
A Handbook to support local government authorities in addressing HIV/AIDS at the municipal level

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HIV/AIDS has emerged as one of the foremost challenges for poverty alleviation and development. While sub-Saharan Africa is home to nearly 30 million of the world’s 42 million people living with HIV/AIDS, it is not only an African epidemic. The Caribbean region has the second highest prevalence and Eastern and Central Europe are showing the fastest increase. Absolute numbers per country are now largest in S. Asia and growing in E. Asia. At the same time, urbanization has been occurring at an unprecedented rate, with more than half of the world’s population expected to be living in urban areas by 2008. Urbanization, when well-managed, can present an opportunity for development, facilitating sustainable economic growth and promoting broad social welfare gains.

Unfortunately, however, cities and towns are often the driving force behind the spread of disease as well as economic and social growth. This is due to high population density, the presence of transportation hubs and the existence of large groups of vulnerable persons (e.g. sex workers, unemployed youth, migrant labor, drug users). While affecting countless individual lives and livelihoods, HIV/AIDS also has the potential to undermine local governance in all its aspects. Through its profound impact on health and human resources, HIV/AIDS can undermine the capacity of local governments to carry out their core functions of local service delivery (particularly to the poor) and local economic development.

As more people are infected with HIV/AIDS, a town or city will see decreases in labor productivity, increased demand for services, lower capacity of users to pay for services, greater household vulnerability and increased numbers of absolute poor (e.g. orphans, people living with HIV/AIDS). The climate for private investment will deteriorate and local government itself will suffer the absenteeism and productivity losses that result from increasing prevalence.

Many countries are now making progress in developing and implementing National AIDS Programs. In most cases, however, local governments have not received sufficient support in dealing with the epidemic, even though they are closest to affected communities and their own capacity to deliver services is undermined by HIV/AIDS. In supporting local government responses to HIV/AIDS, this Handbook is intended as an input to strengthen local, sustainable and accountable responses to HIV/AIDS so as to ensure that local governments can continue to address the key issues of poverty alleviation and local economic development.

Local governments cannot continue with ‘business as usual’ in the face of the AIDS epidemic. They need to be proactive and preemptive in order to avoid disruption of their core activities now or in the future. Local governments are much needed partners in the fight against HIV/AIDS. We hope that Local Government Responses to HIV/AIDS: A Handbook will inspire and assist local governments to take action.

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HIV/AIDS is a global epidemic, but the greatest opportunity for addressing it rests at the local level. This realization has encouraged a shift towards supporting local responses to HIV/AIDS, largely by supporting responses at the community level, carried out by partners in civil society. Yet HIV/AIDS is also increasingly being viewed as a governance issue. While decentralization is at the forefront of many governance discussions, there has been less focus on the impact of HIV/AIDS on local governments and the role local government authorities (LGA) can play in the fight against HIV/AIDS. As the organ of government that is closest to communities, LGAs can add significant efforts to the global fight against HIV/AIDS. Nowhere is this more urgent than in the countries of Sub-Saharan Africa. 

Local Government Responses to HIV/AIDS: A Handbook has been written for LGA mayors, councilors, advisors and officials that are interested in developing or strengthening local responses to HIV/AIDS. It provides information, examples, and illustrative tools (surveys, checklists, modules, etc.) that guide users through the steps of recognizing and publicly acknowledging the importance of addressing HIV/AIDS, assessing the impact of HIV/AIDS on the locality, and identifying key stakeholders to initiate and coordinate a Local Government (LG) HIV/AIDS Response Strategy. The Handbook also focuses on the implementation process, and suggests ways to mobilize new and existing resources, develop productive relationships with civil society organizations (CSOs), and establish systems of monitoring, learning and evaluation. While it is not appropriate to expect all LGAs roll out extensive HIV/AIDS programs, in general they can play an important role in identifying local needs, mainstreaming HIV/AIDS activities within LGA departments, and coordinating local responses (i.e. facilitating partnerships).

Much of the content of the Handbook is targeted towards LGAs in medium to large sized towns and cities. However, the document can also be used by other levels of government (e.g., state or province) and in smaller towns. In all cases but particularly in smaller towns, it is recommended that a facilitator be appointed to work with LGA to adapt and implement the Handbook in a manner appropriate to the local context. This facilitator could directly support one or more LGAs in working through the steps and tools set out in the Handbook.

While this Handbook is targeted at LGAs and does not deal directly with many intergovernmental issues, it should be stated clearly that national leaders, policies and frameworks play critical roles in enabling LG HIV/AIDS Responses. Any local responses should ideally occur within the context of co-operative governance, wherein national and local governments have a common understanding of their respective roles and actively collaborate with each other. The Handbook could be used to encourage national governments to recognize the value of LG contributions to the fight against HIV/AIDS as well spur national associations of LGAs to support HIV/AIDS activities by their members. There are, however, many actions in the Handbook that are geared to assist LGAs to address HIV/AIDS even in less conducive national contexts.

Why was this Handbook developed and for whom?
What is in the Handbook and how to use it?

The Handbook has been divided into five parts.

The Introduction provides an overview of why it is important for LGAs to address HIV/AIDS. (Note: This section can be used in developing advocacy messages.)

The Operations section offers a narrative overview of the steps and challenges in developing and implementing a LG HIV/AIDS Response Strategy. Within the Operations section, there are a number of text boxes that offer short case studies, clarifications, and examples of ideas and principles outlined in the text.

Each Operations chapter (there are 5) has a corresponding set of Tools that can be found in Annex 1. The tools provide suggested activities, exercises, checklists, frameworks, models, and questionnaires that can help LGA work through the process of developing and implementing an HIV/AIDS Response Strategy. These tools are by no means exhaustive or prescriptive. They are simply starting points that can and should be adapted to meet the specific context of the locality. In some cases, a LGA may already be addressing HIV/AIDS with various partners but may still be developing some areas (e.g., a workplace policy or a monitoring and evaluation framework). The tools should be able to provide assistance to LGAs in a range of situations.

To clarify key concepts and ideas, a short Glossary provides definitions and clarifications of technical terms (Annex 2). A detailed list of References (with internet links where possible) indicates a range of materials that are related to the themes addressed in the text (Annex 3). The 1997 Abidjan Declaration by Mayors and Municipal Leaders (Annex 4) is an important reference document for LGAs interested in addressing HIV/AIDS.

NOTE: A cross-referencing system has been put in place to highlight the linkages between different parts of the Handbook. In the Operations Chapters, when text is followed by a reference to Tools in parenthesis, this suggests that the mentioned Tool may be useful in the discussed activity or approach. In the Tools Section, there is extensive cross-referencing because many of the Tools build upon or provide information for other exercises. The cross-referencing is intended to facilitate the use of the Handbook and is not intended to be prescriptive.
What is the impact of HIV/AIDS?

There are now over 29 million people living with HIV/AIDS in Sub-Saharan Africa alone. In other regions of the world, prevalence is still growing rapidly. HIV/AIDS is not only a health issue, but affects all sectors and aspects of life. The HIV/AIDS epidemic is, at this stage, a central governance issue that national and local governments cannot afford to ignore. Some statistics that illustrate this point, include:

- In virtually any country where 15% or more of adults are currently infected, it is estimated that AIDS will claim the lives of at least 1/3 of today’s 15 year olds.

- A study in Zambia shows that 2/3 of urban households that lost their main breadwinner to AIDS experienced an 80% loss of income. The same study found that 61% of these households had moved to cheaper housing, 39% lost piped water, and 21% of girls and 17% of boys dropped out of school.

- In urban areas of Cote d’Ivoire, spending on school education fell by half, food consumption went down 41% per capita, and health care expenditure more than quadrupled in households where a family member had AIDS.

- In the first 10 months of 1998, Zambia lost 1300 teachers, equivalent to 2/3 of the new teachers the country trains every year.

- Public health spending on AIDS alone exceeded 2% of GDP in 7 of 16 African countries (1997) where total health expenditure from public and private sources on all diseases accounts for 3-5% of GDP.

- In one Zambian hospital, deaths among health care workers increased 13-fold between 1980–1990, largely because of HIV/AIDS.

Why should local government authorities address HIV/AIDS?

Urban areas provide specific challenges and opportunities in the fight against HIV/AIDS. There are four core arguments for why LGAs should be concerned with responding to HIV/AIDS:

1. Urban areas are often the nexus for the spread of HIV/AIDS because of high population density and mixing, locus of location of transport hubs, and prevalence of vulnerable groups—including youth, migrant workers, commercial sex workers, truckers, etc.

2. The urban poor are disproportionately affected by HIV/AIDS, with the costs of care and loss of income resulting from HIV increasing the vulnerability of poor families. This is especially true among families living in informal settlements who have limited access to secure livelihoods, healthcare, and information.

3. The costs of HIV/AIDS to urban areas extend beyond the loss of life and increased suffering. Increasing health service demands are coupled with a decreasing ability to pay for municipal services. A decreasing pool of labor supply, skills, and tax revenue also
impede the ability of a municipality to pursue goals of development and threaten its ability to provide its core services.

4. LGAs are responsible for the social and economic development of the communities they serve through the delivery of many services. HIV/AIDS has the potential to undermine the considerable investments by national and local governments, donors and other supporting agencies, to strengthen municipal management, municipal finance, local service delivery (particularly to the poor) and local economic development. LGAs must therefore define their response to HIV/AIDS within the context of their responsibilities.

What can local government authorities do?

All of the HIV/AIDS challenges facing urban areas also provide opportunities for action. LGAs are closest to those affected by HIV/AIDS and are therefore optimally placed to intervene. However, LGAs can only succeed at confronting HIV/AIDS by working closely with all levels of government as well as working with local partners in civil society that are fighting HIV/AIDS at the community level.

LGAs have many functions, but implementing extensive HIV/AIDS responses has not traditionally fallen within their core business. Indeed, their clearer comparative advantage may be their capacity to foster an enabling environment by coordinating, managing, and contracting out new and existing local responses to HIV/AIDS. In addition, recent studies suggest that the most effective prevention strategies for HIV/AIDS may be very closely linked to how openly and honestly the threat of HIV/AIDS is addressed in local communities. Local leaders may be able (with limited resources) to do a great deal to fight HIV/AIDS by using their position to fight stigma and facilitate open community discussion about the real and immediate impacts of HIV/AIDS on family members, friends, and coworkers.

By taking action against HIV/AIDS, LGAs are securing the future of their towns, cities and communities; and by supporting LG HIV/AIDS Responses, National AIDS Programs are fulfilling their mandates of supporting sustainable, accountable and local responses to HIV/AIDS.

The following box offers an overview of what could be involved in mounting a LG HIV/AIDS Response. The remainder of the document clarifies what, why, and most importantly, how to accomplish these tasks.
An effective LGA Response to HIV/AIDS should be:

- Consistent in what it does with National AIDS Policy and oriented to needs of the local context.
- Informed by an understanding of local realities, norms and trends; specifically the impact of HIV/AIDS on the local community, the impact of HIV/AIDS on municipal functioning, and the existing resources and possibilities for responding to HIV/AIDS. Sensitive to the special risks facing women and young people.7
- Promoted and supported by LGA leadership and a Task Team of LGA and community stakeholders.
- Multisectoral, recognizing that the impact of HIV/AIDS and the response require a multi-pronged approach.
- Comprehensive in assessing how best to deal with prevention, treatment/care, and impact mitigation.
- Two-pronged, with an internal (LGA staff and their families) and external (service delivery and coordination) focus.
- Oriented to achieve functional integration of programs and services addressing HIV/AIDS, both within the LGA (especially integration of health and welfare services) and between the LGA and community agencies working in HIV/AIDS (integration of efforts of different providers).
- Mainstreamed into development programs of the LGA rather than treated as a stand-alone area of intervention.
- Committed to enhance community participation in planning, program design, and implementation. This includes the need to proactively include people infected and affected by HIV/AIDS and their representative organizations in consultation processes.
- Committed to address issues related to stigma and discrimination as well as the gender dimensions of the epidemic.
- Oriented to mobilizing and coordinating resources within (business and civil society) and beyond the LGA environment (external funding and support) for responding to HIV/AIDS.
- Based on a developmental approach of learning by doing, using monitoring and evaluation systems to strengthen response frameworks over time.
Overview of Chapters

The scope of activities carried out by a LGA will be a function of a range of factors. This includes the scope and nature of national HIV/AIDS policies, time and commitment of leadership and key officials, extent and understanding of the local epidemic, existing activities and organizations dealing with HIV/AIDS, access to resources, communication channels to other stakeholders including national government, and the extent of decentralization and community participation in decision-making at local level. The following five chapters offer an overview of the tasks recommended for LGAs interested in creating and/or expanding an effective response to HIV/AIDS.8

Each of these chapters is supported by a number of tools that can be found in Annex 1, these tools are identified by number and name, in the text box at the beginning of each chapter.

Chapters:

1. Leadership and Teambuilding
   1A. Involving Leadership
   1B. Establishing or Strengthening Local Government HIV/AIDS Focal Points

2. Understanding the Local Situation
   2A. Situation and Impact Analysis
   2B. Assessing Local Government Roles and Responsibilities
   2C. Taking Stock of Local HIV/AIDS Responses


4. Implementing the Local Government HIV/AIDS Response Strategy

5. Monitoring and Evaluation

Annex 2. Glossary of Terms
Annex 3. Useful Resources, Websites and References
Annex 4. Abidjan Declaration
Annex 5. Partners
Acronyms and Abbreviations

ART  Antiretroviral Treatment
AIDS  Acquired ImmunoDeficiency Syndrome
AMICAALL  Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
CSO  Civil Society Organization
HBC  Home-based Care
HAPN  HIV/AIDS Partnership Network
HIV  Human Immunodeficiency Virus
IDP  Integrated Development Planning
LGA  Local Government Authority
MAP  Multi-country HIV/AIDS Program
NAC  National AIDS Council (or Commission)
NAP  National AIDS Program
OVC  Orphans and Vulnerable Children
PEP  Post-Exposure Prophylaxis
PMTCT  Prevention of Mother to Child Transmission
PHC  Primary Health Care
PLWHA  Person Living With HIV/AIDS
STI  Sexually Transmitted Infection
UNAIDS  Joint United Nations Program on HIV/AIDS
VCT  Voluntary Counseling and Testing
As the leaders of LGAs, Mayors/Councilors/CEOs/Executive Management Committees have a powerful role to play in raising awareness of HIV/AIDS, prioritizing HIV/AIDS activities, and supporting HIV/AIDS Focal Points and Task Teams.

- In general, mayors and councilors are responsible for policy direction while CEOs provide strategic leadership and management. Buy-in from both is essential for an effective LG HIV/AIDS Response. LGA leaders must be personally committed to generate an effective HIV/AIDS response as well as to inspire others to take a stand in addressing the epidemic.

- By publicly recognizing the present and future challenges that HIV/AIDS poses to municipalities (e.g., breakdown of families, loss of staff productivity in public and private sector, increased costs of health services, loss of community members, challenges to municipal service delivery from lower local revenues and higher demand) leaders can promote and support long-term investments in HIV/AIDS responses.

- Where leadership has not yet become actively involved in supporting HIV/AIDS responses, informal groups spearheaded by community leaders may be able to catalyze the process through independent community-oriented initiatives. However, the support of local leadership is a key element in creating widespread and sustainable HIV/AIDS responses at the municipal level.

- Collaboration between LGA leaders and community leaders (from religious groups, CSOs, membership associations, etc.) can be a powerful force in stirring public dialogue on HIV/AIDS and generating community involvement in LG HIV/AIDS Responses.

Chapter 1. Leadership and Teambuilding

1A. Involving Leadership

1B. Establishing or Strengthening LG HIV/AIDS Focal Points

1A. Involving Leadership

Purpose:
- Promote LGA leadership on HIV/AIDS.

Process:
- Public statements, media events.
  Commitment to creating and supporting HIV/AIDS work plans and fundraising.

Participants/ Suggested Requirements:
- Mayors, Councilors, Municipal Officials, Community leaders

Lessons Learned/ Examples:
- Box 1.1 Leadership and Promoting Openness: Uganda and South Africa
- Box 1.2 AMICAALL: Supporting HIV/AIDS Leadership, Partnership and Action

Tools:
- 1.1 Mayors/CEOs/municipal managers: Checklist
- 1.2 The elected councilor: Checklist
- 1.3 Municipal officials: Checklist
Box. 1.1 Leadership and Promoting Openness: Uganda and South Africa

In South Africa, nearly 500,000 people become infected by HIV each year, a large percentage of whom are between the ages of 15-24. In a country where nearly a quarter of the population is HIV positive, it would seem that the impact of HIV/AIDS would be stark, as neighbors, family members and colleagues die from the epidemic. Yet, stigma and secrecy are central to the lives of many who are living and dying with AIDS. As one hospice group notes, “the worst thing is that many of the (AIDS) patients are socially isolated and live alone in flimsy shacks.”

Recent studies comparing the success of Uganda (which has reversed its HIV prevalence) with the continued struggle of South Africa to fight HIV/AIDS, have argued that the success in Uganda may be in large part due to the openness surrounding the personal impacts of HIV/AIDS and the role of leaders and communities in discussing this more openly. In Zimbabwe and South Africa the majority of those interviewed reported hearing about HIV/AIDS from the media, and public awareness campaigns, whereas in Uganda most respondents mentioned primarily personal experiences, openly referring to “my father,” “my neighbor,” or “my friend.” The studies suggest that the openness of Ugandans regarding HIV/AIDS may be a function of strong community bonds (or social cohesion) that fosters local trust, whereas in South Africa this social cohesion having been undermined by the legacy of apartheid and less open leadership, causes people to be more secretive and shameful of their personal experiences with HIV/AIDS.

For LGAs, understanding how people learn about HIV/AIDS, and supporting open, frank discussion of the impact of AIDS may be a central way to fight stigma and foster real behavior change.

The work of AMICAALL (Alliance of Mayors Initiative for Community Action on AIDS at the Local Level) focuses on developing a cadre of African leaders who inspire LGA responses to HIV/AIDS. National chapters of the Alliance have been launched in Burkina Faso, Cote d’Ivoire, Mali, Namibia, South Africa, Swaziland, Tanzania, Uganda and Zambia. Together, these national chapters serve as an important, politically supported, continent wide Alliance on HIV/AIDS in Africa.

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

Political leaders at the local government level have a high turnover. For example, in the 2002 elections in Uganda, there was over 70% turnover of LGA leadership. This points to the need to institutionalize leadership by establishment of structures and processes in LG institutions. AMICAALL works towards embedding AIDS response in municipal functioning rather than establishing separate structures. This sometimes requires placing coordinators within municipalities as a first step in establishing a multisectoral approach. AMICAALL’s experience shows that a LG HIV/AIDS Response requires strong leadership along with capacity building and partnership development.

AMICAALL’s engagement with municipalities follows a sequenced process, beginning with a sensitization workshop where municipal leaders are introduced to ideas about what they might in their capacity as municipal leaders. This is followed by a launching of municipal initiatives, accompanied by a program development process and resource mobilization. Then attempts are made to find ways of strengthening the municipal framework for multisectoral response. This is done with special sensitivity to the need to avoid imposing additional burdens on already burdened structures.

AMICAALL promotes a partnership approach to implementing LG HIV/AIDS Responses by encouraging cooperation and coordination between LGA and civil society. Partnerships are also central to the organization of AMICAALL, which is built upon networks within and across countries. AMICAALL recognizes that while empowering LGA leaders to address HIV/AIDS is critical, to be effective any LGA response to HIV/AIDS must be integrated with ongoing activities at the local and national levels.

Creating and allocating funds for the development of an **HIV/AIDS Focal Point** within the LGA is a first step in developing a LG HIV/AIDS Response Strategy. The focal point may be supported by a multisectoral **HIV/AIDS Task Team** (of LGA departments and the community) that is linked to the National AIDS Council (NAC) as well as to the line ministries.

**HIV/AIDS** is increasingly addressed as a multi-sectoral issue, and responses have shifted accordingly from Ministries of Health to specialized units responsible for overseeing the mainstreaming of HIV/AIDS Responses in all sectors. Most National AIDS Plans (NAP) are now being coordinated and rolled out by National AIDS Councils. To facilitate the involvement of LGA within the NAP, including access to funding, it is essential that the LGA identify an HIV/AIDS Focal Point (**Tool 1.4**) and HIV/AIDS Task Team (**Tool 1.5**) to coordinate LGA HIV/AIDS Responses.

A truly multisectoral HIV/AIDS Task Team would include representatives from a range of LG sectors (health, education, planning, social services, etc.), LGA leadership (a representative from the Mayor’s office), and representatives from civil society, including People Living With HIV/AIDS (PLWHA).

It may also be useful to establish a **Workplace Policy Sub-Team**, within the HIV/AIDS Task Team, to oversee the development of a Workplace Policy and Program (as the internal part of the LG HIV/AIDS Response Strategy) (**Tool 1.6**).

The LGA may also take a lead in facilitating the development of an **HIV/AIDS Partnership Network** to coordinate communication between community groups and the LGA (**Tool 1.7**).
Chapter 2. Understanding the Local Situation

2A. Situation and Impact Analysis

2B. Assessing LGA Roles and Responsibilities

2C. Taking Stock of Local HIV/AIDS Responses

2A. Situation and Impact Analysis

Purpose:

- Assess the scope and scale of the local HIV/AIDS epidemic in the local area.

Process:

- Gather data. Identify local risk factors. Assess impact on municipality and LGA. Share findings within LGA and invite public comment.

Participants/Suggested Requirements:

- HIV/AIDS Task Team, Health and/or HIV/AIDS specialists, National data on HIV/AIDS, other data.

Lessons Learned/Examples:

- Box 2.1 Mapping High Transmission Areas in Burkina Faso (PLACE)
- Box 2.2 HIV/AIDS and Gender Equality: A Local Issue

Tools:

- 2.1 What is the local HIV/AIDS epidemic classification? Gathering and Analyzing available data
- 2.2 Are there local variations to consider? Creating a comparison checklist
- 2.3 Estimating HIV/AIDS impact on locality: Chart
- 2.4 Estimating HIV/AIDS impact on LGA functioning: Chart

An understanding of the HIV/AIDS epidemic, as it affects the locality, should underpin the development of a LG HIV/AIDS Response Strategy. Expensive in-depth research is not necessary, as a good sense of the local HIV/AIDS situation can be developed using existing national and local data and conducting participatory assessments. This can be carried out by members of the HIV/AIDS Task Team with support from a Health and/or HIV/AIDS specialist (from the Ministry of Health or a local/regional health service organization). A situation analysis will provide a picture of what HIV/AIDS issues (vulnerable groups, stigma, lack of services, etc.) are of greatest concern to the locality. It will also identify opportunities for action and highlight potential obstacles (interest groups, lack of resources, LGA capacity, etc.). The analysis must explore the role of individual attitudes and behavior, and social values and norms, in the spread of the epidemic, as well as systemic and structural factors.

Using a participatory methodology, members of the Task Team can generate an impact analysis that estimates the toll that HIV/AIDS can and will have on the municipality. This can be a powerful advocacy tool.

- Using the national data as a starting point (unless, of course, high quality local data is available), a situation analysis can be developed by assessing the quantity and quality of various risk factors within the locality. These may include: high population density,
presence of urban informal settlements and recently urbanized groups, mobile and displaced populations, concentration of migrant labor (outgoing and incoming), areas on or close to main transport routes, sex industry, economic migration attached to seasonal industries (e.g., harvesting, fishing), crime and gang activity, intravenous drug use, disrupted family and community life due to war, famine or rapid social change, local cultural practices, high levels of poverty and inequality, high levels of other sexually transmitted infections, and low levels of education and intervention (Tools 2.1 & 2.2).

An HIV/AIDS epidemic has serious consequences for local socio-economic and service delivery systems. Areas in which HIV/AIDS will almost certainly have an impact include: local economic development, service delivery and community development (e.g., health services, community services, infrastructure planning, housing delivery), demographic structure of the population (e.g., age distribution of the population), large numbers of orphans, street children, and child-headed households, increased number of burial plots required, reduced ability of households to pay for rates, rents, taxes, reduced productivity due to increased absenteeism, loss of skills, and less investment made in training and education (Tools 2.3 & 2.4).

Both the situation and impact analysis can be presented to, and if possible developed with, a wide array of stakeholders both within the LGA and the public. Where direct public participation has not been used, inviting public comment on the draft analysis, especially from People Living With HIV/AIDS (PLWHA), will be a useful way to ensure that the LG priorities are in line with community priorities.
Understanding the Local Situation

Box 2.2 HIV/AIDS and Gender Equality: A Local Issue

Worldwide, more than 50 percent of the 42 million people infected with the HIV virus are male, but women’s infection rates continue to spiral. Women now constitute 50 percent of the infected in the Caribbean and 58 percent in Sub-Saharan Africa, where 68 percent of all young persons infected are female.*

Prevailing gender norms influence attitudes towards sex, sexuality, masculinity and femininity. These norms combine with the power differences in sexual relations to determine gender-based HIV/AIDS risks and vulnerability. Key female and male vulnerabilities and risk factors include:

- The culture of silence around sexual matters
- Female roles as caregivers
- Women’s economic dependence on male earners
- The value placed on marriage and marital relations in some societies
- Gender-based violence, especially among intimate sexual partners
- Gender-discriminatory legal and regulatory frameworks
- Hazards in certain female-dominated professions (e.g., commercial sex work)
- Socialization of males and “tacit” condoning of male risk-taking, including multiple sexual partners
- Homophobia and stigmatization of men who have sex with men
- Hazards in certain male-dominated professions (such as the military, long distance driving, mining, and migrant work)

As opinion leaders and policy makers, LGA leaders and institutions can bring significant pressure to bear on HIV/AIDS through policies and interventions that account for gender dynamics. They can emphasize the cross-cutting nature of gender issues, reinforce positive gender roles or negative stereotypes, and influence social and cultural norms of masculinity and femininity. Further, LGA officials have a good understanding of the situation of people in the local area and an ability to identify populations at risk or in need of services. They can also mobilize support for public information campaigns that target different groups of males and females with gender-specific and age-appropriate information.

*Statistics from UNAIDS 2002.
The first part of the situation analysis (2A) offers the LGA and community a sense of the priority HIV/AIDS issues facing the locality. From this understanding, the LGA will need to develop a strategy that addresses the local priority issues in a way that builds upon existing LGA capacity and strengths, and works within the constraints and opportunities facing the LGA (in the context of existing National AIDS Plans and governance systems). It will also need to set up systems of accountability, and reflect on the LGA capacity to identify and mobilize adequate resources.

As part of the situation analysis, the LGA is encouraged to analyze its own powers, functions, and capacity in responding to HIV/AIDS (Tools 2.5 & 2.6). The shape of the LG HIV/AIDS Response will likely be determined by the National AIDS Plan (if there is one) and the framework for local governance that exists within (the constitution of) the country. Recognizing the constraints and opportunities within the given system is an important step in designing and implementing an HIV/AIDS strategy. Developing long-term strategies for overcoming some of the structural (governance) constraints will be a valuable investment over time.

Before a LGA engages in developing services or forming service delivery partnership agreements for HIV/AIDS (Tool 4.3), it is essential to clarify the powers and functions for which the LGA is responsible. This requires answering the following questions:

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

It is also valuable to assess potential strengths and weaknesses of LGA management of

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### 2B. Assessing LGA Roles and Responsibilities

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<th><strong>Purpose:</strong></th>
<th><strong>Participants/Suggested Requirements:</strong></th>
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<tr>
<td>- Develop an understanding of LGA responsibilities within the National AIDS Plan, recognize the potential strengths and weaknesses of LGA in responding to HIV/AIDS, and prioritize areas for LGA responses to HIV/AIDS.</td>
<td>- HIV/AIDS Task Team in collaboration with participants from all sectors.</td>
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<tr>
<th><strong>Process:</strong></th>
<th><strong>Lessons Learned/Examples:</strong></th>
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| - Review of Constitution and National AIDS Plans to determine LGA mandate and responsibilities, self-assessment, review of budgets and budget priorities. | - Box 2.3 Enabling LGA Responses to Health: Senegal  
- Box 2.4: An HIV/AIDS City Consultation Process: Malawi |

| **Tools:** |  
| --- | --- |
| - 2.5 Understanding the responsibilities of national, provincial and municipal players: Chart  
- 2.6 Conducting a LGA Self-Assessment: Survey |  

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HIV/AIDS programs. Areas of particular importance include: fiscal decentralization relating to budgeting at the local level, intergovernmental relations and support, functional integration, capacity for managing partnerships, procurement capacity, monitoring and evaluation capacity and previous and continuing efforts aimed at managing and coordinating HIV/AIDS at the local level including assessment of performance and challenges.

- The process of self-assessment will highlight areas where the LGA requires capacity building. This information will be important in identifying LGA needs for technical assistance (Tools 4.4), recognizing areas where contracting-out services may be valuable, and highlighting potentially untapped resources within the LGA. In addition, it is valuable to recognize the comparative advantages of an LGA. This may include having access to a large public-service staff, having access to funding sources, being able to use or allocate the use of public buildings, and having legitimacy with community members.

Box 2.3 Enabling LGA Responses to Health: Senegal

DISC (Décentralisation et Initiatives de Santé Communautaire) is a small community health organization in Dakar, Senegal that works towards developing the capacity of district LGAs for responding to health needs. The core team consists of five highly skilled professionals who have developed a structured process for training district health teams. Upon completion of training, the district management team is geared to function as an accountable legal entity, understands its powers and functions, and has the capacity to form partnerships and raise funds.

Some highlights of this process are the way DISC:

- Uses technical agencies of international health organizations to provide focused technical support.
- Works horizontally through a consultative process to develop support for community initiatives for better health services.
- Brings community members and LGA representatives together in a mentored planning process.
- Trains candidates from the health sector and the community in health planning. The training addresses health and decentralization as well as community interaction/facilitation methods.
- Coordinates, with participants, a 5-day community-level planning process that links locally elected bodies, government administration officials, and health technicians (medical personnel). Through the planning process, the community develops a project scope, priorities, a budget, and an annual work plan. It then enters into a matching funds arrangement with funders.

In a fairly short space of time, the community is able to generate a workable plan. The program makes optimal use of available technical assistance, and more importantly, clearly focuses the intervention process. The process has been crafted and mentored by experts, but is conducted by communities and LGA leaders themselves.
Box 2.4 An HIV/AIDS City Consultation Process: Malawi

According to 1998 estimates by the National Aids Commission of Malawi (NAC), Blantyre City had 69,600 HIV positive adults. It is estimated that by December 2005, the adult HIV infections would reach 105,236, with 7436 new orphans. In light of these alarming statistics, the City Assembly of Blantyre decided to transform its response to the HIV/AIDS epidemic.

The Urban Management Program (UMP) provides support to an innovative program, assisting Blantyre City Assembly and local civic organizations to enhance their capacity to manage HIV/AIDS. UMP has developed an HIV/AIDS City-Consultation process to help mobilize the resources and potential of the Blantyre City Assembly, civic organizations and communities at large and enable them to collaborate in order for innovative and strengthened responses to be instituted.

There are eight key tasks in the process and these will be facilitated through a partnership between UMP and its regional anchor institution the Municipal Development Programme and Blantyre City Assembly.

2. Implement a training for transformational leaders with facilitation support from UNDP (May 2003).
3. Undertake a base line survey of HIV/AIDS and its impacts in Blantyre City Assembly using a participatory rapid urban assessment methodology.
4. On the basis of the survey, implement a city wide consultative process to develop a common vision on managing HIV/AIDS in the city and to strengthen partnerships to achieve this vision.
5. Nurture citizens conversations to reinforce the capacity of individuals to better understand the HIV/AIDS epidemic and provide space to debate their concerns with facilitation support from UNDP.
6. Hold an action planning workshop to develop a HIV/AIDS Prevention and Management Strategy for the Blantyre City Assembly.
7. Establish the Blantyre City Assembly Information Corner on HIV-AIDS with support from Southern Africa AIDS Information Dissemination Service (SAfAIDS).
8. Share the experience of Blantyre with other municipalities in Malawi and support the launch of the National Chapter of the Alliance of Mayors Against HIV/AIDS in Malawi with support from Malawi Local Government Association and the secretariat of the Alliance of Mayors Against HIV/AIDS.

Key anticipated outputs from the process include a forum or task team within the city to provide a continuing focus on HIV/AIDS in council decision-making processes, and an increased level of coordination between civil society organizations working in the area of HIV/AIDS at a city level. Additional HIV/AIDS City Consultations are underway in 7 cities.

Also central to situation analysis is determining what resources (both human and financial) are available to the LGA. In terms of human resources, a district or municipality often encompasses a wide range of responses to HIV/AIDS that have developed haphazardly over time. A lack of real coordination or integrated planning sometimes results in duplications and gaps in the available services.

**Identifying and coordinating these local responses to HIV/AIDS** is a key function for LGAs, especially where budget and time constraints limit the amount of direct service delivery that LGAs can provide. To facilitate the LGA’s access to community responses to HIV/AIDS it is valuable to have up-to-date information on local HIV/AIDS service providers (Tools 2.7 & 1.7). In some countries this information may already be cataloged through a national system that gathers information on all registered CSOs (managed by the Ministry of Local Government or another relevant coordinating body).

### 2C. Taking Stock of Local HIV/AIDS Responses

**Purpose:**  
- Develop relationships with local HIV/AIDS service providers and conduct a gap analysis to determine where there are gaps in service provision.

**Process:**  
- Identify local service providers and conduct a survey. Support the development of an HIV/AIDS Partnership Network.

**Participants/Suggested Requirements:**  
- Focal Person, HIV/AIDS Partnership Network/Survey Team.

**Lessons Learned/Examples:**  
- Box 2.5 Taking Stock of Local Responses: Zambia

**Tools:**  
- 2.7 Taking stock of local HIV/AIDS Responses: Questionnaire
Box 2.5 Taking Stock of Local Responses: Zambia

In the city of Ndola, the Catholic Diocese of Zambia runs a large-scale comprehensive HIV/AIDS program which has trained and deployed over 600 volunteers in a home-based care program. It runs a professionally led staff which is highly motivated, and is arguably at the cutting edge of community HIV/AIDS responses.

The LGA responses were minimal in comparison. Further, there are a number of international organizations working in this area. As these systems of local response have grown, the various stakeholders have had to interact with each other, without a city-wide planning process. This points to a clear need to take stock of what is available, what is being done, what are the gaps, and how much further development and integration might proceed.

Recognizing the need to address this imbalance, Zambian mayors and municipal leaders from the 72 councils have made a commitment to become more engaged in the response to HIV/AIDS at the local level. They have now launched a national chapter of the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa.
While HIV/AIDS is a critical issue facing LGAs, developing and implementing a comprehensive HIV/AIDS program is not necessarily the core business of a LGA. Instead, the LG HIV/AIDS Response Strategy identifies priority areas and develops an enabling framework to address these issues with the coordination and leadership of the LGA and an Implementation Plan involving a range of stakeholders. There are three practical elements to a LG HIV/AIDS Response Strategy.

1. **Internal Strategy (or Workplace Policy).** This demonstrates that the LGA recognizes the risks that HIV/AIDS poses to its staff and capacity to deliver services and supports progressive policies and programs within the workplace (Tools 3.1, 3.2, 3.3).
2. External Strategy. Having identified the priority HIV/AIDS issues affecting the municipality, the external strategy outlines how the LGA plans to address these issues, both through mainstreaming within the LGA as well as developing partnerships with external organizations. Central to the external strategy is the recognition that the LGA cannot effectively address HIV/AIDS without the coordinated support of existing local responses. This includes functional integration or coordination of HIV/AIDS-related services, particularly in the health and welfare area. (Tools 3.4, 3.5, 3.6)

3. Management & Monitoring. For a strategy to move from ideas to actions, it must provide a clear vision of how things will be operationalized (i.e. what partnerships will look like, how funds will be mobilized, what are the expectations of leaders, etc.) While the specifics of these elements are addressed in the Implementation (4) and Monitoring and Evaluation (5) chapters, it is important to recognize that management considerations must also be central to the strategy development process.

A LG HIV/AIDS Workplace Strategy recognizes that HIV/AIDS affects the LGA itself and supports measures to address this impact. Any Workplace Strategy should be developed with reference to existing national policies that may have been developed to address HIV/AIDS in the public sector. A Workplace Policy will include prevention activities (e.g., education, access to testing and counseling, etc.) and care and support (provisions for PLWHA). Fighting discrimination and stigma towards PLWHA should play a central role in all policies. Development, implementation, and monitoring of a LG HIV/AIDS Workplace Policy may be overseen by a Workplace Policy Sub-Team (Tool 1.6).

A Workplace Policy should be developed in consultation with LGA workers and their representatives to ensure that an appropriate policy, designed to prevent the spread of the HIV/AIDS and protect all workers from HIV/AIDS related discrimination, is implemented. The scope of activities to be addressed in a Workplace Policy will reflect the local state of the epidemic and LGA capacity and finances. A Workplace Policy should be developed with reference to existing national policies that may have been developed to address HIV/AIDS in the public sector. A Workplace Policy may be most appropriately implemented by partners.

Box 3.1 Responding to HIV/AIDS: Education as a Public Good

LGAs in developing countries are challenged with providing services while facing a range of internal and external demands (e.g., poverty, conflict, political instability, corruption, and natural disaster). Why should addressing HIV/AIDS be a priority when delivery of basic municipal services can be an overwhelming challenge?

Local government responses to HIV/AIDS do not and should not simply benefit those affected by HIV/AIDS. The education sector serves as an excellent example because it is both an important HIV/AIDS prevention tool as well as an essential component of poverty alleviation. In Malawi and Uganda, national initiatives have eliminated primary school enrollment fees (for up to four children per household) to increase universal access to education, including AIDS orphans and girls (who are particularly vulnerable to HIV/AIDS). To replicate this on a smaller scale, LGAs may waive enrollment fees or eliminate uniform requirements, thus helping poor families and those affected by HIV/AIDS alike.

The purpose of an External Strategy is to translate the local HIV/AIDS prevention, care and impact management and mitigation priorities (Tools 2.1-2.4) into a framework for LGA action that is informed by the mandates and capacity of the LGA (Tools 2.5 & 2.6) and shaped by the resources that are or could be made available to the LGA (Tools 4.6-4.8). The strategy may include:

- A clear articulation of the priority target groups and areas (e.g., women, youth and other vulnerable groups, service provision (VCT), support for PLWHA, etc.)
- Specific objectives for addressing the priority areas (e.g., integrate VCT facilities into all local clinics, etc.)
- Institutions responsible for achieving objectives (e.g., LGA units/depts. and/or local partners)

Mainstreaming and functional integration are valuable planning tools for creating and implementing an effective external LG HIV/AIDS Response Strategy. Mainstreaming means that departments from different sectors consider how they might contribute to the alleviation of HIV/AIDS through

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Box 3.2 The Msunduzi Municipal AIDS Strategy: South Africa

The Msunduzi Municipal AIDS Strategy is a co-ordinated partnership between the City Council, the Children in Distress Network (CINDI), Lifeline, and more than 60 CSOs working in the area. To set the process in motion, a workshop was convened to identify what was needed to address the AIDS epidemic in the area, where 100,000 people are infected, 250 deaths occur each month, and where 60% of hospital in-patients have AIDS-related conditions.

Priority areas for action that were identified included: community empowerment, education awareness, a referral system, supporting the rollout of treatment with Nevirapine (for HIV-infected pregnant women), improving access to social grants, the welfare of orphans, and improvement in treatment and care through the clinics and community volunteers. Each priority area was spelt out with the objectives, activity, timeframe, partners, and progress indicators.

Crucial to the success of the campaign was addressing the needs of the CSOs who, as a result of the Council’s “open-door” policies, are able to raise issues at the highest level. For example, if an organization dealing with the training of home-based care workers requires a building from which to operate, the Council will try to identify suitable premises. The municipality’s Director of Health explains: “This scheme has had some positive benefits for the city. Historic buildings that were derelict have been restored by CSOs through their own funding.” A disused government office near Edendale Hospital was made available to the CINDI Network. Here, care kits containing basic medicines and antiseptics are assembled and given to home-based care workers trained by CINDI partners.

Another example of effective leadership centered on the problem of access to birth certificates, for those working with orphans and vulnerable children (OVC). The office of the Deputy Mayor took the lead in initiating discussions with the National Department of Home Affairs. As a result, the Department agreed to identify a person in the Department that would be available daily to assist CSOs working with OVC.

SOURCE: HIVAN (http://www.hivan.org.za)
### Box 3.3 What does Mainstreaming for HIV/AIDS Mean?

<table>
<thead>
<tr>
<th>In most instances LGA responsibilities cover provision of:</th>
<th>Examples of what Mainstreaming for HIV/AIDS may include:</th>
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| Administrative infrastructure and services               | • Provide, display, disseminate information and education materials on HIV/AIDS prevention.  
• Ensure that non-discrimination policies are implemented and monitored in all areas of LG work. |
| Water and waste infrastructure and services               | • Collaborate with local hospitals and parks to ensure there is a system for safe disposal of needles and effective waste management. |
| Road and transport infrastructure and services            | • Condom distribution and prevention messages on public bus routes and at bus depots (for drivers, truckers).  
• Contracts awarded for road building should include HIV/AIDS awareness activities for road builders. |
| Health and education infrastructure and services          | • Ensure that all health workers have adequate information about HIV/AIDS.  
• Support needle exchange programs where IV drug use is prevalent.  
• Establish a referral system for all HIV/AIDS related testing, counseling, treatment and care as well as a referral system (with depts. of social welfare and education) for vulnerable families.  
• Include HIV/AIDS awareness training in school curriculum.  
• Provide referral system between schools and adolescent health services. |
| Social and welfare infrastructure and services            | • Coordinate with health department to establish a referral system for families affected by HIV/AIDS.  
• Support micro-credit and insurance programs for people and families effected by HIV/AIDS.  
• Set up a school-fees fund for orphans. |
| Economic infrastructure (markets) and services             | • Use market infrastructure to display HIV/AIDS prevention messages. |
| Land/Buildings for residential, business or other uses such as burial grounds | • Identify and assist in meeting the housing needs that may result from HIV/AIDS (e.g., those taking in orphans, child-headed households).  
• Integrate HIV/AIDS awareness activities into slum upgrading projects.  
• Identify buildings that may be used in HIV/AIDS projects. |
Mainstreaming is most effective when activities are integrated into a cohesive framework addressing clear priority areas and when inter-sectoral collaboration is emphasized (Tools 3.5 & 4.2).

**Functional integration** focuses on health service provision, ensuring that the range of services for HIV/AIDS is offered in a consistent and logical manner. Key elements in successful functional integration are **continuum of care** and **continuum of prevention and care**, meaning that all aspects relating to HIV/AIDS health prevention and care (VCT, counseling, access to treatment, home based care, care for orphans, etc.) are linked to each other in an accessible way. Functional integration requires a well-developed system of communication among service providers (within and outside of the LGA) as well as between different sectors within the LGA. For example, someone who goes for testing, and is found positive, should be entered into a program where they have access to counseling and referrals to clinics for treatment of opportunistic infections. They should also be put in contact with local CSOs or LG departments that can provide care and guidance, and also help them access any welfare support. (Tool 3.6).

Developing **partnerships** (or mobilizing human resources) with CSOs and other levels and departments of government can be an efficient way to access skills and resources that are not available within or do not fit within the mandate of the LGA. The kind of partnership that a LGA will decide upon will depend upon the type of service the partner is providing and the capacity of the partner (Tools 4.1-4.4).

Central to all partnerships is the need to **articulate the expectations** of the partnership (i.e. output-based performance indicators) and to **establish appropriate and transparent communication mechanisms** for effective coordination and a harmonious working environment (Tool 5.4).
When a draft LG HIV/AIDS Response Strategy has been prepared, preferably with community participation, the LGA may choose to create an opportunity for community comments, particularly for PLWHA. If an HIV/AIDS Partnership Network (HAPN) is already established (Tool 1.7), it may be the most appropriate venue for feedback. For a more public discussion, the media may be asked to disseminate a draft of the strategy, and the LGA may offer to host a public meeting.

**Box 3.4 Rapid Results and Functional Integration: Eritrea**

In the central Zoba (District) of Eritrea, the HAMSET control project (addressing HIV/AIDS, Malaria, Sexually Transmitted Disease, and Tuberculosis) initiated a Rapid Results approach to rolling out the national HIV/AIDS Strategy. A motivated team of national and local government representatives along with members of locally active HIV/AIDS service CSOs developed a strategy to meet specific project targets within a 100-day deadline. This process was supported by all levels of leadership and generated a great amount of publicity and enthusiasm. Working to meet the 100 day targets, the team developed an effective and responsive monitoring and evaluation tool and discovered creative mechanisms to overcome obstacles.

An example target was “Ensuring that 25% of PLWHA and their affected family members in Aba-shawl and Edaga-Argby will be provided with holistic home-based care.” The Home-Based Care (HBC) team realized that to meet the objective they have to go “upstream” in the process. So they met with the VCT counselors and asked them to incorporate into their counseling, some encouragement for home based care and a referral service. They soon found, however, that because of the stigma associated with being HIV positive, infected individuals are reluctant to accept HBC from religious institutions (that do not maintain high standards of confidentiality), so the existing services are not being fully exploited. They are trying to get around this problem in two ways: (1) short term, having a referral center run by religious institutions to which infected individuals can go before setting up the home visits, and (2) long term, dealing with the stigma issue head-on through information and media campaigns.

With the target of increasing the number of individuals receiving quality home-based care, the HBC team encountered a new area for functional integration by linking VCT and HBC, and they also began to address a previously unrecognized source of stigma.
**Box 3.5 When are Memoranda of Understanding Most Appropriate? Uganda**

A memorandum of understanding between a Ugandan CSO concerned with providing voluntary counseling and testing (VCT) services and the LGA set out a framework for working together to provide VCT services and training in a district capital. The CSO is to provide training and support to staff in three municipal clinics where VCT will be provided by government services and laboratory testing services. The LGA is to provide consumables involved in testing procedures and close co-operation in referring to and from PHC clinics. They also agree to work together in other areas of mutual interest.

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

In spite of this apparent failure to meet expectations, the LGA and the CSO feel that the partnership has been more or less successful. The CSO recognizes the financial difficulties facing the LGA. Essential to the partnership is a sense that the partners are pooling resources to deal with a problem about which they need to co-operate. The delivery of consumables, while important, is secondary to this sense of joint obligation.

A stronger and more legally binding agreement would have been inappropriate and may have eroded the spirit of necessary co-operation, which has survived, as has the hope on both sides that the LGA might ultimately meet all of its commitments. When there are risks of non-delivery, the flexibility of a memorandum of understanding may be a more promising framework of agreement than a legally binding contract.
Box 3.6 Supporting Orphans and Vulnerable Children: South Africa and Uganda

It has been estimated that of the more than 13 million children under the age of 15 orphaned by HIV/AIDS, 95% live in sub-Saharan Africa. In South Africa alone, almost a million children (under 15) will have lost their parents to HIV/AIDS by 2005. Losing one or both parents to HIV/AIDS greatly increases the likelihood that a young person will not attend school and will not receive adequate nutrition and care. There is also increased likelihood that a young person will migrate to urban centers in search of livelihoods, in many cases increasing their risk of becoming infected by HIV, especially girls.

Meeting the needs of AIDS orphans requires a coordinated system that can identify children at risk and provide them with necessary support. In Bulawayo City, the city council’s health services department has created the Bulawayo Terminally Ill Committee which is tasked with identifying the sick and destitute and ensuring that children in these families are brought into the social services system. This includes local health care givers providing stipends for food, clothing and counseling, and the social welfare department ensuring that educational needs are met. The primary aim of the Committee is to ensure that vulnerable children are supported, to the extent possible, within their community.

In the Tororo and Luwero districts of Uganda, LGAs and communities have partnered together with Plan International to provide integrated support to families impacted by HIV/AIDS. A key objective of their approach (using their “Circle of Hope” methodology) is to help HIV-positive parents and future care-givers prepare for the best possible future for the children concerned, by addressing the economic, legal, emotional and practical aspects of moving on and leaving behind children orphaned by AIDS. To be sustainable these types of local initiatives must be community driven and the capacity of LGAs to support this through facilitating multi-institutional partnerships is essential to achieve the desired outcomes.

Chapter 4. Implementing the Local Government HIV/AIDS Response Strategy

4. Implementing the LG HIV/AIDS Response Strategy

Purpose:
- To develop appropriate management and funding mechanisms to implement the strategy.

Process:
- Developing an Implementation Plan (including budget), identifying essential management skills, identifying funding mechanisms and resources, and allocating management and monitoring responsibilities.

Participants/Suggested Requirements:
- HIV/AIDS Task Team with active involvement of all LGA sectors (including Finance), and community.

Lessons Learned/Examples:
- Box 4.1 A Win-Win Partnership: South Africa
- Box 4.2 Ways of creating opportunities for People Living with HIV/AIDS

Tools:
- 4.1 Developing an Implementation Plan (IP): Checklist
- 4.2 Frameworks for Implementation: Chart
- 4.3 Frameworks for Partnership: Checklist
- 4.4 Making the most of Technical Assistance: Checklist
- 4.5 Budgeting a LG HIV/AIDS Response: Example
- 4.6 Looking in the right places; Identifying Resources: Checklist
- 4.7 Essential Financial Management Skills: Chart
- 4.8 Procurement: Categories and Methods: Chart

The purpose of developing a LG HIV/AIDS Response Strategy is to implement it, and implementing any strategy will require funding and management. In the process of conducting the Situation Analysis, the LGA will likely have developed a sense of what funding is available and what may still be needed.

In order to access additional funding, a LGA will be required to provide a strategy (shaped by clear priorities and outlining inputs, activities, outputs, and outcomes), an implementation plan (identifying all partners, resources, and time-frames), and a budget (illustrating existing and required funding).
The main objective of the LG HIV/AIDS Response Strategy and its implementation is to support ongoing local responses to HIV/AIDS, leverage funding, build partnerships to fill unmet needs in the locality (i.e. VCT services, adolescent outreach programs, etc.), and integrate HIV/AIDS activities into LGA work. An important ingredient for meeting these objectives is a positive relationship with the community and organizations of PLWHA. Community participation is essential in all aspects of strategy development and implementation planning.

An Implementation Plan provides a realistic picture of how and when the strategy will be implemented, with what resources, and by whom. It will also identify how progress will be measured and evaluated (more in Chapter 5). There are many ways of creating an Implementation Plan, and the format will depend on the preferences of the LGA. For LGAs that are just starting to address HIV/AIDS, it may be useful to start with an Implementation Plan that highlights a few strategic activities, rather than an extensive list of proposed activities.

Regardless of what method is used, there are two central ingredients to creating a successful Implementation Plan. The first is participation. Whether the activities are being mainstreamed into existing LGA sector activities, or whether partner agencies are being contracted to carry out specific services, the parties involved in any activity must be engaged in the process of identifying what their tasks will be, what outputs and outcomes they will accomplish, and when they will do so. The second ingredient is institutional commitment, referring to the continued support of leadership and the development of institutional mechanisms that hold LGA officials and sectors accountable for their progress on HIV/AIDS issues. There will also need to be continued support of the Task Team that will be responsible for overseeing all contracts with external partners, coordinating functional integration projects, and facilitating LGA sectors with their mainstreaming activities.

Mobilizing resources for HIV/AIDS is a key part of both strategy development and implementation. In the Situation Analysis (2) and Strategy (3) chapters, the focus was on identifying

NOTE: The structure of the Implementation Plan will be central in the development of the Monitoring and Evaluation framework. (Tools 5.1-5.3)
local resources (e.g., CSOs) and developing partnerships and coordination mechanisms with them. In this section, we look at the issues of fiduciary management.

There are multiple functions performed by a LGA with regards to accessing, managing and disbursing funding for HIV/AIDS responses. HIV/AIDS funding may be requested by the LGA for:

- **LGA activities** such as developing and implementing an internal Workplace Policy and mainstreaming HIV/AIDS components into LGA work.

- **Activities contracted to partner agencies**, through the LGA, for specific project components that are implemented through partnerships.

- **Civil society organizations**, to which the LGA may provide community grants to support new or ongoing local HIV/AIDS initiatives.

Some LGAs may have budgeted an amount to address HIV/AIDS or received a transfer from the national government. If limited own funds are available, however, the LGA can still undertake many activities but will need to tailor their Implementation Plans accordingly. In most cases, however, some **new sources of funding** may be required. Many National AIDS Programs have developed mechanisms (through the NACs or their Financial Management Agencies) to facilitate the disbursement of HIV/AIDS funds to LGAs and other local partners. If the strategy development process has been coordinated with the appropriate NAC partners, the LGA may be able to access funding this way. Soliciting funds from national and international donors may also be a viable option (e.g., Global Fund for AIDS, Malaria and Tuberculosis, foundations, bilateral donors, large NGOs).

The **budget** for implementing a LG HIV/AIDS Response Strategy will be comprised of the inputs required for the implementation of activities that are carried out to meet strategic objectives. A detailed Implementation Plan will be the starting point for developing the budget. Most donors will require that the LGA provide some contribution towards the budget, even ‘in kind’, and so the budget should indicate where the LGA is able to support activities. Funding the salary of the LG HIV/AIDS Focal Point is a strong sign of LGA commitment to HIV/AIDS.

Managing outside funds requires the LGA to critically examine its own fiduciary management capacity and requires that the LGA set (and monitor) standards for its partners and itself. Common elements of fiduciary management include transparent **procurement, disbursement, and reporting** (Tools 4.5–4.8). Where this is lacking, it must be a priority to develop the necessary skills to be able to effectively mobilize and manage resources (Tool 4.4).

Without **community participation** and public support, any strategy is likely to fail. Encouraging community participation, specifically PLWHA, throughout the process of identifying priorities, developing a strategy, creating an action plan and mobilizing resources is essential for both developing an appropriate strategy and program of action in the first place, as well as ensuring its sustainability. As will be discussed in the Monitoring and Evaluation chapter (5), all the activities of the LG HIV/AIDS Response Strategy must ultimately be in line with creating favorable outcomes (e.g., reduced HIV/AIDS, increased care and support for PLWHA) in the community and should therefore be developed with community input.

There are many opportunities for community participation, including:

- Involving community members in the situation analysis through participatory methodologies.

- **Public participation in HIV/AIDS Task Team** (by supporting community representation—ideally such representation should include a PLWHA.)
Public Stakeholder Meetings for voicing community priorities and updating communities on decisions and strategies. (These should be well-publicized open events and welcoming to PLWHAs, women, youth and other vulnerable groups.)

Promoting HIV/AIDS initiatives (through LGA funding or leadership) in ongoing community driven poverty-alleviation activities.

Supporting a HIV/AIDS Partnership Network (Separate from the Task Team, an HAPN is a community network that the LGA can help coordinate and participate in, but it should ultimately be a venue for community groups and individuals.) (Tool 1.7).

Support public involvement in facility committees (e.g., hospital boards, clinic committees, etc.)

Volunteerism in large community projects, such as HIV/AIDS Awareness Days.

Box 4.2 Ways of creating opportunities for People Living with HIV/AIDS (PLWA)

- Identify opportunities for involvement of PLWHAs by considering each of the following levels: contributors (educators, speakers, campaign volunteers), service delivery (caretakers, peer educators, counsellors), experts (advisors on specialised areas), advocacy (spokespersons), training, managing (decision making), strategizing (policy formulation), being consulted, and recipients (information or services).

- Identify ways of engaging with PLWHAs, which may be through established organizations.

- Include those affected by HIV/AIDS, particularly children. Also reach out to those who may be very sick and/or isolated socially or geographically and not in a position to directly involve themselves in projects and programs. This requires the use of consultation and advocacy.

- Plan to measure and monitor the impact of greater involvement in programs and in the lives of people with HIV/AIDS.
Chapter 5. Monitoring and Evaluation

5. Monitoring & Evaluation

Purpose:
- To develop and implement a useful Monitoring and Evaluation framework (indicators, methodology, data analysis).

Process:
- Building upon any existing M&E framework, identify LGA specific questions to be addressed in the framework, develop indicators and methodology, and integrate monitoring data into program development and learning.

Participants/Suggested Requirements:

Lessons Learned/Examples:
- Box 5.1 Indicators, Methods and Measures
- Box 5.2 Innovations in Knowledge Sharing: Uganda

Tools:
- 5.1 Guidelines for developing and implementing M&E: Overview
- 5.2 Identifying national indicators: Chart
- 5.3 Basic M&E Module: Chart
- 5.4 Measuring partner performance: Checklist
- 5.5 Rapid assessment of LGA action in key areas: Evaluation Survey
- 5.6 Making use of monitoring and evaluation

Monitoring and Evaluation (M&E) activities are not only key for evaluating the success and coverage of a program but are also key learning tools. Indicators will reflect the priorities of the LGA but should also be responsive to national M&E frameworks. An HIV/AIDS M&E framework will account for what is being monitored and evaluated, why, by whom, and to what end.

The difference between monitoring and evaluation is often unclear. Monitoring is the routine assessment of ongoing activities and progress. Monitoring asks: “What are we doing?” Monitoring covers all aspects of program activity and ideally involves a plan for systematically collecting key program information relating to inputs, activities/processes and outputs.

In contrast, evaluation is the episodic assessment of overall achievements. Evaluation concerns the outcomes and ultimately the impact of a program. Evaluation asks: “What have we achieved?” Frequently evaluation uses program
monitoring data, but it also involves a specific and often independent program of research.

- M&E frameworks can easily become too complex and end up demanding more data than the LGA can effectively use. Simple and action-oriented M&E systems are most cost-effective and useful to develop and manage (Tool 5.1).

- A first step in developing an M&E framework is to evaluate what questions the LGA wants to answer through monitoring (what needs to be examined and addressed during the implementation process) and evaluation (how have the goals of the strategy been met and what can we improve). M&E addresses both how effectively the LGA is carrying out what it has committed to carrying out and what the impact of the LGAs activities are on the lives of the people living in the municipality.

- Two types of monitoring will be involved in addressing HIV/AIDS. The first is epidemiological surveillance, which is largely a technical process to monitor the state of the epidemic. This is generally carried out largely by the national government (Ministry of Health) or specialized institutions.

However, the LGA may also want to monitor the impact of HIV/AIDS on its own functioning (Tools 2.4 & 3.1). The second type of monitoring, and the one addressed here, is programmatic monitoring which measures the extent to which finances and activities are being properly managed and carried out.

- In developing an M&E framework, it will be valuable to collect and analyze available local and national data on HIV/AIDS. Useful national data may come from the Ministry of Health while local data may be gathered from administrative records (e.g., on health, education, demographics, etc) (Tools 5.2 & 2.2).

- The monitoring priorities that the LGA develops and the amount of available data will inform the process of developing indicators and methods for collecting data. While monitoring is most effectively conducted by the LGA (HIV/AIDS Task Team) itself, it may be useful to contract evaluation tasks to an outside organization/consultant.

- Monitoring indicators will likely be derived from the objectives put forth in the LG

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**Box 5.1 Indicators, Methods and Measures**

**Indicators** are definitions of areas in which the program is expected to have an effect, or components thereof. For instance, a program to establish voluntary counseling and HIV testing amongst municipal employees may need to ask the question: ‘How effective has the program been in promoting VCT?’

An appropriate indicator might be the percentage of municipal employees who have undergone VCT. Specific measures of this, may include the number of completed VCT procedures that have been done in the VCT facility. This is the **measure**. An alternative measure may be the percentage of municipal employees who have undergone VCT.

Measures and methods used are interrelated. Common **methods** used in program M&E are surveys of users of services, focus group discussion groups, interviews, monitoring of operational processes, analysis of program documentation and minutes, and monitoring of resource allocation.
The timely (annual, or biannual) reporting on these indicators will allow the LGA to assess its performance and to revise the strategy (and specific objectives), if needed.

The goal of the LG HIV/AIDS Response Strategy is ultimately to reduce the spread of HIV/AIDS and improve the care and support for PLWHA and their families. Measuring these outcomes is more difficult, but some effort should be made to capture the positive impact that the LGA effort has on people’s lives. Evaluation indicators based on community perception and knowledge can be collected through participatory methods.

For the process of both monitoring and evaluation to be useful, there is a need to incorporate the findings into institutional learning (Tool 5.6). This may involve scheduling workshops after each evaluation, where participants revise work plans to reflect lessons learned. Another approach may be to post a bulletin board in a public space where individuals can post suggestions, complaints or comments about the LGA’s work on HIV/AIDS. The Task Team may address public comments and post relevant updates on the bulletin boards.

Box 5.2 Innovations in Knowledge Sharing: Uganda

In most countries, provinces, and districts, there is an uneven process of developing and rolling out LG HIV/AIDS Response Strategies. Some LGAs may have strong donor or leadership-driven support for developing LG Response HIV/AIDS Strategies, while others may be hindered with obstacles that delay their ability to develop similar strategies.

Recognizing this reality, the World Bank supported National AIDS Programme in Uganda has started to facilitate horizontal district-level learning and training. Designed to be inexpensive and informative, DACs (District AIDS Councils) are encouraged to identify districts that may be further along in strategy development and implementation, and to set up information-gathering site visits with poorer performing districts. This is a much less expensive and more efficient process than trying to hold national meetings for this purpose.

The development of Technical Networks offers another example of finding solutions to knowledge sharing issues. The DAC is responsible for channeling funds from the National AIDS Council (NAC) to support community-level micro-projects. Depending on the size of the district (30 of which are participating in this project) the DAC may receive an unmanageable number of proposals that range from education and prevention to care and counseling.

To facilitate a thorough and critical analysis of proposals, some DACs have supported the creation of Technical Networks. Comprised largely of local experts working on various HIV/AIDS work, the Technical Network fills in the knowledge gaps that the DAC might have with regards to the technical merits of the community-level micro-projects. The Technical Network is invited to review the community proposals on a monthly basis and give their recommendations to the DAC.

Both the district-level learning initiative and the Technical Networks illustrate innovative approaches to the need for knowledge sharing and capacity building at the local government level.
1. The term partners is used in this text to refer to organizations that are contracted (whether formally or informally) to undertake a specific task relating to a LG HIV/AIDS Responses Strategy. While most often partners will come from Civil Society Organizations (CSOs) or the private sector, in some cases partnerships may be developed across different levels of government.

2. While local government may, depending on the country, refer to a range of sub-national tiers of government, in this document, local government refers to the level of government that is closest to the community and where key sectors are represented (for example, agriculture, education, and health).

3. In the text CSO refers to all civil society organizations, including faith-based organizations, community-based organizations, non-governmental organizations, trade unions, business associations, private companies etc.

4. These statistics have been gathered from UNDP and UNAIDS publications.

5. Migration, especially rural-urban, requires that policies be geared towards assisting both sending and receiving localities. Urbanization and the consequent proliferation of high-density settlements are placing considerable strain on resources and contribute towards HIV/AIDS through multiple vectors.


8. The Handbook provides a general set of guidelines for LGAs. The extent to which these can be followed will depend largely on the local context. For this reason, local adaptation and modification of the Handbook is encouraged.

9. Sub-teams may be developed to address other cross-cutting issues such as gender, care for orphans, etc.

10. The situation analysis should enroll local stakeholders so that they share ownership of the effort and are committed to its successful implementation. This can be achieved through collaborative inquiries into the successes, strengths, best practices, hopes and aspirations of each stakeholder.

11. A Workplace Policy may also include a clear statement of how broadly it applies—i.e. to staff and their families, or also to utilities and suppliers of the LGA.

12. The E-workspace on Local Responses to HIV/AIDS (http://ews.unaids.org) sponsored by UNAIDS/CITY-AIDS offers an extensive library of practices, techniques and guidelines on fostering and supporting community driven local responses to HIV/AIDS.

13. The programmatic monitoring that is recommended here is performance-based monitoring, which emphasizes the quality of how an activity is undertaken and the satisfaction of the users, as much as the output of the activity (e.g., to monitor a home-based care initiative, the input of patients, and service providers would be essential. Simply recording the flow of funds to a home-based care initiative would not constitute good monitoring).
Conclusion

The preceding chapters have set out the framework for a Local Government HIV/AIDS Response, identifying the main steps and activity areas recommended for a comprehensive response. In Annex 1 there are a number of supporting Tools that can be used for working through each of the areas: Building Leadership, Understanding the Local Situation, Developing Strategies, Implementing Responses, and Monitoring and Evaluation. Again, particularly for smaller towns, it is recommended that a facilitator be appointed to assist the authorities in adapting the tools to the local context and to work with Focal Points and Task Teams as they move through the steps.

Local Government Responses to HIV/AIDS: A Handbook is intended to be a living document. An annual review process will be instituted to update it with lessons learned, good practice examples and other suggestions for improvement. Please share any questions, suggestions and examples that relate to the Handbook and its implementation.

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For those who have access to web technology, this Handbook and related materials can also be found at: http://www.worldbank.org/urban/hivaid/index.htm.
ANNEX 1 Tools for Supporting Local Government Responses to HIV/AIDS

Introduction

In the following pages, you will find 34 tools and activities that could help a Local Government Authority (LGA) move along the continuum of HIV/AIDS responses. The table below roughly outlines the steps that can be followed to mount a comprehensive Local Government (LG) HIV/AIDS Response. However, the order, number, and content of activities will need to be modified to address local context. For smaller towns and cities, it might be best to begin with only a few tools and then increase the range of activities over time. In addition, it is recommended that a facilitator be appointed to assist LGAs (number of LGAs per facilitator best determined locally) in adapting and implementing the Handbook and tools with the relevant local government authority (LGA) focal points.

The following table is intended to serve as an example of how the Tools may be combined and sequenced to form a work plan.

<table>
<thead>
<tr>
<th>STEPS</th>
<th>TOOLS</th>
</tr>
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<tbody>
<tr>
<td>(what steps may be involved)</td>
<td>(what tools may be used)</td>
</tr>
<tr>
<td>1. Commit to addressing HIV/AIDS in the locality.</td>
<td>1.1, 1.2, 1.3</td>
</tr>
<tr>
<td>2. Appoint HIV/AIDS Focal Point.</td>
<td>1.4</td>
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<tr>
<td>3. Create a HIV/AIDS Task Team.</td>
<td>1.5</td>
</tr>
<tr>
<td>4. Conduct a Situation and Impact Analysis of HIV/AIDS in the locality (produce reports and hold workshop).</td>
<td>2.1, 2.2, 2.3</td>
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<tr>
<td>5. Assess the Impact of HIV/AIDS on the functioning of the municipality (produce reports) and conduct an assessment of the LG roles and responsibilities regarding HIV/AIDS (hold Task Team workshop).</td>
<td>2.4, 2.5, 2.6</td>
</tr>
<tr>
<td>6. Identify some preliminary ‘priority areas’ (hold Task Team workshop).</td>
<td>2.4</td>
</tr>
<tr>
<td>7. Conduct a Rapid Assessment of existing LG Response to HIV/AIDS (produce report).</td>
<td>5.5</td>
</tr>
<tr>
<td>8. Identify and coordinate a survey of local organizations providing HIV/AIDS-related services (establish a database of all organizations).</td>
<td>2.7</td>
</tr>
<tr>
<td>10. Analyze all of the information above to identify a list of strategic priority areas.</td>
<td>3.4</td>
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### STEPS (continued)

<table>
<thead>
<tr>
<th>Steps</th>
<th>Tools</th>
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<tbody>
<tr>
<td>11. Gain consensus on priority areas and invite mainstreaming proposals from all LG Departments.</td>
<td>3.5</td>
</tr>
<tr>
<td>12. Assess mainstreaming proposals and identify gaps in service.</td>
<td>3.5, 3.6</td>
</tr>
<tr>
<td>13. Invite proposals from HAPN to meet the identified gaps in service.</td>
<td>3.5</td>
</tr>
<tr>
<td>14. Evaluate all (LGA and Partner) proposals and develop a draft Strategy</td>
<td>3.4</td>
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<tr>
<td>15. Circulate draft Strategy within LGA and with HAPN for review and comments.</td>
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<tr>
<td>16. Revise Strategy and submit to Mayor’s office for approval when approved publicize widely.</td>
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<tr>
<td>17. Use the database on local service providers (step 8) and the LG and partner activities detailed in the Strategy to identify areas for improved service linkages, communication and integration. Establish small task teams to address issues of functional integration.</td>
<td>2.7, 3.6, 4.3</td>
</tr>
<tr>
<td>18. Note: steps 18-22 can be carried out concurrently with steps 10-17. Review existing local and national workplace policies and determine whether the LGA should develop an HIV/AIDS Workplace Policy.</td>
<td>1.6, 3.1, 3.2</td>
</tr>
<tr>
<td>19. Review impact assessment of HIV/AIDS on municipality and determine the extent of prevention, care and mitigation appropriate.</td>
<td>2.4, 2.6</td>
</tr>
<tr>
<td>20. Draft Workplace Policy and submit for LGA review.</td>
<td>3.3</td>
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<tr>
<td>21. Develop necessary partnerships for capacity building, service delivery within the workplace.</td>
<td>4.3</td>
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<tr>
<td>22. Publicize final Workplace Policy and hold information meetings to clarify components.</td>
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<tr>
<td>23. Hold meeting with potential funding sources to determine available budget for Strategy. Identify any areas of financial management where capacity building may be required.</td>
<td>4.6, 2.6, 4.7, 4.8</td>
</tr>
<tr>
<td>24. If necessary, request technical assistance for capacity building within the LGA. If necessary, conduct financial management training for partner agencies.</td>
<td>4.4, 4.3</td>
</tr>
<tr>
<td>25. Request each LG Department to develop an Implementation Plan (including activities, outputs, time frame, budget, accountability, monitoring).</td>
<td>4.1, 4.5</td>
</tr>
<tr>
<td>26. Establish and formalize (where necessary) contracts with all external partners. Include all relevant performance indicators and funding mechanisms.</td>
<td>4.3, 5.4</td>
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<tr>
<td>27. Consolidate all Implementation Plans and identify gaps in resources.</td>
<td>4.5, 4.2</td>
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<tr>
<th>STEPS (continued)</th>
<th>TOOLS</th>
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<tbody>
<tr>
<td>28. Identify possible external fundraising resources and develop appropriate proposals.</td>
<td></td>
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<tr>
<td>29. Draft a Monitoring and Evaluation (M&amp;E) framework with selected indicators drawn from Implementation Plans.</td>
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<tr>
<td>30. Submit M&amp;E framework to all stakeholders for review and comments.</td>
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<tr>
<td>31. Finalize M&amp;E framework and disseminate widely within the LGA and to relevant stakeholders with clear indications of when monitoring reports will be due.</td>
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<tr>
<td>32. After the first cycle of monitoring has been completed, hold workshops to discuss obstacles and accomplishments.</td>
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### Tools

The Tools appear in the same order as the Operations text of the Handbook.

#### Sections:

1. Leadership and Teambuilding
   1A. Involving Leadership
   1B. Establishing or Strengthening Local Government HIV/AIDS Focal Points

2. Understanding the Local Situation
   2A. Situation and Impact Analysis
   2B. Assessing Local Government Roles and Responsibilities
   2C. Taking Stock of Local HIV/AIDS Responses


4. Implementing the Local Government HIV/AIDS Response Strategy

5. Monitoring and Evaluation
1. Leadership and Teambuilding

1A. Involving Leadership

Tools:
1.1 Mayors/CEOs/municipal managers: Checklist
1.2 The elected councilor: Checklist
1.3 Municipal officials: Checklist

PURPOSE:
Leadership that is openly committed to supporting HIV/AIDS strategies can be very effective in both creating public awareness, reducing stigma and ensuring that LGA efforts in addressing HIV/AIDS are effective.

HOW TO USE:
Use these tools to identify areas where mayors, elected councilors and municipal officials can be supportive of HIV/AIDS responses. Share these checklists with colleagues in the LGA and encourage a discussion on areas where they are active already and areas where they would like to be more active.

1.1 Mayors/CEOs/municipal managers: Checklist

In general, mayors and councilors are responsible for policy direction while CEOs/managers provide strategic leadership and management. Buy-in from both is essential for an effective LG HIV/AIDS response. The following are some specific actions or qualities of top leadership which have proved helpful in different contexts in the development of HIV/AIDS responses at the LG level:

- Set a personal example by: opposing stigma and discrimination through establishing contact with organizations representing people living with HIV/AIDS (PLWHA), openly talking about HIV/AIDS in public forums; undergoing VCT to lead public uptake of VCT campaigns, etc. Be a champion of concern about the impact of HIV/AIDS on families, neighbors, and communities and make response efforts a priority.

- Take a lead in identifying and addressing capacity problems of the LGA in responding to HIV/AIDS, including issues relating to sector coordination, particularly with higher levels of government and within the health sector.

- Support the establishment of an HIV/AIDS Task Team (Tool 1.5) and ensure that this entity reports directly to the senior executive management committee and has the authority to function effectively. Require all departments to report any activities that are addressing or planning to address HIV/AIDS.
Participate in the Alliance of Mayors and Municipal Leaders on HIV/AIDS and AMICAALL (Alliance of Mayors Initiative for Community Action on AIDS at the Local Level), or similar international networks\(^2\) that support LG HIV/AIDS Responses. Work with other LGAs striving to develop HIV/AIDS Response Strategies. Mobilize volunteers and encourage community responses to HIV/AIDS by supporting an HIV/AIDS Partnership Network (Tool 1.7).

Champion fundraising efforts (e.g., by supporting applications for discretionary funds available for special projects in local government or special funding to support development of an HIV/AIDS strategy for the municipality). Develop a mayoral trust fund for supporting a specific HIV/AIDS cause (e.g., support to orphans and vulnerable children.)

### 1.2 The elected councilor: Checklist

Here are some ideas for elected councilors which have been put to good effect in different circumstances. **NOTE:** These activities may be appropriate for a range of officials in LGA and local community leaders, not just elected councilors.

**Set a public agenda:** Councilors are in the public eye and their public commitments and pledges can set standards for their communities.
- Councilors may develop a pledge to actively and consistently support HIV/AIDS action, and invite other councilors and officials to adopt this pledge on a volunteer basis.
- Ward councilors can make HIV/AIDS a standing item at ward (electoral area) meetings.
- Councilors can visit clinics, TB hospitals, and facilities for caring for people with HIV/AIDS to show support, build morale, and attract attention to the needs of vulnerable communities.
- Encourage involvement of communities in developing LG HIV/AIDS Responses.

**Be educated and promote awareness of HIV/AIDS issues:** Councilors may commit themselves to being knowledgeable about HIV/AIDS and ensure that they keep abreast of new developments in the field.
- Door-to-door education campaigns can be conducted at the ward level and ward-level support groups may be mobilized as well as Ward-level HIV/AIDS action committees.
- Councilors can commit themselves to be advocates for particular causes, such as treatment action, or youth education and advocacy. Openly discussing these issues can raise the awareness of the LGA and public.

**Lead by example:** Councilors may publicly commit themselves to behavioural interventions such as talking to their children about HIV/AIDS, encouraging their children to use condoms, faithfulness to one partner, non-discrimination towards people with HIV/AIDS, or whatever else in the context may be advisable good practice.
- A councilor who undergoes VCT or who is open about his/her HIV status creates a powerful lead for others to follow, including other leaders.
1.3 Municipal officials: Checklist

Municipal officials, in carrying out their roles in planning and service delivery, have many opportunities to influence the responses to and ultimately the impact of the epidemic.

In an HIV/AIDS responsive LGA, department heads and managers can make a difference by:

- Identifying areas where HIV/AIDS may have specific impacts on their core business (i.e. impact on housing, sanitation, etc.) (Tools 2.3 & 2.4).

- Being abreast of developments in their field with respect to HIV/AIDS. In every area of local government there are models for responding to HIV/AIDS, from housing to agriculture.

- Establishing working groups across departments to share experiences and ideas.

- Mainstreaming HIV/AIDS issues into their areas of responsibility (Tool 3.5).

- Actively supporting implementation of the workplace policy (Tool 3.3).

- Talking about HIV/AIDS in a way that recognizes the need to develop better response systems to address the needs of people directly affected, and act early to launch an effective response to HIV/AIDS.
1B. Establishing or Strengthening LG HIV/AIDS Focal Points

Tools:
1.4 HIV/AIDS Focal Point: Terms of Reference (TOR)
1.5 HIV/AIDS Task Team: Composition and function
1.6 Workplace Policy Sub-Team: Composition and function
1.7 LGA HIV/AIDS Partnership Network (HAPN): Composition and function

PURPOSE:
In the process of developing and implementing a LG HIV/AIDS Response Strategy, there will be many tasks and activities to be carried out and coordinated. It will be important to allocate responsibilities early on in the process.

Within the LGA, it may be useful to identify certain positions and groups that will take responsibility for different aspects of this process (HIV/AIDS Focal Point, HIV/AIDS Task Teams, Workplace Policy Sub-Team). In addition, the LGA may want to facilitate the development of a network of community organizations involved with HIV/AIDS (HIV/AIDS Partnership Network).

HOW TO USE:
Read through all of these Tools (1.4–1.7) to identify some of the roles that individuals and groups can play in addressing HIV/AIDS in the municipality.

Use the TOR (Tool 1.4) to facilitate the process of identifying and appointing an HIV/AIDS Focal Point. The HIV/AIDS Focal Point should be responsible for creating an HIV/AIDS Task Team and can use Tool 1.5 to help shape the team’s composition and function.

When planning to develop the internal Workplace Policy (Tool 3.1), refer to Tool 1.6 to develop a Workplace Policy Sub-Team that will take this process forward.

Community involvement in the LG HIV/AIDS Response Strategy is desirable as early as possible. In a small municipality, it may be easy to facilitate the development of an HIV/AIDS Partnership Network early on through known organizations. In larger municipalities it may be necessary to first conduct stocktaking of local responses (Tool 2.7). In either case Tool 1.7 can be used as a guideline when conducting an introductory meeting with community groups active in HIV/AIDS.
1.4 HIV/AIDS Focal Point: Terms of Reference (TOR)

Whilst the head of a local government system in a democratic local governance framework is the elected leader to whom civil servants report, the head of a special committee on HIV/AIDS that reports to the mayor’s office could be either a civil servant or a councilor.

NOTE: It has often been found that the professional experience of officials and their better understanding of operational aspects of service delivery provide a better base for planning. However, passionate and experienced councilors are sometimes equally effective.

Management Issues:
The Focal Point should be:

- A new or existing full-time employee of the LGA with a portfolio in the area of social and economic development, planning, health, education, or community/social services.

- Formally designated as the nominated HIV/AIDS Focal Point, preferably by the LGA Executive/Management Committee. The HIV/AIDS Focal Point should ideally be created and funded as a full-time position. If that is not feasible, then the percentage of time to be allocated to HIV/AIDS Tasks should be clearly articulated and reflected in the individual’s performance evaluation.

- Accountable to management (the Executive/Management Committee).

His/her job description should reflect the following responsibilities:

**Internal functions:**

- Manage and facilitate the work of the HIV/AIDS Task Team (Tool 1.5).

- Co-ordinate and report on the development, implementation, monitoring, and evaluation of the Workplace HIV/AIDS Policy and Program.

**External functions:**


- Conduct an analysis of potential partnerships with CSOs.

- Facilitate the creation of and provide support to an HIV/AIDS Partnership Network (Tool 1.7).

In instances where the nominated person has not received training in HIV/AIDS, he/she should undergo training.

**Qualifications:**
The ideal person for such a position would have:

- Seniority within the municipality, and influence within the LGA and community.
Good standing and an uncontroversial reputation within the municipality and the community.

- A clear mandate from senior management.

- Good organizational abilities.

- A strong interest in HIV/AIDS.

- Leadership qualities: including good interpersonal, communication, and facilitation skills.

- Experience with planning and basic financial management.

1.5 HIV/AIDS Task Team: Composition and function

**Composition:**
The size of the HIV/AIDS Task Team will vary depending on the size of the municipality and the resources available. A Task Team may have as few as 5 or 6 people or as many as 10 or 12. Because the Task Team is a working group, it is important that members are committed to HIV/AIDS and have the time/capacity to carry out the tasks that are allocated to them. Where possible, LGA members on the Task Team should be permitted to alter their job descriptions to allocate a percentage of time (e.g., 15%) to HIV/AIDS work.

The HIV/AIDS Task Team should include:

- HIV/AIDS Focal Point

- Local Government Planning Officials

- Multisectoral group of officials and councilors (including representatives from the Mayor’s office, health, education, etc.)

- Some community representatives and other stakeholders (e.g. CSOs including PLWHA, women’s groups, youth representatives, faith-based organizations, informal neighborhood organizations, private sector representatives, local utility providers).

**Function:** To take responsibility for developing and implementing the LG HIV/AIDS Response program, in collaboration with all key LGA and community stakeholders.

**Management:** Is coordinated and managed by the HIV/AIDS Focal Point, is accountable to the highest authority of the LGA (i.e. Mayor) and is situated as an independent entity (NOT as part of Health or
Social Services Departments). Has a working relationship with District, Regional or National HIV/AIDS Councils.

The Task Team will likely meet often in the process of conducting the situation and impact analysis, developing the strategy and implementation plan, and applying for funding. After an HIV/AIDS Response Strategy has been put in place and implementation has started, the Task Team will function more as a monitoring and coordination team and will likely meet less often (perhaps monthly or bi-monthly). (Tool 5.3)

Tasks:

- Create a coherent HIV/AIDS strategy internally (workplace) and externally (service delivery and local coordination).
- Provide a coordination structure for the implementation of an HIV/AIDS response.
- Identify and work with Focal Points in all LGA departments that will be responsible for mainstreaming activities and monitoring their progress.
- Facilitate communication and reporting on the LG HIV/AIDS Response both within the LGA and to the public.
- Serve as trouble-shooters when LGA departments or partners face obstacles to implementing the HIV/AIDS Response.
- Manage any specific funding (and requirements attached to funding) allocated to the LG HIV/AIDS Response and/or manage community proposals for HIV/AIDS money that the LGA has been given authority to disburse. Monitor and report on how the money is spent within the LGA.
- Facilitate and support the HIV/AIDS Partnership (HAPN) Network (Tool 1.7)
- Meet with similar Task Teams from other municipalities to share lessons learned.

1.6 Workplace Policy Sub-Team: Composition and function

**Composition:** A small sub-team (2-3 persons) of the HIV/AIDS Task Team. The team should include representatives from appropriate trade unions and staff associations. Where possible, a person living with HIV/AIDS should either be represented in the Team and/or take a leadership role therein.

**Function:** To take responsibility for developing, implementing, monitoring/evaluation, and troubleshoot the internal Workplace HIV/AIDS Policy and Program (Tools 3.1-3.3).

**Management:** The Head of the Workplace Policy Team will be accountable to the HIV/AIDS Focal Point and should be given the authority to liaison, as a peer, with directors of all LGA sectors, especially the Human Resources director. Leadership of the internal response is best done by someone with human resources experience.

Tasks:

- Establish the rationale and aims of a workplace policy through a consultation process.
- Draft a workplace policy.
- Coordinate an internal review of the Workplace Policy and facilitate its ratification at all levels.
- Clarify the responsibility of the LGA to its employees and investigate the legal and rights issues concerned with the relationship of the LGA and its employees.
- Develop a transparent (and non-confrontational) mechanism for dealing with special cases and complaints.
- Outline steps to be taken in implementing the policy and monitoring implementation.
- Report on program implementation and progress.
- Facilitate communication of Workplace Policy issues with District/Regional/National government representatives, as needed.

1.7 LG HIV/AIDS Partnership Network (HAPN): Composition and function

A LGA can accomplish a great deal by supporting existing local responses to HIV/AIDS. (This is discussed at length in Tool 2.7: Taking stock of local HIV/AIDS responses.) To facilitate this process, it is suggested that the LGA support the development of an HIV/AIDS Partnership Network (HAPN).5

Composition: The size will vary according to interest and number of organizations providing HIV/AIDS related services in the municipality. The HAPN should be a representative network and include:
- Individuals and organizational representatives
- People Living with HIV/AIDS (PLWHA)
- Local CSOs providing AIDS related services
- Decision makers from key sectors or people who can influence decision makers
- Technical experts
- Municipal service organizations and utilities (not HIV/AIDS organizations)
**Function:** To create a forum for information sharing and relationship-building among community based HIV/AIDS response organizations and facilitate communication/cooperation between these groups and the LGA. HAPN can also be supportive in HIV/AIDS strategy development, outreach and advocacy activities.

**Management:** Representatives of the LGA can participate and facilitate a HAPN, but the actual network should remain outside of the LGA management structure. To facilitate community participation, representatives from the HAPN may be invited to participate in some activities of the HIV/AIDS Task Team.

### HAPN Activities

**Alliance building.** Provide for relationships among partners.

**Generating and sharing information.** Provide a structure for members to establish and maintain essential communications with each other.

**Advocacy.** Co-ordinate advocacy action on matters identified by members.

**Skills and capacity building.** Provide both formal and informal opportunities for enhancing the skills of members.

**Building solidarity.** Assure members that their work is important, particularly when the political and social environment is not hospitable. Encourage, motivate and galvanize partners.

**Creating opportunities for co-operation.** Generate and/or support programs which are complementary, collaborative and which reinforce one another.

**Monitoring network indicators.** Assess progress being made and identify problems needing to be addressed.
2. Understanding the Local Situation

OVERVIEW

This section is divided into three parts. All of the activities in this section are designed to facilitate the LGA in gathering the information they will require to develop an HIV/AIDS Response Strategy.

- Situation and Impact Analysis (2A)
- Assessing LGA Roles and Responsibilities (2B)
- Taking Stock of Local HIV/AIDS Responses (2C)

The information gathered through this process will help the LGA target its HIV/AIDS strategy, identifying areas where the LGA can most effectively expand its own activities, and mobilize resources through partnerships with local organizations.
2A. Situation and Impact Analysis

Tools:
2.1 What is the local HIV/AIDS epidemic classification? Gathering and Analyzing available data
2.2 Are there local variations to consider? Creating a comparison checklist
2.3 Estimating HIV/AIDS impact on locality: Chart
2.4 Estimating HIV/AIDS impact on LGA functioning: Chart

PURPOSE:
A LG HIV/AIDS Response will need to reflect the specific HIV/AIDS issues affecting the municipality. In order to do this, the LGA must better understand how the epidemic spreads in the municipality, how it is likely to impact the LGA, and what the specific target areas for intervention should be. While the main output of these tools will be information that can be used in strategy development, this information can also be used for advocacy within the LGA (convincing reluctant colleagues) and in the community (with community leaders, educators, etc.)

HOW TO USE:
Read through these tools to become familiar with the 3 exercises (Tools 2.2, 2.3, 2.4) that will be carried out in conducting the situation and impact analysis. Gather available HIV/AIDS data at the national and/or local level to identify the classification of the epidemic (Tool 2.1).

Assign the task of creating a situation analysis (Tool 2.2) to individual(s) on the Task Team. The Tool (2.2) may also be complemented by using participatory methodologies with community members, such as mapping (refer to Box 2.1 in Operations), to gain a richer picture of the local epidemic. A local CSO may be able to facilitate with this type of activity. A report of findings will be required. Follow the same process for Tool 2.3.

Organize a Task Team meeting (additional representatives from within or outside of the LGA may be invited as well) to discuss the findings from Tools (2.2 & 2.3). To facilitate discussion, it may be useful to encourage the members of the Task Team to carry out the impact analysis exercise in Tool 2.3 before hearing the presentation of the report.

At this meeting use Tool 2.4 as a group exercise to analyze the impact of HIV/AIDS on the functioning of the LGA.

By the completion of the meeting, the participants should have a better sense of the HIV/AIDS situation in their locality. The HIV/AIDS Focal Point should facilitate a discussion to identify some of the priority areas in the community and within the LGA.
2.1 What is the local HIV/AIDS epidemic classification? Gathering and Analyzing available data

Information on the national HIV/AIDS epidemic can be useful in understanding the local epidemic. This information may be available from national health ministries, household surveys, the UNAIDS web site, and from country profiles available at USAID and World Bank web sites. In some (although few) localities, where there are urban sentinel sites, accurate local data may be available. Local data may also be gathered from administrative data such as death statistics, school attendance rates, and intake of patients at municipal health centers (e.g., TB).

UNAIDS Classification of HIV/AIDS Epidemics

- **Low level:** HIV prevalence assumed to be less than 5% in all known sub-populations presumed to practice higher risk behaviors, such as commercial sex workers, truckers, migrant workers, the military, men who have sex with men, and injection drug users.

- **Concentrated:** HIV prevalence that has surpassed 5% in one or more sub-populations presumed to practice higher risk behaviors, but prevalence among pregnant women is still less than 1%.

- **Generalised:** HIV has spread far beyond the sub-populations with higher risk behaviors, which are now heavily infected, and the prevalence among pregnant women is above 1%. In such populations, the rural population may be mirroring the infection levels in urban areas. Most sub-Saharan African countries would fit into this category.

2.2 Are there local variations to consider? Creating a comparison checklist

Once national data has been gathered, it should then be asked: ‘Is there any reason to believe that the local situation differs substantially from the general country profile?’ Available country reports may give some indication of certain regions having higher prevalence and will give some idea of the relative prevalence of urban and rural areas. In addition special risk or protective factors for the area should be taken into account in rating the area.

**Preparation:** Before conducting this exercise, someone should be tasked to collect whatever data is available on ‘at risk’ sub-populations nationally.

**Who:** The ratings exercise should be done by a group of the most expert people available who have an understanding of the local community and who are involved in the HIV/AIDS field. This individual or team can be supervised by a member of the Task Team.
Considerations:
The factors that are known to increase risk are:

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Risk Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>High population density.</td>
<td>Disrupted family and community life due to war, famine, or rapid social change/migratory patterns.</td>
</tr>
<tr>
<td>Presence of urban informal settlements and recently urbanized groups.</td>
<td>High levels of poverty and inequality.</td>
</tr>
<tr>
<td>Mobile and displaced populations, concentration of migrant labor (outgoing and incoming).</td>
<td>High levels of other sexually transmitted infections.</td>
</tr>
<tr>
<td>Areas on or close to main transport routes.</td>
<td>Multi-partner relationships.</td>
</tr>
<tr>
<td>Sex industry.</td>
<td>Poor condom use or uptake of prevention behaviors.</td>
</tr>
<tr>
<td>Economic migration attached to seasonal industries (e.g., harvesting, fishing)</td>
<td>Low levels of education and intervention.</td>
</tr>
<tr>
<td>Crime and gang activity.</td>
<td></td>
</tr>
</tbody>
</table>

Note: There may well be other social dynamics particular to the area that are not generally known as infection risks and that should be included.

Task: After gathering available data on HIV/AIDS, use the chart below to develop a comparison of the locality with national HIV prevalence data. The considerations listed in the table above can be useful in focusing the analysis.
NOTE: This exercise is designed to facilitate discussion about local HIV/AIDS risks and the impact that these may have on HIV/AIDS prevalence. While this exercise may provide a better picture of the local HIV/AIDS situation, it is only an estimation.

Presenting the findings: Following the above comparison exercise, a report should be drawn up with a summary description written for each of the following headings:

- The estimated state of the epidemic in the area: In comparison to national data and using available local data.
- Sub-populations at high risk: Derived from the above step.
- Risk dynamics of the epidemic in the area: What are the main driving forces of the epidemic in the area?
- Protective dynamics of the epidemic in the area: What are the main factors acting against the spread of the epidemic in the area?

### EXAMPLE

<table>
<thead>
<tr>
<th>Compared with the national HIV/AIDS profile, the local HIV/AIDS situation is:</th>
<th>Yes</th>
<th>No</th>
<th>Reason/ Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probably higher than the national HIV prevalence in all groups.</td>
<td>X</td>
<td></td>
<td>Mainly rural area; VCT data from neighboring town suggests lower prevalence for area; few reported AIDS cases to date and mainly migrant workers</td>
</tr>
<tr>
<td>Probably higher than the national HIV prevalence average in some sub-populations.</td>
<td>X</td>
<td></td>
<td>Few sex workers in the town; away from main transport routes.</td>
</tr>
<tr>
<td>Probably the same as national HIV prevalence in all groups.</td>
<td>X</td>
<td></td>
<td>Same reasons as above.</td>
</tr>
<tr>
<td>Probably the same as national average prevalence in some sub-populations.</td>
<td>X</td>
<td></td>
<td>Migrant workers and partners.</td>
</tr>
<tr>
<td>Probably lower than the national prevalence in all groups.</td>
<td>X</td>
<td></td>
<td>Traditional area; little movement of people.</td>
</tr>
<tr>
<td>Probably lower than the national prevalence in some sub-populations.</td>
<td>X</td>
<td></td>
<td>Strong taboos on young men becoming sexually active before initiation into manhood.</td>
</tr>
</tbody>
</table>
Using Partnerships to Conduct a Situation Analysis

To make the most use of its resources (time, money, information) the LGA will want to encourage broad participation and cooperation. In the case of conducting a situation analysis, the LGA may find that participation by different groups/individuals may contribute to a much richer analysis. For example:

**Civil Society Organizations** (from an HIV/AIDS Partnership Network) may provide input on community issues and priorities. *E.g.* a gender training group may conduct a participatory assessment activity that highlights how women learn about HIV/AIDS and what challenges they face. *Sharing information with the LGA may facilitate a targeted program to address gender-based challenges.*

**Municipal Officials** may have a clear understanding of sector-specific HIV/AIDS risks. *E.g.* a parks manager may identify a certain public area that is being used by intravenous drug users. *Sharing information with the LGA may facilitate a localized needle exchange program.*

**People Living with HIV/AIDS** can offer a valuable perspective on care and stigma. *E.g.* interviews with PLWHA may reveal that VCT sites are not being used because of breaches in confidentiality by clinic staff. *Sharing information with the LGA may encourage the development and enforcement of confidentiality protocols.*

### 2.3 Estimating HIV/AIDS impact on locality: Chart

**Who:** The individual(s) responsible for the Situation Analysis (Tool 2.2) may also facilitate this exercise.

**Task:** The chart below identifies some of the major areas where HIV/AIDS can/will impact a municipality. Modify this list, as needed, and then rate each area along an impact scale of severe-moderate-low. Provide a description of whether the impact is likely to be concentrated or generalized in terms of its location or focus on a particular sub-population. The following table provides a useful structure for this. After filling in the table, draw up a description of areas of ‘severe’ and ‘moderate’ impact over the five-year and fifteen-year projected scenarios.

**NOTE:** It is expected that at this level of analysis, the outcome is less an epidemiological analysis than an indication of local priorities with a view to inform the development of an appropriate local strategy.
Presenting the Findings: A report on the local impact of HIV/AIDS may include the following:

- Estimation of the severity of the HIV epidemic in the area.
- Descriptions of high- and low-risk sub-populations.
- Description of high-risk factors and protective factors.
- Estimation of the likely prevalence of AIDS within five years.
- Estimation of the likely areas of high impact, rated for each area along a scale of severe–moderate–low.
- Impact on the society in the medium- and long-term.
- Recommendations relating to intervention options in terms of areas of focus.

Conduct a workshop for LGA leaders based on information gathered through the above process. As a group workshop exercise, the participants may be asked to provide their own understanding of the implications for the community and the LGA. They should also be encouraged to suggest what they think should be done in the short, medium, and long term to mitigate the impact of HIV/AIDS.

Although recommendations are not appropriate without taking into account the powers, functions, and capacities of the LGA (Tools 2.5-2.6) and the existing response resources in the community (Tool 2.7), it is useful to consider the results of the impact assessment and the implied need for particular types of intervention.
2.4 Estimating HIV/AIDS impact on LGA functioning: Chart

Who: This tool may be used by members of the Task Team (perhaps the Workplace Policy Sub-Team (Tool 1.6)). Input from all departments of the LGA will be important, as much for gathering information as for raising awareness.

Task: Use the following chart to stimulate discussion on the impact of HIV/AIDS on the functioning and performance of the LGA. Begin by reviewing the list and including additional areas of local impact that have been identified. Use the chart to rate the severity of each issue and provide some explanations.

NOTE: Many of these questions will be difficult to answer and should be largely approached as open discussion tools.
### Understanding the Local Situation

#### Impact area on LGA functioning

<table>
<thead>
<tr>
<th>Impact area on LGA functioning</th>
<th>Severity rating: potential cost or other negative impact</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of senior management skills</td>
<td>Moderate</td>
<td>X</td>
</tr>
</tbody>
</table>
| Impact on productivity of lowest level workers | X | | – Many lower level staff from most vulnerable sub-population group, so potential high HIV prevalence  
| | | | – Easily replaceable, so impact moderate |
| Cost of employee benefits, such as housing loans, | X | | – Costs of early boarding and medical benefits, and pensions disability potentially devastating to municipal pension fund |
| Need for a support system for orphans and vulnerable children | | | – Looming orphan problem, estimating over 1000 orphans within 5 years  
| | | | – No social welfare or formal support structures in place, so basic infrastructure will need to be developed |
| Productivity impacted by illness and absenteeism | | | |
| Shift in focus away from other areas | | | |
| Cost of recruiting and training replacements | | | |
| Need for additional services (by LGA) to mitigate impacts of HIV/AIDS on affected communities | | | |
| Impact on service delivery due to illness, absenteeism, and loss of productivity | | | |
| Other impact areas of relevance | | | |
Presenting the Findings: A report on the impact of HIV/AIDS on the LGA may be structured under the following headings:

- Local impact of HIV/AIDS.
- Risk to the human resources of the LGA.
- Impact in terms of service delivery demands.
- Impact on effectiveness of service delivery.
- Financial risks and budgetary areas of impact.

This report will be a valuable tool in highlighting the priorities for a Workplace Policy and Program (Tool 3.1).

NOTE: In the case of large towns and cities, it may be worth conducting a formal impact assessment with cost estimates, but in most cases a qualitative assessment of areas of risk will suffice. The point of such an assessment is to provide a framework for developing strategies for internal HIV/AIDS response and much of what needs to be ascertained can be achieved without the need for a highly technical and expensive impact assessment.
2B. Assessing LGA Roles and Responsibilities

Tools:
2.5 Understanding the responsibilities of national, provincial and municipal players: Chart
2.6 Conducting a LGA Self-Assessment: Survey

PURPOSE:
LGAs do not have the capacity or the mandate to carry out extensive local HIV/AIDS programs. Instead the LGA can integrate HIV/AIDS activities into its work, and create a supportive environment for partnerships with local CSOs working on HIV/AIDS (Section 2C). In this section, the LGA is encouraged to analyze its own functions, mandates, and responsibilities with regards to HIV/AIDS. The picture that emerges from these exercises can offer the LGA a framework for understanding what the parameters of an HIV/AIDS Response Strategy may look like.

HOW TO USE:
The Focal Point, alone or with a small team, can gather relevant documentation (National AIDS Plan, Constitution, etc.) to better understand the mandates of the LGA. Using Tools 2.5 and 2.6, the Focal Point should be able to identify some of the key obstacles and strengths of the LGA. A workshop with the Task Team and other LGA members can be held to address the findings. [Note: At this workshop it may also be useful to conduct a baseline evaluation of the LGA’s existing work on HIV/AIDS. A tool for this can be found in the Evaluation section (Tool 5.5).]

2.5 Understanding the responsibilities of national, provincial, and municipal players: Chart

The specific role and responsibilities relating to addressing HIV/AIDS will vary depending on the extent and success of decentralization policies, particularly with regards to health. The chart below gives a general schematic of some of the more common roles and responsibilities relating to HIV/AIDS.

<table>
<thead>
<tr>
<th>NATIONAL GOVT. (MoH, MoLG, NAC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- National AIDS Plan (including general Workplace Policy)</td>
</tr>
<tr>
<td>- Coordinating decentralization of health services</td>
</tr>
<tr>
<td>- Fiscal transfers to regional and local government</td>
</tr>
<tr>
<td>- Legal framework for partnerships</td>
</tr>
<tr>
<td>- National M&amp;E</td>
</tr>
<tr>
<td>PROVINCIAL GOVT. (Province/District Health Office)</td>
</tr>
<tr>
<td>- Tertiary health services</td>
</tr>
<tr>
<td>- Coordinate referral mechanisms</td>
</tr>
<tr>
<td>- HIV/AIDS training for all health staff, also some technical support for local service delivery partners</td>
</tr>
<tr>
<td>- Procurement and dissemination to all levels, of condoms, VCT kits, etc.</td>
</tr>
<tr>
<td>- M&amp;E</td>
</tr>
<tr>
<td>LOCAL GOVT. (LGA, Primary Health Care Clinics)</td>
</tr>
<tr>
<td>- Link PHC clinics and local service providers into district/province referral mechanisms</td>
</tr>
<tr>
<td>- Collection of user fees</td>
</tr>
<tr>
<td>- HIV/AIDS mainstreaming</td>
</tr>
<tr>
<td>- Gap analysis of service provision and local partner contracting</td>
</tr>
<tr>
<td>- M&amp;E</td>
</tr>
</tbody>
</table>
2.6 Conducting a LGA Self-Assessment: Survey

Who: The HIV/AIDS Focal Point, or a nominated alternative, can go through the questionnaire and for each of the 15 items provide a rating. The rating should be provided after consideration of each of the discussion points and any other questions of local relevance.

Task: Use the following questions and chart to better understand the powers and functions of local government with regards to HIV/AIDS.

<table>
<thead>
<tr>
<th>Area of local government functioning</th>
<th>No problem</th>
<th>Slight problem</th>
<th>Strong problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Clarity about the expectations of local government (mandates) in terms of service delivery.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ In which areas of HIV/AIDS service delivery is there lack of clarity about mandates?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Is the mandate to local government within the National AIDS Strategy/Plan clear?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Is the mandate from the department of local government about responding to HIV/AIDS clear?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ Are there specific directives from the department of local government about responding to HIV/AIDS?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Limitation of the powers of the LGA to make decisions about priorities, strategies, and programs for responding to HIV/AIDS.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ What are the limitations on local government autonomy in terms of decision-making in the area of HIV/AIDS response?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Expectation that the LGA take responsibility for making decisions and planning that are beyond its present capacity to engage with HIV/AIDS responses.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ In what areas of LGA functioning are the expectations beyond LGA capacity?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. The LGA is expected to fulfill mandated functions without the necessary fiscal provision from the central authorities holding LG to the mandate. (Problems of unfunded mandates.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>■ In what areas are there unfunded mandates?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Continued next page)
5. The extent to which the functions of a LG HIV/AIDS response are constrained by the problem of split functions of government. (One element of a service—e.g., laboratory costs for VCT—being funded by one tier of government and another element being funded at a different level—e.g., human resources and training for counseling for VCT.)

**Discussion:**
- In what areas of mandated response to HIV/AIDS are there split functions of government? (Start with discussing the more common problem areas: e.g., VCT, PMTCT, social welfare grants.)
- What are the problems experienced at each level?

6. Intergovernmental relations are such that co-operation and communication between decentralized government departments make integrated development planning difficult.

**Discussion:**
- What inter-departmental structures exist through which integrated planning can take place?
- Has decentralization taken place vertically such that co-operation between departments is problematic in terms of basic infrastructure? (LGA offices of different departments in different towns.)
- Is there resistance from some departments to integration into the LGA framework?

<table>
<thead>
<tr>
<th>Area of local government functioning</th>
<th>No problem</th>
<th>Slight problem</th>
<th>Strong problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td></td>
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<tr>
<td>6.</td>
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<td>7.</td>
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<td>8.</td>
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<tr>
<td>9.</td>
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<td></td>
<td></td>
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<tr>
<td>10.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. The problems experienced in governing HIV/AIDS response at the local level are able to be resolved at the functional level by improving intergovernmental relations and clarification of co-operative action around split functions of government.

**Discussion:**
- What kind of solutions can be initiated by the LGA?
- How far can these go in resolving the problems experienced?

8. The commitment of LGA to HIV/AIDS as indicated by: past actions, plans, pilot projects, ongoing projects, and commitment of resources.

**Discussion:**
- What kind of solutions can be initiated by the LGA?

9. The prioritizing of HIV/AIDS in the LGA.

**Discussion:**
- At what level or in what decision-making process of the LGA is there a problem of prioritization?

10. Poor cooperation between officials and councilors.

**Discussion:**
- Do the relationships or trust between officials and councilors create problems?
- Is the joint working of officials and councilors negatively affected by political tensions?

(Continued next page)

<table>
<thead>
<tr>
<th>Area of local government functioning</th>
<th>No problem</th>
<th>Slight problem</th>
<th>Strong problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Leadership of the LGA is strongly supportive of LG HIV/AIDS Responses.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion:</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><img src="image1.png" alt="image" /></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. The resources available to the LGA in developing responses to HIV/AIDS.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><img src="image2.png" alt="image" /></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Insufficient understanding of the local impact of HIV/AIDS or response to HIV/AIDS.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><img src="image3.png" alt="image" /></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Capacity to form partnerships.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><img src="image4.png" alt="image" /></td>
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<td></td>
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</tr>
<tr>
<td>15. Capacity to plan and manage HIV/AIDS response.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discussion:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><img src="image5.png" alt="image" /></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Presenting the Findings:
1. Having decided on a rating, the person filling out the survey may note down central points that were important in assigning the rating and write a working report on his/her analysis.
2. The analysis may be reported as a presentation with a supporting document to a special workshop of the HIV/AIDS Task Team with leadership of the LGA in attendance. This workshop may take half a day or 4 hours.
3. For each of the 15 points, a facilitated group discussion can be coordinated to confirm or change of the ‘problem rating’ for each point.
4. For all points rated as a ‘slight’ or ‘strong’ problem, the discussion may consider possible solutions. In this process, it should be noted which issues involve internal LGA-level solutions (functional) and those which need to be addressed at a structural level, by engaging, for example, with departments in the LGA in clarifying mandates and lobbying, perhaps with the support of other LGAs for reform of budget arrangements to support LG HIV/AIDS Responses.
5. The HIV/AIDS Task Team can create an action plan or decide on a process for taking particular issues forward.

*NOTE: Alternately, this could be conducted as a group exercise. This may however be time-consuming and provide a less in-depth analysis.*
2C. Taking stock of local HIV/AIDS responses

Tools:
2.7 Taking stock of local HIV/AIDS Responses: Questionnaire

PURPOSE:
Taking stock of local HIV/AIDS Responses serves four purposes. First, the activity itself offers the Task Team an opportunity to establish direct relationships with local service providers and demonstrate the LGA commitment to supporting HIV/AIDS. Second, the survey allows the Task Team to understand what services are and are not being provided so that it can create incentives and partnerships to better address unmet needs. Third, through the survey process, it is anticipated that the local service providers will develop a HIV/AIDS Partnership Network that may serve as a communication mechanism between the LGA and local partners. Finally, a detailed database of local service providers offers LGA administrators a tool to keep track of local organizations.

2.7 Taking stock of local HIV/AIDS responses


Task: Use this tool to identify gaps in local service provision, and to identify potential partners that can assist in developing and implementing the LG HIV/AIDS Response Strategy (Tools 3.5, 3.6, 4.2, 4.3). The group of participants gathered for this activity may also be interested in developing an HIV/AIDS Partnership Network (refer to Tool 1.7).

NOTE: The process is designed to suit the situation of a small- to medium-sized LGA, with a population of up to about 250,000 and which has an existing organizational infrastructure of no more than about 30 community-based organizations and government departments working in HIV/AIDS service provision. The model questionnaire is appropriate for larger areas, but the process in such areas, and especially in cities, will be more expensive in terms of time and resources and may require a more elaborate launching, planning, administration, analysis, and feedback process.

1. Launching the initiative

- Convene a meeting, preferably addressed by the mayor or head of the LGA. This may be publicized in the local press and through local CSO channels and networks.

- Encourage organizations to introduce themselves and describe their main areas of work.

- Propose formation of a ‘survey team’ to coordinate a ‘stock taking’ of local responses. This should include a small group of people who are present at the meeting, have some administrative and communications support, are local leaders in the field, and who represent a range of networks and organizations. (This Survey Team may later become the core HIV/AIDS Partnership Network (Tool 1.7)
Offer the resources of the LGA to host a meeting of this survey team.

Register participants at the meeting and construct a preliminary list of CSOs. Request participating CSOs to list on a separate piece of paper organizations that are not present but which are involved in HIV/AIDS work at the community level.

2. Planning the survey

Initial survey team meeting

- Convene a meeting of the Survey Team.
- Appoint a person to oversee the questionnaire administration process, and do a preliminary analysis of the survey.
- Establish a time line for activities and resourcing of the mainly administrative costs of the survey.

(This can all be achieved in one meeting.)

Instrument development process

- Review the model questionnaire and adapt it to local needs in the context of the meeting.
- Mandate the overseer to arrange translation and pre-testing of the questionnaire.
- Discuss an administration plan and offer support for administration. (See below for administration.)

3. Conducting the Survey

Create an administrative team of a small fieldwork team (2-3 people) to take on the administrative task (of revising, administering, and analyzing the questionnaires).

Translate and revise the survey. Parts of the questionnaire can be omitted if they are not relevant, and there may be issues of local relevance that need to be added. It may also need to be translated into local languages and administered to 2-3 organizations to test that the language is easily understood and the questions are clear. This ‘pilot’ is a useful step for identifying necessary changes that can be made before the questionnaire is prepared in final form.

Administer the survey to all of the organizations on the list as well as new organizations that are learned about in the course of the survey. The questionnaire can be self-administered by organizations that have experience in completing questionnaires. In this case it can be sent by fax or mail with a covering letter and a request that it be returned by a certain date. It would ideally be sent to the head of an organization or department. In other cases the questionnaire would need to be administered on a one-to-one basis, and this should not take longer than half an hour to administer.
Ensure widespread participation. Present a list of all organizations on the existing list to participating organizations and request organizations to add to the list so that a comprehensive audit is undertaken. For larger institutions it will be necessary to include departments which offer different services and which are not likely to report on activities of other departments.

Formally introduce the questionnaire. The questionnaire may be accompanied by a letter from the head of the LGA that outlines the purpose and goals of the research process and what will be done with the information. Respondents may be invited to a workshop to discuss the findings, explore the implications and discuss ways to move forward in developing responses to HIV/AIDS.
COMMUNITY RESPONSES TO HIV/AIDS IN MUNICIPALITY X
HIV/AIDS Questionnaire for Departments, Institutions and Organizations Involved in HIV/AIDS Programs

This questionnaire has been developed by an HIV/AIDS Task Team supported by ______ (LGA). The survey is undertaken with the support of a meeting of community HIV/AIDS organizations on ______ (date). It is designed to assist in taking stock of what we are doing in ______ (LGA area) to respond to HIV/AIDS and to find ways of improving this. You will be invited to discuss the results of the survey so that we can together plan to strengthen our ways of dealing with the problem of HIV/AIDS in our community.

Where the option is Yes or No, please tick (✓) the option that is applicable to your organization.

<table>
<thead>
<tr>
<th>Name of organization or institution:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department within organization or institution (if applicable):</td>
</tr>
<tr>
<td>Contact details (telephone, fax, email):</td>
</tr>
<tr>
<td>Person providing information:</td>
</tr>
<tr>
<td>Position of person in organization:</td>
</tr>
</tbody>
</table>

How would you describe your organization? (You can mark more than one category)?

<table>
<thead>
<tr>
<th>Government</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-governmental organization (NGO)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Community based organization (CBO)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Faith-based organization (FBO)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Profit-making</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Development</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Political</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Women’s</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Youth</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other (describe)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Understanding the local situation

1. DO YOU HAVE A PROGRAM IN ANY OF THE FOLLOWING AREAS?

<table>
<thead>
<tr>
<th>Area</th>
<th>Yes</th>
<th>No</th>
<th>If yes, complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS prevention and education</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Care and support for people living with or affected by HIV/AIDS</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>HIV/AIDS related treatment</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>HIV/AIDS related training</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>HIV/AIDS related rights and legal assistance</td>
<td></td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

2. HIV/AIDS PREVENTION EDUCATION

2.1 Which of the following groups do you include amongst your target audience?

<table>
<thead>
<tr>
<th>Group</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-school or primary school learners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school learners/youth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students and staff at tertiary institutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community members (including community and public events, door-to-door)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Members of community organizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traditional leaders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People at taverns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commercial sex workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traditional healers and faith healers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Street children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Victims of rape, sexual violence and/or domestic abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People living with or directly affected by HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workers (the work force)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Church or mosque members or members of other faith-based organizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: write down other audiences which you target</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.2 In which of the following areas do you offer education or prevention services?

<table>
<thead>
<tr>
<th>Area</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fighting stigma relating to HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition and HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income generating activities including food gardens</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural responses to HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious responses to HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Aid and HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention of mother to child transmission of HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Targeted interventions: e.g., for commercial sex workers or truck drivers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STI treatment and education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-exposure prophylaxis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent-oriented health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Condom distribution</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling and support services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Understanding the Local Situation

2.3 VCT (voluntary counseling and testing) services

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your organization offer voluntary counseling and testing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If so, what is the cost of such services?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can one obtain VCT on request? (i.e. without medical referral)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there any follow-up counseling offered?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you think you have the capacity for VCT?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you think that VCT is a priority area?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.4 Post-exposure services and post-exposure prophylaxis (PEP)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your organization provide PEP and anti-retroviral (ARV) medication after a needle-prick injury?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does your organization offer PEP and ARV medication after rape?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can one obtain PEP on request? (i.e. without medical referral)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there any counseling offered?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there any medical monitoring offered?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What is the cost of such services?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.5 PLWHA as educators

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your organization use HIV positive people as educators?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are they paid for their services?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who trained them for this work?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.6 Workplace policies and programs

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your organization have an HIV/AIDS policy for its employees?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is your organization involved in helping other organizations to develop workplace policies around HIV/AIDS?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is your organization involved in promoting responses to HIV/AIDS in workplaces?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please explain:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.7 Which of the following education materials do you have access to?

<table>
<thead>
<tr>
<th>Material</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Videos</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pamphlets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What language:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any difficulties getting hold of communications materials?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What kind of materials do you need and on what topics?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.8 If your organization distributes condoms
Are they distributed free? Yes No
Are female condoms distributed? Yes No
About how many are distributed a month? Male condoms: Female condoms:
Where are they distributed?

How are they distributed?

Where do you obtain them?

Do you have difficulties in obtaining condoms for distribution? Yes No
Further comments

2.9 What assistance do you need to improve your prevention efforts?

3. CARE AND SUPPORT FOR PLWHA AND FAMILIES DIRECTLY AFFECTED
3.1 Which areas of care and support does your organization focus on?
Orphans and vulnerable children Yes No
Social work services Yes No
Grants Yes No
Counseling Yes No
Support groups Yes No
Shelter and placement Yes No
People living with HIV/AIDS Yes No
Peer support Yes No
Supporting families and care givers Yes No
Inpatient care for people sick with AIDS Yes No
Terminal care Yes No
Support for caregivers Yes No
Home-based care Yes No
Training in home-based care Yes No
Respite care (temporary inpatient care) Yes No
Emotional care Yes No
Spiritual care (pastoral care) Yes No
Promoting community care Yes No
### Physical care (bed care/ bathing/ dressing/ basic physical care)
- Yes
- No

### Financial assistance (including fees and financial advice)
- Yes
- No

### Household assistance (including cooking and cleaning)
- Yes
- No

### Nutrition support (including food parcels and supplemental nutrition)
- Yes
- No

### Treatment of opportunistic infections
- Yes
- No

### Immune system support (vitamins and other)
- Yes
- No

### Medical consultation for PLWHA
- Yes
- No

#### 3.2 Who in your organization provides care?

<table>
<thead>
<tr>
<th>Role</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical doctors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Volunteer care-givers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional (paid) staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other: (please explain)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 4. TREATMENT (only for organizations offering treatment)

#### 4.1 What forms of treatment do you offer?

<table>
<thead>
<tr>
<th>Treatment Type</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Health Clinic consulting which offers treatment of opportunistic infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syndromic management of STIs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syndromic management of TB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOTS support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antiretroviral therapy paid for by patient (including medical aid)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antiretroviral drug trials</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 4.2 What forms of assistance do you need to improve your treatment efforts?

#### 5. TRAINING (only for organizations offering training)

#### 5.1 Do you offer training in the following areas or to the following groups?

<table>
<thead>
<tr>
<th>Training Area</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling skills (with an emphasis on HIV/AIDS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home care/Palliative care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training of life skills trainers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traditional healers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workers from other local organizations, apart from your own</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women’s empowerment issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender issues</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
5.2 What (1) professional qualifications and (2) experience does the main training person in your organization have?

(1)

(2)

6. RIGHTS AND LEGAL ASSISTANCE (only for organizations offering such services)

<table>
<thead>
<tr>
<th>Does your organization have a program that offers rights education on HIV/AIDS issues?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your organization have a person who offers legal advice concerning HIV/AIDS issues?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Explain

7. WHAT ARE THE FUTURE PLANS OF YOUR ORGANIZATION IN RESPONDING TO HIV/AIDS?

7.1 Plans which have only been discussed but not implemented.

7.2 Plans that have been implemented in a pilot form or are in the process of implementation.

7.3 Plans which are in full implementation but which are to be rolled-out further.
7.4 What are the main obstacles and challenges facing your organization in fulfilling its mission in relation to HIV/AIDS?

8. ORGANIZATIONAL NETWORKS

8.1 Organizational linkages

A. List the organizations which you have regular contact with (at least once a week) in connection with your HIV/AIDS work.

B. List the organizations that you have contact with at least once a month, but not as much as once a week, in connection with HIV/AIDS issues.

8.2 How does your organization refer patients or clients to other organizations (you may respond with more than one).

Other: (explain)

<table>
<thead>
<tr>
<th>Method</th>
<th>Fax</th>
<th>Telephone</th>
<th>Writing</th>
</tr>
</thead>
</table>

9. STAFF

Number of staff in your organization.
Number of staff involved in HIV/AIDS programs.
Number of volunteers working for your organization.
On average, how many hours does each volunteer give to the organization each month?
Are volunteers expenses covered? | Yes | No
10. FUNDING

What are your organization’s funding sources, if any?

<table>
<thead>
<tr>
<th>Annual budget of your organization.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Budget spent on HIV/AIDS programs.</td>
</tr>
<tr>
<td>Has your organization ever had programs or activities evaluated? Yes</td>
</tr>
<tr>
<td>If yes, explain:</td>
</tr>
</tbody>
</table>

Does your organization receive financial assistance from the Government? Yes | No

What is the source of government funding?

What is the annual amount of government funding?

ADDITIONAL ACTIVITIES:

Mapping Exercise

Where time and resources allow, it may be useful to conduct a mapping exercise to better understand the geographic distribution of services, especially in districts and larger municipalities that may cover several small towns and rural areas. The emphasis is on service provision and reach of interventions, so distance and transport access are important factors in distinguishing areas.

Task: Draw as many distinct areas as is necessary and label each with a letter of the alphabet. As part of the questionnaire administration, the respondent should be shown the map of the municipality and asked to identify their current location on the map and be generally familiar with the different designated areas of the map: e.g., A, B, C, D, E. The following questions should then be asked:

11. Mapping the HIV/AIDS response framework: please tick (✓) ALL of those that apply:

<table>
<thead>
<tr>
<th>Geographic areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
</tr>
</tbody>
</table>

In which geographic areas do you provide services? First write down the name of the service and then tick which boxes apply.

Service: A | B | C | D | E

Service: A | B | C | D | E

Service: A | B | C | D | E

Service: A | B | C | D | E

In which areas are you based? A | B | C | D | E

From which areas do most of your clients/patients come? A | B | C | D | E

If you have operational plans to extend your services to areas where you do not currently provide services, which areas do you hope to be providing services in the next year? A | B | C | D | E

Note down any additional comments:
4. Analyzing the questionnaire

The following procedure for analyzing the questionnaire data does not require specialized understanding of research methods; all that is needed is time, commitment, and an ability to write a summary. To bring rigor to the process of drawing up a final version, two different people can write summaries and compare their interpretations or they can write it together, discussing as they go.

a. Names of organizations should be written down in a two-column list, noting the types of services provided by each organization.

<table>
<thead>
<tr>
<th>Name of organization</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization x</td>
<td>VCT full service</td>
</tr>
<tr>
<td></td>
<td>Support groups</td>
</tr>
<tr>
<td>etc.</td>
<td></td>
</tr>
</tbody>
</table>

b. For each service area, construct a two-column list of organizations active in the area and the specific skills, resources, and services they have.

Service area: VCT

<table>
<thead>
<tr>
<th>Name of organization</th>
<th>Specific services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Organization x</td>
<td>Pre- and post-test counselling</td>
</tr>
<tr>
<td></td>
<td>Support groups</td>
</tr>
<tr>
<td></td>
<td>Follow-up counselling</td>
</tr>
<tr>
<td>2. Organization y</td>
<td>Laboratory services</td>
</tr>
<tr>
<td>3. Organization z</td>
<td>Full VCT service</td>
</tr>
<tr>
<td></td>
<td>PMTCT program</td>
</tr>
<tr>
<td>4. etc.</td>
<td></td>
</tr>
</tbody>
</table>

c. For each of the specific service areas in sections 2 to 6 of the questionnaire a list of organizations should then be developed.

Service area: VCT

<table>
<thead>
<tr>
<th>Specific services</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pre-test counselling</td>
<td>Organization B</td>
</tr>
<tr>
<td></td>
<td>Organization D</td>
</tr>
<tr>
<td></td>
<td>Organization K</td>
</tr>
<tr>
<td>2. VCT promotion</td>
<td>Organization D</td>
</tr>
<tr>
<td>3. etc.</td>
<td></td>
</tr>
</tbody>
</table>

d. Each of the stage 3 (Care and Support) tables should be studied and a summary description written of the scope of service provision in the area. This should focus on understanding: which areas are neglected; in which areas there are overlaps and duplications; and where there are obvious possibilities for collaboration. The comments made by organizations relating to challenges, difficulties, needs, and plans (qualitative data from each of sections 2 to 7) should be summarised in drawing up these descriptions.
e. Descriptions can be developed of areas in which there are strong possibilities for functional integration of different services at points of service delivery.

f. A section on the relationships between organizations can be written based on looking at which organizations communicate actively with each other (questionnaire Section 8). Referring to the tables derived from analytic process “c” above, descriptions should be written about areas where collaboration could be enhanced.

g. A section on the funding and staff resources (questionnaire sections 9 and 10) available to CSOs should be written, including summary descriptions written under the following headings: total funds available for CSOs; levels of funding to different areas of service provision; service areas where there is more and less support, including government sources of support; and areas in which there is more and less professional expertise and use made of volunteer assistance.

h. If the mapping exercise has been completed (Section 11), use the following two-column format to develop lists of services available in each area.

<table>
<thead>
<tr>
<th>Area</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Area A</td>
<td>■ Home-based care</td>
</tr>
<tr>
<td>2. Area B</td>
<td>■ Full VCT services ■ Home-based care ■ Respite care ■ Education projects: schools ■ Peer-group: training; support</td>
</tr>
</tbody>
</table>

Based on this, a description should be written of the distribution of service programs in the area.

i. The above steps should provide a good start towards developing a database of local HIV/AIDS service organizations. The process of constructing a database would need to be initiated by the LGA and actively maintained by either the HIV/AIDS Task Team within the LGA or, once it is established, by the HIV/AIDS Partnership Network.

5. Presenting the Findings

■ Present the findings at a one-day workshop of CSOs and members of the HIV/AIDS Task Team. Half of the time may be devoted to presenting the results and the rest to jointly identifying areas of collaboration and recommendations for coordination and future development.

■ Propose formation of a local HIV/AIDS Partnership Network (HAPN, Tool 1.7) which might be hosted by the LGA, or if one already exists, propose that the findings of the questionnaire be adopted by a planning meeting of this forum and used as the basis for integrating HIV/AIDS into the LGAs development plan.

■ Complete the work of the audit task team by writing up the recommendations that arise from the meeting and submitting these to the convener of the HAPN.

Tools:
a. INTERNAL STRATEGY
   3.1 Developing an Internal Strategy: Overview
   3.2 Compliance with Minimum Workplace Standards: Checklist
   3.3 Model Workplace HIV/AIDS Policy: Example

b. EXTERNAL STRATEGY
   3.4 An External Strategy Document: Example
   3.5 Developing the External LG HIV/AIDS Response Strategy: Worksheet
   3.6 Promoting Functional Integration: Task Management

PURPOSE:
The purpose of a strategy is to provide a framework for how the LGA will address HIV/AIDS in its locality. This framework should identify the objectives of the strategy, how these objectives will be met, and who will be involved in the process.

HOW TO USE:
The development of an Internal (Workplace) Strategy (Tools 3.1, 3.2, 3.3) may be facilitated by a Workplace Policy Sub-Team (Tool 1.7). The development of this policy may occur at the same time or after the development of the External Strategy (Tools 3.4-3.6). Note: A strategy that has broad support requires much consultation with many stakeholders. This process may take some time but will be worth it.
3.1 Developing an Internal Strategy: A 6-Step Overview

Step 1: Establish a Workplace Policy Sub-Team (refer to Tool 1.6)

Step 2: Gather all necessary background information.9 (This may include existing national HIV/AIDS Workplace policies, existing LG workplace policies, local impact assessments (refer to Tool 2.1-2.4), and available budgets.)

Step 3: Reach consensus on:

- Goals
- Guiding principles
- Elements of the policy

Step 4: Draft the Policy (Tool 3.3 below)

Step 5: Ensure broad consultation on the policy, and then revise based on the inputs received. (Stakeholders that should be consulted include staff associations, union representatives, and partner groups that may be asked to provide services, training for the policy implementation).

Step 6: Develop an implementation plan, and make the policy widely available to all LG staff.

3.2 Compliance with Minimum Workplace Standards: Checklist10

The Minimum Standards are a mechanism used in South Africa to provide guidance for workplace responses to HIV/AIDS. While they do not specifically require the development of an HIV/AIDS Workplace Policy, they do contain important principles that should be included in any internal policy that is developed. The following questions may serve as a guideline to the Minimum Standards:

Does the policy:

- Prohibit unfair discrimination and provide for steps to promote non-discrimination on the basis of HIV/AIDS?
- Prohibit HIV testing without legal authorization?
- Promote VCT?
- Provide for confidentiality of an employee’s HIV status?
Provide for HIV/AIDS education, awareness, and prevention programs?

Encourage openness and acceptance of PLWHA?

Provide for steps to assess and prevent the risk of occupational exposure to HIV?

Provide for steps to facilitate compensation for employees infected as a result of an occupational accident?

Allocate responsibilities for HIV/AIDS?

Provide for a communication strategy on aspects of HIV/AIDS?

Make provision for monitoring and evaluation of the policy?

Look at the gender implications for all of the above and make provision for gender issues in the working environment?

These Minimum Standards are intended to be the baseline from which any policy is developed. A workplace HIV/AIDS policy should, to the extent allowed by budget and capacity, address issues of prevention, care, and mitigation.

### 3.3 Model Workplace HIV/AIDS Policy: Example

The development of a LGA Workplace HIV/AIDS Policy should be coordinated by the members of a Workplace Policy Sub-Team (See Tool 1.6) and developed and implemented in keeping with national workplace policies.

<table>
<thead>
<tr>
<th>MODEL WORKPLACE HIV/AIDS POLICY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background</strong></td>
</tr>
<tr>
<td>This section may include:</td>
</tr>
<tr>
<td>■ A brief paragraph about the seriousness of HIV/AIDS and the risk it poses to the well-being of the community and social fabric of the country.</td>
</tr>
<tr>
<td>■ A statement that communities require strong LGAs to support the struggle against AIDS at the community level. It should be stated that the specific LGA is itself susceptible to the effects of HIV/AIDS, and its ability to lead and deliver services is threatened by the epidemic.</td>
</tr>
<tr>
<td>■ A statement of the need to develop and implement comprehensive LGA workplace HIV/AIDS policies and programs so that the municipality can minimize the impact of HIV/AIDS on its own functioning and so that the LGA can set an example to the community of good practice in responding to the epidemic and caring for the well-being of its members.</td>
</tr>
</tbody>
</table>
A statement that the workplace program complements the HIV/AIDS strategy of the LGA which expresses the LGAs commitment to supporting the fight against AIDS in all of its functioning.

**Principles**

This section sets out the core principles of the LGA approach to HIV/AIDS. These may include, but not be limited to:

- The principle of consultation with employees and their representatives in developing and implementing policy.
- The principle of affording the same rights and responsibilities (non-discrimination) to employees living with HIV/AIDS as are afforded to all employees, supported by the right to confidentiality regarding HIV status.
- The principle that HIV testing will not be imposed on employees and where it is done, it will be done with informed consent and accompanied by counselling.

**Commitment**

This section describes:

- The commitments of the necessary human and financial resources to develop, implement, and sustain the Workplace HIV/AIDS Program and should spell out the budgetary arrangements which will support the program.
- The commitment of LGA leadership to translating the policy into practice.

**Key elements of program**

These are the essential features of what can be expected of a workplace policy. Details will be different for different types and sizes of LGAs, but the central concepts can easily be adapted to fit.

### 1. Coordination and management

- Nomination of an HIV/AIDS Focal Point who will be supported by an HIV/AIDS Task Team with representation from all LGA departments and mandated to report to senior management.
- Assumption of responsibility of this person for translating workplace HIV/AIDS policy into a workplace HIV/AIDS program.
- Regular reports on progress within the program to be made to the LGA executive/management Committee.
- Pledge that the leadership of the LGA will utilize appropriate opportunities to demonstrate support for the Workplace HIV/AIDS Program.
- Recruitment: statement that provides a prospective employee is deemed fit to perform a job applied for, he/she will not be denied employment if HIV positive.
- The LGA will conduct an annual internal needs review of the implementation of the workplace HIV/AIDS Policy, including a review of changing needs of the Workplace Program as the epidemic progresses.
- The LGA will commission impact assessments as needs be, to inform strategic planning, including an assessment of the costs of the epidemic to the municipality due to HIV infection within the LGA.
- The LGA will regularly review employee benefits in the context of the impact of the epidemic.
- The LGA will develop a skills succession plan as part of human resource development in the context of HIV/AIDS.
- The workplace program will be subject to regular monitoring and review. Data will be collected and analysed to monitor trends.
- Any amendments to the policy will be communicated to all employees.

2. **Prevention**

   **Information and education:** access to comprehensive and on-going education programs including awareness activities and distribution of small media materials.
   **Peer education:** the use of peer educators within areas of the workplace who will be trained and supported to disseminate information on HIV/AIDS.
   **Barrier methods:** Free access to condoms for protection against STIs and HIV.
   **HIV testing and counselling**
   **STI management**
   **Occupational exposure**

3. **Care and support**

   **Health care:** Although there is no cure for HIV infection, preventive health care and lifestyle adjustments (including dietary information) can significantly affect the quality and length of life of PLWHA. The LGA should commit itself to offering affordable intervention and education relating to healthy lifestyles as part of the package of health services offered to all employees.
   **Counselling:** The LGA should endeavour to provide access to counselling for infected and affected employees either at work or in conjunction with community services.
   **Disclosure:** When an employee is no longer able to perform his/her duties as a result of HIV disease, he/she is encouraged to inform his/her supervisor.
   **Protecting the rights of employees with HIV:** Non-discrimination and the protection of the rights of employees with HIV/AIDS are necessary to create an environment for an effective Workplace HIV/AIDS Program. The LGA will act decisively to prevent discrimination and to promote equal rights regardless of HIV status.
   **Benefits:** HIV positive employees are entitled to the same benefits as uninfected employees.
3.4 An External Strategy Document: Example

The Strategy should be a simple and straightforward document that can be understood by people who are not intimately familiar with the LGA. The framework below offers an example of a narrative strategy. Note: It may also be useful to include a Background/Rationale section that describes the HIV/AIDS epidemic in the locality and why LG action is relevant. Refer to the Introduction in the main text for a general rationale.

**Vision:**

Municipality X will reduce the rate of HIV/AIDS transmission and ensure a safe and caring environment for those living with and affected by HIV/AIDS.

**Goals:**

[These are statements about the Priority Areas and why the LGA is addressing them.]

1. To ensure that all young people have access to information and resources to make safe sexual decisions.
2. To create an environment free from HIV/AIDS stigma.
3. To ensure that individuals and families affected by HIV/AIDS are not forced into destitution by the disease.

**Objectives:**

[These are how the strategy proposes to meet the goals. If the objectives are met, they should facilitate reaching the goal. There may be several objectives per goal.]

1. To ensure that every student in the seventh grade understands the risks of HIV/AIDS and how to protect themselves.
2. To ensure that all PHC clinic staff have been sensitized and follow all confidentiality policies.
3. To ensure that all individuals and families affected by HIV/AIDS are aware of their rights and the services available to them.

3.5 Developing the external LG HIV/AIDS Response Strategy: Worksheet

**Step 1:** Gather information on priority areas (Tools 2.2-2.3), LGA Assessment (Tools 2.4-2.6), and existing local responses (Tool 2.7).

**Step 2:** Articulate the Priority Areas. The priority areas should reflect the specific local needs that were identified in Section 2 (e.g., unmet needs of youth, gender-specific risks, the negative impact of stigma on access to care for PLWHA and on VCT usage, impact of HIV/AIDS on vulnerable households, etc.). Priority areas should include targets for Prevention, Care and Mitigation.
**Step 3:** For each of the priority areas identified, reflect on the **roles and responsibilities of the LGA** to see if there are any specific strengths or weaknesses that will impact or define the scope of the LGA’s response.

**Step 4:** The **LGA Activities Area** should be developed in consultation with all LGA departments. First, share the list of priority areas (section a in box below) and **LGA strengths/weaknesses (b)** with all of the LGA departments and request that they list any **ongoing activities in this area (c)**. The bulk of the exercise will be for departments to make recommendations for **activities that they could undertake (mainstream)** to address the priority areas. These activities should be easily integrated into ongoing work and not require large new programs. Some departments may be involved in addressing many of the priority areas; others may only be involved with a few (refer to Box 3.2 in Operations). When all of the departments have submitted their proposals, the Task Team should select the **activities that it will include in the strategy** (d). This revised list should then be resubmitted to the Departments who will draw up the budgets and implementation plans (Section 4). This can also be done in a workshop.

**Step 5:** After the Task Team has a better picture of what activities will be mainstreamed into the LGA activities, it can then identify what activities it may support, contract, or encourage among local service providers. The Task Team may begin the process by identifying critical areas where **contracting partner services** will be a high priority. It may then list desired activities that it may be willing to support or assist (e). This draft list should be shared with the HIV/AIDS Partnership Network, discussed and negotiated.
<table>
<thead>
<tr>
<th><strong>Priority Areas</strong> (refer to Tools 2.1, 2.2, 2.3)</th>
<th><strong>a. Setting Priorities</strong></th>
<th><strong>b. Assessing LGA Strengths/Weaknesses</strong></th>
<th><strong>c. Is the LGA already addressing this issue? If yes, How?</strong></th>
<th><strong>d. Identifying LGA Activity Areas</strong></th>
<th><strong>e. Identifying Partner Activities Areas</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Targeting at-risk youth with HIV/AIDS prevention</strong></td>
<td><strong>S. Recent national initiative to address HIV/AIDS in school creating a receptive environment to initiatives</strong></td>
<td>1. LGA Strengths (S) 2. LGA Weaknesses (W) (refer to Tools 2.5, 2.6)</td>
<td>YES (explain) NO</td>
<td>1. In what departments could the LGA address this issue (within its mandate)? 2. What activities could the LGA integrate into its work? (Mainstreaming)</td>
<td>What activities could be contracted out to local partners? (refer to Tool 2.7) (Partnerships) 1. Activity 2. Partners</td>
</tr>
<tr>
<td><strong>W.</strong> Teachers have not been paid because of district revenue problems</td>
<td><strong>W.</strong> Curriculum controlled by central ministry. New curriculum not yet available.</td>
<td><strong>W.</strong> PHC clinics poorly staffed and do not have time for non-essential health interventions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>W.</strong></td>
<td><strong>Health:</strong> 1. Depts. of Education, Health, Parks, Mayor’s Office 2. <strong>Education:</strong> - Allow the use of school building for HIV/AIDS prevention events coordinated by community youth groups. - Request training in HIV/AIDS prevention for teachers. - Develop a certificate program for students in the 7th grade on HIV/AIDS prevention.</td>
<td></td>
<td></td>
<td>1. Train teachers in HIV/AIDS prevention. 2. CSO</td>
<td></td>
</tr>
<tr>
<td><strong>Parks:</strong> 1. Host safe after-school activities for at-risk youth 2. CSO (faith-based organization)</td>
<td><strong>Health:</strong> 1. Develop youth-centered HIV/AIDS Information and Education materials 2. CSO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Mayor's Office:**
Ask the Mayor to address youth on HIV/AIDS issues, and invite a youth representative to be on the Task Team.

1. Hold workshops for at-risk girls on HIV/AIDS, self-esteem, family planning
2. CSO (Women’s organization)

- Decreasing the stigma associated with HIV/AIDS.
  a) in the treatment of PLWHA and their families
  b) as a barrier to accessing VCT

- The Mayor has been very vocal about the importance of reducing stigma.

- Health providers at referral hospitals, who are not under the jurisdiction of the LGA, are reluctant to treat patients that are HIV positive.

- YES (explain) NO

1. Mayor’s Office, Depts. of Health, Education
2. Mayor’s Office:
   - Initiate a Mayoral Campaign Against Stigma that invites community leaders to speak out against stigma.
   - Ensure that all policies of non-discrimination are enforced.

- LGA staff:
   - Invite representative from PLWHA organization to conduct workshops with LGA staff.

- Health:
   - Lobby the District or Provincial AIDS Council (or Ministry of Health) to coordinate a forum on stigma.
   - Request sensitization workshops for all health workers (ideally a combined workshop with district and local health workers), sensitizations should include issues of confidentiality.
   - Improve awareness of VCT through public education campaign, and community outreach.

- Education:
   - Invite members of a PLWHA group to speak to students about HIV/AIDS.

1. Provide training and workshops to LGA, students, and other NGOs.
2. CSO (PLWHA organization)

- Establish additional VCT services
2. CSO

1. Develop a community outreach campaign to fight stigma
2. CSO (Community based organization)

1. Sensitize health workers to issues of stigma and confidentiality
2. CSO (private consulting firm)

1. Develop Information and Education messages and performances to eliminate stigma.
2. CSO (Youth group)
3.6 Promoting Functional Integration: Task Management

In addition to mainstreaming HIV/AIDS activities into LGA work and contracting out additional services to partners, a LG HIV/AIDS Response Strategy must address the relationships between all of the available services, particularly with regards to health and welfare. This is referred to as functional integration and simply means ensuring that there are appropriate links and referrals among all providers of HIV/AIDS related care and welfare (e.g., voluntary counseling and testing (VCT), home based care (HBC), hospital treatment, nutrition and good health counseling, etc.) The LGA may be in a good position to facilitate this process because it may have relationships with all of the public health service providers in the region (in many cases a hospital may be shared by multiple municipalities). Functional integration refers to the coordination of health, counseling and welfare services so that the essential services are linked in a clear and logical way.

Who: The Focal Point may choose to develop a small sub-team (one or two members of the Task Team, including a representative from the Health Department) to address functional integration.

Task: Make a list of all of the HIV/AIDS related health services that are provided in the locality, both public and private (non-governmental). Use Section 8 of Tool 2.7 to identify all of the existing linkages between private health services. Ask the representative from the Health Department to identify any existing linkages among the public health services and those with private health services. After identifying these relationships, use the checklists below to examine where and how the LG can facilitate better operational linkages and referrals among local providers. The outcome of this process should be a set of specific tasks that will be presented to each of the health service providers (this may include procedural suggestions, referral forms, etc.)
Developing a LG HIV/AIDS Response

Functional Integration

Continuum of care refers to establishment of an experience of continuity for users of care services across the different locations where care is provided. This would mean that services ranging from social grants to medical treatment to psychosocial support are knitted into an integrated framework for improvement of access to care. This may be as simple as rearranging HIV/AIDS clinic times to coincide with social work support or arranging office space for social support services in health clinics. It may involve more complex and systemic changes relating to referral procedures. It could also require development of services across departments that are unfamiliar with each other’s ways of working (e.g., social welfare grants and medical officers) and possibly across tiers of government.

Challenges: Such arrangements require careful planning, and coordination, and achievement of a continuum of care is not easily achieved in the context of services that are slow to change.

Continuum of prevention and care: While it is clear that HIV is transmitted by people who are already HIV positive, these individuals are seldom targeted in HIV prevention programs. Prevention efforts can be greatly enhanced by bringing those who are already infected into the system of HIV/AIDS care. VCT programs, PWLHA support programs, and PMTCT (Prevention of Mother to Child Transmission) programs are examples of where prevention and care need to be developed alongside each other.

Challenges: Synchronization of service delivery is especially challenging when multiple points of delivery are involved.
Goals of functional integration in an HIV/AIDS context:

- Creation of a continuum of prevention and care
- Creation of a continuum of health services delivery and social support
- Bringing together HIV/AIDS and mental health services
- Linking community resources and health services
- Utilization of one service increases utilization of another
- Counselling in STI and HIV programs
- Integrated management of AIDS and TB epidemics
- Syndromic management of STIs and TB
- Creation of record keeping systems which promote efficient and user friendly referral between multiple agencies

Functional integration may take many forms including:

- Routine referral linkages between different service providers.
- Bringing together of curative and preventive services, sometimes presented by different levels of government (e.g., curative services administered provincially and preventive services administered at LGA level).
- Providing two or more services together that were formerly run separately.
- Adding new or upgraded services to an existing PHC clinic.
- Integrating PHC into community, family or development activities.
- Multi-purpose clinic and staff.
- Planning of programs that include other sectors and budgeting to reflects this.
- Information systems that report on sources and destinations of referral.
- Supervisory visits that deal with all aspects of a service.
- Integration of STI treatment into primary health care, as well as youth behavioral prevention and empowerment programs.
- Involvement of traditional leaders, churches, and community support services in providing care services.

Supporting the process of functional integration may be done by:

- Publicizing and recognizing successful examples and active promotion of functional integration in relation to HIV/AIDS services.
- Creating models for achieving functional integration.
- Developing protocols to support the practice of functional integration (e.g., new referral or record keeping protocols).
- Investing adequate authority in the agent(s) motivating and driving functional integration.
- Creating expectations, incentives and vertical support for achieving functional integration targets.
- Making allowances for the extra work which functional integration initially requires.
4. Implementing the Local Government HIV/AIDS Response Strategy

**Tools:**
a. **IMPLEMENTATION PLANS**
   4.1 Developing an Implementation Plan (IP): Checklist
   4.2 Frameworks for Implementation: Chart
b. **MANAGING PARTNERSHIPS**
   4.3 Frameworks for Partnership: Checklist
   4.4 Making the most of Technical Assistance: Checklist
c. **MOBILIZING RESOURCES**
   4.5 Budgeting a LG HIV/AIDS Response: Example
   4.6 Looking in the right places; Identifying Resources: Checklist
   4.7 Essential Financial Management Skills: Chart
   4.8 Procurement: Categories and Methods: Chart

**PURPOSE:**
Implementing a LG HIV/AIDS Response Strategy requires the Task Team, with broad assistance from colleagues in the LGA and partners, to develop an appropriate management system to ensure that proposed activities are funded, implemented and monitored. The development of the Implementation Plan should follow closely with the development of a monitoring and evaluation framework (Section 5).

**HOW TO USE:**
Much of the information needed to develop an Implementation Plan and secure funding should be gathered from the previous exercises in the strategy development process. Since many of the activities of the strategy will in fact be carried out by partners, it is important to identify the types of relationships and requirements needed to manage these (Tool 4.3, 4.4). While the Focal Point (with the Task Team) has the responsibility of consolidating the final LG Implementation Plan (Tool 4.1, 4.2) and budget (Tool 4.5), the various components will be provided by the LGA departments, and partners (Tool 4.2). The Focal Point, along with colleagues in the Finance Department will need to determine what funds are or are not available, and determine where/how to access additional funding (Tool 4.6). It will also fall to them to reflect upon their own (and their partners') fiduciary management procedures to ensure that they will meet the scrutiny of potential donors (Tools 4.7, 4.8).
4.1 Developing an Implementation Plan (IP): Checklist.

The Implementation Plan should include:

- Description of the context of the Strategy and the priority areas it plans to address (Tool 3.4)
- Statement of the strategy objectives
- Activities through which such objectives will be met
- Brief description of the partners and stakeholders in the program and their responsibilities (Tools 3.5 & 4.2)
- Monitoring and evaluation plan (Tool 5.3)
- Budget (Tool 4.5)

Process Questions:

- Is the Plan organized in stages that are sequenced appropriately and are time-bound?
- What are the overall goals, and the separate goals for Year 1? Is there a detailed work plan for the first year of operations?
- Does the work plan reflect available financial and human resources? If not, what is being done to augment these?
- When will implementation begin? It is important that there is a balance between the need to develop foundations for the program as a whole and the need to begin implementation soon, even if on a trial or small-scale.
- Has ‘learning’ been effectively incorporated into the Plan through appropriate integration of M&E Tools? (Section 5)
- Are sound financial management systems in place?
- What are the performance indicators for the Plan?

4.2 Frameworks for Implementation: Chart

Task: Use the charts below to identify the activities that will be carried out, who will be responsible for implementation and monitoring (likely not the same), what the necessary budget will be for Year 1 of the project, what funds are already available for this activity, what funds are still required (this will feed into the overall budget proposal), and what the specific (quantified) outputs of the activity will be (i.e. numbers of teacher’s trained, amount of micro-credit lending extended, etc.). In addition there may be
considerations specific to the activity or relationship that should be considered (i.e. a contract may be dependent on the partner fulfilling certain requirements, etc.)

**Note:** These sample frameworks have been organized to correlate with the External Strategy (mainstreaming, functional integration, partnership building) and Internal Strategy (Workplace Policy). Partnerships used in implementing the Workplace Policy should be included in the Workplace Policy box.

### EXAMPLE:

(Providing youth with HIV/AIDS prevention skills)  
*Mainstreaming*  

<table>
<thead>
<tr>
<th>What (Activity)</th>
<th>Place HIV/AIDS awareness posters in all classrooms</th>
<th>Activity 2</th>
<th>Activity 3</th>
<th>Activity 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Who will implement?</td>
<td>1. Education Focal Point, CSO</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Budget (Y1)</td>
<td>(refer to Tool 4.5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available Funds</td>
<td>(Information provided by Focal Point, with Finance Department/ Budgeting Office)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Funds Required</td>
<td>(difference between above 2 items)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Outputs (Y1) | - 50 posters designed and produced  
- posters placed in 50 classrooms | | | |
| Other considerations | | | | |

### Functional Integration

(Linking all HIV/AIDS related services—creating a continuum of care)  

<table>
<thead>
<tr>
<th>What (Activity)</th>
<th>Link all local VCT centers with a CSO working on nutrition</th>
<th>Activity 2</th>
<th>Activity 3</th>
<th>Activity 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Who will implement?</td>
<td>1. Health Focal Point, CSO, VCT centers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Who will monitor?</td>
<td>2. HIV/AIDS Focal Point</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Budget (Y1)</td>
<td>(refer to Tool 4.5)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available Funds</td>
<td>(Information provided by Focal Point, with Finance Department/ Budgeting Office)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional Funds Required</td>
<td>(difference between above 2 items)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Outputs (Y1) | - Database to track patients  
- Information form for VCT visitor with contact details for local CSOs offering nutrition and other services, counselling and care. | | | |
| Other considerations | | | | |
**Example:**

<table>
<thead>
<tr>
<th><strong>Partnerships</strong></th>
<th><strong>What (Activity)</strong></th>
<th><strong>Priority Area X</strong></th>
<th><strong>Priority Area Y</strong></th>
<th><strong>Priority Area Y</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity</strong></td>
<td><strong>Providing a safe environment for orphans and vulnerable children (OVC)</strong></td>
<td><strong>Activity 2</strong></td>
<td><strong>Activity 3</strong></td>
<td><strong>Activity 4</strong></td>
</tr>
<tr>
<td><strong>Provide shelter and services for 125 local OVC</strong></td>
<td>1. Who will implement?</td>
<td>1. CSOs</td>
<td>2. HIV/AIDS Focal Point</td>
<td></td>
</tr>
<tr>
<td>2. Who will monitor?</td>
<td>Budget (Y1)</td>
<td><em>To be determined</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Available Funds</td>
<td>May include ‘in kind’ (i.e. staff time, available LGA building space, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional Funds Required</td>
<td><em>To be determined</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outputs (Y1)</td>
<td>- Safe and comfortable shelter available for 125 OVC (possibly using vacant LGA building)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other considerations</td>
<td>In addition to being a partnership activity, providing care for OVC will also require functional integration (with teachers, HBC staff, etc.) to ensure that vulnerable children are identified and provided for.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Example:**

<table>
<thead>
<tr>
<th><strong>Workplace Policy</strong></th>
<th><strong>What (Activity)</strong></th>
<th><strong>Priority Area X</strong></th>
<th><strong>Priority Area Y</strong></th>
<th><strong>Priority Area Y</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity</strong></td>
<td><strong>Ensuring that LGA staff and family are informed about HIV/AIDS</strong></td>
<td><strong>Activity 2</strong></td>
<td><strong>Activity 3</strong></td>
<td><strong>Activity 4</strong></td>
</tr>
<tr>
<td>1. Implement a peer counseling program in the LGA</td>
<td>1. Workplace Policy Sub-Team, CSO, LGA staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Who will monitor?</td>
<td>Budget (Y1)</td>
<td><em>To be determined</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Available Funds</td>
<td>- Staff time</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Additional Funds Required</td>
<td><em>To be determined</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outputs (Y1)</td>
<td>- 20 peer counselors trained in the LGA</td>
<td>- 5 workshops on HIV/AIDS issues held for LGA staff</td>
<td></td>
</tr>
</tbody>
</table>
4.3 Frameworks for partnerships: Checklist

As illustrated in earlier tools, partners will likely carry out the bulk of activities articulated in the Strategy. Because addressing HIV/AIDS is not the traditional business of a LGA, working in partnership is the only way HIV/AIDS can be addressed in a strategic way at the local level.

Types of Partnerships and Partnership Agreements

**Memoranda of understanding:** Not a legally binding agreement but an ‘in spirit’ agreement to work together. Can include commitments to provide certain services, but the nature of the agreement is based on trust, co-operation in other spheres and the mutual will to work together. The benefits of the agreement and the trust it creates may outweigh the potential risks of under-delivery on the part of one of the partners. For instance, if an agreement to provide training for PHC Clinic nurses in VCT leads to better co-operation and referral between an AIDS support organization and a local PHC clinic, it may not matter all that much that the clinic is not very productive in offering VCT services (as long as these are also provided elsewhere).

**Technical assistance partnerships:** Agreements to support processes and services in areas where high levels of skill are needed in setting up programs and establishing operational systems (Tool 4.4). Certain forms of TA assistance can contribute to sustainability, but others simply plug the gap of expertise temporarily.

**Service partnership agreements:** Ongoing service provision on the part of an agency on a contract basis for the LG. This may be a non-profit or for-profit organization. In the latter case the agreement will constitute a public-private partnership.

**Consultancy services:** Specific funding services, M&E services, program management services: usually on a fee-for-service and often once-off basis.

Some legal and logistical questions to guide the discussion of partnerships:

- What is the current use of CSOs by the department? What additional roles can such organizations play in the rendering of primary health care?

- Are there national policies or guidelines addressing partnerships (within the health sector or with CSOs)?

- What is the current legal framework for the preparation of partnership agreements?
What is the level of risk associated with the agreement and is the legal framework sufficient to safeguard the interests of government and the public?

Are there sufficient resources and support provided to the unit for preparing and monitoring CSO partnership agreements?

The responsibility of LGA with respect to creating and enforcing legal partnership agreements would include:

- Stipulating the regulations for the provision of the service.
- Monitoring and assessing the implementation of the agreement.
- Providing mechanisms to allow for the transfer of funds, staff, and assets.
- Taking responsibility to continue the provision of the service should the service provider, under perform or cease the performance of the service due to insolvency or any other reason.
- Ensuring that service provision continues once the agreement terminates.
- Stipulating the LGA responsibilities with respect to tariffs.
- Developing mechanisms for amending the partnership agreement.
- Providing and securing conditions to prevent corruption and nepotism.
- Outlining the requirements for competitive bidding (Tool 4.7).
- Creating a standard process for negotiating and finalizing the agreement with the service provider.

The following are some important questions to consider in assessing readiness for partnership on the part of CSOs.

- Is the organization legally registered?
- What financial management capacity does it have?
- Does the organization have any experience of service provision agreements?
- Does the organization have employment contracts for its staff?
- Does the organization use work plans and have in place systems of performance review?
- Does the organization keep written minutes of meetings and have a system for managing documents?
4.4 Making the most of technical support and assistance programs: Checklist

In addition to contracting partners to carry out specific tasks relating to the provision of HIV/AIDS services, there may also be a need for the LGA to contract partners to provide technical assistance to the LGA to support capacity building in areas such as financial and project management. With technical assistance, there is the danger that skills are simply provided by the partner and are not adequately transferred to the LGA. The following are guidelines for LG programs that go some way to ensuring that technical support is not merely a stopgap.

Technical Support/Assistance Programs

The following questions should be asked of technical assistance (TA) programs:

- Has the technical assistance program been carefully designed with clear aims and objectives which relate to the program focus, resource constraints, and technical needs?
- Are the technical assistants adequately trained and versed in the program and familiar with the local context, and if not, what can be done to correct it?
- Is the TA program targeted to all parties involved in the chain of delivery of services including non-governmental partners?
- Does the program include peer tutoring, review?
- Has a post program impact assessment been considered to assess the technical assistance?
- How is the technical assistance embedded in the program? NOTE: The technical assistance component of a proposed program should ideally have two parts. The first would comprise of technical assistants who would act as ‘peers’. They would enter the program on a long-term basis from a parallel but more developed and stable work environment. The second would be the provision of hard-skills specialist technical assistants who would be contracted by the program to provide short- and medium-term skills training and enhancement.
- What is the impact of the program on sustainability? NOTE: It is critical that the technical support program does not fill the capacity ‘gap’ which may exist in a department or local government. In some cases, the technical assistant begins to absorb some of the day-to-day functioning of the local government. Once the assistant leaves, the capacity gap continues to exist and often the institution is worse off than before the program.
4.5 Budgeting a LG HIV/AIDS Response: Example

**Task:** Use the strategy and implementation plan to develop a budget for each activity. Each department and/or partner should be required to develop his or her own budgets. The HIV/AIDS Task Team should provide each department team developing budgets with a rough estimate of the funds that may be requested. After receiving all of the budgets, the Task Team can create a larger simplified budget.

### Sample Budget

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1</td>
<td>To ensure that every student in the seventh grade understands the risks of HIV/AIDS and how to protect themselves.</td>
<td></td>
</tr>
<tr>
<td>Outputs 1</td>
<td>1.1 Train 40 teachers in HIV/AIDS prevention messages.</td>
<td></td>
</tr>
<tr>
<td>Activity 1</td>
<td>Conduct 4 half-day training sessions for 10 teachers.</td>
<td></td>
</tr>
<tr>
<td>Inputs</td>
<td><strong>Goods</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Notepads, pens, training materials ($20)</td>
<td>$53</td>
</tr>
<tr>
<td></td>
<td>- Rent/food for training (11 people@$3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Training consultant (from NGO), 4 days @ $50/day</td>
<td>$208</td>
</tr>
<tr>
<td></td>
<td>- Transport (to and from site) 4 trips @$2</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Civil Works</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Grants</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Other</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Teacher’s time (in-kind contribution)</td>
<td>-$1,000</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td>$261</td>
</tr>
</tbody>
</table>

| Outputs 2        |                                                                                 |        |
| Activity 2       |                                                                                 |        |
| Inputs           | **Goods**                                                                    |        |
| Services         |                                                                                 |        |
| Civil Works      |                                                                                 |        |
| Grants           |                                                                                 |        |
| Other            |                                                                                 |        |
|                  | **Total**                                                                    |        |

4.6 Looking in the Right Places: Identifying Resources

A likely place for a LGA to seek funding for the implementation of an HIV/AIDS Response Strategy is from National AIDS Councils. In many countries it is within the mandate of the NAC to support a decentralized HIV/AIDS strategy.

Depending on the national HIV/AIDS funding system, access to NAC funding may be routed through District AIDS Councils, Regional AIDS Councils, or alternately through Ministries of Local Government that may have special funds for HIV/AIDS. In addition international donors such as the Global Fund and Gates Foundation are becoming increasingly interested in funding local initiatives. National and local CSOs, private foundations, city to city cooperation, and private sponsors may also be able to provide some additional support.
Once the appropriate intermediary unit is identified, the LGA will likely have to submit the following:

- Proposal of LGA Activities

- Prioritized budget for all activities and funding amount requested from various sources (with indication of what sources of funding have been secured and which have not)

If the LGA is proposing to act as a funding intermediary for small CSOs, the Task Team will need to:

- Invite proposals for Community HIV/AIDS initiatives

- Facilitate proposal development, particularly among community-level organizations

- Review proposals and process disbursements for recipients

- Coordinate an output-based evaluation system that links funding with demonstrated project outputs

- Inform organizations that have not been awarded funding through this process as to why they did not receive funding.

### 4.7 Essential financial management skills: Chart

The following matrix illustrates financial management requirements for participating partners that receive and disburse HIV/AIDS resources from the National AIDS Program (NAP). Even where NAP may not be the main source of funding, the following requirements are useful benchmarks for LGAs interested in improving their fiduciary management capacity and assessing the capacity of proposed community-based partner organizations.

<table>
<thead>
<tr>
<th>Accounting method</th>
<th>Decentralized service providers: Local government, etc. (B)</th>
<th>Tertiary organizations: communities, community-based organizations, etc. (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Use official language</td>
<td>i. Cash payment &amp; receipt book</td>
<td>i. Cash issued register</td>
</tr>
<tr>
<td>ii. Double entry bookkeeping system</td>
<td>ii. Petty cash book</td>
<td>ii. Supporting documents retained</td>
</tr>
<tr>
<td>iii. Computer or manual system</td>
<td>iii. Stores records</td>
<td>iii. As few forms as possible to be used</td>
</tr>
<tr>
<td></td>
<td>iv. Fixed asset register</td>
<td>iv. Register of in-kind contributions maintained</td>
</tr>
<tr>
<td></td>
<td>v. Cheques issued register</td>
<td></td>
</tr>
<tr>
<td></td>
<td>vi. Cash issued register</td>
<td></td>
</tr>
<tr>
<td></td>
<td>vii. Journal for non-cash transactions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>viii. Fund replenishment register and register of expenses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ix. General ledger</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Books of account</th>
<th>Decentralized service providers: Local government, etc. (B)</th>
<th>Tertiary organizations: communities, community-based organizations, etc. (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. Cash payment &amp; receipt book</td>
<td></td>
<td>i. Cash issued register</td>
</tr>
<tr>
<td>ii. Petty cash book</td>
<td></td>
<td>ii. Supporting documents retained</td>
</tr>
<tr>
<td>iii. Stores records</td>
<td></td>
<td>iii. As few forms as possible to be used</td>
</tr>
<tr>
<td>iv. Fixed asset register</td>
<td></td>
<td>iv. Register of in-kind contributions maintained</td>
</tr>
<tr>
<td>v. Cheques issued register</td>
<td></td>
<td></td>
</tr>
<tr>
<td>vi. Cash issued register</td>
<td></td>
<td></td>
</tr>
<tr>
<td>vii. Journal for non-cash transactions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>viii. Fund replenishment register and register of expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ix. General ledger</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Financial statements and reports

- Monthly and annual bank reconciliation statement
- Fund Replenishment Request as required
- Physical progress report
- Balance Sheet
- Income and Expenditure statement or Summary of Sources and Uses of Funds by agreed categories
- Actual Expenditure and Income against budget.
- Budget for next fiscal year 3 months before year end
- Monthly cash fund reconciliation statement
- Fund Replenishment Request as required
- Annual Statement of In-kind Contributions in predetermined categories
- Milestone report

### Reporting cascade

- All LGA activities financed directly by LG Fund (B), plus, sum of all tertiary organization activities (C) funded by LG Fund
- Output-based evaluation relying on demonstration of agreed outputs, rather than many receipts
- All Fund activities

### Internal audit

- Annual review of financial management procedures
- Random ex post review of financial management procedures and practices

### External annual audit

- Random selection for accounts with less than USDx,000 annual expenditure
- Full annual audit for accounts with USDx,000 or more annual expenditure
- Random selection

## 4.8 Procurement: Categories and Methods

Procurement is a process of purchasing resources that facilitate the implementation of a project. These resources include goods (equipment, material, consumables), civil works (construction/repairs/rehabilitation/extension), services (individual consultants, consulting firms, training, workshops) that are purchased from local and international markets through a transparent and competitive process. The function of a procurement policy is to ensure that goods are purchased at a competitive market rate and that the process is transparent and open.

There are different procurement methods depending on what is being bought and how much it will cost. Some of the key methods, their definition, and to whom they may be applicable are given in the following table. These are methods promoted by many donors and government agencies.

(NOTE: Only methods that may be relevant to LGA have been included here.)
### Procurement Method

<table>
<thead>
<tr>
<th>For Goods &amp; Civil Works</th>
<th>What is it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Competitive Bidding (NCB)</td>
<td>This procedure is usually for the groups of items that are of higher monetary values and/or items that are not locally available. An invitation for bids should be published in the national press at least 35 days before the opening of bids.</td>
</tr>
<tr>
<td>Local Bidding (LB)</td>
<td>Similar to NCB, but not national in scope. An invitation for bids (usually this method is used for large quantities of goods) is published in the local press at least 15 days before the opening of bids.</td>
</tr>
<tr>
<td>Local Shopping (LS)</td>
<td>This method is used for the procurement of readily available, off-the-shelf items that cannot be grouped together into a bigger package of goods. Items are procured on the basis of quotations from at least 3 eligible suppliers in the country. Requests for such quotations will include a clear description/specification and quantity of the goods as well as requirements for delivery time, place for the delivery or services, including any installation requirements as appropriate. <strong>NOTE:</strong> This will be the most common method for small LGAs.</td>
</tr>
</tbody>
</table>

### For Services (firms and individuals)

<table>
<thead>
<tr>
<th>Method</th>
<th>What is it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Least Cost Selection (LC)</td>
<td>This method is more appropriate for the selection of consultants for assignments of a standard or routine nature (audits, engineering design of noncomplex works, and so forth) where well-established practices and standards exist and in which the contract amount is small (amount is determined during project preparation).</td>
</tr>
<tr>
<td>Quality and Cost Based Selection (QCBS)</td>
<td>QCBS is used to procure services of individuals or firms when the quality of the output is of the first concern and then the cost. QCBS uses a competitive process among short-listed firms that takes into account the quality of the proposal and the cost of the services in the selection of the successful bidder. Cost as a factor of selection is used judiciously. The relative weight to be given to the quality and cost is determined for each case depending on the nature of the assignment.</td>
</tr>
<tr>
<td>Selection Based on Consultant’s Qualification (SBCQ)</td>
<td>This method may be used for very small assignments for which the need for preparing and evaluating competitive proposals is not justified.</td>
</tr>
<tr>
<td>Single Source Selection (SSS)</td>
<td>Single-source selection may be appropriate only if it presents a clear advantage over competition: (a) for tasks that represent a natural continuation of previous work carried out by the firm/consultant, (b) where a rapid selection is essential (for example, in an emergency operation), (c) for very small assignments, or (d) when only one firm is qualified or has experience of exceptional worth for the assignment.</td>
</tr>
</tbody>
</table>

**NOTE:** More detailed guidelines are available from the World Bank country offices.
5. Monitoring and Evaluation

Tools:
5.1 Guidelines for developing and implementing M&E: Overview
5.2 Identifying national indicators: Chart
5.3 Basic M&E Module: Chart
5.4 Measuring partner performance: Checklist
5.5 Rapid assessment of LGA action in key areas: Evaluation Survey
5.6 Making use of monitoring and evaluation

PURPOSE:

Monitoring activities allows the LGAs to ensure that they are getting what they are paying for (i.e. activities are generating real outputs). Evaluation activities make sure that these are in fact the most appropriate activities (i.e. producing the desired outcome). While M&E activities may appear to simply fulfill bureaucratic requirements, they can in fact be useful tools for establishing accountability and for integrating learning (i.e. by allowing responsible parties to discuss the obstacles they face and find the creative solutions) (Tool 5.6).

HOW TO USE:

In previous exercises, the Task Team may have found existing and related M&E frameworks in the LGA (Tool 5.2). Because the goal of useful M&E is simplicity and usability, it will be valuable to build upon any existing activities. Much of the M&E framework development can be coordinated by the Focal Point, by using the Strategy and Implementation Plans laid out in earlier Tools (Tools 5.1, 5.3). However, the process of finalizing the M&E Frameworks will require full consultation with all stakeholders and require special considerations in measuring the performance of partners (Tool 5.4). Evaluation activities require baseline data so that any impacts brought about by the new activities can be measured. The Self-Assessment (Tool 5.5) provides a useful baseline for an evaluation of the LGA and can be carried out during the Understanding the Local Situation phase of the project (Section 2).

5.1 Guidelines for developing and implementing M&E

While monitoring and evaluation considerations should be an ongoing part of the process of strategy and implementation plan development, there is a need to step back and coordinate the strategy and objectives for an M&E system.
Taking Initiative

Step 1. Establish an oversight group/person to oversee development of M&E system.

- Within the LGA, there should be an M&E person in the HIV/AIDS Task Team. Broad participation (by members of the LGA, community leaders, CSO representatives) in the process of monitoring is encouraged.

Step 2: Determine the scope.

- Developing an M&E framework requires time and effort. If the LGA has not conducted any type of M&E activity before, it may want to limit the scope of the process to simply a few elements of the strategy. If however, the LGA has experience (or support) in M&E, this may be an opportunity to develop a wider LGA M&E framework, of which the HIV/AIDS strategy may be just one part.

Step 3: Establish a point-person in each agency to focus on the M&E process.

- To ensure that M&E is meaningful, an individual person within each sector responsible for implementing HIV/AIDS related work plans should be held accountable for explaining the purpose of the M&E framework to the sector and assist in the regular collection of indicators.

Step 4: Identify the program’s goals, objectives, and beneficiaries.

- These will have been laid out clearly in the strategy and implementation plan development. In the context of a M&E framework, it is important to ensure that all activities planned are designed with a beneficiary-driven outcome in mind.

Step 5: Decide which outcomes to measure

- This should be considered in line with measures that may be expected from the LGA from the NAC (Tool 5.2) as well as what progress and goals the LGA would like to set for itself.

Step 6: Select indicators

- The main consideration in selecting indicators should be their measurability, their ability to contribute to improving the effectiveness and efficiency of a program.

Data Collection

Step 7: Identify data sources and collect data

- Depending on the indicators selected, there is a range of methods that can be used to gather existing and new data; including collecting administrative records and conducting surveys, and focus groups.
Data Analysis

Step 8: Compare findings to benchmarks

Comparing the findings to benchmarks (decided in advance: Step 5) will determine whether and to what extent the LGA has done well or poorly in meeting its objectives. Benchmarks may be based on previous performance, pre-selected targets, and/or comparison across sectors.

Step 9: Provide explanatory information to better understand indicators

Sometimes there may be situations that severely hinder the capacity of a LGA to fulfill its function with regards to particular indicators (i.e. funding may be held up because of an administrative bottleneck, or there may be political unrest, etc.) In analyzing the indicators, it will be important to acknowledge any such challenges.

Step 10: Finish analysis, report the indicators and learn from experience

An analytical report on the indicators should be produced and shared with all relevant stakeholders (within and outside of the LGA). The dissemination of the report should be coordinated with open meetings for critical discussion of the findings. The reporting for monitoring will obviously occur more often than for evaluation.

Using M&E

Step 11: Integrate information into programs

The information provided through M&E can help identify (and overcome) obstacles, facilitate the planning of new or additional activities, and provide incentives to well-performing sectors or units.

5.2 Identifying national indicators

In some cases, HIV/AIDS data may already be collected by the LGA for input into national monitoring systems. Determine what indicators may already be collected and required before developing a new M&E Framework.

This chart indicates some generalized M&E indicators collected by the National AIDS Councils. Coordinating the LG HIV/AIDS M&E framework with the national framework will facilitate data sharing.
### Measuring National HIV/AIDS Response: Sample Indicators

<table>
<thead>
<tr>
<th>Increase civil society services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Number of civil society organizations receiving NAC funding</td>
<td></td>
</tr>
<tr>
<td>18. Percentage of overall funding granted to civil society services</td>
<td></td>
</tr>
<tr>
<td>19. Number of new civil society partners introduced to HIV/AIDS programming with NAC support</td>
<td></td>
</tr>
<tr>
<td>20. Total HIV/AIDS services delivered by civil society</td>
<td></td>
</tr>
</tbody>
</table>

**HIV/AIDS services: prevention**

| 21. The (a) number of HIV/AIDS radio/television programs produced and (b) number of hours aired |  |
| 22. The number of HIV/AIDS prevention brochures/booklets (a) developed and (b) distributed |  |
| 23. The number of (a) HIV prevention staff and (b) volunteers trained |  |
| 24. The (a) number of HIV prevention meetings held and (b) number of men/women reached |  |
| 25. The number of condoms sold/given |  |
| 26. The number of men/women receiving STI care from health facilities with trained staff an uninterrupted supply of drugs |  |
| 27. The (a) number and (b) percentage of men/women receiving HIV testing and counseling |  |
| 28. The (a) number and (b) percentage of women tested and receiving PMTCT if HIV-positive |  |

**HIV/AIDS services: care**

| 29. Number of care (a) staff and (b) volunteers trained |  |
| 30. The (a) number of PLWHA support groups; (b) number of men/women enrolled; and (c) percentage of men/women enrolled |  |
| 31. The (a) number of community HIV/AIDS care projects; (b) number of men/women enrolled; and (c) percentage of men/women enrolled |  |
| 32. The (a) number of community orphan support projects; (b) number of orphan boys/girls enrolled; and (c) percentage of orphan boys/girls enrolled |  |
| 33. The (a) number and (b) percentage of orphan boys/girls receiving support for school fees |  |

### 5.3 Basic M&E Module: Chart

The following table provides a template for basic planning of an M&E program. **Inputs** refer to the resources required for a program activity. **Activities** are what is done, described as discrete units such as training modules, meetings, and situation analyses. **Outputs** are results of activities such as number of people trained and project reports completed. **Outcomes** are the achievements of the program in terms of specific targeted objectives. **Impacts** are the effectiveness of the program in addressing the problems and challenges that motivated it.

For example, an **activity** to conduct training on HIV/AIDS prevention and project planning for municipal staff will require training materials and trainers (**inputs**). The training should lead to a specific number of staff with better HIV/AIDS awareness than before (**output**). These trained LGA
staff workers will now have the skills to create HIV/AIDS activities (**objective**). Members of the LGA begin speaking publicly about HIV/AIDS prevention, and they start implementing HIV/AIDS activities. As a result of the training the municipal staff has integrated HIV/AIDS into three departmental work plans (**outcome**). The reason that we want LGA to do more to address HIV/AIDS is because we want to reduce the rate of HIV infection in the municipality (**impact**).

**NOTE:** While the chart below offers a stylized framework for designing an M&E program, the actual monitoring process will require that the inputs and outputs for each activity are documented and **compared** with the targets identified in the general framework. It is in this comparison between the actual results and the target that lessons will be learned.

---

**MONITORING AND EVALUATION FRAMEWORK**

<table>
<thead>
<tr>
<th>Monitoring and Evaluation (example)</th>
<th>Description</th>
<th>Key Performance Indicators</th>
<th>Sources of Information</th>
<th>Risks/Special Considerations</th>
<th>Who is responsible for monitoring</th>
<th>Time interval</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Monitoring</strong></td>
<td>Objective 1</td>
<td>Provide youth with HIV/AIDS prevention skills</td>
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<tr>
<td><strong>Activities (Inputs)</strong></td>
<td></td>
<td>1. Place HIV/AIDS awareness posters in all classrooms</td>
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<tr>
<td><strong>Outputs</strong></td>
<td></td>
<td>1a. 50 posters designed and produced</td>
<td>1a. Copy of poster shared with Education Focal Point</td>
<td>1a. Reporting to Education Focal Point</td>
<td>1. Head of Education Department</td>
<td>1. Twice a year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1b. Posters placed in all classrooms</td>
<td>1b. Posters visible in all classrooms</td>
<td>1b. Site visit</td>
<td></td>
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<tr>
<td><strong>Evaluation</strong></td>
<td>Outcomes</td>
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<td></td>
<td>Impacts</td>
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</table>

**Hints:**

1. Use the tools in the Strategy (3) and Implementation Plan (4) sections to determine what the various categories are.

2. To help simplify the system, select only some of the activities and outputs that will be carried out to meet each of the objectives. Selecting the representative activities should be done through a consultative process.
3. Key Performance Indicators can be the same thing as the output, if these have been articulated specifically enough.

4. Sources of information should be considered the ‘evidence’ that is used to show that the task was actually achieved. This may be in the form of reports from departments, training certificates issued, etc.

5. In some areas, there may be external events or circumstances that may impede performance, (e.g., conflict, problems with disbursement from national accounts, loss of a key staff member, political upheaval, etc.). This should be noted.

6. In the implementation plan, people should have been tasked with the responsibility to monitor activities. These individuals should be clearly named so that there is a clear system of accountability.

7. Monitoring activities should occur on a regular basis, perhaps every 6 months, to ensure that money is not being misspent and that lessons learned can be incorporated into the implementation plan.

8. Evaluation can occur less frequently, perhaps every 2 years. (Tool 5.5)

5.4 Measuring partner performance

In addition to monitoring and evaluating its own activities, the LGA (Task Team) is also responsible for measuring the performance of its partners. Ensuring successful LGA/CSO partnership agreements requires inclusion of performance management/supervision in the planning, preparation, monitoring and implementation of the partnership agreements/contracts.

Issues for consideration in establishing performance management systems in partnerships:

- What are the elements to be contained in the performance management system?

Key terms in performance management/supervision

Performance targets: Planned levels of performance or milestones of achievement on specific tasks at either an individual or organizational level.

Key performance indicators (KPIs): Statements that describe the dimensions of performance that are considered key when assessments and reviews are undertaken.

Performance appraisal: Analysis or performance in terms of indicators and targets to determine success or failure.

Performance monitoring: Ongoing tracking to assess whether targets are being met.

Input, output, and outcome indicators: Indicators relating to the resources that go into program activities, the products of the program (outputs), and the outcomes of the program (fulfillment of objectives).
Are there sufficient internal local government resources to monitor the performance management system linked to the contract? If not, can these activities be contracted out?

How does one best establish a system that builds trust and rigorous monitoring of performance?

It is recommended that the LGA establish a performance management/supervision system that relates directly to the contract requirements and which:

- Is in line with the priorities, objectives, indicators, and targets contained in the partnership agreement.
- Includes steps to be taken to improve contract performance where performance targets are not being met.
- Establish a process of regular reporting to the council/political structures and the public.
- Engages the partnered organization in the process of establishing a performance management system.

**5.5 Evaluation: Rapid assessment of LGA action in key areas: Survey**

This tool offers the LGA an opportunity to assess its performance without the need for an expensive evaluation exercise.

**Who:** Use as a group exercise with the Task Team and invited participants from all sectors. Participants may first fill out the table for themselves and then afterwards compare and discuss their ratings in a group discussion. They can then pool their understanding to reach a group verdict on the performance of the LG in each area. In this way, without the need for technical experts, they can rapidly gain an understanding of the most important areas of oversight or neglect and the areas of strength in LGA response.

**When:** This tool can be used to develop a baseline of LGA performance and then be used at set intervals (2-3 years) as an evaluation tool.

**Task:** The list of activities represents essential features of an HIV/AIDS responsive LGA and the ideal scenario would be scores of 5 for each activity. Go through each action area and rate the performance of the LGA by placing a cross in one of the boxes.

**Using the findings:** This exercise may be conducted at regular intervals (e.g. annually) to assess progress and to identify where developments may be stuck.

**NOTE:** There may be differences of opinion about whether some activity areas are relevant or not. Careful attention should be paid to these areas as they often become areas of inaction. Lack of clarity about mandated responsibility for a particular activity relating to a split function of government or uncoordinated action in relation to a split function may lead to failure of services. It is important to identify these areas in the process of the assessment and to take special note of them for later discussion.
### RAPID ASSESSMENT OF LGA ACTION IN KEY AREAS

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>1: Little to no attention in this area</th>
<th>2: Identified for future action</th>
<th>3: In planning or advocacy stage</th>
<th>4: Initial activity, but not well established or at full-scale</th>
<th>5: Well-developed program or completed activity</th>
<th>Not relevant or not a function of LGA</th>
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<tbody>
<tr>
<td>Informed by an understanding of local realities and trends</td>
<td>Assessed the local impact of HIV/AIDS. Assessed impact of HIV/AIDS on municipal functioning.</td>
<td>Identified high transmission areas and populations at especially high risk.</td>
<td>Undertaken an exercise or process for assessing existing resources and priorities.</td>
<td>Taken stock of the existing services offered within LGA boundaries by government health services, including those not under the jurisdiction of the LGA.</td>
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<tr>
<td>Programs for dealing with prevention, treatment/care and impact mitigation in areas of LGA jurisdiction (i.e. within scope of mandated functions of LGA)</td>
<td>Educational prevention programs targeted. Programs directed at high transmission areas and populations at especially high risk. Activity to achieve or promote access to condoms. Action to achieve universal access to VCT services. Action to achieve universal access to PMTCT. Action to achieve access to PEP for rape survivors and occupational infections.</td>
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<tr>
<td>INDICATORS</td>
<td>1 Little to no attention in this area</td>
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<td>Not relevant or not a function of LGA</td>
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<tr>
<td>Action to address the plight of orphans, vulnerable children, and families in distress.</td>
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<tr>
<td>Action to address the need for home-based care and chronic care.</td>
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<td>Action to combat stigma and discrimination towards PLWHAs.</td>
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<tr>
<td>Action to achieve or support actions of others lobbying for access to treatment.</td>
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<tr>
<td>Consistent with national AIDS policy and oriented to the local context.</td>
<td>Awareness and reference to national AIDS policy and/or strategic framework in planning processes.</td>
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<tr>
<td>Leadership</td>
<td>Mayor, municipal CEO, executive management committee, or equivalent publicly known as champion for local responses to HIV/AIDS.</td>
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<td></td>
<td>Existence of an LGA Task Team mandated by head of LGA or equivalent and reporting directly to head.</td>
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<tr>
<td>Internal (workplace) HIV/AIDS policy</td>
<td>Existence of a formal policy ratified by senior LGA decision making body.</td>
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<td></td>
<td>Activities to promote and activate the policy.</td>
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<td>INDICATORS</td>
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<tr>
<td><strong>Education and prevention programs in the workplace.</strong></td>
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<td><strong>External HIV/AIDS Strategy and Response</strong></td>
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<tr>
<td>Identification of key services not evident in district.</td>
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<tr>
<td>Participation of LGA leaders in community HIV/AIDS forums and committees.</td>
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<tr>
<td>Promotion of responses to HIV/AIDS on part of CSOs and businesses.</td>
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<tr>
<td>Coordination of a community-wide planning process to address areas of poor or non-existent services.</td>
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<td><strong>Functional integration of services both within the LGA and between the LGA and community agencies working in HIV/AIDS.</strong></td>
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<tr>
<td>Participation of all relevant sectors and departments in HIV/AIDS task team.</td>
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<tr>
<td>Program to develop functional integration between municipal services.</td>
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<tr>
<td>Efforts to improve care and support services for PLWHA including referral networks.</td>
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<td>Existence of a plan for enhancement of continuum of care.</td>
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<tr>
<td>Convened a meeting of local CSOs to plan coordination of local responses.</td>
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<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>1 Little to no attention in this area</th>
<th>2 Identified for future action</th>
<th>3 In planning or advocacy stage</th>
<th>4 Initial activity, but not well established or at full-scale</th>
<th>5 Well-developed program or completed activity</th>
<th>Not relevant or not a function of LGA</th>
</tr>
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<tbody>
<tr>
<td>Integrated vertically, between the levels of local government (e.g. provincial-district-municipal).</td>
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<tr>
<td>Clarity about responsibility for and financing of split functions of government in providing prevention services.</td>
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<tr>
<td>Existence of lines of communication between LGA and more central authorities.</td>
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<tr>
<td>Existence of clear lines of communication between LGA and more decentralized authorities.</td>
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<tr>
<td>Reporting back of activities of departments to HIV/AIDS Task Team.</td>
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<tr>
<td>Community participation</td>
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<tr>
<td>Community representation and active participation on LGA HIV/AIDS committee/s.</td>
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<tr>
<td>Involvement of people living with or directly affected by HIV/AIDS in municipal HIV/AIDS program.</td>
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</table>
### 5.6 Making use of Monitoring and Evaluation

**Keeping Track (Monitoring):**

- Conduct monitoring exercise at regular intervals (perhaps every 6 months). (Teams should be given at least 2 weeks to prepare their reports.)

- When the Task Team has received all of the monitoring reports, it develops a short Summary Report that highlights Targets met, Targets not met, Obstacles and Proposed Next Steps.

- After the Summary Report has been disseminated, the Task Team organizes a workshop with all of the teams to discuss lessons learned and to discuss whether there are any changes that should be made to the implementation plan or strategy. In addition the monitoring and evaluation framework may be revised to include/delete/revise indicators.

- It may be useful to conduct a similar exercise with partners. This could be coordinated through the HIV/AIDS Partnership Network.

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<tr>
<th>INDICATORS</th>
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<tbody>
<tr>
<td>Needs of PLWHA, and vulnerable groups identified (OVC, youth, girls, etc.).</td>
<td>Little to no attention in this area</td>
<td>Identified for future action</td>
<td>In planning or advocacy stage</td>
<td>Initial activity, but not well established or at full-scale</td>
<td>Well-developed program or completed activity</td>
</tr>
<tr>
<td>Program development and support processes</td>
<td>Training or technical assistance in areas where LGA capacity is not strong.</td>
<td>Existence of annual work plan for HIV/AIDS Task Team.</td>
<td>Quarterly review of progress of HIV/AIDS task team.</td>
<td>Development of key indicators for monitoring progress in key projects.</td>
<td>Not relevant or not a function of LGA</td>
</tr>
</tbody>
</table>
How well have we done? (Evaluation):

- Evaluation occurs less frequently than monitoring and looks at the larger picture to assess whether and to what extent the LGA is successful in making an impact.

- A baseline report should be written before any activities in the strategy are implemented. This report should include:
  - Situation and Impact Analysis (Tools 2.1-2.4)
  - Roles and Functions of LGA (Tools 2.5 & 2.6)
  - Rapid Assessment of LGA Action in Key Areas (Tool 5.5)

- In some cases it may be useful to hire an outside firm to conduct a thorough evaluation, perhaps every 2-3 years. On an annual basis, the Task Team can coordinate an evaluation by revisiting the Rapid Assessment Survey and revisiting any monitoring reports that have been developed.

- Involving community participation in the evaluation process may create a richer understanding of how effective the LGA strategy and activities may be in reaching the community. It may therefore be useful to contract a CSO to conduct some participatory evaluations.17
1. An important first step in involving leadership in the fight against HIV/AIDS is to provide relevant useful information about HIV/AIDS. This is a key ingredient in all HIV/AIDS outreach activities. Colleagues at HEARD (http://www.und.ac.za/und/heard/) and ETU (http://www.etu.org.za/toolbox/aids.html) have developed useful toolkits to provide leaders and community members with important HIV/AIDS information.

2. Other international networks may include the CITY-AIDS project (http://ews.unaids.org), Healthy Cities (http://www.healthycities.org/index_english.html), World Federation of United Cities (http://www.fmcu-uto.org/), and AIMF (International Association of the Mayors/ Francophone: http://www.aimf.asso.fr/).

3. While this Handbook only makes reference to a Workplace Policy Sub-Team, a LGA may opt to have additional sub-teams to focus on particular areas of local concern (e.g., orphans, access to treatment, etc.)

4. The HIV/AIDS Partnership Network should not be confined to only organizations addressing HIV/AIDS explicitly, but should instead be a forum open to a range of CSOs whose work impacts on HIV/AIDS (e.g., a community based organization that focuses on gender training.)

5. Networks can be important tools for facilitating information exchange. In addition to the HAPN for CSO, the LGA may also be involved in national (Local Government Associations) and international networks (refer to Resources for a list).

6. These collect data regularly to update national surveillance data.

7. Where migration is identified as a local risk factor, the LGA may consider working with counterparts in the receiving or sending communities so as to develop a complementary strategy. (Refer to UNDP's Toolkit for HIV Prevention among Mobile Populations.)

8. One of the more difficult but important areas of impact is ‘critical posts‘- those that halt or delay work if not performed (e.g., the individual responsible for maintaining a central database). It may be useful for the LGA to conduct a separate exercise to identify what these critical posts are and to develop a strategy for ensuring that they are appropriately provided for.

9. As with many of the activities and initiatives suggested in this Handbook, the Workplace Policy should be developed with careful consideration of available and accessible funding as well as nationally defined mandates and policies.


11. While there may be many areas that the LGA identifies as important, it may be necessary to select only a few for immediate action. In selecting priority areas, the LGA may wish to consult the national HIV/AIDS plan so as to align local with national priorities—and thereby increase the likelihood of receiving funding. The LGA may also consider the capacity of CSOs and identify priority areas that may be addressed by CSOs already working locally.

12. Where possible, the activities selected should be associated with individual champions who will advise and guide their implementation.

13. Quality proposals are important, and sometimes NACs or donors provide technical assistance to support proposal development.


15. Amount is determined during project preparation


ANNEX 2 Glossary of Terms

NOTE: The following glossary provides a selection of terms relating to Local Government responses to HIV/AIDS that have been used in the Handbook. This is not an exhaustive glossary of HIV/AIDS or local governance terms.

AIDS (Acquired ImmunoDeficiency Syndrome): The late stage of infection caused by a virus, the Human Immunodeficiency Virus (HIV).

Accountability: The ability to call public officials, private employers or service providers to account, requiring that they be answerable for their policies, actions and use of funds.

Activity: The discrete, specific actions or sets of actions that answer the question: “How will a project reach the objective?” Each activity should start with a verb – e.g. conduct four training courses.

Antiretroviral (ARV): A substance, drug, or process that destroys a retrovirus (such as HIV), or suppresses its replication. Often used to describe a drug active against HIV.

Antiretroviral treatment (ART): A treatment that may prevent HIV from damaging the immune system.

Care: Activities providing some level of health services to those living with HIV/AIDS (e.g. home-based care programs).

Civil society organisation (CSO): Non-governmental groups that provide public services. CSOs may include community based organizations (CBO), faith-based organizations (FBO), trade unions, business associations, foundations, academic institutions and the media.

Confidentiality: Keeping information private. This is an important component of voluntary counselling and testing (VCT) and treatment services.

Cost effectiveness: A measure of the comparative efficiency of discrete strategies and methods for achieving the same objective.

Continuum of care: Establishment of an experience of continuity for users of care services across the different locations where care is provided. This would mean that services ranging from social grants to medical treatment to psychosocial support are knitted into an integrated framework for improvement of access to care.

Discrimination: Treating people unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group. (refer to stigma)

Disbursement: The process or method by which money is provided to recipients (e.g. LGA, CSO) from another organisation (e.g. National AIDS Council, Donor, Central Government)
**Evaluation:** The periodic measurement of the outcomes and ultimately the impact of a program. Evaluation asks: “What have we achieved?” Frequently evaluation uses program monitoring data, but it also involves a specific and often independent program of research.

**Fiscal decentralisation:** The decentralization of government expenditure and revenue-raising authority to local government structures in line with their allocated functional responsibilities.

**Focal point:** A person that has agreed to take an active role in addressing a particular issue—in this case HIV/AIDS—in their area or department of work. For example, a focal point in the Education Department may take responsibility for overseeing HIV/AIDS mainstreaming in the education sector, and agree to act as a liaison with local CSOs working with children.

**Functional integration:** Integration at the points of delivery of the health services, to ensure a continuum of engagement with systems of service delivery, recognizing that integration must primarily be oriented around utility. It also involves development of referral networks and consistency of norms and standards of practice across functionally related services.

**Goals:** A broad statements of intent. They should be phrased as statements in the present tense – e.g. reduce the impact of AIDS on affected communities.

**Goods:** Ready made materials including equipment, consumables, medicines and food supplements.

**Grants:** Financial support to HIV/AIDS activities (e.g. school fees for orphans, support for starting an income generating activity for PLWHA).

**HIV (Human Immunodeficiency Virus):** A virus that steadily weakens the body’s defense (immune) system until it can no longer fight off infections such as pneumonia, diarrhoea, tumours and other illnesses. All of which can be part of AIDS (Acquired ImmunoDeficiency Syndrome). Unable to fight back, most people die within three years of the first signs of AIDS appearing. Most of all HIV infections have been transmitted through unprotected sexual intercourse with someone who is already infected with HIV. HIV can also be transmitted by infected blood or blood products (as in blood transfusions), by the sharing of contaminated needles, and from an infected woman to her baby before birth, during delivery, or through breast-feeding.

**Horizontal decentralisation:** Delegation of decision making powers, functions and resources by the LGA leadership to mandated committees and structures within LGA.

**Immune deficiency:** A breakdown or inability of certain parts of the immune system to function, thus making a person susceptible to certain diseases which they would not ordinarily develop.

**Indicators:** measures of progress towards achieving goals. These can be short or longer term and can reflect process or progress – e.g. 20% of health care workers trained in syndromic management each year.

**Inputs:** Inputs are the resources that the project “consumes” in the course of undertaking the activities. Typically they will be human resources, money, materials, equipment and time.

**Integrated development planning (IDP):** Development of a single development plan for a LGA which incorporates inputs from all sectors of that government at that level. It also refers to integration of
development plans from lower level tiers of government into the development plans of higher levels (e.g. municipal plans into district plans).

**Integrated services:** A general term to refer to services which require inputs from different departments and partners of LGA, but which are interrelated service from the perspective of service users (e.g. health and welfare services).

**Intergovernmental relations:** Relations, communications and operational co-operation agreements between different domains of government at the same level of government and also across the tiers of government (e.g. provincial-district).

**Intergovernmental structures:** Structures within government which are designed to support intergovernmental relations and coordinated functioning between systems.

**Local government authority (LGA):** The constitutionally established government structures that operate at the level of formal government closest to communities.

**Mainstreaming HIV/AIDS:** Embedding HIV/AIDS response in existing development programmes rather than making it a completely separate issue.

**Mitigation:** Activities designed to reduce the impact of the epidemic (e.g. provision of school fees, food and/or clothing to children in a household affected by HIV/AIDS, strengthening of social safety nets, etc.)

**Monitoring:** The routine assessment of ongoing activities and progress. Monitoring asks: “What are we doing?” Monitoring covers all aspects of program activity and ideally involves a plan for systematically collecting key program information relating to inputs, activities/processes and outputs.

**Multisectoral response:** Responses from various sectors which are designed to include the efforts of different government departments.

**Network:** Consists of individuals and/or organizations willing to assist one another or collaborate to achieve common goals. A network can rapidly disseminate information - lessons, innovations, techniques, ideas, news, requests, questions. A network may give its participants a strong sense of solidarity and connection.

**Objectives:** Statements of what needs to be done to achieve a goal – e.g. to improve health service delivery to affected communities.

**Outputs:** Indications that something has been done – e.g. workshop held, pamphlet developed, condoms distributed. The tangible results that the project management team should be able to guarantee. Outputs are generally delivered within specified time frame.

**PLWHA:** People Living with HIV/AIDS. The term may also be used to refer to those affected by HIV/AIDS, i.e. family members.

**Partnership:** An open relationship among different partners, whose strength lies in the diverse but complementary contributions that each one makes toward achieving a common objective.

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1. A more complete definition of types of partnership can be found in Tool 4.3 of Annex 1.
Performance-based monitoring: A management tool that emphasizes how goals are being achieved over time. The aim is to determine the relevance of objectives, efficiency, effectiveness, impact and sustainability so as to incorporate lessons learned into the decision-making process.

Policy: A document setting out an organisation’s official position on a particular issue.

Procurement: The way of purchasing resources in a transparent and cost effective manner.

Project Purpose/Outcome: The anticipated effect that the project will achieve by delivering the planned outputs. There is a tendency for this to be expressed in terms of a “change in behavior” of a group or institution; the project outputs are expected to facilitate this change.

Services: Technical expertise purchased, whether individuals or a group of people (like an CSO or another firm).

Split functions of government: Functions of government which are performed in parts at different levels of decentralisation (e.g. salaries for VCT staff paid at one level, and laboratory costs at another level).

Stakeholders: Those individuals and organizations affected (negatively or positively) by the outcome of an activity/project and/or those who can affect the outcome of a proposed intervention (e.g., PLWHA, youth, Unions, health care providers, local leaders, etc.)

Stigma: the holding of derogatory/negative social attitudes or display of hostile or discriminatory behavior towards members of a group (e.g. PLWHA) on account of their membership of that group.

Strategy: The means employed to reach the objective – e.g. advocacy, education, care etc.

Syndromic management: a method for diagnosing STI (sexually transmitted infections) based on the identification of syndromes, which are combinations of the symptoms the client reports and the signs the health care provider observes. Because of the unavailability of laboratory tests in many low-resource settings and the potential for inaccuracy when providers rely on the clinical approach alone, syndromic management is often the best approach in low-resource settings.

Unfunded mandate: A responsibility imposed by legislation on regional or local governments with no matching funding (e.g. provision of internal workplace HIV/AIDS programmes but without provision for the costs involved).

Vertical decentralization: Decentralization that occurs within sectors and departments, disconnected or not integrated with decentralization structures and frameworks in other sectors and departments.

VCT (voluntary counseling and testing) services: Voluntary HIV counseling and testing is the process by which an individual undergoes counseling to enable him/her to make an informed choice about being tested for the human immunodeficiency virus (HIV). This decision must be entirely the choice of the individual and he or she must be assured that the process will be confidential. VCT is a key component of both HIV prevention and care programs.

Vision (and Mission Statements): statements used to reflect a commitment to action to achieve a desirable state – e.g. we will strive for an AIDS-free generation.
ANNEX 3 Useful Resources, Websites and References

**Toolkits and Best Practices**

*HIV/AIDS Toolkit for Local Government.* (HEARD)
   In addition to providing an extensive HIV/AIDS Toolkit for Local Governments, HEARD has also produced a series of (more general) Toolkits aimed at the central government, with some attention paid to specific sectors such as education, public works, finance, labor, etc.
   http://www.und.ac.za/und/heard/

*UNAIDS E-Workspace on Local Responses to HIV/AIDS and City-AIDS.* (UNAIDS)
http://ews.unaids.org
   This is an e-workspace coordinated by UNAIDS/UNITAR/KIT, providing a venue for sharing case studies and experiences on issues relating to Local Responses to HIV/AIDS. (Note: you must register to use.)

   This paper highlights the challenges faced by LGA in the wake of the HIV/AIDS epidemic in sub-Saharan Africa. Case studies from South Africa and Cote d’Ivoire are presented to demonstrate how different countries are responding to the epidemic.

*HIV/AIDS and Municipalities.* (ETU, South Africa)
http://www.etu.org.za/toolbox/docs/aids/webaidsmun.html#develop
   This is a guide for municipalities interested in addressing HIV/AIDS. It includes basic information about HIV/AIDS, and its impact on municipalities. It also includes basic guidelines for conducting an HIV/AIDS campaign and developing local strategies.
   The Education and Training Unit (ETU) has developed a series of toolkits on a range of topics relating to community responses to HIV/AIDS. http://www.etu.org.za/toolbox/aids.html

*Methods and Approaches for Local Responses to HIV/AIDS (UNAIDS, KIT, Royal Tropical Institute, Netherlands)*
   This project provides a database of practices, techniques and training manuals to facilitate learning about local responses to HIV/AIDS. KIT works closely with UNAIDS, CITY-AIDS, and UNITAR in the development of materials.

*Strengthening Community Responses to HIV/AIDS: a Toolkit.* (UNDP, India)
This is a toolkit developed in India (but intended to be globally adaptable) to provide CSOs with tools and resources to become better informed on HIV/AIDS and thereby more able to engage their target communities in HIV/AIDS interventions.

*Considering HIV/AIDS in Development Assistance: A Toolkit.* (World Bank)
This toolkit is intended to advise EU Project Managers working in high HIV prevalence countries of the value and process of incorporating HIV/AIDS in and within project development and implementation.

*Program on HIV/AIDS and the World of Work* (ILO: International Labour Organization)
Features the ILO “Code of Practice” which provides fundamental principles for policy development and practical guidelines from which concrete responses can be developed at enterprise, community and national levels in the prevention of HIV/AIDS, management and mitigation of the impact of HIV/AIDS on the world of work, care and support of workers infected and affected by HIV/AIDS and elimination of stigma and discrimination on the basis of real or perceived HIV status.

*HIV/AIDS Policy Compendium.* (Policy Project)
http://www.policyproject.com/index.cfm
This database allows user to search national policies for references to HIV/AIDS. It contains over 3,400 annotated citations from policy papers from over 50 countries.

*HIV/AIDS Prevention and Care in Resource-Constrained Settings.* (FHI)
A handbook for the design and management of HIV/AIDS programs, as well as a review of best practice in all areas of intervention.

*HIV/AIDS Responses at Different Levels.* (UNAIDS)
A series of manuals and guides for mainstreaming, mobilizing resources, and monitoring and evaluating HIV/AIDS responses at various governmental and nongovernmental levels.

http://www1.worldbank.org/hiv_aids/tools.asp
These publications offer a detailed explanation of MAP Procedures (including financial management) and provide a comprehensive overview of national monitoring and evaluation frameworks. Both may be useful in situating an LGA response within the national context.

*Tools to Support Participatory Decision Making in Urban Government.* (UN Habitat)
http://www.unhabitat.org/cdrom/governance/start.htm
This extensive online directory provides information on a continuously growing set of urban management tools which are related to or used in the implementation of internationally accepted norms or operational principles of good urban governance (which is a key element for any


This is a toolkit for organisations that plan to work with mobile populations. Specifically, the toolkit addresses ways to work with mobile groups of construction workers, truck drivers, seafarers and migrant sex workers.

■ Additional Resources

a. World Bank sites

Urban Development http://www.worldbank.org/urban/
(also on this topic: http://www.genderandaids.org/)

b. UN, International Development Agencies, and Networks

UNAIDS
■ http://www.unaids.org/
  UNAIDS Epidemiological Fact Sheets (for countries)

UNDP HIV & Development Publications Site
  UNDP HIV Link: http://www.undp.org/hiv/links.htm
  UNDP Local Governance Link: http://www.undp.org/governance/local.htm

UN-Habitat
■ http://www.unhabitat.org/

Urban Management HIV/AIDS Programme
■ http://www.unhabitat.org/programmes/hiv/default.asp

World Health Organization (HIV/AIDS)
■ http://www.who.int/health_topics/hiv_infections/en/

Cities Alliance
■ http://www.citiesalliance.org

ABT Associates Reports (analytical reports on HIV/AIDS related topics)

AIMF (International Association of the Mayors/ Francophone)
- http://www.aimf.asso.fr/

Family Health International (HIV/AIDS)

Healthy Cities
- http://www.healthycities.org/index_english.html

MEASURE Evaluation (Monitoring and Evaluation to ASsess and Use Results) (USAID)
- http://www.cpc.unc.edu/measure/topics/hiv_aids/hiv_aids.html

The Policy Project
  http://www.policyproject.com/countries.cfm?country=South%20Africa

World Federation of United Cities
- http://www.fmcu-uto.org/

c. National and Regional HIV/AIDS Related Resources

The Alliance of Mayors Initiative for Community Action on AIDS at the Local Level (AMICAALL)
- http://www.amicaall.org/
  An alliance of mayors in Sub Saharan Africa that have committed to addressing HIV/AIDS through coordinated work at the municipal level.

AIDSLaw Project, South Africa
- http://www.hri.ca/partners/alp/
  Provides information on the legal aspects of HIV/AIDS. This site is appropriate for both South African citizens and municipalities (in South Africa and elsewhere).

AfroAIDSinfo
- http://www.afroaidsinfo.org/DesktoPServlet
  An Internet project of the South African Medical Research Council disseminating information on HIV/AIDS to researchers, the health profession, the public, infected individuals, educators and policy-makers.

Centre for AIDS Development, Research and Evaluation (CADRE), South Africa
A non-profit organisation working on HIV/AIDS social research, project development and communications. CADRE has an extensive searchable bibliographic database on a range of HIV/AIDS related issues.

Centre for HIV/AIDS Networking (HIVAN), South Africa
  Provides mechanisms for cross-sectoral networking around HIV/AIDS research, training and intervention.

Equity Project, South Africa
  Offers an extensive library of publications and tools relating to health service delivery, including HIV/AIDS.

Health Economics & HIV/AIDS Research Division (HEARD), South Africa
- http://www.und.ac.za/und/heard/
  A research and teaching organization that addresses the economic, development and social impacts of HIV/AIDS. (Refer to Toolkits for specific resources)

Health Systems Trust, South Africa
  Provides a searchable database on Local governments and health, including HIV/AIDS.

Municipal Development Partnership
  A partnership between African leaders and the community of sponsors (CIDA, WB, EU, UN Habitat, and French Co-operation) that support policies of decentralization and capacity-building for African local authorities.

Southern Africa Aids Information Dissemination Service, Zimbabwe
- http://www.safaids.org.zw/safaidsweb/
  A regional HIV/AIDS resource disseminating HIV/AIDS information in order to promote, inform and support appropriate responses to the epidemic in the fields of HIV prevention, care, long-term planning and coping with the impact

Select Bibliography


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


The Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa: Summary Reports.10th International Conference on HIV/AIDS and STDs in Africa.


Abidjan Declaration by African Mayors and Municipal Leaders on STDs/AIDS

We, the Mayors and Municipal Leaders of Africa, meeting December 9, 1997 in Abidjan, Côte d’Ivoire, on the occasion of the Xth International Conference on STD/AIDS in Africa, have adopted the following declaration, called the “ABIDJAN DECLARATION”.

Aware that precarious economic conditions in our cities intensify the impact of HIV/AIDS on vulnerable communities, in particular women and youth, and jeopardize our long term local development plans;

Recognizing that our cities are increasingly becoming centers of demographic growth in our countries and that, given the powers invested in them, our municipalities have an important role to play in responding to the many challenges posed by the HIV/AIDS epidemic;

We hereby commit ourselves to search for solutions relevant to local needs and realities, in accordance with the goals and principles of the United Nations and our own laws and regulations, in order to respond more effectively to HIV/AIDS in our communities.

To this end, we have agreed to:

- Aim to reduce the socio-economic impact of HIV/AIDS in our communities by implementing effective measures to reduce HIV transmission.
- Promote and co-ordinate local multisectoral approaches for HIV prevention and the care of infected and affected people.
- Participate in efforts to mobilize the human and financial resources necessary to implement local strategies.
- Ensure the active involvement of people infected and affected by the HIV epidemic in designing and implementing local strategies.
- Strengthen solidarity amongst our cities and develop an effective partnership with national and international, public and private stakeholders.

We therefore commit ourselves to:

- Ensure that the search for effective solutions to HIV/AIDS is a public policy priority.
- Effectively involve our citizens in designing action plans, defining local strategies, and implementing activities.
- Provide the necessary institutional support to our cities and communities and strengthen their capacity to intervene.
- Guarantee transparency and accountability in program management.
- Create an ALLIANCE OF MAYORS AND MUNICIPAL LEADERS to maximize commitment, participation, leadership, capacity and experience at community level in response to the challenge of the HIV/AIDS epidemic in Africa.

Abidjan, 9 December 1997
Annex 5 Partners

Local Government Response to HIV/AIDS: A Handbook has been developed in collaboration with the following partners.

- The World Bank
- United Nations Development Programme (UNDP)
- Cities Alliance
- The Urban Management Programme (UMP)
- Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL)

The following Partners have programs targeted specifically at LGA addressing HIV/AIDS—Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa (AMICAALL) and The Urban Management Programme (UMP).

LGAs interested in learning more about or becoming involved with these programs are encouraged to contact these organizations directly.

Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa

Launched in 1998, the Alliance of Mayors and Municipal Leaders on HIV/AIDS in Africa is an expanding network of local governments, mayors and municipal leaders committed to supporting sustainable solutions to the challenges of HIV/AIDS at the local level. The overall goal of the Alliance is to encourage and support efforts at the local government level to limit further spread of HIV and reduce the social and economic impact of the epidemic on people and communities in Africa. The Alliance works in partnership with government, civil society organizations, the private sector, community leaders and international organizations.

With support of UNDP and UNAIDS, the Alliance developed a roadmap for country-level action: the Alliance of Mayors’ Initiative for Community Action on AIDS at the Local Level, or AMICAALL. National Chapters of the Alliance have been launched and AMICAALL action programs are in varying stages of implementation in nine countries. The Alliance is being hosted by the Government of Namibia and the City of Windhoek. The Secretariat provides management and administrative support for the activities of the Alliance, facilitates resource mobilization and encourages partnerships with governments and civil society organizations.

Alliance Secretariat
P.O. Box 60401
Katutura, Windhoek
Namibia
Tel: +264 61 224730
Fax. +264 61 227890
E-mail: alliance@iway.na
Website: www.amicaall.org
The Urban Management Programme (UMP)

The Urban Management Programme (UMP) was launched in 1986 as an initiative of UNDP, UN-HABITAT, the World Bank and several bilateral partners (currently the UK, Sweden, and Switzerland). UMP has an explicit focus on activities that impact the living conditions of the poor in cities and towns. The programme continues to develop and apply urban management knowledge in the fields of participatory urban governance, alleviation of urban poverty, urban environmental management and HIV/AIDS.

The HIV/AIDS related activities are implemented through the UMP’s City Consultation Methodology—a technique used in over 120 Cities since 1986 to develop inclusive initiatives involving stakeholders, including local authorities and government in urban areas. The City Consultation Methodology is not only an effective approach for local development, it is also a strategy to reduce the impact of HIV/AIDS by mobilizing the leadership of City Administration in partnership with community-based organizations, people living with HIV/AIDS, academic research institutions, and other civil society actors.

Urban Management Programme
United Nations Human Settlements Programme
P.O. Box 30030, Nairobi, 00100 Kenya
E-mail: umphiv@unhabitat.org
Website: http://www.unhabitat.org/programmes/hiv/default.asp