

An exploration of promoters and inhibitors of coordination between organizations involved in HIV/AIDS activities in Livingstone, District, Zambia.

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A- EXAMINATION

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Promoters

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Zambia



LIST OF ABBREVIATIONS

AIDS	AQUIRED IMMUNE DEFICIENCY SYNDROME
ADF	AFRICAN DEVELOPMENT FORUM
CBO	COMMUNITY BASED ORGANIZATION
CBoH	CENTRAL BOARD OF HEALTH
CSO	CENTRAL STATISTIC OFFICE
DATF	DISTRICT AIDS TASK FORCE
FGD	FOCUS GROUP DISCUSSION
FHI	FAMILY HEALTH INTERNATIONAL
HIV	HUMAN IMMUNO DEFICIENCY VIRUS
IEC	INFORMATION EDUCATION AND COMMUNICATION
MoH	MINISTRY OF HEALTH
NGO	NON-GOVERNMENTAL ORGANIZATION
PATF	PROVINCIAL AIDS TASK FORCE
STI	SEXUALY TRANSMITTED INFECTION
UNAIDS	JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS
UNGASS	UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION
USAID	UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT
WHO	WORLD HEALTH ORGANIZATION

ABSTRACT

The District Health Report for Livingstone, Zambia, outlines an increasing prevalence of HIV/AIDS in the district. In 1998 the prevalence was at 29%, in 2000 at 30%, in 2002 at 31.8% and in 2004 at 31 %. This was above the national prevalence of 20% according to CBoH statistics of 2004.

The District has been implementing a multisectoral approach to HIV/AIDS prevention in various organizations during the past 3 years. However, despite this effort, multi-sectoral collaboration has been low. Most of the organizations implementing the HIV/AIDS preventive activities do not work collaboratively with other sectors and this has resulted in un-coordinated activities and wastage of the limited resources. A literature search has revealed that there are significant barriers in the coordination of multisectoral approaches to HIV/AIDS prevention illustrates considerable benefits in countries where multisectoral approaches have succeeded. This exploratory qualitative study aimed at understanding participants' perceptions of factors influencing coordination between different organizations that are involved in the implementation of HIV/AIDS activities, and to note the impact that this has in the implementation of activities in a multisectoral approach to HIV/AIDS prevention. The sample was drawn from 8 organizations dealing with HIV/AIDS preventive activities, covering Government departments, NGOs, community organizations including managers, HIV/AIDS coordinators and fieldworkers from each organization. The total sample size was 24 respondents. The data collection tools were in form of interviews for heads of organizations and focus group discussions for the others. Data was sorted and categorized. Generating themes were also categorized and analyzed. The study suggests that there are inhibitors and promoters of coordination between

organizations involved in HIV/AIDS activities in Livingstone district. Some of the inhibitors of coordination include inadequate coordination between organizations in the planning, implementation, monitoring and evaluation of planned activities, limited sharing of resources with various organizations, lack of authority to make decisions in the multisectoral teams, limited availability of HIV/AIDS policies in various sectors and organizations, and limited sharing of experiences with various organizations resulting in un-coordinated activities. The promoters of coordination include the involvement of stakeholders undertaking voluntary counseling and testing activities, collaboration between sectors and organizations during the World AIDS day commemoration that include HIV/AIDS activities in various sectors and organizations resulting in coordinated work. This study recommends that the district build on the current promoters of coordination while the inhibitors should be worked on in order to improve the coordination and the implementation of HIV/AIDS activities in the district. The results of the study and the recommendations developed on the basis of the findings will be published and sent to the AIDS council of Zambia.

DECLARATION

I declare that “*An exploration of promoters and inhibitors of coordination between organizations involved in HIV/AIDS activities in Livingston District of Zambia* “ is my own work that has not been submitted for any degree or examination in any other university, and that all sources I have quoted and used have been indicated and acknowledged by references.

Duffrine Chishala Chibwe

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Signed:



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1.0. CHAPTER ONE

1.1. INTRODUCTION

Livingstone is an urban District of Zambia with a population of 122,026. It has an estimated population of 92,273 people aged between 15 and 49 years. Of the total population, 85% live in urban and 15% in peri-urban areas. Livingstone has a high prevalence of human immuno virus/acquired immuno deficiency syndrome (HIV/AIDS), and like many other towns in Sub-Saharan Africa, Livingstone is endeavoring to control the HIV/AIDS pandemic through a multisectoral approach.

The purpose of a multisectoral approach is to ensure that prevention and treatment efforts target the entire population, addressing the causes of HIV/AIDS through the involvement of various sectors of society at all levels, following the approach adopted at the United Nations General Assembly Special Session (UNGASS) of 2000. This approach should be achieved through joint planning and implementation of preventive activities, pooling resources, exchange of information, ideas, opinions, experiences, and understanding of the policies (UNGASS 2000).

Policy guidelines on HIV/AIDS in Zambia provide the framework for all sectors to engage in a multisectoral approach. These include Government Ministries, private sector and civil society. However, although various stakeholders have undertaken a considerable amount of work, the Minister of Health notes in the National Policy Paper on HIV/AIDS/STI/TB that the actions and initiatives to-date have not significantly reduced the HIV/AIDS prevalence levels (MoH 2002). Suggested reasons for the lack of success include poor coordination of potential resources, inadequate time, insufficient

networking, and inadequate understanding of a multisectoral approach to HIV/AIDS prevention activities.

The purpose of the study was to explore with the stakeholders what the promoters and inhibitors of coordination are between organizations involved in HIV/AIDS preventive activities. It was hoped that by conducting various interviews with managers, HIV/AIDS coordinators and field officers, the relevant issues would be identified which would assist the various organizations improve in their coordination of HIV/AIDS activities in the district.

The study begins with literature review. It provides an overview of HIV/AIDS activities in sub Saharan Africa and other parts of the world. It also looks at the broader aspect of the multisectoral concept in the introduction, purpose of multisectoral approach to HIV/AIDS prevention and how this has worked in other countries. Barriers to coordination in other countries have been looked at as well as some case studies on joint working basis to assess the impact it has on coordination.

The literature review has been followed by a section on methodology that discusses the design of the study and the ethical issues that were followed in the field. The interviews and focus groups are discussed and analyzed in a section of the thesis. Lastly, conclusion and recommendations have been made on the findings of the study.

1.2. BACKGROUND INFORMATION

The Human Immunodeficiency Virus and the Acquired Immunodeficiency Syndrome (HIV/AIDS) has become a global epidemic; killing more than three million people in 2003 (UNAIDS 2004). It is estimated that 40 million people are reported to have been living with HIV- virus, and 16.4 million lives have been lost due to the disease. Out of those living with HIV/AIDS, 25.3 million are from Sub Saharan Africa (UNAIDS/WHO, 2000). There are also a growing number of orphans, estimated at 13.2 million world wide, of which 12.1 million are from Africa (UNAIDS/WHO, 2000). In Zambia, 20 % of adults aged between 15-49 years were living with HIV/AIDS. By June 2000, 830,000 people were reported to have been living with AIDS as stated by Central Board of Health (CBoH, 2002). Some of the factors accelerating the epidemic include social economic and cultural factors.

The 2003 Strategic Framework for Zambia states that HIV/AIDS infection is transmitted primarily through heterosexual contact and perinatally through mother to child transmission (CBoH, 2003). Other significant mechanisms of transmission include contaminated blood and re-use of needles. Since the first case of HIV/AIDS in 1984, the Zambian government has initiated interventions and strategies to prevent and control HIV/AIDS through the formation of the AIDS Prevention Council in 1986. The strategies and interventions include multisectoral collaboration, advocacy, laboratory support, and home based care. Despite the above measures, the prevalence of HIV/AIDS is still high (CBOH, 2002).

Zambia is one of the most urbanized countries in Sub Saharan Africa. It is a land locked country covering an area of 752,612 square kilometers with a total population of about 10.3 million. More than half of the population is over 15 years old. Most of the population lives along the line of rail that stretches from the Copperbelt to Livingstone where the prevalence of HIV/AIDS is high.

Livingstone District lies in the southern part of the country. The Zambezi River forms the southern international border with Zimbabwe. Being a border town, a transit point for truckers, fishmongers, business people and a tourist capital, Livingstone attracts a lot of people that might predispose them to sexually transmitted infections (STIs). Livingstone has one of the highest HIV/AIDS rates of 31% that is above the national figure of 20% (CBoH 2002). In the early 1990's most of the companies and factories closed down and most of the people were left unemployed with no other source of income. This in turn resulted in creation of shebeens, an increase in the number of commercial sex workers (Prostitutes) and poverty among the local community. The district in the past years conducted various activities at community, health facilities and organizational levels. These activities included Voluntary Counseling and Testing, education and communication on prevention of HIV/AIDS, syphilis screening, Prevention of mother to child transmission (PMTCT) of HIV/AIDS, Case management, advocacy, and condom distribution to try and reverse the epidemic. However, despite of all these efforts, there has been no coordination of these activities resulting in failure to adequately reduce the prevalence of HIV/AIDS hence the need for this research to be carried out.

2.0. CHAPTER 2

2.1. LITERATURE REVIEW

2.1.1 INTRODUCTION

The vision of government has been to prevent and control the spread of HIV/AIDS, promote care for those who are infected and affected, reduce personal, social and economic impact of the epidemic. This has to be done through guiding principals of legal and policy framework, promotion of integrated approaches that are people centered, culturally and priority centered. Although various stakeholders have already done a lot of work, the actions and initiatives to-date against the epidemic have not significantly reduced the prevalence levels. To this effect the government has established a multisectoral body the National AIDS Council using the partnership approach, (CBoH, 2002). Zambia's context of dealing with HIV/AIDS epidemic has a comparative advantage under the intervention strategy. It has a reception population, an established health care system and civil society structures that can be found at the community level. In other countries, a multisectoral approach to HIV/AIDS prevention has resulted in positive results where it has been implemented. Success has been through a comprehensive and holistic approach. In addition, political commitment through political leadership has been enhanced resulting in reduced prevalence rates.

Therefore, in this chapter, I am going to look at literature in sub Saharan Africa and countries in other parts of the world that have implemented a multi-sectoral approach to HIV/AIDS prevention. These will include the purpose of a multisectoral approach, the

barriers experienced, collaboration requirements/ efforts and how other countries succeeded in the approach and its benefits

2.2. Purpose of a multisectoral approach to HIV/AIDS prevention

The magnitude of the HIV/AIDS pandemic, the severity of its impact and the inadequacy of purely health-based responses have prompted national, bilateral and international organizations alike to adopt multisectoral responses to contain the spread and mitigate the effects (Hemrich et.al. 2000). As the pandemic continued to evolve in the 1990's and its efforts became increasingly cross cutting, there was a realization that the health sector alone could not respond to the ranging social economic consequences and manifestations. Therefore, a shift from a medical to a multi-sectoral, participatory approach that enhances coordination between different sectors/organizations has been advocated. The purpose of multisectoral approach to HIV/AIDS prevention and control is described as ensuring that prevention and treatment efforts are targeted at the entire population, addressing the causes of HIV/AIDS through involvement of various sectors of society at all levels (UNGASS 2000). Furthermore, the approach needs fundamental shifts from administrative cultures, in government, NGOs and UN agencies in processes that overlap i.e. multisectoral approach, decentralization, community empowerment and mobilization of resources. This will ensure that all stakeholders willing and able to help at local level are involved in activities to develop a strategic plan based on bottom up approach. In this multisectoral approach, the actors must include NGOs, development partners such as United Nations (UN) and the private sector (UNGASS 2000).

A review of progress and challenges in other African countries shows a mixed picture. In South Africa an HIV/AIDS campaign reveals that in 1994, South Africa developed a multisectoral HIV/AIDS plans based on international and local experiences. This was supported by all major constituencies (Kenyon et.al. 2001). However, despite the existence of this well thought out plan, sufficient time, a large economy to draw on, a reasonable pool of skilled health and education workers and a sophisticated media, Kenyon found that these policies and laws have not been implemented and therefore, they have not impacted significantly on the ground. Kenyon further states that factors responsible for these include poverty and inequality, restructuring of public sector at every level, high staff turn over, failure to mainstream HIV/AIDS at all levels of society, and a lack of effective leadership. This latter aspect is important as it is against the UNGASS declaration which indicated that the first action required to mount an effective response to the epidemic is development of a “strong leadership at all levels of society”. Therefore, despite the comprehensive HIV/AIDS plan that focuses on a multisectoral approach; there has been a continuing increase in the prevalence of HIV/AIDS in South Africa, an indication of inadequacy in the implementation of the plan. Uganda, under the leadership of Museveni is good a example of the importance of political leadership in helping a country make a mindful shift (Kenyon et.al. 2001).

Although all-high prevalence countries in Sub-Saharan Africa have policies, strategies or mechanisms established for multisectoral approaches in most countries have not fully implemented a multisectoral approach (ADF 2003). The HIV/AIDS policy guidelines in Zambia emphasize coordination and collaboration through integrated programmes that

seek to foster the development of inter-sectoral approaches (CBOH 2002). These encompass government ministries, the private sector and civil society, who need to develop multisectoral approaches for their prevention and control interventions and activities. This partnership approach requires effective coordination of policies and activities in each of these different sectors in order to ensure complementarity in activities and avoid inefficient use of limited financial and human resources as described in the National HIV/AIDS/STI/TB Policy (2002).

However, in South Africa, the National Policy has a national integrated plan that encompasses a government multisectoral response and is guided by a steering committee of heads from three national sector departments (Health, Social Development and Education). Yet despite this, coordination between these sectors remains problematic due to lack of data on multisectoral responses from these sectors. This was described in an HIV/AIDS comparative report of four countries (SANAC, 2004)

A study to ascertain levels of awareness about HIV/AIDS policy in Zimbabwe demonstrated additional problems. Here it was found out that there was a current belief among NGOs that policy documents are little more than rhetoric and that policy awareness and availability was limited and differed amongst NGOs (Zimbabwe AIDS Network, 2003). In this study, civil society, Zimbabwe AIDS association membership, government respondents from national to community level were interviewed. The results show that there was inadequate information and limited response to the policy subject and that there was weak policy advocacy, dissemination and distribution strategy in

place. This in turn affected the implementation of activities, despite the presence of national guidelines due to limited awareness of their existence. Furthermore, there exist poor capacities among civil society to engage in HIV/AIDS programming. As a result, only traditional players (health related NGOs) were implementing the AIDS policy, and these were in a fragmented and un-coordinated manner. HIV/AIDS civil society development program implementers suggest the need for increased mainstreaming and incorporation of HIV/AIDS activities in existing developmental programs. The study was suggestive of a “top-down” approach to policy formulation and strategic planning for policy implementation, consultation, participation and involvement of key civil society stakeholders in the on going national policy implementation, monitoring and evaluation.

The United Nations has attempted to adopt a multisectoral approach in Sub Saharan Africa by mainstreaming HIV/AIDS work with seven co-sponsors (Ala, 2001). . However, a major problem identified is coordinating HIV/AIDS policy among the sponsors, as each organization has a different agenda and different focus (Ala, 2001). Ala further states that although these countries can make an impact on the epidemic by wisely employing their resources at their disposal, their financial and often their technical resources are limited. Thus to sustain the fight against HIV/AIDS in sub Saharan Africa, it is imperative that the international community, or more broadly speaking civil society, renders as much mutual assistance as is possible.

According to a study in Botswana that sought to investigate the responses of corporate sectors on HIV/AIDS epidemic, the study revealed that only a few organizations had policies on HIV/AIDS (Lengwe et al 2003). However, these policies were on HIV/AIDS but not specific multisectoral policies. This was similar to the situation in Zambia where there is a national HIV/AIDS multi-sectoral policy with various activities laid down. None of the organizations had a multisectoral policy in Livingstone. Instead, they have organizational policies that vary from one organization to the other. Therefore, they have different guidelines on implementation of activities as well as the utilization of funds. This has resulted in the fragmentation of activities by various sectors and organizations as they have to follow specific organizational guidelines. However, policy alone is not enough, you need leadership and coordination in the implementation of the policy (USAID, 2004)



2.3. Identified barriers in other countries

The second consultative meeting on re-thinking on HIV/AIDS and development in Africa stated that the most serious obstacle to multisectoral HIV/AIDS efforts is weak coordination between sectors and donors (World Bank, 2002). The African Development Forum (ADF, 2000) states that there are various factors affecting the response to HIV/AIDS prevention and control. These factors include the lack of coordination of interventions with no clear picture of who is doing what, what worked, and what did not work. There are also difficulties in establishing partnership and collaboration arrangement. Currently, the impact on the epidemic at all levels is compromised by fragmentation. Different actors pursue agendas in isolation from each other, instead of working within nationally negotiated and agreed strategic agendas. Actors whether

Government or NGOs, and private have tended to address HIV/AIDS with their own objectives, management, and monitoring systems (ADF, 2000). The forum further states that all sectors should work together, be creative in providing expertise and support each other. Involvement of all sectors leads to wider coverage of population, especially people at grass root level.

Other regions display a similar pattern. A study on HIV/AIDS conducted in Southern Asia in different organizations by Kamala Sarup (2006) also revealed that there is still lack of coordination between NGOs and governmental organizations and that political commitment is lacking. The researcher emphasizes the need for a multisectoral approach to HIV/AIDS prevention so that the HIV/AIDS crisis could be reduced. This, she argues, could be achieved through involvement of different sectors and organizations in the planning, design and implementation of HIV/AIDS preventive programs at national, provincial, district and local community levels.

A comparative report of four African countries (SANAC 2004), Kenya, Mozambique, Namibia and South Africa on funding the fight against HIV/AIDS, found that all countries had adopted a multisectoral approach. All the countries had coordinating bodies but these varied in roles, responsibilities, and authority. The report further states that all the countries have their national AIDS council secretariats in the Ministry of Health offices. This makes it difficult to control programs in other sectors. For example, in Namibia, AIDS coordinators within the regional departments of health find it difficult to coordinate HIV/AIDS activities with other departments, resulting in health dominated

and fragmented responses, while South Africa reported that although offices are located in the office of the Deputy President, the secretariat is within the department of Health. This limits multisectoral coordination, so that coordination between sectors remain problematic. Some of the reasons include lack of data on allocation of resources and of multisectoral responses by various sectors resulting in duplication and fragmentation of services as stated by the South Africa National AIDS Council (SANAC, 2004). The countries require a more comprehensive, accurate, timely and accessible data from all relevant ministries and departments if multi-sectoral responses have to be properly coordinated to avoid duplication

In an article that examined the operational status, implication and constraints of multisectoral responses to HIV/AIDS programmes in South Africa (Hemrich, et.al. 2000) it was found that cross sectional nature of the epidemic is today acknowledged by all sectors. Hemrich et al further state that the agents involved in HIV/AIDS control and multisectoral responses are widely advocated by the national AIDS council and donors. Moreover, the quality of response of non-health ministries is not clear and it has not been assessed in depth to date. They further state that the institutions promoting multisectoral responses encounter formidable structural, logistical and policy constraints, such as the absence of multisectoral policy mandates on HIV/AIDS in donor institutions, which result in difficulties in the implementation of activities. The absence of a cross-sectoral policy mandate on HIV/AIDS control programmes lack the necessary backing and mechanisms to effectively influence strategies and activities within their own institutions. Hemrich et al continue to say that the sectoral based government structures affects

implementation of multisectoral programs given the sectoral hierarchical set up of governments in many developing countries. National Aids Council programmes embedded in ministries of health may not have the instruments and lines of command to involve ministries in other sectors. However, Hemrich et al (2000) emphasises the importance of cross sectoral nature of HIV/AIDS prevention in the country level policy and that strategy documents could assist non-‘health’ projects to participate in the response of epidemic more actively. Existing HIV/AIDS coordinating committees have not always succeeded in bringing about a sustainable integration of HIV/AIDS activities in non-health sectors. They however advised that various sectors should harmonize their activities considering that there are structural, logistical and policy issues involved. In a progress report on declaration of commitment on HIV/AIDS prepared for UNGASS by the Republic of South Africa (Shaun, 2006), the challenges to common public sector partners identified include absorption capacity, inadequate funds, and fragmentation of programs

According to a concept paper (AIDS Commission, 2003) on the National Strategy for HIV/AIDS information and knowledge management in Uganda, the multiplicity of actors demand consistent, relevant and timely information work to ensure focus on common goals. The existence of actors at different levels and in different settings also poses the challenge of processing and packaging the same information differently (AIDS Commission, 2003). The paper further state that there is limited capacity (human, financial, and structural) at organizational level to document experiences and promote knowledge sharing among actors. Furthermore, there is lack of appropriate forum for

sharing such knowledge. There is also fragmentation of information management that create potential for duplication efforts and wastage of resources. The paper also state that there is inadequate physical information delivery system at all levels that could be exploited for information access and sharing. Consequently, many actors are not aware of the existence of needed information sources and appropriate channels of communication. This was also a concern by many actors in the study discussions in Livingstone.

A final report for AIDS program in Thailand by Family health International (FhI, 1991-1996) stated that districts rarely convene meetings and that there was lack of participation from the private sector. Meetings were monthly, bi-monthly and health staff dominated the meetings. The report however advises members to meet regularly, and notes the need for strengthened activities.

A situation analysis conducted for National Strategic Plan for CBOH, (2002-2006) found that the past strategies were found to contain shortcomings that have impacted on the epidemic and that there is inadequate mobilization of truly multisectoral responses. Various sectors were under utilized in the planning and implementation of HIV/AIDS activities and there was insufficient capacity building (World Bank Report MOH 2000). Even the ministries that have understood the importance of HIV/AIDS have not made adequate resources available for implementing multisectoral programs in Africa (Helfenbein & Severo, 2004).

However, multisectoral responses are recognized as being difficult. A review of multisectoral responses to HIV/AIDS nutrition program that involved various sectors in Uganda (USAID, 2003) found that maintaining momentum through out the process is difficult. Especially noted was the maintenance of involvement and ownership by various stakeholders. Engaging the district and community partners in taking the lead to apply the multisectoral process (facilitating, coordinating, funding, monitoring, and evaluation) requires considerable work. Improved nutritional care and support was found to take a long time if developed through top down process from policy makers and managers. The report emphasizes the need to design monitoring and implementation plans and on-going sensitization of stakeholders. Capacity building at different levels is also required, involving the main stakeholders from the start resulted in improved multisectoral collaboration and dialogue. If adhered to, these may contribute to sustainable programs. Furthermore, the National AIDS control program, as well as stakeholders, must find ways to engage and motivate district and communities to apply national guidelines to their reality. The process in Uganda serves as an example. It has brought together stakeholders from different sectors and built consensus that nutritional support is important and that national guidelines are necessary for all sectors (USAID, 2003)

The study of cooperate sector in Botswana found that 76% of the respondents indicated that their organizations cooperated with other organizations in information, and HIV/AIDS campaign program design (Lengwe, et.al. 2003). Lengwe et.al. advises that unless HIV/AIDS activities are mainstreamed into organizational structures, the

cooperate sector will not be effectively involved in the fight against HIV/AIDS and there by fail to make major contributions to the multi-sectoral effort.

Although increasing numbers of countries are engaged in designing multisectoral programmes, real commitment to comprehensive approaches to HIV/AIDS prevention remains low (Cohen, 2003). Cohen states that one of the puzzling factors in many countries is the absence of commitment and leadership. Joint planning has been described as largely been pragmatic and opportunistic, a definite example of “muddling through” (Hudson, 1997). Hudson further states that the challenge in coming months /years is building capacity of different sectors, maintaining that capacity, monitoring their activities and providing relevant feedback

The constraint to collaboration is not unique to HIV/AIDS. A case study to assess interaction between communities and statutory sector authorities in two Health City Projects, one in the UK and one in South Africa, revealed that there are inherent tensions within multisectoral partnerships (Stern & Green 2005). Barriers included limited levels of community involvement, limited financial capacity, time constraints, and rigid allocation of funds according to departmental boundaries. These have resulted in frustration, disappointment and increasing levels of mistrust between the partners. Another research report in the UK, on collaboration between the Health authority, the City Council in Liverpool and a range of other partners reinforced these finding, revealing that community groups did not attend joint health planning meetings regularly. The involvement of business sector was difficult due to inadequate time and no benefit

for them. The research further revealed that the quality, personalities, status of the participants affected the joint working as decisions which needed to be made required the input from influential people, while it was junior staff who attended the meetings (Costongs and Springett, 1995). Furthermore, communication and time constraints complicated and restricted effective joint working and there was hardly any communication between groups, who often received second hand information that was not complete. All groups frequently reported the problem of time constraints.

2.4. Collaboration requirements / efforts

In order for various organizations and sectors to work together, there is a need for open and visible communication structures that will increase trust and reduces potential conflict (Nutbeam, 1994). Good leadership is required to build and improve joint working as a catalyst for action (Dluhy, 1990, Zapka et.al.1992, Kumpfer, et.al. 1993). Clearly defined roles facilitate multi-sectoral collaboration and synergy (Cohen, 2003). If sectors work together, they can be creative in providing expertise and support to each other (ADF2000). In order to ensure effective coordination between many organizations/sectors, all actors in these sectors must be provided with training, financial resources, material and other in puts. Because of limited resources, priorities have to be clearly agreed focusing on a core set of activities in prevention and care which have been proved effective and feasible. Effective inter-sectoral action depends on power, mandate of organizations, commitment, and skills of individuals (Springett, 1996). Springett further states that unless individuals who are engaged in inter-sectoral actions have active support of their own organizations, it is unlikely that sustainable change will be possible.

Even the most knowledgeable, skillful individuals often fail if their organizations do not support their work with other sectors or organization (Harris et.al 1995). Harris et al further state that conversely, an organization that is well prepared and highly motivated to work with other sectors to promote health will succeed only if it ensures that the people leading and managing the process have appropriate knowledge, skills and resources to do so. Sectoral strengthening is essential for inter-sectoral activities. To date, sectors that have shown progress and results had champions who tried to mobilize resources and make special efforts to address HIV/AIDS issues in that particular sector (Ishrat & Renuka 2002). Ishrat and Renuka further state that coordinated and concerted efforts will make a difference. Multisectoral efforts require strong coordination mechanism for various sectors to work together to obtain synergy. In addition, concerted efforts by different sectors will yield results. This again requires different organizations and sectors to have common targets areas or groups in which to work. Similarly, in view of funding shortages, coordination among donors for multisectoral work will be important (Ishrat & Renuka 2002).

Maintaining partnerships have been found to depend upon constant re-appraisal, direct and frequent contact between partners involved in joint working (Nutbeam, 1994). The importance of investigating the added value of joint working in achieving health gain is stressed by Nacon et.al (1993). The desire to strengthen the multisectoral approach in the fight needs to be encouraged (CBOH 2002). Organizations will certainly be prepared to share resources i.e. time, information or human capital and give up power in joint

working if they are aware of likely benefits of it as (Otole, 1988, Dluhy 1990, Delaney et.al. 1993)

Therefore unless multi-sectoral response is endorsed at the highest level of government, as it has been in Uganda and Thailand, field level activities are likely to remain an act of good will (Hemrich et.al 2000). In South Africa, a partnership forum has brought different sectors together in order to implement the national HIV/AIDS strategic Plan. The Challenge in the coming months and years is building capacity, monitoring their activities and providing relevant feedback.

The success of HIV/AIDS prevention efforts must be multi disciplinary and multisectoral in order to confront the pandemic for what it is. The global response to HIV/AIDS like many other diseases has evolved overtime, but it is clear that our response to date has not been effective at halting the spread of the pandemic (Calderon, 1997). Calderon further states that the social economic and health problems cannot be cured with vertical, isolated, un- coordinated and un-integrated approaches or responses. Instead, a truly integrated and long-term multisectoral response is required.

The policy guidelines on HIV/AIDS by the united Agency for International development (USAID, 2004) proposes to operationalize a multisectoral response through policy dialogue with key top level and grass roots decision makers. The multisectoral approach requires the mobilization of groups that may not normally work in collaboration at the country level, key ministries such as education, agriculture, planning, defence, finance

and health will be consulted on impact in order to explore with them possible opportunities for HIV/AIDS prevention and control and that municipalities and community level government must be included in this effort.

Successful programs draw on experiences of others, benefiting from collaboration about “good practices” and “knowledge management” about what works and why, can facilitate program implementation and capacity building. These requirements are noted in the guidelines for implementing multisectoral programs in Africa (Helfenbein & Severo, 2004). The guidelines further state that the challenge is not to create new knowledge but to share existing, relevant knowledge more effectively among program coordinators and implementers, all of whom are overloaded with work and information. Partnerships involves sharing power, responsibilities during program design and implementation, not always easy for organizations used to being dominant in their fields.

The National HIV/AIDS programs should be strategic, and prioritized as described by Zewdie in the World Banks Report (2005). Zewdie, (2005) also states that there are management and implementation constraints. He emphasizes on stronger strategic planning, prioritized national planning to build monitoring and evaluation capacities at all levels and improve HIV/AIDS knowledge and its use, and work closely with various partners for stronger harmonized AIDS responses.

A final AIDS report in Thailand for AIDS program (FhI, 1991-1996) states that the process of holding meetings and round table discussions, coordination was improved and

relationships strengthened in the multisectoral activities. Coordination efforts were creatively visible in Thailand NGO coalition on AIDS. All implementing agencies took part in trainings, meetings or informal coaching dealing with technical skill building, HIV/AIDS updating sessions and reviews, and training out reach workers. They also developed strategic plan, developed monitoring system, participated in report writing.

2.5. Success stories

It is, however, possible within the constraints to achieve success, as has been shown in two countries i.e. Thailand and Uganda. Thailand's success has been due to development of joint plans for prevention of HIV/AIDS (Hollertz, 2001). This was through promotion of enabling environments, and the holistic approach to HIV/AIDS prevention. Thailand also involved community leaders, community hospitals, social welfare services, schools and churches in prevention, and community participation with good governance (Hollertz 2001). Success is also attributed to the strong political commitment through political leadership heading AIDS committees. They raised public awareness about the disease through information education and communication. There has been an increased political momentum from Prime Minister down, together with an increase in the availability of resources at all levels. A coordination center was founded and the community has been involved from the beginning in the planning its activities. Later, the regional, health authorities, NGOs and Thailand's HIV/AIDS Positive People Networks joined the community. Thailand's success shows a comprehensive prevention approach. Hollertz (2001) further states that the country's multisectoral approach to HIV/AIDS has resulted

in the drop of new infections by more than 80% from about 142,819 new infections annually during the peak in 1991 to 23,676 in 2002.

Initial indicators in Uganda, a country severely affected by HIV/AIDS epidemic, are that the prevalence is declining as a result of concerted efforts by Government, NGOs, National AIDS control programme, religious organizations, communities and individuals to stop the spread of HIV. Early and significant mobilization of Uganda is a result of multisectoral responses and diverse community participation (UNAIDS 2004). There have been well-coordinated activities in different ministries, through strengthened participation and governance. In addition, there has been a strengthened management capacity of key sectors, followed by operational plans, and the National Strategic Framework activities (2000-2006). These are inter-sectoral plans involving all relevant ministries such as Education, Health, Agriculture, Defence, Gender and Information. The plans also empowered communities to assess and monitor local responses to HIV/AIDS activities (Ishrat and Renuka 2002). All organizations and sectors are engaged in coordinating a multisectoral approach to HIV/AIDS prevention through joint planning, joint monitoring and evaluation and information sharing. There has been specific mass campaign at grass root level and education health networks were established throughout the country. Between 1990-1995 HIV infection decreased by 29%. Data shows that in three sentinel sites, infection levels diminished by 35% in young women i.e. 9% and 5%, representing one-fifth from 1995 levels (Calderon 2001). The government has not only provided services such as education and blood screening across the country but has also more interestingly implemented a uniquely creative and strategic policy approach to enable non-state actors in their individually target messages on prevention. The openness

of Uganda's joint approach that is often mentioned is that the Ugandan Government included religious groups and NGOs in policy recommending bodies i.e. Uganda AIDS commission which has resulted in cooperative links has enabled wider participation between governmental and non-governmental organizations (Sakboon, 2003). Furthermore political leadership of President Museveni points to the benefit of a national commitment to addressing HIV/AIDS through all available channels (and got involved him in all HIV/AIDS programs in the country). Uganda has demonstrated that early, consistent, and multisectoral control strategy can reduce both the prevalence and incidence of HIV infection a (Sakboon, 2003)

Another good example is Latin America (Brazil) where a multidisciplinary AIDS care team of enhancing care initiative (ECI) has adopted a comprehensive approach to health needs and disease management. The team was defined by experts from diverse fields of knowledge who worked together to build a shared efforts for enhancing care. Several members are affiliated with AIDS services, advocacy and NGOS. In this way, Universities, state, municipal health programs, NGOs and People living with AIDS (PLWA) groups all play an important role in shaping the ECI. The team conducted a situation analysis, developed objectives, designed a study protocol to understand the psychosocial needs of adolescents and needs of women living with HIV/AIDS, and implemented the research together. The results assisted them to plan and monitor activities together as a team. The team plans to extend beyond Brazil (<http://www.eciteam.havard.edu/teams/Brazil>)

In conclusion, most studies conducted are outside Zambia, and reports indicate that there are difficulties in establishing partnerships and collaboration arrangements between organizations (ADF, 2000). Yet, as noted, some countries have had some success. The lessons from these countries show that there are many factors influencing coordination on the implementation of a multisectoral approach to HIV/AIDS prevention. The countries that have succeeded involved different sectors, organizations, and communities from initial planning, implementation and monitoring of activities, strengthened their capacity, and they also had joint multisectoral plans yet in Livingstone, there is no joint planning, implementation and monitoring of activities. The Minister of Health in Zambia notes in the national policy paper on HIV/AIDS/STI/TB that although various stakeholders have undertaken a considerable amount of work, actions and initiatives to-date have not significantly reduced the HIV/AIDS prevalence levels (MOH, 2002). Suggested reasons for the lack of success include poor coordination of potential resources, inadequate time, different organizational objectives, insufficient networking, no joint planning, and inadequate understanding of a multisectoral approach to HIV/AIDS prevention. It is for this reason that this research was conducted in order to determine perceptions of different organizations on the implementation of HIV/AIDS preventive programmes across the sectors, explore promoters and inhibitors of coordination between different organizations and note the impact this has in the implementation of HIV/AIDS activities in a multisectoral approach to HIV/AIDS prevention.

CHAPTER THREE

3.0 STUDY DESIGN AND METHODOLOGY

3.1. Introduction

Research methodology is defined as the procedure, styles and ways of collecting and analyzing data in a research (Polit, Beck & Hungler, 2001:465)

Chapter two presented literature review of this study. The related literature on implementation of a multisectoral approach to HIV/AIDS prevention, the purpose of a multi-sectoral approach, the barriers experienced, collaboration requirements/ efforts and how other countries succeeded in the approach were assessed and discussed.

In this section, I have briefly outlined the aims and objectives, advantages and limitations of the selected methods, the sample and the research setting, the selection of participants for the interviews has been discussed, the specific tools used and the considerations relating to validity. The procedure of administering the interviews, the ethical considerations, and ways of collecting and analyzing data in a research investigation has also been discussed. The qualitative method was chosen as it provided rich in depth data about real life issues, and the importance people attach to their experiences with the respect to the topic of study. A qualitative study was used to gain new perspectives on things about which much is already known and gain more in depth information on that which may be difficult to convey quantitatively (Hoepfl, 1997). In addition, qualitative study has an interpretive character aimed at discovering the meaning that events have for the individuals who experience them and the interpretations of those meanings by the

researcher. The research uses natural settings as sources of data and attempts to observe, describe and interpret settings as they are. Maintaining what Patton calls empathic neutrality (Patton, 1990)

3.2. AIMS AND OBJECTIVES

3.2.1. AIM

To assess the factors influencing coordination between different organizations involved in HIV/AIDS activities in Livingstone, and to note the impact this has on the delivery of multi-sectoral HIV/AIDS programmes.

3.2.2 OBJECTIVES

1. To determine the perceptions of different organizations on the coordination of HIV/AIDS preventive programmes across the sectors.
2. To explore the promoters and inhibitors of coordination between organizations involved with HIV/AIDS prevention and note the impact of these factors on the implementation of a multi-sectoral approach to HIV/AIDS prevention.
3. To develop and share a set of recommendations to strengthen coordination across the sectors and programmes, and feedback to relevant stakeholders

3.3. Study design

The research was an explorative qualitative study, focusing on factors assumed to be promoters and inhibitors of coordination between different organizations involved in

HIV/AIDS activities. A qualitative research is a systematic approach used to describe the life experience of the individual and give meaning to the subjects as described by Burn & Groove, (1993:277). The design clearly defines the purpose, and the methods or approaches that were used to generate valid and reliable data.

3.4. Research setting and study population

The study was conducted in Livingstone District, one of the 11 Districts in Southern Province. The research setting was a physical location in which data collection took place. The study populations were Government Departments, NGOs, and community organizations dealing in HIV/AIDS preventive activities.

3.5. Sample

Purposeful sampling was used as it is a non-probability sampling method in which participants from organizations dealing with HIV/AIDS preventive activities were purposefully selected so that their in-depth information would provide optimal insight in the issues from those who have the best possible knowledge, experience or overview of the topic of study. The aim was to capture and describe the central themes or principal outcomes that cut across a great deal of participants or program variations. The sample was of managers, HIV/AIDS coordinators and field officers from each of the Government Departments, NGOs and community organizations selected. There were 8 organizations, making a total sample of 24 respondents i.e. 3 from Governmental organizations including health sector, 2 from the community organizations, and 3 from Non-Governmental Organizations. There were 8 interviews of managers, one from each organization, and two focus group discussions (FGD) comprising of HIV/AIDS

coordinators for one FGD and Field Officers for the other FGD. The organizations and sectors selected had been working in the area of HIV/AIDS for some years. Therefore, they had enough experience on the topic of study.

3.6 Data collection methods and tools

Information was collected through semi-structured interviews and focus group discussions. The researcher approached all the respondents. She gave an outline of the purpose and aims of the study. Individual appointments were made in each organization for the interviews as well as the focus group discussions and permission was sought from the participating organizations. Interviews were conducted at each organization. All the interviews were conducted in English so an interpreter was not necessary. A semi-structured questionnaire was used to guide the interviews, and a facilitators guide for the focus groups. Both covered the same issues, and included probing questions to go more deeply into issues of interest raised on the perceptions, promoters and inhibitors of coordination between organizations involved in HIV/AIDS activities. Heads of each organization were invited to be interviewed. In each interview, and focus group discussion, permission was sort to proceed with the interview. Detailed notes from the responses were all kept and checked later after the interviews each day. These field notes were later used along side with the focus group transcripts in the analysis of the study. Focus groups were chosen as a method of data collection, as they are valuable in enabling respondents to build on each other's comments. The HIV/AIDS coordinators and field officers took part in the focus groups.

3.7. Data collection

A pre-tested semi-structured questionnaire and facilitators guide for the focus group were used to capture information. This required each respondent to answer questions according to their own understanding, perception and experience on the real situation on coordination of HIV/AIDS activities. The Researcher reviewed the tools for data collection before the start of the study. This was done in two organizations i.e. one NGO and one community organization. This enabled the researcher to develop interview skills and techniques, determine respondent's likely responses, and assess acceptability and applicability of research questions. The researcher did the pilot. The data collected from the two pilot organizations were similar to the data collected in the actual study. There after, researcher collected data, and conducted 8 interviews and led the two focus group discussions. Respondents were urged to ask questions when they were not sure of the questions and also give honest answers. The data collection was done in February 2006 in 8 organizations involved in HIV/AIDS activities in Livingstone district, Zambia using an interview guide containing open-ended questions. An assistant researcher was trained to take notes during the focus group discussions as a second source of data collection. He was trained on how to record data. These were transcribed and used for the data analysis.

3.8. Validity

Validity refers to the degree to which an instrument measures what it is supposed to measure (Uys, and Basson, 2000). I ensured that validity was achieved using triangulation of data collection methods, i.e. interviews and focus group discussions; triangulation of data collection sources i.e. managers, HIV/AIDS coordinators and field

officers. The data was also compared and checked against the literature. The use of transcripts enabled accurate recording of the data and the notes taken by the assistant researcher during the focus groups was compared with the transcripts. Data was also checked thoroughly by the supervisor of the researcher, who ensured that literature searched was on the topic of study and checked the procedure of administering the interviews. The ethical considerations and ways of collecting and analyzing data in a research investigation to ensure that they have been discussed and have been informed by the literature were undertaken (Polit, Beck and Hungler 2001:465). The researcher also fed back to the respondents after data analysis, checking that they agreed with what was recorded in the findings of the study. The feedback sessions confirmed that the information presented in the study was in line with what was discussed in the interviews and focus groups.

3.9. Data analysis

This refers to a process through which qualitative findings are built from original raw data (Patton, 1990). It is a form of “conceptual scaffolding” within which the structure of analysis is formed and it is a continuous and iterative process, as described by Glaser (1992). The goal was to create descriptive, multi -dimensional categories that formed a preliminary framework for analysis. Themes, categories and sub-categories were grouped and concepts generated under which data was labeled, sorted and compared. Re-examinations of categories identified were then done to determine how they were linked in order to get more explanations and recurring themes, using a process recommended by Straus and Corbin (1990). Words, phrases or events that appeared to be similar were

grouped into the same categories. The analysis involved drawing together and comparing discussions of similar themes and examining how these relate to the variation between individuals and groups that assisted in understanding the phenomenon of interest. Finally, researcher translated the conceptual model into the story line that will be read by others

3.10. Limitation

The study, as a qualitative study, is by nature small. This means that only a small number of organizations were included in the study and so the findings cannot therefore be generalized. In addition, all organizations are different from each other, so the sample is heterogeneous. This also means that the individual cases are different from each other.

A second limitation is that confidentiality in focus group discussions cannot be guaranteed, although the confidence shared in the group was respected.

Being the researcher and a well-known person in the district had both advantages and disadvantages. The disadvantages are that as someone who works in the field, I may bring to the research my own interpretations, and therefore may be introducing an element of bias. I endeavored to limit that bias through the measures noted under the section on validity. However, the advantages of being an ‘insider’ were significant. Having established relationships with the respondents and a shared understanding of the issues, means that I am in a better position to elicit information from the respondents. In addition, because of the relationship I have with them, there is an element of trust

3.11. Ethical consideration

Permission was sought from the respondents before the start of each interview and focus group discussion and an explanation on the purpose of the interview was given. Participants were requested to sign a consent form and they were informed that they had a right to withdrawal from study if they wished so. They were informed that this would not affect the study or their professional reputation. Confidentiality (other than in the focus groups, as noted above) was also ensured in that the person assisting the researcher in collecting data was made aware of his ethical responsibilities in this regard. Permission to proceed with the study was obtained from the provincial Health Office, District health Office, and the City Council in Livingstone. Permission was also sought from the Ethics Committee at UWC for the study to be carried out.

3.12. Plan for utilization and dissemination of results

The final results of the research will be given to the AIDS Council of Zambia. A written research report will be submitted to the University of Western Cape, School of Public Health. The research findings will be presented to the heads of departments and the Provincial Task Force at a Provincial level, and the results will be disseminated to the DHMT, HIV/AIDS Task Force, NGOs, health centers staff and communities.

4.0. CHAPTER FOUR

4.1. RESULTS: PRESENTATION AND DISCUSSION

4.1.1 INTRODUCTION

Chapter three presented the methodology used in the study. I looked at aims and objectives, advantages and limitations of the selected methods, the sample and the research setting, the specific tools used and the considerations relating to validity. The procedure of administering the interviews, the ethical considerations, and ways of collecting and analyzing data in a research investigation was also discussed.

In this section, I have looked at the results of the study focusing on the people's perceptions about the coordination between organizations involved in implementation of HIV/AIDS activities across sectors, and the identified promoters and inhibitors. In this study, I looked at different groups due to their different perceptions on the study topic i.e. managers, HIV/AIDS coordinators, and field officers. A summary of the results have been made at the end of the discussion

The results of the study show that there were several issues that were raised in the interviews and focus group discussions. These were put in the following categories: the first relating to the perceptions, the second to the promoters of coordination between organizations involved in HIV/AIDS activities and the third the inhibitors of coordination.

4.1.2 Perceptions of different organizations on the implementation of HIV/AIDS

Preventive programmes across the sectors.

There was generally a good understanding of what is meant by a multisectoral approach. Most of the respondents from all sectors and organizations said they understood the approach and gave a wide range of definitions and explanations. The majority described it as the involvement of everyone, that is, NGOs, Government, civil society and community in implementation of HIV/AIDS activities in the district. Another description by a few respondents was that it refers to a partnership and the sharing of ideas, bringing all partners on board who have the same objectives to combat HIV/AIDS. A third description was that of a system that enhances coordination, and hence avoids duplication. As one government respondent noted in the focus group discussion:

Every one has a role to play compared to previous years when issues of HIV/AIDS were left to Ministry of Health alone. Therefore, we need to work together so that we save resources and also avoid duplication of work in the district through involvement of all sectors. HIV/AIDS is everyone's Business.

{Government respondent}

However, despite the general understanding of a multisectoral approach described above, they did not put into practice what they saw as evident.

Respondents were also asked if they were oriented or trained in the implementation of a multisectoral approach to HIV/AIDS activities. A few government and NGO managers said they had been oriented in the approach, but most of them were not. The HIV/AIDS coordinators and field officers said they were not oriented or trained in the approach. Furthermore, several people that had received orientation had left town. The view of the respondents therefore was that there is a need for re-orientation for all staff involved in HIV/AIDS work.

When respondents were asked what they thought facilitated coordination, a few NGO managers and HIV/AIDS coordinators suggested that the district had adequate material resources that other organizations could utilize. Examples included pamphlets, leaflets, and posters. Material resources were easier to share with other organizations than the financial resources. One respondent noted:

We have shared these material resources most of the time with some organizations but we have not shared the financial resources as we have different organizational guidelines that restrict us to use finances immediately on multisectoral activities without the authority from the Headquarters. We have no mandate to give resources to other organizations

{ NGO respondent }

All respondents did not share this view. Other manager respondents from government and community organizations felt that even the material resources were not adequate to share with others, as they did not have the resources to do so. Some organizations had not

received funding for some months. Another concern of the government managers was the inadequacy of human resources, which meant that they were unable to assist in implementation of programs. Respondents from community organizations felt that transport was also a problem. They had made requests for assistance from other organizations but this could not be provided due to organizational restrictions.

A few NGO respondents noted that there was community and church involvement in implementation of HIV/AIDS activities. This was so especially in the case of information dissemination. Some communities and churches had programs on HIV/AIDS activities through health education, voluntary counseling and testing, prevention of mother to child transmission of HIV/AIDS (PMTCT) and information dissemination through information education and communication (IEC) i.e. distribution of pamphlets, leaflets and letters. Interestingly, the government respondents did not mention the church involvement. However, while the church involvement was valuable, it was not multisectoral as the activities they implemented were not linked to the district multisectoral plans but were restricted to their own church arrangements. It was also not known when these churches were carrying out the HIV/AIDS activities at church level. It is important to strengthen the current church practice in order to improve coordination

Time to attend multisectoral meetings was also an issue. Some NGO respondents in the focus group discussions felt that they could devote time for meetings, as long as meetings are scheduled sufficiently ahead of time. Instead, they felt that there was a communication breakdown i.e. it was not known when meetings would be held as there

was no schedule for them. In addition, when meetings were called, they were called at short notice resulting in difficulties in adjusting organizational programs. This affected their attendance at these meetings as they had their own organizational activities to attend to. Furthermore, these had to be prioritized, as they required reports at the end of each month. This therefore left no time for multisectoral activities. Similarly, most managers in Government, NGOs and community organization felt that time was limited and there was not enough time within their busy schedules to also include meetings that were outside their organizations planned activities. This resulted in the delegation of junior officers for meetings who are not in decision-making positions.

One manager respondent noted:

Some times, our head office calls for meetings abruptly and it is not possible for us to give excuses {and we have to} attend these meetings because this is where our bread and butters is. This resulted in my absence when multisectoral meetings were called at short notice in the district. I have no option but to send a junior staff member who has no authority to make decisions

{ Government respondent }

Most of the respondents felt that the District HIV/AIDS task force (DATF) could have a significant role in organizing other sectors through regular meetings. Instead, they felt that the task force concentrated more in the preparation of single events, such as the World AIDS day event. These were noted as being well coordinated. However, there was no follow through after the event.

4.1.3. Coordination between organizations involved in HIV/AIDS activities

Most of the manager respondents from NGO, government and community when asked about the success of coordination of HIV/AIDS activities said that it has not been successful, while a few manager respondents from the community organizations and the focus group discussions felt they had partially succeeded in Voluntary Counseling and Testing (VCT) activities only. Various reasons were given. These included the lack of joint planning, implementation and monitoring of HIV/AIDS activities. In addition, most of the respondents did not know other organizations plans because communication was poor. All the organizations whether community, NGO or Government had their own objectives, different guidelines on implementation of activities and their own financial guidelines, which could not be changed by other sectors or organizations. This resulted in segmentation of activities to suit individual organizational guidelines. Most of the NGO respondents felt that there was duplication of what other organizations had done especially on drama performances in the community. As a result, they often overlapped with other organizations in the community. One focus group respondent noted:

There is a lot of duplication of work due to un-coordinated activities. You will find that immediately you reach either a market or a certain area in the community, another organization has just finished their drama performance. As a result of this, the community will not be excited, as they were when the other group was performing. This becomes very frustrating to this new drama group. This goes on for some time. Resources could be served if there was coordination of these activities to know who was doing what, when and in which area.

{Community respondent}

In addition, another respondent noted that:

There are a lot of potholes (problems), messages given to the community are contradicting. There was also a need to share information in meetings on key messages within the district so that we do not confuse the community. There is need to coordinate the key messages on various activities as we are all targeting the same community.

{NGO respondent}

4.1.4.0 PROMOTERS OF COORDINATION

4.1.4.1. What worked well in coordination between organizations involved in

HIV/AIDS activities

It was seen that there were only a few remarkable activities that were well coordinated. One example was the VCT programme. Some respondents from organizations in the focus group discussion for HIV/AIDS coordinators and field officers said this was successful because meetings were held regularly. A few manager respondents from NGOs suggested that it might be attributed to the involvement of all stakeholders involved in VCT activities. For example, they gave each other assignments to do in each organization and when they met, each organization could give reports on what had been done. They also knew who was involved in the VCT activities and had agreed on when to meet. All the above resulted in an increased VCT uptake. One respondent in the HIV/AIDS coordinators focus group discussion noted that:

“We meet monthly in the VCT meetings and attendance is very good. We involve all our partners in all our planning and implementation of activities. We have

support groups in the community. There is need to ensure that we continue with this same spirit of working together”.

{ Government respondent }

In addition to the above sentiments on VCT, one manager respondent stated that:

“In our situation, we organize quarterly meetings with organizations who have similar objectives. We have also started identifying same donor funded projects so that there is no duplication of work, save resources, and also it is easy for them to understand our organizational policies”.

{ NGO respondent }

Another example of successful multisectoral collaboration is World AIDS Day commemoration. Most respondents felt that the organization of the World AIDS Day worked well as most of the organizations were involved in the planning process up to the implementation of the activity. A few organizations have put the World AIDS Day celebrations in their sectoral Plans. This enabled them to implement activities during World AIDS Day. Organizations agree on who is going to do what activities and when i.e. certain organizations buy drinks for the occasion, others prepare chairs, others spear head candle lighting ceremony. An action plan for the various activities is drawn and circulated to most organizations. Several meetings are held before the actual day is commemorated. Most respondents in all interviews suggested that this level of planning could be extended to other activities and not only the World AIDS Day celebrations. Some respondents felt that people benefited from the World AIDS Day in most of the organizations i.e., they were provided with soft drinks, snacks and T-shirts. The provision of drinks and T-shirts helps in mobilization of communities. However, the impact that

this has is that when there are no T-shirts and drinks, other organizations and communities turn away from the HIV/AIDS prevention activities. One of the respondents in the Focus group discussion noted:

We have seen that the world AIDS day is well coordinated but other activities are not. May be it is because there are benefits during the world AIDS day. There is need for DATF to coordinate and monitor HIV/AIDS activities regularly throughout the year. We always wait for the World AIDS day, which comes once a year.

{Community organization respondent}

4.1.5.0. INHIBITORS OF COORDINATION

4.1.5.1. What did not work well in coordination between organizations involved in HIV/AIDS activities?

However, there were far more issues raised about inhibitors. When respondents were asked about coordination, most of them said that there was no coordination of activities or sharing of information to know who was doing what activities, in which places and at what time. Some respondents in both focus group discussions and interviews felt that there was no openness in giving information to other organization concerning their implementation of activities. They also felt communication system was poor. Others felt that there was no forum for presenting information so that others could learn from experiences of other organizations, there was no joint planning, implementation, monitoring and evaluation of activities so that various sectors could know when such activities were being conducted for which groups of people and when those activities

could be done so that they put concerted efforts from various sectors to implement those activities. One respondent noted,

“Some organizations do not want to take leading roles, but want to sit behind and criticize what others are doing instead of working as a team. There is selfishness in that they want to promote their own glory so that people could only see them to be the best performers. There is apathy and people pretend to be busy with their own problems. We need to trust each other and come around the table to discuss issues, and reorganize our selves so that we rebuild our trust and this will assist us in the implementation of activities”.

{ NGO respondent }

Another manager noted that:

“There is no information system to capture data from different {organizations}. We do not have a system where players can meet to tackle issues concerning HIV/AIDS prevention. We do not pay attention to each other’s programs and complement each other but we compete. Each organization wants to show that they are the best. We have left the fight of HIV/AIDS to peer educators. Managers do not follow up activities. This has to change if we have to work in a coordinated way.”

{ NGO respondent }

Similarly, most of the respondents said that they also had different organizational guidelines that restricted their financial utilizations of funds for multisectoral activities. They suggested that there was need for various sectors to have adequate financial authority if they have to fully implement their multi-sectoral activities.

4.1.6. Limited sharing of resources with various organizations

Sharing of resources with other organizations was difficult especially financial resources due to organizational bureaucracies and restrictions by the funders of activities. This resulted in each organization planning separately according to their individual organizational guidelines. Many of the respondents felt that financial resources were not adequate to be shared as financial resources depend on donors. However, NGO managers felt they could share material resources, while the government managers and community organizations felt that the material and financial resources were not adequate to be shared due to the irregular funding in their organizations. It was also mentioned by some NGO respondents that transport usage was restricted to certain areas. The NGO manager respondents were also not sure if others using their guidelines could utilize the financial resources properly. One respondent in focus group discussion noted:

“Some times, we make requests from other organizations with similar activities, especially us who are poorly funded and have a lot of planned activities but we have received negative response from our friends. I feel our activities can be funded by those who have adequate financial resources as we are all focusing on the same communities.”

{Community organization respondent}

However, many respondents suggested that there is a need for transparency between organizations so that the limited resources could be shared with those who are poorly funded. Most of the respondents in the organizational interviews and focus group discussion felt that DATF should assist in resource mobilization so that the multisectoral

activities could be implemented and not wait for the world AIDS Day which comes once a year. This could be achieved through their active involvement in the joint planning, monitoring, and evaluation of HIV/AIDS activities across sectors. One respondent noted:

“The district task force needs to do more than what they are doing now. They need to monitor activities and assign organizations in areas where there are gaps. There is an opportunity to do better if we look at our gaps in the previous years. The problem is that we do not have people to pick us from where we are now to the next level or encourage us to forge ahead”

{Community organization}

4.1.7. Lack of authority to make decisions made by the multisectoral team

With regards to authority to make decisions made by the multisectoral team on HIV/AIDS preventive activities across sectors in both interview and focus group discussions, a few Manager respondents from NGO and community organizations said they had some kind of authority but not to their satisfaction. The authority that they had was for their organizational activities. Further more most of the respondents felt it was limited as most of them had to get permission from their head office especially on finances and other major activities that required authority to adjust their organizational plans. The managers from Government said they had authority to make decisions as long as the activities are included in their yearly plans. Although on the other hand, they also felt that the resources were not adequate to implement all the planned activities. For the HIV/AIDS coordinators, they had no authority as they had to seek authority from their heads of their organizations. This was also applied to the field officers who had to get

authority from HIV/AIDS coordinators and their Head of departments. The junior staff that attended meetings had no authority to make decisions made the multi-sectoral team on financial matters and other activities that required adjustments. They stated that their activities are planned and budgeted for. Therefore, any adjustments needed approval from their head offices.

And as one manager respondent noted:

“ In my view, by not having authority to make decisions makes our work difficult. This is so because what we see, discuss, and agree as organizations, need immediate decisions, and actions. This slows progression on what we want to do. Sometimes, decisions border on policy especially financial decisions. The challenge in the organizations is that representation in meetings is not with the top management but with the lower members of staff who have no authority to make decisions immediately as they have to go back to their organizations to make consultations. At times, there is no feedback given to their supervisors”.

{NGO respondent}

4.1.8. Limited availability of HIV/AIDS policies in various sectors and organizations

With regard to HIV/AIDS multisectoral policies, the government managers and government HIV/AIDS coordinators said they were following the national HIV/AIDS multi-sectoral policy. On the other hand, NGO and Community manager respondents said they had no specific policies on HIV/AIDS but were following their general organizational guidelines. For NGO and community HIV/AIDS coordinators and field officers, most of them had limited knowledge on the availability of multisectoral HIV/AIDS policy in their organizations. While a few said they did not even have

HIV/AIDS policies in their organizations. However, most of the respondents said they had their general organizational policies and guidelines that did not include multi-sectoral activities. While some community organizations said they had not yet been given guidelines in their organization on the implementation of the HIV/AIDS multisectoral approach. This had affected their multisectoral decisions. Most of the respondents said that they had to comply with their own organizational objectives and policies. This resulted in restrictive financial usage, as well as different guidelines in implementation of their planned activities. On the other hand most of the respondents said they were not involved in formulation of the policy. One respondent noted:

“We do not have HIV/AIDS policies in our organization but we have an organization policy that is not specific on implementation of multisectoral HIV/AIDS activities. This makes it difficult for us to implement activities with other sectors and organizations, as the guidelines are specific to our organization.”

{NGO respondent}

As seen from the above discussion, many respondents were not aware of the policy and they did not participate in formulation of the multisectoral policy. If they did, they would have had enough information on the multisectoral policy. The lower level participation was poor as policy formulation was done from the National level.

4.1.9. Limited sharing of experiences with various organizations

With reference to sharing experiences on HIV/AIDS activities, many respondents interviewed felt that they did not share experiences. One manager from community

organization felt that NGOs were not ready to share information because of various reasons. He noted that:

“They did not share information because they were afraid that other organizations could capture their information. There is a fear of capturing same beneficiaries. This same information could be used to solicit for funds for another project. As a result of this, there could be a problem of funding hence the duplication of programmes. Organizations have hidden agendas to create employment and also for their individual gain”.

{Community manager respondent}

Most respondents from NGO and community managers felt they had no forum where they could meet and discuss experiences/challenges on the district HIV/AIDS preventive activities implementation, monitoring, and evaluation as meetings were not regularly held. One HIV/AIDS coordinator from a community organization said they were trying to bring youths together so that they could meet regularly to share experiences but noted that it was not easy for them to do so. This was due to different organizational guidelines. Furthermore, some respondents felt that there was no reporting system, commitment, and consultation between different organizations. One manager respondent noted:

“At managerial level, it is difficult to meet, some times quarters and months pass without meetings. The problem is on who is to call for these meetings. Communication is haphazard at individual organizational level. There is need for partnerships to be encouraged through collaboration and also involve competent and skilled staff in coordination of activities. We need to have a forum where as

managers where we can share our experiences so that activities are coordinated to avoid duplication”

{NGO respondent}

Another issue is that there is an expectation among managers that they will receive financial remuneration if they attend meetings. This means that if there is no remuneration, they are reluctant to attend the meetings. This has a detrimental effect on the more junior staff that has to then represent them at the meeting. As one respondent in focus group discussion noted:

“When top leaders know that there are no remunerations in the meeting, they will send you to represent them. This creates apathy among junior officers. As a result of this situation, even when they attend these meetings, they will not be able to provide feedback to their organization. This is very frustrating and affects implementation of assignments given by the multisectoral team. We should be given respect as junior officers representing Managers.”

{NGO respondent}

Most respondents felt that there was a need to improve information sharing through regular meetings, joint planning, and monitoring of activities in the district. Some of the respondents felt that regular meetings could have helped them share experiences that will lead to strengthened collaboration in implementation of HIV/AIDS activities and this will assist them in achieving their goals. Others felt that there was need for various organizations to be open enough so that information could be easily shared even without meetings. Some respondents felt the sharing of experiences in meetings promotes coordination. Respondents also felt that DATF was supposed to coordinate meetings on

HIV/AIDS prevention in the district but did not do so. However, the strength is that DATF has a mandate through National HIV/AIDS multi-sectoral Policy of ensuring that organizations involved HIV/AIDS prevention activities work together so that coordination of activities between organizations involved in HIV/AIDS prevention is strengthened. One manager respondent noted that:

“Few individuals are blocking others, a shell has been made, making it difficult to work. A few individuals in the Task Force implement HIV/AIDS multisectoral activities. A district strategic plan was drafted a few years ago but up to now, the activities planned for are not implemented. The plan is supposed to be availed to all organizations/ sectors but this has not been done. Only few individuals are seen going for various workshops and meetings. We do not know if that is part of the strategic plan”.

{NGO respondent}



4.1.10. Summary of results presentation

From the discussions above, we have seen that various issues were raised on HIV/AIDS prevention across sectors and organizations. VCT activities and World AIDS day were identified to have worked well due to the collaboration and involvement of all the stakeholders in the planning and implementation of planned activities. The rest of the activities did not work well as a result of not coordinating activities well through planning, implementing, monitoring and evaluation of activities. This was supported by various views from different sectors and organizations. Therefore there is a need to work on the inhibitors of coordination and continue upholding of promoters of coordination

4.2.0. DISCUSSION

4.2.1. INTRODUCTION

In the previous section, I looked at results of the study. The focus was on people's perceptions about the coordination between organizations involved in implementation of HIV/AIDS activities across sectors. The identified promoters and inhibitors of coordination were also discussed

In this section, I am going to look at the implications of the findings, and consider them in relation to the literature on multisectoral approaches.

The findings have been compared to the studies conducted in Africa, and other countries outside Africa that have carried out a multi-sectoral approach to HIV/AIDS prevention and control. These will be compared with the Zambian National Policy guidelines on prevention. Any problems that arose during the study are discussed.

4.2.2. Perceptions on implementation of multisectoral activities

The perception of the respondents varied. Most of the respondents, from the managerial level to field officers felt that the activities were not implemented in a coordinated manner. This was evident when coordination was discussed. They also described what worked well in coordination and what did not work well in a similar way showing that they were promoters and inhibitors of coordination in the district.

With regards to the understanding and view on the multi-sectoral approach to HIV/AIDS prevention, the fact that the respondents understood the concept, but that this did not translate in practice, reflects the situation in other countries (ADF, 2003). In both the

literature and my research, it was found that each organization has its own organizational objectives and programs. In addition, the later aspect on the review of multisectoral plan in Zambia (CBOH, 2002-2006) found shortcomings in the mobilization of truly multisectoral response. Among the reasons given for these shortcomings is the need for a shift in administrative cultures at government level, NGOs and UN agencies in processes that overlap, i.e. multisectoral approach, decentralization, community empowerment and mobilization of resources (UNGASS, 2000). Furthermore, this will ensure that stakeholders are willing to help at local level and are involved in activities. In addition, stakeholders have to develop a strategic plan based on a bottom up approach. However, where multisectoral activities do exist, they have succeeded, such as in Uganda, Brazil and Thailand. This was noted in the literature review (UNAIDS, 2004).

Another problem was the lack of orientation of some managers, HIV/AIDS coordinators and field officers on the multisectoral approach to HIV/AIDS prevention. The lack of orientation means that people have a limited understanding of the approach. The implication of people not been orientated has been a lack of understanding about the importance of a multisectoral approach. The difficulties are aggravated by people leaving the district, which shows the importance of the orientation being ongoing, and also done within a foundation of organizational changes which are reliant on individuals. Hence there is a need to continuously orient all sectors and organizations on the approach

The need for sectors to work together has been emphasized by UNGASS (2000) when they discussed the purpose and actors of multisectoral approach. This was again

discussed in a situation analysis in the World Bank Report that reviewed the Zambia National Strategic Plan (2002-2006). This review found that various sectors were under-utilized in the planning and implementation of HIV/AIDS activities and that there was insufficient capacity building outside ministry of health. A review of multisectoral responses to HIV/AIDS nutrition program in Uganda (USAID 2003) also emphasized the need for on going sensitization of stakeholders, capacity building at different levels involving the main stakeholders from the start. It is important to note that national guidelines are necessary for all sectors as this results in sustainable programs (USAID 2003). Another example is the Brazil concept of enhancing care initiative which brought various experts together from various diverse fields using the comprehensive approach to health needs and disease management resulting in addressing specific needs of various groups (<http://www.eci.harvard.edu/teams/Brazil>)

The short notice for meetings was also a problem. When you look at the managers' busy schedules that include attending meetings a considerable amount of the time, the danger is that there will be no time to implement the planned activities. This in turn will compromise the quality of service provision. This was also echoed by Costongs & Springett (1995) when they discussed the constraints of time and communication that restricted effective joint working.

The importance of meeting regularly was also recognized. This was highlighted in the final report of the Thailand for AIDS programme (FhI, 1991 – 1996) which noted that the

process of holding meetings and round table discussions, coordination was improved and relationships strengthened in the multisectoral activities.

The level of commitment by managers was also a problem. We have seen that there is commitment to work by the HIV/AIDS coordinators and field officers as long as they are guided properly. However, the issue of allowances demonstrates a lack of commitment by their managers, which in turn impacts on their ability to do their work. This also sets a bad example by those who should be leading by example. If a manager cannot attend a meeting because of a lack of allowances, then junior officers will also refuse to do so. This means that there is no commitment to the work. To emphasize the importance of working with other organization as stated above, Harris et.al. (1995) argue that even the most knowledgeable individuals often fail if their organizations do not support their work with other sectors or organizations. The support for individuals in organizations who work with other sectors is encouraged (Harris, et.al. 1995). Involvement of leadership in multisectoral programs is important as it points to the benefit of commitment to addressing HIV/AIDS (Sakboon, 2003). UNAIDS (2004) emphasizes strengthened participation and governance in the response to multisectoral programs.

Another reason for the lack of attendance of meetings is that it interferes with core responsibilities. The government manager said he could only attend ‘where his bread and butter is’, that is, meetings that relate to his core responsibilities. This again means that he cannot attend multisectoral meetings because they are not part of his main responsibility and so there is nothing to benefit from the meetings. On the other hand, it results in

sending junior officers for meetings who have no authority in decision-making. In both cases, managers put material benefits first. Therefore, this trend needs to be corrected. It is important for the leaders to realize that commitment to work is very important if they have to serve the community as well as staff. In Uganda and Thailand where multisectoral approach was a success, there was leadership from the top down. This was also emphasized by Kenyon et.al. (2001) when they discussed the importance of leadership at all levels of society to mount an effective response to the epidemic. Failure to do so will result in continuing increase in the prevalence of HIV/AIDS.

Looking at the involvement of the church in the implementation of HIV/AIDS activities, we have seen that they participated in information dissemination but it was not multi-sectoral. Various churches have their own activities that are not coordinated. Churches have a potential for dissemination of information and education. Most people respect, pay attention and listen to their church leaders. In addition, churches provide a good audience for information, education and communication (IEC). Therefore there is a need to involve and coordinate the multisectoral activities through the various churches. The involvement of religious organizations has been emphasized by Ishrat and Renuka (2002) when they discussed the reasons for Uganda's success efforts in implementation of HIV/AIDS multi-sectoral response. One of the reasons for their success was the empowerment of communities to assess and monitor local responses to HIV/AIDS activities. This could as well be achieved in Livingstone, through coordination of activities at all levels. Churches are willing to implement HIV/AIDS activities as seen from the discussion on what the churches are already doing. They need links with other organizations, coordination, and

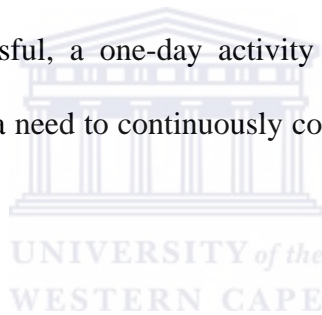
commitment from others to work with them in the implementation of multisectoral activities and this will help in covering a wider population (Uganda AIDS commission, 2004).

4.2.3. Promoters of coordination

There were examples of good practice. In particular, the VCT multisectoral meetings that were held regularly resulting in increased VCT uptake. The community was also involved in the VCT planning and implementation of activities. This also applied to the organization of the World AIDS Day that worked well as most of the organizations were involved in the planning process up to the implementation of the activity. The failure by some organizations to put World AIDS Day celebrations in their sectoral plans meant that they could not participate in the implementation of the HIV/AIDS activities. The importance of ensuring that HIV/AIDS activities are mainstreamed in organizational plans has been highlighted by Helfenbein & Severo (2004), through guidelines in the generic manual for implementing multi-sectoral programs in Africa. The success of the two activities might be attributed to the collaboration of all stakeholders in planning and implementation of activities. In addition to the above, sharing of experiences on good practices and knowledge management on what worked and why it worked is important. This has also been discussed by Helfenbein & Severo, (2004). Meetings are also important in information sharing, as noted in a final AIDS report in Thailand for AIDS program (FhI, 1991-1996). The report emphasises the importance of holding meetings and round table discussions, as it improves and strengthens multi-sectoral activities. Maintaining partnerships have been found to depend upon constant re-appraisal, direct

and frequent contact between partners involved in joint working (Nutbeam, 1994). The frequent contact will assist in keeping partners together resulting in improved collaboration. The importance of investigating the added value of joint working in achieving health gains is emphasized (Nacon, et.al 1993).

It is therefore, important for the Livingstone multisectoral team to build on the identified promoters of coordination, as demonstrated in the VCT and World AIDS Day preparation and implementation of activities. There is ownership in the implementation of VCT activities as most of the partners participate in the planning to implementation of activities. However, as respondents commented, despite the World AIDS Day commemorations being successful, a one-day activity cannot have an impact on the HIV/AIDS reduction. There is a need to continuously coordinate all HIV/AIDS activities in the district.



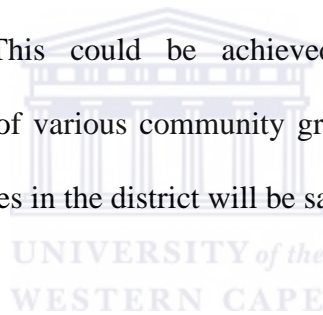
4.2.4. Inhibitors of coordination

As noted above, the most frequently stated reference to the lack of coordination was in relation to limited information sharing about coordination of activities which meant that potential partners did not know who was doing what activities, in which places and at what time. This resulted in duplication of work and wastage of resources that could have been saved if information about the implementation of activities was shared. This also shows that there is no joint planning, joint implementation or joint monitoring of activities. There is a need to ensure that activities are coordinated so that only one specific organization attends to that activity per time. This is in line with the ADF (2000)

who talked about the need for coordination of activities in a multisectoral approach. This will ensure that prevention and treatment efforts target the entire population by addressing causes of HIV/AIDS through involvement of various sectors of society at all levels. It was also in line with the need for multisectoral coordination of activities discussed in a study on HIV/AIDS conducted in NGOs and Governmental organizations (Kamala 2006) in Southern Asia. Furthermore, this need was also discussed in a comparative report of four African countries Kenya, Mozambique, Namibia and South Africa (SANAC 2004). In this study, it was found that all four countries had theoretically adopted multi- sectoral approach to HIV/AIDS prevention and had coordinating bodies, but in practice they had problems in the implementation of activities. These problems included a lack of data on allocation of resources and of multisectoral response and they resulted in duplication and segmentation of activities. However, these countries agreed to provide more comprehensive, accurate, timely and accessible data from all relevant ministries and departments in order to properly coordinate multisectoral response and hence avoid duplication. Therefore, ADF (2000) advises that all sectors should work together, be creative in providing expertise, and support each other as involvement of all sectors leads to wider coverage, especially people at grass root level.

Lack of success in collaboration in Livingstone echoes many of the problems described in the literature. As seen from the above discussion, as a result of not sharing information, messages given to the community were not only duplicating but also contradicting. This again makes the community loose interest and confidence in the messages given to them by various sectors/organizations. Given this confusion, the community will not know

which messages to respond to as all the organizations are targeting same communities. The challenge of processing and packaging same information differently by different actors was discussed by AIDS Commission (2003) when they discussed information and knowledge management in Uganda. They found that, contrary to the experience in Livingstone, it is possible to coordinate messages through information sharing. The actors demanded consistent, relevant and timely information in order to ensure focus on common goals. This assisted in the reduction in duplication of work and in turn helped in reduction of prevalence of HIV/AIDS (Uganda HIV/AIDS AIDS Commission 2003). This was also discussed by Sakboon (2003) when he said multi-sectoral control strategy could reduce both the prevalence and incidence of HIV infection through early consistent and multisectoral strategy. This could be achieved through early mobilization, involvement and coordination of various community groups, sectors and organizations. Furthermore, the scarce resources in the district will be saved.



With regard to success of coordination, it was evident from government, NGOs and community organization's respondents that it was not successful. However, success is possible with improved coordination. This was shown in Uganda, where, despite their problems, they came up with well-coordinated activities in different ministries, through strengthened participation and governance (UNAIDS 2004, Ishrat & Renuka 2002). This is also highlighted in Thailand where an holistic approach to HIV/AIDS prevention was successfully used (Hollertz 2001). The social economic and health problems cannot be cured with vertical, isolated, uncoordinated, and un-integrated approaches or responses. Instead, a truly integrated and long-term multisectoral response is required, as seen in the

Uganda's success (Calderon 1997). There is a need for coordination of activities to enable sectors to work together to obtain synergy. The importance of this has been highlighted by Ishrat & Renuka (2002) when they argued that synergy is necessary in joint working. This is relevant for multi-sectoral action in Livingstone. It was also discussed by ADF (2000) in their report. Hemrich et.al. (2000) in their discussion further advocated on the need to shift from medical to a multisectoral and participatory approach that enhances coordination between sectors.

Looking at sharing of resources, material resources are easier to share for those that have them than those that have limited resources, and so this shows a difference in opinion by the different respondents. The implication of this is that there should be more willingness of the better-resourced organisations to be supporting those less well off.

It is also important to note that transport was not easily provided to other sectors. Other organizations especially NGOs could only use transport in specific areas. This again was a restriction. Sharing of financial resources was extremely difficult, especially where there were specific guidelines from the funders of programmes and activities.

In some cases, there was mistrust between organizations, and organizations were not open on implementation of activities. Respondents from NGOs were also not sure if financial resources could be used properly according to their guidelines. This reflects the experience of Stern & Green (2005) in their case study to assess interaction between communities and statutory sector authorities in partnerships. They found that there was limited community involvement, limited financial capacity, rigid allocation of funds

according to departmental boundaries. This resulted in increase in levels of mistrust. The relevance of this is that despite the lack of trust, people have to find a way of working together (they often do not and partnerships collapse). Successful programs draw on experiences of others, benefiting from collaboration about what works and why can facilitate program implementation and capacity building (Helfenbein & Severo, 2004). Yet, even in the ministries that have understood the importance of a collaborative approach to prevention of HIV/AIDS, adequate resources as recommended by a generic manual for implementing multisectoral programs in Africa (2004), have not been availed.

The absence of a policy on multisectoral collaboration will mean that there is no scope within the budget for joint work. No matter how committed a manager is to joint work and even joint finances, if there is no potential for it in the budget, they cannot shift resources because the policy guidelines have to be specific on the usage of funds. Hemrich (2000) emphasizes the importance of cross- sectoral nature of HIV/AIDS prevention in the country level policy and that strategy documents could assist non-health projects to participate in the response of the epidemic more actively. The value of adequate resources has been shown in Thailand where their success is enhanced by the increased availability of resources for multisectoral programs at all levels (Hollertz 2001). Shaun (2006) advises that there is a need for various sectors to harmonize their activities considering that there are structural, logistical and policy issues involved in the implementation of HIV/AIDS strategies and activities. Therefore, Shaun further states that there is a need for highest level of Government endorsement of sectoral response has

it has been done in Uganda and Thailand. Field level activities are likely to remain an act of good will.

The sharing of experiences in meetings was another problem. The varying views from different respondents were evident. There was also a reluctance by some organizations to release information for fear of others capturing beneficiaries in that, same people (target population) are used in project justification. Using this same information, other projects would be developed, which means that some projects could be laid off because of the new projects. This in turn would result in people losing employment in those organizations. As a result of this they had to hold information within their organization. This again impacts negatively on sharing information. Despite the differences in feelings about meetings, the general picture portrayed in both cases was that meetings were not regularly held. This reflects the discussion in a concept paper on the National Strategy for HIV/AIDS Information and Knowledge Management in Uganda (2003). The impact of poor communication is the segmentation of activities. In addition to the reflection in the Uganda experiences, Costongs and Springett (1995) talk about poor communication and time constraints that complicated and restricted effective joint working.

Furthermore, there was hardly any communication between groups, who often received second hand information that is not complete. This was so because junior staff attended meetings and also failed to make decisions made by the multisectoral team. The remedy for effective joint working is that there is an input from influential people who were committed to work. This is also important to Livingstone.

With regard to authority to make decisions, there were varying levels. Most NGO manager respondents had limited authority, as permission was to be sought from their head offices especially on financial matters resulting in delays in implementation of agreed joint multisectoral activities. For community manager respondents, they had to seek authority from their funders. Government managers reported that they had authority as long as activities are planned for but had also restrictions from donors on how they used funds. In the case of the respondents in the HIV/AIDS coordinators focus group discussion, they felt they had to consult their managements before decisions were made, as they did not have powers as junior officers who were sent for the multisectoral meetings to make decisions on finances and change certain activities to suit multisectoral work.

Furthermore, if the activities that are proposed by the multisectoral team are not reflected in the plans of the different organizations, it means that they cannot implement them. For the NGO organizations, it was not clear as to whether the head office would agree or disagree to their requests to change activities as well as utilize the resources. In all cases, the impact of organizational bureaucracies in both NGOs and government is seen in the article that examined the operational status, implication and constraints of multi-sectoral responses to HIV/AIDS programmes in South Africa (Hemrich 2000). Hemrich further states that given the sectoral and hierarchical set up of Government institutions in many developing countries, the programs embedded in MOH might not have the instruments and lines of command to involve ministries in other sectors and organizations. Kenyon in his study (2004) found that all countries had adopted multi-sectoral approaches, but these

varied in roles, responsibilities and authority. This was also discussed in a research report on collaboration (Costongs and Springett 1995) that revealed that the quality, personalities, status of the participants affected the joint working. It is important to note that sending junior officers to meetings when they cannot make decisions does not work and that the various organizational bureaucracies affect the implementation of multisectoral activities hence the need for clear policy guidelines that will help in the implementation of multisectoral activities at all levels.

With reference to the availability of HIV/AIDS multisectoral policy, very few NGO organizations had HIV/AIDS policies and these were not multisectoral. Most of the NGO and Community manager respondents said they had only organizational policies. These organizational policies had guidelines that could not be changed in order to implement multisectoral activities. Most respondents did not participate in the formulation of the policy as the approach used was “top to bottom”. This again means that the ‘bottom’ level does not take the policy as a mandate because they were not involved in the initial stage. The respondents also claimed that they could not spend their financial resources because of the restrictions by their organizational general policies. On the other hand they were not sure if other organizations could utilize the funds properly. This meant that there was mistrust because there was no report given during the discussions on mismanagement of funds given to any sector or organization.

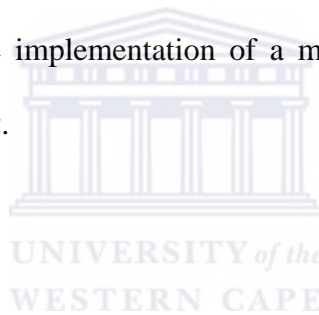
The government managers despite their exposure to the multisectoral policy did not utilize it accordingly. The government sectors could have used their understanding to

show and influence the government policy in the district. This would have assisted in the improved collaboration of activities. In Uganda and Thailand, the political will has enabled change (Sakboon, 2003, & Hollertz 2001). For the NGOs, community HIV/AIDS coordinators and field officers, the emphasis was on using organizational guidelines and not multisectoral policy. The government coordinators and field officers claimed they were using the national policy. As seen from above the three groups had different views on the policy showing that there is no collaboration on the policy issues. An example is seen in Sub-Saharan Africa, where a major problem identified is coordinating HIV/AIDS policy among co-sponsors due to different agendas and focus (Ala, 2001).

The National HIV/AIDS multisectoral policy is available at National level and sent to all districts. However, its implementation has not been critically monitored in all sectors and organizations. There is no mandate endorsed at the highest level to ensure commitment and facilitate the operationalization of multisectoral activities. Policy implementation is not monitored at all levels of society as observed in Livingstone. The importance of this was shown by Hemrich (2000) when he looked at the constraints to multisectoral response which showed that in the absence of a cross-sectoral policy mandate on HIV/AIDS, health units and HIV/AIDS control programs lack the necessary backing and mechanisms to effectively influence strategies and activities within their own institutions. This was also discussed in a study to ascertain levels of awareness about HIV/AIDS policy in Zimbabwe amongst NGOs that found that there was inadequate information and limited response as the policy was not multisectoral. This in turn affected the implementation of activities (Zimbabwe AIDS Network 2003). This was further

reinforced by Hemrich et.al. (2000) when they discussed the implications and structural constraints of sectoral-based government and NGOs. Hemrich et al, however, emphasise the cross sectoral nature of HIV/AIDS prevention in the country level policy and strategy documents that could assist non- health projects to participate in the response of epidemic more actively. They have advised that there is a need for various sectors to harmonize their activities considering that there are structural, logistical and policy issues involved

In conclusion, I have discussed various issues on why different groups said what they said, how and the implications of what was said and how the identified problems could be worked on in relation to experiences in the literature reviewed in various countries and regions. This will assist in the implementation of a multisectoral approach in a more comprehensive and holistic way.



4.2.5. Impact

The study has clearly shown that there are inhibitors to coordination between organizations dealing with HIV/AIDS in Livingstone District that need to be worked on if coordination is to succeed. The respondents defined the approach but did not put into practice what they said. This is because there is no mandate on HIV/AIDS multisectoral policy from the highest level.

The busy schedules of most managers' means that they do not have time even to monitor activities at field level. Therefore, any problems arising in the field could not be attended to. Managers had to send junior officers who are not in decision making to represent

them even when they had no authority to make decision. Junior officers also could not give full information about those meetings resulting in misinformation. Most managers have left the work to the field officers. Therefore, they cannot know whether activities are properly conducted in a coordinated manner.

The sharing of resources was difficult especially financial and transport. This again resulted in duplication of work. Inadequacy of staff also had a negative impact on the implementation of activities. As a result of not sharing information and experiences on various issues, activities were uncoordinated because other organizations were not open enough to share their experiences. This resulted in mistrust and accusations. In the end, the implementations of activities were affected.

The impact of not having authority to make decisions made by the multisectoral team was delayed the implementation of activities. This in turn made joint working very difficult resulting in sectoral planning, which also in turn resulted in segmentation of activities.

As result of DATF not taking a leading role in organization of meetings and various activities according to their mandate, it has contributed to inadequacy in coordination of activities by various sectors and organization. In addition to this, due to the absence of coordination in planning, monitoring, implementation and evaluation of activities, has resulted in duplication of activities, distortion of information, fragmentation of activities and wastage of the limited resources. As a result of not monitoring regularly the implementation of the multi-sectoral policy has impacted negatively on the approach by

different sectors and organizations not taking the policy as a mandate. This in turn has resulted in increased segmentation of activities. Finally, with all these problems encountered in the implementation of the approach has in turn contributed to delayed control of the HIV/AIDS pandemic in the District.

However, there are examples of success, in other countries (Uganda, Thailand and Brazil) and in Livingstone itself, through the VCT examples. It is important, therefore, to investigate more about why VCT programmes were successful than others. I therefore recommend this for further study.

5.0. CHAPTER FIVE

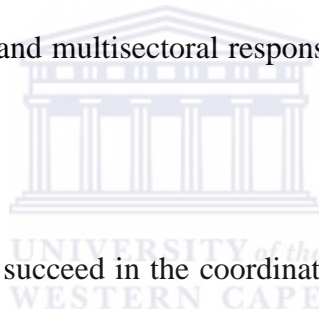
5.1. CONCLUSION

From the discussions on the findings, there is need to coordinate activities through information sharing and collaboration on activity implementation from community to the district level. This could be done by building on the promoters that have been identified and also work on the inhibitors of coordination. It is also important to share information on messages that are taken in the community so that there are no contradictions or misinformation. This will help the district multisectoral team implement various activities in a coordinated way. There is also a need for people to understand the importance of a multisectoral approach and ensure that it is mainstreamed in organizational plans. This should be done at the highest level. This could be achieved through regular sensitization and monitoring of the implementation of multisectoral policies as the approach has been adopted nationally

DATF should utilize their mandate to help in coordinating activities in all sectors and organizations.

There should be openness in information sharing and implementation of activities. It is also important to remove the fears, mistrust and suspicions among organizations through collaboration and coordination of activities. Managers should show commitment and have a scheduled plan of activities so that they participate in multisectoral activities so that junior officers are not sent for meetings where they cannot make decisions.

Evaluation of countries with successful HIV/AIDS campaign have shown that the axis of any effective response is that which draws on the explicit and strong leadership at all levels and built on community and multisectoral response that mainstream HIV/AIDS in their organizational plan.



The district has the capacity to succeed in the coordination of HIV/AIDS activities with the availability of identified promoters. From the findings of this study, it is clear that a multisectoral approach could work in Livingstone when organizations put their concerted efforts in coordination of activities, using the available identified resources in the district. This would assist in strengthening collaboration, and hence reduce duplication of activities and wastage of limited resources.

In order to ensure adequate coordination between organizations involved in implementation of HIV/AIDS activities in Livingstone district, the following recommendations need to be carried out:

5.2. RECOMMENDATIONS

5.2.1. Provincial level

1. The Provincial Coordinating team should provide HIV/AIDS policy guidelines on how to implement multi-sectoral activities through policy dialogue with key top level and grass roots decision makers across the sectors
2. The Provincial HIV/AIDS coordinating team should guide the district in the implementation of coordinated multisectoral activities through capacity building that includes training in the implementation of activities as this will assist the district in planning, monitoring and evaluation of planned activities.
3. The Provincial HIV/AIDS coordinating team should facilitate the development of a reporting system that will help different organizations share information in the District so that there is a coordinated response.
4. The provincial coordinating team should provide leadership to various sectors and organizations through regular monitoring of their activities especially Information Education and Communication (IEC) so that any problems in the implementation of activities could be identified and worked on
5. The provincial coordinating team should assist the districts in mobilizing resources for joint district activities so that activities are implemented properly

5.2.2. District level

1. The district HIV/AIDS coordinating committee (DATF) should work hand in with various sectors and organizations dealing with HIV/AIDS in joint Planning, implementation and monitoring of HIV/AIDS activities so that multisectoral collaboration is enhanced.
2. The DATF should orient all the relevant organizations and sectors in the implementation of a multisectoral approach as most of the staff who were oriented in the approach are no longer in the district. This will also assist in the understanding and implementation of the approach and also implement activities in a collaborative and coordinated way.
3. All the organizations in the district should ensure that staff members are aware of the institution mandate through systematic awareness on steps towards the understanding of the cross sectoral implications of HIV/AIDS
4. Organizations and sectors should meet regularly to plan and review activities so that there is information sharing in the implementation of activities. These should be well coordinated to reduce duplication hence save the limited resources in the district
5. The District coordinating team should have strong coordination mechanism for sectors to work together to obtain synergy. This will be done through different

sectors having common target areas or groups in which to work.

6. There is a need to create a forum to share experiences of managers on the implementation of HIV/AIDS activities, and the challenges they experience so that others could learn from them, and hence improve on the implementation of activities.
7. There should be information flow from one organization to another through a systematic reporting system, so that they do not have to wait to be called for meetings.
8. Information dissemination in the community should be coordinated on HIV/AIDS activities so that communities can benefit from the messages given to them. This would also reduce distortion and misinformation.
9. DATF should involve communities in the District Aids Task Force through joint planning, implementation and monitoring and evaluation of activities from the initial planning of district activities.
10. DATF should provide leadership to various communities through regular monitoring of their activities so that any problems in the implementation of activities could be identified and worked on

5.2.3. Community level

1. Communities should participate in all the planning stages and report all the difficulties that they face in the implementation of activities through their community HIV/AIDS Task Force (CATF). This will assist in the collaboration and coordination of activities at community level
2. The Community AIDS Task Force should assist community-based organizations implement activities through regular monitoring and evaluation of activities



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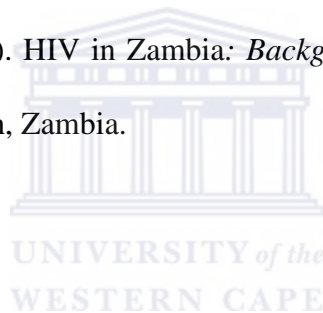
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APPENDIX 1

INFORMATION SHEET

My name is Duffrine Chishala Chibwe student at the University of the Western Cape in South Africa. I am currently studying for a Masters in Public Health. The study that I am taking is looking at the perceptions of different organizations on the implementation of

HIV/AIDS preventive programmes across the sectors and also looking at the promoters and inhibitors of coordination in organizations involved in the implementation of HIV/AIDS preventive activities in a multisectoral approach in 8 organizations in Livingstone, Zambia. HIV/AIDS multisectoral approach helps organizations work together, communicate, share their experiences and views on HIV/AIDS prevention. The study will provide information on coordination and the promoters and inhibitors of coordination between organizations involved in HIV/AIDS activities in the approach hence this will assist in the improvement in the approach. The result of this study will also help me give a feedback to various sectors and organizations.

I am therefore requesting for your consent to take part in this study. You are free to ask for further clarifications if you are not clear, and to withdraw from the study at any time if you wish so. I request you to answer the questions honestly and freely. Some of the questions might be sensitive and needs further explanation. The interview will be highly confidential. No names will be recorded. The interview will be for 30 minutes or more.

May I be permitted to go ahead with this interview? Yes () or No ()

Respondent's signature ----- Date-----

CONTACT DETAILS OF THE RESEARCHER

Duffrine. Chishala Chibwe

41/23 Kanyanta Road, Livingstone

Tel No: 03 324170

Signature-----Date-----



APPENDIX 2

Structured Interview for Heads of Government Departments/ NGO/community

Name of Organization:

Date of Interview:

Time-----

A. Background information

- 1 Sex: (a) Male () (b) Female ()

What is your Professional status in this organization/Sector?

2. What is your organization workforce?

B. Coordination of activities

1. A, what is your understanding and view on multisectoral approach to HIV/AIDS prevention? B, Where you trained or oriented in the implementation of this approach

2. Do you have a policy to support multisectoral approach to HIV/AIDS prevention activities in your organization, If yes, explain what Policy and strategies, If no explain why?
3. Does your organization have authority to make decisions on coordination of HIV/AIDS preventive activities made by the multisectoral team? If yes explain how, if no explain why?
4. Do you share your experiences on HIV/AIDS prevention with other organizations? If yes explain how, if no explain why?

8. What are some of the previous positive and negative experiences in
Collaboration
- 9 What resources do you have in your organization to implement the
multisectoral HIV/AIDS preventive activities and are you able to share the
resources with other organizations and sectors
If yes explain how it has worked, if no explain why it did not work?
- 10 Do you feel you have succeeded in the implementation of a multisectoral
approach to HIV/AIDS prevention in the District
If yes explain how it has succeeded, if no explain why it has not worked,
And explain how it could be implemented
- 11 Do you have any suggestions for the improvements in coordinating the
approach? If yes explain how
- 12 Do you have anything else to add that you think may be useful?

Thank you for your help.

APPENDIX 3

FGD DISCUSSION GUIDE FOR HIV/AIDS COORDINATORS/ AND FIELD OFFICERS

1. What is your understanding and view on multisectoral approach to HIV/AIDS prevention?
2. Do you have a policy to support multisectoral approach to HIV/AIDS prevention activities in your organization, If yes, explain what Policy and strategies, If no explain why?
3. Does your organization have authority to make decisions on coordination of HIV/AIDS preventive activities made by the multisectoral team? If yes explain how, if no explain why?
4. Do you share your experiences on HIV/AIDS prevention with other organizations If yes explain how, if no explain why?
5. What are some of the previous positive and negative experiences in Collaboration?
6. What resources do you have in your organization to implement the multisectoral HIV/AIDS preventive activities and are you able to share the resources with other organizations and sectors, If yes explain how it has worked, if no explain why it did not work?
7. Do you feel you have succeeded in the implementation of a multisectoral approach to HIV/AIDS prevention in the district, If yes explain how it has succeeded, if no explain why it has not worked, and explain how it could be implemented
8. Do you have any suggestions for the improvements in coordinating the approach? If yes explain how
9. Do you have anything else to add that you think may be useful?

Thank you for your active participation

ANNEX 4- Definition of Terms

Multisectoral collaboration – Participation of several stakeholders in an activity with a common Goal. In the context of HIV/AIDS, it refers to bringing different line ministries, Civil society, private sector and community to plan, coordinate, monitor and evaluate HIV/AIDS prevention, care and support activities to effectively address the epidemic

Exploration- Looking around and examining thoroughly in order to learn, or find out about the state or nature of the subject of interest.

Involvement: It is taking part in or being part of an activity. This is a basic right of all people through their involvement in decisions and actions affecting people's health that build self-esteem and encourage a sense of responsibility

Promoters: A person, organization, company or things that help the progress of, encourage better communication between people and support many good causes.

Inhibitors: Things that prevent people, organizations or companies from doing what is required to be done

Coo-ordination: This is an action of several people working or functioning together efficiently and in an organized way. It is also the ability to control ones involvement properly

Policy: It is a course or principal of action that provides guidelines for decision-making, written statement of ideals. Policies provide consistence in management decisions while offering approaches that can be adopted.

Organization- The condition or state of being organized.

Collaboration: Working together/ the action of Pooling of tangible resources by two or more stakeholders to solve asset of problems that can neither be solved individually.