (Bor, 2007). Ward Councilors and members of Parliament are representatives of the people. In fact they are duly elected to represent the electorate from constituencies and wards respectively. Activities are carried out in the community and services are provided in the same communities. The lowest governance structure at community level is the ward and several wards constitute a constituency. The researcher has since come to learn that through the ward development fund and the constituency development fund, the DATF can receive financial support from the local authority which disburses these funds. For this reason, therefore, civic leaders and politicians become very important stakeholders to the DATF. It was against this background that Politicians and ward councilors were asked to state how well they knew and understood DAFT activities.

*“The MP has already made his confession that he doesn’t know what is happening in his own constituency. I am like him. For me I have never seen the DACA in my ward. As a ward councilor I have never been invited for any official HIV/AIDS activity. I have no record of any activity in my ward.” FGD 5.*

It would appear, from the statement above, that systems for the effective management of HIV/AIDS in this ward are dysfunctional. This scenario can be likened with a similar situation in South Africa. In 2010, the open Society for Southern Africa (OSISA) commissioned a research study to assess the role of councillors in service delivery at local government level in South Africa. Among the many findings, one of them was around a decision-making structure in the

municipality and ordinary councillors including poor channels of communication from the municipal administration, non-functional ward committees, the lack of a meaningful mechanism for councillors to influence decision-making and the dysfunctionality of Ward Committees in many municipalities (Paradza et al, 2010).

#### **4.9 RECOMMENDED CHANGES TO THE DATF BY PARTICIPANTS**

Participants shared several suggestions on how coordination of DATF activities can be strengthened. Some participants made proposals on how to address the DATF legal status. For example, a political leaders stated that:

*“If I had the power, the first thing I would do is to revise the NAC Act so that the DATF is also enshrined in the Act of Parliament. The second thing is to develop clear guidelines for the DATF including powers to impose sanctions against erring stakeholders”.* Key Informant 6

the DACA suggested that it is better to address the issue of DATF legal mandate through the policy.

*“For me I would revisit the policy so that the DATF is also recognised unlike the situation is now. I would want to put an end to this lack of sharing among local implementers. We need to know what each one is doing”.* Key Informant 2

This finding was strengthened by another reflection from the District Commissioner:

*“NAC must develop subsidiary legislation so that Act of Parliament No. 10 of 2002 which created NAC becomes operational. The legislation must include guidelines on district level coordination, planning, advocacy, documentation and capacity building”.* Key Informant 7

Participants also discussed how to address stakeholders’ attitudinal factors affecting the core mandate of coordination. Some participants proposed the strengthening of legislation which will in turn help improve the negative attitude of some stakeholders towards the DATF. For example the NZP+ representative said that:

*“I think that the only way to compel local organisations to work through the DATF is to introduce a law which first recognises the DATF as a coordination authority and*

*secondly makes it a condition for any organization intending to perform HIV/AIDS work in the district to initially register with and get a certificate of registration from the DATF at a small fee. This way, we get the allegiance and some financial sustainability”.* Key Informant 1

This was amplified by a participant among civic leaders:

*“What I would like to see come to an immediate end is the practice of local stakeholders not reporting their achievements through the DATF. I would achieve this by creating a by-law through the Local Authority which will make it mandatory for any data collected from district activities to first be reported to the DATF and get a verification certificate before it can be transmitted to provincial and national bodies.”* FGD 5

Another participant from the DATF executive committee proposed the following:

*“What I can do immediately is to amend the NAC Act because at the moment it is silent about the existence of the DATF, its functions and powers. In amending it I would propose that the DATF is identified as a legal entity. I would make it compulsory for all district stakeholders to be members of the DATF. I would go further to define and proscribe sanctions of all those members who fail to comply with agreed upon district programmes and reporting mechanisms.”* FGD 4

Some participants were very strong on the issue of guidelines. Another DATF executive participant proposed the following:

*“Since we have gained some experience, we need to undertake exchange visits with other DATFs and then help NAC to come up with operational and management guidelines.”* FGD 4

This issue of guidelines was to be echoed among the civil society representatives as follows:

*“I would create some guidelines which would compel all donors working in a given district to pull their resources/money in some form of pool funding. I would then have all project proposals submitted to the DATF and have a small technical multi-skilled project*

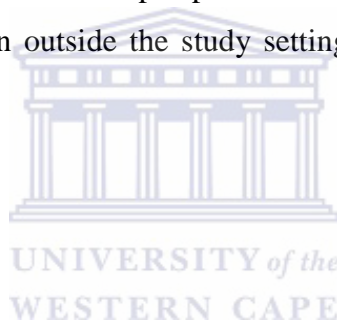
*team to analyze all applications, awarding of funds and together with funding organisations make regular follow ups and evaluations.” FGD 3:*

On DACA technical competence proposed the following:

*“I see the need to introduce a deliberate qualifying training course at the National Institute of Public Administration for DACAs. Furthermore, I see the need for clear guidelines which should be used to train DATFs like ours and if possible certify them using some standard score”.* Key informant 3

#### **4.10 STUDY LIMITATIONS**

Being a qualitative study, sample size is small so the study cannot be generalized to either the whole country or indeed other comparable settings. The results can, nonetheless, be used to support existing literature as well as add new perspectives on the topic. Therefore, where there is a likelihood of broader application outside the study setting which may not apply this would have to be judged independently.



## **CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS**

### **5.1 CONCLUSIONS**

This study was aimed at exploring factors which impact on the capacity of DATF to coordinate an effective and sustainable local HIV/AIDS response. Specifically it has identified and described both internal and external factors which promote as well as factors that inhibit the capacity of the DATF to coordinate the local response. It has also identified some existing opportunities that have the potential to strengthen coordination through the DATF.

The following factors have been found to be supportive of an effectively coordinated DATF:

Lusaka DATF, like all other DATFs was not created in a void. It was created through a government circular and it was placed with a government institutional framework. This aspect makes it a formal structure, within government provisions to undertake the mandate of coordinating the local HIV/AIDS response agenda.

Effective management of stakeholders through regular engagements is essential to effective coordination. The study has established that holding regular stakeholders forum meetings to exchange experiences and lessons learnt motivates stakeholders to be coordinated through the DATF. A stakeholders inventory is an important tool because it documents the names of stakeholders, the type of services provided and areas where they provide those services. In this way it becomes easier for stakeholders to collaborate and form linkages and synergies.

Joint planning and collaborative undertaking of planned activities particularly during national commemoration days such as the World AIDS Day and the National VCT Day has shown that the DATF has the capacity to coordinate because those are the times when there is need for optimal coordination and the DATF has done just that.

While appreciating that the DATF has shown some signs of coordination, it must be appreciated that this study has also highlighted a number of factors which have been inhibiting effective coordination in Lusaka DATF. Some of these include the following:

Although the DATF is a formal structure, enshrined into the government institutional framework, does not still exist as a legal entity because it is not enshrined in any part of the Act of Parliament No. 10 of 2002 which created the NAC. This act of omission does not compel stakeholders to be

coordinated through the DATF which has led to multiple reporting channels for local stakeholders instead of having only one reporting framework through the DFATF.

Lusaka DATF holds some stakeholder forums but they are inadequate to cause the desired impact in terms of coordination. It has been established that lack of memoranda of understanding between the DATF and stakeholders.

This study has shown that there are different understandings and interpretations of the concept of coordination by different stakeholders which might begin to explain why some stakeholders behave in the manner they do towards DATF coordinated activities.

The feedback mechanisms from the DATF secretariat to stakeholders are very weak and almost nonexistent in most cases; which implies that there is very little effective communication happening. Other mandates which have been found to be weak are that the DATF does not have a joint strategic plan which all local stakeholders are supposed to buy into; the DATF does not have a jointly developed priority based resource mobilisation and management plan which is a missed opportunity in coordination terms. This factor probably explains why the DATF is faced with inadequate resources to execute its mandate.

The multiplicity of DATF guidelines by different partners which have, at times, contradicted each other is not helping much either. Additionally, it has been established that in the absence of a well-structured orientation programme for the DACAs, the technical capacity of the DACA has remained sub-optimal.

Additionally the study has shown that although there is knowledge about the importance of leadership involvement, there is very poor political, civic and technical leadership engagement to the extent that political and civic leaders are not aware of DATF coordinated activities.

All these factors, in the end, have created a perception among most stakeholders that the DATF is technical weak and that it does not possess the capacity to coordinate them effectively.

## 5.2 RECOMMENDATIONS

It is important to note that several of the recommendations listed below are built on participants' suggestions also viewed as opportunities:

1. There is need to review, through amendment, the National HIV/AIDS/STI/TB Act No. 10 of 2002 with a view to including DATFs and PATFs as formal structures through which NAC will decentralize its functions to the district and provincial levels respectively;
2. In order for the legal framework to be effective, it is not enough to amend the Act of Parliament (above), but to go further and develop Statutory Instruments or guidelines subordinate to the parent Act (above) so that practical building blocks of coordination, duties and responsibilities of both the DATF and stakeholders are clearly stipulated;
3. NAC needs to develop a decentralization Strategy which will clearly outline the course which NAC intends to take towards devolution of some of its functions to the local level in line with the National Decentralization Policy;
4. Lusaka DATF should strengthen the current weak stakeholders' forum. A good starting point will be the DATF to update the current stakeholders' inventory to include the concept of geo-programmatic mapping and other aspects which make it possible for stakeholders to know who is working in which area and what type of services they are offering;
5. DATF and stakeholders should sign memoranda of understanding clearly stipulating expectations and responsibilities as well as accountabilities to each other;
6. NAC, in collaboration with institutions of higher learning such as the National Institute of Public Administration (NIPA) and the University of Zambia among others should formulate, institute and support a deliberate learning curriculum for DACAs based on a sound curriculum for the type of work they do. This could also include mentorship;
7. Lusaka DATF should strengthen and support the practice of joint planning and collaborative work during national events such as World AIDS Day and the National VCT day and take lessons learnt to other aspects of joint activities;
8. Lusaka DATF should develop and support a feedback mechanism so that there is information flow among stakeholders and to and from the DATF;
9. In view of the multiplicity of DATF guidelines which have been developed by different stakeholders, NAC must play a leading role to firstly assess the relevance of all these



guidelines and then go on to develop one DATF guideline or DATF handbook and then orient all DATFs in the use of the guidelines.

10. The DATF should develop a mechanism of involving members of Parliament and Ward Councillors and other community leaders in its activities;
11. It might be prudent to develop a Bylaw which will compel stakeholders working in the district to report their activities through the DATF and to participate in joint strategic and operational planning and monitoring and evaluation;
12. NAC should consider advocating for an HIV/AIDS basket fund at district level which will be a common pooled fund coordinated by the DATF and all local stakeholders in the will be encouraged to apply through the DATF.



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## LIST OF APPENDICES

### Annex 1: Questions for the Lusaka District AIDS Task Force's Focus Group Discussion QUESTIONS

1. As members of DATF could you explain to me what your major functions have been in the last few years?
2. Could you share with me how you have been working together as local stakeholders
3. Let us discuss the practical aspects of coordination further. Could you explain how you have been working together as district stakeholders
4. I understand that you have more than 100 key stakeholders, could you kindly give examples of what you have as expectations from your stakeholders? As you conclude this question could you kindly hint as to whether or not they are meeting these expectations.
5. Could you discuss the strongest points inherent within the DATF and how you have used these to coordinate the response
6. Now that you have highlighted the strengths, what do you think are some critical factors inherent within the DATF (Structures, systems, staff, skills, organisational culture, strategies and shared values) which you feel are preventing the DATF from performing its function of coordinating all key stakeholders responding to HIV and IADS in the district?
7. Take some time and reflect on how you as the DATF perceive your stakeholders and their practices towards DATF coordinated activities. Could you discuss what you perceive to be factors that cause them not to adhere to or perform their duties in a way that fosters coordination according to DATF expectations?
8. Why do you think they behave this way, for example why some of them do not report their activities to the DATF or why they don't participate in joint activities?
9. If you had the power what "bad" practices would you like to change and how would you propose to do this in order to improve the poor of coordination that currently characterize your DATF?
10. What last words do you have for NAC and both local and external stakeholders?

## **Annex 2: Stakeholders Focus Group Discussion (Public, Private, Civil Society) Questions**

1. The DATF has identified you as a key stakeholder, could you kindly explain what role you play in the district Multisectoral response?
2. What are your expectations from the DATF? In answering this question could you kindly explain whether or not your expectations are being met?
3. Could you share with me how you have implemented the teaching which expects district stakeholders to have one coordinating body, one strategic framework and one monitoring and evaluation framework.
4. Could you discuss what you think are the strongest points inherent within the DATF which attract your organisation to participate in joint activities coordinated by DATF.
5. Now that you have highlighted the strengths, what do you think are some critical factors inherent within the DATF (Structures, systems, staff, skills, organisational culture, strategies and shared values) that discourage you from participating or which you think are preventing the DATF from performing its function of coordinating all key stakeholders responding to HIV and IADS in the district?
6. Take some time and reflect on how you as a DATF stakeholder have behaved towards DATF coordinated activities. If you have failed to work within the framework of a coordinated response, could you discuss what you think could be practices within your organisation which caused you to behave in this way?
7. In what ways do you think other stakeholders have contributed to the failure of the DATF to coordinate the response more effectively?
8. If you had the power what “bad” practices would you like to change among stakeholders and how would you propose to do this in order to improve the lack of coordination that currently characterize your DATF?
9. What last words do you have for DATF, Stakeholders and for NAC?

### **Annex 3: Questions for Key Informant Interview - District Commissioner**

#### **Questions:**

1. Could you kindly discuss the official role of the DATF in the whole development plan of Lusaka?
2. As a key stakeholder, how would you rate the performance of the DATF relative to its mandates? Explain.
3. What is your opinion concerning the DATF composition? Suggest how you would strengthen it.
4. What is your opinion concerning DATF management systems? Are they working? Explain.
5. Being in a position where you have strategic oversight of all the sub-committees of the DDCC, including the DATF, what critical factors have you observed to have negatively affected the capacity of the DATF to perform its function of coordination? Discuss in relation to the thematic areas of the DATF strategic plan.
6. Although the prevalence of HIV in people aged 15 to 49 has gone down from 16.2% to 14.3% nationally, the prevalence for Lusaka in the same age group remains high at 21%. Could you propose an ideal DATF which you would like to see in Lusaka towards making the city free from the threat of HIV as per the HIV/AIDS Multisectoral strategic plan for Lusaka 2006-2010?
7. Do you have any questions for us?

## **Annex 4: Key Informant Interview with the Zambia Chamber of Small and Medium Business Associations (ZACSMBA) (Private Sector)**

### **Questions**

1. Could you kindly discuss what you think is the role of the DATF in the in the work of the private sector including the informal sector?
2. As a key stakeholder, how would you rate the performance of the DATF relative to its mandates? Explain.
3. What is your opinion concerning the DATF composition? Suggest how you would strengthen it.
4. What is your opinion concerning DATF management systems? Are they working? Explain.
5. Do you think DATF has engaged the private sector meaningfully? Explain.
6. Being in a position where you have strategic oversight of the private sector, what critical factors have you observed in this sector to have negatively affected the capacity of the DATF to perform its function of coordinating the private sector?
7. Although the prevalence of HIV in people aged 15 to 49 has gone down from 16.2% to 14.3% nationally, the prevalence for Lusaka in the same age group remains high at 21%. Could you propose an ideal DATF which you would like to see in Lusaka towards making the city free from the threat of HIV as per the HIV/AIDS Multisectoral strategic plan for Lusaka 2006-2010?
8. What do you think is the role of the private sector in making a contribution towards the reduction of the prevalence of HIV in Lusaka in a coordinated multisectoral response?
9. Do you have any questions for us?

## **Annex 5: Key Informant Interview with NZP+ (Civil Society)**

### **Questions**

1. Could you kindly discuss what you think is the role of the DATF in the in the work of the civil society?
2. As a key stakeholder, how would you rate the performance of the DATF relative to its mandates? Explain.
3. What is your opinion concerning the DATF composition? Suggest how you would strengthen it.
4. What is your opinion concerning DATF management systems? Are they working? Explain.
5. Do you think DATF has engaged civil society meaningfully? Explain.
6. Being in a position where you have strategic oversight of the civil society, what critical factors have you observed in this sector to have negatively affected the capacity of the DATF to perform its function of coordinating the civil society?
7. Although the prevalence of HIV in people aged 15 to 49 has gone down from 16.2% to 14.3% nationally, the prevalence for Lusaka in the same age group remains high at 21%. Could you propose an ideal DATF which you would like to see in Lusaka towards making the city free from the threat of HIV as per the HIV/AIDS Multisectoral strategic plan for Lusaka 2006-2010?
8. Could you kindly propose to be the civil society in making a contribution towards the reduction of the prevalence of HIV in Lusaka in a coordinated multisectoral response?
9. Do you have any questions for us?

## Annex 6 : Record Of Informed Consent To Conduct An Interview

**Date:**

**Interviewer:**

**UWC Student no: 2831661**

**Tel:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

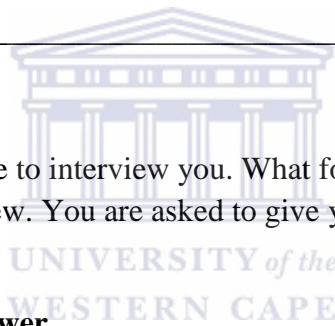
**Institution:** \_\_\_\_\_

**Interviewee's pseudonym:** \_\_\_\_\_

**Place at which the interview was conducted:**

---

Thank you for agreeing to allow me to interview you. What follows is an explanation of the purpose and process of this interview. You are asked to give your consent to me on tape when we meet to conduct the interview.



### **1. Information about the interviewer**

I am Michael Chanda, a student at the SOPH, University of the Western Cape. As part of my Masters in Public Health, I am required to conduct a research. I will be focusing on factors that impact on the capacity of Lusaka DATF to coordinate the district HIV/AIDS response. I am accountable to Professor David Sanders who is contactable at +2721 959 ... or c/o SOPH Fax: +2721 959 2872 or by e-mail at [dsanders@uwc.ac.za](mailto:dsanders@uwc.ac.za), [lmartin@uwc.ac.za](mailto:lmartin@uwc.ac.za)

Here is some information to explain the purpose and usage of my interview. This information can be exactly the same as in the Participant Information Sheet.

### **2. Purpose and contents of interview**

This study is aimed at exploring factors which impact on the capacity of Lusaka DATF to coordinate an effective local HIV/AIDS response in order to improve service delivery in the district.

### **3. The interview process**

This will be a Focus Group Discussion/One on one Key Interview

#### **4. Anonymity of contributors**

At all times, I will keep the source of the information confidential and refer to you or your words by a pseudonym or invented name which I would like you to choose. See name above. I shall keep any other records of your participation locked away at all times, and destroy them after the data has been collected.

#### **5. Things that may affect your willingness to participate**

The interview may touch on issues which might sound sensitive. If there is anything that you would prefer not to discuss, please feel free to say so. I will not be offended and there will be no negative consequences if you would prefer not to answer a question. You are also free to withdraw from this interview at any stage. I would appreciate your guidance should I ask anything which you see as intrusive.

#### **6. Agreement**

##### **6.1 Interviewee's agreement**

You will be given a consent form for you to sign if you agree to participate.

##### **6.2 Interviewer's agreement**

I shall keep the contents of the above research interview confidential in the sense that the pseudonym noted above will be used in all documents which refer to the interview. The contents will be used for the purposes referred to above, but may be used for published or unpublished research at a later stage without further consent. Any change from this agreement will be renegotiated with you.

**Signed by interviewer:** \_\_\_\_\_

**Signed by participant:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Place:** \_\_\_\_\_



**Annex 7: Consent Form for Focus Group Participation**

I have been told of this study whose aim is to explore factors that impact on the capacity of District AIDS Task Forces to coordinate decentralized HIV/AIDS services in Zambia

I fully understand that participation in this study is voluntary, without coercion and I have agreed to participate freely.

I further understand that I am allowed to withdraw from the study at any time I feel like and my withdrawal will not have any negative consequences.

I also understand that I should keep information discussed in this focus group confidential and that I should not share it outside of this discussion group. In this way I shall respect the privacy of my fellow discussants.

Participant’s signature/thumbprint .....

Date.....

Witness.....

Date.....



**Annex 8: Consent Form for Key Informant Participation**

I have been told of this study whose aim is to explore factors that Impact on the capacity of District AIDS Task Forces to coordinate decentralized HIV/AIDS services in Zambia.

I fully understand that participation in this study is voluntary, without coercion and I have agreed to participate freely. I further understand that I am allowed to withdraw from the study at any time I feel like and my withdrawal will not have any negative consequences.

I also understand that I should keep information discussed confidential and that I should not share it outside of interview.

Participant’s signature/thumbprint.....

Date.....

Witness.....



# Annex 9: Cause and Effect Analysis of High prevalence of HIV in Zambia

