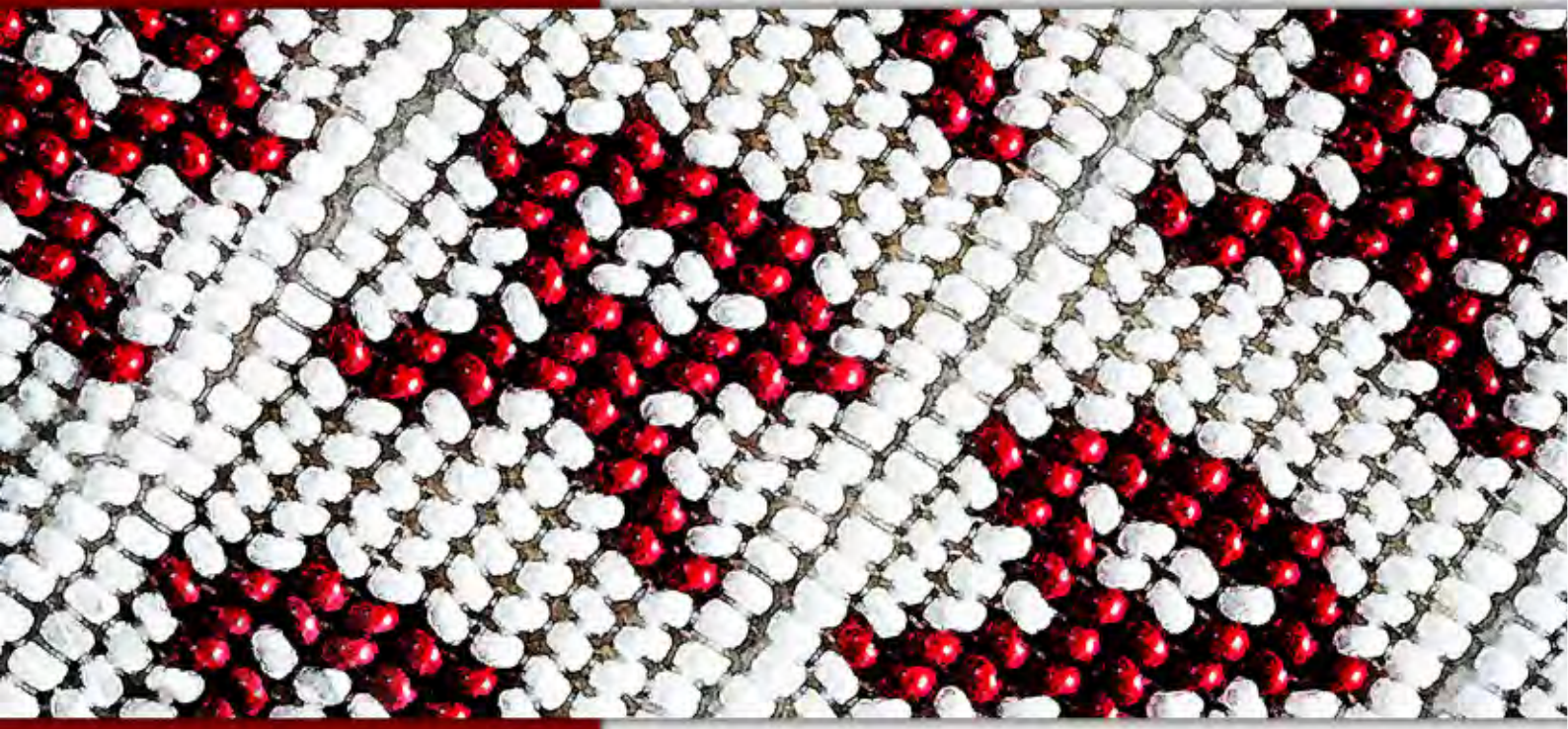
Resource Book For Local AIDS Councils



A Guide for Local Government AIDS Councils

giz

Federal Republic of Germany
The Federal Government

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EVERYONE
HAS AN HIV STATUS

An Overview

The AIDS epidemic is among the greatest hindrances for development in South Africa. Internationally, South Africa has the highest number of HIV-infected citizens, namely 5,6 million within a total population of approximately 48,6 million according to DOH 2010. However, the prevalence (frequency of the disease) show significant differences between regions and risk groups. The infection among young women is disproportionately high. In the age group of 20-24 years, their risk is four times as high as that of the general population. The estimated HIV prevalence among antenatal clinic attendees ranges from 39,5% in KwaZuluNatal (KZN) and 35,1% in Mpumalanga to 29,9% in Eastern Cape and 18,5% in Western Cape. The annual incidence (new infections) in South Africa was still a high 1,5% in 2009, down from 2,4% in 2001 and it varied considerably as already mentioned above - from 0,5% in Western Cape province to 2,3% in KZN, the most severely affected province in the country[1]. These trends have occurred alongside apparent shifts to safer sex among young people due to increased condom use[2].

In order to reduce the infection rate and the impact of the epidemic, the South African government, introduced a national programme to provide universal access to HIV prevention, treatment, care and support This is in line with the National Strategic Plan (NSP) for HIV, STIs and TB, 2012 - 2016 and the preceding ones.

Furthermore, the NSP identifies the importance of multi-sectoral oriented responses to the epidemic, linked to a deep understanding of the local context, including the local drivers of the HIV and TB epidemics.The NSP assigns Provincial and District AIDS Councils the responsibility for the implementation of planned activities at provincial, district and local level as well as the management of the multi-sectoral response to the epidemic at community level. The NSP 2012 - 2016 responds to the need of integrating the management of HIV, STIs and TB through one comprehensive strategy. This is a significant shift from the initial focus mainly on HIV and AIDS and requires that the roles of the AIDS Councils at the different levels change to accommodate this approach.

The Quality Assurance Manual describes standard operating procedures and practice guidelines for the work of District and Local AIDS Councils in South Africa which will guide them to assess their performance and identify capacity development needs. Well-performing AIDS Councils will be the key to an effectively implemented National Strategic Plan.

The German Gesellschaft fuer Internationale Zusammenarbeit (GIZ) GmbH is, in support to the South African National AIDS Council (SANAC), currently implementing a programme to support and strengthen District and Local AIDS Councils. This manual was developed as part of the GIZ supported programme.

[1] National antenatal sentinel HIV and syphilis prevalence survey in South Africa, 2009. Pretoria, Department of Health 2010

[2] Shisana O et. al. South African national HIV prevalence, incidence, behaviour and communication survey 2008: The health of our children. Cape Town, HSRC Press 2010

I am Richard, the Mayor of Ubuntu Local Municipality. Our AIDS Council has decided that we would like to improve our level of functioning and effectiveness. Guided by the National Strategic Plan for HIV, STIs and TB for 2012-2016, our municipality has decided that we would like to have an effective multisectoral AIDS Council to enable us to carry out our roles and responsibilities.

After establishing our AIDS Council, we used the ***Self Assessment Tool*** developed with this Resource Book to identify our level of preparedness for our role. The ***Self Assessment Tool*** helped us to identify the level of knowledge and capacity required for the efficient functioning of AIDS Councils. Using the ***Self Assessment Tool***, we were able to identify our own knowledge and capacity gaps. With an understanding of our capacity strengths and limitations, we used the ***Quality Assurance Manual*** to gain further knowledge on the roles and responsibilities of the different levels of AIDS Councils.

The ***Quality Assurance Manual*** helped our AIDS Council understand the role of Local Government in coordinating the local response to HIV, STIs and TB. We now know **what** we need to do and **why**. Please join me and fellow members of our AIDS Council as we now use this Resource Book for guidance and tools on **how** and **when** to carry out our responsibilities in a manner that will improve the quality and level of functioning of our AIDS Council.

Abbreviations

AIDS	Acquired Immuno-Deficiency Syndrom
AMICAALL	Alliance of Mayors Initiative for Community Action on AIDS at the Local Level
ART	Antiretroviral Treatment
CBO	Community Based Organsiation
DAC	District AIDS Council
DOH	Department of Health
DPLG	Department of Provincial and Local Government (now Department of Cooperative Governance and Traditional Affairs –CogTa)
FHI	Family Health International
GIZ	Gesellschaft für Internationale Zusammenarbeit GmbH
HTC	HIV Testing and Counselling
HIV	Human Immunodeficiency Virus
HR	Human Resources
IDP	Integrated Development Planning
IMC	Interministerial Committee on AIDS
LAC	Local AIDS Council
M&E	Monitoring & Evaluation
MFMA	Municipal Finance Management Act

NACOSA	National AIDS Coordinating Committee of South Africa
NGO	Non-Governmental Organisation
NHC	National Health Council
NSP	National Strategic Plan
PAC	Provincial AIDS Council
PEP	Post-exposure Prophylaxis
PFMA	Public Finance Management Act
PIC	Programme Implementation Committee
PMTCT	Prevention of Mother to Child Transmission
PLWH	People living with HIV
POP	Provincial Operational Plan
SALGA	South African Local Government Association
SANAC	South African National AIDS Council
SCC	Sectoral Coordinating Committees
STI	Sexual Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV and AIDS

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Introduction

The National Strategic Plan (NSP) for HIV, STIs and TB (2012 - 2016) identifies and highlights the importance of integrated local level responses to the HIV and TB epidemics. The current NSP focuses at a high level on the strategic interventions required from all sectors of society, as outlined in the multi-sectoral approach, to reverse the HIV and TB epidemics supported by AIDS Councils at various levels (see **section 1.1**). The previous NSP (2007-2011) was reviewed and the findings of the review formed the basis for the NSP 2012 - 2016. Identified strengths and challenges of the current response to the HIV epidemic are summarized in **section 1.2** below, and detailed information on responsibilities of AIDS Councils at national, provincial, district and local level are outlined in **section 1.3**.

1.1 Strategic direction: Statements from the National Strategic Plan (2012 - 2016)

The National Strategic Plan for HIV, STIs and TB, 2012-2016, South Africa, presents the country's multi-sectoral response to the challenge with HIV and TB and the wide-ranging impacts of the two epidemics. The NSP seeks to provide continued guidance to all government departments and sectors of civil society, building on work done in the past decade. It is informed by the nature, dynamics, character of the epidemic, as well as developments in medical and scientific knowledge.

HIV and AIDS is one of the main challenges facing South Africa today.

HIV and AIDS estimates (UNAIDS 2010)*

Number of people living with HIV	5,600,000 [5,400,000 - 5,900,000]
Adults aged 15 to 49 prevalence rate	17.8% [17.2% - 18.3%]
Adults aged 15 and up living with HIV	5,300,000 [5,100,000 - 5,500,000]
Women aged 15 and up living with HIV	3,300,000 [3,000,000 - 3,500,000]
Children aged 0 to 14 living with HIV	330,000 [190,000 - 440,000]
Deaths due to AIDS	310,000 [260,000 - 390,000]
Orphans due to AIDS aged 0 to 17	1,900,000 [1,600,000 - 2,400,000]

* UNAIDS publishes HIV estimates for individual countries every two years. The most recent set of estimates (for 2009) was published in 2010. Estimates for countries and regions are generated with specific software, using all available data. The results are projected assumptions. For that reason the above mentioned data are represented as an average or as range value.

There are geographic variations with some provinces more severely affected than others. These differences also reflect background socioeconomic conditions as demonstrated by the district level HIV surveillance data in the Western Cape Province. In this province, in 2005, overall HIV prevalence was the lowest in the country at 15.7%, but two metropolitan health districts, Khayelitsha and Gugulethu/ Nyanga registered prevalence rates of 33% and 29% respectively. According to the HSRC Household Survey, people living in rural and urban informal settlements seem to be at highest risk for HIV. Although the rate of the increase in HIV prevalence has slowed down in the past five years, the country is still to experience a reversal in the trends. There are still too many people being newly infected with HIV.

The epidemics of HIV and Tuberculosis (TB) are interlinked. In South Africa, between 50% and 80% of TB patients are HIV positive. Based on the overall number of TB cases reported to the Ministry of Health, the incidence rate of TB has increased from 169 per 100 000 people in 1998 to 645 per 100 000 people in 2005 although reporting rates in many parts of the country are far from complete.

Vision and Goals

The NSP 2012–2016 is driven by a long-term vision for the country with respect to the HIV and TB epidemics. It has adapted, as a 20-year vision, the "Three Zeros" advocated by UNAIDS. The vision for South Africa is:

- Zero new HIV and TB infections;
- Zero new infections due to vertical transmission
- Zero preventable deaths associated with HIV and TB
- Zero discrimination associated with HIV and TB

In line with this 20-year vision, the NSP 2012-2016 has the following broad goals:

- Reduce new HIV infections by at least 50% using combination prevention approaches
- Initiate at least 80% of eligible patients on antiretroviral treatment (ART), with 70% alive and on treatment five years after initiation
- Reduce the number of new TB infections as well as deaths from TB by 50%
- Ensure an enabling and accessible legal framework that protects and promotes human rights in order to support implementation of the NSP
- Reduce self-reported stigma related to HIV and TB by at least 50%

Strategic Objectives

The plan has four strategic objectives, which will form the basis of the HIV, STI and TB response. These are:

- Address social and structural barriers to HIV, STI and TB prevention, care and impact

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- Prevent new HIV, STI and TB infections

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- Sustain health and wellness

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- Increase protection of human rights and improve access to justice.

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Strategic Objective 1: Address Social and Structural Drivers of HIV , STI and TB Prevention, Care and Impact

Strategic Objective 1 (SO 1) is focused specifically on addressing the structural, social, economic and behavioural factors that drive the HIV and TB epidemics. The sub-objectives are:

- Mainstream HIV and TB and its gender- and rights-based dimensions into the core mandates of all government departments and all other sectors of SANAC
- Address social, cultural, economic and behavioural drivers of HIV, STIs and TB. This includes addressing challenges posed by: socialisation practices; living in informal settlements, as well as rural and hard-to-reach areas; migration and mobility; and alcohol and substance abuse
- Implement interventions to address gender norms and gender-based violence
- Mitigate the impact of HIV, STIs and TB on orphans, vulnerable children and youth
- Reduce the vulnerability of young people to HIV infection by retaining them in schools as well as increasing access to post-school education and work opportunities
- Reduce HIV- and TB-related stigma and discrimination
- Strengthen community systems to expand access to services
- Support efforts aimed at poverty alleviation and enhancing food security programmes.

Strategic Objective 2: Prevent New HIV , STI and TB Infections

Strategic Objective 2 (SO 2) is focused on primary strategies to prevent sexual and vertical transmissionof HIV and STIs, and to prevent TB infection and disease, using a combination of prevention approaches. Combination prevention is a mix of biomedical, behavioural, social and structural interventions that will have the greatest impact on reducing transmission and mitigating susceptibility and vulnerability to HIV, STIs and TB. Different combinations of interventions will be designed for the different key populations. The following sub-objectives are included for HIV, STI and TB prevention:

- Maximise opportunities for testing and screening to ensure that everyone in South Africa is tested for HIV and screened for TB, at least annually, and appropriately enrolled in wellness and treatment, care and support programmes;
- Increase access to a package of sexual and reproductive health (SRH) services, including for people living with HIV and young people, and conduct prevention activities in non-traditional outlets. The package includes medical male circumcision (for adults and neonates), emphasis on dual protection, provision of both male and female condoms, termination of pregnancy and provision of contraception;
- Reduce transmission of HIV from mother to child to less than 2% at six weeks after birth and less than 5% at 18 months of age by 2016. This includes strengthening the management, leadership and co-ordination of the prevention of mother to child HIV transmission (PMTCT) programme and ensuring its integration with maternal and child health programmes. TB screening will be integrated into the PMTCT programme. In addition, screening and treatment of syphilis will be strengthened to eliminate neonatal syphilis;
- Implement a comprehensive national social and behavioural change communication strategy with a focus on key populations. This

aims to increase demand and uptake of services, to promote healthy behaviours, and to address norms and behaviours that put people at risk for HIV, STIs and TB;

- Prepare for the potential implementation of future innovative, scientifically proven HIV, STI and TB prevention strategies, such as pre-exposure prophylaxis, new TB vaccines and microbicides;
- Prevent TB infection and disease through intensified TB case finding, TB infection control,workplace / occupational health policies on TB and HIV, Isoniazid preventive therapy (IPT), immunisation, prevention of multidrug-resistant TB (MDR-TB), and reducing TB-related stigma, alcohol consumption and smoking; and
- Address sexual abuse and improve services for survivors of sexual assault.

Strategic Objective 3: Sustain Health and Wellness

The primary focus of Strategic Objective 3 (SO 3) is to achieve significant reduction in deathsand disability as a result of HIV and TB. This will be accomplished by universal access to affordable and goodquality diagnosis, treatmentand care. The sub-objectives of SO 3 are:

- Reduce disability and death resulting from HIV and TB. This includes: annual testing / screening for HIV and TB, particularly for key populations; improved contact tracing; early diagnosis and rapid enrolment into treatment; increased access to high-quality drugs; improved access to treatment for children, adolescents and youth; early initiation of all HIV-positive TB patients on ART; strengthened implementation of a patient-centred pre-ART package; early referral of all patients with complications; appropriate screening and treatment for cryptococcal infection and strengthened screening and treatment of pregnant women for syphilis;
- Ensure that people living with HIV and TB remain within the health care system, are adherent to treatment and maintain optimal health. The means to achieve this includes the establishment of ward-based PHC teams and regular communication using all appropriate media;
- Ensure that systems and services remain responsive to the needs of people living with HIV and TB. This includes integrating HIV and TB care with an efficient chronic care delivery system; expanding operating hours of service delivery points; ensuring continuum of care across service delivery points; strengthening quality standards; and adequate monitoring of drug resistance.

Strategic Objective 4: Ensure Protection of Human Rights and Improve Access to Justice

South Africa's response to HIV, STIs and TB is based on the understanding that the public interest is bestserved when the rights of those living with HIV, STIs and/or TB are respected, protected and promoted. The NSP 2012-2016 recognises the need to continuously assess barriers to access to services and instances of stigma and discrimination and provides the framework for addressing such issues. It aims to ensure that rights are not violated when inter ventions are implemented, and that discrimination on the basis of HIV and TB is reduced, and ultimately eliminated.

In conclusion, the NSP must be seen as a dynamic living document that will be subject to regular critical review. It is believed that when all partners, led by SANAC, and with technical support from the Department of Health, pull together and rally around the identified interventions, the main aims; that of reducing new infections and mitigating the impact of AIDS on millions of people's lives will be realised.

1.2 Strengths and challenges of the current response

Strengths

While South Africa is still the country with the highest numbers of people living with HIV and still experiences a high burden of TB, some major achievements have been realised over the years. The country's response to the HIV and TB epidemics has grown from strength to strength over the years. Some of the critical strengths include:

- The renewed engagement and high-level political leadership spearheading the HIV response, as well as the growing co-operation between government and its partners
- The strong policies that were developed and implemented to deal with the HIV and TB epidemics
- The scale up and strengthening of the programme to prevent mother-to-child transmission of HIV which resulted in the reduction in HIV transmission at 6 weeks post-birth
- The increase in the number of people testing for HIV
- The initiation of 1.4 million people on antiretroviral treatment (ART) since the programme began in December 2003
- The introduction and scale up of medical male circumcision services as part of male sexual and reproductive health
- Rapid scale up of accelerated TB and MDR-TB diagnosis, improving TB case detection, and good adherence to TB treatment and ART
- Improving TB cure rates and a decreasing defaulter rate
- The commitment to focus on the drivers of the HIV and TB epidemics and measures to address the social determinants of health
- The large number of eligible orphans and vulnerable children, among others, who have access to social security services
- The increase in the number of learners who have access to education, particularly girls
- The provision of HIV life-skills education in all schools and grades, as a compulsory part of the education curricula
- The reduction in prices for key commodities, including antiretroviral drugs (ARVs) and TB drugs.

Challenges

South Africa is known to be good at developing good policies and but faces challenges and weaknesses in their implementation. The same criticism can be levelled against the country's response to the HIV and AIDS challenge in that, despite the strengths mentioned above, there are still provinces with no functional Provincial AIDS Councils and some District and Local Municipalities do not have AIDS Councils. The NSP (2012-2016) addresses some of the challenges identified in the previous NSP, such as:

- Inadequate co-ordination of the public sector, private sector and non-government sector responses
- The weak governance and co-ordination structures of SANAC (from ward to national level)
- The lack of robust monitoring and evaluation of the NSP
- The failure to ensure a truly multi-sectoral and integrated response
- Weak focus on human rights and justice; and
- The lack of a comprehensive and integrated approach to HIV and TB prevention.

Conclusion

The HIV epidemic continues to present major developmental challenges for South Africa and many other countries. The nature and extent of the epidemic is being monitored through several reliable methods and new strategies are developed over time. Some of the factors increasing the risk of infection among individuals, groups and communities have been identified and reported on. There is an on-going attempt to find appropriate interventions, with structures and policies either being developed afresh or strengthened to mitigate the impact of the epidemic.

Generally, there is agreement that the challenges presented by the epidemic are such that a well-coordinated, comprehensive multisectoral approach is necessary in managing the epidemic. The need for leadership at Local Municipality level is also acknowledged and the necessary framework and guidelines to enhance this have been developed. However, the reality is that, despite all of these well-intended interventions, the response at Local Municipality is not always as good as it could be. The need to strengthen and support Local AIDS Councils as a means to achieve better implementation of the NSP has prompted the development of this manual.

1.3 Responsibilities and composition of SANAC, PACs and DACs

The challenges South Africa continues to experience in managing the HIV and TB epidemics are an indication that there is an even bigger need for all available avenues and resources to be explored and coordinated fully. This will ensure that there are no gaps in the response at the different levels within the country and that all available resources are used wisely. For coordination to be achieved and sustained, there is a need to develop clarity and a common understanding among the different stakeholders on:

- What kind of structures is necessary?
- Which structures are available and at which level?
- Which structures are working well and which ones are not (and why)?
- Which structure is responsible for which area of the response?
- How do the different structures operate and relate to each other?
- Where do these structures draw their mandate from?
- Relationship between the community, district, provincial and national level?
- Relationship to Local Government and the Integrated Development Planning Process?
- Relationship to other relevant stakeholders? (Who should be involved?)

Drawing from available frameworks, guidelines and best-practice models, the focus of this section is on establishing the mandates, roles and responsibilities of SANAC, Provincial AIDS Councils (PACs),District AIDS Councils (DACs) and Local AIDS Councils (LACs).

The South African National AIDS Council (SANAC)

In 1997, the Inter-Ministerial Committee (IMC) on AIDS was established in line with the NACOSA Plan review recommendations as well as what had been proven to work in other countries. The IMC was the first high-level structure established to oversee the country's

response to the HIV and AIDS epidemic which, at the time, was growing at an alarming rate. The then Deputy President was appointed as the Chairperson of the IMC. The Department of Health launched the Partnership against AIDS Initiative in 1998. The approach of seeking broad participation through the mobilisation of all the sectors of society was initiated through this initiative. The then Deputy-President was the patron of the partnership initiative. This marked the beginning of any structured and sustained involvement of other stakeholders from outside the DOH in managing HIV and AIDS (DOH, 2006).

The need for more structured coordination and collaboration at the different levels of the response to the epidemic was soon realised. To bring the initiatives of civil society, coordinated through the Partnership Against AIDS, together with those of the IMC in line with international best practice, the South African National AIDS Council (SANAC) was launched in January, 2000.

The need to have similar structures at provincial and lower levels resulted in the subsequent establishment of Provincial AIDS Councils (PACs), which has since been followed by the establishment of District AIDS Councils (DACs), Local AIDS Councils (LACs) and even Ward AIDS Committees (WACs) in some municipalities. The National Strategic Plan (2012 - 2016) highlights SANAC's role as being responsible for ensuring that the targets set in the NSP are achieved.

The **objectives of SANAC**, which constitute its mandate, are as follows (Presidency, 2006):

- To advice government on HIV, AIDS and Sexually Transmitted Infections (STIs) policy, strategy and related matters
- To create and strengthen partnership for an expanded national response to HIV and AIDS in South Africa
- To receive and disseminate all sectoral reports on interventions and to consider challenges
- To oversee continual monitoring and evaluation of all aspects of the NSP

SANAC is a three-tiered multi-sectoral advisory body. Both government and civil society participate and are represented at all tiers. The three-tiered structure of SANAC comprises (SANAC, 2008):

- Tier one - the Plenary;
- Tier two - the Programme Implementation Committee and the Resource Management Committee
- Tier three - the Sector Coordination Committees.

The **SANAC Plenary** constitutes the political leadership of SANAC and is chaired by the Deputy President of the Republic of South Africa, with a deputy chairperson being chosen from civil society. The Plenary is made up of representatives of seven government departments and seventeen civil society sectors as follows:

Civil Society Sectors	Children
	Disability
	PLWH
	Traditional Healers
	Women
	Men
	Youth
	Faith-based
	Non-governmental
	Community-based
	Private Sector
Professional Organisations	Health professionals
	Health related research organisations
	Higher education
	Labour
	Law and Human Rights
	Sports and entertainment

Programme Implementation Committee (PIC)

The PIC is a committee whose primary function is to share experiences, review the implementation of programmes and strategies of the NSP and make recommendations to the Plenary. The PIC reports to and is directly accountable to the Plenary. The PIC is comprised of:

- The chairperson of the PIC;
- Seven representatives from the government departments represented at the Plenary
- Seventeen representatives from the civil society sectors represented at the Plenary.

The PIC has standing sub-committees called Technical Task Teams (TTTs). These TTTs are made up of experts in all the priority areas of the NSP. The primary responsibilities of the TTTs are to provide technical advice and strategic support to the PIC regarding:

- Prevention
- Treatment, care and support
- Research, monitoring and surveillance
- Human rights and access to justice
- Communications
- Available good practice
- Policy and implementation gaps
- Any other areas as directed by the PIC

Sectoral Coordinating Committees (SCC)

The primary objectives of the SCCs are to ensure that the implementation of sectoral specific programmes is effectively coordinated and reviewed; and the PIC is regularly provided with information regarding sector specific pro grammes to enable it to make appropriate re-recommendations in this regard to the Plenary. A representative from each SCC attends the

PIC to ensure that sector-specific issues are tabled for discussion and debate at the PIC.

All SCCs are accountable to and report to the Plenary through the PIC. The seven SCCs are comprised of government and civil society representatives and are led by various government departments as follows:

- Public Administration (Department of Public Service and Administration)
- Mining (Department of Minerals and Energy)
- Transport (Department of Transport)
- Agriculture (Department of Agriculture and Land Affairs)
- Community Development (The Presidency and the Department of Social Development)
- Education (Department of Education)
- Justice (Department of Justice and Constitutional Development)

Resource Management Committee (RMC)

The RMC is the fundraising arm of SANAC and is accountable to the Plenary. Its primary objectives are as follows:

- Co-ordinating the submission of the national proposal for grant funding from the Global Fund
- Selecting one or more appropriate organisation(s) for Global Fund grants
- Monitoring the implementation of activities under Global Fund approved programmes, including approving major changes in implementation plans
- Evaluating the performance of Global Fund programmes
- Determining other sources for resource mobilisation to support the implementation of the NSP

The Minister of Health is the chairperson of the RMC. Other members of the RMC include two other Ministers selected from the IMC and civil society representatives. The civil society members of the RMC elect the deputy chairperson of the RMC from amongst themselves and one RMC representative from each of the following sectors:

- Business
- Faith-based organisations
- Higher education
- Non-governmental organisations and community-based organisations
- Organisations of people living with HIV
- Women
- Youth

The Secretariat

This is a highly skilled team employed by SANAC through the South African National AIDS Trust (SANAT). The Secretariat is accountable to the Plenary and carries out its administrative, logistical and technical functions directed by the Plenary, the Chairperson and the Deputy Chairperson. The Secretariat facilitates the implementation of the overall SANAC mandate. Its responsibilities include:

- Managing the multi-sectoral response to HIV
- Supporting resource mobilisation and management for the NSP (2012 - 2016)
- Managing DOH allocated funds designated to the Secretariat to fulfil its functions in terms of the multi-sectoral HIV and AIDS response
- Ensuring collection and analysis of periodic activity reports from various sectors
- Ensuring preparation of annual situation analysis and progress reports

- Providing technical support and capacity building to sectors
- Ensuring sectoral and donor coordination
- Supporting the social mobilisation and advocacy activities of the sectors
- Attending all meetings of the Plenary as well as of the PIC and SCCs in a non-voting capacity and serving as secretary of these meetings
- Informing civil society members of their appointment to the various committees in writing
- Keeping committee members informed of any developments that may be of relevance to the various sectors and/or committees of SANAC
- Coordinating all logistics, meetings, travelling and any other arrangements related to the work of the committees and will bear the costs thereof.

The Monitoring and Evaluation (M&E) Unit

The M&E Unit forms part of the Secretariat and carries out its functions in line with the relevant monitoring and evaluation framework documents as adopted by the Plenary from time to time. This unit is a central coordinating body of the NSP and is responsible for:

- Developing monitoring and evaluation guidelines
- Developing reporting guidelines
- Developing terms of reference for mid-term and five-year term reviews
- Capacity building for effective M&E
- Providing technical support to the research, monitoring and surveillance TTT

Provincial AIDS Councils (PACs)

The NSP makes provision for Provincial AIDS Councils (PACs) and recommends that their structure and membership be similar to SANAC, although the exact composition and size of a Provincial AIDS Council (PAC) can be determined by provincial realities. PACs act as advisory structures to the Executive committee of the Provincial Legislature and are also expected to provide province specific information and recommendations to SANAC. A PAC is responsible for developing a provincial AIDS plan in line with the national strategic plan, and in response to direction received from District and Local AIDS Councils.

The **overall purpose of Provincial AIDS Councils** derived from their mandate, is to ensure greater co-operation, coordination and monitoring of interventions between government, civil society, the private sector and development partners.

The **objectives of Provincial AIDS Councils** are as follows:

- To act as an advisory structure to the executive committee of the provincial legislature on all policies related to HIV, STIs and TB
- To advocate for the effective involvement of sectors and organisations in the implementation of programmes and strategies
- To oversee the development of, and advocate for the Provincial operational plans in line with the NSP
- To provide support and oversight to District AIDS Councils
- To oversee the mobilisation of resources for HIV, STI and TB programmes
- To monitor the implementation of the provincial plans, identify gaps and support the development of strategies to address these gaps

- To collect regular reports on progress towards meeting the objectives of the NSP and to submit these to SANAC
- Assess progress towards achieving the NSP objectives and targets, as well as identify achievements, new opportunities and lessons learned across sectors and implementation levels (national, provincial and district).

The NSP (2007-2011) recommends that the structure of SANAC be replicated at provincial and District (DOH, 2006). However, provinces are advised to consider their unique local context in deciding on the structure of their PACs. As is the case with the mandate and objectives, PACs have mainly adopted the structure of SANAC and have mirrored this at provincial level. At a political level, the PACs have replaced Ministers with Members of the Executive Councils (MECs) of Provincial Government in the same or similar portfolios to those of national Cabinet. The following is an composition of the Eastern Cape Provincial AIDS Council (ECAC) as an example of how PACs are generally constituted:

- Government Representatives
  - The Premier, who is the champion of ECAC
  - Members of the Executive Council of Provincial Government
  - Chairperson of the Standing Committee on Health
  - Other representatives from the Legislature
  - Heads of Department of the Social Needs Cluster Departments
  - Representative from the Provincial HIV and AIDS Directorate
  - Office of the Status of Women, Legislature Women Caucus
  - Representatives from District AIDS Councils
- Representatives From Civil Society Sectors (Business, Organised Labour, NGOs (Eastern Cape NGO coalition) Traditional Leaders, Traditional Healers, Youth, Faith based organisations, Legal and Human rights, People Living with HIV, Media, Disabled People of South Africa Academic sector

Most PACs have adopted the 3-tier structure of SANAC and have a plenary or "Council" as it is commonly referred to, working committees and sub-committees. The Working committees in most provinces have mirrored those of SANAC, namely the Programme Implementation; Sector Coordination; Monitoring and Evaluation and Resource Mobilisation and Management committees. The roles and responsibilities of the different structures and sub-structures are also in line with those of the structures of SANAC.

Strengths of PACs

The strength of PACs mainly lies in the fact that they have increased the acceptance of the multisectoral approach to managing HIV. Where PACs are present and functioning well, like in the Eastern Cape example referred to above, the responses of the provinces to the epidemic has been strengthened by the resultant better co-ordination, political commitment and better planning. The Provincial Strategic Planning process for the development of the Provincial Operational Plans facilitated through the PACs, result in more adequate understanding of the province-specific characteristics; nature; extent as well as socio-cultural determinants of HIV and AIDS. This has allowed the provinces to develop more appropriate plans which are more evidence-based and thus more relevant than previous ways of planning. With adequate planning, programmes are more likely to be costed and funded appropriately. The process involved in the development of the NSP 2012-2016, which allowed for more participation of provinces and the incorporation of provincial priorities into the NSP, facilitated the incorporation of issues identified at province level into the NSP. This will facilitate the development of policies and programmes at a national level informed by the realities at community level. A further strength of functional PACs is that, where the

PAC is functioning well, the likelihood of DACs and LACs also functioning well is increased as a result of the support and oversight provided by the PACs. The ECAC is once again a good example of this.

Challenges of PACs

While there are shining examples like ECAC, PACs in the majority of provinces are far from ideal. Some of the common challenges of PACs include, among others, the following:

- Lack of political commitment and support
- Inadequate resources (financial and human) for the PAC
- Lack of a dedicated Secretariat with clear Job Descriptions
- Lack of requisite skills in those overseeing the PAC's processes
- Challenges between the Office of the Premier and the Department of Health regarding who is responsible for the PAC
- Lack of induction for members of the PAC and the resultant lack of role clarity
- Lack of capacity building for members to enable them to carry out their envisaged roles and responsibilities

The relationship between PACs and SANAC

There is currently no legal basis for the relationship between PACs and SANAC. PACs are also not represented on SANAC. However, PACs are important structures for the implementation of the country's HIV, STI and TB plan and programme. The existing relationship is based on the previous NSP (2007-2011) and its recommendation for SANAC structures to be replicated at provincial and local levels. The relationship is also based on the responsibility for provinces to coordinate the response to HIV, STIs and TB at provincial level as outlined in the current NSP. PACs are, in terms of the NSP (2012-2016), the Implementation agents for the country's response and relate to SANAC through:

- Establishing the multi-sectoral coordination of the HIV, STI and TB programmes for SANAC's objectives to be met
- Ensuring the implementation of the NSP through incorporating it into Provincial Operational Plans
- Establishing and supporting DACs, LACs and WACs
- M&E to ensure that SANAC targets are met
- Reporting to SANAC on achievement of targets, challenges etc
- Contributing towards the development of the NSP through the review of Provincial Operational Plans that inform the development of the NSP, as well as through sending representatives to participate in the development of the NSP.

District AIDS Councils (DACs)

Each District Municipality is expected to have its own AIDS Council. A DAC is an intermediary structure, responsible for providing the link between the Provincial AIDS Council and Local AIDS Councils (LACs). DACs are the highest decision-making structure for District Municipalities. In line with the recommendations in the NSP, most DACs are district-level versions of SANAC and PACs that are expected to advise District Municipalities on HIV, STI and TB matters. DACs also co-ordinate, monitor and support the activities of the LACs. DACs are composed of District Municipal Councillors, officials from various district-level departments and representatives of LACs. Non-governmental organisations that operate in the district also participate. In a nutshell, the structure of the District AIDS Council resembles that of the Provincial AIDS Council.

Local AIDS Councils Shaping Local Governments' response to HIV, STIs and TB

The mandate / objectives of DACs

The DACs are responsible for carrying out the roles of the SANAC and the PACs at District Municipality level and have as such adopted the roles and responsibilities of these. Generally, the objectives of DACs include:

- To act as an advisory structure to the executive committee of the District Mayoral Executive Council on all matters related to HIV, STIs and TB
- To advocate for the effective involvement of sectors and organisations in the implementation of district programmes and strategies
- To oversee the development of, and advocate for the District operational plans in line with the PSP
- To provide support and oversight to Local AIDS Councils
- To oversee the district-level mobilisation of resources for HIV, STI and TB programmes
- To monitor the implementation of the provincial plans, identify gaps and support the development of strategies to address these gaps
- To collect regular reports on progress towards meeting the objectives of the Provincial Operational Plans (POP) and to submit these to the PAC
- Assess progress towards achieving the POP objectives and targets, as well as identify achievements, new opportunities and lessons learned across sectors.

In accordance with NSP recommendations, the structure of most DACs is modelled from that of SANAC and PACs. DACs are thus District-level versions of PACs and their composition and structure, together with the roles of the different sub-structures are similar to those of SANAC and PACs, with slight variations in line with the local context and realities.

Strengths of DACs

DACs bring the multi-sectoral collaboration in the management of HIV, STIs and TB closer to communities. Where DACS are present and functioning well, there are opportunities to identify and manage local realities like the drivers of the epidemic as well as its impact on families and communities. The District planning processes, including the inclusion of the LACs in the development of the Integrated Development Plans (IDPs), allow for more adequate understanding of the district-specific characteristics; nature; extent as well as socio-cultural determinants of the HIV and TB epidemics. This allows the Districts to develop more appropriate plans, and also to mobilise sufficient resources (human, financial and material) for the District HIV, STI and TB programme. Where the PAC is functioning well, the likelihood of LACs also functioning well is increased as a result of the support and oversight provided by the DACs.

Challenges of DACs

The challenges faced by DACs are similar to those of PACs and mainly included:

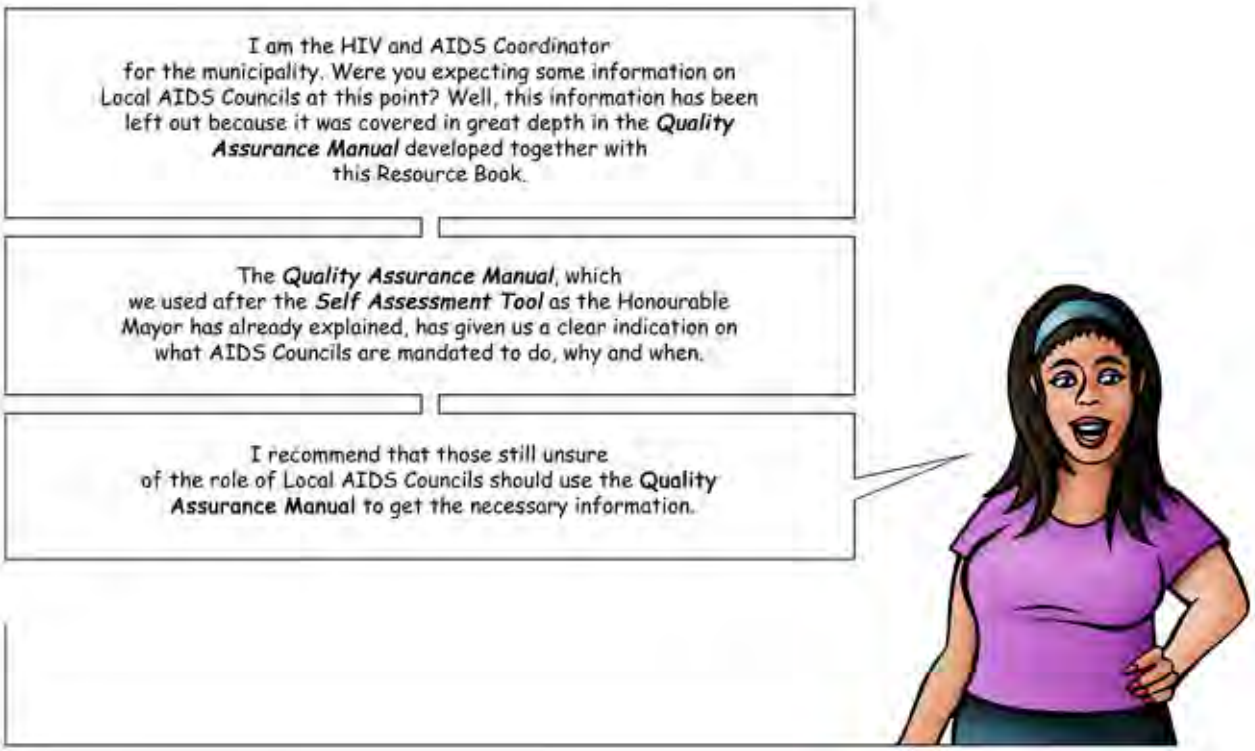
- Lack of political commitment and support
- Lack of support from PACs
- Inadequate resources (financial and human) for the DAC
- Lack of a dedicated Secretariat with clear Job Descriptions
- Lack of requisite skills in those overseeing the DAC's processes
- Lack of induction for members of the DAC and the resultant lack of role clarity
- Lack of capacity building for members to enable them to carry out their envisaged roles and responsibilities.

The relationship between DACs and PACs

As is the case with SANAC and PACs, there is currently no legal basis for the relationship between DACs and PACs. The PACs can thus legally not enforce the compliance of DACs with PAC guidelines and recommendations. However, DACs are important structures for the implementation of the country's HIV, STI and TB plan and programme.

The existing relationship is based on the NSP and its recommendation for SANAC structures to be replicated at provincial and local levels as well as on the responsibility for provinces to coordinate the response to HIV, STI and TB at provincial level outlined in the NSP. DACs are represented on most PACs. They are local implementation agents for the country's response and relate to PACs through:

- Ensuring the implementation of the POP (Provincial Operational Plan) through M&E to ensure that POP targets are met
- Reporting to the PAC on achievement of targets, challenges etc.
- Contributing towards the development of the POP
- Participating in the development of the POP.



Basic Facts of HIV, AIDS, STIs and TB

Introduction[1]

HIV and TB are global epidemics that touch all of us. They can make us feel overwhelmed and frightened and sometimes we may be unsure of how best to respond. What we know is that the greatest opportunity for addressing them rest at the local level and in the communities. In this section background information on HIV, STIs and TB are described (see **2.1**) with special focus on stigma and discrimination (see **2.2**) and the socio-cultural factors and concepts which are important drivers of the global and South African HIV epidemic (see **2.3**). Background information on joint HIV and TB programmes can be found in **section 2.4**.

2.1 Background information on HIV (basic facts, prevention and control)

The South African government is currently implementing a country-wide programme for the prevention of mother-to-child transmission (PMTCT) of HIV. Through this programme, all pregnant women receiving care at public hospitals are requested to test for HIV and if they are found to be positive, they are enrolled on the PMTCT programme which has been proven scientifically to reduce the risk of babies acquiring HIV infection during childbirth and through risky feeding practices. The country also runs a blood transfusion service which is amongst the safest in the world due to the thorough process of screening blood donors and donated blood.

Occupational exposure to HIV from potentially infected blood is managed through the administration of antiretroviral drugs for a short period to reduce the likelihood of becoming positive from such exposure. This is called Post-exposure Prophylaxis (PEP). PEP is administered in the same manner for survivors of rape. It is important to note that a person's HIV status must be confirmed to be negative before PEP can be administered, hence the precondition that an HIV test be done before PEP can be administered to any person.

The HIV epidemic in South Africa is almost entirely driven by unsafe sexual practices. This includes having multiple sexual partners, not using condoms correctly and consistently as well as rape. To reduce the rate of new HIV infections significantly, the following ways of preventing sexual transmission of HIV are to be emphasised at all times:

- Abstinence - deciding not to have any sexual contact. This decision can be made both before one has started being sexually active or afterwards.
- Faithfulness - having one sexual partner. However, faithfulness only works in a couple with both partners being negative and faithful. It is thus important for both partners to be tested for HIV and to be faithful.
- Condoms - the correct and consistent use of condoms during sexual intercourse. Condoms are only as safe as they are used. It is important to ensure that condoms are used correctly and consistently (every time and with every partner). Incorrect condom use is the main cause of problems experienced with

[1] Sources of section 2:
- HIV&AIDS Strategic Plan for South Africa 2007-2011
- National Strategic Plan on HIV, STIs and TB (2012-2016)
- UNAIDS 2010: Factsheet South Africa
- Government of Tanzania (MoH): Training Manuals for HIV and AIDS Committees, 2006
- Rispawood-Mafoya et al: Social Determinants of HIV/AIDS in the Eastern Cape 2009

condoms. Condom demonstrations must thus accompany condom distribution.

- Promoting human rights and access to justice. This includes promotion of gender equality, campaigning against stigma and discrimination, eliminating rape and all forms of gender-based violence and protecting victims of gender-based violence.

What is HIV?

HIV is the short form for "Human Immunodeficiency Virus" It is the name of the virus that destroys the body's immune system (the human defense mechanism that fights diseases). So, HIV infection occurs when a person contracts the virus (HIV) in his / her body. He/she has not yet developed the disease. This person looks healthy but is highly infectious and capable of transmitting the virus to other people.

What is AIDS?

"AIDS" is the short form for Acquired Immune Deficiency Syndrome". This is the collection of diseases resulting from the HIV infection that destroys the body's immune system. At this stage, a person with AIDS has signs and symptoms of AIDS-related diseases.

The relationship between HIV and STIs

Research has shown that contracting sexually transmitted infections increase the risk for HIV infection by more than 50%. The relationship between STIs and HIV infection is that, in most cases STIs infected persons present with genital ulcers or sores, The ulcers are breaks in the skin and become easy entry points for HIV infection if one practices unprotected sexual intercourse with an infected partner. The probability of getting infected becomes much higher. Research has also proven that people who have HIV and STIs have a higher concentration of HIV in their genital fluids than those without STIs. The higher concentration of HIV makes people with STIs and HIV more infectious in cases of unprotected sex than those with HIV and no STIs. These are the reason why those infected with a STI must be properly treated as strategy for preventing HIV infection.

The relationship between HIV and TB

HIV and tuberculosis (TB) are so closely associated that their relationship is often described as a co-epidemic. In the last 15 years, the number of new TB cases has more than doubled in countries where the number of HIV infections is also high. Together, HIV and TB are a deadly combination, each disease making the other disease progress faster. HIV makes the immune system weak, so that someone who is HIV-positive and also infected with TB becomes much more likely to get sick with TB than someone infected with TB who is HIV-negative.

2.2 Background information on stigma and discrimination associated with HIV

The country has come a long way in addressing stigma and discrimination against people living with HIV. The legal and policy frameworks and discrimination still exists. This results in for these have been put in place, coupled with information and awareness campaigns. However, at community and household level, stigma and discrimination still exists. This results in people not wanting to know their status for fear of the potentially negative implications thereof. Some people living with HIV are also still keeping their status to themselves and sometimes even indulging in unsafe sex for fear of the stigma and discrimination they might experience should they disclose their status to their sexual partners and communities.

Definition of stigma

Stigma can be defined as act of identifying, labelling or attributing undesirable qualities targeted towards those who are perceived as being shamefully different and deviant from the social norm. Understanding stigma therefore requires the recognition that it is about a significantly discrediting attribute assigned to people infected by the HIV and TB. It involves treating them as not deserving respect or as less worthy than others

Discrimination refers to some action based on stigma and directed towards people infected or affected by HIV and TB.

Causes of stigma and discrimination

- Misinformation about HIV transmission and
- Religious teaching and influences to sexuality and birth control
- Cultural norms of silence regarding sexual practice preferences and desires
- Fearful pictures or words from mass media (television, radio, magazines)

Effects of stigma and discrimination

Continued marginalisation and denial of one's rights and services

- Further spread of HIV and TB
- Hiding of people living with HIV and TB
- Clients missed opportunities for care provision and change behaviour
- Sometimes people may not be considered for promotion or further study.
- Violence leading to burn out
- Isolation and segregation
- Continued marginalisation and denial of one's rights and services.

2.3 Background information on socio-cultural factors and concepts

The differences in the rates of HIV infection among countries and within countries require that the reasons for these differences be established in order to ensure that the strategies that are put in place are appropriate for the contexts within which they will be implemented. Socio-economic inequalities and lack of respect for human rights are important drivers of the global HIV epidemic and there are general patterns across the world that identify certain individuals, groups and situations as carrying a high-risk of HIV transmission[2]. The reasons why people continue to be exposed to these need to be explored fully. These high-risk groups include, among others, poor people; women and girls in subordinated positions due to gender inequality; migrant workers; truck drivers; people who use drugs through injections; people with many sex partners at the same time; marginalised population groups such as sexual and gender minorities, people with disabilities, sex worker, etc. However, there are individuals and groups that fall within these high risk groups whose personal risks of becoming infected remain relatively low. For an example, not all migrant workers have multiple sexual partners - where they work as well as where they come from. The reasons why some indulge in high risk sexual practices while others do not still need to be explored fully.

Within communities themselves, the rates of infection sometimes differ significantly from one section of the community to the other (e.g. at Ward level). The reasons for these variations also need to be explored to help identify groups or individuals more at risk of becoming infected with HIV, why they are at that level of risk and what needs to be put in place to reduce the level of risk. It must be stressed that, while identifying individuals and groups with increased risk of infection is important; all caution must be taken for this not to result in stigma and discrimination against affected individuals and groups.

The manner in which we live our lives influences our knowledge on the epidemic, our attitude and behaviours. The common characteristics in the way we live our lives and the reasons we live that way are collectively referred to as socio-cultural factors. These are the factors that, to a large extent, determine our risk of becoming infected with HIV because they shape our perceptions, attitudes and behaviour in relation to HIV, STIs and TB. Tool **4.2** of the **Resource Book** provides a template to collect information about HIV, STIs and TB at a local level so as to conduct an adequate analysis of the rate of infection as well as the actual socio-cultural factors that influence this rate within the community. The common socio-cultural factors that have been proven to generally determine the risk of HIV in individuals and groups include the following:

Religious and cultural practices

Religious and cultural practices can reduce or increase the risk of becoming infected. An example of a protective practice promoted in most religious and cultural groups is the prohibition of pre-marital sex. This promotes abstinence and faithfulness. Male circumcision is another religious and cultural practice currently receiving significant credit for reducing the risk of HIV transmission. On the other hand, some cultural methods used in circumcision are believed to be exposing men to the risk of HIV infection. The taboo attached to discussing sex and other relevant information in some cultures is also said to be fuelling the epidemic because children will then rely on the most often wrong

[2] Phaswana-Mafuya et al describe in their document the following social determinants which influence the HIV epidemic: religious and cultural practices, level of education, employment status and income, alcohol and drug use and also the family unit
(Social Determinants of HIV/AIDS in the Eastern Cape 2009)

information they get from their peers and will be more susceptible to negative peer pressure.

Gender inequalities

Women's social, economic and political subordination, which is deeply entrenched in socio-cultural and legal norms, adds to women's greater biological susceptibility to HIV infection and renders them particularly vulnerable to infection and less likely to access treatment and care once infected. The situation is even worse for young women and girls, whose risk of infection stands 2 - 4,5 times as high as that of their male peers[3]. The alarming rates of infection among women of this age group can be explained, among other factors, by their low social status and corresponding lack of negotiating power in relation to sex, and a health and education system which fails to meet their particular sexual and reproductive health related needs. In addition, young women, in contrast to young men, more commonly have partners who are much older than themselves and, thus, more likely to be infected. Gender-based violence, including sexual violence, is another important risk factor which applies women of all ages and social backgrounds.

Levels of education, employment status and income

The level of education influences the level of understanding of HIV, STIs and TB related knowledge and in general, influences the lifestyles people adopt. The level of education generally also influences whether a person will have a job or not, the level of income, the neighbourhood a person lives in and the lifestyle choices available to that person. Poor people, to a large extent, still live in under-serviced communities with limited access to basic services like education, health, recreational facilities, etc. This in turn limits their access to HIV, STIs and TB-related information and services, resulting in a significantly increased risk of contracting HIV or not living healthily and accessing medical care if already infected. While high levels of education, employment and income have always been thought to be protective, there is emerging evidence and anecdotal reports that this might, in some instances, increase the risk for individuals and for the community. An example of how high levels of education and the resultant improved lifestyle can be a risk factor for HIV is a situation in which a man is one of a very few individuals with disposable cash in the community and ends up using this to exploit young women sexually. The money gives the man power to decide whether he will practice safe sex or not with his multiple sexual partners.

Alcohol and drug use

Alcohol and drugs reduce a person's normal inhibitions. While high on drugs or drunk, people tend to do unsafe things they would never consider doing when they are sober, including indulging in unsafe sexual practices. There is a vast body of evidence confirming that gang-rape, date rape, incest and other sexual crimes are closely linked to the use or abuse of alcohol and drugs.

The family unit

The family is, for children, the first point of contact with the world. The family shapes a child's perceptions, attitudes and behaviours from a very early stage in life. Growing up in a family where the sense of wrong and right or good

[3] UNAIDS 2010

and bad is instilled early in life, empowers individuals to make well-considered choices about how they live their lives, including the choice to practice behaviour that is free from the risk of becoming HIV infected. Where the family unit is not ideal, like in child-headed households, households where parents are always away from home and families where no boundaries are set for acceptable and unacceptable behaviour, children make their own decisions, which might increase their risk of becoming infected with HIV and other STIs. Migrant labour also interferes with the family unit and has been proven to be a risk factor for the spread of HIV and TB.

Sexual minorities

Sexual minority groups, especially men who have sex with men (MSM), face high rates of HIV prevalence. They lack the protection of their basic human rights and access to HIV services that would help reduce HIV infections. In South Africa, like in many other countries, sexuality is a taboo subject and same sex relations are still socially disapproved even though they are legally permitted. As a result, health workers are still likely to discriminate against same sex partners (gay and lesbians), and police may still harass them. Consequently, same sex partners (gay and lesbians) may conceal their sexual behaviours and medical symptoms from health care providers and STIs will go undiagnosed and untreated. Such difficulties are worse for men and women living with HIV, who must overcome the joint stigma of HIV infection and that of same-sex relationships.

Gender-based violence

Among the major leading causes of HIV infection is gender-based violence, which is a grave form of human rights violation and a major cause of increased vulnerability among women and young girls to HIV infection.The link between women's economic disempowerment and their vulnerability to HIV and AIDS in southern Africa is made worse by perceptions and attitudes towards women and girls. The situation is further complicated by continued perpetuation of harmful traditional practices and change in social norms as described below. There is an urgent need to address human rights in reducing women and girl's vulnerability to HIV infection. Unfortunately, deeply held negative community perceptions and attitudes towards women and girls in southern Africa continue to increase human rights violations, thereby perpetuating their vulnerability to HIV infections.

Masculine ideologies

Traditional masculinity ideologies often encourage men to be sexually assertive and always be ready to have sex, to view sex primarily as pleasurable and recreational, to control all aspects of sexual activity, and to have multiple sex partners. These dominant ideologies typically place women and men at risk of contracting HIV through reinforcing gender inequalities. Challenging these masculinities is increasingly seen as a precondition for tackling HIV. The media is a central space in which these ideologies of masculinity are produced and reproduced[4].

Disability

Too often, individuals with disability have not been included in HIV prevention and outreach efforts because it is assumed that they are not

[4] Gibbs and Jonsson: Masculinities in the South African Media, University of KwaZulu-Natal, 2008

sexually active and thus at little or no risk for HIV infection. The Global Survey on Disability and HIV/AIDS[5] has proven this assumption wrong. Individuals with disability have equal or greater exposure to all known risk factors for HIV infection. For example, adolescents and adults with disability are as likely as their peers with no disability to be sexually active. Homosexuality and bisexuality appear to occur at the same rate among individuals with disability as among those without disability. Individuals with disability are as likely as those without disability to use drugs and alcohol. Men and women with disabilities are even more likely to be victims of violence or rape, although they are less likely to be able to obtain police intervention, legal protection or prophylactic care.

A further challenge for individuals with disability is that the methods and mediums used to communicate important HIV, STI and TB information do not always reach them adequately. For an example, provision is not always made for blind and deaf individuals to also be reached with important messages on how to prevent or live with HIV, STIs and TB. The health and social development services are also not equipped to communicate effectively with people who are blind, deaf or having speech problems. As a result, people with disabilities do not have the necessary information and can thus not always benefit from the prevention, treatment, care and support programmes available to the rest of the community.

Socio-cultural norms

Socio-cultural norms and values provide the foundation upon which unequal power relations between men and women, rich and poor, dominant and marginalized groups are constructed. Enshrined in social institutions, such as the family, religious groups, the education of the justice system, they shape individual behaviour and determine access to resources and decision making power. Where individuals do not conform to dominant norms, as in the case with gender norms of sexual minorities or sex workers, they could be punished by social stigma, violence and at times legal sanctions. Given the social control such norms exert over individual behaviour, including sexual and health seeking behaviour, any attempt to prevents the spread of HIV and enhance access to available treatment and care services must recognize and address harmful socio-cultural norms.

2.4 Background information for joint HIV and TB programmes

The global HIV epidemic is fuelling an extraordinary increase in tuberculosis cases, and in the number of patients co-infected with both diseases. The management of TB / HIV co-infected patients is often fragmented, with little coordination of care between TB and HIV treatment programmes in many areas and at many levels. Care is further hampered by limitations of current TB diagnostic methods, limited access to and underutilization of HIV counselling and testing services, and a paucity of data regarding optimal regimens and timing of initiation of antiretroviral therapy[6].

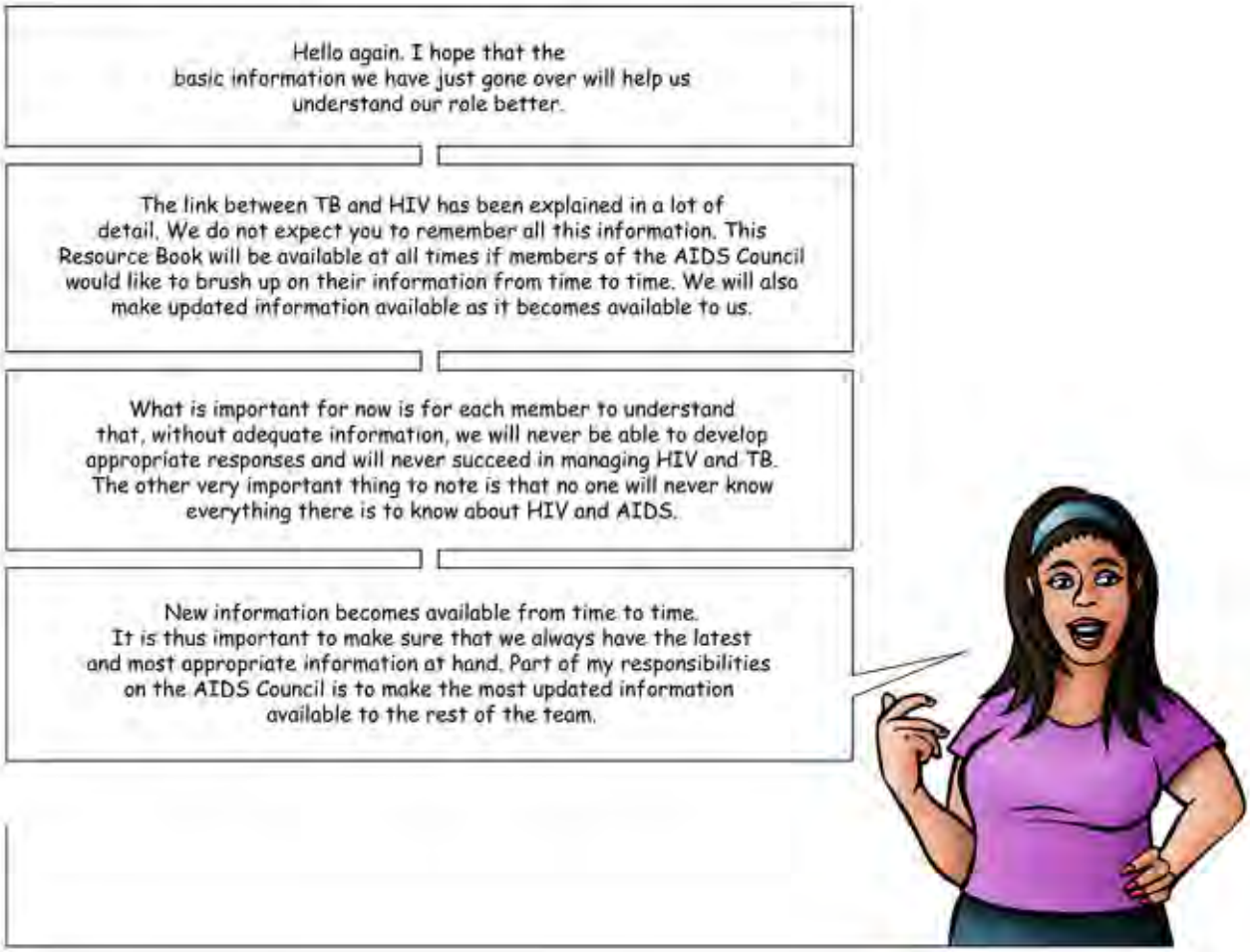
The NSP 2012 – 2016 advocates for integrated HIV, STI and TB programmes. There are vari-

[5] World Bank, The Global Survey on Disability and HIV/AIDS, 2004
[6] Tsaurus, Gandhi et al (2006)

ous challenges which need to be overcome such as the history of independent structures and functions of established national TB programmes and newly implemented HIV programmes that hinder coordinated prevention and care of TB and HIV programmes.

On the other side there are also "good practice" examples which could guide practitioners who work in the area of HIV and TB. One example is the anti-TB immunization programme for children. People, who are immunized, do not develop TB even though they are constantly exposed to it. As TB can influence the progress of HIV related infections enormously it is furthermore medically advisable for people with HIV to also test for TB and those with TB to also test for HIV. It also turned out that TB can be cured even in HIV positive people. HIV positive people who do not have TB yet can be given medication (Isoniazid) to reduce their likelihood of developing TB as a result of their immune systems being wakened by HIV. This is called TB prophylaxis.

The substantial morbidity and mortality among TB / HIV co-infected people necessitates a renewed focus developing new models of collaboration and integration between TB and HIV programmes and services. This should include the focus on operational research to identify practical diagnostic tools and treatment strategies.



Cooperation

Introduction

Cooperation or involving others is an important key to successfully functioning multi-sectoral AIDS Councils. However, involving others is a costly process and it takes time. In order to avoid wasting scarce resources, it has to be handled in a professional manner.

The information and tools offered in this section provide some guidance to do this. Cooperation within the framework of AIDS Councils means involving the public (communities, stakeholders) and it also means involving other spheres of government, involving specialists and consultants. It also means:

- Involving relevant people in an effective manner (see **3.1**).
- Effectively selecting the right people or groups for specific tasks (see **3.2**).
- Encouraging the team building process (**3.3**), giving them clear direction, and making sure that they fulfill their task (see **3.5** and **3.6**)
- Shaping partnerships and promote the dialogue between different sectors (see **3.4**)
- Assessing partners in order to get more information on their capacity (see **3.5**).

3.1 Tools to encourage advocacy and mobilize various sectors such as governmental departments, the private sector and civil society organisations

Overview Adapted from: DPLG: IDP Guide Pack (2006)

Purpose

To make strategic choices regarding the involvement of stakeholders in AIDS Council issues.

When to use

The forms of participation described below include:

A) *Inviting stakeholder representatives*: Members of various governmental departments can be requested to become a member of the AIDS Council or to support the AIDS Council;

B) *Interviewing persons*: Individuals (representative of a specific group) are selected in a strategic manner and face-to-face discussions are conducted

A) Inviting representatives of communities and interest groups

Description

This is a valuable approach where communities and stakeholders are well organized and already sensitized concerning HIV, STIs and TB and have capable representatives with sufficient time and interest to be involved.

Process

Conduct a meeting with key persons of the various stakeholders, discuss and clarify

- What is the purpose of the meeting?
- What are task, roles and responsibilities of AIDS Councils and its members?
- Who should be involved (AIDS Council / initiative)?
- Who should be selected to become a member of the AIDS Council or participate in the initiative?

B) Interviews with individuals

Description

This option allows selecting specific persons to become a member of the AIDS Council or support specific initiatives of the AIDS Council. These persons can be people with specific expertise and knowledge regarding an issue, or it can be affected persons regarding a particular issue.

Process

- **Step 1: Identify possible resource persons** (interviewees). This could possibly include
  - Community leaders
  - Traditional leaders
  - Government officials from relevant departments
  - Committee members of community based organizations
  - Officials from non-governmental organizations
  - Representatives from private sector organizations
  - Representatives from political organizations
  - Advocates for minorities and or disadvantaged groups
  - The selection should be gender-sensitive.
- **Step Two:** Compile a **framework of information requirements (data about the respondent)**.This could be in the format of an interview schedule, or less structured - merely a listing of information requirements. The data about the respondent vary depending on WHO is being interviewed.
  - If a representative of an organization / the private sector is being interviewed, information about the constituency / the company that he / she represents is important.
  - In case of a resource person the area of expertise should be clear.
  - For all interviewees it is important to address their interests and sensitivity on HIV, STIs and TB related issues.
- **Step Three:** Analysis of information. A summary of the analysed information would be required.

C) Conducting public meetings or workshops

Description

This option involves direct contact with a particular group of people through meetings or workshops in order to obtain information and require cooperation for specific initiatives. This will require careful selection of a facilitator who will be able to manage possibly large groups.

This option allows first hand experiences and mobilization, but it can be time consuming and costly.

Process

- Selecting a facilitator (options include: external consultant, capable person in the municipality)
- Ensuring expected outcomes are achieved (using terms or reference for the facilitator / workshop or meeting checklists / approving workshop or meetings procedures)
- Documentation (Indicate responsibility / discuss the format, length and user-friendliness of report or minutes / be clear about what needs to be documented)

3.2 Process of selecting representatives for the AIDS Council

Overview

Adapted from: DPLG: IDP Guide Pack (2006)

Purpose

The checklist of questions will assist in the formation and management of established task teams. The Terms of Reference will give guidance regarding the minimum content required for effectively managing tasks and responsibilities.

When to use

Suitable for selecting new AIDS Council members or replace non-functional representatives. Also suitable for establishing task teams.

A) Establishing AIDS Councils or Task Teams

Description

The checklist consists of critical questions that should be answered prior to the team formation.

Process

Issues to consider

- Is the task clearly stipulated with expected outcomes, time frames and cost considerations prior to team selection?
- What is the relationship of the AIDS Council team with the Task Team?

- Are the requirements regarding knowledge / skills and experiences defined?
- Is there sufficient diversity e.g. gender sensitivity?
- What is the lifespan of the required team?
- What is expected of AIDS Council / Task Team members and what should they know:
  - Work related outputs (Terms of References)
  - Team roles and responsibilities including team leadership
  - Powers and authority
- Are there mechanisms to deal with conflicts that affect the functioning of the team?

B) Drafting Terms of Reference (TOR)

Description

The Terms of Reference is a management tool that ensures that parties involved in particular relationship is clear about what is expected from one another (e.g. AIDS Council members). The tool describes various categories of information that should be dealt with in a TOR namely:

Terms of Reference

Item	Content Guidelines
Background	The task should be placed into context: What created the need for the task?
Purpose	The phrasing of the purpose shall ensure an orientation towards the overall objective of the task.
Outputs	Specify what has to be done to achieve the objectives Include the main list of activities and expected deliverables
Time frames	Specify time to be spent on each component or activity of the work
Required qualification	Include information regarding requirements of the person (level of education / professional experiences)

3.3 Challenges of team building

Overview Adapted from: Government of Tanzania (MoH): Training Manuals for HIV/AIDS Committees at Local Government Authorities in Tanzania: Participatory Management (2006)

Purpose

AIDS Council members identify challenges and opportunities of working together in order to promote their team building process.

When to use

Suitable after the induction of newly appointed AIDS Council members.

Description

The accomplishment of the role as member of the AIDS Council depends very much on how the AIDS Council will be able to work as a team. However, building a team is an evolutionary process that requires commitment of all members involved. What is the difference between a team and a random group of people? How does a leader or a diverse group of people agree on a common goal? How will the team members sustain team commitment and enthusiasm over time? Is there more to being a team than sharing a goal? To get some of the ans-wers, this topic will cover various areas such as the meaning of the term "team", concepts of team formation and qualities of successful teams.

Defining "Team"

The AIDS Council members form a team. A team is a group of people who share a common goal and are committed to working together to achieve it. While a group, is just a collection of individuals with no common goal.

Qualities of effective teams

A team needs the following to come into power and function:

- Common vision and mission on the future of the project / intervention
- Good leadership, with clear roles and responsibilities
- Power within the group to make decisions
- Common goals to which they feel committed
- Clear strategies to attain the goals
- Transparent distribution of the tasks
- Clear idea of the available resources
- Strong team spirit and constructive conflict resolution
- Respect for differences, strengths, weaknesses and mutual trust
- Open communication
- Transparent rules for collaboration
- Attention to process and content
- Knowledge and skills to fulfill the tasks

Challenges of working together

- Some individual objectives may conflict with AIDS Councils roles and responsibilities
- Lack of constructive conflict resolution skills
- Difference in perception, experience, opinion, belief and background

How to proceed

Steps in building a successful team

- Create a team identity
- Develop a team's common vision. This is a statement of what the AIDS Council hope to accomplish in the future to anticipate and fulfill their mandate. It will be a common picture that all AIDS Council members will have in their line of sight.
- Setting team goals. These are specific with measurable standards of performance for the activities to which the AIDS Councils will commit themselves, activities with key milestones will be developed to achieve the goals.
- The team agreeing on operating principles so as to reduce conflict and facilitate group processes. These will cover meetings, handling conflicts, celebration (areas of success), reporting, supervision and performance standards.
- Setting a monitoring plan of how the team will conduct self-evaluation, i.e. on a regular basis the Council will need to look back to the indicators they set for themselves so that they can reflect on their achievements.

3.4 Tool to strengthen partnerships and support the sector dialogue

Overview Adapted from: GIZ: Capacity WORKS, 2009

Purpose

This tool explores the issue of how we initiate and manage successful partnerships.

When to use

Can be used for evaluation purposes in critical situations within a partnership, or for continuous monitoring.

Stetting - Maximum of 25 participants

Facilities and materials - Circle of chairs, pin boards, possibility for working in smaller groups, pin boards, workshop materials

Note - High degree of openness for clear statements are required

Description

Strengthening the AIDS Council as a team and shaping partnerships with the various sectors in the municipality is a broad field. Human beings are social creatures, and as such are constantly connecting and splitting up, both amicably and non-amicably. Having carefully studied the psychological transfer mechanisms, power relations, intrigues, relations of economic exchange, and the institutional and legal aspects involved, experts have concluded that the field is almost inexhaustible. Nonetheless, an attempt will now be made to outline a few fundamental aspects

of successful partnerships within the framework AIDS Councils are active.

As a matter of general principle it should be ensured that the regulation and structuring of partnerships does not hinder the process of cooperation. A minimum of regulation should be applied, so that the cooperation can function and develop as flexibly as possible.

As various partners co-operate the need for coordination and harmonisation increases. The required measures can then help facilitate and optimise the process of cooperation, and improve mutual learning. A partnership has a structure, which we can imagine as a river bed. It develops as a process, which we can imagine as a river that flows relatively fast along the river bed. The participants are carried along by the river. The same moment never occurs twice. The shared journey and the shared experiences are part of the process. Here, it is appropriate to apply the following principles:

A) Create common structures

Gradually establish a coordination platform

In most cases joint coordination is necessary to guarantee cooperation between different partners that goes beyond the exchange best to place this task – with one of the partners or with an independent organisational unit - will certainly depend on the heterogeneity and the number of relationships involved. A coordination platform will simplify cooperation between the partners, and raise their performance. At the same time it will be a source of questions and problems. It generates costs, and can lead to information imbalances and poor transparency.

Agree on binding terms of engagement

Partnerships with explicit terms of engagement tend to be more successful. This starts with the periodicity of meetings and the setting of agendas. This can begin with a simple agreement comprising a joint declaration of intent, which as the partnerships progresses then leads to a list of guidelines on the purpose and coordination of the partnership. The partnership thus gains an institutional framework that provides orientation for the cooperating partners, and that can be reviewed periodically.

Formulate shared objectives as milestones

Some partnerships and alliances define ingenious objectives right from the start. Normally this is not advisable, as the objectives only become more realistic once they are formulated through the process of cooperation. It is helpful to agree on a strategic orientation, and to identify a few milestones pointing in this direction.

Define rules for conflict management

Conflicts are an everyday part of partnerships. They can begin with misunderstandings or coordination gaps, and gradually escalate. It makes sense that these mechanisms, tensions and conflicts can be addressed early on while they are still at a low level of escalation.

B) Manage processes: create trust and build bridges

Identify and understand different interests and expectations

Partnerships always consist of two or more partners with different interests and expectations. All the participating actors have their own reasons for entering into cooperation. The cooperation is based essentially on the different nature of these interests, and on recognition of the fact that joint objectives can only be achieved when these interests are managed and reconciled. Identifying and understanding these interests is key to building a viable partnership.

Create mutual trust

Trust arises when actors communicate and convey transparent information on their own interests and intentions. Mistrust and prejudice

vis-à-vis partners in cooperation are the result of information asymmetries among the participants. The participating parties must be able to rely on each other. Building trust begins with a mutual positive disposition, and with the assumption that each partner is bringing something valuable to the relationship. It is therefore appropriate to make resources available for face-to-face trust-building right at the outset.

Make lessons learned and success stories visible

Partnerships grow in strength when the participants periodically evaluate their experiences and make their success stories visible. Self-steering capacities are the key resource to strengthen partnerships.

How to proceed

➔ **Step 1:** Assess the shaping of successful partnerships

In a first step, the shaping of successful partnerships is assessed using the table below.

Shaping of successful partnerships

A joint coordination platform is established	○ absolutely	○ partially	○ Not at all
Binding terms of engagement are defined	○ absolutely	○ partially	○ Not at all
Joint milestones are defined	○ absolutely	○ partially	○ Not at all
Conflict management rules are formulated	○ absolutely	○ partially	○ Not at all
Different interests and expectations are taken into account	○ absolutely	○ partially	○ Not at all
Mutual trust - including activities are taking place or are planned	○ absolutely	○ partially	○ Not at all
Periodic evaluation of experiences and joint success stories are made visible	○ absolutely	○ partially	○ Not at all

➡ **Step 2:** Assess the features of successful partnerships

In a second step, the features of successful partnerships are assessed.

Features of successful partnerships

Individuality All cooperation partners contribute something that is of value to the others, but remain autonomous.	☐ absolutely	☐ partially	☐ Not at all
Significance of cooperation The cooperation relationship is important to the participating actors.	☐ absolutely	☐ partially	☐ Not at all
Interdependencies The cooperation partners complement and need each other; none can achieve alone what all can achieve.	☐ absolutely	☐ partially	☐ Not at all
Investment The participating partners mobilize the resources available to them, and in so doing demonstrate their interest in partnership.	☐ absolutely	☐ partially	☐ Not at all
Communication The cooperating partners keep each other informed and avail themselves of opportunities for exchange. Tensions and conflicts are addressed early on.	☐ absolutely	☐ partially	☐ Not at all
Integration The cooperating partners offset imbalances of information and participation.	☐ absolutely	☐ partially	☐ Not at all
Learning Periodic evaluation of experiences and joint success stories are made visible.	☐ absolutely	☐ partially	☐ Not at all
Institutionalisation The cooperation relationship is cemented through a minimum of agreed, useful rules.	☐ absolutely	☐ partially	☐ Not at all
Integrity The cooperating partners behave with openly, keep each other informed, and deepen mutual trust.	☐ absolutely	☐ partially	☐ Not at all

➡ **Step 3:** Define Measures

In a final step, the assessments are discussed and first thoughts on appropriate measures are noted down in the table below.

Shaping of successful partnerships

	Measures to develop partnerships
A joint coordination platform is established	
Binding terms of engagement are defined	
Joint milestones are defined	
Conflict management rules are formulated	
Different interests and expectations are taken into account	
Mutual trust - including activities are taking place or are planned	
Periodic evaluation of experiences and joint success stories are made visible	

3.5 Tool to analyse the institutional capacity

Overview Adapted from DPLG: IDP Guide Pack 2006

Purpose

To get a quick overview on the service provision capacities of the municipality and of other service providers who have got service providing units or facilities within the relevant area.

When to use

Well suited to identify the capacity (see below) of relevant institutions.

Stetting - Small group of two to 10 participants (AIDS Council members or task force)

Facilities and materials - Document handout

Note - The format of the overview sheet below has to be flexibly adjusted to the type of institution and to the available information. In each case the personal and financial capacity, the tasks and the related service providing capacity should be indicated.

Description

Assessing the capacity of key stakeholders AIDS Councils are planning to cooperate or monitor is a key to successful partnerships and initiatives. Sector and dimension specific analysis tools provide the relevant variables to get a quick overview on the situation in this specific field.

How to proceed

The relevant institutions provide facets and figures which are suitable to indicate their service providing capacity (such as number of staff, budget and indicators for delivery capacity).

Institutions	Number of staff		Major Tasks		Annual Budget		Limitations
	Total	Profess-ional	Type	Related Capacity	Opera-tional	Capital	
A							
Private service providers within municipality area							

B District service units within local munici-palities							
C Corporate service providers within municipality area							
D Private service providers within municipality area							
E Non-governmental service units (also faith-based)							

3.6 Induction of AIDS Council members (Developed by the Eastern Cape AIDS Council)

Overview

Purpose

All AIDS Council's are required to conduct induction sessions for council members in order to introduce roles and responsibilities of the AIDS Council. Induction is the first step of a process by which new members learn about the Council and become part of it.

When to use

After the selection of new members for the AIDS Council.

Stetting - All members of the AIDS Council and representatives of key stakeholder

Facilities and materials - Workshop facilities

Description

Induction is the first step in building a two-way relationship between the AIDS Council and a sector representative serving on the Council. It is the process by which a new member learns about the AIDS Council, and becomes part of it. A good induction programme gives the necessary information, resources and motivation to assist a new member to adjust quickly to their role in advising government about HIV, STIs and TB matters. It also shows the AIDS Council's commitment to its new members.

The induction process is meant to inform the new members of the AIDS Council about relevant policies and practices in the field of managing and mitigating the impact of the HIV and TB epidemics. New members are advised on what is expected of them as individuals representing various sectors, and what to expect from other fellow Council members. In a nutshell the Induction is designed to give AIDS Council members a clear understanding of:

- The AIDS Council's organisational structure, its mandate and its functions
- The legal framework in which the AIDS Council operates and where to find information on policies, that pertain to managing HIV and AIDS
- The role of local and provincial government in managing HIV and AIDS, STIs and TB
- Their responsibilities towards the sectors they represent
- The training and development they can expect to do their job
- The part they will be expected to play in executing the AIDS Council Mandate
- The meeting procedures: attendance, quorum, proxies and the other logistics of attending AIDS Council meetings
- Reporting requirements and mechanisms
- The relationships between the AIDS Councils and the National body SANAC

Step 1: Preparing for the Induction

Preparing for the induction is just as important as the induction itself. Poor preparation will result in even the most structured induction session to achieve limited success. The following is a check-list to ensure that the process of preparing for the induction is adequate:

Pre-Induction Stage

AIDS Council forms prepared for submission to the Chairperson/Municipal Manager
Member profiles received 2 weeks before the induction (See template below)
Special needs (Disability): reasonable physical adjustments / aids in place (where appropriate)
Letter from sector represented appointing representative on to the Council
Confirmation letters from participants are received with member profiles
Equipment and any resources/documentation to be used for induction
Suitable space for the event (venue)
Prepare an Induction programme Tailor made to the nature and variety of the group to suit the needs of every individual

Preparation for the induction must start with compiling a list of all new AIDS Council members to be inducted. A simple form as indicated below, with relevant information can be used to collect such information:

Member Name & Surname			
Sector Represented			
Contact Details	Physical		
	Telephone	Fax	E-Mail
Highest academic qualification			
Area of expertise in HIV& AIDS			
Other skills possessed			
Signatures	Council Member		Date
	Council		Date

➡ Step 2: The Induction Event

For the induction to happen in a structured and beneficial manner, a well-considered programme is required. All the people appearing on the programme must be well-prepared for their roles. It is important that the programme be adhered to by all means to ensure that sufficient time is available for the items on the programme. The following is a sample programme for an induction session:

Induction Event - Model Programme

09:15 am	Registration and Coffee
09:30 am	Welcome (Usually done by the highest office- PREMIERMEC/ Mayor/ Municipal Manager) and introductions ✗ Aims and Objectives of the Induction Process ✗ The nature of HIV AND AIDS Challenge. This includes the situation analysis of the area concerned (Province, District, Local municipality) and how HIV affects Municipalities in general ✗ Discussion on drivers of HIV and the response of the Government / Municipality ✗ (This is useful to test the understanding of the inductees on issues pertaining to HIV and AIDS, STI and TB in their areas)
09:50 am	Overview of the AIDS Council ✗ The council's structure, mandate and functions, (National to Local) and links of the spheres ✗ Discussion on state of affairs per sphere of government (Province, District, Local) and analysis of what is missing and what is desirable according specifics of spheres
10:50 am	Roles of sectors ✗ Practical Exercise (Case study) ✗ Discussion of current practices + challenges. How to strengthen the existing state of affairs
11:50 am	Efficient use of resources- Multi-sectoral planning ✗ Intra sectoral communication (within offices) ✗ Report coordination (across sectors)

13:00 am	Lunch Break
14:00 am	Technical Task teams * Terms of reference * Composition * Meetings
14:45 am	Running council meetings * SCHEDULE * Quorum * Council agenda * Minutes * Apologies * Proxies * Attendance * Reporting
15:45 am	Mainstreaming HIV and AIDS
16:30 am	Way forward and closure

Steering

Introduction

Steering means coordinating and managing complex and comprehensive tasks and processes such as AIDS Councils are facing. In this section background information on what steering means is described in the context of the framework of AIDS Councils (see 3.7). Preparing and conducting effective workshops and meetings (see 3.10, 3.11 and 3.12) are tools which support the governance process. The **Self-Assessment Tool**, which is described in section 3.8, can be used as a monitoring tool to measure the impact of the work of AIDS Councils, and new processes, structures or standards can be developed by using tools as described in **section 3.9**.

3.7 Background information

Steering towards a goal: The work of AIDS Councils is based on the National Strategic Plan and its defined goals. The practical way to achieve these is not, however, a straight line drawn on a drawing board. We must find the path to the goal. Steering is the method used to find this path together with stakeholders and partners. Work in the field of HIV, STIs and TB is complex, with individuals each with their own cultural, professional and private contexts, their own backgrounds, their perceptions, feelings, individual interests working together.

Steering is a powerful term, especially when we are talking about change processes. It presupposes, interpreted in technocratic terms, that we have something "under control". In the field of HIV, STIs and TB in particular, this is often not the case. We steer interventions within a complex framework highly influenced by social, cultural, political and economical impacts. A dilemma in steering - we must make decisions with as much circumspection as possible, even though we know that tomorrow the decision will prove to have been wrong again, or at least to be in need of revision. Steering is thus an iterative process of observation and self-critical review of the results caused by our decisions. For this reason it is important not to lose sight of the objective and at the same time to find the best possible ways and byways to achieving this objective. Steering should also initiate a review and a modification of the objectives set and the milestones agreed on.

Steering as the result of a process of negotiation: Structured participation in steering is extremely important for two reasons: Firstly, it creates access to information relevant to steering and allows for different perspectives. Secondly it is indispensable in order to foster ownership on the part of participants and to consolidate this. The steering structure of the AIDS Council should meet the following seven requirements:

- **Ownership**: It strengthens ownership and self-reliance of participants at the different working levels. This is achieved primarily through participation and negotiation orientation.
- **Transparency**: It strengthens confidence in the leadership through broad-based communication on decisions and the criteria on which these were based.

- **Efficiency**: It is simple and makes it possible to reach decisions without excessive transaction costs being incurred for consultations, negotiations and coordination.
- **Variety of perspectives**: It takes into account the different perceptions and perspectives of stakeholders. It combines both hard data and reports on individual experiences as well as different interpretations of these data.
- **Conflict sensitivity**: It makes it possible to identify tensions and conflicts at an early stage and to work these through. This is ensured in particular by applying the do-no-harm principle.
- **Flexibility**: It allows for swift decisions, so as to respond to changes in the environment, in the personnel system and in financial resources, as well as to growth and shrinkage.
- **Learning from patterns of action**: It allows actors to take on new roles. It helps them practise new patterns of management action, for instance in communication and decision-making.

3.8 Self-assessment tool: Improving the quality of AIDS Councils

Overview Developed by Dikeledi Tsukulu and Angelika Pochanke-Alff evaplan GmbH at the University of Heidelberg, on behalf of the South African German Multisectoral HIV and AIDS Prevention Programme, GIZ

Purpose

To improve the quality of AIDS Councils by identifying and monitoring capacity gaps of their members and by checking strategic options for the future scope of their work.

When to use

It is a useful tool for self-analysis by members of the AIDS Councils after the new term of office started in order to get baseline information. It can also be used as a monitoring tool to measure the impact of their work. The self-assessment tool can be used by LACs and DACs. In addition it could be used by DACs to monitor the progress of LACs.

Stetting - Can be used in small groups or for individual work. The analysis of the filled questionnaire should be guided by an experienced AIDS coordinator or supported by an external expert

Facilities and materials - Questionnaire and pen, additional blank pages for the answers of open questions (e.g. "please specify")

Note - It requires a high degree of trust and openness

Description

The self-assessment tool is a simple questionnaire, designed to lead the users through a set of questions against which to assess their capacity needs and their specific strategic planning needs or their strategic planning and monitoring strategy. It is intended to be a useful checklist

and evaluation tool for AIDS Councils who are either beginning their strategic work or who wish to assess whether their strategic plan and work is relevant and responsive to the epidemic in their area.

The questionnaire starts with general questions on gender, profession and educational background which is important to identify tailor made capacity building needs of AIDS Council members. As a next step the users move through four programmatic areas which are also introduced in the **Quality Assurance Manual**:

- Mandate and responsibilities of AIDS Councils
- Basic facts about the epidemic
- Cooperation and steering and also
- Strategic development and learning & innovation as relevant operational issues of AIDS Councils

Within each programmatic area the user is presented with a set of questions. For each question, the user must decide whether to answer one of the provided statements or - in some cases - tick all relevant answers. Some questions require a detailed answer in the own works of the user by inviting him or her: "please specify". When all questions have been answered the questionnaire should be given to the AIDS Coordinator or the person who introduced the questionnaire.

The **Self-Assessment Tool** is not intended as a tool for comparing AIDS Council members with each other. Therefore the questionnaire does not provide the user with one single "score" to evaluate the individual performance or the strategic orientation of the AIDS Council, but instead provides a range of information which needs to be analysed by experienced AIDS Coordinators or experts.

How to proceed

- **Step 1**: Introduce the purpose and content of the questionnaire
- **Step 2**: Conduct the self-assessment
- **Step 3**: Evaluate results and conclusions

To analyse the results it is helpful to design key questions for the two areas such as:

A. Identification of capacity needs related to general and basic information such as:

- Is the mandate of the AIDS Council and their responsibilities well understood?
- Are basic facts of HIV, STI and TB well known?
- Which questions are not answered properly or answered with "I don't know"?
- Has the respondent information to provide details when asked "please specify"?

B. Identification of capacity needs in order to improve the strategic and organizational development:

- Is the Municipal committed and do they support the AIDS Council?
- Is a skilled and full time working AIDS Coordinator available?
- Is a Secretariat provided with clear job descriptions?
- Is the multi-sectoral approach working well?
- Does the Municipality have a strategic plan / M& E framework and a budget for HIV, STI and TB activities?
- Are HIV, STIs and TB acknowledged by the IDP steering committee?
- Is the cooperation with the DAC and / or the PAC functioning?
- Are well working HIV, STI and TB programmes available?

- **Step 4**: Use templates introduced in the Annex (CD-ROM) and after the questionnaire:
  - a basis to link results of the questionnaire with information and tools provided in the **Quality Assurance Manual** and the **Resource Book**;
  - a basis to identify capacity needs on various levels;
  - a basis for the follow-up, monitoring and evaluation of changes initiated based on self-assessment results.
- **Step 5**: Periodically repeat the self-assessment

To monitor changes, it is helpful to repeat the analysis periodically and fill results in the attached excel templates "Data Management Tool to identify Capacity Needs"

3.9 Designing initiatives for change process management

Overview Adapted from GIZ: Capacity WORKS (2006)

Purpose

This tool supports the management of change processes by breaking these processes down into smaller change initiatives and implementing a coordination structure.

When to use

Used to develop new processes, structures or standards, etc. or to change existing ones.

Stetting - Total of up to 10 – 25 participants (e.g. sub-committees of AIDS Council)

Facilities and materials - Since this tool involves a longer-term process, facilities and materials will need to be prepared on ad hoc basis

Note - It requires clear objectives and commitment by the management. Change management is a highly complex task, and the inputs of time, money and methodology required should not be underestimated

Description

Change processes promote the search for new forms of effective performance and cooperation. Managing these processes therefore constitutes a particular challenge in the steering of complex projects and programmes. It is not only processes, structures and rules that are changed; quite often, values and goals of the actors involved are also at stake.

Wherever new processes, structures or rules are created, or existing ones changed, this constitutes a deep intervention into the established routines of the actors involved. Consequently, when managing change processes it is advisa-

advisable to adopt a creative but circumspect approach that takes into account these established routines, as well as the relevant contexts and settings.

Change processes are planned, designed, experienced, sometimes suffered, and steered by internal and external actors. As this change unfolds some things are thrown overboard, others become unnecessarily complex, and power relations shift.

Change processes are always politically charged, because they affect existing constellations of influence and power. This usually causes feelings of insecurity and resistance among those involved. Where this resistance occurs within the change process, we need to work constructively with it so that it can be address ed.

The sequence of steps shown below represents one possible strategic approach toward the management of such change processes, and offers corresponding pointers along with possible structural elements.

How to proceed

➡ **Step 1**: Break down change processes into small projects

Change processes need to be broken down into small steps or projects so that at the end of each step planning can be adjusted and corrected. For this reason, in successful change processes small change packages are tied up on an ongoing basis: these are termed change projects. For the purposes of our example below, we will assume that three projects need to be defined.

➡ **Step 2**: Define elements of the change projects

Each change project is supervised by a specific task force and wound up within a predetermined time frame.

A change project must include the following elements:

- Action plan: activities and time schedule
- Necessary financial resources
- Information and communication
- Coordination with other change projects
- Necessary internal and external consultancy services
- Necessary personnel resources and technical capabilities
- Change objectives

➡ **Step 3**: Constitute change projects and task forces

On the basis of three change topics, we set up three task forces, each of which should have no more than seven members. The following rules apply to constituting a task force:

- Several hierarchical levels must be represented.
- Members should have different areas of expertise.
- Members should have different functions and experience in relation to the change topic.

The task forces define and name their respective change projects. The following checklist can be used to help plan the change projects:

Check list: Special features of change projects

- limited term (maximum of one year)
- specific and visible results
- limited number of participants

- flexibility to expand the project at short notice or to abandon it if it proves unsuccessful
- under the aegis of a task force whose members come from various organisations
- abilities and capacities needed to implement the project are available
- clear definition and allocation of tasks and commitments
- managed and supported by a specially trained coordinator
- implemented on the basis of an action plan that defines the activities and resources required
- participatory planning and implementation approaches that include specific actors, each with their own different preferences in relation to the change topic.

Step 4: Form a change network and a coordination unit

From the three task forces, we form an internal change network which deals with the change projects on a fulltime or part-time basis. In order to coordinate activities within the change network, a coordinator is appointed for each of the three task forces. The three coordinators of the change projects set up a coordination unit and are then responsible for coordination within the change network as well as being the contact point for external relations of the network.

Step 5: Consult with the management on a continuous basis

The coordination unit should hold regular meetings with the steering structure in order to

- coordinate the various task forces and inform about progress in the change process assess and evaluate results
- clear up any doubts or uncertainties
- negotiate the continuation or discontinuation of a change project upon its completion.

3.10 Designing initiatives for change process management

Overview Adapted from DPLG: IDP Guide Pack (2006)

Purpose

To provide systematic guidance in the preparation of meetings and workshops and thereby preventing poorly organized events and waste of time.

When to use

Meetings and workshops will be required at regular intervals. Careful preparation and planning are the critical success factors to all gatherings whether it involves an existing institutional structure, for example the AIDS Council, or new groups of people being brought together.

Stetting - Small or large groups

Facilities and materials - Workshop materials as described below

Description

Although aspects of the preparation will be delegated (for example the delegation of catering or logistical arrangements to administrative personnel) the person responsible for the meeting need to stay in charge of every aspect of the preparation. AIDS Councils have to consider the legal obligation (*Systems Act Ch. 4*) to ensure that vulnerable groups, for example the disabled are considered and accommodated in all efforts. The tool provides a step by step approach of the critical issues that should be attended to.

Meetings and workshops are used interchangeably in the process, as both types of gathering require similar preparation. Less effort might be required in cases of well institutionalized meetings.

How to proceed

➧ **Step 1**: Clarify the purpose of the meeting / workshop

Every gathering should have a clearly stated outcome at the outset of the preparation, as it will influence many of the other steps.

➧ **Step 2**: Decision on the type and number of participants

A meeting or workshop can easily be a waste of time when the relevant people are not present or when the "wrong" people are present. Therefore careful consideration should be given to who should attend as well as how and when these relevant people should be invited. The purpose of the meeting will determine who should be there. Timely invitations are important and in some cases a follow-up will be required. It will be useful in the preparation to know who will be able to attend. The following questions should be answered:

- Who should be invited? This could refer to particular persons or organizations. Depending on the nature of the meeting. It is useful to clarify who in an organization (referring to expertise as well as decision-making powers) should attend.
- What would be the best method of informing / inviting the relevant persons? This could refer to public notice, using e-mail, telephonic or written invitations. If you would like a response from delegates you need to indicate this on the invitation. This is normally necessary if catering arrangements have to be made.
- Who would be responsible to make the invitations and do the necessary follow-up?
- By when should invitations be made? This will only be possible once the time and venue has been decided (**steps 3** and **4**)
- How would you ensure delegates come prepared to the meeting? This could include ensuring that the agenda or programme is made available or including reading material with invitations.

➧ **Step 3**: Agree on the timing of the meeting.

Organisers should consider:

- When would be the most convenient time for people to attend in terms of date and day as well as time of day?
- What would be the most viable duration for the meeting / workshop?

➧ **Step 4**: Agree on a suitable venue.

Consider the following:

- How many people should be accommodated?
- Is the location accessible to all participants?
- Will there be any special requirements for example access for disabled persons?
- Will break-away rooms be available, if needed?

- Will the necessary infrastructure be available, for example electricity, internet access, water, sanitation facilities?
- Do you need to include directions / maps to the venue?
- Can the furniture be arranged in a manner that you require?
- What costs will be involved?

➡ **Step 5**: Preparing the programme

In a meeting situation this will refer to the agenda. The programme is directly linked to the time available and the topic of the meeting. Most people have busy schedules and meetings should therefore not be too long, but sufficient time needs to be allocated to ensure the outcomes will be achieved. A time schedule will be useful.

➡ **Step 6**: Preparing visualization

Visualization is used to complement oral communication by visual means Communication theories show us that the reception of information occurs mainly (83%) by eye, compared to 11% by ear. Gatherings can therefore be much more successful if messages are also conveyed visually. This preparation requires you to consider your programme and decide:

- What information will be useful to visualize prior to the meeting? This could include the agenda; a presentation that you intend to do or formats that will be useful during the collection and discussion of ideas.
- What will be the most appropriate format? For example on flipcharts, via PowerPoint or handouts?
- By when should it be ready?
- Who will be responsible?

➡ **Step 7**: Preparing the logistical arrangements

Any gathering requires basic logistical arrangements which should be viewed in context with the venue available. This could be managed by using a checklist. The table below illustrates some considerations.

Checklist for Logistical Arrangements

Area	Considerations
Equipment / material	What equipment will be required during the meeting / workshop? - Projector for PowerPoint presentations - Flipchart - Stationery (pens, nametags, paper etc.) - Whiteboard - Laptop - Printer - Recording equipment - How should the attendance register be structured to ensure you have record of all relevant information of participants?
Administrative support	- Would any registration be required? - How will the proceedings be recorded and documented?
Refreshment / catering	- Tea / coffee (including times) - Any other catering

➡ **Step 8**: Clarify roles and responsibilities.

It should be clear beforehand who will be responsible for what during the meeting or workshop.

Resource persons might also be involved in terms of providing specific inputs. Such inputs should be specified in terms of approach and time.

Other roles might include timekeeping, recording and visualization during discussions.

The documentation of the workshop proceedings and results should be agreed upon in a clear manner. This includes: Who will be responsible? What will be documented? How will it be disseminated?

➡ **Step 9**: Anticipate possible conflicts or difficulties that might occur during the meeting.

If you are able to anticipate them you will also be able to consider possible strategies or approaches to deal with difficulties. This might include preparing additional information. Although you would not be able to preempt everything, preparing for the unforeseen is always advisable.

3.11 General workshop procedures

Overview Adapted from DPLG: IDP Guide Pack 2006

Purpose

Provide general guidelines for facilitators in order to plan workshops.

When to use

All kind of workshops (planning, brainstorming, distribution of information, gaining knowledge etc.)

Stetting - Best would be to have not more than 25 participants per facilitator

Facilities and materials - Workshop materials

Description

In order for a workshop to achieve an intended outcome the facilitator has to design an appropriate procedure that will create:

- Development of common understanding - examination of specialized issues.
- Deal with differing opinions.
- Generate opinions / contributions / proposals
- Reach meaningful conclusions.

The tables on the following pages use different phases in a workshop to describe the various elements and considerations that will assist the facilitator in the design of procedures. The process and sequencing within the phases (especially **phase 2**) will have to be adjusted according to the purpose of the workshop.

PHASES AND ELEMENTS OF WORKSHOPS

Phase 1 Opening

Elements	Considerations
Welcome and introductions	Deciding how participants will introduce themselves • Circulating attendance register • Clarify any logistical issues for example where the toilet facilities are • located • State purpose of the meeting
Setting the climate	Use of "Icebreakers" to create a more relaxed atmosphere Setting group norms to regulate behaviour for example agreeing on how to deal with cellphones / conflicts + differences / participation
Procedural suggestions	The agenda or programme should be discussed to ensure that all participants know what to expect from the meeting. This includes: • Expected outcomes • Time frames and time management i.e. punctuality • Topics to be covered • Activities / group participation The group should be allowed to comment and concerns and suggestions should be noted and dealt with. This could either mean making alterations to the programme or referring unrelated issues to the appropriate forum.

Phase 2	Getting down to Business

Elements	Considerations
Presenting the topic	The facilitator introduces the topic that will be discussed.This could involve: ⁎ Making a short presentation regarding the topic ⁎ Defining the task - what is expected from the participants ⁎ Visualization of the topic
Collecting ideas	1. Statements are elicited from participants. The facilitator has options as to how statements will be collected. It could be: ⁎ Random, oral contributions ⁎ Systematic process of moving from one person to the next ⁎ Written on flipcharts ⁎ Small groups can discuss the matter and provide their views. 2. By limiting the number of inputs per person or group, the amount of contributions can be regulated if so required. 3. All statements should be visualized. Even if you as facilitator do not agree with it. 4. The facilitator provides an overview on the contributions by reading them aloud. Unclear statements should be clarified and revised where necessary. **Note:** Allow people sufficient time to think before starting to collect ideas. Avoid evaluating ideas during the collection phase as this will side-track the discussions and hinder further contributions. Ensure all participants are contributing. Do not allow dominace by a few.
Structuring ideas	Statements are categorized and structured jointly by the participants and the facilitator. It is useful if the facilitator has some meaningful categories in mind to discuss and agree with the participants. This could include: ⁎ Clustering of similar ideas ⁎ Creating themes ⁎ Grouping statements This is the most challenging part of a workshop and the facilitator can easily become lost in a large number of contributions.

Evaluation ideas	The structured contributions can now be discussed and evaluated to determine their usefulness and relevance. It is useful to: ✗ Deal with opinions and misconceptions ✗ Ensure that reality is reflected adequately ✗ Check for any missing pieces of information ✗ Establish consensus and deal with differences in opinion ✗ Reach a basic agreement regarding the body of knowledge The facilitator should consider and prepare for this evaluation.

Phase 3	Closure

Elements	Considerations
Summarize	All insights and decisions should be summarized and visualized to ensure common understanding and agreement. Clarify any differences by referring to discussions and agreements Do not open new topics for debate.
Way forward	Agree on what happens after the workshop. This could include: ✗ How the results of the workshop will be used ✗ Tasks that need to be allocated to people including time frames ✗ Agreeing on the documentation and dissemination of the results ✗ Any future follow-up meeting

3.12 Conducting effective meetings

Overview Just About Everything a Manager needs to know in South Africa, Flanegan & Finger (2009)

Purpose

Meetings that are chaired successfully will make participants feel a sense of accomplishment and their motivation to remain involved will increase.

When to use

Meetings will be required at regular intervals.

Stetting - Small groups and large groups

Facilities and materials - Flipchart, workshop materials

Guidelines

1. Always **start on time**. By waiting for late comers you penalize people that are punctual.

2. The **opening of the meeting** will determine the atmosphere. Be business-like and to the point. This might involve:

   - Doing instructions
   - Clarifying the purpose
   - Ensuring roles and responsibilities are clear
   - Ensure consensus regarding ground rules for example the use of mobile phones

3. **Clarify the agenda**

   Participants should be allowed to comment and make suggestions regarding the agenda.

   Once all participants agree, move on.

4. **Maintain the focus of the meeting**

   - Continuously check whether discussions are still in line with the purpose. Remind people of the objective.
   - Introduce each new topic on the agenda - creating the context for the discussion.
   - Allow people to give inputs.
   - Avoid dominance. Of one or two people hog the floor institute a "one minute" rule which allow each participant only one minute to state their position.
   - Or list the names of all possible contributors prior to opening the floor and follow the order of names. At the end of each issue summarise and move on.

5. **Ensure the decision-making procedure** is clear. Each decision and related comments should be carefully documented.

6. End the meeting on a positive note. Summarise major points including achievements in terms of decisions. **END ON TIME**

7. Make sure **documentation** is done promptly and as agreed. This should be distributed to ensure any tasks allocated during the meeting are known to all participants.


I think that these meeting procedures will help us a lot! Looking back at how we used to conduct our meetings in the past, I now understand why our meetings were not always very effective.

Strategy Development

Introduction

Strategies are used to develop visions and are base for operational planning. In this section background information on the value of strategic planning (4.1), how to conduct strategic and operational planning (4.4) based on situation analysis (4.3), organisational analysis (4.2) or proposal assessment with focus on gender-responsiveness (4.5) are provided. Furthermore strategies on how to mobilize financial and human resources (4.5 and 3.1 / 3.2) are introduced.

4.1 Background information

AIDS Councils like other organisations develop various strategies to fulfil their tasks. One can identify three characteristics of a strategy:

- the taking into account of the actions of other actors and the dynamics of the environment
- the clear distinction between the strategic and the operational levels, and
- the long-term nature of strategic action.

Strategic orientation creates scope for action. An organisation such as the AIDS Council which is heading for efficiency and effectiveness to generate desired benefits must deliver the following:

- **Orientation**: Where are we going?
- **Coordination**: How do we agree on how to go about things?
- **Creation of meaning**: Why are we working together, what binds us to each other?

AIDS Councils should design a strategy that allows actors to orient all their efforts and activities toward those aspects and objectives that are crucial to success. To put it more simply, we need to be able to know whether we are "doing the right things".

Success will, however, depend not only on skilful strategic orientation but also on the degree of coherence and harmonisation of all activities. This will require a large number of mutually harmonised coordination mechanisms. We need to be able to know whether "we are doing properly" what we have chosen to do. This coordination function, which is based on a viable strategy, is performed by the agreements and rules governing structures and processes. However, it is also performed spontaneously by the AIDS Council members themselves, once they have understood the strategy and their own roles have been sufficiently clearly defined.

To enable the members of the AIDS Council to act and respond in individual cases on the basis of a holistic logic, i.e. a logic that goes beyond the aspects of strategic orientation and coordination, the AIDS Council needs a shared horizon of meaning, a culture of cooperation. This horizon of meaning answers the question of why we do something. It can for instance be created by a common vision arrived at through a participatory process within the AIDS Council A shared horizon of meaning performs various

key tasks for cooperation and success.

It is not possible to regulate clearly and conclusively every detail by issuing strategic directives and implementation regulations. Nor would that be desirable, because in a dynamic and volatile setting such as the AIDS Council this would mean the immediate paralysis and failure of planned initiatives. People are capable of self-organisation and self-coordination; they utilise the scope for action created by the strategic orientation for creative problem-solving. They utilise the space for interpretation, and in so doing act holistically. The strategic orientation therefore promotes the self-responsibility of the members of AIDS Councils. The horizon of meaning also performs a supportive function. It provides a sense of security, and enables them to make appropriate sense of ambiguous or even contradictory events, and to reach an understanding of and withstand dissonances. Finally, a shared horizon of meaning helps motivate and inspire AIDS Council members to perform the joint task. Seen against this background, it becomes clear that the strategic orientation is the basic structural element that creates scope for action, strengthens self-responsibility and frees up the creativity of AIDS Councils.

4.2 Situation analysis and assessment

Overview Adapted from DPLG: IDP Guide Book, 2006

Purpose

To assist responsible person/s in defining the information requirements prior to embarking on an information search or an in-depth analysis.

When to use

It is useful once priority issues have been identified (e.g. see main objectives of the Provincial or District Strategic Plan) and a more comprehensive and accurate body of knowledge is required for further decision making (e.g. development of IEC campaigns). It will be useful to develop strategies.

Stetting - AIDS Council members or task force

Facilities and materials - Flipchart, workshop materials

Description

A matrix will be designed which should be able to identify:

- The issue that requires information. This can be done by identifying elements of the issue that will be useful to know, for example when considering a problem it is useful to know (1) who does it affect? (2) what causes the problem (3), what are the effects and (4) are there any problem solving potentials that will be useful.
- The existing level of information.
- Possible professional deductions or the formulation of hypotheses based on existing

information.

- Additional information (specific) that is required.
- Reasons why this information is needed.
- Possible methods of collecting the information.

How to proceed

➡ **Step 1**: Identify aspects (**categories of information**) of the issue that you would like to explore.

For example "What areas of information would add value to your understanding in a particular situation?" This will provide some structure to your analysis. In case of an in-depth analysis on priority issues the following categories could be relevant:

- Specification of the problem
- Causes of the problem
- Effects or consequences of the problem
- Problem solving potentials that exist.

➡ **Step 2**: Identify what you already know.

This will include information that you have already collected, but it could also include professional assumptions that you have made based on your information. **Include any sector specific requirements.**

➡ **Step 3**: Clarify what you still need to know (gaps).

It is at this point that analysis runs in danger of becoming comprehensive. It is therefore important to clarify **why** you need the information.

➡ **Step 4**: Agree on the best method of collecting the required information.

For some issues investigations will be necessary while others would require discussions with resource persons, literature reviews or a combination of all the before mentioned. This can either remain with the responsibility of the AIDS Council or it can be outsourced to the relevant experts. In both instances clear guidance have to be given regarding the scope of the investigation using a terms of reference (see 3.2)

Example of a "gap analysis matrix" to identify priority issues

Major questions	What is known	Hypothesis	What do we need to know	Why is the information necessary	What is the best method to obtain information	Who could be responsible
Whom does it affect (gender, location, socio-economic grouping)						
Specification of the issue						

What are the causes						
What are the consequences						
What problem solving potential exist - Description - Quantity - Quality						
Cost implication						
Capacities required						
Economic feasibility						
Contribution to strategy						
Social impact with specific reference to vulnerable groups						

4.3 Tool to analyse strengths and challenges of organizations (SWOT)

Overview Adapted from GIZ: Capacity WORKS (2009)

Purpose

SWOT is an organizational analysis tool which is useful for self-analysis by the members of an organization (e.g. the AIDS Council), and which provides action-related qualitative information on the Strengths, Weaknesses, Opportunities and Threats of an organisation.

When to use

It is useful tool for self-analysis by members of an organization (e.g. the AIDS Council or the Municipal Government).

Stetting - Small group of two to 10 participants (AIDS Council members or task force)

Facilities and materials - Flipchart, workshop materials

Note - It requires a high degree of trust and openness

Description

The members of an organization unit (maybe together with some well-informed external resource persons) jointly undertake a guided process of self-assessment which included the following steps:

1. Identification of the **strengths** of the organization
2. Identification of the **weaknesses** of the organization.
3. Identification of **opportunities** to overcome the weaknesses.
4. Identification of **threats** (or risks) which may prevent the organization from making successful use of the opportunities.

The results of the four steps of analysis can be listed in a **diagram**:

	Positive	Negative
Present Situation	**Strengths:** Dedicated leadership Strong technical capacity Good relationship between council and… Effective use of limited funds …	**Weaknesses:** Decreasing budget No technical capacity for… Lack of coordination Inexperienced participants Members not committed …
Future or External Factors	**Opportunities:** Increase of budget Partnerships with NGOs Partnerships with the private sector …	**Threats:** Private sector is not interested Staff / members may get tired of too many meetings …

4.4 Strategic and operational planning

Overview Adapted from GIZ: CapacityWORKS. Management Model for sustainable Development (2009)

Purpose

This tool helps define and document concrete indicators and measures. It is applied once the strategic objectives of the project have been defined on the basis of the available strategic options.

When to use

In situations where concrete implementation measures are being negotiated on the basis of strategic options.

Stetting - Individual work or small group settings

Facilities and materials - Workshop materials (pin board, markers, flipcharts)

Note - *Requirements*: Calls for a clear understanding of the basic concept and strategy of a project.
Limits of the tool: The tool is designed to document initiatives or a project whose basic strategic orientation has already been defined.

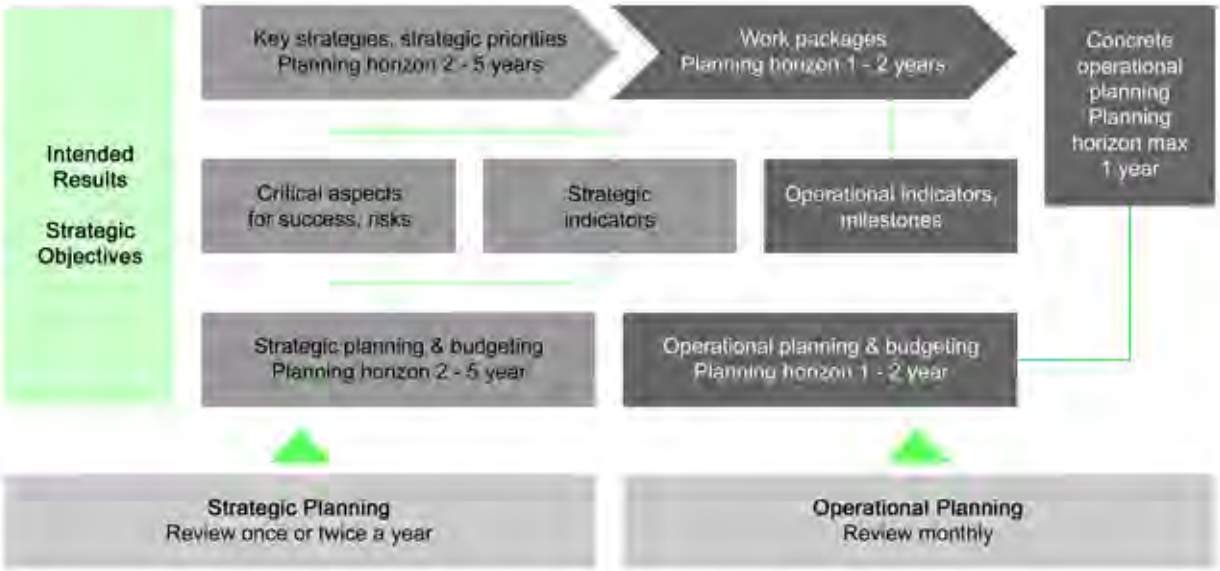
Description

A project overview plan in the sense used here is a harmonised and comprehensive document that identifies all the key options, necessary decisions and activities for implementing a long-term strategy. It forms a basis on which to design the project and serves to document negotiated activities and priorities. A project overview plan visualises and combines several levels in the form of graphics / tables. It should include the following elements:

- intended results of a project
- strategy and strategic objectives
- critical aspects for project success, risks and alternative plans
- indicators to measure the achievement of objectives
- options, milestones and work packages for the achievement of objectives.

To a certain extent the project overview plan translates the strategic objectives of a project or an organisation into measurable indicators of success that are backed with corresponding measures or work packages. How detailed a given planning process will be will depend on the purpose and time-frame of the process in question.

The graphic below shows an example of a planning process:



Model of strategic and operational planning (source: GIZ Capacity Works, 2009)

How to proceed

Drawing up a project overview plan usually involves the step of documenting in a structured form a long-term strategy that has already been discussed and agreed on with the relevant partners. Nevertheless we have outlined below a possible procedure that can be selected where strategic planning is not yet complete.

➡ **Step 1**: Define the vision, mission and strategic objectives

The starting point for any planning process is the intended results of a project and the defined strategic objectives. Where these fundamental dimensions have not been clearly defined, proper planning cannot take place. Questions to be addressed in this context are:

- What results do we expect to achieve through our project?
- Which implicit / explicit mandate have we been given?
- What objectives does that imply and which strategic objectives have already been formulated?

➡ **Step 2**: Outline guiding strategies

The next step is to determine how each individual strategic objective can be achieved. The decisions, options for action and priorities required for this can be recorded in the form of guiding strategies. Question to be addressed when formulating the guiding strategies are:

- How can we achieve the strategic objective?
- Which strategic options for action are available to us in this context?
- Which decisions need to be taken, and under what conditions are which options available?
- How should we set our priorities within the list of strategic objectives?

Objectives and Guiding Strategies

Strategic Objectives	Guiding Strategies, Strategic Options
Objective 1	
Objective 2	
Objective 3	
Etc.	

➡ **Step 3**: Crucial aspects for success

Before proceeding with the next step it is almost always appropriate to pause and first of all consider which will be the crucial aspects when implementing the guiding strategies. The following questions can be helpful in this context:

- Which critical aspects for successful implementation of the guiding strategies can be identified?
- What risks are inherent in the implementation of the guiding strategies / the strategic options?
- What alternative plans would be conceivable should certain risks materialise?

➡ **Step 4**: Identify indicators and define work packages

Once the crucial aspects for success have been identified with sufficient clarity, the next step is to translate the strategic objectives into indicators. These will be used later on to help determine whether the respective strategic objectives have actually been achieved. It is often already appropriate at this level to outline the measures that appear necessary in order to achieve a strategic objective.

Indicators and Work Packages

Strategic Objectives	Indicators	Work Packages
Objective 1		
Objective 2		
Objective 3		
Etc.		

➡ **Step 5**: Operational planning

If the project overview plan is to be made more detailed and needs to include operational planning, then the work packages should be operationalised in detail. Questions to be raised here are:

- How are the rough work packages to be implemented concretely?
- Who will be responsible for implementation?
- What resources are available for the individual work packages?
- When should the relevant milestones have been reached?

A simple version of the operationalisation of work is supported by the table below:

Operationalisation of Work Packages

Work Packages	Tasks and Milestones	Responsible	Resources and Budget
WP 1			
WP 2			
WP 3			
Etc.			

➡ **Step 6**: Document the project overview plan

In a final step the results of steps 1 to 5 should be recorded in a structured document. This can for instance be structured as follows:

Strategic goals

- Targeted results
- Strategic objectives

Strategic planning

- Guiding strategies
- Critical aspects for project success and risks
- Alternative strategies
- Indicators and work packages
- Budgeting

Operational planning

- Work packages and tasks
- Responsible persons and milestones
- Operational budgeting

4.5 Mobilising resources: Writing and Assessing proposals

Overview Adapted from: Government of Tanzania (MoH). Training Manuals for HIV and AIDS Committees at Local Government Authorities (2000)

Purpose

This tool provides basics on proposal writing and furthermore on assessing proposals.

When to use

AIDS Councils might be asked to write a proposal in order to assist their Municipality, or AIDS Councils are asked to assess proposals and decide on the suitability of various proposals which were submitted to them or to the Municipality.

Stetting - Individual work supported by small group work

Facilities and materials - Paper and pen, flip charts and marker pen

Note - The attached proposal assessment form provides the opportunity to assess proposals in general and in particular if they are **gender-oriented**.

Description

Before writing a proposal one should have a problem that needs to be solved in a particular area or locality. A proposal is a plan or an outline of what a project applicant intends to do, how to do it, and the purpose and significance of doing it. A proposal may require the applicant to do research or undertake some interventional activities.

Two types of proposals can be distinguished:

- **Self-generated proposals** whereby one designs a project proposal and submits it to relevant funding agencies for approval and funding respectively.
- **Response proposal**: When proposal is invited from the public or specific groups. Sometimes, the format and Terms of Reference of the project proposal may be given by the client.

How to proceed

➡ **Step 1**: Interpret the Terms of Reference carefully

In all technical proposals the client usually stipulates the Terms of Reference (TOR) to be adhered to by the applicant in developing the proposal. The TORs are the guidelines, which the project applicant is required to follow when writing the proposal so that he or she can achieve the objectives of the project.

➡ **Step 2**: Design the Title

The title of a project proposal usually appears on the cover page. The title is usually a clear heading of the area of interest or a problem to be solved by the project applicant so that appropriate interventions can be instituted. The title should be short, clear and ambiguous.

➡ **Step 3**: Outline the Table of Contents.

The table of contents show all the items indicated in the project proposal and the page numbers on which they appear. It is important that the structure of headings and subheadings is self-explanatory. Give subheadings only if you have a minimum of two different points (e.g. **2.1** and **2.2**)

➡ **Step 4**: The most important part is the Executive Summary.

An executive summary provides a summary of the entire project proposal. It will explain the essential components of the project proposal in brief. The summary includes the problem to be investigated and its justification, project area, strategies, methods to be used and a summary of the major expected outcome of the project. It is often the only part that will be read and it is the last part of the proposal to be written.

➡ **Step 5**: Design Statement of the Problem.

The statement of the problem involves a presentation of known and suspected facts, and an explanation of the existing information, which may have some bearing of the problem. Here the need for the project or the proposed initiative has to be justified.

The problem should describe the following:

- Extent, scope or severity of the problem
- Analysis of the cause of the problem
- Effects of the problem

Furthermore should the statement of the problem refer to a defined geographical area and / or to a well-defined population (beneficiaries).

➡ **Step 6**: Development of Goals and Objectives

Goal: An overall goal describes the long-term changes, which are expected to be achieved as a result of a project. Thus a goal describes the proposed long-range benefits accruing to the target population. For example the goal of a Municipality:

"To reduce the prevalence of HIV, STIs and TB by carrying out prevention, education, litigation, care and support programmes in the Municipality"

Objective: For any goal that you develop, there should be several SMART objectives. The objectives are related to the problem statement and they describe anticipated results that represent for example changes in knowledge, attitudes and or behaviour / practice of the beneficiaries.

SMART objectives are:

S pecific	succinct to avoid differing interpretations
M easurable	to allow for monitoring and evaluation
A chievable	to the problem, goals and strategies
R ealistic	achievable, challenging, and meaningful
T ime bound	with specific time period for achieving them

Step 7: Describe strategies and or methodologies

Strategies are the approaches that will be used in the Implementation of the planned activities so that the desired goal(s) can be achieved. The strategies should clearly indicate the methodology or approaches that will be used. For example the above mentioned Municipality adopted the Multi-sectoral approach of the NSP. Through this approach the Municipality expected to achieve the following in the area of care and support:

- Improved access and quality medical care for PLWH.
- Improved and increased home-based care services for PLWH.
- Improved management of opportunistic infections TB and STIs
- Accessibility to ARVs for PLWH
- Improved orphan care and support in the Municipality

The multi-sectoral planning was the method that had been opted for by the Municipal Council involving different actors and sectors in planning for HIV, AIDS, STI and TB interventions in the Municipality. This involved the AIDS Council, local leaders such as Councillors, village leaders (influential leaders), NGOs, CBOs, and faith-based groups in the participatory planning that was conducted in the Municipality.

Step 8: Design the Implementation Plan

A good proposal should have an implementation plan. The implementation plan indicates the approach and strategies that will be used in the implementation of all the activities of the project. If the implementation of the planned activities will be multi-sectoral, then all sectors that will be involved and their roles should clearly spelt out. The coordinators of the project should be known and their roles should be indicated. All the resources required and their sources should also be identified. For example the above mentioned Municipal Council project proposal for the improvement of HIV, AIDS, STI and TB preventive care, support and impact mitigation programme, indicated that the approach will be multi-sectoral. The proposal was developed through involvement of people from different sectors in the Municipality, namely, education, planning, community development, health, culture and youth development.

Step 9: Design the Monitoring and Evaluation Plan.

Before the implementation of a project starts, monitoring and evaluation mechanisms should be instituted. The essence of monitoring and evaluation is to ensure that the planned activities are implemented properly in accordance with the timeframe, budget and to the quality needed. During the monitoring and evaluation process bottlenecks that impinge on the smooth implementation of the activities can be identified and solutions sought to remove them. The monitoring and evaluation processes should ensure that the purpose and expected outputs of the project are being achieved using the tools that have been developed outputs of the project are being achieved using the tools that have been developed to monitor and evaluate the programme activities.

Step 10: Develop the Timeframe.

The timeframe indicates the duration that it will take to implement the project and each activity. However, each activity planned will also have its own timeframe, that is, the time it will take to implement the planned activities. The timeframe is usually indicated in weeks or months or trimesters.

➡ **Step 11:** Propose the budget and its justification.

A budget proposal is an outline, which shows the amount of money that will be used to implement the various activities of the project. In most cases the planned activities of the project require funds for their implementation. Therefore, the project proposal should contain the breakdown of the budget required to implement each activity. In other words, the proposed budget should be itemised clearly for each activity. In addition to each item of expenditure in the proposed budget being justified, the unit cost of each item should be shown.

Summary

Title of the project proposal and the area where the project will be implemented.

Table of contents which shows all the items indicated in the project proposal and the page numbers on which they appear.

Executive Summary, which explains the essential components of the project proposal in detail.

Terms of Reference (TORs) or statement of the problem depending on the type of the project proposal.

Goals and objectives of the project proposal.

Strategies / methodologies that will be used in executing the project.

Implementation plan, which is simply an action plan for executing the project.

Monitoring and evaluation mechanism of the project in accordance with the implementation plan.

Timeframe indicating the duration of the project.

If the proposal is self-generated then the **dissemination of information** pertaining to the outcome of the implementation process should be included. If it is a response proposal then, the stakeholders should be informed, and they should be part and parcel of the project.

Proposed Budget and its justification. The budget should be itemized for each activity of the project and a justification of the same should be done.

Appendices: This should be the last item of the project proposal, it is normally attached at the end of a project proposal in order to provide extra information about the applicant(s).

Assessment of gender-oriented proposals [7]

The complex interplay between gender and HIV has become more apparent with the availability of better, and more nuanced HIV epidemiological data (see **Section 2**). This has led to calls for better targeted evidence-based strategies which respond to the needs and challenges facing particular population groups. Many governments such as the South African Government[8], international agencies and non-governmental organizations are keenly aware of the need to address gender and the needs of vulnerable populations in HIV programming. Since 2008 both UNAIDS and the Global Fund have released gender equality strategies and frameworks, and parallel strategies to address needs of sexual minorities. The growing number of gender-sensitive HIV programmes reflects this shift in emphasis, as does the greater attention to gender and sexual minorities in national-level strategies and plans. Nevertheless, much more needs to be done in reallocating financial and human resources, and in building the technical and programmatic capacity to scale up and sustain gender-sensitive HIV programmes and services. The following form facilitates the assessment of gender-orientation in proposals.

Proposal Assessment Form

Dimension	Description	Criteria for Evaluation
Gender Analysis		
Evidence of gender analysis	Does the proposal contain a situational analysis or problem description which explicitly addresses gender-specific consequences / impacts of the HIV epidemic?	☐ High ☐ Medium ☐ Low ☐ No
Quality of gender analysis	Does the gender analysis contained in the proposal's situation analysis / problem description provide a well-grounded explanation of gender-related risks and / or impacts of the HIV epidemic?	☐ High ☐ Medium ☐ Low ☐ No
Extent of gender analysis	Does attention to gender appear throughout the proposal?	☐ High ☐ Medium ☐ Low ☐ No
Beneficiaries		
Selection of beneficiaries	Is biological sex and / or gender one of the essential characteristics that defines the direct or indirect beneficiaries of the proposed project?	☐ High ☐ Medium ☐ Low ☐ No
Description of beneficiaries	Does the proposal use specific language to refer to sub-groups of men or women, boys or girls, instead of speaking in collective terms?	☐ High ☐ Medium ☐ Low ☐ No

[7] Adapted from the German BACKUP Initiative – Gesellschaft für internationale Zusammenarbeit (GIZ) in Germany: The German BACKUP Initiative's
[8] Approach to Supporting Gender-Responsive HIV Programming (2010)
DPLG: Gender Policy Framework for Local Government (2009)

Anticipated outcomes for beneficiaries	Does the proposal explain how the project responds to or attempts to transform the gender-specific situations and needs of the identified beneficiary groups?	○ High ○ Medium ○ Low ○ No
Proposed Interventions		
Gender sensitivity of interventions	In line with the gender analysis, do some or all of the proposed interventions address, respond to and/or attempt to transform sex and / or gender-specific risks, vulnerabilities and impacts of the HIV epidemic?	○ High ○ Medium ○ Low ○ No
Selection of interventions	Are the proposed activities and interventions an appropriate response to the gender analysis contained in the proposal?	○ High ○ Medium ○ Low ○ No
Target group participation in interventions	Do the proposed interventions take into account potential gender-based barriers to entry and participation of particular target groups?	○ High ○ Medium ○ Low ○ No
Implementation		
Implementation Plan	Does the proposal show evidence that gender sensitivity has been taken into account in plans for project implementation?	○ High ○ Medium ○ Low ○ No
Project Management & Decision Making	Does the proposal show evidence of gender-sensitive project management?	○ High ○ Medium ○ Low ○ No
Organisation Context	Does the proposal contain information about gender equity issues within the applicant organisation?	○ High ○ Medium ○ Low ○ No
Networking and Collaboration	Does the proposal outline collaborations with (other women's or gender-related groups or organisations?	○ High ○ Medium ○ Low ○ No
Monitoring & Evaluation		
Gender-sensitive indicators	Does the proposal include gender-sensitive indicators for measuring results?	○ High ○ Medium ○ Low ○ No

Selection of beneficiaries	Is biological sex and / or gender one of the essential characteristics that defines the direct or indirect beneficiaries of the proposed project?	○ High ○ Medium ○ Low ○ No

Results (number of scores for each criteria)

Learning and Innovation

Introduction

The National Strategic Plan for HIV, STIs and TB 2012 - 2016 sets out a clear framework for ongoing monitoring and evaluation in order to analyse the performance of implemented activities, to learn from experiences made in the past and to enable innovative strategies for the future. It is the responsibility of AIDS Councils to oversee monitoring and evaluation of projects in Municipalities and to promote a culture of learning and innovation in Municipalities and communities. The information provided in this section outlines the monitoring and evaluation concept, its methods and tools (**4.7**). Other tools, which enable AIDS Councils promoting a culture of learning and innovation, introduce the benefits of knowledge management (**4.10**), report writing (**4.8**) and how to assess the innovative capacity of an organization such as the AIDS Council (**4.9**).

4.6 Introduction to monitoring and evaluation

The following topics will be covered in this introduction to monitoring and evaluation[9]:

- Understand concepts, methods, and tools for intensive and participatory monitoring of HIV prevention and care programmes and initiatives
- Identify ways to overcome barriers to conducting effective programme monitoring

[9] Adapted from: Family Health International: Monitoring HIV and AIDS Programmes (2004)
Other M&E tool which can be recommended: Participatory Monitoring and Evaluation Training of HIV/AIDS Committees at Local Government Authorities Tanzanian Government (MoH) (2006)

- Identify key stakeholders in programme monitoring and evaluation
- Select appropriate indicators for measuring programme outputs and outcomes
- Use appropriate monitoring and evaluation methods and tools

What Is Monitoring and What Is Evaluation?

Monitoring is the routine process of data collection and measurement of progress toward programme objectives.

- Monitoring involves counting what we are doing.
- Monitoring involves routinely looking at the quality of our services.

Evaluation is the use of social research methods to systematically investigate a programme's effectiveness.

- Evaluation requires study design.
- Evaluation sometimes requires a control or comparison group.
- Evaluation involves measurements over time.
- Evaluation involves special studies.

Comprehensive Monitoring and Evaluation Framework

Overview of a Monitoring and Evaluation Framework

- Monitoring and evaluation takes place at multiple stages of programme activities. At each stage we gather different information that comes together to demonstrate how the project has been conducted and what has occurred as a result. It is important to identify at the outset how we will gather the information for each level of evaluation.
- Some of these stages overlap and can, in different situations, represent different levels. For example, outcome-level data on risk behaviours of target groups can be used to evaluate the effectiveness of a programme or set of programmes without associating the changes with any single programme.

Comprehensive Monitoring and Evaluation Framework

➡ Types of Monitoring and Evaluation:

Formative Assessments and Research (concept and design)	**Monitoring** (monitoring inputs,processes, and outputs; assessing service quality)	**Evaluation** (assessing outcome and Impact)	**Cost-Effectiveness Analysis** (including sustainability issues)

➥ Questions Answered by the Different Types of Monitoring and Evaluation:

- Is an intervention needed? - Who needs it? - How should the intervention be carried out?	- To what extent areplanned activitie actually realized? - How well are the services provided?	- What outcomes are observed? - What does it mean? - Does the programme make a difference?	- Should priorities be changed or expanded? - To what extent should resources be reallocated?

1. ***Needs Assessments***

The Needs Assessment should be conducted during the planning (or re-planning) stage of a prevention programme to identify programme needs and resolve issues before a programme is widely implemented. This is the point where flexibility is greatest and programme sponsors have more freedom to make decisions about how to proceed with the implementation.

During a Needs Assessment, the following issues are explored:

a) Identifying the need for interventions

b) Defining realistic goals and objectives for interventions

c) Identifying feasible programme strategies

d) Setting programme targets

The Needs Assessment can be used as an exploratory tool and to help project managers adjust objectives to changing situations. It is also used to identify unacceptable or ineffective intervention approaches, designs, and concepts. Methods of conducting a Formative Needs Assessment could include:

- Reviews of existing information
- Focus group discussions
- Individual in-depth interviews
- Participant observations
- Short surveys with structured questionnaires

The main limitation of a Needs Assessment is its inability to be generalized to other projects.

2. ***Monitoring***

Monitoring is the routine process of data collection and measurement of progress toward programme objectives.

There are **three main domains** of information required in a monitoring system:

1. **Inputs** - Resources going into conducting and carrying out the project or programme. These could include staff, finance, materials, and time.

2. **Process** - Set of activities in which programme resources (human and financial) are used to achieve the results expected from the programme (e.g., number of workshops or number of training sessions).

3. **Outputs** - Immediate results obtained by the programme through the execution of activities (e.g., number of commodities distributed, number of staff trained, number of people reached, or number of people served).

Monitoring addresses the following questions:

- To what extent are planned activities actually realized? Are we making progress toward achieving our objectives?
- What services are provided, to whom, when, how often, for how long, and in what context?
- How well are the services provided?

- What is the quality of the services provided?
- What is the cost per unit service?

Monitoring also assesses the extent to which a programme or project:

- Is undertaken consistently with each design or implementation plan;
- Is directed toward the specified target group.

3. *Evaluation*

Evaluation is the use of social research methods to systematically investigate a programme's effectiveness.

Evaluation is used for the following:

1. To assess the changes in the target group (e.g., changes in risk behaviour)
2. To assess the extent to which objectives have been met. It is the process of determining the effectiveness of a programme or a project.
3. To track the outcomes and impacts of programmes or projects at the larger population level, as opposed to the programme or project level:
   - **Outcomes** - Short-term or intermediate results obtained by the programme through the execution of activities
   - **Impact** - Long-term effects (e.g., changes in health status). This can be through special studies with wide district, regional, or national coverage.

Evaluation addresses the following questions:

- What outcomes are observed?
- What do the outcomes mean?
- Does the programme make a difference?

Evaluations are conducted to find out what has happened as a result of a project or programme or a set of projects and programmes. Conducting evaluations is very challenging for several reasons:

4. *Cost-Effectiveness Analysis*

Cost-effectiveness helps managers and planners make decisions about the use of their budgets and funding. With this information decision-makers can make choices about how to allocate their funds and decide whether or not the funds are being spent appropriately and whether they should be re-allocated.

This entails combining the results of monitoring data and cost data.

Goals, Objectives and M&E Questions

1. *Goals and Objectives*

The core of any M&E system is the goals and objectives of the programme to be monitored and evaluated. If the programme goals and objectives are written in such a way that they can be easily distinguished from one another and measured, the job of the M&E specialist will be much easier. Unfortunately, many times these goals and objectives are not written so that they can be easily monitored or evaluated.

What is the difference between a goal and an objective?

- **Goal** - General statement that describes the hoped-for result of a programme (e.g., reduction of HIV incidence). Goals are achieved over the long term (5 - 10 years and more) and through the combined efforts of

multiple programmes.

- **Objective** - Specific, operationalized statement detailing the desired accomplishment of the programme. A properly stated objective is action-oriented, starts with the word "to," and is followed by an action verb. Objectives address questions of "what" and "when," but not "why" or "how." Objectives are stated in terms of results to be achieved, not processes or activities to be performed.

2. *SMART Objectives*

S - Specificity
M - Measurability
A - Attainability
R - Relevance
T - Time

- *(S) Specificity* - Is it specific? Does it covers only one rather than multiple activities?
- (M) Measurability - Can it be measured or counted in some way?
- *(A) Attainability* - Is the objective actually doable? Can we achieve this goal?
- *(R) Relevance* - How important is this objective to the work that we are doing? How relevant is it to achieving our goal?
- *(T) Time* - Does the objective give a timeframe by when the objective will be achieved, or a timeframe during which the activity will occur?

3. *Developing Monitoring and Evaluation Questions*

Careful selection of the questions you want answered through monitoring and evaluation will greatly help you develop your M&E processes and work plan. At the outset of the planning process, programme managers should ask themselves where they want the programme to take them. Many of these questions will be reflected in the goals and objectives.

- Was the activity carried out as planned?
- Did it reach its target market?
- Did any changes in exposure to HIV infection result?
- How will the risk behaviours of the target population be affected?
- What sort of coverage do you expect to have?
- Did STI/HIV/TB incidence change? How much did it cost?

Selecting Indicators

Indicators are clues, signs, and markers as to how close we are to our path and how much things are changing. These point to or indicate possible changes in the situation that may lead to improved health status.

Examples of indicators for HIV programmes are:

- # VCT test provided in the past year
- # clinicians trained in syndromic management of STIs in the last 6 months
- % men who have sex with men reporting condom use
- # HIV-infected pregnant women started on ARVs

One of the critical steps in designing and conducting an M&E system is selecting the most appropriate indicators. Indicators should always be directly related to your project or programme objective, so the process of selecting indicators can be fairly straightforward if the programme objectives have been presented clearly and in terms that define the quantity, quality, and timeframe of a particular aspect of the programme (SMART).

Even with well-defined objectives, however, selecting evaluation indicators requires careful thought of both the theoretical and practical elements. The following questions can be helpful in selecting indicators:

- Have the definitions of the indicators been tested and can objectives be measured accurately (**operational**) and **reliably**?
- Will the indicators measure only what they are supposed to measure (**valid**)?
- Are there areas of overlap in the content of the indicator with that of other indicators; is it **specific**, or is it too general?
- Will the indicators be able to measure changes over time (**sensitivity**)?
- What resources (human and financial) do the indicators require? (**affordable, feasible**)
- Are there alternative measures that should be considered?
- Will multiple indicators be able to help clarify the results of the primary objective?

Selecting indicators and setting targets is usually done during programme planning, preferably with input from the implementing agency and key stakeholders. To establish benchmarks (i.e., items or amounts to measure) and activities that are measured as either done or not done (e.g., # regional meetings held, final report written) and that are realistic for the target population, resource allocation, and type of intervention, it is useful to refer to previous interventions done in similar settings.

Monitoring Methods and Tools

1. *Methods for Monitoring and Evaluation*

Quantitative Monitoring (measuring how much, how many, quantity) tends to document numbers associated with the programme, such as how many posters were distributed, how many were posted, how many counselling sessions were held, how many times a radio spot was on the air, how many truck drivers were trained as outreach workers and so on. It focuses on which and how often programme elements are being carried out. Quantitative monitoring tends to involve record-keeping and numerical counts. The activities in the project / programme timeline of activities should be closely examined to see what kinds of monitoring activities might be used to assess progress. The method for monitoring and its associated activities should be integrated into the project timeline.

Quantitative Methods are those that generally rely on structured or standardized approaches to collect and analyze numerical data. Almost any evaluation or research question can be investigated using quantitative methods because most phenomena can be measured numerically. Some common quantitative methods include the population census, population-based surveys, and standard components of health facility surveys, including a facility census, provider interviews, provider-client observations, and client exit interviews.

Qualitative Monitoring (quality; qualitative) answers questions about how well the programme elements are being carried out. Includes questions on topics like: changes in people's attitudes toward abstinence, stigma, care and support, or condoms; the influence of programme activities on real or incipient behaviour change; how information permeates the at-risk community; and so on. This type of information can also work as part of the feedback system.

Qualitative Methods are those that generally rely on a variety of semi-structured or open-ended methods to produce in-depth, descriptive information. Some common qualitative methods include focus group discussions and in-depth interviews.

It is possible to use both quantitative methods and qualitative methods in a complementary

way to investigate the same phenomenon:

- One might use open-ended, exploratory (qualitative) methods to investigate what issues are most important and to decide what language to use in a structured questionnaire.
- Alternatively, one might implement a survey and find unusual results that cannot be explained by the survey, but that might be better explained through open-ended focus group discussions
- or in-depth interviews with a subgroup of survey respondents.

2. *Tools for Monitoring and Evaluation*

Whereas a **method** refers to the scientific design or approach to a monitoring, evaluation, or research activity, a data collection **tool** refers to the instrument used to record the information that will be gathered through a particular method.

- Tools are central to quantitative data collection because quantitative methods rely on structured, standardized instruments like questionnaires. Tools (such as open-ended questionnaires or checklists) are often also used in qualitative data collection as a way to guide relatively standardized implementation of a qualitative method.
- Tools may be used or administered by programme staff or may be self-administered (meaning that the programme participant or client fills in the answers on the tool). If tools are to be self-administered, there should be procedures in place to collect the data from clients who are illiterate. Space, privacy, and confidentiality should be observed.

Some common *quantitative* M&E tools include:

- Sign-in (registration) logs
- Registration (enrolment, intake) forms; checklists
- Programme activity forms
- Logs and tally sheets
- Patient charts

Examples of qualitative M&E tools include: Focus group discussion guide / direct observation checklist in-depth interview guide, surveys.

Monitoring and Evaluation Work Plan Overview and Introduction

Why Develop an M&E Work Plan?

- Show how goals/objectives are related to results
- Describe how objectives will be achieved / measured
- Identify data needs
- Define how the data will be collected and analyzed
- Describe how results will be used
- Anticipate resources needed for M&E
- Show stakeholders how program will be accountable

The content and organization of an M&E work plan are flexible. They should be appropriate for the level (e.g., province, district, community, or AIDS Council) and the programme areas.

4.7 Report Writing

Overview Adapted from: Government of Tanzania (MoH): Training Manuals for HIV and AIDS Committees at Local Government Authorities (2009)

Purpose

To enable AIDS Councils to get relevant information, record lessons learned and summarize "good practices".

When to use

Reports should be written when feedback is requested.

Stetting - Individual work

Facilities and materials - Paper and pen

Description

Reports are requested for various reasons such as a requirement of law, a requirement of our job description, a requirement by donors or financiers of our activities etc. The main aim of report writing is to give feedback to those who assigned us a job or gave us resources to implement a particular projects. Reports are used for information, documentation or control to ensure that things are done the way they should be done.

How to proceed

➧ **Step 1**: Title and how it should be

A title is the heading of the report. It gives information about what is inside the report. A title should be short, clear and unambiguous. The title should be consistent with the content of the report.

➧ **Step 2**: Table of contents

A table of contents is a list of the major items that are inside a report. It helps readers to quickly and easily find where a particular item is found in a report. Tables of contents make reports more reader-friendly. The major items in a report are normally presented in topics and sub-topics and the page(s) in which these appear are shown. Besides, the major topics and sub-topics such things like foreword, acknowledgement, appendices, list of tables, list of abbreviations and references / bibliography should also appear in the table of contents.

➧ **Step 3**: Acknowledgements

Acknowledgements in reports are words of appreciation the author(s) give to all those who made the accomplishment of the projects and activities possible. It is a way of appreciation and recognizing their very valuable inputs and participation in preparing the reports.

➧ **Step 4**: Executive summary

An executive summary is a precise and brief description of the whole report and the context / background to which the report is written. It is a condensed presentation of the major contents in a report or simply a summary of the contents. It helps the readers to get a general and concise picture of what is being reported. It should be kept in mind that some people are very busy and may not

have time to read long reports word-by-word or page-by-page. These people can get highlights or insights of what is in the report by going through an executive summary.

"Often the executive summary is the only part of the report which is read"

- **Step 5**: Introduction

An introduction is like an eye opener for the reader about the topic being reported. It gives the first general but not detailed description of the topic. Therefore, when writing an introduction the first general but not detailed description should be presented. This requires good knowledge about the topic. The reader should be introduced to the report and to the problem or issue that initiated the work in the first place.

- **Step 6**: The "body" of a report

The body of a report contains all major issues related to the described project or initiative. These major issues are the approach with its goal and objectives, the methods used, the results achieved and the problems or lessons learned encountered.

- **Step 7**: Conclusion

A conclusion should be written in complete and concise paragraphs. The most important paragraphs must be written first. It should only be written what follows or comes from the work. The conclusion should only contain issues that have been discussed in the report and are anchored in project results or in the findings of a study. New ideas should not be introduced in this part of the report.

- **Step 8**: Recommendations

The author of a report gives his or her suggestion and opinions that are based on the issues that have been reported. Recommendations are like polite ways of instructing, ordering, counselling and consulting the practitioners on what should be done to make things better in the future.

Recommendations are needed. It is a way of digesting and synthesizing the issues presented in the report for policy or decision makers or simply to have the opportunity to share experiences made with others.

- **Step 9**: Appendices

Appendices are attachments to a report. They are illustrations and supporting materials, documents and evidence for what has been represented in the report.

Characteristics of a good report

A good report has several characteristics as follows:

- Comprehensiveness
- Well-elaborated and concise executive summary
- Covering all major issues concerned
- Well written with no grammatical or spelling errors
- Having a logical flow and presentation of ideas and issues
- Well-designed layout and general organization (readable and appealing)

Contents of a good report

- Title
- Table of contents
- Acknowledgement(s)
- Executive summary
- Introduction
- The "body" or major issues
- Summary and conclusion
- Recommendations
- List of references (where applicable)

4.8 Patterns of innovation

Overview Adapted from: GIZ, Capacity WORKS, The management model for sustainable development (2009)

Purpose

This tool is designed to assess the innovative capacity of an organization and / or its network

When to use

Use for periodic review of the innovative capacity of the organization or its network

Stetting - For use either by individuals as a checklist, or as a procedure applied in a small group (up to 15 people)

Facilities and materials - Copies of the evaluation worksheets; flipchart and workshop materials

Note - *Requirements*: Sound knowledge of the culture, structures and resources of the organization / network
Limits of the tool: When working in a large group, make sure there is practical scope for evaluation of individual assessments

Description

From the perspective of the success factor "Learning and Innovation", every development cooperation project or network should ask itself how its own innovative capacity is to be rated. This question should be answered in relation to the following four criteria:

- Culture of innovation
- Strategy for innovation
- Resources for innovation
- Structure for innovation.

To assess the four criteria, three to four items should be rated in relation to each of them. The rated values range from 1 (strongly disagree) to 5 (strongly agree). The items listed below can of course be modified or adapted to a specific area of innovation. The results are then entered in a graphic. This produces a simple pattern of innovation (innovation diamond) that provides information on the innovative capability.

How to proceed

➡ **Step 1**: Discuss general points

When assessing the innovative capacity of a group, it is helpful in a first step to discuss the following general points in order to prepare for the more detailed rating:

- What is the culture of innovation like in the network / in the organisation?
- Is there a strategy for innovation?
- What resources are available for innovation?
- Are structures for innovation in place?

A general discussion of these points will usually help provide sharper focus for the subsequent assessment.

➡ **Step 2**: Rate the innovative capacity

In a second step the innovative capacity of the network is assessed by rating items in four categories (see the example of a completed table below).

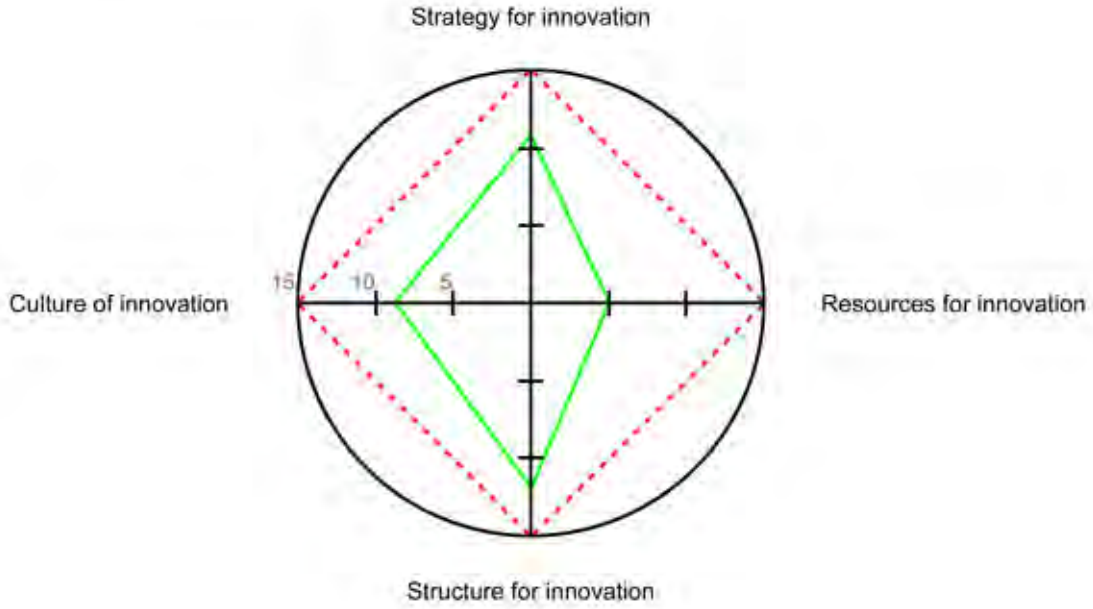
Criteria	Key Statements	Rating
Culture of innovation	Innovations enjoy high status within the value system of the organisation.	3
	A positive culture of mistakes is in place.	1
	There are concrete incentives to innovating thinking and action: acknowledgement, reward, promotion, etc.	4
		Total 8
Strategy for innovation	The thematic areas for innovation are clearly defined and communicated.	5
	Performance assessment and personnel development of the seconding organisation take innovation into account.	2
	Strategic and operative teams are selected on the basis of innovative capability and heterogeneity.	4
		Total 11

Resources for innovation	Funds for innovation are a fixed component of financial planning, the allocation of funds is transparent.	0
	Further training promotes the innovative capacities of staff members / network partners.	3
	Staff have access to external expertise and can be released.	2
		Total 5

Structure for innovation	Communication and coordination mechanisms are defined for innovative projects.	4
	Organisational learning is carefully promoted, there is scope for creative thinking.	4
	The experience of staff members is incorporated into innovative processes.	4
		Total 12

➡ **Step 3:** Interpret results

In a next step the rated values should be entered in the diagram below, and the results interpreted. Both the IDEAL innovative capacity of the project (red dotted lines) and the ACTUAL innovative capacity of the project (black unbroken lines) can then be visualised in the diagram.



Possible conclusions concerning the innovative capacity of the organisation or network:

Although the organisation / network would like to be innovative, as manifested in the innovative aspects of its strategy and structure, insufficient resources are being made available. This might also be the reason why the culture of innovation is weak, because although the project talks about innovation, it doesn't practice it, because that would mean incurring costs. This is fatal for the network partners, because innovation for them means having to make more effort, while motivation for creative thinking and action remains low.

➡ **Step 4**: Define development measures

Ultimately the aim is once again to determine whether measures can be identified to further develop the innovative capacity of the network, and if so what they would be.

4.9 Knowledge management

Overview Adapted from: GIZ, Capacity WORKS, The management model for sustainable development (2009)

Purpose

This tool is designed to help identify relevant experience and knowledge, and systematically manage it for later exchange with others.

When to use

Usually on occasions allowing structured retrospective analysis within the team.

Stetting - In a small group (4 to 8 persons).

Facilities and materials - Project documents and materials that make it easier to present key experiences.

Note - *Requirements*: It is important to focus on just one of two key lessons learned in the organization / project, and to describe these from the perspective of the later beneficiaries of the knowledge product.
Limits of the tool: As always in knowledge management, certain experiences cannot be transferred, on can only be transferred through direct personal contact.

Description

Learning and innovation are based on knowledge, actors' knowledge about themselves and their environment that is systematised and shared within an organisation. This knowledge arises at various points within a cooperation system, and is usually made available in the following condensed explicit form: strategy and concept, procedures and problem-solving, methods and instruments.

AIDS Councils are usually knowledge producers. Experiences and knowledge gained over

of period of time should be systematised, exchanged and disseminated. It should be discussed how knowledge could be stored (data base, best practice brochure etc.)

The table below provides an overview of the various forms of knowledge products.

Topic	Content	Examples
Description	All documents used for description of a project or initiative. Key question: How can we make our approach clear to other colleagues?	newsletter internet / database texts
Information and PR materials	All information and PR materials in the context of the products that may also be passed on to externals. Key question: How can we communi-cate our approach to those outside the AIDS Council	brochures posters, flyers films, presentations
Results	All documents that tell the reader something about the link between our work and the results achieved. Key question: Which good examples are there of the results of our projects	best practice document progress report (evaluation)
References	Links to lists of reference projects and / or materials on important projects: Key question: Which projects should be emphasised?	reference lists short descriptions (best practice)
Personnel and Partners	Documents on AIDS Council or external partners. Here, personal data protection regulations must be observed. Key question: What expertise can we mobilise?	terms of references description of roles and functions
Methods and Instruments	Documents that are methodologically relevant and contain information on methods and procedures. Key question: What has proven to be successful?	aids, handbooks, manuals, checklists, training materials
Lessons learned	All documents of the AIDS Council or other organisations containing information on lessons learned. Key question: What have we learned?	evaluation reports office reports

Knowledge management can serve two purposes: On the one hand it should feed the knowledge that has arisen within the project activities back into the organisation. On the other hand the project-specific lessons learned and knowledge are a driving force for learning and innovation within the network of the participating actors. In this second function know-

ledge management is part of organisational or project steering.

It responds to the following key questions:

- Which strategies and procedures have proven their worth in practice, and have contributed to effective and sustainable cooperation?
- Which knowledge will also be of benefit to the actors involved in the future?

It is the aim to identify, define and disseminate key knowledge together with the participating actors. In the process of cooperation the participating actors develop and apply a variety of knowledge, for example:

- A **strategy** (programme / project concept, guideline, rule, policy) that provides orientation and has proven effective and economically efficient.
- An **explanatory model** that helps us better understand, represent and interpret a situation or a constellation of interests.
- A **problem-solving path** that shows how a problem can gradually be solved.
- A **lesson learned** that shows how the project learned from its mistakes and how mistakes can be avoided in the future.
- A **description of a change process** in which the participating actors were able to negotiate their interests and achieve their objective.
- A **tool** or method that helps generate a response to a concrete question and leads to a tangible result.
- Methods for representing the **local knowledge** inherent in a social system.
- **Intuitive knowledge** created on the basis of personal experience or empathy.

In the case of **intuitive knowledge** (h) it becomes clear that a significant proportion of our knowledge is person-bound, and resides in our hearts and minds, which is to say it remains implicit knowledge (soft copies) that goes home with us in the evenings after work.

This kind of knowledge will remain with the organisation even if its premises go up in flames and burn down overnight. Explicit knowledge is documented knowledge that goes down on paper or other data storage media, where it remains available (hard copies). This knowledge stays inside the organisation, even though people may come and go.

It is important to select what will be helpful to us in the future. Useful knowledge products display the following features:

- They speed up and simplify procedures and are replicable, provided that they are adapted appropriately to the given context.
- They facilitate cooperation within the cooperation system and raise the performance capability of individual actors.
- They create access to external sources of knowledge, and condense externally acquired knowledge into a comprehensible form.
- They are presented simply, comprehensibly and concisely.
- They sharpen our awareness of unutilised potentials.
- They give the organisation a profile, for instance when dealing with other bilateral and multilateral agencies.

Knowledge management calls for simplicity and comprehensibility. Knowledge must be presented concisely and be to the point. Comprehensibility and transparency are supremely important. Text, images, graphics and concise stories facilitate exchange and dissemination.

How to proceed

Knowledge management is a task for all actors in the organisation. It therefore makes sense if members of the organisation ask themselves when conducting their annual planning which

knowledge is to be produced by whom. The most important guiding principle is simplicity. The complexity of a procedure becomes evident when it is applied. This is why any knowledge product must also include an offer of user support. Focused product oriented knowledge management involves four steps.

➡ **Step 1**: Identify areas to be looked at

AIDS Councils are supposed to reflect regularly on their work (through strategic controlling, monitoring and evaluation) in order to learn from their experiences. Within the scope of annual planning or the review of evaluations, the participating actors identify the areas to be monitored in which a knowledge product will be produced: Which issues and problems did we address last year? Where did we develop a solution that could also be useful to others?

⇨ Who might be interested in that?

➡ **Step 2**: Agree on inputs to planned knowledge management products

The participating actors draw up an open list and select those topics and sources that are to be produced. The key criteria for selection are:

- The possible benefits generated by the knowledge products, for instance as a result of their simplifying or speeding up a procedure.
- The distinctiveness and profile of the knowledge product, which make it exchangeable.
- The degree of innovation, which enhances the distinctiveness and profile of the product.
- The scope for user support.

➡ **Step 3**: Create inputs to knowledge products

Knowledge products are usually produced within a task force that is given a clear, limited-term mandate and the necessary resources. It is helpful if the members of the task force also include a future user. The task force should answer the following questions:

Product outline

- How did we go about answering the question about how the problem should be solved?
- What was especially helpful in that context?
- What were the success factors?
- Where were the stumbling blocks, where did we come up against hurdles?
- How did we overcome these?

Innovation

- What was new and unfamiliar about those solutions?
- Can we sum it up in a single sentence?

Presentation

- How can we present the knowledge product simply, concisely and comprehensibly?
- The presentation should display the following features:
  - benefit of the knowledge product to a user
  - clear profile: The product answers a question.
  - catchy name for the product
  - innovative and future-oriented
  - logical, simple, comprehensible, practical
  - estimated cost of application
  - adaptability in different contexts
  - information on user support.

It has proved useful in practice for the task force after one or two meetings to prepare a

one-page outline that can then be discussed outside the task force. This consultation, especially with future users, provides the task force with important pointers for further steps to develop the knowledge product.

Title of the knowledge product	Brief description
Theme and context • What is this product for? • What does an interested individual need to know about the context?	
Description of content • How did we proceed? • With whom? • What minimum requirements must be met? • What stumbling blocks or risks should people look out for?	
Benefits and results • What results does the knowledge product achieve? • Who will find the knowledge product useful?	
Contact and support • Who is available to provide further information? • Who will support the users?	

➡ **Step 4**: Exchange and disseminate knowledge products

The products can now be exchanged and disseminated through various channels:

- via networks
- via internet and intranet platforms
- at fora, congresses and workshops
- as printed publications

User support is also useful because it provides important pointers for improving the knowledge product. The cycle from selection to application of the knowledge product can be closed by networking the users horizontally. This usually in turn opens up fresh avenues for the development of further knowledge products.

I am Themba and I represent the labour movement on this AIDS Council. The information we have received on how to run effective AIDS Councils is very useful. I am a member of this AIDS Council for the second term and I wish we had this information for our previous term as an AIDS Council.!

Those of you who served on the previous AIDS Council with me will all agree that the absence of or inadequacies in the operational issues we just discussed were the reasons why we were not as effective as we could have been.

I think we all agree that, with the information we now have, our AIDS Council will function at a higher standard than we did in the previous term. In fact, I think we should encourage members to use the same information to strengthen the sectors and organisations we belong to.

Thank you Themba and all other members for your contributions thus far. We have now conducted our Self Assessment using the tool provided and we know where we are lacking as an AIDS Council. We have the **Quality Assurance Manual**, the **Resource Book** and skilled professionals like Sophie and all other members.

I think we can all agree that this time around, we are better equipped t turn our AIDS Council into a model of good practice. I can tell, from the enthusiasm on all your faces, that our AIDS Council will manage HIV and TB in a manner that will make those we represent and / or serve proud of us! I am looking forward to a fruitful and rewarding term of office for this AIDS Council.

Remember that, should we get stuck along the way or experience challenges we cannot handle, the District, Provincial and National AIDS Councils are all available to assist us.

Interesting links and references

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